Practice Efficiency and Population Management

“A PCMH Model”

Stacy C. Zimmerman MD FACP FAAP
Disclosures:

- AFMC board of directors
- CMS Technical expert panel 2016–2017
Objectives:

- Importance of practice transformation
- Outline basis of Population Management
- Outline Patient Centered Medical Home (PCMH)
- Basic practice transformation activities
- Align measures and activities for the PCMH programs
- Practice and patient outcomes
It's the only way to go, Frank. Why, my life's changed, ever since I discovered population management!!!
Triple Aim

Better Care

Smarter Spending

Healthier People
Quadruple Aim

- Better Care
- Smarter Spending
- Healthier People
- Physician Satisfaction
AFMC 2014 Gold Award for Excellence in Healthcare!

NCQA LEVEL 3 PATIENT-CENTERED MEDICAL HOME !!!!

Voted 2012, 2013, & 2014
Reader's Choice
**Best Clinic**

Dr. Zimmerman was voted the 2009 & 2014
Reader's Choice
**Best Doctor**

Like us on Facebook!
Red River Family Medicine

Location: Clinton, AR
Providers: 2
Empanelment: 3370
EHR: eMDs
Contact Info: Stacy Zimmerman, MD
sczimmerman@yahoo.com
“If I only knew then all of the things I know now”!!
Fee For Service!!
Provider barriers to a value-based system?

- Assets to assist in physician recruitment and retention for the small practice.
- Employee recruitment and retention, options for temporary staffing??
- Practical care management options for the small practice to replace the expensive cost(s) of the patient care coordinator.
- Incentives to develop specialist care coordination agreements for seamless exchange of patient information.
- Innovative practice efficiency and patient care strategies / techniques that do not increase physician workload.
- Vendors to support EMR’s with affordable seamless population management and data exchange functions.
- IT support systems to combine provider/payer data for multiple initiatives
- Development of an Arkansas Practice registry for the small to large practice. (For practices to access information for collaboration with state and federal initiatives).
- Competition barriers between practices
What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015.

- What does Title I of MACRA do?
  - Repeals the Sustainable Growth Rate (SGR) Formula
  - Changes the way that Medicare rewards clinicians for value over volume
  - Streamlines multiple quality programs under the new Merit-Based Incentive Payments System (MIPS)
  - Provides bonus payments for participation in eligible alternative payment models (APMs)
MIPS changes how Medicare links performance to payment:

MACRA streamlines those programs into MIPS: (Merit-Based Incentive Payment System (MIPS))

Value-Based Payment Modifier Medicare EHR Incentive Programs:

CPC Plus
ACO’s and qualifying private payer incentive programs
Physician Quality Reporting Program (PQRS)

These quality and value programs for physicians and practitioners are known as Alternative Payment Models (APM).

Medicaid Value-Based Incentive Programs:

Arkansas Medicaid PCMH
How much can MIPS adjust your Medicare payments?

Based on the MIPS composite performance score, physicians and practitioners will receive positive, negative, or neutral adjustments based on the percentages below.

MAXIMUM Adjustments

Adjustment to provider’s base rate of Medicare Part B payment
Merit-Based Incentive Payment System (MIPS)

- 4% 2019
- 5% 2020
- 7% 2021
- 9% 2022 and onward

MIPS composite performance score is based on the following: (Data collection to begin 2017)

- Quality
- Resource use
- Clinical practice improvement activities
- Meaningful use of certified EHR technology
Clinical Leader (physician champion)

Technical expertise

Effective Team

Day to Day Leadership

Project sponsor
Patient Family Advisory Counsel (PFAC) (the value of patient feedback)

Alternative visits or extended office hours, Same day access and 24hr access

Patient Portal

Patient-centered processes
  Team-based care
  Population health management
  Pre and post visit planning
  Medical neighborhood collaboration

Transition of care protocol for ER and Hospital follow ups

Performance measurement and quality improvement
PCMH Practice Transformation Goals

Annual wellness visits

Emergency room and Hospital utilization reduction

Care management with Care Coordination

Decreased pharmacy costs

Access to providers and specialists

Improvement in Population health outcomes
EMR + Population Risk Stratification Model → PCMH
RISK STRATIFICATION MODEL:

Create ICD codes to track your population:

RS4 EHR HEALTH MANAGEMENT (this would be the sickest 5% of pts)

RS3 HR HEALTH MANAGEMENT (the next 25%)

RS2 MR HEALTH MANAGEMENT (the next 30%)

RS1 LR HEALTH MANAGEMENT (the remaining 40%)
Reduction in ER Utilization

Providers must educate patients during office visits about proper ED utilization.

