Secondary Driver 1.2: Planned Care and Population Health

This secondary driver focuses on using a team to support patients in learning self-management of their chronic health conditions, and being organized and proactive in providing routine and preventive care for all patients assigned to a provider or team.

Change Concepts for planned care and population health

- Team-based care
- Proactive management of chronic and preventive care
- Self-management support

Planned Care and Population Health

Before moving forward with this work, practices should understand the purpose and elements of **Planned Care** and **Population Health**.

- **Planned care** is the identification of preventive and chronic care needs prior to the encounter by a well-organized practice team, informed by data on what services are due.
- **Population health** is a systematic approach to health care that focuses on preventing and curing disease by working to keep a population or panel of patients healthy.

The phases of the work in CPC:

- Initially in CPC, practices focused much of their effort on managing patients as one large population (often in a reactive manner). Practices then began focusing their efforts on patients identified as highest risk according to their risk stratification system for more proactive care.
- Using tools and data they were developing as part of their CPC work, practices also began to identify sub-populations that may need specific resources or services.
- As practices identified populations, such as those with chronic conditions, they began to define aspects of optimal care and to develop programs to effectively plan and accomplish proactive care for the patient population.
- Leveraging the entire team became an essential strategy to meet population health needs efficiently and effectively.

Change Concept: Use team-based care to meet patient needs efficiently

Team-based care describes how primary care team members jointly take responsibility for a panel of patients. Teams leverage multiple skills to focus on the whole patient's health, not just his or her presenting medical problem. Effective teams delegate responsibilities to the person most adequately qualified to meet the need. A number of CPC practices have demonstrated that many primary care visits can be managed by non-physician team members under protocols or standing orders.

The transformational shift for a medical team

- **Traditional practice** > *Everyone works for the* ***physician/clinician***
- **Team-based practice** > *Everyone works for the* ***patient***

Team-based care is more than a group of people who work in the same space. It involves developing roles that depend on the size and resources of the practice and the needs of the patient population. Teams often consist of a primary care provider (e.g., physician, advanced practice nurse, physician assistant), medical assistants, nurses and some combination of pharmacists, nutritionists, behavioral health (BH) specialists, educators and care managers/coordinators. In smaller practices, teams may have fewer members. To pool resources, some practices may also build virtual teams through teleconferencing equipment spread across a number of practices.

What are the benefits of team-based care?

Provider	Staff	Patient
• Improved workflow • Shift workload to decrease stress • More effective counseling and goal setting • Time to do more doctoring	• More engagement in team care • Increased job satisfaction • Increased self-efficacy	• Better quality of care • More personalized care • More effective care

Implementation tips for team-based care

- Determine the needs of the population through high frequency diagnosis and review of community social needs.
- Determine tasks needed to meet the needs of the population.
- Develop a team composition and staffing ratio to meet those needs.
- Develop workflows and clinical protocols that support hand-offs and coordination among team members.
- Train teams to function interdependently.

Change tactics CPC practices have used:

- Define roles and distribute tasks among care team members, consistent with the skills, abilities and credentials of team members to better meet patient needs effectively and efficiently
- Build an enhanced care team to better support patient needs by adding staff such as a health coach, nutritionist, BH specialist, pharmacist and physical/occupational therapist as feasible
- Create protocols to manage workflow in the team to meet patient needs
- Use pre-visit planning and huddles to address chronic and preventive care

Change Tactic: Define roles and distribute tasks among care team members, consistent with the skills, abilities and credentials of team members to better meet patient needs effectively and efficiently

An effective team-based strategy that optimizes the practice's resources begins with evaluating all the tasks and roles needed on a daily, weekly and monthly basis to meet patient populations' comprehensive health needs. Beyond their clinical needs, it also includes their behavioral, social service and nutritional needs.

The practice should ask, "Who is the best team member to meet the patient's needs?" The answer is often not the physician. Maybe the team's RN knows the patient well and can meet the need over the phone with nurse advice, or maybe a behavior health specialist, pharmacist, dietitian or medical assistant on the team can meet the need. Consider how best to determine the patient's need and then offer access to the appropriate team member.

CPC resources related to team-based care

CPC On Demand Video: Leveraging the Whole Team for Planned Care (2017). This practice demonstrates how team-based care and pre-visit planning helped improve its quality measures. https://www.youtube.com/watch?v=PlDg27RvJQc&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=2

CPC practices found continual evaluation of roles fostered a sustainable team-based care strategy that provided more efficient and timely care through streamlined workflows.

Essential components

- Build team member skill sets to reflect the patient population's comprehensive needs.
- Adjust team size to meet the number of patients empaneled.
- Organize tasks based on adjusted roles.
- Train and cross-train personnel to carry out new and different roles/tasks (see inset for resources).
- Introduce patients to their care team, and encourage them to speak to different members of the team depending on their need.

Online (external) resources for team-based care

The Primary Care Team Guide (2016). A guide for establishing team-based care in the primary care setting. http://www.improvingprimarycare.org/

An Organized Approach to Chronic Disease Care (2011). The authors identified not only an improvement in clinical measures but improved staff and provider satisfaction as well. This is an excellent example of the outcome of development of team-based care in a family practice residency. http://www.aafp.org/fpm/2011/0500/p27.html

Considerations for your practice

- Initially your personnel may hesitate to take on new roles or tasks. Provide required training and support to instill confidence and set them up for success. This requires consistent and intensive follow-up to ensure training is having the desired outcome and meeting your teams' needs. Many clinicians find team-based care to be empowering and positive once it has been fine-tuned.
- Document what roles (or even individuals) are responsible for what tasks and what the expectations are and how to accomplish them. Documentation is extremely beneficial in cross-training, orientations, and meeting coverage needs without interrupting patient care.
- Provide comprehensive new employee orientation to ensure continued practice of team-based care.

Change Tactic: Build an enhanced care team

Expanding your care team with the expertise of a health coach, dietitian, social worker, pharmacist and/or behaviorist benefits both the practice team and your patients. In addition to providing direct care for patients, they can support, educate and train other team members.

