CPCPracticeSpotlights

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

This PDF document includes the Spotlight stories for August – December 2014 and all of 2016.

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For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

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(Upper Valley Family Care, Ohio)

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(Integrated Medical Group, Ohio)

CPCPracticeSpotlight15

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Ensure High-Risk Patients Carry Up-to-Date Medical Information with a Digital Personal Health Record

Marc Feingold, MD, Manalapan, New Jersey
Independent; one physician, one APN; 2,200 patients

Situation: Patients whose diseases and conditions are poorly controlled and whose health goals written in their care plans have not been met are at highest risk for needing emergency medical services or an unplanned hospitalization. Often, when this occurs, health care providers treating these patients do not have immediate access to the patient's full medical history and current health status.

Patients treated by multiple specialists also need access to their most current medical information during appointments to promote timely treatment, and prevent duplicative testing and medication errors.
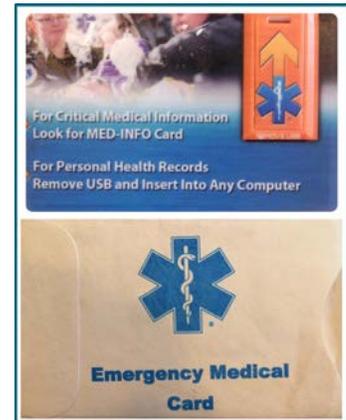
Strategy: Marc Feingold, MD, provides selected highest risk patients in his practice with an updated digital personal health record (PHR) at each office visit. The information is loaded onto a password-protected USB drive mounted on a plastic card. The card is stored in a paper sleeve clearly marked with a bright blue caduceus.

The patient record is stored on the USB drive (upper right corner) that attaches to the card, which is stored in the paper sleeve (below). The size and format makes it easy for patients to keep in their wallets.

The USB drive contains a PDF of the patient's full medical record, including diagnoses, treatments, medications, recent lab results and allergies. Because local first responders are trained to check patients' wallets for health information, patients are encouraged to carry the file with them at all times. They also share the information with specialty providers.

The patient's social security number is redacted on the PDF to protect the patient's identity if the USB drive is lost or stolen. The USB drives cost about $13 each and were purchased with CPC funds. About 75 patients have been provided with the USB drives.

Dr. Feingold and his staff identified the patients who could most benefit from the PHRs by assessing each patient's diagnosed diseases and conditions, current state of disease control, stability of overall health, status of care plan goals and other significant risk factors. All patients in the practice are assigned a risk level using a modified version of the American Academy of Family Physicians risk stratification tool. Those in the highest risk strata were eligible to receive these PHRs. The PHR enhances the care coordination between providers and facilities, providing safer delivery of care with reduced duplication and thus reduced cost.

While too early to share data, the practice is tracking their patients' use of the drive to evaluate effectiveness and identify any resulting cost-savings or improved delivery of care. To date, some patients report they carry the card at all times and have shared the drive with their specialist providers.

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CPCPracticeSpotlight16

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Lower A1c Among Patients with Diabetes Through Standardized Team Approach

Warren Clinic – Bishops offices 220 and 420, Tulsa, Oklahoma
System; 37 physicians; 46,400 patients

Situation: Warren Clinic physicians **Dina Azadi, DO,** and **Christy Mayfield, MD,** chose to address lowering A1c values among their patients with diabetes as one of the clinic's clinical quality measures. Baseline data collected on Dec. 31, 2012, showed only 3.8% of patients with diabetes in their combined two practices had an A1c <9.

Innovation: When **Tim Ingram, BSN, RN,** care guidance nurse, was hired in August 2013, he worked with the physicians to identify patients to whom this quality measure is

Baseline data in Dec. 2012 was 3.8%; A1c <9 rates in Aug. 2013 had improved to 30%. Most current data as of May 2014 is 76% for both practices.

applicable and to create a standardized approach called INCOGNITO. The strengths of this approach are that it leverages data to identify patients, uses the consistency of a team approach to reach out to patients, adapts to address each patient's needs and provides a follow-up mechanism for patients who remain at high risk. Both practices' care teams followed the steps below to help patients with diabetes:

I – **Identify:** Use risk stratification methodology to identify patients with diabetes.

N – **Numbers:** Most recent A1c values were evaluated as overdue, controlled and uncontrolled.

C – **Call Beforehand:** Patients overdue for diabetes care were contacted for appointments.

O – **Organize:** Staff called patients with diabetes the week before their scheduled appointments to ensure lab work was completed prior to the upcoming appointment.

G – **Goal Setting:** During appointments, the care guidance nurse discussed personal goal setting with each patient.

N – **Needs:** The care guidance nurse evaluated each patient for potential financial or social needs that prevented acceptance of medication recommendations and addressed those needs.

I – **Initiation:** Based on assessment, the physician and care guidance nurse provide more in-depth and personalized diabetes education. The care guidance nurse sees all patients with an A1c >7.

T – **Telephone Afterward:** Staff flagged patients with a history of poor acceptance of medication recommendations and planned follow-up contact within two weeks to evaluate current control and regimen effectiveness.

O – **Open Door Policy:** Patients are invited to call the care guidance nurse any time with questions or concerns.

Most recent data show the practices' combined rate has improved to 76% of patients with diabetes having an A1c <9.

Aug. 15, 2014

This strategy addresses CPC Milestones 2, 4 and 5.

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Patient-Centered Care Management Resonates with Patients with Diabetes, Hypertension and Obesity

Clopton Clinic, Jonesboro, Arkansas
Multi-specialty; 9 physicians, 4 APRNs; 9,732 patients

Situation: Patients who struggle with self-management of chronic conditions such as diabetes need additional support and education from their clinical care teams. Uncontrolled A1c values and poor medication acceptance among patients with diabetes demonstrated an opportunity to improve provider-patient communication through intensive staff training and patient-centered care management.

Strategy: Clopton's care management staff crafted a patient-centered approach, using the EHR to identify a group of patients with the greatest need for improvement related to diabetes management, hypertension and obesity. To support self-management in diabetes care, the staff improved their capability by completing 26 hours of online health coaching classes through Clinical Health Coach. The curriculum emphasizes inspiring patient accountability through coaching and effective communications that improves health literacy. The staff also trained with a Certified Diabetes Educator for four hours to better understand the diabetes disease process and how to be more effective in addressing patients' concerns and needs.

The team identified these potential barriers to successful implementation and sustainability: ability reach patients in a timely manner to communicate health care recommendations, inaccurate or incomplete contact and medical information from patients and their caregivers, and patients' lack of knowledge of self-care. Robust teamwork, coordination and communication among the care teams have addressed most barriers.

Hypertension 2013
Percent of Pts <140/90

	QTR 1	QTR 2	QTR 3	QTR 4
Hypertension 2013	55.76%	62.72%	64.88%	69.27%

— Hypertension 2013

Table 1. Improved control of hypertension (<140/90)

As care management staff met one-on-one with patients and their caregivers, they developed personalized care plans for each patient and called them monthly to evaluate progress and address any emerging concerns or barriers. Preventive care and routine screenings are monitored through the EHR, and phone call reminders are made as care is needed or past due. Other practices seeking to implement this approach should also consider how to access available community resources to supplement in-clinic education and how to incorporate ongoing follow-up into regular workflows.

Patients report they appreciate the extra time care management staff takes with them to ensure they are receiving appropriate care. They acknowledge the clinic is investing in them, and in turn, they are more engaged, accountable and accepting of treatment recommendations that meet their values. Data are beginning to show improved hypertension control, improved A1c values and increased patient acceptance of medication recommendations.
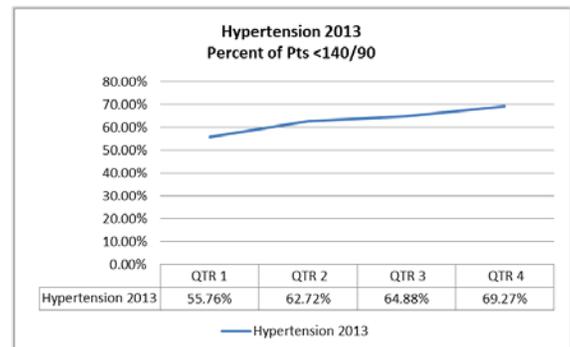
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Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Shared Decision Making Helps Patients Make Cost-Efficient, Safe Choices for Lower Back Pain Radiological Assessments

Brunswick Family Practice, Troy, New York
Independent; 1 physician; 1,200 patients

Situation: Patients with lower back pain and no indication of nerve damage (red flags) often request unnecessary and expensive radiology services. Research suggests that an MRI, which costs approximately $1,500, is "unlikely to avert a procedure, diminish complications or improve outcomes."[1]
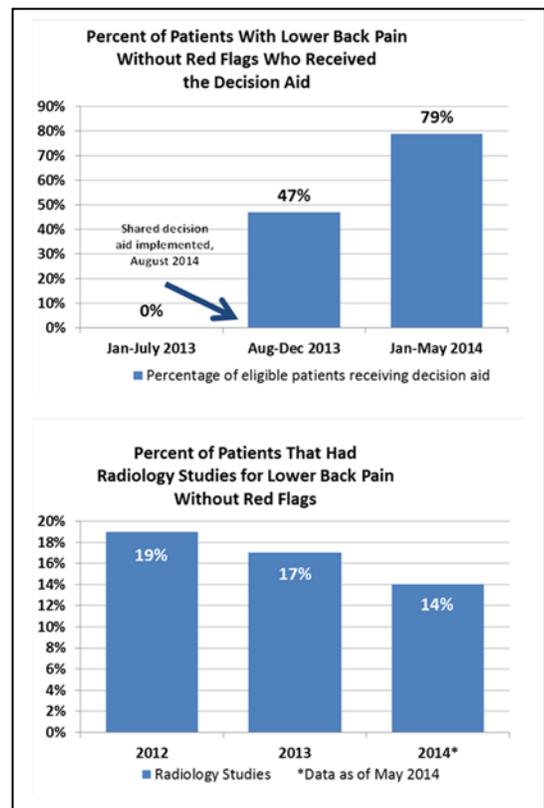
Strategy: Analysis of the top diagnosis codes in his practice helped **James Aram, MD,** select radiological screening options for patients with lower back pain as a focus for shared decision making in February 2013. This issue was clinically relevant to his patient population, and research clearly showed opportunities to lower costs and reduce unnecessary radiation exposure.

After consulting with their EHR vendor (Medent) to develop the appropriate data collection and reporting functions, Dr. Aram's team developed a video decision aid patients could view from a laptop while in the examination room.

Their workflow initially hinged on Dr. Aram's examination of the patient, but they found smoother solution was to train the practice nurse to screen patients during the initial intake interview. Patients

Percent of Patients With Lower Back Pain Without Red Flags Who Received the Decision Aid

Shared decision aid implemented, August 2014

Jan-July 2013: 0%
Aug-Dec 2013: 47%
Jan-May 2014: 79%

■ Percentage of eligible patients receiving decision aid

Percent of Patients That Had Radiology Studies for Lower Back Pain Without Red Flags

2012: 19%
2013: 17%
2014*: 14%

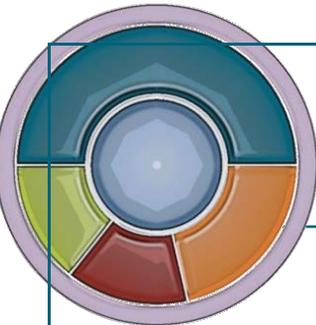■ Radiology Studies   *Data as of May 2014

with low back pain viewed the video before meeting with the doctor; this not only helped the patients to understand their options for diagnostic screenings better; it also introduced the patients to treatment strategies before meeting Dr. Aram. This "preview" strategy prompted a second refinement to the workflow. Patients citing lower back pain as their chief complaint are directed to view the video through the patient portal before the appointment. This also allows the patient to share information at home with caregivers or family and offers greater opportunity for the patient's involvement in shared decision making with the provider.

As of May 2014, practice data show 79 percent of eligible patients had viewed the decision aid, and radiology studies among eligible patients had dropped more than 4 percentage points. In addition to reduced costs associated with fewer radiological studies, no patient adverse events have occurred since implementing this strategy into the practice.

[1] Johns Hopkins Medicine news release, Dec. 12, 2011. http://www.hopkinsmedicine.org/news/media/releases

Aug. 29, 2014

This strategy addresses CPC Milestone 6.

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Want to learn more about Mayfair's success with care compacts? Join the Sept. 23 Milestone 6 Action Group. See the CPC curriculum for details.

Forming Successful Care Compacts with a High-Volume Specialist and a Behavioral Health Provider

Mayfair Internal Medicine, Denver, Colorado — Independent; 3 physicians, 1 NP; 3,000 patients

Tips from Mayfair:
- Have patience with the process.
- Advocate for what you need from your fellow referral practices.
- Be a good partner. Take suggestions for your own practice's improvement seriously.
- Make the best of what resources you have to build great working relationships in your medical neighborhood.

Situation: Care compacts with other providers in the medical neighborhood improve patients' transitions by standardizing communication and collaborative care management. Effective compacts can help bridge seams of care for patients, providing the potential to improve care while reducing harm and costs.

Strategy: Mayfair Internal Medicine sought care compacts with two specialists to address the following: patient needs, high utilization, and the need to establish consistent providers and communications for specific referrals. Mayfair sent more referrals to **Denver Digestive Health Specialists** (DDHS) than other specialists, and so had an existing affinity with this group. The practice created a second care compact with **Maria Droste Counseling Center** (MDCC) for behavioral health referrals. Mayfair reached out to MDCC with a cold call and was fortunate to connect with a staff person interested in integrating behavioral health with primary care. Care compacts with both providers were finalized in June 2014.

While Mayfair had a good rapport with DDHS, the care compact standardized how the practices exchanged information, specifically bi-directional pathology notes on colonoscopies. The care compact defines that reports should be submitted with 72 hours.

Smoothing out processes with MDCC was more complicated as neither practice had an established communication process for behavioral health referrals. MDCC developed new forms for release of information, plan of care and communication between the practices and then Mayfair established workflows to integrate them. Navigating insurance issues and ensuring provider availability still pose some concerns, but both groups are committed to continue to work through these processes.

Mayfair's Referral Tracking Process:

1. Patients are referred to specialist and an "open referral" is flagged on the record.

2. After 30 days, if the referral remains open, the practice messages the patient through the portal or calls the patient to follow up on these possible statuses:

- If the issue has resolved and the consult isn't needed, the referral is closed.
- The consultation is pending a future appointment.
- The consultation is complete and communication to the PCP is pending.
  If this is the status:
  - o Mayfair faxes a medical records request to the specialty practice and allows two weeks for response.
  - o If no response within two weeks, Mayfair repeats the fax request or telephones the specialist.
  - o Practice continues outreach to patient in 30-day increments as needed for completion of follow up.

3. If a referral exceeds 90 days, it is deferred to the PCP to determine further action.

Collaboration site resources: Sample care compact agreements and Mayfair's care compacts
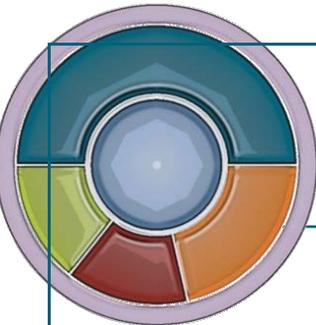
CPCPracticeSpotlight20

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Focused Care Management and Coordination Reduced Emergency Room Visits for Patient

Group Health Associates – Springdale, Cincinnati, Ohio
System (TriHealth), 14,000 patients

Situation: Weekly visits to the local emergency department (ED) were routine for "Martha,"* an elderly patient who suffers from multiple co-morbidities. Martha depends on portable oxygen, takes more than two dozen medications and lacks significant family support and resources. She also struggles with managing her chronic pain.

Strategy: ED utilization reports brought Martha to the attention of the care management team at **Group Health Associates' Springdale practice.** Within 72 hours of Martha's ED visit, a care management team member contacted her to discuss her reasons for seeking care at the ED and to identify her follow-up needs. This phone call sparked collaboration between her physician and the care management team to initiate intensive care management in response to Martha's complex medical needs and barriers stemming from her social support needs.

In addition to scheduling Martha's follow-up appointments and coordinating any needed referrals, the RN care managers' outreach also revealed Martha would benefit from home health nursing. Although the care managers would call frequently – sometimes daily – to check on Martha's condition, the home health nurse also maintained constant communication with Group Health Associates' care managers.

> **Tenets from Springdale's "It takes a village" strategy:**
> - Collaboration among multiple disciplines is essential.
> - Clear and frequent communication among all team members keeps everyone on task.
> - Care coordination is fundamental to the patient's success.
> - Patients return to the center of the care continuum when their barriers to treatment are addressed.

The team's assessment of her need for social support led to contacting local community-based agencies that offered services Martha could use, such as making her home safer and a healthier environment and helping her with other resources.

Springdale care managers tracked Martha's progress through their care management dashboard. Along with ensuring office visits are completed, the dashboard showed how frequently outreach occurred and when the next communication was scheduled. Any notes from the home care nurse were documented here as well.

Martha began to recognize that consistent monitoring was stabilizing her conditions, and the frequent check-ins helped her build new-found trust in her care team. She became engaged in contributing to her treatment plan and was willing to learn about better managing her symptoms. As Martha gained confidence that help would be available when she needed it, her trips to the ED decreased significantly and eventually stopped. Martha made no visits to the ED for more than a year.

*Name changed to protect patient privacy.

Collaboration site resources: Care Management at TriHealth, Spotlight 6

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CPCPracticeSpotlight21

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Data-Driven Improvement Using Medication Management and Shared Decision Making with High-Risk Patients with Diabetes

Cherokee Nation Health Services Wilma P. Mankiller Health Center, Stilwell, Oklahoma
System; 3 physicians, 3 NPs; 2,500 patients

Situation: Data from March 2014 showed more than 30% of Mankiller Health Center's patients with diabetes demonstrated poor glucose control with an HgbA1c >9. **Cherokee Nation Health Services** (CNHS) set a population management goal of 18% or less for HgbA1c >9. Among all CNHS clinics, Mankiller clinic was furthest out of range for meeting this goal.

Strategy: The target population for intervention was divided into for two groups of patients: first, those whose HgbA1c values were close to goal range and likely to improve with a lighter intervention, and second, those patients whose HgbA1c values were far out of goal range and would need intensive interventions to help them reach goal range. Starting in April 2014, Care Manager **Jill Eubanks, BSN, RN**, reached out to the first group of patients to assess their needs and schedule clinic visits for clinical management.

A1c > 9.0
Cherokee Nation Goal: 18% or less

Arrow indicates start of interventions in April 2014.
Data source: Christie Cooper, MPA, Cherokee Nation Health Services
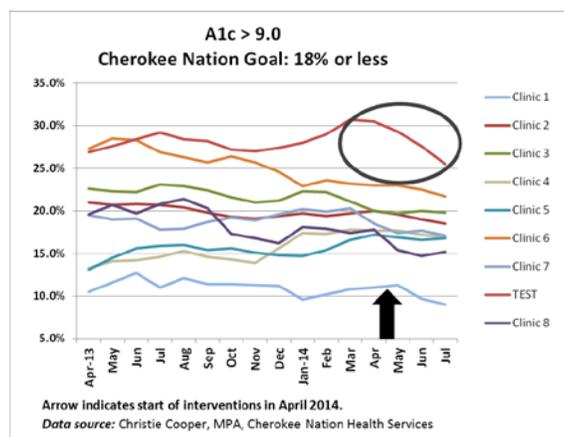
Concurrently, the care teams began working with CNHS CPC Nurse Consultant LCDR **Tara Ritter, DNP, MSN, RN, CDE,** to launch the system's intensive diabetes management education program at Mankiller for those patients at highest risk for adverse events related to very poor glucose control. They opted to deepen the existing curriculum by adding a full-time pharmacist for medication management and 1:1 patient education. By providing high-risk patients with individualized medication counseling, they believed this would encourage patient engagement with treatment and result in improved HgbA1c values.

During the ramp-up period **Travis Fleming, PharmD**, shadowed clinic operations and trained on the diabetes education curriculum. While clinic data pinpointed a pilot group of patients for this intervention, physicians also weighed in with their clinical knowledge of the patients' particular situation and condition that may affect their success with the intervention.

