Arkansas & Oklahoma: Incorporating and Leveraging Evidence-Based Medicine into CPC Efforts

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Hello everyone. My name is Kym Patrick from the TMF Health Quality Institute. Welcome to our combined Oklahoma and Arkansas CPC regional webinar entitled Incorporating and Leveraging Evidence-Based Medicine into CPC Efforts. I would like to start things off today with just a few announcements. Today's program is being recorded and it will be posted along with all the slides and materials to the Collaboration site. You can also download the slides directly from the WebEx environment during the event by going to the top toolbar and selecting File, Save As, and then Document. We appreciate the presenters' time and effort in preparing for and sharing their valuable knowledge. Any statements about the quality or utility of any product or vendor made in this presentation is an expression of the opinion of the person making a statement only and is not an opinion or endorsement of the Center for Medicare & Medicaid Innovation, TMF Health Quality Institute, or the host of the presentation. Just a few instructions before we get started. As a reminder, all of the lines have been muted throughout the session. If you want to submit a question, please click on the Q&A tab at the right-hand slide of your screen. You can also raise your hand if you would like to verbally ask the question by selecting the hand icon in the participant panel. You might also be prompted during the presentation to use the arrow annotation. This is located at the top left of your screen, and please remember to click on the arrow again after using it so that the annotation does not stay on the screen. I would now like to introduce Laurie Paul and Rachel Wallis who will be presenting today.

Well, good afternoon Arkansas and Oklahoma. I'm so excited to do this joint webinar on evidence-based medicine leveraging and incorporating them into your practice. This is our first joint webinar and it is exciting to see all the participants and know that we get to have not only our Oklahoma practices or just not only the Arkansas practices, but the joint practices together. I do want to let you know that at the top of your screen, above your slide, the risk stratification that our presenter is using at their practice is available for you, and you can go ahead and go to File and download that and print it all for yourself. So do know that's there for you to utilize if you want to. And then of course all the slides will be available on the Collaboration website after today's presentation. Our shared purpose today is to inspire and promote evidence-based medicine policies, procedures, and cultures in CPC practices. We want to make sure that we're doing things the best practice way. Making patient-centered decisions in the face of competing medical evidence and then taking these evidence-based summaries and leveraging them and giving you just-in-time technology for all members of the clinical team to be able to use the best

utilization of their time and work at the top of their licensure. So, on that little arrow on the upper left-hand side of your screen, I would appreciate if you now click on that little arrow, and then bring it down into where you are. If you're in Oklahoma, if you're in Arkansas, kind of give us a sense from where you are. And again, that little arrow is on the left-hand control panel, click on it, and put it in Oklahoma or Arkansas. It's exciting. Once you're done, if you'll please click on it again, so that you don't accidentally annotate on our other slides. OK. Well, this is really exciting. I see lot in Oklahoma and lot in Arkansas, just kind of all over each of the areas. Thank you very much for doing that. OK. Now, we're going to click on the arrow again, and this is a yes-no poll. Question, do you currently have or use evidence-based protocols or—in practice? So if you'll take the little arrow and click in. Kind of give us a sense of who our audience is and what's your needs are. So exciting because most everybody is using evidence-based protocols in their practice. Give you just another minute. OK. And then again, if you'll go up to the left-hand arrow and click on it again, so it kind of turns it off and no accidental annotations happen. So at this time, we want to use the chat function, kind of keeping you busy and active in this webinar. Over in the chat function, you want to make sure that you got the send to on all participants. The chat function if it isn't open is on the upper right-hand side of your panel. It's a little bubble, elliptical bubble, and it says Chat underneath it. And if you click on that, it opens the chat function. And what we'd love for you to do is to please chat on what you want to know about evidence-based guidelines, how to do evidence-based medicine and protocols today. So what do you hope to get out of today's webinar and discussion? And I'll just give you a minute to go ahead and chat in there. OK. We're going to move on and keep going. If you will please go ahead and chat to everybody, all participants, so we can see what your intent is. Setting your intent is always good at the beginning of whatever you're starting. Then we can go from there. So interestingly, I thought, I'll just look up what evidence-based medicine or evidence-based guidelines means, and everybody uses the Institute of Medicine's definition that's way back from like 1999, there's a 1996 definition. So I tried to find something a little more recent, and this is a 2011 quote. And what has kind of evolved over time is it—as it's gone from just being called evidence-based medicine into clinical practice guidelines. And so, the definition that I came up with, and this was from the Institute of Medicine as well. It's, "Clinical practice guidelines are statements that include recommendations intended to optimize patient care." We all—"They are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options." And we all know there's lots of evidence-based guidelines, clinical practice guidelines out there. The important thing to remember is that they are indeed guidelines. They are not, you must do it this way, they're not eat it, they are guidelines. They are based on research, and most evidence-based guidelines are based on multiple, multiple studies that really clearly show what the best thing to do, what the best practice is for that condition or that patient. Kind of a visual that I found that is interesting, this is from Florida State University, College of Medicine, and they call it their Evidence-Based Medicine Triad. And I thought it was really interesting because you have your individual clinical expertise here, OK, on this corner, and then you've got the patient's values and expectations down here, which also come into it. But you also got this great big circle over here that talks about the best external evidence, and that's what we're talking about here. But taking all of that external research and evidence, and putting it together with your individual clinical expertise and what your patients value and expect, that gives us this little cross section in the middle, that it's really where the evidence-based medicine is. It's your best thoughts, your patient's values and expectations plus all that research. I am so excited to show you this slide. This is

