Primary Care

CONNECTED CARE PARTNERS

COMMON PRACTICE

Happy Spring!

We thought it would be nice to share a brief update on recent events within Connected Care Partners and the Primary Care Collaborative. It has been a busy time for all of us as we begin the transition to value-based care. Connected Care Partners and our work in an ACO Track 1+ provides a nice pathway to new models of care and allows us to continue to focus on improving the lives of those we serve in the community. Here are a few highlights from each of the committees that are involved in this transition.

Primary Care Collaborative

- The effort to transform primary care into a more holistic model of care using the Patient-Centered Medical Home as a template is well underway. By the end of this year, we hope to have four clinics certified as a Patient-Centered Medical Home. It is not a place, but a philosophy and culture of care that puts the patient in the center and makes them feel at home in the process by which they are cared for! This will be the structure for efficiently realizing value from quality measurement capture and cost reduction. Work has begun in the four clinics, and we are learning each day on ways to achieve this goal, but remain efficient and productive during the change process.
- Integration of mental health into primary care continues to move forward. In March, we saw more than 140 patients via telehealth for mental health services. Many of these patients were seen in primary care clinics. The team continues to look for ways to treat patients collaboratively between mental health and primary care providers.
- The Connected Care Partners Portal is being deployed. The portal will allow any provider in the network the ability to access patient information from the electronic medical record, use Up-To-Date and obtain medical CME.

Performance Improvement & Quality Committee

This committee is helping oversee the quality of care provided across the network. Last year, they adopted several quality metrics. They continue to monitor performance and also are working with the Primary Care Collaborative and Clinical Efficiency Committee to help reduce variations in care.

- Dashboards are being created and will be distributed with five key

clinical performance measures. Each of you should receive a roster of your primary care patients and associated performance in diabetic and preventive health screenings. Be checking your email for instructions on how to obtain this information.
- Three key strategic initiatives: CHF care across the continuum, clinical documentation improvement to ensure we are correctly identifying all the medical issues of the patient, and improving the capture of diabetic eye exams using health information exchanges between various EMRs.

Clinical Efficiency Committee

This committee is charged with improving reliability of care and reducing inefficient utilization of services. The newest of the committees in the network, but charged with ensuring we deliver value to our patients. Here are a few highlights:

- Working with the Performance Improvement and Quality Committee they are discussing three key areas of focus:
  Appropriate imaging for low back pain, evidence-based pharmacological management of diabetes mellitus and evaluating ways to reduce inappropriate ED utilization
- Evaluating ways to share with the patient about alternatives to Emergency Room care for non-emergent or urgent conditions; Identifying patients who tend to over-utilize ED services
- Appropriate utilization of post-acute care services; Recent evaluation of cost of care for hospice, home health and rehab services across the system

As you can see, a lot of work is going into the transformation to value-based care. The committee members and leadership are working to ensure we are successful in the coming years. Please feel free to reach out to us for any questions or input. Thanks to all for your commitment to excellence in patient care.

Best,
Erik

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