UCSF Medical Center

UCSF Benioff Children's Hospital

Centralized Telephone Outreach at UCSF

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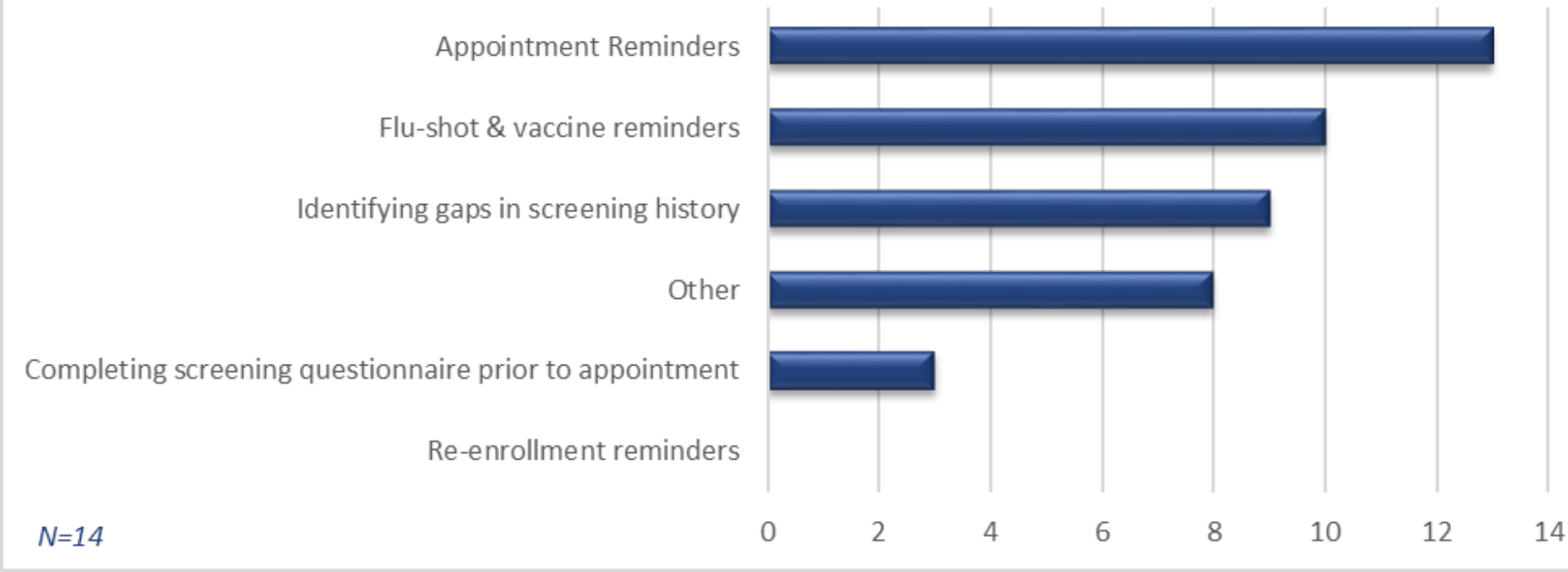
For what services does your organization conduct centralized telephone outreach?



Other (please specify):

- Post-discharge follow-up (Contra Costa, Riverside, UC Davis, UCLA)
- Scheduling appointments, generally (Alameda)
  - *Mammograms (San Francisco, San Mateo)*
  - *FIT testing (Contra Costa, San Francisco)*
  - *Pap (San Francisco)*

For additional outreach efforts, see handout

Q3: If you use a vendor, which vendor do you use?

- **CipherHealth** *(San Joaquin, UC Davis, UCLA)*
- **ClienTell** *(UC Davis, UCLA)*
- **Emmi** *(UC Davis)*
- **Televox** *(Contra Costa, Riverside)*
- **NRC** *(Contra Costa)*
- **Alliance DMS** *(San Mateo)*
- **Patient Prompt** *(Arrowhead)*

UCSF Care Transitions Outreach Program

Presentation Roadmap

Goals for Today:

- Provide a background of UCSF Office of Population Health & Centralized Outreach Programs
- Describe the Care Transitions Outreach Program
- Dive deeper into keys to success of the program
- Answer questions

UCSF Health

Academic Medical Center

- Three campuses in San Francisco at Parnassus, Mission Bay, and Mount Zion
- 979 inpatient beds in total

Primary Care Services

- 9 primary care practices
  - Serving ~80,000 patients
    - Payor mix: 36% government insured

The Office of Population Health and Accountable Care (OPHAC)

Our Mission: *Combining* ***innovation*** *with* ***compassion*** *to transform health care delivery across UCSF Health.*

Innovative Clinical Programs across the Care Continuum

Inpatient → **Transition** → **Community** → **Ambulatory**

- Care Transitions Inpatient Program
- Care Transitions Outreach Program
- Post-Acute NP & HCN
- Care at Home Program
- Post-Acute Care Collaborative
- Ambulatory Outreach Team
- Care Support Program
- COPD Management
- Virtual High Risk Transitions

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Post-Discharge Outreach History

- 2012 - 2015 DSRIP Transitions of Care
  - ✓ Expanded medicine inpatient model to cardiology, orthopedics, neurology, neurovascular, and pediatric hospital medicine populations
  - **September, 2013 → Centralized & Automated**
- 2015 Office of Population Health & Accountable Care
  - ✓ Continued expansion & integration, bundled payment, PRIME
- 2017 Scaled up to UCSF Health
  - ✓ 100% implemented to adult populations
    - ✓ 95% pediatric specialties
  - ✓ 55 service-line/specialty clinic partnerships

Centralization & Automation Benefits

- Consistency
  - All patients are automatically enrolled, called, asked the same questions
- Standardization
  - Scripting, protocols, reports
- Efficiency & Patient Engagement
  - 80% reach rate
  - RN time to target patients in need
- Affordability
  - Cut our cost/call in half
- Expansion
  - From 5 to 55 patient populations

Centralization & Automation Costs

- Initial scepticism & change management
  - Relationship building
    - Unit directors, front-line RNs, Chiefs of services, clinic providers
    - Patient Relations, Pharmacy, Quality, Medication Safety Departments
  - Minimizing redundancies
  - Building trust
- Lack of understanding of the acute transition needs of diverse & complex patient populations
  - Ensuring competency
    - Clinical details & resources for RNs
- Provider and staff communication/escalation preferences not consistent, difficult to standardize
  - 4 years to fully implement, with service-by-service approach

Five Years Later…

- Well accepted as an integral part of the health system
- Patients are receptive & appreciative
- Providers are eager to partner with us
- Partnership with School of Pharmacy stronger than ever
- Strengthened partnership with Case Management
- Expert in the transition segment of the care continuum, across all populations
- Able to set the standards around communication

Care Transitions Outreach Program

Program Overview

- Centralized group of 6 expert RNs with diverse clinical backgrounds, 1 Healthcare Navigator & 3 Pharmacy faculty
- Provide a safety net through discharge follow-up phone calls

Goals of the Program

- Support patients during transition from hospital to home
- Complete the discharge process
- Facilitate the right care at the right time
- Prevent patient harm & report opportunities for improvement

Care Transitions Outreach Program

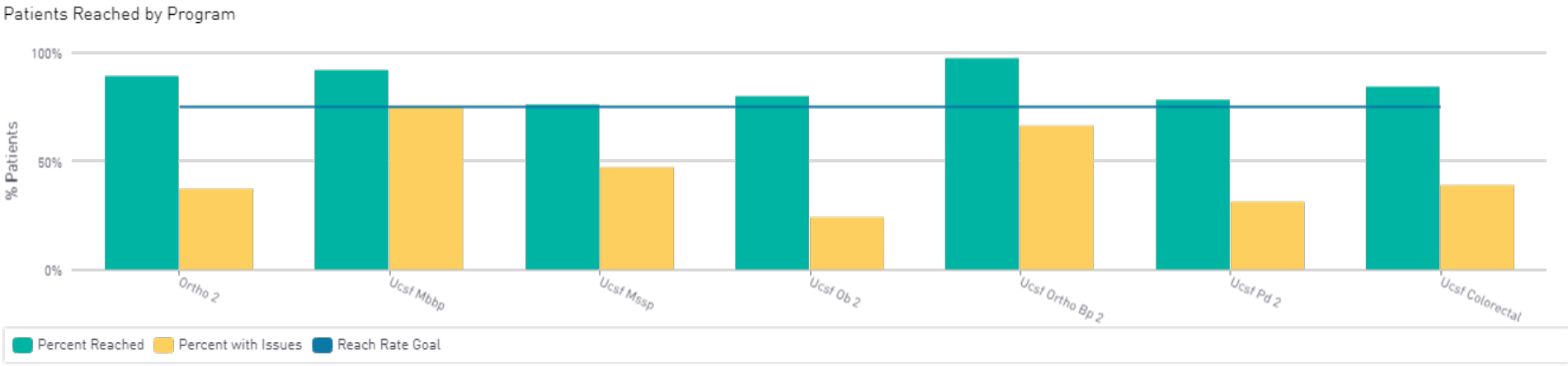
How the Program Works:

- Patients are told to expect our call at discharge (on AVS)
- Automated call is sent out 48-72H after discharge
- Patient/family respond to automated call (interactive)
- Outreach RN team is notified of patients who need help
- RN reviews chart, calls patient & addresses issues/questions
  - Often independently, but also collaborates with inpatient/outpatient providers, PCPs, case managers, home health agencies, and pharmacists
- RN documents in EMR and communicates outcome of call to care teams
- Team manually calls select patients who do not answer automated call

