PCMH User Group Highlights 6/18/19

Slides from presentations are attached to email and on website (slides and highlights under PCMH User Group)

Introductions -Bryanna of NPO thanked those who filled out surveys for the recent HIE, ADT, Med Rec project and announced winners of the related downtown gift certificate drawing: Marty Whitcomb, Julie Davis, Terri Councilor, Penny Starkey and Teresa Miller.

Diabetic Microalbumin and A1C Quality Measures

Christina Cicchelli, former Population Health Manager at Northern Pines Health Center, presented Diabetic Microalbumin and A1C quality measures. NPO asked the practice to present on Diabetes Quality measures because it has had exceptional scores on these measures in the last few years.

Some simple ways NP approaches these measures are:

- Regular staff training on the importance of the microalbumin A1c lab test (staff trained multiple times per year at staff meetings and one-on-one as needed by Ashley and providers)
- Diabetic chronic care patients are seen quarterly for their chronic care visit
- Microalbumin as a standing order at first non-acute visit of year for all diabetic patients has improved various outcomes. Several payers cover one microalbumin per calendar year, so this timeframe is beneficial for completion.
- Uncontrolled patients are referred to care management.

Running a Diabetic Registry has "probably played a huge part in our increase in numbers," Christina said. Data deliverables to physicians, medical director and care management in the practice include most recent A1c results, last microalbumin date, vitals demographics and other structured fields.

Chart prep was a LEAN project for the approximately 2,500-patient-practice last year, with their MA now spending an estimated 40 to 50 percent of her time working to prepare charts one to two business days prior to the patient's appt. Gaps in care are transferred to the patient encounter sheet prior to the patient's appt.

MA is not just checking and showing that microalbumin is due in the Priority Health patient portal, she is actually going into the chart and seeing if it has been done in a different format than a structured field, so that she can make sure it gets added to the appropriate registries.

Munson Family Practice

Munson Family Practice Care Manager Cherie Bostwick, RN presented a takeoff of a fall leadership project she completed, which studied reasons for ED Over Utilization among the practice's patients. The group discussed that since cost of care is an incentive in most payer programs and as a stand-alone BCBSM PCP VBR, and ED utilization also is a new VBR incentive for BCBS PDCM, these are relevant issues.

Open discussion took place amongst User Group members to identify drivers for ER Utilization, including patient types such as those required to pay less, at end-of-life stage, and patients who are attention-seeking, lonely, scared, having social behavioral issues or without a PCP.

Cherie's November 2018 study involved interviewing 84 ER patients post-utilization about why— in patient's own words— patients chose to go to the ER, recording whether patients called the clinic first for triaging, if they were aware of same-day appt. availability and about physicians on call after hours. Scheduling a follow-up appt. was another purpose of this call.

More than half of the patients called would have been appropriate patients to have seen their PCP before heading to the ER, findings showed. Cherie said they noted that very few patients interviewed were unaware that same-day care at the PCP office existed, but they still weren't using it. The group mentioned that jobs and transportation can be barriers to M-F 8-5 hours.

The practice looked at ways to approach decreasing the utilization rate and some ideas discussed among PCMH User Group members were:

- Educate patients about types of symptoms that the PCP can address at the clinic: pain , nausea, diarrhea, nosebleed, cough, rash, headache, fever, anxiety
- Promote concept of ease and timeliness of Same-Day Care available at the PCP clinic.
- Have a care plan in place for patients in the event they are not feeling better (especially if seen in a timeframe approaching a weekend).
- Evaluate your practice's After Hours voicemail message. Cherie shared that two studies have shown that mentioning symptoms the PCP can handle first and making an ER mention take place at the end of the message, has had a positive impact on PCP utilization.
- Educate clinic providers about what is being done to encourage clinic use vs. ER use, to avoid a potential lasting impression of a grumpy provider inconvenienced by a patient call.
- Provide office hours outside M-F, 8-5.

After this project, an interdisciplinary team at the practice formed to meet weekly and as needed to discuss high utilizers of the ER, communication with the ER teams was enhanced, enrollment in care management was prioritized and post-ER follow-up calls continued.

Transition of Care

Thirlby's Assistant Office Manager Deb Schepperly spoke about Thirlby's Transition of Care (TOC) methodology. Deb shared Thirlby's Standard Work documents and a TOC template. This is how Thirlby documents processes so that staff can be trained and use as a reference (great for PCMH site visits, too!).

Thirlby currently utilizes one nursing supervisor to call discharged within last 3 days. Some details in their process include:

- A medication review that covers meds changed and stopped in the hospital.
- A hospital discharge follow-up appointment scheduled by clinical staff (not front desk staff) within 7 business days.
- TOC template is merged into telephone encounter.
- The telephone encounter is merged into notes (ecw has a clickable carrot icon which expands the section to allow a user to do this).
- Billers monitor and review using a Transition of Care folder in ecw to review and follow these patients for 30 day billing (need to ensure patient not readmitted within 30 days as can't bill TOC then).

There were some questions about billing raised. NPO did follow up with Lori Boctor, BCBSM. Please find a summary below:

CARE MANAGEMENT PHONE CODE BILLING Q&A with Lori Boctor, BCBSM 6/20/19

Question from NPO: A practice thought they heard you say when you were here that the practice can bill a phone code (I think they mean 99487 or 99489) when a nurse is on the phone trying to get a pre-auth.

1. Is this correct?
2. If correct, the nurse would have to meet CM education requirements?

Lori Boctor Response: So, the care coordination codes should be billed when they are coordinating care on behalf of the member, like contacting the meals on wheels or setting up DME to come to the home. Those codes shouldn't be done if they are requesting pre-authorization for an MRI/CT scan. Does that help?

Question from NPO: Thanks – so the answer to that led to the next question, please:

I have an ADT message that a patient went to the ED. I call the patient to see how it went and remind them that office was open, and they could have come there. We discuss their ED instructions and see if they need anything. We are on phone a good 5-10 minutes, then I document.

Can I bill and if so, what code? If I cannot bill, what is missing so that I can?

Lori Boctor Response: In this scenario, most definitely a telephone code can be billed. At our PDCM workgroup last week, we asked a few of the PO's what they were using the telephone code for and they specifically said that they were billing for follow up to an ED visit.

Question from NPO: Thanks – which code specifically do you hear people using?

Lori Boctor Response: The 98966 code because it's typically the Medical Assistant that has been doing them since we expanded it to allow them to do it now so long as they have had the training.

Question from NPO: And if a Care Manager doing calls?

Lori Boctor Response: If it's the care managers, then they can bill any of the telephone based services (98966, 98967 & 98968). Hope that helps. Please let me know if you have any questions. Have a great day!

2019 meeting dates:

- Wed, 8/21/19
- Thu, 9/26/19
- Tues, 10/22/19
- Wed, 11/20/19