

# **Topic-Specific Implementation Guides**

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An Initiative of the Center for Medicare & Medicaid Innovation



## **Care Management:** A Review of CPC Practice Approaches June 2014



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## Care Management: A Study of CPC Practice Approaches

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## **Purpose of this Guide**



This guide reflects on how CPC practices across the country have approached the care management component of Milestone 2. These practice strategies represent samples of the work and are not representative of every strategy for implementing robust care management in a practice.

CPC practices are heterogeneous in size, geography, ownership and organization; they are encouraged to innovate and test strategies derived from evidence-based and/or best practices, and customize the work according to their particular needs, local dynamics and other practice aspects that may shape how they deliver care management services.

This Guide captures the energy, innovative ideas and rigorous and determined execution of the CPC practices as they test and implement care management in their practice. Through this Guide we hope you find in your colleagues' work the support for implementing Comprehensive Primary Care.

June 11, 2014

## **Overview of the Care Management Component in Milestone 2**

Milestone 2: Population Health and Care Management for High-Risk Patients addresses population health, with a priority of focus on those at highest risk for poor outcomes and preventable harm. In Program Year (PY) 2013, practices engaged in routinely assigning risk status to all empanelled patients through a risk stratification methodology and built care management capacity into their care teams to address outreach and intense intervention needs of those patients identified at highest risk. Effective Care Management results from a complex exercise of

#### **Steps before Care Management:**

- 1. Empanel patients using EHR
- 2. Develop risk stratification methodology
- 3. Develop care management strategy
- 4. Build care management capacity into care teams

clinical judgment. It happens as relationship-based engagement with a care team that is proactive, longitudinal and focused on meeting the patient's clinical and health care needs is built. The ultimate goal is to work with the patient to meet his or her health care goals.

## **Essentials of Care Management of High-Risk Patients**

#### 1. Plan of Care

A mutually agreed upon and documented plan of care based on the patient's goals

#### 2. Evidenced-Based Pathways of Care

Planned and documented pathways of care based on best available evidence and guidelines for care in the unique context of the individual patient

#### **3. Proactive Delivery**

Do not wait for visits or acute decompensation – this is not primarily visit-based. Patient visits are opportunities to define goals, plan care, engage in Shared Decision Making and build a trusting relationship, but most care management activities take place by phone, email or home visits (as well as visits to SNFs or hospitals to support transitional care). These activities are appropriately targeted based on patient needs.

#### 4. Team-Based Approach

Care management includes dedicated clinically trained staff working closely with the physician in a teambased approach to care for individuals with complex health needs. Staff is typically in the nursing or social work disciplines but occasionally from other disciplines such as pharmacy and dietetics.

#### 5. Care Management Documentation

Documented activities are included the medical record with input to capture critical information. These include the nature and substance of the contact, assessment of current status, changes to the care pathway or overall care plan, unresolved questions and next scheduled follow-up contact.

#### **Care Management versus Care Coordination**

Care Management is distinct from Care Coordination, which in CPC refers to the organization of care both within the practice and between the practice and community settings, labs, specialists and hospitals. Care Coordination activities include closing care gaps, coordinating care between transitions and reducing fragmentation.

Care Management activities are person-focused, ensuring individuals at high risk get the care they need and desire, and Care Coordination activities are system-focused, ensuring that care is seamless across providers and transitions.

Care Management	Care Coordination
Person-focused	System-focused
Organization of care within a practice and	<ul> <li>Closing care gaps by coordinating between</li></ul>
between health organizations	transitions and reducing fragmentation
Ensure individuals are getting the care they	<ul> <li>Ensure seamless care across providers and</li></ul>
need	transition

## **Reporting for PY 2014**

Practice-based empanelment, risk stratification and care management will remain an essential part of CPC throughout the program. While practices will work toward achieving **risk stratification of 75 percent of empanelled patients**, the care management target is to **provide care management to at least 80 percent of patients identified as those at highest risk**: those that are clinically unstable, in transition and/or otherwise need active, ongoing, intensive care management. Quarterly reporting will include updating information about the practice's care management staffing and activities. (Complete reporting requirements for this work are described on page 13 of the <u>2014 Implementation Guide</u>.)

Achieving a successful balance for effective care management may require adjustments over time. If the number of patients in the highest risk cohort is disproportionately large, the risk stratification process may not be discriminating enough, calling for a more narrow definition to meet the patients' care management needs adequately. Similarly, if the risk stratification method is too narrowly defined, opportunities to identify and care-manage some patients may be missed. Using the PDSA cycle, a practice can further refine the risk stratification process to help ensure the highest risk cohort has a proportional distribution of empanelled patients. Furthermore, the patient caseload must align with the care management resources to ensure timely and appropriate services. Finally, tracking the care management interventions is essential for identifying gains in key data points such as fewer hospitalizations, reduced ER visits and better health. This facilitates movement of patients from a high-risk stratum to a lower risk stratum. Each of these key components work in tandem with each other, and practices will need to carefully plan their approaches and tests for effectiveness to make the most timely gains.

## **CPC Practice Approaches**

The CPC initiative encourages practices to develop creative, innovative solutions to achieve the three aims of better health, better care and lower cost. As a result, CPC practices have undertaken diverse approaches to care management implementation. Several practices have chosen to hire a designated care manager whose primary responsibility is to address care management specifically, while others have taken a team approach by dividing portions of the care management responsibilities among existing team members. In both models, there is a net increase in time spent managing the care of complex patients.

Care managers across CPC represent a spectrum of backgrounds from registered nurses (RN), social workers (SW), licensed practical nurses (LPN), medical assistants (MA) and medical office assistants (MOA). In the case of some smaller practices, the providers (physicians, nurse practitioners [NP] or physician assistants [PA]) have also assumed the bulk of care management responsibilities.

In general, smaller practices tended to hire MAs or LPNs for this role, while larger multipleprovider practices usually hired RNs as care managers. Some of the larger system-based practices have centralized care management by housing and training care managers in one location for all the practices in the system. In



some instances, the care managers are located onsite within the practices after completing the initial training. Is it important to note that some CPC practices use the terms care management, case management, health coach and care coordinator interchangeably. The semantics are not as important as identifying the care management responsibilities each role performs.

To best illustrate the diversity of CPC practices' approaches to care management, this Guide provides a sampling from CPC practices across the regions. These case studies demonstrate how innovation can vary within CPC. As you examine these practice stories, keep in mind that each practice should determine the best approach for its practice, culture and patient population.



**Case Studies** In the following case studies, CPC practices explain how they provided care management services to best meet the needs of their patient population.

## Case Studies Designated Care Manager

Many CPC practices across the United States have hired a care manager to implement care management successfully. Designated care managers are motivated and focused on resources devoted to helping patients achieve their health goals. This approach is more common in larger practices that can devote a FTE to care management duties. Smaller practices can also work together to share a designated care manager. The following case studies highlight how CPC practices recruit, hire, train and on-board designated care managers as well as work with care coordinators.

## Finding the Right Designated Care Manager

Summit Medical Clinic, Colorado Springs, Colorado Independent; one physician, one PA, two ANPs; 3,000 patients



#### Figure 2: PDSA Cycle Refer to Improvement Basics webinar (Oct. 23, 2013) for additional information about how to design and apply PDSA cycles to your work.

While some practices began the care management journey with a designated care manager, other practices arrived at that solution after several iterations of PDSA cycles, like **Summit Medical Clinic** of Colorado Springs, Colorado. Following the best tenets of practice transformation, Summit used <u>PDSA cycles</u> to test care management activities in its practice, eventually finding a dedicated care manager was the best fit for the practice. Summit's care management strategy stems from ongoing empanelment and risk stratification of patients.

**PDSA 1**: Early in the work, the practice hired a medical assistant to serve as the care manager and care coordinator. However, Summit found that a high-level MA lacked the training and skills to be an effective care manager. The practice revised the focus of the MA's work to population management, including generating reports for the practice, with some follow-up calls to high-risk patients between visits.

**PDSA 2:** The higher level care management responsibilities shifted to the providers with the goal of seeing all high-risk patients. Providers each carved out three hours per week for chart review on high-risk patients and conferenced with their MA and the care coordinator as needed. Again, while this brought the needs of the patients to light, this effort did not meet their expectations because patients were generally unavailable for appointments during the three-hour blocks.

**PDSA 3:** The practice then set up weekly visits focused on care management during a three-hour block of time. For these patients, the provider created a patient-focused care plan that included short- and long-term goals. This model proved to be an ineffective use of provider time as each appointment tended to last at least 45 minutes. The pace made little progress toward achieving the practices' goal of seeing all high-risk patients.

**PDSA 4:** The final PDSA led the practice to hire a full-time <u>RN care manager</u> and assign a <u>care coordinator</u> (complete job descriptions for these two roles can be found in the Appendix). Since hiring the care manager, <u>the clinical</u> <u>workflow</u> (see the Appendix for details) appears to work well for the practice. The care manager has an identified panel of 155 patients who are at high risk and a goal to engage each of these patients in active care management.

#### Designated Care Manager: Selected Best Practices

- 1. Develop robust job description
- 2. Build consensus on particular issues
- 3. Get buy-in from staff
- 4. Re-arrange workflow

Summit Medical Clinic is now testing a collaborative care plan process. This team approach introduces the patient to the care management program through the provider's warm handoff to the care manager. Currently, the RN care manager meets with patients, between or in conjunction with primary care visits, in the office, at their home and over the phone. As part of this program's continued growth, the practice

intends to add email communication as a component of care management in 2014. The care manager is also responsible for calling all care-managed patients after hospital discharges or ED visits for follow-up care and appointments, as needed. The care coordinator is primarily responsible for overall population management, coordinating follow-up care for patients in the lower risk categories after hospital discharges or ED visits, and management of reports such as clinical quality measures (CQM) and utilization measures (UM). Each provider's MA is responsible for pre-visit chart review/update and tracking referrals, labs and tests.

#### **Implementing Designated Care Managers**

#### Baptist Health Family Clinic, Bryant, Arkansas System based; three physicians, one ANP; 6,000 patients

**Baptist Health Family Clinic** in Bryant, Arkansas, found the implementation of dedicated care management to be an exciting and rewarding aspect of CPC. The addition of the care managers and the staff's increased awareness and knowledge of care management have allowed the practice to provide more intensive care management by helping patients identify their self-care goals, developing care plans for those patients and effectively following up on their progress. This practice's leadership feels that patient experience of care improves when patients are able to sit down with someone during their visit to develop a personalized self-management plan.

This practice realized that by employing a range of staffing levels for care management roles, the likelihood of improved communication with patients increased. Some patients who are reluctant to ask questions of primary care providers may be more open and receptive to communicating freely with the care management staff, including discussing their barriers to care or concerns about treatment.

Baptist Health's care management workflow begins when a patient checks in. The nurse or MA updates completion of any routine screenings or tests, reconciles the medication list with the patient and updates social, surgical and past medical history. This practice emphasizes accurate medication reconciliation as a critical step. The providers and care facilitators update risk status and, if a patient is due for preference-sensitive preventive screenings, they provide decision making aids to the patient. If the nurses and providers recognize a need for more intensive care management, they refer the patient to a care manager for a same-day or scheduled appointment.

Care managers provide support to patients living with many chronic health conditions such as diabetes, hypertension, hyperlipidemia, COPD and asthma management. If a patient may benefit from home health, the care manager initiates this level of care. They assist patients with access to medications, meals, medical equipment and some specialists. The care managers also work with patients to develop patient-focused care plans for their chronic conditions.

Baptist Health has found that its efforts in care management are improving outcomes. The practice's focus for PY 2013 was to improve hemoglobin A1c results among patients with diabetes. In the summer of 2013, a provider diagnosed diabetes in a patient who was in her late sixties. The patient met with a care manager on the day of the diagnosis and set a personal goal to lose 30 pounds by using the <u>Plate Method</u>, a basic method to eat healthfully with diabetes, along with starting to exercise regularly and adhering to a regimen of oral diabetes medication. She attended evening education classes about diabetes at the practice and

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learned how to check her blood sugar daily. Six months later, the patient had lost 28 pounds and dropped her A1c from 8.5 to 6.6. She told staff she felt empowered because she received support for learning how

"She feels empowered because she learned how to take care of herself with diabetes." to take care of herself and manage her diabetes. The care management program further bolstered her confidence in disease management because she learned when she should call the clinic to address concerns or questions. If she called, she knew someone would take the time to talk with her and resolve her concerns.

Since beginning intensive care management in 2013, Baptist Health Family Clinic's data shows improvement in A1c levels among the entire empanelled patient population who have diabetes.

#### **Training Care Managers**

#### St. John Clinics, Sapulpa, Oklahoma System; three physicians, one ANP; 5,378 patients

**St. John Clinic of Sapulpa** is a part of the St. John Clinics in Tulsa, Oklahoma. The care management program is centralized within the St. John Clinics system. They hired primarily RN care managers, following the suggested staffing plan found in several care management resources.

The St. John Clinics began their journey toward care management with only medical assistants and used the CPC Regional Care Management Webinar to learn about hiring guidelines and duty assignments as well as how to establish a process for identifying high-risk patients. The number of care managers needed was determined by evaluating a physician's panel and estimated 10 percent of the patients to a care manager, based upon findings in the literature. However, this strategy proved ineffective for St. John. Using the AAFP risk stratification model, the practices focus the care managers' efforts on patients in category 5 and 6. This calculation netted each care manager an average of 750 patients. They attribute this disproportionate number to low socioeconomic status, and low education level among their population. St. John Sapulpa has one care manager, with 943 patients that are risk 5 and 116 patients that are a risk 6, which makes a total of 1,059 patients identified as needing intensive care management.

St. John Clinics hired a central care manager to help identify the target patient population, a decision the practice insists was their best during the implementation of care management. The central care manager was housed in a vacant suite at one of the practices. As other care managers were hired, they would work at that office for training. The central care manager trained new care managers on the risk stratification tool and validated that they could use it properly. While it was tedious work to sit in a room and risk stratify patients, an unexpected benefit emerged. The care managers developed relationships that they have maintained after they were "deployed" to their individual clinics. They also see the central care manager as the leader, although they technically report to their clinic's practice manager.

Currently the central care manager represents the St. John Clinics at readmissions meetings with their system hospitals as well as at the CPC group meetings outside their health system. Each month the central care manager meets the practice managers and other site-based care managers for a check-in, to keep communication flowing and to discuss points of interest or concern (e.g., care plans, CPC-related activities, etc.). St. John envisions the role of care managers will continue to change and grow as the system's

workflows evolve. It is expected that more care managers will be added as the new workflows are established.

## **Using a Team Approach**

Rather than hiring one or two staff that solely focus on care management, some practices have chosen to implement a team approach where each team member takes responsibility for some aspect of the overall care management program. The team approach incorporates the multidisciplinary specialties of individuals working in the practice to help provide care management for the patients. Many smaller practices have chosen the team approach. The examples described here show effective care management is possible in the small practice. The following practices' stories illustrate use of multidisciplinary care management strategies.

## Assigning Duties in a Care Management Team

Village Primary Care, Hoosick Falls, New York Independent; two physicians, one ANP; 4,689 patients

**Village Primary Care**, a small, rural practice in Hoosick Falls, New York, has adopted a team approach to care management. CPC funding was used for a part-time RN nurse case manager, a part-time diabetes educator, a transitional care nurse and an MA. The practice combined roles to provide comprehensive yet efficient use of the disciplines. The MA manages the patient panel, working from reports and directly with patients to arrange needed health care services. The RN is a contracted care manager who works with high-risk patients to develop and implement care plans in conjunction with the primary care provider. The diabetes educator is contracted two and half days per month to work with at-risk patients with diabetes in both one-on-one and group settings.

Due to the practice's rural location, most patients use one hospital, Southwest Vermont Medical Center, and a transitional care nurse is contracted 16 hours per week to work with high-risk patients upon discharge from that facility. The transitional care nurse works at the hospital and coordinates patient care upon discharge with a warm hand-off to the RN care manager in the practice (see an <u>example of the workflow</u> in the Appendix). The role of the transitional care nurse focuses more on care coordination across the medical neighborhood instead of traditional care management, similar to the traditional case manager role in the hospital setting. Practices seeking to follow this strategy may want to attempt to recruit ideal candidates from current hospital case managers.

#### Hudson Valley Primary Care, Wappingers Falls, New York Independent; two physicians, two ANP; 8,290 patients

**Hudson Valley Primary Care** in Wappingers Falls, New York, also uses a team approach to care management and coordination with duties designated to the appropriate discipline. The care team "huddles" regularly and uses a physician, a NP, a RN, a LPN and administrative support for a combined set of activities focused on ensuring a coordinated system of care for all patients. The full-time RN is certified in care management and has nine years of clinical nursing and three years of experience working in a primary care medical home. She supports the patients in the highest risk strata, and her typical case load consists of approximately 1 to 2 percent of the practice's patient population. Essential activities of the nurse care manger include managing transitions of care, completing medication reconciliation, providing self-

#### Huddles:

The huddle is an informal meeting that occurs at the end and beginning of the day where the provider, nurse and secretary review the patients as a team. The nurse looks at the chart to see why the patient is coming in, inserts the correct templates and uses order sets to enter the correct labs. Then, the nurse confirms the patient is up to date with all preventive screening and vaccinations and flags the chart to indicate if they need anything. The nurse also reviews same day appointments to make sure that these patients are up to date with their chronic disease management. If the patient is a case-managed patient, the nurse will then communicate with the RN CCM to allow time for the RN CCM to meet with the patient. The provider and the nurse will complete the huddle in the morning before starting appointments but also may huddle throughout the day to ensure that all the patients' needs are being addressed. The nurse also reviews referrals that have been outsourced to specialists and makes sure that the consult is in the chart for the providers.

management support and developing individualized care plans with patients. In addition to clinic huddles, the team has regular medical home meetings where the nurse care manager can alert and provide details to the full team about patients of concern. The monthly medical home meetings cover the CQMs and review patient experience results. The team also reviews all the patients who have been in the hospital and the ER to see if an admission could have been prevented. Patient-centered care plans are part of the EHR and are printed and provided to all high-risk patients at the end of each visit.

#### Upper Valley Family Care, Troy, Ohio Independent; six physicians, two ANP; 12,485 patients

One individual performing all the tasks required of the care manager may not be sufficient for a practice based on size or that has high levels of risk in the patient population. **Upper Valley Family Care** in Troy, Ohio, divided the care manager role between these two FTEs and titled them health coach and transitional care coordinator. This practice began by developing a job description for a health coach and transitional care coordinator and made the decision to contract these new positions.

In this practice, the role of the <u>health coach</u> performs care management for the low-risk population while the care coordinator performs the role of external care coordination across the medical neighborhood, as well as care management of the high-risk population. They share duties fluidly, with the health coach focusing on helping patients attain the knowledge, skills, tools and confidence to become effective participants in their care so they can reach their self-identified health goals. They work with patients at all risk levels, encouraging them to obtain regular preventive health care and assisting patients in setting simple goals toward achieving better health.

The <u>care coordinator</u> in this practice provides care coordination for Upper Valley patients identified as being at higher risk according to the AAFP stratification scoring tool. The care coordinator develops and monitors care coordination processes by first identifying the high acuity patient population or receiving a referral from the care team. The care coordinator implements specific care planning

#### **Care Management Tip:**

Develop patient care plans as a part of the EMR so it can be printed and provided to the patient upon completion of the visit.

activities, assisting patients with goal setting and self-management activities during scheduled care coordinator appointments and regular follow-up phone calls. Patients are referred to community resources as needed. The care coordinator also contacts and assists patients in the transition from the hospital or skilled nursing facility to the home. Home visits are also made when indicated.

