Colorado: Continuity of Care

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Good afternoon everyone. I'm Nicole Banister from the TMF Health Quality Institute, and I want to welcome you to our CPC Regional Webinar entitled the Continuity of Care. Today's program is being recorded and will be posted along with slides and materials to the Collaboration Site. You can also download the slides directly from WebEx during today's event by going to the top toolbar and selecting File, Save As, and then Document. We appreciate the presenter's time and effort in preparing for and sharing their valuable knowledge. Any statements regarding their technology, products, or vendors are expressions and opinions of the person speaking and not an opinion of nor endorsement by the Center for Medicare & Medicaid Innovation nor TMF Health Quality Institute nor the host of the program. As a reminder, your lines are muted throughout today's session. However, to submit questions or comments, you can use the Q&A or the chat icons on the right-hand side of your screen in the participant panel. Some attendees like to turn on the chat feature now. You can click this balloon icon bubble so that you can see the chat of other participants during the session. The presenter may also ask you to raise your hand if you'd like to verbally ask a question and have your line unmuted. You can do this by selecting the hand icon in the participant panel. And from there I would like to introduce Elisha Jewett from HealthTeamWorks who is our facilitator for today's presentation who will get us started. Elisha?

Hello. Welcome everyone to the Colorado January Regional Webinar on Milestone 3, Continuity of Care. I am Elisha Jewett, HealthTeamWorks' Quality Improvement Coach. Today we hope you leave with the ability to discuss the value of care continuity and understanding of different methods to measure and track continuity and having identified opportunities to improve continuity of care at your site. Using the annotation arrow on the left side of your screen toward the top, please select the number one item you hope to learn more about today or use the chat box to type something not listed. We will come back to this at the end of the session. The listed options are, what does continuity in CPC mean? How to make continuity data actionable? How do we track continuity? What makes continuity data meaningful to providers? Or other using the chat box. I'll give you about 20 seconds here. All right. It looks like folks are still clicking away. Feel free to keep putting those arrows in. So, a lot of you clicked on what makes continuity data meaningful to providers, which is great since our presenter today is a provider. We should get that viewpoint very well. Looks like a lot of you said how to make continuity data actionable. We'll be talking about all of these things. So, at the end of the presentation I'll come back to this slide to make sure we got you what you needed. Now you can put your annotation tool away by clicking on the arrow in the upper, left corner once again. This will keep you from marking the slides as we progress forward. The AAFP explains the continuity of care is rooted in a long-term patient-physician partnership

in which the physician knows the patient's history from experience and can integrate new information and decisions from a whole patient perspective efficiently without extensive investigation or record review. This creates a longitudinal and ongoing therapeutic provider-patient relationship and or care team-patient relationship in scenarios where there's a defined and known care team caring for the patient. The CPC Implementation Guide, Implementation and Reporting Guide discusses continuity in three dimensions. Interpersonal or relationship continuity with a provider or care team. Management continuity where there's not conflicts in the ongoing care or inconsistency between providers and in the care plans for the patient. And information continuity whereby all providers and teams that may care for the patient has access to the patient's EHR, which most of you probably recognize as one of the requirements of 24-7 access to care driven by the EHR. Continuity of care has proven to result in better care for the patient and a better perception of care by patients and families. Studies show that continuity of care increases patient satisfaction especially for the most complex and vulnerable populations and improves efficiency by saving time for the patients, not having to repeat themselves or provide lengthy medical history to new providers, and care teams by eliminating some duplication. Continuity of care can foster patient engagement through relationship development. In the end, improving care continuity increases access to the patient's provider or care team, which is desired by both the patient and the care team. There are many ways to track and measure care continuity. The biggest takeaway that I hope you get from today's webinar is that you need to identify what measure or measures are meaningful to your site because each site is uniquely structured. This table shows several different kinds of measurements. Each of your sites will want to select at least one of the providers or care team continuity measures to track. Provider continuity looks at the frequency with which patients see their provider to whom they are empanelled. The measure looks at the number of patient visits with their provider over a defined period of time and divides that by the total number of patient visits with any provider. Similarly, the care team continuity measures look at the frequency with which patients see any of their specified care team members. This could be a physician, nurse practitioner, care manager, as long as they are a defined care team member that the patient is aware of. The care team measure takes the number of patient visits with their specified care team divided by the total number of patient visits with any provider. Please note these measures can be calculated at the practice level, but looking at the measure for each provider is more informative. Additionally, the numerator and denominator for each measure should look at the same time period. So, that might be a look back period of six months or a year, whatever you are looking at. Additionally, you could measure patient perception of care continuity using patient survey questions such as in the last six months when you went to the doctor, how often did you see your personal provider or care team? Is there a particular provider you prefer to see? And how often did you see the provider you prefer to see. So, that's something that you could incorporate. Now I'll show you an example. Jeff, so one person commented that they could not hear the presentation. I don't know if you can help Francis Haynes.

