From Check-In to Checkout: Maximizing Your Practice’s Patient Flow

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Rosemarie Nelson and Adam Jones do not have any financial conflicts to report at this time.
Learning Objectives

• Assess techniques to leverage your existing technology (EHR) to assist with patient flow

• Evaluate staff usage in the patient flow to improve patient and provider satisfaction

• Develop a plan to identify where your practice flow is inefficient and where you have opportunities to create change

Flow and Practice Transformation

• What’s the recipe?

• “How do they do it” resources
  • MGMA
  • Prescription for the Future, Ezekiel J. Emanuel

• Be the patient or caregiver
  • VIP?
**Leverage your EHR**

- Talk thru templates with voice recognition
- Templates, templates, templates
  - All are not created equal
  - Resurrect, revise, reformat, revisit
- Incorporate scribes

**Scheduling Transformation**

- Centralize scheduling
  - Decreases per-unit cost.
- Open access to scheduling: leave 20%-50% of provider appointment slots unscheduled at the start of every day.
  - Decreases utilization of high-cost sites or care such as the ER.
Scheduling Problems Today

- First available appointment: urgent v. non-urgent
- Gaps
  - No-show patients
  - “Fast” patients
- Overbooking
- Wait times
- Wait lists

Scheduling Urgent Appointments

- Availability?
- Who is gatekeeper?
- What is process to get through the gate?
- Ramifications of add-on appointments
Is the Schedule Patient-Centric?

- Physician control and autonomy
- Who benefits seeing low-risk patients with stable hypertension or those with well-controlled diabetes or asthma?
- Rules and preferences (and variability)
- Overwhelming and unusable number of appointment type definitions

Centralized Scheduling

- Call center v. specific office or pod
- Algorithm for scheduling rules
  - 80-20 rule for general v. customized
  - Next step allows patients to follow the algorithm and self-schedule
Appointment No-Show Rates

• Average across all practices 5%-10%
• Primary care providers average 18%
• Ob-gyn providers average 30%
• Dermatology providers average 26%


Fight the No-Show Stats

• Do NOT book appointments further than two weeks into the future
• If you MUST schedule beyond two weeks, reconfirm appointments (instead of reminding patients)
• Automate confirmation outreach
• Use text messaging to confirm
  • Customize contact method to each patient preference
Easy for Patient to Confirm Texts

- Make your patient call back to confirm?
- One character reply with text message
- One practice’s story
  - No contact with patient resulting no show rate >10%
  - Remind patient and no show rate dropped to 6%
  - Ask patient to confirm text, no show rate dropped to 3%

Effectiveness of Texting

- Average American has their phone on them 22 hours/day
- 96% of texts are read within 4 minutes
  - 95% of texts are read within 3 minutes
- Americans text twice as much as they call, on average
- Texting is 10X quicker than phone calls
- Texts have a 99% open rate
- Average response time for a text is 90 seconds
Revenue Gain Using Text Appointment Reminder

• Average 18% no show rate resulting in daily loss of $725.42
• Implemented reminder tactic
• Recouped 3.8% to 10.5% in revenue, or $166.61 to $463.09/day

Open access

• Eliminate double booking
• Purposely create open time: 20%-50% of slots are open at start of the day
  • More on Mondays and after holidays
• Patient offered slot with personal physician same day, or next available, or colleague
• Reduces patient wait time (in office)
• Reduces patient no-show rates (and cost of patient reminders)
• Happier physicians and staff and reduces negotiations
• Reduces “leakages” (patients going to other physicians/practices)
• Reduces use of ER and urgent care
Barriers to Open Access

• Fear of too many unfilled appointments and a drop in revenue
• Shifting control of scheduling painful and time-consuming

