Improving Patient Inreach & Outreach Workshop

Thursday, August 15, 2019

Oakland, CA

Breakfast, Networking & Registration

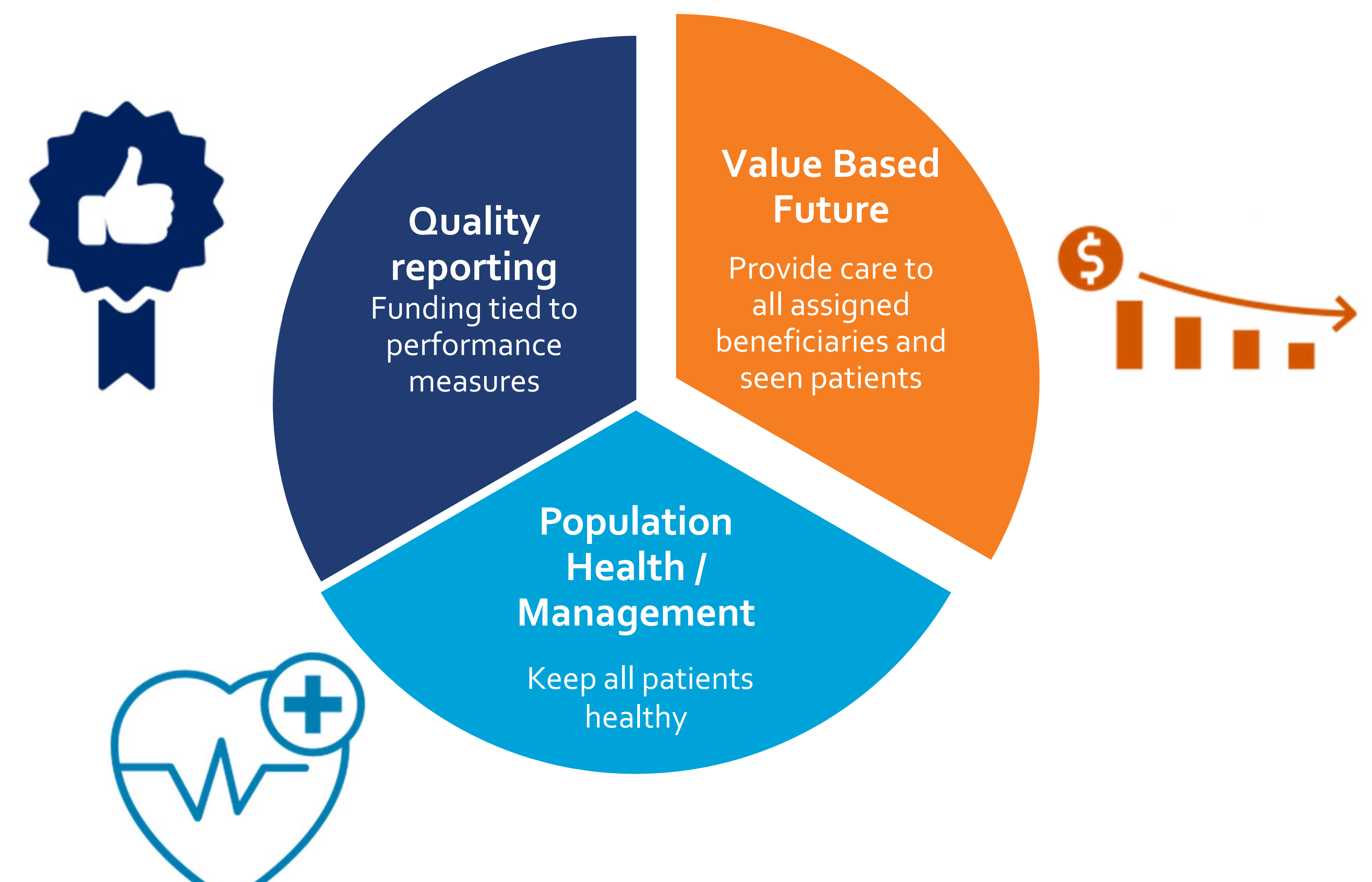
8:30—9:00

Welcome & Why We're Here

Improving Patient Inreach & Outreach
Workshop

Giovanna Giuliani, Executive Director
Safety Net Institute

Why we're here today



Current state, and changes ahead

Current state

- PY1-2 QIP measures* include "DPH Engagement Factor"
- PY3 Five new measures don't include "DPH Engagement Factor"

Current state

- Eligibility & assignment information difficult to update for plans, providers & patients

Future state

- QIP measures may evolve to native specifications – removing engagement factor

Future state

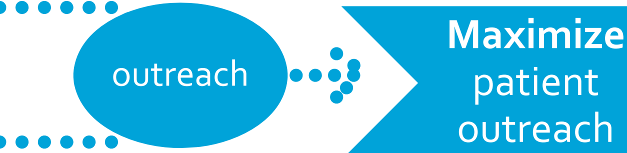
- DHCS could update eligibility data systems & processes

*Exception: QPC-7 "Access to Care for Children & Adolescents"

Outreach → Inreach
Assigned → Engaged

Understand assigned population → Data exchange with plan → Patient outreach → Data cleanup → Reconcile

Assigned, not seen



Maximize patient outreach → Letters → Phone (centralized & clinic) → Portals/ emails → Texts

Engaged, seen

Optimize patient visit → Prep charts → Coordinate care → Plan today's visit → Team prep

Today's agenda

Understand assigned population

Maximize patient outreach

Optimize patient visit

8:30-9:00	Breakfast, networking & registration
9:00-9:15	Welcome & Why We're Here
9:15-9:40	The State of the Digital Divide and Implications for Patient Outreach
9:40-11:00	Assigned-Not-Yet-Seen Patients: Data Problems & Promising Solutions
11:00-12:10	Outreach Implementation Sessions ▪ Centralized Telephone Outreach *OR* ▪ Moving the Needle on Active Portal Use
12:10-1:00	Lunch & Networking
1:00-2:00	Optimizing Inreach for In-Person Visits
2:00-2:55	Patient-Centered Outreach: Designing Ideal Processes
2:55-3:00	Team Time, Snacks, & Closing

Logistics

Thank you for completing pre-work!

- Materials / packets
  - Materials on SNI Link/Data
  - **Evaluations!**

Resource alert!

- Restrooms
- Wifi network = HILTON_MEETINGS ; Code = SNI2019
- Charging station
- See SNI reg desk (Abby/Zoe) for
  - Parking sticker
  - Reimbursement form

The State of the Digital Divide and Implications for Patient Outreach

Courtney Rees Lyles, PhD
Center for Vulnerable Populations
Division of General Internal Medicine at
Zuckerberg San Francisco General Hospital
University of California, San Francisco

Disclosures

- No disclosures to report

Contributors

- Jessica Fields, BA
- Anupama Cemballi, MA
- Lina Tieu, MPH
- Shobha Sadasivaiah, MD, MPH
- Stephen Kiyoi, MA, MLIS
- Urmimala Sarkar, MD, MPH
- Dean Schillinger, MD
- Neda Ratanawongsa, MD, MPH
- David Bates, MD, MSc
- Margot Kushel, MD
- Maria Raven, MSc, MPH, MD
- Lauren M Kaplan, PhD

Outline

- The state of the digital divide
- Examples from our research
  - Portal use and engagement
  - Training and usability
  - External digital literacy and training opportunities
- Implications for patient outreach

The Digital Divide: National, State, and Local

Digital divide shrinking by race/ethnicity, persisting by income & education

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Men Women
Gender

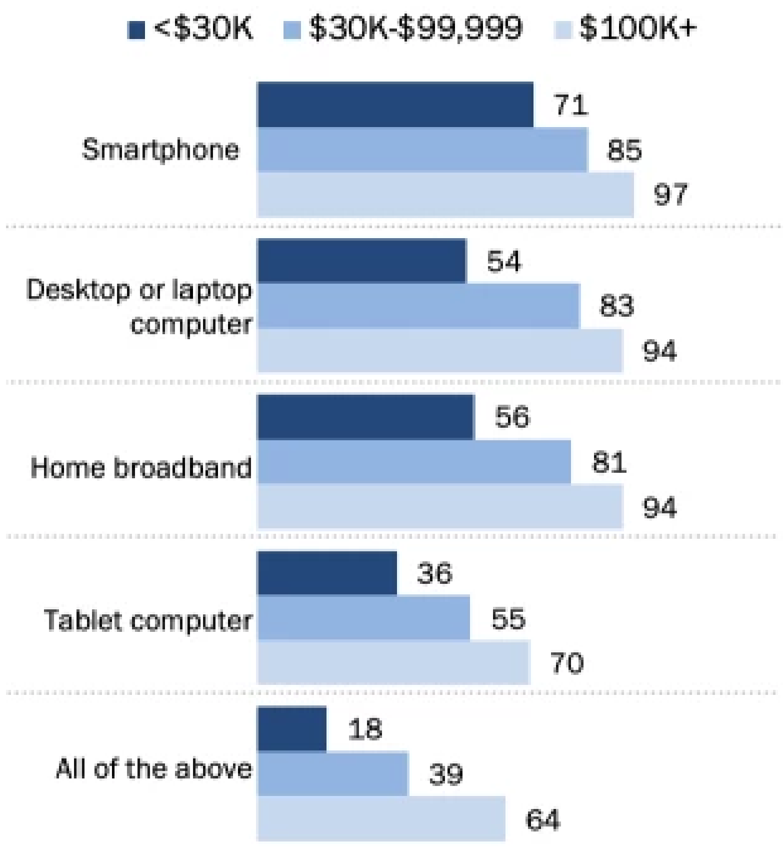
White Black Latino
Race/Ethnicity

<$30K $30-49K $50-74K >$75K
Income

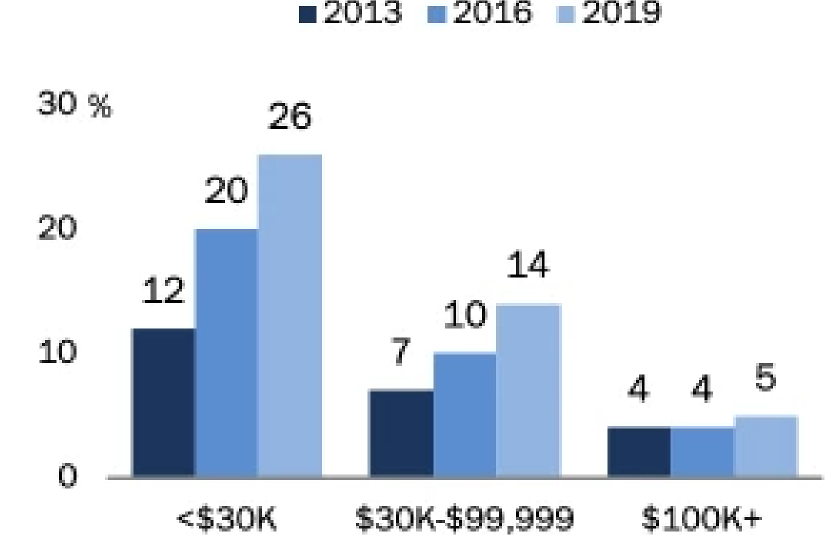
<HS
HSG
Some college
College Graduate
Education

Urban
Suburban
Rural
Community

Pew Research Center 2018 US Smartphone Ownership Data - http://www.pewinternet.org/fact-sheet/mobile/



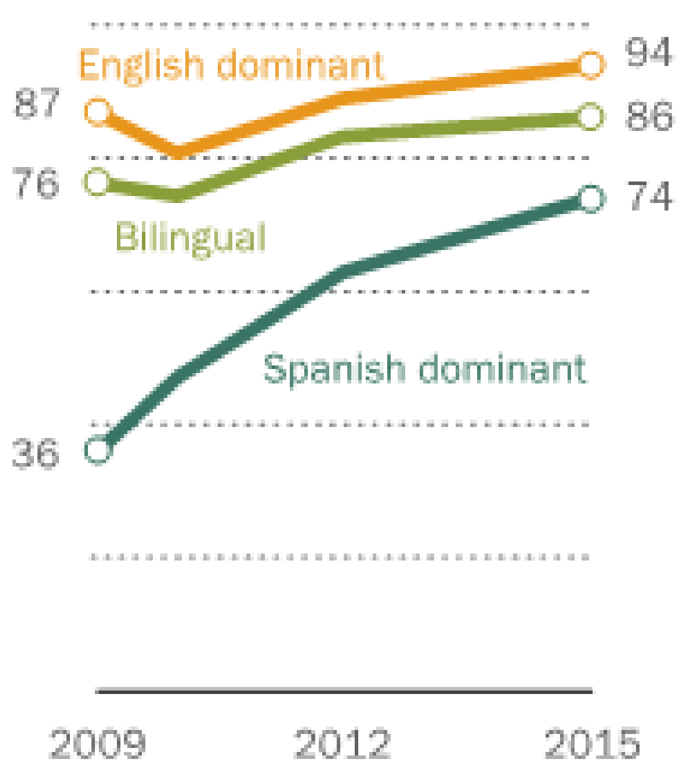
Lower-income Americans have lower levels of technology adoption
% of U.S. adults who say they have the following ...
<$30K
$30K-$99,999
$100K+
Smartphone
71
85
97
Desktop or laptop computer
54
83
94
Home broadband
56
81
94
Tablet computer
36
55
70
All of the above
18
39
64
Note: Respondents who did not give an answer are not shown.
Source: Survey conducted Jan. 8-Feb. 7, 2019.
PEW RESEARCH CENTER



The share of lower-income Americans who rely on their smartphone for going online has roughly doubled since 2013
% of U.S. adults who say they have smartphone, but no broadband at home, by annual household income
2013
2016
2019
30 %
20
10
0
12
20
26
7
10
14
4
4
5
<$30K
$30K-$99,999
$100K+
Note: Respondents who did not give an answer are not shown.
Source: Survey conducted Jan. 8-Feb. 7, 2019. Trend data from previous Pew Research Center surveys.
PEW RESEARCH CENTER

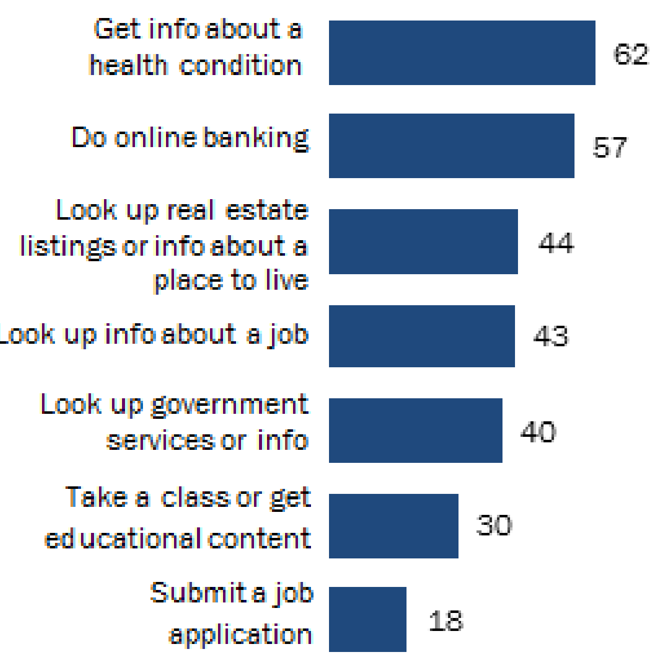
Disparities in internet use by language

Percent saying they use the internet



More than Half of Smartphone Owners Have Used Their Phone to get Health Information, do Online Banking

% of smartphone owners who have used their phone to do the following in the last year



Pew Research Center American Trends Panel survey, October 3-27 2014.

PEW RESEARCH CENTER

Interest is not the barrier

- 70% of patients in the SF safety net interested in e-communication w/ providers:
  - 90% of pts w/ current email account, 50% of pts w/out email account

DIGITAL HEALTH ADOPTION
Across segments, 2017

ROCK HEALTH

	OVERALL SAMPLE	CHRONICALLY ILL SENIORS	VULNERABLE	WORRIED WELL	AGING ADULTS
Telemedicine use—live video	19%	3%	18%	42%	24%
Digital health goal tracking	24%	10%	17%	65%	39%
Wearable use	24%	12%	14%	63%	41%
Searched for online health information	79%	73%	75%	88%	84%
Searched for provider reviews	58%	39%	55%	77%	66%

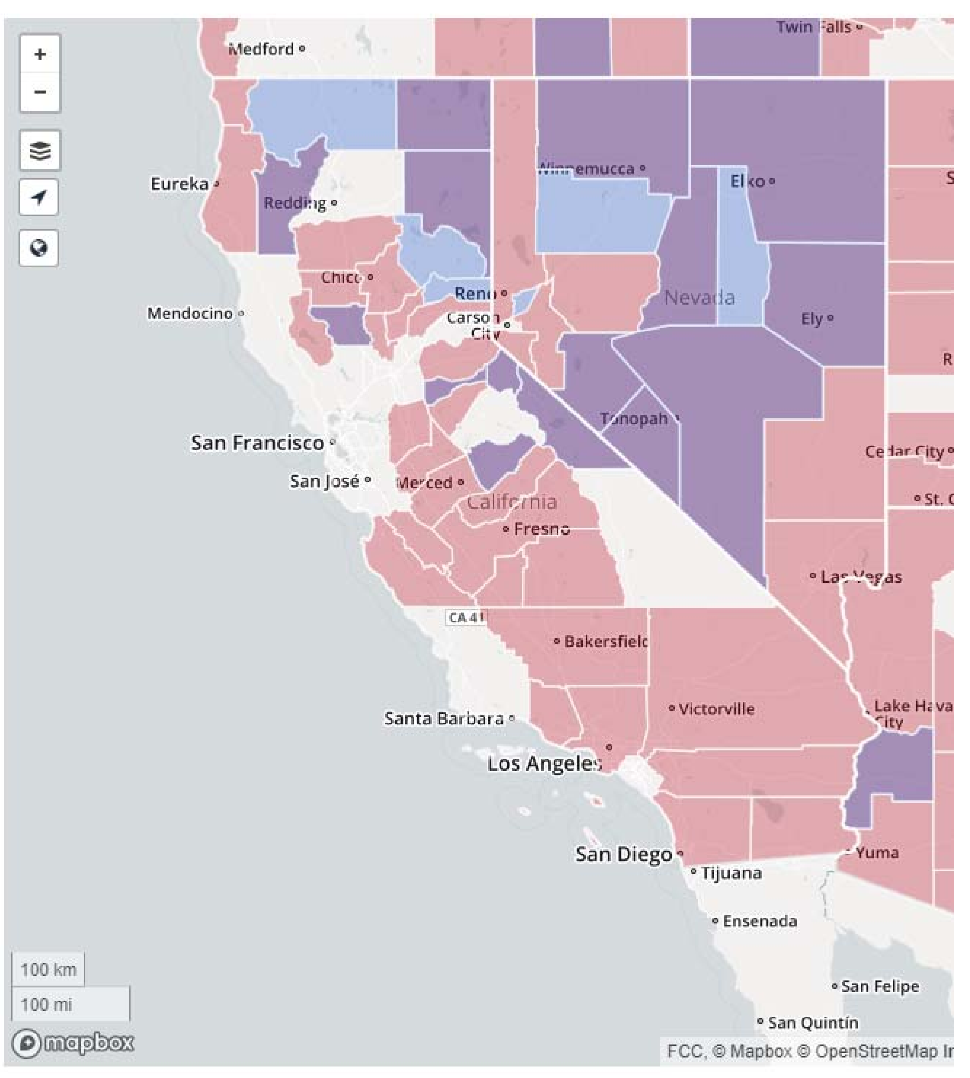
CHRONICALLY ILL SENIORS — AGED 65+ WITH 1+ CHRONIC DISEASES, n=533

