CPC Best Practice Sharing: Integrating Non-Traditional Providers into Primary Care

Kelli Barnes, PharmD, BCACP, Ohio State University Internal Medicine
Carlsie Crutchfield, DDS, Centerpoint Health
David Schenkelberg, LPCC-S, Hopewell Health Centers
Welcome and Agenda

• OSU/Pharmacy
• Centerpoint/Dentistry
• Hopewell/Behavioral Health
• Upcoming Webinars and Important CPC program updates
The Ohio State University Internal Medicine - Pharmacy
Pharmacist Practice in Ohio CPC Clinics

Kelli D. Barnes, PharmD, BCACP
Specialty Practice Pharmacist – Ambulatory Care
The Ohio State University General Internal Medicine Clinics
OSU General Internal Medicine Clinics

» 7 NCQA Tier-3 PCMHs

» >200 health care professionals
  • 57 Physicians
  • 115 medical residents
  • 8 CNP/PAs
  • 9 clinical pharmacists (6.3 FTE)
  • 7 social workers
  • 24 nurse case managers

» 60,000 patient lives
OSUGIM Staffing Model

Managing the Staffing Infrastructure for a Patient-Centered Medical Home

Mitesh S. Patel, MD, MBA; Martin J. Arron, MD, MBA; Thomas A. Sinsky, MD; Eric H. Green, MD; David W. Baker, MD; Judith L. Bowen, MD; and Susan Day, MD, MPH

Among a shortage of primary care physicians, the need to provide high-quality, affordable care to a growing population drives the patient-centered medical home (PCMH) movement. The patient-centered medical home (PCMH) offers an innovative method of delivering primary care. However, the necessary staffing infrastructure is not well established.
### Table 2. Staffing Ratios for PCMHs

<table>
<thead>
<tr>
<th>Staffing Variable</th>
<th>Interview Range&lt;sup&gt;a&lt;/sup&gt;</th>
<th>MGMA&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider FTE</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Provider panels</td>
<td>625-2500</td>
<td>2435</td>
<td>2150</td>
</tr>
<tr>
<td>Patient panels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk adjustment</td>
<td>Most were unadjusted; several used risk stratification techniques</td>
<td>No</td>
<td>Based on proprietary risk adjustment software&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Staffing ratio estimates (FTEs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerical</td>
<td>0.18-1.85</td>
<td>1.12</td>
<td>1.42</td>
</tr>
<tr>
<td>MA, technician, LPN</td>
<td>0-1.66</td>
<td>1.33</td>
<td>1.33</td>
</tr>
<tr>
<td>RN</td>
<td>0.21-1.78</td>
<td>1.33</td>
<td>1.33</td>
</tr>
<tr>
<td>RN care manager</td>
<td>0-1.0</td>
<td>1.33</td>
<td>0.40</td>
</tr>
<tr>
<td>NP/PA</td>
<td>0-1.36</td>
<td>0.23</td>
<td>0.25</td>
</tr>
<tr>
<td>Health coaches</td>
<td>0-0.25</td>
<td>0</td>
<td>0.25</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>0-0.53</td>
<td>0</td>
<td>0.20</td>
</tr>
<tr>
<td>SW (includes mental health)</td>
<td>0-0.50</td>
<td>0</td>
<td>0.25</td>
</tr>
<tr>
<td>Mental health providers</td>
<td>0-0.83</td>
<td>0</td>
<td>0.25</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>0-0.20</td>
<td>0</td>
<td>0.10</td>
</tr>
<tr>
<td>Clinical data analyst</td>
<td>NA</td>
<td>0</td>
<td>0.05</td>
</tr>
</tbody>
</table>

**Total**

<table>
<thead>
<tr>
<th></th>
<th>Interview Range&lt;sup&gt;a&lt;/sup&gt;</th>
<th>MGMA&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2.68</td>
<td>4.25</td>
</tr>
</tbody>
</table>

<sup>a</sup>FTE indicates full-time equivalent; LPN, licensed practical nurse; MA, medical assistant; MGMA, Medical Group Management Association; NA, not applicable; NP, nurse practitioner; PA, physician assistant; PCMH, patient-centered medical home; RN, registered nurse; SW, social worker.

<sup>b</sup>Based on telephone interviews.

