Achieving Medical Home Access and Communication in an Academic Medical Practice

University of Pennsylvania

University of Pittsburgh
Workshop Structure

- NCQA/Medical Home background
- Overview of how an academic practice can approach selected standards:
  - Continuity and enhanced access
  - Communications from patients (requests, clinical advice)
  - Communications to patients (results)
- Small group discussions of specific strategies
- Regroup to share ideas
Disclaimers

- We are all from the great state of Pennsylvania
  - University of Pennsylvania
  - University of Pittsburgh

- We all use the same electronic medical record, EPIC

- You know your practice best!
NCQA Medical Home

Monica O. Ferguson, M.D.
Assistant Professor of Clinical Medicine
University of Pennsylvania
What Is A Medical Home?

The medical home is a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.
The four primary care provider associations have developed **joint principles** to describe the characteristics of a patient-centered medical home (PCMH).
Joint Principles of the PCMH

- These principles seek to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care.
  - Provides continuous, coordinated, team based care
  - Features enhanced access to care
  - Quality and safety are hallmarks
  - Incorporates enhanced payment
What is the NCQA?

The National Committee for Quality Assurance is a private, non-profit organization dedicated to improving health care quality.

[www.ncqa.org](http://www.ncqa.org)

- Process for achieving recognition as a PCMH by the NCQA
- Complete NCQA recognition standards
- Joint principles of the PCMH
Why Should My Practice Obtain NCQA Recognition as a PCMH?

- The NCQA is the only organization with a PCMH recognition process in place.
- Achieving recognition may enable your practice to receive enhanced payment from insurers:
  - Directly from insurers
  - Improved quality scores can result in increased reimbursement
- To improve quality of care and reduce costs
NCQA Recognition Process

- Nine standards
- Each component of the nine standards is assigned a score on a 100-point scale.
- Three levels of recognition can be awarded based on total points.
- This workshop will focus on two standards:
  - Standard 1: Access and Communication
  - Standard 6: Test Tracking
NCQA Standards

- **Standard 1: Access and Communication**
  - Has written standards for patient access and patient communication
  - Uses data to show it meets standards for patient access and communication

- **Standard 6: Test Tracking**
  - Tracks tests and identifies abnormal results systematically
NCQA Standards

- **Standard 8: Performance Reporting and Improvement**
  - Measures and reports performance by physician or across the practice
  - Survey of patients’ care experience
  - Sets goals and takes action to improve performance
  - Produces reports using standardized measures
  - Transmits reports with standardized measures electronically to external entities
Standard 1: Access and Communication

- Schedule each patient with a personal clinician for continuity of care
- Determine through triage how soon a patient needs to be seen
- Maintain the capacity to schedule patients the same day they call
- Provide telephone advice on clinical issues during office hours
Standard 1: Access and Communication

- Provide urgent phone response within a specific time with clinician support available 24/7
- Provide secure email consultation and an interactive practice Web site
- Meet practice standards for a timely response to telephone, email, and interactive Web requests
Standard 6: Test Tracking

- Tracks all laboratory and imaging tests ordered until results are available to the clinician
- Overdue results are flagged
- Abnormal results are flagged
- Follows up with patients for all abnormal test results
- Notifies patients of all normal test results
Patient Access

Gillian Lautenbach, MD
Assistant Professor of Clinical Medicine
Hospital of the University of Pennsylvania
Why Is Access Important?

- Quality of care measure
- Patient satisfaction
- Improved outcomes
Defining Patient Access

ACP: “Superb access to care [includes] ease of making an appointment and email and telephone visits when they are an appropriate substitute”

From: “Statement of the ACP to the Senate Health, Education, Labor and Pension Committee”
NCQA PCMH Standards

PPC 1: Access and Communication
Element A: Access and Communication Processes

The practice establishes in writing standards for the following processes to support patient access:

- Scheduling each patient with a personal clinician for continuity of care
- Determining through triage how soon a patient needs to be seen
- Maintaining the capacity to schedule patients the same day they call
- Scheduling same day appointments based on practice's triage of patients' conditions
- Scheduling same day appointments based on patient’s/family’s requests

Element B: Access and Communication Results

The practice’s data shows that it meets access and communication standards in 1A

- Visits with assigned personal clinician for each patient
- Appointments scheduled to meet the standards in Items 2-6 in 1A
State of Patient Access in the US
AHRQ National Healthcare and Disparities Report, 2008

