

# THE RAPP Sheet

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RAPP PARTNER  
**Q&A**

**Dr. Michael Naarendorp**  
New York, New York



## We Need a Workflow Revolution

*Rheumatologist Proposes 4-Step Solution to “Broken Process”*

IN A TAN STONE BUILDING two blocks north of Central Park, the warm ambiance of Harlem Rheumatology is for patients a calming refuge from the cacophony of New York City life. Likewise, the quiet charisma and gentle humor of its owner and sole practitioner, Dr. Michael Naarendorp, effortlessly put patients at ease.

Michael came to the U.S. from Suriname in 1993 to complete an internal medicine residency at North General Hospital in Harlem. “I was then given a great opportunity to do a fellowship in rheumatology at Mount Sinai Hospital New York,” he explains, “after which I returned to North General to practice internal medicine.” But he was also eager to begin pursuing his true aspiration: to practice rheumatology and only rheumatology. So while continuing full-time in his internist position, he got the hospital’s blessing

to also begin building what was, and 17 years later still is, the only private rheumatology practice in Harlem.

Despite his pleasantly relaxed manner, Michael is tenacious in his quest to provide the highest possible standard of care to patients, and these days the RAPP Project is playing a central role in this pursuit. In fact, since attending the RAPP meeting last September in Atlanta he has worked tirelessly to improve his systems of care. In a recent Q&A he talked about this journey and the insights he has gleaned along the way.

### What was your most important takeaway from the RAPP meeting?

I really had an epiphany, an “Aha!” moment when I realized it is impossible, and I repeat impossible, to achieve the level of care we want to give our patients if we maintain the same processes. A provider in an exam room with a patient trying to collect data and figure everything out in 15 to 20 minutes – it’s impossible. And this broken process is not specific to my office; it’s a pattern in rheumatology practices all over America. Everyone is working hard, that’s not in question, but we will never get that rocket up to the moon if we keep placing all the decisions on the shoulder of the provider in the room with the patient. We have to build a new process.

### What sort of process do you propose?

Everything needs to be reconsidered. In the same way biologics revolutionized the medications we’re using in the treatment of RA, we as physicians have to revolutionize our systems of care. We need to build a process of team care that actually works and that we apply consistently with all of our patients.

A systemic process like this is a necessary foundation for population management as well, which in turn enables us to provide timely assessments and differentiate patient care. We desperately need these capabilities so we can focus more of our time and resources on the patients who need it most without compromising the care of those who are doing well. We need the ability to accelerate care for patients on the higher end of the disease activity spectrum, to monitor rather than over-manage those with controlled disease, and to tailor care as appropriate for those in the

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middle. All told, this will enable us provide extraordinarily better care for a lot more patients and get the disease under control for many more of them as well.

So what exactly do I propose? I see the solution as a four-step process: 1) pre-visit data collection, 2) data evaluation, 3) the patient visit, and 4) a post-encounter review. I believe this approach will enable us to vastly improve our patient care.

### **Tell us about your first step, the data collection.**

I was already doing this half way, but after the RAPP meeting I started to explain more to the patients why we need to collect as much assessment data as we can before the actual visit. That means they come in a week or two before their scheduled visit for what I call a pre-encounter visit. This usually includes the RAPID3, a blood draw – with or without a Vectra DA, serum drug levels, and/or serum drug antibody levels – and occasionally X-rays or an ultrasound.

### **How involved are you in this process?**

Only to the extent that I have to make sure patients understand why they have to come in to do blood work first. I have eight staff members who have all bought into these ideas and they do a great job of reinforcing and implementing them, whether this is a receptionist, a medical assistant or an MRI technician. I am not involved with collecting the actual data – the blood work, administering the RAPID3 questionnaire, or getting imaging studies. I may run into the patient in the hallway and then it's simply, "Hi, how are you? See you next week."

### **Are patients on board with making the extra trip to your practice?**

I would say 98 percent are because they understand the benefits of this process *for them*. They feel that they have a seat at the table with the most recent information right in front of them and where they can ask questions, express doubts and fears, while looking the provider in the eye. Once patients experience how this works they all say that it makes sense.

