Arkansas: Asynchronous Access

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Thank you Marie. Hey, thanks for joining us on this holiday weekend. We appreciate having 20 folks right before you head to the lake. I am delighted today to be here in Harrison, Arkansas, Dr. Brownfield's Clinic is hosting us today and I'm here with Rhelinda McFadden. I've spent the last week being indoctrinated into the Arkansas highways and also a lot of really neat practices. In fact, last night I drove on the pig trail. I really do have respect for anything that is a major highway with a speed limit of 10 miles per hour. So, I've learned a whole lot about Arkansas this week and I'm going to spend a little bit more time next week and just thanks again for being here. Also joining me today, I really want to thank these folks. I have Kourtney Matlock from Practice-Plus and Kourtney has a team with her which I'm going to have her introduce in just a second. Then we also have Brenda Sutherland who's at Hamilton West Family Medicine, which I had the pleasure to visit earlier in the week and they're doing very well in CPC. So, Kourtney could you introduce the team members that you have kind of readied up also?

Absolutely. I'm Kourtney Matlock and I'm Regional Practice Administrator here for Practice-Plus. Practice-Plus owns and operates the Babbage Health Clinics and so we are speaking about Babbage Health Clinics when any of us talk. I'm also here with Darlene Lackey. Darlene is the Clinical Informatics Nurse for our group and she's also responsible for Meaningful Use, and PQRS, and anything else that has

quality attached to it. And soon to join us will be Nicki Mitchell she's our Software Support Supervisor here, and Stacey Hines who's the Director of Revenue [inaudible].

Thanks a lot Kourtney. So, I'll ask Brenda, Kourtney, and all of those to keep their phones un-muted at least at the ready as I ask questions, and as well as Rhelinda as well. So, we're going to get started with saying I am not the expert on this topic. Many of you are experiencing the dilemmas of trying to navigate this, the possibilities of this particular Milestone element, which is using technology for non-visit based care, and that technology component has some things that are a really great promise and I know many of you are navigating your vendors and some of those conversations as we speak now, so this is really not a webinar that's going to focus on telling you how to operate this within your specific software, although we can begin to answer some questions and have conversations through the webinar itself, to generate some interest that we can put together for the learning session at the end of this month. What we're anticipating being able to do, is put groups of folks together with the same EMR's at the learning session at the end of this month so that you can kind or tackle these problems together and figure out ways that you've navigated those. So, I just want to give you that context for the day. All questions are available, if we can't answer them today we're certainly going to try to answer them during the course of the learning session that's coming up at the end of this month. So, let's get started, we want to just kind of take a quick poll right now. There's a questions on your screen, Marie. This says; on average what percentage of your patients in any given day merits a face to face encounter with you? So, as you think about all the patient visits you have, all of those things that really need a face to face visit, now this is not, I don't want you to think about it from a billing perspective, I want you to think about it from sort of a care perspective. Who really needs that visit? If you would go ahead and mark on the right there, what you think your percentage is, or closest estimate to it is, that would be great. We've got this poll open for about five minutes, we're not going to take that long for five minutes, so I'm going to give you about elapsed time, it's kind of counting down, so I'm going to give you about a minute to do that if you would please.

All right, I'm going to close out -- Marie, we're going to go ahead and close up that poll and if you could show the results that would be great. Marie, I'm not seeing the results posted yet. There we go. All right. So, right now it looks like those that did answer, about 26% of you indicated that 50-74% of your folks really in a given day needed a face to face encounter so, you know, there's a suggestion there that maybe there's some folks that would benefit from access to your clinic in a non-traditional method, and as you know the payment environment has really supported that. Although, for years in family medicine and primary care you have been providing non-visit based care for as long as you can remember. Every time you follow-up on a lab test result, that's part of the non-visit based care dynamic. What we're wanting to think about here, is to expand that to even the next level if we can, and so we'll talk a little bit more about that today. So, just a quick reminder, there was a terrific webinar delivered by Dr. David Kendrick who actually resides in the Tulsa CPC market, and it's posted up on the Collab site. I don't want to spend a lot of time going through the technical elements of it, because it's actually very good, and if you have not had a chance to see that, you can go to the Collab site, download both his slides, as well as a transcript of the session. The transcript is really very valuable, and it's worth your time to read. It'll take you about 20 minutes to read it, but there's some really great suggestions about how to start some

