Rapid Cycle Action Group: Leveraging Your Whole Team to Improve Chronic Disease Management, Session 4

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Welcome, everyone, this is Rose Langdon from TMF Health Quality Institute, and welcome to our final Rapid Cycle Action Group live discussion for the group leveraging your whole team to improve chronic disease management. Today's focus will be on sustaining performance. We have several faculty that are going to guide the discussion today, including Kay Lynn Olmsted who will be our facilitator and Emily Glynn, both from TMF. We'll also hear from Rachel Blackburn from Providence Medical Group at Providence St. Vincent in Oregon. Pete Atkinson from SAMA Healthcare in Arkansas, and Amanda Flores and Dr. Brent Laughlin from St. John Clinic in Oklahoma. We do have a great session planned for today, but I'd like to make a few announcements before we get started. First of all, thank you to each and every one of you who put time and effort into preparing for today's session. As a reminder, 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 the statement only and is not an opinion or endorsement of the Center for Medicare and Medicaid Innovation, TMF Health Quality Institute or the host of this presentation. This is your live discussion, and we want you to be as interactive as you can possibly be. So there are several ways that you can join in the conversation. First of all, above your name in the right-hand panel you'll see the Chat icon, click on that icon to open the Chat box, then double check that the send to box is set to all participants so that everyone on this webinar can join in the conversation with you. Below the Chat box you will also see that near your name, you can raise your hand to speak verbally and we encourage you to do that to join in the conversation. And now I'm going to ask you to get out your annotation arrow and indicate to us where you are joining from today. If you cannot see your arrow, there's a marker at the top left, click on that and then click on the black arrow. You guys have this down to an art and a science and it looks like we're represented by pretty much every region, which is wonderful. Excellent. All right, we have a good group today. And now still using the annotation arrow we'd like to know what your role is in the practice. This helps us understand who's out there that we're talking with and we can work with you on that. Kay Lynn, I'm seeing that we have some physicians, nurses, a good number of care managers and care coordinators, but then a blend across the entire team.

I think this is so wonderful Rose, we have so many people on board with us today and I'm excited that we're going to be able to reach out to them and include them in our discussions and the learning process that we've been going through. So welcome everybody.

And I do see some people have clicked into Other, if you could share with us in the Chat what your role is in the practice that helps Kay Lynn and I understand also that we want to make sure that we're attending to your needs as well. And now what I'd like to do is pass the microphone over to Kay Lynn to begin the discussion. Kay Lynn.

Thank you, Rose. We need to advance to the next slide, thank you. So in today's discussion we're going to be able to look backwards to our four weeks of process measured data and describe how the tracking worked. We're going to look at areas that weren't working quite as planned and troubleshoot new approaches. We'll have the opportunity today to share success stories and novel ideas. We'll be able to identify workflow areas for autonomy or automation, select measures for inclusion into practice dashboard, and develop a solid plan for sustainment of effort. I am so pleased that we are joined today by this fine group of panelists that will take us through this process and these discussion points. So let's take a look back over the past few weeks. Let's consider the things that we have found satisfying about this rapid change process. So once again using your annotation arrow try aiming for the circle rather than the pink arrow, indicate what you have found to be the most satisfying of this rapid cycle process, leveraging the whole team. Take a look here and consider is it working as a team, the communication, getting reenergized, making a positive difference in patient care, actually getting through PDSA which can be a challenge or if you select other, chat in what your response might be. Rose, I can see from the response that it's been satisfying to a lot of folks that making a positive difference in patient care has been an outcome.

I can see that as well and I'd love to hear from some of the people in the audience as to what was your story, why did you find the satisfying and how did it impact your team. Either chat in or please raise your hand, we'd love to have you join in the conversation.

And by all means continue sending us those chats and that type of thing, but we'll let Kay Lynn continue.

Thank you so much for your response to that. Let's go and look at the challenges. So what has presented a challenge for you in our rapid cycle action group? Has it even been getting started, the communication in the team, the rapid pace at which we moved, measuring the process, that identifying what data to look at and how to measure it or perhaps it was something else that you found challenging. And if so, please feel free to chat in what that would be.

Kay Lynn, I'm seeing that the rapid pace has been a challenge for a number of people, as well as some other things, just getting started sometimes. Again, I would love to hear from the people on that are responding and let us know a little bit more about those challenges and how you're dealing with them or what you might need help with.

