

CPC Practice Spotlights

This list contains **CPC Practice Spotlights** published between January and December 2015. These feature articles highlight the work of CPC practices.

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CPC Practice Spotlight

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

Feb. 6, 2015

This strategy addresses these drivers:

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.4: Patient and Caregiver Engagement

Change Driver 3:

Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

Change Driver 4:

Optimal Use of Health IT

- Continuous Improvement of HIT

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



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Patient Engagement Matters

De Queen Family Practice, De Queen, Arkansas; independent; 1 physician, 1 NP; 3,500 patients

This interview was recorded at the Arkansas Learning Session, Nov. 13, 2014.

I'm Angie Walker. I'm office manager for Dr. Randy Walker, and we're located in southwest Arkansas, De Queen, Arkansas. We have a physician, a nurse practitioner and of course support staff. We provide care to approximately 3,500 residents there, and we offer lab services, radiological; pretty much you know anything that we can do to take care of our patient.

Why was your practice interested in the CPC initiative? We're always looking for a challenge, and so I like the idea of it. We were starting to get bored with medicine, bored with what was going on, and so this is a way for us to ratchet it up both for patients and for the providers and for our staff. And so we were just very excited about that. Any time you can offer more or be more to your patient or your customer you have to jump at those opportunities.

What was new to you in CPC? Mine's probably going to be patient experience and satisfaction. I had never really given a thought to engaging the patient, sending the patient a postcard, sending the patient a reminder; it just never dawned on me. I just thought the provider told them when to come back, and they came back. And so we started slow. We started sending out a few mailers, and we're really excited about the way that patients grasped it and then actually made those appointments or took care of that preventative service. Also, you know we sent out that first survey and I thought oh this is not going to fly. And we sent out 1,300 surveys, and got 900 responses, and so we were just floored. And so we knew at that point that patients were engaged; they were just waiting on us. And so that kind of spiraled into okay, we've got to do more. We've got to get them, you know. We've got to start texting them. We've got to email. You know we've got to do something. And so we did that for the last year in our EMR, and then found that it just wasn't doing enough as far as the patient engagement portion of it, and did a rip and replace and had found one that's very engaging with the patient and love it. We also do our patient advisory board. You know I'd never really thought about asking the patient you know what they thought or what they wanted. We have 18 members that are both patients and stakeholders in the community; they represent different professions: pharmacy, teacher, nurse. And it's wonderful; I have guinea pigs, and so we meet a couple of times a year and we let them know what we're doing; where we're moving towards, and then we give them the opportunity to speak freely and say yes I like that service or no I don't, or you know basically anything that comes out of our clinic before it goes to our patient population it goes through them first. And so we're able to gauge that reaction, and so it's nice.

How you share survey results with your patients? We work closely with our local community college, and so they help us with the surveys. We distribute the surveys. They take them in, and then they do the results. We then put those into run sheets you know within Excel. We'll design a flyer or a postcard or something like that. That'll get mailed out to the patient. We'll also post it on either our Facebook or website and kind of gear them towards looking at it. They're in the office at the checkout window, so they can pick it up and take it with them when they go. We mail it in their statements, or if we're going to mail a reminder or something like that it goes with them as well.

What changes has your practice made based on this feedback? One of them was going to be access. You know our big question was, "Have you ever called our office and had an emergency and were unable to be seen?" And of course, you know we had feedback that yes, we did. You know we have an access issue. And so we went back and we took the nurse practitioner. We took some of her schedule and made it same day only. We then took one spot for every hour of Dr. Walker's schedule and said no this is for same-day only. And so we make sure our patients understand that we do have same-day access. We also do the 24/7 access where they have access to a nurse after hours, and so she has that at her disposal as well. And so if that patient calls and says, "You know I think I'm, you know I'm sick. I don't really—I don't know if in need to go to the emergency room or not." she has those appointments at her disposal, and so she can also help that patient make a good decision about whether going to the ER is appropriate or just coming in the next morning is more appropriate. Probably one of the other ones was communication. Our initial survey said you know that they really didn't receive a lot of communication from our office, and it was true they got no communication from our office because we simply didn't think about it. And so we've kind of been watching that over the last couple of months, and we're seeing of course those numbers are going up because we're probably communicating them to death now. But you know it's exciting. You know you love it and so now we're at the point where we're like, "Okay are we're sending you too much stuff?" And so far it's no, but you know we're going to have to get some kind of a schedule as far as how many times we send something out. So, but I mean, so far they love it.



CPC Practice Spotlight

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

Feb. 13, 2015

These strategies stem from

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.3: Risk-Stratified Care Management
- 1.4: Patient and Caregiver Engagement
- 1.5: Care Coordination Across the Medical Neighborhood

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

For more information about the CPC initiative, visit

<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>.



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Care Team as a Partner in Wellness: Helping Patients Improve Health with Lifestyle Modifications

Moreno Medical Associates, Jersey City, New Jersey; solo practitioner; 2,014 patients

Situation: Margarita Borghini, MD, witnessed a rising number of patients diagnosed with diabetes in her practice in 2014. As she spoke with these patients, it became clear that many did not understand how their long-term health was tied to maintaining their HgbA1c and LDL values within a normal range.

Strategy: After 13 years in practice, Dr. Borghini understood the futility of simply directing a patient to lose weight, start eating better and exercising. She recognized that patients frequently receive these instructions

as strategies to improve their health. However, patients typically do not receive active support to manage and maintain these strategies in a way that results in sustainable changes.

Working with **Christine Pipchick, PA**, Dr. Borghini began to engage with her patients differently by “partnering” with them through education, self-management support and accountability, using lifestyle modifications as the anchor for achieving better health.

Through the practice’s EHR, Dr. Borghini identified a group of patients with HgbA1c >8 and LDL >120 or who were obese (BMI >30). The practice contacted all patients in this group, either face-to-face during appointments, by phone between appointments or with a letter if the patient was not likely to be seen soon. They were invited to come in for an office visit solely focused on wellness and nutrition. This appointment started with a detailed history of the patient’s weight, which often revealed that life events or specific circumstances led to the weight gain, while others struggled with obesity all their lives. Frequently, patients’ untreated behavioral health needs complicate their ability to manage their weight. Dr. Borghini referred these patients to behavioral health specialists as the needs were identified.

The appointment then focused on nutrition, education and goal-setting. Dr. Borghini provided healthy eating education, supported by visual teaching aids such as a portion control plate. Together they discussed and set patient-desired goals, which the provider documented in the patient’s record and care plan. Finally, the care team provided patients a food diary and a booklet that summarizes the information from the visit. Dr. Borghini emphasized to patients that this is a group effort, and she and her team will all coach, encourage and celebrate patients as they progress.

To provide patients with an additional support system, Dr. Borghini hosts a Healthy Living Action Group that meet in the practice waiting room on Friday nights. Group size has ranged from three to 15 participants.

Dr. Borghini moderates the discussion in English and Spanish as needed, guiding the group to share and discuss issues relating to the lifestyle changes they are making to improve their health.

The care team supports the patients in tracking their wellness goals by providing easy access to the patients whose health goals include losing weight. These patients are able to visit the office at their convenience during regular hours to check their weight. The medical assistant (MA) weighs the patient, records the weight in the chart and does a quick check-in with the patient about their progress toward achieving their goals. This process takes fewer than five minutes. Typically, four patients per day visit the office to check their weight and touch base with the MA. The care team believes these check-ins further build continuity and a sense of team support for the patient’s efforts.

In 2014, Dr. Borghini tracked the HgbA1c and LDL levels for the patients diagnosed with diabetes. One of the two examples shown in Figure 1 (above) represents the results attributed to a patient whose A1c dropped from 10.3 to 7.7 over the year. Rather than changing the patient’s medication, the care team provided nutritional education as a way to meet her lifestyle modification plans. As a result, the patient used portion control to manage her daily rice intake. Dr. Borghini says successes like this demonstrate how “meeting the patient where they are,” and engaging with them on their goals can result in long-term and positive effects on their health.

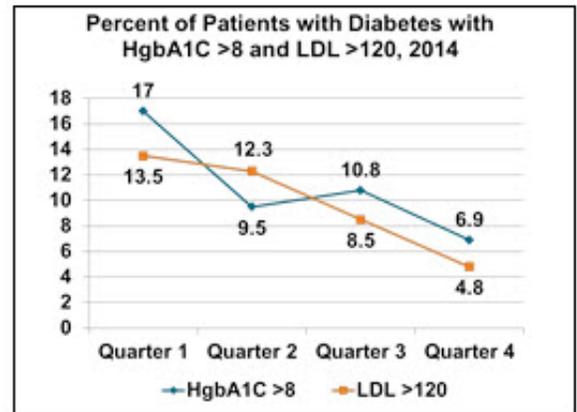


Figure 1: Realistic goal setting, support and education have helped Dr. Borghini's patients improve their overall A1c and LDL values.



CPC Practice Spotlight

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

Feb. 20, 2015

These strategies stem from

CPC Change Driver 1: Comprehensive Primary Care Functions

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

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review
- 3.2: Culture of Improvement

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Effective, Meaningful Shared Decision Making Has a Learning Curve for Both Providers and Patients

CapitalCare Medical Group, Albany, New York; multi-specialty; 58,000 patients

Situation: With 10 CPC practices, **CapitalCare Medical Group** balances supporting the needs for its 10 offices and maintaining autonomy at each site, while simultaneously building effective workflow processes that would not derail daily schedules and locating aids from credible sources. At the point of care, providers found that shared decision making (SDM) varied according to patients' expectations, preferences and willingness to engage with the care team. Providers realized that to move toward an effective SDM conversation fostering bi-directional communication with the patient is fundamental.

Strategy: The quality team at CapitalCare provided each CPC site with data to guide selection of conditions where SDM in preference-sensitive care* could be applied meaningfully within a manageable patient population size. While each site selected its targeted conditions, members of the quality team supported sites by identifying tools and aids that were affordable, clinically appropriate and formatted to promote a structured conversation between the patient and provider. This allowed sites to maintain their autonomy in implementing SDM while establishing a consistent approach to standardization regarding reporting and monitoring. Their initial selection of eligible patients for SDM includes those receiving a new diagnosis within the last six months for one of the targeted conditions.

A simple, streamlined workflow eased integration into daily routines. Eligible patients are flagged during pre-visit planning and daily huddles. The provider orders and prints the decision aid, and then discusses the options with the patient during the encounter. The order is completed when a decision is made either at that visit or at a follow-up. The team at CapitalCare warns against building in too many "clicks" in the EHR or adding convoluted steps that do not align neatly within the regular workflow. Also, they note that implementation goals in the first measurement period should consider the care team's learning curve. Once SDM fits seamlessly into the workflow, they anticipate the rates of decision-aid use will increase, patient-provider relationships will be further enhanced and patient outcomes will improve.

While SDM was warmly received by CapitalCare's Patient and Family Advisory Councils, patient response varied. A few patients shied away from engaging in the decision or would only skim the materials, preferring the physician recommend the optimal course of treatment. Others would delve deeply into the information, sometimes frustrated that a single, "best" treatment option was not clearly delineated.

