Enhanced Access: Extending Care Services 24 Hours/7 Days a Week

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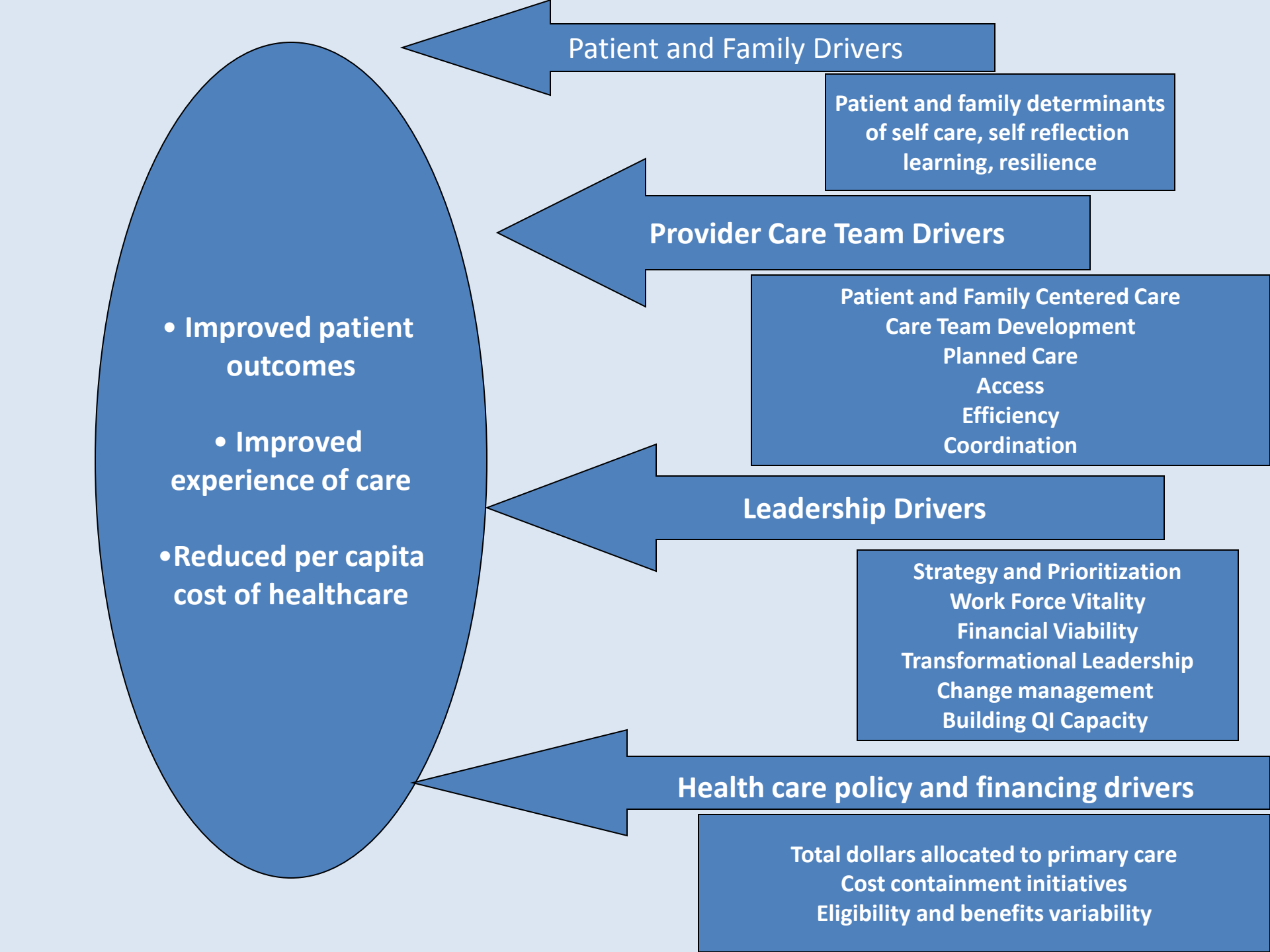
Enhanced Access

No access = no care


Patient and Family Drivers
Patient and family determinants of self care, self reflection learning, resilience
Provider Care Team Drivers
Patient and Family Centered Care
Care Team Development
Planned Care
Access
Efficiency
Coordination
Leadership Drivers
Strategy and Prioritization
Work Force Vitality
Financial Viability
Transformational Leadership
Change management
Building QI Capacity
Health care policy and financing drivers
Total dollars allocated to primary care
Cost containment initiatives
Eligibility and benefits variability
• Improved patient outcomes
• Improved experience of care
• Reduced per capita cost of healthcare

Cost of Poor Access

- Patients who face waits and delays will sometimes skip needed care
  - Lacy, N., Pullman, A. Reuter, M., Lovejoy, B. **Why we don't come: Patient perceptions on No-shows**. *Annals of Family Medicine* 2004;2:541-545.
- More access to primary care results in improved outcomes and reduced Medicare spending per beneficiary
  - Fisher ES, Wennberg DE, Stukel TA, et al. **The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care.** *Ann Intern Med.* 2003;138:273–287.

Continuity

- Medical assistance beneficiaries with longer tenure in a primary care practice had lower ER visits
  - Roby DH, Pourat N, Pirritano MJ, Vrungos SM, Dajee H, Castillo D, Kominski GF. Impact of patient-centered medical home assignment on emergency room visits among uninsured patients in a county health system. Medical Care Research and Review 2010 Aug;67(4):412-30. Epub 2010 Jun 2.

