Adirondacks ACO
Better Community Care Through Collaboration

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Adirondack Health Institute

PRE-VISIT PLANNING

MEASURES

MEASURE(S):

MEASURE(S) TRACKED BY:

MEASURE STEWARD:

NCQA

ALTERNATIVE MEASURES:

STANDARD SPECIFICATIONS

DESCRIPTION:

2014 NCQA PCMH 2: Team Based Care Element D: The Practice Team # 3 (Critical Factor): Holding scheduled Patient care team meetings or a structured communication process focused on individual patient care.

2017 NCQA PCMH Team Based Care and Practice Organization Competency B: TC 06 (Core) Individual Patient Care Meetings/Communication: Has regular patient care team meetings or structured communication process focused on individual patient care.

FUNCTIONAL MEASURE IDENTIFIED:

BEST PRACTICE

SUMMARY:

Standard Guidance:
2014 – Team meetings may be informal daily meetings or review daily schedules, with follow – up tasks. A structured communication process may include regular email exchanges, tasks or messages about a patient in the medical record and how the clinician or team leader is engaged in the communication structure.
Evidence: Documented process for structured communication between clinician and other team members, which states frequency of communication; along with review of three samples of meetings summaries, checklists, appointment notes or chart notes for evidence of process.
2017 – The practice maintains a structured communication process, sharing information about patients, care needs, concerns for the day and other information that encourages efficient patient care and practice flow. The process may include tasks or messages in the medical record, regular email exchanges or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process.
Huddles provide a forum for practice staff to communicate about upcoming appointments, patient needs and workflow updates.
Evidence: Documented process for the practice and evidence of implementation

