Practice Wisely, Save Time & Improve Outcomes

Presented by:
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- Dr Brown has no conflicts of interest to disclose

Utilizing Data and quality Improvement Techniques to Improve Clinical Quality Measures ... and Save 2 hours a day.

Learning objectives:

- Discuss population health management with emphasis on tracking/outreach
- Collaborate with medical neighbors to close gaps in care
- Educate patients on the importance of preventable health measures
- Coordinate and leverage appointments to improve compliance with pre-visit planning
- Implement one simple change to improve access and efficiency in your own practice
- Use teamwork to ease the physician burden, improve documentation and provide better, more efficient patient care
- Become inspired about the possibility of reconnecting with the purpose and pleasure of practicing medicine

Quality & Appropriateness Measures

Disclaimer: ***For demonstration purposes only. Information may not be complete and is subject to change.***

Specialty Care

OB/GYN

- HEDIS Breast cancer screening in past 2 years
- HEDIS Chlamydia annual screening *
- Cervical Cancer Screen
- Elective Delivery prior to 39 weeks gestation

Cardiology

- New hypertension glucose test
- CHD post-MI on ACE inhibitor
- Lipid RX non-compliance *
- HEDIS ACEI or ARB annual potassium and creatinine
- HEDIS Diuretics annual potassium and creatinine
- ACE ARB Adherence
- Statin Adherence
- Diabetes hypertension nephropathy on ACE or ARB *

Endocrinology

- HEDIS Diabetes annual hemoglobin A1c
- HEDIS Diabetes annual nephropathy screening
- Diabetes hypertension nephropathy on ACE or ARB *
- Lipid RX non-compliance *
- DM Adherence

Typical

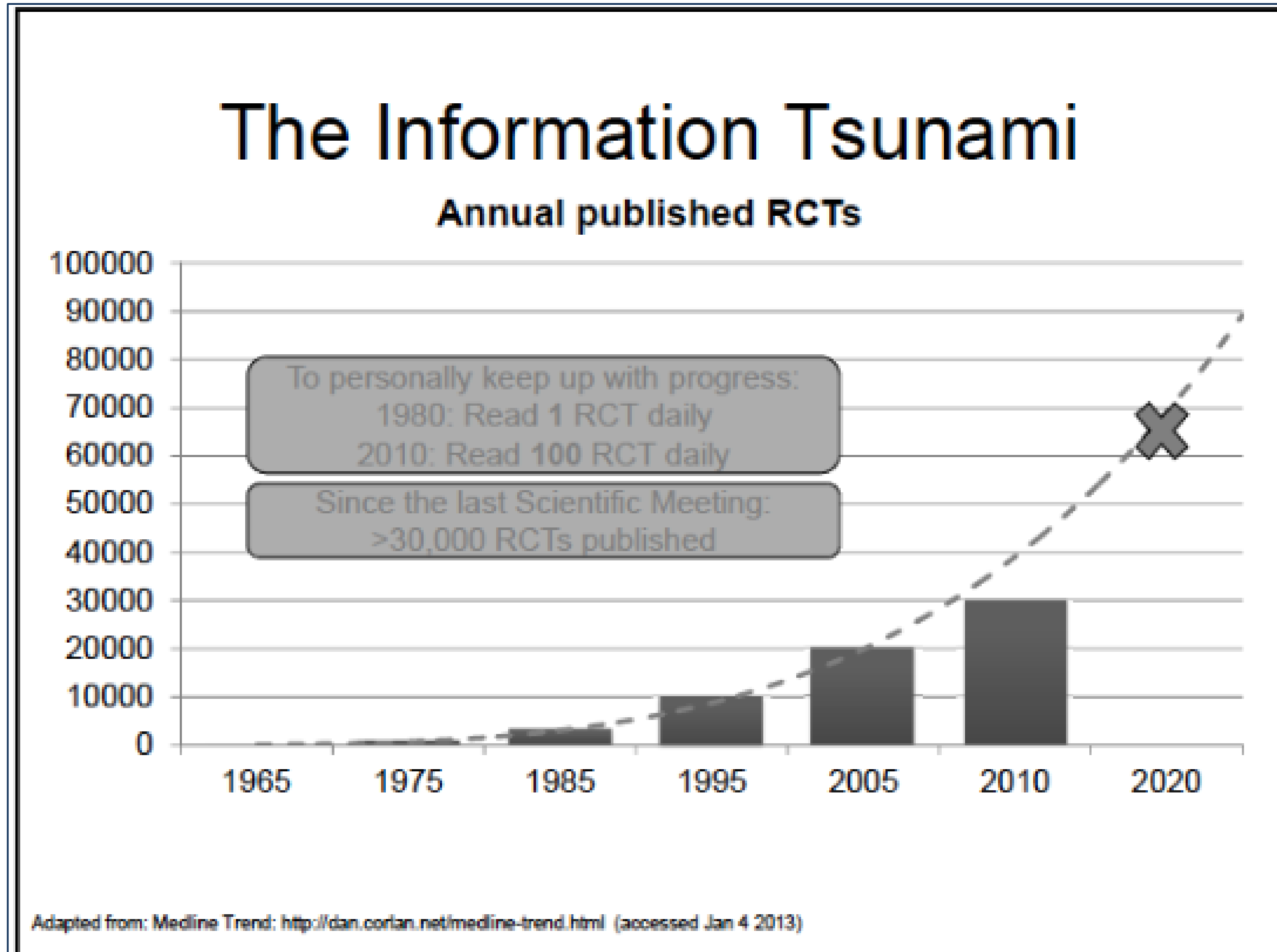
Managing ~~Complex~~ Patients And Save Time

1. Develop a time efficient approach to patients with numerous comorbidities

2. Implement a team based approach to meet needs of the complex patient

3. Identify and engage external resources to meet needs of the complex patient

1600 guidelines in 17 minutes

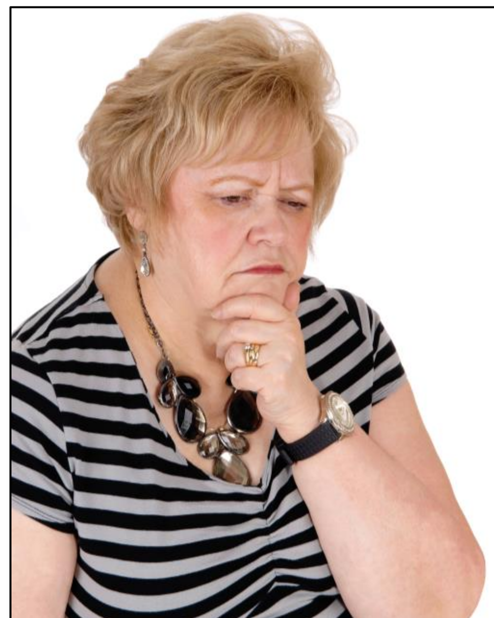


Mrs Hennessey 10:20-10:40

60 yo woman retired teacher here for follow up. She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills. No chest pain, dyspnea. Gyne visit – needs pap.

Problem list:

T2DM
CAD
Depression
Obesity
HTN
Hyperlipidemia
Hypothyroidism
Low back pain
Urinary incontinence



Meds:

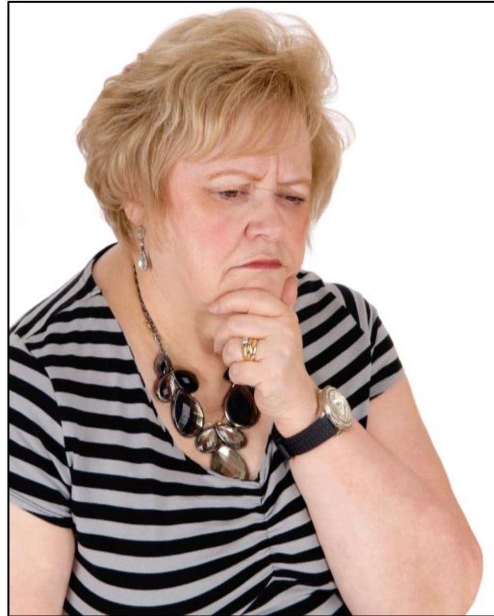
Metformin
Glimepiride
Sitagliptin
Chlorthalidone
Lisinopril
metoprolol
Paroxetine
lorazepam
Estrogen
Atorvastatin
Levothyroxine
Pantoprozole
Vit D,E,A
ASA
Clopidogrel

1) You are 35 min behind schedule
2) Received notice health maintenance levels were not at goal
3) Her A1c was 8.0% 6 months ago, no record of TSH or BMP
4) BP today is 170/100
5) She has gained 5 lbs since last visit 6 months ago
6) She thinks she needs refills
7) She is not sure which blood pressure medicines she is taking

Mrs Hennessey 10:20-10:40

60 yo woman retired teacher here for follow up. She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills.

Problem list:
T2DM
Depression
Obesity
HTN
Hypothyroidism
Osteoarthritis of both knees
Low back pain
Asthma
CAD



- Unknown DM and thyroid control
- Uncontrolled HTN
- Uncontrolled depression
- Uncontrolled weight
- Uncontrolled pain
- You need to check if she is up to date on breast and pap smear screening, immunizations
- She probably needs refills

Mrs Hennessey 10:20-10:40

60 yo woman retired teacher here for follow up. She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills.

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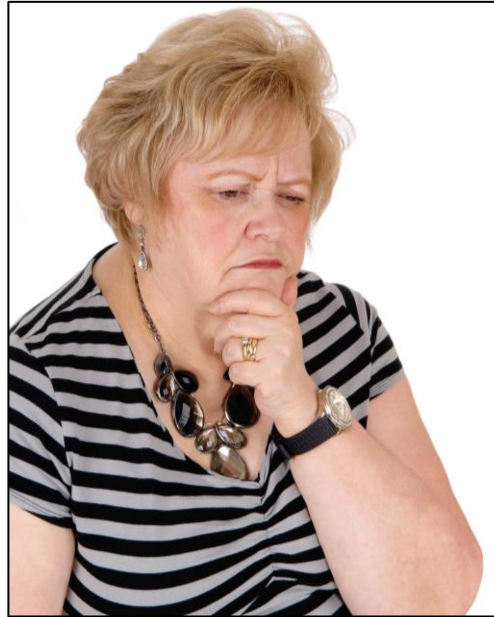

Meds:

Metformin
Glyburide
Sitagliptin
Chlorthalidone
Lisinopril
metoprolol
Paroxetine
lorazepam
Estrogen
Atorvastatin
Levothyroxine
Pantoprozole
Vit D,E,A
Albuterol
fluticasone

What can you do in the 10 minutes remaining?

Mrs Hennessey 10:20-10:40

60 yo woman retired teacher here for follow up. She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills.

Problem list:
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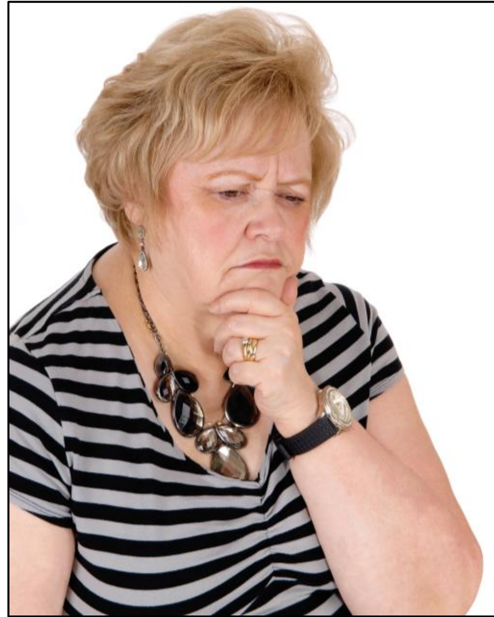


As you leave the room she remembers that she needs a mammogram, a handicapped parking sticker, eye referral, and something more to help her sleep and something to give her energy.

