Harnessing the Power of Primary Care Access to Improve Cost of Care

Terry “Lee” Mills, MD, MMM, CPE, FAAFP

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Terry “Lee” Mills, MD, MMM, CPE, FAAFP

Medical Director, St. John Clinic, Tulsa, Oklahoma

Dr. Mills earned his medical degree from the University of Oklahoma College of Medicine in Oklahoma City, and completed his family medicine residency at McLennan County Medical Education and Research Foundation in Waco, Texas. As a medical director, he is responsible for primary care operations, quality improvement, population health efforts, medical home and team-based care, and coding and compliance functions. Dr. Mills has led the St. John Clinic’s participation in the multi-payer Comprehensive Primary Care Initiative (CPC) and Comprehensive Primary Care Plus (CPC+) programs, as well as guiding a multi-site transformation to a National Committee for Quality Assurance (NCQA) Level 3 Patient-Centered Medical Home (PCMH) designation.

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Learning Objectives

1. Identify why reducing total cost of care matters.
2. Understand how improving primary care access can impact cost of care metrics.
3. Evaluate current barriers to access and opportunities for improvement.

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Associated Session

- MACRA: Medicare's Shift to Value-based Delivery & Payment Models
- MACRA Medicare's Shift to Value-based Delivery & Payment Models: Ask the Expert
- Patient Attribution: Why It Matters Now More Than Ever
- What is Risk? Am I Ready for Advanced Alternative Payment Models
- Your Prescription for MIPS

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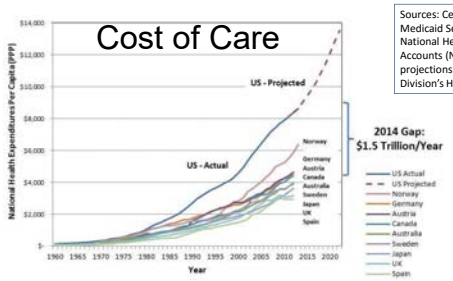
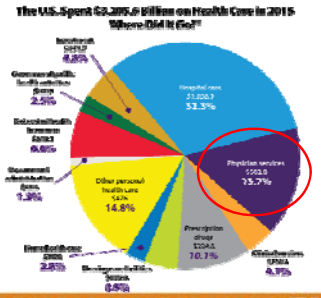
Cost of Care

Cost of Care



Sources: Centers for Medicare & Medicaid Services (CMS) National Health Expenditure Accounts (NHEA); CMS projections of NHE; OECD Health Division's HealthData, 2013

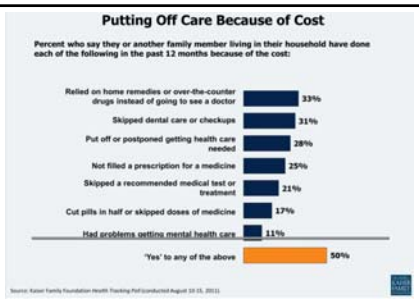
Dividing Up the Cost of Care



www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Tren... NHE Tables [Zip].

Physician Spending Growth 2006-2015

www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Tran... NHE Tables [zip].



AES POLL QUESTION

- True or False
  - Increasing the number of primary care physicians per 10,000 population has been found to reduce total cost of care and increase quality.

Baicker and Chandra, 2004.

- "Increasing the number of general practitioners in a state by 1 per 10,000 population (while decreasing the number of specialists to hold constant the total number of physicians) is associated with a rise in that state's quality rank of more than 10 places ($p < .0005$) as well as a reduction in overall spending of $684 per beneficiary." ($p < .0005$)

Katherine Baicker and Amitabh Chandra. Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care. Health Affairs published online April 7, 2004

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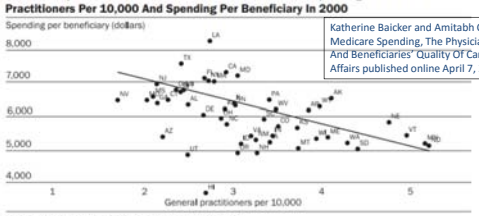
EXHIBIT 9
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

Katherine Baicker and Amitabh Chandra. Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care. Health Affairs published online April 7, 2004

