National: Risk Stratification

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Everyone, I'm Krystal Gomez from TMS Health Quality Institute. Welcome to our national CPC webinar entitled Risk Stratification, CPC Practice Strategies. I'd like to start things off today with a few announcements. The slides for today presentation will be available for download on the collaboration site. You can also download the slides directly from the WebEx environment today by using the top toolbar and selecting file, which will open a dropdown menu. Then select save as, then document. Today's program is being recorded and will be posted on the collaboration site once transcripts have been completed. We appreciate the presenter's time and effort in preparing for and sharing their valuable knowledge. Any statements regarding their technology, products or vendors are expressions and opinions of the person speaking and not an opinion of nor endorsement by the Center for Medicare and Medicaid Innovations nor TMF Health Quality Institute, nor the host of the program. As a reminder, all the lines will remain muted throughout today's session. To submit questions, click on the Q&A tab on the right-hand side of your screen. I am delighted to introduce today's speaker, Dr. Bruce Bagley. Dr. Bagley is the President and CEO of TransforMED. During his nearly 30 year practice career, Dr. Bagley was provided the full range of family medicine services in his single specialty family medicine group practice in Albany, New York. Under his leadership, the ten physician group was a well-known pioneer in the community, adapting to the challenges in managed care, quality improvement, informatics and patient-centered care. We will also have two practices that will be sharing on today's webinar. Tracie Kaplan, the Practice Manager from Physician's Medical Center PC in McMinnville, Oregon, and Dr. Cathryn Heath, who is the Medical Director of Ambulatory Services at RWJ Medical Group in New Brunswick, New Jersey. Now I'd like to hand the presentation over to Dr. Laura Sessums, who is a Division Director of Advanced Primary Care at the Centers for Medicare and Medicaid Innovation. Dr. Sessums.

Thanks, Krystal, and hello again everyone. Some of you are probably scratching your heads about now about why we're having another webinar on risk stratification. I know there were several webinars last year on this topic. Every CPC practice has had to grapple with the hard work of first empaneling all active patients. Then you had to choose a way to risk stratify them. Since there was no clearly superior risk stratification tool for use in an outpatient population, CPC did not mandate a particular method for risk stratification. But instead, left that for the practice to choose. As we at CMS have spent time reviewing

the Milestone data, all the practices have submitted for Program year 2013, we've learned from you about the risk stratification work you've done so far. We now know that some of you chose risk stratification tools that allowed you to quickly risk stratify your entire population. Some of you chose much more complicated methodologies that took a lot longer to implement. There were also some differences in the number of risk stratum that practices shows. No matter which method you chose however, it's clear that practices took a lot of time, effort and care in this work. Both in choosing the stratification tool, and then in developing work flow and processes for using this new information in the care of your patient population. We've heard about the positive ways practices have used their risk stratification in care management as expected. But also in unexpected ways, such as in triage and same day appointments. We've also heard from some practices recently that want to revise and refine their risk stratification methodology. For example, some have found that they want to increase the number of stratum so they can focus more effort and resources on patients at greatest need. So for these reasons, it's time to revisit risk stratification in program year 2014 to work on improving and refining the methodology so that it does for your practice and your patients what it needs to do. Which is, of course, 1, give you a view of your entire population so you can focus your scarce care management resources on those patients who both need and will benefit from it most. And 2, allow you to see where your advanced primary care strategies, and remember those are the integrating behavioral health, building robust support for self-management of chronic conditions, or medication management and review, will have the most impact. This is really cutting edge work, and we will collectively be refining this over the next several years. We are really pleased to have Dr. Bruce Bagley with us today to discuss risk stratification in detail so you can decide how you might refine your methodology. And he will also provide the first insight into what CPC practices have done to date in the area of risk stratification. This is the first look to see what you all are doing as you blaze this new trail for primary care. So now I will turn it over to Dr. Bagley.

