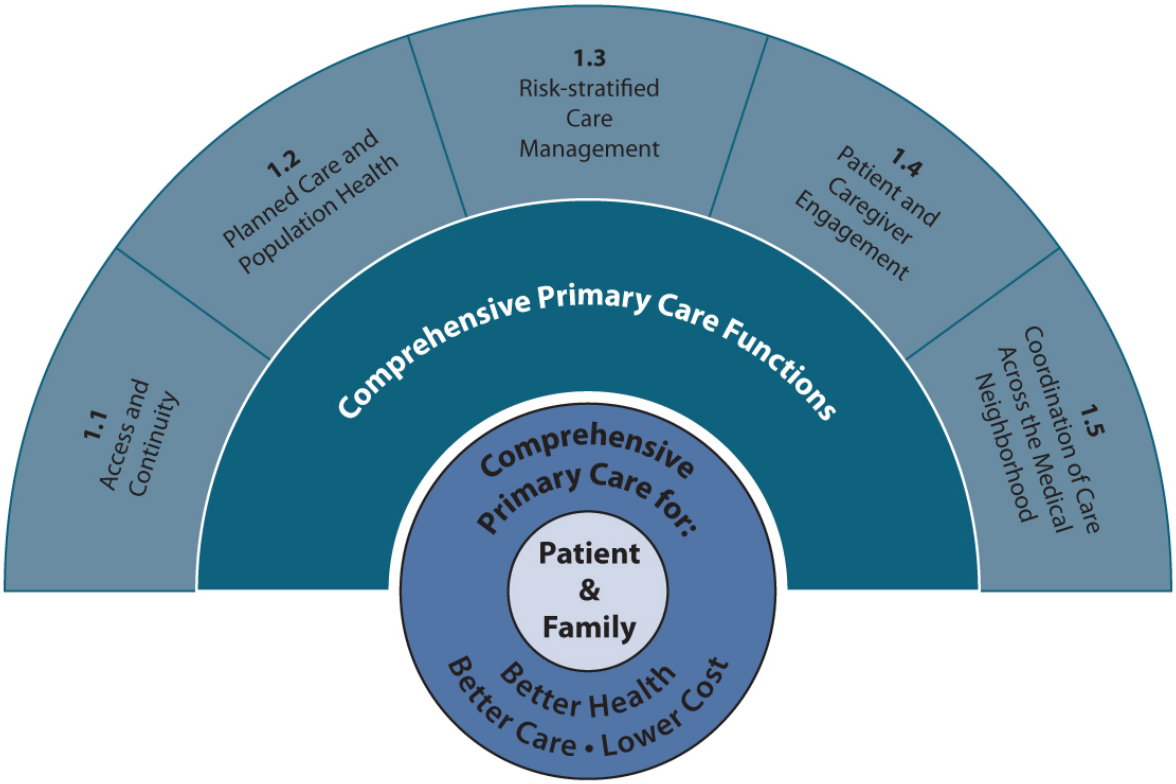
Driver 1: The Comprehensive Primary Care Functions

CPC practices developed capabilities in the delivery of five comprehensive primary care functions to achieve better health outcomes and improve the experience of care, as well as to reduce the cost of care.



Driver 1: The Secondary Drivers

The secondary drivers that support the Comprehensive Primary Care Functions are described as follows.

1.1 Access and Continuity

Improving access to care by using the full medical record to ensure appropriate empanelment, build relationships through the continuity of care, and maintain continuity in the management of acute and chronic conditions.

1.2 Planned Care and Population Health

Using teams to provide planned, proactive care including chronic conditions and preventive care, integrated behavioral health services, and medication management that is designed to maximize efficiency, effectiveness and safety.

1.3 Risk-stratified Care Management

Addressing the health of both the individual and the practice by conducting risk stratification of the practice population, managing transitions in care, and providing practice-based care management for those at highest risk.

1.4 Patient and Caregiver Engagement

Including patients, families, and caregivers in how they manage their own care as well as how the practice provides care.

1.5 Coordination of Care Across the Medical Neighborhood

Serving as the hub of care for patients to systematically bridge care handoffs and transitions of care as well as link to community-based resources to support patients in achieving desired outcomes.

Secondary Driver 1.1: Access and Continuity

This section focuses on the concepts of increasing access to care beyond the traditional office visit and leveraging empanelment to support and enhance a patient's continuity of care.

