INTRODUCTION | BACKGROUND & CONTEXT

- Family Practice Center (FPC) is a resident lead primary care clinic
  - Leader in global health providing care for diverse underrepresented populations
- Despite our best efforts, there are subsets of our community that have persistent care gaps in multiple quality measures
  - What are the barriers to meeting these health maintenance needs?
    - Transportation, mobility issues, childcare, financial constraints, work obligations
  - How can we help to overcome these barriers?
    - Population Hot-Spotting or "Pop-Spotting" 1-2
      - Interdisciplinary approach designed to improve outcomes for our most at-risk patients by mobilizing primary care services

AIM | PURPOSE | OBJECTIVES

- To use Population Health Indicator (PHI) data to identify patients & schedule Pop Spot or in-person visit
- To create a pop spotting model that can replicated across any primary care setting

PROJECT ALIGNMENT/ADVANCE ORGANIZATION PRIORITIES

- Address health care needs for our patients most affected by various social determinants of health
- Emphasizes primary care services including preventative health and routine screenings

METHODS: INTERVENTIONS

<table>
<thead>
<tr>
<th>Flowchart Diagram</th>
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<tbody>
<tr>
<td>MAs run Integrated Quality Measures (IQM) report</td>
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<tr>
<td>MAs provides clinic scheduling staff (PSR) with a list of 12 eligible pts/wk</td>
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<tr>
<td>PSRs reach out to eligible patients to offer home pop spotting appt</td>
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<tr>
<td>Patient answers</td>
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<tr>
<td>PSR schedules home pop-spot or in-person clinic visit</td>
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<tr>
<td>NP and residents complete home pop-spotting visit</td>
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<td>Administer vaccines, collect labs, assist in scheduling CA screenings, perform med reviews, obtain vital signs</td>
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<tr>
<td>Complete Medicare wellness visits</td>
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<tr>
<td>Social determinants of health screening</td>
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<tr>
<td>Patient declines</td>
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<tr>
<td>PSR attempts second outreach the following week</td>
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<tr>
<td>No answer</td>
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RESULTS: PRELIMINARY

- Insufficient outreach attempts
  - Initial MA & clinical scheduling staff outreach attempts did not fill the pop spotting schedule
- Implemented social determinants of health (SDH) screening questionnaire has resulted in:
  - Deeper connections with our patients
  - Improved ability to identify their limitations
    - Primary barriers: Transportation and financial resource strain
- Consider comparing screening scores from in-person FPC visits vs home pop-spotting visits
- Tracking longitudinal improvement in PHI quality improvement scores

BARRIERS – STRATEGIES

- Inadequate clinic support staff for outreach efforts
  - STRATEGY: Hiring new lead RN and clinic supervisor to ensure adherence to workflows
- Recent EMR system change in quality measures interrupting data stratification and metrics
  - STRATEGY: Await Epic update
- Eligible patients are declining appointments or not responding to outreach attempts
  - STRATEGY: Make 2nd attempt to schedule the following week
- Time constraints during rooming process to complete control group screening
  - STRATEGY: Incorporate criteria and flow process into current rooming processes and staff training

DISCUSSION

CRITICAL NEXT STEPS

- Reassess if revised methodology has resulted in increased pop spotting visits
- Further data analysis
- Create a final model that can be replicated in any primary care clinic environment & adapting it to our second Family Care Center (FCC) clinic

AREAS SEEKING GUIDANCE

- How should we measure standards of success?
- How can we increase clinic stakeholder engagement?

REFERENCES

1. Sundberg G. Solutions to Address Frequent Hospital Attendance. JPCRR. 2020;7(3):222.