

## CPC Practice Spotlights

*This list contains **CPC Practice Spotlights** published between November 2013 and June 2014.  
These feature articles highlight the work of CPC practices.*

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## CPC Practice Spotlights

*This list contains **CPC Practice Spotlights** published between August and December 2014. These feature articles highlight the work of CPC practices in a shorter, one-page format.*

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## Practice Spotlight 1

**November 15, 2013**



*This week we go to El Dorado, Ark., to visit SAMA Healthcare Services, an independent four-physician family practice located in rural southeast Arkansas. Employing about 45 people, the practice has on-site lab and radiology, offers bone density testing and does its own billing. Its EMR is Allscripts. The clinic's four physicians care for approximately 19,000 patients, many who travel from the surrounding rural communities for health care.*

"Sometimes Arkansas feels like it's five years behind everyone else," said Gary Bevill, MD, a physician partner in SAMA Healthcare Services. "But not us. Our partnership has always pushed the envelope, and we see this as the leading edge of where medicine is going."

Keeping their eye on the leading edge is what attracted physicians **Gary Bevill, Matthew Callaway, Eric Hatley** and **James Sheppard** for their practice to apply for the CPC initiative. Already robust users of their Allscripts system, the team see the CPC opportunity as an opening for accelerating their progress toward higher quality care in a proactive, coordinated patient-centered environment.

"A lot of the things we're doing now are things we wanted to do in the past," said **Pete Atkinson**, SAMA's practice administrator. "We needed the front-end investment of start-up money to develop our teams and our processes."

Leveraging the CPC dollars helped Pete and the physicians re-configure the clinic into four care teams, each led by a physician and supported by a nurse practitioner, three additional nurses and a care coordinator. The funding allowed them to hire the needed nurse practitioners, including one who is a certified diabetes educator and another with a pediatrics specialty certification.

Early in the founding of the clinic, all patients were assigned to a physician, making 100% empanelment easy. Going forward, they now have a dedicated care team tracking and monitoring their care.

### **Risk Stratification and Care Management**

Physicians trained nurses on using the risk stratification feature in Allscripts as well as [the AAFP six-level risk stratification tool](#). Nurses mark records and the physician confirms the stratification during the patient encounter. As nurses are reviewing records for the next day's appointments, not only are they able to risk-stratify the patients, they are also able to ensure preventive care and screenings are up to date.



*SAMA staff wears team shirts and colors to help patients see the continuity and collaboration in their care.*

“We also turned on all the Allscripts metrics including the clinical decision support,” continued Dr. Bevill. “We are being very proactive, and now I’m seeing patients with everything up to date and current. The first time it happened, I nearly dropped the iPad.”

Even from Pete’s practice manager perspective, he’s seeing the difference the coordination and care management is making.

“We have found early stages of cancer in our patients through this process,” he says. “Sure, we’re kind of pestering our patients to get that preventive care done, but it’s paying off. The big picture is that we’re saving the system money and improving lives by finding a stage 1 cancer rather than a stage 3. We may have saved the overall system what they have paid us to participate in CPC.”

### Demonstrating a New Approach

Informing patients about the changes at SAMA has taken many forms, ranging from each care team adopting its own color to refreshing the clinic’s logo to show how the four teams underscore SAMA’s brand promise of quality and continuity. Each exam room is tagged with a team color.

SAMA also keeps its [Facebook page](#) filled with clinic updates, such as an illustration of its care team model and links to media coverage about its CPC engagement.

“We are proud of our business,” Dr. Bevill said. “But it’s always really and truly been about the patients. We wanted to do this our way, doing what’s best for our patients and our community. A lot of people don’t like change, but our staff has seen this is change for the better.

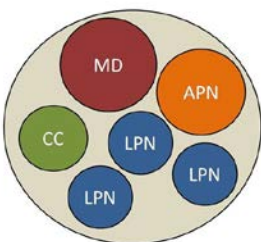
“They all see we’re providing better care.”



*SAMA’s Facebook page is one outlet for sharing information about CPC activities, including announcing practice surveys and explaining the new care team model.*

### Next Spotlight: The How and Why of SAMA’s Success

## Using Social Media to Educate and to Inform



“I was asked this weekend about Care Teams so I thought I'd take a minute to explain what we are doing. This picture shows the basic concept. In the past each provider acted independently. One complaint we heard was that patients wanted to see “their doctor.” From the physician's standpoint they want to see their patients as continuity of care is very important. So the team is designed to correct this issue as well as address the need for more attention to preventive services. Each team will consist of a doctor, a nurse practitioner, a care coordinator and three nurses. Once in place, a patient will be able to be seen by their team 99% of the time (doctors do take

vacations) during normal business hours. When patients call, they will be speaking with the members of their team who will know them personally and will be better able to address their needs. After hours and on weekends will still be covered by an APN or physician on call. The results will be more same-day visits with each provider/team and increased quality of care.” – SAMA Practice Administrator Pete Atkinson’s Facebook post about the new team approach

## Practice Spotlight 2

December 6, 2013

*In this installment of the Practice Spotlight, we take a deeper look at how SAMA Healthcare Services in El Dorado, Ark., has blended risk stratification and care management to improve its already strong preventive care services. As described in the Nov. 15 article, the practice created four care teams, each headed by a physician and supported with a nurse practitioner, three additional nurses and a care coordinator. This team model not only fosters better coordination, but as you will read below, it creates a culture where all staff take ownership of patient care, resulting in measurably better care.*



### Risk Stratification Levels (merging of AAFP and Site Risk)

#### AAFP (Level 5 & 6) / Site Risk = HIGH

- ✓ Diabetes Mellitus, uncontrolled
- ✓ Hypertension, uncontrolled
- ✓ COPD
- ✓ CHF
- ✓ History of CVA
- ✓ CAD/Vascular Disease
- ✓ Obesity, morbid (BMI > 35)
- ✓ Renal Disease
- ✓ Cancer (active disease and/or on hospice)
- ✓ Hospitalization in the last 12 months

#### AAFP (Level 3 & 4) / Site Risk = MEDIUM

- ✓ Diabetes Mellitus, controlled
- ✓ Hypertension, controlled
- ✓ Hypercholesterolemia, controlled
- ✓ Obesity (BMI > 30 but <35)
- ✓ Hypothyroidism, stable
- ✓ Asthma
- ✓ Cancer (remission)

#### AAFP (Level 1 & 2) / Site Risk = LOW

- ✓ No chronic medical conditions, no medications

Change is a constant at SAMA Healthcare Services. While the most significant event was adopting an electronic health record nearly 12 years ago, continual re-evaluation among the practice's partner physicians has kept them "out on that edge," as **Gary Bevill, MD**, put it.

### How SAMA Risk Stratifies

Through its work with CPC, SAMA formed care management and care teams, who drive proactive preventive care for the practice's approximately 19,000 patients. **Risk stratification** is among the core functions of the new care team.

**Nancy New, LPN**, clinical informatics coordinator, described the process, "Our doctors got together and agreed on a set of diagnoses as risk factors and what level that factor would be. Then, they trained their teams by going over those lists and talking through their questions. Now when patients make appointments, the team care coordinator reviews the medical record before the appointment."

SAMA turned on Allscripts' Clinical Decision Support features, which alerts the care team to missing screenings or lab work and checks health maintenance measures. Occasionally gaps are rectified when results are re-entered in the discrete fields, but when screenings are needed, the coordinator asks the patient to visit SAMA's in-house lab before the appointment.

Using the recent Allscripts stratification product release and combined with the [AAFP Risk Stratification Tool](#), the coordinator flags the patient record prior to the appointment. The coordinator assigns a high risk (red) flag if the patient has complications of a major

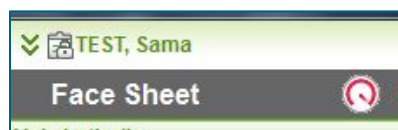
diagnosis (diabetes, HTN, COPD, CHF, CVD/stroke) or more than two diagnoses in that group. A medium risk (blue) flag is assigned if disease management is in control. Low risk (green) is assigned to patients with no chronic medical conditions or medications.



**Right:** Note the icons for patients in the appointment view. Blue is medium risk; red is high risk.

Patients under 18 are not stratified.

**Below:** Face sheets are also tagged with risk levels.



Checked out: 0		Total: 8					
S...	Labs	Risk	Age / Gender	Patient #	Location	Refer...	Comments
	Yes			27533	SAMA ...		30 .PB OV d
	No	🔵		17964	SAMA ...		15 PB OV -
	Yes	🔴		159470	SAMA ...		15 PB OV -
	No			155312	SAMA ...		30 NP OV -
	Yes	🔴		398	SAMA ...		30 .PB OV d
	Yes	🔴		4599	SAMA ...		30 .PB OV d
	Yes	🔴		26153	SAMA ...		15 PB OV -
	Yes			6204	SAMA ...		30 .PB OV d

During the patient encounter, the physician further reviews the assessment and confirms the appropriate flag in the medical record.

“We were doing some risk assessment earlier and making that happen with some work-arounds in the EHR,” continued Dr. Beville. “When the new product release came out, we jumped on that.”

Before enrolling in CPC, SAMA physicians decided to focus on timely A1c testing for their patients with diabetes.

“First, we educated patients to ask for the test every quarter. We told them why it’s important, and we asked them to work with us,” said Dr. Beville.

Over time, rates of A1c testing increased. When the practice took its first measurement for CPC, the results were pretty good for their demographics.

However, increased care coordination made a significant difference. Care coordinators called patients due for an A1c.

A nurse practitioner who is also a Certified Diabetes Educator increased patient education efforts and coaching tactics. Physicians wrote “prescriptions” to a local gym to encourage exercise. Patients with diabetes learned to ask about the A1c. And the numbers started to move. **The percent of patients with diabetes considered poorly controlled has dropped 1.5 percentage points from 2012 to 2013.**

“If you look at our A1c rates to date for 2013, we’ve tested more patients than in all of 2012 and our numbers are dropping,” pointed out Dr. Beville. “My patients are way better off with this new system.” (See screenshots.)

Dr. Beville reflected on this progress. “You know, I found one of our old (EHR) manuals from 2002 the other day. It was nowhere near to what we’re doing today. At first running those reports was tedious, but as it evolved, it got easier. If we had been late adopters, these changes would have been more challenging.”

He continued, “We as doctors often think our way is the only way. You really have to be flexible in your thinking and use what’s out there to get you where you need to go. My partners and I are willing to try things. It’s been a fun run.”

Results

Information

CPCI-Diabetes: Hgb A1c Poor Control

Reporting period: 01/01/2012 to 12/31/2012

\* Report results were calculated using Allscripts Professional EHR version: 13.1

Details: Denominator - patients  $\geq 17$  and  $\leq 74$  years of age before the beginning of the measurement period who were taking a medication indicative of diabetes or who had an active diagnosis of diabetes and at least two billable encounters on different dates, in the 2 years preceding the end of the reporting period  
Numerator - patients in the denominator whose most recent laboratory result for HgbA1c is  $> 9.0\%$

By Location

Location Name	Numerator	Denominator	Exclusions	Percentage
SAMA HealthCare Services PA	96	909	8	10.6%

Results

Information

CPCI-Diabetes: Hgb A1c Poor Control

Reporting period: 01/01/2013 to 10/31/2013

\* Report results were calculated using Allscripts Professional EHR version: 13.1

Details: Denominator - patients  $\geq 17$  and  $\leq 74$  years of age before the beginning of the measurement period who were taking a medication indicative of diabetes or who had an active diagnosis of diabetes and at least two billable encounters on different dates, in the 2 years preceding the end of the reporting period  
Numerator - patients in the denominator whose most recent laboratory result for HgbA1c is  $> 9.0\%$

By Location

Location Name	Numerator	Denominator	Exclusions	Percentage
SAMA HealthCare Services PA	84	922	10	9.1%

## Practice Spotlight 3

December 20, 2013



**Primary Care Partners, P.C.**

*Your Partner in Health*

Drive west from Denver on I-70, and just before you head into Utah, you will arrive at Grand Junction, Colorado. Abutting the scenic Colorado National Monument, Grand Junction is where **Primary Care Partners** operates a multi-site primary care practice serving 65,000 active patients through three family medicine offices, a pediatrics office, an after-hours facility and a satellite pediatrics office. Two sites are CPC practices. Primary Care Partners employs 54 physicians and 13 mid-level practitioners.

It's a moment most physicians dread.

"The appointment is nearly over, and the doctor is wrapping up the visit, and that's when the patient says, 'Oh, by the way, you should know...' and she bursts into tears."

Managing Associate **Carol Schlageck** described an encounter that happens every day in a family practice.

"That moment is when you really find out what's going on and why the patient is in crisis. The question for most practices is, 'Do you have the resources right there in the clinic to help that patient?'" she explains.

"Today, we do," was Carol's confident reply.

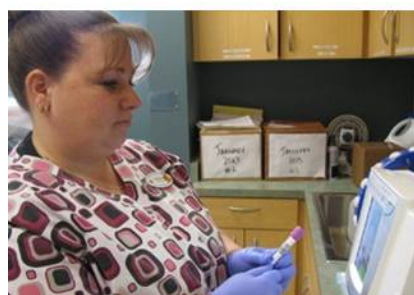
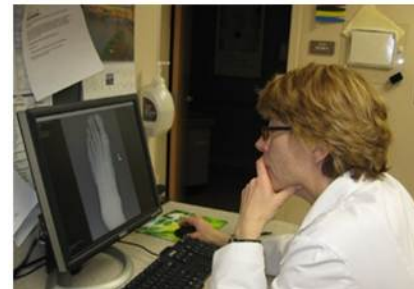
### CPC at Primary Care Partners

While Primary Care Partners has long benefitted from physician leadership who emphasized quality improvement as a daily activity, engagement with CPC has taken the practice to a new level of service.

"CPC has offered us a wealth of information to help facilitate systems change," Carol said. "We knew the opportunities were out there, but the funding helped us test and implement strategies we had been eyeing for years."

She continued, "The Initiative gave us the resources to build the practice we envisioned. Who would argue with that? Who wouldn't want the medication reconciliation support? Additional tools to help patients with their social and psychological needs?"

Primary Care Partners has leveraged involvement in CPC to fill pressing needs in their daily workflow. To manage care, they added six staff who are a mix of RNs and social workers, which Carol said "gives us the best of both professions" in working with patients' care management or a situational crisis requiring resource coordination.



*From the top: The Primary Care Partners office in Grand Junction offers a range of services, including diabetes education, in-house radiology and an in-house diagnostic lab.*



Prior to enrolling in CPC, the practice used a program within the EHR to highlight patient status based on various NCQA quality measures and standards. Through CPC, they developed a formal process through tools and provider identification to evaluate all patients in the practice for risk. At this time, they actively manage care for about 750 to 1,000 patients.

During weekly and bi-weekly care coordination meetings the entire team reviews patients' status. Providers report that these meetings have changed how they have addressed after-hours situations for some patients. One said, "Because we talked about [this patient], I was able to handle his call during the night differently and saw [the patient] first thing the next morning. If I didn't know the history, I would have referred [the patient] to the ER."

The new risk stratification process has helped prevent at least seven hospital admissions in three months, as well as decrease ED utilization for a "frequent flier," who had been in the ED 41 times in the previous year. Working closely with a care manager, the patient went seven weeks without an ED visit.

"Through CPC we now have behavioral health clinicians embedded in our clinics," Carol said. "Previously we had a relationship with a behavioral health office in one of our facilities, basically 25 feet from our reception desk. The close proximity let us to do a 'warm hand-off' for patients in crisis. CPC allowed us to subcontract with several behavioral health clinicians who assist with all sorts of behavioral and life issues, such as grief counseling, marriage discord, depression, anxiety, stress, drug use/abuse, parenting issues and eating disorders. The behavioral health clinician can meet the patient with the provider or see the patient independently."

## What Happens at the Top Sets the Tone for Embracing Change

When Primary Care Partners enrolled in CPC, every employee at every level became a participant in the effort. **Executive Director Michael Pramenko, MD**, and Carol made presentations to all staff – including housekeeping and facilities – to help them understand the project and how they could contribute.



*Michael Pramenko, MD,  
Primary Care Partners  
Executive Director*

"We talked to everyone. We wanted to energize them and to fully explain that we're not asking you to work *harder*, but to work *smarter*," Carol said. "They were terrific. They saw the opportunity for improvement, and they embraced the new systems and staff."

Several processes feed the momentum for change, including a Quality Improvement Series (QIS) Task Force that meets every two weeks with physician leadership and representation from both CPC practices as well as the IT department. The QIS sets policies and helps implement change. Additionally, regular Care Team meetings involve physicians, mid-levels, care managers, behavioral health clinicians and even the office managers. Staff who manage care and coordinate resources meet biweekly for education sessions. Community organizations often present at these meetings to discuss resources and opportunities.

A clinical quality improvement committee meets every two weeks to review CPC progress. Although only two practices are CPC sites, all clinical areas at Primary Care Partners "sit at the table" and are shadowing the work in their own settings. Carol reports that the

conversations are lively and highly interactive. Physicians' engagement and interest has prompted an upcoming four-hour retreat for a deep dive session.

## The Unexpected Benefits of the CPC Community

"We feel we've been on the cutting edge of practice transformation for a long time," said Carol, pointing to Primary Care Partner's engagement with multiple quality improvement and innovation projects, including serving as a "beta" site for the Informed Medical Decision Foundation's shared decision-making project.

"The camaraderie we feel in the medical community is remarkable. It's exciting to sit with your peers and share the same passion and vision with others who think like we do," she said. "We are part of that larger group and we draw strength from the community. You can see the cohesive effort happening."

## Next Spotlight: How Colorado's Primary Care Partners Tackled Shared Decision Making

## Practice Spotlight 4

January 10, 2014



Michael Pramenko, MD,  
Primary Care Partners  
executive director

Located in far west Colorado in Grand Junction, **Primary Care Partners** is a multi-site practice that employs 52 physicians and 10 mid-level practitioners. Michael Pramenko, MD, is the practice's executive director and a past president of the Colorado Medical Society (2010–2011). In this article, Dr. Pramenko discussed how Primary Care Partners' journey with **Shared Decision Making** began and what work still lies ahead to fully integrate SDM in primary care.

According to **Michael Pramenko, MD**, successfully integrating Shared Decision Making into a practice takes aligning three drivers: *incentives, incentives and incentives*.

He fired off the three sides of this SDM triangle: "The patient needs an incentive to say 'this is something I want to do,' the payer needs an incentive to create the sustainable model that matches the utilization and the physician needs the incentive to open up communication in a new way."

Dr. Pramenko continued, "We believe Shared Decision Making will reduce health care costs. That's not the question. The question is how do we align the patient, the payer and the doctor?"

### Let's Start with the Practice

Dr. Pramenko saw two opportunities in 2011. First, he learned of the CPC initiative and knew that Shared Decision Making figured prominently in the Milestones. Second, the [Informed Medical Decisions Foundation](#) approached Primary Care Partners as a beta site to test the organization's tools for Shared Decision Making.

In 2012, the practice started using 36 tools covering a range of topics and conditions. The tools are a mix of videos and booklets. The videos include a pre- and post-test to gauge the patient's understanding of the condition as well as to evaluate the usefulness of the tool. IMDF provided the tools at cost. "We started using the tools before we had a care management system in place, and the workflow wasn't very clean," Dr. Pramenko described the process. "As we developed care management with CPC, our workflow shifted to having designated staff (care managers) help eligible patients view the materials either before or after the encounter. Then, eventually we designated rooms and equipment where patients could view the videos." (See sidebar titled "Primary Care Partners' Workflow for SDM" for specific steps.)

Primary Care Partners is testing and tracking [end-of-life care patient decision aids](#) for CPC. In addition to the IMDF tools, the practices' care managers use a Colorado state-based form/booklet titled, "[Your Right to Make Healthcare Decisions](#)."

"We selected this first as it has a significant effect on the quality and cost of care at the end of life," said Dr. Pramenko. "We have many patients over 80, and we have seen many cases where opportunities for more age-appropriate care were missed because proper planning and counseling did not occur ahead of time."

### The Doctor Weighs In

"We want people to be fully educated on their options," Dr. Pramenko said, "but it's a time-consuming process."



**Primary Care Partners, P.C.**  
Your Partner in Health

**The Shared Decision Making statement from the [Primary Care Partners website](#):**

"After a challenging diagnosis, you have some decisions to make.

[Family Physicians of Western Colorado](#) and [Western Colorado Physicians Group](#) provide their patients with information on a newly diagnosed condition and then explore the best treatment options available.

Together, you can then choose which treatment option is best for you. Treatments can vary, depending on each patient's needs. As your partner in health, we are here to help guide you as you make those decisions.

We share your challenge. We respect your choices. We are your Partner in Health."