#### Health Coach versus Care Coordinator

#### Health Coach

- Patient-focused
- Works 1:1 with patients
- Patient education and support
- Preventive screening for all risk levels

#### **Care Coordinator**

- Patient-focused goal setting for high risk
- Care planning, follow-up
- Care transitions
- Works directly with external facilities

Upper Valley Family Care has established workflows to define both roles. Both roles spend most of their time interacting with patients so a major focus has been defining a staged approach to conversations to prevent overwhelming the patients with information. This practice emphasizes

accurate, discrete EHR entries to eliminate time-wasting patient changes. Correctly entered information helps the care coordinator or health coach to access information quickly to identify relevant patient needs.

**Care Management Tip:** One efficient method of avoiding patient chases is recording information in designated fields within the EHR so it can be accessed quickly by the care manager.

Upper Valley Family Care believes the care management process slows the patient visit process and increases staffing patterns. However, the provider now focuses solely on why the patient is

presenting, knowing the health coach has already dealt with any outstanding health maintenance needs. Providers commented on this improvement immediately after the health coach joined the staff. Dealing with the preventive care for patients at all risk levels helps to lower the risk status of the individual so that the care coordinator need only deal with the process of care management of the high-risk individuals.

Upper Valley Family Care has a sister office in Piqua, Ohio, that is served by the same provider group. The team approach to care management was initiated at the Troy office, where the health coach role was initially added. CQM scores clearly demonstrate which of the two Upper Valley offices had a health coach as a part of care management initially: preventive care measures were 8 to 12

Survey data shows 100% of patients seeing the care coordination agree or moderately agree that it was a positive experience and that they received helpful information.

percent better for the office with the health coach. As for the care coordinator services, 100 percent of the patients seeing the care coordinator agree or moderately agree that it was a positive experience and that they received helpful information and services. They have since added a health coach to both sites, and have determined the best staffing for total care management is one health coach per two providers. For high-risk patients, there is a care coordinator at each site as well.

As Upper Valley created its care management program, the most significant barrier it encountered was identifying and dealing with varying socioeconomic and education levels in their patient population. In the process of implementing care management, it became apparent that patients weren't completely forthcoming in the office. Home visits by care coordinators revealed patients who could not read and others who were improperly taking their medications. The practice realized that determining the full perspective of the patient and then matching the patient to needed services was critical to effective care management.

## **Care Management Teams Working with Care Coordinators**

## Dennis Novak, MD, PA, Forked River, New Jersey Independent; one physician, one PA, one ANP; 3,694 patients

The distinction between care management and care coordination is important. A care management teambased approach can be tailored to best suit the practice and its empanelled patient population. The duties of care management and care coordination can be combined into one FTE or divided among several members of the team. The care management responsibilities can be divided among the entire spectrum of



providers, or in the following example, between one RN and the practice's PA and APN.

**Dennis Novak, MD,** in Forked River, New Jersey, is a onephysician practice supported by a PA and an APN. With the goal of providing the best care to its patients in a timely manner, this practice decided that the care manager role (also known as nurse care coordinator in this practice) should be filled by someone who knows their patients, practice and providers and has a good understanding of the practice mission. This practice attempted to achieve care management initially with a part-time nurse care coordinator but found that patients often returned calls when the coordinator was off. Making the nurse care coordinator a full-time position facilitated her role as a key component in the clinic's communication process. An RN who was already on staff

eagerly accepted the challenge of the new role.

Practice culture and dynamics helped accelerate transformation in this office. The PA and ANP who had strong rapport with the patient panel also had personal knowledge of patient goals and needs. Understanding how care management tied into improved outcomes motivated the staff to willingly accept additional responsibilities and improve coordination with each other.

#### Tips for Successful Care Management:

- Ensure constant communication between all staff.
- 2. Educate staff on the goals and their roles in the process.
- 3. Solicit staff input in process.

Providers notify the nurse care coordinator of all patients sent to or referred to other facilities. Support staff alerts the care coordinator of patient admissions. The care coordinator initiates the preliminary tracking of care transitions with the assistance of support staff. The PA and ANP then assume the care management responsibilities of the highrisk patients so that each person functions to the highest degree of their capabilities.

Dr. Novak feels the RN care coordinator is the linchpin for successful care management. This role must have the authority and skill to make

decisions and the confidence that the practitioners trust her expertise and support her role. While this is not an easy job, the care coordinator has found patient response gratifying.

Like other practices, Dr. Novak has found that thorough care management may extend the overall patient visit time. Prior to the visit, the RN coordinator addresses gaps in care or preventive needs. During the provider encounter, the physician is able to solely focus on the patient's acute concerns.

The practice experienced how the nurse coordinator contributes to improved overall care during the care of a patient with a possible critical medical need. A specialist had ordered an imaging study that showed a critical condition. The specialist's office filed the report with the primary care office in preparation for a scheduled follow-up appointment. However, the specialist's office canceled the appointment due to inclement weather and failed to reschedule the patient. When the follow-up paperwork came to the nurse coordinator's attention in the primary care office, she recognized the urgency of the situation and alerted the primary care physician, who contacted the specialist. The appointment was quickly re-established, resulting in a timely and safer outcome for the patient.

#### **Embedding Care Management into Workflow**

### TriHealth Physician Partners, Springdale, Ohio System; five physicians, one ANP; 12-13,000 patients

<u>TriHealth</u> is a Cincinnati-based, not-for-profit health system. Nineteen of the 34 TriHealth practices are CPC practices that serve 149,420 empanelled patients. The Springdale practice providers have an average of 2,800 patients per provider. 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.

As physicians meet with patients, they introduce the care manager, explain their role and describe how the care manager will regularly contact them. All practice sites follow the same care management processes, but daily work varies among the care managers in accordance with the patient's level of need. In each risk 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 ineffective self-management and other barriers to successful disease management and wellness.

As physicians meet with these patients, they introduce the care manager, explain the role in their care and describe how the care manager will regularly contact them. The physician introduction of the care manager role increases patient engagement especially for the high-risk patients who need more services.

**Washington Regional Clinic for Senior Health** in Fayetteville, Arkansas, consists of four geriatricians, one internist, one neurologist, three APNs and two social workers. The social workers are available to patients and their care partners to assist with their social service needs, such as finding appropriate in-home care support, making the transition to a nursing home and applying for prescription assistance. Caregivers appreciate the psycho-educational support groups and one-to-one support to help them manage their loved ones' needs. Washington Regional followed the <u>workflow diagram</u> below to help them visualize the care manager's role in the practice.



Figure 4: Washington Regional Clinic for Senior Health Workflow

**Erickson Health Medical Group** created a <u>workflow diagram</u> to describe its care management practice. The workflow begins with a quarterly risk report on all patients. This report is generated from the Centricity and ranks all patients by risk score according to their diagnosis.

The horizontal swim lanes delineate each participant in the care management work process and that person's role in the process. The workflow also connects and sequences the activities each participant performs.



Figure 5: Erickson Health Medical Group Care Management Workflow

## Conclusion

Care management is crucial for practices to achieve the aims of CPC by creating a relationship-based engagement between the patient and care team that is proactive, longitudinal and focused on improving the patient's health and meeting their health care goals. These case studies exemplify strategic options in support of CPC practices building their care management capabilities. The capabilities' larger context of care management derives from and in turn supports the key change concepts supporting the five comprehensive primary care functions:

- Access and continuity
- Planned care for chronic conditions and preventive care
- Risk-stratified care management
- Patient and care giver engagement
- Coordination of care

Since the inception of the CPC program the hire and use of care managers has increased from 980 FTEs to 2,500 care manager FTEs. Care management has many benefits for patients. As the CPC work continues, practices will develop more innovative approaches to ensure patients receive these valuable services.

## Resources

### **Care Management**

#### **Care Management Tools**

#### Care Management in CPC (1-page PDF)

Definition, essential features and distinction between care management and care coordination. This is a critical document for educating team members and framing how to do the work of care management.

Compilation: Care Coordinator Job Descriptions

Examples of care coordinator job descriptions.

#### **IHI: Chronic Care Management**

This web page lists several tools, articles, models and assessments available at the Institute for Healthcare Improvement Knowledge Center. The resources available include identification of six fundamental areas forming a system that encourages high-quality chronic disease management, and a survey to assess your organization's current levels of care with respect to the six components of the Chronic Care Model.

#### Infographic of the Transitional Care Management (TCM) Process (1-page PDF)

This workflow map summarizes a practice's transitional care management process, outlining the process following a patient's hospital discharge. Includes the documentation process and lists responsibilities by role.

#### Spotlight: TriHealth, Feb. 21, 2014 (3-page PDF)

This perspective on care management comes from TriHealth, a Cincinnati-based, not-for-profit health system. Four LLCs operate a total of 34 primary care offices affiliated with TriHealth; 19 of those are CPC practices that serve nearly 150,000 empanelled patients. 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.

#### Transitional Care Management (3-page PDF)

Policy, procedures, billing requirements and resources for Transitional Care Management.

#### **Care Management Webinars**

<u>Care Management</u>, Oregon Learning Session, Dec. 20, 2012 (40-page PDF) An overview of care management strategies, starting with who will provide the service and working through issues practices need to address as they operationalize.

#### Complex Care Management, Colorado Learning Session, March 8, 2013

This webinar describes high-risk care management, how it works and how practices can get started.

## Coordinated Systems of Care, New York Learning Session, Jan. 24, 2013 (50-page PDF)

This webinar summarizes the common perspectives of coordinated care, strategies for formation of a comprehensive care team, strategy for delivery of case/care management.

<u>An Overview of Risk Stratification and Care Management</u>, CPC National Learning Community, Feb. 27, 2013 (59-page PDF)

Outlines the basics of risk stratification and how it underpins successful care management.

## **Empanelment**

#### Empanelment Implementation Guide (5-page PDF)

This Implementation Guide explains empanelment within the context of CPC Program Year 2013 Milestones. It serves as a road map for empaneling patients in your practice.

## Appendix

## **Job Descriptions**

#### Care Manager, RN

#### Summit Medical Center, Colorado Springs, Colorado

The incumbent reports directly to the Office Manager at Summit Medical Clinic (SMC). The incumbent works collaboratively with clinic staff and management within SMC to achieve objectives of the patient-centered medical home, promote patient engagement and satisfaction, improve quality outcomes and maximize the use of available resources. The incumbent has contact with patients, physicians, allied health professionals, community groups, third party payers, agencies, vendors and other health care organizations.

#### PRINCIPLE ACCOUNTABILITIES:

The principal purpose of this position is to coordinate the activities within an interdisciplinary care team that takes collective responsibility for proactively supporting patients' unity of body, mind and spirit.

Develops, assesses and implements a comprehensive individualized care plan to patients.

- Completes comprehensive, age appropriate assessments based on patient's individual strengths, goals and needs. Includes assessment of both acute and chronic health conditions, social environments and psychosocial determinants of health
- In consultation with the patient, physicians and other care team members, coordinator develops proactive care plan to provide unity of body, mind and spirit
- Proactive outreach to patients between primary care visits
- Conducts ongoing assessments to determine response to care plan or services. Reprioritizes care plan based on new information and updates patient care plan accordingly. Assures patient, family and care team members who participate are informed of updated plan on regular basis
- Serves as primary advocate and liaison between patient, family, provider and other care team members
- Manages care coordinators. Responsibilities include but are not limited to: delegation of administrative work, assigning duties, serving as primary point of contact and ensuring high quality care coordination

#### QUALIFICATIONS:

#### Education/Experience

- Medical Assistant or Registered Nurse Degree required
- Experience in working in public health, social work and community nursing would be a plus
- 2 years' experience working in clinical and/or community health nursing position is preferred

#### **Knowledge/Skills/Abilities**

Knowledge of community health concepts, principals of community health and ambulatory clinical nursing care, case management, care coordination and epidemiology. Skills in health assessments, interviewing techniques, teaching, communication and nursing practice. Ability to function independently, prioritize and organize work, solve problems, adapt to change, function as a team member and relate to the public.

#### Care Coordinator

#### PRINCIPLE RESPONSIBILITIES:

- Assists care manager in running reports that support care management services
- Responsible for tracking referrals and tests for completion, attaching documentation to chart and tasking provider for review
- Call non-high-risk patients following ED discharge, and schedule for follow-up visit as needed within 7 days
- Call non-high-risk patients following hospital discharge and schedule follow-up appointment within 7-14 days based on acuity
- Proactive population management, running reports for gaps in care (preventative screenings, overdue labs and tests)
- Performs and directs patient care services including, but not limited to, admission interview, assessment, accurate documentation and timely patient flow
- Ensures patient is appropriately prepared for provider encounter. Prepares and obtains patient medical records and other information/documentation pertinent to patient encounter
- Screens patients to ensure priority is provided to patients in an emergency/acute situation
- Fills in for absent MAs as needed (see MA job description)

#### **QUALIFICATIONS:**

#### Experience:

<u>Preferred</u>: Two or more years ancillary health care experience in an ambulatory health care setting. <u>Education and/or Licensure/Certification</u>: Must meet one of the following criteria:

- CMA: requires active certification as a Certified Medical Assistant by AAMA or a National Certified Medical Assistant (NCMA) through the National Center for Competency Testing
- RMA: requires active registration as a Registered Medical Assistant by AMT
- MA: requires completion of an accredited Medical Assistant program CMA Certification required within 24 months of hire date

BLS or BLS instructor certification is required upon hire. Acceptable credentialing bodies and certifications include the following: American Red Cross: CPR/AED for the Professional Rescuer; American Safety and Health Institute: CPR, PRO, must say "Professional Level with AED;" and American Heart Association: Basic Life Support for Healthcare Providers.

#### Knowledge/Skill/Abilities:

- personal management skills and tools
- organizational policies, regulations and procedures
- medical equipment and instruments
- risk management, quality improvement and infection control
- ICD-9 and CPT coding skills
- insurance protocols

#### Skills as demonstrated through:

- applying and modifying the principles, methods and techniques related to ancillary health care services
- continuous accurate verbal and written communication
- establishing and maintaining cooperative and collaborative working relationships with patients, medical staff and the public
- continuous time, resource and task management

#### **Health Coach**

**General Summary of Duties:** Works as a team member with physicians/NPPs, care managers and floor nurses to provide quality health care. Assists physicians by helping patients gain knowledge, skills, tools and confidence to become active participants in their own care so they can reach their self-identified health goals. Identify overdue health maintenance items based on national guidelines by reviewing patient charts, reports and other tools available. Discusses national guidelines and UVFC protocols with patients.

**This position is considered a Team Leader position.** Nurse filling this position must also be able to work the floor as a team nurse and remain current on UVFC policies and procedures. This position is included in the Saturday nursing rotation.

Reports To: Nursing Supervisor

#### 5 Principle Roles of a Health Coach:

- 1. **Provide Self-management Support**. Train patients in seven domains of self-management support; providing information, teaching disease-specific skills, promoting healthy behaviors, imparting problem-solving skills, assisting with the emotional impact of chronic illness, providing regular follow-up and encouraging patients to be active in their care.
- 2. Bridge The Gap between Provider and Patient. Throughout the care process, there are plenty of opportunities for disconnects between the provider and the patient. Health Coach bridges these gaps by following up with patients, asking about needs and obstacles and addressing cultural issues and social class barriers. Health Coach serves as the patient's liaison and ensures the patient understands and agrees with the plan of care.
- 3. Help Patients Navigate the Health Care System. Connect the patient with resources. Navigate patients, particularly the elderly or disabled to locate and engage in services.
- 4. **Offer Emotional Support.** Coping with illness is emotionally challenging. Health Coach offers emotional support to help patients cope with their illness. Health Coach must exhibit compassion, patience and be able to teach coping skills.
- 5. **Serve as a Continuity Manager.** Health Coach connects with patients not only at office visits but also between visits, creating familiarity and continuity. Health Coach is available and establishes a trust with their patients. Health Coach is particularly helpful where providers work part-time or see one another's patients. Health Coach is the "linking of care" provided by different providers.

**Examples of Duties:** This list is intended to describe the general nature and level of work performed. They include the responsibilities listed in the job description of a Medical Assistant, **in addition** to the responsibilities listed below. It is not intended to serve as an exhaustive list of all duties, skills and responsibilities required of personnel.

#### **Health Maintenance Responsibilities**

Using available reporting from CINA, i21, the EMR and other possible sources, review patient charts based on established standards of care for health maintenance needs.

- Disease management regular checks, lab levels, other testing
- Medication management regular checks, lab levels, other testing
- Preventive care needs pelvic exams, mammograms, PSA, etc.
- 1. Discus needs with the patient.
- 2. Educate patients about their care and the importance of meeting their goals and assists with goal setting and plans for behavior change.
- 3. Make referrals as ordered by providers or by protocol.

#### Care Management: A Review of CPC Practice Approaches

- 4. Proactively contact patients to arrange follow-up on outcome goals that CINA Report shows are not being met.
- 5. Assist with obtaining test results from hospitals, specialists or out of area facilities if not readily available in patient's EMR.
- 6. Participate effectively as a team member in the clinic being accountable and helpful to co-workers, providers and patients.
- 7. Update patient history and health maintenance.
- 8. Re-index scanned documents when needed.
- 9. Review and clean up diagnosis lists.
- 10. May assist with EMR development/customization.
- 11. Attend scheduled and periodic meetings, trainings and other job-specific events as required.
- 12. Act as a "Champion" and serve as a role model to staff nurses.
- 13. Participate in staff/physician "huddles" and maintain "huddles."
- 14. Perform additional duties as assigned.

#### SERVE AS PUBLIC RELATION PERSON AT ALL TIMES

#### **Performance Requirements**

#### Knowledge, Skills & Abilities:

Knowledge of grammar, spelling and punctuation. Current knowledge of medical terminology. Current knowledge of medical practice and care to assist in giving patient care over the telephone. Skill in maintaining records, including charting and recording medications. Skill in establishing and maintaining effective working relationships with patients, medical staff and the public. Ability to react calmly and effectively in emergency situations. Ability to communicate clearly. Ability to read, understand and follow oral and written instructions. Ability to make mathematical computations. Ability to see and act on priorities. Strong interpersonal skills and ability to work collaboratively with patients, non-clinical staff and clinical staff. Skill in motivational interviewing.

**Education:** High school diploma or GED. Graduation from an accredited school for nursing, RN or LPN or RMA/CMA.

Experience: Over one year medical office experience required.

Certificate/License: Current nursing license (RN, LPN, RMA, CMA) from the state of Ohio.

**Physical Requirements:** Work requires standing and walking and carrying tablet computer for long periods of time. May require stooping, bending and stretching for supplies. Occasionally lifting supplies weighing up to 30 pounds. Requires manual and finger dexterity sufficient to operate a keyboard, telephone, copier and such other office equipment as necessary. Sight and dexterity to operate a PC, copy machine, fax machine, telephone and medical equipment. Hearing must be in the normal range for patient and telephone contacts.