By late May, Fleming and Eubanks began scheduling 1:1 meetings with 10 patients. During these initial one-hour appointments, the pharmacist reviewed the patient's current medications and offered a paper-based shared decision aid on diabetes medication choices. The goal was to help the patient make an informed selection of a regimen that best suited the patient's tolerance for side effects, fit well with the patient's lifestyle and in general would make it easiest for the patient to follow the suggested protocols. CNHS developed the decision aid, which aligns with the system's formulary, to ensure patients have timely access to affordable medications through the system's pharmacy. Fleming continued to meet 1:1 with patients as medications were adjusted and to support continued self-management with the medication regimen.

The pilot group expanded to about 20 patients once the care team had a better grasp of the process and workflows to make the medication management element work efficiently.

Within weeks of operationalizing both interventions, the data began to show improvement. The July 2014 data shows a decrease from 30% to 25% of patients with HgbA1c >9.
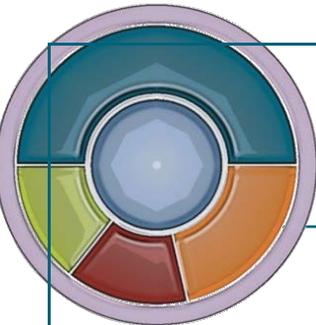
Sept. 19, 2014

This strategy addresses CPC Milestone 2.

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Heeding the Signs: Know When It's Time to Modify Your Risk Stratification Methodology

Freeman Family Medicine, Conway, Arkansas
Independent; 2 physicians, 2 APRNs; 3,021 patients

Situation: Nearly a year after **Freeman Family Medicine** completed risk stratifying its patients, the staff spotted some troubling trends. Fewer care plans were documented. Distribution of decision aids to eligible patients was down. Visits with patients with intensive needs were running over, causing longer wait times for other patients. Staff felt consistently pressured to make up time and yet weren't able to complete all assigned care management tasks. By spring 2014, it was clear a reassessment of the current workflow was needed.

Strategy: To identify opportunities for improvement, the team started by reviewing the schedule and patient flow. Three problem areas came to light: the highest level of the three-level risk stratification tool captured too many patients, patient encounter times needed some flexibility and, finally, the role of nurse practitioners could expand to better serve patients.

Alexander Freeman, MD, and **William Freeman, MD,** along with **Melissa Tyler, BSN, RN,** care manager, targeted the disproportionate load of high-risk patients in the risk stratification tool by adding a fourth "extreme high risk" category for patients with multiple uncontrolled chronic conditions. They also halved each risk strata into "15 minute" and "30 minute" groups, which indicated the time needed for appointments to address that patient's needs. For example, a patient with three or more chronic conditions is a high-risk patient, but if all conditions are controlled and with no recent hospitalizations, a 15-minute appointment may be sufficient rather than the longer 30-minute slot.

> *Risk stratification is very individualized to each clinic. Don't be afraid to play with it and figure out what works best for your practice.*
> *— Melissa Tyler, RN, Care Manager, Freeman Family Practice*

Appointments for patients with complex chronic issues would be assigned to physicians, and APRNs would see patients with acute needs and/or less complex health needs. This strategy allowed all providers to work to the top of their license.

As patients were seen in the office, providers and nursing staff updated their risk scores, which appear in the EMR (Aprima) in a re-purposed existing data field. Providers can see the score in the top tool bar of the patient demographic screen, and it is visible when notes are open.

After restructuring the appointment times, the practice went live with the new scheduling method on August 1. The practice care manager reports that it was "decently smooth," with a couple hiccups around handling patients whose risk scores needed updating and selecting the appropriate length of visit for that patient.

Now a few weeks into the new process, Melissa says no significant rework has been needed. They continue to monitor effectiveness and efficiencies around completed care plans, distribution of decision aids and daily visit totals. During weekly staff meetings, everyone is encouraged to make suggestions and give feedback. Melissa points out that each staff role has a different view of the patients' needs, and when you engage everyone as changes are made, your team's overall approach is in sync.

Collaboration site resources: Risk Stratification Implementation Guide and Freeman Family Clinic's Risk Stratification methodology

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Blending Care Coordination with Wellness Counseling: Low-Cost, Low-Intensity Intervention Supports Preventive Care

Telluride Medical Center, Telluride, Colorado
Independent; 3 physicians, 2 PAs, 1 APRN; 4,792 patients

Sept. 26, 2014

This innovation addresses CPC Milestone 2.

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Read two patient success stories from Telluride on the Collaboration website:

Weight control in pregnancy

Hyperlipidemia, weight gain and acid reflux

Situation: Recognizing some patients are more willing to collaborate with their health care teams to actively improve their health, clinical leadership at **Telluride Medical Center** sought strategies to leverage this willingness to better support these patients as well as assist patients seeking help in self-management to prevent worsening conditions and to lower risk factors for disease. Located in far southwestern Colorado, Telluride is a seasonal resort community that permanent residents support through service-industry jobs. Because few community health care resources are available, patients frequently turn to this clinic for information and support for all of their health care needs.

Innovation: In March 2013, this practice began to explore wellness counseling as an additional care management strategy by creating two hybrid positions on the care management team to coordinate care and provide wellness counseling to patients with diabetes.

To identify patients who would most likely benefit from this enhanced care management, Telluride staff meet monthly to review charts of patients recently treated in the clinic. Ideal candidates for wellness counseling are patients who express to the PCP a willingness to improve their wellness management. With physician sign off, patients are referred to wellness counseling.

Improvement in HgbA1c in Patients with Diabetes By Number of Wellness Counseling Visits
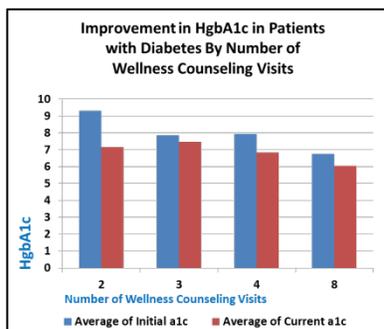
The care manager then calls patients to schedule the initial wellness counseling visit. During the two-hour intake appointment, the counselor educates patients on the condition(s) that qualified them for counseling, provides educational materials to take home and emphasizes the root causes and lifestyle changes needed to manage symptoms. Using motivational interviewing techniques the counselor works with the patient to build a care plan specific to the patient's goals, preferences and willingness to make changes. They discuss barriers to success and problem-solve together to identify workable, sustainable solutions. They also create a schedule for ongoing follow-up sessions, which can vary from weekly, monthly or longer intervals, although most patients are seen monthly. Follow-up sessions occur in the clinic or by telephone and are scheduled in 60-minute blocks, during which the wellness counselor will review the patient's progress toward goals, take all vitals and review any new lab reports (based on patient's diagnosis), and update medication history. Caregivers and family members are welcome to participate with the patient in the counseling sessions.

As the clinic began to see success with patients with diabetes, services were expanded to include patients with changing health status, such as a new diagnosis of pre-diabetes, hypertension or weight reduction.

In June 2014, Telluride began to administer a Patient Activation Measure (PAM) at all initial wellness visits to further refine how the clinic identifies candidate for wellness counseling. This score along with the clinician's assessment is brought to the monthly care management meetings for evaluation for wellness counseling referrals.

About the Patient Activation Measure: This assesses patient's knowledge, skill and confidence for self-management. A clinical assessment of these abilities helps shape goals appropriate to the patient's level of activation. As patients gain success with initial goals, they build confidence and develop the skills they need for effective self-management.

When the project began, a care manager and wellness counselors saw wellness patients on Thursdays. By August 2014, the practice PCPs' confidence in the effectiveness of counseling and their resulting increase in referrals pushed the need for counseling appointments to six days per month. Word-of-mouth referrals from satisfied patients also increased the requests for counseling appointments.

Generally, six patients are seen per day, but scheduling can flex from three to 10 patients, depending on visit length (initial intake versus follow-up visits). To date, 84 patients are enrolled in wellness counseling for a range of conditions and diagnoses, including irritable bowel disease, eating disorders and depression.

Practice data is showing consistent improvement across disease management in measures such as blood pressure, BMI, LDL and smoking cessation attempts. For example, one data point shows improved HgbA1c results over the series of counseling sessions (see graph above).

The practice charges $25 (intake) and $10 (follow up) per session, simply to prevent no shows. Only a small number of patients are paying for the counseling sessions, and that income returns to the general funds. Insurance has not reimbursed for visits. Patients who cannot pay are not billed. Funding for these positions stem partially from CPC funds, state funds and grant monies from a private community foundation called Tri County Health Network. Practice leadership sees such value in these positions that budgets have been adjusted to accommodate the services. They see a reduction in ED use and hospitalizations, but have no firm data at this time to directly correlate with participation in this program.

Ideal candidates for this hybrid role could be a registered nurse, registered dietitian, exercise physiologist or another discipline with a background in motivational interviewing and lifestyle management training.

CPCPracticeSpotlight24

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

How Your Approaches to Improvement Strategies Also Builds Your Culture for Improvement

Utica Park Clinic, Tulsa, Oklahoma—Multi-Specialty (15 clinics); 131,000 patients

Situation: When leadership at **Utica Park Clinic** sought to implement a quality improvement (QI) methodology across its 17 CPC sites, the team quickly discovered that the best results emerge from engaged staff members who are confident in the process and see their contribution to the outcomes.

Strategy: In the Q&A below, **Jeff Galles, DO, medical director**, and **Verda Weston, director of care management,** share some lessons learned from building a culture focused on improvement across its clinics.

Q: How did you engage teams in QI?
A: We discovered that collaboration is the core of moving ahead. Our strategy is to use the "power of positive regard," meaning we are present in person, we listen and we reinforce the positive. Doing this removes resistance and defensiveness.

One example is when we pulled data to track timely HgbA1cs on patients with diabetes, the data had gaps despite the staff assuring us all values had been documented. Working together with staff across clinics, we found data had indeed been reported but in the wrong field. The cause for this variation stemmed from inconsistent training during onboarding of medical assistants.

We brought the data to a staff meeting, acknowledged the work that had been done and then opened the discussion on how to improve the process to support accurate documentation.

Follow this link to see examples of Utica Park's process mapping and QI activities on the Collaboration site.

Involving them in the discussion built their ownership of the improvement process, from which a workflow refinement tool was created. Illustrated with screen shots, this quick reference guide is now in use across all clinics and in training. Our improvement in this measure can be partly attributed to the workflow refinement to accurately capture the work.

Q: Who do you engage at the beginning of an improvement project and why?
A: We brought in as many internal subject matter experts as available from the start. Harvesting institutional knowledge from our staff not only better informed our QI efforts, but it also validated our staff's valued input that shaped actionable, sustainable process improvements.

Q: What projects are ideal for helping to shape your QI culture?
A: Success with smaller projects helped build acceptance and confidence from our staff. Once their expertise broadened, we moved on to more complex or challenging processes.
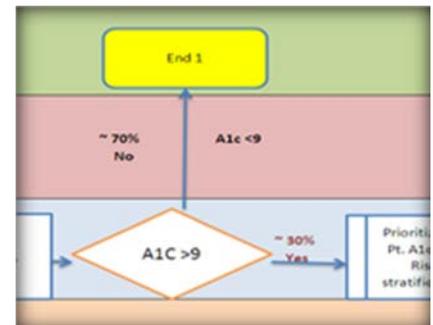
For example, Utica started one QI project focusing on improving HgbA1c rates among patients with diabetes. Our first attempt to reach patients was basic: We mailed a letter that invited them to enhanced diabetes education with a care coordinator. Only a couple of patients responded. What we found was that our letter was ineffective because we didn't tell patients it was a free service, and our letter looked like we were selling something. Our barriers were patient skepticism and lack of detail.

We decided we could be more effective if we reached out to patients while they were in the clinic. We added a step in the pre-visit work flow that would alert the care coordinator when eligible patients were scheduled for an appointment. The care coordinator would speak to the patients and invite them to the education session. This simple change proved very effective; the face-to-face invite was more influential, and the care coordinator could answer any questions immediately. Our enrollment went up considerably.

With that success under our belt, we started looking at other aspects of the diabetes care management program that could be enhanced through improved communication methods. Over the course of several iterations, we've added follow-up calls and more frequent contacts with patients to better support their care management.

Q: Any tips for other practices?
A: Celebrate and share. When we make the connection between our projects and a result that affected a patient's life, it is a powerful testimony to others on our team that they can make a difference that matters to those they serve.

One-Two Combination of Surveys and PFAC Guide
This Practice's Implementation of Patient-Centered Changes

Springfield Center for Family Medicine, Springfield, Ohio
Independent; 7 physicians, 1 PA, 1 APRN; 7,600 patients

Situation: The time commitment to administer and tally surveys made the staff at **Springfield Center for Family Medicine** reluctant to pursue this option for Milestone 4 and thus opted to convene a Patient and Family Advisory Council (PFAC) in June 2013. However, the practice's physician champion urged them to attempt **both** options to gain the most insight into the practice's ability to engage patients and meet their needs while informing practice improvements.

Strategy: By using survey findings to guide the PFAC meeting agendas, Springfield's two-pronged approach brings to light the "what" as well as the "why" of changes patients would like to see in the practice.

Two months before a quarterly PFAC meeting, the practice surveys patients over a one-week period, gathering about 300 responses. Front desk staff distributes the surveys as patients check in, and patients turn them in at check out. The lead-time allows staff the necessary time to administer the surveys, tally results in a spreadsheet and graph them to present to the physicians and staff. The staff's comments and feedback, along with the survey results, build the list of topics for the PFAC to address in the upcoming meeting.

Springfield Center for Family Medicine invites all patients to join in its PFAC with posters like this posted in the practice. Click through here to see a sample meeting agenda.
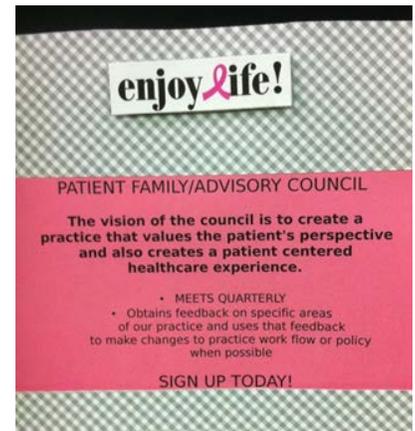
The PFAC meets over lunch at one end of the practice's waiting room, near a large sign announcing the PFAC meeting. The sign often prompts interest from other patients. PFAC information and invitation to join is also posted to the practice bulletin boards.

Six to eight patients participate in the PFAC, which comprises a diverse mix of new and long-standing patients with a range of medical needs. Patients are encouraged to participate for one year, and then the practice builds a new list of candidates based on physician and staff nominations, patients selected from the empanelment lists and those who express interest in joining the PFAC.

Practice staff rotates attendance at the meetings; along with the office manager and PFAC coordinator there is staff representation from providers, reception area, billing department and clinical support at all meetings. An unexpected benefit of staff attending these meetings has been the interpersonal rapport they have built with participants. It enhances their understanding of the importance of customer service, especially for patients who call the practice when they are unwell. Gaining this new perspective has improved staff ability to manage their stress level when caring for patients who are not always courteous due to their acute health issues.

To date, survey results have largely driven Springfield's PFAC agendas. For example, patient wait times emerged as a concern in the surveys, and the PFAC's guidance helped create a new policy that staff will communicate with and update patients who have been waiting for 15 minutes beyond their appointment time. If the appointment is running late around lunch, patients are offered a light snack or drink to help keep them comfortable. Complaints about the practice's phone tree were discussed at length, with the practice modifying the system based on the PFAC's recommendations.

The PFAC also independently raises improvement ideas the practice has taken under consideration, such as installing a diaper changing station in the restroom, a suggestion box in the lobby and a beverage table in the waiting room as well as starting a patient mentoring program to further support care management.

CPCPracticeSpotlight26

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Digging Deeper Into Your Risk Stratification: Prevention and CM Opportunities for Patients at Moderate Risk

Hurley Avenue Family Medicine, Kingston, NY — Independent; 5 physicians, 1 PA; 5,500 patients

Situation: Like many CPC practices, **Hurley Avenue Family Medicine** stratified its patients with the six-level AAFP risk stratification model. Levels 5 and 6 capture the highest risk patients who require intensive care management (CM); these levels represent about 2 percent of this practice's patients. In this practice, level 4 encompasses about 12 percent of patients and reflects difficulty with disease or condition management but no significant complications or adverse outcomes.

Strategy: Thinking of the patients in the fourth risk level as a "long-term investment" toward improved health outcomes and prevention, the practice invites them to meet with a care manager as part of the patient's newly expanded primary care team.

During weekly meetings, providers and CM staff identify patients who would benefit from an introduction to care management, not because they are high risk, but to prevent complication that could lead to them entering the high risk category. Patients who express to their provider, a willingness to improve their health status are also considered. Providers reassess patients' health risk at every encounter, and patients newly assigned to level 4 or above are candidates for CM.

The invitation is made during an office visit or with a follow-up letter mailed to the patient's home. A flyer describing the no-cost CM service and its benefits accompanies the letter, along with any pertinent patient education materials.

While patients in the level 4 risk category may not need intensive CM like higher risk patients, this early introduction to a care manager serves two purposes.

First, it initiates the relationship before the patient experiences a change in health status. Practice Manager **Jennifer Hamilton** notes that establishing a rapport can be challenging as some patients are reluctant to meet with a care manager, not seeing the need or understanding the benefit. She says that persistence pays off, and once patients recognize how the care manager supports improving their health, they come around.

Second, pre-emptive meetings with a care manager offer additional education and self-management coaching opportunities for these patients who have a higher risk of complications. Working with patients before their health worsens and helping them maintain or improve their health status heightens the patients' awareness of prevention and further engages them as active participants in their care. Patients learn to watch for changing conditions and symptoms that warrant a call to their primary care office, rather than unknowingly allowing a situation to worsen and result in an emergency room visit or hospitalization.

Readmissions data for Hurley Avenue shows CM and other improvement activities are contributing to a marked decline in readmissions rates.

This early CM connection facilitated care for a patient at risk level 4 who underwent an orthopedic surgery in September. Because the care manager was familiar with the patient's usual ability to manage her medications and daily activities, during the post-discharge follow-up call, she easily detected signs the patient couldn't manage her pain and was a fall risk, both of which made the patient hesitant to leave home for necessary follow-up care. The care manager contacted the orthopedic surgeon's office for a referral for home care physical therapy and skilled nursing visits to oversee medications. She also spotted and quickly reconciled medication discrepancies between the discharge instructions and summary. The home care allowed the patient to regain her strength and lessen her fall risk. Now, the patient expects to be able to resume her regular activities and self-care in the usual recovery time frame.

Hurley Avenue Family Practice care managers (from top): Donna Ranieri, RN, CCM, and Ruth Mandelbaum, MSN, RN, CHPN

CPCPracticeSpotlight27

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

RN Care Coordinators as Diabetes Educators:
Expanding Patient-Centered Disease Management Support

Corvallis Clinic, Corvallis, Oregon
Multi-Specialty (3 CPC sites); 20 physicians, 17 PAs, 1 APRN; 21,747 patients

Situation: In early 2014, the **Corvallis Clinic** team was looking for evidence-based strategies that would further enhance care coordination with measurable patient outcomes to address the rising clinical need for improving diabetes care.

Strategy: The Clinic saw an opportunity to merge existing staff resources by assigning two RNs with an endocrinology background as care coordinators. Of adult patients seen at Corvallis in the past 24 months, nearly 7,000 or 30%* have a diagnosis of Type 1 diabetes, pre-diabetes, Type 2 or gestational diabetes. Plans to integrate diabetes self-management education (DSME) and support with care coordination services began in spring 2014. This effort included clinical team members, IT staff, billing and marketing among others to shape an evidence-based, outcomes-oriented and patient-centered program that could be ultimately sustained as a billable service.

The provision of DSME and support to clinic patients by RN care coordinators also offers a fortuitous overlap of experience, skills and resources that greatly benefit the patient with a new diabetes diagnosis. By expertly navigating insurance formularies, medication promotions and local resources for patient financial assistance, Corvallis' care coordinators can address medication issues and behavioral health needs that frequently hamper patients' success. Corvallis has integrated behavioral health into clinic services; care coordinators can screen patients and quickly connect them to appropriate services.

