ETSU Family Medicine

2018 HIMSS DAVIES APPLICANT

EAST TENNESSEE STATE UNIVERSITY

Quality Improvement Team Introductions

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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

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.

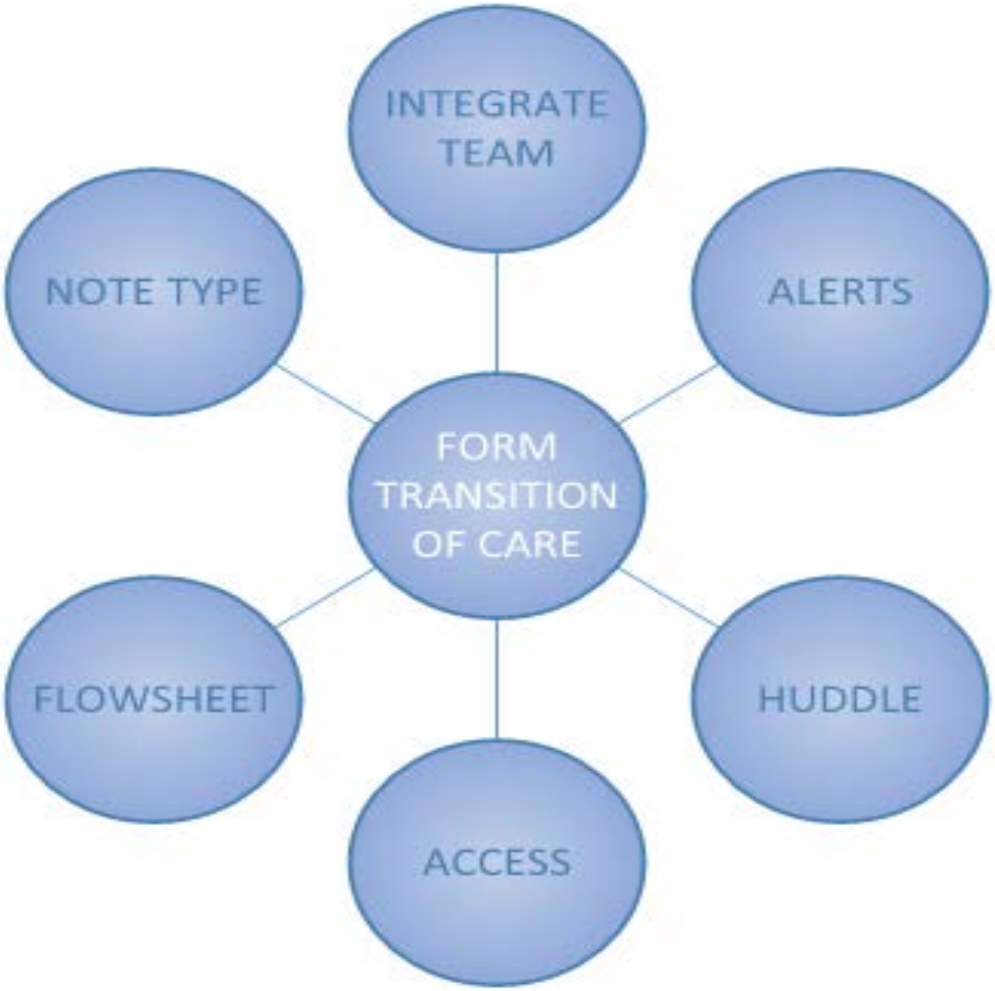
Local Problem

- 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

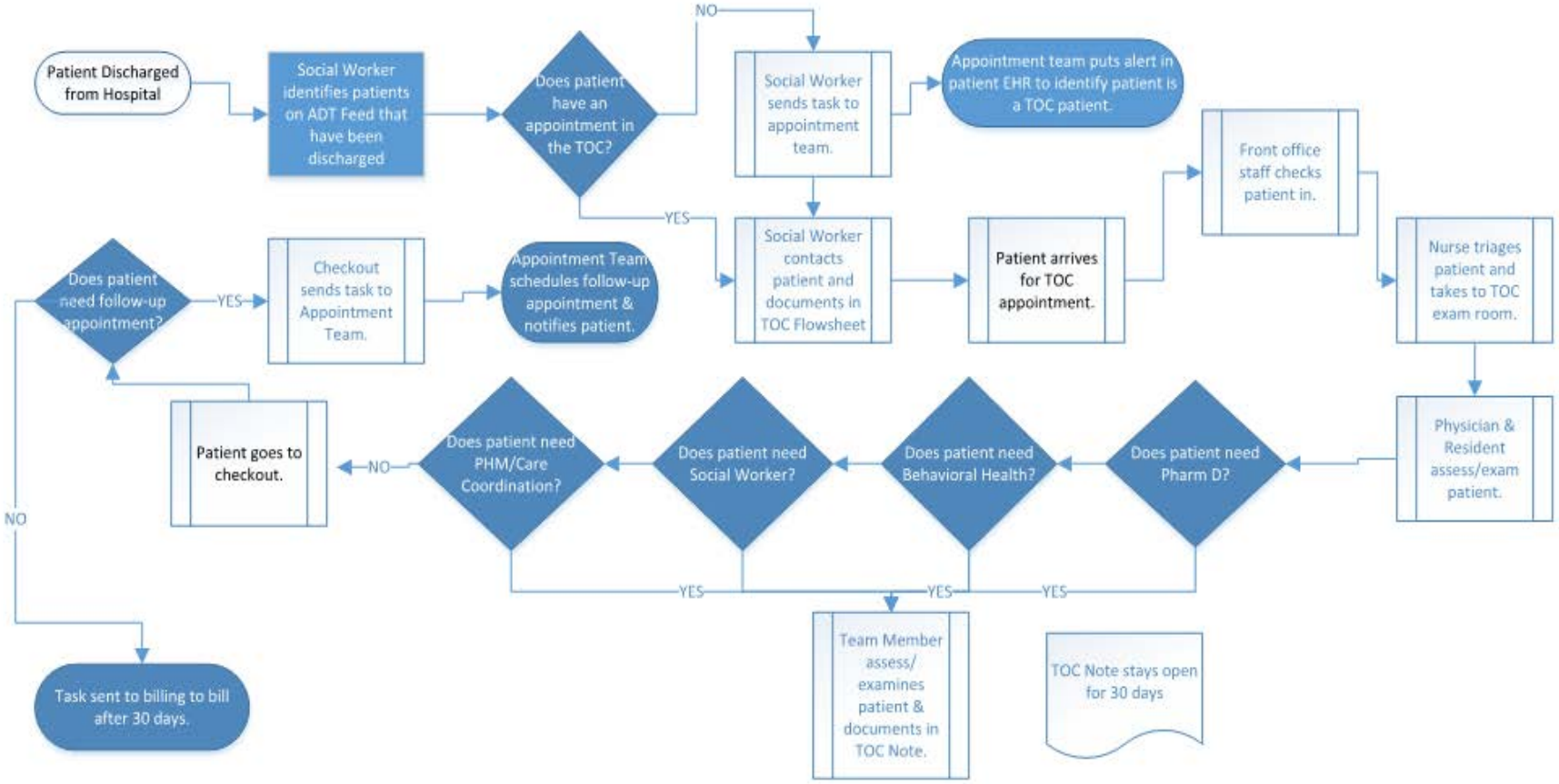


Design & Implementation

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