Care Transitions Outreach Program

May 1, 2018 – April 30, 2019

- 28.5K patients called
- 80% (23.6K) reached
- 32% self-identified issues
- 3-hour median time to resolve all issues



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Closing the Digital Divide for Language

- Patients/families choose between top 3 languages on auto-call
  - *English, Spanish, Cantonese*
- Those who don't speak one of those three languages either:
  - Hit buttons and show up on RN dashboard
  - Populate on "unreached" dashboard
- RNs call non-English speaking patients with telephone interpreter of their preferred language
- With this process, we have spoken to patients in 54 languages

Language	Total	Responded	Percent
English	17879	13833	77%
Spanish	1298	1041	80%
Cantonese	553	380	69%
Other	837	571	68%

Lessons Learned - Keys to Success

- Patient Engagement
- Staffing Model
- Workflow Management
- Standardization & Optimization
  - Scripting
  - Communication & documentation
  - Training & competency
- Collaboration
  - Reliable escalation protocols
  - Across the health system and with the community

Patient Engagement

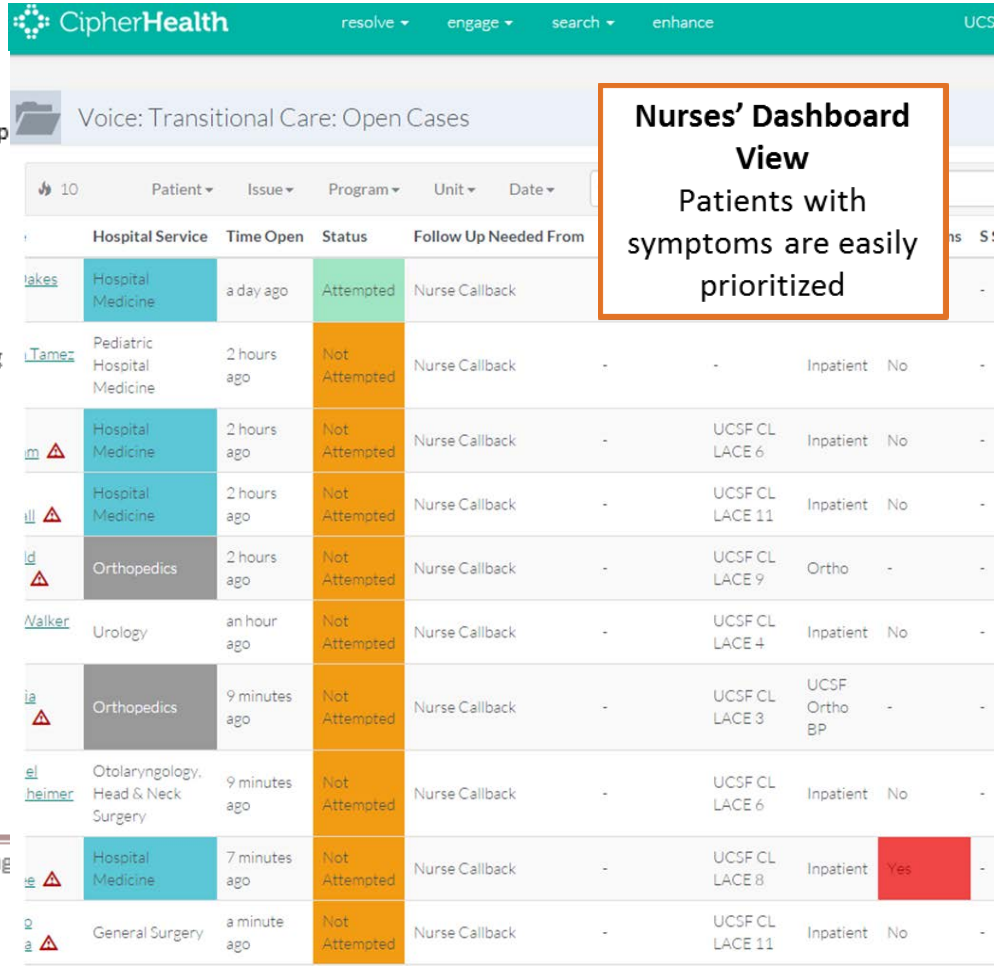
- Patients told to expect our call
- Automated Call script personally recorded
- Questions cover common post-discharge clinical issues
- Voicemail message left on first attempt
  - *Patients/families can call back into system at their convenience*
- Call contact is attempted 5x/day for 2 consecutive days
- Calls primary & secondary phone numbers

Staffing Model

- Telephonic outreach is effective & efficient
  - 4 FTE RNs + 1 FTE HCN + 20HR PharmD
  - Each RN calls 20 patients per 8-hour shift, on average
- Experiment with different roles
  - Some post-discharge needs to not require a clinical license
  - Healthcare Navigators can support the work of the RNs
  - Consultative and auxiliary support from other departments
- Dedicate staff and/or time to own this work
  - Ensures consistency, quality, & satisfaction
  - Median time to resolve patient issues is 3 hours
  - 95% mean percentile rank for Gallup Q12 survey

Workflow Management

6. Review chart in APeX
    a. Login and open patient chart, same as **Voice Call 1 Workflow**
    b. Check encounters for the following "Not Called" reasons & select radio buttons/drop downs in accordance with **"Manual Outreach Documentation"** & **"Documentation Defined"**
        i. Appointments attended
        ii. Admissions/ED visits
        iii. Telephone encounters
        iv. MyChart emails between patient and provider(s)
    c. If weekend discharge is only criterion for chart review, assess chart for the following High Risk criteria:
        i. Med/soc/psych complexity
        ii. New/change in high-risk meds
        iii. *For OB patients*:
            1. Preeclampsia
            2. Premature delivery
            3. Separation from infant
            4. Multiple infants (twins)
            5. GHTN or GDM
            6. Mood disorder
    d. If patient falls within these inclusion (and out of exclusion) criteria, prepare for call:
        i. Read DC Summary/AVS
        ii. Read CM, RN, MD notes
7. Place manual call to patient/caregiver



Nurses' Dashboard View
Patients with symptoms are easily prioritized

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Standardization & Optimization

Script improvements in April, 2018 aimed at reducing false positives

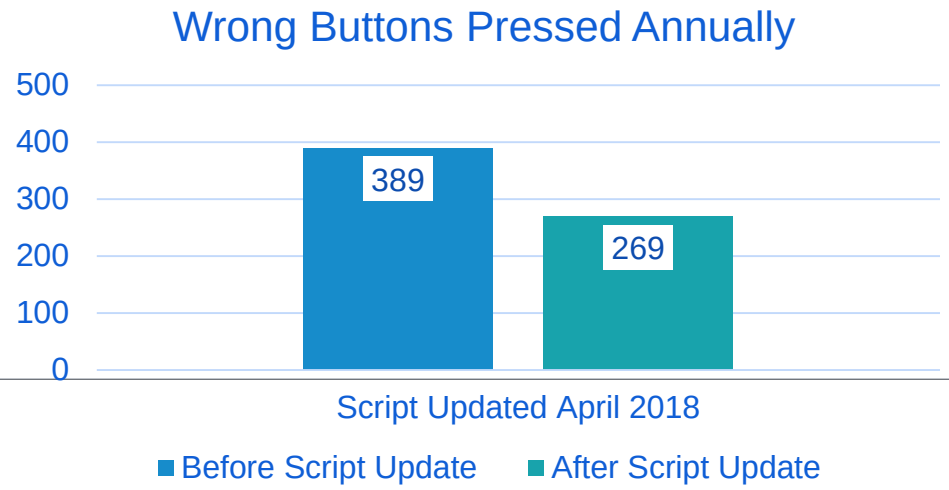
Q1 OLD: If you were prescribed medications at discharge, were you able to fill your prescriptions?

Q1 NEW: If you were prescribed new medications when you left the hospital, press 1; if you were not prescribed new medications when you left the hospital press 2

Q2 OLD: Have you started taking your medicines?

Q2 NEW: Do you need help getting your new medications?

11% Relative Reduction in Patients Requiring Intervention after April 2018 Script Update



UCSF Health

Standardization & Optimization
Staff Scripting

- **Talking with patient/caregiver:**
  - "Hello, may I please speak to [*Peds: the parent or caregiver of]* __(patient)__? My name is __(name)__. I'm a nurse with the UCSF follow-up team, and I am calling in response to the automated phone call you received __(day/time)__. You indicated…:
    - …that you are having new or worsening symptoms. How are you doing?"
    - …that you need help getting your medications. What issues are you having?"
    - …that you have questions about your medication(s). What questions to you have?"
      - "I work with a team of pharmacy experts who can __[assist with this issue] OR [go over these questions in more detail]__. I am going to escalate to our pharmacy team. When they call you, is it OK if they leave a detailed message on your VM, if you are not able to answer the phone?"
    - …that you have questions about your follow-up plan, appointments, or home visits, so I'm calling to see what I can do to assist you."
      - "The clinics prefer to speak with you directly, to schedule at a time and day that works best for you, but I can provide you with the correct phone number." *(direct scheduling a common request, but we do not have access)*
    - …that you have questions about your discharge instructions. I have your discharge paperwork in front of me, what questions can I answer for you?"
    - …that you would like to speak with a UCSF nurse about a clinical issue so I'm calling to see what I can do to assist you."
- **Answering machine or voicemail:**
  - "Hello, this message is for/regarding __(patient)__. My name is __(name)__. I'm a nurse with the UCSF follow-up team. I'm calling to follow up with you regarding your responses to the automated call you received __(day/time)__. You can reach me at __(number)__. I will also try you again later. Thank you.

