

PCMH **Best Practice** OF THE YEAR AWARD



Submitted by:
Westminster Medical Clinic
Westminster, Colorado

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PHYSICIAN PRACTICE CONNECTIONS
PATIENT-CENTERED MEDICAL HOME

Certificate of Recognition

National Committee for Quality Assurance commends

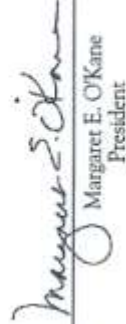
Westminster Medical Clinic

Recognized - Level 3

on Achievement of Recognition for Systematic use
of Patient-Centered, Coordinated Care Management Processes

Awarded from: June 17, 2009 to: June 17, 2012




Margaret E. O'Kane
President

Physicians

R. Scott Hammond, M.D.

CAFP member since 1983

AAFP member since 1983

R. Scott Hammond, M.D., FAAFP is board certified in Family Medicine and holds the position of Associate Clinical Professor in the Department of Family Medicine at the University of Colorado Health Sciences Center. He graduated from the University of Miami School of Medicine in 1978 where he was elected to the AOA Medical Honor Society. After several years as an Emergency Department physician at St. Anthony Hospital System in Denver, he attended the Mercy Medical Center Family Medicine program. He briefly served as faculty and has been in practice at the Westminster Medical Clinic since 1985.

He has served on numerous committees both at the hospital and organized medicine level, including an appointment to the Governor's steering committee for SBIRT. He is a strong advocate for primary care and is currently participating in several activities focusing on the Patient-Centered Medical Home as Medical Director of the Systems of Care/PCMH Pilot directed by the Colorado Medical Society 2009-2011, as well as, participating in the Colorado Multi-State, Multi-Stakeholder PCMH Pilot, the Ideal Medical Practices project and Improving Performance In Practice (IPIP).

He was a Board member of Colorado Academy Family Physicians (2008-2011) and the Chair of the CAFP Medical Home Task Force and representative to the Colorado PCMH Pilot Physician Advisory Board during his tenure. In addition, he is a member of the Health TeamWorks and serves as a mentor for the AAFP's Patient Enhancement Forum.

In 2011, he has given 35 lectures and presentations:

1. PCMH Speaker's Bureau
 1. CAFP
 2. Merck
2. Media presentations or articles
 1. CAFP Medical Home Muse newsletter, Editor (bimonthly Jan-July)
 2. Featured in Colorado Medicine, Colorado Medical Society
 3. Featured in the Westminster Window
 4. Medical Home News, "A Toolkit for Primary Care-Specialty Care Integration".
3. Conferences, Webinars and Lectures
 1. PCMH lectures
 1. CAFP Medical Student Reception
 2. University of Colorado School of Medicine PCMH Elective (2 lectures)
 1. History of the PCMH
 2. Care Coordination
 3. PCMH "Topics in Health Care" Speaker (3 lectures) -
 1. Fort Bliss, TX
 2. Layton, UT
 3. Spokane, WA
 2. Medical Neighborhood lectures
 1. Colorado Rural Health Center conference- Parker, CO
 2. Colorado PCMH Pilot (February conference)- Lakewood, CO

3. Physician Health Partners – Arvada, CO
4. Poudre Valley Medical Group – Loveland, CO
5. Medical Home Summit – Philadelphia, PA
6. Maine PCMH Collaborative (webinar)
7. Colorado Health Institute – Denver, CO
8. El Paso Medical Society – Colorado Springs, CO
9. Weld County Medical Society – Greeley, CO
10. Colorado PCMH Pilot (November conference) – Lakewood, CO
11. St. Mary’s Hospital – Durango, CO
4. Parade of Medical Homes and Medical Neighborhood meetings
 1. Hosted 4 POMH tours
 2. Hosted 9 Medical Neighborhood sessions
5. Legislative Meetings as CAFP representative promoting the PCMH
 1. Representative Gerou
 2. Representative Kefalas
 3. Senator Aquilar
 4. Representative Ferrandino
 5. Sue Birch, Director, Dept. of Health Care Policy and Financing

Robin Smith, D.O.

AOA member since 1994
 AAFP member since 1994
 CSOM member since 1997

Robin Smith, D.O. is a graduate of Western University of Health Sciences, College of Osteopathic Medicine of the Pacific in Pomona, California in 1994 and completed her residency in Family Medicine at the Community Hospital/Health ONE Osteopathic Family Medicine Internship and Residency P/SL Denver, Aurora and Community Hospital Grand Junction, Colorado in 1997. Her certification from the American Osteopathic Board of Family Practice is current from 1997 to 2013. She has been in practice at Westminster Medical Clinic from 1997 and partner since 2002.

Committees and Boards

- CSOM representative to Systems of Care/PCMH grant – 9/09 to 2011
- Physician Advisory Work Group, United Healthcare – 9/09 to 2011
- Colorado Society of Osteopathic Medicine
 - Nominating Committee – 8/10 to present
 - Past-past President - 8/09 to 8/10
 - Past President - 8/08 to 8/09
 - President - 8/07 to 8/08
 - President Elect - 8/05 to 8/07
 - Secretary/Treasurer - 11/03 to 7/05
 - Denver Trustee - 10/02 to 11/03
- Chairperson 2006 Midwinter Conference - Colorado Society of Osteopathic Medicine.
- CME Committee Chairperson from 8/05 to present - Colorado Society of Osteopathic Medicine.
- Credential’s Committee Chairperson from 1/01/02 to 6/01/04 - North Suburban Medical Center.
- Hospital Bylaws Committee from 1/01/00 to 6/01/04 - North Suburban Medical Center

Tracy H. Saffer, MD

CAFP member 1996-present

AAFP member 1995-present

Tracy H. Saffer MD has been board certified by the American Board of Family Physicians since 1995. She graduated medical school from Texas A&M Health sciences center in 1992 and completed her Family Medicine residency in 1995 from Phoenix Baptist Hospital. She served as Chief Resident her final year of residency and continued on as faculty for a short amount of time at Phoenix Baptist Hospital. Since moving to Colorado in 1996, she has participated in many community outreach projects including:

Committees and Boards

- Vice Chairman of the Family Medicine Department, Exempla Lutheran Hospital, 2004-2008
- Chairman, Family Medicine Department Exempla Lutheran, Hospital 2008- 2010.
- Preceptor
 - University of Colorado School of Medicine Foundations of Doctoring, 2011
 - Red Rocks Community College
 - Regis University, 1996- 2011

Volunteer Activities

- Tar Wars
- Doctor of the Day
- 9 News Health Fair
- Jefferson Action Center's weekly medical clinic
- Samaritan House Homeless Shelter's weekly medical clinic.

Letter of Patient Support

To Whom It May Concern:

The news is often filled with heroes who've rescued a cat from a tree for a little old lady; or, a young man diving into ice water to save a struggling child.

My heroes won't claim a headline.... Except in my heart! Dr. Tracy Saffer and her assistant Lee Anna are my heroes, whom I will always hold in the highest esteem. I thank the Lord for creating their hearts, hands, wisdom and passion.

My husband, Sam has recently suffered several mini strokes (TIAs). When he first suffered such an episode, I called our fire department. From home he was taken to Lutheran Hospital. There, they called Dr. Saffer. I was told by their staff that she told them to take us seriously. That she was well acquainted with us and our concerns would be legitimate.

How often does that, physician's personal endorsements of ones character, happen in life? When someone's personal physician knows them well enough to be their immediate advocate!

Several months later, when the TIA attack happened again, I called Dr. Saffer. Her assistant, Lee Anna called us twice in that day to make sure Sam was relaxed and doing fine. I will never forget such first hand kindness. It meant the world to me.

