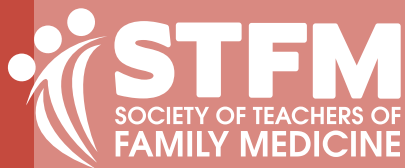


— Conference on —  
**Practice Improvement**

Redesign your practice. Improve patient care. Sustain your changes.

**Conference Program**

**November 29 – December 2, 2012**  
**Hyatt Regency Greenville**  
**Greenville, South Carolina**



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  
STRONG MEDICINE FOR AMERICA

# Table of Contents

**Overall Conference Schedule – 3**

**General Conference Information – 6**

**Conference Partners and Supporters – 7**

**Acknowledgements – 8**

**Award and Scholarship Citations – 9**

**Session Formats – 11**

**Posters – 12**

**Daily Schedules**

**Friday, November 30 – 18**

**Saturday, December 1 – 34**

**Sunday, December 2 – 58**

**Breakfast Roundtable Presentations – 34**

**Hotel Meeting Space Map – back cover**

## **Using QR Codes to Access the Conference Mobile Site**

QR Codes, like the one below, are used to easily link smartphone or tablet users to information on the web. You need special software to scan the codes. Search your smartphone or tablet's app store for "QR Code Reader." Once installed, the software will use your device's camera to scan the code.

Aim your mobile device at this block to scan and access the mobile site for the Conference on Practice Improvement.



Join the conversation on Twitter: #CPI12

# Conference Schedule



## Thursday, November 29

- 11 am–6:30 pm** ..... Conference Registration  
**Regency Ballroom Foyer**
- Noon–6:30 pm** ..... Computer Café  
**Board Room (1st floor)**
- 1–5 pm** ..... Preconference Workshops
- PR1: The Medical Neighborhood: Primary Care as a Catalyst to Effective Collaboration**  
*Bruce Bagley, MD, Diane Cardwell, MPA, ARNP, PA-C, Tracy Hartman, MHA, CPHQ, Pete Moyer CCLS, MHCL, TransforMED, Leawood, KS*  
..... **Regency D**
- PR2: Tools of the Trade: Using Decision Support Tools to Bring About Support for Change**  
*Lynn Schwenger, MHSA; Maria Pellerano, MA, MBA, MPH; David Swee, MD; Kenneth Faistl, MD; Martha Lansing, MD, UMDNJ-Robert Wood Johnson Medical School*  
..... **Regency F**
- 5–5:30 pm** ..... First-Time Attendee Orientation  
**Regency B-C**
- 5:30–6:30 pm** ..... Welcoming Reception With Conference Partners and Poster Presenters  
**Continental Ballroom & Foyer**

## Friday, November 30

- 7 am–5:30 pm** ..... Conference Registration  
**Regency Ballroom Foyer**
- 7–8 am** ..... Continental Breakfast  
**Regency Ballroom**
- 7:30 am–5:30 pm** ..... Computer Café  
**Board Room (1st floor)**
- 8:15–9:45 am**  
**Conference Announcements and STFM Greetings**  
*Rebecca Malouin, PhD, MPH, conference chair and moderator*  
*Jerry Kruse, MD, MPH, STFM president*
- Opening General Session**  
**Patient-Centered Care: What Is It and How Do We Get There?**  
*Christine Bechtel, MA, vice president,*  
*National Partnership for Women & Families, Washington, DC*  
..... **Regency Ballroom**
- 9:45–10:15 am** ..... Refreshment Break With Conference Partners and Poster Presenters  
**Continental Ballroom & Foyer**
- 10:15–11:15 am** ..... Lectures
- 11:15–11:30 am** ..... Transition Break



# Conference Schedule

## Friday, November 30 (cont.)

11:30 am–Noon.....	Papers
Noon–1:15 pm.....	Networking Luncheon <b>Regency Ballroom</b>
1:15–2 pm.....	Poster Presentations (dedicated time) <b>Continental Ballroom</b>
2–2:15 pm.....	Transition Break
2:15–3:45 pm.....	Seminars and Special Session
3:45–4:15 pm.....	Refreshment Break With Conference Partners <b>Continental Foyer</b>
4:15–5:15 pm.....	Lectures
5:30–6:30 pm.....	AAFP National Research Network Reception (conference attendees invited!) <b>Continental Ballroom</b>
6:30 pm.....	Dine-Out Groups see pg. 6

## Saturday, December 1

7 am–5:15 pm.....	Conference Registration <b>Regency Ballroom Foyer</b>
7–8 am.....	Continental Breakfast With Special Interest Roundtables <b>Regency Ballroom</b>
7:30 am–5:15 pm.....	Computer Café <b>Board Room (1st floor)</b>
8:15–9:30 am	
<b>AAFP Greetings</b>	
<i>Perry Pugno, MD, MPH, CPE, AAFP vice president for Education</i>	
<b>2012 Family Practice Management Award and H. Winter Griffith Scholarship Presentations</b>	
<i>Leigh Ann Backer, MA, executive editor, Family Practice Management</i>	
<i>Herbert Young, MD, MA, FFAFP, Director, AAFP Health of the Public and Science Division</i>	
.....	see pg. 9-10
<b>General Session</b>	
<b>Patient-Centered Medical Home: Transforming the US Health Care System</b>	
<i>Marcia Nielsen, PhD, MPH</i>	
<i>Patient-Centered Primary Care Collaborative, Washington, DC</i>	
.....	<b>Regency Ballroom</b>

# Conference Schedule



## Saturday, December 1 (cont.)

9:30–10 am	Refreshment Break With Conference Partners <b>Continental Foyer</b>
10–11 am	Lectures
11–11:15 am	Transition Break
11:15–11:45 am	Papers
11:45 am–1 pm	Lunch on Your Own
1–2:30 pm	Seminars and Special Session
2:30–2:45 pm	Refreshment Break With Conference Partners <b>Continental Foyer</b>
2:45–3:15 pm	Papers
3:15–3:30 pm	Transition Break
3:30–4:30 pm	Lectures
4:30–4:45 pm	Transition Break
4:45–5:15 pm	Papers

## Sunday, December 2

7:30–10:15 am	Conference Registration <b>Regency Ballroom Foyer</b>
7:30–9:30 am	Computer Café <b>Board Room (1st floor)</b>
7:30–8 am	Coffee Service <b>Regency Ballroom Foyer</b>
8–9 am	Lectures
9–9:15 am	Refreshment Break <b>Regency Ballroom Foyer</b>
9:15–10:15 am	<b>Closing General Session</b> <b>Redefining the Payer–Physician Relationship</b> <i>Bruce Nash, MD, MBA, senior vice president and chief medical officer, Capital District Physicians' Health Plan, Albany, NY</i> ..... <b>Regency Ballroom</b>
10:15 am	Conference Adjourns



# General Conference Information

## Hotel and Conference Location

Hyatt Regency Greenville  
220 North Main Street  
Greenville, South Carolina 29601  
864-235-1234

## Fitness Facilities

The Hyatt Regency Greenville 24-hour fitness facilities are complimentary to all guests of the hotel and feature state-of-the-art Life Fitness Equipment.

## Hotel Parking

Self-parking: Available at city-owned garage for \$6 daily. Parking can be charged to your room and includes in and out privileges.

Valet: \$15 daily. Parking can be charged to your room.

## Ground Transportation

The Hyatt Regency provides complimentary shuttle service to and from Greenville-Spartanburg International Airport. The Hyatt shuttle will make regularly scheduled runs hourly (regular business hours).

Taxi service between the airport and the Hyatt Regency averages \$35 one way. The hotel is 11 miles from the airport.

## Dine-out Groups

Dine-out Groups are offered on Friday evening at 6:30 pm for several different restaurants with a variety of foods and prices within walking distance of the hotel. (each pays own)

- Blue Ridge Brewery – <http://www.blueridgebrewing.com>
- Sticky Fingers - <http://www.stickyfingers.com/default.aspx>
- The Nose Dive - <http://www.thenosedive.com>
- Ristorante Bergamo - <http://www.ristorantebergamo.com>
- Sassafras Southern Bistro - <http://www.sassafrasbistro.com>

If you would like to join one of the groups for dinner, please check the board in the registration area and signup! Seating is limited. Groups will meet in the hotel lobby at 6:30 pm (dinner reservations are for 7 pm).

## Conference Mobile Site

[www.stfm.org/mobile/cpi](http://www.stfm.org/mobile/cpi)

This site provides information and updates for the conference schedule, general sessions, educational breakout sessions, conference partners, and more!

## Accreditation

This live course activity has been jointly planned and implemented in accordance with the Essential Areas and Elements and policies of the Accreditation Council for Continuing Medical Education by the American Academy of Family Physicians and Society of Teachers of Family Medicine. The American Academy of Family Physicians is accredited by the ACCME to provide continuing medical education for physicians.

The American Academy of Family Physicians has been designated to take responsibility for the content, quality, and scientific integrity of this CME activity. (96-C-7)

## CME Credit

This live activity, Conference on Practice Improvement, with a beginning date of November 29, 2012, has been reviewed and is acceptable for up to 17.75 Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity has been planned and implemented in accordance with the Essential Areas and Elements of the Accreditation Council for Continuing Medical Education through the joint sponsorship of American Academy of Family Physicians and Society of Teachers of Family Medicine. The AAFP is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The American Academy of Family Physicians designates this live activity for a maximum of 17.75 AMA PRA Category 1 credit(s)<sup>™</sup>. Physicians should only claim credit commensurate with the extent of their participation in the activity.

## CNE Credit

The American Academy of Family Physicians is approved as a provider of continuing nursing education by the Kansas State Board of Nursing. This course offering is approved for 21.3 contact hours application for RN, LPN, or LMHT relicensure. Kansas State Board of Nursing Provider Number; LT0278-0312.

## Faculty Disclosures

It is the policy of the AAFP that all CME planning committee/faculty/authors/editors/staff disclose relationships with commercial entities upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflicts of interest and, if identified, they are resolved prior to confirmation of participation. Only these participants who have no conflict of interest or who agree to an identified resolution process prior to their participation were involved in this CME activity.

## Photo/Video Permission

We will be taking photos and video throughout this conference. By attending, you give the AAFP and STFM permission to use images taken at the conference in any electronic or printed communications created by AAFP or STFM for any advertising and promotional purposes. You agree to release the AAFP and STFM and their employees, agents and designees from liability for any violation of any personal or proprietary right you may have in connection with such use.



**A special thank you for support provided by the following conference partners:**

**The Center for Integrated Primary Care**

**Cerner Corporation**

**Hello Health**

**Iowa Chronic Care Consortium**

**Merck**

**National Institute on Drug Abuse,  
National Institutes of Health, US Department of Health and Human Services**

**Patient Centered Primary Care**

**United Allergy Services (UAS)**

**The following organizations have provided an educational grant in support of CME activities:**

**Lilly USA, LLC**

For further information concerning Lilly grant funding visit [www.lillygrantoffice.com](http://www.lillygrantoffice.com)

**Merck**

**The following organization has provided an  
educational grant in support of the Saturday Keynote Session:  
“Patient-Centered Medical Home: Transforming the US Health Care System”**

**TransforMED**

**The following organization has provided support for the conference tote bags:**

**Iowa Chronic Care Consortium**



# Acknowledgements

The Conference Steering Committee would like to acknowledge the following collaborators for their assistance and support in planning and promoting this year's conference.



[www.transformed.com](http://www.transformed.com)



[www.aafp.org/nrn](http://www.aafp.org/nrn)

Family Practice Management

[www.aafp.org/fpm](http://www.aafp.org/fpm)

---

## Extending Our SPECIAL THANKS to the 2012 Conference Steering Committee

**Rebecca Malouin**, PhD, MPH, conference chair, Michigan State University, East Lansing, MI

**Elisabeth Righter**, MD, FAAFP, conference cochair, University of Wisconsin, Appleton, WI

**Daniel Mullin**, PsyD, University of Massachusetts Medical School/UMassMemorial Health Care, Barre, MA

**Carrie Nelson**, MD, MS, FAAFP, Advocate Physician Partners, Mount Prospect, IL

**Mary Hartwig**, PhD, APN, UAMS/AHEC Northeast

**Stacy Brungardt**, CAE, Society of Teachers of Family Medicine, Leawood, KS

**Bruce Bagley**, MD, FAAFP, American Academy of Family Physicians, Leawood, KS



# 2012 Family Practice Management Award for Practice Improvement Cosponsored by *Family Practice Management*



## Award Citation

### **Terry Reilly Health Services (TRHS)**

211 6th Avenue North

Nampa, ID 83653

Practice Representative: Bethany Gadzinski, Medical Operations program manager

Email: bgadzinski@trhs.org

In 2009, during a time when TRHS was going through the process of identifying ways to create positive behavior change in our patients, the opportunity came along to participate in the Safety Net Medical Home Initiative (SNMHI). Our participation in the SNMHI began with a critical decision that has laid the foundation to long-term and sustained change at TRHS, engaging leadership. Our PCMH transformation has required the visible and sustained engagement and tangible support of our leaders to include front office, nursing, administration, medical, behavioral health, lab, pharmacy, and dental. Without the foundation of engaged leadership, PCMH transformation cannot happen.

Once our foundation was laid, we began to develop and implement the other change concepts to include:

Empanelment and continuous, Team-based Healing Relationships:

- Working with front office staff to understand the importance of scheduling patients with their PCP
- Creating and using panel reports to drive balancing of supply and demand
- Developing metrics and standard reports to help us monitor the patient's ability to access their PCP
- Developing methods to determine when a provider's panel needs to be closed to new patients

Quality Improvement, Patient-centered Interactions and Organized, Evidence-based Care:

- Streamlining our rooming protocols
- Creating registries
- Choosing and using a formal model for quality improvement
- Establishing, and monthly monitoring, metrics to evaluate improvement efforts and outcomes
- Creating templates and tools in our EMR to assure clinicians have the support to provide organized evidence-based care to our patients

Enhancing Access and Care Coordination:

- Establishing and providing organizational support for clinic level care teams
- Creating and implementing a closed loop referral coordination process
- Developing policies and protocols for behavioral health/medical care integration
- Developing scheduling options that are patient and family centered and accessible
- Developing and implementing a patient portal

*Please Note:*

This year's winning practice will be highlighted at a poster presentation in the Poster Hall on Thursday and Friday.



## 2012 H. Winter Griffith Resident Scholarship Excellence in Practice Improvement and Patient-Centered Care

### Scholarship Citation

#### **Jeffrey Paul Cashman, MD**

AnMed Health

2000 East Greenville Street #3600

Anderson, SC 29621

Email: [Jeffrey.cashman@anmedhealth.org](mailto:Jeffrey.cashman@anmedhealth.org)

Program Director: Stoney Abercrombie, MD

I am honored to be the recipient of the 2012 H. Winter Griffith Scholarship for Excellence in Practice Improvement in Patient-Centered Care. I would like to discuss the process my fellow residents and our program have taken to improve patient-centered care.

AnMed Health Family Medicine Residency has been able to improve our quality measures on patient-centered care in a unique way. Our faculty educated and trained residents and allowed us to take the lead on different practice improvement initiatives leading to better care of patients with chronic illnesses. We have educated all of the residents that establishing quality improvement is a process that involves a team approach from all involved in an office setting. At our residency program it was determined that improvement could be made on multiple measurements of chronic diseases, starting with diabetes. To bring better care to our diverse set of patients a quality improvement initiative was established in our practice made up of 27 residents and 10 physicians and one APRN. The initiative was driven by a committee made up of faculty, APRN and residents, but led by the residents. Bi-monthly meetings were held with progress toward goals evaluated. During these meetings residents led groups of physicians to determine interventions that would improve care and outcomes. We had terrific results with improvements in all measured facets of diabetes care (A1C, LDL, blood pressure, eye and foot exams in last year, and microalbumin measured). We have now started to move toward other chronic illnesses including hypertension and COPD. New residents have seen the interest from upper levels and have been quick to join in the process.

#### *Please Note:*

This year's winning practice will be highlighted at a poster presentation in the Poster Hall on Thursday and Friday.



## Session Formats:

**Seminar** – Provides practical information and methods to enhance practice improvement through health information and patient education. Seminars include a combination of presentation and active involvement of participants. 90 minutes.

**Lecture** – Provides a forum for focused didactic presentation and discussion of a topic. These topics may include clinical, research, administrative, or education issues. 60 minutes.

**Paper** – Provides research or programs for educating health professionals or patients. 30 minutes.

**Poster** – Provides an opportunity for one-on-one discussion of a presenter's innovative project or research in practice improvement through health information or patient education. Presentation is during reception and refreshment breaks.

**Special Interest Roundtable Discussion** – Provides a learning venue to share information, experiences, and ideas during breakfast. Leaders will briefly present the topics and then facilitate discussion. 60 minutes.

---

**NRN Sessions** - Highly interactive sessions that present new research or quality improvement concepts and allow participants to provide feedback on the design and feasibility of successful implementation into family physicians' practices. Sessions in this format are identified by (NRN) following each session's title.

### **AAFP National Research Network (NRN):**

The AAFP National Research Network (AAFP NRN) is a voluntary practice-based research collaborative of primary care physicians who work together on research studies and quality improvement projects.

During the conference, the AAFP NRN will present three sessions, all designed to be interactive discussions of concepts currently under development. All conference attendees are invited to attend these sessions, and the NRN welcomes participation and engagement.

In addition, please plan to attend the AAFP NRN reception on Friday from 5:30-6:30 pm, or visit the AAFP NRN interest table during breakfast on Saturday. During both of these times you can speak with AAFP NRN staff, as well as current NRN members. Visit the NRN online at [www.aafp.org/nrn](http://www.aafp.org/nrn).

### **Using QR Codes to Access the Conference Mobile Site**

QR Codes, like the one below, are used to easily link smartphone or tablet users to information on the web. You need special software to scan the codes. Search your smartphone or tablet's app store for "QR Code Reader." Once installed, the software will use your device's camera to scan the code.

Aim your mobile device at this block to scan and access the mobile site for the Conference on Practice Improvement.





# Thursday, November 29 and Friday, November 30 Poster Presentations

## Thursday, November 29:

**5:30-6:30 pm**

Welcoming Reception With Conference Partners and Poster Presenters

## Friday, November 30:

**9:45-10:15 am** refreshment break

**1:15-2 pm** dedicated time

Poster presenters will be available to discuss their presentations during the times noted above.

### **Room: Continental Ballroom**

#### **P1: Impact of a 360-Degree Evaluation in Family Medicine Residency Education Through Home Visit Curriculum**

*Mayur Rali, MD, Nancy Weitzman, PhD, Tochi Iroku-Malize, MD, MPH, FAAFP, SFHM, Southside Hospital Family Medicine Residency, Bayshore, NY*

Use 360 degree evaluation to enhance residency education through Home Visit Curriculum. Methods: Home visit curriculum was revamped in March 2010. An extensive evaluation tool is used for patient, resident, physician, and psychologist. Results: A total of 34 home visits were conducted since March 2010 and all evaluators scored the home visit highly in the form of positive feedback and improvement in team work. Patients and family members also highly appreciated home visits. We plan to include a social worker in our team. It is an ongoing study. Significance/Implications/Relevance: The 360-degree feedback model gives a multi-lens view of their performance. It allows mentors and residents an opportunity to provide feedback and influence the way the patients are managed for better care.

