The Great Lakes Practice Transformation Network is supported by Funding Opportunity Number CMS-1L1-15-003 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.
In 2016, the Centers for Medicare and Medicaid Services (CMS) Innovation Centers’ Transforming Clinical Practices Initiative (TCPI) established the Great Lakes Practice Transformation Network (GLPTN) and 28 other PTNs across the country to support 140,000 clinicians in the shift to value-based care.

This GLPTN Program Summary takes a look back at the program’s impact on the four-year, practice transformation journey of clinics, health centers, and practices in Indiana.
As an outreach arm for the Regenstrief Center for Healthcare Engineering at Purdue University, Purdue Healthcare Advisors’ mission to support small, rural, and under-served organizations aligned well with the push by the Centers for Medicare and Medicaid Services (CMS) for clinicians to transition from volume-based to patient-centered healthcare services. CMS had been testing Alternative Payment Models (APMs) for years and its Transforming Clinical Practice Initiative (TCPi) that funded the Great Lakes Practice Transformation Network (GLPTN) encouraged clinicians to embrace the models.

As GLPTN’s work wraps up, I am struck by just how far our enrolled practices have come in spite of all the obstacles they faced at the beginning of their transformation journey. The culture shift from programs that were pay-for-reporting to a pay-for-outcomes paradigm presented a challenge because while groups were eager to adopt new initiatives to drive improvements, they lacked the tools, time, and financial alignment to effectively implement the programs. In addition, PHA’s experience with helping providers adopt electronic health records systems prepared us for the reality that organization-wide change is always a slow and tedious process. So our Quality Improvement Advisors (QIAs) were not surprised by the calls for assistance with EHR workflows, generating reports, and general optimization as many of our network members didn’t have a formal process for using their data to drive improvement.

To support their efforts to make and sustain change, we chose to train our QIAs in Lean process improvement methodologies. Our entire QIA team became certified Lean Daily Improvement (LDI) Facilitators and also trained as Lean Practitioners, a designation for which three QIAs (Fundisani, Kelley, and Fiona) were certified. GLPTN supported their data to drive improvement. To support their efforts to make and sustain change, we chose to train our QIAs in Lean process improvement methodologies. Our entire QIA team became certified Lean Daily Improvement (LDI) Facilitators and also trained as Lean Practitioners, a designation for which three QIAs (Fundisani, Kelley, and Fiona) were certified. GLPTN encouraged clinicians to embrace the models.

As 92 initial Indiana members moved through the phases of practice transformation, many produced change that resulted in the formation of collaborative, peer-based learning initiatives. As GLPTN’s work wraps up, I am struck by just how far our enrolled practices have come in spite of all the obstacles they faced at the beginning of their transformation journey. The culture shift from programs that were pay-for-reporting to a pay-for-outcomes paradigm presented a challenge because while groups were eager to adopt new initiatives to drive improvements, they lacked the tools, time, and financial alignment to effectively implement the programs. In addition, PHA’s experience with helping providers adopt electronic health records systems prepared us for the reality that organization-wide change is always a slow and tedious process. So our Quality Improvement Advisors (QIAs) were not surprised by the calls for assistance with EHR workflows, generating reports, and general optimization as many of our network members didn’t have a formal process for using their data to drive improvement.

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The Overview

Practice Transformation Networks

Practice Transformation Networks (PTNs) were established by the Centers for Medicare and Medicaid Services (CMS) to support practices in the shift to value-based care. Nationwide, the CMS Innovation Centers’ Transforming Clinical Practices Initiative (TCPi) funded 29 PTNs with a goal of supporting more than 140,000 clinicians over a four-year time frame. The initiative’s overarching goals: to improve key clinical quality measures; to reduce unnecessary tests and utilization; to generate cost savings for payers; and to prepare practices to adopt Alternative Payment Models (APMs) through CMS or commercial payer programs.

