Care Delivery Innovations in Primary Care First (PCF)

The CMS Innovation Center is proud to share **lessons learned from ten advanced primary care practices** in the Primary Care First (PCF) Model.

This resource highlights the **care delivery changes** that practices made to **achieve better outcomes for patients**. Click through this interactive resource to discover the steps taken to transform care one practice at a time.

Explore More: Select each icon below to uncover detailed tactics that can inspire and enhance your practice.

How to get started with this interactive PDF:

Step 1: Download the PDF.

Step 2: Access instructions on how to use the document's interactive features.

Transitions of Care

Personalized Care Management

Behavioral Health

Access to Care

Health Equity

All data shared in this document was generated by practices in PCF for the annual PCF National Meeting and it does not constitute model evaluation data. CMS disclaims responsibility for the content provided by non-CMS organizations. No CMS endorsement is implied by their inclusion in this resource.

Integrating Behavioral Healthcare

Incorporate Specialized Staff

Provide behavioral health services in the primary care setting by **adding a specialist to the multidisciplinary care team** or training staff such as social workers to specialize in behavioral health

Collaborate and Share Data Across Care Teams

Hold multidisciplinary huddles to **increase clinician communication touchpoints** and better coordinate care, share data, and identify patients with high-risk conditions

Individualize Care

Develop care plans that **meet patients' behavioral health needs** (e.g., medical accompaniment, intensive therapy services, and health-related social needs)

St. Mary's Family Medicine (Colorado, Urban, System)

Reduced emergency department (ED) visits by 66% for individuals who participated in their program for one year by:

- Building an Integration to Minimize Potentially Avoidable Costs (IMPAC) program to provide behavioral healthcare for the practice's highest-need and most complex patients
- Seeing patients for behavioral health appointments in a setting that works for them (e.g., home, park, homeless shelter)
- Creating individualized plans of care that are applicable to patients' daily lives which included activities like group exercise and cooking classes through the practice

Ann's Choice Medical Center (Pennsylvania, Urban, Independent)

Increased depression screenings by 28% year-over-year and **Advance Care Planning (ACP) discussions by 18%** by:

- Discussing anticipated patient needs and prioritize plans for the day (e.g., ACPs) during the multidisciplinary daily huddle
- Meeting quarterly with the Patient Family Affairs Council to get their insight on practice improvement
- Using a social worker to offer patients individual and group sessions to teach breathing and resiliency exercises

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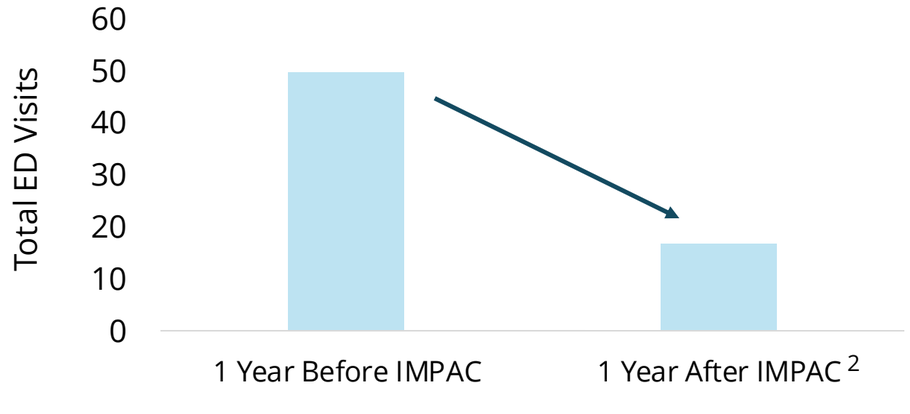
Integrating Behavioral Healthcare: Outcomes

St. Mary's Family Medicine

ED visits decreased with participation in IMPAC program[1]

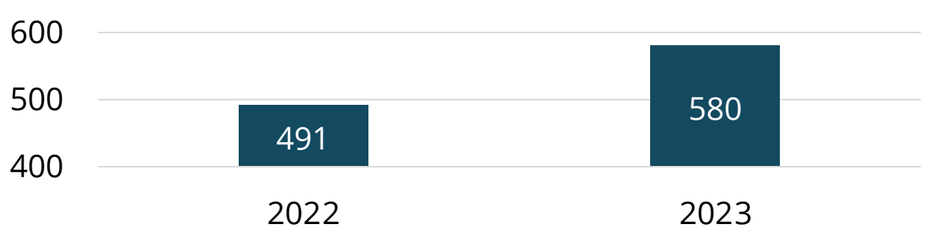


66% decrease in the number of ED visits of patients who participated in IMPAC for at least one year

