PRACTICE INNOVATION PROGRAM COLORADO
INNOVATION SUPPORT PROJECT

Learning Plan ISP- Cost of care utilization

Utilization management is a process that works to improve healthcare quality, reduce costs, and improve the overall health of the population. It began in the 1970s, but became prevalent in the 1980s, as healthcare costs started to rise more significantly than they had in past decades. It is defined as the group of activities and processes focused on ***medical necessity*** and ***appropriate care,*** utilization management has proven invaluable in balancing providers' compliance and revenue.

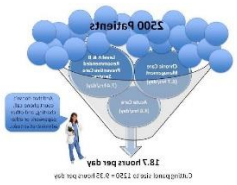
Understanding your practices cost of care can be useful in establishing your value to APMs ACOs and payers. Payer reports calculating cost of care and utilization can assist in evaluating and changing your cost of care.

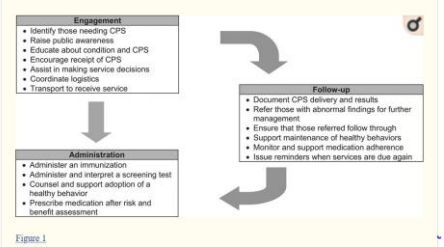
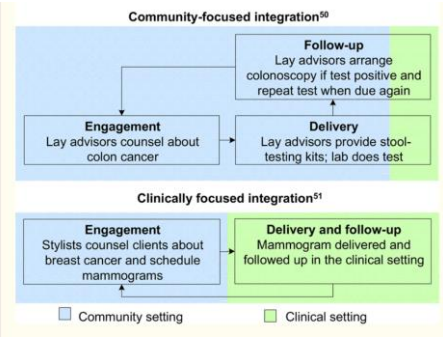
Programs such as "*Choosing Wisely"* assist the practice engage patients/consumers in reducing costs through appropriate care choices.

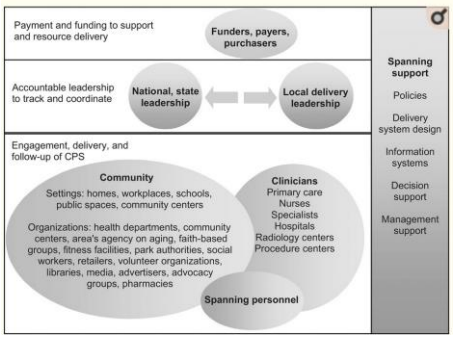
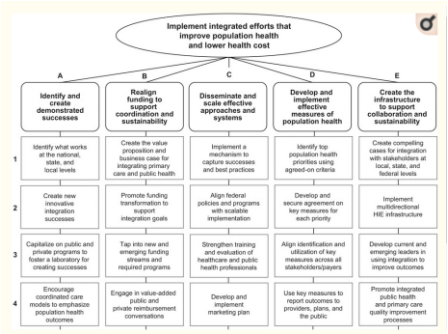
Efficient effective chronic care management programs reduce cost and over utilization. By many estimates, only 5 percent of U.S. patients are high-need, high-cost, yet they account for about 50 percent of healthcare spending. New research published in the New England Journal of Medicine finds it's necessary to understand the needs of this patient cohort, identify drivers of their utilization, and implement solutions to improve their clinical outcomes while reducing their costs.

Prevention and preventive services are key drivers to reduce costs. However, clinical preventive services are substantially underutilized despite the human and economic burden of chronic diseases, the availability of evidence-based tools to prevent or ameliorate them, and the effectiveness of prevention strategies (Health Care Industry Insights: Why the Use of Preventive Services Is Still Low ESSAY — Volume 16 — March 14, 2019)

Goals /outcomes	**Steps /Process to reach goals**	**Support Required Responsibility**	**Resources**
Evaluate payer cost data and consider your cost per visit. Also, total cost of care metrics if available. See examples in budget planning	Cost-per-visit or procedure cost data is useful when setting fees, planning for expansion, or negotiating rates with health care insurers. TCOC data will come from Payers	Assistance from PF may be required for this one and the accountant for the practice may be able to calculate the cost per visit base on the E&M and or CPT code for procedures. PF can assist practice obtain and understand cost data from payers.	**https://www.physicianspractice.com/article/metric-quantify-cost-patient-visits** **https://www.aafp.org/fpm/2004/0400/p41.pdf** **https://www.physicianspractice.com/article/costs-doing-**

			business?utm_source=bibblio_recommendation
Chronic care management as a tool can decrease costs and prevent over utilization Care delivery solutions, including care management, telemedicine, and home health visits, have had mixed levels of success for various outcome measures. 	Patient centered care involves the voice of the patient not what we think the patient want or needs. In the article listed in resources the patient voice was included A qualitative researchers from Weill Cornell Medicine and University of Florida led several focus group discussions with 21 high-need, high-cost patients and three primary caregivers, representing an urban healthcare system in New York City and Gainesville, Florida. Participants -- a racially diverse group ranging in age from 23 to 80 -- identified five solutions they felt would help prevent overuse of the ED and other hospital services for symptoms and/or conditions that can be well-managed at primary care clinics. The five solutions include: 1. care management 2. readily available at-home physical therapy 3.and nursing services 4.home delivery of prescription medication easier refills 5. telemedicine; and more after-hours clinics.	Assist the practice with a focus group for their own high-risk high need patients. Evaluate telehealth visits for chronic care high risk patients. Assist the practice evaluate their care management program, or assist practice set up care plans and management for high risk high need patients.	High-need, high-cost patients often have multiple chronic conditions, complex needs, and limited ability to perform activities of daily living. https://www.healthcarefinancenews.com/news/why-theres-need-reduce-high-healthcare-utilization-among-high-need-high-risk-patients How to Set Up a Chronic Care Management Program (A 5 Step Guide) https://aetonix.com/2019/10/08/t/#:~:text=%20How%20to%20Set%20Up%20a%20Chronic%20Care,Patients.%20After%20determining%20the%20scale%20of...%20More%20 Designing CCM program https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm1.html Rural Health https://www.ruralhealthinfo.org/care-management/chronic-care-management Resources for telehealth program https://www.ruralhealthinfo.org/toolkits/telehealth/4/resources-needed#:~:text=%20Resources%20Needed%20for%20Implementing%20Telehealth%20Programs%20,telehealth%20technology%20that%20rural%20programs%20might...%20More%20