I did respond to her, yes.

OK. Thank you. OK. So, let me give you an example of provider continuity. Today, 20 patients were seen at Primary Care Clinic. Two providers worked today. Provider A saw seven patients that are on her panel as seen in green and three patients that are on different provider's, practice's panel. Provider continuity

for Provider A is therefore seven patients divided by 10 patients equaling 70 percent. Provider B saw eight patients that are on his panel and two that are not. Provider continuity for Provider B then is eight divided by 10, 80 percent. To look at provider continuity at the practice, we look at the total number of patients that saw their provider divided by the total number of patients that were seen. So, that's 15 patients that saw their assigned provider divided by 20 total visits meaning today's practice level provider continuity is 75 percent. So, this is a very simplified exampled looking at just one day's schedule. But hopefully it starts to help you understand what care continuity is looking at. Now how you get the data is up to you. Ideally what you should be working toward over the upcoming year is getting the data from your practice management and or electronic health record technology by running a report looking back over a defined period of time. If your current technology does not have this ability or if you don't know if it has this ability, I encourage you to reach out to your vendors or value added resellers to find out what your options are. Additionally, you could consider having a custom report created. It may be possible to track continuity using billing and or scheduling information. In the meantime, another option to begin thinking about continuity is to manually track continuity by providers or care teams using billing or scheduling information on a regular basis. I'll ask a question later that lists the different ways you might collect continuity data. So, hopefully your wheels are turning so that you can answer that question. The bar graph seen here is from the National Fast Facts document found on the Collaboration site. As you can see, across the nation 72 percent of PFACs and 75 percent of surveys included a focus on access. Have you started to jump into continuity? Once again, please use the annotation tool on the left-hand side of the screen at the top to put an arrow next to one of these options to show how you have engaged your patients in discussions and actions to address care continuity at your site. The options are through your PFAC, through your survey, or that's a good idea, I should talk to my patients.

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From these initial responses it looks like most of you have started having these conversations with your patients. So, I'm not sure if that's because we introduced the Milestones this fall and you got a head start on it, or for some of you this might be something you've already been doing. But either way it's a great idea to include your patients in conversations about care continuity, what they value, how you can make policy changes and scheduling changes at your practice. I'm going to go on to the next slide, but you can keep your annotation tool out. Please answer the following question. Do you track care continuity. The options are yes, track continuity of each provider. Yes, we track provider and care team continuity. Yes, we track multi-provider care team continuity. No, we have not started tracking. Or I don't know if we've begun tracking yet because some of you may not be aware. From the responses so far, this pretty much exactly what I expected. There's a handful of practices that are tracking continuity already. And it might be care team or individual provider continuity. And then a lot of you have not started tracking yet, which is why it's a new part of the Milestone in 2015. So, it's great you're on the webinar to start thinking about it. And then as I expected, some of you just don't know if you're tracking it because you might not be the person at your practice that would do that. So, it's a good conversation to have and you can bring back to your QI team meetings and find out where your practice is. All right. Now you can put your annotation tool away by clicking once again on the arrow on the left-hand side toward the top of your screen. Oh, sorry Melody. So, now I'd like to introduce Dr. Aaron Gale from

Bruner Family Medicine Center in Denver, Colorado. Dr. Gale attended medical school at the University of Colorado and completed his residency at Saint Joseph Hospital here in Denver. He is currently a provider at Bruner, which is a residency practice, which cares for the underserved population. I now would like to turn it over to Dr. Gale so that he can tell you more about his practice, how and why they utilize care continuity data. Dr. Gale, I will turn it over to you.

