Spreading Solutions That Work

2018-19 Outcomes Celebration Webinar

Moderated by Melissa Schoen
Telephone Visits

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Cohort Coach

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Spreading Solutions That Work

In partnership with Blue Shield of California Foundation, CCI supports the spread and implementation of five successful solutions:

- Patient Portal Optimization
- Medical Scribes
- Group Visits
- Telephone Visits
- Texting Solutions
Telephone Visits Grant Goals & Teams

Goal: Provide an alternative to face-to-face visits via clinical exchanges over the phone

TEAMS:
- Venice Family Health
- North County Health Services
- Alameda County Health System
Venice Family Clinic
Who We Are

- **Our Location**: Venice, CA

- **# of Sites**: 10 clinical sites (5 are full-time primary care sites)

- **# of FTE Providers**: 30

- **Solution/Technology Implemented**: Phone Visits
  - 1st Phase (with hepatitis C patients) went live April 2017
  - 2nd Phase (with stable diabetic patients) went live December 2018
Goals & Objectives

- Increase clinic access
- Improve patient satisfaction
- Develop scalable workflows that can be adapted to other patients & providers
Phone Visit Implementation

**Hep C (Apr 2017)**

- Clinical Criteria:
  - Needs 2\textsuperscript{nd} or 3\textsuperscript{rd} Hep C Visit at VFC

**Stable DM (Dec 2018)**

- Clinical Criteria:
  - Patient aged 18-64 years with DM, HTN, and/or hyperlipidemia diagnosis
  - A1c < 8 for last 3 reading
  - BP under 140/90 at their last visit
  - Kept at least 3 appts in the past year
  - Last DM visit was in-person

**Additional Criteria:**
- Can access a phone
- Likely to answer phone at appt time
- Likely to understand info over the phone
- Has not no-showed on 2 phone visits
Workflow

Scheduling

**Reminder Call** 1 wk prior to appt
*Hep C Coordinator/Medical Case Mgr*

Reminder Call 1-2 days prior to appt
*Front Desk*

Check In day before or day of appt
*Front Desk*

Visit day of appt
*Provider*
Visit Data (Apr 2017 – Dec 2018)

**UNIQUE PATIENTS (N = 66)**
- Hep C (n = 62)
- Stable DM (n = 4)
- 94%
- 6%

**VISITS (N = 102)**
- Kept (n=86)
- No Show (n=16)
- 84%
- 16%
Hep C- Patient Satisfaction Results

- **97%** are very likely to use a phone visit again (n=29)
- **89%** are very likely to recommend a phone visit to someone else (n=27)
- **93%** preferred a phone visit instead of a visit to the clinic (n=29)
  - Many stated only for visits with no blood work or physical exams
Hep C- Patient Satisfaction Results (cont’d)

Overall Rating of Phone Visit (n=29)

- Excellent: 76%
- Very Good: 17%
- Good: 7%

“[The] medical provider explained everything thoroughly and in a detailed manner through a language that was understandable. I would much rather prefer phone visits due to convenience.”

“I loved the phone visit! I live in San Pedro & work in LA. It is much easier...to get care”

“I really liked the phone visit program & hope it is expanded.”
Accomplishments

- Developed new workflows with input from the team & leadership
- Implemented phone visits with hep C & stable diabetic patients
- Shared our pilot with others
Challenges & Solutions

- Patients wait ~30 mins between check in & the provider call on the day of the visit
  - Piloted pre-registration workflow
  - Based on success, we are implementing pre-registration for some in-person visits

- Medical Care Managers had some issues ordering labs for patients before visit
  - Developed new workflow to order labs

- Had a small roll out since we defined our target populations with a narrow criteria
  - Good for initial roll out
  - May broaden populations in the future

- Lack of funding/reimbursement for visits
  - Kept scale small
Tips

- Have frequent team meetings to adjust workflows & discuss staff and patient needs
- Track everyone!
- Try to target large patient populations
- Make sure to have organizational buy-in
- Continue to Assess Current Workflows
- Expand Pilot to Depression or Anxiety Patients
North County Health Services
North County Health Services

- Where We Are Located: North San Diego County
- Number of Clinics in the Organization: 12 clinical sites
- Total Number of FTE Providers: 125
- Solution/Technology Implemented: Telephone Visits
- Date Telephone Visits First Went Live: September 2018
- Target Population: Uninsured Diabetics at our Encinitas Health Center
Implementation Status

*Current phase of this work:* Implementation, evaluation, spread

Our overarching goal was to successfully implement and evaluate the effectiveness of telephone visits among our uninsured diabetic population with at least one provider in order to prepare for a value based payment model.

