CPC
Comprehensive Primary Care

An Initiative of the Center for Medicare & Medicaid Innovation

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

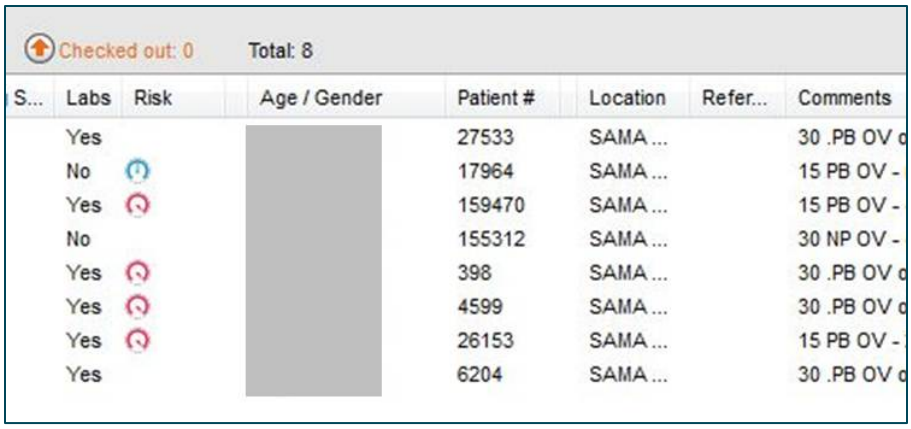
Through its work with CPC, SAMA formed care management and care teams, who drive proactive preventive care for the practice's approximately 19,000 patients. **Risk stratification** is among the core functions of the new care team.

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."

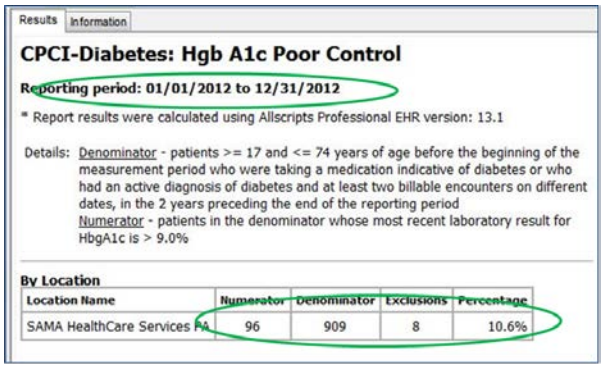
SAMA turned on Allscripts' Clinical Decision Support features, which alerts the care team to missing screenings or lab work and checks health maintenance measures. Occasionally gaps are rectified when results are re-entered in the discrete fields, but when screenings are needed, the coordinator asks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

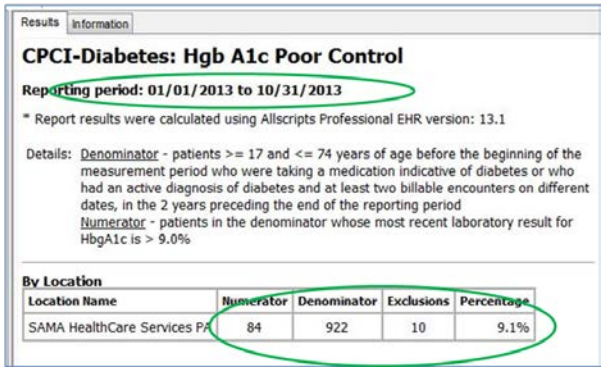
Using the recent Allscripts stratification product release and combined with the AAFP Risk Stratification Tool, the coordinator flags the patient record prior to the appointment. The coordinator assigns a high risk (red) flag if the patient has complications of a major diagnosis (diabetes, HTN, COPD,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



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. Bevill. "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. Bevill.

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. Bevill. "My patients are way better off with this new system." *(See screenshots.)*

Dr. Bevill 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."

TMF Health Quality Institute

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