Engaging the Entire Care Team to Facilitate a Comprehensive Pain Management Program in the Primary Care Setting

A Quality Improvement Activity

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Main Section

Overall Goal & Objectives. Develop and deploy an educational and quality improvement (QI) initiative to assist physicians and care teams in up to 10 nationally recognized patient-centered medical home (PCMH) practices improve knowledge, skills and competencies in the area of pain management to foster enhanced patient care, satisfaction and outcomes. The key objectives for this initiative are to:

1. Develop and implement an educational and QI program for primary care multi-disciplinary teams to foster enhanced ability and confidence to appropriately treat and manage patients who present with pain based on current evidence-based (EB) guidelines
2. Increase use of EB guidelines, screening tools and treatment options for patients with pain in the primary care setting
3. Introduce primary care teams to QI and population health management principles to assist in effectively treating and managing patients with pain

Technical Approach: Current Assessment of Need in Target Area

Gap: Physician Knowledge and Confidence. A survey conducted by O'Rorke et al. [1] revealed that more than 50% of primary care physicians felt they should serve as principle physician in the management of their patients' pain, yet only 34 % said they felt comfortable doing so. In a recent NJAFP assessment, family physicians indicated a need for focused education on pain treatment, tools, and assessing effectiveness and response to modalities, both pharmacological and non-pharmacological [Unpublished report, October, 2013]. Physicians need to learn about all aspects of pain management, including differences between addiction, pseudo-addiction and dependency and substance abuse - areas which are intricately woven into pain management - to effectively treat patients [2, 3]. There is a need for consistent and formal education so physicians can implement pain control strategies and mitigate barriers to comprehensive pain management for patients [4]. Family physicians recognize this need, with more than 84% indicating they wanted more pain management education in recent needs assessments conducted by AAFP and NJAFP [Unpublished report, NJAFP]. Many clinicians are simply not well versed in pain and its many forms or in pain management [4]. One study found that 76% of physicians admitted there were gaps in their knowledge about the treatment of pain which affected their ability to manage their patient's pain [5]. Another study found physicians were better at treating acute pain and were consistent in under-treatment of chronic pain [6].

Gap: Patient's Negative Perceptions of Physicians and Pain. Inadequate and sometimes inappropriate pain treatment is significant in primary care. In a survey of patients with chronic pain, almost half changed physicians three or more times because they felt their physician did not know a lot about pain treatment (31%), did not take their pain seriously enough (29%), were unwilling to treat their pain aggressively (27%), or did not listen to them (22%) [7]. In a study of family physician's assessment of patient pain, researchers found 30% did not recognize pain in patients reporting severe pain in pre-visit interviews [8]. Another study looked at communication between primary care physicians and patients with chronic pain and found

patients were dissatisfied with care they were receiving from their physician, citing lack of continuity of care, poor listening skills, and under- or overprescribing of medication [9]. Other studies have shown physicians consistently underestimate intensity of patient's pain [10, 11]. It has also been shown physicians do not routinely address issues of pain with patients [8]. Inadequate pain management can be attributed to incomplete understanding of the nature of pain and available treatments. Compounding this situation is lack of formal pain management training for family physicians who see the majority of chronic pain patients [12-14].

Gap: Pain Management Needed Using Patient-Centered Model. The PCMH is a care model, where healthcare professionals work as a team to provide care to meet each patient's needs. Research reveals when patients have a primary care physician in medical home chronic conditions are better managed and they have fewer complications, resulting in fewer hospitalizations [15]. A recent report from the University of Pennsylvania posited that incorporating tenants of PCMH into care of patients with chronic pain has the potential to improve quality of treatment, integrate care provided by primary care physicians and specialists, allow for collection of outcomes, and improved care coordination [16].

NJAFP has strong experience in the PCMH model. An on-going PCMH program with Horizon Blue Cross and Blue Shield of New Jersey (Horizon) showed the PCMH concept can improve quality of care and clinical outcomes, and also lower total healthcare costs. Data from the NJAFP and Horizon PCMH program, for 24,000 participating patients indicated a 10% lower cost of care per member per month; 26% reduction in emergency room visits; 25% reduction in hospital readmissions; and 21% lower rate in hospital inpatient admissions [17]. The Institute of Medicine (2011) posited care and management of chronic pain patients should take place through self-management and primary care, with specialty services being focused on recalcitrant or more complex cases and that health care provider organizations should take the lead in developing educational approaches and materials for people with pain and their families that promote and enable self-management. This is more likely to happen when physicians are operating a PCMH model with the patient as an active member of the healthcare team.

