Milestone 3 Action Group: Access to Care Outside of Office Visits

Presenter: Cari Miller, NJAFP (NJ faculty)

Moderator: Rose Langdon, TMF Health Quality Institute

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Hello everyone, this is Rose Langdon from TMF Health Quality Institute. Welcome to our Milestone 3 Access to Care Action Group session entitled Measuring and Optimizing Continuity in Your Practice. I'd like to start things off today with a few announcements. A new post event survey has been developed with the aim of capturing information that will help us understand our audience as we plan for future events. We are requesting that all attendees, practices, panelists, faculty, and other guests complete the attendance and organization demographics portion of the survey as well as provide feedback on today's session. Up to 10 attendees participating in the same room may be listed on one survey. We appreciate the presenters' time and effort in preparing for and sharing their valuable knowledge. Any statements about the quality or utility of any product or vendor made in this presentation is an expression of the opinion of the person making the statement only and not an opinion or endorsement of the Center for Medicare and Medicaid Innovation, TMF Quality Institute, or the host of this presentation. And now, I'd like to introduce you to our speakers for today's session. Leading our discussion will be Doctor Gerry Prosswimmer from Hunterdon Healthcare Partners and Cari Miller with the New Jersey Regional Faculty will be facilitating this session. And now, as you are so familiar with, if you could please click the annotation button on the left side of your screen and select the black arrow underneath it and indicate where you're listening to us from. You guys have this down to an art and a science. Excellent. We should have some great discussion today. We have all regions represented and I would bet that this is going to be a very interesting presentation. We want you to be discussing during the session. Okay and until we need the annotation arrow again, if you could please go back up, click the black arrow again to turn it off until it is needed again. And now a couple of live session pointers. Keep in mind that this is your action group. We are going to be very interactive using polling on the screen, the Chat box, and also we want you to raise your hand. The discussion will be continued in the forum after the session. The most activity, the more learning. We encourage you to click the Chat bubble at the top of your screen and let us know what question you would like to be answered today when we talk about tracking for continuity. And now, I'd like to turn the microphone over to Cari Miller to kick off our session.

Great, thanks Ruth. Welcome everybody. So for us to get a feel for who is in our audience today, if you can again, click on the arrow button that you know so well and let us know what your role is within the practice. Its gives us an idea on who our audience is today. Great. So we have a lot of project management for sure and a lot of care managers. It looks like you are all leading the pack as far as winners. If we were giving out prizes today, both of those categories would win for sheer number. So that gives us a great idea on who is participating in today's call, and we really appreciate your time and

letting us know that. Doesn't look like we have any physicians in the audience and we have somebody who has another category. We'd love to hear from you in the Chat box when you get a chance on what your role is within the practice. We were trying to cover everybody, so again, if we've missed a professional area we'd love to hear about it. So to get the presentation started today, what we want to do is also get a feel for where you are currently in your practice as far as how do you implement the strategy for measuring continuity of care in your practice. So again, if you can click on the arrow and please let us know with one of these four boxes to where you currently are in your practice. So we did have a no there and I saw you quickly change it, that's great. So we have a lot of yeses, but we also do have a bit of I'm not sure, so that's great. This presentation is going to provide information on that and then we also have quite a few of you who are in the planning stages, so I'm sure you're going to get a couple of great ideas from this presentation that's going to put you in the right direction. Okay terrific. So if you could just again click on that annotation arrow to stop the annotation and remember, the Collaboration website is where we share information. Jay Runyon, part of the New Jersey faculty posts there often. We have had a couple of posts come in, so again we just want to remind you to go to the forum to post your thoughts about this action group. Specifically, focusing on the continuity of care or access to office visits outside of the traditional office visit. Post the ideas that you may have come from, away from from this presentation and again, we want to keep this going between now and the next action group. So please, we know right now the subscription service is not working, so we do recommend that you check there frequently just to see if anybody has posted anything, especially if you've posted a question or shared something to see if you have gotten any response from your colleagues and peers in other regions that are also focusing on action group three for access outside of the office visit. So again, just a reminder, keep the discussion going. We'll do our part and we're hoping that you'll join us in doing your part. So we are focusing today on the benefits that include, to include patient access outside of normal office hours. Jay Runyon has been posting. These are two of the latest posts that we've put up there regarding virtual office visits, regarding health apps, regarding social media, and we want a thanks to Tammy from Batesville Family Practice Clinic who we've posted your most recent post to the Collaboration website here for everybody to see. One of the most recent posts we put out there had to do with some Facebook and social media questions and Tammy posted a comment regarding that they are currently working on a Facebook page for the practice and they're hoping to have that up soon. So if you have any insight or any thoughts or any lessons learned or anything you'd like to share, please visit the website and contribute your knowledge and wisdom and experience. It would be greatly appreciated by all your colleagues and peers in the regions. So again, just a quick reminder. I'm going to be turning this presentation over to Dr. Prosswimmer, but again, please utilize the Chat box or raise your hand and we'll unmute your phone because we want to keep this as interactive as possible and the way to do that is for you to contribute with your questions or your comments or just general statements about what's going on in your practice regarding continuity of care. So at the end of this session, we're hoping that you'll be able to — we're confident I should say that you'll be able to determine how to generate continuity of care reports from an electronic system, you'll describe who is responsible for the continuity of care reporting within your practice and also determine the frequency for when and how much this information should be generated and the methods and communication vehicles to share this information with your practice team, with your providers, and your physicians and also discuss how practices such as Dr. Prosswimmer's are using the