actually one of the Oklahoma practice slides, it's on the Warren Jenks Clinic. And they have—They're going to be our presenters today, and I wanted to get you really involved and seeing what—why we asked them to present. So, this their practice-level rate of hospital admission for any cause and their feedback report, and you all know that this is figure eight, and you received that report. You all have access to this report in your Quarter 7 Feedback Report which you should all have downloaded by now. And this is still the Quarter 6 data actually I believe so. But the important thing to know her is that their practice is way down here on the left-hand side. Very exciting because they must be doing something right, and that's why we invited them to speak today because practices that are doing well on all kinds of these measures are the ones that we really want to hear from and learn from. So at this time, now that I've got your attention, I'd like to introduce Joseph Schlecht, DO, and Sherry Fisher, RN, Care Guidance Nurse from the Warren Jenks Clinic.

10:04

Thank you. It's exciting to be here and talk to you. I'm Joseph Schlecht, I've been involved with the CPC since its founding. We're in a relatively rural practice just outside of Tulsa. Next slide. One of the things that we have put real hard on, we've been—there's three of us primary care physicians in this office, obviously family practice. And all three of the physicians have made a commitment to chronic disease management, through evidence-based guidelines, through the use of registries. Using the registries to measure our outcomes and look for improvement. And as a result of this, increased quality and decreased cost, that's our goals and objectives and I'm going to show you here in a little while how we've achieved that. We pay particular attention to developing evidence-based guidelines in reference to diabetes, congestive failure and COPD. We have used what the CPC has—excuse me. What CPC has allowed for us to do is to bring on a care guidance nurse that has assisted us through all of this. Evidence-based medicine, through that, they develop evidence-based guidelines. Where are these guidelines coming from? This slide talks about the NCQA, the National Committee for Quality Assurance and one of the big dogs in evidence-based medicine and guidelines. The National Quality Forum, that's something that you guys need to look up. You need to follow because it's a very important organization, I'll explain that in a minute. You got the American College of Cardiology. Obviously, all of our colleges are involved in the development of evidence-based guidelines. I've put up ACC because we're using their guidelines for congestive failure, which I'll show you after a little bit. NIT has its own guidelines on different issues. GOLD, the Global Initiative for Chronic Obstructive Lung Disease, we've done a real good job on diabetes and diabetic registries. We've got a good job, we're doing a good job on congestive failure. We're just now getting into the COPD guidelines and I think we'll have the same success with those what we'll have—that we're having with the others. Then you also got the payers. One of the problems we physicians have and all those participating in this thing is whose guidelines are you going to use and how many guidelines are there going to be out there. Are there going to be guidelines from United Health? Are there going to be guidelines from Blue Cross Blue Shield, from CMS, you know. And all of a sudden, the practices could be inundated with the platform of different types of guidelines which would be chaotic. NCQA, everybody pretty well recognizes those folks as a gold standard and that's very helpful. But I mentioned, you got to pay attention to National Quality Forum. It is an organization that is addressing the issue I just raised. One of their big issues, they call it MAP, it's Measures Application Partnership. And what the National Quality Forum is doing is they're bridging the gap between the