of these first activities or how to construct it, and we'll talk a little bit about those, but if you want to get that very technical detail, I would go to that learning session, I'm sorry, that set of slides, and the transcript on the Collab site because I think you'll find that very valuable. If you have any trouble getting to that, just send me an email at jayfetter@transformed.com and I'll help you find that. So, here's what Milestone 3 is really about, we're trying to create a multiplier effect for primary care. We know that you're the secret sauce, we've known that you're the secret sauce for a long time, there's just not enough of you. So, this -- using a team based approach, and using non-visit based access as a way to create a multiplier effect, and we think we have some strategies now that work and actually make that better, and we've been learning that for a few years now. We're going to try to enhance some old technology with teams, so that telephone not just is owned by the position if you will, but is also, can spread out so that we maximize those folks skill sets that are in your current practice setting. We're also going to try to use a merging technology. Now the technology is not perfect by any means of the imagination but there's enough perfectionism in it if you will, to allow us to do some things that we couldn't do before and CPC is about experimentation, and so as part of Milestone 3, we would like you to try to experiment with some of these notions. Perfect is the enemy of the good here though, and then we want you to kind of use that merging technology and your team to combine new access points. Any questions about that, I'll stop for just a second and see if there's any questions that are emerging, just about the concepts of the milestone. I know you all have read the 69 pages because I've been in many of your clinics over the last few weeks, and you've pulled them out, and it's dog-eared and it's kind of beat up. So, I won't go into great depth about those requirements unless you have questions about it, but what I will kind of start with is this is not a new notion, so this fellow by the name of Joe Scherger, who's a family physician based out of San Diego has been writing about online communication with patients actually all through the late 90s and early 2000s.

10:17

Joe as a family physician has really been inspired by what his experience has been in accessing patients and having communication with patients online. What we also see from a lot of the practices here in Arkansas in particular is that you have taken those notions and you are starting to experiment with them. This is just an example of what we see progressing as far as patients using the patient portal established by the practices, either through Meaningful Use 1 criteria, or if you will, Meaningful Use 2 criteria, some of you have done it because that's the way you think. You have imagined new possibilities about using technology, and said gosh, if I can use technology at the airport, and the bank, why can't we use that in medicine, and you've experimented with it, and we really appreciate that. So, we're going to try to learn a little bit from you and others. Just to refresh your memory, on the Milestone here, it's not exactly parallel with Meaningful Use, there is no minimum threshold here, so it's important to caveat that and you'll see that in some of the technical language that was described by Dr. Kendrick. But, the first piece of it is that implement at least implement one type of opportunity for care, outside of office visits again, patient portal, email, text messaging, instruction phone visits. The other option here is communicating commitment to timely responses to asynchronous forms of communication. Again, this is portal messages, email, text. The key here is timely responses, so these communications can't look like my inbox that has 3000 emails in it, and I think there's about 30% that maybe are still unanswered or unviewed so, trying to find a mechanism to do that without kind of causing strain on the practice is

important. Now Dr. Kendrick outlined there's some options that you can consider, and you can think about them from a less technical perspective, to a more technical perspective. He went on to say in his learning session that he shared, that sometimes people think that telephone protocols are actually easier, but they're still hard because you want to structure them in a way that's valuable to the patient and it's valuable to the clinician, so it's a little bit like care plans. You got to think about what does that conversation look like when I can't see your body language, and I can't see your face, and how does that become more effective? There's some real wisdom in how to do that, and we're going to talk about that and actually get a lot of your experience to kind of emerge I hope. Then there's the more technical elements, and I think this is where many of you are trying to go, if I could just adopt some form of technology, this will satisfy the Milestone and make my life easier. Well, as you are finding out, you are finding out that just adopting a technology off the shelf doesn't make your life easier, inherently sometimes it makes your life a little harder. Okay, so let's talk about "the simplest of the things" first. Now, these -- this is where I'm going to need your participation and help. One thing I want to emphasize here is we can un-mute your phone and you can talk about what you're doing as far as structured phone visits, but I'm going to call on our folks here that I've kind of lined up as kind of ringers, and Kourtney, and Brenda, and Rhelinda, to kind of talk about what they see practices doing with structured calls. So, Kourtney, can you describe at least from your team's perspective here at this point, what you're doing with structured calls, or if you've started structured calls in any way outside of maybe care management calls?

Well, ours mainly are focused around care management I would say. We do structured phone calls, those that are high-risk patients, we follow-up with them if they haven't been in in a timely manner. This is still new to us, but now that we have the Milestone that we need to meet with 80% of patients that are high risk being followed up with, we have began using structured phone calls for that purpose, and we see using it more so in the future, but given this point in time that's how we're using it.

Okay, great. Thanks for sharing that. Brenda, have you started using structured calls that you've like maybe put on the schedule for example?

No, we have not started putting them on the schedule. Now, we are following up with our high-risk patients after their visit. Within five days we've been calling the patient to make sure you know if they have any questions regarding their visit, but as far as putting them on a schedule, no we have not done that.

