Integrating Community Based Doctors into PACE
Demographics of the Service Area

- Delta County
  - Population 30,451
  - 1142 sq. miles
  - 27 ppsqm
  - Population > 65 6395 or 21%

- Montrose County
  - Population 41,011
  - 2240 sq. miles
  - 18.4 ppsqm
  - Population > 65 7587 or 18.4%
Medical Resources

- Two small hospitals (49 bed and 75 bed)
- Two private ALS ambulance services and one BLS volunteer ambulance service
- 43 primary care physicians (FM and IM), 6 NPs in 17 practices
- 7 general surgeons, 6 orthos, 5 gynes, 4 opthos, 3 psyches, 3 pulmos, 2 uros, 2 cards, 2 oncs, 2 otos, 1 neuro, 1 rheum, a partridge in pear tree
The Waiver

- (1) CB PCPs will have the same responsibilities as staff PCPs, including, but not limited to:
  - Regular participation in IDT meetings when the CB PCP’s patients are being discussed
  - Performance of required assessments
  - Involvement in participant’s plan of care
  - Participation in QAPI
The Waiver

- (2) Staff PCPs (me) and the nurse practitioners will play a key role in facilitating collaborative relationships and an ongoing communication process that will keep both the community based PCPs and the IDT actively involved in the care and treatment of each participant that chooses to utilize this arrangement.

- (3) Staff nurse practitioners will facilitate timely and complete transfer of information between CB PCPs and SCCs electronic medical records. This process shall be overseen by the medical records supervisor and medical director.
The Waiver

(4) SCC will ensure that all individuals associated with SCC’s CB PCP model have a comprehensive understanding of the philosophy and principles necessary to ensure integration and communication among all team members

- Orient the CB PCPs to PACE philosophy of care
- Orient the office staff to PACE philosophy of care
The Waiver

(5) SCC’s medical director will retain overall responsibility for the delivery of participant care, for clinical outcomes, and for the implementation and oversight of the QAPI program as outlined in 460.60(c) of the PACE regulation.
The Basic Model

- Community PCP remains the attending
- Community PCP participates in IDT (call ins)
- Community PCP participates in care planning
- No restrictions on number of appointments
- 6 month periodic comprehensive assessments shared
- Reimbursed generously (148% of Medicare) for OV
- Monthly stipend for call ins
- Close collaboration with PACE NP
Barriers & Pitfalls

- Trust
- Practice habits
- RAPS
- Referral patterns
- Entrepreneurs
- Rascally office personnel
- Litigation fears
- Captain Kirk syndrome
Solutions

- Proof of time and outcomes
- NPA Model Practices
- Diagnoses reviews
- Orienting the specialists
- Selective contracting
- Focus on the office staff
- Shared responsibility and risk comfort
- Respect
Benefits

• Call coverage
• Market penetration
• True community integration
• Geriatric care awareness
• Patient care benefits
• Flexibility
• Institutional cost savings
The Numbers

SENIOR COMMUNITY CARE

- Diagnostics $101
- OP Specialist $52
- Hospital $356
- Total $509
- PCP $202
- Real Total $711

NPA BENCHMARK

- Diagnostics $259
- OP Specialist $64
- Hospital $597
- Total $920
More Numbers

SENIOR COMMUNITY CARE
- Hospital Days/1000 = 1622
- ER visits = 0.4 pmpy
- Hospitalizations = 0.66
- 30 day readmits = 6.8%
- Pharmacy = $649
- September 2012 = $462

NPA BENCHMARK
- Hospital Days/1000 = 3440
- ER visits = 0.63 pmpy
- Hospitalizations = 0.68
- 30 day readmits = 19.3%
- Pharmacy = $480 - $560
What Would We Do Without PACE?
Dory B. Funk, M.D.  
Medical Director  
Montrose, Colorado  
970-252-0522  
dfunk@voa.org
INTEGRATING COMMUNITY PHYSICIANS INTO THE PACE CARE MODEL

Mary Parish Gavinski, M.D.
Chief Medical Officer
Community Care, Inc
Milwaukee, WI

October 15, 2012
Serving the residents of Wisconsin since 1977
Timeline for use of Community Physicians At Community Care

- 1977: CC is formed
- 1990: CC PACE Program Begins
- 1996: CC begins WI Partnership waiver Program
- 1997: PACE Permanent waiver status
- 2002: CC granted Community Physician waiver
- 2006: WI Partnership becomes a SNP
- 2008: 2010
- 2012: *PACE
*PACE with waiver docs
*Partnership
Waivers From PACE Regulations

- §460.102(a)(1) Establish a multidisciplinary team at each center to comprehensively assess and meet the individual needs of each participant
- §460.102(d)(3) that members of the multidisciplinary team must serve primarily PACE participants
TITLE: Community Primary Care Physicians in PACE

ATTACHMENT(S): (1) NP Collaborative Practice Guideline

POLICY:

PACE participants may have their primary care delivered by designated contracted Primary Care Providers in the PACE model under certain conditions. All participants who have a cPCP and their NP’s will be on a team that also has an employed PACE physician.