We have had the distinct pleasure of having Dr. Saffer manage a mirage of illness for both Sam and Me. Sam has Multiple Sclerosis, Diabetic, Alzimers and I've had two hip replacement surgeries. We have found constant intelligence, handling and referrals when necessary.

When I first met Dr. Saffer and also Lee Anna we loved them - from the minute we shook their hands, greeting each like we were old friends. Their office is contagious with friendliness! They each listened, really listened and answered all of my questions

Because Dr. Saffer is not your ordinary physician, she has cared and given me her time until I was comfortable with what I was asking; and, the whole time she makes me feel like I am the only one in the world at that moment.

In stating all that, we are so thankful for Dr. Staffer managing our health and our meds. My husband and I are 74 and 73 respectfully and expecting a much better health future because of Dr. Saffers' care of us. If only everyone could have her as their physician and friend. She's a role model in my eyes for all medical professionals.

God bless her hands and Lee Anna, too!

Carman and Sam Keene

November 11, 2011

To Whom It May Concern:

I have been a patient at Westminster Medical since 2004. My PC is Robin Smith, but I have been seen by others there, as necessity dictated.

Because of Dr. Smith's skill, my heart murmur was diagnosed. I was born with a defective valve and it must have been missed before then. Dr. Smith followed up with tests and eventually referred me to a great cardiologist, who also tracked the narrowing of the valve, until heart surgery became necessary in January of this year.

My COBRA insurance ended 6 weeks after the surgery. Dr. Smith continued to see me on a pay-as-you-can basis, even offering to see me for free, rather than let me go without care. I believe that Dr. Smith is the reason I am alive and healthy today.

I live with my elderly mother who needs help with bathing, etc. I could not afford the \$60 per visit charged by for-profit agencies. The stress of being her caregiver was telling. I could not keep up with her needs by myself. Dr. Smith gave me a referral to the Dominican Sisters home health agency. This referral was a Godsend.

Thank you, Doctor Smith and all the friendly people at Westminster Medical.

Sincerely,

Kitty Smith

2815 W. 116th Pl. #104

Westminster CO 80234

October 28, 2011

TO; PATIENT-CETERED MEDICAL HOME:

I would like you to know how very pleased I have been with The Westminster Medical Clinic (WMC) as a Patient-Centered Medical Home (PCMH).

Dr. R. Scott Hammond has been my PCP for almost 16 years; so, long before they became a PCMH I was pleased, but, I have been more able to become a true partner in my health care lately. Just a few examples to follow:

In February, 2010, I fell on my front porch. My Letter Carrier heard my fall, came back to see me covered in blood and wanted to call 911 and an ambulance. I refused the help, told her I would go to the E.R., grabbed my purse and keys, got in my car and headed toward the hospital,(which by the way, is only about 8 or 9 blocks away from my house,) I drove past the hospital and went another 30 or so blocks to the WMC, Where they promptly took me in, helped me clean my bloodied face, treated my broken nose, and compassionately made sure I was OK much more promptly and easily than would have been at the E.R..

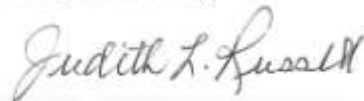
A couple months later I was seen by Dr. Hammond with "back issues". He sent me to get an MRI which showed Degenerative Disc Disorder. I was referred to a Spine Specialist, who said surgery was the only answer. They were able to use the MRI from Dr. Hammond instead of putting me and my Insurance Company through more time and expense. This is only one benefit of the "Medical Neighborhood". The tests performed before surgery were then forwarded to my PCP – again saving additional time, stress and money.

After my bone fusion surgery, release from the hospital and Re-Hab facility, Westminster Medical Clinic set me up with in-home Physical Therapy and I received several calls from the M.A.'s to see how I was doing.

I had the misfortune to somehow come down with a severe intestinal infection (C-Diff) and was instructed to go to the hospital to clear it up. This hospital stay lasted 6 days. After being released I was contacted by the M.A.'s and even once by Dr. Hammond. Even though I was on a steady regimen of antibiotics, the infection remained. On a Sunday morning, Dr. Hammond's M.A. arranged for me to go back to the hospital, being directly admitted, avoiding the E.R. experience. This hospital stay lasted 4 days. After my release, I was in touch with Dr. Hammond and trying to finally be rid of this nasty, debilitating infection. I was on a constant regiment of antibiotics, 7 rounds of them. Dr. Hammond said we needed more aggressive treatment so prescribed Vancomycin. A 10-day prescription cost me (after my insurance's part) \$967.00 – when this didn't cure it, he referred me to the Infectious Disease doctors. He called first, explained to the Dr. how severe this had been. They were able to round up some samples of a brand new drug to help my expense. Again, because of the Medical Neighborhood and the PCMH I benefitted.

The office provides Health Coaching, Chronic pain and conditions counseling, Diabetic Group meetings where all who attend explain how various situations are more easily handled, diet do's and don'ts. Every person in the office is friendly, welcoming and compassionate. I can't imagine not being afforded this great service. From the Providers, the P.A.'s, M.A.'s, front desk, referrals and billing people, they are all great. Would they be good without Patient-Centered Medical Home, probably, but with it, I'm fortunate to be part of a Super Medical Team.

Thank you for listening,



Judith L. Russell
7792 Zuni St.
Denver, CO. 80221

Patient Satisfaction Surveys

We conducted 2 surveys last year. Our scores continue to show high satisfaction rates. We had, however, a significant shift from Good to Very Good from 2010 in several categories (2011 % in black and 2010 % in parentheses).

1. PHP survey summary scores of 200 patients in general population, reported in 2011 (Scale: Very Poor, Poor, Fair, Good, Very Good).

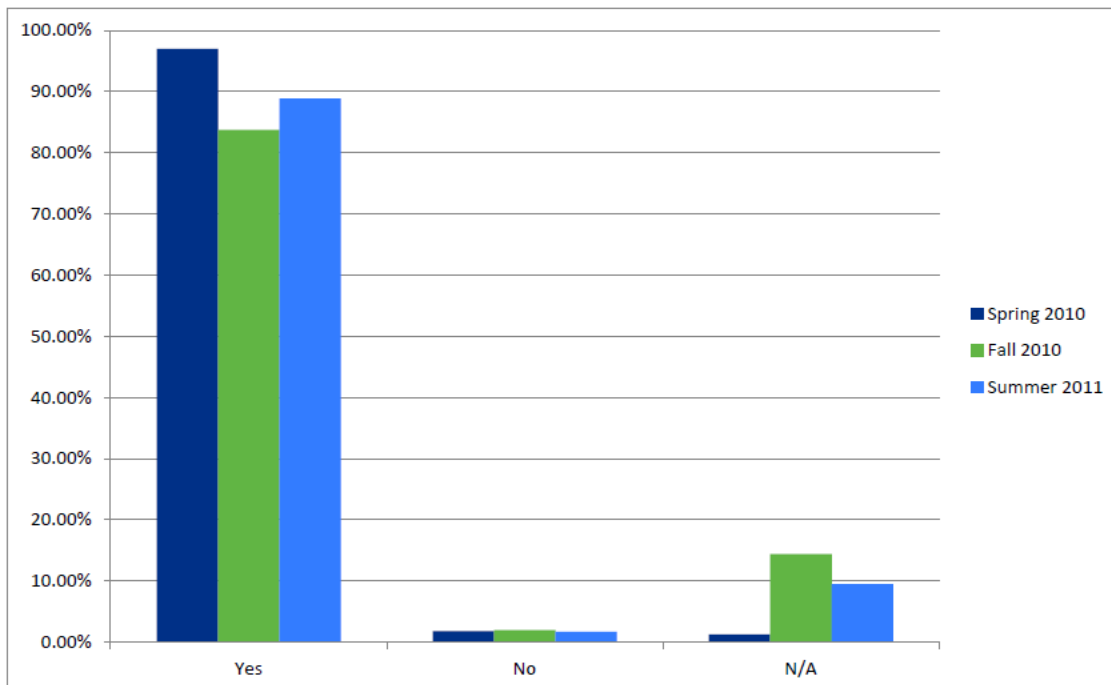
| Composite Category | Good | Very Good | Combined Total |
|--|---------------------|---------------------|----------------|
| Access to Care Scheduling, courtesy, helpfulness, promptness on returning calls | 36% (32% - 2010) | 62% (64% - 2010) | 97% |
| Visit Experience Speed of registration, staff courtesy, waiting area comfort, waiting time | 6% (41% - 2010) | 92% (55% - 2010) | 98% |
| Nurse/Medical Assistant Courtesy, concern | 4% (22% - 2010) | 92% (78% - 2010) | 96% |
| Care Provider Courtesy, concern, met expectations, included in decisions, clear language, confidence | 3% (28% - 2010) | 93% (68% - 2010) | 96% |
| Personal Issues Convenience, sensitivity to needs, privacy | 31% (35% - 2010) | 65% (62% - 2010) | 96% |
| Overall Assessment Cheerfulness, cleanliness of practice, care received, likelihood of recommending | 9% (26% - 2010) | 88% (71% - 2010) | 97% |