% of respondents, total

Always | Usually | Never
--- | --- | ---
50% | 35% | 15%
Measuring Access

- Wait time for new patients
- # same day appointments available
- 3\textsuperscript{rd} next available appointment
- Patient satisfaction surveys
Academic Practices, special barriers to access

- Attending providers with multiple roles: teaching, administrative
- Residents with even more limited clinical time in the office, long periods of being unavailable
Scheduling Paradigms Affect Access

- **Carve out**
  - Keep a few appointments open for acute visits daily
  - Can be altered in a “wave” with differing lengths of time
  - Favors routine appointments, harder to get urgent appointments

- **Open Access**
  - Less than ½ appointments are booked far in advance
  - Favors urgent care, harder to make routine appointments in advance

- **Rapid Access**
  - Some features of both models, 50-70% of appointments are booked in advance
Access to Whom? (continuity)

- **Defining Continuity - Caregiver perspective**
  - Interpersonal (one doctor to one patient)
  - Team
  - Site (one clinic, one health care system)

- **Additional Continuity Elements (can be combined with above forms of continuity)**
  - Informational
  - Continuum of care
  - Attitudinal “cornerstone caregiver”
Does interpersonal continuity matter?

- Patient satisfaction
- Outcomes: preventive services
- Efficiency/resource conservation
- Empathy/trust
Does Team based Continuity Improve Patient Care?

- Team based continuity does improve care on in-patient medical units
- Outpatient data less clear: possibly in pediatric asthma
- Despite paucity of information, team based care, especially for patients with chronic medical conditions seems compelling, especially in academic practices
  - Shortage of primary care doctors
  - Residents/attendings who are not always available
Continuity in the Medical Home

- PCMH criteria emphasize team care for chronic medical conditions
- But mostly PCMH criteria define continuity as interpersonal
Defining Team Based Care

- Defining the team
  - Who are the team members?
  - Roles of the team members:
    - Who coordinates care?
    - Who oversees overall care?
    - Who sees the patients?
      - Acute visits
      - Routine follow up visits
      - Chronic care visits
- Deciding in which practice this model might improve care:
  Resident practice? Academic Practice?
Measuring Continuity

- Measurement depends on what type of continuity you are measuring
  - Proportion of visits with PCP (interpersonal)
  - Proportion of visits with team (team-based)
  - Number of providers encountered in specified time (interpersonal, team, site)
  - Access to EHR (informational)
  - PCP identified (attitudinal)
Principles of Access

- Timely
- Appropriate to patient need
- Achieving type of continuity which is most beneficial to patient and practice as a whole
- Specific practices may find different ways to meet the same principles
In-bound Communication

Patient-Initiated Requests

Susan C. Day, MD, MPH
University of Pennsylvania
Responding to patient requests is Core to PCMH

- **Quality and Patient Safety:** better outcomes, fewer errors
  - Timely triage of urgent problems
  - Improved chronic care management, adherence by addressing concerns between visits

- **Improved Patient Experience**
  - Improved patient satisfaction scores
What do patients want?

- To reach their doctor easily, 24/7
- To get a timely response
- To have the issue resolved quickly
- To feel connected

All challenges in the academic world
What patients (often) get

- Voice mail and prompts
- Faculty and residents who may only be in office for 1 to 3 sessions a week, then out for the extended periods
- Long appointment lags for urgent and routine follow up appointments
- Delay in responses to requests for clinical advice, form completion, result turnaround
NCQA expectations

- The practice should:
  - Determine through triage how soon a patient needs to be seen
  - Provide telephone advice on clinical issues during office hours within a specified time.
  - Provide urgent phone response within a specified time (24/7)
  - Provide secure email and an interactive practice Web Site
Steps in meeting the standard

- Review/Establish Practice Standards
- Evaluate Current Performance
- Examine and define your process, identifying gaps between ideal and real performance
- Apply medical home/advanced practice principles to close the gap
What are your practice standards?