My experience has been when doing PDSA that identifying what processes to measure is definitely a challenge and then when you get the data how to manage it. What gives you the best evaluation or interpretation of those numbers? The other thing I found about working with data is that there are people behind those numbers and sometimes it's like well, you know, maybe we're not doing our job or maybe this person is doing this or not so well. So having the respect for the people that have formed the data, which is probably not exactly where you all are thinking, but that's one of the things that has

meant something to me in working with data. The rapid pace definitely can be a challenge. We have our plate full and to add more change on top of it can sometimes be a real reality check on how much we can do. And, of course, getting started, knowing where to start, how to figure out what process to go with and getting the whole team together. Team communication, we're all busy, everybody goes in different directions. So I want to thank you all for identifying your challenges. If we have time we'll come back to the satisfiers and the challenges, but at this time I would like to invite one of our panelists here to talk about her experience. So allow me to introduce to you Rachel Blackburn. Rachel, let me turn this over to you and you can tell us about yourself and we'll talk about your process.

Great, thanks so much, Kay Lynn. Well, I'm Rachel, I am over here at Providence Medical Group at Providence St. Vincent. Our clinic is an internal medicine residency clinic. We are a medical home, we're located over here in Portland, Oregon. You can kind of see the makeup of our clinic there, I won't go into too much detail. Can I get the next slide please? So the challenge, I mean CPC is all about innovation right and so really have tried to take this to heart. We wanted to find a way to engage the whole clinic in chronic disease management and preventative health or population health management and that was quite the challenge for us.

10:05

We want to improve our patients' health, we want to improve our clinic quality metrics, but primarily we focus on the impact to our patient. Next slide please. So what have we done previously? Epic is our EHR, electronic health record, it has a couple of things built in that assisted with the preventative care and chronic disease management side of things. Care manager will pull patients up by either disease process or by preventative care and it'll tell us hey they're due for a lipid panel or they're due for a blood pressure check. Best practice advisory they're also built into the system, those ring up what the patient or in the moment in the room which is nice, but it doesn't tell you how to go about getting those done, what buttons to click and what orders to put in and things like that. So something else we did was team by team competition focusing on one quality measure. That was good, it's just that we discovered that we have one very competitive team and another team that the quality metrics were not their focus and then a couple of teams that were somewhere in the middle. So it felt like we didn't accomplish the bigger picture, I guess you could say, as much as we had wanted to. When we went to medical home a couple of years ago we got a clinical care coordinator for each team and a clinical care coordinator is a high functioning MA who's kind of a hub of the team, but it was left up to us to determine what they were going to do it and how they were going to do it. And so what the clinical care coordinators wound up doing was a lot of phone work and desktop work and just kind of picking up where they needed to fill in, it wasn't so much about preventing fires, it was more about putting out fires. Can I get the next slide please? So how did we change? Earlier this we completely revamped our entire clinical care coordinator role, we want them to focus on population health and chronic disease management. So we took them off the phones, we took them off desktop and we implemented a role that basically has four parts to it, all of which focus on population health chronic disease management, preventing readmissions that sort of thing. We also as part of that instituted and in-depth chart scrub and our deck of cards which is what I'm going to share with you guys today. So our chart scrub, the clinical care coordinator goes in and pulls

from the medical record, they pull from the alert immunization registry, which is our state immunization registry and then we also because we're a residency clinic we have ongoing QI projects with our residents and some of them involve the clinic. So they'll pull patients off of those lists as well and note that in their scrub. They review the last office visit to determine what was ordered, did it get done, did the patient have that done, and did we get any specialist notes and records that we need for anything that was ordered at the last visit. The nice thing about the scrub is that they mark items for both MAs, as well as the providers, so it's something that involves everybody on the team which has been really great to see the teamwork kind of solidify and gel. And then one other interesting thing to note when we started this it wasn't necessarily in a checkbox format, but we got feedback from our docs that said, you know, it would be a lot easier if we just had Xs and boxes and took a look at it quickly. So this is the scrub, we drop it in as a smart phrase in EPIC, and you can see I mean there's a lot of things on here. What the CCCs will do is they mark if it's needed and they delete the lines that are not needed. So you wind up with this pretty one page chart scrub that actually doesn't have a whole lot of things on it. And as time has gone on we're seeing that there are fewer and fewer things being put on it, which is nice. So as part of the scrub we then have the deck of cards. So our deck of cards are ways for–they're basically reminders, reminders for the staff and the providers about what the patient needs and then how to do it. So all the disciplines in our clinic contribute to this development. We had physicians, our pharmacist, behaviorists, diabetic educator, our MAs contributed, our clinical care coordinators helped a lot. It was something that the whole team got behind. So the nice thing about them is that they're easily changed and updated. Sometimes people ask and say, you know, isn't this duplication of what you already have in the EHR. It is yes, but I feel like it fills a gap that was missing before because when the teams huddle in the morning they might talk about what the patients that are coming in that day are due for, but it's really hard to remember that when you're in the midst of a busy clinic day and in the room with a patient. So it's something that just is a cue. I was talking to one of our faculty providers last week I was rounding with her and she said, you know, it really helps because it focuses her on what actually has to be done. She looks at the cards, she decides what she can do, she can do as much or as little as she wants in the visit and then from there she knows that if she doesn't get it done at this is that it will reappear at the next visit. But she has faith in the system that at some point this is going to get done and she doesn't feel the pressure that everything has to be done right in this moment. So the cards are easily changed and updated. We are part of a system that spans five states and trying to get anything changed in our electronic health record has to be approved by five states, which kind of requires an act of Congress. So it's a lot easier to change things on the clinic level, also as best practices changes we can update the card immediately so that we are staying current and up-to-date on that. I talked about it being flexible, I talked about it reducing kind of the noise of I've got to remember what all I've got to do for this patient. It gives instructions, so kind of a funny story, when we've highlighted this on one of our teams we told the faculty doctors what we were doing, one of them was our medical director and he was part of the project putting this all together so he was very familiar with it. We purposely did not tell our residents what we were doing. All of a sudden these cards started appearing on their screen and the residents without missing a beat were able to just pick up and do what needed to be done. There were a couple of questions about it, but by and large it was so self-explanatory that they just knew what needed to be done. The other benefit to it is that it gives the MAs and the providers another way to communicate. We are finding that, you know, we piloted this project on one team and the MAs on that

