Quality and Productivity Commission

33rd Annual Productivity and Quality Awards Program

"Empowering Innovative Solutions"

2019 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: PATIENT OUTREACH IMPROVES CARE & HEALTH OUTCOMES

DATE OF IMPLEMENTATION/ADOPTION: **APRIL 1, 2017**
(Must have been **fully** implemented **for a minimum of** at least one year - on or before July 1, 2018)

PROJECT STATUS: X Ongoing _____ One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? _____ Yes X No

EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

Data driven improvement is one of the 10 building blocks of high performing primary care clinics[1]. Our goal at LAC+USC Medical Center was to implement a comprehensive patient outreach program that would result in improved patient care and health outcomes. Engaged local clinic leadership and front-line staff at all 10 of our Primary Care clinics were taught about the importance of patient outreach and a comprehensive strategy was implemented, which focused on patient outreach utilizing new tools for communication and reporting. Our efforts led to significant improvements in clinical measures, including a 39% increase in colorectal cancer screening and 28% increase in depression screening and follow-up. Additionally, patient outreach efforts helped LAC+USC meet ambitious pay-for-performance targets for PRIME (Public Hospital Redesign and Incentives in Medi-Cal) and QIP (Quality Incentives Program) at a facility as complex as ours.

BENEFITS TO THE COUNTY

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED **ANNUAL** REVENUE	(1) + (2) + (3) = TOTAL **ANNUAL** ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$	$	$	$	X

ANNUAL = 12 MONTHS ONLY

SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS LAC+USC Primary Care 2010 Zonal Avenue, OPD 4p41 Los Angeles, California 90033		**TELEPHONE NUMBER** 323 409 7689
PROGRAM MANAGER'S NAME Jagruti Shukla Barbara Rubino		**TELEPHONE NUMBER** 323 409 7689 **EMAIL** jshukla@dhs.lacounty.gov
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE (PLEASE CALL (213) 893-0322 IF YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER'S NAME) Connie Salgado-Sanchez C. Salgado-Sanchez	**DATE** 6/27/19	**TELEPHONE NUMBER** 213-288-8483 **EMAIL** cosanchez@dhs.lacounty.gov
DEPARTMENT HEAD'S NAME AND SIGNATURE Christina Ghaly	**DATE** 6/27/19	**TELEPHONE NUMBER** 213-288-8050

We Support Plain Language

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):
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1st FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project **to the County.** What quality and/or productivity-related outcome(s) has the project achieved? Provide measures of success **and specify assessment time frame**. Use Arial 12 point font.

Challenge(s): In healthcare, we too often practice reactive medicine, waiting until the patient is sick and sitting in front of us to address immediate symptoms. Yet, we know a more proactive approach to prevent or reduce the progression of disease should also be our priority. Patient outreach provides valuable education and reminders to patients about *preventive* care visits and tests *via* letters and phone calls. This type of patient outreach increases patient engagement, builds trust and continuity, and helps to close care gaps that are critical to quality.

However, patient outreach has often been neglected in primary care due to ambivalence about its value, lack of time, and inadequate support for process improvement. Not all clinic leaders have been comfortable with existing reports and the data has not been framed in such a way that is easily understood by front-line staff. Our staff needed training related to data basics and our reporting solutions. A cultural shift was also required to achieve a proactive approach to patient care.

In addition to these challenges, no tool existed to document and monitor outreach systematically across our campus. Locally managed spreadsheets and paper lists were not sufficient and actionable data was needed. Our 10 Primary Care clinics serve over 54,000 unique patients, ranging in size from clinics with only two providers to those with 167 providers. Seven of our clinics are teaching clinics, primarily staffed by 222 residents and 9 fellows. In addition to serving children, adolescents and adults, our specialized primary care clinics focus on the care of premature infants, HIV positive adults, mothers & children affected by HIV, geriatric patients and women's health. Given the diversity across our clinics and patient populations, it can be challenging to ensure that we are providing equitable and high-quality care across all sites.