Mrs Hennessey 10:20-10:40

60 yo woman retired teacher here for follow up. She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills.

Problem list:
T2DM
Depression
Obesity
HTN
Hypothyroidism
Osteoarthritis of both knees
Low back pain
Asthma
CAD

As you leave the room she remembers that she needs a mammogram, a handicapped parking sticker, eye referral, and something more to help her sleep. She asks when she Is due for another mammogram and refills.

Mrs Hennessey 10:20-10:40

60 yo woman retired teacher here for follow up. She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills.

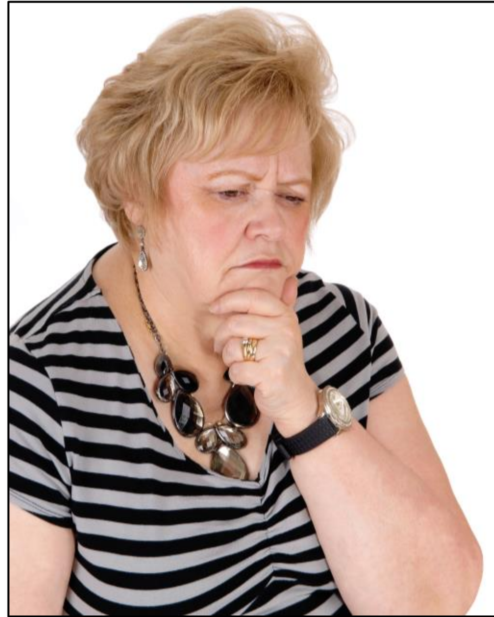
Problem list:
T2DM
Depression
Obesity
HTN
Hypothyroidism
Osteoarthritis of both knees
Low back pain
Asthma
CAD

You order mammogram, a handicapped parking sticker, eye referral, labs and tell her to increase her lisinopril, take advil, call for results and refills if needed. Return visit in 4 months. It is now 10:55 and you are 50 min behind schedule.

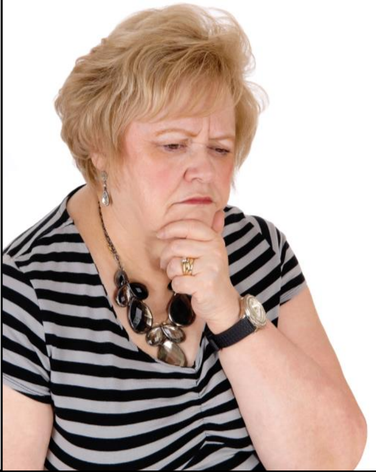
Mrs Hennessey between this visit and next

60 yo woman retired teacher here for follow up. She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills.

Problem list:
T2DM
Depression
Obesity
HTN
Hypothyroidism
Osteoarthritis of both knees
Low back pain
Asthma
CAD



1. She calls for a refill on her metformin as soon as she gets home
2. She calls for something for her knee pain
3. She calls for lab results and you note her TSH is high
4. You increase her levothyroxine and order repeat TSH in 6 weeks
5. You note her A1c is 8.2 and you increase her metformin and send in refill
6. She calls for a new rx for her lisinopril as you increased it
7. She would like an xray of her back



Mrs. Hennessey between this visit and next (Unplanned and not reimbursed)

1. Phones for a refill on her metformin as soon as she gets home
2. She calls asking for medication for her knee pain
3. She calls for lab results and you note her TSH is high
4. You increase her levothyroxine and order repeat TSH in 6 weeks
5. You note her A1c is 8.2, you increase her metformin and send in refill
6. She calls for a new rx for her lisinopril as you increased it
7. She would like an x ray of her back
8. She calls for her TSH result in 6 weeks
9. She calls for her mammogram result which is normal
10. She asks if she should get a shingles shot
11. Quality metrics report shows she has not had colonoscopy, Tdap, influenza, PCV, PPSV, zoster, foot exam, urine protein.
12. BP and A1c not at goal-tied to evaluation/bonus
13. Patient satisfaction is low due to 1-2 hours behind schedule

Staff	Minutes
3	5
3	10
3	10
1	5
1	10
3	5
3	10
3	10
3	10
1	5
24	1 hr 20min

1 hr 20 min x 3 (between visits)= 4 hours/year

Lost time is never found again

1 hr 20 min x 3 (between visits)= 4 hours/year for 1 patient

200 patients= 800 hours/yr or 100 work days- not reimbursed

Over 3 months

Mrs. Hennessey 4 months later 4:20-4:40

65 yo woman retired teacher here for follow up. She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills.

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Hypothyroidism
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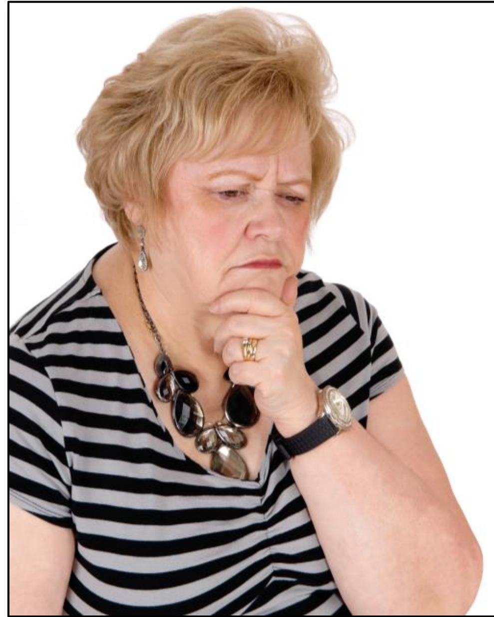

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Sitagliptin
Chlorthalidone
Lisinopril
metoprolol
Paroxetine
lorazepam
Estrogen
Atorvastatin
Levothyroxine
Pantoprozole
Vit D,E,A
Albuterol
fluticasone

1. You are already 45 min behind schedule
2. Her A1c was 8.2% 4 months ago
3. BP today is 165/100
4. She has gained 5 lbs since last visit 4 months ago
5. She thinks she needs refills
6. She is not sure which blood pressure medicines she is taking
7. Your health maintenance levels were not at goal

Creative Solutions

How do you effect change?

Identify and engage the members of the team

Meet to discuss the project

on the clock
protected time
administratively supported

Address:

What's in it for each team member?
Is it more work?
Who benefits?
Choose a project that lends itself to a visual run chart.

The team chooses the first PDSA (plan-do-study-act)

How are you going to celebrate the completion? (not the improvement)

We all want world peace

But we need to start very small and score some easy wins

The true test –

Is it sustainable?
Will the team be engaged when you are out of town?

Where will we find the time?

Adding additional work to an already overloaded system is a recipe for failure and increased burnout

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IMPROVING CLINICAL CARE

- MANAGE PATIENTS' MEDICATIONS
- DEPRESSION SCREENING & CARE
- MANAGE DIABETES MELLITUS
- IMMUNIZE ADULTS
- CHRONIC PAIN MANAGEMENT
- OPIOID RISK MANAGEMENT
- OSTEOARTHRITIS
- RHEUMATOID ARTHRITIS
- GOUT
- ADDRESSING SUBSTANCE USE
- MOTIVATIONAL INTERVIEWING
- ASSESSING CARDIOVASCULAR RISK

MANAGING YOUR PRACTICE

Transformation Toolkits

- Teams
  - Expanded rooming
  - Team documentation
  - Prescription management
  - Pre-visit planning/lab
  - Team meetings
  - Daily huddles
- Culture
  - Preventing Burnout
  - Resiliency
  - Wellness in Residency
  - Transforming culture
- Value
  - Panel management
  - Medication adherence
  - Burnout Prevention
  - Diabetes prevention
  - Hypertension
- Technology
  - Telemedicine
  - EHR implementation

www.stepsforward.org

CHAOTIC VISITS
Patient and team not prepared
No agenda
Impossible schedule
Urgent not important
Medications unmanaged
No access

Practice Redesign

Challenge

Chaos

Solutions

Previsit Labs
Previsit Planning
Medication Adherence
Medication sync[3]
- 90 x 4 refill 1x/yr
- One stop shop
- Indication based

Panel Management

Actions

Insurers/pharmacy plans/regulatory
- One copay for lab/visit
- Refill for 15 months

Administration
- Flexible schedule
- Provide time
- Imbed PDSA cycle in the office

Team
- Shared tasks
- Build trust

Patient
- Engaged

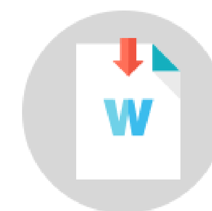
PREVISIT PLANNING

Fairview: Care Model Redesign
MA pre-visit call
Agenda, Med review
Depression screen
Advanced directive

Rooming Checklist

Preventive screening	Due	Up-to-date	N/A	Target population and recommendation
PAP				Age 21 to 65 years Every 3 years if no history of abnormal PAPs (or every 5 years if over 30 and most recent PAP negative and HPV-negative)
Mammogram				Age 50 to 75 years Every 1 to 2 years; or for those 40 to 50 and >75 screening is optional
Colonoscopy				Age 50 to 75 years Every 10 years (more frequent if history of colon polyp or family history of colon cancer)
Bone density scan (DEXA)				Age 65 years Every 10 years for women if previous results were normal; every 5 years if symptoms of osteopenia exist
Abdominal aortic aneurysm				Age 65 to 75 years One-time screening for men who have ever smoked
Visual acuity				Age >65 years (new Medicare enrolees) Can be completed during the “Welcome to Medicare” visit
Glaucoma screen				Age >65 years Annually

Immunization	Due	Up-to-date	N/A	Target population and recommendation
Tdap vaccine				Age >19 years Administer Tdap once; boost with Td every 10 years
Influenza vaccine				Age >6 months Annually
Shingles vaccine				Age >60 years Option if >50 years
Pneumococcal vaccine (PCV13 or PPSV23)				Age >65 years • PCV13 now, followed by PPSV23 six to 12 months later • If already received PPSV23, wait at least one year before giving PCV13 Patients age 18 to 65 with a chronic* or immunocompromising condition may also need a pneumococcal vaccine.



