ACM August Facilitation Webinar

New Patient On-Boarding Deep Dive

OHSU – Scappoose

What new patient on boarding work are you doing and what has the experience been like so far?

- Increased staffing and offering sat new patient appointment day. Experience been great, Saturday appointments have been a huge success. With the increase of staffing the training is always a big issue.

What are some early successes and challenges in this redesign effort?

- Increase in patient satisfaction, not only for new patients but for established. New patients are not having to wait 5-6 weeks for an appointment and already established patients could be seen sooner.
- One of the biggest challenges are our no-show rates have increased. This is not due to the redesign, it is a common challenge with longer new patient appointments.

What are key external and internal factors for success?

- Provider and staff availability for increased hours
- Scripting for front and back staff when scheduling appointments
- Establish work flows
- Establish protocols on appointment type

Share-out: Saturday visits for new patient appointments.

Seeing about 200 new patients a month once per month.

Patient receives a complete physical that lasts 1 hour. 10 minutes is spent with the provider (Medical Director) The result is increased access and patient satisfaction. Medical Director is pleased.

May extend to well-child check. Excess supply used for onboarding after long visit—2 new residents and one MD, plus some PAs. Not promoting outside of the clinic—callers informed about 5-6 week wait OR a Saturday appointment, which they're happy to choose.

Key questions/needs:

- How to lengthen follow-up time to create more access/slots
- More provider template standardization
- How do we have multiple team-members involved while avoiding duplicity?

Mosaic:

ACA expansion and new patient on-boarding:

Prior to January 2014- 6 months of assessment and community planning for expansion including clinics/organizations that accept Medicaid.

Mosaic approach

1. We did analytics to predict number of new patients per month over the first year that we would be able to see.
2. We assessed number of our uninsured patients would be eligible for Medicaid.
3. We worked with the OB/GYN group to streamline appropriate referrals to help with capacity and ability for the OB/GYN to handle the increase in Medicaid volume.
4. We continued to build our team construct to expand on BHC, pharmacist, nutrition, panel management, RNCC and team care assistant support.

January 2014:-Number of new Medicaid lives grows to double the expected number. Impact felt with both patients new to Mosaic as well as Mosaic patients newly insured by Medicaid.

Mosaic approach-

1. We held regular clinic manager meetings (from each site) with updated data on access from analytics team. Sites shared the shifting of work due to increased pressures in certain areas (referrals) and lessoning of pressures in other areas (ie medication assistance program)
2. Our largest clinic with largest population significantly increased new patient per day number. This became unsustainable and we reset the new patient number along with a couple other key changes in June. Key changes included hospital d/c new patients were routed to our Internal Medicine clinic and we re-instituted a no chronic controlled substance policy for new patients.
3. We have a locum pool of providers who helped with patient access.
4. We have a patient navigator role help new patients with paperwork and orientation to Mosaic services. Leads to more informed patients.
5. Our panel management pilot site implemented a chart prep/scrubbing workflow that significantly decreased provider time with data entry on new patients (as well as established patients).

Community approach

1. Our health system primary care had capacity for a large number of new Medicaid patients

2. Our volunteers in medicine (VIM) clinic changed their policies to allow their patients who were newly on Medicaid to continue seeking care with their providers until they had access to a new clinic.
3. The hospital is sharing data re: ER visits to help navigate patients to PCP's for non-emergent care.

Share-out:

Using 'Building Blocks' by Bodenheimer. One clinic with weekly or biweekly meetings. Volume way beyond prediction, so the team meetings are about adjusting/navigating.

Looking at both the supply and demand sides for the entire clinic. Community Health Workers can help out in different areas, if cross-trained—but reactive.

Patient navigator role leads to informed patients, but more work is needed to optimize role. Help with new paperwork and enrollment. Insurance—patients more savvy, leads to more fluid operations, even with longer first visit.

Data piece—new demand and access across team members. How to train, in terms of analytics? Mosaic hired two guys out of school with no health care experience. OHSU used summer interns to work on population health, and will also have entry level hire (but not forever). Need permanent position. Need to offload work for senior staff to engage more fully in analytics.

Key questions/needs:

- On the data piece, how do we balance between what we want and what we can afford?
- How to start thinking about 'patient overload'

<u>OHSU – Richmond:</u>

Work in process/barriers/factors to consider:

- Working to define scope and charter for this project; identified issues around how to meet needs of new pts with urgent medical needs.
- Define project team to consider how to use Walk In clinic as new pt access point. Thinking about how to implement a continuity clinic there, or best serve as an establishment site for pts wanting PCP. Scope and model issues to consider as the WI staffing model is "lean" with only MA and provider – no care coordination/fu support staff. No appointments scheduled and purely walk in for either preventive or urgent care.
- Currently implementing a revised No Show Policy to redirect frequent no showing pts to the WI clinic if a non-appt system better meets their needs or dismissing pts from the Richmond site after address barriers to coming to appts and freeing up access for new pts
- Currently making changes to providers' scheduling templates to decrease variability in appt lengths and provider preference
- Efficient onboarding is a major priority in our newly approved Strategic Plan

Share out: Walk-in clinic near their existing Richmond clinic.

