

ETSU Family Medicine

**2018 HIMSS DAVIES
APPLICANT**



EAST TENNESSEE STATE
UNIVERSITY

Quality Improvement Team Introductions

Monaco Briggs
Director of Informatics
& Optimization



Julie Montgomery
Clinical Quality
Data Manager



Mission of ETSU Family Medicine

"Our Mission is to provide community-focused medical education and evidence-based, patient centered care; to improve health in rural southern Appalachia, especially among the underserved population; to model compassionate and efficient care using effective communication skills; and to advance scholarly investigation. We lead through excellence, collaboration and innovation."



EAST TENNESSEE STATE
UNIVERSITY

ETSU Family Medicine

3 Locations in Northeast Tennessee

Bristol, Johnson City, and Kingsport

ETSU Family Physicians of Bristol
ETSU Family Medicine Associates
ETSU Family Physicians of Kingsport

2 Counties

Washington and Sullivan



Facts About ETSU Family Medicine

- 2007- Named best Rural program in the nation by National Rural Health Association
- 2010 - Health Information Technology (HIT) committee formed to implement electronic health record (EHR) platform
- 2011 - NCQA level 1 PCMH recognition
- 2014 - NCQA level 3 PCMH recognition
- 2015 - Chronic Care Management team formed
- 2015 - ACO Qualuable
- 2017 - PCMH recertification level 3
- 2017 - CPC + designation
- 2017- Clinical quality team formed
- 2018 - Currently 13 managed care contracts



Team Members 2018

Each clinic has 11 to 13 Faculty Physicians (to include a Medical and Program Director), 18 to 22 Resident Physicians, 1 Nurse Practitioner, Social Worker, Pharm D, and a Psychologist.

Current # of Team Members per clinic including the above and to include Site Managers, Nurse Managers, Nurses, Patient Care Reps etc.

Bristol Family Medicine: 60

Kingsport Family Medicine: 57

Johnson City Family Medicine: 56

Administrative Staff to include Chair, Vice Chair, Executive Director, Operations Manager, Business Manager, Quality Team, Research Division

Total Family Medicine Employees: 185



Case Study

Improved Transitional Care Management



EAST TENNESSEE STATE
UNIVERSITY

Local Problem

- In 2014, after joining our accountable care organization, ETSU Family Medicine began looking at hospital follow-up data. We determined that only 20% of our patient population were being seen for a hospital follow-up appointment. This percentage did not significantly improve in 2015 and to address this, ETSU Family Medicine set a goal for 2016 to increase our number of patients being seen for hospital follow-up after a hospitalization.



Local Problem

- Patients were being re-admitted to the hospital within 30 days of discharge without having a follow-up appointment with the primary care physician.
- Our organization identified the need to be able to identify patients being admitted and discharged to and from the hospital in hopes to prevent a re-admission.



Local Problem

- Our organization needed to provide better access to care for our patient population.
- Locally we lacked coordinated efforts between disciplines outside our organization.
- We identified the need to be able to track our patients that were being hospitalized in hopes of being more proactive.



Steps to Improved Transitional Care Management

- ❖ Design and Implementation
- ❖ How HIT was Utilized
- ❖ Value Derived

Design & Implementation



Design & Implementation

We integrated a team including Social workers, Physicians, Resident Physicians, Pharm D's, Behavioral Health, and Patient Health Manager's.

