CPC
Comprehensive Primary Care

Evidence-Based Medicine

Arkansas/Oklahoma Regional Webinar

12-04-14

Our Shared Purpose Today…

- Inspire and promote evidence-based medicine policies, procedures and culture in CPC practices
- Making patient-centered decisions in the face of competing medical evidence
- Leveraging evidence-based summaries and just-in-time technology for all members of the clinical team

Where are you today?

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Do you currently have evidence-based protocols in practice?

Yes

No

What do you want to know about Evidence-Based Guidelines and protocols today?

Please use the chat function to tell us what you hope to get out of today's session

Evidence-Based Medicine aka Clinical Practice Guidelines

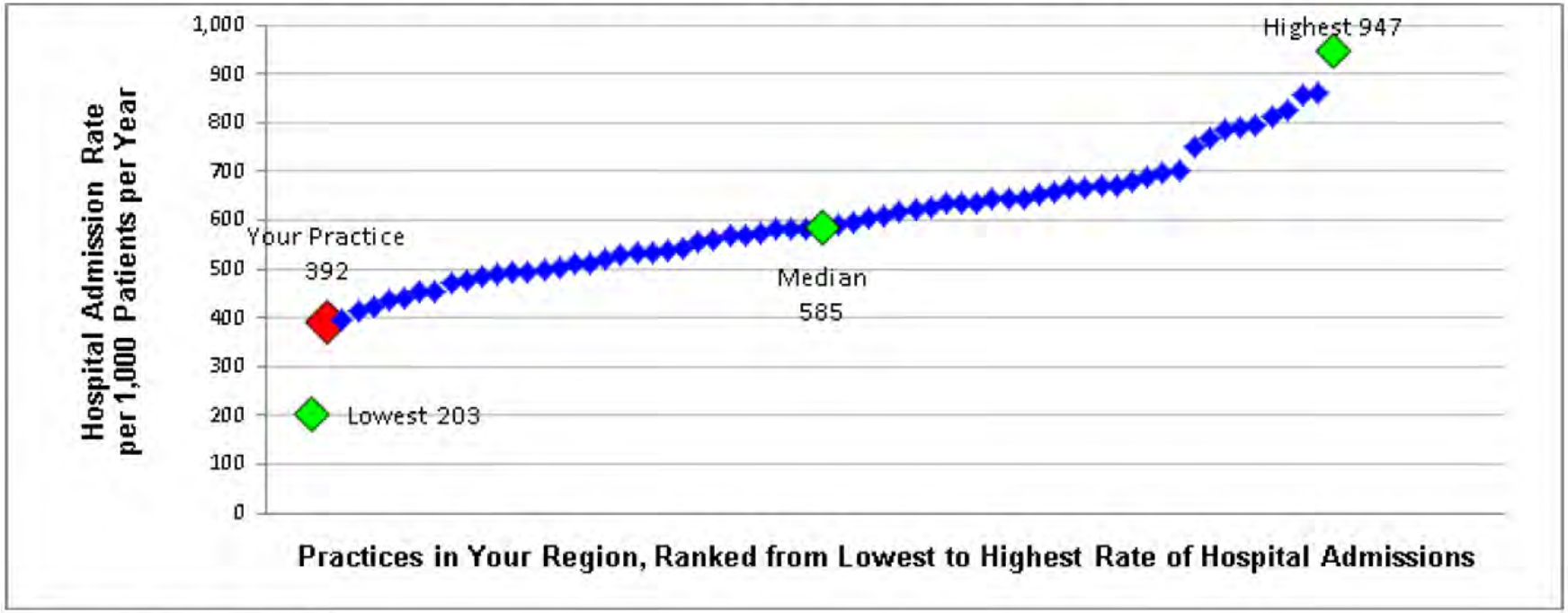
"Clinical practice guidelines are statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."

http://www.iom.edu/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx accessed 12-3-14

The Evidence-Based Medicine Triad
Source: Florida State University, College of Medicine. Retrieved 08.07.11.

