eClinicalWorks

CASE STUDY

NORTHERN OHIO MEDICAL SPECIALISTS (NOMS)

A MULTI-SPECIALTY PHYSICIAN GROUP SERVING THOUSANDS IN RURAL NORTHERN OHIO, WITH A FOCUS ON CHRONIC CARE MANAGEMENT.

improving healthcare together

eClinicalWorks

CASE STUDY

Northern Ohio Medical Specialists (NOMS)

Building a Team for Chronic Care Management

The Challenge

A rapidly growing regional medical center serving several largely rural counties in Northern Ohio needed more effective outreach to chronically ill patients — to enhance wellness, to quantify the services they were providing, and to help implement a new reimbursement models.

The Solution

NOMS Healthcare implemented Chronic Care Management from eClinicalWorks, building a team of 18 care providers and case managers to assist physicians, and keeping a relentless focus on enrolling patients and providing the highest quality care.

The Results

In two years with CCM, NOMS enrolled more than 860 of 16,000 eligible patients, and documented better care, fewer hospitalizations, and cases of early detection of cancer and other conditions that meant better outcomes for individuals and their families.

Introduction

NOMS Healthcare — Northern Ohio Medical Specialists — is a 120-provider group practice with locations in six counties in Northern Ohio, including a main location in Sandusky. With thousands of patients of all ages and from all walks of life, NOMS providers have seen it all, including a growing population of older patients with multiple chronic conditions.

As at so many practices across the country, the physicians and other providers at NOMS found they were spending more and more time with those patients, many of whom have heart disease, diabetes, high blood pressure, and other conditions that require frequent checkups, close monitoring, and occasional hospitalizations.

Providers at NOMS found themselves in a place that is familiar to many medical professionals — torn between wanting to provide the high-quality and intensive care such patients need, and the knowledge that reimbursement models were failing to keep up with the realities of their healthcare practices.

In 2013, NOMS began implementing eClinicalWorks' CCMR Population Health solution, which was later revised as the Chronic Care Management (CCM) module, designed to work with new reimbursement models developed by the Centers for Medicare & Medicaid Services (CMS). NOMS began implementing CCM in January 2016.

"Part of the problem is that we were providing these services before CMS recognized the value of them and began offering reimbursement," said Rebecca Rohrbach, Doctor of Nursing Practice, Vice President of Population Health for NOMS, and the manager of the Sandusky headquarters.

"So when our patients were suddenly being asked to pay $8 a month as a copay, they didn't understand," she said. "They wondered why we were now charging them. So that was a huge barrier for some of our patients. We're dealing with many patients who can't afford their medicine, and there are a lot of social determinants that affect their health which were not being met."

But the providers in the NOMS system knew that full-scale implementation of CCM was the best answer to meeting the needs of their patients. From modest beginnings, they set out to build a team to improve the quality and range of the care they could offer.

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Building a CCM Implementation Team

While providers at NOMS knew they had a workable idea, making that idea a reality was a challenge.

"At first, we did not have all the providers on board," said Kira Rodriguez, a social services care manager. "It was a very new idea, and it still is. Then, slowly but surely, the doctors would let us work with a couple of their patients. They'd say to us 'I don't know what to do with this patient, they're calling us every day, they're in the emergency room all the time. Would you call them?'"

Getting the doctors to buy in was just the start. Patients, too, were initially skeptical.

“It was like we were cold-calling,” Rodriguez said. “They thought that we were telemarketers. It was so new. The idea of the doctor having someone call them at home? They were like ‘What do you mean, my doctor has you calling me at home? I don’t have an appointment coming up.’”

“Sometimes they don’t understand it at first because they’re not getting anything out of it,” said Tammy Wallhead, a registered nurse. “So that’s where you try to build that trust, just calling them every month. I’ll say ‘You’re not due until September to see your provider, but I want to let him know how you’re doing at home, in between appointments.’”

NOMS providers have successfully implemented the Chronic Care Management program, capturing value for non-face-to-face interactions as they analyze patient cases and data in the eClinicalWorks EHR.

Wallhead and her colleagues use those calls to find out whether a patient may have seen other providers or specialists, giving them time to obtain notes and records from those interactions.

“It’s not just a primary care provider doing it all,” she noted. “We have a team, and so, when they finally trust that I’m part of their team, I can build that relationship.”