#### **P2: Expedition PCMH: The Journey of a Residency-Based Practice**

*Edmund Kim, MD, Edward Van Baak, MBI, University of Connecticut St Francis Hospital Family Medicine Residency, Hartford, CT*

This poster is designed to discuss some of the challenges encountered, successes achieved, and tools utilized to transform a family medicine residency practice into a patient-centered medical home that was awarded a level 3 certification by NCQA. While acknowledging that the certification serves as a foundation for transformation, the poster then details the ongoing work and team-based strategies for successful coordination of care for our patients with improved health outcomes as well as lessons learned within our office.

#### **P3: Impact of Coding Education on Production in a Multi-Clinic Family Medicine Residency Program**

*Toby Free, MD, University of Nebraska Medical Center*

Proper coding is a problem most physicians deal with in their practices. This is intensified in a residency program, and in our case is also challenged by the existence of three separate clinics where residents are trained. This results in perceived loss of productivity as well as real loss of reimbursement. A system to educate and maintain proper habits in coding was pursued over the last 4 years at UNMC showing an increase in production measured by RVUs and revenue to the clinics, even when accounting for a slight increase in number of patients seen. The program has been deemed a success and is now showing signs that the results are sustainable.

Join the conversation on Twitter: #CPI12

# Thursday, November 29 and Friday, November 30 Poster Presentations



## **P4: Merit III: A Pilot Study to Close the Loop on Consultant Referrals**

*Mary Hartwig, PhD, APN, Tom Frank, PharmD, Leslye McGrath, MD, Kasey Holder, MD, Dosha Cummins, PharmD, Ron Cole, MBA, FACMPE, Scott Dickson, MD, Elaine Gillespie, MD, Michael Mackey, MD, Joe Stallings, MD, Scott Laffoon, MD, Shane Speights, MD, AHEC Northeast Family Medicine Residency, Jonesboro, AR*

This poster will present the results of UAMS/AHEC-NE's third MERIT project focused on medication reconciliation. Having addressed transitions of care following ER visits and hospital discharge, our current project focuses on transition to specialist care. An inherent difficulty in "closing the loop" with referrals is that there are eight steps in making the two-way transition from primary care to specialist care. Research to date concerning referral outcomes has investigated the process only as far as the actual specialist visit. However, study was needed to investigate the entire referral process from request to consultant's report. We will report the results of a quantitative, multifactorial study to reveal the extent and determinants of specialist referral completion in the clinic and the impact of referral completion on medication reconciliation.

## **P5: Clinical Outcomes of a Remote Clinical Pharmacist Service in a Family Medicine Clinic**

*Joseph Vande Griend, PharmD, Colleen Conry, MD, Joseph Saseen, PharmD, Debra Bislip, MD, Gina Moore, PharmD, University of Colorado*

A remote Clinical Pharmacy Service at the University of Colorado Park Meadows Family Medicine Clinic was started in July 2011. The clinical pharmacist prospectively screens patients with appointments and performs medication review on those most likely to benefit. Recommendations are documented in the EMR, reviewed by the provider, and implemented when deemed appropriate at the patient appointment. Through January 2012, the clinical pharmacist made 184 recommendations in 77 patients; 69% were implemented. In 11 patients, recommendations resulted in HgbA1c, LDL-cholesterol, or blood pressure goal attainment. Twenty-seven vaccinations were administered and 22 potentially dangerous drug interactions were resolved. Twelve unnecessary high-cost drugs were discontinued resulting in annual cost-avoidance of over \$20,000. Estimated cost-avoidance from stopping unnecessary high-cost drugs alone is up to \$50,000 through July 2012.

## **P6: Exploring Patients' Wishes and Perceptions of Participation in Family Medicine Consultations and Ways to Carry Out**

*Roger Ruiz-Moral, MD, Luis Perula de Torres, MD, University of Cordoba, Cordoba, Spain; Jose Ramon Loayssa-Lara, MD, Servicio Navarro de Salud, Pamplona, Spain*

Objectives: To explore patients' participation in the discussion of options in family doctors consultations (FDC). Identify the patients' wish to participate and their perceptions of their participation. Methods: Patients attending 97 FDC: 658. After consultation FDs completed a questionnaire about biomedical and relational information. Patients' preferences and perception of participation was explored with different type of questions. Results: Questionnaires collected: 645. In 60% of the situations (390 encounters), patients wished they could have stated their views about the proposed option(s), but they perceived this did not happen. The degree of participation at the consultation did not relate significantly with the physician's ideas about the type of problem, evolution, and treatment. Conclusions: The results revealed an important mismatch between what patients wish and what they perceive.

## **P7: Contraception Information in the After-Visit Summary**

*Amy Pandya, MD, Linda Prine, MD, Ruth Lesnewski, MD, MS, Beth Israel Residency Program in Urban Family Practice, New York, NY*

Through the integration of the birth control fact sheets in a clinical Electronic Medical Record, patients easily receive printed contraception information integrated in their After Visit Summary. This allows for increased patient adherence and satisfies meaningful use criteria by providing accessible, understandable education about the chosen birth control at the end of the patient encounter.



## Thursday, November 29 and Friday, November 30 Poster Presentations

### **P9: Care Coordination in the Patient-Centered Medical Home: A Process to Improve ED Visit Follow-up**

*Emily Sego, MSN, RN, CMSRN, Community Health Network Family Medicine Residency, Greenfield, IN*

A care manager role was used to standardize a follow-up process with patients who sought care in the ED resulting in prompt access to quality, coordinated care. Baseline data were obtained and analyzed prior to intervention. A phone call follow-up process was then established and implemented. During the call, an offer to schedule an appointment within 7 days of ED visit was provided to the patient. Prior to intervention, only 19% of patients secured an appointment after their ED visit. After implementation, ED follow-up appointments increased to 43%. Subjective feedback also indicated high patient and physician satisfaction with the process. Follow-up phone calls to patients within 72 hours of ED visits increase access to care resulting in coordination that proves valuable to the patient.

### **P10: The Centering Pregnancy Model of Prenatal Care in a Family and Community Medicine Residency Practice**

*Montiel Rosenthal, MD, Hillary Mount, MD, Andrea Klass, MD, Christina Gonzalez, DO, Saundra Regan, PhD, Judy Piron, RN, Barbara Hoffrogge, BSN, The Christ Hospital/University Cincinnati Family Medicine Residency, Cincinnati, OH*

Centering Pregnancy is a model of group prenatal care involving education, health assessment, comprehensive care, self-management, and empowerment. Our residency practice implemented this group model of prenatal care as an option for Medicaid and uninsured patients. Residents learn the group model of prenatal care during their OB-Gyn rotation. Our study compared group versus traditional prenatal care on patient outcomes of preterm birth, infant death, no-show rate, birth weight, and breastfeeding. We also measured patient satisfaction, staff beliefs, and resident learning experiences. The group model of prenatal care had improved positive patient outcomes and satisfaction. Staff beliefs and resident learning experiences were also positive. The group model of prenatal care can be successful in a family medicine residency practice.

### **P11: Improving Vaccination Practices in a Large Urban Academic Family Medicine Center**

*Victor Diaz, MD, Mona Sarfaty, MD, Michele Zawora, MD, Kathleen Hilbert, RN, Tara Dibruno, CRNP, Carmen Campos, MA, Thomas Jefferson University*

Jefferson Family Medicine Associates is a large urban academic family practice center that treats a large population of low-income residents of Philadelphia and is an active member of the federal Vaccines for Children program (VFC). There are approximately 6,300 patients that are covered by Medicaid insurance. Of that number 28% (1,764) are children between the ages of 0-18 years. We also provide care for a population of refugee patients referred to us by a local refugee resettlement agency. The overarching goal of our vaccine program is to improve our completed immunizations rate for children with appropriately stocked, stored and handled vaccines that are properly administered and accurately recorded in our electronic medical record. We will summarize our progress on these objectives.

### **P12: Incorporating Medical Students in Department-Wide Quality Improvement Activities: A Focus on Chronic Disease Registries**

*Alexei Decastro, MD, Vanessa Diaz, MD, MS, Medical University of South Carolina; Lori Dickerson, PharmD, Trident Family Medicine Residency, Charleston, SC; Alexander Chessman, MD, Medical University of South Carolina*

Teachers responsible for resident and medical student education face the same dilemma: how to engage their learners in meaningful improvement projects with limited curricular time and resources. At the same time, practices and providers seek certification and recognition from organizations like the National Committee for Quality Assurance (NCQA). Within our NCQA patient-centered medical home Level 3-Certified residency practice, medical students complete practice improvement projects during a 6-week-long clerkship that interdigitate with residents' required scholarly projects conducted over 2 years. This poster will present information about how the projects overlap, what the students and residents are able to accomplish together, and barriers and drivers to this approach.



# Thursday, November 29 and Friday, November 30 Poster Presentations



## **P13: Monitoring Process for Pregnancy Category D or X Medications in Women of Childbearing Age**

*Jody Lounsbery, PharmD, Barbara Leone, MD, University of Minnesota North Memorial Health Care Family Medicine Residency, Minneapolis, MN*

Revising a triage refill protocol created concern for the appropriate management of refills for Pregnancy Category D or X medications for women of childbearing age when contraceptive use was unknown. The purpose of the project was to develop a process to identify and monitor the use of common Pregnancy Category D or X medications in this patient population. Medication reports for these patients were collected from the clinic's electronic medical record and cross referenced against any forms of contraception being used. The reports were distributed to providers for assessment of needed action. This process highlighted the need to focus on prescribing practices for women of childbearing age within a residency clinic. This project provides one model of ongoing surveillance and aids in active panel management.

## **P14: Building and Teaching the Patient-Centered Medical Home**

*Tiffany Diaz, MD, Kara Vormittag, MD, Advocate Lutheran General Hospital Family Medicine Residency, Park Ridge, IL*

Health care reform legislation has accelerated discussion and demonstration projects exploring patient centered medical homes (PCMH). The PCMH brings challenges and opportunities to family medicine practices. The situation is more complex in a residency training program. This study will explore the impact of educational interventions on increasing the NCQA criteria met and the perception of the care team. A baseline NCQA assessment of the Nessel Family Medicine practice and a survey to identify knowledge and attitudes will be conducted. Other family medicine residencies will serve as a control. The results of this assessment will help prioritize a plan for achieving NCQA PCMH recognition (or equivalency) within 1 year and will guide the development and deployment of PCMH educational strategies.

## **P15: Evaluation of a Resident Training Curriculum on Unhealthy Pediatric Weight Through Process Improvement**

*Carolyn Shue, PhD, Justin Whitt, MD, Linda Daniel, PhD, Alan Young, MD, Ball Memorial Family Medicine Residency, Muncie, IN*

The diagnosis and management of unhealthy pediatric weight is a critical skill set required of all family physicians. The IU-Health, BMH Family Medicine Residency designed and evaluated a residency curriculum that 1) presents evidence-based recommendations, 2) facilitates the documentation of pediatric weight management in the EMR, and 3) promotes consistency of practice. This poster presents 1) practice improvement (PI) base-line data that demonstrated a clinic population with high rates of unhealthy pediatric weight (42%) and limited documentation of obesity (22%) on the problem list or management of pediatric weight in the clinic note (16%) by physicians, 2) curriculum interventions designed to improve clinical management of pediatric weight, and 3) corresponding PI data that demonstrated improvement in weight management processes within this residency clinic.

## **P16: Defining Our Discharge Program: Utilization of an EHR in a PCMH to Improve Discharge Management**

*Niladri Das, MD, Mary Pat Friedlander, MD, Jennie Broders, PharmD, Patricia Klatt, PharmD, Gretchen Shelesky, MD, University of Pittsburgh Medical Center St Margaret Family Medicine Residency, Pittsburgh, PA*

Purpose: The three patient-centered medical homes (PCMH) at the St. Margaret Family Medicine Residency Program noted that the hospital discharge process was different during the day, evening, and weekend shifts. In an effort to eliminate inconsistencies and potentially impact office follow-up rates (OFR) and hospital readmission rates (HRR), a pharmacist-led initiative was established. Intervention: Our clinical pharmacists are informed of all discharges through our electronic medical record via a specifically designed messaging "pool." The pharmacists then contact the patient within 48 hours, review his/her medications, and ensure office follow-up within 4 days of discharge. OFR and HRR will be monitored to evaluate the value of our intervention. Summary/Hypothesis: We hypothesize this project will result in increased OFR and decreased HRR.

Join the conversation on Twitter: #CPI12



## Thursday, November 29 and Friday, November 30 Poster Presentations

### **P17: Closing the Prevention Gap: An Age- and Sex-Based Quality Improvement Program**

*Maurice Lee, MD, Gary Reichard, MD, Phoenix Baptist Family Medicine Residency, Phoenix, AZ*

Preventive services such as smoking cessation, diet/lifestyle counseling, cancer screenings, etc, are often postponed or forgotten during a 15-minute visit when the patient has multiple chronic diseases or being seen on an urgent care basis without continuity. This project addressed this prevention gap and met curricular requirements for teaching aspects of population-based care and quality improvement. A health care maintenance program, based on age and sex, was developed by the PGY-2 residents to ensure that patients receive preventative services despite their chief complaint, lack of continuity, or provider schedule. As a result of a staff-administered prevention questionnaire, more patients are receiving counseling, vaccines, and screenings. Staff empowerment had led to a more “up stream” approach that has further aided physicians to provide better comprehensive care.

### **P18: Patient Navigator: Navigating Health Care Barriers Using Health Information Technology (HIT)**

*Janis Coffin, DO, Thad Wilkins, MD, Georgia Health Sciences University*

Various barriers in the current health care arena prohibit patients from obtaining the most effective, efficient health care. The GHSU FMC patient navigator was created by a multi-disciplinary team of health care providers and patient advisors to provide enhanced access (during and beyond business hours ) and address these perceived barriers by utilizing technology that can be accessed from home computers, laptops, and smart phones. Our goal is for the patient navigator, in its final form, to provide an online resource for GHSU FMC patients that will serve to overcome these barriers, thus improving patient outcomes. In a large institution such as GHSU, the FMC patient navigator will provide one place where patients can find helpful information, such as maps, directions, physician profiles, procedures, etc.

### **P19: Attaining Patient-Centered Medical Home Status in an Independent Private Practice Setting**

*James Early, MD, FAAFP, East Asheville Family Health Care PA, Asheville, NC*

Collaboration with the Mountain Area Health Education Center has enabled my small private practice to attain PPC-medical home recognized status and meet meaningful use criteria.

### **P20: How One PBRN Took Advantage of Electronic Health Record Implementation in Primary Care**

*Jeri Ann Basden, MS, Heather Anderson, MPH, Fred Tudiver, MD, East Tennessee State University*

A goal of the Appalachian Practice Based Research Network (AppNET) is to assist with quality improvement (QI) in rural primary care practices. As the project began, participating clinics were adopting electronic health records (EHRs) and were struggling with related workflow and information management. Critical challenges (and AppNET solutions) were: (1) data not entered in a standard way or place in the EHR (solution: training to use standard terms and entry in the EHR), (2) no standard method for extracting required metrics (solution: regional REC and IT personnel were consulted to train staff to access Continuity of Care Record/Data (CCR/CCD), (3) workflow was disrupted, and providers were working many extra hours to complete EHR documentation (solution: workflow efficiency QI projects were implemented in several clinics).

### **P22: Evaluation of an Integrated Electronic System for Inpatient Handoffs and Data Analysis**

*Charles Carter, MD, FAAFP, Sharm Steadman, PharmD, Trey Edwards, MD, FAAFP, Edward Krusling, MD, University of South Carolina*

The advent of new resident duty hour limitations risks increasing the number of patient care transitions (ie, handoffs) in the inpatient setting. This could contribute to patient safety concerns and diminished inpatient continuity and clinical efficiency. An integrated electronic data analysis and handoff system was developed for use on a family medicine residency inpatient service. Since using this tool, service mean length of stay has declined by 5% and readmissions within 72 hours and 30 days have declined. Residents using the tool perceive improved quality and efficiency of patient handoffs. The new system also allows for data analysis regarding most frequent admitting diagnosis and aids in identifying patients with frequent hospitalization who would benefit from care management.



# Thursday, November 29 & Friday, November 30 Poster Presentations



## **P23: Computer-Assisted Counseling Tools for Enhancing Health Behavior Change in Practice**

*Scott Strayer, MD, MPH, Donna Strong, MPH, Michele Stanek, MHS, University of South Carolina; Kawai Tanabe, MPH, Virginia Commonwealth University-Hanover Family Practice, Charlottesville, VA; Karen Ingersoll, PhD, John Schorling, MD, MPH, University of Virginia*

The majority of disease, death, and disability in the United States is caused by unhealthy behaviors, including sedentary lifestyles, poor diet, smoking, and alcohol misuse, leading to over \$435 billion in annual health care costs and accounting for over 20% of annual health care expenditures. Because a majority of physicians report inadequate training and perform poorly in health behavior change counseling, we have developed several computer-assisted counseling tools for addressing smoking cessation, obesity, and alcohol misuse. These have been tested in a series of trials that have included approximately 200 physicians. Our studies illustrate challenges and potential solutions for implementing computer-assisted counseling tools for unhealthy behaviors in primary care settings.

## **P24: Creating a Family Medicine Travel Clinic (or Other Expanded Services) Within a Large Health System**

*Jeffrey Hall, MD, Brian Keisler, MD, Karen Springfield, RN, University of South Carolina*

In 2010, the Palmetto Health Family Medicine Center began offering pre-travel consultations in response to community needs and resident interest in expanded global health training. Providing a specialty service within a patient-centered medical home embedded in a larger health system posed several challenges, including developing a transparent and reasonable pricing system that did not adversely affect the larger system's insurance contract negotiations, differentiating travel patients from our FMC continuity patients, training a travel-specific nurse, managing a unique vaccine inventory, and establishing linkages with the local health department. We will discuss outcomes from the first year of operations and focus on lessons learned that may apply to others interested in offering travel immunizations or other special services in their own settings.

### **Using QR Codes to Access the Conference Mobile Site**

QR Codes, like the one below, are used to easily link smartphone or tablet users to information on the web. You need special software to scan the codes. Search your smartphone or tablet's app store for "QR Code Reader." Once installed, the software will use your device's camera to scan the code.

Aim your mobile device at this block to scan and access the mobile site for the Conference on Practice Improvement.



Join the conversation on Twitter: #CPI12



## 8:15–9:45 am Opening Session

**Room: Regency Ballroom**



### **Patient-Centered Care: What Is It and How Do We Get There?**

*Christine Bechtel, MA, vice president, National Partnership for Women & Families, Washington, DC*

Christine Bechtel will outline an operational definition of “patient-centered care” as defined by patients and families themselves. This approach to patient centeredness can be used to ensure delivery of high-quality care that improves health outcomes in a medical home model. Bechtel will also provide an overview and discussion how to achieve this level of patient-centered care using a model called Collaborative Consumer Engagement. The process and benefits of this model will be explored.

#### Objectives:

At the end of this session, participants will be able to:

1. Define patient-centered care from a consumer perspective.
2. Explain what it means to operationalize patient-centered care in a medical home.
3. Relate the process and benefits of collaboratively engaging consumers in the journey toward patient centeredness.

Christine Bechtel is the vice president of the National Partnership for Women & Families, a non-profit consumer advocacy organization based in Washington, DC. The National Partnership has been the driving force behind some of the country’s most important policies and initiatives, including the Family and Medical Leave Act, the Pregnancy Discrimination Act, and the Consumer Partnership for eHealth. As vice president, Bechtel oversees the day to day operations of the organization, including its work on health care quality, information technology, and patient engagement. She also serves on the federal Health IT Policy Committee.

