CPC
Comprehensive Primary Care

Leveraging Your Whole Team to Improve Chronic Disease Management

October 14, 2015

Sustaining Performance

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- **Facilitator:** Kay Lynn Olmsted, DNP, APRN (TMF)
- **Moderator:** Rose Langdon, MBA, RN, CPHQ (TMF)
- **Panelists:**
  - Rachel Blackburn, MA, CRRN (Providence Medical Group at Providence St. Vincent, Oregon)
  - Pete Atkinson, MHA (SAMA Healthcare, Arkansas)
  - Amanda Flores (St. John Clinic, Oklahoma)
  - Brent Laughlin, MD (St. John Clinic, Oklahoma)
  - Emily Glynn (TMF)

Participation Pointers

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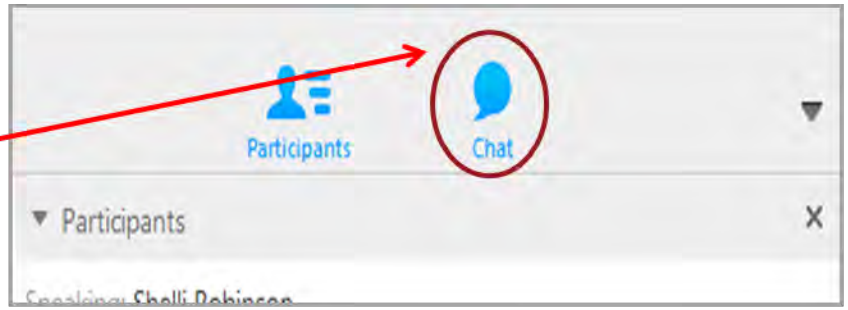
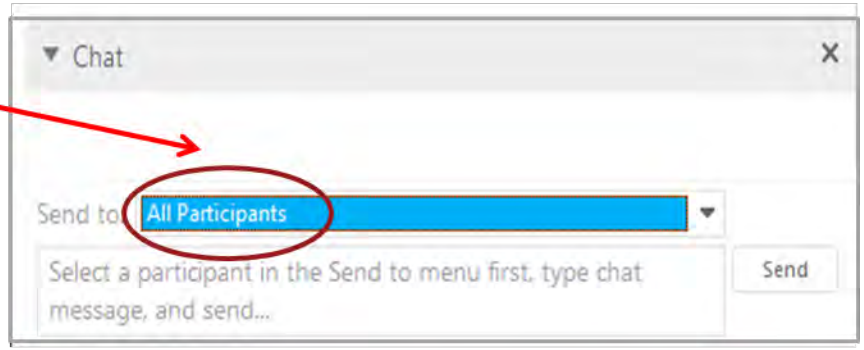
Active Learning Tips:

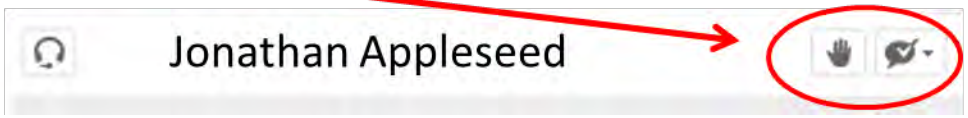
- Please open your Chat



- Set the "Send to" to **All Participants**



- Raise your hand to share verbally



Click the arrow on the annotation toolbar, then point to your location.

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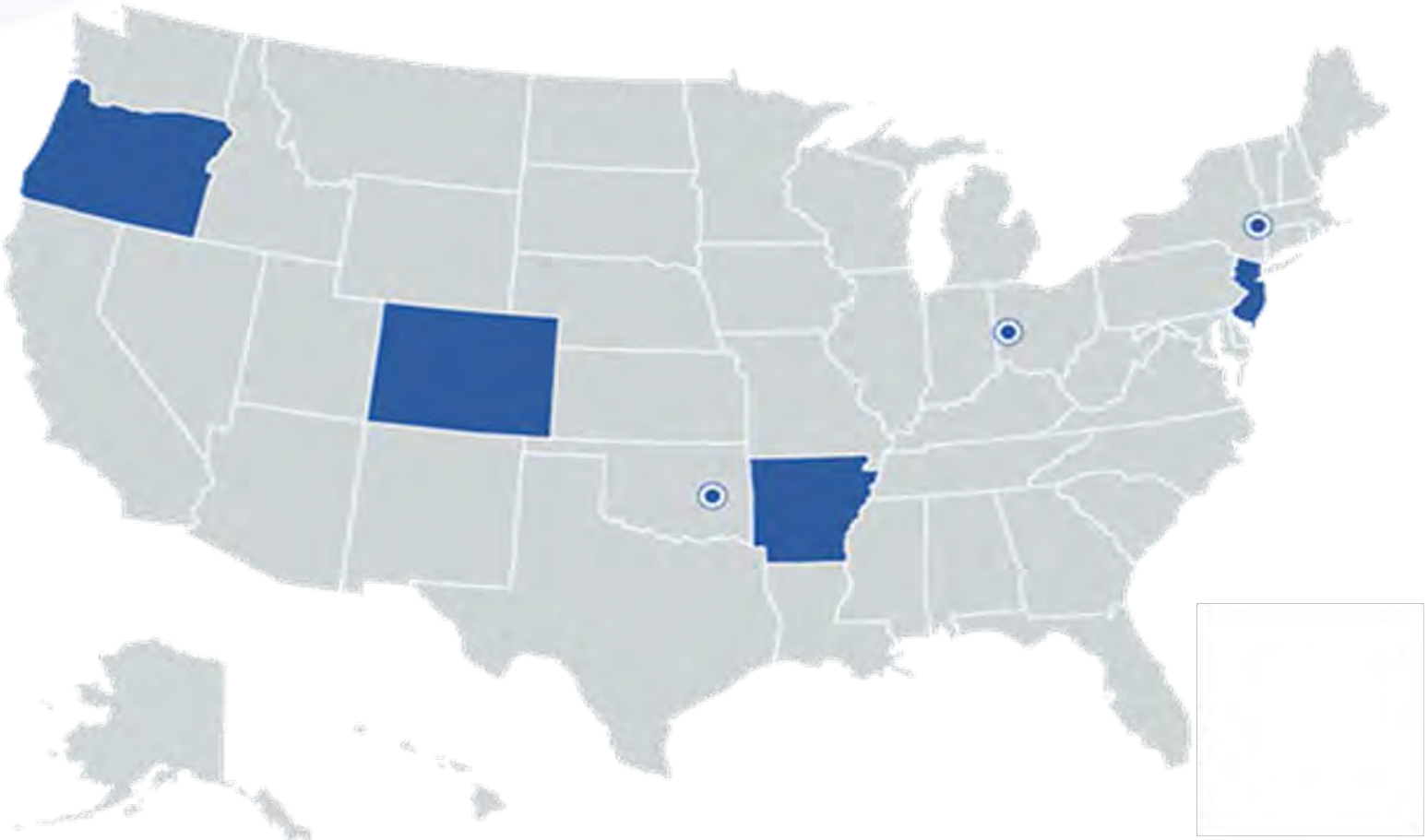

