Division of TennCare

STATE OF TENNESSEE

PCMH: Population Management
Stratification Part 2
3/21/18

Today's Agenda:

11:00-11:50am

- Stratification of Patients by Access
- Stratification of Patients to Determine Resources
  - Assessing Resource Needs
  - Resources to Consider

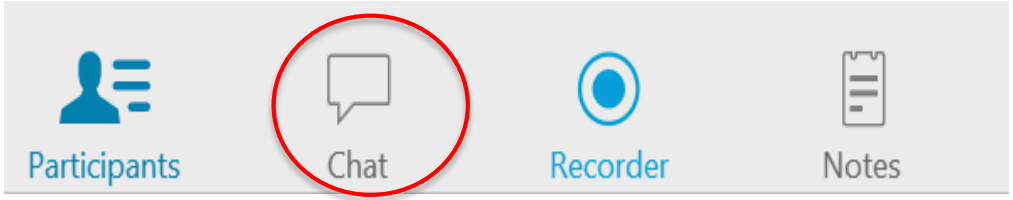
11:50-12:00pm

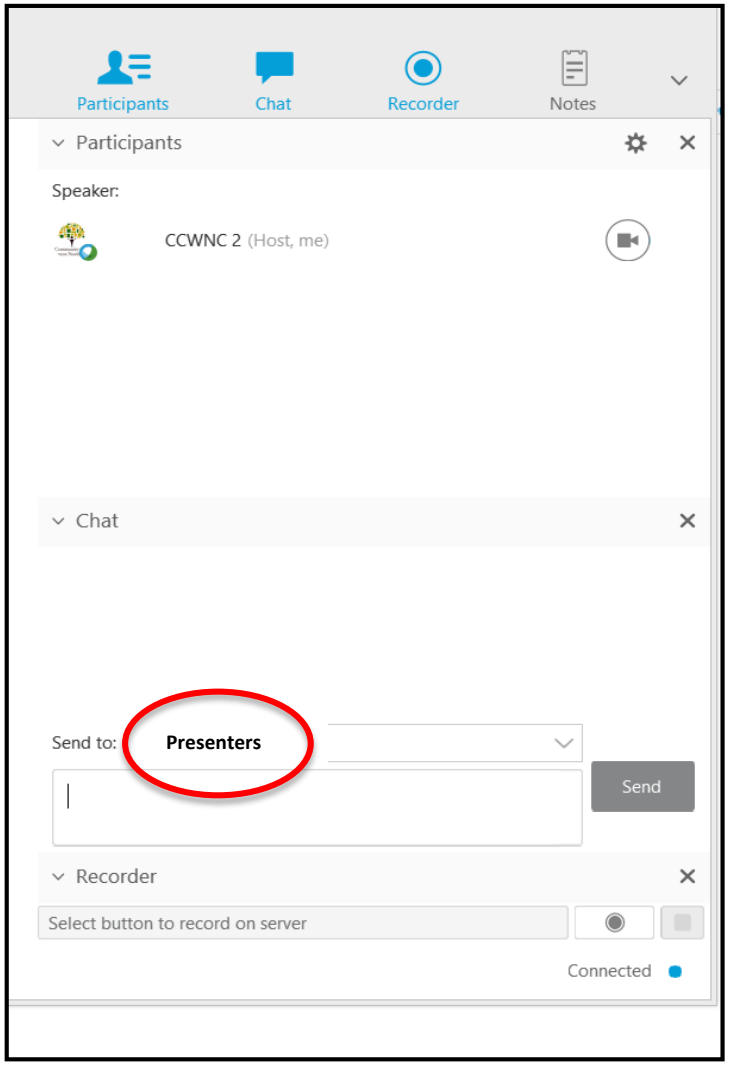
- Facilitated Discussion
  - Best Practices, Challenges and Novel Ideas

Introduction to the Collaborative

Chat box during the presentation:

- ➢ Send to the Host
- BEST PRACTICES
- CHALLENGES
- NOVEL IDEAS
- QUESTIONS





Quick Review:
PCMH 2017 Terminology

Today's Concepts:

AC : Patient-Centered Access & Continuity

KM : Knowing and Managing your Patients

Division of TennCare

STRATIFICATION BY ACCESS

How do Practices Stratify by Access?

- AC 01 (Core): Assess the access needs and preferences of the patient population
- AC 09 (1 Credit): Use information on the population served by the practice to assess equity of access that considers health disparities.
- AC 13 (1 Credit): Review and actively manages panel sizes.
- AC 14 (1 Credit): Review and reconcile panel based on health plan or other outside patient assignments.