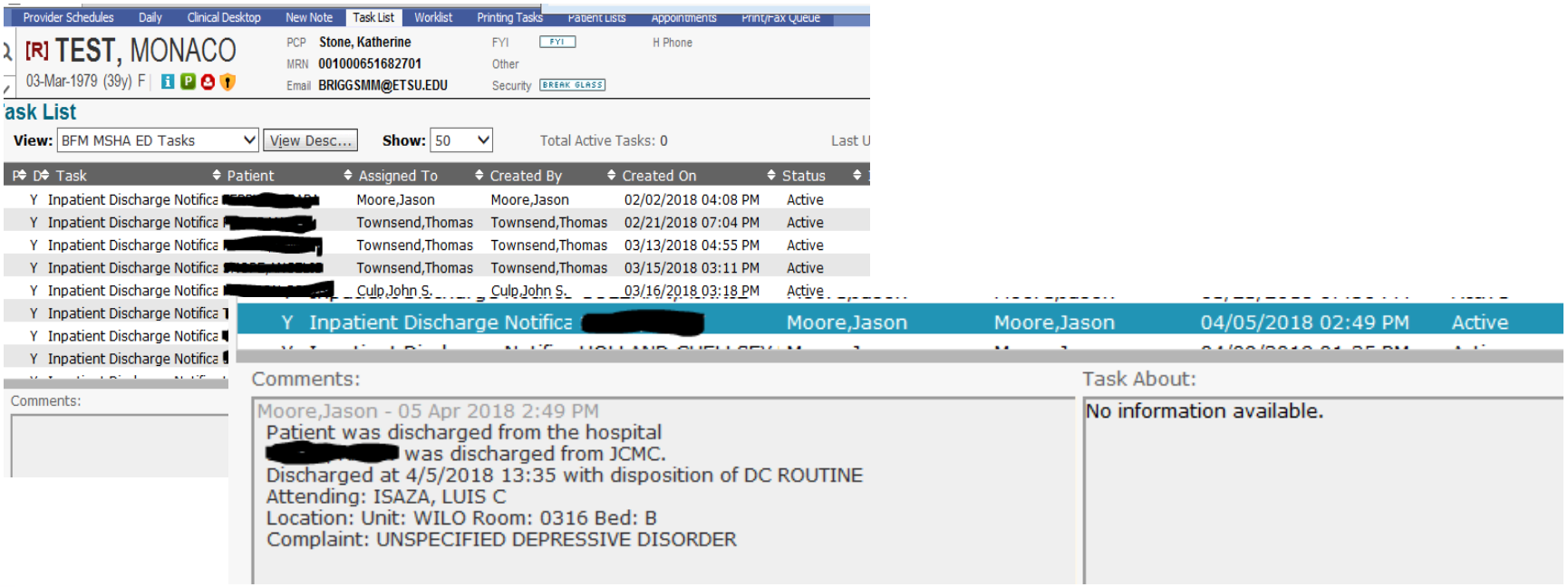
- At the time the TOC clinic was established we did not have patient health manager/care coordinators on board. Social workers at the time made sense.
- Our first patient health manager/care coordinator established the chronic management program.
- Once we had a patient health manger in each clinic there focus is on ER patient, AWV'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

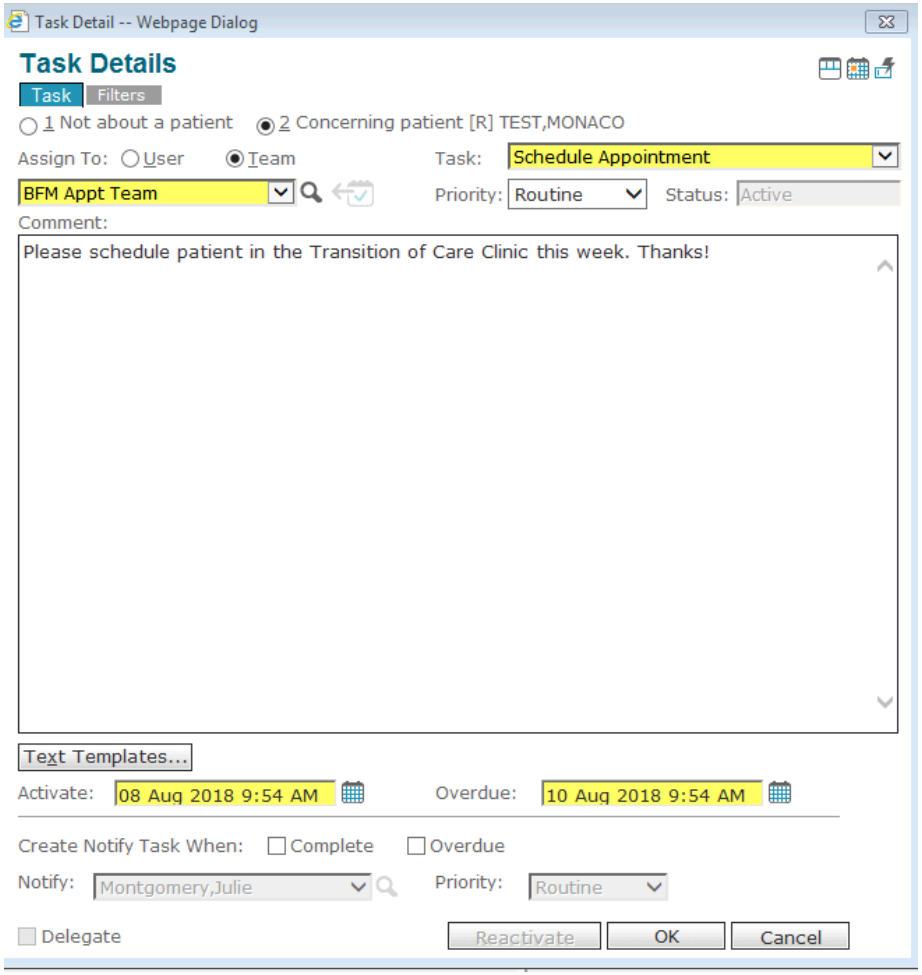
How Health IT Was Utilized

- 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.