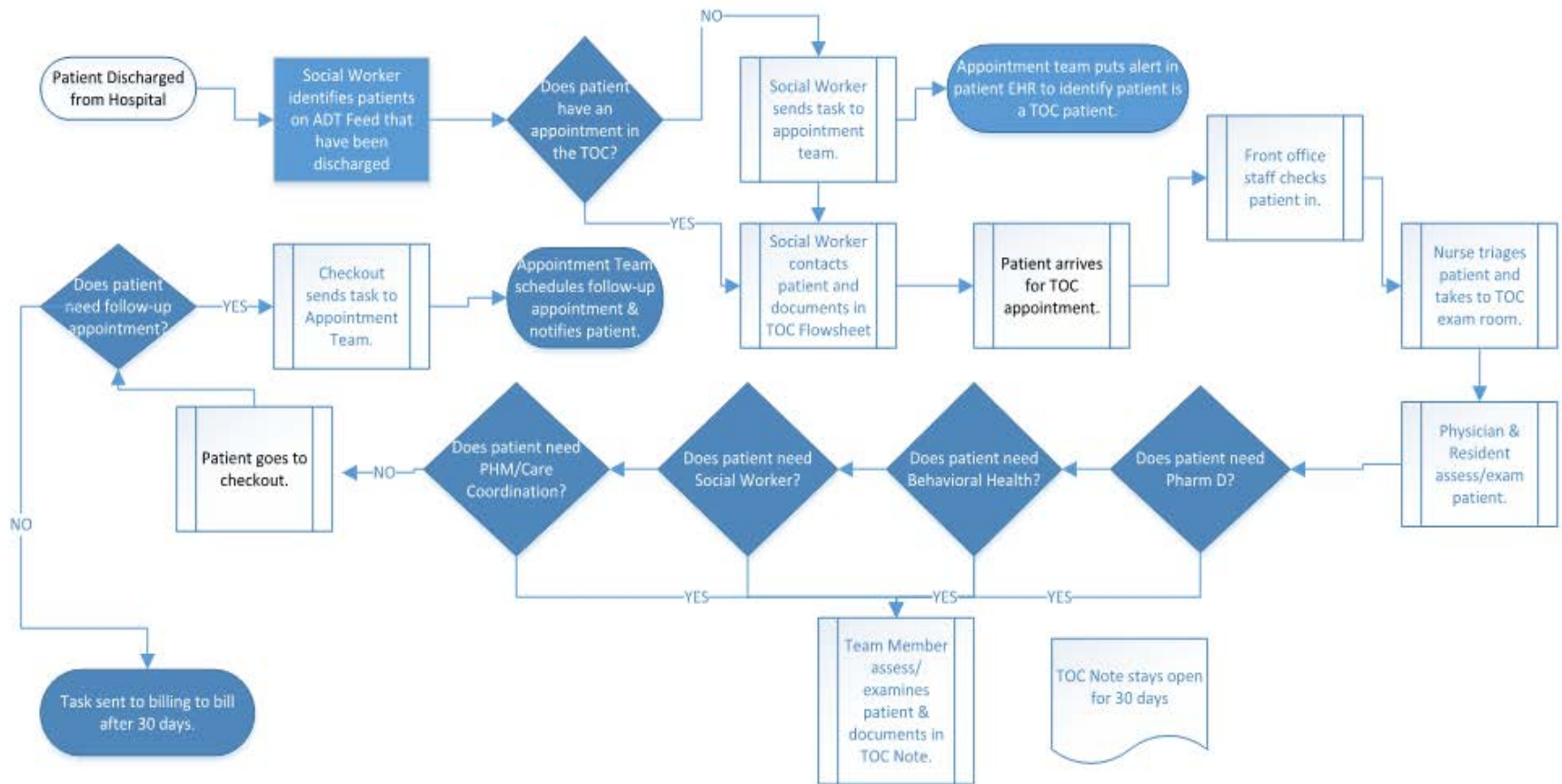
This team helped to incorporate, develop, and provide feedback on the execution of the Admission Discharge Transfer (ADT) feeds, huddle design, transition of care note, EHR alerts, flowsheet set up, and access to care. They were also incorporated into the development of the work process.



Design & Implementation



How Health IT Was Utilized TOC Process Flowchart



Social Worker vs. Patient Health Manager

- At the time the TOC clinic was established we did not have patient health manager/care coordinators on board. Social workers at the time made sense.
- Our first patient health manager/care coordinator established the chronic management program.
- Once we had a patient health manager in each clinic there focus is on ER patient, AWW's, Home Visits, and CCM.
- Are in the beginning processes of transitioning TOC to the patient health managers.



ADT Interface

- Interface
- Build with hospital system
- Patient identifies PCP
- PCP triggers feed
- Backups in place



How Health IT Was Utilized

- The ADT feed populates in our EHR task list.
- The ADT feed is used to notify the clinic that a patient has been and/or discharged from the hospital.

The screenshot displays an EHR interface with a navigation bar at the top containing tabs like 'Provider Schedules', 'Daily', 'Clinical Desktop', 'New Note', 'Task List', 'Worklist', 'Printing Tasks', 'Patient Lists', 'Appointments', and 'Print/Fax Queue'. The main header area shows patient information for 'TEST, MONACO', including their PCP 'Stone, Katherine', MRN '001000651682701', and email 'BRIGGSMM@ETSU.EDU'. Below this is a 'Task List' section with a filter set to 'BFM MSHA ED Tasks' and a 'Show' dropdown set to '50'. A table of tasks is visible, with columns for Task, Patient, Assigned To, Created By, Created On, and Status. One task is highlighted in blue: 'Y Inpatient Discharge Notifica' assigned to 'Moore, Jason' and created on '04/05/2018 02:49 PM'. Below the table, there are sections for 'Comments' and 'Task About:'. The comments section contains a message from 'Moore, Jason - 05 Apr 2018 2:49 PM' stating that the patient was discharged from the hospital at 4/5/2018 13:35 with a disposition of 'DC ROUTINE'. The 'Task About:' section indicates 'No information available.'

