# AGENDA

## Care Management Training

**September 13, 2019 – DoubleTree by Hilton**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>7:30-8:00AM</td>
<td>Registration and Continental Breakfast</td>
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<tr>
<td>8:00-8:10AM</td>
<td>Opening/Welcome</td>
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<tr>
<td>8:10-9:10AM</td>
<td><strong>Do it Well, Make it Fun</strong></td>
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<td></td>
<td>The Key to Success in Life, Death, and Almost Everything in Between</td>
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<td></td>
<td>Ron Culberson, MSW, CSP, CPAE</td>
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<td>If you’ve ever had a boss who was really good at what he or she did but was also fun to be around, you didn’t mind arriving early or working late. In fact, you probably loved your job. That’s the power of Do it Well, Make it Fun. It’s about seeking excellence but making the process of life and work more fun. Based on Ron Culberson’s book by the same name, this hilarious presentation shows staff and leaders how to create a less stressful work environment where people want to work. It also helps them understand that excellence combined with fun and humor can improve productivity, create better working relationships, enhance creativity, change the workplace culture, and lead to the delivery of better products and services.</td>
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<tr>
<td>9:10-9:25AM</td>
<td>Break</td>
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<tr>
<td>Breakout #1</td>
<td>A Ballroom</td>
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<tr>
<td>9:25-10:10AM</td>
<td>Using De-escalation Techniques when Working with Challenging Patients</td>
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<td></td>
<td>Becky Ela, MSW, LCSW</td>
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<td>Delta County Memorial Hospital</td>
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<td>Let’s face it: working with patients can be as frustrating as it is rewarding. From working with patients who are demanding medications on Friday afternoon at 3:00 pm to being yelled at on the phone, learning these basic verbal de-escalation techniques will help you navigate the challenging world of patient care.</td>
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<tr>
<td>Breakout #2</td>
<td>B Parlor</td>
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<tr>
<td>10:10-10:25AM</td>
<td>Break</td>
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<tr>
<td>10:25-11:15AM</td>
<td>Provider Buy-in for Care Management</td>
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<td>Facilitator: Chelsea Watkins, MHA, BS, CHES</td>
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<td>Rocky Mountain Health Plans</td>
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<td>Panelists: Joe Adragna, MD, MHA, MGH</td>
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<td></td>
<td>Luisa Valenzuela</td>
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<td>Gary Knaus, MD</td>
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<td>Peak Family Medicine</td>
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<td>Western Valley Family Practice</td>
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<td>Roaring Fork Family Physicians</td>
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<td>Struggling with provider buy-in for care management? This panel consists of providers and a care manager who are highly engaged in care management functions in their practices. The panelists will discuss what makes their care management work, how they got provider buy-in, and even some patient success stories. Participants will learn tips and tricks for a successful care management program and also have the opportunity to ask the panelists questions.</td>
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<tr>
<td>11:15-11:30AM</td>
<td>Break</td>
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<tr>
<td>Breakout #2</td>
<td>A Ballroom</td>
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<tr>
<td>11:30-12:15PM</td>
<td>Encouraging Others to Take Initiative</td>
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<td>Jarid Rollins, LCSW</td>
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<td>MidValley Family Practice</td>
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<td>Setting a client centered treatment plan is hard. You must listen and use your genuine self as a way to drive the conversation towards creating a comprehensive plan for change. In this session,</td>
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Learn how the use of self can guide this challenging and essential process of care, and how the care team can work together to empower change.

**B Parlor**

**The Importance of Patient and Family Engagement**

Matthew Allen, DDS  
*MDavid Mi Inc*

In this session, participants will explore the ever-increasing importance of patient and family engagement as it relates to health outcomes. Participants will develop an understanding of why this work is critical to modern patient care, and, via “real play” scenarios, will practice concrete skills to help engage patients and families in their own care.

**C Kokopelli**

**Engaging in Advance Care Planning Talks through Group Visits**

Hillary Lum, MD, PhD  
*Division of Geriatric Medicine - University of Colorado*

Group medical visits can be an ideal way to promote advance care planning engagement. This session will describe this innovative model, benefits to patients and provider teams, and opportunities for your practices to consider how to implement an advance care planning group visit.

<table>
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<th>Time</th>
<th>Session</th>
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<tr>
<td>12:15-1:15PM</td>
<td><strong>Lunch</strong></td>
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<tr>
<td>12:30-12:45PM</td>
<td><strong>Coordinating with RMHP Care Management</strong></td>
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|               | Eve Presler, MA, MSW  
|               | *Rocky Mountain Health Plans*                  |
| 1:15-2:00PM   | **Breakout #3**                                |
|               | **Strategies for Reducing ED Utilization: It’s Not Just a Call**  
|               | Annie Schudy, BSN, BA, RN  
|               | *Rocky Mountain Health Plans*                  |
|               | Alexandra Hulst, PhD, LMFT  
|               | *Rocky Mountain Health Plans*                  |
|               | **Creating a Sustainable Care Management Program**  
|               | Kris Hubbell, MHA, RN, CHC  
|               | *Roaring Fork Family Practice*                 |
|               | **Practical Tips for Addressing Social Isolation**  
|               | Anna Messinger, MHA, PCMH CCE  
|               | *Rocky Mountain Health Plans*                  |
|               | Heidi Goodyear, RN, BSN  
|               | *Western Medical Associates*                   |
|               | Glenn Kotz, MD  
|               | *MidValley Family Practice*                    |
| 2:00-2:10PM   | **Break**                                      |
| 2:10-3:10PM   | **Now What?**                                 |
|               | **Turning Endings into Beginnings**            |
|               | Ron Culberson, MSW, CSP, CPAE                  |
| 3:10-3:15PM   | **Closing Remarks**                           |
Do it Well. Make it Fun.
A White Paper...With Writing on It

Ron Culberson, MSW, CSP, CPAE

Life is short—in a relative, big picture kind of way.

So, it’s up to us to make the most of the time we do have in this world. Whether we’re young and just begun our careers or we’re old and cranky, there is always time to change the way we approach our work and life. Abraham Lincoln said, “It’s not about the days in your life, but the life in your days.” And while Lincoln was not known as a party animal, he clearly understood the need for the proper perspective.

A balanced approach is the best way to achieve success in life and work and that’s the foundational principle of “Do it Well. Make it Fun.” It’s the idea that excellence plus fun lead to both a valuable and valued existence.

I spent the first decade of my career in hospice care. I was a home care social worker and then moved into middle management and ultimately, a senior leadership position. I couldn’t have asked for a better way to begin my professional career. My hospice experience made me acutely aware of my mortality. And by working with people at the end of their lives, I realized that the best way to prepare for the end of my life was to work towards living a good life. In fact, I had a sign in my office that read, “Live each day as if it were your last—because one day, you’ll be right.”

I love that concept. It combines a universal truth with a bit of humor and becomes a wonderful blueprint for living. We don’t know what tomorrow will bring so we better make the most of today. In his book The Power of Now, Eckhart Tolle suggests that we must pay attention to the here and now because now is all we have. We can’t make an impact on our future nor change our past except through what we can do right now. It’s about being present throughout our entire life.

The concept of Do it Well, Make it Fun is also about the here and now. If we are paying attention to everything we do, we will see opportunities to improve the way we manage our work and our life. The Do it Well part means seeking excellence while the Make it Fun part means making the process of what we do more enjoyable.

So if we want to add more life to our days as Lincoln suggested, then we need to find both the best and the funnest ways to do what we do. Let’s break this concept down a little more.

Do it Well. There’s an old joke about a man who asks a bookstore employee where the Self Help section is located. The employee says, “Well, it would defeat the purpose if I told you now, wouldn’t it?”

Do it Well. Make it Fun.  
www.RonCulberson.com
The key to successful self help or personal development is that you have to make a commitment to yourself. For instance, doing things well means always striving for excellence. And striving for excellence means continual improvement. Most of us want to be excellent at what we do but knowing how and what to improve is often a challenge. Self awareness is the first step toward excellence. You cannot seek excellence if you’re not aware of how good you are now and how good you want to be at any particular task.

I once had a supervisor who had serious blind spots. He was forever saying things out loud that were better said in his head. His comments regularly offended others creating a work environment that was unhealthy. When I suggested that he might want to improve his communication skills, he looked at me as if I didn’t know what I was talking about. He felt his communication skills were fine and did not see the need to change a thing. So, he had two problems. He had poor communication skills and he had no insight or awareness into the problem. Eventually, he was fired. I can’t help but wonder if he ever recognized the relationship between the communication skills, the lack of self awareness, and being fired. Somehow I doubt it.

To do things well, we must constantly seek feedback and look objectively at the things we do to determine where we need to improve. Do we show up on time? Do we follow through? Do we thank others? Do we put the toilet seat down? Look at the areas in your life and work that are not going as well as you wish and explore ways to improve them. If you constantly seek to do things well, you will live a rich life and what’s more, you will enrich the lives of those around you. That’s the power of excellence.

**Make it Fun.** I’ve been studying the benefits of humor and laughter for more than 30 years. And while there is a difference between humor and fun, both are important to us. You see, life contains both joy and tragedy. To appreciate one, you have to appreciate the other. Those who don’t have the ability to experience tragedy cannot truly experience joy. And vice versa. Joy, fun, humor, and enjoyment are all necessary for a rich and balanced life. And it’s the addition of fun to excellence that is really powerful.

If you’ve ever had a boss who was really good at what he or she did but was also fun to be around, you didn’t mind coming to work. You respected them for their expertise but enjoyed being around them because they were fun. When combined with excellence, humor and fun create an approachability and an effectiveness that stands out.

Southwest Airlines has cracked this excellence-fun code by running a profitable and successful company where people enjoy working. The culture is fun but they do not sacrifice success or effectiveness just to achieve the fun part.

I was on a Southwest flight one day when the plane landed roughly. The pilot came on the intercom and said, “I’m really sorry about that landing folks but it wasn’t my fault. And it wasn’t the co-pilots fault. It was the asphalt.”

Do it Well. Make it Fun.  

www.RonCulberson.com
The passengers were laughing and instantly became relaxed after the pilot’s very effective comic relief. The key, though, is that he was also a good pilot.

The perfect icing on the excellence cake is to add a bit of fun.

**Everything is Process.** In order to combine excellence and fun, we must understand that everything we do in life and work is a process. And every process has steps. And every step has the potential of being both better *and* more fun. It’s that simple.

For instance, do you remember when you took Driver's Ed? There was a series of steps you had to go through before the instructor would let you put the key in the ignition.

Here’s what I had to do:

1. Put my seat belt on.
2. Adjust the mirror.
3. Make sure the car was in Park.
4. Put my foot on the brake.

If I didn’t do these things, the instructor would make me start all over. Today, however, we get in the car and go. Some of us are several miles down the road and we’re still struggling to put our seatbelt on. We no longer pay attention to the steps and therefore miss the chance to improve them.

In a recent training session, I asked the group to pick a process they’d like to improve. They chose the task of walking a dog. So, we outlined all the different steps associated with the process of walking a dog. They listed things like getting the leash, putting on their shoes, getting a bag to pick up the poop, etc.

Then we discussed ways to make the steps better or more fun. My favorite idea was when someone suggested putting a picture of someone they don’t like on the poop bag. Then, the disgusting process of cleaning up poop would seem much more enjoyable. Now, that’s how you take one step and make the entire process more tolerable!

Everything in life is a process. If you try to do every process well while making it more fun, I truly believe you will add life to your days.

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Ron Culberson, MSW, CSP, CPAE is a speaker, humorist, and author of four books including *Do it Well. Make it Fun. The Key to Success in Life, Death, and Almost Everything in Between*. His mission is to change the workplace culture so that organizations are more productive and staff are more content. He was the 2012-2013 president of the National Speakers Association and was inducted into that organization’s speaker hall of fame. He is also a recognized expert in the benefits of humor and laughter. For more information, visit [www.RonCulberson.com](http://www.RonCulberson.com)

Do it Well. Make it Fun.  
[www.RonCulberson.com](http://www.RonCulberson.com)
The Goal in Life is Not Seriousness

We are hardwired to be negative and when we add other sources of negativity to the mix through social media, news, and those whiney friends and family, it’s hard not to be negative in our approach to life and work.

The key to a fulfilling existence is to recognize this tendency and work towards a more positive approach. Instead of ending up in the “Whine Cellar,” you can choose to pursue a more fruitful existence.

Life is a Journey

A good result comes from a clear focus on the goal and attention to the process to get there. The best thing we can do to enrich our life is to embrace the concept that it will one day end. By keeping our eye on our goals and managing the processes along the way, we create a path to a rich and fulfilling life. So, imagine how you want to be remembered—and then make it happen.

The Do it Well, Make it Fun Process

Everything in life and work is a process. Every process involves a series of steps. Every step has the potential for being improved. Every step has the potential for being more fun.

Once we make the processes in our life and work better and more fun, the journey and the destination become both fulfilling and enjoyable.
Managing Ourselves

Stress is not inherently stress-full. Instead, stress is created by our interpretation of the stressor—an event or an experience in our lives. If stress were inherently stressful, then the same things would cause stress for everyone, which is not the case. A simple equation for stress looks like the one below. Thus, if we change the interpretation, we can change the effects of stress.