Bechtel was previously vice president of the eHealth Initiative (eHI), where she led the organization’s membership, public policy, and government relations work. She has a background in health care quality improvement from her work with the American Health Quality Association and Louisiana Health Care Review, now eQHealth Solutions, a Medicare Quality Improvement Organization (QIO). As a senior research advisor at AARP, Bechtel conducted public opinion studies with consumers regarding their views on national political issues. She began her career as a legislative associate for United States Senator Barbara A. Mikulski (D-MD), where she focused on legislative issues ranging from women’s health and stem cell research to Medicare and Social Security.

#### **Using QR Codes to Access the Conference Mobile Site**

QR Codes, like the one below, are used to easily link smartphone or tablet users to information on the web. You need special software to scan the codes. Search your smartphone or tablet’s app store for “QR Code Reader.” Once installed, the software will use your device’s camera to scan the code.

Aim your mobile device at this block to scan and access the mobile site for the Conference on Practice Improvement.





10:15–11:15 am

Lectures

**L1: Testing for Hepatitis C: Tailoring an Approach for Your Practice and Your Patients (NRN)**

*Elizabeth Horsley, MSJ, Deborah Graham, MSPH, Kim Kimminau, PhD, American Academy of Family Physicians, Leawood, KS*

Many people born between 1945 and 1964 are chronically infected with Hepatitis C and are unaware of their infection. People from this large age cohort are unlikely to be identified through venues that serve persons with high-risk behaviors. Because patients may know little or nothing about Hepatitis C, they are unlikely to request a hepatitis C antibody test. This places a burden on the clinician to initiate, educate, and provide counseling about the test, results, and follow up. This session is designed as an interactive session to exchange ideas on various aspects of the health care team’s readiness to provide education, screening, referral, and other services for their asymptomatic healthy and HCV-infected patients. This discussion will inform the development of a future practice-based research study.

Objectives:

- 1 Participants will have a greater awareness of upcoming guidelines for testing for Hepatitis C.
- 2. Participants will be introduced to a CDC-sponsored project that is testing the efficacy of a new practice-based resource to address hepatitis C screening and counseling.
- 3. Identifying concerns for addressing hepatitis C in the asymptomatic patient will be shared among participants, including feedback on who is “best” suited to counsel, educate, and motivate patients to decide on screening.

**Room: Magnolia**

**Comprehensive Ambulatory Solutions for your family practice.**



**Health care is personal.**

Because it’s more than just an annual checkup, physicians use Cerner Ambulatory solutions to connect with their patients and improve the quality of care anytime, anywhere.

We can show you how.



800.927.1024 | CernerAmbulatory@cerner.com | www.cerner.com

For a free Ambulatory EHR demonstration specific to your day, call 800.927.1024 or email CernerAmbulatory@cerner.com with the best time for you.



Friday, November 30

## **L2: Health Literacy: Stimulating the Conversation, Having the Conversation, Taking Action**

*LuAnne Stockton, BA, BS, Susan Labuda-Schrop, PhD, Brian Pendleton, PhD, Northeast Ohio Medical University*

In order to address issues of literacy in practices substantially, measures are necessary beyond providing “readable” written patient education materials. A literacy-attentive practice must consider literacy and health literacy in all aspects of the practice. These aspects include but are not limited to patient interactions with front desk personnel, nurses, and physicians; provision of readable and comprehensible written materials; empowering patients to take active roles in their health care; and providing applicable support services. This session will introduce participants to the “Health Literacy Assessment Questions,” which is a tool that can be used to assess the practice for literacy applications to identify areas where the delivery of health care can be improved. Such improvements should optimize literacy applications, thus improving health outcomes for all patients.

Objectives:

1. Define health literacy and appreciate the impact of health literacy on patient care and patient outcomes
2. Utilize the Health Literacy Assessment to identify areas in which their practices are doing well and those areas where improvement is needed
3. Determine ways in which their practices can take action to improve the attention to literacy

**Room: Redbud A-B**

## **L3: Clinic Redesign for Implementation of a Call Center**

*Marcia Snook, RN, Mark Schiffers, CPA, Michelle Hilaire, PharmD, Fort Collins Family Medicine Residency, Fort Collins, CO*

Continuous practice improvement initiatives are vital to developing patient-centered medical homes. In 2010, a call center was developed in response to increased amounts of frustration from clinic staff experiencing “message overload.” Nurses and providers were inundated with electronic tasks resulting in an inability to contact patients in a timely fashion. Our goal was to improve the timeliness, efficiency, and effectiveness of patient messages by utilizing a call center approach. The number of calls in queue, scanning processes, and task templates were reviewed; staff was cross-trained to fill a new hybrid work role. In this lecture-discussion, we will describe our call center, share guidelines established for providers and staff, and discuss the effects of the call center on satisfaction scores and phone stats.

Objectives:

1. Describe strategies to engage providers and staff in practice redesign within a community residency program
2. Discuss the benefits and challenges to establishing a call center within a family medicine residency
3. Implement the necessary changes to the office workflow to improve the quality of patient and provider satisfaction with electronic task/messages

**Room: Regency D**

## **L4: Navigating Conflict While Constructing a Patient Centered Medical Home**

*Margot Savoy, MD, MPH, FAFP, CPE, Deborah Hoffman, MSN, ANP, BC, Christiana Care Health System, Wilmington, DE*

Redesigning a practice into a patient-centered medical home is stressful on clinical teams. Having strong change management leadership skills including conflict management and resolution makes it possible to help your team navigate through the difficult transitions. Our presentation includes a didactic about organizational development techniques for fostering team development and conflict management, a discussion of how we used these techniques within our practices, and ends with an open space for questions and sharing.

Objectives:

1. Describe how organizational development models/tools can apply to redesigning family medicine practice teams
2. Identify and utilize assessment tools for gauging individual team member conflict management styles
3. Be familiar with three techniques for assisting a practice team through a stressful change or conflict

**Room: Gardenia**

Join the conversation on Twitter: #CPI12



## **L5: Establishing and Maintaining Team-Based, High Quality Care**

*Kirsten Meisinger, MD, Veronica Miranda, MA, Cambridge Health Alliance, Somerville, MA*

Union Square is now widely recognized as a leader in team care for Safety Net Populations. The clinic is one of a few to be involved in both the National Medical Home demonstration project and the MA state-wide demonstration project. It is an NCQA-recognized level 3 site since 10/2010. The site has time tested workflows and processes to distribute as part of this presentation and a team care starter toolkit for participants. All of the family medicine-trained MDs teach medical students and residents at the Tufts residency site, and are expert at communicating the medical home principles and quality focus to trainees. The presentation includes the MA perspective on the MA/MD dyad experience.

Objectives:

1. Identify and utilize materials sufficient to establish or extend a team care model at their site
2. Understand the evolving nature of the team care in the context of the emerging ACO environment
3. Set up systems and expectations at their site that use staff at their highest level of training

**Room: Regency E**

## **L6: Improving Diabetic Eye Screening: Should There Be Such a Thing As a Free Lunch?**

*Mary Beth Wright, NP, Nata Young, MD, AnMed Health Family Medicine Residency, Anderson, SC; Vaughn Parfitt, OD, Eye Associates, P.A., Anderson, SC*

Sustaining excellent care in chronic disease management is difficult and requires well functioning and innovative team-based care. Our residency-based practice delivers care to over 700 diabetic patients, many of whom are underinsured and uninsured. We partnered with a community optometrist to offer free dilated eye exams to our uninsured diabetic patients. We describe how this community-based partnership helped our practice achieve NCQA Diabetes Recognition. We will present methods and data from 3 years of this partnership and outline the impact of this service on patient outcomes, local community, and involved providers. We will review current literature on offering free screening services. We will discuss our successes and failures and ways participants' programs can form community partnerships to offer needed services in their practice.

Objectives:

1. Understand novel team-based methods for partnering with a community health care provider and setting up free screening services within a practice
2. Identify the benefits and disadvantages of a collaborative partnership that includes their health care provider colleagues, their patients, and a community optometrist
3. Review the current literature on offering free screening services and discuss ways to take their learnings from our experience to their practices.

**Room: Think Tank@NOMA**



Friday, November 30

**L7: Better Together: Building an Interprofessional Curriculum in Patient Safety and Quality**

*Elizabeth Baxley, MD, Brody School of Medicine; Betsy Blake, PharmD, Ross Hilliard, MD, Mary Beth Poston, MD, Sharm Steadman, PharmD, University of South Carolina*

Achieving safe, high quality, patient-centered care requires that health professions students develop competencies needed to practice effective team-based care. In May 2011, Core Competencies for Interprofessional Collaboration was published by the major academic health professional organizations in an effort to promote interprofessional education (IPE). At the University of South Carolina, an interdisciplinary faculty committee evaluated opportunities for IPE among the colleges of medicine, pharmacy, nursing, social work, and public health. Building on the success of USC's IHI Open School Chapter, we developed a Vertical Curriculum in Patient Safety and Quality for medical students and subsequently implemented a pilot IPE course between first year pharmacy and medicine students that focused on competencies and teamwork in health care. Expansion plans for all health science programs will be presented.

Objectives:

1. Identify local and national resources for planning inter-professional education offerings for undergraduate and graduate programs for health science students
2. Describe the experiences of students and faculty in a Vertical Curriculum in Patient Safety and Quality and an interprofessional pilot of IPE that utilized large group teaching, small group facilitation, web-based cases and writing assignments, and an independent small group project that resulted in a root cause analysis presentation
3. Assess the resources needed to survey students regarding needs and desires for IPE, to develop an appropriate curriculum that integrates IPE and patient safety and quality improvement skills, and to implement cross-campus teaching and learning activities

**Room: Studio 220@NOMA-A**

**L8: Self-Management in the PCMH: A Multidisciplinary Multimedia Approach to Patient Engagement**

*Anne Van Dyke, PhD, ABPP, Jennifer Tucciarone, MD, Cheryl Gorman, William Beaumont Hospital Family Medicine Residency, Sterling Heights, MI*

"Routine health care" is becoming an oxymoron. There is nothing "routine" in today's health care environment as it undergoes unprecedented change. This presentation will focus on the changing landscape of "routine health care" for chronically ill patients. Studies have shown that increasing patient involvement in the management of chronic illness leads to more positive and enduring medical outcomes. Two goals of the PCMH are to provide integrated care as well as to promote patient engagement. A multidisciplinary team approach to rolling out the concept of self-management in one residency program will be discussed. Self-management techniques will be taught through a multimedia presentation involving audience participation. Necessary steps to build on this level of integrated care and patient engagement will be outlined, and outcome data be shared.

Objectives:

1. Describe the principles of self-management and how it benefits individuals, health care providers, and health care systems
2. Understand the differences between self-management programs and patient education
3. Describe the various self-management techniques and how to effectively integrate them into a residency program and clinical care

**Room: Regency F**





### **L9: Utilizing Motivational Interviewing in School-Based Health Centers to Promote Adolescent Healthy Behaviors**

*Kay McLean, BSN, MSN, Mary Stephens, MD, MPH, Martha Coppage-Lawrence, BSN, MSN, Lauren Foy, DO, Christiana Care Health System, Wilmington, DE*

The adolescent population presents with health care needs that require the utilization of methods of coaching best suited to illicit behavior change and/or involvement in screening and treatment recommendations. Motivational interviewing (MI) is one approach which can support the unique learning style of teenagers. Adolescent overweight and STI prevention and identification are health care priorities in this population (Healthy People 2020). Two performance improvement projects developed and implemented in nine SBHCs in Delaware will be presented as examples of how MI techniques can be utilized to promote successful changes in a frequently challenging population. Also discussed will be how the process of project implementation fostered a climate change for SBHC providers and how these projects can be adapted to work in other primary care settings.

Objectives:

1. Utilize the presentation of two performance improvement projects as examples of successful implementation of practice change in an organization
2. Describe a culture change within an organization leading to a focus on performance improvement
3. Learn the basics of motivational interviewing and have an opportunity to practice in a small group setting

**Room: Dogwood**

### **L10: Fostering Consumer Engagement: A Toolkit for Practices on the Journey to Patient-Centered Medical Homes**

*Linda Cragin, MS, University of Massachusetts Medical School*

Engaging patients in patient-centered transformation activities can be challenging for busy primary care practices yet is a requirement by NCQA. A toolkit developed for the Massachusetts Patient Centered Medical Home Initiative will be presented as a resource. The development was guided by information from patient focus groups and key informant interviews conducted with internal and external stakeholders. The toolkit contains templates, sample documents, and links to resources designed to help care teams learn how to engage consumers in quality improvement activities such as patient advisory councils and patient walk-arounds, and gather information on consumers' experience and perceptions of care through surveys and focus groups. The tools offered have been tried and tested in practice settings and have proven to be of benefit.

Objectives:

1. Describe essential considerations when fostering consumer engagement in PCMH practice transformation
2. Identify key methods for collecting patient feedback to drive quality improvement practices
3. Define strategies applicable in their practices to strengthen consumer engagement in practice transformation

**Room: Studio 220@NOMA-B**

#### **Using QR Codes to Access the Conference Mobile Site**

QR Codes, like the one below, are used to easily link smartphone or tablet users to information on the web. You need special software to scan the codes. Search your smartphone or tablet's app store for "QR Code Reader." Once installed, the software will use your device's camera to scan the code.

Aim your mobile device at this block to scan and access the mobile site for the Conference on Practice Improvement.





## 11:30 am–Noon

### Papers

#### **PA1: Computerized Technologies Integrating With Electronic Health Records to Meet Quality Initiatives**

*Edward Bujold, MD, Family Medical Care Center/National Research Network, Granite Falls, NC; Cathy Bryan, BS, MBA, CINA, Dallas, TX*

Electronic Health Records have done a poor job to date of extracting data from multiple sources within their computerized formats to help practices become patient-centered medical home certified, attest for Meaningful Use and meet PRQI reporting requirements for Medicare. We describe a powerful technology interface that accomplishes this and much more. In addition, we propose a method to certify these interfaces with Medicare, Medicaid and Third Party Payers to make reporting this data seamless and efficient relieving practices the labor intensive burden of meeting these requirements.

#### Objectives:

1. Show how this technology empowers physicians to practice evidence-based medicine, improve adherence to national guidelines, and successfully participate in quality reporting
2. Show how this technology interfaces with multiple disparate electronic health records enabling functionality necessary for successful deployment of the patient-centered medical home and demonstration of Meaningful Use criteria.
3. Describe how the technology supports the infrastructure for health information exchange and data sharing across communities and supports the efforts of comparative effectiveness research to create new evidence-based knowledge.

#### **Room: Regency F**

#### **PA2: Psycho-Educational Group for Patients With Chronic Pain**

*Christine Gray, PsyD, Bethany Picker, MD, Jen Fish, LSW, Central Maine Medical Family Medicine Residency, Lisbon Falls, ME*

It often feels as if we are in an epidemic of chronic pain. Much energy gets spent on pharmacologic approaches to pain management. At the Central Maine Medical Center Family Medicine Residency, we have started a series of group chronic pain management classes. These classes are primarily facilitated by a health psychologist who is paired each class with a resident. Participants and residents therefore simultaneously learn non-pharmacologic approaches to chronic pain.

#### Objectives:

1. Identify advantages of incorporation of non-pharmacologic approaches to chronic pain in standard practice.
2. List three cognitive behavioral topics appropriate for patients with chronic pain.
3. Effectively discuss benefits of this approach with patients in chronic pain.

#### **Room: Dogwood**

#### **PA3: The Third World in Your Own Backyard**

*Beth Damitz, MD, Sylvia Rozek, MD, Medical College of Wisconsin*

In the city of Milwaukee, there is a significant health disparity between African American infants and infants of other ethnic backgrounds. According to the Wisconsin Department of Health Services, January 2010, infants born to African American women have been three to four times more likely to die before their first birthday than infants born to white women. With respect to selected causes of infant death such as disorders related to preterm birth and low birthweight this occurs 28.8% in African Americans versus 19.0% in all races/ethnicities. In an effort to improve the health of babies in our community we have developed this patient-centered medical home approach to obstetrical care. Early results demonstrate improvement in birth outcomes since our program started almost 2 years ago.

#### Objectives:

1. Understand the components of a patient-centered medical home
2. Understand how medical information traditionally delivered on an individual basis can be done in a group setting
3. See how incorporating innovative approaches to traditional care can positively impact obstetrical outcomes

#### **Room: Think Tank@NOMA**

Join the conversation on Twitter: #CPI12





#### **PA4: Team Engagement to Improve Functionality of the EHR Problem List in an Academic Medical Enterprise**

*Tim Burdick, MD, University of Vermont*

Paper medical records commonly used separate charts at each specialty clinic, the hospital, and the emergency department. EHRs often unite the medical center on one problem list, but poor implementation often limits the clinical benefits. Fletcher Allen Health Care implemented an EHR in 2009 and 2010 throughout the enterprise. In 2012, executive leaders identified improvement of the problem list as a strategic initiative which could facilitate Meaningful Use, PCMH, and the ICD-10 transition. They assembled a multidisciplinary team of 20 stakeholders to optimize the EHR, agree on conventions, update policy, and adopt dashboarding metrics. Clinical decision support (CDS) tools leverage the EHR to improve clinical utility. The authors will discuss in detail the processes and measurable outcomes of this improvement project.

Objectives:

1. Describe the role of the Problem List in electronic health records
2. Name the key stakeholders involved in improving the EHR Problem List
3. Describe how clinical decision support tools can improve the Problem List

**Room: Studio 220@NOMA-B**

#### **PA5: Development of an Evidence-Based Clinical Decision Support Tool in a Large Family Medicine Practice**

*James Jenkins, MD, Susie Smith, MSN, RN, CNA-BC, John Loomis, BA, Virginia Commonwealth University*

In 2011 FFPC decided to develop an evidence-based decision support tool to enhance the delivery of preventive and chronic care. The tool was developed by IT with input from the Quality and IT Committees. The tool generates a report that can be used at the time of the visit to recommend needed labs, vaccines or counseling based on the medical information in the EHR. Current evidence-based guidelines were used to generate recommendations on preventive and chronic care. This report is used by clinical staff when rooming the patient, by providers when seeing the patient and can be used along with the clinical summary by the patient to establish goals from the clinical encounter.

Objectives:

1. Describe how to use data collection and reporting technology to support population management at the point of care
2. Explain how the team approach using technology can support data collection, goal setting and improved outcomes.
3. Show how technology can provide a tool to enhance patient understanding of health care objectives through dialog, recommendations, goal setting, and plan of care.

**Room: Regency D**

#### **PA6: Beyond Perinatal: Expanding PCC's Maternal Child Health Model to Include an Interconception Perspective in Primary Care**

*Amelia Ryan, MD, Andrea McGlynn, CNM, Karole Lakota, MD, PCC Community Wellness Center, Chicago, IL*

In maternal and child health, disparities between racial/ethnic groups persist. Minority women are more likely to suffer poor birth outcomes: premature birth, low birthweight, high infant mortality, unintended pregnancy, and short interpregnancy intervals. Objective: to reduce/eliminate maternal child health disparities between racial/ethnic groups by improving internatal care for minority women via development of strategic approach to caring for women who are interconceptional and actively involving them in comprehensive health care during reproductive years. Interconception care plan was created to guide providers on care of women in internatal period. Support, including case management, was provided for highest risk women. Providers were trained at regular intervals as care plan commenced, with increased topic knowledge and provider buy-in at each interval, based on provider knowledge surveys.

Objectives:

1. Greater appreciation of the role of family medicine in caring for women and children throughout their lifecycle, including the vital role the family physician can play in improving maternal child health outcomes.
2. Apply a new care management plan to care for internatal patients in their own primary care practices.
3. Teach providers a new care management plan in a stepwise fashion, to increase topic knowledge and provider buy-in, which enhances the success of the new program's implementation.