Registration and Rooming Transformation

• Create electronic registration that includes all patient and insurance information to eliminate repeat completion of forms by hand.
  • Decreases per-unit cost.
• Electronically link patients and EHRs to identify gaps in recommended test and treatments that should be addressed (care gaps).
  • Increases utilization of recommended services.
• Have medical assistants rather than nurses room patients.
• Empower medical assistants to close care gaps while rooming patients.
• Have medical assistants highlight care gaps and abnormal values (for example, high blood pressure or hemoglobin A1c measurements) for providers to address.
Registration: Patient Frustrations

• Repetitive, unproductive, fraught with errors
• Fill out all that paperwork by hand, over and over
  • Redundant information on two or three forms
  • Address, next of kin, review of potential problems for every organ system, medications, allergies, etc.
  • Does the provider even look at the information?

Technology to the Fix

• Patient portal still undersold
• RF ID cards specific to a practice
• Kiosk or tablet pulls up accounts with the swipe of a credit card
• Confirm patient identity with two-factor authentication including biometric
  • Eliminate duplicate records, insurance fraud, inappropriate requests for narcotics
• Gather data from time stamps to measure wait times and bottlenecks to flow
• Expand mobile messaging to patients beyond appointment confirmation
Get Started with One-Way Texts

- Offer appointment reminders via text
- Offer test results via text (link to portal)
- Offer medication management reminder texts
- Get specific consent from each patient to receive texts, including types of text messages
  - Notify patients that their cellular plan may charge for receiving text messages
  - Regularly verify and update patient cell numbers
  - Inform patients that their PHI is at risk if their device is lost, stolen, or recycled
- Require authentication or password for patients to access text messages
- Archive messages

Text Message Interventions

- Health promotion and disease prevention – close the gap!
  - Reminders to schedule screenings
  - Messages to encourage healthy behaviors
- Treatment adherence
  - Patient reminders to take medications
  - Encourage patients to make follow up appointments
  - Health tips and actionable items
    - Blood pressure, glucose monitoring and transmittal
Mobile Messaging

- One strategy to maximize flow and efficiency
- Deliver high quality of care and improve population health
- Improve medication adherence
- Increase rates of preventive care services
- Provide post-discharge or post-procedure follow up
- Responsive to patient expectations
- Retain patients

Effectiveness of Health Text Messaging Programs

- 3 of 4 preventive interventions showed positive changes in smoking cessation, physical activity, or weight reduction
- 5 of 10 clinical care programs showed improved HbA1c levels, metabolic control, or blood pressure control
- 8 of 9 support text messaging as tool for changing behavior or improving clinical care outcomes

Let’s Talk Portal

- Let new patients in!
- “Sell” (encourage) use when confirming appointments
- Promote portal as alternative to the patient packet that you mail to patients with log-on information printed on the paper forms
- If you must “invite” to create accounts, do it in the exam room OR at check out

Data Capture Workflow

- Patient portal feed to EHR
  - Eliminate staff data entry work and rooming delays
  - More accurate and comprehensive patient information
  - Interview to clarify/verify not repeat
Rooming Transformation

• Not just social encounter but valuable medical intervention
• Record height, weight, blood pressure, temperature
• Close gap on quality of care standards
  • Age-appropriate cancer screenings
  • Ensure blood pressure is controlled
  • Verify diabetic patients hemoglobin A1c in acceptable range
  • Verify patients with high cholesterol are on and using right medications
• Rooming staff close as many care gaps as possible, off-loading from the physician as much of nonmedical work as possible
  • Order mammograms, DXA scans, other screening test
  • Administer required immunizations, such as flu and pneumonia vaccines
  • Conduct depression and fall screening test
  • Medication reconciliation
  • Disease specific assessments for patients with chronic conditions and disease-specific education
• Standardize for all physicians

Performance Measurement and Reporting Transformation

• Establish metrics in collaboration with and acceptable to physicians.
• Obtain timely – ideally real-time data – on individual provider performance, and benchmark to national standards.
• Provide performance results to physicians in a timely manner – not longer than quarterly.
• Disclose identified physician performance data so all physicians can learn from top performers.
Who Starts What When

