Making Meaningful Use of Meaningful Use: Combining Medicine and Technology to Improve Quality and Transform Healthcare

Presented by [Dr. Christian Tashjian] (1-hr Webinar) [12/11/2013]

Jane McGraw: Good afternoon everyone and thank you for joining the Learning in Action Network, which is focused on using health information technology to improve quality and physician practices. This webinar series is a collaboration between Stratis Health, North Dakota Healthcare Review and the Regional Extension Center for North Dakota and Minnesota (REACH).

Today’s presentation is going to be presented by Dr. Christopher Tashjian. Our objectives for today’s webinar are…

- Discovering why you should think of Meaningful Use as a team sport
- Learning how, using your basic EHR functionality and performing common tasks to meet Meaningful Use, and
- Learning how a team based care model can improve blood pressure control and screening rates in your clinic

For our webinar today we are going to have everyone on mute until the end of the presentation, at which time, Dr. Tashjian will be able to take questions from you. If you want to ask a question in between feel free to put it into the chat on the right hand side of the screen and direct it to all participants which should be the default.

We're pleased to have Dr. Christian Tashjian as our presenter today. Dr. Tashjian is Chief of Medicine for the River Falls, Wisconsin area hospital, a regional facility of Olina Hospitals. He is also the Medical Advisor for Wi-Tech, Wisconsin's Regional Extension Center for Health Information and Technology. He serves on the Board of Directors of Health Partners, Inc. where he is a co-chair of the Medical Board of Governors and Chair of the Health Transformation Committee.

Dr. Tashjian is an HIT Fellow, using EHR and practice innovations to increase participation in the Million Hearts Initiative and Improved Performance on the Million Hearts Goal. By empowering everyone in the clinic to contribute to quality care, the Ellsworth Medical Clinic was named one of two hypertension control champions in the nation by the CDC and Million Hearts Program.

Without further ado, I'd like to turn it over to Dr. Tashjian.

Christopher Tashjian: Thanks Jane. I’m going to get going here so we can get moving now, and thanks to everyone else who’s logged on for the webinar. I hope it’s not as chilly at your place as it is at ours, as we’re still below zero with a -30 wind chill.
We'll start with having to make an active decision in our clinic, which is two physicians and a physician's assistant. We had to change the idea that this is physician-driven, to this is really a team challenge which relies on everyone that's on the team to make it work, to get better results and take better care of patients. In retrospect it sounds pretty simple, but for physicians it's a fundamental change saying I can lead the ship but I don't have to be the only one, and then you delegate and use the staff to actually improve care.

Once we did this we saw dramatic changes, so again, we as physicians had to give up total ownership and say this is a team sport. Then we had to ask and teach our nurses, our lab and care coordinators and front office what it means to be part of the team and what our expectations were of them. So, we had to teach them what is hypertension, what it needs to be rechecked, when it has to be addressed and we went with obvious people like nurses and lab techs, as well as the care coordinators next, who do a lot of the coordination of our chronic disease.

It also means the front office, which was often an overlooked valuable member of the team. Our patients can’t get good care if they don’t get through the front doors and get in to see us, and therefore, we incorporated the front office as well, which I think is something important that’s been helpful for us.

The second part of what it means is that my patients are my partner’s patients and vice versa. What I mean is that in the old days when we thought we were doing a great job and we wanted the best for our patients, if I saw one of my partner’s patients and their blood pressure is elevated I’d say, the next time you’re in why don’t you have Dr. Lieski look at your blood pressure and recheck it to make sure it’s okay.

We don't do that anymore. If the expectation is if this patient has high blood pressure and you're seeing them, and you can go back and see they’ve had a couple high blood pressures, the expectation now on the partner’s is that it's up to the person seeing the patient to do something. Maybe to modify medications, talk about lifestyle changes to get them in to see the dietician, but not to pass it off to the next visit when they're seen by their primary care physician.

That meant if Dr. Lieski added a medicine I didn’t question why or what she did and likewise with me and that's helped a lot. It brings the hypertension right to the forefront. The next thing is that every visit is a hypertension visit, so if you come in, one of the Meaningful Use guidelines is to take a blood pressure on everybody. We did it already, but now with Meaningful Use we’re required to check the blood pressure every time.