**Stressor + Interpretation = Effects of Stress.**

Managing Our Work

The core work-related benefit of Do It Well, Make It Fun is that by combining excellence and fun, we will design a work environment that is both productive and enjoyable. Try breaking down the boring, mundane, or stressful processes into individual steps. Then, look for ways to either improve the steps or to make them more fun.

A few Do it Well, Make it Fun Tips

1. Examine your interpretation of stress and see if you can change it.
2. Look everywhere for humor as a way to balance the effects of stress.
3. To communicate with clarity, pay attention to:
   • What you intend to say.
   • What and how you say it.
   • What was heard.
4. Be willing to laugh at your mistakes. Self-directed humor is a powerful communication tool.
5. To be excellent in your work, determine what skills you need and continually seek to improve them.
6. Ask yourself every day, “How am I going to have fun in my work today?”
7. Never take your life for granted. Appreciate what you have.
8. Live each day as if it were your last. One day, you’ll be right!

_I never did a day of work in my life. It was all fun._
—Thomas Edison

www.RonCulberson.com
Recommended Reading


Your Speaker

Ron Culberson, MSW, CSP, CPAE is a former hospice social worker, middle manager, and senior manager whose mission is to change the workplace culture so that organizations are more productive and staff are more content. He was the 2012-2013 president of the National Speakers Association and in 2014 was inducted into the CPAE Speaker Hall of Fame®.

Ron’s book titles:


- *Do it Well. Make it Fun. The Key to Success in Life, Death and Almost Everything in Between* (2012)


Using De-escalation Techniques to manage difficult Humans

Becky Ela, MSW, LCSW
Delta County Memorial Hospital
Goal of Verbal De-escalation

To help people get and maintain control of their emotions
How Come we Need this Skill?

To give ourselves the ability to manage and control a situation with people who are emotionally charged
10 Steps of Verbal De-escalation
Step 1: Respect personal space

- Maintain 2 arms length distance
- Open gesture (arms at side, turned slightly)
- Knees bent, relaxed posture
- In line of egress
Step 2: Be Calm

- Take a breath~Don’t be provocative
- Relax your stance~Don’t square off your stance
- Pay attention to your body~Don’t clench your fists
- Slow down~Don’t argue
- Keep a pleasant tone~Don’t yell
Step 3: Establish Verbal Contact

- “Hello Mr. Wilson, I can help you”
- “It sounds like you’re frustrated with having to wait for Dr. Jones”

- When we’re emotional, we have a narrowed range of attention, so...
Step 4: Be Concise

- Keep it simple
- Repeat basic phrases
- Let the patient respond before moving on

- The more we talk, the less the person hears and the more confused & fearful they become
Step 5: Identify Wants & Feelings

- We often misinterpret what someone wants & feels based on our own reaction to the event
- Clarify the issue at hand so that you are clear
To work well with agitated patients, staff members must be able to recognize and control countertransference issues and their own negative reactions. These include the clinician's understanding of his own vulnerabilities, tendencies to retaliate, argue, or otherwise become defensive and “act-in” with the patient. Such behaviors on the part of the clinician only serve to worsen the situation.

Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup
Step 6: Listen Closely to what the Patient is saying

- Listen for content, clarify the issue so you’re not making assumptions
- Watch the non-verbal cues (hand gestures, movement, facial expression)
Step 7: Validate the patient’s experience

- “It sounds like you’re frustrated because Dr. Wilson is behind on her schedule”

- **Most important component of verbal deescalation**
  - Patient feels heard
People who are effective at de-escalation are:

- open,
- honest,
- supportive,
- self-aware,
- coherent,
- non-judgmental,
- confident,
- do not appear arrogant

Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup
Step 8, 9: Set Clear Limits & Offer Choices/Optimism

- “Dr. Wilson will be able to see you in 10-15 minutes. Until then, you are welcome to sit in the waiting room with a cup of coffee and a magazine, or we can reschedule your appointment at a time more convenient for you”

- Coffee, magazines, water offer optimism
- Choice gives people a means of empowerment and sense of control
Step 10: Debrief Difficult Situations with Staff

- Doing so increases problem solving, can result in needed changes to work flows
- Makes staff feel validated and heard

- Debrief away from patient setting
- Plan regular scheduled debriefing sessions for staff (both co-workers & supervisors)
Incorporate Regular De-escalation practice

- Use staff meetings to discuss this
- Use strategic visualization
- Make a decision about a stressful event before it happens & practice dealing with it
- Gives staff confidence to manage difficult situations & people
- Role Play
- Role Play again
The American Psychiatric Association Task Force on Psychiatric Emergency Services has recommended that staff receive annual training on managing behavioral emergencies.

Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup
Use a Team Approach

- Use your co-workers and manager

- Support and back up help us stay professional and keep our cool

- Staff member is not trying to de-escalate a situation on their own
Pay attention to

- HIPPA violation
- PHI
- Physical space of your environment; needs to be designed or laid out for safety, change it if need be
Guideline: Physical Space Should Be Designed for Safety
Guideline: Staff Should Be Appropriate for the Job
Guideline: Staff Must Be Adequately Trained
Guideline: An Adequate Number of Trained Staff Must Be Available

Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup
Role Play helpful hints…

- Validate (until they feel heard)
- Help to find Options
- Allow for Choice
Role Play

Scenario #1
Scenario #2
Scenario #3
Use posters and flyers to inform patients
Resources

- Crisis Prevention Intervention
  https://www.crisisprevention.com


- Dr. Christian Conte, emotional/anger mgmt expert
  www.youtube.com

- https://www.medpro.com/deescalating-aggressive-behavior
Becky Ela, MSW, LCSW
Director, Behavioral Health
Delta County Memorial Hospital
West Elk Clinic, Hotchkiss, CO
rela@delthaospital.org
970-872-1400
Stepping on the scale
What is change talk?
What is sustain talk?
“My baby cries at night unless I give him the bottle with milk. I’m exhausted. I know I shouldn’t, but I’m at the end of my rope.”
“I’ve tried to lose weight, but my schedule is so busy that I just end up eating fast food instead of cooking. My job is a really big deal to me and they are depending on me to get the work done.”
“It’s hard to remember to take my medication every day. I do it some days, but I don’t love how feel after I take it.”
“Look, I know there’s some sort of opioid crisis, but it’s the only thing that helps my back. My doctor won’t write me any more prescriptions, but I don’t want to be in pain.”
Responding to Change Talk
How can we respond to change talk?
“My baby cries at night unless I give him the bottle with milk. I’m exhausted. I know I shouldn’t, but I’m at the end of my rope.”
“I’ve tried to lose weight, but my schedule is so busy that I just end up eating fast food instead of cooking. My job is a really big deal to me and they are depending on me to get the work done.”
“It’s hard to remember to take my medication every day. I do it some days, but I don’t love how feel after I take it.”
“Look, I know there’s some sort of opioid crisis, but it’s the only thing that helps my back. My doctor won’t write me any more prescriptions, but I don’t want to be in pain.”
Evoking the Direction

Think about goal you have for the rest of 2019

Set the table (name, role, time, agenda, permission)

“What concerns do you about accomplishing the goal you have set for yourself?”

Use active listening to continue the conversation
Evoking the Direction

Think about goal you have for 2019

Set the table (name, role, time, agenda, permission)

“What excites you about accomplishing the goal you have set for yourself?”

Use active listening to continue the conversation
Evoking the Direction
10 Strategies for Evoking Change Talk
Sustain Talk → Change Talk
Stepping on the scale
“I don’t see motivational interviewing as the solution; I see motivational interviewing as a powerful ingredient in the fuel that drives good practice. And it’s good practice that we are after.”

-Stephen Rollnick
Thank you!

mdavidmi.com
matt@mdavidmi.com
Physician and Staff Acceptance of Care Managers in Primary Care Offices

- After a 3 years of care management, embedded care managers are accepted by both staff and physicians.

- Physicians and staff noted that care managers are an important member to the team and improved the team’s ability to meet patient needs.

- Unlike previous studies, this study shows the favorability of care managers. This is thought to be due to culture change: improved communication, defined roles, and trust.

Jean M. Malouin, Rebecca A. Malouin, Issidoros Sarinopoulos, Marie Beisel, Diane Bechel-Marriot, Amanda First, Ginger M. Gamble and Clare Tanner
The Journal of the American Board of Family Medicine March 2017, 30 (2) 140-149; DOI: https://doi.org/10.3122/jabfm.2017.02.160246
Physician and Staff Acceptance of Care Managers in Primary Care Offices

The more embedded a care manager is, the higher satisfaction of care management in the practice.

Jean M. Malouin, Rebecca A. Malouin, Issidoros Sarinopoulos, Marie Beisel, Diane Bechel-Marrrot, Amanda First, Ginger M. Gamble and Clare Tanner
The Journal of the American Board of Family Medicine March 2017, 30 (2) 140-149; DOI: https://doi.org/10.3122/jabfm.2017.02.160246
Peak Family Medicine –
Dr. Joe Adragna

- **Number of providers:** 9 (2 MDs, 1 PhD, 1 DC, 3 PA, 2 NP)
- **Number of staff:** 17
- **Number of care managers:** 1
- **Number of active patients:** 4600
- **Years with care management at practice:** 2
Western Valley Family Practice – Luisa Valenzuela, Care Manager

- **Number of providers**: 16
- **Number of staff**: 48
- **Number of care managers**: 1
- **Number of active patients**: 9468
- **Years with care management at WVFP almost 5 years**
Roaring Fork Family Practice – Dr. Gary Knaus

- **Number of providers**: 9
- **Number of staff**: 29
- **Number of care managers**: 1.5
- **Number of active patients**: 1,200 provider panel
- **Years with care management at practice**: 7 years
Questions?
ENCOURAGING OTHERS TO TAKE INITIATIVE

JARID ROLLINS MSW LCSW
MIDVALLEY FAMILY PRACTICE
PLEASE ASK QUESTIONS...

LCSW AT MIDVALLEY FAMILY PRACTICE WORKED 5 YEARS IN A CLINICAL CAPACITY

TRAIL RUNNER

BIRDER

TYPE 1 DIABETIC
Taking the Expert Role

- Theories
- Modalities
- Jargon
- Interventions
- Problem Solving
An expert is just somebody from out of town with slides.

NAOMI JUDD
SHAME V GUILT

- FEELING BAD ABOUT WHO YOU ARE
- ISOLATING
- SOMETIMES VOICED OTHER TIMES REMAINS SECRET
- MOST PEOPLE HAVE SOME SHAME

- FEELING BAD ABOUT WHAT YOU DID
- CAN BE ACTIVATING
TYPE 1 DIABETES

- A1C
- MICROALBUMIN
- CHOLESTEROL
- BLOOD PRESSURE
- FOOT EXAM
- ASPIRIN

- BLOOD GLUCOSE
- WEIGHT/BMI
- IMMUNIZATIONS
- EYE EXAM
RUGGED INDIVIDUALISM

BREEDING GROUND FOR SHAME
WHAT HAPPENS WHEN WE GO IT ALONE

WE FALL INTO THE RIGHTING REFLEX TRAP
WE SCALE UP OUR ARMOR
WE FORM BAD HABITS
WE ARE TRULY UNEMPLOYED
RETHINKING SELF DISCLOSURE

- AVOID AT ALL COSTS
- BE AFRAID BE VERY AFRAID

“Endeavor to normalize the shady side in any way possible. We therapists should be open to all our own dark, ignoble parts, and there are times when sharing them will enable patients to stop flagellating themselves for their own real or imaginary transgressions.”

- IRVIN YALOM
PHYSICIAN SELF DISCLOSURE (PSD)

- PSD occurred in 15% of all PCP and surgery appointments
- PSD decreases patient satisfaction.
- 85% of PSD is “not useful”
  - AMA Journal of Ethics (2011)

Transference is unavoidable from our patients they will tell stories about us.
TURN TO THE PERSON TO YOUR RIGHT AND SHARE A TIME WHEN YOU USED SELF DISCLOSURE EARLY IN YOUR CAREER…

• HOW DID IT GO?
• HOW DID YOU FEEL AFTERWARD?
• WHAT WAS THE RESPONSE FROM THE PATIENT?
NEXT, TALK ABOUT A TIME RECENTLY THAT YOU USED SELF DISCLOSURE…

• WHAT WAS DIFFERENT?
• HOW WAS IT RECEIVED?
SO WHAT IS THE BALANCE...
HOW CAN SELF DISCLOSURE BE LEVERAGED TO DECREASE SHAME?

• SELF INVOLVING SELF DISCLOSURE

• SPEAKING TO THE SHADOW PARTS OF HUMAN NATURE IN GENERALITIES AND STORIES
  • TAKES THE PATIENT AWAY FROM THE EXPERIENCER BRAIN INTO THE OBSERVER BRAIN
GROUP INTERVENTION

• I WILL BE THE PATIENT DEALING WITH MY VERY REAL PROBLEM OF NOT BEING ON THE ROLLER COASTER OF BLOOD SUGAR EVERY DAY.