Identify frequent users of the ED with claims data.

“Gold Pass” card for “frequent fliers” to encourage them to call the clinic BEFORE going to the ER.

Posters on appropriate ED use placed in exam rooms.
Should I really be in the ER?

YES
You should seek emergency care if you believe that your health is in serious danger or if your doctor tells you to go.

NO
You shouldn’t seek emergency care if you have something minor like a cough or cold, a small scrape or cut, or you just need refills or shots.

WHY?
Your insurance may not pay for ER care unless it’s a real emergency. Also, you might be waiting in the ER for a long time.

A FEW POSSIBLE REASONS YOU MIGHT GO TO THE ER
If you have sudden or recent onset of one of the following:
- A broken bone
- Choking
- Bleeding that won’t stop
- Blacking out (fainting)
- Swallowing poison
- Sudden, severe swelling of a joint
- A gaping wound
- Suddenly can’t speak or move
- Chest pain

If it’s not an emergency, go to your primary care physician (PCP) or family doctor. If you’re on Medicaid or ARKids First, ConnectCare can help you choose a PCP. Call 1-800-275-1131.
## Ozark Internal Medicine and Pediatrics - Care Team Tasks

### Clerical Team Members
- Greet patient in a way that engages them as a partner
- Identify patients at risk: offer improved access, refer to nurse, physician, and/or care manager
- Identify gaps in care outreach: refer high risk to nurse, physician, and/or care manager
- Collect visit/admission history since last appointment
- Document demographic information
  - Update contact information
  - Update transportation needs
- Provide patient access to community resource brochures, phone numbers and information including patient portal

### Clinical Team Members
- Complete pre-visit planning and assess history since last visit
- Address EBG care gaps/notifying team of identified gaps
- Phone portal message management
- Visit: Document clinical information
- Appropriate screening
- Patient activation engagement & education, encourage patient-physician discussions through utilization of shared decision aids or tools
- Follow-up: test, specialty, hospital, Emergency Department, transition management including education of patient upon discharge, identifying any needs, confirming correct understanding of discharge instructions, and confirming f/u with PCP
- Identify patients at risk or high utilizers- refer to care manager
- Participate in care plan, updating, adjusting accordingly, educate patients how to use in the neighborhood
- Record Care Coordination performance data
  - Timeliness of referrals, # of patients with appropriate hospital discharge protocol, etc.

### Provider Team Members (MD, NP)
- Define, implement, and utilize evidence based care for patient populations, educate clinical team members to improve continuity of care within practice
- Review & support delegation to team including creating disease specific protocols for our team to follow in order to decrease overall workload
- Leader and knowledge resource to the team
- Refer high risk/utilizers to care manager as appropriate
- Review clinical information provided
- Clinical assessment, management & recommendations
- Promote PCP- patient- team relationship
- Identify key members of medical neighborhood and inform team of resources identified
- Educate patient on reason for referral and encourage shared decision making
- Assess and improve care coordination according to performance data
...AND THAT IS WHY WE LIFT ON THREE...
Red pop up reminders for staff to address care gaps

SUBJECTIVE:

OC:
Mr. Keeling is a 55-year-old White male. This is a follow-up visit. He is here for influenza immunization.

HPI:
He presents with acquired hypothyroidism. This was first diagnosed several years ago. He is currently taking Synthroid. He denies any related symptoms.

Additionally, he presents with history of type 2 diabetes requiring insulin. Compliance with treatment has been good; he takes his medication as directed, maintains his diet and exercise regimen, and follows up as directed. Patient’s diabetes was first diagnosed 14 months ago. He follows an 1800 calorie ADA diet. Primary symptoms reported include still with bilateral leg edema and discoloration. Current mediations include metformin hydrochloride and glyburide. Most recent lab results include: HgbA1c: 8.1% (total Hgb) (12/20/19) He has lost 8 lbs.
EMR Front Office Check-In

**Process Summary:** The front office check in process describes the interaction between the patient and the front desk staff prior to the patient being ready to be seen by the nursing staff. It also highlights key system actions with a focus on Front Office and Clinical touch points.