Dr. Pramenko described the push and pull of patients' expectations and needs, "Some patients will still rest on every word I say, and that's hard to change. These decisions are a huge gray area in medicine, where you know something needs to happen. Patients get polarized in the gray area when they shouldn't. Shared Decision Making means they take ownership over a decision that's right for them. It can put the brakes on business-driven decisions."

At Primary Care Partners, embedded behavioral health professionals can meet with patients along with the physician as needed to help with the decision-making visit. Dr. Pramenko notes that high utilizers also often have a behavioral health concern and meeting with both providers ensures a well-rounded approach. In this context, the behavioral health specialists assist in facilitating the patient communication — tapping into motivation and behaviors to support the process.

Currently, leadership at Primary Care Partners is crafting an incentive plan to encourage multiple patient-centered initiatives, including SDM. In the meantime, posting providers' SDM utilization rates spurs conversation about improving use and rouses a competitive spirit among the teams.

## The Patients' Turn

Patients weren't reluctant to participate in Shared Decision Making, according to Dr. Pramenko. The biggest barrier was time, or rather lack of it, to view the tools. The viewing time ranges from 20 to 55 minutes.

The practice shared the tools with its Patient and Family Advisory Council, which had the same feedback: These are fabulous resources, but they're too long. No one plans to be at the doctors' office for an additional hour. Patients want to watch when it's convenient for them. They may want to include a family member.

"Now we're looking at a web-based solution," Dr. Pramenko said. "Patients are very comfortable looking at materials from the web. We're working out how to expand our patient portal so that we can document the use of our online SDM tools."

## What's the Incentive for Payers?

Dr. Pramenko pointed to Primary Care Partners' agreement with Hilltop, a local, self-funded employer, which created a list of 13 procedures that are considered elective to some degree. Hilltop employees who are considering any of these procedures are eligible for a \$500 reduction in their out-of-pocket expenses if the employee views the decision aid for that procedure and has a follow-up decision conversation with the primary care physician.

"This is a great example of how the payer is addressing the costs with us at the primary care level," Dr. Pramenko said. "We know these patients and we're best equipped to help them. The payer knows that spending dollars with us treating the patient and working through these decisions is money well spent."

## Sources and more reading:

D. Arterburn et al., "Introducing Decision Aids at Group Health Was Linked to Sharply Lowering Hip and Knee Surgery Rates and Costs" *Health Affairs*, September 2012 31: 2094-2104. ([Abstract](#))

Informed Medical Decisions Foundation:  
<http://www.informedmedicaldecisions.org/>

## Primary Care Partners' Workflow for SDM

*Provide an educational opportunity to patients at their convenience. Patients may schedule a specific time to come in, walk in during office hours or view videos before or after their scheduled appointment.*

- The provider's nurse will notify the appropriate staff member of the patient's location in the clinic and which Patient Decision Aid (PDA) is to be viewed.
- Documentation by the provider in the EMR under "plan" is particularly helpful if the patient prefers to return on another day to watch the video.
- Assigned staff will meet with patients and walk with them to a private room where a portable DVD player will be available. Patients will be given a booklet to follow along with the DVD.
- The staff member allows the patient and family to watch the video privately; staff members help the patient complete the pre- and post-survey while in the viewing room.
- An order will be entered into a flow sheet called "Patient Decision Aids." To document either the video or the booklet, the assigned staff goes to the Lab/Procedure tab in the Add Clinical Item area, type in PDA, which will pull up the order for the Patient Decision Aids. From here, staff members use the drop down arrow to select which PDAs were used with patients on that day.
- Staff enters "No Charge" in the encounter charges for the PDA. This enables tracking and reporting of the data.
- Staff also enters the patient responses to the pre and post survey questions in an online "Survey Monkey" form for routine analysis.

*Is your practice ready for the Spotlight? Email Belinda McGhee, [belinda.mcghee@tnf.org](mailto:belinda.mcghee@tnf.org), with your story suggestions.*

## Practice Spotlight 5

January 24, 2014

*TriHealth is an integrated not-for-profit health system with four hospitals and more than 120 clinical locations throughout the greater Cincinnati area. It traces its beginnings to 1852, when the Sisters of Charity of Cincinnati opened a 21-bed hospital to care for those who couldn't afford medical treatment. In 1995, two Cincinnati hospitals formed a partnership to become TriHealth, so named to reflect the partnership of physicians, hospitals and community. Today, the system employs more than 500 physicians among its 11,400 staff. Operating under four LLCs, TriHealth has 32 Patient-Centered Medical Home primary care offices, 19 of which are CPC practices. One hundred percent of CPC primary care patients are empanelled.*



“What has been exciting for us about CPC has been the passion,” Senior Performance Improvement Consultant **John Butler, PMP**, remarked on TriHealth’s CPC work in 2012 and 2013.

“As we have looked back over the past year, it was remarkable to see how passion really drove our physicians and administration to make CPC happen at TriHealth.”

He continued, “We saw CPC as a better vehicle to meet the Triple Aim, and that sparked a lot of energy. And then, as we were hiring our care management team members, they brought a level of passion to the process as well. It’s contagious.”

As CPC Program Year 2014 expands on the groundwork laid, John turned to what lies ahead, “We’re investing in ourselves and we want to make sure we’re fully able to use shared-savings opportunities to keep the resources in the practices to ensure this is a win-win for everyone over the long term.”

### **CPC at the System Level: Leadership, Physicians and Talking About Change**

Like many health systems, TriHealth’s model for seamless care includes expanding outpatient care by growing a base of physician practices. Currently, TriHealth’s physician enterprise encompasses multiple specialties as well as primary care. The primary care practices function through four distinct LLCs that in turn operate three separate EMRs.

“We have one goal, but we have the reality of four work cultures within our LLCs,” John pointed out. “It makes for an interesting dance to pull together on this work. What I think has smoothed the way for CPC is our physician alignment.”

According to John, TriHealth has been “extraordinarily diligent” in placing physicians in leadership roles who can engage other physicians. While reaching consensus among a larger group can take longer, he remarked that “physicians in



*To clearly demonstrate a commitment to the continuum of care, TriHealth routinely features primary care physicians in high-profile media outlets, such as a cover photo for the system’s Facebook page like the image shown here. These personality-driven portraits are also a fresher, more engaging approach than traditional headshots.*





*Helping patients, families and the community better understand preventive and primary care and how the Triple Aim focuses on better health, improved experience and lower cost are regular features of [TriHealth's Facebook posts](#). The links jump to the TriHealth website's newsroom pages, which lead to other consumer-oriented information about health care, such as palliative care.*

agreement help build engagement and they are very involved stakeholders.”

It also helps that everyone speaks the same “change language.” TriHealth adopted the Lean approach about six years ago and training is offered several times a year across the system. John said Lean process improvement projects are common throughout TriHealth. This is building a culture of recognizing and removing waste.

“I regularly see sites running all kinds of little experiments to test new things. We encourage this and point out that PDCA [Plan-Do-Check-Act] cycles are not that difficult, ‘Hey, you’re making change happen right there. Just write it down in your PDCA log and add a little rigor to it,’” he said.

### No ‘One Size Fits All’ Answer

Like many CPC sites, TriHealth has explored options for integrating CPC functions into workflow, allowing each physician group to find solutions that work best for them, including hiring and staffing patterns for the RN-based care management program.

“Finding the right staff for our care management team was a little challenging. We were picky,” John recalled the processes. “We were looking for the right people for the right positions. We made it clear we’re in development and you need to be comfortable in ambiguity and ready to speak up.”

Each LLC decided how and where to staff their care management personnel, with a focus on flexibility and responsiveness. Some larger sites may have two care managers, and smaller sites may share a care manager who visits and calls in as needed across the practices.

### The ‘Ah Ha!’ of What We’re Really Doing

One interesting revelation in the care management work came about as a physician listened in on the planning process around risk stratification.

“When the teams were working through the details of how care would be delivered at each level of ‘risk,’ our CMO [Dr. Georges Feghali] spoke up,” John recalled. “He asked why should we talk about levels of *risk*? Risk is the higher cost. Risk is an adverse outcome. What we should be doing is looking at what the patient *needs*.”

John also noted that risk isn’t a healthy motivator for health care professionals. It doesn’t inspire excellence, or as he said, “It doesn’t feel good.” However, *needs* taps into why people are in health care: to serve and to heal. The teams promptly redefined levels according to needs, such as community resources, medication management, diabetes self-management education and the like.

“It just took someone to articulate it in a new way for that ‘ah ha!’ moment,” John said. “And then we make it happen.”

### Next Spotlight: TriHealth Runs the Numbers on Care Management



## Practice Spotlight 6

February 21, 2014



*This perspective on care management comes from TriHealth, a Cincinnati-based, not-for-profit health system. Four LLCs operate a total of 32 primary care offices affiliated with TriHealth; 19 of those are CPC practices.*

“How would you want your own family cared for?” This is how Care Manager **Anna Bowman, RN**, describes a guiding principle in

TriHealth’s care management approach in CPC. As the multi-practice system tackled the administrative and clinic logistics of integrating care management into workflow, staffing and other processes, TriHealth’s care management staff pulled tenets from best practices to get started. Communication, flexibility and peer-to-peer sharing have carried them through.

### Getting Started: Care Management ‘Pivots’ on Risk Stratification

Building on work done for NCQA Patient Centered Medical Home (PCMH) recognition, TriHealth created two teams in 2012 to start the CPC care management work: while one team was focused on care management processes, the other created TriHealth’s risk stratification methodology.

“While care management is the heart of the work, it pivots on risk stratification,” said **John Butler, PMP**, senior performance improvement consultant. “We farmed out the best practice materials for our teams to review, and then we came back with recommendations. We wanted our CPC care management plan to be simple and intuitive but also could flex as our patients’ needs changed.”

The teams created a four-level Care Management Needs (CMN) assessment (see table for detail). As patients are seen, physicians and care managers evaluate them through a series of Care Level screening questions covering clinical needs as well as behavioral health, socio-economic and home life needs (see inset for High CMN screening questions). The result is a well-rounded picture of the patient’s general wellness and ability to participate in the care management process.

#### Care Level Screening Questions

##### High Care Coordination

- Would you not be surprised if patient is admitted to the hospital within the next six months, or has the patient been admitted into the hospital at least twice in the past year?
- Has the patient presented at the ED three or more times in the past year?
- Would you not be surprised if the patient would pass away in the next year?
- Is the patient in need of end of life care planning?
- Has the patient’s chronic disease progressed, become unstable or new conditions and/or significant complications developed?
- Does the patient have extreme situations (e.g., severe head injury, highly complex treatment, dual eligibility, recent MI, progression to ESRD, care by several sub-specialists)?
- Does the patient have significant social needs that require care coordination?
- Does the patient have significant behavioral health needs requiring care coordination?
- Does patient need assistance with ADLs?
- Are there home safety concerns?
- Is the patient a high user of health care resources?

Source: TriHealth

Care Management Needs (CMN) Level	No or Undetermined CMN	Low CMN	Medium	High CMN
Staff	MA	MA	LPN	RN
Percent of Patients	10 to 20%	34 to 45%	40 to 50%	5 to 10%
Goal	Maintain wellness	Wellness	Health and disease management	Complex disease and care management; follows through on care

## Care Management and Coordination Services for Patient with High Care Management Needs

### Patient Presentation

Advanced complex disease; advancing and need for in-depth intervention; advanced disease; little or no support; in need of End-of-Life planning; frequent ED visit or inpatient discharge; significant change in life or health that requires high-level care coordination

### Universal Services

- Work with team to adjust to appropriate care level
- Work with patient and provider to set, communicate and achieve care goals
- Patient education (confirm understanding)
- Pre-visit calls (tests prior to visit; info from other providers)
- Post-visit calls
- Assess needs and identify barriers to care (transportation, affordable meds, psycho-social needs)
- Identify gaps in care
- Screening patient panel for changes in care level

### Care Management and Coordination Services

- Coordinate frequent follow up (> once every 3 months) or as outlined by care plan
- Coordinate referrals across multiple providers or care givers
- Provides in-depth education and behavioral reinforcement to patient and/or support point person
- Teach and check home monitoring (BP, HBGM, weight)
- Executes delivery of educational, behavioral or community resources
- Provides End-of-Life Facilitation
- Assure compliance to post hospital D/C plan
- Resolve barriers to care
- Coordinate mental health referral
- Initiate a care management round table/family conference as indicated
- Request and coordinate clinical pharmacy consult with patient on multiple prescriptions
- Know every day how many patients are in house, their names and planned disposition
- Assure team catches the discharge and sets the follow-up appointment
- Delegate to the LPN and MA/PCMH team members
- Call the morning and mid-day huddles
- Refers and coordinates patient's or point person's participation in educational, behavioral or community resources (social worker, pharmacist, dietitian)

*Excerpted from TriHealth's four-level Care Management Needs Plan document*

"While we had started PCMH at the same time, the CPC care management work was new in the physician practice setting," explained **Robin Thomas, RN**, care manager. "During planning, we sat down with all the providers to define what the work would look like and get their input. We asked them what they wanted managed, and they saw the value."

Early discussions with physicians led to an initial focus on patients who had difficulty controlling their diabetes and patients with hypertension.

**Joan Metze, BSN, RN**, care manager, agreed that provider engagement opened doors, "The transition was easy with physician buy in. They were excited about getting assistance to fill that gap of missing services."

As care managers blended into the care teams, they leaned heavily on communication and flexibility. They met regularly with the care teams to set a baseline understanding of roles with the expectation that nothing was permanent, and shifting workflows would be the norm as they worked through processes.

TriHealth's previous PCMH work was an asset; staff had learned to better manage change, especially when a clear benefit was in sight.

### What the Work Looks Like

All practice sites follow the same care management processes, but daily work varies among the care managers according to the patient's level of need.

In each CMN level, TriHealth has identified "universal" services that apply to all patients in that level. Those services are augmented by care coordination services that often extend outside the practice walls, across other clinical services (dietitian, for example) and into the patient's home and community. This wrap-around approach helps eliminate the gaps that often lead to barriers to successful disease management and wellness.

Community resources to support patient wellness include the local Goodwill, which sells discounted medical equipment, or a local nonprofit that can help patients pay back rent or a late utility bill. Another community group helps patients pay for medications.

Joan Metze is a care manager for patients with high CMNs. As her physicians meet with these patients, they introduce her, explain her role in their care and describe how she will regularly contact them. The physician introduction of the care manager role increases patient engagement, she said, especially for the high CMN patients who need more services. (See inset for an excerpt of TriHealth's approach for these patients.) She tracks patients through the EMR, and she encourages patients to call her as needed.

"I tell them, 'Call us if you have changes. We're here to prevent those hospital and ED visits,'" Joan said.

Care managers also check daily reports from hospitals and EDs. If a care manager's patient was treated or admitted, the care manager follows up with the patient to assess needs.

### Sharing the Knowledge

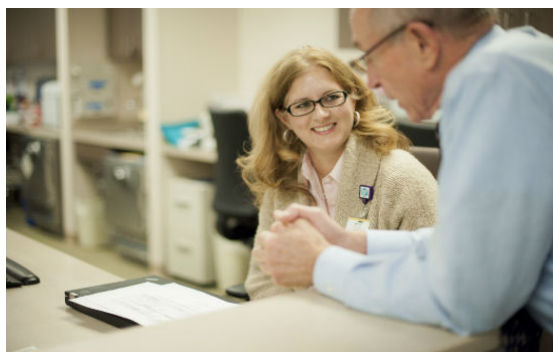
Care managers convene for monthly calls, which are a resource rich with valuable information and insight. In this forum, they discuss barriers and solutions as well as success stories. Hospital navigators are frequent visitors to meetings.

"We piggyback on each other's experiences, and we reach out when we have a difficult case," Anna Bowman said. "The hospital navigators are great because they often can point us to new community resources to help us better support our patients. I've learned about a prescription website that can help patients and our council on aging offers a lot of services."

Care managers are also encouraged to network with other care managers outside the TriHealth system through the RN Ambulatory Care Coordinators Association ([www.RNACCA.com](http://www.RNACCA.com)), which has Cincinnati roots but a national reach.



*In-depth patient education is among a care manager's responsibilities, meaning the necessary skill set expands beyond clinical knowledge. Finding staff with soft skills like empathy and graciousness have helped TriHealth practices put the "right people for the right roles," according to John Butler, performance improvement consultant for TriHealth.*



*Care managers and physicians risk stratify patients through a series of Care Level screening questions. TriHealth combed best practice literature to develop its stratification process, looking for universal tenets to apply across the system but also for approaches that allowed flexibility by site.*

### What's Ahead for 2014

The new primary care strategies in PY 2014 (Milestone 2) offer a new opportunity for TriHealth to deepen its care management work.

"We're looking at a focus on medication management, but it's still under discussion with our lead physician steering committee," said John Butler. Practices have until March 2014 to report a direction.

Regardless of the strategy chosen, the care management team is ready to do the work, which Robin, Anna and Joan agreed is demanding but satisfying.

"Compared with other nursing jobs, this isn't the technical part, but it's rewarding. You start working with high-risk patients and then find solutions for them," said Joan Metze. "You see them grow, and they thank you for caring for them and making their life better."

***Is your practice ready for the Spotlight? Please email Belinda McGhee, [belinda.mcghee@tmf.org](mailto:belinda.mcghee@tmf.org), with your story suggestions.***

## Practice Spotlight 7

March 7, 2014

In PY 2014, CPC practices will select one of three advanced primary care strategies — **behavioral health integration (BHI)**, **comprehensive medication management (MM)** or **support for self-management (SMS)** — to build their practices' capability to provide comprehensive primary care. Each strategy may require refining your methodologies or enhancing your care team resources. In the coming weeks, the Practice Spotlight articles will highlight practices that have taken on these new strategies and share their “boots on the ground” approaches for this work.



*More than one in three people in the Eugene metro area sees an Oregon Medical Group physician as their primary care provider. Employing more than 120 practitioners across 13 clinical sites, Oregon Medical Group is a physician-owned independent practice offering primary care in family practice as well as audiology, dermatology, gastroenterology, lab services, obstetrics, gynecology, otolaryngology, physical therapy, radiology and imaging services. Two practice sites are enrolled in CPC with about 21,000 empanelled patients.*

Oregon Medical Group is well underway with integrating behavioral health specialists (BHS) in its two CPC practices and has started a pilot project of tracking improvement among patients with diabetes and depression. **Kathleen Howard, MS**, director of patient care and clinical support, is delighted with how far the group has come and how quickly they made it happen.

“Of course CPC funding was a kick-start,” she said. “But revenue is just one part of the picture until payer reform happens. When we started out, we looked at the whole picture. What would staffing patterns look like? How do we access other providers in the community? How will we know we’re on the right path?”

The Eugene health care community is like every other health care community in this country: It has unique local characteristics that require institutional knowledge and working relationships with key providers.

To help Oregon Medical Group navigate the local health care environment as well as the payer expectations, **Terry Stimac, PhD**, a licensed clinical psychologist came on board in July 2013 as a subject matter expert and consulting psychologist. Terry’s previous experience included serving as director of outpatient behavioral health at PeaceHealth, a large health care system in Oregon.

“Terry’s insight helped us steer through the community dynamics and helped us form a feasible model by coordinating with the local health plans,” Kathleen said.

Terry and Kathleen started planning for the integration of BHSs by matching reimbursements with clinical

*Although Oregon Medical Group is working with BHS as part of its team, it is not required to do the work of BHI for Milestone 2.*



*Terry Stimac, PhD, licensed clinical psychologist, and Kathleen Howard, MS, director of patient care and clinical support at Oregon Medical Group*



licensing standards. While complete payer reform will shift the model to population health and away from Fee-for-Service (FFS), the reality is that the start-up period must include a revenue stream to support staffing additions and expanded workloads.

Practices should consider engaging billing specialists or other persons knowledgeable about FFS reimbursement trends in the planning stages. Terry noted that not all payers in his area will reimburse for triage and care management, but they will pay for assessment and therapy in the practice setting.

Details like this are fundamental considerations in establishing the workflow and assigned tasks for staff. *(See table for tasks and assigned staff.)*

Task	Oregon Medical Group Staff Responsible
Screening/identification	MOA, BHS, Nurse or Care Mgr.
Evaluation/dx	Physician (hand off to BHS)
Referral Coordination	BHS
Tracking/measurement	Data analyst (data and risk mgmt.)
Family and caregiver support	Care Mgr.
Consultation	Consulting Psychologist

*Note: This table can be adapted so the tasks Oregon Medical Group assigned to a BHS can be accomplished with other team members.*

The next step was to engage physicians. Not only does physician buy-in influence how staff will embrace change, but it was also important to have a two-way conversation about expectations and needs during the integration of BHSs.

“Before planning the workflow, you need to ask your physicians what they want,” Terry advised. “Our physicians specifically said they wanted access and real-time feedback when they referred patients to the BHS.”