Standardization & Optimization

Training & Competency

UCSF Health
Office of Population Health & Accountable Care

Outreach Nurse Competency for Follow-Up Telephone Calls

Employee: Preceptor/Evaluators:

CRITERIA CHECK LIST	CRITERIA MET	
	Date	Preceptor Initials
Organizational Skills - Manages multiple electronic systems simultaneously, utilizing dual screens; understands complex triage protocols and educational resource materials; identifies all pertinent information & applies it appropriately		
1) Logs into Evolve portal, prioritizes list of patients on dashboard in order of acuity and time open, coordinates calls with team (uses Stop Clock function for all patients)		
2) Correctly identifies patient responses to automated phone call, language, D/C date, discharging service, attending provider; notes previous care notes or Voice/View encounters		
3) Efficiently accesses APeX chart to prepare for call		
4) Quickly retrieves & assimilates key components of the APeX chart: other recent telephone encounters/emails/appointments since discharge, previous UCSF/Care Everywhere encounters, caregiver or family information, hospital course (including consults), D/C summary, AVS, future appointment details, medications (noting med changes and/or new meds), preferred language, home health services ordered & agency employed, DME/IV antibiotics ordered & agency employed, social/housing situation		
a. Reviews chart elements in appropriate order, using the patient's responses to the automated phone call to prioritize dissection & anticipate patient needs		
b. Surgical patients: notes surgical site, wound closure method, special use of collar/brace, special precautions for wound care, bathing/shower protocols, exercise and or physical limitations for specific patient populations		
c. ACO patients: correctly identifies ACO patients; makes note of documentation by Transitional Care Managers or other OPH Clinical Program team members		
d. UCSF PCP patients: correctly identifies patients who receive primary care at one of many UCSF sites; routes documentation to PCP and/or scheduler, in accordance with practice standard		
e. Ortho BP patients: correctly identifies Ortho BP patients, which phone call the patient has received, refers to HealthLoop (when appropriate), and references next call to patient		
Is organized & fully prepared for call within 5 minutes (10 minutes for high complexity patients)		
Communication Skills - Articulates clearly; uses a friendly, engaging, pleasant, helpful, non-hurried, non-shaming tone & demeanor during call; respectfully and professionally interacts with team members, partners, and all other providers		
1) Correctly introduces self to patient/caregiver upon initiation of call, referencing automated phone call/responses		
2) Adheres to script in introduction and when leaving messages on voicemail/answering machine		

Revised 7/11/18 by Margaret Wheeler
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Standardization & Optimization

Streamlining Documentation

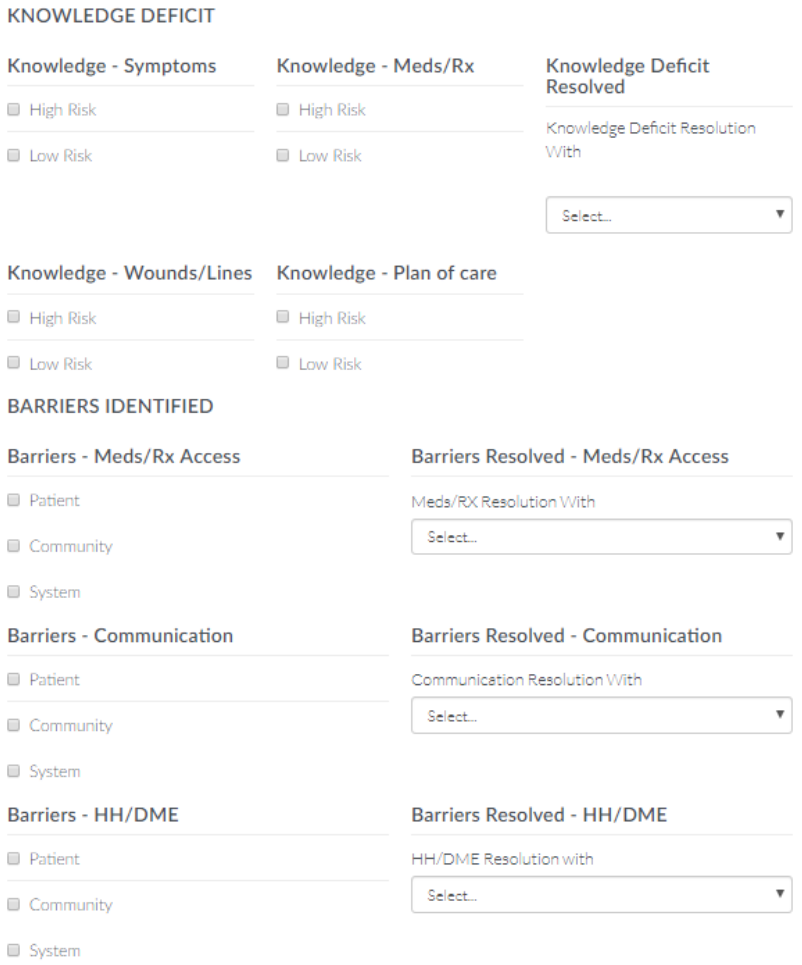
MSSP ACO POST-DISCHARGE CONSULT NOTE

Date of Consult Call: @TD@
Date of Discharge Encounter: ***
Reason for Call: @NAME@ is a member of our UCSF Medicare Shared Savings Program Accountable Care Organization (MSSP ACO). As such, the Care Transitions Outreach Program (CTOP) calls MSSP patients 24-48H post-discharge and follows patients for up to 30 days, assisting in ongoing care management and utilization of appropriate resources.
In Reference to: MSSP Call #***

Provider *:**
*** states "***."

APeX assessed for the following:
Number of IP visits in the last year: ***
Number of ED visits in the last year: ***
Number of Obs visits in the last year: ***
[***] ED/IP visits since discharge
[***] No PCP
[***] Non-UCSF PCP
[***] Active in MyChart/contacts clinic appropriately
[***] Pattern of appointment cancelation/"no show"

Active with OPH Programs:
[***] Bridges
[***] Housecalls
[***] Care Support Program



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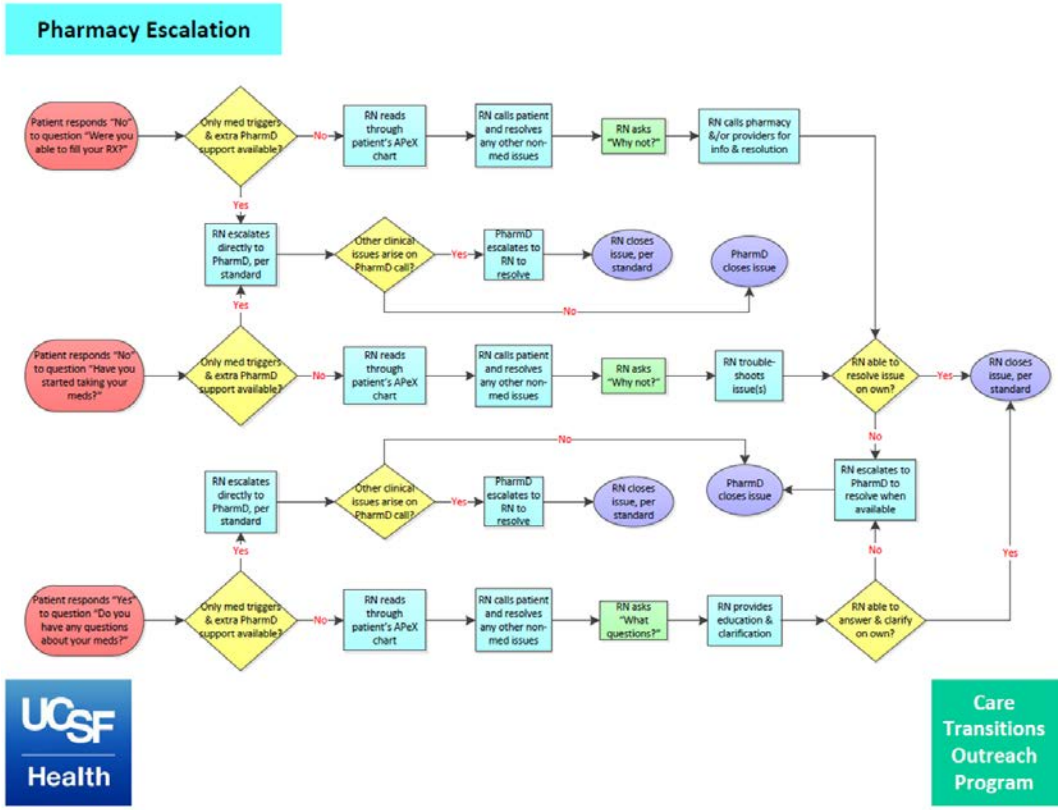
Collaboration

Reliable Escalation



Home Services	**Reference:** Scanned Admin Documents AVS Discharge summary Case management/social work note • If patient hasn't heard from home care agency → read CM/SW note to verify that services were ordered, obtain details regarding the company & start date o If services haven't been ordered → Call Jenny Check (353-1063) o If services have been ordered → retrieve agency name & phone # from CM note, call agency to verify start date and details of service. • If the equipment hasn't arrived → read CM note and call company • If the patient/family isn't comfortable managing equipment (i.e. Bipap, wound vac) → call company and request that a technician provide further teaching.
Symptoms	**Reference:** AVS Discharge summary (patient instructions) • Emergent → Tell caregiver to prepare to go to nearest ED. Call Jenny Check (**353-1063**). If no answer, call clinic (**476-2188**). If no answer, call on-call BMT attending via access line (**353-1611**). Route note to discharging attending & Jenny Check ▪ Temperature 38.0-38.2°C or 100.4-100.9°F for one hour, ▪ OR ≥38.3°C or 101°F ▪ Change in level of consciousness: increased sleepiness, confusion, mood changes, fussiness • Urgent → Call Jenny Check (**353-1063**). If no answer, call clinic (**476-2188**). Route note to discharging attending & Jenny Check. Ensure provider has contacted family within 1 hour. • Signs/symptoms of GvHD: rash- new or worsening; nausea, vomiting, diarrhea and/or decreased oral intake • Problems with central line and/or central line site: difficulty flushing, drawing blood, signs of infection at site (redness, oozing) • Symptoms of upper respiratory illness: coughing, runny nose, congestion • Non-urgent → o Route note to discharging attending & Jenny Check. Instruct family to call clinic if no response in 2 business days