team said, can we just have a blank note card because that would allow us if we're missing the doctor in between room and patient to give them the information that the patient wants them to be here and that part has worked really well. Can you go to the next slide please? So this is what the deck of cards looks like, that's Nicola, she's one of our clinical care coordinators, she's fabulous. The cards are little, they're laminated, they have hey they're due for [inaudible] greater than nine. It shows the doctor on there, please talk to the patient about it. You could consider consulting another team member to help you with this is if you're running out of time or if you would just like to do that. And then it gives them a little bit of information about what's covered for patients, which is a constant question we're getting, especially because we're a residency clinic. Next slide please. This is the way the system works. So we have technically two sets of cards, one is the clinical care coordinator set that they use for a chart scrub and that's got all the stuff that they find in the system. The other set sits on the keyboard tray right there you can see it on the top left and those cards are ones that are like patient requires tobacco cessation counseling, hey they're blood pressure is high, they declined to be weighed, things like that that might be more useful to MA in the room. So the MA goes into the room with the chart scrub, they finish their rooming, they put up the cards across the top of the computer monitor so that they have to be physically moved in order to get at the screen. We did that on purpose because we were hearing from our doctors that our MAs and CCCs would leave care manager up on the screen when they exited the room, they would secure out, and then that would pop up for the doctors when they came into the room and they'd immediately click out of it. So this way they actually have to move it in order to get at the screen, it's something that–it's a physical reminder. The doctors can decide to do as many or as few of these cards in a visit as they want. We understand the patient comes in for a 20 minute appointment and they've got four things they want to talk about, you may not have time to get it. But if they have time to do say a flu vaccine or a Prevnar or, you know, something small, then they can take care of that one thing. They put it in the completed QM card, little envelope there, that hangs on the keyboard tray when they're done and they flip the ones up on the screen that they're not going to be able to get to, which is kind of a visual cue to the MA to say hey, I didn't get to all of it, but let's get them in for another appointment, and we can work some more on this. Next slide please. We also have our data board that I review with the clinical care coordinators monthly. We really like this, I actually took this idea from Dr. [inaudible] practice article that we were talking about a year or maybe two years ago over at our in-person session here in Oregon. So we put this data up for everybody to see and then once a month I stand at the board with the clinical care coordinators and we review how we're doing. The bonus to this is that our clinical care coordinators really see the numbers demonstrating that they are making an impact on our patients' lives. They're watching our numbers climb and that's such a huge satisfier for them. It also increases their awareness, it's not something that's like oh there's this ambiguous number thing out there that I have to do, it's concrete and right there in front of them. Next slide please. So impact, what impact has this made? You know, our providers were frustrated when they see the ever-growing list of boxes to check, every entity has its own quality metric right and it's so hard to focus down to what those are because there are so many of them.