5x more patients reported that their healthcare needs were met *after participating in the IMPAC program*

Ann's Choice Medical Center

Advance Care Plan (ACP) Discussions[3]



18% increase in advance care plan discussions

Other Behavioral Health Outcomes[3]

22% decrease in use of sedative-hypnotics & benzodiazepines

9% decrease in avoidable ED transfers

940+ depression screenings conducted in 2023[3] **(28%** increase year-over-year**)**

1. Data cited in St. Mary's Year End Report 2023 – Integration to Minimize Potentially Avoidable Costs (IMPAC) Program. 100 patients enrolled in IMPAC since October 2022.
2. Following IMPAC enrollment, total ED visits were measured between 2-12 months of the program.
3. Data provided by Ann's Choice Medical Center.

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Addressing Health Disparities

Step 1 | **Step 2** | **Step 3**

Click on the icons below to see more details.

Collect Data

Collect patient characteristic data like race, ethnicity, and language

Analyze Data

Use patient characteristic data and quality measure data to **identify differences in health outcomes**

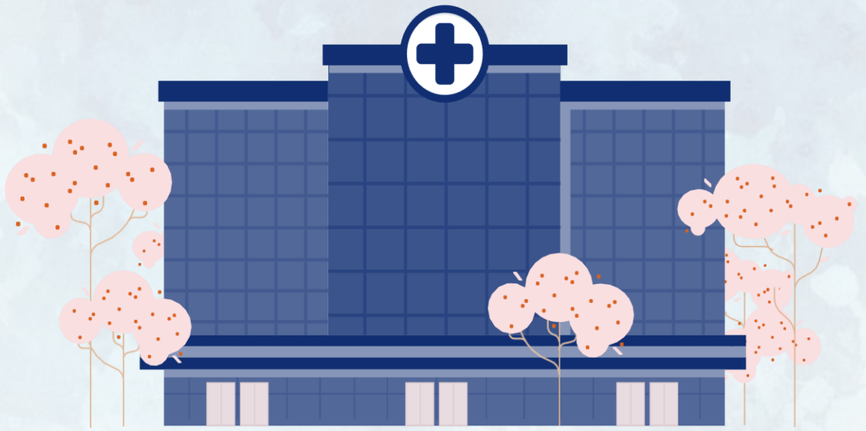
Act on Data

Develop customized actions or implement strategies to address the identified health disparities

Cambridge Public Health Commission (Massachusetts, Urban, System)

Addresses health disparities and gaps by:

- Collecting patient characteristic data (e.g., race, ethnicity, language of care, disability status) during patient registration using a form built into the Electronic Health Record
- Pulling characteristic data automatically into a Tableau dashboard to look for differences in quality measures across different characteristic variables
- Reviewing patients' charts with clinical staff to understand why these disparities might occur and identifying opportunities to address health disparities
- Creating tailored action plans to improve health outcomes for identified sub-population (e.g., improving hypertension control for Black Haitian Creole speaking patients)



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Addressing Health Disparities: Process Details

Step 1
Collect Data

Infrastructure

Adhere to state requirements while developing the data collection process

Training

Train staff on how data are collected in their system

Step 2
Analyze Data

Standardize Variables

Manually standardize fields within Electronic Health Record so distinct variables can be analyzed together

Identify Disparities

Synthesize data from Tableau dashboard to ask: “Who’s falling through the cracks?”

Validate Data

Meet with leadership and on-the-ground clinic teams for feedback

Step 3
Act on Data

Implement Strategies (“Outreach”)

When patients are not in the clinic, allocate time and resources to send reminders via phone calls or text

Plan Interventions (“In-Reach”)

Develop guidelines so care teams can address health disparity needs while patients are in the clinic

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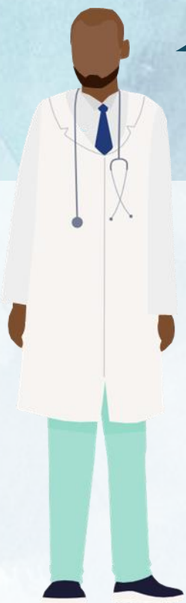
Explore new ideas from your peers.