Okay, great. Well, so I think I -- I knew they weren't actually but I wanted them to share what they were doing, in part because I think that's what many of you are doing from what I've seen this last week and as I've had conversations with you. One thing to think about, and you'll see this in some of the webinar content, is that there is a conversation about how could you maybe structure a call where you literally put them on the schedule. Patient has a particular chronic illness, that you can -- that you want to manage over time without them having a face to face visit. And maybe you're going to do that combined call with your certified diabetes educator, your dietitian, your social worker and the physician. Maybe that's the only way you can get all those folks in a visit at the same time, and maybe you're going to augment that with a care plan that you're going to send out to the patient in advance, and you're talking

about the progress of that care plan. That's an example of a structured phone call where you can kind of take into account some other resources that might not always exist within your practice on the same day that that patient comes. It might be, allow for more convenience for the patient, and also allow you some more flexibility so that you can stay on track on your kind of classic patient schedule. So, that's an example that you may want to kind of consider, do a little bit of research on. If anybody on the call has had any experience with that to date, I would love for them to kind of raise their hand and share with us what your experience is with that. So far I haven't heard of any practices in Arkansas doing this, but I wanted to just double check in case I've missed them. I don't see any hands raising. All right, okay. Thanks. So, I know Nermal's on the line here, and so I don't know, she might want to whack me for calling her out here, I know she's had a rough last couple days here where their technology actually went down and she's had to go back to paper, which is kind of interesting. My questions to you Nermal, and I'm really wanting you to kind of talk about when you had to go back to paper, have you had to then use the phone in a different way over these last three days as your technology kind of fumbled on you? So, if you want to raise your hand and kind of tell us a little about your experience, I'd love for you to share that.

Good morning. [inaudible] a telephone calls where we have a [inaudible] the day, the time it's taken, patient, of course patient's name and all that history is put on there, and the detailed message is taken by whoever is taking the phone call and then given back to the providers, then the providers act on it, they write their timestamp, and all that and return it back to whoever needs to return that call to the patient.

Right.

That way when we go back, our contingency plan is that when we go back to enter all this into the EMR, we will also scan it in and then we'll record in telephone encounter.

Yeah, terrific. Nermal, I know in your email to me you said the good news is, you got to test your plan B, is that right?

Yes, yes. This is a good learning experience.

So, tell me a little bit how did you structure to have a plan B?

It was a matter of just pulling all that paper out and printing it off again and handing it to the employees. Some of the employees are new so we had to train them. We don't want any of the patients falling through the cracks.

Okay, great. So the telephone this week has been your friend maybe -- and it's been sort of like that old reliable friend that you can always count on, is that right?

That is correct.

And paper, though not probably perfect, it's at least provided an opportunity for you and I think that's -- thanks Nermal for sharing that. When Nermal sent me that email I thought it might be kind of

interesting to know that we're not saying completely hey, we want you to dock everything electronic because we know that there are fumbles with electronics. So you have to kind of think about plan A, B and sometimes C, and you want to make sure you have those plans in place. If you have structured time on the telephone, that is a good way to get started, it's not technically hard but from a structural standpoint it might be logistically important to figure out how you're going to do that on a regular basis if your technology were to kind of fumble for a prolonged period of time.

20:10

So, just wanted to kind of share that. We can kind of talk a little bit more about that process when we're face to face at the learning session. So, I want you to imagine the possibilities. If you have additional questions about how you might do structured calls, actually there's a couple different resources that Dr. Kendrick noted in his webinar, but if you are not interested in reading 10 pages of transcript and you want to get some information directly from me, you just send us an email and we'll be happy to help you kind of structure that so just give us a holler. So, here's what I'm interested in, as I've kind of navigated some of the Arkansas practices this week, everybody's talking about upgrading their EHR software to the 2014 version, I know Nermal, I think you have, but many of you haven't. So, if you could do me a favor and use the little polling tool that's on the right here, it's a little check mark. If you hit the yes, tell me that you already upgraded to 2014. So, not that you're just planning to do that, but that you've upgraded it, hit the yes. If you haven't, hit the no. That'll give me a little sense about where you are so far. We've got one person that's already said yes. Oh, we've got a couple people already saying yes. That's great. We'll just wait here just a few more seconds, we've got more yes's. We've got no no's. So, that's really surprising.

Jay rather, while we're waiting there is a comment in the question box about what happens when there is a multiple day outage, perhaps you can comment on that as well.

So, this is Christy Brownfield who by the way, we're in her practice today so she's in another room somewhere. Christy's saying, after a multiple day outage we prepared an emergency paper kit that includes all resources needed, and processes to follow from the telephone log to nurse charge with staining orders. So, sounds like Christy has a tool that she's developed that might be kind of interesting for Christy to maybe bring along and share with folks at the learning session that we have at the end of this month that might be something that you can use to inspire your toolkit if you haven't created one of those. That's a great, thanks Christy, I'll give you a high-five after we, once we leave this room here. All right, let me look at the results of our survey, and it looks like the people who have taken the survey here, three of you have said yes, you have upgraded, and most of you haven't replied. So, I'm going to assume that you don't have access to your computer, or you're at lunch somewhere and your computer's just on. So, great, thanks for those folks that have upgraded. I think that's going to be very valuable, how you reconcile what the perfect is supposed to be, with the reality, and we'd love for you to share your story in just a second. So, I decided that one of the things that might help folks understand the value of e-patient visit, which we'll talk a little about that in a second, is to kind of hear a story from a patient who uses e-visits, and that patient is me. So, I've had the pleasure -- I live in Kansas City, I think I've told you, and in Kansas City one of the large systems adopted a tool called Relay Health, which is a McKesson related tool, about five years ago. I had -- I look healthy, I look young, but I am an unhealthy