Task	Patient	Assigned To	Created By	Created On	Status
Y Inpatient Discharge Notifica	[REDACTED]	Moore, Jason	Moore, Jason	02/02/2018 04:08 PM	Active
Y Inpatient Discharge Notifica	[REDACTED]	Townsend, Thomas	Townsend, Thomas	02/21/2018 07:04 PM	Active
Y Inpatient Discharge Notifica	[REDACTED]	Townsend, Thomas	Townsend, Thomas	03/13/2018 04:55 PM	Active
Y Inpatient Discharge Notifica	[REDACTED]	Townsend, Thomas	Townsend, Thomas	03/15/2018 03:11 PM	Active
Y Inpatient Discharge Notifica	[REDACTED]	Culp, John S.	Culp, John S.	03/16/2018 03:18 PM	Active
Y Inpatient Discharge Notifica	[REDACTED]	Moore, Jason	Moore, Jason	04/05/2018 02:49 PM	Active

Comments:
Moore, Jason - 05 Apr 2018 2:49 PM
Patient was discharged from the hospital
[REDACTED] was discharged from JCMC.
Discharged at 4/5/2018 13:35 with disposition of DC ROUTINE
Attending: ISAZA, LUIS C
Location: Unit: WILO Room: 0316 Bed: B
Complaint: UNSPECIFIED DEPRESSIVE DISORDER

Task About:
No information available.



How Health IT Was Utilized

- Task sent to the appointment team for scheduling in the Transition of Care Clinic.

Task Detail -- Webpage Dialog

Task Details

Task Filters

1 Not about a patient 2 Concerning patient [R] TEST,MONACO

Assign To: User Team Task: **Schedule Appointment**

BFM Appt Team Priority: Routine Status: Active

Comment:
Please schedule patient in the Transition of Care Clinic this week. Thanks!

Text Templates...

Activate: 08 Aug 2018 9:54 AM Overdue: 10 Aug 2018 9:54 AM

Create Notify Task When: Complete Overdue

Notify: Montgomery, Julie Priority: Routine

Delegate

Compliance on Task Appointment Completion

Policy No. FMPP 3-26

Page | 1-2

Policy No: FMPP 3-26

Subject: Office Note and EHR Patient Task Completion Policy

Purpose: To provide all providers of ambulatory clinical patient care information, direction, and guidance regarding note and task completion requirements

Applies to: All Family Medicine Clinical Providers, Residents, and Staff

Effective: December 1, 2016



Compliance on Task Appointment Completion

- Staff members are held to a 24 hour standard to complete an appointment task.
- Staff members each have a task work list that is worked daily.
- Red frowny face will show on task list if task not done in correct time frame.
- Tracked on the back end and report is generated monthly to identify those not complying with policy.
- If area is identified as a problem area then a audit is generated, reviewed, and corrected.



How Health IT was Utilized

- If needed a chart alert can be added in EHR to the patient banner.

The screenshot displays an EHR patient banner interface. At the top, it shows the user 'ETSU - Nurse' and a toolbar with icons for refresh, print, and calendar. Below this is a row of icons for various clinical functions, with a green arrow icon highlighted by a blue box. To the right of these icons are buttons for 'Commit' and 'Pat Loc'. A red circle highlights the 'TOC' (Table of Contents) alert in the banner. Below the banner is a navigation menu with tabs for 'Problem', 'Notes', 'Labs', 'Procedures/Pathology', 'Radiology', 'Chart', and 'Worklist'. At the bottom, there is a filter section showing 'All' selected, a 'Problem List' dropdown, a refresh icon, and a record date of 'Rec: 06Mar2018'.

ETSU - Nurse													
[Refresh] [Print] [Calendar]													
[Home]	[X]	[Person]	[R]	[Heart]	[P]	[Rx]	[Flask]	[P]	[C]	[+]	[Green Arrow]	Commit	Pat Loc
HIPAA 2018		Risk Score 7		CPC+ Patient		Qualifies for CCM		TOC					
Problem	Notes	Labs	Procedures/Pathology	Radiology	Chart	Worklist							
All	▼ Problem List		[Refresh]	[+]	Rec: 06Mar2018	[Filter]	[Check]	[Menu]					

Tools for Outreach

1 Outreach for our patient population is by phone.

2 Outreach for our patient population is by letter.

Provider Schedules Daily Clinical Desktop New Note Task List Worklist Printing Tasks Patient Lists Appointments Print/Fax Queue

SEARCH [R] TEST, MONACO PCP Stone, Katherine Other
03-Mar-1979 (39y) F MRN 001000651682701 Security [BREAK GLASS]
FYI [FYI] H Phone