[Inaudible] has some experience with risk stratification, but I am going to spend a little bit of time going over some basics. So I hope that we'll keep it moving so that everybody remains on board. And I really want to give a big thanks to Tracie Koepplin and Cathryn Heath for joining me. I will ask them at various times during their presentation to give actual examples of the kind of work that they're doing. So, I always like to have sort of a simple goal, a simple mission. What are we actually trying to accomplish. And to me, what we're trying to do is develop and run and maintain a systematic and reliable and organized way to get patients what they need when they need it. So, if you need sort of something to stick up on the wall about why you're doing this or what you're trying to accomplish, something similar to this might be helpful to you. So we are going to talk a little bit about the progress today. We do have some information about that. And we're going to talk a little bit about the Why, although I realize that most of you are engaged and are beginning to already to realize that it's an advantage and that it's a whole lot better than what we were doing before, which was basically winging it on some of these more complex patients. And then we'll talk a little bit about the conceptual framework. But I really want to get into a discussion, a conversation, a dialogue if you will, about what makes us work well and what some of the issues are and how we might get over those hurdles. And then we'll talk a little bit about work flow and care management strategies. So, let's move on. By this time, I would think that all CPC practices should have some kind of an explicit risk stratified care management strategy, or risk stratification

strategy in place. Now some are far more sophisticated than others. But you should be pretty well on the way to this kind of assessment of how you're going to do this and what things are needed and who's going to do it. I hope most of you by this time have some kind of a well-defined risk assignment algorithm that's pretty easy to understand for everyone who needs to use it. In other words, it has to be fairly straight forward and something that somebody can pick up and use readily without a lot of training. I think that it's critical also to assign some clear roles and responsibilities to support this effort. And even though virtually everyone on the team has to understand how and why you're using it, there usually has to be at least one person assigned to make sure it's running well and to make sure the system's working and that people are using it effectively. And then finally, I believe that most of you realize or have found out that you can't do this without some kind of a system to keep track of everything. And when I say the word registry, that's what I mean, registry function. To manage this work and keep track of who's on the list and what they need next. And to service a particular file and support the team approach. So here's the first slide from the CPC faculty survey that was done. And it shows that a little over the third of the practices have used some form of the AAFP risk stratification tool or at least something that's derived from that conceptual framework. And nearly an equal number have used a provider determined algorithm, and then you can see from the slide that there are some that are using just clinical intuition. I think that's fine. But there's probably pretty wide variation, what people would call their intuition about an individual patient. And I think we'll find that if we rely only on clinical intuition, there'll be a lot of variation and how people are assigned depending on whose intuition we're using. So, I think that we need to move that to more of a systematic or algorithmic approach. I do think that clinician intuition has to figure in at some point, but it can't be the sole source.

10:13

So, what we've seen with various themes among all the CPC practices is that almost everyone has implemented some kind of a risk stratification guide to guide the care management. And this is sort of a reiteration of what we just saw in the last slide. But, you know, the good news is that people are trying different things. And we're going to get some feedback from you all along the line to see what's working best. So just to put this work in context, risk, assigning a specific risk category or risk strata is part of an overall approach to caring for your patient population. And under the larger banner of population health management, there's a lot of talk about population health management. And we'll talk a little more about why that is and what they're really talking about. But the tools that you have been using and have developed in the risk stratification pieces absolutely fundamental to managing this particular population, this high risk population. There are other aspects that population health could take. For instance managing all the people in your practice with diabetes or asthma or COPD. Those would all be subpopulations as well. In case of today, we're going to talk mostly about the subpopulation of people that you have identified as high risk. I wanted to just for the record kind of back up a little bit and say something about the patient's care versus the patients' care. And you see that I've moved the apostrophe there on purpose. Clinicians generally are trained and have practiced in a manner for many years that were, their sole responsibility, their sole focus when they're taking care of a patient is the individual in front of them. And that's fine. And we're not trying to say that you need to step aside from that. But in addition to that, if we're going to really look at a population of patients, whether it be all of the people with diabetes or all the people that are at high risk for finding their way around our

