Complex Care Planning

Evaluation Plan

Fraser Northwest Division of Family Practice

July 27th, 2017

Program Background

The Complex Care Planning initiative is a joint project between the Fraser Northwest Division of Family Practice and Fraser Health's Practice Support Program (PSP). Modeled after the North Shore Division's successful initiative, this project aims to equip family physicians with the necessary skills to accurately identify and register complex care patients in their EMR and bill for the appropriate care provided. Through one-on-one coaching and interactive group learning sessions, GPs, together with their MOAs, learn how to "analyze" and "clean up" their data while implementing processes to optimize the functionality of their EMR and define/refine their workflow with their MOA to provide care to patients with complex needs.

Patients who are deemed "complex" (i.e. have two or more comorbid conditions) or are frail and/or home bound require more and different care from other patients. Recognizing this, GPSC has implemented incentive fees for this work including managing patients with chronic disease(s). However, these fees are often underutilized due to complexities of the billing system and EMR (Patient) panels that are often not accurate and up to date. By differentiating between active and non-active patients and ensuring that every complex care patient and patients with chronic disease(s) are accurately identified and recorded in the EMR, the physician will be able to identify all patients fitting the complex care criteria and/or annual CDM care criteria. Once this is achieved, systems are put in place to:

- Provide guideline informed care that meets GPSC incentive requirements
- Record complex care and/or chronic disease conditions in each Patients' EMR ensuring accurate, consistent use of ICD9 codes as outlined by GPSC
- Bill for the care provided
- Establish recalls for care/billing to move to be more proactive
- Maintain ongoing accuracy of data and timeliness of care

Program Objectives/Goals

- Identify Patients with Complex Care requirements including Chronic Diseases
- Record said conditions in the Patient Medical Record (EMR) using accurate and consistent ICD9 codes as per GPSC/MSC

- Learn and implement various GPSC incentive fees to be paid for this care/work
- Establish GP and MOA processes in support of this care /work; sustainability and spread
- Explore and utilize various EMR features /functionality to support/guide this work

Program Implementation

Cohort 1 launched in April 2017 with 13 physician/MOA dyads. Cohort 2 will launch in September 2017.

The structure for both cohorts consists of three group sessions, with individual in-practice support meetings in between.

Through one-on-one coaching with the PSP coach/facilitator, physicians first gain an understanding of their patient panel and learn how to analyze and clean their data. This involves:

- ➢ Individual panel assessment with each GP to establish a baseline and action plan
- ➢ Review and understanding of current GPSC ICD9 codes and fees pertaining to Complex Care and/or Chronic Diseases (including diagnostic criteria)
- ➢ Recording said eligible conditions in Patient Medical Records (EMR) for ALL APPROPRIATE patients with this diagnosis
- ➢ Addressing any other data or knowledge gaps

Once an understanding of their current patient panel is achieved, physicians are coached on establishing processes to optimize efficiency and utilization of their EMR for chronic disease management. This involves:

- ➢ Establishing registries for each CDM group and complex patients
- ➢ Establishing recall cycles
- ➢ Following up on overdue appointments and scheduling future follow up visits
- ➢ Ensuring appropriate billing for each visit

As a team-based care model, the participants' success in this project is highly dependent upon the ability and willingness of the GP and MOA working together to achieve common goals. Separate roles and responsibilities are assigned to each to ensure smooth workflow.

GP:

- Consistent coding (ICD9), chart and/or disease registry
- Documenting diagnosis and care; clinical decision support, cdm forms/flowsheets, care plans etc.
- Proactive care; activate recalls for care and billing

MOA:

- Manage/maintain patient status, MRP, demographics
- Run disease registry and/or billing reports to find eligible billings
- Manage patient recalls; scripts to call patients back for care

Purpose

The purpose of this evaluation is to provide evidence to understand the process and outcomes of the first two Complex Care Planning cohorts, and to gather learnings to inform the future strategic direction of this program.

As a 'Process/Outcome' evaluation, this will serve to assess both the effectiveness of the program itself at achieving its intended goals, as well as how well the program was delivered.

The evaluation is intended for distribution among the project's key stakeholders, including the Fraser Northwest Division of Family Practice board of directions and Patient Medical Home Advisory Committee, Fraser Health Practice Support Program, and the GPSC/Doctors of BC evaluation team

Evaluation Goals and Objectives

1. Provide evidence to understand and articulate the process and outcomes of the first two Complex Care Planning cohorts
2. Gather learnings to inform QI initiatives and future strategic direction
3. Determine how Complex Care Planning aligns with FNW Division's Patient Medical Home landscape, and how the following Division objectives are met:
    a. PCH attributes
    b. Team-based care
    c. Resource for family physicians

Evaluation Questions

Program Effectiveness:

1. How effective was the program at enabling family physicians to identify complex care and chronic disease patients?
2. To what extent did physicians see an increase in complex care and chronic disease management billings?
3. To what extent did the program improve the accuracy of how complex care and chronic disease conditions are coded in the patient record/chart?
4. To what extent did the program contribute to an increase in physician (and MOA) knowledge and use of the EMR features and functionality

Program Delivery:

1. To what extent was the program delivered as intended?
2. To what extent were the participants satisfied with the mode of delivery?