Addressing the Drivers

- Individual and family
- Care team
- Leadership
- Policy

Care Team

- Connect uninsured with benefits
- Reduce or eliminate barriers
- Improve continuity
- Extend hours of operation
- Extend modes of communication

Financial/Benefits

- Enrollment facilitation
  - New patient enrollment group
  - Separate new patient financial appointment
  - On site specialists

Reducing Barriers

- Reduce the complexity of the process: the number of steps and people involved in making an appointment
  - Simplified patient scheduling
  - Open/Advanced access

Continuity

- Empanelment
- Care team

PCMH Access Standard

- ***Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, email, or in-person visits.***
  - Evening and weekend hours
  - Urgent care clinic
  - 24/7 on call system

Expand Modes of Communication

- Patient portals
  - Secure email
  - Video/phone visits
  - Personal health records
- Barriers:
  - FFS financing
  - Technology costs




Developing the Capacity to Care for ***Our*** Patients

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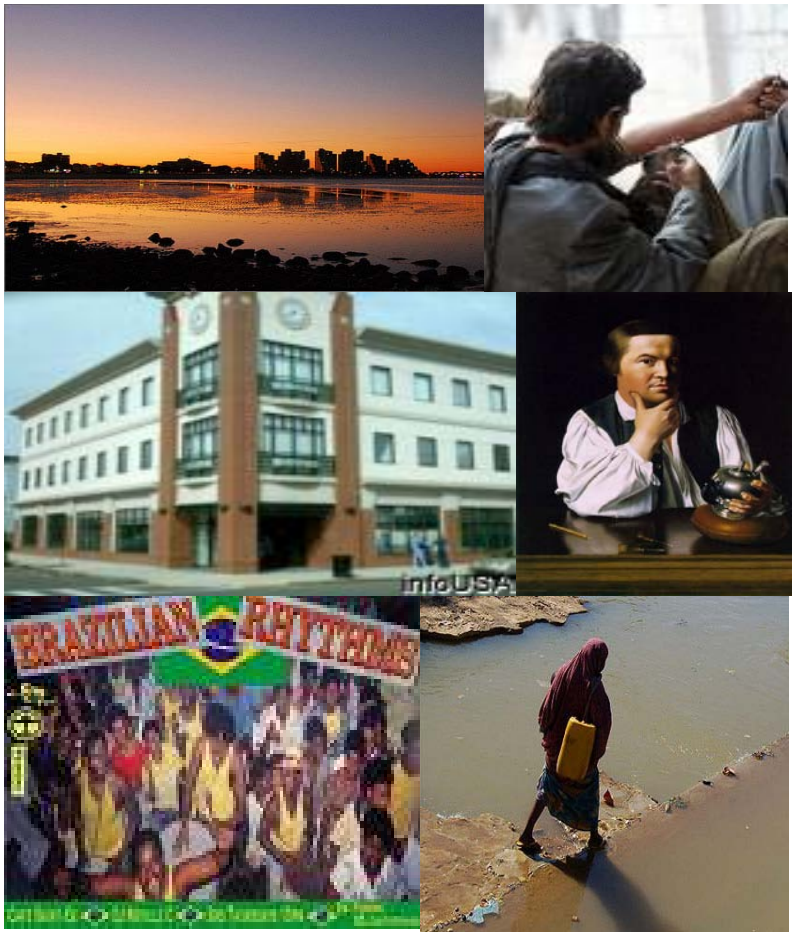
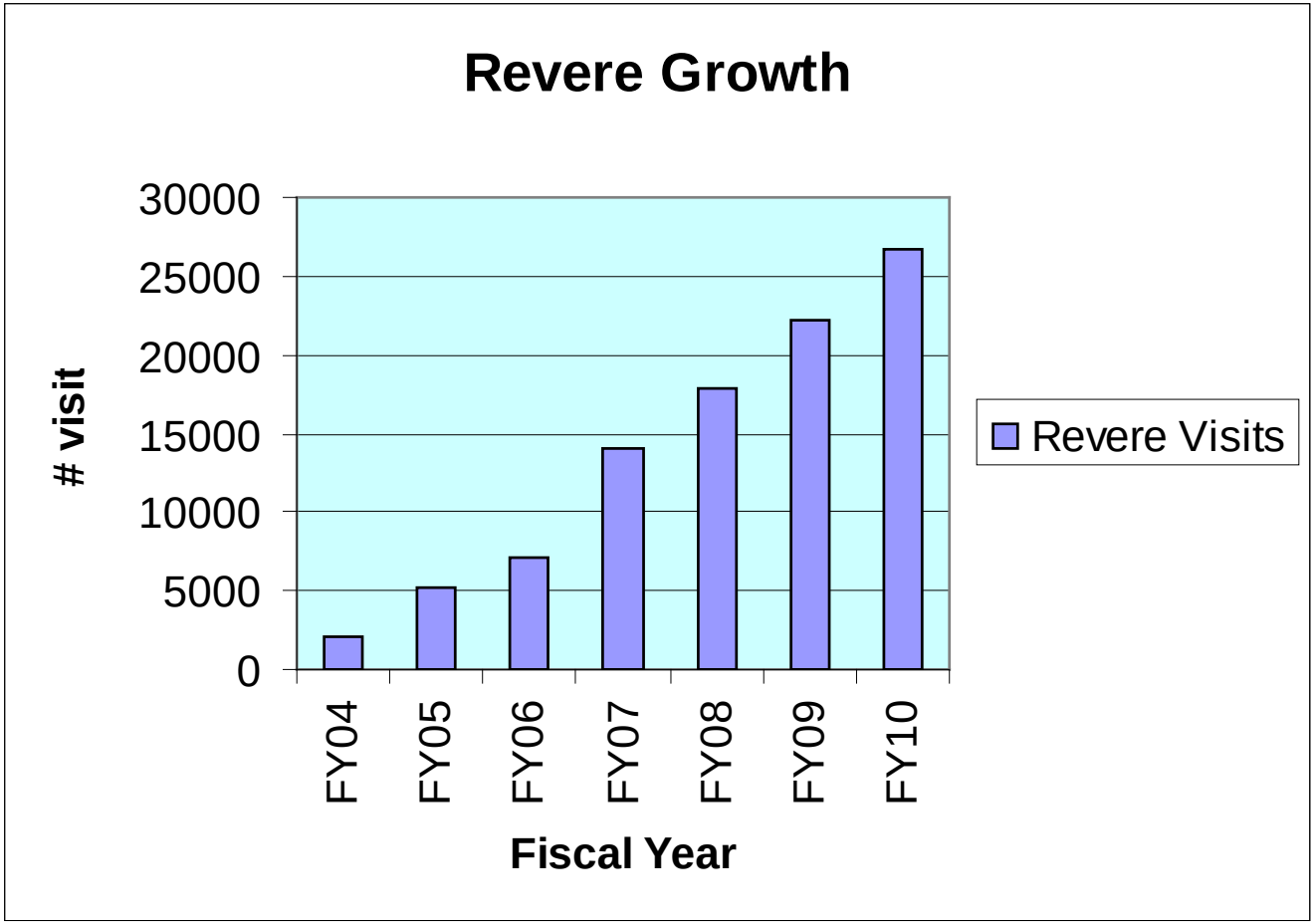
Co-Medical Director, CHA Revere Family Health Center
President of the Medical Staff, Cambridge Health Alliance
October 12, 2010