2. PCMH Pilot Patient satisfaction, 2011 (n=209)

| | N/A | Very Difficult | Difficult | Easy | Very Easy |
|----------------------------|-----|----------------|-----------|------|-----------|
| Received care when needed | 1% | 0% | 2% | 36% | 61% |
| Ease of making appointment | 2% | 0% | 2% | 34% | 62% |
| Ease of prescription | 5% | 0% | 3% | 33% | 59% |

| | | | | | |
|--|-----|----|----|-----|-----|
| refills | | | | | |
| Ease of lab results | 4% | 0% | 3% | 31% | 62% |
| Talk to a nurse | 10% | 0% | 1% | 36% | 53% |
| Talk to doctor | 17% | 3% | 6% | 35% | 39% |
| Office organized, efficient and not wasteful of time | 0% | 1% | 2% | 9% | 88% |
| Doctor Listen | 3% | 0% | 1% | 3% | 93% |
| Doctor explain | 1% | 0% | 0% | 3% | 96% |
| Included in decisions | 10% | 0% | 1% | 8% | 81% |
| Practice and specialist communication about care | 12% | 0% | 3% | 13% | 72% |
| Staff helpful | 2% | 0% | 2% | 4% | 92% |

Would you recommend this practice to your friends and family?



Recommendations of Specialist Support

References submitted directly to CAFP from:

Paul Denault, M.D.

Russell Tolley, M.D.

Quality Improvement projects and recognition

- Advancing Care Together, The Colorado Health Foundation, 2011-2014
 - WMC was awarded \$150,000 over 3 years to integrate mental health and behavioral health coaching in a primary care setting. We have co-located a Licensed Clinical Social Worker from Community Reach. We use the grant funds to pay her salary thus enabling us to provide her services at no cost to patients. This eliminates the two major barriers to receiving mental health services - cost and access. The second aspect of the grant is to offer health coaching to patients with chronic disease. The visits are billable through fee-for-service reimbursement. Our hope is to make this project a sustainable program.
- Systems of Care –PCMH Initiative, The Colorado Medical Society Foundation, 2009-2011
 - WMC piloted the implementation of the Medical Neighborhood between primary care and specialty physicians in a non-integrated system, as well as, developed a Compact and Toolkit that defined the relationship and responsibilities. This model has served as a template for Colorado and has spread as far as Maine. Centura extended the model to include hospitals with the adoption of the Physician-Hospital compact created at WMC in 2011. This compact outlines the responsibilities and accountability between community physicians and Skilled Nursing Facilities with the hospital and hospital-based physicians. Pilots are currently testing the flow and content of bi-directional information. WMC has received national attention from ACP, AHRQ, PCPCC and the Safety Net Medical Home Initiative as Medical Neighborhood and care coordination innovators.
- Colorado Multi-state, Multi-stakeholder PCMH Pilot, 2009-2012
- NCQA PCC-PCMH 2009
- NCQA Heart/Stroke 2007, re-recognized 2010
- NCQA Diabetes 2006, re-recognized 2009
- Bridges to Excellence 2008 - present
- Improving Performance in Practice (IPIP) 2006 -2011
- Diabetes and Cardiovascular Collaborative (CCGC, Colorado Department of Health, Colorado Foundation for Health Care) 2004 -2006

Internal QI projects

- QI Meetings
 - WMC conducts regular meetings to monitor our quality improvement projects and ensure sustainability of our successes. We have weekly meetings: all staff and providers, PCMH focus meeting, Provider focus meeting and MA focus meeting, as well as ACT grant meetings. Patient representatives attend our PCMH and MA focus meetings.
- Medical Assistants PDSAs (Plan-DO-Study-Act). Our MAs have conducted 11 PDSAs in 2011.
 - Analyze EMR capacity for MA next-day patient preparation and planning
 - Medical Assistants were able to increase their capacity for next-day preparation by utilizing the patient experience checklist and medical summary printout. Medical Assistants have an hour carved out to prepare for the next day by utilizing a floating MA for clinical coverage. The Patient Experience Checklist is attached below:

Patient Experience Checklist- Front Desk

Front Desk-check in

- Intake Forms**
 - Give PVA**
 - Give ROS (New patients, annual exams)**
- Collect or update insurance card**
- Collect Co-pay**
- Issues password for patient portal**

Front Desk-check out

- Set up next appointment**
- Give out information on PCMH**
- Give out information on medical neighborhood**
- Patient portal sign up**
- Check out supplements**

Patient Experience Checklist- MA

MA: PREVISIT PREP

- Print patient lab/diagnostic results (relevant to appt)**
- Obtain hospital records and consults as needed**

- Cross check the following are documented in eCW or needed: (Circle “alerts” in next section)**

Diabetic Standing orders:

**A1c
BP
Retinal Eye Exam
LDL
BMI
Foot check
Microalbumin
Self-management goal**

CVD Standing orders:

**BP
LDL
BMI
Self-management goal**

Immunizations

Td, Tdap, Pneumo, Influenza

Health Promotion and Maintenance

**Colonoscopies
Mammograms
DXA
Depression screening
Alcohol screening
Labs
Chronic care visit due: DM, CVD, COPD, Asthma,
Depression, pain
Preventative care and health assessment
Referral**

- Write “alerts” on PVA/CINA for providers**
- HUDDLE: Provider & MA (morning/afternoon/evening)**

MA- The Visit

- Urine Sample**
- Height**
- Weight**
- PHQ-2 questions answered**
- ETOH question answered**
- Reason for visit**
- Review medications**
- Smoking Status**
- Allergies**
- Update Pharmacy**
- Rx refills needed?**
- Immunizations/Vaccinations**

- Advance directives**
- Caregiver Status**
- Care team**
- Circle "Alerts"**
 - A1c >9**
 - BP > 130/80**
 - LDL >100**
 - BMI >27**
 - Microalbumin test > 1yr**
 - PHQ-2 is +**
 - Immunizations > 1yr**
 - Influenza, Pneumo**
 - Referral needed**
 - Retinal Eye Exam > 1yr**
 - Colonoscopy > 10 yrs**
 - Mammogram > 2 yrs** **(Patient over 50 yrs)**
 - Diabetic or CVD visit due**
 - Labs > 3 months**
 - DXA > 2-5 yrs**
 - Yearly physical**
 - Diabetic or CVD visit due**
 - Chronic care education**
- Vision (sports physical)**
- Review of systems**
- Temperature**
- Pulse**
- Respiration rate**
- BP**
- Foot check (Diabetics)**

