Innovative Patient Access & Care Management: A Rural FQHC Model

Mission: to improve the health and well-being of the individuals, families and communities we serve
The Importance of Patient Access

Patient access is related to a number of health-related outcomes.

Communities with poor access to primary care have higher death and disease rates and greater health disparities than in communities where access to primary care is better. Communities with worse primary care access have higher rates of emergency department visits and hospitalizations as a result.

National Access Issues

• The estimated shortage of primary care physicians is 33,000 to 45,000 by 2035.
• Nationwide there is a primary care physician (PCP) shortage, especially in rural areas where there are only 68 PCPs per 100,000 people (as compared to 84 PCPs per 100,000 people in urban areas) (AAFP, June 20, 2013).
• 10% of physicians practice in the rural USA; however, they serve 25% of the total USA population (National Rural Health Association, 2010).
Oregon Access Issues

Oregon Projected Primary Care Physicians Need

Access Issues

Rural residents face:

• Transportation challenges
• High poverty rates
• Low educational attainment
• Mental health challenges
• Cultural views
Analyzing Access

- The patient/provider ratio is increasing
- Throughput (Visit Flow) problems
- Resource and staffing allocation issues
- Aging and chronically ill population
- Newly graduated providers want a better life/work balance
Innovative Access: Three Approaches

1. Group Visits

2. Modifying Provider Templates

3. Remote Patient Monitoring
ACCESS SOLUTION #1: GROUP VISITS
A New Application: The Mosaic Medical Community

Health Disparities
Cardiovascular Disease
Diabetes Mellitus
Hypertension

Barriers to Care
Transportation
Economic Status
Low health literacy

Population
20,000 patients served in 2014
12% uninsured
62% OHP
14% Medicare
12% private insurance
### Patient - Population Demographics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Crook County</th>
<th>Jefferson County</th>
<th>Deschutes County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population, 2014</td>
<td>20,998</td>
<td>22,192</td>
<td>170,388</td>
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<tr>
<td>Population per square mile, 2010</td>
<td>7</td>
<td>12.2</td>
<td>52.3</td>
</tr>
<tr>
<td>% Persons 65 years and over, 2013</td>
<td>23.6</td>
<td>17.9</td>
<td>17.4</td>
</tr>
<tr>
<td>% Hispanic or Latino, 2013</td>
<td>7.4</td>
<td>19.9</td>
<td>7.7</td>
</tr>
<tr>
<td>% High school graduate or higher, 2009-2013</td>
<td>84.9</td>
<td>84.7</td>
<td>93.1</td>
</tr>
<tr>
<td>% Bachelor's degree or higher, 2009-2013</td>
<td>14.5</td>
<td>17.3</td>
<td>31</td>
</tr>
<tr>
<td>Per capita income in past 12 months (in 2013 dollars), 2009-2013</td>
<td>20883</td>
<td>21593</td>
<td>27524</td>
</tr>
<tr>
<td>% Persons without health insurance, under age 65 years (pre-ACA)</td>
<td>18.3</td>
<td>24.1</td>
<td>18.3</td>
</tr>
<tr>
<td>% Persons in poverty</td>
<td>18.9</td>
<td>21</td>
<td>15.8</td>
</tr>
<tr>
<td>% Obese</td>
<td>27</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>% Diabetic</td>
<td>10</td>
<td>9</td>
<td>8</td>
</tr>
</tbody>
</table>

- Crook County: very rural and high percentage of population age 65+
- Mostly Caucasian/white with sizeable Latino population (especially Jefferson Co)
- Relatively high poverty, obesity, diabetes compared to state averages
- Data from Census.gov and Countyhealthrankings.org
The Purpose of our Study

• Beginning in March 2014, group visits for patients newly diagnosed with pre-diabetes were piloted at the Mosaic Medical clinic in rural Prineville, Oregon.

• The purpose of this study was to investigate the effectiveness of using group visits to provide care for patients newly diagnosed with pre-diabetes.

