How We Close the Gaps: Our Interprofessional Team Approach to Meeting Quality Measures

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How We Close the Gaps: Our Interprofessional Team Approach to Meeting Quality Measures

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How We Close the Gaps

Our Interprofessional Team Approach to Meeting Quality Measures

ETSU Family Physicians of Kingsport
ETSU Department of Family Medicine

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Conference on Practice Improvement

Disclosures

• Financial disclosures - none
Objectives

• Define the role/function of an interprofessional team in the management of complex outpatients.

• Identify the types of patients that would benefit most from a team-based approach.

• Implement elements of our team-based patient care model into individual practices.
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Our Team

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Our Place

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Our Practice

- City of Kingsport: 52,806
- Tri-Cities population: 130,000
- Catchment area: 2.5 million

- Our Residency
  - 6/6/6
  - PCMH Level 3 May 2015
  - PharmD, Psychology, Social Work, PHM
Our Practice

• Disadvantaged population in the Appalachian Region.
• Sullivan County median household income: $39,577
• Low health literacy, transportation issues.
• One of the top 3 CSA regions in all-cause mortality.
• #1 NAS-Sullivan County
  – 48/1,000
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Practice Improvement

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Initial Success

• IPTC (Inter-professional Transitional Care)  
  – Implemented in 2013, encouraged by PCMH application
• Reduced overall hospital re-admission rates from 20% to 12%
• Practice ownership
• Patient satisfaction 95%  
  – 4 question survey (2016)
• Reimbursement
McKenzie Calhoun PharmD

- Pharmacists’ Patient Care Process (PPCP)
  - Disease-oriented, pharmacy-led clinic
- Extensivist consultant
- Pharm Clinic
- IPTC Champion
Jesse Gilreath LCSW

• IPTC Champion
• Point-of-Care handoffs
• Extensivist consultant
• Home Visits
• Nursing home coordinator
So Then What Happened?

- Identified complex medical patients in our practice.
- What does that term mean to you?
  - Multiple significant comorbidities + multiple inpatient/ED visits
- CMS: number of HCC codes
Refocused the bright light of IPTC on a broader range of outpatients.

Began to develop a complex patient champion team.

Sky’s the limit
Conference on Practice Improvement

Quality Metrics/Gaps-ACO

- Partnered Summer 2015
- Top third in shared savings with CMS
- Comprised of 500 primary care providers and specialists
- 10 to 15 Consensus PCMH/ACO metrics
- Potential for significant shared savings for our department
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<thead>
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<tr>
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<tr>
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<td>80.60%</td>
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<tr>
<td>Pneumonia Immunization</td>
<td>72.90%</td>
<td>94.10%</td>
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<tr>
<td>BMI Screening &amp; Follow-Up Plan</td>
<td>38.00%</td>
<td>64.90%</td>
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<tr>
<td>Tobacco Screening &amp; Cessation</td>
<td>65.90%</td>
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<tr>
<td>Depression Screening</td>
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<td>BP Screening</td>
<td>56.60%</td>
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<td>Statin Therapy for EX of Cardiovascular Disease</td>
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<td>Depression Remission at 12 Months</td>
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<tr>
<td>Diabetic: % with A1c &gt;9</td>
<td>31.70%</td>
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<td>Diabetic Eye Exam</td>
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<td>HTN: % with BP &lt;140/90</td>
<td>72.70%</td>
<td>85.60%</td>
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<tr>
<td>IVD: % on Aspirin or Antithrombotic</td>
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<td>76.00%</td>
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<tr>
<td>HF: Beta Blocker Therapy for LVSD</td>
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<td>91.10%</td>
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<tr>
<td>CAD: ACE/ARB Therapy</td>
<td>89.19%</td>
<td>92.94%</td>
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</tbody>
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Despair

Initial thoughts....
Oh my
Reality
Time to re-invent more wheels?
So we’re not finished.....

