Striving for Equitable Outreach

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Office of Population Health: Care Transitions Outreach Program

Background

The Care Transitions Outreach Program (CTOP) sends an automated call to patients within 3 days of hospital discharge in order to identify and address care transition problems.

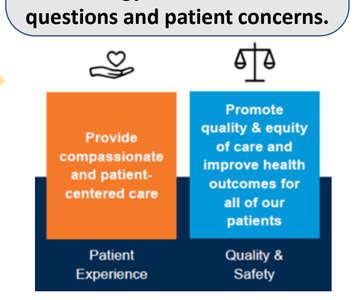
If a patient indicates they need help, a team of nurses, social worker, and pharmacists can address clinical issues including:

-Symptom Management
-Prescription/Med issues
-Follow-up planning
-Discharge instructions

CTOP has an outstanding annual reach rate of 77%

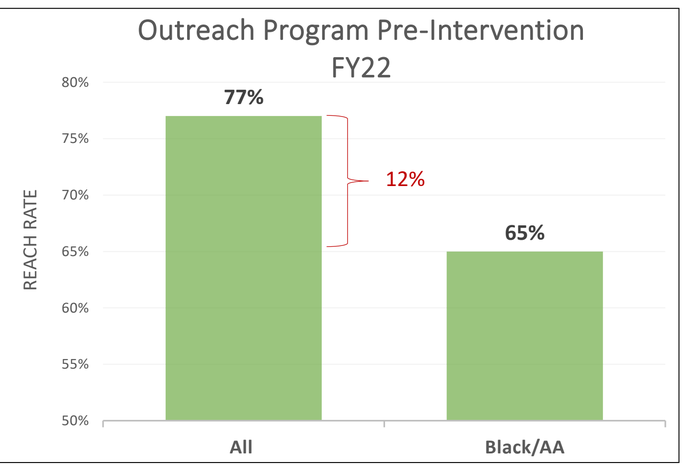
However, when analyzed by Race/Ethnicity, health disparities exist. Our Black/AA patients had a reach rate of 65%.

This program aligns with UCSF True North goals of improving Quality and Safety and Patient Experience by leveraging technology to address clinical questions and patient concerns.



Project Goals

The goal is to increase engagement with Black/African American patients by 7% with the addition of SMS and manual outreach. Introducing SMS allows patients to respond to our outreach in a potentially more convenient format than an automated call.



PROBLEM STATEMENT:

We identified that the largest disparity in engagement rates in response to our Discharge Outreach program's automated calls was in our Black/African American patients.

We increased post-discharge follow-up reach rates for Black/African American patients from 65% to 76% with the addition of SMS and manual outreach calls to UCSF's standard automated outreach calls.

Project Plan and Intervention(s)

We hypothesized that people who do not engage with the post-discharge automated call may respond to an SMS message.

We implemented an outgoing SMS message as an addition to our post-discharge automated call that asks the exact same transitions questions.

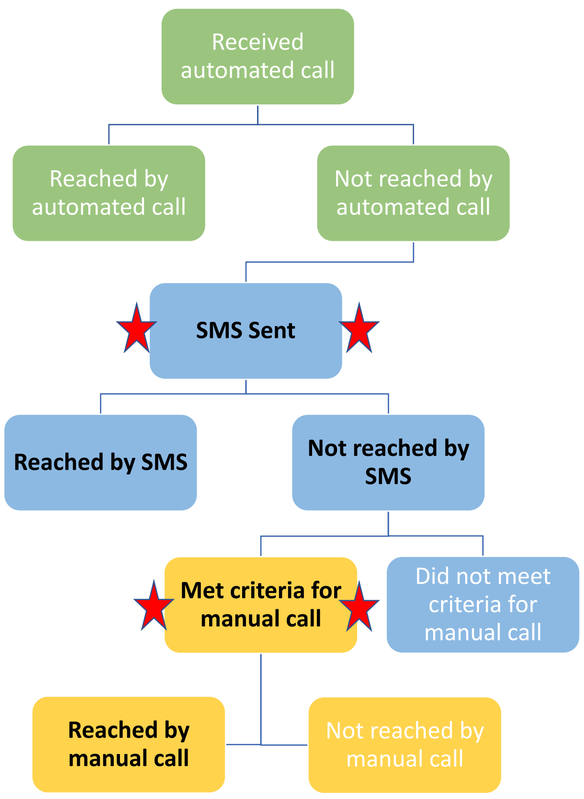
If a patient does not respond to the last automated call attempt of the day, they will receive an SMS which remains active for 3 hours.