The phases of the work in CPC:

- Early work in CPC focused on ensuring 24/7 access to the patient's medical record for the provider and team and any on-call providers.
- Subsequent work focused on empaneling all patients to either a specific provider or a care team and beginning to track patient practice utilization patterns.
- Following empanelment, practices began to measure continuity between patients and the providers/care team to whom they were empaneled.
- Building on what they learned, practices embarked on enhanced access to care based on the population's needs and began to measure access and implement various methods of scheduling to better match demand.
- Over the initiatives final year, practices monitored and addressed trends in the access and continuity data.

These approaches served as the foundation for comprehensive primary care within the participating practices.

Change Concepts for access and continuity

- Empanelment
- Ensure timely access to care
- Continuity with providers

Change Concept: Empanel all patients to a care team or provider

Empanelment is a process that assigns each active patient to a provider and/or care team in the practice. Managing a panel of patients as a population allows optimal care for the entire panel by organizing work processes, managing supply and demand, coordinating care and identifying and preventing care gaps. Well-constructed panels foster the development of care teams as well as foster the patient-provider/team partnership.

Assigning patients to a panel is the basic premise of population management. Once all patients are empaneled, the data obtained may be used to proactively improve care. As the teams collect and document trackable data (for example, patients with diabetes receiving an A1c every three months) for each empaneled patient, they can create panel reports. Monitoring these reports will help manage preventive care and care gaps in the panel. Examples of this may include chronic disease tracking, quality care measures and risk status of the patients assigned to that panel. This approach has lowered the cost of care by reducing emergency department (ED) visits and hospitalizations as well as resulting in overall healthier patients.[1]

Once panel empanelment is established, providers and their team can be clear about the group of patients that they are responsible for managing, and patients have a clear understanding about who their provider and/or team is. Then reliable workflows can be developed to address both access and meet the health needs of the entire panel.

Implementation tips for empanelment

- Determine leadership and a team to lead empanelment.
- Determine panel tracking method.
- Determine who is responsible for ongoing monitoring, analysis and adjustment of individual panels.
- Develop a communication plan and confirm assignments with patients and clinicians.
- Assign each active patient to a provider and/or care team.
- Determine a process for new patient panel assignment or when a patient requests to change panels.
- Design a plan for opening and closing panels.

Change tactics CPC practices used:

- Empanelment — Assign responsibility for the total patient population, linking each patient to a provider or care team

[1] Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. Ann Fam Med. 2005;3(2):159-66.).

Change Tactic: Empanelment — Assign responsibility for the total patient population, linking each patient to a provider or care team

The goal of empanelment is to ensure every patient receives optimal care from the practice by a designated primary care provider/team. The empanelment process has essentially three stages, all of which are equally important in developing panel management:

- The preparation
- The implementation
- The ongoing management

> ***Active population*** *includes those patients who identify and use your practice as a source for primary care.*

Essential components

- ***The preparation: Steps practices need to take prior to empanelment.***
  - Review patient visit history. Identify active patients (for example, anyone seen by the practice in the last 18 to 36 months). If the patient has not been seen within the active patient timeframe identified by the practice, consider contacting the patient to confirm status. Remove patients who do not meet the practice definition of an active patient once you have reached out to them.
  - Determine the empanelment approach your practice will use: **provider** or **care team** empanelment.
    - **Provider-centric —** patients empaneled to an individual primary care provider (PCP): physician, APRN or PA
    - **Care team-centric —** patients empaneled to a care team (may include a medical provider, RN, behavioral health specialist, and medical assistant that are jointly responsible for the panel).
  - Outline clear goals, purpose, process steps and review with all health care team members on how empanelment will proceed. Include discussion points that can be used with patients.

Online (external) resources for empanelment

Empanelment Implementation Guide, Safety Net Medical Home Initiative (2013). This guide outlines four in-depth methodologies to reducing barriers of implementation and ensuring right panel sizes for practices through examples based on practice size and Average Visit per Patient per Year (AVPY). http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment.pdf

- ***The implementation: Assign patients to a panel.***
  The patient's initial empanelment is usually based on historical care data. Enhancing access depends on how these assignments are appropriately made. Consider the following when making assignments:
  - **Patient preference —** Provider preference should be taken into consideration when assignments are made. For example, the patient may have preferences on provider gender, and the patient's learning needs or language fluency should also be considered.
  - **Supply and demand of the practice —** Balance the availability of care teams and the patient's needs. Weigh appointment availability versus how often the patients request services (include appointments, phone calls and portal requests in that assessment).
  - **Acuity and needs of the patients assigned to the provider/care team —** Providers caring for patients with higher acuity need more time and resources to safely care for those patients.[2] These factors affect the number of patients that can be assigned to any one panel. As the number of high acuity patients increases on that panel, review the total size of the panel.