How Health IT Was Utilized

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



Compliance on Task Appointment Completion

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

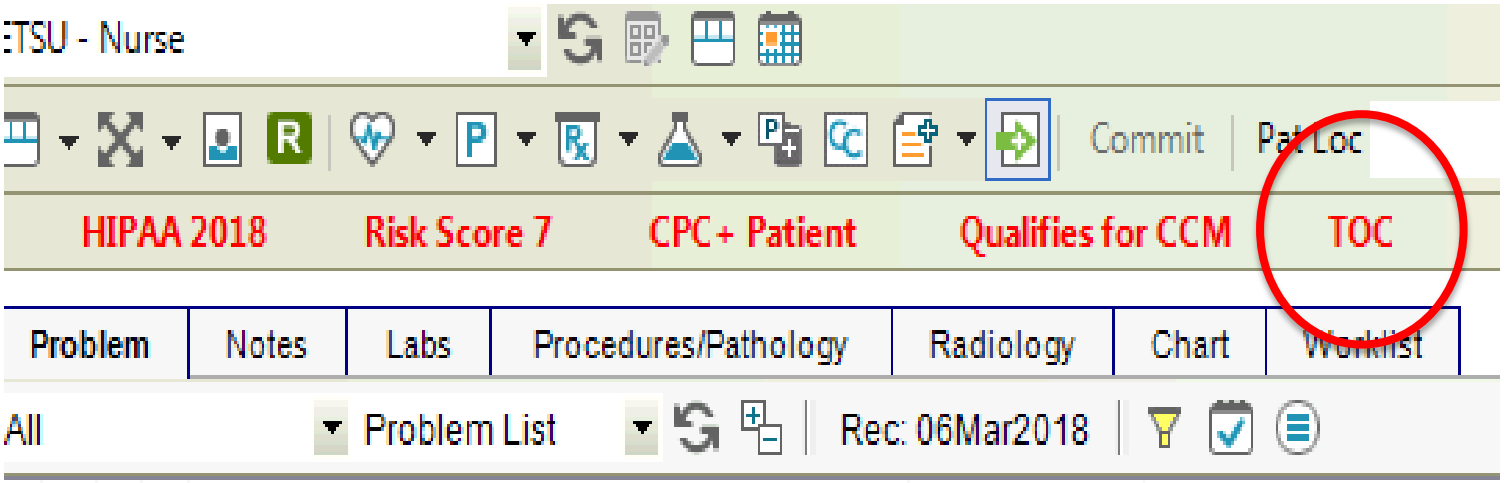
Effective: December 1, 2016

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.

