



Individual Care Management

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Individual Care Management

Overview: The goal of the initiative is to ensure that patients with chronic conditions receive organized and well planned care that will help them to take greater responsibility for their health.

These Blue Cross Blue Shield of Michigan criteria pertain to the individual care management initiative:

Criteria

Met 

- 4.1 Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of the Patient Centered-Medical Home model, the Chronic Care model, and practice transformation concepts
- 4.2 Practice Unit has ability to deliver coordinated care management services with an integrated team of multi-disciplinary providers and a systematic approach is in place to deliver comprehensive care that addresses patients' full range of health care needs
- 4.3 Systematic approach is in place to ensure that evidence-based care guidelines are established and in use at the point of care by all team members of the Practice Unit
- 4.4 At least one chronic condition has been identified for initial focus, and practice has assembled and is monitoring all key clinical data, clinical outcomes measures, process measures, and patient satisfaction/office efficiency measures
- 4.5 Action plan development and self-management goal-setting is systematically offered to all patients with the chronic condition selected for initial focus
- 4.6 A systematic approach is in place for appointment tracking and generation of reminders for all patients with the chronic condition selected for initial focus
- 4.7 A systematic approach is in place to ensure that follow-up for needed services is provided for all patients with the chronic condition selected for initial focus
- 4.8 Planned visits are offered to all patients with the chronic condition selected for initial focus
- 4.9 Group visit option is available for all patients with the chronic condition selected for initial focus (as appropriate for the patient)
- 4.10 Medication review and management is provided at every visit for all patients with chronic conditions

- 4.11 Action plan development and self-management goal-setting is systematically offered to all patients with chronic conditions or other complex health care needs
- 4.12 A systematic approach is in place for appointment tracking and generation of reminders for all patients
- 4.13 A systematic approach is in place to ensure follow-up for needed services for all patients
- 4.14 Planned visits are offered to all patients with chronic conditions
- 4.15 Group visit option is available to all patients with chronic conditions

4.0 Individual Care Management

4.1

Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of the Patient Centered-Medical Home model, the Chronic Care model, and practice transformation concepts

Guidelines:

- Training content should include comprehensive information about the Chronic Care Model
 - o Reference information provided at the Improving Chronic Illness Care website: <http://www.improvingchroniccare.org>
- Training/educational activity is documented in personnel or training records, and content material used for training is available for review.

4.2

Practice Unit has ability to deliver coordinated care management services with an integrated team of multi-disciplinary providers and a systematic approach is in place to deliver comprehensive care that addresses patients' full range of health care needs

Guidelines:

- The integrated team of multi-disciplinary providers must include an RN and at least 2 of the following: certified diabetes educator, nutritionist, respiratory therapist, PharmD, social worker, certified asthma health educator or other certified health educator, or an NP and/or PA with training/experience in health education who is actively engaged in care coordination/self-management training separate from their office visit E&M duties
 - o When they are unable to include RNs or PharmDs on the multi-disciplinary care management team, individual practices may use LPNs or PharmD students, in which case these ancillary providers with lesser training must be actively supervised by the physician and/or by a supervising RN or PharmD, respectively, with regard to the educational and care management interventions provided to each individual patient. This supervision may be provided directly in the practice (e.g., by the primary care physician) or by staff employed by the Physician Organization.
- Practice unit team members hold regular team meetings.
- All members of the team do not have to be at the same location or at the practice site, but care delivered by the team must be coordinated and integrated with the PCMH practice.
 - o Care may be delivered by travel teams or at sites other than the PCMH practice, provided that:
 - the care is fully coordinated by a PCMH practice team member or a health navigator who has ongoing communication with the practice
 - the PCMH practice is involved in ongoing monitoring, follow-up and reinforcement of health education/training received by patients at other sites

- monitoring includes proactive outreach to patients to engage the patient in actively addressing ongoing health needs and health care goals on a longitudinal basis
- The multi-disciplinary providers are not required to be employees of the PCMH practice, but must have an ongoing relationship with, and communication with, the practice team members
 - Communication can be a combination of verbal, written, and electronic methods, preferably including some direct verbal communication and participation in in-person team meetings, although individual team members who are not on-site at a practice can make their information and perspective known to specific team members so that their information about individual patients is actively considered by the team as a routine part of case review and planning
- The care management services must be coordinated and integrated with the patient's overall care plan
 - Standard referrals to hospital-based diabetes educators with summary reports sent back to the PCP do not constitute care that is coordinated and integrated, and would not meet the requirements for capability 4.2
 - Referrals to hospital-based diabetes educators that take place in the context of an overall coordinated, integrated care plan and include communication between the diabetes educator and physician, as well as ongoing patient outreach and communication, would meet the requirements for capability 4.2

4.3

Systematic approach is in place to ensure that evidence-based care guidelines are established and in use at the point of care by all team members of the Practice Unit

Guidelines:

- Guidelines are available and used at the point of care by all clinical staff in the Practice Unit
 - Guidelines are activated and used regularly to provide alerts about gaps in care on the Point of Care report or in the EMR
- All members in the practice, including front office staff who work with clinicians and patients, are knowledgeable about the type and length of appointments to book and their responsibilities for preparing resources for visits, based on the guidelines
 - Guidelines are actively used to monitor, track, and conduct outreach to patients to schedule care as needed
- Guidelines are used by PO to evaluate performance of physicians, Practice Units, and PO.

4.4

At least one chronic condition has been identified for initial focus, and practice has assembled and is monitoring all key clinical data, clinical outcomes measures, process measures, and patient satisfaction/office efficiency measures

Guidelines:

- Key clinical indicators relevant to the chronic condition are tracked in the patient registry
- Process of care measures relevant to evidence-based standards for the chronic condition are monitored.
- Patient satisfaction and office efficiency measures (e.g., patient waiting time to obtain appointment, office visit cycle time, percentage of no-show appointments) are monitored
 - o May be based on surveys conducted by the office or information provided by health plans, the PO, or other sources
 - Surveys do not need to focus on single specific chronic condition, providing they are capturing information relevant to all chronic conditions, such as asking about whether the primary practitioner discusses health care goals, diet and exercise, and supports the patient in achieving health management goals
 - o Reference information at Institute for Healthcare Improvement: <http://www.ihl.org/IHI/Topics/OfficePractices/Access/Measures/>
- Evidence-based care clinical outcomes measures are used to track patient health care status

4.5

Development of written action plan and self-management goal-setting is systematically offered to all patients with the chronic condition selected for initial focus, with patient-friendly documentation provided to the patient

Guidelines:

- Physicians and other practice team members are actively involved in working with patients to use self-management goal-setting techniques and develop action plans
 - o Goal-setting should focus on specific changes in behavior (e.g., walking around the block once a day) or concrete, tangible results (e.g., losing 2 pounds) rather than general clinical goals (such as lowering blood pressure or reducing LDL levels)
- Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org/index.php?p=self-management_support&s=39
 - o “The goal of self-management support is to assist and sustain the patient's ability to engage in self-management behaviors that fit within their own life patterns. The creation of a personal action plan is an important way in which providers can support their patients' self-management goals. Another key skill is to help patients learn to solve problems. Patients with chronic conditions must

- manage the illness (such as learning to take medications and monitor the condition)
- carry on normal roles and activities
- manage the emotional impact of the illness”

4.6

A systematic approach is in place for appointment tracking and generation of reminders for all patients with the chronic condition selected for initial focus

Guidelines:

- Evidence-based guidelines are used systematically as a basis for:
 - o Conducting tracking and follow-up regarding missed appointments
 - o Providing patients with mail and/or telephone reminders of upcoming appointments

4.7

A systematic approach is in place to ensure that follow-up for needed services is provided for all patients with the chronic condition selected for initial focus

Guidelines:

- Evidence-based guidelines are used systematically as a basis for:
 - o Following up with patients to ensure that needed services, whether at the PCMH practice site or at another care site, are obtained by the patients

4.8

Planned visits are offered to all patients with the chronic condition selected for initial focus

Guidelines:

- Planned visits consist of a proactive, comprehensive, documented approach to ensure that patients receive needed care in an efficient and effective manner.
 - o Planned visits include the well-orchestrated, team-based approach to managing the patient’s care during the visit, all performed on a routine basis, as well as the tracking and scheduling of regular visits, and the guideline-based preparation that occurs prior to the visit.
- Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org/index.php?p=Planned_Visits&s=48
- “Many healthcare providers believe themselves to already be doing ‘planned’ visits. They note that their patients with chronic conditions come back at defined intervals. Yet upon closer inspection, these visits may look a lot like acute care: the provider might lack necessary information about the patient’s care needs; provider and patient might have different expectations for the visit; and staff may not be fully utilized to help with the organization of the visit and delivery of care. These “check-back” visits, while scheduled in advance, are often not efficient nor productive for the provider and patient.
- Key Components of a Planned Visit
 - o Assign Team Roles and Responsibilities
 - For example, the following questions might need to be addressed: who is going to call the patient to schedule the visit? Who will room

the patient? If the patient has diabetes, who will remove her/his shoes and socks? Who will examine the feet? Who will prepare the patient encounter form for use during the visit? All tasks need to be delegated to specific team members so that nothing is left to chance.

- Call a Patient In For a Visit
 - Develop a script for the call, and decide which team member will make the call. Set the tone and expectations for the issues addressed in the visit.
 - If you choose to mail an invitation to patients, be sure to track respondents. Typically, less than 50% of patients respond to a letter. You will need to plan an alternative method of contacting non-responders.
- Deliver Clinical Care and Self-Management Support
 - In preparation for the visit, print an encounter form from your registry or pull the chart in advance so that you can review the patient's care to date. Document what clinical care needs to be done during the visit.
- Until new roles are well integrated into the normal work flow, many practices have team huddles for 5-10 minutes...to review the schedule and identify chronic care patients coming in that day for an acute care visit. Decide how best to meet as a team to manage these patients. Determine the best intervals and timing for these meetings, and stick to them. The brief get-togethers help the team stay focused on practice redesign and create a spirit of 'one for all'."

4.9

Group visit option is available for all patients in the practice unit with the chronic condition selected for initial focus (as appropriate for the patient)

Guidelines:

- Reference AAFP information on group visits at: <http://www.aafp.org/fpm/20060100/37grou.html>
- Group visits are a form of office visit. (They are not the same as care coordination/care management services, which are follow-up services delivered by non-physician clinicians antecedent to an office visit at which individual treatment and/or health behavior goals have been established.)
- Group visits include not only group education and interaction but also all essential elements of an individual patient visit, including but not limited to the collection of vital signs, history taking, relevant physical examination and clinical decision-making.
 - Group visits differ from other forms of group interventions, such as support groups, which are generally led by peers and do not include one-on-one consultations with physicians.
- The clinician is directly involved and meets with each patient individually
- Members of the care management team may take vital signs and other measurements and assist with individual encounters
- Dietitians or pharmacists may lead educational sessions. Topics such as medication management, stress management, exercise and nutrition, and community resources, may be suggested by the group facilitator or by patients, who raise concerns, share information and ask questions. In programs emphasizing self-management, physicians and patients work together to create behavior-change action plans, which detail achievable and behavior-specific goals that participants aim to accomplish by

the next session. Once plans are set, the group discusses ways to overcome potential obstacles, which raises patients' self-efficacy and commitment to behavioral change. Patients' family members can also be included in these group sessions.”

- Group visits generally last from two to 2.5 hours and include no more than 20 patients at a time.
- Group visits may be conducted in collaboration with other Practice Units

4.10

Medication review and management is provided at every visit for all patients with chronic conditions

Guidelines:

- Chronic conditions under 4.10 are defined as any condition requiring maintenance drug therapy.
- During every patient encounter, a list of all medications currently taken by the patient is reviewed and updated, and any concerns regarding medication interactions or side effects are addressed.