VULNERABLE — INCOME <$25,000 OR COVERED BY MEDICAID, n=1162*

WORRIED WELL — AGED 18-35 AND INCOME>$75,000, n=320

AGING ADULTS — AGED 35-55 AND INCOME >$50,000, n=793

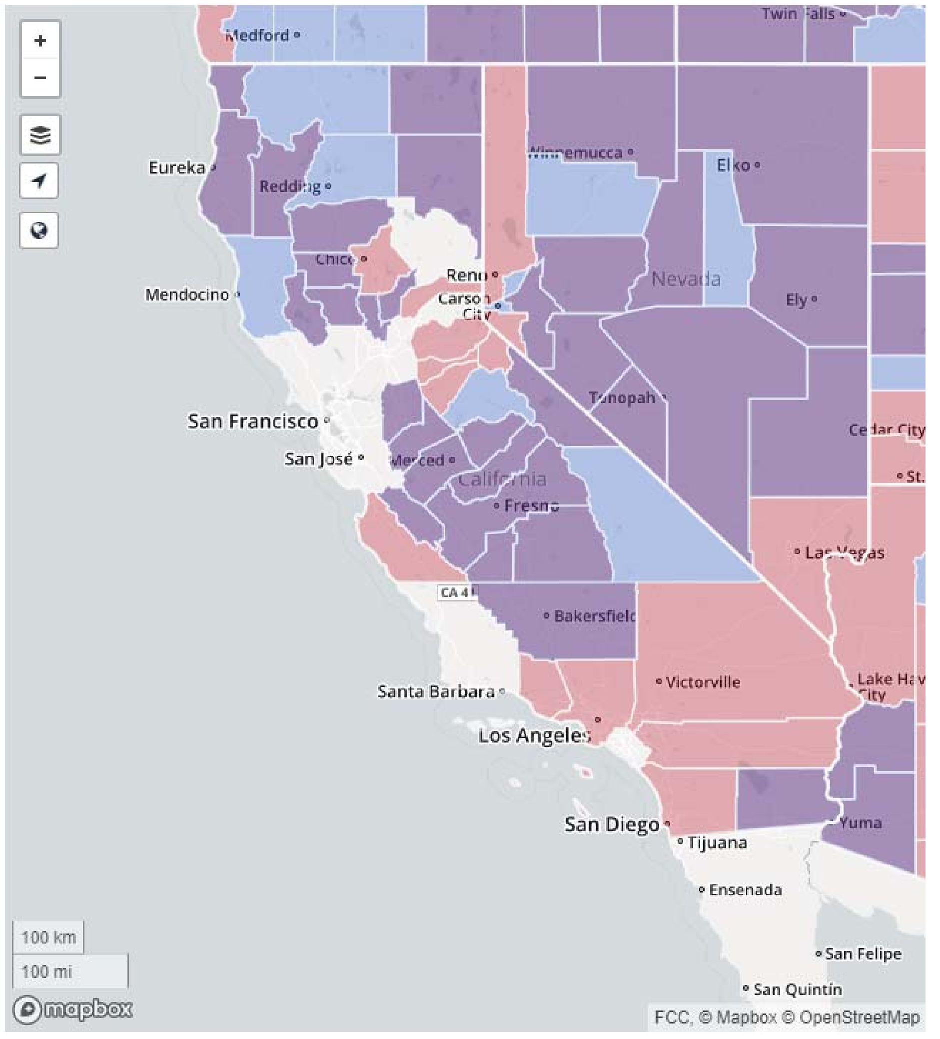
Broadband Access and Physician Shortages



- **Purple shading** = "double burden" counties where broadband access is <50% and physician shortages are above the national avg
- **Pink shading** = counties with higher broadband access where connectivity can be part of the solution to primary care physician shortages in those areas

https://www.fcc.gov/health/maps

Internet Adoption and Physician Shortages



- **Purple shading** = "double burden" counties where internet adoption is <80% and physician shortages are above the national avg
- **Pink shading** = counties with higher internet adoption where connectivity can be part of the solution to primary care physician shortages in those areas

https://www.fcc.gov/health/maps

Internet Usage & Basic Digital Literacy in San Francisco

	Internet User & Basic Digital Literacy	Internet User Only	Non User
Overall	86%	8%	6%
LATINO	76%	16%	8%
NON-ENGLISH	63%	26%	11%
65 & UP	60%	17%	23%
<$25k	53%	22%	25%

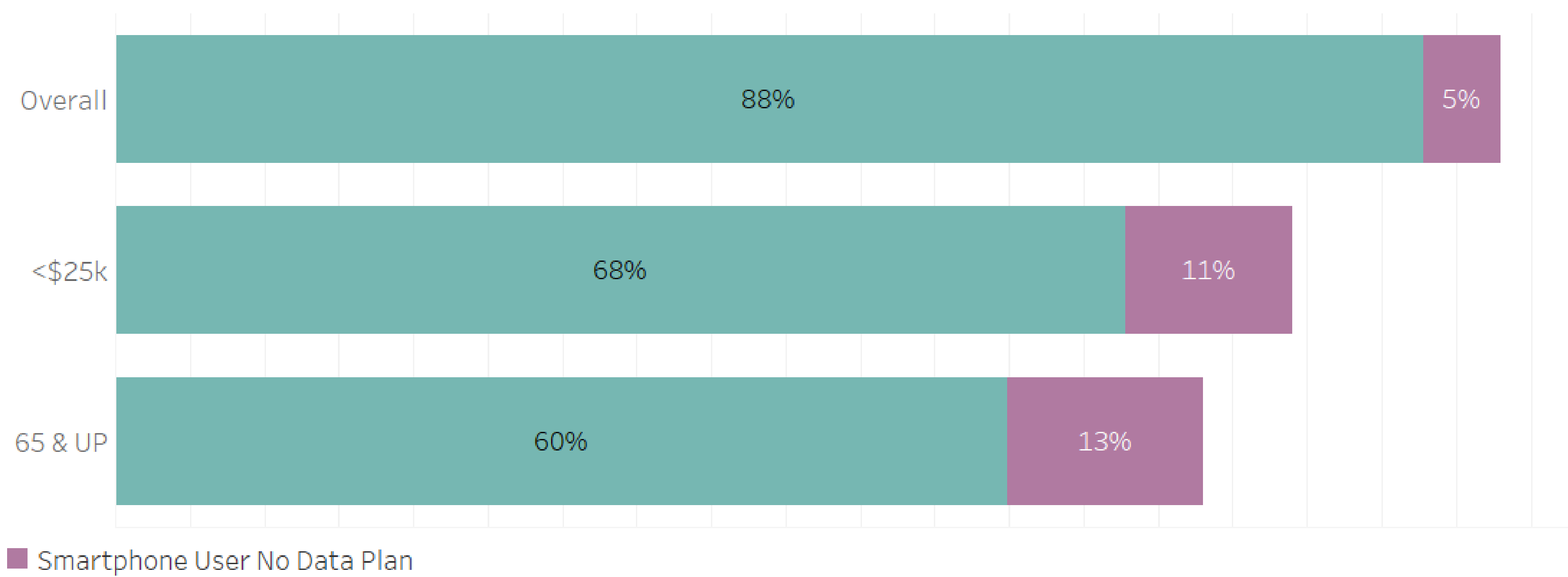
SF Office of Digital Equity, 2017-2018

Interest in internet training and access in San Francisco

- 42% of non internet users are interested in free computer/Internet classes
- 74% of less connected users are interested in subscribing to high speed internet if offered at an affordable price

SF Office of Digital Equity, 2017-2018

Smartphone + Data Plan Access in San Francisco



SF Office of Digital Equity, 2017-2018

Digital Programs for Low-Income Adults

- California and Federal LifeLine phone discount programs (mobile or landline)
  - Qualify based on household income or if participating in programs such as Medicaid/Medi-Cal, SNAP, SSI, & more
  - Flat rate or measured rate options. ~$10/month
- Discounted broadband
  - AT&T Access, Comcast Internet Essentials, & more
  - Qualify based on participation in programs such as SNAP, SSI, Medicaid, & more; address serviceable by company
  - ~$10/month

Mobile Phone Use Among Older Homeless Adults in Oakland

- Of 300 homeless older adults (>50yo)
  - 55% had ever accessed the internet
  - 72% currently owned or had access to a mobile phone
  - Of those with access to a mobile phone
    - 76% feature phone; 32% smartphone
    - 94% w/ no annual contract
      - → frequent changes in phone number limit utility for 2-way communication
    - >80% reported easy to use mobile phones
    - 65% used phones to communicate w/ medical personnel
  - Barriers: cost, functional and cognitive impairments, stolen or lost phones, charging locations

Raven et al. 2018 JMIR Mhealth Uhealth

Key Take-Away Points

Disparities persist in home internet access/speed, smartphone ownership, and digital skills, particularly among certain groups (e.g. low-income older adults).

Increasingly people either have >1 device or are smartphone-only users. Non-white and low-income populations increasingly smartphone-only users.

There is broad interest in improving digital skills and using technology for health, including among safety-net populations.

Examples From Our Research: Portal Use and Engagement

Patient Interest in Portal During Inpatient Admission to Academic Safety Net Hospital

(N=23,994 hospitalizations, Sept 2015-2017; 16,507 patients)

- Lower interest among older adults, non-white, and non-English speaking patients

Patients expressed portal interest at 31% of hospitalizations

44% of patients expressed portal interest

- Offering portal to patients who have previously declined may be useful for engagement

Sadasivaiah et al 2019 JMIR

Reasons for lack of portal interest

(N=15,380 hospitalizations, Sept 2015-2017)

Sadasivaiah et al 2019 JMIR

Reasons for lack of portal interest

Desire for personal connection with doctor

"I wouldn't want anything like...I've seen those things on television where they got the doctor and you see the doctor on the computer screen and stuff. Is that kind of like what you're talking about?"

Feeling that emails won't get answered

"Well, unless I'm missing something very basic, email just doesn't seem to work...it's like it goes into this pot."

Lack of understanding of portal content/fear of use

Probably to see a blood test result. I wouldn't really—unless somebody explained it, I wouldn't know what I was looking at, really. It's like diagnosing your car, tells you all this stuff but then you don't know what it is. I got so much stuff.

Tieu et al. 2015 JMIR

Examples From Our Research: Training and Usability

Portal Training and Usability in the Safety Net

- Participants asked to speak aloud as they interacted with the MYSFHEALTH portal website
- Video-recorded computer screen and participant while completing 5 portal tasks
- Interviewer gave assistance if participant was stuck after 2 attempts or gave up on the task
- Recorded time to complete, number of attempts, assistance needed
  - Overall and stratified on a validated, single item measuring self-reported health literacy

Tieu Lyles et al JAMIA 2016

Usability Interviews: Results

	Limited Health Literacy	Adequate Health Literacy
Mean # tasks completed without assistance	1.3	4.2
% with Novice Computer Barrier	69%	10%

Tieu Lyles et al JAMIA 2016

Mobile Apps for Vulnerable Populations

- Same thinkaloud approach with patients in safety net:
  - Diabetes (n=10)
  - Depression (n=10)
  - Caregiving (n=9)
- Evaluated the use of 4 apps for depression and diabetes, and 3 apps for caregivers on iPad 4 and Samsung Android tablets

Tasks for Diabetes Group

- Data Entry Task: Enter blood sugar (4 apps)

Sarkar et al. 2016 JGIM

% Patients with diabetes able to log blood sugar with vs. without assistance

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Diabetes Connect (n=10)
InCheck (n=9)
Diabetes App (n=10)
Social Diabetes (n=10)

Successful/Straight forward
Successful/Prolonged
Partial
Unsuccessful/Prolonged

Sarkar et al. 2016 JGIM

Examples From Our Research: External Training

Referring to Outside Digital Literacy and Skills Training: Tech Allies

% Does Not Use Internet or Email at Baseline and 2-Month by Study Arm

	Baseline	2-Month
Waitlist	53	60
Training	35	

p=0.63 (Waitlist); p=0.004 (Training)

You know, before I just was afraid of touching, uh, iPad or something…even – even my computer. Now I – I feel a little bit more confident.

Key Take-Away Points for Health Systems

Offering health technology options to all patients is important in reducing disparities. There are many reasons why patients can’t engage in one particular moment, but they may be able to at a later point.

Approaching health tech as an IT solution will fail. Needs to be integrated across clinic workflows and approached as a shift in care delivery. Usability challenges and language barriers remain.

Building out technical support (call centers, in-person training) and connecting patients to outside resources for broader digital literacy training and low-income broadband programs is key.

Potential for Partnership and Advocacy

- Advocate for greater inclusion of safety-net patients in tech companies' usability testing for new digital tools/apps.

- Advocate for improved language options for portals, apps, and other digital health tools.

- Advocate for broader eligibility and more streamlined enrollment in low-cost internet and mobile phone programs.

- Partner with public libraries, free computer labs, and community-based organizations focused on digital inclusion.

Q&A

Courtney Lyles, PhD

Associate Professor, Center for Vulnerable Populations, UCSF

Courtney.Lyles@ucsf.edu

Additional Slides

Mobile Phone Use Among Older Homeless Adults in Oakland

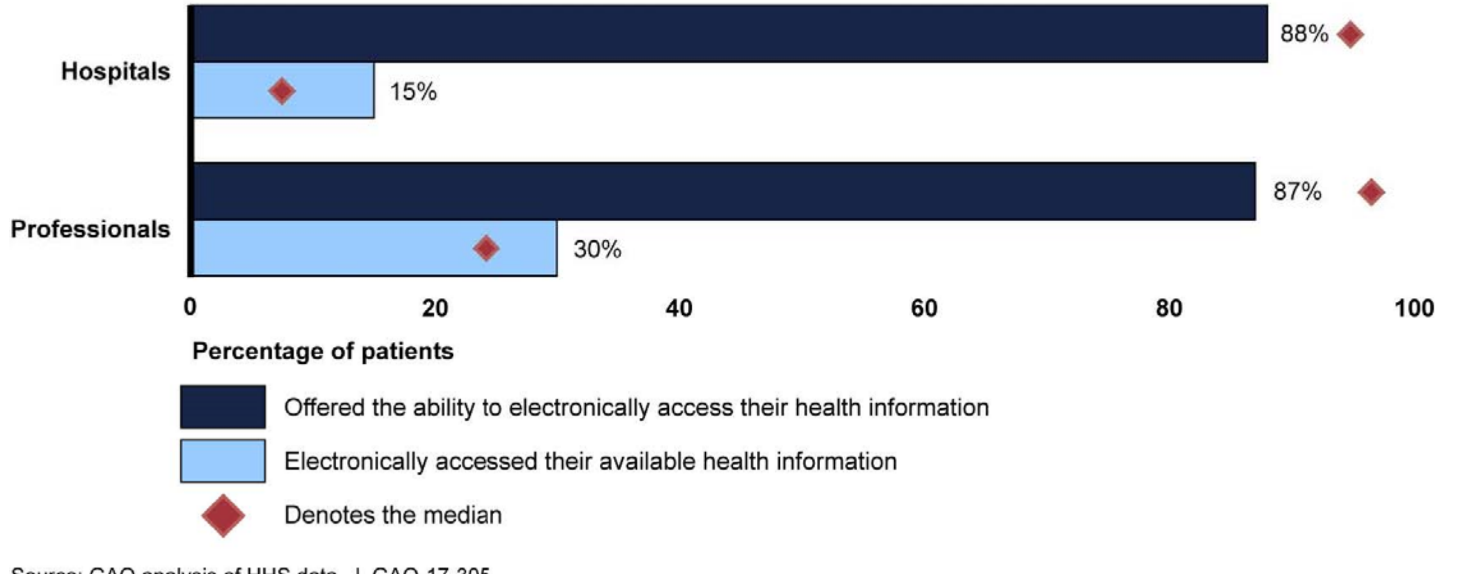
- Used phones and internet to
  - Communicate w/ medical personnel (65%)
  - Search for housing and employment (31%)
  - Contact family (82%)
- Barriers to mobile phone and internet access/use
  - Cost
    - Low enrollment in programs to address cost barriers to phone use (e.g. "Lifeline" program – requires mailing address)
  - Functional and cognitive impairments
  - Over half had phones stolen (53%) or lost (53%)
  - Charging locations

Raven et al. 2018

Rapid EHR/portal spread across diverse healthcare systems

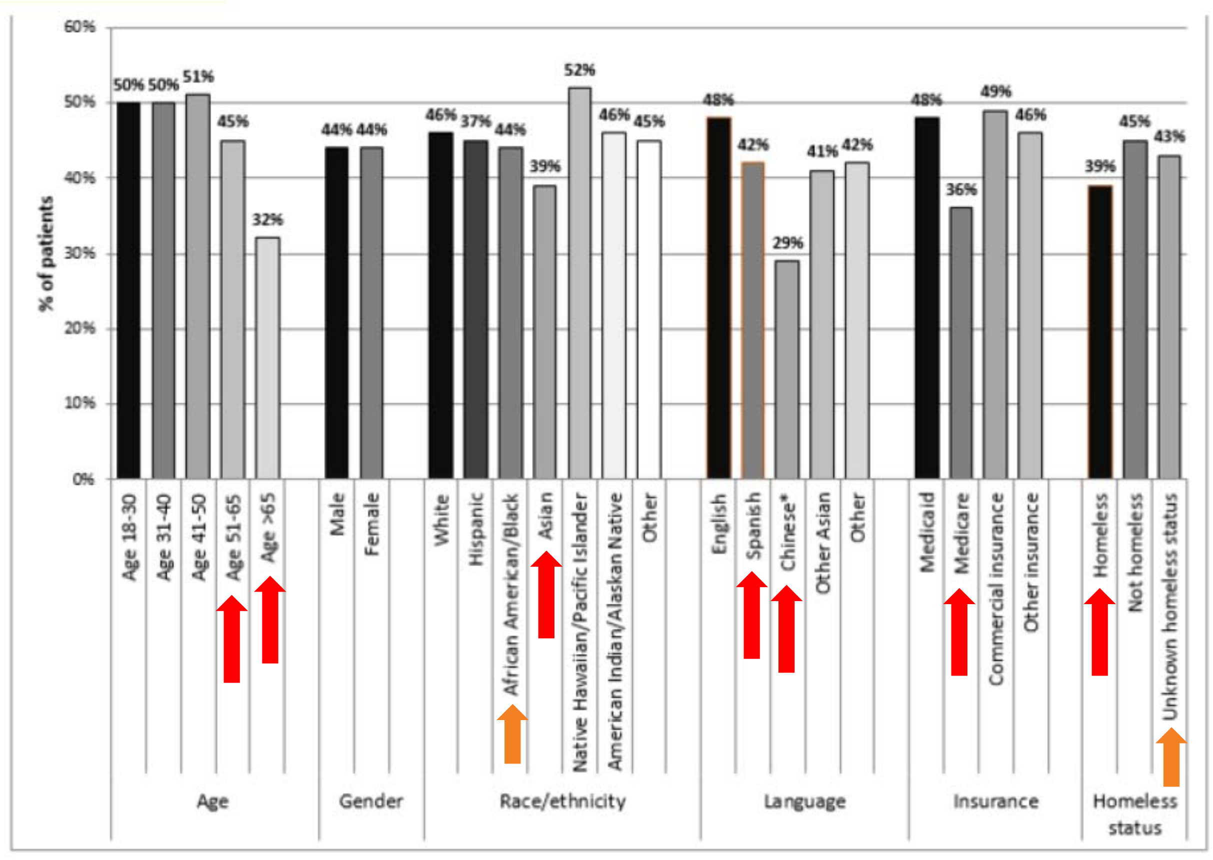
- Driven by financial incentives (Meaningful Use → >$30 billion)
- Includes targeted portal metrics

