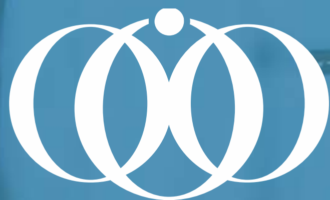
Tackling Tobacco Through Re-engineered Primary Care

Daren Wu, M.D.
Chief Medical Officer



OPEN DOOR
FAMILY MEDICAL CENTERS

Learning Objectives

- Understand the key stumbling blocks that can interfere with tobacco screening and treatment, including the difficulties in prioritizing projects and engaging clinicians around quality improvement in a busy primary care setting
- Develop and train support staff to work in a team-based primary care environment, broadening accountability and increasing workflow efficiency
- Incentive clinicians through pay-for-performance to help achieve organizational aims around tobacco screening and treatment

Key Stumbling Blocks

- Perceived lack of time for clinicians to spend with patients
- Documentation issues: clinicians do not always document tobacco screening and cessation activities correctly and efficiently in the electronic medical record
- Clinicians not realizing/believing how poorly they may be performing on tobacco screening and cessation
- Organizational culture, defined by leadership, may not support a drive towards improving clinical quality, including tobacco initiatives

Why we should care about Tobacco

Per the CDC:

"Tobacco use remains the single largest preventable cause of death and disease in the US. Cigarette smoking kills 480,000 Americans each year. In addition, smoking-related illness in the US costs more than $300 billion a year."

The Conundrum

Despite the widely publicized risks, and in spite of the gradual decrease in smoking prevalence over the years, there are still more than 37.8 million smokers in the US, as of 2016. That's 15.5% of the adult population!

It’s worse among the underserved

By Education[3]

Education Level	Prevalence
Less than high school	24.1%
GED	40.6%
High school graduate	19.7%
Some college	18.9%
Associate degree	16.8%
Undergraduate degree	7.7%
Graduate degree	4.5%

By Race/Ethnicity[3]

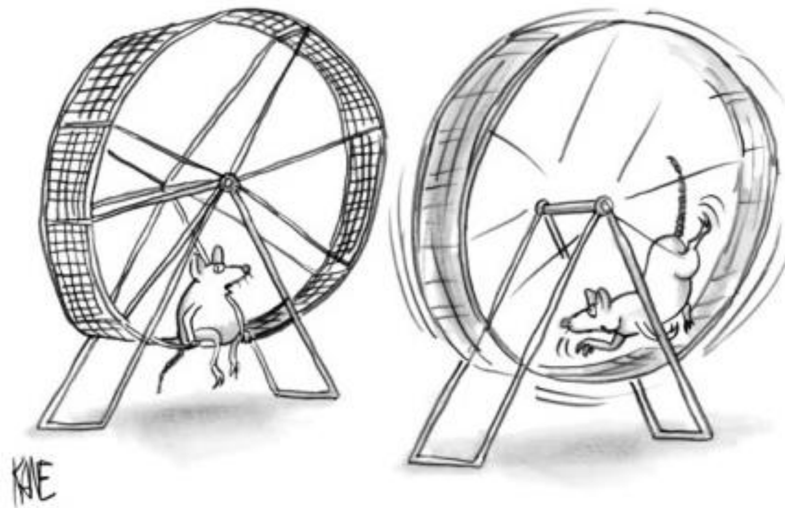
Race/Ethnicity	Prevalence
American Indian/Alaska Natives (non-Hispanic)	31.8%
Asians (non-Hispanic)	9.0%
Blacks (non-Hispanic)	16.5%
Hispanics	10.7%
Multiple Races (non-Hispanic)	25.2%
Whites (non-Hispanic)	16.6%

By Poverty Status[3]

Income Status	Prevalence
Below poverty level	25.3%
At or above poverty level	14.3%

3. Jamal A, Phillips E, Gentzke AS, et al. Current Cigarette Smoking Among Adults—United States, 2016. Morbidity and Mortality Weekly Report 2018;67:53-59. DOI: https://www.cdc.gov/mmwr/volumes/67/wr/mm6702a1.htm [accessed 2018 Jan 30].

