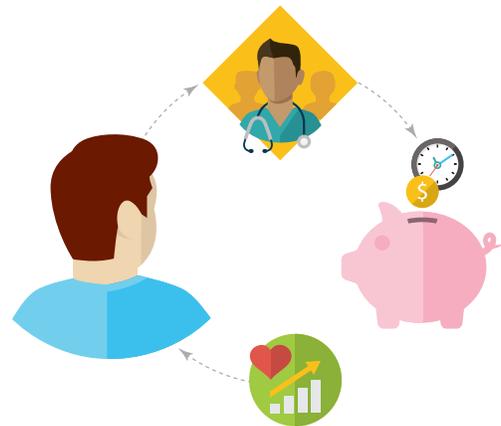# Building an Intensive Primary Care Practice

Provide better care to the patients who need it most

CME CREDITS: 0.5

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How will this module help me successfully care for patients with complex health conditions?

1. Identify patients in need of expanded services

2. Design the care model to fit the needs of the target population

3. Get to know a practice designed to deliver intensive primary care

Increasing administrative responsibilities—due to regulatory pressures and evolving payment and care delivery models—reduce the amount of time physicians spend delivering direct patient care. In the intensive primary care model, the team takes care of a targeted panel of patients with multiple chronic conditions. This approach allows practices to devote the time and develop the appropriate skillsets needed to address the complex medical needs of these patients, whose health care goals would likely not be met during a typical short primary care visit.

Intensive primary care
Release Date: October 2015
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Objectives
At the end of this activity, participants will be able to:

1. Identify patients in need of expanded primary care services.

2. Design an intensive primary care model to fit the needs of the target population.

3. Customize the staffing model required to support the intensive primary care practice.

4. Determine which outcomes will indicate the success of the intensive primary care model.

Target Audience
This activity is designed to meet the educational needs of practicing physicians.

Statement of Need
In certain health care populations, five percent of patients account for approximately 50 percent of health care costs. Primary care practices may be unable to effectively accommodate the complex needs of these patients. Building an intensive primary care practice that addresses the needs of patients with complex health issues requires engaging patients in a shared vision for a better future. This module will help physicians identify patients in need of expanded primary care services and design an intensive primary care model that will fit the needs of patients with complex health conditions.

Statement of Competency
This activity is designed to address the following ABMS/ACGME competencies: practice-based learning and improvement, interpersonal and communications skills, professionalism, systems-based practice and also address interdisciplinary teamwork and quality improvement.

Accreditation Statement
The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation Statement
The American Medical Association designates this enduring material for a maximum of 0.5 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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To claim *AMA PRA Category 1 Credit*™, you must 1) view the module content in its entirety, 2) successfully complete the quiz answering 4 out of 5 questions correctly and 3) complete the evaluation.

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About the Professional Satisfaction, Practice Sustainability Group
The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, "Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy," and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity and reduce health care costs.

Disclosure Statement
The content of this activity does not relate to any product of a commercial interest as defined by the ACCME; therefore, neither the planners nor the faculty have relevant financial relationships to disclose.

Media Types
This activity is available to learners through Internet and Print.

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ⓘ Introduction

What is intensive primary care?

Intensive primary care is delivered by a primary care team that is dedicated to comprehensively addressing the goals and medical needs of patients with multiple chronic conditions whose needs would likely not be met in a short primary care visit. Intensive primary care teams are also designed to provide patients with expanded in-person and remote access to the provider team.

When is intensive primary care used?