• I NEED A VOLUNTEER TO BE THE LEAD

• EVERYONE OUT THERE HAS A CHANCE TO CONTINUE THE CONVERSATION IF THE LEAD IS STUCK...
**DIABETES ROLLER COASTER**

- **Jarid**, the patient is a 31-year-old male who works as a professional and can control most of his day. He is able to come and go to get food if needed and exercise throughout the day. He is active most days and feels like his diet is okay. He has had T1D for 2 years.

- As the provider/care manager/nurse/MA, how do you use yourself to speak to shame, use self-involving self-disclosure and encourage client towards greater self-actualization.
HOW DID YOU DO?

WHAT ELSE WOULD YOU ASK? DISCLOSE? STATE?
USE OF SELF

- MOTIVATIONAL INTERVIEWING IS A WAY OF BEING WITH A PERSON…
  - “A COLLABORATIVE PERSON CENTERED FORM OF GUIDING TO ELICIT AND STRENGTHEN MOTIVATION FOR CHANGE”

- AUTHENTIC
- VULNERABILITY
- BEING WRONG
- INTRODUCING OTHERS TO THE CARE TEAM
WHO ELSE CAN YOU INVOLVE?

A DOCTOR SPENDS AN AVERAGE OF 17.5 MINUTES PER VISIT WITH A PATIENT…

“TIME SPENT IN FACE TO FACE CARE AND WORK OUTSIDE THE EXAMINATION ROOM” ANDREW GOTTSCHALK
17.5 MINUTES COMPARED TO WHAT

THERE ARE 10,080 MINUTES IN A WEEK
THERE ARE 43,800 MINUTES IN A MONTH
AND OBVIOUSLY 525,600 MINUTES IN A YEAR
HOW DO WE BRING IN OTHER PROVIDERS TO THE OFFICE VISIT TO CONTINUE THE WORK?

1. DEVELOP A RELATIONSHIP WITH OUTSIDE PROVIDERS.
2. CREATE AN MOU
3. KEEP THE RELATIONSHIP GOING
4. COLLABORATE OPENLY
TURN TO THE PERSON TO YOUR LEFT

• TELL A STORY ABOUT A TIME WHEN YOU HELD A JOINT VISIT WITH AN OUTSIDE PROVIDER AND IT WAS SUCCESSFUL...

• WHY?

• TELL A STORY ABOUT A TIME WHEN YOU HELD A JOINT VISIT WITH AN OUTSIDE PROVIDER AND IT WAS NOT SUCCESSFUL...

• WHY NOT?
GROUP INTERVENTION

• I’m still the patient, it is my second visit following up on the same issue and not much has changed. Your mission should you choose to accept it is to approach the subject of bringing in another provider and overcome my shame?
HOW DID YOU DO?

WHAT ELSE WOULD YOU ASK? DISCLOSE? CHANGE?
THE END

IF YOU WANT TO CHOOSE THE PLEASURE OF GROWTH, PREPARE YOURSELF FOR SOME PAIN.

-IRVIN YALOM
My strengths/virtues
My strengths/virtues

Acceptance     Accountability     Appreciation     Assertiveness      Awe      Beauty      Caring
Certitude      Charity      Cheerfulness     Cleanliness      Commitment      Compassion      Confidence
Consideration  Contentment  Cooperation  Courage  Courtesy  Creativity  Decisiveness  
Determination  Devotion  Dignity  Diligence  Discernment  Empathy  Endurance  Enthusiasm
Excellence     Fairness     Faith     Faithfulness     Fidelity     Flexibility     Forbearance     Forgiveness
Fortitude      Friendliness  Generosity  Gentleness  Grace  Gratitude  Helpfulness  Honesty
Honor          Hope          Humanity  Humility  Idealism     Initiative  Integrity  Joyfulness  Justice
Kindness      Love          Loyalty    Mercy    Mindfulness  Moderation  Modesty  Nobility
Openness      Optimism     Orderliness  Patience  Peacefulness  Perceptiveness  Perseverance
Prayerfulness  Purity       Purposefulness  Reliability  Resilience  Respect  Responsibility
Reverence      Righteousness  Sacrifice  Self-discipline  Serenity  Service  Simplicity
Sincerity      Steadfastness  Strength  Tact  Thoughtfulness  Tolerance  Trust
Trustworthiness  Truthfulness  Understanding  Unity  Wisdom  Wonder  Zeal
Stepping on the scale
Understanding Engagement
What is the matter with you?
What is the matter with you?

What matters to you?
Creating Engagement
How do you currently go about engaging your patients?
What questions are patients asking related to engagement?
What traps can we fall into that promote disengagement?
What promotes engagement?
What promotes engagement?

Desires or goals
Importance
Positivity
Expectations
Hope
What promotes engagement?

**Setting the table**

- Name
- Role
- Time
- Agenda
- Ask permission
What promotes engagement?

**Nonverbal Empathy and Curiosity**

- Eye Contact
- Body Posture/Proximity
- Facial Expression
- Head nodding
- Touching
Our Daily Flow

In partners, set the table (name, role, time, agenda, permission)

Ask an engaging question

LISTEN!
Patient and Family Engagement 201
“Do not depend on the hope of results. You may have to face the fact that your work will be apparently worthless and even achieve no result at all, if not perhaps results opposite to what you expect. As you get used to this idea, you start more and more to concentrate not on the results, but on the value, the rightness, the truth of the work itself. You gradually struggle less and less for an idea and more and more for specific people. In the end, it is the reality of personal relationship that saves everything.”

-Thomas Merton
Thank you!

mdavidmi.com
matt@mdavidmi.com
Engaging in Advance Care Planning Talks through Group Visits

Hillary Lum, MD, PhD
September 13, 2019
Objectives

• Recognize the need for advance care planning in Colorado
• Describe an Advance Care Planning Group Visit model
• Describe benefits to patients and provider teams
• Consider opportunities for your practices to implement an Advance Care Planning Group Visit
Advance Care Planning Group Visits

Group medical visits can be an ideal way to promote advance care planning engagement.

- Engage patients in interactive discussions of advance care planning concepts
- Support patient-initiated advance care planning actions and outcomes
- Emphasize education and support through group dynamics
- Use standard outpatient billing codes and documentation

ENACT Group Visits Intervention

<table>
<thead>
<tr>
<th></th>
<th>CO</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older adults</td>
<td>66.4%</td>
<td>45.6%</td>
</tr>
<tr>
<td>Younger adults</td>
<td>29.3%</td>
<td>31.6%</td>
</tr>
<tr>
<td>All ages</td>
<td>35.7%</td>
<td>36.7%</td>
</tr>
</tbody>
</table>

Source: Colorado Health Access Survey, 2017; Health Affairs, 2017
LEVERS OF CULTURE CHANGE FOR ACP

Engagement
- General Public
- Healthcare systems
- Legal system

Education
- Training of professionals
- Public education

System Infrastructure
- Tools for conversations & documentation
- Policy & programs

Research & Quality Improvement
- Data
- Quality Metrics

Colorado MOST Program

• Quarterly standing agenda item at Center to Improve Value in Health Care’s ACP Stakeholder Workgroup meeting
• **Open meeting – 1st Thursdays of every month**

https://www.civhc.org/programs-and-services/advance-care-planning/

Contacts:
Member, Alissa Schramm - alissa@compasscaresforseniors.com
Alternate, Hillary Lum – Hillary.Lum@ucdenver.edu
Where are we currently?

- How do you or your organization currently engage people in advance care planning?
- What challenges do you face related to advance care planning?
Objectives

• Recognize the need for advance care planning in Colorado
• Describe an Advance Care Planning Group Visit model
Group medical visits can be an ideal way to promote advance care planning engagement.

- **Engage patients in interactive discussions of advance care planning concepts**
- **Support patient-initiated advance care planning actions and outcomes**
- **Emphasize education and support through group dynamics**
- **Use standard outpatient billing codes and documentation**

---

**ENACT Group Visits Intervention**

Facilitation based on Collaborative Learning Theory

- Learning is a shared and social process
- Learners are diverse
- Learning includes individual experiences

ACP outcomes through group dynamics and behavior change

- Individual Experiences
- Factual/Medical Knowledge
Structure of Advance Care Planning Group Visits

Engaging in Advance Care planning Talks (ENACT) Group Visits

# Group Visit Facilitation Guide

## Topics Facilitator Questions and Sample Prompts

### Session 1

<table>
<thead>
<tr>
<th>Topic</th>
<th>Facilitator Questions and Sample Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction:</strong> Reasons for coming</td>
<td>Today’s goals are to talk about what’s important to you for your future healthcare choices and advance care planning. To start, can you introduce yourself and share why you chose to come today?</td>
</tr>
<tr>
<td>Participants share personal ACP stories</td>
<td>Has anyone started thinking about what is most important to you? Have you or someone close to you had experiences with serious illness or death?</td>
</tr>
<tr>
<td>Participants discuss role of surrogate decision makers</td>
<td>Who makes a good decision maker? Do you have a medical durable power of attorney? Have you talked with them?</td>
</tr>
</tbody>
</table>
Advance Care Planning Discussion Core Topics

- **Values clarification**
- **Ongoing conversations** (patients, family, decision makers, clinicians)
- **Surrogate decision makers** (flexibility)
- **Advance Directives** (medical power of attorney, living will)
- **Common medical treatment options** (risks, benefits, burdens)

What does facilitation look like?

- Initiate interactive discussions
- Encourage personal stories related to ACP
- Use diverse ACP patient resources (PREPARE videos; Conversation Starter Kit; Colorado advance directive forms)
- Prompt patients to ask and answer questions of each other
Objectives

• Recognize the need for advance care planning in Colorado
• Describe an Advance Care Planning Group Visit model
• Describe benefits to patients and provider teams
ACP Group Visit Outcomes

N=55 participants per arm

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>6 months</th>
<th>Baseline</th>
<th>6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Directive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>40</td>
<td>45</td>
<td>69</td>
<td>73</td>
</tr>
<tr>
<td>ENACT Group Visit</td>
<td>44</td>
<td>71</td>
<td>75</td>
<td>93</td>
</tr>
</tbody>
</table>

% of Participants

- Control
- ENACT Group Visit
University of Colorado Primary Care Results: ACP conversations

Patient report of ACP conversations after the 2nd Session (n=98):

Detailed conversations – “The conversations included enough details that I feel confident my loved ones know my wishes.”
Feedback from patients

Facilitators' encouraged patients to share their own experiences:

[My husband had] hospice in a nursing home. It was just wonderful — they kept him very comfortable — it was a beautiful death. It is a horrible thing to say, but it was a peaceful, wonderful end to his life.
Feedback from patients

Patients responded to diverse ACP resources:

• Conversation Starter Kit
  "I'll finish this sentence: What matters to me at the end of life is... I've had some experience. I put down "No Nursing Home". Because I had an experience of two months with assisted living and then I had two months in rehab. And so I indicated in my own family, that is really the last place I want to be."

• PREPARE website videos (flexibility)
Objectives

• Recognize the need for advance care planning in Colorado
• Describe an Advance Care Planning Group Visit model
• Describe benefits to patients and provider teams
• Consider opportunities for your practices to implement an Advance Care Planning Group Visit
## Intervention Components

<table>
<thead>
<tr>
<th>Intervention Components</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and Group characteristics</td>
<td>Willing to be in a group; Group size; Participation with spouse/partner; Cognitive level</td>
</tr>
<tr>
<td>Facilitation approaches</td>
<td>Helpful phrases; Teaching skills; Medical and ACP topic discussion</td>
</tr>
<tr>
<td>ACP resources</td>
<td>Conversation Project⁴⁹; PRE PARE website⁴¹; advance directives</td>
</tr>
<tr>
<td>Integration into medical care</td>
<td>Desire for follow up with oncologist; Desire to share ACP with PCP</td>
</tr>
<tr>
<td>Clinic resources</td>
<td>Meeting space; Workflows; Staffing Recruiting process; documentation</td>
</tr>
</tbody>
</table>
Tools for Implementation

• Worksheet for adapting a Group Visit program to your setting

• Intervention Checklist
  • Facilitators & Facilitation Guide
  • ACP patient resources (handouts, videos, advance directives)

• Group Medical Visit Checklist
  • Recruitment strategy (flyers, outreach calls, letters, referrals)
  • Medical Check In; Consent Forms
  • Medical Documentation Templates and Billing
Documentation and Billing for Group Visits

• Group medical visits are billable using outpatient evaluation and management (E/M) codes for new and established patients.

• Codes should relate to level of complexity of the visit.
  - Typically use a Level III Outpatient E/M Visit – **CPT 99213**.
  - Seeing a patient individually after the group may relate to moderate complexity (CPT code 99214) visit.

• Tips: Create templates that describe the common elements of the group; **DO NOT** document based on time.
Do you have a next step?

• How will you increase how you engage others in advance care planning?
Colorado Care Planning

A free, public website to help Coloradans find information for future medical planning, including choosing a medical decision maker. Funded by the Colorado Health Foundation.

Contact:
Hillary Lum – Hillary.Lum@ucdenver.edu  https://coloradocareplanning.org/
Thank you!