AC 01 (Core): Assess the access needs and preferences of the patient population

Health Disparities

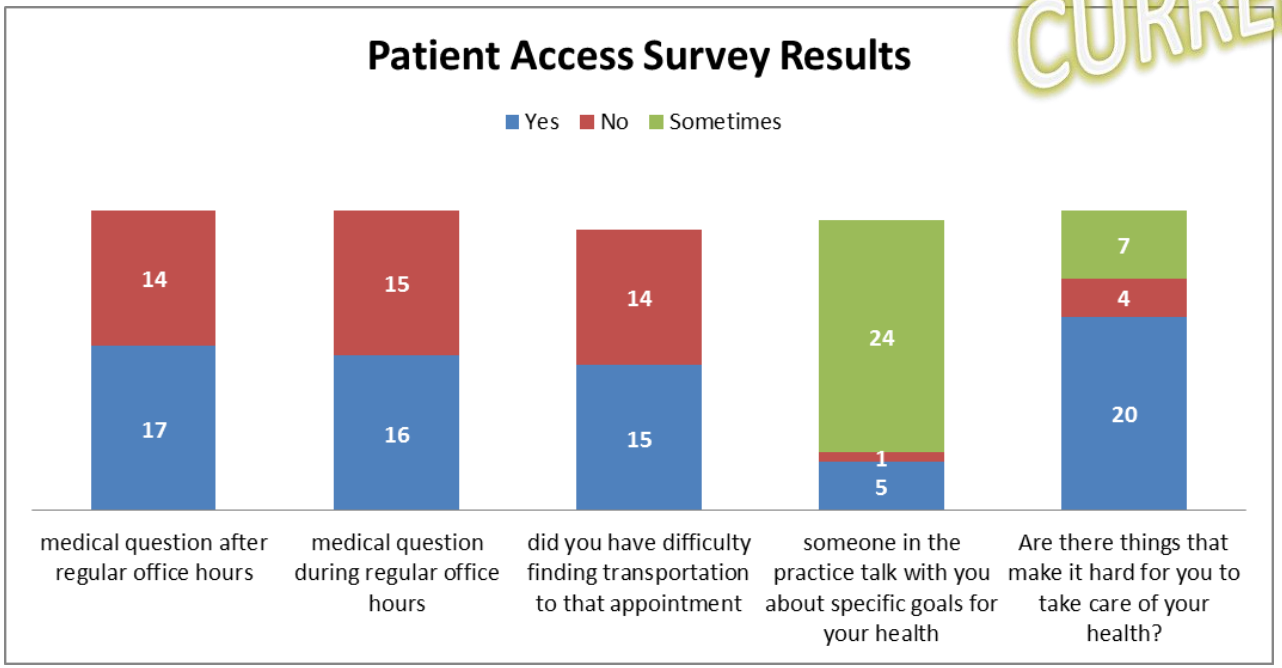
Health Outcomes

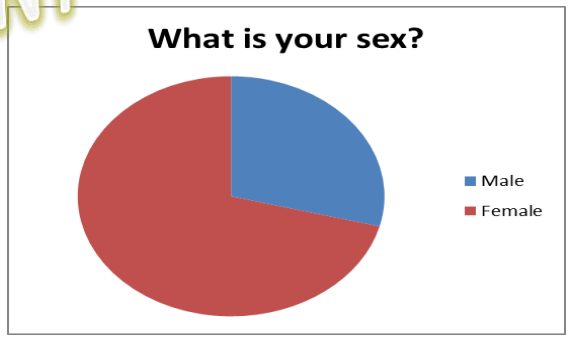
AC 01 (Core): Assess the access needs and preferences of the patient population

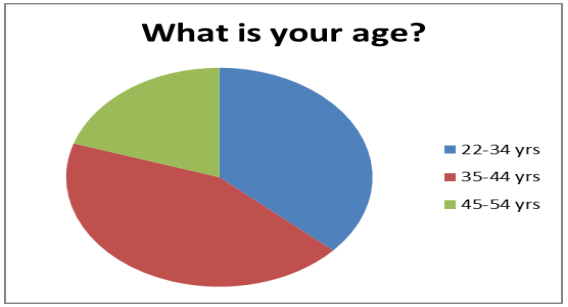
Patient Access Survey
In the last 12 months: When you phoned this provider's office to get an appointment, how often did you get an appointment as soon as you needed?
How many days did you usually have to wait for an appointment?
When you made an appointment, did you have difficulty finding transportation to that appointment?
Did you need care for yourself during evenings, weekends, or holidays?
Did you phone this provider's office with a medical question after regular office hours?
How often did someone in the practice ask you if there are things that make it hard for you to take care of your health.
What is the highest degree or level of school you have completed?

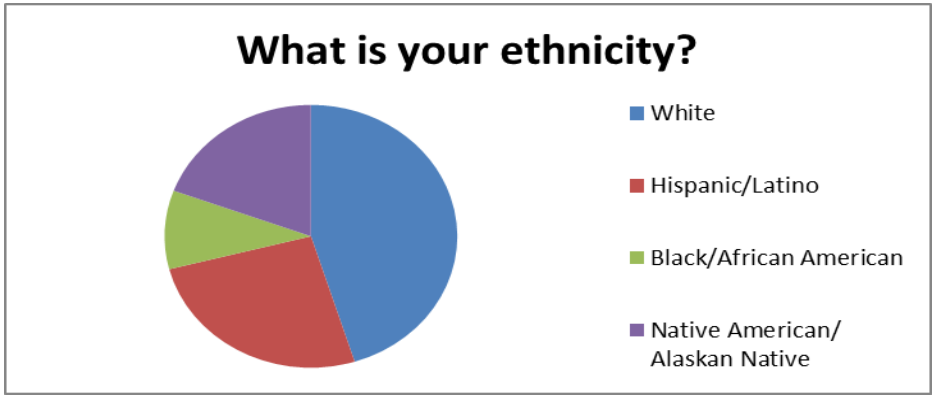
AC 09 (1 Credit): Use information on the population served by the practice to assess equity of access that considers health disparities.

