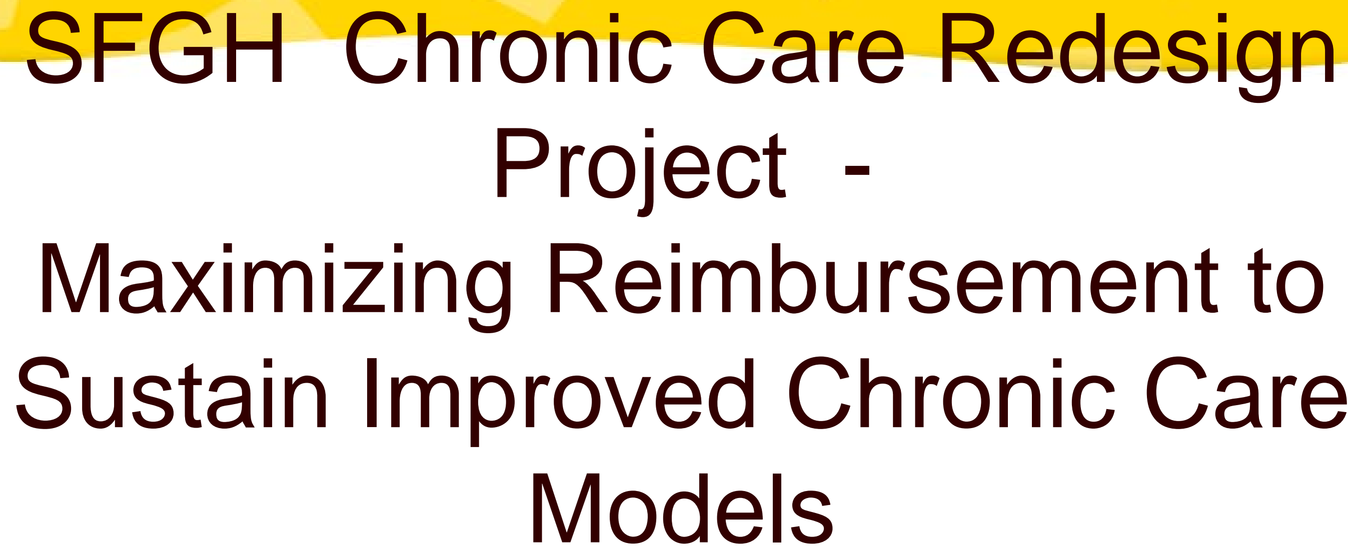

SFGH Chronic Care Redesign Project - Maximizing Reimbursement to Sustain Improved Chronic Care Models

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Specialty Care Roundtable Forum

November 3, 2008

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1. Clinic-based projects emphasizing primary care-specialty care collaboration & the use of NPs can provide innovative, successful models of chronic care.
2. Successful projects will improve care for complex, at-risk pts; improve chronic care infrastructure; improve access to specialty care in a cost-effective manner; & enhance the local Safety Net system.
3. Financial strategy should be in sync with programmatic strategy/strategic plan.

4. NPs can be trained to provide excellent, cost effective specialty care with adequate attending involvement.
5. Specialty care can be provided in primary care clinics, with numerous advantages.
6. FQHC can be utilized to support initiatives that help a Safety Net system meet modern standards of ambulatory care.

Outline

- What, which, why, when, where, who, how, how much
- Current state of projects
- Common elements, Primary Care - Specialty Care Collaboration Projects
- Benefits of successful projects
- FQHC Issues
- The Future
- Take Home Points

What?

- Development of 6 clinic improvement projects at SFGH & referring Safety Net primary care clinics, part of Healthy San Francisco
- All clinic projects are designed to be financially self-sustainable by utilizing FQHC
- Focus on primary care - specialty care collaboration projects & chronic care projects

- Chronic care projects (medical specialties)
  - Diabetes (Endocrinology)
  - Heart Failure (Cardiology)
  - Adult Asthma (Pulmonary)
- Primary care - Non-medical specialty collaboration projects
  - Primary care - mental health integration (Psychiatry)
  - Chronic back pain (Orthopedics-Rheumatology)
- Use of NPs to improve continuity in resident clinics at SFGH (General Medicine Clinic)

What? (are projects' goals)

- To implement clinic-based projects that will improve patient care and patient outcomes by enhancing primary care-specialty care collaboration, improving access to specialty care, & increasing chronic care infrastructure.
- To maximize reimbursement, esp. FQHC
- To enhance the role of SFGH as the hub of a Safety Net system by implementing new models of specialty care–primary care collaboration, with use of NPs as specialty providers providing care in the primary care clinics