health system, then we need to have some aggregate of that information. So if you think about the individual patient in front of the clinician, it's really like an anecdote or a study with an N of 1. But if we look at all the people, for instance, who have diabetes where there's 1 or 200 patients within the practice that have diabetes, only when we aggregate all the observations about that group of patients, that population of patients, can we know about the quality of our care for that condition. So, important thing to make sure that you may need to use this to convince physicians why we're doing this type of work. So why is this important? I think that most of you recognize now that to identify people that need extra help, and I want to draw the distinction between care management and care coordination. This webinar is really not about those two things. But it's so closely related to the activity that we at least need to mention it once in a while. So care management of course, according to CPCI definitions is about helping the individual patient manage their chronic condition. In other words, it's about the individual patient. Whereas navigating the medical neighborhood might be more in the realm of care coordination or how do we get them around the medical neighborhood. How do we get them the things they need at all the different points of care when they need it. And the other reason if it needs a reminder is that one of the reasons we're trying to get this high risk population segmented out is to help leverage cost management. And in the past, I think there've been instances where people have truly fallen through the cracks or we lose track of them. When they're out in different points of care and no one seems to have the power or the systems or the effort that it takes to keep track of them and make sure they don't fall through the cracks. So that's an important part of this work. I wanted to mention this. This is just a screen shot of a publication that the CPCI faculty will release. I think as early as Friday of this week. Or at least sometime in mid-April. So watch for that. It's kind of a summary of the experience to-date. And some stories and also some examples of risk stratification systems that different practices have chosen to use. Now, I want to go back to this algorithm just for a minute. This, some people have called this a risk stratification tool. And I think more appropriately, this is a conceptual framework that you should use to evaluate whatever method you choose. In other words, does the method that you've chosen take into account most of the issues that are raised in this conceptual framework. And I think it's just a good touch point to go back once in a while and say, are we accomplishing, are we using all the factors or most of the factors in the conceptual framework as we roll out or as we refine our risk stratification methodology and conduct and how it works in the practice. So, I really still think this is very valuable. I don't want people to think that the only way to do this is with six levels or with this particular construct, but I think it still remains valuable in assessing whether your particular method is working well and takes into consideration all of these things. So, just wanted to mention that. So one of the things that has come up, there seems to be quite a bit of variability in a number of risk strata or buckets if you will that people have come up with. And I don't think that there is a hard and fast rule about how many there has to be, but most people have found that three or four seems to be a minimum. If you have too few categories, then you have too many people in the highest risk category, or you have the risk of having too many people in the high risk category to actually manage. And then if you have too many, then you have too many different approaches. So, there's some sweet spot in between. And I'd like to pause for just a minute and ask first Tracie what, how many risk categories they use. And then after you tell us about that, tell us how you managed the highest risk category so that it doesn't have more people in it then you have resources to manage. So could you take those one at a time. Then I'll ask Cathryn to do the same.

Sure, we have five strategic focus areas in our risk stratification model. And how we manage our highest risk patients, we created a care management team. So we have one care coordinator that manages highest risk patients. And we took into consideration like how many is that going to be when we ran our algorithm. So, we have found that the management that is going to sustainable is about [inaudible]. So that's what we're currently working with in just one of our care coordinators. And we also have advice nurses that help us manage those patients as well.

Good Tracie. I have a question. So that's 200 patients for how many physicians, nurse practitioners, PAs, I mean how many total clinicians that generates the 200 patients?

We have 17 providers, including, ant that's including two [inaudible] practitioners.

So great. That's a good point to make in the sense that you're not going to have 1 or 200 per clinician. You're going to have, you know, 5 to 10 to 15. So keep in mind, I mean I'm not going to try to set a specific number. But it's not hundreds per clinician. Great, thanks. Keep going.

And we're focusing on our top 1 percent of our active patient population.

Okay. Cathryn, do you have any comments?

Yeah, we chose the AFP 1 through 6 risk stratification system. And we initially thought that our clinical care coordinators would be able to handle the fives and sixes, only to find out that the numbers were too overwhelming for them. So essentially, they're working their way through the sixes, and then working down to get into the fives. And it's again, that's why, in at least year 2014 we have elected to adding another population care coordinator because we realized that the numbers are quite significant of the people that we have that are landing in the fives and six categories.

20:12

The rest of our populations are the ones through fours are mostly dealt with through our LPN triage staff. So that's how we kind of separate who is in taking care of which patients.

Great, and can you share or do you know offhand about how many patients per clinician might be in those top two groups?

We have a mixed practice of, or one of the academic practices in CPCI, and we have a residency practice with that. So we have about 45 physicians, but all of them are part time.

Okay.

Yeah, so it's a little hard to gauge. Let's say that we probably have the same as 17 full time equivalents.