Avg % of Patients of 2015 Medicare EHR Program Participating Providers Who Were Offered Access and Electronically Accessed Health Information



Patient interest in an online healthcare system portal during at least one admission to an academic safety net hospital (n=16507 patients, Sept 2015-2017)

Overall, 36% of inpatients expressed interest in patient portal



Sadasivaiah et al 2019

Meaningful Use in the Safety Net

- Rapid ethnography of patient portal implementation at 5 community health centers in CA
- In-person site visits and phone interviews
  - In-depth interviews w/ executives and clinicians (n=12)
  - Informal focus groups w/ clinical and IT support staff (n=35)
  - Observations of patient portal sign-up procedures and clinic work
  - Reviews of marketing materials and EHR use data

Ackerman et al. 2016

Illustrative Quotes

Enrolling patients

"We think it's the right thing to do, but. . . we stopped other work to get our enrollment numbers." (executive, Site 2)

Moving patients from enrollment to use

"I think nearly every patient, we had to explain what the portal was. Some of them didn't even use technology at all, so we had to set them up with an e-mail. If there was time, we would teach them how to navigate their inbox. That was a new experience for them." (program coordinator, Site 2)

Routing patients' messages

"... Now you have two different ways of doing things because you have patients who are on Portal and patients who aren't on Portal. . . You have an extra workflow to figure out." (program coordinator, Site 1)

Limits to portal access and usability

"Most of our patients are Hispanic. They would get on the portal and say, I don't know what it's saying." (clinic manager, Site 1)

Ackerman et al. 2016

Theme	Subtheme	Illustrative Quotes
Enlisting staff support	Pursuing financial benefit and competitive advantage	“We had already budgeted to receive the meaningful use money, so we were committed.” (executive, Site 2)
	Providing all patients with access to their EHR data	“It revolutionizes the way patients can have access to their records.” (program coordinator, Site 3)
	Promising improved quality and efficiency	“This is convenient. You can save a phone call. You can save time.” (nurse midwife, Site 3)
Fitting the portal into clinic routines	Enrolling patients	“We think it’s the right thing to do, but. . . we stopped other work to get our enrollment numbers.” (executive, Site 2)
	Moving patients from enrollment to use	“I think nearly every patient, we had to explain what the portal was. Some of them didn’t even use technology at all, so we had to set them up with an e-mail. If there was time, we would teach them how to navigate their inbox. That was a new experience for them.” (program coordinator, Site 2)
	Routing patients’ messages	“... Now you have two different ways of doing things because you have patients who are on Portal and patients who aren’t on Portal. . . You have an extra workflow to figure out.” (program coordinator, Site 1)
Rethinking meaningful use	Limits to portal access and usability	“Most of our patients are Hispanic. They would get on the portal and say, I don’t know what it’s saying.” (clinic manager, Site 1) “I think they’re interested. They just don’t know how to do it. They haven’t been shown how to do it. I think showing them and helping them is going to be the best thing.” (staff member, Site 3)

Ackerman et al. 2016

Portal Implementation Activities

- Promote portal to patients
  - Brochures, fact sheets, and posters in English and Spanish
  - Gifts for enrolled patients (buttons, pens, raffles w/ prizes, etc.)
  - Marketing slogans
  - Promotional letter mailed w/ registration guide and FAQs
  - Advertised as faster, more reliable way to communicate w/ health center
- Assist patients with enrollment and use
  - Front desk staff, volunteers, and MAs available to assist w/ enrollment. New staff and volunteers hired as well.
  - Computer kiosks w/ balloons in waiting room for self-enrollment
  - Training – portal training 2x/week, help w/ setting up email accounts, library extension for computer skills instruction on-site
  - Video on portal enrollment and use in multiple languages

Ackerman et al. 2016

Portal Implementation Activities

- Route patient messages
  - Secure messages received by call center, directed to nurses, then routed to physician if necessary. One physician per day providing medical advice for secure messages.
  - MAs and clinicians w/ access to messages – whoever reviewed message first responded
  - Secure messages routed through front desk staff, nurses managed message queue in physicians' inboxes
  - 50+ templates for responses
  - Response time goals 24-72 hrs
- Build support among clinicians and staff
  - Enrollment competitions, trainings, live demos, regular meetings
  - Portal "champions" appointed
  - Promoted to staff and clinicians as more efficient way of communicating w/ patients and scheduling, and as beneficial to patients
  - Chief Medical Officer observed portal enrollment at clinics
  - Clinics encouraged to enroll 1 patient/day to reach MU benchmark; celebration for meeting MU goal

Ackerman et al. 2016

Implications of Efforts to Achieve Meaningful Use Certification

- Creative, sustained attempts to ensure patients benefit from EHR
- Clinic staff united under shared ethos of improved quality of care
- MU assumption about patients' pent-up demand for access to EHR info and ability to make use of it clinics focused on enrollment and message management rather than relevance and usability of tool for safety net patient populations

Usability interviews findings
% of Participants Needing Assistance to Complete Tasks, by Health Literacy

Tieu Lyles et al JAMIA 2016

Video-Based Training Patients to Use the Portal

	Study Participants, n=93	Clinic Comparison Group, n=2462
Initiated sign-up		
Logged in at least once		

Tieu Lyles et al JAMIA 2016

What does portal implementation mean for patients served in the safety net?

- Despite high interest, challenges with usability
  - Often not tested and/or reported, but known health literacy barriers
  - Language barriers are mostly unexamined
- Moving forward: patient-centered goals with an eye toward accessible implementation

Tips about Diverse Patient Engagement

- In-person support is critical
  - Partnership and referral to community-based organizations such as public libraries with expertise in digital inclusion
  - Appropriate technical support services (e.g. call centers) to support and troubleshoot
- Communication is key
  - Portal will not replace in-person relationships, but can replace some inefficient elements of current systems
  - Specific features can be more meaningful (e.g. lab test views) than explaining the entire website
- Untapped caregiver/proxy potential

Apps and Tasks by Groups

	Diabetes	Depression	Caregiving
Data Entry Task	Enter blood sugar • Diabetes Connect • Diabetes App • Social Diabetes • InCheck	Enter mood • Optimism • T2 Mood Tracker Take PHQ-9 Test • Depression CBT • Mood Tools	Enter med or appt • Capzule • CareSync • CareZone Senior
Data Retrieval Task	Find average blood sugar • Diabetes Connect • Diabetes App • Social Diabetes Find recipe • InCheck	Retrieve graph of mood trends • Optimism • T2 Mood Tracker Retrieve audio/video clip for stress reduction • Depression CBT • Mood Tools	Review medication or appt list • CareSync • CareZone Senior Retrieve BP flow sheet • Capzule

Sarkar et al. 2016

Apps and Tasks for Diabetes Group

- Data Entry Task: Enter blood sugar (4 apps)
- Data Retrieval Task: Find avg blood sugar (3 apps) or recipe (1 app)

Sarkar et al. 2016

% Patients with diabetes able to retrieve blood sugars/recipes with vs. without assistance

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Diabetes Connect (n=8)
InCheck (n=9)*
Diabetes App (n=10)
Social Diabetes (n=5)

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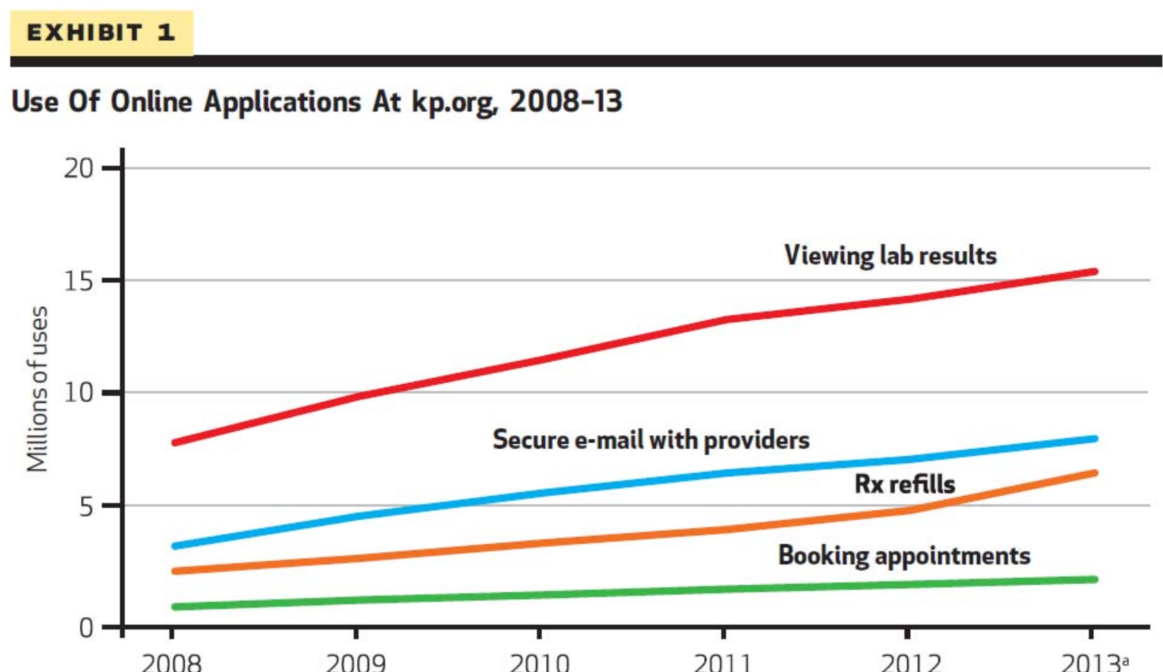
Sarkar et al. 2016

Overall Portal Use among Early Adopters: Kaiser Permanente Northern California

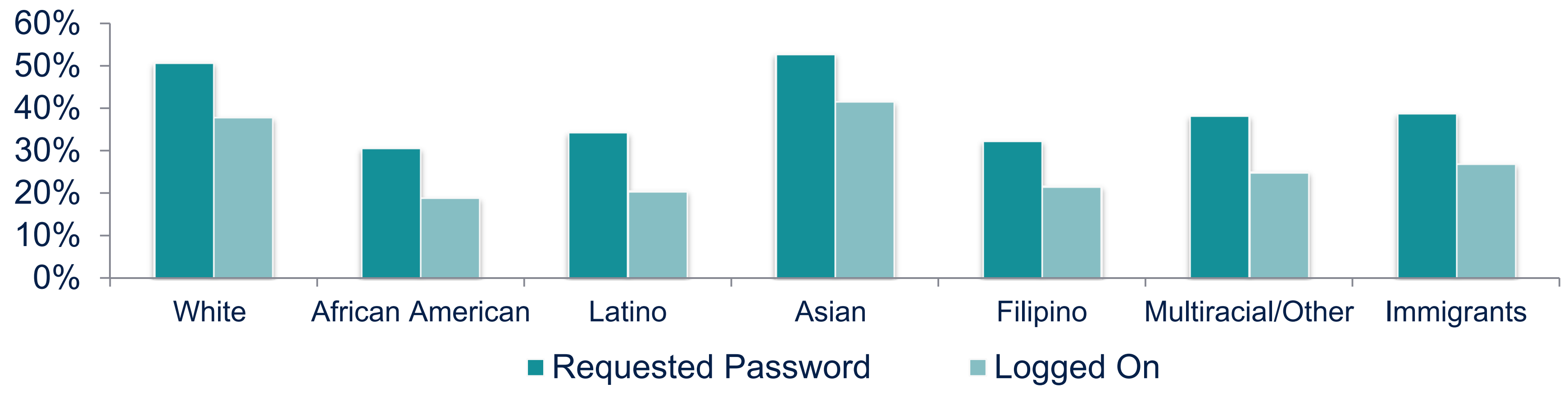


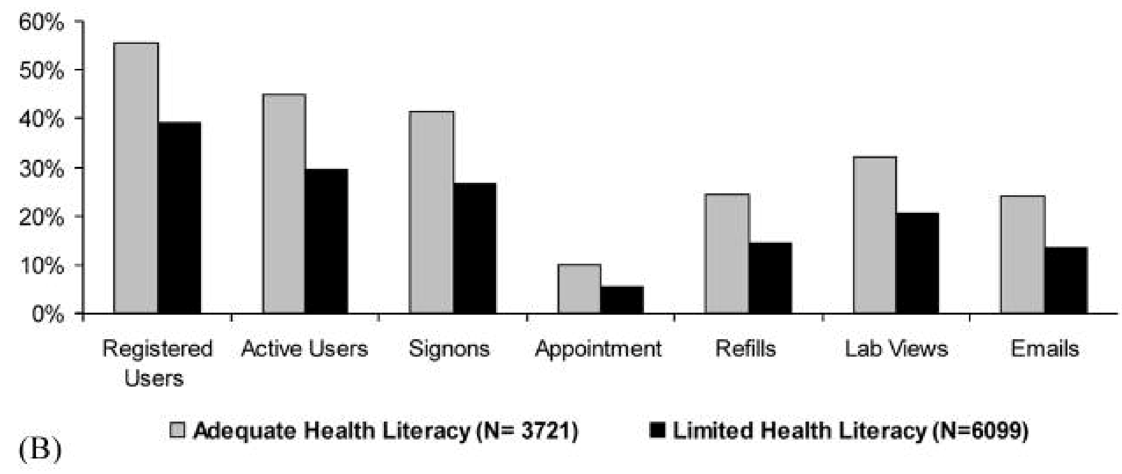
73%

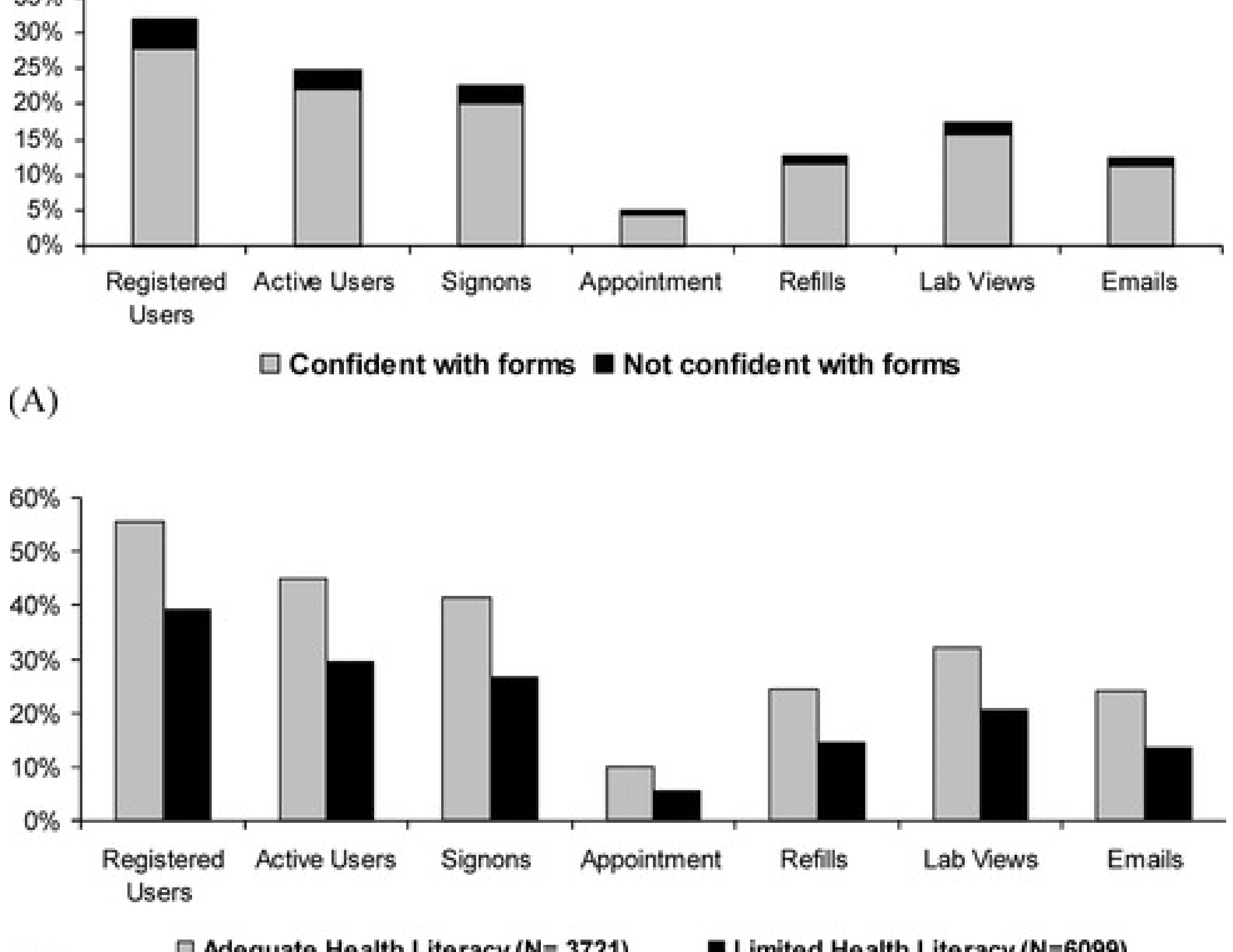
Registered

As of September 2013 approximately 73 percent of KPNC patients had registered on the kp.org website.