continuity of care reporting and other reporting capabilities to determine whether changes need to be made access to care based on patient population within the practice and also discuss changes that have been made based on the data that they look at from their reporting. So I'm going to turn this over to Dr. Prosswimmer.

And Dr. Prosswimmer you need to unmute your phone please. There you go.

There we go. Hi everybody I'm Gerry Prosswimmer. I'm happy to talk to you today a little bit about the continuity of care experience at Hunterdon Healthcare. Let's see if I can get my slide advancing skills on par here. There we go. First, a little bit about Hunterdon Healthcare. We are an integrated delivery system, an IDS, with both employed and independent physicians. We're located in central New Jersey. We're in an area I would describe as agricultural, but with ready access to two major cities in the northeast; New York and Philadelphia. We have two NCQA, I'm sorry 24 NCQA Level 3 Patient-Centered Medical Home sites, and we became Patient-Centered Medical Home certified in 2002 and just went through our first cycle of recertification. Of those 24 medical homes, 11 are CPC sites, six of which are employed and five of which are independent practices. We've got just over 30 physicians plus our advanced practice nurses and PAs who are involved at CPC sites and just over 44,000 patients enrolled. We all have a single EMR, which is NextGen. When we started to think about continuity of care and how we were going to define it, we looked at a couple of different ways to do that and the first definition of continuity of care that we looked at was the NCQA definition. And according to the NCQA, element 1D3 of the 2011 survey, continuity of care was defined as the total proportion of patient encounters that occurred with the selected person or clinician or team, and according to the NCQA, you could also include structured electronics visits or e-visits as well as phone visits in these statistics, if relevant. We then looked at the CPC definition of continuity of care and as I'm sure you all know, there are two different versions of a definition of continuity of care provided by CPC: the provider-centric and the patient-centric measures. In the provider-centric measure, you divide the number of visits to a clinician by patients in panel to that clinician or team by the total number of visits for that clinician. So you want to know how many of that doctor's visits occurred with their own patients versus the patient-centric measure where you take the number of times a patient sees the provider to whom they are empanelled and you divide that by the total number of visits in the practice. We opted to use this more patient-centric definition of continuity of care. So we devised a field in our EMR that we call PPP: patients preferred provider, and this field captures and displays the patient's preference to the team members on each clinical screen in NextGen, our EMR, and all of our continuity of care reports pull from that PPP field. This is a screenshot of NextGen, this is a test patient, and you see that the arrows are pointing to two different places; the gray demographic bar across the top of the screen is consistent on every template in NextGen and you see the PPP displayed there. In this case it happens to be Dr. Polizzi as well as the little blue rectangle on the left and that's a field that's display in the PPP right within the template in the EMR. Designating the PPP in this manner allows us to improve our continuity in a couple of different ways. It allows the scheduler who is making appointments for the patient to prioritize the PPP for appointments and the scheduler should be able to do this for routine visits all the time and for acute same-day visits whenever possible. Designating the PPP also allows team members to easily identify the provider that they should access in order to handle questions or problems that present asynchronously.

