

Utilizing an E H R and the Chronic Disease Model to Improve Quality in Health Care Delivery

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Madrid III ~ 3:25pm - 4:10pm

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Objectives

- Learner will be able to verbalize 3 common primary care PQRI objectives.
- Learner will be able to state how to document and track 2 PQRI objectives in their office
- Learner will verbalize the required Core Objectives for the E H R incentive programs
- The learner will be able to verbalize how to use the Chronic Disease Model in primary care to achieve quality outcomes
- The learner will be able to state 3 advantages to utilizing an RN in primary care

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Quality Improvement in Primary Care: How We Use Our EHR to Improve Patient Care.

Kristy Baker MS, APRN
Owner - Westview Health Clinic

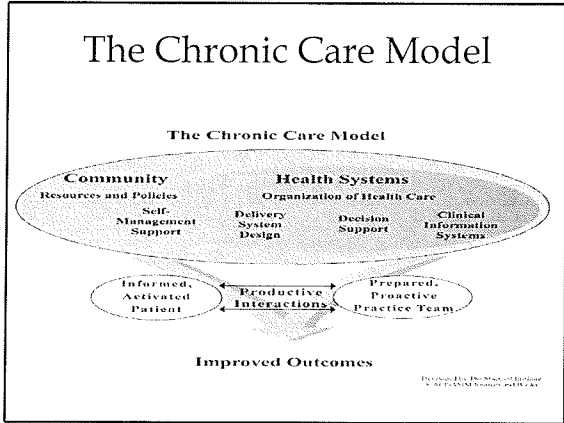
Quality Improvement Projects

- Asthma
- BMI/Weight Counseling
- Diabetes

Choosing a QI Project

- Asthma was a research study we are involved in.
- BMI was to prepare us for meaningful use
- Diabetes was because we initiated RN case management and the Chronic Care management model

- Interdisciplinary team management is key!!



Why Chronic Care Model (and what does that have to do with the EHR?)

- EHR's have too many capabilities for the provider to manage alone
- Registry functions can enhance population based care and patient-centered care
- Nurses and other staff should be utilized to the full extent of their license and/or training!

Team Approach

- Entire office staff shares responsibility for the quality and reliability of care delivery
- Common understanding of roles, responsibilities and hand-offs
- Everyone has a defined role in patient care
- The patient is the team captain!

Decision Support

- Evidence based guidelines
- Team members are trained on the guidelines
- Patients own the targets

Registry

- Real time data
- Care reminders
- Population based care and outcomes tracking
- Patient care planning
- Identifies gaps in care

Patient Self Management Support

- Coaching
- Shared goal setting
- Fostering patient responsibility
- Group Visits

- In our clinic, this is conducted by an RN case manager and a dedicated CNA for our Diabetic, Cardiovascular and Pulmonary patients

How do we use the RN, and how do we afford her?

- \$18.00/hour
- She conducts all of our diabetes visits
- She knows the guidelines, the meds, the goals.
- RN's are trained to educate
- She does VS, Ht., Wt, and waist circumference, foot exam, fingerstick(36416) for in-house A1c (83037), Lipid (80061), protein to creatinine ratio (82570), liver panel (84450, 84460), eye exam (snellen)

RN diabetes continued:

- RN coordinates the Diabetic eye exam and makes sure we have a copy in chart, gives script for diabetic footwear and updates their script for glucometer supplies.
- RN updates ROS and FSH
- RN enters appropriate PQRI codes: such as 3074F, 3078F, 3044F, 3061F, G8506, 2028F, 2022F, G8410, and G8443
- RN orders refill per standing order

Benefit of RN lead visits

- Enhanced reimbursement - by having the RN initiate and do most of the counseling, data collection, and code tracking we capture more reimbursement, we capture for extended visits, patients get individualized one-on-one diabetes care and counseling, the chart is well organized and complete when the provider finishes the visit, patient satisfaction with care is enhanced.

This visit can be billed:

- 99214 (first 25 minutes)
- 99354 (additional 60 minutes)
- And if patient requires extensive counseling, medication management, care coordination and the visit is very extended, we use 99355 for every ½ hour after that.
- We capture the costs of the in-house tests.
- The cost of the RN is covered if she does 2-3 visits per day. It usually only takes 10 minutes of my time to finish with the patient.

How is the rest of the team involved in the diabetes scenario

- The receptionist knows how long to block these visits, who to assign them to, what time of day is best.
- The CNA knows what necessary labs and vitals should be done, what refills can be given in the interim between visits.
- The patient services coordinator knows who to make referrals to, what is urgent and what can wait until next available. What meds might require prior authorization and how to qualify the patient for pump therapy or talking glucometers

Team (continued)

- The coder knows that all of the PQRI codes must be entered, what diagnosis codes are necessary and captures all of the CPT codes for procedure and lab reimbursement
- The biller knows which insurance companies will balk at the extended visit code or who bundles and carefully reviews EOB's to make sure reimbursement was appropriate

The ASTHMA project

- I was horrible at documenting asthma care
- I did not ask about control
- I did not counsel on step-therapy, just the medications use
- I rarely ordered spirometry
- I did not enjoy pulmonary disease management!