Preventive care **A few examples of preventive care services:** Wellness visits and standard immunizations. Screenings for blood pressure, cancer, cholesterol, depression, obesity, and Type 2 diabetes. Pediatric screenings for hearing, vision, autism and developmental disorders, depression, and obesity. Involve community in preventive services.	Team based care is essential to reduce cost, decrease utilization, and improve outcomes. Clinical a community health workers can team up to deliver preventive care services. **Outlining the Stages of Preventive Services Delivery** Clinical preventive services are often defined as screening tests, immunizations, health behavior counseling, and preventive medications.[1] But prevention is more than simply ordering a test, administering an immunization, counseling a patient, or prescribing a medication. Effective delivery requires much more, including (1) engaging individuals in need of services; (2) administering the Clinical Preventive Services ; and (3) following up https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4544711/	PF can facilitate this activity to demonstrate if team-based care is part of the practice culture. **Perform Team Visualization Exercise** The goal of this exercise is to illustrate how the current models in most primary care practices do not function as team-based care. When working with your practice, be sure to get all care team members to participate. Each staff member will be given 60 jellybeans and a short, clear plastic cup. Also have a cup in the middle labeled "No one." **Ask the group** which staff member performs each of 10 tasks (listed below). **Instruct all staff members** to drop a jellybean into **each** staff member's cup who they think **currently performs** that task. **Instruct staff members** to drop a jellybean into the "No one" cup if they don't think anyone currently performs that task. For example, if a staff member thinks a task is currently performed by two physicians, a nurse practitioner, and a physician's assistant, that staff member would put a jellybean in each of the cups of those four providers.	Preventive services https://www.cdc.gov/pcd/issues/2019/18_0625.htm Implementing care teams https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod19.html This link above has additional team-based care exercises. Clinical and Community Delivery Systems for Preventive Care: An Integration Framework https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4544711/  Figure 1 

	Clinical–community integration is most successful when all key stakeholders are engaged. The framework recognizes six critical stakeholder groups: (1) clinicians; (2) community members and organizations; (3) spanning personnel and infrastructure; (4) national and/or state leadership; (5) local leadership; and (6) funders and purchasers. Integrated efforts improve population health and decrease coats.	**Ask which staff member:** SETS the intervals for blood monitoring for patients on warfarin. DECIDES when to call a patient with diabetes to come in for a visit? SELECTS the vaccines to be given to an 18-month-old baby. DECIDES to arrange a diabetes retinal screening referral. ORDERS the mammogram for a 55-year-old woman with severe hypertension and heart disease? INITIATES diabetes microfilament foot testing to prevent amputations. FINDS patients with severe persistent asthma who are not on controller medications and brings them in for an appointment? DECIDES which children with ADHD should come for a visit? DECIDES when a patient with major depression (PHQ 17) should come back for a visit? ADMINISTERS Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening to patients in your practice?	 

		At the end of the exercise, the group will probably discover that most of the jellybeans end up in the primary care providers' cups. Facilitate a discussion using the following prompts: What did you observe about this exercise? What did you learn from it? What implications do you think this has for you all as a care team? Why are there jellybeans in the "No one" cup? What can you do about that? What should the distribution of jellybeans look like to be real team-based care? What changes would you need to make to how you are currently practicing to do this? How would this affect your workflow? *Provided by Carolyn Shepherd, M.D* Implementing care teams https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod19.html	

Choosing Wisely Program The **Choosing Wisely**® campaign is one of our most well-known initiatives. The goal of the campaign is to promote conversations between clinicians and patients by helping patients **choose** care that is: Supported by evidence. Not duplicative of other tests or procedures already received. **Choosing Wisely Initiative ABIM Foundation** https://www.choosingwisely.org/our-mission/	See Choosing Wisely toolkit for Question Sheet Workflow Goal: Encourage patients to further engage in their care through questions that foster an open and effective dialog with their provider	PF can suggest making Choosing *Wisely* a standard agenda item for: • staff meetings • Provider meetings • Clinical/admin meetings.	Choosing Wisely https://www.choosingwisely.org/getting-started/resource-library/additional-materials-for-patients/ Choosing wisely toolkit https://www.choosingwisely.org/getting-started/implementation-toolkits/ Acting as a Physician Champion for Choosing Wisely in an FQHC" with Dr. Robert Kolker, CW Learning Network Webinar, April 2019. "Engaging Providers to Reduce Medical Overuse," CW Learning Network Webinar, August 2018
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