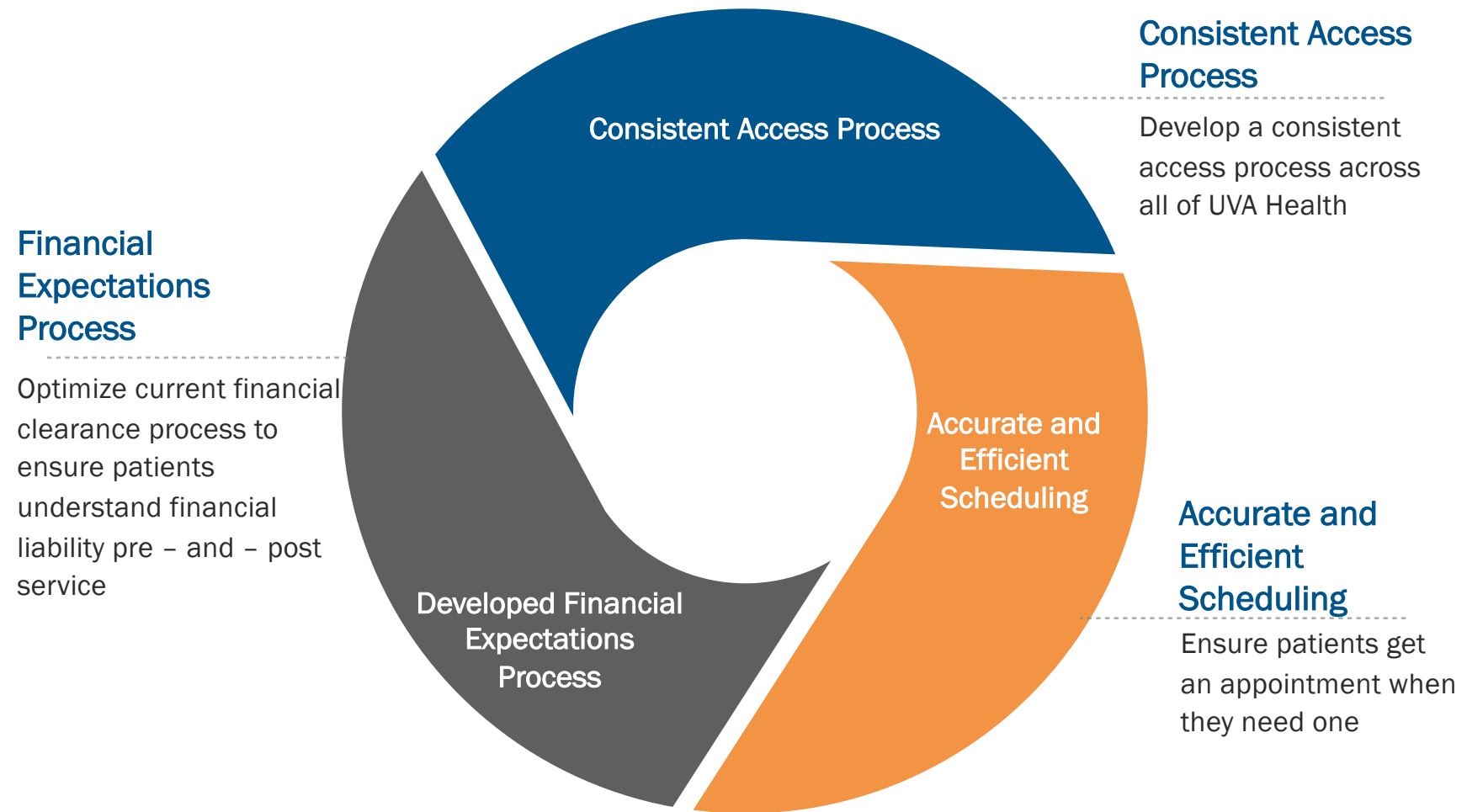


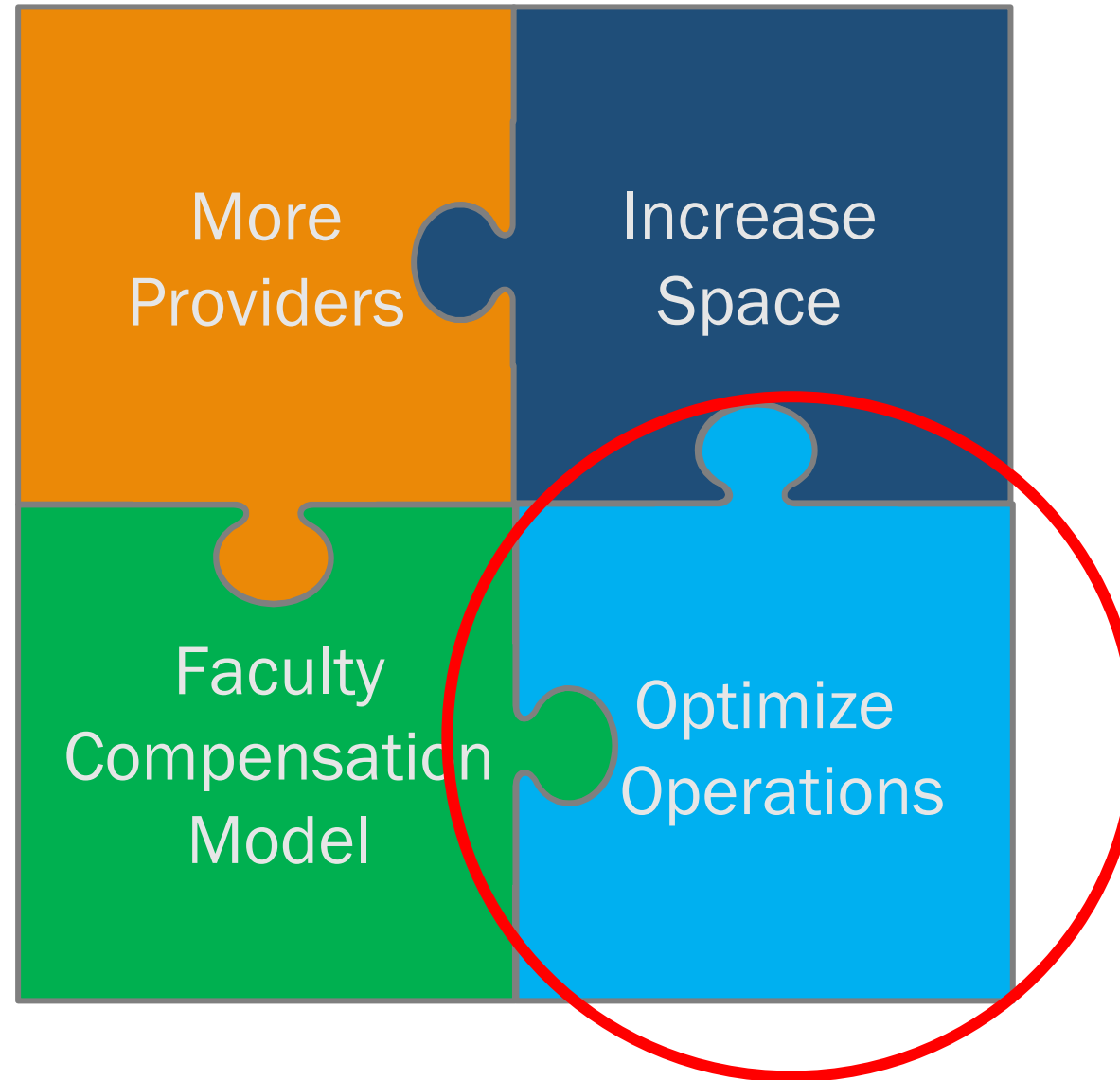


One Team | United on Access

Overview



Building Blocks of Improved Access



One Team Project Principles



• **Patients are first in everything we do** – improve the experience for our patients when scheduling an appointment and when in our clinics for their appointment



• **Care team members are supported in their work and in their career** – streamlined processes using enhanced Epic functionality is a satisfier; offering career progression opportunities for all team members promotes retention



• **Physicians/APPs are partners in the work** – these efforts are most effective when our physicians/APPs are engaged in the development of decision trees, diagnosis matrices, visit types, templates, and outside medical record set specific to their specialty



• **One access model, tailored for specialties** – this model has been designed with best-in-class principles from other public, academic health systems using common tools across each specialty that are applied to meet the needs of that specialty



• **Clinics will optimize resources** – when clinics are open they will have patients and care teams present to ensure we are matching our crucial staffing and space resources with the needs of the patients



