

NEW PERSPECTIVES

Practice-based Population Management: Using Your Team to Maximize Your Time

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Improving outcomes, minimizing costs, and ensuring every patient receives recommended care are priorities in primary care practices throughout the country. Historically, primary care has centered on providing face-to-face care to patients with varying degrees of engagement in their own health. To minimize costs and improve the overall health of our patients, we must provide optimal care to every patient within our practice regardless of his/her presence or engagement. Practice-based population management (PBPM) is a valuable tool that can increase the number of patients receiving optimal care. PBPM uses proactive targeted interventions to improve clinical and financial outcomes in a population of patients.¹ PBPM is commonly completed using patient registries that can characterize patients (i.e. diagnosed with a specific disease, prescribed a high-risk medication, or targeted for preventive care interventions) to identify opportunities for improvement in care.

Legislation such as the Meaningful Use of Electronic Health Records, the Patient Protection and Affordable Care Act of 2010, and the American Recovery and Reinvestment Act have started to lay the groundwork for a system where reimbursement is based on clinical and financial accountability.¹⁻⁵ PBPM will be necessary for success in these evolving models, such as accountable care organizations (ACO) and patient-centered medical homes (PCMH). PBPM aligns with PCMH standards relating to using patient registries to monitor patients who need care management, to track and improve patient outcomes, and to support preventive care.⁶ To be successful in the future, primary

care offices must maximize the use of health information technology and patient care teams to conduct PBPM and other collaborative models to provide patients with optimal preventive care and chronic disease management.

Practices staffed by multidisciplinary teams have shown they can effectively incorporate PBPM into daily activities. It has been estimated that primary care physicians would need to work 18 hours per day to provide all of the care needed by patient populations. Multidisciplinary care teams can manage more patients than a physician working alone and can spend more time providing preventive health maintenance, chronic disease management, and patient education.¹ This multidisciplinary effort also aligns well with PBPM models by using the skill set of a particular team member to provide targeted interventions.

Electronic health records (EHR) also make PBPM feasible because patient data is readily accessible.¹ Many EHRs come equipped with patient registry and population management tools. These tools make pulling patient data by diagnosis, lab result, or medication usage from the EHR straightforward. In 2005, a survey of physician practices in Massachusetts indicated that 79.8% of practices could generate patient registries by diagnosis, 56.1% by laboratory result, and 55.8% by medication usage.¹ Many of these patient registries can then be exported to electronic databases for easy manipulation of the data to identify and target select areas for improvement.

Pharmacists in our PCMH are currently using the EHR and collaborating with physicians on two PBPM

projects. The first project uses the EHR to identify and contact patients needing the herpes zoster vaccine. For patients interested in the vaccine, their chart is reviewed for vaccine contraindications by the pharmacist before a prescription is sent to the community pharmacy, when appropriate. The second project identifies patients with chronic kidney disease (CKD). For each patient with CKD, the EHR is reviewed for all preventive care and laboratory monitoring recommended by the National Kidney Foundation Kidney Disease Outcome Quality Initiative (KDOQI) guidelines and to ensure all medications are dosed appropriately based on the patient's renal function.⁷ Any identified gaps in care are then addressed with the primary care physician. These projects are just a few examples of the many opportunities to use PBPM to improve patient care.

These two projects have improved the care of patients in our practice; however, PBPM does not come without barriers, most notably the lack of reimbursement for this type of service.^{1,2,8} Already 40% of primary care is not reimbursable because it does not occur during face-to-face interaction; this leads to a considerable amount of time spent on non-reimbursable activities.⁹ PBPM initiatives, such as those discussed above, increase the amount of time spent completing non-reimbursable but clinically beneficial activities. Other barriers include incomplete information in the EHR, the need to enter outside data into the EHR for it to be searchable, and limited physician time available for PBPM activities.¹ Effective use of the EHR and multidisciplinary care teams

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will be necessary to overcome these barriers if population management is to become a priority. At this point, grants and third-party incentives can help fund pilot projects; however, sustainable reimbursement will be a necessity if PBPM is to be incorporated into quality care models.

Our current model of care is not financially or reasonably designed to identify or provide preventive or disease-targeted care to patients who are not personally engaged in their own health. As we move toward ACOs and PCMH, financial reimbursement will likely be based on all patients, not just those who are proactive and engaged or those who present to their physician.⁸ Primary care will need to be re-engineered to continue providing top-quality cost-effective care; physicians will become the leaders of diverse multidisciplinary teams sharing the responsibility of patient care with other team members. These teams will work to ensure that practices use PBPM and do not miss the opportunity to prevent advanced illness in entire patient populations.⁶ We must take small steps in the care of our patients today if we plan to provide optimal primary care to the patient populations of the future. We must strive to provide PBPM to our patients and ensure we closely analyze the feasibility, efficiency, and sustain-

ability of the processes we use to manage patient populations and share these experiences with other practices throughout the country. Research directed at determining the best most efficient process for PBPM activities will be essential in the next five to ten years.

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