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CPC Vital Signs
Knowing the Pulse of Your Practice

Practice Showcase of Data-Driven CPC Improvement Strategies

Moderator

Rose Langdon

TMF Health Quality Institute

Introductory Comments

Bruce Finke, MD
CMS Innovation Center
Learning and Diffusion Group

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CPC VITAL SIGNS

KNOWING THE PULSE OF YOUR PRACTICE

Jay Fetter

Regional Learning Faculty - Oklahoma

Click the arrow above, then point to your location…

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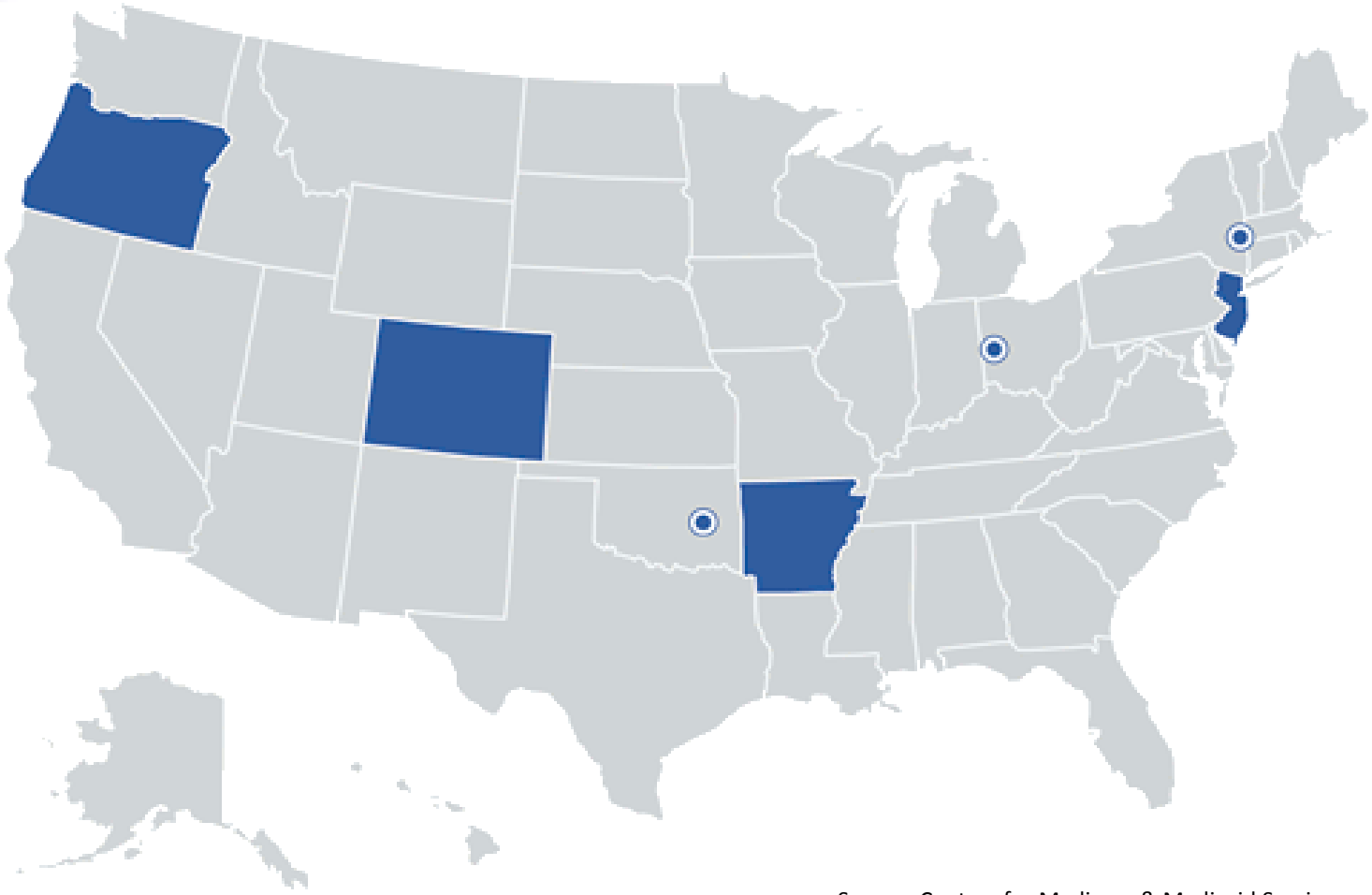


Source: Centers for Medicare & Medicaid Services

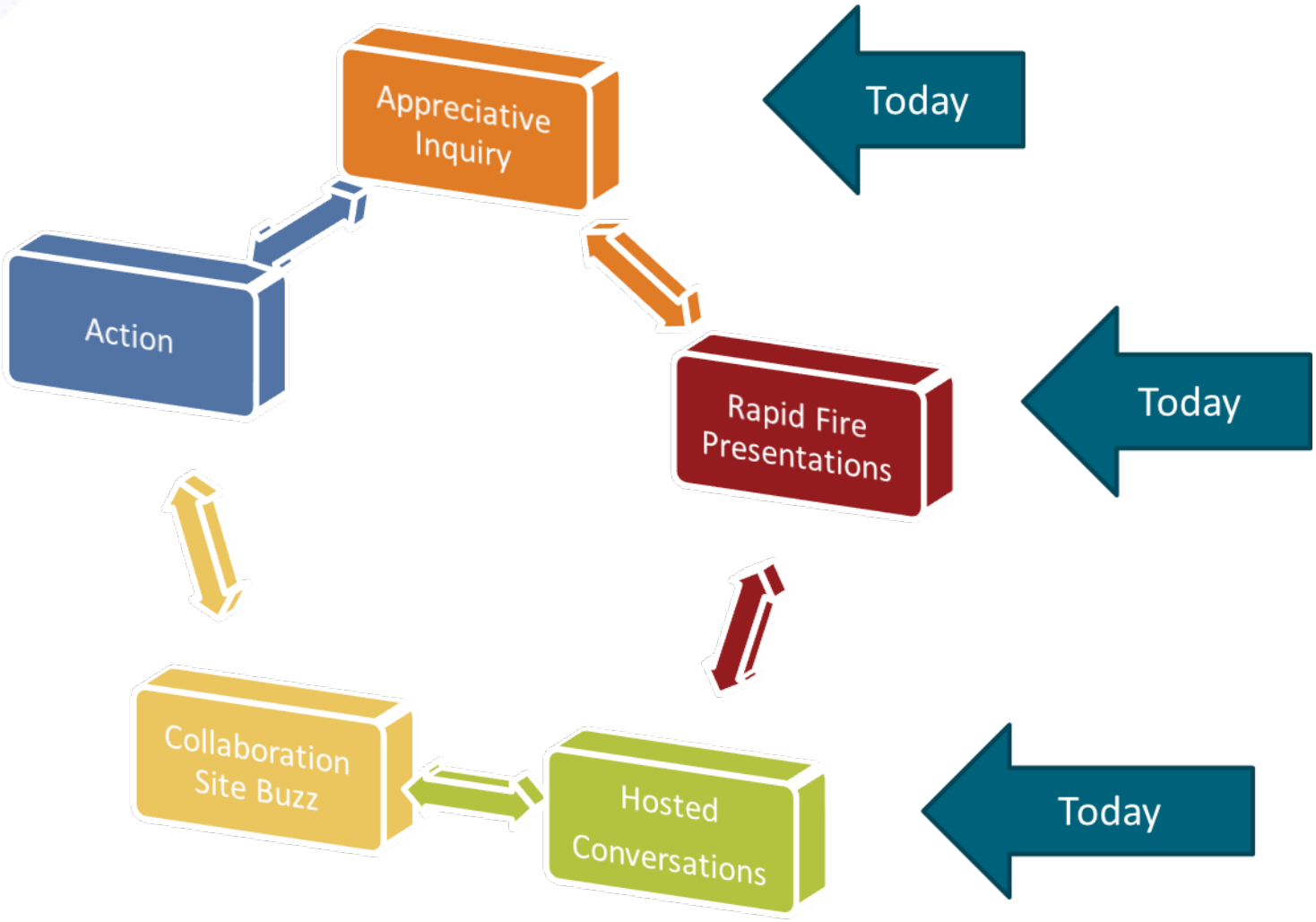
What is your Role in the Practice?

