Population Management

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Objectives

- Gain increased understanding of population management.
- Access tools to manage patient populations in your practice.
- Increased understanding of how teams across your practice and community support and improve population management.

Population Management

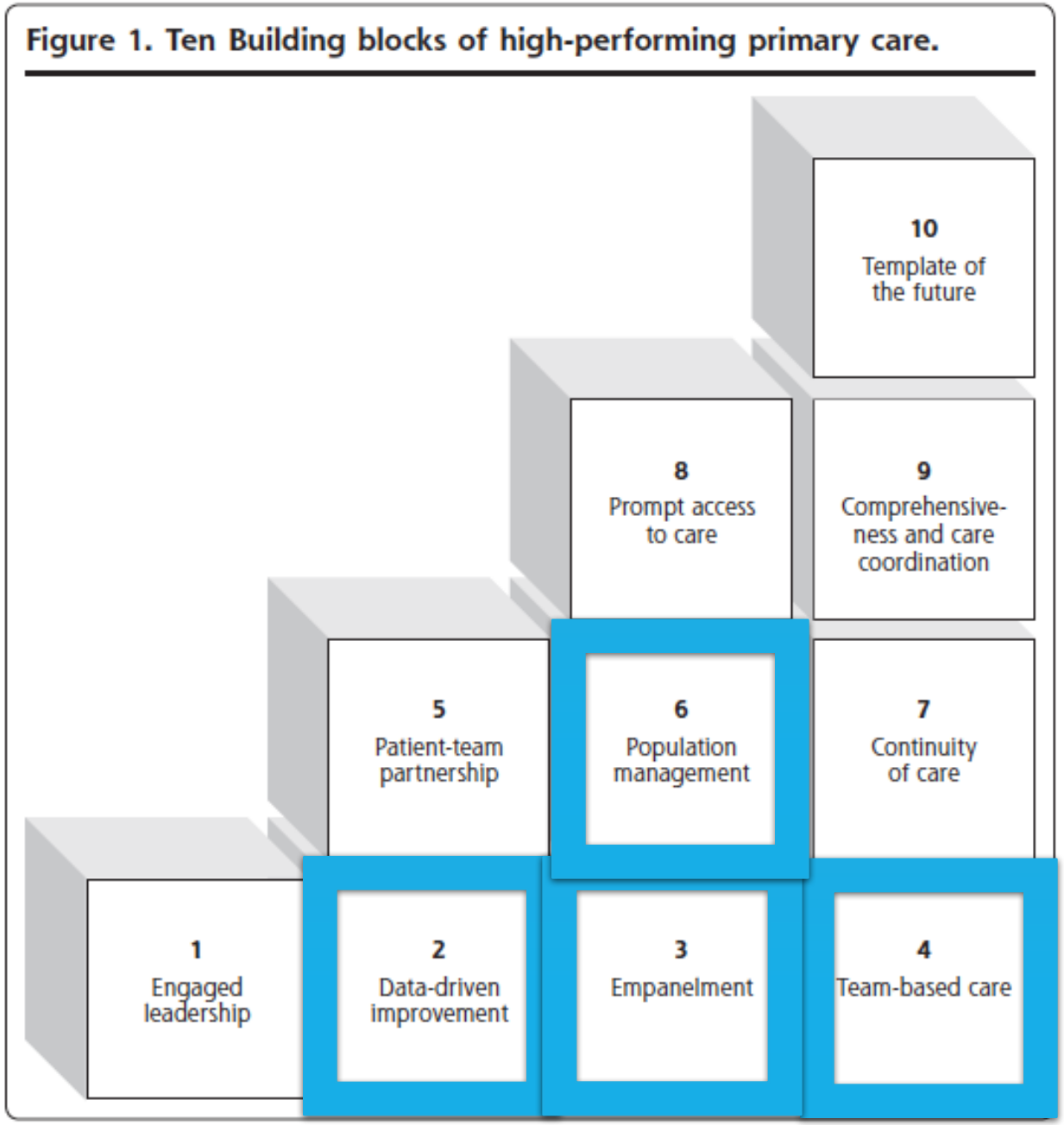
"For a primary care doc it's about improving the big picture while staying focused on the individual."

Example: A patient with elevated cholesterol.

Individually: this patient is unique

Globally: this patient is very much the same as many others that you see

Figure 1. Ten Building blocks of high-performing primary care.



Bodenheimer, et al. Annals of Family Medicine. 2014

Empanelment

- Who are your patients?
- Who do your patients say their doctor is?

- Identify your denominator – key to population managment
  - To know how many patients have an A1C > 9, first need to know who your patients are with diabetes.

Empanelment cont.

- Linking each patient to a primary care provider and care team.
- Improves continuity.
- Supports a team approach to patient care.