[2] Patient Safety and Quality: An Evidence-Based Handbook for Nurses (2008). https://www.ncbi.nlm.nih.gov/books/NBK2680

- **Provider availability (FTE) and skill level (physician, NP, PA) —** It is difficult to empanel providers when they are not available on a full-time schedule. This can sometimes risk patient access to care. If your practice employs part-time providers, you may want to consider empaneling patients to a care team rather than with an individual provider. In addition, panel enrollment to non-physician providers must be dependent on state licensure guidelines and the practice's individual philosophy.

Once initial assignments are made, practices may want to "weight" panels to ensure no provider is particularly overburdened. Weighting can be done by age group and gender. Weighting should be done as panels are developed and assessed annually thereafter.

➢ ***The ongoing management: Adjusting and analyzing panel size.***
A primary function of empanelment is ensuring that providers and/or team are assigned a patient panel that they can reasonably manage. To ensure reasonable management, the practice must regularly compare a provider's supply of appointments to the demand for them. Patients will regularly move away, change insurance plans, pass away or have other life altering events that may change demand on the practice. Ongoing review of the panel size achieves a balance in supply and demand **(**more about this under same-day access on page 10). Practices may find that they need to review changes over time or may need to run additional annual reports to project workload for the following year.[3] In addition to qualitative data, gather information from providers and team members about the panel size in relation to their workload and ability to function as a team. Care teams may report that they are fine even though their panel size looks overly large. Also ask patients about their experience in the newly paneled practice. Can they get an appointment easily when they want one? Are patients able to see their provider/care team, or are they displaced to another provider?

Other factors that need to be considered in the adjustment of panels are as follows:

- Adjustments in FTE, changes in provider status (terminations, vacations, resignation)
- Transfer of care upon request by provider
- Provider/team assignment (new patients)
- Transfer of care initiated by patient (to another practice or provider)
- Patient self-discontinues care or death

This information, together with the review of the data provides input to develop and maintain the "right" panel size.

Considerations for your practice

- Ensure your EHR has registry capabilities or can interface with a system that can access the information needed for an in-depth examination of any particular group of patients.
- Take special considerations when empaneling patients in a teaching facility. Medical residents may encounter challenges if assigned a panel of patients. Take into account the resident's year and faculty provider oversight.
- Manage coverage for providers' planned and unplanned absences.
- Team composition and structure may affect the empanelment size capabilities. Well-organized, capable teams working to the scope of their practice will allow for a larger panel size.
- If a clinic accepts "walk ins," there may need to be accommodation in the panel for one-time visits.

[3] Safety Net Medical Home Initiative. Empanelment Part 1: Establishing Patient-Provider Relationships, May, 2013. http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment-1.pdf.)

Measure Success for Change Concept: Empanel all patients to a care team or provider

At the beginning of empanelment, run panel reports every month to check for outliers. Once the process is established, review the panel size quarterly. On an annual basis, the practice may review provider supply for the coming year to ensure appointment availability meets the demands of the current panel size.[4] Identifying empanelment goals and progress toward these goals is a fundamental part of managing panels.

Practice empanelment measures

- Total number of patients
- Percent of patients empaneled
- Total percent of patients empaneled to each team or provider
- Clinic goal for empanelment

Practice measures to inform panel size

- Total number of visits per year to a provider and/or team
- Number of visits per year per patient in the panel
- Total number of available slots per year (if team based, include all team member slots)

[4] Empanelment: Establishing Patient-Provider Relationships. Safety Net Medical Home Initiative (May 2013), page 22.

Change Concept: Ensure timely access to care guided by the medical record

Access is ensuring that patients are able to get the services that they need at the time that they need them. When practices can accomplish this they can provide better access to health care services that will lead to better health outcomes:

- Shorter wait times for appointments
- Option of booking "same day" appointments
- Option for patients to discuss several concerns during one visit, leading to fewer clinic visits per year for the patient

Another benefit that expanded access offers is that care teams have the opportunity to identify patients' health issues earlier. This can lead to more timely interventions and treatment and can contribute to improved health outcomes.

In the past, access was seen as only a face-to-face visit between the patient and the physician. Now access can take many forms depending on the patient's need, ranging from an in-person visit to a phone call with someone on the clinical team (and often not the primary care provider). The access can be asynchronous by way of the patient portal where a patient logs in to view a lab result or other information. Further access options include texting, emails or even video conferencing.

