National: CPC Vital Signs: Knowing the Pulse of Your Practice

Presenter: Jay Fetter, TransforMED (OK faculty)

Moderator: Rose Langdon, TMF Health Quality Institute

Sept. 3, 2014

Our national CPC webinar entitled CPC Vital Signs: Knowing the Pulse of Your Practice. I'd like to start things off today with a few announcements. We appreciate the presenters' time and efforts in preparing for and sharing their valuable knowledge. Any statements regarding their technology, products or vendors are expressions and opinions of the person speaking and not an opinion of, nor endorsement by, the Center for Medicare & Medicaid Innovation nor TMF Health Quality Institute nor the host of the program. Now I'd like to turn the introduction over to Dr. Bruce Finke a family physician and geriatrician who is our senior advisor for learning and diffusion on the CPC team. Dr. Finke. Dr. Finke are you on the line?

Rose, it looks like we lost Dr. Finke.

Well, and I wish he could give those introductory remarks. But we will move it along and what I'd like to do now is to introduce today's presenters. This session is hosted by the Oklahoma Regional Learning Faculty. Jay Fetter will be our host for this very interactive webinar. Jay will introduce the panelists prior to their presentation. I would now like to hand the presentation over to Jay.

Good afternoon or morning depending on what time zone you're in today. Again, as Rose indicated I am a Regional Learning Faculty member for the Oklahoma market and I've had the pleasure of getting to know really five really interesting practices and panelists who are going to share a lot of wisdom with you today. As Rose indicated, this is a national webinar but our intention for national webinars is not for you to just sit on your hands and kind of watch this like a movie but also to interact with our speakers, presenters, as well as each other. So today we have really tried to take this WebEx technology and activate it a little bit by encouraging some of your peers to come and serve as chatters for our team. And as chatters their role within the context will be to kind of provoke some conversation. So we'll be kind of talking to you a little bit more about that process in a just a second. But know that we want to be as interactive as possible today. We'll start by kind of demonstrating our interactive, by getting a sense of where everybody's from today. You can use this arrow feature that's on your computer, right above this arrow on the slide, to point to the state or market in which you currently are residing and are participating in today's call. I'm based out of Kansas City so I get the pleasure of working across three markets but being in Kansas City I get to kind of spot people on each side. So we got a pretty equal distribution of folks from just about everywhere including Texas and Kansas City and even St. Louis, a

peer of mine and colleague of mine that works at TransforMED. So thank you all for utilizing this technology and participating. It looks like Cindy getting oriented to her arrow there too. Thanks Cindy. So we'll continue to use this technology to get a sense of who you are within the context of the practice. So go ahead and push the right button that matters to you. All right. So we've got some others. If you are an other we'd like to know who that other is, so we'd like for you to, on the, on the chat box to note the type of position that you have within the practice, your health system or as a stakeholder within the community that is CPC. So go ahead and just type that into the all participants section. I'll type in mine. So I am regional learning faculty and I'll do it real quick. And just do that. So we've got some care coordinators. We've got some additional, thanks Sarah for being on here, the call today. Great. All right, thank you. Okay, our purpose really today is to be really pragmatic about this notion of using data to guide improvement. We've, each of you at the market level have had great conversations about this. I know that your learning sessions have also focused on this topic and this will continue to be an important theme and I, I think Dr. Finke would've told you that this is probably the central element to being successful in CPC as we move forward. So our goal today is really to share some of the wisdom that is emerging out of each of the respective markets, to apply those concepts in real, everyday situations that you're working through and then also to identify some ways to leverage the community as well as the data reports to address a current problem that you have. So we want to hopefully enable you at the end of this call to be involved in the learning community to help solve problems whether that be at the local level with your coaches, like Kari and Sara that are out there on the call today, or to come on to the Collaboration site and to present a dilemma that you're experiencing and you can get some support from your peers that are practices and so on. Today we're going to use an appreciative inquiry approach. We're also gonna use something called rapid fire presentations. Our goal is to do really quick, meaningful presentations from our panelists today that help you get to sort of the seed that makes them successful. And then we're gonna kind of host some conversations again using the chat function. So those of you who have assigned to chatters you can begin chatting now, and that includes our panelists, but a couple of things here just to kind of make sure that it's clear. If you have a oral question we have the ability to field that question or you have an observation. Just raise your hand at any time during the course of this conversation and we will un-mute your phone because all of your phones are currently muted. If you'd like to share your wisdom or thoughts or even where you are in this perspective, again, mark all participants here and this is really important, this all participants if you just do it privately to an individual we won't all be able to see it. So in order to get that kind of tweet-like function working you need to mark it all participants but go ahead and frame things, so tell us what you think, where you're at, what pain points you have. We'd like to hear that and our panelists as well as our chatters will help facilitate some of that conversation. And then if you have a question for the panelists themselves, we'd really like you to use the Q and A feature that you have here at the bottom of your screen. That helps us distinguish between the two. Okay. There's an example of a question that might come up and make sure that you hit “All Participants.” So here are our chat hosts and rapid fire panelists today. I'll just let you take a look at it but you can see it's a distribution from across all the markets and these are folks that have either been voluntold, which is, or volunteered, so we thank them a whole lot for giving up their time. And also experimenting with us a little bit on this technology and being able to use the community a little differently. So first chat question for you, here is a quote from a really terrific book on using data to guide improvement. It's called Data Sanity and it says, "Good data collection

