

Provider Engagement/Collaborations

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Presenters

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Provider Engagement/Collaborations – general statements

- It's all about relationships
- County entity, thus no ability to spend tax payer dollars on gift baskets, cookies, or other fun introductory get to know you door openers
- Variety (methods) and consistency (contacts)
- Treat them with kindness and help them do their work more efficiently



In no particular order

- Health Links Membership cards



_____	_____
Health Links Care Manager	Phone
_____	_____
Primary Care Physician	Phone
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- **PCP engagement**

- Consistently send letters (assigned to our health home, HAPs reported med changes, transitions of care documents, successes, etc.)
- Face-to-face on complex patients (attend appts)
 - Proven most beneficial
 - Increases likelihood of preventive screenings
 - Aids in referrals to specialty care
 - Assist the PCP by reinforcing instructions, etc.
 - Gives credibility to the patient



- **PCP engagement cont.**

- Develop HAPs collaboratively during PCP visits
 - Have even had some PCPs bring HAPs into exam rooms with other documents
 - Feedback into HAPs we send PCPs is increasing
- *Get to know the nursing staff
- Labs and medications and other
 - Utilize all available resources to obtain and/or share
 - If none available, establish lab work as a HAP goal, as appropriate
 - Communicate duplications (see a lot of this with labs when both a Psychiatrist and PCP or Nurse Practitioner are doing similar labs). Also sometimes with medications



- **PCP engagement cont.**

- Successes

- Residents are particularly grateful for the added supports Health Homes provide
- Increasing number of HAP goals tied to PCP appointments and follow up needs
- Frequency of contacts increases PCP participation
- Consistency of contact with PCP practices, our patient centered approach and our visible presence at appointments has given us name recognition and credibility



- **Appointment preparation**

- We call day or two ahead and provide the PCP clinic information about the patient and reason for visit – **this really gets results
- Nurses record this in the patient record for use by PCP or nurse practitioner at time of service
- Prepare the patient for the visit –focuses the visit and establishes expectations
 - Results in more planned follow up visits for other needs vs. crisis management
- We bring medication lists to increase accuracy and reduce time in appointment trying to go through a bag of medications
- Alert clinics to cancellations in advance whenever possible – builds positive regard and understanding of our patients. Clinics more inclined to reschedule.
- We meet patients at their appointments so that we can help moderate frustration as we act as clarifier and prompt priorities during the appt.
- Very intentional efforts to increase satisfaction and outcome of visits
- Preparing the PCP/Nurse practitioner and Patient increases rapport and **gratitude** for all parties



- Appointment Preparation cont.
 - Pt. education:
 - Normal/abnormal health metrics
 - PCP etiquette training
 - Do not get angry and yell
 - No shows are a problem
 - Focus on priorities
 - No one is going to prescribe pain meds when they do not know you or your history – need to establish a relationship over time
 - Realistic expectations
 - Specialty care appointments take time **Pain and dental



- Appointment Preparation cont.
 - Use health home team and MCO nurse lines before using the ER – Explore alternatives (intermediate care if PCP unavailable), etc.
 - Medication adherence



Collaborative Activities Cont.

- **Care Transitions**

- Our HH nurse care managers – huge asset – got us in the door early
 - ER/Critical care hospital experience
 - Inpatient behavioral health experience
- Via Christi Case Management Team
 - Lisa Yingling – Case Management Manager
 - They call us if they have someone they suspect may be in a health home
 - We call them when we learn of an admission and Lisa provides us the name of the Via Christi case manager
 - » Allows us to get involved quickly and meet with patient at the hospital and participate in discharge planning
 - Available to us if we cannot get critical information from other hospital staff
- Amerigroup and United Nurse Care Managers
 - Help us obtain critical information when we cannot
 - Partner on most complex of cases



- **Care Transitions cont.**
 - Other key players in care transitions
 - Our COMCARE inpatient liaison
 - Our COMCARE State Hospital Liaison
 - Our COMCARE community nurses
 - Care transition documents