William Busino, MD, an internist at two CapitalCare sites, saw SDM as a valuable tool in the patient-provider relationship. Even when patients chose not to engage in SDM (with decision aids or discussion), offering options (when appropriate) is optimal care. When providers at CapitalCare see their colleagues' patients about treatment or diagnosis for which preference-sensitive care is appropriate, they are fully aware of the information provided to the patient, which improves consistency of communication. SDM aids also help zero in on what the patient needs and expects with regard to treatment and outcomes, which supports patient-centered care. Further, the continued interaction between patient and provider when weighing the options pairs well with ongoing self-management support conversations, where patient engagement helps drive improved health and outcomes.

The quality team at CapitalCare would like to measure SDM beyond fulfilling the steps at point of care and be able to pinpoint improved patient outcomes. At this place in the CPC initiative, the span of treatment time and numbers of patients cannot demonstrate that improvement. However, they remain committed to SDM knowing that measurement will be a "marathon" and not a sprint.

*Preference-sensitive care comprises treatments for conditions where legitimate treatment options exist – options involving significant tradeoffs among different possible outcomes of treatment (some people will prefer to accept a small risk of death to improve their function; others won't). Decisions about these interventions – whether to have them, and which ones to have – should thus reflect patients' personal values and preferences and should be only made after patients have enough information to make an informed choice in partnership with their provider.

CapitalCare's selections for preference-sensitive conditions and aids:

- Cholesterol – [Option Grid](#)
- PSA – [Option Grid](#), [USPSTF](#)
- Antibiotics for pharyngitis – [Option Grid](#)
- Menopause – Mayo Clinic (no longer available online)
- Sciatica – [Option Grid](#)
- Knee Pain – [Option Grid](#)
- Diabetes – [ACP](#)
- Obesity – [ACP](#)
- Hypertension – [ACP](#)



CPC Practice Spotlight

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

March 13, 2015

This strategy stems from

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.3: Risk Stratified Care Management
- 1.5: Coordination of Care Across the Medical Neighborhood

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review
- 3.2: Culture of Improvement

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Following Data Over the Long Term Aids in Maintaining Improvement

Central Oregon Family Medicine, Redmond, Oregon; independent, 2 physicians; 3,100 patients

Situation: At the start of 2013, **Central Oregon Family Medicine** (COFM) identified tracking and follow-up on specialist referrals as an opportunity for improvement. Anecdotally, the team at COFM knew that gaps existed in documenting and confirming specialist referrals, appointments, screenings and other treatment notes. However, without a standard workflow and method to capture and analyze data, they were unable to determine how much improvement was needed or how to assess where the practice could intervene to improve the process.

Strategy: COFM looked to develop a workflow that would touch on several points in the referral process and the ensuing follow-up to ensure patients were seeking and receiving timely specialty consultations recommended by their PCP.

By the second quarter of 2013, **Mark Hughes, DO**, and partner **Bruce McElroy, MD**, along with the practice team, had designed a process that would “tag” each outgoing referral in the electronic patient record, and that tag would remain open until the specialist’s notes were received in the practice. Additionally if testing and/or screenings were recommended in conjunction with the referral, those would be tagged in the EHR and remain open until results were received. Tagging the referral and the labs/screens separately effectively wraps around the referral process to ensure completion.

Each week the practice’s medical assistant (MA) runs a report to identify open tags in patient records. If she can reconcile a lab report or the specialist’s consultation notes to each tag, she closes the tags. Other tags may be marked pending (i.e., patient not yet evaluated or notes not yet received). If a consultation note is not received within four weeks of referral, the MA calls the specialist’s office to follow-up. However, the RN care manager makes the contact if the patient in question has been assigned to her due to high or escalated risk. Her familiarity with these patients’ complex conditions is often pertinent in these contacts.

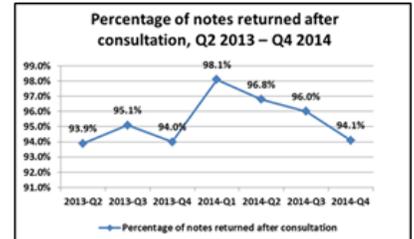
If the specialist indicates the patient has not scheduled the appointment, the MA (or RN care manager if appropriate) reaches out to the patient to assist with setting up the appointment and resolving barriers as needed.

Dr. Hughes can run the reports by provider or service, allowing him to track communications patterns and pinpoint specialties where follow-up consistently lags beyond four weeks. The practice mails a letter to these providers, reminding them of the necessity of timely follow-up and requesting compliance with this standard of care. COFM has found this strategy highly effective. In the rare instances where communications and notes remain delinquent after the letter is sent, a practice physician sends a follow-up letter to the lead physician in the specialty practice. This physician-to-physician outreach generally resolves remaining issues.

The practice has tracked four metrics related to referrals since Q2 2013: total patients referred, patients seen/consult notes returned, patients seen/no consult notes returned and patient not seen. The data from 2013 show incremental improvement nearing the practice’s goal of 100% follow-up. Over the following months, improvement dipped slightly, prompting the practice to again make additional efforts with identified providers. While the practice can consistently monitor the referrals and take corrective action as appropriate, 100% compliance remains dependent on specialist practices’ willingness to collaborate on timeliness.

To help maintain the COFM team’s focus on these metrics, Dr. Hughes and Dr. McElroy use the weekly practice-wide QI/CPC meeting to review their efforts and brainstorm new approaches. One tactic has been networking within the physician community at professional events. Dr. Hughes reports that discussing COFM’s focus on specialty follow-ups as well as other CPC-related work has sparked the attention of his peers. Knowing that COFM tracks response rates has appeared to influence more timely communication among specialists.

While COFM has not reached its 100% goal of follow-up from specialists, this process has increased the likelihood that patients are seeing their specialists and getting their recommended screenings and tests.



COFM has tracked percentage of referral notes returned to the practice since Q2 2013. COFM attributes the uptick in Q1 2014 to the practice identifying trends among providers and reaching out to them specifically.



CPC Practice Spotlight

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

March 27, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.3: Risk Stratified Care Management
- 1.5: Coordination of Care Across the Medical Neighborhood

Change Driver 2: Enhanced Accountable Payment

- 2.2: Analytic Capability

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review
- 3.2: Culture of Improvement

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Critical Elements in Care Management: Process/Data, Protocols and Reinforcement/Response

Sangre de Cristo Internal Medicine, Pueblo, Colorado; solo practitioner; 981 patients

Situation: When solo practitioner **Doug Duffee, MD**, considered how to implement effective care management as a support to overall comprehensive primary care in his practice, he saw a range of disparate activities and functions that needed to come together and function in a uniform process. Dr. Duffee also understood that to make it work efficiently and effectively, he needed to be willing to take risks and make transformative changes, such as expanded access discussed below.

Innovation: Dr. Duffee's approach is a series of interrelated but hierarchical processes that drive toward the outcome of effective and efficient care management. His intention was to "re-engineer" how his practice works by hardwiring steps of service across the continuum of care to ensure consistency and thoroughness.

The overarching effort focuses on creating a uniform **QI process with data capture** that identifies all areas to be monitored. In one spreadsheet Dr. Duffee tracks 19 care coordination measures including the number of acute appointments and timeliness of scheduling (same day or within 48 hours), patients' ER visits, hospitalizations and re-admits as well as the subsequent care coordination follow-up phone calls. A second spreadsheet covers care management activities, including rates of use for seven shared decision making aids, contacts/outreach for high-risk disease management (diabetes, CHF and asthma) and NQF population health measures. From this spreadsheet, Dr. Duffee has identified specific areas for improvement and then follow-up with targeted interventions. Further, he can quantify total utilization and associated costs.

For each targeted activity, the office follows standard **in-reach and outreach protocols** for risk- and disease-based care management, self-management support and care/transitional care coordination. For example, the care coordinator calls for an ER follow-up by phone using a script to ensure conversations with patients consistently touch on all key risks associated with poor outcomes. Ensuring all team members follow the same steps for each area of coordination further strengthens the validity of the data tracking these activities. Having documented protocols also helps staff recognize when interventions are in place for improvement and maintains consistency in that improvement effort.

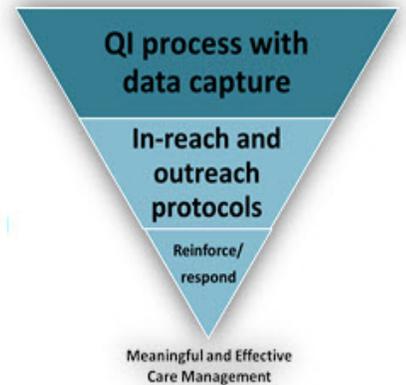
Lastly, regular QI meetings with all staff **reinforce the processes** and provide opportunities to **respond to the data**. When Dr. Duffee first introduced these changes in 2013, the staff met every two weeks to review progress and brainstorm strategies to strengthen processes and improve performance. Together they review spreadsheets to gauge their progress. As they have worked through the most obvious snags in processes, the meetings have moved to a monthly schedule. Using the same spreadsheet tools over time has supported sustainability in the practice's efforts as well – all staff know what it is being tracked and what efforts need maintenance or increased support.

Among the risks Dr. Duffee weighed was expanding same-day access and using telephone triage to assess urgency of patient complaints. He pointed out that telephone triage is difficult depending on the patient and the nurse's ability to assess. While the goal is to keep patients from unnecessarily using the emergency room, the flip side is that primary care physicians don't want a patient with a heart attack coming to the office for care with potential life-threatening delay in treatment.

Transformational change that the practice undertook was to provide the continuum of care management and care coordination services to all patients, regardless of payer reimbursement for those services. Dr. Duffee noted that many of his colleagues felt deluged by utilization data, anxious that insurance company administrators would dictate that physicians run their practices to meet or beat the numbers. Dr. Duffee interpreted the rush of data as an opportunity to correlate quality with a lower cost of care, namely providing the expanded, appropriate care at the primary care level that would overall lower utilization costs for the entire patient population.

Payers can be partners in care management and population health, he said. For example, when he has a particularly complex patient, he will contact the payer's nurse care coordinator for assistance. Because payers' nurse navigators are making the patient follow-up calls as well, he sees coordinating with them as leveraging their engagement and creating a synergy between the practice's care management and the payer's efforts.

The consistent use of data to measure progress, and continuous process improvement has resulted in a consistency in care management, and indeed total population management. Partnering with payer care managers has expanded the work of the team, with the patients coming out as winners in the end.





CPC Practice Spotlight

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

April 10, 2015

This strategy stems from

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.3: Risk Stratified Care Management
- 1.4: Patient and Caregiver Engagement
- 1.5: Coordination of Care Across the Medical Neighborhood

To see Hunterdon's SMS intake packet, follow [this link to the CPC Collaboration site](#).

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



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Beyond Patient Education: Self-Management Support

Hunterdon Family Practice & Obstetrics, Flemington, New Jersey; independent, 5 physicians, 2 NPs; 6,000 patients

Situation: Health care providers as well as patients often mistake self-management support (SMS) as a variation of patient education. While providing information is a part of SMS, the larger framework of an effective SMS program is “the systematic provision of education and supportive interventions by health care staff to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting and problem-solving support.”*

Strategy: **Hunterdon Family Practice & Obstetrics** engages patients in SMS by way of a structured SMS visit where patients are guided to take the lead on improving their health through appropriate goal setting, planning strategies to overcome barriers and using the practice’s guidance and support.

The practice offers SMS to patients based on their general risk status, a poorly controlled disease state, provider referral and patient expression of interest. About 60 patients are currently enrolled, two-thirds of whom have been recently identified as high risk for developing diabetes. To date, three SMS patients have “graduated” by meeting their goals, such as controlling their A1c and lowering their lipids.

