RIQI/RI-PTN TCPI Exemplary Story:
Comprehensive Community Action Program (CCAP)

At Comprehensive Community Action Program (CCAP), we boast a very committed management team and staff who work together to "lend a helping hand" to the approximately 25,000 people our agency serves. As a Federally Qualified Health Center (FQHC) and one of the largest Rhode Island organizations dedicated to fighting the war on poverty, CCAP provides a wide spectrum of services across the state of Rhode Island. Our programs include: health (we have four primary care locations) and dental care, behavioral health counseling, a food bank, housing and fuel assistance, weatherization, family support and services, the largest Head Start program in the state, options for child care, emergency assistance and education (including a GED program for teens and adults), and job training. Further details about our unique programming and services can be found at our website: http://www.comcap.org/.

Specifically regarding healthcare, we have 12 clinicians, 10 behavioral health providers, and 7 dentists that serve approximately 16,500 patients per year at four locations across the state. With all the extensive programming we have available, probably the most significant facet of CCAP is our dedication and caring that is evident through the teams within our organization. CCAP has many patients who are struggling based on their social determinants of health. They may not have necessities, such as housing, heat, and food. Along with providing healthcare, CCAP can provide targeted *support* for these individuals. We are able to align them, as needed, with social workers, heating assistance, and food from the food bank. We strive to be innovative and find the best methods to provide optimal care and meet the needs of all our patients. The clinical care we provide is buoyed by the integration of technology and data into our workflows, along with an ongoing engagement of our internal teams as well as patients and families.

Leveraging Teamwork, Education and Technology to Provide Data Driven, Exemplary Care

Our staff at CCAP strive to provide targeted, team based care that addresses the specific needs of each, individual patient. The positive impact this approach has on our patients is witnessed regularly. For instance, we recently had a distressed and emotional patient call our practice. He had been experiencing depression and may have been suicidal. In this situation, the patient was embarrassed because he hadn't been taking his medications, and he was nervous to see his provider. Our CCAP nurse talked him into coming in for an appointment the next day. Because of our integrated team approach, he was able to walk right from his primary care appointment to meet with the social worker and complete an SBIRT assessment. After some additional follow-up and coordination, the patient restarted all his medications and was able to receive counseling. This example demonstrates the true integration of behavioral health within our primary care facilities that is available through CCAP's design. We regularly provide a warm hand-off from one group to the other so patients can get everything they need in one day. Such successes are built over time from an organization-wide quality-minded approach that is driven by patient outcomes and data. From our clinical teams to our HIT team, staff at CCAP *care about quality* and work hard to figure out what is working and what they can do better for our patients. As can be seen in the adjacent table, our clinical quality measures are a reflection of this excellence. Our performance is significantly above the national MIPS benchmarks for the *Tobacco Use: Screening and Cessation Intervention (97%), Body Mass Index (BMI) Screening and Follow-up Plan* (99%), and *Screening for Clinical Depression and Follow-up Plan (100%) measures*.

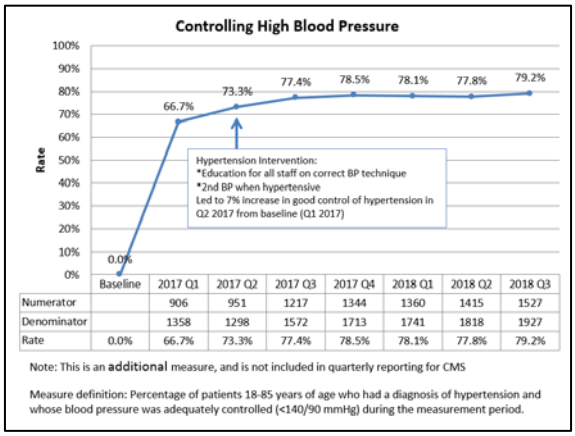
Our *Controlling High Blood Pressure* measure also exceeds the national benchmark, with our current performance rate of 74% (12% over the national benchmark).Given our improvement mindset, we recently instituted changes to our processes that led to