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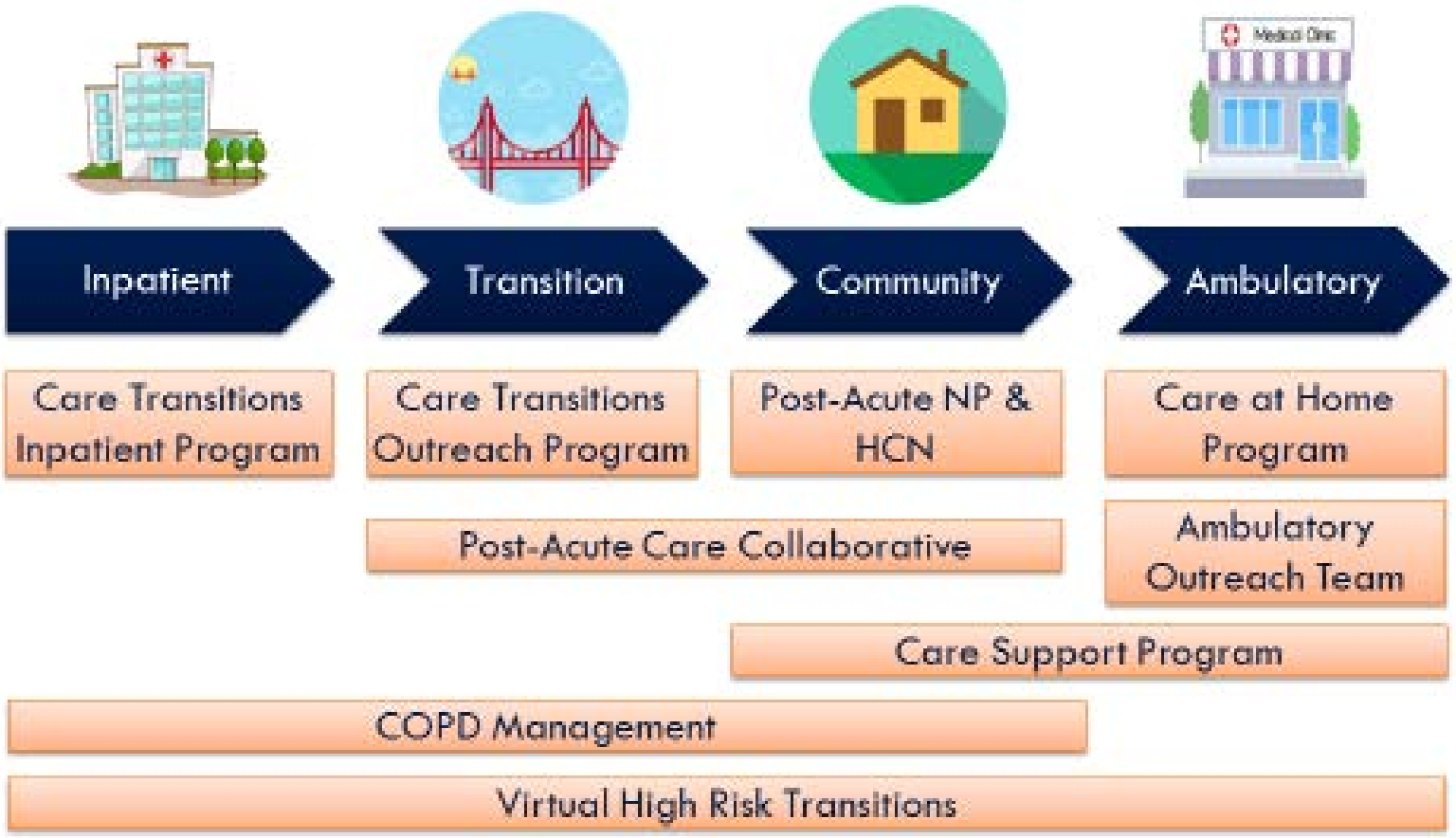
Collaboration