Providers introduce patients to their “health coach” (an RN care coordinator) either during an office visit or at a later scheduled appointment. During this 30-minute meeting, the nurse describes SMS and health coaching to the patient, framed as the patient learning to take charge confidently of his or her health with the health coach providing support, guidance, information and resources as needed. Together they review a few pages of SMS materials, starting with the definition of SMS and health coaching and then assessing the patient’s confidence in self-management with an 11-question survey. The nurse then offers a PHQ-2, a two-question depression screening tool, and if needed, a PHQ-9 is provided as follow-up.

The SMS appointment continues with the nurse guiding the patient in tailoring a one-page personal action plan. With the nurse’s assistance, the patient describes his or her goal and then maps out steps toward success. This includes describing barriers and strategies to overcome them. Next, the patient rates how well he or she understands why the goal is important and how confident he or she is about making this change. Finally, the patient sets up a follow-up plan.

The health coach call patients every two weeks until the patients demonstrate progress and a plan to sustain that progress. The calls are then made monthly. The practice offers to contact patients through the portal, but coaches have found that patients prefer a phone call. The coaches often call patients when new lab results come in — it’s an opportunity to check in, celebrate progress or re-assess patient confidence in meeting goals. Coaches report that patients tell them they enjoy the real-time opportunity to ask their health coach questions between check-ins. Providers also assess their patients’ SMS progress during regularly scheduled appointments.

Hunterdon has found documenting SMS a work in progress. While process measures such as patient goals and follow-up phone calls are easily tracked in the EHR, the practice follows their SMS patients’ progress by tracking outcomes in a spreadsheet. Health coaches record lab results, assessment scores, PHQ scores, and any community resources patient’s access to support their goals as well as notes from their check-in calls. To keep the team updated on SMS patients, weekly team meetings with providers and care coordinators, and the practice culture also encourages “drive by” questions from care coordinators as needed throughout the day.

While SMS is intensive work, Hunterdon providers find the successes highly rewarding and worth the effort. Helping patients live healthier lives is why they sought health care careers. Success with patients confirms it was the right choice.

*Source: Institute of Medicine. Priority areas for national action: transforming health care quality. Washington, DC: National Academies Press; 2003.

SMS at Hunterdon:

“Patient A is overweight and has hyperlipidemia. At our first meeting, she set a goal to lose 15 pounds in three months and make healthier food choices. As we talked, she realized one of her barriers was that she did not know how to put herself first so that she could focus on eating better and exercising. The more we talked, the more she realized its importance, and that it was okay to put herself first.

I also recommended that she schedule an appointment with the nutritionist at a local grocery store to learn about healthier food choices and meal planning.

At the follow-up phone call, she reported that she is exercising three times a week for 30 minutes on her treadmill and that she chooses raw vegetables as snacks instead of chips and candy. She had lost 5 pounds. Most importantly, she stated that she feels better both physically and emotionally because she is putting herself first to manage her health. I gave her positive feedback and encouraged her to keep going.

Our next call will be in a month.”



CPC Practice Spotlight

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

Teamwork, Transparency and Rewards Drive Improvement in Quality Measures

PriMed Physicians, Dayton, Ohio; multispecialty (6 CPC sites); 30,167 patients

April 24, 2015

These strategies stem from

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.3: Risk-Stratified Care Management
- 1.5: Care Coordination Across the Medical Neighborhood

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review
- 3.2: Culture of Improvement

Change Driver 4: Optimal Use of Health IT

- 4.3: EHR-Based Quality Reporting

For more information about the CPC initiative, visit

<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>



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Situation: In early 2014, clinical leadership at PriMed Physicians began planning how to implement CPC clinical quality measures (CQMs) at its six CPC sites. At that time, PriMed was concurrently implementing multiple other measures associated with PCMH and payer initiatives as well as regulatory measures. In the past, when new initiatives were rolled out, PriMed physicians expressed some concerns about how they could achieve goals. First, physicians often perceived that they would need to do the work individually, and second, the new processes would disrupt and slow their daily schedules, resulting in hectic, stressful days for everyone on their teams.

Strategy: PriMed pursued three strategies to help physicians and their teams adapt and embrace integrating the CPC CQMs: teamwork, data transparency and rewards for performance.

Teamwork. CPC CQMs and other Milestone work clearly depend on effective teamwork for implementation. Knowing this and that physicians would need to see some early wins to lend their support to the work, PriMed jump started the process by emphasizing a whole team approach. Daily huddles included everyone from the front desk to the care coordinators. Attendance in huddles is also a metric included in the physicians' individual scorecards. When the practice clearly expected every role to contribute to the CQMs' success, this motivated how teams performed. The resulting gains demonstrated to physicians they have support from a capable team in the new endeavors. Once physicians were confident their teams could carry out the work, their positive influence further encouraged the teams' progress toward goals. Success with this approach is seen in the data sample shown in the inset where the pilot site for implementing the depression screening workflow doubled its rates of PHQ orders in two successive quarters.

Data transparency. Sharing data sparks friendly competition among teams as well as clearly recognizes high performers. All teams see outcomes by clinic site and physician team (see sample above for the PHQ screenings). In 2014, the data was run quarterly to share with teams; in 2015 with the learning curve with new processes behind them, teams will begin seeing data monthly.

Starting in fall 2014, PriMed provided physicians with individual score cards displaying performance metrics, which included five CPC-related metrics such as depression screening and care conferences (Milestone 2), monthly adult patient meetings (Milestone 4) and following hypertension processes (Milestone 5). Each metric is also tied to a larger goal such as quality, patient experience and physician/personal experience. This again connects daily work to the larger goals the practice has targeted.

Rewarding performance. "Treating You Well" is PriMed's tagline for both patients and employed personnel. PriMed acts on this by recognizing high performers at meetings and practice events, as well as through financial incentives. Storytelling has been particularly effective at all levels of the organization. When team members share success stories with peers and leadership, they help teach best practices, model leadership and confirm goals are attainable. Physicians earn individual incentives based on results from their score cards, and teams are recognized and rewarded, too.

Combined with the three strategies described above, PriMed leadership emphasizes two key components to engaging physicians and their teams: follow through and consistency. Teams operate effectively and with confidence when clinical and administrative leadership is a steady influence.

Office & Provider	% PHQ Resulted Orders				Change [Q1 to Q4]
	Q1	Q2	Q3	Q4	
SITE 1 (Started pilot in Q1)	11%	20%	54%	57%	46.1%
DR A	6%	17%	60%	58%	51.6%
DR B	20%	29%	65%	65%	44.8%
DR C		11%	27%	45%	
SITE 2	0%	2%	14%	28%	27.6%
DR D	0%	0%	13%	22%	22.0%
DR E				21%	21.3%

Above: A sample of 2014 quarterly data (de-identified) that is shared with all PriMed physicians. As of 2015, outcomes data is tracked monthly. A separate dashboard displays physician performance on 11 measures, each tied to a larger strategic goal.



CPC Practice Spotlight

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

May 8, 2015

These strategies stem from

CPC Change Driver 1: Comprehensive Primary Care Functions

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

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

For more information about the CPC initiative, visit

<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>



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PDSA Cycles Focused on Reducing Falls Risk Help Reduce ED Use

Family Medical Group Northeast, Portland, Oregon; independent; 5 physicians, 1 NP, 9,600 patients

Situation: At a spring 2014 Oregon learning session, the care management team at **Family Medical Group Northeast** (FMG) learned about falls risk assessment and saw it as an opportunity for their practice. However, the practice was in start-up mode on multiple other CPC-related activities, and falls risk was tabled for future consideration. In fall 2014, FMG was surprised to see that their internal tracking data showed nearly 31% of their patients' ED visits in Q2 were attributed to "falls, injury or laceration," which renewed their interest in pursuing falls risk assessments.

Strategy: Although FMG had deferred working on falls assessments, the care managers began the background work to launch an initiative, including developing potential workflows and processes for testing as described below.

When physicians saw the care managers had completed most of the prep work for implementing a new screening into workflows with the work spread across the team, they readily endorsed the plan and testing began. FMG's first quarter goal was to screen 80% of the practice's patients 65+, regardless of falls history (1,608 patients), and the practice would run data weekly to monitor progress. FMG ran a series of PDSAs through fall 2014 to test multiple tactics. In September 2014, medical assistants began giving the screening to patients as they roomed them. Data showed rates lagged considerably behind expectations; one cause was lack of time. If the patient was running late or the staff needed to make up time in the schedule, other parts of the workflow such as depression screening took priority over the falls screening.

A second test was to screen patients during an October 2014 flu shot clinic, which would attract the same target group of patients and their families. The practice set up an information table during the clinic, and a staff person was available to answer questions and offer a same-day screening. Unfortunately, turnout for the clinic was unusually low. However, all eligible patients who came in for a flu shot (five) were also screened for fall risk.

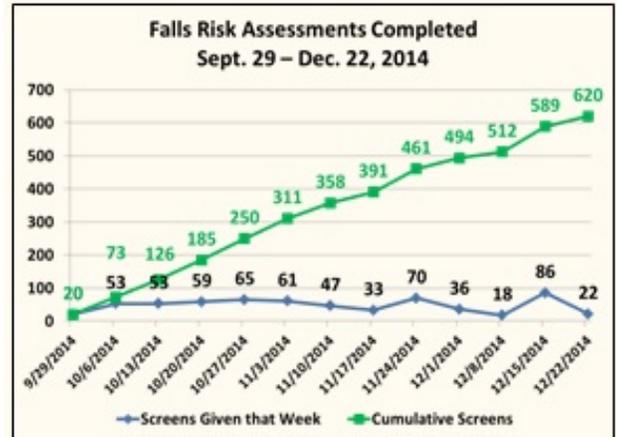
Next the practice conducted a PDSA cycle with a direct mail outreach. In mid-November, FMG mailed 75 patients a packet containing a letter of explanation; the falls risk screener and a pre-addressed return envelope to facilitate the response rate. Only 10 patients put their names on the returned screeners. Because FMG provided its own envelopes in the mailing, the practice was unable to track the remaining responses. For the follow-up PDSA in early December, staff put patient names on the mailed screeners. The response rate increased to 83%, but staff and care managers noted that the follow-up for the positive screeners was more labor and resource intensive than the screeners administered at point of care. *A positive screener in the office could be immediately addressed with the patient, and additional interventions (Timed Up & Go test and education resources) could be completed at the visit. Positive screeners from the mailings required additional phone calls and office visits to complete the work. Although the rate of screeners administered was high, the rate of interventions on positive screeners was lower for the screens mailed.*

Also in November, FMG revisited how to deliver the screeners while eligible patients were seen in the office. For this PDSA cycle, the screener was delivered at check in, which resulted in 100% of eligible patients receiving the screener.

At the end of December 2014, the practice had screened 620 patients. While this was short of FMG's goal – which they admit may have been overly ambitious – several key learnings had emerged:

- Conducting the screeners at point of care allowed for more meaningful dialogue, education and interventions for at-risk patients.
- Direct mailings were resource intensive and resulted in a lower intervention rate for at-risk patients.
- At each ED follow-up call, care coordinators again remind patients about the after-hours call line.
- FMG found that trusted care coordinators can influence patients to call the practice before heading to the ED.

