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Revolutionizing Ambulatory Care: Rapid Access and Financial Sustainability

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Executive Director
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Medical Director / Vice Chair

Children's HealthSystem

1

Disclosure

No Conflict of Interests to Disclose

We are however heavy coffee drinkers, so we apologize if we overwhelm with our awesomeness.

2

Yale New Haven Children's Hospital – About Us



209 Beds

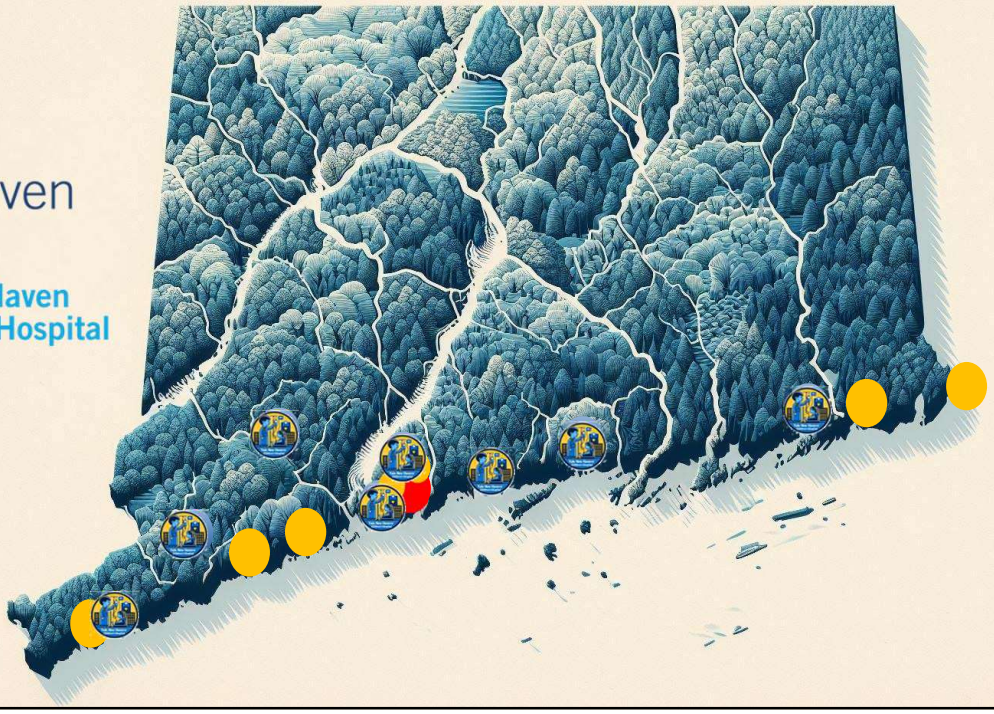
12 Ambulatory Care Sites
8 Regional Specialty Centers
>300,000 annual ambulatory visits

Magnet Designated

Teaching Hospital
Yale University

3

Yale NewHaven Health
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The 8 Moves That Changed Our Game

- **Strategic Leadership & Governance Alignment**
- **Standardized Templates & FTE Model**
- **Digital Patient Access Enablement**
- **Data & Reporting Foundation (Epic Grouper)**
- **Demand–Supply & Workforce Planning**
- **Care Team Optimization & Revenue Integrity**
- **Capacity & Community Engagement**

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Standards With Teeth

How we stopped debating and started doing

C-Suite & Board Buy-In First – Secured enterprise approval from executives and department chairs before any operational changes.

Backbone for Bold Moves – Their commitment enabled coordinated shifts in provider hours, locations, and scheduling templates.

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Think Big. Grow Smart.

Where strategy meets sustainability

Smart Growth, By Design — Use a Mission–Margin matrix to prioritize specialties for investment; stack-rank by demand, access gaps, and contribution margin.

Strategic Playbook 3 → 5-Year — Standardize how programs grow: quick wins, year-by-year milestones, and triggers for recruitment, space, and capital.

Program Development Committee — One intake & governance lane to vet, and fast-track proposals.