The 4-Cut Method for Panel Assignment

CUT	PATIENT DESCRIPTION	ASSIGNMENT
1	Patients who have seen only one provider	To that sole provider
2	Patients who have seen multiple providers, but one provider the majority of the time	To the majority provider
3	Patients who have seen two or more providers equally (no majority can be determined)	To the provider who performed the last physical
4	Patients without a physical or health check who have seen multiple providers	To provider seen most recently

Source: Murray et .al,. "Panel Size: How Many Patients Can One Doctor Manage?" Family Practice Management, April 2007

Managing the panel

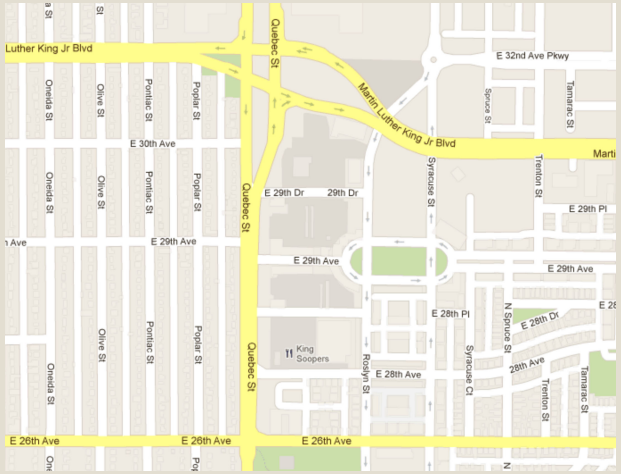
- Building patient registries
  - Slice and dice the data
  - Tells the big stories about the patients that you treat

Using Registries

- Used at point of care to identify what is needed at visit
- ID gaps in care for populations
- Tracking trends over time
- Comparisons between providers, practices, systems
- Outreach and care management

Primary Care Provider Dashboard:

UFM-AF Williams

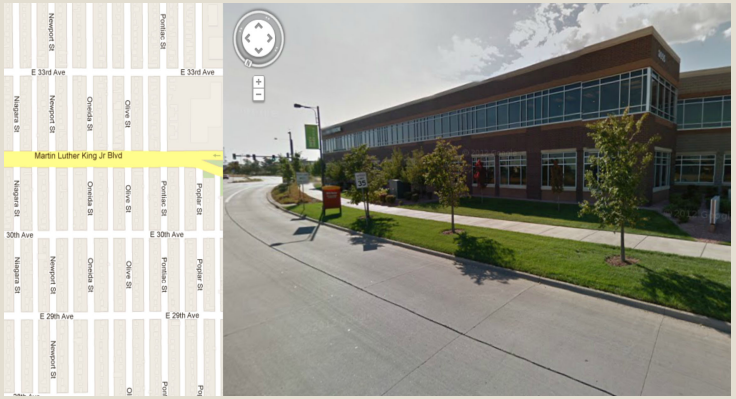


Diabetes Care:	12-Jun	12-Jul	12-Aug	12-Sep	12-Oct	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Number of Patients	471	470	472	411	465	467	468	466	472	473	483	479	440	485	517
A1C in past 13 Months	90%	90%	90%	90%	89%	91%	91%	93%	92%	92%	94%	92%	93%	92%	93%
A1C < 7%	51%	51%	49%	50%	52%	52%	52%	52%	51%	50%	44%	44%	43%	44%	45%
A1C < 8%	72%	72%	73%	74%	75%	75%	74%	73%	73%	71%	65%	65%	64%	64%	66%
A1C > 9%	15%	15%	15%	13%	13%	14%	16%	16%	16%	16%	19%	18%	21%	20%	19%
Blood Pressure <140/90	67%	66%	67%	66%	65%	66%	65%	66%	65%	67%	72%	66%	70%	72%	73%
Blood Pressure <130/80	35%	35%	35%	36%	34%	35%	31%	34%	32%	33%	40%	34%	40%	41%	42%
Lipids in past 13 Months	76%	5%	76%	76%	77%	76%	75%	77%	75%	76%	87%	83%	85%	84%	85%
Non HDL <130	68%	68%	67%	70%	68%	68%	68%	69%	68%	67%	54%	53%	55%	54%	53%
LDL <100	70%	70%	71%	73%	0%	78%	78%	78%	77%	77%	64%	65%	66%	63%	62%
Microalbum in past 13mo	52%	58%	59%	61%	60%	62%	60%	63%	63%	63%	69%	62%	63%	62%	61%
Foot Exam in past 13mo	21%	22%	21%	23%	21%	21%	21%	22%	21%	21%	65%	60%	64%	61%	62%
Retinal Exam in past 13mo	25%	25%	24%	26%	25%	25%	25%	25%	25%	23%	27%	23%	25%	25%	27%
Active Tobacco User	20%	20%	20%	21%	20%	21%	21%	21%	22%	21%	23%	22%	23%	22%	23%
Tobacco Users Cnsld in 13mo	7%	7%	6%	8%	29%	34%	38%	39%	42%	49%	53%	58%	59%	63%	63%