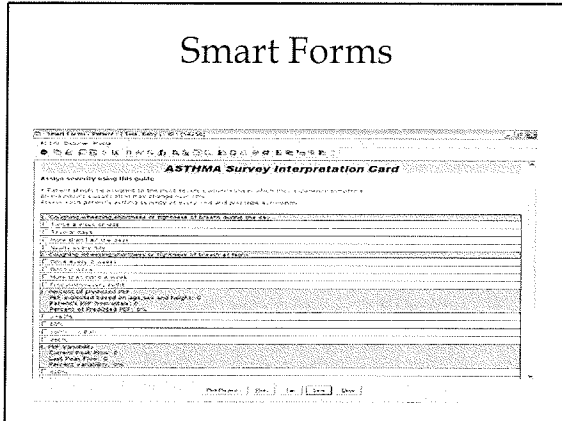
The Team

- We took on this project to get the money to buy a spirometer!
- The team took on this project to improve our asthma care delivery
- We succeeded

Screening

- Smart Forms
- Diagnosis triggers

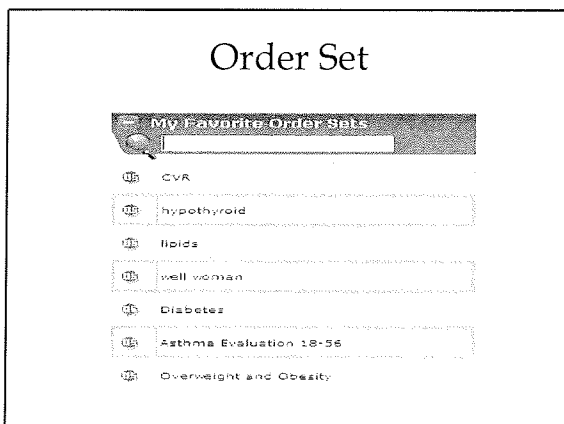
Smart Forms



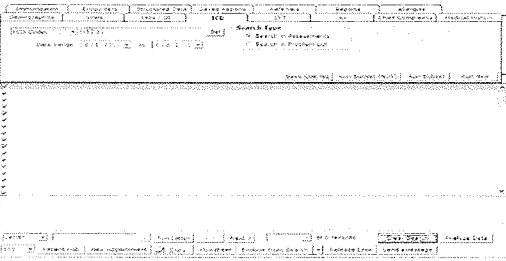
Order Sets

- Medications
- Labs
- Spirometry
- Guidelines
- Patient Education
- Asthma self management plans

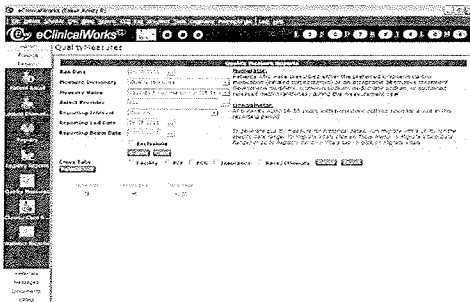
Order Set



Registry



Outcomes management



I don't have to manage asthma anymore

- The team works with the patients to manage their asthma
- I review data, advise interventions, prescribe medications and work with the patient to achieve their goals.
- The team gets them in the door, tests them, reviews their symptoms, counsels them, refers them, enters the correct codes.
- Now - asthma management is effective, efficient and even fun!

So what does this mean for you?

- If you do not have an EHR or an RN – think about how either or both of these tools can enhance your care delivery in your office. Initially, it is a lot of work and up-front cost, but with the new incentives and appropriate billing, these costs will be off-set and will eventually result in profit

Choose to be a team

- Quality improvement cannot be successful without the team approach. Empower and train your staff to work to their full potential. It will free you to do what you really should be doing in regards to patient care.

Order Sets and Templates

- Save yourself some work, take the time to develop these useful tools and your routine orders will be a click away, already linked to the CPT codes and diagnosis and you can pre-type your common patient educational phrasing to be inserted in the note.

Registry

- Pull a list of your asthma patients, narrow it down to a specific age-group, then narrow down to who is not on an inhaled steroid. Then from this list, see who has been in frequently for cough/cold symptoms. Get them in for spirometry and get them under control!
- The registry can give you a list of everyone on a specific med, everyone with a specific diagnosis, everyone with a specific vital sign. This is true population disease management.

The tool, NOT the fix!

- Our EHR did not cause quality improvement!
- It was a tool we had available to use and it allowed us to put pathways in place for the team to improve the quality of our care delivery.
- Mistake providers make - that EHR's will improve care. They can't! They are just software. Only the healthcare team and the patients can improve care!

Summary

- EHR's make it easier to enter and track data and document interventional care.
- Team care using a model like the Chronic Care model is necessary because the provider cannot do it all and is not even qualified to do it all!
- Having an RN in the clinic might sound costly, but will actually make money, improve patient care and satisfaction and take a lot of burden off the provider!