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What we are going to do

Addressing Evolving Expectations

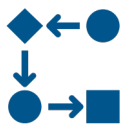
Why Behind This Work



Improve patient experience through consistent access and financial expectation processes



Ensure accurate and efficient scheduling



Promote workflows that support staff and providers

What will the work include

Tailoring One Team guard rails to each specialty for a unified access experience and rolling out a Financial Clearance policy

Consistent scheduling protocols across a specialty and optimized provider templates

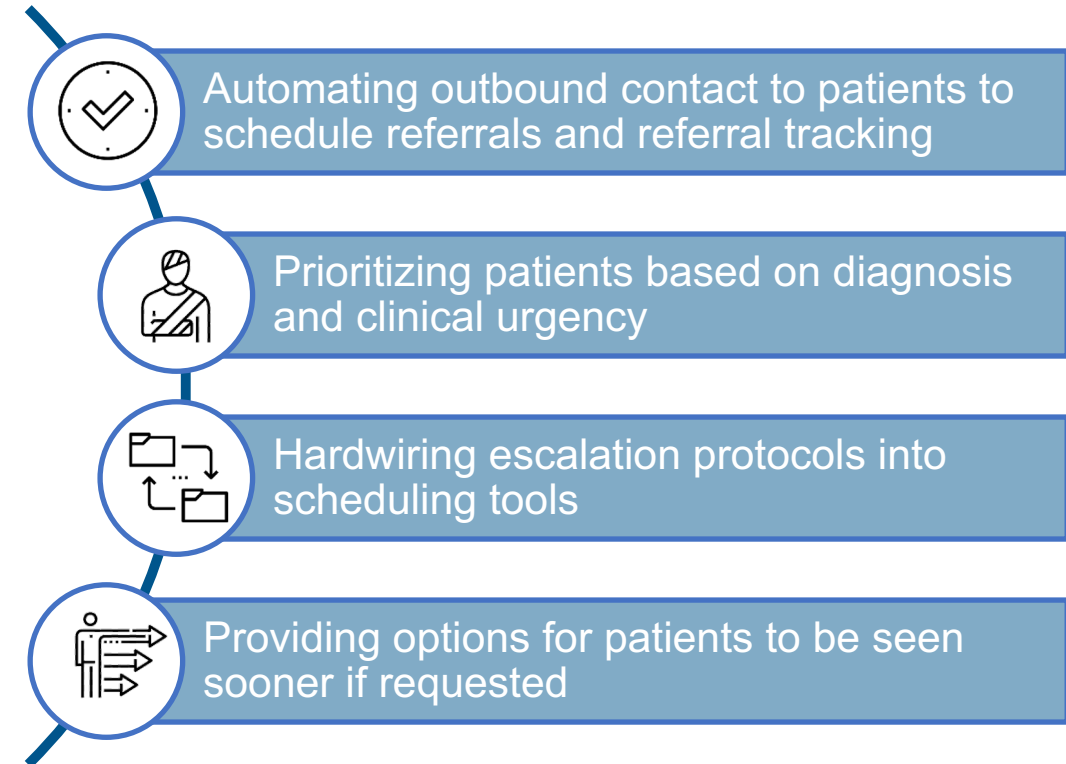
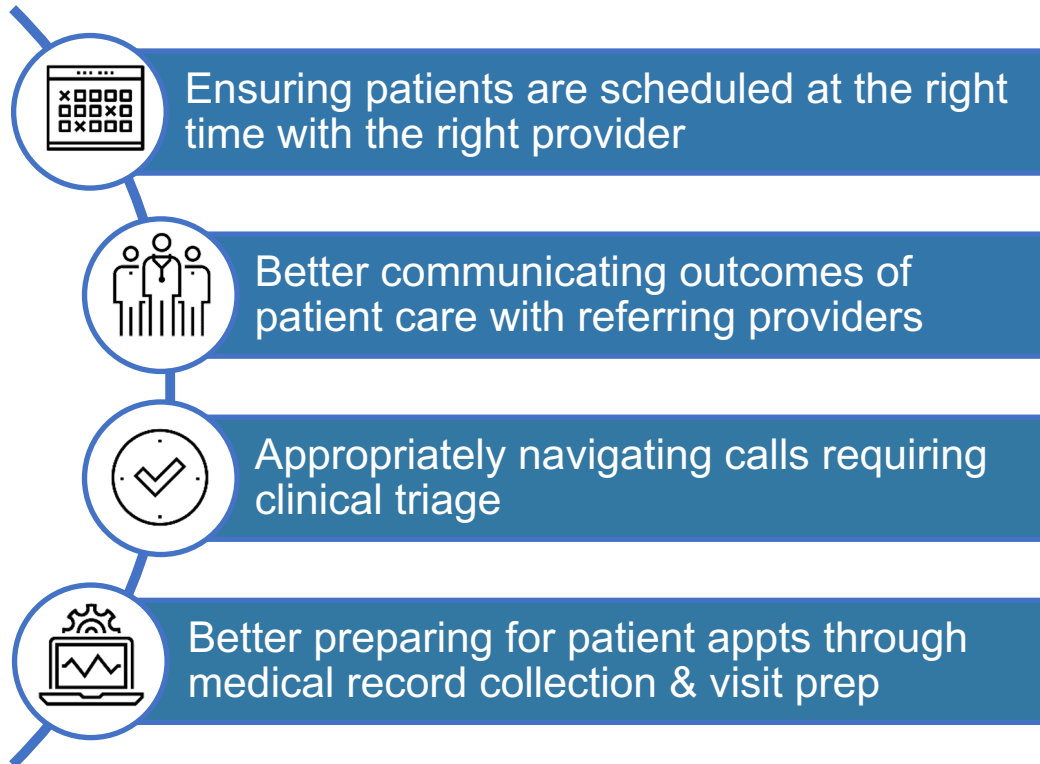
Supporting tools and workflows such as Wait Lists and unified referral workqueues to support scheduling processes and promote role clarity

How we will accomplish this

Collaborative design meetings with specialty stakeholders, HIT, and access operations to tailor One Team design principles to each specialty

Scheduling Initiatives Goals & Impact

Goals of scheduling initiatives are to improve patient access and access tools and support to deliver a consistent patient experience while enhancing provider satisfaction by:



One Team Stakeholder Impact



Patients

- Improved/consistent **pre-visit experience**
- **Patient-centric** scheduling process
- Accurate patient scheduling and one-touch call resolution leading to **improved patient satisfaction**



Providers

- Improved provider **satisfaction**
- **Efficient & predictable schedules** results in less manual management of Epic schedules
- **Accurate** scheduling requires less service recovery for the providers
- Decreased access patient complaints



Support Staff

- Greater **role and responsibility clarity**
- Standardized protocols and accountability measures create a **consistent experience**
- Established **escalation protocols** for when to engage clinical care team
- Decreased competing priorities within clinic



Technology

- **Optimized technology** to support efficient clinical care
- Utilize **close the loop** communication tools for patients & providers
- Deeper operational insights and **data-driven performance** improvement initiatives

Patient Journey

Patient Impact

Patient is notified that referral was received

Most patients experience **one call resolution**

Patient can **self schedule** for some specialties/scenarios

Patient receives **financial estimate**

Patient receives **financial counseling** – if needed

Patient receives **instructions** for visit

Financial responsibility is collected, and patient is checked in

Patient is **scheduled for follow-up**

Functional Changes

Internal and incoming referrals are managed from workqueues (WQs) with external requests for service captured for the system

Unified scheduling process driven by **Decision Trees** to guide patients to the appropriate provider and appointment type

Registration information and initial insurance verification are completed

If Triage required, call is transferred to clinical team

Financial Considerations

Insurance verification is sent to appropriate WQs to be reviewed or prepared for authorization, as needed by scoping

Pre-Auth completed – if needed

Pre-Visit Planning

Medical Records are collected and reviewed

Check-In

Clinic staff and hubs **complete registration**

Provider Visit

Next Steps In Care

Check-out staff schedule or help patients schedule. If necessary, financial obligation communicated.