### If you choose to hire BHS, what should you look for?

When adding a BHS to your team, Terry had three recommendations for practices:

1. Identify the professional who is familiar with your community resources and providers.
2. Make sure the BHS is a match for your clinic’s culture and patients.
3. Ensure the BHS’s credentialing allows for appropriate billing and reimbursement as well as clinical tasks.

For Oregon Medical Group, a licensed clinical social worker (LCSW) was a good fit for assessment and triage as well as working with the clinic’s care management team. Oregon licensing requirements also allow them to use MOAs (medical office assistant) or MAs (medical assistant) for administering screenings.

“Our LCSWs quickly proved their value to our physicians,” Terry said. “They are reliable and experienced, and their willingness in general helped smooth out operations.”

At this time, BHSs are embedded in the two CPC clinics one day a week. The medical group has plans to add a second day as the schedules fill. At that point, behavioral health integration will then expand to other clinic sites, which they expect to happen in 2015.

### Who to screen? How do you screen? What tool?

Currently, Oregon Medical Group screens patients as physicians refer them. The MOA or MA provides the patient

with a [Patient Health Questionnaire, or PHQ-9](#). Patients can easily complete the one-page tool in a few minutes, and the MOA can score it equally quickly. It also can be administered repeatedly over time, which is useful for tracking a patient’s progress. *(See insert on the next page for Oregon Medical Group’s scoring, diagnosis and treatment considerations for adults.)*

BHSs also may use other screening instruments according to patient needs. Terry pointed to the [SBIRT \(Screening, Brief Intervention and Referral to Treatment\) tool](#) as appropriate for early identification of chemical dependency and referral for treatment. The practice’s physicians selected patients with diabetes who also have a diagnosis of depression as a patient subgroup to track over time. Later this month, Oregon Medical Group will mail a PHQ-9 to about 700 patients eligible for this subgroup. As responses are returned, scores will be

*CPC practices are encouraged to refer to the Program Year 2014 Implementation and Milestone Reporting Summary Guide, pages 10–13, for an implementation framework for behavioral health integration. This section of the Implementation Guide also includes key questions practices should work through as they plan this work.*



recorded in the EHR. Over time the practice will track scores on the screening tool as well as look for improvement in the patients' HbA1c results.

"We're following a model called [the DIAMOND study](#) that had exceptional results," Terry said. "Based on the patient's score, we'll modify care management and intervention."

Later in 2014, the practice will expand screening by asking all patients to complete a PHQ-9 during their office visits. One important consideration in operationalizing this workflow was to ensure payers would reimburse for administering the PHQ-9 separately from the E/M code.

At Oregon Medical Group the BHSs record the PHQ-9 scores in the practice's EHR, allowing physicians the quick feedback and input they wanted. If a referral is needed, the BHS coordinates that as well as any care coordination services with the care management team. The follow up and follow through assures the physician that patient needs are met appropriately and in a timely manner.

If the patient is referred to a specialist, the referring specialists agree to communicate patient status back to Oregon Medical Group, so the BHSs can track if patients are adhering to treatment. If patients drop out or are a "no show" at appointments, the BHS contacts the patient.

### Putting it all together

At first, integrating behavioral health was an intimidating task for Kathleen.

"It's big and it can be hard to do," she said. "Our physicians knew they needed this in our practice, but it takes time to make it work."

However, when it works, it immediately makes a difference for patients who need the services.

"One Friday afternoon at the end of the patient visit, we identified a patient who was clearly in crisis with suicidal ideation," Terry recounted. "The physician connected the patient to our BHS with a warm handoff through a phone call. The BHS evaluated the patient over the phone and set up an appointment for him on Saturday morning."

Terry continued, "She also set up a crisis plan if he worsened overnight. They talked about who he should call and where he should go if he felt he needed help. He understood that help was waiting for him the next day, but just in case, he had a plan."

The patient was seen the following day and started treatment.

"Our physicians are thrilled," Kathleen said. "They are relieved that we can help people like this and it's amazing to get the right services at the right time. That's what it means to be a patient's medical home."

### In the next Spotlight: An In-Depth Look at Medication Management

#### PHQ-9 Scores, Diagnosis and Treatment Consideration for Adults

1. If PHQ-9 is less than five, no intervention is necessary. Re-test in 9-12 months. If second score remains less than five, consider changing diagnosis from depression to history of depression.
2. If PHQ-9 is between five and nine, ongoing follow up with PCP is suggested with a PHQ-9 in three to four months or when seen in follow up at least once per year.
3. If PHQ-9 is between 10 and 14, consider diagnosis of Dysthymia and antidepressant medication and possible referral for mental health evaluation. Re-administer PHQ-9 in three to four months.
4. If PHQ-9 is between 15 and 19, consider diagnosis of Major Depression, moderate to severe and antidepressant medication and referral to mental health provider for assessment and treatment.
5. If PHQ-9 is 20 or greater, and/or current suicidal ideation, immediate referral to a mental health provider for assessment or warm hand-off to the mental health specialist in the medical home is recommended.

*Author: Terry Stimac, PhD*

## Practice Spotlight 8

March 21, 2014

This week's Spotlight takes a deeper look at **comprehensive medication management**, one of the three advanced primary care strategies in Program Year 2014 Milestone 2. Two practices have been profiled for this article — OU Physicians has included pharmacists in its practice for 10 years and Associates in Family Medicine hired its pharmacist in July 2013. Their pharmacists have had evolving roles in the integration process that other CPC practices may see in their own work as they undertake comprehensive medication management.



ASSOCIATES IN  
FAMILY MEDICINE, P.C.

Quality Care for Life

**OU Physicians** is an academic group practice affiliated with the University of Oklahoma School of Community Medicine. Employing nearly 190 providers, OU Physicians operates five clinical sites in Tulsa. Two clinics serving about 14,000 patients are CPC sites. In addition to pediatrics and internal medicine, OU Physicians offers services in adult diabetes, dermatology, obstetrics and gynecology, nephrology, pediatrics, perinatal medicine, psychiatry and surgery.

**Associates in Family Medicine** of Fort Collins, Colo., operates eight clinical sites; three clinics are CPC sites with 48,000 patients. Services include family medicine, gynecology and obstetrics, pediatrics, sports medicine and urgent care along with ancillary services such as imaging/radiology, complementary medicine, lactation consultation, senior care and workplace care. AFM employs 50 providers, including midlevels, and about 80 nurses.

About 10 years ago, the pharmacy program at the University of Oklahoma added an ambulatory care rotation to its training. While the pharmacy school's objective was to round out students' education with additional experience in a clinical setting and increased patient interaction, the academic practices receiving these students saw potential for a new dimension to comprehensive care.

"Having a pharmacist on the team who could consult and meet with patients would surely affect quality levels," said **William Yarborough, MD**, medical director of internal medicine for OU Physicians. "The potential for improved patient care was obvious. The barrier was the financial turf. How do you support the pharmacist over time?"

Associates in Family Medicine leadership wrangled with the same dilemma. Through a HealthTeamWorks demonstration project, AFM CEO **James Sprowell, MD**, was introduced to potential grant opportunities that would provide short-term funding for an embedded pharmacist. Unfortunately the grant dollars did not materialize, but the prospect continued to intrigue Dr. Sprowell, especially as newly trained providers joined AFM's growing practice.

These providers' training emphasized an interdisciplinary approach, including pharmacists and licensed social workers on care teams. Dr. Sprowell recognized that the need for transformation in family medicine stemmed not only from increasingly complex patients and systemic issues, but also from changes in the providers themselves. This wave of providers is prepared to deliver care in a new way. So are pharmacists.



From the left: William Yarborough, MD, medical director, and Katherine O'Neal, PharmD, BCACP, CDE, OU Physicians

CPC practices are encouraged to refer to the Program Year 2014 Implementation and Milestone Reporting Summary Guide, pages 16–18, for an implementation framework for medication management. Included in this section of the implementation guide are key questions practices should work through as they plan this work.



*Amy L. Stump, PharmD, BCPS, and John C. Cawley, MD, Associates in Family Medicine of Fort Collins, Colorado.*



## How pharmacist training has changed

When the majority of pharmacy training programs became doctoral programs (Doctor of Pharmacy or PharmD) in 2004, the field's intent shifted away from a product focus and toward a patient-centered profession.

After completing pre-pharmacy work of two to four years, students enroll in a four-year professional/graduate training program. About one-third of the curriculum is clinical and experiential training that includes work in fields such as cardiology, oncology, family medicine, pediatrics and geriatrics. Additional coursework includes patient assessment, pathophysiology, disease management, clinical guidelines and more. Post-graduate training options include general and specialized residency training programs. Training in Ambulatory care is keeping pace with demand at this time, but if jobs open in primary care, university programs are likely to expand training options.

## What happens when a pharmacist is on the care team

Dr. Yarborough advises practices to use a pharmacist's time strategically to address risk areas and improve quality. At OU Physicians, **Katherine O'Neal, PharmD, BCACP, CDE**, initially focused on a medication management strata of patients who were at high risk for serotonin syndrome.

"I also worked with the nurses who do follow-up with patients as they transition through care settings," Katherine said. "Another piece of my day is to work on a combination of same-day or same-hour requests. As the care management team visits with patients, I can get pulled in for a consult."

Katherine is included on the care team for patients with multiple ED visits or hospitalizations and patients with high-risk meds or complex regimens. She may review charts before patients are seen or during the encounter with a warm hand off from the provider.

ED and admissions reports from the main admitting hospital are sent at least daily to OU Physicians.

As the practice delves deeper into CPC work, a more formalized workflow for tracking metrics will be established.

"Although we have had integration, we didn't have the measurement piece," said **Renee Engleking, MPH, RN**, director for clinical operations at OU Physicians. "We're now looking at what processes need to be improved and which measures need our focus. We know we should see a downward trend in readmissions, and that will hone down to disease management numbers, too. We're just not there yet."

When **Amy L. Stump, PharmD, BCPS**, joined AFM in July 2013, some of the practice's providers were unsure how to best use her expertise. Amy brought with her an extensive background in ambulatory care, and the perspective quickly shifted.

"At first they weren't sure about the utility of a pharmacist outside of the price tag," said **John C. Cawley, MD**, one of the practice's family physicians. "I trained with a pharmacist and I knew she could bring that extra support we need for complex patients. The attitude changed rapidly because everyone sees the value of having a pharmacist's time and expertise. It's one of those rare changes that affects the entire practice in a positive way."

"I started out by listening," Amy shared. "I would hang out in the nurses' bullpens and listen to their challenges. It helped me pinpoint where the practice needed a pharmacist and where my skills would make difference."

### When a pharmacist is embedded in the practice, these are the questions that get answered:

*"My patient keeps getting readmitted with dizziness. Can you review her meds?"*

*"My patient calls EMS with hypoglycemia weekly. Can you help with his diabetes?"*

*"My post-partum patient had a seizure. Neuro says her new meds are safe in breastfeeding. Can you research this?"*

*"My patient stopped her DM meds and now her A1c is 12%. Can you help?"*

Source: Associates in Family Medicine

Amy engages in a variety of daily care roles (see inset), as well as runs an in-house focus group for pharmacy-related patient care. Her focus group activities range from administrative functions such as writing policies and protocols for opioids and how to screen for abuse, to operational tasks such as standardizing emergency kits and ensuring medications are stored properly in the clinics.

She has also undertaken four pilot projects: collaborative drug therapy management (warfarin and diabetes), diabetes “pre-visits” with patients, shared medical visits and an anticoagulation clinic.

The anticoagulation clinic grew out of AFM’s “small clinic” philosophy for patient care. Clinical sites are kept intentionally small with only a few providers per site to promote a “medical home” culture among patients. To improve tracking and real-time feedback for patients taking anticoagulant drugs, Amy oversaw the purchase of home self-testing meters for these patients and the creation of a secure online portal for reporting results. This allows patients to come to their medical home for appointments with their established PCP, but practice-site nurses can send INRs to the clinic for immediate feedback.

AFM expects having a pharmacist on board to affect outcomes in the near term. QI staff are tracking all diabetes-related measures, especially for patients with an A1c > 9; PIMS (potentially inappropriate medication use in older adults); TTR (time in therapeutic range) for patients taking warfarin and a bleeding/clotting events among those patients; and decreased ED visits and hospitalizations among the practice’s high-risk population.

### **High-value care and the business case for a pharmacist in primary care**

Everyone agrees on two things: pharmacists increase quality of patient care in the primary care setting and it’s challenging to find a way to fund those positions. Currently pharmacists are not classified as health care providers in the Federal Social Security Act, [although recently introduced Federal legislation may change that](#). Only Medicare Part D pays medication therapy management (99605, 99606, 99607). When adding a pharmacist to the practice, leadership will need to weigh the return on investment elements, such as cost savings, cost avoidance, shared savings or incentive bonuses in addition to revenue generation.

Although it may not show up on the books, leadership must consider the key payoffs when hiring a pharmacist: improved patient outcomes and increased nursing and provider satisfaction.

***Is your practice ready for the Spotlight? Please email Belinda McGhee, [belinda.mcghee@tmf.org](mailto:belinda.mcghee@tmf.org), with your story suggestions.***

#### **Clinical Pharmacists’ Role at AFM**

- Chart review
- Curbside consults
- Collaborate with care management team
- Prior authorization processes
- Patient medication access and affordability
- Create evidence-based algorithms and protocols
- Educate providers, nursing and staff
- Pharmaceutical care team member

#### **Other Potential Roles**

- Medication reconciliation
- Transitions of care
- More work with SNF patients
- CDTM in more disease state areas (e.g., asthma, hypertension, dyslipidemia, CHF)
- Annual Medicare Wellness visits
- Manage patients with insulin pumps
- Continuous glucose monitoring
- Poly-pharmacy clinics



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## Practice Spotlight 9

March 28, 2014



*Spanning four counties in the Capital District of upstate New York, CapitalCare Medical Group serves nearly 165,000 patients through 28 clinical sites offering primary care in family practice, internal medicine and pediatrics.*

*Its speciality services include endocrinology, pulmonary and sleep medicine, developmental-behavioral pediatrics, pediatric and adult neurology, nephrology, medical nutritional therapy and an ADA-recognized Diabetes Self-Management Education program. The physician-owned group employs more than 120 prescribing practitioners and 110 nurses among a staff that numbers about 600. Ten practices are enrolled in CPC (seven family practice, three internal medicine) with 58,000 empanelled patients.*

“Which would you choose,” asked **Kathleen Mattice**, BSN, RN, PCMH-CCE, director of clinical services for CapitalCare, “to be a partner in planning the future of health care or to respond to a future designed by others? CPC puts us on the practice transformation design team.”

Why is CPC right for this medical group? The multi-payer engagement ensured they could offer services to all patients in their CPC sites with payer type essentially “invisible” to the patient. Having colleagues in the region working on the initiative with them was another plus. They also were attracted to the Milestone structure, which they called a critical roadmap for success.

During the medical group’s earlier experience with a single-payer PCMH initiative, they realized the potential of transformation as well as how overwhelming the range of tasks could be. The CPC Milestones provided direction and targets.



*Left: Kathleen Mattice, director of clinical services. Group from left: Julie Adamec, manager of clinical quality initiatives; clinical quality analysts Brian Litz, MBAH; Christina Shephard, MPH; and Brittany Bardin, MBAH.*



*Louis Snitkoff, MD, FACP,  
medical director for  
CapitalCare Medical Group*

**Julie Adamec**, manager of clinical quality initiatives, said, “For the first time a roadmap was delivered and we could say, ‘Follow this.’ The Milestones gave us the timeframes for the work and held us accountable.”

She continued, “We have highly motivated individuals here who want to do *everything* to the best of their abilities. Having a clear direction and specific goals built confidence that we could meet expectations in CPC.”

Kathleen agreed, “CPC allowed us to focus on what we needed to do. As a large group, we had robust financial information that we knew how to use. We learned how to use the EHR in the same way: to mine the data, set priorities and move forward.”

Medical Director **Lou Snitkoff**, MD, FACP, found another aspect of CPC compelling. “CPC enhanced our understanding that many factors contribute to process improvement in primary care and that tapping into our patients’ experience in a more systematic way could provide us with their valuable perspective on how to make the most of our efforts to care for them.”



**Quality (kwä' - lə - tē): n. < L. *qualitas, qualis*, of what kind > how good or bad something is**

CapitalCare is a highly structured, well-organized group whose teams had successfully completed other quality improvement (QI) work. Despite that, Kathleen was surprised when she used terms like “practice transformation” or “QI” and found that definitions varied among the clinical staff. That insight led to a powerful project planning component.

“Familiarity assumes everyone thinks the same thing,” Kathleen commented. “Not so. We spent more time to create operational definitions and a level setting so we all started at the same spot and moved forward together.”

Julie had a similar experience during a planning meeting for the CapitalCare’s patient engagement work.

“We’re at the table and we realized we had been defining quality by the health care industry’s standards,” she recalled. “Quality for the patient is really about the patient’s perception of the care they received in the office and *what mattered to them*. We learned to shift our momentum from measuring numbers to look at what patients told us was important.” That shift led CapitalCare sites to opt for creating Patient and Family Advisory Councils (PFAC) in PY 2013.

**CapitalCare’s PFAC journey began with CPC**

As a PY 2013 Milestone 4 activity in CPC, practices had the option of choosing to survey patients or creating PFACs as a way to understand the patient perspective and engage patients and families as partners in improving care.

In contrast to most CPC practices, all 10 of CapitalCare’s CPC sites opted for creating Patient and Family Advisory Councils.

“We didn’t mandate this; it’s not part of our culture to prescribe activities for each site,” Dr. Snitkoff pointed out. “They chose it because they wanted a more meaningful way to engage and learn from their patients.”

“The sites felt a patient council allowed for deeper insight,” Julie said. “They recognized that only a certain subset will respond to the paper surveys, and what they tell you may not be actionable.”

“Our patients also have survey fatigue,” Kathleen added. “We know they are getting surveys from everyone about health care. We wanted an up-close and personal interaction with more open communication.”

***In the next Spotlight: CapitalCare shares how it operationalized 10 PFACs in Program Year 2013.***

**How PFACs Are Shaping Change**

Input from CapitalCare’s PFACs have prompted a variety of changes in the practices:

- User-friendly changes to the phone system – including not signing out to the answering service at lunchtime
- All staff wear name tags
- Created site-specific brochures with information about office procedures and providers
- White board updated daily with names of the providers seeing patients that day and other timely/seasonal information
- Bulletin board with prescription discounts and general health information
- New walk-in hours for same-day visits
- Expanded evening hours
- One-on-one assistance for patients who need help registering, logging in or using the patient portal
- Improved and more timely communication with patients if providers are running behind schedule

## Practice Spotlight 10

April 11, 2014

CapitalCare Medical Group of upstate New York has 10 CPC sites that all chose to pursue the **Patient and Family Advisory Council** option for Milestone 4 (Improve Patient Experience). In this week's Spotlight, CapitalCare shares how they planned and recruited for the councils as well as how insights gleaned from council input have sparked a range of changes in their practices.



"We've been working so long at putting the patient at the center," said **Kathleen Mattice**, BSN, RN, PCMH-CCE, director of clinical services for CapitalCare Medical Group, "but we've been doing it *around* them through processes and outcomes. The councils are our way of saying 'You are our partner. We want to hear the good and the bad.'"

**"Participating in PFAC fosters harmony between the patient and caregiver visions for compassionate and comprehensive therapeutic relationships, which motivate us to seek out one another in the first place."**

*Cindy Chan, MD  
Internal Medicine Nott Street*

The concept of engaging patients and families wasn't new to CapitalCare. During its previous work in a PCMH project, the medical group had used survey data to shape some aspects of the medical home. While the information was generally useful, all 10 CPC practices agreed the surveys only skimmed the surface of patient engagement needs. The practices collectively decided the PFAC approach would provide up-close and actionable feedback that was specific to their sites, staff and workflow. Additionally, the council approach could foster an ongoing conversation about patient care as the practice continued its path toward comprehensive primary care.

CapitalCare's 10 CPC sites all held initial PFAC meetings in the third quarter of 2013 and successfully repeated meetings for all sites in the fourth quarter. During each site's weekly CPC meeting, PFACs are a standing agenda item for ongoing planning for the quarterly meetings. This timing ensures all team members are aware of the process and can contribute as well as make decisions as needed. This lessens the burden on individual members and spreads the work over several weeks.

"The PFAC has given us specific ideas of how to improve our care," said **Carol Braungart**, FNP-BC, from the Internal Medicine Nott Street site. "Our patients provide us with their perceptions and ideas of what they want from their health care provider, enabling us to move health care to a higher level."