- Safety Net systems have difficult time meeting modern standards of amb. care / QI
  - Structured systems of care for specific conditions
  - Chronic care programs
  - Population management
  - Cost-effective, evidence-based care for hi-risk pts.
- Public insurance often doesn't reimburse components
- Safety Net systems tend to be "on the edge" & often unable to fund programs that improve quality but hurt the "bottom line"

- Healthy San Francisco
  - Program to provide health care to all uninsured adults. Not insurance, but provides a Medical Home and PCP to participants, backed up by the Safety Net system of care.
  - Open to city residents 18-64 not eligible for other public insurance
  - Health Care Security Ordinance (2006) requires employers with more than 20 workers to either provide health insurance or contribute to HSF, in which case employees are covered by HSF
  - Major participating primary care clinics are SFGH, DPH, Consortium, + several nonprofit hospital partners
  - Uninsured have been registering for the program in large numbers

- Funded in part x 3 yrs. under State's Health Care Coverage Initiative
- DPH felt infusion of new primary care pts. would increase demand for specialty care
- Funding used to expand infrastructure (evening clinics, inpatient capacity, IS, etc.)
- Health Commission charged DPH to use HSF not just to expand access to care, but to use the opportunity to change the way care was provided.

- 1/05 - 1/06 Work on Planning Grant
- 1/06 - 1/07 ☐Planning year funded by Kaiser - Community Benefit; extensive discussions with PCPs, specialists, administrators
- 11/06 Projects proposed for ’07-’08 DPH budget

When? (History)

- 3/07 SF funded under State's Health Care Coverage Initiative
- 5/07 Health Commission approves budget for Healthy SF, including all 6 projects
- 10/07 Hiring of staff begins. Projects administratively located in General Medicine Clinic & Family Health Center at SFGH.

When? (History)

- 2/08 Diabetes NPs begin seeing pts.
- 3/08 Continuity NPs begin seeing pts.
- 4/08 Back Pain NP begins seeing pts.
- 7/08 Mental Health team begins seeing pts.
- 11/08 Specialty Care Round Table

Where?

- SFGH specialty services
- 3 primary care systems that refer to SFGH specialty services
  - SFGH primary care clinics - General Medicine Clinic & Family Health Center (UCSF-DPH)
  - DPH primary care clinics (in future)
  - SF Community Clinic Consortium (nonprofit community clinics) (in future)
- Role of SFGH as "hub" of Safety Net system enhanced, as specialty providers provide care in multiple PCCs & better support PCPs in the care of complex pts.

- David Ofman (SFGH Foundation)
- Hali Hammer (FHC) & Alice Chen (GMC)
- FQHC consultants
- SFGH/UCSF Departments of Medicine (specialty & primary care), Psychiatry, Family Medicine, Orthopedics
- SFGH Administration
- Department of Public Health (DPH)
- SF Community Clinic Consortium (SFCCC)
- Many others

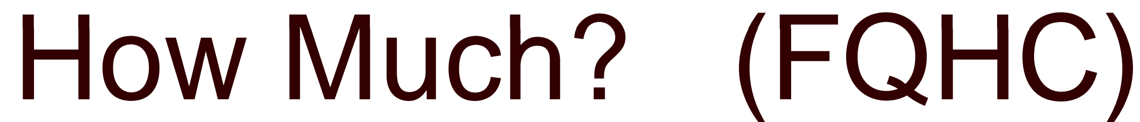
- Those with chronic conditions (esp. diabetes, asthma, heart failure, back pain) and 1 or more complicating features:

- Chronic condition out of control
- Multiple co-morbid conditions
- Medically frail (older, disabled, symptomatic)
- Mental health / substance abuse problems
- Psychosocial issues (homeless, poor, etc)

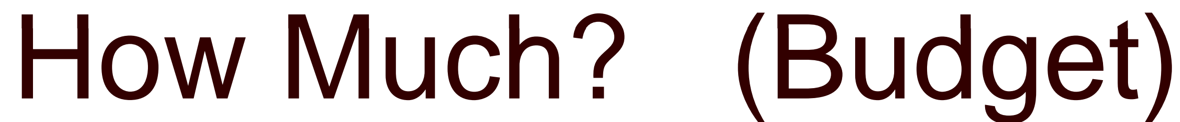
Who? (are the target pts.?)