Changes in templates, no show/cancel/waitlist **management streamlined**



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How we are going to do the work

Implementation Roadmap

Approach Overview



System Level Initiatives

- Designed and implemented across UVA Health

Access Specialty Waves & Implementation

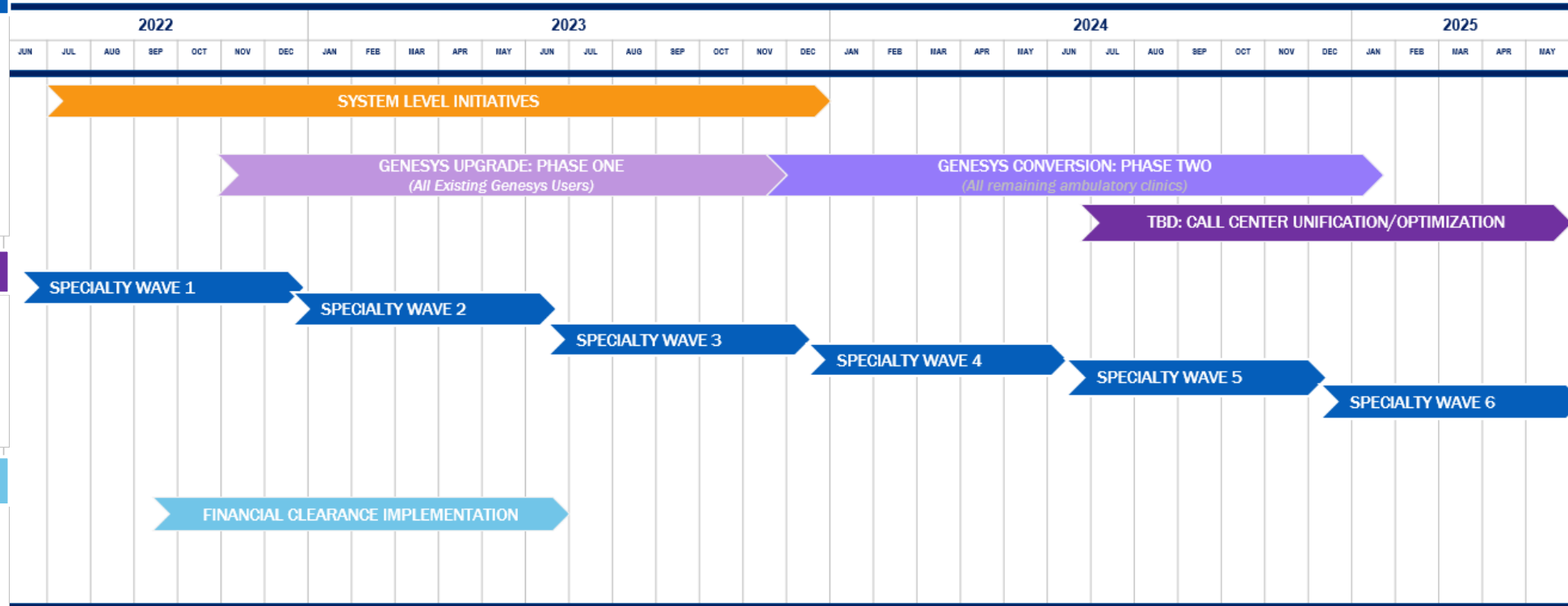
- Requires specific design and implementation one specialty at a time
- Includes 4-6 specialties mixing appropriate size and change management needs

Telecom Technology Enhancements

- Designed and implemented in phases for all existing genesys users across the organization, and for all remaining ambulatory areas

Revenue Cycle Implementation

- Designed and implemented across UVA Health



Implementation Roadmap

Approach Detail

System Level Initiatives

Projects that will be implemented across the organization, including:

- Access Policy and Standard Operating Procedure development/roll-out
- Metrics & Reporting – Daily operations dashboard and provider scorecards
- MyChart Pre-Visit Update Optimization
- Customer Relationship Manager (CRM) integration strategy
- RTPB Optimization

Telecom Technology Updates

- Genesys Phone system upgrade to cloud version
- Call center optimization planning & strategy

Specialty Wave: Core Scheduling & Access Initiatives

- Decision Trees
- Template refinement and visit type updates
- Schedule Management
- Clinical support & care navigation
- Close the loop communication
- Pre-registration
- Records collection
- Referral work queue centralization and outbound workflow
- Visit preparation
- Appointment Reminder/Confirmation
- Online patient self-scheduling
- No-show and cancellation follow-up
- Surgical scheduling roles/workflows
- Wait List and Fast Pass management

Revenue Cycle Optimization

- Baseline patient access metrics
- Reporting & analytics
- Financial Clearance policy roll-out (FCP)
- FCP Epic workflow enhancements
- Financial clearance workflows
- Staff performance management

Sequenced approach to improve speed and level change management

Implementation Timeline

Specialty Waves

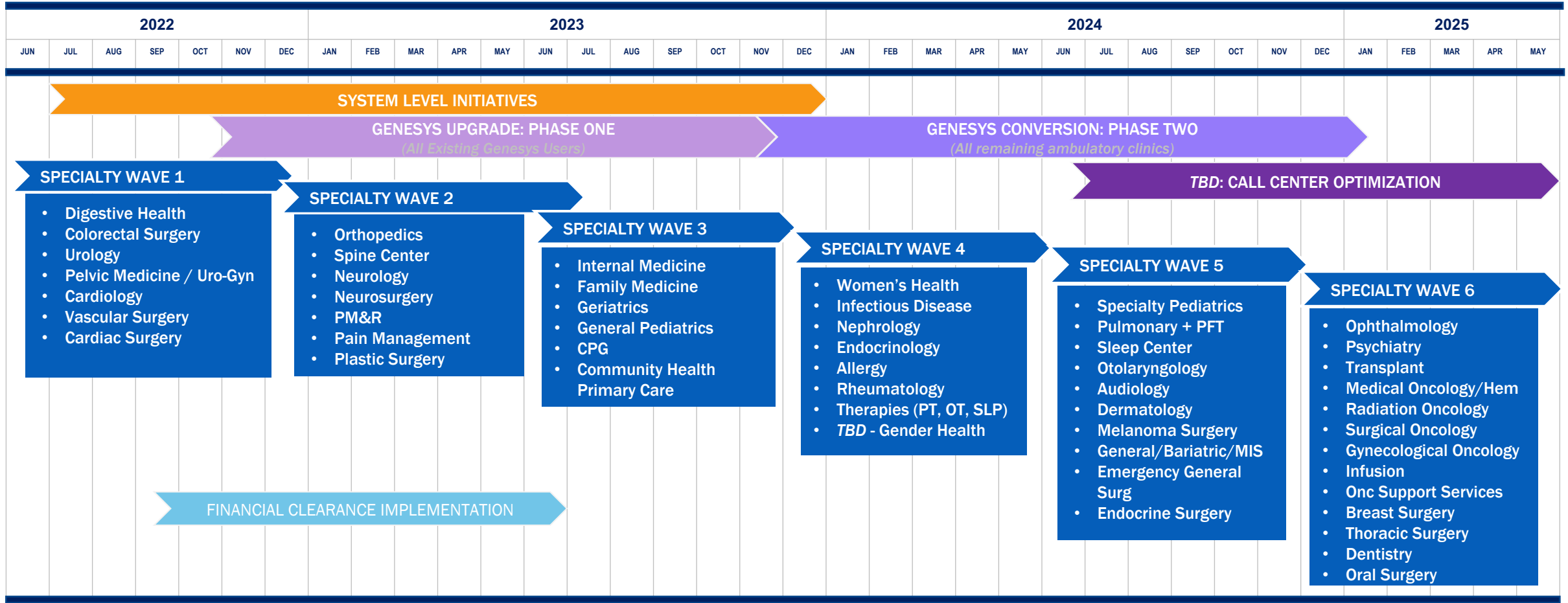
System Level Initiatives



Access Specialty Waves & Implementation

Telecom Technology Optimization

Financial Clearance



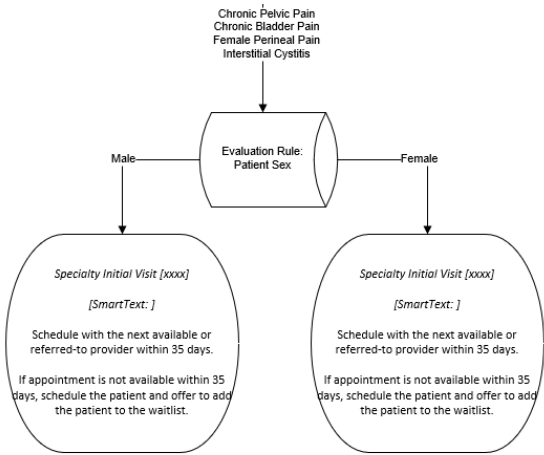
*Future waves are subject to change.