Hello everybody. I hope that you all can hear me. Melody, I really appreciate that you left your arrow there. And I, like you, would do the same thing. I'd be putting my arrow all over the place in an anarchic way because that's how I am. But one thing I don't feel anarchic about is helping my patients get continuity with their providers here in the residency clinic. I believe I can control these slides. Excellent. All right. So, we're a community-based residency. I just want to give you a picture of what our clinic is like. It's a pretty big clinic. I think we've got 25 rooms, three procedure rooms. We schedule 120 visits a day. We have no full-time providers in the clinic. We have nine faculty, 24 residents, one OB fellow, and three nurse practitioners. And we are just recently certified as a Level 3 NCQA-certified patient-centered medical home for what that's worth. I really love Bruner a lot because of the mission-based work that we do. In other words, our mission is to improve the health and health care of the community that we serve, particularly underserved communities. Similar to an FQHC you can see that we have a diverse patient population. Thirty percent of our patients are Spanish speaking. Thirty-three percent are uninsured. Forty-three percent have Medicaid and that's an ever-climbing number thankfully. Fourteen percent have Medicare. And ten percent are commercially insured. We do full spectrum family medicine with peds, OB, inpatient, outpatient, surgical procedure, nursing home and home visits as well. You know, I just put at the bottom of this slide a note to myself regarding one of the greatest innovations that we got through our NCQA process which was starting the Patient Advisory Board. And it has been one of the transformative aspects of our NCQA transformation. So, if anybody has any thoughts about that towards the end, they can ask me about what that's like. So, continuity. Why should I care as a primary care doctor or as a team that's striving to provide primary care for patients? Well, there's this great researcher. Her name is Barbara Starfield, actually the late Barbara Starfield. She is a pediatrician at Johns Hopkins who was also a master's of public health and devoted her research career to figuring out what it is about primary care that leads to what we call the primary care paradox. In other words, in areas where there are high numbers of specialists as opposed to the number of primary care doctors that you see situations in which patient quality measures including morbidity and mortality go down. And if you reverse that ratio, which seems like, you know, if you have a lot of specialists that should be great, but if you reverse that trend then you see improved care in those communities. And this has been replicated in the U.S. as well as in other countries. And she came up with what she called the four pillars of evidence-based primary care. They are all Cs actually. It should be first contact access, which is basically access. So in other words, when your patient needs something, they need to be seen, you know, when they need to be seen, when they feel they need to be seen. So, for example, a rash today is here today and it should be seen today whereas health maintenance may or may not need to be seen today. And we want to help people be able to have that access point be us. Sometimes they come in and we say, "Oh, you know, you need to go to the emergency room." But at least we've had an opportunity to help make that assessment. The next pillar is continuity or person-centered and not a disease-centered care based on a continuous relationship. And one of my gurus who ran an FQH, started a FQHC

in Northern Colorado said the widget of primary care is continuous healing relationships, which I tend to agree with. And that's why continuity is one of the four pillars. There's also comprehensive care as I explained, you know, in a residency-type clinic we get to do very comprehensive care. And then coordinated care, so helping our patients navigate the system when they need care outside the primary care clinic. So, helping them navigate the neighborhood is very important to us. So, the continuity is really a main basis. It's something that a lot of the providers come in to primary care valuing highly. And it's not only valued highly by the providers but also by the patients. And then it's also one of the evidence-based pillars of good primary care. Just a little snippet here from a research study in the late '90s. So, people who say they have a primary care physician rather than a specialist as their regular source of care have lower subsequent five-year mortality rates after controlling for all of the things that you can control for. I think it's just further evidence of what we already know, which is continuity is good. You prefer it. I prefer it. If you go to your doctor, that's what you want. If your loved one goes to their doctor that's what they want. So, what can we do to figure out how to make that better for everybody? All right. The reason I mentioned medical students in this slide here is because we are constantly hiring. Every year we hire eight new doctors that need to be trained. And medical students are very into this concept of the continuous healing relationship. And they say it's why they chose family medicine. We want to help provide them with the experience of continuity so that they can then go out and replicate it in their practice in the future. And obviously more efficient. So, when I walk in the room with one of my continuity patients, I don't have to ask them about, you know, certain social data. I already have a picture in my mind of what's going on, what kind of care arc they've experienced. And oftentimes because of continuity I have already seen any emergency room reports that have been sent directly to me. I've seen their most recent labs. So, a repository of data in my head when I walk in the room with the patient. All right. So, measuring continuity. Now, first off, easier said than done, and I'm going to talk to you a little bit more about what the challenges are around measuring continuity. But one of the main challenges is somebody has to do it. And it's not automatic. It takes time. It takes time even when you use an electronic medical record. We have a specific field for primary care provider. And actually we are able to extract data fairly easily from the EHR, but in the beginning making that set up happen is a technical feat that requires from up front work.

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So, we, you know, you kind of have to sell it to anybody who is sponsoring you and your work. Yes, continuity is important, and yes I need this help to make these reports happen. All right. So, lots of math. You know, the way I started with our continuity work, which was basically starting with nothing. We did not know if we had continuity. We did not know about our panel sizes. Well, it's first deciding well what is a good panel size for us. And, you know, those of you who see a lot of commercial insurance and are out there, you may even laugh at these numbers and say well a private doc may have more than 2,500 patients, that's a lot, but in residency we use a lower standard for a panel. So, a 1.0 employed doc or provider would be taking care of a panel of about 1,500 patients. And that's what we use for our residents as well. So, we have the ideal panel sizes. And then you assess what your real panel sizes are. And I think that a lot of you have already been working on this kind of stuff, but I think in the end it's very valuable. So, you kind of choose a time frame 18 months to 3 years. I heard that many of you have been perhaps using two years as your kind of patient panel look back. One thing that is important is to