CCAP Performance Chart

Quality Measure	Performance Target	Current Performance	National MIPS Benchmark
Prevention			
Tobacco Use: Screening and Cessation Intervention	100%	97%	83%
Body Mass Index (BMI) Screening and Follow-up Plan	100%	99%	45%
Screening for Clinical Depression and Follow-Up Plan	100%	100%	28%
Disease Management			
A1c Good Control <8	68%	69%	64%[a]
Controlling High Blood Pressure[b]	N/A	74%	62%

[a] an additional measure not included in quarterly reporting for CMS
[b] comparative benchmark based on data from RI-PTN practices

At CCAP, our excellent Clinical Quality Measures are a reflection of the care we provide and our strong efforts to engage our patients in preventative care.

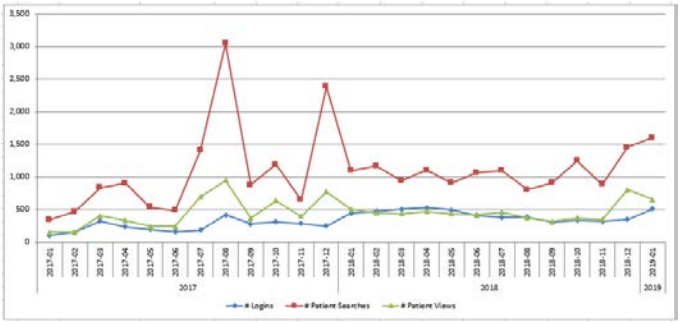


Recent improvement efforts at CCAP led to a 7% increase in our *Controlling High Blood Pressure Measure* rate for our patients.

more accurate assessments of blood pressure for our patients and a corresponding 7% improvement in our *Controlling High Blood Pressure* rate. This improvement can be observed in the adjacent run chart that tracks the rate from our baseline in quarter one of 2017 through quarter 3, 2018. Our patients have benefitted from the enhanced understanding our staff now has regarding the best techniques for accurately assessing blood pressure, along with better accounting for white coat syndrome. By following best practice for a high reading, we reassess with a second blood pressure at the end of the patient's visit. This improvement to our process has led a more accurate understanding of our patient population with hypertension and significantly reduced the number of high blood pressure readings for our patients.

This success was achieved through an in-service on how to take an accurate blood pressure that was provided for the Medical Assistants and Nursing staff at our clinics. Our Director of Nursing worked with each individual to ensure that everyone was clear on the process and had an opportunity to ask questions. Additionally, we made sure that all of the blood pressure cuffs at our facilities were correctly calibrated. As demonstrated through our data, this improvement has been consistently maintained since the time of the initial intervention. Given this achievement, we are currently planning to provide training for new staff, as needed, so these interventions will be maintained going forward. Also, given our improvement mindset, we have recently engaged with the RIQI RI-PTN to provide Diabetes specific training for our Medical Assistants. While we are already above the national benchmark for the *A1C Good Control* Measure (with our current rate of 69%: 5% higher than the National MIPS benchmark), this educational series provides a comprehensive understanding of the disease and associated health impacts, risks and laboratory results. Our Medical Assistants will also learn Motivational Interviewing techniques they can use when providing care. Once this training is completed, we will be tracking our *A1C Good Control* data to assess how this educational intervention will translate to further improvements in health outcomes for our patients.

The care provided by our clinical teams is also enhanced by an integration of *data* in our practice. As can be seen in the adjacent run chart of CurrentCare Viewer (Rhode Island's Health Information Exchange) use at CCAP, staff at our organization regularly log in to the Viewer to access patient records and important clinical data. Through leveraging this information, we avoid unnecessarily duplicating tests and help improve the quality of care provided by our clinical teams. As explained by our Director or Nursing, Arthur Taylor, "we look to CurrentCare for a lot of lab values, particularly the A1C. Sometimes we don't order it if they go to an endocrinologist or go to the hospital. We will have the information [in CurrentCare]." Likewise, CurrentCare is used by our HIT team to help ensure we have important information about key health screenings that we track. We are able to find results for PAP tests, colonoscopies and other pathology and laboratory reports. Our quality measures consistently reflect our success in this area. For example, our current colon cancer screening rate for 2018 was at 49%, which was a 9% improvement over the previous year. We also check in CurrentCare to see if patients are going to other providers so we can be sure that patients are not falling through the gaps. In some cases, we will call the other provider to



CurrentCare Viewer Use for staff at CCAP demonstrates a high level of engagement. Spikes in use at this organization typically represent quality improvement efforts or relate to CurrentCare enrollment.

coordinate care or confirm and be sure the patients are still getting care and then facilitate the transfer of the patient's record.