Grow / Sustain / Grow-to-Demand — Clearly delineate programs: scale high-impact lines, sustain core services, and expand others in step with referral volume

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⏱ Time, Tamed

240-minute sessions that print capacity

	Dept		Time	Openings
1p	PED CARDIOGY	1	1:00 p	
2p		1	2:00 p	Unavailable - Freeze (OFFICE APPROVAL ONLY)
3p		1	3:00 p	
4p		0	4:00 p	

Dept		Time	Openings
PED CARDIOGY	1	8:00 a	
	1	8:40 a	
	1	9:20 a	
	1	10:00 a	
	1	10:40 a	
	1	11:20 a	
PED CARDIOGY	1	1:00 p	
	1	1:40 p	
	1	2:20 p	
	1	3:00 p	
	1	3:40 p	
	1	4:20 p	

Department Name	Avg Session Length
YNH SMILOW PEDI HEM ONC BMT	240
YNH PEDI RESPIRATORY	240
YNH PEDI NEUROLOGY	240
YNH PEDI RHEUMATOLOGY SERVICE	240
YNH PEDI GENDER NORWALK	240
YNH PEDI CARDIOLOGY	240
YNH PEDI GENDER NORWALK	240
YNH SMILOW PEDI HEM ONC COAG	240
YM PEDI ALLERGY IMMUNOLOGY SHAWS COVE	240
YNH PEDI GI	240
YNH SMILOW PEDIATRIC HEM/ONC	240
YNH PEDI NORWALK CARDIOLOGY	240
YNH PEDI NORWALK RHEUMATOLOGY	240
YNH SMILOW PEDI HEM ONC BMT	240
YNH PEDI CARDIOLOGY	240
YNH PEDI CARDIOLOGY	240
YNH PEDI RESPIRATORY	240
YNH PEDI NORWALK NEUROLOGY	240
YNH SMILOW PEDIATRIC HEM/ONC	240
YNH PEDI ALLERGY IMMUNOLOGY NORWALK	240
YNH PEDI RESPIRATORY	240
YNH OBGYN GEN ADOLES NORWALK	240
YNH PEDI RESPIRATORY	240
YNH SMILOW PEDIATRIC HEM/ONC	240

From drift to discipline — Locked sessions to **8–12** and **1–5**; ended late starts/early stops to convert time into capacity.

Template clean sweep — Retired old builds; **audited every active template** across ambulatory and set to the **240-minute standard** (tracked to the minute).

Leaders led the change — Section chiefs aligned teams; implemented for MDs, APRNs, and ancillary clinics to maximize room and staff utilization.

Metric we watch: Template adherence (% sessions at full 240)

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Split the Hour, Double the Power

Divisible visits + auto-release magic

- Standardize visit type
- New/Return percentage set at 30%
- Session limits & appointment divisibility
- Release of unused urgent and disease specific appointments

CURRENT		PROPOSED	
YNH PEDI GI - 2nd Tuesday			
8:10	Follow Up	8:00	Follow Up
8:30	Follow Up	8:20	Follow Up
8:50	New Patient	8:40	New Patient
9:20	IBD/Follow Up	9:00	
9:40	New Patient	9:20	IBD
10:10	IBD/Follow Up	9:40	New Patient
10:30	New Patient	10:00	
11:00	Follow Up	10:20	IBD
11:20	New Patient	10:40	New Patient
11:50	Follow Up	11:00	
12:10	Lunch	11:20	New Patient
12:30	Lunch	11:40	
13:00	Follow Up	12:00	
13:20	Follow Up	12:20	
13:40	Follow Up	12:40	
14:00	Follow Up	13:00	Follow Up
14:20	Follow Up	13:20	Follow Up
14:40	Follow Up	13:40	Follow Up
15:00	Follow Up	14:00	Follow Up
15:20	Follow Up	14:20	Follow Up
15:40	Follow Up	14:40	Follow Up
16:00	Follow Up	15:00	Follow Up
16:20	Follow Up	15:20	Follow Up
16:40	Follow Up	15:40	Follow Up
		16:00	Follow Up

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Tap. Book. Done.

If families can book flights, they can book specialty care

Universal Self-Scheduling

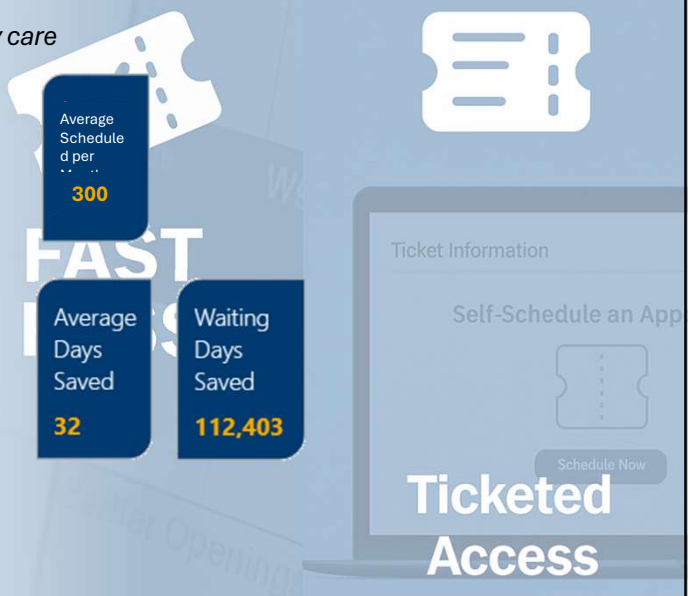
Every specialty is live with template-accurate scheduling; we QA for accuracy while freeing staff to handle complex calls instead of basic booking.