Care guided by access to the medical record is a significant component to achieving this work. CPC practices found multiple solutions to achieve this, including secure VPN access and encrypted messaging technologies. Practices working toward expanded access should explore options through their HIT vendors, partnering facilities and others that have successfully implemented secure access options.

Implementation tips for access

- Work down the backlog of appointments.
- Show patients how access works as opposed to trying to tell them how it works.
- Offer all patients, regardless of visit type, a same-day visit appointment on the day they call your office.
- If patients do not want to be seen on the day of the call, schedule for the day of their choosing.
- Only "pre-schedule" patients when it is clinically necessary.
- Reduce the complexity of your schedule system to just three kinds of appointments (personal, team and unestablished) and one standard length of time.
- Determine the right panel size to balance supply and demand.
- Ensure that patients see their chosen provider/team.
- Plan for extreme demand or physician absence.

Access and regular opportunities to care for patients allow providers to get to know their patients better. As the clinical team becomes more familiar with its patients, continual adjustments can be made to access options that will benefit the overall needs of the practice's patient population.

Change tactics CPC practices have used:

- Provide 24/7 access to a care team member
- Provide same-day or next-day access
- Expanded hours in evenings and on weekends with access to the patient medical record
- Use alternatives to face to face office visits to increase access, such as e-visits, phone visits, group visits, portal communication and video conferencing visits
- Provide a patient portal for patient-controlled access to health information

Change Tactic:
Provide 24/7 access to a care team member

Increasing access availability can improve patient outcomes, experience and reduce health care costs.[5] Traditional "office hours" are frequently a barrier to access. When a health need arises outside of those traditional hours, patients will seek care elsewhere, often in a more costly setting such as an ED or urgent care facility. To effectively eliminate the "office hours" barrier, practices must also seek to provide reliable care when the patient needs it. Not only does it improve the practice's capacity to provide real-time care, it allows patients to make informed decisions and avoid unnecessary ED visits.

Explore creating 24/7 access to the health care team through a combination of options. During working hours, this can be in-person visits, telephone or email consults. When the practice is closed, live coverage or a call line may be a viable solution.

Essential components

- Successful coordination of 24/7 access relies heavily on all health care members having secure access to the medical record and a plan to maintain continuity and care plan documentation. This includes health care providers and others rendering care outside of normal primary care office visits to enable real-time documentation.
- Training on triage and after-hours protocols increases availability to health care advice and ensures team members are working within the full scope of their license to increase availability for the patient.
- Staff appropriately for a 24/7 call schedule.
- Ensure all patients know that 24/7 access is available and how to access it. Educating patients on their scheduling options reduces barriers and can reduce missed opportunities for available care options.
- Create an on-call system that may connect to your clinic, a local hospital system, a nurse advice line or urgent care clinic.
- Establish metrics for measuring utilization of the service and guiding process improvement over time.
- Ensure bi-directional communication between the PCP/team and on-call providers.

Considerations for your practice

- Explore health IT products and other options that support secure access to the medical record by offsite and/or on-call providers.
- Creating standing orders and protocols for nurses and other clinicians is suggested to standardize 24/7 care of the patients.

[5] Safety Net Medical Home Initiative. Enhanced Access: Providing the care Patients Need, When they need It, May, 2013 http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Enhanced-Access.pdf).

Change Tactic:
Same-day or next-day access

Many clinical practices have lengthy wait times for routine appointments, often due to rigid scheduling tactics. This includes "holding" appointments for urgent care and reserving other blocks of time for specific types of appointments (for example, new patient visits). Another common method is "triage," where the clinic determines if the patient is "sick" enough to be seen that day. Although these tactics were intended to better organize the work day, they generally don't work well for patients. Designated slots frequently result in no-shows because patients have waited so long that they forget the appointment or go elsewhere for more immediate care.

To provide same-day access for all appointments (routine and urgent), the supply of appointments must be equal to or greater than the demand for appointments. As long as supply and demand are balanced, same-day access is attainable. Supply and demand is explained in more detail on page 15.

Working through the "backlog" also helps maintain same-day access. For example: Clinic X knows that it has a four-week delay for a routine appointment. This clinic has worked for years with the same four-week delay. If the clinic team creates a backlog reduction plan — for example, some extra evening or weekend appointments for a while — the backlog can be addressed quickly. The clinic can then move forward with maintaining same-day availability.