A NJ family physician for 20 years stated the PCMH model enhances interactions between primary care physician, care team and patient; providing a focused and effective patient visit, which permits the patient to be engaged in care plans and allows physician and team to provide a more comprehensive visit to address patients' concerns. Most important communication and care continuity fostered by PCMH helps providers and patients experience greater satisfaction, safety, and quality [18]. This can greatly enhance the physician and care team's abilities to treat patients with pain complaints. A NJ health plan began focusing on pain measures in primary care practices, but recently abandoned activities due to reduction in health plan staff available to provide assistance to practices [19]. The medical director stated one entity does not have resources, knowledge and time to assist practices with chronic pain metrics; a focused collaborative effort with many stakeholders is needed to be a success; starting a chronic pain program in PCMH practices is efficient, since these practices have infrastructure for population health for chronic disease that can easily be expanded to other areas, such as chronic pain [19]. A NJ gap assessment indicated the majority practices do not focus QI on pain diagnosis, do not

have EB pain guidelines in the electronic health record (EHR) and are not systematically assessing and documenting pain scores. In addition, NJAFP's extensive PCMH experiences revealed that close to 90% of practices that have worked on, or are currently in process of working on NCQA PCMH recognition, have needed assistance and education on completing Standard 6 pertaining to QI activities within the practice. This includes assistance with identification and selection of measures, measuring intervals, tracking and reporting data, and providing feedback to the practice team. NJ practices would greatly benefit from participation in this project.

Targeted Audiences and Project Benefits. Primary audiences for intervention include primary care physicians/providers (advanced practice nurses and physician assistants), care teams (nurses, care coordinators, medical assistants, office staff), patients, health plans, community partners, specialists, and the healthcare system. Specific targeted partners may include NJ health plan, integrated delivery networks, NJ Pharmacist Association, American Physical Therapy Association of NJ, NJ Occupational Therapy Association and Association of Social Workers NJ Chapter. Physicians and teams will benefit from enhanced knowledge, expertise and confidence in treating patients with pain; patients will experience greater satisfaction in care and enhanced quality of life; health plans, specialists and community partners will benefit through enriched communication and collaboration in working with primary care practices to treat and manage patients with pain; while the health system will benefit from cost reduction related to decreased use of services (e.g., avoidable emergency room visits, specialty care).

Intervention Design and Methods. The intervention for this project is a 12 month education and QI initiative designed to focus primary care practices teams on implementing a QI Plan to target improving measures in three of the four following domains, 1) clinical outcomes measures; 2) process measures; 3) utilization measures; and 4) patient satisfaction.

NJAFP will develop a comprehensive educational and QI program for participating PCMH practice teams. For success, it is critical that representatives from the entire practice team, from front desk to clinical team members, participate in project activities. To this end, project components will be developed to target specific practice team members in three key roles, clinical staff (physicians, nurses, physician assistants, advanced practice nurses), non-clinical/operations staff (office managers/practice administrators) and medical assistants. In addition, external targeted audiences (specialists, physical and occupational therapists, pharmacists, social workers/behavioral health, and others) will be targeted for education efforts focusing on collaboration and communication with the primary care practice team. The project will consist of three intervention components, a learning session, web-based education and on-site assistance and guidance.

The project will follow a collaborative quality improvement project platform, which is modeled with a focus on the Demming Quality Improvement Cycle, which include Plan, Do, Study, Act (PDSA) cycles. Primary care practice teams will engage in education that focuses on rapid cycle changes within the practice setting. This project provides opportunities for practice teams to learn together on how to make identified improvements in practice from topic experts in

specific fields, while learning from each other, resulting in project outcomes that close the gap between what is done and what is known. The project model with use a short-term learning time frame, approximately six to 12 months, during which time all practice teams will come together for a learning session, followed by hands-on, face-to-face assistance provided by an NJAFP QI Facilitator every three months. Supplemental educational opportunities for practice teams and external targeted partners will include web-based education and guidance to facilitate the learning and change.