Totals for: KNIERIM, KYLE E

	Blood Pressure		BMI		A1C					Lipids						Screening of Complications			Smoking	Patient Goal	Diabetes Education
Total # Patients	BP < 140/90	BP < 130/80	BMI 25 - 29.9	BMI 30 +	A1C in past 13 mo	A1C in past 6 mo	A1C < 7%	A1C 7-9%	A1C > 9%	Lipids in 13 mo	LDL <130	LDL <100	HDL Men > 40	HDL Women > 50	Triglyc < 150	Nephropathy Screen or Trtmnt in past year	Neuropathy Foot Exam in past year	Retinopathy Eye Exam in past year	Active Smoker & Counseling in past year	Patient Goal on Record	Diabetes Education in past year
18	10	3	2	15	17	13	8	7	3	16	15	11	7	3	8	13	8	1	Non- 14 / 78%	4	2
	28%	14%	11%	83%	94%	72%	44%	39%	17%	89%	83%	61%	39%	17%	44%	72%	44%	6%	Smkr- 4 / 22% Cnsld-1 / 25%	22%	11%

Patient Level



Blood Pressure		BMI	A1C	Lipids				Nephropathy				Neuro pathy	Retino pathy	Smoking
Systolic BP	Diastolic BP	BMI	A1C	LDL	HDL	TRIGLY	Non HDL	Serum Creatinine	Ur Micro Creat Ratio	GFR	PT on ACE/ ARB Yes/No	Foot Exam in Past year	Retinal Eye Exam in past year	
04/27/2012	04/27/2012	31.8	01/20/2012	04/27/2012	04/27/2012	04/27/2012	04/27/2012	04/27/2012	01/20/2012	121.48	NO	NO	NO	
131	82		5.6	235	49	118	259	1.06	1.3					
02/26/2013	02/26/2013	95.7	02/07/2012	11/14/2011	11/14/2011	11/14/2011	11/14/2011	06/28/2012	06/28/2012	363.75	YES	YES	NO	
149	82		6.0	54	54	86	71	0.78	0.2					
01/28/2013	01/28/2013	27.0	10/01/2012	08/02/2012	08/02/2012	08/02/2012	08/02/2012	08/02/2012	04/16/2010	16.40	NO	NO	NO	NO
130	53		7.2	84	39	222	128	5.27	296.5					
01/10/2013	01/10/2013	30.6	01/10/2013	01/10/2013	01/10/2013	01/10/2013	01/10/2013	01/10/2013	01/10/2013	130.10	YES	NO	NO	
119	81		5.6	92	57	62	104	1.03	1.5					
02/07/2013	02/07/2013	36.8	01/08/2013	05/16/2012	05/16/2012	05/16/2012	05/16/2012	02/07/2013	08/30/2012	133.89	YES	YES	NO	
145	97		6.9	113	54	206	154	1.03	0.6					
06/11/2012	06/11/2012	37.4	05/23/2012	05/23/2012	05/23/2012	05/23/2012	05/23/2012	05/23/2012	08/03/2011	124.31	YES	NO	NO	
142	88		7.0	98	38	318	162	0.93	0.6					
11/16/2012	11/16/2012	31.4	11/16/2012	11/16/2012	11/16/2012	11/16/2012	11/16/2012	11/16/2012	11/16/2012	164.35	YES	YES	NO	NO
142	90		8.2	--	38	712	196	0.90	5.8					
01/09/2013	01/09/2013	31.0	01/09/2013	11/01/2011	11/01/2011	11/01/2011	11/01/2011	01/09/2013	11/01/2011	28.98	YES	YES	NO	
110	65		7.3	56	51	46	65	2.80	18.6					
02/15/2013	02/15/2013	37.7	09/11/2012	09/11/2012	09/11/2012	09/11/2012	09/11/2012	05/22/2012	10/14/2011	135.70	YES	NO	NO	
143	75		7.8	50	43	305	111	1.19	1.2					
02/08/2013	02/08/2013	72.0	02/06/2013	02/06/2013	02/06/2013	02/06/2013	02/06/2013	02/06/2013	02/06/2013	310.64	NO	NO	NO	NO
153	95		11.2	130	28	281	186	1.01	31.0					
02/22/2013	02/22/2013	36.2	02/22/2013	02/22/2013	02/22/2013	02/22/2013	02/22/2013	02/22/2013	02/22/2013	211.21	NO	YES	NO	
138	84		6.9	107	48	96	126	0.83	1.2					
06/19/2012	06/19/2012	54.1	03/13/2012	03/13/2012	03/13/2012	03/13/2012	03/13/2012	03/13/2012	03/13/2012	230.58	NO	NO	NO	
136	83		14.3	92	48	249	142	0.82	0.5					
12/14/2012	12/14/2012	64.4	10/15/2012	10/15/2012	10/15/2012	10/15/2012	10/15/2012	06/04/2012	03/19/2012	265.37	YES	NO	YES	
135	80		7.4	61	37	108	83	0.94	2.5					

SO WE HAVE THE DATA, NOW WHAT?