Getting around Time Barriers through Team-based Care



"I had an epiphany."

Take all that Prevention…

It would take a typical primary care physician in this country 7.4 hours per day just to attend to the recommendations on preventive services found in the USPSTF

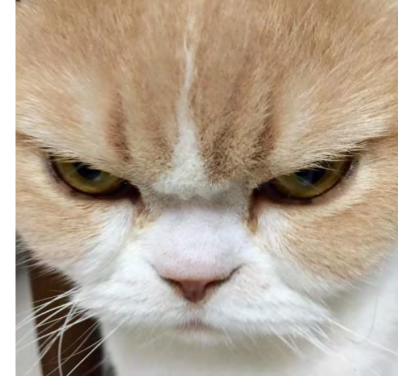
- American Journal of Public Health, April 2003

…throw in Chronic Diseases…

It would take a typical primary care physician 10.6 hours per day to attend to the 10 most commonly seen chronic conditions.

- Annals of Family Medicine, May 2005

…and sprinkle in the acute care



Adding acute care needs to the usual preventive and chronic illness management that a family physician takes care of, we arrive at 21.7 hours per day needed by a physician to adequately handle all these areas of needs

- Annals of Family Medicine, Sept/Oct 2012

Given the impossibility of their situation, are we surprised when clinicians don't respond?

Point…and Counterpoint!

Reality check #1: In a traditional workflow setting, clinicians do NOT have the time to do a good job in the time they typically are allotted

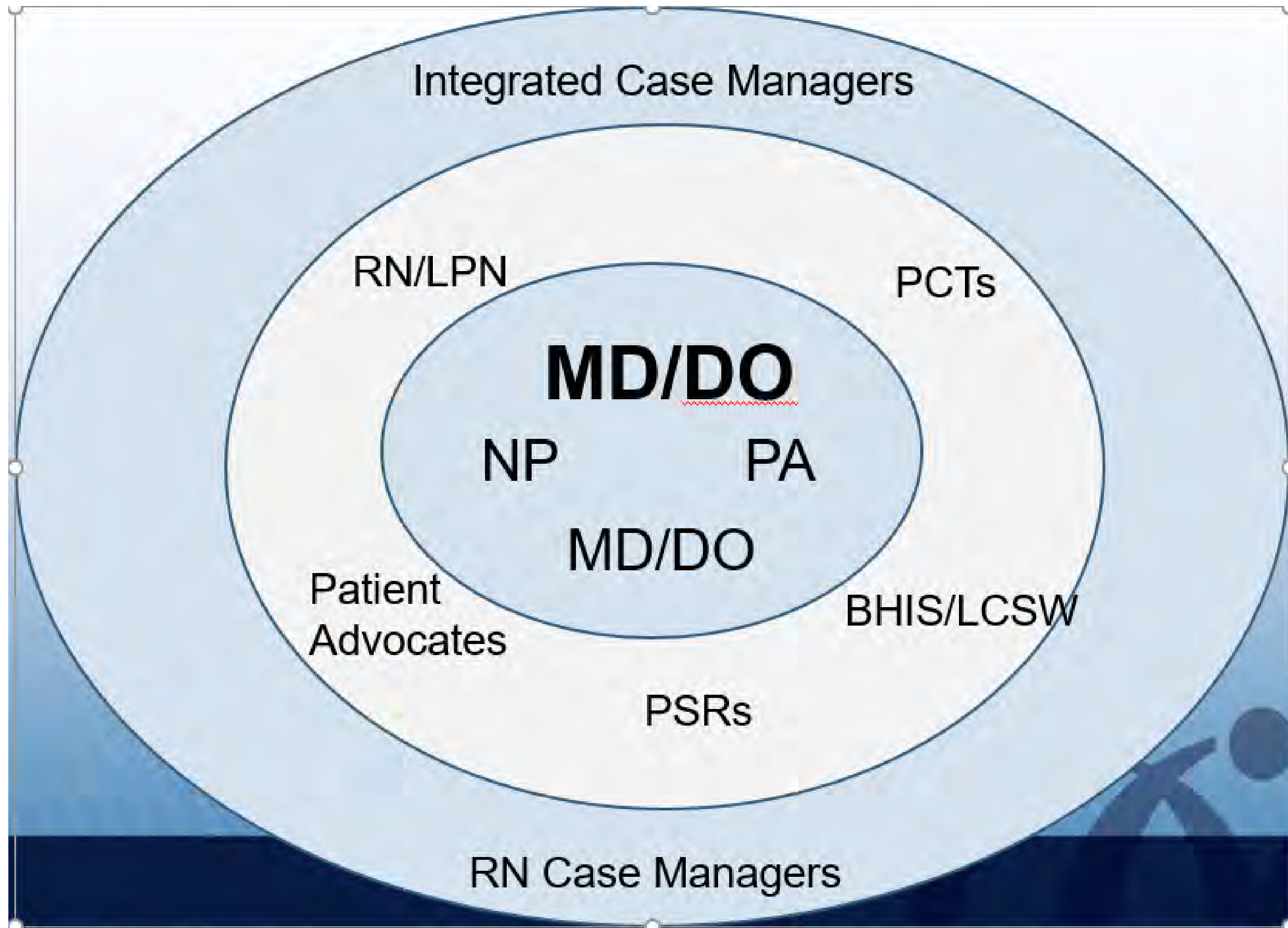
Reality check #2: We cannot afford to give every patient the time they need at every visit because due to the expenses of running a practice, the majority of practices would fail financially if every patient got all the time he/she needed

