Improving the health and quality of life for members of the community.
Who We Are

- FQHC in San Joaquin, Solano, and Yolo Counties
  - We Serve 36% of our entire community in San Joaquin County and 9% in Solano County
- Medical, Dental, and Behavioral Health
- 21 Locations in 7 Cities
- Membership Population:
  - Medi-Cal: 81%
  - Uninsured: 15%
  - Medicare: 5%
- Hispanic 67%, Asian 13%, White 13%, and African American 7%
- Next Gen and i2i Patient Registry
PHLN Year 2 Project Aim

Service Delivery to a Higher Percentage of Our Assigned Membership Consistent With Organization’s Mission:

Focusing on outreach strategies, we aim to improve above our Health Plan of San Joaquin assigned members seen by reaching 80% membership engagement by December 31, 2019.

Measures for Success

Process measures:
• Implement a population health based roster system by April 30, 2019
• Identify number of members who have not had a visit with CMC
• Outreach all members newly assigned per month (last 90 days and 91-120 days) and schedule appointments for an annual wellness visit (new patient physical)

Outcomes Measures:
Run specific reports to track:
• Number of members reached
And of those members reached:
• How many resulted in appointments scheduled
• How many of those appointments were kept
• How many of those kept appointments were annual wellness visits
Changes

Tested Changes

• Developed an Outreach In-Reach Activity Matrix to help clearly identify what items teams are to work on.

• Cultivate and sustain Tiered Approaches for outreaching members.

Implemented Changes

• Implemented Enrollment Manager, a new roster management tool through eMedApps, which identifies newly assigned and established members who have received or not received services; and documents outreach efforts and results.

• Mailing Welcome Letters to newly enrolled members on a monthly basis.

• Sending Text Message Campaigns and Post-card follow-up communications.
# OUTREACH/IN-REACH ACTIVITY MATRIX

<table>
<thead>
<tr>
<th>Who's Responsible?</th>
<th>In-Reach (Patients) Tasks</th>
<th>Outreach (Members) Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Care Teams</td>
<td>For new and established patients --- Generate i2i Huddle report; Huddle; conduct robust confirmation calls; manage patient panels; perform annual wellness visit (physical)/CHDP; use appropriate codes; perform SHA (age-appropriate, annually); print out anticipatory guidance; recall no-show patients; recall patients with abnormal labs/clinically significant follow up</td>
<td>Designated Care Team Staff: Schedule Non-Engaged Members (not new members) by documenting in Enrollment Manager as directed by Center Manager, Supervisors, Leaders. Center Managers will provide feedback to Membership Services Director on O &amp; E staff progress at sites.</td>
</tr>
<tr>
<td>Health Educators</td>
<td>Conduct group classes; recall patients with gaps in care for diabetic labs CDC-HT; CDC-N; MPM-ACE; and MPM-Diuretics (standing orders); Recall patients who have not had an annual wellness visit (prioritize CHDPs) in the past 12 months (lists retrieved from Health Plans) Note: Documentation in NextGen only.</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient Services Center</td>
<td>Schedule appointments in a timely manner for all patients</td>
<td>Conduct outreach; schedule appointments from the Enrollment Manger list from designated health plans for members assigned within the last 0-90 days. If all 0-90 day New Members have been contacted, available staff time should be concentrated on Non-Engaged members with a focus on sites that have available access.</td>
</tr>
<tr>
<td>Outreach and Enrollment Staff</td>
<td>Recall patients who are identified as uninsured and pursue enrollment of health coverage</td>
<td>Conduct outreach; schedule appointments from the Enrollment Manger list from designated health plans for members assigned within 91-120 days and Non-Engaged members as a second priority. Health coverage schedules are blocked for 4 hours weekly. Documentation will be done in Enrollment Manager. This time commitment will be allocated in full or part by the O &amp; E Team Leader. O &amp; E Team members will also communicate with Center Managers on weekly progress.</td>
</tr>
</tbody>
</table>
Using Data for Improvement

We had Staff/Resources role changes and training that effected a dip in outreach attempts.

1. # HPSJ members outreach attempts (phone, mailer, text - members assigned 0-120 days)
2. Target (100% of members newly enrolled that month, 0-30 days)
3. Of Total HPSJ Assigned Membership, % appts kept

Target 80%
2018 v. 2019 Comparison
Total # HPSJ Members (Assigned & Not Assigned) Engagement

- Blue: Jan. 18 - Dec. 18 (41389)
- Orange: Jan. 19 - Oct. 19 (48595)
- Red: Projected Scheduled Appts for Nov-Dec 19 (1073)

HPSJ Assigned Members Preventive Visits Kept

- # HPSJ members Engaged (38388)
- # HPSJ Preventive Visits Kept (24458)
- # HPSJ members NOT Engaged (37255)

Total HPSJ Assigned Membership (Oct 2019): 75643
### Member Statistics

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<tr>
<td>EM_New Enrollment</td>
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<tr>
<td>EM_No Contact From Member</td>
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<tr>
<td>EM_Not Engaged</td>
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<td>EM_Scheduled Member</td>
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<td>EM_Termed Member</td>
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<td><strong>Total:</strong></td>
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### Member Processing Filters

- **Status**
- **Sub Status**
- **Days Since Outreach**
- **Days Since Followup**
- **Days Since End Date**
- **From End Date**
- **To End Date**
- **Patient**
- **PCP Name**
- **Assigned To**
- **First Name**
- **Last Name**
- **DOB**
- **New Member**
- **Risk Level**
Strategies for Success

1. Creating an Interdisciplinary Team
2. Developed an Outreach In-Reach Activity Matrix
3. Improve reporting on progress where results are readily available
4. Tiered approaches to outreach member engagement
In efforts to expand our outreach goals to also help with meeting inreach of our non-engaged members, we have updated our matrix to include resources from our direct Clinical Care Teams.

Staff training on new Enrollment Manager tool. **Training materials** on using the roster product have been developed by our Applications Department with the support of super users from our Patient Services Center.

We added Text Reminders to come for care via integration from our established Appointment Reminder System, Well App. We used a Special Text Campaign.
Next Steps

**Spreading**

Add 2 new health plans to the Enrollment Manager roster process, bringing our total participating percentage to 92%.

Integrate our unassigned “members” into this process, primarily our Uninsured and Standard Medi-Cal and Medicare.

Incorporate Enrollment Manager into Health Educator outreach efforts

**Sustaining**

Utilize the Enrollment Manager to facilitate appointments to improve HEDIS outcomes and member engagement.

Hardwire an ongoing process by refining and learning on what works and does not work.
We’re Proud of What We’ve Learned!

Outreaching 100% of newly assigned members within 30 days

Implemented Enrollment Manager that will help track outreach/inreach documentation efforts

Learned how to improve our data analytics to work for us

To date, we have seen 3% more HPSJ Members for Preventive Visits compared to last year

We now have better tools and a stronger understanding of how to continue engaging our members!
Current Challenges or Barriers

1. What relationship tools and techniques are the most effective methods to engage our members in receiving our services?

2. Membership changes monthly which creates a moving target for tracking outreach results. What tactics may be utilized to help mitigate this?
Questions?

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Laura Thao Vang, Operations Special Projects Manager
Marc Smith, Director of Member Services

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