Approach to Establishing Home-Based Primary Care

Refer

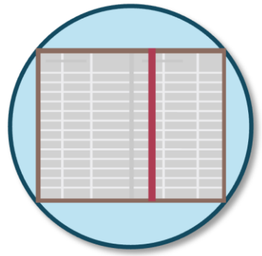
The **care team or patients and caregivers** can refer via EHR, email, fax, or phone

Schedule

Visits are scheduled on weekdays during business hours **when patient and caregiver are available**

Assess

First visit includes a **comprehensive patient assessment**



Follow Up

The **nurse practitioner schedules follow-up visit** with the patient and caregiver

*For patients that require urgent / acute visits, partner with organizations who can do urgent house call checks; this partnership helps keeps patients from **unnecessarily utilizing ED services.***

Internal Medicine Faculty Associates (New Jersey, Urban, System)

Improved its Acute Hospital Utilization (AHU) observed-to-expected ratios by 0.11 points over a year by:

- Identifying homebound patients to include in the Primary Care At Home (PCAH) program, as defined under the Medicaid definition of having to exert extreme effort to leave the home
- Expanding the clinical care team by including a full-time nurse practitioner, assigned to the PCAH program
- Seeing patients in their home environment for primary care services to gain insight into additional services they may need to manage their own care at home
- Expanding primary care services (e.g., laboratory and imaging services, dentist) provided in the home setting through partnerships

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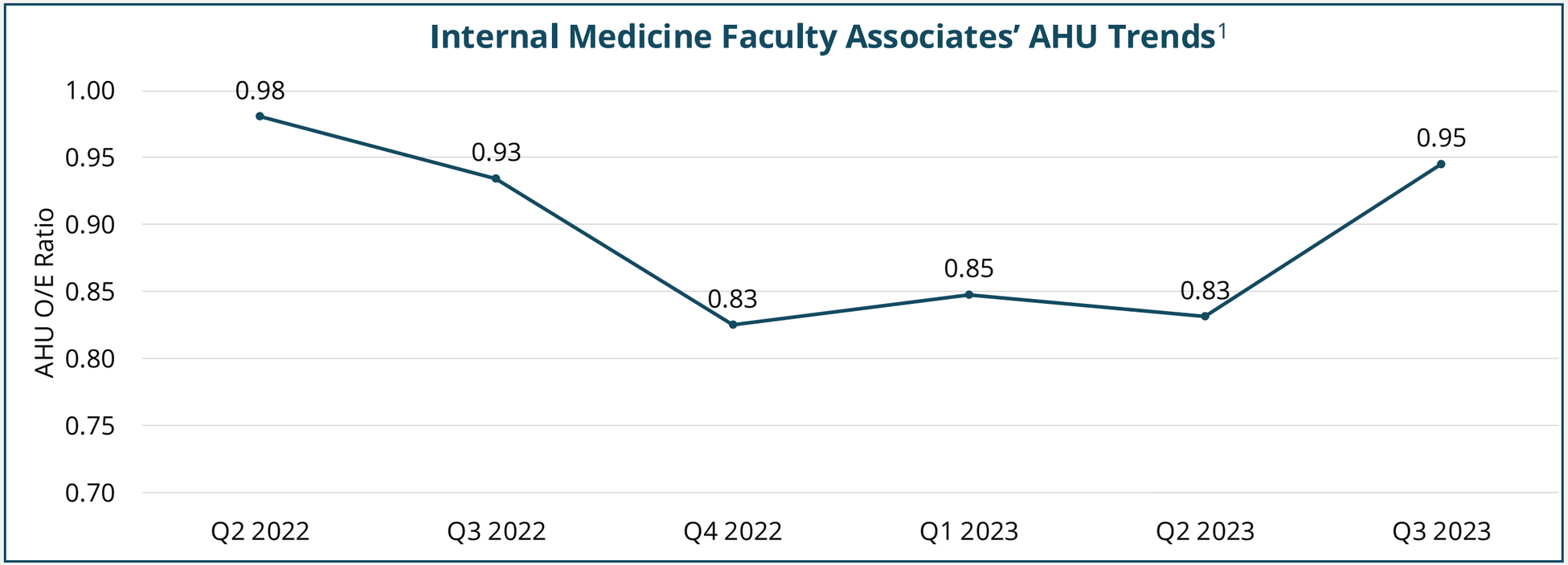
Approach to Establishing Home-Based Primary Care: Outcomes

Internal Medicine Faculty Associates



1. Data provided by Internal Medicine Faculty Associates (IMFA).
IMFA's nurse practitioner went on leave between Q2 2023 and Q3 2023. Certain measures in the Primary Care First (PCF) model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer and use provisions related to the NCQA measures can be found at: https://www.cms.gov/priorities/innovation/about/notices-disclaimers.