#### Health and Social Requirements:

Self-Confidence – Can diplomatically express views that may be unpopular Self-Control – Composed, positive and focused under pressure Conscientious – Organized and always meets deadlines/commitments Innovation – Open to new ideas, approaches and information Achievement Drive – Consistently strives to improve standards of excellence Commitment – Makes sacrifices to meet goals and believes in core values

Care Management: A Review of CPC Practice Approaches

Initiative – Pursues goals beyond what is expected of them Understanding – Senses others' feelings/perspectives and takes interest in them Influence – Can effectively persuade others Communication – Deals with issues, listens and seeks mutual understanding Conflict-Management – Diplomatic, tactful and able to calm tense situations Collaboration and Cooperation – Shares plans, information and resources Optimism – Persistent despite obstacles and expects success, not failure

**Working Requirements:** Work is performed in the office environment. Involves contact with the staff and patients. Work may be repetitious at times. Interactions with others can be interruptive. Requires exposure to communicable diseases or body fluids, with frequent exposure to toxic substances, medicinal preparations and other conditions common to a medical environment. Work can be stressful and fast-paced. Interaction with others is constant and interruptive

#### **Nurse Care Coordinator**

#### Upper Valley Family Care, Troy, Ohio

**General Summary of Duties:** Provides care coordination for Upper Valley Family Care patients and support our Patient-Centered Medical Home. This includes developing and monitoring care coordination processes and supporting primary clinical teams with these efforts. It also includes identifying the high-acuity patient population and working to ensure care coordination for this patient population. The Nurse Care Coordinator is responsible for implementing specific care planning activities as well as referring to available community resources. Care Coordinator also assists patients in the transition from the hospital or SNF to home. Also includes evaluating the patient in the home when appropriate. The position may involve some patient triage.

The Nurse Care Coordinator will lead a Care Coordination Team which consists of the Care Coordination Manager, Providers, Clinical and Business staff and Practice Manager to best serve the needs of the patient.

The Nurse Care Coordinator will be responsible for appropriate documentation, report running, analysis and report development.

**Reports To:** Physicians and management team of Upper Valley Family Care and Care Coordination Manager of HPC

#### Direct Supervision of: None

#### Team Supervision of: None

**Typical Physical Demands:** Requires full range of body motion including stooping, bending, stretching and lifting, manual and finger dexterity and hand-eye coordination. Requires standing and walking for extended periods of time. Requires carrying and operating a notebook and or tablet computer. Occasionally lifts or carries items weighing up to 50 lbs. Requires corrected vision and hearing to normal range to record, prepare and communicate with patients and complete appropriate reports. Requires sight and dexterity to operate office equipment. Requires dexterity and typing skills to operate and document in an electronic environment. May require working under stressful conditions or working late or irregular hours. Requires travel to patient homes.

**Typical Working Demands:** Requires high level of tolerance in telephone situations. Remains calm during stressful periods and act appropriately. Establishes and maintains a tactful and strong level of interpersonal skills and the ability to work collaboratively with patients, non-clinical staff, clinical staff workers and the

public. Must be able to quickly learn new skills and concepts and adapt to change. Must have strong skills in independent problem solving and process management. Must be a self-starter, self-directed and must be able to implement new programs. Must be highly organized and detail oriented. Accepts responsibility and follows through on projects and activities. Must have the ability to analyze and present data accurately and effectively. Attends and participates in mandatory facility wide and department training/meetings as required.

**Typical Working Hours:** Work hours are varied Monday through Friday. Must be able to work early and/or evening hours. Must be able to travel between offices and to patient homes as necessary.

## Example of Duties: This list is not intended to serve as an exhaustive list of all duties, skills and responsibilities required.

Works with all teams as a resource on care management of Upper Valley Family Care patients. This includes:

- 1. Planning pre-visit workflow to ensure care completion prior to visit whenever possible.
- 2. Coordinating care with hospitals, ER, SNF, consulting physicians and community resources.
- 3. Developing a workflow to ensure smooth transition of care for patients treated in a facility (inpatient or emergency department), by a specialty physician or by another health care provider.
- 4. Providing after-visit summary review with patients whenever appropriate.
- 5. Involving the patients in activities to improve their health (patient engagement)
- 6. Educating the patient about self-management tasks they can undertake to gain greater control of their health status

Actively manage assigned panel of chronic care patients (high acuity, risks levels 4, 5, 6). This includes:

- 1. Perform initial patient assessment and develop individual patient care plan.
- 2. Ensure the care plan is followed.
- 3. Develop relationships with the patients as an integral team member.
- 4. Provide follow-up contact with patients as indicated to ensure compliance with recommendations, medications, lab/x-ray, specialist visits, PCP visits, dieticians etc.
- 5. Manage many aspects of patient care as needed. This includes referrals to specialists, hospitalizations, ER visit, ancillary testing and other enabling services.
- 6. Provide telephone advice, handling urgent calls and emergent calls.
- 7. Anticipate the needs for this patient population, see that the necessary documentation and previsit planning is completed or requested before the patient visit. Work patients and their care teams to coordinate change, readiness, needs, assessment and develop an individualized treatment care plan.
- 8. Assist patients in setting *SMART* goals for self-management, teaching them how to do self-management tasks and reporting abnormal findings to their physician.
- 9. Collaborate with patients, physicians and other care team members in assessing patient progress toward individual health care goals.
- 10. Assess barriers when patients are not meeting treatment goals, not following treatment care plan or have not kept important appointments.
- 11. Collaborate with payer case managers for additional services when appropriate.
- 12. Help develop and maintain a list of medical supply and community resources available to patients.
- 13. Assist in developing protocols for PCMH delivery model and reporting outcomes.
- 14. Appropriately utilize EMR to ensure consistent documentation of services and use of searchable and reportable fields for activity tracking and measurement of change/outcomes.

#### **Performance Requirements:**

#### Knowledge, Skills and Abilities:

Knowledge of grammar, spelling and punctuation. Current knowledge of medical terminology. Current knowledge of medical practice and care to assist in giving patient care over the telephone. Skill in maintaining electronic medical record including charting and recording medications. Skill in establishing and maintaining effective working relationships with patients, medical staff and the public. Ability to react calmly and effectively in emergency situations. Ability to communicate clearly. Ability to read, understand and follow oral and written instructions. Ability to make mathematical computations. Ability to see priorities. Ability to analyze and present data accurately and effectively. Strong skills in independent problem solving and process management. Strong interpersonal skills and ability to work collaboratively with patients, non-clinical staff, clinical staff and project teams. Effective oral and written skills to document and communicate information correctly. Ability to communicate with tact and diplomacy.

Education: RN (BSN preferred) from accredited school of nursing required.

**Experience:** At least 3 years clinical experience in acute and outpatient settings, homecare and/or physician offices. Previous experience with clinical pathways, data analysis and health care operations preferred.

**Computer Experience:** Previous experience with electronic medical records preferred. Proficiency in use of Windows, Word, Excel, database entry and the internet preferred.

Licenses: Current Ohio RN License and CPR certification. Current unrestricted Ohio driver's license.

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## **Clinical Workflows**

#### Summit Medical Clinical Care Coordination Job Flow

**<u>Goal</u>**: To capture high-risk patients during each visit within the clinic

**Purpose**: To allow the clinic to recognize who the high-risk patients are, so that the care of the patient is approached in a meaningful and purposeful manner.

#### Recognizing and caring for the high-risk patient:

- 1. Develop office protocols that will be congruent between all providers and staff members for determining the proper approach to the care of the high-risk patient population such as patient empanelment, risk stratification and the care management templates.
- 2. Care coordinator will print and review the daily schedule for all providers and identify the high-risk patients.
- 3. Each provider and their medical assistant will be notified of their high-risk patients for the day.
- 4. Care coordination will review each chart before the patients are seen by the physician to determine that their routine maintenance is up to date.
- 5. If the patient is missing any routine procedures or necessary referral to community specialists, per disease protocol, the care coordinator will order, notify the patient and follow-up to ensure they are completed.
- 6. To ensure that the patient is aware that the care coordinator is an additional point-of-contact for them, during the office visit the care coordinator will be introduced to the patient.

#### Village Primary Care, Hoosick, NY Transitional Care Nurse Job Flow

**Description**: Workflow for integration with Transitional Care Nurse (TCN) for patients who are discharged from Southwest Vermont Medical Center (SVMC)

- 1. Identify inpatient for TCN (PCP listed as Carroll, Romac or Rowe).
- 2. TCN reviews hospital chart and Village Primary Care chart and meets with inpatient (if inpatient meets TCN criteria proceed to step 3).
- 3. A. Inpatient interested in TCN services (proceed to step 4) <u>or</u> B. Inpatient not interested in TCN services (stop and note in chart).
- 4. Secure inpatient consent (if consent is obtained proceed to step 5).
- 5. TCN follows and meets with inpatient and family, completes needs assessment, screening and discharge plan.
- 6. Patient discharged to home or other facility.
- 7. TCN does home visit or other facility visit within three days.
- 8. TCN assists in scheduling patient follow-up visit with PCP and attends visit with patient.
- 9. TCN continues to follow patient post discharge working with PCP to ensure discharge plan is followed and updated as necessary.

## **Risk Stratification Tools**

#### Grand Lake Primary Care Risk Stratification Tool

This three-strata risk stratification tool may work well for smaller practices or those that do not have the ability to integrate a risk stratification tool within the EHR.

Risk Stratification Protocol LOW No problems. Minimal problems.		IN HEALTH
Risk Stratification Protocol LOW No problems. Minimal problems.	for Staff	
LOW No problems. Minimal problems.	MEDIUM	
No problems. Minimal problems.		нісн
Minimal problems.	Controlled	CHE
	HTN, Hyperlipidemia.	COPD
	Diabetes A1c less than 7	DIABETES: A1c greater than 7
	Allergies	CANCER
	Asthma	DEMENTIA
	Low ER or Hospital utilizer.	High ER/Hospital Utilizer
	Cancers in remission	HIGH MORTALITY RISK
Preventive Care	Preventive Care	Preventive Care
	Medication Compliance Checks	Medication Compliance Checks
	Specialty Referrals if needed	Specialty Referrals if Needed
	Home Management Education	Home Health? Or Hospice?
	Diabetes Ed Classes	Weekly Phone calls/Monthly visits
		Home Management Education
		Home Visits?
Adopted Renee J Russell, I	MD, INC, PC 1/23/2013	
Medical Assistants:		
Every Patient seen for off	ice visit that day is risk stratified an	d care plan is developed. Remind Providers that you have
done it. Remind Providers	s to double check your work or help	o with development. MA's can make a referral to Home
Health.		
Care Manager:		
Every patient that comes of	out of ER or hospital: risk stratify a	nd develop care plan while setting up follow up and
referrals.		
RISK STRATIFICATION: for	entry into soapware type the follo	wing:
Riskcat(space)		
Carex(space)		
car su(space)		

### Village Primary Care Risk Stratification Tool

*This five-strata risk stratification tool will help show a greater distribution within the practice's patient population.* 

Patient N	ame:				Age:	
Medical Record Number: Date of Risk Assessment:						
Does pati	ent present with these condition	ns?				
PRESEN	т	CHRONIC	PRESEN	т	CHRONIC	
	Allergy, asthma			Malignancies		
	Cardiovascular			Mental health/psychosoc	ial 🗆	
	Ear, nose, mouth and throat			Musculoskeletal		
	Endocrine			Neurologic		
	Eye			Nutrition		
	Female Reproductive			Renal		
	Gastrointestinal/hepatic			Respiratory		
	Genetic			Rheumatologic		
	Genito-Urinary			Skin		
	Hematologic			Toxic effects		
	Infections					
Count as	chronic:					
	The patient of caregiver of a	a dependent patier	nt has a serious	and persistent mental illne	ess	
	Hospitalization during last 1	2 months				
	More than two emergency r	oom visits in last 1	2 months			
	wore than two enlergency i	OOTTI VISILS ITTIASL T	2 11011015			
Chronic C	ondition Count:			Chronic Count	Tier	
				0	1	
Initial ass	igned risk tier:			1-3	2	
				4-6	3	
				7-9	4	
				10 or more	5	

#### St. Bernards Clopton Clinic Risk Stratification Tool

This four-strata risk stratification tool adds points to account for mental health conditions.

Utilization	Points	Yes/No	
One hospitalization in the last 12 months	2	103/110	
Two hospitalizations or ED visits in the last 12 months	5		
Three or more hospitalizations in the last 12 months	10		
Age	Points	Yes/No	Low Risk 0-6
0-69 years of age	1	,	Mod Risk 7-12
0-79 years of age	2		Mod-High Risk 13-15
0 and older	3		High Risk >16
ealth Conditions	Points	Yes/No	ingi non v 10
IDS (not just HIV positive)	6	100,110	
sthma	1		Score:
rial Fibrillation	1		
	1		
ancer. Active (Current therapy-Place as High Risk)	13		
ancer. Remission (Mod. risk if in remission but	10		
pontinues to have related problems or still under			
nc./Rad.Onc care)	7		
ncer, Hx of (Low Risk if in remission and no problems)	1		
IF	1		
nronic Pain	2		
D, Stage 3 or 4 or on Dialysis (moderate to severe)	5		
PD	2		
A	1		
mentia/Alzheimer's Disease/Parkinson's Disease	2		
1. Controlled	3		
1. Complicated/Uncontrolled	6		
miplegia	1		
N	1		
perlipidemia/Hypercholesterolemia	1		
pothyroidism	1		
er Disease	2		
	2		
pesity	2		
raplegia	2		
lypharmacy (6 or more routine medications)	4		
ripheral Vascular Disease	1		
ental Health	Points	Yes/No	
ixiety	2		
 epression	2		
ental Retardation	1		
ehavioral	Points	Yes/No	
urrent Smoker	2		
Ion-compliance (Ex. 2 or more "No Show" appts./vear			
r Ex. DM/CHF/HTN pts that have not been seen in past			
	_		
mos)	4		