Solution(s)/Benefit(s): Our goal was to implement a comprehensive patient outreach program that would result in improved patient care and health outcomes. Key components of our strategy include:

(1) Improved communication and engaged leadership: Leadership from all 10 Primary Care clinics was engaged early in this initiative. System-wide goals and their purposes were communicated at our monthly Operations meetings. Education on our reporting and analytic platforms was provided and we shared which reports were most meaningful for our priorities. We helped increase access to operational and clinical data to support local process improvement endeavors and encouraged data transparency. We entrusted leaders to customize interventions to their respective clinics and respective populations and encouraged communication of needs, challenges, and successes along the way. Regular in-person meetings, follow-up communications, and flexibility in strategies were keys to our success.

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Use Arial 12 point font.

(2) Improved data access, transparency, and literacy: Our team worked arduously to support our care team's efforts to use the data and reports available to them for operational and clinical improvement at all staff levels, from clerks to clinic Medical Directors. For example, clinic Medical Directors now use analytics solutions to determine where to concentrate efforts to improve colorectal cancer screening. Nurses (RNs) use the Flu Vaccine Tracer Reports to efficiently prepare for scheduled patients needing the vaccine. A licensed vocational nurse (LVN) or certified medical assistant (CMA) might pull outreach lists for closing gaps in Tobacco Cessation Education in response to quality reports. These are a few examples of how staff express initiative and responsiveness to our population's health. We created a bimonthly "Pulse" report in a poster format to engage all staff members with system-wide and local priorities **(Figure A).** It incorporates useful background information on metrics and infographics in addition to traditional analysis. It not only captures attention and encourages team interaction, but also reduces "data fatigue" by providing opportunities for elevating the work of care teams and individuals that might otherwise get overlooked.

(3) Effective Strategies for Improvement (Outreach Form and Champions): To track how much patient outreach was being done across our 10 clinics, we created a Patient Outreach Form in the electronic medical record (ORCHID). This electronic form is completed with each patient outreach attempt, so we can measure productivity and acknowledge staff for their efforts in patient engagement. Each month, a Patient Outreach Summary Report was shared with local clinic leadership to assist nursing leaders in assessing levels of outreach, acknowledging the efforts of frontline staff, investigating barriers to outreach if not done, and to ensure protected time to conduct outreach. Over a 12-month period, the number of outreaches increased from 0 to 2,361 attempts **(Figure B).** Outreach Champions attend local clinic meetings to share their process and discoveries. We also acknowledge and congratulate "Outreach Champions" at our monthly Operations meeting and various other recognition activities.

(4) Track Progress and Share Outcomes: We created the "Primary Care Snapshot" **(Figure C)** to report clinical metrics during our monthly Operations meetings. It provides an at-a-glance view for clinic leadership of how all clinics are doing across core performance metrics and how we fare against other DHS clinics, reinforcing our connection to a larger system of care. The color-coded performance trends are easy to read and clearly demark opportunities for improvement and milestones to celebrate. It facilitates efficient monitoring of our strategic priorities and models a strategy for evaluation at the local level. Medical Directors and nursing leaders, in turn, have taken interest in creating their own local "Snapshot" for their clinic as a 12-month trend report. Use of the "Snapshot" has facilitated population health management at the local level.

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As a result, we have a demonstrated a significant improvement in quality metrics. **Table A** lists a few of the clinical metrics in which we saw a significant improvement, including a 39% increase in colorectal cancer screening and 28% increase in depression screening and follow-up.