If you are coming in for a rash and we notice your blood pressure is up, we feel that’s our obligation to deal with that as well. If someone comes in and needs an INR checked, they don’t even see a physician and their blood pressure is up. It’s up to that lab tech or nurse who’s handling the INR to deal with the blood pressure and find out if they need to be seen today or if they need to be scheduled for a visit to address the blood pressure issue as well.

A lot of those were slipping through the cracks because as physicians we didn’t even know they were in. Next is a nice schematic that talks about it takes everybody. We used to think it was just the physician and then the other obvious one you’d think would be the registered nurse, but it’s also the receptionist and even the office manager, making sure things are running smoothly, the physician's assistant, the clinical staff and lab staff, virtually everyone is now responsible for the patient’s care.
It doesn't mean that the physician can say I'm out from under it, because they still have to lead the team and be part of it, they just aren't the only part and that's been liberating for everyone.

So Meaningful Use and Million Hearts are built-in now to every one of our patient's visits and it starts if you notice in the green square on the left that it starts in the planning that our nurses will look at head to see who's coming, what their problems are, what their past pressure has been and if they're due for lab for. Take care of registration to make sure they get in the door, patient in-take means everyone gets their blood pressure, height and weight taken.

They're going to have their problems addressed and they get an after visit summary and then post-visit we have care coordinators to make sure they understand their instructions and then for anyone who's not in control, the care coordinator reaches out to, to make sure they're following their new directions and also coming back for follow up visits. So the continuous quality improvement never stops. We are constantly addressing their hypertension, and to be honest, it also includes their diabetes, coronary artery disease or heart failure.

You can really slip in any chronic disease, but we are constantly monitoring that and trying to proactively deal with it to prevent illness as opposed to trying to treat it, which has made it more fun and more successful.

These are the stages of Meaningful Use and by now everyone has gotten through stage one, and learning how to catch your data. One of the things we’ve done from the start is to take the data and use it. That's really in preparation for stage two but that's coordinating the care and starting to exchange information with, for us, being a primary care clinic I would be the specialists and for specialists it would be sending the information back to us.

For stage three, which they've just pushed back a year and from my standpoint is okay, but we’ve been pushing hard to get them to start looking at outcomes and improved outcomes as being the goal, so rather than having to do a bunch of items 1-18, it's like if you have 90% of your blood pressure under control that counts for all of those other measures. If you have 50% of your diabetics controlled, and they haven’t settled on the numbers, but I think from a provider's standpoint it would be so much more valuable to say let's focus on outcomes because that's really what helps patients.

It's not the fact that we measured the blood pressure but the fact that we acted on it and brought their blood pressure down so they had fewer strokes and heart attacks. That's what I’d like to see in stage three. I think the ONC has been really receptive to this and we’ll see how that goes.

So Million Hearts goal is made by the CDC and the office of the National Coordinators, to prevent a million heart attacks and strokes within five years and I really think we can do it. We’re into year two, but it crosses federal and state agencies as well as private organizations like our independent clinic. Heart disease and stroke are the leading killers in the U.S. There are 800k deaths which isn't insignificant, each year caused from two million heart attacks and strokes.

So saving over a million in five years is really saying something as roughly over 200k as what we’re trying to prevent. I think we can. It costs $444 billion in healthcare costs and lost productivity, so it’s not minor but significantly impacts the overall cost of care to our patients. For every dollar we spend on preventing it, right now the average they figure they can save is about $6.
Last but not least, it’s the greatest contributor to racial disparities and life expectancy and one of the things you may have noticed, and I received flack from my partners about why we need to check and keep track of race, ethnicity, age and things like that, and the reason is so it can be measured. We do so in order to make sure we give just as good a care and it’s not dependent on race, ethnicity or insurance status.

When we look at this if you have the data you can look at it and make sure that you’re treating everyone the same and eliminating these disparities.

The key components then of Million Hearts is to focus on the ABCs, but like everything else if we can make this simple it makes it so much easier, as well as easier to communicate to both our patients and staff. The use of health information technology and simple innovations can make a huge difference.

If you look at the model and how much healthcare health we can change in our exam room and it’s somewhere between 20-30%, with the rest coming out of the community, so we need to be cognizant of that and we need to be mindful that we’re approaching that front as well. In that case we need to work on smoking cessation community-wide. We need to look at reducing salt intake and trans fat intake as well.

