MDPCP Primary Care Staff Training Academy

MARYLAND DEPARTMENT OF HEALTH

September 2019

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Department of Health

Opening remarks

Welcome to the MDPCP Advanced Primary Care Staff Training!

Training will be recorded

WIFI

Agenda overview

Breaktimes and lunch

Breakout sessions

Training Folder & Evaluation Form

Bathroom locations

Interactive Polls

PollEv.com/medicalincs683 Text **MEDICALINCS683** to **22333** once to join

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CME/CEU Credits

"This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society and The Maryland Department of Health, and Medicalincs LLC. MedChi is accredited by the ACCME to provide continuing medical education for physicians.

MedChi
The Maryland State Medical Society

MedChi designates this live educational activity for a maximum of 7 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity."

Non-physicians receive an attendance certificate which indicates the number of CME credits the activity was awarded*. Non-physicians should contact their accrediting or credentialing organization's to make sure they accept CME's (most all do to some extent or another).*

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Session 1:
Maryland Primary Care Program

Howard M. Haft, MD, MMM, CPE, FACPE

Program Management Office

September 2019

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Department of Health

Presenter

Howard Haft, MD, MMM, CPE, FACPE

Executive Director,
Maryland Primary Care Program

Nkem Okeke, MD, MPH, MBA, MSPM, CCMP

CEO/Primary Care Transformation Expert
Medicalincs LLC

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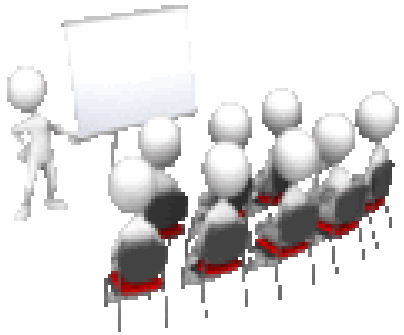
Department of Health

Disclosure Announcement

No disclosure related to this presentation

Training Design



- Focused more on Practice Staff
- Working on Training specific to MDPCP Practitioners
- However, depending on the practitioner's role in the practice (e.g. executive officer, quality improvement champion etc.), this training could also be informative

Pre-Survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

1. The Maryland Primary Care Program framework

Scale Key

1 = Fair
2 = Building
3 = Steady
4 = Strong
5 = Invincible

Remember the "Why"

- **Provide the best quality health for all Marylanders**
- **Shift from an ever-increasing volume demand to rewards for value-based care**
- **Avoid unnecessary emergency department and hospital visits**
- Show the nation that Maryland can be the leader in healthcare

"Know Your Why":

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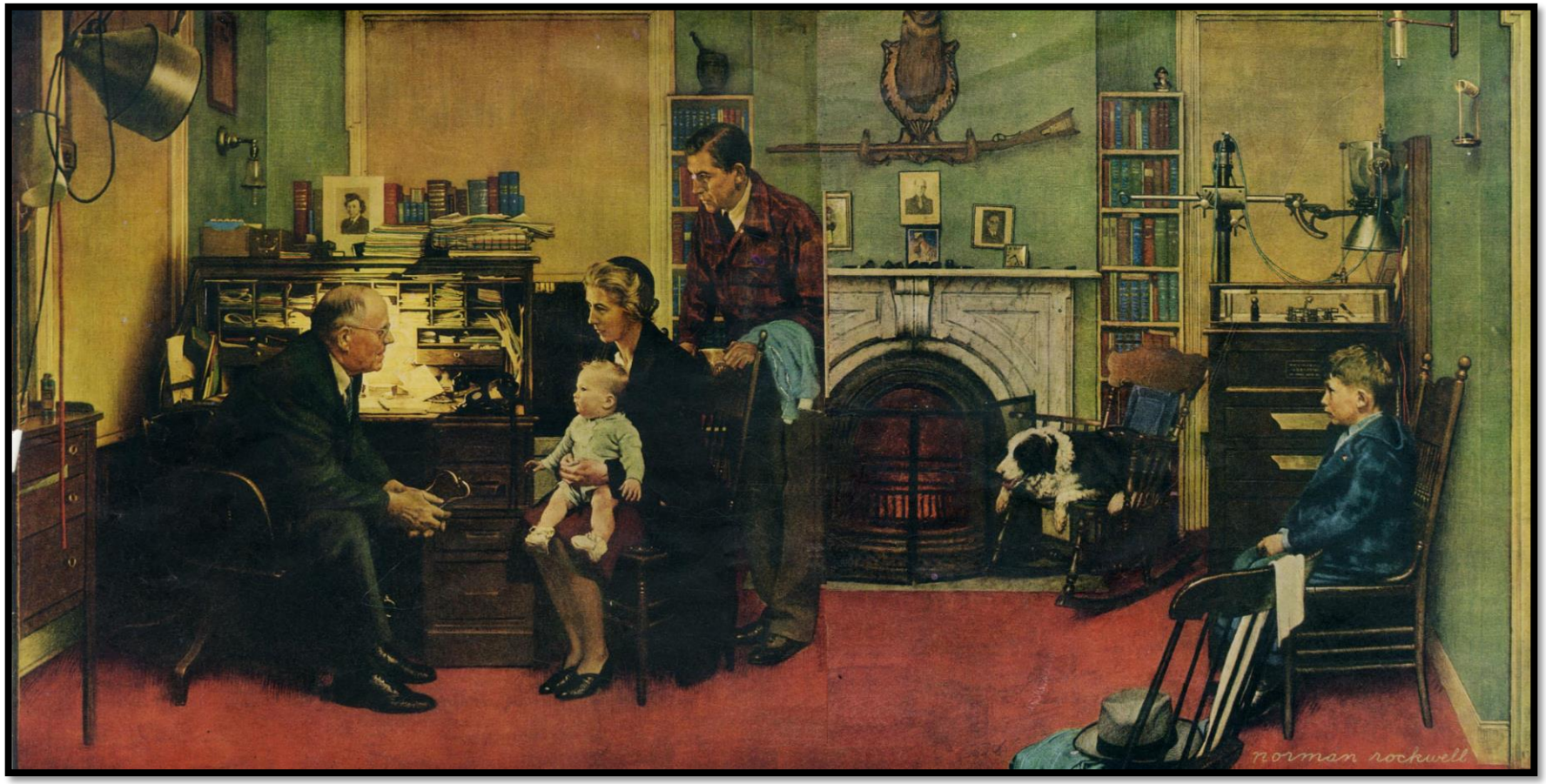
Remember the "Why"

"We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win."
- JFK Rice Univ. 1962

Past, *Present and Future*



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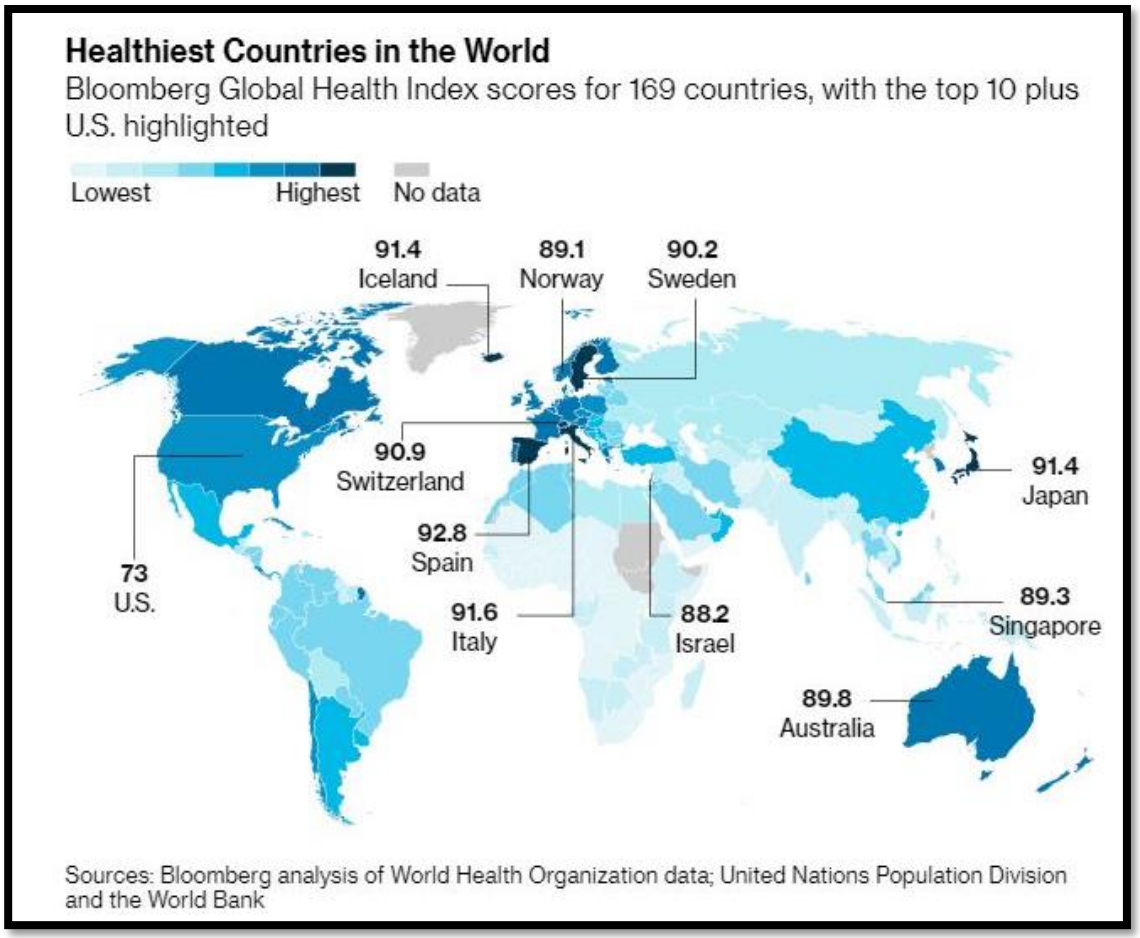
US Ranks 39th Healthiest Nation



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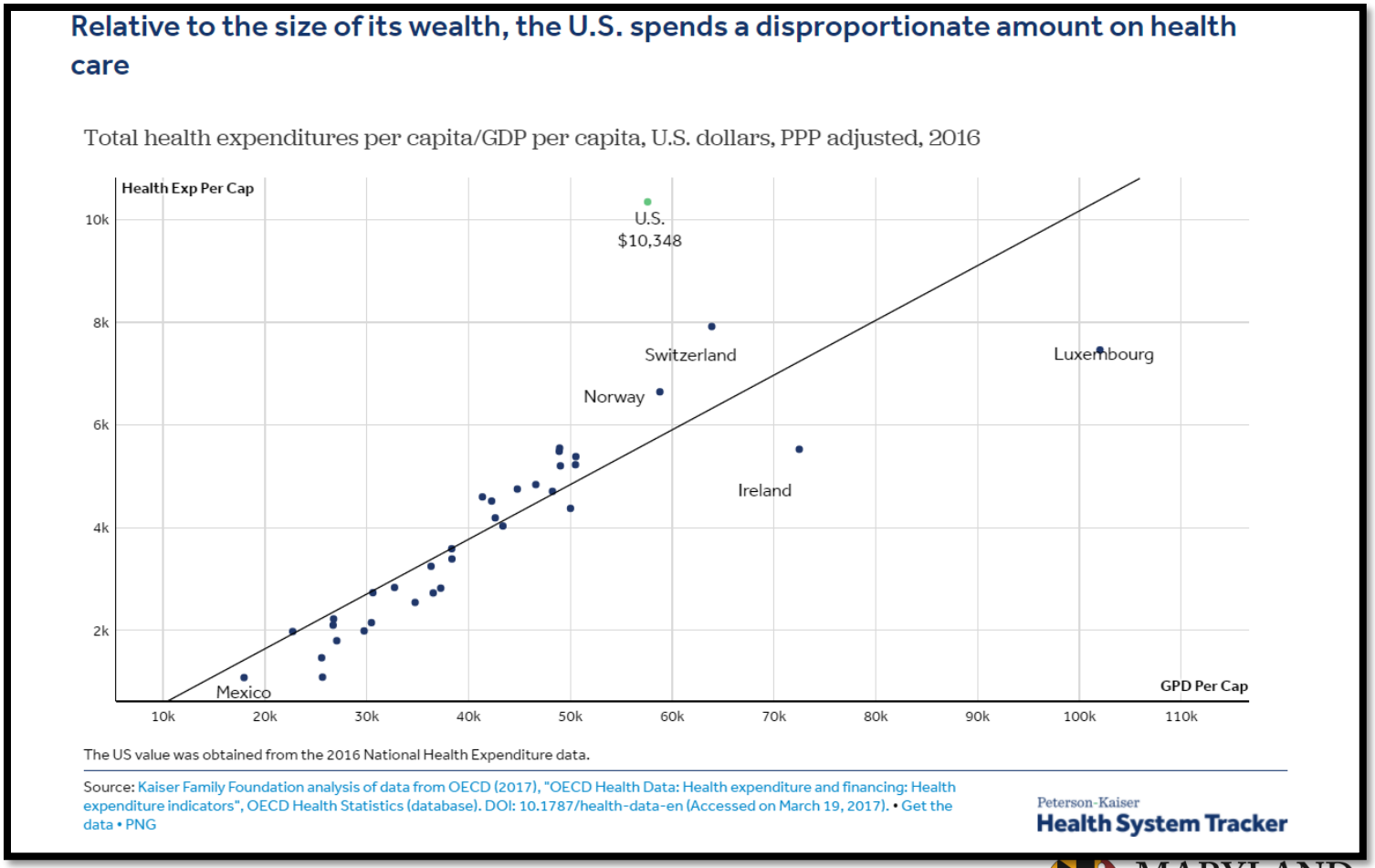
Per Capita Health Care Spending – US Has No Peer



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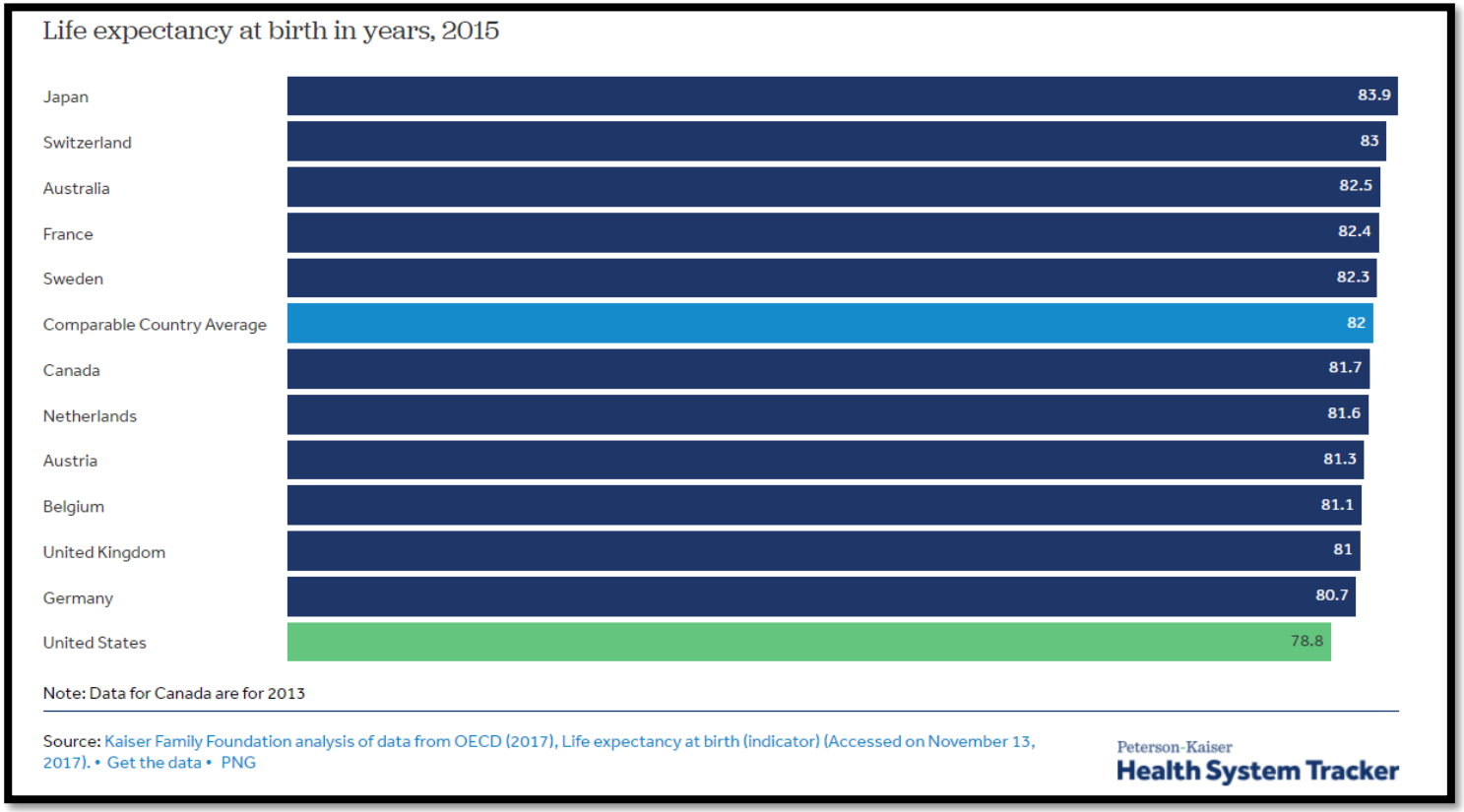
US Life Expectancy Lowest in World Among Peers



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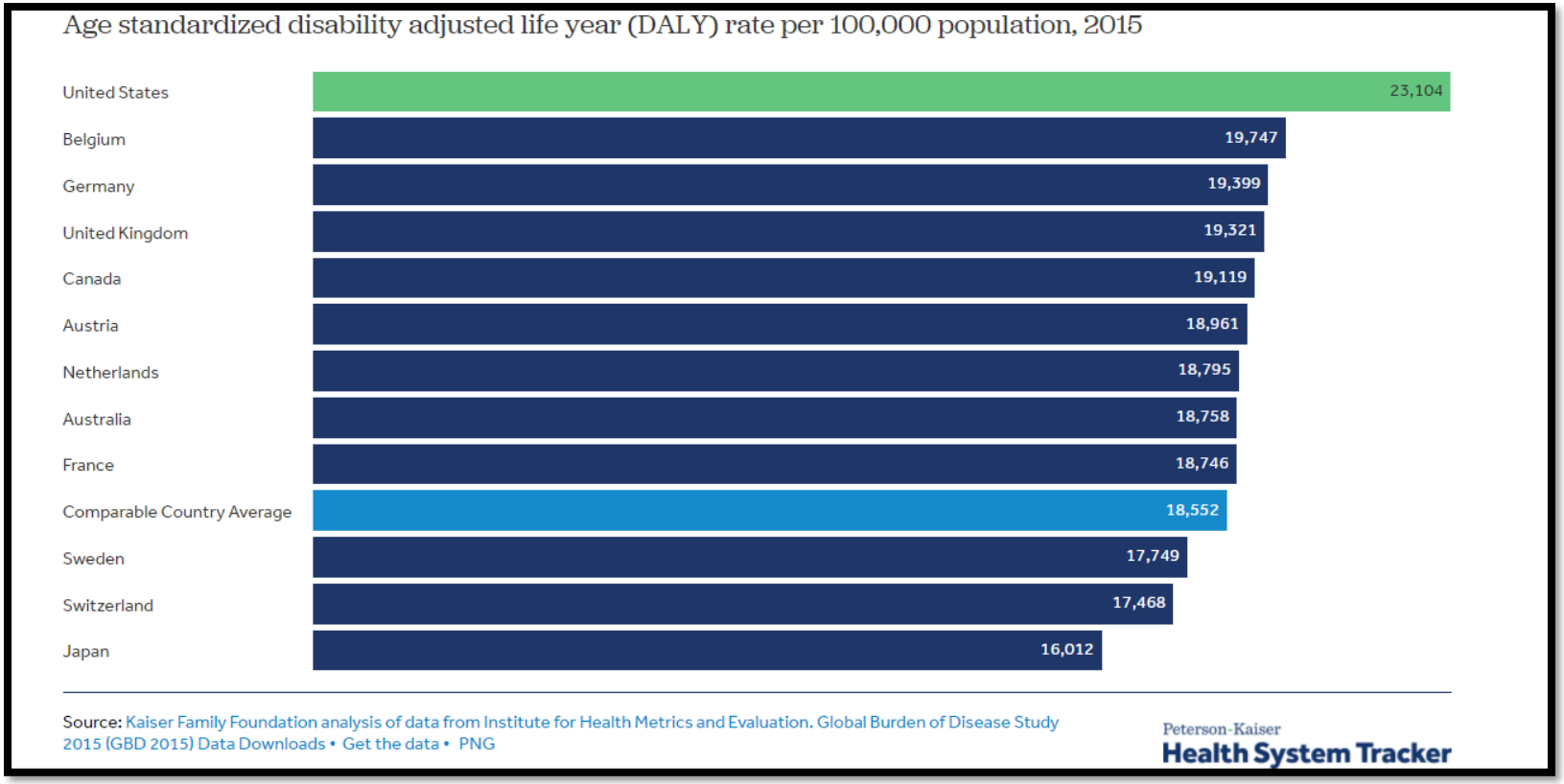
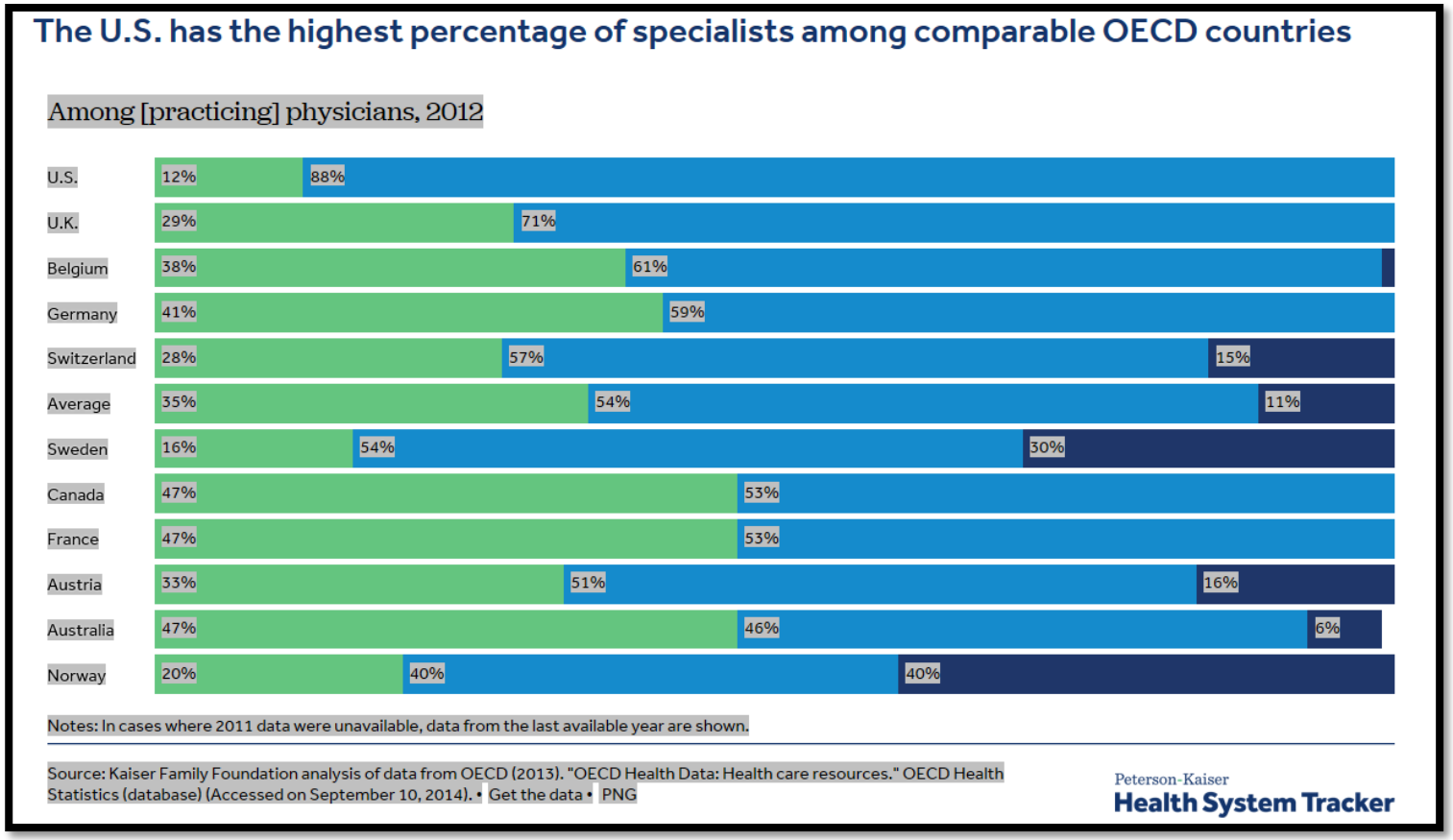
Disease Burden is Higher in the US than in Comparable Countries



Past

Ratios of Primary Care to Specialists



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Addressing the Issues: Total Cost of Care Model Co[illegible]

GOVERNOR OF MARYLAND

Date: 7/9/18

By: _____

Lawrence Joseph Hogan, Jr., Governor

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 7/5/18

By: _____

Adam Boehler, Director, Center for Medicare and Medicaid Innovation

HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

By: _____

Nelson Sabatini, Chairman

TCOC Model Agreement Signed on July 9, 2018!

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Date: 7/9/2018

By: _____

Robert R. Neall, Secretary of Health

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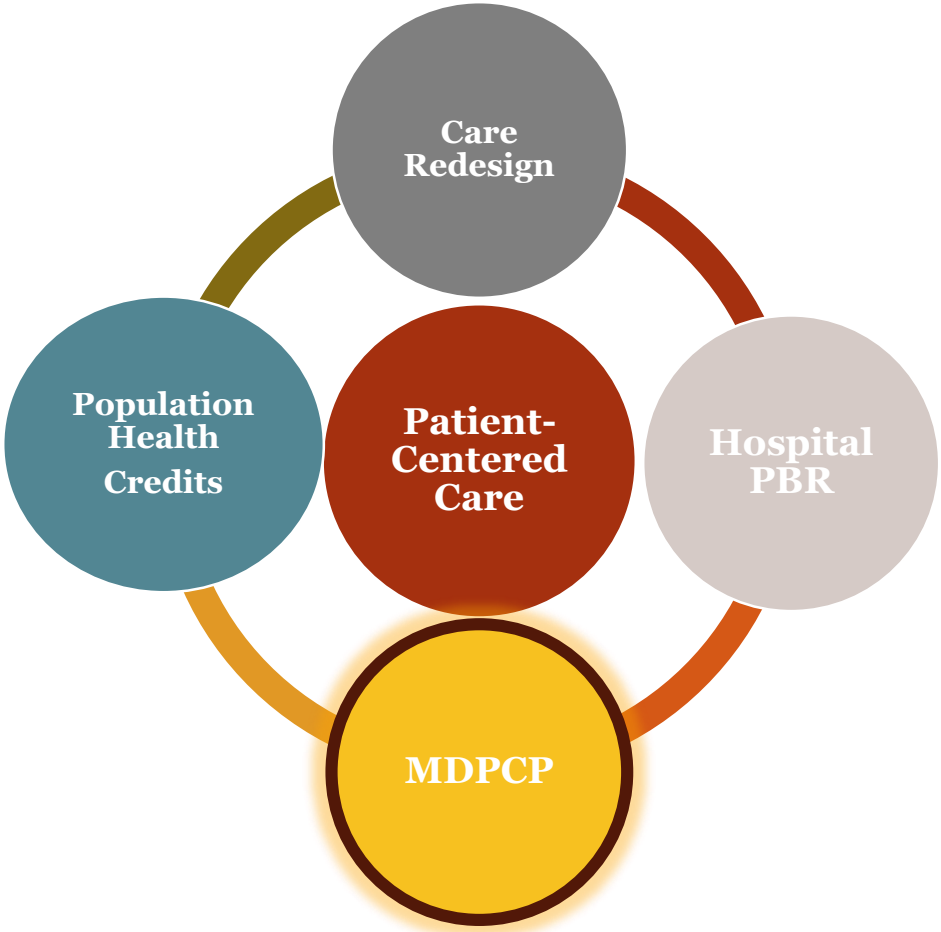
Total Cost of Care Model Components



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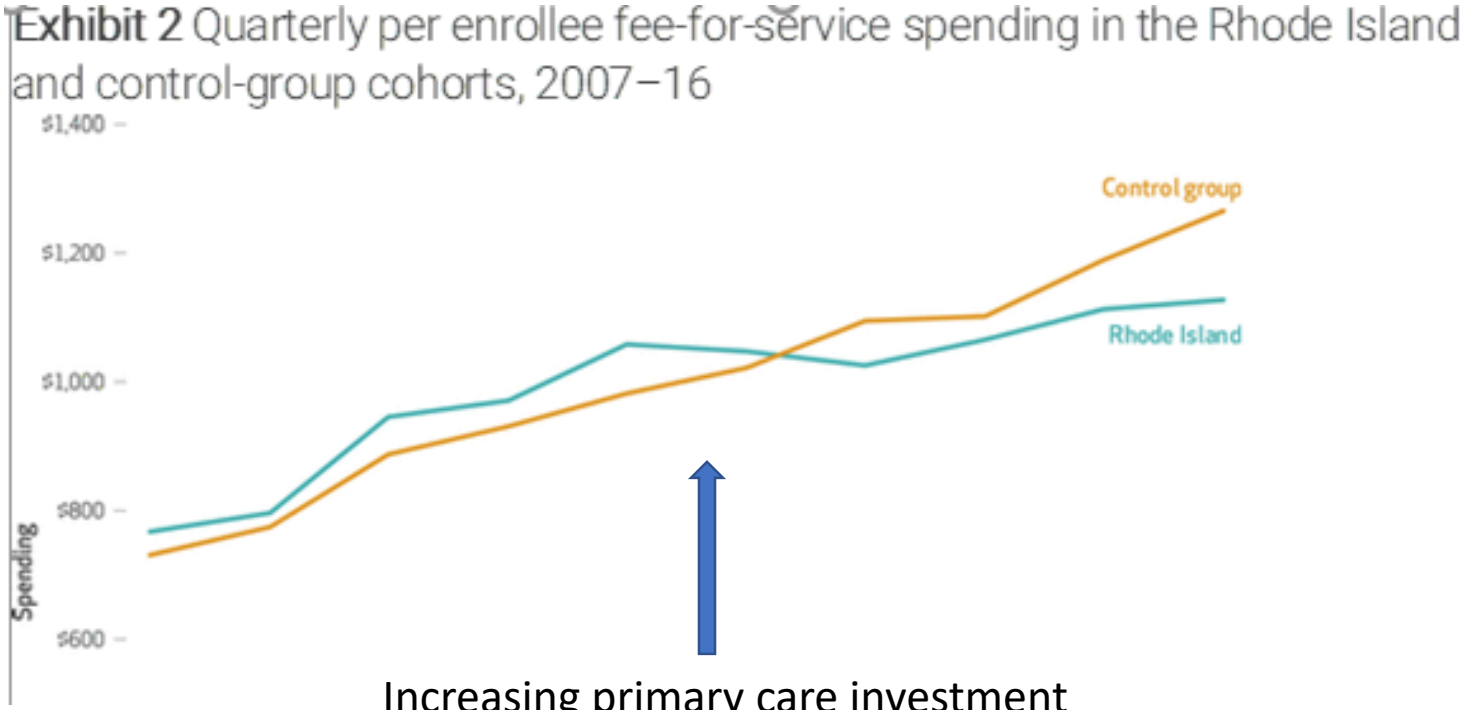
So- Why Primary Care?