Practice-Level Rate of Hospital Admission for Any Cause – Medicare Fee-for-Service (MFFS)

Figure 8. Distribution of Practice-Level Rates of Hospital Admissions for Any Cause (unadjusted): Q3 to Q6 Four-Quarter Average for Attributed Medicare FFS Patients in the Highest-Risk Quartile



Source: Medicare claims data.

Note: Each diamond-shaped marker represents the most recent four-quarter average hospital admission rate for a unique practice in your region.

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Joseph Schlecht, DO
Sherry Fisher, RN, CGN

Warren Clinic Jenks

Context of Our Work

Our Clinic

Warren Clinic Jenks

- Rural practice
- 3 physicians
- Number of patients empanelled = 4,370
- 1 Care Guidance Nurse
- EPIC EMR
- System practice

Chronic Disease Management/Population Care

Evidence-Based Guidelines

Registries

Measure Outcomes for Improvement

Increase Quality and Decrease Cost

We Selected Evidence-Based Guidelines to Focus on Patients With:

- Diabetes
- CHF
- COPD

Think population health!

Evidence-Based Medicine → Develop Evidence-Based Guidelines

- NCQA – National Comm. for Quality Assurance
- NQF – National Quality Forum
- ACC – American College of Cardiology
- NIH – National Institute of Health
- GOLD – Global Initiative for Chronic Obstructive Lung Disease
- Payers

NCQA Evidence-Based Guidelines

- Gold Standards
- 501(c)(3) non profit
- 1990
- Seal of Quality is recognized by most payers and industry as the center of excellence
- HEDIS
- CAHPS (same that CPC uses)

By 2017

9% of CMS payments will be PERFORMANCE based

NCQA Evidence-Based Guidelines

- Center of Excellence for Diabetes Management
- DM Guidelines
- Diabetes Registry
- Set criteria to accomplish guidelines

  See patient every 3 months

  Shoes off in room

  Less than 7%, greater than 9%
- Shared Decision Making with patients

Tools Used to Implement EBG

- Physician Commitment – Using EBG helps bring physicians "onboard." We all want to do the best for our patients
- Care Guidance Nurse – team members practice "at the top of their license." Using EBG helps all staff to be involved as the guidelines inform best practice

Tools Used to Implement EBG

- EHR Reports (again, think Population Healthcare):
  - Risk Stratification
  - Registry
  - Transitional Care
  - 30-Day Readmissions
- The Evidence-Based Guidelines
  - With standing orders
- Huddles (daily and ad hoc)

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Patient Tracking/Population Health

pat_mm_id	pat_name	birth_date	ris	care_pla	Q	current_pcp	lastAppt	nextappt	chf	cop	diabetes	alertsOn	lastAWV
			6	10/08/20	4	Dalton, C	10/15/2014		chf	copd	dm	not set	
			6	10/13/20	4	Dalton, C	10/01/20	12/23/20	chf	copd	dm	not set	
			6	10/28/20	4	Schlecht, J	05/15/20	Hospice			dm		eligible
			6	10/28/20	4	Dalton, C	10/21/2014		chf	copd		not set	eligible
			6	10/29/20	4	Dalton, C	11/21/2014		chf	copd	dm	not set	eligible
			6	11/20/20	4	Schlecht, J	11/19/20	12/29/2014			dm	not set	
			5	10/28/20	4	Dalton, C	11/03/2014					not set	
			5	10/28/20	4	Schlecht, J	11/21/20	12/04/20	chf			not set	
			5	10/29/20	4	Dalton, C	11/14/20	12/15/20	chf	copd		not set	
			5	10/30/20	4	Dalton, C	11/12/20	11/25/20	chf		dm		
			5	11/05/20	4	Dalton, C	07/28/2014		chf			not set	eligible
			5	11/05/20	4	Roman, V		11/25/2014				not set	
			5	11/06/20	4	Schlecht, J	11/06/2014		chf		dm		
			5	11/07/20	4	Dalton, C	11/18/2014			copd		not set	eligible
			5	11/05/20	4	Dalton, C	10/29/20	04/29/2015				not set	
			5	11/05/20	4	Roman, V		11/25/2014				not set	
			5	11/06/20	4	Schlecht, J	11/06/2014		chf		dm		
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			5	11/06/20	4	Schlecht, J	11/06/2014		chf		dm		
			5	11/07/20	4	Dalton, C	11/18/2014			copd		not set	eligible