4.11

Action plan development and self-management goal-setting is systematically offered to all patients with chronic conditions or other complex health care needs prevalent in practice's patient population

Guidelines:

- See guidelines for 4.5

4.12

A systematic approach is in place for appointment tracking and generation of reminders for all patients

Guidelines:

- See guidelines for 4.6

4.13

A systematic approach is in place to ensure follow-up for needed services for all patients

Guidelines:

- See guidelines for 4.7

4.14

Planned visits are offered to all patients with chronic conditions prevalent in practice population

Guidelines:

- See guidelines for 4.8



4.15

Group visit option is available to all patients with chronic conditions prevalent in practice population

Guidelines:

- See guidelines for 4.9

Staff pre and post test on Patient-Centered Medical Home

Note: The PCMH PowerPoint™ is under the Patient Provider Partnership tab

1. **What is a Patient-Centered Medical Home (PCMH)?**
 - a) A medical practice organized to produce higher quality care
 - b) A medical practice organized to produce improved cost efficiency
 - c) A personal relationship between patient and physician
 - d) An experience with enhanced access and communication
 - e) All of the above
2. **A PCMH coordinates care across specialties.**
 - a) True
 - b) False
3. **A PCMH makes use of which of the following?**
 - a) Evidence-based medicine
 - b) Clinical decision making
 - c) Health care registries
 - d) All of the above
4. **A PCMH office functions as a team of multi-disciplinary professionals who collectively take responsibility for ongoing patient care.**
 - a) True
 - b) False
5. **Which of the following are goals of a PCMH 'activated patient'?**
 - a) Understand the disease process
 - b) Understand their role as self-manager
 - c) Take an active role in self-management
 - d) All of the above
6. **Benefits of PCMH include which of the following?**
 - a) Improved quality of care
 - b) More efficient use of resources
 - c) Increased patient satisfaction
 - d) Improved office staff satisfaction
 - e) All of the above
7. **A PCMH will result in fewer of the following:**
 - a) Unnecessary emergency room visits
 - b) Inappropriate inpatient admissions
 - c) Less duplication of tests and labs
 - d) All of the above
8. **Goals and action plans are one component of:**
 - a) E-prescribing
 - b) Individual care management
 - c) Performance reporting
9. **If I have the capability to fax prescriptions I have e-prescribing.**
 - a) True
 - b) False
10. **A patient registry manages a population of patients with:**
 - a) Chronic conditions
 - b) Preventive care
 - c) All of the above

Quiz – Answer key

1. E
2. A
3. D
4. A
5. D
6. E
7. D
8. B
9. B
10. C

Staff pre and post test on Chronic Care Model

1. **What is a Chronic Care Model?**
 - a) A model of care that creates an informed, activated patient
 - b) A model that depends on a prepared, proactive practice team
 - c) A model that uses organized health care and community resources
 - d) All of the above
2. **Patients have a central role in their care and take responsibility for their own health.**
 - a) True
 - b) False
3. **What's different about the delivery of care in this model?**
 - a) Not only determine what care is needed also clarifies roles and tasks to ensure the patient gets the care
 - b) All clinical decision makers must have current information on the patient's status
 - c) Follow up is part of the standard procedure
 - d) All of the above
4. **This model uses a registry to manage chronic illness and preventive care.**
 - a) True
 - b) False
5. **Which of the following may be used in the care of patients?**
 - a) State programs
 - b) Local agencies
 - c) Faith organizations
 - d) All of the above
6. **Which of the following are elements of the Chronic Care Model?**
 - a) Community
 - b) Health systems
 - c) Self-management support
 - d) Delivery system design
 - e) Decision support and clinical information systems
 - f) All of the above
7. **Which self-management tools are part of the model?**
 - a) Collaborative goal setting
 - b) Creating an action plan
 - c) Doing problem solving
 - d) All of the above
8. **Deficiencies in caring for chronically ill include:**
 - a) Lack of care coordination
 - b) Lack of follow up to ensure the best outcomes
 - c) Rushed practitioners not following established practice guidelines
 - d) All of the above
9. **The Chronic Care Model is only appropriate for certain diseases.**
 - a) True
 - b) False
10. **Treatment decisions need to be based on proven guidelines:**
 - a) True
 - b) False

Quiz – Answer key

1. D
2. A
3. D
4. A
5. D
6. F
7. D
8. D
9. B
10. A

Chronic Care Model

Staff Education

Tool 4-3

Initiative 4.1



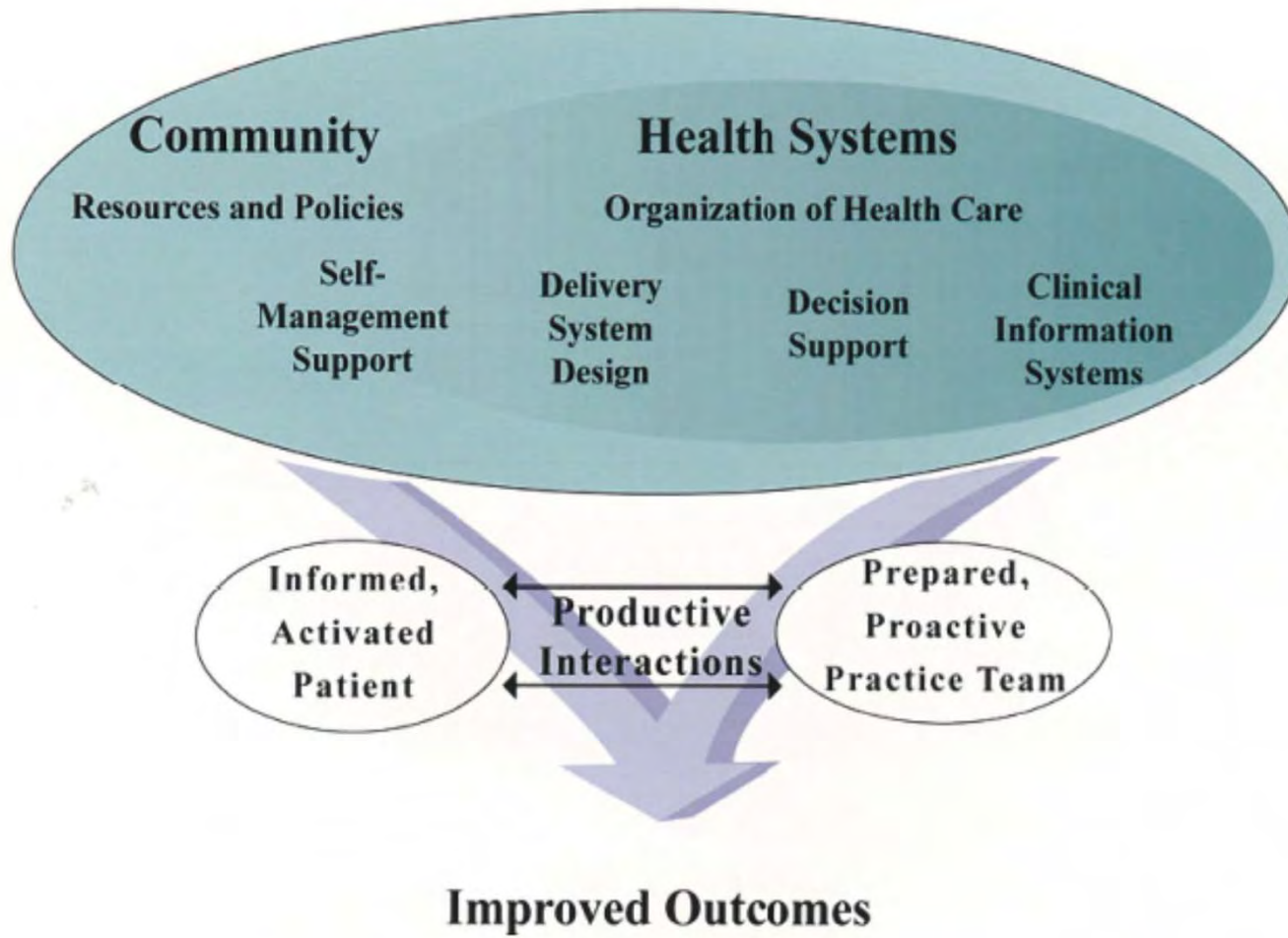
Chronic Care Model

- Consists of 6 key areas that make up a system that encourages high-quality chronic disease management
- Focus is on these key areas and developing productive interactions between patients who take an active part in their care and providers supported by resources and expertise
- Can be applied to a variety of health care settings, chronic illnesses and populations



Chronic Care Model

The Chronic Care Model



Care prior to new model

Chronically ill experienced:

- Lack of care coordination
- Lack of follow up to ensure the best outcomes
- Rushed practitioners not following established guidelines



Self-Management

- Patients have a central role in determining their care, one that fosters a sense of responsibility for their own health
 - Collaborative goal setting
 - Create action plans
 - Work at problem solving

Decision Support

- Treatment decisions need to be based on explicit, proven guidelines supported by at least one defining study

Delivery System Design

- Requires not only determining what care is needed, but clarifies roles and tasks to ensure the patient gets the care
- Make sure that all clinicians who take care of a patient have current information about the patient's status
- Make follow-up part of the standard procedure



Clinical Information System

- A patient/disease registry – an information system that can track individual patients and populations of patients
 - A necessity for managing any form of chronic illness or preventive care

Organization of Health Care

- Health care systems can create an environment in which organized efforts to improve the care of people with chronic illness take hold and flourish

Community

- To improve the health of the population, health care organizations reach out to form powerful alliances and partnerships with state programs, local agencies, schools, faith organizations, businesses, etc.



Sources/Additional Resources

- Institute for Healthcare Improvement
 - www.ihl.org
- www.improvingchroniccare.org



Plan Do Study Act

Staff Education

Tool 4-4
Initiative 4.1



Plan Do Study Act (PDSA)

- A methodology used to test change – by planning it, trying it, observing results and acting on what is learned.
- Guides the test to determine if the change is an improvement
- Reasons to test changes:
 - To increase your belief that the change will result in improvement
 - To decide which of several proposed changes will work best
 - To evaluate how much improvement can be expected from the change
 - To decide if the proposed change will work in the true environment
 - To minimize resistance upon implementation, etc.



How to Improve with PDSA

- First, form a team
- Team answers the following questions:
 - What are we trying to accomplish?
 - How will we know that a change is an improvement?
 - What changes can we make that will result in improvement?



PDSA Improvement

- Set an aim or goal
 - Time specific and measureable
- Establish measures
 - Use quantitative measures to determine if a change leads to improvement
- Select changes
 - Identify changes that are most likely to result in improvement
- Test changes
 - Implement PDSA cycle to test change
- Implement changes
 - Implement change on a broader scale
- Spread changes
 - Team spreads changes throughout organization



Steps in the PDSA Cycle

- **Step 1: Plan**

- *Plan the test or observation, including a plan for collecting data*

- State the objective of the test
- Make predictions about what will happen and why
- Develop a plan to test the change (Who? What? When? Where? What data need to be collected?)

- **Step 2: Do**

- *Try out the test on a small scale*

- Implement the test
- Document problems and unexpected observations
- Begin analysis of the data



Plan Do Study Act

- **Step 3: Study**

- *Set aside time to analyze the data and study the results*

- Complete the analysis of the data
- Compare the data to your predictions
- Summarize and reflect on what was learned

- **Step 4: Act**

- *Refine the change, based on what was learned from the test*

- Determine what modifications should be made
- Prepare a plan for the next test



Sources/ Additional Resources

- Institute for Healthcare Improvement
 - www.ihl.org
- Michigan Peer Review Organization
 - www.mpro.org/education



PDSA Worksheet for Testing Change

Aim: (overall goal you wish to achieve)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan

List the tasks needed to set up this test of change:	Person responsible	When to be done	Where to be done

Predict what will happen when the test is carried out:	Measures to determine if prediction succeeds:

Do

Describe what actually happened when you ran the test

Study

Describe the measured results and how they compared to the predictions

Act

Describe what modifications to the plan will be made for the next cycle from what you learned

Project Planning Form

The Project Planning Form is a useful tool for planning an entire improvement project, including a listing of all of the changes that the team is testing, all of the Plan-Do-Study-Act (PDSA) cycles for each change, the person responsible for each test of change, and the timeframe for each test. The form allows a team to see at a glance the overall picture of the project.

Use the Project Planning Form to help your team plan and keep track of an entire improvement project. At the start of the project, state the aim and the goal of the project. List the changes you are testing, and the PDSA cycles for each change. Assign an individual responsibility for each change. Estimate the time frame for each cycle. As the project continues, update the Project Planning Form.

This tool contains:

- Project Planning Form
- Example Project Planning Form: Athsma
- Example Project Planning Form: Depression



Project Planning Form

Project Planning Form

Project / Team:

Aim:

Measure(s):

Cycle No.	Change Tested	Person(s) Responsible	Week																	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18

Project Planning Form

Example: Project Planning Form – Depression

Aim: To redesign our system of care for people with depression to achieve a 30% increase in the proportion of patients experiencing a major improvement in depressive symptoms after 12 weeks, and a 25% increase in the number of patients continuing depression treatment at 12 weeks after initiation, *in Medicine clinic and in three other primary care clinics (Family Practice, OB, Adolescent Med)*

Measures (goals): 75% of patients will have a structured diagnostic assessment, 80% of patients will have documented use of education materials, > 75% will have a follow-up assessment within 1st 8 weeks, and 60% of patients will have a 15 point decrease in PHQ-9 scores.