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Implementation Core Deliverables

Specialty Waves



Decision Tree

Appropriate Visit Type, Duration and Scheduling or Triage Pathway for each patient

	Provider A	Provider B	Provider C	Provider D	Provider E	Provider F	Provider G
Diagnoses	Urology						
Bladder Scan/Uroflow			X				
Bladder Installation for Bladder Pain		X					
Foley Catheter Removal							
Catheter Complications							
Cystoscopy	X	X	X	X	X	X	X
Cystoscopy with Biopsy	X	X	X	X	X	X	X
Cystoscopy with Stent Removal	X	X	X	X	X	X	X
Percutaneous Tibial Nerve Stimulation (PTNS)			X				

Diagnosis Matrix

All clinically appropriate providers to see each patient

TIME	Quota/ Overbook	Monday Block Name or Open Scheduling
8:00 AM	1/0	IVS
8:15 AM	1/0	FV
8:30 AM	1/0	FV/PO
8:45 AM	1/0	IVS
9:00 AM	1/0	IVS
9:15 AM	1/0	IVS
9:30 AM	1/0	FV
9:45 AM	1/0	FV
10:00 AM	1/0	IVG
10:15 AM	1/0	FV
10:30 AM	1/0	FV
10:45 AM	1/0	FV
11:00 AM	1/0	IVS
11:15 AM	1/0	IVS
11:30 AM	1/0	EV
11:45 AM	1/0	EV

Provider Templates

All appropriate scheduling times to see each patient

All information integrated into Epic

Complemented by MyChart Scheduling, Fast Pass Use, Wait List Management, RN triage workdrivers and medical record collection workdrivers



Implementation Timeline

System Level Initiatives

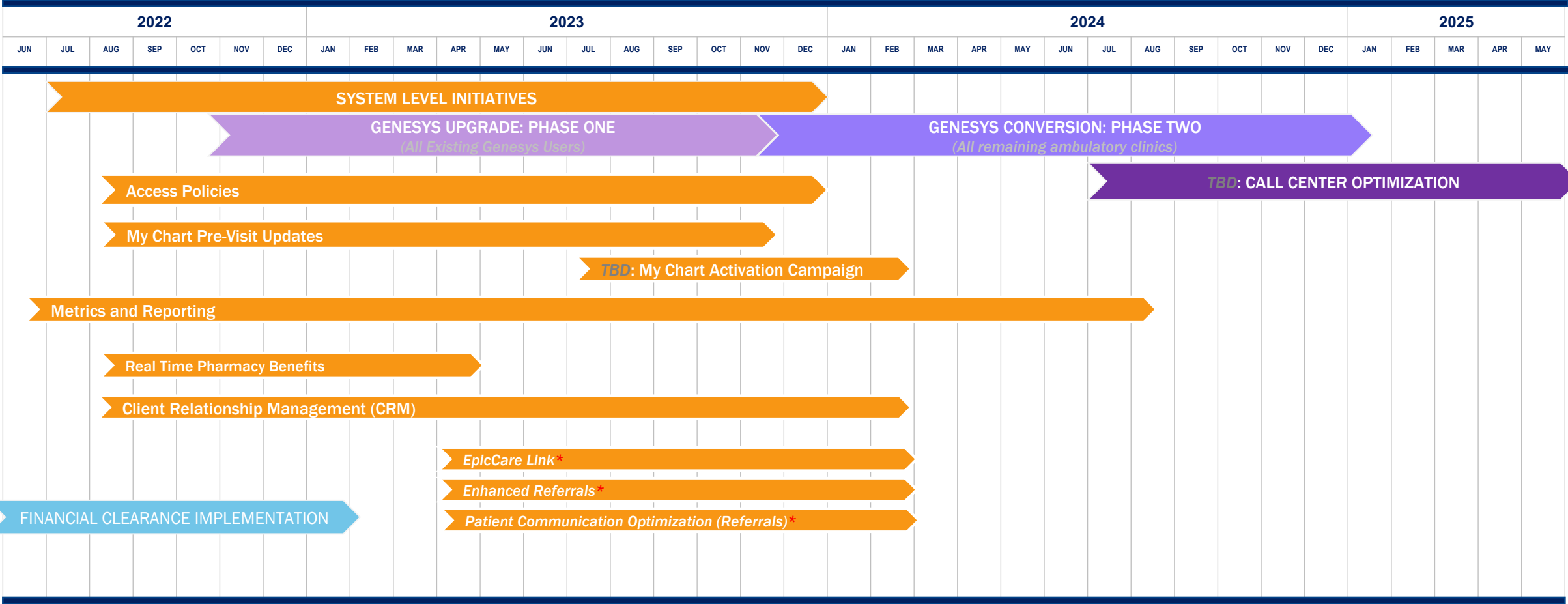


★ System Level Initiatives

Access Specialty Waves & Implementation

★ Telecom Technology Optimization

Financial Clearance



Notes:

1. * Additional development / planning needed behind resources & timelines. These items may overlap with specialty specific waves.

2. TBD Additional development / planning needed behind timelines. These items are dependent upon completion of other projects.



