PHM INITIATIVE

Outreach Protocol Affinity Group Session #2

April 15th, 2025

This presentation is a living document that is regularly updated

WELCOME EVERYONE!!

How Do We Want to Be In Community?

- **Join with computer and turn on your video**
- **Set the intention to be fully present**. This is the time for you to dive deep and fully take advantage of the wisdom in this room.
- **Be brief and succinct** when you share to make space for many thoughts/ideas.
- **Be open and honest.** Share what's not working as well as what is working!
- **Engaging patients can be challenging and creates vulnerability** for receiving information …. let's share what this is like as this evolves.
- **Relax and have fun.**

Session 2 Agenda

- Welcome, Agenda, Learning Objectives
- Recap and Level Setting for Front End Approaches
- CHC Examples: Venice Family Clinic and Long Valley Health Center
- Small Group Discussions
- Next Steps and Wrap Up

Affinity Group Learning Objectives

- **Advance your team's competency in implementing an outreach protocol to reach the foundational competency.**

Foundational Competency	Validation Criteria
Create an outreach protocol to reach and engage all attributed patients due for care	The center has a documented outreach approach for the PoF or evidence that an outreach approach exists (a workflow, de-identified list, etc)

Affinity Group Learning Objectives

- Exchange insights and experiences with peers on outreach strategies.
- Articulate the steps needed to create an effective outreach protocol
- Optimize the functionality of our CHC's PHM Tool to obtain and manage input data from multiple sources.
- Gain insights into promising outreach strategies from the field to inform your work.
- Learn how to use outreach strategies to address health inequities.
- Explore small, actionable change ideas that can be tested to build and document a robust outreach protocol

Recap & Level Setting

Headlines

- Here's what we heard through the Miro board exercise:
  - Health centers are already **doing outreach**
    - Challenges are staff time and documentation of process
  - **Bad data** is a real challenge!
    - Shows up throughout outreach work
  - HCs are **using technology**
    - Ex. bi-directional texting for outreach
  - Effective outreach takes **getting the right people to the table**
    - Including representatives from outreach, data, technology, patient feedback teams

Coach/CHC worksheet to identify OP opportunities

Approaches Leading to a Documented Outreach Protocol	Is this an approach that needs work? What people, processes and platform should be considered?	If work needs to be done, who needs to be Involved? What is next step?	Is it documented? Where is it documented?
1. Accept that attributed patients are part of our patient population.			
2. Develop understanding of the process by which patients are assigned to a center. Delineate roles between health center and health plans.			
3. Establish process for ingesting the data, measures of data quality, and resolution approach for bad data.			
4. Monitoring and managing the patient attribution process.			
5. Organize/categorize attributed patients to tailor outreach strategies.			
6. Establish Outreach Strategies that consider equity, financial incentives and PoF.			
7. Document/Track Outreach as you attempt to reach patients.			
8. Establish/Refine roles and responsibilities for outreach.			
9. Establish process to circle back to health plans on resolution for those patients who have declined care.			
10. Draft an outreach protocol and determine who will need to approve.			
11. Establish an outreach dashboard to track progress & improvement.			

"Front End" Capabilities

Current approach | What has been effective | Pain points

	Approach	People	Process	Platform	Ideas / Evidence
1	Accept that attributed patients are part of our population				Incorporated into vision or mission statement for center or outreach function
2	Develop understanding of the process by which patients are assigned to a center. Delineate roles between CHC and health plans				Procedure for downloading or interfacing attributed patient lists including frequency and roles of center and health plan
3	Establish process for ingesting data, measures of data quality and resolution for bad data				Procedure for ensuring attributed patients list are accurate and complete and incorporated into EHR and/or PHM.
4	Monitor and manage the patient attribution process				Tracking of attribution list updates and data quality issues and periodic monitoring in outreach function forum.
5	Organize/categorize attributed patients to tailor outreach strategies				Some form of risk stratification (e.g., in chronic condition IG, frequent no shows)

Here are some ideas to establish more systematic outreach approaches

More discussion on bad data in breakouts

ODCHC: Having bad contact information for patients

Outreach tailored by HEDIS care gaps

APHCV-newly assigned members get IHA outreach; after 120 days, members get outreached via specific HEDIS gap lists

VFC: phone calls to newly assigned pts. Letters to pts due for care gaps.