• Patient and Family Advisors
• CIVHC & the ACP Workgroup
• UCH Seniors Clinic staff
• UCHealth Operational Partners
• Sue Felton, Dana Lahoff, Sarah Jordan, Adreanne Brungardt, Andrea Daddato
• Pat Schulof, LCSW & Kirbie Hartley, LSW
• Ingrid Lobo, MD & John Scott, MD
• Mentors, colleagues, & community partners
Reducing Preventable Emergency Room (ER) Utilization

Problem: Emergency Room Over-Utilization

Drivers of ER Utilization

- Individuals are unsure where to seek care
- Lack of advice or triage options
- ER access is “easy”—one stop shopping
- Office hours (after hours & weekends)
- Poor care coordination
- Proximity to ER
- High volume of potentially avoidable visits
- Uncoordinated care (PCP unaware of visit)
- Lack of access to appropriate care
- ER overcrowding
- Risk for medication errors
- Increased unnecessary testing
- Wasteful spending

Results of ER Utilization

- High cost
- Risk for medication errors
- Lack of advice or triage options
- Patients are unsure where to seek care
- Uncoordinated care
- ER overcrowding
- Increased unnecessary testing
- Wasteful spending

Opportunity: Decrease Inappropriate ER Utilization Through Coordinated Efforts

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

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

LANE Definition

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

On average, an ER visit costs 7 TIMES more than receiving care for the same reason in a doctors office or clinic.  

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 appointment availability

Appropriate Triage

- Evaluate and refine processes for ‘ triaging’ patients who call for a same day appointment
- Evaluate nursing triage protocols
- Update after hours voicemail messaging
- Consider an after-hours call service and/or nurse advice line
- Ensure a physician or nurse is on-call for urgent patient needs

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 availability
- Post patient-facing fliers to remind patients when to use their PCP or Urgent Care.

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 process to make appointment in clinic?
  - Shared determination with ED physician on admit decisions?
  - Consider partnerships with urgent care clinics

Post-ER Follow-up: Care & Learn

- 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 care in the most appropriate setting (if applicable)

Percentage LANE Visits

- Non-LANE
- LANE

On average, an ER visit costs 7 TIMES more than receiving care for the same reason in a doctors office or clinic.

Daily ED Discharges

- Non-Business Hours
- Business Hours

<table>
<thead>
<tr>
<th>Day</th>
<th>Sum</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>6%</td>
<td>7%</td>
<td>14%</td>
</tr>
</tbody>
</table>

1. MidSouth PTN Sampled Data
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 appointment availability
PATIENT SURVEY TEMPLATE

Instructions: Please answer the following questions about your overall experience with Insert Practice Name during the past year.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is easy to schedule an appointment in a timely manner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I call Insert Practice Name, my needs are met in a timely manner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I have an urgent medical issue, I am offered a same-day or next-day appointment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When scheduling a routine follow-up appointment, I am offered an appointment that meets my needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know how to get in touch with someone from my doctor’s office after normal business hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Insert Practice Name offered appointments during evening hours, I would use them</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Insert Practice Name offered appointments during weekend hours, I would use them</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Things to consider as a team:

- Are your patients satisfied with the current “ease of access” to your practice providers?
- Is there a need to offer evening hours?
  - If yes, is there a way to ‘test’ evening hours to determine value?
- Is there a need to offer weekend hours?
  - If yes, is there a way to ‘test’ weekend hours to determine value?
- Are your patients aware of how to contact their provider after hours?
APPONTMENT UTILIZATION ASSESSMENT

There is not a perfect template or ‘one size fits all’ option when it comes to scheduling. Ideally, you want to increase capacity while making sure the practice isn’t slowed down, leading to longer patient waiting times or overtime. A good place to start is to assess current state of your practice.

Step 1: Current State of Scheduling Template/Process

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the average no show/ cancellation rate?</td>
<td></td>
</tr>
<tr>
<td>2. What is the average appointment time scheduled?</td>
<td></td>
</tr>
<tr>
<td><em>(Ex: 15min, 30min)</em></td>
<td></td>
</tr>
<tr>
<td>3. Do ‘physicals’ get 2 slots per patient?</td>
<td></td>
</tr>
<tr>
<td>4. Are ‘new patient’ appointments designated in the current template?</td>
<td></td>
</tr>
<tr>
<td>a. If yes, what is the policy if that patient no shows/cancels?</td>
<td></td>
</tr>
<tr>
<td>5. What is the policy for an appointment slot that remains unfilled 24 hours prior to the time? <em>(Can staff ‘work in’ patients?)</em></td>
<td></td>
</tr>
<tr>
<td>6. Does the provider ‘block time’ to get caught up during the day?</td>
<td></td>
</tr>
<tr>
<td>7. What is the protocol for overbooking/double-booking for urgent care needs?</td>
<td></td>
</tr>
</tbody>
</table>
Step 2: Time Motion Study

Another important step in assessing the current state of your practice is to compare the length of scheduled appointments with the time actually spent. During a standard day, have one staff member be dedicated to measuring and recording how long each clinician and staff member spends with patients. A simple template to document observations and a stopwatch or cell phone is all that is needed. It is important to measure how long a provider is actually in the room with the patient. Most providers overestimate the time spent in a room.

Example Template:

<table>
<thead>
<tr>
<th>Task</th>
<th>Person</th>
<th>Start (Timestamp)</th>
<th>Stop (Timestamp)</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Patient vitals taken</td>
<td>Nurse</td>
<td></td>
<td></td>
<td>5 min</td>
</tr>
<tr>
<td>Example: Patient roomed</td>
<td>Nurse</td>
<td></td>
<td></td>
<td>2 min</td>
</tr>
<tr>
<td>Example: Nurse assessment</td>
<td>Nurse</td>
<td></td>
<td></td>
<td>15 min</td>
</tr>
<tr>
<td>Example: Physician assessment</td>
<td>Physician</td>
<td></td>
<td></td>
<td>20 min</td>
</tr>
<tr>
<td>Example: Patient check-out, payment, and follow-up appointment scheduled</td>
<td>Receptionist</td>
<td>8 min</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At the end of the day, calculate an average for the time spent by providers during various appointment types.

Example Template:

<table>
<thead>
<tr>
<th>Appointment type</th>
<th>Ave Nurse Time (minutes)</th>
<th>Ave Physician Time (minutes)</th>
<th>Ave Total Time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Flu-like symptoms</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Routine follow-up post-procedure</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Average appointment time</td>
<td>8 min</td>
<td>10 min</td>
<td>18.3 min</td>
</tr>
</tbody>
</table>

Do the observed times match the time blocked during appointment scheduling? Where can changes be made to optimize scheduling?
PROTOCOLS FOR EFFICIENCY

In addition to optimizing the patient scheduling template and process, standard protocols allow for increased efficiency in workflows and shared understanding among care teams. Consider the following areas to review, updated, or create protocols:

- Treatment protocols for common conditions
  - Example: When a patient arrives for an acute visit for a UTI, can the staff that collects the sample also run the urine point of care test so that the results are ready for the provider?

- Standing Orders
  - Example: Are standing orders in place for immunizations?

- Scheduling protocols
  - Are there medical concerns that are always acceptable to ‘work in’ during a normal day?
  - Under what conditions are staff allowed to ‘work in’ patients without asking permission?

The opportunity to streamline work and optimize efficiency helps ensure that adding walk-ins or same day appointments for urgent care needs will not slow the care team down or affect the timeliness of care for those patients who had regularly scheduled appointments. Engaging providers to work through these protocols makes it easier for staff to understand what is acceptable and encourages team-based care.

SAME DAY AND NEXT-DAY APPOINTMENTS

The process of taking stock of the current state of your practices’ scheduling template and protocols, assessing patient experience and remaining needs for access to care, optimizing patient appointment times, and streamlining workflows will allow your practice to schedule same day appointments often without any substantial changes to the template itself.

Optimal hours for same day appointments are late morning/early afternoon. Average appointment time for primary care is 15 minutes, and many providers can offer 2-4 same day slots in their template to see patients for urgent concerns.– FIND CITATION TO SUPPORT THIS.
• Evaluate and refine processes for ‘triaging’ patients who call for a same day appointment
• Evaluate nursing triage protocols
• Update after hours voicemail messaging
• Consider an after-hours call service and/or nurse advice line
• Ensure a physician or nurse is on-call for urgent patient needs
EVALUATE CURRENT PROCESS FOR TRIAGING PATIENTS VIA TELEPHONE

When patients or family members call the practice during business hours with an urgent care need, what is the current protocol?

Things to consider as a team:

- What is the current protocol for when a patient calls with an urgent care need?
  - Who is responsible for determining if an appointment is made?
  - Is the patient instructed by the receptionist or a nurse?
- Is there an escalation process for which a patient would be transferred to a nurse?
- Is there an escalation process for which a patient would be transferred to a physician?
- Are there clear guidelines for when to tell a patient to go to the Emergency Room and what can be cared for by the practice?
- Are triage protocols for the phone an appropriate solution for your practice?
EXAMPLE PROTOCOL FOR PHONE TRIAGE: PEDIATRIC COUGH

Assessment Questions

Note to Triager - Respiratory Distress: Always rule out respiratory distress (also known as working hard to breathe or shortness of breath). Listen for grunting, stridor, wheezing, tachypnea in these calls. How to assess: Listen to the child's breathing early in your assessment. Reason: What you hear is often more valid than the caller's answers to your triage questions.

1. ONSET: "When did the cough start?"
2. SEVERITY: "How bad is the cough today?"
3. COUGHING SPELLS: "Does he go into coughing spells where he can't stop?" If so, ask: "How long do they last?"
4. CROUP: "Is it a barky, croupy cough?"
5. RESPIRATORY STATUS: "Describe your child's breathing when he's not coughing. What does it sound like?" (assess for wheezing, stridor, grunting, weak cry, unable to speak, rapid rate)
6. CHILD'S APPEARANCE: "How sick is your child acting?" "What is he doing right now?" If asleep, ask: "How was he acting before he went to sleep?"
7. FEVER: "Does your child have a fever?" If so, ask: "What is it, how was it measured, and when did it start?"
8. CAUSE: "What do you think is causing the cough?" Age 6 months to 4 years, ask: "Could he have choked on something?"

Triage Assessment Questions

1. Call EMS if:
   a. Difficult breathing AND SEVERE shortness of breath and shortness of breath present when not coughing
   b. Slow, shallow weak breathing
   c. Passes out or stopped breathing
   d. Bluish lips, tongue or face AND persists when not coughing
   e. Age < 1 year AND very weak (doesn't move or make eye contact)
   f. Sound like a life threatening emergency to triager

2. Go to ER now if:
   a. Coughed up a large amount of blood
   b. Ribs are pulling in with each breath (retractions) when not coughing
   c. Stridor (harsh sound with breathing in) is present
   d. Lips or face have turned bluish but only during coughing fits
   e. Age < 12 weeks AND fever 100.4 or higher
   f. Difficulty breathing, not severe, still present when not coughing
   g. Age <3 years AND continuous coughing AND sudden onset today AND no fever or cold symptoms
   h. Rapid breathing (Breaths/min > 60 if < 2 mo; > 50 if 2-12 mo; > 40 if 1-5 years; > 30 if 6-12 years; >20 if > 12 years old)
   i. Age , 6 months AND wheezing is present but no severe trouble breathing
j. SEVERE chest pain present now
k. Drooling/spitting out saliva AND can’t swallow fluids
l. Shaking chills and cough present for > 30 minutes
m. Fever > 104 axillary (or 105 by any route)
n. Fever and weak immune system
o. Child sounds very sick or weak to the traiger

3. See physician within 4 hours if:
   a. Age < 1 month AND lots of coughing
   b. MODERATE chest pain and can’t take a deep breath
   c. Age < 1 year AND continuous coughing keeps from feeding and sleeping AND no improvement from cough treatment guidelines

4. Call primary care provider now if:
   a. High-risk child (underlying lung, heart or neuromuscular disease)

5. See primary care provider within 24 Hours
   a. Age < 3 months
   b. Age > 6 months and mild wheezing but no trouble breathing
   c. Blood tinged sputum has been coughed up more than once
   d. Age > 1 year AND continuous coughing keeps from feeding and sleeping AND no improvement from cough treatment guidelines
   e. Earache is also present
   f. Age > 5 years AND sinus pain is also present
   g. Fever present > 3 days

6. See primary care provider when office is open (within 3 days)
   a. Age 3 to 6 months AND fever with cough
   b. Fever returns after gone for over 24 hours and symptoms are worse
   c. New fever develops after having a coughing for 3 days and symptoms get worse
   d. Coughing has cause chest pain that is present even when not coughing
   e. Pollen-related cough not relieved by antihistamines
   f. Cough only occurs with exercise
   g. Vomiting from hard coughing 3 or more times
   h. Coughing has kept child home from school for 3 or more days
   i. Nasal discharge for > 14 days
   j. Whooping cough present in the community, cough lasts for > 2 weeks
   k. Cough present for > 3 weeks

Provide home care recommendations and refer to other guidelines as applicable

EXAMPLE PROTOCOL FOR PHONE TRIAGE: ADULT HIGH BLOOD GLUCOSE

Assessment Questions

1. BLOOD SUGAR: "What is your blood sugar level?" ____________
2. ONSET: "When did you check your blood sugar?" ____________
3. USUAL RANGE: "What is your sugar level usually?" (e.g., usual fasting morning value, usual evening value) ______________
4. URINE KETONES: "Do you test your urine?" If yes, ask: "What does the test show now?" ______________
5. TYPE 1 or 2: "Do you know what type of diabetes you have?" (e.g., Type 1, Type 2, Gestational; doesn't know) _____________
6. INSULIN: "Do you take insulin?" If yes, ask: "Have you missed any shots recently?" ____________
7. DIABETES PILLS: "Do you take any pills for your diabetes?" If yes, ask: "Have you missed taking any pills recently?" ____________
8. OTHER SYMPTOMS: "Do you have any symptoms?" (e.g., fever, frequent urination, difficulty breathing, dizziness, weakness, vomiting) ___________________________________
9. PREGNANCY: "Is there any chance you are pregnant?" "When was your last menstrual period?"

