San Francisco Health Network (SFHN)

PHLN Year 2 Project Aim

• **Background:** Timely access to primary care among children and adolescents was identified as an area for improvement in alignment with the Quality Incentive Program (QIP), a pay-for-performance program through the Centers for Medicare & Medicaid Services.
  
  • **Financial stake:** ~ $1M/fiscal year

• **Aim:** Our Mid-year rates were below goal and prompted action. We evaluated a centralized proactive outreach intervention, in coordination with the SFHN’s Centralized Call Center, to increase child and adolescent access to Primary Care Providers (PCPs) by June 2019, in alignment with the QIP metric.

Measures for Success

The percent of children and adolescents who have had a visit with a PCP:

- within the last one year for children 12 months to 6 years old, **OR**
- within the last two years for children and adolescents 7 – 19 years old.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>PY 1 QIP Baseline %</th>
<th>Mid-Year (PY1/2) %</th>
<th>PY 2 QIP Target %</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 – 24 mos.</td>
<td>96.90</td>
<td>96.98</td>
<td>97.00</td>
</tr>
<tr>
<td>25 mos. – 6 yrs</td>
<td>89.12</td>
<td>88.38</td>
<td>89.50</td>
</tr>
<tr>
<td>7 – 11 yrs</td>
<td>89.66</td>
<td>87.94</td>
<td>90.30</td>
</tr>
<tr>
<td>12 – 19 yrs</td>
<td>88.43</td>
<td>88.51</td>
<td>89.10</td>
</tr>
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</table>
Changes

Tested Changes

Fall 2018
• Peds QI workgroup: Developed standard workflow (e.g. outreach scripts, call trackers)
• Developed outreach lists using internal & enrollment data

Winter 2019
• Recognizing mid-year rate decline, PC team reached out to formalize collaboration with call center to PDSA pediatric access outreach
• Three call center agents conducted outreach on Fridays and Sunday afternoons
• A minimum of two call attempts per patients

Spring 2019
• Completed and expanded PDSAs with ongoing monitoring of call outcomes to support the last two months of outreach by the target date.

Implemented Changes

Strategies for April-June 2019
1.) Enhance outreach efforts centrally and at clinics
   • Weekly clinic appointment targets with ongoing monitoring
   • Included appointment reminder calls (2 days prior)
   • Incentives- Movie tickets were offered during outreach and distributed by clinics

2.) Prioritization of outreach lists
   • By age group
   • By clinics with appointment availability

3.) Increased Access to PCP by end of June 2019
   • Collaborated with clinics on creating access to appts.
   • Offered more immediate appointments to patients at clinics based on location rather than assignment.
For those that did not meet the metric requirements for PCP appointments, the majority had not been seen by our network in > 2 years and were “inactive”.

• For future outreach, strategies may need to be adapted to better engage inactive patients and ENYS (enrolled not yet seen)

Appointment Tracker - Access to PCP

<table>
<thead>
<tr>
<th>Date</th>
<th>OM PRICARE Capacity</th>
<th>% to Target (14/week)</th>
<th># from List</th>
<th>PHC PRICARE Capacity</th>
<th>% to Target (15/week)</th>
<th># from List</th>
<th>Access Capacity (Open Qty)</th>
<th>TARGET # of Apps Scheduled</th>
<th>Actual # Scheduled (among num 0)</th>
<th>Difference to appointment target</th>
<th>Weekly Goal (newly Num = 1)</th>
<th>Numerator Confirmed (Num 0 -&gt;1 that week)</th>
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</thead>
<tbody>
<tr>
<td>Sunday</td>
<td>5/16/19</td>
<td></td>
<td></td>
<td>4</td>
<td>15</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Monday</td>
<td>5/17/19</td>
<td></td>
<td></td>
<td>1</td>
<td>9</td>
<td>3</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Tuesday</td>
<td>5/20/19</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>18</td>
<td></td>
<td></td>
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<tr>
<td>Wednesday</td>
<td>5/21/19</td>
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<td>3</td>
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<td>18</td>
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<tr>
<td>Thursday</td>
<td>5/24/19</td>
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<td>1</td>
<td>1</td>
<td>15</td>
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<tr>
<td>Friday</td>
<td>5/25/19</td>
<td></td>
<td></td>
<td>1</td>
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<tr>
<td>Saturday</td>
<td>5/26/19</td>
<td></td>
<td></td>
<td>1</td>
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<td></td>
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<tr>
<td>Week end 5/29</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>10</td>
<td>75</td>
<td>7</td>
<td>47%</td>
<td>62</td>
<td>50</td>
<td>23</td>
<td>27</td>
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Appointment Access Tracker was updated frequently to identify gaps in access and work with clinics to create additional appointments.
Outreach Findings

1 in 6 children outreached ultimately attended a primary care appointment

Metric Performance 6/30/2019
Met P4P targets in two of the four age groups
Strategies for Success

1. We built a **partnership** with our centralized call center to establish regular communication, garner buy-in, and engage staff through outreach PDSAs.

2. We created and validated a **standard work**, outreach call scripts, and Excel outreach trackers that helped staff communicate important information to patients, clinics, and sharing feedback with the primary care central team.

3. We provided **support** for the outreach process by utilizing standard documentation, facilitating training and onboarding for outreach staff and visited the call center to assist with outreach activities.

4. Regular **feedback** such as presenting data and progress at monthly management team meetings and the call center retreat helped foster a relationship and make work more meaningful for employees.
People
Staff engagement and motivation to conduct outreach for pediatric access was critical for our campaign’s success.

Products
Creating call trackers helped standardize data collection and allow for evaluation of outcomes.

Process
Call scripts using ICARE format helped facilitate training and formalize the outreach process.
Next Steps

**Spreading**

**Peds QI Workgroup**
Regular updates are provided to the monthly workgroup and feedback solicited on new workflows and barriers.

**Centralized Call Center**
Initial findings were presented in the Spring at the Call Center Retreat. Final analysis will also be shared back.

**Central PC Team**
Utilizing findings to inform future outreach strategies.

**Health Plan**
Sharing data with the SF Health Plan to forge new partnerships for future outreach PDSAs.

**Sustaining**

**Integration and Utilization of Epic tools**
Including standardized outreach lists within the EHR which will streamline documentation and allow for real-time access to patient worklists and tracking.

**Dedicated centralized outreach coordinator**
To facilitate communication and evaluate outreach efforts across SFHN primary care clinics.

**Continued outreach centered on pediatric access and clinical quality improvement**
Metrics will be supported in part by pay-for-performance incentive programs (e.g. QIP, health plans).
Limited resources and inability to evaluate the direct effects or impacts of outreach presents ongoing challenges for prioritizing outreach as an intervention strategy.

Inaccurate or incomplete patient contact information and inaccessible real-time health plan enrollment details are obstacles to patient engagement and are contributors to inefficient use of outreach resources.