- Such complex patients are quite common in the Safety Net.
- Current programs often unsuccessful at meeting their needs, due in large part to over-reliance on individual providers treating individual patients without the support of organized systems of care.
- A major goal of primary care- specialty care collaboration projects is to better meet the clinical needs of such complex patients, & to better support PCPs in meeting their needs.

- Developed individual clinic project proposals with business plans
- Projects' clinical staff funded for 3 years as part of Healthy San Francisco (7/07 - 6/10)
- Demonstrate during first 3 years that projects are financially self-sustainable through revenues generated
- Request DPH to include projects in ongoing budget so that projects become institutionalized & not "1-time only' projects



- FQHC = Federally Qualified Health Center, special designation under Medicaid/Medicare, enhanced reimbursement. FQHC reimbursement is central to demonstrating cost effectiveness & financial sustainability.
- FQHC rates at SFGH & DPH clinics are several times the fee-for-service MediCal rate of $37 - $60 per visit
- All participating clinics in the 6 projects are FQHC designated, and all project providers are “FQHC billable providers.”



- Budget for 6 projects totals $4.2 million per year
- Clinical & support staff total 33 FTEs, both UCSF (MDs, psychologists) & City/DPH (NPs, LCSW, PT, support staff)
- 6 projects together are projected to see 21,000 pt. visits per year

Diabetes Project (Description)

- NPs intensively trained in diabetes care, supported by part-time diabetologist
- NPs see targeted pts. in collaboration with PCP in diabetes clinic & primary care clinics. Pts. referred by PCP or ED.
- Targeted pts. are high-risk and in need of frequent, intensive visits, especially when PCP unable to provide them. High risk includes newly diagnosed, recently hospitalized or in ED, and worsening or poor control.
- NPs do medication management, group visits, intensive support of pt. self-management. NPs & diabetologist also work on diabetes registries, guidelines, provider education, patient education resources, etc.
- NPs refer patients back to their PCP after a period of intensive interventions (several months).
- Clinical staff - 1.5 FTE NP, 0.4 FTE diabetologist

Diabetes Project (Current Status)

- NPs seeing pts. primarily in Diabetes Clinic, with diabetologist, lipidologist, nutritionist
- Concentrating on insulin initiation & intensification
- Strong emphasis on system approach to DM (needs assessment, website, newsletter, trainings, insulin & oral agents guidelines, talks to providers)
- Working on group visits, group ed. sessions
- Using Diabetes Registry to bring in high risk pts., with PCP approval
- Emphasis on back-&-forth communication with PCPs

Asthma/COPD & Heart Failure Projects (Descriptions)

- Similar to diabetes project in design
- Clinical staff - each project has 1 FTE NP & 0.25 FTE attending (pulmonologist / cardiologist)

Asthma/COPD & Heart Failure Projects (Current Status)

- Asthma/COPD NP hired, starting soon
- Heart Failure NP not yet hired

Back Pain / Spine Health Project (Description)

- NPs trained in non-surgical back pain, chronic musculoskeletal pain, & rehabilitation medicine
- NPs supported by Rehabilitation / Physiatrist MD (Dept. of Orthopedics)
- Pts. moved from over-crowded Ortho. Clinic (not FQHC, not interested) to Back Clinic in primary care clinics & Rheumatology Clinic (FQHCs)
- Pt.s offered a multidisciplinary approach (detailed eval., medical therapy, Physiatry, PT, acupuncture, psychosocial interventions)
- Targeted pts. include those with chronic back pain that is functionally significant.
- Back Clinic utilizes on-site PT, other treatment modalities planned (e.g. alternative therapies)
- NPs support PCPs in the care of these pts.
- Clinical Staff - 1 FTE NP, 0.5 FTE Physiatrist, 0.75 FTE PT

- Physiatrist & NP doing detailed initial evaluations
- Concentrating on physiatry approaches (analysis of posture & movement, exercises tailored to correct abnormal spine physiology)
- Room & equipment limitations
- PTs learning to modify standard PT approach

Mental Health - Primary Care Project (Description)

