Our Health Care Home Journey
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• 20 years of nursing experience with a degree in public health nursing and a master’s degree in education.

• Patient Care Coordinator with Riverwood Healthcare Center in Aitkin Minnesota.

• Prior to starting at Riverwood 2 years ago, worked as the District School Nurse for the Aitkin School District for 12 years.

• Currently works with implementing the patient centered healthcare home philosophy of care at Riverwood and works as a Team RN providing health coaching and care management for chronically ill patients.
About Riverwood Healthcare Center

• Largest Employer in Aitkin County-400
• Primary Healthcare Facility for Aitkin County since 1955
• 1 Critical Access Hospital
  • Aitkin- 19,885 visits per year
  • McGregor- 11,795 visits per year
  • Garrison- 4,232 visits per year
• Primary Care Providers (each see an average of 11-18 patients/day)
  • 9 Family Practice Physicians
  • 2 Internal Medicine Physicians
  • 1 Internal Medicine PA
  • 7 NPs
  • 1 Midwife
• Excellian EHR Platform in clinics and hospital
Aitkin County is entirely rural.

Total Population for Aitkin County = 15,964 residents.

The percent of older adults 65+ is two times higher than found statewide or nationally - 28.7%.

95.4% White.

36.1% of service area residents live below 200% of the federal poverty level - worse than state and national.

7.0% unemployment rate - worse than state and national.
1. Learn about how the culture of healthcare is changing and why patient centered health care is a key to success for both the patient and the healthcare facility.

2. Define the components required for Health Care Home certification

3. Learn examples of how to engage staff and patients in the patient centered health care journey.
What comes to mind when you think of Patient Centered Healthcare?
What is Patient Centered Health Care?

a) A system that places control of health care choices in the hands of the patient.
b) It is a philosophy of care that puts the patient and their preferences at the center of everything we do.
c) A place where patient’s are engaged and connected with the resources and tools they need to confidently self manage their health.
d) All the above
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The Culture of Healthcare is Changing

We are thinking more about working with patients and families, rather than just doing to or for them.
Why have we chosen to seek HCH Certification?

• Healthcare is changing and we must address the care of the patients in our communities differently. We are moving from an acute care model and using the chronic care model to address self-management and wellness.

• HCH provides a framework to transform care while allowing the individual clinic to implement the model uniquely for the population they serve.

• The model provides an approach that aligns with our organizations strategic plan.

• Certification validates a higher standard of care delivery that the clinic voluntarily chooses to hold themselves to.
80% of healthcare dollars are spent on chronic illness

80% of these dollars are spent on expensive care (hospitalizations, ED/ER visits, Intensive Care Units, etc.)

80% of reasons for readmissions are related to patient engagement and self care or lack thereof.

80% of healthcare happens outside the four walls of the hospital or medical office

91.5% of those age 65 and over have at least one chronic illness and 1 in 5 have 5 or more.
• Most care is self care

• The patient is the biggest untapped resource in healthcare and they are the experts of what they need.

• When healthcare providers motivate patients to discover in their own words how they can best self manage their illness or health, behavior and lifestyle changes begin.

• “People are generally better persuaded by the reasons which they have themselves discovered, than by those which have come into the mind of others.” Pascal’s Pensees (17th Century)
Life happens: Staff changes, new EHR’s, building projects, new initiatives, and some embrace change more gracefully than others.

Keep steadfast and remember: Change is inevitable... and it is not always easy or in our comfort zone. Keep your eye on the prize.
What is Riverwood Doing?

We actively engaged in our healthcare home journey two years ago. We’ve experienced challenges and mostly successes along the way. One thing we have learned is that the Health Care Home Certification Process has been nothing but positive.
It is a coordinated team approach where everyone has a responsibility to deliver high quality patient centered health care with the goal of improving patient care and satisfaction both inside and outside of the clinic. —Defined by RHCC’s PCHH Committee
2013 Care Management Pilot at McGregor Clinic. Positive outcomes lead to desire to further work in this area.

2013-2014 contracted with TransforMED to develop a transformation plan.

2015 added Patient Centered Medical Home to the organizations strategic plan.

2015 Remedy Health Consultant hired for 6 months.

April 2015 Hired first RN Care Coordinator dedicated to leading efforts to implement the patient centered healthcare home philosophy of care.

2015 held various interdepartmental work groups.
  - Communications, Swim Lanes, Standards of Care, Empanelment.