Left to right: Erin Bartek, BSN, RN, CDE; Lindsay Bromley, MD, endocrinology; and Lindsay Rickli, BSN, RN

Further, these care coordinators' familiarity with diabetes care management and established working relationships with Corvallis providers increases their efficiency and effectiveness. In their dual roles as educator and coordinator, they are able to provide continuity in care that strongly supports successful care management and increased patient engagement.

Care coordinators **Erin Bartek, BSN, RN, CDE,** and **Lindsay Rickli, BSN, RN,** developed the infrastructure, measurement and clinical processes for the new program with support from their leadership team: endocrinologist **Lindsay Bromley, MD;** medical director **Dennis Regan, MD;** and **Charlene Yager, BSN, RN,** director of clinical services.

Working with IT, the clinical team designed EMR interfaces for DSME referrals. At this time, referrals stem from hospital discharge diagnosis and providers' identification of patients who need diabetes self-management education and support to achieve their health goals. Looking ahead, the team would like to mine data reports to identify patients and automate the referrals.

To bill for diabetes education, providers must follow a curriculum recognized by the American Diabetes Association (ADA). Corvallis chose the International Diabetes Center's BASICS curriculum, which allows interdisciplinary participation and can flex from 1:1 education to group settings. It also aligned with Corvallis' preference for an evidence-based curriculum with an emphasis on patient centeredness and overall improved patient health. The curriculum includes patient feedback mechanisms to help evaluate progress and care coordinators began seeing patients this summer while in CDE training. So far, about 20 patients are enrolled in the program. Future plans are to train a registered dietitian as a CDE, expand patient access by implementing group classes and track effectiveness through patient satisfaction surveys and health outcomes.

This number does not include patients with diabetes who were seen by specialist only.

CPCPracticeSpotlight28

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

It Takes a Neighborhood to Increase Medication Safety for Patients

Saline Med Peds, Benton, Ark. — Independent; 1 full-time and 3 part-time physicians; 2,400 patients

Situation: Patients whose health status qualifies them as a high-risk patient often struggle with their complex medication regimens. They are especially vulnerable to medication errors when new prescriptions are issued after an emergency room visit, hospitalization or other transition in health care setting.

Strategy: Attempting to close gaps in the medical neighborhood, **Saline Med Peds** has collaborated with key health care partners in the community to make medication information easily accessible, and the practice arms patients with up-to-date medication information at each appointment.

First, **Mark Martindale, MD,** and **Cindy Martindale, RPh,** reached out to key community health care partners. The practice met with community pharmacists to propose establishing informal care compacts based on a short list of practice needs. Two local pharmacies agreed to collaborate with the practice. Both offer delivery, and one is a compounding pharmacy. In the agreement, the practice provides these pharmacists the practice providers' cell phone numbers. Cindy reports that she only occasionally receives calls from the pharmacists and to date the relationship has benefitted patients with enhanced service and lower costs. Patient feedback affirms they are seeing more attention to their medication needs and expenses.

Another mechanism the practice uses to make information accessible is to share an EHR interface with the local community hospital, which can then access the practice's medication lists. The practice pharmacist also sends lists and coordinates information with an assisted living facility in the community.

Second, patients are reminded before, during and after appointments about updating medication lists. Before patients' appointments, Cindy reviews their medical record for recent hospital discharges or specialist notes that indicate medication changes. She flags records where a consult is needed.

When staff makes appointment reminder calls, they ask patients with a flagged record to bring in all medications and supplements they are currently taking plus their current medication list for Cindy to review.

To help patients remember their medications, all medication management patients are given a brightly colored insulated tote bag purchased with CPC funds. Patients like that the bag has a handle and zips closed; it's sturdy, easy to carry and won't spill its contents. While each bag cost less than $3, these "special bags" effectively convey the importance of bringing medications to office visits.

During scheduled clinic visits, Cindy meets with patients and reviews all current medications, answers questions and makes any necessary adjustments. She documents the outcome of the medication reconciliation in the patient's chart prior to the patient's visit with the physician.

Medication management patients bring these bags to appointments.

Transitions in care from various facilities often results in patients filling the same medications in varying forms. Case in point: A patient arrived at the office for a post-discharge follow-up appointment carrying three plastic grocery sacks filled with pill bottles. Following a recent hospital discharge, she promptly filled her new prescriptions, but her deteriorating condition led to a readmission within hours. Upon the second discharge, she went directly to a rehab facility, which then issued a new set of prescriptions upon discharge, based on the facility's available formulary. At her follow-up appointment, the patient had three sets of medications: those she took before her hospitalization, the hospital-prescribed medications and medications prescribed at the rehab facility. Among the medications were two different statins and one drug the patient was having an allergic reaction to. The patient had no idea what to do. Over the course of an hour, Cindy sorted out the patient's medications, eliminating duplicates, switching to less expensive options, adjusting dosages and educating the patient on the updated regimen.

At the end of the visit, Cindy provided the patient an updated medication list. She instructed this patient, as she does all patients, to share the list with her other health care providers. If the other providers make changes, the patient is asked to bring the updated list to subsequent appointments at Saline Med Peds. This action is then documented in the EHR.

Practices building collaboration agreements in their medical neighborhoods may want to consider two of Saline Med Peds' successful tactics: look beyond physician practices for partners and involve patients as communications liaison among providers.

CPCPracticeSpotlight29

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Care Compacts Can Work with Various Health Partners
Springfield Health Care Center, Springfield, Ohio — Independent; 3 physicians; 3,600 patients

Situation: In April 2013, as **Care Manager Kim Blackburn, LPN,** completed hospitalization/discharge follow-up calls with patients from **Springfield Health Care Center** (SHCC)**,** she spotted multiple readmissions risks that were preventable by way of bi-directional communication among the providers and with SHCC.

Strategy: With support of the practice physicians, Kim set up group face-to-face meetings with leadership from local hospitals, home health agencies (HHAs) and extended care facilities (ECFs) to jump start conversations about collaborative agreements. Her intent was to engage providers as they cared for patients at critical points of transitions in care, emphasizing the process was two-way and would focus on identifying urgent patient care needs among newly discharged patients.

Care Manager Kim Blackburn, LPN, pictured here with Vipul K. Patel, MD.

At these meetings, Kim shared examples of how her discharge follow-up calls revealed significant risk for readmission and preventable harm, such as issues in post-acute care for "Betty" (name changed to protect patient privacy), a SHCC patient who had been recently hospitalized. Betty went without her medications for a week after discharged from the hospital. Betty was hospitalized on an acute-care floor, and then transferred to the hospital's rehab unit prior to being discharged home, all without notification of her primary care provider at SHCC. Betty complained to Kim that she could not find her medications. As Kim unraveled the story, she found that the patient gave her medications to the hospital upon admission; however, she left the rehab unit without them. Despite an interim visit from a home health nurse, the medications had not been located, reconciled or filled, including a new prescription for a blood thinner. As the clinic's care manager, Kim's established relationships with the PCP, lab and pharmacy enabled her to resolve these issues quickly before Betty experienced any complications.

This patient story clearly demonstrated how establishing collaborative agreements could meet the objective of reducing harm and cost by bridging seams of care for patients as they transition between settings and providers. Over time, the group created a robust list of needs and expectations while also managing to help each other create solutions for recurring problems. For example, Kim designed a one-page admissions notification for discharge planners at ECFs. It alerts them that a SHCC patient has been admitted to their facility, identifies the patient's PCP and requests a discharge medication list and other instructions be faxed to SHCC *before* the patient goes home.

To prevent a situation like Betty's, SHCC emphasizes medication issues in its agreements. Its agreement with an ECF specifies that patients go home with at least a seven-day supply of medications; in turn, SHCC agrees to see the patient within seven days of discharge. In the agreement with an HHA, the agency commits to initiate start of care within 24 hours of hospital discharge and to call SHCC during the first home visit to reconcile medications. SHCC has specific time periods for medication reconciliation phone calls to eliminate phone tag.

By fall 2014, the community partners agreed to terms in writing, which were signed in September 2014.

Springfield-area providers acknowledge these agreements have effectively streamlined two-way communication in patients' post-acute care. One hospital is now approaching other physician practices and facilities about forming collaboration agreements using the template developed with SHCC. Other providers have contacted SHCC for guidance on how to get started with collaborative agreements.

SHCC is tracking all ER and inpatient encounters, noting discharge dates and when SHCC makes follow-up contact. Last quarter, more 59 of 60 patients were contacted and provided with transitional care within 48 hours. This success rate is largely attributable to the bi-directional communication agreement in the care compacts, which facilitates timely outreach.

To learn more about Springfield Health Care Center's care compact work, see Kim Blackburn's presentation in the Milestone 6 Action Group on Sept. 23, 2014; slides and recordings are posted to the Collaboration site here. More discussion about care compacts and collaborative agreements can be found in the Milestone 6 Action Group forum here.

CPCPracticeSpotlight30

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Full HIE Access Facilitates Real-Time Care Management

Internal Medicine Associates of the Grand Valley, Grand Junction, Colorado
System (affiliation as of Dec. 2013); 4 physicians; 4,500 patients

Situation: Like 80 percent of the medical providers in western Colorado, **Internal Medicine Associates** (IMA) accesses a health information exchange (HIE) for notification and tracking of the practice's hospitalized patients. Administered through Quality Health Network (QHN), the HIE allows physician subscribers direct access to all patients' information with real-time status updates through its data repository.

However, non-physician clinical staffers have more limited access. For example, a nurse care manager may only view information pertaining to her provider's patients, and not all practice patients admitted by a specialist or surgeon. Additionally, non-physicians cannot access daily admissions updates until a physician reviews and transfers them to the patients' medical records within the practice.

Innovation: With support from the practice's physician champion, **Donald Maier, MD, FACP,** IMA petitioned QHN in November 2012 to grant full repository access to the practice's care manager, **Kirsten Wiegert, BSN, RN**. IMA's rationale was that real-time, daily access to the QHN data repository by a qualified nurse care manager facilitates proactive team-based care management. Further, coordination at times of transition is instrumental to patient safety and continuity of care.

In January 2013, QHN granted Wiegert repository access for her care management work, but a volume of similar requests from subscribers prompted QHN to re-evaluate its access policies. In April 2014 QHN updated its policies for repository data access for care teams of QHN participating physician providers, who agree to assume responsibility for monitoring the care team members' appropriate usage.

Wiegert's repository access is filtered to specific streams of information: emergency department registrations, admissions and discharge reports. Working across two monitors, she displays the repository dashboard beside the practice and hospital EHR dashboards. As she sifts through QHN notifications throughout the day, she can see when patients are admitted and for what reasons. If patients transfer from the ED to observation or are admitted, this notification also crosses her dashboard. Typically she sees eight to 10 admissions and five to seven ER visits in a 24-hour period.
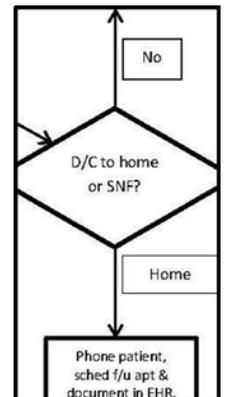
Each morning, she reviews inpatient and ED charts from the previous 24 hours. She reviews labs, imaging and EKG reports, as well as nursing, therapy and consultation notes as appropriate. Wiegert relays pertinent information to practice physicians to keep them abreast of patient conditions.

For one patient with a lengthy and complex hospital stay involving multiple specialties, IMA's consistent monitoring eased his transition to home with an appropriate care plan. The patient's family understood the patient was terminally ill but misunderstood the purpose of a palliative care consultation in the hospital. When they sought clarification from IMA, the physician was ready to explain the situation and provide appropriate care planning because Wiegert had already passed along salient points from the notes.

A second, parallel effort to improve continuity of care involved collaborating with hospitalists. Dr. Maier and Wiegert met with hospital and physician leadership in 2012 to build partnerships that improve patients' transitions and ongoing needs. Wiegert attended hospitalist staff meetings to introduce herself, discuss her acute care experience and answer their questions. A similar meeting took place at a smaller hospital a few months later to explore how the practice's physicians could best make social rounds on admitted patients, which resulted in a collaborative agreement. IMA found hospitalists too are increasingly concerned with reducing avoidable readmissions, and many were interested in learning more about IMA's approach.

Hospitalists now routinely contact Wiegert as patients are discharged to discuss follow-up needs, any pending tests or to review medication changes. If the patient is in the practice's highest risk strata, Wiegert generally makes a follow-up call within 24 hours. Lower-risk patients are assigned to trained MAs for follow-up. IMA's post-discharge follow-up was 100% for the first two quarters of 2014. From quarter 2 to quarter 3, the practice's ED follow-up improved from 59.37% to 76.75%, an improvement Wiegert attributes to closing gaps in processes.

Clearly the increased requests for expanded HIE access shows care coordination is of rising importance in this medical neighborhood. Until the care team is the mainstream model for care delivery, Wiegert points to developing relationships with acute care facilities as a key to IMA's care management success.

Learn more about IMA's workflow for inpatient discharge follow-up on the Collaboration site.

CPCPracticeSpotlight31

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Building a Transformative Culture to Sustain Change

Providence Medical Group, Dayton, Ohio
Multi-Specialty; 13 physicians, 3 PAs, 3 APRNs; 27,198 patients

Situation: With nine CPC practices, **Providence Medical Group** (PMG) encompasses 39 office sites spread across 14 cities in the Dayton area. PMG is committed to positive, transformational health care and, like most health care settings, is experiencing rapid, frequent change. To stave off "change fatigue," PMG has sought ways to cultivate engagement, sustain staff morale and further build a culture focused on continual improvement.

Innovation: PMG leadership has committed to a cohesive approach that supports transformation in the CPC practices and weaves innovation through all practice sites. They use elements of consensus-driven change to engage staff and drive healthy competition toward excellence through transparency. These efforts are clearly evident in how PMG participates in the **CPC learning community,** the focused practice transformation work the group pursues in quarterly **staff retreats** and how **care coordinators** serve as resources for both patients and staff.

Learning with CPC. PMG encourages CPC practices to participate in three CPC learning events monthly. Clinical leaders participate in additional events and then share their insights with their practices. By integrating CPC information throughout all PMG practices, it generates discussion across disciplines, eliciting a range of perspectives. This fosters camaraderie and empathy among all levels of staff, lifting morale and re-igniting focus. As they undertake new processes, everyone speaks "CPC" and can frame the endeavors as the big picture of sustaining comprehensive primary care rather than simply attempting a stand-alone QI project.

Quarterly staff retreats. PMG hosts a group-wide, off-site evening retreat for all providers, site supervisors, care coordinators/navigators and their support staff. Free from the distractions of daily work, attendance is robust, averaging of 100 participants. The agenda blends presentations and interactive learning opportunities with a focus on celebrating successes, reviewing data, developing workflows, brainstorming solutions and sharing information.

CPC-related work is consistently highlighted at these retreats, again engaging non-CPC practices to take away best practices. A recent meeting focused on "deep dives" into care management and shared decision making, with breakout groups comprising a mix of disciplines and practice sites to brainstorm ideas. After each group proposed tactics, everyone voted, and they chose these strategies for implementation across all PMG

This medication wallet card is an example of one strategy that emerged from PMG's multi-disciplinary staff retreat.

sites: a new workflow for colorectal cancer screenings, wallet-sized medication cards for patients, improvements to the community services resource list and developing relationships across the medical neighborhood.

Following the meeting PMG sent supporting resources and additional information to all practice sites to expedite implementation. Additionally, staff from each office who attended the retreat became on-site change agents for the tactics. They could speak to the details with their peers, answering questions and providing background. The wrap-around of resources, information and a peer contact are confidence-builders for staff.

Care coordinators. The care coordinator often centers the care team, connecting information, people and resources for staff and patients alike. While they work within each practice site, they also meet weekly as a group, forming a natural hub for sharing information and building cross-team relationships. Care coordinators also mentor their counterparts at non-CPC practices (care navigators), offering support and guidance as needed.

How does PMG know these approaches are working? While they track gains in clinical quality measures, the practice also checks in with PMG staff in semi-annual surveys. Another indicator that has been gratifying for the staff is the increased positive patient feedback. The care coordination supervisor believes patients see and experience PMG's commitment to transformation and quality by way of an empowered and knowledgeable staff. Across all disciplines, PMG providers know their expertise contributes to not only to improved patient outcomes but also enhances the patients' satisfaction with the care they receive.

CPC Milestones 2 and 3: They Changed How We Work
Princeton Medicine, Plainsboro, New Jersey —Multi-Specialty

Dec. 12, 2014

This Spotlight addresses CPC Milestones 2 and 3.

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Tobe M. Fisch, MD, PhD, Director of Practice Innovation, Princeton Medicine, shared her thoughts on her practice's CPC work on the Oct. 22, 2014, national webinar, "CPC at the Pivot Point: Looking Ahead to PY 2015." A video of her presentation is posted [here](#).

I was asked to give a brief reflection on how the CPC Milestones have affected our practice. I can say that the Milestones unquestionably have had a deep and lasting influence on the way we practice and structure patient care. While all the Milestones have made their mark in some way, I'm going to focus on the two Milestones that have had the most profound impact for us, Milestones 2 and 3.

The risk stratification elements of Milestone 2 fundamentally changed the way we approach patient care, away from an individual to a more population health-oriented approach. When CPC first began, for the first time, we formally identified a cohort of very high and high-risk patients and over the past two years, we have followed that cohort carefully, revising and refining our high-risk list on an ongoing basis.

So we now have a very good grasp of who our higher risk patients are and what their care needs are. In the past year, we extended our risk stratification down yet another three levels, encompassing all primary care patients in the practice, but we still continue to focus on the higher risk patients. And to meet the needs of this cohort, we introduced the concept of care coordination and a team-based approach to care. Our team consists of physicians, a geriatric nurse practitioner, two RN nursing care coordinators, a social worker, a data entry specialist, and most recently, a behavioral health nurse practitioner. While this was all very new for us just two years ago, we now can't imagine how we ever got along without our nursing care coordinators. They meet with patients and their families, make regular check-in phone calls, and generally are a tremendous resource for all aspects of care. They help anticipate problems before they occur, and after they occur, they call every patient who has had an ER visit or an admission to help facilitate follow-up care. Keeping close track of our high-risk patients in this way has enabled us to decrease their number of ER visits and admission rates for ambulatory care sensitive conditions.

The integration of behavioral health has been a big, positive transformation for our practice. Bringing on our behavioral health nurse practitioner uncovered a huge need for her services. Since last spring, she has seen several hundred patients at our practice site alone. She regularly follows a subset of these patients and has referred others on to community practitioners and resources in the community.

Milestone 3 has also transformed our practice. Because of this Milestone, along with Stage 2 Meaningful Use requirements, we have adopted secure electronic two-way patient provider communication, on a much shorter timescale than we ever would have done otherwise. Over the spring and summer of 2014, we rolled out secure messaging with patients via our patient portal, which is sponsored by our health care system's health information exchange platform.

Primary care providers and specialists alike in our practice can now exchange secure messages with patients addressing health-related issues and explaining test results, which are also posted on the portal. We get lots of messages every day. Patients can also communicate back and forth with our nurses via this portal. They can request prescription refills and appointments, as well as addressing clinical questions. We have found that this greatly facilitates care by eliminating the middle man and freeing us of telephone tag and time constraints. The patients love it as well.

We can use this as a way of efficient, daily quick check-ins on our active higher risk patients who use the portal or with family members who share access. This CPC-inspired change has permanently transformed the way we care not only for high-risk patients but for all patients in our practice.

In the coming year, we look forward to building on the foundation that we have established for Milestones 2 and 3. Our goals for the near future include getting more sophisticated data analytics tools that will run off a data warehouse extracted from our EHR database. We want to be able to revise our risk stratification in a much more dynamic and less manual and labor-intensive way than we've been doing so far. We will be making, therefore, a significant investment in population health software that includes algorithm-based risk stratification tools and a care management tool for following risk stratified populations. We are really excited to begin using these tools and we hope then to be able to extend our care management services out to the next level of the population at "pre–high-risk," before they cross the line into the higher risk category.