PURPOSE:

To establish guidelines for the use of community Primary Care Physicians (cPCP) at Community Care.
Community Care, Inc.
Physician/Advanced Practice Nurse Prescriber
Collaborating Agreement

- Member receives Primary Care from NP and Collaborating PCP

- CC is responsible for the supervision, performance and liability of their NP’s

- Collaborating Practice Agreement outlines how the APNP will function and communicate with the PCP

- Descriptor of the APNP’s credentials and guidelines

- Area for PCP to outline any specifics they want to include around how the 2 will collaborate and communicate.
Community Care, Inc.
Physician/Advanced Practice Nurse Prescriber
Collaborating Agreement

Members enrolled in Community Care (CC) Partnership programs receive their primary care from CC Advanced Practice Nurse Prescriber’s (APNP’s) in coordination with contracted Network Community Physicians. CC APNP’s operate under the direction and supervision of Community Care. Community Care is responsible for their supervision and performance, and holds all liability for their actions.

To provide coordinated care for the members enrolled in the CC Partnership Program, the APNP’s work with contracted network physicians. This document outlines how the APNP will function and communicate with the Network Physician, to assure continuity of care between the physician and the APNP.

The undersigned Advanced Practice Nurse Prescriber APNP is an advanced practice nurse who has a current license to practice professional nursing in this state, is currently certified by a national certifying body approved by the board as a nurse practitioner or clinical nurse specialist, and has been granted a certificate to independently issue prescription orders under s. 441(2), Wisconsin Stat.

In the Community Care Program APNP’s work collaboratively with a primary care physician to manage the participants’ medical care.

1. Acting without consultation the APNP may perform the following tasks:
   - Clinical Monitoring, Activity Levels
   - Order Physical Therapy, Occupational Therapy, Speech Therapy, Diet changes, Skin/Wound Care, Diagnostic testing
   - Referrals to Podiatry, Osteopathy and Dental.
   - Follow up referrals to medical specialists. (Initial Referrals to Medical Specialists require consultation with the Primary Care Physician.)
   - The APNP has been given authority by the Wisconsin Board of Nursing the authority to prescribe medications (Wisconsin Board of Nursing rule Chapter N603 (2) subparagraph (a,b,c,d), excluding prescribing controlled substances (per Wisconsin statute 61.01(4). Community Care will accept the APNP’s Signature as authorization to dispense or administer the medications prescribed.
   - Other duties as outlined in the Community Care Primary Care Policy and Procedure Manual.

Community Care will accept all above orders from the APNP without physician co-signature.

2. Telephone and written communication regarding the Community Care participants’ health status can be directed to the APNP initially. In an urgent care situation, the APNP will assess the urgency of the patient care situation. The APNP will then initiate diagnostic procedures and/or treatment if within her scope of practice and knowledge of the participant, previous discussions with the participant’s physician, and within the scope of this collaborative agreement. If the situation is more complex the APNP will contact the physician for their input or to arrange for a physician evaluation.

3. The APNP may perform the physical examination for admission to the Community Care program, as well as periodic re-evaluations.

4. The APNP will assess, monitor and manage common acute and chronic health problems of the elderly based on their educational knowledge, Community Care References and Protocols.

The Community Care APNP’s uses the following guidelines, references and protocol books:

- Community Care Primary Care Policy and Procedure Manual
- Community Care Primary Care Guidelines
- 2011 Up to Date
- USPHS Preventative Task Force Guidelines

5. The physician and APNP may develop additional protocols to address particular situations.
6. The APNP will consult with the physician when encountering patient care situations not covered by protocol or requiring additional consultation/direction. If the primary care physician is not available they will designate an alternate physician to be available to cover the participant.

7. The APNP functions collaboratively with the physician and will work with the physician and their office staff to transfer non-emergent clinical information to the primary care provider in a timely manner. The APNP will utilize the Partnership Communication Form to convey this information.

8. This agreement can be reviewed, updated or modified by the Primary Care Physician or Community Care as needed.

I have discussed my working relationship with the Community Care Nurse Practitioner.

I understand the Advance Practice Nurse Prescriber may write orders and authorize services as mentioned in the aforementioned manuals and agreements.