figure out that every patient is assigned to a PCP. Otherwise, and by that I mean primary care provider. By that, by doing that you ensure that you're able to measure, you know, what are people's experiences really. If those are blank it's important to figure out why they're blank. But it's most important to systematize, making sure that the PCP or primary care provider field is filled out in the electronic medical record if you have it. And we use EPIC. I just mentioned that. So, I can actually just open up EPIC and write my own report for a specific provider and find out who are the patients who are assigned to that provider. So, this is just an example. It's not a great example. But this is the provider here. These represent the patients with no identifiers. This is just Excel data on the left here. But it gives me an idea of the patients who are empanelled to D. Mays. He had 420 when I ran this report. You can see they range in age and gender all over the place. And actually the way I wrote those report you can see when their last visit with us was as well. So, I like to see, OK, is this patient actively using our services? But just by running that report I can say, hey, Dr. Mays has 420 patients. He is a third year resident. He essentially sees patients 0.5 FTE. So, he probably has a little bit of room on his panel. All right. Next, you've got to track the continuity. So, make sure that you balance as best you can. And I'm constantly rebalancing our panels. And then you've got to figure out form the patient's point of view if they saw their PCP. So, when our patients came in as an aggregate, were they able to see their primary care provider. We had a benchmark that we set at 40 percent. And a lot of you, you know, I saw Elisha had used, numbers like 75 percent, which is totally great, but when you have 24 part-time providers, that's just not realistic for us. And we'll see some real data from our clinic and get an idea of what that looks like. All right. So, the patients who saw their PCP. So, of all of Dr. Berngard's patients, every patient who has the PCP filed, PCP field filled out with her name, of all of them that came in in the past month, what percentage saw Dr. Berngard? And so Dr. Berngard is a 0.5 FTE third year resident. And she, so 64 or six or seven out of 10 of her patients who came in during whatever month I ran this report for were able to see her. So, that's actually pretty good for us. But check out Dr. Sushinsky next door. Dr. Sushinsky was working the ICU during which time he has no continuity clinics for an entire month. And obviously of all of his patients that came in to see him, 0 percent were actually able to see him personally. And then you can see Dr. Bloom. She's a, let's see, a 0.2 roughly FTE. Of all of her patients that came in about five out of 10 were able to see here. So, this is looking from the patient perspective. Patients who came in, were they able to see their doctor. So, given the more challenging setting of the multiple part-time providers, which actually I think is becoming more of the norm in primary care, we also like to measure team-based continuity and put some benchmarks on that. So, we chose a benchmark of 70 percent for our team-based continuity. And so of the number of patients who came in who were assigned to providers on a team, how many were actually seen by other providers on that team or their own primary care doctor. So, Dr. Lebsack is an intern. He's like basically 0.05 FTE or something like that. No, he's 0.1. That's right. He's 0.1 FTE. So, of all of this patients that came in, and I can tell you his patient panel is 100 patients, 92 percent were able to see either him or somebody else on his team. Dr. Young, another intern, another 0.1 FTE was closer to 60 percent. And then we see the team as a total. OK. So, this is the green team. All the patients who were assigned to green team providers, how many were actually seen by green team providers? Seventy-eight percent, which is great. And then finally the grand total for the entire clinic, so how are we doing as a whole clinic, team continuity in around the 80 to 81 percent. So, that's a good month for us. And we like that. All right. Third measure for us, we call it the provider pain index. When you walk in to see a patient it is a beautiful thing to walk in and see the smiling face of

somebody with whom you have a continuous healing relationship. And that can make or break a day if you have a lot of continuity and you're seeing patients whom you know. Some of them whom you really like a lot, some of them maybe who are more challenging. It makes the day better for everybody. Your patients who are complex get better care. You don't have to say, "Hey, you got to follow up with your primary doctor because you're so complex I don't understand you." That decreases access because let's say, you know, Dr. Switzer sees one of my patients. She doesn't quite get what's going on with them in that 20-minute visit. And she says, "Well, come see Dr. Gale in a month," when I can say, "Oh, I can see you in three months. You know, I know your current status is stable, and this is how you've looked for years." So, that's kind of why we measure the provider-based continuity. So, let's talk about what does it mean. All right. So, the number of patients seen by me under the number of patients that are actually mine. So, 80, let's say I saw 10 patients this month or this week or whatever this day, eight or nine of them were actually assigned to me. So, when I walked in the room, eight out of ten times that was my patient. Now, Dr. Merrill is an intern. She hasn't established good continuity with her patients yet. And you can see that when she walks in the room only two out of 10 times is that patient hers. So, I probably experience less of that, "Oh my goodness, this is a very complicated patient or somebody I don't know," than Dr. Merrill. And then you can see for different people, a second year and a second year they have different, and then a third year who is more like a 0.5 FTE is almost 5 out of 10 times when they walk in the room they are seeing their patients. And, again, like I said, it's just more gratifying. All right. How do we, what do we do besides just assigning patients and following numbers? Well, I think it's really important to engage your patients in the concept of continuity from the start. So, every time during check in we systematically assess whether a primary care provider has been assigned for each patient. And we encourage the patients to understand who their primary care provider is. We have pictures of our primary care providers all over the office including in all of the check in stations and in all of the rooms. We have all of the team doctors on the wall. And we are able to point at pictures and say, "Who did you see? Who is your primary care doctor?" And reinforce to our patients that that is the person who is ultimately their teammate in their health care journey.

