Separate disease activity assessments from disease management visits.

The conventional approach to chronic disease care typically involves doing both disease activity assessment and disease management during a physician visit. Seems logical and efficient, but is it? Consider it objectively. Does disease management get sufficient attention when assessment work is included in such a brief timeslot? Is assessment work the best use of the physician's time and expertise? Why are we making treatment decisions without all the assessment results in hand? Does this approach enable the best possible care?

Imagine how different physician visits would be for you and your patients if their assessment work were done in advance. The entire visit would be about *disease management* – reviewing assessment results with the patient and making a fully informed treatment plan together. You'd have all the necessary data in hand right then and there, eliminating the need to reevaluate treatment decisions once assessment results are back and then contact the patient if changes are needed.

If the idea of separating assessment work from disease management visits sounds far-reaching or unfeasible, keep reading – you might just change your mind. The fact is that every practice team in our initial pilot of this approach deemed it an overwhelmingly positive change. Vast improvements have been documented in practice workflows, patient care, patient and staff satisfaction, and practice finances.

WHEN SHOULD ASSESSMENT VISITS BE DONE?

This decision is yours to make – you just want to be sure your team has adequate time to collect all test results and compile them in the patient record prior to the physician visit. Doing the assessment work two weeks ahead of the physician visit generally allows for this, and scheduling the two visits concurrently ensures the appropriate interval between them.

WHO SHOULD DO THE ASSESSMENT WORK?

In most practices the physician is actively involved in administering disease activity assessments, even though other members of the practice team often have the skills needed for this task. So separating assessments from disease management visits involves shifting most, if not all, assessment work to other qualified team members. This has the added benefit of enabling the physician to focus on the work that only they can do, especially in the area of disease management.

So who should be doing the assessment work in *your* practice? That depends on a number of factors unique to your practice, including the makeup of your team and the kinds of assessments your patients need. Obviously, it must be someone who has the necessary competencies or is in a position to attain them. Options proving successful in other practices include nurse practitioners, nurses, and medical assistants. Some small practices have one individual responsible for assessments. Larger practices typically have more than one person doing them. Some practices that use ultrasound in their assessments are finding it more efficient, cost effective, and consistent (quality of imaging) to have a certified ultrasound technician perform all their ultrasounds rather than the physician.

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WHAT ARE THE ECONOMIC AND CARE IMPLICATIONS OF THE ASSESSMENT VISIT?

On the surface it may not make a lot of economic sense to do two visits instead of one, especially in a practice that already feels stretched beyond capacity. And you obviously can't bill both as Level 4 visits. Yet practices are finding this approach to have a positive impact on their bottom line, all while improving the quality and efficiency of care they provide. Here are a few ways practices are optimizing this two-visit approach:

a) Some practices are fine with billing assessment visits at lower rates than they could if the physician were doing them. That's because having other members of the practice care team do these visits is freeing vast amounts of time in the physician's schedule. This means the physician has more visit slots available to do more disease management visits and see more new consults, which is resulting in increased revenue and better patient access to care.

b) In other practices the physician is opting to step into each assessment visit for a brief physician global assessment. This generally takes less than five minutes and means that the visit can be billed as a Level 4 visit. This works well for practices that are cancelling disease management visits for many patients whose assessment data shows low or controlled disease activity (see C below), as it ensures a Level 4 visit even when the second visit is cancelled.

c) Having assessment data in advance of the physician visit is enabling care teams to review each patient's data prior to that visit and make a decision on whether or not a disease management visit is necessary. For patients whose disease is well controlled, that visit can often be cancelled and the next pair of assessment and disease management visits scheduled instead. The capability to cancel appointments based on comprehensive assessment data opens up many physician visit slots for sicker patients and for new patients.

WHAT DO PATIENTS THINK OF ASSESSMENT VISITS?

Patients have many different opinions, as can be expected. You'll likely find the majority agreeing that it makes absolute sense to have all their assessment results at the physician visit. You'll probably also have some who are less amenable to change or consider it too inconvenient to come in twice. But practices that are using separate assessment visits report that with a little patient education about the benefits of this approach most patients readily get on board with it. Physicians are also anecdotally reporting a higher level of engagement from many of their patients as a result of being able to see and track changes in their assessment data over time.

INTEGRATE CHANGE SLOWLY

It's not necessary, nor is it recommended, that you switch to assessment visits with all patients all at once. Changing protocols requires flexibility and a certain amount of trial and error, which is easiest to undertake on a small scale. So try out assessment visits with a small group of patients and work out any kinks in the process before adding more patients. For example, you might try scheduling assessment visits for just two or three patients a day to begin with and then continue adding to that number at a pace that is comfortable for the team. In time the assessment visit will become fully integrated into your practice and will become the new norm.