CPC practices often started this process by determining unmet needs of their patient populations. Helpful data sources for this analysis were emergency department (ED) visits and hospital admissions as well as a review of unsuccessful referrals. For example, practices identified a group of patients who used the ED for acute issues with medication and flagged that group for targeted pharmacist support. Another common trend was patients with high utilization who could benefit from behavioral health services. These patients often had unsuccessful referrals to mental health specialists due to long waits. To address this gap, many practices opted to have behavioral health support onsite.

Essential components

- Understand your population's needs and staff accordingly.
- Onboard new team members with comprehensive training across team roles with an emphasis on team-based care.
- Create referral tracking and document processes to connect individual patients to new services.
- Design a sustainable reporting and oversight structure.

Considerations for your practice

- Current personnel may have skills, experience or interest in specific areas, or they may be interested and willing to take on new responsibilities. Consider skills, ambition, and potential when hiring for these roles.
- CPC practices often said finding the "right people" is critical. Specialists may not be familiar with the primary care setting and will likely be filling a role quite different from their traditional training. Clearly communicate about the role and needs of your practice during the applicant search to identify the candidates who best match your practice's needs.
- Roles and workflows will evolve over time. Check in with the team periodically for new ideas to add and test, as well as to gauge effectiveness over time.
- Assess options for adding team members onsite or remotely through a virtual capability or in a partnership capacity.

CPC resources related to building an enhanced care team

CPC Spotlight 17: Patient-Centered Care Management Resonates with Patients with Diabetes, Hypertension and Obesity (2014). Clopton Clinic in Arkansas uses the skill of the practice health coach to improve the outcomes for chronically ill patients. This practice identified patients in need of assistance using its EHR. Then it added a health coach to the team to assist the patient. This practice's outcomes were a higher level of patient satisfaction, a higher number of personalized plans of care and improvement in the practice's related clinical quality measures. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=39

CPC Spotlight 84: Geriatric Care Coordinator Boosts Patient Confidence, Satisfaction (2016). This New Jersey practice found it could best serve the needs of its largely elderly population by including a care coordinator specializing in geriatrics on its care team. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=42

CPC On Demand Video: Integrating Advanced Primary Care Strategies: Behavioral Health and Medication Management (2017). On-site BH specialists and a strong focus on medication management benefited the patients at this practice. https://www.youtube.com/watch?v=6yfH-nSTPJ0&index=16&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

Change Tactic:
Create protocols to manage workflow in the team to meet patient needs

CPC practices revised their workflows to ensure all team members engaged in patient care. Because no one workflow is a universal solution for efficient delivery of care, practices continually tailored and adjusted workflows. Large CPC practices often had multiple teams function smoothly as a unit to provide care, while smaller practices leveraged a single care team comprising the entire office to redistribute roles and tasks.

The example on the following page illustrates the difference between a traditional practice and team-based care. Practices organized team-based care around identifying and meeting immediate and future needs. This fundamentally shifted the focus from episodic, reactive care to proactive, planned care for every patient. This process allowed teams to address core needs of patients in real time. This often eliminated the need for future visits, or ensured that when there was a visit, they were efficient and productive because they were driven by patient goals and outcomes.

Essential components

- Define roles and assign responsibilities for each step and task in a workflow.
- Create detailed handoff protocols among team members.
- Ensure timely communication methods are in place (for example, huddles and alerts in the EHR).
- Use data and registry functions in the EHR to inform workflow priorities.
- Build decision support into the workflow.

Considerations for your practice

- Workflow changes are initially disruptive until the new patterns become routine. Help your teams manage these changes by emphasizing the goals and outcomes, especially how the workflows will improve the patient's experience and health care.
- Document workflows and role descriptions as an ongoing resource for the team and to assist with future onboarding and cross-training.
- Create time for everyone to have input on workflows to allow for consistent re-evaluation and new tests of change.
- Train the entire team to document appropriately in the EHR to ensure clean data reports.
- Monitor outcomes and track goals closely in the early stages of implementation to harvest wins to share with teams and to quickly identify potential gaps that could compromise care.

Example of traditional practice versus team-based care (*Note: This is a sample case; no actual patient information is shown.*)

Mary is a 58-year-old with a 15-year history of Type 2 diabetes complicated by elevated blood pressure. Mary has a BMI of 35 and has struggled with weight control since young adulthood. Mary was recently seen because of recurrent headaches, fatigue and depressive symptoms. She was found to have an A1c of 9.7% and a blood pressure of 186/110.

	Traditional Practice	Team-Based Care
Pre-visit	• The day before the appointment, the front desk person calls Mary to remind her of her appointment.	• Several days before the visit, the front desk person calls Mary to remind her of the appointment and schedules routine labs to be completed before the visit. • RN care manager reviews labs the day before the visit and notes any preventive care needs.
	• Provider quickly reviews chart before he/she walks in the room.	• During the huddle, the care manager reviews Mary's lab results and informs team that Mary is due for an eye exam.
Mary's Visit	• Mary checks in.	• When Mary checks in, the front desk or care coordinator schedules the eye exam.
	• Medical assistant collects vitals.	• Medical assistant collects vitals, sets the visit agenda with Mary and preps her for the visit. The MA scores the PHQ-9, and Mary's score is 15.
	• Provider reviews and addresses A1c and blood pressure. o Mary starts to cry and says that she is exhausted.	• Provider asks Mary about the problem as she sees it. o Mary ends up expressing how overwhelmed she feels. • The provider introduces the BH specialist and moves on to the next patient. • The BH specialist completes a brief assessment in the exam room.
	• Provider tells Mary to call the insurer to find out about BH therapy.	• Assessment reveals a history of depression and panic attacks several times per week since caring for sick husband. The BH specialist educates on how stress can impact Mary's health and teaches stress management techniques.
	• The provider adjusts HTN medication and insulin dose.	• The pharmacist works with Mary to understand her meds and reviews dosing. The pharmacist makes suggestions to the provider.
	• Provider once again urges patient to exercise and lose weight. • Asks Mary to complete labs on her way out. • Provider informs Mary to come back in one month and front desk schedules the appointment.	• Team co-creates plan of care with Mary in the visit o Stress management self-care with BH follow-up o Antidepressants are adjusted o Referral to dietitian o Coordinates respite services o Begins participation in church activities o RN to follow-up by phone in two weeks • Uses Teach-back[1] to ensure Mary understands the plan and provides her with a written copy.
	• Provider will review Mary's labs results at her follow-up visit.	• Care Coordinator completes referrals and arranges transportation to eye appointment and schedules follow-up with team RN. • Mary's progress is tracked and reviewed in team huddles.
Outcomes	**Mary ends up in the hospital due to taking old and new blood pressure pills**.	**Mary reports increased energy and decreased depression and anxiety. Her panic attacks completely resolve. She starts exercising and meeting with friends again. Her BP falls to target levels and her A1c is at 6.3%.**

[1] **Always Use Teach-back! Training Toolkit**, http://www.teachbacktraining.org/

Change Tactic: Use pre-visit planning and team communication to address chronic and preventive care

Pre-visit planning is fundamental to effective team-based care delivery because this activity focuses on gathering the information and resources needed for a smooth, efficient patient visit.