- Physician
- Nurse/MA
- Practice Admin
- Quality Specialist
- APN/PA
- Other

Our shared purpose today

- Identify practical data management concepts from effective and varied types of CPC practices.
- Apply concepts of run chart analysis to understand and improve everyday work processes, leading to improvement.
- Identify ways to leverage data reports to address a current problem or situation that is a priority for the care team.

How


Appreciative Inquiry
Today
Rapid Fire Presentations
Today
Hosted Conversations
Today
Collaboration Site Buzz
Action

Participation Pointers

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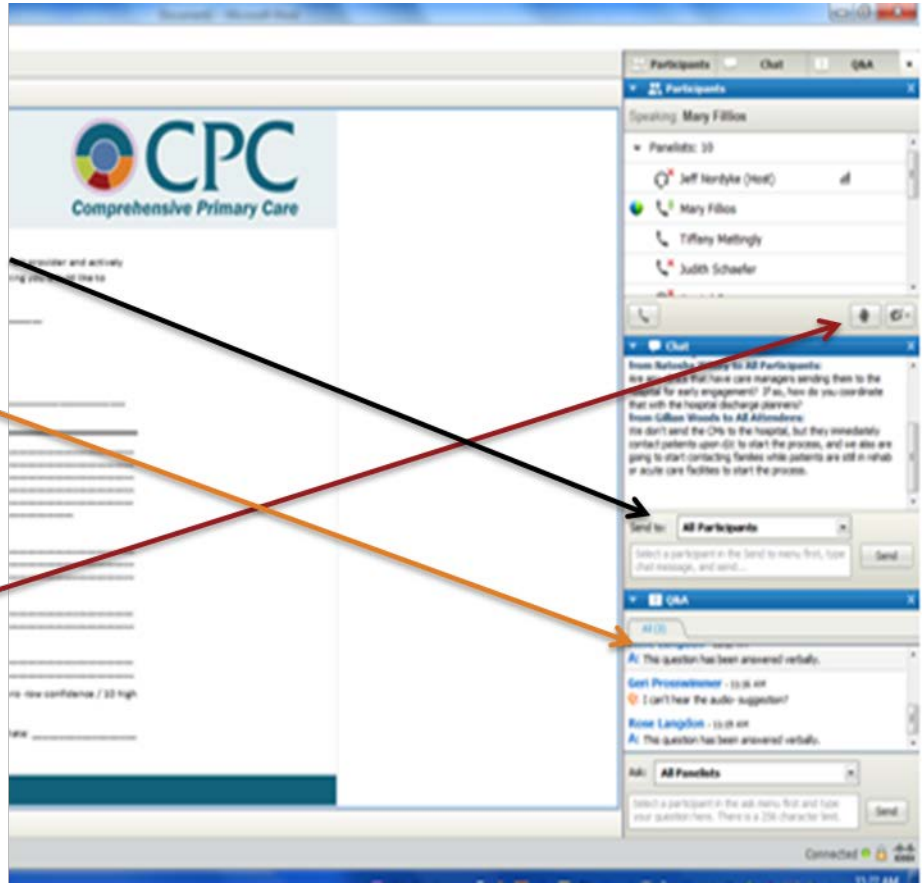
Active Learning Tips

- Set Chat to All Participants
- Use Q&A to interact with panelists
- Raise your hand to contribute your thinking



Chat, Chat, Chat…

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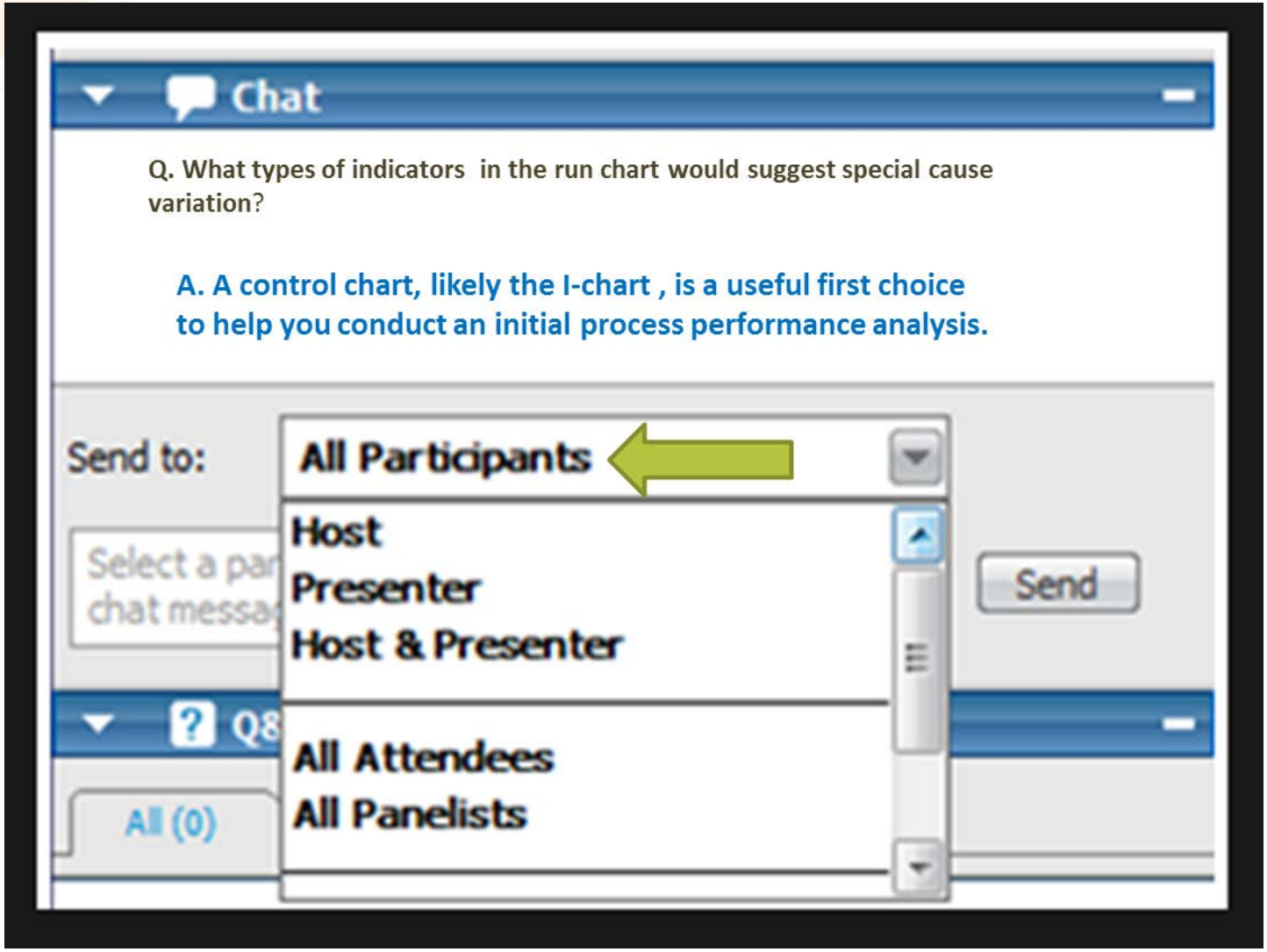