- Other Critical Relationships
 - Pharmacies
 - Dr. Minns – our physician consultant
 - Chronic condition education (sugar is the enemy)
 - Primary care is use to treating acute symptoms and is still learning to treat chronic conditions – thus new world for everyone
 - Large COMCARE Crisis Program – help us with welfare checks
 - Healthy Babies – house in same building – natural resource for high risk pregnancies



- **Positive progress – relationships, relationships, relationships**
 - PCP clinics are calling us directly to reinforce messages with patients following visits
 - Pharmacies call us to help get corrected prescriptions from medical providers and alert us to prescription renewal needs
 - We educate patients to call us so we manage the angry outbursts and frustration to reduce such calls to the clinics and thus do not jeopardize ongoing care
 - Several clinics are now asking for our patient referrals because they know we will be there to help



- **Other things that have worked**
 - Three way phone calling with patient and PCP office or other community provider (help them to communicate more effectively)
 - Sharing success stories with all treatment service providers
 - Timely and short consultation huddles – helps cut through the learned behaviors/survival skills
 - Being consistent, focused and intentional



- **Next step**
 - Helping patients navigate patient portals for primary care and hospitals
- **Most proud of?**
 - Building a strong network in such a short period of time
 - We find things in documentation that others have not reviewed due to time constraints
 - Care transition processes – we manage an average of 24 hospital patients a week (14 physical health admissions, 10 behavioral health admissions to local hospitals)
 - Positive relationships with health care community
 - Responsiveness
 - Patient centered
 - Getting more info to treatment providers – we are finding that PCPs know very little about our patients
 - Having a lot of small, cumulative successes
 - Use of KHIN to improve PCP care to patients (many not using the information available to them)
 - If we can locate and engage them we are able to do remarkable work with our patients



- **Struggles?**

- Volume of health care providers in our community
- Wesley Hospital not as cooperative as Via Christi and utilize an external company to manage record requests thus delays timely flow of information
- Size of our own mental health workforce
- Patients on spend down – limits our impact on those who transition to and from the hospital
- Not having an admission/discharge report from Sunflower similar to what we receive from United and Amerigroup
- Transient nature of our population – start making progress and then we cannot locate them for several months
- Large number of patients we have not been able to locate
- Capturing data on near misses (cost savings of diverting a hospitalization and/or ER visit due to hh team actions with patient)
- Prioritizing all priorities – high risk population plus large pools of hospitalized patients with high needs



- **Collaborations that work:**

- CJ

- 42 y.o. male
- Diabetes, pain, pancreatitis
- Bedridden 20 + hrs. a day when we started working with him
- Hospitalizations and specialty care in history
- Terminated by PCP office for raising his voice at a nurse
- Arranged appt with new PCP – educated them on patient history
- Brought portal and KHIN information to initial appointment with patient
- Focused discussion on priority of pain
- Reviewed treatment regimen of former provider
- Collaborated on goals (pt., PCP, Health Home Care Coordinator)
- Initiated conservative medication regimen
- Outcome?



- **Collaborations that work:**

- DM

- 62 y.o. female
- Lower back pain – identified health problem by patient
- So nervous she could not effectively communicate with PCP staff
- Attended next appointment with patient
- Shared information we found on portals and KHIN – kidney ultrasound during last hospitalization
- HH Nurse Care Manager asked lots of questions and asked if there could be a correlation between the pain and kidneys
- Through proper diagnosis, patient was placed on physical therapy and no medication was needed to manage her condition



- MS

- Discovered through KHIN and pharmacy that pt. was on three different blood thinners prescribed by three different medical providers.
- HH asked patient to bring all medications to scheduled PCP visit
- Found patient was bleeding internally and could have died due to the extent of internal damage.
- Through good team work and collaboration, PCP was willing to spend the time necessary to sort all this out, educate the patient on his options and set a course to resolve his bleeding issues.
- Client now calls Health Links weekly to voice his gratitude. Physicians office also communicates regularly regarding this patient and the success of this case.
- Lesson learned – focus on contradictory and duplicative indicators and getting an accurate medication list are huge game changers.



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