- What time does the day start?
  - Support staff
  - Providers
  - Patients
- Start on time and you may end on time
- Start late and ...
- Patient frustrations
  - Not seen at their appointment time
  - Long waits in the exam room

Be Prepared

- Rooms prepped and stocked
- Care Team Huddle ten minutes before the first patient is roomed
- Ready? Start early!
Action Plan

- Measure patient cycle time at each interaction
- Report daily actual patient encounter start times and last patient exit times for each provider care team
- Examine your intake packet (new and established patients)
  - Redundant information
  - What can you produce and pre-fill from your EHR for patients
- Script patient portal pitches for staff
- Ask yourself what you find frustrating and time-wasting when you visit your care provider

Mini-Max Principle

The lowest level of performance by any employee, allowed to continue without corrective action, becomes the highest level of performance that can be required of any other employee in a similar position with the employer.
Thank You.

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Case Study: Using Medical Scribes to Maximize Your Practice Patient Flow
Kootenai Urgent Care, LLC (KUC)

- KUC formed in 2010 and currently consists of 4 clinics (3 urgent care and 1 occupational medicine) solely located in Kootenai County
- KUC is a for-profit physician practice owned by North Idaho Family Physicians, LLC (NIFP) & Kootenai Health (a local public hospital district)
- The organization is managed by NIFP (management company) and Medical Practice Management Services (revenue cycle company – billing, coding, & credentialing)

Key Differences Between Urgent Care Compared to Traditional Practices

- Urgent cares are more focused on provider throughput & door-to-door times in order to treat patients quicker to prevent bottlenecks in workflow and maintain patient satisfaction
- Patients do not make appointments (they can get in-line online and are reminded via text message at our practice)
- Patient volumes and demographics are unpredictable
- Limited patient medical history and relationship even if patient is established
- Rotating provider and staff scheduling – usually seeing different providers every visit
What is a Medical Scribe?

• A medical scribe works with a provider and completes the documentation during the visit, suggests the appropriate coding, manages/sorts medical documents within EMR, & assists with e-prescribing

• This allows the provider to spend more time engaging and caring for the patient, less time looking at a computer screen, and ultimately increases productivity to sees more patients

• Provider reviews documentation at the end of the encounter and signs off on it

• The provider still maintains ultimate control and authority over all documentation and coding

Defining the Issue

Fall 2015

• Kootenai County’s population has continued grow due to industry growth, increase in retirees moving to the region, and growth of local community college

• Additionally, Kootenai County’s tourism industry continued to grow at a rapid pace corresponding with the nation’s economic recovery (increase in disposable income)

• Reimbursement levels have been stagnant for 2 years and may decrease for certain payers in 2017 and beyond

• During this time our government payers as a % of patient mix had also grown

• Decreased face-to-face provider engagement with patients due to electronically charting patient documentation

• Provider burnout had increased due to:
  • Increased overtime
  • Increased compliance and reporting requirements
  • Support staff turnover
  • Difficulty recruiting strong mid-levels
# First Decision

## Medical Scribes

**Pros**
- More hiring options
- Ability to flex hours
- More cost-effective
- Provider production pay not affected
- Potential for improved coding & documentation

**Cons**
- More difficult to train
- Change – unfamiliar workflows to most

## Midlevel Support

**Pros**
- Providers are comfortable with traditional model
- Training ground to eventually work solo if needed
- Increases overall provider coverage during shortages

**Cons**
- Difficult to recruit
- Initially more expensive and will decrease existing provider compensation (production bonuses)
- Would have to hire more than one
- Hours expectations

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# We Chose Scribes – now what?