- Pts. with chronic medical conditions seen by mental health providers in primary care clinics (FQHC) instead of Psychosocial Medicine Clinic (not FQHC)
- Psychosocial component integrated into chronic care projects (diabetes, heart failure, asthma, back pain) to address psychosocial impediments to effective self-management of chronic illnesses (lack of self-confidence, poor sense of self-efficacy, & common mental health disorders). Mental Health team to develop curricula for teaching self-management techniques & develop evidence-based treatment guidelines.
- Mental Health providers integrated into primary care clinics to form primary care - mental health teams (groups, individual counseling, support for PCPs in managing psychosocial conditions as part of the treatment of chronic medical conditions)
- Clinical Staff - 2 FTE Ph.D. Psychologists, 1 FTE LCSW, 0.5 FTE Psychiatrist

Mental Health - Primary Care Project (Current Status)

- Psychosocial Medicine Clinic closed 7/1/08- major outpt. psychiatry clinic on campus, planned as back-up for Project
- Made it difficult to maintain focus on addressing psychosocial impediments to self-management, as PCPs have few alternatives for general mental health referrals
- Hard for mental health team to integrate into huge primary care clinics with multiple part-time providers
- The medical projects (DM, Asthma, CHF, Back) don’t refer much to the MH project without organized mechanisms (joint groups, MH provider attends diabetes clinic, joint provider meetings/case conferences, etc.)
- Groups starting

- Not a specialty care project
- Focused on continuity problems in resident clinics in General Medicine Clinic (residents frequently miss clinics)
- Utilizes NPs as “team glue” for team of residents, attendings, NPs
- NPs see team pts. as drop-ins or on scheduled visits in absence of resident PCP, thus improving continuity of care and providing improved “hand offs” of ill patients.
- Improved continuity, access, & team structure capacity allow better integration of primary care-specialty care collaboration projects into GMC’s operations, thus serving as a model for academic, residency-based primary care clinics
- Clinical Staff - 1.5 FTE NPs

Continuity NP Project (Current Status)

- Working as designed (NP as team “glue”)
- Teams functioning well, communication between NP & resident stressed
- NPs have developed guidelines for referrals - OK if clinical decision needed (e.g. med adjustment), not OK for paperwork
- Residents very enthusiastic, training not adversely affected
- NPs assisting with practice management (re-establishing contact with pts. lost to F/U)
- Attendings want NPs for their clinics
- Continuity & access appear to be improving

Primary Care - Specialty Care Collaboration Projects - Common Elements

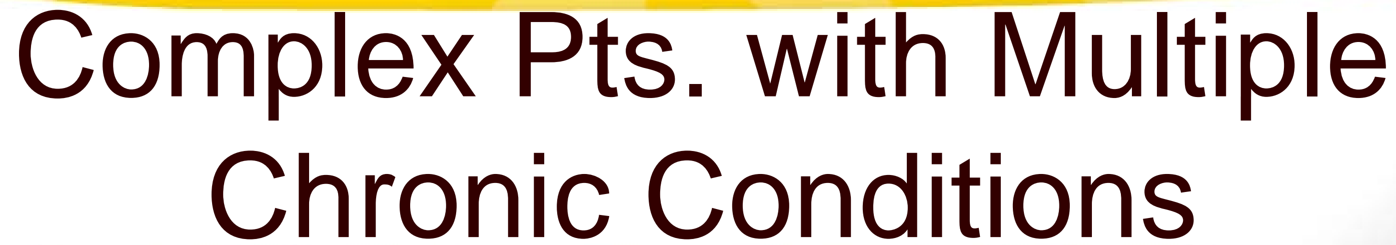
- Use of FQHC-billable providers (NPs, Ph.D. psychologists, LCSWs) + attending support
- NPs trained to become experts in their areas & part of the bridge between PCPs & specialists
- NPs provide more intensive interventions than is often feasible by PCPs
- NPs collaborate with PCPs in pt. care
- Specialty care providers see pts. in both specialty clinics & primary care clinics

Primary Care - Specialty Care Collaboration Projects - Common Elements

- Combination of individual patient care, group care, & population medicine (e.g. registries)
- Primary care - specialty care collaboration in both patient care & programmatic activities
- Emphasis on support for pt. self-management
- Individualize services to each primary care clinic
- Projects are reinforcing new ways of providing care, & are helping clinics to integrate other restructuring efforts (collaboratives, registries, E-consults) into a coherent package of clinic improvement

- Supportive specialty dept. willing to provide nontraditional specialty care
- Specialist champion
- Develop a cadre of specialists interested in communicating with and supporting PCPs in the care of complex patients
- Primary care clinics willing to change

