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.

Age Group	PY 1 QIP Baseline %	Mid-Year (PY1/2) %	PY 2 QIP Target % 10% Gap Closure
12 – 24 mos.	96.90	96.98	**97.00**
25 mos. – 6 yrs	89.12	88.38	**89.50**
7 – 11 yrs	89.66	87.94	**90.30**
12 – 19 yrs	88.43	88.51	**89.10**

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

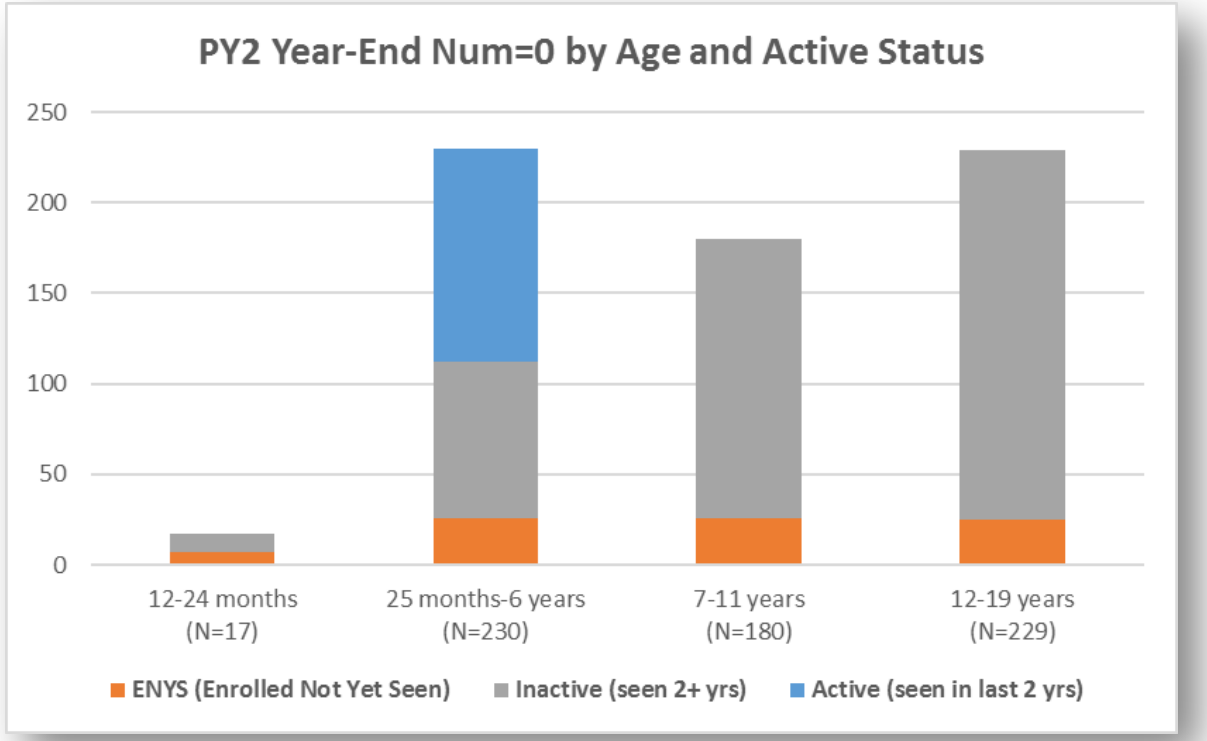
2.) Prioritization of outreach lists
- By age group
- By clinics with appointment availability

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.

Using Data for Improvement

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)