For example, portal messages, phone messages, inquiries or correspondence from our medical neighborhood. It's important to note that it is the patient who chooses the PPP and the patient can choose or change the PPP at any time and we verify their choice at every office visit. So we've built this into our auto flow for check in and my next slide shows you a screen shot of how the PPP is added or changed as part of the check in procedure at each visit. Now that we've designated our PPP for each patient, we do two kinds of reports based on that field. We do continuity of care reports and we also track metrics for our empanelled patients. So the first type of reporting is continuity reporting and in this types of reporting, we want to get a sense of what percentage of visits at our practice occur with the patient's preferred provider. So we've devised a report that shows the numerator as the total number of visits with the PPP this quarter and the dominator is the total number of visits to the practice this quarter. So these are reports that we only run on a quarterly basis. One challenge we have with these reports is that they don't aggregate teams. You could make the argument that a smaller practice, say a two-doctor practice really is just one team, but for larger practices there may be more than one team contained within one practice and we have examples of that within our organization where we've created teams, but our reporting doesn't aggregate teams. It only reports at the individual provider level. This is an example of one of our quarterly continuity reports. This is from one of our small practices. You can see that there were 432 appointments in total during a quarter at that particular site and of those 432, 341 occurred with the patient's preferred provider. So about 79 percent continuity. The second type of reporting we do based on our PPP field is quality metrics. So we report and track the quality performance of each individual provider based on metrics for their attributed patient panel. Currently we're tracking 12 different clinical quality metrics and we do this on a monthly basis and automatically distribute those reports to each practice. We display the performance on a dashboard that allows the providers to compare themselves to one another within the group and as an aside, we also have dashboards that allow the practices to compare their performance to one another on a practice compare dashboard. That dashboard is by practice though and not by PPP. Each practice is responsible for setting their own goals based on national benchmarks. And this is a screenshot of one of our newest metrics that we just introduced, which is osteoporosis screening for women over the age of 65, and you can see that there are four different lines on this graph and this particular practice has three different providers. So the blue line is the practice performance as a whole and then the three other lines are the three providers in the practice. So you can see how their performance differs and they can learn from one another about how to do better. I thought I'd also say a few words about continuity in the medical neighborhood. We think it's important to assure that our medical neighbors can identify our patient's primary provider and have access to necessary information about that patient, so we debuted a unified chart in November of 2013. This means that all the providers in our integrated delivery system chart in the same record and see the same problem list, medication list, allergy list, social family history, they can look at each other's office visit notes, they can see the same labs and imaging. So you can imagine this has been a very powerful tool for us. This screenshot shows an example of what a unified chart looks like. So in the box on the right-hand side and I'm going to see if I can point to it, so this gray box on the right-hand side has two different colored manila folders. There are blue ones and then there are the yellowish ones. So the yellowish ones are visits that occurred within your own practice and the blue ones are visits that occurred at another practice. So you can see who the patient's cardiologist is, you can see who the patient's family doctor is, you can see who the patient's endocrinologist is, et

cetera, and you can actually read their notes. Importantly, you see that I highlighted that the care coordination template is visible by all of the different medical neighbors who are taking care of this patient, as is the care plan. So this is the first half of the top page of our Hunterdon Healthcare diabetes care plan. So this care plan scanned into an office visit would be viewable by not only any member of our own team within our own practice, but can also be seen by other specialists who are caring for the patient. And with that, I'll turn it back over to Cari.

Great. Thank you Doctor Prosswimmer. So again, from our audience to encourage participation, we'd like to know what are some changes that you may have made recently or made as part of this project or other projects you may be working on regarding continuity care reporting? So if you can turn on your arrow annotation device and let us know. So we see that several of you have made some provider scheduling changes, we see that some have added more staff, looks like office hours have been changed. I think leading the pack is definitely needs some scheduling changes for the providing staff. Looks like that seems to be the most frequent answer, followed by expanded office hours, but we are getting some reporting in some other areas and some practices have been very aggressive and actually have done changes in all these areas. We have at least three practices reporting, four practices, reporting that they've actually done all of these changes based on continuity of care reporting. We also do have some practices who right now; oh we do have quite a handful out there indicated that they do not currently have the continuity of care reporting. So we're hopeful and we're very grateful to Dr. Prosswimmer for sharing her information. Hopefully you've got some good information on where to get started or opportunities to improve or expand some of your planning or strategies right now. But it looks like overwhelmingly the taking the lead has included that they have made some provider scheduling changes. So we're hoping during the open dialog we're going to hear about some of those changes that you made based on continuity of care reporting, so you can share with your colleagues. Okay, if you could turn your annotation device off, that'd be great. So we've gotten into the interactive part of this session and I know that we did get a couple questions, I think, coming in over the Chat box for Dr. Prosswimmer. One of those first questions had to, was asked Dr. Prosswimmer, could you share with us why you selected the patient-centric measure opposed to the provider-centric measure?

