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Background

"Augusta Health will be a national model for a community based health system delivering unrivaled coordinated care of the highest quality." This is our audacious vision for the future, and my transformative project will help us deliver on our vision.

We recently convened a strategic steering committee to create our five-year strategic plan. The committee consisted of physicians, senior leadership, managers and members of our board of directors. We surveyed our community, and my CEO and I rounded on all of the primary care providers in our community. The consistent theme with all of our stakeholders was the need to improve the coordination of care. Our patients and community members told us that we were doing a good job, but that something was missing. They crave a personalized and compassionate experience. They envision flexibility, convenience and easier transactions. Our referring physicians encounter daily frustrations trying to arrange care for their patients. This is a source of dissatisfaction for our patients and for the clinicians. This daily frustration leads to loss of patients to competing systems, reduced compliance with recommendations, and provider burnout. Consequently, illnesses become more complicated and yield greater expense for the entire health care system.

Augusta Health has the opportunity to create the next generation of health care for our community and our region. Imagine if we can transform the way that we think about care delivery and implement innovative operational solutions to meet the needs of our patients and our clinicians. Imagine if Augusta Health provides a world-class patient experience in a caring community setting that is the envy of other health care systems. Imagine if the unrelenting focus is on the collaboration of the entire health care team and system to keep our community well. Imagine if Augusta Health patients have personalized access to a dedicated health care coach to help them stay well, better control their chronic health conditions, navigate the cadre of services available from our health system and avoid hospitalization. Imagine if patients have a reliable care partner to escort them through the health care system from the time health risks are identified, through treatment, through post-acute services and follow-up. Imagine that the patient is in constant contact with the care team through a convenient, easy-to-use electronic platform to support and extend in-person communications.

I proposed a project to align and coordinate all aspects of health care within our community, with the intention to develop a disruptive model that would move us away from our current system that is riddled with care gaps, fragmentation and silos. My aim was for us to create a coordinated system that would provide a dedicated and ready resource that would carefully and empathetically listen to each patient's concerns, develop a long-term relationship, and assist with any related health care needs such as providing support to answer clinical questions, scheduling questions and billing questions and even to complete required paperwork.

Approach

We set out to develop a primary care navigator/concierge program to improve coordination of care by providing a consistently available clinical coordinator/navigator resource. We selected an interested three-provider community-based primary care practice that is not currently affiliated with our health system. Our tactics included selecting a knowledgeable, empathetic clinical resource to embed in our centralized call center. This clinical navigator will have a direct telephone and video line for access with the primary care practice. The navigator will be available Monday through Friday 8 a.m. until 4 p.m. to accept referrals, schedule appointments, schedule tests, answer patient questions, assist patients with wayfinding, plan transportation, collect results from consults and testing, and return the patient and results to the primary care provider.

We expect that this approach will facilitate efficient scheduling and coordination of appointments. Ideally, patients will be able to coordinate consultation appointments and testing appointments on the same day. These appointments will be scheduled based on patient preference and convenience.

Outcomes

This approach should significantly impact the patient and physician referral experience. I expect to improve the referring physician's satisfaction with specialist access and timeliness of results. I also expect significant improvement in patient satisfaction with efficiency of referrals and convenience of access, as well as coordination of appointments. Optimal navigation should improve health outcomes by reducing cancelled or missed appointments due to delays and frustration. Ideally, we will see reduced leakage, and increased referrals due to improved access and satisfaction. By reducing the friction in the system, I believe that the organization will benefit through improved referring physician relationships and increased volume of referrals. Our review of claims data confirms that our system is the low-cost provider in the region with equal or superior outcomes. Therefore, we believe that improved utilization of our system will result in improved outcomes and cost reduction for the health care system.

Lessons Learned

"During the COVID-19 pandemic, we have **experienced challenges regarding staff availability and clinical resource availability.**"

We have identified the optimal clinical resource within the system, who is currently deployed in our COVID-19 community vaccination effort. Our goal is to keep this project full-time employee neutral for the organization and as our vaccine efforts wind down, we will ramp up the navigator role.

We have taken advantage of this time to kick off the project with our project management team and craft the value stream map. We are also creating call center workflows and message maps as well as creating a dedicated phone line. We are working with the identified primary care practice to establish connectivity. The highest volume referral need is for our Cardiology, Gastroenterology and Endocrinology specialists. We are forging ahead to build the workflows for these practices as well as the associated testing pathways, such as stress testing, echocardiography and colonoscopy scheduling.

Next Steps

We expect to have our full project launched in the coming weeks. We will closely track our outcome metrics to identify successes or opportunities for improvement. We will be tracking patient satisfaction, referring provider satisfaction, kept appointment/cancelled appointment rates, leakage rate, referral and testing completion rates, time to appointment and results turnaround times.

If we experience the success that we anticipate, we will then roll out the navigator service to more of our community primary care physicians and to our network primary care team.