The Solution to the Time Challenge

Re-imagine primary care

Clinicians need more help if they are to succeed in what we ask them to do. If we want them succeed in delivering high quality care to the largest population of patients possible, we have to surround them with a capable team, armed with data, to help them achieve our goals

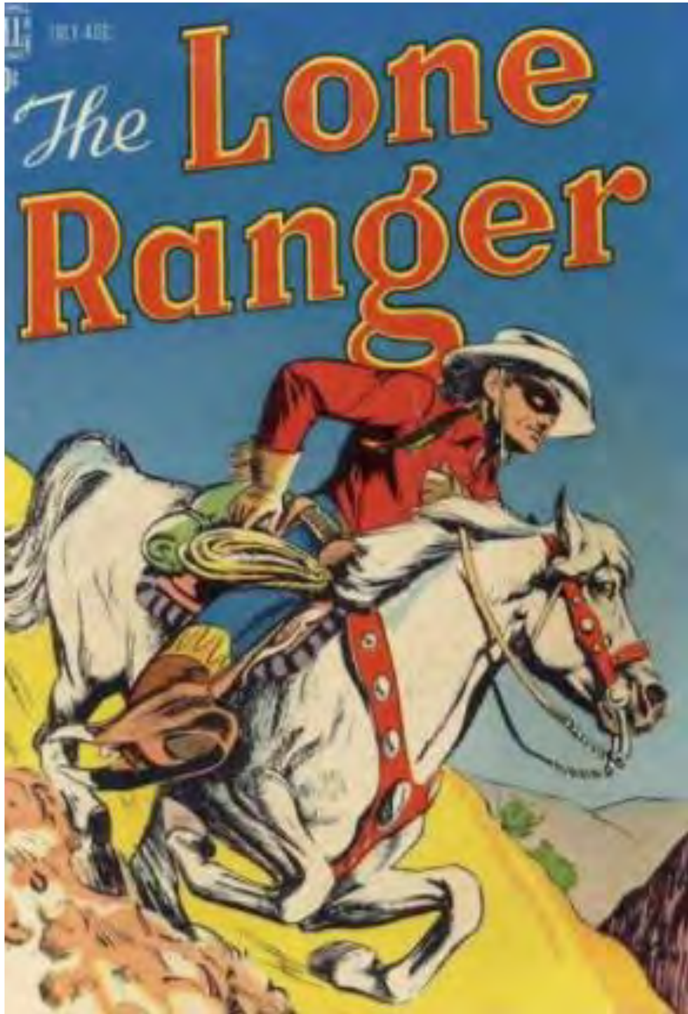
Team-Based Care in Open Door

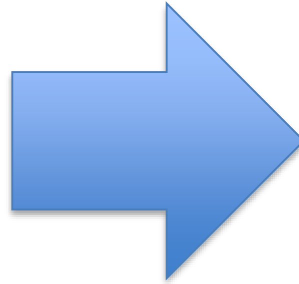


The Morning Huddle

- Pre-visit Planning (PVP) is a key practice transformation undertaking
- Done consistently, it significantly reduces the usual chaos and free-for-all that often characterizes busy primary care practices
- It brings the medical assistant into sharing the care so that more is done for the patient, with less time needed from the clinician

Team-based Care Transforms the Clinician





Our Pre-Visit Planning tool

- For our morning huddles, we use products called Azara and Relevant to pull out recognized gaps in care from the EMR and then summarize them in a printable handout

Visit Planning

Daren Wu has 22 appointments on **02/23/2018**

9:00 AM
Comp M

Male [redacted] PCG: Daren Wu
Risk Score: 0.5

Care Gaps

Seasonal Flu Vaccine
Recommended Intervention: Provide seasonal flu vaccine

Tobacco use screening - P4P
Recommended Intervention: Screen for tobacco use

Quality Measure Warnings

Adolescent Well Care (Goal 69%)
Tobacco Screening/Intervention (Goal 85%)
Depression Screening and Followup (Goal 60%)

9:30 AM
Brief M

Male [redacted] PCG: Daren Wu
Risk Score: 0.5

Care Gaps

Dental
Recommended Intervention: Schedule Dental Appointment

Seasonal Flu Vaccine
Recommended Intervention: Provide seasonal flu vaccine

HCV Screening
Recommended Intervention: Order HCV Ab. test

Quality Measure Warnings

Depression Screening and Followup (Goal 60%)