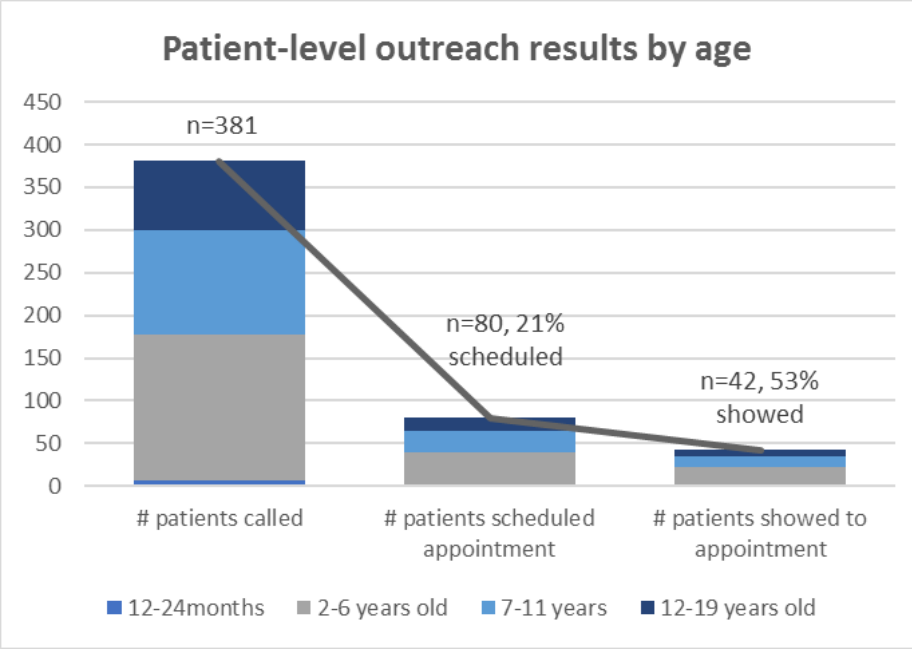


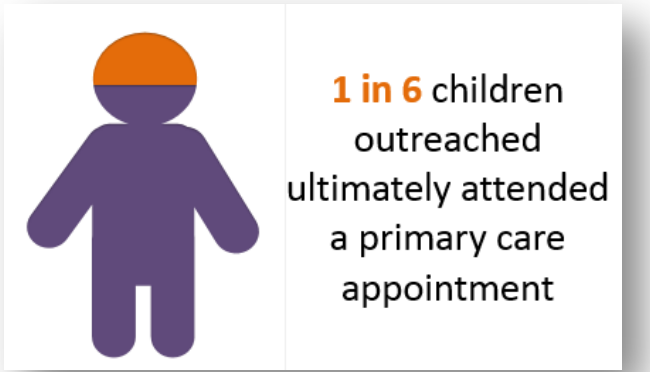
Appointment Tracker- Access to PCP

		6M			FHC			Appointment Goal				Metric Goal	
	Date	PRICARE Capacity (Appts Avail)	# Scheduled from List	% to Target = (14/week)	PRICARE Capacity (Appts Avail)	# scheduled from List	% to Target = (15/week)	Access Capacity (Open Qty)	TARGET # of Appts Scheduled	Actual# Scheduled (among num 0)	Difference to appointment target	Weekly Goal (newly Num = 1)	Numerator Confirmed (Num 0 -> 1 that week)
Sunday	5/19/19												
Monday	5/20/19		4		15	2							
Tuesday	5/21/19				9	3							
Wednesday	5/22/19	1	2		18								
Thursday	5/23/19		3		18	2							
Friday	5/24/19	1	1		15								
Saturday	5/25/19												
Week end 5/25		2	10	71%	75	7	47%	92	50	23	27	29	18

Appointment Access Tracker was updated frequently to identify gaps in access and work with clinics to create additional appointments.