NJAFP will engage topic experts/faculty to assist in content and materials development for project activities. These experts faculty will come together for meetings and may participate in conference calls/webinars providing expertise in pain topic areas. Faculty will include pharmacists, social workers, physical and occupational therapists, pain management specialists and other specialists, nurses and care coordinators with expertise in population health.

Learning Session. Team members from the primary care practice will form a multi-disciplinary learning team and attend the learning session. At the learning session, teams will also participate in break-out sessions tailored to their specific roles and responsibilities on the practice care team. These team members will then go back to the practice, and during the action period (action period is the six -12 months after the learning session) work with the entire staff to introduce the intended changes through rapid PDSA cycles, to foster the intended outcomes. Content for the learning session will be provided by the Principal Investigator, NJAFP staff and external topic experts.

The learning session will begin with an educational program that will highlight key learnings that are important to all members of the multi-disciplinary team regarding chronic pain management in the primary care setting. After the plenary session, the three audiences will participate in educational tracks related to their specific role within the practice setting.

The clinical education track will include system-based practice engagement (selecting, using, and documenting EB guidelines in EHR systems, coordination with pain professionals, selection and assessment of pain assessment tools i.e., Wong-Baker Scale, Pain Quality Assessment Scale); and medical knowledge enhancement (effectiveness and adverse effects of therapy; dosing protocols, treating co-morbidities; and population health management/care management and care plan development).

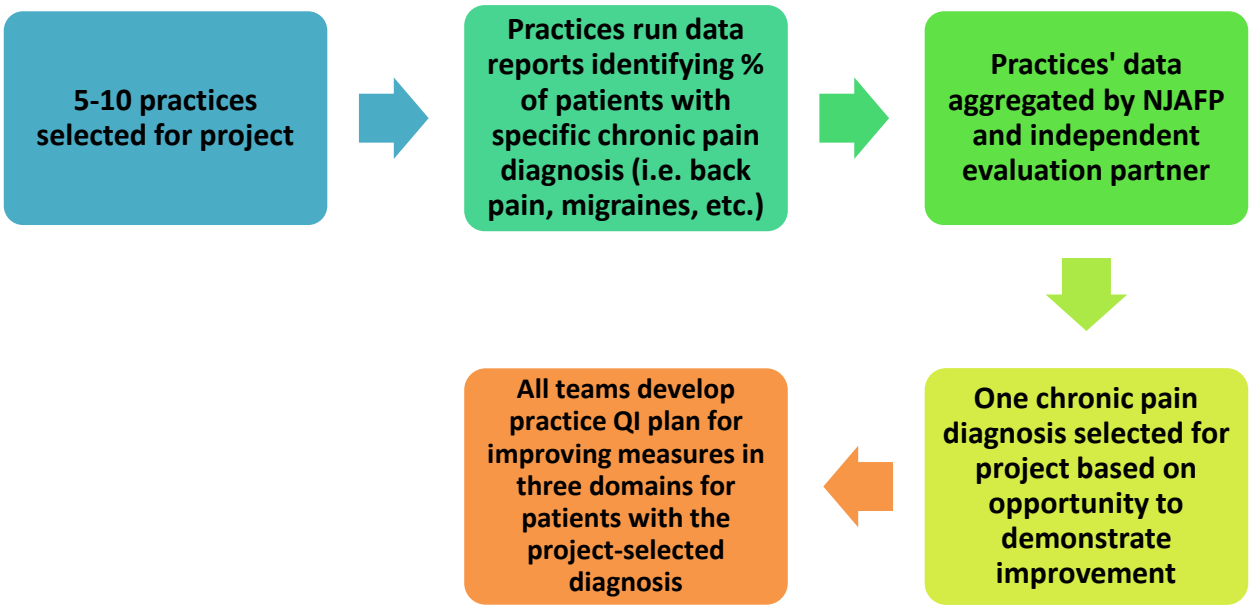
The track for non-clinical team members (office managers) will include development and deployment of processes, policies and systems needed to implement and sustain a chronic pain management program including same day appointment scheduling, pre-visit planning, referral and tracking for care coordination, monitoring and reporting on data collected related to process and system implementation, and patient satisfaction.