Chronic Care Model Component: *Practice Redesign*

Cycle No.	Change Tested	Person(s) Responsible	Week																	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1a	Expand use of red flags and structured assessment to Family Practice clinic	Rob, Dr. Johnson	—————●																	
1b *	Assist with spread to other primary care clinics (OB, Adolescent Med)	Rob									—————●									
2a	Implement active follow-up to all of Medicine Clinic.	Lynn	—————●																	
2b	Test active Follow-up in Family Practice	Sandy, Rob	—————●																	
2c	Implement follow-up in Family Practice	Rob								—————●										
2d *	Assist w/ Spread: Teach process for active follow-up to other primary care clinics	Lynn													—————●					
3a	Implement Same Day consults for Medicine and Family Practice	Dr. Smith								—————●										
3b *	Spread: Teach to Test and try Same Day consults in other primary care clinics	Dr. Smith													—————●					

Patient Goals and Action Plan

_____ (NAME) _____ has set the following goals for improvement in coordination with my primary care physician and my patient-centered medical home team.

	Goals	Start Date	Notes	Results
Overall Health				
Smoking				
Blood Pressure				
Cholesterol				
Weight				
Alcohol Use				
Blood Sugar				
Nutrition				
Exercise				
Stress				
Other				

As part of the patient-centered medical home, I am committed to improving my health through the above action steps and goals. I am invested in this partnership with my physician and his/her team.

Patient

Date

Physician

Date

Patient Satisfaction Survey

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses will help us improve our services. All responses will be kept confidential and anonymous. Thank you for your time.

Your Age: _____

Your Race/Ethnicity: ___ Asian

Your Sex:

Male _____

Female _____

___ Pacific Islander

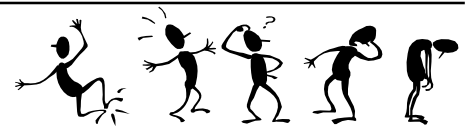
___ Black/African American

___ American Indian/Alaska Native

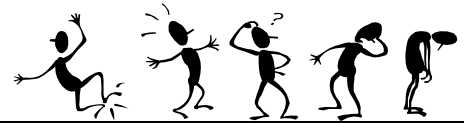
___ White (Not Hispanic or Latino)

___ Hispanic or Latino (All Races)

___ Unknown



Please circle how well you think we are doing in the following areas:	GREAT 5	GOOD 4	OK 3	FAIR 2	POOR 1
Ease of getting care:					
Ability to get in to be seen	5	4	3	2	1
Hours our office is open	5	4	3	2	1
Convenience of our office location	5	4	3	2	1
Prompt return on calls	5	4	3	2	1
Getting care before or after regular business hours	5	4	3	2	1
Getting referrals to specialists	5	4	3	2	1
Waiting:					
Time in waiting room	5	4	3	2	1
Time in exam room	5	4	3	2	1
Waiting for tests to be performed	5	4	3	2	1
Waiting for test results	5	4	3	2	1
Staff:					
<i>Provider: (Physician, Physician Assistant, Nurse Practitioner)</i>					
Listens to you	5	4	3	2	1
Takes enough time with you	5	4	3	2	1
Explains what you want to know	5	4	3	2	1
Gives you good advice and treatment	5	4	3	2	1
<i>Nurses and Medical Assistants:</i>					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1



Please circle how well you think we are doing in the following areas:	GREAT	GOOD	OK	FAIR	POOR
	5	4	3	2	1
All Others:					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
Payment:					
What you pay	5	4	3	2	1
Explanation of charges	5	4	3	2	1
Collection of payment/money	5	4	3	2	1
Facility:					
Neat and clean building	5	4	3	2	1
Ease of finding where to go	5	4	3	2	1
Comfort and safety while waiting	5	4	3	2	1
Privacy	5	4	3	2	1
Confidentiality:					
Keeping my personal information private	5	4	3	2	1
The likelihood of referring your friends and relatives to us:	5	4	3	2	1
Does this office provide your main source of care?	Yes ____ No ____				

What do you like best about our office? _____

What do you like least about our office? _____

Suggestions for improvement? _____

Thank you for completing our survey!

Collecting data, analyzing it and making sense of it

Collecting data

Determine the period of time that you want the survey to cover (i.e. survey all patients during the month of February). The more surveys you have, the more accurate the responses will be. Give patients a survey at the time of check in or give it to them at the end of their visit. Have a centrally located envelope or box for patients to place completed surveys.

Honor the patient's confidentiality; do not discuss the patient's responses. If a patient has difficulty reading, have a family member or non-health care staff member assist them.

Let them know they are helping you improve the quality of your services and that their responses are confidential and anonymous.

Analyzing data

To put your data into a useable format create a spreadsheet similar to the survey (Excel or Lotus 1-2-3 will work fine). Count up the total number of answers for each possible answer and put in the cell. Divide by the total number of surveys collected. (see sample report - 40 people marked the Ability to get in to be seen as, Great. There were 100 surveys taken, $40/100=40\%$).

Ease of getting care	Great	Good	OK	Fair	Poor	No response
Ability to get in to be seen	40	44	16	0	0	0
Hours our office is open	56	36	4	4	0	0

Making sense of it

Capture the demographics from the survey (age, sex, race) and list the patient responses after the data. Note the comments that were made multiple times by putting a number after the comment. This gives you a snapshot of how your patients view your practice at that point in time.

Sample Report - Patient Satisfaction Survey for Jan. – March, 20XX

Question	Great	Good	OK	Fair	Poor	No Response
EASE OF GETTING CARE						
Ability to get in to be seen	40%	44%	16%	0%	0%	0%
Hours our office is open	56%	36%	4%	4%	0%	0%
Convenience of our office location	48%	44%	4%	0%	4%	0%
Prompt return on calls	60%	36%	4%	0%	0%	0%
Getting care before or after regular business hours	48%	44%	4%	0%	4%	0%
Getting referrals to specialists	60%	36%	4%	0%	0%	0%
WAITING						
Time in waiting room	56%	36%	8%	0%	0%	0%
Time in exam room	56%	44%	0%	0%	0%	0%
Waiting for tests to be performed	40%	56%	4%	0%	0%	0%
Waiting for test results	40%	56%	4%	0%	0%	0%
STAFF - PROVIDER						
Listens to you	84%	16%	0%	0%	0%	0%
Takes enough time with you	80%	20%	0%	0%	0%	0%
Explains what you want to know	76%	24%	0%	0%	0%	0%
Gives you good advice and treatment	80%	20%	0%	0%	0%	0%
STAFF - NURSES AND MEDICAL ASSISTANTS						
Friendly and helpful to you	84%	16%	0%	0%	0%	0%
Answers your questions	84%	16%	0%	0%	0%	0%
STAFF - ALL OTHERS						
Friendly and helpful to you	72%	28%	0%	0%	0%	0%
Answers your questions	72%	28%	0%	0%	0%	0%
PAYMENT						
What you pay is reasonable	48%	44%	8%	0%	0%	0%
Explanation of charges	48%	44%	8%	0%	0%	0%
Collection of payment/	48%	44%	4%	0%	0%	4%



money						
-------	--	--	--	--	--	--

FACILITY						
Neat and clean building	64%	28%	4%	0%	4%	0%
Ease of finding where to go	72%	28%	0%	0%	0%	0%
Comfort and safety while waiting	72%	28%	0%	0%	0%	0%
Privacy	60%	36%	0%	0%	0%	4%
CONFIDENTIALITY						
Keeping my personal information private	72%	28%	0%	0%	0%	0%
The likelihood of referring your friends and relatives to us.	72%	20%	0%	0%	0%	8%
Does this office provide your regular source of care?	Yes – 91%		No - 2%		No Response – 7%	

Age - Ranged from 5 - 61

Sex - 76% Female
 24% Male

Race - 92% White
 4% Unknown
 4% No Response

What do you like best about our center?

Friendliness of everyone (2)

Everyone is very, very nice and pleasant. Everyone seems to like their job and it reflects in their mood, which seems happy.

The personal interest shown

The people and the location

Treatment I have received has been done in a professional and very pleasant way.

What do you like least about our center?

Location (3)

Not too clean.

Hours could be longer (after 4:30)

Bathroom not handicap accessible.

Takes a long time for appointments.

Suggestions for improvement

In the Medical area (it sometimes is like a circus; the nurse and sometimes doctors are laughing and joking) that is not professional. Also the secretaries are the same way. I also think when you have tests done, they should let you know promptly instead of letting a week or so go by and then you have to call them.

Call to remind me of appointment. I forget them easy.

Guide to Group Visits



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What are group visits?

The term, 'group visits' is applied to a variety of visits designed for groups of patients rather than individual patient-provider appointments.

The American Academy of Family Physicians defines group medical appointments as, *A shared medical appointment, also known as a group visit, is when multiple patients are seen as a group for follow-up or routine care. These visits are voluntary for patients and provide a secure but interactive setting in which patients have improved access to their physicians, the benefit of counseling with additional members of a health care team (for example a behaviorist, nutritionist or health educator), and can share experience and advice with one another.*

Patients best served by the group visit are those with chronic conditions such as arthritis, diabetes, hypertension, asthma, and COPD that require regular follow-up. The monitoring and support components of a group visit make them excellent for newly diagnosed patients or those with newly prescribed medications.

Different models of group visits

Dr. John Scott, an internist and geriatrician of Kaiser Permanente in Colorado developed the Cooperative Health Care Clinic (CHCC) model in 1991. About 15 to 20 of the physician's patients gather for a 2.5 hour monthly visit. The primary purpose of the visit is to provide health care with education and social support. Group visits are offered for seniors, and for those with diabetes, fibromyalgia, asthma, hypertension, and just about any type of chronic condition.

Ed Noffsinger, PhD a health psychologist from Kaiser Permanente, San Jose Medical Center developed the Drop In Group Medical Appointment (DIGMA) in 1996. The DIGMA was designed to improve access, increase service and quality and improve satisfaction for both physicians and patients. The DIGMA differs from the CHCC model in that it focuses on the physician's entire patient panel. These groups are usually co-facilitated by a mental health professional or behaviorist. Although these visits are scheduled for a number of patients, dropping in at the beginning is also a way to participate.

There are four types of DIGMA groups. In the Heterogeneous model patients come in for a variety of reasons and conditions. In the Homogeneous model patients are scheduled by having the same disease. The Mixed model combines the Heterogeneous and Homogeneous model. In the Physical model, the patient comes in to an exam room like for an individual appointment. Afterwards they join the group visit.

Benefits for the patient

Group visits offer substantial benefits to patients:

- Patients can be seen more quickly and more frequently
- Patients get more time with their physician along with extended access to a broad range of medical services in a supportive group setting.
- Patients feel they get better care. They are able to share the emotional aspects of a difficult illness.
- Patients get care specific to their needs, their perception of health improves.
- Patients get more guidance with lifestyle changes because they are able to come back more frequently. This leads to better outcomes in chronic disease management.
- Patients become partners in their own care, action plans start to work.
- Patients learn from others in the group and feel good about sharing their own experiences.

Benefits for the practice

Group visits are beneficial for practices:

- Physicians can see more patients without sacrificing the quality of care.
- Physicians are better able to manage large patient panels, while extended, in-depth interaction with patients provide a more satisfying level of medical care for both patient and physician.
- Time is used more productively.
- Group visits are very cost effective. Set a minimum number of patients for the group meeting. The rule of thumb is to set the minimum at triple the number of patients you would see in individual appointments. If you see four patients in two hours, a two hour group visit should have a minimum of 12 patients.
- Patients perceive physician as more competent.
- Relationships with patients improve.
- Physician satisfaction improves.
- Physician productivity, patient access and quality of care all improve using existing resources.

Resources for information on group visits

The American Academy of Family Physicians has several sources of information on group visits, <http://www.aafp.org>.

- Diabetic group visits, obesity group visits, well-infant group visits, low income and Latino group visits.

Family Medicine Digital Resource Library, <http://www.fmdrl.org>

- Many articles on group visits, tobacco cessation group visits, online group visits, coding for group visits, consent form.

