

# Integrated Outpatient Care

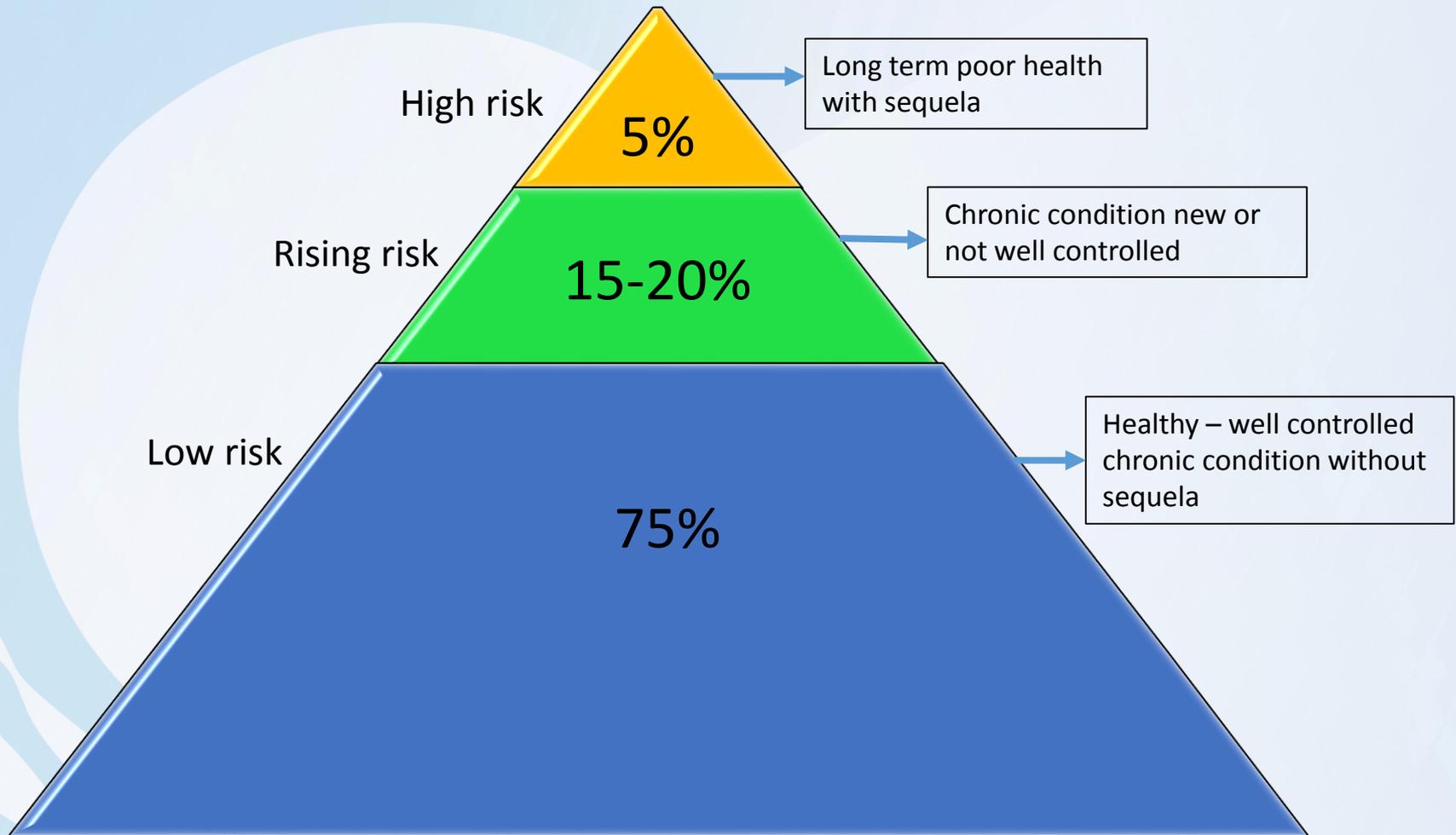
---

What is the benefit?

To whom?

How is Confluence Health implementing it?

# In what population does Care Integration really make a difference?



# What Do Patients Want From Their Healthcare?

- Improved Health
  - Not in fear
  - Can do what they want to do
  - Not in pain or uncomfortable
- Feel in control of their destiny
- Being understood
  - They are where they are with their health
  - Not looked down on, not being negatively judged
- To be listened to
- Trusting relationships with those helping them with their healthcare needs
- Patients with complex conditions don't want to feel like they are a burden
- *Most patients with opioid addiction and or chronic pain have lost most of these relationships with healthcare.*

# What Do Physicians Want From Their Career?

---

- Intrinsic Reward
- See patients have improved health, see them feel better
- Trusting relationships with their patients
- Recognition and respect for their efforts and contributions
- To use their skills and knowledge in the practice of medicine
- Help from others, so that they can do what only they can do, in the best way possible
- Work-life balance

# What Don't Physicians Want From Their Career?

---

- See the same patients over and over with the same problem, with no improvement.
- Feeling that they contributed to a poor patient outcome.
- Having to do things that do not require their unique skills and knowledge, that others can do, or do not add perceived value.
- Emotional overhead of administrative detail. (MU, MIPS, data entry)
- Patients with opioid abuse problems and or chronic pain make many Physicians feel out of control, vulnerable and unhelpful.