So in summary, in 2015, we are looking forward to continued practice transformation in accordance with the CPC Milestones, extending our successes and improving our processes in other areas that we find the most challenging.

CPCPracticeSpotlight33

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Check for Literacy When Evaluating Patient Self-Management Skills
Warren Clinic – Jenks office, Jenks, Oklahoma; system affiliation; 3 physicians, 1 RN; 4,500 patients

Situation: In April 2014, a Jenks physician asked Patient Care Manager **Sherry Fisher**, BSN, RN, to help "Sam" (patient name changed to protect privacy) with his diabetes self-management skills. "Fired" by his previous physician, Sam struggled with proper insulin dosing and, consequently, his HgbA1c was hovering around 10. During Sam's office visit, the physician observed Sam was reluctant to answer questions, did not bring in his insulin logs and would not engage with the physician. Frustrated by Sam's behavior and out of concern for the patient's health, the physician reached out to Sherry for assistance.

When Sherry met with Sam, she began by asking him how he measured his Novolog (insulin) units. Sam shrugged off the question with a vague "whatever I need" type of response. Then she picked up a Novolog pen to set the number of units, which prompted him to remark, "Oh, the *orange* one. Do you mean the number of *clicks*?"

Sam's remark reminded Sherry of her experiences when she had worked as a school nurse with elementary-age children. This prompted her realization that Sam could not read.

Strategy: Sherry altered a Novolog chart with icons and color-coding for Sam. She delivered the new charts to his house, where she sat down with him to explain how he would track his insulin use.

Not only could he "teach back" the color coding to her, he did so with an enthusiastic grin. "I understand now," he told her. "I take the green one at night and the orange one with meals."

Sam was due for a follow-up in 30 days, but he showed up at the Jenks office two weeks later. Proudly, he handed over completed insulin logs, and more importantly, he had questions about how to take care of himself. Between his monthly appointments, Sam would call the office weekly to check-in with Sherry. Three months later, not only had Sam's A1c improved to 7.3, but he joined the practice's Patient and Family Advisory Council.

Looking back, Sherry could identify several earlier cues that showed Sam needed help with written materials. When Sam first came to the practice, he always brought his wife, who completed his paperwork. When she fell ill and could not attend his visits, he would tell the staff that he had forgotten his glasses and asked them to fill out any forms. Sam would not bring in his insulin logs, and he did not ask questions or engage with providers, often deflecting with humor or changing the subject.

To help identify and better engage patients with low literacy, the Jenks clinic cross-trained staff to recognize signs that patients may need assistance. Asking to take home their paperwork, having difficulty following directions for taking medications, or like Sam, consistently "forgetting" their glasses may be signs of possible low literacy. Now trained to recognize low literacy, the staff volunteer to help these patients with their paperwork and they flag the patient's record so other staff knows to alter their teaching styles accordingly.

When teaching self-management to patients, Sherry will ask, "What is the best way for you to learn new things? Watching TV? Reading about it on the internet?" Patients who learn from watching may need more help with written materials. If your office is producing new materials, Sherry suggests asking a third or fourth grader to read and explain the content so that you can be sure the content is understandable at that reading level.
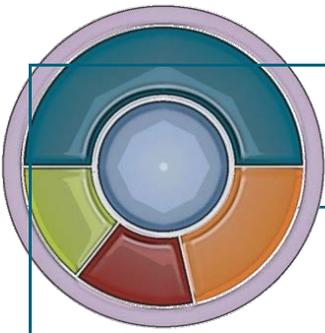
Lastly, Sherry emphasizes that her goal is always to provide every patient the "utmost care with the utmost dignity." It is important to remember that patients frequently hide their struggles with understanding materials and directions because they are ashamed. Reaching out to patients in a way that respects their dignity and contributions opens opportunities for effective and collaborative engagement.

This thumbnail image shows how Sherry Fisher modified this patient tool to improve Sam's management of his insulin. She color-coded the categories and added simple icons to indicate time of day. Within three months of using this tool, her patient's A1c dropped from 10.5 to 7.3. This tool is posted on the Collaboration website here.

Dec. 19, 2014

This strategy addresses
CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.4: Patient and Care Giver Engagement

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

FYI: The Colorado region hosted an event focused on health literacy on Dec. 18. Check the Collaboration site for recording and materials to be posted in early January 2015.

This material was prepared by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Any statements expressed by the individual and resources cited in this publication are not an opinion of, nor endorsement by, TMF or CMS.

Marrying Actionable Data with Better Operations to Improve Care

Bridge Street Family Medicine, Saugerties, New York; independent; 4 providers; 7,500 patients

Jan. 8, 2016

TMF
Health Quality Institute

This interview with Eugene Heslin, MD, and his team was recorded in his practice on November 3, 2015. We became interested in the comprehensive primary care initiative because we felt that this was where medicine was going in the future. We felt that the need to practice up-to-date medicine in a fashion that allowed us to be able to be progressive and help to model where the country was going in terms of value-based purchasing was incredibly important. And that, when we did that value-based purchasing model, we had the opportunity to be leaders not only in our community but throughout the entire country. So part of what we're trying to talk about today is utilization and how we marry utilization and improvement in that with quality care and patient satisfaction. So my four-provider office is involved in the project. And thankfully federal government and five insurance companies got together and decided to make a collaborative that allows us to be able to function in a pseudo value-based world. So the testing that we're currently doing is to say, if we were to build a value-based world, can we actually practice more efficient medicine? And at the same point in time improve our quality and improve our patient satisfaction? So we actually have accomplished some of those things. We're not great at everything. But part of what we try to do is to be able to figure out how to work on projects. We work on projects and we work on process. So part of the process components of what we're doing is work on team building. So think about anything that you do in life. You figure out how to build a system. You then design it. Then you test it. And then you think about how you can make it better. That's pretty much what we do in medicine here. Why are we doing that? Because what we found is that, when we first built our first computer system, we thought we were great. Then we got data from other computer systems, insurance companies, et cetera. And what we found was their data must be skewed because it couldn't be right. We weren't that good. And then we did our own, and we figured out that our system was broken. Because it couldn't be right either because we weren't that good. What we then found was that we may be good at any given time, but we needed to be good at every given time. And so that meant we had to change the way we did medicine. To not just think about the person that's sitting in front of us, but also think about the people that were not in front of us. We were able to practice medicine in an asynchronous way. So what we had to do is to look at where we were. Do a gap analysis, if you will. And then turn around and be able to take the information given to us by the supporting organizations. And then make it into actionable data. That requires team building. That requires understanding who's working for you. You always hear in medicine that should you practice to the top of your license. I think of it differently. We have people that practice to the top of their abilities. And then we use their licenses to be able to accomplish the task we need to accomplish. And in small-town medicine, a lot of times you don't have lots of extra licenses around. But you have lots of really smart people that care about patients. So, as we get to the utilization component of the discussion today, what we found was, is that if we picked off pieces of the puzzle, we could do things better. So, for example, when we looked at our ambulatory sensitive conditions, we actually were doing pretty well. And then we started to do worse. When we did worse, we had to actually change our business. So we built a tiger team. That was the entire office. We sat in one big room. Front desk. Medical records. Billing. Pre-visit planning. Post-visit planning. Care manager. Triage. And management. And we decided how we were going to try to make changes. We decided we'd start a simple project. Simply was patients like to sleep in their own beds. And we like to get you there. And so we started that off with that simple premise. And then we started to build a process around that premise. Whether it was case management, speaking to the patients, sometimes a weekly basis. And bring them into the office frequently. Or it was post-discharge planning to keep them out of the hospital from readmissions. We were able to make the changes. Then see how we're going to improve based upon the data that we received. So what we did was really my team. Because, although I may be the leader of that team, I can't do any of this without a supporting cast of people that allow me to be able to function in all ways. So all the credit belongs to them. I simply am the cheerleader who sit at the front of the pile. Utilization in our office starts with our front desk. Our front desk is not a receptionist. Our front desk person is part of our care management team. When they make a decision and ask the questions who, what, when, where and why. They're able to then get information necessary for a person to be able to decide triage. Are they coming to the office? Are they going to urgent care? Are they going to the emergency room? And when they need to be seen. At that point in time, care management becomes involved in the process. And sometimes has to organize for resources to be used at home. So it's a care continuum that actually improves your utilization. It's not any one single person. But it's the entire team and the management of that entire team that allows us to able to function as a high-performing office. So you say, well, you got to have a big management team. My management team is composed of one person. That's my office manager. She also happens to be my wife. With that I have a billing manager. Her job is more than just billing. Her job is also to look at what's coming up. For example, that little project called ICD 10. And then preparing us for that. So our team meets. We discuss all the possibilities of what's happening with that. And then we roll out the next process. People ask all the time, are we in transformation? And the answer is we've been in transformation for a long time. But transformation is really learning the language and the processes needed to be successful. In fact, I may be done with transformation in some respects, but really I'm into operation now. And the mode we have to be in as we move forward in value-based medicine is to look at how we're going to build better operation. So some people say this is all hard stuff. And it really is conceptually hard to do this type of work. So you have to think outside the box. You have to think in nontraditional ways. You have to decide that you can take the processes that you've always used, structure them a little bit. Give them to people in roles. Look at how they accomplish the tasks that are being done. And then build the new process on top of that. So it's a game of what I call sequential approximation. Have you ever played pool? I'm not so good at pool. So I knock the ball close to the hole. And then I block a hole sometimes. And then sometimes I knock a ball in the hole. And sometimes I win. But the way I win is not by trying to get the table cleared all at one time. The way I win is by trying to get a ball close and then move it better. You can't let perfect get in the way of good enough as you're building these systems. You have to decide that you're going to look at how you get started and then improve it. As we continue to move through these turbulent times in medicine, we have to stand strong in primary care to be able to understand what we need. It's not about our pills and potions. It's how we stand in front of our patients, beside them and behind them in terms of our technology and our processes that allow us to move forward. Thank you.

CPCPracticeSpotlight63

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Telehealth Model Moves Knowledge to Improve Access and Timeliness of Care

W.W. Hastings Hospital, Tahlequah, Oklahoma; system-affiliated (Cherokee Nation Health Services); 10 providers; 142,207 patients (in system)

Jan. 22, 2016

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.2: Planned Care and Population Health
- 1.3: Risk-Stratified Care Management

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: In 2013, data at **Cherokee Nation Health Services** (CNHS) showed the prevalence of patients infected with Hepatitis C (HCV positive) was estimated at 5,160 adult patients. Weighing that estimate against CNHS' current resources and personnel, the system projected that it would take many years to treat all patients with chronic HCV infection. The rate and need clearly outpaced CNHS' resources, and a new strategy was needed to deliver timely, affordable access to specialty care for HCV positive patients. Further, new treatment strategies were being approved for HCV patients, and clinicians at Cherokee lacked a peer group of HCV specialists to learn from and share with.

Innovation: In 2013, **Jorge Mera, MD,** of CNHS' **W.W. Hastings Hospital**, began to explore participation in Project ECHO (Extending Community Health Outcomes), a telehealth model that aims to increase the primary care workforce's capacity to deliver high quality specialty care, especially in rural and underserved communities. Expert teams lead Project ECHO's hub-and-spoke learning networks, where knowledge is shared via videoconferencing in weekly virtual clinics where clinicians meet to share best practices in a case-based learning environment. Research published in the New England Journal of Medicine in 2011 shows that the care ECHO-trained clinicians provided to their patients was equal to that of care provided by specialists in university/medical school settings.

This run chart illustrates CNHS' expanded capabilities to evaluate and treat HCV positive patients once ECHO was introduced. Further, these are patients who were cared for in their "home" clinic rather than travelling to a specialist's office in another city.

About ECHO – Albuquerque liver specialist **Sanjeev Arora, MD,** created Project ECHO in 2003. Frustrated that thousands of HCV positive patients in New Mexico lacked access to timely, high quality treatment due to a shortage of specialists, Dr. Arora envisioned the project would help primary care offices treat hepatitis C in their own communities, and thus patients could get the right care when they needed it where they live. Today Project ECHO is administrated through the School of Medicine at the University of New Mexico. It operates 70 hubs worldwide, with 48 in the U.S. and 22 in 11 additional countries for more than 45 diseases and complex conditions, which include gastrointestinal conditions, diabetes/endocrinology, geriatrics/dementia, palliative care, rheumatology, chronic pain, addiction/psychiatry and HIV. Multiple federal agencies and private organizations provide grant funding for ECHO. Participants do not pay fees for joining.
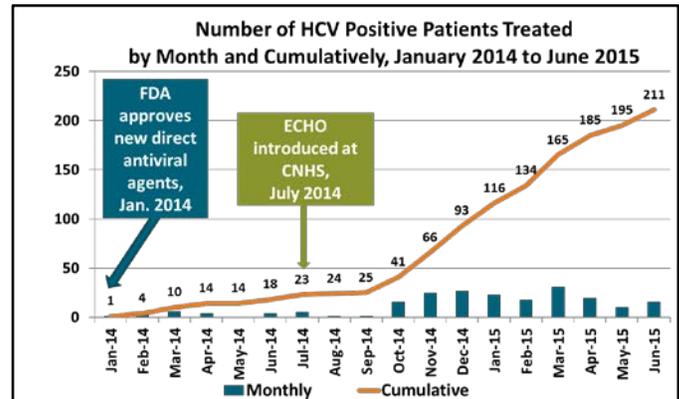
Getting started – Dr. Mera and his team joined Project ECHO initially as a "spoke" clinic in July 2013. The process was simple: they contacted the university to sign up, agreed to follow PHI/HIPAA restrictions and to regularly report data to the central administration. The only technical requirement was the ability to connect to the internet.

Meetings – To prepare for meetings, each spoke clinic faxes or emails a de-identified clinical case along with their questions to the hub site. In a format similar to physician residency training in the hospital setting, each spoke site presents its case to the entire learning network, and all participants can ask questions. Participation is open to all clinicians and specialties treating the patient, including PAs, APRNs and educators as well as pharmacy and behavioral health. Each 10- to 15-minute presentation is followed by recommendations from the hub specialty experts. Four to six cases are shared at each meeting, which wraps up with a 15-minute didactic lecture. Attending clinicians may earn free CME or CNE for attending the session.

As of May 2014, W.W. Hastings began serving as an HCV treatment hub for Cherokee Nation outlying clinics. To become a hub, staff underwent two days of training with ECHO and signed a memorandum of understanding regarding sharing data. An IHS grant funded the hiring of an ECHO coordinator.

How Project ECHO has benefitted CNHS and its patients: The ECHO meetings offer benefits that increase clinician job satisfaction at no cost as well as integrate a public health dynamic into the treatment paradigm. Providers rapidly gain meaningful, clinically relevant information that they can use immediately in practice to treat complex patients. Despite their rural location, they can easily connect to experts and peer physicians, and they can earn free CME and CNE as they learn emerging best practices.
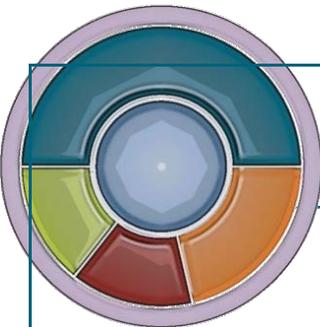
Patient outcomes are improved through easier access to specialty care that is delivered in their "medical home" primary care clinic as opposed to a specialist's office more than an hour away. The model reduces disparities for rural patients and also prevents costs associated with untreated disease, such as a liver transplant, cirrhosis or cancer.

CPCPracticeSpotlight64

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Toolkit for End-of-Life Care Helps Care Teams with Effective Conversations

Hunterdon Healthcare Partners, Flemington, New Jersey; system with 6 independent and 6 employed (28 physicians and 43,000 patients) CPC sites

Situation: An informal conversation in the cafeteria among physicians interested in end-of-life (EOL) care evolved into the Hunterdon End of Life Summit, which featured national speakers and a series of focus groups. Focus group feedback indicated that physicians needed help with EOL conversations. They didn't feel they were well-trained as to when and how to approach patients, and they needed help in guiding patients to define goals so that their EOL care reflected what was important to the patients and their families. Lastly, providers wanted guidance on how to speak with patients in a way that would best support them. Concurrently, analysis of CMS feedback reports for the New Jersey region shows that the six employed practices at **Hunterdon Healthcare Partners** that have the highest PMPM (per member, per month) costs in hospice services also consistently have the lowest overall PMPM costs in the region.

Innovation: Hunterdon's Chief Medical Officer, **Geralyn Prosswimmer, MD, FAAP**, convened a multi-disciplinary working group to design "Care Planning for Serious Illness," a toolkit of resources for providers. Not only would providers have quick, easy access to the content they wanted, the Hunterdon system would also have a consistent, well-informed approach to EOL planning across the system. Input was gathered over three months from palliative care physicians, the Hunterdon hospice team, the director of population health, the system's organizational effectiveness group and Hunterdon Regional Community Health. They recommended key subject areas and identified in-house subject matter experts to develop appropriate content and supporting resources. To include the patient perspective, Hunterdon surveyed families and patients experiencing an advanced illness and interviewed team members from Hunterdon's palliative and hospice services. Dr. Prosswimmer oversaw how the content was developed and formatted for its use among providers across all settings at Hunterdon.

Giving providers what they need — Recognizing the range of needs the resource would support, the content varies from the most basic ("Palliative care versus hospice care" and "Criteria for hospice admission") to complex topics ("Tips to help with difficult discussions" and "How to have an EOL conversation"). One section describes the primary care physician's responsibilities for the seriously ill. Another section lists helpful online resources, contains key forms and documents to help patients create hard copy documentation of their EOL plan and describes how patients should use them.

Considering how and when providers would access the toolkit shaped its format. An electronic document was posted to the system intranet and the inpatient EMR as well as embedded within the outpatient EMR. To help readers easily navigate what's relevant to them, hyperlinks connect to supporting content and documents, such as instructional videos or the advance directive forms.

Rollout and implementation — Frequent, repeated and multi-modal presentations supported a system-wide rollout campaign. The toolkit was introduced to practice and hospital leaders at a system leadership forum in tandem with palliative care physicians presenting to each physician group at their respective sites. At the practice level, all providers working in care teams are invited to presentations. At the hospital, a three-part grand round series open to all medical staff covered the topics in the toolkit.

To familiarize the Hunterdon medical neighborhood and its partnering community organizations with the toolkit, it was presented at Partnership for Health meetings, where hospital leaders, public health stakeholders and others meet regularly to discuss health-related priorities and identify solutions within the community.

Tracking and measurement: Both outpatient and inpatient EMRs capture usage rates for EOL planning conversations as well as the number of completed advance care plans that have been scanned into patient records. The current target patient groups for measurement are all patients 65+, patients with CHF and patients with COPD. Another tactic to track rates is to look back on all patients deceased in the last year and count documentation rates for EOL conversations and scanned planning documents. Practices are shown their rates and asked to set their own improvement goals; the system would like to see a 90% rate within five years. Hunterdon has also attempted to review the number of patients who received chemotherapy in the last two weeks of life and tie those numbers to EOL planning.

Goals for 2016: Provider feedback indicates a complementary effort to educate patients about EOL planning is needed. Hunterdon plans to bring a trained volunteer from hospice to patients' medical homes for group meetings. Patients will be invited to evening meetings through a formal invitation accompanied by a handwritten note from their physician, a tactic that has proven successful for other patient-focused events. Additionally, planning is underway for a summit with the community's faith-based leaders.
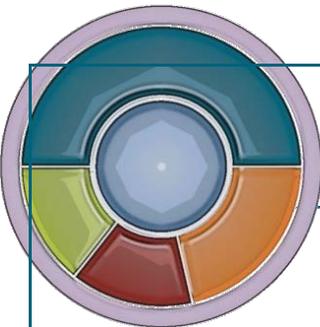
New Jersey Region Q10 PMPM Costs		
	Hospice	**Overall PMPM**
NJ Region	**$13**	**$910**
HHP Site 1	$21 (+$8)	$719 (-$191)
HHP Site 2	$15 (+$2)	$828 (-$82)

A small increase in hospice PMPM is associated with lower overall PMPM costs. *Hunterdon's analysis of CMS data for the New Jersey region pointed to a consistent trend of employed practices the highest hospice PMPM costs also having the lower overall PMPM expenditures.*

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CPCPracticeSpotlight65

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Social Worker Contributes to Collaborative, Team-based Care Management

Stillwater Medical Physicians Clinic, Stillwater, Oklahoma; single-site group; 9 providers; 10,484 patients

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.2: Planned Care and Population Health
- 1.3: Risk-Stratified Care Management
- 1.5 Coordination of Care Across the Medical Neighborhood

CPC Change Driver 2: Use of Enhanced Accountable Payment

- 2.1 Strategic Use of Practice Revenue

CPC Change Driver 3: Continuous Improvement Driven by Data

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: In 2015, the care managers at **Stillwater Medical Physicians Clinic** worked with providers to determine the patients who physicians thought could have benefited from the assistance of an in-office social worker. After reviewing the data, they decided that adding a social worker would round out the care management team's expertise and ability to address patients' non-clinical needs. With the support of all nine providers, leadership approved the new position.