20:10

These cards allow our doctors to focus on just what needs to be done in this moment. The majority of doctors in our practice really love these because it simplifies things for them. There are one or two that feel very overwhelmed and they've given me that feedback and I can appreciate that, I mean it's a lot of things coming up, and if you've got a busy clinic schedule and a busy day and the patient is asking a lot of questions, you know, it would be easy to be overwhelmed by that. The clinical care coordinators, like I mentioned earlier, are seeing a decrease in items coming up on their chart scrubs. We started this process in March, and, since then, they are saying by and large lots of these items are getting taken care of, which is really great to see because we know that that's going to make a positive impact on our patient health. Their job satisfaction is also way up, they are so proud to be working directly with the patients making a huge impact on their health and wellness. I love that our whole team participates. We are always talking about these, I'm always rounding with the different members of the team and say how's it going, what do you think, is there a suggestion you have for this. And then an interesting kind of sidebar thing that happened was that the Department of Medicine is encouraging the residents to do QI projects within the clinic now because they're seeing that we care so much about our patient's health and wellness and also the data end of it. Next slide please. So what did it do to our data? I just pulled numbers from right before we started the scrub and then current and then the one in June was just the first one we had for that particular measure, but you can see that our numbers are climbing. Our readmissions are also trending slightly down, which has been really exciting to see. And then our transitions of care management coding is the highest in all of TMG Oregon. We have a card that specifically is saying to the doctors this is a hospital follow-up visit, don't forget your TCM code. So that's been really exciting to see that impact. Next slide please. Lessons learned, make sure your data is solid so you can reliably track changes. It's really hard when you don't have solid data to feel the impact of what you're doing and then it feels almost like whatever you're doing is a little bit futile. If you have solid data, then you can really back what you're doing. Consider the other team members, when we made this change to have the clinical care coordinators go off of the phones and off of the desktop that made a huge impact on the medical assistants and patient relations representatives. The PRRs do kind of an admin assistant role in our clinic and it was hard for them, so we had to take into consideration, you know, how much are we asking them to do, is it too much, what support are we providing them. It's important to recognize no one technique works for everybody, that's how we kind of sold this this program to our practice is you can do as much or as little of it is you want, you can tweak it how you need to just so long as it works for your team and helps you accomplish the end goal. It's really important to keep communication going. We are constantly talking to everybody about how this is going, what can we change, is there something we can do better, what's working well. And then we're following up always with everybody. The other piece in all of this is that we really had to build an extensive training program for our clinical care coordinators as part of this. I provided a lot of didactic education to them about disease processes and things like that, so that they would know why they were doing what they were doing and they got a lot of satisfaction out of that too and have reported that they feel much more confident in their role because of that. Next slide. So how are we doing today? Everything QM card wise is fully integrated into the clinic. We have been up and running on that fully since August, but our cards were presented to other CPC clinics, we have 13 TMG clinics that I presented to and they're welcome to use those, some have implemented them, some partially, some fully. And

then over the next couple of weeks I'm going to be presenting this program to the rest of the clinics within Providence Medical Group and they can use it if they choose. We're constantly adding to the cards and tweaking them. I added a new one last week, it's kind of by request that we do that. And then we continue to follow up with everybody to ensure that the cards are used optimally. I was [inaudible] everybody saying how is it going specifically with the cards in the room, what's working, what's not and we're always monitoring the data to watch for trends. If we can make another impact somewhere, we're going to try. So that's pretty much it.

Thank you, Rachel. There is a question from the audience, how many critical care coordinators are in your practice?

We have four, one for each team.

Thank you, any other questions or comments for Rachel? Please feel free to raise your hand or chat. Let me just comment this, Rachel, I am so pleased with your process what you did instead of just tackling one disease process you tackled the whole entirety of chronic disease management and you came up with a process that worked. And measuring the data to show the impact of it clearly demonstrates that what you were doing was working. And regarding sustainability, since that's part of our focus, it sounds to me like you are still using communication, your frequent touches with the team, communication and the tweaking.

Yes, we're constantly talking. The card it's interesting because we've had–when I started I started with a much smaller batch of cards then what I have now and it's grown over time because as I talk to people they'll say what about this, what about that and we just keep adding.

Yeah, that's great. There's another question for you from the audience, what was provider involvement like for the development of this project?

So our medical director is very interested in the quality metric side of things, he actually has a quality clinic here for Providence Medical Group, so he was highly involved. And then as we piloted this, we piloted on one team. So that was two faculty physicians and six resident physicians and we got all of their feedback. And it was interesting because as other teams residents swung over to that team for a little bit they'd be like well can I use the cards, where are my cards, can I have cards. So we kept getting feedback from them, their feedback was also how the format of the chart scrub itself was done, the visual aspect of it. And then I also touched bases with another provider on the team that we do rounds on patients with basically high doses of pain medication and she's the champion for that and so she asked if we could develop a card for that as well and we went ahead and did that.

Very good, excellent. So Rachel, thank you so much. At this time I'd like to move on to our next presenter and I'm going to turn this over to Emily Glynn. Emily, would you like to introduce our next speakers.

Sure, sure I'd be happy to. We have Dr. Brent Laughlin and Amanda Flores with St. John Clinic in Tulsa, Oklahoma. I did want to mention that before we jump into their presentation and do kind of a question-

and-answer with them, they do have quite a few workflows that they've created regarding the processes that we're going to talk about and Amanda is going to be posting those to CPC Connect later today or tomorrow. So thank you very much, welcome Dr. Loughlin and Amanda.