- Reconcile RMD/eCW**
 - Update patient info for Diabetics, CVD, CONTRA meds**

Patient Experience Checklist- Prepared Provider

Provider pre-visit

- Check appointment time**
- Review PVA**
- EMR: Sticky note, CC, vital signs, Medications, lab work, previous encounter**
- Review History-acute/chronic**

- Review patient documents**
- “Alerts” on PVA/CINA**

Provider visit

- Engage patient**
- Negotiate PVA, PHQ, ROS, Alerts**
- Choose template, if appropriate**
- IF DM/CVD patient, complete registry for smoking counseling**
- Review labs and diagnostics**
- HPI and exam – type/template**
- Assessment**
- Disposition**
 - **Recommendations and counseling**
 - **RX (e-prescribe medicare – fax for others)**
 - **Xymogen supplements (consent)**
 - **Referrals (medical neighborhood flyer)**
 - **Order Tests**
 - **Labs (lab result preference)**
 - **Diagnostics**
 - **Alerts**
- Complete chart**

Beth Neuhalfen 2/2011

Additional PDSAs completed in 2011

- Increase aspirin use in patients with Diabetes
 - In one year, we increased antiplatelet use from 64% to 84%
- Increase use of Patient Portal
 - 3,897 of our patients use the patient portal. This is an increase of 37% in one year. 74% of our patients now use the patient portal.
- Test revisions of Mental Health Tracking tool, Rooming protocol, Diabetes Retinal exam reports
 - Retinal Eye exams: 38% (2010) - 57% (2011)
 - Standardized the Rooming protocol and the patient visit experience.

- Revision of Mental health tracking form
 - Improve Patient visit cycle time – increase value (face-to-face time); decrease waste (waiting)
 - Face-to-face time increased 3.25 minutes
 - Increase tobacco, depression and alcohol screening to 80% of patients seen
 - Depression screening (October data)
 - Diabetes – 92%
 - Cardiovascular disease - 89%
 - All WMC patients – 85%
 - Tobacco use screening (October data)
 - Diabetes – 100%
 - Cardiovascular disease - 99%
 - All patients - 97%
 - Alcohol use screening (October data)
 - All patients – 95%
 - Increase number of patient representative panelists to PCMH Transformation Committee
 - We now have a panel of 6 Patient representatives that alternate schedules to ensure 2-3 reps per meeting.
 - Increase efficiency of huddles with care teams
 - Huddles include the Physician, PA, MA and care coordinator. These huddles include a checklist of items to be covered including high acuity patients, hospital and ED patients. Huddles last an average of 5 minutes.
 - Increase in identification and efficiency of normal lab results sent to patient per patient preference.
 - Successfully implemented use of the revised lab routing sheets that specify patient preferences and recorded the preference in chart.
 - Increase awareness of measures through patient education boards in rooms
 - Developed protocol to identify and electronically track high priority procedures.
- Participation in DARTNet practice – based research studies
 - Anti-depressant side effects in relation to prescription adherence
 - Cardiovascular risk reduction learning community
 - Tested DARTNet registry functionality

Results of Practice Measures for 3 Important Conditions (NCQA)

Diabetes

The above measures are results from our Pilot project through October 2011. The solid line reflects Health Team Works 'stretch' goals.

Westminster Medical Clinic Data - Report Period: October 2011

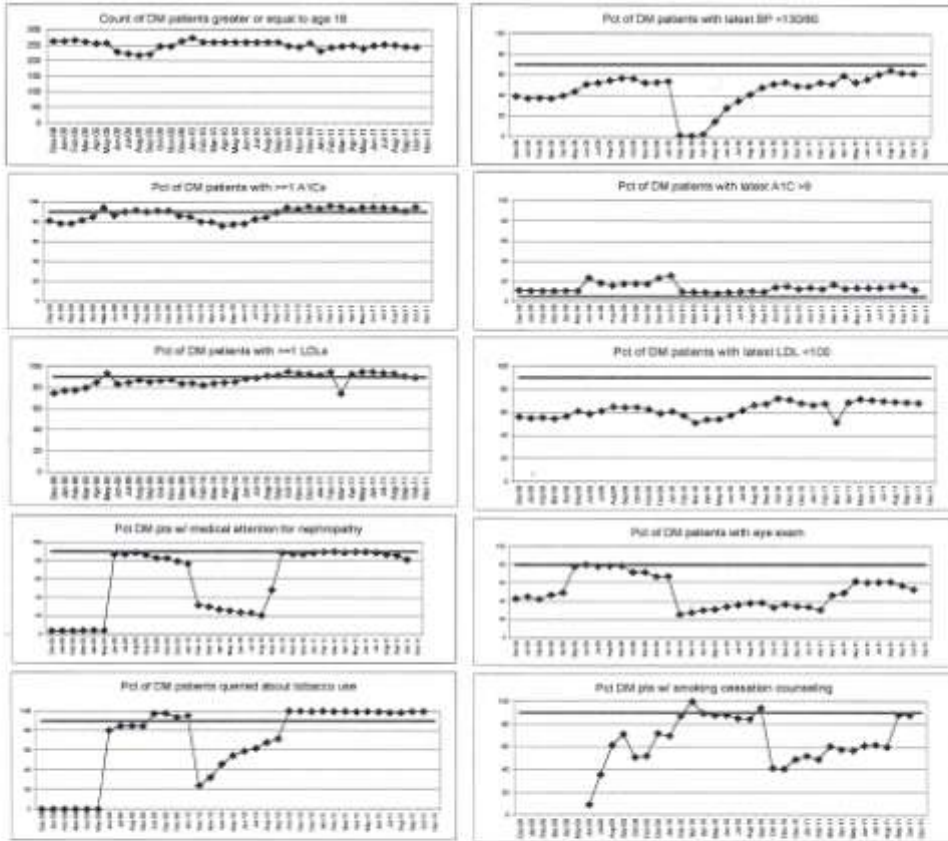
Diabetes Graphs

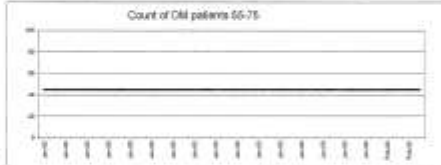
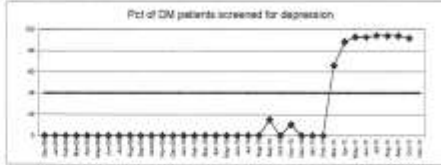
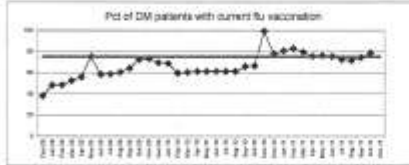
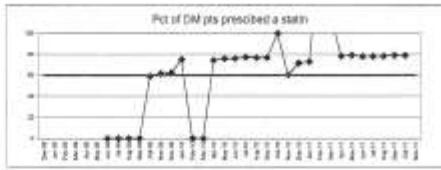
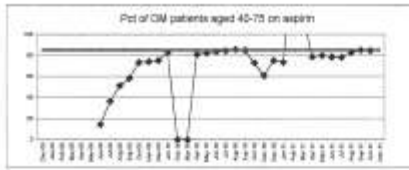
Show data for