Daily Schedule Arrived, Pending and Rescheduled AM: 0 PM: 0 All: 0

Patient Profile Dialog

TEST, Monaco 03-Mar-1979 (39 years) F

FYI

Chart Alert	Date Added	Remove
HIPAA 2018	19Feb2018	Delete
Risk Score 7	17May2018	Delete
CPC+ Patient	13Jul2018	Delete
Qualifies for CCM	30Jul2018	Delete

Clinical Info | Demographics | Community Info | Employer/Contact | Insurance | Rx Benefit Plan | Pharmacy | Patient Care Team | Conser

Directives: Presented
Instructions:

Demographics

Deceased:
PM/Admin Sex: Female
AKA: MONACO
Previous First Name:
Previous Last Name:
222 E MAIN ST
JOHNSON CITY, 37604
TN
Home:
Work: (423) 123-4567
Cell: (423) 123-4567
Fax:

MRN: 001000651682701
Other:
Other2:
SSN: XXX-XX-6789
Current Chart Location:
Home Chart Location:
Patient Location:
Birth Place:

Preferred Communication
Clinical Summary: Patient Portal
Reminders: Patient Portal
Chart Update: Patient Portal
Result Notification: Patient Portal

Portal Status
Portal/PHR: Registered

PCP: Stone, Katherine
Language: NORWEGIAN



Tools for Outreach

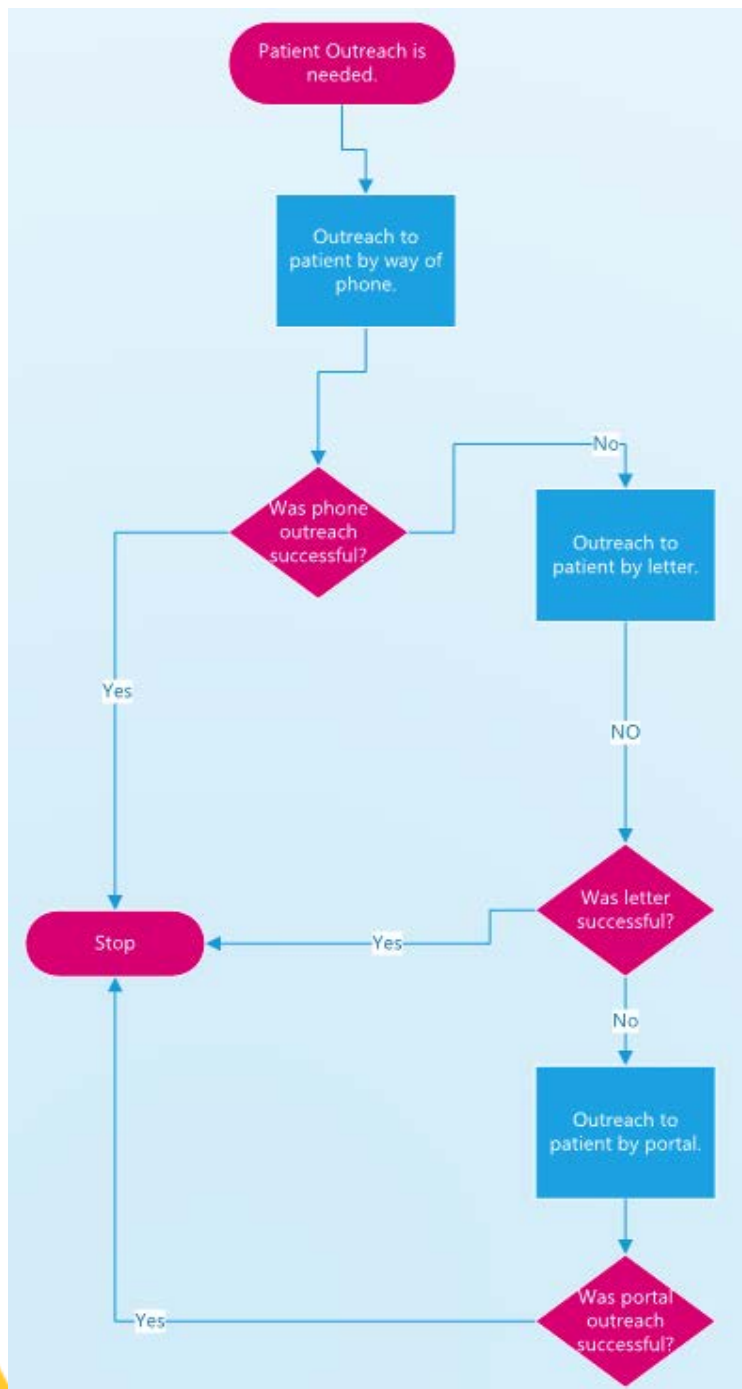
3 Outreach of our patient population is our patient portal.