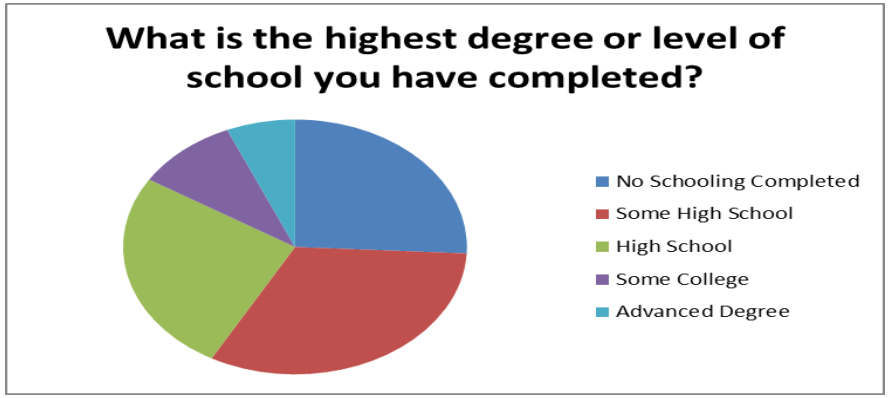
CURRENT





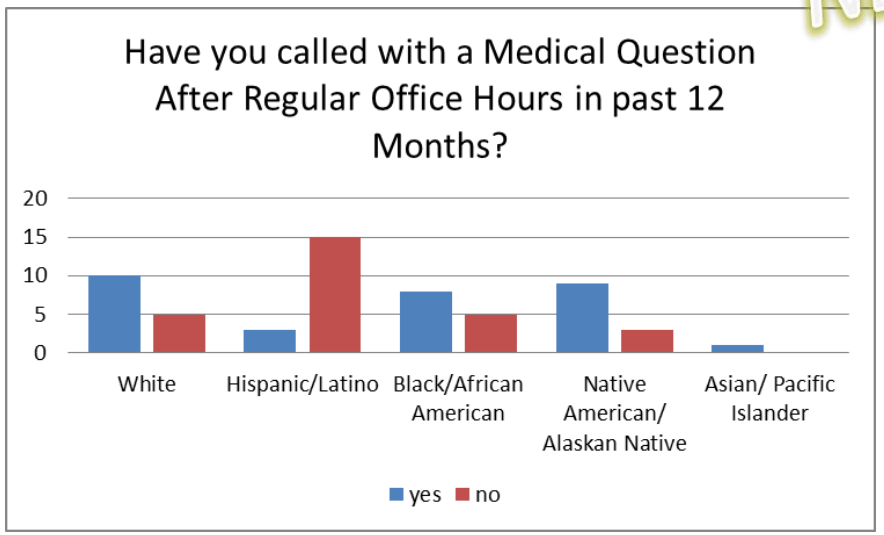


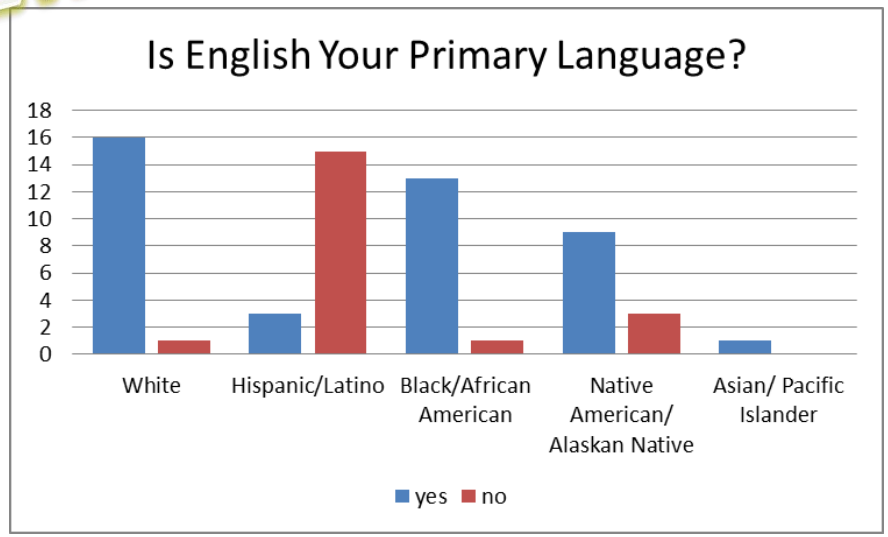


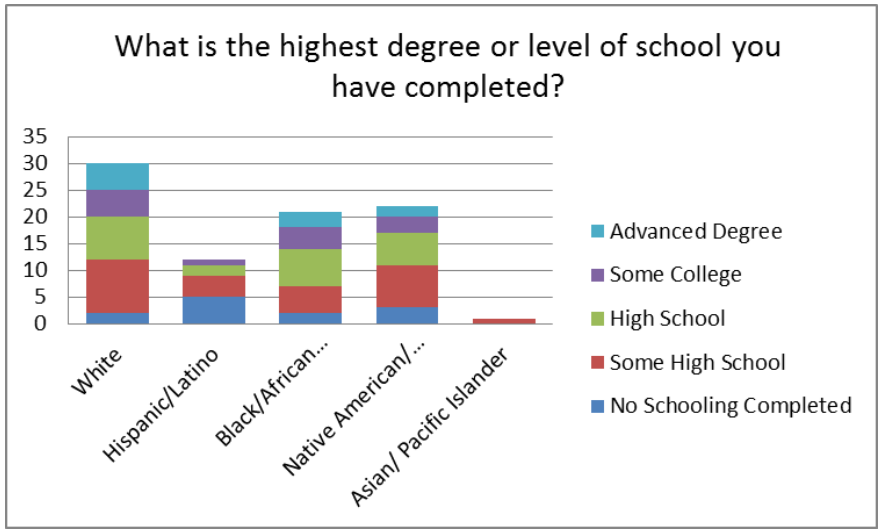


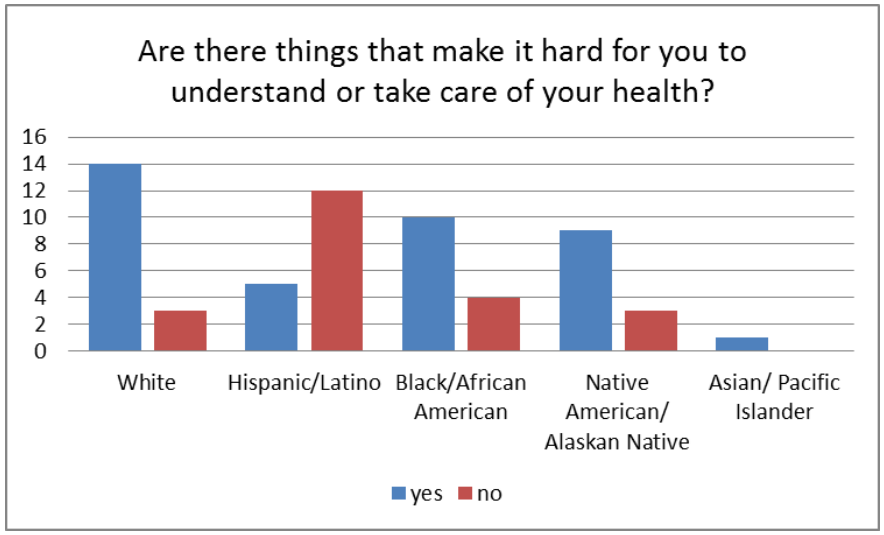
AC 09 (1 Credit): Use information on the population served by the practice to assess equity of access that considers health disparities.