"Front End" Capabilities cont.

Current approach | What has been effective | Pain points

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Approach

Establish outreach strategies that consider equity, financial incentives and CHC's PHMI Pop of Focus

Centers have many outreach approaches in place

Most often mentioned as pain point: Limited staffing for outreach

People

We utilize different staff members, such as our outreach team, front desk team, and text messaging services.- GVHC

PHC- Creating training material for scripting

APHCV: access challenge at clinic that has high no show. short of manpower to do 2 attempts phone calls.

PCHC - Limited staff to do outreach

PHC- Training and consistency

ODCHC: Being short the staff in clinics to do outreach or working off the patient lists. Having bad contact information for patients.

Process

PCHC - SMS outreach and calls

APHCV: phone calls and send self-scheduling link text message

PHC - Call and text msg

SRCH: Text outreach campaigns (ongoing and targeted) and Phone Calls, Targeted Outreach lists

PHC patient Incentives

PCHC - Bidirectional text messaging for scheduling and patient incentives.

Most often mentioned as effective: text msg campaigns

APHCV: phone calls on Saturdays. self-scheduling link text for tech savvy patients

Platform

ODCHC: We currently do centralized outreach through text (Artera) and patient portal (MyChart). Lists are also generated for staff to conduct phone call outreach off of

ODCHC: on going outreach--trying to reach patients in the way they prefer. Texting has been effective since we can send a high volume of messages all at once.

text message campaigns with options to reply for scheduling and the teams schedule the patients and send them the appt. schedule notice-GVHC

SRCH: bidirectional text outreach campaigns to identify patients ready to schedule, biweekly check-

Ideas / Evidence

Plan with specifics on which population should get outreach and at what interval such as calendar of campaigns:

- Screening and vaccine reminders
- Closing referral loops
- Re-engaging inactive patients
- Education on health programs

<u>Incorporates procedure for:</u>

- Mitigating access issues (e.g., outreach is in patient's language and otherwise culturally affirming)
- Segmenting of data (R/E, age, health condition)
- Channel type such as phone calls, emails, or SMS.
- Linkages, such as mobile-friendly options, online forms, etc. that allow patients to take action (e.g., scheduling a screening)