Oct-11

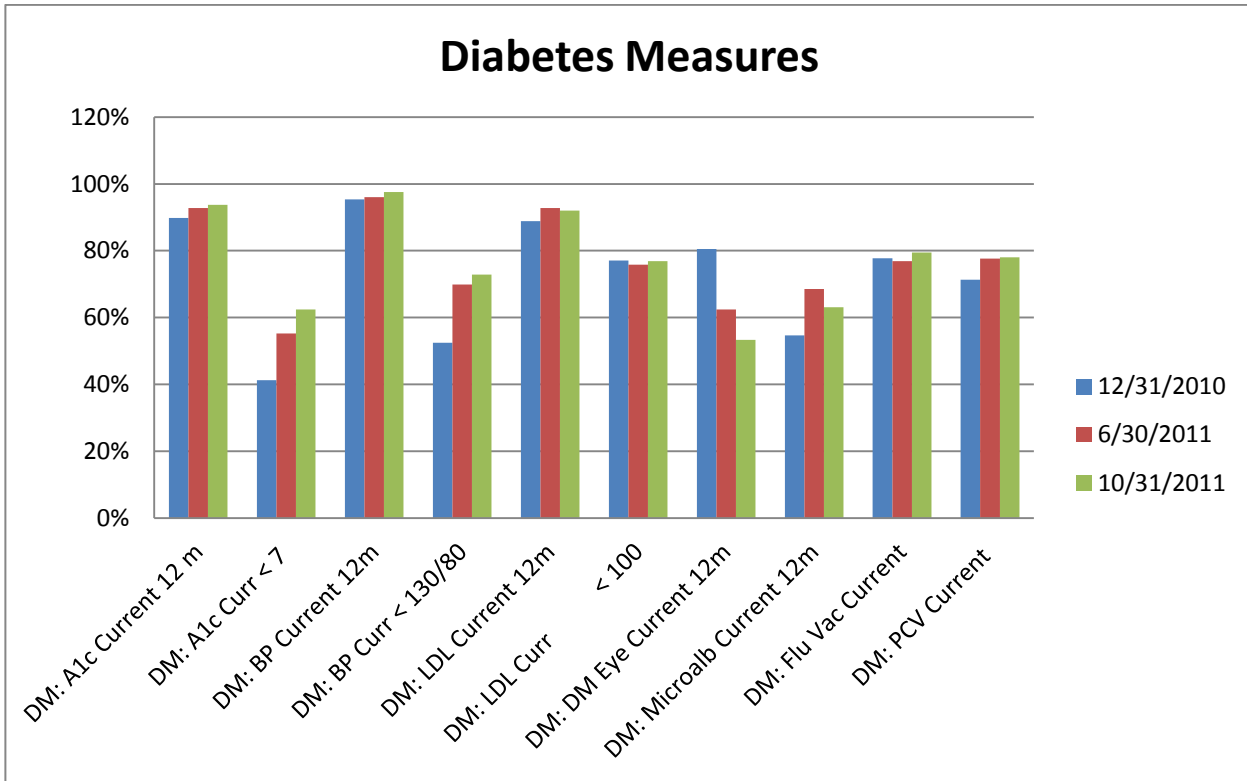
| | Goal | Oct-11 |
|---|------|--------|
| Count of DM patients greater or equal to age 18 | 245 | 245 |
| Pct of DM patients with ≥ 1 A1Cs | 90 | 95 |
| Pct of DM patients with ≥ 1 LDLs | 90 | 90 |
| Pct DM pts w/ medical attention for nephropathy | 90 | 81 |
| Pct of DM patients queried about tobacco use | 90 | 100 |
| Pct of DM patients aged 40-75 on aspirin | 85 | 84 |
| Pct of DM patients with latest BP <130/80 | 70 | 61 |
| Pct DM pts screened for depression | 40 | 92 |
| Pct DM pts screened - Positive | 50 | 0 |
| Count of DM patients 55-75 | 45 | 0 |
| Pct DM patients with latest LDL <130 | 50 | 0 |
| Pct DM patients with SM Goal | 55 | 0 |
| Pct DM pts with pneumo vacc | 60 | 0 |

| | Goal | Oct-11 |
|--|------|--------|
| Count of DM patients 40+ yo | 223 | 223 |
| Pct of DM patients with latest A1C >9 | 5 | 12 |
| Pct of DM patients with latest LDL <100 | 60 | 88 |
| Pct of DM patients with eye exam | 80 | 53 |
| Pct DM pts w/ smoking cessation counseling | 90 | 88 |
| Pct of DM pts prescribed a statin | 60 | 79 |
| Pct of DM patients with current flu vaccination | 75 | 79 |
| Pct of DM pts reassessed w/severity scale in 3 mos | 60 | 0 |
| Pct of DM pts w/6 mo assessment decreased 50% | 60 | 0 |
| Pct DM patients with latest BP <140/90 | 47 | 0 |
| Pct DM patients with foot exam | 52 | 0 |
| Pct DM pts 55-75 taking ACE/ARB | 57 | 0 |
| Pct DM patients referred for eye exam | 62 | 0 |





WMC measures have improved in all but one category over the year.

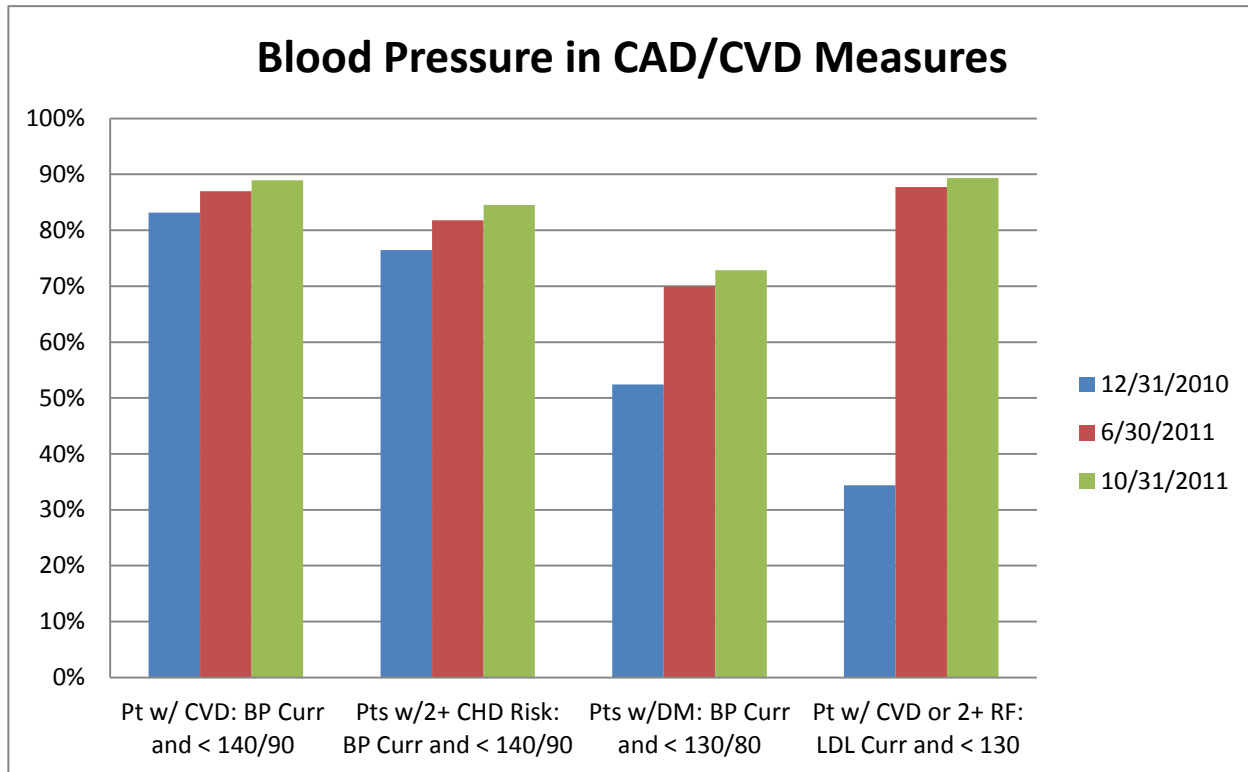


Hypertension and Cardiovascular Measures

The data below reflects the control of Hypertension in our general population, as well as, stratified across risk from 2010 to 2011. The last column in the table adds concurrent LDL < 130 in HTN patients.

