Rapid Cycle Action Group: Capturing the Opportunity in Transitions of Care, Session 2

Presenter: Connie Sixkiller, Warren Clinic Jenks; Pratheep Arora, Summit Medical Clinic; and Verda Weston, Utica Park

Moderator: Rose Langdon, Lisa Gatti, Rachel Wallis and Dr. Russell Kohl, TMF Health Quality Institute

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Hello, everyone and welcome. This is Rose Langdon from TMF Health Quality Institute. And we'd like to welcome you to the second live discussion for this action group, Capturing the Opportunities in Transitions of Care. Today, our focus will be on finding your ideal workflow for transitions in care. Keep in mind that these new Rapid Cycle Action Groups are really designed to help your practice make focused and meaningful changes over the course of the group. Many of you have already accessed the group folder on CPC connect and done a lot of posting, which allows you to connect with other practices and share tools, ideas, and examples with one another. Please be sure to log in and take full advantage of the use of this new and improved resource. Today we have several faculty to help guide the discussion, including Lisa Gatti, Rachel Wallis, and Dr. Russell Kohl from TMF. We'll also hear from Connie Sixkiller from Warren Clinic Jenks, Dr. Pratheep Arora from Summit Medical Clinic, and Verda Weston from Utica Park. We have a great discussion planned for today, but I'd like to make a few announcements before we get started. First of all, thank you to all of you who have put a lot of 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 program. This is your live discussion. So we'd like to be as active as possible. There are several ways you can join in the conversation. Above your name in the right hand panel, you will see the Chat icon. Click on that icon to open the Chat box. Now if you could just take a moment to be sure that the Send To box is set to all participants. This is how you can communicate with everyone that's on the line today. We'll be asking questions, taking polls, and many other things. So we want to see what the group is doing. You can always use the Hand icon just above your name to be unmuted and ask a question or share an idea verbally. And now, as you've done in many of these groups, please tell us where you are joining us from. If your annotation toolbar is not visible to you, click the marker at the top left to drop it down and select the black arrow. Wow, we're coming from all across all of our regions. This is wonderful. Excellent. We've got a good crowd here. Should have a lively discussion. And now we'd also like to know what your role is in your practice. If you could, once again, use your annotation toolbar to indicate your role. I see a good number of care managers, care coordinators, nurses, practice managers. We have physicians, administrative staff. And if you have indicated other, could you please go to the Chat box and type in what your role is in your clinic.

That would help us tremendously. And now if you'd like to turn your annotation arrow off to prevent annotating on the slides.

Thank you, Rose. And, again, welcome to everyone. We have a really exciting group of folks with us today that are going to share some of the wonderful work that they are currently doing in relation to transitions of care. So we're going to jump in and have them share pretty quickly. If you recall from the road map, we had asked folks at this point to be looking through some of your cases and do some chart review. And also try to sketch your first workflow, and what you might change. And we're going to see some examples of that. Hopefully by the end of this first session, everyone will feel prepared to initiate their first test of change. Okay, so we're going to jump right in and if any of you have either completed this formally or just want to share verbally, I would love to hear some examples that are coming from your practices of some either really excellent, unique times that transitions went well. Or some really challenging times that have occurred. You can either raise your hand, and it looks like we have a hand raised by Jerilyn Proximmer [phonetic]. Jerilyn? Oh, I think we lost Jerilyn. So if you would like to share verbally, raise your hand, and we'll unmute you. Otherwise you can also text in.

I have one for you.

Hi, Connie, thanks. What would you like to share?

We had a particular case where a patient was being discharged from SNF and went home. I called, spoke with the patient's wife, I'm doing a medication reconciliation with her. And everything's going swimmingly. And then we get down to his Lovenox. She's like, I'm not familiar with Lovenox. And I said that would be the injectible. And she's like, well, we don't have anything injectible. So after more discussion, I called the SNF. They were like, oh, yes, we have a whole bag of his Lovenox sitting, we forgot to send it home with him. And so it's, you'll have the patient's wife come back and get it, we'll give it to her. And so I called, spoke with her, she went back and got it, patient continued on it, and was fine. But to me, that was a perfect example of really why this is important. It's to catch those kinds of things because there is a classic example of a patient that would have fallen through the cracks had the phone call not been made and the medication reconciliation not done. And then obviously the patient was a high risk for DBT or PE. And we managed to prevent that by use of this role, which I think is really a great illustration of what we're even doing here.

Yeah, excellent, that's a great example, particularly because it is such a safety issue. And I think that's probably, that's, like you said, that's why we're doing a lot of this work and so focused on it, so. And if you hadn't made that call, it would have just absolutely slipped through the cracks.

Right.

