

# Physician Practice Alignment and Collaboration

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## Physician Practice Alignment and Collaboration

Covering today:

- Using a patient centered care model
  - Explore the value add of breaking down barriers/silos to:
    - enhance communication
    - improve quality
    - align goals
    - streamline care
    - create opportunities for excellence.
- Collaborate strategies between hospitals, physician practices and post-acute recovery throughout the episode of care
- Plans, communicates and delivers care to the patient at the right time and place for optimal recovery and organizational value .

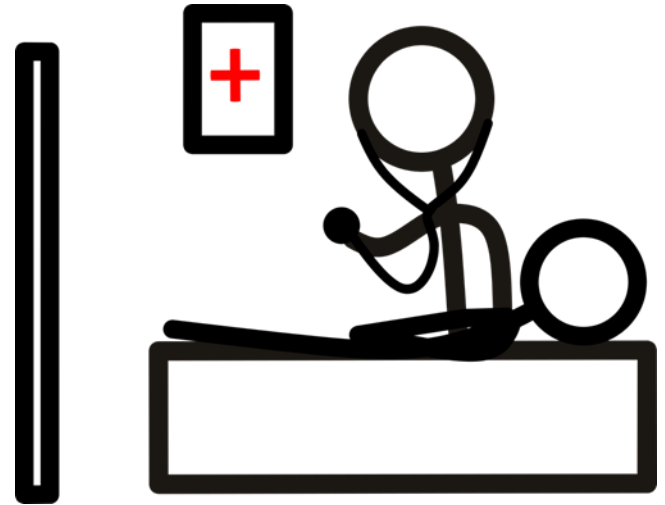
# Patient Centered Care



- Provider Practices
- Focus on the patient's problem vs diagnosis
  - Requires trusted, personal relationships with the care team including the patient and associated family
  - Empathy
  - Two-way communication
  - Eye to Eye contact
  - See beyond a patient's immediate symptom or pain
  - Communicate next steps in simple terms
  - Collaborate with the patient to eliminate barriers to care

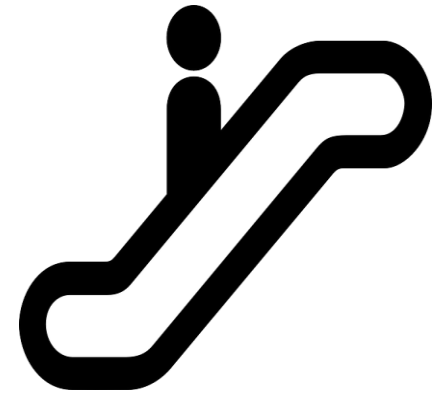
# Patient Centered Care

- Referral to
  - peer support
  - social workers
  - financial counselors
  - mental health
  - transportation
  - daily living assistance
- Employs a variety of technology- based tools
  - 24/7 Portals for appointments, care instructions, diagnostic test results, pay bills
  - Track important clinical information
    - Weight/BP/Glucose/Cholesterol



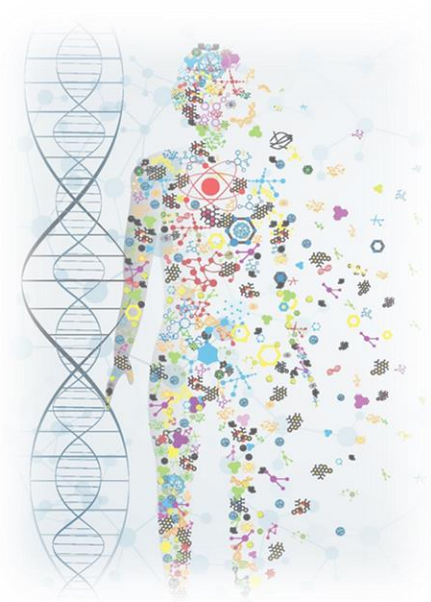
# Patient Centered Care

- Health Care Facilities
- Family
  - As defined by the patient
  - Welcome 24/7 by patient invitation
  - Participative member of their CARE TEAM
  - Provided timely updates on loved one's progress
  - Collaboration in a home like environment
- Meeting the needs of the patients and family
- Connect with post discharge care referrals



# Patient Centered Care

- Personalized Medicine
  - Treatments and therapies
  - Care plans
  - Medications involving
    - individual genetics
    - metabolism
    - biomarkers
    - immune system



# Shift to Patient Centered Care

- Effects the design management and reimbursement of our current system
- Driven by a traditional hierarchy of providers and clinicians as the authority figure
- To shift, everyone in the organization must be engaged in the process
- Impacts
  - Hiring
  - Training
  - Leadership style
  - Organizational structure



# Shift to Patient Centered Care



- Traditional roles of patients and families shift from a passive “order taker” to an active “team member.”
  - Patients know best how well their needs were met
  - Patient satisfaction surveys
  - Patient and family advisory councils
  - Focus groups
  - Using the resulting information to continuously improve
- The way provider offices and health care facilities are designed, managed, and maintained from both a physical and operational perspective – have to shift so they become centered more on the individual person than on a checklist of services provided.
- No longer can health care be a “task” oriented discussion



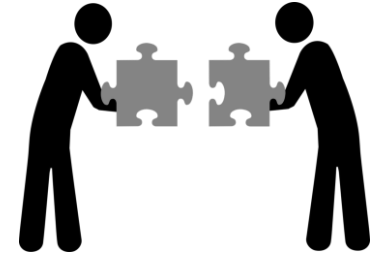
# Shift to Patient Centered Care



- Why now?
  - Public opinion of health care has suffered
  - New entrants compete with patient centric care changing the game for the entire industry
  - Patient engagement leads to satisfaction with the delivery of their care, thus leading to gains in clinical efficacy
  - Financial and labor constraints within our industry