Innovation: When recruiting for the new social worker position, finding someone who would fit well and contribute to a cohesive care team was important, shares **Elizabeth Wilbourn, RN, care manager lead**. The hiring process included peer interviews and meeting the care management team. **Tonya Ingram, MSW,** started in July 2015, working in the clinic on Mondays, Wednesdays and Fridays from 8 a.m. to 3 p.m.

Broadening care – Having a social worker on the care management team enables Stillwater to provide non-nurse driven services that the care managers struggled to manage. Ingram connects patients to community resources, such as food banks, housekeeping and meal delivery, counseling and support groups, and caregiver respite. Her training lets her address some behavioral health issues, such as using motivational interviewing to encourage patients to seek help for substance abuse. Ingram assists patients with filling out various

Number of Patient Encounters with Social Worker, Sept. – Dec. 2015

Sept.: 50, Oct.: 63, Nov.: 70, Dec.*: 47 — Total Encounters

This graph shows the number of patient contacts Ingram has had with her three-day-a-week schedule in the clinic.
*Note: Ingram was out of office part of December.

applications, and she follows up on resources that patients are referred to, such as assisted living and prescription financial assistance. She helps overcome any roadblocks patients experience accessing these resources. Further, she conducts home visits, often in conjunction with a care manager. Stillwater is also exploring how to add Ingram's social work expertise to the depression screening process for helping patients with positive PHQ-9s but who don't have a current behavioral health diagnosis.
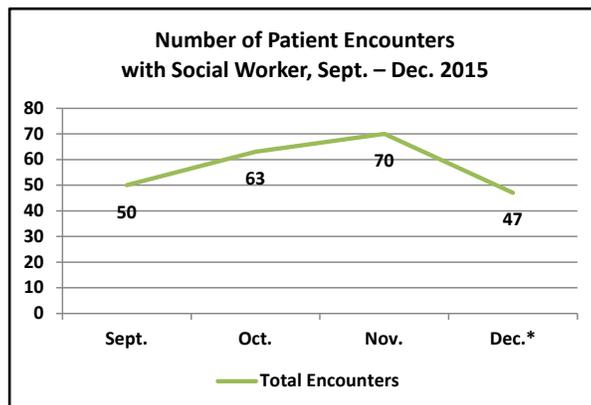
Much of the assistance that Ingram gives patients focuses on connecting them with resources they need before issues develop into medical emergencies. For example, Ingram worked with a patient who had behavioral health concerns and who could not use the community clinic. He was also unable to keep employment and was uninsured, which prevented him from getting the medications he needed. Ingram intervened with the community clinic and worked with them so she could pick up the maintenance medications on his behalf, and then she personally delivered the medication to him. Ingram also coordinates community resources to help lower-income patients fill basic needs that are hindering their ability to self-manage their health. For example, a low-income patient with chronic conditions was struggling to pay for food and medications. Ingram helped the patient apply for disability, food stamps and Medicaid assistance. Taking care of basic needs lowered stress for the patient and helped her focus on her health.

Creating a team – When she joined the clinic, Ingram was actively involved in developing the process for how her role as social worker would integrate into the care management workflow. Through conversations about the goals for her position and the current care management workflow, they added referrals to her as an option for care managers when they identify a patient who needs assistance or resources that a social worker can best provide. Sometimes these referrals result in immediate action, such as Ingram joining a patient visit to address an emergent issue. Other times, Ingram follows up with a phone call or by scheduling an appointment with the patient. In the beginning, Ingram was working with patients already under care management who needed additional resources. However, as providers witnessed the resources Ingram can provide patients, they began directly referring patients to Ingram when they identify a one-time need that does not require ongoing care management for the patient. Physicians give Ingram's business card to patients and encourage them to call her, or providers can create a message in the EHR asking Ingram to follow up with a patient.

Additionally, Ingram maintains a library of resources at her desk that care managers can access when she's not there. If she knows a patient is coming when she will be out of office, Ingram prepares a packet of resource information for the care manager to go through with and give the patient. Ingram also networks with the hospital social worker to learn about and share new resources and updated information.

Tracking – Ingram tracks the number of patient contacts she has, as well as resources and follow-up for each patient. Data includes a running total of patient encounters, as well as the number of new patients she works with each month.
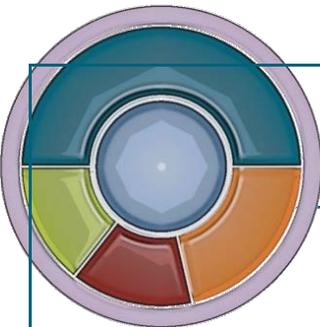
Takeaways: A social worker's expertise can complement the clinical expertise of the care managers, enabling the team to provide person-centered care that addresses patients' non-clinical needs that are affecting patients' health priorities or access to care. Having Ingram in-office allows the care management team to seamlessly provide support and connections with community resources and to promptly address emergent issues.

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CPCPracticeSpotlight66

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Co-located Primary and Urgent Care Helps Reduce ED Use

Colorado Springs Health Partners–Roundhouse, Colorado Springs, Colorado; multi-specialty (9 CPC sites); 4 providers; 4,520 patients

Situation: In Q2 2014, **Colorado Springs Health Partners** (CSHP) opened CSHP–Roundhouse, a co-located urgent care (UC) and primary care office, in an effort to address rising emergency department (ED) visits among its patients. While the primary care side keeps traditional office hours, the UC side is open Monday through Friday, 8 a.m. to 8 p.m. and Saturdays, 9 a.m. to 5 p.m., and Sundays, 9 a.m. to 3 p.m.

How they identified the problem—While monitoring several data sources in early 2013, CSHP leadership spotted an unwelcome trend. The CPC quarterly feedback reports, payer data and CSHP in-house research all revealed ED use continued to increase at CSHP CPC practices despite CSHP's efforts to tamp down unnecessary or preventable ED visits (for example, 24/7 call center access, patient education and nurse follow-up for high-risk patients and offering same-day visits with an easy online check-in system).

Digging into other CSHP market data, a potential cause for the trend emerged: Patients could easily walk into any of Colorado Springs' new stand-alone UC sites during evenings and weekends when their primary care office was closed. Further insight was gathered from patients' anecdotal feedback in follow-up calls. Some patients perceived urgent care as an after-hours primary care, and yet other patients went to the ED when UC would have been more appropriate, quicker and, in many cases, less costly overall.

Concurrently, overcrowding at other primary sites was prompting CSHP to scope new locations for expansion.

	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015
ED	582	590	607	606	607	582	574	576	579
ED $	$28	$29	$32	$30	$34	$23	$20	$19	$18

When CSHP opened its urgent care and primary care co-located site at Roundhouse, ED visits among its patient populations dropped sharply. When comparing Q2 2013 with Q2 2015, ED visits are nearly the same, but overall ED costs have dropped $10 per patient.

Innovation: Opening CSHP–Roundhouse addressed both the need to expand primary care sites and to offer an UC option for CSHP patients and others. Two CSHP primary care physicians transferred their practices to Roundhouse location, and with the clinic's location on Highway 24—a main east-west corridor that catches incoming traffic from the nearby mountain resorts—they had immediate business. To build sustainable patient volumes on both sides, CSHP mapped out multiple strategies described below.

Spreading the word—CSHP alerted existing patients to the new UC through direct mail, in-office posters at other CSHP sites and refrigerator magnet giveaways. Fliers were sent to residences in ZIP codes adjacent to the new clinic. They also placed print and radio ads along with online advertising in social media channels. Within the medical neighborhood, CSHP promoted the UC through the local medical society, the Chamber of Commerce and an open house event.

Planting the seed—High-risk patients rely on their care managers (called RN navigators at CSHP) for health information; the navigators updated their follow-up call checklists to include suggesting the Roundhouse UC as an alternative to the ED. CSHP also revised scheduling center scripts to mention Roundhouse's expanded UC hours for acute needs.
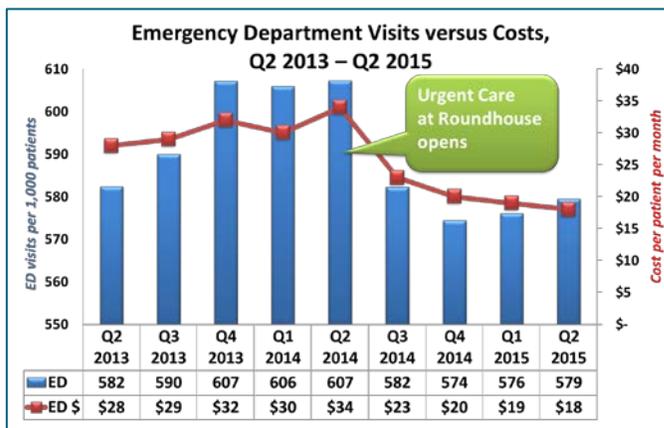
Closing some gaps—For patients who need to establish care with a primary care physician, it allowed them the convenience to make an appointment with the primary care side located in the same building. Returning to a familiar place for follow-up helped ease the transition to a new PCP for some patients.

The takeaways: Urgent care requires distinctly different capabilities than primary care in clinical aptitudes, team skills, time management and administration. While CSHP generally staffed the urgent care with providers experienced in acute care, an onboarding PCP with acute experience did cover shifts.

The insurance and administrative workflows for UC differ from that of primary care. CSHP staff needed more time to plan out workable, efficient processes than they would have needed with simply opening another primary care site.

The initial patient volumes at the Roundhouse UC surprised CSHP. They happened to open Roundhouse ahead of stand-alone UCs in this part of Colorado Springs. A subsequent CSHP UC in another part of Colorado Springs with more competition had smaller volumes in its opening weeks.

Not only is the care timely and generally less expensive at Roundhouse UC than the ED, the patient experience has been positive. Survey feedback from fall 2015 ranks Roundhouse physicians at 4-plus points on a 5-point scale, with high marks in thoroughness, team work, communication and patient confidence in their physician's care.

TMF
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CPCPracticeSpotlight69

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Simple, Web-based Enhancement Shows Appointment Wait Times: Lessens Patient and Provider Frustration Alike

Meetinghouse Family Physicians, Marlton, New Jersey; independent; 3 physicians; 7,500 patients

Situation: As one of the first physicians in south New Jersey to work on PCMH, **Sloan Robinson, MD,** has a reputation with his patients for being an early adopter of technology. During his daughter's recent pregnancy, he heard time and time again about how she waited two and three hours for routine office visits with her obstetrician. Dr. Robinson's exasperated daughter challenged him to find a way to alert patients to longer wait times so they could plan accordingly.

Innovation: For a real-time status of wait times, Dr. Robinson's patients can check his physician page at the practice web site, www.MeetinghouseFamilyPhysicians.com (see screenshot at right), to learn current wait time. If Dr. Robinson's schedule is running behind, patients know they can run another errand or leave their homes a little later to spend less time in the waiting room.

*Patient friendly—*Any patient can navigate to his webpage to locate the appointment status announcement. Because it is not tied to a specific patient appointment or record, no additional security features (registrations, log-ins or firewall) are needed.

Dr. Robinson's wait time ticker appears in the upper right corner of his physician web page, which is visible without a log in or registration. He updates the ticker with a few taps on a tablet. This stand-alone feature is not integrated with the practice EHR, meaning security and privacy issues are not a concern.

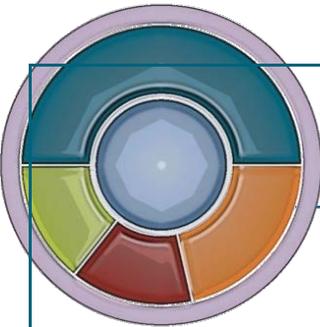When patients check in for their appointment, they are given a one-page tip sheet about the appointment status feature. The tip sheet shows them how to locate Dr. Robinson's page and then encourages them to check the status from home or their phones before future appointments so they spend less time in the waiting room.

Quick and easy to manage—"If I can do it, anyone can do it," is Dr. Robinson's mantra. Both he and his staff have access to the website to make updates as needed during the work day. They use a small tablet (Apple iPad) to log on to the website as an administrator and then select Dr. Robinson's personal physician page to edit the "current status" of appointment times. They first choose one option from a list of times (on time, 15 minutes late, 30 minutes late or one hour late), and then select the time of day (morning, afternoon or evening). If Dr. Robinson is out of the office, they choose "nothing to display" and the status will not appear. Once the selections are saved, the page updates within a few minutes.

*Less expensive than you think—*The practice website runs on WordPress, a popular open-source content management system. Open source means the programming language is publicly available, which allows programmers everywhere to share low-cost coding features that expand functionality called plug-ins. The site designer located an existing plug-in for an appointment status feature and added it to the site.

After four weeks of testing the functionality and ease of use, the feature went live. At first, Dr. Robinson held formal updates with the front desk to maintain status, but they have found a more casual check-in process works just as effectively. It's been available to patients since February. Dr. Robinson estimates after three to six months of informing patients of the new feature, the practice will have a better sense of its usefulness and effectiveness.

*Unexpected benefits—*While communicating to patients is the status update's primary function, Dr. Robinson says making the updates also has helped him be mindful of his time throughout the day. When his schedule runs on time, he says he feels less stressed and more able to enjoy seeing his patients. From his patients' anecdotal comments, he feels his patients also appreciate his practice's focus on patient experience by respecting their time.

What's next: The quick success of the appointment status feature has Dr. Robinson contemplating other ways to keep his schedule on track that would best benefit patients. He would like to explore new ways to design his schedule so he can maximize his effectiveness and improve every patient experience.

CPCPracticeSpotlight70

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Practice 'Re-attacks' ED Visits Following Changes in the Medical Neighborhood

Harrison Family Practice Clinic, Harrison, Arkansas; independent with hospital affiliation; 1 physician, 2 APRNs; 2,800 patients

Situation: By March 2014 (quarter 6), **Harrison Family Practice** could see sustained improvement in several key Medicare outcomes, including all-cause admissions, expenditures, 30-day readmissions and admissions through the emergency department. However, their ED visits began to show a small increase, and then despite continued progress in the other metrics over the next quarters, the ED visits persistently increased.

Strategies: This practice has considerable QI experience, having engaged in PCMH before CPC, and they know how to dig deeper into complex problems to find multi-pronged solutions. Part of their digging in was to assess conditions both inside and outside the clinic's walls to identify factors that could affect the increased ED visits. The second part of their follow-up analysis was determining which factors they could effectively influence in the near term to slow this trend.

After strong performance in quarters 2 through quarter 5, Harrison began to see an uptick in ED visits starting in quarter 6. This shift prompted the practice to explore what factors had changed that could affect patient behaviors and which of those factors they could influence through education, information and outreach.

Community-based factors — Rural and small-town practices like Harrison frequently struggle with limited community resources. The local community hospital recently acquired the only urgent care center in Harrison. Unfortunately they did n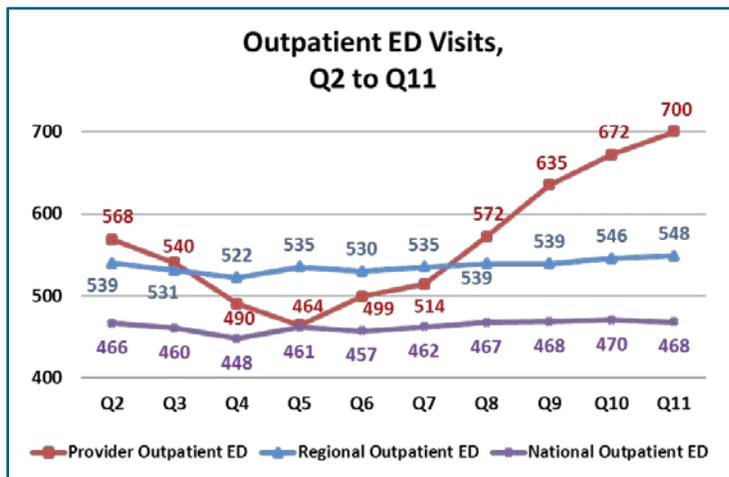ot expand its hours, leaving the ED as the sole late-night acute care option in town. Patients needing prescription-strength pain medications after hours are another concern. The only 24-hour pharmacy is a 40-minute drive, and patients frequently turn to the ED for immediate relief. While these situations offer the practice little opportunity to influence change, the practice found other possibilities to act on after it reviewed its in-house data.

Clinic-based opportunities — When Harrison broadened the types of information care managers were collecting on ED follow-up calls, this effort yielded a range of prospects the practice could explore for improvement. For example, they found a need to repeat and refresh their outreach to patients about the practice's expanded same-day appointment availability and 24-hour on-call service through portal messages, posters and newsletter blurbs. To ensure the information was shared during appointments, they surveyed patients at check-in and check-out and repeated details if needed.

When they looked at the diagnosis codes at time of treatment in the ED, they found fewer patients with higher risk conditions (e.g., COPD, CHF, CVD or depression) were being admitted through the ED, which indicated an improvement in their overall self-management of their conditions. However, some of these patients were still seeking care there for situations that were potentially preventable had they been seen at the practice first. A new process is to assign these patients to the APRN for more in-depth follow-up and outreach. As the former care manager, she was familiar with the patients and their specific situations, and her outreach was tailored to each patient's needs.

Some patients stated they used the ED for care because no payment was collected at the time of service or because they had an outstanding balance at the practice and didn't want to call there first. Through Harrison's hospital affiliation, a benevolent fund and other payment options are available to patients who need help with meeting their health care costs. The office manager works with patients to create workable payment plans to eliminate any stigma about seeking care at the practice due to financial reasons.
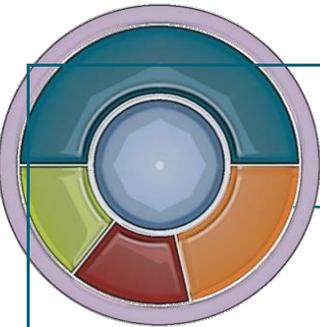
Focusing on the Big Picture: At this time, the uptick in ED visits appears to have flattened, yet the practice continues to see sustained improvement in expenditures, any cause and ASCS admissions, 30-day readmissions and ED to inpatient admissions. For the team at Harrison, this is evidence that all of the work is connected, and the improvements will eventually spill across all areas, resulting in improved health outcomes and lowered costs overall for all of their patients.

CPCPracticeSpotlight72

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Small Practice Leverages Team-based Care and Care Management

Lawrence P. Wang, MD LLC, Terrace Park, Ohio; solo practitioner; 1,500 patients

Situation: In a region where 85% of CPC practices belong to a multi-specialty group or are affiliated with a hospital system, solo practitioner **Lawrence Wang, MD,** frequently stands out in regional CPC meetings — in a good way. His suburban Cincinnati practice appears consistently on regional high performance lists for Milestone performance and Medicare outcomes measures.

Strategies: Dr. Wang says his practice "hit the ground running" in CPC's first quarter due to the flexibility of being a small, experienced team coupled with considerable tenure with the same patient panel. While larger practices have more resources (i.e., staff), a solo practitioner benefits from a flat management structure. In short, fewer meetings and more action fast-tracked how Dr. Wang and his team were able to quickly test changes to re-structure their workflows into a proactive, care-management focused model.