guy. I've got some genetic predisposition to hypertension and have some other conditions that are kind of chronic as well. And so, for me -- and I'm also a busy guy, as you know I'm traveling Arkansas, New Jersey, and other places, so for me taking time to go in and have my blood pressure checked on a regular basis feels painful because it just keeps my hypertension up actually, makes me feel stressed. So when the practice introduced e-visits through the patient portal, it was a really great opportunity for me to now have an interaction with my doctor that was more valuable from my perspective as a patient. The other thing that I really liked about it is, they are a big conglomo practice, a very large practice. The doctors were great, the people at the front desk were great, but their processes were terrible, and from a patient perspective it put me away from the office and the people I love far too often. So for me, when they opened up this way I got to navigate some of the bureaucracy that I felt like existed within the practice that through no fault of their own or the people, it created more opportunity. So I had direct access to the doctor's nurse now, they replied really rapidly to my emails, usually within 24-hours and no later than 48 hours. They coached me a little bit about how they -- how to use it. They shared with me for example, every Friday I take my blood pressure and I send it to them. So, that blood pressure reading, even though it's taken by me through another device, they can use that as a guide to help me with my medication management to make sure -- in fact, this last year, great news, I've lost weight, did some things, and I'm off blood pressure medicines, all because I'm able to have a more interactive exchange with my physician more regularly than before when I was showing up once a year, and maybe that's only when my wife pestered me to take the time off to do that. So, from my -- I'll tell you my story is, an e-visit for me has been terrific. Now, I know a lot of you don't have patients like me who are Gen-Xers who kind of have a propensity to use their computers a lot, those kinds of things but, what we're finding from the community -- this is a survey from folks who do e-visits. By the way people who do e-visits might surprise you. For example, the biggest users of Facebook today are not your 15-year-olds, it's your 63-year-olds who sometimes only get on the computer twice a month, but they get on to look at their grandkid's photos. So, computers by large, are a growing value to different generations. So, it's really not a generational issue anymore for use of computers. People at different generations use electronic banking, all the time. My father-in-law, who's 73, would -- I don't know how he ever used a regular, practical, analog bank. He used this, so just so you know, I'll let you look at the screen but for most folks an e-visit is a new possibility to create new levels of service and a new level of patient experience that you may not have imagined. It does create some dilemmas for you from a work flow perspective, and we'll talk about that and we'll also create some dilemmas for how you kind of traditionally do your work and think about people working at the top of their license, but I will tell you from a service perspective, as a patient, it was like a life saver for me. So, thanks for letting me share my story. Anybody else have a story, patients who have asked you about wanting to do e-visits? Rhelinda have you heard of patients at least indicating to you that hey, if my doctor just had an e-visit I would be in heaven, anything like that?

There are a few around that are identifying that they would utilize it but, still it is your younger generation. It is not necessarily your Medicare population. So --

Right, right. Thanks. One of the dilemmas for adoption of e-visits, at least in my community, the payer in that community pays for the e-visits. So, that's why they were an adopter. It was initially a $10 visit. In

some cases in our community, people were charging for those visits, about $35 I think for an e-visit. It was their choice obviously. You have to check with your payer about what you can do and can't do but there are options to provide the service even if it's a self-pay kind of option. You mind find some folks particularly in Gen-Y, Gen-X who might say, that's worth it to me. So, whether they pay their $25 co-pay or they pay their $35 e-visit, I think they might value an e-visit in some cases, so think about that. This is where you can use your Patient Family Advisory Council, to check with those different generations of patients to see what would they value, how might they value it from a cost perspective, how might you price it? So think of it from that avenue. Right now I don't believe the commercial payers that are NCPC are paying for e-visits and I know that's a conversation that they're having though as part of a multi-stay [inaudible] conversations so, go ahead. Okay, so here's what I'd like to kind of share with you a little bit, most of you are using a portal with a direct email, I know this is what Kourtney is using, and her team, and so, Kourtney I would love for you -- and Brenda, I know she is doing this too. So, I know each of you are having fits and starts with this so, I'm going to ask Brenda to kind of share what their experience is that she shared with me here just a couple days ago about how they got started with their patient portal, ad how they've had an interruption of service, and what that's meant for a couple clinics, and what that's meaning for others. So, Brenda if you're still on the line feel free to go ahead and start sharing your story.

Yes Jay, our clinic with Hamilton West Family Medicine, they have five physicians and five nurse practitioners, and they use the patient portal a lot.

30:11

We have approximately, last year we saw about 8000 patients, and I would say probably 25% of those patients used the patient portal. So, we did in our last update, there was some problems with the patient portal so we were not able to use that for several months. We -- it created phone calls, we would get about -- approximately 45 phone calls a day, patients wanting to know when the portal was going to be up, you know, that they really -- they used that all the time to communicate with the nurse, they would request appointments, if there was medication that needed to be refilled. So, we just recently got that fixed and so we've trying to navigate, I mean migrate, our patients over to the new version and it's working well, and they're making some improvements to the portal. We're fixing to go on our new update for 2014 and so there are going to be some more changes to the portal. One of the really good features is that if a patient is on the portal, they can actually have a patient representative account setup for them, and this works well for the elderly population and they can access the account and communicate with the provider or nurse regarding that patient. So, we're looking forward, we're hoping to do that in the next week.