Great Lakes Practice Transformation Network

Led by the Indiana University School of Medicine, the Great Lakes Practice Transformation Network (GLPTN) covers the states of Kentucky, Illinois, Indiana, Michigan, and Ohio. Purdue Healthcare Advisors (PHA) is the lead organization in Indiana and is supported by HealthLINC in southern Indiana.

At the onset of the TCPi program, CMS was preparing to roll out the Merit-based Incentive Payment System (MIPS) that scores practices based on their performance. Indiana groups were eager to participate in GLPTN to receive MIPS assistance and to learn how to improve metrics to achieve higher performance scores. GLPTN Indiana recruited 92 practices representing all corners of the state. Its membership consisted of 60% specialists and 40% primary care providers. Approximately 70% of the practices recruited met CMS’ definition of a small practice (15 or less clinicians).

Transformation Strategy

GLPTN’s work focused on several key clinical quality measures: 1) Diabetes Poor Control, 2) Controlling Hypertension, 3) Flu Immunization, 4) Depression Screening, and 5) Depression Remission.

Some of the strategies employed by GLPTN included a focus on reducing unnecessary testing (imaging) involving low back pain; reducing opioid prescriptions; implementing Chronic Care Management (CCM) to reduce unnecessary ED utilization; and implementing Transitional Care Management (TCM) codes to reduce hospital readmissions.

Transformation efforts in Indiana revolved around the dual strategies of leveraging the CMS change package to prepare practices to participate in an APM while building capacity for change by training and certifying their staff in lean improvement methodologies. According to GLPTN Indiana Program Manager and Network QI Lead Allison Bryan-Jungels this strategy offered the greatest likelihood that practices will be able to sustain efforts and continue transformation post-GLPTN.

Lean training included in-person; onsite trainings; virtual trainings; and self-paced, online training — all combined with live coaching to ensure success. Lean tools were used to transform the way practices worked with patients by improving workflows associated with clinical staff, patient access, and the referral process as well as those that reduced the clinician burden by completing tasks in a timely fashion (see pages 8-9).

As the work progressed, GLPTN Indiana worked in partnership with healthcare associations to promote its strategy, speaking frequently at statewide conferences about practice transformation (Indiana Rural Health Association, IMGMA, and others); holding a MACRA conference in conjunction with QSource; and co-hosting two road shows with the Indiana Hospital Association and QSource — the first focused on TCM and the second on sepsis awareness for reducing readmissions.

Impact on Transformation

PHA’s tools from its Lean First toolbox — Lean Daily Improvement (LDI) and Rapid Improvement Events (RIE) — impacted members’ clinical operations by improving targeted clinical quality measures, closing care gaps, and implementing processes associated with the state’s opioid registry (see pages 10-11).

“Working with the PHA team not only enhanced our organization in terms of process outcomes, it gave us the tools and resources to sustain continuous improvement by coaching key staff members in the implementation of lean methodologies,” said Ashley Wilson with Open Door Health Services. Lean tools also were used to implement components of GLPTN’s push for CCM/TCM, which encouraged practices to apply new billable codes to improve patient engagement and outcomes as well as get reimbursed for the services provided (see pages 12-13).

Along with a lean-thinking approach, QIAs guided practices to consider adopting technologies, preparing to transition to an APM, and enhancing EHR usage (see pages 14-15). Solo clinician Dr. Ann Patterson, MD, said, “GLPTN helped me transform my practice and, although I’m not totally reliant on my EHR, I’m certainly farther along than I would be without my QIA.”

Of the 92 practices that joined the Indiana network, 12 graduated to an APM and 57 remained active.