requires planning, which is equally as important as the data themselves. The first question must be what is the objective?" So my question to you, if you'd like to chat about this is how is your team organized to have sustained focus on the practice's operational and clinical improvement objectives? In other words, do you meet as a QI team? You know, what are the things that you have structurally in your practice that you think is helping you to support this notion here? So feel free to start chatting there and we will bring your ideas and thoughts to the table in a just a few minutes. Another question, if you're interested, a little bit, if you're not interested in that question is this quote, again from the same book, "The important problems are the opportunities that no one is aware of." I know that many of you have told us as faculty that being able to be involved in the CPC project has a shed a light on some dilemmas that you are trying to solve that you had a hunch for for a long time but now you have some of the data to be able to guide your improvement efforts. So really love for you to chat about your thoughts and features at a practice-level report that you think has been helpful to you to act upon those notions, whether that be at an internal practice report or it's a payer-based report or it's another report that comes out from, say, the Commonwealth Fund or another entity. So tell us a little bit about the features that you find most helpful. We're all very attentive to that and trying to make our data reports more useful to you so thank you for your thoughts and wisdom in advance. All right, another interactive piece here.

10:03

I'd like to kind of get a sense of sort of your experience or your competency, if you will, on using data so I'll read this real quickly. On a scale of zero to 10 with zero being a beginner and 10 being an expert, what number would you pick to describe your practice's competency and experience choosing a problem based on data understanding that process or coming to have an understanding of that process, generating potential causes, implementing a solution and then evaluating that solution, in other words that PDSA or that improvement cycle? So go ahead and start putting your arrow up there to see what best fits for you. Great. Looks like we have a lot of folks with an emerging competency and we also have quite a few folks with a high competency. We've got some folks that are at the early levels, beginners, and so what we want to attend to today in this call is those of you who spread across this, across this set of competencies from either high to beginner. The beginners will value those who are at the stage just above of them and those that are at the highest level of competency here, we're gonna value your perspectives and wisdom and so we want you to weigh in here for sure. Thanks. This is really cool to see where our community is. All right. So, whoops, I skipped, thank you, sorry about that Sandra. So today I just want to overview with you our rapid fire format. Our format really is going to be pretty fast paced. Each of our presenters have just 5 minutes to kind of share wisdom with you. They're going to share the context of the work in which they're doing it, so it's small practices, it's large practices cause I know 1 of the things as you look at an idea or someone's example and you go, well that wouldn't work in my practice because, fill in the x, it's too big, it's too small, we don't have that capacity. Well, we've tried to bring forward a range of different practices, sizes, shapes, and so you'll see some context for what they're doing their work. You'll hear how they have addressed that problem that they have identified and what they're doing about it. More importantly, you'll understand what are some of the adoption considerations that, that they might advise others who are in a very similar situation to kind of think

about and at the end of the call today we'll kind of try to put those packages together so everybody can see the wisdom.

And Jay, if we could, before you get started Dr. Bruce Finke has joined us and would like to make a few comments before all of the physicians present.

Oh, okay, great. Go ahead Bruce.

Great, thanks. Sorry about that. I was on and then lost you for a few minutes. I just wanted to observe that primary care has always been an entirely data-driven endeavor, right? The first thing that happens when the patient walks in the door is we collect qualitative, we look at the qualitative or quantitative data. We understand their chief complaint and we look at their vitals. And then we use data from a variety of sources as we're seeing the patient from their, from the patient themselves, from quantitative data that they may collect, their weight, their blood sugar, from quantitative data that we may collect on their behalf in terms of lab data, to help them manage their, their health, to achieve their, to manage their care to achieve their health outcomes. What we're gonna hear about today and what I'm so excited and I won't delay you any longer, is from a variety of practices that are, it's, what we're gonna hear from them is the extension of that process, about how they're using data from a variety of sources, from patients, from their EHR, from the CMS feedback report and other payer data to help manage the practice in such a way as to achieve better care, better health outcomes and lower total cost of care for patients. So in that sense it's, it's a total extension of that data-driven practice that is what primary care is. And I'll shut up now and I want to hear what everyone has to say and thank you and it's great to be with you all.

Thank you Bruce. I'm gonna get Renee all readied up here for just a second and she is from University of Oklahoma. Hold on Renee I'm passing the ball to you, if I can find your name. Ah, here we go. So Renee, if you would un-mute your phone now I'll go on mute. I'll have you introduce yourself and Rose will start the timer. You have 5 minutes.