In certain health care populations, a small percentage of patients account for a large percentage of health care costs in any given year.[1,2] High costs associated with the care of patients with complex health issues warrant an advanced primary team care model designed to achieve the quadruple aim of better health, better care, lower cost and care-team satisfaction.[3]
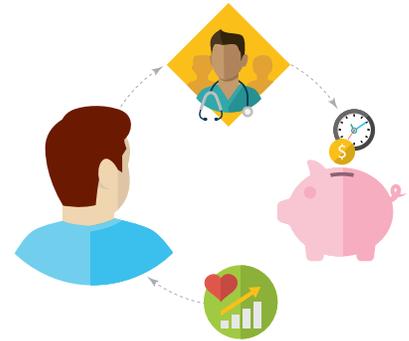
Eight steps to implementing intensive primary care in your practice

1. Identify the target patient population

2. Assess the target patient population

3. Compose the appropriate care team

4. Appropriately engage patients

5. Design the patient-centered care model

6. Build the team

7. Implement the new model

8. Track outcomes

1 Identify the target patient population

Planning care for high-risk and/or high-cost patients begins with identifying program goals and the population you seek to serve. The following are examples of potential target patients:

- Patients exceeding a specified threshold for expensive services, such as emergency department (ED) visits or hospital admissions
- Patients with multiple comorbidities who "keep us up at night"
- Patients identified by health plans or medical care organizations as being in the top five percent of predictive risk for continued high cost
- Patients with chronic conditions, such as diabetes, chronic obstructive pulmonary disease (COPD) or advanced cardiovascular disease, who are at high risk for hospitalization
- Patients who suffer from serious illness, frailty and social isolation, but who are not appropriate for hospice

More information about risk stratification can be found **here**. Also determine which patients you do not want to target for the program. For example, high-utilizing oncology patients would likely not be targeted by the intensive primary care team, although they may be evaluated for palliative and hospice care to maintain a focus on quality of life.

Q&A

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How common is the intensive primary care model?

While the primary care practice is designed to address the full continuum of needs and preferences within a population, patients who face the challenges and expenses associated with multiple chronic conditions may benefit from a response specifically designed to better meet their needs. Many programs focused on enhanced primary care for patients with complex health needs are in development. **The Pacific Business Group on Health**, **the Institute for Health Care Improvement**, **the University Health System Consortium** and **the Center for Health Care Strategies** are among the organizations seeking to enhance and spread the intensive primary care model. Common themes that have emerged from these programs are presented in this module.

2 Assess the target patient population

To understand the needs within the identified target patient population, it can be helpful to interview a minimum of five patients in the target population. Include both struggling patients and those who manage their conditions well to understand the challenges the population faces as well as the characteristics of those who successfully manage their condition(s). Understand their current situation and what aspects of the current care model work for them and what aspects do not. The intensive primary care model can then be designed to specifically meet the identified needs of the target patient population and take advantage of their strengths. Patients may identify needs that lie outside of the health care system, such as transportation or housing challenges. This information will help the team determine the best staffing complement to address the multi-faceted needs of the target population, such as involving:

- A social worker as the behavioral health specialist
- A health care navigator to assist with care coordination and connecting patients with social programs
- A health coach to accomplish teaching, <u>**motivational interviewing**</u> and long-term planning and follow up

Motivational interviewing: a coaching technique that focuses on a patient's feelings regarding healthy behaviors to collaboratively and positively develop an action plan rather than giving the patient general suggestions.

Engaging patients and asking them these four questions may give the practice a better understanding of their patients' needs:

- What is the worst thing about your health situation?
- What in your life helps to make it better?
- What does medical care do that helps make the situation better?
- What does medical care do that doesn't help or makes the situation worse?[4]

3 Compose the appropriate care team

The composition of the intensive primary care team should be based on the anticipated health and social needs of the target population.

- **Behavioral health specialist.** People with complex health conditions have higher rates of depression; depression as a comorbidity impacts outcomes and doubles the cost of care.[5] Integrating a behavioral health specialist (e.g., a licensed clinical social worker with the combined skills of a social worker and therapist) in the primary care team is often helpful.

- **Physical therapist.** Chronic pain is also common in this population, and a physical therapist could be a valuable addition to the care team.

- **Clinical pharmacist.** A pharmacist can also add value to the primary care team, since patients with complex health issues are often on multiple medications. Clinical pharmacists can monitor for potential adverse drug interactions, help patients understand their medications, promote adherence and adjust medications by protocol in order to "treat to target" conditions such as diabetes and hypertension. Additionally, the clinical pharmacist can promote a dialogue with the care team about reducing the number of nonessential medications on each patient's list.