So Brenda, when it went down for -- notwithstanding the fact that you've got this flurry of calls and patients really hoping to get that back up, tell me what needed to change at the provider and clinical team level because this went down. Did it make your life harder or easier form a standpoint of being able to do follow-up care and visits around care management?

Right. It just created so many more phone calls, because with the portal we could actually send our patient their lab results with a note, and they would communicate information back to us, where this

meant that the nurse was having to spend more time calling the patient to give them their lab results, and then patients were calling in, they would have to leave a message for the nurse, you know, and they would have to call them back. So yes, it created a lot more phone calls.

Yeah, and at Hamilton West what tool did you use to run your patient portal?

What tool?

What EHR? Sorry?

Oh, EMDs.

Okay, and was the outage something as a result of EMDs or was that something at your level that you had control over?

No, it was EMDs, it was one of their updates, and as a result of all the problems that they had with that update, they stopped releasing it, I mean I think there was only maybe about 24 clinics that had updated to that version before they started realizing all the issues and so they, you know, didn't release, you know, send anymore out and asked everyone not to upgrade. So --

So, is there -- from your perspective, if EMDs has another upgrade here in, you now, a year, how will you navigate sort of the roll out of that so that you avoid that dilemma again? Have you guys kind of talked about that from a PDSA cycle kind of perspective, or is that something you're still in the works of doing?

Well, we've had numerous conversations so we feel pretty confident that this new, the 8.0 that they have just released, you know, we feel very confident in all the conversations that we've had, and with EMDs, and you know, with our clinic managers, we've talked a lot about, you know, trying to set a plan in place if we have outages, you know, things not working, the portal, you know, what we're going to do. We're actually starting June 1st, we're going to put a nurse -- we've been to a clinic where they have pods, the SAMA Clinic, and, we are going to have a nurse with each pod that will handle phone calls. So, if the portal, you know, does -- doesn't work as it didn't with the 7.2 then we'll have, you know, a specific nurse for those doctors and nurse practitioners that can handle some of those phone calls.

That's great, that's great. So, stay on the line because I want to talk to you because Kourtney's probably going to want to know how you got 25% of those folks to use a portal, so Kourtney tell us about your experience and rolling out the portal, and some of those things either technically, or getting folks to kind of subscribe to it, what your experience is so far.

Sure, we use NextGen in all of our clinics, and we use a NextGen patient portal, we are very similar to Brenda in that we've had a recent upgrade and it has broken a few of the features that we have, but I guess one of the struggles that we're having with our portal is sign-ups. We have clinics, we have 15 clinics participating in CPCi, and they're in various areas of Arkansas, many of those areas are rural and so as, you know, it's hard to get people signed up for something like this that don't have internet access at all. So, one of the things that we've done in the clinics to maybe encourage these sign-ups is to add kiosks in the waiting areas so that patients can sign-up while they're waiting for their visit. There have

been some issues with that, in that with this upgrade, the issues we've seen is that the tokens -- we issue tokens in order for the patients to be able to sign up for our portal, it takes longer to get the tokens than your wait time, and so the kiosks aren't being utilized as much as we were hoping, but once that feature is fixed we are hoping they'll utilize them more. The other issue that we're seeing is that it takes a lot of the front office staff's time to get patients signed up on the portal through the kiosk, because, you know, patients don't have the education to understand how to do it. So, I guess that's our struggle, so I would like to hear how Brenda is getting that many people signed up in her practice, and how you guys are utilizing it as much as you are.

Yes, our front desk, we have made that part of the check-in process, that they talk to the patient about the portal but, I think our key is that our nurses were very much on board with this because they realized what this was going to do for them, not having to be on the phone so much. So, I would say probably as many nurses are signing our patients up on the patient portal as our front desk. So, they are able to go in there and set the patient up. If they have the patient in the room, it's very easy for them to go in and set that patient up on the portal.