# Clinical Integration as a Means to Better Deliver Care

---

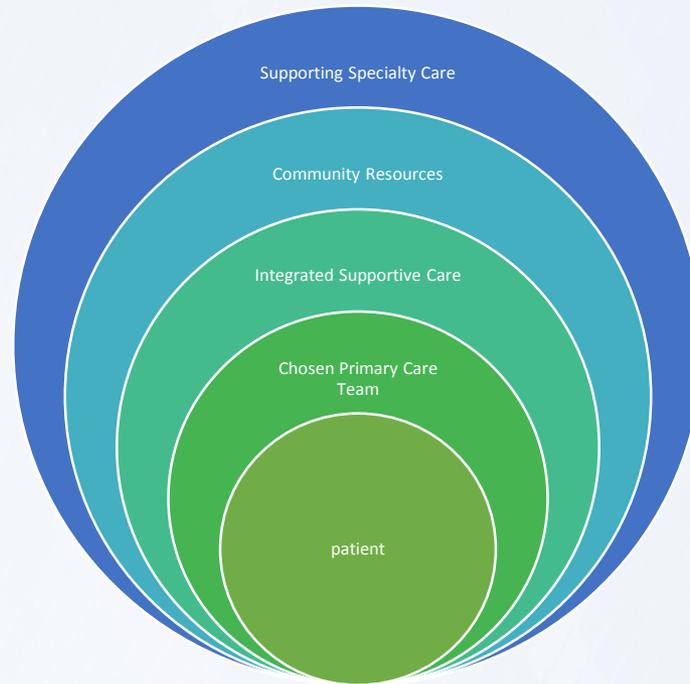
What Potential Solutions are Being Tested at Confluence Health?

# An Integrated Vision = Patient Centered Medical Home



Too much choice can feel like no one is taking responsibility and can be confusing.

---



# What's the Difference?

---

- In the second model, the patient is still in the position of being the ultimate “decider” regarding their care.
- The chosen PCP team takes on the role of primary facilitator of those decisions.
  - This may be as little as helping the patient make appropriate contact or as much as directed consultation with necessary specialists.
  - The challenge is to move from being “one option” for the patient’s care to being a facilitator of “options”.
- This requires the willingness and the capacity to have these conversations.

# Building Capacity. “Let Doctors be Doctors”

- Who needs to be on the Primary Care Team?
  - Pharmacy Support
  - Integrated Behavioral Health
  - RN Case Management
    - Centralized Resource
    - Embedded Nurse Navigator
    - Empowered, engaged support staff
  - Available to the team?
    - Chemical Dependency
    - Social work
    - Community resources/ church/ other
- Standard Work!
  - Local Practice teams creating work flow that supports best practice.
    - This drives specific job expectations, skills training and skill task alignment.
- Accountable leadership, willing to invest in resource and training.
  - Support metrics and reliable dashboards that encourage performance.

# Pharmacy Support

- This was the easiest issue to sell!
- Centralized Pharmacy team to coordinate prescription refills and lend advise re: polypharmacy, hypertension management, etc.
- Version 2.0
  - Embedded Pharmacist within the Primary Care Team
  - Coordinating prescription refills
  - Coordinating necessary lab and follow up
  - Performing patient consultations re: polypharmacy, hypertension management, etc.
  - Notification of potential drug harm due to Rx.
- Results
  - Marked reduction in prescription errors (18% decrease)
  - Marked reduction in dangerous medication combinations (narc/benzo).
  - Tremendous increase in Physician/APC satisfaction
  - Reduction in phone calls regarding Prescriptions back to the department.

# Integrated Behavioral Health

- These are not simply “co-located” Behavioral Health Providers
- This is a specific care model, which requires staff trained to deliver it appropriately.
  - The Psychologist is part of the Primary Care Team and available to see patients and “co-manage” issues related to mental or emotional health in an “open access” model.
    - Some patients “always” see the BH provider at the time of their medical visit:
      - New patients on chronic opioids.
      - Chronic pain patients
      - All patients on chronic opioids who are stalled in treatment progress.
    - This requires coordination and cooperation of both the Psychologist and the Medical team. It also requires that the sponsoring organization sees the “value” of this model is in increasing the capacity of the entire team.
  - Results so far are very encouraging. Most Primary Care Departments are now involved and working through the model. Access is increasing dramatically.