- International Experience
- US Experience
- Stakeholder Input through TCOC Model development
- Single largest provider category
- Low relative healthcare spend (~5%)
- Low cost venue for care
- Best place to invest to avoid unnecessary hospital and ED visits
- Offset to burnout of PCPs

Recent US Experience in Primary Care Policy



Increasing primary care investment

Source: Baum et al. Health Affairs, February 2019

More Primary Care Increases Life Expectancy

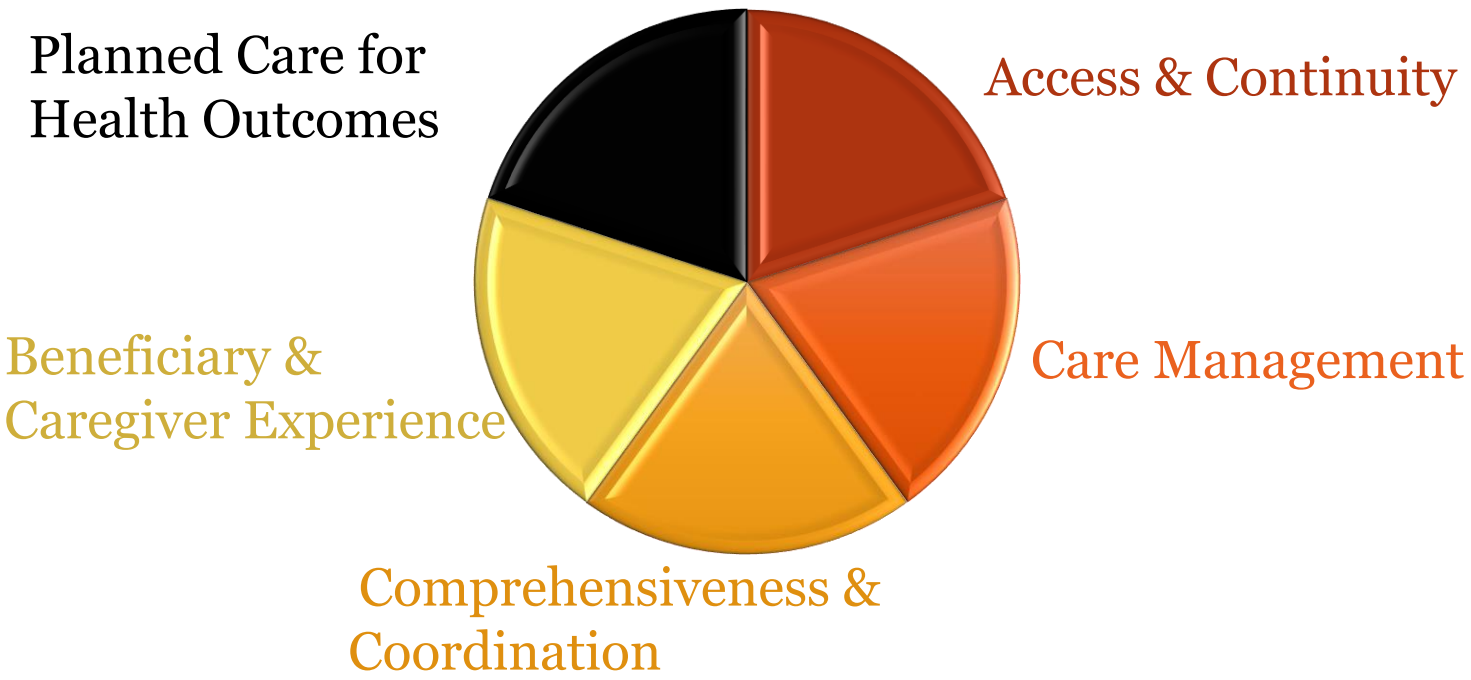
Table 2. Results of Mixed-Effects Regressions Associating Physician Density and County-Level Covariates With Age-Standardized Life Expectancy at Birth in 3142 US Counties, 2005-2015

Variable	Change in Age-Standardized Life Expectancy (95% CI)			
	Model 1 (Total Physician Density)	Model 2 (Primary Care Physician Density)	Model 3 (Specialist Density)	Model 4 (Primary Care Physician and Specialist Density)
Total physicians, per 100 000 population[a]	66.7 (47.5 to 85.8)	–NA	NA	NA
Covariate, per +10 physicians per 100 000[b]	88.9	NA	NA	NA
Primary care physicians, per 100 000 population	NA	31.8 (17.7 to 45.9)	NA	33.1 (19.0 to 47.3)
Covariate, per +10 physicians per 100 000[b]	NA	49.7	NA	51.5
Specialty physicians, per 100 000 population	NA	NA	23.3 (9.3 to 37.3)	20.6 (7.5 to 33.6)
Covariate, per +10 physicians per 100 000[b]	NA	NA	21.7	19.2
Metro area, change to nonmetro area, d	−54.6 (−79.8 to −29.5)	−55.8 (−81.0 to −30.7)	−51.0 (−76.5 to −25.6)	−54.2 (−79.4 to −29.0)

JAMA, Basu, Feb 2019

Requirements: Primary Care Functions

Five advanced primary care functions:



Access and Continuity

Track One

- Empanel patients to care teams
- 24/7 patient access

Track Two (all of the above, plus)

- Alternatives to traditional office visits

Care Management

Track One

- Risk stratify patient population
- Short-and long-term care management
- Follow-up on patient hospitalizations

Track Two (all of the above, plus)

- Care plans & medication management for high risk chronic disease patients

Comprehensiveness and Coordination

Track One

- Coordinate referrals with high volume/cost specialists serving population
- Integrate behavioral health

Track Two (all of the above, plus)

- Facilitate access to community resources and supports for social needs

Beneficiary and Caregiver Engagement

Track One

- Convene Patient Family Advisory Council (PFAC) and integrate recommendations into care, as appropriate

Track Two (all of the above, plus)

- Advance care planning

Planned Care for Health Outcomes

Track One & Two

- Continuously improve performance on key outcomes

2019 Metrics

electronic Clinical Quality Measures (eCQM) include:

- Outcome Measures – Diabetes and Hypertension Control (NQF 0018 & 0059)
- Screening and Initiation of treatment for Substance Abuse (NQF 0004)

Patient Satisfaction

- Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) – survey of practice patients (NQF 0005)

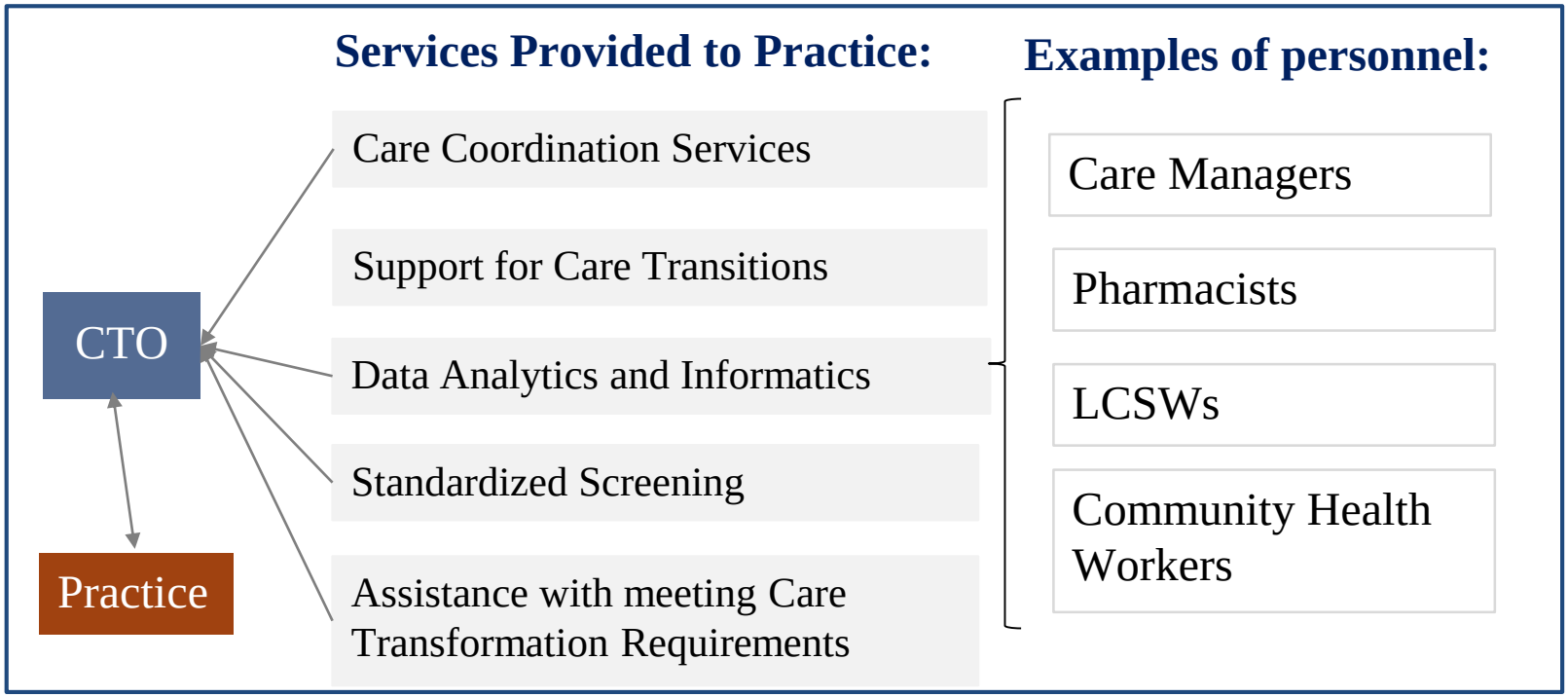
Utilization

- Emergency department visits and Hospitalizations per 1,000 attributed beneficiaries (HEDIS)

Current metrics as of 2019 – May be updated for 2020

Care Transformation Organization (CTO)

On request – assisting the practice in meeting care transformation requirements



Existing CRISP HIT Services for Practices

Maryland Prescription Drug Monitoring Program
Monitor the prescribing and dispensing of drugs that contain controlled dangerous substances

Encounter Notification Service (ENS)
Be notified in real time about patient visits to the hospital

Query Portal
Search for your patients' prior hospital and medication records

Direct Secure Messaging
Use secure email instead of fax/phone for referrals and other care coordination

Additional MDPCP HIT through CRISP

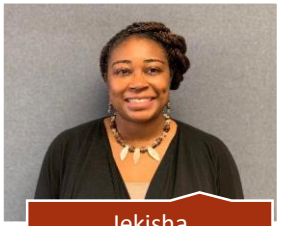
- Quality Measures Reporting to CMMI
- Hospital and Emergency Department Utilization Data
- Specialists costs and utilization
- Risk Stratification for Medicare beneficiaries
- Social Determinant Screening and Resource Directory
- Care plan and Care Alert sharing
- Others TBD

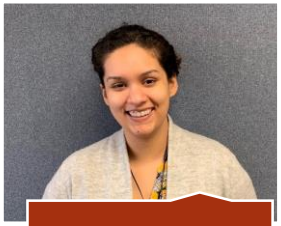
MDPCP Learning System

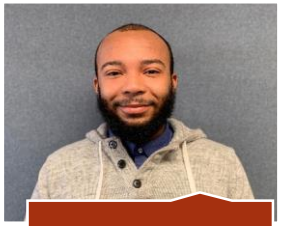
- Practice Coaches- State and CTOs
- Webinars
- Office Hours
- Online Manuals
- Collaborative Communities
- Newsletter
- Connect Site
- 3 Annual Face-to-Face Meetings
- Quarterly Reporting

Practice Coaches

- Care Transformation Requirement Support
- Understanding and using resources
  - Documents and Learning Events
  - Tool navigation and support, including CRISP, MDPCP Portal, and Connect
- Timeline and reporting guidance
- Coordination with other support elements (i.e., CRISP and SBIRT Vendor)


Jekisha Elliott (Lead Coach)


Kelly Brown


Nicholas Brown


Lawrence Devadason


Shant'e Gilmore


Derrick Shaw

Kim Gibson

Tammy Liu

TJ Naim

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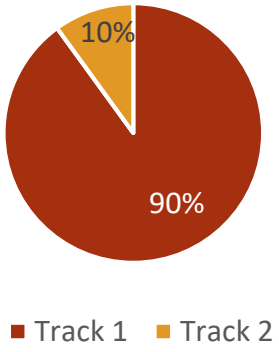
Program Year 1

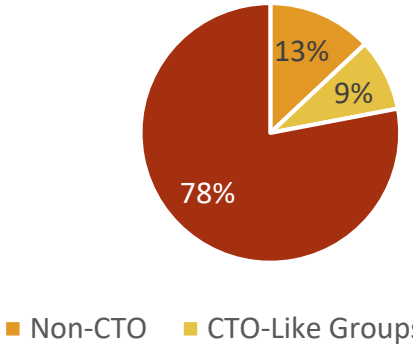
380 Practices Accepted Statewide

- ~ 220,000 Medicare FFS beneficiaries
- ~ 1,500 Primary Care Providers
- ~ 40% employed by hospitals
- All counties represented
- 21 Care Transformation Organizations (min 6/county)
  - 14 of 21 are hospital-based

Practice Tracks



Practices Partnered with a CTO



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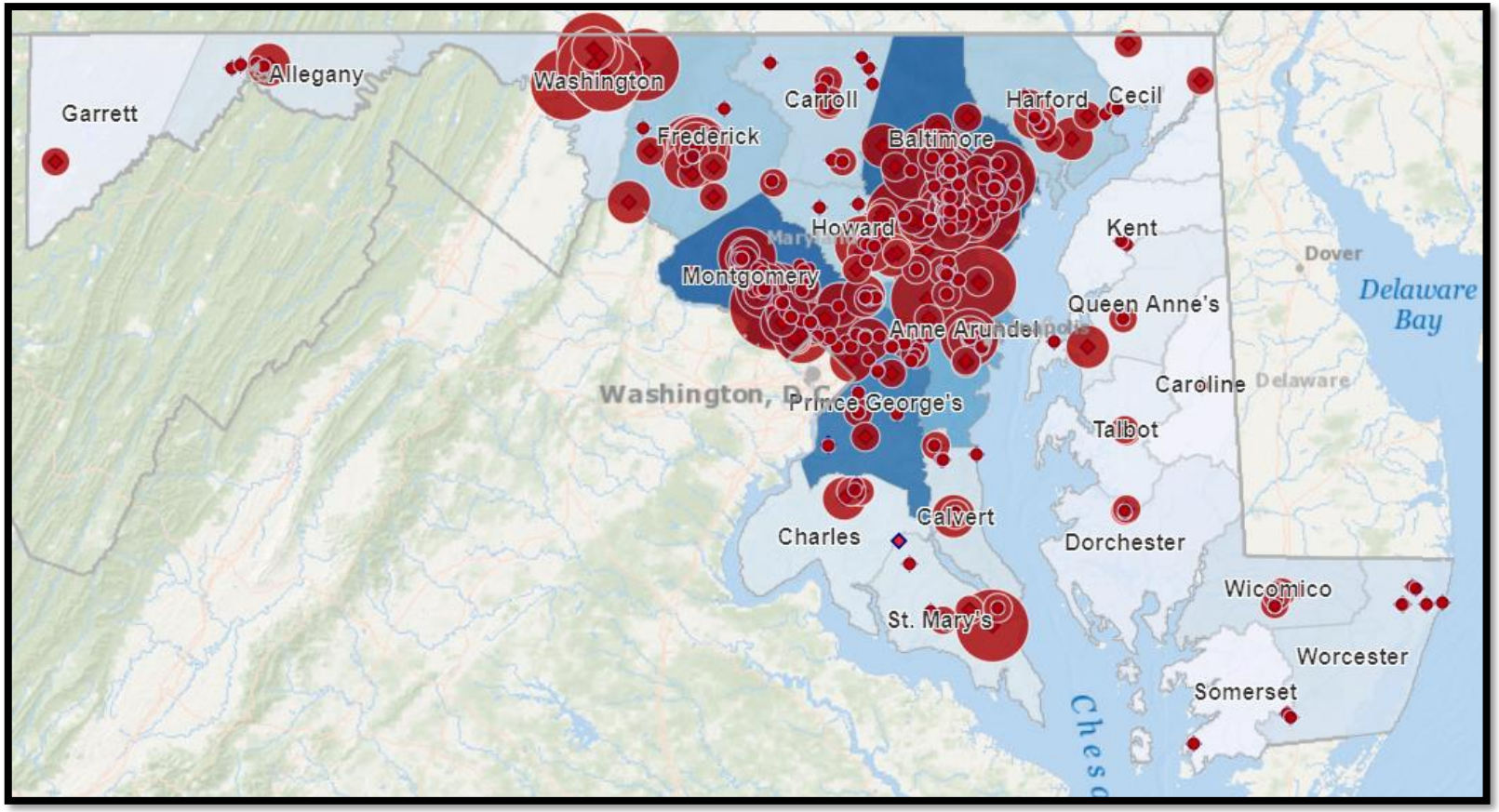
380 MDPCP Practices



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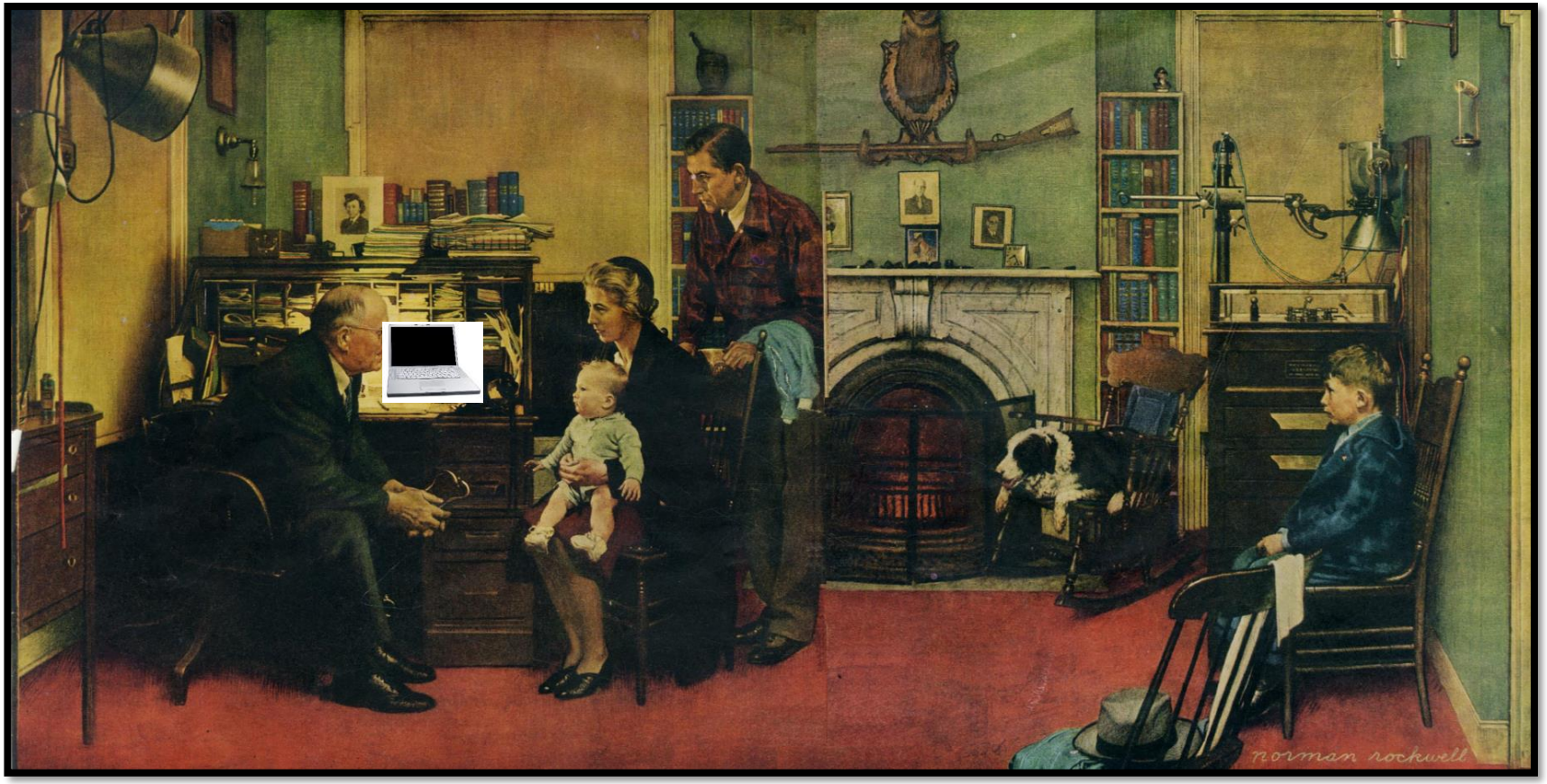
*Past, Present and **Future***



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Post-Survey

Questions:

After this session- on a scale of 1-5 how would you rate your knowledge on:

1. The Maryland Primary Care Program framework

Scale Key

1 = Fair
2 = Building
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Session 2

I. Training Sessions Overview

II. Dealing with change in PY1 & following years [Change Management & Quality Improvement]

Nkem Okeke, MD, MPH, MBA, MSPM, CLSS, CCMP

Medicalincs LLC

September 2019

MARYLAND Department of Health

Presenter

Nkem Okeke, MD, MPH, MBA, MSPM, CCMP

CEO/Primary Care Transformation Expert
Medicalincs LLC

MARYLAND Department of Health

Disclosure Announcement

No disclosure directly related to this presentation

Qrtly. Reporting (QR)

Sessions-MDPCP Requirements Crosswalk

Comprehensive Primary Care Functions of Advanced Primary Care	Care Transformation Requirement	Sessions
Access and Continuity	1.1 Empanelment	2 & 4
	1.2 24/7 access to a care team AND practitioner to the EHR	3
	1.3 Alternative Care Visits	3
Care Management	2.1 Risk Stratification	4
	2.2 Longitudinal care management.	6
	2.3 ED discharges & Hospital discharges follow-up	6
	2.4 Episodic care management	6
	2.5 Care Planning & Self-Management Support	8
	2.6 Comprehensive medication management	5 & 6
Comprehensiveness & Coordination across the Continuum of care	3.1 Coordinated referral management	6
	3.2 Behavioral Health Integration: Screening & Rx initiation for SUD	5
	3.3 Social needs	9
Beneficiary & Caregiver Experience	4.1 Patient-Family/ Caregiver Advisory Council (PFAC)	10 & 11
	4.2 Advance care planning	8
Planned Care for Health Outcomes	5.1 Performance Improvement|Population Health|Analytics: ▪ electronic clinical quality measures (eCQMs) ▪ beneficiary experience (CAHPS) ▪ utilization measures (ED & IPU)	2, 3, 10 & 6

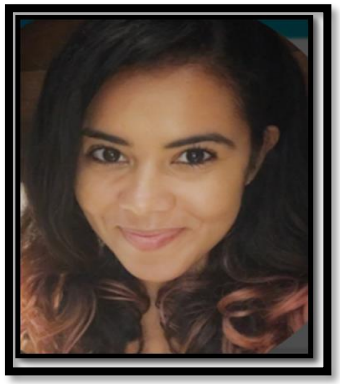
Presenters

Nkem Okeke
MD, MPH, MBA, MSPM, CCMP

Chief Executive Officer, Medicalincs
Primary Care Transformation Expert

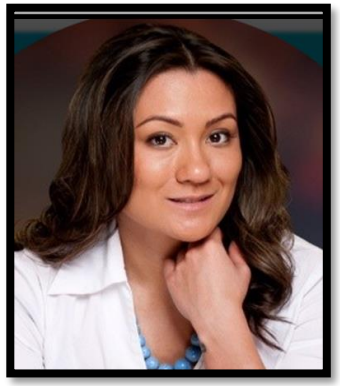
Kyanni N. Fleming
RN, BSN, MS, MBA

Care Management Subject Matter Expert, Medicalincs LLC



Sonia Almonte
BPA

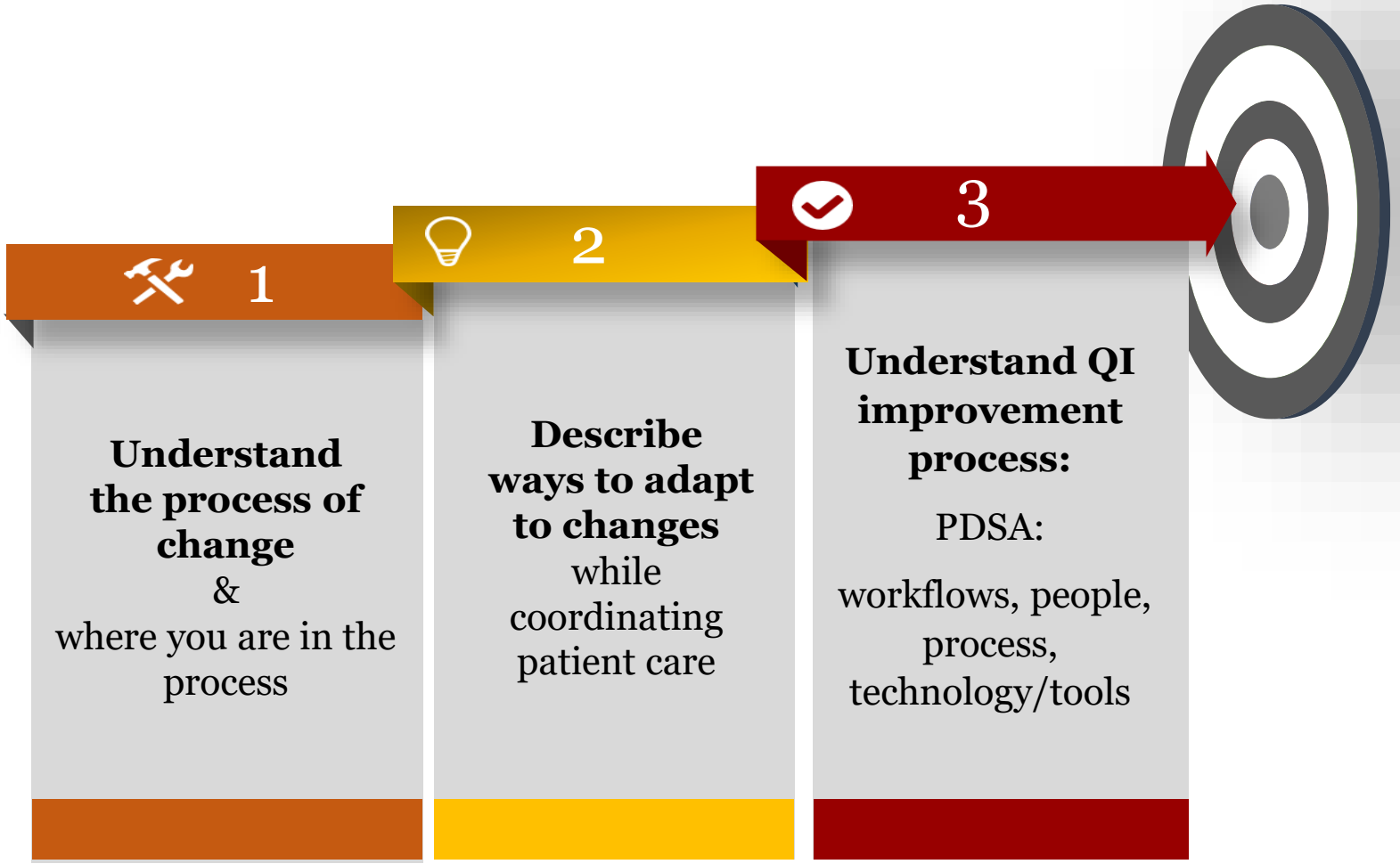
Care Coordination (Community Health) Expert



Angelica Ortman
MHA, MBA, PhD-c

Executive Consultant, Medicalincs
(Population Health Expert)

Session Objectives



Pre-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

2. The process of change & where you are in the process
3. Ways to adapt to and manage changes while coordinating patient care
4. Quality improvement process & PDSA

Scale Key

1 = Fair
2 = Building
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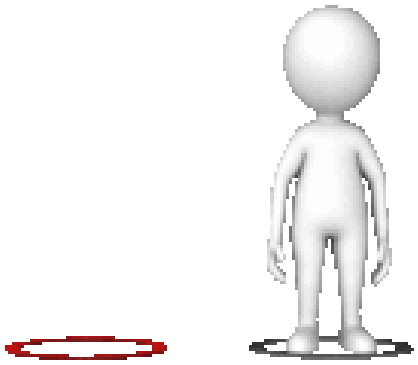
Change Management

"Everyone thinks of changing the world, but no one thinks of changing himself"~ Leo Tolstoy

CHANGE for the better = IMPROVEMENT

~~Change~~ **"IMPROVEMENT" Management** is the application of a **structured process** and **set of tools** for leading the **people side** of change **to achieve a desired outcome**



- A **leadership competency** for enabling change within an organization or your practice

  "Do as I do …" *leadership approach*

- A **strategic capability** designed to increase change capacity and responsiveness

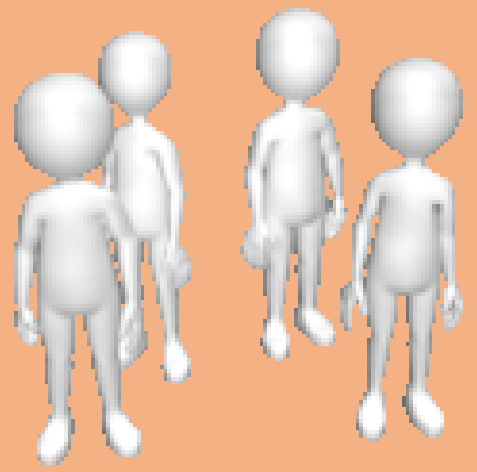
Why Change Management?

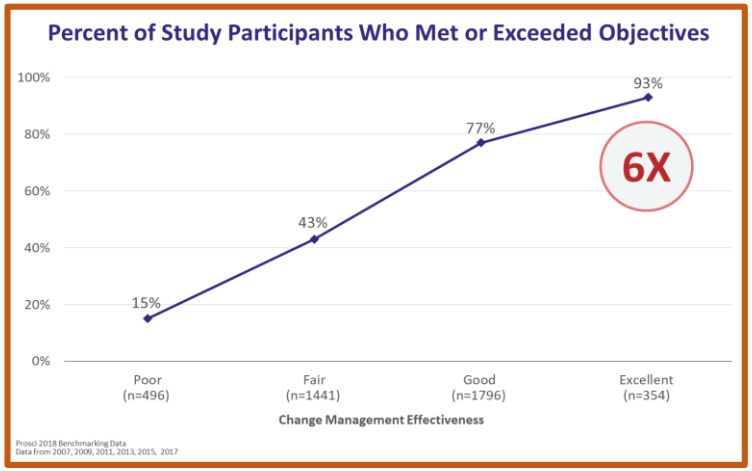
… The value in the Total Cost of Care Model

Physician & Practice Staff Engagement

Providers need to be supported through change & transformation to:

- ❑ **Reduce admin burden**
- ❑ **Speed up adoption rate and reduce costs**
- ❑ **Achieve ultimate utilization & proficiency**





To increase the probability of the program (MDPCP) & overall practice success, you need to manage

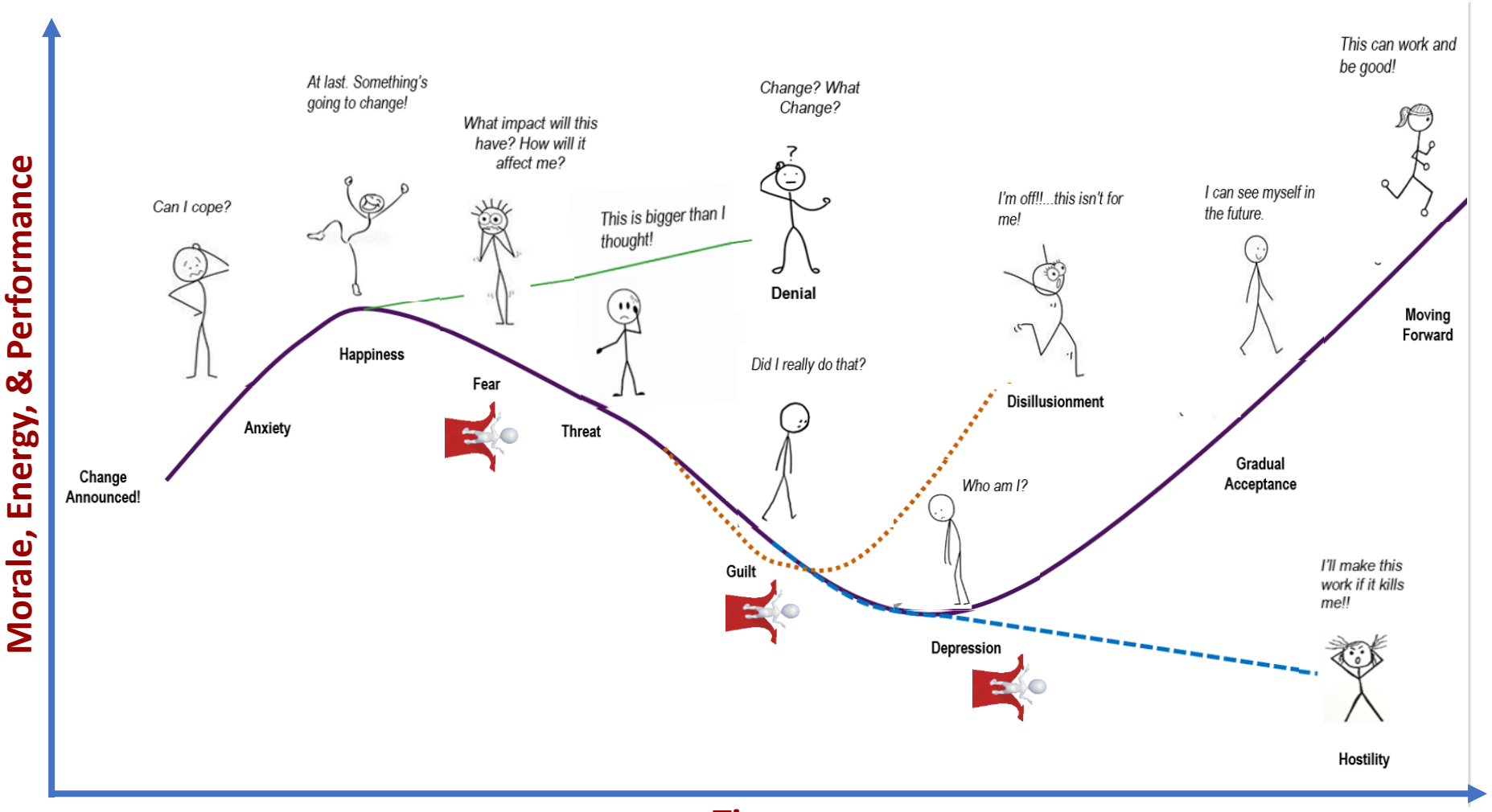
"People-Dependent ROI"

(i.e. People side of Change)

Challenges with Implementing Change

- ❑ No SHARED ownership of the VISION
- ❑ Internal focus instead of seeking external support
- ❑ Success Syndrome
- ❑ Preexisting Biases
- ❑ Treating the symptom
- ❑ No "Sense of Urgency"
- ❑ Imbalanced Participation: *Staff on different stages of change*

Stages of Change –
Practice Staff Change Journey



Source: CoEvolve

Change Management Phases

Practice (Organizational) Phases:

1. **Prepare for change**
2. **Manage change**
3. **Reinforce change**

Individual Phases:

1. **A-Awareness -** *I understand why*
2. **D- Decide -** *I have decided to*
3. **K- Knowledge -** *I know how to*
4. **A- Ability -** *I am able to*
5. **R- Reinforce -** *I will continue to*

If you don't like something, change it. If you can't change it, change your attitude ~ Maya Angelou

Practice & Individual Change Management Phases Occur simultaneously

1. Preparing for Change

A. Align Key Stakeholders [Create Awareness]:

- **Understand**: the need for a change (the Why)
- **Enlist**: the support of the team to work on a solution (the Who)
- **Envisage**: the opportunities & implications of the solution (the What)

2. Managing Change

B. Engage the Practice Staff [Increase Desire & Knowledge]

- **Motivate**: connect at emotional level around the 'why'
- **Communicate**: the vision

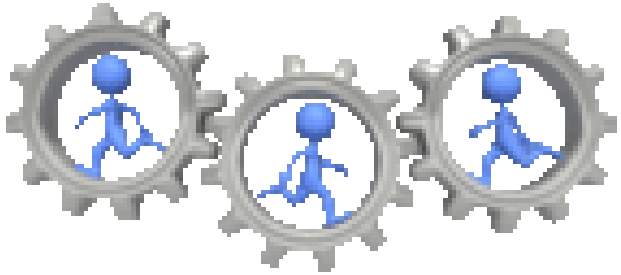
C. Act [Ability & Reinforce]

- **Mobilize**: practice staff around 'how' to rollout the solution (the How)
- **Act**: align people (and structure/process) with the new solution (What)
- **Consolidate**: by reinforcing which things are working (Which)

3. Reinforcing Change

Quality Improvement
… as a part of Transformational Culture

Quality improvement (QI) is about **designing changes** in both systems and processes that lead to **operational improvements**



An **organizational culture of quality** is one in which **concepts of quality** are ingrained in organizational values, goals, practices/activities, and processes.

A **culture of quality improvement** encourages **ALL** the practice care team/staff to continuously ask:

- *"How are we doing?" and "Can we do it better?"*
- *"Can we do it more efficiently? Or be more effective?"*
- *"Can we do it faster? Or Can we do it in a more timely way?"*

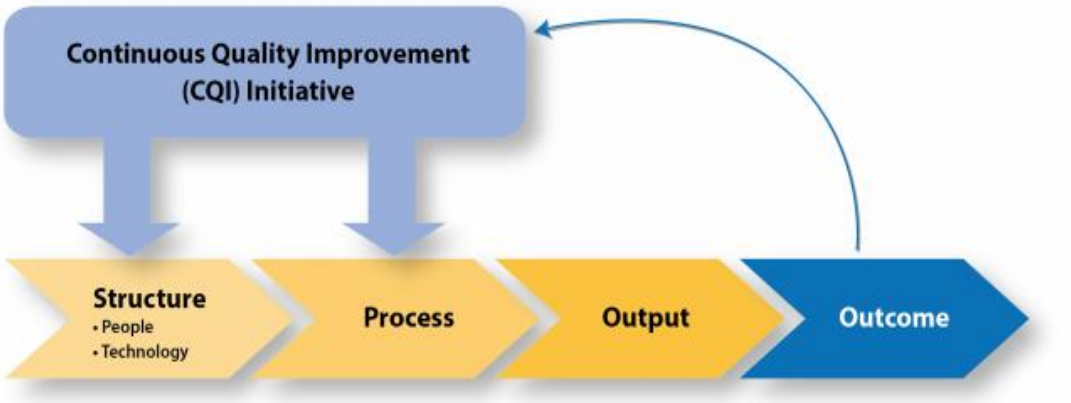
To build a transformational culture of quality, you need to -

Teach it, Define it, Live it, Measure it, and Reward it!

Establishing a Continuous Quality Improvement (CQI) Strategy

To Establish an effective CQI strategy, a practice should …

- ☑ **Choose and use a formal model** for QI – **(PDSA).**
- ☑ **Establish and monitor measures** to evaluate improvement efforts and outcomes routinely.
- ☑ Ensure **ALL** staff members understand the **measures for success**.
- ☑ Ensure that **patients, families, providers, and care team members** are involved in QI activities.
- ☑ **Optimize use of an EHR** and health IT.



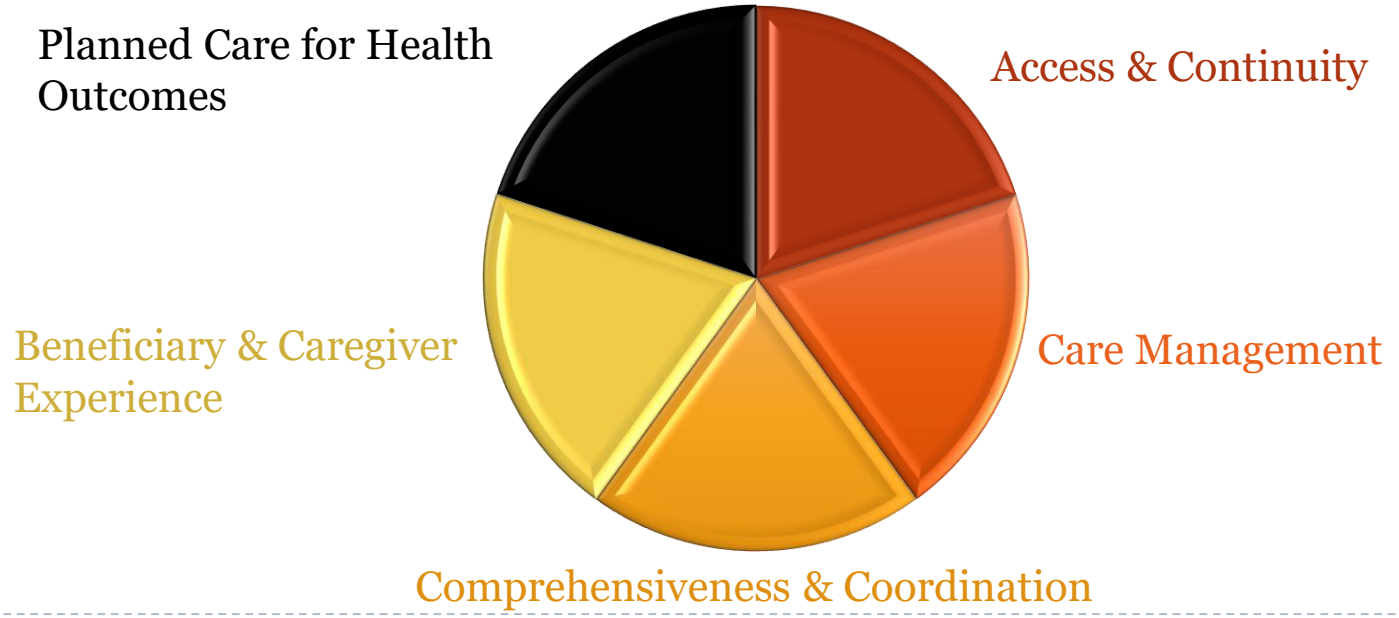
(Wagner et al., 2012)

Why focus on Quality Improvement?

