FQHC CHRONIC DISEASE IMPROVEMENT TOOLKIT: BEST PRACTICES AND PATIENT ENGAGEMENT

IPHCA
Illinois Primary Health Care Association

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The Illinois Primary Health Care Association (IPHCA) would like to acknowledge and thank the Illinois Department of Public Health (IDPH) for providing funding to support our health centers that received the Chronic Disease and School Health (CDASH) mini-grants and the Chronic Disease Improvement Learning Collaborative. This allowed health centers to improve chronic disease prevention within their patient population, specifically diabetes and hypertension. The final reports and evaluation results from the CDASH mini-grants and the Learning Collaborative made it possible for us to create a chronic disease best practices document for health centers to use as support for patient engagement and the prevention of chronic diseases.

We would also like to give a special thanks to the health centers that gave us permission to use their best practices in this toolkit. We appreciate all of the support and positive feedback we have received.

Health centers include:

- Chestnut Family Health Center
- Christopher Greater Area Rural Health Planning Corporation
- Crossing Healthcare
- Erie Family Health Center, Inc.
- Lake County Health Department and Community Health Center
- Near North Health Service Corporation
- SIHF Healthcare
- Whiteside County Community Health Clinic
- Will County Community Health Center

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INTRODUCTION

IPHCA participated in the CDC's Chronic Disease and School Health (CDASH) grant through a partnership with the Illinois Department of Public Health (IDPH). Through this partnership, IPHCA was able to provide health centers mini-grant funding to facilitate chronic disease awareness and outcomes at Federally Qualified Health Centers (FQHCs), specifically diabetes and hypertension. This was accomplished through a survey of electronic health record capabilities, increasing referral of eligible patients to community-based chronic disease self-management programs and enhancing quality improvement processes in health systems.

IPHCA also established a Chronic Disease Improvement Learning Collaborative, composed of ten Federally Qualified Health Centers (FQHCs), to improve quality and health outcomes of health center patients specifically at risk for diabetes, those diagnosed and identified as either "in control" and/or "uncontrolled", and those with certain co-occurring conditions.

IPHCA partnered with Curis Consulting and IDPH to support the Learning Collaborative and to develop a comprehensive set of strategies, services and tools that supported the ten FQHCs in their efforts toward outcomes and achievements. A strong focus was put on optimizing resources, aligning priorities and interventions, achieving meaningful and quantifiable outcomes across all aspects of health center care delivery – Clinical, Quality, Operational, and Financial.

Topic areas included, but were not limited to:

- Evidence-based quality improvement strategies around chronic diseases, specifically diabetes and hypertension;
- Implementation of policies or systems that support chronic disease awareness, team-based care, and quality reporting;
- Referral of patients with chronic diseases;
- Etiology, risk, prevention, impact, and strategies for improvement;
- Care coordination and care management;
- Leveraging technology information and data.

Health centers that participated in the Learning Collaborative over a span of six months saw an average decrease of 1.04% in the percentage of adult patients (18-75 years old) diagnosed with diabetes and an average 3% decrease on the percentage of adult patients (18-75 years old) with diagnosed diabetes whose HbA1c >9%. Within this toolkit you will find the best practices and resources that were shared by the health centers that participated in either the mini-grants or the Learning Collaborative.

Lake County Health Department and Community Health Center

Lake County Health Department and Community Health Center (LCHD & CHC) uses a patient registry (i2i, which is a population health management software) that is used with their EHR (NextGen) to run patient lists and other reports that allows them to follow-up with patients who have a greater need based on clinical outcomes. Patients identified with diabetes at highest risk are invited to participate in a specialized clinic to focus on diabetes as well as referred to Diabetes Self-Management Education and Support (DSMES) sessions.

LCHD & CHC offer individual nutrition counseling by a registered dietician for patients referred by their primary care provider. The dietician addresses diet, lifestyle, and coping tools. A standard practice guideline was produced for both hypertension and diabetes to help ensure consistency in evidence-based practice.

LCHD & CHC uses Facebook (including Facebook Live) and Twitter to provide outreach to patients via social media. Facebook has been used to provide education and cooking demonstrations to help improve chronic diseases. Texting has also been in place as an alternate way to reach patients for appointment confirmations.

Crossing Healthcare

Crossing Healthcare became a recognized Diabetes Self-Management Education program from the American Diabetes Association. Providers refer patients to the program and an initial assessment is completed. Once the assessment is completed, patients are enrolled in two days of education classes for a total of eight hours. Three months later, a follow-up appointment is completed to review lab work changes, weight changes and where each patient is with their personal goals. A review of ongoing support and follow–up is also discussed. Patients receive a total of 10 hours of comprehensive diabetes care education. Once they complete the educational program, patients are enrolled in a social media support group. The social media support group is provided to patients by giving them an online link to a closed Facebook group. Patients are invited to the closed group and have to answer a few questions about what kind of content they are interested in and also read about confidentiality within the social media platform. Content regarding diabetes and prediabetes information is generated and conversations are lead on this platform to provide consistent and ongoing support.

Crossing Healthcare also has a CDC recognized Diabetes Prevention Program (DPP) which allows patients to be enrolled in a year-long lifestyle intervention program if their Hgb A1C's are between 5.7 to 6.4. Through this program, patients are weighed weekly, report their number of minutes of activity for the week and participate in group discussion using an approved DPP curriculum lead by certified lifestyle coaches (two registered dieticians and one counselor).

Near North Health Service Corporation

Near North Health Service Corporation's Care Coordination Team uses CareMessage, a population health technology tool, that allows text messages to be sent to patients enrolled in the Hypertension and Diabetes programs. Hypertensive patients are enrolled in a 20-week health education program, and high-risk diabetic patients (HbA1c ≥ 9.0) are enrolled in a 25-week health education program. The content of the programs includes general health education on hypertension and diabetes, self-management tools, medication, nutrition, physical activities, and community support. These health education programs were written and reviewed by clinical staff and were designed to address holistic mental and physical health. They address the most common barriers faced by underserved populations.

Near North also schedules their diabetic patients for office visits every 3 months with a Near North internal medicine provider. Patients are then referred to nutritionists to be seen the same day of their office visit or to be scheduled at patient's preference. Patients are also scheduled for their annual specialty care with podiatrist, ophthalmologist (one of the Near North sites is equipped with Intelligent Retinal Imaging Systems (IRIS) for diabetic retinopathy care in addition to ophthalmologists), and a dentist. Near North offers diabetes group visits/shared medical

visits to provide their patients with additional access to education and peer support/learning.

Chestnut Family Health Center

Chestnut Family Health Center uses a warm hand-off model in which a provider can quickly access a resource, such as a nurse care coordinator or behavioral health clinician while the patient is still in the exam room and then, this resource is able to connect with the patient through an introduction from the provider. This model is used for patients, regardless of the medical issue, but is frequently used for patients with diabetes and/or hypertension.

Chestnut Family Health Center is using the population health management functions of their EHR to identify the population that would most benefit from care coordination related to their hypertension diagnosis. These patients can be provided with care coordination services to meet their needs. The population health management module allows their nurse care coordinators a listing that is "at their finger-tips" of patients they are working with and since their population health management programs are organized by patient needs, the nurse care coordinator can quickly see what the patient needs may involve (i.e. diabetes or hypertension). The population health management module can also be of assistance for pre-planning the visit with the patient. Pre-visit planning allows the nurse care coordinator to proactively schedule time to speak with the patient before their office visit.

Chestnut is in the process of developing a workflow to screen patients for diabetes and prediabetes based on a risk criteria that will take into consideration the patient's age and certain risk factors (identified by the American Diabetes Association).

Erie Family Health Center, Inc.

Erie Family Health Center (EFHC) uses the EHR system Centricity. Centricity allows EFHC to track health measures related to diabetes and blood pressure for not only their clinicians to use but also their care managers and care coordinators. EFHC also has a business intelligence team that allows for easier reporting and analytics to improve outreach efforts and decision making to benefit their patients.

To ensure diabetic patients' continuity of care, adherence to medication and self-management, EFHC has health educators that provide free glucometers and a 30-minute glucometer training session to all uninsured diabetic patients. The health educator conducts follow-up phone interviews five to seven days after the glucometer training to ensure patients are properly using their glucometer and to ask if there are any additional questions. If the patient has gestational diabetes then the health educator will follow-up within two days of their last visit. Follow-up visits are also scheduled at the time of the last patient visit.