TransforMed, <http://www.transformed.com>

- A guide to group visits, many articles and resources on group visits.

Institute for Healthcare Improvement, <http://www.ihl.org>

- Tools and case studies, starter kit, diabetic group visits, HIV/AIDS group visits, use in self-management

Preparation for a group visit

Group visits require careful, thorough preparation. They are not just another form of a medical visit. They require that you relate differently to your patients. In order for group visits to work for your practice they must be a solution to a current problem. Take time to think about how appropriate they would be for your practice. Ask yourself,

- What is the most pressing problem in my practice?
- What would a group visit do to fill this challenge? If many of your patients have diabetes, a disease specific group visit could offer patients emotional support from the group, encourage them to take responsibility for maintaining glucose targets and ensure they are seen regularly enough to ward off bigger problems. If access is a challenge for your practice, a physician specific group will allow patients to be seen more quickly and more frequently.
- Is there a particular segment of my patient panel that I want to target?
- Do I have enough patients to do one group visit per week or per month?
- What resources are available, i.e. space, staff, marketing, funding?
- Decide outcomes and how they will be measured
- Plan team review strategies, debrief for 5 minutes after every group and team meets monthly to problem solve

If you decide to do a group visit, another set of questions must be asked and answered:

- Will your group visits be physician specific, disease specific or a combination?
- Will it include the same patients every time or can they drop in?
- How often will they meet and where will they meet?
- Will you have a facilitator i.e. mental health professional, health educator, nurse?
- What day of the week and what time will the group be scheduled?

Roles in the group visit

If your practice is part of a large organization you will need to schedule and meet with the administrative team to discuss the possibilities and logistics of group visits.

Enlist the help of a project manager to establish the group and get it up and running smoothly. The responsibilities of the **project manager** are as follows:

- Help identify physicians to participate in the group visit
- Meet with physician to design the group visit
- Identify all of the personnel involved with starting and maintaining the group visit
- Spend time with staff educating them and answering questions
- Introduce the facilitator to the physician and staff
- Go over the group visit roles and responsibilities with staff
- Collaborate with marketing or the staff to promote the visits
- Locate the appropriate space to hold the group visit
- Contact physicians weekly to monitor scheduling and answer questions for the first couple of months
- Track the number of participants signed up for the group
- Motivate physicians to ensure attendance goals are met
- Orient staff to documentation, scheduling and billing procedures

There are several other key roles that create successful group visits. The roles and responsibilities for key positions are listed below:

Physician role and responsibilities

- Market group idea to patients and staff
- Encourage patients to make the next appointment in the group (exclude first time visits, physicals and procedures)
- Physicians, office schedulers and MAs have the responsibility for keeping the groups full
- Physician works initially with the program director to create a group to meet the specific needs of the practice

Physician needs to develop a relationship with the behaviorist or facilitator, allow them to spend a day observing your office practice

Behaviorist or facilitator should meet the following requirements:

- Education - MSW (LCSW or PhD in Psychology preferred), RN or other health professional
- Extensive experience with chronic disease management or knows it generally signs/symptoms, diagnosis/treatment options, and specifically psychosocial issues
- Documented group facilitator experience
- Documented experience in participation on multidiscipline teams
- Ability to work autonomously
- Prior experience in partnering with physicians a plus

It would be helpful if the **behaviorist** developed some background information of the following topics:

- Hypertension, essential hypertension
 - Congestive heart failure
 - Diabetes, Type 1 and Type II
 - High cholesterol - HDL, LCL and Lipids
 - Arthritis/Fibromyalgia/ chronic pain
 - Rheumatoid arthritis
 - Asthma
 - Depression - know the meds and their side effects
 - Anxiety - know the med and their side effects
 - Acid reflux
 - Irritable bowel
 - Cancer - common types, i.e. breast, colon, lymphomas
 - Lupus/undifferentiated connective tissue disease
 - Osteoporosis
1. Find out generally what physically happens
 2. Discover psycho-social implications
 - How does this diagnosis change relationships with family, friends?
 - What are the lifestyle changes?
 - What would be some of the losses a person with this diagnosis might have?
 3. What are some of the ways for treating this?
 4. What are some of your thoughts as you learn about this diagnosis?
 5. How does the environment affect them with this diagnosis?

Have the behaviorist develop 2-3 minute lectures on the following topics

Exercise Nutrition Sleep disorders
Stress management Memory disorders

Behaviorist or facilitator role and responsibilities:

- Get to know the physician and how they like to practice, spend a day observing the practice
- Get to know the employees and staff
- Keep track of group scheduling and motivate physicians to keep the numbers up
- Show up early at the group visit and greet patients
- Hand out name tags, releases or other documents prior to the start of the meeting
- Start the group on time
- Facilitate the group
- Act as timekeeper so that everyone has an opportunity to have their issues addressed and the group ends on time.
- Complete required paperwork and review physician's paperwork to check for completion
- Maintain regular contact with the physician and staff outside of the group

Medical assistant role and responsibilities

- Take patient vitals
- Assist physician with documents, lab slips, referral form, etc. as needed
- Participate in the group when appropriate and when time allows

Scheduler role and responsibilities

- Schedule patients as requested by physician
- Schedule patients as they call in
- Offer group to patients who want to ask their doctor a question or receive a call back
- Offer group to patients who are having a difficult time getting on the schedule
- Visit a group to have a first hand experience to speak to patients
- Pay attention to the numbers of participants signed up and assist physician and MA in keeping the numbers up.

Sample meeting agendas

Sample agenda for a diabetic group visit:

1:30 - 1:45pm	Patients arrive; taken to room; vitals are taken
1:45 - 2:00pm	Ice breaker
2:00 - 2:30pm	Diabetic Educator, behaviorist or other facilitator works with group; individualizes education when possible
2:30 - 3:45pm	Physician leads individual diabetic-focused medical check ins, physical exams (heart, lungs, feet) and continues to engage the group regarding common issues. Behaviorist assesses previous goal attainment and facilitates new goal setting
3:45 - 4:00pm	Goals reviewed, final questions and wrap up

Another sample agenda for a group visit:

15 minutes	<ul style="list-style-type: none"> - Introductions, welcome - Facilitator opens the session and introduces all team members. Introductions follow around the room with sharing included
30 minutes	<ul style="list-style-type: none"> - Topic of the day - Physician and nurse provide information, interacting with participants by asking, 'Has anyone here ever had this problem?, How has anyone dealt with this situation before? Or What have you heard about ____?'
15 minutes	<ul style="list-style-type: none"> - Break - Physician starts on one side and nurse on the other. Take blood pressures, ask about specific concerns for the day and if patients need a 1/1 visit. Refill medications.
15 minutes	<ul style="list-style-type: none"> - Questions and answers - Ask for any questions the group has about their health, the visit, recent topics in the news etc.
15 minutes	<ul style="list-style-type: none"> - Planning and closing - Determine the topic for the next month. Thank everyone for coming and proceed to the 1/1 visits
30 minutes	<ul style="list-style-type: none"> - 1/1 visits with provider

Group Visit Confidentiality Agreement

Privacy is something everyone is concerned about when they come for a group medical appointment. You have the right to expect that what is said here is private and confidential. Along with our commitment to maintain your privacy, you will also have a responsibility to respect and protect each other's privacy.

Please share useful information outside of the group, but what you hear and learn about individual group members should stay here.

Printed name _____

Signature _____

Date _____

Authorization for Disclosure of Medical Information

One of the biggest benefits of group medical appointments is the opportunity to learn from other patients. This means you also have the opportunity to positively impact someone else's life. Knowing this:

I authorize _____ physician(s) to share medical information pertaining to my current medical issues with participants of a group medical appointment of which I am in attendance.

This authorization shall become effective immediately and shall remain in effect for one full calendar year from the date of signature.

I further understand that I have a right to receive a copy of this authorization upon my request.

Signature _____

Date _____

Sample scripts for staff to talk about the group visit

Patient: (What is a group visit? I've never heard of it!)

Staff: It's a medical appointment where Dr. _____ meets with a group of patients for 60 to 90 minutes. It's a great opportunity for patients to spend more time with the doctor and to gain a wealth of helpful information from the doctor and from other patients that may pertain to your care. It is relaxed and interactive. All your medical concerns can be addressed (treatment options discussed, prescriptions written, labs ordered, referrals made etc.) Often patients are reluctant at first to attend but the majority like them very much and find much benefit in them.

Staff: Dr. _____ is doing this because s/he wants more time with her/his patients, and the group gives everyone the opportunity to be more creative in healthcare.

Staff: Dr. _____ is excited about this and would like you to try it once and see if it is beneficial and interesting for you.

Staff: Often patients have similar experiences to what you are going through and have helpful ideas. Also, you probably have something of value from your experience that will be very helpful to someone else.

Staff: Generally, other patients will ask questions that pertain to you, but you never thought of asking. You may learn about health issues relevant to a family member, if not yourself.

Staff: These groups have become popular. Our patients tell us how much it helped them. (Or, other physicians are doing them and they have become quite popular and may patients love it. The physicians love doing them too.)

Staff: If needed, you can ask for individual time with the doctor at the end of the group.

Staff: During this group, Dr. _____ prescribes, changes and refills medications, goes over lab or test results, follows up from other appointments, answers questions and reevaluates treatment choices, etc.

Staff: Dr. _____ can spend more time talking about relevant health issues and do more education

Patient: (I work)

Staff: If time is a problem, let Dr. _____ know and your issues will be dealt with first. If you need to leave and return to work, that's fine.

Staff: This is a medical appointment just like any other medical appointment. We find that it takes about the same time as a regular medical appointment, including the time patients wait to see their doctor.

Sample facilitator script

Hello, my name is _____. Welcome to Dr. _____ group medical appointment.

A group medical appointment is just like an individual medical appointment except in here you will have the others in the group present while you speak with your physician. Another difference is that instead of waiting and having a few minutes with Dr. _____ You will have 60 to 90 minutes of time. How many of you have thought of another question right after the physician leaves the room? Some of the advantages of these groups are that you have more time to get answers to your questions and learn from others who have had similar experiences and can share information that may be helpful to you. So this is an open forum and we encourage you to share of your personal experience with each other. Another advantage of group appointments is that they occur every _____ and you can use this as a tool to see your physician more often if you need.

We ask that you look over your list of questions and select your two biggest concerns to discuss today. Often times other patients will ask questions that may provide you with some of the answers you need and if you still have questions we will schedule you for another group until all of your concerns are addressed.

My job is to help Dr. _____ facilitate this group and part of that is keeping track of time. If I interrupt you please know it has nothing to do with the quality of your statement, but my desire to keep things moving along.

Confidentiality - You are going to hear stories in here that could be helpful for you to pass on to your friends and relatives. We ask that you only share the story and not the name or any identifying information about the person who shared their experience with the group.

Does anyone need to leave early? If so, we will take you early on in the group.

Does anyone need to see Dr. _____ privately? If so we will save time at the end of the group.

The restrooms are located..... The coffee, tea, water

Sample letter to patients

Dear patient,

I would like to encourage you to take the opportunity to attend a new group medical appointment program I am starting that is open only to patients from my practice. My group medical appointment provides you with an extended 90-minute medical appointment. This group includes other patients from my practice, other professionals and me.

I am very excited about this new program, which will give us time to get better acquainted and to discuss your questions and concerns in more detail. This group will provide you with support and information from other patients having similar experiences that can help you to better cope with your situation and live life fully despite health problems. During each group visit, I will be able to answer questions, prescribe and refill medications, order tests and procedures, discuss test results, talk about side effects and treatment options, and provide brief private exams when appropriate. These group medical visits are very informative, interesting and more relaxed than a regular private office visit. Group medical appointments are meant as an additional option, not a replacement for individual appointments.

My group medical appointment is available to you every _____ from _____. Please register 15 minutes before the start of the group, where you will pay your regular co-pay and we will then meet in the Group room.

Pre-register for the group by calling (____) xxx-xxxx to make an appointment for the session you would like to attend. Please feel free to bring your spouse or another support person, as they will likely find the interaction helpful as well.

It is a pleasure to be able to strongly recommend this new program to you. It promises to be a warm, supportive and rewarding experience. I look forward to participating in this group opportunity with you. For questions about this program, please call _____ at (____) xxx-xxxx.