DOWNLOAD A SAMPLE ROOMING CHECKLIST

DOWNLOAD A SAMPLE DISCHARGE CHECKLIST

Pre-visit planning

- Don’t let perfection be the enemy of the good
- Maximize staff ‘down time’
- What is your staff doing now?
- Panel management
- Preventive care

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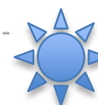
Ten steps to pre-visit planning

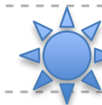
During the current visit

1. Re-appoint the patient at the conclusion of the visit
2. Use a visit planner checklist to arrange the next appointment(s)
3. Arrange for laboratory tests to be completed *before* the next visit



Before the next visit

4. Perform visit preparations
5. Use a visit prep checklist to identify gaps in care

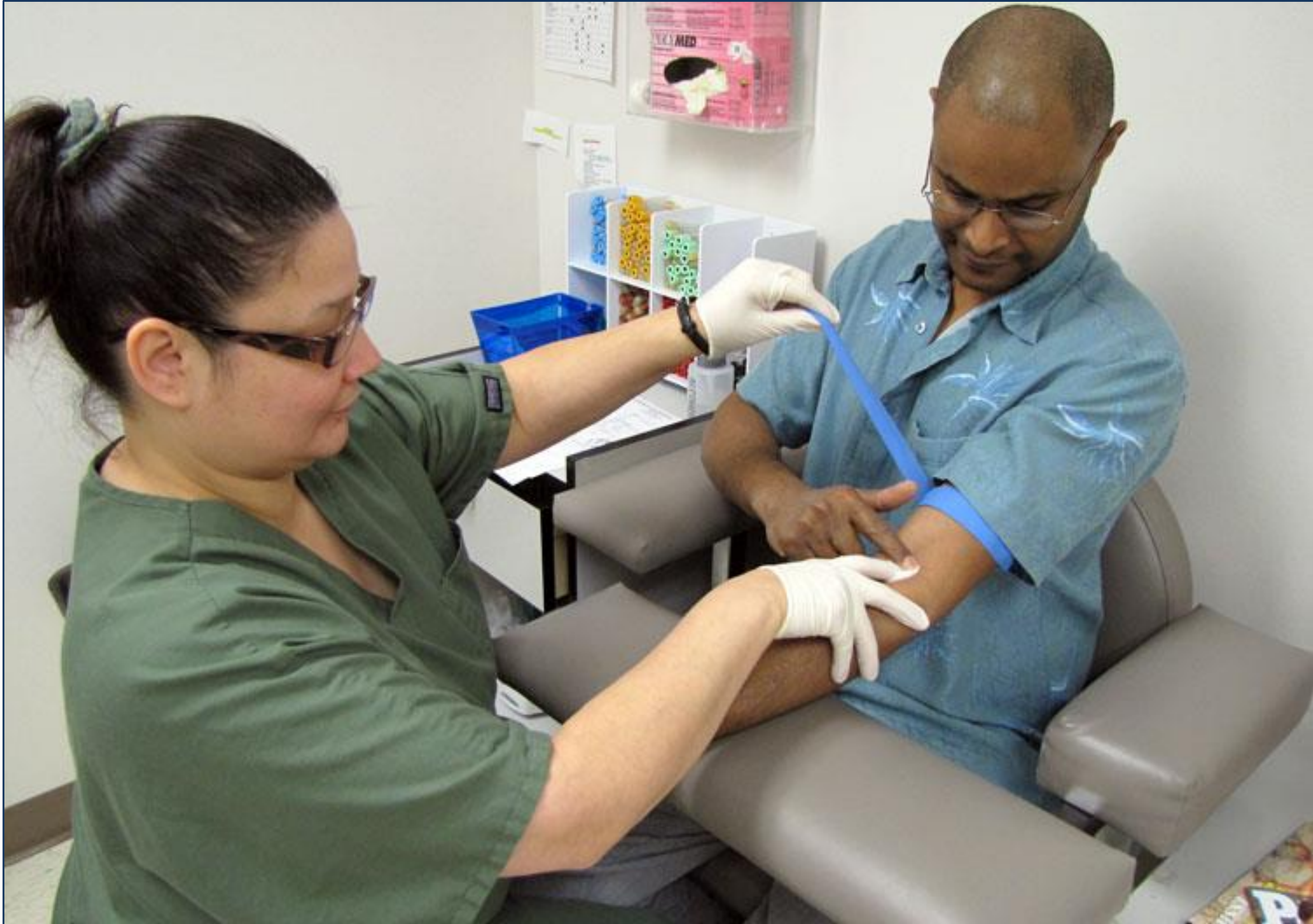


6. Send patients appointment reminders
7. Consider a pre-visit phone call or email

During the next visit

8. Hold a pre-clinic care team huddle
9. Use a pre-appointment questionnaire
10. Hand off patients to the physician

Previsit labs



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Six steps to pre-visit laboratory testing

1. Re-appoint the patient at the conclusion of each visit
2. Pre-order labs and other needed tests
3. Use a visit planner checklist to arrange the patient's next appointment(s)
4. Arrange for tests to be completed *before* the next visit
5. Delegate computerized order entry
6. Empower staff to manage the inbox

Pre-visit Labs

- ✦ 89% ↓ phone calls ($p<0.001$)
- ✦ 85% ↓ letters ($p<0.0001$)
- ✦ 61% ↓ additional visits ($p<0.001$)
- ✦ ↑ patient satisfaction
- Save $24 per visit

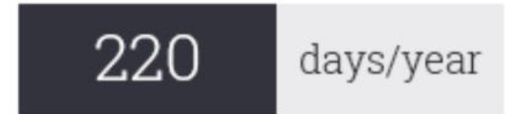
Crocker B, Lewandrowski E, Lewandrowski N, Gregory K, Lewandrowski K. Patient Satisfaction With Point-of-Care Laboratory Testing: Report of a Quality Improvement Program in an Ambulatory Practice of an Academic Medical Center. *Clin Chem Acta* 2013; 424:8-12.; and personal communication/poster 3.4.14;

also http://ajcp.ascpjournals.org/content/142/5/640.abstract
http://ajcp.ascpjournals.org/content/142/5/640.full

Your practice

Cost of physician's time

Cost of staff time

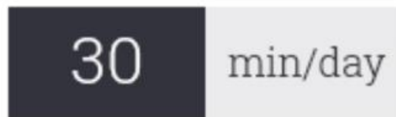


Clinic days per year

Estimate savings

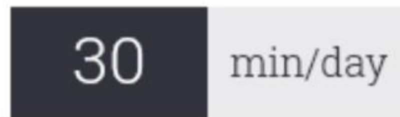
TIME

MONEY



Physician time on results reporting*

+



Staff time on results reporting*

=

Time saved

=

Annual savings with

Q&A

Will there be more "no-shows" if we schedule patients six or 12 months in advance?

Experience suggests that pre-visit laboratory testing, especially when coupled with an automated reminder, will decrease the rate of no-shows in a practice. Implementing an automated or manual

Practice Redesign

Challenge

Chaos

Solutions

Previsit Labs
Previsit Planning
Medication Adherence
Medication sync[3]
- 90 x 4 refill 1x/yr
- One stop shop
- Indication based

Actions

Insurers/pharmacy plans/regulatory
- One copay for lab/visit
- Hold future lab orders
- Refill for 15 months
- Refill synch (90 days +/- 5)

Administration
- Flexible schedule
- Provide **time** for previsit planning
- Provide 'desk time'
- Imbed PDSA cycle in the office
- Develop metrics for inefficiency
- Train team based practice

Agenda and
Medication Review
process starts on
the phone, days
prior or in the
waiting room

YOUR MEDICATIONS

In order for your Doctors and Nurses to better care for you we need your help. Please review your medication list that has been handed to you at each and every visit. Then we need you to look at it carefully and make some notes.

1. Circle the medications you need refills for (you should leave the office today with enough refills to last until your next visit)
2. Cross out any medications you are not taking
3. Put a '?' next to medicine you don't think you need or have questions about
4. Add medications other doctors are giving you (this includes eye drops, creams and especially other pills)
5. Add supplements or vitamins that you are taking (this is very important)

TODAY'S VISIT

Please write down the 3 things you need or want to discuss with the nurse or doctor today: (referrals, forms to be filled, questions, excuses for work, handicapped parking, concerns or symptoms)

1. ____

2. ____

3. ____

Use back of paper if needed

List any doctors or procedures (ex: xrays,mammograms,immunizations) you have seen or had since last visit: ________________________

The visit begins during a previsit plan and/or continues in the waiting room and in the exam room while waiting for the provider

Which 3 things would you like to handle today?

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PDSA Overview

1) **Plan**
   a. Set Aim
      1. Which area will the practice focus on? Foot exam
      2. What is the specific improvement goal? Double the # of pts w footwear removed in 3 months
   b. Develop sampling methodology for data collection
      1. Small number 10
      2. Assign staff and design methodology to fit within workflow Patient roomer, provider
   c. Develop plan to test change View pictures of foot ulcers, field trip to podiatrist,posters,video
   d. Predict what will happen as a result of the test

2) **Do**
   a. Carry out test View pictures of foot ulcers, field trip to podiatrist,posters, videos
   b. Set time frame: 1-2 weeks
   c. Identify patient population to test All diabetics seen on a Tuesday and Thursday
   d. Document problems
      Takes time, patients resist, staff too rushed, provider still doesn't examine feet

3) **Study**
   a. Analyze data (follow up data collection on a small sample)
   b. How does data compare to your initial predictions?
   c. Have there been any improvements?

4) **Act**
   a. Based on analysis, what is the next step in the change cycle?
   b. Abandon, adopt, or change design

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ACP Quality Connect

PDSA Overview

1) **Plan**
   a. Set Aim
      1. Which area will the practice focus on? Annual LDL or annual chlamydia test
      2. What is the specific improvement goal? Increase by 20% over baseline in 3 months. From 20-40%
   b. Develop sampling methodology for data collection
      1. Small number 10
      2. Assign staff and design methodology to fit within workflow Patient roomer, provider, MA, RN?
   c. Develop plan to test change Staff looks at different 10 pts in the study population every wed.
   d. Predict what will happen as a result of the test

Previsit planning prior to visit-MA identifies need for annual lipid/chlamydia
Standing order entered into EHR

2) **Do**
   a. Carry out test
   b. Set time frame: 1-2 weeks
   c. Identify patient population to test All diabetics seen on a Thursday
   d. Document problems

Takes time to develop standing order, patients resist, staff too rushed, provider not on board

3) **Study**
   a. Analyze data (follow up data collection on a small sample)
   b. How does data compare to your initial predictions?
   c. Have there been any improvements?

4) **Act**
   a. Based on analysis, what is the next step in the change cycle?
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Simple Run Chart