Triage Assessment Questions

1. Call EMS if:
   a. Unconscious or difficult to awaken
   b. Acting confused (disoriented, slurred speech)
   c. Very weak (can’t stand, etc)
   d. Sounds like a life-threatening emergency to the triager
2. Go to ER if:
   a. Vomiting and signs of dehydration (dry mouth, lightheaded)
   b. Blood glucose > 240 AND urine ketones moderate-large (if home testing)
   c. Blood glucose > 240 AND vomiting AND unable to check urine ketones
   d. New onset diabetes suspected (frequent urination, weak, weight loss) AND vomiting or rapid breathing
   e. Vomiting last > 4 hours
   f. Patient sounds very sick/weak to the triager
3. See physician within 4 hours if:
   a. Fever > 100.5
4. Call primary care provider now if:
   a. Blood glucose > 400
   b. Blood glucose > 300 two or more times in a row
   c. Urine ketones moderate-large
   d. Caller has URGENT medication or pump question and triager is unable to answer the question
5. See primary care provider within 24 hours
a. Symptoms of high blood sugar (frequent urination, weakness, weight loss) AND unable to test blood glucose
b. New onset diabetes suspected (frequent urination, weakness, weight loss)

6. Call primary care provider within 24 hours if:
   a. Call has NON-URGENT medication question

For each condition, give the appropriate home management advice.

**Modified pathway from** David A. Thompson, MD, FACEP, “After Hours Telephone Triage Protocols- Standard Adult.” Schmitt-Thompson Clinical Content. 2015.
AFTER HOURS MESSAGE

Overview:
When patients or family members call the practice after hours, the message that they hear can influence whether or not they go to an Emergency Room to address their health concern. An effective after hours message is an important element of the practice’s approach to reducing excess Emergency Room Use.

Tips:
- The tone of voice matters. Use a calm, relaxed, and inviting tone when recording the message.
- Start out by explaining that a physician or advice nurse is always available if the patient cannot wait until the office opens.
- If the message must instruct patients to call 911 or go to the nearest Emergency Department, consider putting this at the end of the message, instead of the beginning.
- Know your patient population. The message may need to be recorded in Spanish or another language.

Below are three examples of good after hours messages. Tailor your practice’s message to the resources you have in place.

1) If your practice has a voice mail system and a doctor or nurse on call:
   Thank you for calling [Practice Name]. We are currently closed. If you are calling about an urgent medical problem that cannot wait until regular office hours, there is a [doctor or nurse] available.
   Please call XXX-XXX-XXXX to reach the [doctor or nurse] on call.

   If your concern is less urgent and could be addressed when the office opens, please leave a message after the tone, or call back during normal office hours. Our office is open from XX:XX to XX:XX, and we will do our very best to address your needs.

   If you are calling about a life-threatening emergency, please call 911 or go to the nearest Emergency Room.

2) If your practice has an answering service:
   Thank you for calling [Practice Name]. We are currently closed. If you are calling about an urgent medical problem, please stay on the line to reach the [doctor or nurse] on call.

   If your concern is less urgent and could be addressed by your regular doctor or nurse when the office opens, please call back during normal office hours. Our office is open from XX:XX to XX:XX.

   If you are calling about a life-threatening emergency, please call 911 or go to the nearest Emergency Department.

3) If your practice does not have someone on call after hours:
   Thank you for calling [Practice Name]. We are currently closed. If you are calling about a medical problem that is not an emergency, please call back during normal office hours, and we will do our very best to address your needs. Our office is open from XX:XX to XX:XX. If you are calling about a life-threatening emergency, please call 911 or go to the nearest Emergency Room.
ASSESSING THE VALUE OF AN ANSWERING SERVICE AND/OR NURSE ADVICE LINE

Consider using a medical answering service for continuous 24/7 coverage 365 days a year. Answering services can provide attentive receptionist services, schedule patient appointments, manage messages, and forward calls as appropriate. Many practices find peace of mind in knowing that they are always reachable by patients when needed while serving as a safety net for patient calls during normal business hours.

A nurse advice line is an option to consider as a means for guiding patients in making informed decisions on when and how to seek care. For example, this service may provide instructions ranging from self-care at home or calling 911 in the event of a true emergency. Triage call lines are often staffed by trained nurses guided by vetted standard protocols.

If your practice is considering hiring a triage service....

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>Is the service available 24/7, 365 days a year?</td>
</tr>
<tr>
<td>Cost of Service</td>
<td>Is this service included in any health plans your practice currently collaborates with? Are there cost-effective options?</td>
</tr>
<tr>
<td>Timeline</td>
<td>What is the start-up time and preparation needed to go-live?</td>
</tr>
<tr>
<td>Impact on ED utilization</td>
<td>What are the estimated savings in unnecessary ED visits?</td>
</tr>
<tr>
<td>Population Scope</td>
<td>Is the service available to all practice patients? Is there a buy-up option for patients who aren’t covered?</td>
</tr>
<tr>
<td>Scope of Services</td>
<td>Does this service cover both adult and pediatric concerns? Is the service willing to share protocols for level of care needed? Does the service provide a direct call to the practice when appropriate?</td>
</tr>
<tr>
<td>Quality &amp; Value</td>
<td>Are decision support tools used by staff? What are the qualifications of the staff triaging patients?</td>
</tr>
<tr>
<td>Internal resources needed</td>
<td>Is there a need for internal IT support?</td>
</tr>
<tr>
<td>Data &amp; Measurement</td>
<td>Can the service provide reports on utilization? Can the service measure and report on recommendations made?</td>
</tr>
<tr>
<td></td>
<td>• How many patients were referred to the ED?</td>
</tr>
<tr>
<td></td>
<td>• How many patients were transferred to schedule an appointment?</td>
</tr>
</tbody>
</table>
• Provide information on office hours, services, website and after-hours call number
• 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 availability
• Post patient-facing fliers to remind patients when to use the ER
EDUCATE PATIENTS

Often times, unnecessary ER visits are related to a lack of awareness by patients about where to seek care. Use regularly scheduled appointments as opportunities to educate patients. Use fliers and other forms of communication to let patients know about ways to determine the appropriate place to seek care including availability of same-day and next-day appointments.

Offer patient’s ways to inform them on their options after-hours:
- Update website with after-hours guidelines and calling information
- Give new patients a new patient packet with information about the practice and what to do after-hours
- Send flyers or magnets to current patients at their appointments or with annual physical reminders
- Add a footer to all patient documents with office and after-hours information

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you feel comfortable making the decision on whether to seek care at an ER or calling our practice first?</td>
<td></td>
</tr>
<tr>
<td>2. What ER are you most likely to use?</td>
<td></td>
</tr>
<tr>
<td>3. Do you consider our practice your ‘primary care provider’ or the main source of your medical care?</td>
<td></td>
</tr>
<tr>
<td>4. Do you know about our same-day and next-day appointment availability?</td>
<td></td>
</tr>
</tbody>
</table>
WHERE SHOULD YOU GO?
HOW TO CHOOSE BETWEEN:

**PRIMARY CARE**

$  
Call or see your doctor for your regular medical problems or most urgent needs
- Check-ups or physicals
- Common illnesses
- Flu shots and other vaccines
- Health advice
- Medication refills or changes
- Referral to a specialist
- Routine tests
- Your regular medical problems
...and most things on the urgent care list!

**URGENT CARE**

$$  
Go to the Urgent Care for common things that need to be treated soon, but your doctor is not available.
- Allergic reaction
- Animal or insect bite
- Back pain
- Bad cold or flu
- Cuts requiring stitches
- Ear aches
- Eye infection or irritation
- Mild fever
- Minor burns
- Nausea, vomiting and diarrhea
- Skin conditions
- Sore throat
- Sprains or strains
- Suspected broken bone, not shifted out of place
- Urinary tract infection

**EMERGENCY ROOM**

$$$$  
Go to the Emergency Room for serious life or limb threatening conditions.
- Broken bone, shifted out of place
- Coughing or vomiting blood
- Chest pain
- Difficulty speaking
- Head or eye injury
- Poisoning or overdose
- Severe abdominal pain
- Severe burns
- Signs of stroke such as numbness or weakness of limbs
- Shortness of breath
- Sudden loss of consciousness
- Uncontrolled bleeding
WHERE SHOULD YOU TAKE YOUR CHILD?

**PRIMARY CARE**  $

Call or see your pediatrician for regular medical problems or most urgent needs.

- Check-ups or physicals
- Common illness
- Flu shots and other vaccines
- Health advice
- Medication refills or changes
- Referral to a specialist
- Routine tests
- Your child's regular medical problems
... and most things on the urgent care list!

**URGENT CARE**  $$

Go to the Urgent Care for common things that need to be treated soon, but your doctor is not available.

- Bladder infections
- Congestion
- Cuts requiring stitches
- Dehydration
- Ear aches
- Headache
- Mild Fever
- Minor burns
- Poor feeding
- Rash
- Sore throat
- Sports Injuries
- Stiff Neck
- Vomiting or diarrhea

**EMERGENCY ROOM**  $$$$  

Go to the Emergency Room for serious life or limb threatening conditions.

- Broken bone, shifted out of place
- Difficulty breathing or speaking
- Head or eye injury
- Lethargic or hard to wake
- Loss of consciousness
- Poisoning or overdose
- Severe abdominal pain
- Severe asthma or allergic reaction
- Severe burns or laceration
- Traumatic injury
- Turning blue or pale

Call your pediatrician about:

- High fevers
- Persistent vomiting
Local Collaborations

- 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 ER?
  - Streamlined process to make appointment in clinic?
  - Shared determination with ER physician on admit decisions?
- Consider partnerships with urgent care clinics
Partnerships with urgent care clinics

Partnerships with urgent care clinics or retail clinics can lead to greater access to care for patients while minimizing additional burden to your practice’s providers. Collaboration through open communication, streamlined processes, and standardized protocols can provide peace of mind that this relationship is providing quality care to your patients.

Consider the following collaborative opportunities with high-quality urgent care clinics convenient to your patients:

- Establish relationships with clinic leaders, clinicians, and operational team to discuss the following:
  - Administrator to administrator collaboration
  - Clinician to clinician collaboration
  - Quality leader to quality leader collaboration

- Timely sharing of patient information
  - Protocols for timely notification of patient visits at urgent care back to practice
    - Notify practice when patients are seen at the urgent care facility
    - Sharing of consult notes, test results, medication(s), etc. in standardized format
    - Sharing of care plan and/or defined information sheets for patients
  - Protocols for sharing information between facilities in a timely and HIPAA compliant manner

- Two-way referral relationship
  - Processes for patients who are uninsured or federally supported (ex: Women, Infants, and Children (WIC)) during normal practice business hours
    - Practice refers patients to clinic after hours
    - Clinic refers patients to practice if patient does not have primary care provider or specialty provider in your area
  - Create education materials for referral sharing

- Consider piloting collaboration through target populations such as
  - High ER utilizers
  - Chronically ill, complex patients

High-cost patients (claims data)

- Develop shared educational and informational materials
  - Flyers for guidance on where to seek medical care
- Update after hours messaging for practice
- Add scripting to patient calls for care coordination/appointment scheduling efforts
- Add information to websites
- Add practice information to visit summaries at urgent care to promote follow-up

- Opportunities for collaboration around quality of care
  - Initial review of current state of clinic
    - Review clinic protocols, processes, care pathways
    - Review quality/outcomes data
  - Sharing of best practices and protocols to standardize care
  - Sharing of care plan and/or defined information sheets for patients established at both facilities
  - Establish guidelines for testing/treatment, care management, and transition back to PCP
  - Develop processes for routine review of information by clinicians and administrators in both facilities
    - Case review/Chart review
    - Measure and review utilization trends over time
      - Are patients accessing urgent care instead of ER after hours?
      - Are patients accessing urgent care instead of practice during business hours?
    - Measure and review quality trends over time
      - Are standardized protocols being adhered to?
      - Are patients satisfied with care received?
      - Is information being shared in a timely manner to promote care continuity?
    - Discuss process improvement opportunities to continually improve
      - Are referral patterns changing over time?
      - Do adjustments need to be made to information sharing processes?
Post-ER Follow-up:
Care & Learn

• 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 care in the most appropriate setting (if applicable)
POST- ER PHONE CALL SCRIPT

Introduction

Hello Mr./Mrs. ____, this is ____, I am a nurse from _________________. As part of our continued effort to make sure you receive the best care possible, I am calling to follow-up with you after your recent Emergency Room visit. This should take about 5-10 minutes--is this a good time to talk?