It takes a team

- What does this data mean to the team?
- Who on the team reviews the registry and when?
- How does the team use this information to make changes in workflow and accountability?
- Can standing orders be created to address gaps in care?
- What data from the registry can be used to inform point of care patient needs?

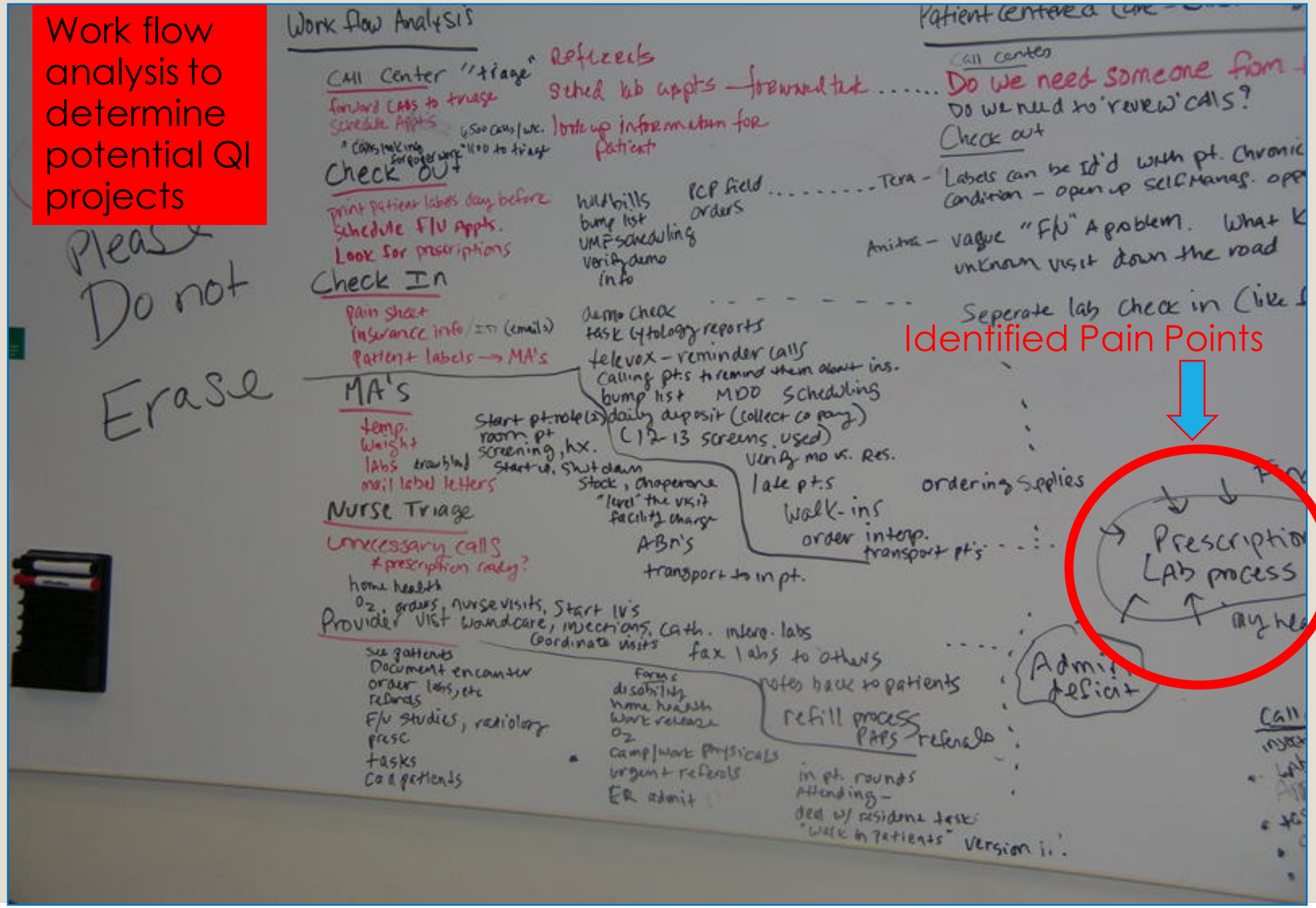
Team Huddles

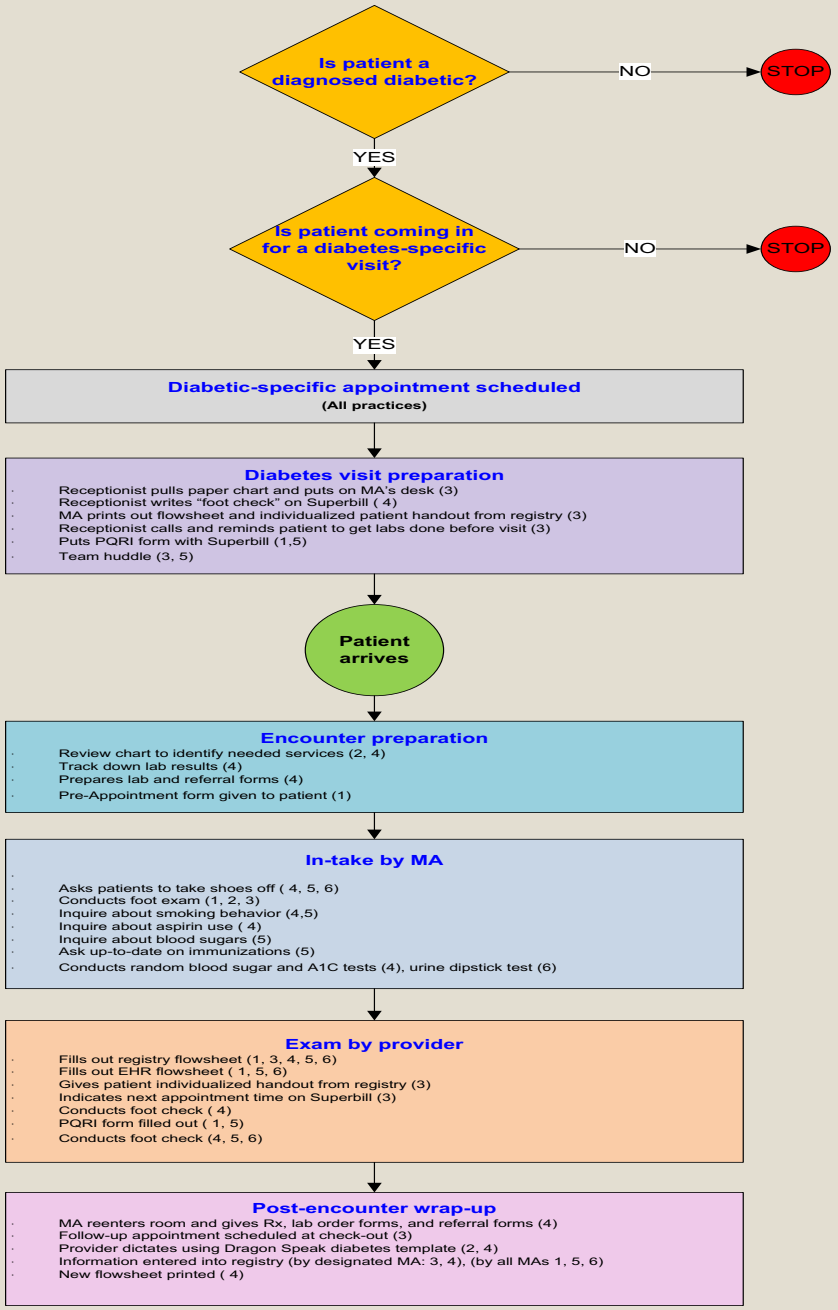
- Use patient level data to identify patient needs
- Prep so that session runs smoothly
- Anticipate issues that may arise
- Understand roles clearly across the team