## In-House (Employees)

**Pros**
- More control of staff
- More cost-effective on paper
- Ability to cross-train medical and/or billing staff

**Cons**
- Difficult and time commitment to train
- Operational management inexperience
- Operational management losing focus on other areas

## Third-Party

**Pros**
- Experienced and familiar with process
- More rigorous training and screening program
- Less of a burden to operational management
- Lower turnover rates

**Cons**
- More expensive on paper
- Perceived lost sense of control
- Multi-year contract
The “Buy-In”

Winter & Spring 2016

• 1st – Operational Management
  • Did not directly reject the concept
  • Stalled the project for at least 6 months before Executive Director took project lead again
  • Provided data requested by Executive Director and supported in team meetings
  • Operational management still lobbied for the hiring of a midlevel

Summer 2016

• 2nd – The Board of Directors (Non-Employee Physician Owners)
  • Data provided by operational management showed high overtime
  • Data provided by CFO throughout year showed material costs associated with provider turnover
  • Executive Director added the need to improve provider morale and using the overtime data believed the cost savings would be sufficient in addition to growing patient volumes providing offset
  • 2 of the 6 Board members had scribes in their respective family practices and another member did earlier in his career. The 3 of them supported this and became our “physician champions” on the Board
  • Board approved the Executive Director’s request

Fall 2016

• 3rd – The Providers
  • The idea was presented at a provider meeting led by the Executive Director, Medical Director (1 of the Board members who used them at his own family medicine practice), and the Operations Director
  • Met with almost unanimous resentment, especially by the providers with the highest productivity in the organization
  • It was agreed to roll-out at one of our clinics that had providers with the least initial resentment (there was an exit clause in the contract)
The “Rollout”

Fall 2016

- The implementation in the first clinic was a success
  - The providers did not feel overwhelmed by the volume
  - Overtime of the providers decreased
  - The providers became our “physician champions”

- Subsequently rolled out to the other 2 urgent care clinics in sequential order of the providers with the least resentment

- Quickly gained unanimous provider support

- Many of the providers believed they would have struggled to get through flu season (peak time for us) without them

### Urgent Care Workflow Metrics

<table>
<thead>
<tr>
<th>Item</th>
<th>2016</th>
<th>2017</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Wait Time in Lobby</td>
<td>21 minutes</td>
<td>21 minutes</td>
<td>0</td>
</tr>
<tr>
<td>Average Room Time</td>
<td>43 minutes</td>
<td>40 minutes</td>
<td>-3 minutes</td>
</tr>
<tr>
<td>Average Door-to-Door Times</td>
<td>64 minutes</td>
<td>61 minutes</td>
<td>-3 minutes</td>
</tr>
<tr>
<td>Total Provider Hours</td>
<td>21,327.41 hours</td>
<td>20,778.23 hours</td>
<td>-549.18 hours</td>
</tr>
</tbody>
</table>
Patient Satisfaction – NPS Scores

KUC Net Provider Scores

- 2016
- 2017

Encounters Per Provider FTE

KUC Urgent Care Encounters Per FTE

- 2016
- 2017
Learning From Our Experience

Before Implementing Consider

- Significant changes to strategy comes from Executive Management and/or requires Executive Management’s full support
- Identify the length of time it takes your current providers to chart
- Review the consistency of provider coding
- Understand the impact on your provider compensation model
- Create a financial model that supports your practice’s operational model and subspecialty
- Consider your providers’ ability to continue to be able to use the EMR
- Consider flexing medical scribes’ schedule to not be available at non-peak times
- Clinics need to see more patients for it to be financially viable regardless of specialty

Continuing Education

ACMPE credit for medical practice executives............... 1.5
* AAPC Core B, CPPM credit ........................................... 1.5
ACHE credit for medical practice executives............... 1.5
CME AMA PRA Category 1 Credits™ ....................... 1.5
CNE credit for continuing nurse education ............. 1.5
* CPE credit for certified public accountants (CPAs) .... 1.8
CEU credit for generic continuing education ............ 1.5

Let the speakers know what you thought!
Evaluations will be emailed to you daily.
Thank You.

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