And while the nurses making the calls had no doubt about the value and effectiveness of their work, even they were surprised by how quickly the time adds up. The CCM program stipulates that reimbursements will be based upon proving 20 minutes of non-face-to-face time with a patient each month, and while those targets were generally being met and exceeded, providers previously lacked an effective way to quantify the time they were spending on their patients.

“The timer is a good tool to have,” Rodriguez said. “Every time we make contact with the patient, that timer keeps track for us. And we found that we were really undervaluing our time before CCM because we didn’t have a time, we were just ‘Oh, I was probably on the phone for 10 minutes.’ Really it was 17 minutes. But now that we have a timer, we’re seeing that.”

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"We're spending a lot more time on our patients than we initially thought we were," said Angela Downs, LPN and Clinical Advocate. "If that clock didn't exist, I still would put in the amount of effort I do for each individual patient. But patients realize our time is valuable, and I do talk personally about what my job is with my patients."

The other critical time element with CCM was the time (and patience) needed to let the program take hold.

"It takes a good six months when you're trying to develop relationships over the phone for them to develop that trust," Rohrbach said. "It goes from our advocates and care managers calling them, repeatedly asking 'How are you doing,' until they finally understand that this is their go-to person."

That buy-in, when it happens, gets noticed by the physicians themselves, who receive better information about their patients, and meet better-prepared patients when the office visit comes around.

"The patients overall are responding well to the program," said Dr. Mark R. Hoelzle, a family practitioner who works in NOMS' Fremont, Ohio location. "I wouldn't say 100%. Some of the patients who I think would get a benefit from the program don't buy in. They are resistant to having more phone calls, they want to be more left alone. But for the most part, most of the patients are appreciative. They really enjoy the phone calls from our staff."

The Care Managers at the Heart of CCM

To understand exactly how NOMS' care managers operate, it helps to forget the conventional wisdom about the roles that doctors, nurses, and other healthcare providers usually play; because, while the CCM program contains plenty of guidance on complying with

CMS rules and regulations, there cannot be a detailed blueprint for how to carry out the work, which is as diverse and challenging as the patients themselves.

Sometimes, the calls that these nurses and case managers place and receive don't have much to do with medicine itself, at least as far as exams and medications go. It could be a matter of an elderly patient who keeps going to the emergency room because they do not have and cannot afford an air conditioner, which exacerbates their breathing problems. That patient's advocate might spend time researching their eligibility for some financial assistance, helping them remain comfortable at home — and out of an expensive hospital setting.

One nurse told about a 90-year-old patient she speaks with frequently about his favorite hobby — kayaking. He insists he'll die before he's found in a senior center playing cards. But that kind of enthusiasm for an active life isn't the sort of thing that a doctor can necessarily take the time to discuss. An advocate has that time and can vouch for the positive impact it has upon that patient's well-being.

There are stories about elders who are eligible for hearing aids, but either didn't realize they were eligible or felt too proud to accept any help — until a case manager helped educate them or work through their feelings about their medical needs. In some cases, advocates help determine that an adjustment to a patient's medication can make a big difference and avoid hospitalization.

There are stories about elders who are eligible for hearing aids, but either didn't realize they were eligible or felt too proud to accept any help — until a case manager helped educate them or work through their feelings about their medical needs. In some cases, advocates help determine that an adjustment to a patient's medication can make a big difference and avoid hospitalization. With others, the work amounts to talk therapy, helping them understand that while others may have still greater needs, there's nothing wrong with accepting a bit of help.

"I manage over 100 patients by phone," said Downs. "I've built extensive relationships with some of them, to where if something was to happen, I would definitely want to be present. They come into the office now after they see their physician, and come see me as well, and we kind of talk about what is the next plan. You know, you've seen the doctor again, what are we going to do? Then we also have small talk about what they're doing next weekend, their hobbies, what they've got going on."

10 Most Common Chronic Conditions For Americans 65+

80% Have at least 1 chronic condition

68% Have 2 or more chronic conditions

According to the Centers for Disease Control (CDC), about half of all adults—117 million people—have one or more chronic health conditions. And eight in ten adults sixty five and older have one or more chronic health conditions. Seven of the top 10 causes of death in 2015 were chronic diseases. Two of these chronic diseases—heart disease and cancer—together accounted for nearly 48% of all deaths.