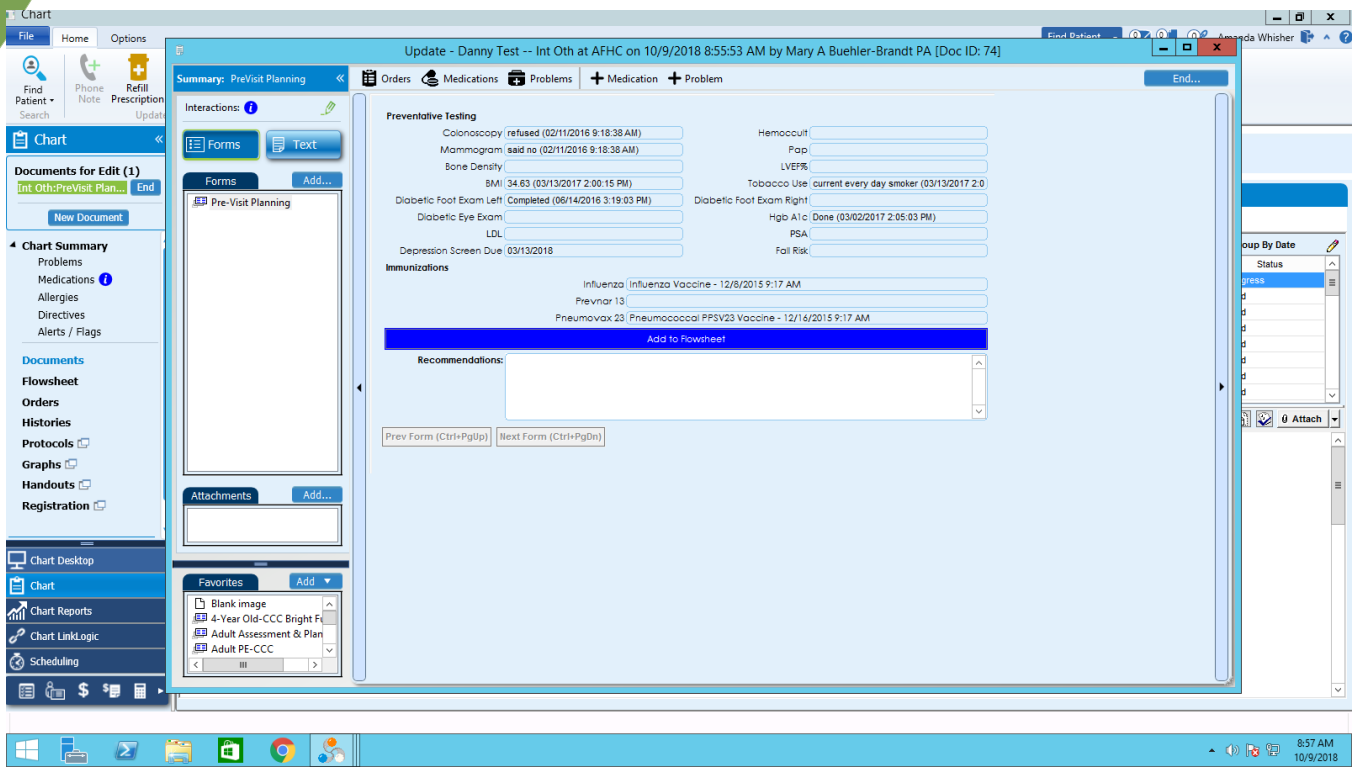
Planned care

- Identify common services required by evidenced based guidelines (HTN, diabetes, etc.) Utilize workflows established by EMR vendor with modifications to assist your practice
- Identification of key staff responsible for identifying gaps and ensure properly educated
- Use protocols and standing orders to allow staff to act independently and to top of licensure
- Utilize EMR and/data sources to identify specific care needs (use or creation of templates and reports to support the identified areas focus)
- Huddle with care team to review the needs of patients scheduled for the day
- Patient Engagement

EDUCATIONAL TOOLS AND SUPPORTS

TITLES AND WEB LINKS:

- Glens Falls Hospital – Ann Marie Hatch, ahatch@glensfallhosp.org
- Hudson Headwaters Health Network– Abby Mowka, amowka@hhhn.org and Erin Dunn edunn@hhhn.org
- Elizabethtown Community Hospital Health Centers – Amanda Whisher, awhisher@ech.org
- NYS PCMH Standards and Guidelines – NCQA website search for NYS PCMH Standards and Guidelines 2017 edition download for free
- AHI – Jolene Munger - Provider Engagement Manager – Practice Transformation Support available to make transition to NYS 2017 PCMH, jmunger@ahihealth.org
- Janet Mann PCMH CCE – jmann@cvph.org
- Team-Based Primary Care: Convergence of Improving Engagement, Safety and Enhanced Joy in Practice https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/teambased-1.pdf
- Putting Pre-Visit Planning into Practice by Christine a. Sinsky, MD FACP, Thomas A. Sinsky MD, FACP and Ellie Rajcevich https://www.aafp.org/fpm/2015/1100/p34.pdf



REASON FOR IMPLEMENTATION

- NCQA Requirements
- Increase compliance with quality measures
- Workflow efficiency and time management

BARRIERS TO IMPLEMENTATION

- Staff resistance
- Technical challenges

WORKFLOW

- LPN or Med Tech
- Chart review
- Recommendations

(Lab and Referral tracking separate from Pre-Visit Planning)

SUCCESS

- Level 3 NCQA Recognition for all sites
- Increased workflow efficiency
- Improvements with risk screenings and quality measures.

COST

- Minimal impact on cost

PROVIDER FEEDBACK

- Information is readily available
- Up to date information obtained prior to appts.

Glens Falls Hospital

Centralization and Standardization

Ann Marie Hatch, CMPE PCMH CCE

Glens Falls Hospital

Why centralize

- Remove the busy from the office
- Allows office staff to focus on face to face encounters with patients
- Creates efficiency and standardized approaches to tasks