Using the EHR or registry reports will help identify gaps in health maintenance and lab testing. This allows patients to receive their care in a timely, organized manner, and it allows teams to identify and prevent future health issues.

CPC practices implemented pre-visit planning with a variety of tactics. Practices pulled reports from the EHR for gap analysis and registry information as well as set up automated point-of-care reminders. EHR reports also identified patients who required additional steps of care in the visit, such as patients with high-risk conditions or recent change in health status. Other practices opted to complete individual chart reviews up to a week before the scheduled appointment to allow time to complete routine labs and screening prior to the visit.

Regardless of tactic and process, team communication is critical. Any needs uncovered during pre-visit planning should be blended into care and ongoing care management activities. Due to this overlap between immediate and ongoing activities, pre-visit planning efforts were frequently combined with both formal and informal practice huddles (see inset for a resource for huddles) as well as care planning, care management and chronic care activities.

Essential components

- Use tools that identify patients' needs before they are in the office. These often include registries or reports that find gaps in care or alert systems in the EHR.
- Assign dedicated time to team members to review registries and reports.
- Collect information prior to the visit, such as test results or specialist notes, that will inform the visit. Specific roles should be responsible for obtaining this information and ensuring it is part of the chart and available for other forms of communication, such as a huddle.
- Develop intentional communication channels that support both immediate and ongoing patient care.
  - Daily huddle and/or visual alerts
  - Person assigned to lead daily huddles
  - Entire team is included in the huddle and has access to the same information

Considerations for your practice

- Not all EHRs have functionality for gap analysis or to generate alerts. You may need to explore options that will effectively perform these functions. There are modules that can be added to EHRs or software that may interface or run separately.
- Ensure all team members are work to the top of their license and abilities. Distribute tasks to match skills to the task.

Online (external) resources related to pre-visit planning

AMA STEPS*forward* (2016). Materials to assist the practice in developing a pre-visit planning process at their site. https://www.stepsforward.org/modules/pre-visit-planning

Healthy Huddles (2013). This tool demonstrates the benefits of this short meeting to plan for the day, and provides assistance with implementation of huddles in your practice. https://cepc.ucsf.edu/healthy-huddles

CPC resources related to pre-visit planning

CPC On Demand Video: Testing New Workflows through Pre-visit Planning (2017). In this video, a practice explains how it established a new system for pre-visit planning. https://www.youtube.com/watch?v=8PurmJIhTEM&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=10

CPC On Demand Video: Utilizing Pre-visit Planning Tools and Teamwork (2017). A CPC practice describes the tools and strategies staff and providers use to prepare for patient visits. Chart scrubs and QM cards are part of the daily workflow. https://www.youtube.com/watch?v=rUG8QV9Hd90&index=11&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC Spotlight 86: Pre-visit Planning Helps Eliminate Gaps in Patient Care (2016). This spotlight describes how an Ohio practice uses both population health software and chart audits to identify patient care needs, including a brief list of the steps in the practice's visit planning process. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=44

Measuring Success for Change Concept: Use team-based care to meet patient needs efficiently

Successful team-based care should improve the efficiency and efficacy of patient care. While patients will see the difference during their appointments as comprehensive services are provided in a timely, efficient manner, make sure that your practice's measurement strategy includes the team's satisfaction with new processes.

To gauge the effectiveness of team-based care, you may consider these measures:

- Patient satisfaction data
- Personnel and provider satisfaction
- Efficiency measures such as patient wait times, length of appointment (scheduled time versus actual time)
- Number of patient contacts per day, per team member
- Number of visits and/or follow-up calls required to close the loop of a primary care appointment
- Clinical quality measures, including control of chronic conditions and preventive measures/screenings
- Percent of referrals to external specialists/partners that result in a patient receiving care

Change Concept: Proactively manage chronic and preventive care for empaneled patients

Successfully implementing proactive management for all of your empaneled patients moves your practice toward data-driven, population-focused delivery of care. Putting systematic interventions in place will strengthen the practice's overall care planning and delivery, ultimately lessening gaps in care and reducing unmet needs.

CPC practices used a mix of systematic, population health interventions to improve proactive management of preventive and chronic care. These included embedding evidence-based protocols for care, registries or the registry functionality of the EHR, reminders and patient education/outreach.

Along with health IT tools, CPC practices looked at their daily work streams — including pre-visit planning and care management — to identify effective tactics that would translate across the practice's entire patient population and not just for those patients at highest risk. Those tactics, such as routine medication reconciliation, helped CPC practices to better manage all of their patients' overall care, rather than simply continually reacting to patients' acute needs. CPC practices noted that patient satisfaction increased once proactive management was underway with patients participating more in their care.

Implementation tips for management of chronic diseases and preventive care

- Review functionality of the EHR for registry capacity and population functions.
- Determine registry data to be tracked (specific preventive health measures, patients with diabetes at high risk for complications, etc.).
- Create registries or "action list" to track patients.
- Determine how the team will be alerted when items are due.
- Determine method and level of outreach.
- Determine method of documentation for completed items.
- Develop clinical protocols.

Change tactics CPC practices have used:

- Include preventive care and screening measures based on age, gender, health status and risk appraisal for each patient
- Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target
- Use panel support tools (registry functionality) to identify services due
- Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due
- Perform routine medication reconciliation

Change Tactic: Include preventive care and screening measures based on age, gender, health status and risk appraisal for each patient

Unlike reactive medicine, which addresses the symptoms after a disease has begun, proactively including preventive and screening measures provides the opportunity for maximizing prevention and treating issues early. This can only happen if a practice actively identifies and gathers such information for each patient. Practices should include measures to screen for diseases, assess risk of future medical problems and update vaccinations if necessary.