Outreach Findings

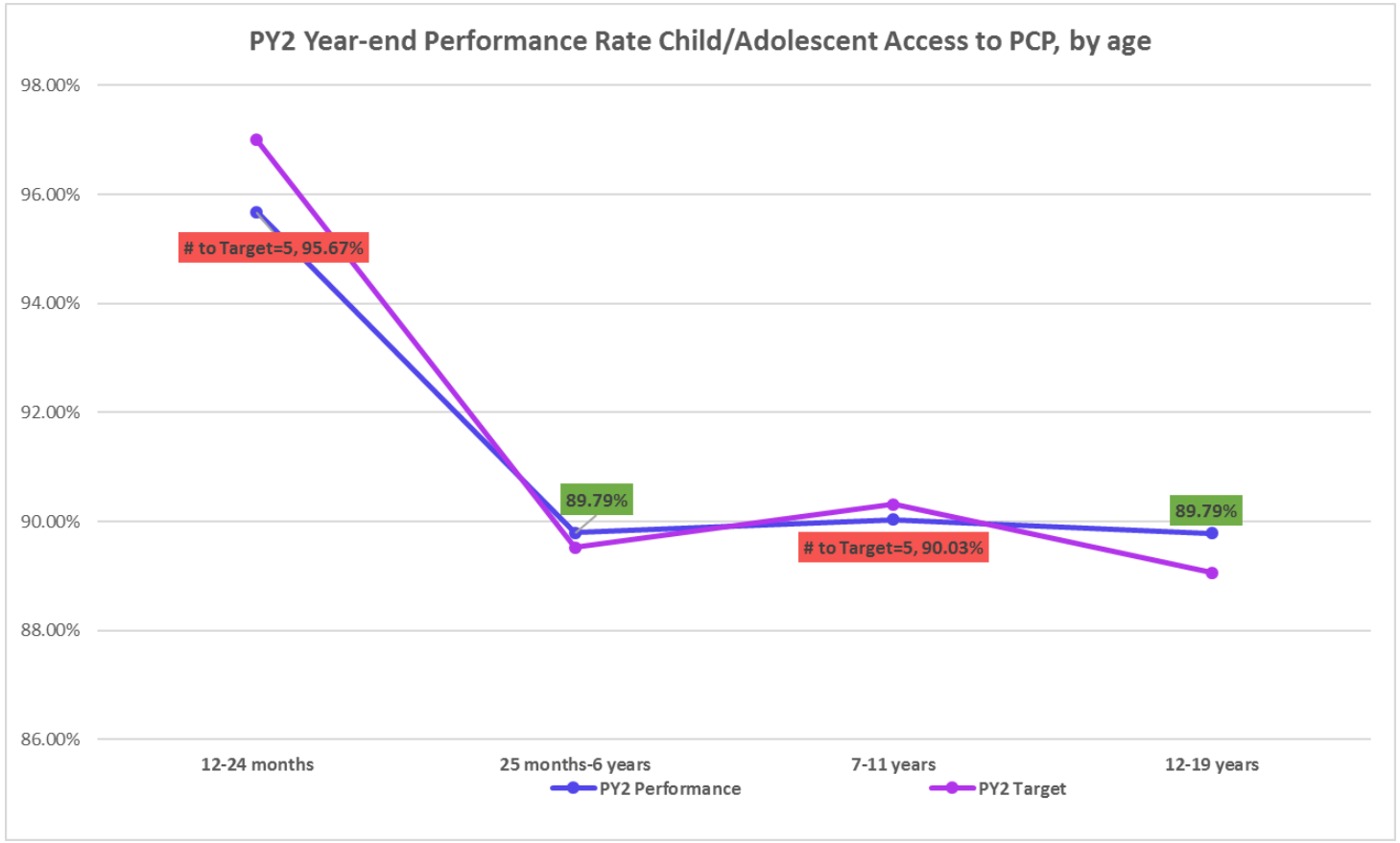




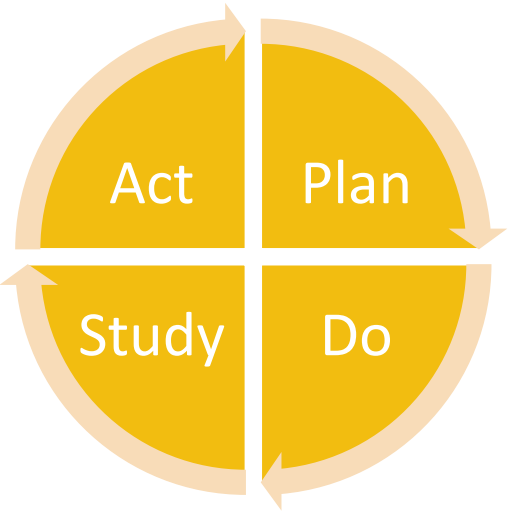
1 in 6 children outreached ultimately attended a primary care appointment

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.

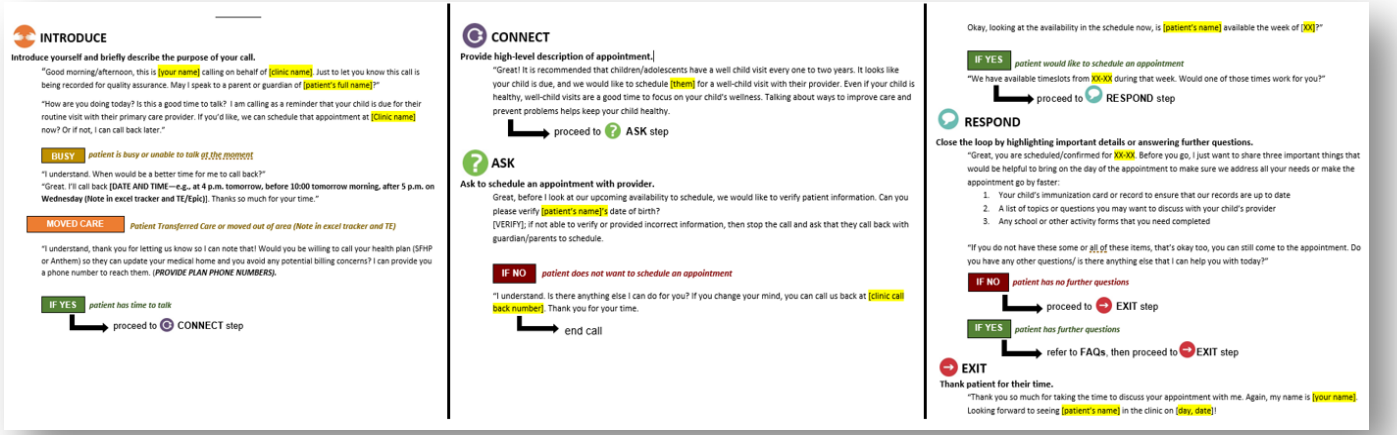
4. Regular **feedback** such as presenting data and progress at monthly management team meetings and the call center retreat helped foster a relationship and make work more meaningful for employees.