<sup>c</sup>Based on proprietary risk adjustment software.
Pharmacist-Provided Care

Patient Interaction Types

- Scheduled visit
  - Pharmacist-only
  - Team-based
- On-demand care

- Telephonic follow-up
- Secure patient-portal follow-up

Care Types

- Chronic disease management
- Transitional care management
- Population health management
- Polypharmacy
Chronic Disease Management

• Pharmacist collaborative practice agreements (CPAs)
  » Manage a patient’s drug therapy for specified diseases
  » Order and evaluate blood and urine tests

• OSUGIM CPAs (Current)
  » Diabetes
  » Smoking cessation
  » Hypertension

Chronic Disease Management - Diabetes

Mean A1c Over Time Managed by Pharmacist

<table>
<thead>
<tr>
<th>Initial A1c</th>
<th>A1c #1</th>
<th>A1c #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.4%</td>
<td>7.9%</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

Number of A1c when following with Pharmacy
Chronic Disease Management - Diabetes

Percentage of Patients with A1c > 9% Over Time Managed by Pharmacist

<table>
<thead>
<tr>
<th>Initial A1c</th>
<th>A1c #1</th>
<th>A1c #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>60.0%</td>
<td>21.1%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

Number of A1c when following with Pharmacy
OSUGIM Transitional Care Management

<table>
<thead>
<tr>
<th>Readmit Risk</th>
<th>Account</th>
<th>Patient Name</th>
<th>MRN</th>
<th>PCP</th>
<th>Revenue Location</th>
<th>Disch Date/Time</th>
<th>Hosp follow up</th>
<th>Next PCP Visit</th>
<th>MyChart Status</th>
<th>Primary Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Inpatient [200]</td>
<td>Camilla Curren, MD</td>
<td></td>
<td>UNIVERSITY HOSPITAL</td>
<td>7/11/2017 1115</td>
<td>11/08/2017</td>
<td>1/4/18 Activated</td>
<td>Colsomy present (HCC) (Principal Hospital Problem)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Inpatient [200]</td>
<td>Gobin Li, MD, PhD</td>
<td>14</td>
<td>JAMES</td>
<td>11/09/2017</td>
<td>Activated</td>
<td>Multiple myeloma (HCC) (Principal Hospital Problem)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Inpatient [200]</td>
<td>Aaron J Friedberg, MD</td>
<td>5</td>
<td>JAMES</td>
<td>09/11/2017</td>
<td>4/2/18 Activated</td>
<td>Pseudomyxoma peritonei (HCC) (Additional Hospital Problems)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>Inpatient [200]</td>
<td>Meera G Bhatt, MD</td>
<td>3</td>
<td>OSU EAST</td>
<td>11/08/2017</td>
<td>11/14/17 Patient Declined</td>
<td>Hypoglycemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Inpatient [200]</td>
<td>Neeraj H Tayal, MD</td>
<td>5</td>
<td>JAMES</td>
<td>11/07/2017</td>
<td>12/17/17 Patient Declined</td>
<td>DLEBL (diffuse large B cell lymphoma) (HCC) (Principal Hospital Problem)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>Inpatient [200]</td>
<td>Harrison G Weed, MD</td>
<td>1</td>
<td>UNIVERSITY HOSPITAL</td>
<td>11/08/2017</td>
<td>11/28/17 Activated</td>
<td>DKA, type 2 (Additional Hospital Problems)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Inpatient [200]</td>
<td>Aaron J Friedberg, MD</td>
<td>4</td>
<td>UNIVERSITY HOSPITAL</td>
<td>11/07/2017</td>
<td>11/21/17</td>
<td>Activated</td>
<td>Weakness of lower extremity (Principal Hospital Problem)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Transitional Care Management - Volume

- **Pharmacist Calls**
- **All Calls**
Transitional Care Management - Outcomes

30-day Readmissions
- OSUGIM Received Call: 11.96%
- OSUGIM No Call: 15.07%
- Outside PCP: 13.69%

30-day ED visits
- OSUGIM Received Call: 13.54%
- OSUGIM No Call: 28.66%
- Outside PCP: 12.74%
Other OSU GIM Population Health Management

- 2010: Herpes zoster vaccinations
- 2011: CKD and renal medication dosing
- 2012: Bisphosphonate use
- 2013: Metformin monitoring
- 2014: Controlled substance monitoring
- 2016: ASCVD risk reduction
- 2017: PPI Deprescribing Million Hearts Intervention

