Alternative Visits, Part 2

CCI CP3 Population Health Management
Low-Intensity Track Webinar
Wednesday, November 30, 2016 from 11am-12pm
ALTERNATIVE VISITS, PART 1

• November 17, 2016 at 1-2pm
• Topics Covered:
  – Definitions and examples of "meaningful" alternative visits
  – Why they need to be measured, EHR considerations
  – How workflows could evolve with Value-Based Care

ALTERNATIVE VISITS, PART 2

• November 30, 2016 at 11am
• Topics Covered:
  – Nuts & Bolts of Implementing Alternative Visits:
    • Telephone Visits: San Mateo Medical Center
    • Patient Portals: Shasta Health Center
    • Shared Medical Appointments: Clinica Family Health Services
Today’s Faculty

- Melissa Rombaoa, MPH CHFP
  Operations Strategist
  San Mateo Medical Center

- Dr. Carolyn Shepherd,
  CP3 Clinical Director, former
  CMO of Clinica Family Health

- Charles Kitzman,
  MMI Chief Information Officer
  Shasta Community Health Center

- Megan O’Brien,
  Value-Based Care Program Manager,
  CCI

- Ned Mossman,
  Program Manager,
  Payment Reform and Social Determinants of Health, OCHIN
Reminders

1. Everyone is muted
2. Remember to chat in questions!
3. Webinar is being recorded and slides/recording will be posted and sent out
Office Hours

Virtual office hours via phone or a web-based service are opportunities to **dive deeper** and ask questions of presenters.

Email Megan (mobrien@careinnovations.org) and include the following:

1. which faculty you are interested in;
2. scope of your questions;
3. 30 or 60 minutes;
4. if you are interested in other organizations joining in, or want individualized time.

**I will work with you on scheduling office hours.**
1. Telemedicine
2. Texting
3. Co-Visits/Flip Visits
4. Group Visits/Shared Medical Appointment
5. Home Visits
6. Patient Portals
7. eConsults
8. Other??
Technology Enhanced or Enabled Care

- Telephonic visits
- Patient portals
- eConsults
- Telemedicine
- Texting

Adapted from: UCSF Center for Excellence and CareOregon Practice Coach Training, 2016
Non-Traditional Visit Models

- Group Visits/shared medical appointments
- Home Visits
- Flip visits (co-visits)

Adapted from: UCSF Center for Excellence and CareOregon Practice Coach Training, 2016
TELEPHONE VISITS

Melissa Rombaoa
Operations Strategist
San Mateo Medical Center
San Mateo Medical Center Ambulatory Operations

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>14</td>
<td>Primary Care Practices</td>
</tr>
<tr>
<td>22</td>
<td>Medical &amp; Surgical Specialties</td>
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<tr>
<td>20</td>
<td>Dental Laboratories</td>
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<tr>
<td>180</td>
<td>Exam Rooms</td>
</tr>
<tr>
<td>400</td>
<td>Staff and Providers</td>
</tr>
<tr>
<td>240,000</td>
<td>Annual visits</td>
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</table>
History/Business Case for Telephone Visits

Drivers
- Assigned 20,000 capitated patients through Medicaid Expansion
- Issues with access
- Organizational strategic priority to move from volume to value
- Alternative payment programs (APM, GPP)

Goals
- Increase clinic access
- Increase patient satisfaction
- Improve staff satisfaction
- Reduce unnecessary emergency room visits and hospital readmissions
No provider payment? No problem! (Kind of..)

Telephone visits can be used for:

• Nurse Visits
• Other non-reimbursable care team visits (PharmD, Health Coach, etc)
• Structure for provider calls that are already happening
  – Improve documentation
  – Reduce phone tag
Timeline for Implementation

• **August 2015**: Lean Design Event
• **September 2015**: Training and implementation for 2 pilot clinics
  - Select providers and RN’s within each clinic
  - PDSA’s
  - Organic spread throughout the clinic
• **January 2016**: Finalize standard work and documentation requirements to be used across all clinics
• **February 2016**: Spread to Specialty provider in Endocrinology
• **Ongoing**: Spread to the rest of the primary care clinics
Gathering Feedback to Inform Design