Portal Use at Kaiser Northern California

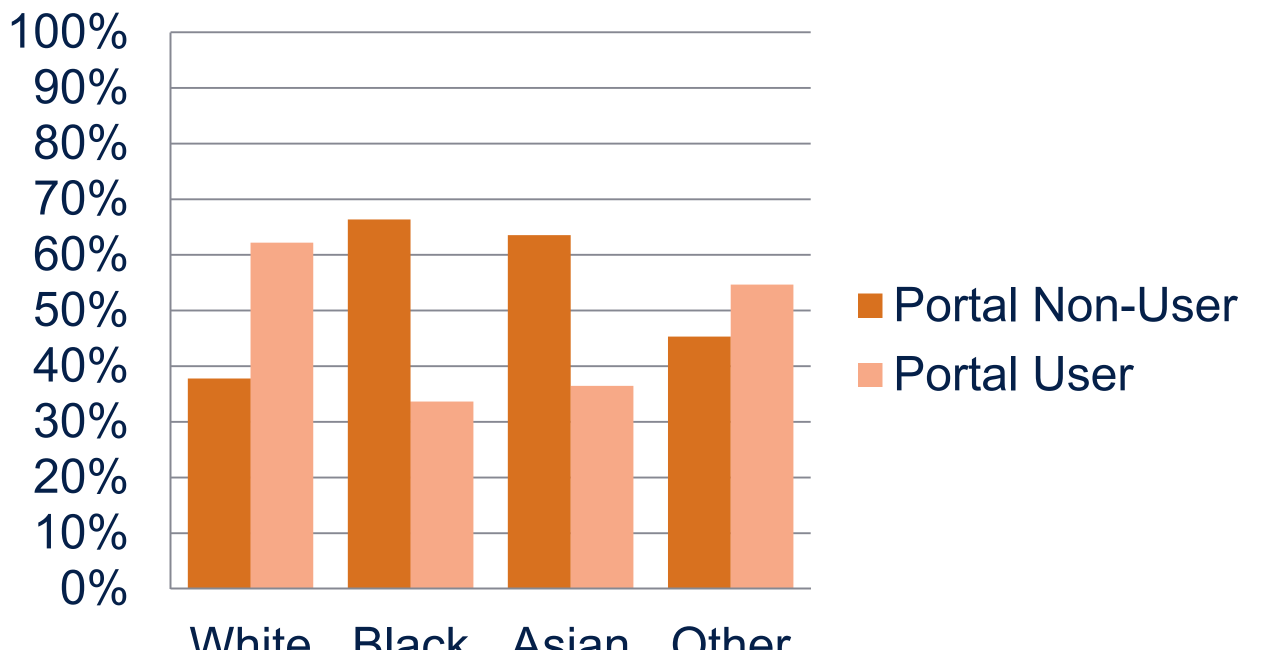





35%
30%
25%
20%
15%
10%
5%
0%
Registered Users
Active Users
Signons
Appointment
Refills
Lab Views
Emails
Confident with forms
Not confident with forms
(A)
60%
50%
40%
30%
20%
10%
0%
Registered Users
Active Users
Signons
Appointment
Refills
Lab Views
Emails
Adequate Health Literacy (N= 3721)
Limited Health Literacy (N=6099)
(B)

Uptake: Healthcare Disparities in Portal Use Persist at Early Adopter Sites

2 to 4 times lower odds of use:

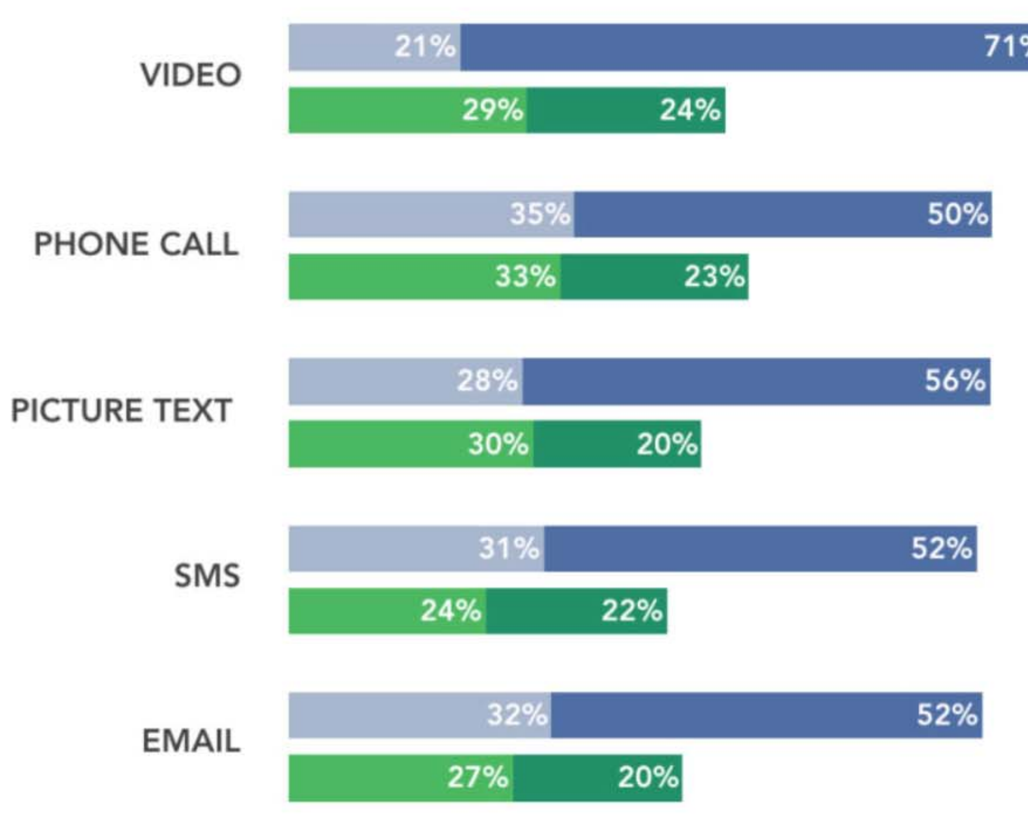


- Significantly lower portal use among Blacks and Latinos (and some Asian subgroups), as well as those with limited health literacy
  - Not accounted for by access to computers or Internet use
  - Not accounted for by provider recommendation/ encouragement

Lyles et al. Medical Care 2012
Sarkar JAMIA 2011; Goel JGIM 2011; Roblin JAMIA 2009

CONSUMER SATISFACTION WITH TELEMEDICINE, BY CHANNEL

For those with prior in-person visit vs. those without, 2017

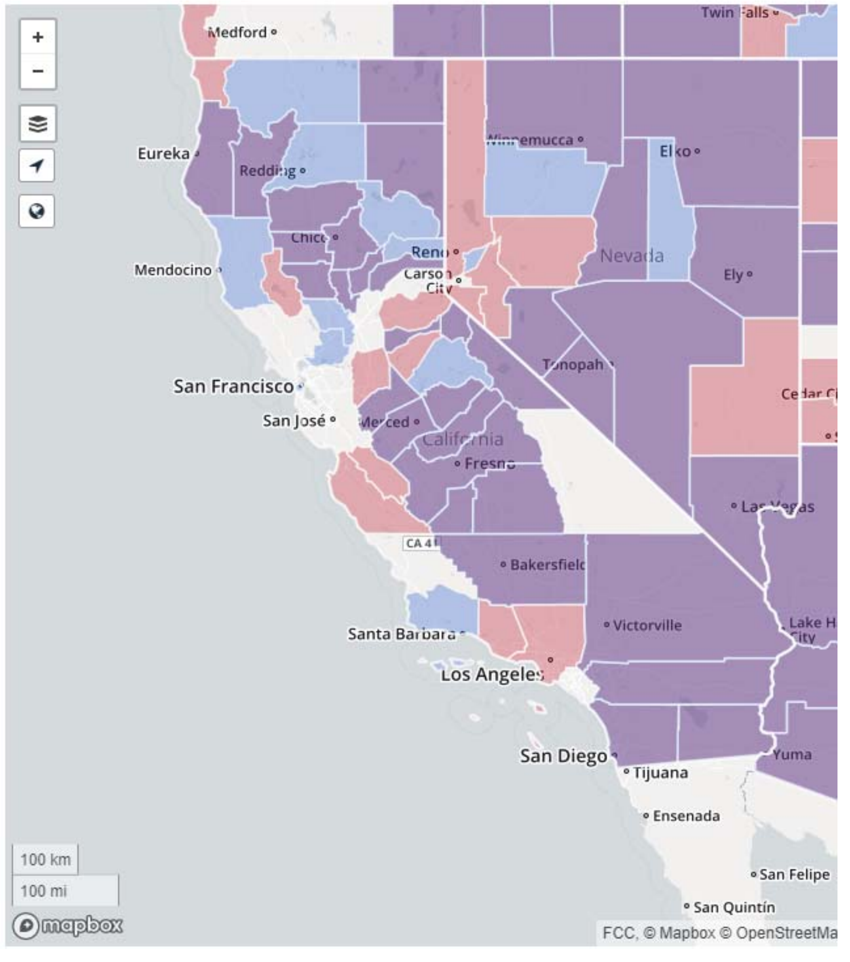


LEGEND

- Had a previous in-person visit with telemedicine provider, moderately satisfied
- Had a previous in-person visit with telemedicine provider, extremely satisfied
- No previous in-person visit, moderately satisfied
- No previous in-person visit, extremely satisfied

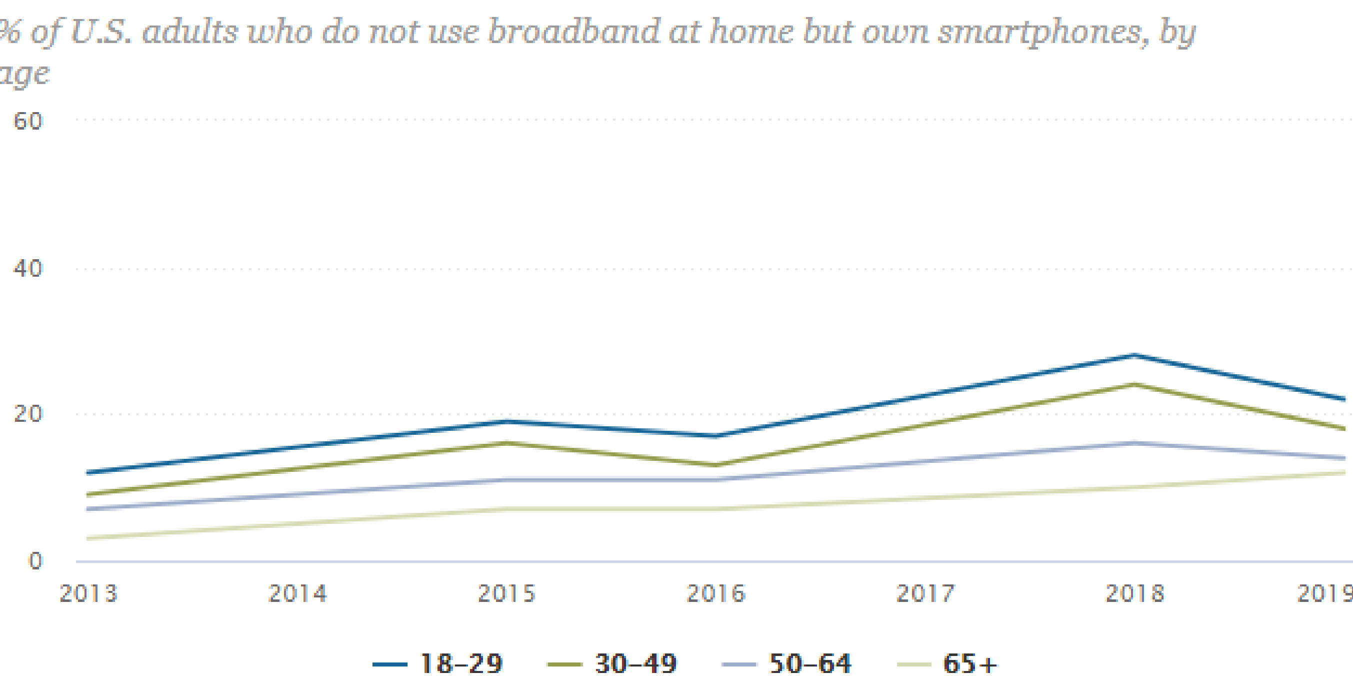
Source: Rock Health Digital Health Consumer Adoption Survey (n_{2017} = 3,997)
Note: 76% of all telemedicine users had a previous in-person visit with same provider.

Rural Broadband and Physician Shortages

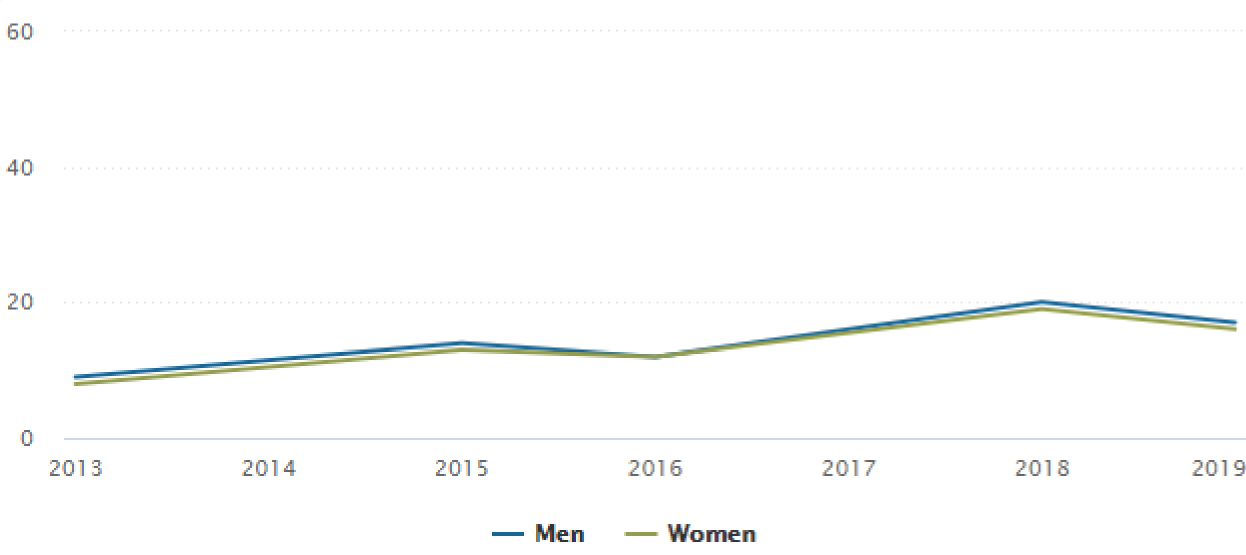


- Purple shading = "double burden" counties where rural broadband access is <50% and physician shortages are above the national avg
- Pink shading = counties with higher broadband access where connectivity can be part of the solution to primary care physician shortages in those areas

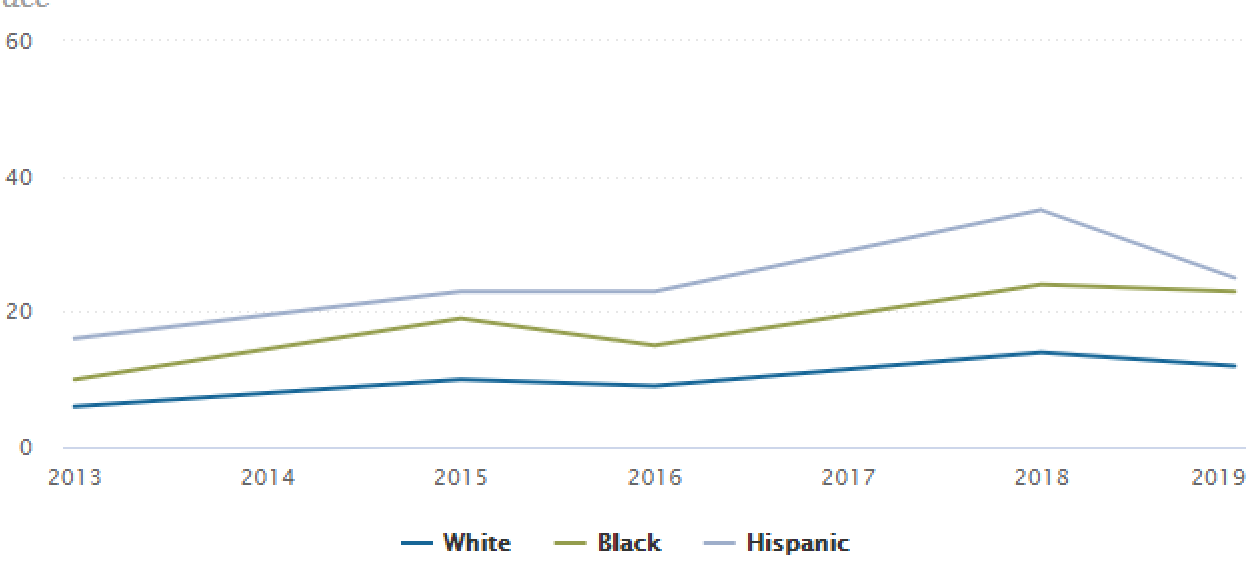
https://www.fcc.gov/health/maps



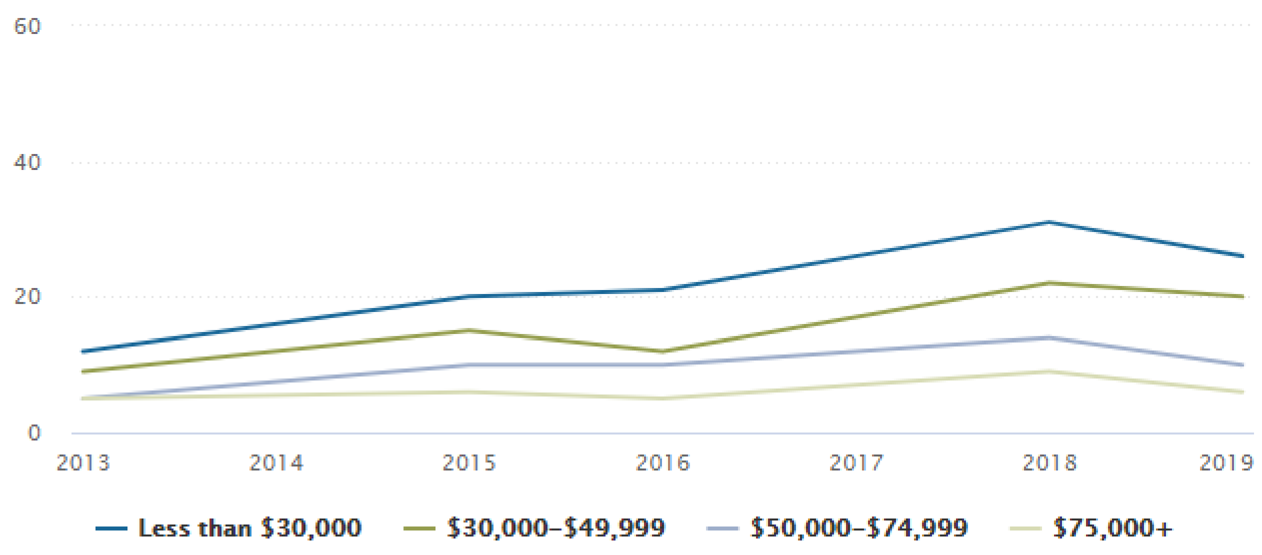
Source: Surveys conducted 2013-2019. Data for each year based on a pooled analysis of all surveys containing broadband and smartphone questions fielded during that year.



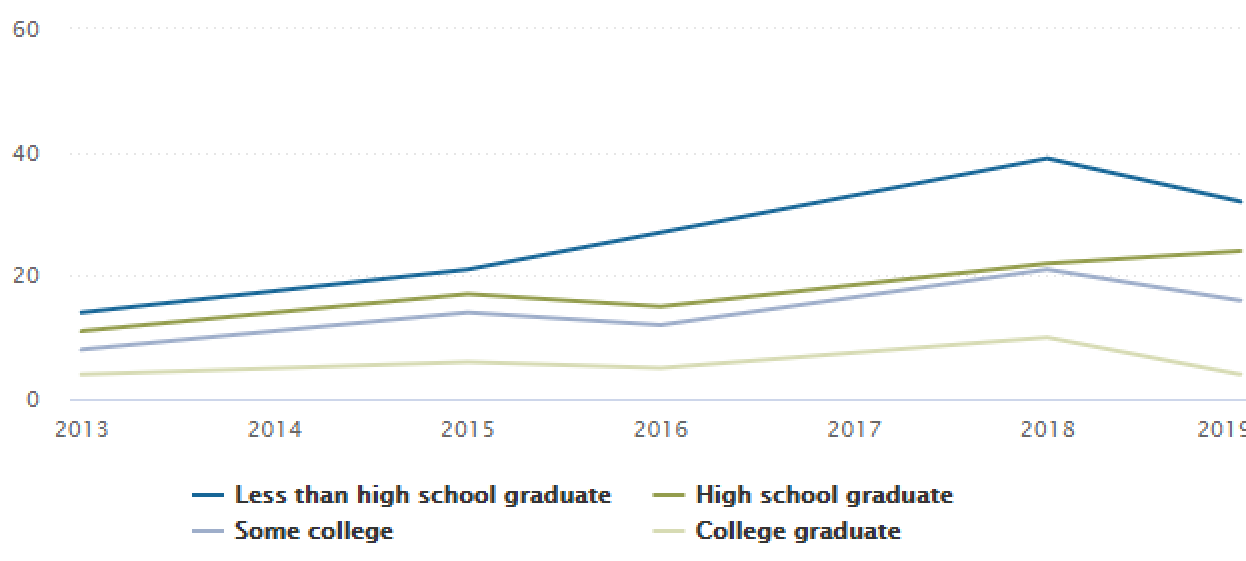
Source: Surveys conducted 2013-2019. Data for each year based on a pooled analysis of all surveys containing broadband and smartphone questions fielded during that year.