NEW









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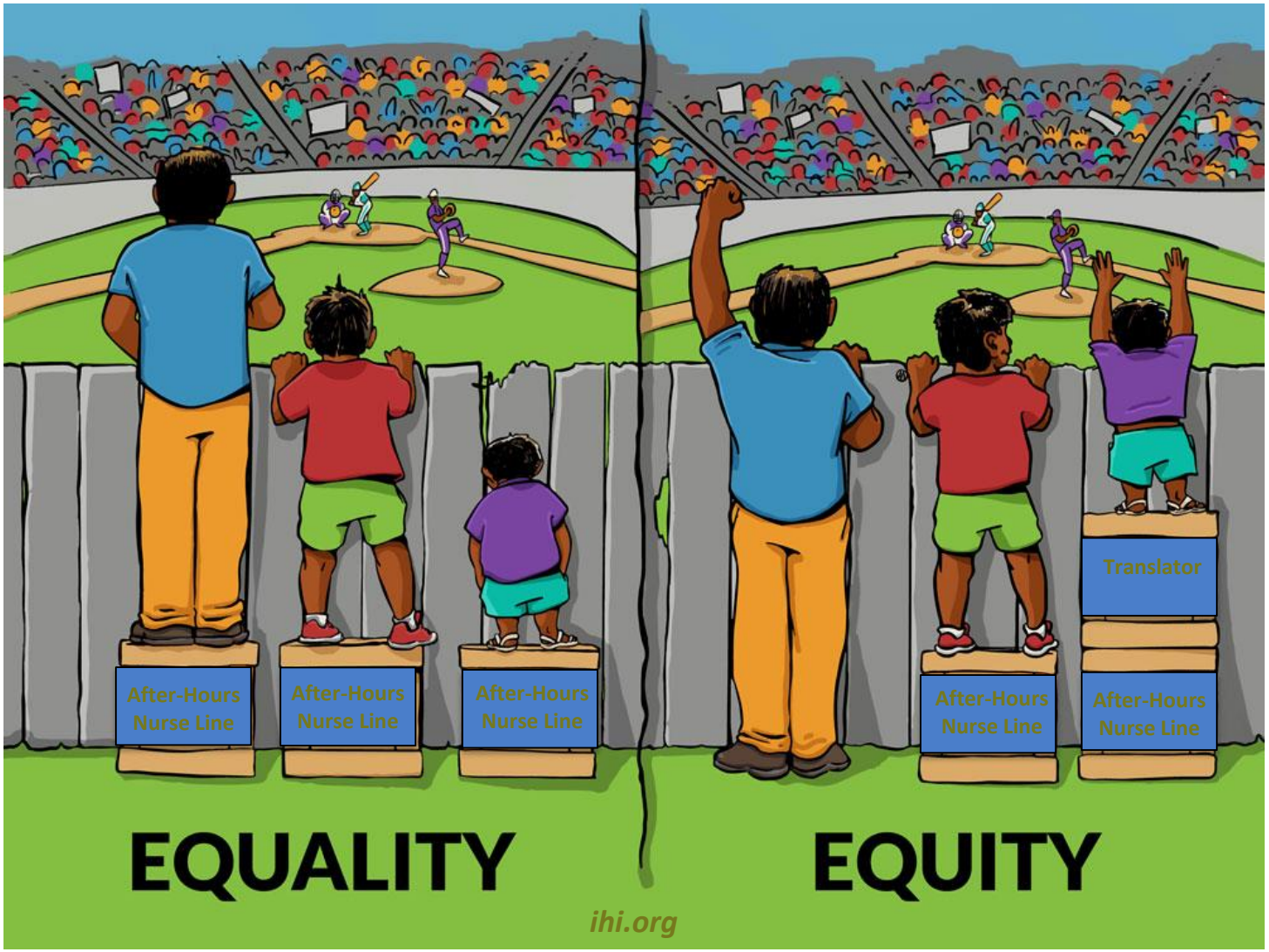
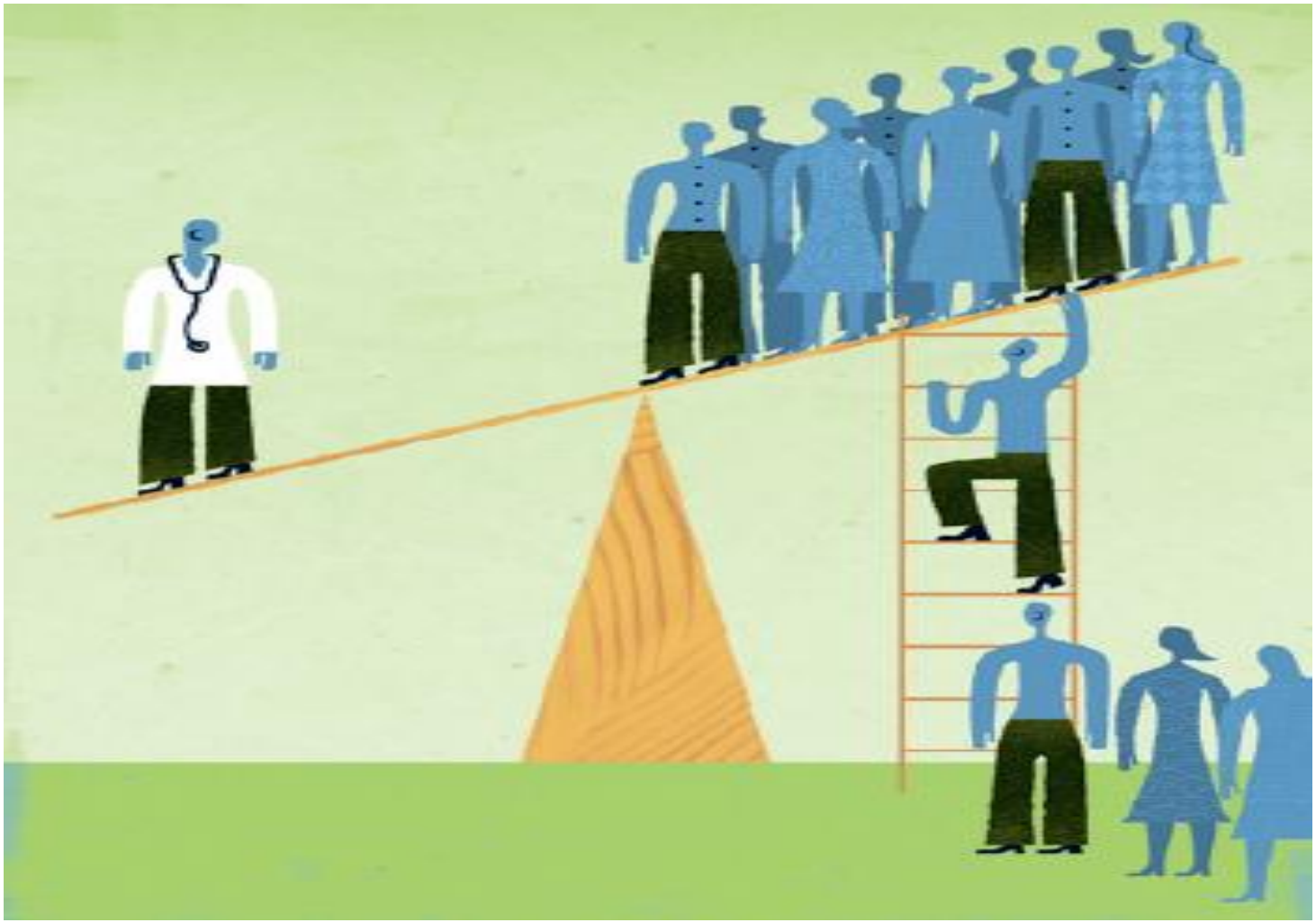


AC 13 (1 Credit): Review and actively manages panel sizes.



http://www.aafp.org/fpm/2007/0400/p44.pdf

AC 13 (1 Credit): Review and actively manages panel sizes.

CURRENT PANEL	Example
The practice panel: The number of unique patients who have seen any provider (physician, NP or PA) in the practice in the last 12 or 18 months	6000
Number of Full-Time Clinical Providers	3
Number of Patients ÷ by Number of Providers	2000
Average Number of Patients per Provider	2000

AC 13 (1 Credit): Review and actively manages panel sizes.