Across the Health System & Beyond

Population Health Clinical Programs



UCSF Health

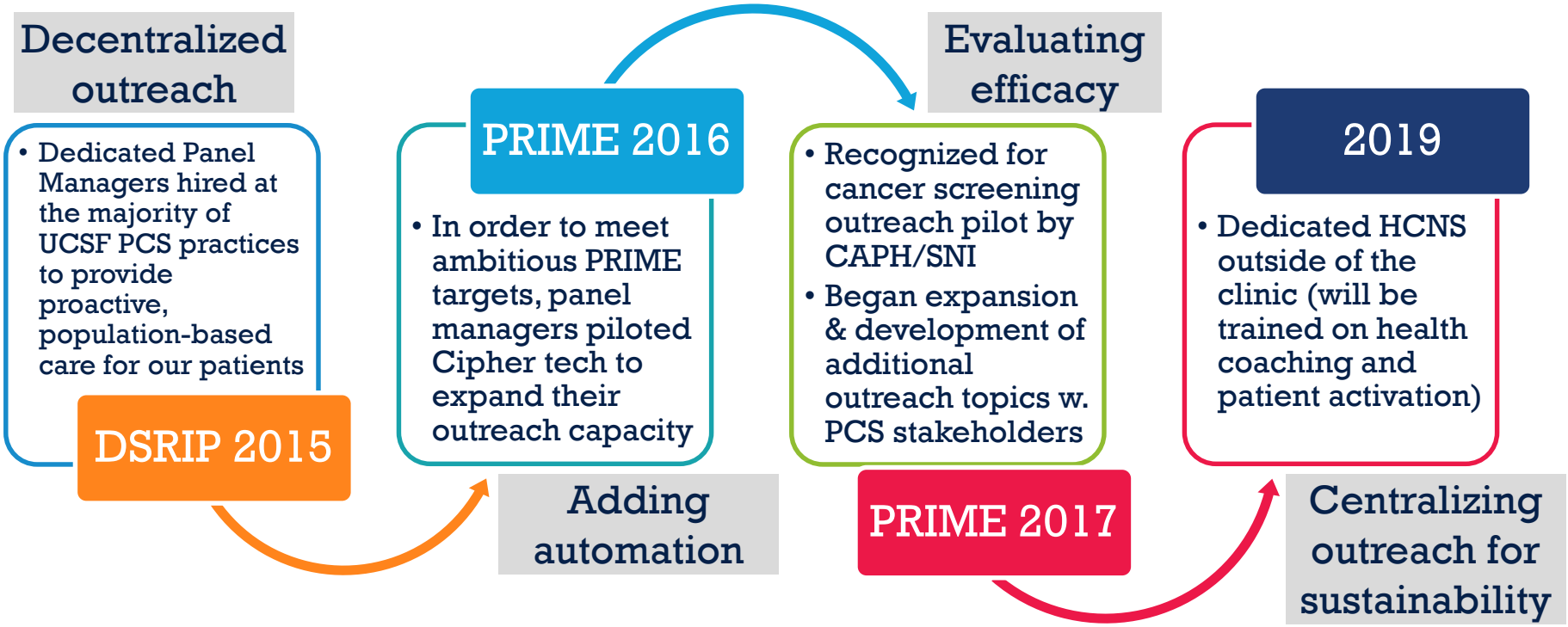
UCSF Primary Care Outreach Program

Presentation Roadmap

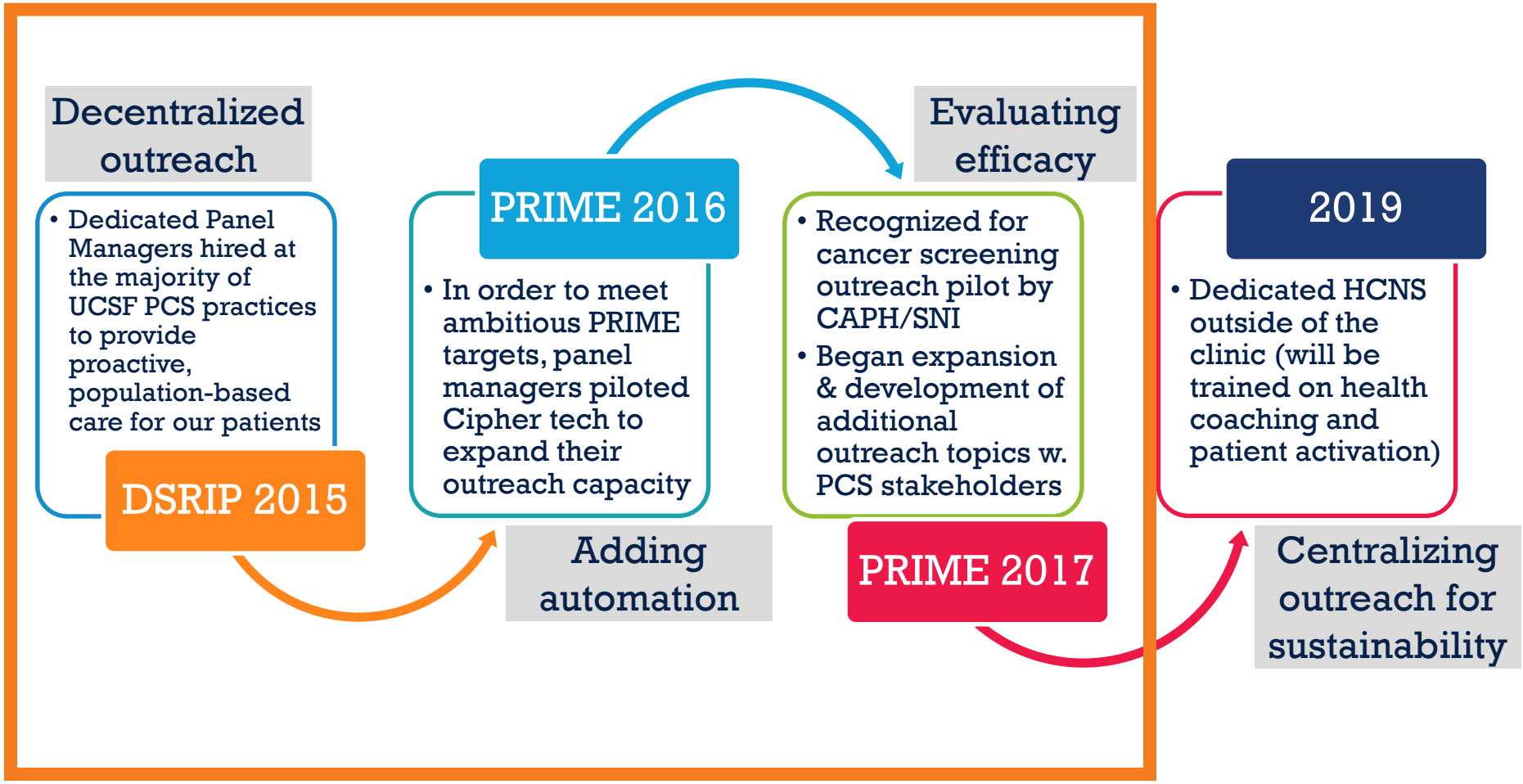
Goals for Today:

- Share UCSF's history of care gaps outreach
  - Learnings (de-centralized vs. centralized)
- Review UCSF's current outreach programs, & future state roadmap
- Review HCN Sample Workflows/Patient Story
- Delve into technical integrations (EMR & ACS)
- Shareable Materials
- Questions

Brief History of Primary Care Outreach Team



Learnings From Decentralized Outreach



“Care gaps” outreach topics successfully implemented through decentralized, clinic-based outreach - using automated system

- ✓ Cancer Screenings
- ✓ Blood Pressure Monitoring & Disparity Reduction
- ✓ Advanced Care Planning
- ✓ Influenza Immunizations
- ✓ Panel Cleanup

Learnings From Decentralized Outreach
Staffing

- Adding automated call system & workflow optimization dashboard helped to protect staff time for outreach - PMs were often pulled into day-to-day clinic operations

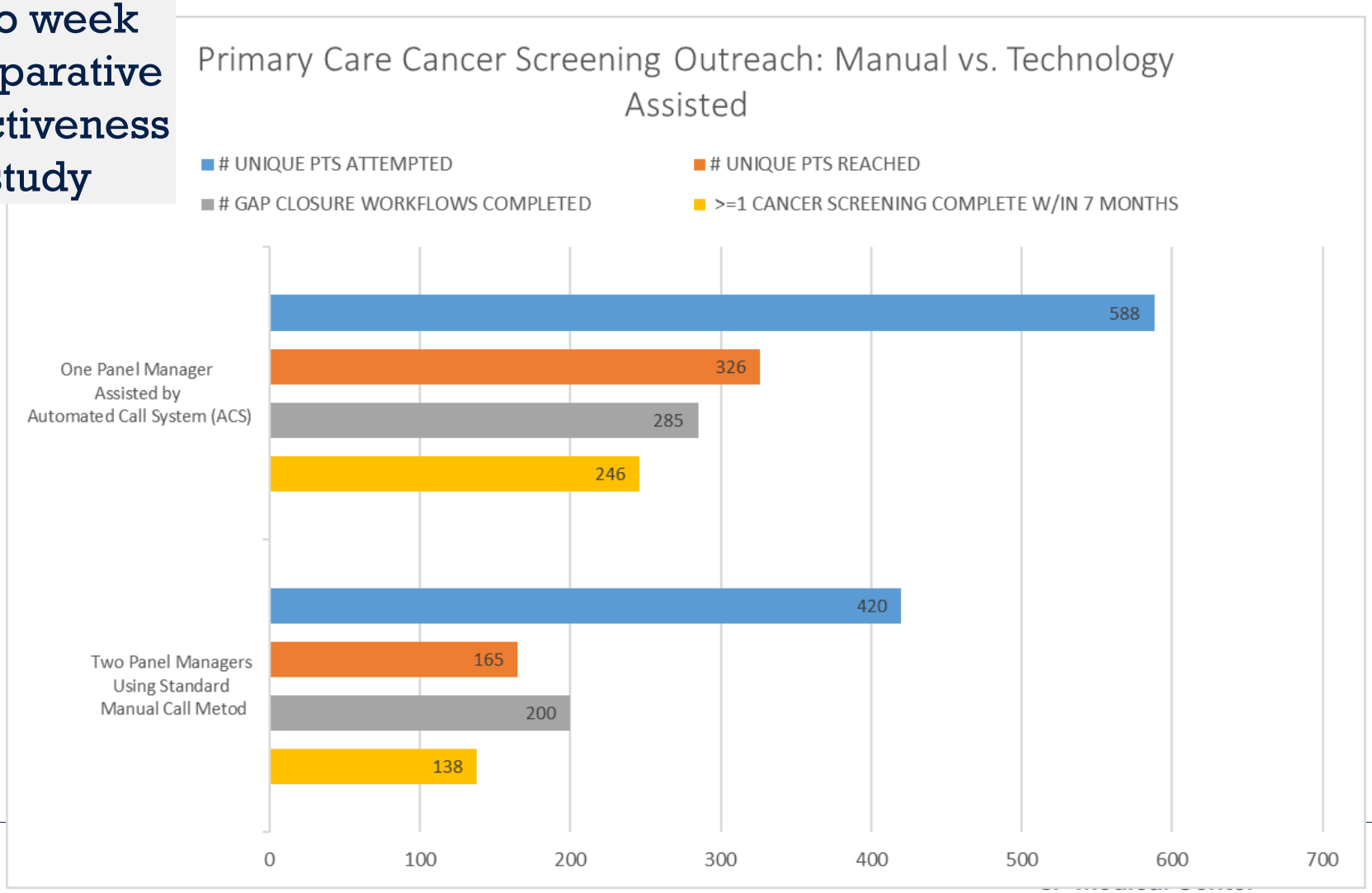
- It also improved staff engagement & satisfaction

"With the automated system, everything feels more organized. Patients are more satisfied when we contact them about their cancer screenings. They feel grateful about us taking the time to contact them and they feel cared for. They are usually ready and expecting our phone call."