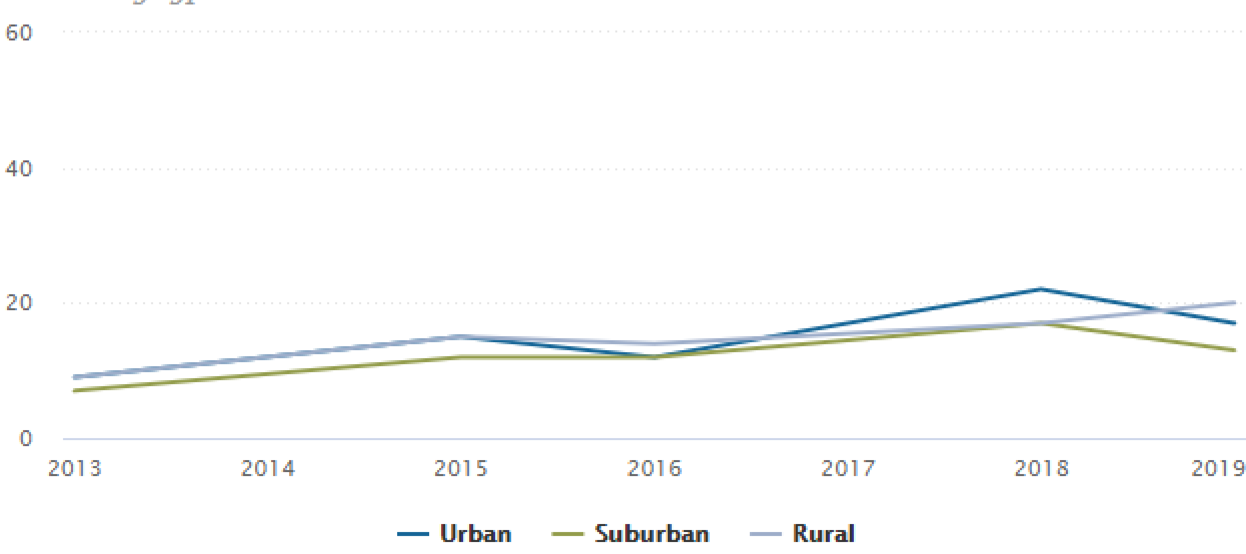
Source: Surveys conducted 2013-2019. Data for each year based on a pooled analysis of all surveys containing broadband and smartphone questions fielded during that year.



Source: Surveys conducted 2013-2019. Data for each year based on a pooled analysis of all surveys containing broadband and smartphone questions fielded during that year.

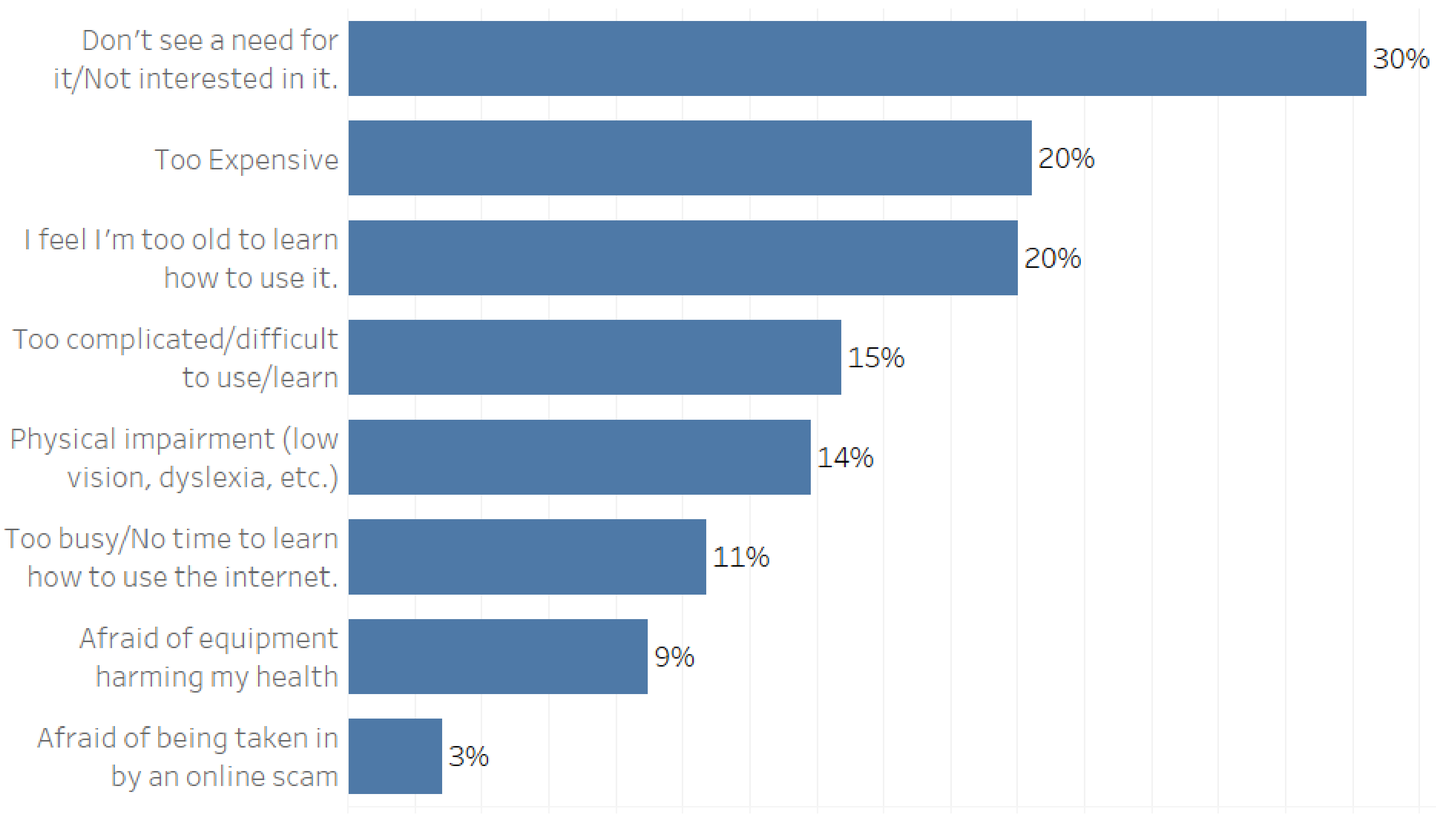


Source: Surveys conducted 2013-2019. Data for each year based on a pooled analysis of all surveys containing broadband and smartphone questions fielded during that year.

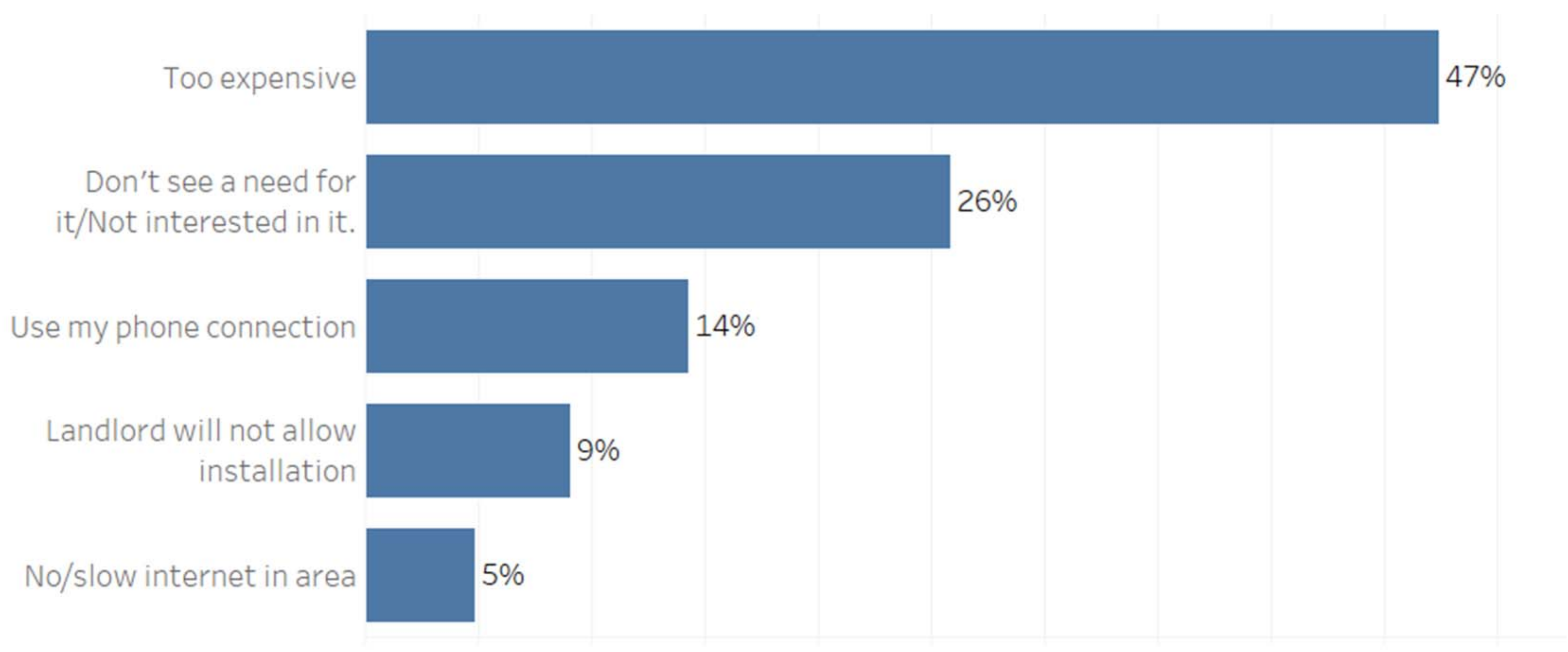


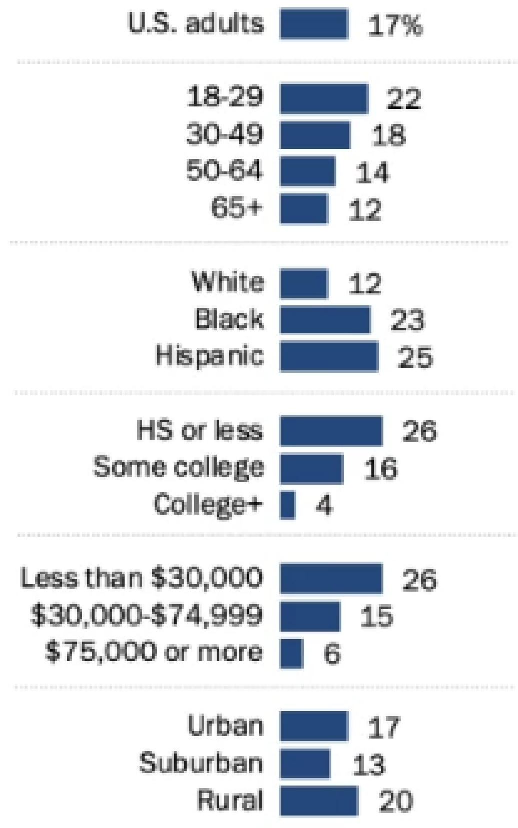
Source: Surveys conducted 2013-2019. Data for each year based on a pooled analysis of all surveys containing broadband and smartphone questions fielded during that year.

Non Internet Users in San Francisco: Primary reason for not using Internet



Less Connected Internet Users in San Francisco: Primary reason for not using Internet




17% of Americans are "smartphone only" internet users
% of U.S. adults who say they own a smartphone, but do not have a high-speed internet connection at home
U.S. adults 17%
18-29 22
30-49 18
50-64 14
65+ 12
White 12
Black 23
Hispanic 25
HS or less 26
Some college 16
College+ 4
Less than $30,000 26
$30,000-$74,999 15
$75,000 or more 6
Urban 17
Suburban 13
Rural 20

UCSF

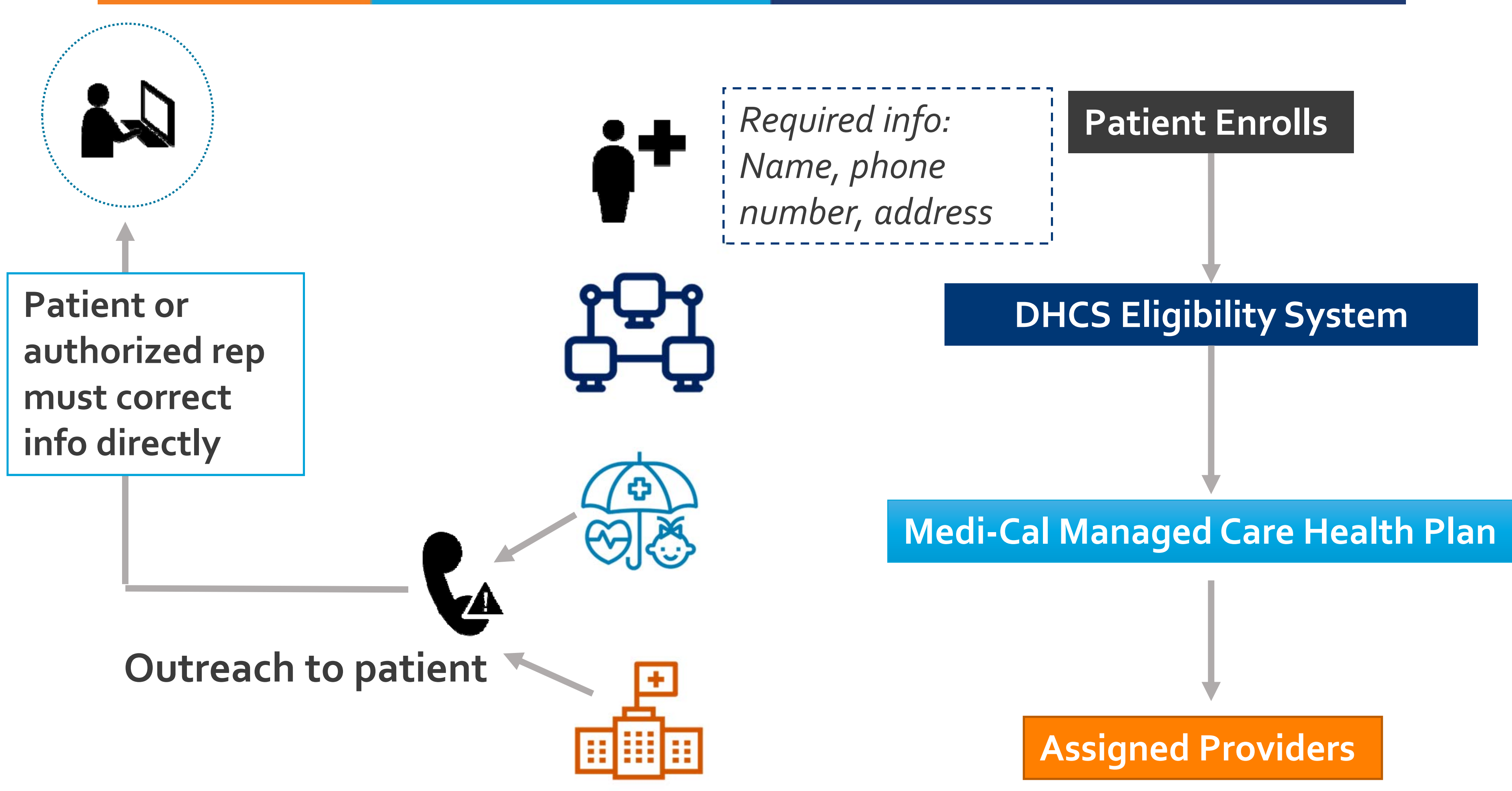
Assigned-Not-Yet-Seen Patients: Data Problems & Promising Solutions

Improving Patient Inreach & Outreach
Workshop

Facilitator: David Lown, MD, CMO, SNI

Alameda Health System
Riverside University Health System

Data flow



How do patients update contact info?

Do you need to update your information with Medi-Cal?

- Change of address
- Change of income
- Change of name
- Change of employment

To report change of address, income, name, or employment, please contact your **local county office**.

https://www.dhcs.ca.gov/pages/contacts.aspx

Report a Change

If information that you put on your application changes during the year, you must report it. Changes in things like address, family size and income can affect whether you qualify for Medi-Cal or qualify to get help paying for your health insurance through Covered California.

If you have Medi-Cal, you must report changes to your local county office within 10 days of the change. If you have health insurance through Covered California, you must report changes within 30 days.

https://www.coveredca.com/members/reporting-a-change/

Plan & DPH Impact

QIP Quality Advisory Group Plan reps survey

- Timeframe: ≥11 months CY 2016 continuous DPH assignment
  - No Utilization at all: Range: 16-28%; Mean 24%
  - Utilization but not at DPH: 2-37%; Mean 20%
  - **No utilization with DPH: 18-63%, Mean 44%**

DPH Survey

Timeframe: ≥11 months PY1 (7/2017-6/2018)

- DPH patients continuously assigned with no billable encounters
  - Range: 14%-79% not seen
  - **Weighted Mean: 43% not seen**

QIP Current & future
"DPH engagement" ⇨native specs

PY1 & 2

- All metrics include a "DPH Engagement factor"
  - DPH Encounter/Admission, Prescription or Procedure
  - Exception: Q-PC7 "Access to Care for Children & Adolescents"

PY3

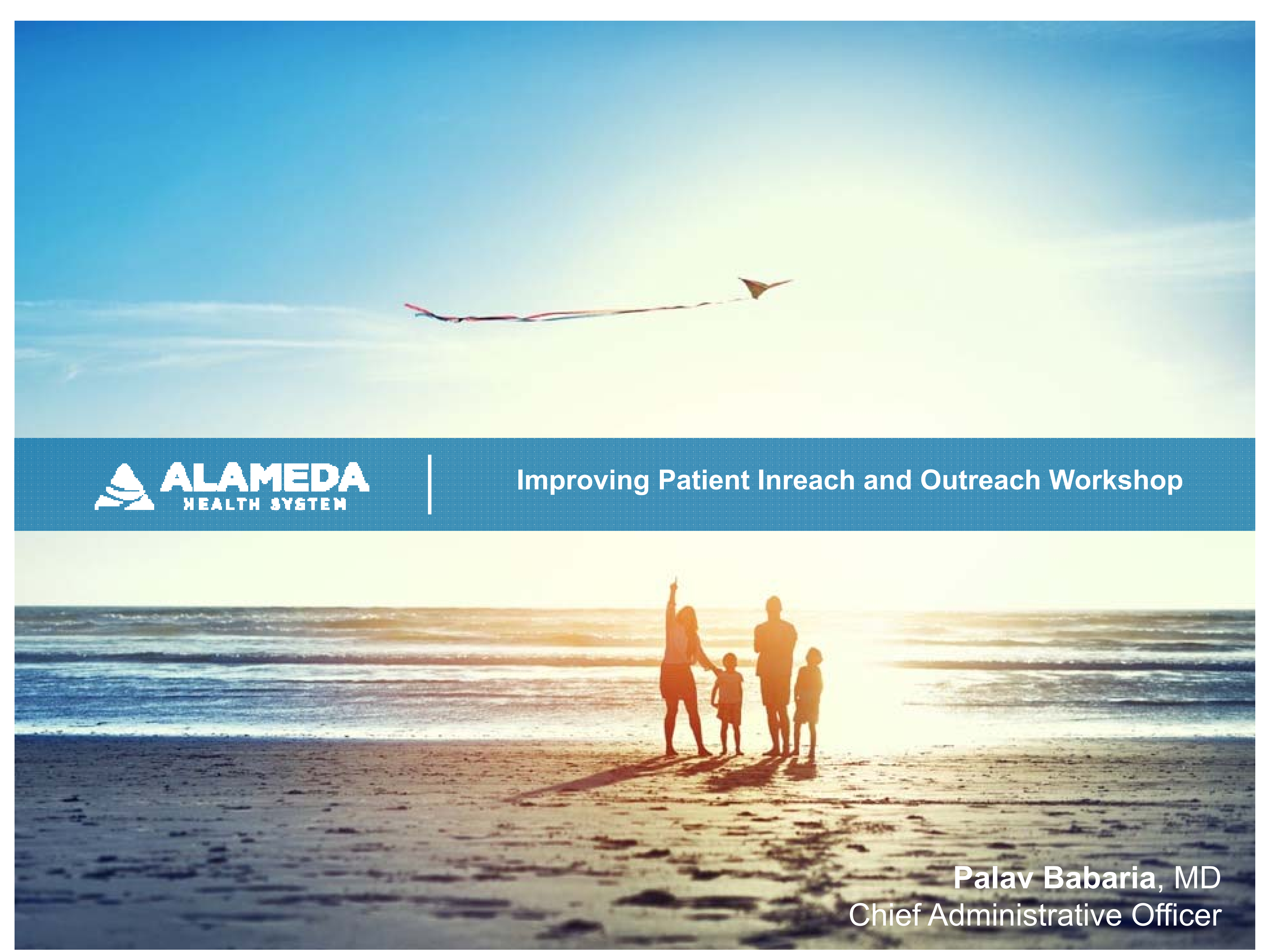
- 6 new measures **don't** include a DPH Engagement factor
- Thus denominator for 4 metrics include:
  - DPH Assigned, not seen by DPH but seen by non-DPH
- Denominator for 2 metrics also include
  - DPH Assigned but not seen by anyone

QIP: Assigned not seen
Example measures

	Enrollment criteria	Event/diagnosis:	Includes beneficiaries
Well-Child Visits in the First 15 Months of Life	Children who turn 15 months old during the measurement year; Continuously enrolled from ages 31 days to 15 months	None	Assigned to the DPH and either • Seen by a non-DPH provider, or • NEVER SEEN BY ANY PROVIDER
Chlamydia Screening In Women Ages 21–24	Continuous enrollment during the measurement year	Sexually active based on encounters or Contraceptive Meds Pharmacy claims	Assigned to the DPH and • Seen by a non-DPH provider • (Does not include assigned but not seen by anyone)

Takeaways

- **Prepare** for increased accountability for assigned lives in P4P
  - Examine performance delta between PRIME & HEDIS/UDS measures
- **Expand** access, capacity and outreach activities
  - Leverage care teams
  - Optimize technology and consider automation
- **Collaborate** on improving patient contact information
  - Foster close partnerships with health plans and county social services


ALAMEDA
HEALTH SYSTEM
Improving Patient Inreach and Outreach Workshop
Palav Babaria, MD
Chief Administrative Officer

Who are we?