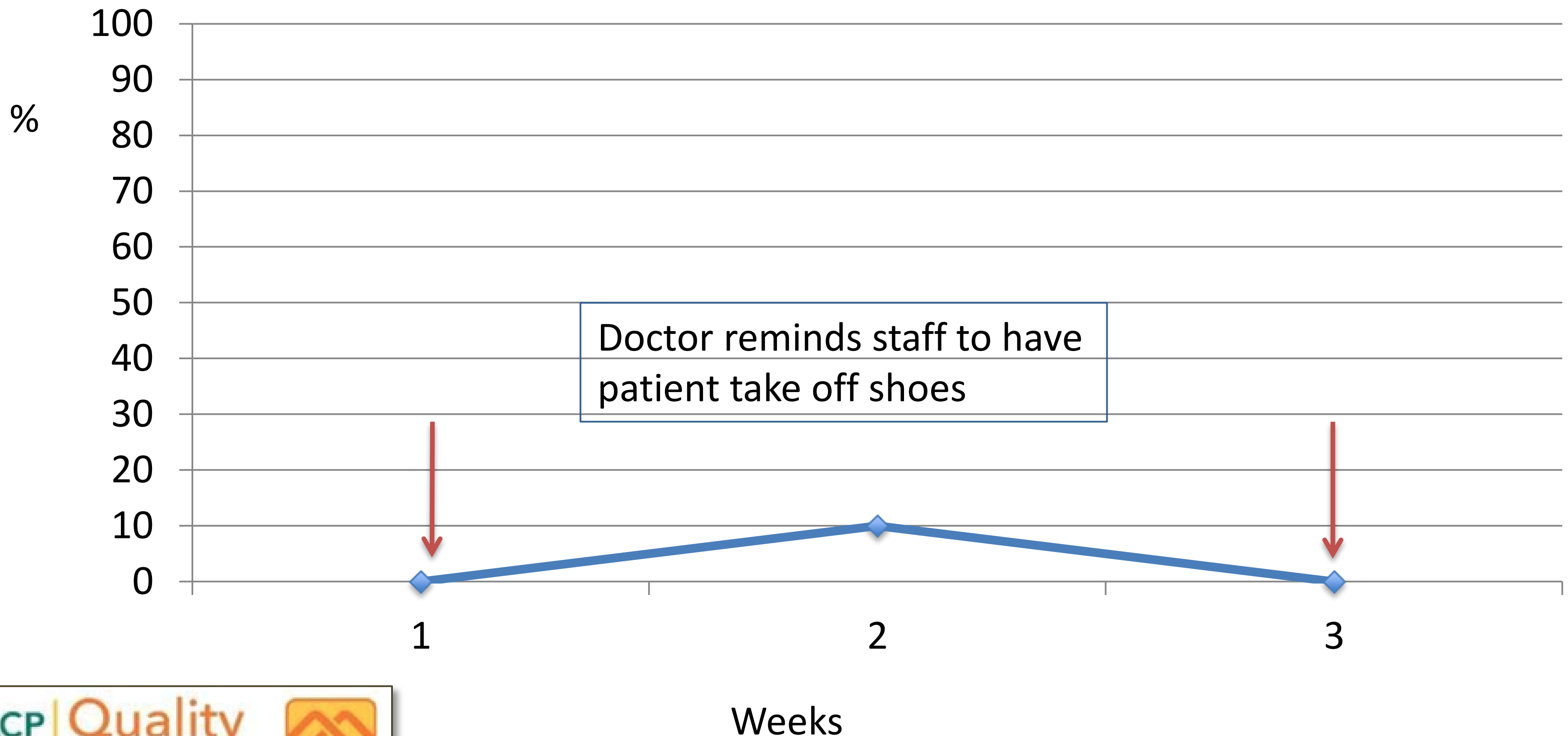
Count how many diabetic patients each Friday are ready for exam

(week 1: 0/10= 0%)

Simple Run Chart

Count how many diabetic patients each Friday are ready for exam

(week 1: 0/10= 0%)

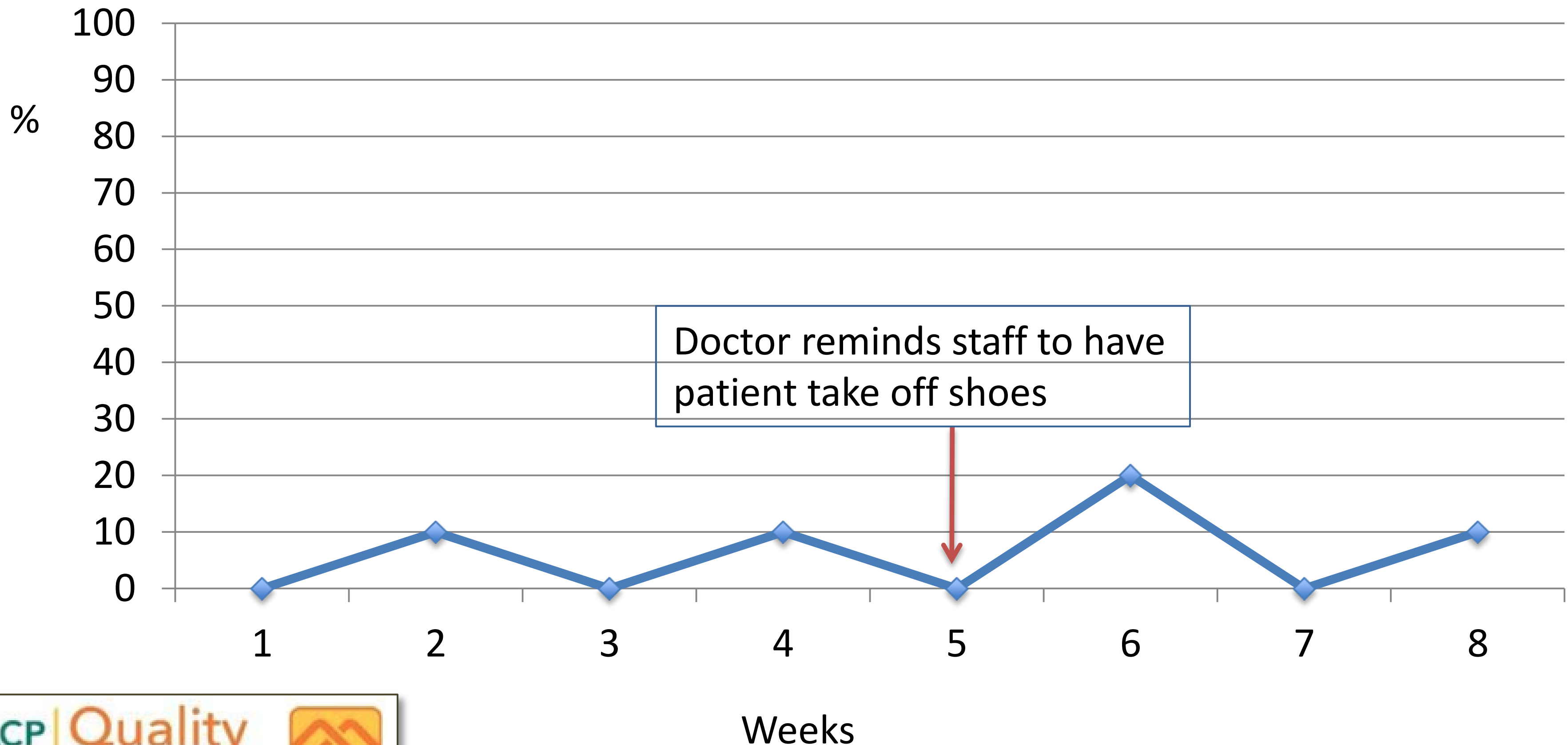


ACP Quality Connect

Simple Run Chart

Count how many diabetic patients each Friday are ready for exam

(week 5: 0/10= 0%)



