CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

# "Using Technology to Improve Care for Patients with Chronic Conditions"

*Care Transformation Collaborative of Rhode Island*

**Before we get started:**

Please log on to
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To add a word to
the word cloud

**Learning Collaborative Quarterly Meeting** | November 17, 2021

# Agenda

| | | |
|---|---|---|
| **5 min** | Welcome & Review Agenda | Susanne Campbell |
| **5 min** | Where are we today? Cohort 1/Cohort 2, Word Cloud | Susanne Campbell |
| **15 min** | Patient Survey polls and discussion | Sarah Summers/Sue Dettling/Group |
| **60 min** | Practice Sharing | Sue Dettling /Group |
| **5 min** | Questions and Answers/Wrap up– Cohort 1/Cohort 2 | Sue Dettling |

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# *Where are we today?*

## Implementation Phase

| **Cohort 1**<br><br>***Implementation phase Cohort 1: June '21 - Jan '22*** | **Cohort 2**<br><br>***Implementation phase Cohort 2: Sept '21 - April '22*** |
|---|---|
| Implementation and Evaluation (start by August '21) | Implementation of Evaluation (start by Oct '21) |
| New tests of change for PDSA: identify high-risk patients and community partnerships (due Sept '21) | New tests of change for PDSA: identify high-risk patients and community partnerships (due Dec '21) |

# Patient Surveys

## Discussion

What feedback have you gotten that has been valuable?

- How are you following up when feedback isn't positive?
- What other actions have you taken in response to the feedback you've gotten?

Were there ways that you used to get input from vulnerable groups such as:

- Non-English speakers
- Those without computer/laptops
- Other marginalized or vulnerable groups

What challenges/setbacks have you experienced with patient surveys?

- For pediatric practices: surveys going to parents/guardians instead of patient

# Our super-star practices:

| **Adult** | **Pediatrics** |
|---|---|
| 1. Anchor Medical Associates (Lincoln, Providence, Warwick) (C2) | 7. Anchor Lincoln Pediatrics (C2) |
| 2. CharterCare Medical Associates – Blackstone (C1) | 8. Barrington Pediatrics (C1) |
| 3. Coastal Medical (Adult Primary Care, Cardiology, Pulmonary) (C1) | 9. Encompass Family Medicine (C1) |
| 4. Medical Associates of RI (Bristol, East Providence) (C1) | 10. Hasbro Children's Hospital Pediatric Primary Care |
| 5. Hasbro Medicine Pediatrics Primary Care (C1) | 11. Kingstown Pediatrics (C2) |
| **Family Medicine** | 12. PRIMA Inc. (C1) |
| 5. A to Z  Primary Care (C1) | 13. Richard Ohnmacht, MD (C1) |
| 6. Barrington Family Medicine (C1) | 14. Santiago Medical (N. Providence, Pawtucket) (C2) |

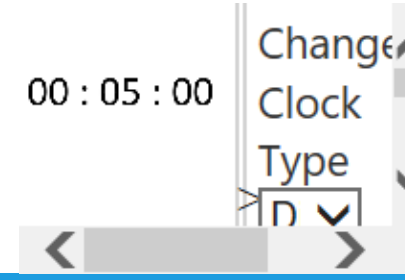
# Practice Sharing

| Presenting practice *(slide shown)* *Each practice has 5 min.* | Condition or Technology | Contributing practices *(slides in appendix)* *Each discussion section has 5 min.* |
|---|---|---|
| 1. Coastal Medical | Remote Patient Monitoring for TOC, DM, COPD, CHF, HTN | • Barrington Family Medicine (BPM)<br>• A to Z Primary Care (CHF) |
| 2. CharterCare Medical Associates | RPM for diabetes | |
| 3. Medical Associates of RI | Ambulatory BP Monitoring | |
| 4. Hasbro Primary Care | Asthma mgmt. | • Encompass Family Medicine (Diabetes)<br>• Hasbro Medicine Pediatrics (Diabetes) |
| 5. Anchor Medical Associates – Adult | Telehealth Optimization/RPM for CHF | |
| 6. Anchor Pediatrics | Adolescent anxiety | • Richard Ohnmacht, MD (ADHD)<br>• Santiago Medical (Obesity) |
| 7. PRIMA | ADHD | |
| 8. Barrington Pediatrics | Students at risk of school failure | |