Chat Hosts and Rapid Fire Panelists

Chatters	Role	Region
Renee Engelking	Panelist & Chat Host	Oklahoma
Lane Mattox	Panelist & Chat Host	Colorado
Natosha Wilsey	Panelist & Chat Host	Oregon
Eugene Heslin	Panelist & Chat Host	New York
Jackie Crain	Chat Host	Arkansas
Sara Bolton	Chat Host	Ohio/Kentucky
Elizabeth Wilbourn	Chat Host	Oklahoma
Laurie Paul	Chat Host	Oklahoma

Lets chat…

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"Good data collection requires planning, which is equally as important as the data themselves. The first question must be, 'what is the objective?'"

Source: Data Sanity by Davis Balestracci, Jr., 2009 Medical Group Management Association

How is your team organized to have sustained focus on the practice's operational and clinical improvement objectives?

Or this

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"The important problems are the opportunities that no one is aware of."

Source: Data Sanity by Davis Balestracci, Jr., 2009 Medical Group Management Association

Chat your thoughts about the features of a practice level report that you feel can be acted upon by your quality improvement and care team members?

On a scale of 0-10, 0 being beginner with no experience at all, and 10 expert level competence, what number would you pick to describe your practice's competency/experience choosing a problem based on data, understanding the process, generating potential causes, implementing solution, and evaluate solution?

Rapid Fire Format

- Presenter will present a fast paced story of an important problem that was addressed using statistical process improvement. They will highlight:
  - Context for the work
  - Problem addressed
  - What they did
  - What and how they measured
  - Adoption considerations for others.

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Physicians

Context of Our Work

OU Physicians- Tulsa Family Medicine Clinic

- Faculty and resident clinic for the OU School of Community Medicine
- Near downtown Tulsa
- 12 family physicians (Faculty) and 26 Resident physicians
- 10,222 patients in practice
- High Medicaid population
- 2 care managers (RN & LPN)
- GE Centricity EMR

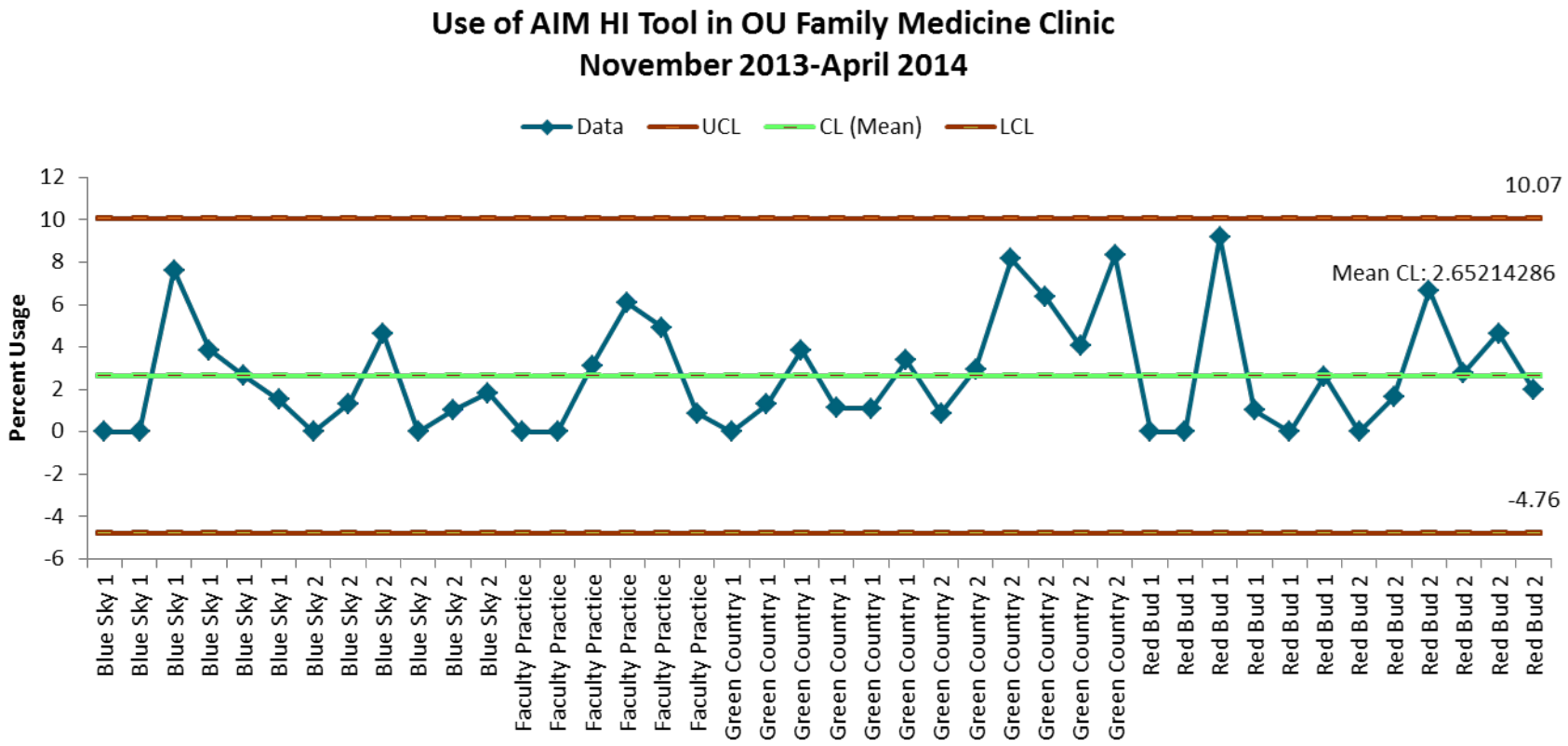
Problem/Issue

- Low utilization of the AIM High and other obesity tools implemented in the EMR in 2013 as part of our shared decision making milestone and for self management support for obesity in 2014.