The Advance Practice Nurse Prescriber will at a minimum communicate the following to keep me apprized of each member’s health status:

- Initial History and Physical
- Periodic Reevaluations
- Interdisciplinary Plan of Care
- All Acute/Urgent Contact:
- Results of diagnostic tests

List any additional protocol or communication process here:

______________________________________________________________________________

I understand that the APNP will maintain ongoing communication with me, including attending some member office visits, so that we may work in collaboration to provide medical care to each member.

Community Care Medical Director, Primary Care Manager, and the Community Care Director of Quality Assurance oversee the Quality of the Partnership APNP’s clinical practice.

In signing this I am acknowledging that I have read this and am willing to work with the CC NP in the care of my patients that are enrolled in CC Partnership Program.

________________________________________________________  __________
Primary Care Physician (signature)  Date

________________________________________________________  
Primary Care Physician (print)

________________________________________________________  __________
APNP (signature)  Date

________________________________________________________  
APNP (print)

NP license#  NP Practitioner Authority #

NP certification#
3 Physician Groups

11 Physicians
- 4 person group practice
- 6 person group practice
- 1 solo practitioner (Spanish speaking)

~60 members (total census around 400)
Organizational Operations

- Bringing in new Physicians
  - Recommended by participants, health system or referral sources
  - Meeting with Medical Director and Primary Care Specialist
- Collaborative Practice Agreement
- Compensation
  - 100% Medicare
  - Few also got pmpm fee
  - Few paid set amount (FTE or hourly)
Graph 6: "From your observations, does the team support produce better health care outcomes?"
2005 PCP Survey
Graph 7: "From your observations, does the team support result in better follow through of treatment recommendations?" 2005 PCP Survey
Graph 13: "Does membership in the Partnership Program make it easier to manage your patient's care?"
2005 & 2004 PCP Survey

<table>
<thead>
<tr>
<th>Comparison</th>
<th>2005</th>
<th>2004</th>
</tr>
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<tbody>
<tr>
<td>Much More Easily</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>More Easily</td>
<td>36%</td>
<td>20%</td>
</tr>
<tr>
<td>About The Same</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Less Easily</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Much Less Easily</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Graph 14: "A key responsibility of the nurse practitioner is to be a liaison between the program and the member's PCP. How would you describe your relationship with the NP?" 2005 & 2004 PCP Survey
Organizational Operations

- Understanding Physician Clinic set-up
  - Meeting with entire medical coverage group
  - Meeting with ancillary clinic staff

- On going Education
  - NP going to initial MD visits & complex ppt
  - Medical Director and Primary Care Specialist as needed
  - CC Primary Care Meetings
  - Education at Medical Systems and Group Practices.

- Oversight, QI & UM
Today:

Population Served

- Total CC census in Dual programs: ~ 1409 ppts (participants)
- PACE census: 815
  - Internal Docs: 775
  - Community Docs: 40
- Partnership census: ~ 594 ppts
Staffing is the same as for our traditional PACE program as to composition and ratios except for:

<table>
<thead>
<tr>
<th>Program</th>
<th>Primary Care Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional PACE</td>
<td>1 Physician &amp; 1 NP : 175-200 members</td>
</tr>
<tr>
<td>PACE with Community Physician</td>
<td>1 NP : 64-70 members</td>
</tr>
</tbody>
</table>
Partnership SNP Team Format

Per 64-80 members:

1 NP
2 RN
2 SW

The rest of the IDT is brought in as needed
Each NP works with ~6-10 MD’s

May also work with Resident physicians

1-2 Hospital Systems
IDT Operations

- Information exchange with PCP
- Where care is delivered
  - Routine
  - Emergency
- After hours Care
- Specialist and other contracted services
- Role of PACE physicians and Medical Director
<table>
<thead>
<tr>
<th></th>
<th>Traditional PACE</th>
<th>PACE w/ Community Physicians</th>
<th>Partnership (this population is &gt;18yo DD, PD, FE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceuticals</td>
<td>$466</td>
<td>$520</td>
<td>$632</td>
</tr>
<tr>
<td>Hospitalization Rate</td>
<td>4.5%</td>
<td>6.0%</td>
<td>7.5% (7-9%)</td>
</tr>
<tr>
<td>Admits per 1000</td>
<td>456</td>
<td>604</td>
<td>719</td>
</tr>
<tr>
<td>ER Rate</td>
<td>4.5%</td>
<td>7.3%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>5.2%</td>
<td>6.2%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>
Opportunities and Challenges
Opportunities and Challenges

Opportunities

- More Choice in medical systems
- Faster Growth by decreasing barrier for those who do not want to change MD or health system
- Physician recruitment

Challenges

- Higher Costs and Utilization for medical/institutional areas
- Some Quality indicators not as good
- Coordination of complex medical cases more difficult for team
- More oversight by Medical Director and Administrative staff
Live Life on Your terms.

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