• The goal of implementing group visits was to improve patient access and patient engagement, allowing providers to address their patients’ common concerns in a group setting.
Group Visit Method

- The piloted group visit program at the Mosaic Medical Prineville clinic was based on a Cooperative Health Care Clinic (CHCC) model of implementing regularly scheduled small-group visits for patients with a shared chronic condition.
- Mosaic Medical Prineville patients newly diagnosed with pre-diabetes in early 2014 were invited to join the monthly group meetings.
- The monthly group meetings were made up of an hour-long session focused on education and discussion, followed by one-on-one time between patients and providers in the group visit room. Each group meeting included the same patients at every meeting, allowing for relational development within each cohort over the course of the program.
Group Visit Format

- Welcome
- Vital Signs Taken
- Lunch and Surveys
- “Roses and Thorns”
- Teaching Time
- Group Discussion
- 1-on-1 Time with Providers/BHC/RNCC
- (An optional group walk was provided after the group visit)
Results

Most of the experimental group responses expressed the following sentiments:

• Enjoyment of the meal.
• Appreciation of the social support aspect of the group.
• Indication that the group visit program was a good use of their time and beneficial to their health.
• Value of the group-learning model.
• Benefit from the guided teaching sessions, especially those addressing meals and diet.
Results

• The providers were unanimously positive prior to the implementation of the group visit program and remained so when questioned at the end of the pilot period.

• The primary concern mentioned by the nurse care coordinators was that their amount of non-clinical administrative work due to the program increased (calling patients to confirm attendance, ordering food, coordinating speakers and guests).

• Despite the increased work, it was also mentioned that more frequent group visits (perhaps weekly or twice-monthly) would help patients keep positive momentum.

• The behaviorist suggested that one-on-one motivational interviewing prior to the first group meeting, as well as group cohesion training, may contribute positively to group dynamics and dedication for future groups.
Results

• This study gave further evidence that group visits can improve patient access, especially related to RNCC and BHC visits.

• Beyond the clinical results, a strong benefit of this study has been the experience gained by the providers in leading and administrating a group visits program.
Lessons Learned

• Expert facilitation is a key to leading a successful group meeting.
• Food and other hospitality elements help patients open up and share.
• Group visits allow a patient’s medical issues to be addressed holistically and comprehensively.
• Group visits provide unique social support that can encourage behavior change in patients with chronic conditions.
Billing for Group Visits

This is the Key (and kind of a mystery)
The question from AAFP: "In other words, is Medicare payment for CPT code 99213, or other similar evaluation and management codes, dependent upon the service being provided in a private exam room or can these codes be billed if the identical service is provided in front of other patients in the course of a shared medical appointment?“

The response from CMS was, "...under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E/M visit (CPT code 99213 or similar code depending on level of complexity) to a patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary." The letter went on to state that any activities of the group (including group counseling activities) should not impact the level of code reported for the individual patient.

Diagnostic codes include the main diagnosis. --in our case this was pre-diabetes

(Diabetes, obesity, hypertension, hyperlipidemia, insomnia, chronic pain, etc.)
Billing for Group Visits

If providing education: use the self-management codes, and both providers bill under the same number.

98960—Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient; each 30 minutes

98961   2-4 patients
98962   5-8 patients
Billing for Group Visits

**Medical Nutrition Therapy:**
97804—Medical nutrition therapy; initial assessment and intervention,—group of 2 or more individual(s), each 30 minutes

**Health & Behavior Assessment/Intervention:**
96150—Health and behavior *assessment*, each 15 minutes, face-to-face with the patient; initial assessment
96152—Health and behavior *intervention*, each 15 minutes face-to-face; individual
96153—group (2 or more patients)
Billing for Group Visits

So the claim would be:
99211 or 99212--(or appropriate E&M) for the provider (based on time)
97804--nutritionist
96153--for BHC

OR:

99211 or 99212--(or appropriate E&M) for the provider (based on time)
98961 --for other professional services.