Well I guess the easiest answer to that is because we're patient centered, and so if we're going to be a patient-centered medical home, it just seems sensible to us that we would really want to look at this form the patient's perspective and not the provider's perspective.

Good. Thank you. So I'm going to check to see if there's anything else in any of the Q and A boxes or at this point we also want to encourage you to please raise your hand. We would be happy to unmute your phones so that you could ask your questions directly. So again, if you look at the kind of mid to the right-hand corner of your screen you'll see a little hand that you can press on to raise your hand to indicate that you do have a question, and I think we do have another question coming into the Q and A box. Yes we do. So where does the diabetic care plan live within your EMR for everybody to see it and share it?

So we have care plans for several chronic conditions as well as a wellness care plan. We have care plans for diabetes, for heart failure, for hypertension, for hyperlipidemia, for COPD, and for wellness and they all have the same look and feel. They were all created by our care coordinators and once produced,

they're scanned into what we call the history bar of NextGen where all documents are viewable, and all you have to do is click on it, and you can see the specifics for that individual patient's care plan.

Great. Thanks.

Looks like we have a question from Allie Manster, she has her hand raised. If we could unmute her line?

Unfortunately the telephone isn't configured to speak, so we can't unmute.

Okay Allie, if you could type your question into the Q and A section, we'll be happy to answer it.

So at this time it looks like we are having some phone difficulties. So I'm going to encourage anybody, if you would like to ask a question or have a question, please go to your Q and A or your Chat box at this point, and type us in your question and we'll be happy to read it on the phone. We did have a follow-up question to that. So Dr. Prosswimmer, are the care plans customized for each patient or are they the same based on the diagnosis?

The care plans are customized for each patient in that they contain patient-specific information such as that patient's last blood pressure, that patient's last A1C, that patient's last weight or whatever the particular metric is as well as the target. In other words, what is the goal we're working toward. Some of the care plan is standardized, like the resources, websites that they can use, community resources that they can use. Those are standardized by the condition, but the, so each care plan has some parts of it that are repeated and some parts of it that are customized.

Great. We have another question coming in. Is increased continuity for providers associated with better quality for any measure that you are currently tracking? Have you been able to make that correlation?

The correlation that I would make is that when we're able to show providers their individual performance and compare their performance to the performance of the other doctors in their practice, there's a very potent behavioral effect that occurs because nobody wants to be at the bottom. Shared wisdom, I think, is really important here. So the opportunity for them to talk about how they do things or how they've been able to accomplish what they've been able to accomplish is really important and we've seen some really nice dialog along that line.

Great, thanks.

If I might expand a little bit more too.

That'd be great.

If you're going to present metrics to providers that are panel specific, you have to be very confident that your panel is accurate. So if you're going to do reporting that has an attribution component to it, you have to make sure that your system is in place to properly identify who is the PPP, as we call it, for the patient is accurate. So that we thought was very important to work out as we were devising these reports and that patients can choose to change their PPP at any time. So a patient could end up on a different provider's PPP report one month versus another if they've made a change.

So I know in the past in other projects and also in other things that we've done, there are different ways to attribute patients to a provider. It could be the most frequent that provider that touched the patient most frequently, that provider who had the most frequent or recent visits, that who have the most recent. How did you determine what you were going to do when you were attributing your patients to your providers so that there would be minimal pushback, for lack of a better word, regarding the appropriate [inaudible] you just talk about?

So when we devised the PPP field, we did an auto assign sweep and by that I mean that we looked for the provider that the patient was willing to wait the longest for and we made that the PPP. So if you waited three days to see Doctor A, but you only waited one day to see Doctor B, we assume that Doctor A was your preferred doctor, but that was just for an initial sweep. It really isn't until you make the designation of the PPP part of the auto flow at check in so that you're constantly re-verifying it that you really end up with a valid attribution model.

So did you see a lot of changes more up front with patients kind of maybe going back and forth between providers and has that kind of settled down now? Are you seeing as many changes?