CCAP also demonstrates tremendous innovation in leveraging the Rhode Island Quality Institute Care Management Alerts and Dashboard to identify, manage, and support our patient population who are utilizing hospital services. These tools provide near real time data for our patients who are going to acute care hospitals (Emergency Department and Inpatient encounters) in the state. An overall analysis of our patient data since we initially went live with Care Management Alerts and Dashboards in July of 2017 shows that, with Care Management Tools, we have had a 4.5% reduction in Emergency Room visits and an 8.6% reduction in inpatient admissions for our patients, leading to a total cost savings of $2,231,200. While our CCAP team initially had only our high risk patients on our panel, through TCPI funding last summer, we had the opportunity to expand to cover our *full panel* of patients. Our number of post-hospital follow-up appointments has notably increased, and we are better aligned to provide education for patients and information regarding access to services available at CCAP. As described in the CCAP Care Management Testimonial (available in the Appendix), our Care Management Alerts and Dashboard also helps shed light on patients who are struggling with mental health and addiction issues. Through being reliably notified when these patients are going to the Emergency Room, nurses and staff at CCAP are more able to outreach and engage with patients who will benefit from the behavioral health and other services provided through this organization. As a new feature, Care Management Alerts now include information when an Emergency Department encounter may involve a potential overdose. Since November 8th, 2018, four Potential Overdose Alerts were sent to our organization so that we may be additionally informed of this possibility.

With RIQI Care Management Tools, we have had a 4.5% reduction in Emergency Room visits and an 8.6% reduction in inpatient admissions for our patients, leading to a total cost savings of $2,231,200

Developing Solutions Based on Data from Patients and Staff

Patient and staff engagement is, of course, a priority at CCAP. Each of our providers has 10 feedback surveys completed per month (on paper) by a randomly selected patient at the end of a visit. Patients are asked about the interaction at their visit and are provided with the opportunity to add comments, as well. These surveys are reviewed through a formal process by our CCAP leadership team. We use the information shared to learn from our patients and gain from the perspective they provide. Additionally, suggestion boxes are available at all sites in waiting rooms, so patients have an opportunity to communicate ideas confidentially at any time. Through receiving input from our patients, we then institute changes that better meet their needs. For example, based on patient feedback we created a new process to help our providers' schedules run on time. On a regular basis, our front desk staff calls patients ahead of an appointment and suggests they arrive early so they can have a buffer of time to check-in and complete any forms that may be needed. This simple intervention helps keep our day-to-day schedules on-track, which ties into higher patient satisfaction.

Along with our strong patient engagement, CCAP also prioritizes getting feedback from staff (using surveys) that can be incorporated into innovations in our practice. For instance, our current process for reporting incidents was put in place based on our team's feedback. Our improved process incorporates incident reporting software that all staff can use to easily report incidents confidentially and anonymously, as needed. Since the new system has been in use, there has been a significant increase in the reporting of incidents. This has made a big difference because, with improved incident reporting, more issues and problems are being identified and addressed. For example, recently, faxing was temporarily disabled within the EHR, but the staff was not aware. Because of this, prescriptions weren't getting automatically faxed to pharmacies. With the new incident reporting system, problems like this are identified so these kinds of issues can be addressed *immediately*. Having the new system also helps in situations when multiple reports of an incident are given. With this perspective, we are able to get a better understanding of the problem.