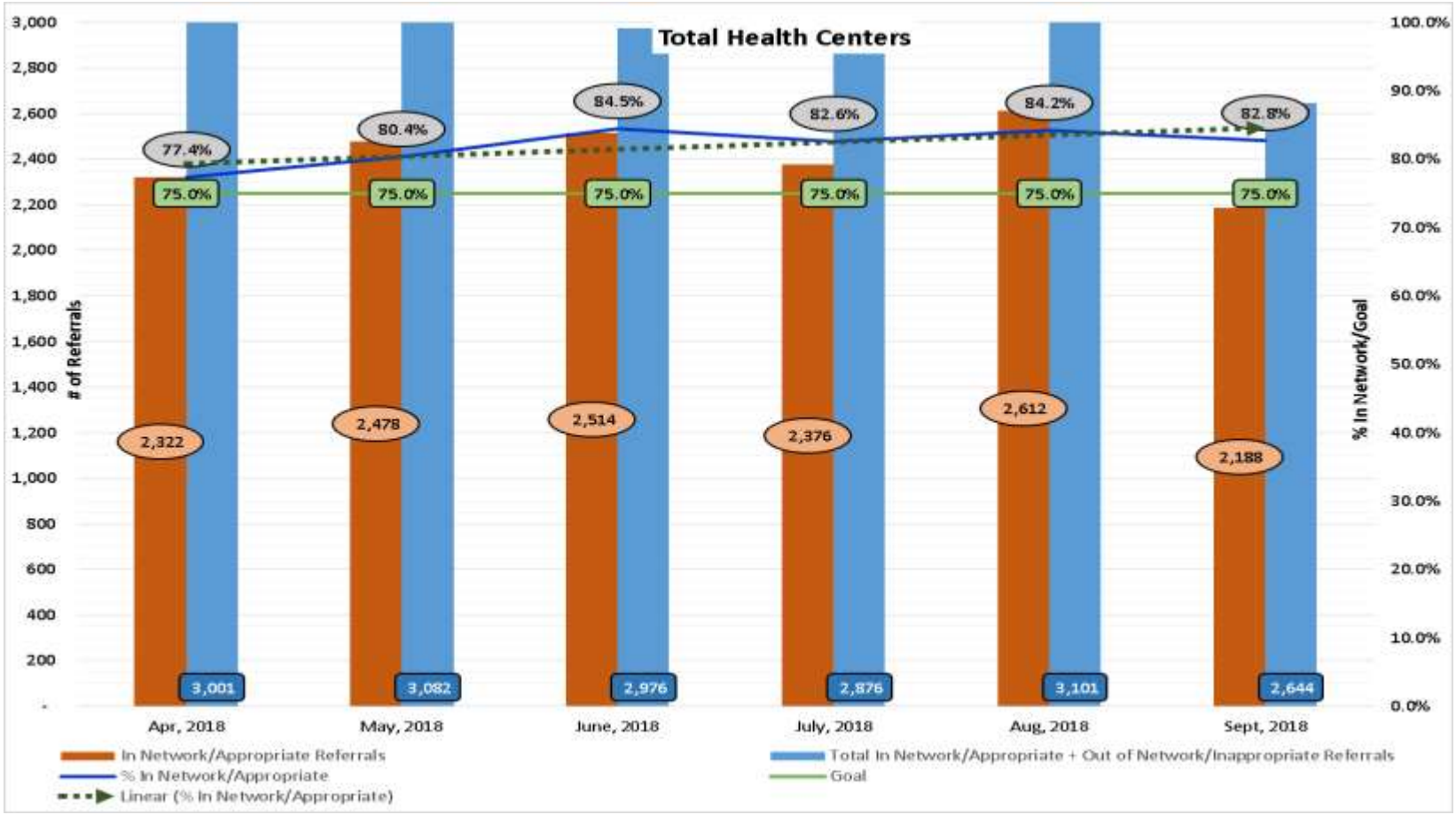
Centralized electronic prescription refills

- Prior workflow
  - All e-scripts went directly to the providers inbox
  - Providers reviewed and acted on
- Current workflow
  - All e-scripts flow to centralized team (2 LPNs for 10 primary care offices)
  - Review for future appointment or gaps in ancillary tests
  - Que up for the provider who signs and forwards
  - Process an estimated 52,000 e-scripts/year
- Lessons learned
  - All controlled substances are better completed within the office
  - Optimization – follow up appointments completed by centralized scheduling rather than sending to the office to complete