Essential components

- Measures included reflect quality metrics and specific population needs.
- Baseline measurement information gathered for each new patient. Develop workflows to capture this information and enter it into a discrete field within the EHR and/or registry.
- Measures captured in a reportable EHR/database for future tracking.
- Preventive care and screening recommendations included in the plan of care.

Considerations for your practice

- Determine measures that will help guide care and are consistent with payer requirements (electronic Clinical Quality Measures (eCQMs), HEDIS, meaningful use, etc.).
- For a well-rounded data set, capture and monitor measures for the individual, the entire panel and the entire practice.

Change Tactic: Use condition-specific pathways for care of chronic conditions with evidence-based protocols

Standardized pathways based on evidence-based guidelines can maximize efficiency as well as efficacy for common chronic conditions and preventive care. They can serve as templates or standing orders for developing actions for team-based care in support of chronic condition management. Practices need to identify care pathways for conditions and work on the development, deployment and fine-tuning of standing orders in support of those pathways.

Online (external) resources related to guidelines

Variety of protocols that support comprehensive primary care:

AHRQ National Guidelines Clearinghouse. https://www.guideline.gov/

Essential components

- Routinely use standardized pathways based or evidence-based guidelines for high frequency conditions and preventive care.
- Adopt evidence-based guidelines that exist for a wide variety of conditions and types of care in individual practice sites.
- Establish workflows to support clinical guidelines and protocols.
- Define associated roles and responsibilities for each team member.
- Train team members thoroughly to meet competencies for pathways and workflows.

Considerations for your practice

- Leverage the entire team for workflow efficiency. Team members working at the top of their credentials and abilities will aid efficiency and effectiveness.
- When developing workflows and protocols, try using small tests of change to find what works best before full implementation.

CPC resources related to care protocols

CPC On Demand Video: Proactive Management of Chronic Conditions to Improve Outcomes and Empower Patients (2017). An Oklahoma CPC practice discusses using COPD rescue packs as part of a team-based approach to delivery of chronic disease management for an at-risk population. https://www.youtube.com/watch?v=TTcFaW0edKg&index=14&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

Change Tactic: Use panel support tools (registry functionality) to identify services due

Mining data from EHRs or registries with incorporated protocols was crucial for CPC practices to proactively identify the chronic care needs for chronically ill patients and the preventive services due for all patients. Practices did this on an individual patient basis (at pre-visit planning or during an unplanned visit) and on a population basis.

Online (external) resources related to HIT

Clinical Decision Support: Using Technology to Identify Patients' Unmet Needs (2012). Describes the use of technology to identify gaps in care for the patient population. http://www.aafp.org/fpm/2012/0300/p22.html

Essential components

- Registry or action list function for tracking.
- Reports that identify overdue items (for example, mammograms or colonoscopies that are beyond the recommended schedule).
- Alert mechanism in EHR when items are due.
- Reports that monitor progress on sub populations (e.g., patients with diabetes at high risk for complications).

Considerations for your practice

- Not all EHRs come with these functionalities. Some have the option to add modules. Others may interface with an external, additional resource.
- Whenever possible, have the reports create an alert for individual patients who need services. This will assist with chart scrubs during pre-visit planning.

Change Tactic: Use reminders and outreach to alert and educate patients about services due

CPC practices used registries and reports to identify gaps in care or services that were due. For patients who did not have appointments scheduled, CPC practices often reached out to inform patients of their gap or upcoming service and educate the patients about these needs. They used letters, phone calls or portal messages. Frequently, CPC practices found that they needed multiple modalities. For example, a letter describing a needed preventive screen with information about the benefits would be followed by a personal phone call to answer questions and try to assist with scheduling onsite or through a referral.

Essential components

- A designated team member to track and perform outreach to patients with items due.
- A clear protocol for how outreach is completed (e.g., letter, portal or call) and how many times an attempt is made.
- Educational material that will assist patients with making informed decisions when they are notified they are due or overdue to a service.

Considerations for your practice

- For services that require a referral to an external partner, it can be easy to miss gaps in care. Develop a care compact with a communications agreement with these external partners, especially those who receive a high volume of referrals. For additional change concepts and tactics to foster improved relationships with providers in your medical neighborhood, see pages 6 – 12 in **Secondary Driver 1.5: Coordination of Care Across the Medical Neighborhood**.
- Patients care how they receive information such as outreach and reminders. You may want to first survey your population to determine the most commonly preferred modality and use this for your first attempt. Keep in mind that preferred modalities may vary with patient age and ethnicity. Watch for trends in your surveys.
- Test reminder messages to see if they increase show-rates for appointments that have been scheduled. If they do, create a workflow to implement this for all scheduled appointments.

Change Tactic: Routine medication reconciliation

Integrate medication reconciliation as a part of planned care and proactive management of all patients. While this tactic supports planned care, it also carries over to risk-stratified care management (see **Secondary Driver 1.3: Risk-stratified Care Management**). Several change tactics in that section go into further detail about routine medication reconciliation and building your practice's capacity to ensure patient needs are met effectively, efficiently and safely.

CPC resources related to pharmacist integration

CPC Practice Spotlight 60: Pharmacist Integration Strategy: Working Directly with Patients to Improve Medication Adherence and Outcomes (2015). Banner Health (Colorado) pharmacists engage directly in patient care, working closely with patients with complex medication regimens. This article includes an outline of workloads and patient touches as well as suggestions for measurement. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=23

This is typically completed when patients experience a transition in care, but it is not necessarily part of other types of interactions or appointments. Rather than waiting for a problem to arise or a transition in care, practices should periodically reconcile patients' full medication list to catch potential issues. This also creates an opportunity for patient engagement and education. These opportunities can occur at regular intervals and/or at specific types of appointments. Note that reconciliation differs from simply collecting an up-to-date list of the patient's current medications. During the process of medication reconciliation, a comparison is completed between all medications the patient has been taking to all medication orders. It should include all OTC and homeopathic supplements as well. This action prevents medication errors such as duplications, omissions, dosing errors and drug interactions.