Impact on Health Outcomes

GLPTN Indiana supported efforts that led to improved clinical quality measures

<table>
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<th>Condition</th>
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<td>Influenza</td>
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2016

- Recruitment
- Baseline Assessments
- Action Plans

2017

- Activities to Progress From Phase 2 to 3
- MACRA Assistance
- Targeted Assistance

2018

- Lean CCM/CCM Initiatives
- Intro to APMs
- Intro to CCM/TCM Billable Codes
- MACRA Readiness
- Targeted Assistance

2019

- Online Lean Training
- MACRA Guidance
- Targeted Assistance
1: Transformation

To drive clinicians toward achievement of the Quadruple Aim, CMS provided a change package and associated assessment tool to identify each practices’ baseline score. From there, each practice was to determine its specific goals. Some wanted to prepare to join an Alternative Payment Model (APM), others sought success with the MIPS program, and others wanted targeted improvement with practice outcomes and operations.

Implementing the Change Package
The change package provided a high-level road map with numerous change tactics for each of the five phases of transformation (crossing 16 key drivers and including up to 27 change tactics). After helping their assigned practices with initial assessment and goal setting, GLPTN Quality Improvement Advisors (QIAs) worked with them to provide information, resources, and assist in the implementation of targeted change tactics.

Implementing change was easier said than done. While the change package was a valuable resource, many practices were overwhelmed by the list of tasks they needed to complete to move to the next phase. Practices encountered challenges along the way including obtaining buy-in from staff, limitations with EHRs, and limited staff time and resources to tackle numerous projects. The many specialties and practice types participating prevented “one-size-fits-all” solutions, so QIAs customized resources to meet client needs as they worked closely with the groups to minimize the burden on practice staff and clinicians.

One consistent gap hindering the change process was the absence of quality improvement know-how throughout the participants. In response, Purdue Healthcare Advisors’ (PHA) process improvement experts were brought in to introduce lean thinking. QIAs were trained to help practices learn how to make sustainable, small-scale change to workflows by creating visual management boards and associated assessment tool to identify each practices’ baseline score. From there, each practice was to determine its specific goals. Some wanted to prepare to join an Alternative Payment Model (APM), others sought success with the MIPS program, and others wanted targeted improvement with practice outcomes and operations.

Transforming Practices Through Lean Training
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“Webinars, day conferences, and lean process improvement training equipped us with resources that we can continue to use in the future. We were able to ask challenging questions and connect with other groups like ours to gain additional insight,” said Tara Foncannon of Evansville Surgical Associates. “Healthcare is constantly evolving, and I believe we were able to continue to do so with the help of GLPTN.”

CASE STUDY

Dupont Family Medicine

Although the formula for practice transformation seems straightforward — create a team, set a vision, develop a plan, implement the plan, and track outcomes — in reality, the extra burden placed on small- and mid-sized groups may seem insurmountable, according to QIA Derek Kendrick.

Since Dupont Family Medicine joined GLPTN, Kendrick’s job has been to coach the Fort Wayne, Ind.-based primary care practice through the transformation process. “At the onset, the requirements of practice transformation seem like too much as practice managers are forced to quickly become familiar with jargon associated with assessments, process improvement, metrics tracking, cost savings initiatives, and transitioning to value based contracts,” Kendrick said.

Taking it slow, Kendrick and Dupont Practice Manager Jaimee Cearbaugh began by reviewing quality data and completing a TCPi Practice Assessment. The network’s practice assessment tool gave the staff a new perspective on value-based reimbursement and how practice management can impact that revenue. “We were doing well before we joined the GLPTN, but that assessment tool really made us think differently about our practice and about meeting its milestones,” Cearbaugh said.

After reporting metrics to CMS in 2017, Dupont decided to tackle a gap highlighted by the practice assessment that recommended putting a consistent process improvement methodology into practice. They used their GLPTN/PHA Lean Daily Improvement (LDI) training as an opportunity to correct inefficiencies in their chart completion process. Overcoming hesitation due to what they perceived as a lot of work, they charted daily as to whether they met their goals, detailing corrective actions and holding daily team huddles. They placed numerator and denominator statistics for the week in an area where all staff could see the progress, instilling the importance of completing every chart every day with the visual management tool. Within 10 weeks the process was hardwired.