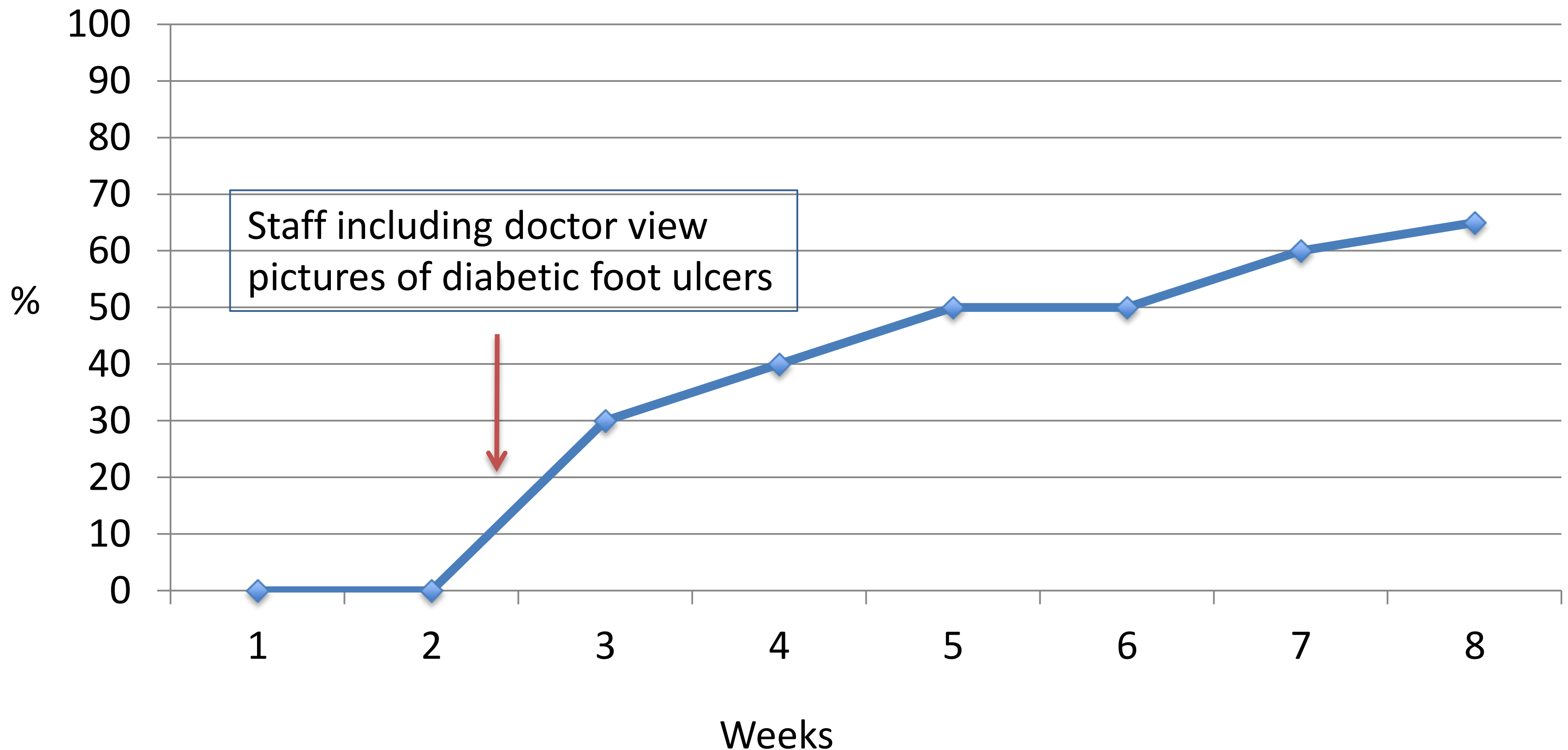
ACP Quality Connect

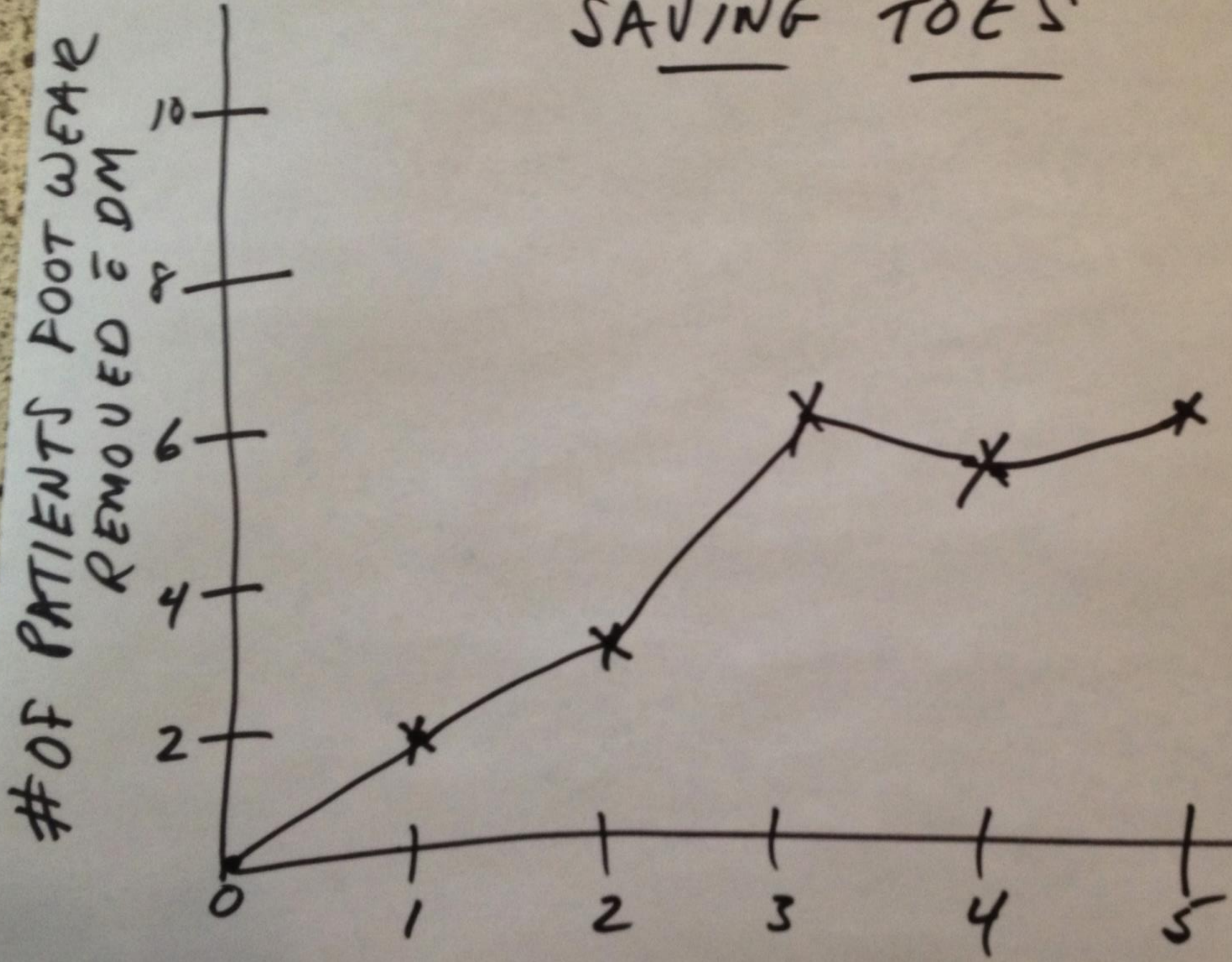
Linking Small Steps of Change

- People are far more willing to test a change when they know that changes can and will be modified as needed
- Linking small tests of change helps overcome a practice's/organization's natural resistance to change and ensure physician buy-in

How many toes did you save today?

Count how many diabetic patients each Friday are ready for exam (week 5: 5/10= 50%)





SAVING TOES
OF PATIENTS FOOT WEAR REMOVED c̄ DM
10
8
6
4
2
0
1
2
3
4
5
WEEK - ON TUES.

Celebrate success!!!!!!!!

Quality & Appropriateness Measures

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Specialty Care

OB/GYN

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- New hypertension glucose test
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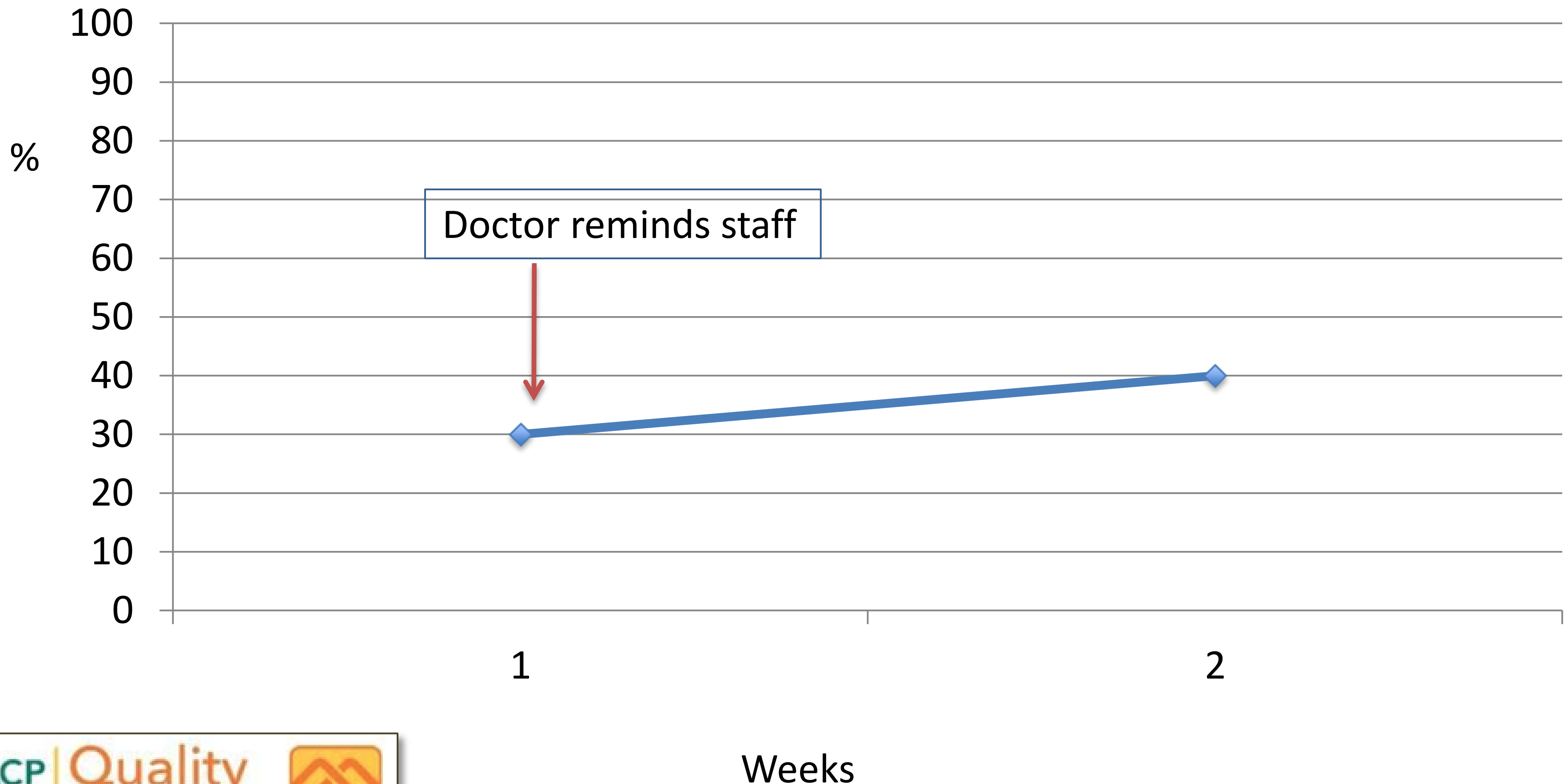
- HEDIS Diuretics annual potassium and creatinine
- ACE ARB Adherence
- Statin Adherence
- Diabetes hypertension nephropathy on ACE or ARB *

Endocrinology

- HEDIS Diabetes annual hemoglobin A1c
- HEDIS Diabetes annual nephropathy screening
- Diabetes hypertension nephropathy on ACE or ARB *
- Lipid RX non-compliance *
- DM Adherence

Simple Run Chart

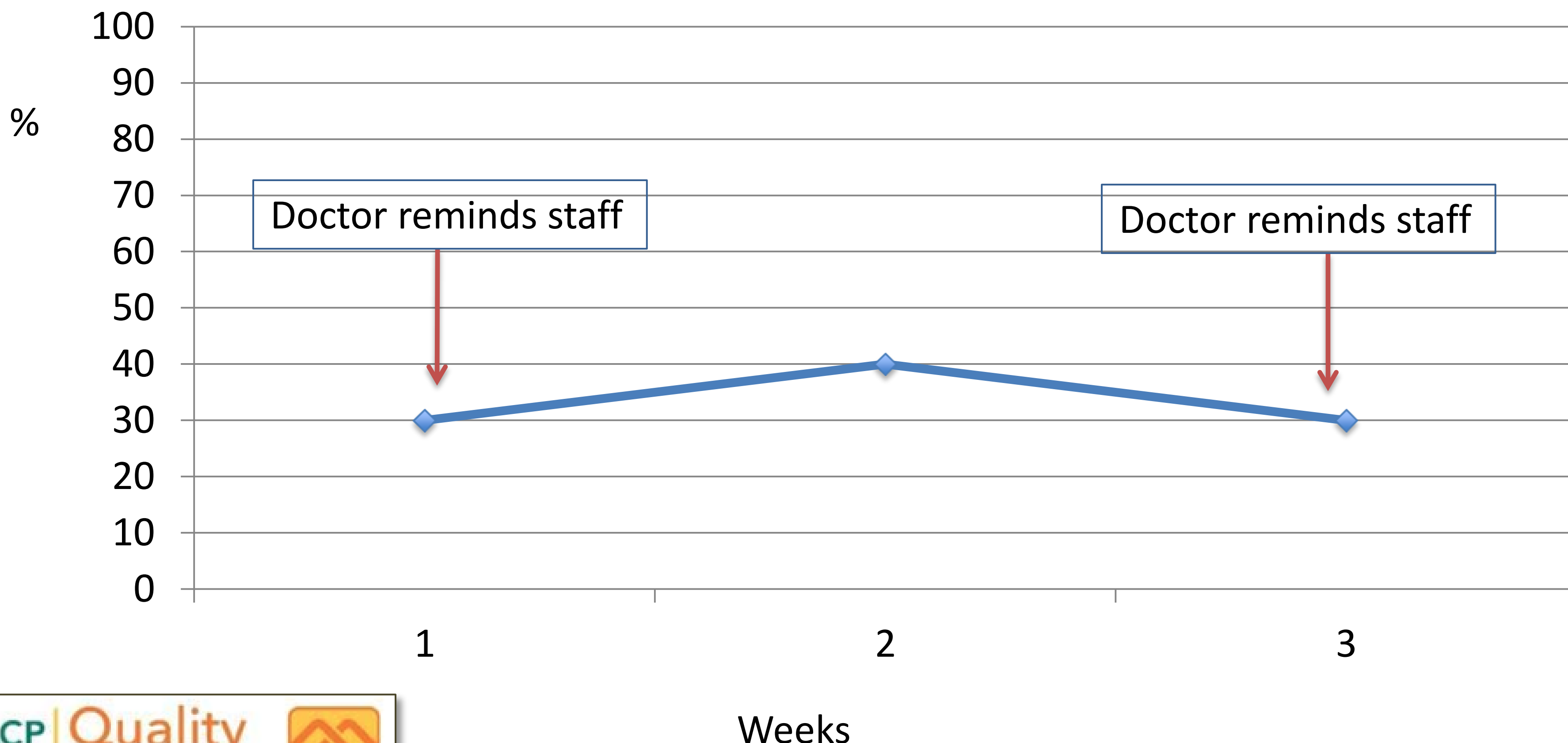
Count how many diabetic patients or women (10) each Wed are on ACE/ARB or have chlamydia test within the year (week 1: 3/10= 30%)