EFHC has developed a "Health Education Core Curriculum" that they follow during the first, second and third visit for their diabetic or hypertensive patients. This "Health Education Core Curriculum" helps assess patients' current nutrition, physical activity, medication adherence and lifestyle practices. The health educator is then able to provide the correct educational content based on severity of condition and provider recommendations. The "Health Education Core Curriculum" can be found on page 10 of this toolkit.

SIHF Healthcare

SIHF Healthcare has implemented a care coordination team of multidisciplinary members including nursing, dietary, pharmacy, counseling, community outreach and providers to improve patient A1C compliance and control within set guidelines and standards of care. The care coordination team implements work flow adjustments as needed and provides education to providers and staff on point of care HgbA1c testing that is to be completed with each office visit for diabetic patients and provide outreach follow-up activities to improve patient compliance. Point of care testing is a tool that provides immediate determination of glucose levels. Based off of the patient's results, a plan of action can be created to give that patient the best care that they need.

Christopher Greater Area Rural Health Planning Corporation

Christopher Greater Area Rural Health Planning Corporation (CRHPC) refers their patients who have pre-diabetes, past gestational diabetes or who scored a 9 or higher on the American Diabetes Associations Risk Test (test can be found on pages 12 and 13 of this toolkit) to their Diabetes Prevention Program (DPP). The program offers weekly meetings for the first six months, followed by monthly sessions thereafter for a whole year. The class is a group class which provides motivation, support and accountability among participants. The efficacy of the program is directly correlated with participants' commitment to their goals and their adherence to healthy lifestyle recommendations. This means it was important for their patients to attend regularly, track their food intake and activity, and have the ability to function well in a group setting if they wanted success.

Whiteside County Community Health Clinic

Whiteside County Community Health Clinic (WCCHC) established a multidisciplinary team to develop policies, procedures and care paths to assist providers and their teams in following standards of care for their hypertensive and diabetic patients. This type of multidisciplinary team approach allowed for better control of blood pressure within their hypertensive patients and better diabetic control as well. WCCHC worked with their hypertensive and diabetic patients on creating self-management plans that may consist of being referred to lifestyle change programs, attending one-time classes on diet and hypertension, and individual education. Some patients were eligible to take blood pressure cuffs to use at home for a short period of time. For those that did not get the opportunity to take a blood pressure cuff home, blood pressure walk-in clinics were offered at different times of the day where patients could come and get their blood pressure checked at a time that was most convenient for them. A more intensive, individualized case management is performed for those patients whose barriers to control their condition go beyond basic disease education.

WCCHC uses Mediquire to make it possible to identify patients within their EHR system by a diagnosis code and allowed for extraction of the targeted population, the ability to track the patient progress, as well as making it possible for the care teams to develop and disseminate patient care plans.

Will County Community Health Center

Will County Community Health Center (Will CHC) developed clinical pathways specific to patients with diabetes. It reinforces a team approach to diabetes management. The identified team members play important roles in the delivery of care for people with diabetes using a team care approach that is envisioned to minimize patients' health risks through assessment, intervention, and surveillance and identify problems early and initiate timely treatment. Orientation on the clinical pathway is conducted by the chief medical officer for the providers and their support staff (including reception) to ensure that everyone knows their role. The "Clinical Pathways for Diabetes and Hypertension" can be found on pages 14-17.

Will County CHC refers patients with pre-diabetes to the Will-Grundy Medical Clinic Diabetes Prevention Program. It is a comprehensive program that can help referred patients towards preventing Type 2 diabetes divided in 2 phases: core phase covering 16 weekly sessions and post-core phase covering 1 monthly session for 6-7 months. This program is comprehensive and allows patients to take charge of their health by starting to make healthy changes. Patients who participate in a structured lifestyle change program can cut their risk of developing type 2 diabetes by 58% (71% for people over 60 years old). The impact of the program can last for years.

The order management module of the center's EHR allows tracking and monitoring of provider referral orders of patients requiring diabetic education. Clinic support staff follows the process for monitoring the referrals as required by the center policy of handling referrals/consults and enters the status of the orders in the EHR system.

RESOURCES FOR CHRONIC DISEASE BEST PRACTICES

HEALTH IMPACT STATEMENT

Quality Improvement Processes in Health Systems in Illinois

I. PROBLEM

In 2016, heart disease killed more than 25,000 people in Illinois.[1] Heart disease is the third leading cause of death for people ages 25–64, and accounts for more direct and indirect medical costs than diabetes and strokes combined.[2] Nationally, the burden of heart disease and related risk factors were highest among low-income and uninsured adults. Adults in households with annual incomes less than $35,000 were 33% more likely to report being diagnosed with heart disease than those with incomes over $35,000 (14.3% vs. 9.6%).[3] Uninsured adults were more than twice as likely to report being diagnosed with heart disease as those with any type of health insurance coverage.[4] High Blood Pressure (HBP) is a significant risk factor for heart disease and stroke. In 2015, over 3 million adults (3,048,058) in Illinois said they were told by their physician they had HBP.[5] The healthcare landscape in Illinois is diverse and complex. Implementing strategies to improve awareness and providing tools for better disease management is essential to improving patient care and preventing poor health outcomes.

PATIENTS SERVED BY ILLINOIS FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

 # ADULTS SERVED BY IDPH REGION

West Chicago	117,830
Edwardsville	72,453
Chicago	50,955
Marion	28,342
Champaign	14,177
Rockford	8,594
ILLINOIS (all health centers)	**803,000**

AVG % UNINSURED BY IDPH REGION

West Chicago	41%
Chicago	40%
Rockford	18%
Edwardsville	10%
Champaign	8%
Marion	7%
ILLINOIS (all health centers)	**20%**

Source: Health Resources & Services Administration (HRSA), Uniform Data System (UDS), 2016 Health Center Profile. Retrieved from https://bphc.hrsa.gov/uds/datacenter.aspx?q=d

II. INTERVENTION

The Illinois Department of Public Health (IDPH), in partnership with the Illinois Primary Health Care Association (IPHCA), recruited health systems throughout the state to improve the quality of care delivered to patients with HBP. Health systems were given a survey to help IDPH determine if their electronic health records (EHRs) were able to track referrals to community self-management programs, use data to improve the quality of care for patients with HBP, and improve blood pressure control. Training and technical assistance was provided to participating health systems to set up or enhance their EHR systems, better utilize patient reports, and improve patient care through electronic exchange of patient information. These intervention were tested with a group of seven federally qualified health centers (FQHCs) in Illinois in 2016. The health systems identified patients with uncontrolled HBP and decided on the best treatment or intervention for the patient. Treatments or interventions used by the FQHCs included: policies or systems for team based care, blood pressure self-monitoring, physician prescribed self-management plan, and/or enhanced electronic health record capabilities. Based on the positive results and feedback from the pilot sites, IDPH and IPHCA: 1) expanded the interventions across other health systems (3 sites in 2017, and 4 sites in 2018) and 2) developed a "learning collaborative" where pilot sites shared their progress and lessons learned with other Illinois health systems. In partnership with the health systems, IDPH set out to achieve HBP goals by June 2018; HBP awareness (target = 55%) and HBP control (target = 60%).

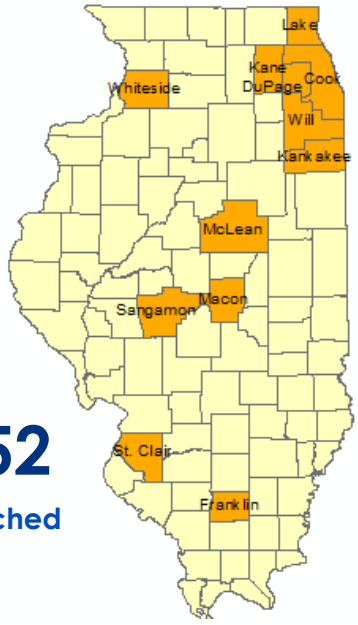
ILLINOIS FQHC PILOT SITES

12 Counties

14 FQHCs

93 Clinics

292,352 Patients Reached



Source: Illinois Health Information Systems Survey, 2016.