Implementation Core Deliverables

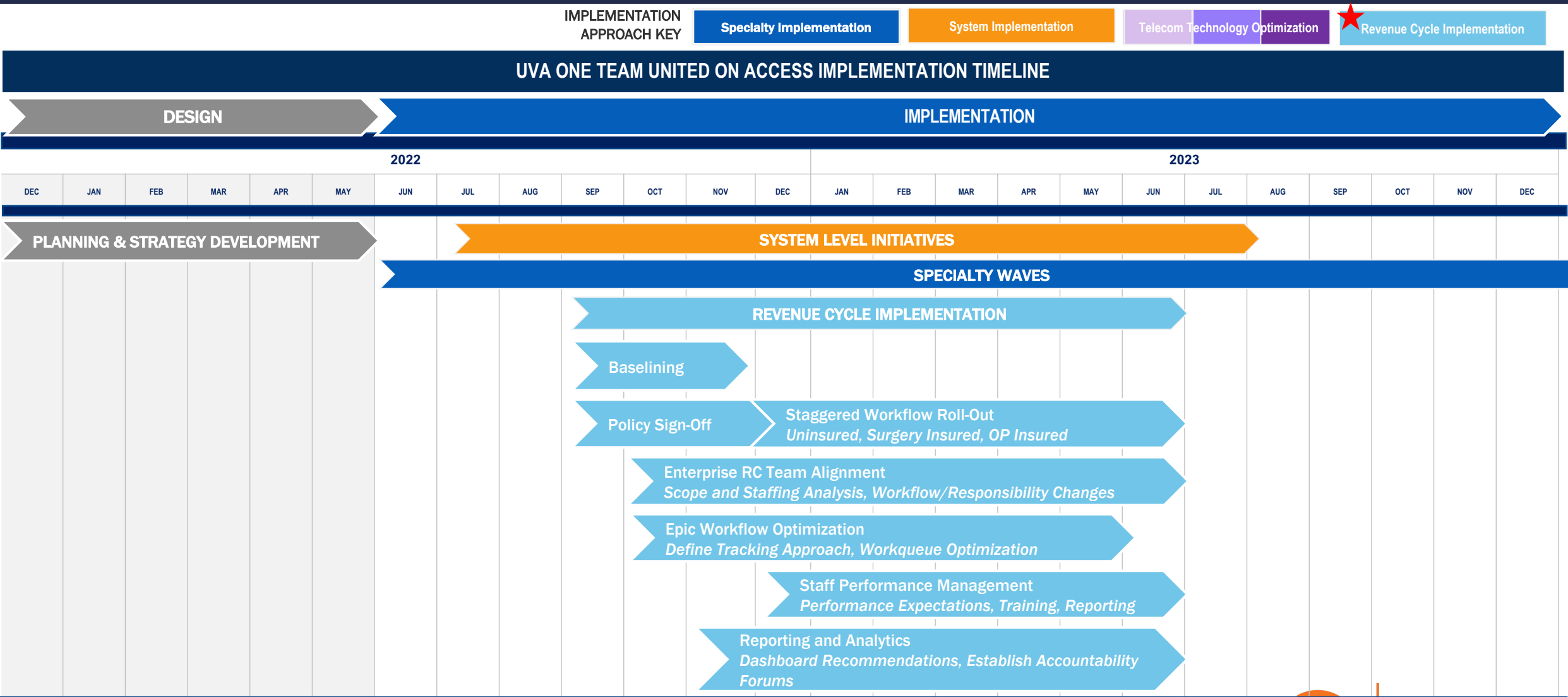
System Level Initiatives

Work Stream Categories	Purpose
Access Policies	<ul style="list-style-type: none">• Create health system policies and standard operating procedures that support the One Team Program Initiatives (may include: no-show, template change mgmt., appointment reminders, waitlist, etc.)
MyChart	<ul style="list-style-type: none">• Evaluate & optimize Pre-Visit Planning (previously e-check-in) + Self-Registration pathways
Metrics & reporting	<ul style="list-style-type: none">• Determine specs for real-time baseline Patient Access Metrics• Create dashboards for access daily operations management
Call Center Optimization	<ul style="list-style-type: none">• Analyze staffing levels for all access positions and & prepare recommendations for grouping• Create approach to optimize & unify call center structures and triage teams where appropriate
Genesys Upgrade	<ul style="list-style-type: none">• Upgrade phone system for all ambulatory clinics to a cloud version• Enhance user experience with standardized phone routing, menus, and tools
Customer Relationship Management (CRM)	<ul style="list-style-type: none">• Integrate marketing CRM technology / platforms in order to track & report marketing campaigns related to patient volume
Real Time Pharmacy Benefits	<ul style="list-style-type: none">• Enhance existing epic functionality to obtain estimated cost for medications based on the patient's benefit plan and pharmacy selection at time of prescribing
Additional work streams that may be included (<i>pending approvals</i>): <ul style="list-style-type: none">• Epic CareLink• Enhanced Referrals• Patient Communication Optimization (Referrals)	<ul style="list-style-type: none">• <i>Epic Care Link: Standardized process for external referral workflows</i>• <i>Enhanced Referrals: Increased and streamlined functionality for internal referral workflows</i>• <i>Patient Communication Optimization: once referrals are received, standardize approach to send patients text messages with a reminder to contact the scheduling team</i>



Implementation Timeline

Revenue Cycle



Implementation Core Deliverables

Revenue Cycle

WORKFLOW GUARD RAILS

Registration, Financial Clearance, POS Collections

Key Tool Decisions

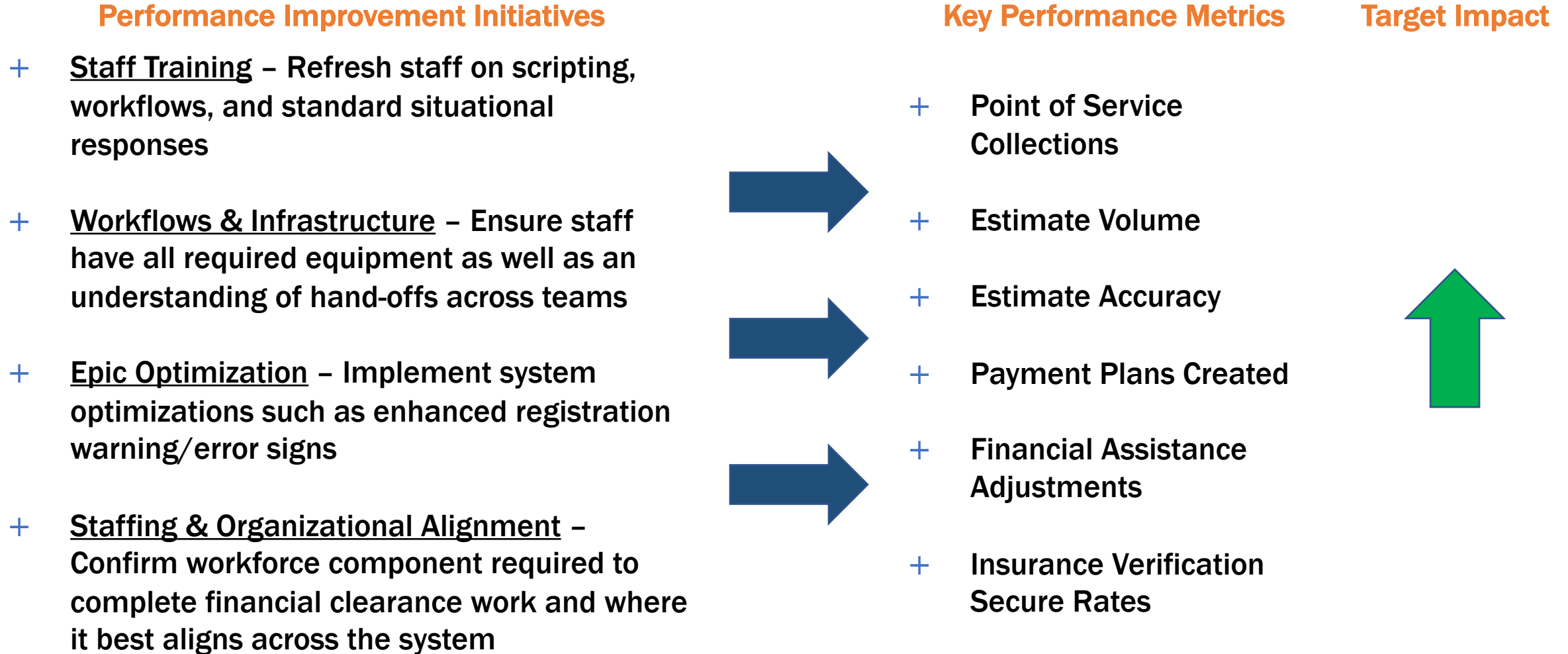
- Hard and soft stops will be built in Epic to ensure workflow consistency
- Authorization requirements will be auto-generated from the referral
- Add-ons and “exceptions” (e.g., CPT code changes) will be managed within workqueues
- Estimates will be generated for self-pay and out-of-network patients
- Patients will be able to pay outstanding balances through a patient financial platform
- e-Check-In will be offered

Workflow Guard Rails

- Pre-registration to be completed as part of the schedgistration process
- Minimum Data Set will be established, enforced by hard and yield stops in Epic
- Authorizations/insurance referrals will not be required before scheduling (with some exceptions)
- Referring clinics will initiate authorizations for outside of the system in select situations
- A standard financial clearance policy will be developed and will include a protocol for service deferrals
- Collection attempts will be made over the phone
- Financial counseling will be available and grouped with like specialties
- Consistent check-out processes to be developed

Implementation Roadmap

Approach Overview



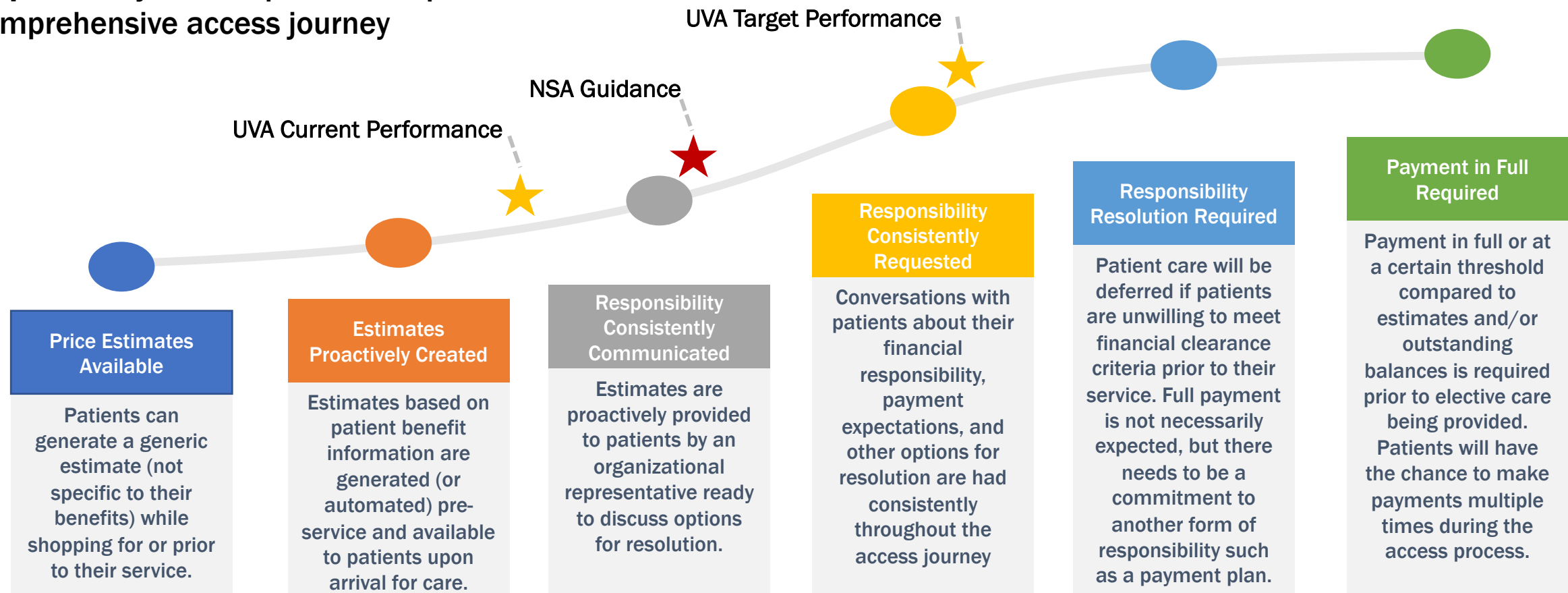
Note:

- + Targeting Q1 2023 for roll out of performance improvement initiatives
- + Key metric baselines and performance will be included in January Steering Committee deck

Implementation Roadmap

Revenue Cycle: Maturity Curve

UVA Health will move towards **consistently communicating and requesting financial responsibility** to their patients as part of a comprehensive access journey



Implementation Core Deliverables

Revenue Cycle: Financial Clearance Policy – Purpose / Focus

Why Financial Clearance Matters

- + Cultivate a **better patient experience** across full access spectrum by creating cost transparency, safe forums for patients to proactively discuss their responsibility, and a sense of ownership of the process
- + Ensure **strong financial health** through reduced risk of administrative write-offs and uncollectible patient balances resulting from incomplete authorizations and patient responsibility not addressed prior to service
- + Drive **better internal processes** across all UVA teams for identifying, addressing, and tracking patients who are financially at risk and the impact to the organization

Key Objectives

- + **Proactive and consistent patient communication** with regards to the financial components of care, such as authorizations, deductibles/co-pays, and outstanding balances from previous care
- + **Reduced write-offs** through improved financial security
- + **Clearer expectations** for staff regarding their role in the financial clearance process
- + **Improved metrics and reporting** on financial clearance outcomes and impact

Financial clearance is part of our comprehensive access to care journey, and should never prevent patients from receiving medically necessary care.

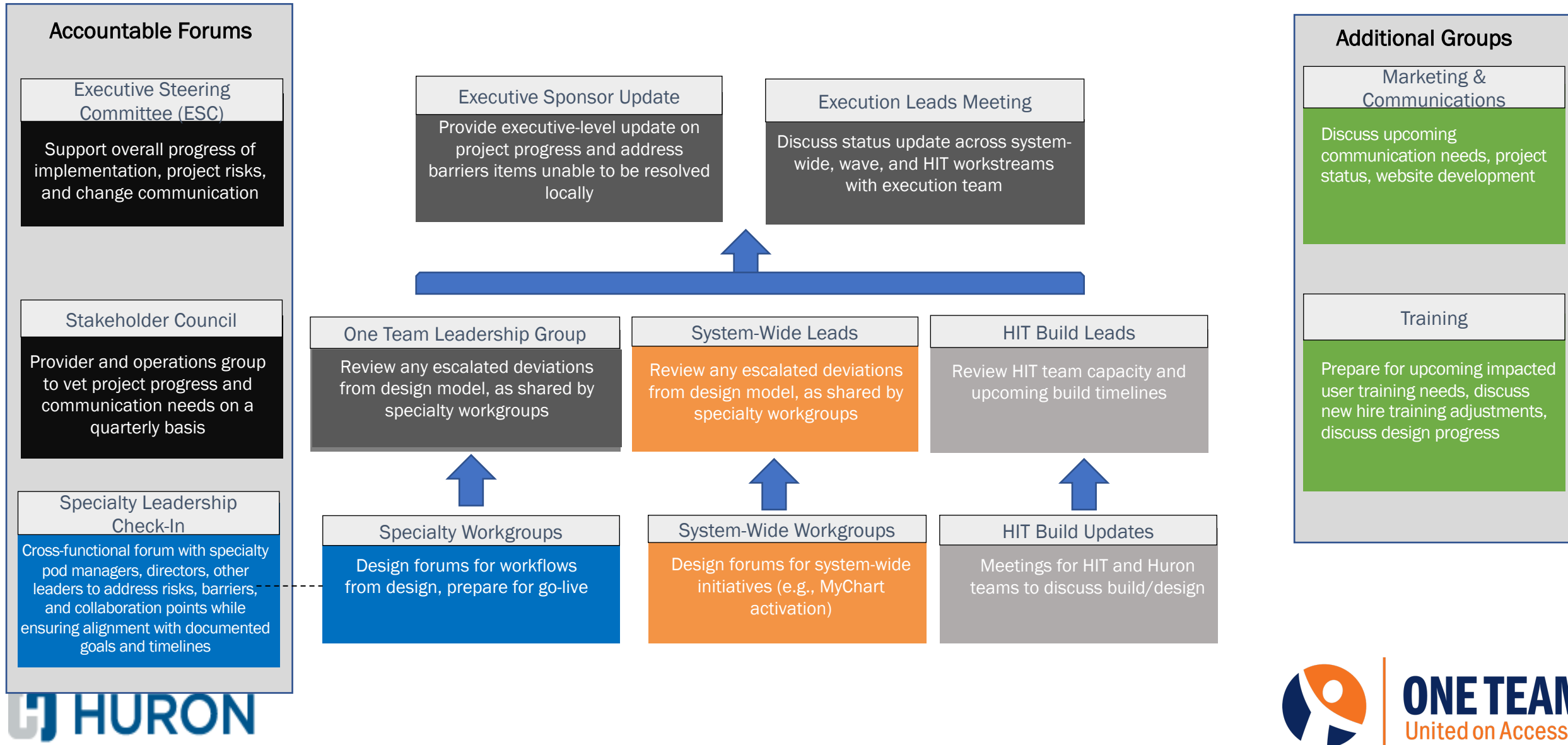


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Who is involved?