ACP Quality Connect

Simple Run Chart

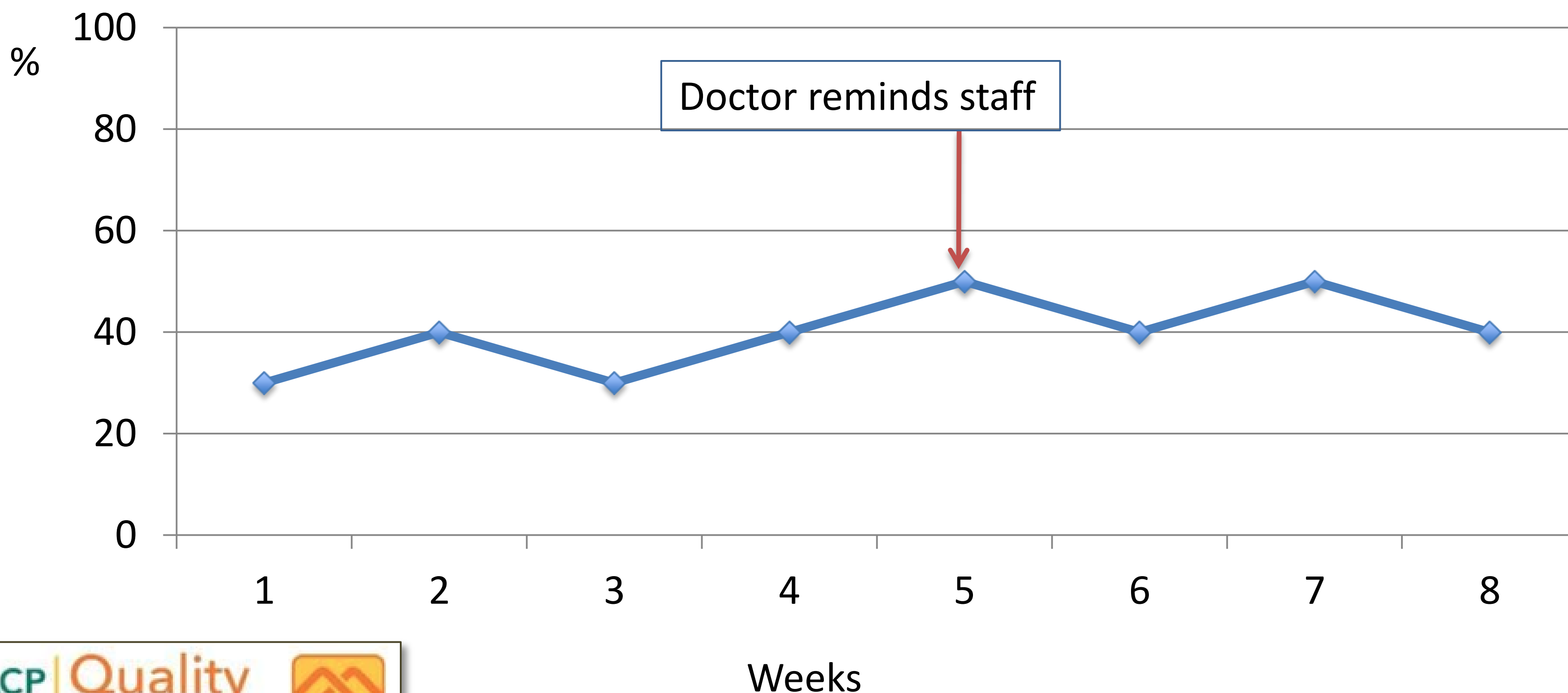
Count how many diabetic patients or women (10) each Wed are on ACE/ARB or have chlamydia test within the year (week 1: 3/10= 30%)



ACP Quality Connect

Simple Run Chart

Count how many diabetic patients or women (10) each Wed are on ACE/ARB or have chlamydia test within the year (week 1: 3/10= 30%)

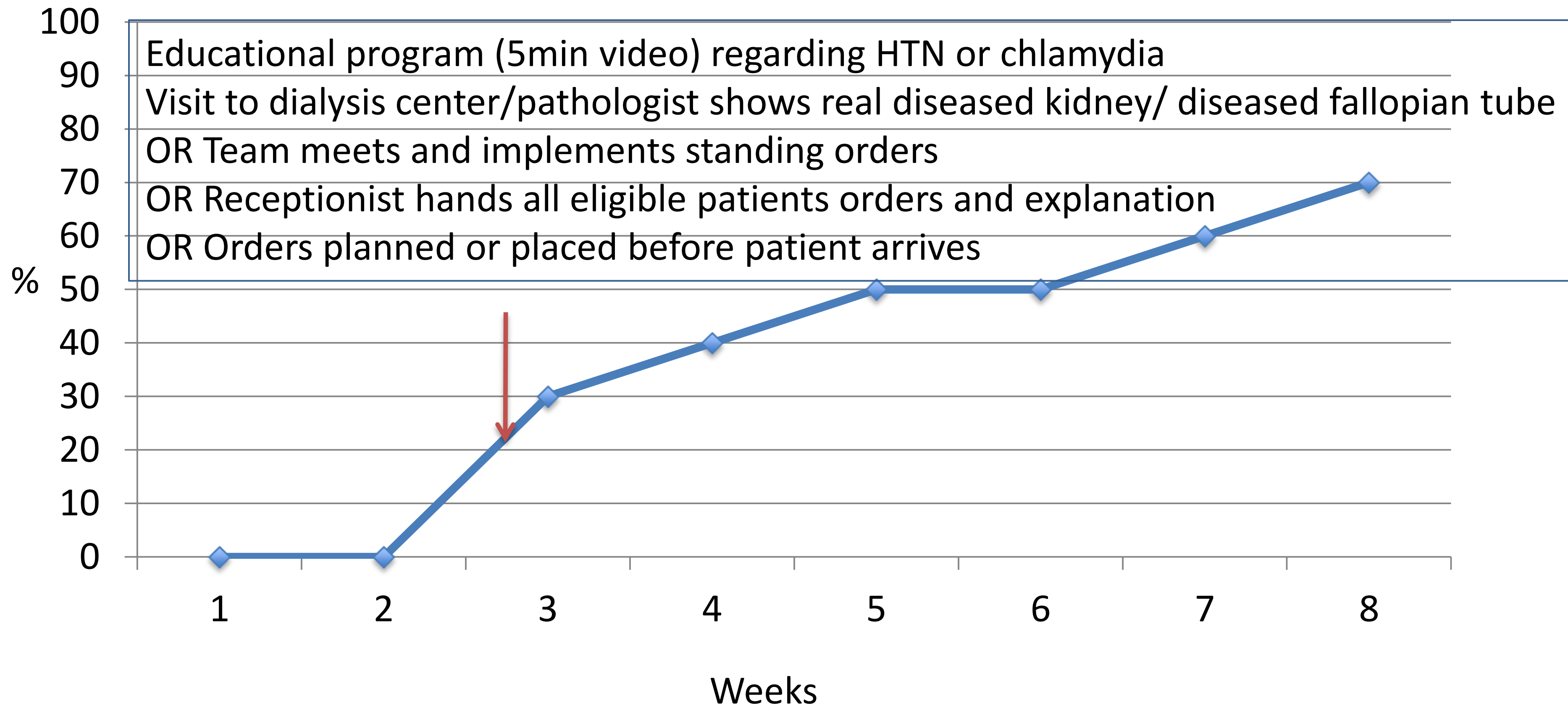


ACP | Quality Connect

Simple Run Chart

Count how many diabetic patients or women (10) each Wed are on ACE/ARB or have chlamydia test within the year

(week 8: 7/10=70%)



Practice Redesign

Challenge

Chaos

Solutions

Previsit Labs
Previsit Planning
Schedule efficiency
Medication Adherence
Medication sync[2]
- **Refill 1x/yr**
- **One stop shop**

Actions

Insurers/pharmacy plans/regulatory
- One copay for lab/visit
- Hold future lab orders
- Refill for 15 months
- Refill synch (90 days +/- 5)

Administration
- Staff queus refills
- Provides time find nonadherence
- Develop metrics for pharmacists
- Train team based practice
- EHR efficiencies user design

MEDICATION MANAGEMENT

Save 2-3 hours each day

Improving medication adherence

Streamlining prescription renewals

Renew Chronic Meds Once a Year (#90 x 4)

Physician time saved > 1 hour/day

Nursing time saved > 2 hours/day

40 million primary care visits each year

Weekend/night calls

Medication errors

Patient satisfaction

Continue to see patients
every 1-3 months

Synchronized prescription renewal

Save physician and staff time by renewing prescriptions until the next annual visit.

CME AVAILABLE

Get started >

Three steps to synchronized prescription renewals

Calculate time saved per year:

Estimate savings

Patients with chronic illness		Medications per patient		Calls per prescription per year		Minutes per call		Time saved
1000	x	5	x	2	x	2	=	TIME 333H 20M /YEAR

Synchronized prescription renewal

Save physician and staff time by renewing prescriptions until the next annual visit.

CME AVAILABLE

Get started >

Calculate money saved per year:

Your practice

$ 3 /min
Cost of physician's time

$ 1 /min
Cost of staff time

220 days/year
Clinic days per year

Estimate savings

30 min/day
Rx time for Physician ?

\+

30 min/day
Rx time for Staff ?

=

TIME
1H 0M /DAY
Time saved

=

MONEY
$26,400
Annual savings with Synchronized Prescription Management

Source: AMA. *Practice transformation series: synchronized prescription renewal.*. 2014.

Improve the health of your patients and reduce overall health care costs.

Medication adherence

CME CREDITS: 0.5 INFORMATION ABOUT CME

Eight steps to improve medication adherence

1. Consider medication nonadherence first as the reason a patient's condition is not under control
2. Develop a process for routinely asking about medication adherence
3. Create a blame-free environment to discuss medications with the patient
4. Identify **why** the patient is not taking their medicine
5. Respond positively and thank the patient for sharing their behavior
6. Tailor the adherence solution to the individual patient
7. Involve the patient in developing their treatment plan
8. Set patients up for success

Medication Adherence

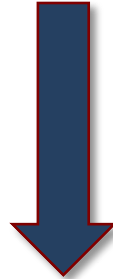
World Health Organization:

Increasing adherence may have a

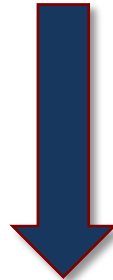
far greater impact

on the health of the population than any improvement in specific medical treatments.

TREATMENT



ADHERENCE



OUTCOMES

PATIENTS DON'T TAKE THEIR MEDICINE AS PRESCRIBED 50% OF THE TIME

25% OF INITIAL PRESCRIPTIONS ARE NEVER FILLED

Osterberg L *N Engl J Med*. 2005;353(5):487-497
Fischer MA, Choudhry NK. *Am J Med*. 2011;124(11):1081.e9-22.
Fischer MA, *J Gen Intern Med*. 2010;25(4):284-290.