The screenshot displays a medical software interface. At the top, there are navigation tabs: Provider Schedules, Daily, Clinical Desktop, New Note, Task List, Worklist, Printing Tasks, Patient Lists, Appointments, and Print/Fax Queue. The main area shows patient information for [R] TEST, MONACO, born 03-Mar-1979 (39y) F. The provider is PCP Stone, Katherine, with MRN 001000651682701. A red circle highlights a 'P' icon in the patient's status bar. Below this is the 'Daily Schedule' section, showing 'Arrived, Pending and Rescheduled' and a date of 29 Aug 2018. The schedule is for Wednesday. A 'Patient Portal Registration' window is open, showing the patient's details and a form for registration. The patient's name is [R] TEST, MONACO, SSN is [REDACTED], MRN is 001000651682701, and address is 222 E MAIN ST, JOHNSON CITY, TN 37604. The registration form includes fields for Name, SSN, DOB, Sex, Address, Home Phone, Mobile Phone, Work Phone, and Portal PatientID. A table at the bottom of the form has columns for Provider, Portal Practice, and Portal PracticeID.

Provider	Portal Practice	Portal PracticeID



Decision Process for Outreach



How Health IT Was Utilized

- The Social Worker fills out the TOC Flowsheet which will then automatically flow into the TOC Note.

Order Details
TEST, Monaco 03-Mar-1979 (39 years) F Chart Up

TOC Flowsheet

For: [0]
Status: Active [Details]
To Be Done: 08Aug2018
Overdue: 15Aug2018 12:00AM

Order Results Goals [Record w/o Ordering]

Vital Signs Input

Date of Discharge: []

Discharge Facility Name: []

Billing Code (99495 or 99496): []

Date and Time Phone Call Made: []

Appt Status (Arrived, Cancelled, No Show): []

30-Day Readmission: []

Communication Type: []

Comments: []

FlowSheets TOC Flowsheet Family Medicine

Data Includes: All

	Select	08 Aug 2018	02 Aug 2018	26 Jul 2018	23 Jul 2018
		1	1	1	1
Date of Discharge	<input type="checkbox"/>		30Jul2018		23Jul2018
Discharge Facility Name	<input type="checkbox"/>		JCMC		Ballad
Billing Code (99495 or 99496)	<input type="checkbox"/>				99495
Date and Time Phone Call Made	<input type="checkbox"/>		31Jul2018		23Jul2018
Appt Status (Arrived, ...	<input type="checkbox"/>				Arrived
30-Day Readmission	<input type="checkbox"/>				No
Communication Type	<input type="checkbox"/>		Spoke to...	Spoke to pat...	
Comments	<input type="checkbox"/>		confirmed		

How Health IT Was Utilized

- The TOC Note is filled out by the interdisciplinary team.

Note Selector

TEST, Monaco 03-Mar-1979 (39 years) F Chart Update: 10-Jul-2018

Create New

Style: Note Unstructured Admin Forms

Specialty: Family Medicine Visit Type: << Please select a Visit Type >>

Owner: [Search]

Chart Documentation
Communication
Chart Documentation
Chronic Care Management
Transitional Care Management

Note Health Management/Reminders
Transitional Care Management ALLSCRIPTS, Family Mec Status: Needs Input

Discharge Information

Discharge Information

Discharge Information

D/C Physician: [Text Box]

D/C Date: [Text Box]

Records Reviewed: [Text Box]

Medications (Clinical Staff or Licensed Provider)

Amoxicillin 250 MG Oral Capsule; TAKE 1 CAPSULE 3 TIMES DAILY;
Therapy: 15Sep2017 to (Evaluate: 19Sep2017) Recorded
Aspirin Low Dose 81 MG TABS;
Therapy: (Recorded: 18May2017) to Recorded
Bilinta 60 MG Oral Tablet; TAKE 1 TABLET BY MOUTH TWICE A DAY;
Therapy: 16Oct2017 to (Evaluate: 17Oct2017); Last Rx: 16Oct2017 Ordered
Singulair 10 MG Oral Tablet (Montelukast Sodium);
Therapy: (Recorded: 18May2017) to Recorded

Discharge Information

Discharge Information

Discharge Information

D/C Physician: [Text Box]

D/C Date: [Text Box]

Records Reviewed: [Text Box]

Medications (Clinical Staff or Licensed Provider)