- If yes, proceed
- If no- can you give me a time that would be better and I will call you back?

Discharge Instructions

I want to make sure the discharge instructions we gave you were clear and understandable...

1. Can you please tell me in your own words what your diagnosis was?
2. Can you please tell me in your own words how you are caring for yourself at home?
3. What questions do you have about your discharge instructions?

Medications

I want to make sure you have a clear understanding of the medicines you were given.

4. What medicines were you given in the ER as prescriptions to fill?
5. Would you like to talk through your daily plan for taking your medicines?
6. What questions do you have about your medicines?
7. Have you been able to fill your prescriptions?

Appointments & Follow Up Services

Making sure you stay well and have the right follow up after your ER visit is important.

8. When is your follow up appointment?
9. Tell me about any equipment or services you have as a result of your visit:

10. Are there barriers to getting services, medical equipment, or to your next appointment?

LEARN SECTION/ASSESSMENT OF ALTERNATIVES

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Did you try to call your doctor before you went to the ER?</td>
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<tr>
<td>If yes, did anyone answer?</td>
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<tr>
<td>If yes, who did you talk to (nurse, doctor, etc)?</td>
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<tr>
<td>12. Did you consider urgent care, retail clinics, or walk-in options prior to going to the ER?</td>
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<tr>
<td>If yes, what made you decide on the ER?</td>
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<tr>
<td>13. Did anyone tell you to go to the ER?</td>
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<tr>
<td>If yes, by whom?</td>
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<td></td>
<td></td>
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<tr>
<td>If yes, why (condition, specialist consultant)?</td>
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<tr>
<td>14. Did you know we offer sick/same day appointments for urgent needs?</td>
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</tbody>
</table>

Alternatives: Assessment of Knowledge and Education Provided

Education Points:
- Your primary doctor should be your first call for anything that isn't life threatening. Often times may offer same-day or next-day appointments.
- Urgent care clinics or walk-in clinics are easy to access and will get you in and out. Often times located in grocery stores or pharmacies—Note that these locations have hours beyond the typical 8a-5p and are open on the weekends.

15. Do you feel confident in your ability to determine where to seek care in the future?

Example language:
"There are some clear signs that a person should consider a trip to the emergency room. But sometimes you may be unsure of where you should go if you are having certain symptoms. We want you to be able to find the
right place for your health care and ideally one that is close to you, where you can receive care quickly, and a place that financially makes sense for you."

PEDIATRIC PATIENTS: Our Pediatricians recommend you call them first before going to the emergency room. Many times they can give you advice over the phone and save a trip the emergency room. Most of those pediatric practices offer same day service and are open extended hours on some evenings and weekends.

**Document Follow Up Resulting from Call**
Follow up as result of call

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient referred into Case Management Program</strong></td>
<td></td>
</tr>
<tr>
<td>Medication related activities</td>
<td></td>
</tr>
<tr>
<td>Appointment related activities</td>
<td></td>
</tr>
<tr>
<td>Referral to other program/resources</td>
<td></td>
</tr>
<tr>
<td>Mailed patient education materials</td>
<td></td>
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<tr>
<td>Messaged/escalated to MD/NP/DO/PA</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
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</tbody>
</table>

Closing:
- Thank you for taking time to talk with me.
- Do you need anything else from us right now?

We wish you all the best in your recovery.
STRATEGIES FOR REDUCING ED UTILIZATION: IT’S NOT JUST A CALL

Annie Schudy, BSN, RN
Alex Hulst, PhD, LMFT
OVERVIEW

• What we sometimes wish could be done
• Financial impact of ED use
• Non-emergency visits
  • For what
  • Reasons why
• Strategies to implement change
• Patient education
• Why should all this matter?

• Role of behavioral health in ED utilization
  • Why patients go
  • Tips for initiating conversation
  • Strategies for leveraging change
ED Utilization Reduction Strategy

Just a follow-up phone call
What can we do?

NOT THIS!
So what can we do?

EDUCATE PATIENTS
Primary or Emergency Care?

Caunt, J., & Kacerauskas, M. (n.d.).
Primary or Emergency Care?

Caunt, J., & Kacerauskas, M. (n.d.).
Primary or Emergency Care?

Caunt, J., & Kacerauskas, M. (n.d.).
Primary or Emergency Care?

We need these everywhere. I work in an ER

Caunt, J., & Kacerauskas, M. (n.d.).
Top 10 List

Ten most common conditions treated in an ED that could be treated in a primary care setting.

- Bronchitis
- Cough
- Dizziness
- Flu
- Headache
- Low back pain
- Nausea
- Sore Throat
- Strep Throat
- Upper Respiratory Infection

WHERE SHOULD YOU GO?
HOW TO CHOOSE BETWEEN:

**PRIMARY CARE $**
Call or see your doctor for your regular medical problems or most urgent needs.
- Check-ups or physicals
- Common illnesses
- Flu shots and other vaccines
- Health advice
- Medication refills or changes
- Referral to a specialist
- Routine tests
- Your regular medical problems
...and most things on the urgent care list!

**URGENT CARE $$**
Go to the Urgent Care for common things that need to be treated soon, but your doctor is not available.
- Allergic reaction
- Animal or insect bite
- Back pain
- Bad cold or flu
- Cuts requiring stitches
- Ear aches
- Eye infection or irritation
- Mild fever
- Minor burns
- Nausea, vomiting and diarrhea
- Skin conditions
- Sore throat
- Sprains or strains
- Suspected broken bone, not shifted out of place
- Urinary tract infection

**EMERGENCY ROOM $$$$**
Go to the Emergency Room for serious life or limb threatening conditions.
- Broken bone, shifted out of place
- Coughing or vomiting blood
- Chest pain
- Difficulty speaking
- Head or eye injury
- Poisoning or overdose
- Severe abdominal pain
- Severe burns
- Signs of stroke such as numbness or weakness of limbs
- Shortness of breath
- Sudden loss of consciousness
- Uncontrolled bleeding
WHERE SHOULD YOU TAKE YOUR CHILD?

PRIMARY CARE $

Call or see your pediatrician for regular medical problems or most urgent needs.

- Check-ups or physicals
- Common illness
- Flu shots and other vaccines
- Health advice
- Medication refills or changes
- Referral to a specialist
- Routine tests
- Your child's regular medical problems
- and most things on the urgent care list

URGENT CARE $$

Go to the Urgent Care for common things that need to be treated soon, but your doctor is not available.

- Bladder infections
- Congestion
- Cuts requiring stitches
- Dehydration
- Ear aches
- Headache
- Mild Fever
- Minor burns
- Poor feeding
- Rash
- Sore throat
- Sports injuries
- Stiff Neck
- Vomiting or diarrhea

EMERGENCY ROOM $$$$

Go to the Emergency Room for serious life or limb threatening conditions.

- Broken bone, shifted out of place
- Difficulty breathing or speaking
- Head or eye injury
- Lethargic or hard to wake
- Loss of consciousness
- Poisoning or overdose
- Severe abdominal pain
- Severe asthma or allergic reactions
- Severe burns or laceration
- Traumatic injury
- Turning blue or pale

Call your pediatrician about:
- High fevers
- Persistent vomiting
Avoidable Costs

- 18 Million **Avoidable** Hospital Emergency Department Visits
- Add $32 Billion in Costs to the Health Care System

- About 36.5 percent of Medicaid enrollees use the ED, more than three times the rate of uninsured Coloradans.

Cost Difference

The Hospital Emergency Department cost is:

- 12 times higher than at a physician office - $167 \times 12 = $2004
- 10 times higher than at an urgent care center $193 \times 10 = $1930

Why the Cost Difference?

Hospital facility fees, which increase the cost of an average ED visit by $1,069

Lab, pathology, and radiology services, which average $335 at an ED, 10 times more costly than at a physician office ($31)

Top Reasons for Non-Emergency Visits

- Needed Care Outside of Normal Hours: 72.4%
- More Convenient: 61.4%
- Unable to Get Appointment Soon Enough: 59.0%
- Was Told By Doctor to Go to ED: 33.0%

72.4% Needed Care Outside Normal Hours

- Aligning appoint times with needs – extending or flexing hours.
- After-hours call service or a nurse advice line.
- Physician or nurse on call for urgent needs.
- Update after-hours voice messages.
Your ideas: Care outside hours
61.4% More Convenient to go the ER

- Telemedicine/virtual office visits
- Surveying patient
- Walk-in hours
- Same day appointments
Your ideas: More convenient
59% Unable to Get Appt. Soon Enough

- Emergency appointments in schedule
- Developing protocols for staff for working in patients
- Having a nurse triage calls to see if an emergency slot should be filled
- Cycle times study
Your ideas: No appt soon enough
33% Told by Doctor to Go to the ED

THEN GO TO THE ED!

But practices can consider...

SOP for triage to send patients to ED

Close the “referral loop.”
Get notes from the ED visit

Timely follow up call with the patient?
ED Utilization Reduction: WMA

ER UTILIZATION

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<th>2018 Q3</th>
<th>2018 Q4</th>
<th>2019 Q1</th>
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<td>Observed-to-Expected Ratio</td>
<td>1.46</td>
<td>1.4</td>
<td>1.2</td>
<td>1.22</td>
<td>1.25</td>
</tr>
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</table>
Practice Spotlight: Western Medical Associates

• Brochures in lobby
• Posters in exam rooms
• Button on website
• Video in waiting room
• Letters to patients who frequently visit ED
• Practice/patient agreement for new patients
• Emails with ER poster info
• Frequent scheduled visits with PCP for patients who frequently visit ED
• RMHP care management support

Call us first!
Education on proper use of the ED

- Magnets
- Scripts
- Phone calls

- Flyers
- Videos
- Brochures
- Posters

- Portal link
  - Messages to patients
  - Newsletters

- Ask PFAC for ideas
  - Letters or emails to patients

MAs
Lobby/Rooms
Website
Other
Why should this matter to you?

We want patients to get the right care, at the right time and at the right place.

With the payment model changing from fee for service to value based payments payers are looking at total cost of care for patients and contracting based on that.

ED visits are significantly more expensive than primary care visits and this drives up per patient costs.

Since non-emergency visits are considered potentially avoidable costs this can affect PMPM payments.
Follow up Call – Non-Judgemental

Introduction
Discharge instructions
Medication review
Appointment and follow up services

Alternative option discussion
1. Did you contact your provider before going to the ER?
2. Did you consider urgent care, retail clinics, or walk-in options prior to going?
3. Did you know we offer same day appointment?
4. What made you decide to go to the ER?
BEHAVIORAL HEALTH... WHAT’S THE CONNECTION?
BH Factors Influencing ED Utilization

50% Patients with frequent ED visits with a mental health diagnosis

↑ Mortality

↑ Morbidity

↑ Medical costs over time

(Hunt et al., 2006)
RMHP 2018 ED Utilization Data

Chronic BH Indicator Claim Count 2018

- Schizophrenia, unspecified
- Alcohol abuse with intoxication, uncomplicated
- Post-traumatic stress disorder, unspecified
- Alcohol abuse with intoxication, unspecified
- Suicidal ideations
- Bipolar disorder, unspecified
- Major depressive disorder, single episode, unspecified
- Anxiety disorder, unspecified
- Nicotine dependence, unspecified, uncomplicated
- Nicotine dependence, cigarettes, uncomplicated
RMHP 2018 ED Utilization Data

Comorbidities Claim Count 2018

- Personal history of nicotine dependence
- Chest pain, unspecified
- Gastro-esophageal reflux disease without esophagitis
- Type 2 diabetes mellitus without complications
- Unspecified asthma, uncomplicated
- Chronic obstructive pulmonary disease, unspecified
- Nausea with vomiting, unspecified
- Other chronic pain
- Other long term (current) drug therapy
- Essential (primary) hypertension
BH Factors Influencing ED Utilization

1 in 8

ED visits for a mental health or substance use reason

(Laderman et al., 2018)
Hey! I'm next!

Hey! I'm next!

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Hey! I'm next!
So...why do patients still go to the ED for mental health symptoms?
BH Factors Influencing ED Utilization

- Poor health behaviors (e.g. poor diet, medication adherence), worsening physical health conditions
- Systemic problems limiting access to BH treatment
- Attempt to have needs met (e.g. housing, food, companionship)
- Exacerbation of mental health conditions (e.g. depression, schizophrenia, substance use)
What Does Your Data Say?

- What percentage of your patients with the highest ED utilization have at least 1 behavioral health diagnosis?
- What percentage of ED visits are listed with a behavioral health reason as the primary diagnosis? Secondary diagnosis?
- What diagnoses appear most often?