"Of all our CPC work, the value from the outcomes with the PFACs is obvious," said **Brittany Bardin**, MBAH, clinical quality analyst. "We can plainly see how we directly and indirectly



From left: Cindy Chan, MD, and Brittany Bardin, MBAH, clinical quality analyst

*CPC practices are encouraged to refer to the Program Year 2014 Implementation and Milestone Reporting Summary Guide, pages 21–22 and 49–52, to review the options for Milestone 4, including Patient and Family Advisory Councils.*

affect patients and what specifically we do that meets our patients' needs."

### **Getting Started: Inviting Patients and Families**

Physicians at each CPC site drew up a list of candidates who would be willing and appropriate to invite to the PFAC. Qualifying criteria were that participants would be a mix of new and long-standing patients and family members. Some long-standing patients were also the parents of pediatric patients, which provided a multi-generational perspective to the care experience. Candidates needed to provide their own transportation to meetings. Physicians didn't shy away from inviting the "grumbler" patients either. All perspectives were welcome.

To ensure 10 to 15 participants in each site, invitation letters signed by physicians were sent to about 25 patients per site. Everyone who responded was asked to participate; a few respondents were designated as back up.

The resulting dynamics of CapitalCare's councils vary by site. Council participants at the three internal medicine sites are slightly older than those at the seven family practice sites. Council sizes range from six to 12 participants.

"We gave the sites free range to build their own agendas," **Julie Adamec**, manager of clinical quality initiatives said. "Our only guidelines were that staff should have defined roles and responsibilities, and they would make sure the participants in the meetings clearly understood the parameters of the council."

CapitalCare site managers have been directing the meetings, borrowing guidelines the group has used with support groups for patients with diabetes. Their tasks include timekeeping, explaining the privacy of health information and defining the topics that pertain directly to the practice site. This helps the discussion stay on track and generates feedback that is pertinent to the site. Meetings generally last one to two hours.

### **Where to Meet**

Some councils meet at the practice site after hours in the waiting area or meeting rooms if available. One practice with extended evening hours takes the participants out to dinner rather than meet on site while the office is busy.

## What to Talk About

Physicians drop in at the start of meetings to thank participants and to encourage them to provide frank input. Knowing that their presence can be distracting or intimidating, physicians then leave to allow the site managers to run the rest of the meeting.

To kick-start conversation at the initial meetings, site managers opened discussion with lines such as “this is what we have heard in the past” and then let council members expand on that. Generally these starters came from previous survey responses.



*Louis Snitkoff, MD, FACP, medical director for CapitalCare Medical Group, and Alicia Sikora, director of marketing and communications*

“Sure, this can feel like heading off into the unknown,” medical director **Lou Snitkoff**, MD, FACP, admitted. “We know we’re not perfect, but the feedback to date has been thoughtful, fair, constructive and actionable.”

**“It makes such a difference to have new walk-in hours in the morning where I can come in and get a flu shot or been seen for a sick visit. I really feel like you are accommodating your patients’ schedules and varying needs.”**

*PFAC participant*

A patient at an internal medicine site PFAC broached a difficult topic: how to complete Advance Directives paperwork. Surprisingly, the entire council was interested, prompting CapitalCare to bring in a subject matter expert from the community to discuss this at an upcoming meeting.

At a family practice PFAC, a care manager nurse described her role in the practice’s approach to comprehensive care. Participants were impressed and appreciative but also unaware that these services were available to help patients. The other CPC practices are now interested in slating a care manager to present at their upcoming PFAC meetings.

Subsequent meetings have included discussion about the launch of CapitalCare’s patient portal and how to communicate this new feature to the patient population. Members of CapitalCare’s Information Services (IS) department attended these meetings to demonstrate the portal, explain the technical aspects and answer questions about capabilities.

“I was really impressed with the level of engagement,” **Alicia Sikora**, director of marketing and communications said. “We understand that patients have trepidation about using portals, but it was great to hear their suggestions and then see how we could put those suggestions into action.”

To date, PFAC feedback has influenced changes ranging from all staff wearing name tags to new walk-in hours for same-day visits. Comments garnered from the patient portal rollout led to provision of one-on-one tutoring on how to use the new features. (*See March 28, 2014, Spotlight article for a complete list of changes.*)

“Don’t hesitate to try a PFAC,” Kathleen advised. “People tend to expect the worst, but the positive far outweighs the negative. It’s been fulfilling to take the constructive comments and do something meaningful for our patients that they have asked for and can appreciate.”

***Would your practice shine in the Spotlight? Please email Belinda McGhee, [belinda.mcghee@tmf.org](mailto:belinda.mcghee@tmf.org), with your story suggestions.***

## Practice Spotlight 11

May 2, 2014

*Located southeast of Denver in Greenwood Village, **DTC Family Health and Walk-In** is a three-physician practice serving about 9,000 active patients. In addition to traditional appointment-based primary care services, the practice offers walk-in services Monday through Friday, 7:30 a.m. to 4:30 p.m., and Saturdays, 8 to 11 a.m. The practice uses AthenaHealth for its EMR and patient portal. The practice website is <http://www.dtcfamilyhealth.com/home.html>.*



“Culture eats strategy for lunch every time,” **Tim Dudley, MD**, of DTC Family Health and Walk-In, said. “Marjie Harbrecht, MD, the CEO of HealthTeamWorks, often says this, and she’s right. We lead change in our practice by emphasizing our culture. We say, ‘This is how we deliver high-quality service. This is how we treat each other professionally and this is how we work together as a team.’ ”



Tim Dudley, MD

This small practice of three physicians — Dr. Dudley works with his wife, **Lindy S. Gilchrist, MD**, and **Lynn Joffe, MD** — relies heavily on daily interaction and communication as it takes on the CPC work along with other initiatives for quality care.

“We start with the big picture of what we’re working on and then we drill down to the workflows, the PDSAs and the like,” Dr. Dudley said. “Our attitudes vary by our roles. As physicians, we can be skeptical. We ask, will this do any good? How will it work? Is it sustainable? Then our PAs are intrigued and genuinely interested, but wary of the workload. The MAs are looking for a combination of the big picture and the drill down.”

With 50 to 70 daily advanced appointments plus walk-in visits, it can be challenging to look up from the day-to-day activity to focus on transformative change. Each staff member’s daily workflows include carve-out time for CPC. This dedicated time is how DTC “steps off the treadmill,” as Dr. Dudley says, from patient visits to focus on other tasks that support the comprehensive approach. For example, each physician-MA team will meet with the care manager for patient updates. Or, MAs will use the time for visit prep, ensuring preventive care like vaccines are administered before appointments. Over time, these processes will work through the entire patient population, meaning future patient encounters will focus solely on acute needs and less on the catch up work of preventive care. A dashboard feature in the practice’s EMR (AthenaHealth) allows providers to monitor patient workflow through real-time updates and data, and then help each other as needed.

### Why CPC Fits for DTC Family Health

After several years in academia, Dr. Dudley returned to private practice when he joined DTC Family Health in 2007. During his tenure as director of the University of Colorado Family Medicine Residency program and director of the University of Colorado Hospital Family Medicine In-Patient team, he began thinking about how aspects of the residency programs could be integrated into primary care.

Change concepts like risk stratification were among those components he could envision at DTC. Joining CPC sped up that integration as well as rounded out the practice’s services with bringing **Heather Cherry**, a registered dietitian, and **Karen Foreman, LPC, NCC**, a behavioral health therapist, on board.



Following DTC's work on PCMH, CPC was the "next logical step" for the practice. Dr. Dudley pointed to the engagement of major payers as well as the hybrid payment model as key factors that piqued his interest. This combination allows practitioners to build a comprehensive approach as the traditional fee-for-service model undergoes reform.

"The benefits of CPC are increasingly obvious," Dr. Dudley remarked. "The daily use of a care manager and how a risk-stratified panel identifies those high-risk patients who need more of our focus — that's very satisfying."

DTC followed a simple methodology for risk stratifying the highest-risk patients: First, the practice identified all patients with two or more co-morbidities and a recent hospitalization or ED visit. Then from this pool of patients, providers further analyzed patient records to flag patients with conditions out of control, potential for preventable readmissions and inappropriate use of EDs.

During weekly meetings with the care manager, providers review the stratification and make adjustments according to their knowledge of the patient and the patient's health behaviors. Currently 2% (or about 180) of the practice's patients fall into the highest risk cohort.

"If there's an emerging concern about a patient, even if he doesn't have the two co-morbidities, we will put him on our high-risk list," Dr. Dudley explained. "We also take patients out of that high-risk group if they are obviously self-managing their conditions well."

### Barriers? What Barriers?

The process of integrating technology into the traditional primary care setting often starts with identifying the barriers, specifically how to overcome patient resistance. Dr. Dudley thinks those attitudes should be shelved with VCRs and Walkman MP3 players.

"The grandmothers in my practice are used to getting email from their kids and grandkids," Dr. Dudley said. "Everyone, even my older patients, is accustomed to instant communication. Once they use the technology, it resets their expectations." The number speaks for itself — **about 72% of DTC's patients actively use the patient portal.**

*Why are 72% of DTC's patients using the patient portal for asynchronous communication? Find out in the next Spotlight how this small practice has shaped workflow around the portal and why patients are embracing it too.*

This perspective has been a key to how DTC has built robust use of its patient portal. In the next Spotlight, DTC shares how the practice has "hardwired" portal use among its patients and how other technology continues to enhance the patient experience and access.

**Next Spotlight: Why 72% of DTC's patients use the practice's online portal.**



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## Practice Spotlight 12

May 16, 2014

*DTC Family Health and Walk-In is a three-physician practice serving about 9,000 active patients in Greenwood Village, Colorado. Four PAs, seven MAs and a care manager round out the practice staff. The practice uses AthenaHealth for its EMR and patient portal. The practice website is <http://www.dtcfamilyhealth.com/home.html>.*



Tim Dudley, MD

The email sent to new patients at **DTC Family Health and Walk-In** has the usual welcome message along with one key piece of information: the patient's log-in information for the practice's portal.

"You have to very deliberately opt-out of using our portal," **Tim Dudley, MD**, admitted. "Over the past six years, we have been pretty clear that this is how we will communicate with you, where we'll post your labs and where we'll answer non-emergent questions."

With many high-tech businesses located in the vicinity of Greenwood Village, the practice's patient panel tends to be gadget-friendly and most patients haven't resisted using the portal. When the practice went electronic in 2008 and introduced the portal, the sign-up rate was predictably sluggish but rates have steadily increased year after year.

"Patients are more familiar with signing on and registering at a website. Sure, some patients hesitate at first, but we remind them that this is how they shop and even how many of them bank these days," Dr. Dudley continued. "Our system is as safe – or even safer – than those systems."

Currently 90 percent of the practice's patients are registered users of the portal, which is accessed through the practice website. Of those, 72 percent are active users, defined as having logged in to access information in the past 12 months. The patients who have not signed up are reminded at each office visit that this valuable tool awaits them. Some patients cling to paper and pen, and the office staff will continue to accommodate their preferences.

As DTC planned its portal adoption, physicians, PAs and MAs weighed in on the design together. They discussed what information to include and then how the staff would blend the portal messaging into the daily processes and workflow. This approach allowed the staff an inside view of the portal, which in turn helped them encourage patients to use it.

Although Dr. Dudley was skeptical at first, the appointment scheduling feature in the portal has been a big plus for patients. Every provider has two open slots per half-day session that are designated as portal appointments. Patients love the access, and despite Dr. Dudley's concern that self-booking would wreak havoc on the workday, it hasn't happened. It's going so well, the practice is incrementally opening up additional appointment slots for portal booking.

### The Good, the Better and the Best Examples

The portal continues to offer DTC savings in time and effort.

Lab results are a good example. When lab results are loaded into the patient record, an email alerts the patient. Once the patient views the information, that time/date stamp is part of the record. If the patient doesn't view the results, the portal alerts the care team for follow up. This provides the care team an opportunity to explore why the patient hasn't accessed the portal, such as a lost password or misdirected email alert.

A better example is how patients and staff save time by communicating through the portal. Patients can log on at any time to ask a non-emergent question or

#### *A patient comment about DTC's portal from Yelp:*

*"This has been my doctor's office for years and I don't plan on leaving. ... **The best thing they did in the last few years is the patient portal.** You can schedule appointments, pay any bills (not associated with a co-pay), get all your lab results and even email your physician if you have questions about the results."*

make a simple request (such as a prescription refill). As requests cross the practice dashboard, an MA scans the messages, answering as appropriate and flagging more complex issues for the physician's attention. Dr. Dudley estimates portal messaging halved the number of phone calls the practice receives for these types of questions and requests.

"Often I can respond between patient visits," Dr. Dudley said, "and an email tells patients a response is in the portal for them. They don't have to call in during office hours or leave a voice mail after hours. We don't have to play phone tag with them to ensure they get a timely response."

DTC's best example of how the portal can spur timely care happened when a patient used the portal to request a specialist referral. Despite the practice's efforts to educate patients about using the portal for non-emergent requests, patients may not realize their concern is out of the ordinary.

"We saw the message from 'Pat' [*name changed to protect patient privacy*] come across the dashboard, and we instantly recognized the patient," Dr. Dudley began. "Pat doesn't like to come in for appointments, grumbles about care and Pat is someone who resists recommended treatment. A little bit of a curmudgeon. So, Pat is asking for a cardiology referral because Pat is having chest pains."

Dr. Dudley paused and chuckled, "Now, I know this is a 60-something diabetic who is a heavy smoker. Pat doesn't need a specialist referral. Pat needs to go the ED. So, we immediately call Pat and send [Pat] to the hospital. Sure enough, Pat's having a heart attack and ends up with bypass surgery later in the day."

### **No, the Patients Aren't Playing Flappy Birds on Those iPads**

DTC has purchased two iPads and is currently piloting their use during the patient check-in process. Should this test prove effective, there are plans to add 10 more. DTC's EHR vendor, AthenaHealth, is partnering with Seamless Medical Systems to integrate the iPad solution, but other EMR vendors also offer this feature. When patients return the iPad to the front desk, the information immediately transfers into the patient record. The clean input of data saves time for a busy administrative staff and, in the long run, money as the staff isn't tracking down patients for follow-up information.

"The only patients who are resistant to the iPads are those who are completely unfamiliar with a tablet and have never touched one," Dr. Dudley said. "Our front office staff will sit with them and coach them through using it, but occasionally we'll have a patient who wants the paper forms."

Dr. Dudley envisions the iPads will eventually accompany the patient throughout the office visit, becoming an informational and educational asset for both the provider and the patient. For example, when a 47-year-old female patient checks in for her annual well visit, the iPad will be loaded with information pertinent to her visit such as a shared decision making tool about mammograms or perhaps new information about her current medication regimen. She can view the information while waiting to be called to her exam room or opt to have the information emailed to her so she can view it later.

### **What Else Is Out There**

Dr. Dudley is excited about how technology will expand patient access beyond the traditional office visit.

"We know that a hefty percentage of patient treatment doesn't have to be in the office," he said. While the CPC care management fee supports increasing our capacity to integrate technology in the daily workflow, "What we need is a sustainable payment mechanism to put technology like Skype and FaceTime into play. Think how that would help a patient with transportation challenges. Or, the patient who can't miss work but can call in from the office."

It's the 21<sup>st</sup> century version of house "calls" as we build our medical home.



*Kathy Wilson, MA, holds one of DTC's iPads, which patients use at check-in to update history and personal information.*

***Would your practice shine in the Spotlight? Email [belinda.mcghee@tmf.org](mailto:belinda.mcghee@tmf.org) with your story ideas.***

## Practice Spotlight 13

June 20, 2014



*Founded in 1949, Grants Pass Clinic is a provider-owned multispecialty group serving the Josephine County community in rural southwestern Oregon. The clinic serves about 18,000 patients, with approximately 17,200 attributed to primary care. The clinic has 19 physicians, two PAs and one NP. Grants Pass Clinic's EHR vendor is Allscripts and the practice website is <http://www.grantspassclinic.com/>.*

"When we saw the CPC utilization baseline data for the first time, that was terrific,"

**Bruce Stowell, MD**, Chairman of the Partnership for Grants Pass Clinic in Oregon, said. That validation through data is an aspect of CPC that Grants Pass Clinic has found rewarding.

"We always thought we were doing a good job from a cost-effective standpoint, but to see it in the data, that was the first time we actually knew how well we were doing."

While the clinic has long operated a team-based care approach, other aspects of CPC have allowed the clinic to grow into a high-functioning medical home by adding staff and deepening its care management work. Dr. Stowell says his team was prepared for the challenge of CPC because they knew how to work together and they had a singular focus.

"When we adopted our EMR, we sat down together every week as a team, and that taught us how to handle change. As we worked on PCMH and other initiatives, everyone brought more to the table, and all of that collegiate group activity was exciting," Dr. Stowell noted. "We like working in a group, and we're here to make things better for our patients. Over the course of these initiatives, we've gone from 20 siloed individual practices to 120 people all trying to go in the same direction, which is very exciting."

He continued, "I'm personally proud that we have accomplished all of this so far, while maintaining the support of the providers and the patients. It's remarkable that we have had little to no turnover or negativity."



*Bruce Stowell, MD,  
Internal Medicine  
provider and Chairman  
of the Partnership,  
Grants Pass Clinic*

### Shared Decision Making at Grants Pass

Grants Pass Clinic's Shared Decision Making work focuses on three major areas: cardiovascular prevention (statin use and/or aspirin use to prevent MI), osteoporosis treatment and colorectal cancer screening options. The practice narrowed its SDM focus to these areas by selecting conditions that were relatively common and for which there were multiple reasonable options.

Eligible patients are ultimately decided by the provider at his or her discretion, but the clinic has also developed, through the use of its analytics tool, a way to identify patients using diagnosis codes and custom searches. For example, a custom search can be run showing eligible patients for the statin SDM tool. These patients are all active patients who have been seen since Jan. 1, 2013, and have one or more of the following:

#### 1. Cardiovascular disease with LDL > 100

- a. includes diagnosis codes related to CVD between 390 and 459.9
- b. most recent LDL dated within the last five years > 100

#### 2. Diabetes with LDL > 100

- a. includes all codes beginning with 250
- b. most recent LDL dated with the last five years > 100

#### 3. Hyperlipidemia with LDL > 130

- a. all active patients with most recent LDL within the last five years > 130 regardless if the patient has an active hyperlipidemia diagnosis

### Milestone 7: Shared Decision Making

#### The key components:

1. A condition where legitimate treatment options exist and the scientific evidence can clarify the options but doesn't present a clear best choice
2. A decision aid that helps the patient to understand the evidence and think through the choices
3. The opportunity to engage with the provider in making the decision (Shared Decision Making)

Providers selected decision aids from Mayo Clinic because they were authoritative, graphically satisfying and were available to share with the patients in real time.

Providers can access the decision aids immediately during the patient encounter through links posted to the exam room's thin client desktop. After putting the patient's numbers into the risk calculator, the provider and the patient together discuss the risks and benefits of treatment options that range from medication to lifestyle changes. Patients who would like more time to weigh the options or discuss the choices with their families can contact the provider later with a decision either by phone or through the portal.

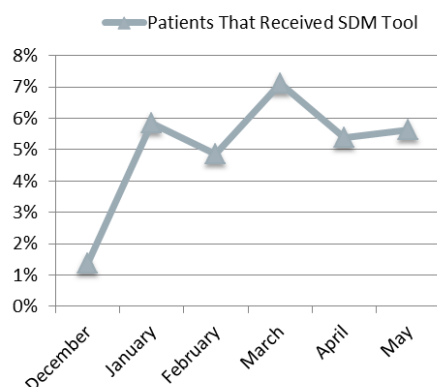
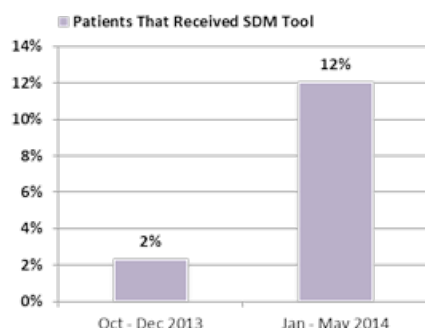


From left: Christi Siedlecki, BSN, RN, and Natosha Wilsey, BSN, RN

The use of the aid is documented in a discrete field in the notes section of the patient's record. The clinic is working toward an SDM dashboard application that is provider-specific so that each provider can monitor his or her patient panel for eligibility for all decision aids. Grants Pass also wrote a policy around how to appropriately use one of its decision aids.

"Having a defined process around a decision aid ensures all providers use the same approach. It must include having a shared decision conversation with a patient," **Natosha Wilsey, BSN, RN**, PCMH coordinator explained. "This is one of those topics where physicians' approaches will vary. Setting a policy about using the decision aid and describing how it should be documented in the EMR solves two issues: one, we get accurate data, and two, it standardizes our approach."