Thank you Jay. Can you hear me? All right. I'll go on. Good afternoon and thank you for the opportunity to share the work of the OU Physicians Family Medicine Clinic and what you see here is most of our team. Not everybody was able to be at the picture and the facility where we practice and you can see the, our facility there overlooks beautiful downtown Tulsa. This is a, as I said, family practice, faculty and resident clinic for the OU School of Community Medicine. We have 12 family physicians who are faculty and 26 resident physicians in the practice. They are caring for just over 10,000 patients in the practice and we do have a fairly high Medicaid population and dual eligible Medicare and Medicaid patients. Currently we have two care managers, a part, half-time RN and a full-time LPN. We are actively recruiting for a full-time RN and 2.5 more LPNs to add to our team. We use GE Centricity EMR. Our problem or issue that we're discussing today was we had worked on using AIM High and some other obesity self-management tools in 2013 and added the access and utilization within our EMR and then have added and built on that this year for our self-management support for obesity and to meet that Milestone. And what we recognized is we had, we had the forms, we had the tools available but we had low utilization. So what we did, we have adopted the Dartmouth Coaching for Clinical Microsystems

Improvement Model and in that format we formed a multi-disciplinary team coached by a peer and the peer in this situation is the lead LPN who attended earlier this year the Dartmouth Coaching program. The first, one of the first things that we needed to do was define the problem and to do that we reviewed the data warehouse reports that we have available on the usage of the AIM High form. We found that across the board we had low utilization, which we suspected and what we've got here is a count of the obese patients that had a visit during the measurement period and for whom self, a shared decision making tool or self-management tool was used. And we grouped each of the care teams together and then by the month between November and April. So what we found here is a mean of only 2.65 patients who, in which this tool was utilized. We saw a lot of common cause variation here but overall just recognized that we wanted to increase the utilization and increase that mean. So what we did first was to set a global and specific aim and after looking at these data we decided on a specific aim that was to increase the percentage of obesity self-management support tools used by providers from the current mean of 2.65 by 5 percent in each module by November 1st, 2014. And we chose the 5 percent increase because our teams ranged from a mean of 1.93 to 5.26 and we wanted to make it achievable by the team. The next thing we did was look at the, some of the reasons why people weren't using it and I'll skip forward here. We used a fishbone diagram and examined six areas that we believe may lead to low utilization of the self-management support resources that we have available and from this have identified the areas that we felt like we could make a change. Going back we just, we also invited the top users to our improvement team meeting to tell us about how they used it, what works, what doesn't work and we were able to make changes accordingly. So adoption considerations for others, our challenges of course are time to get everybody together, physician engagement, we have very good activation and involvement with our, our care team staff members, getting the physicians to the noon meeting is sometimes difficult.

20:01

And then overall the tendency to jump to solutions. So I think I'm out of time.

Renee, that's awesome. So sit tight. We're gonna take some of the questions that are emerging out of the Q and A and the Q and A section. We're gonna come back to you in just a second. We're gonna go to our next speaker and we're gonna kind of wrap those up. So we're gonna bundle you two together. So sit tight there for just a second and thanks for handing me the ball. Next I'm gonna turn the rapid fire presentation over to Natosha at Grant's Pass Clinic. Hold on just a flash as I move that ball here. Oh, I missed it. There we go. All right. And Natosha this is coming your way. So —

All right.

Go ahead and un-mute and you're ready to go.

I'm ready to go. Can you hear me okay?

Yes.

All right. So this is Natosha Wilsey at Grant's Pass Clinic. Our clinic serves about 17,000 primary care patients. We're a multi-specialty group here in Oregon. We currently recently hired a care manager and