**STRATEGY**

- Request support from RMHP’s Quality Improvement Advisors (QIAs) and Clinical Informaticists (CIs) to make sense of this data and create an action plan.
Tips for Initiating Conversation

• Adopt a non-judgmental stance.
• Instead, be curious.
• Watch out for shame-laden responses.

STRATEGY

• Ask questions like:
  • “What do you think led to this visit to the ED?”
  • “What can we do to help prevent that from happening in the future?”
We’ve Tried That…

WHEN YOU’VE TRIED EVERYTHING AND IT STILL DOESN’T WORK

YOU HAVEN’T TRIED EVERYTHING
Tips for Initiating Conversation

• Assess how much the patient wants to change the pattern.

STRATEGY
• Ask questions like:
  • “What problems does going to the ED solve for you?”
  • “What problems are created for you when you go the ED instead of coming to your PCP?”
  • Finances
  • Time
  • Missing work or other responsibilities
  • Dissatisfaction with treatment in the ED
  • Fiscal responsibility/social accountability
  • Phone calls from PCP’s office/health plan 😊

Don’t assume!
Borrow from Motivational Interviewing (MI)

- „How important is it to you to make a change in the number of visits you make to the ED?‰
  - „What motivates you to make these changes?‰
  - „Can I share why itÈs important to me, too?‰
- „Of the options weÈve discussed as alternatives to going to the ED, what seems most appealing to you?‰
  - „WhatÈs the first step in getting started with this?‰
  - „What concerns do you have about putting this plan into action?‰
  - „Who in your life can help encourage you to keep this plan in motion?‰
Missed Opportunity: Family Engagement

- Leverage support from family
- Family members are essential for assessment, discharge planning, and reducing recurrence

Strategy:
- Invite key support system members to join for a medical appointment to discuss plans to reduce reliance on ED
- Ask about who might support follow through on this plan
- Ask about who might interfere with this plan’s success

(Laderman et al., 2018)
### Strategies to Manage Chronic Health Conditions and Reduce ED Utilization

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**What have you tried?**
Strategies for Managing Mental Health Conditions and Reduce ED Utilization

- INCREASED FREQUENCY OR NEW MODALITY FOR SCHEDULED BH VISITS
- ADJUSTMENT IN MEDICATIONS
- ROUTINE CHECK-IN PHONE CALLS FROM NURSES & CARE MANAGERS
- REMIND PATIENTS OF CRISIS LINE OPTIONS
- REMIND PATIENTS OF CARE NOW OPTION

What have you tried?
Wrap-Up

JUST ONE THING
References

Caunt, J., & Kacerauskas, M. (n.d.). Hospital Informs People About The Difference Between Urgent And Emergency Care In Delightful Ads (4 Pics). Retrieved from Hospital Informs People About The Difference Between Urgent And Emergency Care In Delightful Ads (4 Pics)


The Secret to Sustaining your Care Management Program...

Just keep swimming,
Just keep swimming,
Just keep swimming...

Slido.com - Event Code #W237
Please participate in polls....

Join at
slido.com
#W237
The Secret to Sustaining your Care Management Program...

Just keep swimming,
Just keep swimming.
Just keep swimming...

Slido.com - Event Code #W237
Comprehensive documentation is the foundation of a sustainable program

- Define your purpose / goals / values
- Identify team members
- Develop a step-by-step resource
- Maintain an accessible CM registry
- Create open access to care plans
- Define metrics used to track outcomes
- Re-evaluate current performance
- Strategic plan for future practice / patient needs

What happens when you keep working with a fragile foundation?
The Secret to Sustaining your Care Management Program...

Just keep swimming,
Just keep swimming,
Just keep swimming...

Slido.com - Event Code #W237
Staffing is the **HEART** of a sustainable CM program.

**Common threats**
- Feeling that the role is dependent upon value-based payments
- Unrealistic expectations
- Poorly defined roles - underutilized
- BURNOUT

*CPC+ First Annual Report (April, 2019, pg. 34)*
Care managers **THRIVE** in a TEAM environment

Sustainable programs capitalize on collaboration

- What does your CM team look like?
- Who is not currently part of your CM team but should be?

---

Mercer, 2018
Is your care manager sinking or swimming?

<table>
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Is your care manager sinking or swimming?

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<td>CM consistently gets pulled to fill in for other clinic duties, which leaves little time to perform job effectively.</td>
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Minze. (n.d.)
My care manager is sinking.... What do I do?
Create a SAFE and supportive workplace.

SPECIAL skills with unique responsibilities
Acknowledgments + Appreciation = feeling valued
Financially commitment to the role
Expectations between CM leadership are aligned

Be proactive, not reactive.
The Secret to Sustaining your Care Management Program...

Just keep swimming,
Just keep swimming,
Just keep swimming...

Slido.com - Event Code #W237
Learn to love data...WHY?
Learn to love data...WHY?

Data will help show that your care management program is worth the investment!
Learn to love data...WHY?

Data will help show that your care management program is worth the investment!

If you don’t measure it, it does not matter.
Learn to love data...WHY?

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If you don’t measure it, it does not matter.

If you measure it, **but do not share it**, it will not matter to anyone else.
Learn to love data...WHY?

Data will help show that your care management program is worth the investment!

If you don’t measure it, it does not matter.

If you measure it, **but do not share it**, it will not matter to anyone else.

Track data that aligns with organizational values.
Track your impact!

No single metric is sufficient to provide a comprehensive picture of care management value.

Consider several metrics in aggregate to illustrate your true impact.

Advisory (2017)
Optimize your PMPM
Consider your potential savings

- Pre-Post Analysis
- Observed vs. Expected
- Control vs. Intervention
Example: Observed (Practice PMPM) vs Expected (regional PMPM) Analysis

This alone is not enough...To show you play a part in these savings, add another layer of data that explains your contribution.
Utilization: Highlight what is important to your organization

- Care management has a direct affect on utilization rates
- Decrease in high cost services = contribution to PMPM savings

Time-stamping your care management interventions is one way in showing your contribution in those savings.
Direct / Indirect Practice Revenue:
Effective Care Management can contribute to practice revenue without billing CM codes.

Improving patient engagement and closing gaps in care should lead to an increase in primary care visits, increase in patient loyalty and long term attribution.
Don't underestimate the power of positive outcomes.

“My CM is always available to answer questions regarding my medications and recognized when I was taking the wrong dose of my blood pressure medication.”

“My A1C has always been over 9 and I gave up. After working with my CM, I have kept it below 7 and feel great again.”

“We struggled keeping mom out of the hospital and our CM helped guide our family through all of our options including end of life decisions and we were able to get mom on hospice and keep her at home the way she wanted.”

“I am homeless and my CM team was able to help find me a clean place to stay while I recovered from my surgery.”

Real time data of your direct impact!
The Secret to Sustaining your Care Management Program...

Just keep swimming,
Just keep swimming,
Just keep swimming...

Slido.com - Event Code #W237
PSAT: Program Sustainability Assessment Tool

- Allows stakeholders to rate their programs on the extent to which they have processes and structures in place that will increase the likelihood of sustainability.

- Assessment results can be used to identify next steps in building program capacity for sustainability in order to potion efforts for long term success.

https://www.sustaintool.org/
Washington University St. Louis (2012)
Resources:


The Secret to Sustaining your Care Management Program...

Just keep swimming,
Just keep swimming,
Just keep swimming...

Slido.com - Event Code #W237
Loneliness & Social Isolation

22% of Americans report that they experience social isolation or loneliness. Research has linked social isolation and loneliness to higher risk of high blood pressure, heart disease, obesity, weakened immune system, anxiety, depression, cognitive decline, Alzheimer’s, and even death.¹

Improving connectedness and quality of life can help reduce anxiety, depression, loneliness or thoughts of death or suicide.

Volunteering helps people feel less lonely by helping others, building relationships, and enhancing one’s sense of life purpose.

¹Loneliness and Social Isolation in the United States, United Kingdom, and Japan: An International Survey, (KFF, August 30, 2018)

Resource links

- Community Hospital
  https://yourcommunityhospital.com/Volunteers.cfm
- Family Health West
  http://fhw.org/wp/contribute/volunteering/
- Fruita Senior Center
  https://www.fruita.org/parksrec/page/seniors
- Grand Rivers Humane Society
  https://grandrivershumane.org/#volunteer
- Institute for Aging Friendship Line
  https://www.ioaging.org/services/all-inclusive-health-care/friendship-line
- Kaiser Family Foundation (KFF)
- RSVP
  http://rsvpgrandjunction.org/volunteer_services.aspx
- Roice-Hurst Humane Society
  https://rhhumanesociety.org/volunteer-roice-hurst-humane-society/
- Senior Recreation Center
  http://www.gjseniorcenter.com/
- St. Mary’s Hospital
  https://www.sclhealth.org/locations/st-marys-medical-center/ways-to-give/volunteer/
- The CLUB
  https://thecenterforlivingyourbest.org/

Information about local resources for social engagement in the Grand Valley

Credit and appreciation to Andrew of Mesa County 2-1-1 for his help in adding to the above resource list.
Volunteer opportunities

Retired and Senior Volunteer Program (RSVP)
Many opportunities for volunteer placements including:
(SHIP) Senior Health Insurance Assistance Project
Handyman Project
Senior Scholar Project

Work with animals:
Roice-Hurst Humane Society and Grand Rivers Humane Society
Dog walking or cat socialization, transportation to vet appointments, special events or office/clerical work.

Local hospitals that need volunteers

Community Hospital
Enhancing the health and quality of life for all the hospital guests.

Family Health West
There are many ways to help: play board games, deliver flowers, sit and visit, and so much more.

St Mary’s Hospital
Foster Grandparent Program
Gray Gourmet (now Meals on Wheels)
Senior Companions

CALL FOR SUPPORT AND CARE

Friendship Line
1-800-971-0016
Sometimes happiness begins by saying hello to someone who cares. The Institute on Aging’s 24-hour toll-free Friendship Line is the only accredited crisis line in the country for people 60 years and older, and adults 18+ living with disabilities. They also make on-going outreach calls to lonely older adults. Callers can talk with volunteers up to 10 minutes daily.

Colorado Crisis Line
1-844-493-8255
Text “TALK” to 38255
Chat online 4 pm to 12 am

Primary Care Provider Office
You can talk with Care Management or an Integrated Behavioral Health Provider to request support and resources.

PLACES YOU CAN CONNECT WITH OTHERS

Support Groups
There are a large variety of local and online support groups specific to individual needs including groups for caregivers, Alzheimer’s support, bereavement, peer support for Veteran’s, cancer, weight loss and many others.

Caregiver agencies
There are numerous companies in the area who provide personal care and assistance, homemaking, companionship and help with transportation.

Counseling/Therapy
Talk with your primary care provider about a referral.

Additional ideas:
Church groups
Fruita Senior Center
Senior Recreation Center
The CLUB
Objectives

- Define Social Isolation and Loneliness
- Review statistics and prevalence
- Discuss implications for health outcomes and healthcare costs
- Review practical tips for addressing social isolation & loneliness in primary care
Definitions

• Social Isolation: **objective** physical separation from other people (i.e. living alone)

• Loneliness: **subjective** distressed feeling of being alone or separated

OR

• Loneliness: corresponding to a discrepancy between an individual’s preferred and actual social relations; discrepancy then leads to the negative experience of feeling alone and/or the distress and dysphoria of feeling socially isolated even when among family or friends

(National Institute on Aging, 2019)
(Cacioppo et al., 2015)
Definitions

**Presence of:**

Others  Vs.  SIGNIFICANT Others

(Cacioppo et al. 2015)
Manifestations of Isolation

- **Physical**: living in a remote area, limited opportunity for social interaction
- **Emotional**: imposed upon someone or self-imposed
- **Psychological**: disconnection from one’s own identity and reality
- **Rejection or Ostracization**: acts that purposely isolate someone
- **A virtual lifestyle**: preference of internet socialization over in-person relationships

(Nowak, 2018)
Dimensions of Loneliness

- Intimate – “inner core”
- Relational – “sympathy group”
- Collective – “active network”

(Cacioppo et al., 2015)
Prevalence and Statistics

- 11%-17% in 1970s → over 40% in 21st century
- Cigna Study, data released in 2018:

> Nearly half of Americans report sometimes or always feeling alone (46 percent) or left out (47 percent).
> One in four Americans (27 percent) rarely or never feel as though there are people who really understand them.
> Two in five Americans sometimes or always feel that their relationships are not meaningful (43 percent) and that they are isolated from others (43 percent).
> One in five people report they rarely or never feel close to people (20 percent) or feel like there are people they can talk to (18 percent).
> Americans who live with others are less likely to be lonely (average loneliness score of 43.5) compared to those who live alone (46.4). However, this does not apply to single parents/guardians (average loneliness score of 48.2) – even though they live with children, they are more likely to be lonely.
> Only around half of Americans (53 percent) have meaningful in-person social interactions, such as having an extended conversation with a friend or spending quality time with family, on a daily basis.
> Generation Z (adults ages 18-22) is the loneliest generation and claims to be in worse health than older generations.
> Social media use alone is not a predictor of loneliness; respondents defined as very heavy users of social media have a loneliness score (43.5) that is not markedly different from the score of those who never use social media (41.7).

