CPCPracticeSpotlight49

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

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.

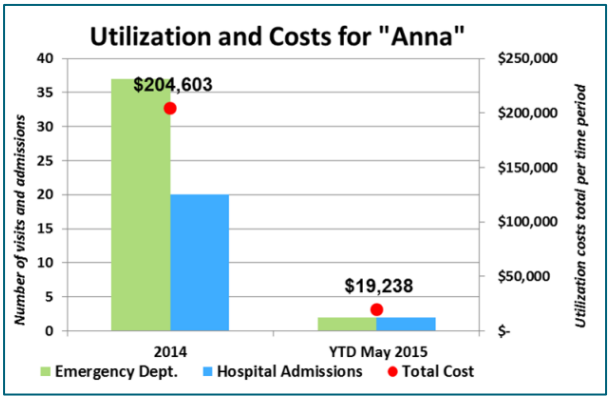
Knowing this intensive care management approach hinged on Anna's buy-in, Dr. Catanzaro had a frank discussion with Anna at the start to set boundaries. The team committed to helping her improve her health, but Anna had to stick with the schedule and follow through as asked.

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.*

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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