Hi.

Hi.

Hello. Okay, Kay Lynn, if you'd advance the slide. So you are working on heart failure, reducing heart failure admissions and COPD admissions. What made you start with these two particular ambulatory sensitive conditions?

Well, unfortunately we saw that our numbers of readmissions were somewhat high, higher than we wanted certainly, so we decided to tackle these. Also these patients are patients who are getting severely and acutely ill, so from a quality-of-life standpoint we wanted to focus on things where we thought we could have the most impact and these were the two we selected.

Sure, so we're really curious in how you developed your plan, who you included in on working on coming up with these workflows and protocols.

Well, so we had a care manager who has since left to take another position and she championed this for both entities and developed similar patient packets, information for the patient and for that staff that we would provide. She did an extensive amount of background research in both conditions looking up a lot of American Heart Association and Lung Association data, Thoracic Association data, consensus recommendation, extensive evidence research and came up with this program. And then at same time the accountable Care Organization at our facility was developing their own program, so we have sort of blended the work she did with their work to come up with our plan that we're using. After she developed the plan we had taken it multiple times to our own all clinic CPC meetings and discussed it, tweaked it, physicians and Pas have looked it over and given their input and so this final plan is really been vetted quite a bit, we feel good about it.

30:02

Great, can you describe your all clinic meeting a little bit, who attends that, what kind of happens in those meetings?

On the all clinic meetings and all of the staff and the physician and physicians' assistants and they do join as well. And we also have a small group meeting–we have two one-hour meetings a week. On small groups, sometimes we break up into what we call committees, and we have an agenda set up for each of those committees to work on certain particular things.

Gotcha, gotcha! Okay, so we're looking at a slide on heart failure. So tell us about the measurement that you guys are doing within your process and your project.

We felt that it was important for us to make sure that the diagnosis that were in our patient registry were accurate, so we went forward and tried to start, but then we had to kind of go back and step in and look to have our medical assistants kind of go through our registry and verify that there's a diagnosis. So our physicians met and we kind of all agreed on certain criteria and looked at the data that we have in the past on the readmissions and came up with what we thought we needed to start with, which was just to make sure that those patients that are on that registry actually do have a valid diagnosis.

Okay, who's managing that registry for you, you mentioned the medical assistants are validating if the diagnosis is correct, but who's kind of spearheading managing that spreadsheet or the registry?

Our care managers.

Gotcha okay.

I was going to say too on heart failure, our previous registry before we changed our current EMR was quite good at giving us the information and allowing us to keep track of it, keeping track of echoes and diagnostic criteria. We had a lot less certainty about our COPD patients, so the validation of that diagnosis has proven to be more difficult. We're having to do a lot more spirometry testing and things to bring our sales into a place where we feel comfortable knowing just for sure who we're treating. So we're less far down the road on COPD than we are on heart failure.

Gotcha, well let's talk about the COPD a little bit more. Yes, thank Kay Lynn. So you kind of decided to tackle both of these at the same time. Is there a reason why you chose to tackle both heart failure and COPD rather than, you know, focusing on heart for a while and then including COPD in?

Well, we felt pretty comfortable already with heart failure. COPD is a big push now in our organization here at St. John and the process is extremely similar. So we felt like the care managers could help us with both of them because they're using a similar process with similar packets and so once we got the process down the workflow and the work of doing it, I don't think it's going to be that difficult for us.

Okay, and it looks like with your COPD process you have almost the entire clinic participating in this process. Can you describe a little bit what it is that you're doing in regards to validating the diagnosis and that sort of thing?

Yes, in our small group meetings that we meet in the committees each team works on their physicians' registry work list that we were talking about. The medical assistants go through the chart and see if the diagnosis is valid based on the criteria that our providers have set up. At that point if they can't see that it's valid, then that message goes to a physician assistant for them to review. At that time that physician assistant looks at the PFT results if they're in the chart, they look at the PFT and determine if by reading that if it's actually accurate or not. At that point they either send a message to the medical assistant or the PCP of the patient to find out what the next step should be to have it done.

Yeah, anybody that says COPD in the chart that we think it's reasonably accurate, but no spirometry, that's the next step is to order spirometry and then we're using the goal criteria which is going to be

system-wide not just even St. John Clinic, but also the ACO. We are using that help validate the patients and so everyone will get a spirometry or they won't have the diagnosis on the chart.

Great.

This is Kay Lynn, I'd like to jump in just for a minute. I am so impressed with the actions that you all have taken because it looks to me like you've involved an entire team from the patient on the way through to the providers and others to make this happen. How's the communication been amongst the team?

