## 2018-19 Outcomes Celebration Webinar

Moderated by Melissa Schoen

# Telephone Visits

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Cohort Coach

Spreading Solutions That Work

2018-19 Outcomes Celebration Webinar

blue of california foundation

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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

Venice Family Clinic

*Providing quality primary health care to people in need*

- 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

Venice Family Clinic

*Providing quality primary health care to people in need*

# 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 2nd or 3rd Hep C Visit at VFC

**Stable DM (Dec 2018)**

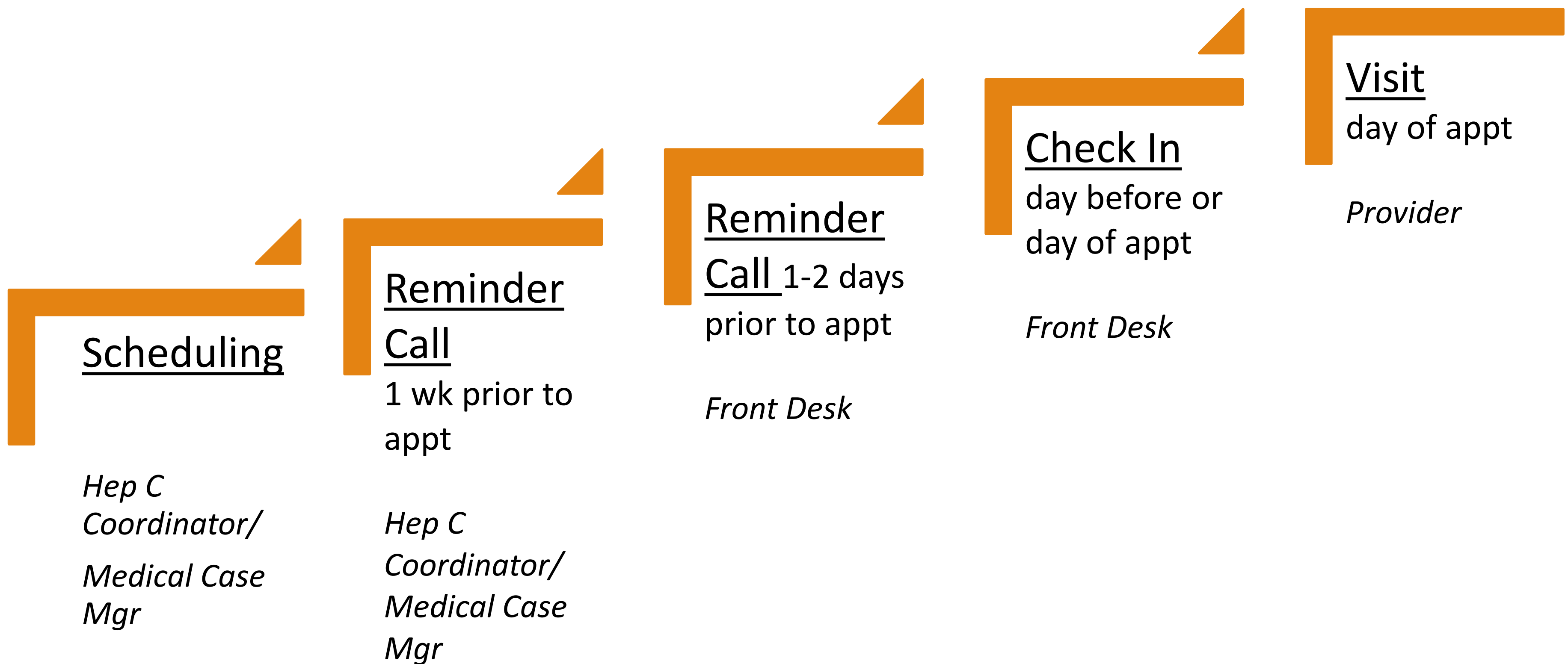
- Clinical Criteria:
  - Patient aged 18-64 years with DM, HTN, and/or hyperlipidemia diagnosis
  - A1c < 8 for last 3 reading
  - BP under 140/90 at their last visit
  - Kept at least 3 appts in the past year
  - Last DM visit was in-person

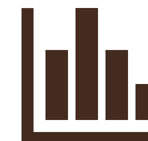
Additional Criteria:

- 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

Venice Family Clinic
Providing quality primary health care to people in need

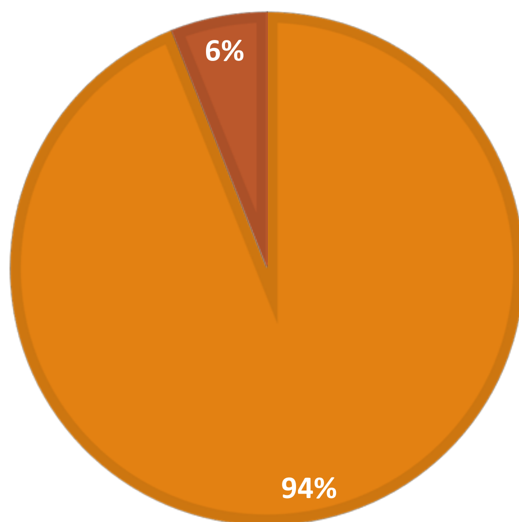




# Visit Data (Apr 2017 – Dec 2018)

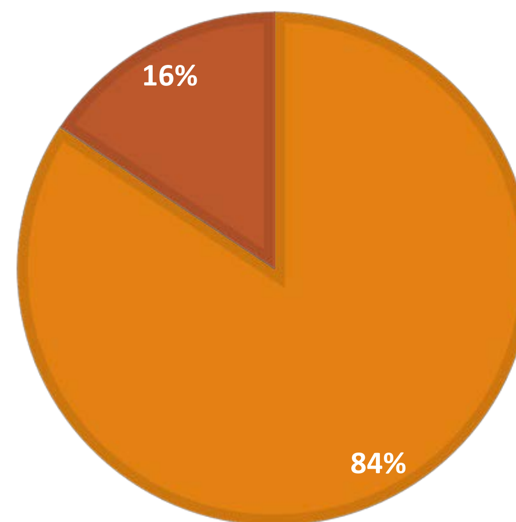
**UNIQUE PATIENTS (N = 66)**

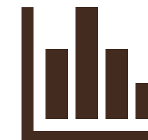
Hep C (n = 62)　Stable DM (n = 4)




**VISITS (N = 102)**

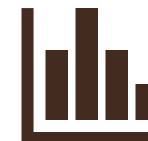
Kept (n=86)　No Show (n=16)



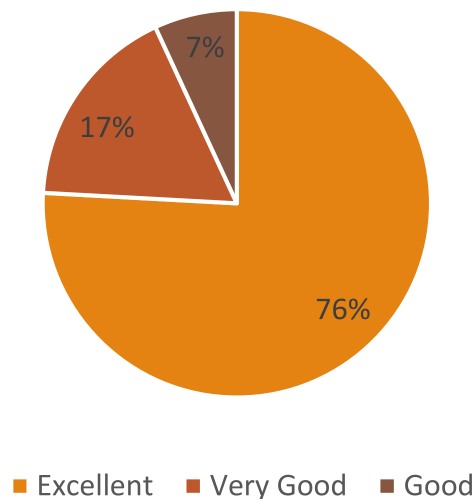


# Hep C- Patient Satisfaction Results

- 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)



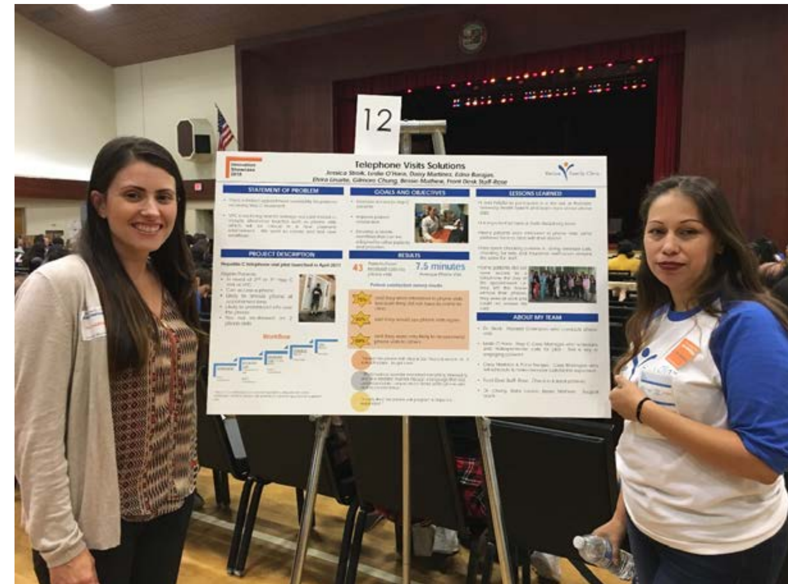

"I loved the phone visit! I live in San Pedro & work in LA. It is much easier…to get care"

"[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 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 waits ~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

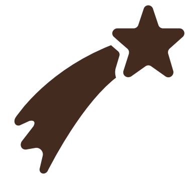
- Medical Care Managers had some issues ordering labs for patients before visit
  - Developed new workflow to order labs