**Room: Gardenia**



Friday, November 30

**PA7: Moving From Compliance to Commitment in Implementing the Diabetes Home**

*Stephanie Eisenstat, MD, Harvard Medical School*

Redesigning care processes requires collaboratively developed, standardized and evolving procedures. An interdisciplinary leadership team at Massachusetts General Hospital has implemented the Diabetes Home, a team-based care model in primary care for patients with diabetes. Unique is the re-training of existing nursing and nutrition staff to serve as “Diabetes Champions” with the physicians, combining Six Sigma LEAN processes with a population-based information management tool “Diabetes TopCare”. Small teams take local ownership for the care process to ensure patients with diabetes get the right care (medication titration, behavioral support, diet and exercise strategies) by the right staff (physicians, nurses, dieticians and support staff) at the right time (as they cross thresholds to trigger adjustment of their treatment plan). Evaluation of the program will be reviewed.

Objectives:

1. Learn how to leverage existing resources in primary care to care for the needs of those with diabetes
2. Discuss the process of moving clinicians to a team-based collaborative care model
3. Review outcome data from the pilot study focused on insulin start in three primary care practices and discuss implications for future expansion

**Room: Redbud A-B**

**PA8: Resident and Faculty Physician Performance Assessment in Electronic Health Record Data Acquisition and Management (e-DAMA)**

*Robert Kelly, MD, MS, Carl Tyler, MD, Adam Miller, BA, Teresa Dalton, MA, David Eberlein, MD, Fred Jorgensen, MD, Sandra Snyder, DO, Fairview Hospital Cleveland Clinic, Cleveland, OH*

Purpose: Residency trainees need to acquire, enter, organize, integrate, and update information in their specific EHRs. There is currently no published literature describing how medical educators teach and assess this aspect of resident performance. Methods: Faculty, chief residents, and staff have developed a chart audit instrument and process for assessing EHR data management. Audit items focus on key data elements, avoiding redundancy, and organization for optimal utility and safety. Audit targets are changed monthly. Results: Pilot testing over the first two cycles has been successful. Data from an additional six months’ audit cycle will be presented, along with the e-DAMA instrument and process. Conclusions: This instrument exemplifies how medical education must keep pace with the competencies necessary to optimally utilize evolving health information technologies.

Objectives:

1. Describe the problems and opportunities in data acquisition and management posed by EHR systems
2. List steps in a rapid cycle audit and feedback process for evaluating electronic data acquisition and management (e-DAMA).
3. Describe improvements in resident and faculty physician e-DAMA performance resulting from rapid cycle audit and feedback.

**Room: Studio 220@NOMA-A**

**PA9: Patients Talk: How to Effectively Manage Incoming Calls to Put Your Patient’s Needs First**

*Thomas West, MBA, Michelle Mastin, GED, Community Health Network Family Medicine Residency, Indianapolis, IN*

The incoming calls process in primary care practice encompasses many important facets of patient care including scheduling, completing medication refills, and referrals. By improving the effectiveness of the incoming calls process a practice can reduce call wait time and improve call service. The DMAIC improvement process was used to map the existing call process, identify areas of improvement, and design an ideal future state. Feedback for the development of the incoming calls process was obtained from all staff and patients. Preliminary data indicate a 10% increase in service level and a 19% decrease in average wait times. The conversation facilitated will help emphasize how being patient centered can change processes – for the better.

Objectives:

1. Map office processes to help identify possible areas of improvement.
2. Apply the basic components of a structured method of improvement.
3. Learn how to utilize process improvement tools to encourage office procedure change.

**Room: Regency E**



**2:15–3:45 pm**

## **Seminars and Special Session**

### **S1: Strategies and Solutions to Enhance Integration of Community-Based Resources for Patients With Obesity**

*Neta Taylor-Post, BA, YMCA of Greater Providence, Providence, RI; Robyn Wearer, RD, National Research Network, Leawood, KS*

More than 1/3 of US adults are considered obese, and this excess weight is a major risk factor for Type 2 diabetes. Few primary care physicians can afford the time to offer intensive coaching/support necessary to implement evidence-based lifestyle change programs such as the Diabetes Prevention Program. A promising solution exists with community-based resources (eg, YMCA) and their ability to deliver evidence-based care in community settings. This seminar is based directly on lessons from two practice-based pilots and will help attendees develop concrete strategies/solutions to develop effective linkages with resources in their community.

Objectives:

1. Describe the role of appropriate community partner(s) in helping primary care practices address current gaps in the fee-for-service system
2. Practice concrete methods for establishing a sustainable, bidirectional referral system to community resources
3. Apply practice patient engagement strategies intended to increase the likelihood that patients are willing to engage with a community resource offering lifestyle change programs.

**Room: Regency E**

### **S2: Transform Your Practice by Negotiating Change: Take a “Walk in the Woods”**

*Jay Lee, MD, MPH, Wendy Linderholm, PsyD, Long Beach Memorial Family Medicine, Long Beach, CA*

With the growth of the patient centered medical home (PCMH) as a construct for practice transformation, there has been an increasing need for health care organizations and their leadership to engage in active change management to limit resistance, reduce fatigue, and ensure successful implementation. An effective method of negotiating the change process is known as interest-based negotiation. In this seminar, a community-based family medicine residency program will share its experience with the early-to-mid stages of PCMH transformation and how interest-based negotiation was utilized to set strategic priorities and to actively manage conflict throughout the change process. Participants will then practice this methodology through role-playing in conflict-based case studies.

Objectives:

1. Recognize change resistance and fatigue when re-designing your practice
2. Describe the difference between positional bargaining and interest-based negotiation
3. Apply interest-based negotiation methodology to actively manage change via conflict-based case studies

**Room: Regency F**

### **S3: It Takes a Village: Building an Integrated Medical Home Supported by an Integrated Medical Neighborhood**

*Kimberly Walter, PhD, Becky Peterson, RMA, St. Anthony North Family Medicine Residency, Westminster, CO*

In attempting to integrate support services, including mental and behavioral health, case management, diabetic education and nutritional education, in the St. Anthony Family Medicine Residency we faced several challenges, including the sheer size of the practice (41 providers and 23 staff), limited staffing, support, or budget for support services, and a highly complex patient population. Despite several roadblocks along our journey we have been able to not only successfully integrate support services within our own clinic and residency program we have also ventured out into our local medical neighborhood to build relationships with community agencies and our larger hospital system. Suggestions for replicating integration into other programs, improvement measures, and data collected will be shared as well.

Objectives:

1. Discuss the process of building an integrated practice in a model that accounts for limited staffing and budget
2. Describe the benefits of integration to both patient care and resident learning
3. Identify potential community resources available for expanding into the medical neighborhood

**Room: Dogwood**



Friday, November 30

#### **S4: Team Building and Conflict Resolution: How To Succeed in Health Care Without Even Trying**

*Sarah Houssayni, MD, Patrick Allen, MD, Via Christi Family Medicine Residency, Wichita, KS; Mara Hover, DO, Arizona College of Osteopathic Medicine of Midwestern University*

The changing face of health care is forcing medical providers to reconsider familiar practices. “New tricks” are mandatory not optional for survival of both old and new players of the health care game. The patient centered medical home concept is getting a lot of attention and focus and is an example of why and how teams are crucial for success. Teams and groups are structurally and operationally different entities, effective teams bring increased efficiency, better work quality, improved creativity and enhanced motivation. Conflict is an inevitable element in team dynamics. While its avoidance can be a sign of team dysfunction properly dealing with conflict strengthens teams. The ability to negotiate remains the most important element of achieving any given destination.

Objectives:

1. Plan team and group interactions to support structural and operational differences to support effective team planning and goal development
2. Describe steps necessary for building a successful team and value the importance of a team charter for effective team functioning
3. Identify conflict within the team to affect behaviors and actions

**Room: Studio 220@NOMA-B**

#### **S5: Planning and Implementing Group Visits and Shared Medical Appointments That Maximize Access and Self-Management**

*Stephanie Eisenstat, MD, Harvard Medical School; Evelina Sands, MS, North Shore Physicians Group, Salem, MA; Allison Siegel, MPH, John D Stoeckle Center for Primary Care Innovation, Boston, MA*

There is good evidence that the group medical visit, or shared medical appointment (SMA), is an important model to complement the individual medical visit in primary care practice, and that groups can enhance access to care and patient self management. However, starting and sustaining group visits in practice is challenging, and requires careful planning, leadership, an interdisciplinary focus, team work, staff redeployment and patient engagement to ensure success. During this seminar, we will describe the tactical details of the development of group visits and SMAs already established in our practice network, discuss process improvement strategies that can improve planning and execution, and help audience participants assess their own practice readiness to start and sustain group visits.

Objectives:

1. Identify the components of effective group programs to improve access to care and patient self management
2. Deconstruct common barriers to the implementation of effective group visit programs
3. Generate strategies to enhance staff and patient engagement, team building, attendance, training and billing, using a structured approach

**Room: Regency D**

#### **S6: Quality Improvement: The Basics**

*John Bachman, MD, Mayo Medical School*

This presentation will spend time dealing with the basics of quality improvement. It will focus on using the fundamentals to solve problems in your office or hospital. It will provide you with the information to find the pearl in the oyster when confronted with typical quality initiatives. Topics that are covered is common sense is the worst enemy of the system, there is no meaning to anything, variation is our friend, and theory into practice.

Objectives:

1. Summarize the basics of the Deming Model
2. Utilize tools to reinforce the basics of quality improvement
3. Apply fundamentals of the quality improvement process to solve problems and improve practice

**Room: Redbud A-B**

Join the conversation on Twitter: #CPI12



## **S7: Motivational Interviewing: A Tool for Communicating With Patients to Facilitate Engagement and Change**

*Denise Ernst, PhD, Denise Ernst Training and Consultation, Portland, OR*

This seminar will provide an introduction to Motivational Interviewing (MI), a patient-centered method for communicating with patients that is helpful in promoting behavior change and engagement in self-management. The status of the evidence supporting MI and the current understanding of the key components and skills involved in the delivery of effective MI in practice will be discussed. The model will be demonstrated with opportunities for the participants to explore how the process is used to build motivation and help patients prepare for change. The participants will have the opportunity to experience for themselves what a MI-like conversation feels like, both as the patient and as the provider.

Objectives:

1. Identify the key components of the definition, spirit, and focus of MI
2. Describe the skills used to facilitate behavior change through conversation
3. Utilize one strategy for enhancing motivation with patients

**Room: Think Tank@NOMA**

## **SS1: Special Session: The ABCs of Doing and Teaching Quality Improvement-Beyond PDSA**

*Daniel Mullin, PsyD, Sara Shields, MD, MS, Stacy Potts, MD, Marie Caggiano, MD, Konstantinos Deligiannidis, MD, MPH, University of Massachusetts-Worcester*

To work in the rapidly changing health system, family physicians must be well-versed in quality improvement (QI) methods. Family medicine residents are increasingly being trained in such practices or entering such practices upon graduation, and also need to meet the ACGME competencies of systems-based practice, practice-based learning, and improvement. In all these aspects—PCMH, practice-based improvement, and public health, QI methods are critical to implementing projects to improve health care in both individual practices and communities. Our interactive presentation will help both clinicians and educators to design a real-life quality improvement project and to teach these skills to students and residents. We will use practical, case-based scenarios to demonstrate several QI tools including process maps, an enhanced plan-do-study-act (PDSA) worksheet, team strategies and run charts.

Objectives:

1. Summarize the basic principles of quality improvement using the Institute for Healthcare Improvement's Model for Improvement
2. Construct a fishbone diagram, a process map, an enhanced PDSA worksheet, and a simple graph of data results for their chosen QI project
3. Compare and contrast strategies for teaching these concepts in residency education

**Room: Studio 220@NOMA-A**

### **Using QR Codes to Access the Conference Mobile Site**

QR Codes, like the one below, are used to easily link smartphone or tablet users to information on the web. You need special software to scan the codes. Search your smartphone or tablet's app store for "QR Code Reader." Once installed, the software will use your device's camera to scan the code.

Aim your mobile device at this block to scan and access the mobile site for the Conference on Practice Improvement.







**4:15-5:15 pm**

**Lecture**

**L11: Practices Learn the Most From Each Other: DARTNet Institute’s Approach to a Learning Community (NRN)**

*Robyn Wearer, RD, University of Colorado; Sharon Hunt, MA, American Academy of Family Physicians, Leawood, KS*

The premise “If you build it, they will come” doesn’t always apply to the many networking sites intended to foster collaborative learning by physicians/practices in a digital environment. While such networks promise convenience and practice-to-practice learning, there is also the risk of information overload and fatigue. The DARTNet Institute (DI) includes a virtual, practice-based learning community with a database of 3 million plus patients. The DI information portal was created so that practices could share performance data and lessons learned, often assisted by virtual facilitators. The challenge will be keeping practices continuously engaged. This presentation, coordinated by DI facilitators, will share current activities and future plans, many grounded in an ongoing NIH study around chronic kidney disease and then ask participants for candid feedback and advice.

**Objectives:**

1. Learn about DARTNet Institute’s Learning Community, population-based performance reporting and current activities and strategies intended to foster practice-to-practice learning.
2. Review and have the opportunity to participate in a simulated learning community, using DI examples of virtual facilitation and performance reports from the ongoing NIH study on chronic kidney disease.
3. Provide feedback and insight on how they personally view virtual learning communities; this feedback will be used to directly inform future strategies in DI development.



**Room: Regency E**

hellohealth®

---

New  
Revenue.™

You’ve earned it.

 <b>Electronic Health Revenue</b> An EHR that generates new revenue for your practice	 <b>Patient Portal</b> A remarkable patient engagement platform	 <b>Simple Transition</b> No cost to implement and remarkable support
Integrated EHR, patient portal and communication suite Business model for new revenue opportunities Single secure cloud-based platform <b>FREE</b> to implement		

hellohealth®

hellohealth.com  
 facebook.com/hellohealth  
 @hellohealth  
 info@hellohealth.com  
 877.610.0119



### **L12: Defining Care Coordination in a Residency-Based PCMH**

*Melly Goodell, MD, Nancy Barr, MD, Family Practice Franklin Square, Baltimore, MD*

NCQA 2011 PCMH criteria require practices to provide care that is “coordinated or integrated across the health care system.” However, there are no widely accepted standards that consistently define “care coordination,” especially within those practices centered around residency training programs. In this presentation, we will highlight our progress around defining and implementing care coordination, identifying the patient population most in need of care coordination, tracking outcomes in this targeted population, and incorporating residents throughout the process. We will also review elements of care plans and team training relevant to care coordination in our setting and lead a discussion around successful methods implemented or challenges encountered by audience members.

Objectives:

1. Define care coordination and the key elements of a care plan
2. Discuss the benefits of increased resident involvement in the spectrum of care coordination
3. Evaluate the criteria and outcomes measures for patients who require care coordination

**Room: Redbud A-B**

### **L13: Continuous, Team-Based High Risk Care Management: The Team RN Model**

*Kirsten Meisinger, MD, Aimee Chevalier, RN, Cambridge Health Alliance, Somerville, MA*

In primary care, the RN role is largely limited to immunizations, triage and secretarial tasks. Getting RNs “off the floor” and into direct patient care has been a challenge. Union Square Family Health Center, a Community Health Center in Somerville, MA, is 1 year into a new initiative that has moved the RN role to that of Care Manager, tasking them with the chronic disease management of their team patients through direct patient visits and patient education. This innovative and patient-centered program has yielded almost immediate results: an increase in the number of patients with completed diabetic RN visits (42%), a decrease in Hgba1c for patients who completed RN visits (20% <9), and an increase in the number of diabetics in the practice (18%).

Objectives:

1. Understand an initial approach to high risk patient stratification, and begin to assign tasks and team roles at their sites to establish an initial care plan for these challenging and time consuming patients
2. Be familiar with an innovative change in the ambulatory RN role with a new focus on outcome improvement in diabetic patients using direct patient education visits
3. Utilize tools to operationalize a daily huddle by the complete team – MA, RN, and MD – to improve flow of patients and more complete “inreach” – ensuring higher quality measures for their practices

**Room: Magnolia**

### **L14: Experience in Quality Improvement for Practice in Primary Care (EQulP PC): A Quality Consortium**

*Peter Carek, MD, MS, FFAFP, Medical University of South Carolina; Lori Dickerson, PharmD, Trident FMR, Charleston, SC, Charles Carter, MD, FFAFP, Palmetto Health Alliance University of South Carolina, Columbia, SC; Michele Stanek, MHS, University of South Carolina*

Over the past 2 years, family medicine residency programs in South Carolina have participated in an ambulatory care practice consortium and project, Experience in Quality Improvement for Practice in Primary Care (EQulP PC). Following the delivery of a standardized curriculum and experience in quality improvement during residency training, the project is evaluating the quality improvement activities of graduates. Programs have integrated quality coordinators, implemented the curriculum and developed patient care registries based on areas of clinical importance in their practice. Several have achieved patient-centered medical home (PCMH) recognition. Participating program faculty have met bi-annually to review project objectives and outcomes. Assessments have been conducted annually to evaluate the impact of the curriculum in the graduates’ PCMH.

Objectives:

1. Review elements of the standardized curriculum and evaluate data from specific quality improvement experiences in each residency program in the Consortium
2. Evaluate the impact of the standardized curriculum on patient care and PCMH outcomes in each residency program in the Consortium
3. Discuss the impact of the standardized quality improvement experience in graduates’ patient-centered medical home

**Room: Gardenia**



Friday, November 30

### **L15: Bringing Data to the Exam Room**

*Daisuke Yamashita, MD, Scott Fields, MD, MHA, Oregon Health & Science University*

OHSU Family Medicine has created clinically relevant quality reports to facilitate quality improvement for our clinical enterprise. The patient-centered medical home calls for population approach to enhance patients' health, as well as team approach to provide timely and high quality patient care of individual patients. Existing data suggests that it is impossible for individual providers to implement all the recommended preventive health measures as well as chronic disease management measures. Translating quality reports into action is a complex task and requires concise planning and continuous effort. Participants will gain skills to create meaningful quality data through their own quality data team and to promote quality improvement, not only among patients seen in the clinic, but also at the population level through their clinical team.

Objectives:

1. Describe the process of developing high quality reports facilitating effective quality improvement in the clinic, including how clinicians and report writers communicate
2. Understand the different type of quality data reports to capture appropriate quality improvement process and enhance quality improvement activities
3. Describe the process of building an effective clinical team to improve the quality of care

**Room: Regency D**

### **L16: Nurses and Clinicians: Partnering for Success**

*John Bachman, MD, Michelle Enos, RN, MSN, Jill Lacey, RN, Wendy Marek-Spartz, LPN, Mayo Medical School*

In a rapidly changing world outpatient offices are stressed. This presentation gets back to the basics as representatives of Mayo Clinic Rochester discuss how nursing roles and representatives have changed. The session promises to have you find out what is going on in the minds of nursing staff and how they can provide support and caring to your patients in effective and different ways. The program will discuss innovations to the tried and true. Topics discussed include population management, handoffs, and rules of the road to get the most from your nursing staff.

