NEW JERSEY HEALTH CARE QUALITY INSTITUTE

Quality powered.

Garden Practice Transformation Network

Practice Transformation Advisors

Population Management

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Virtua

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Population Management

Involves monitoring and evaluating patient populations to ensure that they are receiving timely and adequate preventative and chronic care

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Virtua

BASIC PRACTICE TRANSFORMATION in a nutshell

Or how I learned to stop worrying And love value based care

Why Are We Doing This?

Focus on moving from an isolated environment of episodic patient care to a system-based model emphasizing quality, care coordination, cost of care and overall experience across the continuum.

What ????

- A new world order in this VBP world
- Is this what we went to Medical School for…
- Yeah, the ACA may be going away but MACRA and CPC+ is coming!! No matter what…get used to it.
- Why are we doing this? Triple aim: improving quality, lowering cost, and improving satisfaction
- What about the new Administration???????????
  - Tom Price R-Ga., the president-elect's choice to run HHS, voted yes for MACRA in April of 2015

So I meet you in the parking lot, and you ask me
"How in the world am I gonna do this?"

THERE ARE FIVE THINGS YOU SHOULD DO!

#1- Who are your patients? Really.

- Not only the patients you see but the patients that are yours you don't see
- Something called the 4 cut method to assign patients to your team
  - The patient only saw you
  - The patient saw you the majority of time if they saw more than 3
  - If they only saw 2, the last one they saw
  - If they saw multiple providers, the last one they saw
- Review and update your panel assignments on a regular basis . Are they really yours
- Provide ways for patients to identify their care team without remembering names, such as color designations, posted photos of care team members, or cards with the care team identified
- Determine guidelines for panel size and patient complexity per panel

#2- Identify your highest risk patients.

- You can use one of the scoring measure, like HCC, or the Johns Hopkins scores.
- You KNOW who they are…..
- There is data for high risk patients, high utilizers
- Adjust your panel by severity
- One study, determine risk by “likely to die in the following year”

A simple way to do this….

Does the patient have more than one chronic disease?

- COPD + CAD > than COPD alone
- If DM exists, increases risk
- If behavioral health issue increases risk
- ACE score: the greatest risk
- Where and how do they live

#3 – Make sure you and your care team know who they are…..

- Identify them in your EMR, on the chart. The ones that will need extra attention
- Everyone in practice should know who they are as well, and who they are assigned to know them
- The patient may not need to see the doc all the time… members of the care team… more to come
- Get as much information about the patient that you can
- Get their support system involved

#4 Recognize and correct gaps in care

Current State - Episodic Patient Care

41 year old JD is a typical primary care patient, seen January 8, 2016.

He's overweight, has DM on metformin, newly diagnosed Renal insufficiency with a Creatinine of 1.8 and an abnormal chest x-ray.

You appropriately tell JD to hold his metformin, check a Renal Ultrasound, order repeat labs, and refer him to Pulmonary.

Since he's a diabetic, you refer him to his Ophthalmologist.

You schedule JD for a follow up with you in 3 months.

We all know what JD should do…..but will he?
And how do you know that he did?

JD's Follow-up Visit on April 8

- Seen by you on 1/8/16
- On 1/20/16 – Renal Ultrasound done. Normal.
- On 3/15/16 – CT appears in your PAQ ordered by Dr Rodis. Shows non-specific nodularity but no other concerning findings.
- On 4/8/16 – He shows up at your office for his scheduled appointment.
- Before going into the exam room, after 5 minutes of chart review, you notice the following missing from the chart:
  1) No repeat labs were done
  2) No note from Pulmonary
  3) No note from his Ophthalmologist
  4) His Renal Ultrasound was not found for a few minutes since it was mistakenly scanned under X-ray.

Frustrated, you take a deep breath and enter the room to start asking him if he saw Pulmonary, Optho, and had his repeat labs.

Inefficiencies of Current State

Time Analysis Survey

The average daily **non-clinical time** spent by a current Primary Care Provider:

99 MINUTES DAILY

The average daily **non-clinical time** spent by a current Primary Care Provider PLUS time spent in PAQ handling what YOU determine to be non-urgent tasks:

137 MINUTES DAILY

Total average non-clinical time spent daily by a provider:

2 hours and 17 minutes

Have a "Chart prep" person

- Chart prep is done ahead of the appointment on all patients coming in for a visit.
- The list is reworked up until the day before for any last minute add-ons
- During the chart prep, all documents that came in between the last visit and now are attached
- Gaps in care should be remediated
- Patient is contacted as a reminder and to close further gaps or close gaps in orders not yet completed (labs, consults, diagnostics)
- Medications are refilled by policy

#4 – Change your thinking from "me" to "us"

- You are now the lead of your care team, and your team and you will care for the patient
- Develop a quality team
- Care coordinators and people that can analyze, review, and share data… many payers have this embedded, use them.
- You don't have to, and you can't possibly do it all
- Family dynamics, behavioral health resources, and social determinants of health

#5 – Care Coordinators

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Intervention/Methods

- Enhance relationships - patient, family, provider and community agencies to provide highest quality care
- Identify & evaluate high risk VMG populations with PCP input
  - Recent hospitalization, high ER utilization, chronic disease(s), polypharmacy, social needs
  - Meet with patient in office, patient's home, or telephonically
  - Develop individualized POC including personal, psychosocial and medical goals – reflecting patient's values and building on trust
- Key Components
  - Face-to-face, therapeutic interactions
  - Self-care practices
  - Continuity and ongoing follow-up
  - Teamwork – shared responsibility and accountability

Coordinator Connection to Others

- Coordinator relationship with self
  - Must care for self before caring for others
  - Transference issues
  - Conscious incompetence (recognizing what you don't know)
- Coordinator relationship with patient/caregiver
  - Meeting the patient and caregiver in their environment
  - Individual one-on-one support
  - Becoming a facilitator/point of contact
- Coordinator relationship with team members
  - Documents on chart
  - Collaborates with team members
  - Empowered to fill gaps through order sets

Questions

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