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We also have a couple of brochures that we give to patients at least on a yearly basis, and we strive to document that we've given that brochure to the patients. And on it there is a space to fill in who the primary care provider is. So, it says, "Your primary care doctor or provider is," and then there's a spot there where they can fill out their name. And actually our front office staff the first time fills out the name for them. We have a TV in the waiting room that has health-based kind of programming on it. And we create some of our own programming, a 30-second spot, for example, that describes why we need team-based care in a residency setting, why your doctor isn't here today because they're in the ICU for the next month, and it's part of their learning process that they need to be there. And then we also have team-based cards, so there aren't any individual cards anymore. All of the cards have every provider on the team on the back. And we, you can, when you are giving your card to your patient you just circle name, and you say, "These other doctors are also on my team, and we work collaboratively together. And so if you call and you're feeling like you have an urgent need and are unable to see me, these are the other doctors who would be great to see." All right. So, just because we do it a little bit doesn't mean it's not challenging. OK? So, I'd say it requires technology and reporting writing and query skills. I

don't think that's 100 percent true, but with paper charts I think it makes it a bit more challenging. So, if you have paper charts, one of, you know, you may not be able to get perfect real-time data. And you'd probably have to audit on occasion, just audit a single day for example. Maybe make, you know, Tuesdays or some kind of neutral day, Thursday is your continuity audit day, and every patient who comes in just put a check mark or did they see their personal provider or not, did they see their team or not, everyone who comes in if it's important for you to measure. If you do have the technology, actually getting the information out of the technology is also a technical problem. And certain programs have report writing capabilities. Other times you need to have some technical assistance. So, that's a major challenge actually because your continuity may be down on somebody's list of priorities who is doing the technical work. It takes time. So, somebody who knows about the process and cares need to be involved. And obviously when they're doing that they are not doing something else. So, for example, every year just like we hire eight new providers, we lose eight providers. And I spend almost a week rebalancing all of the panels during that time. And obviously that decreases my patients' access and continuity during that time that I'm doing it. But it's a commitment to the entire practice that I've chosen to prioritize because of the value of continuity. Finally, it is not automated even when the machine is powerful and the data is good. It seems like I should be able to push a couple buttons and tell the computer to "Hey, take all of Dr. Mays's patients, and I want them reassigned to all these other patients." So far I haven't figured out how to do that with a lot of technical assistance. And so I actually have to take reports out of my electronic medical record, put them into Excel. I then have to rebalance them based on age and gender and then create reassignment panel packets, which I then give to a person who goes through every single record and takes Dr. Mays name off and puts the new PCP on it. That's not so easy. Working with part-time providers, so I suspect that a lot of you are dealing with a lot of part-time providers. And I think it's important that our patients understand part-time, why occasionally when they call their doctor is not in. You know, a lot of family docs nowadays are working four days a week. And I think that is a good thing personally for the sustainability for the career. But I think it's really important to engage your patients in education about that and say, "Hey, look, you know, you want to see your doctor, and they want to see you, but sometimes they are not here. So, if it's urgent, we need you to tell us, and we can help you connect with their team." We have a Patient Advisory Board that suggested we develop our educational materials that we did develop with their guidance and that's what we give out on a yearly basis if not more. All right. So, the whole team has to be on board with continuity. And I suspect there are providers and administrators and all sorts of folks from the primary care health team who are on this call. I really think that it's important to talk about continuity and the four pillars of evidence-based primary care so that everybody understands the value of continuity.One of the easiest ways to do that is when you are having a meeting and if you have a reflection, just talking about hey what is a good experience for you. Is it good when your doctor walks in and you see the person whom you know, who you already have a relationship with? That's what we're trying to build here. And that way everybody can be part of the team and enhancing continuity of care in the clinic. And there are small ways that everyone on the team makes a difference. So, making sure the PCP field is current. There are certain things related to scripting when people call for an appointment. And then also helping set expectations with patients who are, you know, a lot of patients kind of remember the old fashioned way when, hey, you just walked in and there was your doctor every time. There was kind of only one to choose from and that was it. It's good to help them with expectations and

