

# Intensive Primary Care



Address the Goals and Medical Needs of High-Risk Patients with Complex Care Needs

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CREDITS:  
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## How Will This Module Help Me?

- 1 Outlines how to identify your patients in need of expanded services.
- 2 Addresses how to customize the care model to fit the needs of your target population.
- 3 Describes a successful model used to deliver intensive primary care in a practice.



## Introduction

**Intensive primary care** is a model of health care delivery by a primary care team dedicated to addressing the comprehensive goals and medical needs of patients with multiple chronic conditions whose needs would likely not be met in a short primary care visit. The intensive primary care model is also designed to provide patients with expanded in-person and remote access to their care team.

In certain health care populations, a small percentage of patients account for a large percentage of health care costs in any given year.<sup>1,2</sup> High costs associated with the care of patients with complex health issues warrant an advanced primary care model designed to achieve the quadruple aim of better health, better care, lower cost, and care-team satisfaction.<sup>3</sup>

# Seven STEPS to Implementing Intensive Primary Care in Your Practice

1. Identify the Target Patient Population.
2. Get to Know Your Target Patient Population and Their Needs.
3. Build Your Intensive Primary Care Team.
4. Engage Patients with Empathy and Respect.
5. Design Your Patient-Centered Care Model
6. Implement Your Model.
7. Track Outcomes.

## 1

### Identify the Target Patient Population.

The primary care practice is designed to address the full continuum of needs and preferences within a population, patients who face the challenges associated with multiple chronic conditions may benefit from a response specifically designed to meet their needs—a central tenet of patient-centered care.

Planning care for patients who have multiple chronic conditions or complex care needs begins with identifying program goals and the population(s) you seek to serve. The following are examples of potential target populations:

- Patients whose care exceeds a pre-determined threshold for high-cost services, such as emergency department (ED) visits or hospital admissions.
- Patients who have multiple comorbidities that result in frequent after-hours reflection on how best to care for them.
- Patients who have been identified by health plans or medical care organizations as being within the top five percent of predictive risk for continued high cost.
- Patients who have chronic conditions, such as diabetes, chronic obstructive pulmonary disease (COPD), or advanced cardiovascular disease—and who are at high risk for hospitalization.

- Patients who suffer from serious illness, frailty, and/or social isolation
- Many programs focused on enhanced primary care for patients with complex health needs are being developed and enhanced, and is often a component of an Accountable Care Organization (ACO). [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.

More information about risk stratification can be found on the [American Academy of Family Physicians \(AAFP\) webpage on care management](#). 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

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.

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## Get to Know Your Target Patient Population and Their Needs.

To understand the needs within the identified target patient population, talk to your patients in that population. Interview a minimum of five such patients who meet your criteria, and include both patients who are currently having difficulty managing their conditions and those who manage their conditions well. This will help you to identify specific challenges the population faces as well as the characteristics of those who successfully manage their condition(s). Understand their current situations and which aspects of the existing care model work for them and which aspects do not. The intensive primary care model can then be designed specifically to meet the identified needs of your target patient population and build on their strengths.

Patients may identify underlying socioeconomic needs, such as challenges with transportation, food or housing. This information will help the team determine the best staffing complement to address the multi-faceted needs of the target population. Many EHR vendors provide the functionality to embed a screening tool into the clinical workflow to identify [social determinants of health](#) and assess your population's needs.

Engaging patients and asking them these four questions can give your practice a better understanding of your patients' needs<sup>4</sup>:

- 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?

3

## Build Your Intensive Primary Care Team.

Once you have identified your target population and have a deeper understanding of the needs of those specific patients, it is time to develop the team of interdisciplinary specialists who will be involved in their care. 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.<sup>5</sup> 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, licensed practical/vocational nurses (LPN/LVNs), and/or community health outreach workers.** Medical assistants, LPN/LVNs, and community health outreach workers can fill the role of health coach, working with patients on chronic disease self-management and long-term planning, or health care navigator, assisting patients with care coordination and connecting them with social programs. Medical assistants, LVNs, and community health outreach workers can also 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. These are cost-effective ways to personalize care and enhance the therapeutic relationship between the patient and the care team. The medical assistants, LPN/LVNs, and/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, or messaging. These high-touch relationships are a critical component of any complex care program. 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.<sup>6,7</sup> You may find your team can already fill some of the roles it needs to practice intensive primary care simply by giving team members opportunities to learn new, relevant skills for their roles as part of their **professional development**.
- **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 medical assistants, LPN/LVNs, and community health outreach workers who compose 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 roles 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, these practices should identify members of their team with the proper interpersonal skills and send them for training in areas such as health coaching, care management/care coordination, and implementing a registry for chronic condition management.

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, especially when they receive care from multiple individuals on the same visit.

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 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 physicians “on-call” for the patient panel to prevent unplanned acute care on nights and weekends.

What other types of training should be considered for the care team?

Any team member entering a new role 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), chronic obstructive pulmonary disease (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 can be pursued. Important skills, such as in trauma-informed care and chronic condition-self management, can be sought out in specific training programs.

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Engage Patients with Empathy and Respect.

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.” It is important to remember that your patients may interpret your medical terminology in a way that it is not intended. For example, telling your patient that they have a chronic disease may be interpreted by them as being told they are a hopeless case. Try substituting the term condition for disease so a chronic disease becomes an ongoing condition. Develop a name for the model, such as the “comprehensive care model” as opposed to calling it “intensive primary care.”