(CVD – Cardiovascular Disease; CHD – Coronary Heart Disease; RF – Risk Factors; DM – Diabetes mellitus)

| | Pt w/ CVD: BP Curr and < 140/90 | Pts w/2+ CHD Risk: BP Curr and < 140/90 | Pts w/DM: BP Curr and < 130/80 | Pt w/ CVD or 2+ RF: LDL Curr and < 130 |
|------------|--|---|---|---|
| 12/31/2010 | 83% | 76% | 52% | 34% |
| 6/30/2011 | 87% | 82% | 70% | 88% |
| 10/31/2011 | 89% | 85% | 73% | 89% |



This data reflects our performance in the PCMH Pilot for patients with ischemic vascular disease (IVD) showing our ability to sustain excellent results and significantly improve smoking and depression counseling.

Westminster Medical Clinic Data • Report Period: October 2011
Heart - Stroke Graphs

Show data for

Oct-11

Count of Heart patients greater or equal to age 18

Goal 190

Pct of Heart patients with ≥ 1 Lipid Profile

80 82

Pct of Heart patients aged 40-75 on aspirin

80 85

Pct of Heart patients queried about tobacco use

80 99

Pct of Heart patients with latest BP < 140

75 86

Pct of Heart patients screened for depression

40 89

Pct of Heart patients Screened for DP - Positive

50 0

Count of patients 18+ with CAD

Goal

Pct of Heart patients with LDL < 100

50 59

Pct of Heart CAD patients on Lipid Lowering Therapy

80 58

Pct Heart pts w/ smoking cessation counseling

80 90

Pct of Heart CAD pts with Managed Risk Profile

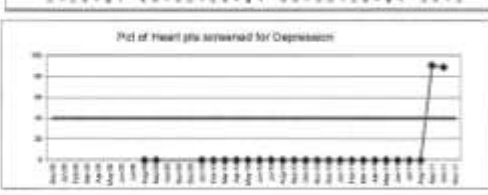
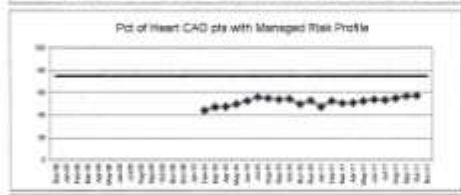
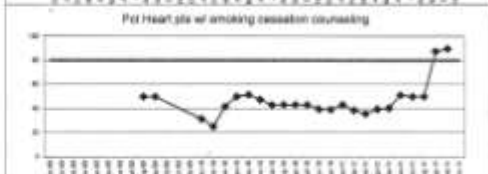
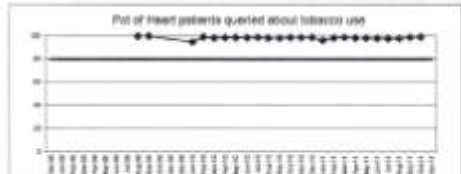
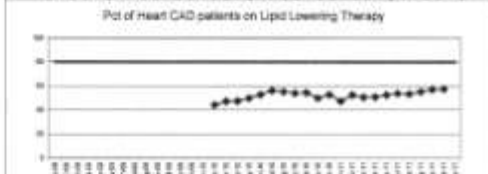
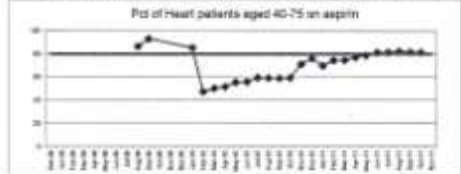
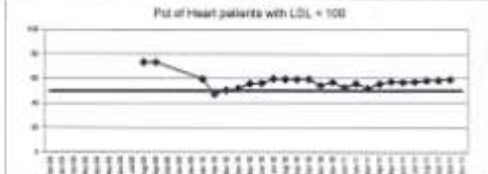
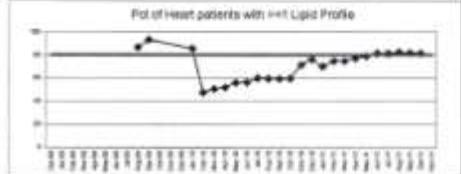
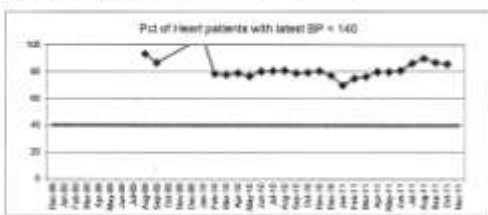
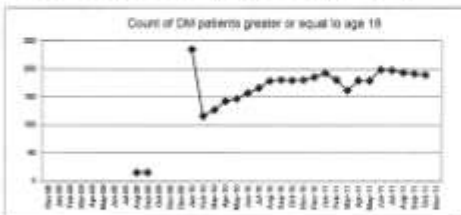
60 58