Brenda, thanks for sharing that. I know one thing I've seen in some practices outside of Arkansas has been where people have utilized volunteer patients from their Patient Family Advisory Councils, and obviously these are kind of mature advisory councils where they'll kind of set up shop on a community day, or a day or two a week with a computer and access to the patient portal, so you learn from another patient. It's kind of got, it's like that Mac store kind of thing, where you walk in the Mac store, and there's all these users who are all stuck around the same problem, all kind of sharing their wisdom about how to do things, and people go wow, I can do that. Now, that doesn't address those folks that don't have computers, and don't have internet access, but it does at least allow for those folks that maybe have this modest orientation to their computers, and know how to Google, but they don't know how to do anything else, and passwords scare them to death. You know, those kinds of things, and I've seen that work really well at least increasing their sort of rate of adoption. Now, CMS and CPC, it's really clear that there is no threshold here, so as you -- you know compared to Meaningful Use which has some thresholds, so from CPC perspective, when you report this you don't have to report that we've got 10%, or 12%, or 15%, what we want you to do is try different methods, so if something doesn't work for you over a course of a month, I think what Kourtney's trying is different things, saying okay well we're going to try this option, we're going to invest in this option, we're going to see what works. One thing that's important too I think is each community has its own culture, and each community has their own sort of fears of technology. Some of them carry over between generations and so sometimes you have to amend your strategy to fit that community, and I think Brenda's kind of demonstrated that with okay, well we've decided in our community the nurses are a better way to navigate that, or in this New Jersey community they've found patients were a better way to navigate it. So, you might try different things over time and see if they work or, if you're like Kourtney and you've got Brenda and you've got multiple clinics in it, you might try something in one clinic and try it at another clinic and see if you get, you know, look for things that work at one clinic and don't work at another and see if you can make that work.

40:12

Terrific. So, follow-up question for both Brenda and Kourtney and her team is so, how do you make this work flow work? This is the biggest bugaboo, and I've got kind of a fun slide I'll get to here, this is how a lot of folks look at work flow, and this is where the design team went insane. You know, when it comes to work flow. So, how many of you have sort of tested and kind of bumped into work flow problems with this, and how have you navigated that? So, Kourtney and Brenda whoever wants to go first, I welcome your wisdom.

Sure, this is Kourtney. One of the things that we've done is that we have -- I guess we've structured it so that all of communication once the patient actually identifies what physician they go to, we actually send those requests to that physician's nurse, and so the nurses are actually answering all of the clinical questions, and then if they're actually requesting a visit or some sort it goes to a scheduler or front office rep or some sort. So, that's how we've worked around it. One of the things we're hoping to add in the future is -- well, a choice is that you can actually ask a question to a care coordinator and they'll know who their care coordinator is and so they can be directed there for clinical questions or management type questions as well.

That's a great idea. That is a really great idea. So, you are in the process of planning that, right?

Yes, we are in the process of planning that, it's another feature to add to our portal. Once we get through all the little bugs we are dealing with right now, we will have that feature available because we have seen that our care coordinators are a major selling point for the portal. Patients now have a one on one relationship with their care coordinator and they want to communicate with them, and we have seen patients who are sending in their vitals on a regular basis through their care coordinator, through the portal, so again it's a major selling point to have them signing up the patients they work with most frequently.

That's terrific. Thanks for sharing that. One thing, Christy's written in here too that sort of divided the work or spread that across folks. So, she writes we divided our work flow between several members of the team, lab requests go to the lab tech, referral requests go to the care manager, nurse doc questions go to nurse and demographics, general questions responded by the receptionist, so no one is overburdened. That's a great idea too. And Christy, is there -- do your folks like that access to their patients in that way, if you could write and kind of share a little bit about what they like about that, I'd love to kind of explore that. What I'm also interested in, is how your patients, do they have to differentiate their email? In other words, I have a lab question so I have to find the lab person at the clinic that I have to write to at the clinic, or is it I have a question, somebody else triages where it goes, and then it goes to that team? So, if you can kind of write in that, or we can un-mute your phone and we can have you share that if you'd like to do that. She writes in, yep they like it very much. They get quick answers. The portal's program to direct it to the person we assign it to. That's great, terrific. Thank you for sharing that. So, some of you probably have that level of sophistication built into your portal, and you may not have turned that function on yet. And so what you want to probably do here is spend a little time with your vendor again. This is the opportunity where you want to sort of maximize the use of that portal and there should be some features there that should make your work flow easier, not

harder. If it's making it harder, this is where we want to kind of give you some insight and wisdom, and I think folks like Rhelinda and I can kind of help you with that. Rhelinda, any wisdom that you want to share at this point about work flow?

Just re-do if it doesn't work. Re-do the end work.

Yeah, great, thank you. One of the things that I was really interested in, I was in one of the practices this weekend, Brenda I think it was yours, where we were talking about portal and you were impressed to read that one of the Colorado practices in CPC decided to open up, use their portal to do some scheduling, and that was a big fear for at least a lot of practices, having patients be able to schedule their own visits. And you said, how you were kind of peaked by that a little bit and how that practice initially opened up a couple slots, I think in a week to kind of do those things. Tell us a little bit about your thought about that and some of what makes you nervous about those things, and I'd love to have kind of a conversation with the practices that are on the call today about that.

Okay, Jay first I would like to say something about the work flow.

Yeah, sure.

You know, last year we were still you know, it was learning, just trying to figure out you know what works best for CPCi, and we actually have now come back and we are making some big changes, because we've kind of looked at, you know, everything we did last year, and so we're making kind of redesigning our work flow in our clinics.

Terrific. So, you've said hey, this is what we tried, and just like Rhelinda said here, not working like we'd like it to work, rather than waiting a long time to just get -- make everybody mad and everybody stressed, you've decided we're just going to kind of iterate, we're going to change that and do some things that we are learning from, not mistakes if you will, but learning from your experience.