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Improved Outcomes & Cost

- With increasing primary care access:
  - People live longer, fewer die due to heart and lung disease
  - Better preventive care
  - Reduced health disparities
  - Less ER and hospital use
  - Fewer tests
  - Lower medication use
  - Lower per capita costs of care

Greenfield S. JAMA. 1992;267:1624-30.
Forrest CB, Starfield B. JFamMed. 1996;43(1):40-8.
Macinko J., Starfield B. HSR. 2003; 38(3):831-65.
Starfield, B. Health Affairs. 2005(3):W5-97

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Practice Recommendation

- Do not underemphasize the importance of ready access to your care in improving outcomes and reducing cost.

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Cost Drivers and Access

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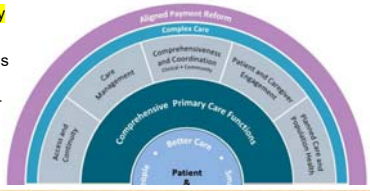
The 5 Functions of Comprehensive Primary Care Plus Program

1. Access & Continuity
2. Care Management
3. Comprehensiveness & Coordination
4. Patient & Caregiver Engagement
5. Planned Care & Population Health



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Access and Continuity

-	Track 1	Track 1, CPC Practices	Track 2
1 Access and Continuity	1.1 Achieve and maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. 1.3 Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity.	Track 1 Requirements 1.1-1.3	Track 1 Requirements 1.1-1.3 + 1.4 Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends.

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Population Health

1. Identify
2. Stratify
3. Engage
4. Intervene
5. Measure

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Cost Drivers

- Unnecessary readmission
- Unnecessary primary admission
- Unnecessary ED visits
- Excessive referral to specialists (limited scope of primary care)
- Prescribing habits
- Lab/Rad ordering habits
- Ineffective chronic disease care
- Suboptimal preventative care

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Medicare Shared Savings Program
Expenditure/Utilization Report

	ACO-Specific		All MSSP ACOs		National FFS	
Number of ACOs		1		416		-
Person-Years		11,927		11,546		32,334,532
Total Expenditures		$ 9,781		$ 10,238		$ 9,956
Component Utilization per Assigned Beneficiary	**Rate per 1000**	**PMPY**	**Rate per 1000**	**PMPY**	**Rate per 1000**	**PMPY**
Hospital Inpatient Facility, Total	328	$ 3,152	306	$ 3,307	294	$ 3,243
Outpatient Facility		$ 1,870		$ 2,026		$ 1,988
Emergency Department Visits	619	$ 747	559	$ 694	601	676
Part B Physician/Supplier		$ 2,711		$ 3,324		$ 2,956
Evaluation and Management		$ 942		$ 1,144		$ 1,055
Procedures		$ 737		$ 866		$ 776
Imaging		$ 168		$ 254		$ 226
Laboratory and Other Tests		$ 263		$ 286		$ 249
Primary Care Services	3,700	$ 8,285	3,521	$ 9,666	2,998	$ 8,586
With a Primary Care Physician		$ 3,970		$ 3,952		$ 3,180
With a Specialist Physician	5,921	$ 3,284	6,996	$ 4,483	6,727	$ 3,873
Transition of Care/Care Coordination Utilization						
30-Day All-Cause Readmissions Per 1,000 Discharges		169.6		161.7		170.4
30-Day Post-Discharge Provider Visits Per		741.3		780.7		748.6
Ambulatory Care Sensitive Conditions (Discharge Per 1,000)						
Chronic Obstructive Pulmonary Disease or Asthma		9.3		9.5		8.7
Congestive Heart Failure		16.6		13.4		12.1
Bacterial Pneumonia		8.0		7.8		7.6

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Cost Drivers and Opportunities

- Readmissions
- ED presentations
- Admissions

- Seamless transition care management and post-acute follow up
- Easy same day access (structure & culture)
- Communicated and recognized in population
- Optimized chronic disease and preventive care

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CPCI Focus on Access

Because it Works! (St. John, Tulsa)

- Quality has improved systematically
- All-cause hospital readmission decreased to 75%tile
- Reduced 1st Private Payer cost >12%
- Reduced 2015 Medicare cost 5.4%
  - $46.88 PMPM (base of $875.21 PMPM)
- Patients are happier: CAHPS scores

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Practice Recommendation

- Understand the main cost drivers for healthcare in your community.
- Considering the many ways better access to Family Physicians can improve costs, select 1-2 priorities for your practice.

