CPCPracticeSpotlight32

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

Dec. 12, 2014

This Spotlight addresses CPC Milestones 2 and 3.

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

CPC Milestones 2 and 3: They Changed How We Work

Princeton Medicine, Plainsboro, New Jersey —Multi-Specialty

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

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

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

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

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

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

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

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

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

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

TMF Health Quality Institute

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