Pct of Heart pts reassessed w/severity scale in 3 mo

60 60

Pct of Heart pts w/6 mo assessment decreased 50%

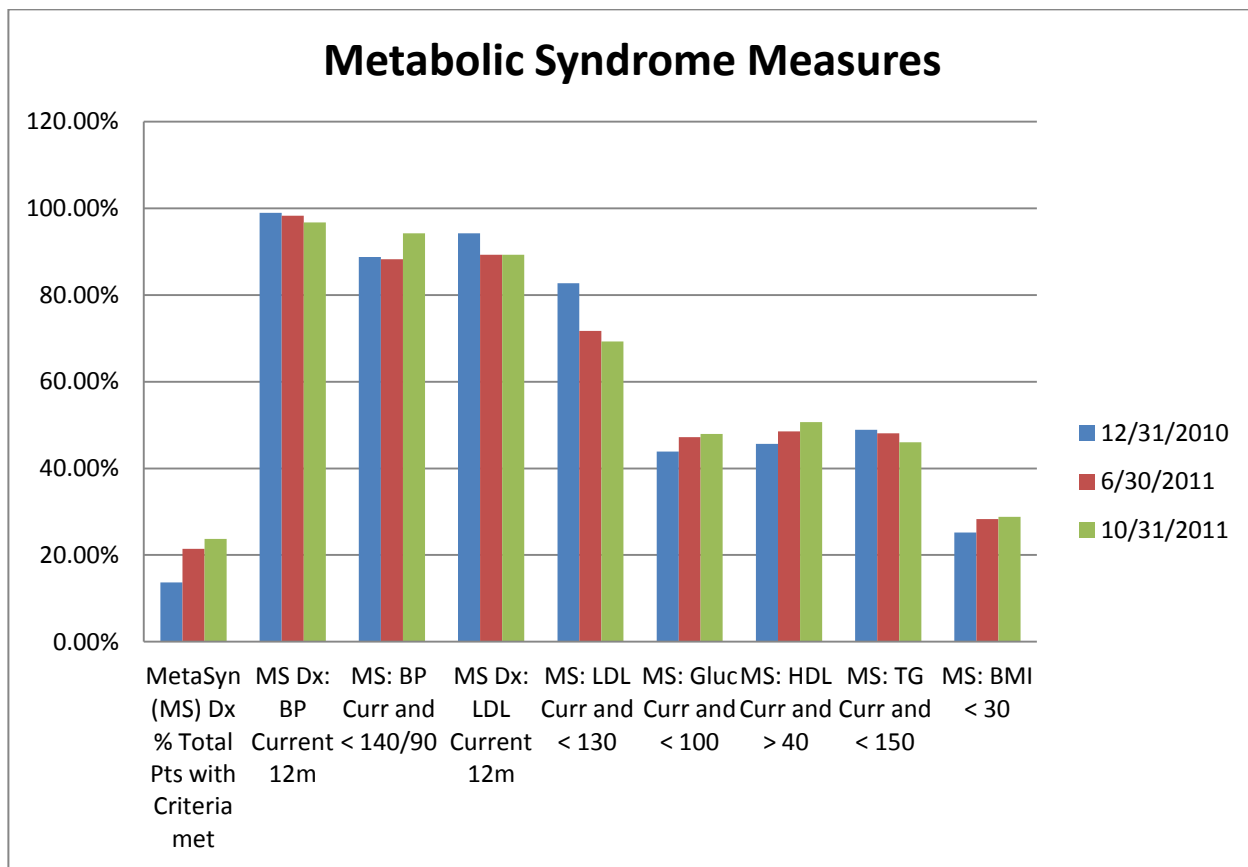
60 60



Metabolic Syndrome

This data reflects the diagnosis of metabolic syndrome and measurement of goals. Our primary goal was to identify our at-risk population and make a diagnosis. The next step is to improve clinical parameters. We have increased our diagnosis rate and improved BP control and increased the % of patients with BMI < 30. All but one parameter improved or remained the same.

| | MetaSyn (MS) Dx % Total Pts with Criteria met | MS Dx: BP Current 12m | MS: BP Curr and < 140/90 | MS Dx: LDL Current 12m | MS: LDL Curr and < 130 | MS: Gluc Curr and < 100 | MS: HDL Curr and > 40 | MS: TG Curr and < 150 | MS: BMI < 30 |
|------------|---|-----------------------|--------------------------|------------------------|------------------------|-------------------------|-----------------------|-----------------------|--------------|
| 12/31/2010 | 13.67% | 99% | 89% | 94% | 83% | 44% | 46% | 49% | 25% |
| 6/30/2011 | 21.46% | 98% | 88% | 89% | 72% | 47% | 48% | 48% | 28% |
| 10/31/2011 | 23.72% | 97% | 94% | 89% | 69% | 48% | 51% | 46% | 29% |



Care Management and Patient Education

2011 Highlights:

Major additions to Care Management at WMC were the integration of a Health Coach and the co-location of a mental health provider. In addition, WMC nurtured the growth of the Medical Neighborhood and extended the concept to hospitals by creating a Physician-Hospital Compact. Elements of the compact have been adopted by Centura Health Systems which have started pilots to facilitate communication between the ED and Hospitalists, as well as, between PCPs and the hospital. They are also piloting communication between SNF and ED/Hospitalists and between discharge advocates and our care coordinator.

We have developed a health literacy questionnaire to facilitate our care management efforts and will be testing its functionality in 2012. In addition, we created a hospital admission pamphlet, "*Your Hospital Experience*" to help patients have the safest hospital experience.

WMC continues to enhance our previous programs and adhere to all NCQA standards by tracking labs and referrals, measuring performance and reporting to providers and staff, outreaching to patients through the patient portal, performing population management, electronically integrating with our laboratories and sending electronic prescriptions. SureScripts provides drug-drug and drug-disease interaction alerts.

Medical Neighborhood (Enhanced care coordination)

WMC developed a care coordinator job description and protocol, as well as, increased our innovative Medical Neighborhood to 20 specialty practices through implementation of a Primary Care-Specialty Compact. Performance is scored for both the PCP and specialist. Core elements of care transition medical records were established and completion rates audited quarterly. Regularly, we visit, call or send e-mail to our specialists to continue constructive dialog. A Medical Neighborhood Information brochure was designed to prepare patients for the visit and outline the benefits of the program. Our practice's efforts were cited in the recent AHRQ white paper, *Care Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms*, and our compact was referenced in the Safety Net Medical Home Initiative Report, *Care Coordination: Reducing Care fragmentation in Primary Care*.

In 2011, WMC has been referenced by or featured in articles for our care coordination pioneering in Colorado:

- Health Policy Solutions
- Health Team Works
- Colorado Medicine
- AAFP News Now, American Academy of Family Physicians
- Westminster Window

Policy and procedures for bidirectional information were created and implemented with our primary hospital in order to track in-hospital patients and ensure that timely medical information is available when and where needed. A Master's in Public Health candidate from the Colorado School of Public Health assisted in the development of a Primary Care – Hospital Compact alongside the WMC Team. We are working closely with St. Anthony Hospital in Westminster to introduce the Compact into their system. Their care coordination program, Continuum Collaborative Guideline, intends to link community and hospital physicians and improve discharge planning. There were unique issues not addressed in our Specialist Compact that were outlined in a new Physician-Hospital Compact.

Health Literacy

WMC is working with a MPH candidate from the University of Colorado School of Public Health to create and test a health literacy questionnaire that will provide our physicians with a thorough picture of the patient's understanding of medical conditions, health and cultural beliefs, educational strengths and personality traits that will allow us to personalize our care plan to the patient.

Website

WMC implemented an interactive website that allows for patients to view lab reports, link to approved medical educational sites and contact the practice or their physician through a secured internet portal.

In 2011, WMC has made further advancements with the website to share patient education content on chronic diseases. The website not only links with medical educational sites but now has patient education directly on the website. Our health coaches use this tool to reinforce behavior change.

Mental Health Program

WMC has improved our mental health program. We added universal depression screening by performing a PHQ-2 on all patients. In 2011, previous discussions with Community Reach culminated when WMC was awarded a grant from The Colorado Health Foundation, *Advancing Care Together*. WMC was 1 of 12 sites awarded the 3-year grant. As part of the grant, Community Reach has placed a LCSW in our clinic. WMC is currently working on developing the most successful integration with the LCSW: not co-location, but collaboration. The LCSW provides both solution-based counseling at no cost to patients via scheduled appointments, as well as, immediate access for patients in crisis (i.e. Same day access).

WMC continues to incorporate evidence-based depression guidelines into practice. A PHQ-9 questionnaire is used to screen patients and monitor their response to drug therapy or counseling. A Mental Health log was developed and recently was revised to track patients and document phone calls at regular intervals to ensure medication adherence and efficacy. As part of the awarded grant, the LCSW, MAs, and Providers are working as a team to communicate effectively using the Mental Health log. The AUDIT and CRAFFT screening tools have been integrated into the screening process for substance abuse and utilized by the Team to help patients navigate to the right care at the right time using the SBIRT model.

Patient Education and engagement

WMC added Patient Education Boards on various health topics in each exam room. The Boards are created by the entire staff in a team based model and rotated quarterly. An electronic newsletter is sent quarterly to all patients on the portal. Our staff has received several sensitivity and communication trainings throughout the year. We completely revised our Patient Welcome Packet to include information on the PCMH, Medical Neighborhood, Portal access and the chronic care programs we offer.

Protime Clinic

WMC has all patients on warfarin entered into a registry. This evidence-based program is directed by the clinic RN to monitor and adjust warfarin within the recommended ranges set by the physician. A tickler system is employed to ensure regular testing.

Diabetes University and Group visits

WMC continues our Diabetes Education program that is directed by the Physician Assistant. This program has 13 sessions that follow the ADA recommendations for self-management. The patient moves through this program at their own pace and does not proceed to the next section until they demonstrate competency. WMC has been providing monthly group visits for patients with Diabetes for 6 years.