Outcomes: FMG has found monitoring data over time will not only document improvements but reveal additional opportunities for the practice to apply their PDSA skills. For example, data for Q4 2014 showed falls, fractures and lacerations accounted for 21% of ED visits, with eight of the patients identified as seniors with falls in October 2014. Data for Q1 of 2015 shows a decrease in this ED visit category to 17.54%. An audit of those patients revealed a possible second target population: many of the injuries were sports-related in 47- to 65-year-old patients. Another positive data point as of March 2015 is that only one patient over 65 has been seen in the ED for a fall.





CPC Practice Spotlight

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

May 22, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.4: Patient and Caregiver Engagement
- 1.5: Coordination of Care Across the Medical Neighborhood

Change Driver 2: Enhanced Accountable Payment

- 2.2: Analytic Capability

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

Change Driver 4: Optimal Use of Health IT

- 4.2: Data Exchange

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



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Innovative Care Compacts Result in Timely Care, Continuity and Efficiency

Comprehensive Primary Care Services, New Rochelle, New York; solo practitioner; 2,361 patients

Situation: After referring patients to specialists for routine screenings or specialty consultations, **Comprehensive Primary Care Services (CPCS)** repeatedly witnessed a frustrating mix of redundant testing, delayed reports or abandoned appointments. Further, the referral process often bewildered patients, who frequently were uncertain which physician was now leading their care and where they should go for treatment going forward.

Innovation: Focusing on timeliness, patient experience and cost of care, **Ijeoma Nduka, MD**, and **Basil Njoku**, CPCS practice administrator, created a wrap-around process for their practice's referrals to high-volume specialists. Developed in collaboration with specialty providers, this process ensures patients have timely access to a specialist, the patient is prepared and educated on the need for the specialist visit and the patient knows to return to CPCS for follow-up and ongoing care as appropriate. Additionally, specialists are granted temporary access to the practice EHR for the most up-to-date patient information.

Data for Quarter 2 of 2014 showed CPCS sent the most referrals to radiology, gastroenterology and pain management. Dr. Nduka then personally contacted physician leadership at these specialties to propose a care compact agreement. Specialists were initially hesitant, mistaking "compact" as a "contract," or a legally binding agreement. Dr. Nduka clarified that the agreement was to create **an enhancement of a team-based care model that provides greater continuity for the patient across care settings**, which ignited interest among the specialists.

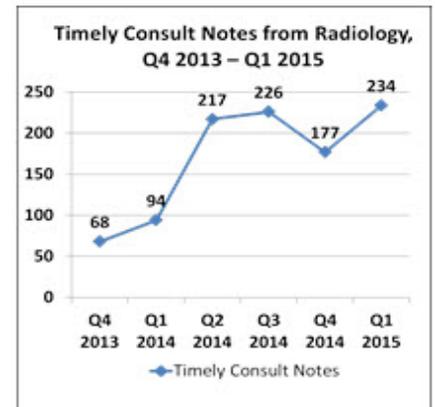
Dr. Nduka then handed the process over to Basil Njoku to finalize with the providers. Using a template as a starting point, Basil collaborated with each provider to work through the finer points. However, **these key points are common across every agreement:**

- The **specialist receives secure access to CPCS' EHR** for a designated period to view pertinent patient history and recent lab and screen results. This eliminates the possibility of duplicative testing.
- The **specialist agrees to see non-urgent cases within one week** and urgent cases within 48 hours. Dr. Nduka's staff will call the specialist to alert the provider if an urgent case needs to be scheduled.
- The **specialist commits to returning consultation notes within 48 hours** of the appointment. Currently these are faxed, and in June CPCS will roll out an option to upload notes directly into the patient record.
- **Dr. Nduka personally prepares the patient.** She explains the consultation's purpose and the follow-up processes as well as emphasizes her role as the patient's primary care provider.
- **Dr. Nduka schedules the patient's follow-up visit at CPCS before the patient leaves the office.** Knowing the specialist will see the patient within a week and notes should be returned two days following the appointment, the CPCS scheduler sets the patient's appointment generally about two weeks later. Urgent cases are seen sooner.
- The **specialist agrees to report any further referrals back to Dr. Nduka** as well as refer only to providers within the patient's network of covered providers.

Dr. Nduka marks referrals as an "in process" or "pending" task, making tracking and follow-up part of everyday workflow. If the consult process is not completed within the expected timeframe, nurses will follow-up with the patient or provider as needed.

As a result of a compact agreement the assurance of a timely appointment with a specialist was the key for a patient of Dr. Nduka's with a high risk for cancer. The patient resisted screening, telling Dr. Nduka she believed she was fated to die of the same disease that had claimed many family members. Dr. Nduka persuaded the patient that early detection and treatment could be the difference for her health. The patient finally agreed to the screening, and the quick response time minimized her anxiety. Unfortunately, the screening showed early stage cancer. The patient is currently in treatment with a positive outcome highly likely. Most importantly, the patient understands that the screening likely saved her life.

Benefits/Outcomes: The timely receipt of consultation notes has dramatically increased (see graph above). Further, patients are less likely to become lost in a referral maze or not pursue specialist care due to lengthy wait times for an appointment.



The data shown here includes all radiology providers, not just those with a care compact agreement. Latest data shows a three-fold improvement.



CPC Practice Spotlight

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

June 22, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

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

Change Driver 2: Enhanced Accountable Payment

- 2.2: Analytic Capability

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review
- 3.2: Culture of Improvement

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



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Million Hearts® ‘Champion’ Practice Honed Performance in Hypertension Control through Multiple Tests of Change

Upper Valley Family Care, Troy and Piqua, Ohio; independent; 5 physicians, 2 NPs, 1 PA; 12,500 patients

Situation: In February 2015, the U.S. Department of Health and Human Services’ Million Hearts® initiative recognized **Upper Valley Family Care** as one of [30 “Hypertension Control Champions”](#) in the U.S. for its success in helping patients control their high blood pressure.

Strategy: Upper Valley’s strategies for improvement originate with “transformation teams,” made up of physicians and clinicians from both sites along with the business manager and the nursing supervisor. The teams’ diverse expertise expedites decision making, plans for training, resource procurement as well as data analysis. To monitor their progress, the team followed the [Million Hearts® reporting parameters](#) and developed rolling 12-month reports. Upper Valley notes that engaged, consistent physician leadership is the bedrock for improvement work and cohesive teams. When physician leaders express confidence in their teams’ critical thinking and assessment skills, this encourages every team member to proactively participate in quality improvement and patient care.

These teams leveraged multiple tests of change to hone workflow, techniques and care management follow-up to improve on strong baseline hypertension (HTN) control among patients with high blood pressure (<140/90).

Timeline Highlights:

2013 Q1 – Transformation teams met to create workflows for initial blood pressure (BP) measurements, follow-up steps in the office (and subsequent visits), as well as ongoing care management for patients working toward HTN control.

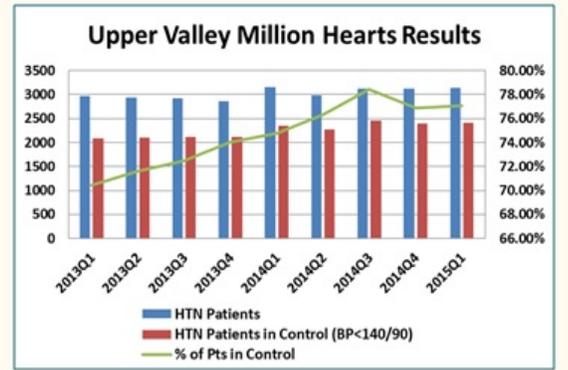
2013 Q2 – Began procuring patient education materials and testing workflows, including identifying where in the workflow to take the patient’s initial BP reading and manual versus electronic measurement (manual technique was not only more accurate, but patients preferred it over the electronic cuff, which some patients found uncomfortable). An evaluation of loaner wrist and arm cuffs for patients to use at home found that wrist cuffs were less accurate, but they were kept in use due to their value in engaging patients in tracking their own BP readings.

2013 Q3 – Both sites implemented the tested workflows and techniques. As care managers and health coaches worked with patients to improve their HTN control through individualized care plans, they used motivational interviewing to shape plans that reflect the patient’s abilities and priorities. As a result, they realized that patients needed materials to support their changes in diet and exercise. The coaches created packets of targeted information (for example, exercise tips for beginners, beginning strength training, goal-focused regimens, etc.), encouraged patients to drop in anytime during regular office hours for blood pressure checks and loaned patients an automated cuff to take at-home readings and send updates through the patient portal. Patients seeking to make healthy eating a priority can meet with the staff registered dietitian.

2013 Q4 – It was observed that measurement techniques varied among staff and was affecting consistency. This was addressed with a refresher training session for clinicians using videos from Million Hearts.® The refresher training then opened a discussion about allowing the patient to rest before taking the reading, which led to additional PDSAs.

2014 Q2 and Q3 – Teams tested taking measurements before and after intake, ultimately finding that readings taken after intake resulted in fewer false positives for HTN. This change in the order of steps led to equipping all exam rooms with cuffs, which was completed in 2014 Q3.

Outcomes and Ongoing Improvement: Over seven quarters, Upper Valley showed continuous improvement in control rates, moving from a baseline of 70.4% to 78.5% by 2014 Q3. Engaged physician leadership and teamwork have helped drive this improvement. The transformation teams are now creating visuals to post in each office to promote sustainability and friendly competition between the sites.





CPC Practice Spotlight

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

July 2, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.4: Patient and Caregiver Engagement

Change Driver 2: Enhanced Accountable Payment

- 2.2: Analytic Capability

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review
- 3.2: Culture of Improvement

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



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Patient-Centered Care Plan Curbs Patient's Hospital Use, Savings to Top \$150,000

Independence Primary Care, Independence, Kentucky; system affiliation; 6 physicians, 1 NP; 9,095 patients

Situation: Suffering from acute anxiety and chronic conditions she struggled to manage, Anna* is a well-known patient to providers at **Independence Primary Care** and **St. Elizabeth hospitals**. A change in symptoms easily caused panic, prompting Anna to call and message **Lori Catanzaro, DO**, or her care team multiple times during the week for same-day appointments. On weekends or late nights, she would seek care at the emergency department. By early 2014, Anna averaged a visit to the ED about every 10 days, and more than half of those visits resulted in a hospital admission.

Strategy: Dr. Catanzaro altered Anna's care plan to ease Anna's anxiety and build her self-management confidence to help her seek care at the appropriate setting as needed. Starting in March 2014, Dr. Catanzaro scheduled Anna for weekly appointments. The Monday afternoon office visit served three purposes. First, Anna wouldn't miss work to make her appointment, which lessened that source of stress. Second, if she had a concern over the weekend, Anna knew she would be seen on Monday and wouldn't need to resort to using the ED for care. Third, the set appointment eliminated the disruption for practice staff of continually working Anna into the schedule.

Knowing this intensive care management approach hinged on Anna's buy-in, Dr. Catanzaro had a frank discussion with Anna at the start to set boundaries. The team committed to helping her improve her health, but Anna had to stick with the schedule and follow through as asked.