Physician	Provider Visits per Day	Provider Days per Year	Appropriate Panel Size	Actual Panel Size	Difference between Actual and Appropriate
Dr. Smith	24	240	1805	2000	195
Dr. Jones	20	230	1442	2000	558
Dr. White	26	300	2445	2000	-445

Provider visits per day x Provider days per year ÷ 3.19 = **Appropriate Panel Size**

** Average Visits per patient per year is 3.19*

http://www.aafp.org/fpm/2007/0400/p44.pdf

AC 14 (1 Credit): Review and reconcile panel based on health plan or other outside patient assignments.

Best Care Internal Medicine
Patient Report

Patient	DOB	Last Visit Date
Adams, J	1/1/70	1/10/17
Ammons, D	2/2/72	6/4/16
Berk, L	3/3/68	10/5/16
Brinkley, M	4/4/65	3/8/17
Carringer, T	5/5/71	8/3/12
Hyde, F	6/6/67	10/27/14
Wallis, P	7/7/73	11/15/11

Medicaid/Medicare
Best Care Internal Patient List

Patient	DOB	Practice	Active, Transferred, or not seen
Adams, J	1/1/70	Best Care Internal	Active
Ammons, D	2/2/72	Best Care Internal	Active
Berk, L	3/3/68	Best Care Internal	Active
Brinkley, M	4/4/65	Best Care Internal	Active
Carringer, T	5/5/71	Best Care Internal	Not Seen
Hyde, F	6/6/67	Best Care Internal	Transferred
Wallis, P	7/7/73	Best Care Internal	Not Seen

ALIGNING COMMUNITY RESOURCES TO YOUR PATIENT'S NEEDS

The Big Picture

Are you trying to do too much, or attempting to know it all ?!?!

We Are All Connected ….

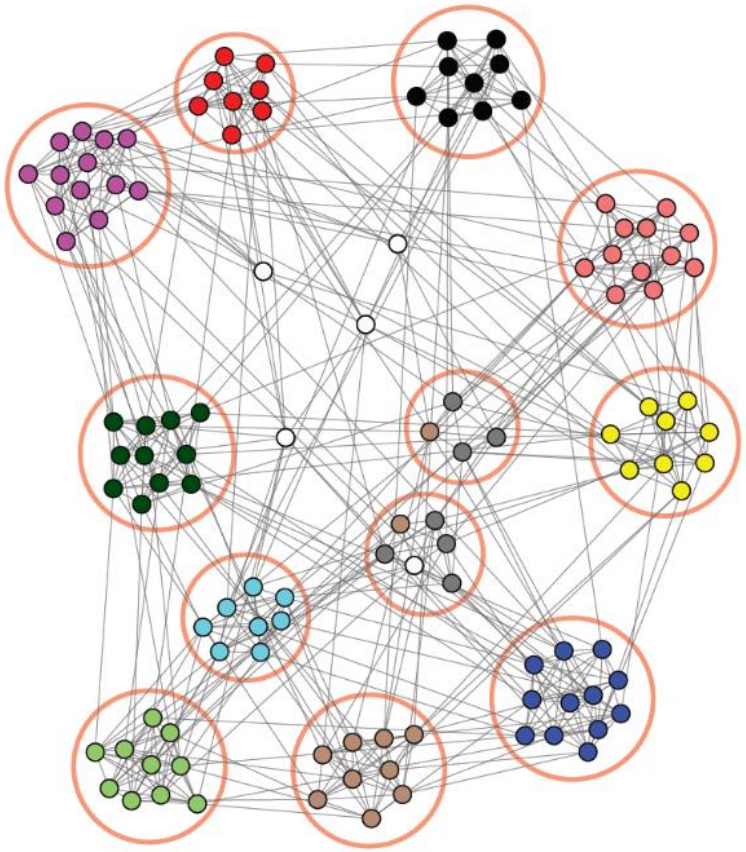
Community resources can help ***support our patients*** beyond our primary care walls & help ***to reduce our burden*** & actually help patients to get

healthier…..

Physically…..

Mentally……

Spiritually….