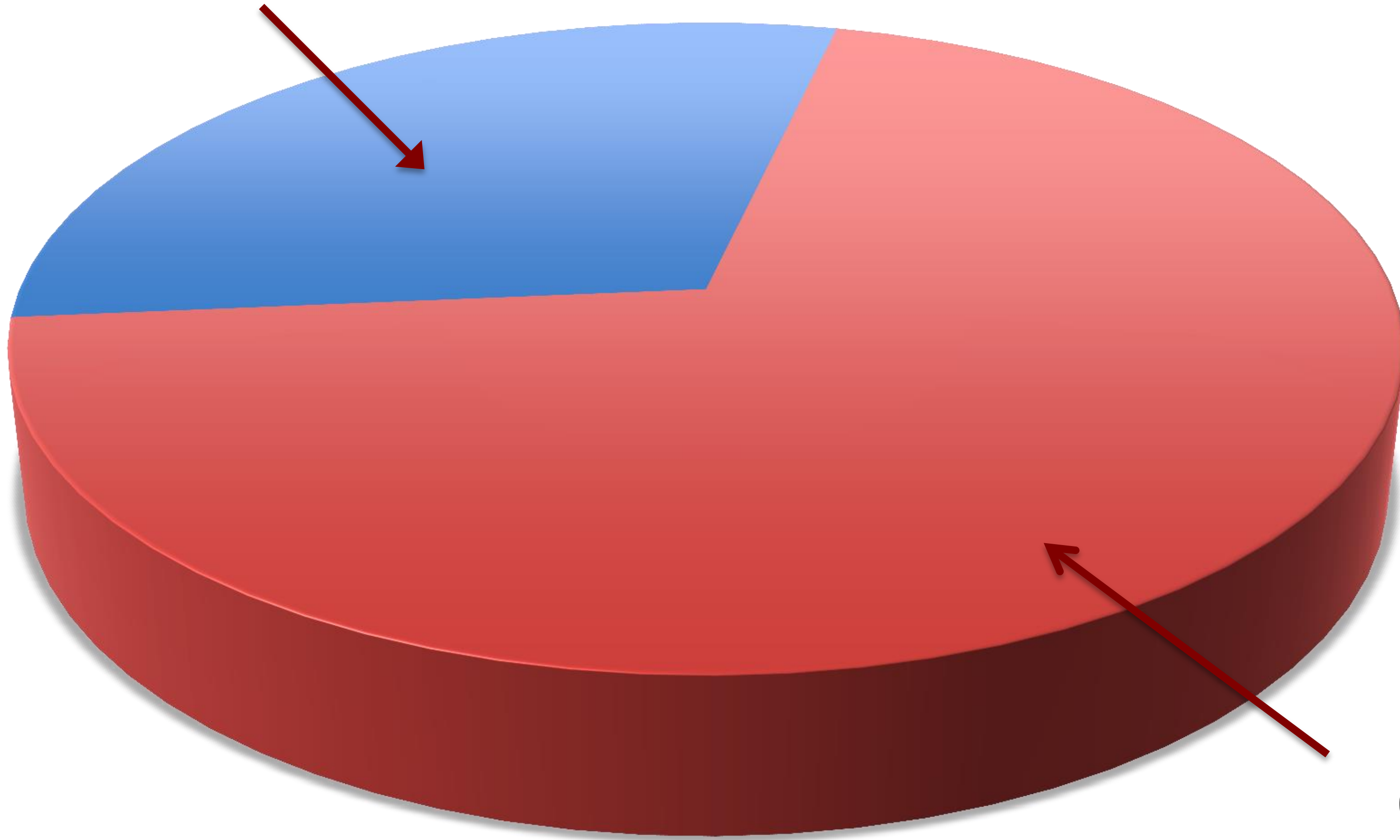
85% OF PHYSICIANS BELIEVE THE MAJORITY OF THEIR PATIENTS ARE ADHERENT

85% OF PATIENTS SURVEYED STATE THAT THEY WOULD NOT TELL THEIR DOCTOR THAT THEY WERE NOT PLANNING ON BUYING A MEDICINE

Brown MT, Sinsky C Family Practice Mgt; March/April 2013
McHorney,C Current Medical Research and Opinion 2009 25:1; 215-238

NONADHERENCE CAUSES

30%
UNINTENTIONAL
(Forgetfulness)



70%
OTHER
CAUSES

Osterberg L NEJM. 2005;353(5):487-497

Practice Redesign

Challenge

Inadequate Support

Solutions

Share the care among the team
2:1 or 3:1 staffing
Rooming protocol
Between visit
- Health coaching
- Care coordination
- Panel management