Source: Centers for Medicare & Medicaid Services

What is your role in the practice?

- Physician
- Nurse
- IT Specialist
- PA-C or ANP
- Care Mgr/ Coord
- Practice Manager
- Quality Specialist
- Admin.
- Other

Today's Discussion

- Share four weeks of process measure data and describe how tracking worked.
- Describe any areas that were not working as planned and troubleshoot new approaches.
- Share success stories and/or novel ideas.
- Identify workflow areas for autonomy or automation.
- Select measures for inclusion into practice dashboard.
- Define a solid plan for sustainment of efforts.

Diving Deeper: Satisfiers

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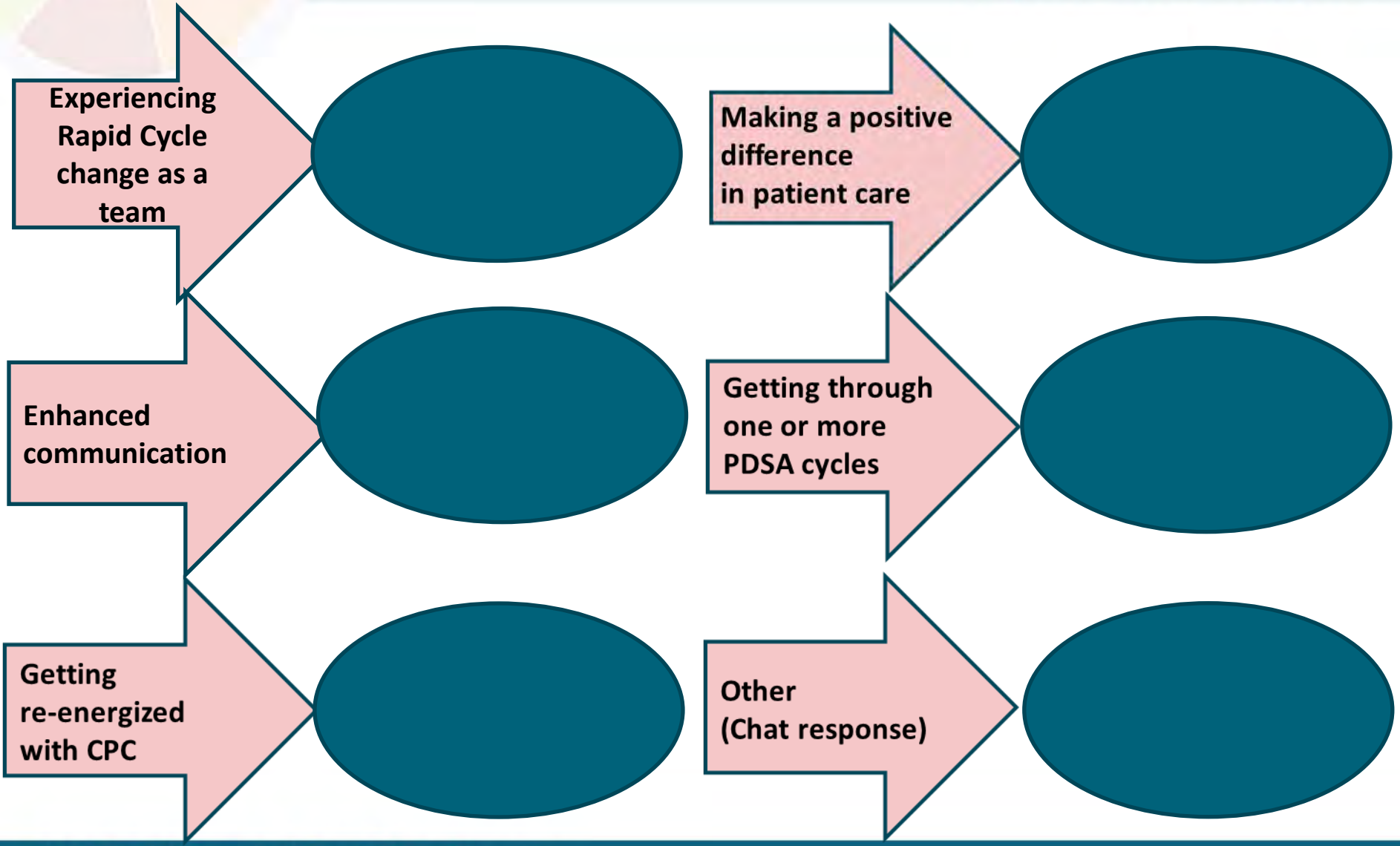