- **Medical assistants (MAs), licensed vocational nurses (LVNs) or community health outreach workers.** MAs, LVNs and community health outreach workers can be assigned a panel of patients and be trained and paired with licensed personnel to perform routine care by protocol in accordance with state law, coach patients using chronic disease self-management principles and assist with care navigation. This is a cost-effective way to personalize care and enhance the therapeutic relationship between the patient and the care team. The MAs, LVNs or outreach workers on the team can work closely with one nurse or social worker under the supervision of the physician. The personnel your practice chooses for the model will be highly dependent on state law and scope of practice guidelines. The model is meant to increase the number of "meaningful touches" with patients through two-way conversations that take place either in-person, telephonically or via secure video call, email and messaging. These high-touch relationships are a critical component of any complex care program. MAs and LVNs can also help document patient visits. Other practices have added peers to the team in the form of community health outreach workers or health promoters with great success, providing another cost-effective approach to providing "high-touch" care.[6,7] The practice has the opportunity to train loyal staff to develop the new skills needed for this work!

- **Registered nurses (RNs).** RNs are highly trained and their skills are often best utilized when providing direct patient care. They are needed to provide care once the physician's assessment is complete and to work closely with the MAs, LVNs and community health outreach workers who comprise the extended care team.

- **Advanced practice clinicians.** Advanced practice clinicians such as nurse practitioners and physician assistants are highly trained professionals who can exercise advanced clinical responsibilities within the care team. As key members of the team, advanced practice clinicians can also help to ensure continuity, comprehensiveness and coordination of care, working with physicians and all other members of the team.

- **Physicians.** Ideally, the physician leader of the interprofessional team should be empowered to perform the full range of medical interventions that he or she is trained to perform, including to diagnose and treat, build relationships with patients, manage specialty care and provide clinical oversight and leadership to the team.

Your team may find that other team members are essential to the success of your intensive primary care model. A receptionist, dietitian and a diabetes educator may round out your practice's team, based on your target patient population's needs. The above list is meant to be a starting point to demonstrate the importance of a physician-led, multi-disciplinary, integrated team. Each practice will have to determine the staffing complement that will enable them to provide the desired level of care to their patients. The reality is that most practices will likely not be able to hire a full-time care coordinator or health coach. Instead they should seek out staff with the proper interpersonal skills and send them for training in areas such as health coaching, care management/care coordination, implementing a registry for chronic condition management and similar tasks.

Q&A

Why is it important to embed a behavioral health specialist and a physical therapist on the care team?

Including behavioral health specialists and physical therapists within the team is more efficient than referring these services outside the primary care practice, since many patients with complex conditions already spend too much time navigating the health care labyrinth and will most likely benefit from proactive care coordination.

Who are the decision-makers on the care team?

While the increased workload of taking care of the most complex patients is shared by the team, physicians are the care team members who make critical medical decisions and drive the care plan for the patients. Following their plan of care can prevent ED visits and hospitalizations, so it is critical to have enough of these team members "on-call" for the patient panel to prevent unplanned acute care on nights and weekends.

Is this model financially viable?

The Medicare Advantage program or other capitated payment models may make it possible to provide clinically and cost-effective service that may not be "billable," such as video and telephonic visits, home visits by non-billable personnel and utilizing peers within a practice setting. Determining the appropriate staffing model and identifying ways to protect physician time for direct patient care will help the practice make the intensive primary care model financially viable.