Recently, we’re looking at all sorts of things in our community to include involving the churches, grocery stores and others, because we know the more times we can get this message out the more successful we’re going to be, because if we only expect to address it in the exam room it won’t work.

So, for those of us who are healthcare providers and one of our goals is to actually become part of this Million Hearts and be part of those who are actually reducing a million heart attacks and strokes over the next four years, is to patiently treat the blood pressure and cholesterol, make sure the right people are on aspirin, discuss goals with patients, coach them, help them out and ask patients about smoking status every time, as well as provide support.

Make sure you look into barriers to stopping smoking and to the medication adherence. Make sure there are ways you can do it. For us, we prescribe over 90% generics. I like medicine that costs $4 or $10 for three months and most of the time you can get people to go use the medications in that category. It’s incumbent on us to make sure we pay attention to that. Use health information technology as necessary also.

So the ABCs are simple measures and is data we’ve already collected and then a Million Hearts is likened performance to incentive. Looking at LDLC, controlling blood pressure for ischemic vascular disease, looking at LDL abuse of aspirin and obvious the tobacco cessation is probably the number one thing we can do to improve the health of our patients. So, for us again we’re relentless about it and our patients know it, which makes a big difference.

Getting the goal, these are the ABCs…

- Aspirin
- Blood pressure control
- Cholesterol management, and
- Smoking cessation

The targets aren’t that terrible. If we’re looking at getting 65% of the people who should be on aspirin, to me these targets are low and we should be able to do it. We measure this each month. Blood pressure control getting 65-70% control, cholesterol management 70% and smoking cessation is 70%.
I personally would like to see them higher, but if we're doing it nationwide I think this is a good place to start. Then again, sodium reduction, trans fat reduction, lessen salt intake, and the use of educational materials and just talking to your patients about it. It amazes me how many people actually listen to us.

So I do see a clinic here where they're talking about in some clinics PAs and nurse practitioners act as primary care providers. In our clinic our PA does act as a primary care provider. We measure his numbers like we measure our own, but the other thing that our PA, at least quarter time, is during our quality work and actually assisting the physician, which we've found a tremendous asset to the team to free up the physician.

For example, my PA goes throughout my labs and all my normal labs he takes care of and I don't even have to see them, because most of the time I'm not acting on a normal lab I'm acting on an abnormal lab. So those are the things that I see and he clears that paperwork out of the way, as well as other paperwork that he gets out so I can focus my care both on the chronic disease management and direct patient care, which works very well.

What are the less tech solutions we've come up with, and I'd like to say we came up with, but I have to be honest we stole this one so feel free to steal it from us. A low tech one is one where we took a standard piece of construction paper, we put recheck blood pressure on it and laminated it and then taped a magnet to the back. Each of our exam rooms has one of these.

It's placed on the inside of the door so that when our nursing assistant takes the blood pressure if it's above 140 over 90, she will take this magnet and put it on the outside of the door, which tells me as the provider that before I even see the patient or look at what they're here for, I need to pay attention to their blood pressure. What does this cost, a nickel at most a quarter? It's a very low tech solution but is very effective.

The other thing it does is it engages the staff which means they're expected to be paying attention. In the early stages when the blood pressure was up and not out, I could go to my nurse or assistant and say hey remember, the plan is if the blood pressure is up, your job is to remind me and help me. Your job is to be part of the team and again, in very short order it almost never happens now, but when it does it engages the staff and focuses the provider.

That too is like a $.25 solution and I don't know any administrator or finance person who wouldn't foot the bill for this.

Next is the high tech solution, which is using our EMR. We have an EMR that's headquartered in Kansas City and we take the data out of our EMR and export it to an Excel spreadsheet. We use one of the reports that's built into the EMR without customizing anything. We start letting the Excel sort the patients out for us and do most of the work, because my job is to look at the right data at the right time and I don't want to sort through a lot. It's something that computers are exceptionally good at.

From Excel we then use an Access database to pull the data from Excel to put it into report format. The reason we use the Access database is because we only have to buy one or two and then the Access database viewers are free, you can download those from Microsoft. So you can have the viewers on every one of the desktops, but you only need to buy access for the one or two people that are actually doing the data manipulation and data management.