OSUGIM ASCVD Risk Reduction

PCP
- Denied: n=502 (54.7%)
- Accepted: n=415 (45.3%)

Patient
- Accepted: n=222 (53.5%)
- Declined: n=193 (46.5%)
Embedded Pharmacist Benefits to CPC

- Integral to meeting quality and efficiency measures
- Increase access to providers
- Improve patient satisfaction
Centerpoint Health - Dentistry
Integrated Dental Visits

Carlsie Crutchfield DDS
Centerpoint Health Services

Centerpoint is certified as a "Level 3" 2017 Patient Centered Medical Home

We offer: Pediatric Services, Adult Medical Care, Women's Health Services, Dental Care, Behavioral Health, Insurance Enrollment, and Mobile & Event Services.

The Dental Department different models:

1. Dental Clinic
2. Mobile Dental
3. Integrated Dental

Franklin Location

Middletown Location
Integrated Dental

Well Child Check = Whole Child Check

- Integrated Dental was our attempt to reduce no show appointments due to multiple factors (transportation, child care, work schedule, etc.)
- We started using the already scheduled well child visit with the medical providers as potential dental appointments.
- We are a patient centered home so physical health including oral health and mental health are all disciplines we attempt to evaluate for our patient families
- All departments use the same EHR. I believe this is key with this model.
- Treatment and exams are performed inside the medical room with the portable hand instruments and parent participation.
Integrated Dental Appointment types

We pull providers schedules and target well child checks, medication refills, nurse visits and urgent visits about the oral cavity/mouth trauma/not eating

Originally we were scheduling dental visits for the dental integration...90% no show rate

Next we tried scheduling double provider appointments (example: 10 am well child visit 10:30 dental visit at the same location...appointments ran to long/people did not want to stay)

Our success has come from the convenience visit. This approach is for existing dental patients and patients new to the dental department.
Services Provided in the Rooms

Clinical Exam-visual/ tactile detection: disposable explores and perio probes and disposable mirrors

Prophylaxis polishing: The children rinse and spit in sink with cups and water or mouth swab

Oral Photo is necessary

Fluoride application

Oral hygiene instructions for the parents on how to help their children and caries risk discussion

Explanation of oral findings and showing the parent what I finds see ie. (low maxillary frenum attachments, deep groves prone to caries)

Limited Oral Evaluation or POE, FL2, Prophy, OHI
Limitations

- X rays
- Already have a dentist
- People not wanting to go to clinic for more extensive treatment
- Number of days per week
Newborns and Baby Book

For our well child checks that are infants we provide a baby book of oral care from United Concordia. They will send you 500 at a time and it has lots of information on brushing tips, eruption charts, photo book and more for free. These are non billable visits be we are sowing the seed of care.

United Concordia

ATTN: Professional Relation Support Services

4401 Deer Path Road
Harrisburg, PA 17110

E-mail: PRSupportServices@ucci.com
Fax: 1-717-260-7190
Monitors

We have only used this model since September 2018 so as we just starting to see if they show up at the dental clinic for their recall with x rays.

Each dental visit has specified appointment types in ECW for tracking. We hope the end of the year report will allow us to analyze this method.

Very positive feedback from parents.
Hopewell Health Centers – Behavioral Health
Access to Affordable, High Quality Integrated Healthcare for All
Our Community...

- 9 Counties
- Rural
- Appalachian Culture
- High Poverty All Counties are MPSA’s and HPSA

Access to Affordable, High Quality Integrated Healthcare for All
• Behavioral Health contract with Tri-County Mental Health & Counseling Services in 2008
• Electronic Medical Records – eClinicalWorks implementation began in fall 2011
• July 1, 2013 Consolidation between Family Healthcare, Inc. and Tri-County Mental Health & Counseling Services, Inc. under one corporate shell.
• Name changed to Hopewell Health Centers, Inc.
1. Enhanced Access/Continuity
   • Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours
   • The practice provides electronic access
   • Patients may select a clinician
   • The focus is on team-based care with trained staff

2. Identify/Manage Patient Pop
   • The practice collects demographic and clinical data for population management
   • The practice assesses and documents patient risk factors
   • The practice identifies patients for proactive reminders