Centralized referrals

- Prior workflow
  - Each primary care office had a referral person who completed referrals (10 staff)
  - Tracked referral closure and receipt of consult with no ability to track performance
- Current workflow
  - Centralized team of 5 to complete same referral volume
  - Ability to track referral performance
- Lessons learned
  - Established process for STAT referrals where patient remained in the office until appointment was confirmed
  - Used date to create collaborative care agreements

Referral Tracking



Glens Falls Hospital

Gaps in Care

- Prior workflow
  - Each individual office received gaps in care lists and were asked to address
  - Health maintenance letters sent to patients
- Current workflow
  - 2 dedicated staff who review appointments 3 days out, retrieve records, place needed gaps in “paperclip” of appointment
    - Screenings = Breast, Cervical, Colorectal
    - Diabetes = Eye exam, HbbA1C, Microalbumin/Creatinine
    - Pneumococcal Vaccine
  - Actively work insurance company gaps in care lists
  - In office care team huddle’s daily to review “paperclip” with nursing staff queuing up orders for the providers.

Gaps in Care continued

- Lessons learned
  - Review revealed only 46% of identified gaps were addressed within the visit – team identified that the “paperclip” could not be printed which added work – we will be adding gap in a field that prints with the schedule
  - Better standardization of huddle process needed – in process
  - Insurance company gaps or care suggestions (i.e. medication changes) – needed better workflow to communicate any gaps to the office staff. Currently work flowing this communication from gaps in care team to the in office Care Manager / Lead RN who will prep for the provider.

Centralized Scheduling

- Important to have this provider led – PCP PGC
  - Created and approved scheduling duration algorithm including which chief complaints required triage – use risk score
  - All provider templates standardized (15/20/30 with double books)
- Standardized all PCP office phone trees
- In parallel created a 926-CARES line
  - VIP services for employees who need a PCP
- Expanded to 24/7 access via education and training for the telecommunications team to schedule appointments
- 5 FTEs = Monday – Friday 7:00am-5:30pm
  - Schedule for 10 PCP offices
  - Starting to add outbound calling to schedule AWV and patients not seen in 13+ months

Centralized Scheduling continued

- Lessons learned
  - Easy to place on paper and challenging to implement – weekly meetings - frequent communication is key
  - Ensure template build is completed before process starts
  - Have a solid warm handoff back to office when patient appointment requires triage – we are questioning having a triage nurse in the centralized area
  - Continuous review and education for OV/EOV/Triage
  - Staffing is tight – recruiting the right staff is important
  - Avoid the we/they and focus on the patient needs and processes
  - Know your “phone guys” really well !

Scheduling algorithm

1 slot (OV)	2 slot (EOV)	Triage
Abnormal urinary symptoms	Well child exam/Annual Wellness/Physician	**Acute trauma**
Sore throat	Preoperative exam	**Active bleeding**
Cough/Cold/Sinus complaint	**COPD exacerbation**	**Headache**
Ear pain/Ear wax removal	**Shortness of breath**	**Dizziness**
Dental pain	Cognitive changes (memory/behavior)	**Difficulty breathing**
Tobacco cessation	**Abdominal pain**	**Chest pain**
Acute diarrhea (less than 2 weeks)	**Chest pain**	**Abdominal pain**
Rash	Leg pain/Swelling	**Changes in mental status**
Acute back/Joint pain	Diabetes – complicated	
Follow up on single chronic condition	**Headache**	
Skin infection without swelling or drainage	**Dizziness**	
Contraception management	Frequent falls	
Plainly presenting tick bite	Chronic diarrhea (greater than 2 weeks)	
Asthma flare up without SOB	Chronic pain/controlled medications	
	Abnormal vaginal bleeding	
	Worsening mental health issues	
	Form completion	
	Concern for tick- borne illness	
	Procedure	

Pre-Visit Planning
at
Hudson Headwaters Health Network

Thursday

October 25th, 2018

HUDSON HEADWATERS HEALTH NETWORK

HEALTHY CONNECTIONS

Agenda

- History of PI PVP program
- The process
- Measuring success
- Provider feedback
- Lessons learned
- Question & answers

Mission

"To provide the best health care, and access to that health care, for everyone in our communities."