- **Located**: Alameda County
- **Organization**:

    5 Hospitals

    5 Wellness Centers
- **Provider FTE**: 200+
- **Ambulatory Services**: 300,000+ visits per year

Our Focus?

- **Outreach:**
  Assigned-not-yet-Seen
  Initial Health Assessment (IHA)
- **Enrollment File Integration**:
  Current State, not supported by EHR,
  Receive file from Health Plan and BI team
  uploads data into shared file
  Future State, will be uploaded automatically into SAPPHIRE (Epic)

Why newly assigned patients?

- **AHS transition to an Alternative Payment Model (APM) for Primary Care,** April 2018
  - 2020 Medi-Cal Waiver Mandate
  - Health Plan, requirements in access performance metrics
  - Newly assigned patients IHA visit within 120 days

How are our efforts documented?

- **AHS Business Intelligence (BI) Department**
  - Created Microsoft Access data base
  - Provides patient records
    - Patients who are due for IHA
    - Patients who have received an outreach attempt
    - Patients who have received an IHA visit

What was the process in identifying patient enrollment?

- **Clinical Information,** was not provided
  - Monthly file provided patient demographic information, non-clinical

- **Patient Enrollment and Eligibility**
  - Verified via Alameda Alliance portal
  - Cross reference current EHR and portal, new vs established patients

How was outreach performed?

- **AHS Wellness Center**
  - Mailed Letters
  - Available in three languages; English, Spanish, and Chinese
  - Over 3,500+ sent, with approximately 5% returned mail

- **AHS Ambulatory Call Center**
  - Live person phone call
  - Available in various languages with the assistance of Interpreter Services
  - Approximately 300 hours of phone calls, and 6% of calls resulted in a new patient appointment scheduled

Data Reporting and Capture

Initial Health Assessment Outreach

IHA Due Date: April 30, 2019

Clinic	Eligible Pop	IHA in Prior 12 months	Total # of Letters Mailed	# of Patients to Call	Incomplete Calls	Total # of Calls Completed	Unable to Reach	Pt. Declined Call	Pt. Transferred Care	Pt. Inactive	First Call Attempt /Left Message	Second Call Attempt	Appts Scheduled	All Results
Newark Wellness Center	265	37	228	228	66	162	18	10	9	6	114	-	5	162
Eastmont Wellness Center	250	38	212	212	75	137	15	4	6	6	100	-	6	137
Highland Wellness Center	218	41	177	177	44	133	14	5	2	10	93	1	8	133
Hayward Wellness Center	325	46	279	279	85	194	24	5	8	13	128	-	16	194
MONTHLY TOTALS	**1,058**	**162**	896	**896**	270	**626**	**71**	**24**	**25**	**35**	**435**	**1**	**35**	**626**
Percentage					**30.1%**	**69.9%**	**11%**	**4%**	**4%**	**6%**	**69%**	**0%**	**6%**	**100%**

IHA Due Date: March 30, 2019

Clinic	Eligible Pop	IHA in Prior 12 months	Total # of Letters Mailed	# of Patients to Call	Incomplete Calls	Total # of Calls Completed	Unable to Reach	Pt. Declined Call	Pt. Transferred Care	Pt. Inactive	First Call Attempt /Left Message	Second Call Attempt	Appts Scheduled	All Results
Newark Wellness Center	439	70	369	369	80	289	34	23	41	16	167	-	8	289
Eastmont Wellness Center	552	104	448	448	154	294	36	11	30	18	177	1	21	294
Highland Wellness Center*	432	93	-	432	157	275	30	8	35	23	162	2	15	275
Hayward Wellness Center	568	109	459	459	128	331	45	9	42	30	187	2	16	331
MONTHLY TOTALS	**1,991**	**376**	**1,276**	**1,708**	**519**	**1,189**	**145**	**51**	**148**	**87**	**693**	**5**	**60**	**1,189**
Percentage					**30.4%**	**69.6%**	**12%**	**4%**	**12%**	**7%**	**58%**	**0%**	**5%**	**100%**

IHA Due Date: February 28, 2019

Clinic	Eligible Pop	IHA in Prior 12 months	Total # of Letters Mailed	# of Patients to Call	Incomplete Calls	Total # of Calls Completed	Unable to Reach	Pt. Declined Call	Pt. Transferred Care	Pt. Inactive	First Call Attempt /Left Message	Second Call Attempt	Appts Scheduled	All Results
Newark Wellness Center	321	60	261	261	168	93	19	3	36	18	16	-	1	93
Eastmont Wellness Center	351	91	260	260	55	205	46	10	13	11	111	-	14	205
Hayward Wellness Center	418	85	333	333	71	261	54	17	34	19	120	1	16	261
MONTHLY TOTALS	**1,090**	**236**	**854**	**854**	**294**	**559**	**119**	**30**	**83**	**48**	**247**	**1**	**31**	**559**
Percentage		**22%**	**78%**		**34.4%**	**65.5%**	**21%**	**5%**	**15%**	**9%**	**44%**	**0%**	**6%**	**100%**

IHA Due Date: January 28, 2019

Clinic	Eligible Pop	IHA in Prior 12 months	Total # of Letters Mailed	# of Patients to Call	Incomplete Calls/In Progress	Total # of Calls Completed	Unable to Reach	Pt. Declined Call	Pt. Transferred Care	Pt. Inactive	First Call Attempt /Left Message	Second Call Attempt	Appts Scheduled	All Results
Newark Wellness Center	280	48	232	232	78	154	33	4	19	2	78	9	9	154
Eastmont Wellness Center	353	78	275	275	49	226	51	4	15	7	128	3	18	226
MONTHLY TOTALS	**633**	**126**	**507**	**507**	**127**	**380**	**84**	**8**	**34**	**9**	**206**	**12**	**27**	**380**
Percentage		**20%**	**80%**		**25%**	**75%**	**22%**	**2%**	**9%**	**2%**	**54%**	**3%**	**7%**	**100%**

Key:

Term	Definition
First Call Attempt/Left M	Called the patient's number once/ Left Message when voicemail was available
Second Call Attempt	Attempted to call patient second time
Pt. Declined Call	Patient hung up or declined scheduling an appointment
Pt. Transferred Care	Patient transferred care to a clinic outside AHS
Pt. Inactive	Alameda Alliance eligibility is inactive or has been terminated
Unable to Reach	Patient number is disconnected or incomplete
Incomplete Calls/In Prog	Either call notes were not included or the calls were not made
Total # of Letters Mailed	Welcome letters mailed to the patients

**** Highland Letter mailings began in March for patients due for a visit by April 30***

IHA Live-person Call Outcomes

(12/1/2018 – 4/30/2019)

N = 2,754

Outcome	Value
Unable to Reach	419 (15%)
Pt. Declined Call	(4%)
Pt. Transferred Care	290 (11%)
Pt. Inactive	179 (6%)
First Call/Left Message	1,581 (57%)
Second Call Attempt	19 (1%)
Scheduled Appointment	153 (6%)

Lessons Learned

What worked well?	• Utilized staff resources; database, phone calls, and letters • Outreach attempts; 100% letters sent, majority of phone calls completed • Population health management, being proactive vs reactive
What area needs attention?	• Number of Outreach attempts • Technical issues with internal Access Database • Data integrity with from Health Plans • Appointment availability

Next Steps?

- **Continued integration of IHA Outreach, and tracking in single system (SAPPHIRE)**
- **Potential mail house vendor, streamline mailing efforts**
- **Potential Incentive Programs, Pilot**
- **Request cell phone numbers be included in data file, potential use of text messaging**

Sustainability

- Assigned-not-seen population biggest driver of poor PRIME/QIP performance; successful outreach essential for QIP metrics w/o DPH engagement criteria
- Some limited pilots w/ health plan partners for outreach; slightly improved 'hit' rates (~20% reached, 10% w/ appointments)
- Need for multiple points of contact at enrollment

Thank You!

- **Thank you to our partners!**

Tangerine Brigham, Chief Administrative Officer, Population Health

Business Intelligence Department

- **Contact Information**

Palav Babaria, MD, Chief Administrative Officer, Ambulatory Services

pbabaria@alamedahealthsystem.org

Rafael Vaquerano, Director, Ambulatory Integration and Access

rvaquerano@alamedahealthsystem.org

Ivonne Spedalieri, Manager, Ambulatory Call Center and Referral Unit

ispedalieri@alamedahealthsystem.org

Unseen Assigned-Lives Outreach : Project Implementation Lookback

Riverside University Health System – Community Health Centers

Victor Lucero, MPH

None of the organizers or presenters of this presentation have any conflicts of interest to disclose.

Who we are

- Shunling Tsang, MD-MPH
  - Associate Medical Director of Quality
- Kimberly Bowker
  - Director of Operations for Community Health Centers
- Jessica Echeverria
  - Subject Matter Expert of Scheduling and Lead for the Outreach Team
- Victor Lucero, MPH
  - Analyst - Empanelment Implementation

Our Organization

- RUHS - Riverside University Health System
- 4 Divisions

- Operate 12 Federally Qualified Health Centers across Riverside County
- From Lake Elsinore, CA to Indio, CA

Riverside University
HEALTH SYSTEM

General Population

- In 2018, Approx 50k unique patients were seen
  - 80% of patients seen were managed care lives
  - 70% continuity throughout the system currently
  - 30% of patients seen were better served in a language other than English (UDS Dashboard)

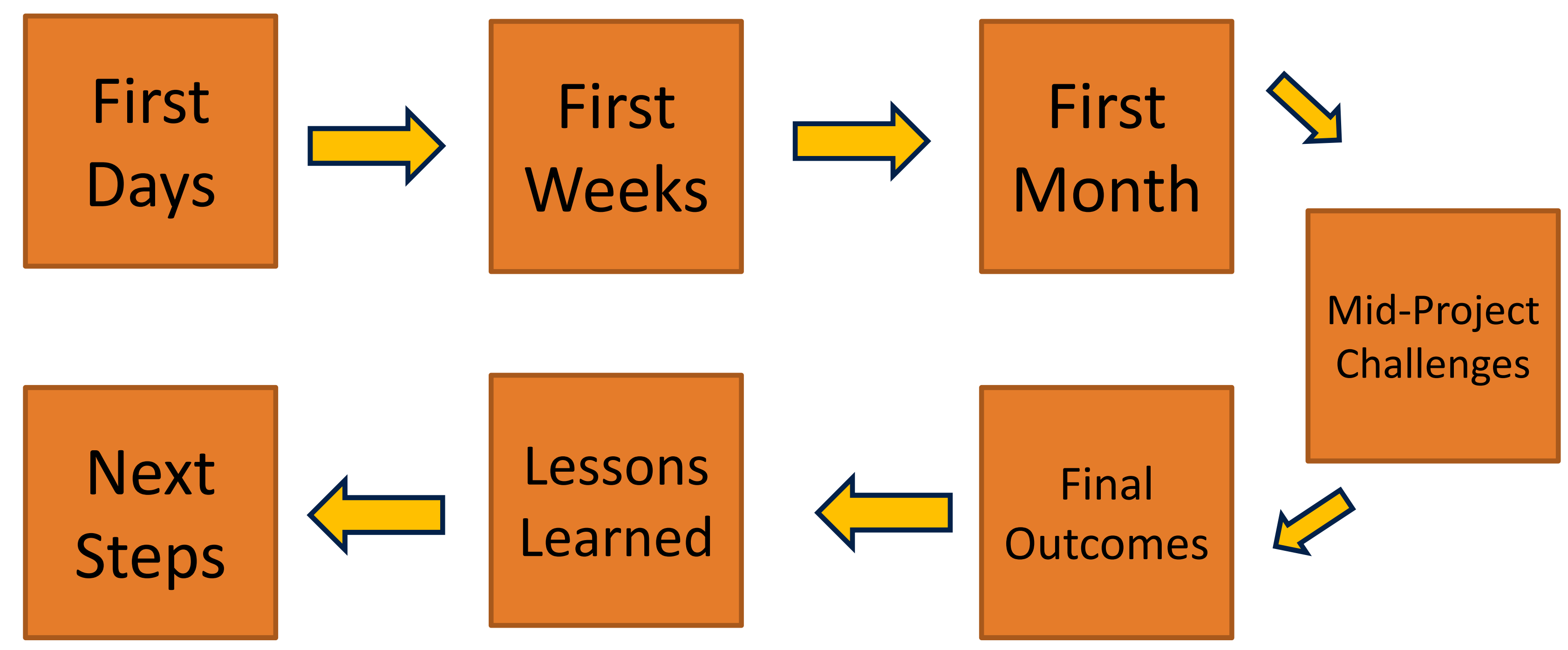
Capitated Population

- Our community health center Assigned Lives through IEHP is around 60k
- Inland Empire Health Plan (IEHP)
  - Joint non-for-profit Medi-Cal and Medicare program between Riverside and San Bernardino Counties
  - 1.2 Million+ Members
  - 6K+ Providers

Our Project Goal

- Health Plan Assigned-Lives Outreach - Capitation Retention
  - Compared list of patients assigned and patients seen
  - Effort to maintain the capitation funding from IEHP
- Objective was to build a team to actively outreach to unseen assigned patients
- Directive was given to call all the patients, not seen in fiscal year 2018, and try to schedule them an appointment
  - Over 42,000 lives!!

Journey Map



Journey Map

- Task was given mid-April (April 15th)
- Director of Operations was in charge
- 2 schedulers were pulled from Scheduling Office to become Leads for the Outreach Project
- Empanelment Team to support tech and data needs

First Days

- Administration initiated attempt to outreach and schedule all unseen capitated lives
  - Started planning on Thursday, and 15 Temporary Office Assistants (TAP OAs) showed on Monday
  - Logistics included security requests, setting-up desks, phones, chairs classes for EHR training
  - Pull together the list of patients who needed outreach

Challenges

- Learning curves
  - Terminology
  - Scheduling appointments under appropriate type
  - Language Needs
- TAP OAs lacked EMR access
- Initial workflows required refinement and went through multiple PDSAs

First Weeks

- First week workflow was informative for orienting OAs to insurance and eligibility
- Pre-work for eligibility verification was inefficient due to eligibility changes at the beginning of the next month
- Tracking process not completely developed
  - TAP OA productivity tracking
  - Outreach outcomes tracking

Outreach Team

- Started with a mixture of Non-Bilingual (12) and Bilingual (4) (Spanish) staff

- Out of the original 16 hired, only 4 remain today
  - 25% Turnover in the First Month

- Current : 10 Outreach staff, with 2 TAP OAs soon promoting to another position/department

Mid Project

- No show rates were around 50% for patients the outreach team scheduled
  - There is little data on outreached patients who called back and scheduled an encounter after receiving a voicemail

- Large amount of patients were disenrolled, or had bad phone numbers/contact information

Mid Project Technical Challenges

- Staff needed headsets to be more efficient and reduce injury
- Computers w/ Dual Screens
  - Using Keyboard & Windows shortcuts (Alt-Tab, Copy, Paste, Screen Docking)
- Resource Sheets w/ Provider Information
- Phone-Hunt Group for Outreach Team

On-Going Training Needs

- Initial Orientation to EMR before official training
- How to use EMR
- Empanelment – General PCP Overview
- Patient Portal Enrollment Education
- What does a “physical” consist of
- Dental Services and Eligibility

Mid Project Outreach Challenges

- Most common reason patients would not book an appointment is:
  - Because of work obligations
  - Patient did not think they needed one

- Most common challenges for patients getting to their appointment was transportation, or paid-time off for medical appointments not available
  - Transportation offered, but access may not be convenient

- As outreach team made appointments for patients, access for appointments became a challenge

Hunt Group for Outreach Team

- Original number was a local area code (951) tied to Clinic Administration Office
- The hunt group switched to an 800 number
- Staff noticed pick-up rates were lower, which meant more voicemails were left

"I did not want to answer, but I am glad I did" –Patient testimony

Outreach Productivity and Workflow

- Average 100+ calls or 150+ patients checked in an 8-hour workday
  - 8:00am to 5:00pm, 1-hour lunch, 5 days a week

- At first, TAP OA would verify and then call immediately after, if eligible

- After the first couple of weeks, TAP OAs would batch verify and then mass call later in the day
  - Some TAP OAs batch their whole day in the morning (100+)
  - Our most effective TAP OAs would only batch 20-30 at a time
    - A little more intimate knowledge when calling the patient
  - Added benefit that patients are not called in the early morning
    - People are groggy
    - Less pick-ups
    - You woke the patient up and now they are upset

Average Scheduling Cycle Times

- Scheduling a patient from start to finish:
  - New patients
    - 7-10 minutes at the beginning
    - 5 minutes after some experience
- Established patients
  - Overall around 3-5 minutes

Final Outcomes

Outreach Productivity

	Total	Percentage of Total
Patients on our list	42.9k	
1st Attempts to Outreach Made	37.6k	
-Messages Left	11.7k	31%
-No working phone number	7.4k	20%
-Disenrolled	5.4k	14%
-Already established	5.2k	14%
-Voice Mail Full – No Voice Mail	2.2k	6%
-Answered & Appt Made	1.9k	5%
-Appt made by other dept	1.1k	3%
-Answered & Appt Declined	1.1k	3%
-Answered & Pt stated they will call later	~800	2%
-Declined – Other Healthcare	~560	1%
-Incarcerated / In Jail	~140	<0.5%
2nd Attempt Calls Made	16.5k	
Total Calls Made	53.2k	

Scheduled Patient Outcomes

	Visits	Total Percentage
Scheduled	2100	
Completed (Encounter Signed)	845	50%
No-Showed	823	48.7%
Cancelled	406	-
Other	22	1.3%

Documentation of Unseen Capitated Patients

- Admin wanted patients in EMR for tracking purposes
- Scheduling and panel management had concerns about this
  - Adds significant amount of "noise" and possible duplicate records
- Other databases choices at the time were unavailable and time-consuming to explore
- Where is the proper home for non-clinical discussion/conversations?

