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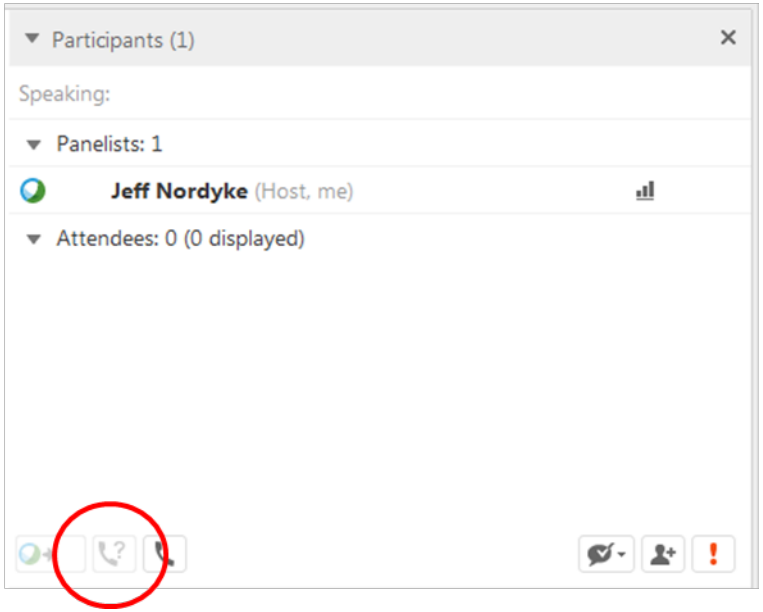

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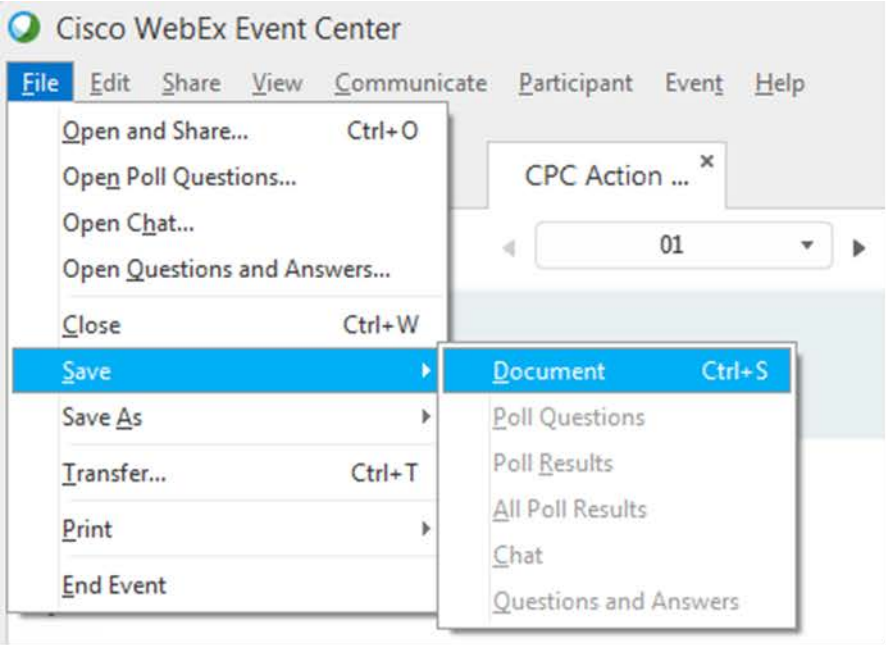