*The charts below show the steady increase of statin SDM aids among eligible patients. A financial incentive is tied to performance on this measure, prompting physicians to seek out the data and track it themselves. That in turn has prompted the analytics staff to ensure measurement is consistent and timely.*



The policy also serves as a documented shift in thinking about the patient's voice in choosing screening and treatment options.

"For example, when we started talking about colorectal cancer screening with physicians, they immediately think, 'colonoscopy.' Well, the patient has other options depending on their values and preferences," said **Christi Siedlecki, BSN, RN**, Nursing Department manager. "This started the deeper conversations we needed to have about the differences between educating the patient and truly sharing the decision."

One example of those conversations occurred as a patient with hyperlipidemia and her provider discussed interventions to reduce her risk of coronary events.

Together the patient and physician worked through the Framingham calculator on the Mayo Clinic website, plugging in the patient's numbers to calculate her 10-year risk, which was 7 percent. They discussed how the use of statins and aspirin could reduce that risk to 5 percent. After considering the patient's circumstances, values and the pros and cons of the alternatives, the patient and provider together decided not to restart the statin. The patient currently takes an alternate lipid-lowering medication and has made changes to her diet and activity levels to lower her cholesterol, which has been trending downward since late 2013.

### Is SDM Easy? No. But There Are Wins.

"Time is a major barrier, and it's not getting easier. The EMR has limitations, and we're doing this work while we're doing many other things," Dr. Stowell said. "However, by using the tools of SDM, we are providing consistent, reliable information. That's worth the time."

Dr. Stowell pointed to the other major positives in using SDM in primary care, "Consistency means our data is more accurate and it brings our focus

together for a more standardized approach to patient care. That's a good thing."

**Learn more about other Shared Decision Making approaches in the next Spotlight.**



## Practice Spotlight 14

June 27, 2014

Hicken Medical Clinic is led by solo-practitioner Michael Hicken, MD, in Hillsboro, Oregon, a suburb west of Portland. The clinical staff includes three PAs, one behavioral health specialist, two nutritional therapists, a care coordinator and a small team of support staff. The clinic also has a full-time QI specialist. Together they serve 6,200 patients. The clinic's EHR vendor is eClinicalWorks and the practice website is <http://www.hickenmd.com/>.



Michael Hicken, MD

When **Michael Hicken, MD**, enrolled his practice in CPC, he saw it as a way to make things happen.

"CPC is a structured framework to make positive changes that I was already contemplating yet didn't have the focus or direction to implement," he said.

Dr. Hicken saw he alone could not drive practice transformation. He continued, "I have learned that it is very difficult to do quality improvement without dedicating time and resources to it. When I hired **Mallori Jirikovic** (the practice enhancement and QI specialist), I felt like we were going to be able to move out of the fog and develop some clear objectives." Hired in September 2013, Mallori manages data and tracks the practice's CPC Milestone work.

He continued, "My biggest realization is that CPC requires a team approach with the whole practice involved if we are going to make meaningful changes." One of those team-based changes was integrating shared decision making (SDM) into the practice's daily workflow.

### Hicken Medical Clinic's Shared Decision Making Approach

The Hicken team followed a framework of criteria as it researched decision aids for the practice. First, they wanted aids that met the [International Decision Aids Standards](#) for quality and content. Second, they preferred tools with a step-by-step approach that clearly compared risks and benefits. Third, the tools needed to integrate with the patient portal and patient health record preferably in a digital format that kept the office paperless. Finally, the tool should help patients understand their choices and help them communicate their preferences. Another desirable feature was the tool would include the option to create a summary of the patient's decision that could be documented within the patient record.

They found [Healthwise's Knowledgebase](#) feature offered interactive decision aids that patients could access through the patient portal and later access the decision summary as well. The Healthwise "Decision Point" tools also offered an array of tools addressing preference-sensitive conditions and treatment that met the clinic's current needs with the ability to easily add other topic areas in the future.

Before implementing their SDM process and tools, the clinic decided to test two decision aids along with a new workflow (*see next page for illustration*)

#### Milestone 7: Shared Decision Making

##### **The key components:**

1. A condition where legitimate treatment options exist and the scientific evidence can clarify the options but doesn't present a clear best choice
2. A decision aid that helps the patient to understand the evidence and think through the choices
3. The opportunity to engage with the provider in making the decision (shared decision making)



Mallori Jirikovic,  
practice enhancement  
and QI specialist

with a small population of patients. They started with “Should My Child Take Medication for ADHD?” and “Depression: Should I Take an Antidepressant?”

They chose these preference-sensitive conditions/treatments because they occur nearly daily in the office’s usual workflow, which afforded providers and the medical assistant staff adequate opportunity to test and adopt the workflow.

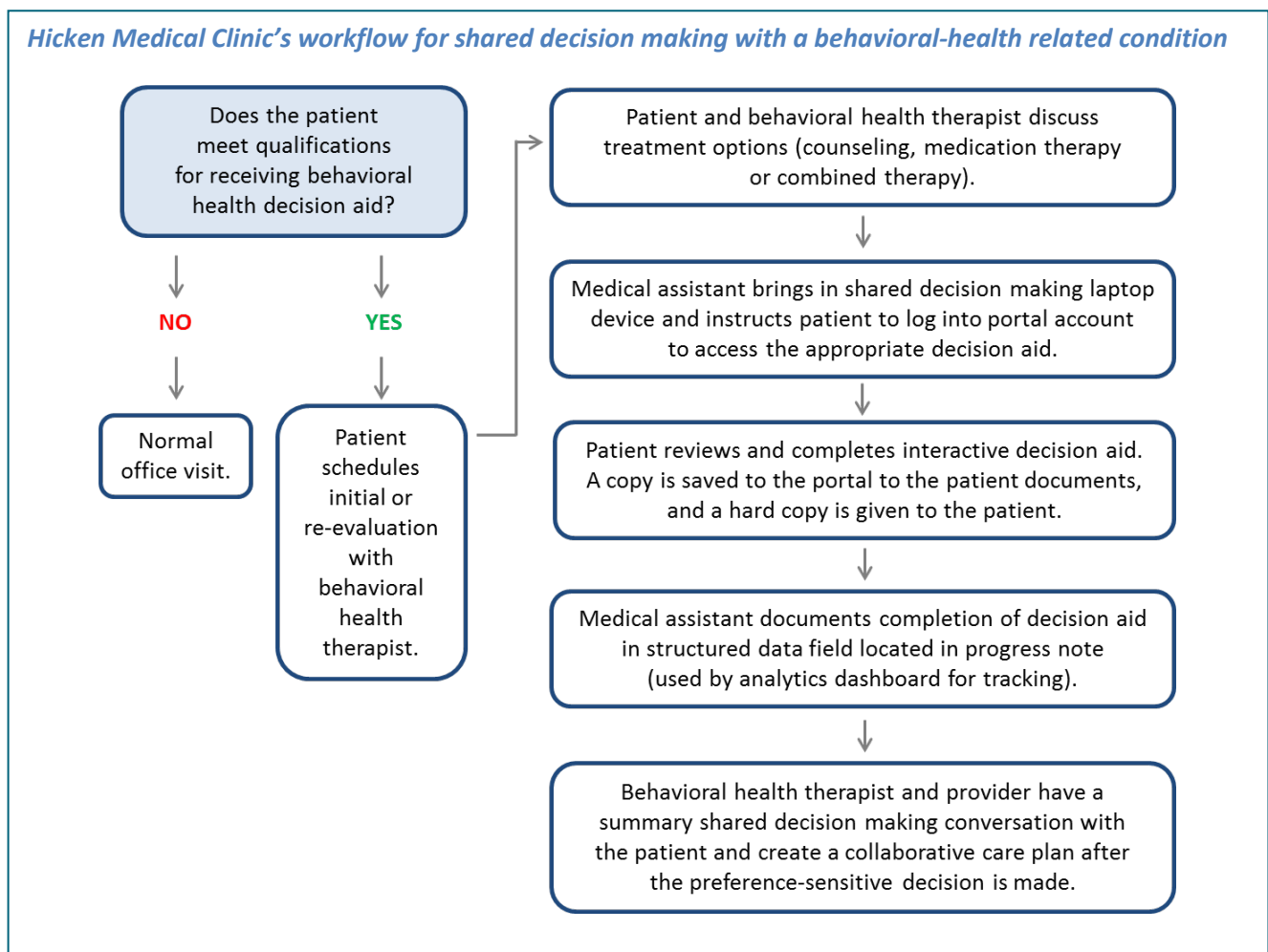
They also chose conditions/treatments that would support the clinic’s newly expanded behavioral health integration services. Because visits related to behavioral health are 30 or 60 minutes versus a 15-minute general visit, these visits afforded more flexibility to introduce SDM to the patient with limited disruption to the overall schedule during the adoption phase.

Later, as the SDM process became more fluid for the team members, they added [“Low Back Pain: Should I Have an MRI?”](#) Like the other topic areas, low back pain is a common complaint among the practice’s patient population.

“We identify eligible patients during pre-visit planning or they will self-identify during the patient visit,” **Mallori Jirikovic** said. “If we know before the visit, we will alert the behavioral health specialist, the PAs and the physician as needed so they can all participate in the decision conversation. Obviously, some patients will prefer to think about the options and come back. We’ll set up the follow-up appointment and give them a summary to take home.”

### Staffing Patterns

Hicken Medical Clinic’s staffing patterns have remained the same as shared decision making was integrated into the office workflow. In the near future, shared decision making may be integrated into the clinic’s proactive population management model.



## Overcoming Barriers

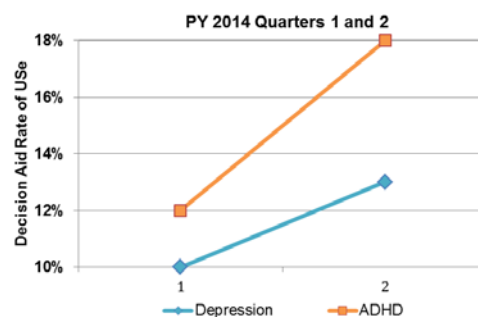
The Hicken team says shared decision making was the most difficult CPC Milestone for the clinic to implement due to multiple barriers that needed to be addressed simultaneously. Active communication – both listening and sharing – underscored their ability to work through each challenge thoughtfully and with full team participation in solutions.

**Adding technology:** The Healthwise decision aids are interactive, digital tools. To ensure patient privacy during viewing the tools, the practice provides patients with laptops to use in exam rooms to view the decision aids. The laptops were purchased with CPC funds. Patients can also browse educational materials on the laptops.

**Culture and education:** Shared decision making is a new concept in family medicine for providers and patients alike. The Hicken team discusses CPC Milestones as a standing agenda at all-hands and clinical staff meetings, and the team sets aside time to discuss the specifics of shared decision making and how it differs from patient education. The practice website also features information for patients.

**Time:** Although staff members were leery that SDM would disrupt daily workflow, they found that it was similar to most new processes in that employees were flustered at the beginning of implementation. Once the steps became more familiar, efficiency resumed and workflow smoothed out.

**Measurement:** Learning how to track and measure implementation of the decision aids without creating extra burden for staff took some effort. Currently the staff tracks completion of the decision aid manually through a structured data point in the office visit progress note. eClinicalWorks is currently helping the practice create an analytics dashboard to track rate of use, which they expect to deploy this summer. Once the dashboard is up, the clinic will share data monthly with all providers and staff to further encourage improvement, engagement and adoption.



The practice says the ideal solution for tracking would be for the EHR to pick up use and completion metrics directly from the patient portal, which they have proposed to the EHR vendor.

## What Patients Have to Say About Shared Decision Making

Hicken Medical Clinic surveys patients about shared decision making and other CPC work using the CAHPS survey and

*"I feel like I've finally found a doctor who cares about the patient and who really invests thought into understanding my issues and coming up with solutions with me."*  
—Patient comment

by using a quarterly electronic survey with questions chosen from the SDM domain of the CAHPS question bank.

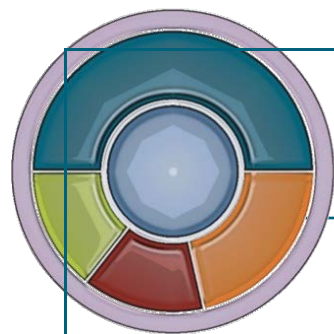
Patients can offer comments in a free text area, and to date, the responses have been positive and something they value, said Mallori, although the practice sees room for improvement and expansion.

One anonymous response clearly showed that the culture of shared decision making was a positive part of the patient's experience. "I love that I can contribute to my care and appreciate being treated like someone who knows their body and whose comments are valued."

Another comment echoed that sentiment, "Excellent care. I feel like I've finally found a doctor who cares about the patient and who really invests thought into understanding my issues and coming up with solutions with me."

Mallori said the positive comments affirm the practice is clearly communicating its mission and vision.

"Our proudest moment in CPC has been recognizing that our patients appreciate our improvement efforts," she noted. "They want to be involved and provide us with constructive feedback on our journey. CPC has given us the motivation to put the tools we have into use to improve care for our patients and families."



# CPCPracticeSpotlight15

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

Aug. 1, 2014

This strategy addresses  
CPC Milestones 2, 3, 4  
and 6.

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

## Ensure High-Risk Patients Carry Up-to-Date Medical Information with a Digital Personal Health Record

Marc Feingold, MD, Manalapan, New Jersey

Independent; one physician, one APN; 2,200 patients

**Situation:** Patients whose diseases and conditions are poorly controlled and whose health goals written in their care plans have not been met are at highest risk for needing emergency medical services or an unplanned hospitalization. Often, when this occurs, health care providers treating these patients do not have immediate access to the patient's full medical history and current health status.

Patients treated by multiple specialists also need access to their most current medical information during appointments to promote timely treatment, and prevent duplicative testing and medication errors.

**Strategy:** Marc Feingold, MD, provides selected highest risk patients in his practice with an updated digital personal health record (PHR) at each office visit. The information is loaded onto a password-protected USB drive mounted on a plastic card. The card is stored in a paper sleeve clearly marked with a bright blue caduceus.

The USB drive contains a PDF of the patient's full medical record, including diagnoses, treatments, medications, recent lab results and allergies. Because local first responders are trained to check patients' wallets for health information, patients are encouraged to carry the file with them at all times. They also share the information with specialty providers.

The patient's social security number is redacted on the PDF to protect the patient's identity if the USB drive is lost or stolen. The USB drives cost about \$13 each and were purchased with CPC funds. About 75 patients have been provided with the USB drives.

Dr. Feingold and his staff identified the patients who could most benefit from the PHRs by assessing each patient's diagnosed diseases and conditions, current state of disease control, stability of overall health, status of care plan goals and other significant risk factors. All patients in the practice are assigned a risk level using a modified version of the [American Academy of Family Physicians risk stratification tool](#). Those in the highest risk strata were eligible to receive these PHRs. The PHR enhances the care coordination between providers and facilities, providing safer delivery of care with reduced duplication and thus reduced cost.

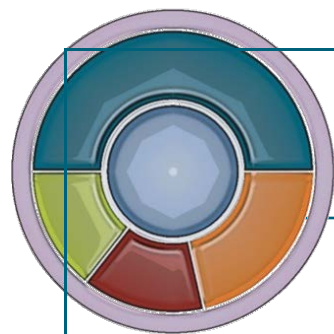
While too early to share data, the practice is tracking their patients' use of the drive to evaluate effectiveness and identify any resulting cost-savings or improved delivery of care. To date, some patients report they carry the card at all times and have shared the drive with their specialist providers.



The patient record is stored on the USB drive (upper right corner) that attaches to the card, which is stored in the paper sleeve (below). The size and format makes it easy for patients to keep in their wallets.



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# CPC Practice Spotlight 16

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

**Aug. 8, 2014**

**This innovation addresses CPC Milestones 2 and 5.**

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

## Lower A1c Among Patients with Diabetes Through Standardized Team Approach

*Warren Clinic – Bishops offices 220 and 420, Tulsa, Oklahoma System; 37 physicians; 46,400 patients*

**Situation:** Warren Clinic physicians

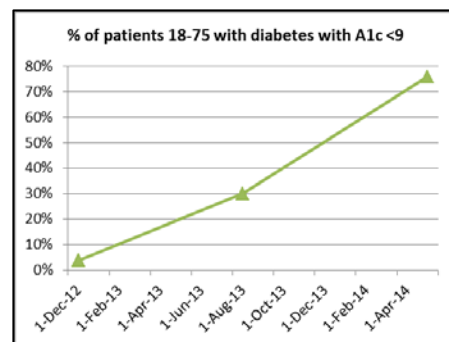
**Dina Azadi, DO, and Christy Mayfield, MD,**

chose to address lowering A1c values among their patients with diabetes as one of the clinic's clinical quality measures. Baseline data collected on Dec. 31, 2012, showed only 3.8% of patients with diabetes in their combined two practices had an A1c <9.

**Innovation:** When **Tim Ingram, BSN, RN,** care

guidance nurse, was hired in August 2013, he worked with the physicians to identify patients to whom this quality measure is

applicable and to create a standardized approach called INCOGNITO. The strengths of this approach are that it leverages data to identify patients, uses the consistency of a team approach to reach out to patients, adapts to address each patient's needs and provides a follow-up mechanism for patients who remain at high risk. Both practices' care teams followed the steps below to help patients with diabetes:



*Baseline data in Dec. 2012 was 3.8%; A1c <9 rates in Aug. 2013 had improved to 30%. Most current data as of May 2014 is 76% for both practices.*

**I – Identify:** Use risk stratification methodology to identify patients with diabetes.

**N – Numbers:** Most recent A1c values were evaluated as overdue, controlled and uncontrolled.

**C – Call Beforehand:** Patients overdue for diabetes care were contacted for appointments.

**O – Organize:** Staff called patients with diabetes the week before their scheduled appointments to ensure lab work was completed prior to the upcoming appointment.

**G – Goal Setting:** During appointments, the care guidance nurse discussed personal goal setting with each patient.

**N – Needs:** The care guidance nurse evaluated each patient for potential financial or social needs that prevented acceptance of medication recommendations and addressed those needs.

**I – Initiation:** Based on assessment, the physician and care guidance nurse provide more in-depth and personalized diabetes education. The care guidance nurse sees all patients with an A1c >7.

**T – Telephone Afterward:** Staff flagged patients with a history of poor acceptance of medication recommendations and planned follow-up contact within two weeks to evaluate current control and regimen effectiveness.

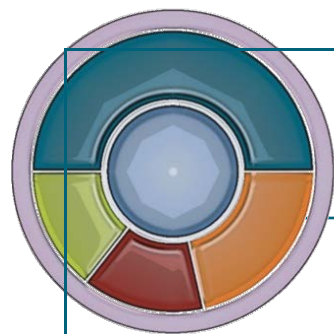
**O – Open Door Policy:** Patients are invited to call the care guidance nurse any time with questions or concerns.

***Most recent data show the practices' combined rate has improved to 76% of patients with diabetes having an A1c <9.***



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# CPCPracticeSpotlight17

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

Aug. 15, 2014

This strategy addresses  
CPC Milestones 2, 4 and 5.

For more information about  
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## Patient-Centered Care Management Resonates with Patients with Diabetes, Hypertension and Obesity

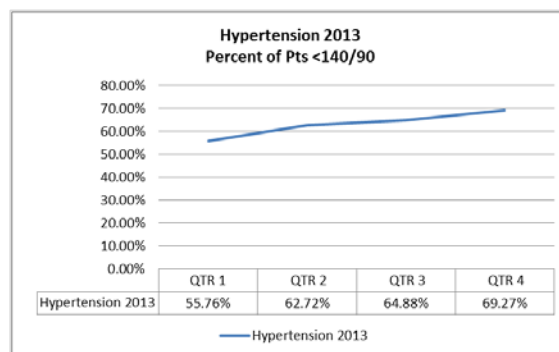
*Clopton Clinic, Jonesboro, Arkansas*

*Multi-specialty; 9 physicians, 4 APRNs; 9,732 patients*

**Situation:** Patients who struggle with self-management of chronic conditions such as diabetes need additional support and education from their clinical care teams. Uncontrolled A1c values and poor medication acceptance among patients with diabetes demonstrated an opportunity to improve provider-patient communication through intensive staff training and patient-centered care management.

**Strategy:** Clopton's care management staff crafted a patient-centered approach, using the EHR to identify a group of patients with the greatest need for improvement related to diabetes management, hypertension and obesity. To support self-management in diabetes care, the staff improved their capability by completing 26 hours of online health coaching classes through [Clinical Health Coach](#). The curriculum emphasizes inspiring patient accountability through coaching and effective communications that improves health literacy. The staff also trained with a Certified Diabetes Educator for four hours to better understand the diabetes disease process and how to be more effective in addressing patients' concerns and needs.

The team identified these potential barriers to successful implementation and sustainability: ability reach patients in a timely manner to communicate health care recommendations, inaccurate or incomplete contact and medical information from patients and their caregivers, and patients' lack of knowledge of self-care. Robust teamwork, coordination and communication among the care teams have addressed most barriers.

