CPCPracticeSpotlight52

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

A Small Practice and Shared Decision Making: Start Simple to Scale Up

Santiam Medical Group, Aumsville, Oregon; system-affiliated; 2 physicians, 1 NP; 2,430 patients

Aug. 14, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.4: Patient and Caregiver Engagement

CPC Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

CPC Change Driver 4: Optimal Use of Health IT

- 4.3: EHR-Based Quality Reporting

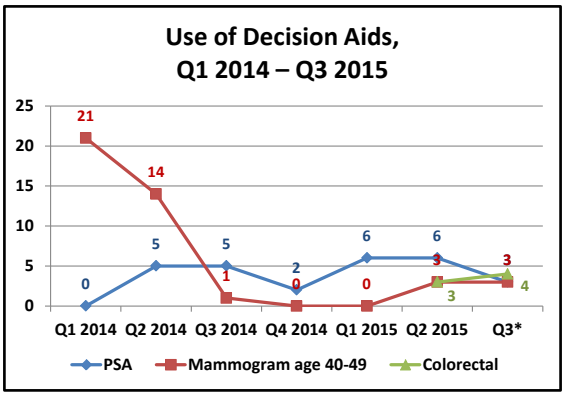
For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: This small practice started CPC shared decision making (SDM) in 2014 when testing prostate-specific antigen (PSA) for eligible patients. To date, **Santiam Medical Group** has expanded its shared decision making (SDM) work to mammography and colorectal cancer screening following the same approaches and process measures described below.

Innovation: While only a small number of its patients are eligible for the PSA screening, Santiam Medical Group designed workflows and process measures that could easily scale to new topics as the practice broadened its SDM work.

After obtaining free decision aids on PSA testing from the American Cancer Society, Santiam printed some for patients to use in the office and to take home.

Process measures are tracked within the EHR (Greenway Prime Suite). With help from the Santiam IT department, dummy billing codes and templates were set up to track use of the decision aid. The template documents the patients' eligibility and also their use of the decision aid. If the patient receives the aid, a fake procedure code is entered into a discrete field. The practice has now added a field to record if the patient declined the aid. A search for those codes easily provides tracking data and reports for these process measures. The document template is not associated with a visit and can be pulled into the patient's notes as needed.



Use of decision aids are documented with a dummy procedure code in the patient record. The practice now also records if the patient accepts or declines the screening. Use of the mammogram decision aid started with another initiative with a high volume requirement at start. Santiam restarted the work in 2015 with CPC tracking measures.

**Q3 data as of July 31, 2015.*

As medical assistants (MAs) complete a patient's intake information, they ask eligible patients (men, age 50+, no history of prostate cancer or symptoms associated with that cancer) about PSA screening. MAs document if the aid was offered as well as if the patient accepted or declined the screening.

Factors that affect implementation and outcomes:
Regardless of practice size, several factors contribute to how shared decision making is deployed into routine workflows.

***Focus on effort* —** Competing priorities and initiatives affecting a larger population can make continuity of effort a challenge. Running data quarterly and sharing about outcomes with the team helps keep the effort visible. At Santiam, physician-led daily huddles include reminders about shared decision making and other quality improvement initiatives.

***Clinical judgment* —** Due to staffing changes, MAs have varying levels of expertise in identifying eligible patients. Training and guidance on patient eligibility is an ongoing process to ensure consistency in delivery and tracking. The practice plans to make all decision aids available in exam rooms for patients to read while waiting. Providers have found that patients will ask questions after viewing the materials, and this helps MAs with identifying eligible patients.

***Patient bias, expectations and behaviors* —** Questions in mass media about the efficacy of PSA screening have swayed patients to particular viewpoint. Conversely, messaging from other health care groups sets the expectation that PSA screening is a "must have" for preventive care. Other patients are surprised that physicians present options for screenings and would prefer to be directed toward the choice most appropriate for them. Although decision aids are generally easy to read with a mix of text and graphics, some patients resist taking five to 10 minutes to read the material and would prefer to have the physician present the options.

Outcomes: Rates have remained relatively stable across implementation (see run chart above). Using templates and dummy billing codes have proven effective for tracking the process measures, and now they are in use as the clinic has started SDM for colorectal cancer screening options (all patients ages 50+) and frequency of mammography (women ages 40–49). Having established workflows for identifying patients and appropriately documenting SDM has made expansion and adoption easier for the care team.

TMF Health Quality Institute

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