Okay, great. Well Cathryn you just made my last bullet point there that basically you want to set up your system to focus on the high risk/high need patients first. And then, you know, fill in the needed features for the lesser risk later. And sort of teach everyone in the practice what it takes to do this work on a, you know, a light basis if you will for the ones who have lesser need. So let's go on. These next couple of slides are simply screenshots. They're not meant for you to be able to read, but these are examples of

some of the risk stratification mechanisms, algorithms that people are using. And I assume that the CPC faculty will make sure that those are available to you. Here's a couple more. And you know, if you don't have something sort of laid out like this that you can just hand somebody, I would encourage to make sure that you try to codify what you're doing in some way so that it's easy to communicate to others. So I wanted to make the point with this slide that this really is a team effort. That there's a lot of components and processes that have to go into doing this work well. And although everyone on the care team will have a role in some way in making this work well, there still has to be somebody who takes charge of the system and makes sure that the system is set up well. That everybody understands how to use it and that everybody's participating in its use. So I think that's a critical issue. I like to think of this work as being the team's responsibility or being a function within the practice, rather than having it be an FTE, in other words a single person who does only this work. In most smaller practices that's just not something that they can afford. And it really probably isn't necessary in a smaller practice to have this be a full time amount of work. So let's keep that in mind. But I just wanted to lay out some of the components. So, I want to make the point that it's absolutely critical to identify the top 5 to 7 percent of patients. This number comes from the typical spread of the cost of patients. So in any large database, claims database, we found that about 3 percent of the patients generate 30 percent of the total medical spend. And you don't even have to get to 10 percent to get up to 50 percent of the total medical spent. So somewhere between let's say 5 and 7 percent will give you about 50 percent of the medical spend. And that will allow you to focus on the high leverage patients for cost savings. And I think that if you try to do the entire patient population at once that your attention to this particularly critical group will be distracted. So, I would certainly want to focus on this group, because part of what we're trying to accomplish in this activity is not only to take better care of this group of patients, but also through that better care, more organized care, more supportive care, save
some money for the system, the total medical spent. I really think it's critical to have a care plan. And I know that people have struggled for what should belong in a care plan, how should it be produced. And I have a suggestion for some of you to think about, if you're still struggling with that. Almost everyone in CPC has qualified for meaningful use 1. Which means that you can produce an after visit summary. And although that's certainly not a complete care plan, it can be the foundation for an interim approach to care plan. So you may already have the automated mechanism to produce that. And then with a free text box on that visit summary, or even scribbling some notes on the bottom of a printed out copy that you give the patient, it may be a service of at least a step towards a more complete care plan that you can work into your system later. So I want to stop here and ask Tracie and Cathryn, what are you using for a care plan? How do you make sure that everyone in the high risk group has some kind of a care plan? And how does it follow them around the different points of care? Tracie, why don't you go first?

Okay. We use some of our incentive dollars from CPCI to build a care management care plan form that our care management team uses. And they document a care plan on all of our high risk patients. And it's actually a living care plan. So that the next time they go into a document on the high risk patients that care plan from the existing visit is active. And so we can act upon that for the next visit. Our current [inaudible] system didn't have a care plan form that we could use. So we knew we had to create something. And being incentivized we, we did that. It's been very beneficial for us in managing our high risk patients.

Cathryn.

Initially we put together a care plan tool fairly soon in the process of CPCI that was paper based, which was then scanned into the record. But, you know, like many practices, we found that document was easy to kind of loose track. So now we're in the process of creating a form as well that can be uploaded and then, you know, have the information put into observational terms so that we can extract things from it that we'll need. So we're looking forward to operationalizing that pretty soon.

Okay great, great. Well let's go on. So, you already know what you'll need. But just again, some kind of algorithm. I want to ask our practices to comment on what you're doing, either with a registry or an EMR field, a searchable field, or for that matter, putting the risk designation on your problem list. I mean there's a lot of different ways to do this. But I believe that it works best if you have some way so that whenever the clinician opens the patient's chart, whether it's for a face-to-face visit or a phone call, that their risk strata is, there's risk stratification designation kinds of pops out. It's kind of in your face so that we know which people are getting the extra attention or need the extra attention. So Cathryn why don't you start this time, and how do you do that? Do you have a, do you put it on a problem list? Do you have a searchable field? Do you use a separate registry? Do you have an embedded registry? How do you guys accomplish all that?

We did a lot of those different things. We actually created a specific template that had a lot of the preventative health tests that we were trying to track on one form. And in the end it had the health risk on it. So that health risk then gets added to the banner of the patient's chart, along with their name. So, it's, you know, Mrs. Smith, and then risk level 4 right on the banner so that everybody can see it. We also created a registry as well so the nurses, the PCC nurses are working off an Excel spreadsheet of the fives and sixes basically. So both is helpful in different ways.

And Tracie.