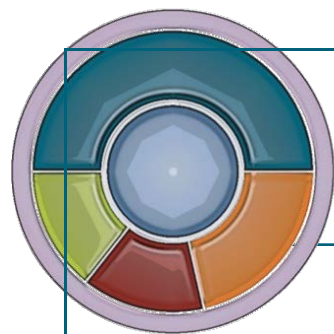


As care management staff met one-on-one with patients and their caregivers, they developed personalized care plans for each patient and called them monthly to evaluate progress and address any emerging concerns or barriers. Preventive care and routine screenings are monitored through the EHR, and phone call reminders are made as care is needed or past due. Other practices seeking to implement this approach should also consider how to access available community resources to supplement in-clinic education and how to incorporate ongoing follow-up into regular workflows.

Patients report they appreciate the extra time care management staff takes with them to ensure they are receiving appropriate care. They acknowledge the clinic is investing in them, and in turn, they are more engaged, accountable and accepting of treatment recommendations that meet their values. Data are beginning to show improved hypertension control, improved A1c values and increased patient acceptance of medication recommendations.



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# CPCPracticeSpotlight18

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

Aug. 22, 2014

This strategy addresses  
CPC Milestone 7.

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Primary-Care-Initiative/](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/).

## Shared Decision Making Helps Patients Make Cost-Efficient, Safe Choices for Lower Back Pain Radiological Assessments

*Brunswick Family Practice, Troy, New York*

*Independent; 1 physician; 1,200 patients*

**Situation:** Patients with lower back pain and no indication of nerve damage (red flags) often request unnecessary and expensive radiology services. Research suggests that an MRI, which costs approximately \$1,500, is “unlikely to avert a procedure, diminish complications or improve outcomes.”<sup>1</sup>

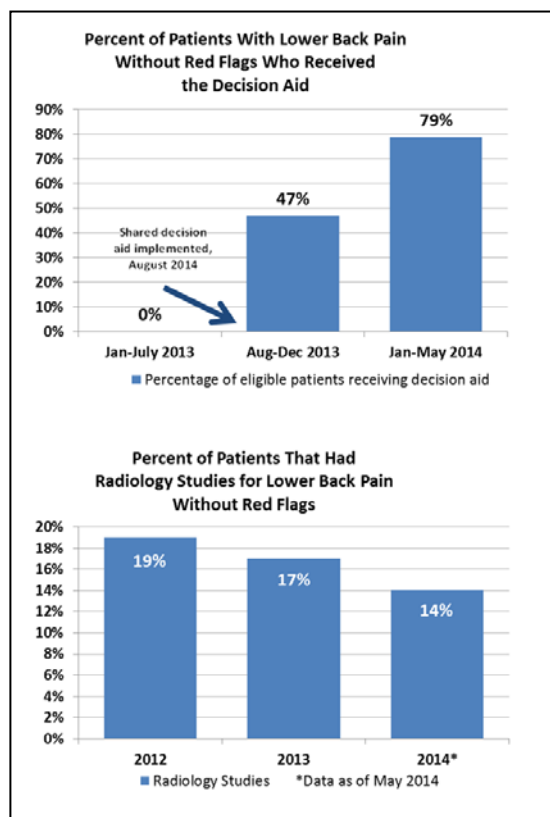
**Strategy:** Analysis of the top diagnosis codes in his practice helped **James Aram, MD**, select radiological screening options for patients with lower back pain as a focus for shared decision making in February 2013. This issue was clinically relevant to his patient population, and research clearly showed opportunities to lower costs and reduce unnecessary radiation exposure.

After consulting with their EHR vendor (Medent) to develop the appropriate data collection and reporting functions, Dr. Aram’s team developed a video decision aid patients could view from a laptop while in the examination room.

Their workflow initially hinged on Dr. Aram’s examination of the patient, but they found smoother solution was to train the practice nurse to screen patients during the initial intake interview. Patients

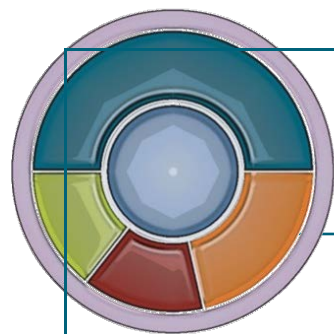
with low back pain viewed the video before meeting with the doctor; this not only helped the patients to understand their options for diagnostic screenings better; it also introduced the patients to treatment strategies before meeting Dr. Aram. This “preview” strategy prompted a second refinement to the workflow. Patients citing lower back pain as their chief complaint are directed to view the video through the patient portal before the appointment. This also allows the patient to share information at home with caregivers or family and offers greater opportunity for the patient’s involvement in shared decision making with the provider.

As of May 2014, practice data show 79 percent of eligible patients had viewed the decision aid, and radiology studies among eligible patients had dropped more than 4 percentage points. In addition to reduced costs associated with fewer radiological studies, no patient adverse events have occurred since implementing this strategy into the practice.



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<sup>1</sup> Johns Hopkins Medicine news release, Dec. 12, 2011. <http://www.hopkinsmedicine.org/news/media/releases>



# CPCPracticeSpotlight19

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

Aug. 29, 2014

This strategy addresses  
CPC Milestone 6.

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Primary-Care-Initiative/](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/).

## Forming Successful Care Compacts with a High-Volume Specialist and a Behavioral Health Provider

*Mayfair Internal Medicine, Denver, Colorado — Independent; 3 physicians, 1 NP; 3,000 patients*

### Tips from Mayfair:

- Have patience with the process.
- Advocate for what you need from your fellow referral practices.
- Be a good partner. Take suggestions for your own practice's improvement seriously.
- Make the best of what resources you have to build great working relationships in your medical neighborhood.

**Situation:** Care compacts with other providers in the medical neighborhood improve patients' transitions by standardizing communication and collaborative care management. Effective compacts can help bridge seams of care for patients, providing the potential to improve care while reducing harm and costs.

**Strategy:** **Mayfair Internal Medicine** sought care compacts with two specialists to address the following: patient needs, high utilization, and the need to establish consistent providers and communications for specific referrals. Mayfair sent more referrals to **Denver Digestive Health Specialists** (DDHS) than other specialists, and so had an existing affinity with this group. The practice created a second care compact with **Maria Droste Counseling Center** (MDCC) for behavioral health referrals. Mayfair reached out to MDCC with a cold call and was fortunate to connect with a staff person interested in integrating behavioral health with primary care.

Care compacts with both providers were finalized in June 2014.

While Mayfair had a good rapport with DDHS, the care compact standardized how the practices exchanged information, specifically bi-directional pathology notes on colonoscopies. The care compact defines that reports should be submitted with 72 hours.

Smoothing out processes with MDCC was more complicated as neither practice had an established communication process for behavioral health referrals. [MDCC developed new forms](#) for release of information, plan of care and communication between the practices and then Mayfair established workflows to integrate them. Navigating insurance issues and ensuring provider availability still pose some concerns, but both groups are committed to continue to work through these processes.

### Mayfair's Referral Tracking Process:

1. Patients are referred to specialist and an "open referral" is flagged on the record.
2. After 30 days, if the referral remains open, the practice messages the patient through the portal or calls the patient to follow up on these possible statuses:

- If the issue has resolved and the consult isn't needed, the referral is closed.
- The consultation is pending a future appointment.
- The consultation is complete and communication to the PCP is pending.

#### *If this is the status:*

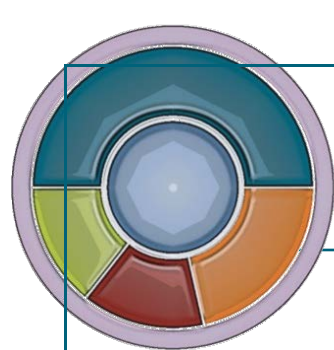
- Mayfair faxes a medical records request to the specialty practice and allows two weeks for response.
- If no response within two weeks, Mayfair repeats the fax request or telephones the specialist.
- Practice continues outreach to patient in 30-day increments as needed for completion of follow up.

3. If a referral exceeds 90 days, it is deferred to the PCP to determine further action.

**Resources:** Mayfair's care compacts with [Denver Digestive Health Specialists](#) and [Maria Droste Counseling Center](#).



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# CPCPracticeSpotlight20

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

Sept. 5, 2014

This strategy addresses  
CPC Milestones 2 and 6.

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## Focused Care Management and Coordination Reduced Emergency Room Visits for Patient

*Group Health Associates – Springdale, Cincinnati, Ohio  
System (TriHealth), 14,000 patients*

**Situation:** Weekly visits to the local emergency department (ED) were routine for “Martha,”\* an elderly patient who suffers from multiple co-morbidities. Martha depends on portable oxygen, takes more than two dozen medications and lacks significant family support and resources. She also struggles with managing her chronic pain.

**Strategy:** ED utilization reports brought Martha to the attention of the care management team at **Group Health Associates’ Springdale practice**. Within 72 hours of Martha’s ED visit, a care management team member contacted her to discuss her reasons for seeking care at the ED and to identify her follow-up needs. This phone call sparked collaboration between her physician and the care management team to initiate intensive care management in response to Martha’s complex medical needs and barriers stemming from her social support needs.

In addition to scheduling Martha’s follow-up appointments and coordinating any needed referrals, the RN care managers’ outreach also revealed Martha would benefit from home health nursing. Although the care managers would call frequently – sometimes daily – to check on Martha’s condition, the home health nurse also maintained constant communication with Group Health Associates’ care managers.

The team’s assessment of her need for social support led to contacting local community-based agencies that offered services Martha could use, such as making her home safer and a healthier environment and helping her with other resources.

Springdale care managers tracked Martha’s progress through their care management dashboard. Along with ensuring office visits are completed, the dashboard showed how frequently outreach occurred and when the next communication was scheduled. Any notes from the home care nurse were documented here as well.

Martha began to recognize that consistent monitoring was stabilizing her conditions, and the frequent check-ins helped her build new-found trust in her care team. She became engaged in contributing to her treatment plan and was willing to learn about better managing her symptoms. As Martha gained confidence that help would be available when she needed it, her trips to the ED decreased significantly and eventually stopped. Martha made no visits to the ED for more than a year.

*\*Name changed to protect patient privacy.*

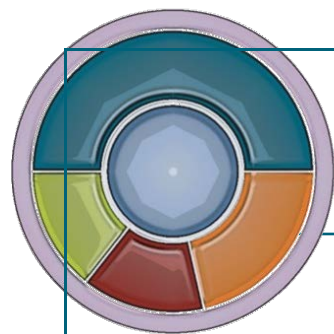
### Tenets from Springdale’s “It takes a village” strategy:

- Collaboration among multiple disciplines is essential.
- Clear and frequent communication among all team members keeps everyone on task.
- Care coordination is fundamental to the patient’s success.
- Patients return to the center of the care continuum when their barriers to treatment are addressed.



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# CPC Practice Spotlight 21

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

Sept. 12, 2014

This strategy addresses  
CPC Milestones 2, 5 and 7.

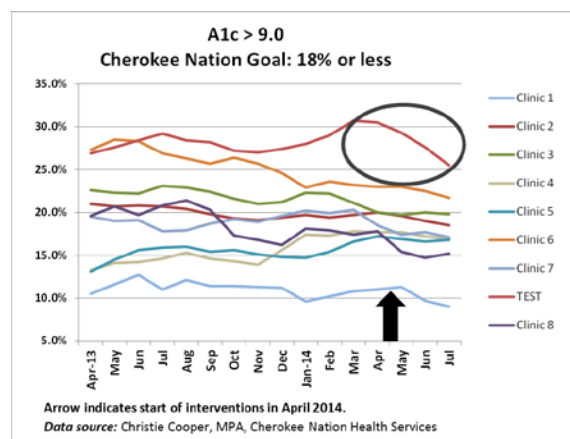
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Primary-Care-Initiative/](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/).

## Data-Driven Improvement Using Medication Management and Shared Decision Making with High-Risk Patients with Diabetes

*Cherokee Nation Health Services Wilma P. Mankiller Health Center, Stilwell, Oklahoma System; 3 physicians, 3 NPs; 2,500 patients*

**Situation:** Data from March 2014 showed more than 30% of Mankiller Health Center's patients with diabetes demonstrated poor glucose control with an HgbA1c >9. [Cherokee Nation Health Services](#) (CNHS) set a population management goal of 18% or less for HgbA1c >9. Among all CNHS clinics, Mankiller clinic was furthest out of range for meeting this goal.

**Strategy:** The target population for intervention was divided into for two groups of patients: first, those whose HgbA1c values were close to goal range and likely to improve with a lighter intervention, and second, those patients whose HgbA1c values were far out of goal range and would need intensive interventions to help them reach goal range. Starting in April 2014, Care Manager **Jill Eubanks, BSN, RN**, reached out to the first group of patients to assess their needs and schedule clinic visits for clinical management.



Concurrently, the care teams began working with CNHS CPC Nurse Consultant LCDR **Tara Ritter, DNP, MSN, RN, CDE**, to launch the system's intensive diabetes management education program at Mankiller for those patients at highest risk for adverse events related to very poor glucose control. They opted to deepen the existing curriculum by adding a full-time pharmacist for medication management and 1:1 patient education. By providing high-risk patients with individualized medication counseling, they believed this would encourage patient engagement with treatment and result in improved HgbA1c values.

During the ramp-up period **Travis Fleming, PharmD**, shadowed clinic operations and trained on the diabetes education curriculum. While clinic data pinpointed a pilot group of patients for this intervention, physicians also weighed in with their clinical knowledge of the patients' particular situation and condition that may affect their success with the intervention.

By late May, Fleming and Eubanks began scheduling 1:1 meetings with 10 patients. During these initial one-hour appointments, the pharmacist reviewed the patient's current medications and offered a [paper-based shared decision aid on diabetes medication choices](#). The goal was to help the patient make an informed selection of a regimen that best suited the patient's tolerance for side effects, fit well with the patient's lifestyle and in general would make it easiest for the patient to follow the suggested protocols. CNHS developed the decision aid, which aligns with the system's formulary, to ensure patients have timely access to affordable medications through the system's pharmacy. Fleming continued to meet 1:1 with patients as medications were adjusted and to support continued self-management with the medication regimen.

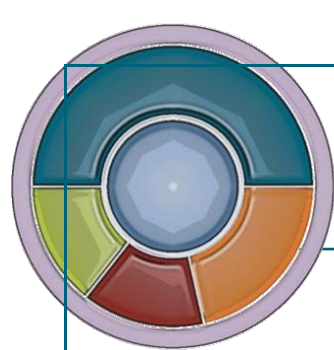
The pilot group expanded to about 20 patients once the care team had a better grasp of the process and workflows to make the medication management element work efficiently.

Within weeks of operationalizing both interventions, the data began to show improvement. The July 2014 data shows a decrease from 30% to 25% of patients with HgbA1c >9.



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# CPCPracticeSpotlight22

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

Sept. 19, 2014

This strategy addresses  
CPC Milestone 2.

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Primary-Care-Initiative/](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/).

## Heeding the Signs: Know When It's Time to Modify Your Risk Stratification Methodology

*Freeman Family Medicine, Conway, Arkansas*

*Independent; 2 physicians, 2 APRNs; 3,021 patients*

**Situation:** Nearly a year after **Freeman Family Medicine** completed risk stratifying its patients, the staff spotted some troubling trends. Fewer care plans were documented. Distribution of decision aids to eligible patients was down. Visits with patients with intensive needs were running over, causing longer wait times for other patients. Staff felt consistently pressured to make up time and yet weren't able to complete all assigned care management tasks. By spring 2014, it was clear a reassessment of the current workflow was needed.

**Strategy:** To identify opportunities for improvement, the team started by reviewing the schedule and patient flow. Three problem areas came to light: the highest level of the three-level risk stratification tool captured too many patients, patient encounter times needed some flexibility and, finally, the role of nurse practitioners could expand to better serve patients.

**Alexander Freeman, MD,** and **William Freeman, MD,** along with **Melissa Tyler, BSN, RN,** care manager, targeted the disproportionate load of high-risk patients in the risk stratification tool by adding a fourth "extreme high risk" category for patients with multiple uncontrolled chronic conditions. They also halved each risk strata into "15 minute" and "30 minute" groups, which indicated the time needed for appointments to address that patient's needs. For example, a patient with three or more chronic conditions is a high-risk patient, but if all conditions are controlled and with no recent hospitalizations, a 15-minute appointment may be sufficient rather than the longer 30-minute slot.

*Risk stratification is very individualized to each clinic. Don't be afraid to play with it and figure out what works best for your practice.*

— *Melissa Tyler, RN,  
Care Manager,  
Freeman Family Practice*

Appointments for patients with complex chronic issues would be assigned to physicians, and APRNs would see patients with acute needs and/or less complex health needs. This strategy allowed all providers to work to the top of their license.

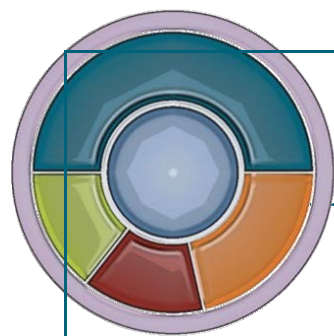
As patients were seen in the office, providers and nursing staff updated their risk scores, which appear in the EMR (Aprima) in a re-purposed existing data field. Providers can see the score in the top tool bar of the patient demographic screen, and it is visible when notes are open.

After restructuring the appointment times, the practice went live with the new scheduling method on August 1. The practice care manager reports that it was "decently smooth," with a couple hiccups around handling patients whose risk scores needed updating and selecting the appropriate length of visit for that patient.

Now a few weeks into the new process, Melissa says no significant rework has been needed. They continue to monitor effectiveness and efficiencies around completed care plans, distribution of decision aids and daily visit totals. During weekly staff meetings, everyone is encouraged to make suggestions and give feedback. Melissa points out that each staff role has a different view of the patients' needs, and when you engage everyone as changes are made, your team's overall approach is in sync.



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# CPCPracticeSpotlight23

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Sept. 26, 2014

This innovation addresses  
CPC Milestone 2.

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<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>.

## Blending Care Coordination with Wellness Counseling: Low-Cost, Low-Intensity Intervention Supports Preventive Care

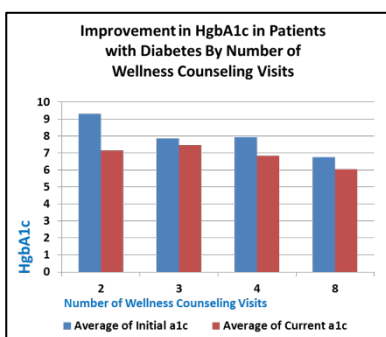
*Telluride Medical Center, Telluride, Colorado*

*Independent; 3 physicians, 2 PAs, 1 APRN; 4,792 patients*

**Situation:** Recognizing some patients are more willing to collaborate with their health care teams to actively improve their health, clinical leadership at **Telluride Medical Center** sought strategies to leverage this willingness to better support these patients as well as assist patients seeking help in self-management to prevent worsening conditions and to lower risk factors for disease. Located in far southwestern Colorado, Telluride is a seasonal resort community that permanent residents support through service-industry jobs. Because few community health care resources are available, patients frequently turn to this clinic for information and support for all of their health care needs.

**Innovation:** In March 2013, this practice began to explore wellness counseling as an additional care management strategy by creating two hybrid positions on the care management team to coordinate care and provide wellness counseling to patients with diabetes.

To identify patients who would most likely benefit from this enhanced care management, Telluride staff meet monthly to review charts of patients recently treated in the clinic. Ideal candidates for wellness counseling are patients who express to the PCP a willingness to improve their wellness management. With physician sign off, patients are referred to wellness counseling.



The care manager then calls patients to schedule the initial wellness counseling visit. During the two-hour intake appointment, the counselor educates patients on the condition(s) that qualified them for counseling, provides educational materials to take home and emphasizes the root causes and lifestyle changes needed to manage symptoms. Using motivational interviewing techniques the counselor works with the patient to build a care plan specific to the patient's goals, preferences and willingness to make changes. They discuss barriers to success and problem-solve together to

identify workable, sustainable solutions. They also create a schedule for ongoing follow-up sessions, which can vary from weekly, monthly or longer intervals, although most patients are seen monthly. Follow-up sessions occur in the clinic or by telephone and are scheduled in 60-minute blocks, during which the wellness counselor will review the patient's progress toward goals, take all vitals and review any new lab reports (based on patient's diagnosis), and update medication history. Caregivers and family members are welcome to participate with the patient in the counseling sessions.

As the clinic began to see success with patients with diabetes, services were expanded to include patients with changing health status, such as a new diagnosis of pre-diabetes, hypertension or weight reduction.