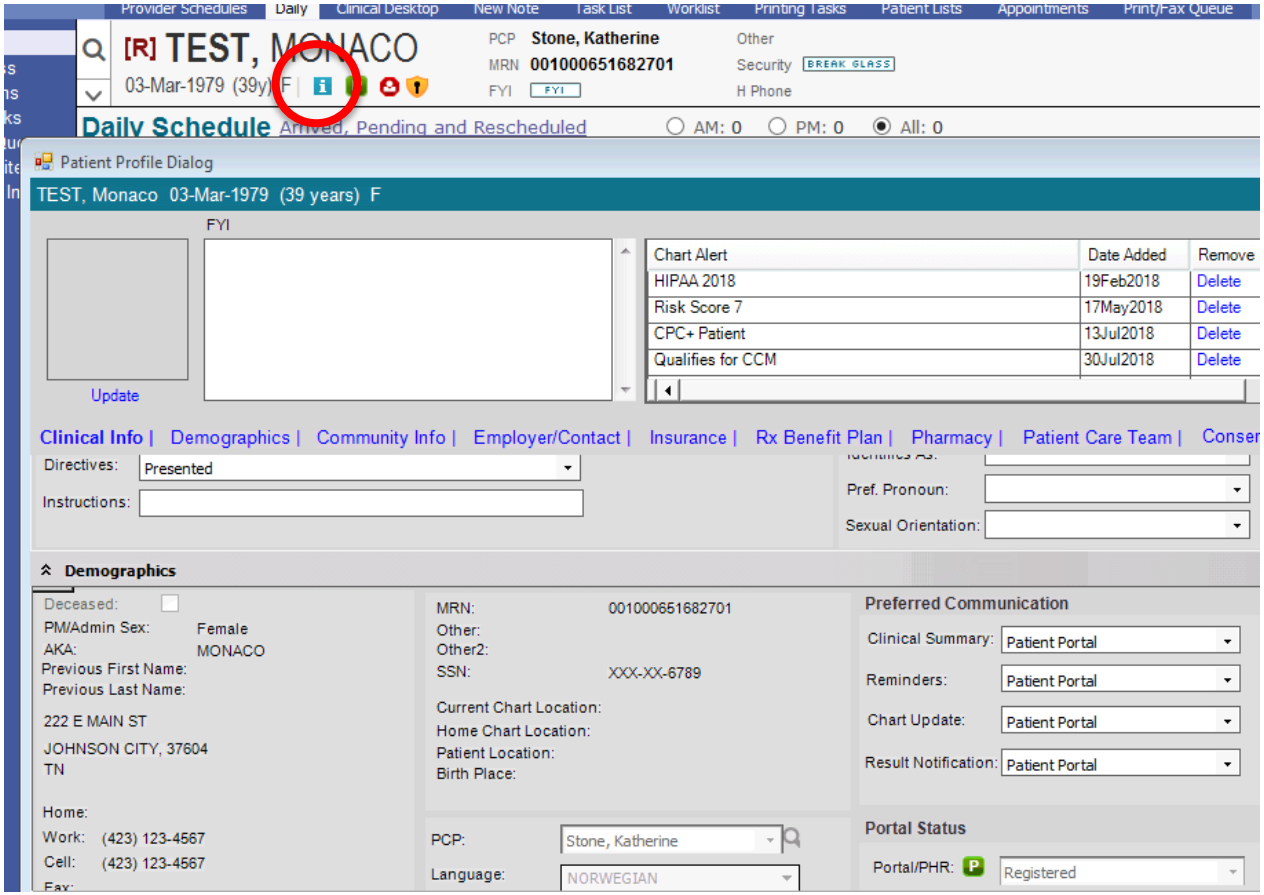
How Health IT was Utilized

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



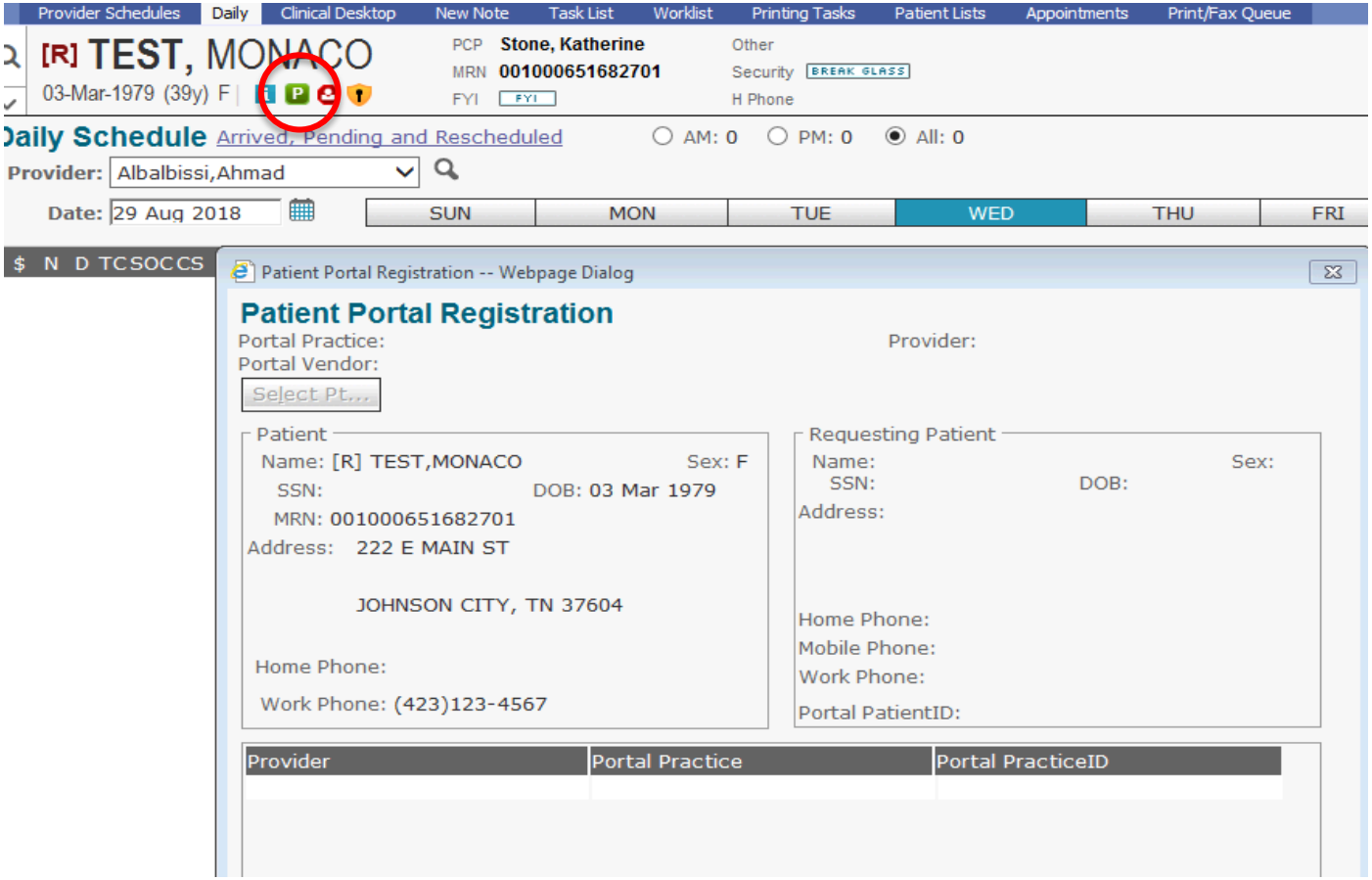
Tools for Outreach

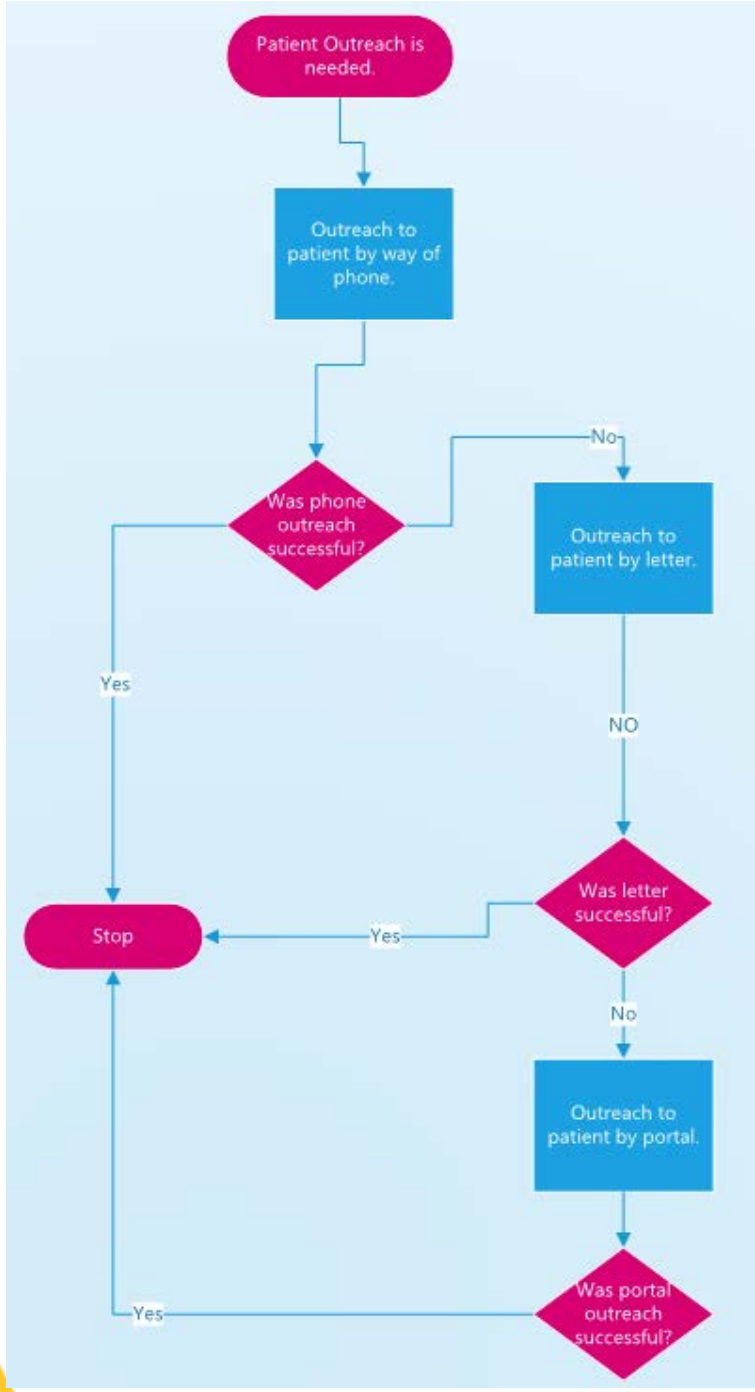
1 Outreach for our patient population is by phone.
2 Outreach for our patient population is by letter.