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### **At what point do you decide which assessments you want a patient to have?**

For both new and continuing patients, tests are ordered prior to the visit. The signal measures we use on all RA patients for population management are the RAPID3, physician global, and Vectra DA because this gives us patient, provider, and objective measures. I typically do the Vectra at about a three-month interval or sometimes sooner if we want to evaluate a response to new treatment.

But beyond the signal measures, the assessments we order vary quite a bit. For continuing patients we determine at each visit which ones will be needed the next time. For new patients there is a standard package with only minor additions for those with established RA or established gout. The only time I would now see a patient without a lot of data collected is if they came in for an urgent visit.

### **Why gather all this assessment data ahead of the visit?**

Because I am not that smart, ok? This allows me to review the data before the patient comes in, think about the problems, do some research, and consult other more experienced providers, if needed. Much more data and communication is becoming available in the medical world, so we have to think big. The idea that you have to come to the best conclusion in five or 10 minutes, sitting with the patient without even having all the data in hand, is ludicrous.

### **Is this pre-encounter visit taking more time?**

Oh no, it's taking less time. Keep in mind that it's all work we were doing anyway, so the only thing that has changed is when it's done. Overall, it's also reducing visits with me. For example, if pre-encounter assessment data show a patient is in remission and everything

is fine, I can just call them or FaceTime with them and say, “These are the data, everything is fine, so you don’t need to come in; I will just send in your refills and we’ll schedule your next assessment.”

**What’s involved in your second step, the data evaluation?**

This is a meeting where you’re just trying to get the best outcome for the patient. The model I am designing has at least two physicians and one staff member evaluating assessment data together. I include my back staff, the people who do the infusions and blood draws. We have a care team meeting at four o’clock each day during which we review the patients coming in over the next day or two. It’s an opportunity to solicit ideas, ask questions, and make suggestions. We discuss the data and, as I mentioned earlier, someone might get on the computer and look something up or contact a colleague with the necessary expertise. The purpose is to get 80 percent of the thinking and planning done before the patient visit.

**How has this data evaluation step changed the patient visit for you?**

Tremendously. First of all, as the provider I am much better prepared. Here’s an example from just last week. In the data evaluation meeting we saw that the patient had elevated liver function tests and we needed to go down on the dose of methotrexate. Yet she had high Vectra DA and RAPID3 scores, indicating that her disease was not well controlled and would need more than methotrexate only. So we had 80 percent of the plan in place before the visit. At the visit I went over the test results with the patient and *she* basically ended up telling *me*, “It looks like I have to go on a biologic.”

With their assessment data in hand, patients become intensely involved with their care. And since I am not scrambling to review data I don’t have to stare at a computer screen, which means I can look them in the eye and really work with them. The patient contribution is very important. What I am seeing and hearing from them is what gets us from the 80-percent plan to the 100-percent plan.

**So you see more patient engagement now in step three, the actual visit?**

Yes, because we have the data in front of us and adequate time to discuss it. I am no longer tracking down random test results, doing assessment work, and reviewing data while the patient just sits there. The patient visit is now an *interactive disease management visit*.

Sometimes rheumatology seems like hocus-pocus, as if you are the wizard in the white coat and you have to make all these complicated decisions. However, life is not that complicated. If you collect the data in advance, work with your team to outline a plan, and then get the patient involved you can do something, you can begin to manage the disease. The more the patient understands and is involved, the more successful you set yourself up to be.

**What is the purpose of the fourth step, the post-encounter review?**

This is where the care team reviews the outcomes of the patient visit. Maybe the 80-percent plan did not go to 100 percent, there was an adjustment, the patient didn’t show up, or plans were modified based on what we learned from patient input. The purpose is to keep the team involved in moving patient care plans forward together. This is a really important component in team care.

**Overall, has this new process added more work for your team or enabled greater efficiency?**

It is definitely making us more efficient. I know it sounds like an enormous amount of work, but it isn’t. You know how a building seems bigger the first time you enter it or a road feels longer the first time you drive it? Likewise, a new process can initially seem more onerous than it really is.