A HEAVY TOLL: Chronic health problems such as cardiovascular disease, diabetes, obesity, cancer, and kidney disease account for more than 75% of the nation's $2.7 trillion in annual spending for medical care.

The Top 10

AMERICA BY THE NUMBERS: Among the 10 most common chronic conditions, the prevalence of multiple chronic conditions is high, with over two-thirds of Americans 65 and older having two or more chronic conditions and 14% having 6 or more chronic conditions.

Hypertension
58%

High Cholesterol
47%

Arthritis
31%

Heart Disease
29%

Diabetes
27%

Kidney Disease
18%

Heart Failure
14%

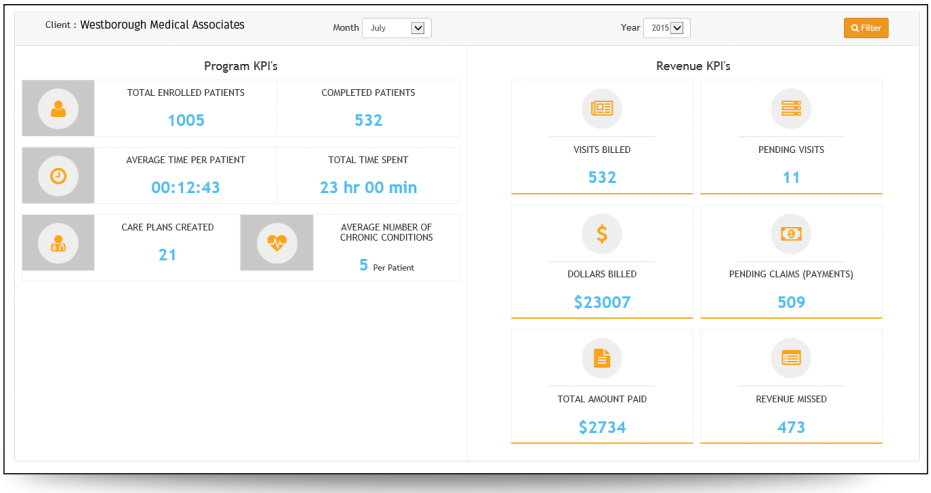
Depression
14%

Alzheimer's/Dementia
11%

COPD
11%

SOURCE: Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov

Make no mistake, proper implementation of the CCM program does require a good deal of careful documentation. But NOMS providers found that eClinicalWorks' CCM solution made that process much easier.



The eClinicalWorks CCM Dashboard.

The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals.

In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions.

"It had been a manual entry process into an Excel sheet, with double-charting, to ensure that we were meeting the requirements," Rohrbach said. "So the program was really helpful. It lets the provider know when a patient qualifies. According to CMS, about 60% of patients do qualify, but in reality not all 60% need that extra attention. But the doctors know which ones do."

"It's really nice because we are able to communicate with the physician through the program," says Amanda Farrell, a clinical advocate. "The physicians are able to get in and look at our care plans to see when they're done. It's nice for us because we can see when another care plan is due. And we can send tasks to the physicians. It really is helpful in our daily functions with the patients."

Documenting Results

For Rohrbach, one of the simplest measures of success was the feedback from physicians, whose quality of life and job satisfaction improved.

"They're not the bottleneck anymore," she said. "Patients can go to the advocate."

"eClinicalWorks is really a key cog in making the CCM program work," said Dr. Hoelzle. "The whole premise is enhanced communication, and medically and legally we need to have a way to document this communication. It's all on one platform, so it really makes it much more efficient than if we had to do a paper chart, or use two or three different programs."

> “We’re focusing on preventive measures, making sure we’re looking at smoking cessation, depression screening, things like that. That’s a big part of what we do. We’re looking at ER utilization, to see why they’re going to the ER, and whether there are things we can educate patients on. And we look at any social supports, because most of the time our senior population is lacking in that kind of support.”
>
> — Kira Rodriguez, social services care manager

For the advocates, documentation to date is largely anecdotal but persuasive.

Rodriguez worked with an older Medicare patient with a family history of colon cancer who was terrified of having a colonoscopy and kept resisting her doctor’s recommendations. Finally, Rodriguez made the appointment, kept encouraging the patient, and helped her follow through. As a result, the doctor found several pre-cancerous polyps and was able to successfully treat her before she developed cancer.