understanding that when it's urgent come in for anybody, when it's not then come see your doctor because it will be a better experience. I mentioned open access scheduling here. So, continuity and access are strongly related. And I believe through the CPC work that you guys are doing, they are actually kind of bundled under the same concept of access. When continuity increases, access can decrease. And that can be related to over empanelment of the providers. On the other hand, if you have total open access, you may actually decrease your level of continuity for obvious reasons. Anybody can come in any time, but they are going to see whichever provider they see. So, measure, like keeping track of both of those measures is very important and understanding that dynamic relationship is very important. So, what do we do in my clinic? We have a half open access schedule that we try and maintain completely open until 48 hours before that providers clinical day so that within 48 hours, half of my schedule is totally open and patients can call in for urgent needs at that time. So, there's scripting around that. So, my patient calls in and says, "Hey, I want to see, you know, Dr. Gale." And the scripting would be something like this, "So, you want an appointment tomorrow? Well, Dr. Gale really likes to see his patients, but he is not available tomorrow, and he could see you in two days. If it's more urgent or convenient then I can make an appointment with one of his teammates at a time that's more convenient for you." And that just helps reinforce that message, low tech, easy to do, pretty quick, doesn't take any more time when you are making the appointment, but reinforces this concept that for a lot of your care needs, it's best to just wait or see if you can make it convenient within that time to see your primary care doctor. Now, if to you, as the patient, it's more important to get in at a certain time, then it doesn't matter whether it's urgent or not, let's get you in. But it's not going to be with Dr. Gale. It'll be with one of his teammates. Oh, yeah. So, we talked about the pictures of all the providers in the rooms. And we can point at them and say, "Hey, this is who you are going to see in a month, and the reason is that I'll be on the inpatient service, and I'm not available to see patients at that time. And I think it's very important that you follow up at that time." Or, "This is who your PCP is. Yeah, you like me, but I'm over empanelled already. So, I apologize, I can't take more patients, but I'm super happy to help you today with this problem. In the future, it's good for you to know that your PCP is Dr. Wheedle." And then they can choose preferred teammates as well. And so that really helps them feel like they have some control in that type of setting. So, what are the benefits? Well, all of the providers are able to see their panels and know that their panels are roughly age and gender matched, which we use as a proxy for health status, the easy proxy for health status, and feel good that somebody is trying to make sure that they are not over empanelled, under empanelled, and that they have similar kind of acuity and complexity as their colleagues. Patients love it. And they are reminded that they do have a primary care doctor and that they also know that somebody can help them with urgent needs, and it doesn't have to be their primary care doctor. And then everyone on the team is aware of continuity and is able to reinforce that. That is really important. More benefits. We are able to talk about continuity objectively. So, if some doctors say, "Well, I do more work," or, "I have more challenging patients," or something like that, well, we can run panels and say, you know, you actually have fewer patients or you do have more patients or you have older patients or you have younger patients. And you don't have to talk about, you know, how you feel about the experience any more. And then people say, "I feel like I never see my own patients," and we are actually able to say, "Well, we have the data that shows how often you do see your patients and how often your patients are able to see you." And then patients are systematically educated and engaged in the process of engaging with their primary care doctor or provider. All right.

So, results from the way we do it. This is three years in a row. I think, no, '12, '13, '14 are the numbers going down. So, team-based continuity improved for us as you can see in 2012. For the year 2012 we had team-based continuity at 64 percent for the entire clinic. And then it went up in the following year by a lot and stayed stable in that time. And you can also see, well, this team, green team, one of the three clinical teams on our practice, is continuing to show some improvement in that time as well. This is the same kind of data but for the entire clinic. Did the patient see their own primary care doctor? So, in 2012, of all the patients who came in 42 percent, so 4 out of 10 roughly were able to see their own doctor. In 2013, that went up to 44 percent. And then in 2014 that's up to 45 percent now. Like I said, our benchmark was 40 percent. We're pretty happy with 45 percent. But it could be even better. And you can run this type of data for subsets. So, for attendings what is your patient continuity data. Patients do notice continuity and team-based care. So, recently I was seeing my long-term continuity patient. And I actually had been moved, I'm a blue team doctor, and they had been roomed in the red team. And they actually, the patient told the medical assistant, "Hey, you're taking me to the wrong place. This is not my home. You are taking me to a different spot." Well, she felt empowered to be part of the care team and know, "Hey, I go to the blue team usually," which just gives her a feeling and sense of ownership and agency in the health care experience. And then finally I have on the bottom here Patient Advisory Panel has been one of the most transformative groups for us. They help us understand patient perspective on a lot of things from communication, from providers being late, from all of the really important quality improvement projects we do. So, and I think I am going to hand it back over to Elisha now, and she can take from here. Thanks a lot of listening. And I'm impressed that you all are engaged in this process.