Staff have since applied that process to other pain points, including a project to correct inefficiencies in the practice’s scheduling system and another to better utilize Transitional Care Management Services codes. Monitoring hospital discharges through a direct-message portal now allows the practice an opportunity to provide better continuity of care through scheduled post-hospital office visits. This also reaches a network milestone aimed at providing better care coordination, and increases MIPS metrics that lead to higher reimbursements.

“Almost everyone was excited to see the visual management boards and have a weekly meeting to discuss what steps we could take to improve,” said Tara Cearbaugh.

“Our practice has improved in productivity, revenue, and consistency since utilizing the PTN practice assessment tools along with having Quality Improvement Advisor Derek Kendrick as our mentor and cheerleader.”

— Jaimee Cearbaugh
Dupont Family Medicine
2: Quality

The key clinical quality measures that GLPTN initially choose for overall programmatic assessment were based on the assumption that participating members would be primary care practices. To meet the needs of the specialty practices that ended up constituting 60% of the GLPTN Indiana membership, the network added the measures depression screening and depression with remission at 12 months to the core measures of diabetes control, hypertension control, and offering flu shots. QIAs then worked to identify meaningful quality measures for each participating practice and often aligned MIPS measures with those of other quality programs in which the practice was participating.

Gathering Practice-Specific Data

Once specific measures were identified, QIAs worked with clients to make targeted improvements — some generated from enhanced data captured in the EHR and others tied directly to patient care improvements. Unfortunately, data gathering is often a challenge for practices for various reasons. EHRs have specific workflows for documenting data to ensure it’s captured in quality reports, but these workflows can shift on an annual basis as measures are modified. It can be time consuming to adjust EHR-specific workflows and establish new standard work so reports accurately reflect the true care provided. On occasion, an EHR could not produce reports detailing the clinical quality measures meaningful to the clinician, and this forced the practice to pay for a custom report or sift through hundreds of measures and modes of reporting to determine its quality-improvement focus.

As a former CMS-designated Regional Extension Center for EHR adoption, Purdue Healthcare Advisors is intimately familiar with the limitations of various EHRs, and has years of experience working with practices to prescribe workflows and suggest alternative solutions. Our QIAs utilized these best practices to minimize the data-gathering burden, then supported the practices as they set targets for their quality measures and implemented improvement initiatives using Lean Daily Improvement (LDI).

Meeting Quality Improvement Goals

Goals ranged from improving MIPS metrics to diabetes care monitoring to physician-patient interactions. Premier Family Medicine (shown in photo) wanted to decrease the number of items waiting for filing in its patient portal. With LDI, they were able to practically eliminate this information bottleneck, which had created inefficiencies affecting clinicians, patients, and the practice’s billing process.

Another practice, Elwood Family Medicine, chose to focus on its diabetic patients. “By everyone working the lean project together as we were instructed, we were able to capture additional A1c results that were not coming in through our EHR. This improved our quality score and helped us create a more complete list of our uncontrolled diabetics,” said Elwood Practice Manager Nancy Bolds.

Case Study

Extended Care Specialists

As a multi-specialty healthcare provider that serves a predominantly geriatric population, Extended Care Specialists often works with patients who are taking opioids post-surgery or for chronic pain. But like many healthcare providers, the ECS team had no standard assessment tool for prescribing narcotics.

In response to the opioids crisis, state and federal guidelines for prescribing narcotics have been updated, and Indiana providers now must earn two opioid-related, continuing medical education credits (CMEs) in order to renew their license. They also are required to review of each patient’s prescription history for controlled substances through the state’s INSECT online monitoring program.

As a GLPTN participant, ECS was able to participate in Altarum Institute’s Advancing Responsible Opioid Prescribing training program, which allowed four ECS nurse practitioners (NPs) to earn CMEs and gave ECS an opportunity to define and incorporate a standard opioid-appropriateness assessment as part of applicable patient exams.