Tools for Outreach

3 Outreach of our patient population is our patient portal.

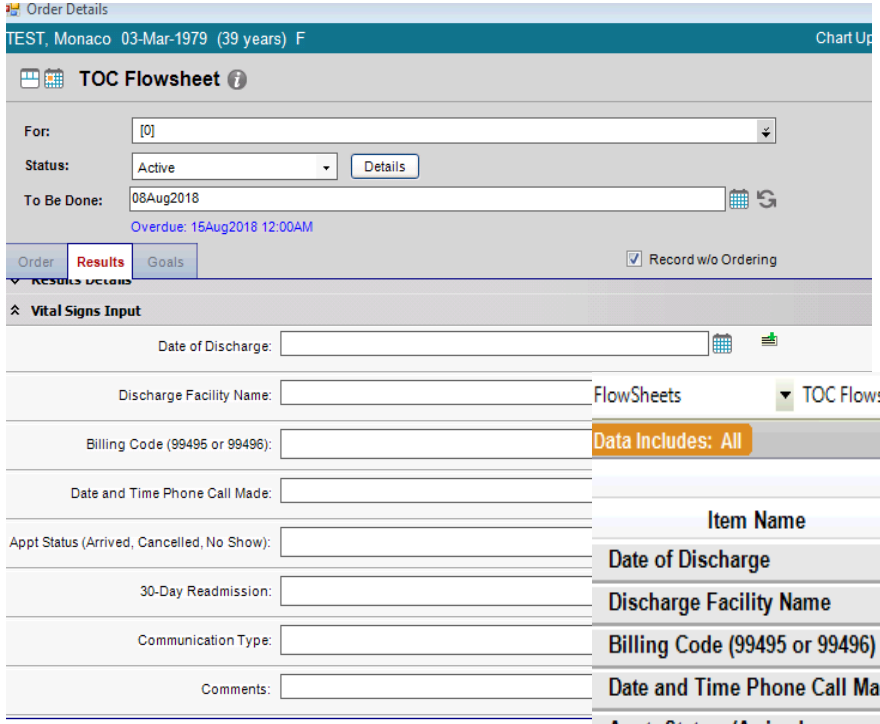




Decision Process for Outreach

How Health IT Was Utilized

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



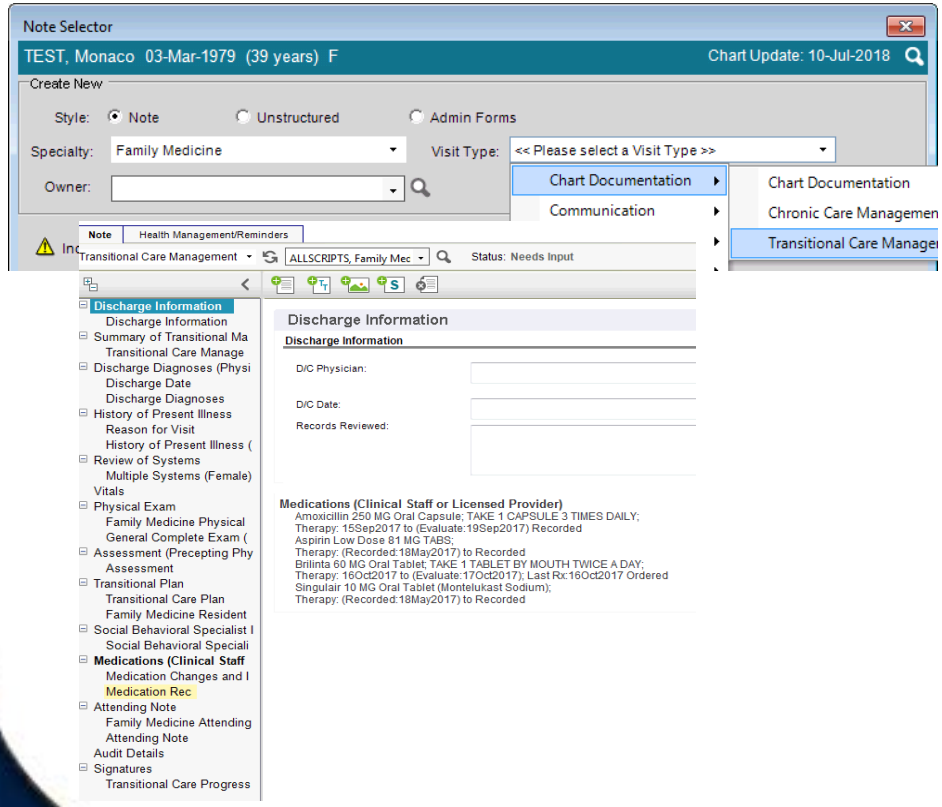
FlowSheets ▾ TOC Flowsheet ▾ Family Medicine ▾