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Strategies to Enhance Transitions of Care Management

Encounter Notification Service (ENS)

Receive near-real time alerts for patients experiencing a transition in care (admission, discharge, transfer)

Integrate a PharmD

Include a **pharmacist who performs a medication reconciliation** when a patient is discharged

Coordinate Care

Share patient information across care settings to coordinate the care plan

A glimpse into aspects of three practices' approaches to transitions of care management:

Holmes Family Medicine (Ohio, Rural, Independent)

Improved its Acute Hospital Utilization (AHU) observed-to-expected ratios by 0.43 points in a year and a half by:

- Identifying patients discharging from the hospital by reviewing daily encounter notification services from their Regional Health Information Exchange (HIE) and cross-checking with local hospital data and claims

Northwest Medical Homes (Oregon, Urban, System)

Improved its Acute Hospital Utilization (AHU) observed-to-expected ratios by 0.34 points in a year and a half by:

- Having a pharmacist who reviews the hospital discharge medication list with the patient's current medication list on file with their primary care practice to identify any discrepancies

Family Physician Group (Nebraska, Urban, Independent)

Reduced repeat Emergency Department (ED) visits by:

- Reaching out to the ED to provide the clinical team with patient information that may help determine the plan of care (e.g., providing an EKG when a patient goes to the ED for chest pain)

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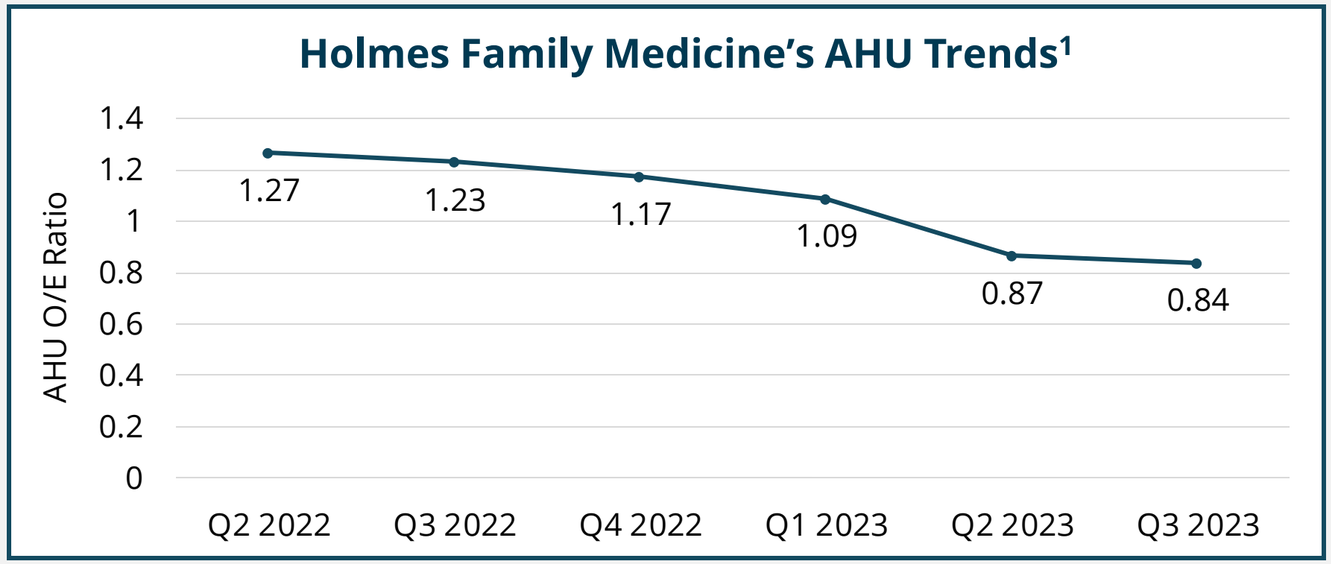
Strategies to Enhance Transitions of Care Management: Outcomes