GLPTN’s Quality Improvement Advisor and PHA Managing Advisor Polly Malloy worked with ECS Project Manager Kari Po and Co-owner Cathy Yaggy, MSN, GNP-BC, to run a plan-do-study-act (PDSA) project to define the right assessment instrument, establish a process for monitoring its use, and gather feedback from the NPs about this new resource. The PDSA helped ECS determine that the Diagnosis, Intractability, Risk, and Efficacy (DIRE) form developed by neurologist Miles Belgrade, MD, would best suit their purpose. To address push back in implementing the DIRE form, Po worked with ECS’ EHR provider to make it a component of the clinic note. She also offered the providers incentive in the form of a billable CPT code attached to the DIRE form that allowed them to receive a financial benefit for this extra step.

The company’s NPs prescribe narcotics on a regular basis to a large percentage of elderly patients. Some patients’ medical conditions may prevent them from actively and accurately helping a provider assess their pain level. Rather than second-guessing a provider’s decision to prescribe opioids, Po says the assessment tool provided a valuable resource to validate their decision-making process.

Results from the six-month program have been overwhelmingly positive. At the project’s midpoint, 60% of eligible patients had the DIRE form completed and in their charts. By the end of the project, NPs had assessed 90% of eligible patients.

“All of our providers need any available tools to confirm their decision-making to have a patient on narcotics long-term rather than short-term.”

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Challenges involved in improving workflows may seem compounded when an organization attempts to improve them across diverse service sites while maintaining program uniformity and quality. HealthLinc, a Federally Qualified Health Center (FQHC) that operates multiple health clinics throughout Indiana, wanted to streamline its process of enrolling patients in Chronic Care Management (CCM) as well as increase the number of patients served. Leadership knew they would need a change plan that was consistent, yet allow individual clinics to solve problems unique to their locations and patient populations. Funding through GLPTN made it possible for HealthLinc to work with PHA’s lean experts to facilitate optimal CCM enrollment by using Lean Daily Improvement (LDI), a continuous quality improvement strategy that helps healthcare organizations make small, sustainable changes in workflows and processes and integrate those changes into daily routines.

To oversee work and ensure success across the organization, a group of key HealthLinc staff members formed a committee. Their goal was to have at least 350 patients receiving billable CCM services by the end of calendar year 2018. They decided to focus efforts on patients with hypertension and depression, which are chronic conditions that affect more of the FQHC’s patient population than diabetes.

At each of the seven clinics, various team members were responsible for taking the steps necessary to identify eligible patients, provide prospective patients with information about CCM, collect consent forms, and provide CCM services. Support from leadership and buy-in at all levels of the organization helped build strong LDI teams at each site. All the LDI teams included front desk staff, medical assistants, and the clinic manager or assistant manager. At locations that employ a pharmacist, that person was part of the LDI team. LDI teams relied on weekly team huddles and visual management boards to monitor their progress and ensure effective communication among team members. What worked well at one clinic didn’t necessarily work well elsewhere; however, HealthLinc discovered common obstacles to CCM enrollment and solutions to implement across the organization.

CCM is billed to Medicare on a month-to-month basis and requires providers to spend a minimum of 20 minutes per month talking with patients. Even though the number of active, enrolled CCM patients is a moving target, HealthLinc has seen a significant increase in billable CCM services, growing its monthly caseload from eight patients to more than 260.

"Front desk staff would prompt other team members for what they needed to make the project a success. They felt valued as part of the huddle team."

— Aleksandra Papadimitriou
Quality Improvement Program Manager
HealthLinc
4: Innovation

As practices looked for ways to meet TCPi’s Quadruple Aim, many showed interest in adopting new technologies; implementing processes and tools to capture social determinants of health; re-formatting patient visits to increase access to care; and establishing new partnerships to integrate behavioral health.