# *Coastal Medical* (Primary Care, Cardiology, Pulmonary)

## Remote Patient Monitoring Expansion

1. **How has this project helped you understand your population and population health management?**
   - **Engaging the "right patient" at the "right time" - Support for patients with chronic conditions EVERY day and not just on the days of their appointments or scheduled follow up calls.**
   - **Patients bring up barriers that they NEVER would bring up to their PCP in a visit.**
   - Patients are engaging with this technology so rapidly and sharing sensitive information to request help.
2. **Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**
   - Feedback is helping us uncover the flaws and inefficiencies in our systems from the patient's perspective daily.
   - **RPM is not about biometric monitoring.** RPM is the ability to monitor all needs of our patients asynchronously.
   - **Connection to the office needs to be seamless, without passwords, portals, or delay.**



# *Charter Care Medical Associates*

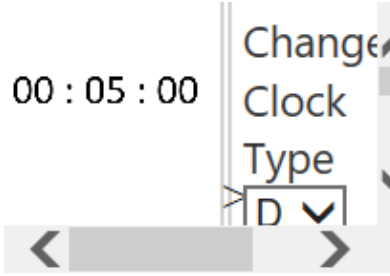
## Remote patient monitoring for diabetes

**1. How has this project helped you understand your population and population health management?**

- RPM could end up being an integral part of patient care.
- It has added many efficiencies (both clinical and financial) to population management.

2**. Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**

- It has made it  much easier to adjust meds for BP and provide intensive DM management.
- It's also allowed for monitoring for AEs (hypoglycemic events) in DM2 patients.

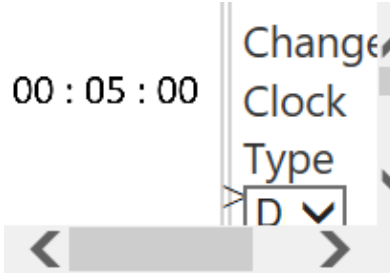


# Medical Associates of Rhode Island (MARI)

## *Pharmacist-directed 24-hour ambulatory blood pressure monitoring*

**1. How has this project helped you understand your population and population health management?**

- *Blood pressure gaps in care were identified as an opportunity of improvement for the practice based on quality data*
- *Prior to the telehealth learning collaborative, the practice did not have any way to detect white coat hypertension, white coat effect, masked hypertension, nocturnal patterns of blood pressure, or the effect of antihypertensive treatment.*
- *Implementation of ABPM allowed us to detect the following which is important for optimizing treatment and understanding cardiovascular risk of our patients*
  - *# White coat hypertension cases*
  - *# Masked hypertension*
  - *# Non-dippers*
  - *# Reverse dippers*



# Medical Associates of Rhode Island (MARI)

## *Pharmacist-directed 24-hour ambulatory blood pressure monitoring*

**2. Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**

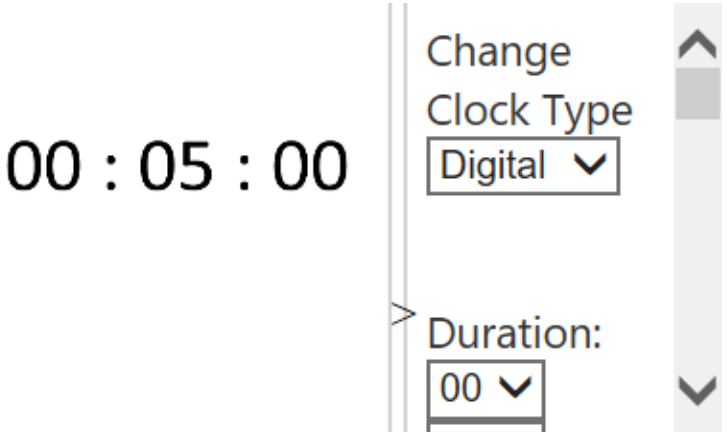
- *All providers have referred at least 1 patient for ABPM and consultation with the clinical pharmacist*
- *Patients and providers have been highly satisfied with this new service*
  - *Patient testimonial*
  - *Provider testimonial*
- *Providers have been referring patients at approximately 3x the anticipated rate*

# Discussion:

Remote Patient Monitoring for chronic conditions, including diabetes; ambulatory blood pressure monitoring