Initial Data

- Used a standard Excel workbook
- Each clinic on its own sheet
- Each row of patient data contained Insurance Subscriber ID, Name, DOB, Gender, Address, Phone #, and Language
- No Medical Record Number was included for any patient, so unknown to us if patient had a record already

Tracking Tool Development

- Columns for data capture
  - Reviewed By
  - Patients Eligibility Status & Comments
  - Patient may be disenrolled by the time we called them
  - Date of Call Attempts
  - Result of Call Attempts
  - Date Appt was made (if applicable)
  - Provider that Appt was Made With
  - Did Patient complete appt?
  - Additional Comments

- Next Phase Optimization
  - Include a column for the patient's MRN, if record found

Lessons Learned : Staff Recommendations

- Dedicating time for staff to go through a practice-based curriculum with multiple patient scenarios

- More hands-on one-to-one training for staff

Lessons Learned : Reporting

- 2 Productivity Reports
  - Outreach List - Combine all sheets into 1 to use in PivotTable to export Data
  - Scheduled/No-Show'ed – Exported from EMR to capture if scheduled patient's no-showed

Lessons Learned - Scripting

- Keep it simple, sweetie – K.I.S.S.
- Scripting is most effective when made with front-line staff
- Do not use complicated language
  - Primary Care Provider (PCP)
  - Physician
  - Initial Health Assessment
  - Preventive Health Screening
- Simple language is more effective, even if "technically" incorrect
  - Doctor (for NPs / PAs)
  - General Check-Up
  - Yearly Physical
    - Some patients do not know what "annual" means

Verbiage used by Staff

- Hello, I'm calling from the [City] Community Health Center, I am looking for [patient name]?
- Hello [First Name], how are you?
  - Patient-centered
- We are your IEHP-designated health care provider, and our records indicate you have:
  - Not completed a physical for this year
  - Not been seen for your yearly physical by your doctor
- This is a courtesy call… in case you would like to schedule an appointment?
- We are checking up on you…

Lessons Learned - Scripting

- “Hard scripts” may theoretically work, but “soft scripting” determines how effective the hard script is
- Inflection, tone, attitude, patience, and indirect body language are important in “soft scripting”
- Never say “Promise” or guarantee anything
- Capture feedback from frustrated patients without sounding disingenuous

Lessons Learned - Scripting

- Some patients just need someone to hear them out
  - Empathy
  - First Contact

- Remember that it is ok to laugh and smile while talking and listening to the patient

- Some days the patient will frustrate you
  - Take a 5-minute breather after a difficult patient
  - Have a buddy/group to vent to (constructively)
  - Understand the perspective of the patient
  - Acknowledging patient's anger
  - Develop warning for patients if they use profane language, and hanging up if refusing to cease abuse

Lessons Learned - Scripting

- Introduce the organization first to disarm the patient
  - Fair amount of patients are in a non-positive mood when answering and can quickly become skeptical and have distrust
  - Some patients experience “pressure” to make an appointment, and are more likely to no show
  - They made the appointment to “be nice” or they do not want to say “no”
- Use patient’s first name
- Be prepared for some calls to end immediately
- Make sure staff is trained to ask for sensitive information in a patient-centered manner when booking an appointment
  - Patients may become uncomfortable when asked for SSN or other UDS data (employment, religion and race)
  - Approach asking for information correctly, as untrained staff will cause patients to develop distrust

Lessons Learned - Scripting

- UDS Data
  - Capturing registration data over the phone saves time at the clinic
    - However, it will cause some patients to distrust you and end the call
- “Would you like to provide your Social Security now or at the time of your appointment?”
- “Some religions do not allow some procedures, so we just want to make sure that you are treated appropriately if you end up at the hospital”
- “Some religions do not allow blood transfusions, so we just want to ensure patients are taken care of properly”

Questions from Patients

- Why are you calling me?
- How did you get my number?
- Confusion regarding language used
- “Why can’t you…?”
  - Book me an earlier appointment
- “Why do I have to…?”
  - See a doctor first to get labs done

Next Steps

- Outreach Team's roles and responsibility are currently in development, and may include:
  - Reminder Calls for Scheduled Patients
  - Offer assistances Clinic Reschedules
    - From providers who call off, FMLA, are transferring clinics, or departing the system
  - New and Currently Enrolled Unseen IEHP Patients
  - Insurance-Patients Discharge from Hospital for PCP Follow-Up
  - Provide assistance for Scheduling Center when call queue is long
  - Call Patients No-Shows to reschedule

Next Steps – Curriculum Building

- Develop curriculum and training for patient-centered outreach staff:
  - General Knowledge of
    - Patient-Centered Medical Home (PCMH)
    - Federally Qualified Health Centers (FQHCs)
    - Clinic Operations (Micro)
    - Division Operations (Macro)
    - Public Health Principles
- Motivational interviewing and listening skills
- Patient engagement
- Community and social services resources
- Insurance types and differences
- Open-and-Closed ended questions

Conclusion – Final Thoughts

- Of our 42.9k lives, there were only 2.1k visits scheduled, and 845 who showed up
- Consistent ongoing outreach for our capitated members
- Dialogue between IEHP and RUHS about patients who were unable to be reached
- Implications for incentive-based programs on capitated lives

Contact Information

RUHS_Empanelment@ruhealth.org

CHCOutreach@ruhealth.org

Victor Lucero – v.lucero@ruhealth.org

Clinic Admin - (951) 358 - 4000

Thank you very much!!

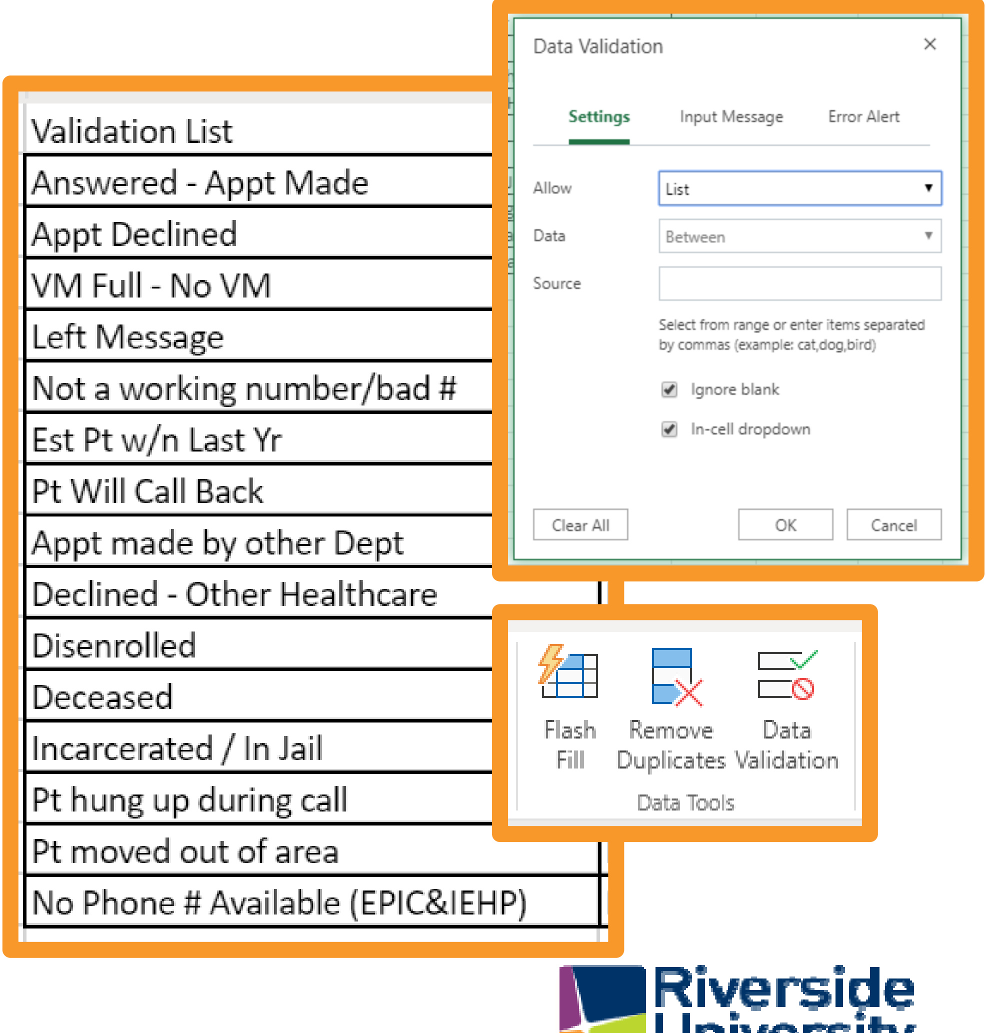
Our Provider Staff

- 54 providers across 11 clinics
  - 15 providers speak Spanish, 32 providers speak a 2nd language

- 45 providers at Family Medicine Residency Clinic
  - 36 residents in a 3 Year Residency
    - 6 residents to a team
    - 12 residents each Program Year (PGY)
    - 2 of each PGY in each team
  - Each team lead by 1-2 Attendings

Data Validation

- These columns needed Data Validation for consistent format of data entry
  - Date of Call Attempts
  - Result of First Call Attempts



Lessons Learned : Reporting

- Would other databases be more reliable for this?
  - Probably, but requires more expertise to set up properly
- What does your “network” structure look like?
  - Can everyone access a central worksheet?
    - Online? Department Drive?
      - Department Drive – Read-Only troubles
      - Online – Remaining HIPAA-Compliant

Q&A Panelists

Alameda Health System

Palav Babaria, MD; Chief Administrative Officer, Ambulatory Services
pbabaria@alamedahealthsystem.org

Rafael Vaquerano, Director, Ambulatory Integration and Access
rvaquerano@alamedahealthsystem.org

Ivonne Spedalieri, Ambulatory Call Center and Referral Unit Manager
ispedalieri@alamedahealthsystem.org

Riverside University Health System

Shunling Tsang, MD, Associate Medical Director for Quality,
s.tsang@ruhealth.org

Kimberly Bowker, Director of Operations
KBowker@ruhealth.org

Victor Lucero, Empanelment Coordinator

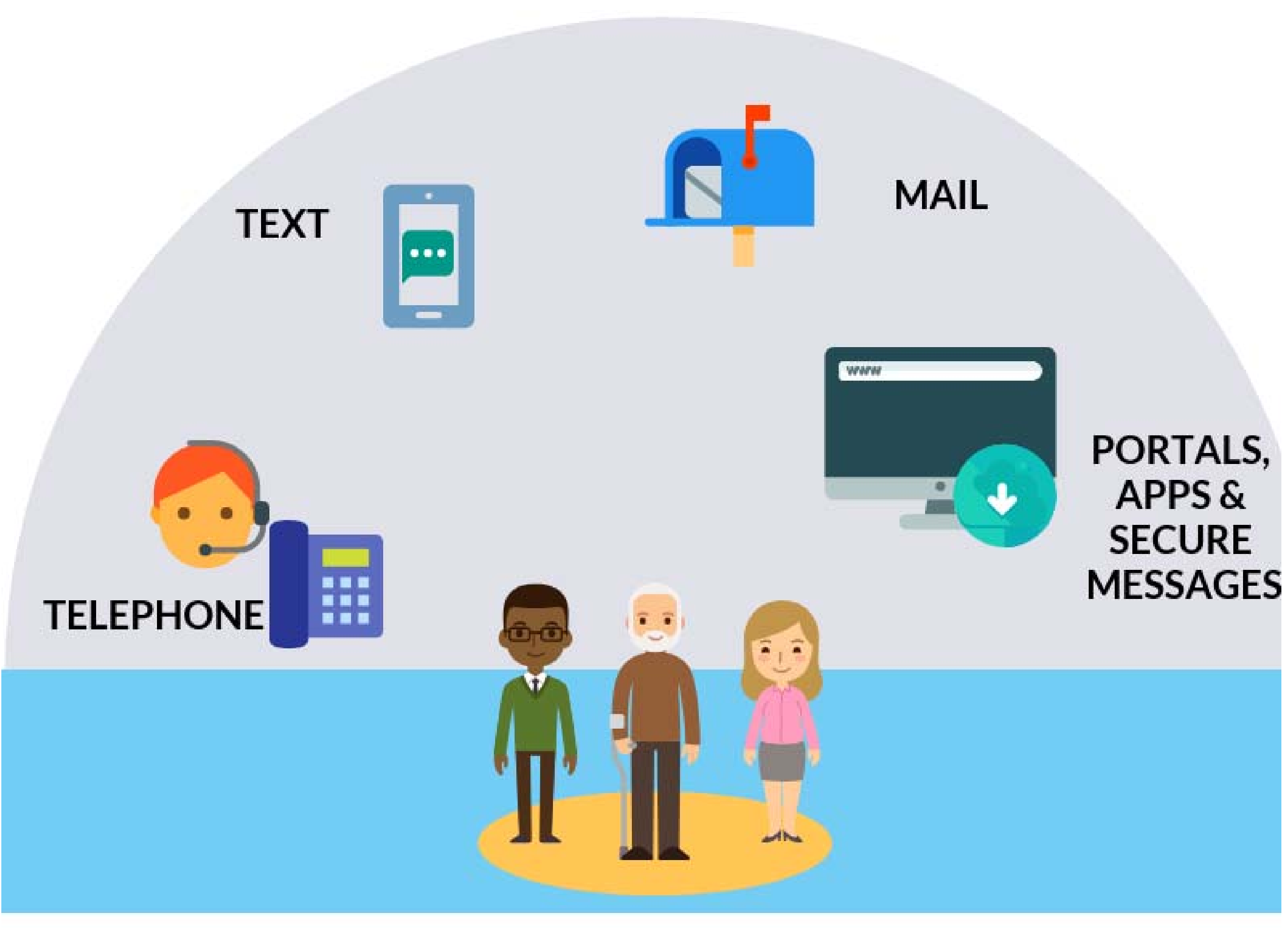
v.lucero@ruhealth.org

Jessica Echeverria, Patient Service Coordinator j.echeverria@ruhealth.org

Outreach Implementation Sessions

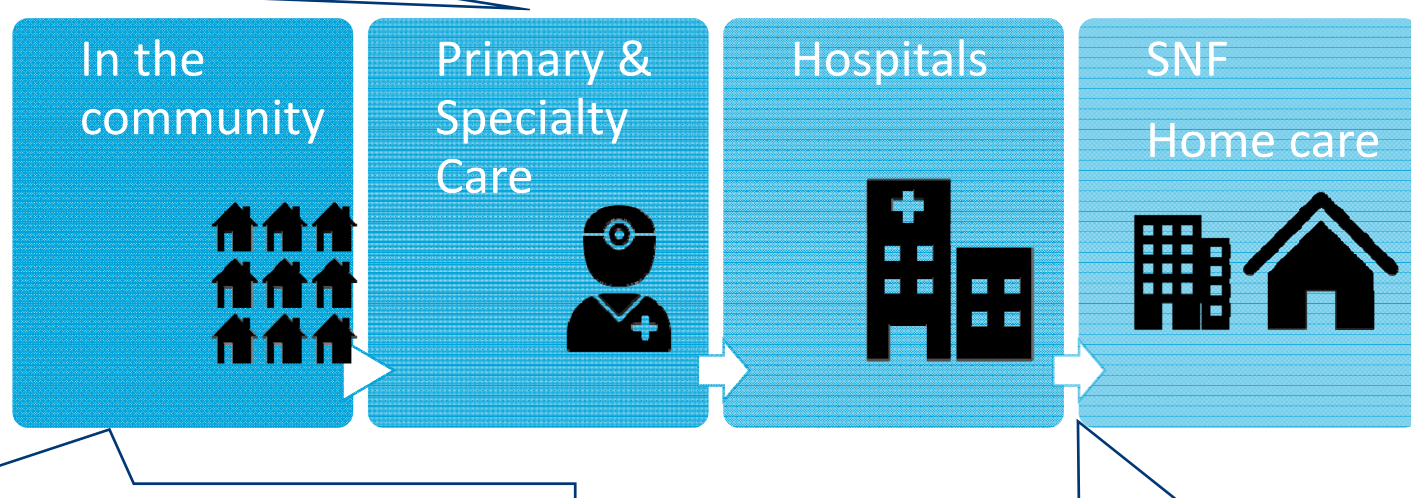
Improving Patient Inreach & Outreach
Workshop

Patient outreach



For the care continuum

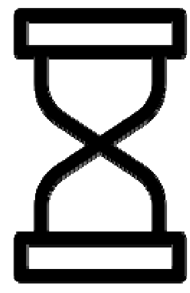
- **Welcome** newly assigned patients
- **Remind patients** of screenings, tests, appointments, immunizations
- **Follow-up** with patients on lab, referrals and chronic conditions
- **Support** patients with goals



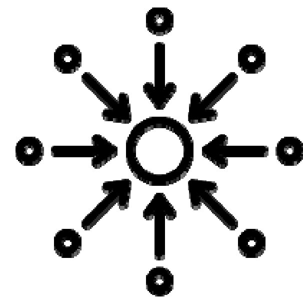
- **Provide education** (e.g. healthy eating)
- **Share news and communications** (flu vaccine is in; upcoming health fair)

- **Support** discharge follow-up
- **Assist** care coordination and minimize re-admissions

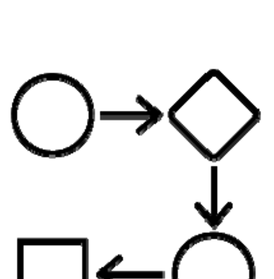
Optimization



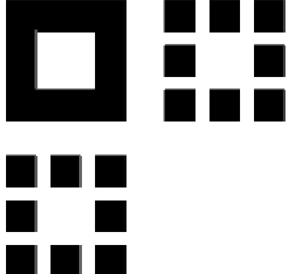
How staff can do outreach so it's not manual & labor-intensive?



What are best approaches keeping outreach centralized vs. local?



What are the workflows & processes needed to support new technologies?

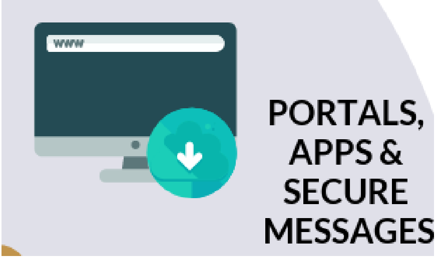


How to avoid duplication when closing patient care gaps?

