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

Terry "Lee" Mills, MD, MMM, CPE, FAAFP

ACTIVITY DISCLAIMER

The material presented here is being made available by the American Academy of Family Physicians for educational purposes only. Please note that medical information is constantly changing; the information contained in this activity was accurate at the time of publication. This material is not intended to represent the only, nor necessarily the best, methods or procedures appropriate for the medical situations discussed. Rather, it is intended to present an approach, view, statement, or opinion of the faculty, which may be helpful to others who face similar situations.

The AAFP disclaims any and all liability for injury or other damages resulting to any individual using this material and for all claims that might arise out of the use of the techniques demonstrated therein. This material might contain recommendations/guidelines developed by other organizations. Please note that although these guidelines might be included, this does not necessarily imply the endorsement by the AAFP.

DISCLOSURE

It is the policy of the AAFP that all individuals in a position to control content disclose any relationships with commercial interests upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflict of interest (COI), and if identified, conflicts are resolved prior to confirmation of participation. Only those participants who had no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this CME activity.

All individuals in a position to control content for this session have indicated they have no relevant financial relationships to disclose.

The content of my material/presentation in this CME activity will not include discussion of unapproved or investigational uses of products or devices.

DISCLOSURE

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.

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.

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 More Than Ever
• What is Risk? Am I Ready for Advanced Alternative Payment Models
• Your Prescription for MIPS
Cost of Care

Dividing Up the Cost of Care

Physician Spending Growth 2006-2015

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.

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


www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Tran...

“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

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

Starfield, B. Health Affairs. 2005(3):W5‐97

Practice Recommendation

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

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

Cost Drivers and Access
**Access and Continuity**

<table>
<thead>
<tr>
<th>Task</th>
<th>Requirement</th>
<th>Requirement 1.2.1</th>
<th>Requirement 1.2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access and Continuity</td>
<td>Track 1</td>
<td>Track 1, PCP Focus</td>
<td>Track 2</td>
</tr>
<tr>
<td></td>
<td>1. Approaches have at least 95% engagement to preventive care.</td>
<td>Track 1, PCP Focus</td>
<td>Track 2</td>
</tr>
<tr>
<td></td>
<td>2. KPIs focus on care access rates (e.g., number of patients seen vs. total number of eligible patients).</td>
<td>Track 1, PCP Focus</td>
<td>Track 2</td>
</tr>
</tbody>
</table>

**Population Health**

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

**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

**Number of ACOs**

- 14 ACOs
- 16 Person-Years
- 11,927, 11,546, 32,334,532

**Total Expenditures**

- $9,781
- $10,238
- $9,956

**Component Utilization per Assigned Beneficiary**

<table>
<thead>
<tr>
<th>Rate per 1000 PMPY</th>
<th>Rate per 1000 PMPY</th>
<th>Rate per 1000 PMPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient Facility, Total</td>
<td>328</td>
<td>3,152</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>2,026</td>
<td>1,988</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>459</td>
<td>559</td>
</tr>
<tr>
<td>Part B Physician/Supplier</td>
<td>2,711</td>
<td>3,324</td>
</tr>
<tr>
<td>Evaluation and Management</td>
<td>942</td>
<td>1,144</td>
</tr>
<tr>
<td>Procedure</td>
<td>737</td>
<td>866</td>
</tr>
<tr>
<td>Imaging</td>
<td>168</td>
<td>254</td>
</tr>
<tr>
<td>Laboratory and Other Tests</td>
<td>263</td>
<td>286</td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>8,285</td>
<td>3,521</td>
</tr>
<tr>
<td>With a Primary Care Physician</td>
<td>3,952</td>
<td>3,180</td>
</tr>
<tr>
<td>With a Specialist Physician</td>
<td>3,284</td>
<td>4,483</td>
</tr>
</tbody>
</table>

**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**

- 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

**Cost Drivers and Opportunities**

- **Readmissions**: Seamless transition of care management and post-discharge follow-up
- **ED Presentations**: Easy same day access (structure & culture)
- **Admissions**: Optimized chronic disease and preventative care

**CPCI Focus on Access**

*Because it Works! (St. John, Tulsa)*

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

Improving Access

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

Traditional View of Access

Fundamental Problem

3 completely different services:
1. Acute care
2. Wellness and Preventive Care
3. Chronic Disease Care
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.”

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-clinical care "system" work – pre-authorizations, FMLA, wellness forms, external screenings to review

CHANGE!

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

= The Patient Will See You Now

Rethink Access

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

Cost of Sites of Care

Hospitalization $$$$$
Emergency Department $$$
Primary Care Access $$
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

Build a System

**Communication and complaint**
- Phone, portal – health question
- Phone, portal – acute illness (mild)
- Phone, portal – acute illness (sick)
- Promoted/Healthcare 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

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)

Strategies to Improve Patient Access

- Open access (same day) scheduling
- Secure messaging
- Web portal for refill requests
- Extended office hours (early morning or evening appointments)
- Weekend appointments
- Access to EHR to provide real-time care [24/7]

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
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

<table>
<thead>
<tr>
<th>Schedule Template Types</th>
<th>800</th>
<th>815</th>
<th>830</th>
<th>845</th>
<th>900</th>
<th>915</th>
<th>930</th>
<th>945</th>
<th>1000</th>
<th>1015</th>
<th>1030</th>
<th>1045</th>
<th>1100</th>
<th>1115</th>
<th>1130</th>
<th>1145</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stream Scheduling</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>46</td>
</tr>
<tr>
<td>Carve-Out Model</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Wave Scheduling</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Advanced Access Model</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Universal Access Scheduling</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Advanced Access Scheduling</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Advanced Access Scheduling</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Advanced Access Scheduling</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Advanced Access Scheduling</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Advanced Access Scheduling</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Advanced Access Scheduling</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

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.
Contact Information

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