Process Mapping

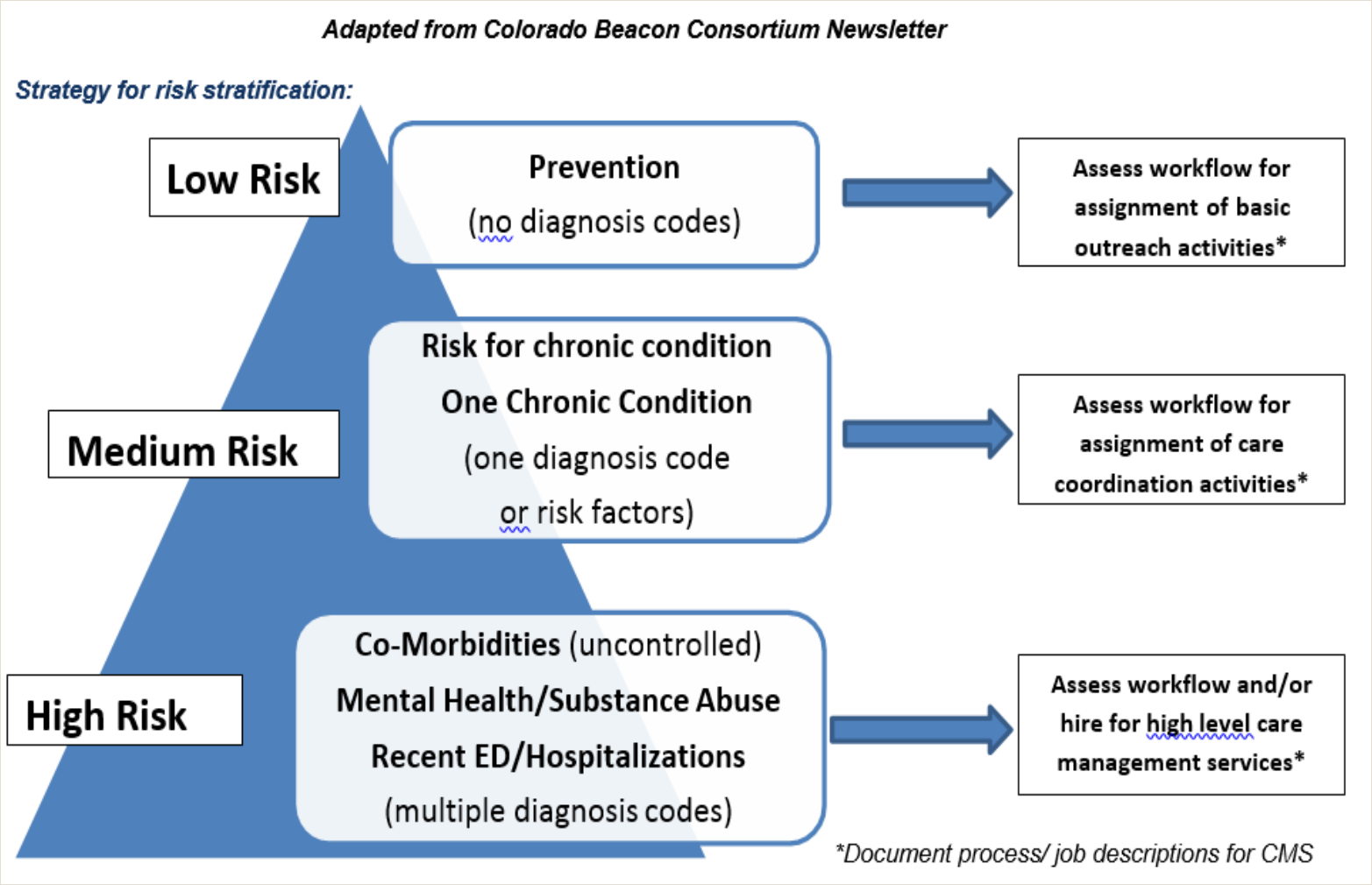
1. Access & entry points to initiate integrated care processes
2. Team members responsible for each step
3. Identification methods / screening
4. Treatment strategies, protocols and decision support
