TOOLS AND TECHNIQUES FOR PRACTICE TRANSFORMATION

TOPICS

- Assessing your current environment
- Cultivating a culture of excellence
- Closing care gaps
- Improving patient self management
- Reducing ED Utilization

ASSESSING YOUR CURRENT ENVIRONMENT

ORGANIZATIONAL CAPACITY FOR IMPROVEMENT

- Organizational leadership is interested in specific or general improvement (improved patient outcomes, patient satisfaction, etc.)
- Organization is willing and able to identify an "improvement" champion who will be the practice facilitator's point person.
- Leadership is willing to provide protected time for key staff to engage in improvement work.
- Team members are willing to meet regularly as a quality improvement team, and members follow through with this plan.

ORGANIZATIONAL CAPACITY FOR IMPROVEMENT

- Team members are willing to gather and report data on practice performance on key metrics
- Practice has sufficient organizational and financial stability to avoid becoming too distracted or overwhelmed by competing demands or financial concerns.
- Practice is not engaged in other large-scale improvement projects and does not have other demanding competing priorities.

CHANGE PROCESS CAPABILITY QUESTIONNAIRE (CPCQ)

- 32 questions targeting:
  1. How your practice approaches quality improvement
  2. How your clinic has used various strategies to improve quality of care in the past

http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod6appendix.html

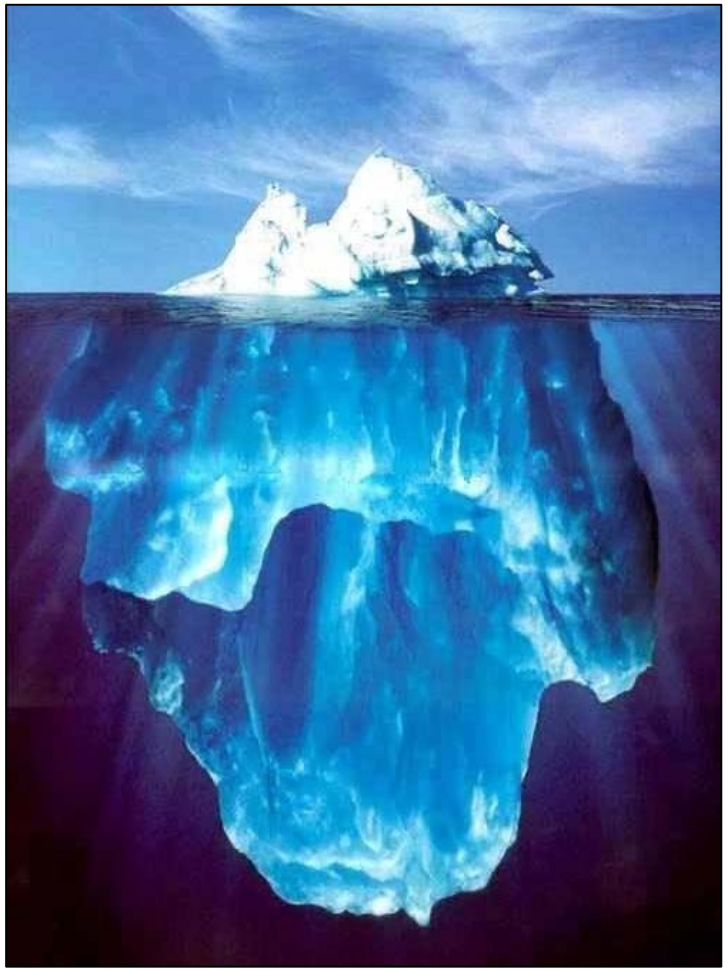
PROCESS CAPABILITY QUESTIONNAIRE (CPCQ)

Dimensions of Focus:

- Importance of quality care and outcomes
- Cares is patient focused
- Deliberate design of systems catered to the patient
- Availability of resources
- Use of data, measurement to gauge performance quality, achieve goals
- Rapid cycle system tests of change, pre-testing, piloting