CHA Revere Family Health

- Started in 2004 to meet the needs of a high-risk, underserved community
- Started with a vision of providing outstanding, high quality patient-centered care
- Developed services to meet the needs of the community
- Full spectrum care for the whole family (primary care, OB-GYN, mental health)
- 27,000 visits/yr
- Part of an integrated, safety net health system (Cambridge Health Alliance).



Growth of the CHA Revere Family Health Center



Key paradigm shifts: “How can we care for all these patients?”

- “These are our patients”
- “This community is ours to take care of”
- “We need to care for these patients as a team across the clinic”

Early steps in Empanelment

- Developed a robust process of PCP assignment – training at all levels
- “No patient left behind”
- We are responsible for all the care our patients receive—and are responsible for all the patients listed on our panels, whether or not they have come in to see us.
- Proactive outreach to new patients assigned to us by insurer lists, new ED referrals, and new patients who don’t keep their initial appointment

Empanelment level

- 86-88% of patients assigned to a PCP have seen their PCP
- 92% have seen someone in our practice
- On average patients see their PCP at a visit 70% of the time.

Understanding our Capacity

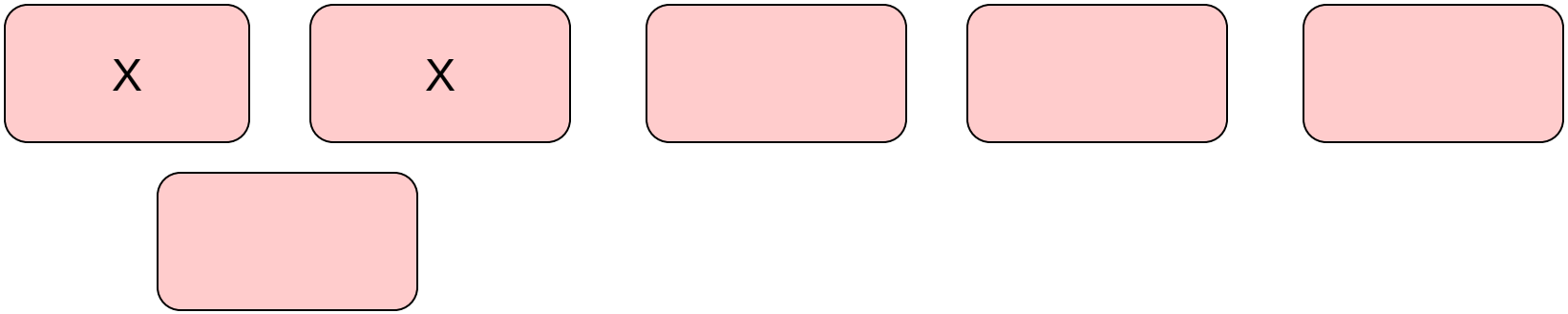
- How many patients do we have and who are they?
- How many patients do we have the capacity to absorb?
  - # providers/panel size
  - number of slots in the template
  - turnover of patients in the community
  - growth rate
  - amount of space in the building
  - what should our risk adjusted panel be?
- How can we grow our capacity without expanding #providers/space?

Growing Our Capacity → Increasing the efficiency of care for the patient

- Work as a team across care teams – shared model of care
- Having the right person providing the right care
- Increasing the efficiency of our scheduling so that more appointments actually led to care
- Make sure every visit met the patient's identified and preventative/disease management needs
- Shared medical appointments, bundling appointments
- Taking the care to the patient

A Local Experiment: “We Need to Reduce the No Show Rate”

- 25% no show rate among return visits
- 50% no show rate for new patients
- 90% new patients came from the emergency room