IDPH HEALTH IMPACT STATEMENT

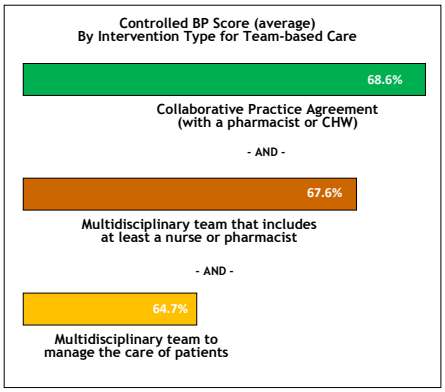
III. HEALTH IMPACT

Overall, program activities are having a positive impact on the number of health systems adopting and using EHRs to manage patients with HBP. When the program began in 2016, only 80% of the pilot sites were using a certified EHR system to coordinate care of HBP patients. During the three year project period, the number of HBP patients treated by an FQHC using certified EHRs increase by 25%, representing an increase in the number of sites using certified systems from 78% to 100% at the end of the funding period. Overall, participating FQHCs increased their use of EHRs, resulting in an increase of adults aware they have HBP from 53.3% to 58.7%. Controlled HBP among Illinois FQHC pilot sites increased from 56.5% to 66.8%. By continuing to increase EHR adoption across FQHC health systems at the statewide-level, more patients will have access to health systems that have the tools needed to better diagnose, monitor, and treat heart disease, stroke and associated risk factors like HBP. This use of EHRs will ultimately lead to improved health outcomes (reduced hospitalizations and death due to heart disease) in Illinois.

Performance Measures	2015	2017	Percent Difference (absolute)	5-Year Goal
HBP Awareness	53.3%	58.7%	5.4%	55% Exceeded
HBP Controlled	56.5%	66.8%	10.3%	60% Exceeded

Source: (1) Illinois Health Information System Survey, 2016;

Since IDPH and IPHCA started working together, program activities are having a positive impact on the way health systems approach and manage the care of HBP patients in Illinois. Using a multi-disciplinary team approach to blood pressure control and patient self-management of HBP have proven successful in identifying and managing HBP. Information gathered before and after IDPH and IPHCA started working together showed that 75% of the pilot sites used a multi-disciplinary team approach to blood pressure control, which increased to 92% after the program. Additionally, 67% of the pilot sites reported using patient self-management plans before the program which increased to 100% after the program. As a result, there was an absolute increase in the number of adults whose HBP was controlled after the program (68.1%) compared to the number of adults whose HBP was controlled before the program (66.6%). By continuing to increase the number of FQHC health systems practicing a multi-disciplinary approach to HBP patient care and teaching patients to self-manage their HBP, more patients in Illinois will have access to health systems with processes in place to better diagnose, monitor, and treat heart disease conditions like high blood pressure. These new approaches to patient care will ultimately lead to improved health outcomes.



Source: Illinois Health Information Systems Survey, 2018 and HRSA UDS Report (2015—2017).

IV. SOURCES

[1] America's Health Rankings analysis of CDC, National Vital Statistics System, United Health Foundation, AmericasHealthRankings.org, Accessed 2018. https://www.americashealthrankings.org/explore/annual/measure/CVDDeaths/state/IL

[2] CDC. Chronic Disease calculator v2. Accessed August 2018.

[3] Illinois Behavioral Risk Factor Surveillance System. Illinois and Strata Area Prevalence Data (2013 – 2016). Accessed August 20, 2018. http://www.idph.state.il.us/brfss/default.asp

[4] Blackwell DL, Lucas JW, Clarke TC. Summary health statistics for U.S. adults: National Health Interview Survey, 2012. National Center for Health Statistics. Vital Health Stat 10(260). 2014. Pp. 24 – 25. https://www.cdc.gov/nchs/data/series/sr_10/sr10_260.pdf. Accessed August 21, 2018.

[5] Illinois Behavioral Risk Factor Surveillance System. Illinois and Strata Area Prevalence Data (2013). Accessed August 20, 2018. http://www.idph.state.il.us/brfss/default.asp

V. FOR MORE INFORMATION

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The interventions highlighted in this document were made possible by funding from the CDC-1305 Chronic Disease and School Health (CDASH) grant and in partnership with the Illinois Department of Public Health CDASH team.

FIRST VISIT (1 hour)

Introduction

1. Introduce yourself and your position
2. Assess patient's tobacco status
3. Create tobacco status order

Patient Assessment

1) Patient's knowledge regarding specific condition
   a. Diabetes
   b. Gestational diabetes
   c. High cholesterol
   d. High Blood Pressure
   e. General nutrition
2) Depending on patient, provide 101 on the specific condition.
3) Patient's eating habits, including skipping meals
   a. 24 hour diet recall
   b. Explain food log
   c. If patient is diabetic, review glucose log
4) Discuss patient's exercise habits
   a. Recommend exercise schedule
   b. Benefits of exercising, relate benefits to specific condition
   c. Assess patient understanding and confidence
   d. Handouts: examples of exercises, Wellness Calendar
5) Inquire about patient's medication adherence

Plate Method

1) 5 food groups
2) Counting carbohydrates

Self-Management Goals (SMG)

1) Can be completed throughout the session while discussing topics above or at the end of session
2) Refer to EMR guide pg. 89-98 for step-by-step instructions to document SMGs

Ending Session 1

1) Ask or suggest that patient come back for follow-up session
2) Based on patient availability, schedule next appointment before patient leaves
a. Refer to EMR guide pg. 122-139 to schedule an appointment

EMR Documentation Checklist for Session 1 (step-by-step instructions in EMR guide)

1) Tobacco screen – pg. 75-77
2) Consultation Note – pg. 99-103 (utilize quick texts when applicable p. 160-164)
3) SMGs – pg. 89-98
4) If diagnosis has not been entered by provider, use Counseling NOS diagnosis pg. 82-88
5) If patient is sent over without referral from provider, submit order pg. 78-81

SECOND VISIT (30 mins)

Review

1) SMGs established in first visit. Assess progress.
   a. If patient is diabetic, focus on food & glucose log, explaining the variance/cause & affect between the two logs
2) Ask patient if they have any questions from the first session and/or regarding SMGs
3) 24 diet recall
   a. Depending on patient's responses
      i. Review plate method again
      ii. Make adjustments where necessary

If time permits, move on to following topics:

Nutrition Labels

1) Start by focusing on serving size and carbohydrates
2) Food label activity in Education binder

Exercise

1) Assess patient's engagement in exercising
2) Ask: What activities do you enjoy doing?
3) Demonstrate some exercises that can be done in a small space

a. Use exercise bands if available and give to patient

Ending Session 2

1) If patient agrees to meet again, schedule 3rd session in EMR

EMR Documentation Checklist for Session 2

1) Reason for Consult
2) Summary of Consult
3) SMGs

THIRD VISIT (30 mins)

Review

1) Review progress of SMGs from 2nd session
2) Make adjustments to goals if needed

Nutrition Labels

1) Review the different types of fat

Ending Session 3

1) Offer patient the options to either continue with sessions or to disengage
2) If patient wants to continue, schedule next appointment in EMR

EMR Documentation Checklist for Session 3

1) Reason for Consult
2) Summary of Consult
3) SMGs

84 MILLION AMERICANS HAVE PREDIABETES. DO YOU?

1. **How old are you?**
   - Less than 40 years (0 points)
   - 40—49 years (1 point)
   - 50—59 years (2 points)
   - 60 years or older (3 points)

2. **Are you a man or a woman?**
   - Man (1 point)
   - Woman (0 points)

3. **If you are a woman, have you ever been diagnosed with gestational diabetes?**
   - Yes (1 point)
   - No (0 points)

4. **Do you have a mother, father, sister, or brother with diabetes?**
   - Yes (1 point)
   - No (0 points)

5. **Have you ever been diagnosed with high blood pressure?**
   - Yes (1 point)
   - No (0 points)

6. **Are you physically active?**
   - Yes (0 points)
   - No (1 point)

7. **What is your weight status? (see chart at right)**

Write your score in the box.

Add up your score.

Height	Weight (lbs.)		
4′ 10″	119-142	143-190	191+
4′ 11″	124-147	148-197	198+
5′ 0″	128-152	153-203	204+
5′ 1″	132-157	158-210	211+
5′ 2″	136-163	164-217	218+
5′ 3″	141-168	169-224	225+
5′ 4″	145-173	174-231	232+
5′ 5″	150-179	180-239	240+
5′ 6″	155-185	186-246	247+
5′ 7″	159-190	191-254	255+
5′ 8″	164-196	197-261	262+
5′ 9″	169-202	203-269	270+
5′ 10″	174-208	209-277	278+
5′ 11″	179-214	215-285	286+
6′ 0″	184-220	221-293	294+
6′ 1″	189-226	227-301	302+
6′ 2″	194-232	233-310	311+
6′ 3″	200-239	240-318	319+
6′ 4″	205-245	246-327	328+
	(1 Point)	(2 Points)	(3 Points)
	You weigh less than the amount in the left column (0 points)		

Adapted from Bang et al., Ann Intern Med 151:775-783, 2009.
Original algorithm was validated without gestational diabetes as part of the model.