#### Mercy Adult Risk Stratification Tool

Mer	cy Adult Risk Stratifi	cation Tool					<b>19 YEARS AND</b>	OLDER
Risk Level: Evaluated by:			Evaluation Date:		Last Evaluation Date:			
Patient Name:			Provider:		Last Risk Level:			
Age		DOB:						
Risk Stratification Level: Score		<b>Risk 1:</b> 0-1	<b>Risk 2:</b> 2-3	<b>Risk 3:</b> 4-6	<b>Risk 4:</b> 7-9	<b>Risk 5:</b> 10-13	<b>Risk 6:</b> 14-18	
	CARE PLANNING						EXTREMELY	
	~~~~	LOV	N	MOL	DERATE	HIGH	HIGH	SCORE
1	SCORE	0			1			
	AGE	19 years - 64 yea	rs	65 years	s to 79 years	80 yea	rs or older	
2	HOSPITALIZATIONS (last 12 months)	0 TO 1			2	3 OR MORE		
3	ER VISITS (last 12 months)	0 TO 1			2	3 OR	MORE	
4	ALL OFFICE VISITS (last 12 months) exclude OB visits	1 to 2		3	to 6	7 OR	MORE	
5	CURRENT PRESCRIPTION MEDICATIONS (including oxygen)	0-2 medications		3-5 m	edications	6 or	MORE	
6	LANGUAGE/HEALTH LITERACY	Primary language:     Carries out plan of     Demonstrates und     care needs     Independently see     information	English care well erstating of health ks health	Limited English: verbal :     Hearing impaired     Carries out some of the     Requires some reinforce	skills plan of care ement	Requires interpreter for all practice interactions     Not able to carry out plan of care without continued reinforcement     Requires routine reinforcement and education		
7	CHRONIC DISEASE (does not include mental health dx)	<ul> <li>No chronic disease</li> <li>AT RISK: pre-diabe hypertension</li> <li>Non Smoker</li> <li>BMI 18.5 - 25</li> </ul>	tes, borderline	<ul> <li>1-3 chronic diseases d</li> <li>1 - 15 years tobacco u</li> <li>BMI &lt; 18.5 -&gt; 25</li> </ul>	iagnoses se history	<ul> <li>4 or more chronic disease diagnoses</li> <li>15 years plus tobacco use history</li> <li>BMI &gt; 35</li> </ul>		
8	CHRONIC DISEASE QUALIFIER	• N/A		<ul> <li>1 or more chronic disea</li> </ul>	se diagnoses uncontrolled	1 or more chronic disease diagnoses, severely uncontrolled		
9	MENTAL & BEHAVIORAL HEALTH (includes but not limited to dementias, substance abuse, autistic disorders, eating disorders, developmental delays)	No Mental Health     Long-term stability     with medication	diagnoses demonstrated	<ul> <li>1-2 Mental health diagnoses</li> <li>Routine follow up with provider and or mental health provider</li> <li>1-2 Significant life stressors (Divorce, Death, Job Loss, Moving, etc.)</li> </ul>		• 3 or more men • 3 or more signi (Divorce, Death, Moving, etc.)	tal health diagnoses ficant life stressors Job Loss,	
10	MENTAL & BEHAVIORAL HEALTH QUALIFIER	• N/A		• 1 or more Mental Healt	h diagnoses uncontrolled	1 or more Mental Health diagnoses severely uncontrolled		
11	SOCIAL DETERMINIATION & SELF- MANAGEMENT	Steady income     Independent     Stable residency     Family or other su     Adequate medical	pport insurance	Receives some support     Some medical insurance     Lives alone needs some	to meet social needs e assistance with ADLs	Lives in a nursing Home or Assisted Living Hospice Homebound Homeless Unsafe home environment Unemployed Lack of financial or family support that impacts care Transportation barrier No medical insurance		
Con	intents. Inlex Care Coordinat	or Referral (Dias	se circle)	VES	NO			
	ipies care coordinat			TES		L		

#### Mercy Pediatric Risk Stratification Tool

Me	Mercy Pediatric Risk Stratification Tool BIRTH TO 18							3 YEARS
Risk Level: Evaluated by:			Evaluation Date:	Last Evalu				
Pati	ent Name:			Provider:		Last Risk Level:		
Age:		DOB:						
Risk	Stratification Level: Score	<b>B</b> -1.4.0.4	<b>D:</b> -1, <b>D</b> , <b>D</b>	<b>Di-h 3:</b> 4.6	<b>D</b> :-1, 4, 7,0	Risk 5:	Risk 6:	
		<b>KISK 1:</b> 0-1	<b>KISK 2:</b> 2-3	<b>KISK 3:</b> 4-6	<b>KISK 4:</b> 7-9	10-13		
	CARE PLANNING	LOV	N	MOD	DERATE	HIGH	HIGH	SCORE
	SCORE	0			1		2	
1	AGE	3 years to	18 years	Birth to 35 months		Premature (<36wks) - 12 months		
2	HOSPITALIZATIONS (last 12 months)	0 то	D 1		2	3 0	R MORE	
3	ER VISITS (last 12 months)	0 TC	01		2	3 0	R MORE	
4	ALL OFFICE VISITS (last 12 months)	Birth to 23 months: 4-5 visits 2 years to 18 years: 1-2 visits		Birth to 23 months: 2 years to 18	Birth to 23 months: 1 visit or >8 visits 2 years to 18 years: >5 visits			
5	CURRENT PRESCRIPTION MEDICATIONS	No Medic	ations	1-2 me	edications	3 or MO	RE Oxygen Use	
6	Family/Caregiver LANGUAGE/HEALTH LITERACY	Primary language: English     Carry's out plan of care well     Demonstrates understating of     health care needs     Independently seeks health     information		<ul> <li>Limited English: verbal skills</li> <li>Hearing impaired</li> <li>Carries out some of the plan of care</li> <li>Requires some reinforcement</li> </ul>		Requires interpreter for all practice interactions     Not able to carry out plan of care without continued reinforcement     Requires routine reinforcement and education		
7	CHRONIC DISEASE (does not include mental health dx)	No chronic disease     Non Smoker/no secondhand smoke     Growth chart: Between the 25th and 75 <sup>th</sup> percentile		<ul> <li>1 chronic diseases diagnosis</li> <li>Exposure to secondhand smoke</li> <li>Growth Chart: &lt;25th percentile or</li> <li>&gt;75th percentile</li> </ul>		<ul> <li>2 or more chronic disease diagnoses</li> <li>Tobacco use</li> <li>Growth chart: &lt;10th percentile or &gt;95th percentile</li> </ul>		
8	CHRONIC DISEASE QUALIFIER	• N/A		<ul> <li>1 or more chronic disea</li> </ul>	1 or more chronic disease diagnoses uncontrolled		nronic disease verely uncontrolled	
9	Family/Caregiver/Patient MENTAL & BEHAVIORAL HEALTH (includes but not limited to dementias, substance abuse, autistic disorders, eating disorders, developmental delays, depression, ADD, ADHD, etc.)	• No Mental Health diagnoses		<ul> <li>Routine follow up with provider and or mental health provider</li> <li>1-2 Significant life stressors (divorced parents, young parents &lt;20, single parent, unemployment)</li> </ul>		<ul> <li>20 more internal neutral diagnoses</li> <li>3 or more significant life stressors (divorced parents, young parents &lt;20, single parent, unemployment)</li> </ul>		
10	MENTAL & BEHAVIORAL HEALTH QUALIFIER	• N/A		1 or more Mental Health diagnoses uncontrolled		<ul> <li>1 or more Mental Health diagnoses severely uncontrolled</li> </ul>		
11	Family/Caregiver/Patient SOCIAL DETERMINIATION & SELF-MANAGEMENT	Steady income     Stable residence     Adequate medica Meets basic ADL's	Il insurance	Receives some support     Some medical insurance     Meets some of basic AD	to meet social needs 2 Ls	Homeless     Unsafe hom     Unemployed     Lack of finan     support that i     Transportati     No medical i     Foster care	e environment d cial or family impacts care on barrier insurance	
Con	nnents: anloy Caro Coordinator Da	formal (Diana	sirclo)	VEC	NO			
Con	iplex care coordinator Re	ererrai (Piease )	circle)	YES	NU	L		

## References

Randall S. Brown, Deborah Peikes, Greg Peterson, Jennifer Schore and Carol M. Razafindrakoto. Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients. *Health Affairs*, 31, no.6 (2012):1156-1166

Haas, Lindsey R. Assessment of Risk Stratification Methods: Identifying Patients for Care Coordination within a Medical Home. Presented at Academy Health Conference June 26, 2012

#### AAFP Risk-Stratified Care Management

This web page explains what risk-stratified care management is, in that it begins with a periodic and systematic assessment of each patient's health risk status, using criteria from multiple sources to develop a personalized care plan.

#### AAFP Risk-Stratified Care Management and Coordination Table (1-page PDF)

This table shows examples of potentially significant risk factors, as well as risk categories and levels. It provides guidance to identifying disease burden and determining health risk status.

#### Advancing Integrated Mental Health Solutions (AIMS)

The AIMS Center, housed within the University of Washington's <u>Division of Integrated Care & Public Health</u>, <u>Department of Psychiatry and Behavioral Sciences</u>, seeks to improve the health and mental health of populations through patient-centered, integrated mental health services for individuals across the age span. The site provides information on integrated mental health care including principles and tasks for integrating care.

#### <u>Assessment of Risk Stratification Methods Identifying Patients for Care Coordination within a Medical</u> <u>Home</u> (27-page PDF)

This Mayo Clinic presentation at the Academy Health Conference in June 2012 focuses on identifying patients with care coordination needs are part of a Medical Home.

#### Care Management in CPC: Definition

Care management is a tailored primary care function. In CPC, specific dynamics of the initiative will shape how and when your practice initiates this care. The definition provided on the Collaboration site describes how care management supports the drivers for comprehensive primary care.

#### Care Management of High Risk Patients by WR Clinic for Senior Health

This resource is provided by Washington Regional Clinic for Senior Health as their approach to Milestone 2: Care Management of High-Risk Patients. Attached is a description of their approach, their care management workflow and definitions of their risk.

#### CPC Practice Spotlight – SAMA Healthcare, Dec. 6, 2013 (2-page PDF)

SAMA Healthcare Services in Arkansas describes the practice's approach to risk stratification.

#### NIHCR High Intensity Primary Care

The National Institute for Health Care Reform offers this article outlining approaches and models for "highintensity primary care," which could prevent costly emergency department visits and hospitalizations. Highintensity primary care could be offered to a handful of patients with complex or multiple chronic conditions, such as diabetes, congestive heart failure, obesity and depression.

<u>An Overview of Risk Stratification and Care Management</u>, CPC National Learning Community, Feb. 27, 2013 (59-page PDF)

Outlines the basics of risk stratification and how to underpins successful care management.

#### PCPCC: Successful Examples of Integrated Models

The Patient-Centered Primary Care Collaborative presents successful examples of integrated models of care in primary care from around the world, including links to project websites.

**Project BOOST Team.** The Society of Hospital Medicine Care Transitions Implementation Guide: Project BOOST: Better Outcomes by Optimizing Safe Transitions. Society of Hospital Medicine website, Care Transitions Quality Improvement Resource Room <a href="http://www.hospitalmedicine.org">http://www.hospitalmedicine.org</a>. Accessed Aug. 1, 2012.

#### Risk Stratification Process (2-page PDF)

Risk stratification method using four levels, which correspond to primary, secondary and tertiary prevention as levels 1, 2 and 3. The 4th level is the patient who is a vastly complicated and high-risk individual.

#### **Risk Stratification Webinars**

<u>Care Plans</u>, New Jersey Learning Session, Nov. 6, 2013 (17-page PDF) Learn to design workflows with a focus on care plans; navigate workflow issues within the process.

#### Risk Stratification, National webinar, April 9, 2014 (38-page PDF)

This presentation describes progress to date from CPC practices as well as showcases success stories from the field. Discussion includes work flow considerations, care management strategies and measures of success.

<u>Risk Stratification</u>, Ohio Learning Session, Jan. 22, 2013 (40-page PDF) A review of risk stratification, a care management overview and practice stories.

#### Risk Stratified Care Management, AR/OK Learning Session, Dec. 21, 2012

This presentation provides steps toward starting a risk stratification care management plan as well as what to avoid. Comprehensive notes for this session are provided here as well.



# **Risk Stratification:** A Study of CPC Practice Approaches

August 1, 2014



An Initiative of the Center for Medicare & Medicaid Innovation

## Risk Stratification: A Study of CPC Practice Approaches

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This material is presented by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.
## **Purpose of This Guide**



This Guide reflects on how CPC practices across the country have approached the risk stratification component of Milestone 2. These practice strategies represent samples of the work and are not representative of every strategy for implementing a risk stratification methodology in a practice.

CPC practices are heterogeneous in size, geography, ownership and organization; they are encouraged to innovate and test strategies derived from evidence-based and/or best practices and customize the work according to their particular needs, local dynamics and other practice aspects that may shape how they deliver care. This Guide captures the energy, innovative ideas and rigorous and determined execution of the CPC practices as they test and implement risk stratification in their practice.

We hope that you find in your colleagues' work support for continuing to explore and refine your approach to this key component of Comprehensive Primary Care.

August 1, 2014

## **Overview of the Risk Stratification Component in Milestone 2**

**Milestone 2: Population Health and Care Management for High-Risk Patients** addresses population health, with a priority focus on those at highest risk for poor outcomes and preventable harm. In Program Year (PY) 2013, practices engaged in routinely assessing and assigning a health risk status to all patients through a practice-identified risk stratification methodology that applies to every empanelled patient.

For many CPC practices, this particular task marked a fundamental shift in how they examined care opportunities in targeted populations. It also sparked opportunities for practices to prioritize resources and address measurements for quality improvement, efficiencies in care delivery processes and innovative use of technology.

### What is Risk Stratification

Risk stratification is the process of evaluating each empanelled patient's condition using established criteria

and assigning that patient to a risk stratum. This process often requires the use of data from registries and payers. Provider input and judgment, as well as the patient's self-assessment, are crucial as well. Using algorithms, patients are assigned to a stratum based upon this information.

This key activity is the first step to planning and implementing a personalized care plan for patients most in need of care management. Stratification allows the staff to focus resources where they would have the most opportunity to prevent poor health outcomes in those patients at highest risk.

## **Essentials of Risk Stratification**

# 1. Select a process or algorithm to risk stratify your population

The tool, or algorithm, your team selects must be simple to use and easy to understand by all involved. It must align with your care management strategy to care for the high-risk patients in your practice. The algorithm should forecast each patient's health risks, allowing for staff to prioritize resources to mitigate adverse outcomes.

The established tool will allow assigned staff to stratify each patient using a set of rules established for the purpose of assigning the patient to a risk level. A practice may have three different risk categories (low, medium and high) or have five or more. The best process is one that stratifies your patients so that resources are applied appropriately in your practice.

## Reporting on Risk Stratification Status for PY 2014

For PY 2014, practices will work toward maintaining at least **95 percent empanelment** to provider(s) or care teams. (Reporting requirements for this work are described in the Milestone 2 section of the <u>2014</u> <u>Implementation Guide</u>.)

The target is to achieve risk stratification of at least 75 percent of empanelled patients and provide care management to at least 80 percent of patients identified as those at highest risk: those that are clinically unstable, in transition and/or otherwise need active, ongoing, intensive care management.

Quarterly reporting will include updating information about the practice's empanelment status, risk stratification methodology, risk stratification data and care management staffing and activities.

	Identifyi	ing Disease Burde	en and Determining F	lealth Risk Status	
Is the patient healthy, with no chronic disease, or significant risk factors?	Is the patient healthy, but at risk for a chronic disease, or has other signifi- cant risk factors?	Does the patient have one or more chronic diseases, with significant risk factors, but is stable or at desired treatment goals?	Does the patient have one or more chronic diseases, with significant risk factors, and is unstable or not at treatment goal(s)?	Does the patient have multiple chronic diseases, significant risk factors, complexions, and/or complex treatment(s)?	Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?
Level 1 PRIMARY PREVENTION	Level 2 PRIMARY PREVENTION	Level 3 Secondary preven- tion	Level 4 SECONDARY PREVENTION	Level 5 Tertiary prevention	Level 6 Catastrophic care
GOAL: To prevent onset of disease (Low Resource Use)	GOAL: To prevent onset of disease (Low Resource Use)	GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)	GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)	GOAL: Treat the late or final stages of a disease and minimize disability (High Resource Use)	GOAL: May range from restoring health to only providing comfort care (Extremely High Resource Use)
CARE PLAN SUGGESTIONS - Preventive screenings and immunizations - Patient education - Health risk assessment (annual) - Appropriate monitoring for warning signs	CARE PLAN SUGGESTIONS - Preventive screenings and immunizations - Patient education and engagement - Health risk assessment (annual) - Appropriate monitoring for warning signs - Interventions for un- healthy lifestyle/habits - Links to community resources to enhance patient education, self- management skills, or special facilities	CARE PLAN SUGGESTIONS - Preventive screenings and immunizations - Patient education and engagement - Health risk assessment (semi-annual) - Appropriate monitoring for warning signs - Interventions for un- healthy lifestyle/habits - Links to community resources to enhance patient education, self- management skills, or special facilities <b>TEAM/PLANNED CARE</b> - Group visits - Home self-monitoring - Links to the medical neighborhood for care management, coordina- tion of care, treatments, communication, and exchange of information with other providers and health care settings	CARE PLAN SUGGESTIONS - Preventive screenings and immunizations - Patient education and engagement - Health risk assessment (semi-annual) - Appropriate monitoring for warning signs - Interventions for unhealthy lifestyle/habits - Links to community resources to enhance patient education, self-management skills, or special facilities <b>TEAM/PLAINED CARE</b> - Group visits - Home self-monitoring - Links to the medical neighbor- hood for care management, coordination of care, treat- ments, communication, and exchange of information with other providers and health care settings - Health coach - Referrals, as appropriate	CARE PLAN SUGCESTIONS    Preventive screenings and immunizations  Patient education and engagement  Health risk assessment (quarterly) Appropriate monitoring for warning signs  Interventions for unhealthy lifestyle/habits  Links to community resources to enhance patient education, self-management skills, or special facilities  TEAM/PLANNED CARE  Caroup visits  Home self-monitoring Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings Health coach/personalized care plan/management ascures as paperopriate Home health	CARE PLAN SUGGESTIONS - Hospitalization - Brahabilitation - Long-term care - Hospice/palliative care <b>TEAM/PLANNED CARE</b> - Support groups - Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings - Health coach/care management - Referrals, as appropriate - Home health - Personalized intensive care plan/ management and resources

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**AAFP Algorithm for Risk Stratification.** *Reproduced with permission from Risk Stratification rubic, 2014, issue of Practice Support.* © *Copyright 2014 American Academy of Family Physicians. All Rights Reserved.* 

In the American Academy of Family Physicians (AAFP) algorithm above, the arrows across the top describe the criteria for placing the patient into the appropriate risk level. Once stratified to the designated level, the goal for caring for individuals in that stratum are stated, with suggestions for the plan of care.

## 2. Risk stratification process

To be effective and efficient, two elements must be in place for risk stratification to work: empanelment of the practice population and an EHR or registry capable of mining the data needed to stratify patients, keeping information current to facilitate reporting. <u>Empanelment</u> entails assigning each patient — with sensitivity to patient and family preferences — to an individual primary care provider (PCP) and a care team. Once the patient is assigned to a team, the EHR should provide the necessary patient information to assign a risk level.

Multiple criteria may be used to assist with risk stratification, but these are some of the basics:

- Patient name
- Age
- Chronic diseases
- Medication profile (look for poly-pharmacy)

Once the initial patient list is obtained, the care team adds their input based upon knowledge of the patient. This is most successfully completed with input from all members of the care team so that a more complete picture of the patient can be obtained. Social, emotional and environmental factors as well as

family dynamics and cognitive ability can all inform the assigned risk level corresponding to the most appropriate care management needs of the patient. Care management, which is addressed separately in the "<u>Care Management: A Review of CPC Practice Approaches</u>" guide, is typically first provided to patients in the highest risk levels.

The team must decide the best location for documenting the risk level on each patient so it is available to the entire team. It should be accessible by the front office staff as well as the caregivers. Protocols related to the risk level management and triage is important. Appointment availability may have a different urgency for a low-risk patient than a high-risk. Medication refill is another area that may have a different management process for the high-risk patient. If patients in the high-risk category call with an issue, the provider may determine they need to be triaged rapidly by the care team. For this reason, all staff must be able to identify a patient's risk level.

## 3. Review risk stratification methods and update information regularly

Continually re-assessing the effectiveness of the selected risk stratification tool should be a routine task in any practice. Once patients are risk stratified, it is crucial to keep the information updated and patients restratified as their conditions change. Risk levels should be evaluated with every hospitalization or emergency room visit and with each visit to the practice. Annual risk stratification reviews of the patient population would help the practice stay current on care needs of the patients. Care managers play a key role in updating information for high-risk patients and working with the team on risk assignment for that population.

## **CPC Practice Approaches to Risk Stratification Methodology and Process**

The number of risk strata among CPC practices ranged from two to seven, clear evidence that practices were modifying models to best fit the practice's needs, population, EHR and other factors. Various risk stratification tools are available to practices (*see appendix for examples from CPC practices*). They vary in complexity, ranging from a simple checklist to an elaborate grid with scaled values for risk factors. Some tools integrate more easily than others into particular EHRs. The key consideration in selecting a risk stratification approach is to find one that best fits the practice's patient population, works with the practice EHR, and can fit into the practice workflow.