3. Plan/Manage Care
   • The practice identifies patients with specific conditions, including high risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems
   • Care management emphasizes:
     • Pre-visit planning
     • Assessing patient progress toward treatment goals
     • Addressing patient barriers to treatment goals
   • The practice reconciles patient medications at visits and post-hospitalization
   • The practice uses e-prescribing

4. Provide Self-Care Support/Community Resources
   • The practice assesses patient/family self-management abilities
   • The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources
   • Practice clinicians counsel patients on healthy behaviors
   • The practice assesses and provides or arranges for mental health/substance abuse treatment

5. Track/Coordinate Care
   • The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals)
   • The practice manages care transitions

6. Measure/Improve Performance
   • The practice uses performance and patient experience data to continuously improve
   • The practice tracks utilization measures such as rates of hospitalizations and ER visits
   • The practice identifies vulnerable patient populations
   • The practice demonstrates improved performance
Integration of full-BHC Role in Primary Care

**Reception Staff**
- Household (# of people/relationships)
- Demographics (age/gender/ethnicity)
- Income (source/amount/sliding-fee)
- Insurance (yes/no) Presumptive Eligibility? Certified Application Counselor?
- Support Network (name / ph#/ Rol)
- Provider Network (name / ph#/ Rol)

**Nursing/CMT**
- Presenting Problems (Urgent/Emergent/Chronic)
- Health History/update (Review and update)
- Current Rx’s/Providers (Care Circles)
- SBIRT screening (Identify High Risk Patients)
- Plans to implement PRAPARE

**Patient**
- Check-in
- Work-up

To Exam-room
Referral for mental & behavioral health needs

Primary Care Provider
- Using “MI & the 5A’s”
  - Assess
  - Advise
  - Agree
  - Assist
  - Arrange
- Assess self-management
- Patient education
- Self-care planning
- Provide tools & resources
- Provide community resources

Behavioral Health Consultant
- BHC assesses need for specialty MH
- Coordinates referrals from Community MH
- Psychiatric Consultation

Specialty Behavioral Health
- Make as seamless as possible
- BH onsite in some locations
- Included in ICT meeting

Collaboration is key

Patient Care Plan Agreement
Care Management Location for SPMI population

1st Level ↓BH↓PH

2nd Level ↑BH↓PH

3rd Level ↓BH↑PH

4th Level ↑BH↑PH

CMH

PCMH

Care Management Location for SPMI population

(Reynolds, 2013)
BHC role working with SPMI in PC

Patient.
Linkage & Referral with specialty MH

Facilitate Psychiatric Consults

Facilitate Staff In-Services on MH

Ongoing Patient Support
We build what we can imagine.
Questions?

David Schenkelberg, LPCC-S - Chief Clinical Officer
David.Schenkelberg@hopewellhealth.org
Upcoming Webinars
Key upcoming dates: Best Practice Sharing Webinars

Last Friday of the Month, 11:30a-12:30p

- April 26
  » Topic: Using non-clinical providers to enhance your CPC practice
- May 31
- June 28
- August 30
- September 27
- October 25

Tentative topic for April: Using Practice Reports

✓ Is your practice utilizing practice reports to meet CPC program requirements?

We are still looking for practices to present on April 26, and for other future dates!
Key upcoming dates: Monthly Webinars

11:30a-12:30p

• January 17 – Understanding your Ohio CPC Payment & Attribution Files
• February 14 – Review of 2017 Ohio CPC Outcomes
• March 14 – Overview of Ohio CPC Activity Requirements
  » Now posted to the ODM website!
• April 18 – Understanding your Quarterly Practice Reports
• May 9 – Understanding your Quarterly Referral Reports
• June 13 – What to Expect from Practice Monitoring
• August 8 – Total Cost of Care Shared Savings Methodology Review
• August 22 – Ohio CPC 2020 Pre-Enrollment Webinar
• November 14 – Review of 2018 Ohio CPC Outcomes
• December 19 – Ohio CPC 2020 Introductory Webinar
New for 2020! CPC Kids

• ODM will be rolling out an extension of the CPC program specific to kids for 2020
  » http://www.ohiohouse.gov/committee/finance
    • March 20th, Director Corcoran, Page 13, bullet 5

• Stakeholder engagement for program development begins mid-April
  » Association outreach
  » CPC provider focus groups
  » Other thoughts?
    • Ohio_cpc@Medicaid.ohio.gov