We're seeing way fewer changes than we did before.

So a lot of pain up front for some continuity of care down the road.

I would say that was an accurate statement. [Laughter] I think some people might say they're still having pain, but [laughter].

So we do have a couple of more questions coming in and I actually have a couple more people and I'll get to them. So we have a couple questions from practices asking about the providers in your practice. Are all the providers primary care providers in your group or do you also have specialists? So I guess this is a question on are you a primary care practice group or are you a multispecialty group?

So all of the data that I'm showing you is practice specific except for the very last part of my presentation that talked a little bit about our medical neighborhood, but all of these reports that I'm describing to you are practice specific. We have 11 practices that are CPC practices in our organization and all of them are only family medicine. So they're all family practitioners.

Great. Do you have care plans on all your patients or only those that you've stratified into a higher risk level?

Well, I would love to tell you that we have care plans on all of our patients, but we don't. Certainly our highest risk patients were the first target for care plans. I think a lot of our challenge is getting our providers to remember to scan the plan into the EMR before they give it to the patient. So that's a workflow challenge. We did devise a place in our EMR where they can check off if they gave a care plan, but even getting them to check that box is difficult. So that would probably be the biggest challenge that I see is getting them to make a copy of it to put in the EMR before the patient leaves with it.

And so the next question kind of flows along with that with how are you updating your care plans?

In our EMR, we have a field that puts the date of the last care plan and our, we have pre-visit planners at our sites that review the charts of the patient before they come in and one of their responsibilities is to look at the date of the last care plan and if it's older than six months, then they attach a new care plan document for the provider and the patient to fill out together at the visit. So our goal is to have our care plans all be less than six months old.

So I know we talked a little bit about that, I think, more regionally than maybe across regions, but I know last year Hunterdon, you group actually won a patient-centered innovation award for introducing that role within the practice. Could you maybe just talk or expand a little bit more on the role of the pre-visit planner and your checklist that you developed? I think we have some interested in that area.

Sure. We devised a checklist and we devised a job description. We created a new role within the care team. We call it pre-visit planner and the role of the pre-visit planner is one to two days before an office visit, to comb through the chart looking for gaps in care that we have specified on the checklist in order to alert the care team to those gaps so that they can be closed during the office visit. So, for example, we included certain cancer screenings, we included certain vaccinations across the board, we included preventative care visit across the board because we think it's really important for all of our patients to have a preventative care visit even if they're coming in every three months for their diabetes [inaudible]. And then we also added condition specific information. So there's a set of things on the checklist that would relate to the patient, for example, with diabetes. There might be certain things that the pre-visit planner would do for patients who are on chronic opioid therapy. The good thing about the pre-visit planning checklist is that we are probably now on version 12 or 13 because over the course of the year or two years that we've had the pre-visit planner role, it's really evolved. When we started it, we thought we knew what would be useful to our care teams and in some instances we were right and in many instances we were wrong and what we thought would be useful wasn't useful at all, but our care and our care teams came up with other ideas that they thought would be more useful than my original ideas were. So I think that's an example of a scenario where failure is a good thing because it leads to improvement in your innovation.

Great, thanks for sharing that Dr. Prosswimmer. So another question did come in and we have a practice that wants to know if the results of the provider's performance on their quality metrics is tied to any type of incentive or bonus program or productivity bonus?

So for the employed practices, the answer is yes and for the independent practices, the answer is it's up to them.

Okay and I think Dr. Prosswimmer talked a little bit about this at the beginning, Hunterdon Healthcare System is an integrated delivery system that is comprised of employed practices that are owned by the hospital, is an accurate description and then there are independent private practices that also are part of an independent physician organization that works really closely together, but they're independent private practices. Would that be a good description of your integrated delivery system?

Yes it is. So, in addition to having primary care practices in the integrated delivery system, we also have specialty practices in the integrated delivery system and that has made it more, well easier for us to work in the medical neighborhood as a result.

We have some requests for if you would be willing to share your job description for your pre-visit planning position and any workflow or policies or processes that you're able to share. Would you be able to share those with other practices? That maybe posting to the Collab site, if you're able to.

Yes, I think that I actually posted to the Collaboration site when I did a little webinar on pre-visit planning. So, I think, actually they're already there.