Diving Deeper: Challenges

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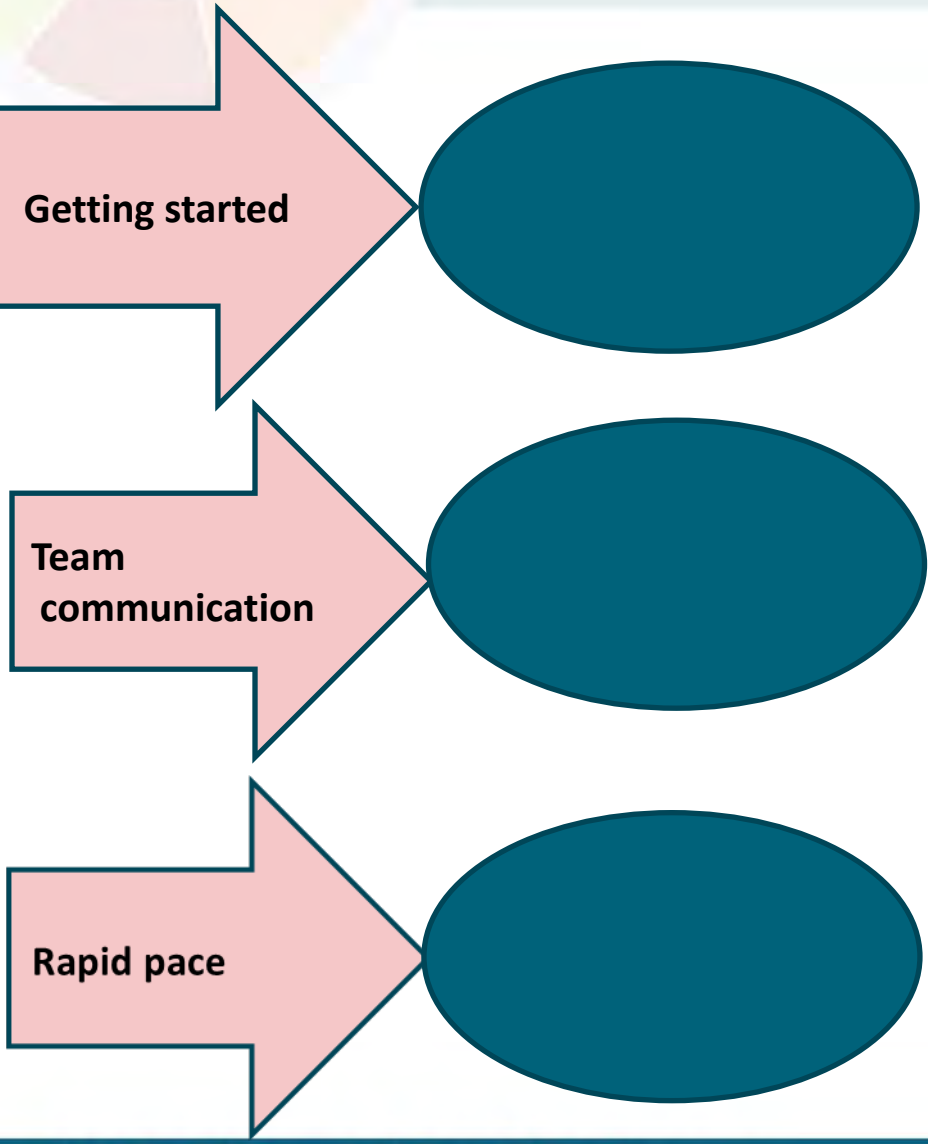