CPC practices found a variety of methods for efficiently blending routine medication reconciliation into their planned care. Some practices used EHR registry tools or alerts; others used flags, follow-up call scripts and visual reminders for the care team. In some CPC practices, MAs and RNs complete general medication reconciliations with care managers and physicians overseeing the high- or rising-risk patient's medication lists.

Practices have found that the initial medication reconciliation helps identify changes, issues or questions that may need to be brought to the next level or to another team member. For example, the provider, pharmacist or diabetic educator can be looped into the conversation when issues arise or to consult as needed.

Essential components

- Develop a protocol for routine medication reconciliation.
- Use EHR or other registry/report tools to regularly assess who is due for routine medication reconciliation.
- Create workflows for conducting initial medication reconciliation as well as a workflow for involving additional team members when necessary.
- Document completed reconciliation in the EHR as well as any updates to the medication list.

Considerations for your practice

- Patients who are high risk or have had a recent transition will likely receive medication reconciliation frequently as part of their transitions of care workflow or targeted medication management. If reconciliation has recently been completed, make sure you document their care in a way that will keep them off any list or alert system for needing additional reconciliation.
- If you have access to a pharmacist, have him or her provide support and periodic training for all team members involved in routine medication reconciliation.

Measuring Success for Change Concept: Proactively manage chronic and preventive care for empaneled patients

These population health strategies align well with many clinical quality metrics. Implementing these strategies should result in improvement of eCQMs. For additional information on eCQMs, see **Driver 4: Optimal Use of Health IT**, "EHR-based Quality Reporting" on page 3).

Process and outcome measures for this work might include the following:

- Clinical quality measures related to preventive care and screening
- Clinical quality measures related to chronic conditions
- Patient satisfaction

Change Concept: Integrate culturally competent self-management

Self-management support (SMS) is "the systemic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of program and problems, goal setting and problem-solving support." [2] In short, it is how health care providers help people with chronic conditions manage their health every day.

Effective SMS can help and inspire people to learn more about their conditions and meaningfully engage in their health care. It can apply to many chronic conditions from depression to diabetes. SMS has multiple pieces:

- Educating patients on understanding their conditions
- Finding out what motivates patients to act willingly on their own behalf (motivational interviewing)
- Teaching patients skills and tools to manage their personal health and wellness (Teach-back)
- Assisting patients in managing chronic conditions

SMS accepts that the majority of a patient's life and health exists outside of the medical practice and supports patients in identifying goals, knowledge and tools to engage in healthy self-care. A combination of evidence-based strategies, family and patient engagement, and integration with peer and community resources can work together to create the environment necessary for successfully incorporating SMS into patients' care and daily lives. Ongoing use of the self-management approach ensures the best opportunity to adopt healthy behaviors over time.

Implementation tips for self-management support

- Provide education and rationale for all clinicians on why and how to use SMS and develop a plan of care.
- Train all clinicians in Motivational Interviewing.
- Build tools into clinical workflows.
- Create needed plan of care template in EHR.
- Build self-management competencies into job descriptions and onboarding of new employees.
- Complete regular competency evaluation for sustainability.

Change tactics CPC practices have used:

- Incorporate evidence-based techniques to promote self-management into usual care
- Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR
- Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's Your Health)
- Provide ongoing self-management support through group visits in the clinic, group programs in the community and peer-led support
- Provide self-management materials at an appropriate literacy level and in an appropriate language

[2] Institute of Medicine. Priority areas for national action: transforming health care quality. Washington, DC: National Academies Press, 2003.

Change Tactic: Evidence-based techniques for self-management

Below are the evidence-based principles associated with improved patient self-management and/or health outcomes[3]:

- Brief targeted assessment
- Evidence-based information to guide shared decision making
- Use of a nonjudgmental approach
- Collaborative priority and goal setting
- Collaborative problem solving
- Self-management support by diverse providers both professionals and trained laypersons
- Self-management interventions delivered by diverse formats
- Patient self-efficacy
- Active follow-up
- Guideline-based case management for selected patients
- Linkages to evidence-based community programs
- Multifaceted interventions

Most medical office staff has limited training in patient activation, goal setting or motivational techniques, as these are not included in traditional preparation for medical personnel. By developing these skillsets within the office, practices can provide patients with greater support in self-management, which is believed will have a long-term effect on utilization patterns.

Motivational interviewing is a technique specifically designed to gain understanding from the patient's perspective, find out underlying motivation, develop goals, create a plan and determine level of follow-up. By developing these skillsets within the office, practices can provide patients with greater support in self-management, which is shown to improve self-responsibility and behavior change resulting in improved overall health.

Online (external) resources for engaging patients in care

Motivational Interviewing

The Ineffective Physician: Non-Motivational Approach (2009).
https://www.youtube.com/watch?v=80XyNE89eCs

The Effective Physician: Motivational Interviewing Demonstration (2009).
https://www.youtube.com/watch?v=URiKA7CKtfc

Teach-back

Always Use Teach-back! Training Toolkit. Provides guidance in using this technique to confirm patient understanding. This toolkit will also provide resources to use as you learn the Teach-back method.
http://www.teachbacktraining.org/

Self-Management Toolkit

Partnering in Self-Management Support: A Tool-kit for Clinicians (2012).
http://www.improvingchroniccare.org/downloads/selfmanagement_support_toolkit_for_clinicians_2012_update.pdf

The Teach-back Method is a communication confirmation method used by health care providers to confirm whether a patient (or caregivers) understands what is being explained to them. If a patient understands, they are able to "teach-back" the information accurately. This is a communication method intended to improve health literacy.

[3] Twelve Evidence-Based Principles for Implementing Self-Management Support in Primary Care. December 2010 Volume 36 Number 12. Malcolm Battersby, PhD, MBBS, FRANZCP, FAChAM; Michael Von Korff, PhD; Judith Schaefer, MPH; Connie Davis, MN, ARNP; Evette Ludman, PhD; Sarah M. Greene, MPH; Melissa Parkerton, MA, ABS; Edward H. Wagner, MD, MPH, FACP.