Complex Pts. with Multiple Chronic Conditions



- All NPs to share training, orientation, meetings, case conferences (facilitates co-management of pts. with multiple diagnoses)
- Clinic projects all share registries, support for pt. self-management, & a mental health component (facilitates collaboration among projects in co-managing complex pts.)
- E-consult referral mechanism will facilitate referring complex pts. to most logical program & enlisting other project clinicians as consultants

Benefits of Successful Clinic Projects

- Improve care for complex, at-risk pts.
- Improve primary care - specialty care collaboration, more support for PCPs in care of complex pts.
- Improve chronic care infrastructure
- Improve access to specialty care in a cost-effective manner
- Improve teaching environment, creation of a model program for an academic public hospital system
- Enhance the local Safety Net system
- Enhance the role of SFGH specialty services as support for local Safety Net system
- Utilize public insurance mechanisms to achieve self-sustainability

Change Strategy

- Incremental
  - Rapid improvement cycles
  - PDSA
- Big Bang
  - Introduce new programs
- Mixed
  - Collaboratives

Spread

- We plan to have some of the specialty care - primary care collaboration projects operate in 1 or 2 DPH clinics and 1 or 2 Consortium clinics (inter-system spread)
- Successful projects may serve as models for additional, similar projects within the DPH/SFGH network (internal spread)
- Successful projects may have relevance to other Safety Net systems (external spread)

- The 6 projects were structured to emphasize reimbursable clinical activity precisely to demonstrate to the DPH that they are financially viable. If they are implemented so as to maximize reimbursement, then their chance of being included in the ongoing budget of the DPH improve. Hence the importance of FQHC.
- FQHC involves regulatory, statutory, billing, & organizational complexity at federal, state, & local levels (FQHC consultants)
- SFGH & DPH clinics acquire their FQHC designation by virtue of being sub-grantees of the Consortium's federal health care for the homeless grant.

FQHC Issues

- 4 walls issues

  With space at a premium, must hold groups & other special sessions within 4 walls in order to bill FQHC

- Scope of Project issues

  All billed services must be within the federal Scope of Project of the entity designated an FQHC, or Scope of Project must be changed.

FQHC Issues

- Specialty care issues

  Fed's approach to provision of and billing for specialty care in FQHCs is in evolution

- Audit issues

  Administrators don't like:

  1. Denied claims
  2. Triggering an audit
  3. Failing an audit

  Which is why it takes so much work to get it right, & why someone needs to have detailed knowledge of FQHC

- SFGH
  - Primary care clinics are FQHC
  - Most medical specialty clinics are FQHC
  - Surgical specialty clinics are not FQHC
- DPH Clinics (CPC)
  - Almost all are FQHC
- SF Community Clinic Consortium
  - 330 Clinics are FQHC
  - Free Clinics are not FQHC

- New Project providers - allow expanded billing of FQHC by expanding number of visits (access)
- In 2 cases, care was moved from a non-FQHC clinic (Ortho, Psychosocial Med.) to an FQHC clinic (GMC, FHC, Rheumatology), consistent with programmatic/clinical priorities.

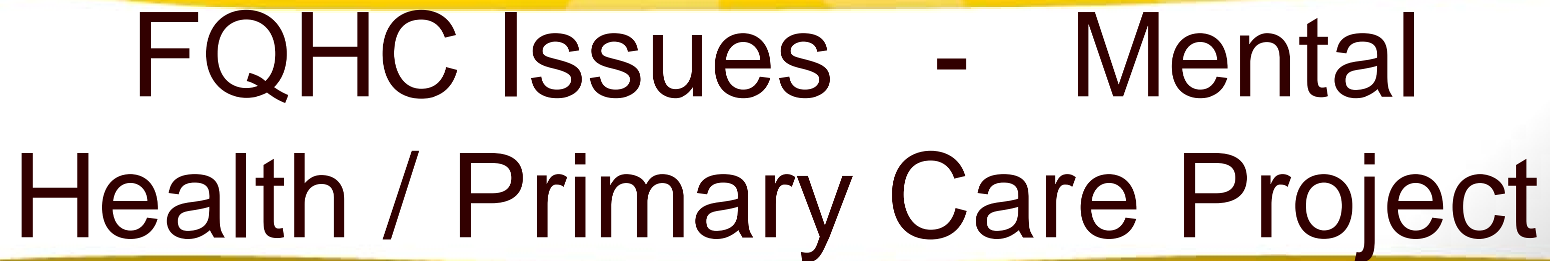
FQHC Issues - Hierarchy of Complexity

- Minimal: Continuity NP Project (GMC)