Innovations That Help Our Patients When and Where They Need Us the Most

As CCAP looks to *lend a hand* to Rhode Islanders in need of support, our most recent endeavor involved integrating our services at a local Crossroads location. Harrington Hall is a men's homeless shelter that provides beds on a first come, first served basis. At this particular facility, only 110 individuals can be accommodated per night, but approximately 1,000 unduplicated men sleep there per year. Forward thinking leaders at CCAP, William Hochstrasser-Walsh and Joanne McGunagle, are currently planning to have a Nurse Practitioner on-site to provide physical exams and care. There is already a social worker going to this location to integrate and get to know the population. As some of the individuals who utilize Crossroads have mental health issues and challenges with addiction, they are also in need of behavioral health supports. Given this, CCAP is additionally planning to have licensed clinical social workers and a psychiatric practitioner available to treat these patients. Moreover, there are plans to buy a dental chair for the site and have staff work there a couple days a week to provide dental exams and hygiene visits. Finally, our plans include acquiring a 15-20 passenger van from RIPTA so individuals needing more resources and services can easily be brought to the other CCAP locations. Ultimately, the goal for this facility is to transform a homeless shelter to be a place where individuals can go to receive the help they need regarding their health and their lives.

Conclusion

Comprehensive Community Action Program is a robust agency that is truly *comprehensive*. Within our organization, our teams work together to provide coordinated care and critical follow-up for our patients. With patients as our priority, we continuously work to assist and engage them with our wide range of available programs and a data-driven approach. By leveraging information available through use of the CurrentCare Viewer and Care Management Alerts and Dashboards, we help patients avoid unnecessary tests and are better able to provide post-hospitalization follow-up and coordinate care. We work to include the voice of both our patients and our team when effecting change and innovations within our practice. But, our staff will argue, what makes the most difference at CCAP is the *people* who work there and the dedication we have to the care we provide. Our clinicians will frequently fit a patient in to their schedule if they need to be seen. They really *care* about their patients and take the time to advocate for them. Our social work team has tools to connect patients to resources beyond our agency: staff at CCAP will often help with intakes to other practices and other resources. Sometimes patients don't know who to talk to and what to say, but they can rely on someone from CCAP to help them through the process. We look to help each individual patient and we are also deeply engaged in moving toward strong population health management through participation in our state's Medicaid Accountable Entity. Through these efforts, we look to provide the greatest value in care that we can for each patient as well as for our community.

Appendix

Care Management Tools Testimonial: CCAP

Names: Monica Martin, Team Nurse; Sandra Cameron, Triage Nurse; Gina Eubank, Director of Operations; Julie Lemaire, Nurse Care Manager Supervisor; Diane Grace, Nurse Care Manager; Evelyn Sanchez, Nurse Care Manager; Corrine Robinson, HIT Administrator; Amber Johnson, Quality Assistant; Cesar Ramirez, Medical Records Coordinator; Arthur Taylor, Director of Nursing; Anjelica Mercadante, Nurse Care Manager

How did things take place before Care Management Services?

Prior to having the RIQI Care Management Alerts and Dashboard at Comprehensive Community Action Program (CCAP), we relied solely on CurrentCare Alerts and the information that we would receive from the facilities that were seeing our patients. While CurrentCare Alerts were helpful, we would only receive those Alerts for patients enrolled in CurrentCare who identified one of our providers as their PCP. Approximately 50% of our patients are enrolled in CurrentCare, so this did not cover a large number of patients we treat. Also, we usually get notifications via fax from the hospitals when our patients are discharged. If the patient couldn't remember his PCP name when they were asked at the hospital, the record would be 'lost' from us until we requested it. We would hope and pray that the patients remembered the name of their PCP when they went to the hospital so we would get records and be contacted.

Given these limitations, our efforts to follow-up after a patient was discharged from a hospital were all *reactive* and not *proactive*. We had to rely on our patients knowing to identify their CCAP provider to the hospitals, so we had no way of consistently knowing, *all the time*, when our patients were using emergency department facilities or being admitted to the hospital. We also had to do a lot of work trying to get data from the hospitals and sorting duplicate notifications, as we would receive *both* fax notifications as well as CurrentCare Alerts for many patients.