Indicators

- # of newly identified complex care patients
- # of newly identified chronic disease patients
- $ increase in complex care and chronic disease management billings; consider % revenues increase and/or use baseline vs. final results
- % increase in accuracy of patient registries; as above use baseline data vs. final results to show actual numbers/figures
- Physician satisfaction scores

Outcome Measures

Alignment with provincial PMH evaluation framework - 4 outcome areas:

1. Physician experience
2. Access
3. Cost
4. Patient experience

Methodology

Data will be collected from the following sources:

1. EMR data collection from participating physicians
2. Chronic disease/complex care MSP billings of participating physicians
3. Mid-point and final session evaluation forms

Fig. 1 Logic Model

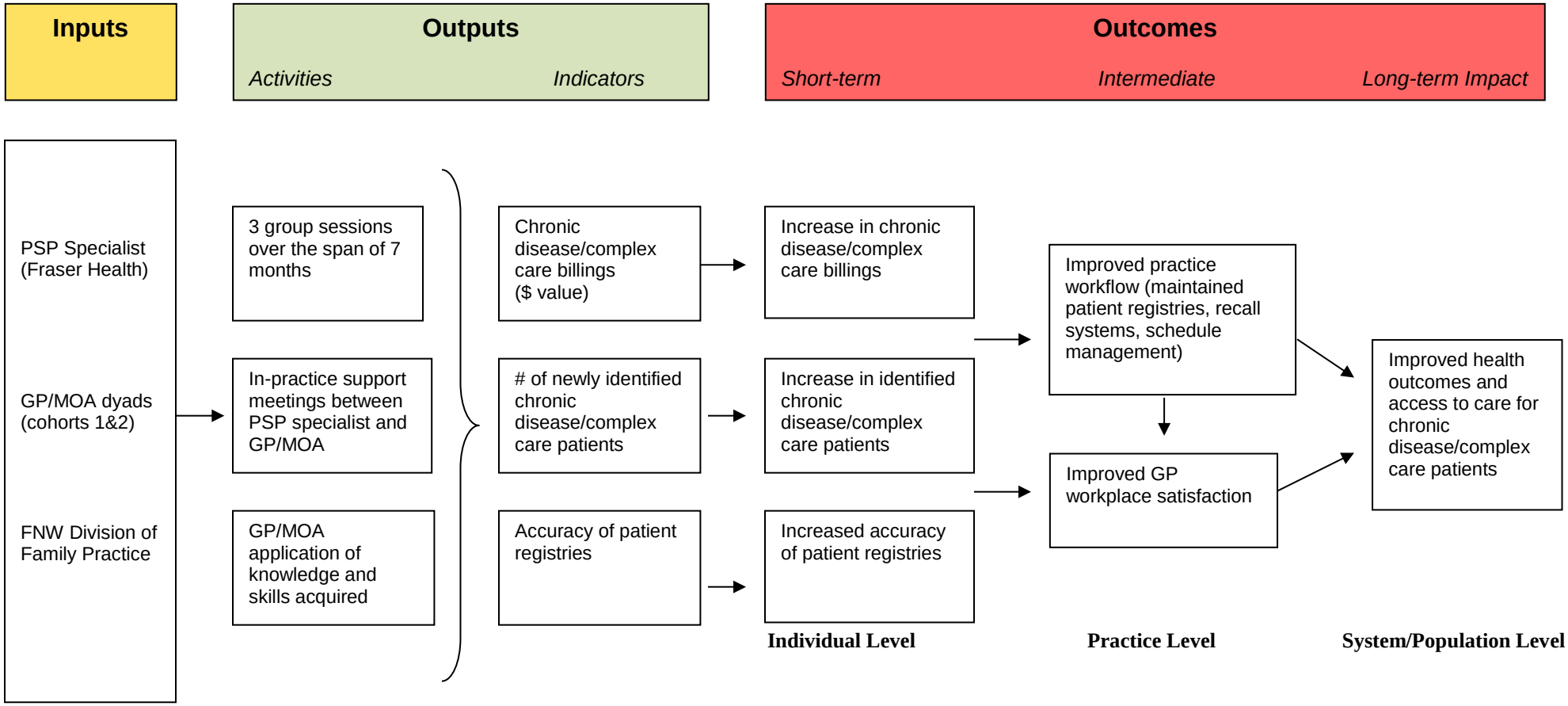

Table 1. Evaluation Matrix

Evaluation Questions	Indicators	Data Sources	Responsibility
How effective was the program at enabling family physicians to identify complex care and chronic disease patients?	• # of newly identified complex care patients • # of newly identified chronic disease patients	Physician EMR	PSP Specialist
To what extent did physicians see an increase in complex care and chronic disease management billings?	• $ increase in complex care and chronic disease management billings; % revenues increase over time	Chronic disease/complex care MSP billings	PSP Specialist
To what extent did the program improve the accuracy of how complex care and chronic disease conditions are coded in the patient record/chart?	• % increase in accuracy of patient registries	Physician EMR	PSP Specialist
To what extent did the program contribute to an increase in physician (and MOA) knowledge and use of the EMR features and functionality	• Physician and MOA satisfaction scores	Mid-point and final evaluation forms Baseline and post-implementation surveys	PSP Specialist/ Division staff