Thank you so much Dr. Gale. I really can't say enough about how meaningful it is to have you as a provider share about your experience doing continuity, the good, the bad, the struggle, the benefit. It's really, I think, timely for our practices right now. So, we really appreciate it. And we will have you stay on the line until the top of the hour. And with that I will open it up for questions. Please raise your hand and we can unmute your line or type into the chat box and let us know what questions you have for Dr. Gale or myself.

Elisha, this is Nicole. And I have a question we can maybe use to get stated. I'm curious to hear from practices. I liked the idea that Dr. Gale shared about the cards and that when they give a business card or an appointment card to a patient as they are finishing up their conversations or leaving the practice that it has the entire, all of the members of the care team listed. And I am wondering if other practices have used this. And maybe if you are not in a residency practice and you're in maybe a smaller, private practice that you might consider using business cards that include the solo provider and the care manager or the medical assistant, any of the professionals that are on your team as part of the material that the patient leaves with. And I'm curious if anybody is doing that right now and how it's working. So hearing nothing I am assuming then that most practices are still using just a single physician name on an appointment card or follow-up materials. Elisha, is that what you are seeing in the practices that you visit and work with?

Yeah. I think so. And I think that's a great idea. And something for practices with care teams to consider certainly.

I can mention a couple more things. Dr. Gale here. So, two of the things that people felt like they wanted to learn are how is it, how is the continuity data actionable and how is it meaningful? And I talked a little bit about how it's meaningful. So, obviously it's actually evidence-based to improve morbidity and mortality for your patients. It also helps improve their care experience. I'll also say that by kind of having a panel of continuity patients, I can, what I would call, own that panel. In other words, if there is actionable data that has been gathered by my administrative team that there's some consensus around how we are going to take care for example, let's see how many of my patients over the age of 50 have had colon cancer screening, then they're able to pass that data on to me with specifics. So, in other words, who the patient was, when their last screening was. And then I can be the team leader in helping to prioritize who needs outreach, who is going to be seen soon, who has already been engaged in that conversation and has chosen to decline colon cancer screenings. So, that's one way that it's meaningful and actionable to me. Another way is when you have a provider quit, what do you do with all of their patients who are assigned to them? This is actionable data. So, in other words, let's say, you know, one of my colleagues is going to go on a mission to Africa, and they are going to be gone for three months, their patients need to be taken care of by other providers. I am able to actually look at a list of those patients and transfer them to another provider and hopefully help them get seen with continuity with a new provider and understanding about who their new provider is in real time. So, it doesn't take months after that provider is cone for me to take action on their panel. And then the final thing is, let's look at so why is Provider X having better continuity than Provider Y. You could use that information to run PDSA cycles regarding the way their schedule works, regarding the amount of time they spend in clinic or regarding how much open access time they have. And then see if it changes over a period of months, their continuity numbers for their patients. So, those are just a few of the ways that we've used that data to take action.

Thank you Dr. Gale. I'll give another opportunity for you guys to ask other questions before I do a couple other slides. If there's no questions, then I must say Dr. Gale must have done a really good job. OK.

As I always say, I like to hear about, you know, when people say, I want to know how this sounds realistic or unrealistic to people. I mean are there major obstacles for some of you in doing this kind of work?

Dr. Gale, this is Nicole. And one of the things that I thought about is in terms of an obstacle or something that makes me hesitate or wonder how I could really improve that percentage or that number of patients that we were seeing their identified PCP or their care team was the element of part-time providers or rotating providers. And I think if anyone can do it in a residency practice with 24 exam rooms, a pretty big practice, and no full-time providers, I have hope that this is a model that with work and team communication that we can make work in lots of different settings. I think that is one of the biggest concerns that I hear and I see is that it is impossible to have good continuity if you don't have full-time providers and I think you've just proven that to be false.

So, one thing, so I went ahead, I put another one of our surveys up on the screen. I see folks are jumping in and doing that. So, I guess we've trained you all very well. I see, Dr. Glancy, you put other or unsure.

Since you are also a provider, could you share with us a little bit your thoughts on continuity data and what you are thinking going forward since you marked other and unsure or put it in the chat box?

50:05

I'm not sure.

Dr. Glancey, your line is unmuted if you have a microphone and can verbally ask a question, that would be great. If not maybe you can type into the chat box. Sometimes people aren't connected in a way that they can speak up. But I also noticed that we have a question from Melody Howell. And Melody I will unmute your line although it looks like you might be a call-in user. If you could type your question in chat we can get it raised to either Dr. Gale or Elisha for discussion.