    We haven’t even started

What do we do?
This is my third career
Moving On

• One team can’t fix everything, but it can be repurposed.
• Can be used for multiple issues.
• Need a “new” team for this.
• New workflows
Maggie Schnell LPN

- Patient Health Manager
- CCM
- Gap Closure Specialist
Monaco Briggs MBA

- Director, Informatics and Optimization, Family Medicine
- Task master
- Maker & sender of spreadsheets
Needs

- Expanding overall knowledge regarding patient needs
  - Training, training, training-monthly meetings with Monaco.
  - List of needs in precepting area-visible to all.
  - Making all preceptors/residents aware of needs both at the time of the visit and via electronic documentation.
  - Gap worksheets attached to encounter forms for all providers of care to review.
  - Pharmacy providers for in depth review, modification and discussion of medication lists, patient education.
  - LCSW as needed for community resources, patient assistance programs, transportation needs.
- Maggie... everything else
**Clinical Quality Measures**

Recommended Prevention

Family Physicians of Kingsport

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Roles

• Attending and resident physicians
  – Supervisory role and direct patient care, documentation review, med reconciliation, billing, review/confirm gap closure.

• Pharmacy team
  – Supervisory role with direct patient care. Individual clinics (PPCP), med reconciliation.

• LCSW
  – Point of Care behavioral health/warm hand-off.

• Nursing staff
  – Direct patient care, Perform “front-end” gap closure, review gap sheets. Follow standing order sets.

• Pharmacy/medical students
  – Information gathering such as hospital discharges, chart histories, med reconciliation, direct patient care.

• Maggie
  – Scrub upcoming visits for gaps/make gap sheets. Contact individual patients for missed gaps, follow standing order sets, CCM.
<table>
<thead>
<tr>
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<td>Fall Screening</td>
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<td>Flu Immunization</td>
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<tr>
<td>HTN: % with BP &lt;140/90</td>
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<td>61.90%</td>
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<td>91.04%</td>
<td>94.35%</td>
<td>94.04%</td>
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</tbody>
</table>
Challenges

• Keeping the culture *consistently* in place.
• Avoiding over-reliance on individuals, but essential to have quality people at critical points.
• Preparing for new and shifting measures
  – They’re always coming
• Developing new processes to cope with change.
• Training every year
• AWV/box-check fatigue
So, we graduate more hospitalists.....?

What could we do outside the box that improves quality, training, and is a lot more fun?

What could we do to keep residents interested in outpatient clinical medicine
Conference on Practice Improvement

Extensivist Clinic

• What is it?
• Who’s involved?
• Reduction of re-admissions
• Reimbursement/Savings
• Coding
Extensivist Clinic

- Limited options for acutely ill patients
- Fee for service model
- Disease-specific care
- Highly selected patients
- Choice of care site
Extensivist Clinic

• Limitations
  – No ischemic events e.g. CP, TIA
  – No nocturnal care
  – No on-site imaging, on-site lab
Conference on
Practice Improvement

Extensivist Clinic

- Nursing
- Residents/Faculty
- Pharmacy
- Social Work
- Family
Extensivist Clinic

- IPTC followup with 40% reduction in re-admission
- Savings estimated at $30,000- $50,000 since August
- Coding can be challenging
- Evidence that re-admission rates improved over TCC (IPTC)
Extensivist Clinic

- Coding can be a challenge

  99354-99355: which includes prolonged face-to-face time - does not have to be continuous time.
  99354: 30-74 minutes (no code for less than 30 mins)
  99355: Each additional 30 minutes

  99358-99359: which includes non face-to-face time - does not have to be continuous time.
  99358: First 30-60 minutes
  99359: Each additional 30 minutes

  99415-99416 which is Prolonged Clinical Staff Services with Physician Supervision
  99415: Reported after 70 minutes of clinical face to face time (first hour after initial 70 minutes of face-to-face time)
  99416: each additional 30 minutes
Extensivist Clinic

- Coding can be a challenge

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<td>99359</td>
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<td>$91.87 +1%</td>
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<tr>
<td>99415 &amp; 99416</td>
<td>Covered but usually not separately reimbursed</td>
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Extensivist Clinic

• Coding can be a challenge

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<th>Description</th>
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<td>96375</td>
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References

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- Do,H. Medical “Extensivists” care for high acuity patients, across settings, lead to reduced hospital use. AHRQ. Innovations Exchange US Dept HHS 2013.
Questions/Feedback

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• Erin Harris MD
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