Attachment F: **Primary Care Site Overview**

Primary Care Site Overview:

The Analysis of Primary Care Processes includes conducting research in a diverse group of primary care sites. The John Snow, Inc. (JSI) project team has partnered with three primary care organizations:

- Cambridge Health Alliance in Massachusetts;
- Kaiser Permanente in Colorado; and
- AltaMed Health Services in California.

The project team will be conducting the Analysis of Primary Care Processes in two primary care practices in each of these organizations, as well as an independent primary practice site in each of these geographic areas for a total of nine sites.

JSI will collaborate with the site investigators of each of these organizations to select the primary care sites to participate in this research, based on site willingness, staff availability, and diversity of site characteristics among the nine sites, such as size, patient population served, and history and types of transitional care work.

Cambridge Health Alliance (CHA)

Cambridge Health Alliance (CHA) is an academic public safety-net system with an ethnically and linguistically diverse, traditionally underserved patient population. CHA is an integrated healthcare provider comprising two hospitals, three emergency departments (ED) and 10 community health centers. CHA has pioneered a number of innovative approaches to safely transitioning patients from hospital to home and back to primary care, including:

- Daily inpatient multidisciplinary rounds to discuss patient care and post-discharge planning. Our care transition Nurse Practitioners participate in these rounds providing critical information about selected patients' home care needs.
- Patients and families are empowered with user-friendly discharge instructions, reinforced by post-discharge outreach phone calls from a nurse at the patient's primary care site, to address the needs and concerns of each patient.
- The cost-effective use of community-health workers (CHWs) to overcome non-medical barriers to effective post-discharge care. Helping with basic needs such as transportation, food, obtaining medications, the logistics of accessing care,

and coordinating social supports, the CHWs effectively extend the reach of primary care nurses into the community.

- Post-discharge home visits by care transition Nurse Practitioners allow Primary Care Providers to expand their scope of care beyond the clinic walls.

CHA was selected by CMS to receive funding through the Community-based Care Transition Program (CCTP). The CCTP aims to provide high-risk hospitalized Medicare beneficiaries with necessary home support and services to allow a safe transition to home and to primary care, in order to reduce avoidable readmissions. CHA's CCTP program involves a collaboration between CHA and two community partners: Somerville-Cambridge Elder Services and Mystic Valley Elder Services.

AltaMed Health Services

AltaMed has been a Federally Qualified Health Center since 1969 and is dedicated to serving the medically-underserved, the under-insured, and the uninsured. AltaMed's mission is *"to eliminate disparities in health care access and outcomes by providing superior quality health and human services through an integrated world-class delivery system for Latino, multi-ethnic and underserved communities in Southern California."* AltaMed now provides a medical home to over 170,000 patients and clients across 21 primary care clinics, seven dental clinics, and eight "Program of All-inclusive Care for the Elderly (PACE)' sites.

Its services include a full continuum of care such as pediatrics, complete primary care, obstetrics and gynecology, senior services with PACE programs, dental care, youth services, behavioral health, and HIV treatment and prevention. AltaMed employs the Patient Centered Medical Home model, which addresses patients' comprehensive clinical and social needs using team based care to effectively coordinate services.

AltaMed's quality improvement works and initiatives are managed by three departments: a) Quality and Performance Improvement Department; b) Clinical Quality and Safety Department; and c) Office of Compliance and Risk Management. These departments are responsible for ongoing organization-wide quality improvement and process improvement activities to enhance the patient experience, to achieve quality outcomes as well as to improve operational efficiency and effectiveness.

In addition, AltaMed's Medical Management Department provides care coordination and review and oversight for members hospitalized both in network and out of network in Los Angeles and Orange Counties. These departments and the primary care clinics will provide insight on the barriers to and potential opportunities for improving patient safety and reducing admissions.

Kaiser Permanente Colorado

Founded in 1945, Kaiser Permanente is the nation's largest non-profit health plan, serving more than 9.6 million members in nine states and the District of Columbia. Kaiser Permanente is divided into eight independent regional organizations, governed by a national board with headquarters in Oakland, California. The Kaiser Permanente Colorado (KPCO) region, established in 1969, has evolved from a predominantly closed-panel, group-model HMO and now provides both HMO and networked care through a range of insurance products. KPCO has over 970 physicians and 6,600 employees who provide integrated health care services to over 650,000 members (covered enrollees) in the Denver-Boulder metropolitan and southern and northern Colorado.

KPCO operates 26 outpatient medical clinics across the Denver/Boulder metropolitan area, two clinics in Southern Colorado and one in Northern Colorado. KPCO members choose a Primary Care Physician (PCP) and obtain most clinical services at their primary care medical clinic. Consistent with the Patient-Centered Medical Home model of care delivery, KPCO primary care physicians, nurses, and pharmacists work as a team to take care of their assigned patients. Specialty care is provided at two large "hub" facilities.

KPCO contracts with several hospital systems: Exempla Healthcare, Health One, Memorial Hospital; Parkview; and the Banner Health system, to provide tertiary care to members living in the Denver/Boulder metropolitan area and for our members in the southern and northern Colorado network service areas.

KPCO has adopted a version of the "Naylor model**"** in which involves a single targeted post-discharge visit by an Advanced Practice Nurse (APN), based in its ambulatory clinics. It has implemented methodology to identify those patients who are at high risk of readmission within 30 days of hospital discharge using the LACE risk tool (Length of stay, Acuity of Visit, Charlson Comorbidity Index and ED visits in the last six months). With this tool, KPCO can quantifiably target those members most at-risk for a poor transition and target interventions accordingly. APNs provide a targeted physical assessment, medication reconciliation and education, implement a care plan, determine needs at the site of care and communicate in real time with primary care physicians and subspecialists. This program has had positive outcomes for the two years since its inception, reducing the overall readmission rate in KPCO from 22% to 10%. However, there are subsets of the population that have readmission rates as high as 18% (heart failure).