# RN Case Management

- Phase One
  - Centralized Ambulatory Case Management Team
    - Once the team was formed and trained, each member was assigned a Primary Care Team for which they were responsible. They made regular contact with the team and worked the list of high risk and rising risk patients involved in that teams care.
    - Clear goals were established.
      - Reduce readmission rates
      - Reduce unnecessary ED admissions.
      - Improve independent function “Promise 10 scores”
- Phase Two
  - Some of the Centralized Case Management Team have now been assigned as embedded Nurse Navigators.
    - The Centralized resource will remain for coordination of new patients and for other issues requiring a centralized team.
      - Nurse navigators assigned to high risk and rising risk patients.
        - All new patients on chronic opioids
        - All chronic pain patients on opioids not making treatment progress.
- Results so far
  - Highly engaged team
  - Primary Care teams eagerly wanting “their own” Navigator
  - Very high patient satisfaction.

To build a good foundation, you need a proper form, the right mix of mortar, sand and substrate and some rebar for strength.

---

Support staff are the foundation of successful Primary Care team.

# The Foundation: define the elements of work and create clear expectations supporting each

- Check in
  - Greet and establish rapport, verify critical information. Initiate Pain survey, Dire/Cage survey (unless done at home)
- Rooming
  - Reconcile meds, record VS,BMI. Confirm agenda for visit. Look for missed care opportunities. PHQ-2/reflex/9reflex suicide screen.
- Visit with the Physician/APC
  - Pull State Pharmacy Rx report for each patient on chronic narcotics.
  - Initiate care agreement document
  - Negotiate agenda for visit. Obtain data (H&P), lab, etc. Learn of patient COD. Confirm collaborative care plan.
- Discharge or Depart
  - Use “teach back to confirm plan”. Facilitate next visit and f/u care needs. Look for opportunities in care management. Patient education.

Each step is valuable and if not done, creates defects in care and waste, if not harm.

---

In order to facilitate this work be done in a reliable fashion.

- Multiple cycles of improvement (Kaizen) were performed by multiple Primary Care Teams to design “standard work” around each role.
- Timings were performed in order to establish how much time would be needed for each role for simple vs complex patient types.
- A “parallel or cascading schedule” was designed to provide staff the necessary time to reliably complete task.
- Training modules were designed to orient and train office staff re: standard work
- Tools (visual aids) were created to help staff remember steps specific to patients with specific conditions.

# Cascading Schedule; a critical step

## Two schedules are created each day

- One is the patient's schedule, which includes designated time for all the staff necessary to complete care for the patient.
  - Most visits total 45-60 minutes in total
  - This is a bit less than the time we measured prior to this project by simply observing how long patients were in the department and did not include "call backs", or other instances of "incomplete care".
- The other schedule is the Physician's or APC's schedule, which is "overlaid" on the Patient's schedule and is staggered with support staff. The average Physician time is 20 min, with 5 min. allowed for documentation.

# Results so far.....

---

- Physicians are consistently finishing their day closer to “on time”, less by more than 60 min per day with no decrease in productivity.
- Patient visits are more completely “prepped”, resulting in fewer gaps in care.
- Patients report much higher level of engagement with their Doctor in the exam room.
- Staff are happy with clear expectations and “time to get my work done”.
- Physicians report “I am spending most of the time with my patient now!” “I will not go back”.
- Fewer phone calls to the department, as patients leave with a better understanding of “the plan for their care”.

# How about patients with opioid issues, chronic pain, etc.?

- All new patients with chronic pain or chronic opioid dependency are shared equally throughout Primary Care (no closed practices)..
- Strong push to have all Primary Care Physicians trained in appropriate use of SBRIT and Suboxone Therapy. (Currently 30 trained = 30%)
- Institutional guidelines in place for chronic narcotic use are in place and available on our EMR. These are update regularly.
  - MED target <90
  - Avoid use of Benzodiazepines or other co-morbid medications.
  - Limit acute Narcotic Rx to 3-7 days. “red flag” at first refill request.
  - Recommended use of supporting information.
    - CAGE/DIRE, pain survey, functional capacity survey, routine depression survey with reflex suicide evaluation.
    - Weaning protocols.

# Unintended Consequence:

---

- Increased accountability to leadership.
  - This model allows us to track, not only the quality of work we are doing but the time it is taking to do it.
- This makes us accountable to resource allocation.
  - Manpower
  - Training
  - Technology

# What's Next?

---

- Spread the model reliably throughout our system.
- Manage our results and continue “Kaizen” to improve continuously.
- Evaluate the cost/benefit honestly.
- Currently lowering MED target to 90.
- Routine reporting of by physician, of patients on more than 90 MED of narcotic for non malignant pain control and or patient on narcotic with benzodiazepine. (this will be a quarterly update).