Fast Pass = Waitlist on Autopilot

Patients are auto-offered earlier openings: **3,000+ moved up**, **300+ years of wait time eliminated**, with **3% no-show** for these rescheduled visits.

Ticketed Access for Referral-Only Clinics

After a referral, families get a digital ticket to self-schedule online—no phone tag, no bottlenecks, same easy experience.



*Data is referenced from the past 12 months and only looks at new patients (**700 years** of waiting eliminated when including follow ups)

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One Ring of Truth

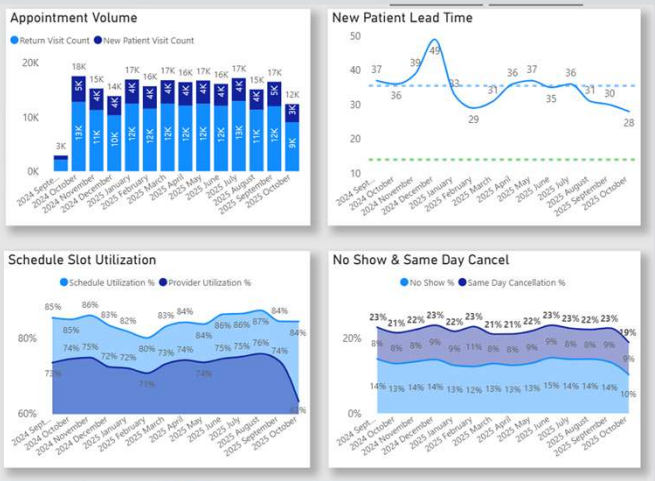
The grouper that stops data debates

Single Source, Zero Confusion – One Epic grouper defines every specialty—no more "who's in, who's out" arguments.

📐 $e = \sum_{n=0}^{\infty} \frac{1}{n}$ 🤓

Aligned Denominators = Aligned Decisions Everyone works from the same baseline, so reports match and conversations stay focused.





🖌️ **Cleaner Data, Faster Action –** Eliminates duplicate lists and conflicting reports, making performance reviews and planning friction-free.

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Recruit to the Math

Math that sets recruitment and space

Active cFTE			Recruitments		Utilization	RVUs		Supply		Demand			
MD	APP	Total	EBPC Approved Recruits	Incremental Monthly Vol	Estimated Unfilled Visits	Met Group RVU Benchmark	Incremental Monthly Vol	Active cFTE Supply	Projected Supply	New Pts Scheduled per Month	Return Pts Scheduled per Month	Demand	Projected Supply vs. Demand
4.6	-	4.6	2.4	431	55	Y	-	600	1,078	300	800	1,100	(22)
1.2	1.8	3.0		-	97	Y	-	300	383	21	470	491	(108)
0.9	2.0	2.9	1.8	305	31	Y	-	285	616	200	500	700	(84)
6.6	3.8	10.4	4.2	736.6	183			1,185	2,077	521	1,770	2,291	(214)

Growth Opportunity					Recommendation	
Growth Rate	Incremental Monthly Growth Vol	Excess Supply Supports Growth?	Monthly Volume to Achieve Growth	1.0 cFTE Monthly Volume	Recruitment Recommendation	Suggested Recruits
5%	55	N	77	18	No Recruitment Recommended	
2%	10	N	118	15	No Recruitment Recommended	
10%	70	N	154	17	No Recruitment Recommended	
6%	137	N	351	17	Consider Recruitment	2.1

- **Capacity by Calculation** – Monthly referral and new-patient slot data drive recruitment targets and space planning—no guesswork, just math.

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Let Pros Be Pros

Right work, right revenue

📈 **RVU Productivity Benchmarks for Physicians**

Apply standard RVU productivity percentiles across all specialties to ensure performance alignment.