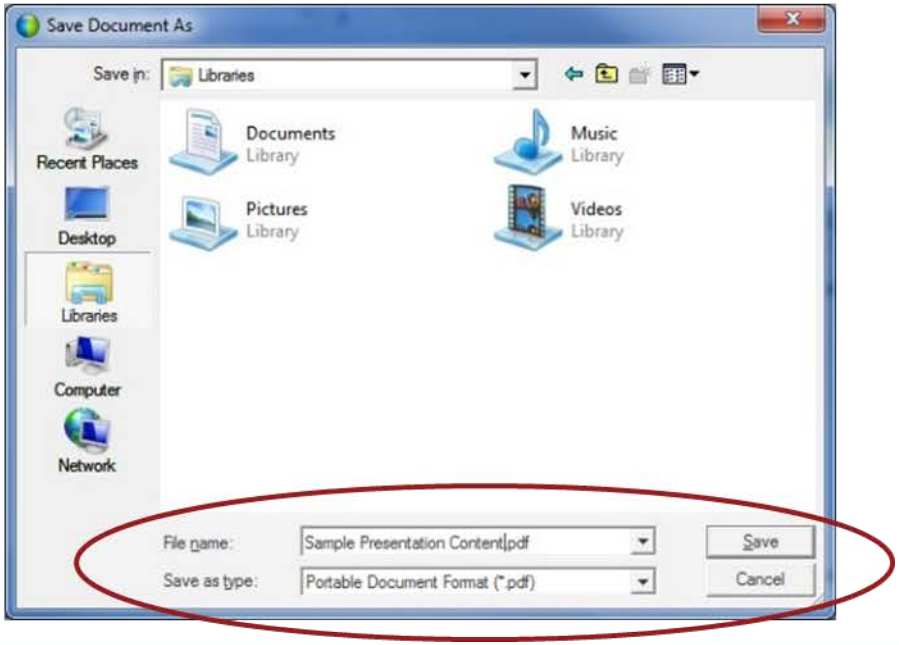

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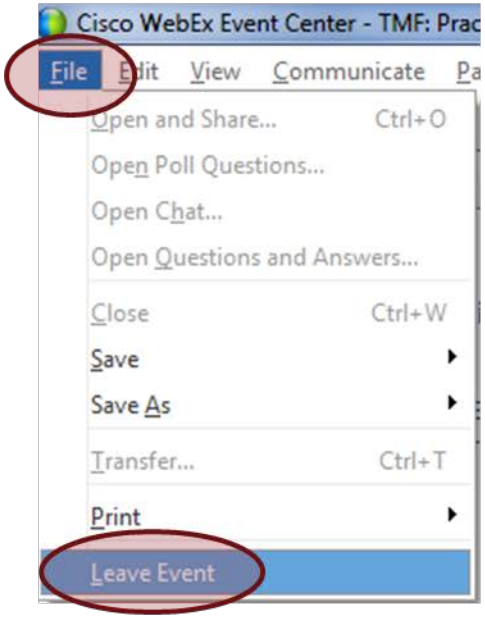
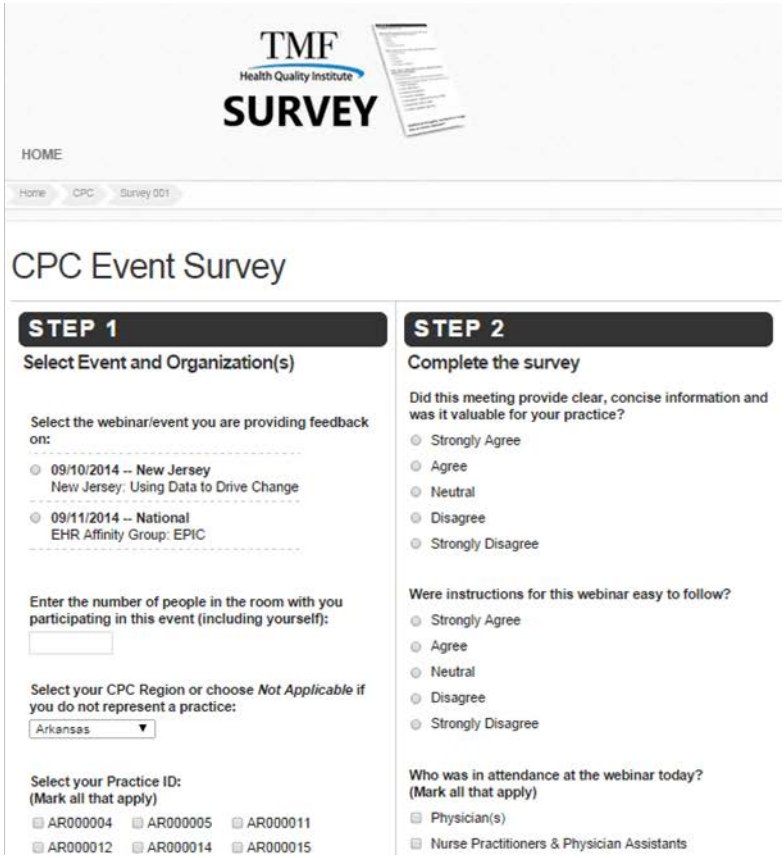