If you scored 5 or higher:

You're likely to have prediabetes and are at high risk for type 2 diabetes. However, only your doctor can tell for sure if you do have type 2 diabetes or prediabetes (a condition that precedes type 2 diabetes in which blood glucose levels are higher than normal). Talk to your doctor to see if additional testing is needed.

Type 2 diabetes is more common in African Americans, Hispanic/Latinos, American Indians, Asian Americans and Pacific Islanders.

Higher body weights increase diabetes risk for everyone. Asian Americans are at increased diabetes risk at lower body weights than the rest of the general public (about 15 pounds lower).

RISK TEST American Diabetes Association. COURTESY OF

LOWER YOUR RISK

Here's the good news: it is possible with small steps to reverse prediabetes - and these measures can help you live a longer and healthier life.

If you are at high risk, the best thing to do is contact your doctor to see if additional testing is needed.

Visit DoIHavePrediabetes.org for more information on how to make small lifestyle changes to help lower your risk.

For more information, visit us at

DoIHavePrediabetes.org

Ad Council · American Diabetes Association. · AMA American Medical Association · CDC

Name: (contact purposes only): _____ **Phone or Email**:_____
Last Grade School Completed:_____ **Address**: (city only)_____

*The purpose of this survey is to assess multiple health-related variables in our communities. Contact information is requested so that those who meet risk criteria may be made aware of appropriate health services.

1. I have a family history of Type 2 Diabetes. True/False
2. Type 2 Diabetes worries me. True/False
3. I find it difficult to manage my weight. True/False
4. I have a hard time making healthy food choices. True/False
5. I have tried many diets and none have brought about the results I was hoping for. True/False
6. I'm interested in learning more about how to prevent Type 2 Diabetes. True/False
7. Eating healthy is too expensive. True/False
8. A healthcare provider has advised me to talk to a Dietitian or Diabetes Educator. True/False
9. Lifestyle changes are effective at reducing my risk for disease. True/False
10. The worst type of Diabetes is when people have to take insulin. True/False
11. I don't have time to eat healthy. True/False
12. Losing weight is a pretty simple matter of calories in vs calories out. True/False
13. I weigh myself more than once a week. True/False
14. A low carb diet is the best way to lose weight. True/False
15. People with diabetes aren't supposed to eat sugar. True/False

16.	This statement is true of me (check 1 box for each statement):	Always	Often	Sometimes	Rarely	Never
17.	Diet information confuses me.					
18.	I have a lot of anxiety about my weight.					
19.	I feel generally confident in my ability to manage my health					
20.	I feel guilty about eating foods I like.					
21.	I eat when I'm emotional (stress, bored, angry, sad, etc)					
22.	I find myself thinking "I know what to do; I'm just not doing it."					
23.	I have a hard time motivating myself to eat healthfully.					
24.	I feel I would be happier if I just lose some weight.					
25.	Friends and family members bug me about my health.					
26.	Most of my meals are unplanned, on-the-go or in front of the TV					

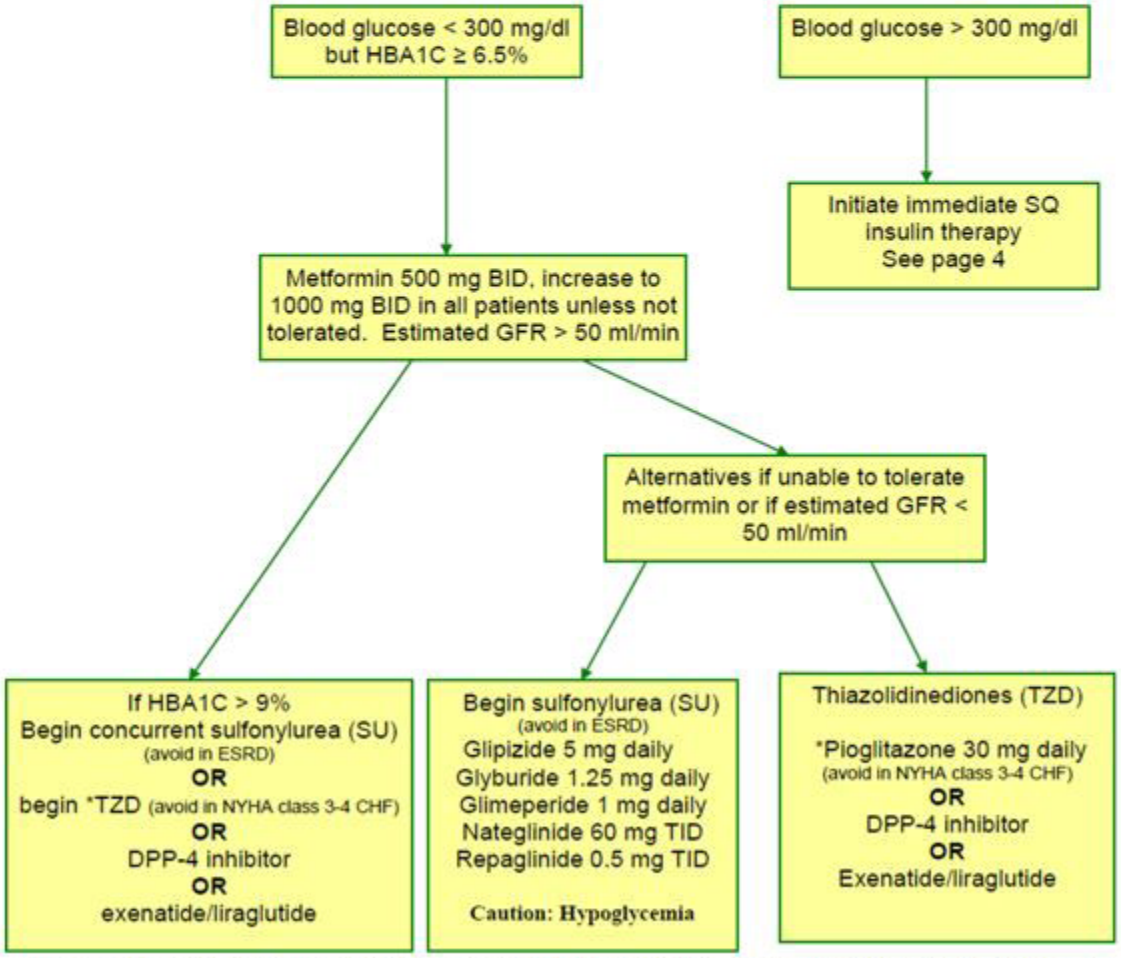
Thank You

DIABETES

Medical Provider

Diagnosis: fasting glucose > 126 mg/dl or random glucose > 200 or HbA1C ≥ 6.5%

Initial evaluation: BMI, CMP, HBA1C, estimated creatinine clearance
Initial referrals: diabetes education for blood glucose monitoring, dietary education and self management skills