Merit increases based on meeting RVU benchmarks

Section-based and physician-based incentives

			FY2026 60th%'ile Benchmarks		
Benchmark Specialty	YTD Staffed cFTE	YTD wRVU Actual	60th% (per 1.0FTE)	YTD wRVU Threshold 60%	Variance
Allergy	0.13	550	3,897	487	63
Allergy	0.23	1,263	3,897	877	386
Allergy	0.36	1,420	3,897	1,413	7
Allergy	0.50	2,144	3,897	1,949	195
Allergy	0.50	2,431	3,897	1,949	482
	1.71	7,807	-	6,674	1,133
Respiratory/Pulmonology	0.50	2,886	4,882	2,441	445
Respiratory/Pulmonology	0.43	2,299	4,882	2,075	224
Respiratory/Pulmonology	0.40	1,795	4,439	1,765	30
Respiratory/Pulmonology	0.14	1,216	4,439	610	606
Respiratory/Pulmonology	0.45	1,960	4,439	1,990	(31)
Respiratory/Pulmonology	0.08	506	4,439	296	210
Respiratory/Pulmonology	0.22	1,008	4,439	962	46
Respiratory/Pulmonology	0.24	1,335	4,882	1,159	175
	2.45	13,004	-	11,299	1,706

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Let Pros Be Pros

Right scope, right value, right impact

			80% of		70% of		60% of						
	YTD cFTE	YTD wRVUs Actual	MD Subspecialty Benchmark	Variance	MD Subspecialty Benchmark	Variance	MD Subspecialty Benchmark	Variance	YTD Salary per cFTE	RVU rate	YTD RVU payment	YTD Salary to RVU payment Variance	Breakeven to YTD Actual Variance
1690	0.42	1,211	3,118	(88)	2,728	75	2,338	237	56,836	59.4	71,955	15,119	255
8208	0.42	1,558	3,118	259	2,728	421	2,338	584	60,432	59.4	92,533	32,101	540
2015	0.42	1,175	3,118	(124)	2,728	38	2,338	201	57,356	59.4	69,799	12,442	209
	1.25	3,944		47		534		1021	174,625		234,286	59,661	1,004
8354	0.42	752	4,107	(960)	3,594	(746)	3,080	(532)	59,784	79.31	59,608	(177)	(2)
0819			4,107	0	3,594	0	3,080	0	-	92.12	-	0	0
	0.42	752		(960)		(746)		(532)	59,784		59,608	(177)	(2)
3787	0.04	262	3,174	130	2,777	146	2,380	163	6,131	53.50	14,006	7,875	147
1369	0.39	1,452	3,174	223	2,777	376	2,380	530	49,586	53.50	77,704	28,118	526
0177	0.25	1,170	3,174	364	2,777	465	2,380	565	39,733	53.50	62,616	22,884	428
8684	0.39	1,586	3,174	356	2,777	510	2,380	663	56,153	53.50	84,827	28,674	536
8521	0.12	469	3,174	99	2,777	145	2,380	191	15,294	53.50	25,092	9,797	183
8591	0.00	41	3,174	41	2,777	41	2,380	41	-	53.50	2,198	2,198	41
	1.38	5,621		1,231		1,780		2,329	166,897		266,443	99,547	1,861

APRNs at Full Scope – Ensured advanced practice nurses work to the top of their license.

80% of MD RVU benchmark, by subspecialty

APPs under one aligned management structure

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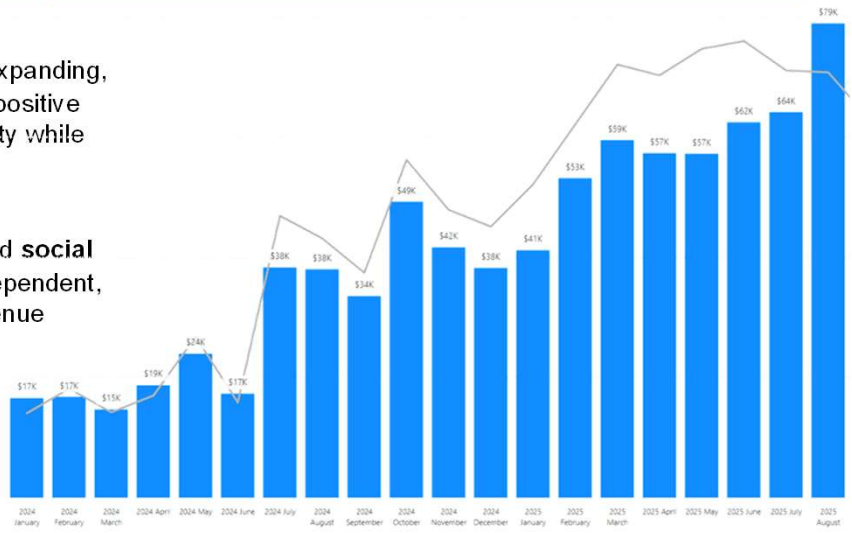
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Account for Care

Right service, right charge, right margin

Pair for Margin 📊 – When expanding, we pair net-loss specialties with net-positive ones to balance financial sustainability while delivering comprehensive care.