**Naarendorp’s 4-Step Team Care Process:**

- 1) Pre-visit data collection
- 2) Data evaluation
- 3) Patient visit
- 4) Post-visit review

First, understand that a lot of this is work my staff and I were already doing; we've just improved the timing and workflow. Second, because we are standardizing the workflow process, everyone – staff and patients – is beginning to understand exactly what they need to do and when, which greatly enhances office efficiency. Third, organized access to all relevant information and test results makes the data evaluation process very efficient.

Fourth, though the data evaluation step does require a meeting, with 80 percent of the treatment plan figured out in that meeting my disease management visits with patients are significantly more efficient and much more effective. Instead of me trying to talk the patient into my plan, we have an informed discussion about what is next for them with the data in front of us. In addition, by using the population registry to track patients' disease activity with them and monitor patterns that emerge over time, I can quickly pick up with them where we left off at the previous visit and get right to the heart of issues. For these reasons, I anticipate many patient visits actually becoming shorter, especially for those with no complications.

We still have work to do on many aspects of the process, especially around implementing population management, but I am very optimistic, as all of this is beginning to transform the quality of our care. As our ability to manage this disease improves patients have better lives, we as provider teams are happier, and we save the nation a lot of money along the way.

#### **What challenges have gone away since implementing your four-step process?**

I used to present whatever plan I came up with in the visit and the patient would inevitably say, "Well, you're the doctor so I'll go along with it." Then they'd go home and *not* go along with it. It's because they felt disconnected from the process. Now that we go over the data and work on disease management together, they own the process. They say, "What's my Vectra number? How was my RAPID score last time I came in? Oh, 5.7 and now its 2.1! All right! Can I get a copy to show my girlfriend?" Patient compliance has improved significantly.

#### **Any bumps that you've encountered along the way?**

The biggest bump is me. Myself. I am trying to implement a process that utilizes the whole team, but the reality is that I am still the only provider and need to start getting everything done in time. It's like working out in the morning. You can do it, but it takes discipline. The good news is that in time it gets easier, right? Every journey, no matter how long, starts with a first step.

#### **Why is team care so important to you?**

The doctor used to be seen as the mysterious medicine person who comes up with all the answers. But in these modern times, to treat chronic disease you need active patient participation; they have to be on the team. Also, information about diseases and treatments is growing exponentially fast, so trying to keep up with absolutely everything yourself is ridiculous. We have to have team care.

#### **What's most exciting to you about implementing your new systems of care?**

The quality of care in the whole population will improve – I am very confident of that. I believe the number of patients who are in remission will go up, and that when patients fall off the track we will be able to pick them up sooner. My intuition is that the only way to get to better outcomes is to first get workflow figured out, and so that's what I am doing.

Actually the patients, in their loyalty to me, have pushed me further along this road. They made me realize that if I develop a process of team care that works, then I don't have to worry about leaving my office, or even retiring, for that matter. The practice can continue to function fluidly because the trust patients have in me will get dispersed throughout the staff and other doctors on the team. We all share the same main goals of early detection, aggressive treatment, Treat-to-Target, and preventing complications. I think our four-step process puts us in a great position to now really accomplish them.

#### **So have we touched on all the important points in your four-step process?**

One very important aspect we did not talk about has to do with access to medications. That is where often the care breaks down, so it's a huge part of my office. I am happy to say that our success rate in getting the medications, i.e., the biologics, we think the patient

needs is probably 98 percent. I cannot think of a case where a patient really needed medications and we could not get them, so our system for that is working really well. But that is another topic for another time.

**What's next?**

Where I am headed next is to figure out how to use our new care process to optimize our population management capabilities and vice versa. Once these pieces become systemically integrated in our practice, I'm confident we will be well on the road to achieving the best possible care for our RA patients. Finally. ■

**The Rheumatoid Arthritis Practice Performance (RAPP) Project is led by clinician rheumatologists and facilitated by Joiner Associates LLC. Questions about the project or this article? Contact:**



Jim Bower, MPA, Managing Partner | 608-256-9797 | [jbower@joinerassoc.com](mailto:jbower@joinerassoc.com)  
Tim Harrington, MD, Partner | 608-233-2622 | [tharrington@joinerassoc.com](mailto:tharrington@joinerassoc.com)  
[joinerassoc.com](http://joinerassoc.com) | Madison, WI