private payers and the public payers in the industry as far as guideline development are concerned. And they're working aggressively to make sure everybody consolidates the guidelines. And that's going to be just absolutely imperative for future success. The guidelines, you don't need to reinvent the wheel. We use—When we first started this process back in 2005, I believe it was, we worked with Park Nicollet on their diabetes registry and they're an international diabetes center. They adopted the guidelines from NCQA for diabetes and we just plagiarized all of that. We—Currently, the clinic is working with Geisinger, I think that's where the COPD guidelines are coming from. So, you can find a lot of folks out there that are already using the guidelines. You can see what we're doing in using guidelines. The NCQA is the best outlet. Next Slide. NCQA is the gold standard for guidelines. It was first established—It's a 501c3 nonprofit organization, first established in 1990. Its Seal of Quality is recognized by most payers and industries as center of excellence. You can apply to NCQA and be recognized as a Center Of Excellence In Diabetes, be recognized as the center of excellence in heart and vascular. The three of us at our clinic, we've had those recognitions for four, five or six years. It is an important thing to look, for your practice to look in to doing. NCQA is also the key for HEDIS reports. So anybody that's affiliated with a hospital knows all about HEDIS and their guidelines, you know, how about the infection rate, how about decubitus, how about 30-day readmissions. The interesting part about HEDIS, I think is for the last four or five years, it's been public knowledge. The public could get on the internet, could find out what the HEDIS reports were for a hospital and compare the two hospitals. Who has best quality, who has the worst quality. NCQA also runs CAHPS, C-A-H-P-S, this is the touchy feely thing that drives me somewhat nuts. It's the patient satisfaction surveys. And a lot of attention is going to be paid in this project you're in right now, the CPC project. In that, we're going to be paid based on not so much of per member per month payment over the last two years but on shared savings. And a lot of that shared—A lot of the ability to get—to participate in shared savings is going to be based on quality and on patient satisfaction. So that's an important entity to understand. By 2017, 9 percent of CMS payments are going to be performance based and that's just the beginning. So, chronic disease management, evidence-based medicine, registries, outcomes, this is what they're going to be looking at. They're going to be looking at the top quartile and the bottom quartile. If you're in the top quartile for quality and patient satisfaction, you're going to do quite well. If you're in the bottom quartile, it's going to hurt. And we got to pay attention to this stuff. Next slide. Evidence-based guidelines. Again, I've already mentioned the center of excellence for diabetes management is NCQA, diabetes guidelines, I'll show you our diabetes guidelines here in just a little bit. But a diabetic registry. Registries, you'll hear me speak a lot to this. These are absolutely imperative. You have got to develop, in this case, I'm talking about a diabetic registry, what does that mean? It means you have to identify every diabetic in the practice. Every 250 point whatever, whatever in the practice. And then you've got to sort—What we did is we sorted the diabetics by the highest A1c to the lowest A1cs and our goal is to be in as best as we can without getting into hyperglycemia if the A1c is under 7. We identified—The reason when we did this in my practice, there was over 230 diabetics that were identified. We went through the process and I thought I was practicing great medicine. Somebody said, "Joseph, your microalbumins aren't going to be there, your exams aren't going to be there," and I won't tell you what I said to him but I had eat my words. Because when we finally did get that data, because nobody had a registry and nobody watched things, that data was terrible. For example at that particular time, my microalbumin on those 230 patients, 21 percent of them had had a microalbumin down. After a year of implementing this registry and using the registry, 87

percent had the microalbumins and it's even higher now. So the point of the matter is you develop the registry, you sort the registry by the most severe—worst A1cs and to the best A1cs. We set policy in place. Every diabetic is going to be seen every three months. When I walk in the room, their shoes are going to be off. My goal is to take their A1c down to less than 7 percent. My goal is to get a microalbumin once a year, eye exam once a year and the other guidelines. Everybody in the office knows what those guidelines are but the most important thing that I do with these guidelines is when the patient first comes in to see me or the patient first gets into this project, you're shared decision making with the patient. I sit down with the patient, I introduce them to the guidelines, I explain to them what the guidelines are all about. I've got posters hanging all over the exam rooms talk about if you drop A1c by 1 percent, you decrease your death from all reasons by 13 percent. Now, there's all sorts of data and you get the patients involved. Then, you get the care guidance nurse involved and you have the whole office staff involved. Next slide. What can—

Dr. Schlecht.

Yes ma'amm.

Dr. Schlecht, this is Rachel. Can I interrupt just a second?

Yes.

You just said something very interesting and I would like to poll the audience really quickly. So with everyone, if you're looking at a full screen if you could hover over the green bar that you see and then click on the blue button that says return, that will take you back to where you can see the chat function. So real quick, I would just like to know via show of hands, who all out there are using disease registry. So if you could raise your hand if you're using a disease registry.

20:00

I think this is an important concept, Dr. Schlecht and I think—

Absolutely.

—some of the practices aren't using these and they could be very helpful in a lot of the practice setting. So I only see just a handful of people that are using disease registry. OK. All right. Well thank you Dr. Schlecht for letting me interrupt and those of you that responded, thank you for that. That may be a topic of an upcoming webinar—

That's [inaudible].

Yup. Go ahead.

I'm going to just going to say, it is absolutely imperative to accomplish the success that our clinic has had. You absolutely have to have disease registries. Disease registries are not difficult to do. I know everybody in CPC is on an electronic health record, but when we first did our first disease registry, we were on a paper chart and it worked in not those results that I was telling you about—that I was telling

you about. That was working out of a paper chart and using a disease registry. It's just absolutely imperative and everybody needs to know how to do it. Tools that we used to implement the evidence-based guidelines and get to success that we've had. Number one, the physician commitment; that is just absolutely imperative. The commitment, so back on one of my previous slide, I think it's slide 11 or 10 where I talked about the current disease management, the evidence-based guidelines or the registries and the outcomes. We three physicians in our clinic made 100 percent commitment that we were on board with that. If the physician does not commit to the evidence-based medicine and evidence-based guidelines or the implementation and development of registries, then we're all blowing in the wind. The bottom line is the doc's got to be on board and I don't see any reason why they wouldn't be on board. One of the reasons that I hear is physicians kind of hesitate on this is where the hell do I get the time to do this, excuse my language. Where do I get the time to do this? And the bottom line is that once this is up and going, it doesn't take any time to develop these registries and to work these registries as far as a physician is concerned. My staff is doing all that. What I'm getting—The benefit I'm getting, the benefit my patients are getting are much better outcomes, much better quality. And very little of my time is spent doing this. So the registry is just an absolute imperative thing. Then we brought on, thanks to CPC, the care guidance nurse. And I like to say that all of us have to practice to the top of our license but the care guidance nurse, I want her doing that without fail because without her, none of this would be successful either. Next slide. The other tools we used, risk stratification. Now, I've brought the risk stratification tool along with me. I wish there was a way you guys could see this, but it is again, the AAFP, the American Academy of Family Physicians tool to risk stratify the patients. I have a question. How many of you folks are using this tool and risk stratifying all your patients? Is there a way we can—

Dr. Schlecht, this is Rachel. If you will undo your full screen, you have the AAFP risk tool on a tab up there that you can click on for people to see. And as Dr. Schlecht said, please raise your hand if you're using the AAFP tool. There's a lot of people Dr. Schlecht that's doing that.