Continuity of Care

Elisha Jewett, MPH
HealthTeamWorks

Shared Purpose

- Discuss the value of care continuity to patients, family and staff
- Learn methods to measure and track continuity
- Identify opportunities to improve care continuity

What is the number one item you hope to learn about today?

- What does continuity in CPC mean
- How do we track continuity
- How to make continuity data actionable
- What makes continuity data meaningful to providers
- Other -- (Please use Chat)

Continuity of Care

- An ongoing relationship between a patient and provider(s)
- Longitudinal continuity with a provider or team continuity with a specified team
- Three dimensions of continuity
  - Interpersonal/Relationship – continuity with a provider/care team
  - Management – there are no conflicts or inconsistency between providers in the management plan for a patient
  - Information – all providers and teams caring for the patient have access to the patient's electronic health record

Making the Case for Continuity

- Better care – both true and perceived
- Increased patient satisfaction, especially for complex and vulnerable populations
- Improve efficiency – save time for patient and care team, decrease duplication
- Increase patient engagement

Measuring Continuity

Role	Measure
Provider: The frequency with which patients see the provider to whom they are empanelled	Number of patient visits with *their* empaneled provider ÷ Total number of patient visits with any provider
Care Team: The frequency with which patients see the provider or other specified care team member such as a NP or PA that is clearly designated and communicated to patients as part of the provider's care team	Number of patient visits with *their* specified care team ÷ Total number of patient visits with any provider
Patient: Many patient satisfaction surveys include elements of care continuity in their questions. Patient experience questions may reveal patient perception and value of continuity	○ "In the last 6 months, when you went to the doctor, how often did you see your personal provider (MD/DO/NP/PA) ?" ○ "Is there a particular provider you prefer to see at (practice name)?" AND ○ "How often do you see the provider (MD/DO/NP/PA) you prefer to see?"

Ex: Provider Continuity*

CPC
Comprehensive Primary Care

Schedule	Provider A	Provider B
9:00:00 AM		
9:30:00 AM		
10:00:00 AM		
10:30:00 AM		
11:00:00 AM		
11:30:00 AM		
12:00:00 PM		
12:30:00 PM		
1:00:00 PM		
1:30:00 PM		

Patient Empaneled to provider seen
Patient Empaneled to Different Provider

Provider A:

7 ÷ 10= 70%

Provider B:

8 ÷ 10= 80%

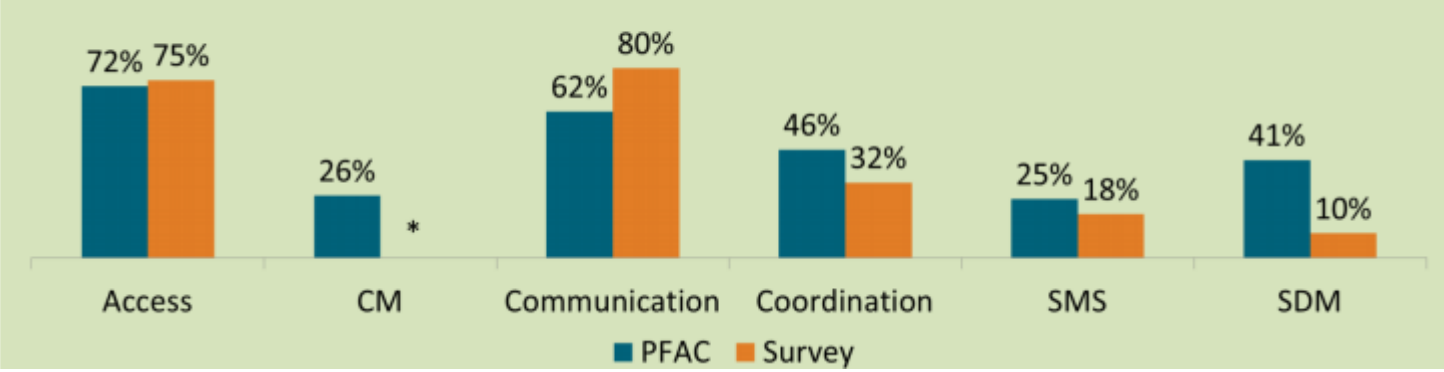
Total Practice:

15 ÷ 20= 75%

*This example looks at one day. The same math can be applied to any length of time.

Ask Your Patients

Figure 13. Area of Improvement or Focus Selected for a PFAC or Survey, by Percentage of Practices that Selected It, July 2014*



- Use your arrow to show how you have engaged patients to address care continuity at your site

PFAC

Survey

Good Idea!

Do you track care continuity?

- Yes, we track care continuity of each provider
- Yes, we track multi-provider care team continuity
- Yes, we track provider AND care team continuity
- No, we have not starting tracking continuity
- I do not know if we have begun tracking continuity yet

CPC
Comprehensive Primary Care

Dr. Aaron Gale, MD

Bruner Family Medicine Center

Bruner is a special place…

- St. Joseph Hospital Family Medicine Residency
- 24 resident doctors, one OB fellow
- 9 full-time faculty seeing patients
- NO full-time patient care providers
- 24 rooms
- Approximately 120 visits scheduled daily
- NCQA Level 3 PCMH

Bruner is a special place (cont'd)

- 30% of our patients are Spanish speaking
- 33% uninsured, 43% Medicaid, 14% Medicare, 10% commercial
- Full spectrum family medicine: Peds, OB, outpt. surgical procedures, inpatient peds and adult medicine, nursing home care, home visit programs
- Patient Advisory Board as a source of innovation

Pillars of Evidence-Based Care

- Barbara Starfield has written about the 4 pillars of evidence-based primary care
  - First-Contact **Access** for new needs
  - Person-centered (not disease centered) care based on a continuous relationship (**Continuity**)
  - **Comprehensive** care for multiple needs
  - **Coordinated** care when needs must be met outside the primary care setting

The Evidence for Continuity

- U.S. respondents who reported having a primary care physician rather than a specialist as their regular source of care had lower subsequent five-year mortality rates after controlling for initial differences in health status, demographic characteristics, health insurance status, health perceptions, reported diagnoses, and smoking status (Franks and Fiscella 1998).