Essential components

- Routinely provide Motivational Interviewing and Teach-back training to all team members in the practice. Train all team members who have any patient contact, not just those providing direct patient care.
- Provide regular practice and feedback to develop and refine clinicians' and other team members' skills. Role-play with team members is one suggested means of accomplishing this.
- Make tools and resources available to assist with conversations.
- Any actionable items as well as follow-up items are documented in the EHR and available for view by entire team.
- Measure and track patient activation and patient satisfaction.

Considerations for your practice

- External trainings and resources are widely available. Practices do not need to create their own.
- Add competencies to job evaluation checklists.
- Single training sessions are not adequate for developing these skills. Teams need practice, tools and continuing education.

CPC resources related to Teach-back

CPC Spotlight 33: Check for Literacy When Evaluating Patient Self-Management Skills (2014). Warren Clinics in Jenks, Okla., found Teach-back to be a valuable tool to use with a patient with limited literacy. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=56

CPC Spotlight 43: Beyond Patient Education: Self-management Support (2015). In this Spotlight article, Hunterdon Family Practice and Obstetrics from Flemington, N.J., describes its observation of changes in process measures (patient goals, community resources accessed and number of follow-up phone calls tracked in the EHR) as well as outcome measures (e.g., CQMs, PHQ scores). https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=8

Change Tactic: Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR

Patients' engagement in their own care is vital for a practice to positively affect the health of its patients. While patient activation and education are crucial to successful self-management, patients frequently struggle when facing complicated clinical directives.

Within CPC, practices flipped the traditional nursing care plan and developed a "Patient Plan of Care" that was *co-created* with the patient. Together, the team and the patient identified realistic, measurable goals and strategies to guide the patient, the patient's family and health care professionals in ongoing care. While the plan of care defined treatment, interventions, expectations, as well as coordinated care, its larger function was to partner with patients for improved quality of life and overall health outcomes.

While developed with the patient, the Plan of Care belongs and should be given to patients. A copy should be housed in the EHR for easy reference by the care team.

Essential components

- The patient and team work together to create prioritized, realistic goals with simple, measurable steps to meet that goal.
- Identify barriers to success, and collaborate with the patient to design solutions for those barriers.
- Include family members and caregivers when appropriate to ensure they understand the patient's condition and know how to support the adoption of new behaviors at home.
- Include schedules for preventive and chronic care, a medication list and end-of-life planning.
- Ensure the documented plan is viewable to the entire team. Identify an area in the EHR for the plan of care that is easily accessible to all team members and can be updated during each interaction.
- Provide printable summaries for the patient to take home.
- Make sure that any specialists caring for the patient receive a copy of the plan of care.
- Decide who on the team is responsible for development, tracking and updating the plan.

Considerations for your practice

- Assess your patients' activation and/or readiness for a plan of care. If they show resistance, seek to understand why. Go slow and start small.
- When acuity is high or capacity is diminished, engage family members in the development process or consider a "crisis plan of care" that may be more team directed.
- Determine if another member of the team (like the RN or BH specialist) might be better suited to complete the care plan with the patient and caregivers.

Online (external) resources for engaging patients in care

Brief Action Planning, The Centre for Collaboration Motivation and Innovation. This support technique is a structured method of working with patients to create a concrete action plan for the area of their health they choose to focus on. http://www.centrecmi.ca/learn/brief-action-planning/

CPC resources related to self-management support and patient engagement

CPC On Demand Video: Proactive Management of Chronic Conditions to Improve Outcomes and Empower Patients (2017). A CPC practice discusses using COPD rescue packs as part of a team-based approach to delivery of chronic disease management for an at-risk population. https://www.youtube.com/watch?v=TTcFaW0edKg&index=14&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC Practice Spotlight 76: Strategies for Meeting Patients 'Where They Are' and Making Self-management Support Work in a Busy Primary Care Practice (2016). This Ohio practice integrates self-management support into how they engage patients. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=36

CPC On Demand Video: Self-management Support for Patients with Chronic Conditions (2017). A practice shares how it established effective goal setting for patients with chronic conditions. https://www.youtube.com/watch?v=aEwPg-unkhY&index=12&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

Change Tactic: Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's Your Health)

As discussed in a previous change tactic (see "Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR," on page 19), patients are a practice's partner in self-management support. However, if they are not activated to engage to make the necessary changes and follow the shared plan of care, their self-management will ultimately be ineffective.

CPC practices have found two tools helpful in determining the level of patient activation. The first is the Patient Activation Measure (PAM), which any team member can quickly give to a patient. The PAM tool identifies the patient's level of activation, which can then guide the practice team in the planning of care with the patient. Note: This tool is a commercial product with a licensing fee associated with its usage (see link in inset). **How's Your Health** (see link in inset) is another assessment that can be completed by the patient him/herself. It measures level of confidence in managing a chronic condition and provides guidance in building a plan that improves confidence.

Essential components

- Use validated tools to conduct an assessment of patient activation.
- Provide a purpose and rationale to the patient.
- Review results with the patient.
- Incorporate the results into ongoing follow up.

Considerations for your practice

- Some practices provide kiosks or tablets to patients to complete tools while they wait in the lobby or in the room.
- Identify timeframes for when this should be completed. Examples include before yearly physical, before enrolling in a care management or health coaching support program, or before every appointment.
- Create a plan for how and where to document the activation measure in the EHR.

Online (external) resources for self-management support

Patient Activation Measure
The Patient Activation Measure Survey, http://www.insigniahealth.com/products/pam-survey

Patient Activation Measure Tool Helps Patients Avoid Hospital Readmissions (2014). http://www.the-hospitalist.org/hospitalist/article/126322/patient-activation-measure-tool-helps-patients-avoid-hospital

How's Your Health
How's Your Health Self-Assessment, https://www.howsyourhealth.org/

CPC resources related to patient involvement in plan of care

CPC Spotlight 50: A Simple Ask: How One Request Can Quickly Engage and Activate Patients (2015). This New Jersey medical group engages patients in their exercise and food tracking activities as a means of self-management support. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=14

Change Tactic: Provide ongoing self-management support through group visits in the clinic, group programs in the community and peer-led support

Self-management of chronic conditions involves daily decisions and behaviors in a patient's home and everyday life environments. They require knowledge and skill, but they also require ongoing support from a care team and community resources. Several options are available to provide such support including group office visits, SMS classes in the community and peer-led groups. Peer-to-peer sharing helps bring to mind specific questions, challenges or solutions that may not have arisen during a solo appointment. It offers peer support and social interaction that increases a patient's comfort in discussing the topic. In peer-led support groups or group educational classes, patients can hear and share real life examples that have been working, or not working, for others. Another variation includes patients, caregivers and family members learning skills together. For chronic conditions such as diabetes, depression, hypertension and COPD, it is particularly beneficial because patients realize that others have successfully learned to manage the condition.