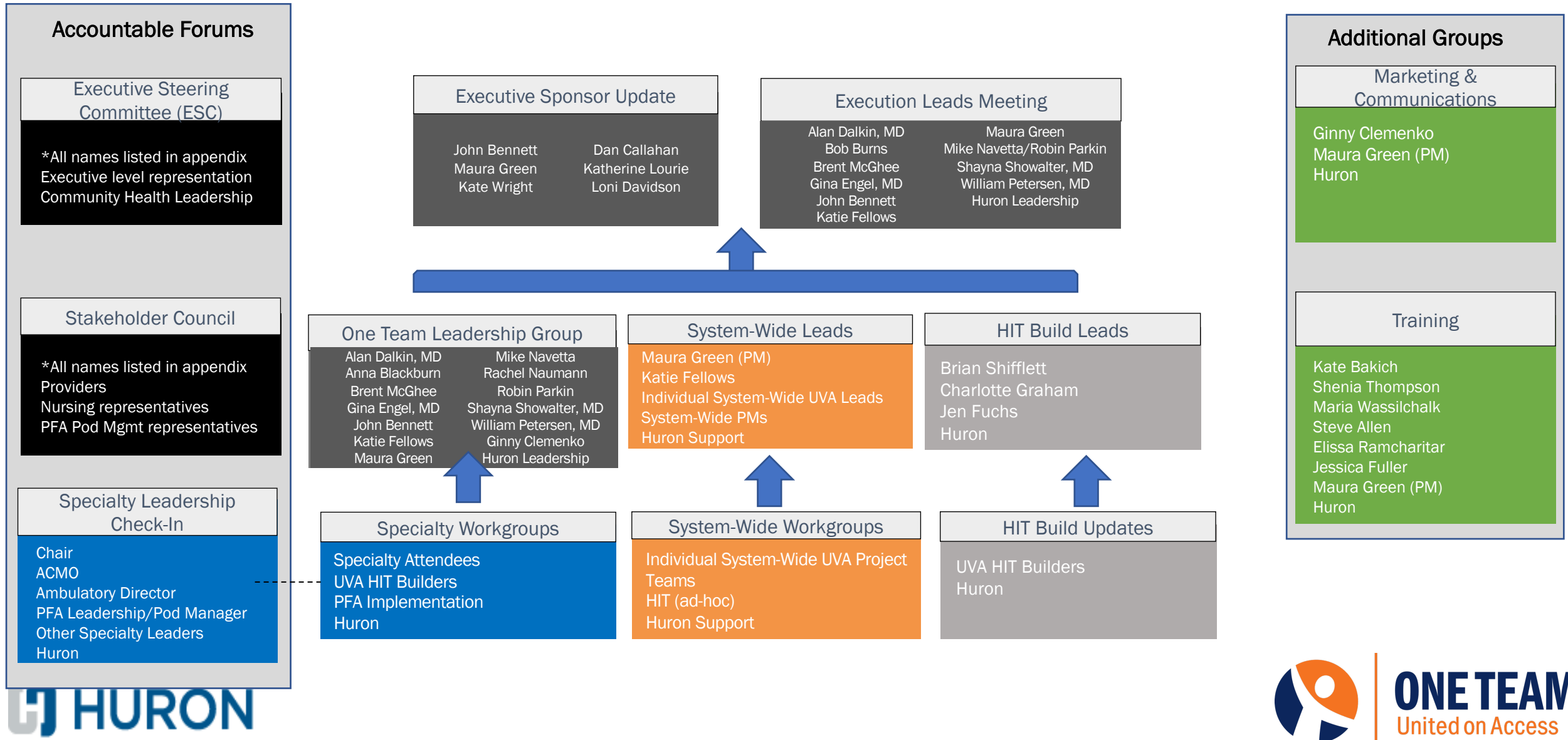
Implementation Governance

Purpose



Implementation Governance

Attendees



Stakeholder Expectations

COLLABORATE, SHARE KNOWLEDGE, BE TRANSPARENT, SPONSOR THE CHANGE

Chair/Physician Leads

- Communicate project goals, objectives, and status with clinicians
- Represent clinician perspective
- Participate in sign-off meetings to implement future state processes in collaboration with Huron
- Advocate change and assist project team in resolution of problems as needed

Workgroup Attendees

- Participate in vetting, design, and sign-off meetings to implement future state design in collaboration with Huron
- Provide department/division-specific context surrounding scheduling & clinical operations
- Support Huron with coordination of staff training, communication, and change management
- Understand project goals and outcomes in order to prepare for long-term support model

ACMOs

- Represent clinician and leadership perspective
- Advocate change and assist project team in resolution of problems as needed
- Respond to and/or escalate provider concerns if they arise
- Understand project goals and outcomes in order to prepare for long-term support model

Huron Team

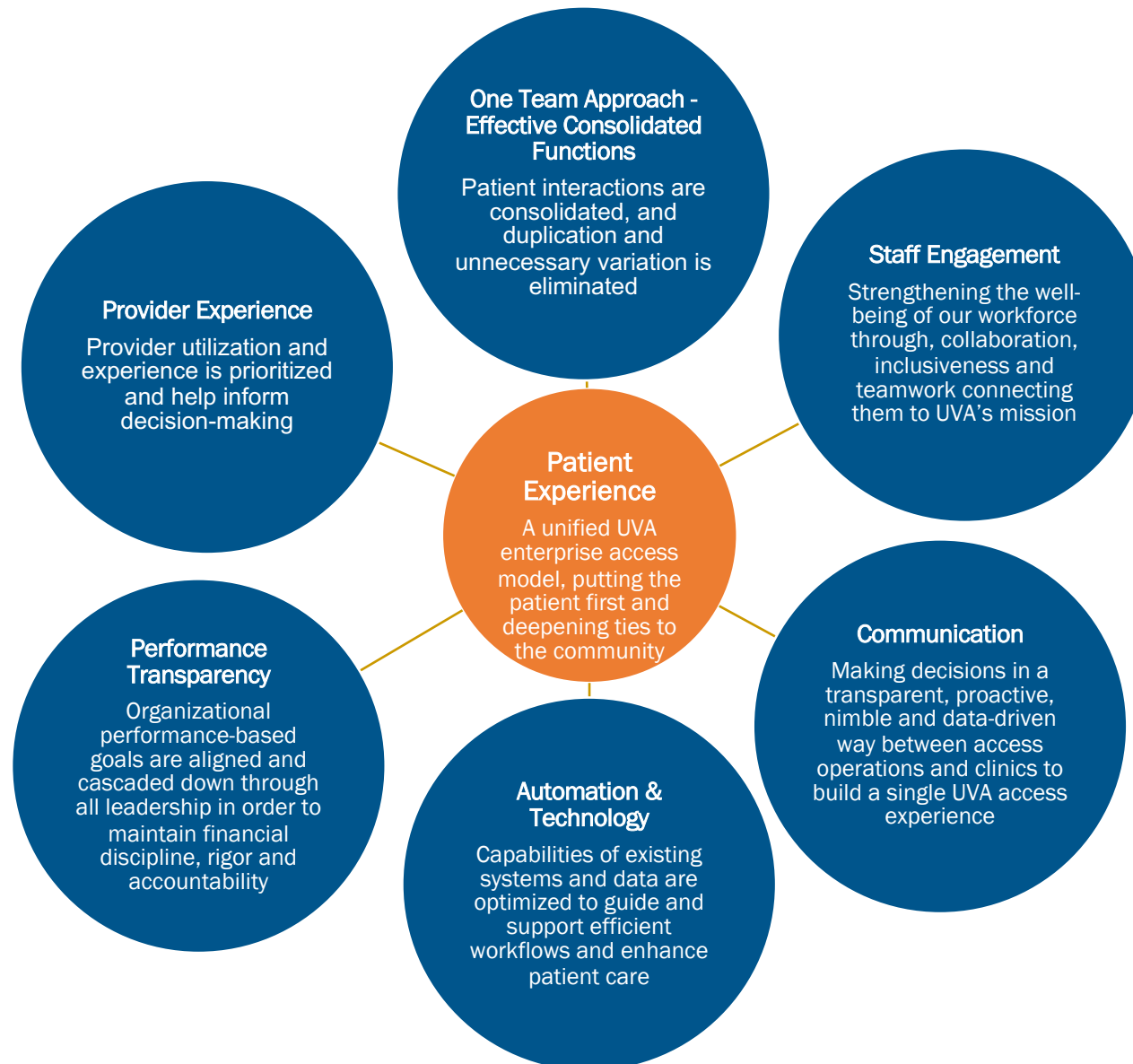
- Identify improvements in access based on best practice recommendations
- Design future state processes in accordance with UVA guardrails & department/division-specific needs
- Vet future state design with specialty & clinic leadership
- Escalate risks/barriers to achieving project goals and/or meeting UVA guardrails to leadership as needed
- Communicate changes to current processes to all impacted



Appendix

One Team Guiding Principles

What Right Looks Like



System Guardrails

The following guardrails were defined for UVA Health to adopt. Highlighted decisions below.

Referral / Request for Service Management

- Epic Care Link will be used to capture external referrals
- Efax & Care Link will be used to transcribe external referrals
- Close the Loop process will be used to inform referring providers of select referral statuses
- Direct referrals will be honored and offered next available appt
- **Self-referrals will be permitted (some specialty considerations)**

New & Established Patient Scheduling

- Decision Trees will be utilized for scheduling patients
- **Self-scheduling and virtual appts will be offered to patients (some specialty considerations)**
- **Patient will be offered next available appt across all applicable locations without delaying for medical record review**
- Age requirements & urgent symptoms will be standardized across specialties

Schedule Management

- **Visit Type & template expectations will be standardized across a specialty**
- Block *Auto-Release* will be utilized and standardized by specialty
- APPs will see patients independently with their own templates
- **Non-single day template changes will be managed by centralized Template Management Team**
- No-Show policy will be implemented

Clinical Support & Care Navigation

- Medical records will not be reviewed prior to scheduling patient
- **Nurses will work in a shared model across locations for a specialty for triage**
- Triage protocols and workflows will be consistent across specialties
- Standard tools and expectations for pre-visit planning
- **Nurses will schedule patients for standard office visits if that is the result of their triage**