5. Systematic monitoring of patient progress and follow up – don't forget about what happens between visits

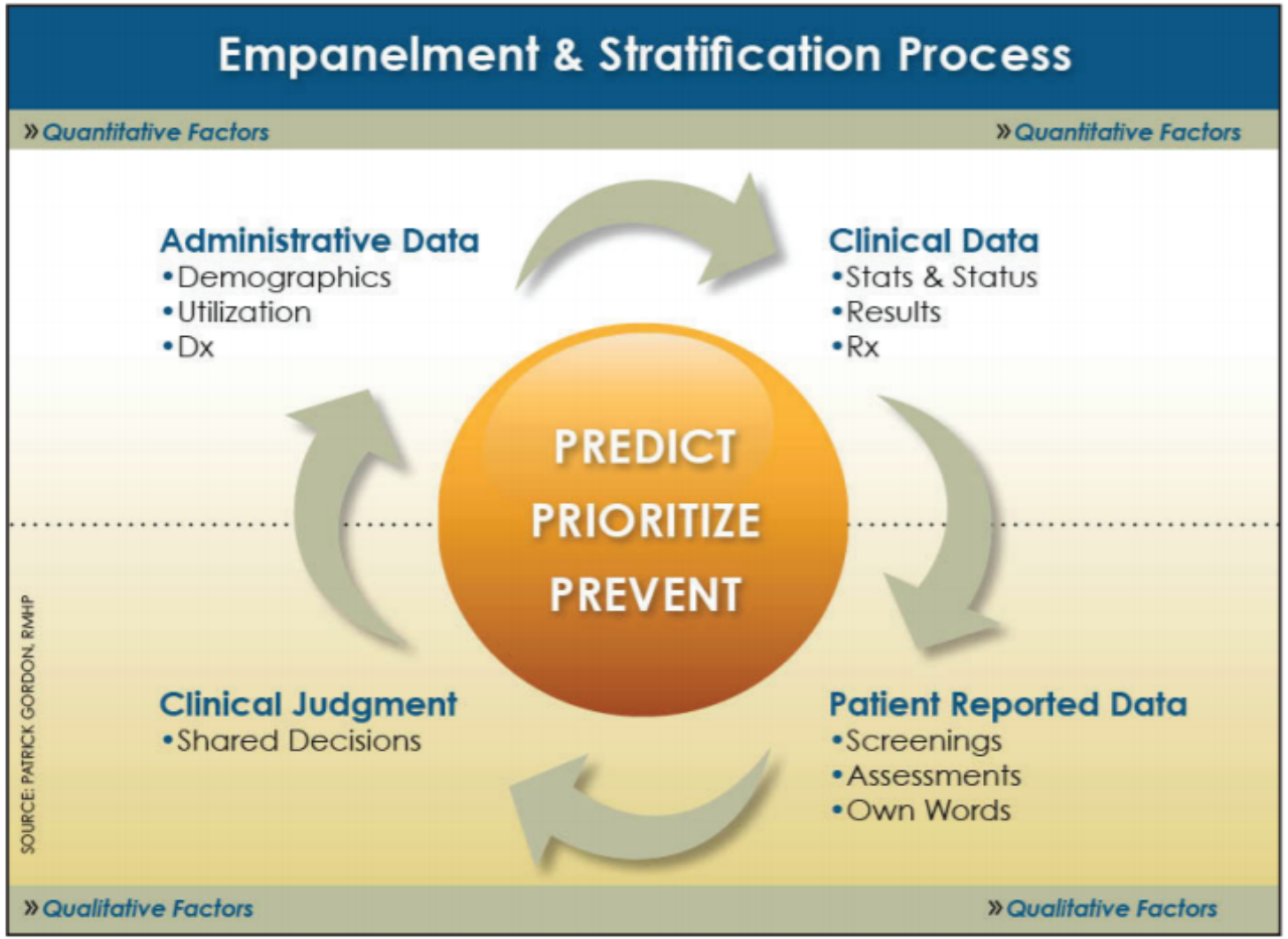
Work flow analysis to determine potential QI projects




