CPCPracticeSpotlight39

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

Care Team as a Partner in Wellness: Helping Patients Improve Health with Lifestyle Modifications

Moreno Medical Associates, Jersey City, New Jersey; solo practitioner; 2,014 patients

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These strategies stem from **CPC Change Driver 1: Comprehensive Primary Care Functions**

- 1.1: Access and Continuity
- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.3: Risk-Stratified Care Management
- 1.4: Patient and Caregiver Engagement
- 1.5: Care Coordination Across the Medical Neighborhood

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

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

Situation: Margarita Borghini, MD, witnessed a rising number of patients diagnosed with diabetes in her practice in 2014. As she spoke with these patients, it became clear that many did not understand how their long-term health was tied to maintaining their HgbA1c and LDL values within a normal range.

Strategy: After 13 years in practice, Dr. Borghini understood the futility of simply directing a patient to lose weight, start eating better and exercising. She recognized that patients frequently receive these instructions as strategies to improve their health. However, patients typically do not receive active support to manage and maintain these strategies in a way that results in sustainable changes.

Working with **Christine Pipchick, PA**, Dr. Borghini began to engage with her patients differently by "partnering" with them through education, self-management support and accountability, using lifestyle modifications as the anchor for achieving better health.

Through the practice's EHR, Dr. Borghini identified a group of patients with HgbA1c >8 and LDL >120 or who were obese (BMI >30). The practice contacted all patients in this group, either face-to-face during appointments, by phone between appointments or with a letter if the patient was not likely to be seen soon. They were invited to come in for an office visit solely focused on wellness and nutrition. This appointment started with a detailed history of the patient's weight, which often revealed that life events or specific circumstances led to the weight gain, while others struggled with obesity all their lives. Frequently, patients' untreated behavioral health needs complicate their ability to manage their weight. Dr. Borghini referred these patients to behavioral health specialists as the needs were identified.

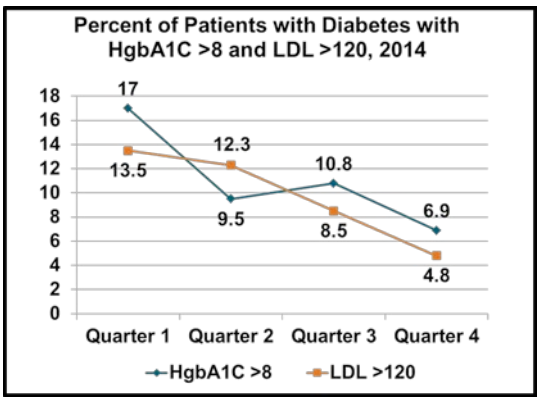

Figure 1: Realistic goal setting, support and education have helped Dr. Borghini's patients improve their overall A1c and LDL values.

The appointment then focused on nutrition, education and goal-setting. Dr. Borghini provided healthy eating education, supported by visual teaching aids such as a portion control plate. Together they discussed and set patient-desired goals, which the provider documented in the patient's record and care plan. Finally, the care team provided patients a food diary and a booklet that summarizes the information from the visit. Dr. Borghini emphasized to patients that this is a group effort, and she and her team will all coach, encourage and celebrate patients as they progress.

To provide patients with an additional support system, Dr. Borghini hosts a Healthy Living Action Group that meet in the practice waiting room on Friday nights. Group size has ranged from three to 15 participants. Dr. Borghini moderates the discussion in English and Spanish as needed, guiding the group to share and discuss issues relating to the lifestyle changes they are making to improve their health.

The care team supports the patients in tracking their wellness goals by providing easy access to the patients whose health goals include losing weight. These patients are able to visit the office at their convenience during regular hours to check their weight. The medical assistant (MA) weighs the patient, records the weight in the chart and does a quick check-in with the patient about their progress toward achieving their goals. This process takes fewer than five minutes. Typically, four patients per day visit the office to check their weight and touch base with the MA. The care team believes these check-ins further build continuity and a sense of team support for the patient's efforts.

In 2014, Dr. Borghini tracked the HgbA1c and LDL levels for the patients diagnosed with diabetes. One of the two examples shown in Figure 1 (above) represents the results attributed to a patient whose A1c dropped from 10.3 to 7.7 over the year. Rather than changing the patient's medication, the care team provided nutritional education as a way to meet her lifestyle modification plans. As a result, the patient used portion control to manage her daily rice intake. Dr. Borghini says successes like this demonstrate how "meeting the patient where they are," and engaging with them on their goals can result in long-term and positive effects on their health.

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