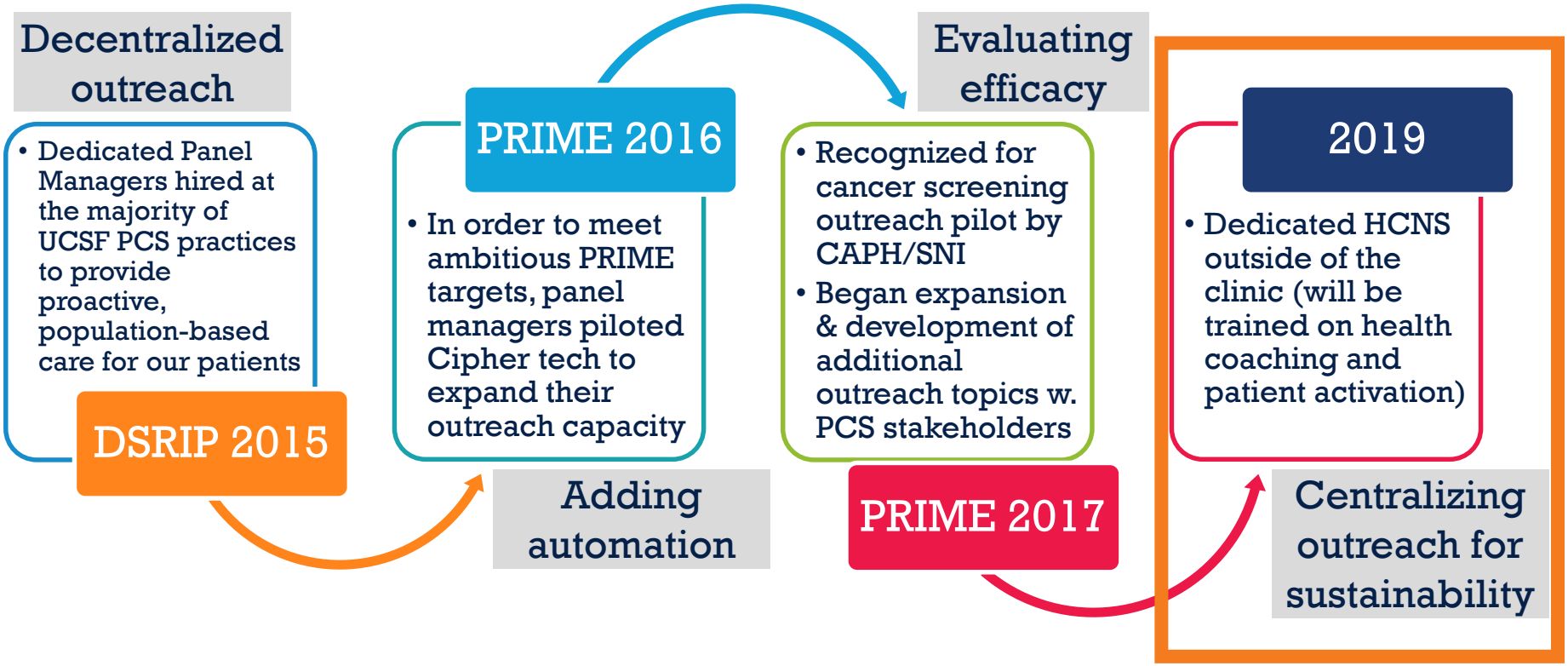
- Edith Huete, Panel Manager

Learnings From Decentralized Outreach
Effectiveness/Efficiency/Outcomes

Two week comparative effectiveness study



Centralizing The Outreach Team

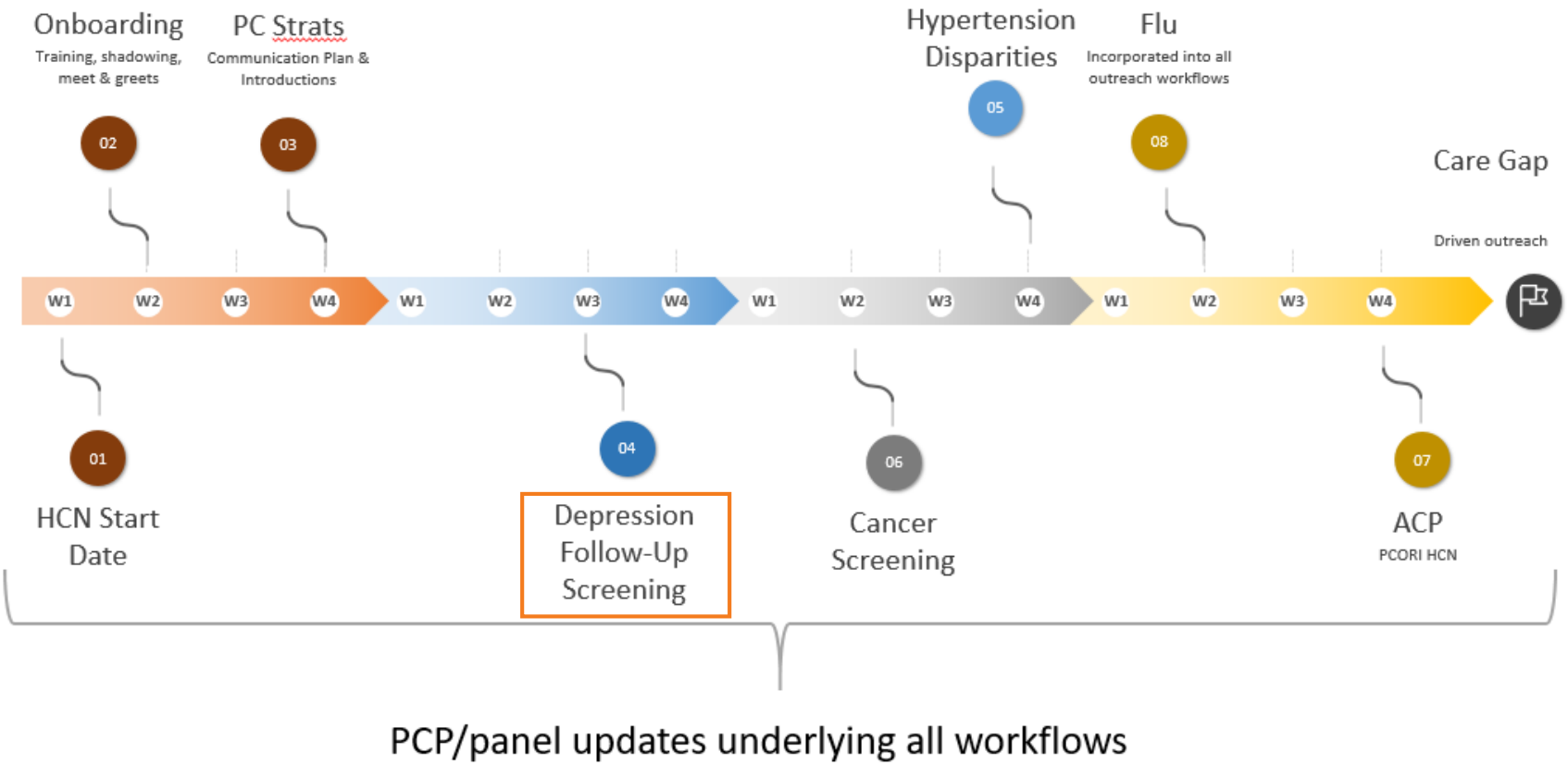


Goals of Centralization

- Achieve P4P quality goals **by expanding the capacity** of our care management teams
  - Full **dedication of staff time** to patient outreach
- **Integrate with existing population health care management teams**
  - Ensure patients are in appropriate care pathways & for clinical escalations
- Expand on the work of the former practice-based panel managers
  - Testing & informing the development of **integrated health technology** such as dynamic RWB registries with bulk outreach capabilities
- **Motivate patients to be proactive in their own care**
  - Incorporating motivational interviewing, health coaching, & behavioral activation into previously "transactional" outreach workflows

Work Ahead: Roadmap for New Centralized Team

Rationale: newly hired team builds competencies across each topic, with goal of shifting to "gap" driven workflows



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Challenges of Centralization

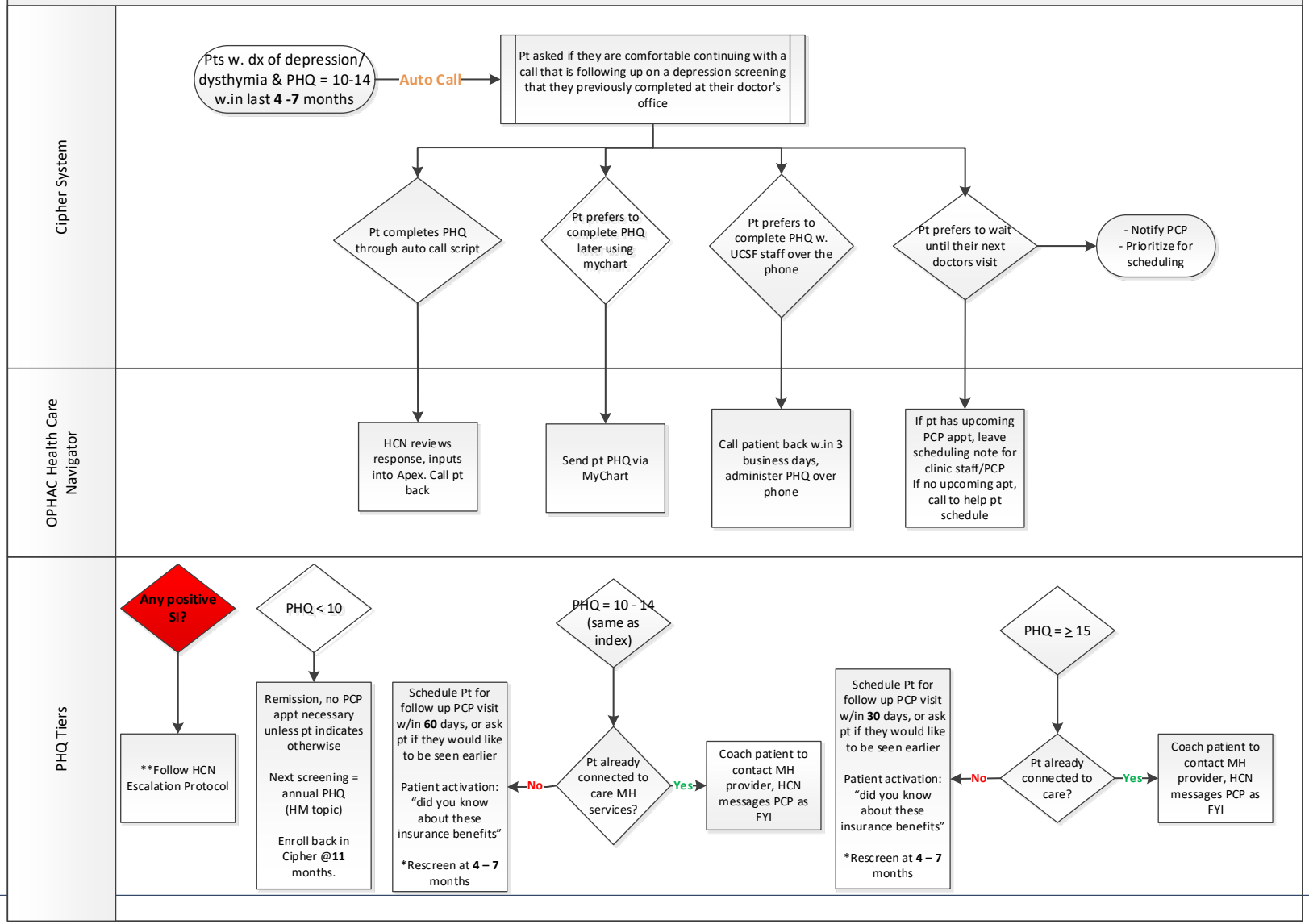
- Appointment scheduling variation across sites
- Patient Education
- Clinic Culture
- Change Management