Maryland Primary Care Program AIM:

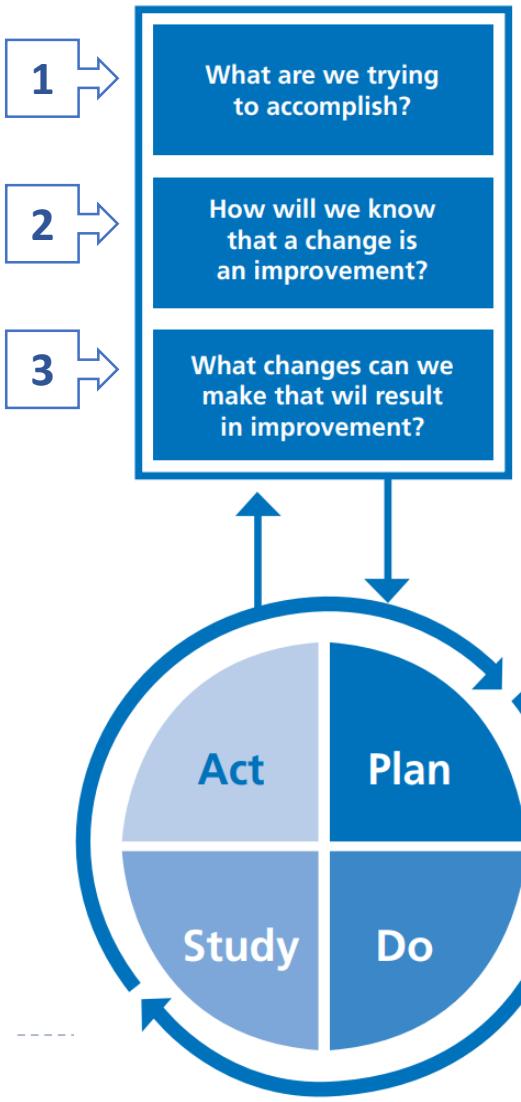
… to transform Primary Care delivery **by improving the QUALITY of care** we provide to Marylanders (and its visitors) – One Primary Care Practice at a time!

Five advanced primary care functions:



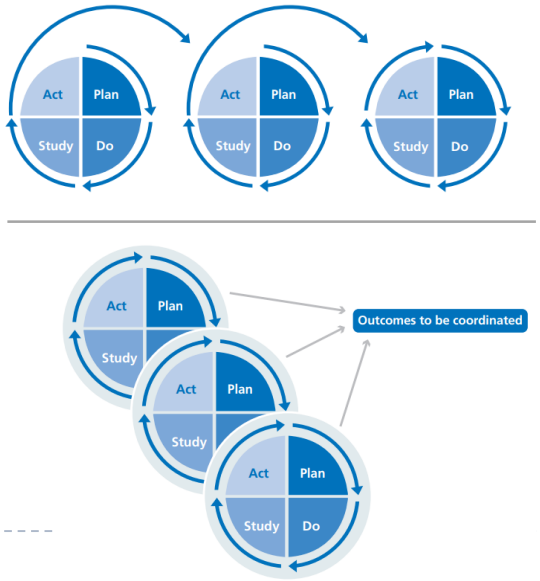
PDSA Model

The PDSA Model enables you to **test out changes on a small scale &** build on the learning from these test cycles.



☑ Test on a **really small scale**. For example, start with **one patient or one clinician at one afternoon clinic** and increase the numbers as you refine the ideas.

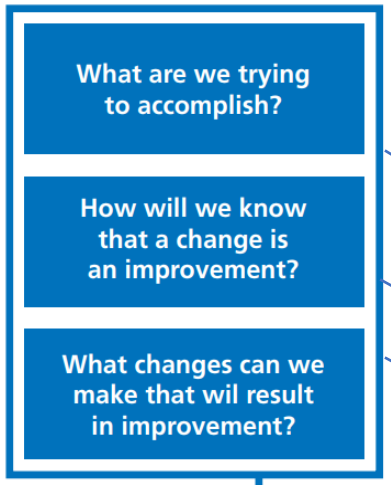
☑ Plan multiple cycles to test ideas.

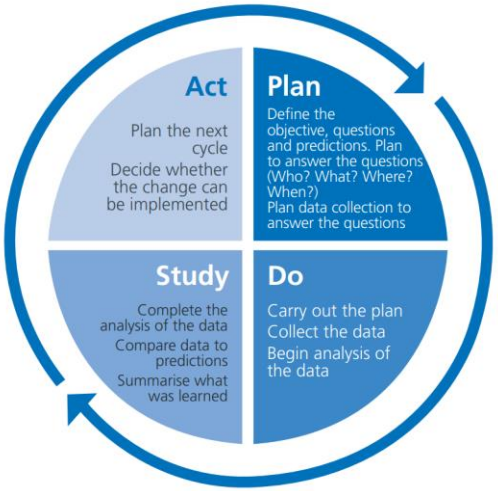


Only implement the idea when you're confident you have considered and tested the possible ways of achieving the change.

https://www.stepsforward.org/modules/pdsa-quality-improvement

PDSA Model & Change Management





Steps to take:

☑ **P: Plan** –

- Identify the team **& Initiate change management**
- Answer the 3 key questions:
  - Set aims – (MDPCP Functions/Requirements)
    - Clarify issues – (Brainstorm & Affinity diagram)
  - Establish measures – (Interim & final outcomes)
  - Select change initiative (Patient centered; Evidence-based)
    - Develop a plan: Process Mapping

☑ **D: Do** - Test Change(s) & Collect the data

☑ **S: Study** - Analysis the data & summarize lessons learned

☑ **A: Act** – Plan next steps …

- Another test of change cycle
- Implement changes & Spread changes

https://www.stepsforward.org/modules/pdsa-quality-improvement

Implementing PDSA: Worksheet

TEAM: **Date:**

AIM **Question you want answered with this test:**

Describe your first (or next) test of change	Person responsible	Time Frame	Where?

PLAN

List the tasks needed to set up this test of change	Person responsible	Due Date	Tools/Technology

DO **RUN THE TEST**

STUDY

Describe what actually happened when you ran the test

Describe the measured results and how they compared to the prediction(s) and what you learned from the cycle

ACT

Describe modifications for the next cycle based on what you learned

Implementing PDSA:
Example - Empanelment

TEAM: **Team A** [Dr. Lincs & LiLincs, MA] **Date:** March 1, 2019

AIM **Question you want answered with this test:** **Are all our patients are empaneled to a PCP and Care team?**

Describe your first (or next) test of change	Person responsible	Time Frame	Where?
1. Empanel all high-risk patients a) **Predicted Outcome**: Patients will be assigned to a PCP and a Care Manager b) **Patients Involved**: Practice high-risk patient population c) **Measure of Success:** Patient have an assigned PCP and CM in the EMR d) **Tracking**: Weekly team review of number of patients assigned	**Lead:** LiLincs, MA **Team**: Dr. Lincs, IT Support	03/1/2019 to 3/30/2019	Practice EMR/Office

PLAN

List the tasks needed to set up this test of change	Person responsible	Due Date	Tools/Technology
1. Assess & prepare team for change	LiLincs, MA	3/8/2019	Change Comm Plan
2. Develop a process or workflow	LiLincs, MA; Dr. Lincs	3/11/2019	Excel spreadsheet/Word
3. Review workflow with the team and assign roles	LiLincs, MA; Dr. Lincs	3/13/2019	EMR
4. Begin the test	LiLincs, MA	3/26/2019	EMR
5. Complete the test	LiLincs, MA	3/27/2019	EMR/Excel spreadsheet
6. Gather the results	LiLincs, MA; Dr. Lincs	3/27/2019	EMR/Excel spreadsheet
7. Study the results	Dr. Lincs	3/28/2019	
8. Decide on next step (new cycle or implement)			

DO **RUN THE TEST** Test ran as scheduled 03/08/19 to 3/26/2019

STUDY

Describe what actually happened when you ran the test

The test ran as planned however, we had to work with IT to make the care manager's name appear on the patient's profile.

Describe the measured results and how they compared to the prediction(s) and what you learned from the cycle

Result: 100% of the high-risk patients were empaneled; and this result was as predicted
Lessons Learned *(what went well? and what did not go well?)*:

1. Set time (about 30 - 45 mins) to review charts earlier in the day before patients start coming in for office visits OR after all office visits are completed
2. The MA is over-allocated because she is assigned to all patients and is solely responsible for prepping patients for office visits & post consult activities during the day. We need to secure additional CM support

ACT

Describe modifications for the next cycle based on what you learned

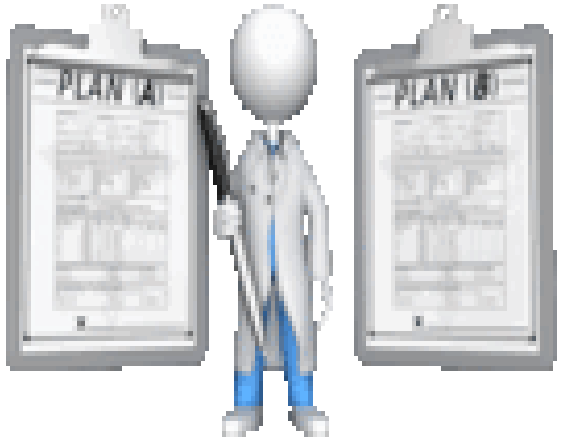
Decision: Move to the next PDSA cycle:
a. Empanel med-low risk patients to PCP
b. Seek additional CM support (and assign to patients)

Implementing PDSA: Change Management

PLAN			
List the tasks needed to set up this test of change	Person responsible	Due Date	Tools/Technology
1. Assess & prepare for change			▪ Communications plan ▪ Resistance management plan ▪ Readiness assessment ▪ Coaching plan ▪ Training plan

Preparing for & Implementing Change includes:

1. **Sponsor Engagement**
2. **Targeted Communications**
3. **Resistance Management**
4. **Readiness Assessment**
5. **Coaching**
6. **Training**



You should have a plan in place for these key elements listed above.

Implementing PDSA: Change Management – Communications Plan

Sample Communication Plan to manage Change

Timing	Audience	Message content	Delivery mechanism	Sender	Date and time
A. Initiation & Early stage of change	**Practice Staff**	▪ Why the potential change? ▪ What is the risk of not change? ▪ Solicit feedback	▪ Face-to-Face meeting (≥1x) ▪ Email updates	**Practice Leader & Supervisor(s)**	Set dates once a Test of change is identified ▪ F2F Meeting(s) ▪ Weekly email updates
B. At Start & During the Test of change	**Test Team**	Share aim & objectives; timeline & projected impact	▪ Face-to-Face (F2F) meetings (Weekly for duration of testing) ▪ Individual/team coaching	**Test Team Lead**	▪ F2F weekly meetings ▪ Coaching sessions
C. End of Test of change	**Test Team Practice Leader & Supervisor(s)**	▪ Discuss results & impact ▪ Decide on next steps	▪ Face-to-Face meeting (1–2x)	**Test Team Lead**	Set date at end of test ▪ F2F meeting(s)
	Practice Staff	▪ Decision made supported with results/findings	▪ Face-to-Face meeting (1x) (and/or conference call)	**Practice Leader & Supervisor(s)**	Set date at end of test ▪ F2F weekly meeting
▪ Decision A: Continue test of change; then begin steps A – C ▪ Decision B: Continue to Implementation, then begin steps D - F					
D. Before implementation	**Practice Staff**	▪ Change Decision ▪ Why the change is needed? ▪ Who will be impacted? ▪ WIIFM? ▪ **Readiness assessment** ▪ **Training plan**	▪ Face-to-Face meetings (2x) ▪ Email updates (weekly) ▪ Individual coaching sessions ▪ Group learning sessions	**Practice Leader & Supervisor(s)**	Set date for F2F once Implementation date is set *(Try to move as much team members to "desire" stage before setting an implementation date)* ▪ F2F weekly meetings ▪ Weekly emails ▪ Coaching/training sessions
E. During implementation	**Implementation Team**	▪ How are things going? What are the results? ▪ What are the gaps? ▪ Additional training needed? ▪ Reinforcement messages	▪ Face-to-Face meeting (2x) ▪ Email updates (weekly/biweekly depending on timeframe)	**Implementation Team Lead/ Supervisor(s)**	Set date for routine meetings ▪ Weekly meetings ▪ Weekly emails
F. Post-implementation	**Practice Staff**	Results, Reinforcement & next steps	▪ Face-to-Face meeting (≥1x) ▪ Email updates (biweekly/monthly/quarterly)	**Practice Leader & Supervisor(s)**	Set date as implementation wraps up ▪ F2F meeting ▪ Periodic updates (emails)

Implementing PDSA:
Change Management – Resistance to Change

Causes of Resistance

Organizational/Practice Context

- History with change – successes, failures, flavor of the month
- Practice's values & culture
- Change saturation and change capacity

Personal Context

- Personal and family situation
- Professional career history & plans
- Degree of personal impact of the change

Implementing PDSA:
Change Management - Managing Resistance

Managing Resistance

1. Don't spend too much time on those in hostility/disillusioned phase
2. Listen & understand objections
3. Focus on the **"What"** and let go of the "How"
4. Remove barriers
5. Provide simple, clear choices, & consequences
6. Create Hope (for the future)
7. Show the benefits in a real & tangible way
8. Make a personal appeal (works when there's a high degree of trust)
9. Converts the strongest dissenters
10. Demonstrate consequences
11. Provide incentives

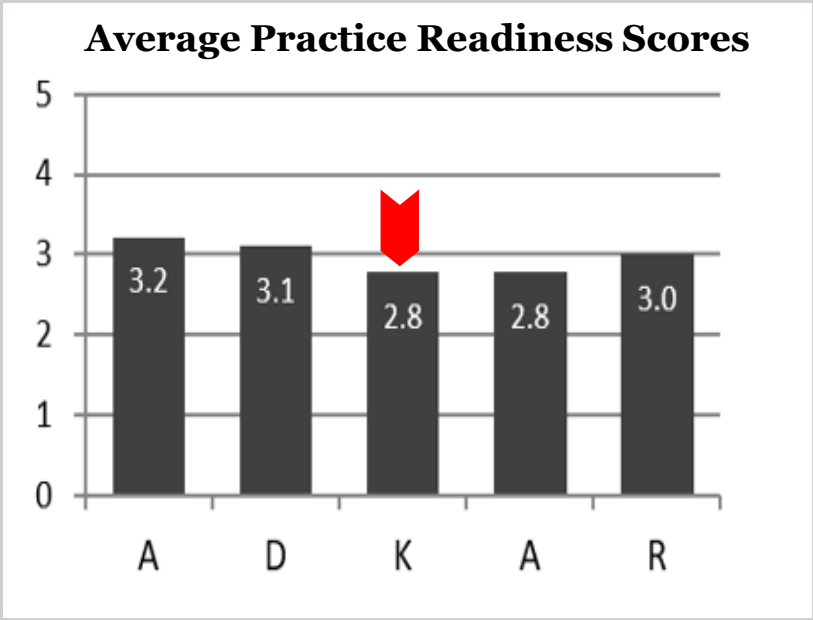
Implementing PDSA: Change Management – Readiness Assessment

Goal: Score of 3 or more

Individual Staff Readiness Scores

	A	D	K	A	R	Barrier Point
A	4	2	2	3	3	Desire
B	2	2	2	3	3	Awareness
C	1	1	2	2	3	Awareness
D	3	3	2	2	3	Awareness
E	4	4	4	3	3	Ability
F	4	4	4	3	3	Ability
G	4	4	3	3	3	Knowledge
H	5	5	3	3	3	Knowledge

Average Practice Readiness Scores

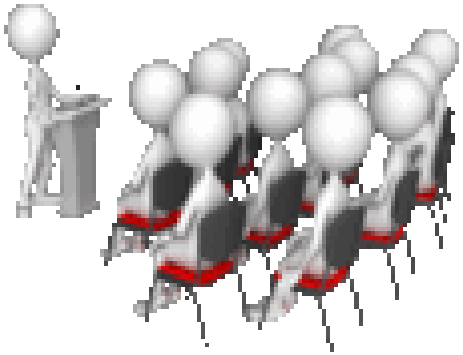


- **In this example, Awareness and Desire/Decide at above 3, so KNOWLEDGE seems to be the barrier point** and the next step here is to provide targeted Training for the staff.
  - *In this instance, expecting the team to successfully start testing the change/begin implementation (ACT) will be a less productive decision*

Implementing PDSA: Change Management – Coaching & Training

At State Level

- **Established learning system** with series of training on several topics – Webinars, Office hours, Peer-to-Peer learning, In-Person comprehensive training etc.
- For coaching, leverage **State Practice transformation coaches**



At Practice Level

A. **Identify different staff/care team roles** impacted
B. Conduct **needs assessment & gap analysis**; & documents training/coaching requirements
C. **Identify learning/training sessions** available (also check MDPCP Connect Calendar)
D. **Provide or refer staff for required training/coaching**
E. **Leverage CTO practice coaches**

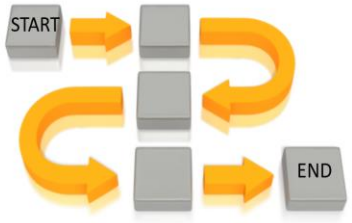
At Individual Level

- **Identify personal areas of improvement** & share with your supervisor
- **Proactively seek learning opportunities**
- **Attend training/coaching sessions**

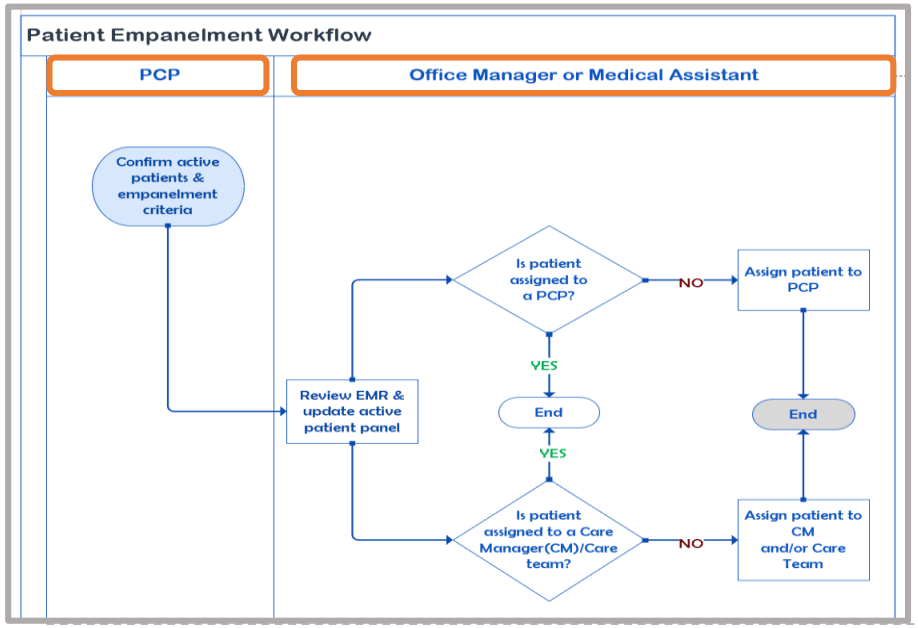
Implementing PDSA: Workflows

PLAN			
List the tasks needed to set up this test of change	Person responsible	Due Date	Tools/Technology
2. Develop process or workflow			Excel Spreadsheet or word/power point

Defining "Workflow" … the sequence of processes through which a piece of work passes from initiation to completion.



Option A



Option B

	Steps	Owner
1	Confirm active patients criteria	PCP
2	Review EMR & update active patient panel	MA/OM
3	Is patient assigned to a PCP? If, NO, assign to PCP	MA/OM
4	Is patient assigned to a CM and/or Care Team? If, NO, assign to CM and/or Care Team	MA/OM
	MA: Medical Assistant | OM: Office Manager | PCP: Primary Care Provider	

Implementing PDSA: Monitoring

PLAN			
List the tasks needed to set up this test of change	Person responsible	Due Date	Tools/Technology
6. Gather the results **7. Study the results**			Excel Spreadsheet & EMR

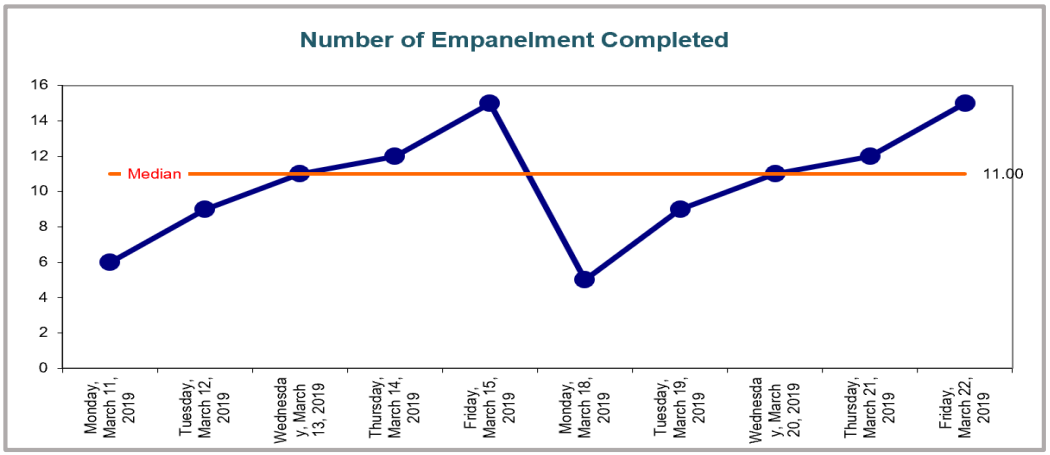
Gather Results – Data Collection

Patient Empanelment				
Patient Name	**Patient ID**	**DOB**	**Risk Tier**	**Completion Date**
Jane Doe	1-101	2/12/1950	High	3/11/2019
Doe James	1-102	2/13/1950	High	3/11/2019
Jane Doe 1	1-103	2/14/1950	High	3/11/2019
Doe James 1	1-104	2/15/1950	High	3/11/2019
Jane Doe 2	1-105	2/16/1950	High	3/11/2019
Doe James 2	1-106	2/17/1950	High	3/11/2019
Jane Doe 2	1-107	2/18/1950	High	3/11/2019
Doe James 2	1-108	2/19/1950	High	3/11/2019
Jane Doe 3	1-109	2/20/1950	High	3/12/2019
Doe James 3	1-110	2/21/1950	High	3/12/2019
Jane Doe 3	1-111	2/22/1950	High	3/12/2019
Doe James 3	1-112	2/23/1950	High	3/12/2019
Jane Doe 4	1-113	2/24/1950	High	3/12/2019
Doe James 4	1-114	2/25/1950	High	3/12/2019
Jane Doe 4	1-115	2/26/1950	High	3/13/2019
Doe James 4	1-116	2/27/1950	High	3/13/2019
Jane Doe 5	1-117	2/28/1950	High	3/13/2019
Doe James 5	1-118	3/1/1950	High	3/13/2019
Jane Doe 5	1-119	3/2/1950	High	3/13/2019
Doe James 5	1-120	3/3/1950	High	3/13/2019
Jane Doe 6	1-121	3/4/1950	High	3/13/2019
Doe James 6	1-122	3/5/1950	High	3/13/2019
Jane Doe 6	1-123	3/6/1950	High	3/13/2019
Doe James 6	1-124	3/7/1950	High	3/13/2019
Jane Doe 7	1-125	3/8/1950	High	3/13/2019
Doe James 7	1-126	3/9/1950	High	3/13/2019
Jane Doe 7	1-127	3/10/1950	High	3/14/2019
Doe James 7	1-128	3/11/1950	High	3/14/2019
ne Doe 8	1-129	3/12/1950	High	3/14/2019

Study the Results - Chart (Baseline)

What do we need to know? …

- ***How many high-risk patients were empaneled in the 2 weeks? And how many patient are remaining?***
- ***How many were empaneled per day? Was there any variations per day AND why?***
- ***How can we improve the process?***



❑ **Based on your observation, what is your decision on next steps?**

Session Recap

☑ Change Management Principles

- The process of change & where you may be in the process
- Walked through ways to adapt to changes while coordinating patient care

☑ Preparing for & Implementing Change:

- Sponsor Engagement
- Targeted Communications
- Resistance Management
- Readiness Assessment
- Coaching
- Training

☑ Quality Improvement

- Transformational culture
- PDSA Implementation
- How Change management is integrated in PDSA Implementation
- PDSA – Workflows, people, process, technology & tools

Post-survey

Questions:

After this session - on a scale of 1-5 how would you rate your knowledge on:

2. The process of change & where you are in the process
3. Ways to adapt to changes while coordinating patient care
4. Quality improvement process & PDSA

** Call to Action: What is your readiness level to try applying this knowledge at your practice?

Scale Key

1 = Fair
2 = Building
3 = Steady
4 = Strong
5 = Invincible

MARYLAND DEPARTMENT OF HEALTH

Session 3

Team Based Care
&
Implementing Improvement Processes

Nkem Okeke, MD, MPH, MBA, MSPM, CLSS, CCMP

Medicalincs LLC

September 2019

MARYLAND
Department of Health

Presenter

Nkem Okeke
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Chief Executive Officer, Medicalincs
Primary Care Transformation Expert

Disclosure Announcement

No disclosure directly related to this presentation

Session Objectives

Pre-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

5. The principles & benefits of team based care
6. The different team base structures (esp. in MDPCP)
7. Navigating team-based care

Scale Key

1 = Fair
2 = Building
3 = Steady
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Team-Based Care Principles

Principles of Team-Based Health Care

- **Shared goals:** The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.
- **Clear roles:** There are clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.
- **Mutual trust:** Team members earn each others' trust, creating strong norms of reciprocity and greater opportunities for shared achievement.
- **Effective communication:** The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.
- **Measurable processes and outcomes:** The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

SOURCE: October 2012 IOM Discussion Paper
"Core Principles & Values of Effective Team-Based Health Care"

Benefits of Team-Based Care

- Care transformation to team-based care requires **an investment**, both in the time to **develop new functions** and to establish **a new culture.**

However, once the initial investment is complete, the benefits of team-based care ensure its sustainability.

- **Benefits to Practice Team:**
  - ☑ improved provider and care team satisfaction
  - ☑ improved team communication, and
  - ☑ improved patient safety

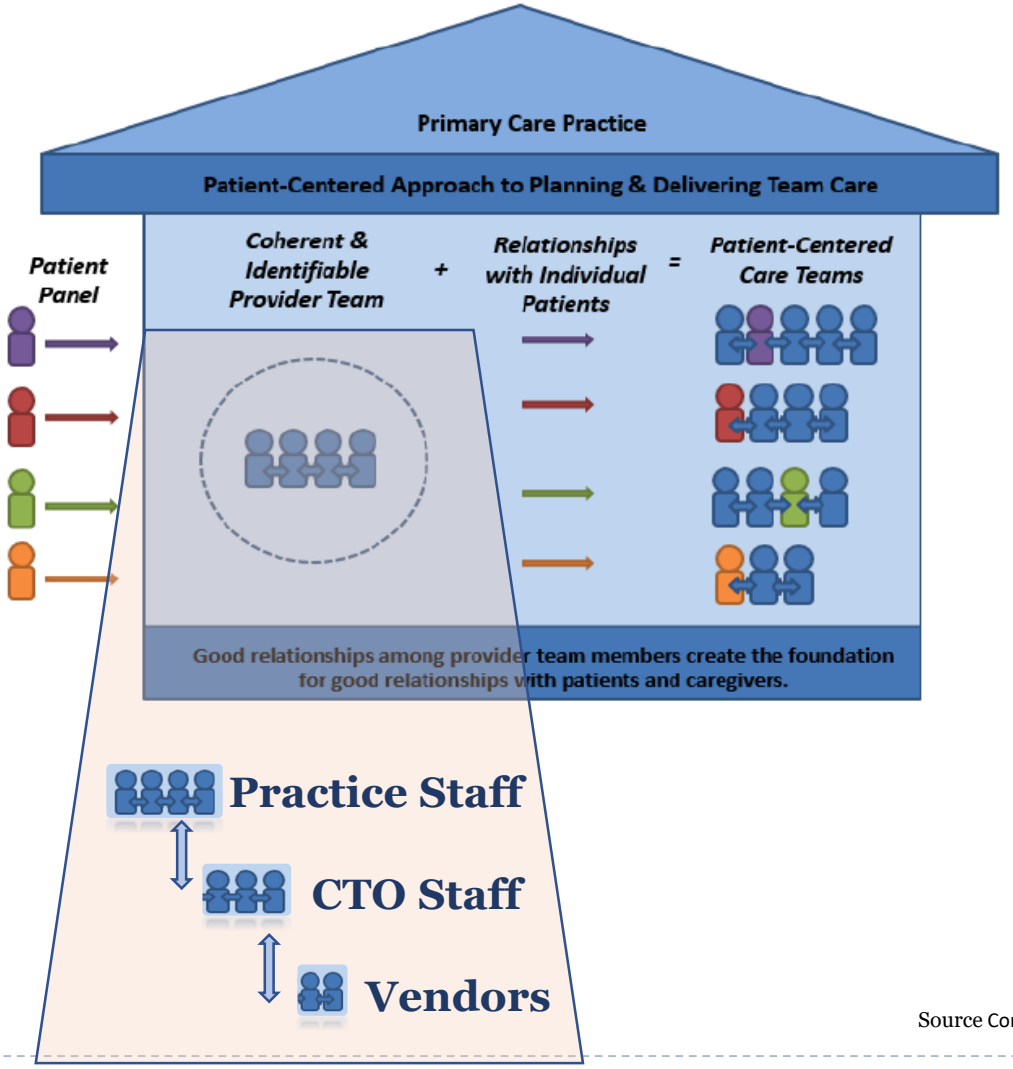
- **Benefits to Patients:**
  - ☑ proactive and timely access to appropriate preventive care
  - ☑ evidence-based management of chronic conditions, and
  - ☑ **improve patients' experience of care**

Patient Experience

According to the Beryl Institute …

Patient experience (PX) is "the **sum of all interactions**, shaped by an organization's culture, that influence patient perceptions, across the continuum of care"

Team-Based Care: Staff Mix (with MDPCP)



Source Conceptual blueprint - - AHRQ White Paper

Team-Based Care: Composition

Practice Team

Clinical Care Team

- ☑ Primary Care Provider
- ☑ Medical Assistant
- ☑ Registered Nurse
- ☑ Care Manager
- ☑ Social Worker
- ☑ Behavioral Health Specialist

Support Care Team

- ☑ Administrative Support
- ☑ QI Specialist
- ☑ Data Analyst
- ☑ IT Specialist
- ☑ Transformation Coach

Team-Building

Team building involves various types of activities used to enhance social relations and define roles within teams, often involving collaborative tasks

Team Building Steps:

- ❑ Explore the team – leaders, innovators, faster processors, decisive
- ❑ Identify the Tasks & the requirements
- ❑ Develop a vision (led by team leader)
- ❑ Perform as a team – build agenda

Benefits of Team Building

- Improve productivity
- Increase motivation
- Increased collaboration
- Encourage creativity
- Positive reinforcement
- Improved communication

Team Building starts with you …

- Know yourself and your goals; and articulate this information clearly and with enthusiasm
- Listen to others and discover what their goals and skills are
- Seek others' feedback, opinions, and collaboration; and Respond to others when asked for feedback, or collaboration

Conflict Resolution

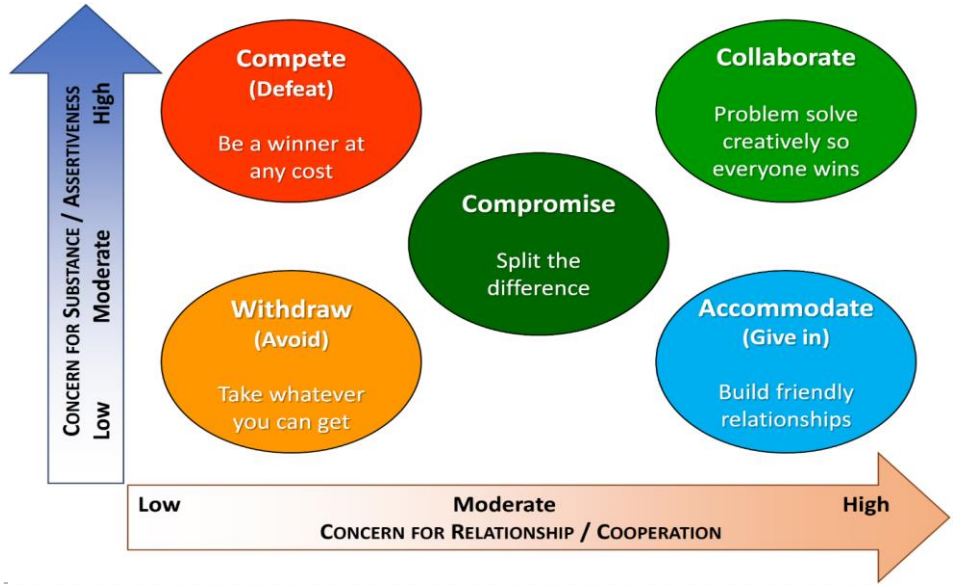
- Conflict natural parts of our lives, as well as the lives of every organization

- **Conflict resolution is a way for two or more parties to find a peaceful solution to a disagreement among them**. The disagreement may be personal, financial, political, or emotional

When a dispute arises, often the **best course of action is negotiation** to resolve the disagreement.

There are **seven steps** to successfully negotiating the resolution of a conflict:

- Understand the conflict
- Communicate with the opposition
- Brainstorm possible resolutions
- Choose the best resolution
- Use a third party mediator
- Explore alternatives



Session Recap

☑ The principles & benefits of team based care

☑ The different team base structures (esp. in MDPCP)

☑ Navigating team-based care:

- *Building Relationships*
- *Team Communication*
- *Dealing with Conflict*

Questions??