*it is necessary to contact the payer to verify that coverage of this service is a payable benefit.
Billing for Group Visits

**In short,** during our pilot, visits were billed as:

- no-charge
- 99211
- 99212

(provider-based visits only).
What has been your experience?
ACCESS SOLUTION #2:
HYBRID OPEN ACCESS MODEL
What We Hear

• New patient feedback: they cannot get an appointment for months, yet open slots are available
• PAC feedback: it is hard to get an appointment as an adult patient
• Provider/care team feedback: they cannot get patients in when they need it
## PDSA/Process Improvement Plan

**Clinic Name/location and Team Name:**
Primeville (Green Team)

**PDSA Contact Name:** Andy Eck/Dr. Laura Gratton
Email: andy.eck@mosaickingmedical.org
Phone Number: 541-323-4281

**PDSA Problem Statement:**
Access for all patients is challenging (average of 12 days to be seen)

**Start Date:** 5/4/15

**Proposed End Date or Goal:** 8/4/15

### AIM: Overall goal you wish to achieve
- Increase patient access (new or established) utilizing advanced access schedule resulting in patient and team satisfaction

### PLAN: What do you plan to do in this PDSA cycle?
- **Questions to be answered from data obtained:**
  1. With the advanced access schedule implemented within two providers, will we increase access for patients?
  2. Will the no show rates decrease?
  3. Can a waitlist be utilized to fill the no show slots?
  4. Will the amount of patients seen each day, increase?
  5. Will this have impact on establish patient’s access to their PCP?
  6. Will the average of days to be seen decrease for patients for all providers?
  7. Will team satisfaction increase with use of advanced access schedule?
  8. Will patient satisfaction increase with use of advanced access schedule?

### Predictions:
1. 20% reduction in new patient no show rates
2. For the providers who will be utilizing the advanced access schedule, their patient slot usage will increase by 5 patients per day.
3. Increased team satisfaction in relation to patient scheduling process by 10%.

### Plan to collect data and answer questions (who, what, when, where, how):
1. Pull the data reflecting three month average for no-show rate, prior to use of advance access schedule and compare.
2. Provide patient survey to established patients who have been seen within the last 6 months to compare their experience from previous appointment to most current.
3. Provide team with survey monkey survey to determine current satisfaction and send same survey in 3 months to see if any improvements were made.
4. Compare provider slot utilization pre and post advance access schedule implementation.

### DO:
- Carry out the change or activity and collect the data. Document your observations and what happened (+/-).
  1. Currently working on determining exact scheduling guidelines and communication to staff.
No Show Rates Before / After Launch of Advanced Access (Last 12 Months)

<table>
<thead>
<tr>
<th></th>
<th>Gratton, Laura</th>
<th>Griffiths, Denise</th>
<th>Rest of Green Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Patient Visit</td>
<td>Before: 12.6%</td>
<td>After: 6.6%</td>
<td>Before: 11.4%</td>
</tr>
<tr>
<td>New Patient Visit</td>
<td>Before: 15.4%</td>
<td>After: 10.0%</td>
<td>After: 10.0%</td>
</tr>
<tr>
<td>Current Patient Visit</td>
<td>Before: 24.1%</td>
<td></td>
<td>Before: 25.0%</td>
</tr>
<tr>
<td>New Patient Visit</td>
<td></td>
<td></td>
<td>After: 16.4%</td>
</tr>
</tbody>
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## New Provider Templates