In June 2014, Telluride began to administer a [Patient Activation Measure \(PAM\)](#) at all initial wellness visits to further refine how the clinic identifies candidate for wellness counseling. This score along with the clinician's assessment is brought to the monthly care management meetings for evaluation for wellness counseling referrals.

### About the Patient Activation Measure:

This assesses patient's knowledge, skill and confidence for self-management. A clinical assessment of these abilities helps shape goals appropriate to the patient's level of activation. As patients gain success with initial goals, they build confidence and develop the skills they need for effective self-management.



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## CPCPracticeSpotlight23,continued

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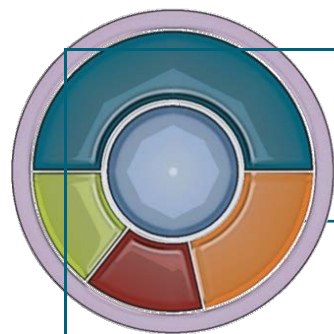
When the project began, a care manager and wellness counselors saw wellness patients on Thursdays. By August 2014, the practice PCPs' confidence in the effectiveness of counseling and their resulting increase in referrals pushed the need for counseling appointments to six days per month. Word-of-mouth referrals from satisfied patients also increased the requests for counseling appointments.

Generally, six patients are seen per day, but scheduling can flex from three to 10 patients, depending on visit length (initial intake versus follow-up visits). To date, 84 patients are enrolled in wellness counseling for a range of conditions and diagnoses, including irritable bowel disease, eating disorders and depression.

Practice data is showing consistent improvement across disease management in measures such as blood pressure, BMI, LDL and smoking cessation attempts. For example, one data point shows improved HgbA1c results over the series of counseling sessions (see graph above).

The practice charges \$25 (intake) and \$10 (follow up) per session, simply to prevent no shows. Only a small number of patients are paying for the counseling sessions, and that income returns to the general funds. Insurance has not reimbursed for visits. Patients who cannot pay are not billed. Funding for these positions stem partially from CPC funds, state funds and grant monies from a private community foundation called Tri County Health Network. Practice leadership sees such value in these positions that budgets have been adjusted to accommodate the services. They see a reduction in ED use and hospitalizations, but have no firm data at this time to directly correlate with participation in this program.

Ideal candidates for this hybrid role could be a registered nurse, registered dietitian, exercise physiologist or another discipline with a background in motivational interviewing and lifestyle management training.



# CPC Practice Spotlight 24

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

Oct. 3, 2014

This strategy addresses  
CPC Milestone 5, specifically  
Driver 3.2.

For more information about  
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Primary-Care-Initiative/](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/).

## How Your Approaches to Improvement Strategies Also Builds Your Culture for Improvement

*Utica Park Clinic, Tulsa, Oklahoma—Multi-Specialty (15 clinics); 131,000 patients*

**Situation:** When leadership at **Utica Park Clinic** sought to implement a quality improvement (QI) methodology across its 17 CPC sites, the team quickly discovered that the best results emerge from engaged staff members who are confident in the process and see their contribution to the outcomes.

**Strategy:** In the Q&A below, **Jeff Galles, DO, medical director**, and **Verda Weston, director of care management**, share some lessons learned from building a culture focused on improvement across its clinics.

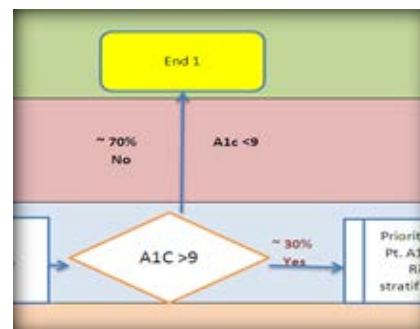
### Q: How did you engage teams in QI?

**A:** We discovered that collaboration is the core of moving ahead. Our strategy is to use the “power of positive regard,” meaning we are present in person, we listen and we reinforce the positive. Doing this removes resistance and defensiveness.

One example is when we pulled data to track timely HgbA1cs on patients with diabetes, the data had gaps despite the staff assuring us all values had been documented. Working together with staff across clinics, we found data had indeed been reported but in the wrong field. The cause for this variation stemmed from inconsistent training during onboarding of medical assistants.

We brought the data to a staff meeting, acknowledged the work that had been done and then opened the discussion on how to improve the process to support accurate documentation.

Involving them in the discussion built their ownership of the improvement process, from which a workflow refinement tool was created. Illustrated with screen shots, this quick reference guide is now in use across all clinics and in training. Our improvement in this measure can be partly attributed to the workflow refinement to accurately capture the work.



[Follow this link to see examples of Utica Park's process mapping and QI activities.](#)

### Q: Who do you engage at the beginning of an improvement project and why?

**A:** We brought in as many internal subject matter experts as available from the start. Harvesting institutional knowledge from our staff not only better informed our QI efforts, but it also validated our staff's valued input that shaped actionable, sustainable process improvements.

### Q: What projects are ideal for helping to shape your QI culture?

**A:** Success with smaller projects helped build acceptance and confidence from our staff. Once their expertise broadened, we moved on to more complex or challenging processes.

For example, Utica started one QI project focusing on improving HgbA1c rates among patients with diabetes. Our first attempt to reach patients was basic: We mailed a letter that invited them to enhanced diabetes education with a care coordinator. Only a couple of patients responded. What we found was that our letter was ineffective because we didn't tell patients it was a free service, and our letter looked like we were selling something. Our barriers were patient skepticism and lack of detail.

We decided we could be more effective if we reached out to patients while they were in the clinic. We added a step in the pre-visit work flow that would alert the care coordinator when eligible patients were scheduled for an appointment. The care coordinator would speak to the patients and invite them to the education session. This simple change proved very effective; the face-to-face invite was more influential, and the care coordinator could answer any questions immediately. Our enrollment went up considerably.

With that success under our belt, we started looking at other aspects of the diabetes care management program that could be enhanced through improved communication methods. Over the course of several iterations, we've added follow-up calls and more frequent contacts with patients to better support their care management.

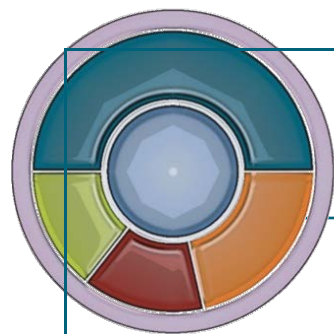
### Q: Any tips for other practices?

**A:** Celebrate and share. When we make the connection between our projects and a result that affected a patient's life, it is a powerful testimony to others on our team that they can make a difference that matters to those they serve.



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# CPCPracticeSpotlight25

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

Oct. 10, 2014

This strategy addresses  
CPC Milestone 4.

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Primary-Care-Initiative/](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/).

## One-Two Combination of Surveys and PFAC Guide This Practice's Implementation of Patient-Centered Changes

*Springfield Center for Family Medicine, Springfield, Ohio  
Independent; 7 physicians, 1 PA, 1 APRN; 7,600 patients*

**Situation:** The time commitment to administer and tally surveys made the staff at **Springfield Center for Family Medicine** reluctant to pursue this option for Milestone 4 and thus opted to convene a Patient and Family Advisory Council (PFAC) in June 2013. However, the practice's physician champion urged them to attempt **both** options to gain the most insight into the practice's ability to engage patients and meet their needs while informing practice improvements.

**Strategy:** By using survey findings to guide the PFAC meeting agendas, Springfield's two-pronged approach brings to light the "what" as well as the "why" of changes patients would like to see in the practice.

Two months before a quarterly PFAC meeting, the practice surveys patients over a one-week period, gathering about 300 responses. Front desk staff distributes the surveys as patients check in, and patients turn them in at check out. The lead-time allows staff the necessary time to administer the surveys, tally results in a spreadsheet and graph them to present to the physicians and staff. The staff's comments and feedback, along with the survey results, build the list of topics for the PFAC to address in the upcoming meeting.

The PFAC meets over lunch at one end of the practice's waiting room, near a large sign announcing the PFAC meeting. The sign often prompts interest from other patients. PFAC information and invitation to join is also posted to the practice bulletin boards.

Six to eight patients participate in the PFAC, which comprises a diverse mix of new and long-standing patients with a range of medical needs. Patients are encouraged to participate for one year, and then the practice builds a new list of candidates based on physician and staff nominations, patients selected from the empanelment lists and those who express interest in joining the PFAC.

Practice staff rotates attendance at the meetings; along with the office manager and PFAC coordinator there is staff representation from providers, reception area, billing department and clinical support at all meetings. An unexpected benefit of staff attending these meetings has been the interpersonal rapport they have built with participants. It enhances their understanding of the importance of customer service, especially for patients who call the practice when they are unwell. Gaining this new perspective has improved staff ability to manage their stress level when caring for patients who are not always courteous due to their acute health issues.

To date, survey results have largely driven Springfield's PFAC agendas. For example, patient wait times emerged as a concern in the surveys, and the PFAC's guidance helped create a new policy that staff will communicate with and update patients who have been waiting for 15 minutes beyond their appointment time. If the appointment is running late around lunch, patients are offered a light snack or drink to help keep them comfortable. Complaints about the practice's phone tree were discussed at length, with the practice modifying the system based on the PFAC's recommendations.

The PFAC also independently raises improvement ideas the practice has taken under consideration, such as installing a diaper changing station in the restroom, a suggestion box in the lobby and a beverage table in the waiting room as well as starting a patient mentoring program to further support care management.

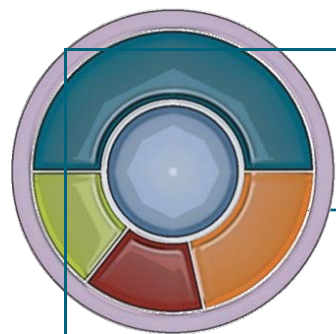


*Springfield Center for Family  
Medicine invites all patients to  
join in its PFAC with posters like  
this posted in the practice. [Click  
through here to see a sample  
meeting agenda.](#)*



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# CPCPracticeSpotlight26

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

Oct. 17, 2014

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## Digging Deeper Into Your Risk Stratification: Prevention and CM Opportunities for Patients at Moderate Risk

*Hurley Avenue Family Medicine, Kingston, NY — Independent; 5 physicians, 1 PA; 5,500 patients*

**Situation:** Like many CPC practices, **Hurley Avenue Family Medicine** stratified its patients with the six-level [AAFP risk stratification model](#). Levels 5 and 6 capture the highest risk patients who require intensive care management (CM); these levels represent about 2 percent of this practice's patients. In this practice, level 4 encompasses about 12 percent of patients and reflects difficulty with disease or condition management but no significant complications or adverse outcomes.

**Strategy:** Thinking of the patients in the fourth risk level as a “long-term investment” toward improved health outcomes and prevention, the practice invites them to meet with a care manager as part of the patient's newly expanded primary care team.

During weekly meetings, providers and CM staff identify patients who would benefit from an introduction to care management, not because they are high risk, but to prevent complication that could lead to them entering the high risk category. Patients who express to their provider, a willingness to improve their health status are also considered. Providers reassess patients' health risk at every encounter, and patients newly assigned to level 4 or above are candidates for CM.

The invitation is made during an office visit or with a follow-up letter mailed to the patient's home. A [flyer describing the no-cost CM service and its benefits](#) accompanies the letter, along with any pertinent patient education materials.

While patients in the level 4 risk category may not need intensive CM like higher risk patients, this early introduction to a care manager serves two purposes.

First, it initiates the relationship before the patient experiences a change in health status. Practice Manager **Jennifer Hamilton** notes that establishing a rapport can be challenging as some patients are reluctant to meet with a care manager, not seeing the need or understanding the benefit. She says that persistence pays off, and once patients recognize how the care manager supports improving their health, they come around.

Second, pre-emptive meetings with a care manager offer additional education and self-management coaching opportunities for these patients who have a higher risk of complications. Working with patients before their health worsens and helping them maintain or improve their health status heightens the patients' awareness of prevention and further engages them as active participants in their care. Patients learn to watch for changing conditions and symptoms that warrant a call to their primary care office, rather than unknowingly allowing a situation to worsen and result in an emergency room visit or hospitalization.

Readmissions data for Hurley Avenue shows CM and other improvement activities are contributing to a marked decline in readmissions rates.

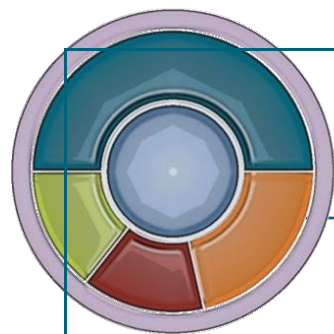
This early CM connection facilitated care for a patient at risk level 4 who underwent an orthopedic surgery in September. Because the care manager was familiar with the patient's usual ability to manage her medications and daily activities, during the post-discharge follow-up call, she easily detected signs the patient couldn't manage her pain and was a fall risk, both of which made the patient hesitant to leave home for necessary follow-up care. The care manager contacted the orthopedic surgeon's office for a referral for home care physical therapy and skilled nursing visits to oversee medications. She also spotted and quickly reconciled medication discrepancies between the discharge instructions and summary. The home care allowed the patient to regain her strength and lessen her fall risk. Now, the patient expects to be able to resume her regular activities and self-care in the usual recovery time frame.



*Hurley Avenue Family  
Practice care managers  
(from top): Donna Ranieri,  
RN, CCM, and Ruth  
Mandelbaum, MSN, RN,  
CHPN*



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# CPCPracticeSpotlight27

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

**Oct. 31, 2014**

**This strategy addresses  
CPC Milestones 2 and 6.**

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## **RN Care Coordinators as Diabetes Educators: Expanding Patient-Centered Disease Management Support**

*Corvallis Clinic, Corvallis, Oregon*

*Multi-Specialty (3 CPC sites); 20 physicians, 17 PAs, 1 APRN; 21,747 patients*

**Situation:** In early 2014, the **Corvallis Clinic** team was looking for evidence-based strategies that would further enhance care coordination with measurable patient outcomes to address the rising clinical need for improving diabetes care.

**Strategy:** The Clinic saw an opportunity to merge existing staff resources by assigning two RNs with an endocrinology background as care coordinators. Of adult patients seen at Corvallis in the past 24 months, nearly 7,000 or 30%\* have a diagnosis of Type 1 diabetes, pre-diabetes, Type 2 or gestational diabetes. Plans to integrate diabetes self-management education (DSME) and support with care coordination services began in spring 2014. This effort included clinical team members, IT staff, billing and marketing among others to shape an evidence-based, outcomes-oriented and patient-centered program that could be ultimately sustained as a billable service.

The provision of DSME and support to clinic patients by RN care coordinators also offers a fortuitous overlap of experience, skills and resources that greatly benefit the patient with a new diabetes diagnosis. By expertly navigating insurance formularies, medication promotions and local resources for patient financial assistance, Corvallis' care coordinators can address medication issues and behavioral health needs that frequently hamper patients' success. Corvallis has integrated behavioral health into clinic services; care coordinators can screen patients and quickly connect them to appropriate services.



*Left to right: Erin Bartek, BSN, RN, CDE; Lindsay Bromley, MD, endocrinology; and Lindsay Rickli, BSN, RN*

Further, these care coordinators' familiarity with diabetes care management and established working relationships with Corvallis providers increases their efficiency and effectiveness. In their dual roles as educator and coordinator, they are able to provide continuity in care that strongly supports successful care management and increased patient engagement.

Care coordinators **Erin Bartek, BSN, RN, CDE**, and **Lindsay Rickli, BSN, RN**, developed the infrastructure, measurement and clinical processes for the new program with support from their leadership team: endocrinologist **Lindsay Bromley, MD**; medical director **Dennis Regan, MD**; and **Charlene Yager, BSN, RN**, director of clinical services.

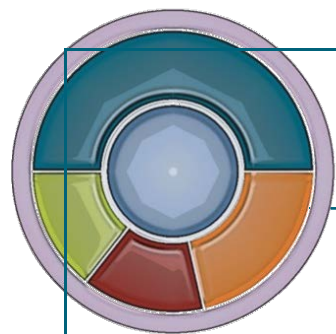
Working with IT, the clinical team designed EMR interfaces for DSME referrals. At this time, referrals stem from hospital discharge diagnosis and providers' identification of patients who need diabetes self-management education and support to achieve their health goals. Looking ahead, the team would like to mine data reports to identify patients and automate the referrals.

To bill for diabetes education, providers must follow [a curriculum recognized by the American Diabetes Association \(ADA\)](#). Corvallis chose the [International Diabetes Center's BASICS curriculum](#), which allows interdisciplinary participation and can flex from 1:1 education to group settings. It also aligned with Corvallis' preference for an evidence-based curriculum with an emphasis on patient centeredness and overall improved patient health. The curriculum includes patient feedback mechanisms to help evaluate progress and care coordinators began seeing patients this summer while in CDE training. So far, about 20 patients are enrolled in the program. Future plans are to train a registered dietitian as a CDE, expand patient access by implementing group classes and track effectiveness through patient satisfaction surveys and health outcomes.

*\*This number does not include patients with diabetes who were seen by specialist only.*



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# CPCPracticeSpotlight28

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

Nov. 7, 2014

This strategy addresses  
CPC Milestones 2 and 6.

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Primary-Care-Initiative/](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/).

## It Takes a Neighborhood to Increase Medication Safety for Patients

*Saline Med Peds, Benton, Ark. — Independent; 1 full-time and 3 part-time physicians; 2,400 patients*

**Situation:** Patients whose health status qualifies them as a high-risk patient often struggle with their complex medication regimens. They are especially vulnerable to medication errors when new prescriptions are issued after an emergency room visit, hospitalization or other transition in health care setting.

**Strategy:** Attempting to close gaps in the medical neighborhood, **Saline Med Peds** has collaborated with key health care partners in the community to make medication information easily accessible, and the practice arms patients with up-to-date medication information at each appointment.

First, **Mark Martindale, MD**, and **Cindy Martindale, RPh**, reached out to key community health care partners. The practice met with community pharmacists to propose establishing informal care compacts based on a short list of practice needs. Two local pharmacies agreed to collaborate with the practice. Both offer delivery, and one is a compounding pharmacy. In the agreement, the practice provides these pharmacists the practice providers' cell phone numbers. Cindy reports that she only occasionally receives calls from the pharmacists and to date the relationship has benefitted patients with enhanced service and lower costs. Patient feedback affirms they are seeing more attention to their medication needs and expenses.

Another mechanism the practice uses to make information accessible is to share an EHR interface with the local community hospital, which can then access the practice's medication lists. The practice pharmacist also sends lists and coordinates information with an assisted living facility in the community.

Second, patients are reminded before, during and after appointments about updating medication lists. Before patients' appointments, Cindy reviews their medical record for recent hospital discharges or specialist notes that indicate medication changes. She flags records where a consult is needed.

When staff makes appointment reminder calls, they ask patients with a flagged record to bring in all medications and supplements they are currently taking plus their current medication list for Cindy to review.

To help patients remember their medications, all medication management patients are given a brightly colored insulated tote bag purchased with CPC funds. Patients like that the bag has a handle and zips closed; it's sturdy, easy to carry and won't spill its contents. While each bag cost less than \$3, these "special bags" effectively convey the importance of bringing medications to office visits.

During scheduled clinic visits, Cindy meets with patients and reviews all current medications, answers questions and makes any necessary adjustments. She documents the outcome of the medication reconciliation in the patient's chart prior to the patient's visit with the physician.

Transitions in care from various facilities often results in patients filling the same medications in varying forms. Case in point: A patient arrived at the office for a post-discharge follow-up appointment carrying three plastic grocery sacks filled with pill bottles. Following a recent hospital discharge, she promptly filled her new prescriptions, but her deteriorating condition led to a readmission within hours. Upon the second discharge, she went directly to a rehab facility, which then issued a new set of prescriptions upon discharge, based on the facility's available formulary. At her follow-up appointment, the patient had three sets of medications: those she took before her hospitalization, the hospital-prescribed medications and medications prescribed at the rehab facility. Among the medications were two different statins and one drug the patient was having an allergic reaction to. The patient had no idea what to do. Over the course of an hour, Cindy sorted out the patient's medications, eliminating duplicates, switching to less expensive options, adjusting dosages and educating the patient on the updated regimen.

At the end of the visit, Cindy provided the patient an updated medication list. She instructed this patient, as she does all patients, to share the list with her other health care providers. If the other providers make changes, the patient is asked to bring the updated list to subsequent appointments at Saline Med Peds. This action is then documented in the EHR.

Practices building collaboration agreements in their medical neighborhoods may want to consider two of Saline Med Peds' successful tactics: look beyond physician practices for partners and involve patients as communications liaison among providers.



*Medication management patients bring these bags to appointments.*



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# CPCPracticeSpotlight29

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

Nov. 14, 2014

This strategy addresses  
CPC Milestone 6.