Good. Good. Because that's absolutely imperative. Now my point being, and let's go back to my slide here. First thing you've got—we've got to do is use this tool and risk stratify our patients. In our clinic, I believe Sherry, we've got what, 85, 90 percent of all of our patients risk stratified. And we're not just keying in on CPC. Every patient that walks in the office is getting risk stratified. And then, here's that good word again, registry. We have a risk stratification registry and I'll show you a copy of that here in a minute. And basically, once we had all the patients risk stratified one through six, then we sort—develop the registry and we sorted them from the sixes down to the ones. And I feel strongly that the physicians should be the ones that are doing the risk stratification, not the care guidance nurse. She's got a lot of other work to do that's more important. We can risk stratify our patients, it takes less than a minute for a brand new patient walking in for me to figure out whether it's a one through six. So, I'm just telling you that, in my opinion, that will be the physicians doing that. We develop this registry, the risk stratification registry, it's very important for you to do that and it's not that difficult. Transition of care, this has been a wooly booger throughout the country. This is something that I think probably quality of care is just absolutely terrible when transition of care is involved. And I think you can go to any research any place and find out that's the case. Particularly, when you're talking about the patient moving from a hospital to the outpatient setting. My patient Mary Sue, congestive failure, some of the frequent flier. She goes

in the hospital in the past and she gets her congestive failure treated, she goes home form the hospital and her old man—she's tired, her old man is a little old and little confused [inaudible] and they get a look and they said, "Can you believe what the young stupid doctor at the hospital is trying to do? He put me on all this medicine, Dr. Schlecht knows my case, he knows who I am, he knows where I'm coming from. To heck with those meds, I'm going to take Dr. Schlecht's meds." And Mary Sue in three and a half weeks is back in the hospital. What happens now, is our care guidance nurse, when she has time, she makes rounds at the hospital. She'll go by and make howdy rounds and the patients just love it. And one in a while, she'll take the medical assistants with her and they'll just go around and see the patients. And one of the things that Sherry has done is develop a good relationship with the discharge planners at the hospital. Now, Mary Sue comes in the hospital with her acute congestive heart failure and there's a phone call. They've got their own code I think, but they communicate via phones and the discharge planner says, "Hey Mary Sue is in here, Sherry I just want to give you a heads up." And as soon as she's ready to be discharged, she's back on the phone to Sherry and Sherry says, "Great." She gets on the phone, she calls Mary Sue and it's the same scenario. Mary Sue says, "Can you believe what we're doing? I'm going to take Dr. Schlecht's medicine." But this time around, Sherry says, "No, don't do that. Dr. Schlecht wants you taking that new medicine. In fact, he wants you to put your old medicine aside in a brown bag. He wants to see you in the office in three days and bring all your medicine with you." And by gosh, I'll tell you what, this little old lady doesn't get readmitted right of the bat with her congestive heart failure. That is—That works, I suggest everybody do that. And it's a wonderful thing. You'll see our 30-day readmissions, it's a slide I'm very proud of, dramatically down. And again, it's because of the way our care guidance nurse, the discharge planners that are developing the registries, identifying the sick patients, so on and so forth. Now, evidence-based guidelines and standing orders. What am I talking about there? Everybody knows that on the diabetic, you got to do the yearly foot—or the yearly eye exam. You got to do the microalbumin on them so on and so forth. All of my staff in the office have my authority, the ability to order a microalbumin. They might come and say, "Doc, I notice you didn't order microalbumin. We hadn't one either." They know they can go ahead and order it. They know they can go ahead and refer the patient to the ophthalmologist. I give my staff, I empower my staff to work with me on implementing these guidelines. We do what are called huddles. Every morning, we meet anywhere from two to five minutes, doesn't take much time at all. The patients that we're seeing that very day, Sherry and the rest of the staff have looked them over. If there's any transition of care, Sherry already has the discharge summary pulled up, already has the H&P, already has the new medications in the chart and I walk in to see the patient, I look like a hero because I know everything that's going on. But it's because my staff has backed me up and taken good care of myself and my patient. Another interesting thing about the huddles. In that huddle, that's the medical assistant, that's the office manager, that's the receptionist, the physician obviously. Mary Sue has been known to call in again, say, "Hey I'm a little bit short of breath, I feel kind of puny, I would like to see Dr. Schlecht." And in the past, the receptionist will take a look and say, "Well Dr. Schlecht can see you at 2 o'clock tomorrow afternoon. Thank you for getting me in so quick." Seven o'clock in the morning she's on the line to answer, being transported to the emergency room for acute exacerbation of her CHF. Now what happens, staff up front, they can't make a diagnosis of acute exacerbation of the CHF, but they certainly can look at Mary Sue and on the computer they see that Mary Sue is a four, five or a six. And Mary Sue is calling in and saying, "Hey, I'm having trouble breathing." Well now what happens is Dr. Schlecht will see