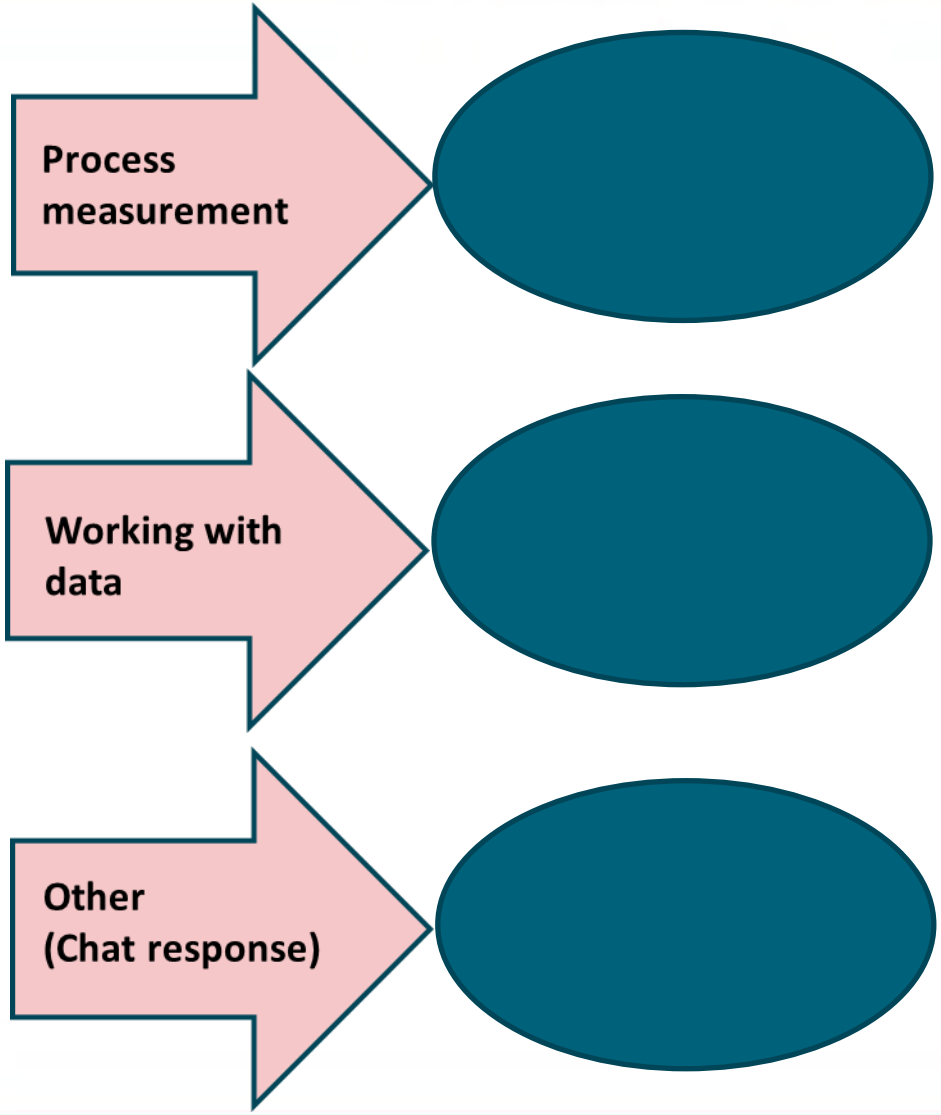

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Providence Medical Group at Providence St. Vincent

Rachel Blackburn, MA, CRRN

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Our Clinic

- Medical Home Internal Medicine Residency Clinic
  - Located within Providence St. Vincent Medical Center
- 9 Faculty Physicians
- 24 Resident Physicians
- 1 Medical Student
- Full-time BHI, PharmD, Case Management, Clinic RN
- 8 MAs, 4 Clinical Care Coordinators (MAs), 6 Patient Relations Representatives (Admin Assistant role)
- Leadership staff

The Challenge

- Find a way to engage the whole clinic in chronic disease management and preventive health/population health management
  - Help improve our patients' health
  - Improve our clinic QMs

Previous Efforts

- Epic (Care Manager, best practice advisories)
- Team-by-team competitions focusing on one quality measure
- Clinical Care Coordinator (CCC) integrated in the team, but focused on phones and desktop work
- We put out fires instead of preventing them
  - Worked individual lists
  - Focus on one thing at a time

How Did We Change?

- Changed the Clinical Care Coordinator (CCC) role entirely
  - Focus on population health and chronic disease management
- Instituted in-depth chart scrub
- Instituted our “Deck of Cards”

Chart Scrub

- Pulls from our EHR, ALERT registry, resident QI project lists
- Reviews last OV to determine what was ordered and if it was done
- Reviews last OV to ensure specialist notes obtained prior to this OV
- Marks items to do for MAs, as well as providers
- Check box format per provider request

PMG at PSV Chart Scrub Smart Phrase (.RBCHARTSCRUB)

Date of Chart Scrub: ***

Patient Name: ***

Date of Appointment: ***

Reason for Appointment: ***

With Dr. ***

Patient is due for PHP AWV. Please schedule.

Card	Check if needed	Notes
Cancer Screening Due Colorectal		
Cancer Screening Due Breast		
Cancer Screening Due Cervical		
Pt due for Flu Vaccine		
Pt is due for TD/Tdap		
Pt due for Pneumococcal Vaccine		
Pt has ASCVD and is not on a Statin		
A1C >9		
DM Retinal Exam Due		
Heart Failure and not on a beta blocker		
Patient needs a care plan		
Hospital or SNF d/c f/u visit – TCM code		
Needs POLST video (>65 y/o, no POLST)		
Acute back pain shared decision making tool		
Chronic back pain shared decision making tool		
Pt is due for A1C		
Pt needs an asthma action plan and ATAQ		
Pt is on chronic opioids		Needs UDS; material risk notice; DIRE score; chronic, continuous use of opioids (304.01/F11.20) added to problem list.
Pt is due for fall risk assessment		
Patient is due for dexa scan (65+, once)		
Pt is due for chlamydia screening (16-24y)		

Preventative Care	Check if Needed	Notes
Care Manager Reviewed. Due for:		
Epic and Alert reviewed. Due for vaccines:		
Pt with liver disease (see list)		Needs Hep A/Hep B vaccine
Last OV, ED or hospitalization reviewed.		Records obtained from: Patient needs to complete:
On highest-risk list.		Consider OV q3 mos or more often.
Intel Patient		Review DM, HTN, depression screening QM's.
PHQ-2/PHQ-9 (required yearly)		
DM foot exam (required yearly)		
SBIRT (required yearly)		
Needs medical home video		
Offer MyChart sign-up		

Deck of Cards

- All disciplines contributed to the development
- Easily changed/updated
- Reduces the “noise”
- Flexible – do as much or as little as you can in the visit
- Gives instructions
- Gives the MAs and Providers another way to communicate

Deck of Cards

Patient has an

A1C >9.