Objectives:

1. Utilize tools to improve effective interaction between nursing and clinicians to enhance patient care
2. Understand a nursing perspective of the rules of the road for a professional relationship that results in continual improvement
3. Implement new ideas into their practice to change their processes and become more effective by better utilization of their staff

**Room: Studio 220@NOMA-A**

### **L17: "Show Me" How to Transform Primary Care: Missouri's Statewide Approach**

*Kathleen Reims, MD, University of Colorado Family Medicine Residency, Lafayette, CO; Laurel Simmons, SM, CSI Solutions, LLC, Bethesda, MD*

A unique statewide initiative in Missouri has brought together 120 teams representing more than 500 physicians from both mental health and primary care organizations in an 18-month modified Breakthrough Series Collaborative aimed at practice transformation and improved clinical outcomes. Practices represent various practice types including federally qualified health centers, private practices, academic practices, hospital-owned practices, and community mental health centers. This presentation will discuss the collaborative approach among primary care providers, payers, foundations and state government to transform the state's health care system. The presentation will share change concepts, challenges, lessons learned, and collaborative results achieved to date. Integration lessons derived from the inclusion of mental health teams in the learning experience will be highlighted.

Objectives:

1. Describe measures that can be used to assess medical home performance along with results that can realistically be achieved based on the outcomes demonstrated in the Missouri Collaborative
2. Describe change concepts and ideas that facilitate transformation in primary care and can be applied in a variety of practice settings
3. Identify challenges and best practices for integration of behavioral and physical health in a medical home setting

**Room: Dogwood**





### **L18: Motivating Diabetics v. 2.3**

*Paul Dake, MD, Elizabeth Imbesi, PhD, McLaren Family Medicine Residency, Flint, MI*

The group model of diabetes management has several advantages over individual visits including optimal use of provider time, increased time for patient interaction with providers, consistency of communication across patients, enhanced patient understanding of diabetes management skills, and improved HbA1c levels, quality of life and health behaviors over individually seen patients. In this presentation, we will outline physical and behavioral patient motivation techniques as delivered in a bimonthly group visit by a multidisciplinary team. We will provide patient physical and mental health outcome data, and information and guidance to health care providers who are interested in developing such group visits in their practices.

Objectives:

1. Identify diabetic patients who would benefit from further interventions designed to motivate patient engagement, and learn specific tracking and measurement approaches as to these patients' outcomes
2. Describe specific behavioral health strategies such as basic motivational interviewing and existential approaches to help improve patient motivation
3. Discuss role of biopsychosocial approach to diabetes management

**Room: Studio 220@NOMA-B**

### **L19: A Special Place in the PCMH: Development and Integration of the Care Management Role**

*Greg Kirschner, MD, MPH, Patrick Piper, MD, MM, Lisa Gills, RN, Advocate Lutheran General Hospital Family Medicine Residency, Park Ridge, IL*

Although inpatient-based care managers have been utilized in many of our institutions, the concept of office-based care managers has rarely received funding or practical implementation. With the development of the PCMH concept, and now with the particular needs and challenges presented to ACOs, the need for embedded care managers is receiving practical support and rapid implementation. The Advocate Lutheran General Hospital Family Medicine Residency has had the opportunity to work with an office-embedded care manager since August 2011. This presentation will share the rationale and support for this placement, as well as practical aspects of the implementation of this function. Coordination with hospital transitions of care efforts will be explained. Practical office opportunities and challenges will be explored.

Objectives:

1. Describe an operational definition of care management that is relevant to the entire spectrum of care for patients within a PCMH and in the larger context and challenges of an ACO
2. Discuss the first year experience of a developing model of embedded care management in a PCMH/ACO setting
3. Understand the variety of practical challenges and opportunities experienced in program roll-out including financial, case load, workflow, utilization, documentation, metrics, and patient and clinical provider experience

**Room: Think Tank@NOMA**

### **L20: PRICARe: Integrating Primary Care Into a Community Mental Health Center**

*Colleen Conry, MD, Venus Mann, University of Colorado; Jeanette Waxmonsky, PhD, Colorado Access, Denver, CO*

This presentation will describe an integrated care model of placing a primary care provider into a Community Mental Health Center:PRICARe - Promoting Resources for Integrated Care and Recovery. We will describe the clinical model, process of integration, communication protocols and data of numbers of patients seen and types of visits. We will share data from qualitative interviews with staff, physicians and patients. We will present the financial model for the program and our plans for sustainability after the grant ends in Fall 2012. 15 minutes of the hour presentation will be reserved for audience sharing of their experiences in implementing similar models and brainstorming of solutions to common barriers.

Objectives:

1. Describe and implement a model of integration of primary care into a community mental health center
2. Identify successes and barriers of the implementation for patients, mental health providers, and primary care providers
3. Describe integrated care outcomes for patients and describe the perspective of primary care providers and mental health providers

**Room: Regency F**

Join the conversation on Twitter: #CPI12



# Saturday, December 1

**7–8 am**

## **Special Interest Discussion Breakfast Roundtable Presentations**

The following presentations/discussions will be offered with the continental breakfast on Saturday morning.

**Room: Regency Ballroom**

### **B1: You Want Us to What? How an Imposed EMR Change Impacts the Medical Home**

*Elizabeth Baxley, MD, Brody School of Medicine; William Anderson, MD, Brad Cole, MBA, University of South Carolina*

Meaningful Use legislation has spawned numerous changes in how health systems are making decisions about selection of electronic medical records. Since most family medicine residency programs are sponsored by large hospitals systems, they are at the mercy of system-wide changes in HIT infrastructure. Family medicine faculty often have the most experience with ambulatory EMRs and information to guide successful HIT changes, yet frequently have the least input into decisions made at the organizational level regarding EMR choice, customization, and implementation. This session describes the structural, fiscal, and cultural changes that occurred when an EMR change was imposed on a Level III recognized PCMH teaching practice, including patient, staff, and provider reactions.

### **B2: Administrative Structure As a Catalyst for Change**

*Tonya Milam, CMA, William Garrett, MD, East Tennessee State University*

We will report on the formation of a steering committee in the setting of the patient-centered medical home. Traditionally, committees often function as administrative extenders, in that they tend to suppress change and support the status quo. Here, we describe a model for advancing change within a pre-established setting of three closely related family medicine Programs: one University related, and two community based. In addition to structural issues, the more important real world inspirations for development and avenues for change are described and evaluated. Both the idea itself and the formal structure are presented in a model for possible adaptation to other programs.

### **B3: Integrating Your Community Mental Health Center With Your Residency: A Win-Win Solution**

*Steven Brown, MA, David Smith, MD, North Colorado Family Medicine, Greeley, CO*

Health care in the US is moving toward an integrated model that may be difficult for residency programs to adopt due to financial constraints for new faculty or staff. Referring patients with mental health needs to outside providers allows for poor follow through on the referral and lack of communication between the medical and mental health providers. We will present and discuss, in a round table format, the importance of integration of medical and mental health providers in a co-located setting, barriers to integration to overcome, and how integrating mental health specialists from a community mental health agency can be a cost effective option. This is unique as the mental health agency can benefit as well without added cost to the family medicine program.

### **B4: Integration of Behavioral Health in Primary Care: Models for Implementation and Funding**

*Jon Thomas, PhD, Adarsh Krishen, MD, MMM, Summa Health System Family Practice, Akron, OH*

Integrated models of care are touted for improvement of office efficiency, patient and physician satisfaction, as well as improved health outcomes at decreased cost. This session will outline the rationale for integrating behavioral health into primary care through a team approach that can improve patient safety. Five models for clinical implementation will be presented along with financial strategies for funding integrated care as part of a patient-centered medical home.



## **B5: Are They Ready? Health Care Marketplace Skills for the Third-Year Resident**

*Maria Pellerano, MA, MBA, MPH, Lynn Schwenger, MHSA, David Swee, MD, UMDNJ Robert Wood Johnson School of Medicine*

Are our residents ready to enter today's constantly shifting health care marketplace? Residents want help with the business of medicine such as the value of a contract, incentive plans, and mergers and acquisitions. Young physicians also have life-style demands such as shorter work hours and higher salaries. Are residencies preparing them for this changing world while helping them find positions that meet their needs? In this session we will provide our perspective on today's residents and how to best equip them for the current marketplace. We will use our experience with a multi-dimensional approach that includes a 2-day workshop, longitudinal rotations, and coaching for residents to provide them with skills such as negotiating contracts and interviewing while managing their expectations about the future.

## **B6: Hiding the Veggies: Practice Redesign and the PCMH Curriculum Without Tears**

*Charles Carter, MD, FAAFP, University of South Carolina*

Residency practices are complex environments, and leaders implementing the practice redesigns necessary for a PCMH in these settings must consider learners, accreditation (example: ACGME), and curricular time. Further, residency care teams are typically larger and more complex due to the part-time nature of residents and faculty work. Improvements in the clinical and educational arenas can be limited by organizational inertia, clinical governance, or competing curricular and administrative demands. In spite of these challenges, the PCMH is a team effort and requires buy in from stakeholders. This presentation will review the inherent challenges of practice redesign in family medicine residencies, provide methods for finding synergy between practice redesign and curricular requirements, and introduce a process for choosing implementation strategies for both curricular and practice redesigns.

## **B7: Defining and Enhancing the Role of the Medical Assistant in a PCMH**

*Melly Goodell, MD, Nancy Barr, MD, Family Practice Franklin Square, Baltimore, MD*

Many tasks traditionally completed by physicians can be accomplished more efficiently by other health care team members. This special interest discussion will center on the expansion of medical assistant (CMA) roles in our setting. We created: (1) new CMA roles—clinical lead, master CMA, team lead, and the traditional clinical role to define and enhance CMA participation in the PCMH, (2) forums for active CMA involvement in PCMH and operational improvements, (3) methods to train CMAs in their new roles, including health coaching and health behavior change, (4) methods to measure PCMH-related CMA activities (vaccination rates, disease registry outcomes, screening tests). This multipronged approach has significantly increased the engagement of our CMAs in PCMH processes and strengthened our team-based approach to care.

## **B8: Learn About Practice-Based Research With the AAFP NRN**

*Deborah Graham, MSPH, AAFP National Research Network, Leawood, KS*

Practice-based Research Networks (PBRNs) are comprised of medical clinics that are interested in examining and evaluating the health care processes that occur in real world practices; often involving innovative ways to care for patients, improving the treatment of chronic diseases, and quality improvement methods. More specifically the AAFP National Research Network (AAFP NRN) is a national PBRN conducting a variety of studies in practices throughout the country. This will be an interactive session to discuss the various research studies and quality improvement concepts currently under development in the AAFP NRN, engage in conversation about novel ideas, and identify topics of interest to practicing clinicians. All conference attendees are welcome to attend and participate in this activity.



# Saturday, December 1

## 8:15-9:30 am General Session

**Room: Regency Ballroom**



### **Patient-Centered Medical Home: Transforming the US Health Care System**

*Marcia Nielsen, PhD, MPH, Patient-Centered Primary Care Collaborative, Washington, DC*

Payment for value is a critical piece of supporting what primary care brings to the US health care system. Empowering primary care to advocate for and advance an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH) needs to be a key role for primary care leaders across the country, but particularly in academic settings. To promote payment for value and advocacy for primary care requires transparency and effective use of metrics. These components are promoted in many of the innovative payment models and projects through CMS & CMMI.

#### Objectives:

At the end of this session, participants will be able to:

1. Describe how the current fragmented US health system pays for volume over value, suffers from inefficiencies based on the current fee-for-service payment methodology, has highly variable health outcomes, and is not financially sustainable.
2. Identify the major features of key CMMI projects that promote value-based reimbursement for primary care.
3. Evaluate how the PCMH can contribute to improved health outcomes, enhanced patient and provider experience of care, and reduce expensive, unnecessary hospital and emergency department utilization.
4. Examine how departments of family medicine can promote the PCMH as a model of primary care that validates value to the patient.

Marcia Nielsen, PhD, MPH, is the executive director of the Patient-Centered Primary Care Collaborative, a large coalition of provider/clinicians, purchaser/payers, and consumer stakeholders who have joined together to advance an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH). She previously served as vice chancellor for public affairs and associate professor within the Department of Health Policy and Management at the University of Kansas School of Medicine, served on the Board of Directors of the Health Care Foundation of Greater Kansas City, TransforMED LLC (a wholly owned, non-profit subsidiary of the American Academy of Family Physicians), and the MidAmerica Coalition on Health Care, and has been a committee member on the Institute of Medicine's Leading Health Indicators for Healthy People 2020 and Living Well With Chronic Illness: A Call for Public Health Action.

Marcia was the first executive director (2006-2009) and board chair (2005) to oversee Kansas' health care agency, the Kansas Health Policy Authority (KHPA), Kansas Medicaid, the State Children's Health Insurance Program, the State Employee Health Program. She worked as a legislative assistant to US Senator Bob Kerrey (D-Nebraska), was the health lobbyist and assistant director of legislation at the AFL-CIO. She has an undergraduate degree in biology and psychology from Briar Cliff College, an MPH from the George Washington University, and a PhD in Health Policy and Management from Johns Hopkins School of Public Health. Early in her career she served as a Peace Corps volunteer working for Thailand's Ministry of Public Health, and also served for 6 years in the US Army Reserves.



## 10-11 am Lectures

### **L21: Did Not Keep Appointment (DNKA): Can You Lower Your Rate?**

*Carin Reust, MD, MSPH, University of Missouri-Columbia*

Patients who do not keep their medical appointments are at risk for poor medical care and clearly impact the efficiency and revenue of a practice. Strategies to lower the DNKA rate that focus on practice factors include run charts; work flow processes (swim lanes) for established, new and recurrent DNKA patients; contacting patients prior to visits; letters to no-show patients including certified mailings; signage in clinic; direct feedback to physician-nurse about their DNKA rate, and specific strategies targeted at length of time to appointment. Each of these will be discussed and results will be presented on DNKA rates in two family medicine clinics.

Objectives:

1. Identify potential causes for a “did not keep appointment” (DNKA)
2. Identify and utilize tools to study the DNKA rate within a practice
3. Discuss methods that lower the DNKA rate

**Room: Studio 220@NOMA-B**

### **L22: Integrating Behavioral Health Care Into the Patient-Centered Medical Home**

*Judith Steinberg, MD, MPH, University of Massachusetts; Megan Burns, MPP, Michael Bailit, MBA, Bailit Health Purchasing, Needham, MA; Alexander Blount, EdD, University of Massachusetts-Worcester*

Many patients receive behavioral health services from their primary care providers, yet these providers are often ill-equipped to provide such services due to lack of clinical training and poor reimbursement policy. As the number of chronically ill patients rises, so does the need to address the behavioral health care of patients in a coordinated and integrated fashion. There is no standard approach for integrating behavioral health care and changing long-standing, traditionally accepted care practices is difficult. The Massachusetts patient-centered medical home Initiative has designed an innovative approach to help practices with behavioral health integration through the creation of a self-assessment tool, a complementary roadmap of strategies and resources, and learning collaborative-based training for practices to use in their efforts to transform into patient-centered medical homes.

Objectives:

1. Describe at least three qualities of behavioral health care integration and at least three challenges to integrating behavioral health care into the primary care practice
2. Discuss one strategy for assessing the level of behavioral health integration within a patient-centered medical home
3. Describe three strategies for improving the level of behavioral health integration within a patient-centered medical home

**Room: Studio 220@NOMA-A**

### **L23: Billing for What We Do: A Financial Model for Integrated Behavioral Health in Primary Care**

*Colleen Conry, MD, Venus Mann, University of Colorado*

In conjunction with our recognition as a NCQA Level III PCMH, we wished to create a more robust, integrated behavioral health program and to develop an Integrated Behavioral Health fellowship. Sustainability of the program is dependent on clinical revenues. This lecture will describe the 4 year process of creating a sustainable financial model for the program. The presentation will describe the financial issues in our setting that presented barriers and describe in detail how we overcome each barrier. Resources for billing issues will be described. We will share our algorithms for patient billing triage as well as protocols for prior authorizations and scheduling.

Objectives:

1. Describe the different mechanisms of behavioral health billing in a primary care setting. This will include the use of health and behavioral codes as well as psychiatry codes.
2. Identify solutions to barriers of behavioral health billing. This will include development of billing algorithms and protocols.
3. Share successes of behavioral health billing with other members of the audience to find workable methods in different settings.

**Room: Regency F**



## **L24: Closing Loops Collaborative: Improving the Referral Process**

*Alfred Reid, MA, University of North Carolina, Chapel Hill; Leslie Dean, MD, University of Illinois, Rockton; Amanda Davis, MD, AnMed Health Family Medicine Residency, Anderson, SC; Justin Edwards, MD, Brody School of Medicine; Matthew Snyder, DO, Nellis Family Medicine Residency, Nellis AFB, Las Vegas, NV; Ankoor Soni, MD, University Hospitals Case Medical Center Family Medicine Residency, Cleveland, OH; Joseph Yancey, MD, Ft. Belvoir Community Hospital Family Medicine Residency, Ft. Belvoir, VA; Sabrina Solomon, MD, Christus Santa Rosa Family Medicine Residency, San Antonio, TX*

The Closing Loops Collaborative was formed to improve the outpatient referral process and increase the percentage of diabetic patients who have an annual screening retinal exam documented in the chart. The collaborative is composed of eight family medicine teaching sites from across the country. After performing initial surveys to assess provider satisfaction with the referral process, each member developed site-specific small tests of change. Through quarterly meetings and teleconferencing, we shared ideas and tracked our progress. The purpose of this presentation is to share methods, results, and best practices of a quality improvement project done through collaboration.

Objectives:

1. Summarize referral process best practices to achieve diabetic retinopathy screening documentation rates as high as 70%, and improve rates as low as 16%
2. Evaluate our referral process small tests-of-change and determine which ones may apply to their own practice sites
3. Discuss the opportunities and challenges involved in working with a collaborative for quality improvement

**Room: Regency E**

## **L25: Social Media and the Changing Health Care Landscape**

*Benjamin Miller, PsyD, University of Colorado; Jay Lee, MD, MPH, Long Beach Memorial Family Medicine, Long Beach, CA; Michael Sevilla, MD, Northeast Ohio Medical University; Mark Ryan, MD, Virginia Commonwealth University*

The virtual explosion of health information technology in the past decade has presented physicians, medical groups, and other health care providers with novel opportunities and challenges. One aspect of health information technology is the growing use of social media by patients, physicians, medical groups, and health systems alike. However, the adoption of social media tools appears to be growing, more from the patient side than from the provider side. This is unfortunate as how providers and practices choose to react in response to the growth of social media will determine, at least in part, their future financial viability in the health care marketplace. This presentation will discuss practical applications for social media use by health care providers with specific attention being paid to patient and community engagement.

Objectives:

1. Define social media and “user-generated content,” and explain how these concepts can influence health care
2. Describe four different social media tools, and describe their differences and potential uses
3. Evaluate the roles social media can play in professional development, and highlight important cautions for using social media

**Room: Redbud A-B**

## **L26: Patient Engagement: How a Patient Advisory Board Keeps the Patient in the Center of PCMH**

*Donald Brautigam, MD, FAAFP, Jean Hanks, LPN, Westfield Family Physicians, Westfield, NY*

As a patient-centered medical home, it is essential that we find ways to engage patients and involve them in our decisions. The pursuit of the triple aim (health care quality, improve population health, and contain costs) is not ours alone, but also that of our patients. Our practice has worked with a Patient Advisory Board for over 3 years, completing several meaningful projects as a result. Our board members are keenly interested in how we manage our practice, work to improve health outcomes, and adapt to the ever changing health care market. A Patient Advisory Board can be an excellent strategy to engage patients in practice policies and improve patient experience while maintaining high staff morale and provider satisfaction.

