How Do You Identify Gaps in Care?

>> Population Health
Define Gaps in Care

>> The management of most medical conditions is influenced by gaps in care: the discrepancy between recommended best practices, and the care that’s actually provided

>> Gaps in care can be referred to as gaps in office visits, lab tests, procedures, and pharmaceuticals

>> Gaps are usually the result of obstacles preventing patients and physicians from implementing care recommendations
  – Age
  – Gender
  – Condition
  – Complications
Why Measure Gaps in Care?

- Centers for Medicare and Medicaid Services requirements
  - MACRA/MIPS
  - Cost utilization
- Value-based care incentives
  - HEDIS
- Triple Aim
  - Improve the health of the population
  - Enhance the patient experience of care (including quality, access, and reliability)
  - Reduce, or at least control, the per capita cost of care
Where Do You Start?

>> Key to measurement
  – Population health – EHR/Registry/Excel
“We just got an update to the user manual for our Electronic Medical Record system. Where do you want it?”
EHR Support

>> Can your EHR build the reports to pull discrete data?
   – A list of patients by age, gender, conditions, preventative services completed
I Don’t Have an EHR – Now What?

>> A list of patients by age, gender, conditions, preventative services completed by your billing service OR in an Excel spreadsheet
EVIDENCE-BASED CARE MEDICINE
Evidence-Based Care Medicine
Evidence-Based Care Medicine

Can your EHR build the guidelines to set alerts?

Where do the guidelines come from?
- HEDIS reports
- Choosing Wisely®
- United States Preventive Services Task Force (USPSTF)
- National Quality Foundation (NQF)
CARE COORDINATION
Team Approach
• Everyone knows their role
• Routine huddles

Team Responsibilities
• Receptionist
• CMA/roomer
• LPN/RN
• Care manager
• Provider

NOTE: Not just for primary care providers
Care Coordination

**Planned care visit**
- Chart prep work
  - Are results received, referral summary in record, due for preventative visits
  - Tracking tests/referrals
- Outreach
  - Ordered tests not completed
  - Preventatives not done
  - Missed appointment

**Short video on PCV** [www.improvingchroniccare.org](http://www.improvingchroniccare.org)
PATIENT ENGAGEMENT
Patient and Family Engagement

Why are they not engaged?
- Patient comments
  - “It’s too hard”
  - “I don’t have time for that”

In the United States, some 3.8 billion prescriptions are written every year, yet over 50% of them are taken incorrectly or not at all

Note: http://www.medscape.com/viewarticle/818850
Patient and Family Engagement

>> What is the level of health literacy of the patient/family?
>> Is there a cognitive issue?
>> What other barriers could be there?
>> Is it functional (basic reading/writing) or is it interactive (social/cultural)?
>> How much education have we given the patient?
Patient and Family Engagement (Cont’d)

>> Screening for patient barriers

Health Literacy
- REALM-SF score
- Test of Functional Health Literacy in Adults (S-TOFHLA)
- Newest Vital Sign (NVS)

Cognition
- Mini-Mental State Examination (MMSE)
- Montreal Cognitive Assessment (MOCA)
Patient and Family Engagement (Cont’d)

>> Simple message from the primary care provider:

“Diabetes is a serious condition. There are things you can do to live better with diabetes and things the medical team can do to assist you. We are going to work together on this.”
Patient and Family Engagement (Cont’d)

>> Patient Action Plans

- Patient sets goals
  - What do you want to work on?
  - What are some barriers you see?
  - How can you overcome those barriers?
  - How confident are you in being successful?
THE ROAD TO CLOSING THE GAP
Closing the Gap

>> Measure the Gaps

Is someone besides the insurance carrier looking to see if you are provided good care?

What about those non-compliant patients?

Specialists who have an point of care (POC) can be a big proponent of closing the gap
Closing the Gap

>>> Measure the Gaps
- Run a regular report that shows what is missing
- Look at your patient panel
  - Who has not been in over 12 months to 24 months
- Start with one condition
  - A large population
Example: Closing the Gap

>> Diabetic Patient
1. Pull report/registry of those patients
2. Identify gaps
3. Conduct patient outreach
4. Prep patient chart
5. Track the tests/referrals
QUESTIONS
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