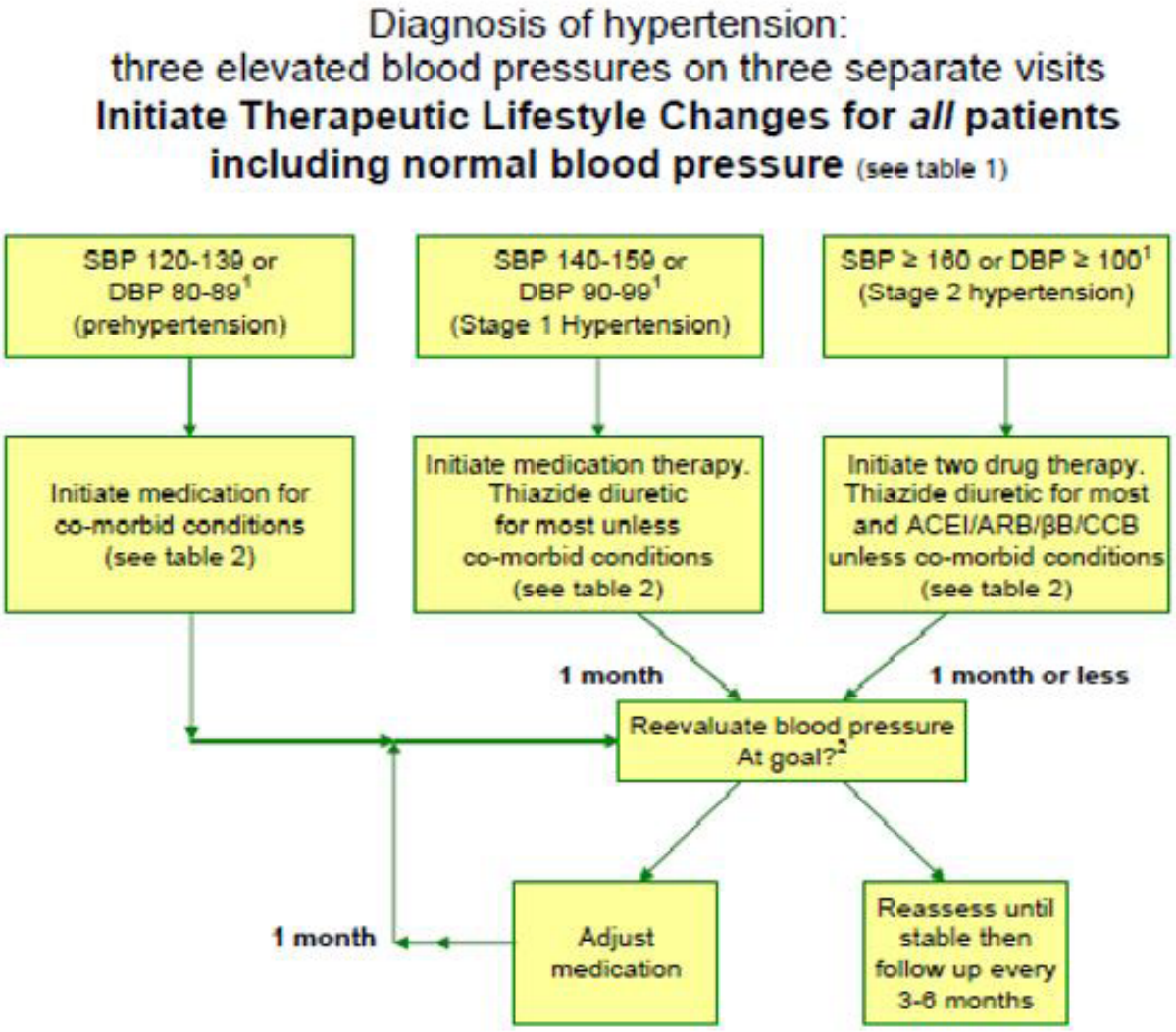


***warning: fluid retention, heart failure, weight gain, bone loss potential associated side effects**

Will County Community Health Center: Clinical Pathways

HYPERTENSION

Medical Provider



Will County Community Health Center: Clinical Pathways

DIABETES

Phone Center	Registration	Clinical Staff	Coordinated Care Staff	Provider
-Bring all medications ***(except refrigerated)*** -Bring home glucose log	**FORM:** -Did you bring meds/list? -Are you registered on our portal?	-Collect urine ***(microalbumin annually)*** -Vitals -Meds -Finger stick ***(A1C q 6 months if ≤ 7)*** - Drape on floor ***(under pts' undressed feet)*** - Perform Monofilament Testing, record on flow sheet -Retrieve home glucose log and make chart copy	- F/U Call for -Education -Self-Mgmt *(diet/ exercise/ meds)* -Referrals	-Review home glucose log -Evaluate monofilament testing -Referral: *Optho *Dental *Podiatry

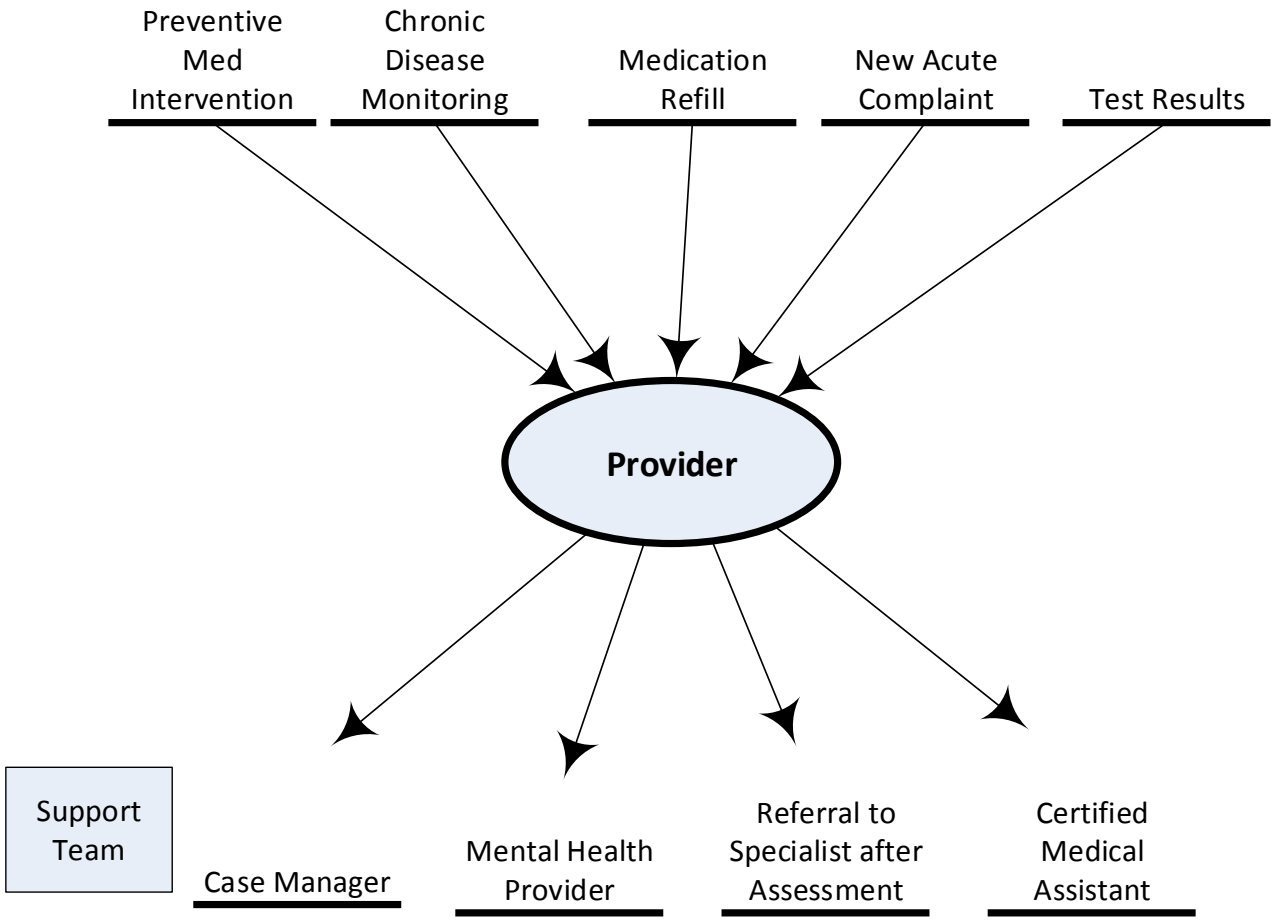
Will County Community Health Center: Clinical Pathways

HYPERTENSION

Phone Center	Registration	Clinical Staff	Coordinated Care Staff	Physician
-Bring all medications	**FORM:** -Did you bring meds/list? -Are you registered on our portal?	- Vitals -Meds -BP Check -pt. sitting for 5 min. -cuff size: 80% Bladder lgth -cuff on **unclothed** right arm If BP is > 140/90, second reading is to be checked and recorded after 15 minutes of rest. - Drape on floor ***(under pts' undressed feet)*** - EKG (annually)	-F/U Call for -Education *(Salt Restriction)* -Self-Mgmt *(diet/exercise/meds)* -Referrals -Diag. Tests *(as ordered)*	-Ensure annual EKG -Referral: *Optho *Dental