Medical assistant education will include information on use and documentation of pain scale assessments, pre-visit planning, referral coordination/patient follow-up and more.

Teams will come back together for education on the PDSA Cycle and review of NJAFP-developed change packets to foster interventions to enhance performance improvement. Practices will select measures in three of the four improvement domains (domains include clinical (quality), process, utilization or patient satisfaction) for targeted interventions. Teams will develop QI plans for each targeted measure. Based on data amassed for the gap analysis, from current NJAFP work with practices, and from the partnering health plan, NJAFP has identified measures that present the greatest opportunities within the primary care practice setting for improvement in each of the four domains. To facilitate the implementation of a common evaluation strategy across participating practices, teams will select three of the four domains with the following measures on which to focus QI plans/efforts.

Clinical (Quality) Outcomes	Process Measures	Utilization Measures	Patient Satisfaction
• Increase number of patients with pain diagnosis with pain care plan in the EHR • Reduction in patients' pain severity	• Increase use of chronic pain screening tool • Increase use of selected EB guidelines	• Reduction in avoidable visits to emergency department or hospital	• Increase patients reporting improvement in communication with practice team • Increase patients reporting improvement in function

Since there are many types of chronic pain, practices NJAFP will select one type of chronic pain to focus improvement efforts, which may include the following patient populations: patients with headache or migraine pain, fibromyalgia, osteoarthritis pain of the knee or joint, or lower back pain. The population will be chosen based on final practice selection and the opportunities the practices' patient populations provide in regards to opportunities for improvement. Data will be aggregated to determine best opportunity for improvement and then practices will focus on improving measures in three of the four domains listed above in the identified specific pain focus area. This will also inform content to be presented at the learning session regarding EB guidelines and treatment recommendations. The figure below outlines the process.



During the learning session, practice teams will receive change packets (a change packet outlines best practice interventions that can be implemented to initiate desired outcomes. The packet provides access to EB knowledge of proven tactics and methods to drive change) and, develop an improvement plan to take back to the practice for implementation. To assist with development and initiation of the improvement plan, practices will also receive education regarding the PDSA cycle for change. This change model provides an opportunity for practices to follow four steps to bring about the desired change. In the Plan Stage the practice will work to develop the aims or goals of the intervention and the necessary processes that are needed to drive the desired results. In the Do Stage, the practice team will deploy the plan and collect data to review in the next phase, the Study Stage. During this stage, the practice team will review the data and determine if change is happening, and if the change will bring about the desired outcomes. In the next stage, the Act Stage, the practice will use the data from the Study Stage to either make corrective actions or continue on course to achieve the desired results. ***This session will address key objectives # 1, #2 and #3 (See Goal and Objective Section).***

The physicians and practice staff will work as a team in collaboration with NJAFP QI Facilitators to develop a QI Plan, which will be tested and implemented using PDSA cycles back at the practice. NJAFP will work on-site at the practice to facilitate and assist the practice team in implementing their QI Plan. NJAFP on-site facilitation visits will occur three-times with each practice throughout the 12 month project engagement. During these onsite visits NJAFP will work with the team on assessing interventions, barriers and challenges encountered, successes and lessons learned to date. In addition, NJAFP QI Facilitators will contact a minimum of one conference call each month to assess practice progress, answer questions and assist in overcoming barriers encountered. NJAFP will use quantitative and qualitative assessment documents at each practice visit and during each monthly call to assess progress. This assessment will be used as proxy measures for interim data, to help ensure practice is on track

for meeting goals, or if not, alert NJAFP project staff that additional facilitation intervention maybe needed to assist this practice achieve practice and project goals.

Face-to-Face QI Practice Visits. NJAFP QI Facilitators will conduct site visits to the practice teams three times throughout project engagement (approximately once every two-three months). NJAFP staff will conduct the site visits to ensure a QI plan is put into action, assess barriers and challenges encountered, and assist the practice in implementing and monitoring interventions to address measures in the three selected domains.