We use our patient banner to put highest risk level. So, we have a risk model that goes up to a level 5. So we put that number in the patient banner so when our patient calls in, they call in to say the call center to make an appointment. Our call center knows quickly that there's a level 5 there. And that tells them this patient is the highest risk. And therefore, we need to make sure to get them an appointment sooner than later. And it just helps us identify those patients to meet the needs of those high risk individuals.

30:14

So we have the patient banner. And then also our term coordinator will put pop ups in the charts to remind the staff or the PCP of that patient that may need some additional, you know, some additional things done for them. So we use our alert system as well.

Let me ask you both one other question about the registry, now the registry function. Obviously it's going to have some demographic stuff in it. But what types of information do you put into the registry? And I'm thinking about things that might be hard to find in the regular EMR notes. So, you know, are they on home oxygen? Or are the on meals on wheels. I mean do you have extra stuff in your registry? What kind of stuff do you put in there that helps with this outreach function?

We put various common diagnoses that people have, when their last appointment was, and when the doctor wanted to see them next. So that we can kind of track them. Because, you know, I worry more about the patients that I'm not seeing than my patients that I'm seeing sometimes. So who's dropped out that we need to contact so that they can come in again. So, it's not just name, date of birth and insurance. It's the common problems. It's when they were last seen. It's when they're supposed to be seen next. So we keep a running total of what's happening with the person.

Would, might you have a column or a box that says when the next outreach call might be? I mean if it's just about visits that's one thing. But you know, that if there's somebody designated to contact people on a regular basis. There has to be a way to generate a tickler list for that.

Right exactly. So that's one of the things on the actual spreadsheet that keeps it useful. So our population care coordinator's more work off the registry than work, you know, they work on the EMR too. But they track the patients on the registry. We set it up so that our level fives and sixes get automatically sent to the nurse manager so she can divvy up those patients. That's kind of the integration between the Excel spreadsheet and the EMR.

Great, and Tracie, how about you?

Well we, that's the benefit that we have found with our share plan form is that we can actually track inside there. We have looked at if a patient is involved with care outside of our clinic, like specialists or social services. Or if there is socioeconomic needs. Or if there are other family members that we should be contacting instead of the patient. So we use our care plan, and we're able to run. We're able to collect information to help us going forward with our high risk. And the whole entire team, including, you know the PCPs and other staff can see what's going on with our patients. We don't really have like a registry per se. We just basically use our care management tool, which is the care plan.

You know while we're still on this slide, let me ask you both to talk a little bit about your staffing. So, certainly some of this work is almost clerical in nature in the sense it doesn't require a lot of clinical background. So outreach to, you know, for a social contactor to make appointments or things like that. And whereas other parts of this work require fairly high level clinical understanding of the problems that the patient has. So, how do you decide who does what work? And also, I'll make an outrageous statement here to see what you guys think about it. Very little of this work is physician work. Physicians obviously have to oversee and make sure the thing's set up properly and that they're kind of the go-to people if there's some difficult clinical things to sort out. But this is not a lot of work, additional work for physicians. So, could you comment on the staffing and how, what's the physician's role? Cathryn, why don't you take it first?

Well, the way we have it set up with the fives and sixes that are set up through the alert when the patient comes in the next time for an appointment, the population care coordinator and the physician have that appointment together with the patients.

Right, right.

So the patient feels comfortable with the care coordinator. We have a direct line for our care coordinators for the patients to call. They get a card basically. Which they really feel is a great tool to get some access to somebody as soon as they need. So our fives and sixes are with our population care coordinator. And our other levels are handled by our LPN triage staff. Some of whom have a long relationship with some of our patients because they've been in our practice for a really long time. So there's, you know, sometimes the patients will cross back over from one team to the other for care. And the doctors work with both sets of people. We're divided into three care teams in our office because we have so many doctors. So and each care team has their particular LPN that they work with as well.

Great. Tracie.

We are just managing our highest risk patient ovulation, and so we have an RN care coordinator who manages those, that patient population. But one of the things that she does is she will scrub the next day's schedule, or maybe a week out, to identify those high risk patients that are going to be coming into our organization. And she does an actual face-to-face meeting with them before they actually see their provider. And she does give them her card. And she does have a direct line. And then she does reach out to them quarterly, and she also meets with our providers on all of their high risk patients quarterly to review each high risk patient's care plan and determine if there are any changes or additions that those providers may want or need. And she also can, anybody in our clinic can become a high risk patient per their provider. And so by meeting with them quarterly, she reviews their fives or fours or threes, their twos and their ones. So the provider has complete transparency on what patients they have according to the algorithm that we use.