Mary Sue at 2 o'clock this afternoon today. And she comes in, we see her weight is up, we reeducate her on how to handle that. Give her a little extra Lasix and we abort the readmissions. Next slide. But it's using the whole staff is what we're doing. The receptionists now understand what that severity index that you see right here is all about. This is—They call that—Somebody is calling this patient tracking population health. This actually is a severity index registry is what it is. And—But you take a look off to the left there we de-identified everything but these are actual patients. And you'll see, we're going from the sixes and then heading down. We have about, I don't know, 25 pages of this stuff and—but this is a tool that Sherry uses on a daily basis taking a look at—look right there at the second column, care plan. You see the dates there? That's what a care guidance nurse does.

30:01

That's one of her strengths is the ability to develop care plans. Care plans are so very important to taking good care of the patient and you could see most of these. There's care plans there. Now, we're still working on that and but—and take a look at the one, two, third one down, Schlecht, it's a six that means if the patient is six, in my opinion, they ought to be in hospice or awfully close to hospice. Chance of taking them down to five are very rare. And in that particular case, you'll see the patient hadn't been in since May 15th but on the other side of the coin, you see the patient is in hospice. I normally delegate my hospice patients to the hospice doctor but Sherry stays on top of this stuff. And once in a while, she gives me reports on how the patient is doing so and so. But we use this tool—And I talked about the diabetic registry. I said, we sort by the worst case, you know, highest A1cs to the best to the lowest A1cs. It's very interesting how many of the ones with the high A1cs are also the four, five, or six severity indexed. The two registries, they correlate, they work together. You could see we can sort this by—on the far right by CHF, by COPD, by diabetes. It's a tool that you got to have to identify are the patients doing what you want them to do and if they're not, what can you do next? Next slide. This is the NCQA guidelines as far as being recognized as the Center of Excellence in Diabetes. And, it's the A1cs less than seven, the A1c is over 9 percent. You can read all this but talks about the blood pressure, talks about the LDL cholesterol, talks about the eye exam, the foot exam, the microalbumin, that's in nephropathy, smoking status. These are NCQA guidelines recognized by everybody in the country, used by Park Nicollet, Geisinger and Warren clinic as a guideline that this is where we want our diabetics to be. And you'll see below that NCQA box below there. When we move from NextGen to EPIC, we ended up losing our registry. I'm screaming about registries and how they lost the damn thing on me but, anyway, but we are now getting that rebuilt. We're getting that rebuilt and it's going to be—it's going to work very well for us and it just helps us improve quality. That's all it amounts to. I'm going to just tell you, this is not a slide of just to know. Over the last 30—there's been no 30-day hospital readmissions from our practice, our three docs for October. There's been one congestive heart failure admission for August, September and October from our docs. Why is this occurring? And why are we going to—this data that I'm showing you? It's because we're implementing the using the tools I just talk to you about. How do we know that using the evidence-based guidelines are making a difference? Like I said, our hospital admissions for any calls. We look close at that. Our ED visits, our emergency department visits, we look close at that. The ACSC, that's something you need to pay a whole lot of attention to and I'm sure, you guys studied those quarterly reports and pour over them to try to see what you can do to make things better in your practices, but that Ambulatory Care Sensitive Conditions but that's one where the idea

being that if you take good care of that diabetic, that CHF, that COPD then, they shouldn't be getting readmitted to the hospital. That's the data that comes out of the big dogs at the Geisinger, the national [inaudible] and so on and so forth. And, so looking at that data and where do you stand on that? And like—I just told you, we had only had one CHF admitted over the last three months. We're developing some quality measures. Next slide. You guys have already seen this, but I'm really proud of it. We're the red star down there at the very bottom of this graph and that's the practice-level rate of hospital admissions for any cause and that's where we're at and we're doing that because we are doing what I consider to be aggressive evidence-based, registry-based care of our patients. And as a result of that, we're preventing a lot of hospital admissions. The next one is the one that I'm real pleased with too, and I think there's some interesting data here. This is that ACSC stuff I was talking about and the sort of things that where patients should be getting admitted. Take a look at January 13th 2013, we were terrible. We had over 89 admits in that quarter. CPCi started October 12 and so, we—you know, we really did good that first quarter. But take a look since then, in—I think around May of 2013, Sherry came on board. But look at where we're at in the last two quarters, we are way below the average in our region for admits for these particular kind of diagnosis and—there's no doubt in my mind, it's because CPC and because of the processes I just talked to you about. Then look at this next one. This is the one that the hospital really loves because this is where they get their clocks cleaned and that is on readmissions. Their readmissions, they don't get paid for a bunch of them, it's true. And you take a look at where we're at, again, same thing. Back when CPCi first started, we weren't doing very well at that. Now that we're in to it, now that Sherry is on board, now that we've got registries and guidelines, look at the last four quarters on our readmissions. That will make any hospital administrator smile and they'll hopefully pay us a little bit more cash flow. The—All right. We've already talked about this. Adoption consideration for others. Physician commitment to practice evidence-based medicine. Now that really—That slide I have to apologize to you guys, that slide really should read, physician commitment to the process and that is again what I talked about at the very beginning, chronic disease management, the evidence-based guidelines, developing the registries, looking at the outcomes, increase in quality, decrease in cost. You cannot get anywhere if you don't have the physician commitment to this process. In our practice, we've got three docs that are strongly committed but I will tell you four or five years ago, we had three doctors, one strongly committed, one moderately committed and one oh well we'll see what happens. But it's—They've turned around and everybody feels strong about it and you've got to have the physician involved. And then, the entire office has to be involved. And again, there is some typos here, not selecting the evidence-based guidelines but implementing the evidence-based guidelines and not writing the standing orders but implementing the standing orders. I apologize to you for that. But that's what I've already talked about using diabetes as an example. The staff has the ability to do things to make sure that we're working as a team. Communication is with everything. Now, the tools—And I believe these slides are numbered. Just write this, you know, write these numbers down but you got back to slide 16 and, you know, it talks about the tools and the physician commitment and the care guidance nurse. Seventeen it talks about the risk stratification, it talks about the registries. Developing a mechanism to handle transitional care and 30-day readmissions. And then the severity index and registry. You develop these entities and use these entities and you can accomplish what I just showed you that we have done. A little slide—I'm jumping around on you a little bit here but I think it's slide 20. It looks like this is just before the graphs. All right. Again, by using the registries, by using