**Q: What are your expectations of a telephone visit?**

<table>
<thead>
<tr>
<th>Providers</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Themes from provider survey:</strong></td>
<td><strong>Themes from patient advisory council:</strong></td>
</tr>
<tr>
<td>➢ Already providing phone-based care <em>informally</em></td>
<td>➢ There must be an appointment time, not just a random call</td>
</tr>
<tr>
<td>➢ Provide allotted time dedicated to phone visits</td>
<td>➢ Make sure that the provider has the patients file available during the phone visit</td>
</tr>
<tr>
<td>➢ Don’t take away from admin time</td>
<td>➢ Not a call from a private number</td>
</tr>
<tr>
<td>➢ Involve the whole care team</td>
<td>➢ Okay with speaking to nurses who know them</td>
</tr>
<tr>
<td>➢ Set patient expectations</td>
<td></td>
</tr>
</tbody>
</table>
### Staff Involved in Design & Implementation

<table>
<thead>
<tr>
<th>Staff</th>
<th>Key Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frontline Clinic Staff (PSA's, MA's, RN's, Providers)</td>
<td>- Design workflows, implement in clinic</td>
</tr>
<tr>
<td>LEAP Institute (Lean partners)</td>
<td>- Support process design, standard work development, implementation, PDSA's</td>
</tr>
<tr>
<td>Health Information Management</td>
<td>- Coding and documentation requirements</td>
</tr>
<tr>
<td>Health IT</td>
<td>- Create EMR templates, visit types, and automatic reminder calls</td>
</tr>
<tr>
<td></td>
<td>- Provide EMR support &amp; training</td>
</tr>
<tr>
<td>Finance</td>
<td>- Build financial models</td>
</tr>
<tr>
<td></td>
<td>- Provide CDM, billing and revenue cycle support</td>
</tr>
<tr>
<td>Office of Managed Care</td>
<td>- Coordinate with health plan</td>
</tr>
<tr>
<td></td>
<td>- Integrate into APM activities</td>
</tr>
<tr>
<td></td>
<td>- Program evaluation</td>
</tr>
<tr>
<td>Clinic Leadership and Administration</td>
<td>- Provide resources (i.e. protected staff time, space, equipment, etc)</td>
</tr>
<tr>
<td></td>
<td>- Set priorities</td>
</tr>
<tr>
<td></td>
<td>- Support and encouragement!</td>
</tr>
</tbody>
</table>
Engaging staff

• Present as a pilot, use small tests of change
• Staff typically go through 3 phases when experimenting with phone visits:
  – **PHASE 1**: Provider and nurses able to scrub schedule and convert future visits that they feel can be conducted over the phone
  – **PHASE 2**: As providers and nurses get comfortable with the process, they start to schedule more and more follow up appointments by phone
  – **PHASE 3**: Providers and nurses know exactly what they are comfortable dealing with over the phone → able to produce a guideline for front desk staff as to what can be scheduled directly into telephone visit slots
Challenges

• Gathering quantitative patient feedback
• Core tenets of standard work v. pieces that can vary between sites
Evaluation

Goals:

• Improve patient satisfaction
• Improve staff satisfaction
• Improves clinic access
• Reduce unnecessary emergency room visits and hospital readmissions
  ▪ Ongoing evaluation over time
Patient Satisfaction

- Saves time
- Feeling that provider is paying more attention to their needs
- Thankful that providers are available in this way.
- Appreciate not having to come into the clinic
Staff Satisfaction

• For me as a provider, I feel like it is helping the patients to focus more on a specific problem and I also feel accountable to follow through until next visit. For example, when I call them regarding their Diabetes, I have a specific agenda to discuss with them like glucose readings and adjusting their insulin dosing until their next appt.

• Telephone visits provide a structure (and recognition!) around calls we already make.

• Reduces phone tag, since patients know to expect our call.

• Phone visits, when successful, are generally quicker and some patients much prefer them (when transportation or work schedule is an issue). They do have limitations and certainly do not replace, or even significantly compete with, the usefulness of in-office visits.
Access

Third to Next Available Appointment

- Need more data on direct impact
- Potential future measure: Alternative encounters by non-provider staff that do not require a provider visit within X days
### Rate Ratio (95% CI) of Selected Utilization Metrics of Telehealth Patients to Regular Outpatient

<table>
<thead>
<tr>
<th>Service</th>
<th>Rate Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth v no Telehealth</td>
<td>1.01 (1.00 - 1.03)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>1.07 (1.03 - 1.11)</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>1.07 (1.03 - 1.11)</td>
</tr>
</tbody>
</table>

Patients assigned to Daily City Adult, Coastside Adult, and Coastside Pediatrics, and encountered these clinics Sep 1, 2015 – July 18, 2016

Telehealth versus any outpatient encounter

Compared demographics and utilization of outpatient, emergency and inpatient services at SMMC
Key Learnings

• Engage all stakeholders at the beginning
  – Think through the whole process, from scheduling to billing and tracking.