And it looks like we have some chats in as well. Someone saying that a challenge is when they don't receive enough information from the hospital. We certainly know that that happens. And we also have an excellent TOC when the hospital has called. So that's great, that's great to hear that hospitals are involved and engaged. Wouldn't that be great if that could be standard, so. Anybody else want to share another challenge or a good example? Okay. If you have completed this activity, it would be great if you

wanted to share anything on CPC Connect as well. Oh, we do have a hand. Nope, we had a hand, Jacob Roberts. Would you like to be unmuted to speak?

Yes, I was going to say, you know, for the most part we have a relationship with Baptist Health and most of our patients do go there. But there's another hospital, Saint Vincent's. And their current way they do things, they just fax over the records at the time of discharge for ED or inpatient. Problem is, their entire system has had a problem lately where they're not faxing the full record over. Or it's getting jumbled up or we're only getting half a page. And we can't even say the patient's name, so when we call back to get them to resend the records, they say, well we need the patient name. And we have no idea what patient it is that this occurred on. And we've asked for like full access like Baptist has, but even that apparently is down. So we're kind of left in the dark with this, with one very large hospital system whereas another one is working. And even here lately I've been seeing that they're importing it electronically now. And we can see them come right on in from Baptist, but Saint Vincent's on the other hand has not been the case.

Yeah. And that's an excellent point. We all know that there are some times when our EHR's communicate well and sometimes when they're extremely challenging. So thank you for sharing. I'm sure you are not alone in that challenge. Okay, great.

Lisa?

Yes?

Rose Mason mentioned that outside hospitals not notifying them is also a challenge which kind of relates to what Jacob mentioned.

Yes. I think these three that we have listed right here show just how commonly this is an issue. That, you know, we know that if we're not being notified, or we're only getting part of the information. For example, not the name, that that is, obviously we can't initiate the transitions work that we would like to do. So I think that that's a very, a common problem and if anybody, we are going to hear in a little bit from Verda about a great strategy that they've been working on and they've been using to try to help with getting notifications and information from some of these trickier cells or outside hospitals and other facilities. So if anyone has ideas, suggestions, please feel free to chat or use CPC Connect to share those. Okay. I think that we're going to move right into then hearing an example from Connie Sixkiller. And Connie was kind enough to post this on CPC Connect quite early on. And she's going to walk us through how she's used that worksheet that was shared on CPC Connect to identify the areas that they will be working on during this action group as well as the workflow that they've come up with. So, Connie, I'm just going to turn it over to you. If you want to walk us through these areas, that would be great.

Okay, thank you. When this action group was posted, I decided that really this was an area that I thought we could really stand some improvement on in the office because there seemed to be a lot of transition of care visits falling through the cracks, if you will. They would be on the schedule, and I would not know anything about it. The patients would call, I didn't know that they had called and this is

particularly a problem when they were being discharged from an outside hospital because we have no way to track that.

12:20

So I decided that this worksheet was actually really helpful to help me kind of hone in on what I thought areas that we might improve. And I decided really kind of a standardized communication system. Particularly between our front desk with our patient service representatives and myself would help increase me being able to talk to people and not have so many people fall through the cracks. One of the things that I found also happening was we would have calls in and then if I was not available or they said she will be calling you later, seemed like when I would try to go to call them later, I would have trouble getting them. And then they might call me back a week later. So one of the things I decided that we should probably really work on was increased use of what we'd call a warm hand off from the front office to myself. And as you can see on there, CGN, I don't know what other people call it in other offices. Our role is the care guidance nurse in this program. And so we decided after discussing this with the girls up front and troubleshooting, we decided we would try to increase the use of a warm hand off where they schedule the appointment and then transfer the call directly to me. So I could go ahead and do my phone visit, do the medication reconciliation. And do all of my stuff right then and then it's all done and completed. If I am not available, then it was decided as opposed to word of mouth or them bringing me a note and putting it on my desk which was frequently getting lost. That we would use our EMR which we have EPIC here, and they would send me a phone note. That way it would not get lost in the shuffle. And I encourage team buy in with that by saying, you know, this is to help us track this stuff and see where there's breakdown. I said, that way if I miss anything, then I can tell that what areas I need to work on. And so, I was very careful not to try to assign blame or anything like that, just stating that the workflow needed some improvement and wanted their ideas and wanted their input as well. And actually they seemed very open to that. We are also trying to increase enrollment in our patient portal. And I'm hoping that we can get better access to the patients with patient portal. We have a lot of people non-English speaking. You get in there and their phone numbers are not valid phone numbers, and that makes it a lot harder to get ahold of the patients as well.

Yeah, great, that's wonderful that you brought up a lot of good examples that are, I think, common challenges as well as some real good, concrete ways of trying to address them. So thank you. And here now is the workflow that you've come up with which I think is just terrific because it right away illustrates that there are several different ways that these calls come in. So if you wouldn't mind just walking us through this, that would be great.