- How quickly do you expect
  - refills to be filled, referrals to be completed?
  - Patients with urgent issues to be triaged
- Do you have a practice handbook/policy manual?
  - Do you know where it is?
  - How often do you review your policies?
- Do patients know your practice policies? Do your providers? Your residents?
- How do your expectations match benchmarks?
Where to find Benchmarks

- NCQA.org
  - HEDIS: Healthcare Effectiveness Data and Information Set
  - CAPHS: Consumer Assessment of Healthcare Providers and Systems
- Institute for Healthcare Improvement (IHI.org)
- Medical Group Management Association (MGMA.org)
Measuring Current Performance

- How easy/hard is it for patients to access the office?
  - Dropped calls
  - Repeat calls
  - Accommodated calls, scheduling on demand

- How long does it take to respond to request?
  - Time to completion/resolution

- Patient satisfaction
Tools for obtaining this data:

- Technological solutions
  - Telephone technology (tracking calls)
  - Web portal (track patient requests)
  - EMR (canned reports)
- Real time surveys
- Chart Audits
- Patient satisfaction
Examine and Define your current process

- How do messages come into the office?
- What do patients want?
- Who takes off messages?
- How are they routed?
- Who is responsible for addressing the issue, and being sure it is addressed in a timely fashion?
- Who monitors whether the faculty and residents are doing their part?
Process mapping

- Creating a diagram of flowchart that uses graphic symbols to show the steps and flow of a process

- Benefits
  - Engage all involved staff
  - Gain agreement on the current process
  - Create a visual image of the flow
  - Identify problem areas/bottlenecks
Closing the Gap

Some ideas, based on Medical Home principles

- **Clear practice standards** clarify expectations for patients, staff, and providers.

- **Team based care** reduces need to wait for MD, empowers staff

- **Use of EMR, Patient Portals** creates a **virtual office** and improved access

- **Protected office time** for non-face to face provider contact with patients can expedite care (phone hour, e-mail)

- **Regular feedback** on performance to faculty and residents highlights importance of communication
Outbound Communication to Patients: Notification of Results

Gary S. Fischer, MD
Associate Professor of Medicine
University of Pittsburgh
Why Notify Patients About ALL Results?

- Safety
  - “No news is good news” or maybe it was just missed
- Leads to consistent processes
  - Less likely to miss important abnormalities if all results need to be communicated
- Patient activation
- Patient satisfaction
NCQA PCMH Standards

- Standard 1: Access and Communication
  - A. Has written standards for patient access and patient communication
  - B. Uses data to show it meets its standards …

- Standard 6: Test Tracking
  - A. Tracks tests and identifies abnormal results systematically
Defining Standards

- What is appropriate turn-around time?
  - Patient expectations?
  - Prioritization with other work
  - UPP-GIM set generous standard of 2 weeks from result date

- Checking EMR
  - Standards for faculty and residents
Defining Standards

- Documentation of Communication
  - Signing off on result (is this enough?)
  - Telephone notes
  - Letter
  - “Result notes”
  - Electronic messages
  - Automatic electronic lab release

- Acceptance and communication to all physicians (faculty and residents)
Measurement

- Is EMR being checked?
  - EMR Reports
- Are results being reviewed?
  - EMR reports
  - Manual audit
- Are results being communicated?
  - EMR Reports
    - Processes may be too complex
  - Manual Audit
    - How large of a sample size
Devising Solutions

- **System redesign**
  - Results flow
    - Who gets them?
    - Who interprets them (is there escalation process)?
    - Who notifies patient?
  - Communication Methods
    - Efficient for clinicians to use
    - Based on patient preference
    - Use of electronic communication
      - (Are we sure message gets through?)
Devising Solutions

- Audit and Feedback
  - Clear standards
  - Standardized documentation
- Manual Audit
  - (32 faculty, 40 residents -- lots of auditing)
  - Sample size???
Test Tracking

- Patient safety and satisfaction
  - Tests not scheduled
    - Patient unaware
    - Order ‘falls through the cracks’
  - Result does not reach ordering provider
Test Tracking

- **Identification of Critical Tests for Tracking**
  - GI tests, cardiac tests, CT, MRI

- **Method of tracking**
  - Manual
  - Electronic Reporting
Test Tracking

- Outreach for Unresulted Orders
  - Done – obtain result
  - Not done
    - Help patient schedule
    - Patient Declines – Tell PCP

- Challenges
  - Orders not matching results
Supporting Documents
NCQA Patient-Centered Medical Home Standards

Access and Communications
The practice has standards for access to care and communication with patients, and monitors its performance to meet the standards.

Element A: Access and Communication Processes
The practice establishes in writing standards for the following processes to support patient access:

1. Scheduling each patient with a personal clinician for continuity of care
2. Coordinating visits with multiple clinicians and/or diagnostic tests during one trip
3. Determining through triage how soon a patient needs to be seen
4. Maintaining the capacity to schedule patients the same day they call
5. Scheduling same day appointments based on practice's triage of patients' conditions
6. Scheduling same day appointments based on patient's/family's requests
7. Providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time
8. Providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week
9. Providing secure email consultations with physician or other clinician on clinical issues, answering within a specified time
10. Providing an interactive practice Web site
11. Making language services available for patients with limited English proficiency
12. Identifying health insurance resources for patients/families without insurance
Access and Communications

The practice has standards for access to care and communication with patients, and monitors its performance to meet the standards.