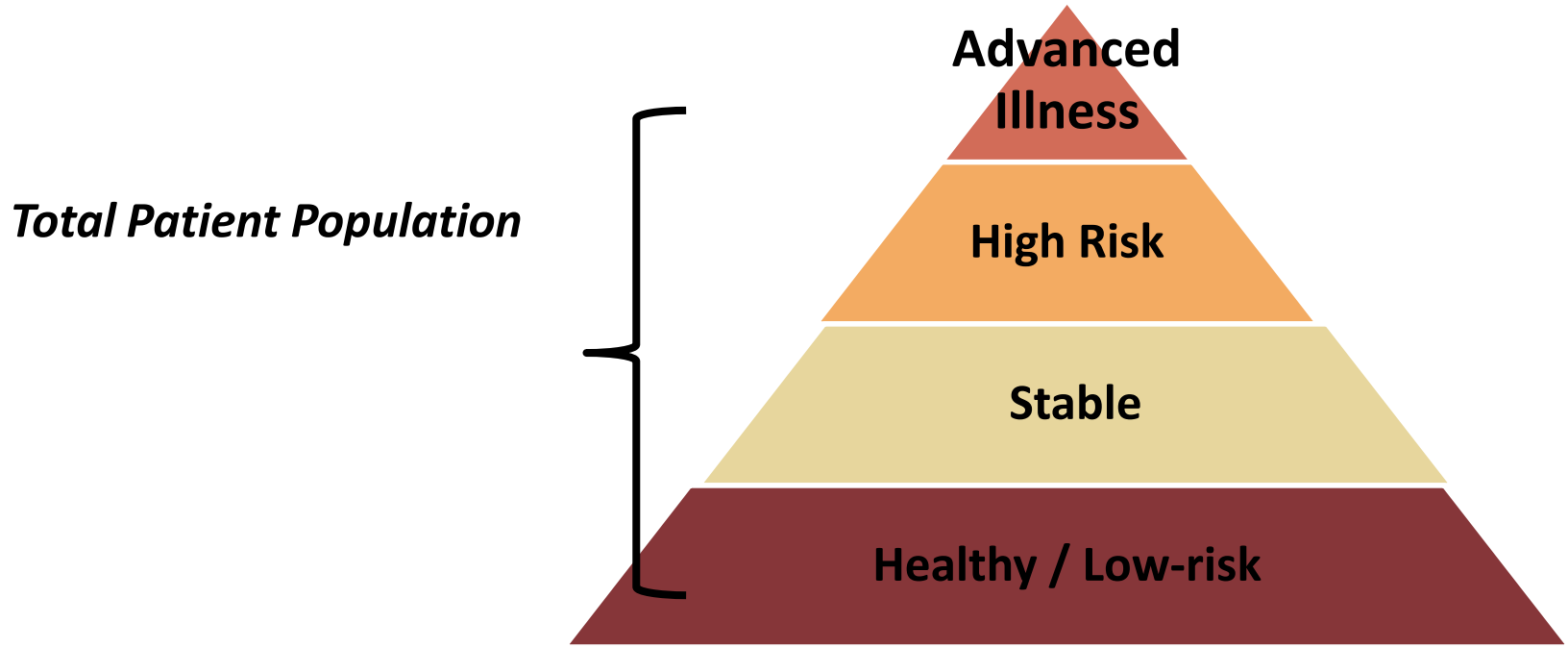
Taking It One Step Further …

The Medical Neighborhood

Patient-Centered
Primary Care
COLLABORATIVE

www.pcpcc.org

Population Health

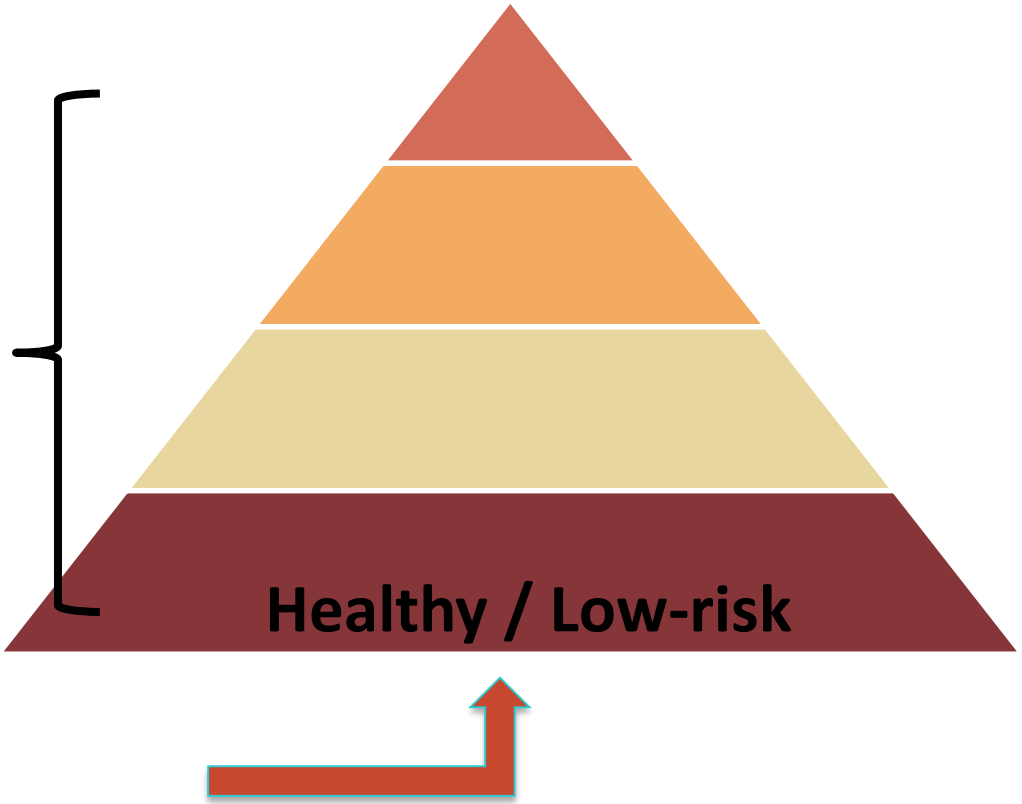


KM 7 (2) - Understands social determinants of health for patients, monitors at the population health level, implements care interventions based on these data.

KM21 (Core): Uses information on the population served by the practice to prioritize needed community resources.

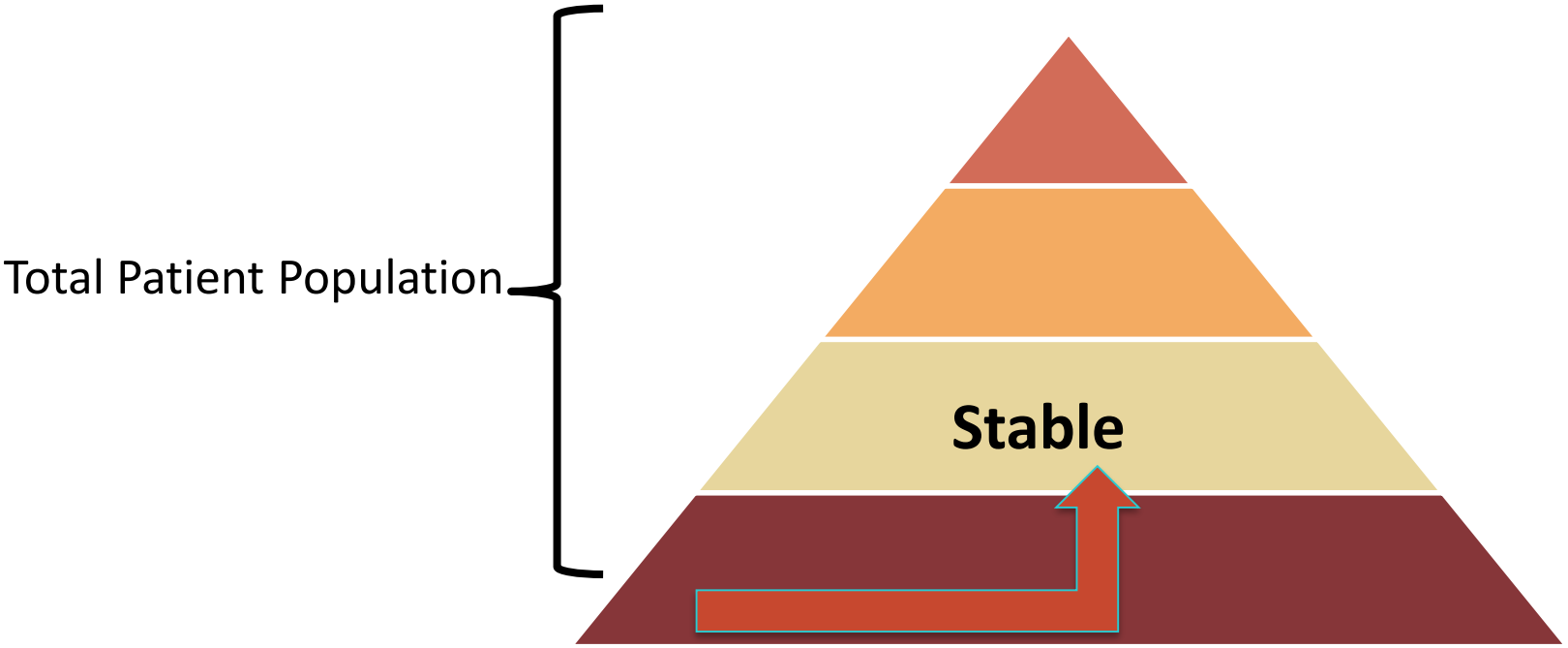
Population Health

Total Patient Population



Mike: 27 y/o, family hx of DMII, HTN. Healthy weight, gets regular exercise. Keeps routine and preventive health appointments.