Okay and really our focus is workflow on what happens after the patient is discharged, and identifying those discharges and what happens once those calls come in. Occasionally, our clinical assistant may be notified. She has told me before like a patient called and they were needing a refill on something and, oh, by the way, they just got discharged from SNF yesterday. And so that is the rarest occurrence of that. Typically, most calls originate either with myself and I run the daily reports from our EMR and I can identify all the patients who were discharged from inpatient. And then calls from hospital personnel. Sometimes SNF personnel will call when a patient is being discharged, and typically they speak with our

patient service reps up at the front. So as we talked about the changes with the patient service representative. They go ahead and schedule the appointment while they have the person on the phone, be that staff or the patient. Then they transfer it to me and hopefully are able to get me directly into a warm handoff. And if not, they notify me by telephone or by a phone note in our EMR. If the phone calls originate with myself, and one of the things I'm trying to work on is I'm going to start making calls every other day to the SNFs where patients of ours are because we are finding we're really not getting good feedback from them. So I'm going to start doing every other day calls basically to check on the status and see if they have been discharged. And then if I originate those calls and I go ahead and schedule the, you guys call it TOC, we call it a transitional care management appointment. I go ahead and schedule that appointment. And then if the CA gets a phone call, she notifies me either via warm handoff or via a phone note in EPIC. And once that's scheduled, and I've talked to the patient or the caregiver and done everything that we're supposed to do, then I go ahead and document my phone note.

Wonderful. So as I am hearing you talk and looking at this, I'm seeing a lot of things that you're going to be changing and trying to make standardized. Do you, have you thought yet about how you're going to monitor this and you know calling them - labeling them as process measures. It doesn't even have to be that formal. But ways that you're going to see whether or not this new workflow is being implemented, and how frequently that's happening. Have you gotten that far?

I think it will actually be fairly easy to track because we do a daily huddle before clinic starts with both the physicians. Go over the patients that are coming in. And that is how I identified where the breakdown was in the first place. So what I'm thinking is I can compare the random previous 30-day time period to a 30-day time period implementing this workflow and see if we have people who fall through there cracks. And then identify specifically the reasons for that and see if there are any other changes we can make. That sounds wonderful, that's great. And we can certainly think more when it comes to the actual process measures. If there are ideas if anybody wants to share or if you want to brainstorm at all, we can do this today or via CPC Connect. It's also great to have some actual measures that you're looking at. So if there's a simple way to just count like a checkmark whether or not this flow was followed, yes, no-type of thing. Even though, ultimately, you know, what you're interested in is are we having folks slip through the cracks. But there are even ways before the, I love the idea of the 30-days because that's going to give you a very real comparison. But also in the meantime kind of just seeing, are we even implementing this as we planned? Or is there a breakdown just like you said you had identified that there were breakdowns in those huddles, you might be able to identify earlier on that, in fact, one of these components isn't happening as you had planned, so.

Hey, Lisa?

Yeah?

This is Rachel Wallis. So we have a question in the Chat for Connie about what CA means in the workflow in the upper right hand corner.

Clinical assistant.

Okay, thank you for that, Connie. And then I also had another comment. Connie, I know that you mentioned you were going to call the SNF's office every other day to try to get the information. I've been hearing in the field that some of the practices have kind of resorted to forming a medical neighborhood type group with the hospital discharge clerks, SNF, representatives, home health representatives just to try to hammer out everyone's needs. Have you guys thought about that or anyone on the line that might be willing to speak about that a little bit?

I would love to hear some input on that because I really have found that to be particularly challenging. My other thought was just to go out and actually go to the facilities, introduce myself to the discharge planners. Like I said, the hospital isn't a big deal, but it's really SNF and rehab that I'm finding problematic. And just introduce myself to discharge planners with the hope that then maybe the fact that they could put a name with a face might remind them better to give me a call, perhaps. I had initially tried sending them emails and leaving them voicemails, and that has not really seemed to help.

Yeah, Connie, that's what we were a lot in the field as well. Let me ask by raise of hand if someone might be willing that's on the line to comment to that. Angie Walker, I know you guys started meeting with home health. If you might be willing to raise your hand and share with us if you're still doing that and how that's going. If you're working with your nursing facilities there, we would love to hear from you. Or anyone else on the line that might be willing to share. If you'll just raise your hand, we'll unmute you. There's Susan. Hi, Susan.

Hi, there. We've worked in coordination with community care which is one of our health plans involved in the CPCi. And they have a meeting of all of the contracted skilled nursing facilities in our area. We frequently attend that and get an opportunity to reinforce with those discharge planners and with the administrators of those skilled nursing facilities how important it is for us to be made aware of the patients that are under their care. They have an obligation to start discharge planning as soon as those patients are admitted to their facilities. So, you know, I think we're seeing some improvement, but we still have a long way to go as far as impressing upon their staff how critical it is to have these positive handoffs once those patients are leaving skilled nursing.