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

As patients with complex care needs 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 the answer is yes, engage the patient in a conversation about what other types of helpful support the practice could offer. For patients who are seeing multiple specialists, stress that your team will help to coordinate care, ensuring that every member of the care team is on the same page.

Communicate openly with patients. Help them understand that the practice is shifting to a comprehensive care model to meet each individual patient’s needs. During these conversations, be prepared to have conversations with patients about 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&amp;A

### How can we help our patients to be more engaged in their care?

Showing your empathy to your patients while using a variety of outreach methods can help to engage your patients. Use personal phone calls to prepare them for their upcoming appointments. Ideally, these calls would be made by the most appropriate person in the extended care team, based on your patient population. Using methods like motivational interviewing and involving patients and their support system (e.g., family member or caregiver) in setting goals and shared-decision making will increase involvement and engagement, helping them to take control of their own health. Assist them in setting up a patient portal or ask the patient if they would like to provide access (proxy) to the EHR patient portal for a family member or friend. This process of coaching takes time for patients to learn new techniques and develop a stronger sense of self-efficacy in managing their own care. Patients may be skeptical at first, but it is important for the team to reinforce the benefits in improved health that this model provides.

### 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.

### 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 form their intensive primary care panel as the team's time may not be completely dedicated to managing only this population. The staffing level of the physician's or other licensed practitioner's team should limit the **patient panel** to a reasonable size. Intensive primary care panels vary from 50 to 500 patients per physician, 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. To provide the best possible care to all patients, it is important to monitor the patient panel for each practitioner on a regular basis to ensure appropriate staffing ratios are in place. Working with patients who have complex care needs may also require longer appointment times, more frequent contact, and additional protected time for the practitioner.

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 members, and 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.

## 5

## Design Your 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.<sup>9</sup> 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 and ability to self-manage effectively.<sup>10</sup> 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 difficulty navigating 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.<sup>11</sup>

The domains assessment is used to help the care team understand specific issues facing a patient.<sup>10,12</sup> 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).

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.<sup>15</sup> 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.

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 a medical assistant with a **visit prep checklist** or, ideally, it could be a feature in your electronic medical record (EMR) or **panel management** software. The registry can automatically track all patients with high risk scores, identify gaps in care, identify 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 EMR. If appropriate, the **advanced medical assistant** can manage their patient panel, performing routine testing by protocol without having to open individual charts.<sup>13,14</sup>
- Secure, HIPAA-compliant e-mail or messaging between team members and patients.
- Secure, HIPAA-compliant e-mail among all physicians caring for the patient.

## 6

### Implement Your 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 medical assistant 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 medical assistant who is overseeing that work in the interim has the support that he or she needs. Flexibility and perseverance on everyone's part will help make the transition a success.

**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.

**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

Track Outcomes.

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.<sup>16</sup> Diagnoses that fall into this category include heart failure, community-acquired pneumonia, and diabetes, among others.

Choose the measurable outcomes or indicators that you think will best reflect success in the eyes of your patients, your practice, and your payors. 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, bed days per 1000 patients and readmission within 30 days 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.

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## Conclusion

The intensive primary care model 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.

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## AMA Pearls

### 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 may allow 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.

Keep in mind expanding the role of non-licensed team members requires careful attention. Having protocols in place helps to ensure safety and high-quality care.<sup>13,14</sup> Other activities have also proven useful when training team members 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.

## Case Reports

1

### Intensive Primary Care Case Report: Stanford Coordinated Care

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 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 adequately listen to them 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 the target population's health care needs, physician panels are limited to 300 patients, and medical assistant care coordinators are limited to 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 or her health issues.

The initial SCC visit for new patients takes a total of two hours. Before the visit, the primary care physician 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, services offered, 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<sup>®</sup> 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 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

The care coordinator remains in the room to document 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.

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:

- Drawing necessary labs.
- Confirming the patient's understanding of the visit.
- Review the action plan(s).
- Agreeing on a follow-up plan to check in about how the action plan went for the patient over the coming week.

- Arranging referrals both within and outside the SCC.
- Sending 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 primary care physician 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 not just the patient's concerns, but the concerns of the medical system, as well. 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.

### A3 Report Template

Use this template to create your own A3 one-page report.

(PPT, 100 KB)

#### 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 time needed for 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.

You can find the SCC care coordinators' protocols on the [Stanford website](#).

#### Commitment to quality

SCC has two dashboards that draw from the electronic medical record (EMR):

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/or costly outcomes.

Care gaps are the responsibility of the care coordinators working under protocol. The SCC care coordinators have achieved the 90th percentile on 9 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 patients appreciate the services provided to them, and the SCC team members enjoy their work. The SCC has scored in the 99th percentile in the Press Ganey® “Likelihood to Recommend” category for 19 of its first 20 months.

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#### Learning Objectives

1. Define intensive primary care and explain when it should be used
2. Describe the importance of identifying and assessing the target patient population
3. Identify the composition of an appropriate care team and the steps needed to build the team
4. Explain what is needed to design and implement a patient-centered care model and the importance of tracking outcomes

# Article Information

## AMA CME Accreditation Information

**Credit Designation Statement:** The American Medical Association designates this enduring material activity for a maximum of .50 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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**Renewal Date:** December 10, 2016; October 03, 2019

**Disclosure Statement:** Unless noted, all individuals in control of content reported no relevant financial relationships.

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