1. Patient presents for appointment.
2. Patient completes Pre-Visit paperwork.
3. Change visit status to "Pending Check In".
4. Give necessary PPMS paperwork to patient to complete.
5. Scan Pre-Visit Paperwork documentation into EMD’s.
6. Verify insurance eligibility as applicable per Pre-Visit process.
7. Collect co-pay as applicable per Pre-Visit process.
8. Review and/or update Reason For Visit on appointment.
9. Change visit status to "Checked-In".
11. Nurse notified.
NURSE INTAKE

Patient is roomed by

Review and/or document patient advanced directives

Prior to the visit, nurses should review charts for completeness similar to their current process. (Ex: have lab results required for the apt been received?)

Review and/or document patient allergies

Review and/or document patient preferred pharmacy

Nurse opens progress and reviews/updates Chief Complaint

Review and/or document current medications

Nurse records vital signs

Nurse selects vitals taken checkbox

Should the nurse collect/review history for the visit?

Social Hx
Family Hx
OBGYN Hx
Surgical Hx
Historical Imm?

Are protocol orders appropriate for visit?

NO

YES

The nurse order set can also be used to select the assessment/place orders.

Document the patient assessment.

Place protocol order for the patient.

No protocol orders appropriate for visit?

Change visit status to "Provider".

If protocol orders appropriate for visit?

Review and/or enter patient Hx items.

Provider is notified patient is ready.

PROCESS SUMMARY: Nurse intake flow accounts for nursing process that occurs between the time the patient is roomed and when the patient is ready to be seen by the provider.
**Ozark Internal Medicine & Pediatrics:**

**Patient:**

DOB:

I, the patient and care team mgr, have discussed the following care plan and the patient has received a copy.

<table>
<thead>
<tr>
<th>Assessment/Nursing DX</th>
<th>Medications associated with Care Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td></td>
</tr>
<tr>
<td>Ineffective Airway Clearance</td>
<td></td>
</tr>
<tr>
<td>r/t: increased production of secretions, decreased energy &amp; fatigue</td>
<td></td>
</tr>
<tr>
<td>AEB: Patient states “I am having difficulty breathing”.</td>
<td></td>
</tr>
</tbody>
</table>

**Patient:**

**PCP:** Zimmerman

**Care Mgr.:** Yates LPN

Patient signature & date

Care Manager signature

**Patient Goals:**

Patient demonstrates behaviors to improve airway clearance, such as:
- Coughs effectively and expectorates secretions, maintains a SpO2 of >90% on a daily basis.
- First aid and emergency care as needed.

**Patient Actions:**

- Increase fluid intake to 2000 ml/day.
- Keep environmental pollutants to a minimal, including cigarette smoke.
- Will stay current with pneumonia vaccine.

**Expected Outcome:**

- Hydration helps decrease the viscosity of secretions, facilitating expectoration.
- Precipitators of allergic type of respiratory reactions that can trigger onset of acute episode
- This vaccine lowers your risk of pneumococcal pneumonia and its complications. People who have COPD are at higher risk of pneumonia than people who don't have COPD.

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Medications associated with Care Plan:

**I will work on:**
- Staying active (within level of activity)
- Use my oxygen
- Use my inhalers as prescribed
- Attempt to stop Smoking
  *Call my PCP at 501-745-3033 or 501-253-8534 (after hours) if any changes in respirations or mentation**

**Patient Goals:**

**Patient Actions:**

**Expected Outcome:**
Front office intake and update of patient care reminders

PATIENT CHECK IN

EXAM ROOM

Nursing updates reminders

VISIT

Provider reviews reminders
Practice Schedule Summary

Appointment Summary

<table>
<thead>
<tr>
<th>Provider</th>
<th>Scheduled</th>
<th>New Patients</th>
<th>Normal</th>
<th>% Booked of Scheduled</th>
<th>Cancelled</th>
<th>No Show</th>
<th>Blocked*</th>
</tr>
</thead>
<tbody>
<tr>
<td>G- Same Day</td>
<td>822</td>
<td>39</td>
<td>733</td>
<td>93.9%</td>
<td>32</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Gensheimer, Helene</td>
<td>1,369</td>
<td>75</td>
<td>519</td>
<td>43.4%</td>
<td>90</td>
<td>74</td>
<td>611</td>
</tr>
<tr>
<td>Nurse</td>
<td>151</td>
<td>1</td>
<td>138</td>
<td>92.1%</td>
<td>9</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Z- Same Day</td>
<td>499</td>
<td>21</td>
<td>437</td>
<td>91.8%</td>
<td>28</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Zimmerman, Stacy C.</td>
<td>1,464</td>
<td>79</td>
<td>703</td>
<td>53.4%</td>
<td>123</td>
<td>43</td>
<td>516</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,305</strong></td>
<td><strong>215</strong></td>
<td><strong>2,530</strong></td>
<td><strong>53.4%</strong></td>
<td><strong>282</strong></td>
<td><strong>151</strong></td>
<td><strong>1,127</strong></td>
</tr>
</tbody>
</table>