Right, exactly. We're regrouping and we're going to make some changes, and part of that is what I talked about earlier, the pods. We're very excited about what Pete Atkinson has done in his clinic and it seems to really be working. We're kind of set up the same way so I think that is part of you know, why we decided to redesign our work flow in our clinics. As far as the allowing patients to schedule appointments through the portal, I have been really [laughter] worried about that because we were afraid patients would just make appointments for -- I think our portal is set where you can have specific visit types for what they can come in for, and we were afraid that maybe they would, the patient would, you know, make a visit for kind of a short 15 minute visit, but by the time the patient got there it might turn into, you know, a long visit, maybe a 30-minute visit, and it would cause the schedule to be backed up. We're taking a look at that since our meeting, we've decided to look at that and try that with one or two providers and see how that works. Our providers, we've told them that if a patient comes in and they have, maybe they're made an appointment for you know, say sinusitis, and they come in with a lot of other issues, that we may have to schedule a follow-up appointment for that. So, we're going to try to see how it works, just try it with a couple of providers.

All right, terrific. And we've got someone that wrote in here. Check this out; this will make your hair curl. Mercy Clinic in North West Arkansas has an appointment schedule available through the portal for same day follow-up and physicals. About 50% of each primary care physician schedule is open for Mercy online appointments. Our goal for this year is to increase to 75%. So, one of the things that I've been really pleased to find out as I've been navigating Arkansas here these last couple weeks is that you all in many cases are going to visit other clinics to learn how to do things. I've seen for example, Brenda's talking about Pete from SAMA, I -- you know I think there's opportunities here as these things emerge, if you want to reach out and do visits, I think your colleagues are interested in that. So, I don't know if the folks at Mercy would say hey, come on see how we do it. But, if you're interested in thinking about it, you might at least reach out to Lori and see how they do it, see what conversations they have with their patients in particular, to setup that conversation so that it doesn't become a burden on the practice, and Lori says come and see us. So, I might have to come down and see it, I'd like to see how that works and have you talk to my practice, because I'd love to be able to schedule my visits online. Thanks Lori, appreciate the willingness and we'll make some information available. We've got just about eight minutes left here, and I think this has been a good conversation but I want to make sure we cover the things that are important to you guys so, you know, as we talk about how do you market this, that's the biggest challenge, and here's some wisdom that actually comes from some of our experience at TransforMED, and seeing this across the country, and these slides will be available to you but, I think some of the things that I see that's really important is I was talking to a practice yesterday and they said well, we're going to create a brochure. And, we talked about the value of brochures and non-brochures, and it depends from each market. But, after a conversation we realized and talked about that it's not the brochure that matters, what would matter for them in this case, they actually liked the idea of having a patient helping folks with some of that. So, you're going to have to work with your voice of your patients to figure out what works but here's some models to think about here, and we'll send that along as well, and if you're interested in talking more about these and what works, I'd be happy to share my experience but I also will try to find experiences within Arkansas that have been working as well.

50:32

All right, okay you've seen my re-design so, actually plan for Tuesday, because Monday is a holiday, I was correctly pointed out here. So, we'll try to cover that up, that's Tuesday by the way. So, key things here, you want to select the highest value approach. So, you have a couple different options there. You don't want to probably take a leap all the way to texting or synchronous visits through video. That might be a pretty steep leap, so don't tackle that. Tackle those things that start from low technology ad team, to higher technology with a combination of team, and as you've heard today try stuff on, see if it fits, if it doesn't fit take it off and try on a new thing. Tell your vendor what you need, and this is really important, sometimes we feel like we're held hostage to our vendors, and it's important to tell your vendor what you need, and by when. So, we know that you're struggling with all these and sometimes they're not paying attention to you, even if you're shaking money in front of them and this is where Rhelinda and I can be a resource to you. If you want us to be on the call with your vendor to help explain why you need it and when you need it, we'd be delighted to help, and I know CMS wants to learn about vendors who are not being responsive to your needs, so let us know who those are and we would like to help you. As you heard from Nermal today, have plan A, and plan B and you probably remember there are 26 letters in the alphabet so, probably A-Z, and it takes a little bit of