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Improving Access

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Traditional View of Access

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Rethink Access

- Often WE are greatest barrier!
  - Control
  - Failure of communication and trust
  - Paternalism
  - We want to believe it comes from the best of intention, instincts, and intuition

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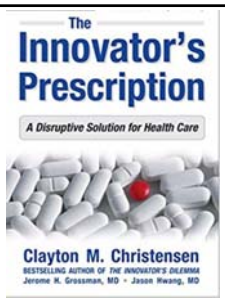
Fundamental Problem

3 completely different services:

1. Acute care
2. Wellness and Preventive Care
3. Chronic Disease Care



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PREVENTING CHRONIC DISEASE

PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY

VOLUME 6: NO. 2, A59 APRIL 2009

SPECIAL TOPIC

Family Physicians as Team Leaders: "Time" to Share the Care

Table 2. Time Required to Meet Current Clinical Guideline Recommendations

Type of Visit	Hours/Day	Hours/Week	% of Clinical Time
Acute	3.7[a]	18.4	17.0
Chronic	10.0[b]	50.0	46.0
Preventive	7.4[c]	37.0	34.1
Total	21.7	108.4	100.0

CONCLUSION: "There are not enough primary care physicians to meet the recommended care guidelines within the current model of a single physician providing all required preventive, chronic disease, and acute care to patients in his or her practice."

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Current Issues with Access

- Slower documentation and cycle time with EHR
- Professional & lifestyle choices of new generation of physicians
- Team based care requiring interaction with physician
- Increased demand due to aging population and characteristics of baby boomers
- Reduction in Family Medicine workforce – aging physician population slowing down; alternative practice choices available to new residency graduates
- Value Based care - Emphasis on quality and outcomes and related workflows; working the list; data entry
- Trend of care being pushed to lower acuity settings
- Increase in non-direct care "system" work – preauthorizations, FMLA, wellness forms, external screenings to review

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CHANGE!

- Patient autonomy
- Consumerism, digital & wearable
- Trend to transparent pricing & quality
- High Deductible Health Plans
- Competing access points

= The Patient Will See You Now

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Rethink Access

- Was a linear relationship
  - An encounter = a visit, a visit = a charge
- Now more of fan shaped distribution – many incoming access points centered on the team
- Consider menu of team access options

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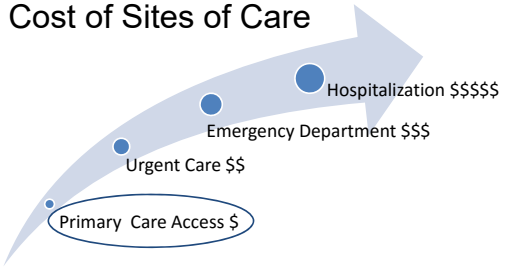
Cost of Sites of Care



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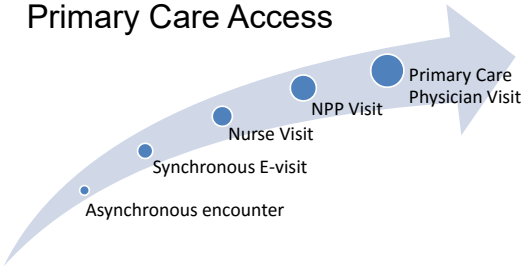
Primary Care Access



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Access Options

In Person

- Office physician visit
- Office NPP visit
- Office visit with team members
  - Nurse
  - Care manager
  - Pharmacist
  - Health coach
  - Social worker
  - Behavioral health specialist

Not In Person

- Phone encounter
- Online asynchronous encounter
- Online synchronous encounter (Telehealth visit)
- Gap management – team engagement with patient present or knowing