### Visit Type Options

<table>
<thead>
<tr>
<th>Time</th>
<th>Carol Terzi</th>
<th>Angie Enos</th>
<th>Heather Barr</th>
<th>Heather Holmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00:00 AM</td>
<td>Open 30</td>
<td>Open 30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:15:00 AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:30:00 AM</td>
<td>Open 15</td>
<td>Open 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:45:00 AM</td>
<td>Open 15</td>
<td>Open 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00:00 AM</td>
<td>Open 30</td>
<td>Open 30</td>
<td>Open 30</td>
<td>Open 30</td>
</tr>
<tr>
<td>9:15:00 AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30:00 AM</td>
<td>Triage - RN</td>
<td>Triage - RN</td>
<td>Same Day</td>
<td>Open 15</td>
</tr>
<tr>
<td>9:45:00 AM</td>
<td>Same Day</td>
<td>Same Day</td>
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<td>Open 15</td>
</tr>
<tr>
<td>10:00:00 AM</td>
<td>Open 30</td>
<td>Open 30</td>
<td>Open 30</td>
<td>Triage - RN</td>
</tr>
<tr>
<td>10:15:00 AM</td>
<td></td>
<td></td>
<td>Open 15</td>
<td></td>
</tr>
<tr>
<td>10:30:00 AM</td>
<td>Open 15</td>
<td>Open 15</td>
<td>Triage - RN</td>
<td>Triage - RN</td>
</tr>
<tr>
<td>10:45:00 AM</td>
<td>Open 15</td>
<td>Same Day</td>
<td>Same Day</td>
<td>Triage - RN</td>
</tr>
<tr>
<td>11:00:00 AM</td>
<td>Open 30</td>
<td>Open 30</td>
<td>Open 30</td>
<td></td>
</tr>
<tr>
<td>11:15:00 AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30:00 AM</td>
<td>Same Day</td>
<td>Admin/TPOD</td>
<td>Triage - RN</td>
<td>Admin/TPOD</td>
</tr>
<tr>
<td>11:45:00 AM</td>
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<td>Open 15</td>
<td>Admin/TPOD</td>
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<td>Lunch/Adm</td>
<td>Admin Lunch</td>
<td>Lunch/Adm</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>12:30:00 PM</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>12:45:00 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00:00 PM</td>
<td>Admin/PC</td>
<td>Open 30</td>
<td>Admin/TPOD</td>
<td>Open 30</td>
</tr>
<tr>
<td>1:15:00 PM</td>
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<td>Admin/TPOD</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>Open 15</td>
<td>Open 15</td>
<td>Open 15</td>
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<tr>
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<td>Triage - RN</td>
<td>Same Day</td>
<td>Triage - RN</td>
</tr>
<tr>
<td>2:00:00 PM</td>
<td>Open 30</td>
<td>Provider Only</td>
<td>Open 30</td>
<td>Provider Only</td>
</tr>
<tr>
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<td>Provider Only</td>
<td></td>
<td>Provider Only</td>
<td></td>
</tr>
<tr>
<td>2:30:00 PM</td>
<td>Triage/RN</td>
<td>Same Day</td>
<td>Triage - RN</td>
<td>Same Day</td>
</tr>
<tr>
<td>2:45:00 PM</td>
<td>Same Day</td>
<td>Open 15</td>
<td>Open 15</td>
<td>Open 15</td>
</tr>
<tr>
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<td>Open 30</td>
<td>Open 30</td>
</tr>
<tr>
<td>3:15:00 PM</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:30:00 PM</td>
<td>Same Day</td>
<td>Same Day</td>
<td>Provider On</td>
<td>Same Day</td>
</tr>
<tr>
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<td>Same Day</td>
<td>Provider On</td>
<td>Same Day</td>
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<tr>
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<td>Open 30</td>
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<td>4:15:00 PM</td>
<td>Provider O</td>
<td></td>
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<td>4:45:00 PM</td>
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<td>Open 15</td>
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</tbody>
</table>

### Provider Visit Summary

<table>
<thead>
<tr>
<th>Provider</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terzi</td>
<td>22</td>
</tr>
<tr>
<td>Enos</td>
<td>23</td>
</tr>
<tr>
<td>Barr</td>
<td>17</td>
</tr>
</tbody>
</table>

### Providers
- **Terzi**: 22 visits
- **Enos**: 23 visits
- **Barr**: 17 visits

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**Mosaic Medical**

Quality Care For All
Access Improvement Project: Daily Dashboard

Total and New Patient Visits Per Day (Updated: 10/20/2015 6:18:15 AM)

<table>
<thead>
<tr>
<th>Provider</th>
<th>Mon</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>TERRY, KATRINA</td>
<td>10.0</td>
<td></td>
</tr>
<tr>
<td>VAUGHAN, DARIN</td>
<td>14.0</td>
<td></td>
</tr>
<tr>
<td>HENDRICK, ANGELA</td>
<td>10.0</td>
<td></td>
</tr>
<tr>
<td>TYNE, KARI</td>
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<td></td>
</tr>
</tbody>
</table>

Unused Slots

<table>
<thead>
<tr>
<th>Provider</th>
<th>No Show / Late Cancel</th>
<th>Unused Blocked Slot</th>
<th>Unused Slot</th>
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</thead>
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<tr>
<td>TERRY, KATRINA</td>
<td>3</td>
<td>1</td>
<td>4</td>
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<tr>
<td>VAUGHAN, DARIN</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>HENDRICK, ANGELA</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TYNE, KARI</td>
<td>2</td>
<td>2</td>
<td>2</td>
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</table>