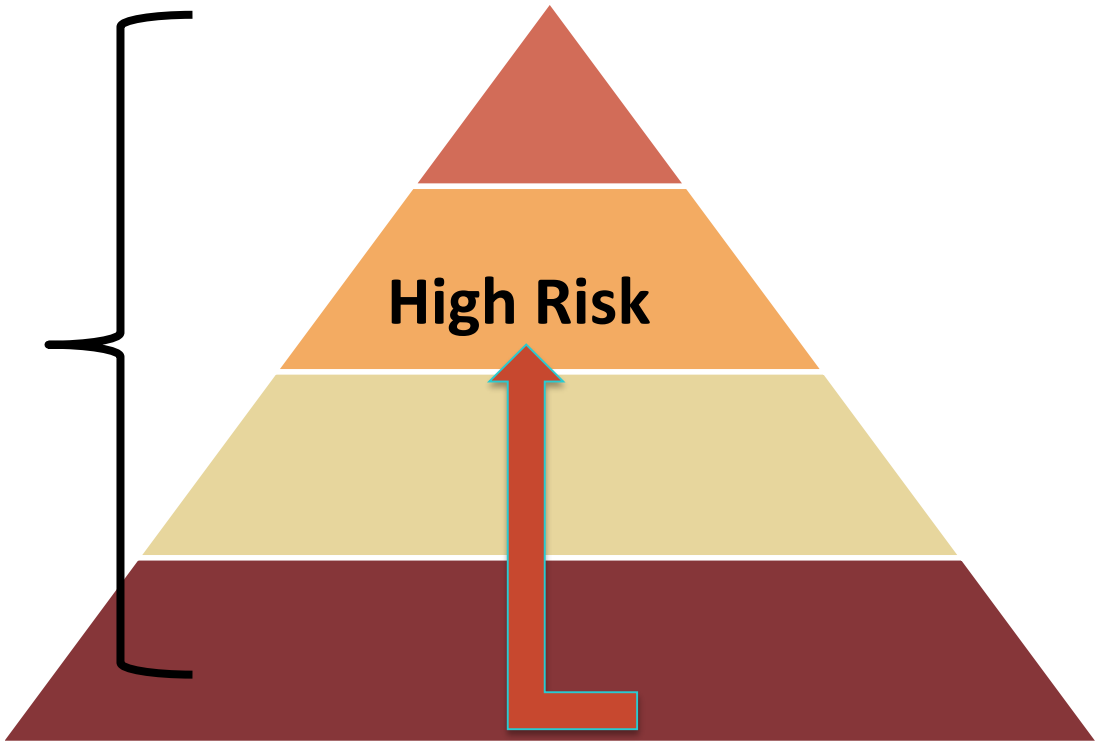
Population Health



Susan: **41 y/o: DMII, HTN, & Depression. Well-controlled with Metformin and Lisinopril. Keeps routine and preventive health appointments. Considering outpatient BH services.**

Population Health

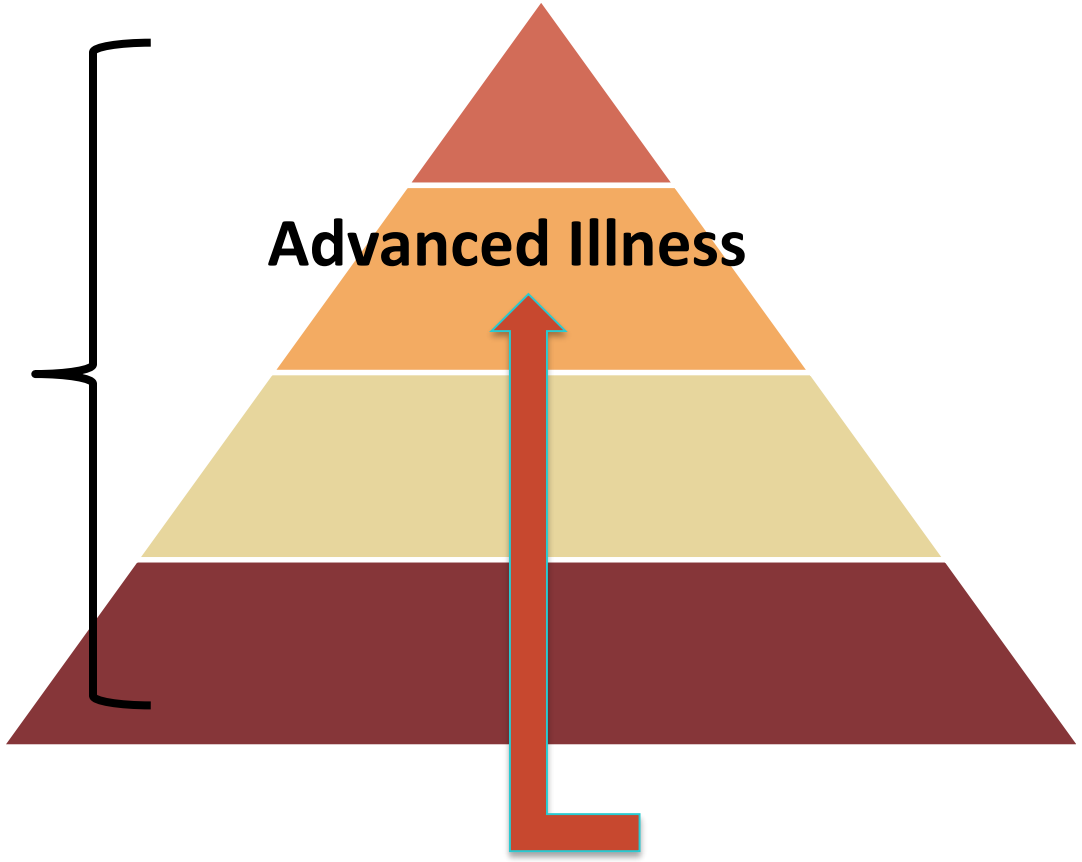
Total Patient Population



Floyd: 40 y/o, Obesity, HTN, Hyperlipidemia, CAD, recent MI & CABG. Often misses follow-up & routine appointments. Poor adherence to medications.