Every 10-minute appointment had a consistent pattern of self-management support and patient education. While everyone on the team worked with Anna, Dr. Catanzaro proved to be the most influential communicator. She repeatedly educated Anna about her care and how and when to contact the physician office according to her condition and needs. Previously, Anna would call Dr. Catanzaro, then her medical assistant and then send messages through the portal (EPIC's MyChart). The flurry of communication often had several people working through Anna's messages concurrently. Teaching Anna to use the portal for non-urgent issues – and assuring her that Dr. Catanzaro's team would respond within a couple of hours – gradually decreased the multiple calls and emails.

Because the team communicated about Anna's current status during pre-visit planning, it became obvious to Anna during the office visits that her physician and care team were kept informed about her MyChart messages and her specialist visits. This added another layer of assurance that her needs were acknowledged and being met.

The after-visit summary also served as a self-management tool for Anna. She was encouraged to refer to it for physician instructions, reminders about upcoming specialist appointments and other messages pertaining to her current state of health. Prior to this coaching, it was not unusual for Anna to leave an appointment and then send a follow-up question through the portal because she forgot what was directed in the office visit.

The team was "insistent and consistent" about Anna's follow through medications and specialist referrals – especially counseling sessions to help with her anxiety. The medical assistant or a healthcare advocate would call her between appointments to further encourage her to keep her specialist appointments as well as informally check in on her status.

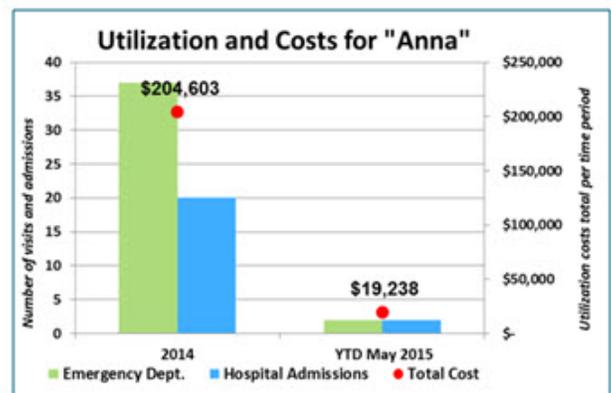
The frequency of Anna's appointments made her a familiar face in the office. As she built a friendly rapport with the staff, she came to see everyone as someone on her team. This further aided her willingness to make improvements in her health.

Outcomes: As of May 2015, Anna has been to the ED twice and had two admissions for a total utilization cost to date of less than \$20,000. If this improvement rate holds steady and Anna continues to avoid seeking unnecessary care through the ED, this will reduce her health care expenditures by more than \$150,000 in 2015.

Anna's ability to confidently self-manage continues to improve. Her follow-up with specialists and behavioral health providers is more consistent, and she has remarked to her care team that she feels she's "getting better." She will now occasionally cancel a standing appointment when she feels she's on track and doesn't need the check in.

Anna's story and how Dr. Catanzaro's team used a tailored approach to address Anna's needs has been shared across the St. Elizabeth's system as a model for patient-centered care.

* Name changed to protect patient privacy.





CPC Practice Spotlight

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

July 17, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

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

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

A Simple Ask: How One Request Can Quickly Engage and Activate Patients

Firstcare Medical Group, Lyndhurst and Verona, NJ; independent; 5 physicians, 8 PAs; 14,000 patients

Situation: George Ambrosio, MD, knows that patients who follow a tailored plan of care are more likely to successfully manage their health conditions. He follows a simple two-part process to engage his patients with obesity and a co-morbid condition. First, he asks them to track behaviors that affect their health. Second, when patients return for the critical follow-up visits, he starts and maintains a collaborative dialogue based on what they learned.

Innovation: When patients track their behaviors, it sparks what Dr. Ambrosio calls their “mindfulness,” which opens the way to meaningful activation and engagement in their care plans.

Tracking is kept simple and tailored to the patient. To help patients track their daily activity by way of counting their steps, the practice provides a pedometer or shows the patient how to download a fitness app to their smart phones. Patients also track three foods, such as sugary drinks (including alcohol), bread and cheese. The food log is adapted to the patient’s lifestyle and habits and patients may substitute other foods to track, such as candy, rice or fried foods. However, the list is limited to three foods to keep it manageable for the patient.

Patients then bring completed logs to the follow-up appointment, which is timed according to the patient need for support. This varies between a week to four weeks, but the necessity of a timely follow-up visit is emphasized to the patient as an important part of the patient’s care plan.

Before each follow-up visit, care managers call or text patients with encouraging reminders about logging activity and food choices. They offer support or share helpful resources, such as [The Walking Site](#). This outreach helps keep patients on track and it also assures patients that Dr. Ambrosio and his team are available to offer continual support.

At the report back and every follow-up visit, Dr. Ambrosio starts by asking, “Where’s your log?” and “How do you think you’re doing?” Then he listens. Patients frequently take the lead, sharing revelations, such as “The five coffees I drink every day have 14 teaspoons of sugar each,” “I eat ice cream every night” or “walking around the block is easier than I expected.” This heightened awareness then guides collaborative goal setting between Dr. Ambrosio and his patient, based on the patient’s abilities, feedback and willingness. He believes patients respond because they feel genuinely listened to and cared about, and “no one cares what you know, until they know you care,” he says, paraphrasing Teddy Roosevelt’s famous quote.

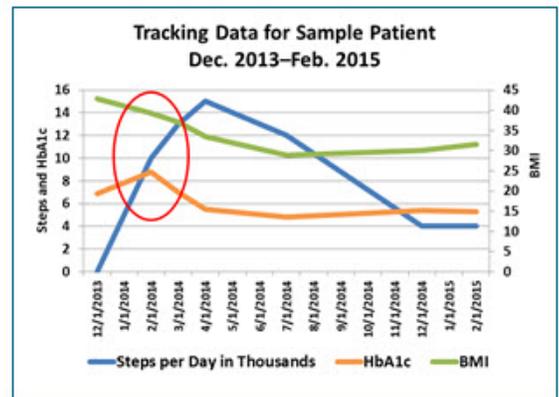
Dr. Ambrosio also explicitly tells patients that “exercise is medicine.” He points to research from the [American College of Sports Medicine](#) that shows consistent exercise over time can create the same health benefits as many prescribed medications. Hearing their physician “prescribe” exercise stresses its importance and helps patients correlate increased activity to their overall wellbeing and not just a weight-loss strategy.

One example of how this engagement helped a patient is shown in the chart on this page.

Dr. Ambrosio and his team had been treating Barb*, a middle-aged, obese woman with diabetes, for many years. At a December 2013 check-in, Dr. Ambrosio asked her to start tracking her daily steps and three foods. By February 2014, Barb made considerable progress, averaging 10,000 or more steps per day. Over 12 months, her BMI dropped from 43 to 27 and her A1c dropped from 7.5 to 5.2. In late 2014, she wavered from her exercise commitment and by February 2015, her BMI increased to 31 and her A1c to 6.2. Barb is currently working on increasing her exercise and is back on track to once again improve her BMI and A1c.

Sustainability: Dr. Ambrosio believes the challenge is to maintain the patients’ mindfulness of their behaviors after they have achieved their health outcome goals. Patients with acute needs are seen frequently, but those who reach their goals have less intensive care management from the practice. To this end, Dr. Ambrosio is exploring how patients can stay engaged by reporting steps and other metrics through an online platform. This would help patients and their care team monitor and promote healthy behaviors before adverse health outcomes develop.

*Name changed to protect patient privacy.



Above: Run chart used with patient described in this story. The red oval highlights a point of considerable improvement and correlates to the patient’s increased exercise.



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CPC Practice Spotlight

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

July 31, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.4: Patient and Caregiver Engagement

For more information about the CPC initiative, visit

<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>

Developing a Highly Effective PFAC over Time: How Structure and Transparency Foster Useful and Actionable Feedback

Batesville Family Practice Clinic, Batesville, Ark.; independent; 6 physicians; 8,800 patients

Situation: When **Batesville Family Practice Clinic** first implemented a patient and family advisory council (PFAC) in 2013, the early meetings were not promising. Only two patients came to the kick-off meeting, and in later meetings, patients' feedback was not always useful. Some patients focused on narrow topics of interest to them, while others were reluctant to offer any constructive criticism.

Strategy: Batesville regrouped its efforts and broadened recruitment to build the council's size and diversity. They also pursued a more structured meeting style where being open about their need for improvement would facilitate participation and actionable feedback.

Recruitment — Combing through their panels, physicians and nurses nominated patients and caregivers from various backgrounds, family types and professional experience for the council. They also included "chronically displeased" patients to ensure representation of an array of viewpoints. Care managers called the nominated individuals, describing the PFAC's function while inviting them to serve as advisors. Further, they stipulated conditions for participation included regular attendance and adherence to the council's bylaws.

Structured Meetings — In addition to setting bylaws for conduct and participation, Batesville cultivates a structured environment in its PFAC by using the rules of order to run meetings. Council members receive agendas and a call for discussion topics prior to meetings, which not only remind them about the upcoming meeting, but it helps them prepare for discussions and stay on topic. The agendas also eliminate repeating previous topics.

Transparency — To elicit meaningful discussion from the council, Batesville shares its patient survey results as well as findings from in-house occasional surveys. Data from quality improvement projects are also reviewed in council meetings. By giving the council a complete view of the clinic's activities and challenges, it helps them to provide actionable suggestions for improvement. Further, transparency has fostered rapport over time between the council and the Batesville team. As suggestions are carried out and shown to be successful, the "chronically displeased" members of the PFAC have turned into cheerleaders. Other members see the transparency as proof of the practice's genuine commitment to improvement.

Participation and Actionable Feedback — Council members are treated as experts on the patient experience, which demonstrates how the practice values the council's input. Their fresh perspective also helps elevate the need to address patient concerns that might not have been a priority for the staff to resolve. For example, the council pointed to lengthy wait times as a negative experience for patients. Their recommended solution was for the staff to check-in with patients who had been waiting 15 minutes past their appointment time and provide a status update or explanation. The PFAC understood that tweaks to workflows and schedules were solutions but reminded them that patients value a personal touch too.

An example is their suggestion to post an "Ask for a List of Your Medications" sign at checkout, a simple solution that allows patients to track their current medications plus gives them a list they can share with other providers.

The council also suggested reducing patients' frustration with "phone tag" by having patients' emergent phone calls roll over to the care managers if that patient's nurse was unable to take the call.

Outcomes: Two years later, Batesville convenes a 10-member PFAC that provides astute guidance on patient concerns and perspectives. Its advice influences improvement across all aspects of the clinic, such as a robust New Patient Welcome packet with an array of practice information along with reminders about calling the practice before using the emergency room. The council advocated for education materials written in plain language and suggested posting education information in designated areas. The council assisted in developing a comment card (shown above) and brochures about the patient portal and community resources. The clinic tracks satisfaction and comments from the comment cards to keep tabs on trends as well as interviews patients during their visits about changes made in the clinic. Batesville's approach had risks, such as openly sharing deficiencies and including their critics on the PFAC. However, taking those risks has afforded them invaluable insight into patients' perspectives.

Batesville's PFAC suggested using this comment card to solicit regular feedback from patients. Comments from these cards drove improvement on wait times.