4 Appropriately engage patients

The language the team uses when engaging patients is important. Patients do not like being referred to as "super utilizers," "frequent flyers," "high risk," "too expensive" or "challenging." Many patients may view having a "chronic disease" as equivalent to being a "hopeless case." It is important to craft the right message for the targeted patient population. For instance, try substituting the term "ongoing conditions" for "chronic conditions." Use "condition" instead of "disease." Develop a name for the model, such as the "comprehensive care model" as opposed to calling it "intensive primary care." As patients in the "complex" category often require longer visits, an appealing opening question during a visit may be, "Do you think that having more time with the care team would enable us to better meet your needs?" If yes, engage the patient in a conversation about what else the practice can do for them. For patients who are seeing multiple specialists, stress that your team helps to "coordinate care, ensuring that every member of the care team is on the same page." Patients will appreciate that the team is going to provide extra help and support because they have identified the patient's individual needs, which are a priority for the entire practice.

Communicate openly with patients. Help them understand that the practice is reshaping to better meet each individual patient's needs. During these conversations, be prepared to inform patients what this may mean for them: more time spent with the physician and extended care team, more between-visit follow-up and support and ultimately, improved health.

Q&A

Many of our patients who are appropriate for this model are disengaged. How can we make them more engaged in their care?

Your disengaged patients will need you to be high-touch with them until they become engaged. Use personal phone calls to prepare them for their upcoming appointments. Ideally, these calls would be made by the MA, LVN or community outreach worker who would also see the patient when they come into the office for the appointment. Using tools like motivational interviewing and involving patients and their support system (e.g., family member or caregiver) in setting goals will increase involvement and engagement; help them take control of their own health. This will take time, coaching and a shift in their approach to self-care. Patients may be skeptical at first; it is important for the team to follow through on the promise of the new care model.

How many patients should we have in our intensive primary care patient panel?

The number of patients in the panel will depend on several factors. A primary care practice may take on a smaller subset of patients to comprise their intensive primary care panel; the team's time may not be completely dedicated to managing high-risk patients. The staffing level of the physician's or other licensed provider's team should limit the patient panel to a reasonable size. Intensive primary care provider panels vary from 50 to 500 patients per provider, depending on the health conditions being treated and the level and skill of team support. As patients are added to the model, a risk stratification score should be considered that will help guide panel numbers. For example, a team may be able to care for 50-80 level 1 (sickest) patients but 300-500 level 5 (healthier) patients. Merging the care of complex patients into a busy practice will require additional staff and protected time to adequately care for patients. This may include longer appointment times and more frequent contact with patients.

Building an intensive primary care practice that addresses the needs of patients with complex health issues requires engaging patients in a shared vision for a better future. It can be helpful to enlist a core of trusted patients/family/caregivers who are willing to preview your communication plan and provide feedback to avoid mistakes. An effective communication plan starts with a description of the current state of health to help the patient understand what is needed to move towards a better future. See below for examples of shifting patients' perspectives that can serve as the practice's "true north" as the transition to intensive primary care begins:

FROM	TO
Feeling alone and suspicious	Feeling the care team's support
Forced to be the organizer of one's own care	Feeling supported and confident
Feeling studied	Feeling heard
Bombarded with facts	Involved in developing hands-on action steps
Passed between providers	Building continuous, personal relationships
Stalled in life	Thriving

Source: AMA. *Practice transformation series: intensive primary care.* 2015.

5 Design the patient-centered care model

Patients with complex health care issues need a trusting relationship with their primary care physician and team. Additionally, they need convenient access, especially to meet acute needs, either in clinic during business hours or by phone or video visit when the clinic is closed. An effective care team focuses on the patient's self-identified goals to build a meaningful relationship and ensure that the care being delivered meets the patient's needs rather than the needs of the practice or system. A patient's behavior and choices (e.g., whether they adhere to a treatment plan, what they eat and how they set priorities and solve problems) often contribute more to health outcomes than the medical care they receive.[9] Accordingly, it is important that the care team focus on promoting self-management so that patients can remain healthy despite their chronic condition(s).