Holmes Family Medicine

34%

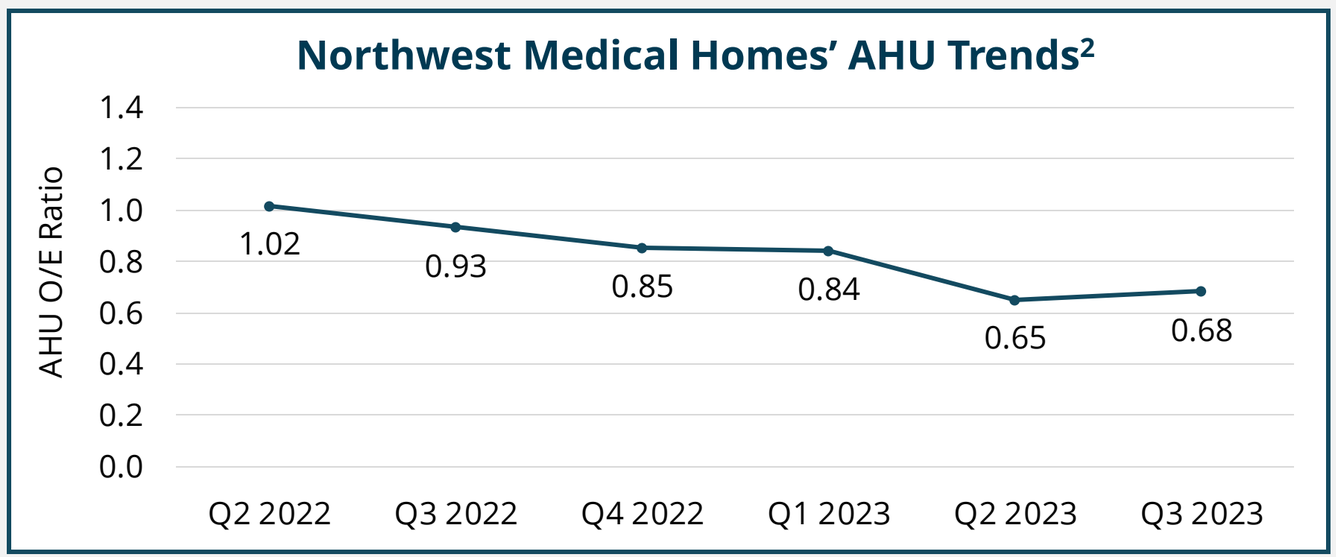
0.43-point decrease in AHU O/E ratios from Q2 2022 to Q3 2023 (1.27 to 0.84)[1]



Northwest Medical Homes

33%

0.34-point decrease in AHU O/E ratios from Q2 2022 to Q3 2023 (1.02 to 0.68)[2]



1. Data provided by Holmes Family Medicine.
2. Data provided by Northwest Medical Homes.

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Advancing Personalized Care Management

Identify High-Risk Complex Patients

Use reports from resources like an Accountable Care Organization (ACO) to identify **patients with higher-risk conditions needing personalized care management**

Personalized Patient Outreach

Send notifications to patients in-between appointments with reminders of needed care to manage their chronic conditions

Prompt Care Adjustment

Regularly review clinical data to **detect changes in patients' chronic conditions** that may prompt needed changes to their plan of care

Explore new ideas from your peers.

Penn Primary Care Pottstown (Pennsylvania, Urban, System)

Improved its Acute Hospital Utilization (AHU) by 0.33 points in eighteen months by:

- Identifying high-risk patients (5% of total patient population) for a longitudinal care management program using clinical judgement and risk scores in the Electronic Health Record (EHR)
- Assigning each patient a care manager, who regularly contacts the patient to set goals, provide education, and help coordinate care
- Further explore **in-depth insights**

University of Colorado Anschutz (Colorado, Urban, System)

Improved hypertension control by 5% in eight months by:

- Identifying patients bi-monthly who are not meeting their chronic condition management goals or coming in for their Annual Wellness Visits (AWVs)
- Hiring a clinical coordinator to conduct personalized phone outreach and helping patients navigate needed services
- Further explore **in-depth insights**

Dr. Andy's Family Practice (Arkansas, Rural, Independent)

Decreased Emergency Department (ED) utilization and improved HbA1c control by:

- Reviewing quarterly HbA1c reports from their regional Health Information Exchange (HIE) to identify patients with high levels
- Reaching out to these patients to reengage with them about their diabetes management plans
- Further explore **in-depth insights**

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Advancing Personalized Care Management: Process Details

Penn Primary Care Pottstown

Risk-Stratify

Leverage reports from their Accountable Care Organization (ACO) to **target high-risk patients (~3%-5% of patient population)**

Intervene

Provide patients with both longitudinal care management and transitions of care management and ensure they have the **right access to care** (e.g., social screen, disease education)

Collaborate

Include additional services:

- Nutritional services
- Behavioral health
- Pharmacy
- Social work
- Home care
- Post-acute care services
- Community resources

Track

Set patient and population **program goals**:

- Improve chronic disease management
- Reduce psycho-social barriers
- Reduce Acute Hospital Utilization (AHU)

University of Colorado Anschutz

Identify

A clinical coordinator **identifies patients with care gaps using reports** around:

- Preventive care (Annual Wellness Visits)
- Diabetes care
- Hypertension care
- Panel assessments

Outreach

Using **protocols with automatic action points,** the clinical coordinator performs personalized 1:1 patient outreach

Prepare

Coordinate care by:

- Scheduling clinic visits (e.g., Annuals, diabetes or hypertension focused)
- Ordering labs/exams proactively (e.g., colonoscopy, mammogram, A1c)
- Engage care management resources (e.g., nutrition, pharmacy, social work, nursing)

Personalize

Understand patient preferences and address barriers by:

- Providing an interpreter for preferred language
- Addressing transportation, cost, insurance barriers
- Providing free staff visits for blood pressure checks or home cuff validation
- Updating outside records in patient medical record

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Advancing Personalized Care Management: Process Details

Dr. Andy's Family Practice

How did we integrate hospitalization and HbA1c Reports into our workflow?

1. State Health Alliance for Records Exchange (SHARE) **delivers hospitalization** notifications in near real-time and **HbA1c Reports** quarterly.
2. Patients due for HbA1c testing are **flagged at check-in.**
3. **HbA1c tests are performed**, and results can be retrieved via SHARE and Electronic Health Record.
4. The Care Team **reviews results and adjusts care plans** as needed.
5. Patients are promptly **informed of their results.**
6. Patients and Care Team **coordinate** on an **effective diabetes management plan**.

Before HbA1c Reports

Dr. Andy's Family Practice **relied on manual record-keeping and patient self-reporting,** which led to gaps in diabetes management.
In addition, HbA1c Poor Control rates were higher due to **delayed intervention.**

After HbA1c Reports

Now, we **receive automated tracking** and **immediate access to HbA1c results and near-real-time hospitalization notifications** via SHARE, which allows us to make proactive adjustments to care plans.
Integrating hospitalization notifications and HbA1c Reports into our practice workflow has **improved patient outcomes with HbA1c Poor Control rates and ED utilization dropping.**

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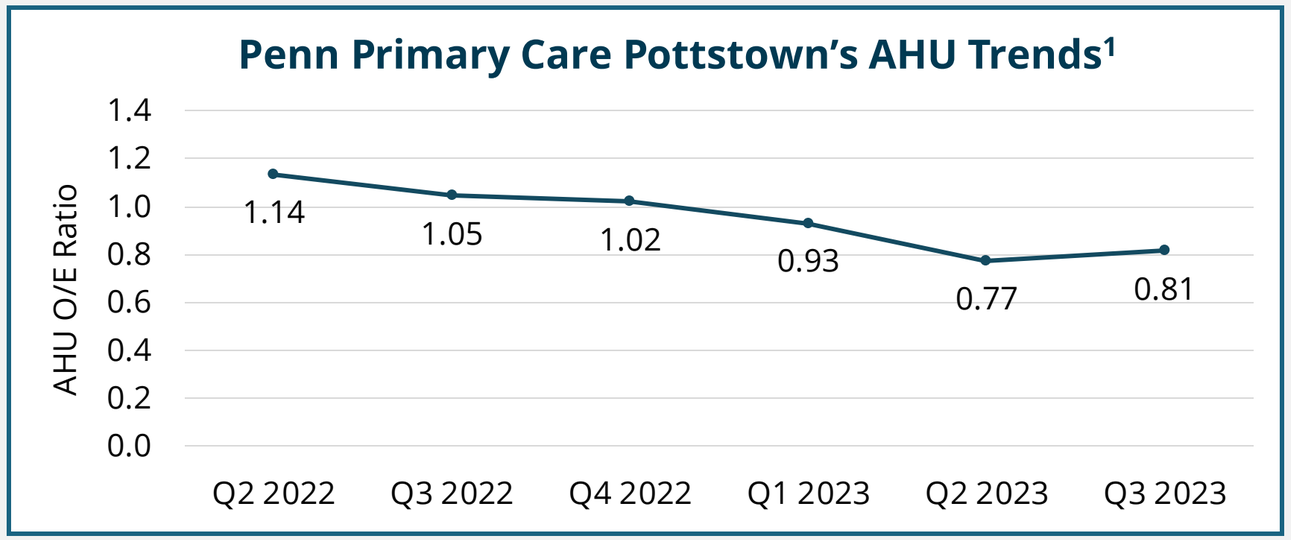
Advancing Personalized Care Management: Outcomes

