



Scaling Enterprise Access
AMGA Virtual Executive Roundtable Summary
April 28, 2026

The AMGA Hospital & Health System Advisory Committee convened physician executives and health system leaders to discuss strategies for scaling enterprise access—with a focus on how large, decentralized health systems can drive a customer-centric care model by reducing patient friction and building hybrid primary care capacity. The session was led by Sarah Gam, senior vice president and president of clinic operations, and Brett Butler, vice president of access services at Baylor Scott & White. Drawing on a two-and-a-half-year transformation journey at one of the nation's largest health systems, presenters shared governance frameworks, analytics tools, clinical FTE definitions, and partnership models—followed by open discussion among participants representing large multispecialty and academic health system groups.

Key Themes & Takeaways

1. Governance as the Foundation

- Governance scales access. Without it, well-intentioned teams make changes that quietly erode capacity—often going undetected until significant damage is done.
- Baylor Scott & White established a Medical Group Access Advisory Council—comprising regional CMOs, operators, and dyad leaders—to own visit type strategy, Epic build standards, and enterprise access expectations.
- Template access was locked down to a small, trained group, with an intentionally rigorous exception pathway. This level of control took approximately two years of framework-building to achieve; it was not possible on day one.
- Participants echoed the same challenge: how to enforce standards across decentralized, multispecialty systems without alienating physician leaders.

2. Infrastructure: Standards, Analytics, and the CAP Model

- Access standards were anchored in four core domains—schedule utilization, load leveling, session duration, and patient availability—with referral standards added: 80% scheduled at point of care, outreach within 48 hours, specialty appointments within 14 days.
- A custom access dashboard tracks the full lifecycle of provider time—from expected clinic hours to realized arrived visits—giving frontline managers and senior leaders a shared language for performance. A capacity estimator tool models template strategy against panel size, attrition, and acuity.
- The Clinic Access Partnership (CAP) model embeds an expert central team between clinic operators, call center, and physicians, filling coordination gaps that organizational structure typically leaves open. In one year, this team recovered more than one million hours of blocked template time and generated over 250,000 new patient appointments.
- Two targeted programs operate within the CAP model: Rapid Access Deployment (a one-week clinic-level SWAT process that produced a 10% improvement in arrived visits) and Schedule Optimization (a cross-enterprise specialty alignment effort focused on visit types and online scheduling pathways).



3. Reimagining Supply: Virtual Care and Hybrid Primary Care

- Baylor Scott & White is targeting 20% of physician volume as virtual (currently at 11%), with a structured hybrid model: Physicians block dedicated half- or full-day virtual sessions, freeing in-person slots and expanding capacity without adding capital.
- Digital quick care—asynchronous visits for chronic disease management—expanded from 15 to 31 eligible disease states, trending toward 50-plus. Adoption depends on deliberate patient education and care team retraining; the first virtual encounter is the hardest to achieve.
- Participants noted that virtual utilization has declined post-COVID at many systems, with patients defaulting to in-person. The solution is proactive outreach and care team activation—not building virtual capacity and waiting for it to fill.

4. Metrics, Panel, and Workforce Definitions

- North Star access metrics: 80% of new primary care patients seen within 7 days (currently averaging 70%); 80% of new specialty patients within 14 days. Leaders debated third-next-available versus lag time as the right measurement lens.
- Panel size standardization required an internal case study: Baylor Scott & White found roughly a dozen different panel approaches across their primary care enterprise before aligning on a risk-adjusted standard of approximately 1,600 patients, with an aspiration of 2.5 visits per patient per year.
- A consistent clinical FTE definition was established—a prerequisite for architecting supply. Established physicians are expected at 36 clinical hours per week above the 50th RVU percentile, with reduced hours and added admin time above the 80th percentile.

Outcomes Highlighted

- 1 million+ hours of blocked template time recovered by the CAP team in a single year; 250,000+ new patient appointments generated.
- 10% improvement in arrived visits at clinics completing the Rapid Access Deployment program.
- 13% reduction in no-show rates following standardized reminder cadence implementation.
- Digital quick care expanded from 15 to 31+ eligible disease states; virtual care volume tracking toward a 20% target.
- 80% of new primary care patients targeted for scheduling within 7 days (currently averaging 70%); 80% of new specialty patients within 14 days.

Overall Conclusion

Scaling enterprise access is not a technology or staffing problem alone—it is a governance and culture challenge. Baylor Scott & White’s two-and-a-half-year journey demonstrates that durable improvement requires a structured framework: locked-down governance, standardized expectations, embedded partnership teams, and shared analytics. Participants affirmed that the same barriers—exception creep, decentralized template control, and stalled virtual adoption—are widespread. Progress is achievable, but it requires patience and a willingness to build infrastructure before results materialize. AMGA members expressed continued interest in peer learning around governance sustainability, hybrid primary care models, and standardized access metrics.