Post-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

5. The principles & benefits of team based care
6. The different team base structures (esp. in MDPCP)
7. Navigating team-based care

** Call to Action: What is your readiness level to try applying this knowledge at your practice?

Scale Key

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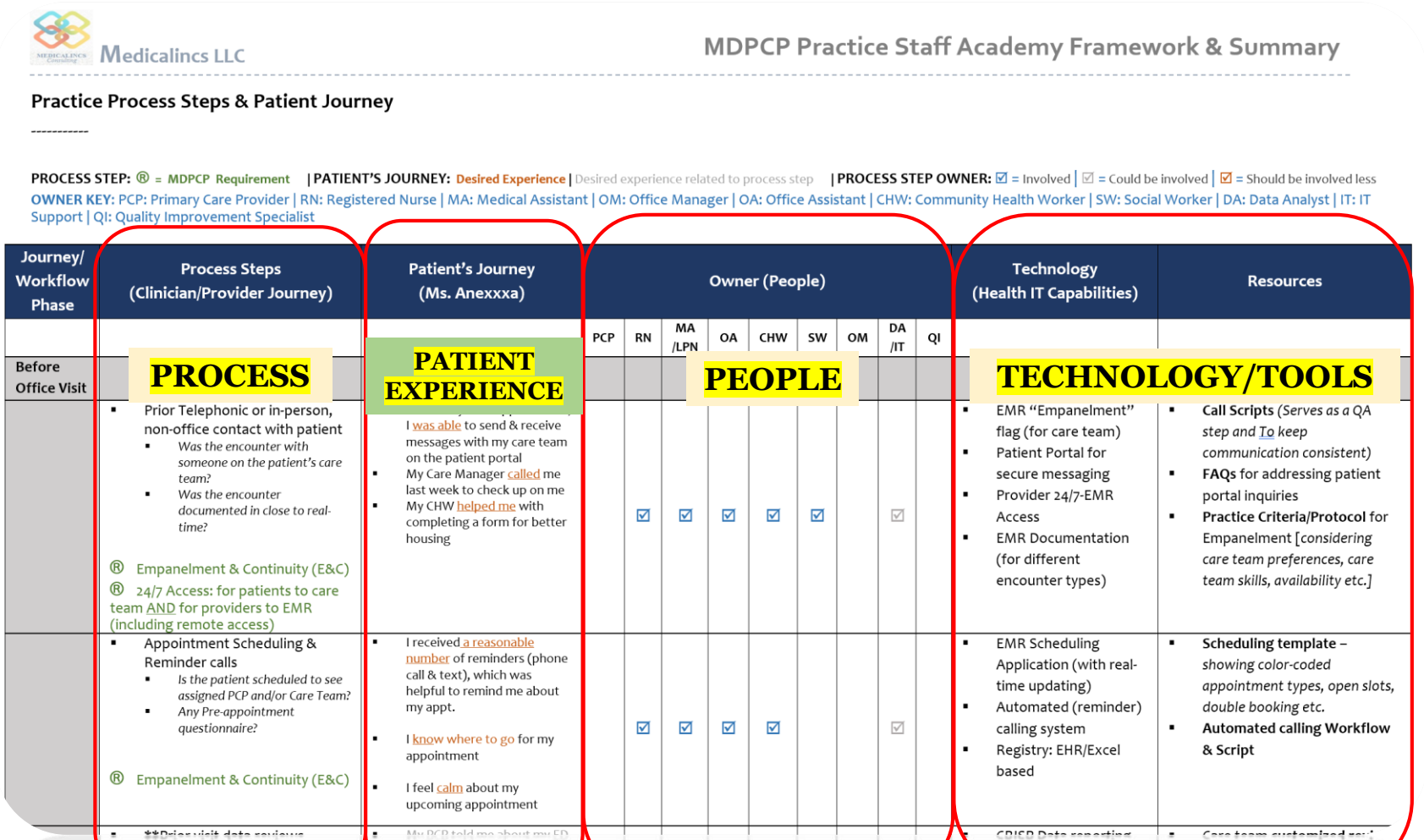
Patient Care Framework

MARYLAND
Department of Health

Care Transformation Journey with the Patient: Framework



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MDPCP Practice Staff Academy Framework & Summary

Practice Process Steps & Patient Journey

PROCESS STEP: ® = MDPCP Requirement | **PATIENT'S JOURNEY:** Desired Experience | Desired experience related to process step | **PROCESS STEP OWNER:** ☑ = Involved | ☑ = Could be involved | ☑ = Should be involved less

OWNER KEY: PCP: Primary Care Provider | RN: Registered Nurse | MA: Medical Assistant | OM: Office Manager | OA: Office Assistant | CHW: Community Health Worker | SW: Social Worker | DA: Data Analyst | IT: IT Support | QI: Quality Improvement Specialist

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)									Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
Before Office Visit	**PROCESS**	**PATIENT EXPERIENCE**					**PEOPLE**					**TECHNOLOGY/TOOLS**	
	▪ Prior Telephonic or in-person, non-office contact with patient ▪ *Was the encounter with someone on the patient's care team?* ▪ *Was the encounter documented in close to real-time?* ® Empanelment & Continuity (E&C) ® 24/7 Access: for patients to care team AND for providers to EMR (including remote access)	▪ I was able to send & receive messages with my care team on the patient portal ▪ My Care Manager called me last week to check up on me ▪ My CHW helped me with completing a form for better housing		☑	☑	☑	☑	☑		☑		▪ EMR "Empanelment" flag (for care team) ▪ Patient Portal for secure messaging ▪ Provider 24/7-EMR Access ▪ EMR Documentation (for different encounter types)	▪ **Call Scripts** *(Serves as a QA step and To keep communication consistent)* ▪ **FAQs** for addressing patient portal inquiries ▪ **Practice Criteria/Protocol** for Empanelment [*considering care team preferences, care team skills, availability etc.*]
	▪ Appointment Scheduling & Reminder calls ▪ *Is the patient scheduled to see assigned PCP and/or Care Team?* ▪ *Any Pre-appointment questionnaire?* ® Empanelment & Continuity (E&C)	▪ I received a reasonable number of reminders (phone call & text), which was helpful to remind me about my appt. ▪ I know where to go for my appointment ▪ I feel calm about my upcoming appointment		☑	☑	☑	☑			☑		▪ EMR Scheduling Application (with real-time updating) ▪ Automated (reminder) calling system ▪ Registry: EHR/Excel based	▪ **Scheduling template** – *showing color-coded appointment types, open slots, double booking etc.* ▪ **Automated calling Workflow & Script**
	▪ **Prior visit data reviews**	▪ My PCP told me about my ED										▪ CRISP Data reporting	▪ Care team customized rou

Care Transformation Journey with the Patient: Test Patient

Ms. Anexxa, 71-year old Medicare beneficiary

Clinical Profile — CLINICAL PROFILE

- Type II Diabetes
- Long standing Hypertension (Last BP: 140/90 mmHg)
- CHF following a heart attack from 3 years prior
- Dependent on Opioid – which started after pain management for a hip fracture 4 years earlier
- Other Medications: Metformin 500 mg daily; Enalapril 30 mg/day PO qd; Aspirin 81 mg PO qd ; Lovastatin 40 mg PO qd
- Lifestyle modifications: Exercise - 30 mins moderate-intensity aerobic activity – 5d/week, Nutrition therapy (DASH diet)

Social Profile — SOCIAL PROFILE

- Retired widow who lives alone and her son lives 5 hours away & uses public transportation
- High school education; Worked as a kitchen staff in a school cafeteria; On fixed income
- She has no fresh food at home – due to her recent stay for 4 days in the hospital
- Experiences other care transition challenges such as: Off-road options, snapshot treatment, diminished ability and increased responsibility

Personality/Behavior Profile — PERSONALITY PROFILE

- She is an extrovert, usually lively, a "people person" and does not like to be alone
- Enjoys attending group meetings when she can (e.g. Diabetes group)
- Does not exercise much and tries to maintain good eating habit
- She engages well with her peers and encourages them through life challenges

Utilization Profile (last 6m) — UTILIZATION PROFILE

- 5 ED visits
- 2 Hospitalizations
- Most recent hospitalization after being treated for uncontrolled CHF & unaware of 2 of the 3 new prescriptions b/c they were electronically sent to the pharmacy

Cost (Utilization) — UTILIZATION COST

- Short term hospital – $27,000
- ER - $7,500

Total ED & Hosp (last 6m) - $34,500

Care Transformation Journey with the Patient:
Test Practice

Healthlincs Primary Care

(Based on an actual MDPCP Practice's Profile)

Practice Type: Independent

Location: Glen Burnie, MD

 # Practitioners: 4 [1 PCP, 1 NP, 2 PA]

 # Support Staff: 6 [3 MA, 1 LPN, 1 OM, 1 AOM]

# of MDPCP Beneficiaries: ~ 800

# of Patients: ~ 8,000

Dr. Lincs (PCP)

MARYLAND DEPARTMENT OF HEALTH

Session 4

The Patient Care Journey

Phase I: Patient Care BEFORE the Visit

MARYLAND
Department of Health

Presenters

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Care Management Subject Matter Expert,
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MD, MPH, MBA, MSPM, CCMP

Chief Executive Officer, Medicalincs
Primary Care Transformation Expert

Disclosure Statement

No disclosure directly related to this presentation

Phase I Overview:
Before the Office Visit

A	▪ **Prior Telephonic or in-person, non-office contact with patient** ▪ *Was the encounter with someone on the patient's care team?* ▪ *Was the encounter documented in close to real-time?* ® Empanelment & Continuity (E&C) ® 24/7 Access: for patients to care team AND for providers to EMR (including remote access)
B	▪ **Appointment Scheduling & Reminder calls** ▪ *Is the patient scheduled to see assigned PCP and/or Care Team?* ▪ *Any Pre-appointment questionnaire?* ® Empanelment & Continuity (E&C)
C	▪ ****Prior visit data reviews (population & individual data/reports)** ▪ *Is the patient scheduled to see assigned PCP and/or Care Team?* ▪ *Do you perform routine panel empanelment optimization? – Dead patients, New physician etc.* ® Empanelment & Continuity (E&C) ® Data driven care improvement (Data) ® Risk Stratification (RS)
D	▪ **Pre-visit huddle (medical records review)** ▪ *Frequency – daily or weekly* ▪ *Agenda – driven by utilization review? disease-specific patient cohort? PCP weekly schedule?*

Session Objectives

Understand the following concepts applied during Phase I:

- ☑ Workflow: People, Process & Technology/Tools
- ☑ Interdisciplinary Teams/Care Team Roles
- ☑ Team Huddles
- ☑ EMR tools for empanelment
- ☑ CRISP tools for risk stratification
- ☑ Minimum data sets necessary for hand-offs
- ☑ Proper & secure documentation for each transition of care

Pre-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

8. Interdisciplinary Teams/Care Team Roles
9. Team Huddles
10. Minimum data sets necessary for huddles
11. Empanelment
12. Risk Stratification

Scale Key

1 = Fair
2 = Building
3 = Steady
4 = Strong
5 = Invincible

Interdisciplinary Team Overview

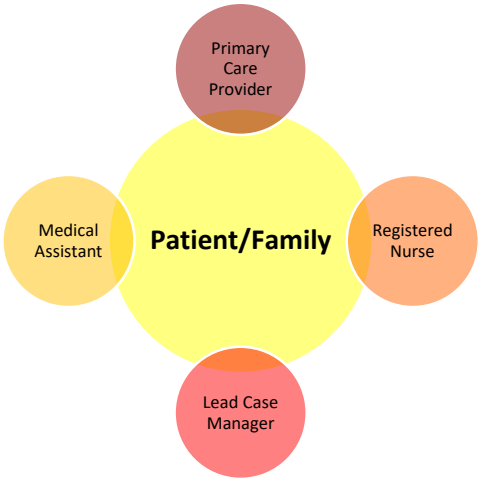
The Value of Team Based Care

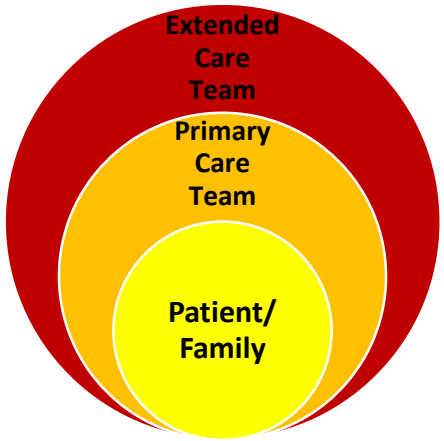
Interdisciplinary Teams *(Contd.)*

Why are they important?

- ☑ Deliver comprehensive care
- ☑ Increased productivity
- ☑ Improved health outcomes
- ☑ Decreased cost/Increased healthcare savings
- ☑ Increased patient satisfaction
- ☑ Effective collaboration and use of resources
- ☑ Satisfaction among team members
- ☑ Improved patient safety

Care Team Roles





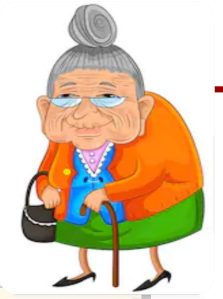
Primary Team

- Primary Care Provider
- Medical Assistant (Care Coordinator)
- Registered Nurse (Support/Practice CM)
- Lead Case Manager (CTO RN)

Extended Team

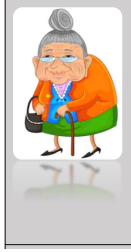
- Community Health Worker
- Social Worker
- Behavioral Health Specialist
- Health Coach
- Pharmacist
- Diabetic Educator
- Specialist

Our Patient: Ms. Anexxa, 71-year old Medicare beneficiary



Clinical Profile
▪ Type II Diabetes
▪ Long standing Hypertension (Last BP: 140/90 mmHg)
▪ CHF following a heart attack from 3 years prior
▪ Dependent on Opioid – which started after pain management for a hip fracture 4 years earlier
▪ Other Medications: Metformin 500 mg daily; Enalapril 30 mg/day PO qd; Aspirin 81 mg PO qd ; Lovastatin 40 mg PO qd
▪ Lifestyle modifications: Exercise - 30 mins moderate-intensity aerobic activity – 5d/week, Nutrition therapy (DASH diet)
Social Profile
▪ Retired widow who lives alone and her son lives 5 hours away & uses public transportation
▪ High school education; Worked as a kitchen staff in a school cafeteria; On fixed income
▪ She has no fresh food at home – due to her recent stay for 4 days in the hospital
▪ Experiences other care transition challenges such as: Off-road options, snapshot treatment, diminished ability and increased responsibility
Personality/Behavior Profile
▪ She is an extrovert, usually lively, a "people person" and does not like to be alone
▪ Enjoys attending group meetings when she can (e.g. Diabetes group)
▪ Does not exercise much and tries to maintain good eating habit
▪ She engages well with her peers and encourages them through life challenges
Utilization Profile (last 6m)
▪ 5 ED visits
▪ 2 Hospitalizations
▪ Most recent hospitalization after being treated for uncontrolled CHF & unaware of 2 of the 3 new prescriptions b/c they were electronically sent to the pharmacy
Cost (Utilization)
▪ Short term hospital – $27,000
▪ ER - $7,500
Total ED & Hosp (last 6m) - $34,500

Phase I, Step A: Prior Encounter(s) with Ms. Anexxa

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)									Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
Before Office Visit													
	▪ Prior Telephonic or in-person, non-office contact with patient ▪ *Was the encounter with someone on the patient's care team?* ▪ *Was the encounter documented in close to real-time?* ® Empanelment & Continuity (E&C) ® 24/7 Access: for patients to care team AND for providers to EMR (including remote access)	▪ Before my next appointment, I was able to send & receive messages with my care team on the patient portal ▪ My Care Manager called me last week to check up on me ▪ My CHW helped me with completing a form for better housing		☑	☑	☑	☑	☑		☑		▪ EMR "Empanelment" flag (for care team) ▪ Patient Portal for secure messaging ▪ Provider 24/7-EMR Access ▪ EMR Documentation (for different encounter types)	▪ **Call Scripts** *(Serves as a QA step and To keep communication consistent)* ▪ **FAQs** for addressing patient portal inquiries ▪ **Practice Criteria/Protocol** for Empanelment [*considering care team preferences, care team skills, availability etc.*]

- The Care Team's encounter with Ms. Anexxa occurs in multiples ways before her next doctor's visit ***(24/7 Access)***
- We need to ensure that Ms. Anexxa (and other patients) are empaneled to a care team to promote a more comprehensive encounter – phone, secure messaging etc. ***(Empanelment)***

Ms. Anexxa's experience captured here – shows that she is happy to have access to members on her care team and even when they contact her before her office visit.

- Workflow here should capture key things like your practice's process for empanelment, responding to questions on the patient portal etc. ***(Quality Improvement)***

Patient Empanelment Process

Know your "Why"

- ☑ Empanelment **promotes continuity of care**
- ☑ Builds trusting patient-provider relationship & **promotes better health outcomes**
- ☑ Increases **provider satisfaction** by effective use of time & effort
- ☑ Improves **patient satisfaction**
- ☑ Facilitates panel-level population management

Patient Empanelment Process – Example 1

Empanelment Steps	Primary Care Practice A
Identify active patients/beneficiaries	Active patients are identified: ▪ 24 m look back period using EMR data

Empanel patients to practitioners and/or care teams	**A. Empanelment criteria:**
	▪ Care team composition: 1 PCP, 1 MA, 1 Front desk staff
	▪ *Extended (CTO) care team: 1 Data Analyst (OM/DA), 1 Care Manager*
	▪ Provider : Patient ratio?
	  ▪ PCP – 4000
	  ▪ MA – 4000
	  ▪ CTO RN: 2000
	▪ Assigning high-risk patients? PCP? CM? Other?
	  ▪ MD assigned to all patients
	  ▪ Lead CM is assigned all high-risk patients (up to 2000)
	  ▪ Support CM/Front desk staff: support lead CM with episodic care management
	  ▪ Patient's preference also considered
	B. Empanel Patients: Assigned in EMR (Appears on patient's profile)
	C. Panel Review – Frequency? Process?
	  ▪ Frequency: Every year
	  ▪ Process: DA helps to identify active patients & patients are reassigned as needed based on empanelment criteria above

Measure & Optimize Continuity	▪ Easy to assess due to care team composition

Patient Empanelment Process: Example 2

Empanelment Steps	Healthlincs Primary Care Practice
Identify active patients/beneficiaries	Active patients are identified: ▪ 24 m look back period using EMR data
Empanel patients to practitioners and/or care teams	**A. Empanelment criteria:** ▪ Care team: 1 PCP, 1 NP, 2 PA, 1 RN, 3 MA, 1 LPN ○ *Extended care team: 1 Office Manager/Data Analyst (OM/DA), 1 Office Assistant Manager (front desk)* ▪ Provider : Patient ratio? ▪ PCP – 1500 (8000) ▪ NP/PA - 2000 ▪ RN - 2000 ▪ Assigning high-risk patients? PCP? CM? Other? ▪ MD assigned 90% of high-risk patients ▪ More senior/experience PA/NP panel is assigned remaining 10% high-risk patients ▪ Lead CM is assigned all high-risk patients (up to 2000) ▪ Each lead CM is assigned a support MA to manage caseload ▪ Patient's preference also considered **B. Empanel Patients:** Assigned in EMR (Appears on patient's profile) **C. Panel Review – Frequency? Process?** ▪ Frequency: Every 6 months (and ad-hoc with staff changes) ▪ Process: DA helps to identify active patients & patients are reassigned as needed based on empanelment criteria above
Measure & Optimize Continuity	▪ What is the preferred method of measuring continuity? ▪ Provider-Centric Continuity ▪ How often is continuity measured? Semi-annually

Ms. Anexxa is assigned to a Care Team:
PCP – Dr. Lincs (MD); Lead CM (RN); and 1 Support CM (MA)

Phase I, Step B: Appointment Scheduling & Reminder calls

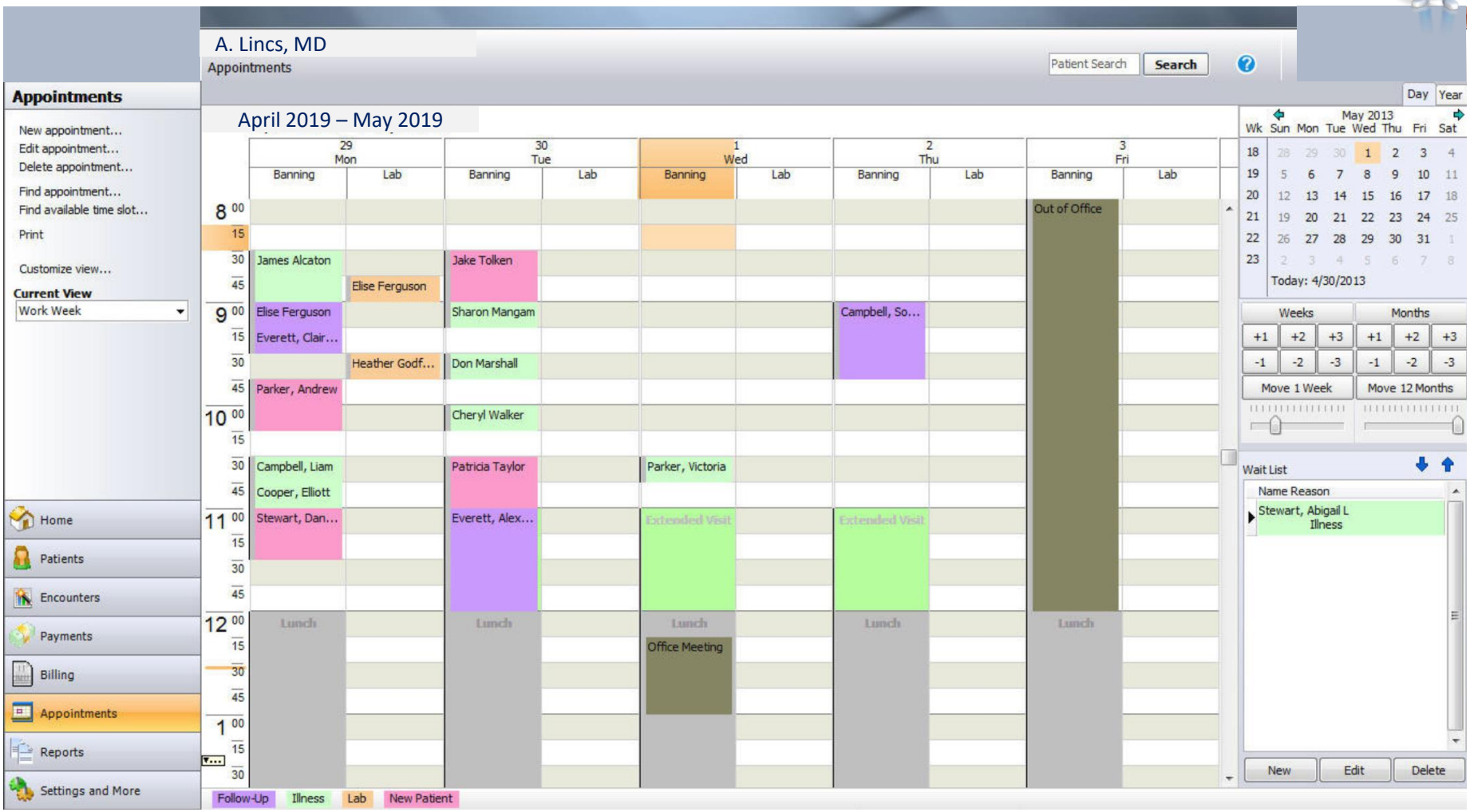
Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)								Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
	▪ Appointment Scheduling & Reminder calls ▪ *Is the patient scheduled to see assigned PCP and/or Care Team?* ▪ *Any Pre-appointment questionnaire?* ® Empanelment & Continuity (E&C)	▪ I received a reasonable number of reminders (phone call & text), which was helpful to remind me about my appt. ▪ I know where to go for my appointment ▪ I feel calm about my upcoming appointment		☑	☑	☑	☑			☑		▪ EMR Scheduling Application (with real-time updating) ▪ Automated (reminder) calling system ▪ Registry: EHR/Excel based	▪ **Scheduling template** – *showing color-coded appointment types, open slots, double booking etc.* ▪ **Automated calling Workflow & Script**

- Ms. Anexxa has is scheduled for a doctor's visit in 2 days with Dr. Lincs. The visit type is "Established patient – Follow up" – as indicated by the **PURPLE CODE** in the EMR scheduling template ***(Continuity)***

- Ms. Anexxa received reminder calls from her doctor's office. She also received a text message to confirm that she'll be attending the visit & she confirmed

Ms. Anexxa's experience captured here – shows that she is happy with the number of reminders she got and the details of her appointment.

Scheduling Template

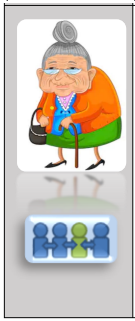


***Fictious Patient names shown*

Appointment Types:

- *Follow-up*
- *Illness*
- *Lab*
- *New Patient*

Phase I, Step C: Prior Visit Data/Report Reviews

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)								Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
	▪ **Prior visit data reviews (population & individual data/reports) ▪ *Is the patient scheduled to see assigned PCP and/or Care Team?* ▪ *Do you perform routine panel empanelment optimization? – Dead patients, New physician etc.* ® Empanelment & Continuity (E&C) ® Data driven care improvement (Data) ® Risk Stratification (RS)	▪ My PCP told me about my ED visit/hospitalization and BP trend; it is good to know my progress is monitored	☑	☑	☑				☑	☑	☑	▪ CRISP Data reporting portal ▪ Other payer reporting portal ▪ EMR reporting portal/dashboards	▪ Care team **customized review reports –** *outlining benchmarks and outcomes* ▪ Defined measure criteria – e.g. risk scores, key measures etc.

- Care Team review different patient panel reports. Some reports are reviewed on a daily, weekly, monthly, and quarterly basis. Examples are: Disease-specific or eCQM-specific EMR Dashboard, Care team Panel scheduled for office visits in the coming week, CRISP report, ENS notification/report etc. ***(Data Driven Care Improvement)***

Reviewing Ms. Anexxa's utilization and clinical data, will elicit a positive experience from Ms. Anexxa's later on in the process because … the doctor is able to communicate her progress with her comprehensively and recommend appropriate treatment modalities

- Attribution list and current risk scores are reviewed – Algorithm-Based ***(Risk Stratification – Step 1)***

Risk Stratification

Know your "Why"

- ☑ Provides an actionable view into the needs of the patient population
- ☑ **Target resources** to your patients demonstrating the greatest needs
- ☑ Supports your efforts to address **care management needs of high-or rising-risk patients**
- ☑ Supports your efforts to **address preventive care needs of low-risk patients**

Risk Stratification – Algorithm

- Algorithm-based risk stratification is the first step of risk stratification.
- It is based on defined diagnoses, claims, or other electronic data allowing population-level stratification.

- There are a variety of algorithm-based methods available, using utilization, co-morbid conditions, EHR, and claims data.
- **In MDPCP, CRISP data (utilization & cost) provides a great risk stratification framework you can use; and it is updated monthly.**

Risk Stratification – Factors

High Risk

Pre-defined Risk : Top Quartile (HCC, EHR, etc.)

Utilization:
- 3 or more ED visits
- Any admission
- 1 hospitalization related to chronic conditions
- Admission to hospice or palliative care

Clinical:
- 1 unstable BH diagnosis
- 2 or more stable BH diagnosis
- 3 or more active chronic conditions
- Active Cancer
- Clinical metrics out of normal range (A1C >9)

Medium Risk

Pre-defined Risk: 2nd and 3rd Quartile (HCC, EHR, etc.)

Utilization:
- 1 ED visit related to chronic condition
- Any hospitalization

Clinical:
- 1 stable BH diagnosis
- Less than 3 active chronic conditions
- History of Cancer
- Clinical metric moderately out of normal range (A1C < 9)

Low Risk

Pre-defined Risk: Bottom Quartile (HCC, EHR, etc.)

Utilization:
- No ED visits or hospitalizations

Clinical:
- No Chronic medical or BH conditions

Risk Stratification – Clinical Intuition

- Clinical intuition is simply adjusting the risk score based on information not available through the structured fields and data sources the algorithm uses.

- May include:
  - *patients' social needs*
  - *health literacy*
  - *activation*
  - *family or caregiver support*
  - *behavioral or medical need*

Risk Stratifying Ms. Anexxa

QR
CTO/Coach Support

High Risk

Pre-defined Risk : Top Quartile (HCC, EHR, etc.)

Utilization:

- 3 or more ED visits
- Any admission
- 1 hospitalization related to chronic conditions
- Admission to hospice or palliative care

Utilization Profile (last 6m)
▪ 5 ED visits
▪ 2 Hospitalizations
▪ Most recent hospitalization after being treated for uncontrolled CHF & unaware of 2 of the 3 new prescriptions b/c they were electronically sent to the pharmacy

Clinical:

- 1 unstable BH diagnosis
- 2 or more stable BH diagnosis
- 3 or more active chronic conditions
- Active Cancer
- Clinical metrics out of normal range (A1C >9)

Clinical Profile
▪ Type II Diabetes
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▪ Dependent on Opioid – which started after pain management for a hip fracture 4 years earlier
▪ Other Medications: Metformin 500 mg daily; Enalapril 30 mg/day PO qd; Aspirin 81 mg PO qd ; Lovastatin 40 mg PO qd
▪ Lifestyle modifications: Exercise - 30 mins moderate-intensity aerobic activity – 5d/week, Nutrition therapy (DASH diet)

Risk Stratifying – PDSA Example

QUESTION: How can we be sure we are capturing the most appropriate patient risk levels?

Test of Change: Create an efficient risk stratification process to capture empaneled patients

Plan: Identify risk stratification criteria & Who will perform the risk stratification

Do: 1) Risk stratify empaneled patients using CRISP data.

a. low risk- no ER visits/hospitalizations in past 6 months

b. medium risk- 1-3 ER visits/hospitalizations in past 6 months

c. high risk- > 3 ER visits/hospitalizations in past 6 months.

2) Use SDOH/Clinical Information/EHR as a secondary sources of identifying risks

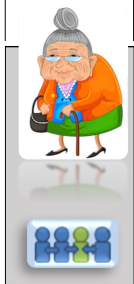
Study: 1) How do the two risk stratification sources compare when used alone?

2) The number of empaneled patients without CRISP utilization that stratify as high-risk based on SDOH/EHR/Clinical Information.

3) The number of empaneled patients with CRISP high-risk utilization that have not had a visit within the last 3 months

Act: Use at least two sources to refine the risk stratification process of empaneled patients to ensure the appropriate resources are used to improve patient engagement, outcomes and satisfaction.

Phase I, Step D: Pre-visit Huddle

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)									Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
	▪ Pre-visit huddle (medical records review) ▪ *Frequency – daily or weekly* ▪ *Agenda – driven by utilization review? disease-specific patient cohort? PCP weekly schedule?*	▪ My PCP/Care team seem to be collaborating well to provide me the best care; my PCP did not ask me all of the same questions the MA just asked me a few minutes ago & my CHW asked me last week	☑	☑	☑		☑	☑				▪ EMR ▪ Macro-enabled Excel reports	▪ **Care team huddle template and/or agenda**

- This step builds on the previous step. Care Teams conduct a pre-visit huddle to specifically discuss patient on their panel to review patients' care needs. Some care teams huddle daily or weekly

- The healthlincs team discussed Ms. Anexxa's status 1 day prior to her office visit. Her CM realized amongst other things that we was eligible for an AWV and BH Screening; so the team will send out a message to notify her that these will be done in her office visit tomorrow. ***(Data Driven Care Improvement)***

The efforts made here will elicit a positive experience from Ms. Anexxa's later in the process because she will not be asked the same questions multiple times & feels like her care team "knows" her.

Team Huddle Overview

Huddles: Structure

- ☑ An evidenced-based tool
- ☑ Used by the primary care team
- ☑ Should occur daily
- ☑ Should have an agenda
- ☑ Should be less than 10 minutes
- ☑ Should discuss/call-out care needs for visit

Team Huddle: Agenda

Team huddle checklist

Use this modifiable checklist to lead your team through efficient, effective huddles at the beginning of the clinic day or session.

Date:	Start time:
Huddle leader:	
Team members in attendance:	
Check in with the team	
	How is everyone doing?
	Are there any anticipated staffing issues for the day?
	Is anyone on the team out / planning to leave early / have upcoming vacation?
Huddle agenda	
	Review today's schedule
	Identify scheduling opportunities • Same-day appointment capacity • Urgent care visits requested • Recent cancellations • Recent hospital discharge follow-ups
	Determine any special patient needs for clinic day • Patients who are having a procedure done and need special exam room setup • Patients who may require a health educator, social work or behavioral health visit while at the practice • Patients who are returning after diagnostic work or other referral(s)
	Identify patients who need care outside of a scheduled visit
	Determine patient needs and follow up • Patients recently discharged from the hospital who require follow up • Patients who are overdue for chronic or preventive care • Patients who recently missed an appointment and need to be rescheduled
	Share a shout-out and/or patient compliment
	Share important reminders about practice changes, policy implementation or downtimes for the day
	End on a positive, team-oriented note • Thank everyone for being present at the huddle
	Huddle end time:

Source: AMA. Practice transformation series: implementing a daily team huddle. 2015.

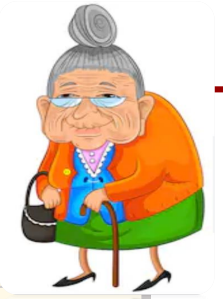
Team Huddle: Template

Huddle Warm-Up

Scrub Report for:______________________ Clinic Date: ______________ Completed by: __________

Appt Time	Last Name/ Last 4 MR	New or F/U Last seen?	Confirmed Appt	Pre-Clinic Labs	Pertinent Lab Values	Screening/ Immunizations Needed	Health Coaching/ Patient Concerns/ Consults/Etc.	FOLLOW UP (Post Huddle or Appt)
		D New Patient D F/U last Seen:	D Yes D No D Cancelled D Resched	D Completed D Not Done D Pt called D N/A-no orders		D Td / TdaP D CRC D Pneumovax D Mammo D Influenza/H1N1 D Pap D Other:		
		D New Patient D F/U last seen:	D Yes D No D Cancelled D Resched	D Completed D Not Done D Pt called D N/A-no orders		D Td / TdaP D CRC D Pneumovax D Mammo D Influenza/H1N1 D Pap D Other:		
		D New Patient D F/U last seen:	D Yes D No D Cancelled D Resched	D Completed D Not Done D Pt called D N/A-no orders		D Td / TdaP D CRC D Pneumovax D Mammo D Influenza/H1N1 D Pap D Other:		
		D New Patient D F/U last seen:	D Yes D No D Cancelled D Resched	D Completed D Not Done D Pt called D N/A-no orders		D Td / TdaP D CRC D Pneumovax D Mammo D Influenza/H1N1 D Pap D Other:		
		D New Patient D F/U last seen:	D Yes D No D Cancelled D Resched	D Completed D Not Done D Pt called D N/A-no orders		D Td / TdaP D CRC D Pneumovax D Mammo D Influenza/H1N1 D Pap D Other:		
		D New Patient D F/U last seen:	D Yes D No D Cancelled D Resched	D Completed D Not Done D Pt called D N/A-no orders		D Td / TdaP D CRC D Pneumovax D Mammo D Influenza/H1N1 D Pap D Other:		
		D New Patient D F/U	D Yes D No D Cancelled D Resched	D Completed D Not Done D Pt called D N/A-no orders		D Td / TdaP D CRC D Pneumovax D Mammo D Influenza/H1N1 D Pap D Other::		

Our Patient: Ms. Anexxa, 71-year old Medicare beneficiary



Clinical Profile
▪ Type II Diabetes
▪ Long standing Hypertension (Last BP: 140/90 mmHg)
▪ CHF following a heart attack from 3 years prior
▪ Dependent on Opioid – which started after pain management for a hip fracture 4 years earlier
▪ Other Medications: Metformin 500 mg daily; Enalapril 30 mg/day PO qd; Aspirin 81 mg PO qd ; Lovastatin 40 mg PO qd
▪ Lifestyle modifications: Exercise - 30 mins moderate-intensity aerobic activity – 5d/week, Nutrition therapy (DASH diet)
Social Profile
▪ Retired widow who lives alone and her son lives 5 hours away & uses public transportation
▪ High school education; Worked as a kitchen staff in a school cafeteria; On fixed income
▪ She has no fresh food at home – due to her recent stay for 4 days in the hospital
▪ Experiences other care transition challenges such as: Off-road options, snapshot treatment, diminished ability and increased responsibility
Personality/Behavior Profile
▪ She is an extrovert, usually lively, a "people person" and does not like to be alone
▪ Enjoys attending group meetings when she can (e.g. Diabetes group)
▪ Does not exercise much and tries to maintain good eating habit
▪ She engages well with her peers and encourages them through life challenges
Utilization Profile (last 6m)
▪ 5 ED visits
▪ 2 Hospitalizations
▪ Most recent hospitalization after being treated for uncontrolled CHF & unaware of 2 of the 3 new prescriptions b/c they were electronically sent to the pharmacy
Cost (Utilization)
▪ Short term hospital – $27,000
▪ ER - $7,500
Total ED & Hosp (last 6m) - $34,500

Session Recap

- ☑ We discussed care team roles and learned more about how care teams work together
- ☑ We learned about the value of the extended & support teams
- ☑ Used our test patient Ms. Anexxa to have a practical conversation about activities that usually occur before the patient comes in for a doctor's office visit at Healthlincs Primary Care; and reviewed some key requirements on:
  - *Using data to continuously improve care delivery*
  - *Empanelment & Continuity*
  - *Risk Stratification (and Leveraging CRISP data)*
  - *Team huddles*

Post-survey

Questions:

After this session - on a scale of 1-5 how would you rate your knowledge on:

8. Interdisciplinary Teams/Care Team Roles
9. Team Huddles
10. Minimum data sets necessary for huddles
11. Empanelment
12. Risk Stratification

** Call to Action: What is your readiness level to try applying this knowledge at your practice?

Scale Key

1 = Fair
2 = Building
3 = Steady
4 = Strong
5 = Invincible

MARYLAND DEPARTMENT OF HEALTH

Session 5

The Patient Care Journey

Phase II: Patient Care DURING the Visit

MARYLAND
Department of Health

Presenter

Kyanni N. Fleming
RN, BSN, MS, MBA

Care Management Subject Matter Expert,
Medicalincs LLC

Nkem Okeke
MD, MPH, MBA, MSPM, CCMP

Chief Executive Officer, Medicalincs
Primary Care Transformation Expert

Disclosure Statement

No disclosure directly related to this presentation

Phase II Overview:
During the Office Visit

A	**1. Check in:** ▪ *Insurance/Copay etc.* ▪ *Confirm address & contact info* ▪ *Review of symptoms*
B	**2. Rooming** ▪ Call & Room Patient *(Involves prepping room)*
C	**3. Pre-Consult**
	a. Check Vitals, Review of symptoms, & document health concerns
	b. Medication reconciliation ®
	c. BH Screening ® BHI
	d. AWV
	e. Signal patient is ready
D	**4. Consultation**
	a. Examination ▪ Review & confirm risk tier ® Risk Stratification
	b. Discuss additional tests ▪ Place/enter order if needed ▪ A1C Test ® eCQM ▪ 3m – 6m Kidney profile (eGFR)
	c. Prescriptions (Medication Management) ® ▪ Medical nutrition therapy (MNT) ▪ Physical Activity/Exercise
E	**5. Post-Consult**
	a. Patient education
	b. Place med orders
	c. Place non-med orders
	d. Clean room
F	**6. Check out**

Session Objectives

Understand the following concepts applied during Phase II:

- ☑ Workflow: People, Process & Technology/Tools
- ☑ Interdisciplinary Teams/Care Team Roles
- ☑ Annual Wellness Visits (AWV) & EMR tools
- ☑ Other screening tools (Risk Assessment, PHQ, GAD 7, SBIRT)
- ☑ Data necessary for warm-hand offs (minimum data sets)
- ☑ Documentation best practices