time to plan those but you want to have a plan A and B, and we'll ask Christy to share her safety packet, paper packet if you will at the learning sessions so that folks can see that. Work flow; the work flow doesn't have to be perfect. Do around -- put it up on the white board in your office, let people play with it, have them change it, if they like it have them walk by on their lunch break, make changes of it, really use an iterative approach using your whole team. If someone just hands me the work flow, and says this is the way we're going to do it, I'm not likely to adopt it unless I had something in it. So, be careful about that and you might kind of keep in mind the iterative approach. And then Christy's going to have me, give me kind of a thought to ponder. And again, don't wait until your computer to be perfect, it never will be, it never has been. Your paper charts weren't perfect by the way for 50 years, so and you still sort of managed those things, so perfect is the enemy of the good again, is one of my favorite saying so keep that in mind as we go through, and as you have stress or strain about this sometimes just give each other a hug, because as you just want to throw the computer out the door, and that probably isn't in your best interest. Christy's got a thought here. Thought to ponder, the quality of lifestyle physicians can be altered if reimbursed and it's realized for e-visits. I completely agree. I know my doctors in Kansas City, that e-visits have been a terrific change for them. She just goes on to say, they can have time out of the office facility and still be paid to care for patients when the patients desire that care via visits. I have friends who run model practices called Direct Primary Care, places like Seattle and North Carolina, and e-visits are their central way. Now, it's an all cash based model but it's a reasonable cash based model and they use typically about $35 e-visits to support both their lifestyle, and also provide the care. I really love my e-visits when I have pink eye. Look me and my doctor; we had a relationship for a long time. He knew, I knew what pink eye was. I had twin boys who had pink eye. And so, he would write that script. There wasn't a whole lot of rigamoro at visits, and he could do that because he was paid to do that. So, keep that in mind and we're going to try to find out -- if you think about it, some of the resources that you get for the CPC initiative is to support some of these kind of activities, and in that sense you're kind of getting paid to do some of these. Maybe not as much as you'd like or from everybody that you'd like, but you are getting some resources to do this, particularly from your PMPM fees. So, that said, I'm going to have the folks who are panelists have the last word here, and I'm going to start with -- let's see, let's start with Kourtney. Kourtney you got assembled your whole team that does all this kind of work. What kind of wisdom would you kind of have as a parting shot there for folks to kind of keep in mind?

Well, [laughter] I don't have the best words of wisdom ever, but I would say being similar to us in that we've put a group of folks together with a lot of different strengths has been good for us for moving the patient portal along, I think we have a lot of different perspectives in our group, and I think it's helped us throughout the process, and I think integrating your care coordinators into the sign up process, into the process in general, just using them and having them in the work flow, will make it successful.

Terrific. That sounds like good wisdom to me. I like that again, making everything a team makes a lot of sense and investing them. So, let's see Rhelinda, tell me -- what would be -- so, everybody's headache is their EMR vendor, right? What would be your word or wisdom outside of the you know, beat them on the head kind of stuff, which I guess we're not allowed to propagate violence as part of CPC.

>> Have patience and don't get frustrated.

Okay, great.

It's going to continue to change and the technology is going to continue to improve so don't get frustrated and don't give up.

Yeah. See what you can do in the window that you can and go with that flow if you will. All right, and then Brenda, you've probably tried more and had some successes and also kind of some stinky moments when the darn thing went down. Any words of wisdom from you to folks as they sort of navigate those kind of dynamics, because I know you've got some clinics that are still kind of a little nervous about this option as well, while you've got some other clinics that are like, you know, give it back I need it back.

I think -- when I call our vendor, a lot of them that answer now recognize my voice [laughter] and I don't know if that's a good thing or a bad thing, but I think it's just keeping after your vendor. I think that you have to, you know, stay on them. You know, we have tickets that if we don't stay on them, sometimes those tickets cannot get answered for weeks. So, I just constantly am calling our vendor, and what I tell everyone is if you do not like change, do not get into health care [laughter]. That is, you know, because it's constantly changing. This is learning what works, what works today it may not work you know, two months from now. So, just be willing to, you know, make changes in your practice and find what works, you know, the best.

Terrific. I also want to pick, up, there's been some chat on the line here. Thank you very much Brenda, I think Kerry Peaton has got an interesting solution, they employ HIT students from some of the local technical colleges to support some of the re-launch of their portal, and to sort of maximize recruitment. I think that's kind of a really innovative way. Anytime you can use learners who have some capacity but also have some new ways of thinking about some things, I think that's a really valuable way. And then Brenda says, again she met with Blue Cross yesterday, or maybe today and spoke to them about e-visits and they are preparing to talk some more about that with some of the other payers that are in the community as well, so it sounds like this is a conversation that has started, you know, folks like the doctors in San Diego started this in 2004 but in Arkansas, we're still at the precipice of this and you guys are in many ways the front leaders in that community to try and move that along so, we really thank you and appreciate you for that effort. You know, those early settlers had a lot of pains to go through, and we do appreciate you doing that kind of, if you will, God's work [laughter]. Well, I've overstepped my time here, it's two minutes past the hour, so I'm going to be respectful of your time and holiday, I hope you all have a great holiday. I will see some of you next week when I come back down to Arkansas, appreciate your time. I want to thank everybody for the hospitality, particularly Dr. Brownfiled for having me in their clinic today and having Rhelinda drive up from Little Rock to meet me here and also be a part of the presentation. We thank everybody, have a great weekend. We'll talk to you real soon. Marie, I turn it back over to you to make sure everyone does their recording.

1:00:08

Yes Jay, thank you so much everyone for attending. Be sure to complete the survey on leaving the event. You will see how on the screen. You click on file, leave event, complete that survey, attach any comments you have that will help us to improve, have a great weekend. Thank you.

^E01:00:25