Okay, great. So if anybody needs any help in finding those in the Collaboration website, we know it has been a little bit of a challenge since the migration, but your faculty can definitely help you migrate through that site or feel free to call us here in New Jersey or shoot us an email as part of the action group or post something to Collaboration website and we'll get that to you if you have any challenges or difficulty finding anything. So just doing another double check for questions specifically for Dr. Prosswimmer and it looks like, oh another one is coming in. Do you run reports on utilization metrics as well in addition to your quality metrics for each individual provider? And if you do, what measures did you select and why?

That's a great question. We have a lot of difficulty pulling reports from our EMR on utilization metrics because it would be an incomplete picture. So we really don't use our EMR for utilization reports; however, we share utilization reports, but they are typically a payer origin rather than coming directly from our system. So, for example, we're involved in a couple of different ACO projects with payers who are willing to provide us with data about our generic prescribing rate, our high-end radiology utilization rate, readmissions, ED utilization, and so forth. In some of these areas we've been able to show really significant improvement over time by reporting at provider-level data. I think generic prescribing is probably is the easiest example of that. So organization wide, across our entire IDS, we've been able to increase our generic prescribing rate by about 10 percent in a period of about two years and we focused specifically on certain categories of medicines. We focused on anti-lipid drugs and we focused on proton pump inhibitors because we knew that those were two big areas of opportunity. So we do that kind of provider-specific reporting, but that's not being pulled from our EMR, that's being pulled from payer claims data. That we came up with was a way to look at patients who were in the emergency room frequently rather than our overall ED utilization, we tried to look at our frequent flyers. We call them frequent ED utilizers and that’s data that we pulled from our hospital partner's EMR. So that's another data source for utilization. Again, not part of our NextGen EMR, but data that we share on a monthly basis, it’s provider-level specificity and we expect our practices to take that data and work with the care coordinator or whatever other resource they wish to use to improve that number.

Great. So going back to the counter use care reporting and when you first started to establish your empanelment list, did you get any sense that perhaps a physician or provider had patients with a higher risk score, those that were much higher risk and how did you distribute risk across evenly? Did you have

some providers that ended up with a lot of patients that have the higher HCC scores? Was there any of that kind of thought or process that went into the empanelment of the physicians?

That's another excellent question actually. So the short answer is no, I haven't figured out how to do that. I will tell you that when I look at the risk stratification in our practices, we've done a great job of risk stratifying our patients. Greater than 99 percent of our patients have a risk score. When I look at the risk score distribution in one practice versus another practice, there's sometimes a difference. For example, in the percentage of patients who are stratified as high risk, but in looking at it, I think it's more the interpretation of the risk score by the practice than the actual risk profile of the patient panel. Does that make sense?

It does to me because I know we've been having these conversations about the risk scores, so and I know some of the apprehension at first when practices start to migrate to empanelment, which then leads to risk stratification, which then leads to potentially opportunities to really focus on your high or higher risk patients. Some of the pushback that may occur is that we'll as a provider I'm ending up, most of the patients on my list have higher risk scores or are more of the frail elderly, or what have you. So then when you start to tie that into potentially bonus or incentive payments, what do you do? So because —

Oh I have an answer to that and the way —

Okay.

The way we do it is the performance of the practice as a whole is what's tied into the incentive. So the entire practice has to do well for any sort of an incentive to accrue to an individual because it's a team delivering the care and we very carefully decided to do it that way because we don't want to see providers doing things like, for example, encouraging higher risk patients to pick another PPP or to be able to explain away or justify their own score, their own performance based on matters out of their control, like how sick their patients are. But really the most important reason is we want, we want the practice to think of themselves as a team that works together to improve the quality delivered to the entire practice.

Great and I know we've had some questions around that regarding even continuity of care because how and I think we've talked about this and I remember actually a couple years ago even regarding how you might be able to start to look at these continuity of care reports to start to say do we need some more providers? Do we need to start changing our hours? Which, based on the poll looks like some of the practices actually have used continuity of care reporting to say we might need some more providers here, patients are waiting too long or they're not typically seeing their PPP on a regular basis or we might need to change hours because that's contributing to the reason why patients aren't seeing their PPP because they're only here nine to five or nine to four. Did you run into any of those challenges or having any of your aha moments as it related to using some of those reports to change, work with patients to maybe change their providers or expand hours or add providers to specific practices?