Direct Scheduling Guidelines
University of California San Francisco

Contents

HCN Follow Up PHQ-9 Screening

6/5/19



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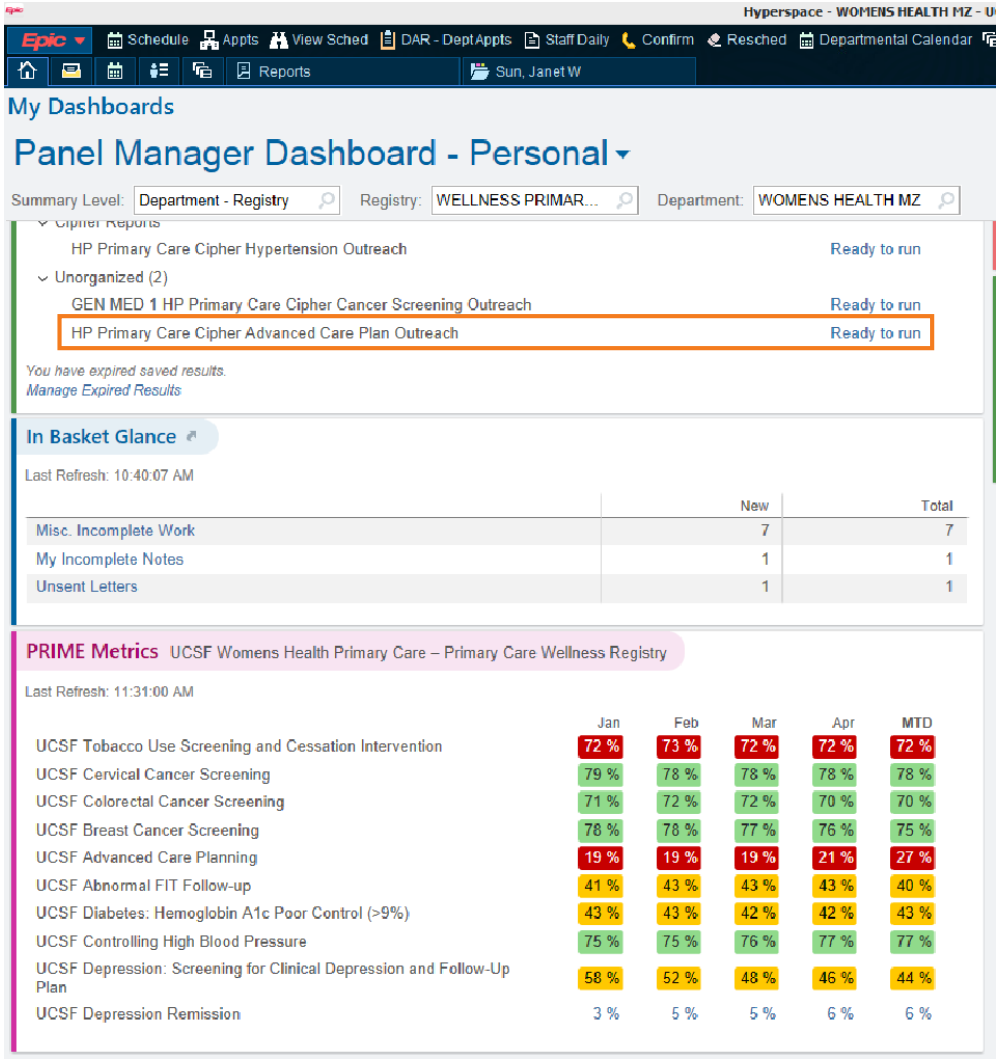
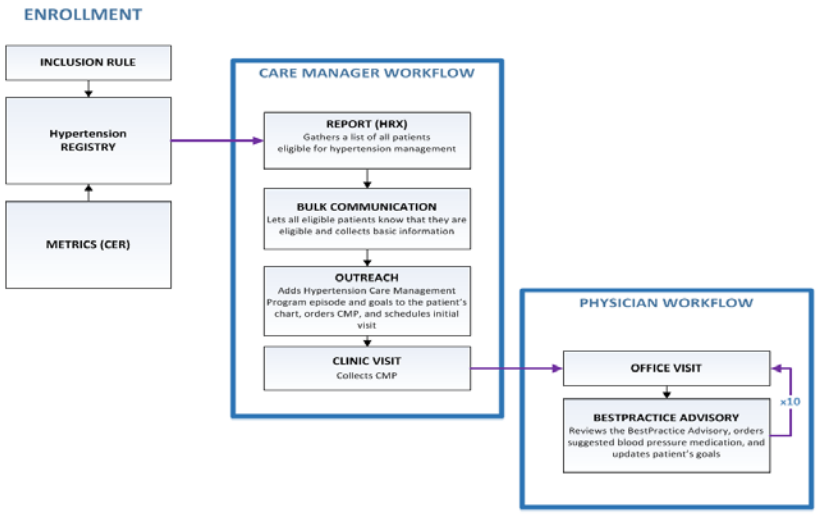
Technology & Integration

Technology: RWB Registries in EPIC link to Cipher





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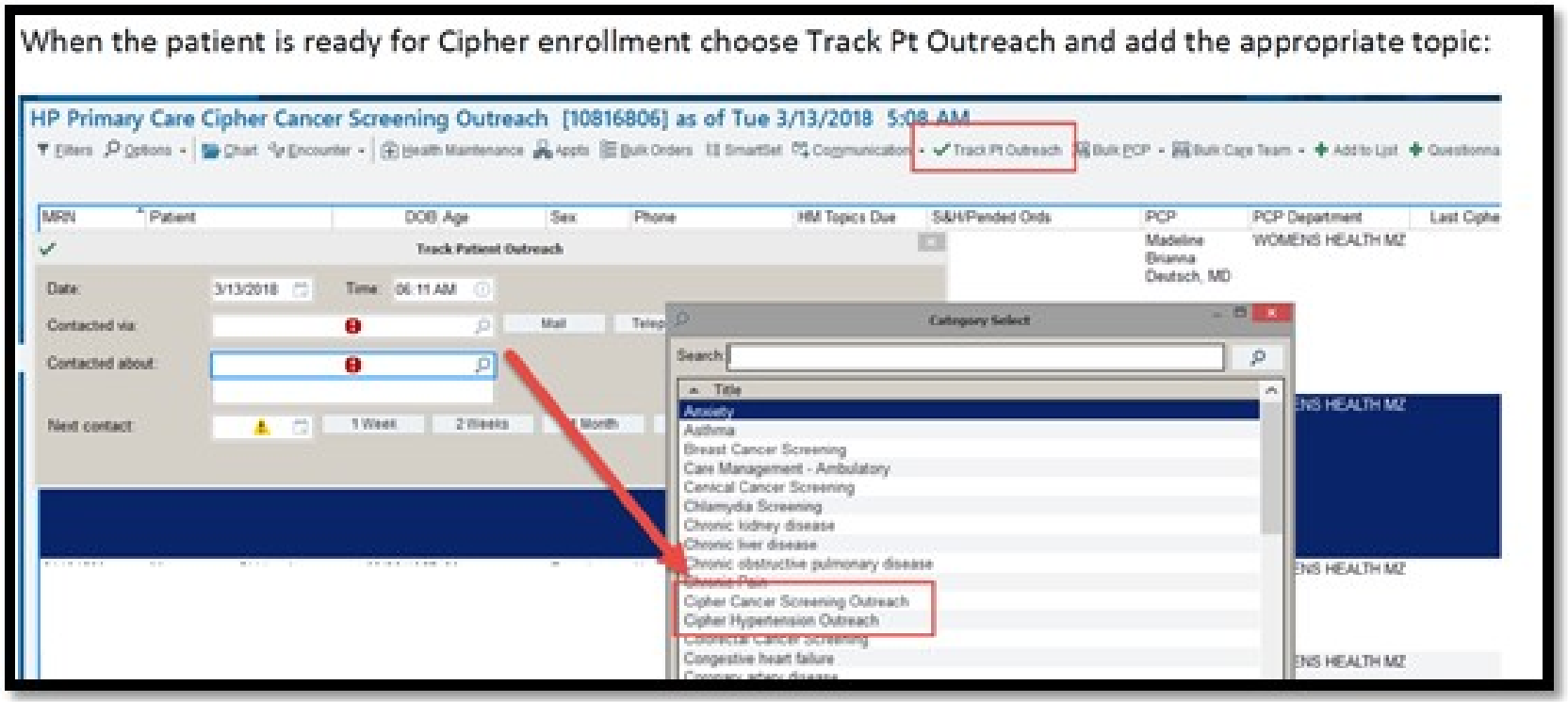
Technology: Current State

Topic-based Dynamic Registries In EMR that link to Cipher

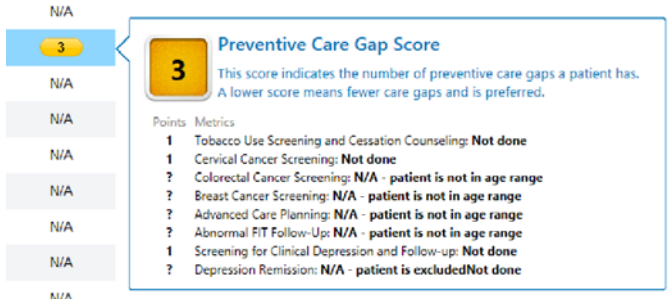
When the patient is ready for Cipher enrollment choose Track Pt Outreach and add the appropriate topic:



Tools: Future State
Patient Centered "Care Gap" Driven Outreach

Care Gaps score in individual registries

#1



"All Care Gaps" Registry (sample)