Colorectal Cancer Screening (Goal 60%)
Adult Seasonal Flu Vaccine
HIV Testing
Tdap Last 10 Years: Adults 18+
BMI Screening and Follow-Up for Adults (UDS)

Staff “Ask”, and Clinicians “Act”

Staff “Ask” about Tobacco use and willingness to quit:

- Clinicians and their support staff review these gaps in care sheets in the morning, before patient care starts
- Staff start the conversation around these care gaps while rooming patients, such as asking about tobacco use, and – if they smoke – whether they are willing to consider quitting

The not-so "Smart Form" in our EMR

Mt Kisco Open Door
30 West Main Street
Mt Kisco NY 105491910
Ph: 914-666-3272 Fax:914-666-3287

Name:

Are you a:

- ☐ current smoker
- ☐ former smoker
- ☐ never smoker
- ☐ light tobacco smoker
- ☐ heavy tobacco smoker

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Name:

If 'current smoker' : Are you interested in quitting?

- [ ] Ready to quit
- [ ] Thinking about quitting
- [ ] Not ready to quit

Staff “Ask”, and Clinicians “Act”

Because the staff has already asked about tobacco use and - if an active smoker - the willingness to quit, clinicians can be more engaged with their patients. Tobacco cessation can be a more vibrant conversation, rather than a rushed one.

If a patient is not ready to quit, the clinician can note that and move on, or engage in motivational interviewing and assess the patient’s readiness to change

Incentivizing Clinicians to tackle Tobacco Use/Cessation through Pay-For-Performance

Pay-For-Performance

Since 2012, Open Door has been using Pay-For-Performance (P4P) to incentive clinicians to work on quality of care and process measures, rather than just paying entirely on productivity or a straight salary. P4P is also helpful to prioritize things when there are many competing needs.