Practices' approaches to identifying risk factors — ranging from poly-pharmacy use to severity of specific diseases such as hypertension or cancer — varied widely. By reviewing EHR-generated patient/diagnoses lists, some practices identified these risk factor categories after reflecting on patterns of disease and severity in their empanelled population. Others included the clinical care team's knowledge of the patient, and many practices incorporated one or more social determinants of health.

Practices with more experience in population health incorporated data outside of the practice such as labs and hospital utilization. These practices also chose more sophisticated methods to calculate a risk score for each patient, such as programming the EHR to auto-generate a risk score as the clinician updated the medical record.

## **Reporting for PY 2014**

Practice-based empanelment, risk stratification and care management will remain an essential part of CPC throughout the initiative. While practices will work toward achieving **risk stratification of 75 percent of empanelled patients**, the care management target is to **provide care management to at least 80 percent of patients identified as those at highest risk** (those that are clinically unstable, in transition and/or otherwise need active, ongoing, intensive care management). Quarterly reporting will include updating information about your practice's risk stratification methodology, empanelment status, risk stratification data and care management staffing and activities. (Complete reporting requirements for this work are described on page 13 of the 2014 Implementation Guide.)



#### **Case Studies**

Risk stratification is not a "one size fits all." In the following case studies, CPC practices describe how they identified, designed, tested and implemented a risk stratification process to best suit their patient population. These processes included further refining each stratum to achieve an optimal stratification and conducting multiple iterations of a Plan-Do-Study-Act (PDSA) cycle. The concepts from the Model for Improvement and PDSA are applied to describing the last practice approach in these case studies.

## Selecting a Risk Stratification Tool Village Primary Care, Hoosick Falls, New York Independent; 2 physicians, 1 ANP; 4,689 patients

This rural practice chose to use a <u>risk stratification tool</u> loosely based on the <u>Minnesota Tiering Model</u>, which stratifies patients primarily by the number of chronic condition categories or conditions the patients currently deal with that last longer than six months.

Village Primary Care further modified the tool to include hospital utilization and social factors such as if the patient has a serious and persistent mental illness, was hospitalized in the last 12 months or has been to the emergency room twice in the last 12 months. Conditions meeting any of these hospital utilization and social factors are added to the "category" counts for the purpose of the risk stratification tool. All conditions are tallied together. The total number of conditions determines the patient's risk score, which ranges from 1 (lowest risk) to 5 (highest risk).

Chronic Count	Tier
0	1
1-3	2
4-6	3
7-9	4
10 or more	5

Example of strata by chronic count

When the practice began the task of risk stratifying its entire

empanelled patient population, they started with patients seen in the last three years. Initially, risk scores were assigned through a chart review of all active patients over an eight-month period. This allowed the practice to stratify 99 percent of its patient population.

Although the risk assessment is calculated on paper, the tool is scanned and loaded into Allscripts for easier tracking. A discrete data field is located in the patient's Risk Tier Flow Sheet within the EHR, which allows the practice to track the patient's movement across risk tiers over time. The Risk Tier Flow Sheet even tracks when the physician updates the risk score that an MA or nurse may have initially assessed.

Village Primary Care strives to maintain risk stratification for 99 percent of the empanelled patient population. To do this, maintenance reports are run quarterly using the analytics package that is an add-on to Allscripts. The reports show how many patients are in each risk strata and flag those who need to be risk stratified. The care manager reviews all the "4s" and "5s" for a closer look at risks and to assign subsequent interventions as needed. Particular attention is paid to the last visit date of the patients in these higher risk strata to ensure they are routinely and appropriately followed by their physician.

## Team Approach to Risk Stratification Development Family Physicians of Greeley, Colorado Independent; 23 physicians, 2 PAs; 10,041 patients

This practice uses a four-stratum risk stratification model that was modified to achieve 100 percent risk stratification of its patients in one work day. By selecting a risk stratification methodology that aligns with their care management resources, practices can identify those patients who need advanced strategies and resources and thus benefit the most from <u>care management</u>.

**Family Physicians of Greeley** researched several established risk stratification methods in use by systems across the U.S., including <u>Geisinger</u> and the Washington University (<u>Missouri</u>) model. Knowing that preventing the conditions that lead to admissions and increasing costs should factor into the practice's risk assessment strategy, the team also researched AHRQ and hospital costs to identify key potentially preventable conditions. The practice's quality and systems manager brought these models to the quality improvement team, where the team identified similarities and considered characteristics in the practice's patient population to develop a hybrid of these two models to implement across its three practice sites.

Once the team determined a scoring method, the practice tested the model against a small subset of patients to evaluate if the scoring algorithm captured the "right" patients. The practice found the model worked satisfactorily. The quality and systems manager then built a custom report within its EHR (NextGen) to automate the process. The crystal report pulls the key risk data from discrete data fields within each patient's chart to calculate a risk score. Using this automated process, the practice was able to complete the first step in their risk stratification process for 100 percent of patients in *less than a day*.

The final step of the process was a physician review. The quality and systems manager provided each physician with a report of his or her empanelled patients. Physicians reviewed the reports, moving their patients across risk stratum as they saw appropriate based on their clinical judgment. A follow-up correlation analysis compared each physician's mean risk score with the physician's number of patients admitted in the last year. The analysis revealed a strongly associated relationship and further validated the risk stratification tool's effectiveness for this practice's patient population.

The practice assigned a risk score to the patients based on the sum of the points assigned to the criteria that they meet. A higher score means higher risk. The practice assigned the following risk tiers based on risk score:

- low risk (0–1)
- medium risk (2–3)
- high risk (4-8)
- highest risk (9+)

The patient's risk score is documented in the EHR as a dummy diagnosis code (e.g., RiskLow, RiskMod, RiskHigh and RiskTop).

A patient's risk score can be calculated in real-time as the team encounters the patient's medical record. It is also recalculated for all patients every six months to identify new highest risk patients for proactive care management. To help track patients' status that may have changed between appointments, a re-stratification report is triggered when a hospitalization or visit to the emergency department is recorded.

Criteria	Points
Diabetes	2
DM HgbA1c > 9	2
Hypertension	1
BP > 140/90	1
Systolic BP > 180	2
Congestive Heart Failure	2
COPD	2
Dialysis	4
Fracture/osteoporosis, age	n
50+	Z
CAD/AMI	1
Depression/bipolar	1
Intellectual disability	1
Current smoker	1
BMI > 30	1
LDL > 100	1
Age 75+	1
6+ prescription medications	1
2+ specialist referrals	1

Family Physicians' point assignment for various chronic conditions

In addition, patients with a hospital admission are

automatically considered highest risk, except for those in chemotherapy, long-term SNF patients, hospice patients and pediatric and obstetric patients who are included with hospitalization criteria but may be lower risk because, although they are closely managed by their specialist, additional primary care oversight is given for other health concerns they may have.

## Mercy Family Medicine Clinics, Durango, Colorado (three locations) Independent (rural); 7 physicians, 7 ANPs/PAs; 9,344 patients

Clinical staff at **Mercy Family Medicine Clinics** in Durango, Colorado, started building its risk stratification method by looking at the <u>AAFP risk stratification tool</u>, which has six levels: Level 1 — lowest risk, Level 2 — low risk, Level 3 — moderate risk, Level 4 — moderately high risk, Level 5 — high risk and Level 6 — catastrophic risk. They also reviewed various tools from the <u>California Quality Collaborative</u> as well as Telluride Medical Center in Colorado. Using these as a model, they created their own risk stratification tools.

All patients are assigned a risk score using an <u>Adult Risk Stratification Tool</u> or a <u>Pediatric Risk Stratification</u> <u>Tool</u>. The team evaluates the risk level of each scheduled patient during the team huddle at the beginning of the day. This is completed by record review, provider input and information obtained at the time of the patient visit. Initially it took varying times to risk stratify each patient, based on the comfort of the individual staff member. Some nurses could work ahead, others needed to develop a comfort level with the process. Currently it takes about three minutes per patient to risk stratify.

The practices use each provider's daily appointment schedule to analyze the medical record and assign patients a risk level. The care team (provider, nurse and MA) seeing the patient that day are jointly responsible for completing this task. The nurse/MA submits completed risk stratification tools to business support to enter on a spreadsheet. For all patients who are Level 6, the tool is copied and given to the RN Care Coordinator responsible for care management. The spreadsheet lists the patient name, provider, risk level and date of evaluation and allows the team to keep track of who has been assessed. The spreadsheets are analyzed quarterly by the providers to assess for accuracy. The stratification sheet is then scanned into the patients' encounter in the EHR, LSS Data Systems. It is located under "other records" and labeled with the patient's score for easy accessibility.

#### **Proposed Workflow Steps:**

- Analyze each patient on provider's daily schedule and obtain risk level
- 2. All patients assigned a risk level
- Nurse/MA place all completed risk stratification tools at the front desk
- Business support enters risk stratification tools into spreadsheet
- 5. Risk stratification tool scanned into chart under "other records" and a chart note is labeled "Risk Strat Adult or Peds, Level X" to refer to easily

The risk stratification process was difficult in the onset, but it eased over time. Some nurses were quickly proficient with the new tasks and were able to complete assessments several days in advance of appointments. Initially only about 1 percent of patients were stratified to the extremely high risk level (Level 6) and about 15 percent scored at the high risk level (Level 5). The team then refined the tool by adding a "Chronic Disease Qualifier" and a "Mental and Behavioral Health Qualifier" to ensure additional points were scored for patients with highly complicated illnesses. Furthermore, they added "Significant Life Stressors" to the Mental and Behavioral Health assessment categories to better differentiate higher risk patients. The practice also lowered the threshold for high-risk and extremely high-risk scores by one point. With these refinements, the current risk stratification tool is 95 percent stable. Few changes, if any, need to be made, but the team continues to evaluate.

## Baptist Health Family Clinic, Bryant, Arkansas Independent; 3 physicians, 1 NP; 5,066 patients

**Baptist Health Family Clinic** in Bryant, Arkansas, is a four-provider clinic consisting of three physicians and a nurse practitioner. Similar to other CPC Practices, Baptist Health decided to use the six-category AAFP risk stratification guidelines and selected risk levels based on the number of chronic conditions, risk factors, recent hospitalizations, age and cognitive function. No modification of the AAFP tool was needed; it has been found to be effective in its original format. Initially as patients presented for an office visit, the providers assigned a risk score, with input from other clinical staff. Then they then document the risk level in the EHR. The patients are risk stratified based on their *current* health status. Each patient is re-assessed for risk at each visit. Risk levels change often as patients' health conditions become more or less controlled. Helping to fill in any blanks, the care managers review schedules daily to ensure their patients are

stratified. In addition, reports are run on those patients who have not been risk stratified. The care coordinators then risk stratify them using information in their medical record, and they contact the patient to set up an appointment if they are due for a visit.

Initially, all clinical staff members were trained to use the risk stratification tool during their monthly staff meeting. Initial education included how to use it, how often to stratify and specifics of each risk level. This education was presented by the care coordinators and providers, and training took less than an hour because the tool is user friendly. The tool is posted at each workstation throughout the clinic. Each new clinical employee in the practice is given an overview on risk stratification by the care coordinators, the physician they work with and the software support team. Software Support helps with documentation training in the EMR (NextGen). No changes have been made to the tool since implementation so no additional training has been necessary. The practice has risk stratified more than 88 percent of the patient population.

In June 2013 the clinic built a risk stratification radio button into the EHR (NextGen), which now allows them to complete the patient's risk status directly in the EHR. This modification allows accurate and efficient tracking and reporting of the practice's risk stratification status.

At Baptist Health, care management begins for patients at Level 3 risk status (moderately high risk). Providing care management to patients at moderately high risk allows for preventive interventions as well as a significant opportunity for intensive care management for the highest risk patients.

## Applying the Model for Improvement to Risk Stratification Methodology Development St. Bernards Clopton Clinic, Jonesboro, Arkansas Affiliated with system; 9 physicians, 4 ANPs; 7,500 patients

Realizing that risk stratification tools range from simple to very complex, **St. Bernards Clopton Clinic's** leadership and clinical team implemented a risk stratification methodology after conducting several Plan-Do-Study-Act (PDSA) rapid improvement cycles to test, refine and create the most effective tool for their clinic's patient population.

**Formed a Team and Determined the Aim**: Including the right people when making a complex change is critical to success. St. Bernards Clopton Clinic risk stratification development team, led by its care managers, encompasses one physician, the IT director and a nursing administrator. The team aimed to improve its risk stratification methodology by researching and evaluating best practices to make recommendations that would support the clinic's population health goals and adequately distinguish the practice's high-risk patients. The team completed this task by conducting an in-depth evaluation of various tools for patient risk stratification available online and by interviewing other facilities currently doing risk stratification. The team also attended an in-person CPC learning session that addressed risk stratification methodology development.

**Established Measures:** The practice's outcome measure of success for this aim was the rate at which the staff's use of the tool to assess and distinguish the practice's high-risk patients matched the provider's assessment using the same tool.

**Identified The Change**: The inclusion criteria used to determine which risk stratification methodology might meet the practices' needs included several disease conditions, hospital admissions and ED visits. The following were some of the initial criteria applied to determine the risk status for all active patients (seen in the past two years):

- A diagnosis of hypertension, diabetes, heart failure, chronic kidney disease and/or chronic obstructive pulmonary disease
- Two or more hospital admissions in the past year
- Two or more ED visits in the past six months
- Dual eligibility with Medicare/Medicaid

At first the team considered the following risk strata levels based on the inclusion criteria:

- High Risk (3 or more)
- Moderate Risk (2)
- Low Risk (less than 2)

However, it did not take long for the risk stratification team to realize that this three-level strata was too narrow and lacked ability to differentiate sufficiently among the higher risk patients, thus too many patients received a high-risk score. They determined that the risk stratification methodology needed more flexibility in distinguishing which high-risk patients had needs best met by the practice's care management resources.

The team eventually landed on a <u>point-based risk stratification</u> system adapted from the <u>AAFP model</u> and a <u>Risk Stratification tool</u> presented at an Arkansas CPC learning session. The practice developed the points for the risk strata based on the providers' knowledge of the medical needs of their patients. They predicted that this tool would provide the practice with the numeric classification needed to risk stratify the patients using the following risk levels:

- Low Risk (0-6)
- Moderate Risk (7-12)
- Moderate-High Risk (13-15)
- High Risk (16 and above)





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#### **Tested the Change**

*Plan:* Having developed the risk stratification method, the team planned to test the tool on two physicians' patient panels. Patients were risk stratified during a pre-visit review of the patient's medical record by both. The plan included the providers using the tool to complete the process independent of the care managers. The providers also considered in their assessment their knowledge of the patient, the cost of their care, resources needed and patient's behavioral aspects. The objective of the test was to validate the usefulness of the tool as well as its effectiveness in producing the same independent results between the care management staff and the providers.

*Do:* The team carried out the test of the new risk stratification methodology as planned. They used the tool with two physicians' patient populations over a two-week period and recorded their observations, noting problems as they arose.

*Study:* The team analyzed the outcome of the test and determined that the tool was effective in assigning risk levels to the patients. However, they realized that as patients' risk levels are determined, some patients' scores did not match their care management needs. The providers also identified a few gaps in disease conditions and advised including additional disease types in the tool.

*Act:* The care managers adjusted the tool to incorporate the providers' suggestions. They also decided that when they identify a patient straddling two risk categories, the care manager would have the responsibility of contacting the patient's provider for additional input before assigning the risk score. With these refinements, the team planned to re-stratify the same patients using the adjusted tool and process for the next iteration of the PDSA cycle. The initial PDSA cycle took approximately six weeks.

The result from this series of small-scale tests of change using PDSA cycles was a redesigned risk stratification tool and process deemed as an adequate measure of risk for the practice's patient population.

**Implemented the Change**: At St. Bernard's Clopton Clinic, developing the risk stratification tool took about two months, and once they decided to apply the methodology to the entire practice, training the staff took an additional four to five months. The final process follows these steps:

- A staff member (often the radiology technician) reviews the provider's daily schedule and applies the risk stratification tool during manual review of each patient's record.
- The same staff member obtains the utilization information about hospital admissions and emergency room visits since the patient's last visit, using the practice's link to the hospital's records.
- Once these steps are completed, the staff member enters the risk status information into the patient's EHR (Allscripts Enterprise) using an order field. The strata are in descriptive and numerical form. The order is stated in the descriptive form, and the score is then entered into the order. This allows a descriptive or numerical search in the EHR.
  - Providers may further assess and place a patient into a different strata based upon their knowledge of the patient. In this case, the numerical score remains the same, but the descriptive strata changes. An example is a patient whose numerical score remains 17, but the order is entered as moderate-high risk.

- The care manager can query patients by numerical range. This enhances their ability readily focus on a specific risk group.
- A comment may be added to the patient comment field to expand on why a patient was placed within a certain strata.

Once the staff completes the risk stratification process, the care managers can run a report through the EHR to create a list of high-risk patients to ensure application of care management resources as necessary.

**Maintenance**: The care managers and providers regularly adjust the risk level for individual patients. Although the staff re-stratified patients at any given time based on an event (such as new diagnosis or repeated ER or hospital admissions), regular reviews are completed based upon the following schedule:

- High Risk every three months
- Moderate-High Risk every four months
- Medium Risk every six months
- Low Risk every year

The practice's goal is to have care plans on all patients who are high risk. They may also create care plans for patients in a lower risk level as a strategy to proactively manage and prevent patients from moving into a high-risk category.

The team also updated the Risk Stratification tool this year to include socio-economic factors (homebound, live alone, social support and lack of insurance) as well as the mental health diagnoses of schizophrenia and bipolar disorder. This increases the tool's sensitivity to the patient's total needs.

## Conclusions

With a target for PY 2014 to achieve **risk stratification of at least 75 percent of empanelled patients**, this guide provided insight into the strategies CPC practices used to accomplish this goal. Adoption of risk stratification methodologies that prioritize provider and care team knowledge and insights about the patients was high among CPC practices in PY 2013. In PY 2014, we anticipate continual refinement in the risk stratification tools and methods used by CPC practice to evaluate all empanelled patients to provide apply care management resources to those at highest risk for poor health outcomes.