We generate a group of lists, the first being the patient list. This shows where we've given the instructions to Excel that says show me every time the LDL is greater than 100, show me every time it's more than a year old or show me
every time the blood pressure is too high or more than a year old. Show me every time the A1C is above 8 and every time the patient smokes or show me every time the patient is on aspirin.

Basically, when the computer starts sorting things out and then presenting it when it’s filtered through the database we start presenting it by which of our patients have four out of five controlled, three out of five controlled, two out of five control which makes it much easier for us to focus our attention on the people who we think we can improve and concentrate on.

So we use these filters and we can filter it by disease process, especially the number of issues they had or by age. By doing that we can start creating lists and I go over it every month with my care coordinator. One month I do diabetics, next it’s ischemic vascular disease patients, the next month it’s the hypertensive patients and then we start over again. So every three months I’m looking at the data.

In the paper world we looked at the data once or twice a year but it was so expensive that we couldn’t do it more often than that, whereas now we basically look at it each month and the expense is almost zero. Once it’s setup the reports run automatically, because we let the computer do the work. Then we do the actual thinking part of it after the computer does the grunt work. So we think what are we going to do for Mr. Alan? How are we going to improve it? He’s out of date so we just need to send him a letter and get him back in and make sure his cholesterol is controlled.

Then, for the harder ones we decide if this is someone we’re going after which we can do on an one-on-one basis, which we have the time to do because we’re not spending time sorting through all the data, we’re getting the computer to present the data to us in usable format.

We’re big proponents of same day access and advanced care, so for a lot of our patients my nurse can’t pre-visit plan because they call today and get in today, which is something our patient’s love. I think that’s one key to having good quality numbers is to be available and have good access. It means you have to have ready access to the data. My nurse can then print out one of these scorecards which tells her what needs to be done.

She’s empowered to order the lipid profile or direct LDL if the patient isn’t fasting and she can take care of that so I don’t have to. I know she’ll do the blood pressure so we look at that and maybe this patient is diabetic so we look at creatinine ratio and if that’s not done she can do that as well. She doesn’t have to worry about the aspirin it’s already there. She doesn’t have to worry about the smoking, because it says they aren’t smokers. So again, she can pull this up using the computer making it work for you rather than you working for the computer.

When we implement our computers we spend a great deal of effort entering data in. We enter the blood pressures, medicines, tobacco status, etc. It makes no sense to enter it if we don’t use it, so we’re really keen on saying it matters to enter the data but it matters even more to use the data and change the care.

We also do provider scorecards because physicians tend to be anal and what we find out is that when you match the physician with their MA, the competition goes up at least two-fold and sometimes more so, because our medical assistant’s don’t like to be at the bottom either and we publish this. So we print this and put them on the walls of our clinic.

And you notice that while I mentioned we’re a two physician, one PA clinic is that we’re a satellite and there are two other clinics, so we put everybody up against
everybody and every month whatever we’re studying. We look at how many patients you have and how many you have in control, four out of four or three out of four, etc. and you can see where you rank as can the MAs, because we think of them teams between a provider and an MA.

That has done a world of good because people who didn’t believe in it, even if they didn’t think this helped, they don’t want to be at the bottom. They have a competitive spirit and it really engages them. The nice part is; is once they start doing this they can actually see for themselves what a difference it makes in their practice. I can tell you personally my hospital practice is almost half from five years ago. It’s not that I see fewer patients, if anything I see more. I just send fewer of them to the hospital and I think that’s because we give them better control.

The results we got in four years, we went from 73 to 97% and as people with cardio vascular disease we went from 68 to 97%. That tells you it’s sustainable and then if you look at it from December 2012 and then now in 2013, all of our patients who have any kind of diagnosis of hypertension are controlled at 90%, whereas the national average is somewhere between 45-55%.

So again if you look at it we’re a small rural clinic in a town of 2000 whose claim to fame is that we can sell more cheese skirts than anyone else. We are in Wisconsin, but from my standpoint that puts us behind the eight ball not in front of it, yet if we can do it using this systematic way and using the computer to help us rather than get in our way, you can get some dramatic outcomes.

The other thing that I notice as one of the things you heard is that I sit on the board of one of the health insurance companies. They can tell me exactly how much money I save them and they can tell me how many heart attacks were prevented because they have all the data. They can say what was predicted and what actually happened. They can tell me how many eye surgeries were prevented, how many amputations were prevented and that’s real dollars in the healthcare game.