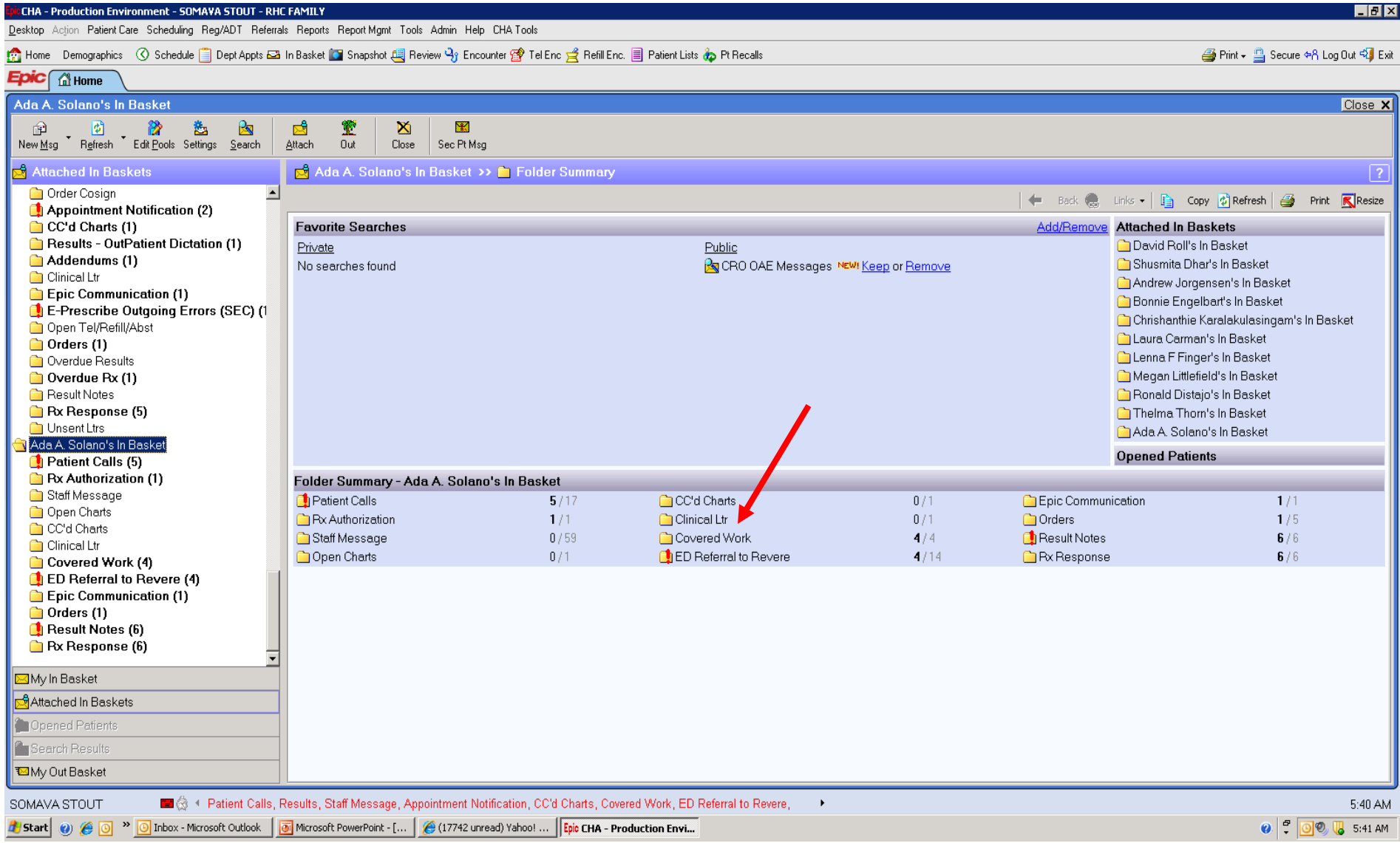
“Surely, if patients just knew about the appointments they would come”

- Appointment reminder letters 1 week before appointment
- Automated phone reminder system 1-2 days before appointment
- Personal phone calls to new pts
- 3 outreaches to all new patients who didn’t show

Net Impact: Reduced no-show rate by 1-2%. Why were patients not coming?

WE realized we needed to better understand the flow of our patients and the flow of the ED.

At the point of discharge from ED: making referral to primary care easier



Outreach Call to those who DNKAed

- 12/07: Outreach study of 84 patients who no showed in a week in December at the CHA Revere Family Health Center
  - 2-3 outreach attempts made to each pt with interpreter as needed
  - Goal was to identify barriers to appointment completion
  - Identified a number of system, agreement and cultural gaps which led to no shows.

Cultural gaps

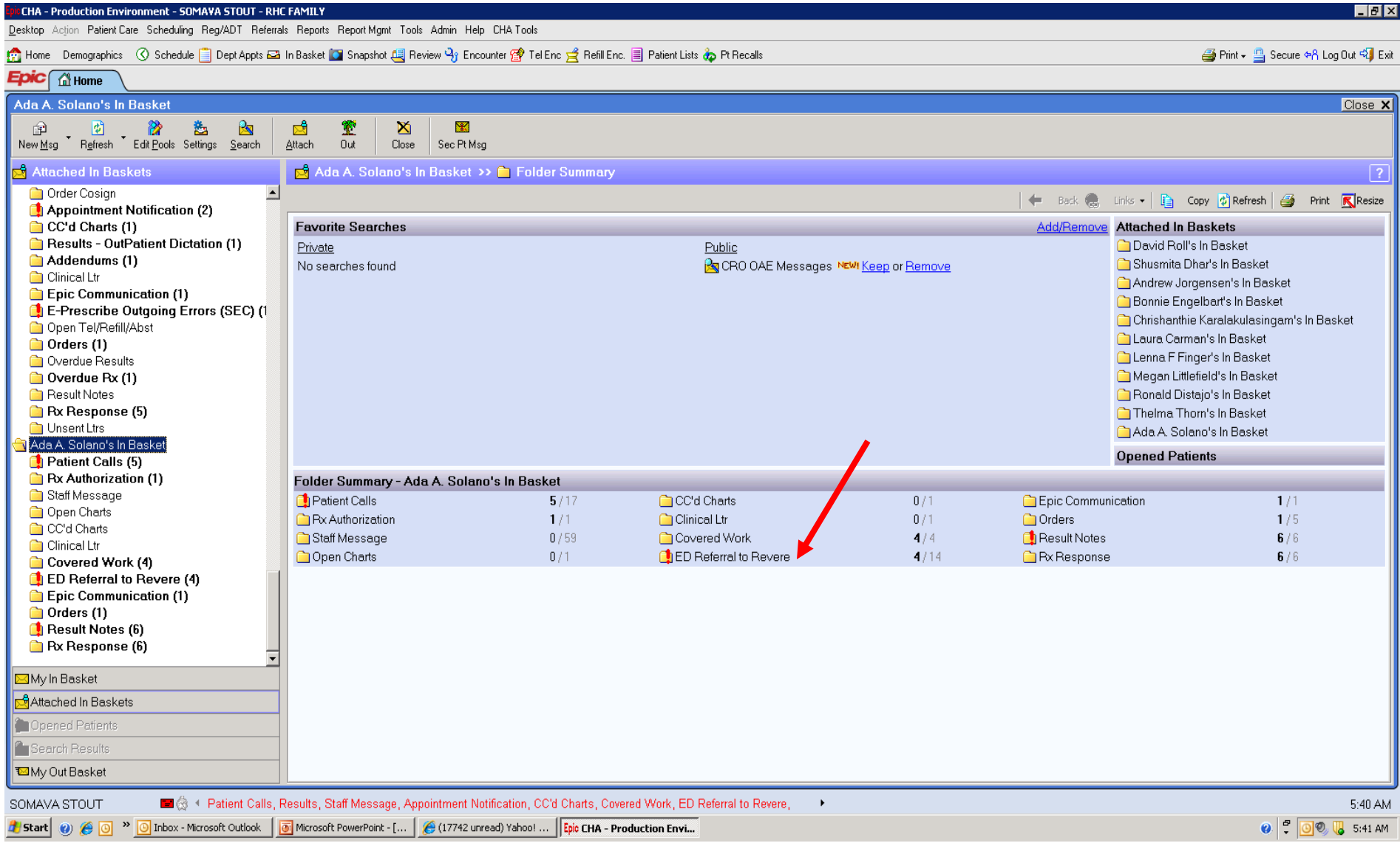
- Different understanding of what an appointment was and how it was meant to be used
- DNKA was a sin of omission (lesser evil), cancelling was a sin of commission
- While 25% of people DNKAed, an additional 25% of people cancelled their appointments within 24 hours.
- >50% of appts made were never completed ➔ rework, muda on part of pts and staff
- 67% of psychiatry appts were never completed