(Cigna, 2018)
AHCM Data (Western Slope)

Total AHCM Screenings: 11,527

Reported Feeling Socially Isolated: 986 patients

8.5% of patients screened
Mechanisms Affecting Health

- Prolonged inflammation → risk or exacerbation of chronic disease
- Weakened immunity → more vulnerable to infectious diseases
- Elevated sympathetic nervous system activity → accelerated brain and cardiovascular aging
- Risk-factor for depression → increased risk of all-cause mortality by 24%
- Insomnia/disrupted sleep → immune function, glucose regulation, cardiovascular risk, dementia risk, mood, and daytime function

(National Institute on Aging, 2019)
(Singer, 2018)
Impact on Individual and Population Health

- Cardiovascular disease
- Social Isolation
- Depression/Anxiety & Suicidal Thoughts
- Injuries (i.e. fall risk)
- Infectious disease/infections
- Risk/exacerbation of chronic disease
- Alcoholism

(Cacioppo et al., 2015)
(Singer, 2018)
Primary Care Practices Share Practical Tips

Western Medical Associates—Heidi Goodyear, RN, BSN
MidValley Family Practice—Glenn Kotz, MD
Friendship Line
Loneliness

Glenn Kotz, MD
MidValley Family Practice
Friends to Share EVERYTHING
Multi-Generation Relationships
Community Solutions
Life Long Physical Activity
Healthy Diet
Purpose
Christakis and Fowler: Framingham Study: Happiness and Obesity
The Roseto Effect

- Three generations in each household
- 22 civic organizations in town
- Very little ostentation
- Evening strolls were the norm
- No social isolation
- Zero crime rate
The Roseto Effect
No one under the age of 55 had died of a heart attack in 30 years.

Those between ages 65–85 had a 1% chance of dying.

Deaths from any cause were 35% lower than the national average.
Loneliness the Next Healthcare Crisis

- “we live in the most technologically connected age in the history of civilization, yet rates of loneliness have doubled since the 1980s.”
- “what’s really interesting is loneliness has been found to be associated with a reduction of life span. The reduction in life span [for loneliness] is similar to that caused by smoking 15 cigarettes a day, and it’s greater than the impact on life span of obesity.”
Loneliness
Rebecca Mullen, MD

- An internal perception of inadequacy of personal relationships
- Isolation and loneliness The relationship between social isolation and loneliness is complex and varies between individuals.
- Isolation An emotional perception that can be experienced by individuals regardless of the breadth of their social networks.
Social Connection: A Basic Human Need

• When separated from others, humans find themselves in a psychological stress state some might refer to as “fight or flight.” Being around other people provides safety and security that stifles this stress state and decreases the perception of loneliness. When alone, or feeling alone, humans subconsciously sense that they must be more aware of threats in the environment, so the body prepares to deal with them via a stress response.
Loneliness Prevalence

- Dr Mullen Study – 20% (higher in adolescents and elderly)
- ART2 – 20%
- An online U.S. survey of 20,000 adults conducted in 2018 by the health insurer Cigna revealed that 40 percent of Americans said they lacked a meaningful relationship and felt isolated from others
- Range with other studies 10-48%
Loneliness Across the Lifespan: Adolescent High Point

Figure 2  Age trends in loneliness.
Chronically Lonely – NEARLY HALF of Americans report sometimes or always feeling alone (46%) or left out (47%).

ONE IN FOUR Americans (27%) rarely or never feel as though there are people who really understand them.

TWO IN FIVE Americans sometimes or always feel that their relationships are not meaningful (43%) and that they are isolated from others (43%).
Most Americans are Considered Lonely

as measured by a score of 43 or higher on the UCLA Loneliness Scale

Study of 20,000+ U.S. Adults

Gen Z is the loneliest generation and claims to be in worse health than older generations

Loneliness and Healthcare Utilization

<table>
<thead>
<tr>
<th>Measure, mean (SD)</th>
<th>Nonlonely (n = 982)</th>
<th>Lonely (n = 244)</th>
<th>OR (95% CI)</th>
<th>P</th>
<th>Adj OR1 (95% CI)</th>
<th>P</th>
<th>Adj OR2 (95% CI)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor physical or mental health days</td>
<td>4.2 (8.2)</td>
<td>10.4 (11.1)</td>
<td>1.06 (1.04-1.07)</td>
<td>&lt;.01</td>
<td>1.04 (1.02-1.06)</td>
<td>&lt;.01</td>
<td>1.05 (1.03-1.07)</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Primary care visits</td>
<td>3.0 (4.3)</td>
<td>5.0 (7.0)</td>
<td>1.07 (1.03-1.10)</td>
<td>&lt;.01</td>
<td>1.02 (0.99-1.05)</td>
<td>.17</td>
<td>1.04 (1.00-1.07)</td>
<td>.03</td>
</tr>
<tr>
<td>ED/urgent care visits</td>
<td>0.3 (1.0)</td>
<td>0.5 (1.2)</td>
<td>1.24 (1.12-1.38)</td>
<td>&lt;.01</td>
<td>1.09 (0.98-1.22)</td>
<td>.12</td>
<td>1.15 (1.04-1.28)</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>0.8 (1.4)</td>
<td>1.6 (2.2)</td>
<td>1.15 (1.01-1.31)</td>
<td>.04</td>
<td>1.02 (0.88-1.17)</td>
<td>.82</td>
<td>1.08 (0.94-1.24)</td>
<td>.29</td>
</tr>
</tbody>
</table>
Diseases & Medical Ailments Caused or Worsened by Chronic Loneliness

- Alzheimer's
- Heart Disease
- High Blood Pressure
- Obesity
- Neurodegenerative Diseases
- Even Cancer

(studies show cancerous tumors can metastasize faster in lonely people)
Prospective Longitudinal Study
Perissinotto et al., 2012. Archives of Internal Medicine

Community sample, nationally representative, followed 2002 -2008,
N = 1604,
Age = 60+

<table>
<thead>
<tr>
<th></th>
<th>Lonely</th>
<th>Not Lonely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decline in ADL</td>
<td>24.8</td>
<td>12.5</td>
</tr>
<tr>
<td>Difficulties with Upper Extremity Tasks</td>
<td>41.5</td>
<td>28.3</td>
</tr>
<tr>
<td>Decline in Mobility</td>
<td>38.1</td>
<td>29.4</td>
</tr>
<tr>
<td>Trouble with Stairs</td>
<td>40.8</td>
<td>27.9</td>
</tr>
<tr>
<td>Death</td>
<td>22.8</td>
<td>14.2</td>
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</table>
AARP Survey: Loneliness as a Function of Age

% Lonely

<table>
<thead>
<tr>
<th>Age Range</th>
<th>% Lonely</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-49</td>
<td>43</td>
</tr>
<tr>
<td>50-59</td>
<td>41</td>
</tr>
<tr>
<td>60-69</td>
<td>32</td>
</tr>
<tr>
<td>70+</td>
<td>25</td>
</tr>
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</table>
SOCIAL MEDIA USE ALONE IS NOT A PREDICTOR OF LONELINESS. Levels of in-person interactions, physical and mental wellness, and life balance are more likely to predict loneliness than social media usage.

PEOPLE WHO REPORT BEING LESS LONELY ARE MORE LIKELY TO:

• Have regular, meaningful, in-person interactions;
• Be in good overall physical and mental health;
• Be employed and have good relationships with their coworkers;
• Have found a balance in their daily activities, including getting the right amount of sleep, socialization and work/life balance.
Loneliness by Time Spent on Hobbies per Week

% Lonely

- None: 51
- 1-10 Hours: 35
- 11+ Hours: 30
Loneliness by Marital Status

- Married: 29%
- Widowed: 31%
- Divorced: 45%
- Separated: 49%
- Never Married: 51%
- Cohabiting: 33%
Community Involvement and Loneliness

<table>
<thead>
<tr>
<th></th>
<th>% Lonely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer</td>
<td>28</td>
</tr>
<tr>
<td>Don't Volunteer</td>
<td>41</td>
</tr>
<tr>
<td>Participate</td>
<td>26</td>
</tr>
<tr>
<td>Don't Participate</td>
<td>39</td>
</tr>
</tbody>
</table>
What are the Answers?
Thank you
How often do you feel a lack of companionship?

- Hardly ever: 67
- Sometimes: 25
- Often: 8

How often do you feel left out?

- Hardly ever: 68
- Sometimes: 25
- Often: 7

How often do you feel isolated from others?

- Hardly ever: 71
- Sometimes: 21
- Often: 8
There are two general theoretical models that propose processes through which social relationships may influence health: the stress buffering and main effects models [5]. The buffering hypothesis suggests that social relationships may provide resources (informational, emotional, or tangible) that promote adaptive behavioral or neuroendocrine responses to acute or chronic stressors (e.g., illness, life events, life transitions). The aid from social relationships thereby moderates or buffers the deleterious influence of stressors on health. From this perspective, the term social support is used to refer to the real or perceived availability of social resources [6]. The main effects model proposes that social relationships may be associated with protective health effects through more direct means, such as cognitive, emotional, behavioral, and biological influences that are not explicitly intended as help or support. For instance, social relationships may directly encourage or indirectly model healthy behaviors; thus, being part of a social network is typically associated with conformity to social norms relevant to health and self-care. In addition, being part of a social network gives individuals meaningful roles that provide self-esteem and purpose to life [7,8].
How Loneliness Can Affect Your Health

- Heart problems
- Depression
- Higher stress
- Decreased memory
- Drug abuse risk
- Brain changes
Gender Differences: Mixed Results

- Meta-Analysis
  - Results Measure Specific
  - Women higher in self-labeling
  - Women higher on UCLA
  - No Difference on Dutch Measure

Bar chart showing:
- Males: 37
- Females: 34
Loneliness by Income
ONE IN FIVE people report they rarely or never feel close to people (20%) or feel like there are people they can talk to (18%).

ONLY AROUND HALF OF AMERICANS (53%) have meaningful in-person social interactions, such as having an extended conversation with a friend or spending quality time with family, on a daily basis.
• Impact on health and wellbeing • Social isolation and loneliness are harmful to physical and mental health and increase risk of morbidity and mortality. • Social isolation and feelings of loneliness can also be physical or psychosocial stressor resulting in behaviour that is damaging to health. • Social networks and friendships not only have an impact on reducing the risk of mortality or developing certain diseases, but they also help individuals to recover when they do fall ill (Marmot, 2010).
Letting Go of Control

Control is an illusion. While we certainly have control over a variety of things in our lives, there are many things which we cannot control. For instance, we can’t control whether or not we get an illness but we can control our eating and exercise habits. We can’t control whether or not our significant others love us but we can control how we treat them. Take advantage of those things you can control and then find freedom in letting go of those you can’t.

Being Present

The only time we have is right now. The only way we can impact the future is through what we can do right now. We cannot change things in our past other than what we can change right now. Yet, we spend a lot of our time worrying about the future or regretting the past. How are you spending the time that you have right now?

One of the ways we miss the reality of the moment is to have unrealistic expectations. Our experiences are often determined by the expectations we have going into them. And whether our expectations are good or bad, they can color how we experience the situation. If, on the other hand, we open our minds to experience whatever the situation delivers, we are truly living in the moment. This allows us to respond more genuinely to the reality rather than to the expectations in our heads.

Worry does not empty tomorrow of its sorrow, it empties today of its strength.
—Corrie ten Boom
Communicating with Presence, Empathy, and Clarity

When we communicate, we are typically sharing information as a way to solve a problem or build a relationship. We can enhance the communication process by focusing on two important qualities: Empathy and Clarity.

Empathy helps us understand others so that we can communicate to them more clearly. And the key to both is asking questions. When we ask questions, we gain more empathy and make sure our communication was clear.

Asking, “How Can I Help?”

Have you ever been in a situation and asked, “What should I do?” The question is full of responsibility and pressure. If, on the other hand, we ask ourselves, “How can I help?”, we’ll find that we not only find good solutions, we approach problems and situations with an attitude of service.

Being Aware in All We Do

Being effective in our work means finding a combination of excellent skills, demonstrated values, and a bit of fun. First, we must seek the skills we need to do our jobs. We must be objective and determine where we need to improve and then seek improvement. Second, we need to embrace values in the way we do our work. “Walking the Talk” means demonstrating those values. Lastly, our work must have an element of fun. If work is more fun, if just feels less like work.

We judge ourselves by what we feel capable of doing, while others judge us by what we have already done.
—Henry Wadsworth Longfellow

www.RonCulberson.com
Recommended Reading


Your Speaker

Ron Culberson, MSW, CSP, CPAE is a former hospice social worker, middle manager, and senior manager whose mission is to change the workplace culture so that organizations are more productive and staff are more content. He was the 2012-2013 president of the National Speakers Association and in 2014 was inducted into the CPAE Speaker Hall of Fame®.

Ron’s book titles:


- *Do it Well. Make it Fun. The Key to Success in Life, Death and Almost Everything in Between* (2012)


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