Thanks for that, Susan, so much. I can't stress the importance of that, so it's just something kind of caught fire for us. At least in my market, what I'm hearing in the last six months or so, people really actively reaching out to those individuals and having regular meetings with them. And not just individually, so not just with the SNF and not just with the hospital. But trying to actually bring them together. And I see a lot of that going on in the actual meeting space being at a hospital facility. So I just wanted to throw that comment out there, Lisa, to get people thinking about that idea if they are not already doing so.

Yeah, that's a great, Rachel, thank you for bringing that up. And if I, one way that we can use CPC Connect is to start a train, you know a communication chain right there where if folks have ideas if they've tried things that have worked or not worked, that they can add that there so that folks that are working on this now have some ideas and some support. So and I think this is one of those areas that would be great. And Dr. Arora, did you have something to add? You can unmute yourself.

24:16

One of the challenges that we see in our practice is this enormous request in home care increasing utilization. And I think that's become an area of concern that we really don't have any good mechanics to track down to try to really see what degree of services are needed. And I wonder if anyone has some experience in the practice about increasing requests for, you know, increasing care for these patients?

Yeah, that's another really good area. So does anybody want to share whether or not they've had some experiences, positive or negative, with the increased request or use of home care? That would be another area that would be great for CPC Connect. Oh, so we have several hands. Melanie, can we unmute Melanie? Hi, Melanie. You might be muted on your phone, we're not hearing you. Still not able to hear you. Why don't we have, if you wouldn't mind just trying to Chat in, I don't think that the connection is working, to hear you verbally. Sheila, can we unmute Sheila?

Hi. Yeah, what we did here at Claussen, we hired a care coordinator specifically to go to the hospital and follow our high risk, frequent readmits. And she has been very good in getting with the doctors and ordering home health. She's laying eyes on these people, talking to them, seeing their home situation. And we have really increased our home health usage and, in turn, I really think that's keeping them out of the hospital.

Great. So for you, overall, the increase in the requests and the use of this has actually been positive? But it sounds like you've also put some things in place where you're able to communicate with them and see what's happening with that so that you are in the loop.

That's right. Even some of the pharmacists, we have part-time pharmacists, will round with her, do some education. You know, the ones that are on multiple meds and just kind of different things like that. And that's really, it seems to help so far.

That's wonderful, thank you for sharing.

Thank you.

And, Melanie, did we want to try, do you want to try to unmute again and see if we can hear you?

Lisa, it looks like Melanie is connected through her computer, and the microphone may not be configured properly. So the Chat is the best option.

Okay, sorry about that. And it looks like we already have in the Chat from Tony that the increase in requests has put a burden on the PHNs. So they don't have a lot of options in rural areas for other nursing groups to come unless they are qualified for that service. So it seems like Dr. Arora, that, you know, there are folks that are experiencing some increased burden or work because of this as well. And in Boulder County. Oh, this is a different comment. So, yeah, I think that's another area that we can post up there and CPC connect to maybe get some dialogue going to see if folks have found ways to make that change be more positive for you and your practice rather than more negative. Because it seems like it's an area that is certainly going to continue to increase. So, great. I am going to keep us rolling because we have several topics to talk about. But I did have, so Connie, you had also posted this on CPC Connect

a little while ago. And I wanted to bring it up here. This is the checklist that you, yourself, use, I believe, during the visit. And there was some conversation stimulated on CPC Connect about billing, because this is one of the, one of the tools that you use to help with the billing. So I want today just give an opportunity if either you wanted to share anything about billing or anybody wanted to add to that conversation because I know that that's another potentially hot topic within this work.

There is provided to the physician at the visit along with a printed copy of the discharge summary. Medication, reconciliation has already been done on the phone by myself, but then that's also verified by the clinical assistant when they come in for the visit. And it's really just to help guide the physician and make sure that we're hitting all components that are needed for the transitional care billing. Basically, just make sure we don't [inaudible].

That's wonderful. It seems like a really great solution. Does anybody have any questions for Connie or any comments that they would like to make specifically related to billing and documenting for that? Again, feel free to raise your hand or chat any questions or comments. And there will be some time at the end as well if you want to revisit any of these topics, we can do that.

Lisa, this is Rose. Melanie did chat in that she frequently utilizes home health services to assess for needs. Once services are in place, this allows her to have the skilled assessment on a regular basis. The nurses are very thankful to have a contact point within the primary care office. It is very valuable resource, especially to those high risk patients.