we've operated with 1 to 1 teams so our physicians work directly with a, what we call a primary, which is an LPN or RN or MA. So, and we currently work on Allscripts Touchworks. And I think we have about 19 physicians, two PAs, and one nurse practitioner. So we've quite a bit of staff and that's just sort of a general picture to kind of see what we look like and who helps, you know, keep this boat moving along. So our issue that we identified from the, from the utilization reports, from the feedback reports is that we weren't doing really great on our hospital re-admissions per 1000 discharges compared to similar practices that were in our region and in our risk level. So we, along with some of the requirements with CPCi we implemented a follow-up protocol to ensure that our patients were contacted within 72 hours after hospital or ER discharges. And it was also created in conjunction with the option to bill for transitional care management visits. So what we did was we created within our EMR a note, specific note to say that our primaries outreach to the patient and when they outreach they'd fill out that note and using our analytic system we were able to search and track and compare that to the number of patients that had a hospital discharge as well. So in February we decided to use our analytic system along with manually chart checking and we realized that our analytics program wasn't capturing everything 100 percent correctly so by using a combination of manual chart checks and the analytics program we were able to bump up our numbers quite a bit and you can see that the data's kind of trending up and it's required a lot of ongoing training. We've had some issues with if a patient isn't going to be seen by their provider, you know, if the provider didn't want to see them after the ER discharge or the hospital discharge then the outreach wasn't happening or if the provider wasn't going to bill for a transitional care management visit the outreach wasn't happening so we've had to continually go back and address these issues and make sure that our primaries are following up in a timely manner and set benchmarks and sharing the data with our providers and with the other staff has really made a huge difference in the engagement levels because we can see how well they're doing across the board. When you have one person in the red and everyone else is in the green it really draws their attention to, you know, what can I do differently? How can we bump up our numbers? And it's really helped to engage everyone to get on board with this and start to improve our numbers a little bit and not just this program but all of the other improvement projects that we have going. It has really helped to use data to drive these things forward. And ensuring that you have the most accurate data possible is really key. So we do quite a bit of, you know, double checking, chart checking just to make sure that our EMR is pulling adequate information or that the reports are showing accurate information because if it's disputable it's going to make the project irrelevant. And right now we're still working on how to best utilize a care manager in our practice and how to involve them in our transitional care management workflow. And we'll be tracking the utilization before and after we implement a care manager and are hoping to see our rates improve from that point forward. And that's it for us so I'm gonna move this back to Jay.

All right. So, a couple questions have not yet emerged from the Q and A but it seems like it's kind of a conversation starter in the chat. So I'm gonna kind of bring them forward and, Laurie, ask that you un-mute your phone now too if you see anything as well but, so I'll start it off with you guys have demonstrated that a really high level of competency and you have the vernacular down, common cause, variation, and talking about when to benchmark with peers versus benchmarking yourself. How do you support the, the people in your practice who may not be as comfortable or familiar with P values and

things of that nature to get up to speed and not find that this stuff is just, as they like to say in Arkansas, word salad? And you can go first, I'm not sure who is best positioned, so I'll let you guys choose, Natosha or Renee. Okay, so I'll call on you. Renee, I'll have you go first. I'll put you on the spot.

Okay. Well, for us, I mean we just, we keep talking about the need to get the data and how to understand it. As I said earlier too, we sent seven people to the Dartmouth Microsystems Coaching program and they get a lot of education, training in that about the use of control charts and how to use those and their improvement. So, again, what we end up with is peers within the clinic teaching their peers about how to use the information and the data they're getting.

Natosha, same question for you please and you can un-mute.

Yeah, it's a fairly new concept, you know, using this data in our clinic and it's been something that we have just kind of ran with and we just provide education at our monthly meetings and let people know what it means and that kind of thing. A few of us have gone to some conferences to learn more about the QI process, that kind of thing. But the staff as a whole, the majority of them have not been trained on these, on this type of improvement but they respond well, I think to, you know, the graphs and just making it easily readable, not loading it with too much information I think has helped them to kind of understand and always making ourselves available if anyone has any questions they know that they can always stop by my office and go over anything. So, and just constantly talking about it and having an open dialogue and putting all of it out there has really helped people to understand what's going on.

Sure. Jan makes a really great point in the chat here about how the care is so important and that sometimes the putting together of the diagrams and having, as she said, beautiful graphics seems like it distracts from the care delivered, particularly when you're up against a pretty heavy workload in the day. And so, over time, what I'd like the panelists to kind of be thinking about is how do you deal with that same issue of pace and, and trying to, you know, make sure that you walk this fine line between doing the right data and, and putting the right measures together and maintaining the right dashboard, if you will, and also still being attentive to the care and the interaction, the personal interaction you have. So, I'm gonna save that for the next Q and A but I'd also love for other people to chat about that as you're experiencing this cause we do have, on the call today, we've got lots of expertise as we've identified. So if you're in a smaller practice environment and you are experiencing that, love for you to talk about your story, how you're doing that. Give Jan a little bit of insight cause I think she's making a really great point for us to pursue. I'm gonna move on here just real quick here. So next up is the folks at Greeley. I'm gonna introduce, or have Lane introduce himself in just a second. Here, Lane let me open up this session to you and if you'll un-mute your phone, which you've done, you're ready to go.

Okay, hi everybody. I'm Lane Mattox. I'm from Family Physicians of Greeley. We're an independent physician-owned family practice. We have three locations all in the city of Greeley, Colorado with 24 providers.