Key Tools & Resources

Call Center Retreat 5/31/19

People

Staff engagement and motivation to conduct outreach for pediatric access was critical for our campaign's success.



INTRODUCE

Introduce yourself and briefly describe the purpose of your call.

"Good morning/afternoon, this is [your name] calling on behalf of [clinic name]. Just to let you know this call is being recorded for quality assurance. May I speak to a parent or guardian of [patient's full name]?"

"How are you doing today? Is this a good time to talk? I am calling as a reminder that your child is due for their routine visit with their primary care provider. If you'd like, we can schedule that appointment at [Clinic name] now? Or if not, I can call back later."

BUSY *patient is busy or unable to talk at the moment*

"I understand. When would be a better time for me to call back?"
"Great. I'll call back **[DATE AND TIME—e.g., at 4 p.m. tomorrow, before 10:00 tomorrow morning, after 5 p.m. on Wednesday (Note in excel tracker and TE/Epic)]**. Thanks so much for your time."

MOVED CARE *Patient Transferred Care or moved out of area (Note in excel tracker and TE)*

"I understand, thank you for letting us know so I can note that! Would you be willing to call your health plan (SFHP or Anthem) so they can update your medical home and you avoid any potential billing concerns? I can provide you a phone number to reach them. **(PROVIDE PLAN PHONE NUMBERS)**.

IF YES *patient has time to talk*
→ proceed to CONNECT step

CONNECT

Provide high-level description of appointment.

"Great! It is recommended that children/adolescents have a well child visit every one to two years. It looks like your child is due, and we would like to schedule [them] for a well-child visit with their provider. Even if your child is healthy, well-child visits are a good time to focus on your child's wellness. Talking about ways to improve care and prevent problems helps keep your child healthy.

→ proceed to ASK step

ASK

Ask to schedule an appointment with provider.

Great, before I look at our upcoming availability to schedule, we would like to verify patient information. Can you please verify [patient's name]'s date of birth?
[VERIFY]; if not able to verify or provided incorrect information, then stop the call and ask that they call back with guardian/parents to schedule.

IF NO *patient does not want to schedule an appointment*

"I understand. Is there anything else I can do for you? If you change your mind, you can call us back at [clinic call back number]. Thank you for your time.

→ end call

Okay, looking at the availability in the schedule now, is [patient's name] available the week of [XX]?"

IF YES *patient would like to schedule an appointment*

"We have available timeslots from XX-XX during that week. Would one of those times work for you?"

→ proceed to RESPOND step

RESPOND

Close the loop by highlighting important details or answering further questions.

"Great, you are scheduled/confirmed for XX-XX. Before you go, I just want to share three important things that would be helpful to bring on the day of the appointment to make sure we address all your needs or make the appointment go by faster:

1. Your child's immunization card or record to ensure that our records are up to date
2. A list of topics or questions you may want to discuss with your child's provider
3. Any school or other activity forms that you need completed

"If you do not have these some or all of these items, that's okay too, you can still come to the appointment. Do you have any other questions/ is there anything else that I can help you with today?"

IF NO *patient has no further questions*
→ proceed to EXIT step

IF YES *patient has further questions*
→ refer to FAQs, then proceed to EXIT step

EXIT

Thank patient for their time.

"Thank you so much for taking the time to discuss your appointment with me. Again, my name is [your name]. Looking forward to seeing [patient's name] in the clinic on [day, date]!

Outreach Script

Process

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

1st Call Date	1st Call Outcome	1st Call Notes	2nd Call Date	2nd Call Outcome	2nd Call Notes
5/19/2019	Unable to reach/No answer	ECW and SFHP Numbers both Are Not working	6/5/2019	Scheduled appt.	Appt 6/17/19
6/3/2019	LVM		6/6/2019	Declined appt. scheduling	She want to us to call back, she was driving and stuck with traffic
Not Needed	Already Scheduled				
6/13/2019	Declined appt. scheduling	Kaiser pt TE sent, transition			
6/13/2019	Unable to reach/No answer	No mailbox set up	6/20/2019	Unable to reach/No answer	No mailbox set up

Outreach Tracking Form

Products

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

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).

Current Challenges or Barriers

1. **Limited resources and inability to evaluate the direct effects or impacts of outreach presents ongoing challenges for prioritizing outreach as an intervention strategy.**

2. **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.**