Improving Ambulatory Care Access

Contra Costa County Joint Conference Committee

July 22, 2024

CONTRA COSTA HEALTH

Access: Meaningful Contact to Care

- Gold standard = the right care for the right patient at the right time
- Access to care is all of these things:
  1. Direct patient-provider in person visit in brick-and-mortar location
  2. Direct patient-provider telehealth visit: telephone or video
  3. Touch points that meet health care needs: medication refills, patient emails & other communications, nurse visits, health education, pharmacy communication/visits
  4. Population health: immunizations, cancer screening, chronic disease management
- Access is affected by supply (system capacity) and demand (patients & need)
- Access affects our bottom line: QIP fund eligibility, MediCal & MediCare reimbursements

Measures to Improve Access: Recruitment

- Primary Care Providers: 115 Currently with 4 leaving and 8 starting soon
- Engaged Spin Recruitment Advertising Agency
  - Revised job postings for internal and external sites
  - Advertising with major primary care recruitment website
  - Direct mailings to primary care providers in this area
  - Search Engine marketing – 3-month trial
- Obtaining additional contract with placement agency

Measures to Improve Access: Clinic Backfill

- In 2023, we lost ~**53,400** completed visits to clinics cancelled with >35d notice
- Backfill = temporary coverage for planned provider absences
- Initiative in process to replace providers in cancelled clinics with temporary substitute providers
- Requires IT adaptations to MyChart, scheduling, and patient notification systems (and substitutes!)

Measures to Improve Access: Engaging Assigned but not Served Patients

- All safety-net systems in California have a substantial "assigned but not served" population
- As of May 2024, Contra Costa had ~45,000 CCHP Medi-Cal members who were assigned to CCRMC/HC but had not accessed CCRMC/HC services in the prior 12m+.
- Unserved patients…
  - Have known, likely, and unknown care gaps.
  - Reduce potential state waiver revenue (QIP).
  - *Are known to be difficult to engage. Historical success rates = 2-5%*

We are making concerted efforts to serve these patients.

- Coordinated CCH-wide measure organized by Ambulatory Care and leaders from other CCH divisions, including Dennis Deas, Improvement Advisor
  - CCHP, Public Health, Behavioral Health, H3, Business Intelligence, Equity
  - Goals are to improve integration of our healthcare safety net, create meaningful connections to care, and address population health needs while increasing QIP utilization rate and income.
- Proposed goal at 10% or 2,500 people touched by 12/31/24
  - Refer to definition of Access for "touches"

Ambulatory Care Redesign (ACR) 2.0

- Changing the structure of an existing meeting to refocus improvement work to increase access to care.
- Multidisciplinary teams forming to address Primary Care Access, Specialty Care Access, Population Health, and Alternative Care Models under the guidance of Improvement Advisor Dennis Deas
- Will continue to use principles of Advanced Access to best utilize each appointment and avoid system waste
- Looking to create disease pathways and tools to "treat" patients without a doctor's appointment
- Will leverage rapid improvement events and tests in 30-day increments to establish new ways to manage and coordinate care workflows and interfaces with patients

Estimated Timeframe for ACR Improvement Projects

Listen	Evaluate	Apply	Replicate	Nurture
What are we trying to accomplish?	**How will we know that a change is an improvement?**	**What change can we make that will result in improvement?**	**What change can we scale and spread?**	**How will we sustain improvements?**

60 days

Next 60-90 days

Set goals and measures for working teams

Identify measures, baseline and data collection

Use Rapid Improvement Event to determine changes to test

Determine keep, stop or expand

Changes in EPIC and functional work for successful interventions