The patient activation measure (PAM) consists of **13 questions** that assess the patient's confidence, knowledge, willingness[10] and ability to self-manage effectively. The patient's responses to the individual PAM questions can help guide the care team in how to support self-management in specific areas, such as **medication adherence**, information deficits and inability to handle change. PAM can also serve as an outcome measure for promoting self-management in a population. Improving certain PAM scores correlates with improved outcomes and a decrease in total cost of care.[11]

The domains assessment[12] is widely used to help the care team understand specific issues facing a patient.[10] Four domains are identified for exploration:

1. Trust and access to medical care
2. Mental health and its contribution to a given patient's approach to self-management
3. Social support
4. The medical complexity facing a given patient (and its likely trajectory over time)

While the domains assessment tool has not been fully validated, it helps the team focus on the areas of greatest leverage with a patient[12] and the greatest opportunities in constructing the model.

6 Build the team

A | Hiring the team

Hiring the right team members is both an art and a science. Most agree that the team should hire for personality and empathy and train for specific skills. Behavioral interviewing by team members allows for more accurate assessments of potential team members by asking candidates to describe a time when they gracefully handled a challenging situation or when they effectively worked in a difficult team environment. Applicants are presented with patient scenarios and asked to "think on their feet." Some of the best applicants may come from the service sector and have limited or no health care experience, as a good patient experience helps establish the trust that will result in a better patient outcome.

Expanding the role of non-licensed staff requires particular attention. Having protocols in place helps to ensure safety and high-quality care.[13,14] Other activities have also proven useful when training staff new to a clinical setting (while being mindful of applicable state law and ethical considerations):

• Pair a new team member with a mentor
• Allow new team members to shadow visits to learn about the patients and care processes
• Have new team members present a patient case at a team meeting

B   Train to develop new skillsets

Any staff member with new roles needs excellent training on health coaching and patient navigation to get started as members of the intensive primary care team. They also should learn the essentials of such illnesses as diabetes, hypertension, chronic heart failure (CHF), COPD and depression so that they are comfortable interacting with patients with those conditions. Training programs can be developed to meet specific physician-determined needs within the practice, or external training resources, such as those offered by the Duke University Integrative Medicine program and the National Society of Health Coaches, can be pursued. Important skills, such as in trauma-informed care and chronic condition-self management, can be sought out in specific training programs. The AMA does not endorse any particular training program referenced in this module.

C   Skillset development: motivational interviewing

Working with complex patients also requires a new skill to promote positive behavior change in patients, rather than simply telling patients what they should do. Motivational interviewing is a coaching technique that focuses on a patient's feelings regarding healthy behaviors to collaboratively and positively develop an action plan rather than giving the patient general suggestions. Motivational interviewing has proven invaluable in helping patients commit to behavioral changes that they already know they should make, but haven't yet implemented. The method seeks to build upon a series of small successes, rather than taking an "all or nothing" approach to changing patient behaviors.

Q&A

How can my team and I learn how to use motivational interviewing?

Because motivational interviewing will be such a useful tool for you and your team in working with your patients to help them self-manage their conditions more effectively, training and education are worth pursuing. There are several training programs that are available such as through the Motivational Interviewing Network of Trainers and the Case Western Reserve Center for Best Practices. If you are hesitant to invest in training programs and want to first try out motivational interviewing, have one of your team members become the "resident expert" in motivational interviewing and develop a training program complete with role-playing and simulated patient encounters. Practicing will help the entire team develop this important skill set. The AMA does not endorse any particular training program referenced in this module.

D   Stay on track with team meetings and huddles

Teams need dedicated time to meet together. This can include brief daily huddles to discuss the coming day's work and regular meetings when the whole team can sit down and meet together. At these weekly meetings, the team will have the opportunity to present new cases, celebrate successes, solve problems, provide clinical education and operations training and focus on quality improvement efforts. Successful team meetings create a culture where everyone feels included and empowered to do all that they can for their patients.