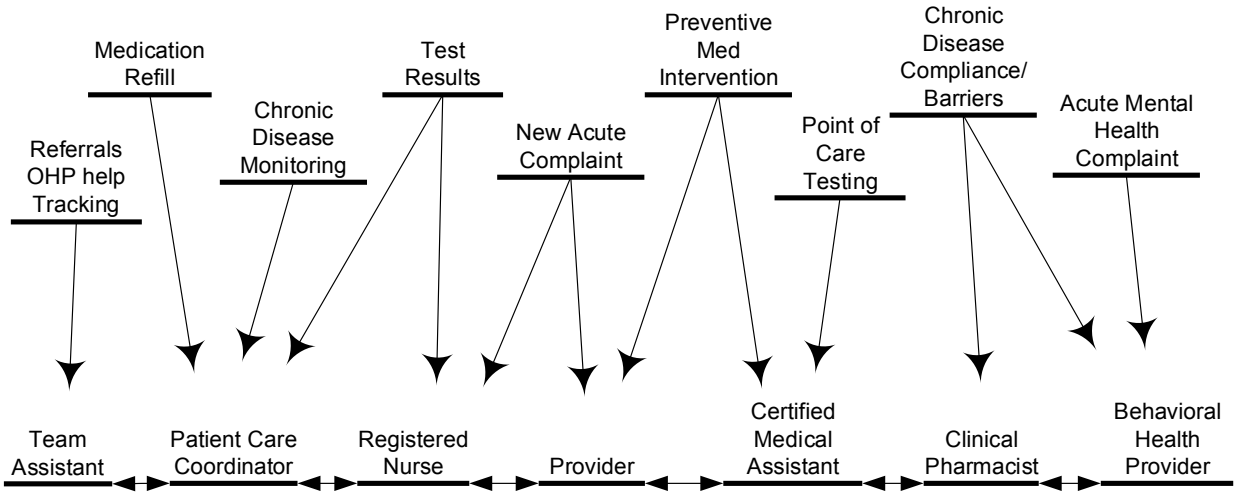
Will County Community Health Center: Clinical Pathways

Traditional Methods of Managing Work Flow



Credit: Image borrowed from South Central Foundation

Team based care model for managing workflow



Will County Community Health Center: Clinical Pathways

CDC Vitalsigns™
#vitalsigns
SEPT. 2018

Preventing 1 Million Heart Attacks and Strokes

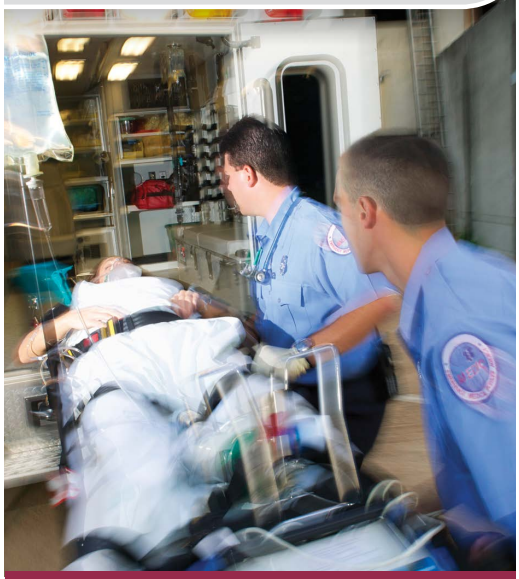
Middle-aged adults are being hard hit

Heart attacks and strokes can be catastrophic, life-changing events that are all too common. Heart disease and stroke are preventable, yet they remain leading causes of death, disability, and healthcare spending in the US. Alarmingly, many of these events happen to adults ages 35-64—over 800,000 in 2016. Million Hearts® is a national initiative with a network of partners focused on preventing one million heart attacks, strokes, and other cardiovascular events by 2022. Coordinated actions by public health and healthcare professionals, communities, and healthcare systems can and will keep people healthy, optimize care, and improve outcomes within priority populations.

16M About **16 million** heart attacks, strokes, and related heart-threatening events* could happen by 2022.

1 in 3 **1 in 3** of these life-changing cardiovascular events happened in adults 35-64 years old in 2016.

80% **80%** of premature heart disease and strokes are preventable.



Healthcare professionals and systems can

- Focus on the ABCS of heart health: **A**spirin use when appropriate, **B**lood pressure control, **C**holesterol management, and **S**moking cessation.
- Take a team approach—use technology, standard processes, and the skills of everyone in the healthcare system to find and treat those at risk for heart disease and stroke.
- Make sure people who have had a heart attack or stroke get the care they need to recover well and reduce their risk of another event.
- Promote physical activity and healthy eating among their patients and employees.

* deaths, hospitalizations, and emergency room visits due to heart attack, stroke, and other cardiovascular conditions like heart failure that could be prevented if Million Hearts 2022 actions are taken.

Want to learn more?
Visit: www.cdc.gov/vitalsigns

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

PROBLEM:

Heart attacks and strokes are common and preventable.

- More than 1,000 Americans died each day in 2016 from heart attack, stroke, and other events Million Hearts® is trying to prevent.
- Many opportunities to find and treat risk factors are missed every day.

9 Million
PEOPLE NOT TAKING ASPIRIN AS RECOMMENDED

40 Million
PEOPLE WITH UNCONTROLLED BLOOD PRESSURE

39 Million
ADULTS NOT USING STATINS (CHOLESTEROL-LOWERING MEDICINES) WHEN INDICATED

54 Million
ADULT SMOKERS

71 Million
ADULTS WHO ARE PHYSICALLY INACTIVE

POPULATIONS MORE AT RISK

- Americans aged 35-64 are less likely to use aspirin or statins (cholesterol-lowering medicines) when indicated, and only about half have their blood pressure under control.
- Blacks/African Americans are more likely than whites to develop high blood pressure—especially at earlier ages—and are less likely to have it under control.
- People with mental health and/or substance use disorders use tobacco more frequently.
- People who have already had one heart attack or stroke are at high risk for a second.

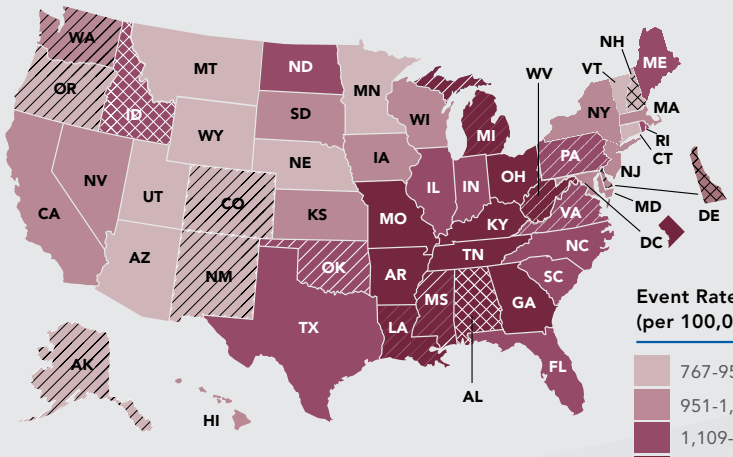
SOURCE: *Million Hearts® At-A-Glance, 2017*

35-64 year olds

In 2016, about 775,000 hospitalizations and 75,000 deaths from cardiovascular events occurred in younger Americans, who are America's workforce, parents, partners, and caregivers.

Getting to One Million

Everyone can take small steps to improve their own health, the health of their families and loved ones, patients, communities, and the heart health of our nation. We have to act now.



SOURCE: Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project; National Vital Statistics System Mortality Data.

SMALL CHANGES IN EVERY STATE CAN HAVE A BIG IMPACT.

One million events could be prevented by 2022 if every state reduced these life-changing events by 6 percent. While rates are higher in the Southeast and Midwest, small changes to improve heart health are needed in all states.

MAP: 2016 event rates by state (deaths, hospitalizations, and emergency department [ED] visits combined).

ED data not available, estimated

ED and hospitalization data not available, estimated

Million Hearts®: EVERYONE CAN MAKE SMALL CHANGES THAT MATTER.

The solution to the crisis is already in front of us. Small changes sustained over time will result in big improvements to the heart health of our nation. Everyone can take action.

Million Hearts® is working with more than **120** partners, all **50** states and the District of Columbia, and **20** federal agencies to:

Keep people healthy by making changes to environments in which people live, learn, work, and play to make it easier to make healthy choices.

↓20%

HOW: Achieve a **20%** reduction in **sodium intake, tobacco use, and physical inactivity**.

Communities making physical activity easier by creating walking and biking trails.

People adding 10 minutes of physical activity a day–like walking or gardening.

Optimize care so that those at risk for cardiovascular disease get services and skills needed to reduce the risk of having a heart attack or stroke.