Amoxicillin 250 MG Oral Capsule; TAKE 1 CAPSULE 3 TIMES DAILY;
Therapy: 15Sep2017 to (Evaluate: 19Sep2017) Recorded
Aspirin Low Dose 81 MG TABS;
Therapy: (Recorded: 18May2017) to Recorded
Bilinta 60 MG Oral Tablet; TAKE 1 TABLET BY MOUTH TWICE A DAY;
Therapy: 16Oct2017 to (Evaluate: 17Oct2017); Last Rx: 16Oct2017 Ordered
Singulair 10 MG Oral Tablet (Montelukast Sodium);
Therapy: (Recorded: 18May2017) to Recorded

TEST, Monaco 03-Mar-1979 (39 years) F

Transitional Care Management Owner: ALLSCRIPTS, Family Medicine Status: Final

Transitional Care Management

Discharge Information

D/C Physician: Dr. Montgomery D/C Date: 7/8/2018
Records Reviewed: Amy Lee reviewed on 7/9/2018

Summary of Transitional Management

Communication was initiated with the patient and/or caregiver. Date and Time: 7/10/2018 Type of Contact: phone
Patient states doing ok is aware of fu appointment scheduled for 7/11/2018 Medication Reconciliation and Management occurred no later than the date of the face-to-face visit.

Discharge Diagnoses

COPD exacerbation

1. COPD Exacerbation
2. Hypertension
3. Congested Heart Failure
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

History of Present Illness

COPD, CHF, DM Type2, HTN, CAD
Hospital follow-up appointment
Reason for Visit
MONACO TEST presents in clinic today for transitional care management services following her recent hospital discharge.
Date of Face-to-Face Visit: 7/10/2018

Review of Systems

The patient presents with complaints of mild fatigue. Symptoms are improved by rest and adequate sleep. Symptoms are made worse by exertion, walking and walking up stairs. Symptoms are worsening.

Head and Face: negative.
Eyes: negative.
ENT: negative.
Cardiovascular: lower extremity edema.
Respiratory: shortness of breath and wheezing.
Gastrointestinal: negative.
Genitourinary: negative.
Musculoskeletal: negative.
Integumentary and Breasts: negative.
Psychiatric: negative.
Endocrine: negative.
Hematologic and Lymphatic: negative.

How Health IT Was Utilized

- After 30 days the note is signed, finalized, and billed.

Progress/Signatures
Electronically signed by : Julie Montgomery, L.P.N.; Jul 10 2018 9:24AM EST (Author)

▼ Annotate

Sign Edit Audit Document Hx Task Attach to Result Print Fax Invalidate Close

[R] TEST, MONACO PCP **Stone, Katherine** Other
MRN **001000651682701** Security **BREAK GLAS**
03-Mar-1979 (39y) F | i P ⓘ FYI FYI H Phone

ETSU - Nurse

HIPAA 2018 Risk Score 7 CPC+ Patient Qualifies for CCM TOC

Problem	Notes	Labs	Procedures/Pathology	Radiology	Chart	Worklist
All by Section by Sub-Section None						
542 of 1491 Chart Items (99 Invalid and 845 Audit Items)						
Office Visit (Complex Patient Note) - Holt, James; Enc: 11-Jul-2018 - Chart Update						
Transitional Care Management (Transitional Care Management) - ALLSCRIPTS, Fa						
Acute (Acute) - Radadiya, Dhruvil; Enc: 06-Jul-2018 - Appointment - Radadiya, Dhr						

Sign Note Process

- Resident completes the note and signs it
- Co-sign note task pops up (this pops up on every note)

Task Detail -- Webpage Dialog

Task Details

Task Filters

1 Not about a patient 2 Concerning patient [R] TEST,ETHAN

Assign To: User Team Task: **Co-Sign Note**

Priority: Routine Status: Active

Comment:

Text Templates...

Activate: 29 Aug 2018 1:33 PM Overdue: 05 Sep 2018 1:33 PM

Create Notify Task When: Complete Overdue

Notify: ALLSCRIPTS, Resident Priority: Routine

Delegate



Sign Note Process

- Resident sends the task to their attending/preceptor
- Attending/Preceptor receives the co-sign note task in their task box

Daily Clinical Desktop New Note Worklist Task List Batch Sign Appointments Patient Lists Provider Schedules

SELECT PATIENT

Task List Pe

View: My Active Tasks Show: 50 Total Active Tasks: 22 Last Updated: 08/29/2018 1:35

P	D	Task	Patient	Assigned To	Created By	Created On	Status	ID	Due	MRN
		Co-Sign Note	TEST,ETHAN	Briggs,Monaco	ALLSCRIPTS,Resident	08/29/2018 01:34 PM	Active	6335932		001000778162801



Sign Note Process

- Attending/Preceptor double clicks on the task which automatically opens the note that needs to be reviewed and finalized
- Attending/Preceptor completes the Family Medicine Attending Note section and signs the note