Where everybody knows your name — With about 1,500 patients in his panel, Dr. Wang says he can identify by name all of his high-risk patients. In fact, so can everyone on the care team due to low staff turnover. Three of the four team members have been with the practice for more than 15 years, and the newest addition has been on board for three years. The small team with long-standing relationships with patients makes a difference, Dr. Wang emphasizes. When someone from the practice reaches out to patients for care management support or a hospitalization follow-up call, patients have a face to pair with the voice on the phone line, and that makes the outreach personal.

"Our patients know we are calling because we care about them," Dr. Wang says. "They know it's not a scripted call from a stranger at the insurance company, but from someone they know in my office and they know we're here to support them."

Further, the long-term, personal rapport with patients has guided the practice's expanded self-management support efforts. The care manager reports that patients feel comfortable calling the practice to ask for assistance because they view the care team as a trusted partner in their health.

Prioritizing areas for improvement — Looking through the lens of lowering costs and unnecessary utilization, Dr. Wang initially focused on working with those patients who were frequent users of high-cost health care services, especially those patients using the ED for ambulatory conditions such as low-back pain. Having daily access to the local health information exchange to check hospital admissions and ED visits made the effort considerably easier, but consistent outreach helped push overall admissions down. As of Q12 (July–Sept. 2015), the practice's admissions had dropped 60% from its Q1 (Oct.–Dec. 2012) rate. ED visits for the same period are down about 15%.

Hardwiring outreach — Recurring contact with high-risk or high-use patients was a priority item for this practice. By embedding the ongoing phone calls and messages into workflows, time was planned for these new tasks. This carried over to hospitalization and ED follow-up calls, so "everyone gets that touch" from the practice.

Hurdles they're still working on — The drawbacks of running a small practice in a data-driven environment is the lack of access to data. Dr. Wang feels as a solo, independent practitioner he lacks leverage with EHR vendors to influence custom reports or to add data reporting. He would like to see more work-arounds and flexibility from payers and EHR vendors for practices like his.

Looking beyond CPC: For Dr. Wang, the underlying premise that care management for high-risk and high-utilizing patients leads to overall savings in dollars and resources for the system makes complete sense. He sees care management as an essential part of his practice, not only for monitoring the usage and cost aspects but also because it provides the kind of wrap-around care those high-risk and high-utilizing patients clearly need.

100% CARE MANAGEMENT SUPPORT FOR HIGH-RISK PATIENTS

Dr. Wang's practice has been recognized for providing care management support for 100% of his patients in the top two risk factor tiers for three consecutive quarters in 2015. Additionally, this solo practitioner is a consistent top performer in the Ohio/ Northern Kentucky region in reducing admissions.

June 10, 2016

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Utica Park Clinic: CPC from the Leader's Perspective
Utica Park Clinic, Tulsa, Oklahoma; multi-specialty; 15 CPC sites; 131,000 patients

"My role in CPC is dual. I'm a practitioner. I have an office-based practice, and my practice is CPC focused. I'm a medical director for a physician group. I think the difference is really seeing the role of a leader and how leaders can implement change, and then measuring the change at the practice level. And so one of the things I've seen at the practice level is that I can tell you my day-to-day functions have changed significantly since began participating in CPC. When I have a diabetic patient who comes into my office and their A1c is 11, and they need to be placed on insulin, I run. I grab my care coordinator. We spent time with the educational process. I get that patient home safely with the information and knowledge about how to administer insulin. These are things that would have taken me weeks to do before CPC occurred. I see the value of this at the clinic side, which then reinforces the things that we've done on the administrative side in a leadership role. So I think it's been really wonderful to be able to have a foot in each camp around CPC.

This interview with Jeffrey Galles, DO, CPC Director, was filmed on April 6, 2016.

How Utica Park Approached Teambuilding — Setting the stage for teambuilding is really a group process. I think from a leadership perspective, you have to bring in all of your key leaders, and everyone has to be on the same page. One of first things we did was really build infrastructure around group meetings and bringing all of our leaders together on a regular basis to understand our goals and to understand where we're trying to go with our value-based programs. But I think the other part of that is the knowledge and, and the mission, and then implementation. One of the things we've done which has been very valuable to our organization was to build a LEAN process and bring LEAN training in and really spend a lot of time with our leadership understanding what LEAN Six Sigma and LEAN processes look like. We've done training, and we've trained about 150 employees now on LEAN Six Sigma training. Then we began the process of implementing that across the organization. I think it's not just understanding the goals but it's how do you implement those goals? And I think I'm bringing infrastructure like that has been really valuable to our organization.

Spreading Change Across a System — We know as a health care system that we can't implement transformation and leave it only isolated to our office-based clinics. We have a wonderful leadership structure within Hillcrest Healthcare System. The CEO of our system [and] the CMO of our health care system have all been supportive and really integral to our success. One of the values that we've had is that because we've got such a good relationship across the leadership and the health care system, they've been able to understand where we're going and support that, but also build our expertise and bring our expertise into that, into the hospital systems, and really from that perspective, understand how we change at the hospital level as well. So they've embraced some of the cultural changes we've had because of CPC. They've integrated those cultural changes into some of the cultural changes at the hospital level. So we built our work from [the] outpatient setting back to the inpatient setting, but we couldn't have done that without the support of our leadership.

Overcoming Resistance to Change — The challenges that we deal with are the same challenges that every organization does. It's the resistance to change, and I think, you know, we've really spent a lot of time understanding change management and understanding what change management looks like, and I think not being frustrated because change doesn't happen fast enough. I think that's some of the biggest barriers we've dealt with. We take our physician leaders who embrace these programs and we really engage them. We make them leaders, and our practices where we've struggled, we've put more resources in their laps. We do everything we can to show them the value of providing… these additional resources to our high-risk patients. I think the biggest issue has always been that cultural transformation, and for every organization that's a struggle. But I think it's understanding the importance of walking into a headwind and knowing that you have to continue to persist and that you can't back down when you feel pressure. You just have to continue to move forward, and I think with that in mind, I think we've gotten past a lot of the barriers that, that we didn't anticipate having when we first began this transformation.
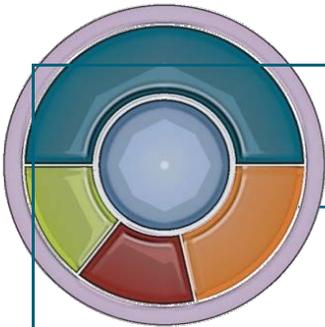
CPCPracticeSpotlight73, *continued*

Alignment and Motivation — Alignment is a real challenge, and I think every health care system struggles with the same thing. You know, what is it that you can do to, to align not only the physicians but the staff and the management. I think our initial alignment was really, this is the right thing to do, and I think our providers understood that this was the right thing to do, but it didn't always motivate all the behaviors we wanted to motivate. So then we really began to look at compensation models, and I think that compensation is another way of creating a really motivating alignment, and so we began to align physician compensation with our quality metrics and with our patient experience metrics like a lot of other organizations do. But we felt that wasn't really enough, and so we've also aligned our executives' compensation and the alignment is really almost exactly the same. They are aligned with quality and with patient experience as well, and so between all those alignments, you really begin to see the push towards how do we change a system in a way that, that we can see individual benefit but, group benefit as well.

I think one of the things that we've seen as a result of the alignment is that our metrics have improved substantially. We've been able to see a substantial change in really the attitude of our executive leadership as well because they've begun to ask the questions they weren't asking before. Why are our blood pressure controls not improving any better? Why are we not doing better job at colon cancer screening? Because now they're interested in the outcomes and, and because of that alignment I think the system is, is really better prepared for value-based care than it has been in the past."

CPCPracticeSpotlight74

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June 24, 2016

Utica Park: Starting at the Clinic and Going Beyond

Utica Park Clinic, Tulsa, Oklahoma; multi-specialty; 15 CPC sites; 131,000 patients

These interviews with Jeffrey Galles, DO, CPC Director, Hillcrest HealthCare System, and Verda Weston, Director of Population Health, were recorded in February and April 2016.

Dr. Galles: Our strategy as a health care system was really to begin to build some infrastructure. We started at — like most groups do — as a completely volume-based organization. We understood that the world was changing around us and that there were health care systems that were leading the way, and we didn't want to get left behind. And so our strategy was really to begin the value-based component of health care in our office setting. So, CPC was a wonderful opportunity for us to provide some funding to build some care coordination, some resources at the clinic level, which we think is really the foundation for our health care system. So, the strategy was really ideal for us. The hospital system was not ready. They were not ready to change all of the things that have to be changed at a hospital level, but we knew we could change those at a clinic level. And so our strategy was really, build the infrastructure for value-based care at the group level, and then expand that up the ladder, up into the hospitals.

Engaging Hospitals in Transitions of Care

Dr. Galles: One of the initiatives that we worked on, that really engaged the hospitals, was our relationship between the hospital and our provider group, around transitions of care. And one of the things that we really wanted to form a strong connection with was the hospital discharge process. And so we really built a program around transitions of care, where we brought a couple of transition of care nurses and embedded them at the hospital. We focused on some high risk conditions, including heart failure and COPD, and we really linked those care coordinators to our offices. I

Jeffrey Galles, DO, CPC Director (left) and Verda Weston, Director of Population Health, Utica Park Clinic

think that's probably been one of the strongest initiatives we've had because it really gave us a chance to work through a quality improvement process that linked both the hospital and the office-based practices together. And it gave us the opportunity to really get those patients into a primary care office in a reasonable time frame, but in a systematic way, so that we had an infrastructure in place, we had processes in place, and I think after a year's worth of time we really seen a big improvement in a connection between the hospital and the offices, and on top of that we really began to see some improvement on our readmission rates, and our readmission penalty processes as well.

Verda Weston: So, for the past several years Hillcrest Medical Center has had a focus on those diagnoses that are marked as high risk for readmission. We've developed patient education material and a process for finding those patients while they're in the hospital, seeking them out, providing some disease-specific education, and talking to them for at least 30 days after discharge, and during this process we learned a lot, and then being able to add that to the CPC process we've heard from our patients, "So, what do I do now?" So, from the hospital side the program officially ends at the end of the 30-day period, and the patient still needs support. They still need help. They still need questions answered. So, we began working with the hospital, the transition care nurses, and the CPC coordinators within each clinic to make sure that patient information and instructions were the same so that patients weren't getting conflicting information.

We also began doing hand-offs, sort of like a nursing report hand-off you'd see from shift to shift, and it would be very specific with what questions a patient had before, what had been addressed, how we resolved those. And we also utilize the same social worker after discharge. So, the social worker has a link between the transition care nurses and the CPC nurses in the clinic. And what we have found is that the patients respond to that. They like having the hand-off, the next person that's going to help take care of them, and they're not just left to fend for themselves after a 30-day period of time.

CPCPracticeSpotlight74, *continued*

The Value of a Patient and Family Advisory Council

Dr. Galles: Patient advisory councils have probably one of the most valuable tools that we've used across our health care system. And before CPC we really never even considered using a patient advisory council as a tool to improve care. But we initially began with a pilot program in one of our metropolitan clinics, and we invited patients to come in and share their stories, and we specifically addressed one topic in each one of our advisory committee meetings. One of the things we found was that the patients were probably the best source of information for how we can improve care in our practices. We were so delighted with what we received from that initial encounter, we expanded this out to include our rural practices, and with that we began to look at what's the value of a patient-family advisory council in our specialty clinics? And then we began to initiate an oncology-focused patient advisory council. And every one of those we've had stories that have impacted what we do. We specifically address items and issues that we're frustrated with, and the patients always come up with great ideas about how to improve what we do, and then how we deliver care. And so I would be absolutely enthusiastic for anyone to consider doing this on their own because it took very little cost, and the patients are more than willing to share their stories with us. And so I think for us it's been one of the best investments we've made of time.

Verda Weston: Within the Utica Park Clinic we have five patient-family advisory councils that have been operational for about two years. As we ask the patient questions we get insight into what they're thinking. I think the other thing that we learned when we discussed the CGCAHPS scoring was that patients see things a lot differently than we do, and wait time was one of those important items that popped up. "I don't understand why you have me come in 15 minutes early prior to my appointments to wait in the waiting room for 15 minutes to be roomed, and then wait in the room for an additional 15 minutes. That's already 45 minutes of my time." So, it was an eye opener, for office managers in particular, to hear that. And so we're making some efforts to decrease the wait time, to make it more patient friendly. So they can walk in and expect to see their provider sooner. And then giving them the opportunity to ask questions, "Why am I waiting so long?" and for that to be an okay question.

Transforming to Value-based Care and Beyond

Dr. Galles: Last insights really are the transformation to a value-based care system is a real challenge for every organization. But I think as we've begun to have a little maturity with this, and began to see some of the benefits I think, you know every organization will feel the same, that ultimately value based care is far superior than volume-based care. And it's helping people understand that, you know we have to manage those patients that are in our clinics, but we also have to manage those patients that are not in our clinics. And I think once that recognition and that transformation begins to happen, it really snowballs. And I think for any organization who's beginning this process, I think that the biggest insight is, continue to push, continue to look past the barriers, continue to look at how you can provide the best care you can provide to your patients because ultimately that's our goal, and that's what all of our goals are. It's just getting past some of the barriers that is the real challenge, and I think once you begin to get a taste of how the patients respond, and you get the positive feedback from those high-risk patients, and those patients who have been kind of left on their own, you really begin to understand how much of an impact you can make on a person's life by providing a better quality of care. And I think that's really the end game for all of us is just hanging in there, working hard, and understanding that the light at the end of the tunnel really does exist and it's not a train, it's a happy patient, and that's what we're all looking for.

CPCPracticeSpotlight75

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Amplifying the Patient Voice: Oregon Practice Consults Its PFAC for Guidance on 'Everything That Affects Patients' and More

Providence Medical Group–Sunnyside, Clackamas, Ore.; system affiliation; 14 providers; 17,000 patients

Situation: Walk into **Providence Medical Group – Sunnyside** and the influence of the practice's patient and family advisory council (PFAC) appears across the clinic. From patient education displays in the lobby to how clinical workflows pertain to the patient experience, "everything that affects patients," said Clinic Manager **Angeline Hill,** is presented to the practice's PFAC for insight on how patients perceive a quality care experience.

Innovation: The PFAC's role at Sunnyside has evolved over time. At the council's first meetings in 2013, the clinic staff would share patient education materials with the PFAC for its review. Representing both new and long-standing patients as well a mix of ages and ethnicities, the council seemed an apt choice for that task. However, the council had its own ideas. Pushing back, they said not only did the practice have too many fliers posted around the practice, but the handouts weren't effective. Council members said they largely ignored generic, slickly designed brochures that applied to anyone, anywhere. Instead, they wanted timely health information tailored to their needs and interests. Finally, they wanted outreach materials to be a genuine reflection of the practice's concern for them *as individuals*.

Sunnyside has fully embraced that feedback, which aligns well with its system mission to respect the dignity of every person, especially those who are vulnerable.

Now, at the council's monthly meetings, physician leader **Darla Stupey, DO,** and Angeline Hill consult the council members about how they think the practice could improve patients' experience at every point of contact in care. The PFAC fully partners with the practice to guide all patient education collateral as well as weighs in on any changes that may affect how patients perceive their care. Plus, the council advises on content for the monthly patient newsletter to ensure the stories are relevant to patients. Also attending these meetings are a medical assistant and a patient relations representative, who then take the council recommendations back to the clinic team to test implementation.

The PFAC's influence appears again in the patient education displays that rotate out monthly. The clinic's Quality Committee puts together these

The PFAC suggests patient education topics for monthly displays in the practice, such as nutrition information (top) and promoting prostate cancer screening (bottom), where practice providers all don mustaches in the photos to remind patients not only about screening but that each patient's health matters to someone, including their clinical team. These homegrown outreach projects are popular with patients, confirming the PFAC's guidance that patients prefer this more personal approach as opposed to generic brochures and handouts.

humorous, quirky displays, which are popular with patients and families and often a topic of conversation. After hearing about the "How much sugar are you really eating?" board, a pediatrician from a neighboring practice came by to see if his practice could create a similar display for parents.

What makes this work—Most of the Sunnyside physicians have been with this practice for eight to 10 years, and they have a long-standing commitment to patient engagement. Their leadership has helped the staff focus on this as a priority. Feedback from the PFAC is a standing item on meeting agendas, cementing their contribution as essential to how the practice functions. If the PFAC makes a recommendation, it's taken seriously. Feedback about front desk workflows resulted in a customer service "boot camp" for staff. The bottom line: If the PFAC sees value in altering or improving an aspect of care, all of Sunnyside's team members are willing to make that happen.

CPCPracticeSpotlight76

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Strategies for Meeting Patients 'Where They Are' and Making Self-Management Support Work in a Busy Primary Care Practice

Summit Family Physicians, Middletown, Ohio; independent; 3 physicians, 1 CNP; 7,500 patients

To access Summit's SMS tool on CPC Connect, use "Summit" as the search term to locate the document.

Situation: Several practical considerations needed to be addressed as **Mark Frazer, MD,** and his care management team at **Summit Family Physicians** integrated self-management support (SMS) into how they engaged patients. For example, how would they incorporate this work without it derailing the daily schedule? How should they tailor their efforts to make it meaningful for the patient and the provider alike? And, should they engage patients who simply wanted to be told what to do?

Strategy: Together with **Leah Brunie, CNP**, and care coordinator **Vickie Sawtelle, LPN**, Dr. Frazer's team found they could balance a busy workload with an extended effort to engage patients in SMS. Their foundational strategy was to provide every employee – clinical and administrative – with the knowledge and resources to start important SMS conversations if the opportunity arose. Next, they created a tool everyone could use to narrow the conversation about SMS to a specific goal with detailed steps. Finally, they set realistic expectations about how and when SMS would be appropriate, useful and effective.

Marry preparation with opportunity — Dr. Frazer and his colleagues combed through stacks of collateral to select a core set of handouts for SMS and patient education. They narrowed the topics to those most frequently raised in the office: smoking cessation, weight loss, mammography, diabetes, depression medications and colorectal cancer screening options among others.

Above: Education materials are placed in every exam room. Note the distinct appearance of each piece. This makes it easy when the provider enters the room to quickly identify what patient has been reading.

Using these materials as a baseline resource, everyone at Summit learned the content and how to answer basic questions for each topic. The handouts are stored in a central area for the staff's easy access as well as placed on every exam room wall in eye-level racks for patients.
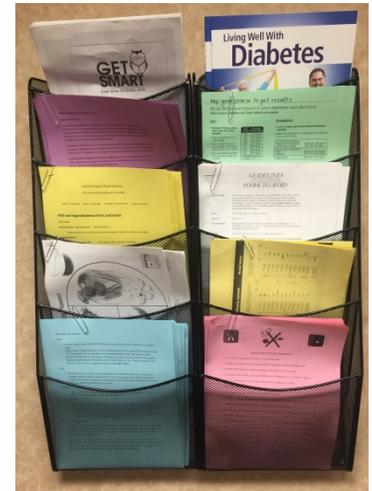
If the patient expresses interest in any of these health-related matters, someone can immediately step in to help and to bring the patient's concern to the provider's attention. By spreading the responsibility of active patient education and SMS across the entire clinic, this alleviates the provider from being the sole source of information. With appropriate handoffs, it also prevents an encounter from going over time and throwing off the day's schedule.

A guided, focused conversation — Summit's care teams created a one-page tool to guide the SMS conversation. Deceptively simple, the tool asks the patient to name "the one thing I want to change about my health today" and then to state "my goal for next month." This frames the subsequent prompts about action steps, overcoming barriers and resources as they relate to that **one goal the patient (not the provider) has chosen.** While the provider may see a high A1c as priority, the patient may simply want to have the energy to help her daughter with babysitting. Dr. Frazer emphasizes that goals should be framed around what is important to the patient. **Successful SMS hinges on meeting patients where they are, not where you as the provider want them to be.**

Last, the form asks the patient to rate his or her confidence level on a scale of 1 (low) to 10 (high). Dr. Frazer warns that if the score is less than 8, the goal should be revisited. Patient confidence in their ability to self-manage is built up incrementally; if you help them set goals with attainable, early wins, they will build their confidence as they work toward larger, more challenging goals.