## References

## AAFP Risk-Stratified Care Management

This web page explains what risk-stratified care management is, in that it begins with a periodic and systematic assessment of each patient's health risk status, using criteria from multiple sources to develop a personalized care plan.

## Advancing Integrated Mental Health Solutions (AIMS)

The AIMS Center, housed within the University of Washington's <u>Division of Integrated Care & Public Health</u>, <u>Department of Psychiatry and Behavioral Sciences</u>, seeks to improve the health and mental health of populations through patient-centered, integrated mental health services for individuals across the age span. The site provides information on integrated mental health care including principles and tasks for integrating care.

## Assessment of Risk Stratification Methods Identifying Patients for Care Coordination within a Medical Home (27-page PDF)

This Mayo Clinic presentation at the Academy Health Conference in June 2012 focuses on identifying patients with care coordination needs who are part of a Medical Home.

## Care Management in CPC: Definition

Care management is a tailored primary care function. In CPC, specific dynamics of the initiative will shape how and when your practice initiates this care. The definition provided on the Collaboration site describes how care management supports the drivers for comprehensive primary care.

## Care Management of High-Risk Patients by WR Clinic for Senior Health

This resource is provided by Washington Regional Clinic for Senior Health as their approach to Milestone 2: Care Management of High-Risk Patients. Attached is a description of their approach, their care management workflow and their definitions of their risk.

### <u>CPC Practice Spotlight – SAMA Healthcare</u>, Dec. 6, 2013 (2-page PDF)

SAMA Healthcare Services in Arkansas describes the practice's approach to risk stratification.

Haas, Lindsey R. Assessment of Risk Stratification Methods: Identifying Patients for Care Coordination within a Medical Home. Presented at Academy Health Conference, June 26, 2012

## NIHCR High Intensity Primary Care

The National Institute for Health Care Reform offers this article outlining approaches and models for "highintensity primary care," which could prevent costly emergency department visits and hospitalizations. High intensity primary care could be offered to a handful of patients with complex or multiple chronic conditions such as diabetes, congestive heart failure, obesity and depression.

# <u>An Overview of Risk Stratification and Care Management</u>, CPC National Learning Community, Feb. 27, 2013 (59-page PDF)

Outlines the basics of risk stratification and how to underpins successful care management.

#### PCPCC: Successful Examples of Integrated Models

The Patient-Centered Primary Care Collaborative presents successful examples of integrated models of care in primary care from around the world, including links to project websites.

**Project BOOST Team.** The Society of Hospital Medicine Care Transitions Implementation Guide: Project BOOST: Better Outcomes by Optimizing Safe Transitions. Society of Hospital Medicine website, Care Transitions Quality Improvement Resource Room <u>http://www.hospitalmedicine.org</u> Accessed Aug. 1, 2012.

Randall S. Brown, Deborah Peikes, Greg Peterson, Jennifer Schore and Carol M. Razafindrakoto. Six Features of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions of High-Risk Patients. *Health Affairs*, 31, no.6 (2012):1156-1166

#### **Risk Stratification Process** (2-page PDF)

Risk stratification method using four levels which correspond to primary, secondary and tertiary prevention as Levels 1, 2 and 3. The 4th level is the patient who is a vastly complicated and high-risk individual.

#### **Risk Stratification Webinars**

<u>Care Plans</u>, New Jersey Learning Session, Nov. 6, 2013 (17-page PDF) Learn to design workflows with a focus on care plans; navigate workflow issues within the process.

#### Risk Stratification, National webinar, April 9, 2014 (38-page PDF)

This presentation describes progress to date from CPC practices as well as showcases success stories from the field. Discussion includes work flow considerations, care management strategies and measures of success.

<u>Risk Stratification</u>, Ohio Learning Session, Jan. 22, 2013 (40-page PDF) A review of risk stratification, a care management overview and practice stories.

#### Risk-Stratified Care Management, ARK/OK Learning Session, Dec. 21, 2012

This presentation provides steps toward starting a risk stratification care management plan as well as what to avoid. Comprehensive notes for this session are provided here as well.

#### PDSA Your Risk Stratification Methodology, Arkansas Regional Webinar, Feb. 7, 2014

This presentation includes an overview of a risk stratification tool followed by a discussion of tools from three different practice sites.

## Appendix

## AAFP Risk Stratification Tool.



**Risk-Stratified Care Management and Coordination** 

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Table 2: Risk	<b>K</b> Categories	and Levels usi	ing Diabetes Ex	ample Case		
CATEGORY	PRIMARY F (Low Res GOAL: To preve	PREVENTION source Use) nt onset of disease	SECONDARY F (Moderate Re- GOAL To treat a di serious com	PREVENTION source Use) sease and avoid plications	TERTIARY (High Resource Use) GOAL To treat the late or final stages of a disease and minimize disability	CATASTROPHIC/COMPLEX (Extremely High Resource Use) GOAL May range from restoring health to only providing comfort care
Stage	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	No known diag- noses or complex treatments	No known diagnoses but demonstrates warming signs or potentially significant risk factors	Has diagnosis, but stabilized or in control; potentially significant risk factors	Has diagnosis and/or complex treatment, and at higher risk for compli- cations or potentially significant risk factors	Has diagnosis, complex treatment, and complications or potentially significant risk factors - goal is to prevent further complications	<ul> <li>Very severe illness or condition and potentially significant risk factors</li> <li>End-of-life care</li> <li>Premature baby (May have high costs with limited or no opportunity for improvement, stabilization, or cost control)</li> </ul>
Example of using uncontrolled progression of diabetes	• Healthy	<ul> <li>Blood glucose and lipids rising, but still within desired parameters</li> <li>BMI elevated</li> <li>Smoker</li> </ul>	<ul> <li>Diagnosed with type 2 diabetes, blood sugar, and lipids brought within desired parameters</li> <li>Married, farnity involved</li> </ul>	<ul> <li>Blood sugar and lipids not within desired param- eters, and financial situation impacting negatively</li> <li>Lives alone</li> <li>One ER visit and one hospitalization in past year</li> </ul>	<ul> <li>Has diabetes with early renal disease, coronary artery disease, tailing eyesight, and lives alone</li> <li>Three ER visits and two hospitalizations in past year</li> <li>Dual eligible Medicare</li> <li>Needs Assistance with Activities of Daily Living (ADLs)</li> </ul>	<ul> <li>Diagnosed with lung cancer</li> <li>Recent myocardial infarction</li> <li>Progression to ESRD with renal dialysis</li> <li>Amputation of one leg</li> <li>Blind</li> <li>Lives in nursing home</li> </ul>
Example of Care Plan Considerations for patient with uncontrolled progression of diabetes	<ul> <li>Preventive screem immunizations</li> <li>Patient education</li> <li>Appropriate monit</li> <li>Health risk assess</li> <li>Care plan that incl tion counseling an</li> </ul>	ngs and and engagement oring tor warning signs ment (annual) udes smoking cessa- id program offered	<ul> <li>Preventive screenings a</li> <li>Patient education and e</li> <li>Appropriate monitoring</li> <li>Health risk assessment</li> <li>Care plan with smoking and program offered</li> <li>Team/planned care</li> <li>Group visits</li> <li>Health coach</li> <li>Keriertais as appropriate,</li> <li>Community resources</li> <li>Home soft-monitoring</li> </ul>	nd immunizations ngagement (semi-annual) cessation counseling such as social services	<ul> <li>Preventive screenings and immunizations</li> <li>Patient education and engagement</li> <li>Appropriate monitoring</li> <li>Health risk assessment (quarterly)</li> <li>Intensive care management plan</li> <li>Intensive care management plan</li> <li>Intensive cast and engagement plan</li> <li>Health coach</li> <li>Home health</li> </ul>	<ul> <li>Hospitalization</li> <li>Rehabilitation</li> <li>Long-term care</li> <li>Horspice</li> <li>Horne health</li> <li>Individualized intensive care</li> <li>management and coordination</li> <li>May or may not conduct preventive screenings</li> <li>Health risk assessment, as appropriate</li> </ul>

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Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?	Level 6 CATASTROPHIC CARE	GOAL: May range from restoring health to only providing comfort care (Extremely High Resource Use)	CARE PLAN SUGGESTIONS - Hospitalization - Rehabilitation - Long term care - Hospice/palliative care - Hospice/palliative care TEAM/PLANNED CARE - Support groups - Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care sattings and health care sattings - Hearth care sattings - Hearth care sattings - Hearth care sattings - Hearth care sattings - Herentals, as appropriate - Home health - Personalized intensive care plan/ management and resources
Does the patient have multiple chronic diseases, significant risk factors, complex treatment(s)?	Level 5 TERTIARY PREVENTION	GOAL: Treat the late or final stages of a disease and minimize disability (High Resource Use)	<ul> <li>CARE PLAN SUGGESTIONS         <ul> <li>Preventive screenings and immunizations</li> <li>Patient education and engagement</li> <li>Health risk assessment (quarterly)</li> <li>Appropriate monitoring for warning signs</li> <li>Interventions for unhealthy lifestyle/habits</li> <li>Links to community resources to enhance patient education, self-management skills, or special facilities</li> </ul> </li> <li>TEAM/PLANNED CARE         <ul> <li>Group visits</li> <li>Home self-monitoring 0.</li> <li>Links to community resources to enhance patient education, self-management skills, or special facilities</li> </ul> </li> <li>Home self-monitoring         <ul> <li>Home self-monitoring</li> <li>Home self-monitoring</li> <li>Home self-monitoring</li> <li>Health coach/personalized care plan/management and resources</li> <li>Health on coach/personalized care plan/management and resources</li> <li>Heetrals, as appropriate plan/management and resources</li> <li>Heetrals, as appropriate</li> <li>Home health</li> </ul> </li> </ul>
Does the patient have one or more chronic diseases, with significant risk factors, and is unstable or not at treatment goal(s)?	Level 4 Secondary Prevention	GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)	<ul> <li>CARE PLAN SUGGESTIONS         <ul> <li>Preventive screenings and immunizations</li> <li>Patient education and engagement</li> <li>Reaminations</li> <li>Health risk assessment (semi-annual)</li> <li>Appropriate monitoring for warming sigms</li> <li>Interventions for unhealthy lifestyle/habits</li> <li>Links to community resources to enhance patient education, self-management skills, or special facilities</li> </ul> </li> <li>TEAM/PLANNED CARE         <ul> <li>Group visits</li> <li>Links to the medical reighborhood for care management, coordination of care, treatments, coordination of care, treatments, coordination of care, treatments, settings</li> <li>Health coach</li> <li>Health coach</li> <li>Health coach</li> <li>Health coach</li> </ul> </li> </ul>
Does the patient have one or more chronic diseases, with significant risk factors, but is studie or at desired treatment goals?	Level 3 Secondary preven- Tion	GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)	<ul> <li>CARE PLAN SUGGESTIONS</li> <li>Preventive screenings and immunizations</li> <li>Patient education and engagement</li> <li>Health risk assessment</li> <li>(semi-amual)</li> <li>Appropriate monitoring for warming signs</li> <li>Interventions for un- healthy lifestyle/habits</li> <li>Links to community resources to enhance patient education, seli- management skills, or special facilities</li> <li>Home self-monitoring</li> <li>Links to the medical management, coordina- tion of area, treatments, communication, and exchange of information with other providers and health care settings</li> </ul>
Is the patient healthy, but atrisk for a chronic disease, or has other signifi- cant risk factors?	Level 2 PRIMARY PREVENTION	GOAL: To prevent onset of disease (Low Resource Use)	<ul> <li>CARE PLAN SUGGESTIONS</li> <li>Preventive screenings and immunizations</li> <li>Patient education and engagement</li> <li>Health risk assessment (amual)</li> <li>Appropriate monitoring for warning signs</li> <li>Interventions for un- healthy filestyle/habits</li> <li>Links to community resources to enhance patient education, self- management skills, or special facilities</li> </ul>
Is the patient healthy, with no chronic disease, or significant risk factors?	Level 1 PRIMARY PREVENTION	GOAL: To prevent onset of disease (Low Resource Use)	CARE PLAN SUGGESTIONS - Preventive screenings and immunizations - Patient education - Health risk assessment (annual) - Appropriate monitoring for warning signs

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Mercv	Adult	Risk	Stratification	Tool
MEICY	Auun	<b>NI2</b>	Stratification	1001

Mei	rcy Adult Risk Stratifi	cation Tool					<b>19 YEARS AND</b>	OLDER
Risk	Level:	Evaluated by:		Evaluation Date:		Last Evaluat	ion Date:	
Pati	ent Name:			Provider:		Last Risk Level:		
Age	:	DOB:		1				
Risk Scor	Stratification Level: e	Risk 1: 0-1	Risk 2: 2-3	Risk 3: 4-6	Risk 4: 7-9	Risk 5:         Risk 6:           Risk 4: 7-9         10-13         14-18		
	CARE PLANNING	LOI	N	MO	DERATE	HIGH EXTREMELY HIGH		
	SCORE	0			1		2	SCORE
1	AGE	19 years to	64 years	65 years	to 79 years	80 yea	rs or older	
2	HOSPITALIZATIONS (last 12 months)	0 TO 1			2	3 OR		
3	ER VISITS (last 12 months)	0 ТО 1		2		3 OR MORE		
4	ALL OFFICE VISITS (last 12 months) exclude OB visits	1 to 3	2	3	5 to 6	7 OR MORE		
5	CURRENT PRESCRIPTION MEDICATIONS (including oxygen)	0-2 medications		med	3-5 lications	6 or MORE		
6	LANGUAGE/HEALTH LITERACY	TH • Primary language: English • Carries out plan of care well • Demonstrates understating of health care needs • Independently seeks health information		Limited English: veri Hearing impaired Carries out some of Requires some reinf	bal skills the plan of care forcement	Requires interpreter for all practice interactions     Not able to carry out plan of care without continued reinforcement     Requires routine reinforcement and education		
7	CHRONIC DISEASE (does not include mental health dx)	No chronic disease     AT RISK: pre-diabetes, borderline hypertension     Non Smoker     BMI 18.5 - 25		<ul> <li>1-3 chronic disease</li> <li>1-15 years tobacco</li> <li>BMI &lt; 18.5 -&gt; 25</li> </ul>	es diagnoses o use history	<ul> <li>4 or more ch diagnoses</li> <li>15+ years tob</li> <li>BMI &gt; 35</li> </ul>	ronic disease pacco use history	
8	CHRONIC DISEASE QUALIFIER	• N/A		<ul> <li>1 or more chronic d uncontrolled</li> </ul>	isease diagnoses	<ul> <li>1 or more ch diagnoses, sev uncontrolled</li> </ul>	ronic disease erely	
9	MENTAL & BEHAVIORAL HEALTH (includes but not limited to dementias, substance abuse, autistic disorders, eating disorders, developmental delays)	No Mental Health diagnoses     Long-term stability     demonstrated with medication		<ul> <li>1-2 Mental health d</li> <li>Routine follow-up w mental health provide</li> <li>1-2 Significant life st</li> <li>Job Loss, Moving, etc</li> </ul>	iagnoses vith provider and or er cressors (Divorce, Death, .)	3 or more me diagnoses     3 or more sig stressors (Divo Loss, Moving,	ental health nificant life rce, Death, Job etc.)	
10	MENTAL & BEHAVIORAL HEALTH QUALIFIER	• N/A		<ul> <li>1 or more Mental He uncontrolled</li> </ul>	ealth diagnoses	<ul> <li>1 or more Me diagnoses seve</li> </ul>	ental Health erely uncontrolled	
11	SOCIAL DETERMINIATION & SELF- MANAGEMENT	<ul> <li>Steady income</li> <li>Independent</li> <li>Stable residency</li> <li>Family or other</li> <li>Adequate medic</li> </ul>	support al insurance	<ul> <li>Receives some support to meet social needs</li> <li>Some medical insurance</li> <li>Lives alone needs some assistance with ADLs</li> </ul>		s • Lives in a Nursing Home or Assisted Living • Hospice • Homebound • Homeless • Unsafe home environment • Unemployed • Lack of financial or family support that impacts care • Transportation barrier • No medical insurance		
Con	nplex Care Coordinat	or Referral (Plea	se circle)	YES	NO			

## Mercy Pediatric Risk Stratification Tool

Mercy Pediatric Risk Stratification Tool								BIRTH TO 18	YEARS						
Risk	Level:	Evaluated by:		Evaluation	Evaluation Date:			Last Evaluation Date:							
Pati	ent Name:			Provider:			Last Risk Level	1							
Age	:	DOB:													
Risk	Stratification Level: Score	Risk 1: 0-1	Risk 2: 2-3	Risk 3: 4-6	Risk 4:	7-9	Risk 5: 10-13	Risk 6: 14-18							
CAR	E PLANNING	LOW		M	MODERATE		HIGH	EXTREMELY HIGH	SCORE						
	SCORE		0		1			2							
1	AGE	3 years t	o 18 years	Birth	Birth to 35 months			12 months							
2	HOSPITALIZATIONS (last 12 months)	10	01		2			MORE							
3	ER VISITS (last 12 months)	0 Т	01		2		3 OR	MORE							
4	ALL OFFICE VISITS (last 12 months)	Birth to 23 mo 2 years to 18 y	onths: 4-5 visit: years: 1-2 visit	s Birth t 2-3 S 2 years to 2	Birth to 23 months: 2-3 or 6-7 visits 2 years to 18 years: 3-4 visits			3 months: r >8 visits /ears: >5 visits							
5	CURRENT PRESCRIPTION MEDICATIONS	No med	ications	1-2 n	1-2 medications			3 or MORE Oxygen Use							
6	Family/Caregiver LANGUAGE/HEALTH LITERACY	Family/Caregiver <ul> <li>Primary language: English</li> <li>Carries out plan of care well</li> <li>Demonstrates understating of health care needs</li> <li>Independently seeks health information</li> <li>Requires som reinforcemer</li> </ul> <ul> <li>Limited English</li> <li>Limited English</li> <li>Hearing impa</li> <li>Carries out scoord</li> <li>Grave</li> <li>Requires som reinforcemer</li> </ul>				l skills ne plan	Ils • Requires interpreter for all practice interactions an • Not able to carry out plan of care without continued reinforcement • Requires routine reinforcement and education								
7	CHRONIC DISEASE (does not include mental health diagnosis)	<ul> <li>No chronic disease</li> <li>Nonsmoker/no secondhand smoke</li> <li>Growth chart: &gt;25th and &lt;75th percentile</li> </ul>		<ul> <li>1 chronic</li> <li>Exposure</li> <li>smoke</li> <li>Growth 0</li> <li>percentil</li> <li>percentil</li> </ul>	<ul> <li>1 chronic diseases diagnosis</li> <li>Exposure to secondhand smoke</li> <li>Growth Chart: &gt;5th percentile or &lt;95th percentile</li> </ul>		<ul> <li>2 or more chronic disease diagnoses</li> <li>Tobacco use</li> <li>Growth chart: &lt;5th percentile or &gt;95th percentile</li> </ul>								
8	CHRONIC DISEASE QUALIFIER	• N/A		<ul> <li>1 or mor- diagnose</li> </ul>	<ul> <li>1 or more chronic disease diagnoses uncontrolled</li> </ul>		<ul> <li>1 or more chronic disease diagnoses uncontrolled</li> </ul>		<ul> <li>1 or more ch diagnoses, se</li> </ul>	ronic disease verely					
9	Family/Caregiver/Patient MENTAL & BEHAVIORAL HEALTH (substance abuse, eating disorders, developmental delays, autistic disorders, depression, ADD, ADHD, etc.)	• No mental hea	alth diagnoses	<ul> <li>ses</li> <li>1 mental health diagnos</li> <li>Routine follow-up with provider and or mental health provider</li> <li>1-2 significant life stress (divorced parents, young parents &lt;20, single parent unemployment)</li> </ul>		<ul> <li>1 mental health diagnoses</li> <li>Routine follow-up with provider and or mental health provider</li> <li>1-2 significant life stressors (divorced parents, young parents &lt;20, single parent, unemployment)</li> </ul>		<ul> <li>1 mental health diagnoses</li> <li>Routine follow-up with provider and or mental health provider</li> <li>1-2 significant life stressors (divorced parents, young parents &lt;20, single parent, unemployment)</li> </ul>		ntal health ificant life rced parents, <20, single ployment)					
10	MENTAL & BEHAVIORAL HEALTH QUALIFIER	• N/A		<ul> <li>1 or more diagnoses</li> </ul>	<ul> <li>1 or more mental health diagnoses uncontrolled</li> </ul>		<ul> <li>1 or more mental health diagnoses uncontrolled</li> </ul>		more mental health noses uncontrolled		<ul> <li>1 or more mental health diagnoses uncontrolled</li> </ul>		<ul> <li>1 or more mer diagnoses seve uncontrolled</li> </ul>	ntal health erely	
11	Family/Caregiver/Patient SOCIAL DETERMINATION & SELF-MANAGEMENT	Steady income     Stable residen     Adequate mee     Meets basic A	e ce dical insurance DLs	Receives s meet socia Some meo Meets son	<ul> <li>Receives some support to meet social needs</li> <li>Some medical insurance</li> <li>Meets some of basic ADLs</li> </ul>			<ul> <li>Receives some support to meet social needs</li> <li>Some medical insurance</li> <li>Meets some of basic ADLs</li> </ul>		<ul> <li>Homeless</li> <li>Unsafe home</li> <li>Unemployed</li> <li>Lack of finance</li> <li>support that</li> <li>Transportation</li> <li>No medical in</li> <li>Foster care</li> </ul>	e environment cial or family impacts care on barrier nsurance				
Con	nments:							SCORE							
Con	nplex Care Coordinator Re	eferral (Please c	ircle)	YES	NC										

## St. Bernards Clopton Clinic Risk Stratification Tool

This four-stratum risk stratification tool adds points to account for mental health conditions.

CPC Ris	Stratification, Clopton Clinic, Ark.			
		Delint	I	Mandal Haaldh
Point	Utilization	Point		Mental Health
2	One hospitalization in the last	2		Anxiety
-	12 months	2		Depression
5	Two hospitalizations or ED visits	1		Mental Retardation
	Three or more hospitalizations or	4		Schizophrenia
10	ED visits in the last 12 months	3		Bi-polar Disorder
	Age			Behavioral
1	60-69 years of age	2	$ \Box $	Current tobacco use
2	70-79 years of age	2		Non-compliance (>2 no shows/
3	80 and older	3		DM/HTN/CHE etc.)
		2		Substance abuse
	Health Conditions	3		Substance abuse
6	AIDS not just HIV positive			
1	Asthma			Socioeconomic
1		2		Homebound
1		2		Lives alone
13		2		No/little social support
10	Cancer, active	2		No Insurance
7	continues care of Onc)			
1	Cancer, hx of (low risk if in remission and no problems)			Total right column
1	CHF CHF			Add total from left column
2	Chronic Pain			
5	CKD, Stage 3, 4 or Dialysis			TOTAL RISK SCORE
2				
1				
2	Dementia/Alzheimer's/Parkinson's			
3	DM. controlled			0 – 6 Low Risk
6	DM. complicated/uncontrolled			
1	Hemiplegia/Paraplegia			7 – 12 Moderate Bisk
1				T = 12 Moderate Risk
1				13 – 15 Moderate High Pick
1				13 – 15 moderate Flight Kisk
2				> 16 High Pick
2				2 TO HIGH NOK
2				
2	Polypharmacy (6 or more routine			
4	meds)			
I				
	(transfer total to right column)			

## Village Primary Care Risk Stratification Tool

*This five-stratum risk stratification tool will help show a greater distribution within the practice's patient population.* 

Fatient	lame:			Age	
Medical I	Record Number:			Date of Risk Assessmen	t:
Does pati	ent present with these condition	s?			
PRESE	4T	CHRONIC	PRESEM	IT	CHRONIC
	Allergy, asthma			Malignancies	
	Cardiovascular			Mental health/psychosocial	
	Ear, nose, mouth and throat			Musculoskeletal	
	Endocrine			Neurologic	
	Eye			Nutrition	
	Female Reproductive			Renal	
	Gastrointestinal/hepatic			Respiratory	
	Genetic			Rheumatologic	
	Genito-Urinary			Skin	
	Hematologic			Toxic effects	
	Infections				

#### Count as chronic:

The patient of caregiver of a dependent patient has a serious and persistent mental illness

Hospitalization during last 12 months

More than two emergency room visits in last 12 months

# Chronic Condition Count:

Chronic Count	Tier
0	1
1-3	2
4-6	3
7-9	4
10 or more	5

# **Shared Decision Making:** An In-Depth Review of the Critical Elements for Success

August 2014



An Initiative of the Center for Medicare & Medicaid Innovation