Continuity at Bruner Family Medicine

- Patients and providers like it
- Medical Students site continuous relationships as one of the driving forces in their selection of family medicine as a specialty
- Care is more efficient and personal

Measuring Continuity

Step 1: Panel Sizes

- First, you have to do the math
  - What is the panel size you are going for?
    - Some private practices might choose 2,500 or more
    - In residencies, an industry standard is 1500

Step 2: Empanelment

- So now that you have ideal panel sizes, you have to assess the real panel sizes by making reports
- Your patients are any who have come to your office in the past 18 months to 3 years
- Make sure to assign every patient to a PCP
- I use the EPIC electronic medical record to run a list of patients empanelled to a certain PCP

Example of Provider Panel Report

441	4yr	Male	Mays Israel J	6/2/2014	
442	24yr	Male	Mays Israel J	8/13/2014	
443	30yr	Male	Mays Israel J	11/18/2014	
444	28yr	Male	Mays Israel J	11/5/2014	
445	8mo	Female	Mays Israel J	11/14/2014	
446	28yr	Male	Mays Israel J	11/5/2014	
447	76yr	Male	Mays Israel J	12/9/2014	
448	47yr	Male	Mays Israel J	10/14/2014	
449	29yr	Female	Mays Israel J	6/19/2013	
450	12mo	Male	Mays Israel J	11/18/2014	
451	67yr	Female	Mays Israel J	8/21/2014	
452	36yr	Male	Mays Israel J	8/27/2014	
453	20yr	Male	Mays Israel J	6/19/2013	
454	56yr	Female	Mays Israel J	2/18/2014	
455	6yr	Female	Mays Israel J	11/22/2014	
456	15mo	Female	Mays Israel J	11/25/2014	

Step 3: Track Continuity

- Rebalance panels as needed and then track the continuity as best you can
- Rate of patient seeing own PCP
  - The question is, for the patients who came in, what percent saw their PCP
  - What are your benchmarks? Ours is 40%

1st Measure:

Percent of patients who saw their PCP

BERNGARD, JENNIFER D	SUSHINSKY, STEVEN	BLOOM, ASHLEY E
64.63%	0.00%	56.00%
64.63%	**0.00%**	**56.00%**

2nd Measure:
Team-Based Continuity

- In a situation like ours we also like to measure two other things:
  - Team-based continuity with benchmarks: Ours = 70%
  - # of pts seen by team/# of pts visits assigned to team

LEBSACK, MATTHEW	YOUNG, KRISTEN	BFP GREEN TEAM Total	Grand Total
92.31%	59.09%	78.18%	80.96%
92.31%	**59.09%**	**78.18%**	**80.96%**

3rd Measure:
Provider Pain Index

- Finally, we follow what we call a provider pain index, answering the question "do you see your own patients?"
- Number of pts seen and assigned to provider
- Number of pts seen by provider

BERNGARD, JENNIFER D	BLOOM, ASHLEY E	SWITZER, REBECCA A	GALE, AARON BRETT	MERRILL, ELISABETH
45.30%	38.89%	58.54%	86.96%	20.00%
45.30%	**38.89%**	**58.54%**	**86.96%**	**20.00%**

Low Tech Remedies

- Engage your patients from the start
  - At check-in assess PCP assignment every time
  - Encourage patients to understand who their PCP is and which team they are on
    - We have two brochures we give patients
      - A general users guide to the clinic with a space to fill in PCP
      - A 30 second spot on our waiting room TV that describes team-based care
      - Team-based cards with all of the providers names, team identification and the direct phone number to the team MAs

Challenges

- Requires technology and report writing or query skills
- Takes time. I rebalance and reassign every year and it takes a week at least
- It is not automated, so once I have changes I want to make, the front office staff have to execute the changes record by record