What does giving/having an appointment mean?

- Cultural construct
- Didn’t actually meet the needs of our patients the majority of the time
- Created huge amount of wasted work
- “Aha”: Having an appointment is not the same as receiving care

➔ How do we improve the number of people who are receiving ***care***?

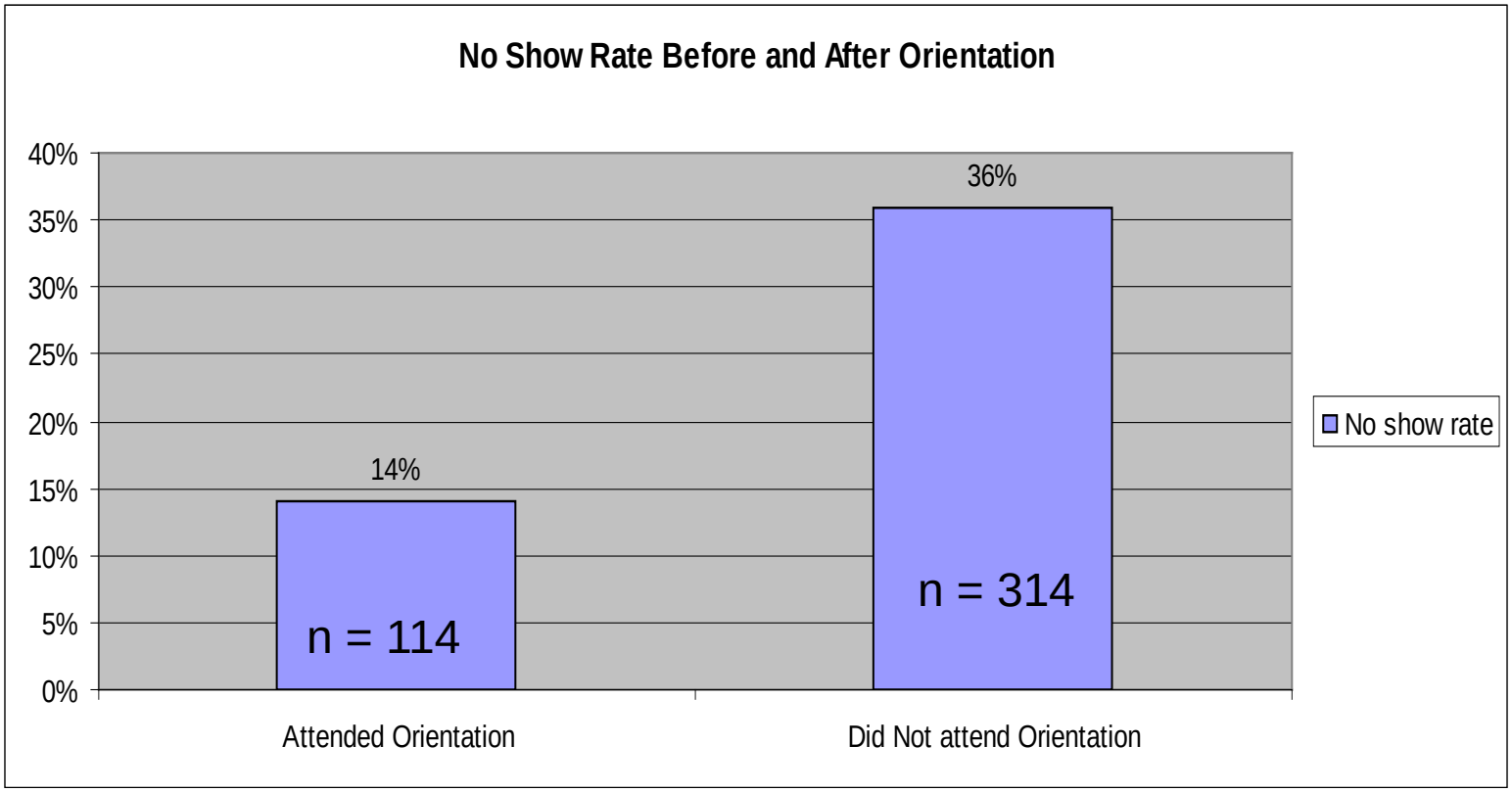
At the point of discharge from ED: making referral to primary care easier