Essential components

- Find champions to motivate the team to get onboard with this change. Finding champions among different disciplines (for example, a physician, an RN or a pharmacist) who really understand same-day access will help to overcome resistance.
- Measure your practice's current delay for a routine appointment with the Third Next Available Appointment measure, which is easy to use and is the industry standard.[6] Set up daily or weekly measurements to determine your practice's delay for a routine appointment. Other measures for same-day access are not widely used now and not recommended.
- Measure supply and demand (see discussion on page 15), which may take a couple of weeks of tracking demand to understand the true demand. Measure supply versus demand at the start and then every three to six months as it can and will shift over time.[7]
- Set up same-day access scheduling guidelines. Several examples can be seen through the Institute for Healthcare Improvement (IHI)[8]. Consulting other clinics using same-day access is also helpful. Generally, keep it simple with few appointment lengths (one or two maximum), few appointment types and no specific times for certain kinds of appointments. Then allow the schedulers to do their job.

Considerations for your practice

- Train staff in the scheduling process. Focus on the why's and how's of same-day scheduling and making schedulers part of the team.
- The closer the appointment time is to the time that the patient made the initial request, the greater the chance that the appointment will be kept (reducing no-shows).

[6] http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx
[7] www.ihi.org/resources/Pages/Changes/MeasureandUnderstandSupplyandDemand.aspx
[8] http://www.ihi.org/resources/Pages/ImprovementStories/ImprovingPatientAccessEverettClinic.aspx

Change Tactic: Expanded hours in evenings and on weekends with access to the patient medical record

A common solution among CPC practices was reconfiguring their practice's office hours to meet the needs of its population. The practice may expand hours by using staggered shifts, moving weekday availability to the weekend or rotate weekend or evening shifts. Others responded creatively by coordinating schedules with nearby practices or urgent care facilities to provide alternative hours. This approach allowed practices to adjust their office hours to their patients' patterns of utilization, which increased continuity of care.

Essential components

- Survey patients to better understand the demand for extended hours and when they would most likely be used. For example, a more senior population may want morning hours primarily, leaving evening hours unused.
- Determine staffing and how much of the facility will need to be open.
- Provide real-time access to the patient's medical record to maintain continuity of record and plan.
- Monitor trends and make adjustments in providers' schedules to add more after-hours availability to meet patient preference and also provide increased opportunities for continuity.

Considerations for your practice

- Determine the scope of services offered. For example, could your practice offer routine appointments such as physicals in the evening?

Change Tactic:
Alternative visits — Group and home visits

Alternatives to the traditional office visit may address the goal of timely access to care. CPC practices have found home visits and group visits can enhance the patient's experience of care while still providing expanded access that supports continual engagement with the patient.

Group visits

For many years, primary care offices have successfully implemented group visits, whether they are drop-in group medical appointments or follow the chronic care health clinic models. Not only are they an effective means to meet several patients with similar conditions concurrently, the interactive format uses resources efficiently and motivates patients' engagement. Resources from Group Health Cooperative (Group Visit Starter Kit), the American Academy of Family Physicians and the American College of Physicians provided practices and coaches with the tools and rationale to effectively employ this tactic, while ensuring financial viability and coding compliance.

Home visits

A number of CPC practices added primary care physician-supervised home visit programs to provide expanded access for high-risk patients [see "CPC Practice Spotlight 59: Home Visits Help Brittle and High-Risk Patients Stay in the Continuum of Care" (2015) in the resource box to the right]. The benefits of these programs include enhanced continuity of care, increased patient satisfaction and reduced unplanned readmissions.

CPC practice examples related to alternative visits

Group visits

CPC On Demand Video: Group Visits: Expanding Access to Care (2017). This video illustrates how group visits can benefit the needs of a practice's patient population. https://www.youtube.com/watch?v=ae--zQ0ufJk&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=5

Home visits

CPC Practice Spotlight 59: Home Visits Help Brittle and High-Risk Patients Stay in the Continuum of Care (2015). Providence Medical Group-Glisan (Oregon) shares its home visit process for high-risk patients. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=22

CPC practices providing home visits are especially effective with chronically ill patients. Frequently the home visit revealed previously unknown barriers to effective self-management, including socio-economic concerns such as food instability, lack of transportation, financial difficulties or even sub-standard living conditions.