Great. Thank you, Melanie, for sharing. So, again, it sounds like it can be a really positive sort of movement, so, okay. So now I'm going to take just a minute to find out where you guys are considering really focusing this work. We had asked this last time, but they were some broader areas. Some of the things that I've been seeing on CPC Connect, some of the conversations that have been occurring have had to do with educating patients about ER visits and that type of thing, as well as some talk about home visits and billing and some phone scripts. So I'm interested to hear from you all where you are actually working. Because I know if you have posted something on CPC Connect it may be a tool that you previously created, it might not be where you're focusing your work now. So if you could just share with us the area that for this action group or this timeframe right now that you're planning on primarily working. I know that you might be doing more than one of these.

31:07

Great. And if you chatted other, if you've pointed to other, if you'd like to chat that in, that would be great. So it looks like the vast majority are working with educating. And this is great because on CPC Connect, we've already had a lot of sharing of tools that folks have used. So hopefully this will help you all with that work so that you're not starting from scratch. Because I know that some practices have already developed and sort of tested some of these educational tools or the different techniques. And same thing for the phone call scripts. The medical neighborhood, it's a little bit harder to share actual tools, but I think the conversation that started earlier about how do you go out and communicate within the medical neighborhood. Whether it's meeting someone face to face or in a group setting or doing

regular phone calls. You know, these are all different types of strategies that could be discussed. So it looks like quite a few of you are working in that area. All right. Did anybody want to share from the other category what they were, what you are working on? Okay. Then we will just move forward. I would like to now ask Dr. Arora to share more with us. So, Dr. Arora comes from a solo practice in Colorado. And he is going to talk about a unique strategy that they've been developing as well as how they're trying to work on evaluating it with process measures or sort of real time evaluation. So, Dr. Arora, I'll turn it over to you.

Thank you. We started forming this idea of home visit about a year, we started around October of last year, when we saw there was a surge in the ER visit despite having extended clinic hours. And what we recognized by looking at those emergency room data and patient admission, that essentially the majority of them are the same patient who keeps going to the ER for noncritical emergency room visit. And this is despite, this has occurred despite having care management done in the office. You know, that the patient has scheduled for at least 30, 40 minutes with the provider and the care manager. So, certainly, that in office discussion of care management did not appear to provide adequate education or a barrier from patient to go to the ER for an office type of a symptoms. So we turn our focus and looked at the list and said why don't we just go ahead and just make an appointment with the patient, go by to their home and try to really figure out what is going on and why is it that they choose to go to the emergency room. And started tracking down this process. Both the local hospital here have an easy access to EHR that we can access by our care manager in the office. So what we do is we look at the list now every day in the morning and discuss it during the huddle. And we inform the team who was in the emergency room and which patient got admitted or which patient got transferred to SNF. And we started keeping a track of this. What we found during the home visit was there were several issues that kind of led them to go to the ER. Some of them being that there is no copay that they visit the emergency room. Some of them did not realize that the office had extended office hours. And some of them did not think that it was necessary to call the office if only go to the ER. With that, what I have seen over these past 12 months is the visit to the emergency room has definitely decreased. And which patient are going to the ER actually patient that really need to be seen in emergency room and majority of them led to an admission of some type with some potential life threatening problem or some very critical condition. So the pattern that we see in the hospital for my practice has suddenly, has changed. And it has changed into more of a more sick patient that really needs, you know, hospitalization. We started tracking down on our Excel sheet and our daily ER visit is now averaging about anywhere between five to eight ER visit. And out of these, you know, about three to four gets admitted for some various reasons. What the data we have found is majority of the patient who goes to the ER are now calling the office first. They're informing us why they're going to the emergency room and if we think that those condition are potentially treatable in the office, we recommended coming as kind of almost like a walk in that we'll make our way to see the patient. If the need for the ER is there, we have already reviewed the chart, we would have talked to the emergency room. Either the charge nurse or the lead doc, letting them know why our patient is there so they're quite aware. We would have reviewed most of the diagnostic testing that's been done like an [inaudible] or colonoscopy. We have seen a surge in the number of patients calling to the office that they're going to the ER. So that is really a good positive outcome for us. And in the same context, we have realized that our high ER utilizer have actually

decreases. And they're fully aware, they know that something is changing and somebody's really looking at their pattern of utilization of the emergency room. And some of these patients, we have kept away from the emergency room for the past several, several months. They're still battling with the hurdle of new patient who comes in who kind of wants to go to the ER for, mainly for pain control. And the pattern of treatment emergency room has changed, and they do not spend much on pain control medication now, so these folks are now being diverted more and more to the office to be seen. So in a very brief, this is what we have done in the past 12 months, I am quite encouraged with the results of what we have seen. I think the hurdle that we have that this is very labor intensive. That when I go with a two MA or an MA or a care manager, between the three of us, we spend about ten hours a week combined time. So that puts us at about 40 hours a week that we are doing out of field, you know, of service. And our care manager is providing at least another 40 to 45 hours in the office. So it's very labor intensive. My concern is about once the CPCi program goes away, whether we would be able to sustain this type of effort to try to cut down the high cost utilization. And in a nutshell, that's what it is.