#2

- Tag Lisa for generic care gaps outreach
- Tag Jon for cancer screening outreach

NAME	MRN	DOB	CARE GAPS SCORE	HTN	ANNUAL DEPRESSION	DEPRESSION REMISSION	CERVICAL CANCER	COLORECTAL CANCER	BREAST CANCER	ACP
Lisa	51691	########	3	DUE	NOT DUE	DUE	DUE	NOT DUE	NOT DUE	n/a
Jon	54874	########	1	n/a - pt not o	DUE ON 6/1/	NOT DUE	n/a	DUE	n/a - pt not ir	NOT DUE

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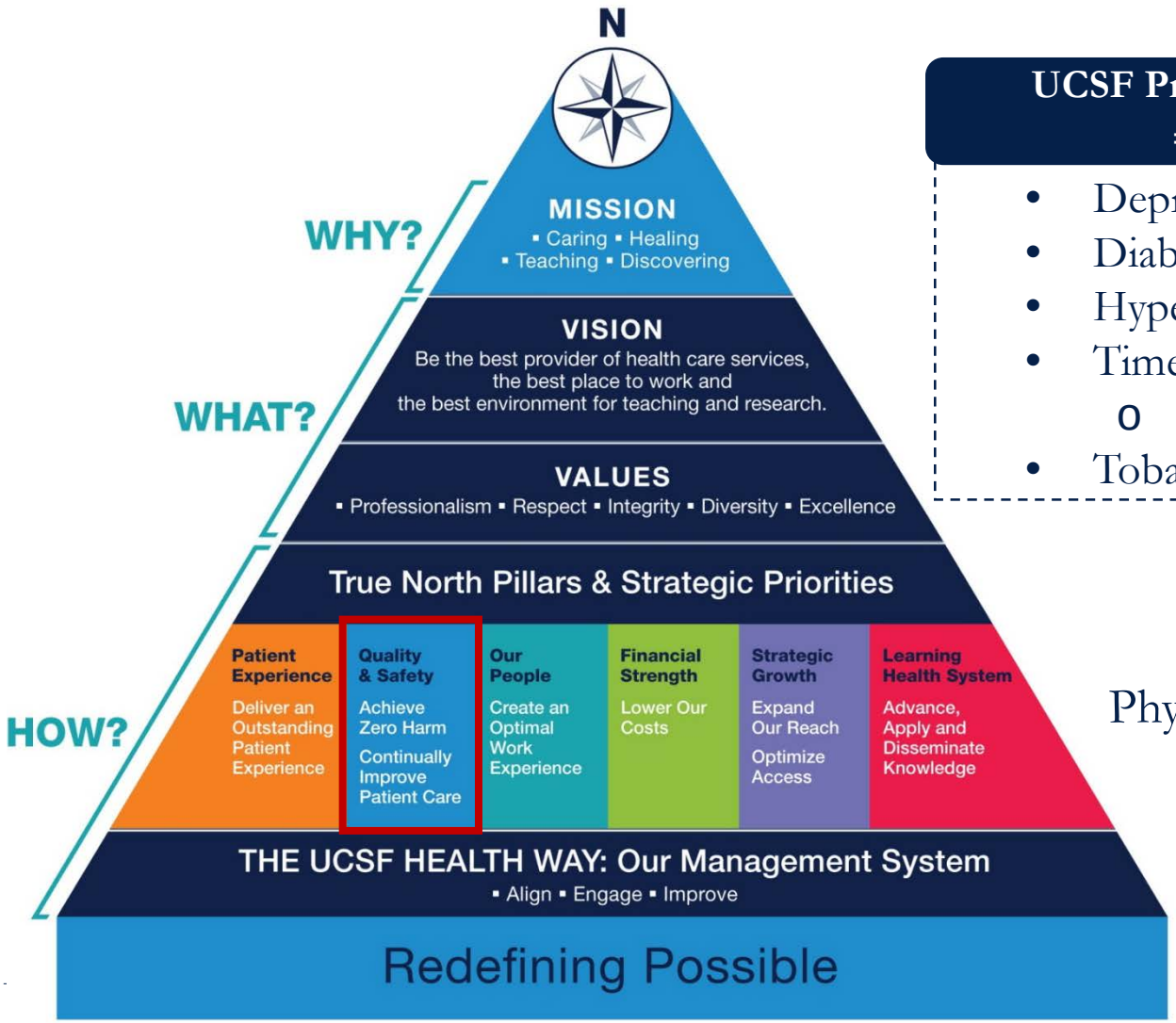
Key Performance Indicators & Alignment with Primary Care

UCSF's True North Pillars: Alignment/Communication



UCSF Primary Care Quality Goals = PRIME Goals:

- Depression Screening & Treatment
- Diabetes HbA1c Control
- Hypertension BP Control
- Timely Cancer Screenings
  - *Breast, Cervical, Colorectal*
- Tobacco Screening and Counseling

Physician and Staff incentives tied to performance on True North goals

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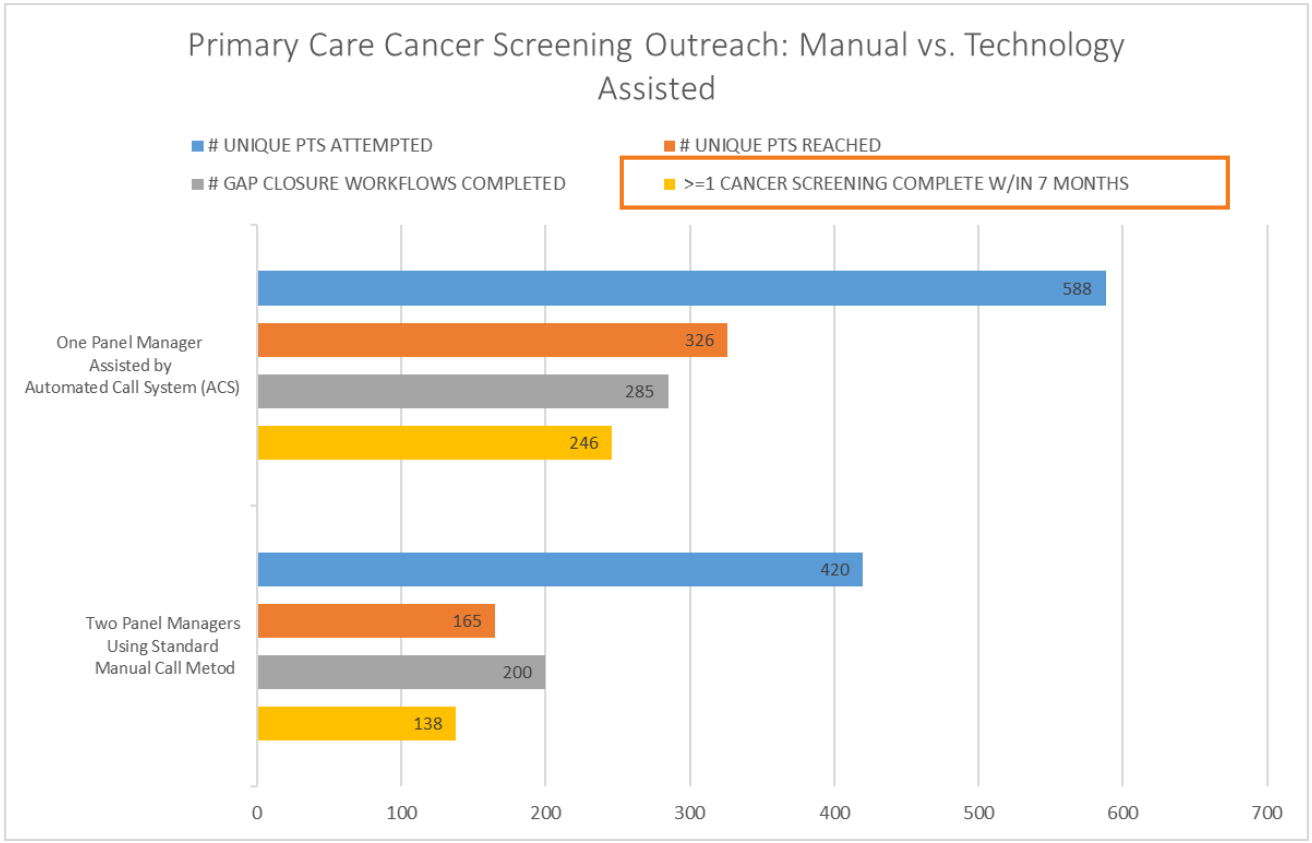
KPI's: Operational Evaluation

Audience: Managers of outreach staff (centralized or de-centralized) local administrative clinic leadership

Purpose:

- ✓ Monitor that technology is working effectively
- ✓ Continue program development/iteration
- ✓ Staff accountability and goal setting

KPI's: Outcomes



Audience: PCPs, Upper management (PCS, Pop Health, etc.)

Purpose:

- ✓ Monitor longer term efficacy of programs
- ✓ On-going communication/transparency for clinical stakeholders and leadership

Thank you!

Kristin Gagliardi
Kristin.Gagliardi@ucsf.edu

Manager of Ambulatory Outreach,
Office of Population Health &
Accountable Care, UCSF

QUESTIONS & SHARING

Scripting and Workflow Diagrams Available to Share:

- ✓ Cancer Screening
- ✓ Blood Pressure Monitoring & Disparity Reduction
- ✓ Panel Cleanup
- ✓ Advanced Care Planning
- ✓ Influenza Immunizations
- ✓ Depression Follow Up Screening 4-8 months post elevated PHQ