CULTIVATING A CULTURE OF EXCELLENCE

CULTURE

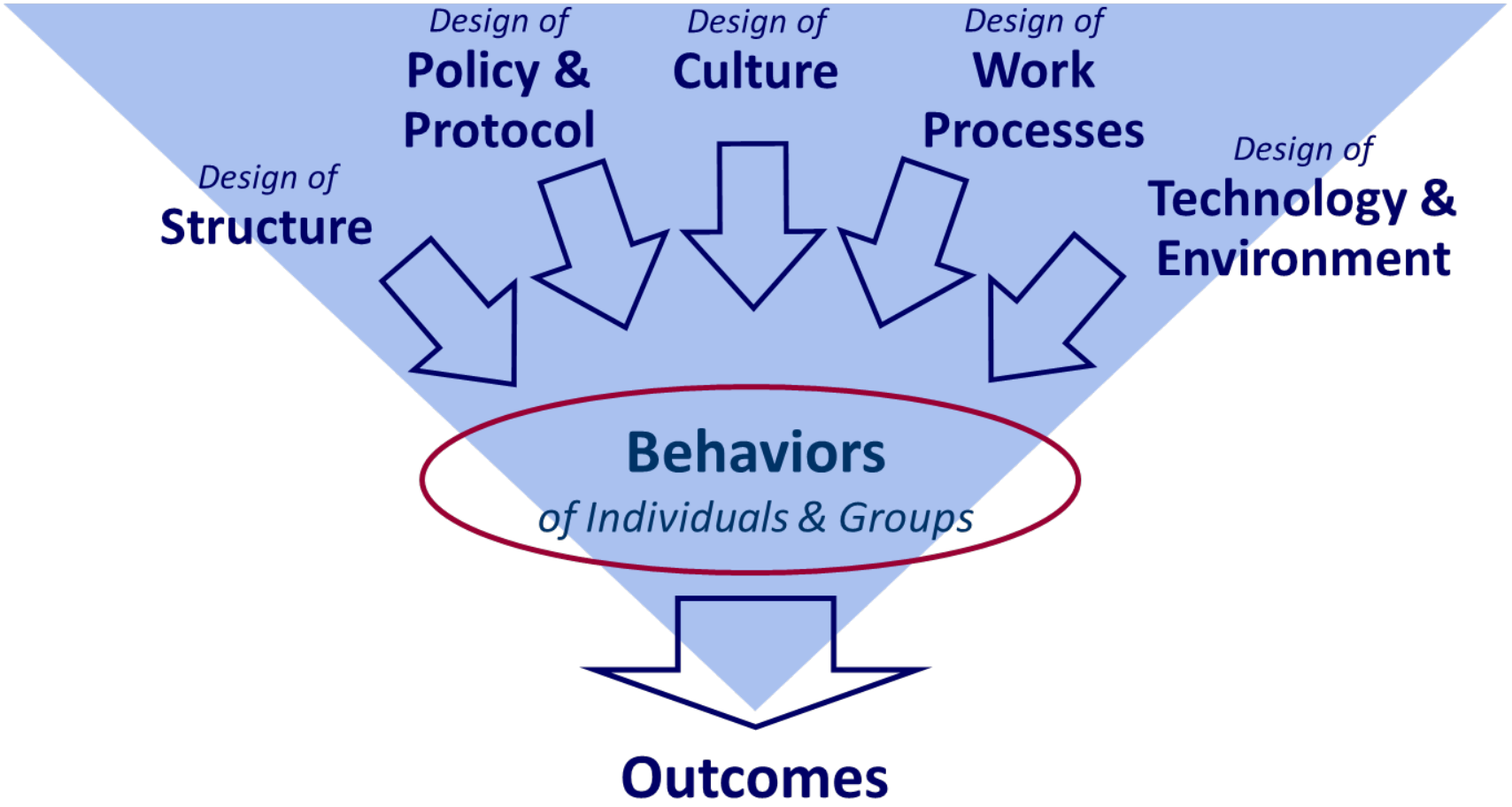


Culture

is the shared values and beliefs of the individuals in the organization
(the way we act when no one is looking)