Penn Primary Care Pottstown

29%

0.33-point decrease in AHU O/E ratios from Q2 2022 to Q3 2023 (1.14 to 0.81)[1]



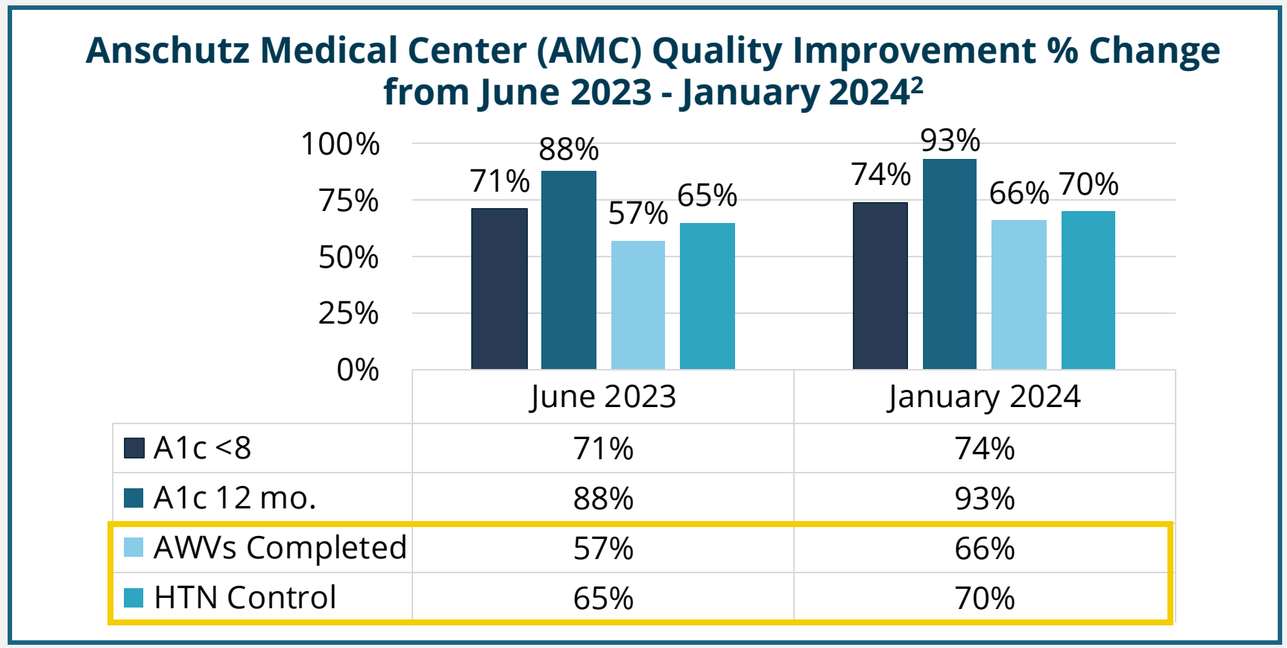
University of Colorado Anschutz

9%

in Medicare Annual Wellness Visits (AWVs)[2]

5%

in patients with controlled hypertension[2]



	June 2023	January 2024
A1c <8	71%	74%
A1c 12 mo.	88%	93%
AWVs Completed	57%	66%
HTN Control	65%	70%

1. Data provided by Penn Primary Care Pottstown.
2. Data provided by Anschutz Medical Center.

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New Tactics Shared by Primary Care Practices

Integrating Behavioral Healthcare

Integrate a geriatric psychiatrist to address population-specific behavioral health needs (e.g., dementia)

"Our practice is integrating a geriatric psychiatrist who provides provider-to-provider consultations without direct billing, supported financially by our practice. This arrangement, facilitated by our participation in PCF, is crucial given our focus on geriatrics and the high prevalence of dementia among our patients, which often results in lengthy wait times for psychiatric services. This setup allows us to initiate medication and make necessary adjustments."