Outreach Breakout sessions

Topic 1: Centralized Telephone Outreach

Location: Pacific Room
Meg Wheeler*; Manager, Care Transitions Program, UCSF*
Kristin Gagliardi*; Population Health Manager, UCSF*



Topic 2: Moving the Needle on Active Portal Use

Location: California Room
Jim Meyers, *DrPH, MHA, National Subject Matter Expert, Patient Portal Operations*

Reminders

- Read Outreach Survey results report.
- Take your belongings
- You may want to divide & conquer
- Lunch served @ 12:10, start again @ 1

Lunch

12:10—1:00

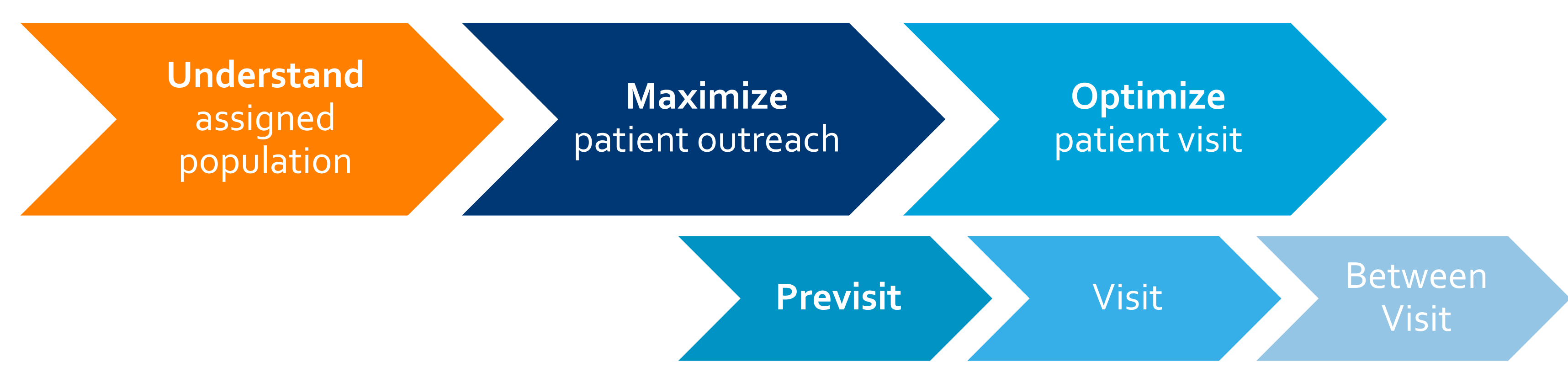
Optional networking opportunity:
Bring your lunch to discuss "Assigned Not Seen" Work with ZSFGH!

Optimizing Inreach for In-Person Visits

Improving Patient Inreach & Outreach
Workshop

Facilitator: Kristina Mody, Sr. Program Associate, SNI

Inreach potential



Potential of effective inreach/planned care:

- Address preventive screening & manage chronic conditions
- Makes care proactive (not reactive)
- Close gaps for quality reporting
- Creates agenda for encounter

Resources & worksheet overview

- **Safety Net Medical Home Initiative: Organized, Evidence-Based Care** Implementation Guides, Tools & Webinars; includes visit templates and definition of planned care
- **Primary Care Team Guide** General introduction to planned care, as part of larger resource library
  - Especially Cambridge Health Model of Team-Based Care Implementation Guide & Toolkit
- **UCSF Center for Excellence in Primary Care – Healthy Huddles**
  - Especially Huddle Guide from West County Health Centers

Definitions

- Planned care
- Inreach
- Outreach
- Patient engagement

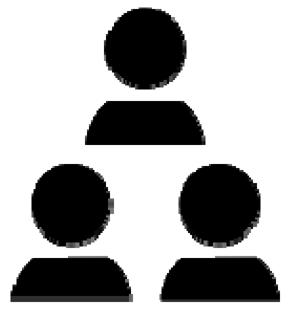
6 aspects of planned care

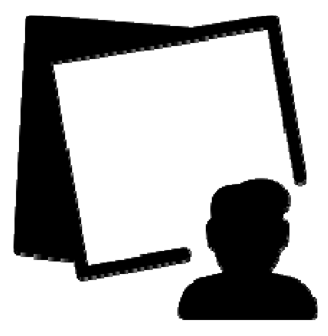
1. Prep charts
2. Coordinate care
3. Plan today's visit
4. Team preps the room
5. Use visit templates
6. Use standing orders

Activity Instructions

Find Pink worksheet in your packet

Red 1	Red 2
Blue 1	Blue 2
Yellow 1	Yellow 2
Green 1	Green 2
Purple 1	Purple 2





Step 1.
As a TEAM:
- Review current in-reach planned care practices
- Prepare to share 1-2 best current practices with other systems

*or complete if you didn't do pre-work

Step 2.
Mix it up!!
- Find color & number on your badge
- Head to that table, and introduce yourself:

Name, role, organization

Step 3.
In your new group:
- Each person: share 1-2 best practices for current in-reach at your organization

Step 4.
- As a group, ID 1-2 Promising Practices, summarize on Post Its and post on butcher paper around room
- Individually, circulate and add Post Its with comments/ questions on Promising Practices

Patient-Centered Outreach: Designing Ideal Processes

Improving Patient Inreach & Outreach
Workshop

Ashley Kokotaylo, Public Health, Contra Costa Health Services

Matt White, Business Intelligence, Contra Costa Health Services

~~Patient~~ Person-Centered Outreach: Designing Ideal Processes

- *Patient: a person receiving or registered to receive medical treatment.*
  - *Synonyms: sick person, case, sufferer, victim;*

- Person**: a human being regarded as an individual.**
  - Synonyms: human being, individual, living soul

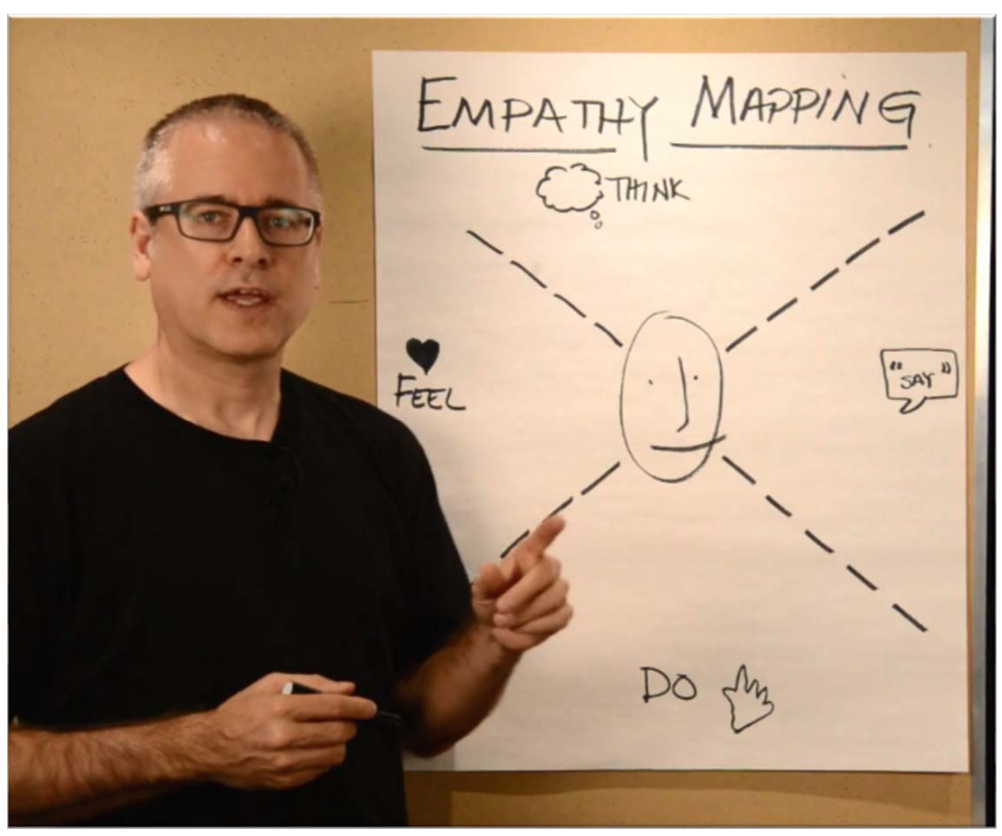
Ashley Kokotaylo
Public Health
Catalyst Alum '18

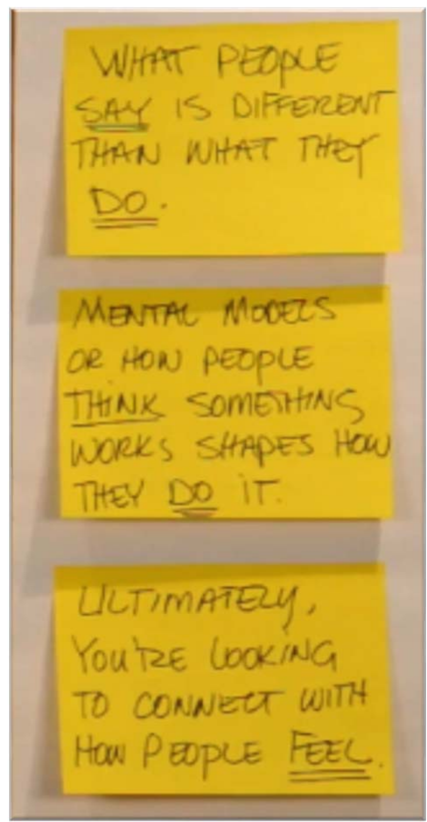
Matt White
Business Intelligence
Catalyst Alum '18
Catalyst Coach '19

Why Human-Centered Design?

Include people in the process and end up with improved results

Empathy Mapping





Your Turn – Take Out Your Wallet!

(6 mins)

Break the table into 2 groups

Have 1 person share their wallet

- Where did the wallet come from?
- What's in your wallet that you haven't used lately?
- How is it organized? ….

Remaining group as active observers

- Document on post-its using Empathy Map (Think, Say, Do, Feel)
- Ask additional questions

Wallet Debrief

(4 mins)

As a single group…

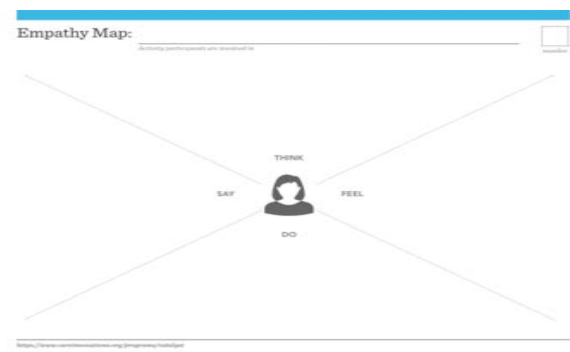
- How did that feel?
- Was there an emotional response?
- Things you want to change about wallet?
- Things you were too uncomfortable to ask?

Your Turn – Complete Empathy Map

(8 mins)

As a table…

- Place post-its in their respective sections (Think, Say, Do, Feel)
- Find areas with light information and follow-up
- Identify Themes/Group them together



Homework Debrief

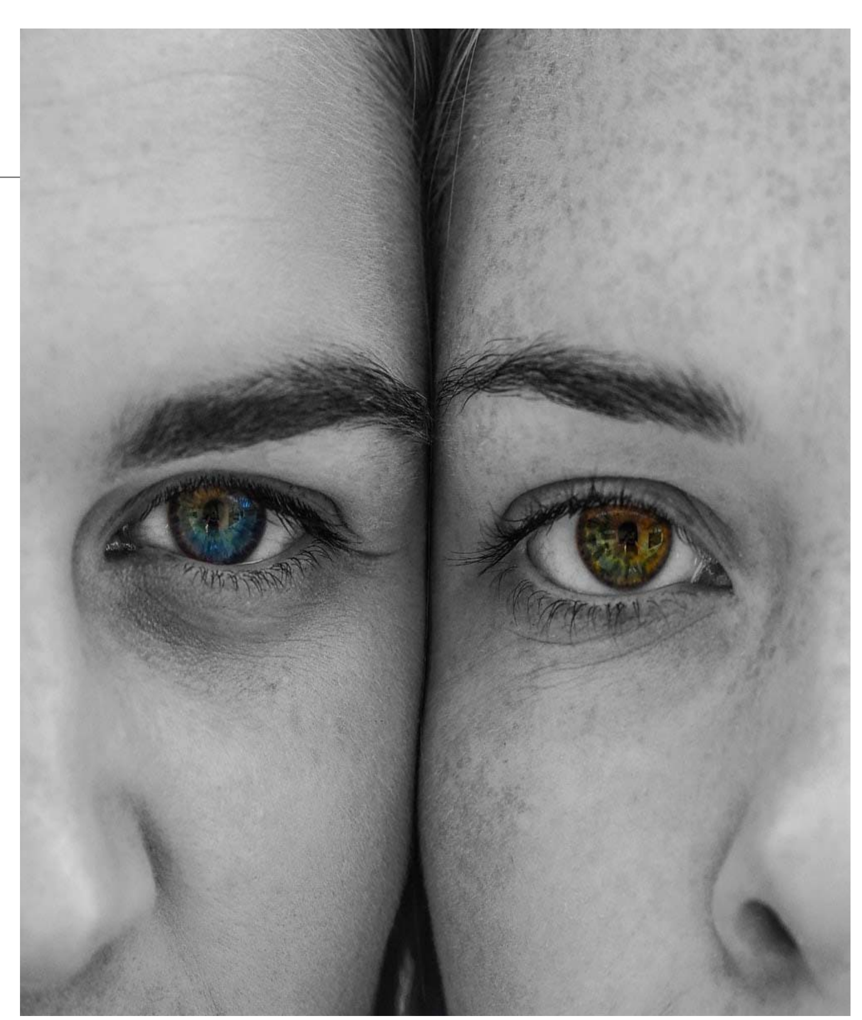
(4 mins)

Homework Question…

Connect with someone outside your department and ask their perspective about client experience in a specific workflow

Find a partner at your table and share (2 mins each):

- Who were the different voices you included?
- What did you take away from the experience?



Homework Next Steps

(4 mins)

Individually

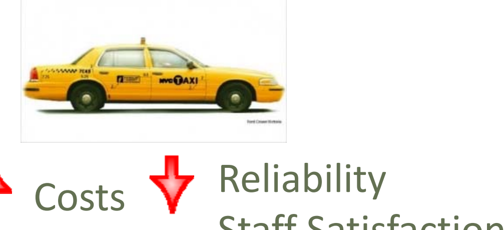
- What's the one action you will take in the next week when you get back?
  - Who will you connect with…
  - What questions will you ask…

In a Pair

- Make a commitment to your partner that you will share an update with them next week….I mean it! And give them permission to pester you until you do ☺

What this can look like...
WPC Transportation

Problem/Opportunity



Costs (up) Reliability, Staff Satisfaction, Access (down)

*How might we **improve** and enhance **transportation** so all **clients** have access to **safe, reliable, flexible, and cost efficient** transportation to **essential services**?*

9 Months...

Discovery + Explore

50 Clients

15 Staff

5 Orgs

6 People + 2 Hrs/Wk 4 Months

Pilot + Learn

10 Staff

3 Months

Scale + Measure

100 Staff

2 Months...

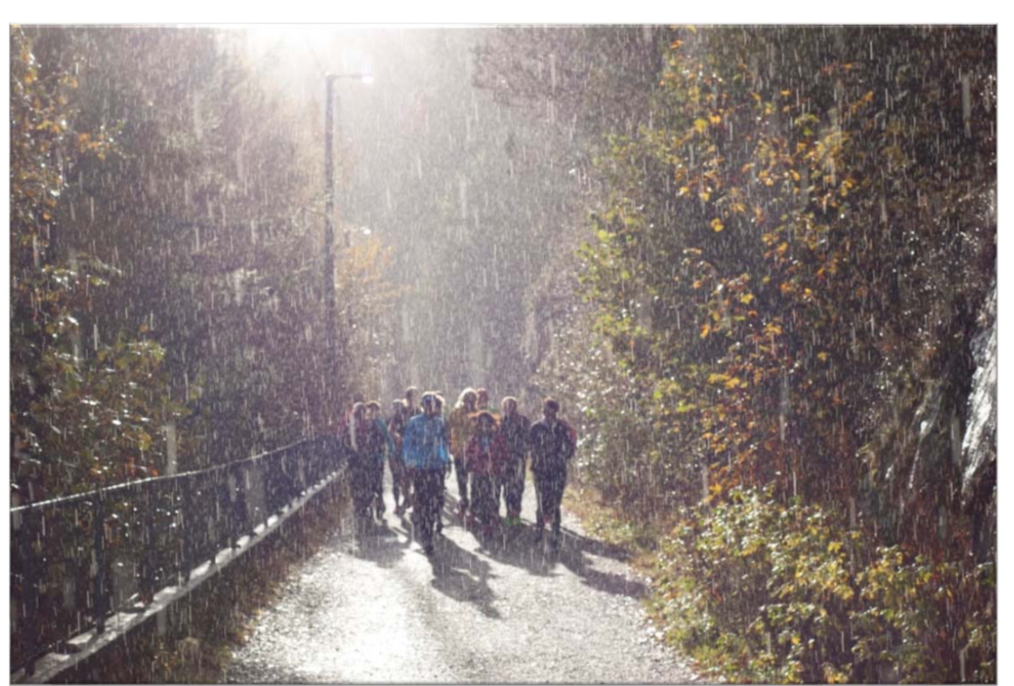
2000+ Rides (estimate was 1600)
40% Savings ($35K)
4.65 Rider Score (Lyft was 4.5)
99% Client Success*
99% Staff Adoption**

**When using the service at least twice, 92% without*
***Based on sampling, waiting on add'l matching data*

Human-Centered Design Resources

Catalyst Links

- https://www.careinnovations.org/wearecatalysts/



Images for Presentation

- https://unsplash.com/

Design Thinking

- https://www.ideo.com/
- https://www.ideo.org/

Contact Info:
Ashley Kokotaylo – Ashley.Kokotaylo@cchealth.org
Matt White – Matthew.C.White@cchealth.org

It’s Not Magic!

Include the Person/Client Voice

Start small and ask for feedback

“Nothing for us Without Us”

Tell Stories / Capture Video

Invite different opinions

Make the work visual

Foster empathy and collaboration

Always ask WHY

Learn fast and measure progress

Have fun!

Team Time, Snacks & Closing

Improving Patient Inreach & Outreach
Workshop

Kristina Mody, Sr. Program Associate, SNI

Evaluation

Feedback on today

What worked?

Where can we improved

More importantly

Ideas on how to continue progress & momentum?

Upcoming SNI Support

Thurs, Aug 22(11-12): Epic Usergroup: Avoiding Burnout and Addressing Provider Experience in Epic [link]

Mon, Sept 9 (12-1): Patient-Centered Care Transitions Communication to Improve H-CAHPS Scores with RUHS [link]

Thurs, Oct 17 (12-1): Chlamydia screening: Best practices and implementation strategies for primary care settings [link]

Wed, Oct 23 (12-1): DY14 Year End PRIME Data Review [link]

Thurs, Nov 7 (12-1): Disparity Reduction in PRIME – Progress to Date [link]

Quality Leaders Awards

AWARD CATAGORIES:

- TOP HONOR
- AMBULATORY CARE REDESIGN
- DATA DRIVEN ORGANIZATION
- PERFORMANCE EXCELLENCE

ABOUT THE AWARDS:

For more than 20 years, CAPH/SNI has delivered the QLAs to recognize outstanding initiatives across California's public health care systems. The awards highlight forward-thinking and innovative approaches to improve care and advance population health.

Awards are presented at the CAPH/SNI Annual Conference on December 4-6 at the Paradise Point Resort in San Diego.

DEADLINE TO APPLY IS AUGUST 31, 2019

http://safetynetinstitute.org/qla

Save the Date

Registration to open in September!

https://caph.org/aboutcaph/annualconference/

Ai-Jen Poo
ED, National Domestic Workers Alliance

Celinda Lake
Pollster & political strategist

Len Nichols
Policy professor, George Mason University

John Ohanian
President & CEO, 211 San Diego