Culture is the way we think, act and interact

HOW BEHAVIORS INFLUENCE OUTCOMES



Adapted from R. Cook and D. Woods, *Operating at the Sharp End: The Complexity of Human Error* (1994)

TOOL FOR CHANGING PRACTICE CULTURE RELATIONSHIP-CENTERED MEETINGS

- Invest Time in Relationship Building; It Will Pay Large Dividends in Efficiency and Performance.
- Foster High-Quality Conversation
- Explore Differences with Openness and Curiosity -stimulus for creativity, not conflict.
- In Pursuing Change, Learn from Successes.
- When Meetings Get Stuck, Interrupt the Pattern
- Trust the Process; Don't Try to Control the Outcome.

CLOSING CARE GAPS

GOALS FOR CLOSING CARE GAPS FOR SAFETY NET PATIENTS

- Reduce costly preventable readmissions
- Improve chronic disease management
- Boost patient engagement
- Develop robust and effective population health management programs.

FOUNDATIONAL STEPS AIMED AT CLOSING GAPS

Shared knowledge and shared decision making

- Improve health literacy
- Provide impactful education
- Focused on patient's individual background, beliefs, and experiences.

Team-based, collaborative care

- Collaborative effort involving caretakers and family members
- Consult other members of the patient's care team,

Cultural sensitivity and respect

- When care impacts cultural norms, religious beliefs, or lifestyle choices, clinicians must approach these issues with respect, sensitivity, and understanding.
- Building trusting relationships

FOUNDATIONAL STEPS AIMED AT CLOSING GAPS

Risk Stratification

- Based on multiple co-morbidities, unstable chronic conditions
- Recent re-admissions, ED visits

Care Management

- Education
- Group visits
- Wellness & prevention classes

IT Systems

- Patient Portals
- Text reminders
- Emails
- Care Gaps Reports
- ADT Feeds

IMPROVING PATIENT SELF MANAGEMENT

HOW CAN SELF-MANAGEMENT SUPPORT BE PUT INTO ACTION?

Defining and sharing the roles and responsibilities of the practice care team.

- Successful teams are made up of clinical and administrative staff whose roles are planned in advance.
- Provides effective self-management support, a team of clinicians and administrative staff need to coordinate closely with each other to provide care before, during, and after the patient visit.
- Maximizes the functionality of the team, streamlines workflow and combats duplication of tasks

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/self/sms_home.html

SELF-MANAGEMENT SUPPORT

Some roles and responsibilities include:

- Conducting a team huddle prior to clinic starting
- Gathering clinical data before a visit
- Setting agendas for the visit
- Helping patients set health goals
- Developing action plans for achieving goals
- Tracking health outcomes
- Referring patients to community programs


Collaborative Care: Cycle of Self-Management Support
Gather Clinical Data
• labs • screenings
• specialist reports
Gather Patient Experiences
• symptom monitoring • medication taking
• stressors
Before the Visit
1
Improved Outcomes
• Increased Healthy Behaviors
• Improved Clinical Outcomes
• Increased Collaboration between Patient and Provider
• Improved Physician Satisfaction and Retention
CARE PLAN
During the Visit
2
Follow Up
• revise action plan
• problem solve
Front Office
• build relationships
• explore needs and preferences
After the Visit
3
Specialist Referrals
• coordinate care referrals
Provider Exam
• set agenda
• review clinical and patient experience information
• collaborate to set SM goals in care plan
Community Linkages
• patient education programs
• fitness and nutrition
• faith-based health promotion programs
Peer Programs
• voluntary health organizations
• web-based chat rooms
• lay-led groups
Nurse/MA Coaching & Support
• create action plan
• assess barriers
• support change
• patient education & skill building
"The purpose of self management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment." —Bodenheimer 2005

REDUCING ED UTILIZATION

REDUCTION IN ED VISITS

Why is this important?