What we did

- Utilized the Dartmouth Coaching for clinical microsystems improvement model
  - Formed a multidisciplinary team
  - Coached by a peer
- Defined the problem
- Reviewed data warehouse reports on usage of the AIM HI form

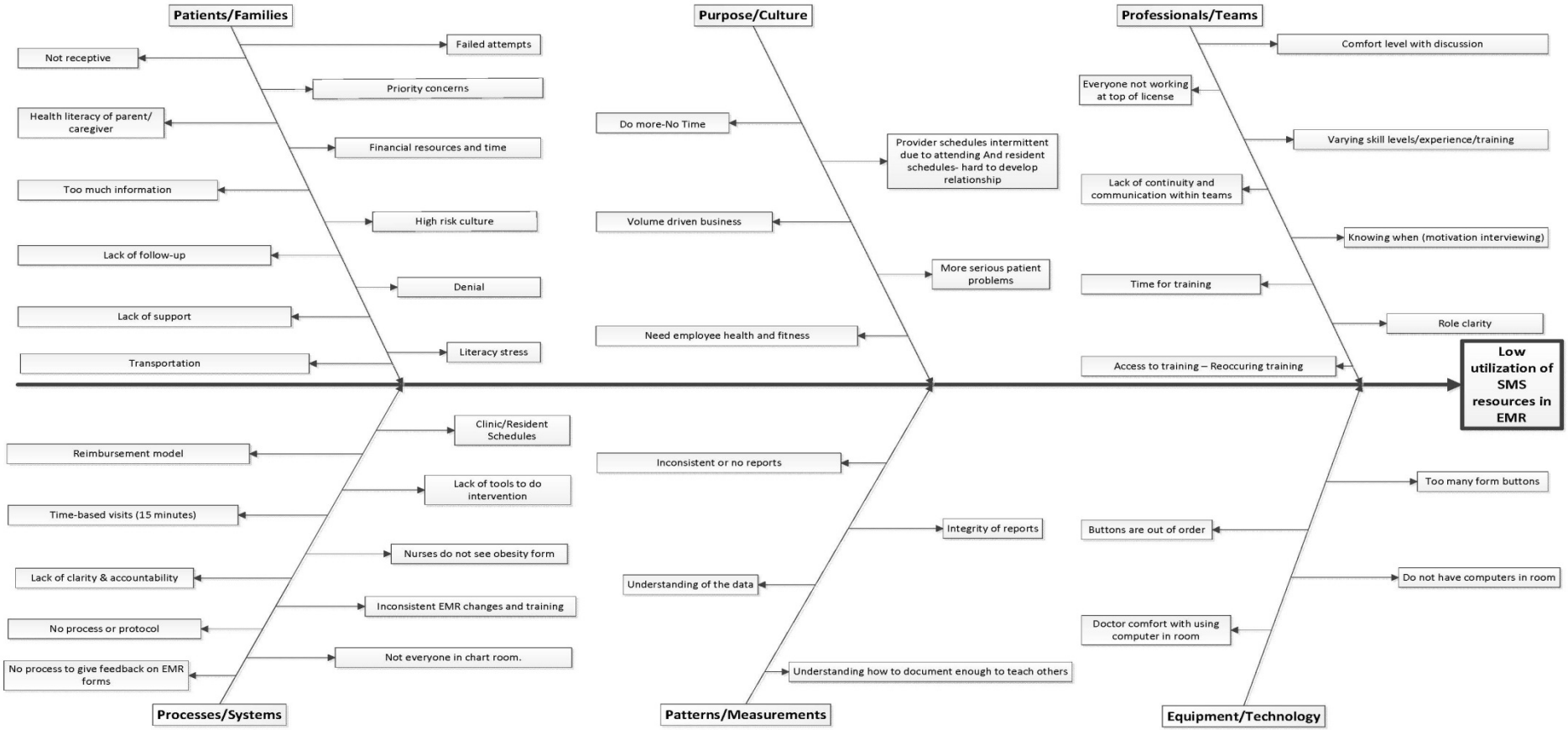
What and How we Measured



What we did

- Set global and specific aims
- Fishbone diagram (why don't people use the form)
- Invited the top users to meeting to tell us what works and what doesn't

OUP Family Medicine SMS for High Risk Patients w/ Obesity Dx – Fishbone Diagram



Adoption Considerations for Others

- Challenges
  - TIME
  - Physician engagement
  - Tendency to jump to solutions
- Next Steps
  - Changes to EMR to capture all options within the form for better reporting
  - Future state process map
  - Conduct short pilot in 2 highest use teams

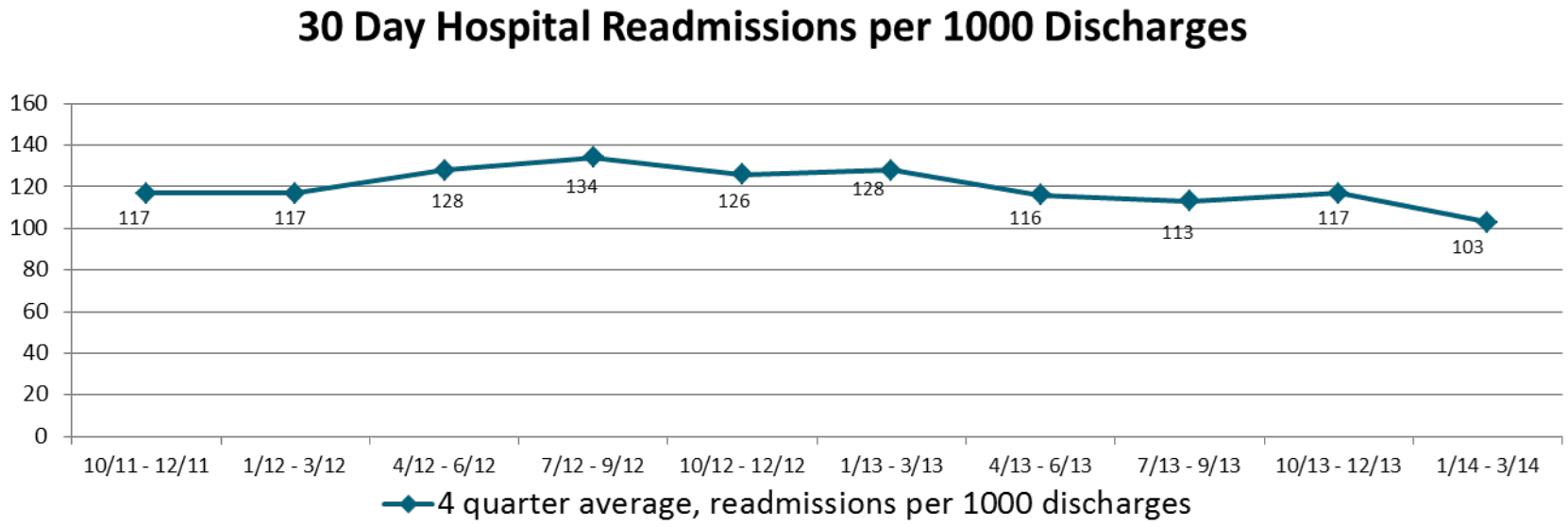
Context of Our Work

Grants Pass Clinic

- Grants Pass, Oregon
- 19 physicians, 2 PAs, 1 NP
- Approx 18,000 patients with 17,200 attributed to primary care
- 1 Care Manager; 1:1 care teams
- Allscripts Touchworks EHR
- Provider-owned, multispecialty group

Problem/Issue

- Using the feedback reports, and in conjunction with overall transformation efforts to decrease utilization as a whole, we determined our readmission and ED utilization rates needed improvement