Monthly Conference Calls/Web Sessions. Monthly conference calls between the NJAFP QI Facilitator and the practice team will be conducted to provide practices on-going support and assistance. These calls will provide the practice teams with the opportunity to ask questions receive support and share lessons learned and best practices. In addition, as NJAFP QI Facilitators identify common barriers and challenges experienced by the participating practices, NJAFP will conduct educational web sessions to foster learning, and sharing and spreading of best practices to overcome barriers among participating practices. It is anticipated base on NJAFP prior experience and gap assessments, web education sessions may include establishing co-management agreements with specialists, training of care team for new or expanded roles related to population health management, overcoming documentation challenges associated with selected project measures, and more.

Practice Participant Selection. To expedite project timelines, and align project activities for successes, NJAFP has already assessed interest from primary care practices with current PCMH recognition status from NCQA. ***NJAFP has received Letters of Participation from more than 20 PCMH primary care practices and federally qualified health centers (FQHCs) indicating an interest and desire to be selected to participate in this project.*** Furthermore, these practices have been additionally vetted to ensure success -- all practices are utilizing a CCHIT-Certified EHR system – and have been doing so for more than 24 months. This fosters the likeliness of project success, as all practices selected for participation will have a comprehensive understanding regarding the complexities and use of an EHR system to support process and clinical measures. In addition, all practices have multiple-providers. Practices selected to participate will identify a physician leader and one other staff member (clinical or non-clinical) to serve as a project lead as well.

Evaluation Design

Metrics. NJAFP will implement a quantitative and qualitative assessment for the project to determine if key objectives were addressed. NJAFP will work with an independent evaluation partner, practices and project partners to implement assessments and evaluations, both pre- and post- intervention.

Practice Performance Impact. NJAFP and an independent evaluation partner will assess the impact of the program on practice performance through the use of an NJAFP-developed standardized data collection tool. Practices will receive the tool prior to project commencement and will be asked to generate data reports from the practice EHR system for specific measures

identified for the project. NJAFP and the evaluation partner will analyze the data to determine baseline measurements (pre-intervention measurements) for each individual practice and aggregate the data to create a baseline for the entire project. Based on the practice-specific data, NJAFP will work with each practice to identify appropriate improvement goals, which will be incorporated into aim statements for the practice-specific QI plan. At the conclusion of intervention activities, NJAFP will again, provide the standardized data collection tool to practices, so that practices can generate data reports from the practice EHR system for specific measures identified for the project. NJAFP and the evaluation partner will analyze the data to determine re-measurement data results (post-intervention measurements) for each individual practice and aggregate the data to create a final post-intervention measurement for the entire project for measures in each domain. The standardized data collection tool will ask the practice to generate reports for specific measures that include numerator (all patients eligible for the measure), denominator (all patients that received/had compliance to the measure) and the percentage of compliance for the measure (using the numerator and denominator), i.e. percentage of patients in the specified population with a documented care plan for pain, percentage of patients with a completed and documented pain assessment.

Use of EB Guidelines. At project initiation and completion, each practice will also provide data for a quantitative assessment of the number of practices using an EHR with pain EB guidelines embedded in the system for use at point of patient care.

Patient Satisfaction. In addition, NJAFP will work with practices to collect a baseline (pre-intervention) data for patient-satisfaction measurements. Practices will incorporate patient satisfaction questions into patient satisfaction surveys (no patient identification information will be collected) and provide the data to NJAFP and the evaluation partner for analysis to determine baseline measurements (pre-intervention measurements) for each individual practice and aggregate the data to create a baseline for the entire project. Based on the practice-specific data, NJAFP will work with each practice to identify appropriate improvement goals, which will be incorporated into aim statements for the practice-specific improvement plan. At the conclusion of intervention activities, NJAFP will again, provide standardized questions for the practice to use to collect re-measurement data (post-intervention) to assess outcomes. NJAFP and the evaluation partner will analyze the data to determine re-measurement data (post-intervention measurements) for each individual practice and aggregate the data to create a final post-intervention measurement for the entire project.

Utilization Analysis Evaluation. NJAFP will work with practices and health plan partners to use data reports to assess utilization reduction associated for patients with pain. NJAFP will work with practices to demonstrate how to utilize emergency department and hospital tracking logs to generate baseline and re-measurement data. Practices will provide baseline data to NJAFP and evaluation partner utilizing standardized data collection tool. NJAFP and evaluation partner will analyze data and provide practice-specific data and aggregated data for all practices to all participants pre- and post-intervention.