I think good, as we said we have meetings twice a week, we break down into sometimes provider only meetings to kind of all of those medical assistants. As you know, in a smaller meeting people are more likely to speak out. So by breaking into the small groups we do get comment and input from everybody. But, you know, that's the big thing isn't it about CPC and I'll be speaking to this a little bit tomorrow at the face-to-face is that we're just meeting and we're discussing and we're involving and we don't let everybody sit around and not participate and it's made, you know, that's one of the big differences that we've identified.

So the group process itself keeps the momentum going and keeps the engagement it sounds like.

Yes, and you know our meetings believe it or not fun and engaging and informative and I think most of the time people come out of our meetings and they are really glad they went and just thought of it is as one other thing that they had to do today. So we get a lot of good out of it no doubt it.

Great, well I wanted to open it up to all of the participants to see if anyone had any questions for Dr. Laughlin and Amanda regarding either their team process and how they've created an entire clinic that works on something together or specifically their workflows. Does anyone have any questions to chat in or raise your hand and we can call on you.

Okay, Dr. Laughlin or Amanda do you have any kind of final comments like maybe tell us what your next steps are with your COPD and heart failure workflows.

Well, we're putting in these action plans and so every patient that has a validated diagnosis will have an action plan for them to have at home on the refrigerator, in their purse or pocket, so they can become familiar with the steps they can take on their own to help prevent a crisis from occurring. And so our goal is to improve their quality of life by preventing ER visits, exacerbations of their disease and certainly hospitalization. And we're were early in the process, we can't really give you the numbers yet, but we're going to be closely monitoring it on a monthly basis and in maybe three or four we can make another report.

That would be great, thank you, Dr. Laughlin.

And, Dr. Laughlin this is Rose Langdon, on that action plan that you were just talking about, who has input into that, is that done jointly with the patient?

Yeah, so it's–I don't know if you all can see this or not I thought we had a slide, but it's stay in the zone, green, yellow and red zone. So this just information for the patient on one side of each of the two action plans. On the other side the care manager is going to have a small educational session with each of these patients, gone over the plan with them individually and then they will be including certain steps and specific functions for each patient. So it will be a one-on-one with the care manager. For example for CHF what's your dry weight, how much weight if you gain so much in a day do you need to do something or call us and then on COPD, excuse me, likewise will be what steps would be taken or need to be taken to decide about starting the nebulizer. Some of us are going to adopt medicine packs so the patient may have a few dosages of prednisone or an antibiotic to take depending on symptoms before they could get into the office. And so they'll go over that with them one-on-one and then the medical assistants will be reinforcing that at each of visit, each of these patients that has that diagnosis.

That's wonderful, thank you for describing that.

You're welcome.

Thank you, Amanda, Dr. Laughlin, that was wonderful, excellent. I'd like to move us forward and at this time, please allow me to introduce our next speaker, Pete Atkinson. Pete let me turn this over to you and tell us about SAMA Healthcare and what you've done.

40:01

Well, earlier a lot of people notated that rapid change was an issue that definitely is our pace. When we started CPC we had six providers, four physicians, two nurse practitioners, 18 months later we doubled in size. So it was a lot of rapid growth and a lot of it was around care management and identifying areas that we needed additional help. We're located in South Arkansas in the town of El Dorado. Our population in town is 18,000, the county has 45,000 and our patient population is right at 18,000 as well.

Pete, your team identified a gap in care that was the foot exam for the patient with diabetes. You felt like you all were doing it, but your clinical quality measures said otherwise. And you questioned a few things: documentation, performance, and what did you learn?

Well, when we were going through the initial CPC reports, this jumped out at us because again the numbers said that we were only doing 6 percent, only 6 percent of the diabetics were actually getting an annual foot exam. We found out that that was the numbers we've seen that was actually the national average, and we don't like the average and we also felt like this was an easy one that we should be doing a lot better. So like you said, the first question was this being done and not documented, or were we putting it in the wrong place in the EMR, so that you know when we ran our reports it wasn't reported. Then again, you know, were we not doing them at all. So the first thing we did is we talked to the staff, educated the providers about documentation, we contacted our EMR vendor, which is Allscripts, and we did find out that several people were actually documenting in the wrong place in the EMR. So it was not being picked up by our report. Modified our EMR, customized it so that that wasn't an option and again educated everybody. And then the next thing that we did was for our process for those that weren't being done at all. You know, you talk about involving the whole team, our approach

to this is we also do a chart scrub looking at a lot of different things and diabetics are one of those. And the foot exam is one of those gaps of care that we look at. So our care coordinators, we also have one for every team. They're looking at the patients ahead of time that are going to be coming in and looking for those gaps of care. If the care coordinator sees that they've not had a diabetic foot exam, they notate it in the chart, not like the deck of cards we actually use the EMR to do those notifications. So the care coordinators makes that note in the EMR, then when the patient comes in the nurse that actually is pulling them sees that note through the triage process and when they get them to the room that nurse will ask the patient to remove their socks and their shoes. And then what that is, is a visual cue for the provider when they walk in the room. So that was one of the things we came up with, it was pretty easy to do a foot exam if they were coming in a visit that was diabetic related, but what if a diabetic comes in for, you know, cough and cold symptoms, and they've not had a foot exam. So what this does is if the provider walks in the regardless of why they're there if they see that they don't have any shoes and socks on, that's their visual cue that they need to go ahead and do that foot exam and get that documented.