Is patient a diagnosed diabetic?
NO
STOP
YES
Is patient coming in for a diabetes-specific visit?
NO
STOP
YES
Diabetic-specific appointment scheduled
(All practices)
Diabetes visit preparation
Receptionist pulls paper chart and puts on MA's desk (3)
Receptionist writes "foot check" on Superbill (4)
MA prints out flowsheet and individualized patient handout from registry (3)
Receptionist calls and reminds patient to get labs done before visit (3)
Puts PQRI form with Superbill (1,5)
Team huddle (3, 5)
Patient arrives
Encounter preparation
Review chart to identify needed services (2, 4)
Track down lab results (4)
Prepares lab and referral forms (4)
Pre-Appointment form given to patient (1)
In-take by MA
Asks patients to take shoes off (4, 5, 6)
Conducts foot exam (1, 2, 3)
Inquire about smoking behavior (4,5)
Inquire about aspirin use (4)
Inquire about blood sugars (5)
Ask up-to-date on immunizations (5)
Conducts random blood sugar and A1C tests (4), urine dipstick test (6)
Exam by provider
Fills out registry flowsheet (1, 3, 4, 5, 6)
Fills out EHR flowsheet (1, 5, 6)
Gives patient individualized handout from registry (3)
Indicates next appointment time on Superbill (3)
Conducts foot check (4)
PQRI form filled out (1, 5)
Conducts foot check (4, 5, 6)
Post-encounter wrap-up
MA reenters room and gives Rx, lab order forms, and referral forms (4)
Follow-up appointment scheduled at check-out (3)
Provider dictates using Dragon Speak diabetes template (2, 4)
Information entered into registry (by designated MA: 3, 4), (by all MAs 1, 5, 6)
New flowsheet printed (4)