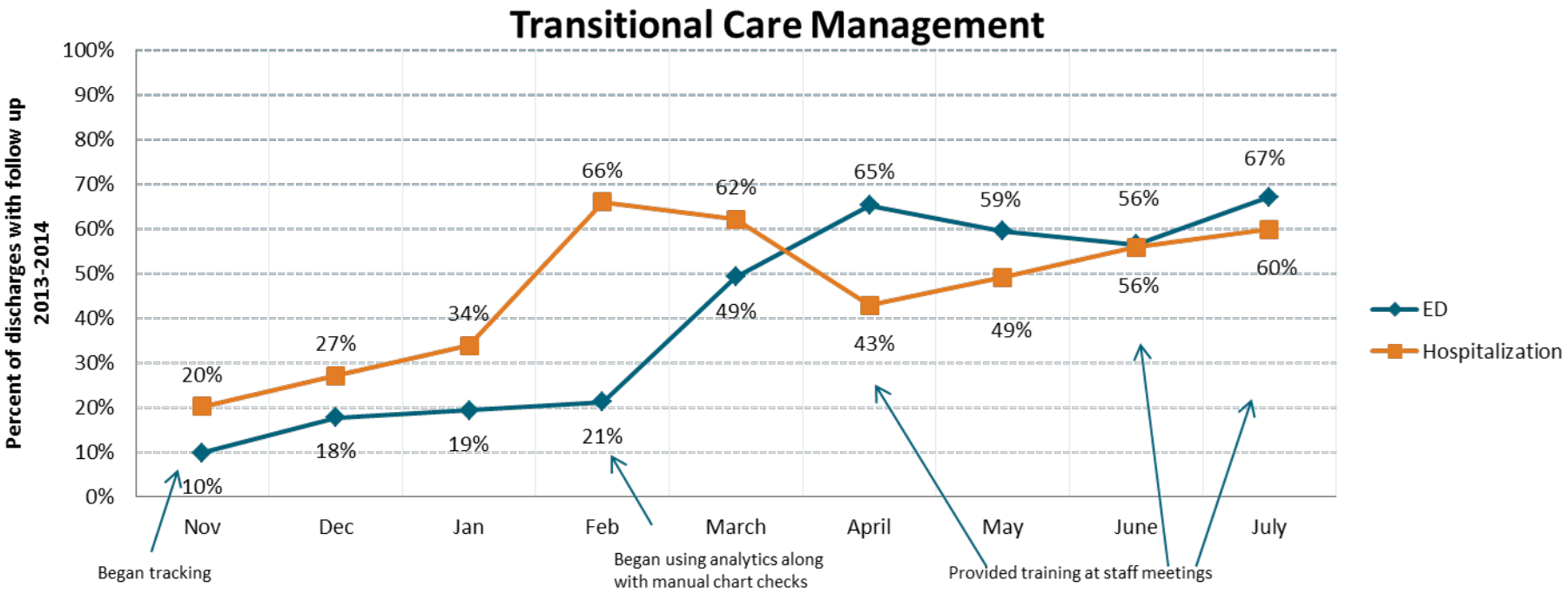
What we did

- Implemented follow up protocol ensuring patients who were discharged from the local hospital or ED unit received a follow up phone call or visit with their provider in 72 hours

- This protocol was created in conjunction with the option to bill for Transitional Care Management visits

What and How we Measured

- Monthly tracking of hospital and ER discharges using HIE with local hospital (denominator)
- Of the discharges, which patients received a follow – up phone call or visit with their provider (numerator)
- Tracked using analytics program initially, then required manual chart reviews



Adoption Considerations for Others

- Problems we faced and how we addressed them
  - Confusion with billing requirements surrounding Transitional Care Management – staff required education that regardless of billing requirements, or if the provider doesn't want to see the patient in the office, the outreach still needs to happen
  - Staff requires continuing education regarding use of note types, and how clinic tracks the data
- Sharing the data (physical graphs per provider/department) with all staff makes a huge difference in engagement levels
- Ensure you have the most accurate data – disputable data makes the projects irrelevant
- We are still working on how best to utilize a care manager in our practice, and how to involve her in the TCM workflow
  - We will be tracking utilization before and after implementation of a care manager, and hope to see our rates improve

Chat Harvest plus Q&A

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Context of Our Work

Family Physicians of Greeley, LLP

- 3 locations in Greeley, CO
- 22 physicians, 2 PAs
- 30,000 empanelled patients
- 9 members of CM staff
- NextGen EHR
- Independent family practice

Problem/Issue

- How to get physicians to take quality reports seriously

What we did

- Gave them accurate data
  - Our EHR-generated reports are chronically wrong and can't be altered
  - Used a report-writer (Crystal Reports) and did it ourselves
  - Let them see all the patients that make up the numerator and denominator so they could verify accuracy (or find errors)

What we did

- Gave them timely data
  - Our EHR-generated data is produced weekly and is not easy to access or use
  - Let them run up-to-date reports (Crystal Reports) whenever they want

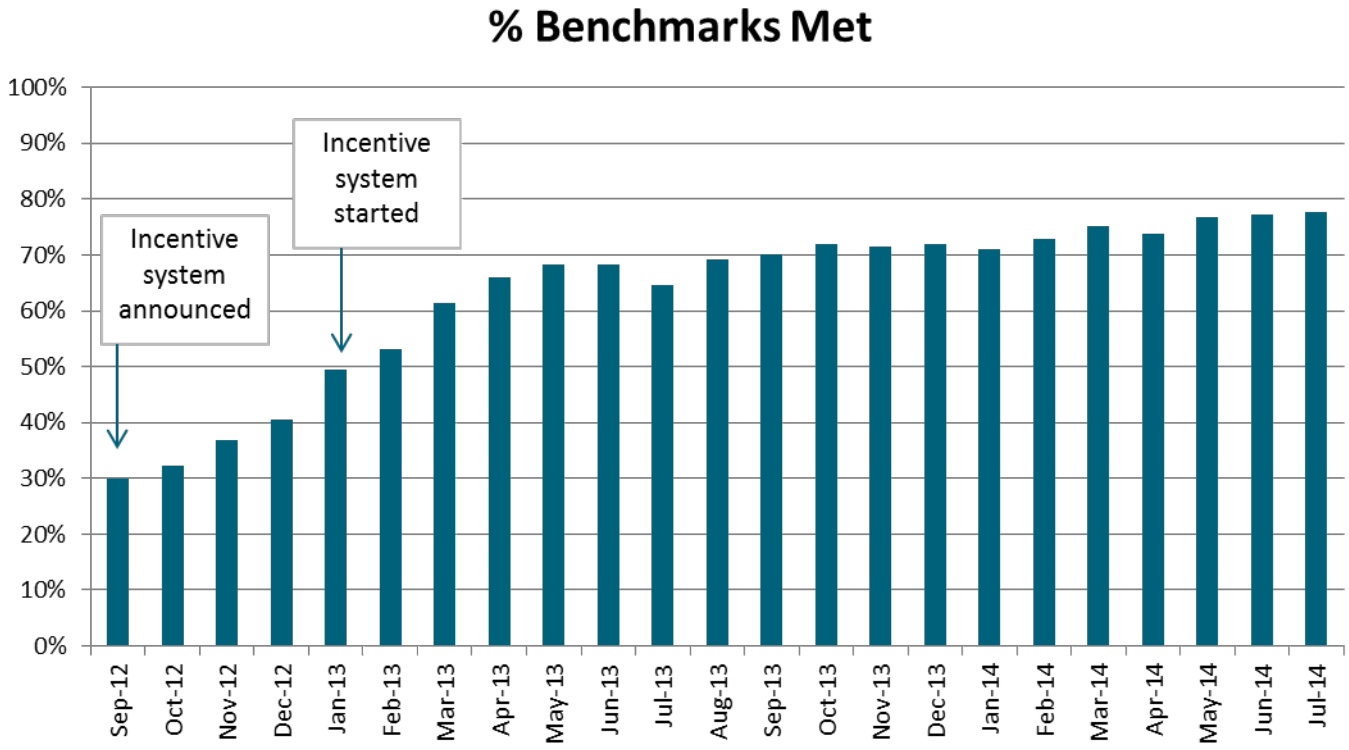
What we did

- Gave them their own data and everyone else's
  - Creates urgency, competition, peer pressure and sharing of best practices

What we did

- Created incentives to meet benchmarks and penalties for poor performance
  - Let the physicians design the incentive system
  - Must be perceived as fair to physicians of varying practice sizes and mixes
  - Must not damage collegial environment
  - Must put enough at stake (but maybe not as much as you think)

What and How we Measured



Adoption Considerations for Others

- The result of this is each individual physician experiments with process improvements for their own practice.
- Make sure to find a way to find and spread best practices.