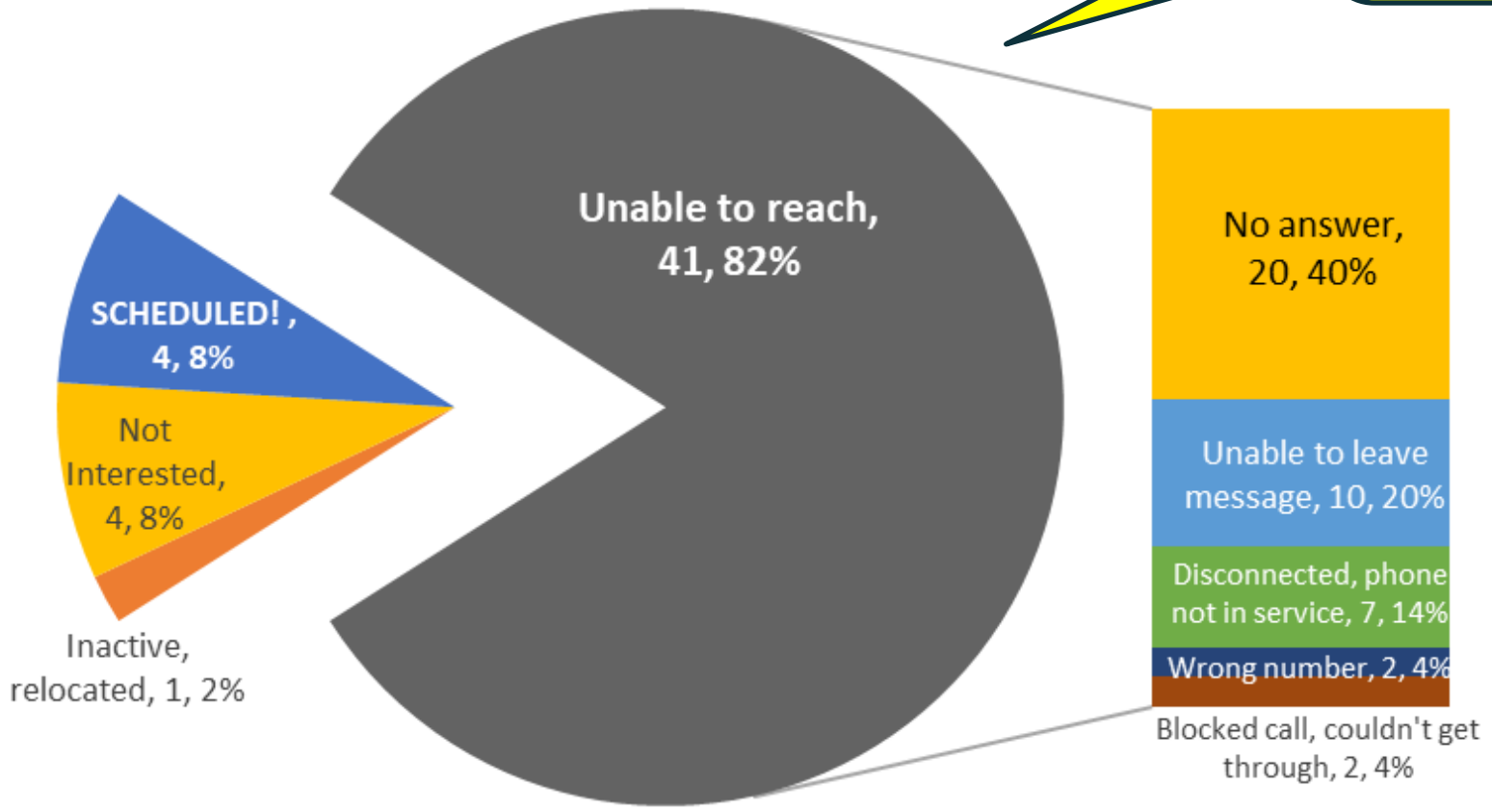
More discussion on campaigns in breakouts

CHC Examples

Outreach Challenges

Called 50 randomly selected patients from 700 outreach letters sent

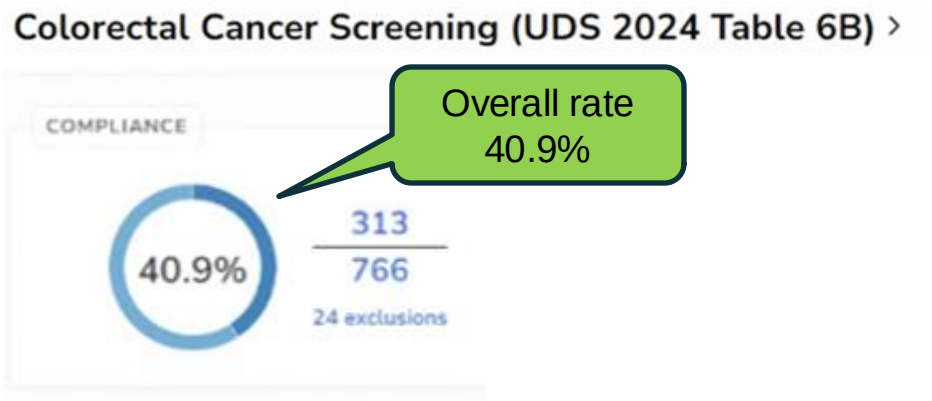
Outreach effort can get eaten up. Important to use good data and use it to guide outreach focus.