- **HOW:** Achieve **80%** performance in the ABCS, and **70%** participation in cardiac rehabilitation.
- **Insurers** providing coverage for home blood pressure monitors.
- **Clinicians** using a standard treatment protocol for high blood pressure, cholesterol management, and tobacco cessation.

Improve outcomes for priority populations who suffer more from cardiovascular disease and where we know we can make an impact.

- **HOW: Employers** providing places and time for employees to walk during the workday.
- **Behavioral health providers** receiving training in smoking cessation and using it in their practice.

SOURCE: *Million Hearts® At-A-Glance, 2017*

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Co-leading the Million Hearts® initiative (CDC and the Centers for Medicare & Medicaid Services) to prevent 1 million heart attacks and strokes by 2022. millionhearts.hhs.gov
- Helping improve the heart health of millions of Americans by investing in improving delivery of care, including rewarding clinicians for providing care we know works.
- Providing funding and support to all 50 states, the District of Columbia, municipalities, and tribal communities to ensure clinical and public health agencies are working together to prevent heart disease and stroke.

HEALTHCARE PROFESSIONALS & SYSTEMS CAN

- Focus on the ABCS of heart health: **A**spirin use when appropriate, **B**lood pressure control, **C**holesterol management, and **S**moking cessation.
- Take a team approach—use technology, standard processes, and the skills of everyone in the healthcare system to find and treat those at risk for heart disease and stroke.
- Make sure people who have had a heart attack or stroke get the care they need to recover well and reduce their risk of another event.
- Promote physical activity and healthy eating among their patients and employees.

STATE AND LOCAL HEALTH DEPARTMENTS CAN

- Use their state's heart disease and stroke events data to drive Million Hearts® actions locally.
- Promote tobacco control interventions, smoke-free environments, and programs to help tobacco users quit.
- Work to improve heart-healthy nutrition and physical activity by promoting the use of healthy food service guidelines and making communities more walkable.

EMPLOYERS CAN

- Make it easier for employees to get needed medicines, blood pressure monitors, and services by providing insurance coverage with no or low out-of-pocket costs.
- Provide on-site blood pressure monitoring and physical activity programs.
- Ensure smoke-free spaces and access to healthy food and beverages in vending machines and facilities.

EVERYONE CAN

- Start **one** heart healthy behavior today – eat a heart-healthy diet, get physically active, or quit smoking! Keep it going to keep your heart healthy now and later in life!
- Learn your heart age and take action to improve it. www.cdc.gov/heartdisease/heartage.htm
- If you don't use tobacco, don't start. If you do, seek help at 1-800-QUIT-NOW or www.smokefree.gov.

More information about Million Hearts® and tools you can use are available at www.millionhearts.hhs.gov.

Stories from people who have taken control of their blood pressure are available at https://bit.ly/2N9ahqX.

www.cdc.gov/vitalsigns/million-hearts
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov

Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333

Publication date: September 6, 2018

CS294959-A

ADDITIONAL RESOURCES FOR CHRONIC DISEASE BEST PRACTICES

Diabetes

Managing Type 2 Diabetes: A Team-Based Approach
Preventing Type 2 Diabetes in At-Risk Patients: Help your Patients Find Ways to Prevent Type 2 Diabetes through Education, Screening and Local Referral Programs
ADA Updated Guidelines for Cardiovascular Risk Management in Diabetes
Standards of Medical Care in Diabetes - 2019
Patient Engagement with a Diabetes Self-Management Intervention
Opportunities to Improve Diabetes Outcomes through Electronic Patient Engagement

Hypertension

Improving Blood Pressure Control: Measure, Act and Partner (M.A.P.) to Help Patients Control Blood Pressure and Ultimately Prevent Heart Disease
Million Hearts®: Meaningful Progress 2012-2016—A Final Report
Million Hearts® 2012: Building Strong Partnerships for Progress
Patient Visit Checklist: Supporting Your Patients with High Blood Pressure
Improving Medication Adherence among Patients with Hypertension

RESOURCES FOR PATIENT ENGAGEMENT

ENGAGING PATIENTS WITH TYPE 2 DIABETES

A Healthcare Provider's Checklist

Engaging and involving patients with diabetes in treatment decisions, along with your clinical expertise, can help foster a patient-centered approach to diabetes care. This concept involves a shared decision-making process where you and your patient act as partners, mutually exchanging information and weighing options, in order to reach an agreement on appropriate courses of action. This may help build an individualized diabetes care plan to which your patient can more readily adhere.[1]

Below is a checklist of important diabetes issues to discuss with your patients to help assess their level of engagement in their care plans and to help track their progress.

Patient Engagement Checklist[2]

Engagement Points	ADA Guidelines and Recommendations[a]	Individualized Patient Goals/ Results	Date of Last Patient Engagement Discussion
Diabetes self-management education (DSME)	All patients with diabetes should receive DSME		
Physical activity Adapted for individual patient capabilities and comorbidities	• At least 150 min/week of moderate-intensity aerobic physical activity, spread over at least 3 days/week with no more than 2 consecutive days without exercise • In the absence of contraindications, resistance training at least 2x/week		
Medical Nutrition Therapy (MNT)	• Individualized MNT as needed to achieve treatment goals, preferably provided by a registered dietitian • Nutrition counseling should be sensitive to individual and cultural needs as well as willingness and ability to change		
A1C Measure at least 2x/year if at goal; if not at goal, measure quarterly	Goal: <7% (nonpregnant adults)		

Please note that the recommendations listed are intended as a guide for you and your staff and not meant to direct your clinical discussions or treatment decisions.

1 Patient Engagement Checklist

ENGAGING PATIENTS WITH TYPE 2 DIABETES

A Healthcare Provider's Checklist

Patient Engagement Checklist[2]

Engagement Points	ADA Guidelines and Recommendations[a]	Individualized Patient Goals/ Results	Date of Last Patient Engagement Discussion
Fasting plasma glucose (FPG)	70-130 mg/dL		
Postprandial plasma glucose (PPG)	<180 mg/dL		
Lipids **LDL-C** **HDL-C** **Triglycerides** Measure every 2 years if at goal; if not at goal, measure at least 1x/year or more frequently as needed	Goals: <100 mg/dL >40 mg/dL (men); >50 mg/dL (women) <150 mg/dL		
Blood Pressure Measure at every office visit	Goal: <140/90 mm Hg		
Weight/Body mass index	Weight loss is recommended for all overweight and obese individuals with diabetes		
Urinary albumin	Perform annual test		
Retinal examination	Ophthalmologist/optometrist-performed dilated eye exams 1x/year		
Foot examination	Comprehensive foot exam at least 1x/year		
Flu vaccination	Annual vaccination for patients with diabetes ≥6 months of age		

Please note that the recommendations listed are intended as a guide for you and your staff and not meant to direct your clinical discussions or treatment decisions.

2 Patient Engagement Checklist

ENGAGING PATIENTS WITH TYPE 2 DIABETES

A Healthcare Provider's Checklist

Patient Engagement Checklist[2]

Engagement Points	ADA Guidelines and Recommendations[a]	Individualized Patient Goals/ Results	Date of Last Patient Engagement Discussion
Pneumococcal vaccination	One lifetime vaccination for patients with diabetes ≥2 years of age[b]		
Hepatitis B vaccination	A vaccination for previously unvaccinated adults with diabetes who are 19-59 years old[c]		
Smoking status and cessation advice or treatment	Smoking advice and cessation counseling		

Please note that the recommendations listed are intended as a guide for you and your staff and not meant to direct your clinical discussions or treatment decisions.

[a] Not all goals and recommendations apply to all patients, and individual goals may vary based on clinical judgment.[2]
[b] A one-time revaccination is recommended for patients 65 years old or older who were previously immunized when they were younger than 65 years of age if the vaccine was administered more than 5 years ago.[2]
[c] A vaccination for previously unvaccinated adults with diabetes aged 60 and older should be considered.[2]

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Together 2 Goal®
AMGA Foundation
National Diabetes Campaign

	Patient *Engagement*	Patient *Experience*
Goals	1. Drive better health and outcomes 2. Empower patients and loved ones to be active in their own care 3. Reduce costs	1. Drive better health and outcomes 2. Exceed expectations 3. Reduce suffering 4. Brand differentiation
Stakeholders	Patient, likely others	Patient, likely others
Context	Patient's own health	All-encompassing (access, communication, food, etc.)
Patient involvement (behaviors and ownership)	Required	Not required (though in an ideal experience, patients are partners and co-designers)
Time	Transactional or longitudinal	Transactional or longitudinal
Use of health self-management tools/services	Yes	No
Validated measurement	Patient Activation Measure (PAM), PROMIS, Patient Health Engagement (PHE) Scale	HCAHPS, CGCAHPS, etc.

