HIMSS Analytics

HIMSS Analytics Stage 7 Case Study

Hattiesburg Clinic

Profile

Hattiesburg Clinic is a physician-owned multispecialty medical group that was established in 1963 in southeast Mississippi by 10 physicians. It has since grown to 350 providers covering 41 specialties, serving a market area of approximately 525,000 patients and providing outpatient services of over 750,000 office visits and 22,000 surgeries annually. To improve healthcare in Mississippi, the state with the highest chronic disease burden, worst mortality rate, and lowest physician-to-patient ratio in the U.S., we believe that expansion of the care team is crucial. Furthermore, a better delivery model for population health is contingent upon having standardized tools and workflows that are electronically connected throughout an organization such as ours that spans over 80 locations and 18 counties.

Implementation Overview

In 2014 and 2015, Hattiesburg Clinic developed 4 programs that have relied heavily upon clinician input and EMR tools to streamline workflows and improve quality:

1. Diabetes outreach. We have expanded the care team into rural areas to deliver endocrinology services, so our patients no longer have to commute such long distances for these specialty resources. Using a team composed of an endocrinologist, nurse practitioner, dietician, and case manager, patients receive comprehensive diabetes care in their primary care physician's office, and the care plan and results are incorporated in the shared medical record amongst all team members. We provide the case manager with standardized documentation and reporting tools, along with dashboards to display performance metrics and analytic tools. The case manager has frequent points of contact with patients between office visits using a variety of communication methods including mail, telephone, patient portal, and telemedicine. With identification and addressing of social and behavior barriers, intense education and connection to resources, and frequent medication adjustments made via electronic messaging between the members of the care team and patients, results have been very positive. Over 250 diabetics have been enrolled, and 97% have had sustained A1c reduction over the course of 18 months. Average A1c has improved from 9.6 to 7.5, and the percentage of patients with an A1c greater than 9 has plunged from 59% to 1%.

2. Chronic Pain Management: Standardizing the workflow with the use of EMR tools has allowed for better assessment and monitoring of patients. Using tablets in the waiting room, patients complete questionnaires such as PROMIS and PHQ-9, and the discrete data is immediately incorporated into the medical record at the visit. With synopsis reports, this discrete patient-entered information is correlated with medication dosing, drug screens, labs, pain contract material, and results of imaging studies and pain procedures. Genomic data is incorporated within the medical record as well, and decision support tools alert providers throughout the organization with metabolism information if narcotics are prescribed. Pulling all this information together, a registry for these patients allows for generation of reports for close tracking, and this helps facilitate accordance with appointments, ancillaries and medications.

3. Medicare Annual Wellness Visits (AWVs): Beginning in March 2015, a team of registered nurses was employed to perform Medicare AWVs. Previously, these visits were done exclusively by physicians in our organization; in 2014, only 801 visits occurred. Transitioning to this nurse-based program while building standardized documentation tools to ensure compliance with CMS requirements not only increased the number of visits performed, but it also aided in the visits being done correctly. Technology allowed us to be positive that these visits were performed the same way in all of the 36 primary care locations. As of December 1, 2015, we have completed 6,561 fully-compliant visits and are projected to reach over 9,500 by the 12-month mark of the program. More

importantly, quality has improved as a result of this project. Fulfillment of items such as depression screening, Health Risk, Fall Risk, and ADL Assessments has improved from less than 1% to 95% for patients seen in this service as nurses complete a checklist of requirements for the visit and electronically notify the primary care provider of concerns areas. Likewise, other wellness items such as pneumococcal vaccination for patients over 65 has improved from 33% to 68%, and mammogram screening adherence has improved from 41% to 83%.

4. Medicare Chronic Care Management (CCM): A desire to expand the care team proved to be a challenge in a fee-for-service environment, so we felt that Medicare's Chronic Care Management code, new in 2015, was an opportunity to help fund such efforts. Similar to AWVs, we again felt a standardized toolset for enrollment encounters and serial documentation was needed for this service to guarantee compliance and promote quality. Technologically, we helped our EMR vendor develop those tools and began providing the CCM service to patients in April. Clinically, a steering committee of primary care physicians and specialist subject matter experts developed 22 disease-specific protocols for following these patients. With the implementation of each protocol, we built disease-specific tools within the EMR to allow the nurses to document discretely, track patients, and easily communicate with patients' primary care providers. Through December, we have enrolled over 1,900 patients, and these numbers continue to rise. Case managers have panel sizes from 250-300 patients and are centrally managed but imbedded in the primary care settings. The ROI on the venture has been favorable, and we continue to promote the project and expand the efforts. Like with nurse AWVs, more important than the quantity of services we have provided is the outcome of this intervention. For instance, in the diabetic population, patients followed in the CCM service compared to Medicare patients not followed in CCM are twice as likely to be up-to-date on eye exam, foot exam, and lab testing. A further addition to this project in the fall of 2015 was incorporation of predictive modeling data to do two things: first to focus more intense management on CCM-enrolled patients who are at higher risk of ER usage and/or hospitalization, and second to promote CCM enrollment for the patients with high risk scores. Beyond what is 'required' for CCM, we are also capturing self-efficacy and intervention data to help mold our efforts of the future. Leveraging the EMR has been critical to the success of the CCM program, not only in performing the services in a compliant fashion but also in a way that is advancing our goal of providing better care. While still too early to make conclusions regarding the ultimate long-range target of better quality with lower cost, CCM has clearly had significant favorable impact on both patients reporting a sense of feeling better-cared-for and physicians reporting an ability to function more efficiently and effectively.

Lessons Learned

Hattiesburg Clinic received the Stage 7 Award on November 16, 2015. We are still early in our journey of population health and have a path ahead full of additional opportunities. We are making positive strides, and it has only been by leveraging Health IT that we have been able to take the important first steps toward closing care gaps that are so widely prevalent in our region of the country. Looking forward, we embrace the exciting challenges still to come, fully understanding that using HIT is paramount to our efforts.