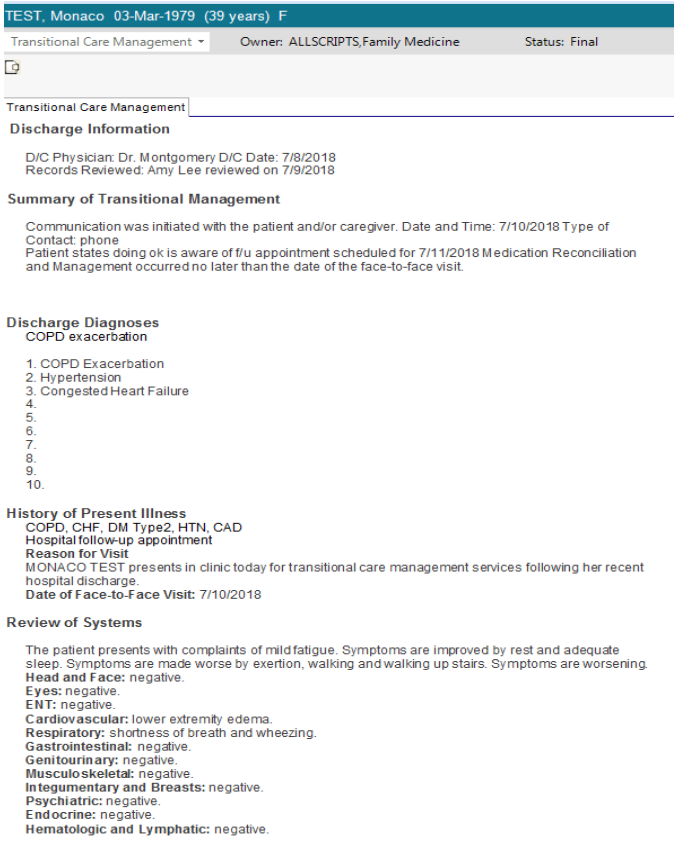
Data Includes: All

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

How Health IT Was Utilized

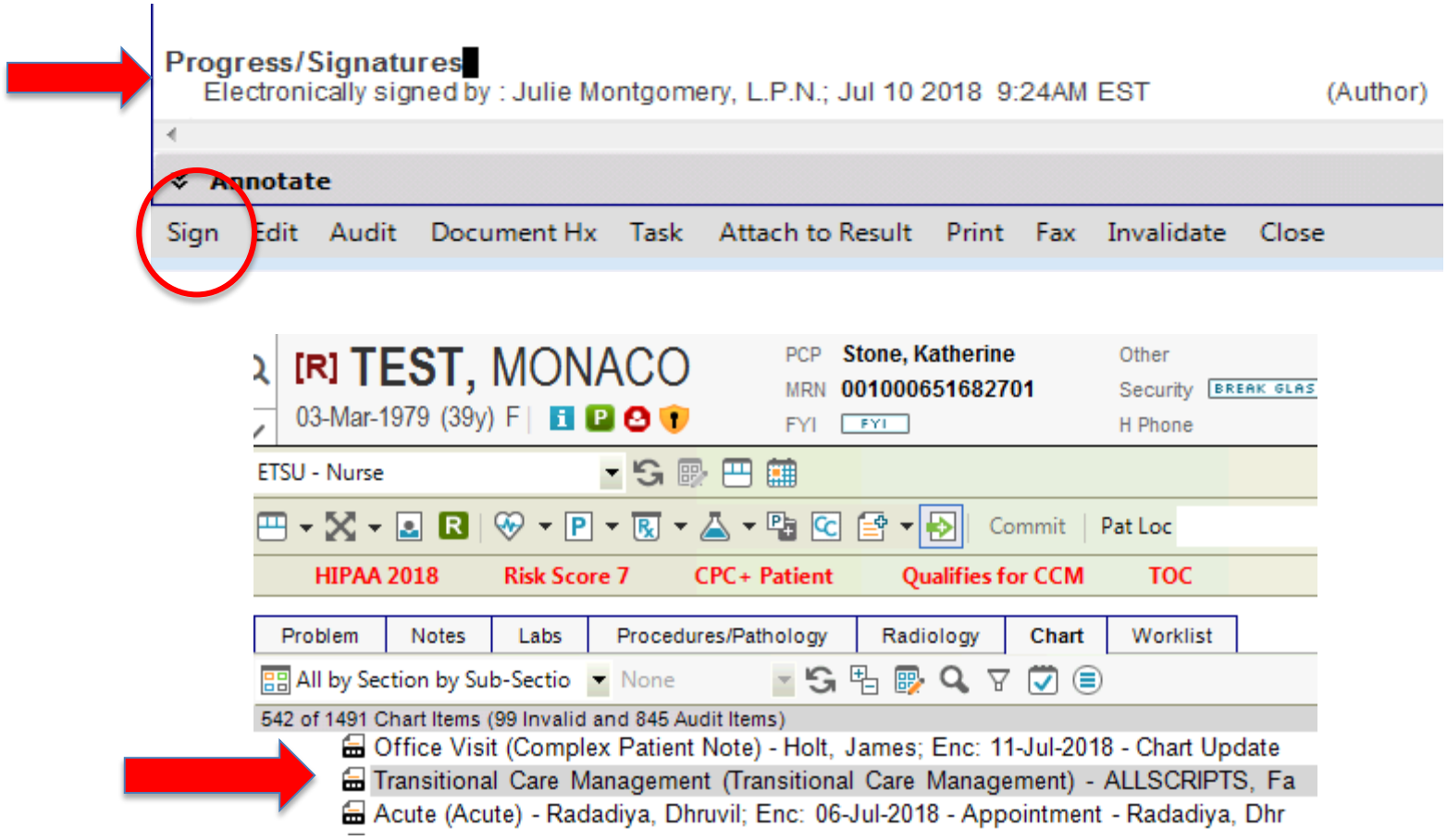
- The TOC Note is filled out by the interdisciplinary team.