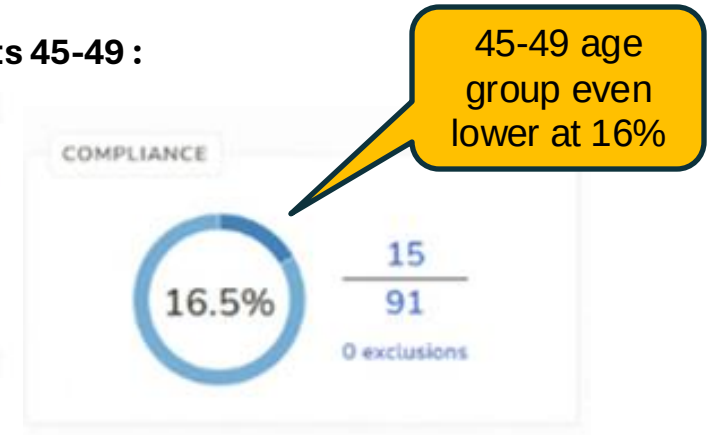
Venice Family Clinic, March 2025

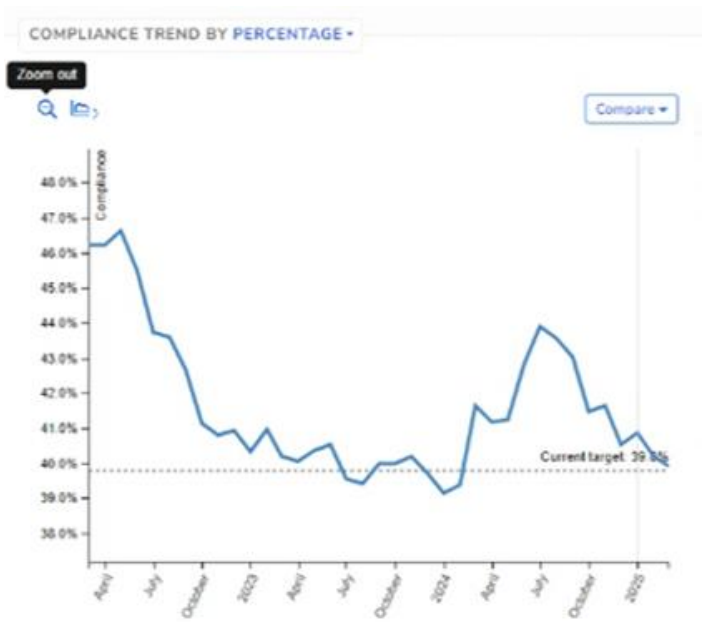
Thank you Meghan and team for this analysis!