Report data will be furnished on an aggregate level to maintain confidentiality of the healthcare professionals and practices participating in the project. NJAFP will provide a final written report with data, analysis and findings.

Expected Change. Since project implementation is scheduled for only 12 months, NJAFP is using a conservative measurement profile to anticipate expected change from implemented interventions. Based *on* NJAFP experience, NJAFP is targeting a 5-10% increase change from baseline to re-measurement for all practices and metrics, other than utilization or costs, identified for this project. NJAFP will target a 2% decrease in utilization metrics identified for this project. When assessing using a Likert scale measurement, NJAFP is targeting a one point score increase or decrease, depending on the metric and the intent of the outcome i.e. for patient satisfaction NJAFP would target and increase, for pain scale rating, NJAFP would target a decrease for expected change in outcomes.

Target Audience Engagement. A comprehensive plan is used to determine target audience engagement. This comprehensive plan outlines all project tasks, time frames and goals, and is used as an internal quality control document. In addition, measures will be developed and deployed to monitor and evaluate project activities and all training sessions. These measures serve as criteria to determine what constitutes active physician/practice project involvement. Criteria will include proxy measures that will alert NJAFP staff to potential issues.

NJAFP uses this assessment to collect qualitative and quantitative data via learning sessions (attendance, satisfaction and knowledge surveys), site visits to the practices (observations, QI plan assessments) and monthly check-in calls. If NJAFP identifies any concerns, NJAFP will contact and communicate concerns to practices, indicating the physician/practice's project participation status is in jeopardy. NJAFP will work with the practice to assist in overcoming project participation barriers, if possible. If, after issuing the warning, and based on developed criteria, it is determined that a physician/practice is not actively participating or engaged in the project, this practice shall be removed from the project, and will therefore, forfeit any potential stipend payments. This monitoring and evaluation strategy will assist NJAFP project staff in identifying what is working, what is not, and if and when adjustments are needed to ensure successful project implementation. In addition, barriers encountered and project successes achieved will be documented.

NJAFP has successfully utilized this strategy for many projects that are similar in size, scope and complexity, including the Centers for Medicare & Medicaid Services Comprehensive Primary Care Initiative, in which this assessment has been identified as a best practice among all participating regions. NJAFP facilitators complete a quantitative and qualitative assessment after each visit and monthly check-in call with a practice team. The quantitative assessment utilizes a Likert scale to assess practice team engagement in project activities, progress to date and ability of the practice team to achieve success in outlined project objectives. The qualitative assessment identifies any challenges or barriers the practice is experiencing and identifies additional educational opportunities acknowledged by the facilitator or the practices. These

assessments provide real-time data to the project manager/director regarding physician/practice team engagement.

Dissemination of Project Outcomes. Project outcomes will be broadly disseminated through NJAFP activities to expand project learnings beyond participating practices; activities include:

- *Toolkit* – NJAFP will post a Best Practices Toolkit to the NJAFP website. This toolkit will contain change packet information practices used during project implementation to assist in overcome challenges and barriers associated with implementing a chronic pain QI plan in practice. This toolkit will be available for all physicians and providers, locally, regionally and nationally and will be publicized via e-mails, publications, social media and mass communications. In addition, NJAFP will promote availability of the toolkit to all AAFP State Chapters via announcements and social media.
- *Live Meetings:* Each year NJAFP conducts a scientific assembly attended by approximately 300 family physicians, medical residents, medical students and other primary care practice team members. A presentation of best practices learned during the project will be offered to disseminate project outcomes on a statewide scale. The 2015 Assembly will include a panel of project practices who will present the program, the results, and the learned best practices to spread learning statewide.
- *Publications:* NJAFP publishes and distributes *Perspectives*: *A View of Family Medicine in NJ*, a quarterly, peer-reviewed, continuing medical education journal to close to 2000 family physicians, medical residents, medical students and other key stakeholders both in NJ and nationally. NJAFP will write and publish articles in this journal to disseminate project progress and outcomes beyond participating practices.
- *Mass Communications:* NJAFP will foster wide-spread dissemination of project activities and outcomes through the use of our website, e-newsletter, and local, regional and national presentation opportunities and poster sessions.