Bill Every Skill 🧠 – Converted **social work** and **dietitian** consults into independent, billable visits—unlocking hidden revenue streams.



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Care Where Kids Live

Smart space + loud launch = full schedules

Redistribute to Optimize – Reassigned provider locations and balanced volume across existing sites to maximize capacity.

Data-Driven Growth – Used patient origin and volume analytics to prioritize expansion and business planning.

Reality Check – Discovered more providers than available rooms, creating bottlenecks for patient access.

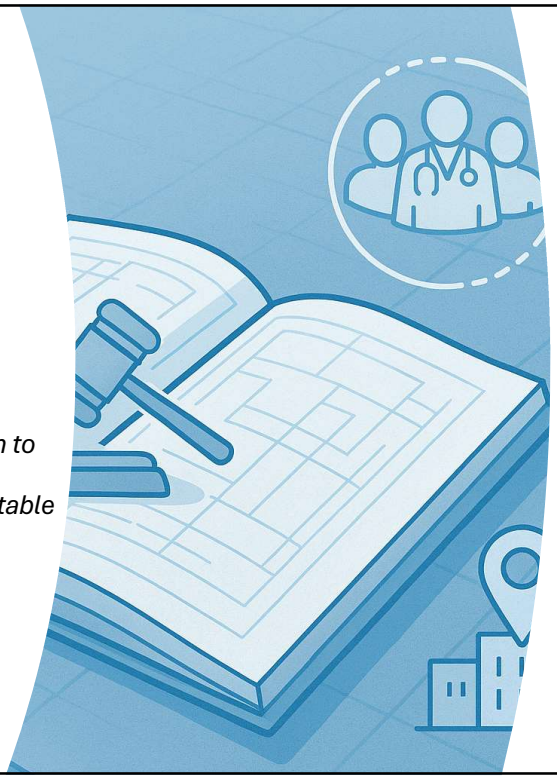
***Next Step:* Build Where Kids Live –** Expanding footprint by adding new sites and increasing exam rooms in high-demand regions.



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Steal This Playbook (Please)

A zero-excuses path to rapid access, real capacity, and repeatable results



🏛️ **Govern the standard**
Secure C-suite & Chair sign-off

📝 **Set a strategy**

📊 **One ring of truth for data**

🧩 **Make time a system - Engineer the hour**
240 minutes / Divisible visit lengths / auto release

👷 **Let pros be pros & fund the margin**
MD & APP RVU percentiles / pairing margin winners with others / redistribute to where kids live

📲 **Turn on digital access**
Let it do the work for you

➗ **Staff to the math**
Recruit to meet demand and retain your flow

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Thank You



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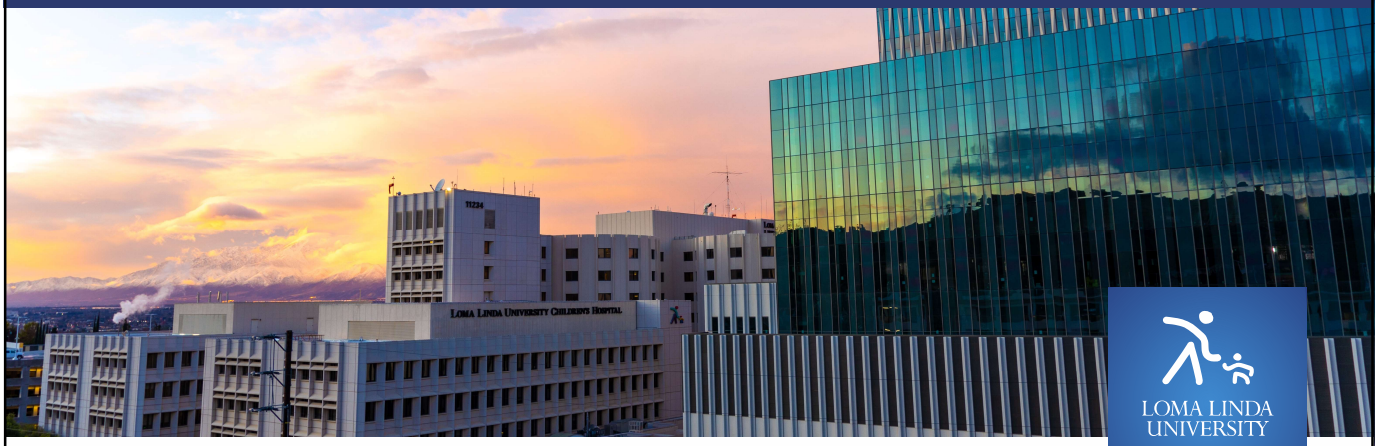
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Ambulatory Care Reimagined: Equity, Access, and Sustainable Innovation