MyChart Activation %

<table>
<thead>
<tr>
<th>Provider</th>
<th>Mon</th>
<th>Average</th>
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<tbody>
<tr>
<td>TERRY, KATRINA</td>
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<tr>
<td>VAUGHAN, DARIN</td>
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<tr>
<td>HENDRICK, ANGELA</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>TYNE, KARI</td>
<td>27</td>
<td></td>
</tr>
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</table>

Behavioral Health Consultant Visits Per Day

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Mon</th>
<th>Average</th>
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<tbody>
<tr>
<td>SCHUURMAN, RICHARD</td>
<td>3</td>
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</tr>
<tr>
<td>SHEPPARD, LACEY</td>
<td>6</td>
<td>6.0</td>
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</tbody>
</table>
What has been your experience?
ACCESS SOLUTION #3: REMOTE PATIENT MONITORING
How it works

- Process
- Personnel
- Equipment
- Management
Equipment
Ready Kit™

Content:
- Blood pressure monitor
- Cell pod
- Scale
- Glucose Enabler
- Oxygenation Monitor
- Patient Consent and Inventory Score
- Instructions
- My Chart
- Contact Information
• Sustained health improvements
• ED utilization
• Patient engagement
• Enrollment/Participation
What is the age of patients on the program?

# of Patients by Age Range
(total = 297, range = 15-87)

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Number of Patients</th>
</tr>
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<tbody>
<tr>
<td>10-19</td>
<td>1</td>
</tr>
<tr>
<td>20-29</td>
<td>3</td>
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<tr>
<td>30-39</td>
<td>27</td>
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<tr>
<td>40-49</td>
<td>42</td>
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<tr>
<td>50-59</td>
<td>85</td>
</tr>
<tr>
<td>60-69</td>
<td>93</td>
</tr>
<tr>
<td>70-79</td>
<td>31</td>
</tr>
<tr>
<td>80+</td>
<td>15</td>
</tr>
</tbody>
</table>
• 112 out of 296 of all current and former patients have at least 2 of the above diagnoses
• Other common chronic conditions: depression (101 patients), CAD (35), asthma (37)
Did patients successfully complete the program?

76% of all patients – 226 Patients - have successfully graduated or remain on the program.
Are blood pressure readings improving (continued)?

Blood pressures before and after enrollment (office visit BP recordings)

RPM Patients’ Blood Pressures were Trending Up Prior to Enrollment (in Blue); Trend Downwards After Enrollment (in Orange) (p<.001)
Did Diabetic A1C readings improve?

Diabetic A1C before, during and after

Average A1C by Enrollment Status

Before Enrollment: 8.1
During Enrollment: 7.8
Post Discharge: 7.4

12 Months After RPM Enrollment, A1C Values Improved an Average of .47 (p<.05)

Status at A1c
- Before Enrollment
- During Enrollment
- Post Discharge

Time Since Enrollment in RPM (in months)
Did Patient Activation Metric (PAM) score improve?

Pre and post intervention PAM scores

PAM Scores Improved Significantly, Pre to Post RPM
(only patients with both recorded n=91, p<.05)

Avg. Pre PAM Numeric: 57.7
Avg. Post PAM Score: 62.4
Is RPM keeping patients out of the Emergency Department?

ED visits

ED Visits by Telehealth Patients: 6 Months Prior to Enrollment vs. First 6 Months After Enrollment
(Medicaid only, excludes patients discharged for non-compliance)

- 6 Months Prior to Enrolling: 45
- 1st 6 Months After RPM Installed: 39
Next Steps with RPM

• Complete new interface roll-out
• Partner with local Hospital ED
• Continue to pay attention to CMS billing guideline revisions.
• Collect Data and partner with local CCO
What has been your experience?
In closing...

Triple Aim:
A new vision for Oregon

2. Better care.
3. Lower costs.

www.health.oregon.gov
Resources

Andy Eck
*Regional Director of Operations*
[Andy.eck@mosaicmedical.org](mailto:Andy.eck@mosaicmedical.org)

Laura Gratton, DO
*Regional Medical Director*
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