Long Valley Example: Using Relevant to identify patients for outreach

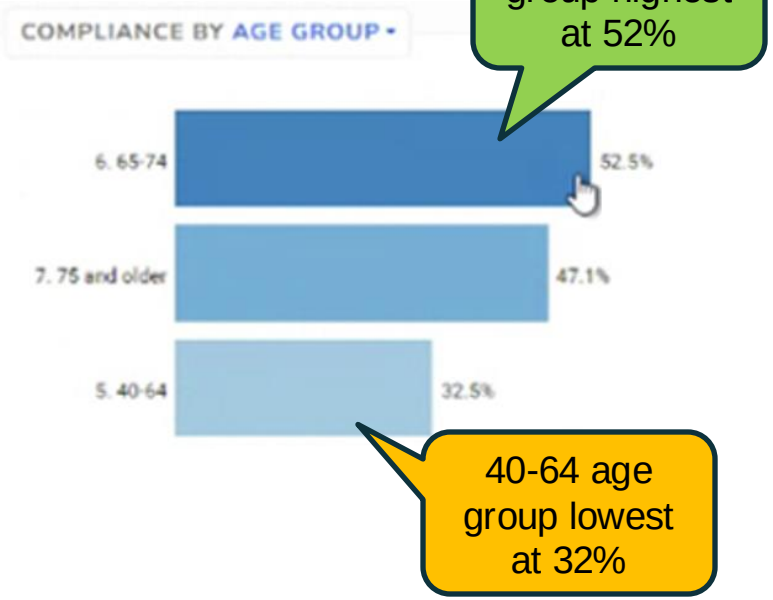


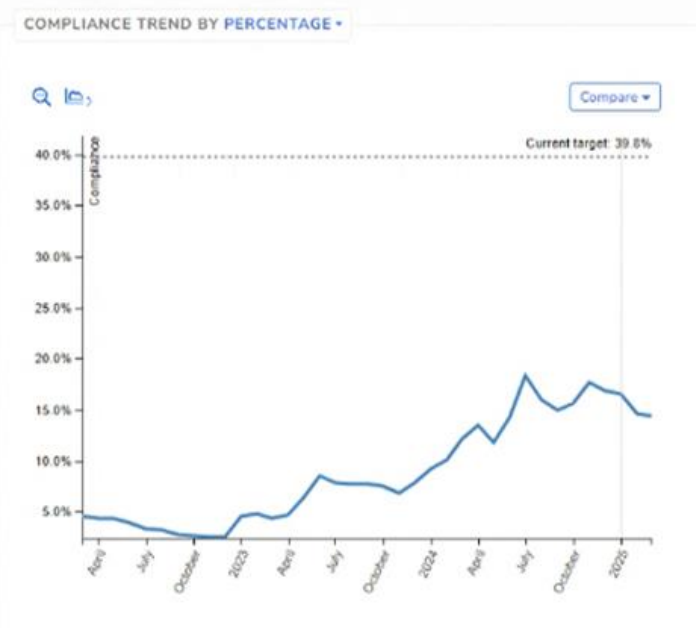
Add age filter for patients 45-49 :





Segment by age:





16 patients 45-49 identified for outreach!

Long Valley Campaigns & Outreach Protocol

Outreach Flyer

Outreach Protocol - DRAFT

- **Phone call to patient**
  - eCW # more likely to be accurate
- If patient doesn't answer phone, send a text in Clearwave
- Staff introduction and why you are calling

- **If patient HAS NOT been seen**
  - Promote great services LVHC offers
  - Emphasize importance of visit/screenings for patient's healthcare
  - Schedule a NP visit
- **If patient HAS been seen**
  - Chart prep before you call (in eÇW?, due?, special schedule?)
  - Mammo, diabetic eye exam, other measures too?
  - Verify if still a pt? If not, give instructions to call Partnership to re-assign
  - Email selection form via Clearwave?

- **If had a service elsewhere** (e.g., pap), send ROI in Clearwave
  - Cerner external record check needed?
  - When record in eCW, highlight row in spreadsheet in green
- If due for mammo, help create order, schedule transport
- For each patient call/text/chart prep, make notes in QIP spreadsheet
- Complete any patient specific follow-up

- **If not interested, ask why**
  - We want to better understand what barriers are preventing you from getting your screening/lab/eye exam/ets
  - Do you mind telling me why?
  - If made an appt why did you schedule today?
  - Thank you

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Small Group Discussions

Small Group Discussion Questions

Choose one of the following topics to discuss in your group:

Topic 1: Tackling Bad Data

- What is your approach for reviewing newly attributed and existing patient data to ensure contact and other information is accurate?
- Which staff support this?
- How often is data reviewed?