Set your own expectations appropriately — Some patients will resist SMS, while others cannot participate as your partner in their health. For example, some patients will want to be told what to do. While frustrating to the provider, at least the patients are being frank about their expectations. Patients with untreated depression are also poor candidates for SMS due to existing feelings of hopelessness or helplessness. CNP Leah Brunie refers these patients to appropriate behavioral health services but keeps in touch as a supportive partner as they seek treatment. Dr. Frazer emphasizes that continuing the SMS effort shows patients that their care team wants to be their partner and cares about their health. He sees evidence that patients acknowledge this effort in his practice's CGCAHPS scores, where questions related to patient engagement and communication have steadily improved.
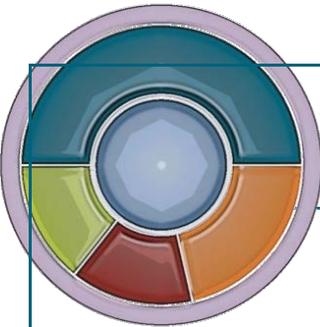
Good for the patient, good for the team — While SMS is clearly essential to forming a partnership with patients in their health, Dr. Frazer says it benefits his staff. Their ability to engage meaningfully with patients has contributed to increases in employee satisfaction, despite working in an environment where change is the norm.

CPCPracticeSpotlight77

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Integrated Versus Co-located: A New York Practice Fully Integrates Behavioral Health and Finds Benefits Beyond Timely Access for Patients and Providers

Latham Medical Group, Latham, New York; multi-specialty affiliated with Community Care Physicians (8 CPC sites); 9 physicians, 1NP, 5 PAs; 16,000 patients

Situation: Behavioral health (BH) services at **Latham Medical Group (LMG)** have evolved from a co-located strategy into a high-level, fully integrated delivery of BH services. This includes sharing the EHR, dedicated workspace, a steady work stream of coordinated care with care teams, assessment on behavioral health and co-morbidities following evidence-based guidelines, identifying risk and behavioral conditions that could affect outcomes and the BH consultant (BHC) contributing to overall care. This full integration has affected — and clearly benefitted — nearly all aspects of the practice's work.

Innovation: LMG found that integration involved a complex synthesis of multiple moving parts: finding the right providers, locating helpful resources to support the transformation work, refining workflows and then finally measuring effectiveness.

LMG recommends resources from SAMHSA for developing an integration strategy. Pictured above is a portion of SAMHSA's easy-to-follow interactive flowchart that can guide practices on how to work through administration concerns, build a business case, recruit staff and test workflows.

Hire the Right People — Traditional behavioral health specialists are rarely trained to work in the fast pace of a primary care clinic where brief focused therapy techniques are needed. Group leader **Holly Cleney, MD,** advises to hire for talent and willingness to learn over experience. She recommends looking for a provider who can support teams in improving their motivational interviewing skills, how they work through change as well as serve in other capacities, such as a leader for smoking cessation classes or diabetes self-management education and support courses. Then, be sure to allow ample time for the provider to adapt to the team-based care model, which differs vastly from BH's traditional 60-minute appointment model for outpatient services. At this time, a PhD-candidate behaviorist and a health coach are part of the Latham team. Further, the Latham team is developing a training program with the intention of building a candidate pool for this work. They are also working on a training program for other primary care practices within their larger organization to develop BH programs with full integration.

Build a Toolbox – This practice followed an implementation framework (*see insert*) developed by SAMHSA (Substance Abuse and Mental Health Services Administration). The SAMHSA model lays out starting points for administration, recruitment and onboarding, engaging psychiatrists for referrals, measures and process maps. Dr. Cleney forewarns that any framework is simply a launching point — practices will need to carefully consider their individual strengths and needs that will affect how they successfully integrated BH services.

Test, Revise, Repeat — LMG repeatedly worked through different workflows and scheduling strategies to strike an effective balance of same-day availability, scheduled appointments, co-visits with BH and warm hand-offs with behavioral health providers. The benefit and challenge of effectively integrating a BH specialist is that her expertise is helpful in myriad situations: assessing and screening for patient needs, teaching behavioral solutions to complement a pharmaceutical regimen, tandem self-management support with care managers and providers, supporting providers' teaching skills such as Motivational Interviewing, and more.

Moving the Needle — To measure effectiveness, LMG tracks pre- and post-treatment depression and anxiety scores with the PHQ-9 and GAD 7 among other standard screening tools. About 65% of the patients receive treatment within the practice using shorter behaviorally focused sessions with the BHC or health coach. Often patients' ongoing medical needs require frequent contact anyway and continued BH support blends well with their course of treatment. The others need longer term specialty mental health for optimal care. For that group, LMG's behavioral receptionist makes the initial appointment at one of LMG partner counseling practices and ensures that progress notes are returned to continue care integration.
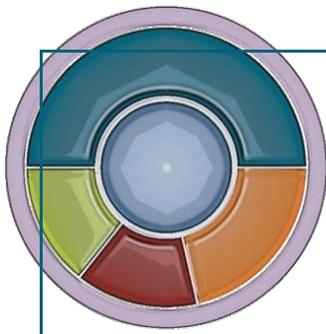
Not Easy, But Worth It: LMG estimates that full integration has been an 18-month process and is not finished. As providers gain experience with having BH specialists on their teams, they continue to develop increasing levels of collaborative care and treatment processes focused on population health. Additionally the practice is involved in a research study involving teaching Motivational Interviewing to providers. Part of its purpose is to reduce their own work-related frustrations as they learn to elicit "the change talk" with patients rather than the usually go-nowhere repetitive suggestions. Fully integrating BH into the primary care practice is a win-win for all: providers see patient engagement and progress, and patients are given the assistance they need to make a meaningful, effective plan toward change.

Manage Care Coordination with Teamwork, Persistence and Technological Support

Farmingdale Family Practice, Farmingdale, NJ; independent; 2 physicians, 1 APRN; 11,358 patients

Aug. 19, 2016

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.3: Risk-Stratified Care Management
- 1.5: Care Coordination across the Medical Neighborhood

Situation: The culture at **Farmingdale Family Practice (FFP)** emphasizes collaborative teaming and shared responsibility. While always evolving, the adopted processes are effective in providing patients with seamless coordinated care, according to FFP team members.

Innovation: Teamwork is not left to chance at FFP—it's a norm, outlined in the practice's policy manual that all new employees must review. Mandatory cross training helps team members better understand each other's workloads and helps them see how their efforts lead to FFP's success in reaching its goals. Making collaboration a clear expectation contributes to FFP's reputation for being "relentless" in meeting its patients' needs. According to **Louann Hillegass**, practice manager, at least three other characteristics describe FFP's culture and help the practice manage care coordination:

Suraiya (Sue) Sultana (left), Toni Crispino (center) and Maite Fuentes (right) review FFP's policy manual together as part of the practice's cross-training strategy.

Care coordinator Daniel Martinez creates single-theme posters for display in exam rooms. The posters are part of FFP's patient education effort and reinforce the message the practice wants to convey.

Fearlessly Diligent — Care coordinator **Daniel Martinez, LPN,** enjoys being "the go-to person" for patients. Beyond hospital and ED follow-ups, Martinez scours his community for helpful, often free, resources to share with patients, such as where they can obtain medical equipment or find dietary advice. After one patient was treated for anxiety—he was overwhelmed by his duties as a caregiver—Martinez found several local agencies that could assist the patient in caring for his elderly family members. Martinez also gained login credentials for the EMR portals at two area hospitals*, better ensuring continuity of care if patients forget to name FFP as their primary practice.

Mutually Supportive — FFP uses a team-based approach to deliver care, which is why cross training is so important. If his colleagues are busy, Martinez can help with intake and rooming. Likewise, **Toni Crispono**, senior front desk patient representative, **Lynn Brower**, **CMA**, and **Susan Perrone**, **CMA**, know what kind of data to share with Martinez so he can help patients arrange for appropriate tests or services. Additionally, the team meets monthly with the practice's lead physician to set long-term goals. On a day-to-day basis, the team huddles to address more immediate challenges, such as ensuring that release forms are obtained during check in. At all meetings, every team member can contribute, "from the administrative person to the clinical," says Martinez.

IT Inclusive — At FFP, those who work in information technology (IT) are fully integrated into collaborative culture and have been a part of all monthly and quarterly quality and procedural meetings since the inception of CPC. The value of making IT integral to the team became clear when the practice wanted to alter the workflow and documentation fields in its EHR. Such customization is usually cost-prohibitive. Fortunately, "we had someone with a deep understanding of the software and CPC requirements," says Hillegass. As a result, the EHR now feature custom reportable fields, based on front desk, medical assistant, and provider workflows. These fields allow team members to set goals and track progress, and create system-wide notifications that help FFP "close the loop" when the patient is in the office.

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Input from IT was critical in improving the patient experience *outside* the office, too. When patient survey results revealed that few patients knew how to access care after hours, FFP sought to increase awareness through website announcements and patient portal bulletins, as well as on-hold messaging. The message was clear and consistent: patients should always call the practice first with their health care concerns, regardless of the hour. This information blitz resulted in a 30-percent jump in patients stating, when surveyed, that they understood how to obtain after-hours care. What's more, because providers were given access to the EHR via their home computers, notepads, iPads and phones, they "truly have 24/7 access to patient information, no matter where they are," says Hillegass.

Continuity of Care: Through teamwork, persistence and technological prowess, FFP has become a leader in primary care, always striving, says Martinez, to provide seamless care. He adds that he and his colleagues understand that their primary responsibility is to "make sure patients have what they need to stay healthy."

* Martinez's ability to secure timely notification from local hospitals has been made easier by CPC multi-stakeholder engagement activities in New Jersey. The New Jersey Hospital Association has offered guidance on how to facilitate timely two-way communication between practices and hospitals that helps secure the continuum of care for patients.

Site-based Mobile Carts Amplify Timely Access to Behavioral Health Services

Arkansas Health Group-Baptist Health, Little Rock, system-affiliation; 23 practices, 14 CPC sites; 59 physicians, 24 mid-level practitioners; 123,980 patients

CPC Change Driver 1: Comprehensive Primary Care Functions
- 1.1: Access and Continuity
- 1.3: Risk-Stratified Care Management
- 1.5: Care Coordination across the Medical Neighborhood

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: In Arkansas, securing an appointment with a behavioral health (BH) provider can take a patient as long as six weeks to several months. "We feel this isn't ideal for the population we are trying to serve," said **Amy Stephenson, RN, Supervisor of Care Coordination** at Arkansas Health Group (AHG) in Little Rock. "The body is only as healthy as the mind."

Innovation: AHG created a BH clinic (Baptist Health Behavioral Health Center), staffed it with their own providers and implemented a telehealth option for patients in rural areas who were unable, or unwilling, to make the long trek (sometimes as long as two hours) to central Arkansas

Getting started. The program was piloted in two clinics. One was selected to provide more support for the on-site BH provider who was overwhelmed with referrals– some of those patients could be candidates for the telehealth option. The other clinic was selected for location—the proximity of the clinic to the Baptist Behavioral Health Center allowed for collaboration. These locations allowed AHG to "work out the bugs," Stephenson explained. This included nailing down a process that served patients and providers alike. AHG relies on a care coordinator, **Caitlyn Webb, LSW**, to triage the behavioral health referrals she receives.

"I act as a liaison between the patient and the counseling they seek," Webb said. The patient's first point of contact is, of course, the primary care provider, who determines when an intervention is needed. Once a referral is sent, Webb then assesses which is most appropriate for the patient: an on-site visit to the BH clinic or services delivered via telehealth. As a care manager, Webb is uniquely positioned to alert physicians if a patient's behavior is troubling. "If a patient goes to the ED seven times a year complaining of shortness of breath, it might mean anxiety," she said, which should trigger an assessment for BH.

Going virtual. To access telehealth services, patients must report to an AHG clinic closest to them. This is a billing requirement in Arkansas, as well as a means for providing emergency hands-on care, if necessary. The patient is shown to an exam room and the telehealth mobile cart is rolled in. (The mobile cart is portable, giving the clinic flexibility in deciding where to room patients.) The patient is then virtually connected to his BH provider. "Think in terms of a secure, virtual, face-to-face call on your smart phone," Stephenson explained. "You're seeing your provider on a screen and your provider is seeing you."

Early lessons. The telehealth model AHG has debuted is in its emergent phase, so data on the effectiveness of the approach is not yet available. Stephenson does offer some observations for other practices considering such an approach:

Be sure to follow-up with patients. Most patients respond well to the telehealth approach, mainly because they are receiving timely access to care. Still, if patients say they are uncomfortable with the process or service, it's important to find a different route for them.
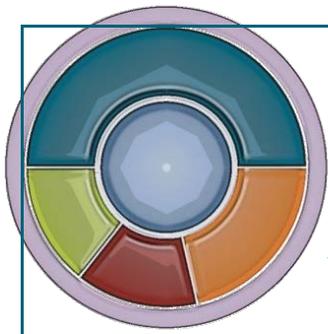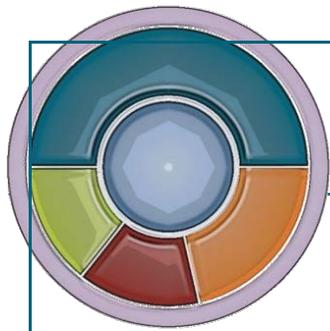
Remind practices that the service is available. "Often primary care physicians and staff members are overwhelmed and may not recall that these BH services are available for patients who may benefit from them," Stephenson says. Frequent communication to practices and education is important.

Know when to promote. Educating does not mean advertising, however. Because the program is in its infancy, Stephenson has not promoted the service to patients. "We want to be sure that this is an effective program for our patient population" before publicizing it, she said. "We don't want to put a program out there and then have to pull it back."

Showing Promise. AHG plans to set up mobile carts, which can be used to deliver other clinical services in addition to behavioral health, in each of its 23 practices. AHG is also adding a physician and other advanced practice providers to its telehealth sites for medication management. Medicaid, Medicare and other payers are reimbursing for these services and activity in the state legislature is favorable to telehealth. As a result, Stephenson believes the program has staying power.
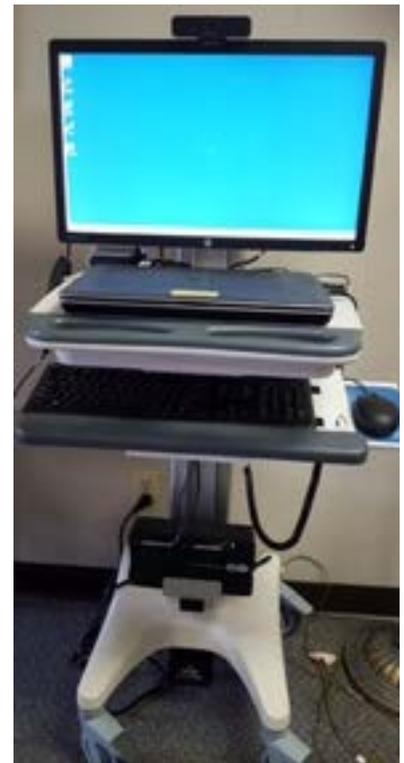
AHG created its own telehealth mobile cart which runs a HIPAA-compliant video-conferencing platform called Vidyo (see http://www.vidyo.com/). Working with IT to build these kiosks saved the group more than $25,000 per unit. Each kiosk is built to order and is delivered to a practice within a month to six weeks.

CPCPracticeSpotlight81

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Better Follow-Up + Improved Communication + Expanded Services = Reductions in Admissions and Expenditures

Providence Medical Group – The Heights, Huber Heights, Ohio; multi-specialty;
1 physician, 1 NP; 3,000 patients

Situation: When the Huber Health Center Urgent Care began closing its doors at 7:45 p.m. in 2014**,** at least one of the medical practices housed in the same building was affected by that decision. **Joni Koren, DO**, **Providence Medical Group-The Heights (PMGTH)**, noticed that the number of patients seeking treatment in the ER increased after the facility reduced its hours. What the practice did next to address the issue coincided with **Providence Medical Group's** expansion of services, which helped reduce costs while providing more options to patients.

Strategy: To address the increase in ER visits, Dr. Koren and her team immediately redoubled efforts to follow what have become the practice's tenets: to coordinate patient care after ER visits or hospital stays and to educate patients about their health care options so they can seek and receive the right care at the right time.

Make Contact Routine. "Before CPC, it was difficult to find the time or resources to contact every patient who went to the emergency room," said Dr. Koren. The practice is now more proactive. **Rochelle Miller, RN,** care coordinator, reviews ER notes and checks the local health information exchange to obtain patients' records. She then calls each patient at least twice. If she can't reach the patients by telephone, Miller sends a letter. This two-pronged approach to patient outreach has helped the practice reach a 95 percent response rate. It's a strategy that enables Dr. Koren and her team to address any health issues patients may have "before they become serious enough to require hospitalization."

Educate Patients. Patients headed to the ER because they didn't know where else to go, Dr. Koren acknowledged. "We knew it was important to inform patients about their options for after-hours care," she said. The initial messaging from PMGTH focused on cost savings. To avoid a sizeable ER bill, patients could see the nurse practitioner who had extended evening hours several times a week and thus only pay the cost of an office visit. "Once patients saw how much they could save using this alternative, they understood that the ER should be a last resort," Dr. Koren stated.

Additionally, on-hold messaging, along with posters and pamphlets in the clinic, reminded patients that they could reach the practice 24/7. "I also respond to emails frequently," said Dr. Koren. "My patients now know that I check the email portal three or four times a day and on the weekend. If someone is sick with a UTI or sinus problem, I can call in a prescription and they can be on the mend while waiting for an appointment with me."

Expand Services. If better follow-up and improved communication has benefitted patients, so, too, has an expanded array of services PMG now offers. "Providence now has a pharmacist on board, so if someone calls in and says the meds are too expensive, I can call and ask about cheaper alternatives," Dr. Koren explained.

PMG also offers "all sorts of testing," from echocardiograms to abdominal aorta scans to venous duplex scans. "We have three locations, which makes it easier for patients to get the tests done," said Dr. Koren, adding that offering these services in multiple locations makes it easier for her to coordinate care for her patients. In turn, her patients are reassured because their provider knows who will be administering the tests. "I can explain the procedures and results in layman's terms," Dr. Koren explained.

Outcomes: In addition to reducing ER visits, PMGTH was among a handful of practices that also reduced expenditures during the time period represented in recent Medicare feedback data. Dr. Koren credits much of PMGTH's success to its diligence in working toward achieving the larger aims of CPC. "CPC has helped us become more of a team and the entire staff feels that we're all equal. We just couldn't do what we do if it were otherwise," Dr. Koren said. "We're more attuned to preventive care and keeping up with our patients' health than ever before."

Dr. Koren and her team huddle daily to review the appointment schedule and identify patients' needs, ensuring that health goals are reviewed and emerging needs are addressed.

"Before we became a CPC practice, we didn't huddle with the regularity we do now," said Dr. Koren. "Our communication has improved, every staff member understands what role he or she plays and, as a result, patients benefit."

TMF
Health Quality Institute
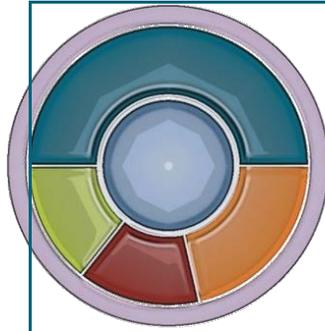
CPCPracticeSpotlight83

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Group Visits: Providing Support and Education While Enhancing Health

Washington Regional Medical Center-Senior Health Clinic, Fayetteville, Ark.; system-affiliation; 5 physicians; 5 APRNs; 3,000 patients

Oct. 28, 2016

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care and Population Health

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: Offering group visits to geriatric patients to promote self-management has turned out to be a terrific idea, said **Gillian Woods, PhD, Senior Health Education/Outreach Coordinator** for the **Washington Regional Medical System** in Fayetteville, Arkansas. "We thought the group visits would be beneficial for patients who are already pretty healthy, as well as for those who needed help managing chronic diseases," Woods said. Juggling competing expectations—participants wanted more group time with their peers whereas providers wanted more individual time with their patients—was the only issue Woods had to resolve.

Strategy: After testing different formats, compromise was found in a strategic schedule: the clinic would host four, two-hour group visits on Wednesdays, once a month over a four-month period. Providers would meet with patients during the first and last meetings to conduct physical examinations; the second and third sessions would be devoted entirely to the group visit, with conversations ranging from diet and exercise to memory and behavioral health issues. This format offered many benefits.