- 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

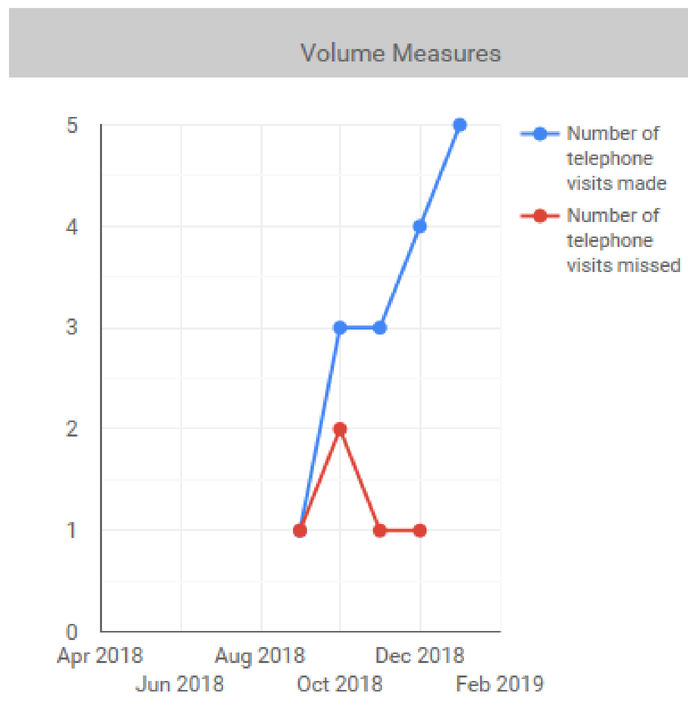
## Value Matrix

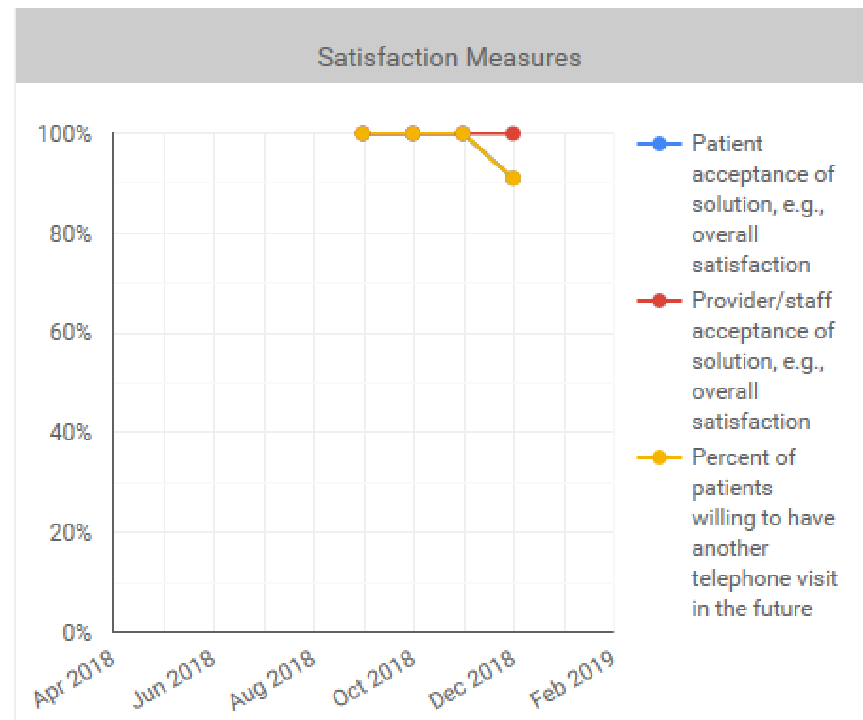
How will your solution impact the Health Center?

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

# 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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Alameda Health Systems

# Who We Are

| | |
|---|---|
| **Where we are Located:** | Oakland, CA |
| **Number of Clinics in the Organization:** | 5 Hospitals<br>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 |

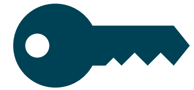
# Implementation Status

## **Chronic Care Teams**, Testing and Implementation

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

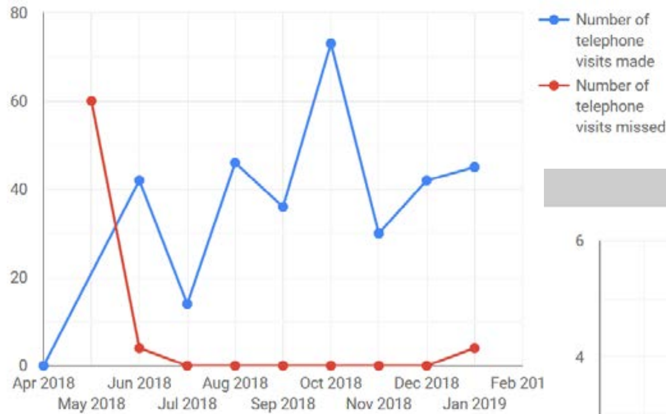
| CURRENT | Focus | Sites Included | Patients Involved | Providers/Resources |
|---|---|---|---|---|
| **Spread Goal** (September 2018 – January 2019) | **Chronic Care Teams**, Diabetes | **One Site** **Highland**, Primary Care – Adult | **206 Visits**, Automated data capture | **Team of 3;**<br>• Pharmacist (1)<br>• Registered Nurse (1)<br>• Registered Diabetic Educator (1) |