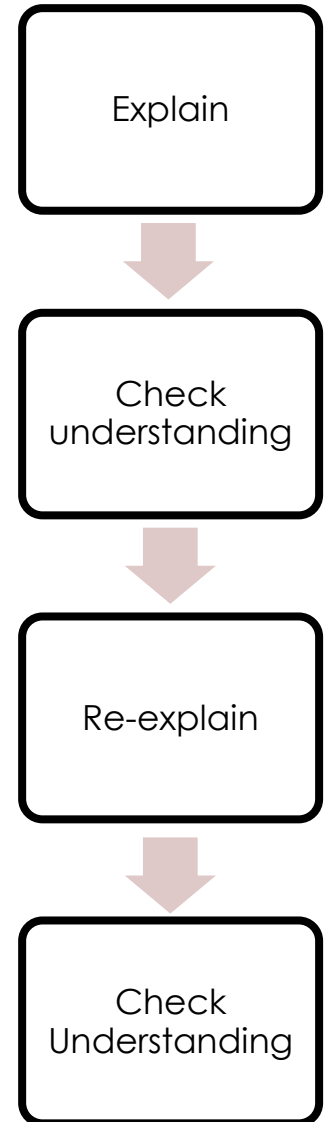
# Culture Shift to Patient Centered Care

- Fill out the forms – inability to read
- Use our portal – digital divides exist
- Take this medication – inability to pay
- See your primary care physician in a week – no appointment available for 30 days
- Eat healthy – no fruits and vegetables within walking distance
- See this specialist – no bus stop near the building
- Where do you see silos in your practice setting that can be broken down?



# Collaborative Strategies

- Between health care facilities, provider practices and post-acute recovery throughout the episode of care
- Readmission to avoid penalties and cost
- Additional incentives/information promote quality health care by suppliers/providers
- Care Management coordination in any setting
  - Provider coordination before patient care to set patient expectations
  - Comprehensive discharge planning
  - Complete and timely communication of information
  - Medication reconciliation
  - Patient/care giver education using the “teach back” method
  - Open communication between providers
  - Prompt follow-up visit with the appropriate provider after discharge



# Collaborative Strategies



- The transition will be neither linear nor swift
- Multiple payment models with varying exposure to risk
- Experiences of providers, hospitals and post-acute providers indicate there is opportunity for closer collaborations to improve post-acute care outcomes.
- Orchestrating pathways for medically complex patients requires meaningful post-acute change for a range of conditions
- Another hurdle to coordinating care is that each setting has different accreditation and staffing requirements
- Optimally sending more patients directly home, followed by flexible home health or coordinated outpatient provider care for appropriate services

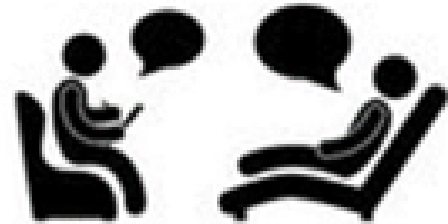
# Plan, Communicate & Deliver

- Silo mentality is viewed from an organization wide perspective when planning.
- Consider it doesn't just hurt the organization, but also patients, providers and staff
- Pressing health care problems don't get solved
- Dedicated professionals encounter friction
- Promotes conflicts, redundancy and waste
- Stresses and demotivates employees and frustrates patients by not resolving their issues timely



# Plan, Communicate & Deliver

- Start with how we lead and interact with others
  - do you facilitate or impede patient centered care?
  - do you see staff as team members, workers or an expense?
  - Look first within your office/department
- Obstacles to compassion
  - Negative personal attitudes
  - Difficult team members
- Don't get discouraged, this takes years to accomplish



# Plan, Communicate & Deliver

- Focus on processes, tactical goals
- Communicate priorities to a wide range of audiences
- Establish time frames
- Delegate objectives to other members of the management team
- Hold employees accountable and give constant reinforcement
- Don't use knowledge as power, instead share
- Encourage collaboration, creativity and confidence
- Foster cross departmental interaction letting everyone see inside each other's silos



# Organizational Value

$$\underset{\text{(VALUE)}}{V} = \frac{\underset{\text{(QUALITY)}}{Q} + \underset{\text{(SERVICE)}}{S}}{\underset{\text{(COST)}}{\$}}$$

- It's not just about feelings
- In 2019 the Journal of the American Medical Association estimated the waste in healthcare expenditure due to failure of care delivery, overtreatment, or low-value care ranges from \$178B to \$268B annually
- Siloed processes and waste costs exceed
  - A trillion dollars over five years
  - Two trillion dollars over a decade.



# Whole Patient Centered Care

- Treating the whole patient not individual problems
- Right patient at the right time
- Focus on the totality of an individual's health
- Holistic approach
  - Open exchange in information
  - Shared accountability



# Where Is Your Opportunity?



- Access
  - Accessible and available
- Waiting
  - Minimize waiting times for all services
  - Review patient responses and data as feedback for constant improvement
- Information
  - Clear patient instruction about procedures, both medical and administrative
  - Consider well trained patient counsellors minimizing provider time
- Administration.
  - Patient friendly check-in and check-out procedures minimizing time and movement between stations
- Communication.
  - Communicate with the patient and family about possible delays, next steps, financial responsibility, other or individualized options



# Questions?

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