Okay. I wanted to talk a little bit about some workflow considerations. And once again, I'm going to ask our practices to chime in here a little bit. If you haven't sort of thought through how this works within your current workflow, I think it's critical that you step back and see how this can be done most efficiently. You know, when does, when do you assign the risk stratification? Is it done when they're empaneled? Is it done during the pre-visit work? Is it done at check-in? Is it done at rooming? Is it done a clinician or any of these places? So it actually doesn't matter so much where you do it as long as it's in the flow and in part of the expectation for each of those clinicians. So how do you do that? If there's a conflict among different evaluators, who gets the final determination? And what kind of things other than what has already been mentioned, do you kind of make sure that everybody gets, I'm making this up but kind of on the way out the door what are the critical things that they should have. So, Tracie, why don't you start this time and just give me some idea of how, where in your workflow does this fit in everyday work?

We, I apologize, I probably talked a little bit about this a few minutes ago, but we run our risk stratification model quarterly. And we see if we have any new additions to our patient panel or our high risk. And so then our care coordinator will meet with that specific provider of that patient and decide on any sort of care plan that they need to work on with the patient. And then after the patient is seen, typically we try to reach out to that patient one week after they were seen in our organization. And if they were in the ED or they were discharged from the hospital, we try to reach out to them within less

than five visit days. And actually we've done a really good job of outreaching out to them, and I think it's probably less than three days. So, that's what we try to do.

Great. And Cathryn.

40:04

Mostly our physicians are responsible for risk stratification, and they can do it at any time. When we initially got the empanelment list, we went through each of the empanelment lists for major insurances and CMS and assigned folks numbers from there. So since then, it's more of a, generally a physician responsibility to assign a risk stratification. But we can assign, anybody's allowed to assign it. If somebody's been in the hospital, since we have EMR access within our local hospital, though we'll have one of the residents or the person who is on service reassign the person's risk stratification. I try to do it almost every visit. That's the goal. So it can happen at any time, but it's generally a clinician's responsibility. Which has good points and bad points, and some doctors are hard to get on the wagon for doing stuff. We're having a risk stratification contest right now to see who can assign the most patients. Just to get a kind of everybody in the flow.

What's the, what's the prize? That's what I want to know.

The prize is for the highest number of patients risk stratified in three months is an iPad mini.

That's worth working for.

Exactly. I actually had somebody say to me, I wouldn't mind seeing a couple extra patients this afternoon just to get that, you know, higher on my list.

Okay.

We post it every month. So, anyway.

Very good. So let's move on. I think, I want to reiterate. Now some of this is, you already know. But remember that Milestone 2 goal for this year is that 95 percent of the patients are empaneled, and of those, 75 percent have some risk stratification. So somewhere between now and the end of the year, you're going to have to work your way down to those who are at lesser risk. But, still I think if your initial efforts are mostly focused on the high risk. The other point I want to make, and this is really critical, there's a lot of people that are agonizing over which category people should go in. And I think as you get farther along in this process, it's going to become pretty obvious who needs the help and who doesn't. And the precision with which you assign the category is not anywhere near as important as what you decide to do with them after they're in a particular category. So don't agonize over whether they go in there or four or four or five or whatever your buckets are. Spend your time designing systematic approaches to what you're going to do for each bucket. And I think that you'll get farther along. And, you know, this is new for most of us to do this work. But like everything else, once you've been doing it for a while, it becomes part of the normal workflow and far more intuitive for everyone. So, just a quick progress check, ask yourself, can you identify the top 5 to 7 percent who really need the help most and to reduce the harm, if you will, or reduce the chances of them not getting what they need, if you can't