Challenges

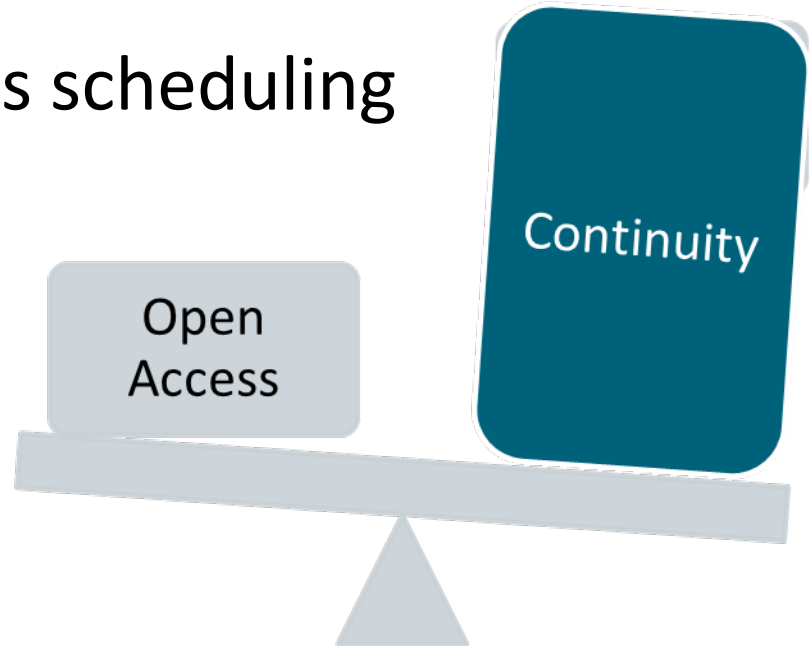
- Working with all part-time providers is a challenge for the patients and they need to be educated about why their provider is unavailable
  - Our Patient Advisory Board suggested that we develop educational materials to be given to patients on at least a yearly basis

Challenges

- Getting the whole team on board
  - Front office, MAs, Admin, Providers and Patients need to understand expectations
  - They also need to understand small ways that they can make a difference
    - Making sure the PCP field is current
    - Scripting
    - Helping set expectations with patients

Challenges

- Open access scheduling



Challenges

- Example of scripting
  - "So you want an appointment tomorrow? Dr. Gale really likes to see his patients, but he is not available tomorrow. He could see you in two days, or if it is more urgent or convenient I can make an appointment with one of his teammates."

Challenges

- Showing the team of providers in every room helps inform patient familiarity
  - Now I can point at a picture and remind the patient who their PCP is
  - I can let them know I'm not available in a month but they can choose their preferred team mate for a follow-up visit

Benefits

- All providers are able to view their panels and their panels are essentially age and gender matched.
- Patients are reminded that they have a PCP and a team and they know how to make more urgent contact regarding clinical needs
- Everyone in the office is on the team in reinforcing continuity of care

Benefits

- We're able to talk about continuity objectively and assess why certain months are good or bad. It's not just about feelings anymore
- There is an answer to "I feel like I never see my own patients"
- Patients are systematically educated and engaged in the process

Results

Team-based continuity improved

	BFP GREEN TEAM Total	Grand Total
	73.66%	64.51%
6	74.64%	81.81%
	78.18%	80.96%
6	**75.49%**	**75.87%**

Results

- Patient saw PCP rate has been rising for three years straight
  - 2012 Total: 42.75%
  - 2013 Total: 44.37%
  - 2014 Total: 45.83%

Patients Notice

- I was recently seeing my long time continuity patient, but I was on the wrong team due to MA provider census
- When I walking into the red painted room she said “I tried to correct the MA because she was bringing me to the wrong team. I told her I’m a Blue Team patient.
- The Patient Advisory Panel!!!!!!!!

Questions

How will you gather continuity data?

- From my existing EHR reports
- From Custom reports to pull data from EHR
- Using multiple inputs to build report
- Manual retrospective audit
- Manual real-time tracking
- Other/Unsure

Back to what you wanted to learn…

What does continuity in CPC mean

How to track continuity

How to make continuity data actionable

Hear what makes continuity data meaningful to providers

Other -- (Please Chat)

HealthTeamWorks Continuity Tool

HealthTeamWorks

Continuity of Care: A Reference Guide

Continuity of care refers to the regularity with which a patient sees the provider to whom they are assigned, also known as their personal provider to whom they are empaneled. It is based on the long-term patient-provider partnership where the provider has personal knowledge of the patient's history and can integrate new information and make efficient decisions from a whole-patient perspective. For patients, it is the experience of care as connected and coherent over time. For providers, it is the experience of having sufficient information and knowledge about a patient to best apply their professional skill.