Brett Walls MBA, FACHE, CUCMP, PMP
Silvinia Gonzalez Cuizon PhD, RN
03/10/2026



HEALING. HEALTHY. HAPPY.
A Seventh-day Adventist Organization

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Disclosure

- No financial disclosures
- No conflict of interest

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Learning Outcomes

- Understand the impact of geographical, social, and economic factors on health outcomes and access to care for children and families in Southern California
- Identify sustainable approaches for addressing barriers to ambulatory care
- Apply lessons learned from the Loma Linda University Children's Hospital ambulatory care model to other outpatient settings, focusing on innovative strategies to improve access, sustainability, and equity for diverse patient populations

Key Points

- About Us
- Voice of Patient
- Our Journey
- Social Drivers of Health (SDOH) Efforts
- New Building
- Next Steps

Who We Are

THE LEAPFROG GROUP TOP CHILDREN'S HOSPITAL 2025

Magnet Recognition Designated American Nurses Credentialing Center

PTAP Accredited American Nurses Credentialing Center

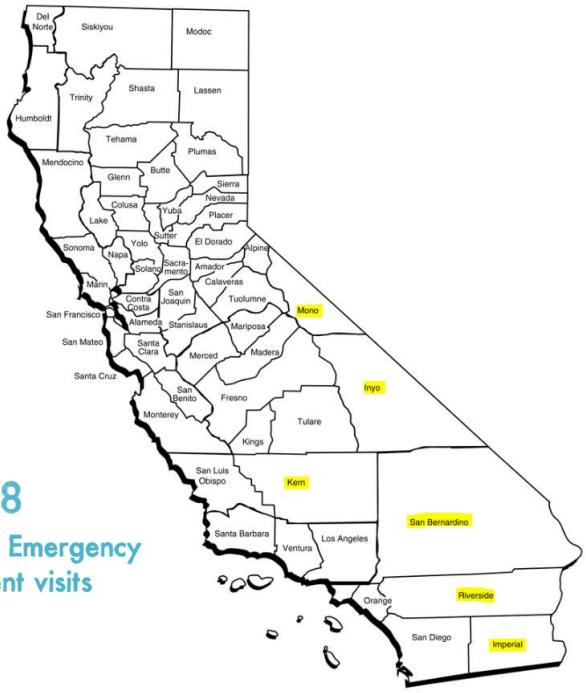
Serving **1.2 million** children in the region

17,629 inpatient visits

168,822 outpatient visits

18,000+ outpatients with complex medical conditions

59,538 Children's Emergency Department visits



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Flu Vaccination Rates for Fee-for-Service Medicare Enrollees are lower than the state average[1]



Life Expectancy[1] IN YEARS



4.7%	12.5%	39%
Unemployment Rate	Living below the Federal Poverty Line	Below Real Cost Measure

Air Quality Days per Year with Unhealthy Ozone Levels[30]



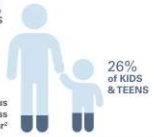
72,753 Children are estimated to have asthma in the Inland Empire[30]

1 IN 9 CALIFORNIANS LIVE IN THE INLAND EMPIRE



Inland Empire Population: **4.6** Million

Mental Health



Reported Serious Psychological Distress during Last Year[2]

Geographical Challenges

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The Heart of Our Mission



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Community Voice

Food Deserts
"And actually [our] communities are like food deserts. Everyone drives to go get their food. Nothing is nearby."

Housing Instability
"The lack of affordable housing. And obviously, in the state of California and Southern California, the definition of affordable continues to shift."

Financial Strain
"The cost it's very high and you work but it's not enough, so it's either you don't pay rent or eat right?"

Food Insecurity
"Access to healthy food and nutrition is not prioritized in this country, let alone this region. So that's an issue when the foods on the shelf are not as healthy as they should be and they are not as affordable as they should be."

Healthcare Workforce Shortage
"The lack of physicians and specialists creates a major barrier to accessing timely and effective healthcare services."

Transportation Barriers
"Many people who are in the community have no way of going to a clinic or hospital and sometimes rely on public transport. But public transport takes too long..."