Element B: Access and Communication Results

The practice’s data shows that it meets access and communication standards in 1A.

1. Visits with assigned personal clinician for each patient
2. Appointments scheduled to meet the standard in Items 2-6 in 1A
3. Response times to meet standards for timely response to telephone requests
4. Response times to meet its standards for timely response to email and interactive Web requests
5. Language services for patients with limited English proficiency

Test Tracking

The practice systematically tracks tests ordered and test results, and systematically follows up with patients.

Element A: Test Tracking and Follow Up

The practice systematically tracks tests and follows up in the following manner:

1. Tracks all laboratory tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
2. Tracks all imaging tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
NCQA Patient-Centered Medical Home Standards

Test Tracking (continued)

3. Flags abnormal test results, bringing them to a clinician’s attention
4. Follows up with patients/families for all abnormal test results
5. Follows up with inpatient facility on hearing screening and metabolic screening to get results
6. Notifies patients/families of all normal test results

Element B: Electronic System for Managing Tests

*The practice uses an electronic system to:*

1. Order lab tests
2. Order imaging tests
3. Retrieve lab results directly from source
4. Retrieve imaging text reports directly from source
5. Retrieve images directly from the source
6. Route and manage current and historical test results to appropriate clinical personnel for review, filtering and comparison
7. Flag duplicate tests ordered
8. Generate alerts for appropriateness of tests ordered
University of Pittsburgh
Call Volume & Response Time

May 07- Dec 09
Goals

- Increase number of calls completed on the same day
- Decrease response time as much as possible (maximize response time less than 2 hours)
- Increase number of log-ins per week by residents (expected to log in 2 days a week other than clinic day)
Patient Call Volume per Month

GIMO Patient Call Volume

- Total Calls
- Calls to Firms

Patient Calls

May'07 Jun'07 Jul'07 Aug'07 Sept'07 Oct'07 Nov'07 Dec'07 Jan'08 Feb'08 Mar'08 Apr'08 May'08 Jun'08 Jul'08 Aug'08 Sept'08 Oct'08 Nov'08 Dec'08 Jan'09 Feb'09 Mar'09 Apr'09 May'09 Jun'09 Jul'09 Aug'09 Sept'09 Oct'09 Nov'09 Dec'09
Patient-Firm-MD Completed Same Date

TAT: Patient-Firm-MD Calls
Percentage Requests Completed Same Date

Completed Same Date
Pts Call Back

May '07  54
Sept '07  69
Dec '07  47
Jun '08  68
Sept '08  80
Dec '08  78
Mar '09  83
Sept '09  58
Dec '09  86

May '07  25
Sept '07  9
Dec '07  14
Jun '08  10
Sept '08  12
Dec '08  4
Mar '09  6
Sept '09  9
Dec '09  7
Patient-Firm Calls Completed Same Date

TAT: Patient-Firm Calls
Percentage Requests Completed Same Date

- Blue diamond: Completed Same Date
- Red square: Pts Call Back

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Patient-Firm-MD Calls Response 0-2 Hours

TAT: Patient-Firm - MD Calls Response TAT:
0-2 Hours for Request Completed on Same Day

- Firm Respond to Pt
- MD Respond to Firm
- Begin to End

May '07  Sept '07  Dec '07  Jun '08  Sept '08  Dec '08  Mar '09  Sept '09  Dec '09
Resident Log-In

All GIMO Resident Log-in Activity
Jul' 07 - Present

PGY 1 (09)  PGY 2 (09)  PGY 3 (09)
Intern Years Compared

Comparison of Intern Year Log-In

- PGY 1 (09)
- PGY 1 (08)
- PGY 1 (07)

July: 10, 36, 25
August: 27, 40, 42
September: 58, 75, 27
October: 58, 25, 27
November: 67, 25
December: 42, 36, 25
Use of Secure Electronic Messaging to Improve Communication
HealthTrak Usage 2009

- New Messages - 9,488
- Total Messages – 13,728
- Unique Patients – 2,833
## HealthTrak Messages by Type - 2009

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References


References, cont’d

## Call Center Report

### Scheduling

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# Call Center Report

## Practice

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### Call Center Report

**Other**

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**Not Coded**

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**Total Calls:**

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