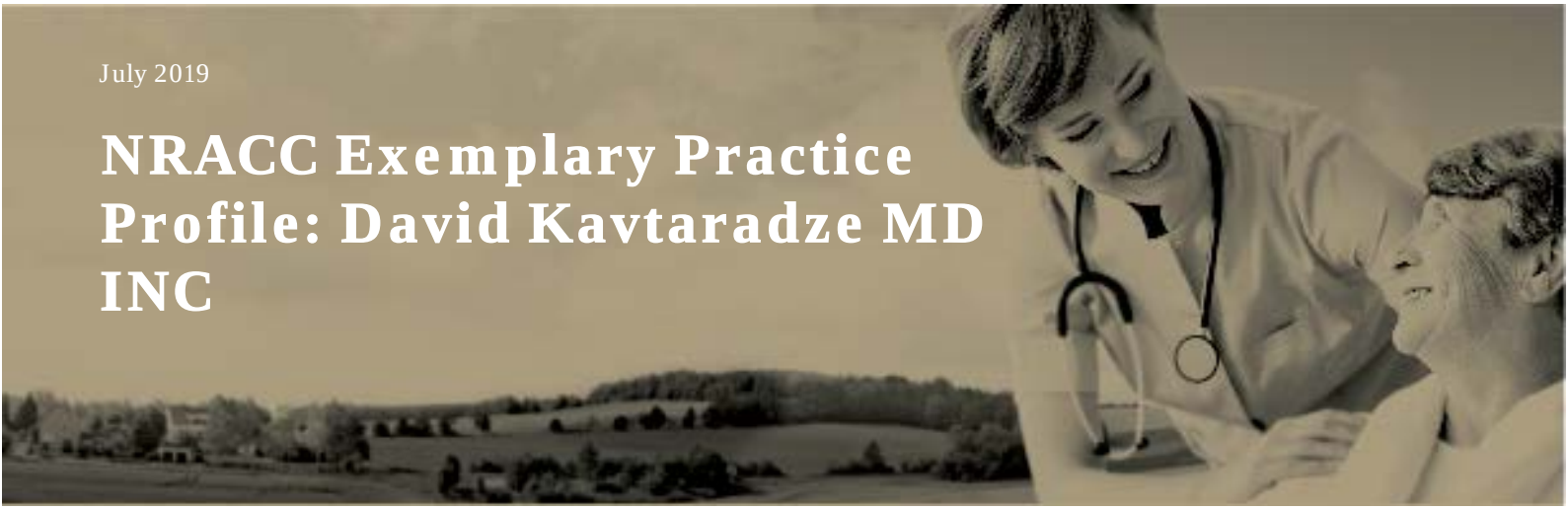
NATIONAL RURAL
ACCOUNTABLE CARE CONSORTIUM
A 501(c)(3) ORGANIZATION



July 2019

NRACC Exemplary Practice Profile: David Kavtaradze MD INC

Dr. David Kavtaradze's clinic is a single office, one provider practice in rural Cordele, Georgia, that serves a primarily Medicare population.

We joined National Rural Accountable Care Consortium with two goals in mind: to gain membership in an Accountable Care Organization and to prepare for transition to an Alternative Payment Model.

With help from NRACC, we were able to streamline and improve many of our processes, significantly increase our Annual Wellness Visits and improve our quality measures.

About the Practice

Dr. David Kavtaradze operates a fee-for-service family practice clinic specializing in geriatric and internal medicine. Located in the rural town of Cordele, Georgia, our clinic is a small practice, with one office and one provider. We currently serve about 750 patients, a majority of them members of the Medicare population. We bill extensively to Medicare Part B for geriatric services, more so than 98% of geriatricians nationally.

Cordele is in Crisp County, a rural community in central Georgia with a population of 22,601. The ethnic composition is 52.3% white, 44.6% black and 3.5% Hispanic, according to the U.S. Census Bureau. Crisp County is somewhat challenged economically, with 29.7% of the population living below the poverty line. The median household income is $33,194, more than $25,000 less than the national median income of $59,039. Poverty is at the heart of many health conditions faced by Crisp County residents, such as high blood pressure and diabetes.

Dr. Kavtaradze joined NRACC in February 2017 as part of the Merit Health Network. We joined NRACC because we wanted to gain membership in an Accountable Care Organization and because we knew NRACC could help prepare us for the transition to an Alternative Payment Model. Our practice was pleasantly surprised to learn we would also receive coaching and technical support for our Merit-based Incentive Payment System reporting. We were able to utilize NRACC resources, services and coaching provided through the Transforming Clinical Practice Initiative to transform multiple processes within our clinic.