Common Reasons for a Lack of Continuity

- Patients not being designated to a single provider or care team, and therefore being scheduled with various providers
- Provider panels that are too large, causing limited timely access
- Lack of availability for acute visits built into provider schedule
- Patient's preference for scheduling flexibility by seeing any provider over continuity with their selected provider

Benefits of Continuity of Care in Primary Care

- Increased patient satisfaction with their visit and increased provider satisfaction
- Increase in appointment efficiency, decrease in duplication
- Improve care coordination occurs with increased continuity
- Decrease inappropriate patient utilization of healthcare including emergency department
- Decrease patients from falling out of the system and missed patient follow up
- Particularly important for more vulnerable and complex patients
- Continuity in primary care is associated with a decrease in long-term mortality
- Patients that have long term relationships with their providers have better outcomes

Continuity Measures

Role	Measure
Provider: The frequency with which patients see the provider to whom they are empaneled	Number of patient visits with *their* empaneled provider ÷ Total number of patient visits with any provider
Care Team: The frequency with which patients see the provider or other specified care team member such as a NP or PA that is clearly designated and communicated to patients as part of the provider's care team	Number of patient visits with *their* specified care team ÷ Total number of patient visits with any provider
Patient: Many patient satisfaction surveys include elements of care continuity in their questions. Patient experience questions may reveal patient perception and value of continuity	▫ "In the last 6 months, when you were went to the doctor, how often did you see your personal doctor?" ▫ "Is there a particular doctor you prefer to see at your GP surgery or health center?" AND ▫ "How often do you see the doctor you prefer to see?"

**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 (i.e. previous 6 months)*

References Available Upon Request
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Rev. 12/10/14

HealthTeamWorks

Steps to Collect and Use Continuity Data

STEP 1: Empanel Patients	•Complete the empanelment process; each patient should have an identified provider
STEP 2: Identify who will access and distribute data	•Identify a staff member to pull or track continuity data, keep track of the continuity trends, and share data with the QI Team or practice
STEP 3: Select measure(s) to track	•Select one or more continuity measures to track including a look back period for the continuity data (e.g., data month-to-month, previous 6 months)
STEP 4: Set targets for each measure selected	•Set targets for each selected measure, these can be consistent across the practice or vary by provider (Provider Continuity: ex: 80% , care team continuity frequency: ex: 95% Patient Satisfaction: would be dependent on selected question)
STEP 5: Create Continuity Policy and Procedure	•Create an access and continuity policy and procedure that includes: regularity with which data is reviewed, goals or targets for each measure being tracked, staff role in supporting and messaging care continuity

Helpful Tips

- Your practice culture should promote ongoing patient-provider relationships, and set this expectation for all staff and patients
- Your practice should always consider your access when looking at continuity, and consider your continuity when making changes to access
- Staff should be well-versed in access and continuity policies and changes to policies. Patients should be informed of all such policies
- NCQA 2014 standards include having a written process for access and continuity, and you must document specific targets and results
- For more tips on patient empanelment, go to www.ahrq.gov

References Available Upon Request
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Thank you!

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Panel Size Resources

- *Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation.* Ann Fam Med September/October 2012 vol. 10 no. 5 396-400 http://www.annfammed.org/content/10/5/396.full.pdf+html

- AHRQ.gov- Module 20. Facilitating Panel Management http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod20.html

- IHI.org- Manage Panel Size and Scope of the Practice http://www.ihi.org/resources/Pages/Changes/ManagePanelSizeandScopeofthePractice.aspx

- AAFP.org - Panel Size: How Many Patients Can One Doctor Manage? http://www.aafp.org/fpm/2007/0400/p44.html