When providers join the group visits at Washington Regional Medical Center-Senior Health Clinic, they conduct a physical exam equal to what patients receive during a booked appointment. As a result, that portion of the workshop is billable as an office visit. All other group visits are free.

Allowing for progress checks: Physicians understood why their attendance at the first meeting was important. "We needed providers to help with intake at the initial meeting," said Woods. "Even if they knew their patients well, it was important for them to take their patients' vitals and help them set long-term goals." Then, at the final group session, providers could assess their patients' progress toward those goals and plan for the future.
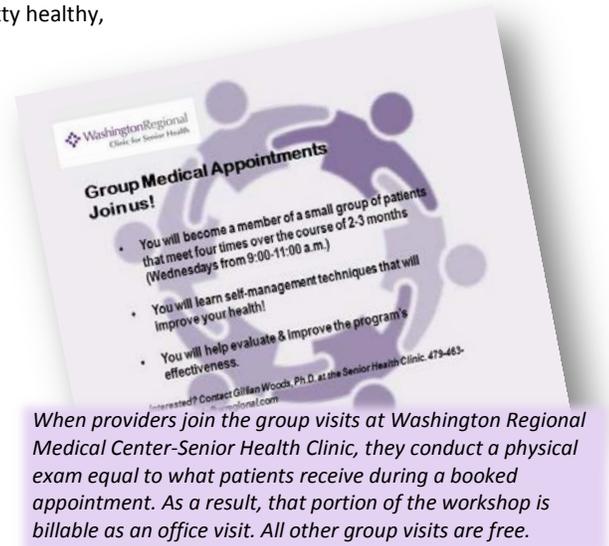
Inspiring candid discussion: Woods invited all of the practice's patients and caregivers to attend the group sessions, but capped the number of participants at 15 (attrition reduced that number to around 10 patients per visit). Woods also decided not to limit discussion to a set topic. As a result, the conversations were patient-driven and often surprising. "The patients shared health information that we hadn't heard before," said Woods, who lead the group sessions. "We'd ask, 'Why haven't we heard about this?'" Woods stated that the response was consistent: the issue—whether it was someone suffering from loneliness, arthritis pain or a newly developed tremor— wasn't "pressing enough" to bring up during a brief, one-on-one doctor's appointment. Such concerns could be shared in a supportive, group environment, however.

Facilitating referrals: That was the beauty of the group setting, Woods noted. "We could casually ask someone, 'Well, have you seen a doctor for that?' We have somebody right down the hall.'" When Woods determined that a participant could benefit from seeing one of the many specialist teams that are integrated into the clinic—for movement disorders or memory issues, for example—she gave a warm hand-off to the appropriate team.

Emphasizing self-management: While they appreciated ready access to additional services, the majority of group session participants wanted to learn how to cope with the physiological changes that come with normal aging, Woods noted. An exercise physiologist attended a session to explain why some physical activities are better than others for easing wear and tear on joints, for example. This led to a robust exchange of personal tips and recommendations. The participants, all of whom were women, "were very supportive of each other, and they received that benefit of peer knowledge."

Participants were also eager to discuss how to boost brain health and stave off cognitive declines—a frightening topic for many because "we don't want to talk about it," Woods said. Her group participants learned specific techniques, such as deep breathing and simple yoga-inspired body movements, designed to calm an anxious brain. "It's important for people to truly understand how the brain responds to such activity," Woods stated. "When the doc suggests yoga, it's because it truly does change chemistry of the body."

Future Plans: While the initial group visits were open to everyone, Woods noted that the senior health clinic also held classes, free of charge, only for patients newly diagnosed with dementia. There will be more open group visits in the future, and the clinic plans to offer group visits devoted to helping patients cope with Parkinson's disease. Woods' peers within the Washington Regional Medical System who are interested in offering group visits at their clinics, which Woods enthusiastically supports. "It's neat that this idea is being replicated."

CPCPracticeSpotlight84

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Geriatric Care Coordinator Boosts Patient Confidence, Satisfaction

Family Practice of Middletown; Middletown, N.J.; system-affiliated; 4 full-time physicians, 1 part-time physician; 8,000 patients

Situation: At **Family Practice of Middletown**, the providers and staff previously felt it was challenging to respond to the frequent calls from and about elderly patients who were homebound or living in a skilled nursing, assisted living or rehabilitation facility. They had to juggle these requests at the same time they were seeing other patients in the office, which sometimes caused interruptions in office visits. In response, the practice developed the Geriatric Care Program. The geriatric care coordinator is **Shirley Bennett**, LPN.

How it works: The Geriatric Care Program of Integrated Medicine Alliance (IMA) is staffed this way:

- One full-time physician and one full-time nurse practitioner for patients in skilled nursing, assisted living and rehab facilities. They care for 175 patients.
- One part-time physician and one part-time nurse practitioner who make home visits for 118 homebound patients.
- Four physicians rotating the on-call geriatric schedule.
- All six primary care practices in IMA refer patients to the program. In total, these practices have about 40,000 patients.

Shirley Bennett, LPN, is the geriatric care coordinator. Patients rely on her, asking for her by name. "I've had patients call me from their bedside," Bennett said.

Bennett works with providers, patients, families and the staff of care facilities to coordinate care. Throughout the day, she addresses a variety of issues, including requests for orders on new admissions. She responds to the concerns of patients and their families, and meets with physicians several times a day about different patients.

"There is a lot of trouble-shooting involved, especially with the home care patients," said **Bonnie Thompson**, lead patient care coordinator for Family Practice of Middletown.

Patients and families are pleased with the program, and with Bennett. "It's good for them, they are able to contact me and get their message to me," Bennett said. "There's better coordination with the doctors."

The program was recognized by the **New Jersey Academy of Family Physicians** with its "Patient-Centered Innovation Award."

In their application for the award, the physicians with Family Practice of Middletown wrote, "We hired a nurse dedicated to geriatric care coordination. Dedicated phone and fax lines were installed and all calls regarding these patients were diverted from the front desk to this nurse. She became familiar with the patients, staffs and families and strong working relationships quickly developed."
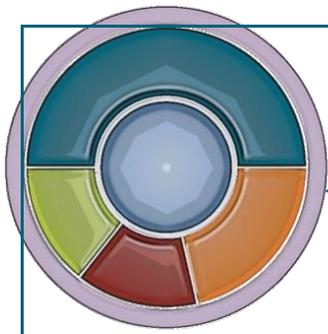
Patients and providers have benefited in the following ways:

Increased patient confidence: Elderly patients and their caregivers "are more relaxed, they are more confident that someone is taking care" of their concerns, Bonnie Thompson said.

Patient care at home: Dr. Thompson knows the value and effectiveness of home visits, having included them as part of his delivery of care for more than 30 years. As the practice expanded and patients aged, more people needed home visits, another reason for the founding of the Geriatric Care Program. Elderly patients who cannot drive especially appreciate the home visits.

Better communication: Having a Geriatric Care Coordinator benefits patients, their families, physicians and the staff at skilled nursing facilities. Shirley ensures that providers and family members understand the plan of care, which has reduced duplication of services and has increased shared knowledge about the patient's condition.

Dedication draws additional patients: In their application to NJAFP, the providers stated, "We have increased our nursing home census by 20 percent and our home care census by 75 percent. We feel these increases are due to our improved dedication to this population, as evidenced and experienced by the facilities, patients and their families."
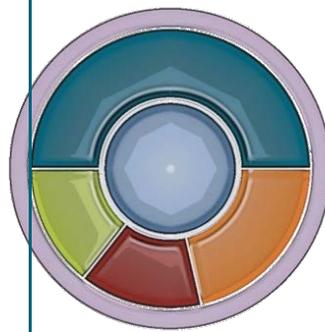
CPCPracticeSpotlight85

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Expanding Access to Care Through E-visit Technology

St. Elizabeth Physicians, greater Cincinnati region; hospital affiliation; 14 CPC sites; 444 providers, 300,000+ patients

Dec. 2, 2016

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity

CPC Change Driver 4: Optimal Use of Health IT

- 4.1: Develop practice capacity for optimal use of EHR

Situation: In 2014, when **St. Elizabeth Physicians** (St. Elizabeth's) decided to offer patients the option to seek virtual treatment for non-urgent medical issues, some physicians were hesitant. However, St. Elizabeth's early adopters, **Karl Schmitt, MD**, and **Bradley Gray, DO**, embraced the innovation and were determined to convince their colleagues to do so as well.

Strategy: The first step toward gaining widespread provider approval of the approach involved convening as many physicians as possible to "define which health conditions could be appropriately diagnosed through the e-visit framework," said Dr. Gray. "We made sure to ask, 'Given this set of symptoms, would it be reasonable to treat them via the patient web portal?'"

Patients **must be established patients** *to take advantage of the e-visit service. In addition, patients* **must** *be over 18 years old, enrolled in MyChart and have been seen by their PCP in the in the previous 12 months, if over 40, or in the past 24 months, if under 40.*

No substitute for a face-to-face. While roughly 21 common ailments have been cleared for the service, including sinus problems, pink eye and the flu, some symptoms, such as shortness of breath, lightheadedness and chest pain will immediately disqualify an e-visit. "The patient receives a message, stating that their symptoms indicate that an office visit is in order," Dr. Schmitt explained. Quality of care is never compromised.

Tackling technological misgivings. "We noticed that some of the discomfort stemmed from the asynchronous nature of e-visits," added Dr. Schmitt. It was important, then, to draw parallels to other uses of technology in primary care. "Many physicians had been providing diagnoses over the telephone for decades because it was a technology they were comfortable with," explained Dr. Schmitt. He often reminds providers that they can query their e-visit patients at any time via email. While not a "live" conversation, it is a two-way information exchange.

According to Drs. Schmitt and Gray, another advantage e-visit technology has over the telephone is that the visit is automatically documented. Patients are required to use the web portal offered by the EHR to request an e-visit, and the robust technology provides a treatment summary along with educational materials and follow-up instructions. For instance, a patient who was set to travel to Belize requested an e-visit to secure the appropriate vaccinations. Her doctor sent an order for the shots and a prescription for anti-diarrheal medicine to her pharmacy, where she could get the vaccinations and pick up her meds in one visit.
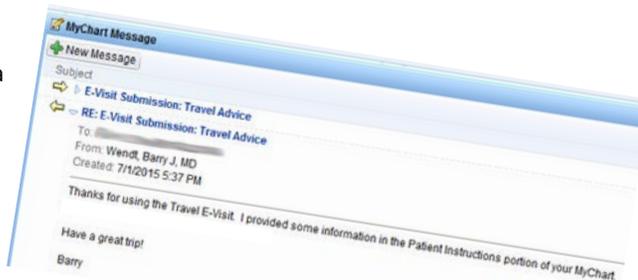
Providing incentives. St. Elizabeth's primary care providers are "strongly encouraged" to participate in the e-visit program, said Dr. Schmitt, who explained that for every e-visit, providers receive $25 of the $35 patient copay. What's more, he added, because the e-visits align with CPC milestones, and because striving to meet those goals is tied to the physician payment structure, providers have a strong incentive to embrace the technology.

Specialists are not currently asked to accept e-visits, although Dr. Gray believes more will explore the option in the near future. "We have an access issue in our region," he stated. There aren't enough dermatologists, for example. Patients often wait weeks to get an appointment. "But if a patient has a rash, he could take a picture of it and upload it to the portal." Treatment could begin right away.

Patient approved. When St. Elizabeth's debuted its e-visit program in 2014, service hours mirrored those of the practices that participated; evenings and weekends weren't included. That was a small misstep, Dr. Gray stated. If they were to do it again, he said, they would immediately provide such coverage "because that's where you see the real growth." If the numbers are any indication, patients agree: in 2014, 82 patients made e-visits. They are on track for 4,800 e-visits in 2016.

CPCPracticeSpotlight86

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Pre-visit Planning Helps Eliminate Gaps in Patient Care

Taking care of many tasks before the visit gives physicians more time to spend with patients

Upper Valley Family Care, two offices (Troy, Ohio and Piqua, Ohio); independent; 5 physicians, 2 PAs; 2 nurse practitioners; approx. 12,000 patients

Situation: At **Upper Valley Family Care** in Ohio, the providers and staff were looking for a way to make visits as efficient and useful as possible. They developed a system of pre-visit planning where, through careful coordination, a patient's health care needs are comprehensively addressed while they are in the office.

By the time the physician steps into the exam room, he or she has a printout of the patient's recent lab results in hand to give to the patient, and a nurse has already talked to the patient about what treatments or screenings may be necessary.

"When the doctor walks through the door, they can focus their time and energy on the patient," instead of searching for lab results or other information, said **Candy Lavy**, nursing supervisor.

How it works: Pre-visit planning at Upper Valley Family Care involves many people. **Joan Hansen**, business supervisor, described their system:

1. The process starts at the time the visit is scheduled, either with the schedulers or the check-out receptionists. The purpose of the visit and any relevant information needed for that visit is entered on the provider's schedule. For example, if the purpose of the visit is to go over radiology results, the scheduler enters the name of the test and where the test was done.

2. **Chart prep** is done one business day ahead of the scheduled appointments, usually by a medical receptionist. Each provider's schedule is printed, showing who is coming in, when and for what purpose. By looking at the schedule, the care team knows what test and other information is needed.

3. The practice uses i2i (a population health management system) for the chart prep report and patient visit summary.

4. At each appointment, before the physician comes in, "the nurses do a lot of work with the patients," Lavy said. "They put in the chief complaint (reason the patient is there today), check their blood pressure, ask patients with diabetes what their blood sugar has been."

*From left to right: **Beth Burroughs**, population health manager; **Candy Lavy**, nursing supervisor; and **Joan Hansen**, business supervisor.*

To learn more about their pre-visit planning system, watch their webinar "Pre-Visit Planning to Improve Workflow, Engagement and Care Outcomes," presented as a Rapid Cycle Action Group on August 17, 2016, and available on CPC Connect.

Gradually building to new goals: The practice began using this pre-visit planning system in December of 2015, and introduced changes incrementally, so as to avoid change fatigue with their staff. "In the beginning, we were out to conquer everything, but we quickly decided that was too overwhelming and too much to accomplish. So we decided to pick quarterly targets and build off of those targets," said **Beth Burroughs**, population health manager for the practice.

For their first-quarter target, the practice chose **depression screenings** and **falls risk assessments**, to be included in quarterly visits for patients with a chronic condition, as well as annual physicals for all patients. "So each quarter we add to our targets, but we do not drop any item off the list," Burroughs said.

Currently, "with it being flu season, when we run the i2i reports, we can see if the patient is due for a **flu vaccine** or a **pneumonia vaccine**," Burroughs said. In this quarter, they are also emphasizing **lung cancer screenings** for smokers and **colonoscopies** for eligible patients. "We try to catch as many of the care gaps as we can," she said.
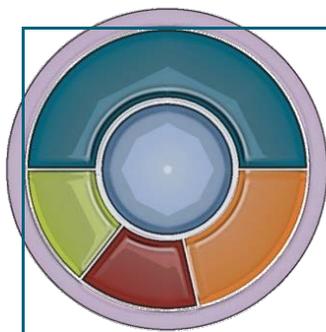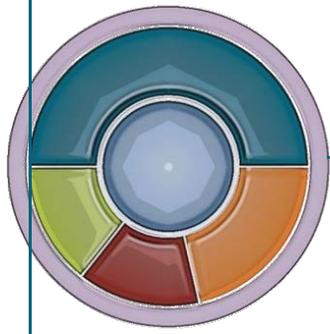
CQM Measures: The pre-visit planning system has had a positive impact on the practice's CQM measures as well, with data from i2i showing improved CQM in Hemoglobin AIC control, as well as LDL management and other areas. "We've definitely seen a positive turn" in the months since they implemented the system, Lavy said.

Provider and patient satisfaction: The physicians like the new system, as it "makes their jobs easier and faster," Lavy said. Because so many tasks are taken care of beforehand, physicians have more time to talk with patients and listen to their concerns. According to a survey the practice conducted in Oct. 2016, patients are satisfied too. They appreciate the paper copies of their test results, which they can bring home for their own records or share with a specialist. "I think our patients are more satisfied because they're getting everything that they need here in one visit," Lavy said. "They're getting everything done, their refills, their questions answered. It's been a very positive thing for us."

CPCPracticeSpotlight87

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Refining and Persistence Pay Off in Continuous Improvement
Integrated Medical Group, Kettering Physicians Network, greater Dayton region; 4 providers; 2,900 patients

Situation: When **Katherine Clark, DO** and the practice team found it difficult to replace staff at **Integrated Medical Group (IMG)** of the **Kettering Physician Network,** team members also learned that the issue affected the remaining staff's ability to make follow-up calls to patients discharged from area hospitals. As a result, the practice met to problem solve for a different approach.

Strategy: Dr. Clark and the staff decided to implement a two-part process with a back-up plan: the care navigator would log the calls she made in a spreadsheet and then turn in those logs to the practice manager each day. The practice manager could then commit additional resources, if necessary, to ensure patients were contacted within 72 hours of leaving the hospital. "Creating the plan helped us focus," said Dr. Clark. The plan also helped IMG better fulfill what she believes is an essential aim of comprehensive primary care transformation—to ensure that the care patients received while hospitalized is integrated with the care their primary care physician provides. "It's about taking care of those ongoing relationships," said Dr. Clark, who explained that she has always been interested in treating the "whole person," and that means knowing when and, more importantly, what care her patients need outside the practice—information that her staff now collects regularly and efficiently.

*Katherine Clark, DO, center, has been with Kettering Physicians for more than two decades. She and her staff at IMG—**Williene Deavers-Isa, LPN,** left, and **Julie Clemmer**, front desk lead right—huddle daily and meet weekly to enhance communication.*

Steady, continuous improvement. While the team was happy with the new follow-up call strategy, Dr. Clark understands that transforming health care delivery is a long-term effort. "Refining how we work is a way of life," she stated. She and her colleagues have been, and remain, "continually focused" on making improvements in how they operate. For example, the practice emphasized hospital and ED follow up in daily huddles and team meetings when it became apparent communication among staff members needed to be more timely and consistent. The key is to keep trying, Dr. Clark noted.

Meanwhile, IMG remains committed to broadening the primary care services it can offer patients, the majority of whom receive Medicare or Medicaid. "We now have a health coach and have recruited a psychiatrist to address behavioral health issues." Dr. Clark and her nurse also have extended hours four nights a week. "I try to see patients on the same day they ask to be seen."

Emphasizing 24/7 availability. However, when patients can't come to the office, Dr. Clark reminds them to call for urgent problems. "We all take calls from our patients after hours. We want them to call us and not head to the emergency room unless it's truly necessary. As a practice, we all do a much better job now of providing medical advice over the phone and computer."

The practice staff and patients make frequent use of MyChart on Epic for non-urgent communication and to access health self-management tools. For example, if a patient with diabetes has a goal to better control blood sugars, there are resources available through the portal as well as support from the health coach. "The patients' goals, along with those we may have for them, are built into the portal," Dr. Clark explained. After-visit summaries, along with lab results, are also made available to patients, and many have become accustomed to checking such results. Indeed, after logging in, one of Dr. Clark's patients discovered he had "failed" a stress test. "He called and asked, '*What should I do?*' before I had even seen the results"

This willingness to take charge of his health impresses Dr. Clark and is one reason she fully embraces CPC's change concepts, one of which is to provide self-management support for patients with poorly controlled chronic conditions. "It's very satisfying to see somebody, over time, make a significant health improvement," she said. "When my patients get their health issues under control, it's a celebration!"

Dr. Clark also celebrates how CPC has spurred improvement at her practice. She is a true believer in the initiative. "I've always wanted to provide comprehensive care," she said, and she is hopeful other providers will join her ranks. "Years ago, students weren't choosing family medicine for residency for multiple reasons," Dr. Clark stated, adding that she has noticed an increase in students' interest. Dr. Clark believes that this new trend reflects a shift in the philosophy about providing care as more physicians have embraced the Patient Centered Medical Home model, changes in payment and, of course, CPC. "CPC is certainly shoring up primary care."

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