30:07

Our problem was how to get physicians to take our quality reports seriously. So Natosha from Grant's Pass Clinic had mentioned the importance of accurate data and our EHR reports that we use for CQMs,

they were chronically wrong and we didn't have access to change them so we didn't feel like we could just put those in front of our doctors. So one of the heroes of our story is Crystal Reports. We have a separate report writer. Now, Crystal Reports is one of many, many report writers out there so I don't know if it's any better or worse than the other options but we used Crystal Reports to make our own reports and ensure that they're accurate. We gave the doctors not just the numerator and denominator of each of their quality measures but the individual patient names that make up the numerator and denominator so that they could verify the accuracy of the reports themselves or they did find errors and so we were able to go back to our report and fix those. Timely data was also a problem. Our EHR reports only came out weekly and it wasn't easy to get to, for the doctors to get to or the medical systems to get to or to use them. So we used Crystal Reports again to build in some patient list, patient-by-patient reports for each of the quality measures that they could run whatever they wanted to. So let's say they had a free afternoon to work on their quality reports or their MA did, they could run it at that time and the data would be up to date. Another, another thing that Natosha mentioned was the importance of showing everyone their own data and everyone else's. We've done that for a while now. It creates a sense of urgency when they see that they're not performing as well as their peers. Competition is good, the peer pressure on those that aren't performing well because they could be dragging down the practice and also it helps us identify who's actually doing a good job and we can pick their brains and spread those best practices. The biggest thing we did to, to get the physicians to take our quality reports seriously was to create financial incentives to meet the benchmarks and financial penalties for poor performance; financial, financial, financial. The, we're a physician-owned partnership so it was, this was natural but it's important to let the physicians design or be part of the designing the incentive system because it's going to affect their, their paycheck and it has to be, it's often not simple to do this because the, it has to be perceived as fair to the variety of physicians or providers you have in your practice. They'll have different practice sizes. They'll have different pair mixes and acuity mixes or whatever formula you may cast to be seen as fair. We also didn't want this to damage our collegial environment. We wanted them all to still be friends and collaborate on these things and not just be in strict competition. And you also have to put enough money at stake to make them move but in our experience it's not as much as you might think. So we measured, so our quality scorecard has 10 measures on it. So, and we assigned a benchmark for each of the 10 measures so if you take the 10 measures times the total number of physicians in our practice that's the total number of potential benchmarks we could meet as a practice, right? So when we started this you can see there, if you can see my arrow here, we started, we announced that we were going to do this incentive system and start putting out all this data, this accurate data, in, in September 2012 and actually kicked off the system in January of 2013, near the start of CPCi. And, and you can, and now we're, so we started off at around 30 percent there and now we're up to pushing 80 percent today or last month. So that's good. You can see that they did take this data seriously. Some considerations are this method, even though it's not a practice-wide PDCA, PDSA process it's basically letting each individual provider, physician, come up with their own process improvements and innovations to implement in their own practice to meet these measures. So it's important to, when you see if somebody's succeeding to find a way to spread those best practices to everyone else. Thanks.

Jay, we have a question on the chat. This is Laurie.

Go ahead Laurie.

The question is, the benchmarks that are being set to be met, are these Meaningful Use benchmarks, are they CPCi quality measures, or do the clinics set their own measures to be met?

We got all those benchmarks from somewhere. We didn't pull them out of thin air.

Okay.

Some of them, actually we set many of these prior to CPCi setting their targets. Some of them are CPCi targets but others, we had different pairs that were already judging us on these things and they had a benchmark we had to meet so we, in those cases we picked those numbers. In other cases we looked for, you know, we Googled some national, national benchmark and just, and took that. So we didn't want to come up with these things out of nowhere but sometimes it was hard to find one so, so yeah. But we did find them somewhere.

Thanks Lane. All right. So I want to go to our next speaker again. We'll have a question and answer session at the end of this one. We'll call on Lane for his wisdom and then we'll also call on Dr. Eugene Heslin. Let me pass the ball to Dr. Heslin here in just a second. Dr. Heslin, you now have the ball and you can un-mute your phone.

Thank you for allowing me to un-mute and thank you for allowing me to participate Jay and Rose. I want to call out to Samantha Sheridan from CMMI who is our local lead who always is so supportive. Anyway, we are a 5-provider group. We have a half time care manager. We're using the EHR ECW. We're unaffiliated. There is a lot of large groups around us and we have about 7000 patients in the practice at this point in time, between 7 and 8000 patients depending upon how you count. Our problem was is that we were having trouble, as I looked at these graphs that I got from CMS on our Quarter 2 reports where we had a significant utilization problem in the ER for our high-risk patients and also for our cost data. Someone asked the question earlier do we use these reports and yes, I do. So what I did was I actually trended us and this was the, the Quarter 2 report was the one I'm pointing to right now where I wasn't happy with where we were and so I've tracked us over time after we made interventions. Now, of course, Quarter 3 was already on its way by the time we got Quarter 2 and so on and so forth, but the key for me wasn't just where we were, it was how were we improving over the courses of the different periods of time. So now I get to put my name on the slides. And the same thing was true with our high-risk patient data. So we started off way over here on the right and then moved our way gradually across and Quarter 6 we're actually somewhere down in this range now. I love that my name pops up even. So how do, you know, what we did was we don't waste opportunities for looking at change. We looked at all the data and we tried to understand why we had a worsening performance. One of the things we recognized was, is that 10 percent of our population is over the age of 75, greater than all the other practices around us. In fact, 54 percent of our population is over the age of 75. So it started to make us think about what we had to do in terms of change, looking at our practice population and demographics. And we're a small shop, we only have our five, my practice administrator whom is dynamite, is my wife, and we don't have any big, you know, analytics. We are the analytics. So it's taking what we get, look at it, see if we can make sense of it and then move it forward. We changed everything. We looked at what