Objectives:

1. Create strategies to recruit and retain members of a Patient Advisory Board
2. Plan and facilitate a Patient Advisory Board Meeting
3. Define how a Patient Advisory Board will help fulfill the patient engagement requirements for NCQA's PCMH Recognition

**Room: Regency D**



**L27: Speech Recognition Technology and the EMR: Preserving the Patient's Narrative**

*Fred Jorgensen, MD, Fairview Hospital Cleveland Clinic, Cleveland, OH*

Documentation of care is a time-consuming and expensive process in medical practices. To minimize prolonged typing, many physicians and other providers use the EMR to produce standardized/templated notes which do not capture the uniqueness of the patient encounter. Speech recognition technology (SRT) can be integrated with existing EMR documentation tools to efficiently document care while preserving both the patient's story and the provider's clinical thinking. To implement use of SRT for medical providers, it's critical to have a clear strategy, realistic expectations for setup time, and effective training and support for new users. This session includes discussion of SRT software, hardware requirements, implementation issues, and a demonstration of speech recognition for documentation and navigation within an EMR.

Objectives:

1. Describe the potential advantages of using speech recognition technology for medical documentation
2. Relate the major issues encountered when considering the use of speech recognition technology in a medical practice
3. Explain a process for using speech-enabled "macros" to efficiently navigate multi-step processes within an EMR

**Room: Dogwood**

**L28: Bridging Health Care: An Innovative Model to Improve Outcomes and Decrease Cost for Difficult Health Care Cohorts**

*Bryan Hodge, DO, Hendersonville, NC*

The most unhealthy and costly patients usually have complex medical, psychiatric, and social needs. Access to appropriate care is further complicated by repeated missed appointments, fragmented primary care, and frequent emergency department use. Using frequent emergency room and hospital care utilization as indicators of high-risk behavior, the Bridges to Health Programs have identified those uninsured and Medicaid patients most in jeopardy of falling through the cracks in our current care delivery system. By offering a more comprehensive, integrated approach, drop-in group medical appointments, improved phone access, and care management for these patients, the Bridges programs strive to improve overall health and functional outcomes, as well as providing cost savings to the system as a whole.

Objectives:

1. Identify patterns of behavior and key characteristics of patients who may benefit from alternative models of patient-centered care
2. Construct the key components of an advanced care model to better address the needs of high-risk patients over-utilizing hospital services
3. Evaluate how an interdisciplinary drop-in group medical visit and enhanced service models impact high-risk patient populations

**Room: Think Tank@NOMA**

**L29: Smoking Cessation Group Visits**

*Janis Bonat, NP, Brooke Salzman, MD, Nancy Brisbon, MD, Victor Diaz, MD, Mona Sarfaty, MD, Kathleen Hilbert, RN, Thomas Jefferson University*

Thomas Jefferson University's Department of Family and Community Medicine has begun phase two of the state of Pennsylvania's chronic care initiative. As with diabetes, a multidisciplinary approach to treatment that engages patients in self-management is the best approach to care. Group visits are one such approach. We invited our behavioral health partners to collaborate with us in developing and implementing a smoking cessation group visit program. Our program will be conducted in four phases to include an orientation, guided imagery/relaxation, medication management by a PharmD, and follow-up for maintaining changes. We will present the details of each phase of this innovative new program.

Objectives:

1. Develop a structured group visit program for a heterogeneous patient population wishing to stop smoking
2. Apply the concept of self-management and support within the context of a multidisciplinary forum for patients wishing to stop smoking
3. Design a program utilizing various resources including pharmacotherapy, hypnosis/relaxation and anticipatory guidance for maintenance and relapse prevention

**Room: Magnolia**



# Saturday, December 1

## **L30: Impact of Clinical Pharmacist Collaborative Care of Patients With Diabetes Mellitus**

*Michele Stanek, MHS, Sharm Steadman, PharmD, University of South Carolina; Elizabeth Baxley, MD, Brody School of Medicine; Kayce Shealy, PharmD, Palmetto Health Alliance University of South Carolina, Columbia, SC*

In the development of a patient-centered medical home, clinical pharmacist visits were initiated within the practice. Physicians are able to refer patients with diabetes for individual visits with a clinical pharmacist. The clinical pharmacist is integrated into the patient care team, promoting collaborative care for the patient. Key activities during the pharmacist visits include the review and optimization of medication therapy, development of self-management skills and goals, and patient education. The impact of the clinical pharmacist has been evaluated and has demonstrated improvements in clinical outcomes, including HbA1c and LDL.

### Objectives:

1. Describe the role, function and impact of an integrated clinical pharmacist who provides individual patient management visits and participates in team-based care
2. Evaluate the effect of the clinical pharmacist on improving patient management, including medication intensification
3. Outline the critical factors in support of direct clinical pharmacist reimbursement

**Room: Gardenia**



# Clinical Health Coach<sup>®</sup>

*Transform the Conversation. Transform the Care.<sup>™</sup>*

Healthcare professionals are challenged to manage a rapidly growing number of patients with chronic conditions. Engaging patients and families in active self-management is essential to improving health and clinical outcomes.

The **Clinical Health Coach<sup>®</sup> Training Program**, offered by the Iowa Chronic Care Consortium, builds skills in health coaching techniques and effective healthcare communications that augment care management processes and support PCMH implementation.

*Choose from two training opportunities:*

**Clinical Health Coach<sup>®</sup> Onsite:** a 40 hour, six week program for professionals who prefer “in class” learning and health coach skills practice along with faculty support in building a health coach role into your care management processes.

**Clinical Health Coach<sup>®</sup> Online:** a 21 hour, self-paced online program for professionals who wish to learn more about health coaching skills and communications to improve health literacy and patient and family engagement.

**Sign-up for more information. Visit us at [www.iowaccc.com](http://www.iowaccc.com).**

*“There is no such thing as a non-compliant patient, we (as healthcare providers) must give them what they need.”*

Join the conversation on Twitter: #CPI12





11:15–11:45 am

## Papers

### **PA10: Results of a Peer Mentoring Intervention in Older Patients With Diabetes: The Care Companions Program**

*Cynthia Henderson, RN, CCM, Well Med Medical Management, San Antonio, TX; Deborah Graham, National Research Network, Leawood, KS*

Diabetes is a complex illness to manage. It can be difficult for patients to make necessary lifestyle changes on their own, and while physicians and other providers can help educate patients, they often lack the time and knowledge of the patients' environments to provide substantial assistance. With this in mind, a peer-to-peer mentoring program was developed at 15 clinics in a large medical group which specializes in senior health care. Over the 18-month recruitment period, 485 patients attended an 8-week introduction to diabetes class (Diabetes 101). Following each Diabetes 101 session, 53 patients were selected for a mentor training program and were subsequently matched with patients to mentor who also went through Diabetes 101. De-identified control patients were selected via EMR extraction to compare medical outcomes.

Objectives:

1. Implementation and effects of a peer-to-peer mentoring program taking place in a large medical organization for older patients with diabetes.
2. List several survey and screening tools that can be used in practice to help measure the psychological and sociological effects of peer mentoring and support group activities.
3. Recognize how peer-to-peer mentoring might affect their own patient outcomes.

**Room: Studio 220@NOMA-B**

### **PA11: Teaching Family Medicine Residents to Recoup Maximum Reimbursement for Inpatient Care: A Proposed 4-week Rotation**

*Fulvanten Mistry, MD, PhD, E.A. Conway Family Practice, Monroe, LA*

Research has shown that medical insurance companies such as Medicare, Medicaid, and others are changing reimbursement rules and developing stricter criteria for reimbursement for inpatient care. Furthermore, physicians are generally not aware of how improper hospital placement can impact payment by insurers and the liability related to such placement. This paper will review the reasons for inadequate reimbursement by insurance companies for inpatient services rendered. It will also present the criteria for proper hospital placements based on the severity of illness and intensity of service. Finally, the paper will present an outline of a proposed 4-week elective rotation for family medicine residents that will be designed to teach them about proper inpatient placements in the hospital so that the hospital will be appropriately reimbursed.

Objectives:

1. Identify the reasons for inadequate reimbursements by insurance companies for inpatient services rendered to patients.
2. List the criteria for proper inpatient hospital placement based on the severity of illness and the intensity of service.
3. Design a 4-week elective rotation for family medicine residents.

**Room: Dogwood**

### **PA13: Using Motivational Interviewing to Improve No-Show Rate**

*Elisabeth Righter, MD, Paul Hershberger, PhD, Wright State University*

Our hypothesis is that our no-show rate will improve by training our scheduling personnel to use motivational interviewing techniques when talking with patients. As part of practice redesign, we are working to improve our no-show rate. Scheduling personnel will learn motivational interviewing. Then they will use motivational interviewing techniques when talking with patients about their upcoming appointments. The no-show rate will be measured monthly. Results of the intervention in progress will be shared.

Objectives:

1. Receive an explanation of our training
2. Receive an explanation to our intervention
3. Hear a review of the results of our intervention

**Room: Regency D**



Saturday, December 1

**PA14: The Effect of Micro-Teams on Continuity of Care in a Family Medicine Residency**

*Michael Clark, MD, Maine Dartmouth Family Medicine Residency, Fairfield, ME*

Continuity is difficult to achieve in family medicine residencies where care is provided by part-time clinicians. To improve continuity, MDFMR established micro-teams consisting of a physician faculty, a PA/NP, and one resident from each class year at each of our model family practice sites. Medical assistants, patient service representatives and nurses were also assigned to each micro-team. Continuity was studied during the same 8 month period of time before and after the initiation of micro-teams. Preliminary results showed a small decrease in the average number of providers seen by a patient and the number of patients seen by more than two providers, as well as a more significant increase in the frequency of patients being seen by their PCP.

Objectives:

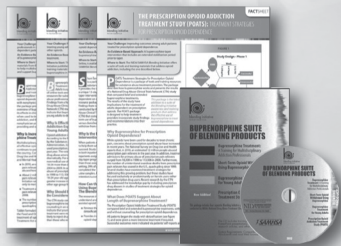
1. Understand the importance of continuity in providing quality care to our patients:
  - A. Improved patient satisfaction
  - B. Improved outcomes
  - C. Decreased cost
2. Understand the effects that small teams can have on continuity of care.
3. Bring back ideas to their practices that could easily improve continuity. Ideally the institution of micro-teams would happen in conjunction with major changes in the physical layout of the clinic, but we did not have the money to undertake these kinds of changes. Our practice changes happened at minimal cost, and with virtually no loss of production

**Room: Studio 220@NOMA-A**



NIDA • SAMHSA  
**blending initiative**

*Accelerating the dissemination of research-based drug abuse treatment into clinical practice and reducing the gap that exists between the publication of research results and their impact on treatment delivery.*



U.S. Department of Health and Human Services  
National Institutes of Health

**NIDA NATIONAL INSTITUTE ON DRUG ABUSE**

*NIH... Turning Discovery Into Health®*



[www.drugabuse.gov/blending-initiative](http://www.drugabuse.gov/blending-initiative)

[www.attcnetwork.org/blendinginitiative](http://www.attcnetwork.org/blendinginitiative)



**PA15: Mapping and Negotiating Across Cultures: A Patient-Centered Chronic Pain Management Service Using Interdisciplinary Teams**

*Mary Spalding, MD, Kacie Cassaday, DO, Jeri Sias, PharmD, MPH, Amanda Loya, PharmD, University of Texas at El Paso*

An academic family medicine clinic recognized the need to improve its existing chronic pain service. We formed an interprofessional team to assess and make recommendations, creating a more patient-centered approach to care. To inform the process, we started with the patient and used “concept mapping” to explore strengths and challenges related to current workflow, practice patterns, and provider perceptions of pain management. We conducted literature reviews of best practices and cultural influences on pain. A chart review revealed lack of documentation of pain assessment, medication, referrals, patient goals, and outcomes. This information guided our improvement plan as we created a core advisory team including a patient advocate. We will share our progress toward implementing a patient-centered approach to chronic pain management.

Objectives:

1. Implement a patient-centered concept mapping strategy to identify strengths, challenges, and opportunities in an interprofessional chronic disease management service focusing on pain.
2. Examine provider and patient biopsychosocial and cultural influences on pain perception and expression as it relates to therapy options.
3. Negotiate a patient-centered chronic pain management plan with a patient using evidenced-based practices, evaluation tools, and interprofessional teams.

**Room: Think Tank@NOMA**

**PA16: Innovations in Primary Care: Implementing Clinical Care Management in Primary Care Practices**

*Judith Steinberg, MD, MPH, Jeanne Cohen, MS, University of Massachusetts Medical School*

Clinical care management of high risk patients is a key element of the patient centered medical home (PCMH) and a new service for most primary care practices. Training for practices in the MA PCMH, a multi-payer, state sponsored PCMH demonstration, includes the clinical care manager (CCM) role, identification/tracking of high risk patients, care plan development/implementation, care coordination, and communications. Content is delivered through learning collaboratives, monthly webinars and practice facilitation. Assessment of progress toward implementation is made through practice-based data on clinical care management measures and self-assessment of transformation. At 7 months into implementation, averages for measures range 52%-67% with 10-26 of 46 practices reporting. An important lesson learned: engaged leadership is critical to successful clinical care management implementation.

Objectives:

1. Explain the role of the clinical care manager and name three challenges to implementation of clinical care management in primary care practices.
2. Explain the components of a clinical care management system and associated processes/workflows.
3. Measure the progress of clinical care management implementation and its effectiveness.

**Room: Redbud A-B**

**PA17: Giving the Patient-Centered Medical Home Some Clas: The Clas Standards and PCMH**

*Portia Jones, MD, MPH, Yakima, WA; Wilma Alvarado-Little, MS, Center for Elimination Minority Health Disparities, Albany, NY*

As we develop new practice models for the medical home, we need to integrate language access for patients of low English proficiency (LEP) and culturally appropriate care for all our patients. The patient-centered medical home is a culture in itself and presents challenges for working in multicultural environments.

Objectives:

1. Understand the CLAS standards, and how they relate to their setting.
2. Articulate the challenges and opportunities the PCMH model presents for working in culturally diverse environments, PCMH is a culture in itself, and may present unique challenges especially to LEP patients.
3. Make a plan about how to intergrate the CLAS standards into their PCMH project.

**Room: Regency E**



# Saturday, December 1

## **PA30: Harnessing Practice Transformation to Improve Smoking Cessation Counseling**

*Scott Strayer, MD, MPH, University of South Carolina*

Effective smoking cessation counseling in primary care settings continues to be challenging due to limited resources, lack of knowledge and skills, and multiple competing demands. We developed a comprehensive approach to office-based smoking cessation counseling that includes physician training, a computer-based counseling tool that can be used by clinicians or office staff, a feedback/audit process to inform practices about their identification of smokers and smoking cessation counseling rates, and a process for providing individual providers with smoking cessation outcomes for their patients. Implementation of this multi-modal approach is being achieved through partnering with a primary care collaborative and during implementation of a system-wide electronic medical record. Successful strategies and approaches will be discussed, including opportunities presented by achieving patient-centered medical home recognition.

Objectives:

1. Identify common barriers to providing evidence-based smoking cessation counseling in primary care practices
2. Develop approaches to successfully deliver smoking cessation counseling at the practice level
3. Apply knowledge of patient centered medical home requirements to implement improvements in smoking cessation counseling in practices

**Room: Think Tank@NOMA**

## **1–2:30 pm**

### **Seminars and Special Session**

## **S9: Intensive Weight Loss Counseling in Primary Care: The New CMS Guidelines (NRN)**

*Adam Tsai, MD, MSCE, FACP, University of Colorado*

In November 2011, Medicare began reimbursing primary care providers for intensive weight loss counseling. Primary care providers can be reimbursed for up to 20 visits over 1 year for counseling patients about their weight. This session will review the 5A approach to obesity (assess, ask, advise, assist, arrange), as is recommended in the new guidelines. We also have an interactive discussion about what goals can reasonably be achieved with intensive but brief counseling and which types of providers should counsel patients. We hope to also discuss the possibility of NRN practices participating in a clinical research study to evaluate the effect of implementing the guidelines, with or without the use of portion-controlled foods for weight loss.

Objectives:

1. Understand and operationalize the “5A” approach to weight loss counseling in the primary care setting
2. Understand the new Medicare guidelines for intensive weight loss counseling in the primary care setting
3. Understand the strengths and limitations of weight loss counseling in the primary care setting and the role of non-physician counselors and adjunctive treatments, such as portion-controlled food regimens.

**Room: Think Tank@NOMA**

## **S10: The EMR Pain Clinic: Solutions to Your Digital Problems**

*John Bachman, MD, Mayo Medical School; Allen Wenner, MD, Palmetto Health Alliance University of South Carolina, West Columbia, SC*

You have an EMR and it is causing you pain. You spend too much time clicking, waiting, or wondering who built the thing to do it that way. You are not as productive! You lose money! Find your greatest pain with your EMR, take some digital photos, and bring it to this session. Dr Allen Wenner from Primetime Practice (Instant Medical History) and John Bachman from Mayo Clinic plus the other participants will help you solve that problem.

Objectives:

1. Address problems with EMR technology
2. Analyze chalk talks, basic workflows, patient computer dialogues, and quality improvement processes
3. Apply best practices when incorporating EMR technology

**Room: Redbud A-B**



### **S11: Partnership With Payer to Advance PCMH Through Payment Reform**

*Michele Stanek, MHS, University of South Carolina; Elizabeth Baxley, MD, Brody School of Medicine; Brad Cole, MBA, Sharm Steadman, PharmD, University of South Carolina*

Reimbursement redesign is critical to primary care practices engaged in practice transformation and the building of PCMHs. Working collaboratively with payer(s) can begin the process of aligning incentives to support new models of care. For over 2 years, the Palmetto Health/USC FMC practice has worked with a major payer to develop and implement a PCMH Demonstration program. This program has focused on care redesign and payment reform for patients with selected chronic diseases. Following the initial year, dramatic improvements were seen in both practice-based process and outcome measures. Additionally, utilization reductions were demonstrated for emergency department visits and hospitalizations.

Objectives:

1. Describe the elements of collaborative PCMH demonstration projects between a family medicine residency practice and a large state payer
2. List the benefits, challenges, and outcomes of a PCMH demonstration project including disease-specific outcomes and utilization measures
3. Discuss the role of family medicine practices in driving payment reform, including the steps for working collaboratively with a payer

**Room: Regency D**

### **S12: The Lean Approach to Behavioral Health Integration and the Development of Strategies for Successful Implementation**

*Connie van Eeghen, DrPH, Rodger Kessler, PhD, ABPP, University of Vermont*

The integration of behavioral health services into primary care practices is an evidence-based solution to the unmet need for care seen in primary care patients. While a model for “primary care behavioral health” services exists, uptake among primary care practices is not systematic. One approach that may help increase uptake is through an implementation method known as “Lean.” This approach combines the components of the model with a front-line provider and staff-based team for analyzing and improving practice systems. This approach has seen initial success but may meet with organizational obstacles that require additional strategies for implementation. In small-group discussions, participants will examine the application of the model using the Lean approach and will identify key success factors that should be addressed.

Objectives:

1. Identify “Lean” as an implementation method to integrate Behavioral Health Into Primary Care
2. Examine “Lean” outcomes related to behavioral health integration using Lean in Family Medicine
3. Generate examples of integration “Lean” concepts and provide feedback on how to engage clinicians and leaders in their organizations

**Room: Regency E**

### **S13: Tools for Your Team to Engage Patients in Collaborative Care Plans**

*Larry Mauksch, MEd, Berdi Safford, MD, University of Washington*

Participants will learn a team-based model to create a collaborative care plan developed in a multi-site family practice in Washington State. Participants will be taught evidence-based time management, goal setting, and action plan development skills. Applications of the electronic health record that support patient engagement, team member training, and team communication with one another and with patients will be presented. This is a highly interactive session that includes the use of team-based learning, skill practice, skill rating forms, and discussion.