In addition, project outcomes will be broadly disseminated through partner activities, including:

- *Live Meetings:* NJ health plans and other partners conduct meetings for physicians, practice team members and key audiences. NJAFP and partners will conduct poster sessions and presentations to disseminate project outcomes on a broad scale to these critical audiences.
- *Publications:* NJ health plans and other partners publish on-line and printed newsletters and publications. NJAFP and partners will write and publish articles to disseminate project progress and outcomes beyond participating practices. NJAFP partners may also offer these articles to national associations for inclusion in their national publications.

Detailed Workplan and Deliverables Schedule. NJAFP has an expertise, knowledgeable team, ready to initiate project activities immediately upon signing Letter of Agreement and is currently holding January 2014 dates for training. The project intervention will be a 12 month QI initiative designed to focus on implementing a QI plan that targets improving measures in three of the four following domains 1) clinical outcomes measures (quality); 2) process measures; 3)utilization measures; and 4) patient satisfaction.

Practice Participant Selection (January 2014). To expedite project timelines and align project activities for successes, NJAFP has already assessed interest from primary care practices with PCMH recognition status. ***NJAFP has received Letters of Participation from more than 20 primary care practices and federally qualified health centers (FQHCs) with PCMH recognition/obtaining PCMH Recognition, indicating interest to participate in this project.*** NJAFP will finalize practice selection by asking practices to generate a report from EHR system, detailing percentage of patients with pain in the practice (i.e. percentage of patients with back pain, osteoarthritis of knee, migraines, etc.) Based on this data, NJAFP will select a patient population to focus project QI efforts. Selected practices will have physician leader sign a Letter of Commitment for NJAFP acknowledging staff and time will be allocated to project.

Finalize Data Collection Tools and Complete Baseline Data Assessments (February 2014). NJAFP will disseminate a data collection tool to all participating practices. Practices will generate data reports from EHR systems, conduct patient satisfaction surveys and provide information for qualitative assessment. NJAFP and independent evaluator will analyze results and provide blinded project group results to practices.

Expert Panel Meeting (February 2014). NJAFP will convene an expert panel to enhance project content, materials and activities related to the selected patient population. This panel will be comprised of content and topic experts including primary care physicians, pharmacists, social workers, physical and occupational therapists, pain management specialists and other specialists, nurses and care coordinators with expertise in population health.

Conduct Learning Session (March 2014). NJAFP will conduct a Learning Session for all participating practices. This will be a full day learning session **(See Intervention Section).**

QI Assistance via Face-to Face Practice Visits, Monthly Calls/Webinars (April – December 2014). NJAFP QI Facilitators will work with each practice to implement a QI Plan focused on improving measures in three of the four domains. NJAFP will visit each practice three times during the project and have at least one contact/call each month. In addition, as NJAFP QI Facilitators identify common challenges and barriers, NJAFP will coordinate group education webinars for the practices. These webinars will be feature content/topic experts who will present information to assist practices overcome challenges and barriers encountered.

Re-measurement (post-intervention) Data Collection and Results Dissemination to Practices (January – February 2015). NJAFP will disseminate a data collection tool to all participating practices. Practices will generate data reports from EHR systems, conduct patient satisfaction surveys and provide information for qualitative assessment. NJAFP and independent evaluator will analyze results and provide feedback report to each practice that identifies changes in measures (post-intervention compared to pre-intervention) for each practice and for the project overall; blinded project group results will be given to the practices.

Complete Final Project Report and Post Toolkit to Web Site (March 2015). NJAFP will complete a final report to the funder specifications and provide report to funder with completed budget reconciliation. In addition, NJAFP will post a Toolkit of best practices garnered from the project activities to the NJAFP website and broadly promote availability to practices beyond project.

Presentation at 2015 NJAFP Scientific Assembly (June 2015). NJAFP will conduct a session with a panel of participating practices at the 2015 Assembly to share project, practice activities, lessons learned, and the Best Practices Toolkit.