Our pilot originally was going to be implemented at our semi rural health center in Ramona Ca

- Moved to our Encinitas Health Center
- Intent was to spread the pilot beyond 1 provider and initial target population
- In the last month, parameters of the pilot were expanded
# Our Value Proposition

## Value Matrix

How will your solution impact the Health Center?

<table>
<thead>
<tr>
<th>Solution</th>
<th>Human</th>
<th>Social</th>
<th>Intellectual</th>
<th>Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Value</td>
<td>• Retention of providers and support staff</td>
<td>• Potentially increase network of services, leading to savings during V2V</td>
<td>• Formalizes tracking mechanisms needed to report on effectiveness</td>
<td>• Generate capacity for additional visits</td>
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<tr>
<td></td>
<td>• Decrease in costs of hiring new providers and staff</td>
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<td>• Cost per patient decrease during P4P</td>
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<tr>
<td>Mission Impact</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Quality / timely care</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td></td>
<td>• Meet pts where they are in care journey</td>
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<tr>
<td>Short Term Impact</td>
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<td></td>
<td>• Increased contact w/ chronic patients</td>
<td>• Possibly increase our capacity to collaborate with referring providers</td>
<td>• Testing of alternative encounter</td>
<td>• Alignment of visit types for providers vs support staff</td>
</tr>
<tr>
<td></td>
<td>• Increase in access</td>
<td></td>
<td>• Development of TV workflow</td>
<td></td>
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<tr>
<td></td>
<td>• Increase in patient exp.</td>
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<tr>
<td></td>
<td>• Provider / staff sat</td>
<td></td>
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<tr>
<td>Long Term Impact</td>
<td>• Higher quality care</td>
<td>• Reputation within community (residents and other stakeholders)</td>
<td>• Help determine if TV is an appropriate solution for patients and org</td>
<td>• Increase cost savings across the health system</td>
</tr>
<tr>
<td></td>
<td>• Increased patient engagement</td>
<td>• Innovative solutions responsive to pts needs</td>
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<tr>
<td>Opportunity Cost</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cost what happens</td>
<td>• Provider / staff burnout and turnover</td>
<td>• Lack of confidence / trust within community</td>
<td>• Lack of Innovation</td>
<td>• Cost to recruit, rehire, and onboard</td>
</tr>
<tr>
<td>if you don’t do</td>
<td></td>
<td></td>
<td>• Preparation for future payment reform</td>
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</table>
Data!

- Total # of Telephone Visits – 22 (includes 6 so far in February)
- Provider & Staff Satisfaction = 100%
- Patients willing to have another TV = 94%
What did you Accomplish?

Our biggest win in this last year: Creating an NCHS specific, telephone visit workflow that could be utilized and incorporated across our organization

- Lots of work went into the development of the workflow as well as the implementation of workflow
- Required input and buy in from a variety of different departments
- The time spent ensuring the workflow was appropriate allowed us to mitigate future challenges (moving the pilot site, changing providers, etc.)

Other accomplishments:

- Launched pilot of alternative encounter in preparation for a value based model
- Provided an innovative alternative to the traditional face to face encounter for patients, and our data indicates telephone visits were well received
- Expanded the target population and parameters of pilot
Challenges and Solutions

Our biggest challenge (and solution) in this last year: Constant turnover and change within our project team and location of the pilot.

• Our pilot site and provider changed twice; the second time was right before we were scheduled to go live
• Various factors contributed to these changes

Other challenges:

• No reimbursement for telephone visits
• Prioritizing face to face visits
• Limited pool of potential patients because of our narrow focus on Uninsured diabetics
Tips for Making an Impact

Most important tips for others implementing telephone visits

• Not just buy-in, but also champions at the clinical and executive level

• Create a multidisciplinary team – (operations, finance, care/clinical, etc.) to provide input and be involved in planning, implementation, and evaluation

• Consistent communication; set regular, recurring project meetings

• Change takes time, continue to be persistent!
Looking Forward

What are your 1-2 major next steps for this body of work?

• Continue the telephone visits to better evaluate their effectiveness within our general patient population

• Possibly expand the telephone visit model to other provider types and or support staff

• Using our experience to be better positioned for future value based reimbursement model
Thank you

Thank you to CCI, Melissa, Kristene, and other cohort members!