Additional Supporting Practices: Barrington Family Medicine, A to Z Primary Care

## Time:



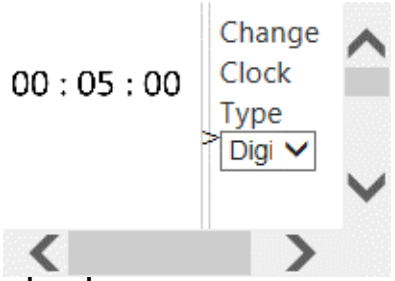
# Hasbro Primary Care

## Asthma-Nurse Educator Telehealth Visits

### 1. How has this project helped you understand your population and population health management?

We have learned that we need to be flexible and use multiple methods of outreach to try to engage our families such as letters, phone calls, texts through doximity and utilize the patient portal. We have also begun to realize that our patients that we are actively referring to the program appear to be more engaging than those who we originally chose as the 50 patients to pilot. Due to this we are actively taking referrals and will begin taken appropriate referrals from our urgent care patients.

Additionally, due to the times that work best for many of our families, we realized it was important to advocate that these nurses be able to work from home on this project to accommodate the scheduling needs of families such as weekends and evenings.




### 1. 2. Are there any “happy surprises” or “bright spots” that you’ve experienced since starting this learning collaborative?

Our 2 nurse educators have been doing a fantastic job to engage and educate our patients and families. They surely had been underutilized and have proven to be an invaluable resource to our team. One nurse in particular has on her own also done additional follow up calls to see how patients are doing and see if they have further questions a few weeks after the telehealth visit. She has been innovative and has helped us develop strategies to use technology that can assist other patients such as taking pictures of insurance card and medications so that they have them readily available on their phones.

# Anchor Medical Associates

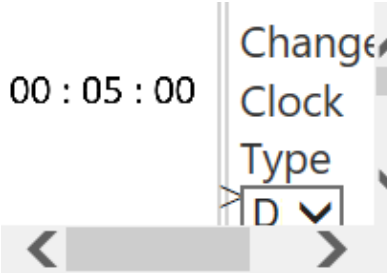
## Telehealth improvement from patient feedback

**1. How has this project helped you understand your population and population health management?**

- This project has helped us develop and refine our telemedicine program and to better understand under our patient needs when it comes to telehealth. We have been able to leverage this information to design our telehealth workflow and technology tools. The expanded telehealth platform has enabled our care management team to have improved and more frequent touch points with our high-risk patients with chronic diseases like heart failure.

**2. Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**

- Happy surprise is that based on our patient feedback survey, we were able to learn about the ways that our telehealth program could improve to better meet the needs of our patients. For example, we identified a need to streamline our telehealth platforms in use by providers and move towards a single telehealth platform and an integrated pre-check-in process.



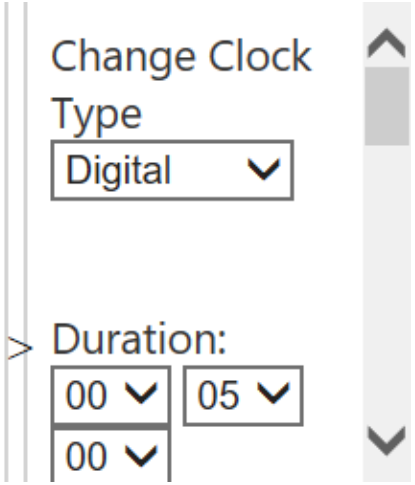
# Discussion:

Telehealth for asthma management

Telehealth improvement from patient feedback

Additional Supporting Practices: Encompass Family Medicine, Hasbro Medicine Pediatrics

Time: 00 : 05 : 00



# Anchor Pediatrics

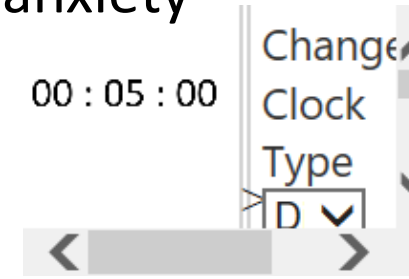
## *Using a BH App for Adolescent Anxiety*

1. **How has this project helped you understand your population and population health management?**

Teens are receptive to using technology to manage their mental health

2**. Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**

After losing BH clinician, pediatric providers now have something else they can use to help their adolescents with anxiety; providers feel they are providing better care to their adolescents; they want to be able to offer them SOMETHING to address anxiety now, other than meds.