Context of Our Work

Eugene Heslin, MD

Bridge Street Family Medicine

- Saugerties, NY
- 5 Provider Group
- ½ time Care Manager
- We Use eCW for our EHR
- We are an unaffiliated Group practice

Problem/Issue

- When we get data, we evaluate all the data and the trends.
- As a practice we did not like the trend in our ER utilization and hospital cost data. This was identified on our Quarter 2 CMS Practice feedback report, which was worse than our Q1 report.

ED Expenditure Comparison for High Risk

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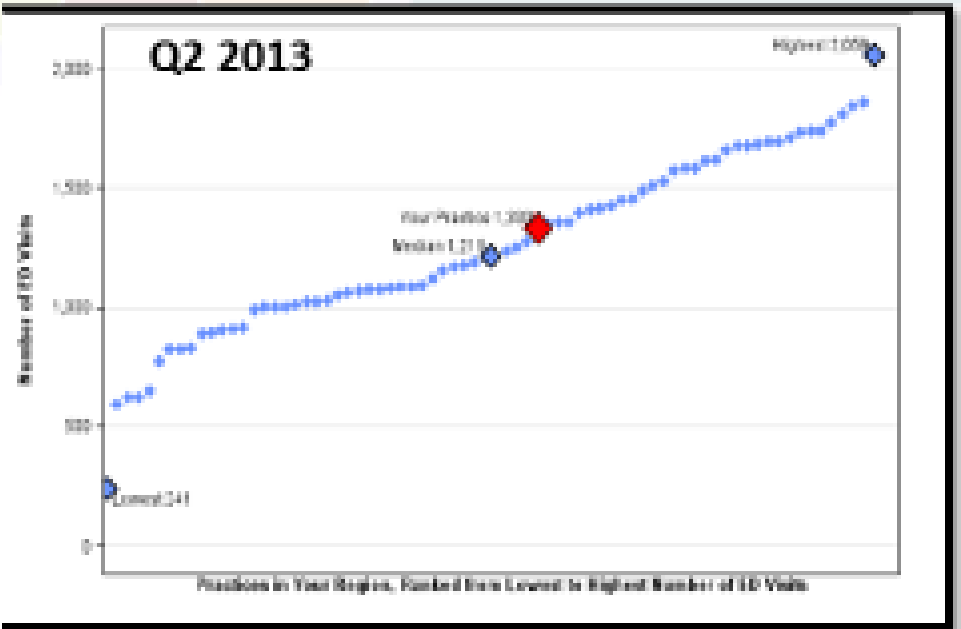