Warmly,

Dr. _____

Sample office flyer

Dr. _____'s

Group medical appointment

OPEN ONLY TO DR. _____'S PATIENTS AND THEIR LOVED ONES

MEDICAL CARE, INFORMATION AND SUPPORT

Bring your questions, concerns and medical issues for discussion

Come any week you like and spend 90 minutes to 2 hours with Dr. _____ and some of his other patients dealing with similar issues. This is an opportunity to experience an exciting new type of medical appointment in a warm and supportive group setting. Medical questions will be answered, prescriptions will be changed and refilled, medical tests and procedures will be ordered and test results discussed. Brief private examinations and discussions are available if necessary.

You are not alone. Be with others who can really understand!

When: _____

Where: Register at Dr. _____ office 15 minutes prior to the start of your appointment, then proceed to the meeting room.

Cost: The copayment is the same as for a regular office visit. Support person or spouse is free.

To make an appointment or for questions, call _____.

The focus of this group is to help you MAKE YOUR LIFE BETTER.



Progress note for group

medical appointment

Patient Name _____ DOB _____ MR# _____

Allergies to Drugs _____

CC: _____

Hx of illness:

Medications

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vital Signs: MA _____ (initials)

BP _____ P _____ T _____ W _____

Physician Exam: _____

COUNSELING: (Time spent) Etoh _____ Diet _____ Cholesterol _____ Exercise _____

Diabetes _____ Smoking _____ Other _____

Assessment:

A _____

B _____

C _____

Plan: _____

Pt to return: as needed

In _____ Days Weeks Months Group Individual

Physician Signature _____ Date _____

Facilitator Signature _____ Date _____

Sample 1 group visit diabetes progress note

This progress note form was developed for a group-visit program for patients with Type 2 diabetes. Using this form to prepare in advance of the visit will help you to proceed more efficiently.

Type 2 Diabetes Progress Note for Group Visits

Date: _____ Patient Name: _____ Patient ID #: _____

Subjective: Any history of hypoglycemia? _____

Current activity level

No activity / Moderate (2-3 times per week) / Moderate (4-6 times per week) / Vigorous (4 or less times per week) / Vigorous (5 or more times per week)

Fat intake (High / Medium / Low / Ultra low) Most common fat intake _____

Produce serving intake: Less than 2 daily / 3 to 4 daily / 5 or more daily

Pertinent past medical history: (See patient chart for details)

Meds: (See med list for details) Tobacco use: Current _____ Ex _____ Never _____

Objective: (labs with month/year)

Weight _____ BP _____/_____ Last monofilament foot exam (date ___/___): _____

Recent lipid profile (date ___/___): TC/HDL _____/_____ LDL _____ TG _____

FBS (date ___/___): _____ or HbA_{1c} (date ___/___): _____ Creatinine (date ___/___): _____ Urine microalbumin (date ___/___): _____ Last retinal screening: _____

Assessment: Type 2 diabetes (at target / not at target); (with / without complications)

Plan:

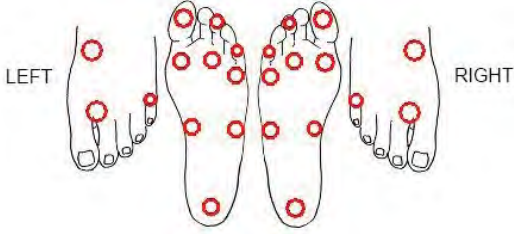
1. Reviewed management of HbA_{1c}.
2. (New Rx: _____)
3. (Labs due: _____)
4. Recommended ASA daily.
5. Encouraged activity.
6. Encouraged diet.
7. Reviewed med options: risks, benefits and side effects (including ACE- inhibitors).
8. Discussed targets and management of lipids, HTN and proteinuria.
9. Spent more than 50 percent of this 105-minute visit in counseling re: therapy options and management of diabetes.

SIGNED: _____

Sample 2 group visit diabetes progress note

An example of a detailed patient encounter form for patients with diabetes

Patient Summary Sheet

		Vital signs	Last visit	Today
Date:		Weight (lbs.):		
Patient ID No.:		Height (inches):		
Patient name:		Blood pressure:		
Patient age:		Body mass index:		
Primary phone:		Vital signs date:		
Alternate phone:		Smoking status:		
Primary Practitioner:				
Priority Registry Health Risk Factors		Working Notes		
1. CAD/CVD Risk Family history of PREMATURE CAD? Most recent lab values: Total Chol.: _____ HDL: _____ TC/HDL: _____ Date: _____ LDL: _____ Date: _____ TG: _____ Date: _____ Baseline LDL Aspirin/day?				
2. Kidney risks Albuminuria/Creat. ratio Date: Serum Creatinine Date:				
3. Retinal screening Latest eye exam: Left eye: Right eye:				
4. Foot risk status Date of last foot exam: High risk foot?				
5. Glycemic control HbA1c: Date: Frequency of SMBG: Shots/day: Insulin dose:				
6. Cardiac/diabetic meds Niacin: BAS/fibrate: Statin: ACE inhibitor: Beta blocker: Diabetic meds:		Changes:		

Sample 3 tobacco cessation progress note

Name: _____ Date: _____

ID #: _____

HPI: Subjective (at least 4 questions)

Years you have smoked? _____ Average cigarettes per day? _____

How many times have you tried to quit? _____

Number Tobacco Pack Years? _____

Hx recent heartburn? yes noHx smoker's Coughing? yes noHx sinus problems? yes noAny specific issues you want addressed at this visit with the group?
_____**ROS:** (at least 2 questions)Has your activity level been recently limited by breathing issues? yes noAny chest pain with exercise? yes noAny problems with insomnia? yes no**Past Med Hx:** (See chart for details)

Meds: (See chart med sheet)

Objective

Wt _____ BP _____ BMI _____ RR _____

Peakflow today _____

Assessment (Tobacco abuse, 305.1);

Other related diagnoses? _____

Plan Quit date planned Behavioral options to quit reviewed Medication options reviewed. Risks, benefits, and side effects discussed and questions answered. Rx _____ Additional Plan _____**Billing:** (circle one) 99213 99214

Provided by Steven C. Masley, MD, FAAFP, CNS

What to look for and ask during a group visit

1. Are they addicted or using any substances that would negatively affect their health?
2. Social support
 - a. Are they married or living with someone. If alone who checks up on them?
 - b. Do they have people to confide in or do they shoulder others burdens?
 - c. Do they attend a church or belong to a community group?
3. Coping ability
 - a. Have they been through difficult times before?
 - b. How have they coped?
 - c. How resourceful are they? What is their level of knowledge and ability to seek help from friends, family and community?
4. Lifestyle changes
 - a. Exercise – everyone needs it regularly
 - i. Do they currently exercise?
 - ii. What do they do for exercise?
 - iii. Are they able to develop a plan and stick with it?
 - b. Diet – a healthy diet is good for all chronic disease
 - i. Are they aware of dietary restrictions?
 - ii. Do they need to see a nutritionist?
 - iii. Do they do their own cooking?
 - iv. Do they eat regular meals?
 - v. Do they do their own grocery shopping, can they afford food?
 - c. Stress
 - i. Does their amount of stress negatively impact their life?
 - ii. What is their level of coping skills?
 - iii. How do they cope with stress?
 - iv. Are they able to look for support?
 - v. Do they report feeling overwhelmed, no options to change their situation, look for depression
5. Sleep – it's a habit
 - a. Do they have trouble sleeping?
 - b. What is their hygiene?
 - i. Do they go to bed at the same time every night?
 - ii. How much caffeine do they have during the day?
 - iii. Do they exercise close to bedtime or work until bedtime?
 - iv. Do they have a TV in the bedroom?
6. Depression
 - a. Food – too much, too little
 - b. Sleep – too much, too little – do they wake up after several hours unable to get back to sleep?
 - c. Don't enjoy activities like they used to
 - d. Frequent accidents
 - e. Suicidal thoughts, plans
 - f. Family history
 - g. Ever been on antidepressants before
 - h. Psychotherapy
 - i. Bring back to group often to monitor

Billing the group visit

When patients have a one-on-one encounter in addition to the group discussions, there should be no problem in billing for an individual visit when they have coverage for office visits.

If the group visits include the services of nutritionists or a behavioral health specialist, contact the payers to determine if that portion of the group visit can be directly billed by the non-physician provider. This typically would include codes for medical nutrition therapy (97804) or health and behavior intervention (96153).

Other codes that may be applicable are the codes for education and training for patient self-management involving a standardized curriculum (98961-98962). Neither these codes nor medical nutrition or behavioral health therapy are billed by physicians. Physicians must use evaluation and management codes to report these services.

Code 99078 describes physician educational services in a group. Again, it is necessary to contact the payers to verify that coverage of this service is a payable benefit.

Beginning April 1, 2009, Priority Health is reimbursing PCPs for code 99078 (group visits) according to the fee schedule on standard Priority Health contracts.

- Payment will be made for all members of fully funded HMO, POS and PPO plans, with the exception of members with health savings accounts (HSAs) with unmet deductibles.
- No modifier is necessary to bill these codes.
- Report 99078 in addition to the evaluation and management (E&M) service.
- These codes are not payable for members of self-funded or shared-funded plans.
- These codes are not payable for members of Medicare, Medicaid or MiChild plans.

Primer on planned visits

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The planned visit

In a patient-centered medical home, physicians see patients with chronic illnesses more proactively, using various methods to manage care between office visits. This care may take the form of a planned visit or may be a phone call or email. A "planned visit" refers to a pre-scheduled, coordinated visit in which the agenda is pre-determined by the needs of a patient with chronic illness. The components of a planned visit include:

- An assessment
- A review of therapy
- A review of medical care
- Setting or reviewing self-management goals
- Helping the patient problem solve
- Follow-up planning including the plan for the next visit

Assign team roles and responsibilities

Assemble a patient visit team, including a provider, nurse, nursing assistant, lay health worker, intake worker, and person in charge of immunization and referrals.

Use the "Roles in Team Care" document on page 6 to identify the logistical and clinical tasks necessary for the preparation and execution of the visit. For example, the following questions might need to be addressed: who is going to call the patient to schedule the visit? Who will room the patient? If the patient has diabetes, who will remove her/his shoes and socks? Who will examine the feet? Who will prepare the patient encounter form for use during the visit? All tasks need to be delegated to specific team members so that nothing is left to chance.

Call the patient in for a visit

Use the registry to identify patients that have gaps in coverage or are otherwise in need of a visit and have the physician and team members review the list.

Develop a script for the call, and decide which team member will make the call. Set the tone and expectations for the issues addressed in the visit. Here is a sample script you can adapt to your setting:

"Hello Ms. Smith. This is Karen calling from Dr. Brown's office. He is interested in making sure all of his patients with chronic conditions are receiving the best possible care. He has asked me to have you come in for visit to discuss your (insert condition here). If you have other health concerns, we may have to address those at a future visit. By focusing on just your (condition here) both you and he can better manage your health.

Can we set up a time that is convenient for you? When you come, please bring all your current medications (and anything else pertinent to the condition). Thank you. We will call you a day before the visit to make sure you are still able to come."

Deliver clinical care and self-management support

In preparation for the visit, print an encounter form from your registry or pull the chart in advance so that you can review the patient's care to date. A sample encounter form "Patient Summary Sheet," is included on page 5. Document what clinical care needs to be done during the visit.

The acute care visit and planned care

Regardless of how much you plan, patients still arrive unexpectedly with acute exacerbations. Assuming that your patient is stable, use this opportunity to provide all or some of their routine chronic care. You can then fold them into the planned care visit schedule. To take advantage of this opportunity, try the following:

Get As Much Done As You Can

- Consider developing standing orders for these kinds of visits
- Make sure the team knows their roles and responsibilities around the standing orders
- Find or develop a tool to keep track of what you've done and still need to do
- Introduce the concept of self-management to the patient and discuss how you want them to have planned visits with your team, and why
- Train staff in the planned visit approach. A planned medical visit should contain an assessment, review of therapy, review of medical care, self-management goals, problem solving, and follow-up planning, including the plan for the next visit.

Chronic illness management goals

Your chronic care patients should have chronic illness management goals and/or self-care skill education goals established by the physician and documented in the physician's notes in the chart. Services provided should support these goals. Here are some best practice examples for chronic care management:



Diabetes/CAD

A nurse educates on diet, exercise, glucose/lipid management and/or blood pressure control. A nurse adjusts medications based on the physician protocol.



Hypertension

Blood pressure monitors are loaned to patients for two weeks. A nurse then calls or visits the patient to review the results and re-educates on medications and lifestyle changes.