• Provide feedback early and often during testing phase and when new staff are implementing

• Phone visits were already happening, now we have a structured and standard way to capture them
Look Forward

• Use by other care team members (PharmD, Health Coaches)
• Further Data Analysis: Utilization for individuals pre-telephone visit services v. post-telephone visit services
• Financial Sustainability Analysis
Thank you!

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Sample Workflow – Scheduling visit initiated by Provider or Nurse

START
Nurse/Provider determines that patient could be seen via phone

Does pt already have a visit scheduled?

YES
Inform PSA to transform existing visit to Tele-PROV or Tele-RN visit

NO
Inform PSA or other support staff to schedule Tele-PROV or Tele-RN visit with patient

Call patient to schedule phone visit

Set visit type as Tele-PROV or Tele-RN

Pre-register patient

In GENERAL NOTES:
- Add telephone number for call back
- Note if patient needs interpreter
- Note if patient could not be pre-registered and needs registration after the telephone visit

Educate patient that the prov/nurse will call within a 30 minute window of their scheduled appointment

END
Sample Workflow – Scheduling visit initiated by Patient

START: Patient calls clinic with need

PSA determines the need (appointment, refill, advice, sick, etc.)

If the following symptoms are given: schedule phone appointment with provider or nurse:
- [SPECIFIC SYMPTOMS SHOULD BE DETERMINED BY PROVIDER AT EACH SITE]

Assign appropriate visit type:
- Tele-PROV
- Tele-RN

For all phone appointments, verify demographics

In GENERAL NOTES:
- Add telephone number for call back
- Note if patient needs interpreter
- Note if patient could NOT be reached for pre-registration and needs registration after the telephone visit

Educate patient that the prov/nurse will call within a 30 minute window of their scheduled appointment.

END
Sample Workflow – Conducting the Phone Visit

START: Double click on the appointment slot in the schedule (within 30 minute window on either end of appointment time)

- Document no answer “n/a and time” in billing notes
- Call patient 2nd time within 10 minutes, or after next appt
- Did patient answer?

- No
  - Document no answer - “n/a and time” in billing Notes
  - Leave voicemail according to script:
    “This is [Your Name] from [Your Clinic] calling for our scheduled phone visit. Please call [Clinic Phone Number] to reschedule your appointment.”

- Yes
  - Is patient reached?
    - Yes
      - Change status from “PEN” to “ARRIVE” in appointment window
      - Close pt appointment window
      - Right click on appointment slot in schedule, click on “View Progress Note”
      - Merge “PhoneVisit” template (to search, parameters should be on “Generic”)
      - Verify patient identity by asking name and DOB

    - No
      - Call patient at preferred number
      - Does patient reach?
        - Yes
          - To document time spent: Under Treatment, click browse → search for Phone based Care → enter minutes
        - No
          - Complete appropriate E&M code:
            - PROVIDER PHONE VISIT 5-10 MINS
            - PROVIDER PHONE VISIT 11-20 MINS
            - PROVIDER PHONE VISIT 21-30 MINS
            - NURSE PHONE VIST 5-10 MINS
            - NURSE PHONE VIST 11-20 MINS
            - NURSE PHONE VIST 21-30 MINS

- Change status to “CHECKED OUT” in appointment window, unless PSA support is needed

END
Alternative Care: Group Visits

November 30, 2016
Carolyn Shepherd, MD
Two Group Visit Types

1. **Access Groups**
   - Goal is to improve access when episodic demand exceeds supply
   - Leadership focus is on didactic education
   - Ex. WCC, Newborn, Diabetes Fair for Eye Screening, Cold & Flu, Financial screening

2. **Continuity Groups**
   - Always with PCP/team

PBS News Hour: https://www.youtube.com/watch?v=wPICn5zkSys
Continuity Group Visits

• Goal activation & engagement
• Care in space designed for groups
• Patients remain in group-continuity
  – Unexpected utilization patterns
  – Poorly controlled chronic disease
  – Social isolation and depression
• Facilitated group process
<table>
<thead>
<tr>
<th><strong>Education</strong></th>
<th><strong>VS.</strong></th>
<th><strong>Facilitation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Leader is teacher</td>
<td></td>
<td>Leader is conductor</td>
</tr>
<tr>
<td>Provider offers answers and support</td>
<td></td>
<td>Patients offer answers and support</td>
</tr>
<tr>
<td>Expert opinion</td>
<td></td>
<td>Peer opinion</td>
</tr>
<tr>
<td>Educated advice</td>
<td></td>
<td>Personal experience</td>
</tr>
<tr>
<td>Care based on provider assessment</td>
<td></td>
<td>Care based on patient self-assessment</td>
</tr>
<tr>
<td>Provider directed</td>
<td></td>
<td>Patient directed</td>
</tr>
<tr>
<td>Educational topics</td>
<td></td>
<td>Use content threads</td>
</tr>
</tbody>
</table>
Kaiser Study on Group Visits