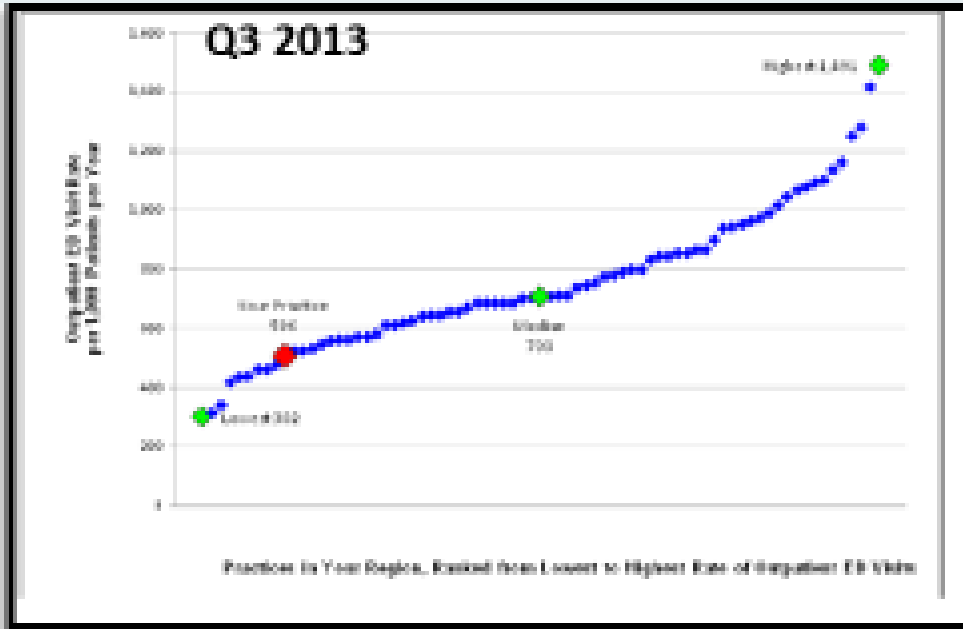

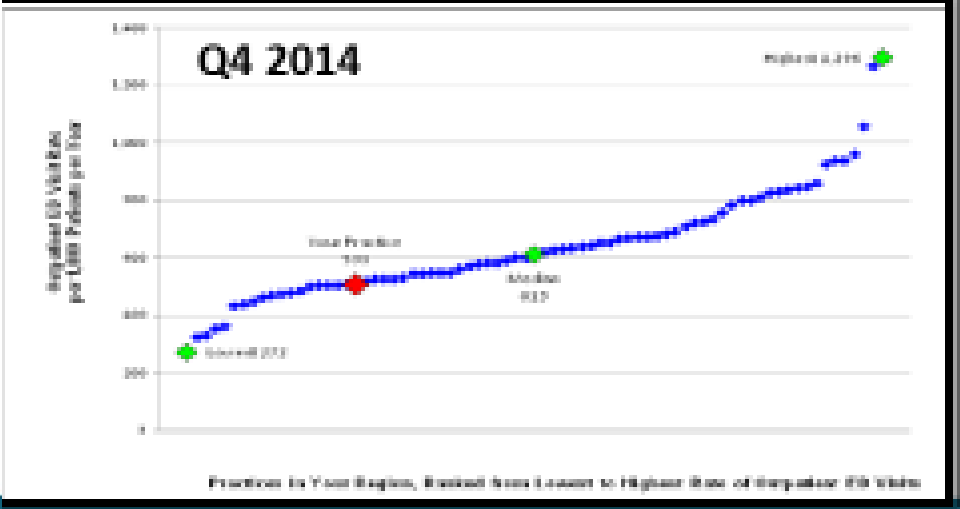

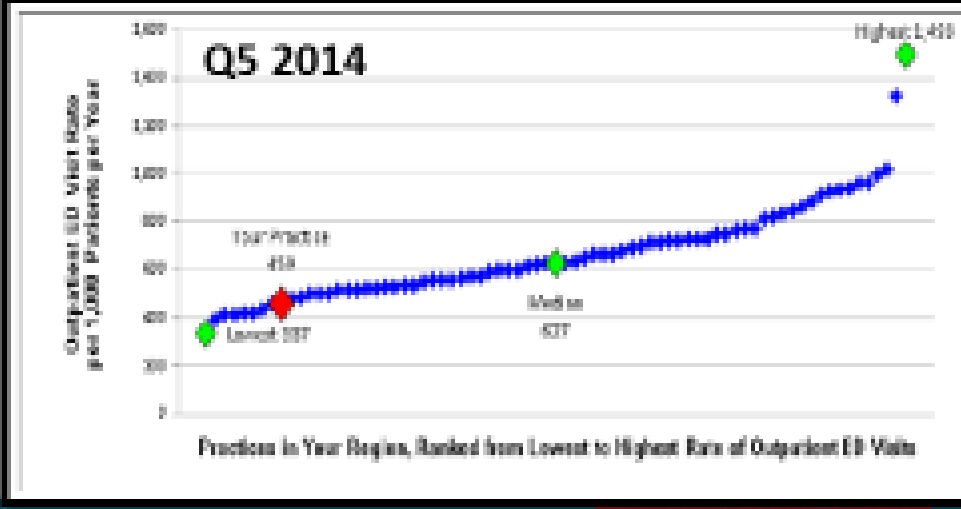

Hospital Admits Expenditure Comparisons for High Risk

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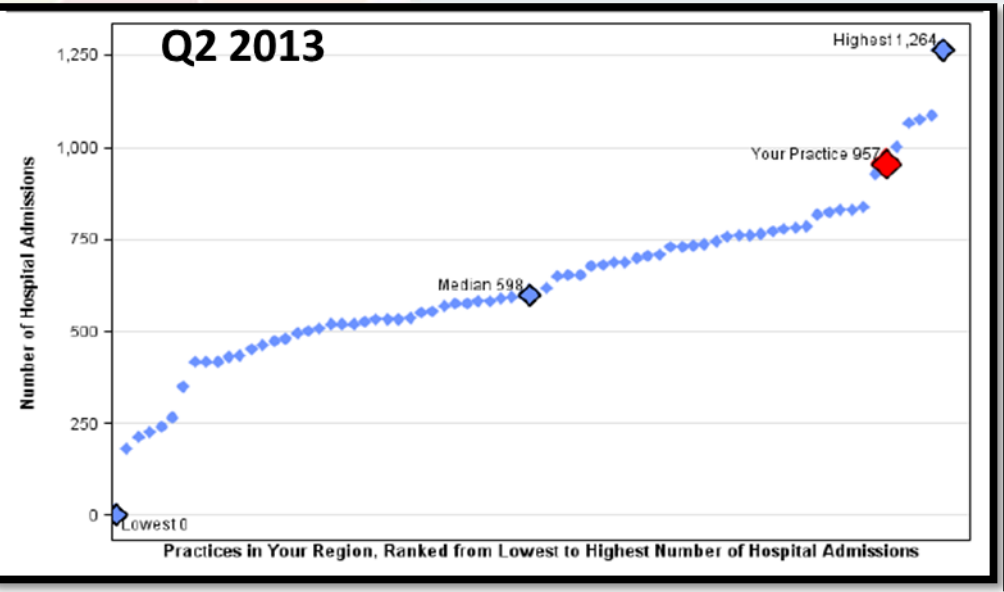

