

# Our Health Care Home Journey





# About Myself



## Heidi Olesen RN, MAED

- 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
- 3 Rural Health Clinics (\*Oct. 2015-Sept. 2016 data)
  - 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



# Population We Serve

- 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



# Today's Objectives

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?

What comes to mind when you think of  
Patient Centered Healthcare?

# Question #1



## 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

# Answer #1



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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 rule



- 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 there of.
- 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.



# The Truth

- 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 (17<sup>th</sup> Century)



# 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.



# PCHH Riverwood's Definition

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*



# Transformation Timeline

- 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 6months
- 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



# Transformation Timeline

**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

## PCMH Connections

Riverwood  
HEALTHCARE CENTER

Mon, June 17, 2013

### Ready – Set – ENGAGE!

**Together, we will put the patient FIRST.**

*A Patient-Centered Medical Home (PCMH) 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 the clinic.*

- RWCC PCMH Committee

**Step by Step Solutions**

Riverwood's clinical delivery model is changing. Along with other health systems locally and nationally, we are proceeding with the implementation of Patient-Centered Medical Home (PCMH). Together with other Riverwood initiatives, we are working to achieve 5-star patient care.

This is a journey requiring staff and provider time, commitment, thought and patience.

*"Coming together is a beginning. Keeping together is progress. Working together is success." - Henry Ford*

**Your Connections**

A multidisciplinary steering committee meets every 2 weeks, driving the implementation of PCMH. Members include: Dr. Elnstrom, Dr. Lawson, Dr. Arnold, Dr. Hoggem, Melissa Magnuson NP, Janet Larson NP, Molly Dow, Gina Henderson, Beth Harris, Heidi Olson, Corinna Bennett, Kelly Berns, Tabitha

## PCHH Connections

Riverwood  
HEALTHCARE CENTER

Mon, June 17, 2013

### Changing Names from PCMH to PCHH *Riverwood's Patient-Centered Healthcare Home*

**Together, we will put the patient FIRST.**

*A Patient-Centered Medical Home (PCMH) or Health Care Home (HCH) 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 the clinic.*

RWCC PCMH Committee

**ACCESS**  
Seamless, convenient access to your services and care

**ACCOUNT**  
Provide timely, high quality health care

**COORDINATION**  
Team of doctors, nurses, therapists, and other professionals work to meet your

**CARE PLAN**  
Team works with you to meet your needs

**QUALITY IMPROVEMENT**  
Partnership to improve care and reduce costs

RWCC PCMH Committee

**Step by Step Solutions**

A Patient-Centered Medical Home or PCMH is a model of team-based care based on specific standards. In Minnesota, this initiative is called a Health Care Home (HCH). Facilities have the choice to call their medical home or health care home whatever they choose. Riverwood has chosen to call itself a Patient-Centered Healthcare Home (PCHH).



# Staff Communication

## Share Point Project Site and Blog:

**Riverwood Site Assessments**

**Information Technology**  
[What's For Lunch?](#)  
**Human Resources**  
[Riverwood Cigna Star Through Levels and](#)  
[Home and Beyond Plan](#)  
[Employee Photo Directory](#)  
[Employee Handbook](#)  
**Education**  
[AACE/CHS Post-Test Retesting Program Intermediate Course](#)  
[January 2017/2018 Calendar](#)

**IT Issues/Requests (SSSU)**

**Service Desk Ticket**

**Access**

**TCI**

**Other Pages**  
[Equipment Cleaning & Sterilizing](#)  
[CIR & Procedures](#)  
[Diet Manual](#)  
[RCR](#)  
[Comodes](#)  
[LBC](#)  
[Bedbath](#)  
[Pharmacy Documents](#)  
[Utility Resources](#)

**Patient Centered Healthcare Home (PCHH)**

**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.

**HCRC values:**  
 Integrity  
 Customer service  
 Unity  
 Personal compassion  
 Excellence/innovation

**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 3 vital 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.

**PCHH FY17**

- Project: PCHH Committee (2)
- Project: PCHH Committee (2)
- Project: Talking Points (2)
- Site Visit Document

**Project Team Document**

- Project: Implementation Meeting Minutes (2)
- Project: Implementation Plan and Quarterly Updates (2)
- Project: Meeting Meeting Minutes (2)

**2016 Document**

- Information Overview
- Workgroup Overview Document
- QA Review
- Call Log 2/14

**FAQ**

**What's New**

**2016 Meeting Calendar**

**2016 Team Contact**  
 Kelly, Wendy  
 Beverly, Lindsey  
 Susan, Brenda





# Community Resources

## Turning Points

We have made it easy for Riverwood employees to be informed about community resources. Check out Share Point 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 provide. *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.

The image displays two screenshots of a SharePoint site. The left screenshot shows the 'EHR Support and Access Tools' page. It features a navigation menu on the left, a main content area with a table of tools, and a 'More Links...' button circled in red at the bottom right. An arrow points from this button to the right screenshot. The right screenshot shows the 'More Links...' page, which is a list of categorized links and documents. A red circle and arrow highlight a specific link in the list.



# Transformation Continues

**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



# Transformation Continues

**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!



## Question #2

**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



## Question #3

**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
- d) All the above

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## Question #4



**In a Healthcare Home, an employee feels?**

- 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 Drucker 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!