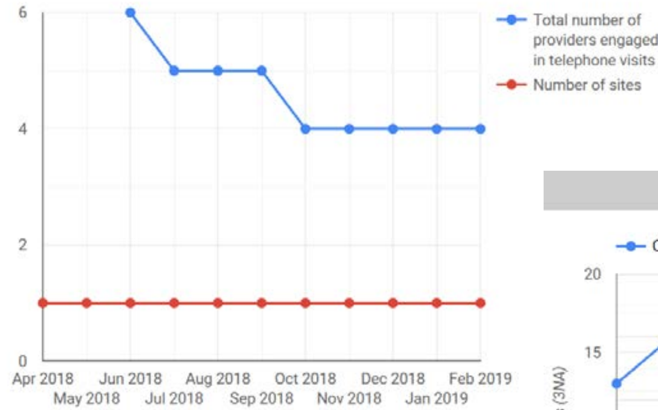
# Our Value Proposition

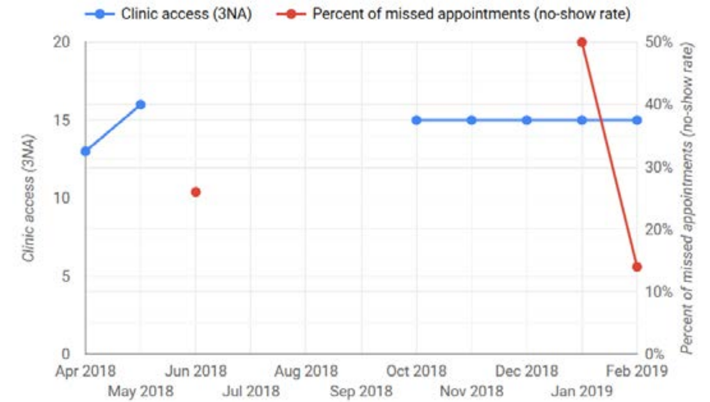


- We want to be the provider of choice for our patients and community members.
- We acknowledge that access, transportation, and time is of great value for Patients, Providers, and Staff.
- We want to develop, implement, and sustain a model of care delivery that will make an impact to the quality of 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<br>• Input and Feedback from the Chronic Care Team pilot site<br>• Community of Problem Solvers |
| **Pilot a Test of Change!** | • Creation of a scheduling template build<br>• Set guidelines as to what is considered an appropriate Telephone Visit<br>• Monitor and track outcomes electronically |
| **Revenue Cycle Support** | • Buy-in and support for growth<br>• Preparation for Epic build |

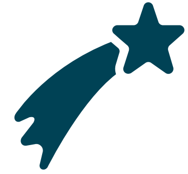
# Challenges and Solutions

| Challenge | Solution |
| --- | --- |
| **Competing Priorities;**<br>• Development and Implementation of Epic<br>• Limited IT Resources | • Utilize current resources and tools, and IT support/accessibility<br>• Creative thinking<br>• Think Big-Picture, what we can do now and where we would like to be with Epic |
| **Time and Availability;**<br>• Spreading Solutions Team-members<br>• Chronic Care Team | • Delegated workload<br>• Increased intervals of meetings and check-ins |
| **Spreading the Work;**<br>• Only able to pilot with one location<br>• Not spread to other Chronic Care Teams | • Reviewed Roles and Responsibilities<br>• Set deadlines, and adhere to them<br>• “Don’t let Perfection be the enemy of Good” |

# Tips for Making an Impact

| | |
|---|---|
| **What was the biggest impact?** | • Structured and Standardized Appointment Scheduling<br>• An alternative level of care for patients<br>• Decrease congestion, while keeping volume at the clinics<br>• Engaging and Empowering staff in the process and decision making.<br>• Development of Operator Standard Work (OSW) |
| **Key Tips for Making an Impact** | • Clear Roles and Responsibilities, early<br>• Clear Expectations and Deadlines, support one another<br>• Engage with Key Stakeholders, and Communicate Regularly<br>• Don’t let perfection be the enemy of good! |

# Looking Forward



| | |
|---|---|
| **Spread the Work!** | • Spread to All Chronic Care Teams, remaining 3 locations<br>• Possibility of including in Provider schedules |
| **Preparation for Epic** | • Building framework to Operationalize within our New EHR system |
| **Revenue Cycle** | • Ability to register patients, and capture volume<br>• Ability to document within encounters, patient care |

# Thank you

- **Rafael Vaquerano,** 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!