Asthma

A nurse educates the patient and caregiver on managing asthma and reviews the Asthma action plan established by the physician.

Reimbursement

In many cases it may be possible to be reimbursed for the extra level of care for planned visits and follow-up care. There are two T-codes that may be reimbursable for management of a chronic illness. The codes are:

T1015 - Clinic visit/encounter, face to face, all inclusive

T1019 - Personal care services, per 15 minutes. May be used with phone counseling

As with other benefits, it's best to verify with the patient's insurance if these T-code services will be covered and if a copayment or coinsurance applies. Medicare, some insurance plans and some groups do not cover T-code services.

Document the services

It is important to document chronic care services in the notes, registry and medical record especially when billing T-code services. The physician's notes must show that chronic illness management goals and/or self-care skill education goals have been established. The notes of the ancillary or nurse who provided the service must reflect that those goals were the focus of the service and that the services documented are pertinent to achieving those goals.

Include in the medical record:

- Date of the encounter
- Specific chronic disease(s) being treated
- Name of supervising physician
- Identify the common shared physician treatment goals
- For code T1015, record an assessment and plan (decision making) and summarize the important details of the personal care services and self-care skills given with patient-specific goals.
- For code T1019, summarize the important details of the personal care services given and record any decisions made
- Record the face to face (or telephonic) time spent with the patient.

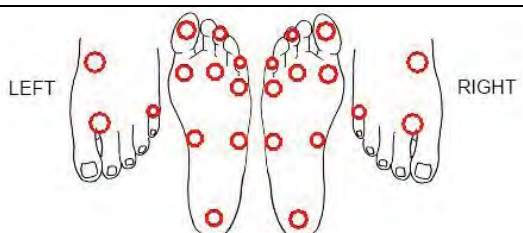
Balance billing and writing off the amount owed

Not all patients will have coverage for extra services typically provided in a patient-centered medical home. When scheduling these services, patients should be informed of any non-covered services and given the option to decline the service.

Although services like phone counseling are valuable, the T-code services are not broadly payable by health plans and employer groups. If unable to bill for these services you may want to provide them anyway. Other benefits such as incentive payments tied to patient health status, patient satisfaction and physician satisfaction should all be considered.

Example of a diabetic patient encounter form for collecting registry data at time of visit (same form can be used as template for automated Patient Summary form for use during next visit)

Patient summary form

Date: Patient ID #: Patient Name: Patient Age: Primary Phone: Alternate Phone: Primary Practitioner:	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Vital Signs</th> <th style="width: 33%;">Last Visit</th> <th style="width: 33%;">Today</th> </tr> </thead> <tbody> <tr> <td>Weight (lbs.):</td> <td></td> <td></td> </tr> <tr> <td>Height (inches):</td> <td></td> <td></td> </tr> <tr> <td>Blood Pressure:</td> <td></td> <td></td> </tr> <tr> <td>Body Mass Index:</td> <td></td> <td></td> </tr> <tr> <td>Vital Signs Date:</td> <td></td> <td></td> </tr> <tr> <td>Smoking Status:</td> <td></td> <td></td> </tr> </tbody> </table>	Vital Signs	Last Visit	Today	Weight (lbs.):			Height (inches):			Blood Pressure:			Body Mass Index:			Vital Signs Date:			Smoking Status:		
Vital Signs	Last Visit	Today																				
Weight (lbs.):																						
Height (inches):																						
Blood Pressure:																						
Body Mass Index:																						
Vital Signs Date:																						
Smoking Status:																						
Priority Registry Health Risk Factors	Working Notes																					
1. CAD/CVD Risk Family History of PREMATURE CAD? Most Recent Lab Values Total Chol.: _____ HDL: _____ TC/HDL: _____ Date: _____ LDL: _____ Date: _____ TG: _____ Date: _____ Baseline LDL Aspirin/day?																						
2. Kidney Risks <i>Albuminuria/Creat. ratio</i> <i>Date:</i> <i>Serum Creatinine</i> <i>Date:</i>																						
3. Retinal Screening Latest Eye Exam: Left Eye: Right Eye:																						
4. Foot Risk Status Date of Last Foot Exam: High Risk Foot?																						
5. Glycemic Control HbA1c: Date: Frequency of SMBG: Shots/day: Insulin Dose:																						
6. Cardiac/Diabetic Meds Niacin: BAS/Fibrate: Statin: ACE Inhibitor: Beta Blocker: Diabetic Meds:	Changes:																					

Roles in team care

Role	Primary Care Provider	Primary Care Nursing Staff	Medical Specialist	Clinical Care Manager	Resource Coordinator	Clerical Staff

Patient Education Topics and Talking Points: Diabetes

Patient Name: _____ DOB: _____ Chart # _____

Topic	Talking Points	Check if pt can repeat back with understanding	Date & Prvdr Initial
What is diabetes?	Do you know what diabetes is? Have you heard of people with “high sugar?” Some people call diabetes, “sugar.” Diabetes is an illness that prevents your body from using sugar from food the right way. The sugar floats around in your blood instead of going into your cells (show cartoon visual).		
	Diabetes is inherited. It runs in families. You don’t get it from eating “too much sugar”.		
	Do you know what insulin is? Insulin is a substance made in the pancreas (point to general area). It helps people use sugar correctly. In type 2 diabetes, your body makes insulin, but the insulin doesn’t work correctly (reshow visual).		
Complications	Eye problems (blindness), amputation, erectile dysfunction, kidney problems, nerve damage, foot problems, heart and blood vessel problems (visual)		
Blood Glucose Testing	How to use patient’s specific glucometer: demonstrate competency in use.		
	When to test? Useful times: before injecting insulin, 1 st thing in the morning, 1-2 hours after meals (Once per day is usually enough for patients not on insulin unless otherwise ordered by provider).		
	What is a “good” glucose level: 1) 80-120 before meals, 2) 100-180 after meals. Visual.		
Insulin use	Pt demonstrates appropriate injection technique		
	Insulin should usually be injected before meals (about ½ hour for regular insulin, 5-15 minutes before Humalog or Novolog)		
	Lantus can be given any time of day.		
	Inject in the abdomen, not the arms or legs.		
	Always check blood sugar before injecting insulin		
	If blood glucose is low, eat first, recheck, then inject if sugar has come up to normal.		
Importance of wt Loss	Re-show cartoon visual showing impact of fat Even a tiny bit of weight loss helps		
The importance of exercise	Exercise lowers your blood sugar for the whole day. Thirty minutes a day is great but EVERY LITTLE BIT HELPS.		
	Ways to get some exercise include: walking (inside or out), dancing, chair exercises, taking the stairs 1-2 flights, parking far from store door, meeting a friend for coffee and walking around the block before or after the coffee. Ask patient for ideas.		
Diet: Foods to limit:	Get patient to understand that they need to be concerned with carbohydrates in general, not just food they think of as sweet. Use food boxes to point out foods high in carbs but low in sugar. Let them know that the body can’t tell rice from chocolate cake.		
	Avoid sugar sodas, malta. Switch to diet soda or water with lemon & sugar substitute.		
	Limit fruit juice to 4 oz. (1/2 cup) at a time : juice has as much sugar as soda.		
	Watch portions of Rice, Pasta, Breads		
	Limit fat intake, switch to canola or olive oil, limit fried foods		
	Limit consumption of red meat, more poultry but remove skin		
Diet: Food to increase	Eat more vegetables, half plate. Discuss what patients think of as vegetables. Remind them that corn and beans are high in carbohydrates (sugar)		
	3 fruits per day		
	Snacks: sugar free jello; tea/coffee with couple gingersnaps or vanilla wafers, fruit, sugar-free low fat yogurt, ½ sugar free pudding made with skim milk (Visual)		

Patient Education Topics and Talking Points: Asthma

Patient Name: _____ DOB: _____ Chart # _____

Topic	Talking Points	Check if pt can repeat back w/understanding	Date & Prvdr Initial
What is Asthma?	Do you know what your lungs do? <i>If no, exaggerate breathing in and out.</i> Asthma is a disease that causes the “air tubes” in the lungs to swell or inflame.		
	When the airways or air tubes swell, they start to close down. This causes you (or your child) to wheeze or cough. It also makes your chest (or your child’s chest) feel tight.		
	People with asthma get “attacks” that make the airways or tubes in their lungs swell. People with asthma sometimes feel fine but sometimes they have attacks.		
What are your triggers?	Doctors and nurses often talk to patients about “triggers.” Triggers are things you or your child breathe that cause wheezing or coughing. Have you ever heard about “triggers?” Can you think of any triggers that might be in your house?		
	<i>Listen to patient and then mention whatever they didn’t mention.</i> Common triggers: smoke, dust, cold, chemicals, roaches, pets.		
	There are things you can do to avoid triggers. Some of these things are throwing out rugs and curtains, staying away from people who smoke, being careful about the kinds of pets you have, and getting rid of roaches (Visual).		
Using your inhaler	How to use the inhaler: have patient demonstrate their technique. Assist if incorrect.		
	Using a spacer (if appropriate)		
	Cleaning an inhaler/spacer		
Using a “controller” medicine	Tell me about how you have been using your “controller” medicine. <i>Let person talk.</i> Your asthma will be controlled best if you use controller medicine (glucocorticoid inhaler or singulair) every day. Sometimes people think that they should use it just when they feel sick or have symptoms of asthma but it is best if it is used everyday.		
	Controller medications are to <i>prevent</i> asthma symptoms from happening.		
	If your controller medicine is working right, you should not wake up wheezing at night		
Using a “rescue” medicine	Tell me about what you do when you have asthma symptoms. <i>Let person talk.</i> One thing that is recommended is that you use your rescue medicine (albuterol) when you have asthma symptoms such as wheezing, coughing or shortness of breath.		
Asthma Action Plan	Review or facilitate an asthma action plan for each patient. Be sure the patient maintains control of the plan. One action per visit is recommended.		

Patient Education Topics and Talking Points: CAD/HTN/Hyperlipidemia

Patient Name: _____ DOB: _____ Chart # _____

Topic	Talking Points	Check if pt can repeat back w/understanding	Date & Prvdr Initial
The importance of exercise	Small amounts of exercise can help		
	Ways to get some exercise include: walking (inside or out), dance, chair exercises, (Visual)		
Diet: Low fat	Common sources of fat/cholesterol: red meats, oils and butter, fried food, whole milk, fast food, chips and Doritos, special sauces, cookies, cakes		
	Healthy cooking choices: grill, steam, boil or broil instead of frying; take skin off chicken. <i>Ask what the patient likes for meat. Ask how they usually cook it. If it is not cooked in a healthy manner, ask how it might be prepared to be healthier.</i>		
	Lower fat food choices: skim or 1% milk; low fat ice cream, sherbet; white meats (chicken, turkey, fish)		
	Fat free: vegetables and fruits. Try to get 5/day. <i>Ask the patient to describe his/her usual eating pattern. Make a hatch mark for each fruit or vegetable mentioned and then discuss how vegetables and fruits might be increased.</i>		
	Use low/no fat spices to add zest: vinegar, hot sauce, mustard, Mrs. Dash, pepper . <i>Ask about usual condiments and explore if there are any that the patient might like.</i>		
Low salt diet (for CAD/HTN)	Limiting salt: avoid canned food or look for those marked "no salt," use salt substitutes and products like Mrs. Dash, limit cold cuts		
Taking Medications	Medications for CAD/HTN/Hyperlipidemia must be taken EVERY day.		
Cholesterol	What is cholesterol? Cholesterol is a waxy, fatty substance in the body. It comes in two forms, HDL and LDL. HDL helps protects your heart. A high level of HDL is good. LDL is the form of cholesterol that causes fat to build up in your blood. It can cause your blood vessels to get clogged much like a drain in a sink gets clogged. When this happens, blood cannot get through. People can have a heart attack or a stroke.		
	If you have heart disease or risks for heart disease, your LDL should be <100.		
	Exercise and a diet low in fats can help your cholesterol levels. The higher the high (HDL) and the lower the low (LDL) the better.		

Sample appointment tracking, patient reminders and follow-up care policy and procedure

I. Appointment tracking

- A. Appointments for referrals to specialists, consults, mental health providers, and community resources are entered in the database by the MA (medical assistant).
- B. The database is checked weekly by the MA.
- C. Follow-up dates are determined by the evidence-based care guidelines. Our office uses the MQIC (Michigan Quality Improvement Consortium) Guidelines. Follow-up dates that are in RED font color (high priority) should be completed within a week of the date. If no activity, alert the nurse or physician.
- D. Other follow-up dates - alert the nurse or physician two weeks after the date if not completed.
- C. Log completed referrals and add initials in the database.
- D. Copy completed referrals to Sheet 2 and delete from Sheet 1 in the database.
- E. The MA ensures that the information is added to the medical record or chart as appropriate.