Scoring of Measures

Scored Measures	Threshold (% of patients in sample)	Weight
HbA1c Control <7.0%	40%	10.0
HbA1c Control >9.0 %*	≤15%	15.0
Blood Pressure Control <130/80 mm Hg	25%	10.0
Blood Pressure Control ≥140/90 mm Hg*	≤35%	15.0
LDL Control <100 mg/dl	36%	10.0
LDL Control ≥130 mg/dl*	≤37%	10.0
Eye Examination	60%	10.0
Foot Examination	80%	5.0
Nephropathy Assessment	80%	5.0
Smoking Status and Cessation Advice or Treatment	80%	10.0

Total Points = 100.0

Points to Achieve Recognition = 75.0

* *A measure of poor control*

NCQA

DPRP Workshop
May 2009

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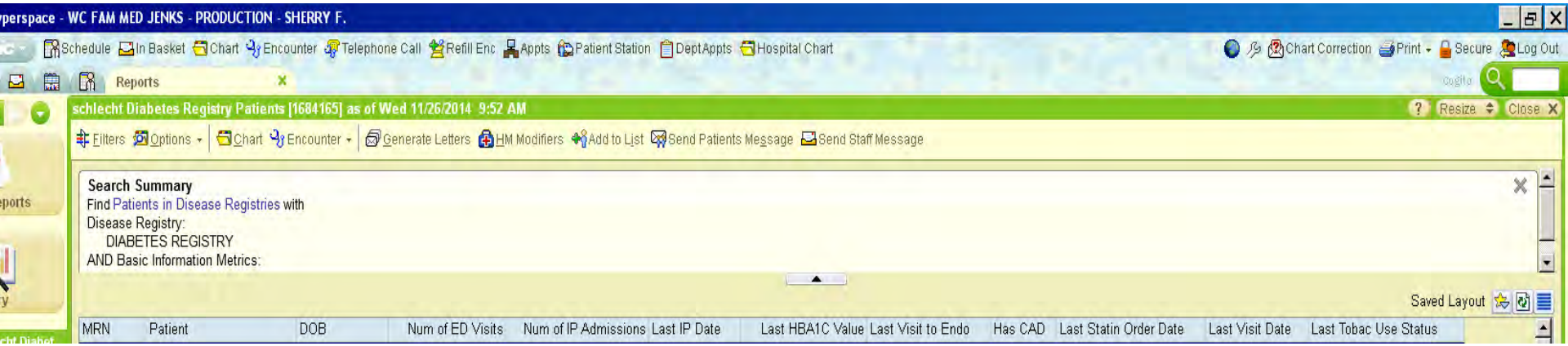
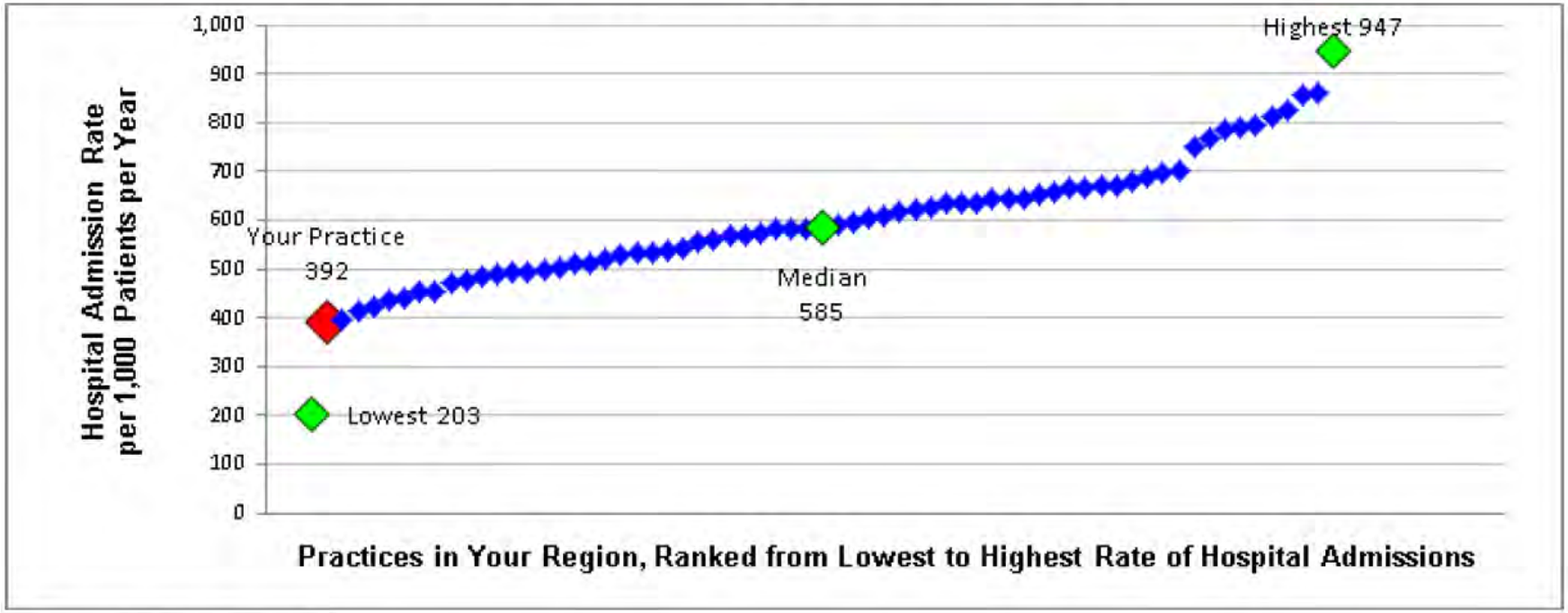