The Transformation Process

Our quality improvement advisor quickly provided us with practical and effective tools to start working toward our goals. We were introduced to the Plan-Do-Study-Act tool as an organized approach to identify and act on improvement opportunities. We used the PDSA tool to review and improve upon the processes in our existing AWV and Chronic Care Management programs.

Upon completion of our AWV PDSA, NRACC told us about the nurse-led model and informed us it would maximize our clinical capability for population health surveillance. Adopting this workflow helped us complete a total of 509 AWVs in 2018, which accounted for 74% of our Medicare patients.

With the assistance of various NRACC resources, we were able to enter a partnership with the Iowa Chronic Care Consortium, in which we designated a care coordinator who took us through the Clinical Health Coach training. This training helped us enroll 560 patients (82% of our Medicare patients) into our CCM program. We believe effective health coaching in our practice setting is essential to engaging patients, building the patient-family partnership, and achieving coordinated and efficient care.

One of requirements for enrollment in NRACC is the submission of quality-measure data on a quarterly basis. Our quality improvement advisor would review our data with us every quarter and highlight areas where we needed improvement. After reviewing our data, we decided as a team to focus on improving our rate of influenza immunizations, pneumonia vaccinations, fall risk screenings, as well as depression screenings, diabetes A1c control and controlling high blood pressure screenings, which are known cost-savers.

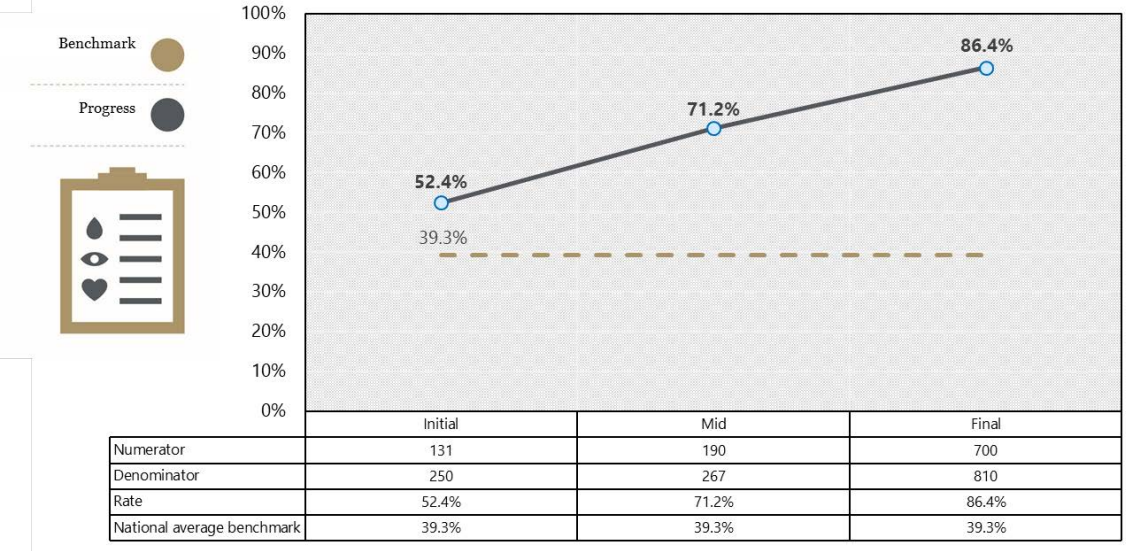
The gains we made in our quality measures were significant. We improved our influenza immunizations from 52.4% of our Medicare patient population to 86.4% and our controlling high blood pressure to 88.1% our patient population, up from 70.4%. We also achieved a significant drop in Hemoglobin A1c Poor Control levels.

During our review of data, we were introduced to a MIPS calculator to better understand why all of these measures are extremely important for our MIPS scoring. This extensive data review and utilization of NRACC tools and technical assistance helped us achieve a score of 84.59 for the MIPS 2017 performance year.

Our adoption of nurse-led AWVs helped us contribute $388,200 to NRACC's cost savings AIM. With new AWV workflows, we garnered savings for improvement of Hemoglobin A1c Poor Control ($253,600), controlling high blood pressure ($74,300) and depression risk screening ($60,300).