Figure A. Pulse Report

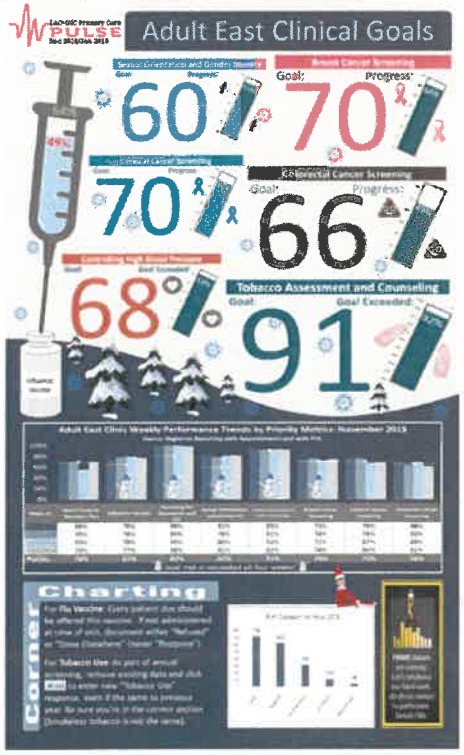


Figure C. Primary Care Snapshot

LAC+USC Primary Care Snapshot: December 2018

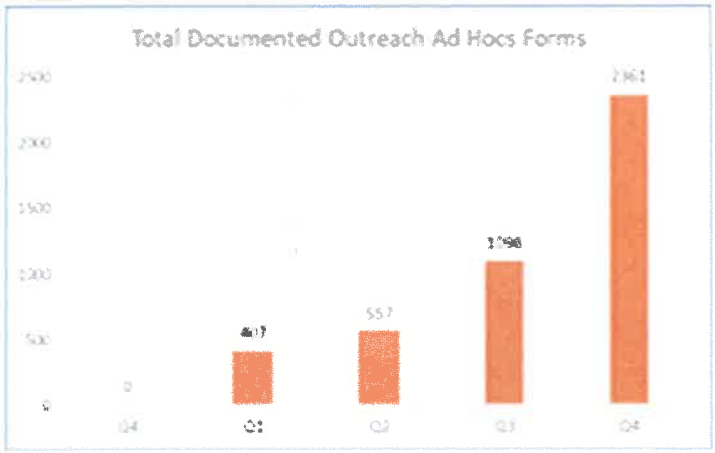
DHS Target	Measure Name	DHS	LAC+USC	East	West	Geri	MCA	MedPeds	RSPC	RS	Womens	Peds	Preemie
60%		79%	68%	68%	71%	93%	32%		64%	75%	88%		
80%		95%	87%	89%	86%	71%	83%		85%	97%	91%	68%	
70%		61%	66%	65%	73%	63%	73%		50%	63%		78%	
29%		33%	21%	21%	20%	13%	27%		27%	20%	100%	58%	
64%		45%	49%	49%	43%	52%	+2 64%		31%	57%	+12 85%	55%	65%
84%		70%	70%	70%	66%	84%	40%		58%	65%			
60%		57%	70%	56%	68%	76%	57%		56%	52%	94%	25%	
91%		87%	+14 88%	92%	85%	+1 99%	+21 84%		+1 69%	+7 92%	+1 87%	+41 60%	
70%		69%	63%	64%	64%	74%	70%	66%	54%	56%			
70%		65%	60%	60%	63%		87%	59%	61%	64%			
66%		51%	48%	49%	52%	69%	44%	40%	46%	47%			
70%			93%				100%	100%				94%	

LAC+USC STRATEGIC PRIORITY | Source: All DHS - % of Intervention if BMI Not Met (>25): Power Insight Report | Source: ELM Analytics/TCS Trending Registries | Not at Goal | Close to Goal | Goal Met! | Milestone Bump up to Yellow | Milestone Bump up to Green | Clinic Internal Goal Met

Decreasing trend desired. | Source: PRIME Dashboard with PHI/ELM Analytics | Source: ELM Registries Reporting (Comprehensive Adult Wellness) | n=0 or n/a

+/- from month before | Source: Registries and PRIME Reporting: PEDS BMI %ile + Ed for Nutrition and Exerc.

Figure B. 2018 Total Documented Outreach Attempts



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Linkage to the County Strategic Plan – 1 page only. Which County Strategic Plan goal(s) does this project address? Explain how. Use Arial 12 point font.