Please discuss with the patient and address as appropriate.

Consider consulting an interdisciplinary team member for assistance.

Consider referral to Diabetic Education. Medicare patients get 4 hours a year of DM education covered.

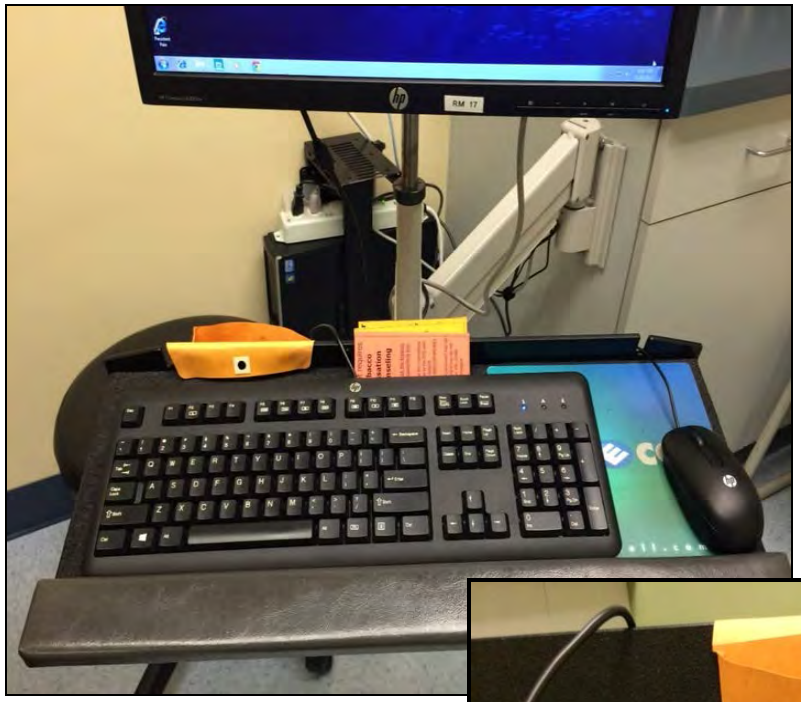
A1C >9

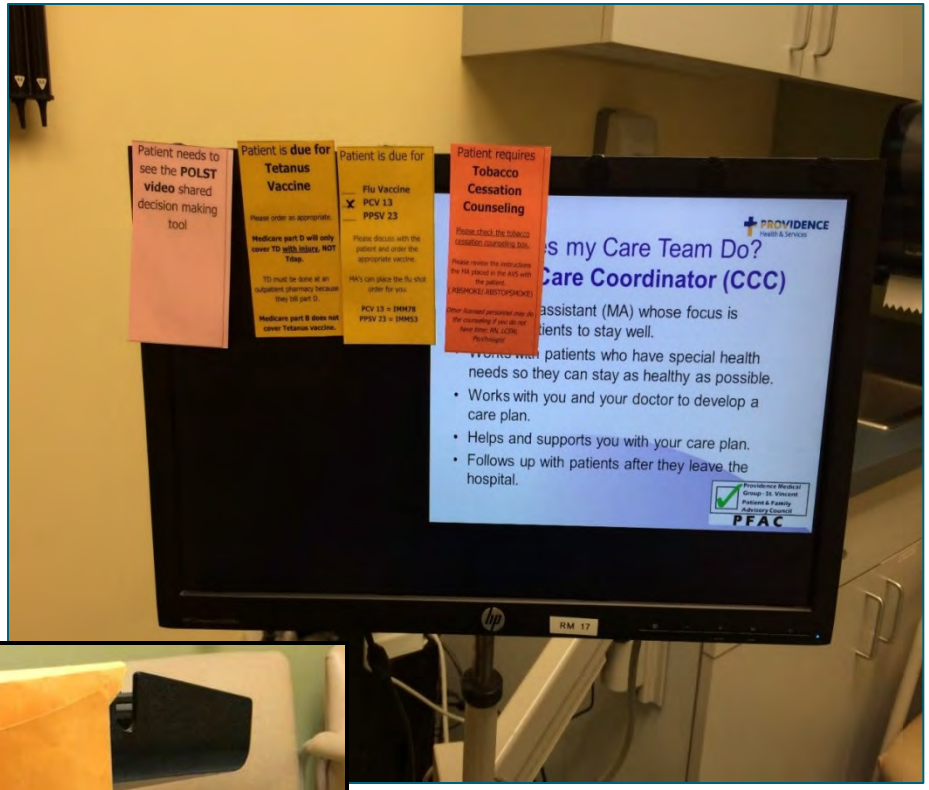
Consider medications, lifestyle changes, behavior changes.

If needed, you may consult:

- Abby Frye for PharmD co-management.
- Rebecca Weiss for behavioral modification or stress reduction techniques.
- Clinic RN's for ongoing health coaching.
- Diabetes Education.