Essential components

- Determine what your patients would like in terms of alternative visits. Are they tech savvy? If so, maybe they would prefer to get information through the patient portal or over secure email or text. Maybe video conferencing is a possibility. If they are a population that likes to gather, maybe you can try offering group visits.
- Create a schedule or agenda for group visits that includes required personnel. If individual assessment will be part of the visit, a provider or RN should be included.
- Create a curriculum tailored to an entire cohort.
- Invite individuals to join the group visits. Letters can be sent to the whole subpopulation (i.e., patients with diabetes), but this is often most effective when a member of the care team discusses this option during a face-to-face office visit.

Considerations for your practice

- Survey the population. To elicit actionable information from your patient population, use a survey method that works best for them. Some examples include paper surveys, electronic/online surveys, informal chats in a waiting room, focus groups or a patient and family advisory council. All of these methods will better inform the clinic about your patients' needs.
- If a provider (physician, NP or PA) is present for the group visit, you will likely be able to bill for the visit.
- Plan to offer a variety of days and times until you identify the most popular time slots.
- Consider including family and caregivers along with patients in these groups.

Online (external) resources for group visits

Group Visit Starter Kit (2001). Group Health. www.improvingchroniccare.org/downloads/group_visit_starter_kit_copy1.doc

Group Visit Billing Information
http://www.acponline.org/running_practice/patient_care/group_visits/billing_info.htm

Coding for Group Visits
http://www.aafp.org/practice-management/payment/coding/group-visits.html

Change Tactic: Patient portals

A portal allows patients immediate, 24/7 access to a variety of information and services, such as scheduling services, viewing lab results, requesting medication refills, requesting paperwork completion or asking non-emergent questions. By providing patients immediate access with this tool, you will reduce the care team's time spent on phone calls, triage and unscheduled services. Diverting some patient communication through the portal allows the care team more time to focus on direct patient care.

CPC practice example related to patient portals

CPC Practice Spotlight 12 (2014). Colorado's DTC Family Health and Walk-in shares insights about use of the patient portal. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=30

Essential components

- Patients can use the patient portal for the following:
  - Schedule appointments
  - Request prescription refills
  - Pay bills
  - Review test and lab results
  - Access portions of medical record, including plan of care
  - Access educational resources, shared decision aids
  - Messaging to staff or provider
- When choosing a portal, prioritize the secure messaging functionality.
- Provide patient-specific education resources. Ensure the EHR incorporates an extensive library of patient education resources.
- Provide clinical summaries on the portal within 72 hours.
- Provide electronic access to health information: Many CPC practices provide lab results through the patient portal. Patients will receive a message via email explaining that their results are in and ready for review. The provider can also add messages with important information.
- Communicate to patients about portal access and the advantages and conveniences this technology offers them.

Considerations for your practice

- Practices may need to invest time in training and preparing of personnel.
- Some customization of the system may be needed based on individual work styles and practice workflows.
- The practice may consider patient education sessions to help patients register and become familiar with the portal's features.
- Consider automating the process to link appropriate health education materials to customized templates used for different types of patient visits.
- If providing clinical summaries, ensure patients are educated about clinical summaries and their purpose.

Measuring Success for Change Concept: Ensure timely access to care guided by the medical record

Identify and evaluate quantitative data that demonstrates the status of access in the practice. The foundation for this measurement is patient empanelment to a provider or care team. This is followed by calculation of supply (clinical resources available including staff, rooms and equipment) and demand (request for appointments). This should be done on a daily, weekly, monthly and seasonal basis.

Supply: Measurement of supply is two-fold. It includes measurement of the total hours of provider or care team time devoted to appointments (daily, weekly, monthly, annually). Follow this with the time for non-appointment processes (refills, messages, review of test results). Be mindful that supply and capacity are not synonymous. While a certain number of people are capable of performing a certain amount of work, when those same staff members are organized into a team with streamlined workflows, there is a multiplier effect on supply and capacity is enhanced (see "Use team-based care to meet patient needs efficiently" in **Secondary Driver 1.2: Planned Care and Population Health**, page 2).

Many practices choose to also use the "Third next available appointment" tactic, which is defined as the "average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam or return visit exam."

Demand: Measurement of demand includes the demand for appointments and all other processes required for patient care. The demand for appointments can be internal (provider- and patient-driven appointments, phone calls, walk-ins and return visits) or external (new patients to the office, referrals and provider-to-provider calls to discuss patient care). Total demand is the number of requests for appointments from both internal and externals sources.