Family Medicine Attending Note

Level of Participation

*****To Be Completed By Attending/Teaching Physician ONLY*****

In Clinic, I Examined the Pt In Clinic, Pt not Examined by Me

Patient seen at Broadmore, examined by preceptor

Patient seen at Broadmore, not examined by preceptor

Case discussed with PharmD

Staff Discussion on the Day of the Visit

Agreement

Agree w/Resident Management Disagree w/Resident Management. See Comments/Findings

Agree w/PharmD Management Disagree w/PharmD Management. See Comments/Findings

Provider Present During History Provider Reviewed History

Patient's History:

Attending Note

Key Parts of the Exam:

Diagnosis and Plan:

Comments/Additional Findings:

Signatures

Resident ALL SCRIPTS - Aug 20 2019 1:22PM EST (Author)

Family Medicine Attending Note:

Return to Work

Letter Greeting

Recompile Sign Spell Check Copy Forward Show Uncopied Form Data Security Codes Audit

Value Derived

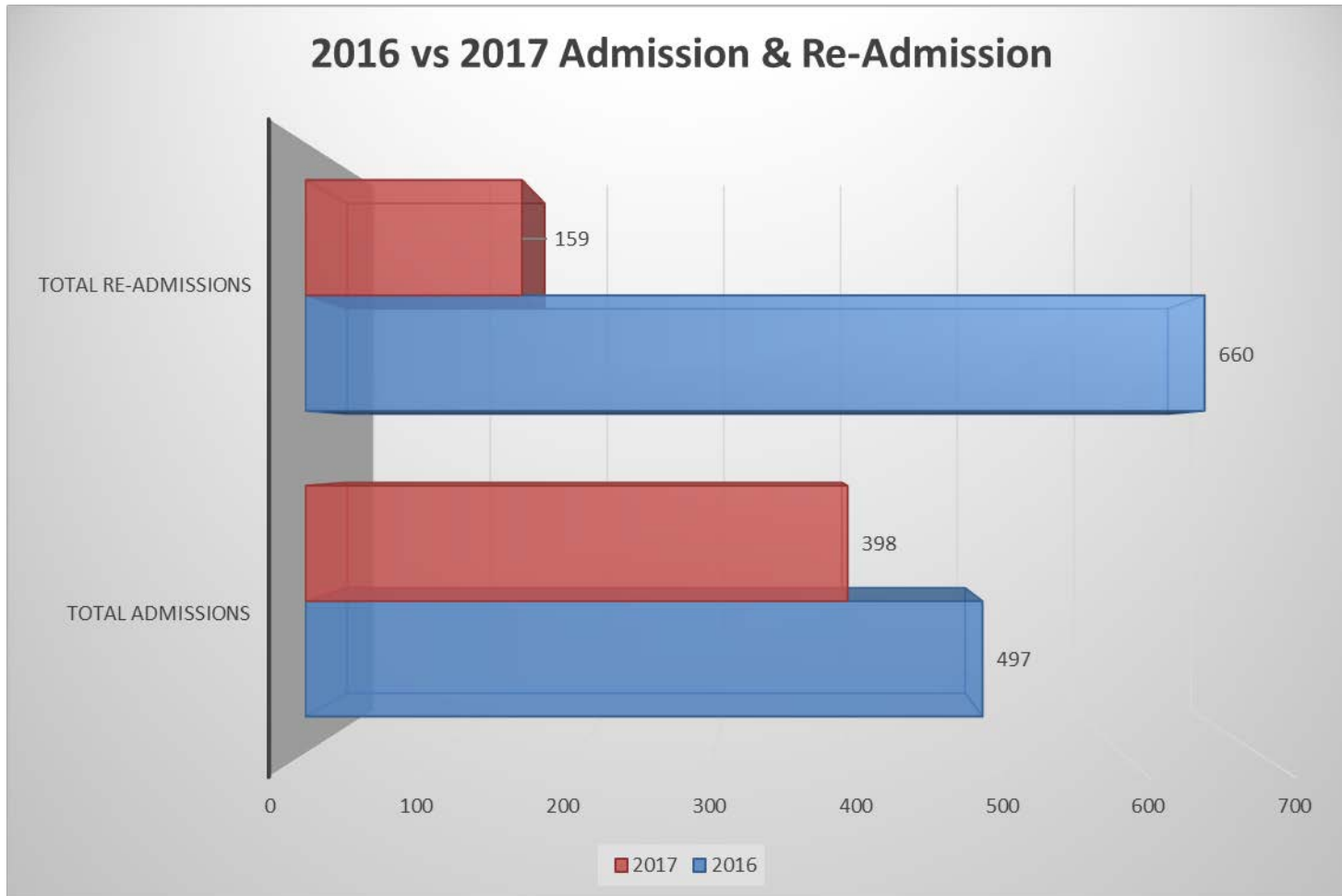
The value we gained using HIT in this process was;

1. Decreased admission and re-admission rates.
2. Decreased cost for patients and payers.
3. Increased patient access.
4. Increased revenue.