Pre-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

13. Interdisciplinary Teams/Care Team Roles
14. Annual Wellness Visits (AWV)
15. Screening tools
16. Data necessary for warm-hand offs (minimum data sets)
17. Documentation best practices & EMR tools

Scale Key

1 = Fair
2 = Building
3 = Steady
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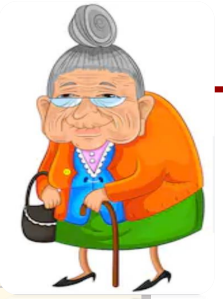
Our Patient: Ms. Anexxa, 71-year old Medicare beneficiary



Clinical Profile
▪ Type II Diabetes
▪ Long standing Hypertension (Last BP: 140/90 mmHg)
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▪ Other Medications: Metformin 500 mg daily; Enalapril 30 mg/day PO qd; Aspirin 81 mg PO qd ; Lovastatin 40 mg PO qd
▪ Lifestyle modifications: Exercise - 30 mins moderate-intensity aerobic activity – 5d/week, Nutrition therapy (DASH diet)
Social Profile
▪ Retired widow who lives alone and her son lives 5 hours away & uses public transportation
▪ High school education; Worked as a kitchen staff in a school cafeteria; On fixed income
▪ She has no fresh food at home – due to her recent stay for 4 days in the hospital
▪ Experiences other care transition challenges such as: Off-road options, snapshot treatment, diminished ability and increased responsibility
Personality/Behavior Profile
▪ She is an extrovert, usually lively, a "people person" and does not like to be alone
▪ Enjoys attending group meetings when she can (e.g. Diabetes group)
▪ Does not exercise much and tries to maintain good eating habit
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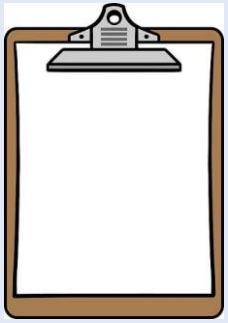
Utilization Profile (last 6m)
▪ 5 ED visits
▪ 2 Hospitalizations
▪ Most recent hospitalization after being treated for uncontrolled CHF & unaware of 2 of the 3 new prescriptions b/c they were electronically sent to the pharmacy
Cost (Utilization)
▪ Short term hospital – $27,000
▪ ER - $7,500
Total ED & Hosp (last 6m) - $34,500

Phase II, Step A: Check In Ms. Anexxa

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)									Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
	1. Check in: ▪ *Insurance/Copay etc.* ▪ *Confirm address & contact info* ▪ *Review of symptoms*	▪ Now that I am at the doctor's office, I feel - comfortable ▪ Not sure why I have to fill out all this information; is anyone really looking at this information? ▪ I wished the front desk staff are not loud when asking me to confirm my personal information			☑	☑						EMR – patient records – *confirm insurance, copay, and address; with ability to update patient information*	Check-in list

Check-In

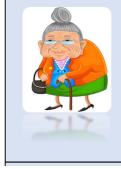


FO/OA MA

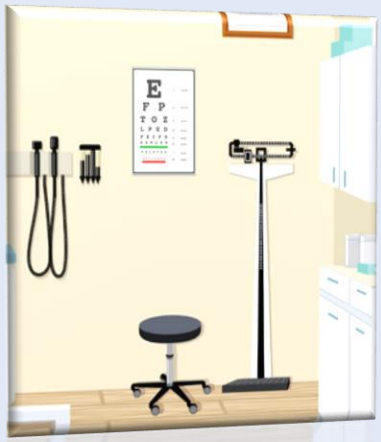
- ☑ Verify insurance
- ☑ Update contact information
- ☑ Accept co-pays
- ☑ Patient Rights, Consent to Treat & Disclosure Forms
- ☑ Update any pre-visit Questionnaire *(e.g. AWV Forms)*

Ms. Anexxa's experience *captured here – shows that she feels comfortable coming for this visit but wishes that she did not need to verify her identification with other patients in the waiting room close enough to hear her reply*

Phase II, Step B: Rooming Ms. Anexxa

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)									Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
	2. Rooming ▪ Call & Room Patient *(Involves prepping room)*	▪ I had a short wait time from the time I checked in to the time I was taken to the examination room ▪ This exam room looks clean & neat		☑	☑								

Rooming



- ☑ Room Prepped to receive patient
- ☑ Patient physically ushered to the room
- ☑ Notify PCP that patient is ready to be seen
- ☑ Considerations for patient satisfaction
  - ➢ Wait time
  - ➢ Cleanliness of exam room

MA

RN

FO/OA

Ms. Anexxa's experience *captured here – shows that she is happy about having a short wait time. The exam room also looks very clean!*

Phase II, Step C: Pre-Consult with Ms. Anexxa

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)									Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
	3. Pre-Consult												
	a. Check Vitals, Review of symptoms, & document health concerns	▪ I wonder what my vitals will be today. ▪ I am happy with my vitals today	☑	☑	☑							EMR – *document in patient record*	
	b. Medication reconciliation ®		☑	☑	☑							EMR – *review & update patient's record*	
	c. BH Screening ® BHI		☑	☑	☑			☑				EMR – *BH Screening form configured in EMR*	**BH Screening:** PHQ2. PHQ9, GAD 7 (**Sample template combining all 3**)
	d. AWV		☑	☑	☑							EMR – *AWV form configured in EMR*	Patient's last AWV information as a frame of reference
	e. Signal patient is ready	I had a short wait time from the time I was taken to the examination room to the time I saw my doctor		☑	☑								**Color code** for rooming patients

- Ms. Anexxa vitals are checked and medication reconciliation done by MA ***(Medication reconciliation).*** Today's results show: ***BP 140/90mmHg, Wgt: 196 pds, Hgt: 5 ft 5 in***
- As part of her prep, a BH Screening is done since she is due to have one. PHQ2/9 is administered ***(BHI).*** She is also due for an AWV and the MA will finalize this shortly after the doctor's consult ***(AWV)***

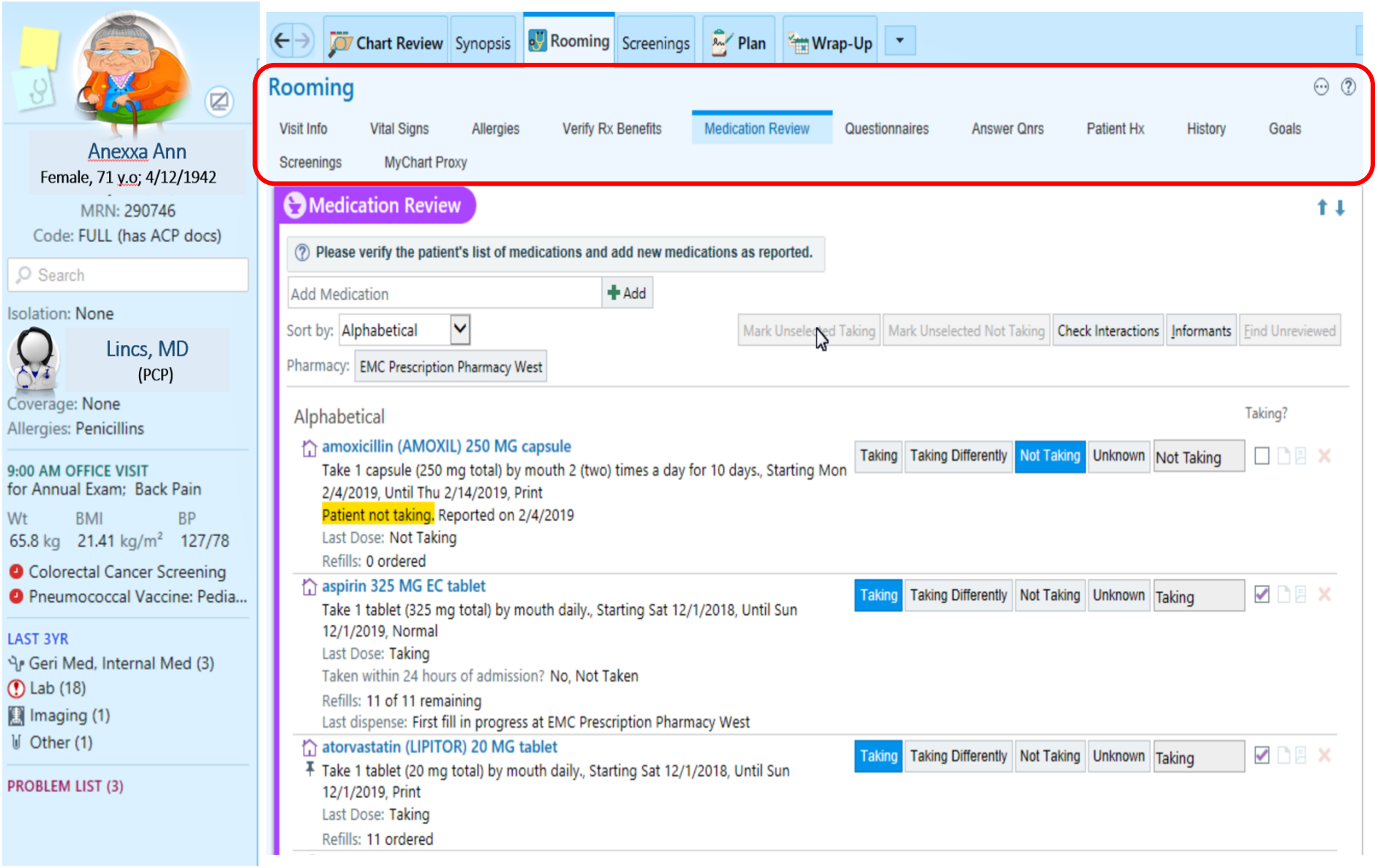
Ms. Anexxa's experience *captured here – shows that she is happy to know what her vitals are today after being concerned for the past 2 days. She lost 5 pds. since her last visit.*

Pre-Consult/Rooming

MA RN

- ☑ Check Vitals
- ☑ Review of Symptoms (ROS)
- ☑ Patient Health Concerns
- ☑ Care Gaps (eCQMS)/Best Practice Advisories (BPAs) EMR Alerts
- ☑ Medication Reconciliation
- ☑ Annual Wellness Visit Screen
- ☑ BH Screening

Rooming Ms. Anexxa: EHR Documentation



Phase II, Step D: Consult with Ms. Anexxa

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)									Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
	4. Consultation												
	a. Examination ▪ Discuss vitals (BP, Weight, Glucose etc.) ▪ Review & confirm risk tier ® Risk Stratification	▪ My PCP & Care team seem to be collaborating well to provide me the best care; my PCP did not ask me all of the same questions the MA just asked me a few minutes ago & my CHW asked me last week ▪ I wonder what the doctor will say about my vitals (and/or results) today	☑									EMR – *Is smart-phrase enabled; auto populates all patients record to patient's entry/page ability to update patient's record*	**Risk Stratification Tool**
	b. Discuss additional tests ▪ Place/enter order if needed ▪ A1C Test ® eCQM ▪ 3m – 6m Kidney profile (eGFR)	▪ More tests? I hope I only need to go across the street and do not have to call and get scheduled for a later date. I'll need to plan for that as well ▪ I'm happy these additional tests might help get to the bottom of my problems	☑									EMR – *order entry capable*	
	c. Prescriptions (Medication Management) ® ▪ Medical nutrition therapy (MNT) ▪ Physical Activity/Exercise	▪ I'd like my doctor to call my meds into my regular pharmacy ▪ Maybe the doctor will give me some samples today	☑									EMR – *Prescription history & Entry*	

- Dr. Lincs can focus more of his time on medication management & discussing Ms. Anexxa's health concerns ***(Medication management).*** Also in examination and reviews with the patient, Dr. Lincs can apply his Clinical Judgement to adjust Ms. Anexxa's risk level ***(Risk stratification).*** Additional tests should also be ordered for Ms. Anexxa such as A1C & Kidney Profile ***(eCQMs)*** and other necessary referrals made

Ms. Anexxa's experience *captured here – shows that she is happy with her meds being called in & additional tests will be done to further explore any other issues*

Consult

MA RN PCP

- ☑ Warm-handoff
  - SBAR
- ☑ Review of pre-consult assessments
- ☑ Examination
- ☑ Confirm pre-visit risk stratification tier with clinical judgment
- ☑ Discuss additional tests
- ☑ Care Gaps (eCQMs)/Best Practice Advisories (BPAs) EMR Alerts
- ☑ Discuss Medication Management
- ☑ Address patient health concerns

Warm-handoff Video

Annual Wellness Visits *(AWV)*

AWV is a yearly appointment with PCP to review the patient's wellness, and develop a personalized prevention plan; it expands to include emotional and psychological well-being, in addition to the patient's physical well-being.

Beneficiary attribution to a practice is generally determined:

- By **Annual Wellness Visits** and Welcome to Medicare Visits,
- and last by the plurality of eligible primary care visits within the 24-month lookback period.

Two CPT codes used to report AWV services are:

- G0438 initial visit
- G0439 subsequent visit

➢ *The services provided during the AWV are different from a typical preventive care visit; & similar to but separate from the one-time Welcome to Medicare preventive visit.*

AWV *(Contd.)*

Health Care Professionals Who May Furnish and Bill AWV:

- Physician
- Physician assistant (PA)
- Nurse practitioner (NP)
- Clinical nurse specialist (CNS)
- Medical professional (including a health educator, registered dietician or nutrition professional, or other licensed practitioner) or a team of medical professionals working under the direct supervision of a physician.

Implementing AWVs in Practices:

Step 1 – Establish program plan and identify eligible patients
Step 2 – Perform outreach and engagement
Step 3 – Perform AWV medical encounter & document in EMR
Step 4 – Complete appropriate and effective coding/billing

Learn more: AWV Implementation Guide

Behavioral Health Screening

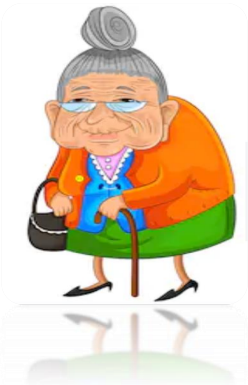
MA

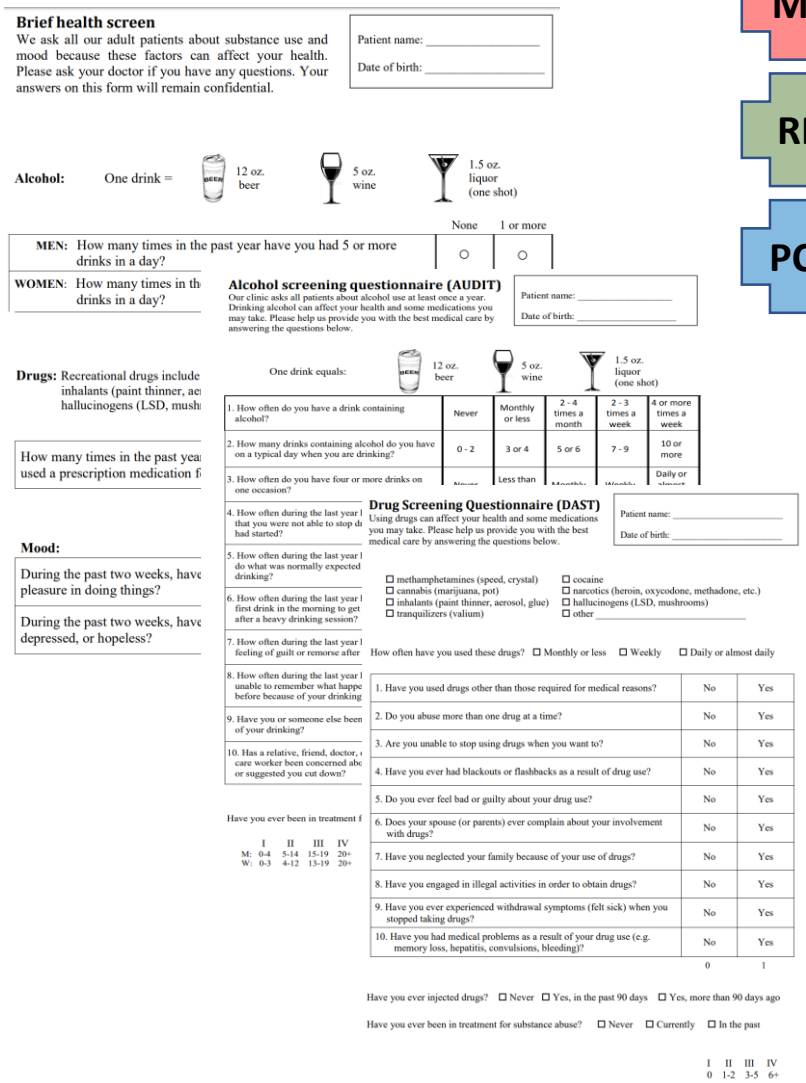
RN

PCP

BHI Tools

- SBIRT (Mosaic)
- IMPACT Model
  - ➢ Behavioral Health Hand-off Video





Brief health screen
We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Patient name: _____
Date of birth: _____

Alcohol: One drink = 12 oz. beer; 5 oz. wine; 1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in th drinks in a day?		

Drugs: Recreational drugs include inhalants (paint thinner, ae hallucinogens (LSD, mush

How many times in the past yea used a prescription medication f

Mood:

During the past two weeks, have pleasure in doing things?

During the past two weeks, have depressed, or hopeless?

Alcohol screening questionnaire (AUDIT)
Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____
Date of birth: _____

One drink equals: 12 oz. beer; 5 oz. wine; 1.5 oz. liquor (one shot)

	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
1. How often do you have a drink containing alcohol?					
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?		Less than			Daily or
4. How often during the last year that you were not able to stop d had started?					
5. How often during the last year do what was normally expected drinking?					
6. How often during the last year first drink in the morning to get after a heavy drinking session?					
7. How often during the last year feeling of guilt or remorse after					
8. How often during the last year unable to remember what happe before because of your drinking					
9. Have you or someone else been of your drinking?					
10. Has a relative, friend, doctor, care worker been concerned abo or suggested you cut down?					

Have you ever been in treatment f

I	II	III	IV
M: 0-4	5-14	15-19	20+
W: 0-3	4-12	13-19	20+

Drug Screening Questionnaire (DAST)
Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____
Date of birth: _____

☐ methamphetamines (speed, crystal) ☐ cocaine
☐ cannabis (marijuana, pot) ☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ inhalants (paint thinner, aerosol, glue) ☐ hallucinogens (LSD, mushrooms)
☐ tranquilizers (valium) ☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

	No	Yes
1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

- Recommend reviewing the **BHI Mini Series** upload on MDPCP Connect **OR** on the **MDH MDPCP Site**: https://health.maryland.gov/mdpcp/Pages/EducationalSessions.aspx

MARYLAND Department of Health

Behavioral Health Hand-off Video

BH Screening – PDSA Example

QUESTION: How can we ensure universal BH screening of all patients?

Test of Change: *Increase the number of Behavioral Health Screenings performed.*

Plan: 1) Develop a workplan 2) Train MA staff to perform BH screenings 3) Document screening results in EMR for care team to access

Do: MA performs BH screening and documents

Study: 1) The percentage of empaneled patients who received an annual BH screening
2) The percentage of BH screenings performed that were positive.

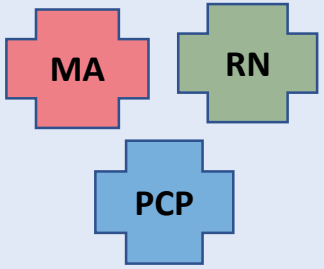
Act: Universal BH screenings will be performed by MA staff during patient visits. This will give providers enough information and time to perform a brief intervention and refer to treatment.

Phase III, Step E: Post-Consult with Ms. Anexxa

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)									Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
	5. Post-Consult												
	a. Patient education	▪ I told the doctor *everything* on my mind related to my symptoms and situation		☑	☑								
	b. Place med orders	▪ I'd like my meds called into my regular pharmacy	☑	☑	☑							EMR - *e-prescription capable*	
	c. Place non-med orders	▪ I'm *happy* someone is helping me coordinate this		☑	☑							EMR – *non-med orders entry (and/or list of preferred referral sources)*	
	d. Clean room	▪ This exam room looks clean & neat		☑	☑								
	6. Check out	▪ My check out process was *seamless*			☑	☑							

Post Consult

- ☑ Patient Education
- ☑ Prescriptions
- ☑ Referrals and Consults
- ☑ Lab work
- ☑ Follow-up
- ☑ Prepare room for next patient



Ms. Anexxa's experience *captured here – shows that she is happy with being able to discuss all her concerns with Dr. Lincs and having a care coordinator help her with understanding next steps*

Check Out

MA FO/OA

- ☑ Schedule next appointment
- ☑ Scripted
- ☑ Reinforce/confirm patient understanding and knowledge of visit
- ☑ Coordinate referrals
- ☑ Solicit questions
- ☑ Close the communication loop

Session Recap

- ☑ Used our test patient Ms. Anexxa to have a practical conversation about activities that usually occur during the patient's office visit; and reviewed requirements on:
  - *Medication Reconciliation & Medication Management*
  - *eCQMs*
  - *Using data to continuously improve care delivery*
  - *BH Screening*

- ☑ Reviewed performing AWV

- ☑ Care team warm handoffs and Ms. Anexxa's care delivery experience

Post-survey

Questions:

After this session - On a scale of 1-5 how would you rate your knowledge on:

13. Interdisciplinary Teams/Care Team Roles
14. Annual Wellness Visits (AWV)
15. Screening tools
16. Data necessary for warm-hand offs (minimum data sets)
17. Documentation best practices & EMR tools

** Call to Action: What is your readiness level to try applying this knowledge at your practice?

Scale Key

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3 = Steady
4 = Strong
5 = Invincible

MARYLAND DEPARTMENT OF HEALTH

Session 6

The Patient Care Journey

Phase III: Patient Care AFTER the Visit

Nkem Okeke, MD, MPH, MBA, MSPM, CLSS, CCMP

Medicalincs LLC

MARYLAND Department of Health

Presenters

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Care Management Subject Matter Expert,
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Disclosure Statement

No disclosure directly related to this presentation

Phase III Overview:
After the Office Visit

A	▪ **Longitudinal Care Management F/U ®:** o Education on Drug-induced hypoglycemia
B	▪ **Episodic Care Management F/U Patient outreach & follow up ®**
	a. CRISP ENS Report Review (ED visit & Hosp Discharge)
	b. Outreach & PCP f/u Appointment scheduling
	c. Medication Reconciliation
	d. Referral F/U support
C	▪ Social Needs support ®
D	▪ BH Needs support ®
E	▪ **Off-Office hours access** ® 24/7 Access: for patients to care team & for providers to EMR
F	▪ ****Post visit data reviews (population & individual data/reports)**
G	▪ PFAC ®

Session Objectives

Understand the following concepts applied during Phase III:

- ☑ Workflow: People, Process & Technology/Tools
- ☑ Interdisciplinary Teams/Care Team Roles
- ☑ Longitudinal Care Management (LCM)
- ☑ Care Plan Basics
- ☑ Episodic/Transitional Care Management (ECM/TCM)

Pre-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

18. Workflow: People, Process & Technology/Tools
19. Longitudinal Care Management (LCM)
20. Care Plan Basics
21. Episodic/Transitional Care Management (ECM/TCM)
22. Alternative care visits

Scale Key

1 = Fair
2 = Building
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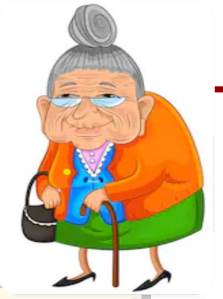
5 = Invincible

Our Patient: Ms. Anexxa, 71-year old Medicare beneficiary

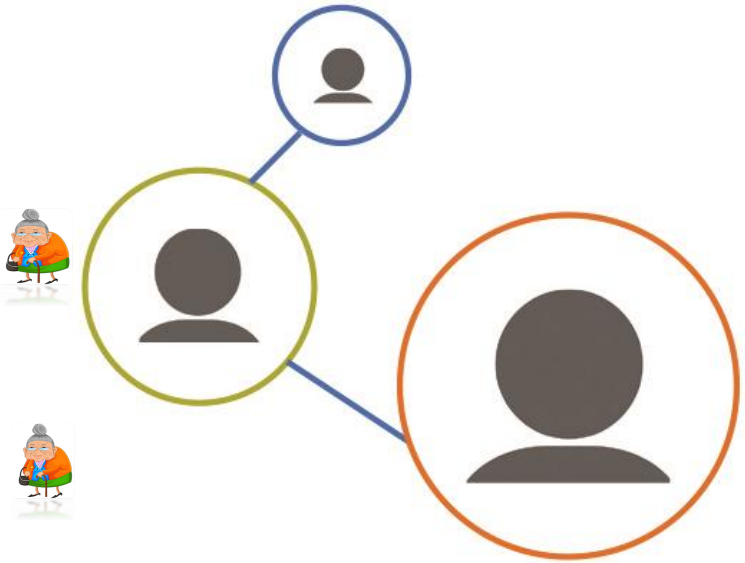


Clinical Profile
▪ Type II Diabetes
▪ Long standing Hypertension (Last BP: 140/90 mmHg)
▪ CHF following a heart attack from 3 years prior
▪ Dependent on Opioid – which started after pain management for a hip fracture 4 years earlier
▪ Other Medications: Metformin 500 mg daily; Enalapril 30 mg/day PO qd; Aspirin 81 mg PO qd ; Lovastatin 40 mg PO qd
▪ Lifestyle modifications: Exercise - 30 mins moderate-intensity aerobic activity – 5d/week, Nutrition therapy (DASH diet)
Social Profile
▪ Retired widow who lives alone and her son lives 5 hours away & uses public transportation
▪ High school education; Worked as a kitchen staff in a school cafeteria; On fixed income
▪ She has no fresh food at home – due to her recent stay for 4 days in the hospital
▪ Experiences other care transition challenges such as: Off-road options, snapshot treatment, diminished ability and increased responsibility
Personality/Behavior Profile
▪ She is an extrovert, usually lively, a "people person" and does not like to be alone
▪ Enjoys attending group meetings when she can (e.g. Diabetes group)
▪ Does not exercise much and tries to maintain good eating habit
▪ She engages well with her peers and encourages them through life challenges
Utilization Profile (last 6m)
▪ 5 ED visits
▪ 2 Hospitalizations
▪ Most recent hospitalization after being treated for uncontrolled CHF & unaware of 2 of the 3 new prescriptions b/c they were electronically sent to the pharmacy
Cost (Utilization)
▪ Short term hospital – $27,000
▪ ER - $7,500
Total ED & Hosp (last 6m) - $34,500

Phase III: Longitudinal & Episodic Care Management

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)									Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
	▪ Longitudinal Care Management F/U ®: o Education on Drug-induced hypoglycemia	▪ My Care Manager calls me every week to see how well I'm doing and educates me on ways to better manage my illness (DM, HTN, etc.)	☑	☑	☑		☑					EMR – *CM module with CM Assessment, Care plan & documentation capability*	Sample of **Care plan & Assessment**
	▪ Episodic Care Management F/U Patient outreach & follow up ®												
	a. CRISP ENS Report Review (ED visit & Hosp Discharge)			☑	☑					☑	☑	▪ EMR – *notifications* ▪ Care Alerts	
	b. Outreach & PCP f/u Appointment scheduling	▪ My doctor's office called me to know how I'm doing after my ED visit (or recent hospital discharge)		☑	☑		☑					▪ EMR Scheduling Application (real-time updating) ▪ Automated (reminder) calling system	
	c. Medication Reconciliation	▪ My Care Manager helped me confirm which medications I should continue taking or stop taking after my recent hospital (or ED) visit		☑								EMR – *review & update patient's record*	
	d. Referral F/U support	▪ My Care Manager helped me coordinate my referrals for follow up. They helped me with scheduling visits with the specialists		☑	☑							▪ EMR – *capability to export and import patient's data* ▪ Capability to view patient's data on other EHR platform	List of preferred specialists
	▪ Social Needs support ®	▪ My Community Health Specialist helped me schedule transportation for my upcoming visits. ▪ She also helped me with filling out a housing application for better accommodation			☑		☑					EMR – CM module - *with Social determinant Assessment, Intervention plan & documentation capability*	Sample of **Intervention plan & Assessment**
	▪ BH Needs support ®	▪ I was happy to see my therapist shortly to discuss my symptoms of depression from dealing with my illness						☑				EMR – *to review & update patient's record*	

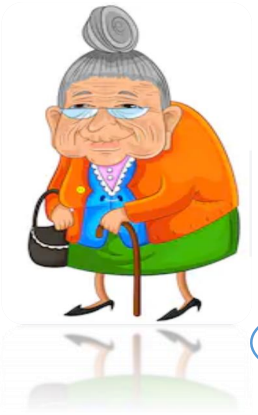
Referrals & Consults



Ensure referral management for attributed patients seeking care from high-volume and/or high-cost specialists; as well as ED and Hospitals

- ✓ **Care Manager (Care Coordinator)**
  (Longitudinal care management for rising risk/high-risk needs, transition need)
- ✓ **Community Health Worker** (SDOH needs)
- ✓ **Pharmacist**
  (medication adherence)
- ✓ **Social Worker**
  (psychosocial needs)
- ✓ **BH Specialist**
  (mental health needs)
- ✓ **Health Coach/Educator**
  (education, self-management needs)
- ✓ **Provider Specialist**
  (medical needs)

Phase III: Longitudinal & Episodic Care Management



Ms. Anexxa's Experience

My Care Manager calls me every week to see how well I'm doing and educates me on ways to better manage my illness (DM, HTN, etc.)

My doctor's office called me to know how I'm doing after my ED visit (or recent hospital discharge)

My Care Manager helped me confirm which medications I should continue taking or stop taking after my recent hospital (or ED) visit

My Care Manager helped me coordinate my referrals for follow up. They helped me with scheduling visits with the specialists

LCM vs. ECM

Movement

Longitudinal Care Management (LCM)

Identified based on risk stratification of empaneled patients

Episodic Care Management (ECM)

Identified based on transition of care such as:

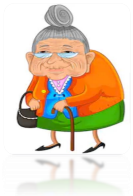
-Recent ED Visit

-Recent Hospitalization

-New Diagnosis

Can be further risk stratified

Care Management Workflow
Example I



STAFF

LCM & ECM

SAMPLE I: CARE MANAGEMENT (LCM/ECM) WORKFLOW – *Showing handoffs*

Primary Care Provider

Panel Manager or QI Specialist

Lead Care Manager (RN)

Support Care Manager

LEGEND:
- Captured in EHR
- Inputs/Referral points to LCM

Refer Patient for CM

Retrieve CRISP List & review for recent ED visit & Hosp. discharge

Review list, Triage & refer to Care Manager

Schedule F/u PCP visit
(Also make reminder calls F/u with No Shows)

Retrieve Patient stratified attribution list

Patient Outreach

Questions to keep in mind:
- What is the outreach protocol?
- How many patients will be reached per day?
- How many attempts will be made per patient?
- What is the next action if patient is not reached?

Conduct Patient assessment

Questions to keep in mind:
- What assessment tool is currently used? Is it configured in the EMR?
- Does it need to be modified?

Patient has CM needs?

YES

NO

Document Decision

NO

Patient has SDH needs?

YES

Refer Patient to resources

Dispositions

- Longitudinal CM High/Complex Risk
- Episodic CM High/Complex Risk
- Episodic CM Med – Low Risk
- CM F/u Med – Low Risk

Initiate appropriate Care Management services

Re-evaluate caseload

Questions to keep in mind:
- What are the guidelines for providing LCM? (e.g. AAFP?)
- What are the guidelines for providing ECM?
- What are the guidelines for f/u with patients that no longer require LCM?

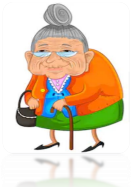
Refer to Support CM

Initiate appropriate Care Management services & Refer Patient to resources

Transition Patient after providing care

The Patient Journey
Phase III

Care Management Workflow
Example II



STAFF

LCM & ECM

- ☑ **Identification/Screening/Stratification/Referral**
- ☑ **Enrollment**
- ☑ **Assessment**
  - EMR Care Plan Triggers/BPAs
- ☑ **Plan of Care**
  - Problems
  - Goals (self-management)
  - Outcomes
- ☑ **Intervention/Implementation**
- ☑ **Analyze/Follow-up/Monitor**
  - CRISP ENS Alerts
  - CRISP Care Alerts
- ☑ **Evaluation**
  - Dashboards/Reports

CHW

SAMPLE CARE MANAGEMENT (LCM/ECM) WORKFLOW – *Showing handoffs*

LEGEND:
Green: Swim lane for Practice Staff
Blue: Swimlane for CTO Staff
EHR/IT Capability
Inputs/Referral points to LCM

Primary Care Provider
- Refer Patient for CHW Support
- Refer Patient for CM

Front Office Staff
- Schedule F/u PCP visit (*Also make reminder calls F/u with No Shows*)

Vendor (Automated Calling)
- Retrieve CRISP List & review for recent ED visit & Hosp. discharge
- Call & Triage patients & generate report

Panel Manager or QI Specialist
- Review Triage report & escalate to Care Manager & document patient contact

Lead Care Manager (RN)
- Retrieve Patient stratified attribution list
- Patient Outreach
  - Questions to keep in mind:
    - What is the outreach protocol?
    - How many patients will be reached per day?
    - How many attempts will be made per patient?
    - What is the next action if patient is not reached?
- Conduct Patient assessment
  - Questions to keep in mind:
    - What assessment tool is currently used? Is it configured in the EMR?
    - Does it need to be modified?
- Patient has CM needs? — Yes / No
- Document Decision
- Patient has SDH needs? — Yes / No
- Dispositions
  - Longitudinal CM High/Complex Risk
  - Episodic CM High/Complex Risk
  - Episodic CM Med – Low Risk
  - CM F/u Med – Low Risk
- Re-evaluate caseload
- Initiate appropriate Care Management services
  - Questions to keep in mind:
    - What are the guidelines for providing LCM? (e.g. AAFP?)
    - What are the guidelines for providing ECM?
    - What are the guidelines for f/u with patients that no longer require LCM?
- Refer to CHW
- Refer to Practice CM

Support Care Manager
- Initiate appropriate Care Management services
- Transition Patient after providing care

Comm Health Worker
- Questions to keep in mind:
  - What is the outreach protocol?
  - How many patients will be reached per day?
  - How many attempts will be made per patient?
  - What is the next action if patient is not reached?
  - What assessment tool is currently used? Is it configured in the EMR?
- Outreach patient & conduct initial assessment
- Initiate CH Services; *Including support with transportation for f/u visit*
- Graduate / Transition Patient once Barriers addressed

LCM: Longitudinal Care Management | ECM: Episodic Care Management

Longitudinal Care Management

Approach

CM CHW

A. Identification:
   - *Screening/Stratification/Referral*

B. Outreach & Enrollment

C. Assessment
   - *EMR Care Plan Triggers/BPAs*

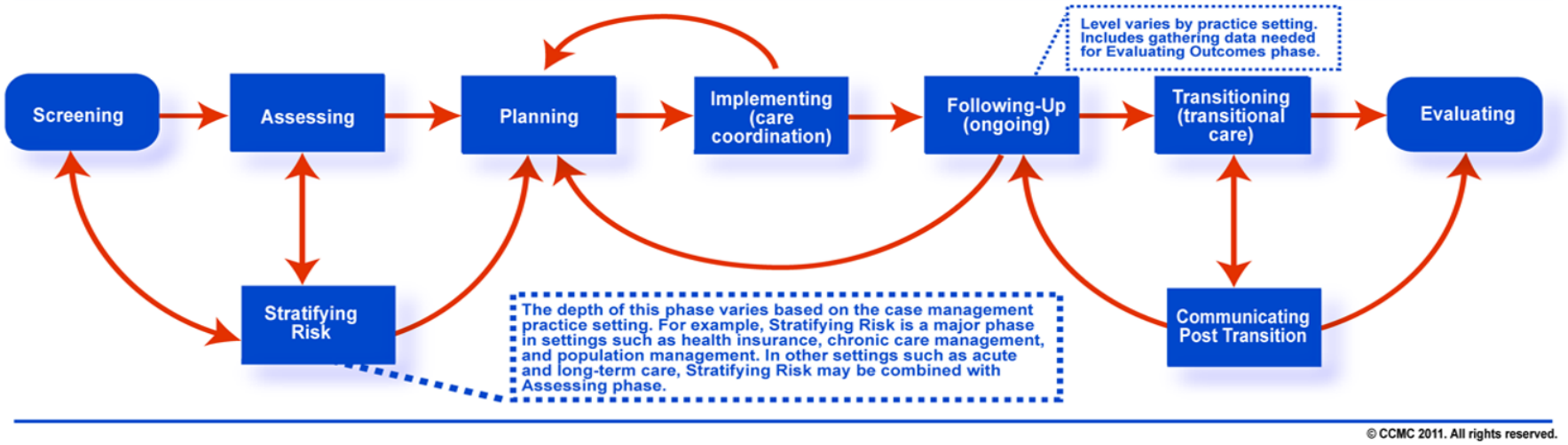
D. Plan of Care
   - *Problems*
   - *Goals (self-management)*
   - *Outcomes*

E. Intervention/Implementation

F. Analyze/Follow-up/Monitor
   - *CRISP ENS Alerts*
   - *CRISP Care Alerts*

G. Evaluation
   - *Dashboards/Reports*

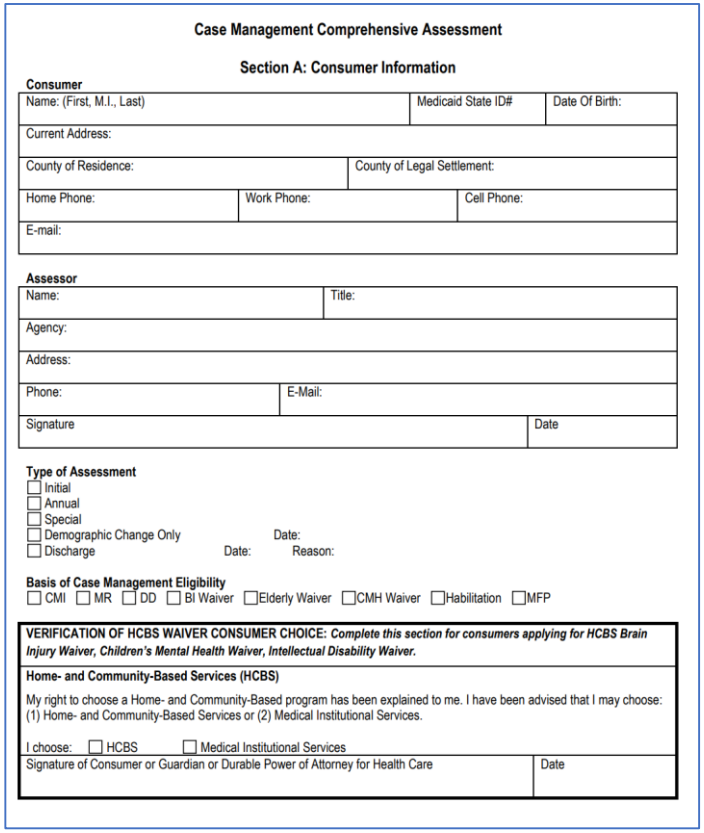
HIGH-LEVEL PROCESS



Care Management Assessment & Care Plan

A Comprehensive Care Management Assessment include:

- ☑ Patient Information
- ☑ Medical & Physical Health
- ☑ Mental Health, Behavioral, & SU
- ☑ Housing & Environment
- ☑ Social
- ☑ Transportation
- ☑ Educational
- ☑ Vocational



Case Management Comprehensive Assessment

Section A: Consumer Information

Consumer

Name: (First, M.I., Last)	Medicaid State ID#	Date Of Birth:
Current Address:		
County of Residence:	County of Legal Settlement:	
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Assessor

Name:	Title:
Agency:	
Address:	
Phone:	E-Mail:
Signature	Date

Type of Assessment

☐ Initial
☐ Annual
☐ Special
☐ Demographic Change Only Date:
☐ Discharge Date: Reason:

Basis of Case Management Eligibility

☐ CMI ☐ MR ☐ DD ☐ BI Waiver ☐ Elderly Waiver ☐ CMH Waiver ☐ Habilitation ☐ MFP

VERIFICATION OF HCBS WAIVER CONSUMER CHOICE: ***Complete this section for consumers applying for HCBS Brain Injury Waiver, Children's Mental Health Waiver, Intellectual Disability Waiver.***

Home- and Community-Based Services (HCBS)

My right to choose a Home- and Community-Based program has been explained to me. I have been advised that I may choose: (1) Home- and Community-Based Services or (2) Medical Institutional Services.