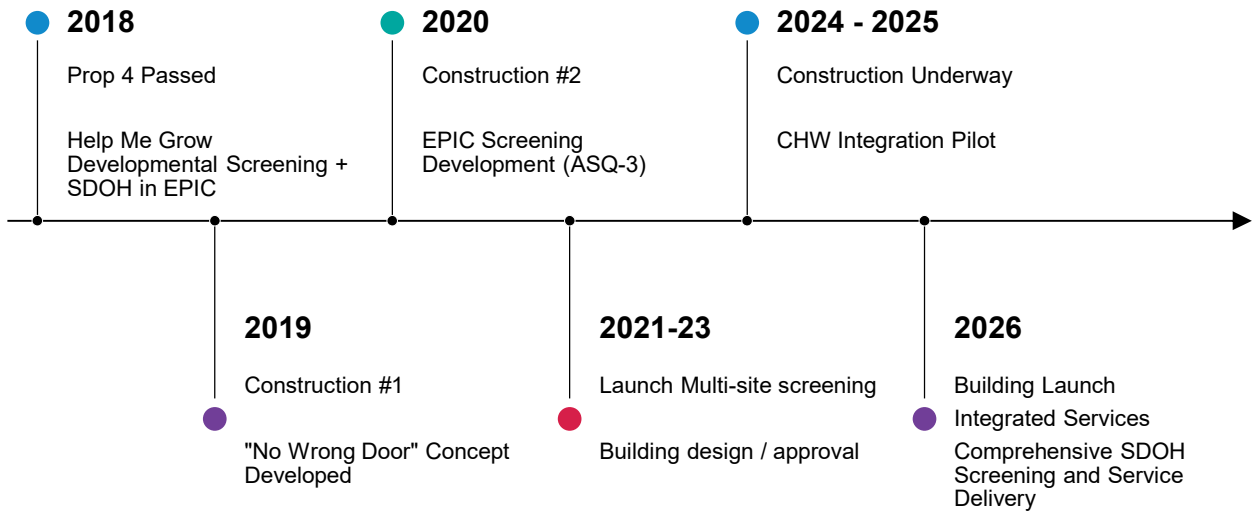
Authorization Barriers
"They give me an appointment, right? Then the doctor approves me, and then oh no wait, this one place where the doctor sends you, is not correct. So, what one does is talk on the phone for a thousand hours, only English... they backtrack that authorization and you waste a year getting an MRI..."

Appointment Scheduling Challenges
That's one of the problems that I have here, there's not even a sidewalk. So, when it rains, it pours. [When] the kids are going to the school, they have to walk in front of the cars to go to their school."

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Our Journey



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SDOH Screening

By The Numbers

SDOH Questionnaires Completed

20,226

Patients with Social Risk

20%

Number of Social Risk Factors

- 1 risk identified – 51%
- 2 risks identified - 23%
- 3 risks identified -15%
- 4 risk identified -8%
- 5 risk identified -3%

SDOH Resources

16,055

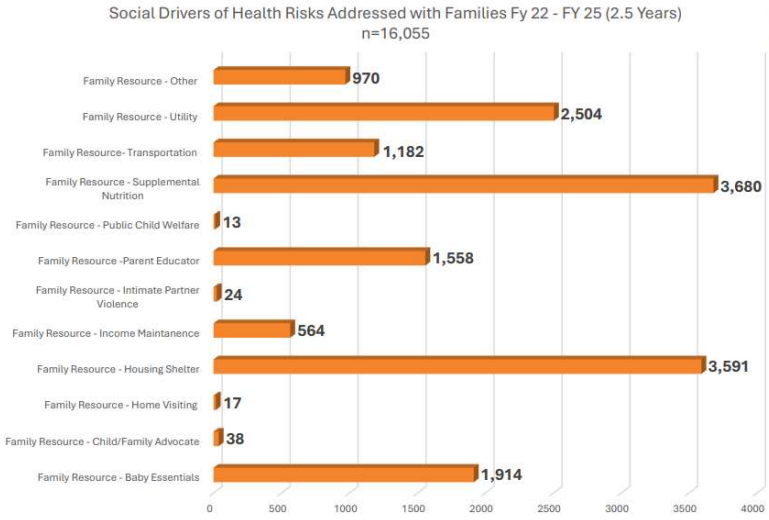
Resources provided by Help Me Grow Inland Empire in 2.5 years

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Families Served: Social Resources Provided

What family needs did HMGIE address and resource?