Objectives:

1. Explain team designs to engage patients in goal setting and action planning
2. Describe EHR tools and design features to efficiently engage patients in self-management
3. Apply a team-training model to use in their sites of practice

**Room: Dogwood**

Join the conversation on Twitter: #CPI12





# Saturday, December 1

## **S14: Aiming Higher: Because Fitness Is Always Good Medicine!**

*Janet Ann McAndrews, MPH, CHES, AIM-HI/Public Health, Leawood, KS; Yvette Rooks, MD, FAAFP, CAQ, Baltimore, MD*

AIM-HI challenges physicians to address their own personal fitness activities, assess the messages the physicians, staff, and office environment send to patients concerning physical activity, healthy eating, and emotional well-being and engage in helping promote fitness at the individual, family, and community levels. A critical caveat of the AIM-HI philosophy is that it is patient directed rather than prescriptive, meaning the delivery of the message is as important as the message itself. AIM-HI promotes a non-diet approach to healthy eating, a small changes/lifestyle-based approach to physical activity with attention to the emotional aspects of daily living and particularly sustained behavior change. AIM-HI encourages the family medicine practice to adopt this version of fitness as the treatment of choice for all patients and their communities.

Objectives:

1. Role model fitness concepts of AIM-HI, the tools used with patients and the need for a patient-centered conversation.
2. Explain how to affect the fitness of their patients by implementing the AIM-HI approach within their practice location.
3. Describe practical, real-time tips and tactics to implement immediately.
4. Design a culture of fitness within the practice that permeates the physical environment.

**Room: Regency F**

## **S15: The Construction Crew: Rolling Out the Blueprints for Your Medical Home, Then Remodeling**

*Stephen Salanski, MD, Donna Forgey, PhD, Research Family Medicine Residency, Kansas City, MO; Cindy McHenry, RN, BSN, Goppert Trinity Family Care, Kansas City, MO*

As we come together to form our medical home teams, it can be a challenge to engage the entire office. This seminar will discuss how our residency program formed our Construction Crew leadership team and brainstormed a unique and innovative way to explain the patient-centered medical home (PCMH) and helped our colleagues become engaged in the process. Come experience firsthand as we recreate our PCMH carnival-like setting of our kickoff event.

Objectives:

1. Design a plan to engage and involve the entire office in an interactive event to begin Patient Centered Medical Home activities.
2. Identify obstacles to change that must be overcome when creating patient-centered teams, and strategies to overcome them.
3. Describe methods of ongoing planning and process change to encourage further development of patient-centered medical home team activities.

**Room: Studio 220@NOMA-B**





## **SS2: The Patient-Centered Medical Home in the Context of a New Health System and a New Payment Environment**

*Bruce Bagley, MD, American Academy of Family Physicians, Leawood, KS*

This session will review the high-leverage elements of the patient-centered medical home that will help practices be successful in the new payment environment. Leadership, teamwork, communication, and metrics combine to guide practices into the future with confidence. PCMH pilots have given way to permanent programs from CMS, state Medicaid agencies and commercial payers. The literature has begun to validate the new model, showing better care, better population health, and lower per capita costs. ACOs now dot the landscape and offer both opportunities and threats to family physicians and the traditional conduct of primary care practice. Participants will learn about new practice capabilities including: risk stratified care management/care coordination; patient/family engagement and self-management support; planned care for chronic illness and preventive care; synergistic interactions with the medical neighborhood; and optimal use of information technology.

### Objectives:

1. Be familiar with the macro changes in the health care system and the implications for practice and payment
2. Know the important characteristics of the successful family medicine practice of the future
3. Share experiences and plan strategies for change during this interactive session

**Room: Studio 220@NOMA-A**

## **Now you can provide a complete allergy testing and immunotherapy service line.**



Your patients no longer have to suffer from seasonal allergies and you don't have to risk losing them by referring out to specialists.

### About United Allergy Services:

- We hire and train a Certified Clinical Allergy Specialist to test, educate and custom build immunotherapy under the supervision of the on-site physician.
- Provide all supplies and materials related to the service line.
- Focus efforts on patient safety, patient compliance and patient outcomes.
- Allow you to treat allergy patients rather than cover their symptoms with medications.

**UnitedAllergy**<sup>SERVICES</sup>  
Testing for a better quality of life.

Interested in becoming a UAS Allergy Center? Visit [www.UnitedAllergyServices.com](http://www.UnitedAllergyServices.com) or call 210.265.3181.



# Saturday, December 1

**2:45–3:15 pm**

## **Papers**

### **PA18: Utilization of Patient-Centered Medical Homes in an Industrial Setting**

*Edward Bujold, MD, Family Medical Care Center/National Research Network, Granite Falls, NC; Cathie Pettit, BS, MBA, Direct Net, LLC, Hickory, NC*

Three self-insured industries in Hickory, NC have struggled with health care costs for years. Numerous “carrots” were in place to entice employees into getting their required preventive care without success. In 2010, one of these industries started a pilot project that embraced the patient-centered medical home. Each employee was assigned a PCMH provider. A bio-risk assessment was done on each employee. Employees were then required to meet with their primary care provider for ongoing preventative care and chronic disease management. In 2010, there were 527 gaps in care. In 2011, there were eight gaps in care. ER visits dropped 37%. Prescription drug costs dropped 21%. Total medical plan costs dropped 5%. Employer, employee, and physician satisfaction rose.

Objectives:

1. To gain an understanding of the difficulty employers face in the world economy trying to compete in a market place with slim profit margins and ever rising health care costs. Employers want to provide health care to their employees but not at the risk of closing their doors. Not offering any insurance to their employees becomes a real possibility.
2. Utilizing PCMH concepts can lower health care cost, improve employee health, and help industry become more competitive in the market place.

**Room: Dogwood**

### **PA19: Cultivating Diabetes Care Coordination in a Family Medicine Residency Program Patient-Centered Medical Home**

*Margot Savoy, MD, MPH, FAAFP, CPE, Mark Sanford, RN, CDE, Deborah Hoffman, MSN, ANP, BC, Karen Anthony, MS, Michael Rosenthal, MD, Christiana Care Health System, Wilmington, DE*

In 2011 the Family Medicine Centers became the first National Committee for Quality Assurance-recognized patient-centered medical homes in Delaware. Our practice redesign identified a need for closer monitoring of our diabetic patients, improved provider communication about their active diabetic patients, and linking high-risk patients with available resources. In March, 2011 we welcomed a 0.5 FTE diabetes care coordinator to our patient care team. Over the first 10 months of clinical care he offered visits to 150 unique high-risk diabetic patients of which 115 arrived for one or more visits. He provided 139 face-to-face visits and over 140 documented phone calls. Our presentation will review the evolving job description, preliminary outcomes, challenges, and our expansion project slated for July 2012.

Objectives:

1. Explain the rationale for providing care coordination for high-risk patients with chronic diseases
2. Identify potential challenges encountered when beginning a care coordination project within a family medicine residency program practice
3. Locate resources for establishing care coordination programs within family medicine residency practices

**Room: Regency E**

Join the conversation on Twitter: #CPI12



## **PA20: The Relationships Among Patient Socioeconomic Status, Patient Satisfaction, and Patient-Centered Communication**

*Susan Labuda-Schrop, PhD, Brian Pendleton, PhD, Northeast Ohio Medical University; Timothy Gallagher, PhD, Kent State University*

The therapeutic efficacy of the patient-physician interaction is of central importance in primary care. Many factors impact the patient-physician interaction, which can affect patient satisfaction and ultimately affect health outcomes. Patient-centered communication and patient satisfaction are key indicators in the patient-centered medical home model. This paper presentation will present the results of research that examined the relationship between patient socioeconomic status and patient satisfaction and determined the mediating effect of patient-centered communication on the relationship.

Objectives:

1. Discuss the relationship between patient-socioeconomic status and patient-physician communication.
2. Discuss the relationship between patient-socioeconomic status and patient satisfaction.
3. Discuss if patient-centered communication mediates the relationship between patient socioeconomic status and patient satisfaction.

**Room: Studio 220@NOMA-A**

## **PA21: Resident-Led Interventions Leading to Quality Improvements in a Patient-Centered Medical Home**

*Jeff Cashman, MD, Janice Brown, MD, AnMed Health Family Medicine Residency, Anderson, SC*

Establishing quality improvement is a process that involves a team approach from all involved in an office setting. At AnMed Health Family Medicine Residency Program it was determined that improvement could be made on multiple measurements of chronic diseases. A Quality Improvement Initiative was established in our practice made up of 27 residents and 10 physicians and one APRN. Bi-monthly meetings were held with progress toward goals evaluated. During these meetings, residents led groups of physicians to determine interventions that would improve care and outcomes. The purpose of this presentation is to show our methods, results, and suggestions toward implementing resident-led interventions to obtain quality care in a patient-centered medical home.

Objectives:

1. Ideas on how residents can lead quality improvement in an office-based PCMH program.
2. Understanding of the complications and limitations of resident-led improvement of quality initiatives.
3. Evaluate our use of interventions to increase quality in patient care.

**Room: Think Tank@NOMA**

## **PA22: Pain Pain Everywhere: How to Teach and Protect Our Patients, Staff, Residents, and Faculty**

*Janis Coffin, DO, Georgia Health Sciences University*

There are more Americans suffering from chronic pain than from diabetes, heart disease, and cancer combined; the estimated health care cost for chronic pain is estimated to be \$635 billion. In 2001, prescription drug abuse and misuse were estimated to impose \$100 billion annually in health care costs. There are adoptions of new pain management rules from state to state. First Assistant US Attorney John Horn stated, "These clinics are proliferating because they lack a database to track the dispensing of prescriptions, and they need stricter guidelines." As teachers of family medicine, we must teach the state laws and rules governing the prescribing of controlled substances and awareness of patient behaviors that may signal abuse and recognize the importance of expectations and documentation regarding these scheduled medications.

Objectives:

1. Awareness of patient behaviors that may signal abuse/diversion
2. Familiarity with State Law and Rules governing the prescribing of controlled substances
3. Recognize the importance of documentation.

**Room: Regency F**



## **PA23: Improving the Process From Hospital Discharge to Follow-Up in a Family Medicine Residency Program**

*Cynthia Ripsin, MD, Yun Kim, MD, Nathan Rylander, MD, University of Texas, Southwestern*

Follow-up after hospital discharge is an important part of maintaining the care continuum and can identify modifiable factors so patients successfully remain at home. We developed a program to increase patient follow-up and decrease the interval between hospital discharge and follow-up. A registered nurse from our clinic reviews all discharges with patients on the day of discharge, then monitors patients until follow-up is achieved. Compared with data from January through October 2011, the no-show rate for follow-up appointments dropped from 50% to 18%, and the average length from hospital discharge to follow-up decreased from 8 to 5 days. We will provide details of our program and walk through a brief exercise of applying this program to diverse work sites.

Objectives:

1. List the key evidence that supports timely hospital discharge follow-up.
2. Adopt and/or adapt a process to improve hospital follow-up that suits their unique practice environment.
3. Apply the concept of enabling support staff to work “at the top of their license”

**Room: Regency D**

## **PA24: Use of a Tobacco Registry and Clinical-Support Tool in a Primary Care Clinic**

*Dana Neutze, MD, PhD, Carol Ripley-Moffit, MDiv, Mark Gwynne, DO, Adam Goldstein, MD, University of North Carolina, Chapel Hill*

Tobacco use is the leading preventable cause of death and disability in the United States yet it is still inadequately managed in primary care clinics. Although providers ask about tobacco use and recommend cessation, less is done to assist patients interested in quitting. This study implemented a tobacco-use registry and decision-support tool in a primary care clinic to improve the number of referrals to both a quitline and a cessation program, counseling by providers, and use of cessation medications. Additionally, preventive care, consisting of pneumococcal vaccination and aortic aneurysm screening, was incorporated into the decision-support tool. Preliminary data indicate the intervention has led to increases in the number of referrals to the quitline and cessation programs as well as billing by providers for counseling services.

Objectives:

1. Integrate the five A's of behavior modification into routine clinical practice
2. Establish a streamlined and standardized approach to providing care to all tobacco users
3. Improve coding and billing for counseling services provided

**Room: Gardenia**

## **PA25: Beyond the Huddle and Toward the Goal Line: Flowstations to Improve Patient Cycle Time**

*Lauren Simon, MD, MPH, Kelly Morton, PhD, William Jih, MD, Loma Linda University*

Inefficient processes in outpatient clinics can lead to long patient cycle times, non-patient-centered care, decreased productivity, and reduced revenues as well as poor staff, physician, and patient satisfaction. Patient cycle times were assessed in an academic family medicine practice using Toyota “Lean” principles to identify inefficient processes that contributed to long patient wait and cycle times. A multidisciplinary process-improvement team addressed this problem by developing flowstations to improve efficiency and reduce patient cycle time.

Objectives:

1. Describe how Toyota “Lean” principles can be used to reduce patient cycle time.
2. Design a patient cycle time instrument.
3. Describe how flowstation use reduces patient cycle time.

**Room: Studio 220@NOMA-B**



## **PA26: Impact of a PCMH Rotation on Residents' Skills and Engagement in PCMH Practice Transformation**

*Lindsay Botsford, MD, MBA, Zynab Hassan, MD, Rebecca Hart, MD, San Jacinto Methodist Hospital, Baytown, TX*

Our community-based, 8-8-8 family medicine residency program embarked on its journey to transform our Family Medicine Center to a PCMH in 2012. As part of this process, we introduced a 4-week rotation for second-year residents focused on teaching the skills needed to work in a patient-centered model of care with varying patient needs and changing care technologies. The rotation involves didactics, interactive online modules, shadowing in advanced access practices, a continuous performance improvement project, assigned readings as well as teamwork and leadership skills. Our first set of residents will complete the rotation in July 2012. Pre- and post-assessments will assess learner's knowledge of PCMH concepts in the six standard categories and their attitudes toward practice in a PCMH before and after the rotation.

Objectives:

1. Design educational experiences for residents that model the six standard categories of a PCMH.
2. Assess the effectiveness of a PCMH rotation in improving residents' skills in PCMH concepts and attitudes toward practice in a PCMH.
3. Apply new concepts in resident education to help facilitate practice transformation.

**Room: Redbud A-B**

### **3:30-4:30 pm**

## **Lectures**

### **L31: Partnering With Universities and Colleges to Facilitate the PCMH Process**

*R.W. Watkins, MD, Community Care of North Carolina, Blowing Rock, NC*

One of the major challenges to promoting the PCMH recognition process within a practice is allocating practice resources. Most estimates of the time it will take to complete the PCMH process are between 100 and 200 hours. Community Care of North Carolina (CCNC) has developed an innovative program with the Appalachian State University College of Health Sciences and their School of Health Care Management to take junior and senior college students and place them within local primary care offices to help those practices through the PCMH process. This lecture will explore what is needed to expand this concept to a local college or university in any practitioner's area to help local practices facilitate the PCMH process.

Objectives:

1. Use the concepts discussed to partner with a local college or university to develop a program to facilitate the PCMH recognition process in their area.
2. Identify the components needed to develop a local program to facilitate the PCMH recognition process.
3. Use CCNC resources and personnel to increase the likelihood of success when promoting a local initiative to increase PCMH recognition in their area.

**Room: Gardenia**

#### **Using QR Codes to Access the Conference Mobile Site**

QR Codes, like the one below, are used to easily link smartphone or tablet users to information on the web. You need special software to scan the codes. Search your smartphone or tablet's app store for "QR Code Reader." Once installed, the software will use your device's camera to scan the code.

Aim your mobile device at this block to scan and access the mobile site for the Conference on Practice Improvement.





# Saturday, December 1

## **L32: Longitudinal Intern Project on Application of Practice Improvement Methods**

*Michele Stanek, MHS, University of South Carolina; Charles Carter, MD, FAAFP, Palmetto Health Alliance-University of South Carolina, Columbia, SC; Patricia Witherspoon, MD, Sharm Steadman, PharmD, University of South Carolina*

Over the past 3 years, interns have participated in a longitudinal quality improvement QI project. The residency's quality improvement team selects a QI project that supports the overall quality goals of the residency program. The current project focuses on improving the identification and management of depression for patients with chronic disease. Previous projects have focused on diabetes standing orders and the prevention of hospitalizations for patients with congestive heart failure. During their community medicine rotation, interns complete web-based didactic training in QI methods, receive face-to-face instruction in developing and implementing change strategies, test an improvement strategy in the practice using the PDSA model, and present their findings at a monthly practice-wide meeting. The impact of the improvement project is measured throughout the year-long project.

Objectives:

1. Describe the essential elements of a longitudinal QI program required for interns to learn practice-based QI methods
2. Evaluate the outcomes of intern longitudinal QI projects conducted in 2010, 2011, and 2012
3. Discuss the introduction of QI methods and practical training during the PGY1 year and the impact this has on overall resident training in practice improvement

**Room: Think Tank@NOMA**

## **L33: Effective Implementation of Embedded Care Management Within Primary Care**

*Sherry Hay, MPA, Timothy Daaleman, DO, MPH, Amy Prentice, P-LCSW, Mark Gwynne, DO, University of North Carolina, Chapel Hill*

The patient-centered medical home model promotes coordinated and integrated care as a core principle. Although integrating care management into primary care has been proposed as a potentially powerful strategy for improving chronic disease management and the quality of care, the effective implementation of embedded care management in busy primary care practices is poorly understood. We describe an implementation process of embedding care management into a large academic family medicine center. Key factors in effective implementation included a clearly defined role for an advanced practice primary care social worker, provider education and buy-in, and building a system for communication and documentation. Preliminary outcome measures suggest that implementation resulted in reduced ED utilization, high provider and patient satisfaction, and improved utilization of community resources.

Objectives:

1. Describe the components of care management in primary care and define roles and responsibilities for care management in teaching family medicine centers
2. Summarize barriers and facilitators to implementation of embedded care management in primary care
3. Discuss process and outcome metrics in evaluating the effective implementation of care management in primary care

**Room: Studio 220@NOMA-B**

## **L34: Making It Stick: Improving Patient Recall of Medical Information**

*Scott Tripler, MD, Jordan Silberman, MA, University of Rochester*

Patients forget information provided by physicians at the alarming rate of approximately 50%. Low levels of patient recall may lead to poor adherence and poor outcomes. Simple communication techniques have been shown to improve patient recall of medical information; however, evidence suggests that primary care physicians use these techniques infrequently and unsystematically. To help physicians better utilize recall-promoting techniques, we will provide an overview of the communication strategies that have been shown to be effective. In an interactive format, demonstrations will be given and opportunities to practice useful recall-promoting techniques will be provided. The presentation will provide actionable information that primary care physicians can use to communicate more effectively and increase patient recall.

Objectives:

1. Describe evidence-based strategies for improving recall in adult patients
2. Apply strategies for recall promotion in the context of patient care
3. Provide a forum for sharing pedagogical strategies that may be useful for improving patient recall

**Room: Regency F**





### **L35: Safely Home: Improving Transitions of Care**

*Bethany Picker, MD, Jen Fish, LSW, Central Maine Medical Family Medicine Residency, Lewiston, ME*

All transitions of care have inherent risk, but the transition from acute hospitalization to home is fraught with potential errors: new diagnoses, medication changes, pending results, consultations, and confusing follow-up. Learning from colleagues at larger medical centers, we now have a post-hospital discharge group visit at our community family medicine residency program. The Safely Home program is open to all FMR patients discharged during the week. Patients are seen in succession by the attending physician responsible for the inpatient care, a pharmacist, psychologist, social worker, and nurse educator. Early results show improved measurable outcomes. We will explain the resources we have invested and steps necessary to recreate a similar program at other sites.