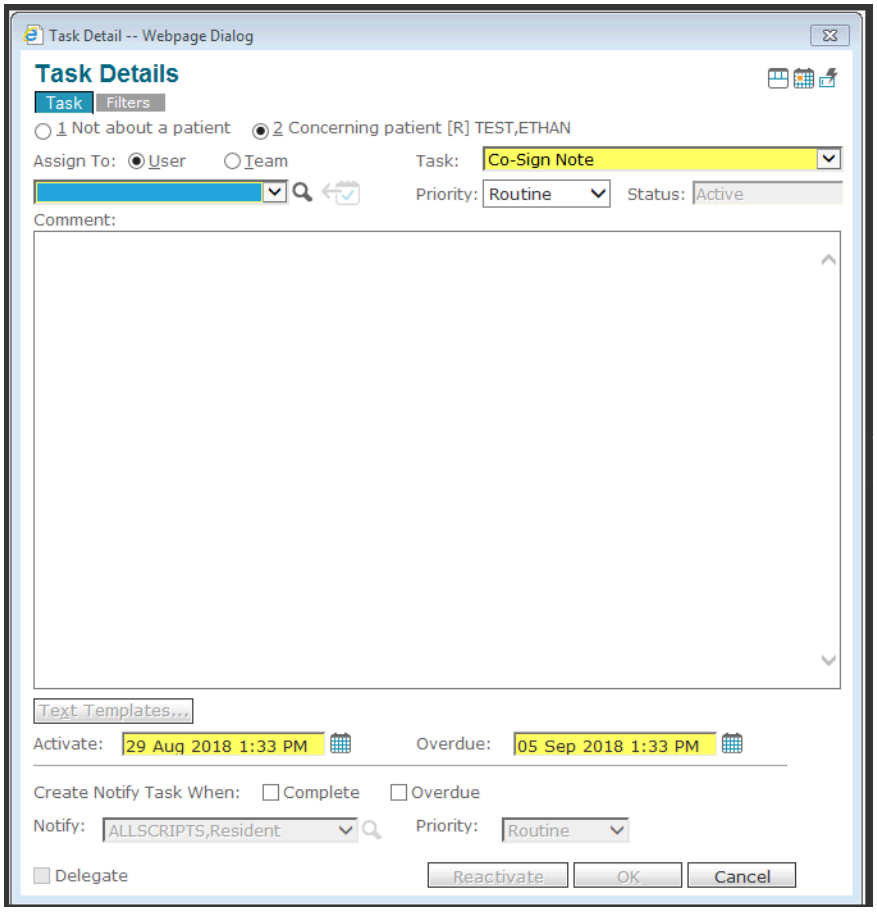
How Health IT Was Utilized

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



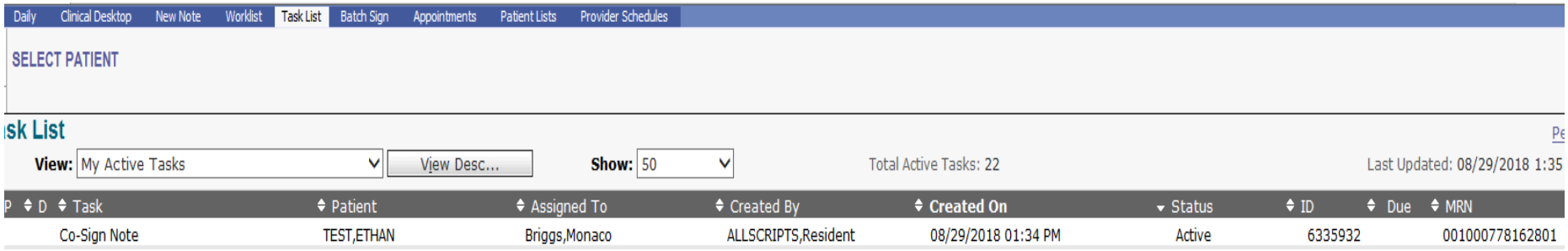
Sign Note Process

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



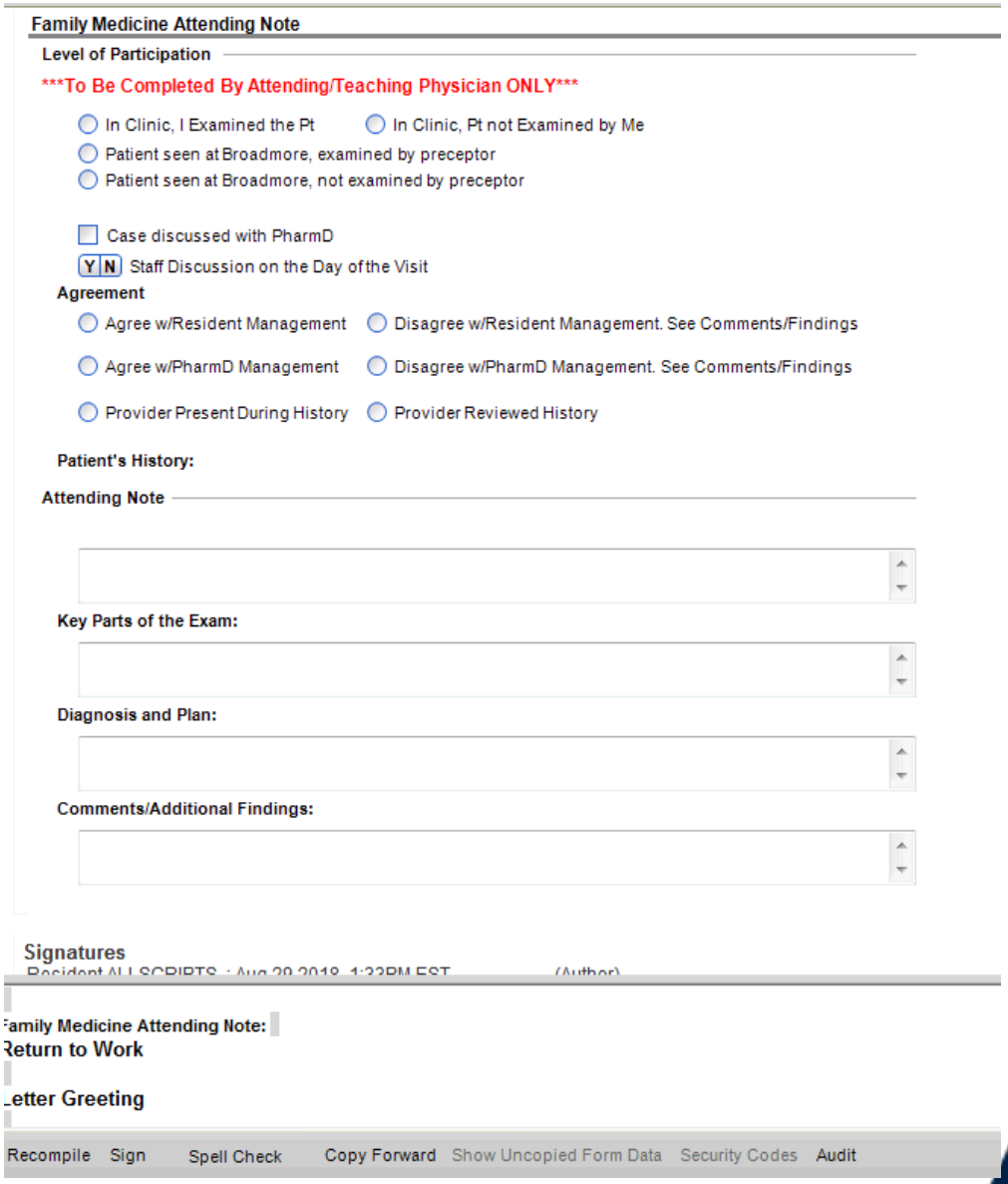
Sign Note Process

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