E   Increase communication through co-location

While practices that provide complex care will likely look different from each other in terms of makeup and layout, co-location of the clinical team members within a single space is critical for the team to act cohesively and optimally. Co-location will decrease the amount of time spent on inter-team messaging and phone calls; all team members can speak in-person throughout the day. More members of the team will be aware of any updates in a patient's care, and the group can discuss important patient care issues in person and in real-time, improving the care that is provided to the most complex patients. In your clinic, this may mean that physicians will change their workflow to be present in the co-located space during their clinic hours.

7   Implement the new model

The approach to implementation can vary depending on practice preferences. A recommended approach is to start with a well-defined group of patients that the practice has determined are the ideal initial candidates for intensive primary care. Approach implementation as a pilot; you and your team will likely be unable to abandon all prior work as the pilot begins. The transition should be slow and deliberate as the patient panel grows and more patients are oriented to the new team with whom they will be working.

Work with the whole team to scale up the care model. The community health outreach worker or MA should be the patient's primary touchstone; a physician, RN, behavioral health specialist, pharmacist and physical therapist might complete the team. While the team is transitioning, most of the team members may have responsibilities beyond the intensive primary care pilot. Work around people's schedules to regularly meet and check in. If the team envisions hiring a community health outreach worker after the panel has grown to a certain size, make sure the MA who is overseeing that work has the support that he or she needs. Flexibility and perseverance on everyone's part will help make the transition a success.

8   Track outcomes

Prior to implementing the intensive primary care model, determine what metrics and outcomes your team would like to track. Evaluation should include four dimensions: patient experience, clinical outcomes of the population, total cost of care or utilization data corresponding to cost of care and team satisfaction.[15] It is critical to capture baseline data in order to show the initiative's effect over time. Selecting metrics and methods for data collection should be done while planning is still in progress, rather than once the initiative is underway.

Commonly, the intensive primary care model is evaluated by measuring what happens to utilization before and after the intervention. Measures applicable here include ED visit rates, admissions and specifically "ambulatory-sensitive admissions"—admissions for diagnoses that are theoretically avoidable with excellent primary care.[16] The list of diagnoses includes heart failure, community-acquired pneumonia and diabetes, among others.

Q&A

What metrics or outcomes should we focus on using?

Choose the measurable outcomes or indicators that you think will best reflect success in the eyes of your practice, the payor and your patients. This could involve measuring how well your patients' conditions are controlled or assessing practice utilization. Also, measures such as the percentage of patients with a documented care plan, ED visits per 1000 patients and bed days per 1000 patients for the patient panel could effectively show the impact and outcomes of the intensive primary care model. Remember to include the discussion of metrics in your planning meetings so you can measure your baseline data, which is essential in order to show how much of an impact your team's intervention is making for your patients.

AMA Pearls

Using technology in intensive primary care

Technology will play an integral role in the success of the intensive primary care program. These required elements will help guarantee that the team will be able to provide the desired quality of care to patients with complex care needs.

- A risk dashboard for the team to review periodically to plan care between visits. This tool identifies patients at high risk who are in danger of "falling through the cracks." The team member who conducts visit preparations for patients can review this dashboard to assess which patients may need additional interval or overdue care. Learn more about risk stratification **here**.

- A care gap and prevention dashboard or registry to measure patient panel outcomes and team performance based on standard quality metrics. This dashboard is critical to success. It could be manually tracked by an MA with a **visit-prep checklist**, or ideally, it could be a feature in your electronic health record (EHR) or panel-management software. The registry can automatically track all patients with high risk scores, identify gaps in care and social, mobility, communication and/or cognition issues and flag those who have fallen out of care or who require follow-up. The registry can identify supportive family members or caregivers and interface with the EHR. If appropriate, the advanced MA can manage their patient panel, performing routine testing by protocol without having to open individual charts.[13,14]

- Secure, HIPAA-compliant e-mail or messaging between team members and patients.

- Secure, HIPAA-compliant e-mail among all providers caring for the patient.

Conclusion

Intensive primary care can help your practice manage your most complex, high-risk, high-cost patients. Using the tools in this module can help your practice implement a model of care that leverages new and existing resources to better meet the needs of your patients. Your efforts may improve your practice's ability to provide more comprehensive care to your patients who need it most.