Thank you so much, Dr. Arora. That was great. I loved the fact that you are able to see some changes, and it's within that time frame and that you have found ways that you can actually track your progress without having to wait for some of the utilization data that, as we know, is quite delayed. And it looks like we have a comment down here specifically from Catherine Clark specifically to you. Saying that they also contact the health plan to help with care management for these high ED utilizers. And that or those that have been hospitalized recurrently for complex problems and that they've gotten significant help. Especially with Medicaid plans. So that might help either you or other practices dealing with some of the time burden. So that's great, thank you. Does anybody have any specific questions for Dr. Arora at this point? Again, I really, I like the fact that you're not only seeing improvement in some of the outcomes, but also that you're able to track a difference that patients are calling you first before they go. So that's really a wonderful way to assess how your patient education and how a lot of this time intensive work has been paying off. So that's an excellent example. And so there will be, like I said, time at the end to ask any questions if anyone thinks of anything for Connie or Dr. Arora. But I think at this point, we're going to switch over to Rachel and Verda.

Thanks so much, Lisa. And, Verda, if you could go ahead and unmute your line for me so we can chat a little bit. Thanks, Verda, for agreeing to help us out such last minute. Verda's with Utica Park, and they're doing a lot of amazing things over there around transitions of care. And so, Verda, what I would like for you to talk about with us today a little bit is, one, how do you get notification from interface outside of your system when someone has been discharged. And, two, I would like for you to also to chat with us a little bit about your program for screening for readmission risk. I believe it's your BOOST program. So with that, Verda, I'll ask for you to share with us a little bit about first how you get information on patients outside of your system.

Okay. Thanks, Rachel, good morning, everyone. Utica Park clinic has 15 practices in CPC, and we have a central office that coordinates a lot of the informatics activities. We have been working with MyHealth since October of last year so almost a year on collecting information about our patients who are seen at other facilities that are captured within the health information exchange at MyHealth. There are more and more facilities beginning to supply information to MyHealth. We worked through several different

issues with them last year. The first one was just patient attribution. MyHealth has a leadership body of physicians and other leaders that had established an algorithm for attributing patients to primary care providers, primarily based on recent activities within the last 18 month. So if a provider's name showed up as the ordering physician for a number of activities and admissions and ER, maybe some laboratory work done at an outside lab. That patient would be attributed to the provider whose name most frequently appeared as the ordering physician. So we worked with them on a couple of issues to try to capture our providers. I'll just share with you some of our challenges that Utica Park clinic providers are always changing. We lose some providers periodically, we add some providers. And so maintaining an up-to-date listing of providers that are participants at Utica Park Clinic within MyHealth required us to establish a workflow and a routine update of that information. So we could make sure that if we added a new position or lost a provider that we would not, we have access to the correct information. So we created a [inaudible] protocol center that we share information with them. They post a file for us, 5 a.m. every morning that we're able to go in and to download the information on patients that were seen that were Utica Park Clinic provider patients at any hospital in any emergency room, any discharge. We did several months of data validation and moved it from an 18 percent capture to about a 95 percent capture of patients. So we've felt very confident that we are getting the [inaudible] and other practices. In the past, we have used that information to do automated phone call outreach for emergency room patient. That did require some integration work between our automated calling system, which we use Phytel Population Management System. And then integrating that into our EMR. So we did create a post back feature into a TOC template, transitional call template. So that escalations could be managed and the ER call interaction was documented in the NextGen EMR. So that's kind of what we've done with MyHealth. We're continuing to work with them on developing more information and trying to utilize their services and their broad network of hospitals to find our patients that are going outside of our system. And MyHealth is expanding their services to the entire state of Oklahoma. So we should have a number of, hopefully. Hopefully we don't have to.

45:52

Southwest Oklahoma, northeast Oklahoma.

That's great, Verda. And so MyHealth is the HIE there and just to let every anyone on the line know and Verda's been working very closely with them to try to fill those gaps. And, Verda, so on the conversation of gaps, we know a lot of times if there are patients that kind of fall through the cracks, and they may be more at risk for being readmitted, then another patient. And so can you talk to us just a little bit about the new program you guys have implemented and how it's working?