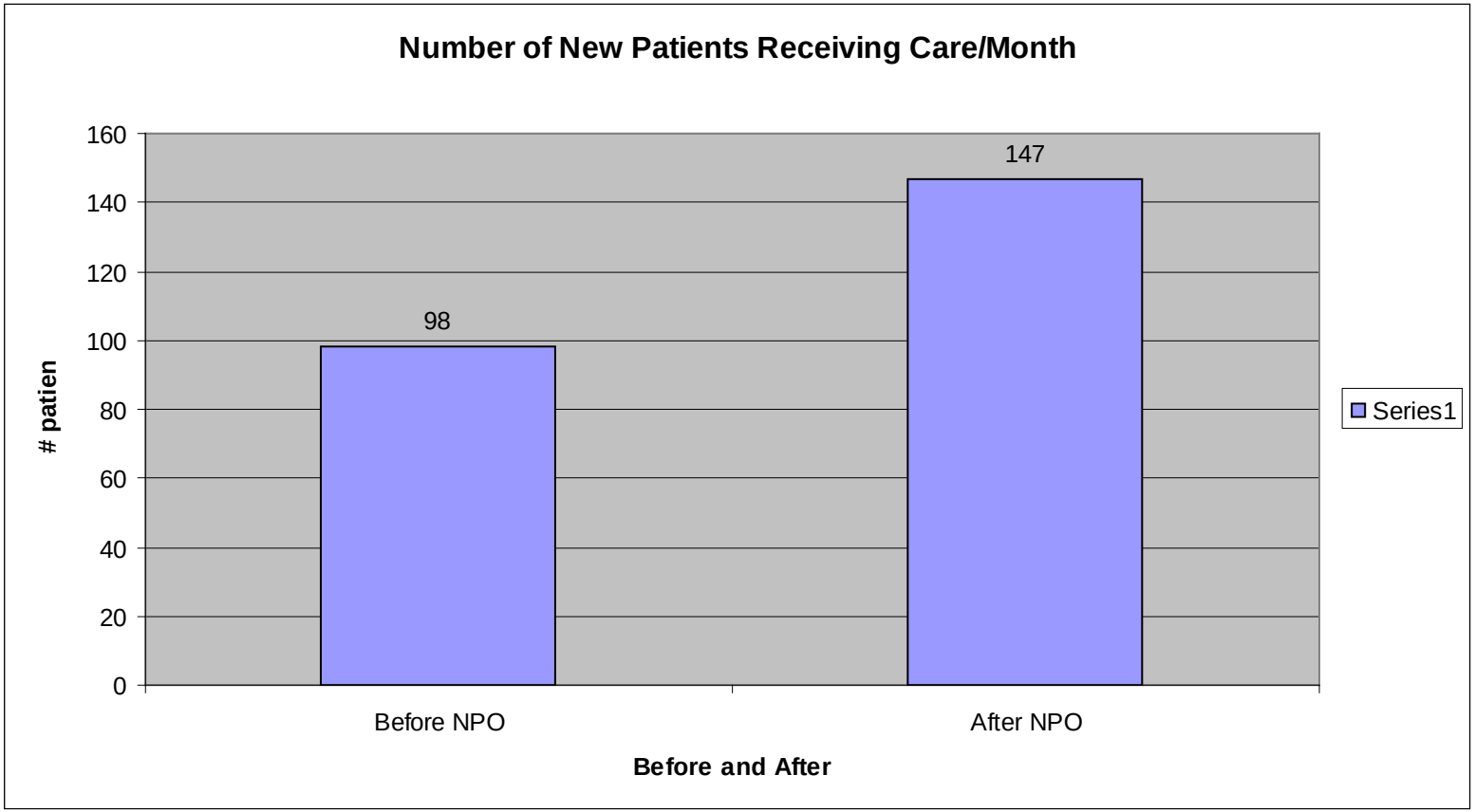
New Patient Orientation

- Goal of new patient orientation was to reduce the gaps in culture and understanding about the healthcare system and to get more people into *care*
- Comprehensive orientation to the site, including hours, on call availability, urgent care availability, services available, etc.
- Required for new patient entry into Revere for most patients aged 18-64
- Attempt to get pts into appointments as soon as possible and to steer pts to available providers
- Only offer the number of new patient appointments that we had capacity for