4


RM 17


Patient needs to see the POLST video shared decision making tool
Patient is due for Tetanus Vaccine
Please order as appropriate.
Medicare part D will only cover TD with injury, NOT Tdap.
TD must be done at an outpatient pharmacy because they bill part D.
Medicare part B does not cover Tetanus vaccine.
Patient is due for
Flu Vaccine
X PCV 13
PPSV 23
Please discuss with the patient and order the appropriate vaccine.
MA's can place the flu shot order for you.
PCV 13 = IMM78
PPSV 23 = IMM53
Patient requires Tobacco Cessation Counseling
Please check the tobacco cessation counseling box.
Please review the instructions the MA placed in the AVS with the patient.
(ABSMOKE/ ABSTOPSMOKE)
Other licensed personnel may do the counseling if you do not have time: RN, LCSW, Psychologist
PROVIDENCE Health & Services
s my Care Team Do?
Care Coordinator (CCC)
assistant (MA) whose focus is
ients to stay well.
patients who have special health needs so they can stay as healthy as possible.
Works with you and your doctor to develop a care plan.
Helps and supports you with your care plan.
Follows up with patients after they leave the hospital.
Providence Medical Group - St. Vincent Patient & Family Advisory Council
PFAC
RM 17

Completed QM
Cards

DATA BOARD

Intel Data

CPCI Quality Measures

Readmissions and TCM Coding (Transitional Care Management)

HCC Code of the Week

Use code 412:
Old Myocardial Infarction

Resident Ambulatory Learning Modules

Care Oregon

Care Oregon Quality Measures 2015

CPCI Quality Measures 2015

Staff Incentives

Vantage

Portland IPA Data

Tobacco Cessation Counseling

Check out the CPCI 2014 year end reporting!

YouRock

YouRock

YouRock

Impact

- Providers were frustrated by the ever-growing list of "boxes to check"
  - Majority in our practice love these
  - A few feel overwhelmed
- CCCs are seeing a decrease in items coming up on chart scrubs
- CCC job satisfaction is way up
- Whole team participates
- The Dept. of Medicine is encouraging resident QI projects involving the clinic

Data Impact

- QM numbers are slowly climbing:

CPC Measure	Feb-15	Jun-15	Oct-15
Blood Pressure Control	66.10%		69.60%
Breast CA Screening	57.10%		59.70%
Colorectal CA Screening	55.60%		58.30%
Pneumonia Vaccine 65 and Older		75.20%	76.30%
HF: Beta-Blocker	93.90%		95.20%

- Readmissions are trending slightly down
- TCM coding is the highest in all of PMG Oregon

Lessons Learned

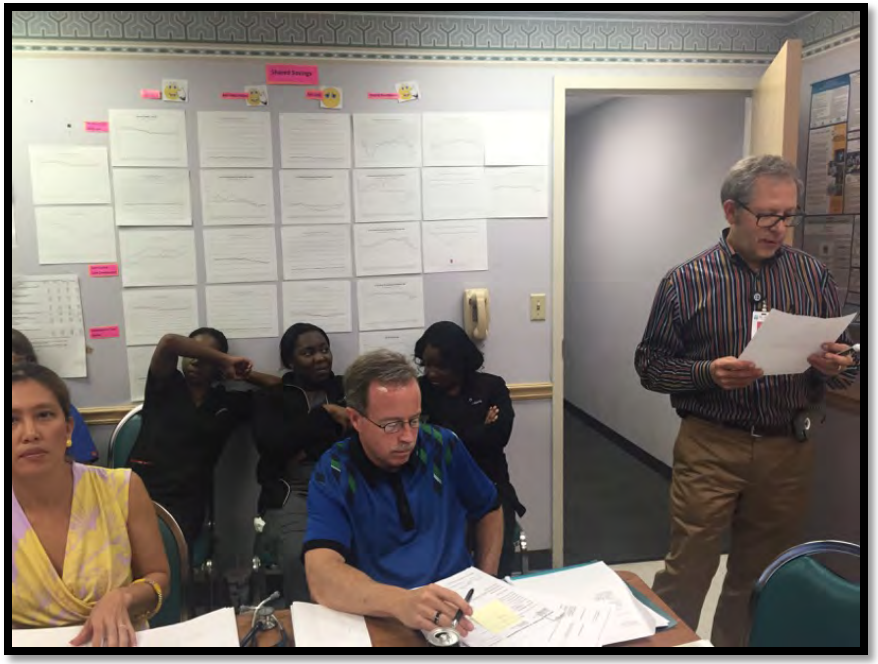
- Make sure your data is solid so you can reliably track changes
- Consider other team members: this change was hard on MAs and Patient Relationship Representatives (PRR)
- No one technique works for everybody
- Communication, communication, communication
- Follow up – continuously, with everybody
- Extensive training for CCCs

How Are We Doing Today?