Sure. Let me just, let me just comment on stratification for just a minute. The initiation [inaudible], we went through a process, and risk stratified I'd say the majority of the patients that were contained in the CPC practices. Because we know that the knowledge that we're gaining in CPC pertains to all patients. We have worked with our population health system to create an algorithm that is - I won't say automatic because there's a lot of work behind it - but it generates a risk predictability score outside of someone actually doing that. We've pulled that up from our variety of different places, and now we are in the implementation phase of this project. And we have validated the risk score in this automated

algorithm, and it's matching our assessment pretty closely. So very soon all of Utica Park Clinic will have all of their patients risk stratified in a field that's in the EMR. For us, that's really important as we look at transition care. Whether it's to SNF or outside of hospitals to know where those high risk patients are. So that's one thing that we're doing to that. We partnered with a primary hospital, Hillcrest Medical Center, a little over a year ago to help identify patients that were high risk for readmission at the time of hospitalization. Because of the health system that we have, Hillcrest Health System has six hospitals. We're able to access their networks pretty easily for EMR information through the hospital, as well as other data. We pull a daily discharge list that is distributed to all of the clinics of patients who were discharged either as an inpatient, as an observation patient, or as an emergency room patient out of the six hospitals. We also create an admin list that's delivered to our social service staff and allows them the opportunity to visit patients while they're in house. But what we were missing were those patients who were high risk potentially for readmission. So using a system called project BOOST, BOOST, all capital letters, stands for better outcomes for transitioning patients. It's a tool developed by the hospital this side of hospital medicine. It's a hospital's professional organization that has researched reasons for readmission for some time. We have implemented with the hospital the BOOST tool, and there are eight questions. They're called Ps because they all start with the letter P. Eight questions that are assessed by the admitting nurse at the time of the patient being placed in their room. Right now we're in a pilot phase with three med surge nursing units getting ready to meet today to plan the roll out for all of the remainders of the nursing units in the hospital. But the questions are, problems with medications. This would be a checkbox would be placed in problems with medications if the patient had more than ten routine medications. If the patient was on any high risk medications which are defined as narcotics, antiplatelets, anticoagulants, insulin, and a couple of other medications. If the patient is on those medications at the time of their admission to the hospital, a checkmark is placed. We're also doing a PHQ2 depression screen to determine if depression is a component to the patient's care. If that PHQ2 is positive, a check is placed under a tab called psychological. And a social worker's contacted for completion of the PHQ9. The additional appeals are principle diagnosis. We're really focusing on those Medicare-targeted diagnosis of AMI, CHF, COPD, pneumonia. And then within the hospital, cancer and stroke as well. Those actually take a little bit different workflow. So if a patient is in one of those, has one of those diagnosis, a checkmark is placed. We're also looking for patient support issues. Do they have care at home? Do they live alone? Physical limitations? Are they frail? Do they have DME? Or will they be needing DME because of their current hospitalization? Poor health literacy is the other, one of the other Ps that we're looking at. Does the patient understand their illness well enough to engage in self-management teachings? Or will they need additional support? And then, finally, palliative care. Is the patient a candidate or currently on palliative care services? We know that for some of those CMS, target diagnoses, there are those illnesses as they advance become a palliative care patient for COPD and CHF. So any of those Ps that are checked positive are discussed at a huddle meeting on the floor every Monday through Friday. And we have transition care coordinators who are in place in those huddles and will listen to the discussions and then begin to educate patients who are identified that need specific education. The transition care coordinators follow those patients for 30 days after discharge. And then like some of the conversation we've had before, we'll do warm handoffs to the care coordinators that are embedded into the CPC clinic.

That's great, Verda. It's such impressive work you guys have going on there. And the fact that you're working on the inpatient side as well as the outpatient side together to prevent these readmissions. That's awesome. Any last things you want to share about that, Verda, before we take some questions?

51:33

I think like everyone, we're starting to get traction in a lot of the activities that we've had. And it begins to open up opportunities to then begin focus on those things where we know were gaps. Like what we've heard on the phone today, we have gaps with home health, and we have gaps with some of the providers. But we are starting a pilot with two SNFs who are willing to look at a project BOOST tool for the SNF services as well. [Inaudible] hospital medicine does have a BOOST tool that's focused on skilled nursing, long-term care patients as well. So we're going to explore there a little bit and see if that's an activity worth pursuing.

That's great, Verda, that's great. Well thanks so much for sharing with us today. And if you have a question for Verda, we can take some in the chat or, Lisa, I'll turn it back over to you to manage the time between now and the end if we want to check in verbally. But we can also take this over to CPC Connect to share as well. So thanks, again, Verda.