Downs worked with a man who was in pain and needed orthopedic surgery but was reluctant to do so because his wife didn’t think he was strong enough to undergo such an operation. She explained to the man’s wife that doctors would first screen her husband to be certain.

“I told her ‘We’re not going to have him go through the surgery if we don’t think he’s going to make it,’” Downs said. His wife was reassured, he had the surgery, and it was a huge success. “He’s right back to the whippersnapper that he was, and he thanks me every single day for doing that. And now I have an amazing relationship with his wife. She calls me when she’s concerned about him, and they both get on the phone and laugh and chat with me. You go home and feel like you’ve done something that day!”

And Wallhead tells of a woman who wasn’t taking her medications — and had rising blood pressure and sugar levels as a result — simply because she thought she couldn’t afford them.

Wallhead did research on the woman’s behalf and determined she was eligible for free medications. A local pharmacy even delivered her medicine for free. And Wallhead helped the woman obtain a special chair so that she can now use the shower without fear of falling.

Possibilities for Growth

The staff at NOMS know that the CCM program has been a success, and are confident they can build upon that success, through statistics, prevention, and outreach.

Improving primary care for patients with chronic illness: the chronic care model

RESEARCH STUDIES have consistently demonstrated that chronic care management services such as medication reconciliation, coordination among all care providers, arrangements for social services, and remote patient monitoring reduce the cost of care for chronic disease patients, while also improving their overall health.

Physician benefits

- A stronger patient-physician relationship
- Improved access to care and continuity of care
- Improved clinical experience and patient satisfaction
- Reduced rates in preventable hospital admissions, readmissions, and emergency room visits
- Improved overall quality and cost performance
- Practice readiness for value-based care payment models
- Enhanced revenue for your practice

Source: Texas Medical Association, 2017
https://www.texmed.org/ChronicCareManagement/

"In the past year-and-a-half, the program has really evolved, because the doctors are embracing it," said Wallhead. "I have a provider who, as soon as the patient leaves his office, sends me a note telling me how the visit went. And he may give me a list of 10 things for them to work on. That's pretty overwhelming for a patient who has a lot of chronic conditions, so he's like, 'Can you please call them tomorrow and follow up with them?' So when I call them they are relieved, and sometimes they call me first, saying 'Tammy, I need some help with this.' So now we have a couple of months to really work on these goals on what he would like to see happen."

"We need to show those statistics," Rohrbach said. "I think we can do it with the claims data. I think eClinicalWorks will continue to develop this program and make it better. We know we're good, but unless they see numbers, patients sometimes won't believe you. So we need that piece to be brought in to show the world that this program is really making a difference in the quality of our patients' lives with prevention. There's so much more to be learned at the point of service."

"We're focusing on preventive measures, making sure we're looking at smoking cessation, depression screening, things like that. That's a big part of what we do," said Rodriguez. "We're looking at ER utilization, to see why they're going to the ER, and whether there are things we can educate patients on. And we look at any social supports because most of the time our senior population is lacking in that kind of support."

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> — Dr. Mark R. Hoelzle, family practitioner, NOMS Fremont

“I think more physicians are going to scratch their heads and say ‘Hey, why aren’t we getting on board with this?’” Downs said. “At first we were so small we couldn’t get our message across. Now that we have things ironed out, we’re seeing it every day in other offices. People are saying ‘Well, get me an advocate, get me a care manager, I want this program in our office.’”

Downs said that the key to success with CCM is to focus on building rapport early by following up with patients and doctors alike, helping each understand the difference the CCM program can make.

“It’s a long road to get the staff and the physicians to understand what it is we can and can’t do and what we can offer,” she said. “but I think once we prove it to them, there’s no reason that every office wouldn’t want to implement our program.”

“And don’t take it too hard,” Farrell cautions. “I’ve been in healthcare for 15 years, and I’ve always been a hands-on nurse, but this is the first time I’ve been building relationships with people over the phone, and for me that’s very hard. But it’s important not to give up, and make sure you’re making those calls to people. Even when they’re saying to you, I don’t want to talk to you. Because eventually, their attitude will change.” ■

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