For patients with immediate needs, as well as establishment. Richmond is where ongoing care is given—that it's the true medical home. Walk-in clinic very leanly staffed—just provider and MA with no supportive services. 18% no show at the other clinic, so instituting no policy:

- First time gets letter and phone call, second time gets warning and phone call, and then third time gets discharge. Going live September 1st, and walk-in clinic might be good alternative for repeat no-shows. Will also choose patients to make immune, based on complexity (and children). Three blocks away from Richmond—shares lobby with Cascadia Behavioral Health.

Key questions/needs:

- How are teams used to support the provider/patient relationship?

Multnomah County:

What new patient on boarding work are you doing and what has the experience been like so far?

- We have not implemented any long term changes in our practices at this point. We had a provider that piloted doing new intakes for PCP's to get them into our primary care practices, but that was a very difficult work flow and so we did not move forward with that strategy. We have had many discussions around how we could best do new patient onboarding that is customer friendly.

What are some early successes and challenges in this redesign effort?

- Our challenges are generally in having capacity in our provider schedules to add new patients, hence the reason why we have not been able to move forward robustly with a new patient initiative to get folks onboarded.

What are key external and internal factors for success?

- We are currently working on hiring new providers to create capacity and are working toward using nurses to do direct patient care through APM to help care for patients and add again capacity for our providers to see new patients in our clinics.

Share out: Nurses giving more direct care. Standardized templates, and built more slots into provider templates. First priority is expanding nurse care to follow-up visits. Not as many standing orders as they'd like, but that's changing. 40%--new patient slots on provider templates. Increasing panel sizes by 20% to an average of 1220 (adjusted for age and gender).

Virginia Garcia:

What new patient on boarding work are you doing and what has the experience been like so far?

1. Created Visual Management Tool and workflow for Call Center and Switchboard to use to determine which providers have open panels and numbers of new patients can be scheduled each day.
2. Piloting "Progressive Visits" at VGB.
    a. 5th PDSA was finally successful with high patient and team, including provider, satisfaction with the process.
    b. PV's: Patient arrives 15-20 min early, is checked in by front office, then roomed by MA (20 min), seen by RN or Clinical Pharmacist (20 min), then Provider (20 min).
    c. Team elicits patients agenda and asked him/her to call out the highest priority issue for the visit
    d. Clinical Pharmacist redesigned New Patient history form to match what is seen in EPIC.
3. Piloting sending outreach letters to patients recently assigned to VG and contacting those who have been in the hospital or ED in past week but never seen by us.

What are some early successes and challenges in this redesign effort?

1. Challenges
    a. RN training on taking history in efficient manner so patient does not have to repeat things twice
    b. Choreography of visit flow (late patients, provider or RN running behind)
    c. Complexity of patients
2. Successes
    a. Enthusiastic team
    b. Excellent support from Clinical Coordinators and Team Lead
    c. Most recent PDSA (5th) ran smoothly and got high praise from team and patients

What are key external and internal factors for success?

1. External
    a. Working with MCO's to get correct patient information, phone numbers and addresses, sending out welcome letters
2. Internal
    a. Staff understanding burning platform of need to establish new patients, those assigned to us by MCO's
    b. Site Leadership support and managing the work day-to-day

c. Creating a workflow that does not decrease provider and team satisfaction with the work

Share out: Was allowing 40 minutes for new adult visit, but are back to 20 minutes (with option for 40 minutes for second visit). Using a visual control tool to fill specific slots. Progressive visits: how to capture story in one shot? On fifth PDSA cycle. MA rooms the patient, RN or clinical pharmacist does history. RNs must be trained on how to capture history efficiently. Clinical pharmacist could be used when there are multiple meds. Provide additional support, and are on call. Patient orientation step—ask patients to show up 20 minutes prior to check-in to fill out forms, SBIRT screen, ROIs, etc.

Yakima Valley:

Share out: Outreach for new patients at three sites. Recreating new patient packets with in-depth view of services. In future will be working on intake visits with nurses.

Coastal:

Share out: New patient workflow. Proactive outreach, including a sports physical clinic to target young adults. Getting youth population in EHR for future outreach opportunities.