STEPS in practice

① How's it working in Palo Alto, CA?

Stanford Coordinated Care (SCC) is a primary care clinic for Stanford employees and dependents on the self-insured health plan who are at high risk for poor (and expensive) outcomes. SCC was established in April 2012 under the stewardship of Arnie Milstein, MD, from the Stanford Clinical Excellence Research Center. The co-directors designed a fully capitated care model based on extensive interviews with 34 Stanford employees with chronic health conditions, in which they shared what worked for them and what they found challenging in achieving the best health possible. The interviewees identified coordination of services as their primary challenge and many reported feeling that providers did not listen to them adequately to address issues of importance. Many of the interviewees continue to serve as patient advisors to SCC.

Analysis of insurance claims showed that pain, depression, poly-pharmacy and medical complexity were common among the SCC target population; services were designed with these needs in mind. To maintain a reasonable workload given the complexity of patients, physician panels are limited to 300 patients, and MA care coordinators have 100 patients per panel.

The SCC model of care

Every morning the SCC team huddles to review the day's schedule for potential snags, plan for procedures and review timing of slots reserved for acute visits. Acute visits are 15-30 minutes and are handled together by the care coordinator and physician. After-hours calls from patients are handled by the patient's primary care physician (PCP), who knows the patient and his/her health issues.

The initial SCC visit for new patients takes a total of two hours. Before the visit, the PCP will have reviewed the patient's records, updated the problem list and past history and huddled with the care coordinator about the new patient.

The care coordinator who will manage that patient's care greets the patient at the front desk, escorts the patient to the exam room and begins a half-hour process of onboarding the patient to SCC, discussing important information (e.g., how the clinic functions, offered services, patient expectations and how to receive acute care and after-hours advice) and populating the medication list. The care coordinator will also perform intake assessments including:

- Patient Activation Measure (PAM)
- Depression screen (PHQ-2 and PHQ-9)
- Physical and mental function (Short-Form 12® or VR-12)

The care coordinator then huddles briefly with the physician, who then joins the visit for the next hour, where the focus is on establishing a trusting relationship, having the patient tell their "story," defining what matters most to them and setting their goals for the upcoming year. The care coordinator remains in the room to scribe the visit, complete orders and arrange follow-up care during this discussion. The care coordinator actively joins in the conversation between the physician and patient during the visit. The patient sees the care coordinator as an important team member, which has several benefits:

- The care coordinator is trusted and knows the patient's story
- The potential for errors that occur during hand-offs to other team members is minimized
- The care coordinator becomes educated on the nature of the chronic conditions the patient is facing, including the subjective complaints, objective findings and important patient education that they can provide

The physician uses open-ended questions to understand the specific challenges facing the patient within four challenge domains:

- Social support
- Experience with health care
- Self-management and mental health
- Health trajectory

Focusing on what matters most to the patient and the patient's overall goals for the upcoming year rapidly builds trust with patients. For one patient, the goal might be to lose weight or control their diabetes. Another may want to attend a family reunion away from home, which requires that they improve their mobility. The patient and care team establish one or more action plans, which are documented in the problem list under the patient's goals of care. The patient's "shared care plan" is elicited via motivational interviewing and consists of discrete achievable actions the patient feels confident he or she can complete successfully in the short term. The provider's action plan may involve attending a specialty visit with the patient, soliciting educational materials or support group information from the health librarian or further delving into the patient's medical history.

The provider then exits to document the assessment and care plan and the care coordinator completes the visit. The care coordinator conducts wrap-up activities, including:

- Draw necessary labs
- Confirm the patient's understanding of the visit
- Review the action plan(s)
- Agree on a follow-up plan to check in about how the action plan went for the patient over the coming week
- Arrange referrals both within and outside the SCC
- Send prescriptions to the patient's preferred pharmacy

For primary care planned-care visits, the established patient has an hour scheduled with his/her care coordinator and PCP following a format similar to that used for the intake visit. A pre-visit huddle is done electronically or in person. During the first 15 minutes the care coordinator:

- Performs assessments
- Administers immunizations
- Carries out routine tests by protocol
- Asks the patient, "What bothers you the most?"