Effect of NPO on No Show Rate



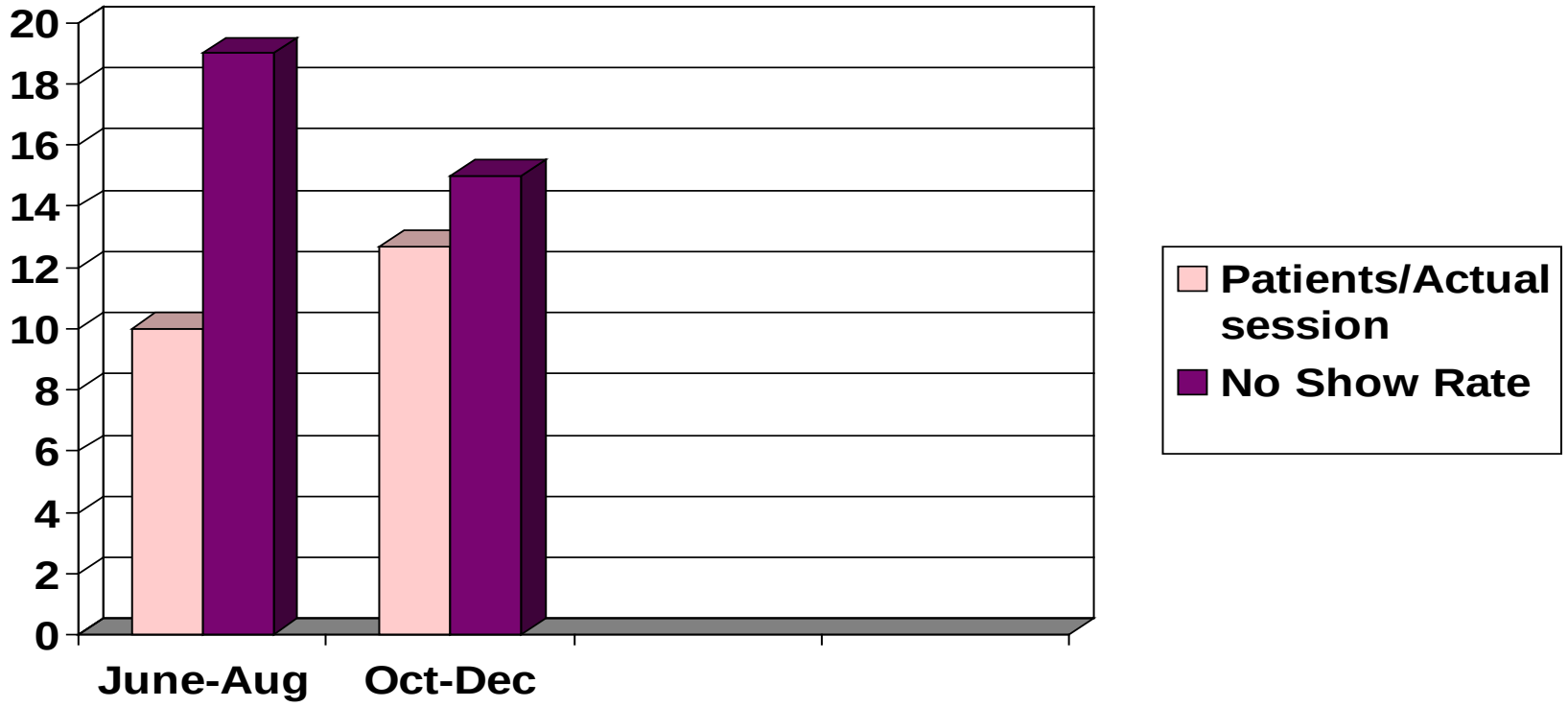
Number of New Patients Receiving Care



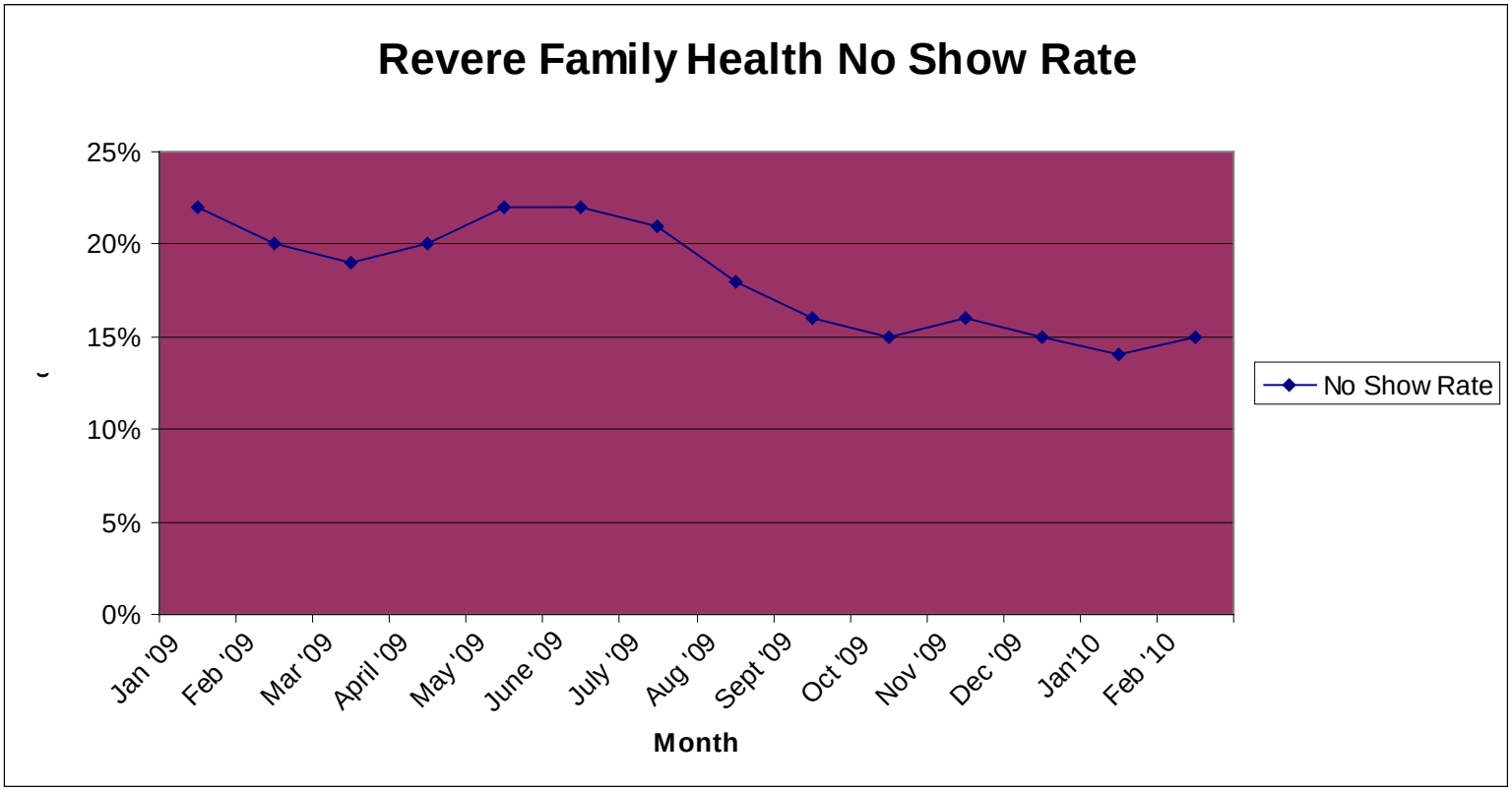
Lessons Learned

- Attending orientation improved show rates significantly, to open access rates (35%→ 14%) as long as appt was scheduled within 30 days
  - People “forgot”
- Wait time to appointment made a substantial difference in the patient’s likelihood of showing
  - Those with highest no show rate had highest wait times, lowest no show rate had lowest wait times
- → moved to Open Access