Population Health

Total Patient Population



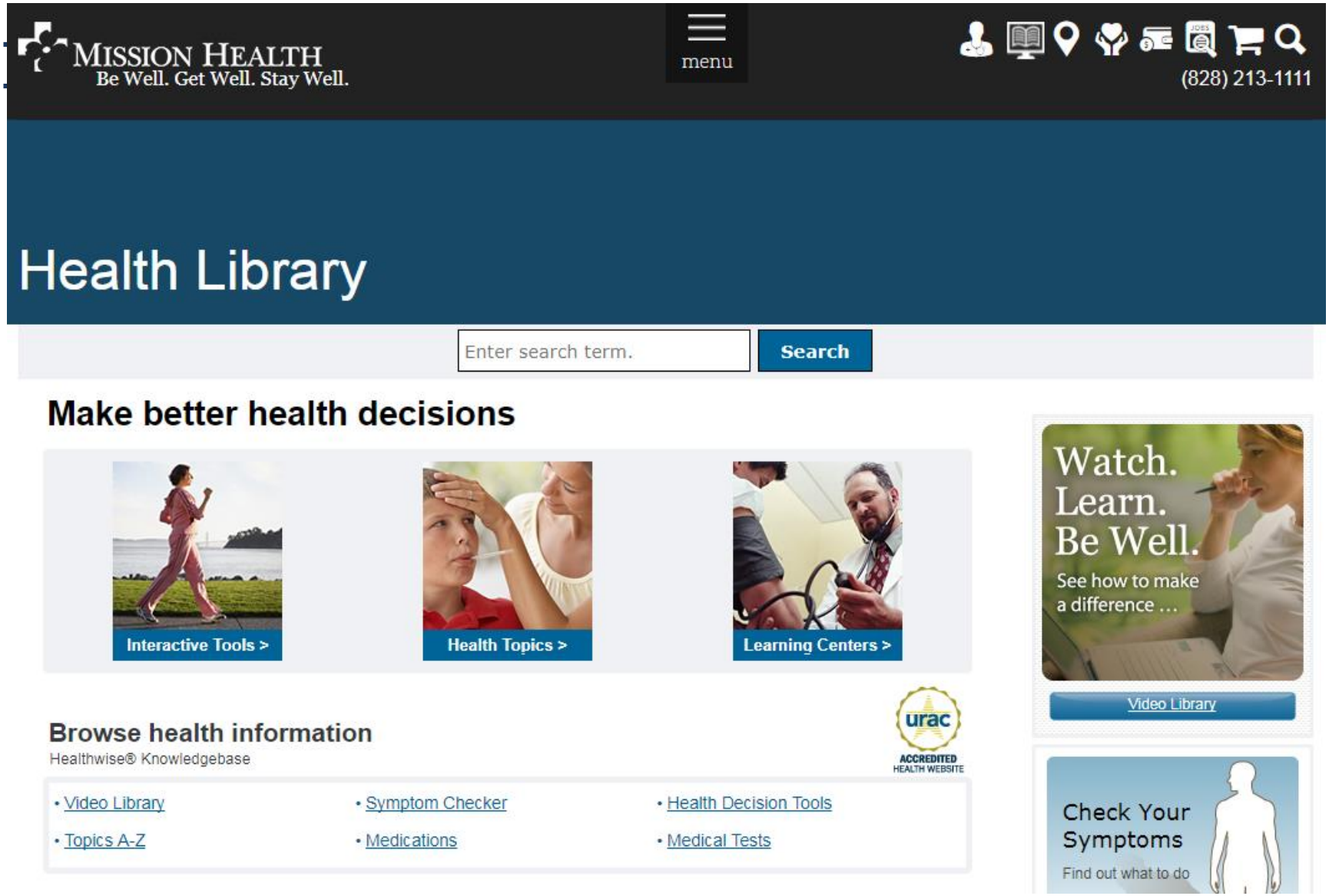
Elaine: 74 y/o, COPD, Stage 4 CKD, Debility. Home Health Services in place

Capitalize on Resource Directory Services already in Place ….!

KM26 (1): ***Routinely maintains a current community resource list based on the needs identified in Core KM21***

KM22 (1): ***Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.***

KM27 (1): ***Assesses the usefulness of community support resources***



www.healthwise.net/missionhealth

Capitalize on Resource Directory Services already in Place ….!

KM26 (1): ***Routinely maintains a current community resource list based on the needs identified in Core KM21***

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KM27 (1): ***Assesses the usefulness of community support resources***

New Concepts for PCMH 2017!
….get involved in the community!

KM23 (1): Provides oral health education resources to patients.

KM25 (1): Engages with schools or intervention agencies in the community.

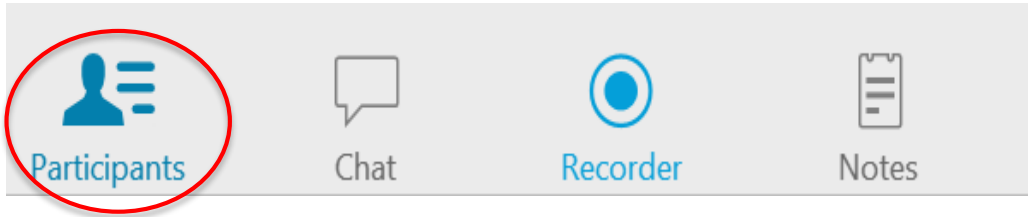
KM28 (2): Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists).

Collaborative Discussion

- BEST PRACTICES
- CHALLENGES
- NOVEL IDEAS
- QUESTIONS

HOUSEKEEPING

- The host will read comments from the chat box
- Please raise your hand to engage in discussion – we will unmute you when we call your name.
- Please lower your hand when you are finished speaking



Next Session

Population Health Management: Action! Part 1

Goal-Setting and Pt. Satisfaction

Next Session

Goal Setting:

- CM4 (Core): Establishes a person-centered care plan for patients identified for care management.
- CM5 (Core): Provides written care plan to the patient/family/caregiver for patients identified for care management.
- CM6 (1): Documents patient preference and functional/lifestyle goals in individual care plans.
- CM7 (1): Identifies and discusses potential barriers to meeting goals in individual care plans.
- CM8 (1): Includes a self-management plan in individual care plans.
- CM9 (1): Care plan is integrated and accessible across settings of care.

Patient Satisfaction:

- TC9 (core): Has a process for informing patients/ families/caregivers about the role of the medical home and provides patients/ families/caregivers materials that contain the information. Such as after-hours access, practice scope of services, evidence-based care, education and self-management support
    - Process for new patients go here too?
- Q14 (core): Monitors patient experience through:
    - A. Quantitative data: The practice conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:
        - i.Access
        - ii.Communication
        - iii. Coordination
        - iv. Whole person care, Self-management support and Comprehensiveness
- Q17 (2): The practice obtains feedback on experiences of vulnerable patient groups.
- Q16 (1): The practice uses a standardized, validated patient experience survey tool with benchmarking data available
- Q14 (core): Monitors patient experience through:
    - B. Qualitative data: The practice obtains feedback from patients/families/caregivers through qualitative means

Thank You!