Understanding and Addressing the No Show Rate in Certain Safety Net Provider Settings

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Executive Summary

The purpose of this inquiry is to begin to determine the scale, roots, and possible solutions to the patient "no show" rates at the specialty clinics. The inquiry is composed of three tasks:

- establish the perceptions of medical, support, and administrative staff who deal with these rates on a daily basis,
- test these perceptions against quantified patterns available by the analysis of data maintained by the data warehouse, and
- identify elements of current practice where useful experimental and pilot solutions could be developed at an acceptable cost/benefit ratio.

Perceptions Supported and Rejected

The following staff perceptions were explored and compared to quantified data:

- No shows are a big problem. This view was not shared by most staff and was attributed to provider concern over personal productivity. The "no show" rate, as defined by quantified data, is lower than perceived and comparable to other important arrival categories. However, there was concurrence that the problem was not defined as the absent patient, but as the empty slot that could not be filled by persons in need to care.

- No shows vary widely among specialties and pose special problems to each practice. Data reflect that the numbers, if not the proportion, of "no shows" do vary across practices, with different implications, and perhaps somewhat different sources and solutions.

- No shows are expensive, but not to "me." This was the general view of staff in different levels and classifications, except for providers.

- Most "no shows" come from community and public health clinics. This view was not supported by the data; indeed, data suggest that approximately half of the "no shows" are referred from the affiliated clinics.

- The failure of community and public health clinic referrals is largely the fault of these clinics. Data suggest that these organizations share with the organization's own clinics some systems features and failures that could and should be addressed in common.

- <u>Most no shows are limited-English proficiency (LEP) patients.</u> Data definitively demonstrate that the great bulk of "no shows" are English-speaking patients.

- <u>Most no shows are from ethnic, racial, cultural, linguistic, or economic minorities.</u> The data do not support this perception. The causes of these perceptions are explored and tentative findings suggested.

- <u>Most no shows are Medicaid, under-insured, uninsured, and/or federally-insured patients.</u> The data suggest the opposite, that "no shows" are insured by a wide variety of plans and HMOs and that publicly-insured and sliding scale patients are in the minority of "no shows."

- <u>Most no shows are initial consultation visits, rather than subsequent visits.</u> Respondents uniformly concurred in this perception and provided explanations. Quantified data require further detailed study beyond the resources of this stage of inquiry.

- <u>Many "no shows" are related to incorrect or disconnected telephone numbers.</u> Respondents uniformly concurred in this perception and provided explanations. Quantified data require further detailed study beyond the resources of this stage of inquiry.

- <u>Late cancellations are the same as "no shows."</u> Respondents uniformly concurred in this perception and provided explanations. Quantified data require further detailed study beyond the resources of this stage of inquiry. Given inconsistent practices in face of a clear policy, it is recommended that the provider organization debate and decide what purposes it serves in capturing and distinguishing between "no show" and "cancellation" information, embed the categories in policy and software, and then stick to them.

Suggested Solutions

- Return inadequate referral forms immediately to the source for repair
- Verify by phone with the patient that he/she is aware that an appointment has been made for him/her and where the appointment is; the earlier this is done, the more likely that phone number errors can be overcome
- Verify by phone with the patient that the scheduled time is one that the patient can keep without major conflict with other obligations; reschedule as necessary
- Encourage patients to call, cancel, and reschedule in a timely fashion
- Avoid implementing solutions to "no shows" that are not supported by data or that serve only the clinic's scheduling convenience or productivity goals
- Install significant signs on all entrances, including the parking garage
- Install significant multi-language signs when approaching the elevator
- Install multi-language signs at each floor
- Install an information desk in the atrium

- Install a greeter position on the 3rd floor entryway to greet and direct patients and notify the interpreter
- Send maps to patients containing easy-to-read bus routes in their language, instructions to bus and cab drivers, and directions to and cost of parking
- Provide cultural competency training to all staff
- Provide specific information about cultures, as needed
- Provide mentoring for staff in customer service [a Nordstrom approach], linked to its desired business outcomes, to capture more, not fewer, referrals from community providers in ethnic populations
- Measure and reward improved customer service
- Employ more bilingual/bicultural staff to produce greater affinity
- Support the individualized attention given by staff to patients
- Collect current information accurately from patients
- Link patients to interpreters at check-in
- Consider re-instituting specialist rounds in the community clinics
- Arrange for routine face-to-face visits with providers, nurses, MAs, referral coordinators, and scheduling staff in the community clinics with their specialist counterparts, to share solutions and exchange materials to create more seamless referrals and patient education and motivation
- Maximize effectiveness of the telephone contact and reminder system
- Provide automated language-specific lines dedicated to cancellations and rescheduling
- Motivate and reward staff for complying with the telephone and address verification process
- Motivate and reward staff for complying with the policy distinguishing between "no shows" and "cancellations"
- Experiment with methods to have reminder calls made during evening hours
- Experiment with methods to have reminder calls accomplished 48-72 hours in advance of the scheduled appointment
- Alter the telephone reminder script to elicit patient questions, particularly about the purpose and location of the appointment, provide answers, and encourage timely cancellations
- If we design an experiment, select a single language for a 3-6 week period, install an evening call process and a new script
- Implement a similar and concurrent experiment for non-LEP and non-community clinic patients
- Develop solutions to unacceptable rates or numbers appearing in specific problems