do that, it's maybe time to reassess your system. So that may be a little harsh. But if you can't kind of identify the people in most need, in a way that allows you to have a manageable number to do something with them, then step back and reassess, okay. And are the interventions that you're using with these patients effective. And I'm not going to necessarily offer a measure of effectiveness. But you kind of have to always be asking yourself, is what we're doing to the, for these people and in our system, is it working? How could it be better? What's not working? What could we make more systematic so it's more reliable and more effective. So that's kind of your ongoing, what's your ongoing QI strategy? So, I also, I mentioned this a little bit earlier. But if you haven't had discussion about roles and responsibilities, I think that's important. You know, I think it's a mistake to hire and train, hire and/or train someone whose only job is to do this and nobody else does it. And therefore, it becomes sort of a one person show. I'll give an example. In my practice a long time ago, we got large enough. We used to have the nurses draw blood after the visit for all the patients in the room where the patient was seen. And we got large enough, so we, you know, we're big enough now we can have a phlebotomist. And the day after we hired the phlebotomist and they came on board, all the nurses forgot how to draw blood. It just, it just made no sense to me whatsoever. So it became this central burden on a single individual, and it made it far less effective than what we were doing before. So, I guess my plea would be, even if you have someone and you've hired or trained them to be in charge of this responsibility, I think part of their duty is to train everyone on why it's important and what lighter roles might be involved for people in the practice, patients in the practice, that have a lesser need if you will. So the responsibility is spread across the team. So the concept of cross training I think is important. You know, whatever algorithm you have, make sure that you have some way to recognize special circumstances. And I've just listed a few of them just to give you some ideas of what I'm thinking about. But, things like cognitive impairment and poly-pharmacy, social isolation, mobility issues. A lot of times these types of things don't jump out when you look at the problem list. So how is it that you handle these with your system? Do you have a systematic approach to addressing these issues? Do either of you want to comment on your approach how this work into your, is it part of your initial algorithm? Or is it something that's sort of added on when it's recognized? What. Go ahead.

You know what I, part of it is in our original premise. In fact we currently have a unit for developmentally disabled adults. So we kind of have the thinking in the background anyway because we, you know, take care of 140 of them. So, yeah that's something that's often brought up. And often these things will end in a pop up so that people understand when they open up the chart that people will have difficulty. It's both in that as well as in the scheduling that there might be an issue and who you're supposed to contact within the family and/or the patient themselves.

Great. I'm going to go on so we can stay on time. So, I wanted to talk just very briefly about palliative and hospice care. And we found with some of the practices, although they only had three risk strata, they had decided to put all the people in palliative and hospice care in a separate strata. In other words, to put them in a different bucket because they needed a different approach, different services. And I wanted to ask our participants if there was anybody, how are you dealing with this? This is a little delicate. You don't want to have this conversation about just cost cutting. We really want to have this conversation about what, have we addressed the real need of the patient? And my point here is that if

you think about moving from the lowest risk strata to the highest risk strata, you have a tendency to kind of just dial up the same knobs. In other words, the same type of activity. Just turn up the intensity. Whereas I think there's a group of patients, probably end of life folks, palliative and hospice care, for our elderly maybe, I'm not sure exactly how to define this, but that really need a different approach. That isn't just dialing the dials about the intensity. So Tracie why don't you start? How do you deal with this group?

We, our care coordinator provides more of a supportive type of coordination of services to the specific patient needs. I know a lot of these patients are inundated with outside appointments from their PCP. And so a lot of them, you know, get lots of phone calls. Lots of other services. And just want to be a support team to them. So if they had any additional questions or needs, we do reach out to them. But they are in our overall risk stratification model. And we also have a behaviorist on staff inside of our organization. So if there are needs that need to be met, if there's a patient that may need some additional services, we can provide that with our behaviorist that we have.

Okay great. Cathryn.

We don't separate palliative and hospice care patients just because, you know, to, it's a different part of the life spectrum. So.

So that's your bucket six.

Right.

Do you kind of have a different approach to that group?

Not, not really. Just where we, we have probably a more intensive contact process for that group than for others, just to make sure they're getting their needs met. So the nurses might put them on a two weekly or even more frequent phone call regimen.

^M00:50:16

And one of my patients passed recently, and I was told that by two of our nurses in our office and given condolences and sent to the family as well. So, they're more intensively covered.

Great, great. Okay well I wanted to make sure that your systems, all of you have given this some special attention. Another suggestion would be to make sure that you consider having service agreements with your palliative care group or your hospice care group or your home care group so that it makes when you have a patient that needs this, it's an easy thing to arrange. I just wanted to make the point with this next slide that most of the people that are going to need this extra help and this highest risk group are very familiar. So you can have a fancy algorithm, but I can be willing to bet that almost anyone in the office can name off who the frequent flyers are, you know, whether he asks the clinicians or the front desk people. They know who the regulars are. So, it may be these are the regular folks, okay. We've already talked about our registry function, and I don't want to push the stand-alone registry too much. But somehow you have to be able to keep track of this in a systematic way. And ideally, eventually all