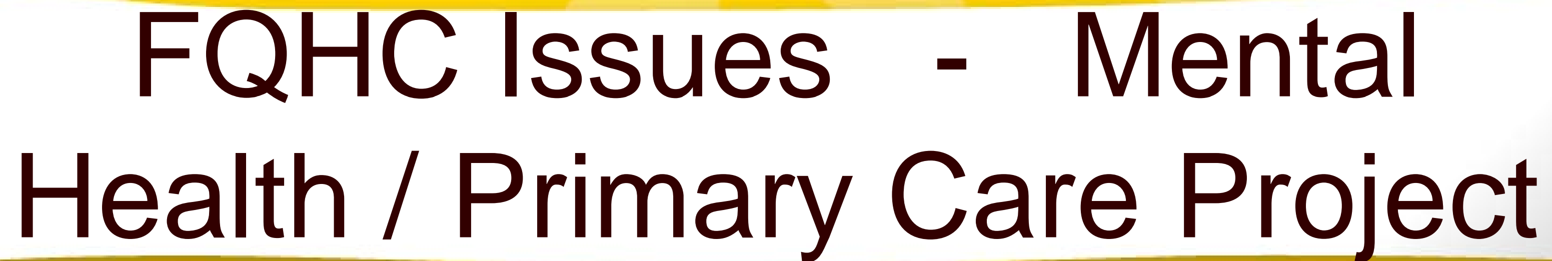
  More of same providers in same FQHC clinic
- Some: Diabetes, Asthma, Heart Failure, Back Pain

  Specialty providers in primary care clinics
- Lots: Mental Health - Primary Care

  Complexity of billing FQHC for Mental Health



- Federal regulations on provision of specialty care in FQHC clinics are evolving
- FQHC clinics currently bill FQHC for eligible mental health visits, but issues are complex
- Detailed regulations govern FQHC billing for mental health services, with limitations on billing (limits on number of visits that may be billed, can’t bill for 2 visits on the same day even if one is mental health and the other is medical, etc.)



FQHC Issues - Mental Health / Primary Care Project

- State pays for local mental health care via the Short-Doyle system (CA Community Mental Health Services Program, state funding structure for community-based MH services)
- In SF, the Short-Doyle system is administered by the DPH, Community Behavioral Health Services
- Short-Doyle systems have both administrative and clinical criteria for patient entry into the system

FQHC Issues - Mental Health / Primary Care Project

- Current plan for Project is to certify participating clinics (GMC, FHC) as Short-Doyle, and to train clinic staff and clinicians in the requirements of billing for services under the Short-Doyle system
- Clinicians in the Mental Health project would then be both FQHC "billable" providers and certified Short-Doyle providers
- Eligible patients would then be assigned to the Short-Doyle system or the regular SFGH billing system (including FQHC) based on clinical criteria (do they meet entry criteria into the Short-Doyle system).
- FQHC consultants are helping us figure all this out

FQHC Issues - Spread

- Participating SFGH clinics and DPH clinics are all FQHCs and part of the same billing system - easier to accommodate SFGH providers seeing pts. in DPH clinics (when projects “spread” to DPH clinics)
- Inter-system issues when Consortium clinics involved
  - NPs are DPH employees, MDs & Psychologists are UCSF employees, none are on staff of Consortium clinics
  - Formal arrangements necessary to cover billing, clinician compensation, charting, liability, on-call coverage, etc.
  - Can theoretically bill FQHC if FQHC “billable” provider from SFGH sees pts. within the “4 walls” of an FQHC Consortium clinic, but possible Scope of Project issues, etc.

- Retreat - focusing on how the projects can collaborate with each other in fostering new ways to care for complex pts., esp. the medical projects with the mental health project
- Special procedures for the multiply diagnosed pts. who could be referred to several projects
- E-consult referral mechanisms
- Registries for heart failure, asthma/COPD, back pain, based on existing diabetes registry
- Home visits, more telephone care

The Future

- Train health workers & MEAs to assist NPs with case management tasks
- "Spread" projects to 1 or 2 DPH clinics & 1 or 2 Consortium clinics
- Telephone monitoring technology for diabetes & heart failure
- Project evaluation mechanisms
- "Spread" successful models of care to other Safety Net systems.

Take Home Points

1. Clinic-based projects emphasizing primary care-specialty care collaboration & the use of NPs can provide innovative, successful models of chronic care.
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Thanks