Registration & Financial Clearance

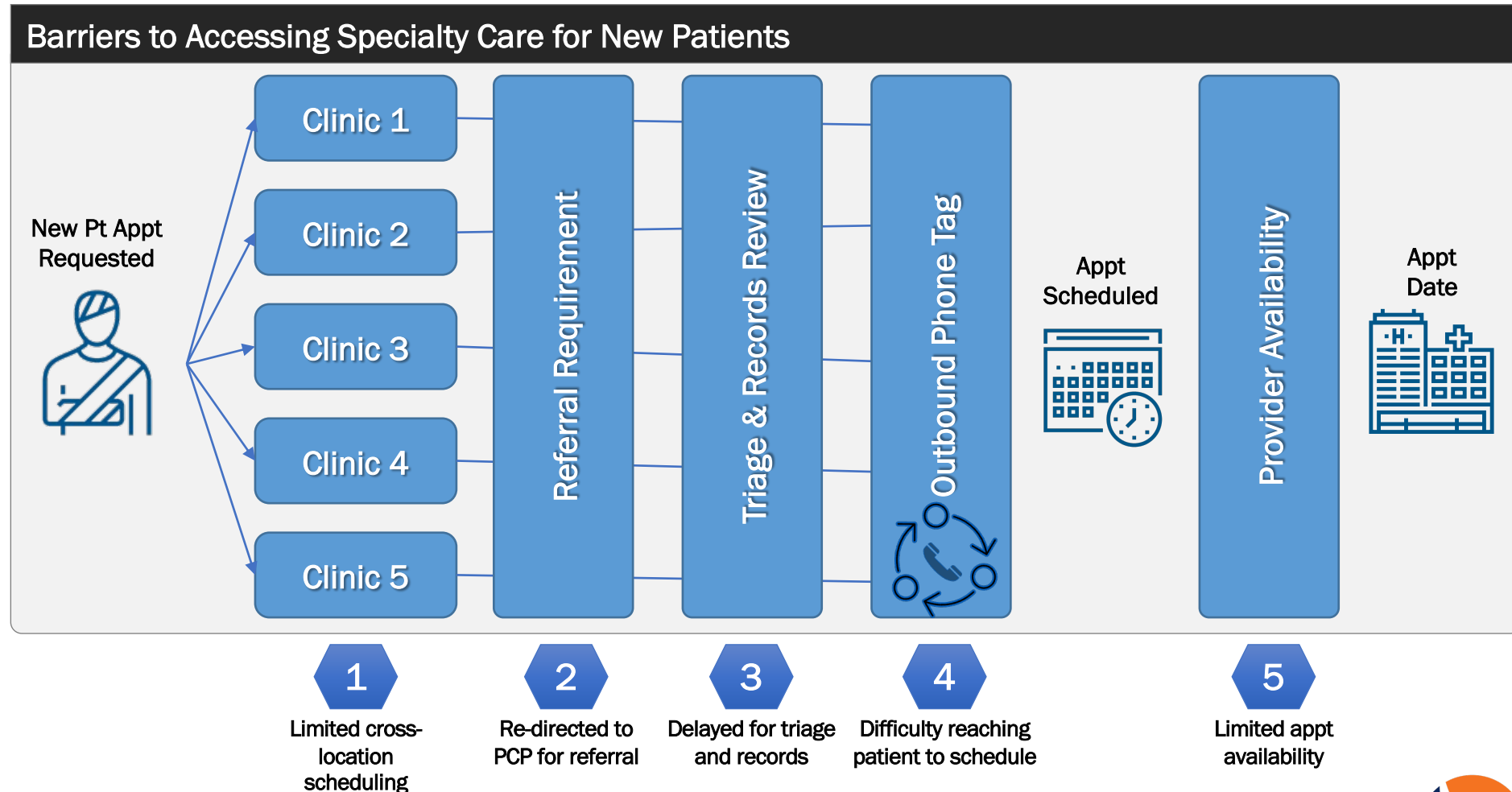
- **Minimum Data Set will be established, enforced by hard and yield stops in Epic**
- Standard financial clearance policy will be published to direct self-pay patients to financial counseling, outline protocol for service deferrals, etc.
- Estimates will be generated for self-pay patients in accordance with No Surprises Act
- Authorization will not be required prior to scheduling (with some exceptions)

POS Collections & Check In/Out

- Onsite financial counseling will be made available, via a regional model
- Collection attempts will be made pre-service via patient portal, e-check-in, and outbound phone campaigns for determined dollar threshold
- Upon check-in, staff will complete registration alerts, and all eligible patients will be asked to sign Advanced Beneficiary Notices (ABNs) and the Long Term Signature Cards

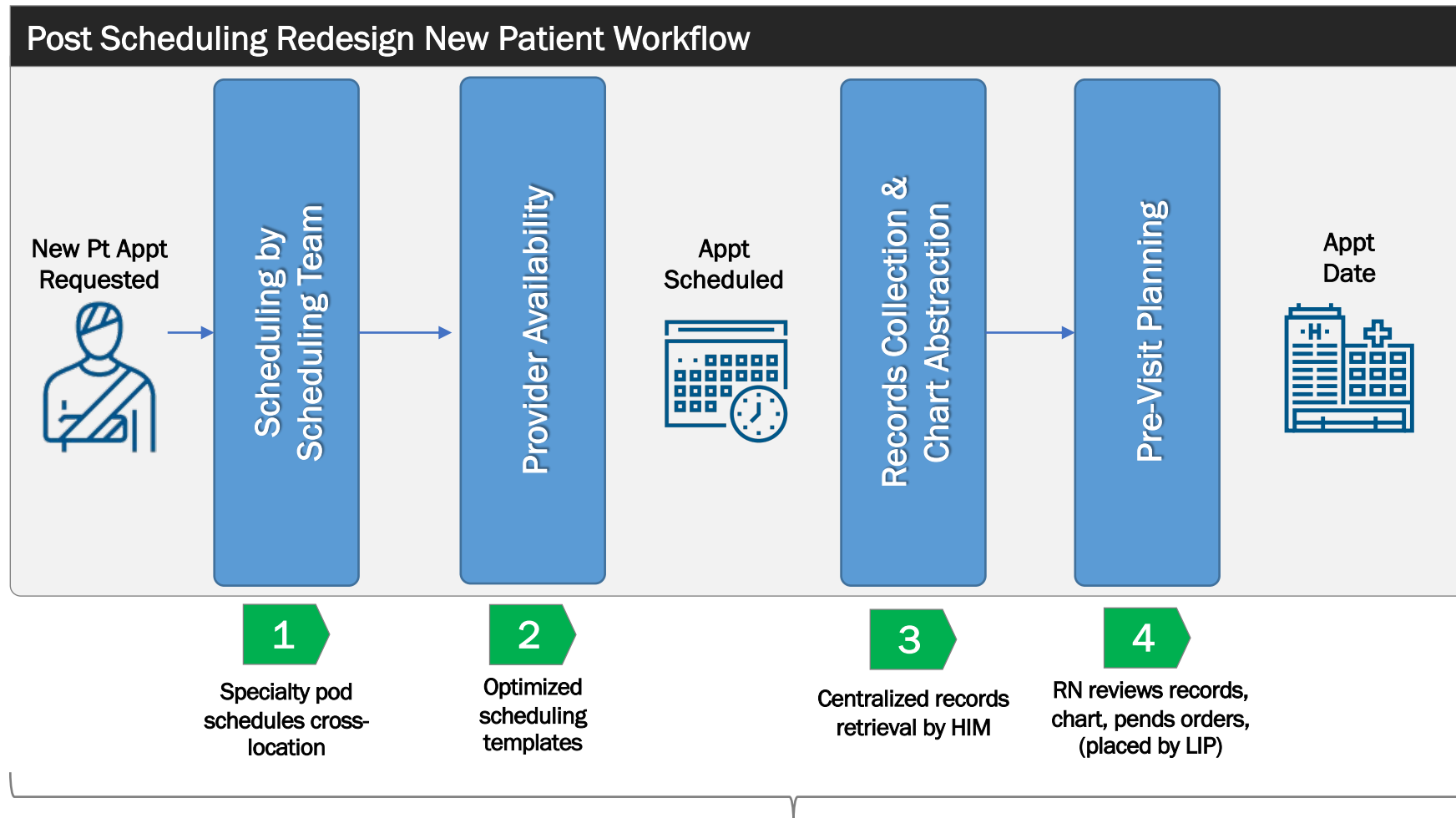
Current State Scheduling Process & Barriers

Typical current state example and barriers with new patient scheduling processes



Future State Scheduling Process

Future state example for new patient scheduling with removed access barriers



Financial Clearance Policy

Definition: Financial Risk Categories

The following categories will be assessed for as part of this policy and procedure. If one of these risk categories is determined prior to service it may be a candidate for deferral, and the patient access team will confirm with providers service is non-medically urgent before continuing.

Risk Category	Definition
Uninsured/Non-covered	Patients who do not have active health insurance coverage, or patients who have insurance that does not cover the scheduled service
Missing or Inaccurate Referral/Pre-cert/Authorization	Patients without a referral or prior authorization from their provider or managed care company if required for services
Outstanding Balances	Patients with financial responsibility (outstanding patient balance and/or balances sent to an agency) greater than or equal to a pre-determined amount
High Expected Liability	Patients who owe greater than or equal to a pre-determined (estimated) amount for upcoming services
Out-of-Network	Patients with an insurance plan that is not in specific facility or offices' contracted network of payers