I see a question from Melody. So, for profit clinics may have some pushback if they don't see the value in some of these changes like team cards. And how could [multiple speakers], how would that be pushed through? So, that's super challenging, you know, Melody. And I don't, I wouldn't pretend to have the answer for that actually because of some of the mission-based work that we have here, profit is not as important to us. Now, seeing a lot of patients is. And the efficiency of the care of the patients is very important. And I think it would be very important also for a for-profit kind of production-based system because, OK, so you say let's get patients coming back to see their own provider. One of the main push through that I could see in supporting any kind of low cost intervention for that would be let's say, you know, this very challenging patient sees me, Dr. Gale, but they're not my patient. They're Dr. McMullins [phonetic] patient. And so when I see them I'm a little overwhelmed. I have 20 minutes, sometimes 15 minutes especially if this clinic is trying to crank through a lot of volume. And I will say, "You need to come back in one week, two weeks, three weeks, or a month," and that decreases efficiency and throughput in the clinic by decreasing access. You can increase your access by having providers who know the patient's chronic condition, and when they look at them they can say this looks the same as always. I know that I see you every three months, and you're going to be the same in three months. And so it's OK to go three months and see me again at that time instead of coming back to see your primary care doctor unnecessarily. Next thing, if providers are owning their continuity panels, then they are more inclined to achieve better care data, not really data, but better care provision to their patients especially in systems that are working on [inaudible] performance stuff. So, that's just a couple thoughts I have about doing these low cost things that you might get some push back on.

And I would also add even that on a day-to-day basis that you can probably see more patients if they are your own patients because of what Dr. Gale is describing. So, for example, I know no one ever has to overbook appointments, but if you were to, you would be much more willing to overbook appointments next to patients that you know and know if you are going to be able to squeeze someone in versus seeing someone else's patients that you are probably not going to be willing to squeeze someone in. So, I think there is efficiency day to day as well.

And Elisha, this is Nicole. I just wanted to raise a great comment that Janet Stevenson put in the Q&A box about some work that their practice did demonstrating the benefit of continuity that when a provider left the practice but a lead MA stayed on board that there was really a smooth transition over

when the new primary care provider was hired because the existing historical medical assistant was still in place and knew the patients very well. And it made for a smooth transition and probably better quality care and more highly satisfied patients during that provider shift.

Yeah. I think that's a really good comment from Janet because when we re-empanel our patients to a new provider, we still keep them on the same team so when they walk in they get to see the same face. And the MA can empower the new provider in the concept of the warm handoff. And that way the MA is giving a warm handoff to the new provider. Hey, this is Dr. Gale. He's the new guy. He's been really cool to work with, or patients are loving him. Or just some little commentary like that if it's true can really help kick start that relationship with the provider and make it seem like, hey, my MA, who I have known for ten years, says this provider is cool. So, I'm going to go in there with a sense of trust and alliance.

That's great. Thank you Janet. That's a great comment. I'd be really interested to hear from the folks that marked other or unsure. If there's any lingering questions or uncertainty or whether you are just kind of trying to figure out what you have available. Feel free to speak up if you have any comments. So, I guess, we don't have any comments yet. Feel free to interrupt me over the next few minutes. A point I really would like to reiterate is that each practice is structured very differently. Our presentation today, obviously, they have a lot of providers that don't work full time. So, you have to take into consideration your structure, your demographic, your patient population, and decide what kind of continuity measure matters to your practice. I think when gathering and using data, the most important thing you can do is make sure it's meaningful to your practice and not just data for the sake of gathering data. That's what's going to make it meaningful and actionable. Dr. Gale or Nicole, any other last thoughts before we wrap up here?

Not from me Elisha.

I think I would just try to help people find the inspiration to do a little bit of work on continuity. I remember this quote being attributed to Bob Marley, one of my favorite artists. He said, "You got to start somewhere if you want to get anywhere." And if you do a little bit of work on this process on a yearly basis. One day you may find that your continuity and quality and experience are all going up. And it might be mysterious as to why that is. But those little investments in continuity that you make on a daily basis using low-tech means might really pay off in the long term in the quality of care that your patients experience.

Well, thank you again Dr. Gale. I don't think we could close on a better note. So, I will certainly leave it with that and turn it over to Nicole Banister for some final notes to the attendees on how to get credit for the webinar. And thank you immensely Dr. Gale.

And thank you all for attending. You can exit the session by clicking on the File menu option, which is on the top left-hand corner of your screen. And from there select the option to leave the session. And as a reminder, you will be directed to an exit survey. And we use this to both collect your attendance data for today's presentation as well as providing us feedback for planning future sessions. Thank you so much for your participation and have a good afternoon.