- QM cards are fully integrated in clinic and working well
- QM cards were presented to other CPC clinics and will be presented to all other PMG primary care clinics over the next couple of weeks to use if they choose
- Constantly adding to the cards and tweaking them
- Continue to follow up with those in clinic to ensure the cards are used optimally
- Continue to monitor the data – watch for trends

St. John Clinic – Family Practice Tulsa, Oklahoma

- 4 physician and 2 physician assistants
- 2 Care Managers
- 20 total staff
- Patent panel is 9,000



Reducing ACSC – Heart Failure

- **AIM:** Reduce hospital admissions within clinic
- **Measurement:**
  - Number of valid diagnosis
  - Monthly utilization data
  - Track patients that are activated
- **Action:**
  - "Stay in Zone" packets
  - Identify patients
  - Care Manager will do action plan at next schedule visit
  - Patient takes packet
    - Symptom specific

Reducing ACSC – COPD

- **AIM**: Reduce ER and hospital admissions due to COPD acerbation
- **Measurement:**
  - Utilization data
  - Validating diagnosis
  - Track patients that are activated
- **Action:**
  - "Stay in Zone" packets
  - Identify patients
  - Care Manager will do action plan at next scheduled visit
  - Patient takes packet
    - Symptom specific

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SAMA HealthCare

SAMA
HEALTHCARE

Our Providers
Our Staff
Our Location
Services
Patient Education
Contact Us
Patient Privacy
Symptom Checker
Miscellaneous
Home

Diabetes

- Foot exam
  - Was it a lack of documentation?
  - Documentation in the wrong place?
  - Not doing it at all?

Workflow Changes

- Care Coordinator activity prior to patient visit
- Nurse has patient remove shoes and socks (visual cue to provider)
- Education on where to document finding

Sustainability of Change

- Data measurement
- Team competition
- Office-wide culture of change

Harrison Family Practice – WRMC

- Chronic Disease: ***Diabetes***

- Evidence-Based Guideline:
  Aspirin therapy for diabetic patients
  (exceptions: allergy, other anti-platelet therapy in place, or other medications/conditions contraindicating therapy)

- Team or test group: ***Solo Practice – entire practice team***

Leveraging Your Whole Team to Improve Chronic Disease Management

ACTION GROUP: ACTIVITY 1

- DIABETES
- ANTI-THROMBIC THERAPY
- ENTIRE PRACTICE TEAM
- CURRENT STATE: 8/17-8/28/15 PRACTICE 70%
- FIRST TEST: CHECK ALERT AND STAFF EDUCATION
- FIRST OUTCOME: IMPROVED THERAPY TO 73%
- SECOND OUTCOME: IMPROVED THERAPY TO 91%

Harrison Family Practice

- Results of Second Test of Change
  - The test resulted in improved compliance with ASA therapy on appropriate diabetic patients.
  - Workflow is successful and will be continued.
  - Keys: current DM guideline knowledge, staff education/training.
  - Could consider same workflow with other similar conditions.

"Just putting a group of highly trained people together around a 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."

Matthew K. Wynia, MD, MPH; Isabelle Von Kohorn, MD, PhD; Pamela H. Mitchell, PhD, RN. Challenges at the Intersection of Team-Based and Patient-Centered Health Care: Insights From an IOM Working Group. *JAMA.* 2012;308(13):1327-1328. doi:10.1001/jama.2012.12601.

Factors for Sustainability of Change

- Organization or practice
- Confidence in the team
- Quality measures
- Make the change part of the culture
- Positive patient experience/feedback

See what the Chatter is all about in CPC:

CPC Connect
Comprehensive Primary Care

Chatter | Groups | CPC Calendar | Events | Libraries | Reports | CPC Connect Help

RCAG1: Screening to Treatment-BHI

RAPID CYCLE ACTION GROUPS

Group Settings
Email Daily Digest

Information

This action group will drill deeply into the process in your practice that begins with the recognition of a behavioral health problem or need (whether in the visit assessment or through screening) and moves effectively into the establishment of an initial treatment plan with the patient. This may occur with the same provider, with an intra-practice "hand-off," or with a referral outside the practice, depending on the practice resources and the severity of the problem.
In every case we'll work together toward an integrated process, with seamless transitions, reliable sharing of information, and a clear, shared plan. Practices know that it's harder than it looks!

Description

From Screening to Treatment in Behavioral Health

Post | File | Link | More

Share with RCAG1: Screening to Treatment-BHI | Share

Show All Updates

Elisha Jewett (HealthTeamWorks- RLF)

Continuing Conversation from Session 1's Chatter: How are you working with patients that experience the behavioral health need of addressing chronic pain?

Comment · Like · Share · September 18, 2015 at 4:20 PM

Show All 5 Comments

Alan Schrader (Customer)

I am using the Cognitive Behavioral Model with special exercises from Beverly Thorn's book Cognitive Therapy for Chronic Pain. It is interesting how relaxation can be taught to go to different deeper levels and how it is hard for people who are busy. It is also difficult to talk and show the concept of amplification when some look at the expectation of more medicine as the only cure. So I would say ... More

Like · September 28, 2015 at 4:03 PM

Rose Langdon (TMF Health Quality Institute)

@Alan Schrader (Customer), do you use it only for chronic pain, or other conditions like additive disorders as well!

Like · Yesterday at 9:19 PM

Alan Schrader (Customer)

Manager

Members Show All (76)

Add/Remove Members
Change Roles

Group Records

No records yet? Learn about adding records to groups.