correctly your case management nurse, using correctly your staff, you can get your hospital admissions down, your—the admissions down, your ACSCs down and your 30-day readmissions. You can get all of those under control. You know, in order—I guess the last slide I've got is this one here, adoption consideration where we corrected some stuff. In order to make this truly work, you've got to have the team. You got to have everybody in the office involved the way I've described. You've got to have the care guidance nurse. You've got to have the patient severity indexed and then you've got to develop the severity indexing registry. You got to develop multiple interrelated registries. So diabetic and the severity index registry. The CHF registry, the guidelines that were used in there. You've got to use care plans and care coordination. And again, it's where the care guidance nurse comes in. You do these things, you know, the same exact results that we've had, I think I've probably gone over my time. The—Even proper utilization of the care guidance nurse, she got to practice at the top of her license. I don't want her severity indexing the patients. I want her pre planning the patient visits. I want her monitoring the development in all these reports that we talk about. Like I said, I don't have the time. It's not my job to monitor those reports. That's what Sherry does very well and then we work as a team when she gives me the information back and we—as a result of this, we end up with better care, better quality of care. Transitional care management, through collaboration with discharge planners, everybody in this office is—in this conference had better be doing that, that's going to be imperative for you in the future and develop a mechanism to do it. By developing relationship with some patients and developing relationships with the discharge planners. Using—being a community resource liaison, we had patient who had a terrible time controlling his diabetes and he was on the sliding scale and he was on Lantus and bolus scale. And he—Every time I check him, "Yeah doc I'm doing it. I'm using it, I'm—you know, I'm using 6 to 8 to 9 units before meals and blah, blah blah."

40:08

Long story short, when he's visiting with Sherry, he said, "Hell, I didn't want to tell doc, but I'm not using my insulin, I can't afford it." She got on the on the line with the community liaison, she got with the drug company, he's getting his insulin for free. He's going from I think a 9.9 A1c down to 7.3. Being a liaison or a resource liaison and care planning and standing orders. These are, you know, those are my comments I have presented before at two that Sherry put together when we do basal-bolus insulin that I'd be glad to talk about. We've got—And we can share with anybody who wants it, it's called Stay In The Zone. It's a tool we use for congestive heart failure. I will tell you, one of the things the tool that Sherry developed for my basal-bolus insulin, it's amazing how many patients do not understand bolus insulin, before meal insulin. And it's also amazing that there's lots of people don't read very well. But she put together a system and the Novolog happens to be in orange pen and the Levemir happens to be a green pen and she color coded this chart and all of a sudden, it's amazing how much better compliant the patients are with this. I'll make one other comment as a result of the situation today in describing and discussing with you and the utilization of our personnel and utilization of these tools. We have one fellow, who's a frequent flier in 2013, he had four admits for congestive heart failure. And 2014, he's had zero admits for congestive heart failure and is leading a much better quality of life. So all I'm saying is, do these things, use the guidelines, use the registries, get the commitment from your physicians and you can have great outcomes. That's it.

Thank you so much Dr. Schlecht. I am so thrilled to hear about all that especially the last point you made about the quality of life for the patient. This isn't just all about numbers, is it? It's about that quality of life for the patient, making it better for the patient is the bottom line. And I'm so pleased that you brought that up. At this time, we have time for harvesting the learning and for question and answer. Everybody's hands are still up from our last poll. So, if you're still in full screen, if you'll click on the green panel up there and on the left-hand side, you'll see go out of the full screen mode. You can go ahead and put you hand down otherwise I might call on you if your hand is still up. So, go out of the full screen and go into the smaller screen so you can see the chat and go ahead and click on your hand icon again and that will put your hand down. If you indeed do have a question, you may chat it in the chat box to all participants or you may raise your hand and we'll be happy to call on you. The only hand I still see up is Jolanta's [assumed spelling]. Jolanta, do you have a question for us? Can we unmute your Jolanta and see if she has a question. Hi Jolanta, you're unmuted, do you have a question for Dr. Schlecht?