% Booked of Scheduled Appointments

- G- Same Day: 25.07%
- Gensheimer, Helene: 11.58%
- Nurse: 24.58%
- Z- Same Day: 24.50%
- Zimmerman, Stacy C.: 14.26%
- **Total**: 100.00%

*Blocked and % booked exclude master content block type of LNCH (Lunch).
Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act

Plan

Study

Do
Use 3 Measures Identified in 6A

<table>
<thead>
<tr>
<th>Measure 1: Pneumococcal immunization (65yrs and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Measure Selected for Improvement &amp; Reason for Selection</td>
</tr>
<tr>
<td>Reason: We wanted to increase pneumonia vaccination rates in patients &gt;65 yrs. This was especially a concern with the newly released pneumococcal vaccine (Prevnar 13) recommendations.</td>
</tr>
<tr>
<td>Baseline Start Date: 1-4-14</td>
</tr>
<tr>
<td>Baseline Performance Rate (% or #): 61%</td>
</tr>
<tr>
<td>Numeric Goal Rate (% or #): 75%</td>
</tr>
<tr>
<td>Action: Red popup reminders were added to the EMR for patients overdue /due for the measure with a reconciliation task assigned to each reminder.</td>
</tr>
<tr>
<td>Date Action Initiated: 1-1-14</td>
</tr>
<tr>
<td>Additional Actions Taken: Clinical rule reminders in our EMR were activated to update nightly. Staff workflow designed to address the reminder and perform reconciliation of the reminder with each patient encounter. New flow sheet workflow was adopted for rapid documentation and access of patient data.</td>
</tr>
<tr>
<td>Start Date: 4-20-15</td>
</tr>
</tbody>
</table>

5. Re-measure Performance (6E 2)

6. Assess Actions & Describe Improvement (6E 1)

Since December of 2014, there has been an increase of 22% noted on our compliance report in patients receiving pneumococcal immunization due to adding team based workflows, overdue reminders with reconciliation features and flowsheets for rapid documentation/access of patient information.
<table>
<thead>
<tr>
<th>Measure 3: Colorectal Cancer Screening (CRC)</th>
<th>Reason: We wanted to increase our percentage of patients who received screening for CRC.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Measure Selected for Improvement &amp; Reason for Selection</strong></td>
<td><strong>Baseline Start Date:</strong> <strong>1-4-14</strong>  <strong>Baseline End Date:</strong> <strong>7-4-14</strong></td>
</tr>
<tr>
<td><strong>2. &amp; 3. Baseline Performance Measurement &amp; Numeric Goal for Improvement (6D 1)</strong></td>
<td><strong>Baseline Performance Rate (% or #):</strong> <strong>42%</strong></td>
</tr>
<tr>
<td><strong>Numeric Goal Rate (% or #):</strong> <strong>55%</strong></td>
<td><strong>Action:</strong> Red popup reminders were added to the EMR for patients overdue /due for the measure with a reconciliation task assigned to each reminder.</td>
</tr>
<tr>
<td><strong>Date Action Initiated:</strong> <strong>11-1-14</strong></td>
<td><strong>Additional Actions Taken:</strong> Clinical rule reminders in our EMR were activated to update nightly. Staff workflow designed to address the reminder and perform reconciliation of the reminder with each patient encounter. New flow sheet workflow was adopted for rapid documentation and access of patient data.</td>
</tr>
<tr>
<td><strong>Start Date:</strong> <strong>4-20-15</strong>  <strong>End Date:</strong> <strong>10-20-15</strong>  <strong>Rate (% or #):</strong> <strong>63%</strong></td>
<td><strong>Since December 2014, there has been an increase of 21% noted on our compliance report in patients receiving CRC screening due to incentivizing the staff and providers to reconcile clinical reminders at patient encounters and document data on patient flow sheets.</strong></td>
</tr>
</tbody>
</table>
Medicaid Attributed Beneficiaries 844 for 2014