So Pete, what have you seen since you started your workflow process change?

Well, immediate improvement. Again, a lot of it was being done but not documented or not documented correctly. So we immediately saw the numbers go up. I ran the numbers yesterday, and we actually think there's another problem, it seems like every time we fix something else happens with our reporting. My best team is about 65, 70 percent; my worst team is about 45 percent. So again, it's a constant, you know, having to re-educate, whether it's being new nurses, new care coordinators, but we're doing a lot better than we were. I think across the board, we're looking at about 50 to 55 percent. We still don't think that that's acceptable, we feel like this is one that we should be in the 90 plus range.

Yes, but let me also remind everyone that the national average for this measurement is 6 percent, and you have teams running at 45 percent or higher, so that works. How do you keep your teams motivated?

Our biggest thing is we're owned by four doctors, we're not part of a university or anything like that, so competition is steep amongst the different teams. So that's been the best motivator for us. We actually– my health informatics person sent out an email this morning with several different quality measures, one of which was this, and I can promise that whoever was the lowest on that list will step it up because that's not the place that you want to be.

Yes, so what words of recommendation do you have that have worked for sustainability of change within your practice?

I think the first thing is it's nice to hear the physicians participate today. The first thing is getting physician buy-in. Unfortunately, that's not always the case, and I've not had that problem, my physicians have bought in from the very beginning, so that's the first thing. And like the slide says, it's an office-wide culture of change. It was a big shock to start with, but we had several staff meetings, our new employees understand that this is the SAMA way now, and again, it's just changing the whole culture with the staff. And now we're focusing on the patients because preventive care and things like this are

still foreign to a lot of people. So we're having to educate now like I said, it's taken time, but we're seeing progress all the time.

Great, Pete, someone in the audience was wondering where you located the national average for this quality measure. Do you recall where you might've gathered that information?

I do not, I can go back. I believe that we got that actually from one of our CPC calls back in the very beginning of the process. But I can do a little bit of digging.

Thank you, thank you for that. Pete, your group has done an amazing job with the diabetic foot exam, and it sounds like you've used this process for other quality measures, is that true?

Yes.

And the difference is you followed the data, have you developed dashboards for your providers?

We have not, we've talked about that with Allscripts. Not actual dashboards per se, we do have the data boards like some of the others. And kind of our approach has been attacking the low hanging fruit. So like the foot exams, I know the national average is 6 percent, we think we can be again 90 percent we believe is our goal. So we're tackling those. We've also–one unique thing about us compared to some other clinics, we were open seven days a week prior to CPC and we are also open extended hours. So there's some things that we were already doing well and we're just focusing on getting better like hospital readmissions and ER visits.

Thank you. One of the things Pete that we did not talk about is how your teams actually look. Could you address how they look and how they work with the patients, what you did culturally to change teamwork?

Sure, when we first started each physician had two nurses, each nurse practitioner had one, and they pretty much work independently under one roof. One of the biggest complaints we had in the very beginning was the lack of continuity of care because if someone called and had an acute issue they would call in and they had basically a 25 percent chance of seeing their doctor because we had like a lot of clinics. We had an on-call doc who handled the majority of those acute visits. And I know continuity of care has been a topic this year, but we actually put that the very front, that was the first thing that we looked at was continuity of care. How do we keep it sufficient, you know, with their position, with the concept, but with the realization that the physicians have a day off they go on vacation, they you know do all of these things. So our model is we have a physician and a nurse practitioner that are paired up, they share a patient panel. Inside that team we have three nurses, one pulls for the doctor, one pulls for the nurse practitioner, and one works the phone and those three rotate every single week. And I could probably talk a long time about that, but basically we wanted every nurse on each team to understand what each provider wanted and also how to work the phones. And then we also have a care coordinator on each team and that care coordinator for us is also an LPN. So they actually provide backup if we are short a nurse on that team. So again all focusing on continuity of care, trying to keep the same core

group of people dealing with the same patient panel. So again, a doctor, a nurse practitioner, three nurses and a care coordinator on one team providing coverage for one patient panel.

