CPCPracticeSpotlight63

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Telehealth Model Moves Knowledge to Improve Access and Timeliness of Care

W.W. Hastings Hospital, Tahlequah, Oklahoma; system-affiliated (Cherokee Nation Health Services); 10 providers; 142,207 patients (in system)

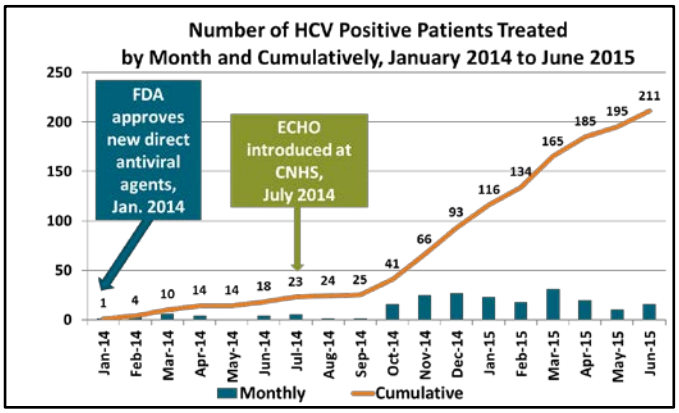
Jan. 22, 2016

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.2: Planned Care and Population Health
- 1.3: Risk-Stratified Care Management

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: In 2013, data at **Cherokee Nation Health Services** (CNHS) showed the prevalence of patients infected with Hepatitis C (HCV positive) was estimated at 5,160 adult patients. Weighing that estimate against CNHS' current resources and personnel, the system projected that it would take many years to treat all patients with chronic HCV infection. The rate and need clearly outpaced CNHS' resources, and a new strategy was needed to deliver timely, affordable access to specialty care for HCV positive patients. Further, new treatment strategies were being approved for HCV patients, and clinicians at Cherokee lacked a peer group of HCV specialists to learn from and share with.



This run chart illustrates CNHS' expanded capabilities to evaluate and treat HCV positive patients once ECHO was introduced. Further, these are patients who were cared for in their "home" clinic rather than travelling to a specialist's office in another city.

Innovation: In 2013, **Jorge Mera, MD,** of CNHS' **W.W. Hastings Hospital**, began to explore participation in Project ECHO (Extending Community Health Outcomes), a telehealth model that aims to increase the primary care workforce's capacity to deliver high quality specialty care, especially in rural and underserved communities. Expert teams lead Project ECHO's hub-and-spoke learning networks, where knowledge is shared via videoconferencing in weekly virtual clinics where clinicians meet to share best practices in a case-based learning environment. Research published in the New England Journal of Medicine in 2011 shows that the care ECHO-trained clinicians provided to their patients was equal to that of care provided by specialists in university/medical school settings.

About ECHO – Albuquerque liver specialist **Sanjeev Arora, MD,** created Project ECHO in 2003. Frustrated that thousands of HCV positive patients in New Mexico lacked access to timely, high quality treatment due to a shortage of specialists, Dr. Arora envisioned the project would help primary care offices treat hepatitis C in their own communities, and thus patients could get the right care when they needed it where they live. Today Project ECHO is administrated through the School of Medicine at the University of New Mexico. It operates 70 hubs worldwide, with 48 in the U.S. and 22 in 11 additional countries for more than 45 diseases and complex conditions, which include gastrointestinal conditions, diabetes/endocrinology, geriatrics/dementia, palliative care, rheumatology, chronic pain, addiction/psychiatry and HIV. Multiple federal agencies and private organizations provide grant funding for ECHO. Participants do not pay fees for joining.

Getting started – Dr. Mera and his team joined Project ECHO initially as a "spoke" clinic in July 2013. The process was simple: they contacted the university to sign up, agreed to follow PHI/HIPAA restrictions and to regularly report data to the central administration. The only technical requirement was the ability to connect to the internet.

Meetings – To prepare for meetings, each spoke clinic faxes or emails a de-identified clinical case along with their questions to the hub site. In a format similar to physician residency training in the hospital setting, each spoke site presents its case to the entire learning network, and all participants can ask questions. Participation is open to all clinicians and specialties treating the patient, including PAs, APRNs and educators as well as pharmacy and behavioral health. Each 10- to 15-minute presentation is followed by recommendations from the hub specialty experts. Four to six cases are shared at each meeting, which wraps up with a 15-minute didactic lecture. Attending clinicians may earn free CME or CNE for attending the session.

As of May 2014, W.W. Hastings began serving as an HCV treatment hub for Cherokee Nation outlying clinics. To become a hub, staff underwent two days of training with ECHO and signed a memorandum of understanding regarding sharing data. An IHS grant funded the hiring of an ECHO coordinator.

How Project ECHO has benefitted CNHS and its patients: The ECHO meetings offer benefits that increase clinician job satisfaction at no cost as well as integrate a public health dynamic into the treatment paradigm. Providers rapidly gain meaningful, clinically relevant information that they can use immediately in practice to treat complex patients. Despite their rural location, they can easily connect to experts and peer physicians, and they can earn free CME and CNE as they learn emerging best practices.

Patient outcomes are improved through easier access to specialty care that is delivered in their "medical home" primary care clinic as opposed to a specialist's office more than an hour away. The model reduces disparities for rural patients and also prevents costs associated with untreated disease, such as a liver transplant, cirrhosis or cancer.