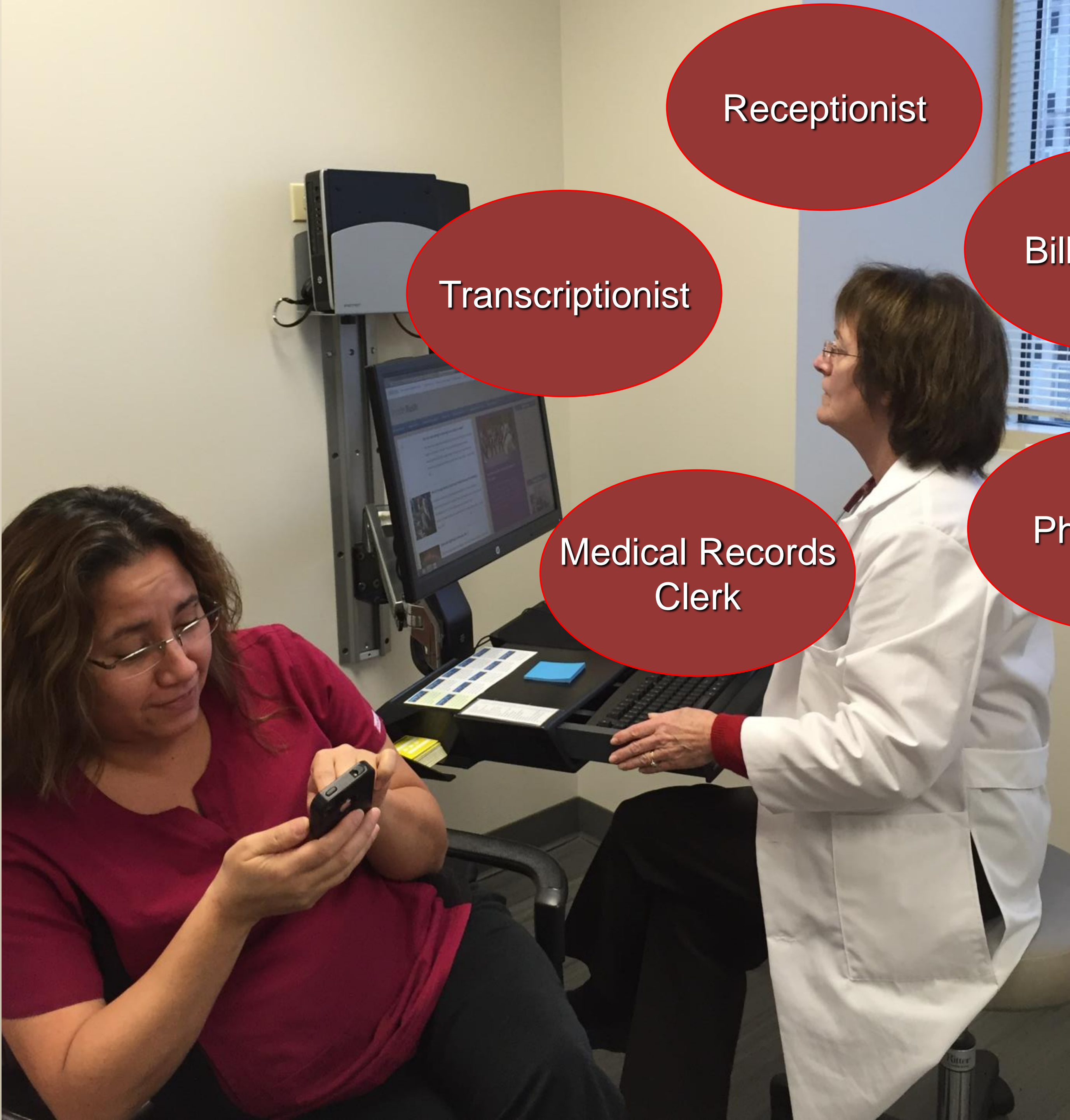
Actions

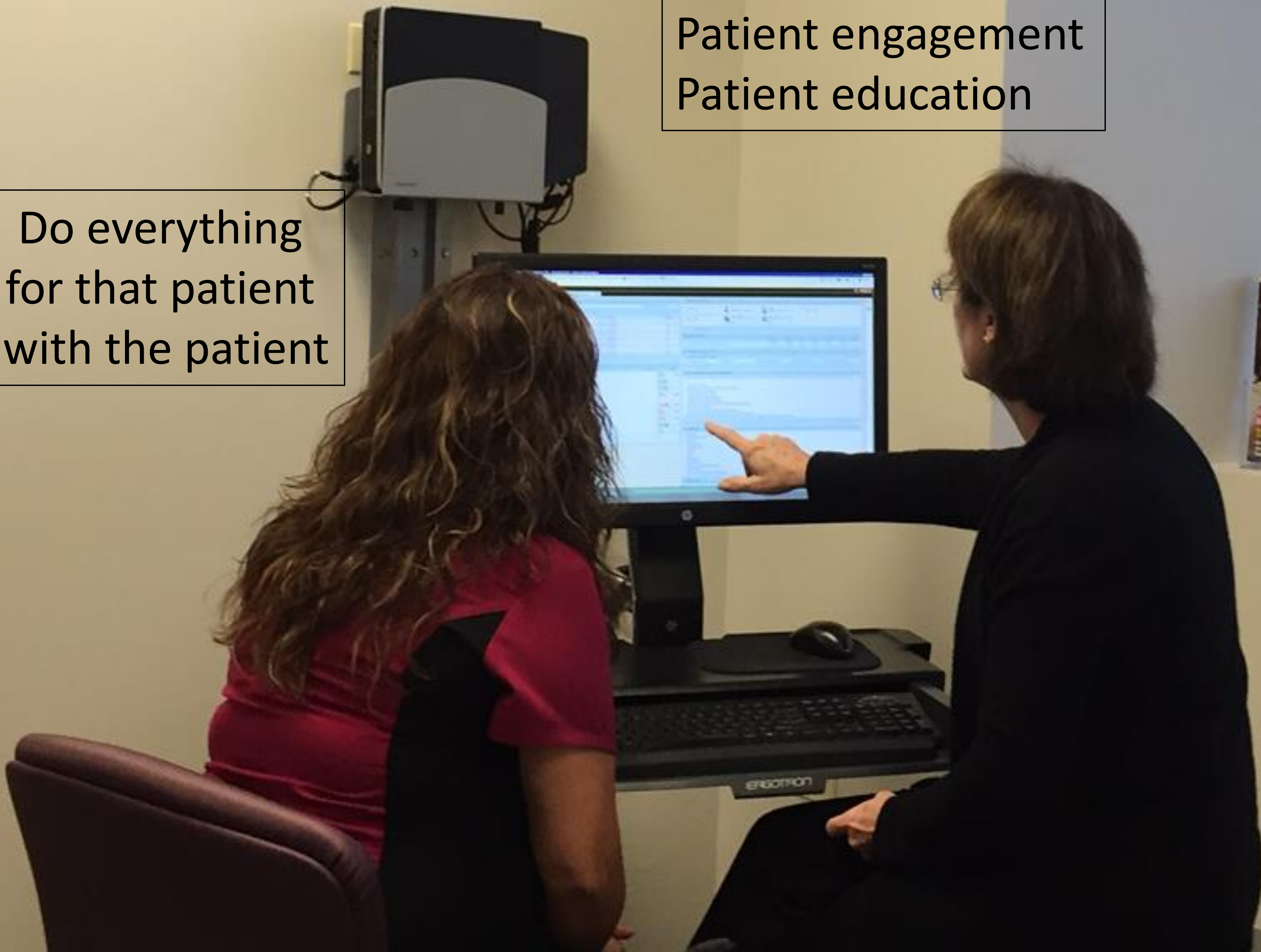
Educators
- MA's, Nurse,PA,APN

Institutions
- Staffing
- Team documentation*
- Staff order entry

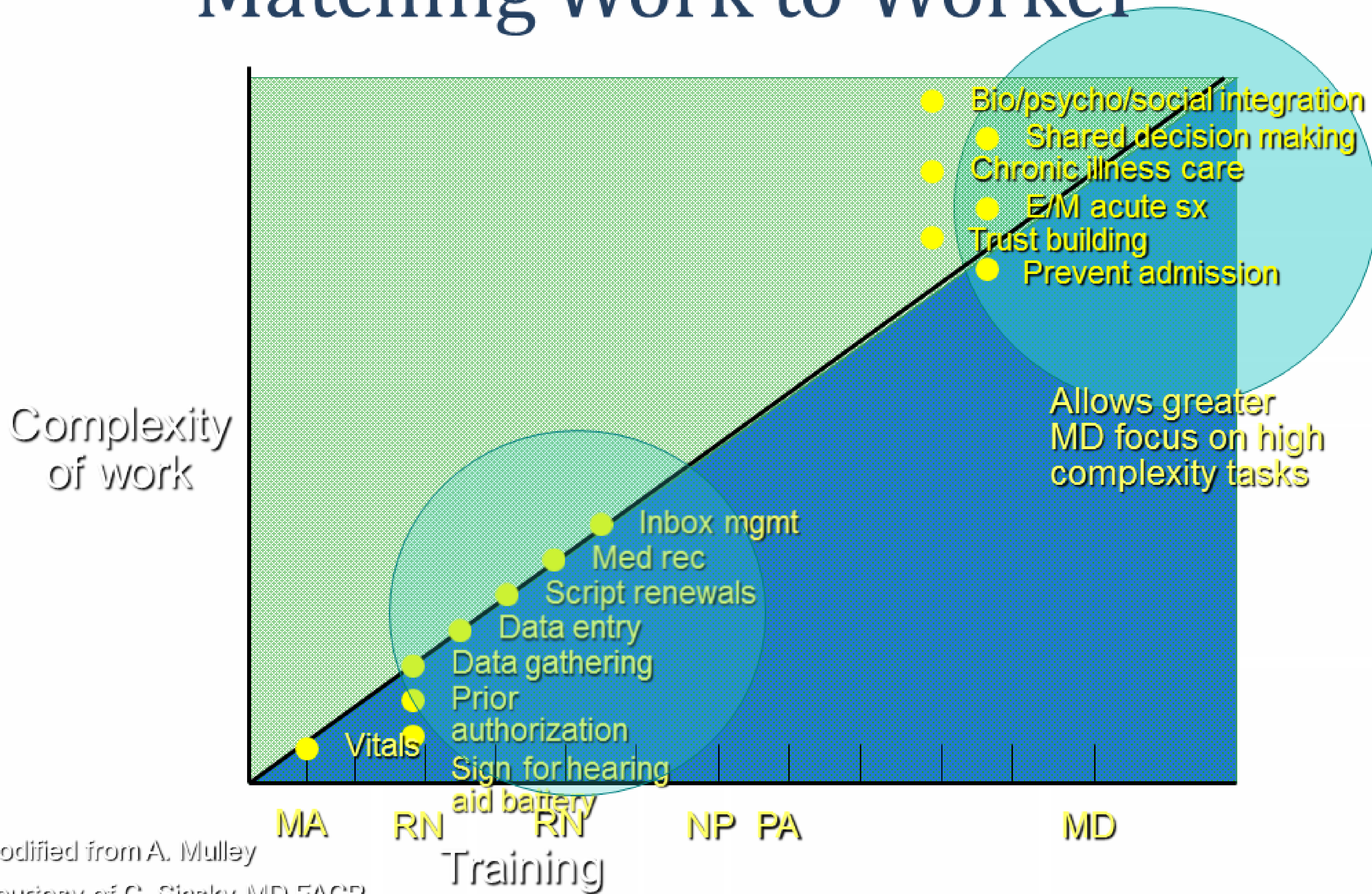
Team
- Cross train
- Share tasks

Payers
- Fund non-MD Service


Receptionist
Transcriptionist
Billing Clerk
Medical Records Clerk
Pharmacist


Patient engagement
Patient education
Do everything for that patient with the patient
ERGOTRON

Matching Work to Worker



Modified from A. Mulley

Courtesy of C. Sinsky MD FACP

Christine Sinsky
PCP Dubuque IA
AMA
VP for Professional Satisfaction

We wouldn't think of asking lawyers to record the legal proceedings of the courtroom at the same time they are doing their job.

So why do we expect doctors to multi-task and be distracted from both doing a good job interacting with their patients as well as simultaneously documenting.

Making the business case

YOUR PRACTICE

$ 3.00 /min	8 hours	220 days/year
Cost of physician's time	Work day	Clinic days per year

PHYSICIAN

20 /day x 10 min/visit

Total visits per day

Physician documentation time ?

FULL-TIME DOCUMENTATION SPECIALIST

$ 23.00 /hour

Documentation specialist hourly rate (including benefits)

TOTAL TIME SAVINGS

3H 20M /DAY

Physician documentation time saved

TOTAL FINANCIAL SAVINGS

$132,000 – ($40,480) = $91,520

$132,000	–	($40,480)	=	$91,520
Gross annual savings with team documentation		Annual cost of dedicated documentation specialist		Net practice savings with team documentation

Team Documentation
Stonebridge

- New Model
  - 2 MA: 1 MD
  - 2 pt/d cover cost
  - 21 → 28 visits/d
  - 30% ↑ revenue
  - Spread to others
  - We're having FUN
  - Quality metrics ↑
  - Physician
    - home hour earlier
    - No documentation work at home

Courtesy C. Sinsky MD FACP

Mrs. Hennessey 10:20-10:40 **with practice redesign***

65 yo woman retired teacher here for follow up. She notes fatigue, insomnia, back and knee pain. Your staff sees she her meds and she needs no refills.

Problem list:

T2DM
Depression
Obesity
Asthma
HTN
Hypothyroidism
Osteoarthritis of knees
Low back pain
CAD

1. Your staff called her yesterday and set the agenda
2. Staff chart prep: diabetes educator, eye/GI referral, vaccines. Labs,cscope, mammo ordered. Physical therapy form completed. Needs flu vaccine <u>10 min-15 min</u>
3. All refills for 1 year were handled last visit. Meds discontinued
4. She had labs drawn 2 days ago and they are ready for review

1. She had previsit labs and these are reviewed with her and meds adjusted
2. Her A1c was 8.2 3 days ago, annual TSH is normal, annual ACR normal
3. BP today is 150/90
4. You increase her metformin and note she has many statin pills left in bottles
5. You discontinue estrogen and identify that she is not taking statin intentionally
6. You listen to her fears and tailor the message about statins
7. You leave on time!

Mrs. Hennessey between this visit and next 3 months later **After practice redesign***

1. She calls for a refill on her metformin as soon as she gets home
2. She calls for something for her knee pain
3. She calls for lab results and you note her TSH is high
4. You increase her levothyroxine and order repeat TSH in 6 weeks
5. You note her A1c is 8.2 and you increase her metformin and send in refill
6. She calls for a new rx for her lisinopril as you increased it
7. She calls for her TSH result in 6 week
8. She asks if she should get a shingles shot
9. Quality metrics report shows she has not had colonoscopy, Tdap, influenza, zoster, foot exam, urine test. BP and A1c not at goal-tied to ev
10. Patient satisfaction is low due to 1-2 hours behind schedule

Staff	Minutes
3	5
3	10
3	10
1	5
1	10
3	5
3	10
3	10
3	10
1	5
24	1 hr 20min

Staff calls to teach her how to use patient portal and asks how exercise classes are going and reviews her sugar and blood pressure readings. 10 min

Mrs. Hennessey 4:20-4:40
After practice redesign*

65 yo woman retired teacher here for follow up. She notes more energy and less pain. She brings in her meds and does not need refills.

Problem list:

T2DM
Depression
Obesity
HTN
Hypothyroidism
Osteoarthritis of knees
Low back pain
CAD

Meds:

Metformin
Sitagliptin
Chlorthalidone
Lisinopril
Bupropion
Atorvastatin
Vit D,B12
clopidogrel/ASA

1. Diabetes educator 2x since last visit and meds, diet exercise were reviewed
2. Physical therapist 3x/week and has lost 3 #.
3. Your staff called her yesterday and set the agenda 5 min
4. Staff chart prep: health maintenance up to date, diabetes educator,vaccines 10 min
5. No refills needed

1. She had previsit labs and these are reviewed with her and med adjustments made
2. Her A1c was 7.0 2 days ago, annual TSH is normal, annual ACR up to date
3. BP today is 150/90
4. You received notice your health maintenance levels were at goal
5. You leave on time! **(No calls between this visit and next visit!)**

Mrs. Hennessey between this visit and next
3 months later
After practice redesign*

TIME FOR
PANEL MANAGEMENT
IDENTIFY PATIENTS WHO HAVE NOT BEEN SEEN AS RECOMMENDED
COORDINATE CARE BETWEEN SUBSPECIALISTS AND PRIMARY CARE

CELEBRATE SUCCESSES
(WWW)
WHAT WENT WELL!

Staff calls to teach her how to use patient portal and asks how exercise classes are going and reviews her sugar and blood pressure readings. 10 min

Utilizing Data and quality Improvement Techniques to Improve Clinical Quality Measures .. . and Save 2 hours a day.

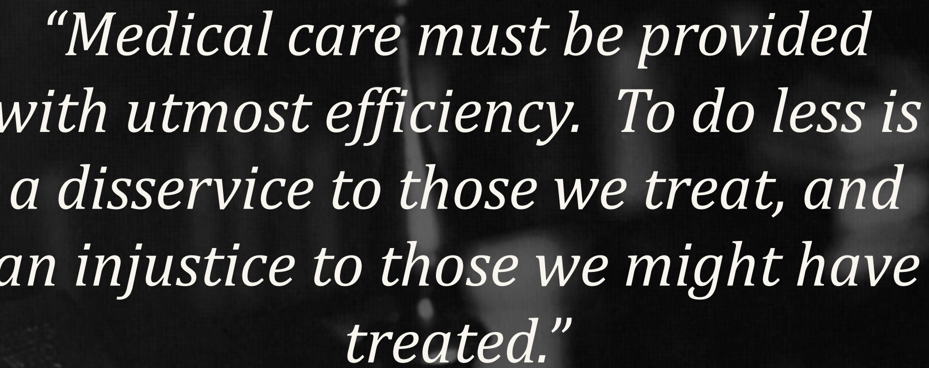
Learning objectives:

- Discuss population health management with emphasis on tracking/outreach
- Collaborate with medical neighbors to close gaps in care
- Educate patients on the importance of preventable health measures
- Coordinate and leverage appointments to improve compliance with previsit planning
- Implement one simple change to improve access and efficiency in your own practice
- Use teamwork to ease the physician burden, improve documentation and provide better, more efficient patient care
- Become inspired about the possibility of reconnecting with the purpose and pleasure of practicing medicine

Take home points

- Practice redesign, medication management and team documentation can save hours each day.
- It takes a team to achieve sustainable change
- Time is needed to work on change
- To double your success rate, you need to triple
- your failure rate
- Completing a PDSA/runchart cycle is success!

START



"Medical care must be provided with utmost efficiency. To do less is a disservice to those we treat, and an injustice to those we might have treated."

Sir William Osler, 1893

Questions?

Patient-Centered Specialty Care (PCSC) program

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