- A large, urban system in Colorado

Monitor population behavioral health systematically on an ongoing basis (e.g., Generalized Anxiety Disorder (GAD), Patient Health Questionnaire (PHQ)-9)

"We are using Power BI (a data visualization and business analytics tool) to track and discuss the GAD and PHQ-9 scores in our team meetings. We maintain and update a spreadsheet that allows us to review a nice layout of score changes and trends."

- A medium, urban system in Michigan

Addressing Health Disparities

Intake education of Race, Ethnicity, and Language (REaL) data

"We recently used patient intake data to identify an increase in Haitian-speaking patients. However, when we pulled the raw patient intake data, the preferred language field stated English. We took a step backward and are now re-training staff to ensure the correct data is going into the patient's chart."

- A medium-sized health system in both rural and urban Delaware

Access to Care

Include additional clinical services (e.g., phlebotomy, radiology) as part of in-home primary care

"We also launched primary care at home program, and we've hired a physician, nurse practitioner, a few Registered Nurses (RNs), one licensed social worker. The program is for patients who are home-bound, especially geriatric patients who are unable to come to the clinics physically or if they are far away from the clinic location. We're also partnering with an organization that helps provide phlebotomy and radiology services to these patients who are homebound or unable to come to the clinics."

- A medium, urban system in California

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New Tactics Shared by Primary Care Practices

Personalized Care Management

Enroll patients in longitudinal care program when transitions of care (TOC) needs are not met (post-30-days)

"We enroll patients in 30-day TOC programs with weekly check-ins to conduct medication reconciliation and schedule follow-ups with specialists. Initially episodic, these often transition to longitudinal care for ongoing issues like unmanaged chronic conditions. This typically extends beyond 30 days, transitioning patients to longitudinal care with monthly follow-ups. After disenrollment, we conduct a three-month follow-up and re-enroll patients if needed."

- A small/medium, urban system in multiple states

Proactive, regular touchpoints to patients (e.g., biweekly using remote patient monitoring)

"We've implemented a remote patient monitoring program that allows us to maintain contact with patients between visits. Our nurses conduct weekly or biweekly check-ins, which have significantly reduced Emergency Department visits by allowing timely interventions. This was initially a pilot, and now we are extending it to all our practices because we find it helpful and the patients appreciate it."

- A medium, urban system in Rhode Island

Transitions of Care

Utilize automatic notifications via EHR to notify when a patient is in the Emergency Department

"We developed an Emergency Department (ED) consult program to reduce ED admissions. Triggered automatically when a patient from our seniors' clinic visits the ED, I am notified through Epic and meet with the ED provider to discuss a consultation. During the consult, I assess the patient and explore alternatives to hospital admission. Our data shows this approach has prevented about 6% of potential admissions. Many patients are directed to hospice care, supported by our palliative care social work team. Patients have expressed a lot of gratitude and feel well-supported by this program."

- A large, urban system in Colorado

Allocate funds to include additional care team members into clinics for whole-person care (e.g., behavioral and social healthcare workers, pharmacists, dieticians)

"The transition from Comprehensive Primary Care Plus (a predecessor model to Primary Care First) rolling into Primary Care First has allowed us to fund 16 additional Full Time Equivalents (FTEs) for our clinics with roles such as pharmacists, behavioral health support social workers, and dieticians. PCF has helped us really improve the quality of care we provide by providing additional resources beyond clinicians."

- A medium, urban independent practice in Massachusetts

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Instructions: Using This Interactive Document

Using this Interactive Document

This guide is interactive. To take advantage of the interactive features, it is best to use a native PDF viewing application such as Adobe Acrobat. The interactive features are not accessible in internet browsers.

Select the icons on the home page to learn more about the innovative work being done across practices within PCF.

Select the session icon to access additional details, including detailed demographic information for each highlighted practice.

Session icon

Select the graph icon to access outcomes practices achieved.

Graph icon

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