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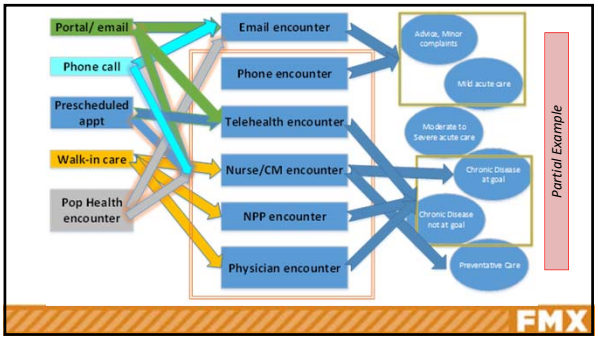

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Build a System

Communication and complaint

- Phone, portal – health question
- Phone, portal – acute illness (mild)
- Phone, portal – acute illness (sick)
- Preventive/Wellness care gap
- Incoming/outgoing - Chronic disease at goal
- Incoming/outgoing - Chronic disease not at goal

Encounter options

- Phone, portal/email/text
- Phone, portal/email/text care pathway; nurse or NPP visit
- NPP or physician visit
- Phone, portal/email/text; nurse visit; NPP or physician visit
- Nurse care pathway, NPP visit
- NPP or physician visit

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AES POLL QUESTION

- What do you consider the most important innovation to increase access to primary care services?
  1. Extended hours
  2. Advanced/Open access models
  3. Coordination with local urgent care clinics
  4. Use of non-physician providers
  5. Team based care (teamlet style)

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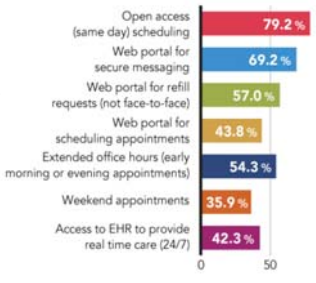
Strategies to Improve Patient Access



Brandi White and David Twiddy *Fam Pract Manag.* 2017 Jan-Feb;24(1):26-33

Source: AAFP. 2015 Practice Profile. July 2016

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Improve Access: Optimizing Schedule

- Template vs work type/appointment type
- Efficient scheduling:
  1. Reduce complexity in work type/appointment type
  2. Single duration
  3. "Any–Any"
- Train and Trust

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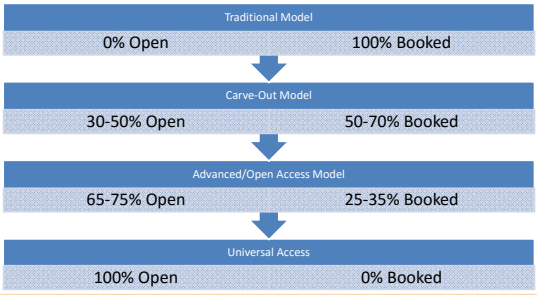
AES POLL QUESTION

- Of the many scheduling styles, which one optimizes same day access without other considerations?
  1. Stream
  2. Modified Wave
  3. Universal Access
  4. Advanced Access



Scheduling Template Systems

Schedule Template Types	Time and Number of Appointments																Total Appts
	800	815	830	845	900	915	930	945	1000	1015	1030	1045	1100	1115	1130	1145	
Stream Scheduling	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	16
Carve Out adaption (3/4 - 1/4)	1	1	1		1	1	1		1	1	1		1	1	1		
Wave Scheduling	4				4				4				4				16
Modified Wave Scheduling	2	1	1		2	1	1		2	1	1		2	1	1		16
Universal Access Scheduling																	16
Advanced Access Scheduling (1/3 - 2/3)	1			1			1			1			1			1	16
Combo (mod wave + advanced)	2	1		1		1			1			1				1	16

Access Metrics

- # daily same-day appointments
- # same day requests
- # new patients requesting appointments
- 3rd next available
- % Continuity visits
- Use of alternate access points

Practice Recommendation

- Take a systematic approach to access in your practice, and begin planning 1-2 steps you will implement in practice to improve your patients access to your care.

Questions

Contact Information

Terry L Mills, MD, MMM
millstlmd@gmail.com

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