No I'm sorry no. No, I don't have a question but I am at awe what a wonderful, wonderful job doctor is doing. So hats off to the doctor and I 100 percent agree with everything he said. Wonderful, wonderful job. Thank you.

That was a great feedback. Thank you so much for chatting in [inaudible].

Laurie this is Rachel and I agree with Jolanta wonderful presentation Dr. Schlecht. I do have a question and it's one that I hear from practices all the time is how did you get the physicians to agree up in the guidelines Dr. Schlecht? Every time we talk to practices, well I won't say every time, a lot of times when we talk to practices about evidence-based guidelines, the nursing staff and the administrators often tell me that it's near impossible to get the providers to agree. So what was your secret sauce?

One of the things that we originally did. Now you got to understand, like I said, we've been doing this since 2000, some sort of variance of this since 2005 and 2006. And we worked with one of the nationally recognized diabetes clinics, Park Nicollet and Park Nicollet has what they call their International Diabetes Center. And I actually brought—As I ran in to that same problem, I brought to Park Nicollet in but didn't cost us a dime as part of what they were trying to do is improve the care to diabetes and we put on a dog and pony show. And we actually showed the staff that if they would use these guidelines and these guidelines are recognized by the NCQA, that were used by Park Nicollet, at the time they were also being use by Geisinger that this was the outcome that you could expect to see. And, when the physicians saw the power brokers were used on this and the outcomes that they were getting and one of the things that staff can do I can guarantee, if you're not using diabetic registries, I can guarantee you that your diabetic patients are not in control. And, if like I said, they pulled out up 230 diabetics of mine a number of years going when we were doing this. And I said, I told everybody, you know, take a walk, I was—everybody is under good control. And less than 20 percent we're having their kidneys checked and having their eyes check. That was an eye opener to me and when you show them here's what your data is, if we do this it's not going to cost you any extra time—but you put it in place like this, you're going to get better quality outcome. It's a long answer to a short question but that's the way we made it work.

OK.

But you're talking Dr. Schlecht more of a pull instead of a push. You're not pushing them into it, you're showing them the data, you're showing them how it's working, so it's pulling them in and dragging them on board. Is that correct?

That's absolutely correct. And I will tell you something else. Back, you know, six, seven years ago, I think I've figured out that by doing this, I was increasing the volume of office visits and they were being paid at level four office visit. So, anytime you can knock on the door and there's a little cash at hand, the docs take a look at that too, that's another incentive. Now, that maybe is not so much so these days and times, but on the other side of coin is like I said, 7 percent or 9 percent of CMS payments in 2017 just three years from now are going to be based on quality and outcomes. The docs got to understand that and they've got to be able to produce the data to show the quality and the outcomes. I think that's probably a big stimulus too. But you're right, you got to pull them.

That's wonderful. Anybody else have any questions please raise your hand or chat them in. I going to go ahead and turn this over to Rachel Wallis. Rachel is going to take us to some more questions and some more ideas.

Thanks Laurie. Dr. Schlecht I still have a couple of questions and I don't see any others in the chat but I have a couple so. Not really questions but more comments, what would it be that you would tell practices to do. What should be their first step, Dr. Schlecht if they want to begin doing registry?

Well first thing, and again, use diabetes as an example. The first thing you got to do is identify the diabetics in your practice and then once you've got them identified, and I can tell you that in a paper chart, I had a staff of four at the time, and they worked over a week and put about 40 hours maybe 50 hours, I was looking at my notes the other day. And they identified every diabetic that was in the practice to the billing system and pulled up all 250s. And—but that's the very first thing that needs to be done. And then you need to decide once you've done that then you need to sort them. You got to sort them by something and I suggest in diabetics, you sort it by the A1cs. You also are going to have in their registry microalbumins and you're going to have the LDLs and the blood pressure and so and so forth, but I suggest you sort it by A1cs, that's where you start. And, if you—The highest A1cs to the lowest A1cs.

OK. Great thank you Dr. Schlecht. And at any time if you maybe have questions for Dr. Schlecht please chime in. Dr. Schlecht I have one more question and it's kind of a take away. So, if you could give practices attending today one piece of valuable advice, what would be the most valuable advice that you would give them?

Well, I would tell you that since all these practice are CPC and they're receiving the cash flow, all kidding aside, getting that care guidance nurse on board. And one, you know, that's willing to work hard and willing to learn this process probably is highly key and then identify them in the practices. We identified CHF, COP and what's the last?

Diabetes.

Diabetes.

Diabetes, yeah. I've been talking about diabetes. Anyway that's why I need my keepers here. But we, you know, we selected the disease processes that are the ones that affect our patients the most and that we felt we could get the biggest bang for the buck

50:00

And then severity indexing the patients, you ask one, I'm giving you two or three. Severity index every one of those patients and then we paid attention to the four, fives and sixes. Our goal is to move the fours to a three, the fives to a four and the sixes to make sure that we're using the most judicious caring of—care that could be delivered because most of these folks are probably all kidding aside hospice patients and working towards end of life care for those sixes. That, you know, severity index to patients and then develop the registries, those are my things.