made a difference. Our receptionists talk slow, we had one that's a mile a minute and she actually got slow. We dedicated a triage RN. We had done some of this stuff prior to actually getting some of the reports but we reinvigorated how much time we spent actually looking at this stuff. We went to the ERs and spoke to the docs. That was a hard thing to do.

39:58

I have a little advantage in that I chair strategic planning for our local hospital so I did have the ability to reach in a little bit but we, as a physician group, decided we were gonna become more active with trying to take care of our patients, particularly in the off hours. We met with the ER director. We communicated with everybody. I think a common theme as we listen to all the panelists is the ability to communicate and the need to communicate. It makes a great big difference. We moved patients to observation and our data showed it. What do we measure? We looked at the feedback reports, as I showed earlier. We anecdotally actually spoke to our patients. We did patient surveys to see where [inaudible]. We also looked at our local payer data and tested payers against payers. No consolidated reports made it difficult to be able to track but if you looked at the different, of course they all have similar sorts of data in them, you just have to think about it and compare apples to apples. Our major challenges included getting our staff to buy in. That took doing things in a smart way. We met weekly. We started off slowly, gradually built up from there. Speaking to the ED was sort of a waste of time so I simply spoke to the CEO of the hospital and after several discussions, amazingly the ED became more interested in wanting to change what they were doing cause the CEO understood why we wanted to change what we're doing and we partnered with them to be able to make that happen. Getting our patients to understand the style of medicine. Well, I should stay overnight, shouldn't I? Well, maybe you'd like sleeping in your own bed better made a difference. All of our communities as we're on this call today have their own idiosyncrasies, you know, but learn your population demographics. How do you figure out how to make adoption better? You don't need to have people with paper degrees. You need to have really smart people with a good heart that work for you. Small practices, that makes such a big difference. We can train people to do almost anything as long as they have a willingness and a desire. So someone asked the question earlier, do we have, you know, some sort of an incentive [inaudible] system. And I actually built 1 that's a 6-point system and what it is is, you know, you have 2 points for each category, three categories. Do you support others in your staff? Do you work on the project? And do you support patients of the practice? You get a zero, 1 or 2. You can add up the total points earned by everybody, that's the denominator. Your points earned is the numerator, and then I multiply it by a pool of money that becomes everybody's money. So you could be a, you know, a lowest paid employee but make a lot if you score a lot of points and other people don't because I take everybody's salary and throw it in the pool, except for the docs. The docs have their own bonus system, which is not necessarily just tied to CPC project. But it made everybody have skin in the game. You try to treat everybody nicely. Things we don't know and things that we need to know better. As our patients get older and sicker and they have more multi-dimensional problems, they're gonna end up in the hospital. We need to be able to develop better medical neighborhoods in our area, more robust services, and hospice and palliative care, something to be able to work on. You know, the next thing after we get done in CPC of knocking out hospital admissions and ER and all the rest of that stuff, is what are we gonna focus on next? Where's the next pool we have to go after cause eventually that stuff runs

out. We have to focus on specialty medicine, imaging, medical management, and as our data sources get better we have to then aggressively go after these things. And I'll end with this, caring for our patients is more than pills, potions and mechanical things. Those are things we can do but we as primary care, to quote my old Irish grandmother, must stand in front of our patients, behind our patients, and beside our patients. That's what gets us to be primary care and that's what gets us to be part of this project. Thank you. So I'll turn this back over to Jay. There you go Jay, I think I did that, and I'll mute myself.

Thank you Dr. Heslin. You've generated quite a buzz on the chat here. So I want to kind of take advantage of a little bit of that buzz. You said many provoking things. Lane I'd also like you to un-mute too because I think this is the opportunity now where we can kind of focus on the, some of the learning that you both have shared. I'll remind participants that you can frame specific questions to these two gentlemen in the Q and A but I'm going to leverage some of the things that have been posted so far. So, Dr. Heslin, you're quotable and so one of the things that I think that I really like to hear is you're deeply curious about the things you don't know and you're deeply curious about the things that you want to know and, and you didn't let, you didn't let degrees or the need for a degree to get in the way of being curious. Can you talk a little bit more about whether you're a small practice or, Lane, you're a larger practice like that, how your teams have self-organized to be able to keep up the resiliency to be curious even sometimes when the data is imperfect and, and kind of share a little bit more about that.