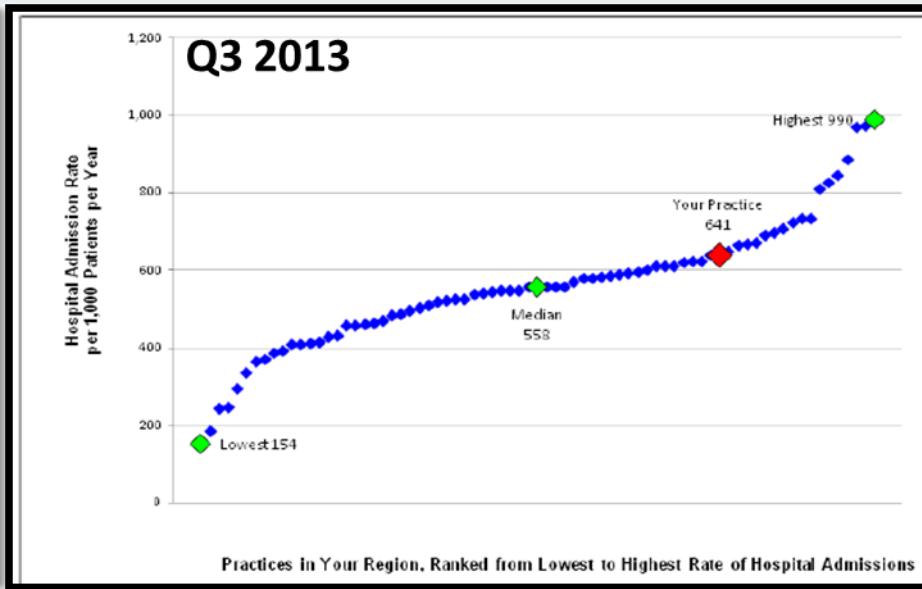

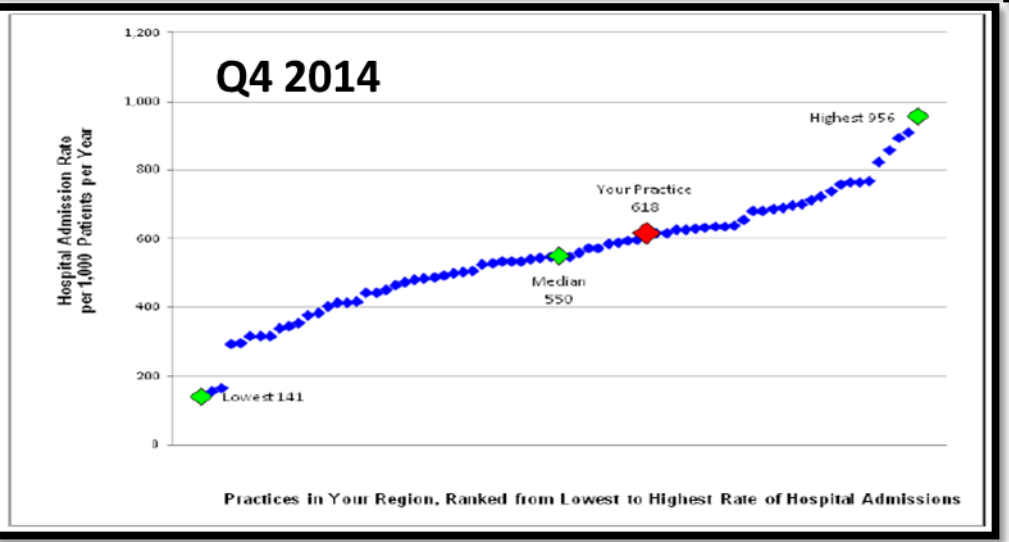

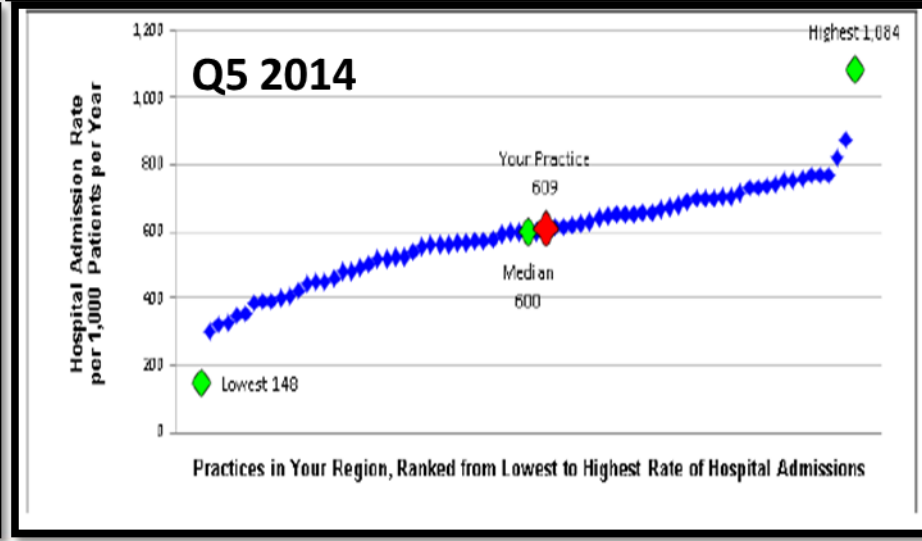

What we did

- Never waste an opportunity for change.
- We looked at all the data (both our own and peers), to explain our worsening performance.
- Our data showed that we take care of an older population than most of our peers (10 Percent more over 75 Y.O.).
- We had weekly meetings.
- We changed our behavior…..

What we did

- We changed everything….
  - Reception….TALKED SLOWER
  - Dedicated Triage RN
  - Care manager contacted every Hospital discharge
  - LPN speaks to every ED and urgent care discharge (that we get information upon)
  - The Doctors went to the ED (in the off hours 5pm till morning) for patients that were of questionable admission criteria….often sent home with next day follow up

What we did

- We met with the ED director to explain what we were trying to accomplish to enlist their support.
- For patients that stayed, we more often have them under observation status (converting to admission status as needed).

We

Communicated

What and How We Measured

- We used the Feedback report to follow our progress
  - As seen in the earlier slide we have had progressive quarterly improvement.

We have anecdotally surveyed our patients with this more aggressive style of practice…..They really do like to sleep in their own beds.

Adoption Considerations for Others

- Major challenges included:
  - getting the staff clinicians and support to buy in to the need for change. (We are great and the data must be wrong.)
  - Getting the hospital, particularly the ED to want to change it's behavior.
  - Getting patients to believe this style of care was in their best interest.
  - Several discussions with CEO

Adoption Considerations for Others

- All of our communities have their own idiosyncrasies, yet…simple team based steps can lead to significant improvement.
  - learn your population's demographics
  - Get the right people to work for your practice, (smart with a good heart wins over a paper degree every time)
  - Communicate all the time.

Adoption Considerations for Others

- Address what we still need to learn/don't know
  - Patients will continue to get older and sicker (they will have more multi-dimensional problems)..... They will end up in the hospital unless:
    - We develop better medical neighborhoods
    - We need more robust home services, particularly in the more rural area's
    - appropriate hospice and palliative care discussions

Adoption Considerations for Others

- Address what we still don't know:
  - After this part of the project is complete and we have appropriately compressed all of the borderline ED and hospital admits down, what is the next Triple Aim Project…
    - Specialty management/co-management,
    - Imaging utilization
    - Medication management
    - Streamlining the administration of insurance

Adoption Considerations for Others

Caring for our patients is more than the pills, potions, and mechanical things that we can do;

We as primary care must stand in front of them, behind them and beside them;

EPH 2014

Chat Harvest plus Q&A, continued

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Actionable Insights

- To be added by host and faculty real time.

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After today's presentation, don't forget to submit your feedback.

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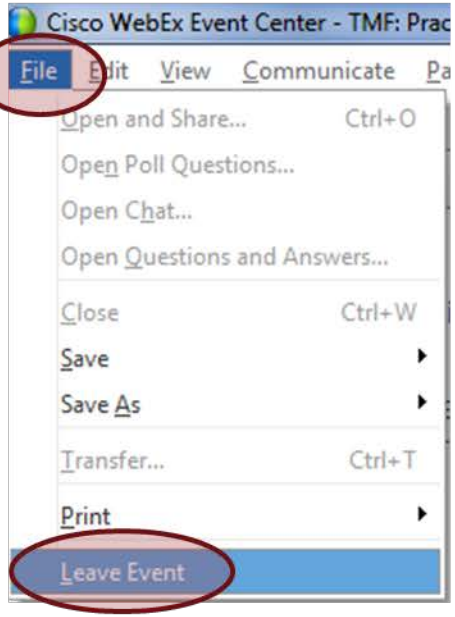

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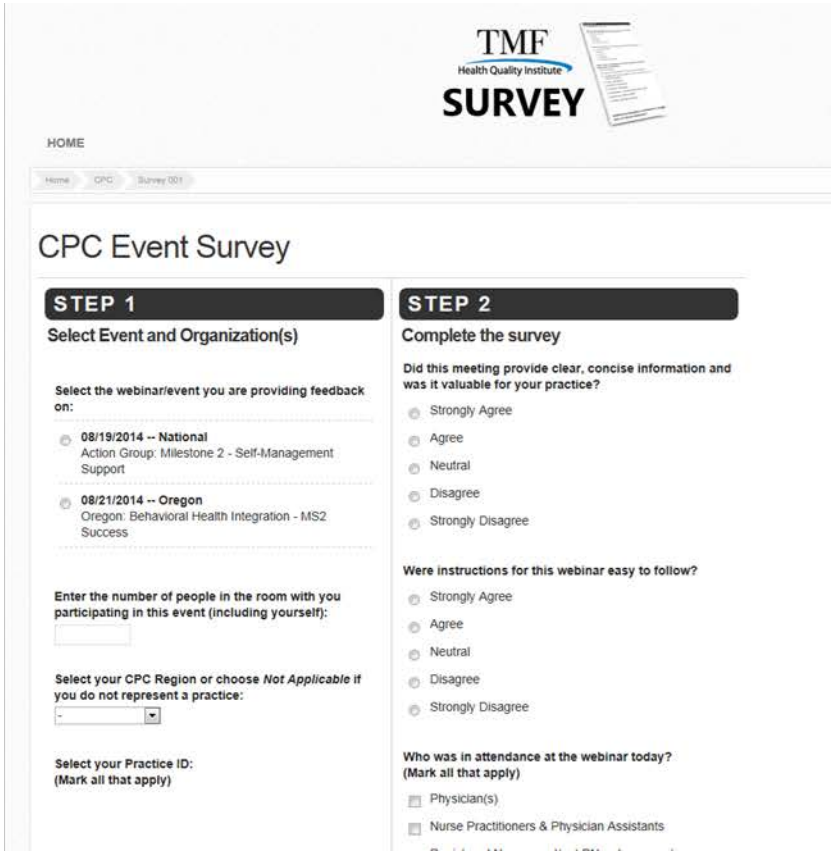
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