II. Patient reminders

- A. The MA calls patients with RED font (high priority) follow-up dates and reminds them of appointments 24 hours prior to the appointment.
- B. Reminders are generated to patients via the patient portal by the EMR.
- C. The nurse runs reports from the registry 4 times a year to identify diabetic patients in need of an annual assessment or A1C test per the MQIC Management of Diabetes Mellitus guideline. A reminder notice is mailed to patients.

III. Follow-up care

- A. Nurses maintain the information on diabetics from the registry quarterly reports.
- B. MA calls the patients that haven't responded to the reminder notice and invites them to a planned, group or individual visit or refers them for eye exams or other services.
- C. A follow-up list is maintained by the MA. Names are crossed off when care is completed. The MA adds information to the registry or chart as necessary.
- D. The MA notifies the nurse when patients have not completed care within 60 days. The nurse contacts the patient.
- E. The nurse notifies the physician for patients who have not completed care within 90 days. The physician contacts the patient.

General Principles for the Diagnosis and Management of Asthma

The following guideline recommends general principles and key clinical activities for the diagnosis and management of asthma.

Eligible Population	Key Components	Recommendation and Level of Evidence
Children and adults with the following: ♦ Wheezing ♦ History of cough (worse particularly at night), recurrent wheeze, recurrent difficulty in breathing, recurrent chest tightness ♦ Symptoms occur or worsen in the presence of exercise, viral infection, inhalant allergens, irritants, changes in weather, strong emotional expression (laughing or crying hard), stress, menstrual cycles ♦ Symptoms occur or worsen at night, awakening the patient	Diagnosis and management goals	<ul style="list-style-type: none"> ♦ Detailed medical history and physical exam to determine that symptoms of recurrent episodes of airflow obstruction are present ♦ Use spirometry in all patients \geq 5 years of age to determine that airway obstruction is at least partially reversible [C]. ♦ Consider alternative causes of airway obstruction. <p>Goals of therapy are to achieve control by [A]:</p> <ul style="list-style-type: none"> ♦ Reducing impairment (prevent chronic symptoms, minimize need for rescue therapy with short-acting beta₂-agonists (SABA), maintain near-normal lung function and activity levels) ♦ Reducing risk (prevent exacerbations, minimize need for emergency care or hospitalization, prevent loss of lung function or prevent reduced lung growth in children, have minimal or no adverse effects of therapy)
	Assessment and monitoring	<ul style="list-style-type: none"> ♦ Assess asthma severity to initiate therapy. (Use severity classification chart, assessing both domains of impairment [B] and risk [C] to determine initial treatment.) ♦ Assess asthma control to monitor and adjust therapy [B]. (Use asthma control chart, assessing both domains of impairment and risk to determine if therapy should be maintained or adjusted. (Step up if necessary; step down if possible.)) ♦ Obtain lung function measures by spirometry at least every 1-2 years [B], more frequently for not well-controlled asthma. ♦ Schedule follow-up care: In general, consider scheduling patients at 2- to 6-week intervals while gaining control [D]; at 1- to 6-month intervals, depending on step of care required or duration of control, to monitor if sufficient control is maintained; at 3-month intervals if a step-down in therapy is anticipated [D]. ♦ Assess asthma control, medication technique, written asthma action plan, patient adherence and concerns at every visit.
	Education	<ul style="list-style-type: none"> ♦ Provide self-management education [A]. Teach and reinforce: self-monitoring to assess control and signs of worsening asthma (either symptom or peak flow monitoring) [B]; using written asthma action plan (review differences between long-term control and quick-relief medication); taking medication correctly (inhaler technique and use of devices); avoiding environmental and occupational factors that worsen asthma. ♦ Tailor education to literacy level of patient; integrate education into all points of care; appreciate potential role of patient's cultural beliefs and practices in asthma management [C]. ♦ Develop written action plan in partnership with patient [B].
	Control environmental factors and comorbid conditions	<ul style="list-style-type: none"> ♦ Recommend measures to control exposures to allergens and pollutants or irritants that make asthma worse [A]. ♦ Consider allergen immunotherapy for patients with persistent asthma and when there is clear evidence of a relationship between symptoms and exposure to an allergen to which the patient is sensitive [B]. ♦ Treat comorbid conditions (e.g., allergic bronchopulmonary aspergillosis [A], gastroesophageal reflux [B], obesity [B], obstructive sleep apnea [D], rhinitis and sinusitis [B], chronic stress or depression) [D]. ♦ Inactivated influenza vaccine for all patients over 6 months of age [A] unless contraindicated
	Medications	<ul style="list-style-type: none"> ♦ Select medication and delivery devices to meet patient's needs. ♦ Use a stepwise approach to pharmacologic therapy to gain and maintain asthma control [A]. (See age-specific guidelines.) ♦ Inhaled corticosteroids (ICS) are the most effective long-term control therapy [A]. Optimize ICS use before advancing to other therapies. When choosing among treatment options, consider patient's impairment and risk, history of response to medication, willingness and ability to use medication.
Referral	<ul style="list-style-type: none"> ♦ Refer to an asthma specialist for consultation or comanagement if there are difficulties achieving or maintaining control (See age-specific guidelines.); immunotherapy or omalizumab is considered; additional testing is indicated; or if the patient required 2 bursts of oral systemic corticosteroids in the past year or a hospitalization [D]. 	

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the 2007 National Asthma Education and Prevention Program Expert Panel Report 3, Guidelines for the Diagnosis and Management of Asthma, National Heart, Lung and Blood Institute (www.nhlbi.nih.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Management of Diabetes Mellitus

The following guideline applies to patients with type 1 and type 2 diabetes mellitus. It recommends specific interventions for periodic medical assessment, laboratory tests and education to guide effective patient self-management.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Patients 18-75 years of age with type 1 or type 2 diabetes mellitus	Periodic assessment	<p>Assessment should include:</p> <ul style="list-style-type: none"> Height, weight, BMI, blood pressure [A] (adult target of < 130/80) Assess cardiovascular risks (smoking, hypertension, dyslipidemia, sedentary lifestyle, obesity, stress, family history, age > 40) Comprehensive foot exam (including monofilament testing annually) [B] Screen for depression [D] Dilated eye exam by ophthalmologist or optometrist [B], or digiscope [B] 	<ul style="list-style-type: none"> At least annually and more frequently as needed In the absence of retinopathy repeat in 2 years
	Laboratory tests	<p>Tests should include:</p> <ul style="list-style-type: none"> A1C [D] Urine microalbumin measurement [D] Serum creatinine and calculated GFR [D] Fasting lipid profile 	A1C 2 - 4 times annually based on individual therapeutic goal ; other tests at least annually
	Education, counseling and risk factor modification	<ul style="list-style-type: none"> Comprehensive diabetes self-management education (DSME) from a collaborative team or diabetic educator if available Education should be individualized, based on the National Standards for DSME¹[B] and include: <ul style="list-style-type: none"> Assessment of patient knowledge, attitudes, self-management skills and health status; strategies for making health behavior changes and addressing psychosocial concerns [C] Description of diabetes disease process and treatment; safe and effective use of medications; prevention, detection and treatment of acute and chronic complications Importance of nutrition management and regular physical activity [A] Role of self-monitoring of blood glucose in glycemic control [A] Cardiovascular risk reduction Smoking cessation intervention [B] and secondhand smoke avoidance [C] Self-care of feet [B]; preconception counseling [D]; encourage patients to receive dental care [D] 	At diagnosis and as needed
Medical recommendations	<p>Care should focus on smoking, hypertension, lipids and glycemic control:</p> <ul style="list-style-type: none"> Medications for tobacco dependence unless contraindicated Treatment of hypertension using up to 3-4 anti-hypertensive medications to achieve adult target of < 130 systolic [B] and < 80 diastolic [A] Prescription of ACE inhibitor or angiotensin receptor blocker in patients with hypertension or albuminuria [A]² Statin therapy for primary prevention against macrovascular complications in patients with diabetes who are ≥ age 40 or who have an LDL-C ≥100 mg/dl [A]³ Anti-platelet therapy [A]: low dose aspirin daily for primary prevention in adults at increased cardiovascular risk with type 1 [C] and type 2 [A] diabetes, unless contraindicated Adjust the plan to eventually achieve normal or near-normal glycemia with an A1C goal for most patients of < 7%. Less stringent treatment goals may be appropriate for patients with a history of severe hypoglycemia, patients with limited life expectancies, very young children or older adults and individuals with comorbid conditions. More stringent treatment goals (i.e., a normal A1C < 6%) for individual patients and in pregnancy. Note: Insulin and sulfonureas sometimes result in weight gain. Assurance of appropriate immunization status (tetanus, diphtheria, pertussis, influenza, pneumococcal vaccine) [C] 	At each visit until therapeutic goals are achieved	

¹ See http://care.diabetesjournals.org/content/vol31/Supplement_1/

² Consider referral of patients with serum creatinine value >2.0 mg/dl (adult value) or persistent albuminuria to nephrologist for evaluation.

³ Target LDL-C < 100 mg/dl **[B]**. For patients with overt CVD, a lower LDL-C goal of < 70 mg/dl is an option **[B]**.

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources, including the 2008 American Diabetes Association Clinical Practice Recommendations (www.diabetes.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Michigan Quality Improvement Consortium Guideline

Adults with Systolic Heart Failure

The following guideline recommends diagnostic evaluation, pharmacologic treatment and education that support effective patient self-management.

Eligible Population	Key Components	Recommendation and Level of Evidence
Adults with suspicion of left-ventricular systolic dysfunction, including heart failure	Evaluation	<p><u>Initial assessment should include:</u></p> <ul style="list-style-type: none"> ◆ Thorough history and physical examination [C] ◆ Depression screening ◆ Assessment for coronary artery disease and risk factors ◆ Chest X-ray [C] ◆ 12-lead electrocardiogram [C] ◆ Lipid profile, CBC, electrolytes, calcium, magnesium, BUN, creatinine, blood glucose, liver function tests, TSH, urinalysis [C] ◆ Two-dimensional echocardiography with Doppler [C] ◆ Serial monitoring should include: weight, volume status, electrolytes, renal function and activity tolerance.
Adults diagnosed with left-ventricular systolic dysfunction, including heart failure	Pharmacological management	<p><u>Drugs recommended for routine use:</u></p> <ul style="list-style-type: none"> ◆ ACE inhibitors in all patients, unless contraindicated¹ [A] ◆ Recommend beta-blockers (carvedilol, sustained-release metoprolol, bisoprolol) in all stable patients, unless contraindicated^{1,2} [A] <p><u>Drugs recommended for use in select patients:</u></p> <ul style="list-style-type: none"> ◆ Diuretics and sodium restriction for evidence of fluid retention [A] ◆ Spironolactone for patients with moderate or severe symptoms of heart failure, preserved renal function (creatinine < 2.0 in women; creatinine < 2.5 in men) and normal serum potassium concentration [A] ◆ In patients who cannot tolerate ACE inhibitors due to cough or angioedema, angiotensin receptor blockers are recommended [A]. ◆ In patients who cannot tolerate ACE inhibitors or ARBs due to angioedema or renal insufficiency; hydralazine and nitrate combination is recommended [A]. ◆ African-American patients who remain symptomatic despite therapy with ACE inhibitors, beta-blockers and PRN diuretics, may be candidates for adding the combination of hydralazine and isosorbide dinitrate [A].
	Education, counseling and risk factor modification	<p><u>Educate patient and family regarding:</u></p> <ul style="list-style-type: none"> ◆ Daily self-monitoring of weight and adherence to recommended patient action plan ◆ Recognition of symptoms and when to seek medical attention ◆ Moderate dietary sodium restriction (e.g., 2,000-2,500 mg sodium/day) ◆ Risk factor modification (regular exercise 5 times per week as tolerated [B]; smoking cessation; control of BP, DM, lipids) ◆ Avoid excessive alcohol intake, illicit drug use, and the use of NSAIDS ◆ Vaccination against influenza and pneumococcal disease

¹ Contraindications include: life-threatening adverse reactions (angioedema or anuric renal failure), pregnancy, hypotensive patients at immediate risk of cardiogenic shock, systolic blood pressure < 80 mm Hg, serum creatinine > 3 mg/dL, bilateral renal artery stenosis, or serum potassium > 5.5 mmol/L.