Thank you. I like that approach, I like the fact that patients identify with the entire team. I'm sure they feel well cared for with many looking out for them. Any questions that you all might have for Pete?

Pete, one question has come in, do you have nurses or medical assistants?

We're using LPNs, there are not a lot of MAs in the state of Arkansas; we use LPNs.

50:01

Thank you. So for doctors and for –, I can't even speak, I'm sorry. So you have four doctors and four care coordinators?

We actually have five doctors now I'm sorry, when we doubled we added another physician. So we have five doctors, we have five team and we actually have seven nurse practitioners. One thing I did not talk about is we have specialty nurse practitioners to help with some other things. I have an adult nurse practitioner who is a certified diabetic educator and she basically works for all the teams doing diabetic education, then she also does some other things. And then we also brought in a pediatric nurse practitioner that works for all teams because we realized with the addition of all these preventative services that we needed those same-day visits and children was the one area that we needed some help with on that, so she fills that gap.

Excellent, excellent. Thank you so much for joining us, Pete, I very much appreciate it.

Let me move, thank you. So let me move us on just a little bit I wanted to highlight something as we're closing in on the ending of our action group today. Posted on CPC Connect within our action group is a PowerPoint presentation that Christie Brownfield posted having to do with the practice, Harrison Family Practice and what they have done with this rapid cycle action group. And I'm going to just invite you all to take a look at it, it's excellent. You can see that with their current state they measured their aspirin therapy, their antithrombotic therapy at 70 percent. After their first workflow process change they increased to 73 percent. They tweaked their process and ended up at 91 percent. So quite the story of success and using the PDSA process. I wanted to point out two things after they did that is they had a successful workflow and they're going to continue it, so that's their sustainability. The same sort of thing that we've heard from others is as they've made change it worked and they will continue to use it, and they want to replicate this same thing perhaps for other conditions. This also addresses what Amanda Flores and Dr. Laughlin said, it's working for heart failure and for COPD. So building success upon success, if the process works you can continue to use it and refine it. One thing we've learned over the course of our action group is just putting a group of highly trained people together around the table or in a patient care environment does not make a functioning health care team. Just as putting 11 highly trained athletes on a field does not make a winning football team. Communication was brought up, working together, the small group setting, and I like what Dr. Laughlin said, having fun with it, working together and enjoying that time. So some factors to consider for sustainability of our change processes

is the culture of our organization or practice, having confidence in our team members that they are doing the job they're doing, quality measures, knowing what we want to measure and how to measure it, making change a part of the culture and then always that patient experience, having positive patient experience and feedback does make a difference. And we saw that from the very beginning when we looked at what was one of the satisfiers and making a difference in patient care lead that. So I want to thank everyone for their participation today, and I'm going to open it up for questions, and, Rose, do you have some more comments.

I was just going to say thank you, Kay Lynn, thank you for posting that link in the Chat to direct us to the HEDIS measures, which is of course one group of measures that can be used as you're working through things in your practice. Have you found in the past that that was very helpful for you?

I also use a number of government websites, I like to go to the CDC. I use Medline Plus.gov, National Institutes of Health, Google is my best friend so. What I want to know I will Google it and then from there select the government-based websites for the most up-to-date information.

Wonderful. I wonder if anybody else on our panel has any other suggestions on where to go for baseline measures.

Let me offer this, Rose, I will post some of my recommendations in CPC Connect, I'll put it into our action group and so people can look there later on this week and hopefully I will have a list of great websites to go to for specific measures.

Very good, I want to mention that earlier someone requested the stay in the zone packets and that Amanda and Dr. Laughlin did respond that they will get those up on CPC Connect so that you have those.

So from our participants, our audience any questions, comments, would you care to share your process that you've gone through over the past few weeks? You may raise your hand or chat in.

56:10

Okay thank you, Rose, I'm turning it over to you.

Thank you so much, this has been an awesome group to take part in and it will continue on CPC Connect. So don't hesitate to continue posting your questions, your suggestions, everything that you can think about on CPC Connect. Everyone now should have the ability to participate and we ask that if you can personalize your page with a picture, you can select the preferences as far as notification and also join groups. We do have the new groups that will start in November, you may start registering for those now and I have posted a link for you so that you can look at what's available and the descriptions for those are located on CPC Connect. And now to wrap everything up I want to remind you that all attendees should complete the survey that is going to appear when you close out. I know that some people have had a hard time where because of a pop-up blocker or whatever it blocks that from happening, so I did post a link in the Chat that you can copy and put into your browser if the post-event

form does not appear right away. I want to thank you for attending today and we want to see you again on CPC Connect and when you complete this form before you log out entirely make sure you complete it fully and go all the way to the bottom to hit submit and you should receive a message that says that your feedback has been received. Again, thank you and we'll see you on CPC Connect.