

THE RAPP Sheet

A Publication of the Rheumatoid Arthritis Practice Performance (RAPP) Project

Sept 2015

RAPP PARTNER
Q&A

Dr. David Sikes
Zephyrhills, Florida



Time for RA Care to Shift into a New Gear

Systems of Care Require Tactical Change, Says Rheumatologist

AS A RECENTLY christened empty nester, Dr. David Sikes spends a lot of time sitting around – on the carbon-rail saddle of an aerodynamic racing bicycle, that is. As a competitive road racer and spin instructor, this 60-year-old rheumatologist, who practices in a large multispecialty clinic outside of Tampa, Florida, regularly cycles 100 to 150 miles each week.

He finds interesting strategic similarities between bike racing and rheumatology practice. “Both tend to be seen as solo endeavors, but they’re not,” David explains. “In both you work with a team to run plays as best you can, and sometimes the race will suddenly change and the tactics need to be adjusted on the fly.”

The first RAPP Project meeting back in June 2013 was just such a race changer for David. As a founder of his 230-physician group, he’d spent decades focused on the strategic aspects of building and running a successful practice, but the RAPP meeting made him realize it was now time to shift into a whole new gear with clinical population management. In a recent Q&A, David explained the tactical changes his clinic’s rheumatology team has been making since that opportune meeting.

How did the RAPP meeting impact your strategy?

It crystalized where we needed to go next, where we need to be. Running clinical trials for 25 years had already enabled us to blend some of the data-driven side of things into day-to-day patient management and implement Treat-to-Target in better ways, but the RAPP meeting put all the pieces together for me and gave them structure. It really boosted my personal incentive to push forward on clinical population management and convinced me that whole field of rheumatology really needs to do the same.

Why the whole field?

Because rheumatology is a scarce resource. There are really only a handful of us in the country, way too few, so we need to make sure we maximize rheumatologists as a resource. Clinical population management enables us to do this on a lot of levels.

So how is your practice using clinical population management?

Well for starters, we now know who all our RA patients are, who is due or overdue for assessment of their disease status, and who has high, moderate, and low or controlled disease activity. Simply knowing this allows us to target care in ways we never could before. I’d say that’s the first major impact of having real-time population management capability.

The newest component we’ve added, and this is a real stroke of genius on the part of the RAPP Project, is the assessment visit. It’s a huge positive change for us and I think it could be for a lot of other practices too. In the old days we physicians did the whole evaluation and did it during the provider visit, but now we’re bringing our low disease activity patients in for an assessment visit two weeks prior to that visit.

“

What I like best about population management is that it gives the clinician a global understanding of how their patients are doing and where their practice is going.

”

Only 40 percent of our patients come from the area right around the practice so there's some judgment involved, but we're trying to get as many of these patients as possible to have their assessment work done ahead of the provider visit. And we're also now working our way into doing the same with higher disease activity patients.

Who does these assessment visits?

Our medical assistants do them because they're all joint assessor trained – which, by the way, was not difficult to accomplish and joint assessment is well within their ability to perform. In fact, MAs can often do it with greater impartiality than providers because they're not as actively involved in the patients' treatment decisions.

Our MAs do a joint assessment, draw the patient's labs, including safety labs and Vectra DA®, and then our tech does an MSA ultrasound. The physician also does a brief exam, which makes it a Level 4 visit, but this takes almost no time because the MA and the tech are handling 95 percent of the visit. We may simplify this process further in the future, but for now it's working really well.



Having the assessment work done in advance means there's ample time during the provider visit to develop a treatment plan with the patient – and we have all the data we need to do it.



What happens after the assessment visit?

Once we get the Vectra score back five to seven days later, we have everything we need to evaluate this patient prior to the physician visit. And if, for example, their CDAI score is low, they look great and feel fine, they're stable in their medications, and their Vectra score looks good, we can call the patient to cancel that appointment and schedule another set of visits for three months down the road.

How often are you canceling the provider visit?

We concurrently schedule the assessment visit and provider visit two weeks apart because we don't want a patient having a problem and not being able to get an appointment with the physician, but for patients with low disease activity we're now cancelling 95 percent of the provider visits based on assessment visit data. And what it's

doing is opening up a lot more provider visit slots for the sicker patients who need them most. It's allowing us providers to invest much more time working with patients who actually need disease management instead of spending large parts of our day on assessment work that other team members are very capable of doing.

This new capacity to clear our schedules of vast amounts of work that can be done by others is having a transformational impact on our ability to provide timely and consistent care. We all know that the starting point for Treat-to-Target care is timely assessment of the disease. If you can't do that, you can't do consistent disease management and you're fooling yourself if you think you can. And the fact is that very few rheumatologists even know whether they're timely in their assessment of the disease. The only ones I know of who truly know the assessment status of all their RA patients are in the RAPP Project.

And how are patients responding to the two-visit model?

The low disease activity patients love it. We do a patient survey at checkout and they just give us all fives, the highest mark. The higher disease activity patients usually want something done when they come in, which can be an impediment to doing a quick exam at the assessment visit, but they largely understand. And even before RAPP we were having them get their blood work drawn in advance, so this isn't actually an *additional* visit, it's just a more comprehensive one. They're also finding that a full assessment visit takes only a few minutes longer than just coming in for blood work, so it saves them a net of 45 to 60 minutes of waiting to get an ultrasound and other assessment work done at the time of the provider visit.

How many assessment visits are you now doing per day?

We have up to 10 assessment visits in a day, and this is on top of our normal patient load, which on average is in the mid-40s. We started with low disease activity patients in part because they're the easiest for the team to manage, but also to begin freeing up provider visit slots for sicker patients who need the level of expertise that only we can provide. And as I mentioned earlier, in the last few months we've started adding assessment visits for sicker patients as well.