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CPC Practice Spotlight

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

Aug. 14, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.4: Patient and Caregiver Engagement

CPC Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

CPC Change Driver 4: Optimal Use of Health IT

- 4.3: EHR-Based Quality Reporting

For more information about the CPC initiative, visit

<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>

A Small Practice and Shared Decision Making: Start Simple to Scale Up

Santiam Medical Group, Aumsville, Oregon; system-affiliated; 2 physicians, 1 NP; 2,430 patients

Situation: This small practice started CPC shared decision making (SDM) in 2014 when testing prostate-specific antigen (PSA) for eligible patients. To date, **Santiam Medical Group** has expanded its shared decision making (SDM) work to mammography and colorectal cancer screening following the same approaches and process measures described below.

Innovation: While only a small number of its patients are eligible for the PSA screening, Santiam Medical Group designed workflows and process measures that could easily scale to new topics as the practice broadened its SDM work.

After obtaining free decision aids on PSA testing from the American Cancer Society, Santiam printed some for patients to use in the office and to take home.

Process measures are tracked within the EHR (Greenway Prime Suite). With help from the Santiam IT department, dummy billing codes and templates were set up to track use of the decision aid. The template documents the patients' eligibility and also their use of the decision aid. If the patient receives the aid, a fake procedure code is entered into a discrete field. The practice has now added a field to record if the patient declined the aid. A search for those codes easily provides tracking data and reports for these process measures. The document template is not associated with a visit and can be pulled into the patient's notes as needed.

As medical assistants (MAs) complete a patient's intake information, they ask eligible patients (men, age 50+, no history of prostate cancer or symptoms associated with that cancer) about PSA screening. MAs document if the aid was offered as well as if the patient accepted or declined the screening.

Factors that affect implementation and outcomes:

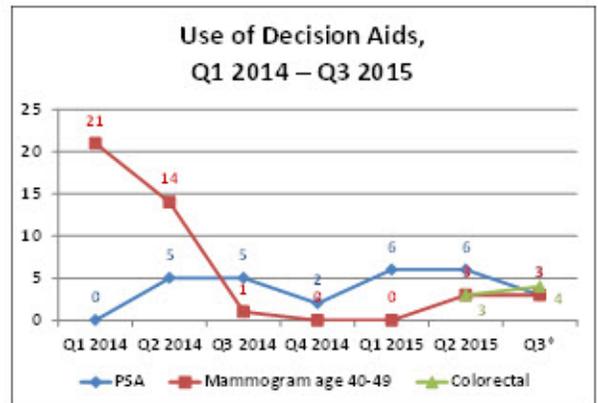
Regardless of practice size, several factors contribute to how shared decision making is deployed into routine workflows.

Focus on effort — Competing priorities and initiatives affecting a larger population can make continuity of effort a challenge. Running data quarterly and sharing about outcomes with the team helps keep the effort visible. At Santiam, physician-led daily huddles include reminders about shared decision making and other quality improvement initiatives.

Clinical judgment — Due to staffing changes, MAs have varying levels of expertise in identifying eligible patients. Training and guidance on patient eligibility is an ongoing process to ensure consistency in delivery and tracking. The practice plans to make all decision aids available in exam rooms for patients to read while waiting. Providers have found that patients will ask questions after viewing the materials, and this helps MAs with identifying eligible patients.

Patient bias, expectations and behaviors — Questions in mass media about the efficacy of PSA screening have swayed patients to particular viewpoint. Conversely, messaging from other health care groups sets the expectation that PSA screening is a "must have" for preventive care. Other patients are surprised that physicians present options for screenings and would prefer to be directed toward the choice most appropriate for them. Although decision aids are generally easy to read with a mix of text and graphics, some patients resist taking five to 10 minutes to read the material and would prefer to have the physician present the options.

Outcomes: Rates have remained relatively stable across implementation (see run chart above). Using templates and dummy billing codes have proven effective for tracking the process measures, and now they are in use as the clinic has started SDM for colorectal cancer screening options (all patients ages 50+) and frequency of mammography (women ages 40–49). Having established workflows for identifying patients and appropriately documenting SDM has made expansion and adoption easier for the care team.

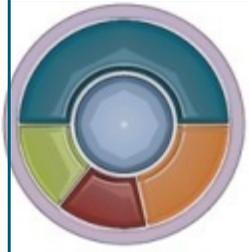


Use of decision aids are documented with a dummy procedure code in the patient record. The practice now also records if the patient accepts or declines the screening. Use of the mammogram decision aid started with another initiative with a high volume requirement at start. Santiam restarted the work in 2015 with CPC tracking measures.

**Q3 data as of July 31, 2015.*



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CPC Practice Spotlight

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

Aug. 28, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

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

CPC Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

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



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A One-Page Tool with Muscle: This Patient Agenda Engages Patients, Keeps Visits on Track and Helps Document BH Screening and the Use of SDM Aids

Sterling Primary Care, Sterling, Colorado; system-affiliated; 2 physicians; 1,650 patients

Situation: Looking for new ways to engage patients and improve their care experience, **Sterling Primary Care** asked its Patient and Family Advisory Council (PFAC) for ideas in early 2014. The PFAC suggested patients complete a pre-visit agenda before their visit. What started as Sterling's simple "why are you here?" form quickly morphed into a highly effective multi-purpose tool that is now available for use across all primary care offices in the University of Colorado (UC) Health system.

Innovation: In spring 2014, Sterling's QI and care management team drafted a patient agenda that front desk personnel would give to patients at check in.

Physician buy-in — Physicians were initially hesitant to add the agenda into the workflow process, concerned that it would derail their already-tight schedules and potentially offend patients. However, the CPC champion physician agreed to test it with his patients. Once he vouched for its benefits — such as keeping visits on track — the practice's other physician was on board.

Testing — The first iteration of the agenda listed only three questions: "What would you like to discuss with the doctor today? Do you need any medication refilled today? Have you been in the hospital or emergency room since your last visit?" When the medical assistant (MA) roomed the patient, she would review the patient's responses and note tasks in the medical record. Within a month, the practice found the agenda streamlined visits, helped prioritize care needs and reduced last minute requests for refills during the appointment. Further, patients appeared to like having some input about their visit.

Seizing another opportunity for efficiency, they then added two more elements: a **behavioral health screen** (PHQ-2) and a **physician expectation** section. The volume of positive depression screens, while surprising, revealed a clear need for behavioral health services. A positive PHQ-2 leads to a PHQ-9, and if needed, an immediate warm hand-off to the care manager for a specialist referral or a consult with a co-located behavioral health specialist. The MA completes the physician expectation section (marked as "nurse only" on the form) during pre-visit planning. When patients receive the agenda at check-in, their type of visit (for example, well woman or physical exam) is checked off and their current diagnosis listed. The purpose is to share with the patient what the physician expects to discuss at the visit.

Lastly, to help shore up gaps in documentation, the practice added a checklist of the **shared decision making tools** at the bottom of the form. Tools used in the visit are checked off here. When the visit is completed, the agenda is routed to the care manager, who double checks the documentation in the EHR. Once she's confirmed documentation, she shreds the form.

Benefits and outcomes — Sterling's physicians value the time saved with the use of agenda. If the patient has complex needs, the nurse will review the form with the patient to set priorities and to schedule additional time as needed.

And, because physicians can then quickly assess the patient's acute needs and concerns against the diagnosis list, they have a better picture of what's happening with the patient and what needs to be addressed in the visit. Often they must focus on behavioral health issues first, as depression or anxiety may be complicating other conditions and affecting the patient's self-management skills.

Nurses find the agenda helps them communicate more meaningfully with patients because they have a better sense of what's important to the patient. They find also that patients are more willing to share embarrassing symptoms or personal information on the form rather than directly tell the nurse. This also saves time in drilling down to what's truly most important to the patient.

Patients who serve on the PFAC report that they felt they had more of a voice in their visits and that they felt listened to during their care.

The screening and documentation sections have provided influential data for the practice to evaluate the need for behavioral health and measure improved use of shared decision making tools.

Finally, as Sterling's physicians and QI team have touted the measurable success of their patient agenda to other UC Health practices, the system has encouraged use of the agenda as a patient engagement tool for all of its primary care practices.

Patient Engagement:

"...actions individuals must take to obtain the greatest benefit from the health care services available to them."

—Center for Advancing Health

How a Patient Agenda Fosters Engagement:

- Prepares the patient and care team for the visit
- Mutually prioritizes concerns
- Builds a relationship
- Makes connections across multiple concerns



CPC Practice Spotlight

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

Sept. 25, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care

CPC Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

For more information about the CPC initiative, visit

<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>



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Measuring the Effectiveness of Behavioral Health Management

Boulder Community Health, Boulder, Colo.; system affiliated (5 CPC sites); 22 physicians, 1 PA; 30,000 patients

Situation: To evaluate effectiveness of its behavioral health (BH) services, **Boulder Community Health** designed a measurement strategy that not only fulfilled CPC reporting requirements but showed the benefit of the services.

Strategy: In May 2015, the BH specialist in one clinic began tracking the PHQ-9 scores among patients with moderate and severe depression following direct treatment. She grouped patients according to baseline PHQ-9 scores: 0–14 is mild to moderate depression, 15–19 is moderate to severe and 20+ is severe depression.

Screening process — All patients ages 12 and above receive depression screening annually. Scores are input in the EHR in an assistant flowsheet that tracks a “yes/no” value for administering the PHQ-2 and provides a drop-down list of values (0–27) for the PHQ-9, if given. The completed PHQ-9 is scanned into the patient record to allow the provider to review and follow-up on specific responses, such as replies to questions about safety.

Providers can access a BH specialist for immediate needs during a patient encounter, for warm hand-offs and for consultations. At this time, one specialist works across two clinics. If she is not available in person for a warm hand-off, the provider can create a task for the specialist to follow-up with the patient by phone to schedule an in-clinic appointment.

Eligible patients — The care teams refer patients to a BH specialist if their evaluation shows a potential benefit from short-term, solution-focused treatment. While patients are referred for a range of behavioral health issues, care teams may also refer patients with behavioral change needs, like weight loss and tobacco cessation strategies.

Patients with complex behavioral health needs, such as severe substance use, chronic and persistent mental illness, or trauma recovery, are referred to external providers and were not included in this sample.

Re-measurement — Patients re-take the PHQ-9 at any time after treatment begins but generally after three visits are completed. Patients meet with a specialist in 30- to 45-minute sessions, up to three times over a six-month period. The BH specialist may administer another PHQ-9 following treatment to assess the patient’s stability.

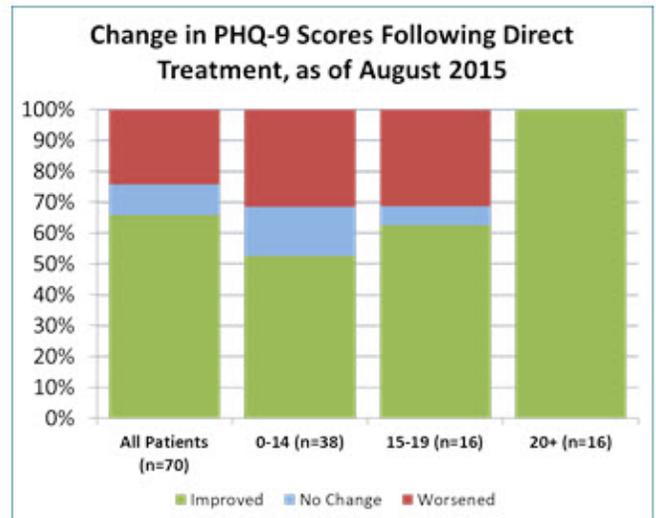
Refinements — Initially the BH specialist measured change in all patients but then further refined the methodology by grouping patients according to the severity of their depression. This allowed the practice to identify which patients benefitted most from the embedded services.