I choose: ☐ HCBS ☐ Medical Institutional Services

Signature of Consumer or Guardian or Durable Power of Attorney for Health Care	Date

https://dhs.iowa.gov/sites/default/files/470-4694.pdf?060220192118

Care Plan Guidelines

QR
CTO/Coach Support

Identifying Disease Burden and Determining Health Risk Status

Is the patient healthy, with no chronic disease, or *significant risk factors?*	Is the patient healthy, but at risk for a chronic disease, or has other *significant risk factors?*	Does the patient have one or more chronic diseases, with *significant risk factors*, but is stable or at desired treatment goals?	Does the patient have one or more chronic diseases, with *significant risk factors*, and is unstable or not at treatment goal(s)?	Does the patient have multiple chronic diseases, *significant risk factors*, complications, and/or complex treatment(s)?	Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?
Level 1 **PRIMARY PREVENTION**	**Level 2** **PRIMARY PREVENTION**	**Level 3** **SECONDARY PREVENTION**	**Level 4** **SECONDARY PREVENTION**	**Level 5** **TERTIARY PREVENTION**	**Level 6** **CATASTROPHIC CARE**
GOAL: To prevent onset of disease (Low Resource Use)	**GOAL: To prevent onset of disease (Low Resource Use)**	**GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)**	**GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)**	**GOAL: Treat the late or final stages of a disease and minimize disability (High Resource Use)**	**GOAL: May range from restoring health to only providing comfort care (Extremely High Resource Use)**
CARE PLAN SUGGESTIONS – Preventive screenings and immunizations – Patient education – Health risk assessment (annual) – Appropriate monitoring for warning signs	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (semi-annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (semi-annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach – Referrals, as appropriate	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (quarterly) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach/personalized care plan/management and resources – Referrals, as appropriate – Home health	**CARE PLAN SUGGESTIONS** – Hospitalization – Rehabilitation – Long-term care – Hospice/palliative care **TEAM/PLANNED CARE** – Support groups – Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach/care management – Referrals, as appropriate – Home health – Personalized intensive care plan/management and resources

- Use Evidence-based guidelines
- Document Care plan and follow up care in EMR

Ms. Anexxa's Individualized Care Plan Example

Problem: Medication Management and Compliance

Goal #1 (Care Management Goal): Ms. Anexxa will receive medication education and counseling at her next office visit.

Intervention: The practice pharmacist will meet with Ms. Anexxa at next office visit.

Outcome: Ms. Anexxa will need on-going medication follow-up to ensure she is compliant with her medications

Action: Ongoing

Goal #2 (Self-Management Goal): Ms. Anexxa will take her medications as prescribed everyday for a week.

Intervention: Ms. Anexxa will receive an electronic reminder medication pillbox that will send a daily report to Care Team.

Outcome: Ms. Anexxa took all her medication as prescribed for the week.

Action: Goal Complete

Episodic Care Management

Approach

- ☑ Identification:
  - *ED & Hosp Discharge **(CRISP ENS Alerts)***
  - *New Diagnosis/Crisis/Instability/Practitioner or care team referral/SNF admission or discharge/Life event*
- ☑ Outreach
  - *ED: 1 week post discharge*
  - *Hosp: 2 days post discharge*
- ☑ Medication Reconciliation/Management
- ☑ Coordinate PCP follow-up appointments
  - *Preferably 7-14 days post-discharge*
- ☑ Follow-up/Monitor
- ☑ Transition

QR
CTO/Coach Support

Phase III: 24/7 Access & Data Reviews

Journey/ Workflow Phase	Process Steps (Clinician/Provider Journey)	Patient's Journey (Ms. Anexxxa)	Owner (People)									Technology (Health IT Capabilities)	Resources
			PCP	RN	MA /LPN	OA	CHW	SW	OM	DA /IT	QI		
	▪ Off-Office hours access ® 24/7 Access: for patients to care team & for providers to EMR	▪ I was able to speak with a provider after office hours when I needed to last week – that saved me a visit to the ED	☑	☑	☑							EMR – *review & update patient's record (Remote access)*	**On-call Plan & EMR Access** (Limited/Full)
	4. **Post visit data reviews (population & individual data/reports)		☑	☑	☑		☑			☑	☑	EMR Reports (CM/CHW) Excel Reports (CM/CHW) CRISP Reports	Sample **EMR Report**
	5. PFAC ®	▪ I was happy to be part of my doctor's office PFAC and give feedback on how my care is delivered		☑	☑		☑						Sample **PFAC Structure/Meeting Agenda**

24/7 Access

✓ **Patients to connect to Care Team**
&
✓ **Care Team to connect to EMR**

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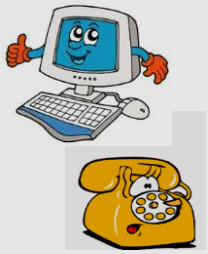
CTO/Coach Support

☑ Same-day, Next-day access
☑ Telephone advice on clinical issues
☑ After-Hours Service
☑ Direct Messaging through Patient Portal
☑ Secure/encrypted email
☑ On-Call Scheduling
☑ Remote Access to EMR



I was able to speak with a provider last week after office hours when I needed to – that saved me a visit to the ED

MARYLAND Department of Health

24/7 Access & Alternative Care Visits

Know your "Why"

- ☑ Provider 24/7 EHR Access, streamlines communication between care team members and patients … & saves costs
- ☑ Reduces patient wait times
- ☑ Effectively meet patients' needs & Increases patient satisfaction
- ☑ Potentially reduces ED visits, IP admission & associated costs
- ☑ Can improve preventive & chronic care with focus on self-management

Alternative Care Visits

Alternative care refers to care delivered outside of traditional office visits with clinicians.

Examples:

- telemedicine/video-based consults
- telephone visits/e-visits
- group visits
- visits in alternative locations
- telehealth: self-management education programs
- home visits

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CTO/Coach Support

Use of Alternative care: To focus on **preventive care and self-management** to help patients maintain and improve their health

Group Visit – PDSA Example

QUESTION: How can improve access to medical care visits for diabetic patients using group visits?

Test of Change: *Establish diabetic group visits*

Plan: 1) Identify practice staff/team 2) Identify space/capacity 3) Provider/staff training on group facilitation 4) Choose appropriate group structure/appropriate patients 5) Develop structure & content of the session 6) Draft group visit invitation

Do: Invite patients & Conduct Group visit (See next slide)

Study: 1) Number of patients who attended
2) Variation between planned vs. actual timeframe for group visit
3) Any key issues noted with the group-visit format

Act: Make adjustments to the group-visit format and conduct another test of change cycle

Group Visit – PDSA Example

Do: Conduct Group visit (1.5 – 2 hrs.)

- ☑ Prior to the group visit, nursing staff typically spend about two hours of preparation time, reviewing and documenting medical records as well as completing forms for diagnostic tests and lab work.
- ☑ Group visits generally begin with a brief check-in and greeting period. During this time, the administrative staff registers patients, collects co-payments, etc.
- ☑ General discussion of the diabetes, focusing on common problems among attendees (approximately 30 minutes). Patients are seated in a circle or semicircle to promote interaction and are encouraged but not required to share their personal information and experiences.
- ☑ Following the discussion, the group takes a break, often with refreshments
- ☑ During the break, a nurse or medical assistant completes vital signs and the physician confers with each patient individually – yet still in the group setting – about specific health problems. (This could take 25 to 35 minutes for a group of 8 to 10.)
- ☑ Followed by a question-and-answer period (approximately 15 minutes).
- ☑ Finally, if needed, physicians conduct private one-on-one visits, usually with just two to three patients (30 to 45 minutes).
- ☑ Physicians may spend about an hour after the group visit to document findings

Using Data to Plan Care

Know your "Why"

- ☑ Using data available through CRISP and your EHR **is critical** to developing the workflows and analytics needed to guide changes that will reduce patient care utilization and improve quality & patient experience

- ☑ Tracking eCQMs has helped practices more **efficiently organize care and resources** around condition-specific needs

Using Data to Plan Care

Quality | Utilization | Patient experience | eCQMs

- ☑ Identify the crucial measures and data

- ☑ Develop processes to regularly collect data
  - CRISP: CMS claims data – include data on:
    - *i. Attributed beneficiaries*
    - *ii. Costs and IP & ED utilization*
    - *iii. Practice trends*
  - Your Internal practice or system data: Practice & Panel level data
    - *i. Interim eCQMs measures*
    - *ii. Assess continuity and Care coordination*
    - *iii. PFAC information*

QR
CTO/Coach Support

- ☑ Establish an internal process to regularly review measures & performance as a team

Using Data to Plan Care for your Patient Population

Session Recap

- ☑ Used our test patient Ms. Anexxa to have a practical conversation about activities that usually occur after the patient's office visit; and reviewed requirements on:
  - *Longitudinal Care Management*
  - *Care Plans*
  - *Referral Management*
  - *Episodic Care Management*
  - *Follow up to ED & Hospital discharge*
  - *Using data to continuously improve care delivery (esp. CRISP ENS)*
  - *Alternative care visits*
  - *Using data to plan for care for your patient population*

- ☑ Ms. Anexxa's experience with her care management services

LCM vs. ECM

Movement

Longitudinal Care Management (LCM)

Identified based on risk stratification of empaneled patients

Episodic Care Management (ECM)

Identified based on transition of care such as:

-Recent ED Visit

-Recent Hospitalization

-New Diagnosis

Can be further risk stratified

Post-survey

Questions:

After this session, on a scale of 1-5 how would you rate your knowledge on:

18. Workflow: People, Process & Technology/Tools
19. Longitudinal Care Management (LCM)
20. Care Plan Basics
21. Episodic/Transitional Care Management (ECM/TCM)
22. Alternative care visits

** Call to Action: What is your readiness level to try applying this knowledge at your practice?

Scale Key

1 = Fair
2 = Building
3 = Steady
4 = Strong
5 = Invincible

CRISP

HIE Services for MDPCP Participants

Summer 2019

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Pre-Survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

23. Using CRISP services and leveraging claims reports

Scale Key

1 = Fair
2 = Building
3 = Steady
4 = Strong
5 = Invincible

Disclosure Announcement

No disclosure related to this presentation

Agenda

1. Brief Overview of CRISP services and role for MDPCP
2. Care alerts and panel management
3. eCQM reporting
4. Using reports to identify target areas
5. Upcoming releases and discussion

Services Overview

About CRISP

Regional Health Information Exchange (HIE) serving Maryland, West Virginia, and the District of Columbia.

Vision: To advance health and wellness by deploying health information technology solutions adopted through cooperation and collaboration

Guiding Principles

1. Begin with a manageable scope and remain incremental.
2. Create opportunities to cooperate even while participating healthcare organizations still compete in other ways.
3. Affirm that competition and market-mechanisms spur innovation and improvement.
4. Promote and enable consumers' control over their own health information.
5. Use best practices and standards.
6. Serve our region's entire healthcare community.

CRISP Core Services

1. POINT OF CARE: **Clinical Query Portal & In-context Information**

- Search for your patients' prior hospital records (e.g., labs, radiology reports, etc.)
- Monitor the prescribing and dispensing of PDMP drugs
- Determine other members of your patient's care team
- Be alerted to important conditions or treatment information

2. CARE COORDINATION: **Encounter Notification Service (ENS)**

- Be notified when your patient is hospitalized in any regional hospital
- Receive special notification about ED visits that are potential readmissions
- Know when your MCO member is in the ED

3. POPULATION HEALTH: **CRISP Reporting Services (CRS)**

- Use Case Mix data and Medicare claims data to:
  - Identify patients who could benefit from services
  - Measure performance of initiatives for QI and program reporting
  - Coordinate with peers on behalf of patients who see multiple providers

4. PUBLIC HEALTH SUPPORT:

- Deploying services in partnership with Maryland Department of Health
- Pursuing projects with the District of Columbia Department of Health Care Finance
- Supporting West Virginia priorities through the WVHIN

5. PROGRAM ADMINISTRATION:

- Making policy discussions more transparent and informed
- Supporting Care Redesign Programs

CRISP Support for MDPCP

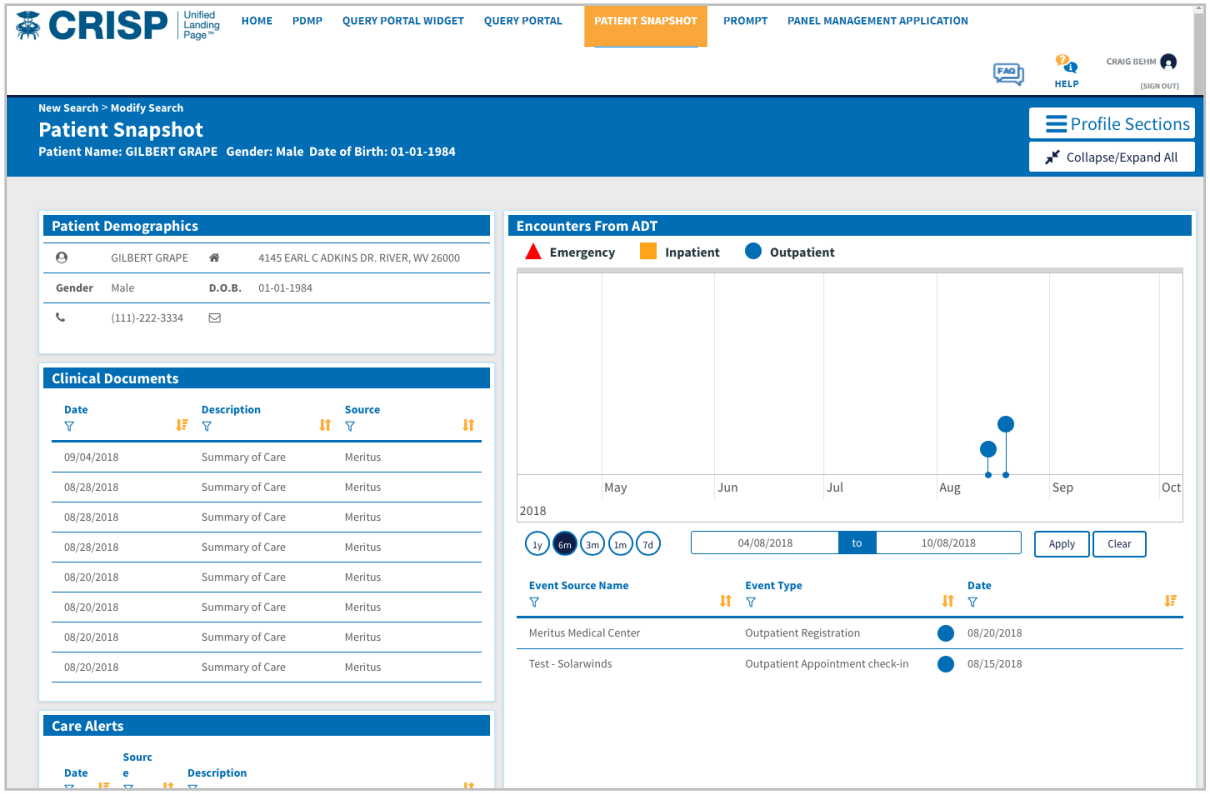
CRISP has committed to support MDPCP in the following three ways:

1. CRISP will enable certain HIE tools which participating practices must use to facilitate better care coordination.
2. CRISP will provide claims-based reports to each participating practice for tracking progress and providing interventions.
3. CRISP will aggregate the quality measure submissions from participating practices to submit to CMS.

Point of Care: Unified Landing Page & Snapshot

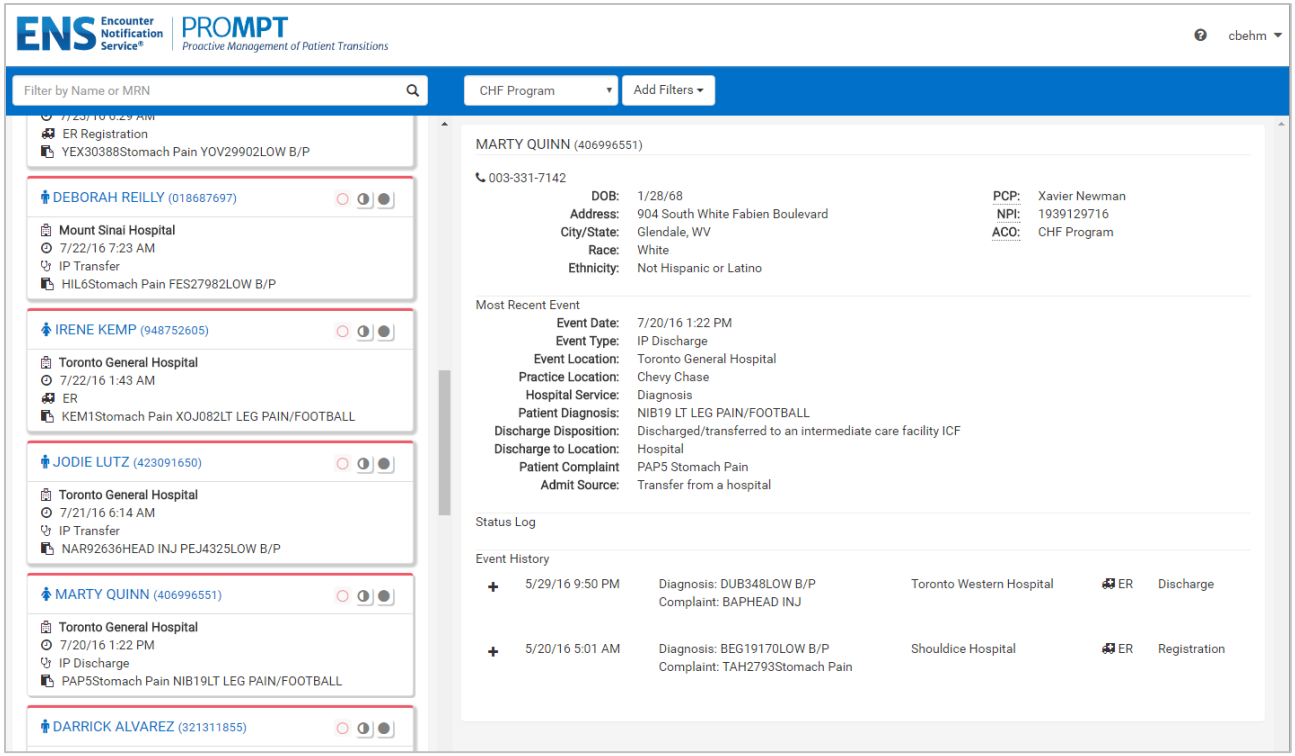
All CRISP applications in a single, secure site with one username and password

- Snapshot: View of critical patient data including care alerts, care teams, and prior visits with customizable widgets
- PDMP (authorized users only per State mandate)
- Health Records: Labs, radiology, images, and other clinical documents



Care Coordination: ENS ProMPT

- Real-time or batch alerts to appropriate providers based on treatment and care management relationships
- User interface within CRISP secure portal or messages delivered into Direct or EHRs

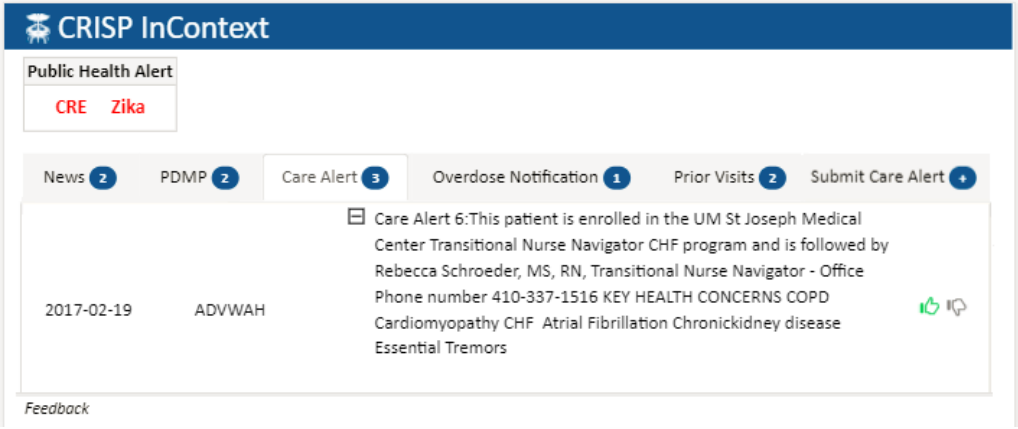


CRISP

Care Alerts

Point of Care: Care Alerts

- Care Alert: a short description of critical information for patient care generated by CRISP participants.
- Viewable in the ULP and in CRISP embedded Apps



"Mr. Stevens has CHF exacerbations that typically and rapidly respond to 40 mg IV furosemide in the ED with close follow up the next day in the office. Call/text Dr. FIRST at 111-333-4444 if you are considering admission."

"This patient has a MOLST. Please note: DNR, DNI, no feeding tube, no antibiotics."

"Mrs. Franklin's pain medications are managed entirely by Dr. Dolor. Securely text him prior to prescribing any controlled substances."

How to write a Care Alert

- **Identify high needs patients** for whom you want to relay critical information to other providers
- Decide on a **workflow** for authorship and hygiene
  - Can be a group of folks, or anyone treating the patient
  - Decide how you will update/remove care alerts (workgroup, quarterly review, etc.)
- Decide on a general **format**
- **Inform CRISP** when you are ready to send alerts

CRISP has guidance available: White Paper and 5x7 card for quick reference, created in partnership with the Maryland Patient Safety Center

https://www.crisphealth.org/wp-content/uploads/2016/03/Care-Alerts-White-Paper-MPSC-final.pdf

CRISP is also happy to provide in person training/guidance on care alert implementation

How to submit Care Alerts to CRISP

- Several options:
  - Send on your existing patient panel by adding a “Care Alert” column
  - Send a separate panel of only care alerts to CRISP
  - If integrated with CRISP, identify an area of your progress notes, or choose a note type or template within your EMR to write care alerts, and work with CRISP + your EMR to configure data feeds to send those note types

Once you determine how you want to submit care alerts, please contact your CRISP representative so that we can allot the necessary resources to implement

Panel Management

- In addition to care alerts, it is vital to share as much information about your patients as possible
- By adding PCP, Care Manager (+phone or email), Care Program, and Insurance columns to your patient panel, you gain the following benefits:
  - These fields will be sent back to you in **ENS notifications**, allowing for more robust filtering and tracking (i.e. Do patients attributed to a specific care manager tend to have higher utilization rates?)
  - Fields will be available in the Care Team widget of the Patient Snapshot application so that other providers can easily see and obtain contact information, facilitating more **effective communication**

How to implement panel changes

- Add columns corresponding to the fields you wish to add, and populate for the appropriate patients
- If integrated, work with your EMR and CRISP to identify how these fields can be incorporated into the data messages that CRISP receives

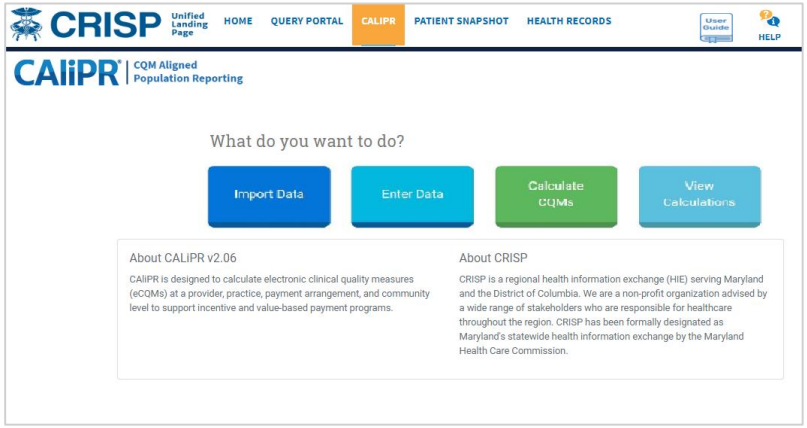
Once you have made these changes, inform your CRISP representative, so that we can confirm accurate processing of any new configurations

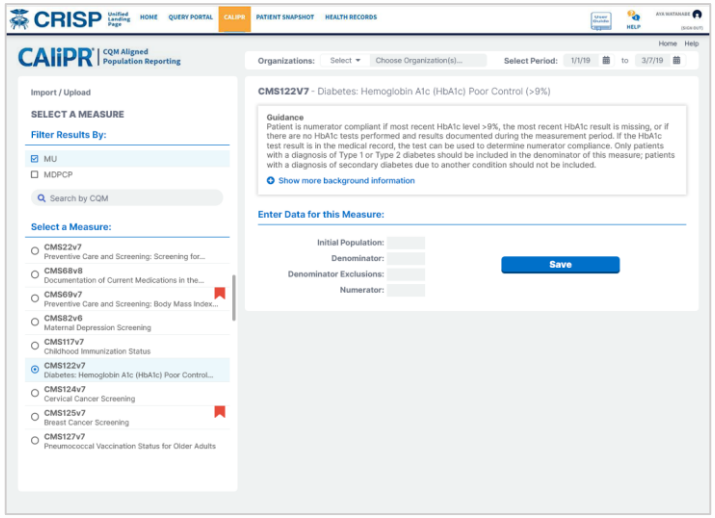
C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
MRN	first_name	middle_name	last_name	address_line_1	address_line_2	city	state	zip	date_of_birth	gender	ssn	home_phone	work_phone	cell_phon	care_program	care_manager	care_manager_phone	pcp	care_alert
999999	John	K	Doe	33 main st	apt 45	baltimore	MD	21230	19990101	M	999999999	4105551212	4105551212	4105551212	Diabetes	Jane Smith	5107775555	Dr. Jones	This patient re
1000000	Jane	K	Doe	34 main st	apt 46	baltimore	MD	21230	19990101	M	999999999	4105551212	4105551212	4105551212	Transitional Care				
1000001	Jim	K	Doe	35 main st	apt 47	baltimore	MD	21230	19990101	M	999999999	4105551212	4105551212	4105551212	Diabetes				

eCQM Reporting

eCQM Reporting

- Participants will extract quality measures from their EHRs either in QRDA III format or a list of numerators, denominators, and exclusions
- Log into CALIPR through CRISP to either upload QRDA III or manually enter values
- CRISP will submit a single file on behalf of Maryland to CMS at the close of the reporting period



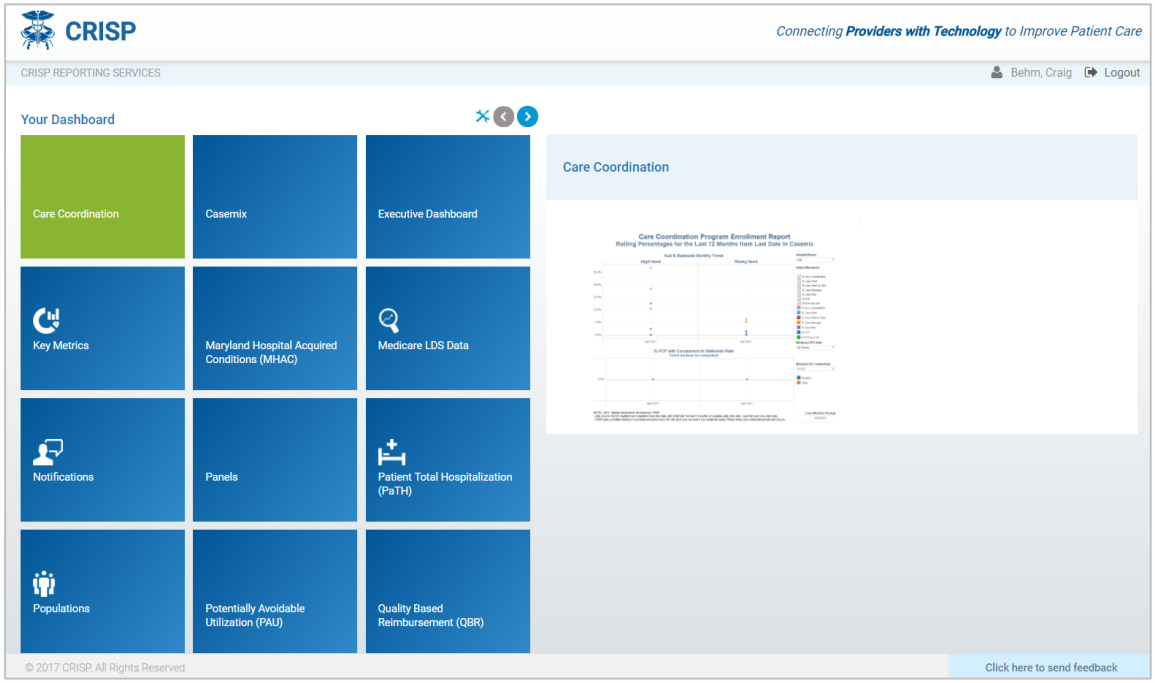


CRISP

Using Reports to Identify High-Cost Providers

Population Health: CRISP Reporting Services

- Dashboards from administrative data to support high-needs patient identification, care coordination, and progress reporting
- Primary data sets are hospital casemix and Medicare claims and claim line feed (CCLF)
- Different levels of patient data available for hospitals based on HSCRC payment requirements and Total Cost of Care Model participation
- There are over **600 active users** viewing **85 reports** over **2,000 times per month**



MDPCP Reports

Reports include:

- Population Summary (Summary Dashboard)
- Base vs Current Year Comparison
- Demographics
- PMPM Trend
- Diagnosis Report (by CCS Category)
- Inpatient / ER Utilization
- Professional Services (BETOS / POS)

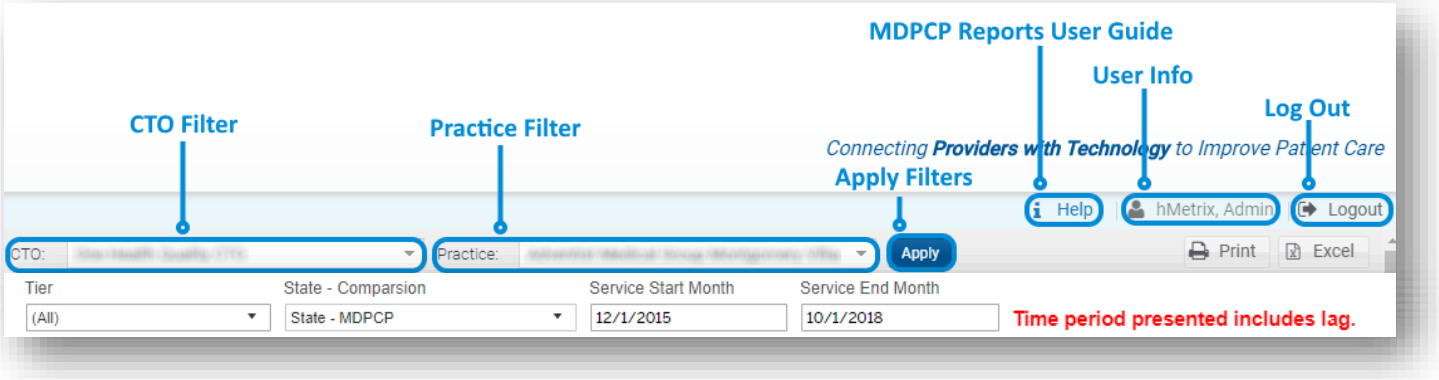
Key Metrics

- Distribution by Beneficiaries by Demographic Categories
- PMPM Spending
- Count of Inpatient Admissions / ER Visits
- Inpatient Admissions / ER Visits per 1,000
- Readmission Rate

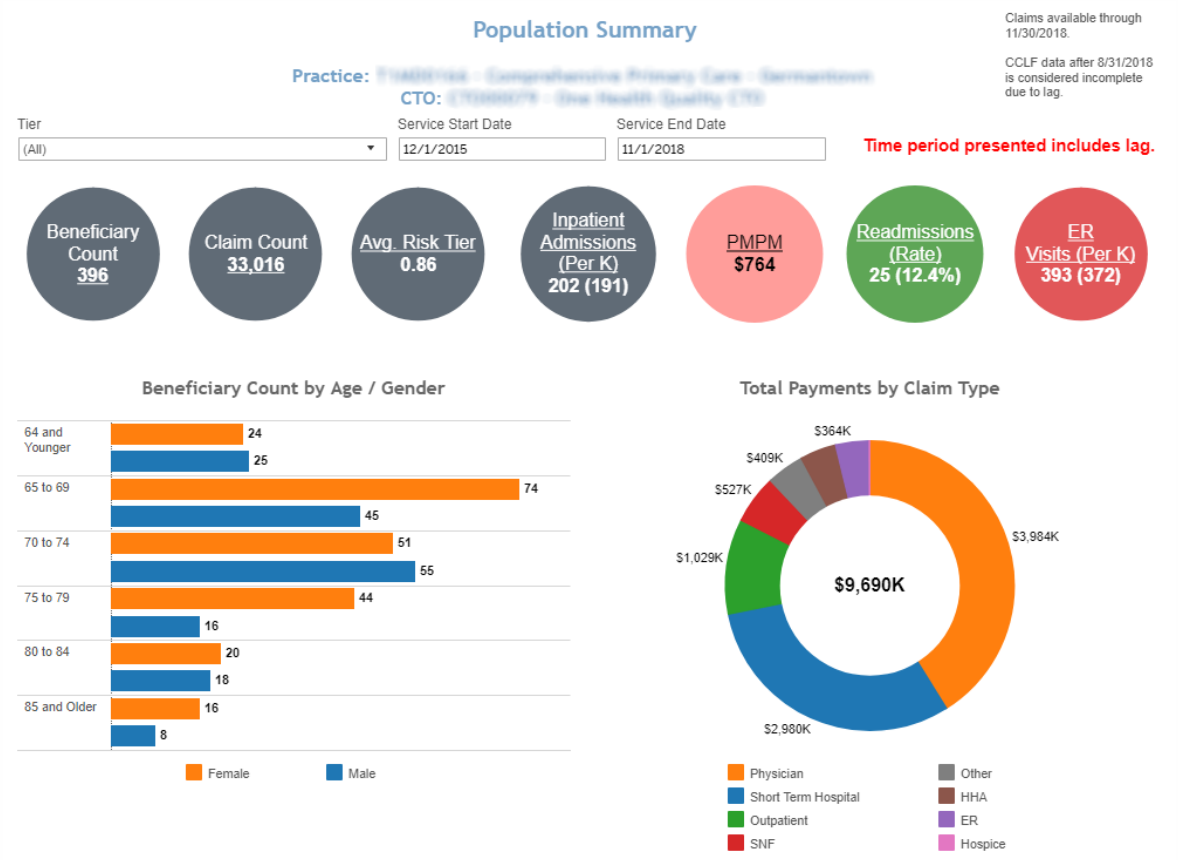
Drill-through capability to access beneficiary lists and claims