Group Files Show All (10)

IHISevenSpreadlySin...
2015_9_16_Topic 4 B...
PHQ9-updated
Banner Health Task A...
BH Task Activity

Recently Talked About

Behavioral Health Integration
Action Group
Ms2

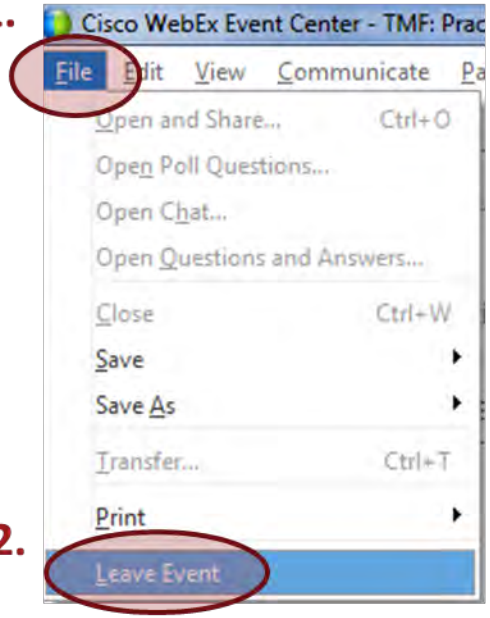
https://cmsorg.force.com/CPCConnect

CPC Connect is a new user-friendly website that just launched. The site is designed to help you achieve CPC Milestones and transform primary care in your practice. Access for all CPC practices is coming soon.

All attendees, including faculty, MUST complete a survey.

You may add multiple participants on one form if you participated as a group.

1.



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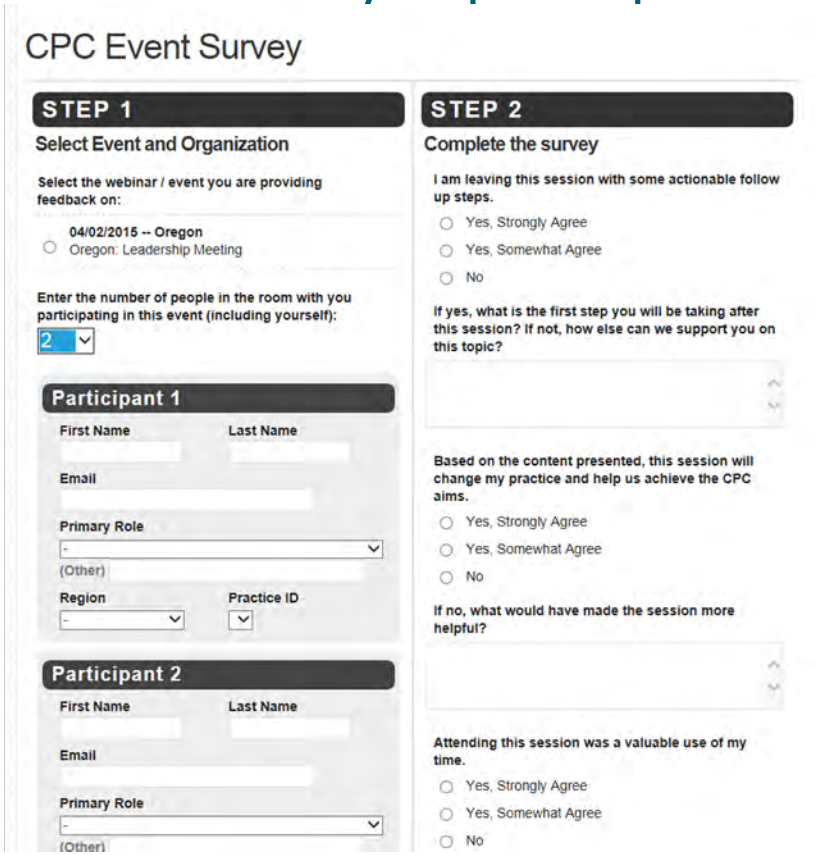

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CPC Event Survey

STEP 1

Select Event and Organization

Select the webinar / event you are providing feedback on:

- (●) **09/09/2015 -- National** Action Group: Tightening the Nuts and Bolts of Your Care Management Process - Session 1 of 4
- ( ) **09/09/2015 -- National** Action Group: Capturing the Opportunity in Transitions of Care, Session 1 of 4

Enter the number of people in the room with you participating in this event (including yourself): 2

Participant 1

First Name: Jane
Last Name: Smith
Email: jane.smith@xyzcorp.com
Primary Role: Care Manager
(Other)
Region: Arkansas
Practice ID: AR00003

Participant 2

First Name: Donald
Last Name: Jones
Email: donald.jones@xyzcorp.com

STEP 2

Complete the survey

I am leaving this session with some actionable follow up steps.

- (●) Yes, Strongly Agree
- ( ) Yes, Somewhat Agree
- ( ) No

If yes, what is the first step you will be taking after this session? If not, how else can we support you on this topic?

Based on the content presented, this session will change my practice and help us achieve the CPC aims.

- (●) Yes, Strongly Agree
- ( ) Yes, Somewhat Agree
- ( ) No

If no, what would have made the session more helpful?

Attending this session was a valuable use of my time.

- (●) Yes, Strongly Agree
- ( ) Yes, Somewhat Agree
- ( ) No

If no, what were you hoping to accomplish in this

on: nsas
Practice ID: AR000036

This discussion/presentation format was engaging.

- (●) Yes, Strongly Agree
- ( ) Yes, Somewhat Agree
- ( ) No

If no, please describe the barriers to engagement you personally experienced.

If you were designing our next session(s), what topic, content or format would make it a great session?

Would you like to share your experience, idea or innovation on a future webinar?
If yes, please provide preferred topic and best contact information.

First Name
Last Name
Email
Telephone

Submit