When BH services were first offered, high demand created a four- to six-week waiting time for visits. Boulder reduced the number of visits from six to three to open slots for quicker access. If patients have continuing needs after completing three visits, they are referred to an external provider. Boulder has emphasized with external providers that timely communication about patient treatment is an important part of the practice’s BH approach. Boulder also offers episodic care as needed.

The team currently manually tracks pre- and post-treatment scores monthly on a separate spreadsheet but is working with its IT specialists to integrate tracking into the medical record.

Findings to date: Cumulative data through August 2015 shows 65% of all patients in direct treatment had improved PHQ-9 scores at re-measurement, and all patients with severe depression (PHQ-9 of 20 points or more) had an improved score.

In planning expansion of BH services, Boulder is now pinpointing clinics with the highest volume of patients with high PHQ-9 scores rather than just volume of patients with positive PHQ-2s. This strategy would put timely services within reach of those who need them most.



While all patients with depression appear to have benefited from receiving direct BH services, patients with PHQ-9 scores of 20 or more (severe depression) have the greatest improvement in scores.



CPC Practice Spotlight

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

Oct. 9, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care

CPC Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

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Explore Potential Efficiencies Using Your Patient Portal as an Outreach Tool

Warren Clinic – Tower 900 site, Tulsa, Oklahoma; system affiliated (St. Francis Health System)

3 physicians; 3,727 patients

Situation: As the **Tower 900 site of Warren Clinic** explored the full implementation of its EHR (EPIC), the staff realized the portal could also contribute to managing a quality measure if the practice messaged eligible patients with a call-back request. While this tied into meeting CPC Milestone goals for improving clinical quality measures, the practice's larger, more sustainable intention was to reach out to and manage a large target group without increasing staff workloads.

Strategy: This practice's initial test for efficiency and effectiveness of the patient portal as a communications tool was with a call back message for patients due for colorectal cancer screening. The team is tracking response rates from its July 2015 outreach effort to weigh the portal's effectiveness efficiency and costs versus those associated with traditional mail outs.

Sample group of patients — All patients eligible for colorectal cancer screening — a total of 311 — were included in the July outreach. Of those, 132 patients who were registered in the MyChart portal received a message to call the office about scheduling screening. The balance of 179 patients received a traditional call-back letter with the same message.

Processes — The message in MyChart was set up with existing features in the software and sent to all eligible patients with minimal staff time, estimated at less than one hour, or "just a few clicks," as the clinic reported. To complete the mail out, various team members took on pieces of the tasks between other duties as time allowed. The letters were printed, folded and inserted into envelopes, and postage was applied. Material costs per piece were at least \$0.60 (about \$108 total for 179 pieces), plus staff time. The mail out was completed over the month of July.

Patient response rates — The percentage of patients who responded to the portal message was nearly six times higher than the percentage of patients who responded to the traditional letter. Of 132 portal messages sent, 17% (22 patients) called the practice to follow-up on screening. Only 3% (six patients) from the 179 letters sent called the practice.

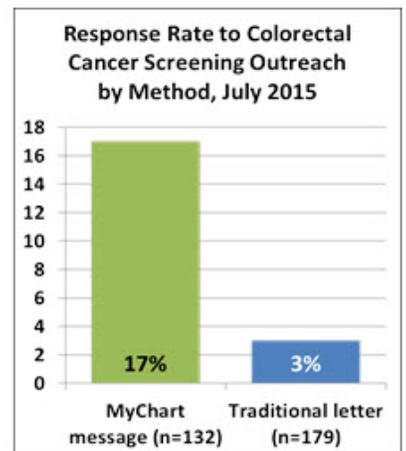
Cost benefits — The costs associated with the portal-prompted responses were a fraction of the mail out's costs. For the 22 responses generated from the portal messaging, about one hour of staff time was used to deploy the message with no associated hard costs in materials. For the six calls to the office prompted by the mail out, each response currently averages about \$15 in materials, postage and accumulated staff time.

The effectiveness of the portal messaging could be attributed to several factors. Because portal messaging is still relatively new to patients, they might assume there's an urgent need to read and reply. It is possible that as portal messaging becomes routine, its effectiveness will wane. An email from the physician office is likely to stand out among a patient's email messages. Patients who access email through a smart phone may also be the type of recipient who responds immediately.

Factors that likely influenced the low response rate to the mailed letters include patients' skepticism that a letter sent through the mail requires an immediate response, even if it comes from the physician office. Or, letters that appear to be part of a mass mailing (i.e., affixed with metered postage and pre-printed address labels) are often mistaken as junk mail and are discarded unopened.

Next steps: This first test shows immediate potential for increased response for multiple patient populations. Tower 900 plans to continue portal messaging to alert patients due for other routine preventive screenings and tests, such as reminders for mammography, another round of colorectal cancer screening prompts and screens for patients with diabetes such as dilated eye exams, microalbumin testing and HgA1c.

The practice has shared its success story and training tips with other Warren Clinic CPC practices, and results from future outreach efforts will be shared across the system in its Quality Improvement Council.



The letter outreach has resulted in only six responses (3% of target) to date. Note that expenses for those responses include more than \$100 in postage and supplies, plus staff time. This roughly equates to at least \$15 in costs per response. The portal message was sent with no hard costs and less than an hour of staff time, and it yielded 22 responses.



CPC Practice Spotlight

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

Oct. 23, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.3: Risk-Stratified Care Management
- 1.4: Patient and Caregiver Engagement

CPC Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

For more information about the CPC initiative, visit

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Shared Decision Making Can Be Part of Behavioral Health

Vanguard Medical Group, Verona, New Jersey; independent; 16 providers; 17,000 patients

Situation: When CPC kicked off advanced primary care strategies in January 2014, the team at **Vanguard Medical Group** was already well underway in integrating behavioral health, having embedded a psychiatric advance nurse practitioner (PsyNP) in its Cranford practice prior to CPC. Now with two PsyNPs on staff, Vanguard saw an opportunity to further broaden patient engagement by adding shared decision making for medications in behavioral health treatment. Their aim was to help patients better understand and weigh options around adding an anti-depressant medication to their treatment plans.

Innovation: Physicians, nurse care coordinators (CC) and the PsyNPs together planned how a decision aid would integrate into BH visits. The practice's existing health library contained four aids addressing specific aspects of depression and medication management, but this team opted to distill key pieces of each aid into a single, introductory-type decision aid. They also looked for content from the National Council for Behavioral Health.

Knowing they often had these conversations when patients were distraught, the goal was to create an aid that would provide a high-level view of options in a brief, easy-to-read format that wouldn't overwhelm a patient. Further, they wanted to be sensitive to the patient's time and level of health literacy.

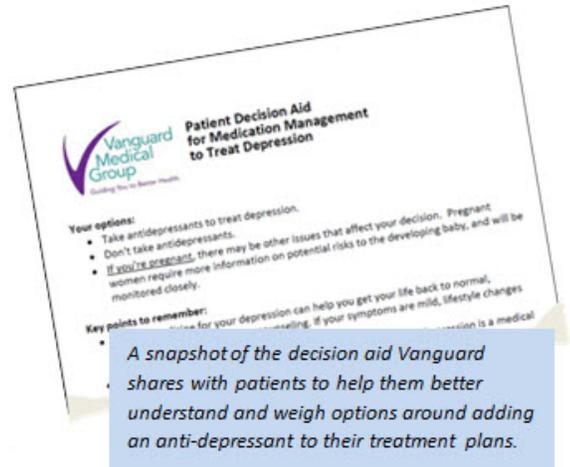
The resulting aid is a single sheet (front and back) in a bulleted-list format that guides a focused decision-making conversation while succinctly framing options around anti-depressants. Along with listing the risks and benefits of using these medications, the decision aid reminds patients that lifestyle choices may also improve depression. It is shared with patients in a hard-copy format during BH appointments with the PsyNP.

Identifying patients – The practice has several processes where patients with depression are identified:

- **PHQ-2 on visit in-take form:** As patients arrive for office visits, the front desk gives them a "My Agenda" form that includes a PHQ-2 at the top. Patients also have the option to check a "There is something else I would like to talk about but prefer not to write" line. The MA records positive screens in the EHR while rooming the patient.
- **During provider encounter:** Providers may flag patients for PHQ-9 screening if they further assess the patient is depressed but didn't self-score as such on the PHQ-2. Also, Vanguard providers have strong experience caring for their empanelled patients, relying on their clinical and institutional knowledge of the patient to order a PHQ-9.
- **During care coordination referrals:** CCs completing transitions of care follow-ups on in-patient hospitalizations and ED visits will screen for depression, especially for patients who recently experienced an unplanned admission and/or a new diagnosis. These situations can be a trigger for additional behavioral health support.
- **Outreach to high-risk patients:** CCs overseeing care plans for high-risk patients routinely screen for depression, with special attention paid to patients who continually struggle to self-manage chronic conditions. CCs make referrals to the PsyNP as part of the care team collaboration.

Implementation and usage of the decision aid – PsyNPs currently use the decision aid to discuss treatment options for depression with eligible patients. Additionally, Vanguard recognizes that more and more often patients seek medication from their PCP before being referred to BH or considering talk therapy. Thus, Vanguard may add the decision aid tool to the PCP workflow to support other providers in having consistent, succinct conversations with patients around treatment for depression.

PsyNPs report that patients generally find the decision aid helpful by providing clarity, especially when the patient is distressed, and by presenting options. Patients also appreciate having the information on paper to take home with them if they opt to make a decision at a later visit. While the practice has more than 150 patients using embedded behavioral health services, total usage among the PsyNPs has remained below 20 patients per quarter total for both PsyNPs. Overall, providers are pleased with the decision aid; other Vanguard PsyNPs use it in their workflows.





CPC Practice Spotlight

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

Nov. 6, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care

CPC Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

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Setting Your Improvement Project in Motion: Get a Quick Start with Pre-Planning, Guidelines, Communication and Tools

Family Physicians of Greeley, Greeley, Colorado; 24 physicians, 3 PAs; 33,000 patients

Situation: A few weeks ago, RN care managers at **Family Physicians of Greeley (FPG)** proposed to their CPC committee that the care management team undertake a short-term improvement project focused on early identification and preventive treatment for COPD. The care managers prepared a brief proposal package that clearly articulated the project, identified resources and laid out a plan for improvement including measures. The pre-work and clear communication about the data-driven need and the expectations helped elicit key physician support to get the project quickly underway.

Strategy: FPG care managers **Kristy Munch, RN**, and **Maria Sanchez, RN**, prepped a two-page proposal that zoomed in on key components. The first page described the current situation, the background and their goal in fewer than 100 words, and the second page delineated the proposed work through a series of lists: a screening process, a workflow and a timeline. The result is a concise yet thorough presentation of the project.

The set up (page one):

The situation – In addition to identifying patients eligible for pulmonary function tests due to their risk factors, the care managers shared data that showed an opportunity for improvement among patients with a COPD diagnosis: “In May 2015, 1,507 FPG patients were identified as having COPD/emphysema/chronic bronchitis/asthma. Only 56% of these patients had a pulmonary function test.”

The background – A driver (or effect) was described here. This proposal cited COPD as the diagnosis accounting for 23% of hospital readmissions.