Done well, P4P can be a triple-win:

1. Patients benefit from improved health interventions
2. Organizations benefit from improved data statistics/outcomes
3. Clinicians benefit from compensation opportunities

Family Medicine Pay-for-Performance system

	Primary Care P4P 2018	N needed	2018 P4P goals
1	Hypertension BP < 140/90, adults 18-75	50	70%
2	Diabetes with A1c < 9 ages 18-75	30	82%
3	Asthma, Persistent ages 5-64 With ICS or LTE-inhibitor Rx	10	85%
4	Immunizations UTD thru 2 yrs Combo 10	25	75%
5	Immunizations UTD at 13 years 3 HPV, 1 TDaP, 2 Varicella, 1 MCV	5	75%
6	Cervical Cancer Screening, in last 3 or 5 years % done, 21-29 yo Q3, or 30-65 yo Q5 co-test	100	80%
7	Breast Cancer Screening, in last 2 years, % done, women ages 50-75	100	70%
8	Colorectal Cancer Screening % done age 50-75	50	60%
9	Depression screening/treatment Age 12 and older	100	75%
10	Tobacco assessment/counseled Age 13 and older	100	75%
11	Adolescents with a Well Visit within the calendar year Ages 12-21	10	80%
12	Chlamydia screening in women Ages 16-24	10	75%
13	One Key Question: Determination of Family Planning needs for women of reproductive age	100	30%
14	Alcohol use screening, using AUDIT-C or template Age 13 and older	100	65%
15	Substance use screening Age 13 and older	100	30%
	Level 1: need to achieve 1-2 metrics Level 2: need to achieve 3-5 metrics Level 3: need to achieve 6-8 metrics Level 4: need to achieve 9-15 metrics		

Open Door's Pay-for-Performance system

Clinicians have a bonus potential ranging from 8-15% of their salary, based on levels of experience.

The bonus potential has four parts:

1. 50% - individual clinician hits visits target
2. 15% - clinician's site hits visits target
3. 25% - clinical pay-for-performance rating
4. 10% - specific goals established between individual clinician and his/her medical director

Leadership: Charting the Course towards Value Based Payment

Value Based Payment

Even though volume-based care continues to be the primary driver for healthcare reimbursement right now, we are accelerating towards a vastly different healthcare payment model, one that is based on improved outcomes, improved process measures, and lower cost. It’s large-scale Pay-for-Performance!

Lead your clinicians towards VBP

Value based payment (VBP) is so alien for many clinicians. Most clinicians are used to the payment methodology of “Production = Compensation”

In the VBP world, it matters more that clinicians spend more time addressing and improving a range of patient issues – which takes more time – rather than just seeing lots of patients

Quality Counts more than ever

While shifting to a payment methodology of quality over quantity should come as a breath of fresh air, it instead is frequently met with doubt and skepticism

Does the organizational culture set the tone for clinicians to do what we want them to do?

Quality is what clinicians want to give!

Once clinicians understand that delivering excellent clinical quality is the most important organizational driver, they ***naturally will start reassessing work flows***. They will be more accepting of having staff help with moving the quality needle. They will search for, and use, data to improve clinical measures.

And…they will figure out that documenting all of this is IMPORTANT!

Surviving the EMR

Helping clinicians and staff document Tobacco screening and Cessation

Documentation is an Achilles Heel

The saying used to be "If it isn't documented, it didn't happen"

Now, it's all about "If it isn't documented in the specific ways that insurance companies and Uncle Sam can track, it didn't happen"

The best clinical and narrative effort can easily be wasted by insufficient or "incorrect" documentation

Documentation must be Easy!