Integrating Behavioral Health

In an effort to change or decrease its patients’ unhealthy habits and to support new behaviors that supplement a healthy lifestyle, Putnam County Hospital tackled a behavioral health integration project involving its primary care practices. Hospital workers acknowledged that this kind of change wasn’t easy for patients, but that the techniques GLPTN introduced — motivational interviewing, relaxation strategies, and basic behavioral principles — went a long way to helping patients conquer their obstacles and achieve personal goals.

Implementing Diabetic Patient Compliance Protocol

To support the implementation of innovative programs, GLPTN helped practices adopt new tools and facilitated workflow redesign at practices to support new initiatives. A 2019 process-improvement project with Premier Family Medicine assisted with the implementation of a Diabetic Patient Compliance Protocol that identifies patients based on their average A1c score. As part of the new protocol, Premier Family Medicine purchased a WelchAllyn RetinaVue retinal camera to perform a diabetic eye exam on every patient on an annual basis. The practice also bought five iPro continuous glucose monitors (CGMs) to test its more “out of control patients.”

Practice Manager Michael Yoder explains the process:

“...A1c thresholds are 6.5, 7, 8 and 10. Patients with an A1c >8 and >10 must be seen at least every 3 months; more frequently if their provider deems it beneficial. Patients whose A1c is >10 qualify automatically for a CGM test, while patients in the >8 category are strong CMG testing candidates and highly encouraged to be tested. Patients who consistently have an A1c >7 are typically scheduled every 3 months, but each provider may modify the appointment interval based on individual patient’s circumstances. These patients also qualify for CGM testing, especially if their A1c is trending upward. Lastly, the frequency of follow-up for patients with an A1c of 6.5 to 7 is up to individual providers, but usually every 3-6 months. These patients are not strong CGM candidates, but are eligible if they are newly diagnosed with diabetes or have an A1c trending upward or show other symptoms of fluctuating sugars.”

Through transformation efforts, practices are embracing new ways to meet their clients’ needs, increase overall care, and reduce costs. These efforts, along with reducing clinical burden, are the objectives of the Quadruple Aim and are key to practice sustainment in a value-based payment model.

CASE STUDY

Southwestern Behavioral Healthcare, Inc.

With funding provided by GLPTN, PHA facilitated a lean Rapid Improvement Event (RIE) at Evansville-based Southwestern Behavioral Healthcare, Inc. (SBH) that targeted care to patients with personality disorders.

PHA lean experts and a handful of SBH staff members gathered in the summer of 2018 to develop a game plan for the RIE, in which a cross-functional team spends two-to-four days analyzing a process, identifying inefficiencies, brainstorming improvement ideas, implementing countermeasures, and establishing better methods. The team determined that group therapy rather than individual therapy was a better fit for these patients for several reasons including better care, greater capacity for treatment, and reduced customer wait time. It would also increase client participation in Dialectical Behavioral Therapy, the gold standard for personality disorder treatment.

“These patients were waiting an average of 18 days from the completion of their assessment appointment to their first treatment appointment,” said SBH’s Director of Adult Services Elizabeth Arnold. “That’s a really long time if you are in crisis.”

Persuading patients that group therapy was a better fit for their mental health issue — one that involved long-term patterns of unhealthy and inflexible thoughts and behaviors that can lead to serious problems with relationships and work — was key to the plan, so the team created advertising materials, frequently asked questions, and testimonials, and every client left their assessment with a brochure about the benefits of group therapy.

The new treatment program was crafted to last from six-to-twelve months to help patients stabilize and develop skills to successfully manage stress and relationships. When it went live, the team’s target patients saw an almost immediate improvement in access to care. “We can get them from assessment to group therapy in about nine days,” Arnold said.

So how do the patients feel about the new protocol? Arnold said SBH had to grow group services in one of its locations from three to nine groups because so many people were involved in group and really liked it. The number of SBH’s 2,000 clients who receive care through group therapy has increased since the RIE from 11% to 25%. Group therapy attendance has dramatically improved as well to more than 82%.