History of PI PVP Initiative

Began in 2011

- The initial focus was to outreach to patients with specific chronic diseases (CAD, HTN, DM) that needed blood work or an educational packet regarding their disease.
- As an FQHC, the primary goal was to show improvement in our UDS Program QMs.

Pre-Visit Planning at a Glance

- Done consistently on a weekly basis
- 2 Pre-Visit Planners (full-time)
- 17 HCs (split between the 2 PVPs)
- PVP database was built and is the foundation of the PI PVP process
- Focuses specifically on a subset of QMs and activities required to meet those measures (e.g. lab work, outreach calls)
- Other PVP activities are completed at the Health Center (e.g. review of hospital admissions, ED visits, other QMs)

Workflow

Diabetes	□ A search for an eye exam and foot exam is conducted □ Evaluate when the last A1c, micro albumin urine, and BMP was done (a complete review of the chart includes looking for endocrinology reports, clinical documents, hospital visits, Hixny, Cerner, UVM, MLH, etc.)
Diabetes & Schizophrenia	□ Evaluate when the last A1c, microalbumin urine and BMP was done, as well as a lipid panel. (a complete review of the chart includes looking for clinical documents, hospital visits, Hixny, Cerner, UVM, MLH, etc.)
Schizophrenia or Bipolar Disorder	□ Reviewed to make sure a screening for diabetes with an A1c or fasting glucose has been done. □
Hypertension or CAD	□ Evaluate if a BMP/CMP was done in the past year (a complete review of the chart includes looking for clinical documents, hospital visits, Hixny, Cerner, UVM, MLH, etc.)

Labwork Order Delegation for PI Staff

Disease Management Labwork Guidelines

Care Guideline	Minimal Frequency
Diabetes	
Hemoglobin A1c	Every 12 months if most recent A1c was < 7 Every 6 months if most recent A1c was >7
Urine for Microalbumin	Every 12 months
BMP	Every 12 months
Diabetes and Schizophrenia	
Labs as above in Diabetes, plus	
Lipid Profile – non-fasting	Every 12 months
Schizophrenia and/or BiPolar Disorder prescribed antipsychotic medications	
Hemoglobin A1c/Glucose Testing-non-fasting	Every 12 months
Hypertension	
BMP if on an ACE or ARB medication	Every 12 months
Coronary Artery Disease/ACSVD	
BMP if on an ACE or ARB medication	Every 12 months

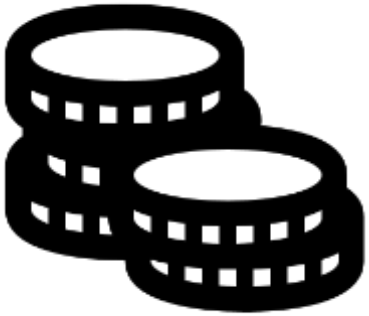
Measuring our Success

- There are limitations to measuring the success of this program as there is currently no way to evaluate if the phone call was the reason the patient went to get their blood work prior to their appointment.
- In September 2018, data was collected in hopes of trying to measure these efforts and the outcome was that 60% of the patients that received a phone call reminding them of bloodwork, completed those labs between the call and their visit.

What's Working?

- Able to modify the quality metrics that we review and data-mine. If we choose to focus on certain measures at a specific time of year, we can do so.
- Able to modify patient population (e.g. targeted chronic diseases, age ranges)

Cost Effectiveness



- Having this process in place has been an integral part of Hudson Headwater's success within our multiple payer incentive programs as well as our annual UDS submission.
- Our quality scores are higher due to all of the data-mining and lab work that is done upon the completion of these reminder phone calls.

Providers

- Providers appreciate the steps that Pre-Visit Planners take with the patients because completed bloodwork adds value to the visit.

- For some labs, order approval is needed. Some providers have given order delegation to our PVPs in order to streamline the process without the need for provider approval.

Lessons Learned

- Be flexible, pre-visit planning changes all the time
- You can work on multiple measures, but be sure to focus your efforts on the ones that align with your organization's strategy, mission and values.
- Start small, this process can become overwhelming quickly.

Q & A

Thank you for your time!

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