I would say yes, I think that when we look at things like the PCMH requirements, excuse me, to look at the third next available appointments helps us with that. I think, if anything though, what these reports have helped us to do is look at how we schedule patients, even more than how many providers we have at a given practice. So the more complicated scheduling rules you have at your practice, the more barriers you're placing for access. So simplifying the scheduling rules is probably one of the easiest things that you can do to improve access and continuity, at least from my perspective. So if you say I can only do this many preventative visits in a day or I can only do that many of chronic condition visits in a day or I only want three chronic condition visits per half day or I don't know. People had all sort of rules that they wanted to impose on their schedules and when you do that it becomes increasingly difficult to achieve access and continuity.

Agreed. Absolutely agree. Dr. Prosswimmer thank you so much for your time and we are going to open this up. We have received some questions from you as a group of participants in this action group prior to this call that we said send us your questions and let us know what you'd like to hear from your colleagues, from our speaker from today, from others in other regions on what they're doing. So the next set of questions really have to do with all of you and you becoming actively involved in your action group and so some of your colleagues and peers sent in questions regarding, we've heard how Dr. Prosswimmer at Hunterdon Healthcare is measuring their continuity, can anybody else share how they're tracking continuity in their EHR? Anybody willing to share? I know we're having some challenges with the phone lines, but if you can type into us, into the Q and A or the Chat box, we'll be happy to share that. I know we can share with you that sometimes there are some big challenges in EHRs, especially here in our region, in New Jersey. We have about 32 different EHRs being used by our CPC practices and many of them are smaller systems. They're not the robust NextGen system that we just heard about and sometimes these systems do not necessarily have a specific feel to capture the primary care provider who is attributed to a patient or the patient vice versa. So we've had some creative work arounds and some of those have been utilizing the billing systems because when practices have been billing out, they're billing it based on a physician and therefore or a provider and therefore they have been able to utilize billing systems to measure their continuity of care in their practice. For all you practices that might be solo physicians, you probably have, you definitely have a major head start on your colleagues and peers that have other physicians or providers working in practice because obviously if you're a solo physician, your continuity of care is your continuity of care. So I think we're getting some Chats in the box regarding how they are tracking continuity in your EHR. Nope, we just repeated the question. So anybody able to share with us how you're tracking continuity in your EHR or maybe some work arounds or other systems you're using to measure continuity of care? And remember, these questions can also be posted to the Collaboration website for further discussion and dialog. Again, we apologize for the telephone component. We'd be asking you to raise your hand and we'd unmute your phone lines, but thank you Kim who has just written in that she tracks the patient portal usage in the EHR for continuity of care, which is another great method and one that we've seen more practices starting to get involved and engaged in as the portal use increases and patients are starting to engage through the portal. So I'm going to go to the next question and you can keep writing or chatting in. I go back here because I think I went too far. Yeah, there we go and Jay is joining me by also capturing some of your Chat messages onto the screen. So I'm going to go to the next one and one of the next questions that practices asked us to bring up on today's call would be to talk

about how practices are currently defining a care team. So if you can give us some insight and thought about how you are defining your care team in your practice that would be terrific and it looks like Jeff has just notified us that you can raise your hand you can ask a question or comment verbally. It looks like the technical difficulties have been fixed. We thank you very much Jeff for that. So again, feel free to raise your hand or type in the Chat box, if you can tell us how is your team, how is your practice defining a care team? We have some practices that would like to know. I will look to see if any hands have gone up. So we do, again Kim, thank you very much for your response. Kim's practice, the patients choose a PCP and then they are empanelled to that PCP and PCP, the primary care giver and his nurses. So a care team in this practice is being defined as the primary care physician and the nurses that work specifically with that physician. So we have seen that in many practices. Sometimes when practices don't have a nurse, sometimes it is the MA; however, that is a little bit easier because the visit is still attribute to the physician even though they have a care team of others to assist them with the care for the patient. The care team itself is the position of the MAs. We do have Stephanie who has written in who indicates their care team is defined as a doctor, a nurse, the receptionist, the schedule, the care manager, and the practice manager. So they have defined their care team as those professionals within the practice; the doctor, nurse, receptionist, scheduler, care manager and practice manager. Thank you very much for your contributions. We're going to move to the next question, so the reason we were asking you about how you're defining your care team is because we had a couple of practices send us in questions regarding about tracking continuity of care that's provided by a team or provided by a provider. So they're asking how are practices currently tracking the continuity of care if they're defining it by a team or if they're defining it by a provider? So for those of you that answered, we have a physician with nurses, we have a physician with nurse, receptionist, scheduler, care manager, how are you tracking continuity? Is it based off of the provider or is it based off of a visit with the care team? So if anybody wants to share how they're doing that, that would be terrific. Again, looks like we have phone lines that can be unmuted now, so please raise your hand if you'd like to talk with us or please feel free to type in the Chat box in the Q and A. A lot of this has been, we did receive a lot of questions regarding team measuring continuity if you're, we have some folks who are writing in that they do it based on a team, and if you're doing it based on a team, how are you measuring that? So if you could share that with us, that'd be terrific. So feel free to raise your hand if you'd rather talk or type it into the Chat box, but we do have some responses about team, so Betty has emailed us that the continuity is tracked by appointments. So either the primary care physician or the nurse practitioner that are part of that specific primary care team. We have several folks that have indicated that it's based off of the providers, so the patient is being assigned to a primary care provider in the EMR and that's how they'll be measuring it and generating it. We do have a few others that have indicated team. A couple practices have also indicated that it is done based on the appointment. So who the appointment is scheduled with and that's how they're running it.