# **Shared Decision Making:** An In-Depth Review of the Critical Elements for Success

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This material is presented by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

## **Purpose of This Guide**



This Guide reflects on how CPC practices across the country have approached using Shared Decision Making to enhance patient care. These practice strategies represent samples of the work and are not representative of every approach for implementing Shared Decision Making methodology in a practice or system.

CPC practices are heterogeneous in size, geography, ownership and organization; they are encouraged to innovate and test strategies derived from evidence-based and/or best practices and customize the work according to their particular needs, local dynamics and other practice aspects that may shape how they deliver care. This Guide captures the energy, innovative ideas and rigorous and determined execution of the CPC practices as they test Shared Decision Making strategies.

We hope that you find in your colleagues' work support for continuing to explore and refine your approach to this key component of Comprehensive Primary Care.

August 1, 2014

## **Overview of the Shared Decision Making in Milestone 7**

Milestone 7: Shared Decision Making (SDM) focuses on supporting patients as engaged, informed and effective partners in their own health care. In Program Year (PY) 2013, your practice tested the use of a decision aid while engaging patients in Shared Decision Making. In PY 2014, your practice will explore the use of decision aids to support Shared Decision Making between providers and patients in preference-sensitive care. Decision aids prepare patients for a full discussion of available treatment options and offer a greater opportunity to discuss the risk and benefits of various treatment plans, as well as clarify the patients' values and health goals related to this decision. The work in this Milestone aligns perfectly with efforts around self-management support, care coordination, care management and patient and family engagement. Milestone 7 also supports the work of improving quality reported through the clinical quality measures.

# Reporting on Shared Decision Making for PY 2014

For PY 2014, practices will identify and implement Shared Decision Making tools or aids in two preference-sensitive health conditions, decisions or tests, make the decision aid available to appropriate patients and generate a metric for the proportion of patients who received the decision aid.

Practices will provide quarterly counts of patients receiving the decision aids and show growth in use of the aids using run charts.

## What is Shared Decision Making?

Shared Decision Making is an approach to care that seeks to fully inform patients about the risks and benefits of available treatments and engage them as participants in decisions about the treatments. (Veroff, Marr and Wennberg at <a href="http://content.healthaffairs.org/content/32/2/285.full.html">http://content.healthaffairs.org/content/32/2/285.full.html</a>)

#### What is Preference-Sensitive Care?

Preference-sensitive care comprises treatments for conditions where legitimate treatment options exist — options involving significant tradeoffs among different possible outcomes of each treatment (some people will prefer to accept a small risk of death to improve their function; others won't). Decisions about these interventions — whether to have them and which ones to have — should thus reflect patients' personal

#### For clinicians, Shared Decision Making can translate into the potential for

- Patients who are more empowered to manage their health and treatment
- Reductions in unwarranted variation of care
- Increased awareness among patients regarding potential adverse consequences from a medical decision or treatment option
- Overall increase in quality of patient care

values and preferences and should be made only after patients have enough information to make an informed choice, in partnership with their provider. (The Dartmouth Atlas of Health Care. http://www.dartmouthatlas.org/kevissues/ issue.aspx?con=2938)

A strong body of evidence shows significant regional variation in preference-sensitive care, and this variation appears not to be due to patient choice but rather to prevailing practice patterns. Additional evidence suggests that when patients are engaged in decision making and provided with the information they need to think through options of care, there is a better match between the care they receive and their health goals and values.

For more information:

- Dartmouth Atlas on Preference-Sensitive Care
- 2014 Cochrane Summary on Decision Aids

#### What is a Decision Aid?

Decision aids are interventions designed to support patients' decision making by making the choice explicit, providing information about treatment or screening options and their associated outcomes, compared to usual care and/or alternative interventions. (<u>Cochrane Database of Systematic Review 2014</u>)

Decision aids provide:

- High-quality, up-to-date information about the condition, including risks and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes
- Values clarification to help patients sort out their values and preferences
- Guidance or coaching in deliberation, designed to improve the patient's involvement in the decision process (<u>http://www.dartmouthatlas.org/downloads/reports/preference\_sensitive.pdf</u>)

Shared Decision Aids versus Patient Education	n
-----------------------------------------------	---

Shared Decision Aids	Patient Education
Helpful for discussing preference-	Helpful for informing patients about tests,
sensitive conditions with multiple	procedures or conditions with two
treatment and test options	options, such as "yes" or "no"

It is common practice to offer patients information about tests or treatment options for which there is **clear** evidence for a recommended action (e.g., immunization or US Preventive Services Task Force recommended screenings). However, Milestone 7 is focused on engaging patients in making choices when the evidence **does not present a clear best choice** and the "right" treatment or test is the one that best fits their health goals and values. The conditions listed below are from page 62 in the <u>2014 Milestone</u> Implementation and Reporting Guide.

### List of Common Preference-Sensitive Conditions

- Management of acute low back pain (without red flags)
- Antibiotic overuse for upper respiratory infection
- Anticoagulation in atrial fibrillation
- Management of anxiety or depression
- Management of asthma
- Cataract surgery
- Management of chronic back pain
- Management of chronic pain
- Management of congestive heart failure
- Management of COPD
- Medications in diabetes
- Joint replacement
- Podiatric surgery
- PSA for prostate cancer screening
- EKG and cardiac stress testing

- Care preferences over the life continuum
- Colon cancer screening
- Management of heart failure
- Management of coronary heart disease
- Management of Peripheral Artery Disease (PAD)
- O Managing health concerns of older adults
- Menopause
- Urinary incontinence
- Knee osteoarthritis

Shared Decision Making: An In-Depth Review of the Critical Elements for Success

**Other** (The following are additional preference-sensitive conditions that can be considered. Note that this list is not all inclusive.):

- Chronic, Stable Angina
- Management of Heavy Menstrual Bleeding
- O Management of Carpal Tunnel Syndrome
- Management of Middle Ear Fluid
- Hip osteoarthritis

#### Management of Psoriasis

- Management of Trigger Finger
- Lung cancer screening in smokers
- Management of Benign Prostatic
   Hyperplasia
- Management of tobacco cessation
- Management of Obesity

## Step 1: Building the Team

To facilitate successful Shared Decision Making implementation, practices are encouraged to designate the following roles and provide protected time for project activities:

- Lead Clinician/Project Champion to serve as the voice for the project across the practice and support staff activities
- Lead Staff Member often a practice manager, QI official, nurse or staff member with an interest in patient engagement
- Decision Aid Implementation Team a small, cross-functional team including the lead clinician, lead staff member and representatives from the front- and back-office staff who understand the importance of decision aid implementation for patients and the practice and who are willing to meet and work on an implementation plan
- **Patient and Family Advisory Council (PFAC)** The team can also consider including recommendations from the PFAC as they determine the best decision for the patient population

Schedule an initial team meeting and develop a preliminary plan keeping the questions above in mind. To begin, it may be helpful to answer the following questions:

- What are some of the common or high-risk conditions involving preference-sensitive care in your patient population?
- What decision aids will help meet this need?
- What format is mostly likely to appeal to your patients?
- Who and how will you identify eligible patients for the use of decision aids?
- Where will the decision aids be stored?
- When and how will the patient use decision aids?
- How will your practice track the use of decision aids?
- How will your practice know if the process needs to be expanded, changed or refined?

Case studies that highlight the team members working on Shared Decision Making may be found at the following CPC practice links:

- Hicken Medical Clinic
- <u>St. Elizabeth Physicians</u>

## **Step 2: Selecting Priority Decision Aids**

An early step in effective program implementation is determining which decision aids are appropriate for your practice. Discussing the pros and cons of choosing decision aids that focus on chronic conditions, specific surgical procedures or more rare but high-risk situations can help the team determine which decision aids will work for the practice's patient population.

Consider these questions:

- Which decision aids will target high-risk or high-cost preference-sensitive conditions faced by some of your patients?
- Which decision aids would be good supplements for viewing before procedural referrals?
- Which decision aids target the preference-sensitive conditions most prevalent in your practice?
- Which decision aids are the staff and clinicians excited about?
- Which decision aids do patients want their health care team to provide?

Case studies involving the choice of a decision aid may be found at the following links:

- Generations Family Medicine
- Hicken Medical Clinic
- Hudson Valley Primary Care
- Sangre de Cristo Internal Medicine

## Step 3: Determine Eligibility Criteria for Decision Aids

Many practices may elect to use the eligibility criteria provided in each decision aid to determine when to present the decision aid to the patient. However, some practices may elect to narrow their criteria to offer decision aids to patients when they present for an annual exam or with a specific condition. Refinement of eligibility criteria may be necessary over time based on clinic capacity for distribution and tracking of decision aids.

Case studies that address eligibility criteria may be found at the following links:

- <u>CapitalCare Medical Group</u>
- Generations Family Medicine
- Grants Pass Clinic LLP
- Hicken Medical Clinic
- <u>St. Elizabeth Physicians</u>

## **Step 4: Identifying Patients**

In addition to clarifying eligibility criteria for the decision aids, the practice will need to determine which personnel will identify specific patients as eligible to receive decision aids. In some practices, multiple personnel are involved in patient identification. These are some of the individuals/roles who have been successfully involved in identifying patients:

- *Front Office Staff/Reception:* These individuals are often the first point of contact in a practice. Reception staff clarifies the reason for patient appointments and they may be able to flag clinicians or back office staff of a patient's eligibility for a decision aid.
- Medical Assistant (MA) or nurse (LPN/RN): Medical Assistants or nurses are often able to review or "scrub" the patient list and medical chart during pre-visit planning to identify specific conditions. They can inform the clinician when a patient may be eligible for a decision aid prior to the appointment time.
- *Clinician:* Clinicians can identify eligible patients during the appointment time and through recommendations made by the MA/LPN/RN.

- *Nurse Care Coordinator:* The nurse care coordinator can be involved when specific populations are targeted for distribution or when clinicians submit referrals for follow-up of certain chronic conditions.
- Patient self-identification: Patients may ask about options for care for their medical conditions.
- *Electronic Health Records (EHR):* Incorporating any or all of the above strategies into practice's EHR system provides the most resource-efficient method to identify patients and distribute decision aids.

Case studies that address patient identification may be found at the following links:

- Hicken Medical Clinic
- Generations Family Medicine
- Grants Pass Clinic LLP
- <u>St. Elizabeth Physicians</u>

## **Step 5: Decision Aid Preparation, Storage and Maintenance**

Easy-to-access decision aid packets facilitate distribution to patients at the point of care when a decision point emerges. Advance preparation of the decision aids can streamline the process and allow for easy tracking of decision aid distribution and use.

Case studies that reflect this element may be found at the following links:

- Generations Family Medicine
- Grants Pass Clinic LLP
- Hicken Medical Clinic
- St. Elizabeth Physicians

## Step 6: Determine When and How to Distribute Shared Decision Making Aids

Every practice visit flows differently so it helps to be flexible and have multiple approaches available for distributing the Shared Decision Making aids.

Case studies that reflect this element may be found at the following links:

- <u>CapitalCare Medical Group</u>
- Hicken Medical Clinic
- Hudson Valley Primary Care
- <u>Sangre de Cristo Internal</u> <u>Medicine</u>

Several options of when to distribute Shared Decision Making aids (hard-copy or link to web-based decision aid):

- Prior to the visit: Practices send decision aids to patients based on established criteria (age, category reached and type of appointment) via mail, email or patient portal.
- During the visit (by MA or clinician): The clinician presents the decision aids to the patient during their appointment.
- After the visit (by MA/LPN/RN): After the clinician has discussed the decision aid topic, the MA/LPN/RN presents the decision aid packet to the patient.
- After the patient has left the practice: A protocol can be established for contacting the patient after the visit to discuss the decision aid, and the MA/RN or front desk staff can mail, email or send via the patient portal the materials or link to the decision aid to the patient. This option is useful if you forget or don't have the time during the office visit.
- When to discuss SDM: at first scheduled or unscheduled visit to office

## Step 7: Decision Aid Tracking, Documentation and Distribution

Documenting decision aid distribution is extremely important to ensuring patient follow-up and managing the resources available to the practice. Coding the distribution of decision aids and discussion with the patient is critical for practice follow through. Discuss options with your billing staff and EHR IT staff to facilitate tracking of this activity. If the decision aids or access via the web is provided, a plan to for ensuring patients have an opportunity to discuss the decision aid with his/her clinician will be necessary. This may occur at a follow-up visit or via telephone or portal.

Case studies that reflect this element may be found at the following links:

- <u>CapitalCare Medical Group</u>
- Generations Family Medicine
- Grants Pass Clinic LLP
- St. Elizabeth Physicians
- Sangre de Cristo Internal Medicine

## **Step 8: Evaluating Implementation and Making Changes**

Practice change is not static. Practices should review and refine the implementation of a SDM process over time on a monthly or quarterly basis. Establish routine conversations about SDM as part of standing all-staff meetings and document internal policies, procedures and/or protocols around your SDM process. This keeps the SDM program on the table and reinforces it as part of daily clinic practice. It also engages clinicians and staff in conversations about what is working and where room for improvement exists.

Case studies that reflect this element may be found at the following links:

- <u>CapitalCare Medical Group</u>
- Grants Pass Clinic LLP
- Hicken Medical Clinic

#### CapitalCare Medical Group, Albany, New York

**Corporate multispecialty clinic; 18 primary care sites; 37 physicians, 14 PAs, 6 ANPs; 58,000 patients** When staff members at **CapitalCare Medical Group** began the selection process for shared decision aids, they kept reminding themselves to focus on what matters to the patients. To help them start small, the practice also decided to narrow its focus to patients with a new diagnosis within six months. Several practice sites chose to focus on shared decision aids for the following conditions:

- High cholesterol
- Sciatica
- Hypertension
- PSA screening
- Antibiotics for pharyngitis

There was some variation with adopted shared decision aids among the 18 primary care sites. Each practice site looked at the size of the eligible patient population for a specific aid and the need to change outcomes.

To track the use of shared decision aids, the practice worked with its EHR vendor, Allscripts, to create an "order" for use of Shared Decision Making with patients. The order is easily tracked for data mining purposes within the EHR. The order is also helpful on the patient level because it is visible during each encounter. The physician can clearly see if Shared Decision Making has happened with the patient, and if there is resolution, the order can be cancelled.

The Shared Decision Making process is performed in multiple steps. It starts with the physician and the patient beginning the conversation during the first visit. If the patient's visit is planned in advance, the SDM aid can be printed and placed in the patient's folder to facilitate the conversation. A note is placed in the patient's record to discuss the SDM aid on next visit. The second visit focuses on the SDM aid discussion.

Shared Decision Making has really become part of the culture at Capital*Care*. SDM is an agenda item at the Patient Family Advisory Council meetings to get feedback from the most important contributors, the patients.

## Generations Family Medicine of SW Ohio, Middletown, Ohio Independent; 1 physician; 2,300 patients

Shared Decision Making is a process that fits well with the style of medicine at **Generations Family Medicine of SW Ohio**. The patient population of this solo practitioner is predominantly older female patients. Using these aids facilitates the conversation as patients make informed decisions about their care.

Generations' first <u>SDM tool</u> assisted with the decision of using antibiotics for upper respiratory infections. The tool was obtained from the CDC. The trigger to use this tool with patients is their request for an antibiotic for an upper respiratory illness. The tool takes them through the pros and cons of various treatment methods for the illness and the consequences of each. In addition to educating the patient on choices, it empowers them to make informed decisions about how to care for this infection, when to seek additional care and the outcomes of each.

The second SDM tool developed is for treatment of osteoporosis. This fits particularly well with the demographics of the practice. The tool was purchased from the <u>National Osteoporosis Foundation</u>. When patients have a new diagnosis of osteoporosis or identified risk factors, the doctor and the patient spend (on average) 10 minutes reviewing the options for care and working on selecting the patient's preference for treatment. The patient is then given the pamphlet to take home. The patient's decision, or their choice to review the information and make a decision later, is recorded in the EHR.

The use of SDM tools is tracked through the EHR (Athena Health) using a miscellaneous CPT code that is not processed by billing.

This practice noted that you cannot underestimate the effect you have on a patient's life when Shared Decision Making is used. When you provide materials for patients to process and absorb prior to making a decision on a preference-sensitive condition, you empower and support them to take control of their own health.

#### Grants Pass Clinic, LLP, Grants Pass, Oregon

#### Provider-owned multispecialty; 19 physicians; 2 ANPs, 2 PAs; 17,200 patients

**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 <u>colorectal cancer screening</u> options. The practice uses their EHR, Allscripts, to create custom searches by diagnosis codes to identify eligible patients to receive the shared decision aids. For example, patients eligible for the statin SDM are all patients who have been seen since January 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

Providers selected decision aids from <u>Mayo Clinic</u> because they were authoritative, graphically satisfying and were available to share with the patients in real time. They can access the decision aids immediately during the patient encounter through links posted to the exam room's client desktop. Providers document use of the aid in a discrete field in the notes section of the patient's record.

The clinic is working toward a SDM dashboard application that is provider-specific so that each provider can monitor his or her patient panel for eligibility for all decision aids.

To ensure the proper use of decision aids in the practice, they created a <u>policy</u> around the defined workflow. The policy helped to make the use of the decision aids more uniformed among the various providers; it addressed how to use of the decision aid and how to document it in the EHR properly. Standardizing the documentation in the EHR helps ensure accurate data for reports in the defined discrete data fields. The policy also serves as a documented shift in thinking about the patient's voice in choosing screening and treatment options.

## Hicken Medical Clinic, Hillsboro, Oregon Independent; 1 physician, 3 PAs; 6,200 patients

Dr. Hicken realized that he alone could not drive practice transformation and that it is important to dedicate time and resources to improve. The CPC initiative has help them adopt a team-based approach to integrate Shared Decision Making into the practice's daily workflow.

The <u>Hicken Medical Clinic</u> team followed their chosen criteria as it researched decision aids for the practice. First, they wanted aids that met the <u>International Decision Aids Standards</u> for quality and content. Second, they preferred tools with a step-by-step approach that clearly compared both risks and benefits. Third, 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 <u>Healthwise's Knowledge Base</u> offered interactive decision aids that patients could access through the patient portal and later access the decision summary as well. The Healthwise aids 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.

For the initial implementation of SDM, the clinic decided to test two decision aids along with a new workflow with a small population of patients. They started with "Should My Child Take Medication for ADHD?" and "Depression: Should I Take an Antidepressant?"



Decision tree for use of Shared Decision tool in Behavioral Health

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 integrated behavioral health 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.