The physician joins for 30 minutes for a clinical and social update, physical exam and action planning. The care coordinator then takes 15 minutes to check the patient's understanding, review the action plan and confirm follow-up instructions.

Care is focused first and foremost on addressing patients' self-identified goals, often requiring patience on the team's part to not focus on the glaring non-emergent health problems that surfaced prior to and during the visit. A discrete action plan is finalized with the patient, using motivational interviewing when indicated to define both the importance of the plan and the patient's confidence in carrying out the plan to ensure that it will be successful. As trust is established over a visit or two, the team becomes more successful in addressing the concerns of the medical system in addition to the patient's concerns. For example, a patient with an A1C of 16 who was only interested in his palpitations may ask after the second or third visit, "Shouldn't I do something about my diabetes?"

The team built for success
Weekly clinical and operations meetings are held for all team members. Care coordinators present all new patients to the group, which improves their communication skills and ability to determine what issues are important. The team then decides who should become involved in each patient's care going forward, for example:

- A physical therapist
- A behavioral health specialist to address depression or anxiety
- A dietitian for weight loss or special diet planning
- A pharmacist to conduct medication review and education
- A diabetes educator to address diabetes, hypertension, lipids or asthma
- A nurse accompaniment to a specialty consult

The licensed clinical social worker (LCSW), physical therapist, pharmacist and dietitian see patients on their own schedules, and only rarely is the care coordinator or PCP in attendance. The clinical nurse specialist supervises the care coordinators and meets with hospitalized patients for care transition planning, following up with a phone call (if low risk) or home visit (if the admission was emergent or the patient is considered to be at high risk for readmission).

The SCC team works in a shared workspace, which promotes moment-to-moment, in-person collaboration. All team members are encouraged to address operational issues; as SCC utilizes Lean as a quality-improvement method, team members at every position have crafted A3 problem analyses and improvement plans. As a result, SCC is continually improving, and staff satisfaction measures 100 percent.

How the model works

As SCC is capitated for services it provides and paid by the month rather than by the visit, alternatives to in-person visits are encouraged, which protects the longer-visit model described above.

The care coordinator enrolls every willing patient in a secure e-mail system on the patient portal at the intake visit. The next day, she sends a message to see who fails to respond, learning who requires more IT help. As a result of this protocol, 95 percent of SCC patients regularly communicate with the team by e-mail. Fifty percent of the e-mails are handled by care coordinators, with physicians handling messages requiring medical judgment.

The SCC sends all lab and X-ray results, primary care visit notes and specialty consults to their patients via the secure patient portal. SCC also offers phone and video visits for patient convenience. The care coordinators check in with patients on an average of one two-way contact a week to:

- Check on the patient's action plans
- Assist with scheduling
- Help with refilling routine medications by protocol
- Ensure completion of preventive care or disease-specific monitoring (e.g., routine mammograms, immunizations or colon cancer screening) by protocol

Protocols that are followed by the SCC care coordinators can be found here.

Commitment to quality

SCC has two dashboards that draw from the EHR:

1. The care gaps dashboard alerts care coordinators about routine tests and immunizations that are due
2. The risk dashboard identifies patients who are high risk for poor and expensive outcomes

Care gaps are the responsibility of the care coordinators working under protocol. The SCC care coordinators have achieved the 90th percentile on nine of 10 Healthcare Effectiveness Data and Information Set (HEDIS) measures. The whole team meets monthly to review which patients are at elevated risk and to plan care for those patients proactively rather than waiting for the patient to appear in the ED.

The SCC team members enjoy their work, and their patients appreciate the services provided to them. The SCC has scored in the 99th percentile in the Press Ganey® "Likelihood to Recommend" category for 19 of the last 20 months.

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