For more information  
about the CPC initiative,  
visit  
[http://innovation.cms.gov/  
v/  
initiatives/Comprehensiv  
e-Primary-Care-  
Initiative/](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/).

## Care Compacts Can Work with Various Health Partners

*Springfield Health Care Center, Springfield, Ohio — Independent; 3 physicians; 3,600 patients*

**Situation:** In April 2013, as **Care Manager Kim Blackburn, LPN**, completed hospitalization/discharge follow-up calls with patients from **Springfield Health Care Center (SHCC)**, she spotted multiple readmissions risks that were preventable by way of bi-directional communication among the providers and with SHCC.

**Strategy:** With support of the practice physicians, Kim set up group face-to-face meetings with leadership from local hospitals, home health agencies (HHAs) and extended care facilities (ECFs) to jump start conversations about collaborative agreements. Her intent was to engage providers as they cared for patients at critical points of transitions in care, emphasizing the process was two-way and would focus on identifying urgent patient care needs among newly discharged patients.

At these meetings, Kim shared examples of how her discharge follow-up calls revealed significant risk for readmission and preventable harm, such as issues in post-acute care for “Betty” (name changed to protect patient privacy), a SHCC patient who had been recently hospitalized. Betty went without her medications for a week after discharged from the hospital. Betty was hospitalized on an acute-care floor, and then transferred to the hospital’s rehab unit prior to being discharged home, all without notification of her primary care provider at SHCC. Betty complained to Kim that she could not find her medications. As Kim unraveled the story, she found that the patient gave her medications to the hospital upon admission; however, she left the rehab unit without them. Despite an interim visit from a home health nurse, the medications had not been located, reconciled or filled, including a new prescription for a blood thinner. As the clinic’s care manager, Kim’s established relationships with the PCP, lab and pharmacy enabled her to resolve these issues quickly before Betty experienced any complications.

This patient story clearly demonstrated how establishing collaborative agreements could meet the objective of reducing harm and cost by bridging seams of care for patients as they transition between settings and providers. Over time, the group created a robust list of needs and expectations while also managing to help each other create solutions for recurring problems. For example, Kim designed a one-page admissions notification for discharge planners at ECFs. It alerts them that a SHCC patient has been admitted to their facility, identifies the patient’s PCP and requests a discharge medication list and other instructions be faxed to SHCC *before* the patient goes home.

To prevent a situation like Betty’s, SHCC emphasizes medication issues in its agreements. Its agreement with an ECF specifies that patients go home with at least a seven-day supply of medications; in turn, SHCC agrees to see the patient within seven days of discharge. In the agreement with an HHA, the agency commits to initiate start of care within 24 hours of hospital discharge and to call SHCC during the first home visit to reconcile medications. SHCC has specific time periods for medication reconciliation phone calls to eliminate phone tag.

By fall 2014, the community partners agreed to terms in writing, which were signed in September 2014.

Springfield-area providers acknowledge these agreements have effectively streamlined two-way communication in patients’ post-acute care. One hospital is now approaching other physician practices and facilities about forming collaboration agreements using the template developed with SHCC. Other providers have contacted SHCC for guidance on how to get started with collaborative agreements.

SHCC is tracking all ER and inpatient encounters, noting discharge dates and when SHCC makes follow-up contact. Last quarter, more 59 of 60 patients were contacted and provided with transitional care within 48 hours. This success rate is largely attributable to the bi-directional communication agreement in the care compacts, which facilitates timely outreach.



Care Manager Kim Blackburn, LPN,  
pictured here with Vipul K. Patel, MD.



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# CPCPracticeSpotlight30

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

## Full HIE Access Facilitates Real-Time Care Management

*Internal Medicine Associates of the Grand Valley, Grand Junction, Colorado System (affiliation as of Dec. 2013); 4 physicians; 4,500 patients*

**Situation:** Like 80 percent of the medical providers in western Colorado, **Internal Medicine Associates (IMA)** accesses a health information exchange (HIE) for notification and tracking of the practice's hospitalized patients. Administered through Quality Health Network (QHN), the HIE allows physician subscribers direct access to all patients' information with real-time status updates through its data repository.

However, non-physician clinical staffers have more limited access. For example, a nurse care manager may only view information pertaining to her provider's patients, and not all practice patients admitted by a specialist or surgeon. Additionally, non-physicians cannot access daily admissions updates until a physician reviews and transfers them to the patients' medical records within the practice.

**Innovation:** With support from the practice's physician champion, **Donald Maier, MD, FACP**, IMA petitioned QHN in November 2012 to grant full repository access to the practice's care manager, **Kirsten Wiegert, BSN, RN**. IMA's rationale was that real-time, daily access to the QHN data repository by a qualified nurse care manager facilitates proactive team-based care management. Further, coordination at times of transition is instrumental to patient safety and continuity of care.

In January 2013, QHN granted Wiegert repository access for her care management work, but a volume of similar requests from subscribers prompted QHN to re-evaluate its access policies. In April 2014 QHN updated its policies for repository data access for care teams of QHN participating physician providers, who agree to assume responsibility for monitoring the care team members' appropriate usage.

Wiegert's repository access is filtered to specific streams of information: emergency department registrations, admissions and discharge reports. Working across two monitors, she displays the repository dashboard beside the practice and hospital EHR dashboards. As she sifts through QHN notifications throughout the day, she can see when patients are admitted and for what reasons. If patients transfer from the ED to observation or are admitted, this notification also crosses her dashboard. Typically she sees eight to 10 admissions and five to seven ER visits in a 24-hour period.

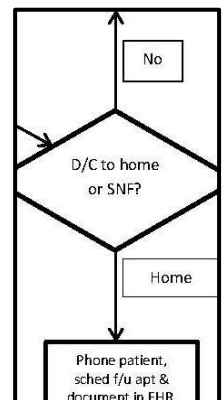
Each morning, she reviews inpatient and ED charts from the previous 24 hours. She reviews labs, imaging and EKG reports, as well as nursing, therapy and consultation notes as appropriate. Wiegert relays pertinent information to practice physicians to keep them abreast of patient conditions.

For one patient with a lengthy and complex hospital stay involving multiple specialties, IMA's consistent monitoring eased his transition to home with an appropriate care plan. The patient's family understood the patient was terminally ill but misunderstood the purpose of a palliative care consultation in the hospital. When they sought clarification from IMA, the physician was ready to explain the situation and provide appropriate care planning because Wiegert had already passed along salient points from the notes.

A second, parallel effort to improve continuity of care involved collaborating with hospitalists. Dr. Maier and Wiegert met with hospital and physician leadership in 2012 to build partnerships that improve patients' transitions and ongoing needs. Wiegert attended hospitalist staff meetings to introduce herself, discuss her acute care experience and answer their questions. A similar meeting took place at a smaller hospital a few months later to explore how the practice's physicians could best make social rounds on admitted patients, which resulted in a collaborative agreement. IMA found hospitalists too are increasingly concerned with reducing avoidable readmissions, and many were interested in learning more about IMA's approach.

Hospitalists now routinely contact Wiegert as patients are discharged to discuss follow-up needs, any pending tests or to review medication changes. If the patient is in the practice's highest risk strata, Wiegert generally makes a follow-up call within 24 hours. Lower-risk patients are assigned to trained MAs for follow-up. IMA's post-discharge follow-up was 100% for the first two quarters of 2014. From quarter 2 to quarter 3, the practice's ED follow-up improved from 59.37% to 76.75%, an improvement Wiegert attributes to closing gaps in processes.

Clearly the increased requests for expanded HIE access shows care coordination is of rising importance in this medical neighborhood. Until the care team is the mainstream model for care delivery, Wiegert points to developing relationships with acute care facilities as a key to IMA's care management success.



[Learn more about IMA's workflow for inpatient discharge follow-up.](#)

Nov. 21, 2014

This innovation addresses CPC Milestones 2, 6 and 9, and these Change Package Drivers:

- 1.1: Access and Continuity
- 1.3: Risk-Stratified Care Management
- 1.5: Coordination of Care Across the Medical Neighborhood
- 4.2: Data Exchange
- 5.1: Engaged Community

For more information about the CPC initiative, visit

<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>.



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# CPCPracticeSpotlight31

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

Dec. 5, 2014

This innovation addresses  
**CPC Change Driver 3: Continuous Improvement Driven by Data**

- 3.1: Internal Measurement and Review
- 3.2: Culture of Improvement

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

## Building a Transformative Culture to Sustain Change

*Providence Medical Group, Dayton, Ohio*

*Multi-Specialty; 13 physicians, 3 PAs, 3 APRNs; 27,198 patients*

**Situation:** With nine CPC practices, **Providence Medical Group (PMG)** encompasses 39 office sites spread across 14 cities in the Dayton area. PMG is committed to positive, transformational health care and, like most health care settings, is experiencing rapid, frequent change. To stave off “change fatigue,” PMG has sought ways to cultivate engagement, sustain staff morale and further build a culture focused on continual improvement.

**Innovation:** PMG leadership has committed to a cohesive approach that supports transformation in the CPC practices and weaves innovation through all practice sites. They use elements of consensus-driven change to engage staff and drive healthy competition toward excellence through transparency. These efforts are clearly evident in how PMG participates in the **CPC learning community**, the focused practice transformation work the group pursues in quarterly **staff retreats** and how **care coordinators** serve as resources for both patients and staff.

**Learning with CPC.** PMG encourages CPC practices to participate in three CPC learning events monthly. Clinical leaders participate in additional events and then share their insights with their practices. By integrating CPC information throughout all PMG practices, it generates discussion across disciplines, eliciting a range of perspectives. This fosters camaraderie and empathy among all levels of staff, lifting morale and re-igniting focus. As they undertake new processes, everyone speaks “CPC” and can frame the endeavors as the big picture of sustaining comprehensive primary care rather than simply attempting a stand-alone QI project.

**Quarterly staff retreats.** PMG hosts a group-wide, off-site evening retreat for all providers, site supervisors, care coordinators/navigators and their support staff. Free from the distractions of daily work, attendance is robust, averaging of 100 participants. The agenda blends presentations and interactive learning opportunities with a focus on celebrating successes, reviewing data, developing workflows, brainstorming solutions and sharing information.

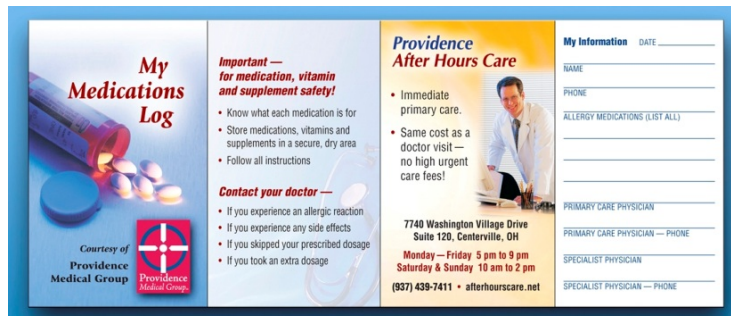
CPC-related work is consistently highlighted at these retreats, again engaging non-CPC practices to take away best practices. A recent meeting focused on “deep dives” into care management and shared decision making, with breakout groups comprising a mix of disciplines and practice sites to brainstorm ideas. After each group proposed tactics, everyone voted, and they chose these strategies for implementation across all PMG sites: a new workflow for

colorectal cancer screenings, wallet-sized medication cards for patients, improvements to the community services resource list and developing relationships across the medical neighborhood.

Following the meeting PMG sent supporting resources and additional information to all practice sites to expedite implementation. Additionally, staff from each office who attended the retreat became on-site change agents for the tactics. They could speak to the details with their peers, answering questions and providing background. The wrap-around of resources, information and a peer contact are confidence-builders for staff.

**Care coordinators.** The care coordinator often centers the care team, connecting information, people and resources for staff and patients alike. While they work within each practice site, they also meet weekly as a group, forming a natural hub for sharing information and building cross-team relationships. Care coordinators also mentor their counterparts at non-CPC practices (care navigators), offering support and guidance as needed.

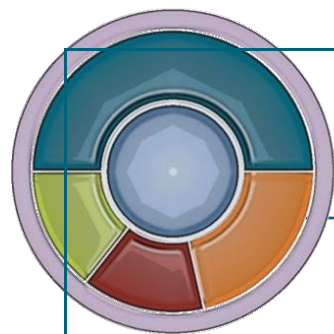
**How does PMG know these approaches are working?** While they track gains in clinical quality measures, the practice also checks in with PMG staff in semi-annual surveys. Another indicator that has been gratifying for the staff is the increased positive patient feedback. The care coordination supervisor believes patients see and experience PMG’s commitment to transformation and quality by way of an empowered and knowledgeable staff. Across all disciplines, PMG providers know their expertise contributes to not only to improved patient outcomes but also enhances the patients’ satisfaction with the care they receive.



*This medication wallet card is an example of one strategy that emerged from PMG’s multi-disciplinary staff retreat.*



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# CPCPracticeSpotlight32

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

Dec. 12, 2014

This Spotlight  
addresses

CPC Milestones 2 and 3.

For more information  
about the CPC initiative,  
visit

[http://innovation.cms.gov/  
initiatives/Comprehensive-Primary-Care-Initiative/](http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/).

## CPC Milestones 2 and 3: They Changed How We Work

Princeton Medicine, Plainsboro, New Jersey —Multi-Specialty

**Tobe M. Fisch, MD, PhD, Director of Practice Innovation, Princeton Medicine, shared her thoughts on her practice's CPC work on the Oct. 22, 2014, national webinar, "CPC at the Pivot Point: Looking Ahead to PY 2015." A video of her presentation is posted [here](#).**

I was asked to give a brief reflection on how the CPC Milestones have affected our practice. I can say that the Milestones unquestionably have had a deep and lasting influence on the way we practice and structure patient care. While all the Milestones have made their mark in some way, I'm going to focus on the two Milestones that have had the most profound impact for us, Milestones 2 and 3.

The risk stratification elements of Milestone 2 fundamentally changed the way we approach patient care, away from an individual to a more population health-oriented approach. When CPC first began, for the first time, we formally identified a cohort of very high and high-risk patients and over the past two years, we have followed that cohort carefully, revising and refining our high-risk list on an ongoing basis.

So we now have a very good grasp of who our higher risk patients are and what their care needs are. In the past year, we extended our risk stratification down yet another three levels, encompassing all primary care patients in the practice, but we still continue to focus on the higher risk patients. And to meet the needs of this cohort, we introduced the concept of care coordination and a team-based approach to care. Our team consists of physicians, a geriatric nurse practitioner, two RN nursing care coordinators, a social worker, a data entry specialist, and most recently, a behavioral health nurse practitioner. While this was all very new for us just two years ago, we now can't imagine how we ever got along without our nursing care coordinators. They meet with patients and their families, make regular check-in phone calls, and generally are a tremendous resource for all aspects of care. They help anticipate problems before they occur, and after they occur, they call every patient who has had an ER visit or an admission to help facilitate follow-up care. Keeping close track of our high-risk patients in this way has enabled us to decrease their number of ER visits and admission rates for ambulatory care sensitive conditions.

The integration of behavioral health has been a big, positive transformation for our practice. Bringing on our behavioral health nurse practitioner uncovered a huge need for her services. Since last spring, she has seen several hundred patients at our practice site alone. She regularly follows a subset of these patients and has referred others on to community practitioners and resources in the community.

Milestone 3 has also transformed our practice. Because of this Milestone, along with Stage 2 Meaningful Use requirements, we have adopted secure electronic two-way patient provider communication, on a much shorter timescale than we ever would have done otherwise. Over the spring and summer of 2014, we rolled out secure messaging with patients via our patient portal, which is sponsored by our health care system's health information exchange platform.

Primary care providers and specialists alike in our practice can now exchange secure messages with patients addressing health-related issues and explaining test results, which are also posted on the portal. We get lots of messages every day. Patients can also communicate back and forth with our nurses via this portal. They can request prescription refills and appointments, as well as addressing clinical questions. We have found that this greatly facilitates care by eliminating the middle man and freeing us of telephone tag and time constraints. The patients love it as well.

We can use this as a way of efficient, daily quick check-ins on our active higher risk patients who use the portal or with family members who share access. This CPC-inspired change has permanently transformed the way we care not only for high-risk patients but for all patients in our practice.

In the coming year, we look forward to building on the foundation that we have established for Milestones 2 and 3. Our goals for the near future include getting more sophisticated data analytics tools that will run off a data warehouse extracted from our EHR database. We want to be able to revise our risk stratification in a much more dynamic and less manual and labor-intensive way than we've been doing so far. We will be making, therefore, a significant investment in population health software that includes algorithm-based risk stratification tools and a care management tool for following risk stratified populations. We are really excited to begin using these tools and we hope then to be able to extend our care management services out to the next level of the population at "pre-high-risk," before they cross the line into the higher risk category.

So in summary, in 2015, we are looking forward to continued practice transformation in accordance with the CPC Milestones, extending our successes and improving our processes in other areas that we find the most challenging.



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# CPCPracticeSpotlight33

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

Dec. 19, 2014

This strategy addresses  
**CPC Change Driver 1:**  
**Comprehensive**  
**Primary Care Functions**

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.4: Patient and Care Giver Engagement

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

## Check for Literacy When Evaluating Patient Self-Management Skills

*Warren Clinic – Jenks office, Jenks, Oklahoma; system affiliation; 3 physicians, 1 RN; 4,500 patients*

**Situation:** In April 2014, a Jenks physician asked Patient Care Manager **Sherry Fisher, BSN, RN**, to help “Sam” (patient name changed to protect privacy) with his diabetes self-management skills. “Fired” by his previous physician, Sam struggled with proper insulin dosing and, consequently, his HgbA1c was hovering around 10. During Sam’s office visit, the physician observed Sam was reluctant to answer questions, did not bring in his insulin logs and would not engage with the physician. Frustrated by Sam’s behavior and out of concern for the patient’s health, the physician reached out to Sherry for assistance.

When Sherry met with Sam, she began by asking him how he measured his Novolog (insulin) units. Sam shrugged off the question with a vague “whatever I need” type of response. Then she picked up a Novolog pen to set the number of units, which prompted him to remark, “Oh, the *orange* one. Do you mean the number of *clicks*?”

Sam’s remark reminded Sherry of her experiences when she had worked as a school nurse with elementary-age children. This prompted her realization that Sam could not read.

**Strategy:** Sherry altered a Novolog chart with icons and color-coding for Sam. She delivered the new charts to his house, where she sat down with him to explain how he would track his insulin use.

Not only could he “teach back” the color coding to her, he did so with an enthusiastic grin. “I understand now,” he told her. “I take the green one at night and the orange one with meals.”

Sam was due for a follow-up in 30 days, but he showed up at the Jenks office two weeks later. Proudly, he handed over completed insulin logs, and more importantly, he had questions about how to take care of himself. Between his monthly appointments, Sam would call the office weekly to check-in with Sherry. Three months later, not only had Sam’s A1c improved to 7.3, but he joined the practice’s Patient and Family Advisory Council.

Looking back, Sherry could identify several earlier cues that showed Sam needed help with written materials. When Sam first came to the practice, he always brought his wife, who completed his paperwork. When she fell ill and could not attend his visits, he would tell the staff that he had forgotten his glasses and asked them to fill out any forms. Sam would not bring in his insulin logs, and he did not ask questions or engage with providers, often deflecting with humor or changing the subject.

To help identify and better engage patients with low literacy, the Jenks clinic cross-trained staff to recognize signs that patients may need assistance. Asking to take home their paperwork, having difficulty following directions for taking medications, or like Sam, consistently “forgetting” their glasses may be signs of possible low literacy. Now trained to recognize low literacy, the staff volunteer to help these patients with their paperwork and they flag the patient’s record so other staff knows to alter their teaching styles accordingly.

When teaching self-management to patients, Sherry will ask, “What is the best way for you to learn new things? Watching TV? Reading about it on the internet?” Patients who learn from watching may need more help with written materials. If your office is producing new materials, Sherry suggests asking a third or fourth grader to read and explain the content so that you can be sure the content is understandable at that reading level.

Lastly, Sherry emphasizes that her goal is always to provide every patient the “utmost care with the utmost dignity.” It is important to remember that patients frequently hide their struggles with understanding materials and directions because they are ashamed. Reaching out to patients in a way that respects their dignity and contributions opens opportunities for effective and collaborative engagement.

0 – 149 = 0	
Novolog (orange)	150 – 200 = 3 unit
	201 – 250 = 6 units
	251 – 300 = 9 units
	301 – 350 = 12 units
	351 – 400 = 15 units
	Over 400 call the office
Lunch Blood Sugar	Supper Blood Sugar
Novolog	Novolog

*This thumbnail image shows how Sherry Fisher modified this patient tool to improve Sam’s management of his insulin. She color-coded the categories and added simple icons to indicate time of day. Within three months of using this tool, her patient’s A1c dropped from 10.5 to 7.3. This tool is posted [here](#).*



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