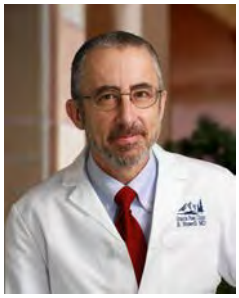
Practice Spotlight 13

June 20, 2014

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

"When we saw the CPC utilization baseline data for the first time, that was terrific," **Bruce Stowell, MD**, Chairman of the Partnership for Grants Pass Clinic in Oregon, said. That validation through data is an aspect of CPC that Grants Pass Clinic has found rewarding. "We always thought we were doing a good job from a cost-effective standpoint, but to see it in the data, that was the first time we actually knew how well we were doing."



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

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

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

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

Shared Decision Making at Grants Pass

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

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

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

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

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

Milestone 7:
Shared Decision Making

The key components:

1. A condition where legitimate treatment options exist and the scientific evidence can clarify the options but doesn't present a clear best choice

2. A decision aid that helps the patient to understand the evidence and think through the choices

3. The opportunity to engage with the provider in making the decision (Shared Decision Making)

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

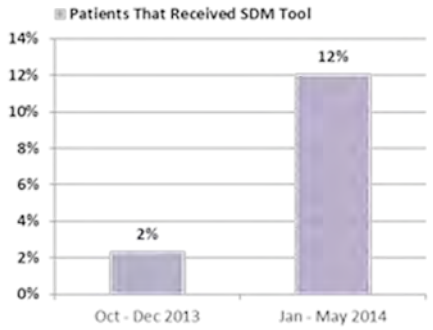
From left: Christi Siedlecki, BSN, RN, and Natosha Wilsey, BSN, RN

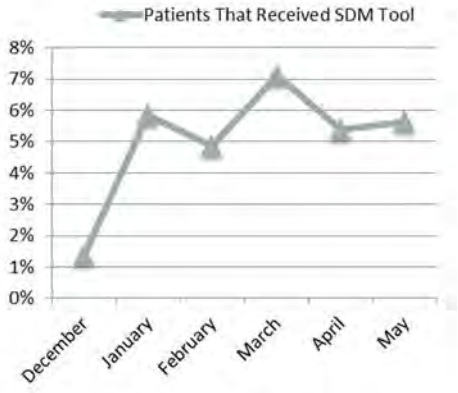
Providers can access the decision aids immediately during the patient encounter through links posted to the exam room's thin client desktop. After putting the patient's numbers into the risk calculator, the provider and the patient together discuss the risks and benefits of treatment options that range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

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

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

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





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

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

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

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

Is SDM Easy? No. But There Are Wins.

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

Dr. Stowell pointed to the other major positives in using SDM in primary care, "Consistency means our data is more accurate and it brings our focus together for a more standardized approach to patient care. That's a good thing."

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

TMF Health Quality Institute

This material was prepared 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. Any statements expressed by the individual and resources cited in this publication are not an opinion of, nor endorsement by, TMF or CMS.