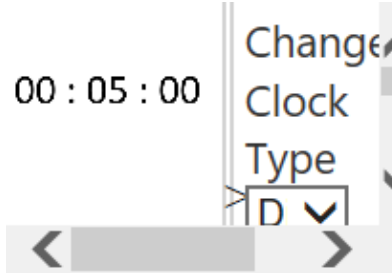
# PRIMA ADHD, Depression, Anxiety

**1. How has this project helped you understand your population and population health management?**

- Made practice more accessible to teens for everything including BH – teens are more comfortable talking to provider using TH
- Teens are taking ownership of appt – they like that feeling of control and are more involved – they are setting up own appts – taking responsibility for their own health – more responsive
- Option of TH – convenience factor for families
- However, there are still issues: families sometimes have to wait and they don't tolerate late virtual appts the way they tolerate late in person appts
- Teens are better about waiting – they are less likely to complain – this doesn't disrupt their world the way it does with parents

**2. Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**

- Bright spots: workflow change -> works better when grouped together
- Overall pt experience is positive
- Pleasantly surprised how quickly the practice was able to get TH going – simple to review platforms options, prices were ok, it was more doable than expected
- Insurers came on board and made it relatively easy to bill (hope they keep this!)
- Telehealth doesn't create need for more staff –makes MA job easier, but front desk tasks are the same



# *Barrington Pediatrics*

## Children at risk of school failure

1. **How has this project helped you understand your population and population health management?**
   - Teachers/School SW provide different perspective and increase our understanding of patient's functioning and needs
   - Example of child failing all his classes but quality of work was good

**2. Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**

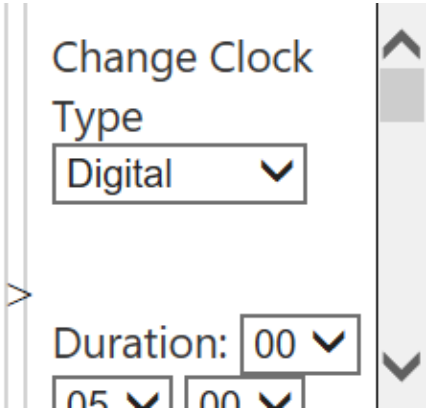
- Collaborating and communicating with other professionals who know, and care about, the same child; it's fun and gratifying
- Level of parental engagement and appreciation

# Discussion:

Telehealth for ADHD, Depression, Anxiety
Telehealth to prevent school failure
Apps

Additional Supporting Practices: Richard Ohmnacht, MD, Santiago Medical

Time: 00 : 05 : 00



# Next Steps: Upcoming Meetings and Deliverables

| Cohort 1 | Cohort 2 |
|---|---|
| **January 27:** Wrap up Meeting C1<br>• Practice takeaways<br>• Remarks from NETRC on looking forward and developments in Telehealth nationally | **Dec 30**: Updated Test of Change for PDSA |
| **April 27**: Wrap up meeting Cohort 2 | ~~**Feb 9:** Quarterly Meeting (C2 only)~~ removed; instead please attend C1 wrap up on Jan 27 |
| | **Jan 27:** Wrap up Meeting C1<br>• Practice takeaways<br>• Remarks from NETRC on looking forward and developments in Telehealth nationally |
| | **April 27**: Wrap up meeting Cohort 2 |

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# *Additional Discussion and Questions?*

# Appendix with contributing practice slides

# *A-Z Primary Care*

## CHF

**1. How has this project helped you understand your population and population health management?**

This project has highlighted the need for continuous education, especially around medications and diet. This will help us with other patients to check in with them around these areas. We are also digging further, asking why patients are not taking medications as prescribed, which helps with problem solving. For example, some patients have not been taking Lasix as prescribed, which we would not have known about. Another patient felt she didn't need cholesterol meds anymore, as her cholesterol had dropped.

**2. Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**

This project has helped us build relationships with patients, which is a particular advantage of being in a small practice. It's helped us tailor treatment plan to their needs.