Our initiative aligns with the Los Angeles County Strategic Plan across multiple domains. To further the county's goal of "Supporting Wellness of our Communities" as part of LA County's Strategic Goal II, we have incorporated patient outreach to improve our rates of depression screening and follow-up by 27% and improved colorectal cancer screening by 39%. By improving patient outreach, we can significantly reduce the burden of disease caused by depression, colorectal cancer and other diseases.

In order to "realize tomorrow's government today" as part of LA County's Strategic Goal III, we have 1) implemented a program to engage and elevate front-line staff as leaders in population health management efforts which has led to 2) improvement in rates of meeting our pay-for-performance measures for DHS LAC+USC Medical Center Primary Care Clinics.

One of the key ways that we've been developed our front-line staff is through new approaches to training as well as training on subjects they may not have traditionally been engaged in. This ties into Strategy III.1.1, to "Develop Staff Through High Quality Multidisciplinary Approaches to Training" as we deploy new learning models, coaching, and encourage front line staff to serve as leaders, present their work, and hone their skills to become champions among their peers in population health management efforts. Uniquely, medical assistants, nurses, and other members of the care team are responsible for developing and driving population health outreach strategies. We have developed the model to support and coach them, as well as provide them with the data and tools they need, so they own the work and move it forward.

Table A. Three clinical process targets in which we accomplished far above 10% annual improvement, including Colorectal Cancer Screening (+38.7%), Depression Screening (+27.8%), and Sexual Orientation and Gender Identity (+59.9%).

Table A: Clinical Process Measures > 10% Improvement

Clinical Process Measures *Population Data **PRIME APM Population Data	Population # Affected at first measure (12/2017)	Population % Achieved at first measure (12/2017)	Population # Currently affected (12/2019)	Population % Currently achieved (12/2019)	% Improvement
Colorectal Cancer Screening: Age 50-75	13,305	11.20%	18,245	49.90%	38.70%
Depression Scr: Age ≥18 w/out exisiting diagnosis + Follow-up	28,484	59.10%	11,908	86.90%	27.80%
SO/GI Data Completeness: Age ≥ 18	12,181	0.00%	13,959	59.90%	59.90%

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COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFITS TO THE COUNTY): If you are claiming cost benefits, include a calculation on this page. Please indicate whether these benefits apply in total or on a per unit basis, e.g., per capita, per transaction, per case, etc. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12 point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes. Please indicate whether these are costs to the County or to other entities.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes. Please indicate whether these were expenditures by the County or by other entities.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

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$	$	$	$	☐X

ANNUAL= 12 MONTHS ONLY

COST SAVINGS:

We have dramatically improved our outcomes on pay-for-performance measures through the cultural shift to proactive care. Through the efforts of our front-line staff leading patient outreach efforts, we've contributed to helping county achieve ambitious pay-for-performance targets for PRIME (Public Hospital Redesign and Incentives in Medi-Cal) and QIP (Quality Incentives Program). These two programs combined bring in nearly 300 million dollars annually to DHS.

Moreover, we know that we are having a societal impact. For example, new cases of colorectal cancers are predicted to occur in more than 144,000 people in the USA this year alone.[2] Approximately half of these patients die of the disease, making colorectal cancer the third leading cause of cancer death in the world.[3] Our improvements in screening can prevent many of these deaths by detecting colorectal cancer in an early, more treatable stage, and in turn result in cost-savings for our department. We can extrapolate a similar impact for the other cancer screening rates that we have improved.

Similarly, we know from studies that untreated depression adds great societal and economic costs. In 2017 alone, an estimated 17.3 million adults in the United States had at least one major depressive episode. Depression can lead to low educational attainment, high risk of teen pregnancy, difficulty sustaining relationships, unstable employment, as well as chronic health problems and death by suicide. By improving our rates of depression screening and follow-up by nearly 30%, we anticipate reducing the burden of disease caused by depression for residents of Los Angeles County.