More importantly and what I think motivates me and the physicians to go to work everyday is that’s another grandfather who can play with their grandson, another grandmother who can babysit or take care of her grandchildren or go to church or coffee, who isn’t stuck in the nursing home with a stroke or hasn’t passed away from a heart attack from something we could have prevented.

Let me share our current progress as of November 2013, which is our most recent look. This demonstrates a couple things. It demonstrates in August that we’re actually doing better. If you look at total patients in control we’re at 55% in August and this is from me personally. These are just my patients. In November I’m at 52%. It’s difficult, once you get going so far it’s hard to maintain that and you have to be relentless and go over it.

The other thing that you’re looking at is if you look at our numbers, for example, for November 2013, 95% control in blood pressure, 75% on A1C, 85% on LDL and 100% on aspirin and 82% on tobacco. Those all look like pretty good numbers, but when you put all five together, even though 74% is our lowest percentage it knocks its all the way down to 52%. So having to get all five definitely makes it more difficult and while some of our physicians will complain and say is that really fair? The real answer is in the genetics and disease outcomes.

If you look at the data its clear that if you control four out of five your patients don’t do as well. If you really want to get the desired results and prevent disease or illness than you have to push for five out of five.
In our case, we are relentless about this. We don’t argue about whether it should or shouldn’t be. We’re pretty insistent on it and if you look at the differences between August and November, you can see the biggest difference is 4% in A1C control and that 4% difference translates into a 3% difference in total patient control. So again you can’t take your eye off the ball of any of it, we need to pay attention to all of it and the only way I know to do that is to make the computer do the work.

It’s too difficult to expect that from our care coordinators. If the computer isn’t keeping track of all this stuff for them, it’s too hard and that’s one of the real keys to the advantage of our high tech age and moving the computer into the exam room. However, it doesn’t help unless you use it and that’s the important part. I see so many people saying the computer is in the way and it makes it difficult for them to get things done, and that can be the case if you let it. What’s really discouraging is if you let it do all that and then you don’t use the data you worked so hard to put in than it is a waste and I certainly understand the frustration.

As we said earlier, we are one of two clinics in the country selected as a Million Hearts hypertension control champion and I’d like to say it’s because we’re great doctors, but the answer is it’s because we have a great team. Earlier this year we met out in Seattle with Robert Johnson and 30 other clinic staff, all of whom were highly performing. The one thing we had in common was that everything was based on teamwork.

None of it was physician led it was all team led and this team lead and having the team involved clearly makes a difference if you want to improve care. It makes a difference if you want to have better care for your patients. So, when I told you at the beginning it was a really hard decision, we knew we had to do but it was amazingly hard to me, actually knowing how to do it and wanting to do it, it was still hard to do.

Therefore, for your physicians, cut them some slack but not too much. Make sure they get it done and they delegate and use the entire team.

This year they said we’re a satellite and as a satellite, the main clinic with 12 providers and a bigger center, they aren’t happy we won the award and they didn’t. They had good numbers but they weren’t as good as ours. It’s amazing what a little competition will do. This year they focused and said if Ellsworth can do it then we should be able to do it. This year now the River Falls Clinic is a Million Hearts finalist and it just goes to show you that if you can motivate people and get the message out, even big systems and larger clinics can change and make a difference.

Again to note, we’re doing this without huge assets and resources. It’s not like we’re one of the 500 physician-health centers, we’re a small independent clinic.

Does it make a difference to our patients? Our patients read Consumers Reports and you wouldn’t believe how many people came up to me and said I thought you were in there, we had no idea you all practiced the best care out here. We just thought it was a small town family clinic we were going to, and our response is, you are going to a small town family clinic, we just think care is the number one thing we do and we strive daily to take the best care of you.

All that’s done is to solidify our physician/patient relationship. The other thing its done is when our patients get a little tired and say they either relapse and their A1C goes up or their LDL goes up or they stop their aspirin, we use good old fashioned guilt and say when you don’t do that you make us look bad and this is published on Consumer Reports and on the web. We are shameless and will use whatever it takes to get our patients to improve their compliance, because in the end they’re the big winners.
As you can tell the big key to this is it takes a team and that’s right from the front office as the first person they see to the nursing assistant, lab tech, x-ray tech, care coordinators and even the physician’s provider is important. So, I know I’m talking to people in Minnesota and North Dakota, and this is the people who have taken the Million Hearts challenge, so I would challenge our North Dakota colleagues to step it up.