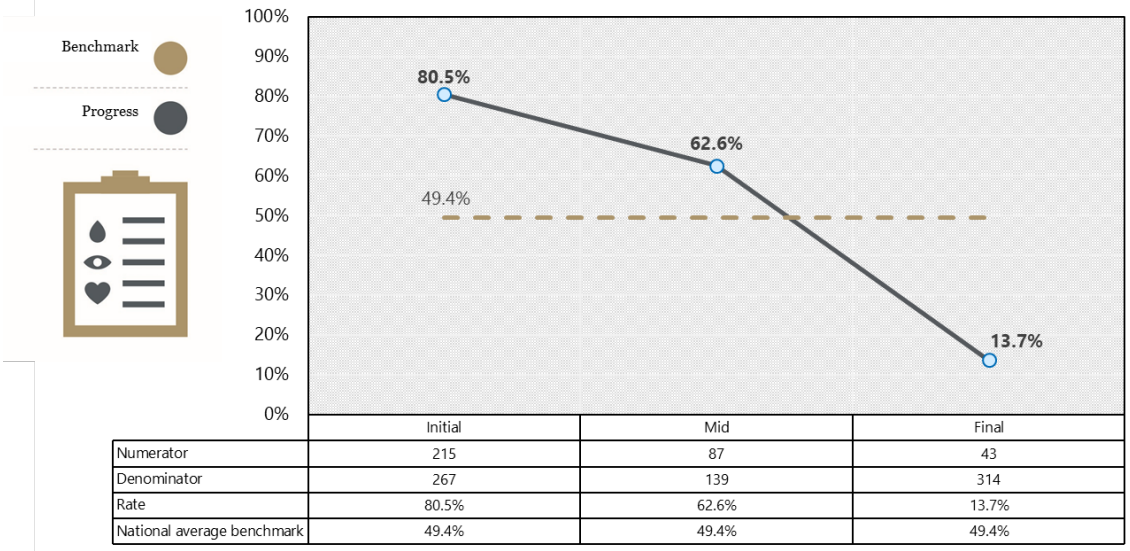
DAVID KAVTARADZE MD INC

Improvement in Influenza Immunization



	Initial	Mid	Final
Numerator	131	190	700
Denominator	250	267	810
Rate	52.4%	71.2%	86.4%
National average benchmark	39.3%	39.3%	39.3%

Improvment in Hemoglobin A1c Poor Control



	Initial	Mid	Final
Numerator	215	87	43
Denominator	267	139	314
Rate	80.5%	62.6%	13.7%
National average benchmark	49.4%	49.4%	49.4%

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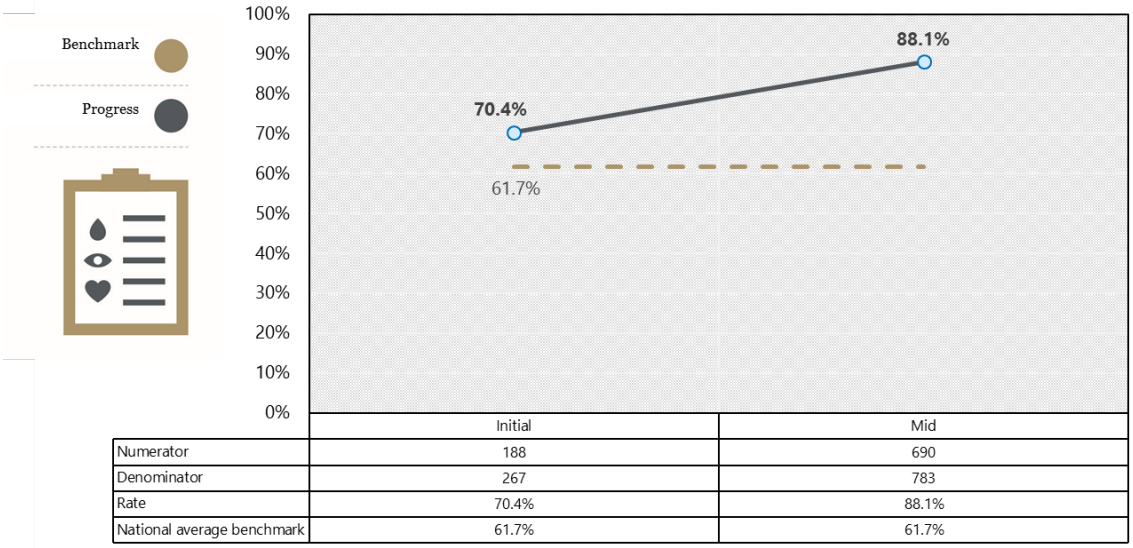
DAVID KAVTARADZE MD INC

Improvement in Controlling High Blood Pressure



	Initial	Mid
Numerator	188	690
Denominator	267	783
Rate	70.4%	88.1%
National average benchmark	61.7%	61.7%

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Providing Patient-Centered Care

Because we work primarily with a Medicare population, it has been a practice goal of ours to streamline our processes surrounding patient and family engagement, including in the areas of advance care planning, shared decision making and medication management. By incorporating shared decision-making best practices into each patient visit, a step supported by health coach training received during our NRACC enrollment, we aim to ensure integration of patient-identified goals and preferences into our care plans, and to better identify patient concerns and motivators for healthy change.

It is important to us that patients and families collaborate with our care team in goal setting, decision making and self-management. Our clinical team is also trained to work with patients and their families to support the management of medications. These initiatives have brought consistent improvement in our overall quality.