MDPCP Report General Features

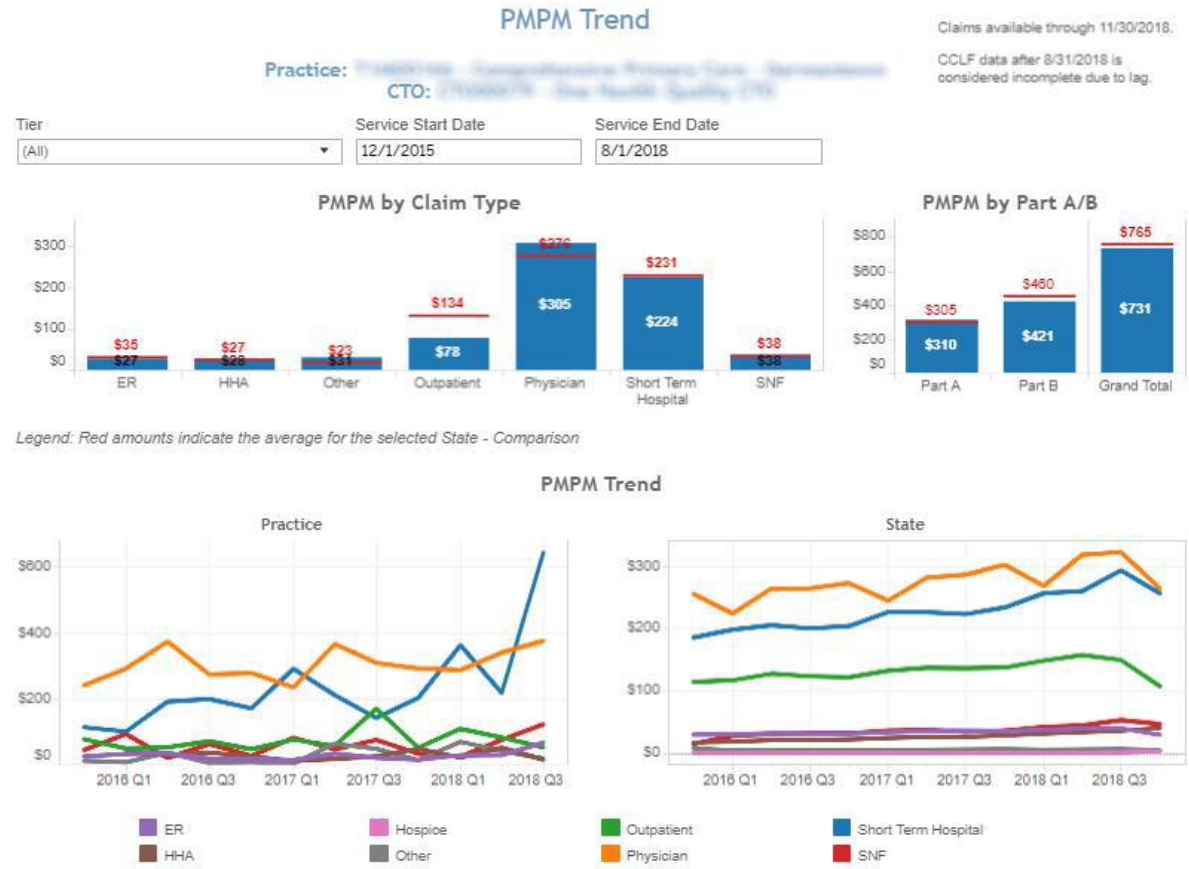
- View data for one or more CTO / Practice at a time
- Customize reports by Risk Tier, State Comparison, and Date filters
- View or download User Guide
- Export to PDF or Excel
- Access patient and claim-level details for export



Population Summary



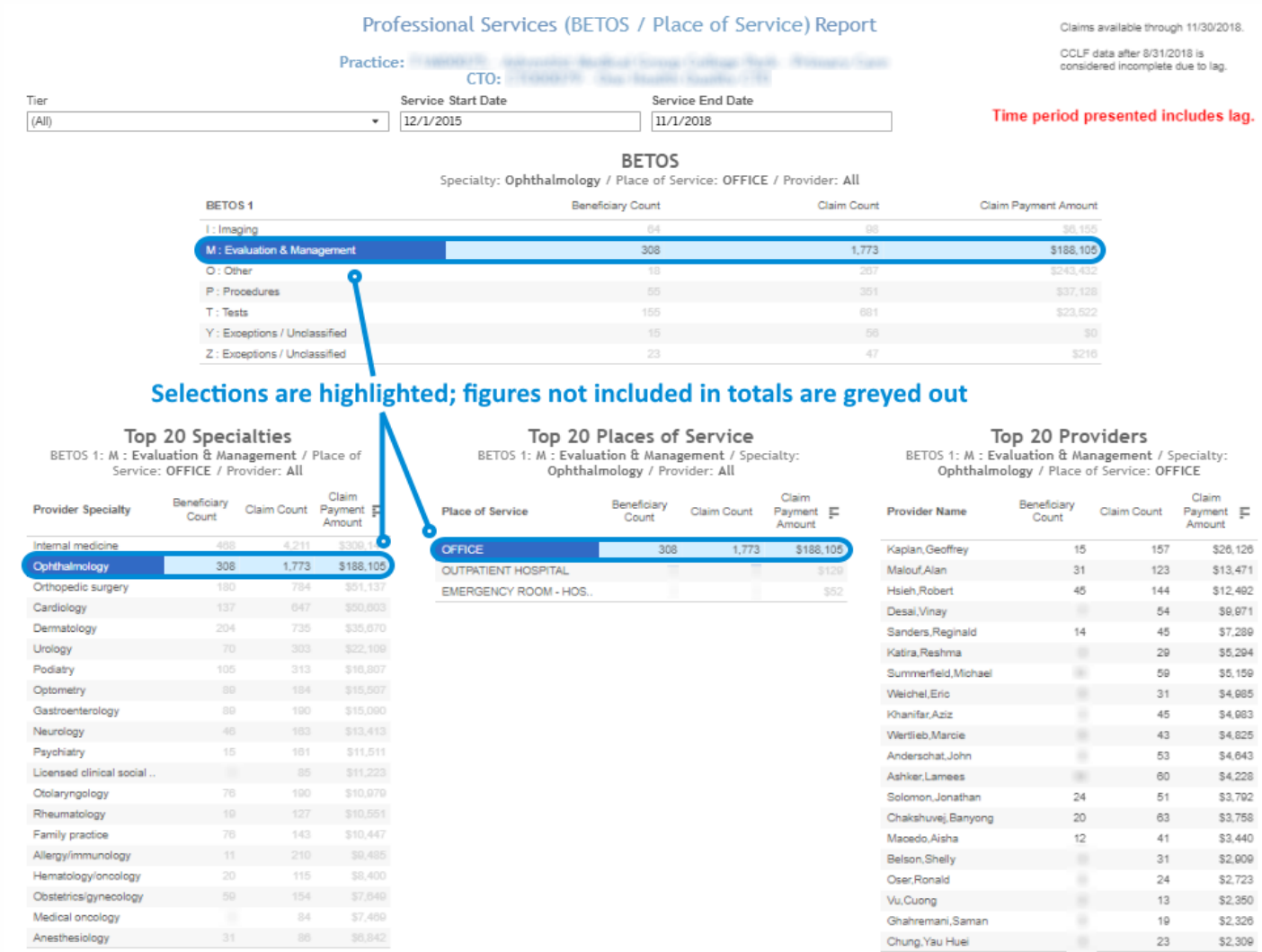
PMPM Trend



Top Providers by Payment Amount - All

Provider Name	Beneficiary Count	Claim Payment Amount	Avg. Claim Payment Amount
[redacted]	[redacted]	[redacted]	$27,832
[redacted]	[redacted]	[redacted]	$19,466
[redacted]	[redacted]	[redacted]	$17,354
[redacted]	[redacted]	[redacted]	$15,104
[redacted]	[redacted]	[redacted]	$14,647

Professional Services (BETOS/POS)



Professional Services (BETOS / Place of Service) Report

Practice: [redacted]
CTO: [redacted]

Claims available through 11/30/2018.

CCLF data after 8/31/2018 is considered incomplete due to lag.

Tier: (All) | Service Start Date: 12/1/2015 | Service End Date: 11/1/2018

Time period presented includes lag.

BETOS

Specialty: **Ophthalmology** / Place of Service: **OFFICE** / Provider: **All**

BETOS 1	Beneficiary Count	Claim Count	Claim Payment Amount
I : Imaging	64	98	$6,155
M : Evaluation & Management	308	1,773	$188,105
O : Other	18	267	$243,432
P : Procedures	55	351	$37,128
T : Tests	155	681	$23,522
Y : Exceptions / Unclassified	15	56	$0
Z : Exceptions / Unclassified	23	47	$216

Selections are highlighted; figures not included in totals are greyed out

Top 20 Specialties

BETOS 1: **M : Evaluation & Management** / Place of Service: **OFFICE** / Provider: **All**

Provider Specialty	Beneficiary Count	Claim Count	Claim Payment Amount
Internal medicine	468	4,211	$309,1[illegible]
Ophthalmology	308	1,773	$188,105
Orthopedic surgery	180	784	$51,137
Cardiology	137	647	$50,603
Dermatology	204	735	$35,670
Urology	70	303	$22,109
Podiatry	105	313	$16,807
Optometry	89	184	$15,507
Gastroenterology	89	190	$15,090
Neurology	46	183	$13,413
Psychiatry	15	161	$11,511
Licensed clinical social ..	[illegible]	85	$11,223
Otolaryngology	76	190	$10,979
Rheumatology	19	127	$10,551
Family practice	76	143	$10,447
Allergy/immunology	11	210	$9,485
Hematology/oncology	20	115	$8,400
Obstetrics/gynecology	59	154	$7,649
Medical oncology	[illegible]	84	$7,469
Anesthesiology	31	86	$6,842

Top 20 Places of Service

BETOS 1: **M : Evaluation & Management** / Specialty: **Ophthalmology** / Provider: **All**

Place of Service	Beneficiary Count	Claim Count	Claim Payment Amount
OFFICE	308	1,773	$188,105
OUTPATIENT HOSPITAL	[illegible]	[illegible]	$129
EMERGENCY ROOM - HOS..	[illegible]	[illegible]	$52

Top 20 Providers

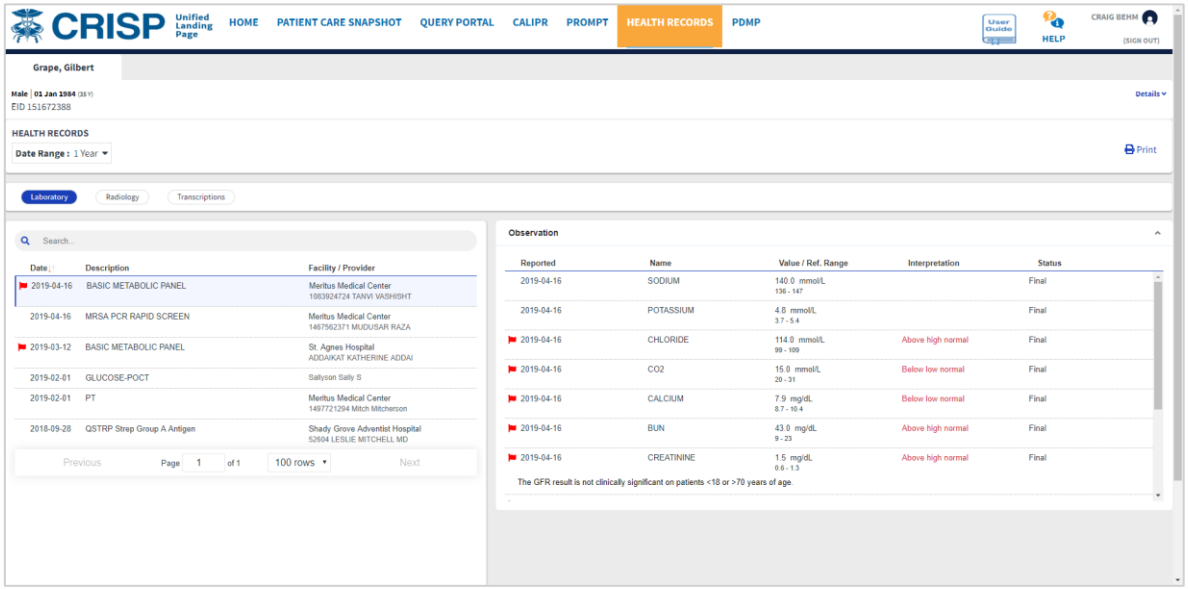
BETOS 1: **M : Evaluation & Management** / Specialty: **Ophthalmology** / Place of Service: **OFFICE**

Provider Name	Beneficiary Count	Claim Count	Claim Payment Amount
Kaplan,Geoffrey	15	157	$26,126
Malouf,Alan	31	123	$13,471
Hsieh,Robert	45	144	$12,492
Desai,Vinay	[illegible]	54	$9,971
Sanders,Reginald	14	45	$7,289
Katira,Reshma	[illegible]	29	$5,294
Summerfield,Michael	[illegible]	59	$5,159
Weichel,Eric	[illegible]	31	$4,985
Khanifar,Aziz	[illegible]	45	$4,983
Wertlieb,Marcie	[illegible]	43	$4,825
Anderschat,John	[illegible]	53	$4,643
Ashker,Lamees	[illegible]	60	$4,228
Solomon,Jonathan	24	51	$3,792
Chakshuvej,Banyong	20	63	$3,758
Macedo,Aisha	12	41	$3,440
Belson,Shelly	[illegible]	31	$2,909
Oser,Ronald	[illegible]	24	$2,723
Vu,Cuong	[illegible]	13	$2,350
Ghahremani,Saman	[illegible]	19	$2,326
Chung,Yau Huei	[illegible]	23	$2,309

New Features

Upcoming Releases

- Health Records application (right): new view of labs, radiology reports/images, and documents; replacing Mirth Results
- Migrating PROMPT into ULP to eliminate separate logins
- Enhancing ENS to allow for smarter alerting
- Report development for additional views and drill downs



Resources

Training materials, recorded webinars, and patient education flyers can be found at:
https://crisphealth.org/resources/

A full user guide is available at:
https://userguide.crisphealth.org

From CRISP Report to Implementation

Requirement: Coordinate referrals with **high volume/cost specialists** serving population

Step A: Identify the high-volume specialists using CRISP Reporting MDPCP Reports (Professional Services Tab)

Step B: Establish a collaborative care agreement with the high-volume specialists

i. Reach out to specialists and request a meeting to discuss collaborative care agreement

ii. Draft the collaborative agreement for discussion

iii. Meet with specialist(s), review agreement & finalize

iv. Schedule at least a bi-monthly meeting to discuss progress/status

Primary Care-Specialty Care Collaborative Guidelines
Level 1 Medical Neighbor

Transition of Care

Mutual Agreement

Maintain accurate and up-to-date clinical record.

Expectations

Primary Care	Specialty Care
☐ Transfers information as outlined in Patient Transition Record. ☐ Provides patient with specialist contact information	☐ Provide single source contact person to coordinate services with specialist or primary care practice. ☐ When PCP uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work-up

Access

Mutual Agreement

Be readily available for urgent help to both the physician and patient via phone.
Be prepared to respond to urgencies.
Provide alternate back-up when unavailable for urgent matters.

Expectations

Primary Care	Specialty Care
☐ Determines reasonable time frame for specialist appointment.	☐ Have timely consultation appointments available to meet patient and referral source requests. Discuss special arrangements, as needed.

Collaborative Care Management

Mutual Agreement

Define responsibilities between PCP, specialist and patient.
Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up).
Give and accept respectful feedback when expectations, guidelines or standard of care are not met

Expectations

Primary Care	Specialty Care
☐ Suggests type of transition of care ☐ Resumes care of patient when patient returns from specialist care and acts on care plan developed by specialist.	☐ Reviews information sent by PCP ☐ Sends timely reports to PCP to include a care plan, follow-up and test results as outlined in Specialist Transition Record.

Patient Communication

Mutual Agreement

Consider patient/family choices in care management, diagnostic testing and treatment plan.
Provide to and obtain informed consent from patient according to community standards.

Expectations

Primary Care	Specialty Care
☐ Explains specialist results and treatment plan to patient, as necessary. ☐ Identifies whom the patient wishes to be included in their care team.	☐ Informs patient of diagnosis, prognosis and follow-up recommendations. ☐ Recommends appropriate follow-up with specialist and PCP.

This physician compact has been developed for general distribution with the support of the Colorado Systems of

Post-Survey

Questions:

After this session- on a scale of 1-5 how would you rate your knowledge on:

23. Using CRISP Services and leveraging claims reports

Scale Key

1 = Fair
2 = Building
3 = Steady
4 = Strong
5 = Invincible

MARYLAND DEPARTMENT OF HEALTH

Session 8

Self Management & Advance Care Planning

Medicalincs LLC

MARYLAND
Department of Health

Presenters

Kyanni N. Fleming
RN, BSN, MS, MBA

Care Management Subject Matter Expert,
Medicalincs LLC

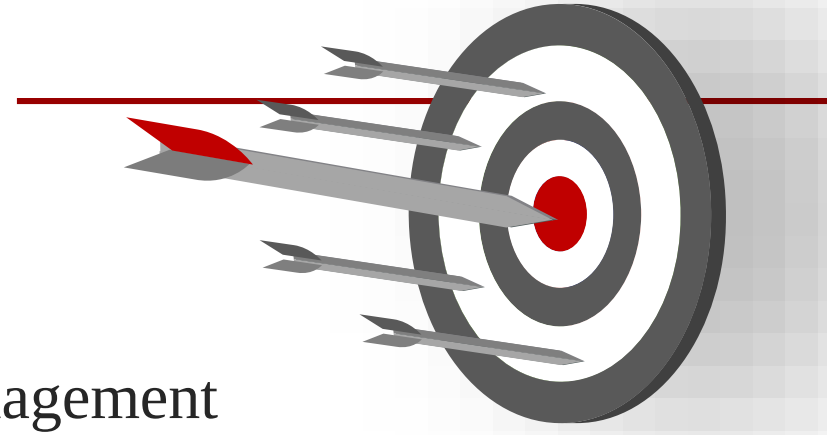
Nkem Okeke
MD, MPH, MBA, MSPM, CCMP

Chief Executive Officer, Medicalincs
Primary Care Transformation Expert

Disclosure Statement

No disclosure directly related to this presentation

Session Objectives



- ☑ Understand what patient self- management looks like
- ☑ Know available and relevant tools to assist patients with self-management & maintaining a resource registry
- ☑ Know tools for patient engagement and assessment such as PAM
- ☑ Understand Advanced Care Planning

Pre-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

24. Self-management
25. Tools to assist with self-management
26. Patient engagement & assessment tools
27. Advanced Care Planning

Scale Key

1 = Fair
2 = Building
3 = Steady
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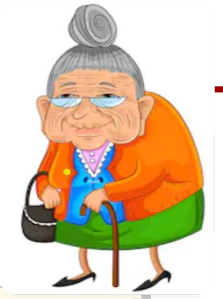
Our Patient: Ms. Anexxa, 71-year old Medicare beneficiary



Clinical Profile
▪ Type II Diabetes
▪ Long standing Hypertension (Last BP: 140/90 mmHg)
▪ CHF following a heart attack from 3 years prior
▪ Dependent on Opioid – which started after pain management for a hip fracture 4 years earlier
▪ Other Medications: Metformin 500 mg daily; Enalapril 30 mg/day PO qd; Aspirin 81 mg PO qd ; Lovastatin 40 mg PO qd
▪ Lifestyle modifications: Exercise - 30 mins moderate-intensity aerobic activity – 5d/week, Nutrition therapy (DASH diet)
Social Profile
▪ Retired widow who lives alone and her son lives 5 hours away & uses public transportation
▪ High school education; Worked as a kitchen staff in a school cafeteria; On fixed income
▪ She has no fresh food at home – due to her recent stay for 4 days in the hospital
▪ Experiences other care transition challenges such as: Off-road options, snapshot treatment, diminished ability and increased responsibility
Personality/Behavior Profile
▪ She is an extrovert, usually lively, a "people person" and does not like to be alone
▪ Enjoys attending group meetings when she can (e.g. Diabetes group)
▪ Does not exercise much and tries to maintain good eating habit
▪ She engages well with her peers and encourages them through life challenges
Utilization Profile (last 6m)
▪ 5 ED visits
▪ 2 Hospitalizations
▪ Most recent hospitalization after being treated for uncontrolled CHF & unaware of 2 of the 3 new prescriptions b/c they were electronically sent to the pharmacy
Cost (Utilization)
▪ Short term hospital – $27,000
▪ ER - $7,500
Total ED & Hosp (last 6m) - $34,500

Self- Management Support (SMS)

SMS is a key **role of the Care Manager** is to provide self-management support & follow up on the patient's care management

- Self-management support (SMS) gives your patients with chronic conditions tools to manage their health on a day-to-day basis and take an active role in their health care.

- SMS goes beyond supplying patients with information. It develops patient confidence by **allowing patients to collaborate with the care team to set goals,** regularly assess progress, provide problem-solving support, and make plans to live a healthier life.

QR
CTO/Coach Support

Self- Management Support (SMS)

Approach

A. Incorporate evidence-based approaches to promote collaborative self-management into usual care using techniques, such as:
   - ❑ ***Goal-setting with structured follow-up***
   - ❑ ***Teach-Back***
   - ❑ ***Action planning, and***
   - ❑ ***Motivational interviewing***

B. Use tools to assist patients in assessing their need for and receptivity to SMS (e.g., the **Patient Activation Measure (PAM)**, How's MyHealth)

PAM

The Patient Activation Measure (PAM) assesses an individual's knowledge, skill, and confidence for managing one's health and healthcare … Each activation level reveals insight into an array of health-related characteristics, including attitudes, motivators, behaviors, and outcomes.

QR
CTO/Coach Support

PAM® ACTIVATION LEVELS

Level 1	Level 2	Level 3	Level 4
DISENGAGED AND OVERWHELMED	**BECOMING AWARE BUT STILL STRUGGLING**	**TAKING ACTION AND GAINING CONTROL**	**MAINTAINING BEHAVIORS AND PUSHING FURTHER**
"My doctor is in charge of my health."	*"I could be doing more for my health."*	*"I'm part of my health care team."*	*"I'm my own health advocate."*
Individuals are passive and lack confidence. Knowledge is low, goal-orientation is weak, and adherence is poor.	Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals.	Individuals have the key facts and are building self-management skills. They strive for best practice behaviors, and are goal-oriented.	Individuals have adopted new behaviors, but may struggle in times of stress or change. Maintaining a healthy lifestyle is a key focus.
Healthcare utilization: Very high ED/ER use, very high risk of Ambulatory Care Sensitive (ACS) utilization, very high risk of readmission, very low use of preventive care and screens.	Healthcare utilization: High ED/ER use, high risk of ACS utilization, high risk of readmission, low use of preventive care and screens.	Healthcare utilization: Low ED/ER use, low risk of ACS utilization, low risk of readmission, good use of preventive care and screens.	Healthcare utilization: Very low ED/ER use, very low risk of ACS utilization, very low risk of readmission, very good use of preventive care and screens.

Self- Management Support (SMS)

Approach (Contd.)

C. Use **group visits** for common chronic conditions (e.g., diabetes)

D. Provide **condition-specific and chronic disease SMS programs or coaching**, or link patients to those programs in the community

E. Provide **self-management materials at an appropriate literacy level** and in an appropriate language

F. Use a shared agenda for the visit and provide health coaching between visits

Self- Management

- ☑ **Patients are in control of their health outcomes**
- ☑ **Assess/Measure patient's activation and readiness to change**
  - PAM
- ☑ **Support**
  - Education/Programs (i.e. DPP)
  - Health Coaching
  - Support Groups/Community Resources
- ☑ **DME**
  - Assistive Devices and Technology
  - Environmental Adaptations
- ☑ **Online Tools & Apps**
  - Lose It!, MyFitnessPal (weight loss)
  - Apple Health App
  - HF Path/MyTherapy /HFSA App (CHF)
  - MySugr/Glucose Buddy App (Diabetes)
  - Dosecast/MediSafe/PillMonitor App (Medication Adherence)

QR
CTO/Coach Support

Breakout Discussion

Share your experiences with implementing self management support ...

How have you used a tool like PAM to improve patient engagement & care?

Advanced Care Planning

Know your "Why"

- ☑ Primary care teams are the ideal personnel to address patient goals & preferences at the end of life as they have built trusting relationships with patients over time

- ☑ Early conversations with patients about serious illnesses can decrease health care utilization and improve the quality of care, and lead to fewer interventions that conflict with the patients' goals

Advance Care Planning (ACP)

QR
CTO/Coach Support

- Only 30% of Marylanders have Advance Directives
- Financial Costs and Emotional Costs high when not done
- **Identify high risk populations** but adopt universal approach
- Documents:
  - *Advance Directives*
  - *Durable Power of Attorney*
  - *Living Will*
  - *MOLST - Maryland Order of Life Sustaining Treatment*
- At the patient's discretion, the initial AWV may also include advance care planning services
- ACP conversations are especially valuable for frail and medically complex patients.
- **Documentation of ACP conversations** is also important

ACP Billing

- Can be a billable event with AWV or Separate Encounter

- **99497 Advance care planning** including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; **first 30 minutes**, face-to-face with the patient, family member(s), and/or surrogate

- **99498 Advance care planning** including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; **each additional 30 minutes** (List separately in addition to code for primary procedure

Resources

On-line Maryland Programs:

- ❑ My Directives at http://www.mydirectives.com/
- ❑ Speak Easy at https://speakeasyhoward.org/
- ❑ Inspiration video

Inspiration video

Session Recap

- ☑ Used our test patient Ms. Anexxa to have a practical conversation about:
  - ❑ self-management *(and resources)*
  - ❑ advance care planning *(and resources)*
- ☑ Ms. Anexxa's experience with her care management services
- ☑ Reviewed billing for Advanced Care Planning

Post-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

24. Self-management
25. Tools to assist with self-management
26. Patient engagement & assessment tools
27. Advanced Care Planning

** Call to Action: What is your readiness level to try applying this knowledge at your practice?

Scale Key

1 = Fair
2 = Building
3 = Steady
4 = Strong
5 = Invincible

MARYLAND DEPARTMENT OF HEALTH

Session 9

Social Determinants/Needs - Screening & Resource Registry

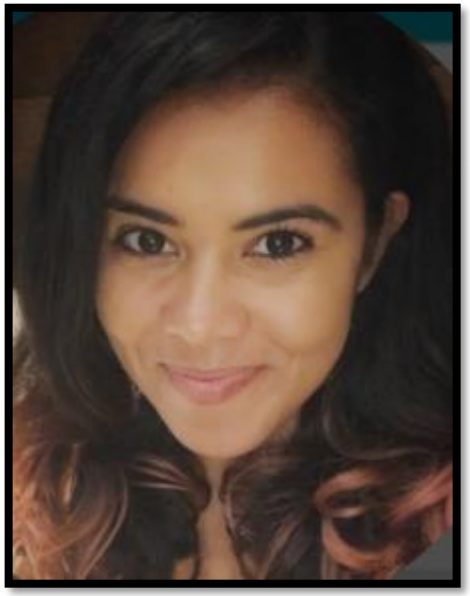
Sonia Almonte, BPA

Medicalincs LLC

September 2019

MARYLAND Department of Health

Presenter



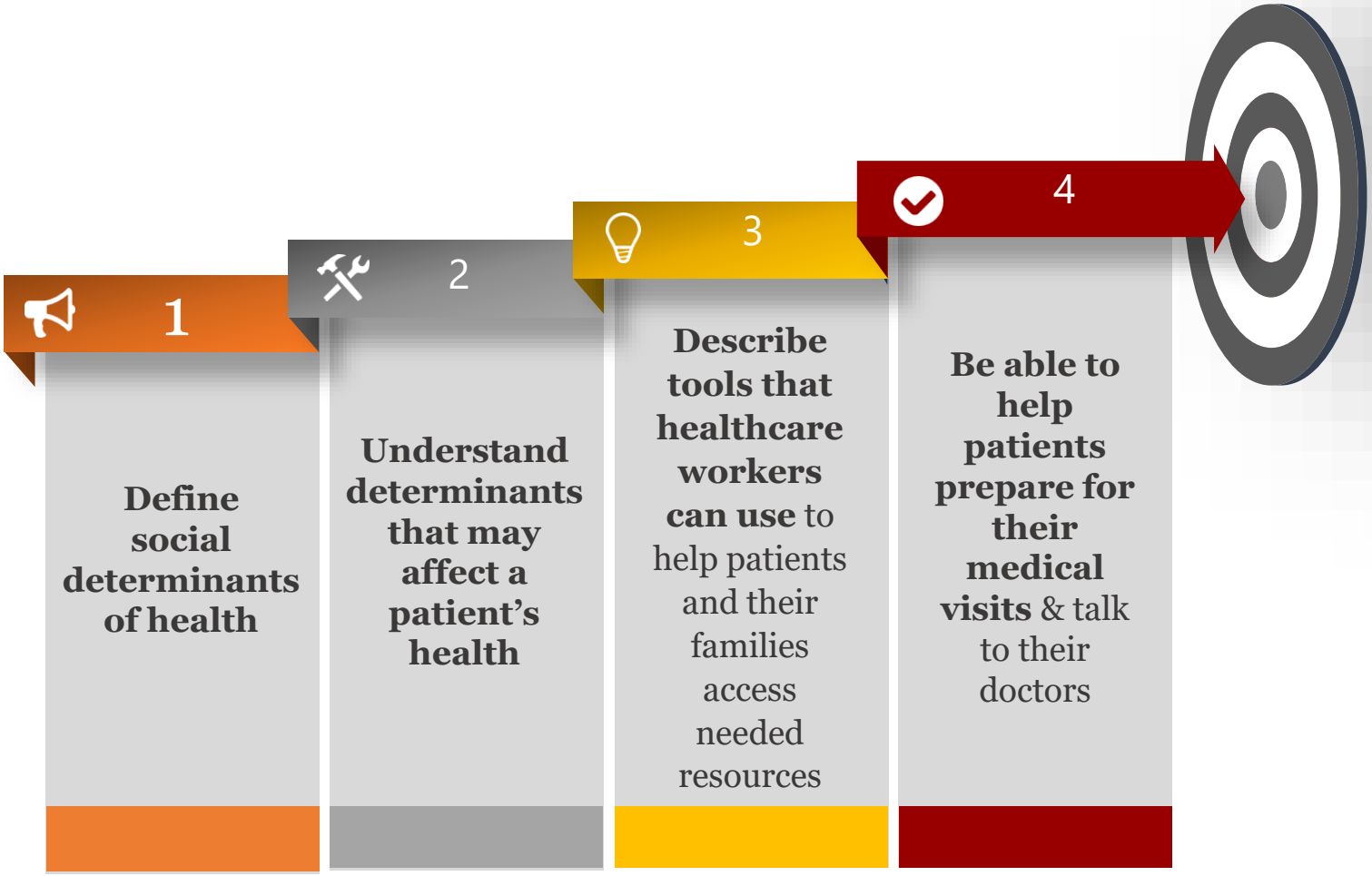
Sonia Almonte, BPA

Care Coordination (Community Health) Expert

Disclosure Announcement

No disclosure related to this presentation

Session Objectives



Pre-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

28. Defining social determinants of health & how they may affect a patient's health
29. Tools that healthcare workers can use to help patients & their families access needed resources
30. Helping patients talk to their doctors & preparing them for medical visits

Scale Key

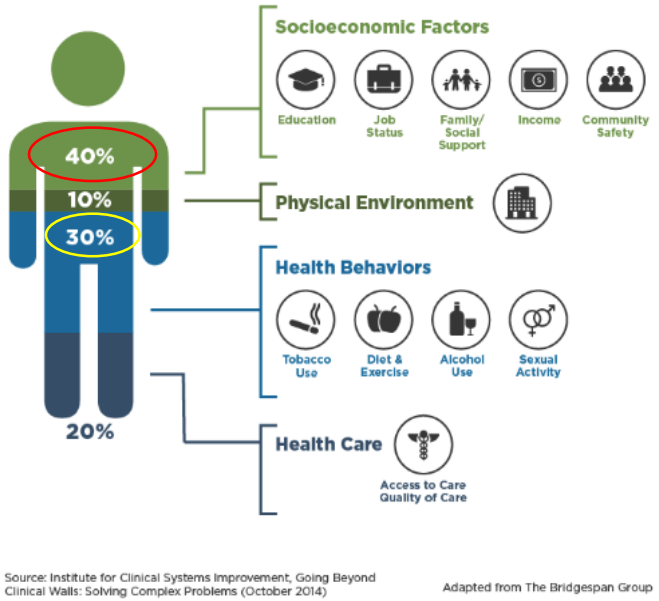
1 = Fair
2 = Building
3 = Steady
4 = Strong
5 = Invincible

Defining Social Determinants of Health (SDOH)

- ☑ The World Health Organization (WHO) defines SDOH as:
  "The conditions in which people are born, grow, live, work and age."

- ☑ WHO further states that **"these circumstances are shaped by the distribution of money, power, and resources at global, national and local levels."**

"The Why": Impact of SDOH



Social Determinants of Health - Examples

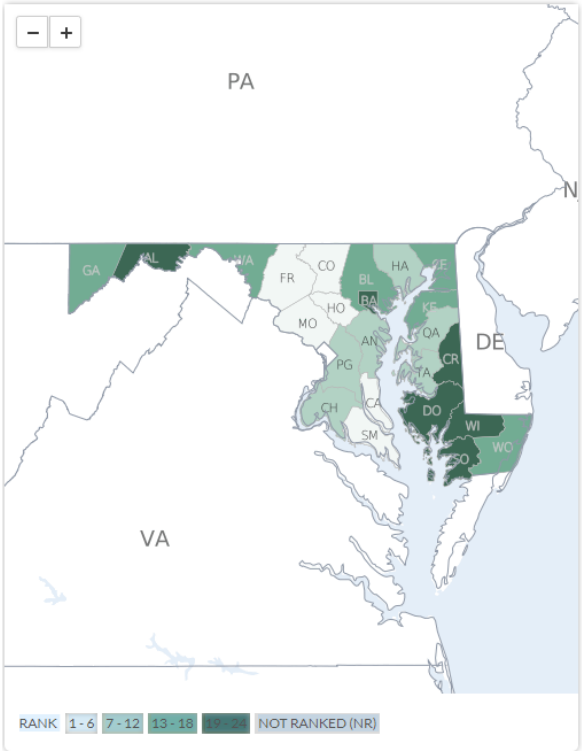
- ☑ Early childhood experiences and development
- ☑ Social support and community inclusivity
- ☑ Crime rates and exposure to violent behavior
- ☑ Availability of transportation
- ☑ Neighborhood conditions and physical environment
- ☑ Access to safe drinking water, clean air, and toxin-free environments
- ☑ Recreational and leisure opportunities

Source: https://catalyst.nejm.org/social-determinants-of-health/

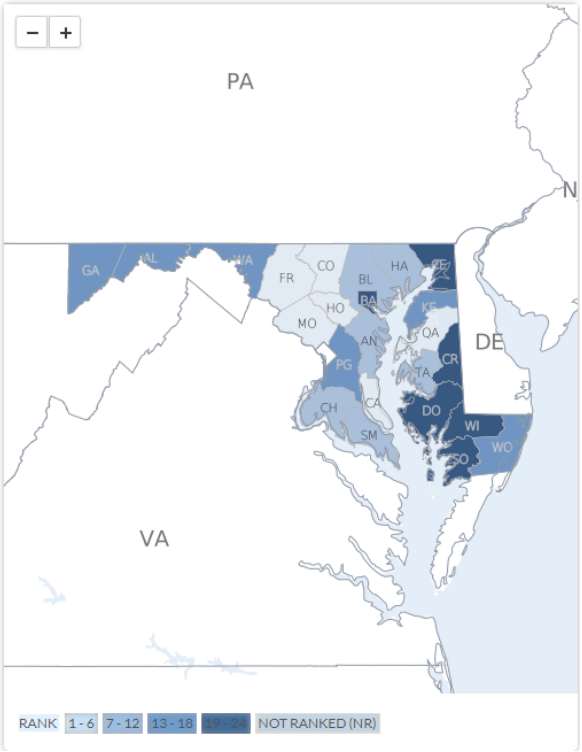
How Healthy is Your Community?