Health Coaching

WMC continues to focus on the obesity epidemic by identifying, assessing and managing overweight or obese patients. A Patient Visit Agenda that includes questions on weight concern is given to patients for almost all visit types. A BMI is recorded by the MA per protocol. Patients identified as obese or overweight with co-morbidities and who are interested in weight loss are tested with indirect calorimetry to determine their Resting Metabolic Rate. The results are given to the patient during a Group Visit and the patient is instructed on energy balance, calorie counting, food labels and clinic and community resources for further help. We see improvement in the obesity rates of our patients with Metabolic Syndrome as indicated in the previous graphs demonstrating our Practice Measures. In patients with Metabolic Syndrome, BMI < 30 increased from 25% to 29% over the last 12 months.

In addition to weight management, WMC has recently integrated a health coaching program specific to chronic disease patient education and self-management. The health coaching program is a standardized program for diabetes, cardiovascular disease, hypertension, hyperlipidemia, and metabolic syndrome. The program consists of 6 visits focusing on nutrition, exercise and behavior modification. Patients are given tools in a thought-provoking and creative process that inspires them to maximize potential. At WMC, we are tracking confidence level, laboratory parameters, as well as, other criteria for best patient outcomes.

Hypertension Clinic

WMC has adopted the 2008 AHA guidelines on Home Blood Pressure Monitoring in order to improve the accuracy and reliability of blood pressure measurements. Patients are trained according to guidelines on the proper technique of blood pressure measurements. 88% of our patients with hypertension and cardiovascular disease have BP < 140/90 (October 2011 data).

Pain Medicine clinic

A formal structure was created to ensure all patients on chronic narcotic treatment sign a contract and agreement on accepted use and clinic policies. The program adapted from the American Academy of Pain Medicine 4A's was incorporated into practice using templates, flow sheets and validated surveys to ensure the most effective and safe use of narcotics in patients with chronic pain. Standing Orders were created for Medical Assistants use in monitoring patients and refilling medications. We utilize COMM screens and the Colorado State Board of Pharmacy's Prescription Drug Monitoring Program (PDMP) to monitor patient safety.

Demonstration of Planned Team Care

2011 Highlights:

WMC has continued to develop and refine the care team concept. Each element noted below has received considerable attention to ensure reliability, consistency and effectiveness.

- Standardized clinical documentation
 - WMC standardized the nomenclature and documentation of key and essential clinical data to ensure accurate reports, timely retrieval of information and enhanced patient safety. WMC formalized the pre-visit activities and procedures (patient experience) of our Medical Assistants, to optimize patient care and preventative screening.
 - In 2011, we reviewed and revamped the clinical documentation protocol in an effort to improve clinical standardization and capture accurate data on performance measures.
- Daily huddles and weekly care coordination meetings
 - WMC conducts morning huddles to prepare for the day's work and weekly team meetings to continue team building, perform PDSAs and address issues of PCMH transformation. WMC has 2-3 patient representatives attend the monthly transformation team meetings and has 6 patients on the panel. Once a month, physicians and physician assistants review performance measures and action plans are created to improve selected clinical parameters.
 - In 2011, we have added care coordination huddles to inform providers of hospitalized and emergency department patients, as well as, updates on high acuity patients.
- Standing Orders
 - WMC has refined Standing Orders for Rooming patients, Routine Medication Refills, Narcotic Refills, Vaccines, and Lab tests.
 - Medical Assistants conduct smoking and alcohol assessment, and perform diabetic foot exams.
 - Medical Assistants participate in follow-up calls to patients in the Mental Health Program and Pain Clinic per standardized protocol.
 - At each visit, Medical Assistants use our EHR alert function and CINA registry to identify evidence-based USPSTF preventive services that are due.
- Care Coordination
 - Our RN identifies and monitors all hospitalized patients. She obtains data from insurance payers and follows up on high acuity patients. She

established bidirectional communication with one hospital that delivers 'medical records to floor' within 30 minutes of notification. The RN calls all discharged patients within 48 hours of discharge to create a care plan, reconcile medications and make a follow-up appointment with their personal physician.

- In 2011 care coordination improvements included daily fax notifications from Sound Inpatient Physicians of our patients who presented to 4 area hospitals and were admitted to their care. Pertinent medical records of these patients were faxed as soon as the care coordinator was notified. Faxed notification was then received upon patients discharge. Patients are contacted within 24 to 48 hours after discharge and an appointment is scheduled with a provider within a week. If a patient is discharged to a skilled nursing facility, follow-up calls to the facility are done and an appointment is made with WMC within a week of discharge.
- Patients who present to the ER and designate WMC as their primary care location, are called within 24-48 hours of release and are scheduled an appointment within a week.
- A log of ER visits and hospitalizations are kept to determine patients who are at increased risk of re-hospitalization and are followed up with phone calls and encouraged to schedule appointments in the office before symptoms worsen.
- Patients who struggle to afford their medications, obtain lab tests or need help with activities of daily living are assisted in locating assistance programs from various community resources.
- Population Management
 - To improve our ability to track patients and facilitate planned visits, we identified our patients with cardiovascular disease and created an alert in their chart. In addition, we created a better system to track colonoscopies and mammograms within or EHR registry. Improving this documentation resulted in improved capture for UTPSTF screening rates: mammogram 29% to 58% and colonoscopies 6% to 55%. These numbers underestimate our true screening rates due to the inability of the EHR to mine the unstructured data from > 1 year ago. We expect the rates to increase as patients come due for testing.
- Evidence-based guidelines
 - Evidence-based point-of-care information is available to all providers through UpToDate.
 - We have discontinued the CINA point-of-care registry reports and, for all patients at every visit, use the evidenced-based recommendations on preventive services and chronic care guidelines imbedded in our EHR alerts and templates.

Summary of Community Activities and Outreach

WMC is committed to serving the Westminster community and sharing our innovations and experience with Colorado.

- We believe PCMH medical education is crucial to the next generation of medical providers. WMC participates in the Foundations of Doctoring at the University of Colorado School of Medicine and hosted 2 students. In addition, WMC was instrumental in creating the first PCMH elective for 3rd year medical students and hosted a student for the 2-week experience. We served as a preceptor for a student from the University of Colorado School of Pharmacy through their experiential program.
- WMC has hosted 2 interns from University of Colorado School of Public Health to conduct their Capstone Projects at our clinic. The projects are listed below.
 - Care coordination – extend the Medical Neighborhood to include hospital systems. Create a Compact and test adoption.
 - Health literacy – develop and test a health literacy questionnaire specific to the needs of primary care
- WMC has hosted 11 Parade of Medical Home tours and Medical Neighborhood conferences in 2011 and welcomed visitors, consultants and researchers interested in a site visit to observe a PCMH. Dr. Hammond has given 35 lectures and presentations in Colorado and around the nation on the PCMH and care coordination.
- WMC staff conducted 2 *Healthier Living Colorado* sessions, open to our patients and community at-large, in chronic disease self-management skills at our facility.
- The Colorado Center Primary Care Innovation in partnership with WMC hosted a golf tournament fundraiser. The funds raised were in support of the Advancing Care Together grant that was awarded to WMC by The Colorado Health Foundation. Approximately \$5800 was raised in September 2011 and the funds were donated from Colorado Center for Primary Care Innovation to WMC to expand the mental and behavioral health services in the practice.
- Community Events participation by WMC staff in 2011:
 - Team in Training Leukemia/lymphoma run
 - Volunteer, Interfaith Hospitality Network (housing for homeless)
 - Volunteer, 9 Health Fair
 - Race for the Cure
 - Breast Cancer 3 day walk
 - Tour De Cure for Diabetes
 - Ralston House volunteer, a center for sexually abused children

- Volunteer phlebotomist, Draws blood monthly for residents in a group home,
- Volunteer, African Community Church - assistance to refugees.