All right Dr. Schlecht wonderful advice, thank you for that. I have a comment here from Carl and Carl is in Arkansas, he's a care manager in Dr. Andy Class [assumed spelling] and he was wondering if you might be interested in sharing your COPD registry, I guess, template, any spirometry protocols, or any care management protocols around COPD that you might have.

We can, yes. We have—Like I said, we plagiarize as much as we possibly can and we have plagiarized a lot of what Geisinger has done with their COPD. And we can send—

And this.

And we've also—It's called the Global Initiative for Chronic Obstructive Lung Disease. Now, I'm going to have to back track just a bit. We're just now aggressively starting to get into COPD, we chose to do the diabetes and CHF first. Now we're getting into the COPD. But this is—And then we can send—we can send you the information on this Global Initiative for Chronic Obstructive Lung Disease and we can also send you the information from Geisinger. Susan can do that for me.

That would be great Dr. Schlecht. And remember Susan, you can also post those up in the Collaboration website and then people will just have access to those.

OK.

All right.

Just what I like to—I like to say boss everybody around and they do it and I get credit.

OK. All right.

It's a team effort.

It is a team effort. That's the key guys. Team effort in all areas of the process. Anyone else have a question for Dr. Schlecht and his team? With that, we're running out of time, we were going to do an exercise today guys so we walked through the evidence-based medicine, the five Ps of the evidence-

based medicine. Those of you on Arkansas are familiar, I do this often on our webinars, but because time does not allow for us to do that, we only have just a few minutes left. I do just want to showcase this on the screen and tell you that if you do not have evidence-based protocols and a team-based protocol in site right now, these are the thought process that you should go through. So, as you're beginning to develop these and as you're beginning to identify the protocols that you want to begin with, you need to think about why. So what is the process of doing evidence-based medicine? What's the why of it and what's the value? And I think that Dr. Schlecht has done an excellent job today at presenting the value of introducing evidence-based medicine into your workplace. Next, I want you to think about your patient population. Who are these patients that would benefit, granted all of them but is there a certain population that we may need to get in control a little quicker such as your diabetes population as Dr. Schlecht mentioned. Next, systems should be involved in this process. So which professional? As Dr. Schlecht mentioned, it took the entire team, right? So it takes your whole team to make these effective at caring for your patients. And everyone needs to be practicing at the top of their licensure so as you're thinking about the protocols, think about who needs to be involved in the different steps. And then what is the actually workflow looks like. Who's doing what and what's the progression from the nurse to the doctor, from the front office to the care manager, what does that process look like? And then patterns. Are you seeing that you're making a difference? So you've implemented these protocols, what's happening now? Are you able to see patterns? Are you able to see that you're reducing your ambulatory care sensitive condition readmissions? Looking at your quarterly Medicare feedback reports, are you seeing any trending down in the data? Looking at your clinical quality measures, are you seeing any trending down in your A1c? So those patients, they might have not been on control that are now in control. And also, as you're thinking about the protocols, as Dr. Schlecht also introduced, we need to be thinking about how do we just identify these patients? And that's—That begins with the registry. So how do we know who these patients are that need extra intervention and need extra monitoring and care management. We know that by having registries of these patients. So again, because we don't have time, we won't walk through this exercise. But the slides will be posted up on the Collaboration website. The audio recording will be posted up as well. Kym, it takes only about 10 days I believe, but correct me if I'm wrong on that before that's on the Collaboration website and we will make that available to anybody that wants to replay or look at the slides. With that, I'm going to stop talking for a second and let's see if there are any additional questions. This is your last chance guys if you want to ask anything of Dr. Schlecht.

And listen, I'd like to make one more comment. Somebody asked, how do you get the docs to buy off on all this and so on and so forth. One of the things that's very important is try to look for the physician in your area that's your early innovator. The guy that seems to be on the cutting edge of this sort of thing, on most practices, there's always one. And, get that early innovator to buy off on this and then he'll bring the other docs along. So, guess that—

That's a great—That's a great advice Dr. Schlecht. So, if you have someone on staff that maybe a little more excited about this work than the other or maybe willing into looking at his data and seeing his measures, that may be your point person for getting the other docs to come on board. So thank you for that Dr. Schlecht, that was a great point. All right everyone, well thank you so much for attending today.

It's always a pleasure and it was really exciting to have everyone brought together today, Arkansas and Oklahoma. Thank you all for presenting. What you see here on the screen really quickly is some great references to some of the tools that Dr. Schlecht presented today. And also some other things that Laurie Paul found and I will provide for you. So again, this will be posted on the Collaboration website. And with that, I'm going to turn it back over to Kym Patrick and Lori Hooks from TMF to make the final announcement. Thank you all so much for attending today.

Thank you Rachel and thanks Laurie and Dr. Schlecht and Sherry for your valuable information this afternoon. I want to thank everybody for attending and then we hope that you found this presentation very information and have some information you can take back to your practices. You can exit this session by clicking on the File menu option at the top left of your screen and selecting the—