How We Know That Using the EBG Is Making a Difference

- Hospital Admissions, Any Cause (Feedback Report and Internal Discharge Follow-up Report)
- ED Visits (Feedback Report)
- Hospitalization for Ambulatory Care Sensitive Conditions (ACSC) (Feedback Report)
  - Only one CHF admission over the last 3 months
- 3 Quality Measures (Dashboard is being developed; fill in the information on Patient Tracking/Population Health spreadsheet by hand now)

Practice-Level Rate of Hospital Admission for Any Cause – Medicare Fee-for-Service (MFFS)

Figure 8. Distribution of Practice-Level Rates of Hospital Admissions for Any Cause (unadjusted): Q3 to Q6 Four-Quarter Average for Attributed Medicare FFS Patients in the Highest-Risk Quartile

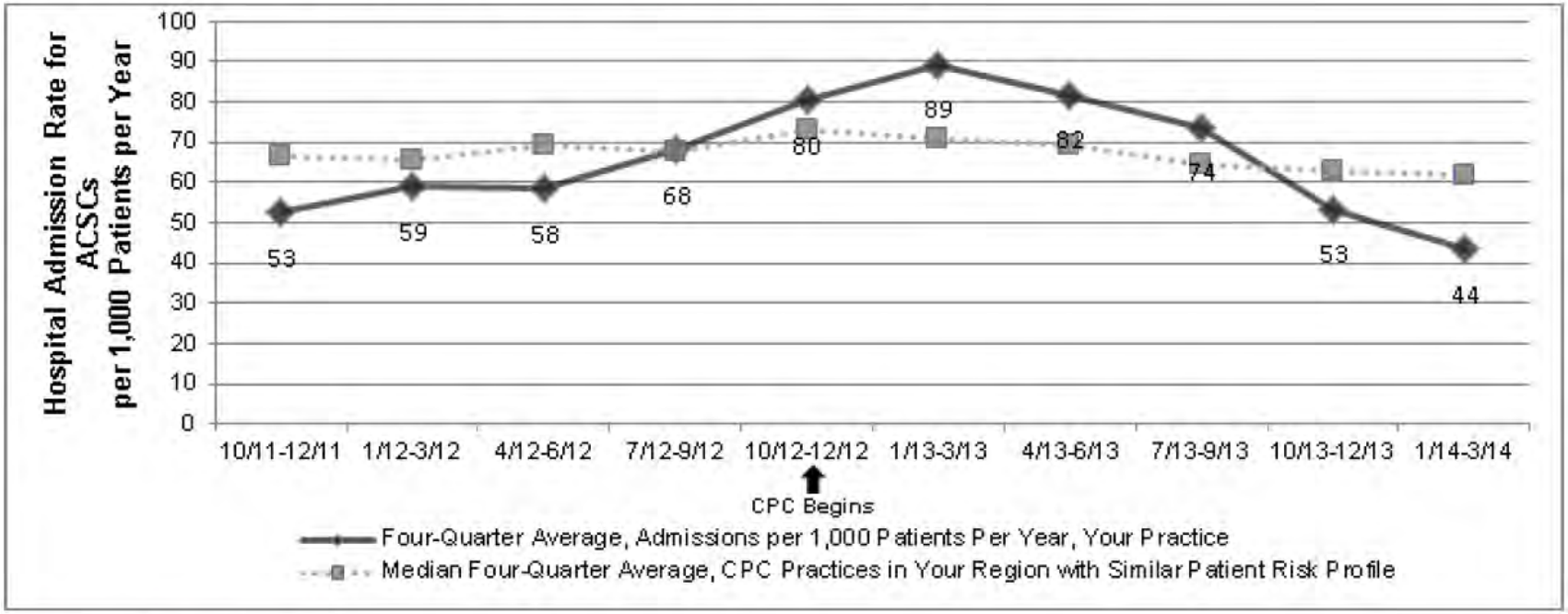


Source: Medicare claims data.

Note: Each diamond-shaped marker represents the most recent four-quarter average hospital admission rate for a unique practice in your region.

Hospital Admissions for ACSC MFFS

Figure 5. Hospital Admissions for Ambulatory Care-Sensitive Conditions (ACSCs): Four-Quarter Average Trends in Annualized Rates of per 1,000 Medicare FFS Patients (unadjusted)