Online (external) resources for self-management support

Chronic Disease Self-Management Program, Stanford Medicine. This is an example of a peer lead, evidence-based support resource. State and local program locations are provided.

https://www.ncoa.org/healthy-aging/chronic-disease/chronic-disease-self-management-program/

http://patienteducation.stanford.edu/programs/cdsmp.html

Essential components

- Identify community-based educational and/or support systems in the local area that use lay persons or peer-led methodology to provide SMS support.
- Develop formal and informal practice relationships to streamline appropriate referrals and information.
- Share resource information with patients through handouts, event boards, newsletters or even an informal "prescription." Provide times, dates, location and applicable websites.
- Follow-up with patients attending groups to further support new skills.
- Include groups into the plan of care or other patient tools for SMS.

Considerations for your practice

- For an in-office group, determine which chronic conditions to address by looking at top diagnoses for your patient population and the frequency of occurrence.
- For in-office groups, measure the effectiveness of group visits by tracking changes in relevant clinical quality measures, patient engagement and patient satisfaction.
- Seek community partners that offer services that support primary factors in the management of chronic conditions (access to healthy food, exercise classes financial support, etc.)
- Staff from community organizations or hospitals, in addition to patient/peer educators, may frequently co-lead groups.
- As the patient to provide a copy of educational materials they receive so that you can incorporate suggestions into plans of care. Finding alignment with other resources helps reinforce good ideas rather than causing confusion.
- Determine if some groups may be available on-line for those who are not interested in traveling or meeting in person.

CPC resources related to self-management support

CPC On Demand Video: Self-management Support for Patients with Chronic Conditions (2017). A practice shares how it established effective goal setting for patients with chronic conditions.
https://www.youtube.com/watch?v=aEwPg-unkhY&index=12&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

Change Tactic: Provide self-management materials at an appropriate literacy level and in an appropriate language

Effective SMS hinges heavily on patient engagement and a frequent barrier to their participation is not being able to understand the educational materials provided to them. Further, patients are frequently reluctant to admit they struggle with written documents.

CPC practices found several strategies to ensure their SMS materials were appropriate, usable and valuable to patients. Practices used tested and approved materials from other large health organizations and community partners. Practices also turned to online videos in lieu of written materials to help patients learn and engage with self-management.

As your practice develops SMS, assessing your patient population's literacy, health literacy and written language skills should guide your library of materials and documents. Do not assume that because a patient communicates easily verbally in a language that they are equally comfortable with the written word in that language. Incorporate brief, validated assessments into patient paperwork. There are also strategies for increasing the appropriateness of materials for all patients, including providing materials in everyone's primary language, using materials that have been tested and approved for low literacy levels and use of visuals. Online resources for incorporating these strategies are in the external resources box on this page (see green inset).

Essential components

- Incorporate tools to assess patients' literacy levels, preferred language and preferred teaching modality.
- Written materials should be tested for literacy level, and your practice should use or create materials that are appropriate for patients with low literacy levels.
- Use additional modalities such as visual aids. For example, props, photos or illustrations can easily illustrate healthy serving sizes.
- Ensure your materials are culturally appropriate, with examples that are applicable to patients' culture and preferences.

Considerations for your practice

- Assess materials from external sources for appropriate literacy levels before sharing with patients and families.
- Evaluate all materials created by a practice to send home with a patient, including plan of care, action plans, medication instructions and patient education. These materials should be provided in a low literacy level, using a preferred language and visual aids.
- Ask patients for feedback on materials. This would be a great project to bring to a patient and family advisory council.

CPC resources related to culturally appropriate SMS

CPC On Demand: Self-management Support for Vulnerable Patient Populations (2017). How to reach the vulnerable patients in your population (economically disadvantaged, racial and ethnic minorities, low-income children, HIV+) and provide them with self-management support. https://www.youtube.com/watch?v=m2f0bJAruWo&index=19&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC Spotlight 33: Health Literacy (2014). An observant care manager realized her patient with diabetes was functionally illiterate. Learn more about how to effectively interact with patients about self-management when they have barriers to learning. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=56

Online (external) resources for health literacy

Health Literacy Universal Precautions Toolkit
http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

Health Literacy Measurement Tools
http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html

Culture and Health Literacy
http://www.cdc.gov/healthliteracy/culture.html

Measuring Success for Change Concept: Integrate culturally competent self-management

Successful promotion of self-management support requires several steps or strategies that should work together to produce change or results over time. Ultimately, the use of these strategies should affect large and important goals, such as improved patient satisfaction and utilization measures. However, most of these outcomes require long periods to change. Further, other interventions or the changes the practice made will affect these outcomes. Therefore, include short-term and interim measurements to assess how the work is progressing.

Quality metrics related to targeted conditions can give meaningful insight into how supporting patient self-management affects outcomes. To assess whether you are making progress with this concept and whether these efforts are making an improvement, you must evaluate a combination of short-term process measures and interim clinical measures in addition to the long-term outcomes.