They aren’t far from the 100 to 249, take the challenge and be willing to measure yourself and be held accountable for your care, because in the end it’s in your patient’s best interest. Plus, who wants to play second fiddle to South Dakota? I don’t. Wisconsin’s saying is we’re pushing hard to get good moves and to get above 250 in the next level and I suspect Minnesota should be there pretty soon as well.

Again, the whole reason they’re doing this is that the goal is to save a million heart attacks and strokes. Those are real numbers and real people, just so you know. I can’t say enough to say it’s worth taking the effort. This is one of those things that costs nothing, it just says I promise to pay attention to this, so it doesn’t use huge resources but we show what we measure really makes a difference.

We would like you to take the pledge and join a Million Hearts, and you can go to MillionHearts.hhs.gov, it’s not too late and it’s one of those things that I think you can really make a difference with in your patient’s care, especially if you incorporate this concept of teamwork.

I want to take a few minutes to talk a little about Meaningful Use and the EHR and another way we’re using it as well as a way to look at quality. Most of you are aware that a year and a half ago the FDA came out and said wait, you take the most common blood pressure and cholesterol pill and there’s a new drug interaction we weren’t aware of.

That is specifically amlodipine and norvasc and pseudo statin or zocor. It says when you mix these two drugs sometimes you can get abnormally high levels. Prior to that we knew there were certain problems with chinochneol or others, but we had no idea that the amlodipine caused that. Then they came out and said this was a dangerous combination, pay attention to it.

In the old days what we would do before we had our EMR is we would say all right, the next time the patient comes in we’ll try and remember this and if we happen to see that they’re on amlodipine and pseudo statin, it may jog our memory to say do we have to do something or remember something? Our rate in dealing with this was atrocious. I don’t fault anyone we simply didn’t have the systems in place to make it work right. Now with the EMR we actually queried and said EMR, we spent all this time entering all this data, show us and it did.

In our clinic there are 241 people and this is from the three clinics that are on the network that are in our overall clinic. So 241 people were on amlodipine and pseudo statin and we had to look at every one of those to make sure they were getting the right care and weren’t getting too much. Then we said we didn’t do anything other than invite them in for a conversation and we notified their physician to say this patient needs… so you need to address this issue.

We send letters to the 241, but also if you look at the other thing we noticed at the lower right hand corner, we had 23 people on pseudo statin where it was a caution or use of care and now it moved to not to ever use period, so we had to change our plans and move them off that in the name of patient safety.
Again, if I’m one of the patients and the new data comes out, I’m more likely to return to the physician who has the ability to notify me and tell me there are new guidelines, and when we prescribed it, it looked good and now the guidelines have changed we want to talk to you and have a thoughtful discussion on where we go from here. That only helps patient compliance and helps to build that relationship between physician and patient.

It says, do you have any knowledge to update practice guidelines or best practice or do you update your order stats on a regular basis? The beauty of being in Minnesota or North Dakota is that we use ICKSE and we look at the ICKSE hypertension and diabetes guidelines and ischemic vascular disease guidelines each year and we modify it unless there’s something that comes out that’s major. Otherwise those guidelines are updated every year. It costs nothing to participate in ICKSE and it costs nothing to use the guidelines.

As you can tell I like it when thins are free or low cost which is all part of being a small independent clinic. That’s what we use to keep our guidelines up to date.

Jane McGraw: Dr. Tashjian, I wanted to thank you for your presentation and to congratulate you and your team at the clinic, because you’ve done some great things with the way you’ve been working with your patients and making changes in their health. One of the questions I had while we wait for people to log on is this.

You talked earlier about a scorecard that you had developed for patients, like when you have a patient to call in that same day and you don’t have time to prep for them. Is that something that was readily available in your EMR product?

Christopher Tashjian: No. That scorecard comes from the Excel spreadsheet. We run the Excel spreadsheets once a week and that spreadsheet is available to anyone. If you run the Access database query, basically there’s a patient scorecard that’s a blank template and if we run that across the Excel spreadsheet it pulls all that data and brings it in so the data is never more than a week old. It doesn’t actually go into the EMR but into the Excel spreadsheet that we use to manage the data.