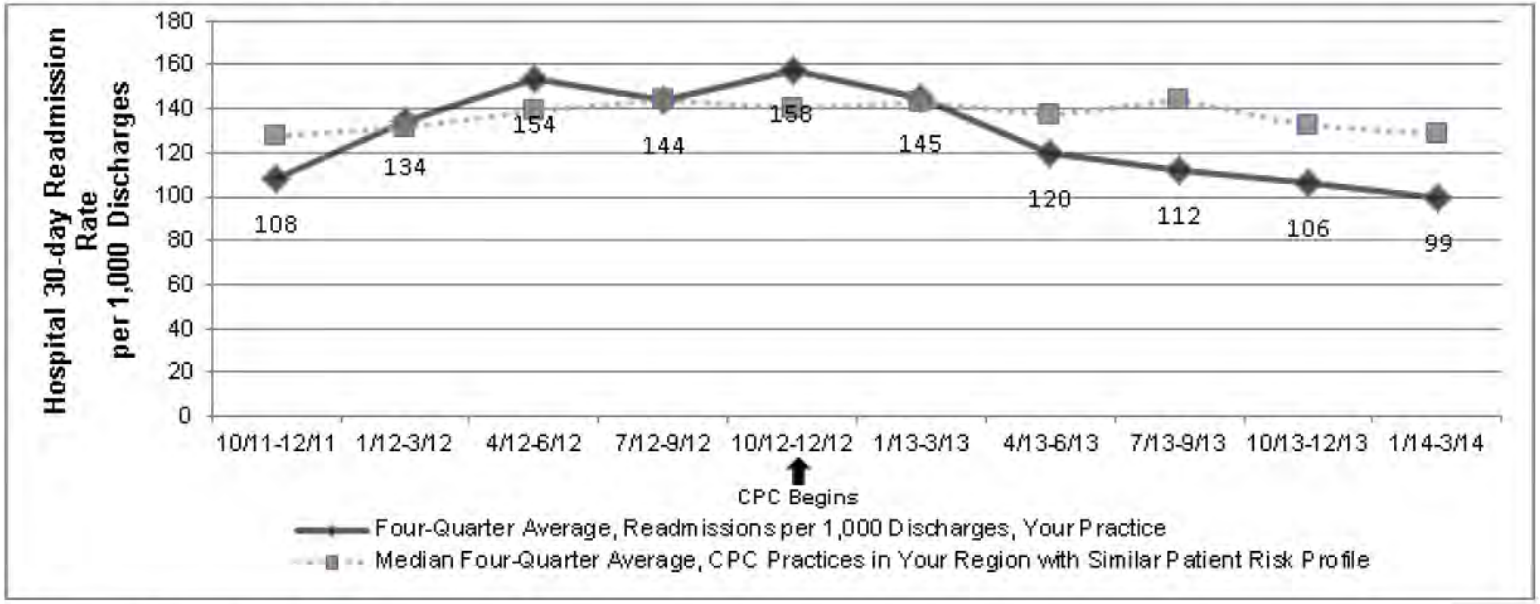


Source: Medicare claims data.

Notes: Data labels refer to averages among attributed Medicare FFS patients in your practice. Utilization data represent actual rates during the respective time periods and are not risk-adjusted. Data for the most recent quarter are estimated, due to the lag in filing and processing Medicare claims.

Hospital 30-Day Readmissions MFFS

Figure 7. 30-Day Unplanned Hospital Readmissions: Four-Quarter Average Trends in Rates per 1,000 Medicare FFS Discharges (unadjusted)



Source: Medicare claims data.

Notes: Data labels refer only to averages among attributed Medicare FFS patients in your practice. Utilization data represent actual rates during the respective time periods and are not risk-adjusted. Data for the most recent quarter are estimated, due to the lag in filing and processing Medicare claims.

Latest Data

No 30-Day Hospital Readmissions for October

ONE CHF Admission for August, September and October

Adoption Considerations for Others

- PHYSICIAN COMMITMENT to practice evidence-based medicine
- **Entire** office has to be involved:
  - Implementing the EBG
  - Following the standing orders/protocols, as needed
  - Treat the patient in a holistic approach, using the whole office!
  - Tools on previous slides "Tools to Implement EBG"
  - Constant communication is key!

Adoption Considerations for Others

- Proper utilization of Care Guidance Nurse (top of license) – Key to success when implementing evidence-based medicine