Practices may also find it valuable to measure important processes related to access:

- What are the average time patients spend on hold when calling the office? What is the number of dropped calls?
- What is the rate of general portal signup among the clinic population? How many appointments are booked through the portal?
- What proportion of patients has sent a message to their provider using the portal?
- What happens to phone volume with introduction of the portal?
- How many ED or urgent care visits are made without a prior phone call from the patient to the practice or to the on-call provider?

Finally, it is imperative not to overlook external sources of data, such as CAHPS surveys or commercial payer data. Additional views of access can be gained by measures that answer questions such as these:

- How many non-emergent visits to the ED or urgent care were made during regular practice business hours?
- How many patients seen in the emergency department or admitted to hospital were for ambulatory care sensitive conditions?
- What is the rate of missed appointments and/or no-shows?
- What is the ratio of ED visits to hospitalization in the practice?

Change Concept: Optimize continuity with provider and care team

Continuity of care is consistent, quality care over a period of time. It ensures engagement of the entire team, reducing fragmentation of care and thus increasing patient safety and quality of care by reducing the potential for medical errors.[9] When the provider already knows the patient's medical and personal history, this helps to establish patients' confidence and enables providers to be effective patient advocates. Empanelment of patients to a provider/care team is fundamental to monitoring continuity.

Online (external) resources for continuity of care

Continuity of Care, Definition of, AAFP (2015). http://www.aafp.org/about/policies/all/definition-care.html

Continuity of Care: a multidisciplinary review, BMJ (2003). http://www.bmj.com/content/327/7425/1219

Although comprehensive primary care focuses on relationship continuity, **continuity** can be thought of more broadly as occurring in three dimensions[10]:

- **Information/continuity of record —** all providers and teams caring for the patient have access to the patient's electronic health record, either by direct access to the EHR, through an HIE or another method.
- **Management/continuity of plan —** there are no conflicts or inconsistencies among providers in the management plan for a patient.
- **Interpersonal/continuity of relationship —** continuity with a provider/care team.

Change tactics CPC practices have used:

- Measure continuity between patient and provider and/or care team
- Use scheduling strategies that optimize continuity while accounting for needs for urgent access
- Use a shared care plan and referral management strategies to ensure continuity of management between within the practice and with consultants
- Ensure that all providers within the practice and all members of the care team have access to the same patient information to guide care

[9] Continuity of Care, Definition of (2015). http://www.aafp.org/about/policies/all/definition-care.html
[10] Continuity of care: a multidisciplinary review, *BMJ* 2003;327:1219; http://www.bmj.com/content/327/7425/1219

Change Tactic: Regular measurement of continuity between patient and provider/care team as a management tool

Having and routinely using an objective measure of continuity is a valuable tool for practices. The measurement helps them monitor how well their panels are functioning and indicates patient activity at the practice. CPC practices varied in how they measured relationship continuity. Some practices chose to measure continuity with a provider (physician, APRN or PA), while others choose to measure it in reference to a care team (see discussion on empanelment preparation on page 5).

Essential components

- **Provider/care team-centric measure —** monitoring a specific provider and/or care team patient visits by their empaneled patients versus total patient visits to detect sub-optimal panel sizes (over- or under-empaneled)
- **Patient-centric measure —** monitoring patients' visits to a practice, noting how many visits are with the assigned provider/care team. This measure may identify high- or rising-risk patients in need of care management.

Considerations for your practice

- If your practice's continuity measurement indicates some patients are in need of care management or self-management support (as indicated by frequent contact with practice and/or appointments), create workflows to alert providers to these needs.

Change Tactic: Development of scheduling strategies accounting for patient needs for urgent or same-day visits

Establish a flexible scheduling protocol that emphasizes provider/care team continuity and make sure all team members know this is a priority. This is particularly important when patients request appointments for urgent needs or same-day visits (see **Same-day or next-day access** on page 10 and **Expanded hours** on page 11). Having the ability to schedule patients consistently with their care team as the first option will lead to improvements in overall continuity.

Essential components

- Ensure provider assignment is clearly identifiable in the EHR when scheduling occurs.
- Re-evaluate and revise same-day appointment availability to ensure the practice is meeting supply/demand for the population while continuing the focus on continuity between patient and provider/care team.

Considerations for your practice

- CPC practices frequently noted the greatest challenge to continuity of care was related to care sought for urgent conditions.
- Address misconceptions that adding urgent or same-day visits to a schedule means never pre-scheduling visits.
- Remember that your health care teams have multiple members. Patient access to any of those team members to address needs will ensure continuity.
- Ensure that access and continuity are balanced. If continuity outweighs access in your scheduling protocols, then a patient could have a delay in care. Conversely, if same-day access is the priority continuity may be sacrificed. Create balance with a policy outlining this subject. Modify scheduling practices to maintain that balance. The primary goal is to always ensure the patient's health care needs are met in the most patient-centered manner possible.