So I, we have almost weekly to every other week meetings. I bring basically everybody into one room, all 25 of us, between billing to everybody. We actually, sometimes we talk about problems in the office, problems with patients. Sometimes we just, you know, you know, do updates, but we keep everybody engaged. I question and answer for people. We are deeply committed to trying to get everybody to participate, you know. We have some people that were very resistant and it's taken 3 or 4 years to get them to turn that resistance around. Some people have left by choice. When we first started all these projects I made a commitment that we were not going to have to fire anybody because of lack of ability. I had one 75-year-old, or 70-year-old nurse who couldn't use a computer but man she could talk to patients. She was my very first, you know, care manager. She called them up, talked to them forever. The patients loved it. She could do it from anywhere. She knew just enough. We have re-focused and changed people's jobs and positions. We're constantly re-tooling. I tell everybody we always live in a state of change, we always have, we're just calling it something now. And now, you know, you have to be supportive that way.

Thanks a lot Dr. Heslin. Lane, any wisdom from your perspective in a larger practice?

Yeah, I'm afraid we haven't done great at getting the right kind of people on board for, for curiosity and for patient centeredness. It's something we gotta improve on but I think our, our patient counsel, which is one of the CPCi Milestones has done a good job of kicking off a lot of discussion that we wouldn't have otherwise had. We bring that to our CPCi committee and our quality committee and to our meetings with the front desk, et cetera, and that's, that's gotten us moving and curious about digging into it more.

I was shocked, by the way, that we didn't have, you know, people in the office didn't know what Milestones were. Front desk didn't know what we were doing, you know? They knew what they needed

to do. I, you know, sat everybody down, gave them all a copy of everything, made them read it, gave them homework, and then made them recite what the Milestones were. It was like we sat around, remember the old Dirty Dozen movie you had to recite number one is this, number two is that. And we did that for a couple of weeks and then we made a game of it where we do it differently and people initially thought it was stupid but once they understood what we were trying to do, it was still stupid but the answer is that sometimes doing stupid things gets people more comfortable.

Mmhmm. I'd like to take a moment to have everybody who is a rapid fire panelist just to open up the lines and, and I'd also like for those that are in the audience to frame, again, any question that comes to you and foremost in your mind about using data as an element. You've got, you've got a really terrific group of folks who have, who have experienced the pain that many of you might be experiencing and you've also got some folks who have figured out what the other side looks like when you've navigated that. So I'd love to open up to all the panelists to answer questions that are coming from the community and if I don't see some then I've got some questions that I hope might create a dialogue amongst panelists. So I'll just, let me see what happens on my dashboard here of sorts. And Laurie if you see anything that's coming up that I'm missing from all the text let me know. All right. So a couple-

Jay, we have a couple of questions that have come up.

Okay, go ahead Rose.

50:00

Alrighty. The first one is from Kathy who wonders if anyone has built their HISP direct address yet and how are you planning to meet this 10 percent Meaningful Use measure of Stage 2?

We, we actually have built, are building our HISP address right now. We are planning to meet the 10 percent by working with our local partner vendor, Med Allies whom is helping us to identify who out in our community has their systems set up that we can connect to to be able to get the impact rather than trying to boil the ocean, we're trying to be strategic about it and we appreciate their help.

Thank you. And that's the only question we have at this point in the Q and A.

Laurie it looks like there's a lot of text coming up. Anything that's notable that we want to, want to talk about here with our panelists?

Well there's a lot of chat going on about the provider commitment that Dr. Heslin talked about so that was really good. And then a lot about what kind of reports people are pulling this data from. So if they can address those two things that would be great.

And these are open to all panelists here and we've got about, we've got about four more minutes here. So any, any wisdom that you have about those, that thread of conversation would be great to add here.

This is Natosha. We've had to use a combination of kind of everything so we get the feedback reports, we get reports from our payers and then we also have our EMR data and right now we've found that a lot of our Meaningful Use data it's showing pretty accurate. Our CQMs aren't as accurate but the reports

that we're able to generate within our analytic system, those have been the most meaningful because we can go in and really check the data and make sure that it's accurate and we can build the searches in the analytics program to kind of match what we're trying to, you know, meet as far as some of these other measures go. But I think a combination of all the reports has really helped and then we've put them all into a spreadsheet to show to our providers and keep them motivated.

Natosha, just a follow up and it sounds like you, you were going right where I was. Do you have a, for lack of a better word, a dashboard of sorts that, that really are the important and urgent measures that you operationally and clinically pay attention to on a daily, weekly basis?

We do. We took all of our CPCi measures, Meaningful Use, CQMs, things that we can actually get accurate data on and we've put them into like a spreadsheet of sorts and that's what we share with our providers and the staff and the stuff that we incentivized really was the, were the measures that the providers had direct influence on and that's what we put out there initially and we found that our primaries, since they work as such a close team, have really stepped up to, you know, to help their provider meet these measures and that kind of thing as well. So we post the results out by our break room as well as giving handouts to all of the staff, the care teams.