Of course, when we did get a notification, we would outreach to the patient and schedule a follow-up appointment. But, when we were not alerted, we would often have to scramble to get records when a patient would come in for an appointment at a later time and let us know they had been to an emergency room. We would be searching for stuff and our timing would sometimes be off. For example, sometimes, in the past, we would get a notification that the patient had an inpatient stay, but they were actually still in the hospital. We would outreach and someone at their home would answer and let us know that our patient hadn't been discharged yet. Given the gaps in the data we were receiving, it was very difficult to implement a reliable workflow around providing consistent follow-up care for our patients.

How do things take place with Care management Tools?

In June of 2018, CCAP had the opportunity (through TCPI grant funding) to receive RIQI Care Management Alerts and Dashboard information for our *full panel* of patients. We included all of our patients who had been seen in one of our facilities within last 18 months. Prior to having this data, we thought we were doing well in identifying our patients who were going to the emergency room. We believed we had a small group of approximately 30 patients per month who were over utilizing the emergency services in the state. It was very eye opening to discover how *few* hospital notices we were actually receiving. Once we started reviewing our full panel data in our Care Management Dashboard, we learned that the number of patients going to the Emergency Room each month was close to 550 patients! We were truly surprised to learn that we were getting maybe 30% of notifications from hospitals prior to implementing our full panel in the Dashboard.

As previously mentioned, one of the biggest challenges in the past is we would get reports through the fax and it was not clear if the patient had been discharged or was still admitted. Now, with Care Management Tools, we get near real time data. We can see *where they are* and we are informed by the discharge disposition codes that are included. Sometimes, through the disposition code, we will know specifically that they are going to a skilled nursing facility. It is also very helpful and interesting to see *why* (the reason for visit) our patients are going to the Emergency Room, and having the updated demographics that are included is very valuable. Our records sometimes need to be updated and we can get this information from the Dashboard. If they have gone to the hospital, we can go into the Dashboard and see the phone number they provided three days ago. As we are always needing to be 'detectives,' having this kind of information about what is going on with the patient is extremely valuable to help triage what follow-up will be more beneficial and then be able to successfully contact the patient.

Now that we have our full panel of data, a challenge we face is making sure that we are able to manage the *volume* of patients that we are identifying as needing interventions and follow-up. Once we started to have an understanding of the scope of information that is now available, we put together a workgroup to determine the best workflow for us to follow. Previously, our Nurse Care Managers would get information for *every* patient that went to the Emergency Room (when we received a notification). They were getting information for *everybody* and then they had to do clerical work, update charts and decide if they should take a patient as part of their high risk caseload or assign them to the staff nurse on the team. Now, with the new process that was developed, that clerical work is being done by other staff who can handle the associated reporting. When we get Care Management Alerts, our Referral Team initially receives the information. They pull the patient's record together and give it to the nursing team who updates the chart and provides outreach, as needed. We are working to act on the data and provide outreach within no more than two days from

the time we learn about their encounter. Also, with Care Management Tools, we can track how many times patients go to the Emergency Room in the last six months. If they have gone three or more times, the Nurse Care Managers automatically take them into their caseload and provide targeted follow-up and education.

Overall, with this new process, the Nurse Care Managers can put more focus on actual *patient care* instead of administrative duties. This redesigned workflow allows for more face to face contact and outreach. Importantly, with this process in place, we are able to give extra service to the patients that really need it. Hopefully, over time, these efforts will reduce the number of unnecessary Emergency visits by our patients.

How does that impact your life/work?

Having Care Management Alerts and Dashboards has had a huge impact on the effectiveness of our nursing staff at CCAP. For the Nurse Care Managers on the team, our efforts are really focused on calling and reaching out to patients when they are identified so we can help prevent them from being readmitted. Armed with the information we receive from Care Management Tools, we can better assist our patients in maintaining their health and managing their comorbidities. We have gotten feedback that patients are impressed that we knew they were in the hospital and by the speed that we can connect with them – and that feels good. Also, sometimes our nurses are happy that they made the call because many patients really appreciate the outreach and feel cared about.