Change Tactic: Use a shared care plan and referral management strategies to ensure continuity of management within the practice and with consultants

Primary care practices must be the center or "hub" of care for the assigned patient. To function as this hub, the primary care practice should be able to share a care plan with specialty services, have readily available follow-up appointments for discharges, be ready to help patents acquire durable medical equipment as needed, and coordinate home health care as needed. Second, the primary care team must be informed of changes made to the plan by other providers. A shared plan and a closed communications loop among the patients' providers allows the PCP and health care team to proactively address any gaps and eliminate redundancies in care. Most importantly, this process keeps the patient at the center of the care provided. More in-depth information on shared care plan and referral management is found in **Secondary Driver 1.5: Coordination of Care Across the Medical Neighborhood** on page 6.

Essential components

- Promote continuity through a plan of care the entire practice team shares, along with external providers of care.
- Knowledge of the overall plan for the patient guides decisions on appointments, referrals, phone calls and portal visits.

Considerations for your practice

- Suggest informing all family members involved in the patient's care of the content of the patient care plan and seek their feedback.
- Ensure the practice EHR has the capabilities to track the referrals and manage care plan information exchange. This could be done using "dummy codes" or other discrete fields.
- Provide adequate training for clinical and administrative personnel of this process. Teamwork is enhanced with the entire team understands the process and rationale for this activity.

Change Tactic: All practice team members have access to the patient information necessary to promote continuity

Any patient contact with the practice is an opportunity to optimize continuity. Phone calls and portal visits directed to the patient's care team strengthen the bond between patients and their provider/care team.

> ***Any patient contact*** *with the practice has the opportunity to optimize continuity.*

Essential components

- Scheduling staff are able to direct patients to appointments with their provider/care team and ensure that information is available in the medical record.
- Ensure confidentiality of PHI in portal messages and that the messages are appropriately distributed to the assigned team member. Avoid the temptation to print out messages. Distribute electronically to protect the patient privacy.

Considerations for your practice

- Ensure everyone in your practice has the appropriate level of EHR access to resolve patient concerns.

Measuring Success for Change Concept: Optimize continuity with provider and care team

Many CPC practices used built-in reporting features of their EHR/practice management software to gather continuity information, while a few used a manual sampling methodology to overcome health IT limitations. Regardless of the data collection method, measurement of continuity largely focused on continuity of relationship. Continuity trends are evaluated at the provider and practice levels, and interventions applied as appropriate to ensure a high degree of continuity. Keep in mind that measurement of continuity is directly related to the practice empanelment method (see page 5).

Consider the following to measure continuity:

- Provider/team name
- Total number of visits last month
- Number of visits to assigned provider/care team
- Number of visits to another provider/care team

Use all of the measures above to determine your practice's continuity percentage. Most practices strive for a continuity percentage of 75 percent or more.

Resources for Secondary Driver 1.1: Access and Continuity

Coding for Group Visits (http://www.aafp.org/practice-management/payment/coding/group-visits.html)

Continuity of Care, Definition of, AAFP (2015). http://www.aafp.org/about/policies/all/definition-care.html

Continuity of Care: a multidisciplinary review, BMJ (2003). http://www.bmj.com/content/327/7425/1219

CPC On Demand Video: Group Visits: Expanding Access to Care (2017). This video illustrates how group visits can benefit the needs of a practice's patient population. https://www.youtube.com/watch?v=ae--zQ0ufJk&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=5

CPC Practice Spotlight 12: DTC Family Health and Walk-in (2014). DTC Family Health and Walk-in from Colorado share insights about use of the portal. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=30

CPC Practice Spotlight 59: Home Visits Help Brittle and High-Risk Patients Stay in the Continuum of Care (2015). Providence Medical Group-Glisan (Ore.) shares its home visit process for high-risk patients. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=22

Empanelment Implementation Guide (2013). Safety Net Medical Home Initiative. http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment.pdf

Group Visit Billing Information (http://www.acponline.org/running_practice/patient_care/group_visits/billing_info.htm)

Group Visit Starter Kit (2001). Group Health. www.improvingchroniccare.org/downloads/group_visit_starter_kit_copy1.doc