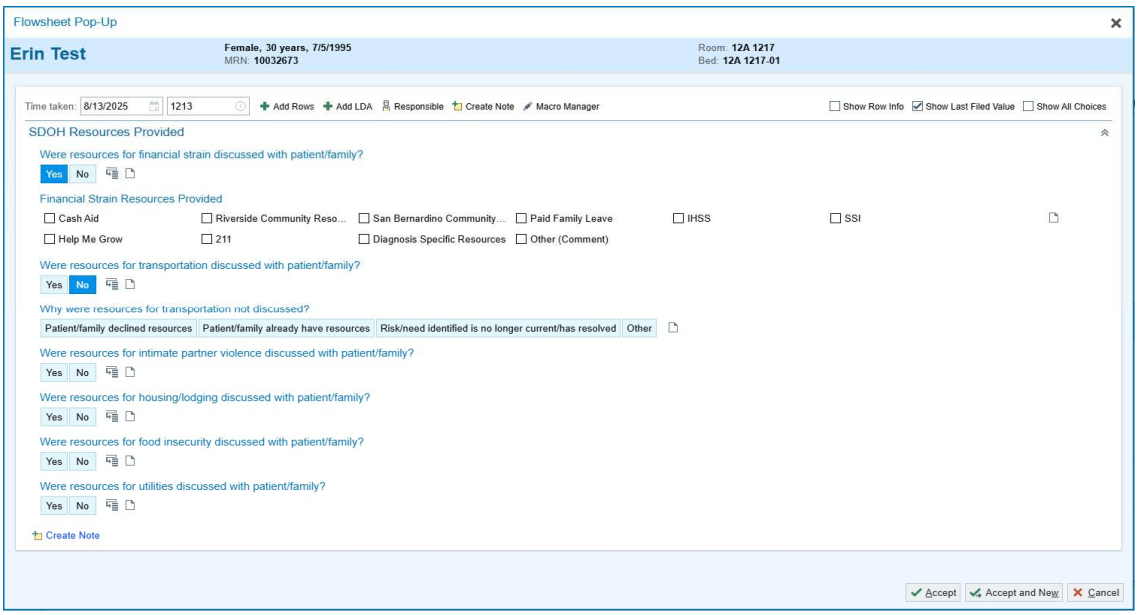


The most frequently resourced family needs:

1. Supplemental nutrition or food assistance
2. Housing/Shelter
3. Utilities
4. Baby Essentials: formula, diapers, and supplies.

Children referred for developmental or care coordination typically also have one social risk associated in the referral or orders. HMGIE coordinators often identify additional risks and resource needs during service engagements with families.

SDOH Resource Tracking: Epic Workflow Build



1. Reimagining Access and Efficiency

- Refreshing Epic scheduling templates to streamline access and delivery
- Integrating all visit types for a smoother staff and family experience

2. Driving Systemwide Integration

- Aligning medicine and surgical services under one scheduling model
- Promoting shared ownership, clarity, and accountability across teams

3. Centering Equity and Family Experience

- Grounded in equity, compassion, and respect for families' time
- Consolidating multidisciplinary visits to reduce access barrier

4. Building the Future of Coordinated Care

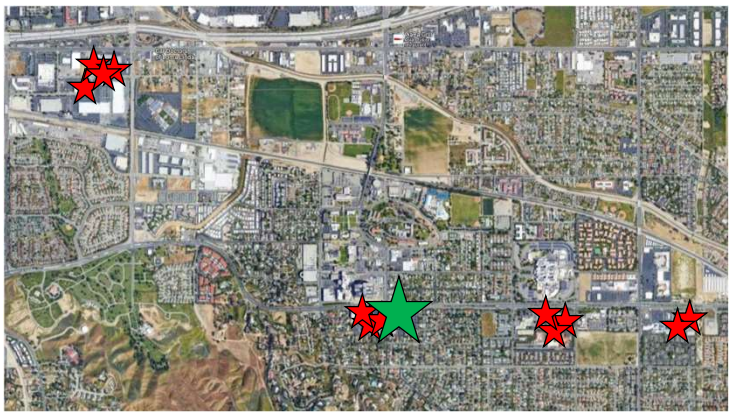
- Homegrown innovation for integrated, patient-centered design
- Using technology creatively to meet real-world care needs

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Genesis of the New Building





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Loma Linda University Children's Health Specialty Clinics



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Next Steps in LLUCH Ambulatory Care

01

Integration in Clinics

- Embed Community Health Workers (CHWs) in LLUCH ambulatory sites.
- Establish workflows for coordination between CHWs and clinical teams.

02

Referral and Coordination

- Strengthen referral pathways between LLUCH clinics and Help Me Grow
- Develop feedback loops to confirm connection to community services.

03

Evaluation and Sustainability

- Monitor referral completion and CHW engagement outcomes.
- Track metrics in the equity dashboard for ongoing performance review.
- Identify long-term funding and staffing models for CHW integration.

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