# *Barrington Family Medicine*

## Blood pressure monitoring

1. **How has this project helped you understand your population and population health management?**

- It's difficult to accurately capture blood pressure – many variables.
- **In-office:** white coat HTN, ability to accurately take bp (feet on the floor, etc), reasons for visit can affect bp, observer in the room can raise blood pressure
- **Home measuring**: pts motivation, understanding why it's important, use of technology, reporting, number of steps

- Multiply those barriers by the number of patients in the project, and it becomes more complicated.
- Project has pointed to need for 8-minute process in office
- Risk of over-treating bp – it's easy to overtreat, based on office readings
- Need for on-going education - can't just be done at time of new dx

# *Barrington Family Medicine*

## Blood pressure monitoring

**2. Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**

- Understanding how good and easy the 10-minute office measurement process is. Correlates well with 24 hour ambulatory measurement.
- 5 minute timer, followed by automatic bp cuff that takes three consecutive readings in a row, one minute between each reading. Using mindfulness skill during 5 minutes.

**Improved clinical outcomes:**

- 10/79 currently out of range or missing, v. 18/77 at baseline
- 23% out of range or missing at baseline, currently 12% out of range or missing
- Have found that it's better to do what is easier and works, than use the more expensive technology that's more complicated

# Encompass Family Medicine

## Telehealth for diabetic follow up visits

**1. How has this project helped you understand your population and population health management?**

*This project allowed us to focus on our patients with diabetes. The overall goal is to improve access to care for this patient population by expanding their access to telehealth services. Use of a PDSA and fishbone diagram has allowed us to define barriers and test ways to overcome these challenges (around patient education, processes, technology, environment, equipment and workflow).*

**2. Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**

- One to one patient education has been successful in helping patients understand how to access telehealth
- Data has shown that telehealth diabetic follow-up visits continue to increase each quarter (Q1 – 26.3%, Q2-42.1%, Q3 – 68.4%)
- Patient satisfaction survey to 22 active patients mostly positive; survey results by email/phone
- 77% of patients were satisfied with length of appointment
- 71% would use telehealth again; 29% said no, they prefer in person visits
- Extension of telehealth to patients with anxiety (100% telehealth)
- Combine telehealth appointments together (i.e. block schedule for telehealth) – allows for flexibility for staff (no patients in office allows for other tasks to be completed – admin, phone calls, etc).

# *Santiago Medical Group*

## Reducing the risk of obesity complications in children and adolescents

**1. How has this project helped you understand your population and population health management?**

The project has pointed to the Importance of mental health and why obesity has been a larger problem, especially during the past year. It's also provided insight into family relationships and supports and helped us realize that some patients really don't have family support, which contributes to mental health concerns. Many of our patients may need support outside of their families.

**2. Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**

- This project has led to the identification of 4 patients with DM, which we might have otherwise missed.
- The project has allowed us to provide additional support to patients, which has been very helpful during the pandemic and social isolation its caused.

# *Dr. Richard Ohnmacht*

## ADHD

**1. How has this project helped you understand your population and population health management?**

The project has made me aware if the fact that patients in general embrace telehealth in at least limited circumstances and welcome the opportunity to maintain optimization of the medical management of their ADHD in a setting that allows for less travel time, no potential illness exposures, with convenient scheduling and w/o the loss of meaningful interactions with their health care team.

**2. Are there any “happy surprises” or “bright spots” that you’ve experienced since starting this learning collaborative?**

While I was, and continue to be, a telehealth skeptic, I've come to recognize that convenience is a major factor in patients' healthcare choices and in “keeping with the times.” Offering this service is both a benefit to the patients and the practice. Another bright spot was the realization that upon review of patients not meeting our predescribed measures of compliance, weather was a major factor in their noncompliance. Telehealth will eliminate “snow days” for students in general but will also cut down on NS and CXs in the future.

# *Hasbro Medicine Pediatrics Primary Care Center*

## Telehealth and diabetes care

1. **How has this project helped you understand your population and population health management?**
   - Developed comprehensive list of patients that would benefit from better control of T2DM
   - Brief weekly check-ins with managers/CDOE/PharmD/MD focused on trouble-shooting
   - Development of structured visit note (consistent attention to outcome measures; easier review)
   - Chart review -> data base clarifying potential barriers: language, medication $, understanding

2. 2. **Are there any "happy surprises" or "bright spots" that you've experienced since starting this learning collaborative?**
   - Better understanding of reporting functions we WANT to see in EHR
   - Mixed availability of telehealth/in-person may be "best fit" for patient preferences
   - Dedicated group – truly enjoy problem solving with them every week, and can see progress