- 30% decrease in ER use
- 20% decrease in hospital use/re-admissions
- Delayed entry into nursing facilities
- Decreased visits to specialists
- Increased total visits to primary care
- Decreased same-day visits
- Increased calls to nurses
- Fewer calls to physicians
- Increased patient satisfaction w/ care
- Increased clinician satisfaction w/ care
- Decreased cost PMPM by $14.79
1. Teams create group visits-GV committee
2. Create, test, and apply checklist to build effective groups
3. Know what you want to accomplish- urgent, temporary need for access or improving clinical outcomes
4. Create content threads
5. Incorporate activities that engage patients-design patient self-assessments
Essential Elements, cont.

6. Create and use tools to walk you through the process—learn from your PDSAs

7. Plan how to recruit and engage the patients

8. Group visit communication plan—who, what, where, when

9. Ensure adequate staff training
10. Systematize tracking of visit logistics-date, locations, clinicians
11. Be prepared for every group visit-plan and prep
12. Measure and compare outcomes
13. Ensure adequate staffing
14. Chart and bill using E&M coding framework
   - History, physical exam, medical decision making
   - Prenatal (99213), chronic disease (99213, 99214)
Why do Group Visits?

• Not because they are more productive (they are)
• Not because they are easier (they aren’t)
• But because they are much better for some patients
Alternative Visit Overview

• Shasta Community Health Center
  – HRSA Top 1% Health Center in the US. June 2015
  – Teaching Health Center – Residency/Post Graduate Fellowship
  – Complex Practice w/ High Acuity Population – 5 sites

• Anticoagulant Home Visits – Started with simple collaboration with RN for PDSA. Non-compliant pts typically have transportation/financial barriers – ER visits etc. Some payers cover home monitoring devices – wanted to build a case for PHC to cover for cost and quality reasons.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Have you had any medication changes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any bruising or bleeding?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you ill or do you have any immediate health concerns?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you taken any over the counter medications or herbal remedies?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you made any diet changes?</td>
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<tr>
<td>Do you have any upcoming surgical procedures?</td>
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</tbody>
</table>

**INR Date:** 11/16/2016  
**INR Result:** 3.0  

**WARNING:** If you have an INR score of 5 or higher, **Communicate with your doctor immediately.**
Anticoagulation Management

INR Date: 11/16/2016
Result: 3.0
View Home Report: Home Reported

Today's Notes:

Order Comments: Clear

Alert Provider:

Has the patient had any medication changes? Yes / No
Does patient have any bruising or bleeding? Yes / No
Does the patient feel ill or have any immediate health concerns? Yes / No
Has the patient taken any over the counter medications or herbal remedies? Yes / No
Has the patient made any diet changes? Yes / No
Does the patient have any upcoming surgical procedures? Yes / No
Alternative Visit Nuts & Bolts

• Started in September 2016 – Design-Build-Test-Train-Monitor
• RN handles the training and manages the data. Patients are trained in person by appointment.
• Monitors purchased with CCI money.
• Limitations of the platform hamper the training process. (Display properties vary by browser, Routing permissions inadequate)
• Self motivated staff, patients selected by RN. Non-compliant Medi-Cal pts.
Key Learnings

• Just started last week – The patients are using the tools. Addressing issues as they arise. Re-training #1 concern.

• Use is good and we’re capturing data without doing the entry.

• Lessons:
  – Assume nothing.
  – Vendor has been very open to suggestions for improving the platform, monthly check-ins.
  – Waiting on Payer/Claims Data for pre-post comparison.
Thank you!

• ckitzman@shastahealth.org

• Cio4shc

• LinkedIn
Upcoming Opportunities

January 2017-September 2017: Webinar & In-person workshops will focus on topics:

- Team-based care
- Patient engagement
- Population health management
- Empanelment 2.0

CCI’s Spreading Solutions that Work Program

- Focus on leveraging technology and care teams more effectively
- Will support orgs. to implement one of 6 solutions: group visits, medical scribes, pharmacist integration, patient portals, telephone visits, and texting.
- **Applications are due Thursday, Dec. 8th**
- Program will start January 27, 2017
- [http://www.careinnovations.org/programs-grants/spreading-innovations](http://www.careinnovations.org/programs-grants/spreading-innovations)
CONTACT INFORMATION

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• Megan O’Brien: mobrien@careinnovations.org

THANK YOU!