Patients are identified during pre-visit planning or are identified during the visit. If the practice staff know about a patient prior to a visit, they are able to alert the behavioral health specialist, physician assistant and the physician as needed so they can participate in the shared decision conversation. Some patients will listen to the information, but prefer to take some time to think about their options and come back for a

second visit. The staff can help the patient set up the follow-up appointment as well as provide a summary for review at their convenience.

Hicken Medical Clinic's staffing patterns have remained the same as Shared Decision Making was integrated into the mid-office workflow. 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.

In the near future, Shared Decision Making may be integrated into the clinic's proactive population management model.

## Hudson Valley Primary Care, Wappingers Falls, New York Independent; 2 physicians, 2 ANPs; 8,290 patients

This practice decided to focus on the area of diabetes medications for Shared Decision Making because both physicians are <u>NCQA-recognized diabetes providers</u>. The <u>Mayo Clinic aid</u> on the use of diabetes medication was selected because it provided the complete picture about the pros and cons of the medications, costs and possible side effects. The aid also allowed the patient to have a very clear picture of their possible options.

After deciding on the aid, the practice worked to incorporate the aid into their workflow. The practice integrated the aid into the EHR, eClinicalWorks. By using the <u>Healthwise</u> products, the practice is able to embed links to shared decision aids directly into the order sets, which really made it easy for the staff to embrace and share the aids with the appropriate patients. Using a tablet, the nurse is able to walk through the aid with the patient prior to the provider entering the exam room. This process allows for the maximum effective use of the provider's time with the patient. Use of pre-visit planning and huddles allow the practice to help identify the patients who could benefit the most from a shared decision aid and therefore make the best use of everyone's time during the appointment. For example, if a provider is able to review a patient's lab work and determines an aid would be appropriate, the clinical team can ensure the patient receives the aid prior to the next appointment through the patient portal. Asynchronous workflow through the patient portal has helped streamline the use of aids in this practice.

## St. Elizabeth Physicians CPC Practices, Northern Kentucky

### System; 14 CPC practices; 65 physicians, 1 PA, 5 ANPs; 65,000 patients

Putting Shared Decision Making into practice within the CPC practices of **St. Elizabeth Physicians** was a team effort. As work began on Milestone 7; the clinical leadership group evaluated the data on their population and selected the first focus of Shared Decision Making. The initial target was tobacco cessation (options to support quitting). This is also a community issue, with a high number of patients that smoke.

As this leadership group reviewed various Shared Decision Making tools, they <u>created a tool</u> that was drawn from evidence-based options for smoking cessation yet included endorsed treatment options by the physicians in the group. Patients are chosen for Shared Decision Making based upon their response when asked if they are ready to quit smoking. If they indicate they wish to quit, the SDM tool is reviewed with them, and the physician reviews the options in the tool with the pros and cons of each option. If the patient selects an option, the physician records this in the EHR (Epic) as the patient's preference. The SDM tool also prints in the after-visit summary with the patient's preference indicated.



Tracking the use of the SDM tools is done in Epic. With discrete fields in the EHR, they are able to track the number of patients eligible for use of SDM and the number of tools used with patients. With that, they can calculate the adoption rate, which now stands at well over 60 percent.

One challenge this group found with implementing Shared Decision Making is the amount of time it took to do the planning and then train all involved parties to implement the process. A 10-month process to accomplish this with the first tool was noted. At this point, process metrics are available, but it is still a bit early to see the actual outcomes of the tobacco cessation activity.

# Sangre de Cristo Internal Medicine, Pueblo, Colorado

### Independent; 1 physician; 1,100 patients

**Sangre de Cristo Internal Medicine** selected shared decision aids based on commonly encountered diagnoses. Three decision aids were selected from Mayo Clinic in the areas <u>of statin and aspirin use for</u> <u>primary prevention</u> and <u>osteoporosis</u>. An additional aid was selected from the American Urological Association on <u>PSA screening</u>. The staff loaded each aid to the practice's website so that patients can view them after the visit.

When patients fall into one of the SDM aid categories, Dr. Duffee uses the tools on the Mayo website to

review with the patients. The patients are very engaged during this process, helping to answer questions and converse with the physician about the important points in the decision aid. Patients often jump out of their chair and walk over to the computer to see the final risk numbers and watch the aid in action.

After the conversation with the patient, the physician documents the risk numbers from the online decision aid in the eMDs data review section. The data review section in this EHR is not a discrete data field and cannot be used for reporting, so the physician enters CPT and ICD-9 codes into the patient's problem list, which the registry can pick up and use for data reporting. Beyond the advantage of reporting, the Shared Decision Making CPT and ICD-9 codes stay in the patient's problem list so that Dr. Duffee can guickly confirm if a shared decision aid has previously been reviewed with the patient. Dr. Duffee believes that the shared decision aids help patients better understand their specific risks. About 80 percent of patients are able to make a decision after the conversation with the use of the decision aid and about 20 percent ask the physician to help them make the final decision.

# CPT Codes that can be used for documenting and tracking SDM use:

- CPT Code 99071—educational supplies, such as books, tapes and pamphlets provided by the physician for the patient's education at cost to the physician
- CPT Code 99078—physician educational services rendered to patients in a group setting (e.g., prenatal, obesity or diabetic instruction)
- CPT Code 98960—education and training for the patient by a qualified, non-physician health care professional using a standardized curriculum, faceto-face with the patient (could include caregiver/family), each 30 minutes; individual patient

## Conclusions

Implementing Shared Decision Making may take some time and require overcoming a few challenges along the way, as this is a significant shift in how some practices are now inviting patients to engage in their care. The benefits of Shared Decision Making in the practices that have experienced successful implementation appear overwhelmingly positive. Shared Decision Making allows patients to engage more in their health care experience by supporting them as they make fully informed choices on the treatment or screening options that are best for them. By placing patient-friendly, easy to use, high quality and up-to-date decision aids into the hands of patients, they can truly be a supported and empowered part of their care team. Practices who have implemented Shared Decision Making have been able to see and hear the positive difference directly from their patients.
# Appendix

	Pharmacology Nicotine Replacement Therapy			No Aid		
	Nicotine Inhaler	Nicotine Gum	E-Cigarette	"Cold Turkey"	Taper	O. St. Elizabeth
Cost Similar This average cost of smoking per year. \$1,600	*12-*15° day	\$2-\$5° day	Starter Kit \$20-\$90 Catridges or "Juice" \$5-\$10	FREE	\$2-\$5° day	PHYSICIANS
Routine	6-16 cartridges per day for 12 works. No additional nicotine products.	Week 1-6:1 every 1-2 hrs. Weeks 7-9:1 every 2-4 hrs. Weeks 7-9:1 every 2-4 hrs. No additional nicotine products.	Varies. No additional nicotine products.	No Smoking	U Uarios	Smoking
Side Effects	Throat and/or mouth initation     Cough     Stomach upset     Change in taste     Sinus pain/pressure     Pain in the jaw, neck or back     Headaches	Burning in throat     Hiccups if chewed too     quickly     Dental problems	Throat/mouth initiation     Cough     Stomach upset     Change in taste     Sinus pain/pressure     Jaw, neck or back pain     Headaches	Nicotine withdrawal	Nicotine withdrawal	Cessation Guide
Success Rate	4%	4*	Research still being conducted as a smoking cessation tool.	3.5%		Your guide to medical care decisions.
Contact Info	Your healthcare provider	Local pharmacy	Local retailers, internet	Congratulations! You have decided to quit - now what? Make an appointment to talk with your provider.		www.stedocs.com

Smoking Cessation Decision Aid from St. Elizabeth's Physicians





# Is Prostate Cancer Screening Right for You?

Prostate cancer is the second most common cancer in men, and the second-leading cause of cancer death in men. One is sit men will be diagonosed in the Tehrma African-American men and men with a family history of prostate cancer have a higher chance of getting the disease. wy w provinse strater have a myner chance or gerthig the GMBAB. Itale cancer is different from many cancen because it often grown i lowly and may not cause problem. In 2017, more than 246,000 nevere diagnosed with prostate cancer, and only about 28,000 erknaw met died of the disease. Many menwith prostate cancerwill er knaw they have it unless they get tested. nwill

- A normal PSA test may put your mind at ease.
- A PSA test may find prostate cancer early before it has spread.
   Early treatment of prostate cancer may help some men to avoid problems from cancer. problems from cancer. • Early treatment of prostate cancer may help some men live longer.
- A normal PSA test may miss some prostate cancen (a "tabe negative").
- Sometimes the text results suggest something is wrong when it inn't (a "fabe positive"). This can cause unneeded worry and stress.
- A "false politive" PSA test may lead to an unneeded prostate biopsy (these sample).
- A high PSA test may find a prostate cancer that is slow-growing and never would have caused you problems.
- Treatment of prostate cancer may cause you harm. Problems with
  getting erections, leaking urine or bowel function can occur.

growing emission, waking unne or bowef function can occur. According to the American Urological Association, in asymptomatic men, the gravation benefit of rockine screening can be found in men ages 50 to 69 years. Men younger than 55 or older than 00 who are worthed about their periodal this factors hould talk with their health care provider to determine whether prostate cancer screening th appropriate.





Association The Official Foundation of the American Underginal Association



# Should You Be Screened for Colon Cancer?

- If you are 50 to 75 years old, you should have regular colon cancer screening.
- If you are 76 to 85 years old, you should talk to your doctor about it.
- Some people who have certain high risk factors may need to be screened before the age of 50. If you think you may be at high risk, talk to your doctor about it.

# Why Should You Be Screened?

- Colon cancer is the second leading cause of deaths caused by cancer in the United States.
- Colon cancer screening tests find problems early, when treatment can work best.
- If everyone had colon cancer screening when it is recommended, over half of all deaths from colon cancer could be prevented.
- · You can have colon cancer without having any symptoms.
- Most cases of colorectal cancer happen in people who do not have risk factors for it.

# What Are Your Choices?

**Fecal Occult Blood Test** – This is a test you do at home. You collect a small amount of stool and smear it on a card that you send to your doctor or a lab. The test shows if there is any **blood in the stool that you cannot see**.

- Works well to reduce deaths from colon cancer.
- Done every year.
- Test may be positive, even if there is not a problem.
- Test may be negative, even if there is a problem.
- Test may not detect early problems before they turn into cancer or some kinds of cancer.
- At least 1 of every 10 people who have this test will be advised to get a colonoscopy.

Flexible Sigmoidoscopy – This test uses a small, flexible tube with a tiny video camera at the tip. The camera lets the doctor see the inside of your rectum and the lower part of your colon.

- · Works very well to reduce death from colon cancer.
- Done every 5 years.
- You do not usually need to be sedated for this test.
- If the doctor sees a problem, a biopsy can be done at the time of the test.
- You usually need to do 1 or 2 enemas to empty your colon before the exam. You might not be able to eat solid food the day before.
- Test may not find problems higher up in the colon.
- You might have cramping or bloating after the test.
- Rare complications include bleeding from a biopsy or a small tear in the lining of the colon. Very rarely, people get a tear in the colon from the test.
- Some people who have this test will still need to get a colonoscopy.

**Colonoscopy** – This test uses a long, flexible tube with a tiny camera. The camera lets your doctor see your **entire colon**.

- This is felt to be **the best** colorectal cancer screen test.
- Done every 10 years.
- Abnormal growths can be removed at the time of the test.
- You will need to be sedated for the test, so you will need someone to drive you home.
- You must take laxatives and avoid solid food the day before the test, so the colon is empty and clean.
- You might have cramping or bloating after the test.
- Rare complications include bleeding from having something removed or from a tear in the colon or the rectal wall. Sometimes, people have to stay in the hospital from complications.
- Very rarely, people die from complications of having this test.

# How Will You Decide What Is Best for You?

It may not be easy to decide which test is best for you, but having a colon cancer screening test can save your life. Talk to your doctor about your options. The most important thing is to get tested.

## The sooner colon cancer is found, the easier it is to treat.

# Where Can You Find More Information?

There are many websites that have good information about colon cancer, colon cancer screening, and ways to prevent colon cancer. Here is a list you may find helpful:

## **Centers for Disease Control and Prevention**

http://www.cdc.gov/cancer/colorectal/basic\_info/screening/

## Mayo Clinic

http://www.mayoclinic.org/diseases-conditions/colon-cancer/basics/ definition/CON-20031877

## National Cancer Institute

http://www.cancer.gov/cancertopics/pdq/screening/colorectal/Patient/

## American Cancer Society

http://www.cancer.org/cancer/colonandrectumcancer/index

## Here is a good tool that walks you through the decision process:

http://www.cancerscreeningdecision.org/about.cfm



This illustration from Centers for Disease Control and Prevention web site (http://www.cdc.gov).

### **Grants Pass Clinic Decision Aid – Colon Cancer Screening Policy and Procedure**



### PURPOSE:

To assure increased rates of colorectal cancer screening among the eligible Grants Pass Clinic patient population while simultaneously providing patients an opportunity to actively participate in the decisions affecting their care.

### POLICY:

Clinic staff will follow the procedure outlined below to provide patients an opportunity to discuss colorectal cancer screening options with their provider using shared decision making techniques.

### PROCEDURE:

During the adult annual office visit, eligible patients aged 50+ will be provided the Colorectal Cancer Screening Decision Aid by the medical assistant, allowing them the opportunity to read the decision aid and formulate any questions they may have. Patients will then be instructed to notify their provider during the office visit that they would like to discuss their options/questions.

Medical Assistants will document by checking the appropriate box in the EMR that the patient has been provided the colorectal cancer screening decision aid, and has been encouraged to discuss the colorectal cancer screening options with their provider/care team.

### **Grants Pass Clinic Decision Aid – Colon Cancer Screening**

#### Ordering and Documenting Colorectal Cancer Screening Decision Aid

- If patient is between ages 50-75 and here for an annual visit, they meet the criteria to receive the Colorectal Cancer Screening Decision Aid
- MAs will distribute the handout when they room the patient and instruct them to read through it. If they have any questions/concerns, or would like to discuss their options, instruct them to bring them up with their provider during this office visit. See scripting below:
  - "Based on your age, we have identified you as being eligible to receive our Colorectal Cancer Screening Decision Aid. If you would like to discuss your options, or have any questions or concerns, you can bring them up to your provider during this office visit."
- The MA will then document in the EMR that the patient received this handout using the following method:



### **Ordering and Documenting**

History	Build Based Rx   Med Admin   Jammin	Click the tab "Instruct"		
CEnterin	Fore	Bagervised By:	- 44	
- Type "colo for "Color	My Favorites rectal Cancer Screening Decision Aid o" and you will see the folder rectal Cancer Screening	Off      Record w/o Ordering     rer Screening Decision Aid	• K V	
Decision	Aid" come up			



### Generations Family Medicine of SW Ohio Antibiotic Decision Aid



hen your child is sick, you want to do everything you can to help. But antibiotics are not the answer for every illness. This brochure will help you know when antibiotics work – and when they won't. For more information, talk to your healthcare provider or visit www.edc.gov/ getsmart.

#### The Risk: Bacteria Become Resistant

What's the harm in giving your child antibiotics anytime? Taking antibiotics when they are not needed can cause some bacteria to become resistant to the antibiotic.

These resistant bacteria are stronger and harder to kill. They can stay in your child's body and can cause severe illnesses that can't be cured with antibiotics. A cure for resistant bacteria may require stronger treatment – and possibly a stay in the hospital.

To help prevent antibiotic resistance, the Centers for Disease Control and Prevention (CDC) recommends giving your child antibiotics only when necessary.



#### Antibiotics Aren't Always the Answer

Most illnesses are caused by two kinds of germs: bacteria or viruses. Antibiotics can cure bacterial infections – not viral infections.

Bacteria cause strep throat, some pneumonia and sinus infections. *Antibiotics can work*. Viruses cause the common cold, most coughs and the flu. *Antibiotics don't work*.

- Using antibiotics for a virus:
- Will NOT cure the infection
- Will NOT help your child feel better
- Will NOT keep others from catching your child's illness

#### Protect Your Child, Give the Best Care



Antibiotics should not be used to treat the common cold, runny noses and most coughs. Children fight off these viral illnesses on their own.

If your child's healthcare provider prescribes an antibiotic to treat a bacterial infection – like strep throat – be sure to give your child all of the medicine. Only using part of the prescription means that only part of the infection has been treated. Not finishing the medicine can cause resistant bacteria to develop.

> Talk to Your Healthcare Provider to Learn More

## Commonly Asked Questions:

#### How Do I Know if My Child has a Viral or Bacterial Infection?

Ask your child's healthcare provider and follow his or her advice on what to do about your child's illness.

Remember, colds are caused by viruses and should not be treated with antibiotics.

#### Does This Mean I Should Never Give My Child Antibiotics?

Antibiotics are very strong medicines and should be used to treat bacterial infections. Your healthcare provider will prescribe antibiotics if your child has a bacterial infection.

#### If Mucus from the Nose Changes from Clear to Yellow or Green — Does This Mean That my Child Needs an Antibiotic?

No. Yellow or green mucus does not mean that your child has a bacterial infection. It is normal for mucus to get thick and change color during a viral cold.

## References

A Dartmouth Atlas Project Topic Brief: Preference-Sensitive Care

This article reviews the various effects and problems of preference-sensitive care in the United States.

Colonoscopy Shared Decision Aid

This colorful decision aid is ready to print for use in practices.

Colorectal Cancer Screening Shared Decision Aid

This link is a shared decision tool used at Grants Pass Clinic.

Decision Aids to Help People Who Are Facing Health Treatment or Screening Decisions

This Cochrane Summary contains useful information on SDM.

Enhanced Support for Shared Decision Making Reduced Costs of Care for Patients with Preference-Sensitive Conditions

A recent Health Affairs article regarding the effect of SDM on costs.

Informed Medical Decision Foundation

This website explains Shared Decision Making through text and movie clips, including a list of demonstration sites who have implemented Shared Decision Making into their practice.

Integrating Patient Decision Aids into Primary Care Practice: A Toolkit to Facilitate Shared Decision Making

This website will take you step by step though practice readiness, planning and evaluating for Shared Decision Making. The implementation content from this guide was from this toolkit.

<u>Milestone 7: Using Decision Aids to Improve Shared Decision Making</u>, Oklahoma (Greater Tulsa) webinar, April 3, 2014

This session is an overview of SDM in Oregon and contains some good resources for practices.

<u>Milestone 7: Shared Decision Making</u>, Oklahoma (Greater Tulsa) webinar, Nov. 8, 2013 This learning session has a good overview of Shared Decision Making, with good practice examples explained.

Patient Decision Aids from the Ottawa Hospital Research Institute

This site has tools you can access and forms ready to use for personal decisions.

<u>Patient-Provider Partnership – Shared Decision-Making Low Back Pain Patient Available Tools</u> Lists the sources for SDM tools for low back pain.

<u>Resources from Million Hearts® Initiative that Supports CPC Practices' Work in Milestones 2, 5 and 7</u> Million Hearts® materials and link to the site are included in this post.

<u>Shared Decision Making Article: Engaging the Patient's Experience</u> This article reviews the work at Carolinas Medical Center – Mercy using asthma SDM.

<u>Shared Decision Making Article: Signs of the Times (Part II)</u> Contains link to an article on the impact of SDM on patient decisions. <u>Shared Decision Making Tools</u>, Arkansas webinar, April 11, 2014 Shared Decision Making Tools and how to develop them in your practice is reviewed.

<u>Shared Decision Making</u>, Colorado webinar, June 6, 2014 Shared Decision Making presentation by Richard Wexler has good information and resources.

<u>Shared Decision Making</u>, New York webinar, June 17, 2014 Webinar contains a presentation by Diana Stilwell, VP for Content, Healthwise Inc.

<u>Shared Decision Making</u>, Ohio/Kentucky webinar, April 9, 2014 This session reviews reporting requirements, tips and practice examples.

**Shared Decision Tools** 

Contains a SDM tool for contraception and link to other SDM tools.

### Six Steps to Shared Decision Making

This link contains a card and the associated language from Informed Medical Decisions Foundation.

Spotlight Article 13: Grants Pass Clinic on Shared Decision Making This article is an overview of the process taken by an Oregon CPC practice.

Spotlight Article 14: Hicken Medical Clinic and SDM

This article has additional information about the Hicken Medical Clinic's SDM process.