“People can backslide into old habits, so we used Lean Daily Improvement to monitor assessments on a daily basis. Any time somebody was not following our standards of care, we let them know, and they would correct it the following day.”

— Elizabeth Arnold

Director of Adult Services

Southwestern Behavioral Healthcare, Inc.
Transitions to an APM

The primary driver behind the TCPI is the preparation of clinicians and practices to transition into an Alternative Payment Model (APM), a payment approach that gives added incentive payments to provide high-quality and cost-efficient care.

A variety of APMs exist, including one-sided and two-sided risk models; those that apply to a specific clinical condition, a care episode, or a population; and those offered by CMS or commercial payers.

GLPTN assisted practices by making them aware of the APM opportunities that exist within their region and/or practice type. Of GLPTN Indiana’s 69 practices (active plus graduated), 21 are participating in some form of APM and this number represents 82% of enrolled clinicians. For many of the remaining practices, options for participating in an APM are not readily available due to the participation requirements (i.e. number of Medicare Beneficiary lives, alignment with clinical specialty or financial reserves to assume risk).

As the initiative progressed, a number of Indiana GLPTN-enrolled practices accepted the opportunity to shift to a CMS-driven APM, and this decision allowed them to effectively graduate from the GLPTN program. Congratulations to the following graduates:

Cardiac Care Associates
Community Health Network
Community Healthcare System
Family Medical Center
Jackson Park Physicians
LaPorte Physician Network
Oak Street Health
Ortho Northeast
Schneck Medical Center
Southeastern Indiana Gastroenterology
Southern Indiana Radiological Associates

The CMS Division of Transforming Clinical Practice recognizes all the hard work and value of the enrolled practices in the Great Lakes PTN with improving the quality of healthcare for patients, enhancing the patient and clinician experience, preparing and moving clinicians into APMs and generating great value within the American healthcare delivery system!

— Dr. Robert Fleming, PhD
Director, CMS Transforming Clinical Practice Initiative
Exemplary Practices

Enrolled practices made significant strides during the TCPI and many reached benchmarks that allowed GLPTN Indiana to designate them as Improvement, Early Exemplary or Exemplary.

To achieve Exemplary status, the practice is making notable improvements in the practice assessment and achieving TCPI Level 4; demonstrating improvement in clinical quality measures; and embracing a patient-centered culture.

Improvement
Central Indiana Neurology
Four County Counseling Center
Greene County Health
Heart and Vascular Clinic
Marion General Hospital
Milestone’s Clinical and Health Resources
Rehabilitation Associates of Indiana
Rose Internal Medicine
Shalom Health Center
Tulip Tree Family Health Care

Early Exemplary
Ann B. Patterson, MD
Ear, Nose and Throat Associates, P.C.
Elkhart Clinic
Eskenazi Health
Evansville Surgical Associates
Gerig Surgical Associates
McKinley Medical Clinic
Riggs Community Health Center
Rush Memorial Hospital
Surendra Shah, MD

Exemplary
Centerstone
Community Health Network
Community Healthcare System
Dupont Family Medicine
Elwood Family Medicine
Extended Care Specialists
Family Medical Center
Fort Wayne Orthopedics
Harrison County Hospital
HealthLinc Community Health Center
Heart City Health Center
Infectious Disease of Indiana
Jackson Park Physicians
John W. Gonzalez, MD
Oak Street Health
Open Door Health Services
Orleans Medical Clinic
Ortho Northeast
Parkview Care Partners
Porter-Starke Services
Premier Family Medicine
Pulaski Memorial Hospital
Putnam County Hospital
Schneck Medical Center
Southern Indiana Radiological Associates
Southwestern Behavioral Healthcare, Inc.

The GLPTN Indiana Team

Shown from left to right:
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