CPCPracticeSpotlight42

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

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

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

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

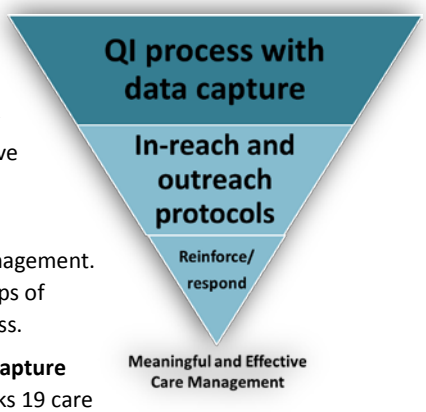
- 2.2: Analytic Capability

Change Driver 3: Continuous Improvement Driven by Data

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

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

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.

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