Hector Orozco

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(760) 736-6709
Alameda Health Systems
## Who We Are

| **Where we are Located:** | Oakland, CA |
| **Number of Clinics in the Organization:** | 5 Hospitals  
5 Wellness Centers; *Primary Care and Specialty Services* |
| **Total Number of FTE Providers:** | 200+ |
| **Solution and Technology Implemented:** | Telephone Visits |
| **Date First Went Live:** | June 2018 |
| **Vendor:** | Melissa Schoen Consulting |
| **Target Population:** | Chronic Disease, Diabetes Management |
## Implementation Status

### Chronic Care Teams, Testing and Implementation

<table>
<thead>
<tr>
<th>ORIGINAL</th>
<th>Focus</th>
<th>Sites Included</th>
<th>Patients Involved</th>
<th>Providers/Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spread Goal (June – August 2018)</td>
<td>Chronic Care Teams, Diabetes</td>
<td>One Site, Pilot Highland, Primary Care – Adult</td>
<td>102 Visits, Manual data capture</td>
<td>Team of 6; • Provider (2) • Pharmacist (1) • Registered Nurse (2) • Registered Diabetic Educator (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CURRENT</th>
<th>Focus</th>
<th>Sites Included</th>
<th>Patients Involved</th>
<th>Providers/Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spread Goal (September 2018 – January 2019)</td>
<td>Chronic Care Teams, Diabetes</td>
<td>One Site Highland, Primary Care – Adult</td>
<td>206 Visits, Automated data capture</td>
<td>Team of 3; • Pharmacist (1) • Registered Nurse (1) • Registered Diabetic Educator (1)</td>
</tr>
</tbody>
</table>
Our Value Proposition

• We want to be the provider of choice for our patients and community members.

• We acknowledge that access, transportation, and time is of great value for Patients, Providers, and Staff.

• We want to develop, implement, and sustain a model of care delivery that will make an impact to the quality of life for our patients.
Data!
What did you Accomplish?

Accomplishments, our wins during Spreading Solutions!

| Engagement of Stakeholders | • Providers, Staff, and Patients involved in process  
|                           | • Input and Feedback from the Chronic Care Team pilot site  
|                           | • Community of Problem Solvers  
| Pilot a Test of Change!    | • Creation of a scheduling template build  
|                           | • Set guidelines as to what is considered an appropriate Telephone Visit  
|                           | • Monitor and track outcomes electronically  
| Revenue Cycle Support      | • Buy-in and support for growth  
|                           | • Preparation for Epic build  

### Challenges and Solutions

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competing Priorities:</strong></td>
<td>• Utilize current resources and tools, and IT support/accessibility&lt;br&gt;• Creative thinking&lt;br&gt;• Think Big-Picture, what we can do now and where we would like to be with Epic</td>
</tr>
<tr>
<td><strong>Time and Availability:</strong></td>
<td>• Delegated workload&lt;br&gt;• Increased intervals of meetings and check-ins</td>
</tr>
<tr>
<td><strong>Spreading the Work:</strong></td>
<td>• Reviewed Roles and Responsibilities&lt;br&gt;• Set deadlines, and adhere to them&lt;br&gt;• “Don’t let Perfection be the enemy of Good”</td>
</tr>
</tbody>
</table>
## Tips for Making an Impact

### What was the biggest impact?

- Structured and Standardized Appointment Scheduling
- An alternative level of care for patients
- Decrease congestion, while keeping volume at the clinics
- Engaging and Empowering staff in the process and decision making.
- Development of Operator Standard Work (OSW)

### Key Tips for Making an Impact

- Clear Roles and Responsibilities, early
- Clear Expectations and Deadlines, support one another
- Engage with Key Stakeholders, and Communicate Regularly
- Don’t let perfection be the enemy of good!
## Looking Forward

<table>
<thead>
<tr>
<th>Spread the Work!</th>
<th>Spread to All Chronic Care Teams, remaining 3 locations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>•</strong> Possibility of including in Provider schedules</td>
<td></td>
</tr>
<tr>
<td>Preparation for Epic</td>
<td>Building framework to Operationalize within our New EHR system</td>
</tr>
<tr>
<td>Revenue Cycle</td>
<td>Ability to register patients, and capture volume</td>
</tr>
<tr>
<td><strong>•</strong> Ability to document within encounters, patient care</td>
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</tbody>
</table>
Thank you

• Rafael Vaquero, Director, Ambulatory Integration and Access

• Neha Gupta, M.D., Medical Director PRIME and Ambulatory Transformation

• Ivonne Spedalieri, Manager, Ambulatory Call Center and Ambulatory Referral Unit

• Anita Roberts, Clinical Nurse Supervisor, Highland Primary Care

• Maritza Brown, Patient Services Supervisor, Eastmont Wellness Center

• Special Thank You!
  • Melissa Schoen, Melissa Schoen Consulting
  • Our Partnered-colleagues; Hector Orozco, North County Health Services and Bessie Mathew, Venice Family Clinic
A few words from the CCI team...

Jaclyn Lau
Program Coordinator

Jennifer Wright
Program Manager
Questions?

Press *7 to unmute your phone.
Or type your questions into the chat box!