The goal (aim) – Goal setting for an improvement project must be realistic for the proposed timeframe. This three-month project simply sought to make an improvement on the 56% rate cited earlier as well as to provide patients identified as at risk with preventive interventions. These are attainable, measurable goals for this time period. They also construct a basic framework that could be expanded upon later.

The proposal (page two): This page described the “how” and “who” of making the improvement by listing roles and their responsibilities. This eliminated process gaps and established accountability.

The screening tool – Medical assistants (MAs) would provide a one-page, seven-question screening tool to all patients 18 or older, and/or those with specific risk factors. If the patients’ responses to the tool indicate a risk for COPD and the physician’s assessment concurs a pulmonary function test (PFT) is appropriate, the patient is scheduled for a PFT and referred to care managers.

The care managers’ role – Care managers would complete the follow-up on setting the screening appointment, recording results, referring the patient for follow-up with the PCP as needed and meeting with the patient to create a care plan with self-management support resources.

The timeframe – For the purposes of the CPC rapid cycle action group, FPG set the improvement period as three months. Currently, they expect to evaluate the outcomes in late December 2015.

Progress to date: FPG is a few weeks into their improvement work, and a few issues have emerged. While one MA whose physician is on the CPC committee has become an enthusiastic champion of screening, others have resisted adding the screening to their workflows, citing lack of time. To help them with time management, a care manager sketched out the MA’s workflow as an example for others; care managers continue to work with MAs to blend the screening into their workflows. Another issue is calibrating the demand for PFTs and filling appointments in a timely manner. Screening slots are filling quickly, but patients whose appointments are few weeks out are cancelling their appointments. A key epiphany of this work is that the focused nature of the project permits tweaks and adjustments for improvement rather than overhauling a large, permanent change in office workflow. These limited-focus projects can also be used to test and create lasting change.

FPG’s Process Measures

1. Total number of assessment screening tools completed by patients
2. Total number of PFT screenings complete as the result of positive results on the assessment screening tool and provider assessment

FPG’s Outcome Measure

Numerator:
Total number of patients diagnosed with COPD as a result of positive results on the assessment screening tool and PFT screening

Denominator:
Total number of patients who have been diagnosed and received treatment for COPD as the result of a positive assessment screening tool and PFT screening

FPG helped focus its teams’ efforts by clearly defining how they would know the process is working (the process measure) and how they would evaluate its effectiveness (the outcome measure).



CPC Practice Spotlight

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

Nov. 20, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.2: Planned Care for Chronic Conditions and Preventive Care

CPC Change Driver 2: Enhanced Accountable Payment

- 2.1: Strategic Use of Practice Revenue

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



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Home Visits Help Brittle and High-Risk Patients Stay in the Continuum of Care

Providence Medical Group – Glisan, Portland, Oregon; multi-specialty; 13 providers; 9,723 patients

Situation: Providence Medical Group (PMG) – Glisan has offered home visits with a Family Nurse Practitioner (FNP) to patients on an as-needed and regularly scheduled basis since spring 2014. These visits provide increased support and expanded access for patients whose struggles to come to the office for appointments could compromise their health.

Innovation: Physicians at PMG's Glisan office refer patients to Patricia Green, FNP, for a home visit for multiple reasons. This includes patients who have frequent hospitalizations or who have ongoing medication issues that need monitoring. Other patients may need more support with their chronic conditions or they are bed-bound and cannot easily travel to the clinic without extensive arrangements and support from family. Another group of patients referred to this service includes those whose behavioral health needs in tandem with debilitating chronic conditions make a trip to the clinic an overwhelming event. To avoid the stress, these patients may inadvertently opt out of the health care system, causing their conditions to worsen until they need emergency care or hospitalization.

Green spreads her visits over two days per week, averaging seven visits per day. Her schedule is a mix of routine visits with high-risk patients who need to be seen frequently and patients with acute needs requiring short-term episodic care.

Her office-on-wheels is a wireless-enabled laptop and a rolling bag stocked with clinical supplies. Clinical supplies in Green's rolling bag include a blood pressure cuff, a pulse-oximeter, otoscope, glucometer, venipuncture kit, testing materials for labs (swabs and urine cups/hats) and supplies for wound care and immunizations.

Connected by a hotspot created on her smart phone, Green can access patients' records in EPIC for an up-to-date summary of the patient's recent care, including labs and meds. During her visit, she will complete a home visit summary, a template with more detail than a regular visit that allows her to document the patients' living situation and conditions, other resources/services patients have in their homes and what needs/assessments they may need to remain safely in their current environment. The information is encrypted when transmitted, ensuring patients' privacy.

Benefits and outcomes: Home visits foster a continuity of care from the clinic setting to the home setting (reducing the need for an outside provider). The care is less expensive with a nurse practitioner who collaborates with the physician who has a long-term relationship with patient. The physician can easily refer for home visit, and then the patient can seamlessly return to physician care at the clinic as needed. Also, home visits provide a clear picture of the patient's home environment, which also supports improved quality of care.

Further, adding home visits to Glisan's care management strategy has likely contributed to the practice's significant improvement in unplanned readmissions for Medicare beneficiaries. To date, the practice's four-quarter average has dropped from 203 to 40.

Lastly, Green reports patients tell her they are highly satisfied with home visits. Having a nurse come to them alleviates the stress of managing transportation and appointments, and they get the care they know they need to stay in their homes.

How Home Visits Bridge Gaps

Patient A--When this patient refused to go to her scheduled appointments, concerned family members contacted her primary care physician, who requested Green make a home visit to rule out a medical or behavioral health cause. The NP's examination included labs, which were normal. During the visit, Green noted that despite the patient's declining ability to care for herself and other safety risks, the patient was adamant about remaining in her home. Green engaged the practice social worker to provide resources and options for the family, such as wrap-around care from palliative services and home health. Green continues to visit the patient monthly. Albeit not a long-term solution, these interim safety-net measures respect the patient's wishes and values while keeping her engaged with her primary care providers for care management.

Patient B--This patient with mild dementia was seen in the office for a skin tear resulting from a fall. Knowing transportation was a barrier for this patient who lived alone, the physician asked Green to visit the patient to assess and treat the wound toward healing. At Green's first visit, she assessed the patient had developed cellulitis and thus prescribed an antibiotic. However, this only moderately improved the patient's symptoms, and the culture taken at Green's next visit showed multiple resistant bacteria. This required either an expensive oral medication or IV antibiotics administered through a PICC line at a skilled nursing facility. Weighing costs and potential strain on the patient, the patient's family opted for the oral antibiotic, and Green made more frequent visits until home health could begin 10 days later. To prevent future falls, Green helped the patient's family set up wrap-around PT/OT services for strength and home safety, and the practice's social worker has arranged for community resources to provide more support for the patient. This patient is on Green's slate of regularly-scheduled patients for consistent monitoring of her conditions.



CPC Practice Spotlight

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

Dec. 4, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care

CPC Change Driver 2: Enhanced Accountable Payment

- 2.1: Strategic Use of Practice Revenue

CPC Change Driver 3: Internal Measurement and Review

For more information about the CPC initiative, visit

<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>



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Pharmacist Integration Strategy: Working Directly with Patients to Improve Medication Adherence and Outcomes

Banner Health (9 CPC sites), Denver, Colorado; system-affiliation; 37 physicians; 53,272 patients

Situation: Banner Health currently has two (and soon to be three) pharmacists integrated across six of its nine Colorado CPC practices. While they are available to care teams for consults and to answer medication-related questions, the pharmacists primarily work directly one-on-one with patients the care teams have identified as needing additional support with their medication therapies. Banner’s data to date suggests that patients, specifically patients with diabetes, benefit from pharmacist consultations.

Strategy: Banner Health identified two groups of patients as most in need of additional support that a pharmacist could provide: patients with diabetes (either complex medication management or new diagnosis) and patients using anticoagulation therapies.

Banner then set up collaborative practice agreements between its clinical pharmacy services and the practices that allow the pharmacist to adjust doses and medications as well as order labs. Since April 2014, pharmacists have worked directly with patients.

Referrals – Care teams identify patients who would benefit from pharmacists’ consultations. Along with the above-mentioned diagnosis groups, providers may refer patients for medication reviews (particularly polypharmacy) to help minimize side effects and eliminate unnecessary medications. Providers create a referral in NextGen for the pharmacist who contacts the patients for a face-to-face intake appointment at the primary care office. As pharmacist availability increases in the coming weeks, office assistants will help with appointment setting.

Patients with diabetes – These 60-minute intake visits include diabetes management education. While some are patients newly diagnosed with the disease, most patients simply need more help managing their medications. In addition to reviewing medications, discussing how to take them and adjusting dosages as needed, the pharmacist may also show patients how to use glucometers and inject insulin.

Frequency and length of follow-up appointments with these patients are tailored to the patient’s ongoing needs.

Natalie Yount, PharmD, BCPS, remarked that she has been on the phone every two to three hours to help patients experiencing a hypoglycemic episode avoid an emergency room visit. Others may need daily support as they build confidence in their ability to self-manage. Still others need only a check-in phone call every two weeks or so. Overall, having pharmacists work closely with these patients to effectively manage their medications has helped free up time for the providers in the clinics, and the patients benefit from timely access as the pharmacists’ schedules offer more flexibility than other providers’.

Patients using anticoagulant therapies – At 30-minute intake appointments, pharmacists review current dosages and make any necessary medication adjustments. Patients new to anticoagulant therapies may be in contact with the pharmacists weekly until they are stable, and then appointments are every four to six weeks.

Workloads – Currently, two pharmacists rotate across three sites each per week, working in designated office spaces. In the coming weeks, a third pharmacist will come on board, which will expand services to all nine Banner sites. Pharmacists balance daily workloads with intake, follow-up phone calls and completing clinical notes. Pharmacists are also available for care teams’ requests for ad hoc consultations and questions, which frequently pop up as instant messages during the day. Dr. Yount says she works with 15 to 20 patients per day on average, not counting impromptu consultations or requests for information from providers.

Measurement and tracking – Based on a patient list pulled from NextGen, pharmacists use a shared spreadsheet to record the number of referrals, types of visits, no shows and phone visits. At this time, they track A1cs for patients with diabetes, and they will soon start tracking outcome measures for patients on anticoagulant therapies.

Outcomes: Data for quarters 1–3 2015 show that 78% of patients with diabetes who have met with pharmacists have A1c scores below 9% and a mean reduction of A1c of 1.7 points. Further, providers appreciate having another in-house clinician support patients toward successfully participating in treatment. Plans are now underway to expand referrals for patients for cardiovascular risk reduction (dyslipidemia and hypertension).

Pharmacist Consult Tracking, Q1–3,

Patients with Diabetes				
	Q1	Q2	Q3	Year to Date
Number of new patients	41	63	45	149
Follow-up appt.	43	50	37	130
Phone follow-up	0	230	63	293
% of pts < 9 A1c	80%	78%	74%	78%
Mean change in A1c	-1.5	-1.6	-1.7	-1.7

Patients Using Anticoagulant Therapies				
	Q1	Q2	Q3	Year to Date
Number of new patients	36	29	33	98
Follow-up appt.	286	370	436	1092
Phone follow-up	0	159	125	284
Bridging patients	1	12	11	24

The above tables are sampled from Banner’s tracking data. Along with outcomes measures, they track the pharmacists’ level of effort and also how much support different patient groups require.