Risk Stratification



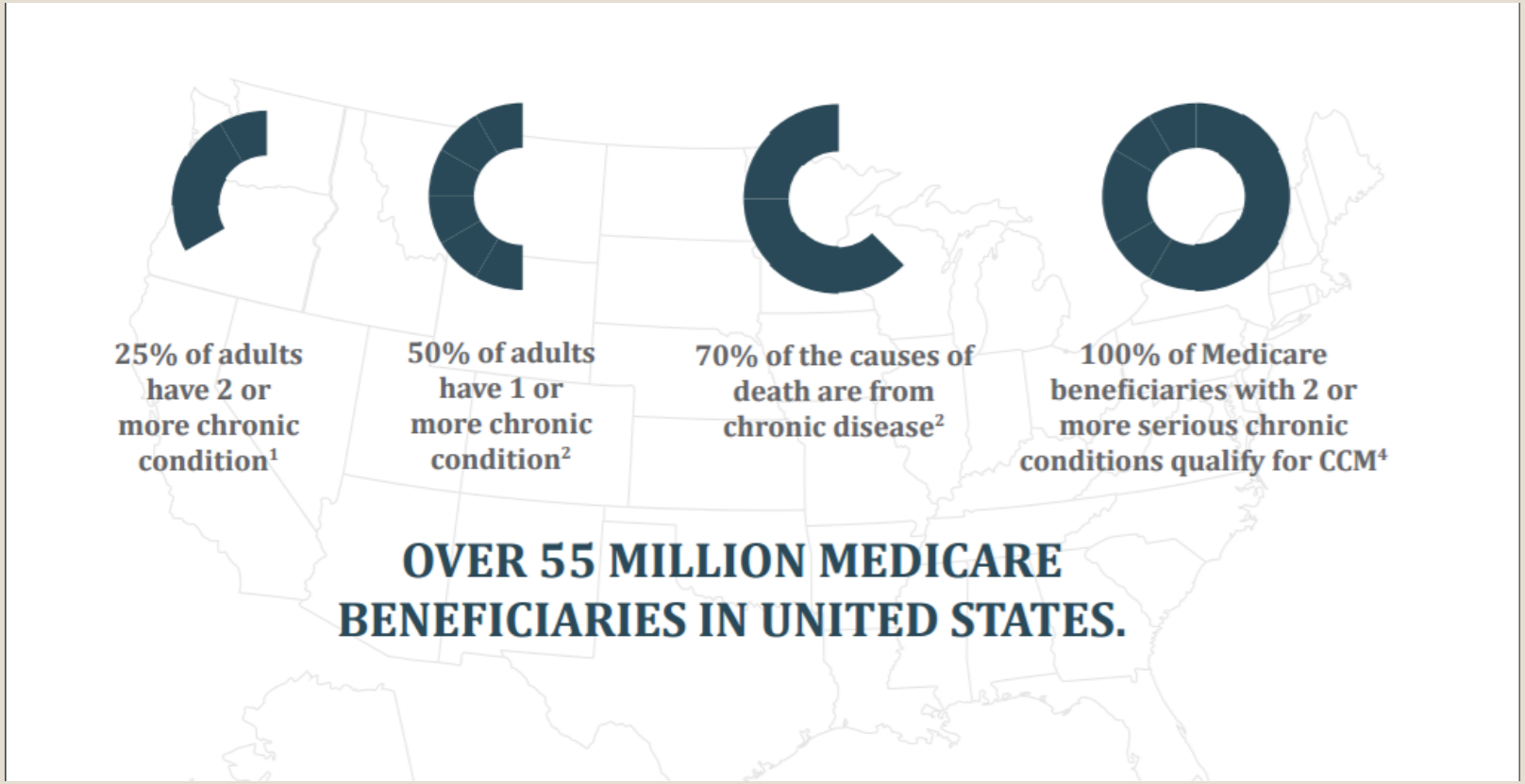

Empanelment & Stratification Process
» Quantitative Factors
» Quantitative Factors
Administrative Data
•Demographics
•Utilization
•Dx
Clinical Data
•Stats & Status
•Results
•Rx
PREDICT
PRIORITIZE
PREVENT
Clinical Judgment
•Shared Decisions
Patient Reported Data
•Screenings
•Assessments
•Own Words
SOURCE: PATRICK GORDON, RMHP
» Qualitative Factors
» Qualitative Factors

Care Management

Registry data can inform outreach and work with patients between visits:

- Medication adherence
- Follow up reminders
- Lab draws ahead of next in-person appointment

Chronic Care Managment



CCM Eligible Patients and Providers

To be eligible, beneficiaries must have:

- Two or more chronic conditions expected to last 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation, or functional decline

Eligible practitioners and suppliers are:

- Physicians, Physician's Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Nurse Midwives
- FQHCs and RHCs
- Hospitals (including critical access hospitals) may bill CCM

https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CCM-Webinar-Presentation.pdf

CCM Coding Summary

BILLING CODE	PAYMENT (NON-FACILITY RATE)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
Non-Complex CCM (CPT 99490)	$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised or monitored	Ongoing oversight, direction and management
Complex CCM (CPT 99487)	$94	60 minutes	Established or substantially revised	Ongoing oversight, direction and management + Medical decision-making of moderate-high complexity
Complex CCM Add-On (CPT 99489, use with 99487)	$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction and management + Medical decision-making of moderate-high complexity
CCM Initiating Visit (AWV, IPPE, TCM or Other Face-to-Face E/M)	$44-$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

Community Team

- Identifying gaps in care allows:
  - Referral clean up
  - Community resource connection
  - Understanding of how social determinants of health effect data

The backwards bike

SOURCE: SMARTEREVERYDAY.COM

THANK YOU

Questions for Discussion:

1. What population management strategies are working well in your practice?
2. What challenges do you anticipate in moving forward with population management strategies in your practice?
3. How can you utilize your existing team to better use the data obtained from your patient registries?
4. How are you using community resources to address identified gaps in care?