Objectives:

1. Identify the risks involved with the transition of hospital discharge
2. Summarize possible components of a hospital discharge group and evidence for each component.
3. Evaluate a template to recreate a similar program at their home institution

**Room: Regency E**

### **L36: Money Talks. Are We Listening? Structuring Physician Compensation in Our Patient-Centered Medical Homes**

*Jennifer Lochner, MD, Beth Potter, MD, Sandra Kamnetz, MD, University of Wisconsin, Madison*

With new models of health care delivery systems such as the patient-centered medical home on the horizon, an operational issue that has received little attention is the structure of primary care physician compensation. In this session we will explore current physician compensation models and research regarding their relationship to various measures of physician performance including traditional measures of productivity and quality of care. We will use our experience with the recent revision of the University of Wisconsin Department of Family Medicine's physician compensation plan to stimulate debate on potential components of compensation plans. Participants will be asked to reflect on their own organization's compensation model with an eye toward preparing for new models of care, incentivizing quality, and different kinds of clinical work.

Objectives:

1. Describe the benefits and drawbacks to the inclusion of various productivity and quality measures in a physician compensation plan
2. Analyze the structure of physician compensation in general and in my organization in specific
3. Devise compensation formulas for their organization to fit future payment models and care delivery models such as the patient-centered medical home

**Room: Regency D**

### **L37: Integrating Family Caregivers Into Primary Care to Improve Patient Outcomes**

*Cynthia Henderson, RN, CCM, BS, ADN, Deborah Billa, MS, Well Med Charitable Foundation, San Antonio, TX*

The integration of family caregivers into the health care arena is critical to improving, or maintaining, the health of our patients. Discover how simple, reliable tools can build a network of appropriate referrals between primary care providers and a community-based caregiver program. This session will provide insight into a program developed in a multi-site primary care practice to identify stressed caregivers and connect those caregivers to a support program, resulting in referrals for respite care, stress management, and other community-based services. The program has produced engaged caregivers who actively contribute to the successful self-management of their family members.

Objectives:

1. Describe how family caregivers can be integrated into a health care setting
2. Evaluate whether the tools used for caregiver assessment and referral would be pertinent in their care setting
3. Justify if the program described during this presentation could be adapted to their care setting

**Room: Redbud A-B**

Join the conversation on Twitter: #CPI12



# Saturday, December 1

## **L38: Working With a Payer to Improve Cardiovascular Outcomes Through a COSEHC CQI Project**

*JaNae Joyner, PhD, COSEHC, Winston Salem, NC; E.G. Ulmer, MD, CPC, Spartanburg Regional Healthcare System, Spartanburg, SC; Michael Moore, MD, Carlos Ferrario, MD, David Carmouche, MD, Debra Simmons, RN, MS, COSEHC, Winston Salem, NC*

COSEHC recently partnered with a payer to improve physician performance in achieving cardiovascular therapeutic target goals. A continuous quality improvement process applying the JNC-7 and ATP III goals was used as the major intervention. Additional NCQA DRP-required data elements were collected and analyzed. The customized process improvement/CME program included modules on evidence-based treatment algorithms, physician-patient relationship and goal setting, lifestyle modifications, and use of the PDCA process. The practices' patient population and various subpopulations included in the baseline will be tracked for 1 year measuring changing in performance quarterly. Project results will be shared. Implementation of this CQI project to date raises awareness among enrolled practices of their performance gaps and leads to the improvement in achieving target goals and eventual NCQA DRP certification.

Objectives:

1. Describe the design and implementation of a cardiovascular disease model for process improvement CME(PI-CME) and NCQA Diabetes Recognition Program (DRP) attainment
2. Discuss best practices in creating cardiovascular disease targeted PI-CME activities that are eligible for maintenance of certification
3. Identify what cardiovascular clinical markers can be used to measure physician/provider performance

**Room: Dogwood**

## **L39: PCMH: The Catalyst to an Effective Medical Neighborhood Model With Primary Care and Subspecialty**

*Pete Moyer CCLS, MHCL, Tracy Hartman, MHA, CPHQ, TransforMED, Leawood, KS*

This session will highlight a PCMH project that expanded from primary care to building an effective medical neighborhood in a community with independent primary care and subspecialty practices. This will include the discussion of the structure used to build engagement and the process of establishing a collaborative network that defined effective communication and partnerships. The session will include sharing of tools used and interactive dialogue to facilitate developing action steps for your practice.

Objectives:

1. Identify the characteristics of team that apply to the medical neighborhood
2. Discuss success factors in one community's efforts to build a medical neighborhood with independent sub-specialty and primary care practices
3. Develop a medical neighborhood strategy for your clinic and/or community that includes specific action steps

**Room: Studio 220@NOMA-A**

## **4:45-5:15 pm**

### **Papers**

#### **PA27: Value Added Pain Clinic Model**

*David Marchant, MD, Tasha Ballard, PhD, RN, Fort Collins Family Medicine Residency, Fort Collins, CO*

Using principles outlined in Innovators Prescription, our clinic has worked on a model for delivery of high-quality, cost-effective pain management for our populations. Moving into our second year of this process we can readily see that we will have the entire pain population managed in this new way within this calendar year. We use group visits, volunteers, outside speakers, integrated services, and case management. We will describe in this presentation our methods and provide suggestions for implementation in other sites. We have improved provider satisfaction, patient satisfaction, resident education, and improved clinic productivity, as well as have numerous pain patients volunteering in the community.

Objectives:

1. Learn about a novel workable model for chronic pain management in a residency setting
2. Learn how to implement a similar system in their clinic
3. Identify the advantages of this system versus usual care

**Room: Redbud A-B**



## **PA28: Decreasing BMIs Through the Use of a Personal Trainer**

*Robert Hanlin, MD, Jeffery Swartz, MD, Chae Ko, MD, Greenville Family Medicine Residency, Greenville, SC*

Obesity is an epidemic that affects 33.8% of US adults. This epidemic carries known risk factors for a myriad of diseases including but not limited to diabetes, hypertension, hyperlipidemia, and cardiovascular and pulmonary diseases. We enrolled 16 obese patients (defined as a BMI of 30 or greater) into a 12-week pilot prospective personal training program. Individuals met with an athletic trainer who was able to provide nutritional, instructional, and exercise counseling every week for 12 weeks at our exercise and conditioning club. These individuals then followed a personal training manual during their daily work-out sessions.

Objectives:

1. List benefits of having an athletic trainer assist patients in a weight loss program.
2. Describe common barriers to behavior change in patients.
3. Develop one strategy for addressing barriers to behavior change in patients.

**Room: Studio 220@NOMA-B**

## **PA29: Focused Anticoagulation Service in Family Medicine Residencies**

*Ivy Click, MA, East Tennessee State University, Johnson City; Emily Flores, PharmD, BCPS, Douglas Rose, MD, East Tennessee State University, Kingsport*

Patients requiring anticoagulation therapy pose unique issues requiring a systematic approach to their care, balancing the potential benefit from therapy with possible adverse events. Here, we describe a model that helps to standardize both the care received by patients on anticoagulation therapy as well as the training of family medicine residents caring for those patients. A team-based model of care (family medicine residents, clinical pharmacists, and nurses) is used to achieve the goals of improved care and education. Clinical pharmacists are used in concert with family medicine residents and attendings to assess patients' medication profiles and help direct patient care and resident learning. Both the idea itself and the formal structure are presented in a model for possible adaptation to other programs.

Objectives:

1. Describe common obstacles to care for ambulatory anticoagulation patients.
2. Describe systematic approaches used to combat common obstacles to care for ambulatory anticoagulation patients.
3. Describe educational approaches used to improve family medicine residents' understanding of anticoagulation care provided to ambulatory patients.

**Room: Gardenia**

## **PA31: Resident Dashboards: Providing Data That Matters**

*Bethany Picker, MD, Donald Woolever, MD, Central Maine Medical Family Medicine Residency, Lewiston, ME*

Because we live in a time when we are required to measure more outcomes, it becomes increasingly important to teach residents in this same manner. For residents to be prepared for management of patient panels and understand their work product they need to be provided with timely information that is easy to access and workable. At the Central Maine Family Medicine Residency we have developed a monthly dashboard that provides residents with this information. Since beginning this report, residents have demonstrated increased accountability for the volume of patients they see, ensuring they have availability for their own panel of patients, and they have been increasingly engaged in systems approaches to improving care.

Objectives:

1. Describe the importance of measurement in practice and how this measurement can positively influence behavior
2. Identify three to five measurements that would improve physician understanding of their own work product
3. Working framework for a dashboard for their own teaching or practice environment

**Room: Studio 220@NOMA-A**



## PA32: Hypertension Screening in Healthy Average Risk Adults: Contrasting Current Practice With Annual Screening

Gregory Garrison, MD, Sara Oberhelman, MD, Mayo Family Medicine Program, Rochester, MN

Screening for hypertension is universally advocated, but little objective information regarding best practices and screening intervals for healthy ambulatory patients exists. Following JNC-7 recommendations for screening blood pressure annually was hypothesized to improve specificity over the usual practice of checking blood pressures at every visit. A retrospective case-control study of 536 patients was conducted. Checking blood pressure at all visits yielded 100% sensitivity (95% CI: 93.2–100%) and 73.7% specificity (95% CI: 69.5–77.7%). Checking blood pressure per JNC-7 recommendations produced 84.8% sensitivity (95% CI: 75.0–91.9%) and 84.2% specificity (95% CI: 80.6–87.5%). A limited annual screening strategy for hypertension can improve specificity without sacrificing sensitivity when compared to routine screening at every visit in healthy, previously normotensive adults.

### Objectives:

1. Understand the statistical characteristics of good screening strategies
2. Identify the practical sensitivity and specificity of the most commonly used technique for hypertension screening, the office-based manual aneroid sphygmomanometer
3. Implement an evidence-based strategy to effectively screen for hypertension while reducing false-positives and improving office efficiency

**Room: Regency F**

## Center for Integrated Primary Care



- ▶ A national leader in **workforce development** for the integration of behavioral health and primary care, training the team members of the Patient Centered Medical Home (PCMH).
- ▶ Providing **technical assistance** to meet the behavioral health requirements of the PCMH.
- ▶ A center of excellence in the **evaluation** of programs that integrate behavioral health and primary care services.

Visit us at: [www.umassmed.edu/cipc](http://www.umassmed.edu/cipc)  
email: [CIPC@umassmed.edu](mailto:CIPC@umassmed.edu)



Center for Integrated  
Primary Care

55 Lake Avenue North, Worcester, MA 01655  
774.441.8171

Join the conversation on Twitter: #CPI12

**PA33: Integration of Mental Health With Primary Care in a Community Health Center**

*Irshad Syed, MD, Grady Health System, Atlanta, GA; Glenda Wrenn, MD, Morehouse School of Medicine*

We are a neighborhood health center providing primary care to patients in the inner-city community in Atlanta and are a part of the Grady Memorial Hospital, one of the largest public hospitals in the United States. We have nine providers providing adult, child, and OB-GYN care. We have integrated mental health with primary care with an embedded psychiatrist. We also have a child psychiatrist to work with the pediatricians and a psychologist for in-house group and individual sessions. Our goal is to provide patient-centered compressive high quality and integrated care to our patients.

Objectives:

1. Increase access to mental health care within the Primary Care Community Clinic and reduce external referrals for depression and anxiety disorders
2. Educate the primary care providers within the clinic to treat psychiatric conditions using treatment algorithms developed by a psychiatrist connected to the project
3. Have non-stigmatizing treatment options and alternate models of care for patients to receive care in an environment that they feel comfortable in

**Room: Regency E**

**PA34: Evaluation of a Natural Frequency-Based Shared Decision Aid in the Prediabetes Office Visit**

*John King, MD, MPH, University of Vermont*

Effective patient-physician communication includes informed activated partners in care and is an essential component of the patient-centered medical home. This pilot study tested the value of a pre-diabetes office visit with and without use of a visual natural frequency-based decision-making aid (DMA) designed to assist the family physician and patient in risk communication and self management goal setting related to lifestyle interventions. The difference between usual care and use of the DMA for both patients and physicians concerning knowledge of the risks of pre-diabetes and the benefits of lifestyle intervention, changes in patients' perceived communication effectiveness, decisional conflict, self efficacy, and intent for healthier lifestyle adoption. The use, perceived value, and feasibility of the DMA from the physicians' perspective will be reported.

Objectives:

1. Describe the risk of developing diabetes in the typical patient with pre-diabetes and the range of risks of heart disease and stroke in the population in this study.
2. Describe the components of a decision aid based on the International Patient Decision Aids Standards and how one might be used in an electronic health record.
3. Describe how this decision aid performed for patient and physician in risk communication and self management goal setting in pre-diabetes.

**Room: Regency D**

**PA35: Reducing the "Pain" of Chronic Pain Management**

*Lauren Simon, MD, MPH, Kelly Morton, PhD, Diana Sepehri-Harvey, DO, MPH, Loma Linda University*

The management of chronic non-cancer pain in the ambulatory clinic can be a source of frustration in a primary care group practice as clinicians use varying therapies and prescribing practices that may not be readily identified in the medical record. Clinician cross-coverage for opioid prescriptions, appointments and refills, pain reduction, and functional reassessment must be clearly communicated across the patient care team. The use of a consistent pain management tool can greatly enhance communication via standardized documentation of pain management progress and risk assessment for patients using opioid medications and improve clinician satisfaction with cross-coverage for those patients.

Objectives:

1. List the expanded "Four A's" of chronic, non-cancer pain surveillance for patients using opioid prescription.
2. Describe core elements of a pain management tool to promote team-based care of patients using opioid prescriptions for chronic, non-cancer pain
3. Provide a systematic framework for clinicians to improve management documentation and cross-coverage for patients using opioid prescriptions for chronic non cancer pain

**Room: Dogwood**





**8-9 am**

## **Lectures**

### **L40: Practice Transformation: Lessons Learned on the Journey From Disease-Specific Collaboratives to Patient-Centered Medical Home**

*Ronald Adler, MD, FAAFP, University of Massachusetts*

Beginning in 2008, a program to enhance the provision of care to patients with diabetes was implemented. Foundational elements included quality improvement interventions, team-based care, and population health management. After meeting with early success, the program was expanded to address hypertension and CAD. It eventually reached >15,000 patients served by 150 clinicians (including 45 residents) in 20 practices. In May 2011, the program evolved to focus on transforming four practices (including one residency site) to PCMHs. This required a substantial increase in the depth and breadth of change, and numerous challenges were encountered: inertia, change fatigue, and compelling competing priorities. This session will review the ways in which these challenges were addressed, including leadership responsibilities, change management strategies, staff/team development, and shared baseline protocols.

Objectives:

1. Identify local assets and threats with the goal of articulating a gap analysis for proposed practice transformation work
2. Create a plan for challenges and obstacles that are likely to be encountered on the practice transformation journey
3. Develop and implement strategies for guiding practice transformation in their own work setting

**Room: Redbud A-B**

### **L41: What It Takes for Parallel Transformation of the Practice and the System**

*Bruce Bagley, M.D., Tracy Hartman, MHA, CPHQ, TransforMED, Leawood, KS*

Managing change effectively is the foundation for system and practice transformation. This session will focus on a FQHC experience with practice and system change happening simultaneously. This will include the use of effective metrics to drive change, validate success, and impact sustainability. This session will focus on one system and one clinic experience but will include case study discussions of transformation efforts in a number of systems and practice settings that highlight various factors that impact change. These include leadership roles, aligning incentives, use of metrics, and examples of how significant obstacles were overcome.

Objectives:

1. Identify key characteristics of culture in a system and a practice that impact change
2. Use culture metrics to drive change, system metrics to validate system success, and key practice metrics to ensure value to the patient
3. Evaluate transformation efforts in a variety of system and practice sessions

**Room: Regency D**

### **L43: Behavioral Screening Tools: Implementation in the Clinical Setting**

*Joane Baumer, MD, John Peter Smith Family Medicine Residency, Fort Worth, TX*

Screening for behavioral health conditions within a primary care population is a relatively new prevention and health promotion initiative in health care. The USPSTF has reviewed screening recommendations for alcohol misuse, dementia, depression, obesity, family and intimate partner violence, and tobacco use. This presentation provides behavioral screening tools that are best suited for the clinical office practice and includes associated clinical practice process changes in the PCMH. They enable provision of evidence-based medicine and add a standardized approach for assessing and understanding the behavioral health functioning of patients in all age groups. Incorporating behavioral health screening into clinical practices not only enhances clinical assessment but brings team-based practices and quality improvement processes into focus for residents, students, and providers.

Objectives:

1. Identify the rationale and evidence for incorporating behavioral health screening tools in clinical practice
2. Describe the range of reliable behavioral health screening tools ranging from pediatric to seniors patients
3. Explain how to address team roles and responsibilities in incorporating behavioral health screening into clinical practices

**Room: Regency F**





## 9:15-10:15 am Closing General Session

**Room: Regency Ballroom**



### **Redefining the Payer-Physician Relationship**

*Bruce Nash, MD, MBA, senior vice president and chief medical officer, Capital District Physicians' Health Plan, Albany, NY*

It has been well documented that the United States has the most expensive health care delivery system in the world and that we are not getting the quality outcomes we desire. It has been demonstrated that societies with strong primary care infrastructures achieve better outcomes at a lower cost. If we are to strengthen primary care, we need to make it a more attractive career choice for graduating medical students and improve the experience of practicing physicians. In this session, we will examine how redefining the payer physician relationship from its historic, transactional roots to one that supports innovation and evidenced-based care can positively affect both family medicine as a discipline, as well as our American health care system.

#### Objectives:

At the end of this session, participants will be able to:

1. Understand what they need to do to be prepared to prosper in a post health reform environment.
2. Gain exposure to alternative reimbursement models that align payment and value.
3. Understand what they need to do to be better prepared for informed conversations with payers.

Bruce Nash, MD, MBA, is the senior vice president for medical affairs and chief medical officer of Capital District Physicians' Health Plan (CDPHP). He is responsible for the strategic direction and operations of medical management and quality improvement initiatives at CDPHP. He also oversees the contracting process for all of CDPHP's facility and provider network. Dr Nash has been active in developing a nationally recognized initiative focused on the transformation of primary care. He has been responsible for the deployment of a unique payment model that aligns financial incentives with physicians who have committed to the principles of patient-centered medical homes.

Dr Nash practiced for more than 20 years in the upstate New York area. He also served as president, North Adams Regional Hospital; vice president, medical affairs, Northern Berkshire Health System; and had a 19-year tenure with Community Health Plan and Kaiser Permanente in Latham, NY, and Oakland, CA.

Dr Nash earned a master's degree of business administration in health sector management from the Fuqua School of Business of Duke University; a medical degree from Albany Medical College; and a bachelor's of science degree in biology from Rensselaer Polytechnic Institute. He completed his medical residency in family practice at Duke University, is Board certified by the American Board of Family Medicine, and is a clinical assistant professor at Albany Medical College. He also serves as chair of the Medical Directors' Council of the Alliance of Community Health Plans, and is a member of the Executive Committee of the Board of that organization.

#### **Using QR Codes to Access the Conference Mobile Site**

QR Codes, like the one below, are used to easily link smartphone or tablet users to information on the web. You need special software to scan the codes. Search your smartphone or tablet's app store for "QR Code Reader." Once installed, the software will use your device's camera to scan the code.

Aim your mobile device at this block to scan and access the mobile site for the Conference on Practice Improvement.