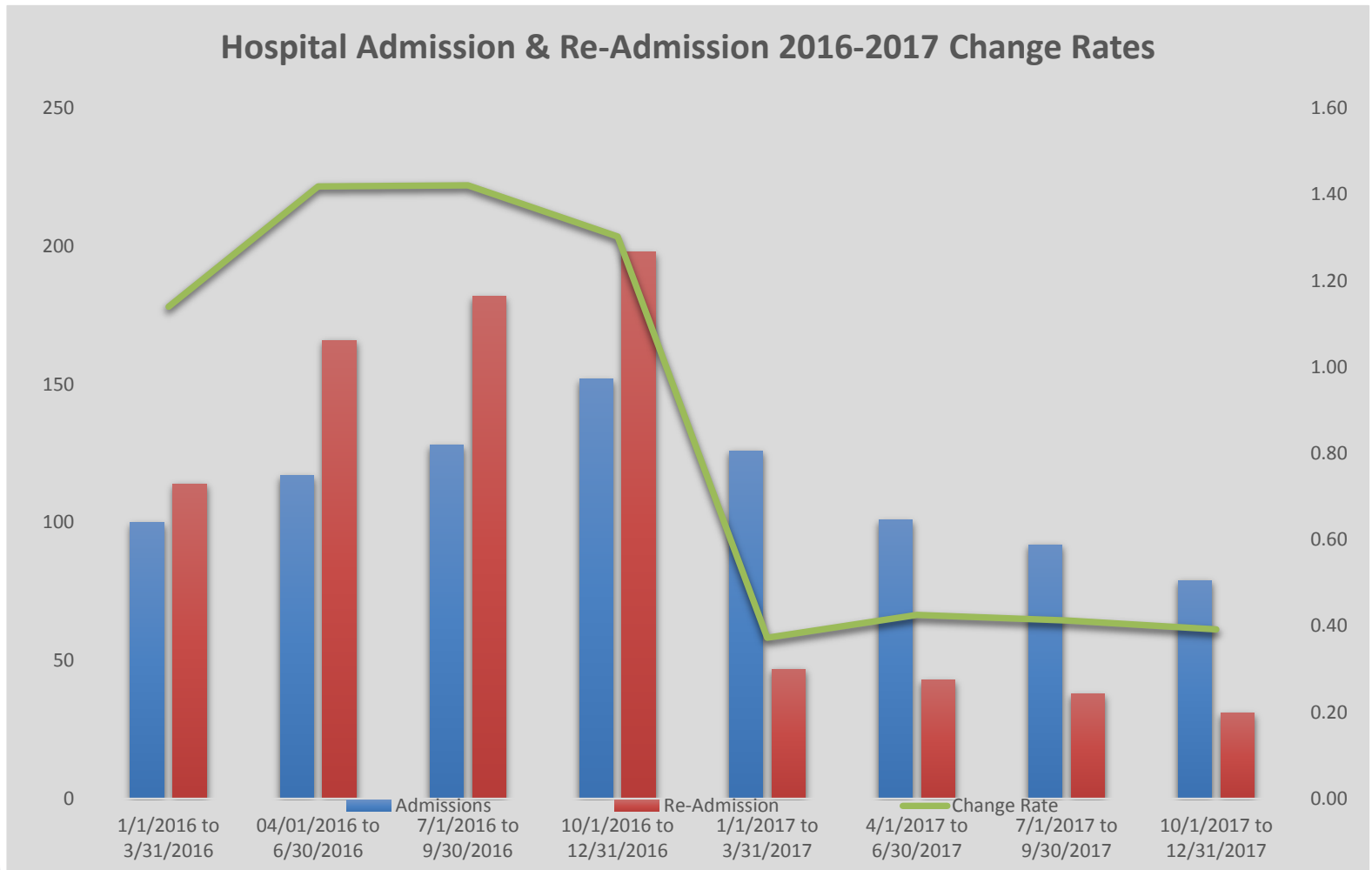
The financial gain using HIT in this process was;

1. Increased access to care from a 1.32 change rate in 2016 to a .40 change rate in 2017.
2. The re-admission change rate was .91.
3. Decreased re-admission by 62%.
4. Increased revenue by \$225,610 in 24 months.

Value Derived



Value Derived



Questions?



EAST TENNESSEE STATE
UNIVERSITY