EMR products will have this kind of function embedded, and it'll be part of the work flow. Unfortunately we have a little ways to go on that. So I wanted to take this opportunity to thank Cathryn and Tracie both. Here's their information. And I suspect that they will be available for other questions and inquiries. So this is nearly the last slide here. And I wanted to give you an opportunity to do sort of a checklist. And this is for everyone on the call. You know, do you have an algorithm that's fairly explicit. And you think about handing it to someone, let's say handing it to an RN that didn't know your practice. Or handing it to a physician who didn't know your practice. Could they read it and pretty much understand what you're trying to accomplish. So something that's fairly explicit. And how to do it. And the risk scores in some kind of a searchable field. And the EMR on the problem list at the very minimum some way that it's kind of in your face when you're connecting with a patient. What's your strategy once you get people stratified? How are you going to do it? What are you going to do for it? Who's going to do it, that kind of stuff? The registry we've talked about. Who's a team member? What team member? Do you have someone who's overall responsibility, responsible for making sure that this system works? And what's your level of trust, training. And then what's your methodology for feedback and QI and testing, small tests of change and sort of rapid cycle redesign or PDSA cycle? So, like any other system we have, make sure you're always looking at it to see how it could work better. So, I won't dwell on this any longer, but do you know if you're not identifying those in most need, then you need a new system. And the care plan is absolutely essential. So, measures of success, obviously most of you I would assume are tracking some clinical quality measures. And you can expect those to improve as this permeates the rest of your practice. Especially around chronic illness care. And that what percentage of patients have a risk score recorded? Obviously your goal is 75 percent in the Milestone 2. What percent have a real care plan on the chart might be another one. Some of these you may have to get from outside sources. So your payers might be able to know your visit, your ER visits per 1,000, your bed days per 1,000. Your total cost of care. I'm not sure what number you want to use for how soon people should be seen after a hospital discharge or ER visit. I put 72 hours. But, have some goal for yourself and then measure your percentage against whatever goal you decided. So that's how you know whether you're successful or not. Just a quick reminder about the three-part aim. By the way, everywhere else it's known as the triple aim, but remember we're trying to do better individual care, better population health and lower per capita costs. The beauty of the triple aim is you don't get to choose two. It's all three. So, this is my conclusions in terms of it has to make clinical sense, or people won't do it. It really requires the entire team to understand and to make it work well. And a systematic approach gets much better results. And it helps everybody understand and feel that they've done a better job for patients. So I think with that I will turn it back over. I've got one concluding slide. And this actually has to do more with Milestone 4, and that's about patient experience. And I liked this quote so well that I put it in most of my presentations. And you know, we've all heard the, if we build it they will come from Field of Dreams. But, you know if you involve patients in how you construct either risk stratified care management or any other endeavor that you're trying to do in terms of office redesign, you know if you have them help you build it, they'll already be there. So, my friend Christine Bechtel from the National Partnership for Women and Families came up with this. So I think it's a great thing to keep in mind. So, Krystal, I'll turn it back over to you. And I don't know how much time we have for questions. We're kind of almost at the top of the hour.

Right. I think we have time for just a couple of questions. And while we're taking those questions Bruce, if you will pass the presenter ball to me.

I'm glad to do that, yeah.

Perfect. Okay, so one of the questions we have is, it's for both Tracie and for Cathryn. What EMR are you using in your practice?

We are using GE's product, Centricity.

Okay.

We're using the GE product too as it turns out, Centricity.

[Inaudible] Centricity.

Yeah maybe I can make a comment on that. You know, regardless of what product you're using or what functionality it has, putting the workflow in helps you be able to know what to ask your vendor to do. So, keep in mind that as you design these systems, you're gaining an understanding of the process. And you begin to know what functionalities that you want your vendor either to have in the product, have custom built, or turn on. So regardless of what EMR you're using, make sure you have a conversation with a vender about what's available to support this work.

Thank you. Okay so the next question is also for Tracie. Would you be willing to share your care plan form on the collaboration site?

Yes, we would be more than happy to share.

Wonderful. Let me see. I think that is really the end of our questions for today. I just to remind everyone that our next national event is an open mic on April the 24th at noon Eastern. And then our next national webinar is on medication management, and it will be held May 7th at 1:00 pm Eastern. Thank you all for attending. We hope that you found this presentation informative. You can exit the session by clicking on the file menu option at the top left of your screen and select the option to leave the session. You will be taken to a post-webinar survey that needs to be completed in order to receive credit for attending this presentation. Thank you very much.