>> If the practices, if the audience is actually able to use the annotation tool with the arrow to choose the box on the screen that applies to how they're tracking continuity, that would be fantastic.

Great, thanks Jay. So if you can turn on your annotation device, we can get a feel and everybody can see. The majority of practices look like they are measuring it based on provider. Although we do have quite a bit who are doing it based on the team. I think there's been some challenges that practices of

experienced when doing it, trying to track it as a team, but if you're doing it based on appointment and you have a scheduled appointment with the care manager or the nurse practitioner, that has been able to help some of those practices get over that hurdle. Great. So you can see overwhelmingly it looks like the majority of you are tracking continuity of care based on the patient's provider. Great. Okay, I'm going to go to the next question. So again, submitted by you, action group participants, if you as a practice check the box where you defined a care team as how you're measuring continuity of care for the patient, how are you tracking that in your EHR, because most of the EHRs are going to give you an opportunity to put in a physician or a name of a provider, but it's not going to allow you, typically, put in several names. So have you named your care teams? How have you defined that and how are you tracking that in your EHR? So again, if we have some raised hands for folks that would like share or if you can type in the Chat box. This has been a tricky area for many practices. We have several practices write in about this question. So we don't have any responses yet on how practices that are using a care team approach to track continuity are actually tracking this in their EHR. So that seems to still be a question that's out there. So I'm going to encourage everybody. We'll be tracking this question and we'll post this to the Collaboration website for follow-up because I think this is an area that many practices wanted to explore. So we'll contribute by putting that onto the Collaboration website. Just a reminder, there is no subscription reminders so we're going to encourage you to go check that website out for responses from your colleagues or peers, or if you do have something to add or contribute to how you are doing that in your practice or how you overcame the challenge, we would very much appreciate you going to the Collaboration website to post your response to this question. But as we're running out of time now. We'll, at this point, close out for questions; we'll thank everybody for their time and their active participation. We will thank Hunterdon Healthcare System and Dr. Prosswimmer for sharing her process for continuity of care up there as well as answering all the questions that came in from you, our audience. As you know, right now, this is our last scheduled action group for this quarter. We are awaiting follow-up and feedback and as soon as we hear anything about future action group dates and times, we will let everybody know as soon as possible. Best place to keep an eye is the Roundup every Friday, the Collaboration site event and as soon as we know the next date and time and how this will precede moving forward, we will let all of you know. But in the meantime, we are here to answer any questions or direct you to resources that we can. Please utilize the Chat box, excuse me, please utilize the Collaboration website. In the Chat box Jay has typed in the Collaboration website address so that you can just cut and paste real quick to get there and at this point I'd like to thank all of you for your time, get you back to your busy offices and busy schedules and say thank you for your participation and we'll conclude today's session on time at 1:59 PM. Rose?

Yep and if you could go to the next slide. Thank you for attending today. As today's WebEx closes, you'll automatically be directed to a survey. Your feedback on the survey is used to continually improve our learning opportunities. In addition, please remember that it is important to accurately collect information on each individual and each organization in attendance. If you are not from a region or practice, please select not applicable in both the region and practice ID drop downs and then select your organization. Again, should multiple people be in the same room together, up to 10 people may be added to the same form. Thank you again and have a wonderful day.