If they do not respond to either, they appear on an "Unreached Dashboard" which we use to make Manual Outreach calls to select patient populations

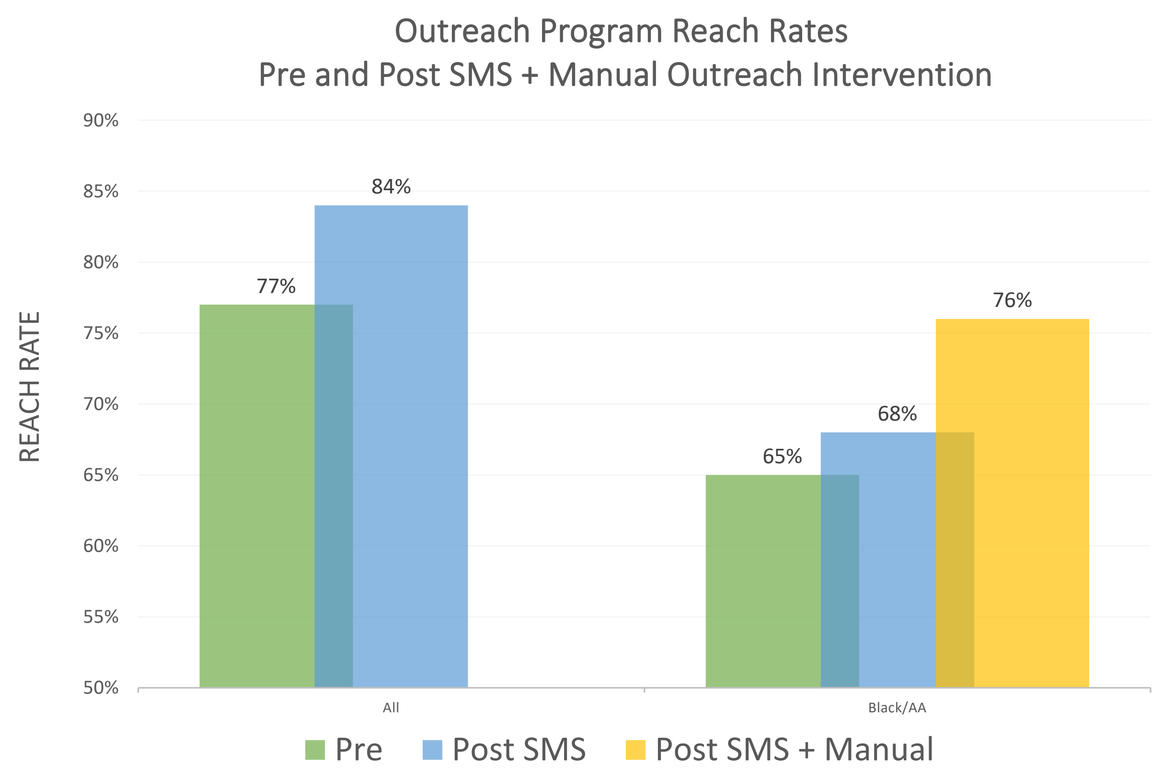
Manual Outreach Criteria

- Age 85 and older
- Primary Language other than English
- Home Health Ordered at Discharge
- Black/African American Patients

CTOP Intervention Workflow



Project Outcomes, Results & Impact



Pre-intervention date range: Jul 1, 2021 – Jun 30, 2022
Post-intervention date range: Feb 13– Apr 13, 2023

Conclusions, Next Steps, & Lessons Learned

Conclusions:

- **Our SMS outreach overall improved our engagement rates from 77 to 84%**
- **Implementing SMS alone did not significantly increase the reach rate for Black/AA patients**
- **We were able to increase the reach rate for Black/AA patients by 3% by SMS and an additional 8% with manual outreach, with a total of 11%**
- **The disparity gap was reduced from 12% to 8%**

Next Steps:

- **Continue to provide additional Manual Outreach to this population to continue to reduce health disparities**
- **Continue to ask for feedback on preferred outreach methods in order to identify potential barriers to using SMS and optimize ways to engage with patients**
- **Continue to monitor reach rates**

Lessons Learned:

- **The seemingly simple addition of an SMS intervention was logistically complex to implement**
- **Increasing overall reach rates created capacity for additional manual outreach**
- **The TCPA (Telephone Consumer Protection Act) enforces guidelines around patient consent and requires organizations to respect patients right to opt out**
- **Offering SMS created an unintentional consequence of patients having the opportunity to opt out of all SMS and future calls from our call program by replying "STOP"**
- **Reach rates were difficult to analyze by Race/Ethnicity because of how that data is grouped/categorized with third party vendor**

UCSF Health Improvement Symposium 2023