2015 site visits to other Health Care Home certified facilities.
2015 Goals: Staff activation and education

Keys to success:
• Involve frontline staff in the work
• Involve PR and Marketing in the process
• Get all key stakeholders at the table
• Present information in a multitude of ways
Staff Communication

PCMH Connections:
Email, cafeteria, bulletin boards and time clocks
Share Point Project Site and Blog:

Patient Centered Healthcare Home (PCHH) Share Point Project Site

Purpose: Together we will put the patient FIRST. Riverwood’s clinical delivery model is changing. Along with other health systems locally and nationally, we are proceeding with the implementation of Patient Centered Healthcare Home (PCHH). Together with other Riverwood initiatives, we are working to achieve the patient care. A multidisciplinary steering committee meets every 2 weeks, driving the implementation of PCHH and special work groups are convening to work on specific tasks.

What is PCHH? A Patient Centered Healthcare Home (PCHH) is a coordinated team approach where everyone has a responsibility to deliver high quality patient centered care with the goal of improving patient care and satisfaction both inside and outside of the clinic.

Riverwood Healthcare Center Mission and Values

Mission: To improve health by providing high quality, compassionate and personalized care.

Values: The region's preferred health system providing exceptional care.

HOME Values:
Integrity
Customer service
Unity
Trust
Fairness/compassion
Excellence/innovation
Community Resources

Turning Points

We have made it easy for Riverwood employees to be informed about community resources. Check out SharePoint and select the Community Resources tab. You will find categorized lists of website links and documents. By selecting “More Links...” at the bottom right of the page, you will be directed to a list all of the resources along with a description of what each resource provides. This page is the staff’s go to site for all community resource links and documents. If you know of a helpful resource that did not make the list, please let Heidi Olesen know and she will update the site.
**2016 Goals:** Implement and hardwire the workflows all while going live with a new EHR in April. Staff strive to work at the top of their scope.

- Began working as coverage teams (Location, huddles)
- Used patient access scripting to assist patients with choosing a PCP
- Began Pre-visit planning for patients based on our approved Standards of Care
- Developed a Patient Family Advisory Council (PFAC)
- Began piloting Care Management and Medication Therapy Management
- Joined the National Rural Accountable Care Consortium, Practice Transformation Network—(provided training and resources for value-based payment preparation)
- Started working with Danette Holznagel Senior Nurse Planner with MDH Health Care Homes
  - Submitted our Letter of Intent
  - Started Application Process
- Started attending Stratis Health Coordination of Care Initiative quarterly meetings
2017 Goals: Team members will work to the top of their scope. The right person will be doing the right task for the right person at the right time. All care team members will be responsible for a positive patient centered care experience. We will:

• Graduate from the Practice Transformation Network and Join the Minnesota Rural ACO January 2017.
• Complete the MDH HCH application, assessment tool, and schedule our onsite visit early this year.
• Optimize use of our EHR and conduct population health management activities
• Further develop and implement Care Management and Medication Therapy Management
• Late summer we will begin a 20 month building project that will effect the ambulatory and outpatient service departments of our facility...More change!
In a HCH all patients receive coordinated care and some patients receive care management. How can care management benefit the patient?

a) Care managers pay the patient’s bills
b) The PCP calls the patient’s family after every visit to keep them updated
c) Chronically ill patients are magically cured
d) Patients have an individualized care plan, an added layer of support, and coordinated care that ensures all of their providers are on the same page.
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Benefits of MDH Assistance

• Resources provided at no upfront cost
• Web resources available outlining the Health Care Home certification process
• Evidence based materials showing how efforts lead to better health, better care, and lower costs.
• Assignment of a nurse planner that can provide face to face, phone, and e-mail communication and guidance.
• We were able to self pace our efforts but keep our momentum with the help of our nurse planner
• Efforts have helped pave the way for new payment and care delivery models such as our Accountable Care Organization.
Patient Centered Healthcare Home Strategies Defined

1. Access and Communication
   Patient receives continuous access to their primary care team

2. Registry and Tracking
   Provider keeps track of patient’s health goals and history

3. Coordination of Care
   The care team in and out of the clinic work together to prevent gaps in care.

4. Care Plan
   The care team creates a unique plan for the patient’s best health

5. Performance Reporting & Quality Improvement
   Provider uses benchmarks to improve care and reduce costs
In a Healthcare Home, a patient will feel?

a) Informed and confident about how to self manage their conditions
b) Their story, preferences, and unique goals matter
c) Appointments are timely and meaningful
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a) Like they are part of a team and can make a difference
b) Trained to work at the top of their scope
c) Like they know what their role is and what is expected of them
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The Journey Continues

- Ongoing commitment to improving patient care and satisfaction

- "Quality in a service is not what you put into it. It is what the patient (customer) gets out of it." (revised from Peter Druker Quote)

- A highly engaged patient is better able to maintain a healthy lifestyle and generally has less re-hospitalizations, better medication compliance, and more satisfaction.
Together, we are committed to including patients and families!