It takes less than an hour to run that for our entire practice. You simply let the computer crunch it in a cloud somewhere and it comes out.


Christopher Tashjian: Being a week old, and it doesn’t happen often, but every once in a while the patient will be in during that week and they’ve done it but they tell us. When we tell them they need an LDL they say I was in on Monday doc aren’t you paying attention? We say my bad and we go on.

Jane McGraw: When you first started this, how did you approach getting at each person’s role and responsibility, in terms of, I think you talked about your PA taking on a lot of looking at your normal lab values, etc. Did you start looking at the workflow of how the patient went through?

Christopher Tashjian: To be totally honest, when we first started we looked at our misses and why we had patients in our system that didn’t have their blood pressure controlled. We went over their most visits and asked how something got by unchecked or unaddressed. Some was provider related and some was the nurse who didn’t know because we’d never taught them to do anything since that was always the provider’s job. Some the lab tech saw and some the care coordinator saw, but it was never their responsibility, so that was the first thing.
The second thing is what we did, which we use all the time now, we process mapped everything we put in our EMR in 2010, and so we have very active process maps and we look for areas in the process maps as the patient flows through the clinic of where are spots where we could drop it. Where are spots where we can let it fall through the cracks and we did our best to fill those up.

Jane McGraw: Thank you.

Are there any others on the line who have things they’ve done in their clinics that they’d like to share, as well as asking Dr. Tashjian questions? A part of the Learning in Action Network is to share things you’re doing at your clinic, so if anyone has anything they’d like to share and how they’ve made improvements with their patient care and such, we’d be happy to hear about it.

Christopher Tashjian: I want to say one more thing while we have time. When I go to these things and do them, if I can take one pearl away from it then I consider it worth the hour I spent. Then I’ll look at my talk and what I tell everyone is the biggest pearl you can take away and do something about before the end of the week is that little recheck blood pressure sign. You can make it in less than an hour and implement it in less than a week.

It’s amazing the difference it makes on the quality of care you provide, because it’s amazing how it focuses things around. So if you’re asking yourself what pearl you can take away from today, that would be one of the things I would suggest. It takes a little more time to setup the database management and analysis, as well as time to setup the team structure, but it takes nearly no time or money to setup that recheck blood pressure magnet and to start using it.

Lisa Gall: Great presentation. How many care coordinators do you have? Are they RNs? Do you use a medical home model as far as care coordination?

Christopher Tashjian: Yes, we use the patient centered medical home. We are level 3. Our care coordinators are MAs. It’s designed that way on purpose for two reasons.

First, is that we can add more because they cost less.

Second, our patients know our MAs, which is important because they reach out to the patients in between visits and call them.

What happened in the old days is that Blue Cross would hire an RN from Pennsylvania to call our patients and they would hang up because they didn’t know them. However, when Roseanne calls it’s the same person they see in the grocery store or church, so they know who she is. So we trained our MAs into what was important to use.

First was the guidelines and making sure they understood all the guidelines for chronic diseases and second is ways to manage it and to use standing orders and guidelines or protocols so they could intervene. We find the MA works fine for that and we haven’t experienced any issues with that.

Lisa Gall: That answered my second questions regarding protocols and orders and entry in utilizing your medical assistants, so they can count towards Meaningful Use.

Christopher Tashjian: Right and not everyone uses certified medical assistants. For us it makes a huge difference because these people can enter orders and follow protocols. I hate to say it but the more you can take away from your physicians the better your numbers will look. The less you rely on them to do that kind of work the better your numbers will look and the better overall population health you’ll receive.

Lisa Gall: Thank you.
Jane McGraw: I want to thank everyone for participating in today’s webinar. Judy is the North Dakota QIO and Jerry Hiniker is from our Stratis Health Minnesota QIO, so if you have any questions about today’s QIO please feel free to send an email to either of them to follow up.

The next webinar is February 19, so we’ll give folks a little time off for the holidays. It’s on shared decision making.

You will all receive an evaluation for today’s webinar and we would appreciate your comments on this presentation. It helps us to preplan to get great speakers in like Dr. Tashjian who can talk about what’s happening in the community with regard to helping us use our EHR efficiently and effectively. Slides will also be sent to everyone.

Since there are no more questions we’ll wrap up today’s webinar and I appreciate all of you being here. Have a great day.

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