- The overuse of U.S. emergency departments (EDs) is responsible for $38 billion in wasteful spending each year
- ED overuse is on the rise across all patient populations, irrespective of age or insurance coverage
- Drivers of ED overuse include lack of access to timely primary care services, referral to the ED by primary care physicians themselves, and financial and legal obligations by hospitals to treat all patients who arrive in the ED
- Strategies to curb ED overuse include redesigning primary care to improve access and scheduling; providing alternative sites for non-urgent primary care; improving case management of patients with chronic disease, and using financial incentives and disincentives for visit to the ED

Low Acuity Non Emergent ED Visit

Definition – NYU Classification Categories

EMERGENT-PRIMARY CARE TREATABLE- Based on information in the record, treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CAT scan or certain lab tests);

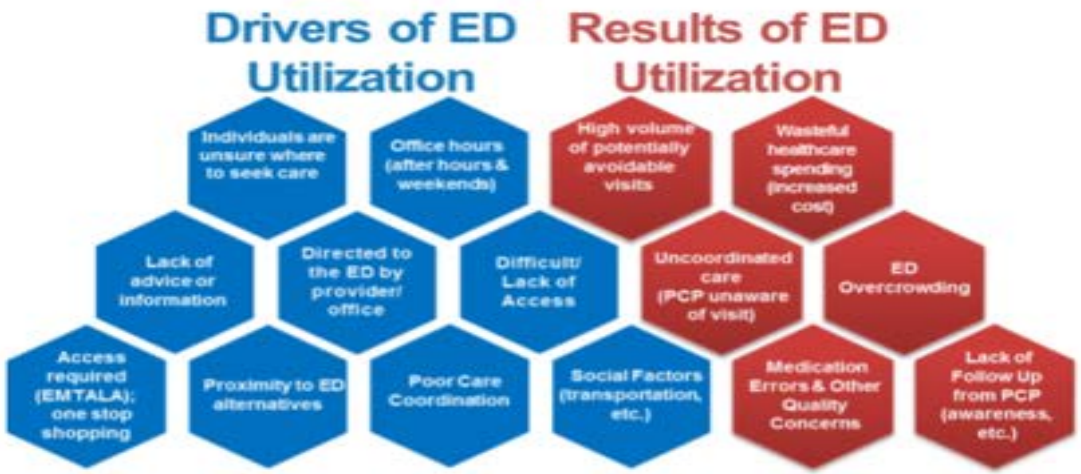
EMERGENT – ED CARE NEEDED-PREVENTABLE/AVOIDABLE - Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.); and

NON-EMERGENT- The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours;

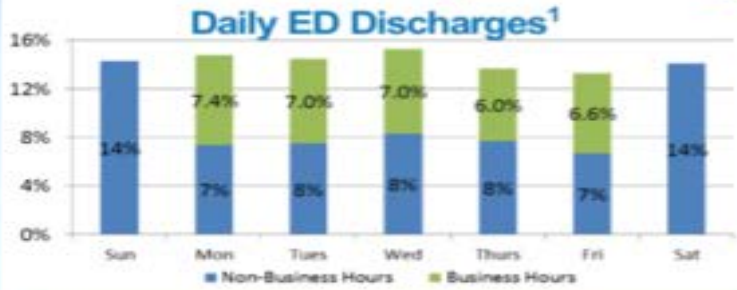
EMERGENT ED CARE NEEDED-NOT PREVENTIABLE/AVOIDABLE: Emergency department care was required and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.)

Reducing Preventable Emergency Room (ER) Utilization

Problem: Emergency Department Over Utilization



Focus: Low-Acuity Non-Emergent (LANE) Visits



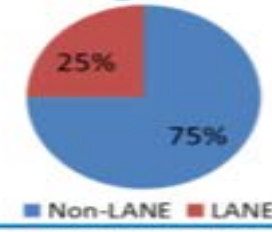
On average, and ER visit costs 7 times more than receiving care for the same reason in a doctors office or clinic.[2]

1. *Sampled Data*
2. *Cost Driver Spot Analysis: Avoidable Emergency Department Use, Center for Improving Value in*

LANE Definition

- Visits for which a delay of serval hours would not increase the likelihood of an adverse outcome.
- Also referred to as preventable, inappropriate, non-emergent, or ambulatory-case sensitive.