² Contraindications include: patients with current or recent fluid retention history, unstable or poorly controlled reactive airway disease, symptomatic bradycardia or advanced heart block (unless treated with a pacemaker), or recent treatment with an intravenous positive inotropic agent.

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (www.acc.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Medical Management of Adults with Hypertension

The following guideline recommends diagnostic evaluation, education and pharmacologic treatment that support effective patient self-management.

Eligible Population	Key Components	Recommendation and Level of Evidence
<p>Adult patients ≥ 18 years of age. Not pregnant.</p> <p>Classification based on mean of 2 or more seated BP readings on each of 2 or more office visits.</p> <p>Normal BP <120/<80</p> <p>Prehypertension 120-139/80-89</p> <p>Hypertension: Stage 1 140-159/90-99 Stage 2 $\geq 160/\geq 100$</p>	Initial assessment	<ul style="list-style-type: none"> The objectives of the initial evaluation are to assess lifestyle, cardiovascular risk factors, concomitant disorders, reveal identifiable causes of hypertension and check for target organ damage and cardiovascular disease. Physical examination: 2 or more BP measurements using regularly calibrated equipment with the appropriate sized cuff and separated by at least 2 minutes, verification in contralateral arm, funduscopic exam, neck exam (bruits), heart and lung exam, abdominal exam for bruits or aortic aneurysm, extremity pulses [A] Laboratory tests prior to initiating therapy: Potassium, creatinine, glucose, hematocrit, calcium, urinalysis, lipid panel, EKG [D]
	Patient education and nonpharmacologic interventions	<ul style="list-style-type: none"> Lifestyle modification: weight reduction (BMI goal < 25), reduction of dietary sodium to less than 2.4 gm/day, DASH diet [A] (i.e. diet high in fruits and vegetables, reduced saturated and total fat), aerobic physical activity ≥ 30 minutes most days of the week, tobacco avoidance, increased dietary potassium and calcium, moderation of alcohol consumption¹ [A] Use of self BP monitoring. Home measurement device should be checked regularly for accuracy. Mean self measured BP > 135/85 generally considered to be hypertensive
	Goals of Therapy	<ul style="list-style-type: none"> Adjust therapy to achieve target BP $\leq 140/90$ (< 130/80 for patients with diabetes or kidney disease)
	Pharmacologic interventions	<ul style="list-style-type: none"> Prehypertension (120-139/80-89): none unless compelling indication (e.g., diabetes, renal failure, CHF, post-MI, stroke arteriosclerotic cardiovascular disease) Hypertension, Stage 1 (140-159/90-99): thiazide-type diuretics alone or in combination with angiotensin converting enzyme inhibitor (ACEI), beta blocker or calcium channel blocker (extended/sustained release or long acting)². Angiotensin receptor blocker (ARB) if ACEI not tolerated Hypertension, Stage 2 ($\geq 160/\geq 100$): two-drug combination (thiazide-type diuretic plus ACEI, beta blocker or calcium channel blocker (extended/sustained release or long acting); use ARB if ACEI not tolerated ACEI (ARB if ACEI not tolerated) are recommended in patients with diabetes or heart failure [A] Beta-blockers are recommended in patients with ischemic heart disease or heart failure 3 or more drugs may be necessary for some patients to achieve goal BP
Monitoring and adjustment of therapy [D]	<ul style="list-style-type: none"> Prehypertension without medication: annual BP check with lifestyle modification counseling Hypertension, Stage 1: initiate therapy and recheck at monthly intervals until goal is reached Hypertension, Stage 2: initiate therapy and recheck weekly or more often if indicated. Symptomatic Stage 2 may require hospital monitoring and treatment Modify antihypertensive therapy as needed if adverse effects become intolerable Once BP controlled with medication: recheck every 3-6 months Serum potassium and creatinine should be monitored at least 1-2 times/year for patients on medication 	

¹Moderate alcohol consumption is defined as up to two drinks per day for men, one drink per day for women and older people.

²Avoid use of short-acting nonsustained release calcium channel blockers **[A]**

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline represents core management steps. It is based on several sources, including: Hypertension Diagnosis and Treatment, Institute for Clinical Systems Improvement, 2006 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline

Screening and Management of Hyperlipidemia

The following guideline recommends risk assessment, stratification, education, counseling and pharmacological interventions for the management of low-density lipoprotein cholesterol (LDL-C)

Eligible Population	Key Components	Recommendation and Level of Evidence								
Age \geq 18 years	Risk Assessment	<ul style="list-style-type: none"> Screening: Initial fasting lipid profile (i.e., total, LDL-C, HDL-C, triglycerides); If normal repeat at least every five years [D] Treatment is based on LDL-C, major risk factors and presence of CHD or equivalent. <table border="1"> <tr> <td> Major Risk Factors: <ul style="list-style-type: none"> Cigarette smoking Hypertension (BP \geq 140/90) On antihypertensives, regardless of current BP levels HDL-C: $<$ 40 (HDL-C \geq 60 = negative risk factor) Family history (first degree) of premature CHD (men $<$ 55 years; women $<$ 65 years) Age (men \geq 45 years; women \geq 55 years) </td> <td> CHD Risk Equivalents: <ul style="list-style-type: none"> Other clinical forms of atherosclerotic disease (e.g., peripheral arterial disease, abdominal aortic aneurysm, and/or symptomatic carotid artery disease) Diabetes Multiple risk factors confer a 10-year risk for CHD $>$ 20% CHD and CHD risk equivalents give a $>$ 20% risk of a CHD event within 10 years </td> </tr> </table>	Major Risk Factors: <ul style="list-style-type: none"> Cigarette smoking Hypertension (BP \geq 140/90) On antihypertensives, regardless of current BP levels HDL-C: $<$ 40 (HDL-C \geq 60 = negative risk factor) Family history (first degree) of premature CHD (men $<$ 55 years; women $<$ 65 years) Age (men \geq 45 years; women \geq 55 years) 	CHD Risk Equivalents: <ul style="list-style-type: none"> Other clinical forms of atherosclerotic disease (e.g., peripheral arterial disease, abdominal aortic aneurysm, and/or symptomatic carotid artery disease) Diabetes Multiple risk factors confer a 10-year risk for CHD $>$ 20% CHD and CHD risk equivalents give a $>$ 20% risk of a CHD event within 10 years 						
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LDL $>$ 100	Risk Stratification	<ul style="list-style-type: none"> Calculate short-term risk for patients with 2+ risk factors using Framingham projection of 10-year absolute risk [D]: <table border="1"> <thead> <tr> <th>Categorical Risk</th> <th>Goal for LDL-C</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> CHD or CHD risk equivalents 10-year risk: $>$ 20% </td> <td>$<$ 100 mg/dL</td> </tr> <tr> <td> <ul style="list-style-type: none"> 2+ risk factors 10-year risk: \leq 20% </td> <td>$<$ 130 mg/dL</td> </tr> <tr> <td> <ul style="list-style-type: none"> 0 - 1 risk factor </td> <td>$<$ 160 mg/dL</td> </tr> </tbody> </table>	Categorical Risk	Goal for LDL-C	<ul style="list-style-type: none"> CHD or CHD risk equivalents 10-year risk: $>$ 20% 	$<$ 100 mg/dL	<ul style="list-style-type: none"> 2+ risk factors 10-year risk: \leq 20% 	$<$ 130 mg/dL	<ul style="list-style-type: none"> 0 - 1 risk factor 	$<$ 160 mg/dL
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<ul style="list-style-type: none"> 0 - 1 risk factor 	$<$ 160 mg/dL									
	Education and risk factor modification	<p>Educate patient/family regarding Therapeutic Lifestyle Changes (TLC):</p> <ul style="list-style-type: none"> Reduce saturated fats and cholesterol [A], increase plant stanols/sterol (e.g. cholesterol-lowering margarines), increase viscous soluble fiber (e.g. oats, barley, lentils, beans). Decrease weight and increase exercise to moderate level of activity for 30 minutes, most days of the week [A]. 								
	Pharmacologic interventions	<ul style="list-style-type: none"> TLC and/or drug therapy may be initiated based on the LDL-C level and/or presence of CHD risk or CHD risk factors. Initiate statin therapy for patients with atherosclerotic CHD or when the LDL-C is not at goal by 6 - 8 weeks after TLC have begun in earnest. Statins are the most commonly used lipid-lowering agents. Liver function test monitoring is recommended for 12 weeks following treatment initiation, or dosage increases, of any statin. Evaluate and adjust drug therapy at 6 - 8 week intervals. For patients who do not reach LDL-C goal, consider referral to lipid specialist. 								

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline represents core management steps. It is based on several sources, including: Lipid Management in Adults, Institute for Clinical Systems Improvement, 2006 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Michigan Quality Improvement Consortium Guideline

Diagnosis and Management of Adults with Chronic Kidney Disease

The following guideline recommends diagnosis and aggressive management of chronic kidney disease by clinical stage.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
All adults at increased risk for CKD	Screening & Diagnosis	<p>For patients at increased risk for CKD (e.g., diabetes, hypertension, family history of kidney failure, kidney stones, etc.) assess for markers of kidney damage:</p> <ul style="list-style-type: none"> ◆ Measure blood pressure [A] ◆ Obtain estimated GFR¹ (serum creatinine levels should <u>not</u> be used as sole means to assess renal function) ◆ Protein-to-creatinine ratio or albumin-to-creatinine ratio (first morning or random spot urine specimen) ◆ Urinalysis, fasting lipid profile, electrolytes, BUN 	<ul style="list-style-type: none"> ◆ Semi-annual blood pressure monitoring; more frequent monitoring if indicated ◆ Monitor GFR every 1-2 years
	Risk Factor Management & Patient Education	<ul style="list-style-type: none"> ◆ Evaluation and management of comorbid conditions (e.g. diabetes, hypertension, urinary tract obstruction, cardiovascular disease)² ◆ Review medications for dose adjustment, drug interactions, adverse effects, therapeutic levels ◆ Educate on therapeutic lifestyle changes: dietary sodium intake < 2.4 g/d recommended for patients with CKD and hypertension [A], weight maintenance if BMI < 25, weight loss if BMI ≥ 25, exercise and physical activity, moderation of alcohol intake, smoking cessation 	At each routine health exam
Adults with CKD		<p>All of the above plus:</p> <ul style="list-style-type: none"> ◆ Develop clinical action plan for each patient, based on disease stage as defined by the National Kidney Foundation, Kidney Disease Outcomes Quality Initiative (K/DOQI) [B] ◆ Incorporate self-management behaviors into treatment plan at all stages of CKD [B] 	
	Core Principles of Treatment	<ul style="list-style-type: none"> ◆ Stage 1 (GFR ≥ 90): Monitor GFR annually, smoking cessation, consider ASA, consider ACE and/or ARB therapy, BP goal <130/80, LDL-C goal < 100 ◆ Stage 2 (GFR 60-89): Nephrology referral if GFR decline > 4ml/min/yr, maintain BP and lipid goals as above ◆ Stage 3 (GFR 30-59): Consult Nephrologist and Renal Dietician; Suppress PTH with Vit D to level appropriate for CKD stage; Phosphorus lowering treatment if > 4.6 mg/dl; Correct iron deficiency before start of erythropoiesis stimulating agent (ESA); ESA if Hgb (Hct) < 10 (30%); Renal-specific vitamins; Update vaccines: HBV, influenza, Tdap and Pneumovax ◆ Stage 4 (GFR 15-29): Nephrology and vascular access surgery referrals, ESA if Hgb < 10 g/dL, Optimize Ca x P product to < 55 with specific agents, update vaccines as indicated, CKD education classes ◆ Stage 5 (GFR < 15): Renal replacement therapy 	As indicated

¹ If not calculated by lab, refer to the National Kidney Foundation website for GFR calculator (<http://www.kidney.org/professionals/tools/>)

² Reference MQIC guidelines on diabetes, hypertension, hyperlipidemia and obesity (www.mqic.org).

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the Henry Ford Health System, Divisions of Nephrology & Hypertension and General Internal Medicine Chronic Kidney Disease (CKD) Clinical Practice Recommendations for Primary Care Physicians and Healthcare Providers, Edition 5.0 (www.ghsrenal.com). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