And how is that working out?

Really well. Having the assessment work done in advance means there's ample time during the provider visit to develop a treatment plan with the patient, and we have *all the data* we need to do it. There's no need to make a tentative plan, wait for additional test results, and then contact the patient to confirm the plan or discuss necessary changes. We can do a quick physical exam and finalize the disease management plan right there, face-to-face with the patient. And this has the added benefit of making the patient feel much more invested in the plan. We haven't absorbed the full impact of this change yet, but over time it's likely to revolutionize our ability to do effective disease management with all of our chronic disease patients, not just those with RA.

What disease activity measures are you using across your entire RA population?

Every patient has a 28-joint exam done for tender and swollen, a physician global, a patient global, and they fill out a RAPID3. These measures allow us to then calculate a CDAL, which is what we're using as our primary signal measure for our population registry. We also routinely order Vectra DAs and conduct ultrasounds on all patients. Aside from this, there are lots of factors – comorbidities, disease duration, patient tolerance, insurances – that dictate to some degree the timing, pace, and cadence of how we take care of the patient.

How do objective measures play into your care of RA patients?

The tech-driven ultrasound has been extremely helpful in managing our RA patients. Most have one every three to six months, based on Treat-to-Target guidelines. It's generally three months if a patient is having problems, starting a new therapy, or if we're making a decision on changing therapy. I think it's made the quality of care dramatically better. The Vectra DA is also helpful because it gives us a solid indicator of current disease activity.

However, if a patient's insurance plan is not going to pay for a biologic, or if the patient refuses to intensify therapy or has some other comorbidity...if it's not going to change my therapy, I don't order ultrasounds or Vectras. Unfortunately, payers aren't yet recognizing the value of objective measures and are largely refusing to pay for them routinely. Given the cost of medications, especially biologics, this position makes no sense. As long as they're unwilling to pay for these objective tests the likelihood of under and over treatment of the disease will remain high.

What are some next steps for you with clinical population management?

Since rheumatology is by far the highest-cost specialty in our clinic, our company has very astutely decided they want our five rheumatologists and five rheumatology NPs all on the same page, so we recently established a written rheumatoid arthritis pathway. But it's very hard to implement without an army of people reviewing charts, so our next step is to build

a simple computer program that will calculate all the scores for us at the time of visit. It's going to require inputting patient data at a visit, but then it's going to let us know that we're on the pathway or not on the pathway and make recommendations based on the guidelines.

You're talking about clinical population management software with care pathways built in?

Yes. This is going to be a population management tool, a compliance tool, and a cost control tool. It's going to put the data we enter straight into the registry and enable us to track our patients on the pathway. It'll also give us the treatment options based on cost, which most of us don't look at. There are big cost differences between different treatments for rheumatoid arthritis and for Medicare patients, so I think that's probably going to have a big effect on our financial picture over the next couple of years.

“

It's allowing us providers to invest much more time working with patients who actually need disease management instead of spending large parts of our day on assessment work that other team members are very capable of doing.

”

“

The only [rheumatologists] I know of who truly know the assessment status of all their RA patients are in the RAPP Project.

”

How would you encourage colleagues to get started with clinical population management?

Most doctors recognize we need to provide a better quality of care, but see this impenetrable wall of way too much stuff to do to implement population management. But the RAPP Project has broken it down into manageable pieces. First you want to answer, *How many RA patients do I have?* That’s doable for most of us. Then you start using an online population registry tool to track your patients’ signal disease activity scores. *Okay, that makes sense; I can do that.* Even if you only implement three or four or five of the objectives of clinical population management, you’ll improve your quality of care dramatically and have a much better understanding of your patient population and what you’re doing with them. And this certainly gives you a level of comfort you wouldn’t have otherwise.

So you see potential benefits in this for any practicing rheumatologist?

Oh, absolutely. With the panel sizes we all manage we’re kidding ourselves if we think we can do effective disease management without it. What I like best about population management is that it gives the clinician a global understanding of how their patients are doing and where their practice is going. From a business standpoint it’s also huge. How many rheumatoid patients you have has a strong impact on your revenue if you’re managing them correctly, and clinical population management allows you to do that. Frankly, this process needs to happen everywhere, not just in rheumatology. Because of RAPP, we’re starting the same process with multiple other specialties in our clinic and using a lot of the RAPP Project models to do it.

“
Frankly, this process needs to happen everywhere, not just in rheumatology.”

Can you prove value of care without clinical population management data?

Absolutely not. We rheumatologists have not yet proven our value across the board to the healthcare system, and in particular to insurance carriers and Medicare. The only way to change that, I believe, is going to be with data. When I go talk to an insurer with our pathway in hand, I’ll say, *Look how much money we’re saving you by what we’re doing in managing our patients!*

And why can I do that? It’s because I can demonstrate that we know exactly who our patients are, that we’re following each of them and assessing their disease consistently and on time, that we know how much we’re spending per patient, that we know what drugs we’re using, and that we’re striving to make the right medication selections at the right time. Most importantly, we’re tracking disease outcomes across our entire RA population.

Only those practices with a population registry can do this, and as far as I know, very few physicians outside of the RAPP Project have this essential capacity. For those of us who do have it, all this data gives us incredible leverage – and we’re just getting started. ■

The Rheumatoid Arthritis Practice Performance (RAPP) Project is led by clinician rheumatologists and facilitated by Joiner Associates LLC. Questions about the project or this article? Contact:



Jim Bower, MPA, Managing Partner | 608-256-9797 | jbower@joinerassoc.com
Tim Harrington, MD, Partner | 608-233-2622 | tharrington@joinerassoc.com
joinerassoc.com | Madison, WI