Percentage LANE Visits



Opportunity: Decrease Inappropriate ER Utilization Through Coordinated Efforts

Action: Develop and implement a toolkit, measure progress

Improved access: right place @ right time

- Survey patient needs to determine if 'ease of access' is satisfactory
- Assess 'slot utilization'
- Align appointment time with need
- Create protocols so staff understand medical concerns that can be 'worked in'
- Ensure same-day and next-day

24/7 Nurse Advice Line

- Evaluate and refine processes for
- 'triaging' patients who call for a
- same day appointment
- Evaluate nursing triage protocols
- After hours voicemail
- messaging
- Consider an after-hours call service and/or nurse advice line

Inform & Educate

- Educate patients on where to seek care during scheduled appointments
- Ask patients what ER they use or are most likely to use
- Do patients consider your practice their primary care provider?
- Let patients know about same-day and next-day appointment

Collaboration with local institutions

- Reach out to ERs most frequented by patients to set up a meeting with both physicians and administrators
- Discuss processes and protocols to standardize across institutions:
  - Real-time notification of patient arrival in ED?
  - Streamlined

Post-ED Phone Calls

- Call patients after an ER visit to:
- Understand reason for ER visit
- Schedule a follow-up appointment in clinic
- Assess the appropriateness of the ER visit and educate on alternatives if needed
- Understand any barriers in receiving

POTENTIAL TACTICS

- **After-hours access:** Practices that implement after hours call systems that allow patients to access care providers have been seen to reduce the frequency of patients going to the ED unnecessarily
- **Specialist Collaboration with Primary Care Physician:** Specialists should consider contacting a patient's primary care provider prior to recommending a patient go to the ED to determine if a PCP clinic visit is appropriate.
- **Patient alerts:** Partnerships with local Emergency Departments can create protocols to alert your practice when your patients are seen in the ED, letting your practice set follow up appointments to see the patient in clinic the next day.
- **Tracking ED visits:** Working with local hospitals to receive monthly reports about ED visits of patients affiliated with your practice can help identify key opportunities to prevent future non-urgent ED visits.
- **Collaboration on care with the local ED:** Developing a relationship with the local ED can help to develop shared approaches to care for patients that could help to reduce unnecessary emergency department visits and hospitalizations. For example, providers can work with local EDs to develop approaches for the prescription of controlled substances such as narcotics, and for management of common conditions (ex. cellulitis, deep vein thrombosis, heart failure, etc.).
- **Community Partnerships:** collaborations with local resources, such as urgent care clinics, can provide after-hours and weekend coverage for patients while ensuring coordinated care. See the case example above.
- **Patient education:** Voice messaging systems should clearly indicate how to reach an on-call physician or answering service for non-emergent requests. Similarly, education of patients regarding after hours needs should be provided during standard care visits, particularly focusing on high utilizers.

Resources and Links

Self Management Support:

1. http://www.aafp.org/fpm/2008/0400/pa6.html
2. https://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/self/sms_home.html

ED Utilization Tool KIT

1. https://midsouthptn.com/milestone-summaries/reducing-ed-visits/

Health Literacy Measurement Tools:

1. Brief Health Literacy Screen (BHLS)
2. Test Of Functional Health Literacy for Adults (TOFHLA)
3. Subjective Numeracy Scale (SNS)
3. Rapid Estimate of Adult Literacy in Medicine (REALM)
4. Newest Vital Sign (NVS)
5. General Health Numeracy Test (GHNT)

RESOURCES & TOOLKITS

- American Academy of Family Physicians' A New Approach to Group Visits: Helping High-Need Patients Make Behavioral Change

- California HealthCare Foundation's Helping Patients Help Themselves: How to Implement Self-Mangement Support

- California HealthCare Foundation's Coaching Patients for Successful Self-Management

- American Academy of Family Physicians' Improve Care With Patient Self-Management Support

- American Medical Association's Self-Management Strategies for Vulnerable Populations

QUESTIONS