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Organizational Detail

Leadership and Organizational Capability. NJAFP has extensive experience in CME, QI and services to assist practices, health systems and others, transform to the PCMH model of care. NJAFP has been a leader in developing and providing CME programs to physicians for more than 10 years and has successfully completed more than 100 programs locally and nationally. NJAFP QI experience includes successful on-line programming including a robust Performance in Practice compendium and programs offered through the AFBM providing physicians opportunities to use NJAFP programs for Maintenance of Certification.

To date, NJAFP has worked with more than 1000 primary care physicians in approximately 750 locations on PCMH activities. NJAFP has developed and implemented programs in which physicians and practices receive curriculum, resources, materials, tools, and hands-on assistance, to transform to a PCMH model and receive recognition from NCQA. In 2009 NJAFP created and implemented the largest PCMH project in NJ to date, collaboratively with the largest NJ health plan. NJAFP's comprehensive PCMH program is uniquely developed with a focus on: Patient Tracking/Registry to assess data systems the physician uses to document clinical information and population management; Care Management to identify if physicians implement EB guidelines for care, uses a care team and engages in continuity and coordination of care; Performance Reporting/Improvement focuses on the practice's ability/process to improve effectiveness, efficiency and timeliness by reporting quality information by clinician/practice; Electronic Communications to evaluate if physician/practice uses technology to maximize performance, efficiency, and coordination of care; and Access/Communication to focus on access and patient/physician communications. Currently, NJAFP is serving as faculty lead for CMS's Comprehensive Primary Care Initiative in NJ, providing assistance and education to 70 practices to achieve success in nine milestones.

NJAFP will engage the following experts in the field of evaluation and health information technology to implement project activities and meet project goals.

Horizon Blue Cross Blue Shield of New Jersey (Horizon) Horizon is NJ's largest health plan. NJAFP collaborates with Horizon on PCMH and practice transformation projects effecting more than 80,000 NJ residents. A letter of support, signed by Steven Peskin, MD, Senior Medical Director Clinical Innovations, has been provided indicating interest to assist in project activities.

CEOutcomes CE Outcomes, LLC is a leading independent assessment services organization with a mission to provide high-quality, objective, and evidence-based assessments for healthcare organizations through identification of practice pattern variation, performance gaps, unmet medical needs and impact of educational and non-educational interventions.

Staff Capacity: NJAFP will utilize a multi-disciplinary team to develop, implement and oversee all project activities. The Project Manager will serve in a leadership capacity for all project activities. The Project Manager has been a full-time employee of NJAFP since 2008, leading both PCMH and QI activities. In addition, the she has developed, implemented and managed QI

projects for more than 15 years for clients that including the Center for Medicare & Medicaid Services (CMS), NCQA, Centers for Disease Control and Prevention, Horizon Blue Cross Blue Shield of NJ, and many others. The Project Manager has developed timeframes to help ensure project success, and incorporated these into an overall implementation project plan. The implementation plan is a resource that provides the overall structure for project deployment. This plan allows project milestones to be tracked and assessed, ultimately resulting in successful project completion.

NJAFP will utilize a comprehensive project plan that outlines all tasks, time frames and deadlines as an internal quality control document. Key NJAFP staff and project team members will review this plan regularly; if review indicates a potential late or missed deliverable, mitigation plans will be rapidly developed and deployed to get tasks on track. In addition, measures will be developed and initiated to monitor and evaluate activities and education sessions. The monitoring and evaluation strategy assists NJAFP in identifying what is working, what is not, and if and when adjustments are needed to ensure successful implementation.

The NJAFP team implements tasks though a multi-module approach, which includes phone consultation, face-to-face meetings, conference calls/WebEx sessions, and e-mail communications. Communications during project implementation are paramount to the success of the project. The NJAFP team will work with each practice to identify a project champion and a physician champion. Each of these individuals receives project-related materials, communications and updates. NJAFP's team will provide an educational curriculum delivered through meetings, site visits and e-mails, conference calls/WebExes for participating practices. A schedule and key milestone dates will be disseminated at the launch of the project. At key intervals during project implementation, practices will schedule on-site sessions with the NJAFP project facilitator to review and assess activities for practice QI including monitoring, reporting and evaluation (feedback).

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