NEJM Catalyst: Patient Engagement Versus Patient Experience

Partnering To Improve Safety, Quality, and the Patient Experience

What is it?

A Patient and Family Advisory Committee (PFAC) is a group of patients, family members, office staff, and primary care providers working together to improve safety, quality, and the patient experience.

How will it help me?

With a PFAC, providers, patients, and staff work in partnership.

A PFAC can:

- Improve communication and build a better relationship between the providers, patients, and staff.
- Increase patient understanding of the complexity of the primary care environment.
- Establish patients and family members as advocates for the practice.
- Improve provider and patient satisfaction.
- Increase patients' engagement in their own care.

How can I get started?

- Develop a plan and timeline.
- Identify patients to be potential members.
- Invite those patients to participate.
- Schedule the first meeting.

Why should I do this?

A PFAC is a mechanism for working in partnership with your patients to improve safety, quality, and the patient experience, all at very little expense of time or funding.

What providers are saying

"If we are unable to come to consensus as a practice team on a new approach or a practice change, our first thought is to take it to the PFAC for their help. They are our partners. This is their practice."

What patients are saying

"I was surprised, and impressed, and excited that there was a practice interested enough in improving that they would take ideas from their patients."

"PFAC helps because it keeps pushing new things forward—what is the best way to do this? What are the best practices doing?"

For a full case study on PFACs, see the Agency for Healthcare Research and Quality, http://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/index.html.

Agency for Healthcare Research and Quality

AHRQ Pub. No. 16-0034-2-EF
May 2016
www.ahrq.gov

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4 keys to patient portal engagement

By Olivia Rybolt | August 23, 2017

Patient portals are a convenient, secure tool for empowering patients — allowing them to check up on their medical information, ask their doctor questions, and handle some paperwork online — while reducing clinician workloads.

Despite all those benefits, it's not always easy for practices to convince patients to use portals — or even to sign up in the first place. A recent study of 5,000 Americans found that just 20 percent were able to schedule medical appointments online and only 15 percent could email their doctor.

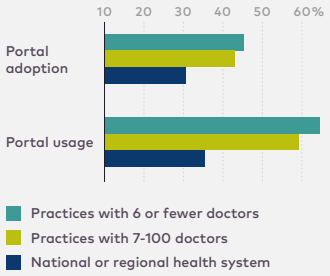
How to boost adoption rates? Reinforce the value of the portal to patients, and provide them with specific training, according to practices in the athenahealth network that successfully engage with their patients online.

A 2017 athenaResearch study of nearly 600 primary care practices across the network evaluated how successful practices were in getting their patients to register for and engage with their portals.

The portal adoption rate determines the percentage of patients who registered for the portal prior to, or within 30 days of, a visit with their doctor. Portal usage rates reflect the percentage who interacted with their portal within 30 days of a visit.

Small practices successfully engage patients on the portal

Percent of patient population



Source: athenaResearch
Sample: Average portal adoption & portal usage rates for 573 primary care practices on the athenahealth network from January 2015 through December 2016

Researchers found that small practices — those with six or fewer physicians — had better portal adoption and usage rates than larger regional and national health systems. On average, 45 percent of patients at small practices adopted the portal, and 65 percent used it within 30 days of an appointment, while national and regional health systems reported only 30 percent adoption and 35 percent usage rates.

While small practices typically have the resources and close patient relationships to be able to engage their clients more fully, practices of any size can benefit from adopting a few simple steps to increase

portal use among their patient populations. Here's what two practices with high adoption and usage rates are doing to engage patients on their portals:

1. Make portals indispensable for both staff and patients

Whitney Kennedy, M.D., heads up Highlands Health for Life, a family medicine practice in Denver that boasts an 86 percent portal adoption rate and 86 percent usage rate among its patient population, which ranges from young, active individuals to older Medicare patients. Kennedy and her team of two physician assistants, front desk staff, and medical assistants drive home the importance of the portal by being straightforward about its role in doctor-patient communication.

"This is how we get your labs back to you," Kennedy tells patients. "This is how we function."

Practices with high portal adoption and usage rates like Kennedy's not only emphasize that the portal is the primary mode of communication for updates, lab results, and appointments, they go as far as possible in making signup mandatory.

"As of this year, if a patient calls to schedule a new-patient appointment, we say, 'Look, you have to go on and register on the portal,' " Kennedy says. "If we notice a week ahead of time they haven't [registered], we call them to remind them to apply on the portal."

In addition to making portals mandatory, Marc Feingold, M.D., sets policies on portal usage for his Manalapan, N.J., family practice. Feingold, a nurse practitioner and the practice's seven-person staff have adopted patient-centric portal guidelines, such as committing to answering patient questions within 24 hours.

Erin Zielinski, Feingold's practice manager, says this rapid response time helps patients feel more comfortable with the technology, facilitates easier communication, and encourages them to use the portal more regularly. All of which have helped drive the practice's 75 percent portal adoption and 89 percent usage rates.

2. Show and tell

High-performing practices find that the real sticking power for portals comes from showing patients how easy and useful these tools are with a hands-on approach.

Zielinski and the front desk staff will help patients register for the portal when they're in the office. They even create email accounts for patients who don't already have one. If the patients are unsure of how to use the portal, the team takes them through the step-by-step process of logging in and accessing their information.

Kennedy uses a large-screen display during patient visits to review portal-based charts and lab results with patients, showing how they've progressed, and explaining the data so they can further digest it at home. This extra effort reduces work for practices in the long run by making patients better agents of their own care.

"We found that if we discuss [the portal] with the patients, and show them right then and there, they are a lot more attuned to doing it at home," Zielinski says.

At Feingold's practice, the goal is to make sure patients understand the portal before they leave the office.

"We try to go above and beyond, which is I think why the patients are so supportive of the portal," Zielinski says. "We really try to make it as easy as possible for them."

3. Integrate the portal into each phase of the patient visit

High-performing practices train staff members on every aspect of their portal, the first step to integrate the portal into each phase of a patient's visit, from check in to check out and beyond.

Kennedy decorated her practice's waiting room herself with printed and framed posters about its portal, and a portal promotional video also runs all

day on an iPad.

At Feingold's practice, Zielinski says, they are "constantly driving it home."

When patients check in, the front desk staff reminds them of the portal and helps them sign up. In the exam room, the doctor offers to send additional information, lab results, and answers to questions via the portal. At check out, the front desk staff reminds patients that they can pay bills and ask follow-up questions online.

"Portal. Portal. Use the portal. You get a faster response [from your doctor] through the portal," Zielinski says, repeating the practice's mantra.

4. Always improve

Despite boasting high portal adoption and usage numbers, Feingold's practice still seeks out ways to improve the scope of the tool.

The practice, which has been on its portal for upwards of five years, recently signed on with Solutionreach, a partner in athenahealth's More Disruption Please program, to send text messages to patients when they have lab results to view in the portal. Zielinski hopes that this next step will continue to boost portal usage and encourage even faster communication.

"We're always trying to come up with different ways of doing things to keep [patients] engaged," Zielinski says.

Combining these strategies helps practices take advantage of the portal's ability to save their time and energy, a welcome convenience in any setting where workloads are high. Streamlined communication allows for "improved continuity of care," says Zielinski, and keeps the practice running smoothly.

"Everyone is connected through their cell phones. Everyone is pretty tech-savvy now," Zielinski says. "So there is no reason not to use it."

Olivia Rybolt is a staff writer at athenaInsight.

ADDITIONAL RESOURCES FOR PATIENT ENGAGEMENT

A Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families for Advanced Practices

Patient Engagement: Safer Primary Care

The Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families

Provider-Patient Texting is Poised for Growth

Partnering with Patients to Improve Quality, Safety, and the Patient Experience

Patient Access to Medical Notes in Primary Care: Improving Engagement and Safety

Eight Elements of Effective Patient Engagement

Listening with Empathy: Save Time, Communicate More Effectively and Improve Patient and Provider Satisfaction

Pre-Visit Planning: Enhance the Patient Experience, Increase Patient Engagement and Improve Practice Efficiency

NACHC Patient Engagement Action Guide

Patient Engagement with a Diabetes Self-Management Intervention

Opportunities to Improve Diabetes Outcomes through Electronic Patient Engagement

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