Topic 2: Planning Outreach Campaigns

- How do you plan for outreach campaigns and establish priorities?
- Which staff members or departments are involved?
- How often do they convene?

Small Group Discussions

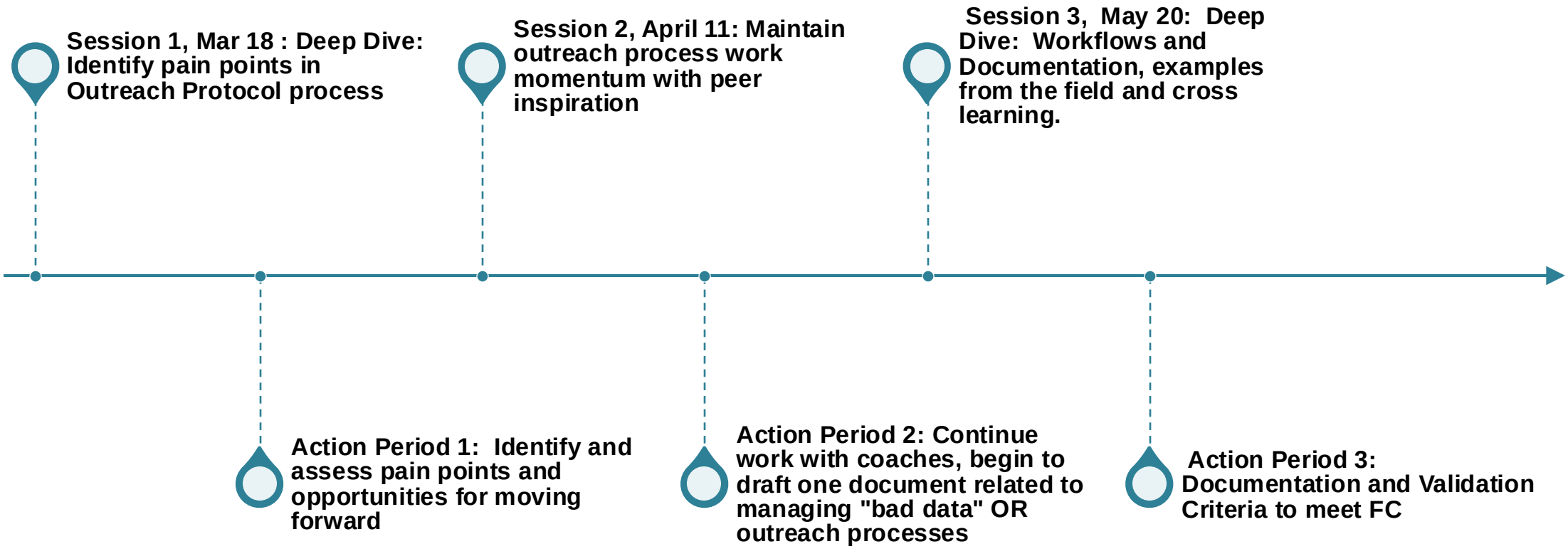
Room 1	Room 2	Room 3	Room 4
Redwood Coast	CMC	Santa Rosa	Venice
Golden Valley	MCC	APHCV	Long Valley
UMMA	Omni	Anderson Valley	Open Door
Petaluma	Park Tree	Redwoods Rural	NEVCH
	VCH	Saban	
Facilitator: Jerry	Facilitator: Fiona	Facilitator: Emma	Facilitator: Hithu

Next Steps & Wrap Up

Pulse Check Poll

- Please take a couple of minutes to complete the **polling questions.** Thank you!

Outreach Protocol Strategies and Implementation Timeline



Wrap Up & Next Steps

- Action Period 2: **Document a process for reconciling bad data** OR **an element of the outreach process**
- This can range from answering:
  - Who is doing this now and how could this be done in a systematic way

  OR
  - Having a detailed flow sheet with accompanying meta-data
- We'll see you on May 20th at noon for the 3rd session!