- Our 2014 Benchmark TCOC (total cost of care) $1,906
- Final TCOC for 2014 was $1,572
- Shared savings for 2014 >25K
Total Alternative Payments for 2015

- CPC PCMH initiative $102,108
- PCMH medicaid managed PMPM $2,045
- Medicaid PCP supplemental payment $55,413
- Medicaid PCMH Shared Savings 2014 $26,000
- PQRS $497
- PCIP (multipayer initiative payments) $5,468
Utilization

Qtr 13 Medicare Utilization: 4 Qtr % Increase/Decrease

- Hospital Admissions for any Cause, per Total ED Visits, per 1,000 Patients, per Year: -22.30%
- Outpatient ED Visits, per 1,000 Patients, per Year: -16.50%
- ED Visits that Led to a Hospital Admission, per 1,000 Patients, per Year: -53.50%

-8.70%
Figure 4. Distribution of Practice-Level Medicare Expenditures per Patient per Month (risk-adjusted Quarter Averages (Q10 through Q13)) for All Attributed Medicare FFS Patients

- Your Practice: $627
- Median: $738
- Lowest: $321
Figure 5. Distribution of Practice-Level Medicare Expenditures per Patient per Month (risk-adjusted): Current Four-Quarter Averages (Q10 through Q13) for Attributed Medicare FFS Patients in the Highest-Risk Quartile

- Median $1,252
- Highest $2,209

Medicare Fee-for-Service Expenditures per Patient per Month

Practices in Your Region, Ranked from Lowest to Highest Expenditures by Percentile
Figure 10. Distribution of Practice-Level Rates of Hospital Admissions for Any Cause (unadjusted): Current Four-Quarter Averages (Q10 through Q13) for Attributed Medicare FFS Patients in the Highest-Risk Quartile
Figure 11. Distribution of Practice-Level Rates of Outpatient ED Visits (unadjusted): Current Four-Quarter Averages (Q10 through Q13) for Attributed Medicare FFS Patients in the Highest-Risk Quartile

- Outpatient ED Visit Rate per 1,000 Patients per Year
- Practices in Your Region, Ranked from Lowest to Highest Rate of Outpatient ED Visits by Percentile

- Lowest 388
- Your Practice 738
- Median 875
- Highest 2,133
## Evolution of Payment Redesign

<table>
<thead>
<tr>
<th></th>
<th>CPC</th>
<th>CPC+ Track 1</th>
<th>CPC+ Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBPM Risk-Adjusted Care Management Fee</td>
<td>$20 average (PY 1-2); $15 average (PY 3-4)</td>
<td>$15 average</td>
<td>$28 average</td>
</tr>
<tr>
<td>Underlying Payment Structure</td>
<td>Standard FFS</td>
<td>Standard FFS</td>
<td>Prospective Comprehensive Primary Care Payment (CPCP) with reduced FFS</td>
</tr>
<tr>
<td>Quality &amp; Cost Performance Incentive</td>
<td>Retrospective regional shared savings</td>
<td>Prospective, at-risk practice-level incentive payment ($2.50 opportunity)</td>
<td>Prospective, at-risk practice-level incentive payment ($4.00 opportunity)</td>
</tr>
</tbody>
</table>
Goals of CPC+

- **Access and continuity of care**: Track 1 with 24/7 patient access and Track 2 e-visit and expanded hours

- **Care Management**: Track 1 risk stratification and Track 2 care plans for high risk patients

- **Clinical and Community Coordination**: Track 1 focus on TOC and Track 2 will add BHS

- **Patient and caregiver engagement**: Track 1 PFAC and Track 2 increase self management of high risk conditions

- **Planned care and population health**: Track 1 analysis of payer reports with process of improvement and Track 2 care team review of population health data
Check data frequently to adapt change to your practice.

Don’t expect huge improvements. Create reliable workflows.

Use PDGAs to drive sustainable change.

Don’t depend on “local heroes”. Make it a team effort.

Allow customization provided core elements to improvements are clear.

Team strategic review of the scope of the change.

Team tracking and monitoring process.

Sustain gains with an infrastructure of staff to support them.

PCMH success
Oh, crap! Was that TODAY?
THANK YOU