Clinicians already spend too much time on EMR documentation

There is widespread “check box” clicking fatigue

Automate cessation efforts through the use of Templates, Order Sets, and Macros

Our Tobacco Order Set, page 1 of 2

Name	Strength	Take	Freq	Duration	Refills	Route	Formulation	Dispense	Date	Status
Chantix Starter Pack	0.5 mg-1 mg	1 tab(s)	2 times a day	12 week(s)		orally	tablet	168	-	Other Actions
Chantix	1 mg	1 tab(s)	2 times a day	12 week(s)		orally	tablet	168	-	Other Actions
Nicotine patches	21mg/24 hour	Apply once daily						1 month	-	Other Actions
Nicotine Patches	14 mg/24 hour	1 patch	daily	28 days	0	to skin	patch	28 patches	06/09/2017	Other Actions
Nicotine Patches	7mg/24hr	Apply once daily						1 month	-	Other Actions
bupropion	150 mg/12 hours	1 tab(s)	2 times a day	30 day(s)		orally	tablet, extended release	60	-	Other Actions

Labs — AssignedTo: — Order — Browse

Description	Lab Company	Frequency	Duration	Date	Status

Diagnostic Imaging — AssignedTo: — Order — Browse

Description	DI Company	Frequency	Duration	Date	Status

Procedures — AssignedTo: — Order — Browse

Description	Frequency	Duration	Date	Status
BEHAV CHNG SMOKING 3-10 MIN	-	-	-	Other Actions
BEHAV CHG SMOKING >10 MIN	-	-	-	Other Actions

Immunizations — Order

Name	Dose	Date	Status
Therapeutic Injections			

Smart Forms

Name
Fax To Quit
Tobacco Control

Our Tobacco Order Set, page 2 of 2

Appointments — Order

	Follow-Up In:	4W
	Follow-Up In:	1W Social work for smoking cessation

Referrals — Order

Physician Education

PDF

WEB REFERENCE

Patient Education

PDF — Order

flyer.pdf

WEB REFERENCE — Order

Letters

	Name	

Speciality Forms

	Name	

Notes — Apply

Apply Browse

Begin using Nicotine patches and Bupropion 150 mg. Apply a nicotine patch to the skin 18-24 hours per day (leaving it on at night might interfere with sleep quality). Start taking the Bupropion 150 mg once daily in the morning for 3-4 days, and if there are no side effects then increase to twice a day (morning and in the late afternoon). Do not take the afternoon dosage past 5 pm, as this may cause insomnia.

Apply Browse

Risks of smoking reviewed, and cessation strongly encouraged. Discussed the various cessation modalities available, including nicotine replacement agents, medications including Chantix and bupropion. Side effects and risks of NRT and medications were discussed.

Apply Browse

Anyone who uses tobacco products is at higher risk for many illnesses that are linked to smoking, including emphysema, stroke, heart disease, many cancers, and other conditions. Smoking cessation is strongly advised, and there are medications and nicotine-replacement agents that can be used, in addition to counseling options.

Our Tobacco Template – It's 1 Click!

Assessment:

Assessment:
1. Current smoker - F17.200 (Primary)

ICD-10 pulled in

Plan:

1. Current smoker
Clinical Notes: Risks of smoking reviewed, and cessation strongly emphasized. Reviewed cessation options with patient.

Generic blurb pulled in

Procedure Codes: 99406 BEHAV CHNG SMOKING 3-10 MIN

CPT 99406 pulled in

Preventive:
Counseling: Smoking - Patient counseled on the dangers of tobacco and if currently smoking urged to quit. ..

Additional thoughts/needs

Do not assume all your clinicians have the knowledge to treat tobacco use! Do they need a training?

Getting patients to say "yes" to considering tobacco cessation is hard. Would trainings on motivational interviewing help?

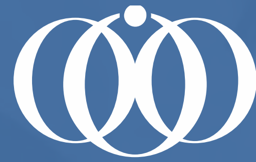
Having good data capabilities is a key necessity, because it takes advantage of some clinicians traits:

- Clinicians are driven by data
- Clinicians do not like knowing that others are outperforming them

Summary

To succeed on Tobacco Screening and Cessation:

- Get around as many key stumbling blocks as possible:
  - make EMR documentation in structured fields as efficient and easy as possible
  - share data with clinicians to gain their engagement in screening and cessation efforts
  - leadership must mandate quality, not just quantity
- Team-based staff involvement to help clinicians around the scarcity of time to tackle so many issues
- Pay-for-performance as a financial incentive



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Questions?

dwu@odfmc.org
(914) 373-0419