Summit Family Physicians

Middletown Ohio

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*

Personal Background

- *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”.*

PCMH Journey

- *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*
- *Out reach 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*

Financial Realities

- *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

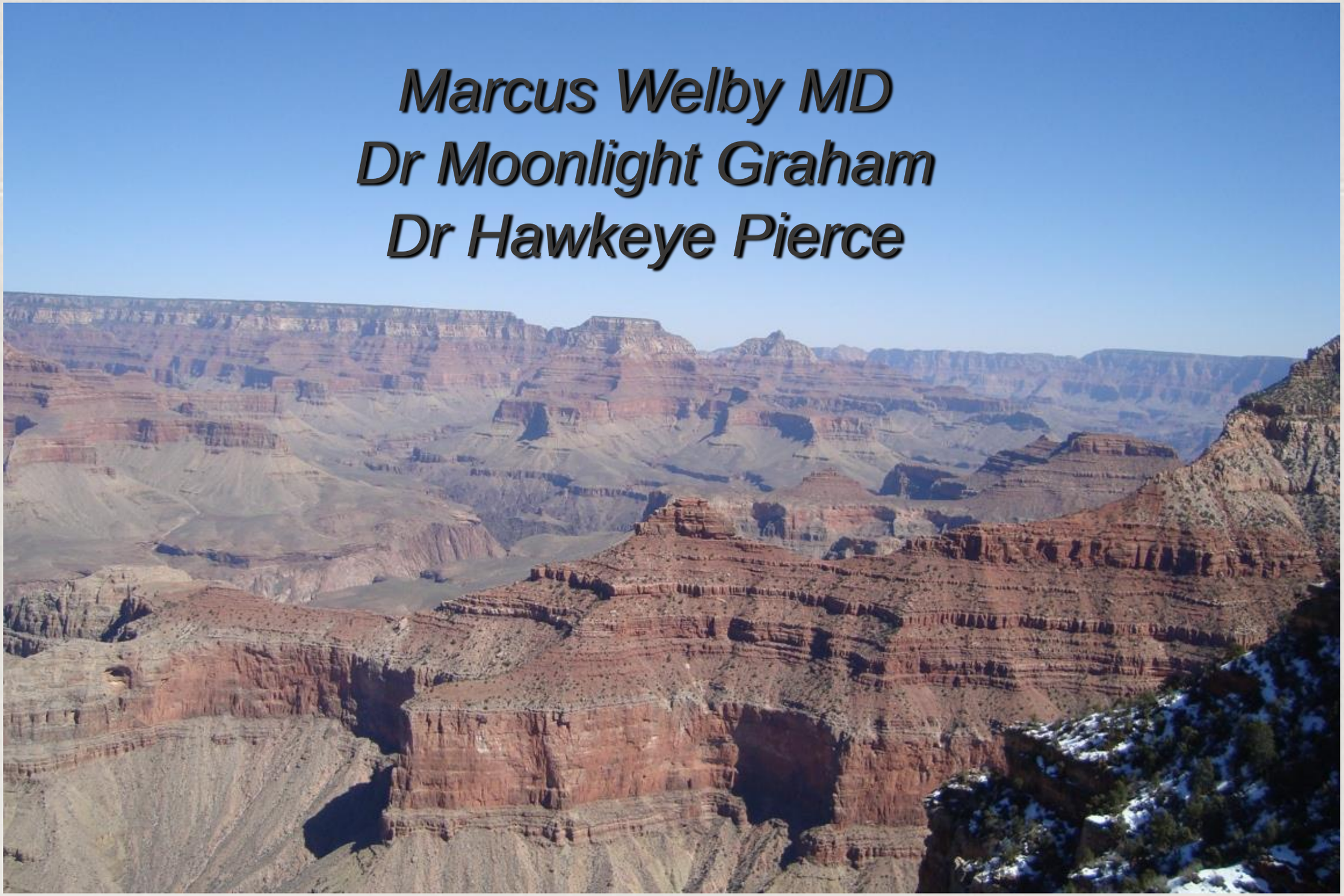
- *Being able to receive quality data from hospitals and insurers to empower change*
- *Connecting all components of care community to provide comprehensive care reducing fragmentation.*
- *Emotional investment of all practice employees to remove barriers for patient's to enjoy better health.*

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.*


Marcus Welby MD
Dr Moonlight Graham
Dr Hawkeye Pierce