PHYSICIANS PRACTICE

Provide Proactive Care with Complex Patients

By Clive Fields, MD - Monday, February 5, 2018

As patient populations present with multiple co-morbidities and more complicated diseases, it takes a consistent and systematic approach to manage these patients for the best clinical results - an important step to succeed in value-based care.

Provide Proactive Care
Once you've identified your complex patients, what diagnosis they have, and how they utilize the healthcare system, you can begin building processes that better manage a complex population. Let's focus on the diabetic patient and how we at my practice, Village Family Practice (VFP) in Houston, Texas use these strategies to achieve the best results.

First, we recognize that diabetics all have the same disease, but are not all are alike. Individual problems need individual attention. Second, we place the patient's primary care physician at the center of a team of health care professionals. Then, we think of medical interventions in three concentric rings around a patient:

• Care within the exam room.
• Services outside the exam room but within our clinic.
• Services within the greater community in which the patient lives.

One of our key strategies is making sure that every interaction between the patient and healthcare professionals contributes positively to success. Our nurses are trained in rooming guidelines that are gender, age, disease, and symptom specific. In the case of our diabetic patient, nurses are responsible for medication reconciliation, quality gap closure, immunizations updates, and ordering disease-specific labs - all before a physician enters the exam room. This allows the physician to focus on treatment and education, minimizing paperwork or record reviews.

Within the practice, there is a suite of services that address the needs of diabetic patients:

1. Diabetic education: We partnered with Healthy Interactions to build an American Diabetes Association certified diabetes education program at each of our practice locations. Most hospital programs focus on insulin administration and basic information for newly diagnosed diabetics. Our patients are more typically Type 2 diabetics needing an understanding of diet, medication education, and a focus on the short- and long-term complications of poorly managed diabetes.

2. Chronic care management: Since 2013, Centers for Medicare & Medicaid Services (CMS) has compensated physicians for providing regular clinical outreach and coordinating patient care. We have used this reimbursement to build and help pay for a team of care coordinators that proactively reach out to our complex diabetic patients, getting in front of their physical, emotional, cultural, and financial healthcare issues before they lead to emergency and inpatient care.

3. Ancillary screening: The screening we have the most difficulty with is diabetic eye exams. Many referrals to an eye professional are simply never completed. In 2015, we brought a simple fundoscopic camera into our two larger clinics and included an immediate referral as part of our rooming guidelines. Patient compliance has improved, and we have detected dozens of cases of early retinopathy.

4. Specialty physicians: Even though we are a primary care group, we added the specialties of podiatry and endocrinology. Having these specialists under the same roof and on the same scheduling system improves patient access and compliance.

5. Pharmacy: In 2013, we added a point-of-service pharmacy to our practice. VillageMD, our management services organization partner, helped us determine how to defray the investment costs of creating an onsite pharmacy. Our pharmacist can access a patient's medical record, meet regularly with our clinical staff, and has collaborative practice agreements with our physicians. The pharmacy team helps patients understand their medications and keeps physicians up-to-date on medication options.

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Measure the Results

We use data to identify care gaps, quality opportunities, and medical utilization. Most importantly, we use data to measure ourselves. Our improved quality and cost results speak to the value of a primary care driven and patient centered approach to the complex patient.

Publicly available CMS data show that our practices' Medicare population performs much better than Medicare patients nationally on diabetes care standard.

In addition, patients who complete the diabetes education program have an additional 15 percent reduction in their HgA1c levels Our patients also receive 10 percent more screenings for neuropathy and 15 percent more retinopathy exams than the national average for the Medicare population.

Total cost of care for our practices diabetes patients in the Medicare population was 20 percent lower ($12,828 versus $16,150) than the national average for the same population.

Patient Centered Care

To successfully manage complex patients under value based contracts, you must focus on cost and quality outcomes. Most of the healthcare expense within an individual practice is driven by 20 percent of patients, and that's where the focus needs to be. Identifying who your patients are and what their risk acuity is improves your ability to change the way your patients utilize the healthcare system. Our practice has made investments in technology and care management teams to help us identify and manage our most complex patients. Regardless of your practice's capabilities, using every patient contact and each member of your team to maximize patient outcomes will help you succeed.

Managing complex populations doesn't have to be complicated, but it does require a consistent and proactive approach to keep patients at the center of the healthcare system.

Dr. Clive Fields is president of the Village Family Practice and co-founder/chief medical officer at VillageMD.