Find out how healthy your county is and explore factors that drive your health

Overall Rankings in Health Outcomes



Overall Rankings in Health Factors



Source: http://www.countyhealthrankings.org/

Our Patient: Ms. Anexxa, 71-year old Medicare beneficiary

Clinical Profile

- Type II Diabetes
- Long standing Hypertension (Last BP: 140/90 mmHg)
- CHF following a heart attack from 3 years prior
- Dependent on Opioid – which started after pain management for a hip fracture 4 years earlier
- Other Medications: Metformin 500 mg daily; Enalapril 30 mg/day PO qd; Aspirin 81 mg PO qd ; Lovastatin 40 mg PO qd
- Lifestyle modifications: Exercise - 30 mins moderate-intensity aerobic activity – 5d/week, Nutrition therapy (DASH diet)

Social Profile

- Retired widow who lives alone and her son lives 5 hours away & uses public transportation
- High school education; Worked as a kitchen staff in a school cafeteria; On fixed income
- She has no fresh food at home – due to her recent stay for 4 days in the hospital
- Experiences other care transition challenges such as: Off-road options, snapshot treatment, diminished ability and increased responsibility

Personality/Behavior Profile

- She is an extrovert, usually lively, a "people person" and does not like to be alone
- Enjoys attending group meetings when she can (e.g. Diabetes group)
- Does not exercise much and tries to maintain good eating habit
- She engages well with her peers and encourages them through life challenges

Utilization Profile (last 6m)

- 5 ED visits
- 2 Hospitalizations
- Most recent hospitalization after being treated for uncontrolled CHF & unaware of 2 of the 3 new prescriptions b/c they were electronically sent to the pharmacy

Cost (Utilization)

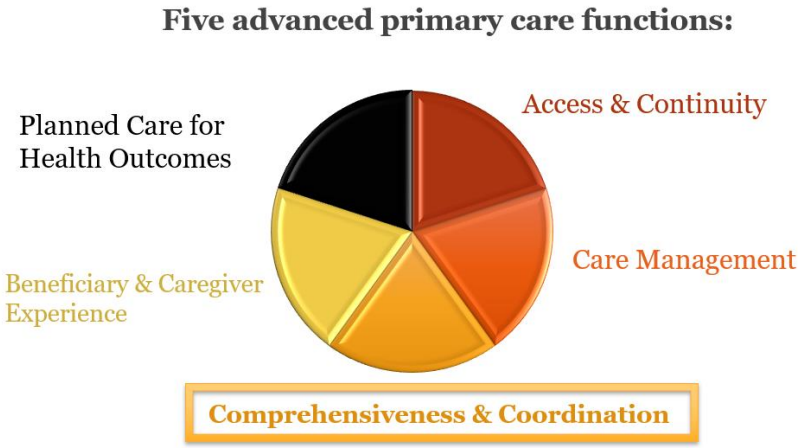
- Short term hospital – $27,000
- ER - $7,500

Total ED & Hosp (last 6m) - $34,500

MDPCP Requirements: Social Needs

☑ Practices should:

- **Complete an assessment** of their attributed beneficiaries' health-related social needs
- **Conduct an inventory of resources** and supports in the community to meet those needs.

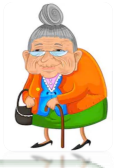


☑ Practices to **utilize the health-related social needs screening tool**

Our Patient: Ms. Anexxa

Workflow for Social Needs Support

Sample Community Health Support Workflow



CHW Received Referral for Services to address SDoH

CHW conducts patient outreach

Suggested outreach protocol:
- 1-3 business days upon receipt of the referral
- 3 telephonic attempts

Patient Reached?

NO

Questions to keep in mind:
- SDH assessment tool identified? Configured in EMR?
- Implementation plan template available? Configured in EMR?

Conduct baseline assessment & develop Intervention plan

Questions to keep in mind:
- Any guidelines for Comm Health Support services?
- Where is the inventory of SDoH resources stored? And often is it updated?

Provide Comm Health support services
Maintain an updated Inventory of Resources

Questions to keep in mind:
- What is the re-assessment schedule? Monthly? Bi-monthly?

Reevaluate periodically

Patient still needs CHW Support?

YES

NO

Follow up weekly for at least 3 attempts

Send outreach notification to the beneficiary providing contact information

Document in EHR and/or Outreach log

Questions to keep in mind:
- Communication channel for sending notification - By mail? By patient portal? Etc.
- Is the notification letter used standard? Does the language seek to encourage the patient to respond?

Patient Reached?

YES

NO

Document & Closeout

NO

CHW Home Visit is Prioritized ...

- At PCP or CM Request
- For patients that practice is unable to reach
- For patient safety Issues
- For patients that need in-person assistance completing applications/paperwork
- For patients without face-to-face contact in 3 months

Examples of Screening Tools

☑ CMS Accountable Health Communities' Health-Related Social Needs Screening Tool(innovation.cms.gov)

- *AHC-HRSN can be self-administered*

☑ American Academy of Family Physicians tool

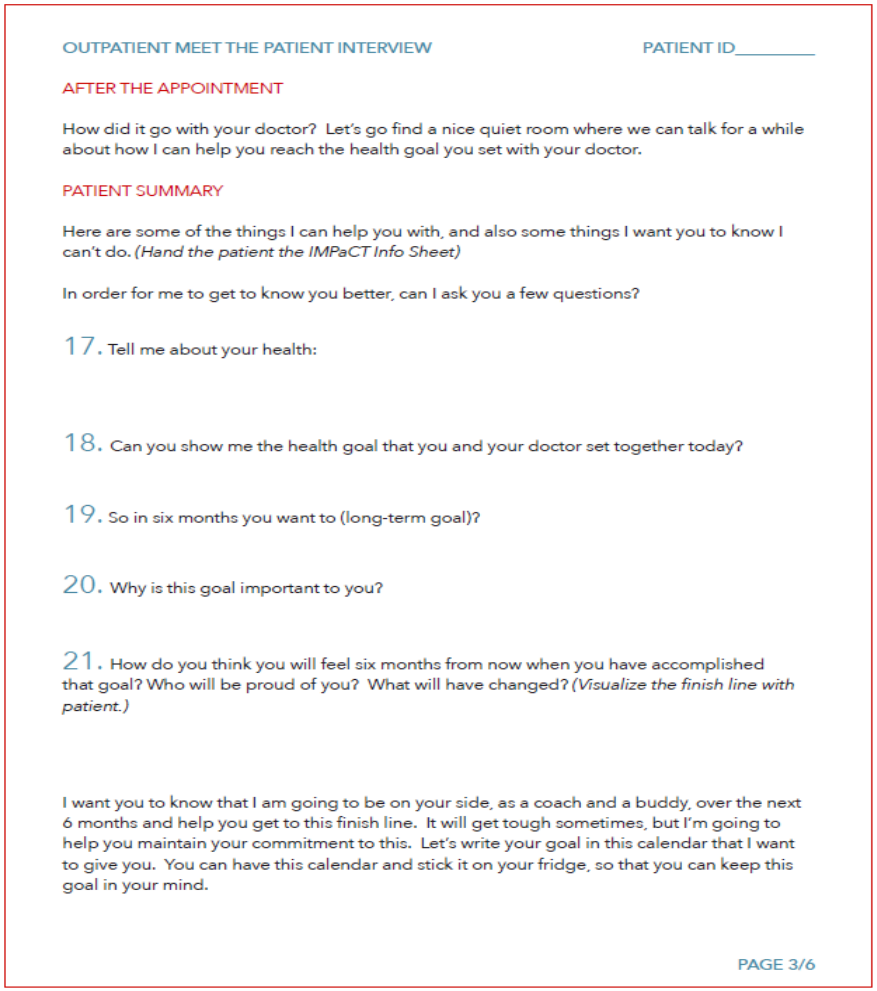
- *The short-form(bit.ly) includes 11 questions*

☑ PRAPARE Toolkit, Chapter 9:

- *The National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool(www.nachc.org)*
- *(PRAPARE) includes 15 core questions and 5 supplemental questions*

Examples of Screening Tools *(Contd.)*

☑ IMPaCT™ Community Health Worker Outpatient Care Manual



OUTPATIENT MEET THE PATIENT INTERVIEW PATIENT ID_____

AFTER THE APPOINTMENT

How did it go with your doctor? Let's go find a nice quiet room where we can talk for a while about how I can help you reach the health goal you set with your doctor.

PATIENT SUMMARY

Here are some of the things I can help you with, and also some things I want you to know I can't do. *(Hand the patient the IMPaCT Info Sheet)*

In order for me to get to know you better, can I ask you a few questions?

17. Tell me about your health:

18. Can you show me the health goal that you and your doctor set together today?

19. So in six months you want to (long-term goal)?

20. Why is this goal important to you?

21. How do you think you will feel six months from now when you have accomplished that goal? Who will be proud of you? What will have changed? *(Visualize the finish line with patient.)*

I want you to know that I am going to be on your side, as a coach and a buddy, over the next 6 months and help you get to this finish line. It will get tough sometimes, but I'm going to help you maintain your commitment to this. Let's write your goal in this calendar that I want to give you. You can have this calendar and stick it on your fridge, so that you can keep this goal in your mind.

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Source: https://chw.upenn.edu/services/#popmake-2868

Tools & Inventory of Resources

☑ Some directories that lists where beneficiaries can get social needs support (by zip-code) include:

- United Way 211
- Aunt Bertha
- Your E.H.R.
- Your Local Health Department
- Maryland Access Point (MAP)

☑ Use these resources to **develop an inventory of resources** for your patient population based on the practice's coverage area (in addition to other resources)

Establishing Home Visits

A. Set aims: Establish what the home visits will be for: Example CHW home visits for high-risk patients

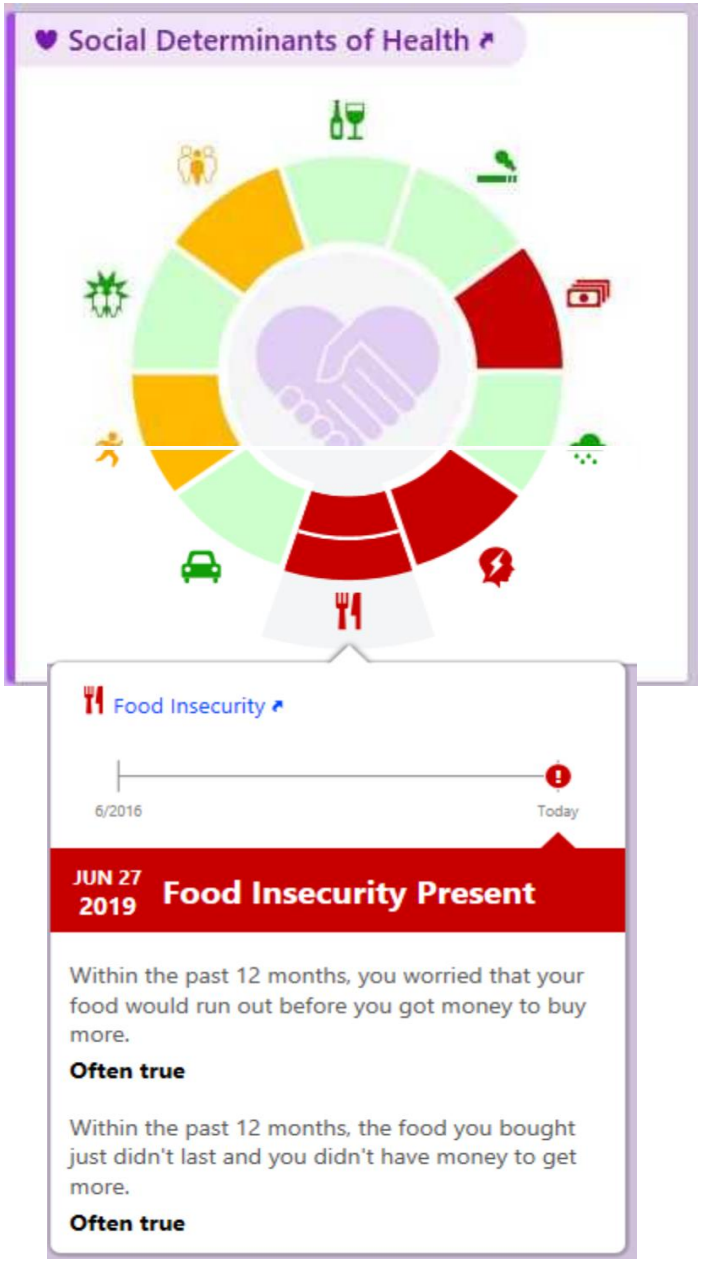
B. Establish measures:
- *Number of home visits attempted/completed per patient*
- *Number of needs assessments completed*
- *Number of social needs identified*
- *Number of social needs interventions initiated & addressed*

C. Establish a protocol for home visit (including staff safety)

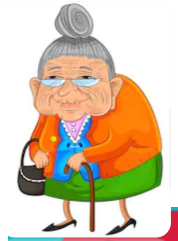
D. Establish protocol for addressing social needs: Transportation, Isolation, and Food insecurity etc.

E. Capture Reporting:

For example:
- ***Home visits attempts****: 1 successful home visit per patient (by 2nd attempt)*
- ***Needs identified & Intervention****: Transportation, Isolation, discussing concerns with PCP*

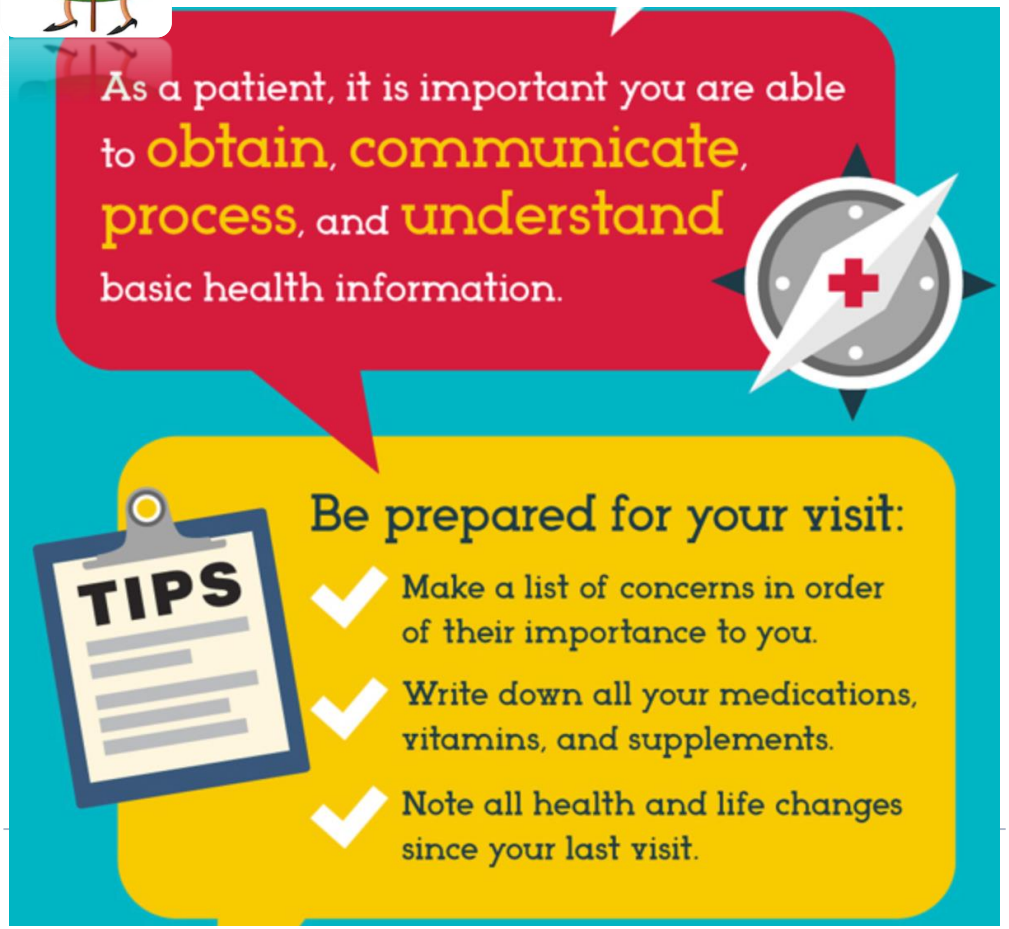


Preparing Ms. Anexxa for The Doctor's Visit



☑ ***According to the national institute of aging - the average time a doctor waits before interrupting a patient is 18 secs !!***

Source: NIH National Institute on Aging



PREPARATION LIST

☑ List and Prioritize Your Concerns

☑ Take Information with You

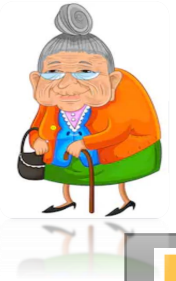
☑ Consider Bringing a Family Member or Friend

☑ Be Sure You Can See and Hear As Well As Possible

☑ Plan to Update the Doctor

☑ Request an Interpreter if You Know You'll Need One

Preparing Ms. Anexxa for the Doctor's visit



Discuss Concerns with your Doctor & Tracking your Medication: Worksheets

Source: NIH National Institute on Aging

Doctor:	Appt. Date:	Time:	Address:	Phone:

Appointment Details (Most Important to Least Important)
1
2
3
4
5
6
7
8
Notes:

Name of Drug	What It's For	Date Started	Doctor	Color/Shape	Dose and Instructions

Preparing Ms. Anexxa for the Doctor's visit

Discussing Changes in Your Health:

Worksheets

Your Health

Topic	Date	Notes
Bone/joint pain or stiffness		
Bowel problems		
Chest pain		
Feeling dizzy or lightheaded		
Headaches		
Hearing changes		
Losing urine or feeling wet		
Recent hospitalizations or emergencies		
Shortness of breath		
Skin changes		
Vision changes		

Everyday Living

Topic	Date	Notes
Accidents, injuries, or falls		
Advance directives		
Daily activities		
Driving/transportation/mobility		
Exercise		
Living situation		

Your Diet, Medication, and Lifestyle

Topic	Date	Notes
Alcohol use		
Appetite changes		
Diet/nutrition		
Medicines		
Tobacco use		
Weight changes		

Your Thoughts and Feelings

Topic	Date	Notes
Feeling lonely or isolated		
Feeling sad, down, or blue		
Intimacy or sexual activity		
Problems with memory or thinking		
Problems with sleep or changes in sleep patterns		

Session Recap

- ☑ SDOH are the **conditions in which people are born, grow, live, work and age**
- ☑ Practices should **complete an assessment** of their attributed beneficiaries' health-related **social needs** and **conduct an inventory of resources**
- ☑ Practices are to **utilize the health-related social needs screening tool to address Ms. Anexxa's social needs and connect her to local resources**

Post-survey

Questions:

After this session - on a scale of 1-5 how would you rate your knowledge on:

28. Defining social determinants of health & how they may affect a patient's health

29. Tools that healthcare workers can use to help patients & their families access needed resources

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** Call to Action: What is your readiness level to try applying this knowledge at your practice?

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1 = Fair
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MARYLAND DEPARTMENT OF HEALTH

Session 10

Patient & Family Advisory Council (PFAC) PFAC Framework

Angelica Ortman, MHA, MBA, PhD-c

Medicalincs LLC

September 2019

MARYLAND Department of Health

Presenter

Angelica Ortman, MHA, MBA, PhD-c

Executive Consultant (Population Health Expert)
Medicalincs LLC

Disclosure Announcement

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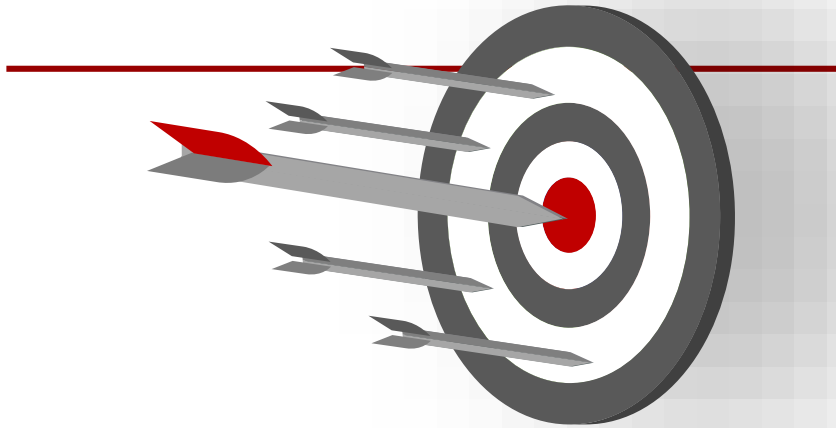
Session Objectives



- ☑ Understand what PFAC is
- ☑ Understand how PFAC captures patient/caregiver feedback to improve care delivery

Pre-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

31. PFAC Framework
32. The importance of PFAC
33. Incorporating PFAC data to improve the patient experience

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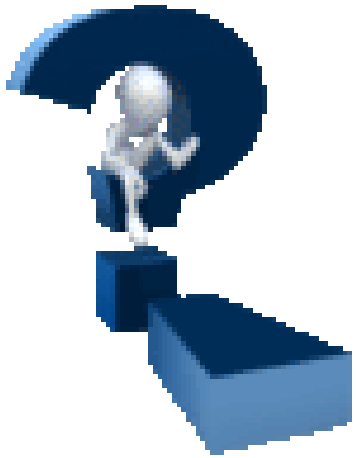
What is PFAC?

"Bringing together key stakeholders (patient, patient family members, & practice staff) on a regular basis to incorporate patient perspective and experience into the delivery of care"

- Advancing Primary Care in the MDPCP: A Guide for Practices and CTOs (dated 5/19/19)

Why is PFAC important?



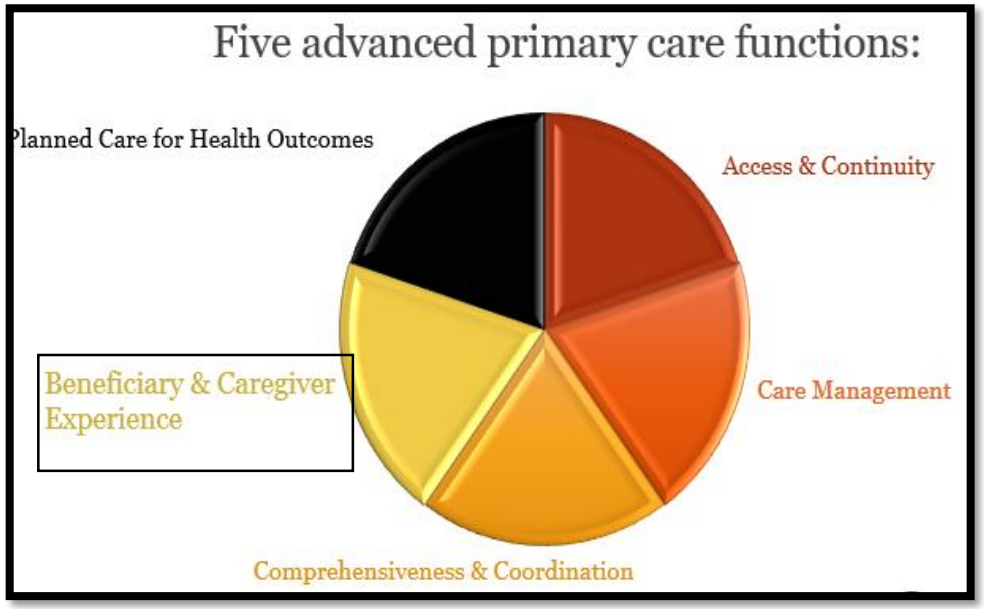
Implementation of a PFAC allows the practice to:

- Obtain feedback on the experience from the patient and family perspective
- Build relationships with the patients and family members
- Gain insights on the strengths and areas where improvement may be needed within your practice

MDPCP requirement: PFAC

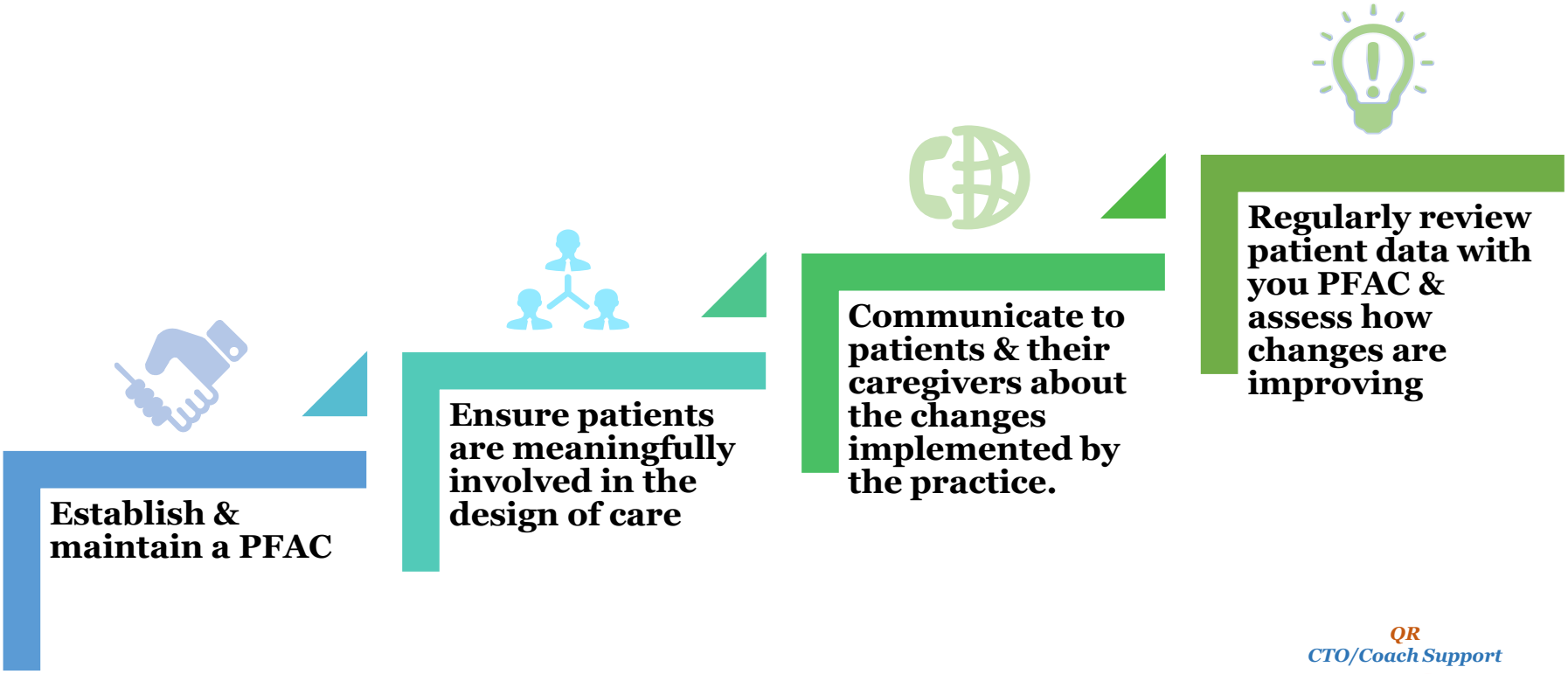
☑ Practices will be required to:

- **Convene** Patient Family Advisory Council (PFAC) and integrate **recommendations into care, as appropriate**



Resource: Advancing Primary Care in the MDPCP: A Guide for Practices and CTOs (dated 5/19/19)

PFAC framework



QR
CTO/Coach Support

Resource: Advancing Primary Care in the MDPCP: A Guide for Practices and CTOs (dated 5/19/19)

PFAC framework

- ❑ Establish the scope of the PFAC
- ❑ Recruitment of the participants
  - Ensuring demographic characteristics are considered (Ability, ethnicity, race, cultural, socioeconomic status, gender, age, etc.)

Our Patient: Ms. Anexxa, 71-year old Medicare beneficiary

Clinical Profile

- Type II Diabetes
- Long standing Hypertension (Last BP: 140/90 mmHg)
- CHF following a heart attack from 3 years prior
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- She has no fresh food at home – due to her recent stay for 4 days in the hospital
- Experiences other care transition challenges such as: Off-road options, snapshot treatment, diminished ability and increased responsibility

Personality/Behavior Profile

- She is an extrovert, usually lively, a "people person" and does not like to be alone
- Enjoys attending group meetings when she can (e.g. Diabetes group)
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Utilization Profile (last 6m)

- 5 ED visits
- 2 Hospitalizations
- Most recent hospitalization after being treated for uncontrolled CHF & unaware of 2 of the 3 new prescriptions b/c they were electronically sent to the pharmacy

Cost (Utilization)

- Short term hospital – $27,000
- ER - $7,500

Total ED & Hosp (last 6m) - $34,500

Reflecting on Ms. Anexxa's Personality Profile

- Ms. Anexxa is a good candidate for Healthlincs Primary Care Practice's PFAC
- Possesses the following qualities and skills:
  - Shares information about her experience so that others can learn from it
  - Sees beyond her own personal experience
  - Shows concerns for more than one issue
  - Collaborates and listens with others
  - Wants to make a difference

PFAC framework

Ensure patients are meaningfully involved in the design of care

- Make effective use of the PFAC meeting

- Examples of PFAC topics include:
  - Patient safety and experience
  - Patient/family education and communication
  - Marketing (Outreach calls and letters to get them into care)
  - Physical design of the practice office

PFAC framework

- Communicate the changes the practice has implemented to improve the patient experience
- Obtain suggestions from PFAC members on how to communicate

PFAC framework

Regularly review patient data with you PFAC & assess how changes are improving

- Review data to inform areas to improve the patient experience
- Measure and assess the improvements to the changes implemented

Session Recap

- ☑ Discussed the PFAC framework and requirement for the MDPCP program
- ☑ Shared qualities of a good patient candidate to recruit
- ☑ Provided examples of how PFAC data can improve the patient experience

Post-survey

Questions:

After this session - on a scale of 1-5 how would you rate your knowledge on:

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32. The importance of PFAC
33. Incorporating PFAC data to improve the patient experience

** Call to Action: What is your readiness level to try applying this knowledge at your practice?

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MARYLAND DEPARTMENT OF HEALTH

Session 11
Interview techniques: Communication & patient engagement techniques (Open ended techniques)

Angelica Ortman, MHA, MBA, PhD-c

Medicalincs LLC

September 2019

MARYLAND
Department of Health

Presenter

Angelica Ortman, MHA, MBA, PhD-c

Executive Consultant (Population Health Expert)
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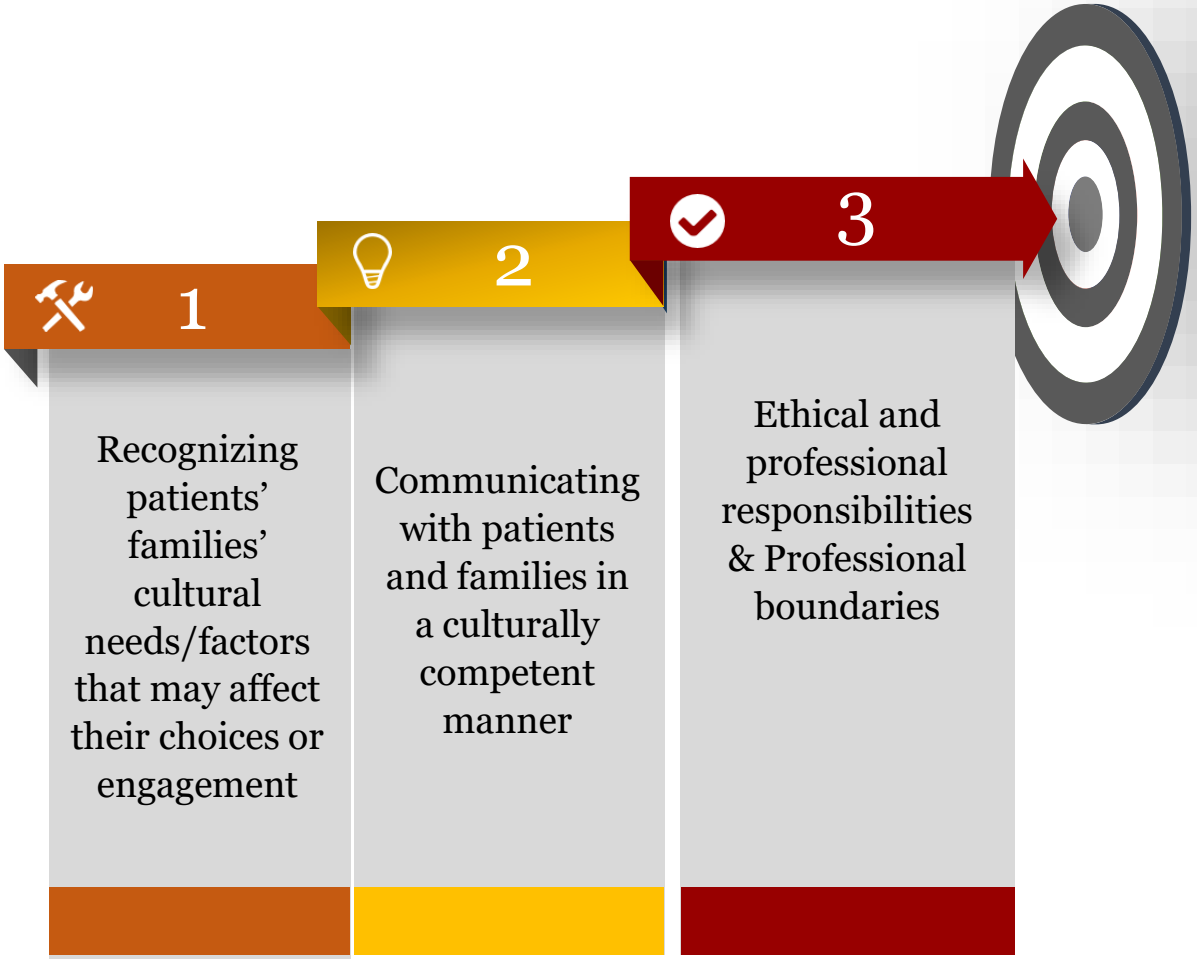

Pre-survey

Questions:

On a scale of 1-5 how would you rate your knowledge on:

34. Interview techniques: Communication & patient engagement techniques (Open ended techniques)

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Why is Communication with patients & family members important?

Barriers

- Health Literacy
- Language Barriers
- Cultural Barriers

Uninformed patient

Adverse Events

- Patient safety
- A risk for medical errors
- Possibility of readmissions
- Poor health outcomes/ Not adherent

Resource: http://minorityhealth.hhs.gov

Communication with patients and family members

Providing Education

- Providing information and guidelines to create awareness of the health condition

Persuasion

- Sharing the advantages or enthusiasm of a treatment plan

Scare Tactics

- Emphasizing the risk
- Scare patient to take action

Motivational Interviewing

- Focused, goal directed
- Patient centered

Motivational Interviewing: Techniques

QR
CTO/Coach Support

Open-ended questions

- Encourages the patient to do most of the talking

Affirmations

- Acknowledging the patient's strengths and behaviors towards positive change

OARS

Reflective listening

- Shows that you have an interest and respect what the patient has to say

Summaries

- Reinforces what has been said during the encounter

Resource: https://www.aafp.org/fpm/2011/0500/p21.html

Breakout Session

Motivational Interviewing Example

(6:19-10:55)

Overview of Ms. Anexxa's Patient Experience

- *I wished the front desk staff are not loud when asking me to confirm my personal information.*
- *My PCP & Care team seem to be collaborating well to provide me the best care; my PCP did not ask me all of the same questions the MA just asked me a few minutes ago & my CHW asked me last week.*
- *I told the doctor everything on my mind related to my symptoms and situation*
- *I was happy to be part of my doctor's office PFAC and give feedback on how my care is delivered*

Session Recap

- ☑ Reviewed communication and patient engagement techniques focusing on motivational interviewing

- ☑ Discussed our patient Ms. Anexxa and her patient experience through out the journey
  - Every interaction with the patient will contribute to the patient experience

Post-survey

Questions:

After this session - on a scale of 1-5 how would you rate your knowledge on:

34. Interview techniques: Communication & patient engagement techniques (Open ended techniques)

** Call to Action: What is your readiness level to try applying this knowledge at your practice?

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Closing remarks

Nkem Okeke
MD, MPH, MBA, MSPM, CCMP

CEO/Primary Care Transformation Expert,
Medicalincs LLC

Next Steps …

- Write down in the evaluation forms, topics you'd like more training on, and turn them in

- Use MDPCP resources available to you …
  - Practice Coaches- State
  - **CTO Resources**
  - Webinars
  - Office Hours
  - Online Manuals
  - Collaborative Communities
  - MDPCP Newsletter
  - **Connect Site**


We Appreciate Your Participation!