Yeah, thank you, Verda and Rachel. I just would like to open it up. If anybody has questions or comments for any of our practices that have shared with us today. You guys have shared some really great ideas and solutions as well as challenges. We will continue this on CPC Connect, but if anybody had anything they wanted to bring up now, please raise your hand or chat it in. I'll just reflect it sounds like I really liked your closing comments, Verda. In terms of that, some of these big pieces are coming together during from the CPC work. And to hopefully other practices are feeling that as well in terms of now is a time that you can really start to focus on maybe some of those gaps, which I think is a really wonderful place to be in terms of how far everybody has come in the last couple of years. Okay, well, we'll move on. If anybody would like to add anything, just chat or raise your hand. But I would like to do a quick status check with everyone, see how we are doing in terms of our road map and making the progress that we would like to for this action group. So if you could use your annotation tool again. And we're just going to have you mark. You can use the green checkmark there on the bottom left to say yes or the red X on the right to say no. And if you're somewhere in between or want to talk about something, use the yellow. So first question is, Have you created a first test state workflow? This is sort of the homework for today. So we're hoping that by the end of today, folks are ready, they have an idea that they are ready to test. It looks like a lot of folks are. So that's great. And for those of you that are in the red or the yellow, if there's anything that - any type of assistance you need - I realize sometimes it's just time that is needed. But if there is someplace that you're stuck or a tool that you would like, please chat in, raise your hand, post on CPC Connect. The whole idea is to be sharing and helping each other so that we can get you over to the green. Anybody want to share now if they're having a particular struggle or have a question that they'd like to post to the group for a group brainstorm?

Hey, Lisa. We have a comment. I'm not sure that it's to this specific thing that we're talking about now, but they're having a little trouble, Rose is, with getting people to return the contacts. So they're reaching

out post-ED, and they're wanting some more information. So I don't know if we want to take this to CPC Connect, but if there's anybody on the line that could share this practice with how to get in touch with people post ED. Lisa, or I'm sorry, Rose would love to hear that.

Yes. And, Rose, if you are on CPC Connect, I think that would be a great place. I can post it, you can post it, that way people can actually even share if they have some tools. They can post them right up there. So we'll make sure I have a little running list here of things that we're going to, the conversations that we're going to start on CPC Connect. So you guys can look for that so that you can share when we're done here, okay. Okay, great. And I'm going to skip now down to the bottom one here. If you want to, I can clear your arrows. And if you wouldn't mind telling us if you have identified measures, process measures that are going to help you evaluate and track your progress with this first test state workflow. And, Verda, I'm just going to ask you while folks are doing that. A question just came in about the BOOST site. Do you know if you need to have a subscription or be a member or is it open access? That's a really good question. The BOOST, there is online information regarding BOOST that you can see and learn more about. The site of hospital medicine has changed their process this last year. In order to, I'm going to call it full advantage of the BOOST program, you do have to subscribe to their service for a year. And that subscription is based on size of facility and a few other pieces. And you do get an onsite orientation. You get a mentor assigned to you for a year that is available to coach you through implementation issues and other things. So that's what we're seeing. And once you sign up to their program, then you get full access, you are assigned access, you get full access to a number of things. Similar to CPC in terms of Chat boards, blogs, other resources. So there is information online that there's a program to engage with BOOST tool in total. And they do have system pricing as well.

Okay, great. That's good to know. So folks can do a little bit of back research, but then if you're interested, it sounds like probably contacting BOOST themselves to find out about if you're actually interested in joining. So, thanks. And it looks like we have said some response about the letters. So in the chat, we have Janet responding that they will send letters to patients who've had an ED visit. So, let me say for two reasons if we needed to leave a voicemail or if the ED visit was an ambulatory care sensitive condition, then those would be the two reasons that they would be sending a letter. So, again, if folks want to contribute to that conversation, that would be great. We'll get something set up on CPC Connect. And I have to say I'm thrilled to see that we have everybody in the green for the measures to track. We're out of time for today, and I think that that's okay because this is a great place to leave off. I would love if folks were willing and able to share that on CPC Connect to let us know what you are, what you're using for your process measures. So I think that's a great way to facilitate creativity or maybe give an idea to somebody that is doing similar work. So I am going to pass this back over to Rose to end. But please go on CPC Connect, and we'll continue these conversations as well as start the conversations about process measures.

1:00:03

Thank you, Lisa. And if you could advance to the next slide as WebEx closes, you'll be automatically directed to a survey. I did post the link to the survey in the chat. If you've had problems in the past and would need to post this in your browser, please copy the link and be prepared to do that if it doesn't

pop up automatically. Keep in mind that your feedback on this survey is used to continually improve our learning opportunities and we're requesting that all attendees, practices, panelists, faculty, and other guests complete the attendance and organization demographics portion of this survey, as well as provide feedback on today's discussion. Up to ten attendees that are participating in the same room may be listed on one survey. Once it's completed, be sure to scroll to the bottom of the survey and hit submit. You will then receive verification on the screen that your survey was complete. We're looking forward to continuing this conversation on CPC Connect. And we'll see you again for our next live session in two weeks. Have a great day.