Now that we are more reliably and efficiently receiving information about utilization of hospital services, significantly more Emergency Department follow-up appointments are being scheduled at CCAP. We are getting people in who need the support that our teams can provide. As a recent example, there was a patient who was seen by us last in 2017. Through our Care Management Tools, we got a hospital update and learned she had been assaulted. One of our nurses called the patient, and when she picked-up the phone, she was crying. Before getting off the phone, the patient was scheduled for an appointment to come-in. We can be sure to provide her with further support and assistance after she is discharged. While it is a lot of effort to provide this level of follow-up and support, through this level of care, we can further prevent patients unnecessarily going to the Emergency Room.

Of course, there are many issues that continue to need to be addressed. With our new workflow, there is another layer of work for our staff, as the volume of follow-up that we need to take care of is significant. Also, for the nurses who provide direct patient care, some days can be tough. Given the current Opioid Epidemic, we are needing to address more issues relating to overdoses. Some patients receive Narcan and emergency treatment and then they don't realize how at risk they are. Also, it was eye opening to start receiving more information about how many patients are going to the ED due to alcohol and drug use, as well as other behavioral health issues. Particularly for staff who do this work every single day, providing support for patients can be emotionally challenging.

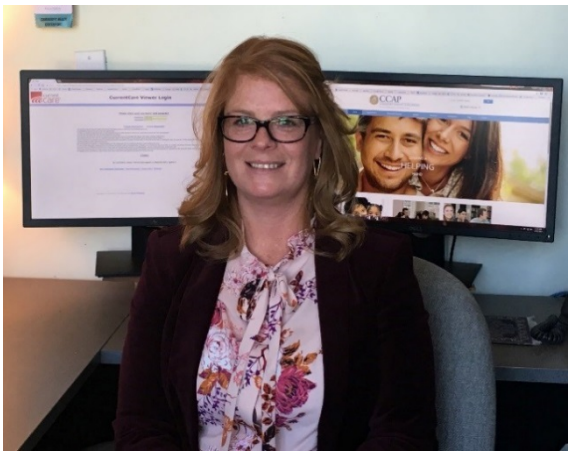
But, we have no question that the efforts we are putting into this new workflow and enhanced patient care is worth it and will have long-term positive impacts. In particular, we find that there is a direct correlation between the care we provide and the amount of utilization we see. In the past, access was a challenge at CCAP. When patients call and can't get an appointment, they are more likely to go to the hospital. But, now we are aligned to help break this cycle, as we have more access than we have ever had. With having more providers on staff and increased access we can help prevent unnecessary utilization of hospital services. Already, in the short time we have had our full panel, we

can identify a handful of patients who seems to have reduced the number of times they are going to the Emergency Department for care. For patients that have not recently engaged with staff at CCAP, when we receive information through Care Management Tools, we can call and touch base with these individuals. It's a nice way to reengage and communicate. We try to remind patients that we have extended time evening appointments and weekends. Hopefully, the more we educate, they will learn to call us instead of going to ED when they need medical attention and support.

CurrentCare Stories

Corrine Robinson, Quality Improvement Coordinator

Cori's Story can be found on-line at:
http://www.currentcareri.org/KnowledgeCenter/ViewerResources/MyCurrentCareStory.aspx#712207-corrine-robinson-ccap



How did things take place before CurrentCare?
I have been using CurrentCare for about 5 to 6 years- pretty much since it became available to clinical staff in Rhode Island. During this time, I have been in various roles at 3 different heath centers in the state. I have found that CurrentCare has consistently been a helpful tool for work I do. When I first started using CurrentCare, many patients weren't enrolled. Because of this, we had a constant push to enroll patients so that we would have their data available in the system in the future. Nobody wants go out of their EHR to get data, but, now that approximately 1 out of every 2 patients is enrolled, it can really be worth it to log in to the Viewer. At CCAP, we have a link to the CurrentCare Viewer right in our EHR so it's even easier to access it now.