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



Value Derived

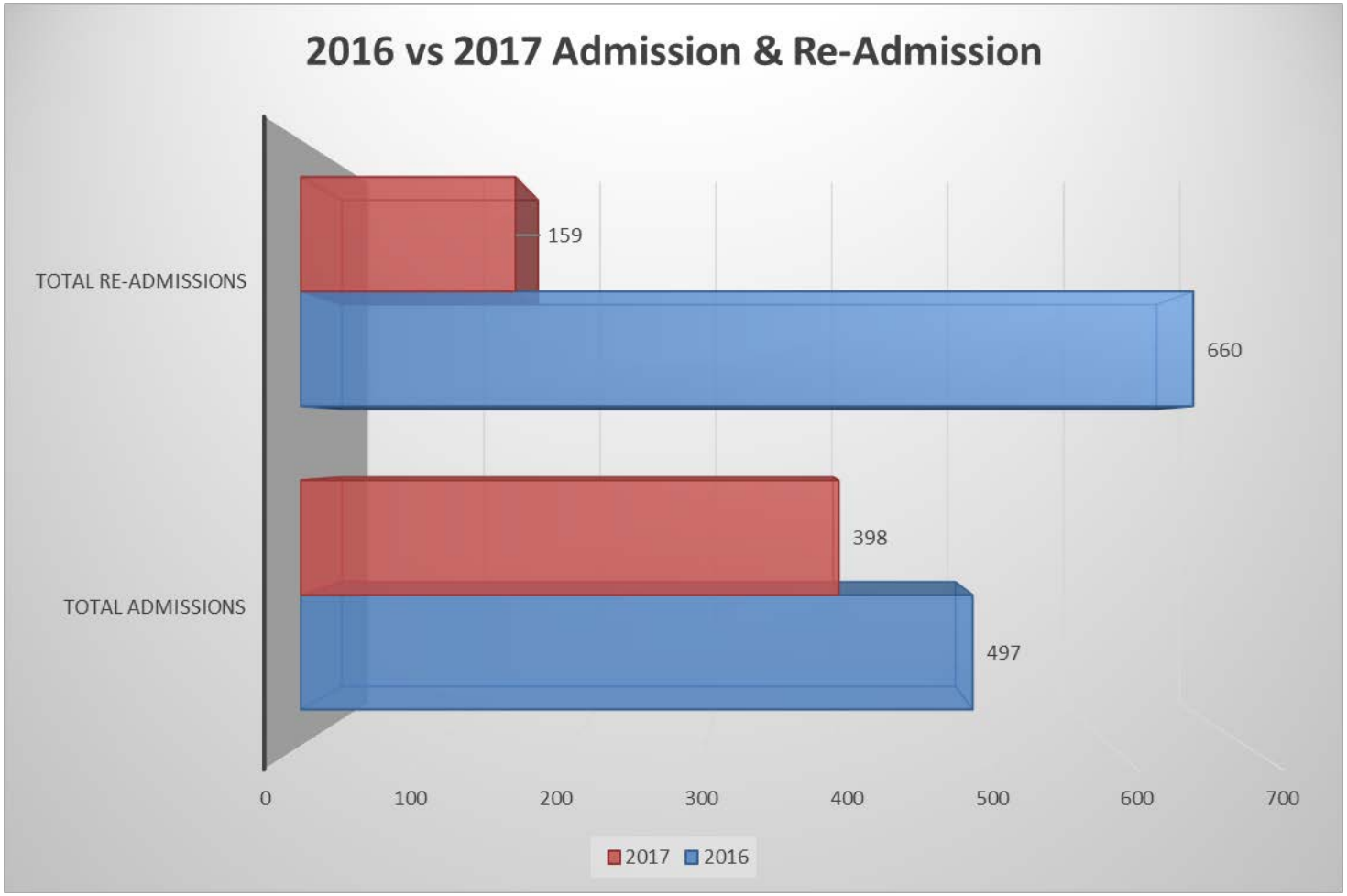
The value we gained using HIT in this process was;

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

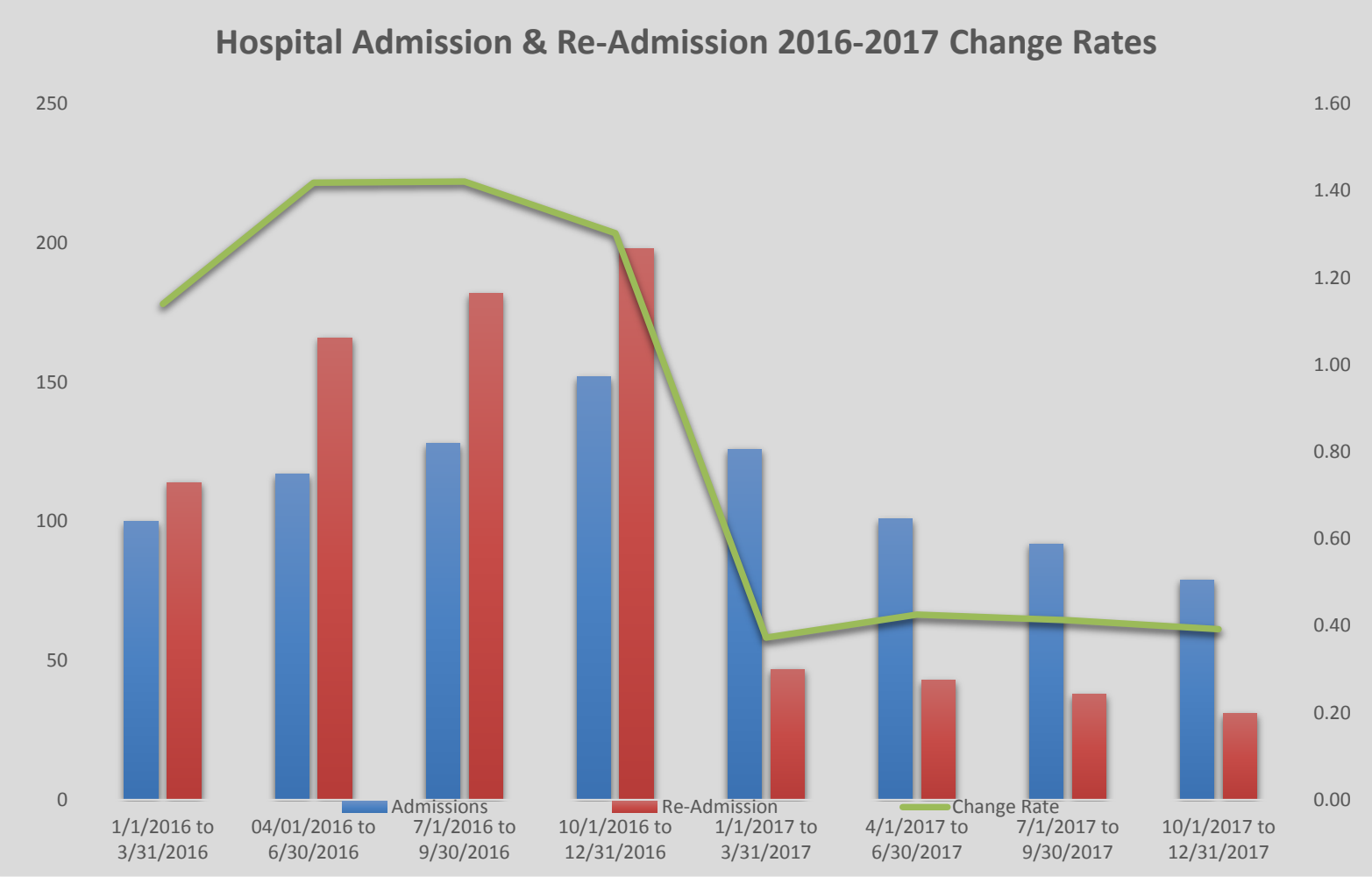
The financial gain using HIT in this process was;

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?