Productivity and No-Show

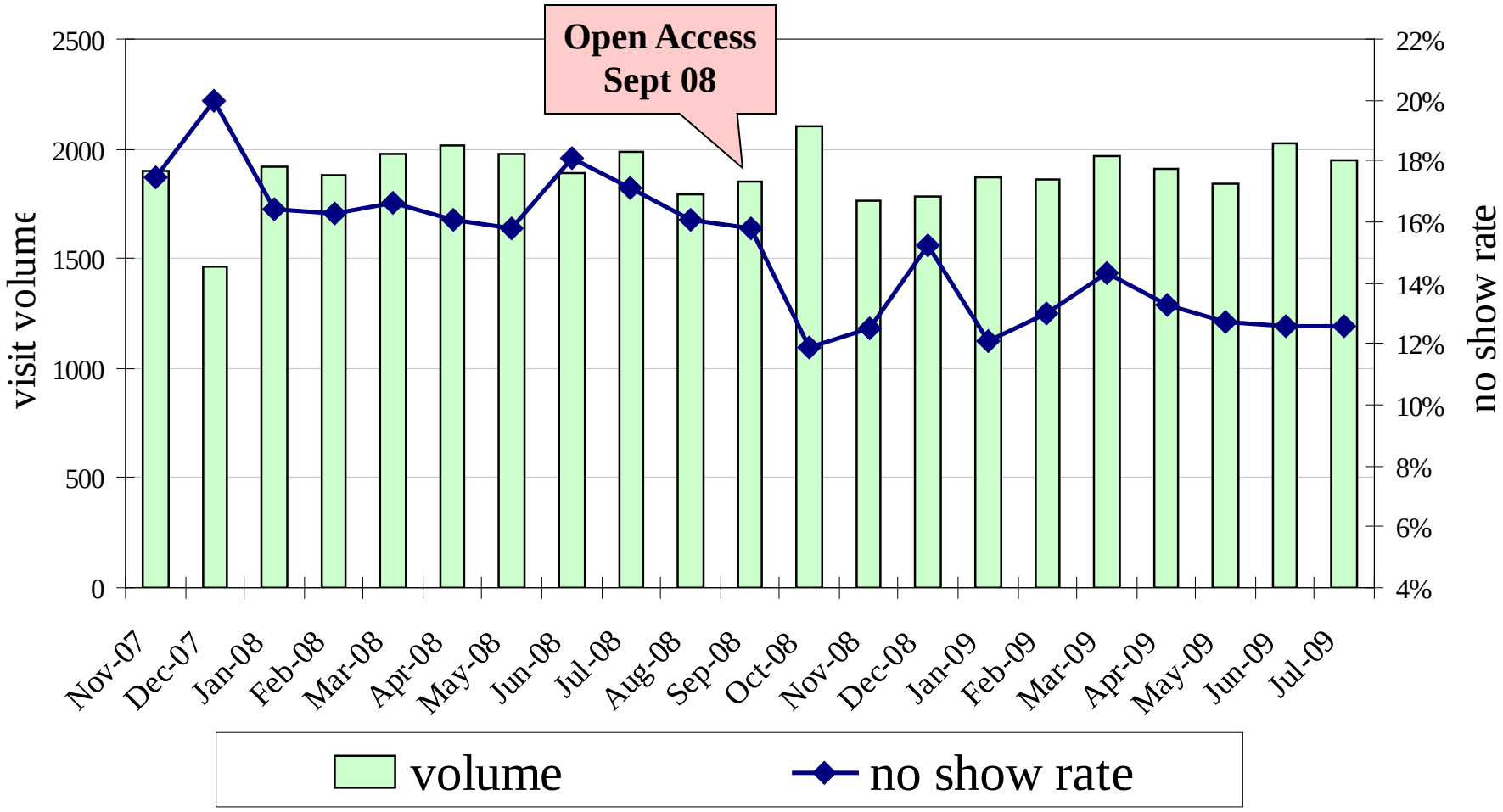


Increase in capacity to care for patients



Union Square Family Health

Visit Volume & No Show Rate



After Open Access

- NPO process continued to show significant reductions in no show rates compared to the control group even after Open Access was implemented (6%)
- Total DNKA+cancellations has dropped by 25% (absolute) – staff time freed up
- No more overbooking – smoother flow
- Patients: “I can’t believe I got in so fast!”
- Continuity of care has dropped.

Shared Medical Appointments

- Creating capacity while improving patient satisfaction and provider and team joy
- Diabetes, addiction services, smoking cessation, healthy living, nutrition, mindfulness
- Moving to drop in group medical appointments (DIGMAs), physical SMAs

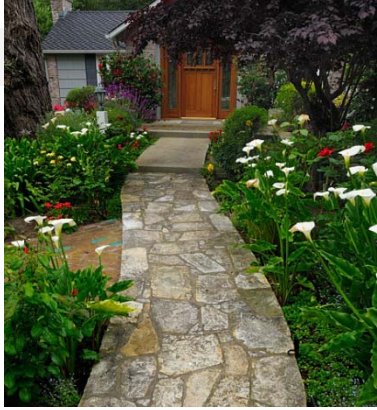
Patient portal: MyChart

- Implemented as part of our PCMH transformation
- Messages to care team, can request appointments, referrals, refills

Looking to the future:

- What if patients could book their own appointments?
- See their own labs (with interpretation)?
- Educate themselves about their health
- Connect with other patients and providers
- Phone visits, e-visits, e-SMAs?

Taking the Care to the Patient's Actual Home



- Partnering with our payors to provide primary care in the home to our highest risk patients.
- Helps us to really know our patients.
- NP and community health worker team who go to the patient's home to provide them with the care they need, case management services, integrated mental health services
- Meet monthly to discuss our patients
- Redefining patient-centered access