  - Preplanning, monitor & develop reports, Transitional Care Management through collaboration with in-patient discharge planners, developing relationships with patients, community resource liaison, care planning, and standing orders based on EBG

Q&A plus Harvesting of Learning

Evidence-Based Medicine

5 Ps	
Your Purpose	What do we want to achieve?
Your Patients	What are their unmet needs that WE can support?
Your Professionals	What are the skill building and training needs of our staff?
Your Processes	What workflow tools and technology do we need to support our processes?
Your Patterns	How do we quantify that what we are doing enables us to achieve our purpose

The 5 P's of Evidence-Based Medicine

(White Board to gather audience feedback)

- ***Purpose*** – What is the value of EBG?
- ***Patients*** – How can patients benefit?
- ***Professionals*** – Who might benefit from EBG and who needs to be involved in the process?
- ***Processes*** – What does the workflow look like?
- ***Patterns*** – What are the patterns in your HR population?

Open Discussion Time

- Discuss how you are doing evidence-based medicine

- Please click the Raise Your Hand icon located beneath your name and we will unmute you so you may add to the discussion

Resources

- **Evidence-based Practice**
  http://www.health.uottawa.ca/rehabguidelines/
- **National Guideline Clearinghouse (NGC)**
  http://www.guideline.gov
- **National Quality Measures Clearinghouse (NQMC)**
  http://www.qualitymeasures.ahrq.gov
- **Quality Tools**
  http://www.innovations.ahrq.gov

THANK YOU

Contact information

- Dr. Joseph Schlecht, jrschlecht@saintfrancis.com
- Sherry Fisher, RN, sjfisher@saintfrancis.com

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