Process measures for this work can include the following:

- Number of team members who have received Motivational Interviewing training
- Number of patients receiving health coaching
- Number of patients receiving training or skills for self-management
- Change in patient activation scores
- Percentage of patients with a personalized goal documented for at least one condition
- Change in patient confidence in the management of their condition(s)
- Percent of patients with plan of care documented in the EHR

Interim or clinical measures can include the following:

- Percent of patients meeting health goals
- Change in clinical quality measures (e.g., A1c or blood pressure) related to targeted chronic conditions
- Patient satisfaction with care experience

Resources for Secondary Driver 1.2: Planned Care and Population Health

AHRQ National Guidelines Clearinghouse. https://www.guideline.gov/

Always Use Teach-back! Training Toolkit. http://www.teachbacktraining.org/

AMA STEPS*forward* (2016). https://www.stepsforward.org/modules/pre-visit-planning

Brief Action Planning – The Centre for Collaboration Motivation and Innovation. This support technique is a structured method of working with patients to create a concrete action plan for their health. http://www.centrecmi.ca/learn/brief-action-planning/

Chronic Disease Self-Management Program, Stanford Medicine. This is an example of a peer-led, evidence-based support resource. There is also be state and local references. https://www.ncoa.org/healthy-aging/chronic-disease/chronic-disease-self-management-program/ and http://patienteducation.stanford.edu/programs/cdsmp.html

Clinical Decision Support: Using Technology to Identify Patients' Unmet Needs (2012). http://www.aafp.org/fpm/2012/0300/p22.html

CPC On Demand Video: Integrating Advanced Primary Care Strategies: Behavioral Health and Medication Management (2017). On-site behavioral health specialists and a strong focus on medication management benefited the patients at this practice. https://www.youtube.com/watch?v=6yfH-nSTPJ0&index=16&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Leveraging the Whole Team for Planned Care (2017). This practice demonstrates how team-based care and pre-visit planning helped improve their quality measures. https://www.youtube.com/watch?v=PlDg27RvJQc&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=2

CPC On Demand Video: Proactive Management of Chronic Conditions to Improve Outcomes and Empower Patients (2017). A CPC practice discusses using COPD rescue packs as part of a team-based approach to delivery of chronic disease management for an at-risk population. https://www.youtube.com/watch?v=TTcFaW0edKg&index=14&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Self-management Support for Patients with Chronic Conditions (2017). A practice shares how they established effective goal setting for patients with chronic conditions. https://www.youtube.com/watch?v=aEwPg-unkhY&index=12&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand: Self-management Support for Vulnerable Patient Populations (2017). How to reach the vulnerable patients in your population (economically disadvantaged, racial and ethnic minorities, low-income children, HIV+) and provide them with self-management support. https://www.youtube.com/watch?v=m2f0bJAruWo&index=19&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Testing New Workflows through Pre-Visit Planning (2017). In this video, a practice describes how they established a new system for pre-visit planning. The new system made patients more engaged, and the physicians and staff appreciate it. https://www.youtube.com/watch?v=8PurmJIhTEM&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=10

CPC On Demand Video: Utilizing Pre-visit Planning Tools and Teamwork (2017). A CPC practice describes the tools and strategies staff and providers use to prepare for patient visits. Chart scrubs and QM cards are part of the daily workflow. https://www.youtube.com/watch?v=rUG8QV9Hd90&index=11&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC Practice Spotlight 17: Patient-centered Care Management Resonates with Patients with Diabetes, Hypertension and Obesity (2014). Clopton Clinic (Ark.) uses the skill of their health coach to improve outcomes for chronically ill patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=39

CPC Practice Spotlight 33: Check for Literacy When Evaluating Patient Self-management Skills (2014). Warren Clinics in Jenks, Okla., found teach back to be a valuable tool to use with a patient with limited literacy. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=56

CPC Practice Spotlight 43: Beyond Patient Education: Self-management Support (2015). Hunterdon Family Practice and Obstetrics from Flemington, N.J., describes its observation of changes in process measures (patient goals, community resources accessed and

number of follow-up phone calls tracked in the EHR) as well as outcome measures (i.e., CQMs, PHQ scores). https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=8

CPC Practice Spotlight 50: A Simple Ask: How One Request Can Quickly Engage and Activate Patients (2015). This New Jersey medical group engages patients in their exercise and food tracking activities as a means of self-management support. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=14

CPC Practice Spotlight 60: Pharmacist Integration Strategy: Working Directly with Patients to Improve Medication Adherence and Outcomes (2015). Banner Health (Colorado) pharmacists engage directly in patient care, working closely with patients with complex medication regimens. This article includes an outline of workloads and patient touches as well as suggestions for measurement. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=23

CPC Practice Spotlight 76: Strategies for Meeting Patients 'Where They Are' and Making Self-management Support Work in a Busy Primary Care Practice (2016). Summit Family Physicians in Middletown, Ohio, integrates self-management support into how they engage patients. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=36

CPC Practice Spotlight 84: Geriatric Care Coordinator Boosts Patient Confidence, Satisfaction (2016). This New Jersey practice found it could best serve the needs of its largely elderly population by including a care coordinator specializing in geriatrics on its care team. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=42

CPC Practice Spotlight 86: Pre-visit Planning Helps Eliminate Gaps in Patient Care (2016). This Spotlight describes how an Ohio practice uses both population health software and chart audits to identify patient care needs, including a brief list of the steps in the practice's visit planning process. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=44

Culture and Health Literacy http://www.cdc.gov/healthliteracy/culture.html

Health Literacy Measurement Tools http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html

Health Literacy Universal Precautions Toolkit http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

Healthy Huddles (2013). https://cepc.ucsf.edu/healthy-huddles

How's Your Health https://www.howsyourhealth.org/

Motivational Interviewing videos:
a. ***The Ineffective Physician: Non-Motivational Approach*** (2009). https://www.youtube.com/watch?v=80XyNE89eCs
b. ***The Effective Physician: Motivational Interviewing Demonstration*** (2009). https://www.youtube.com/watch?v=URiKA7CKtfc

An Organized Approach to Chronic Disease Care (2011). This article discusses the development of organized, team-based care with the use of registries and other tools to improving the care of chronically ill patients. http://www.aafp.org/fpm/2011/0500/p27.html

Partnering in Self-Management Support: A Tool-kit for Clinicians (2012). http://www.improvingchroniccare.org/downloads/selfmanagement_support_toolkit_for_clinicians_2012_update.pdf

The Patient Activation Measure Survey http://www.insigniahealth.com/products/pam-survey

Patient Activation Measure Tool Helps Patients Avoid Hospital Readmissions (2014). http://www.the-hospitalist.org/hospitalist/article/126322/patient-activation-measure-tool-helps-patients-avoid-hospital

The Primary Care Team Guide – Improving Primary Care: A guide to better care through teamwork (2016). Improving Primary Care. http://www.improvingprimarycare.org/