How do things take place with CurrentCare?
There are a number of ways that I use the CurrentCare Viewer. A main reason is to test and support specific workflows that are being employed by our staff. Basically, I run time studies to assess processes that include using the CurrentCare Viewer. For example, we have a front desk pre-visit planning workflow that includes checking for CurrentCare ID numbers in our record. It is part of our process for front desk staff to ask patients about CurrentCare enrollment when they know the individual is not already enrolled. The front desk staff needs to be looking in CurrentCare to see if the patient record is there. When they find their information, they enter the CurrentCare ID number into our EHR so our clinical staff can easily access this data. For new patients, I sometimes help check to make sure we have their CurrentCare number in our system. When we find that a patient is not already enrolled, it is easy for our staff to print the CurrentCare enrollment form because it is available directly out of our EHR as a prepopulated document.
Here at CCAP, we have it as part of our protocol that our staff uses CurrentCare for chart prep, particularly for new patients. With data from CurrentCare, we can get important background and medical record history- there is so much information there! Our Medical Assistants are directed to support pre-visit planning by making sure to find CurrentCare ID numbers in advance of a patient's arrival. MAs should be using CurrentCare for checking for key pieces of health information for all patients, such as Pap and colonoscopy results. In CurrentCare, they can check to see if a procedure has been done and they can get the reports, as well. Since we primarily use Fatima labs, the information is available right in the Viewer. My time studies are looking at how long it should take for our MAs to look up the information so we can best gauge the needs of our staff. As part of our effort to optimize our processes, we are also currently looking to develop an improved, centralized method to complete chart prep for patient appointments. How can we set up the best workflow to get key patient data? When we are missing information, how can we use CurrentCare to efficiently find what we need? As we look to be more efficient and streamline our processes, CurrentCare is part of our plan to get the data we need.

I can also add that, as CCAP is a Federally Qualified Health Center, I work on Uniform Data System (UDS) reporting. In particular, I have been focusing on finding results for Pap test results. When patients are enrolled, we can go into the CurrentCare Viewer to get the important information. I can look at lists of patients we have seen per month and then check in the Viewer for how many Pap test results I can find.

How does that impact your life/work?

CurrentCare is the only place I need to go to for the quality data I need. If I want result information, and I need it quickly, I go to CurrentCare and I can get it. It's quick and it's easy. By retrieving this information from CurrentCare, I can improve our CCAP quality metrics in a day. A great example of this is our use of CurrentCare to get information about Pap and colonoscopy results. For a recent project with the Rhode Island Department of Health, we needed to make sure screenings were happening. At the end of 2016, we were at 40% for our Colon Cancer screening rate. We are now ending 2017 at 49%. In one year we have raised the screening rate of our patients by 9%. We improved this metric, in part, by finding the data in CurrentCare. In the Viewer, we found records of pathology reports from colonoscopies. With this information, we can call to get the full consultant report that we need to have included in our record. This is really helping us to have the information we need to provide improved, informed care.

Amber Johnson, Quality and Compliance Administrator
Lois Teitz, Director of Quality and Compliance

Amber and Lois's story can be found on-line at:
http://www.currentcareri.org/KnowledgeCenter/ViewerResources/MyCurrentCareStory.aspx#712157-amber-johnson--lois-teitz-ccap

CCAP
COMPREHENSIVE COMMUNITY ACTION PROGRAM
CELEBRATING 50 YEARS OF
LENDING A HELPING HAND TO THOSE IN NEED

How has CurrentCare helped you do your job?

Lois: We use CurrentCare Viewer when working on our UDS reports and insurance company lists, especially for Pap results. With all this movement towards a value-based payment model approach, the primary care providers are responsible for the whole scope of care for the patient. We try to make it as easy as possible for the providers, nurse care managers, and patients. We get as much information as we can in the record, to support the morning huddle meeting and reduce duplication of services.

We get a lot of lists from the various insurance companies so Amber responds specifically to those by trying to fill those gaps in care. Also, annually we complete UDS reports that look at key indicators.

What information do you find most useful?

Amber: The biggest thing I find is Paps! I do find some A1Cs, but colonoscopies are scarce [because only the pathology reports are currently in Viewer]. I'm hoping for more colonoscopies to be added, and eye exams for our diabetics would be great. I find a lot of imaging reports from XRA!

Do you have recommendations for others in similar roles?

Amber: **Use it. It's great!** I like it because I can find results that we don't have in our own system.

Lois: The front desk receptionists do a lot of work getting people enrolled in CurrentCare, so that helps our process as well.