Natosha, I have one last follow-up here and this is kind of a granular. Some of the wisdom in the book about data sanity is about the value of graphical displays as opposed to tables and charts in moving people towards quality improvement. Have you sort of, what's your approach at your practice in that dashboard? Is it graphically displayed or is it in tables and graphs? How do you, how do you handle that?

We've, get more of the red light green light type display and that seems to work the best because if they're in the green they know that they're meeting the benchmark, they're doing well, and the red really catches the eye and they want to figure out what am I doing wrong? How can I improve this? So, but some of the reports we also use bar graphs and they can see, you know, where they compare to the rest of the practice and really just putting it out there for everyone to see and comparing it, you know, so family practice can see how well internal medicine is doing and vice versa and it kind of does create that competitive nature.

Great. There's a question that's come up that I'd like for everybody to tackle. Some of our, it says some of our physicians feel that we are telling them they are doing a good job, or not doing a good job I should say, when we show them reports. How can we convince them that the reports are not a critique but a tool for improvement? That's actually [inaudible] that deep curiosity. I know, Lane, you created an incentive to help people pay attention to reports but how did you get folks to look at those reports as actually an improvement device as opposed to a stick?

Yeah, we really made it a tool. It looks like a tool because it's, they can run this up to date report with all their names. It's in a format that would be easy to print off and go down the list and actually address all the patients that are falling short of the measures. So when we give them the numbers, we give them the overall numbers once a month but they always have access to the patient-by-patient data so it really is a tool.

Yeah. Dr. Heslin how, you're a physician, how do you talk to other physicians about this, this potential report card that comes out?

Oh, I don't just share with the physicians. Everybody in the office gets it. We all sit in one big room together. We go over it together. We try to figure out what's good and what's bad and where can we make improvements. It becomes a, you know, even the individual data, as I've said collective wisdom is much better than individual wisdom and, you know, we, we, you know sometimes I'll meet with an individual physician and we'll go over it. A lot of times we'll have just a brief pre-meet so that they know what's coming so nobody's caught off guard as this particularly is stress and most times, honestly, we're pretty open about it. As I said earlier, we all know our sins and we all know each other's sins, we're only five docs in one building. It's pretty easy to see what we do and don't do well. And mostly, a lot of times like with EHR will have a thing like oh, I could do that. Oh, you figured that out? Cool. Why don't you show us all how to do it and so it's become less of a, an accusatory environment and more of a supportive environment and you have to be careful how you manage that in a room. And sometimes we'll start with the entire group, everybody, and then we'll have the front desk go back to work and then we'll have the nurses go back to work. The final bit of the meeting is the doctors by themselves. So it's a tiered meeting structure. We try to tier responsibility as well as tier authority at different levels and that's an experiment and we're seeing how that works, you know? So you test it out and try it and if it fails, as long as it hasn't hurt a patient what difference does it make?

Thanks Dr. Heslin. I know in my experience working with practices often times there's a, there's a bit of lack of psychological safety within the practice that may be unrecognized and it probably doesn't go with just those clinical performance reports but it probably also does with kind of performance coaching and support within a practice so it's, it can be kind of a cultural issue within the practice and it's something that you'll have to attend to across, not just physicians, but across all the staff. So your notion of creating a safe place is, and a safe conversation, is really important.

[inaudible] I have to say, Jay, just very quickly is, is that we, you know, all, we all thought we were great. We were okay and now we're doing better but it's humbling for type A personalities to be put in that humbling experience and, and so it takes great care to be very respectful and I think that as long as we do that for our patients and, as much as possible, for our staffs, we all do better. I think that's what it finally comes down to.

Yeah, I think you're right. With just a minute left I want to first of all thank all of you. I want to thank all of those folks that have been brave enough to also, as learners, chat their experiences, their thoughts and participate. I know, I'm sort of channeling Dr. Finke here, this is what CMS and my hope would happen over time is that this would be cross market learning community where folks are learning together and less talking heads like me. So I want to thank you all for being brave enough to participate in that way. In order for us to, again, improve on this process it's important that you share with us your feedback and your experience. I also want to briefly thank all of our panelists. But there's two things I'd like you to do next. One, if you haven't been onto the Using Data to Guide Improvement Forum within the context of the Collaboration site I want you to think about going there and learning from each other and secondly I think, oop, I need to pass Rose the ball.

1:00:06

We want to launch this, the survey instrument so you can give us some more feedback and we can better tailor our national calls and the use of this tool for your needs. So thank you everybody, delighted. Rose it's all your, it's your ball again.

I want to thank you all for attending and we hope that you found this presentation very informative. You can exit the session by clicking on the file menu option at the top left of your screen and select the option to leave the session. You will be then taken to a post-webinar survey that needs to be completed in order to receive credit for attending this presentation. Thank you and I'll see you at our next webinar.