Practice Background

- Summit Family Physicians Inc. was founded in 1985 and remains an independently owned practice.
- Middletown is a blue collar Appalachian community with industrial base of steel and paper manufacturing.
- Physicians still make daily hospital rounds and care for newborns to 104 year old patients.
Employees

- Three Board Certified Physicians
- One Certified Nurse Practitioner
- Eighteen Dedicated Employees
Patients

- Six thousand patients
  - 45% patients are > 65 yrs old
  - 984 CMS patients with higher disease acuity
    - higher office costs with lower hospital costs
    - ER utilization lowest 25 percentile
I founded the practice in 1985

I work full time as a family physician

I am team physician for Middletown High School for the past 31 years and served 16 years on school board

I enjoy flying my hot air balloon - "Release".
December 2009 partner departed to join administrative medicine

November 2010 attended first PCMH meeting

April 2011 signed EMR contract, selected to PCMH cohort Health Collaborative, hired CNP

August 22, 2011 EMR go live

Dec 2011 attested for Meaningful Use
August 2012 Certified Level 3 PCMH by NCQA

September 2012 Selected as CPC initiative practice by CMS

December 2013 Completed Year 1 CPC

Currently in second year of four year CPC program
Our Motivation

- Our medical system is BROKEN
- Primary care must be central to care delivery
- Future reimbursement will be largely based on patient population management, utilization and quality.
- We believe the PCMH model is improving healthcare delivery, patient health and potentially lower costs.
Patient Care Enhancements

- **Access** - open scheduling daily for 30% of appointments, continued 24/7 MD phone access, payment policy for delinquent accounts reviewed and modified

- **Hospitalized patients contacted within 48 hours of discharge**

- **ED visits are followed up with phone call for care needs and education about practice access and capabilities.**
  Encouraged to call practice first.

- **Established referral tracking to specialists to ensure timely access and followup**
Patient Care Enhancements

- All patients risk stratified to alert staff to care responsibilities with appropriate staff training
- Patient education classes established by partnering with pharmaceutical companies
- Aligning community resources with patient needs
- Outreach to patients not seen in office for chronic disease management and preventative care procedures
Benefits of Change

- Improved employee satisfaction in recognizing they are meeting more patients at their point of need.
- Employees are working at a higher levels of responsibility
- Patients are receiving more comprehensive quality care
- Collaboration with like minded practices and support from CPC faculty both locally and nationally
Costs of Change

- Change is difficult, energizing and exhausting.
- Open access reduces scheduling efficiency
- Added care responsibilities reduces number of patient visits providers see daily - 15 to 20%
- Increase in staff increases practice costs - care coordinator and additional medical assistant and RN hours
Revenue flat in 2011, 2012 during EMR implementation

Non CPC revenue in 2013 decreased by 5%

Office expenses increased by 19.1% year one CPC

Office overhead historically less than 50%

Office overhead 2013 52% including CPC revenue

CPC PMPM revenue covers 45% of patients
National Challenges

The medical delivery system remains broken:

• Shortage of primary care providers
• Speciality care remains more highly valued as shown through current reimbursement.
• Hospitals, insurance companies and providers continue to operate in vertically aligned silos
• EMR do not seamlessly share information
Practice Challenges

- Funding of care management must be sufficient and continued through PMPM payments for practices committed to increasing services for all patients. 100% of patients

- Time - expanded care responsibilities expand time commitment. Time and energy is also consumed negatively by prior authorizations and pre-certifications.

- Realistic expectations as to what services an office should independently provide recognizing limited resources
Practice Challenges

- Being able to receive quality data from hospitals and insurers to empower change
- Connecting all components of care community to provide comprehensive care reducing fragmentation.
- Emotional investment of all practice employees to remove barriers for patient’s to enjoy better health.
Moving Forward

- Patient Centered Medical Home Care Principles should be the standard of care

- Primary care providers must be at the center of our medical care delivery system

- Primary care physician shortage must be addressed and resolved. Compensation must reflect the value of care provided

- Compensation for care management must include all patients
Moving Forward

Care should be provided through coordination of services by providers to hospitals, home care agencies, insurers not vertically independent to reduce costs and redundancy.

Insurers must reduce prior authorizations and pre-certifications to allow practices the ability to utilize their best personnel for care management activity.