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Please stand by for real time captions.

Ladies and gentlemen please stand by the conference will begin momentarily. We thank you for your patience. Please stand by.

Welcome and thank you for joining the coordinating center for the February 2014 community of practice call. Today's title is 24. My name is Ava Richardson all lines are muted during the call we will begin question and answer after the training portion you can estimate question through the checkbox or by prompting one for. -- Prompting 14. On the telephone keypad.

Please complete the evaluation at the end of this presentation. We have an exciting agenda with three speakers they will share their experiences in patient engagement, chronic disease management and community innovation. This speaker biographies have been sent.

Over the next hour we will give you a better understanding of chronic disease management and explore health literacy on how that relates to chronic disease disparities and we want to clog -- talk about innovation in clinical engagement.

I will like to welcome and introduce this first speaker, Jane Kapustin.

She is a nurse practitioner at UMB. With that I will pass this off to you Jane Kapustin.

Can you hear me okay?

Yes.

I will go ahead and launch my first slot, I thank you for inviting me today and allowing me to speak to the group. Ava My slides are not advancing.

You will have to click on the screen and then that will give you control.

So I will go ahead and launch into the slide presentation obviously I take care of people with diabetes. I just put the slide of here to remind us that we are talking about disease that millions of people in our country have. I think you would have to be living under a rock to not know this. I will not bore you with unnecessary stats and information, I will remind you diabetes costs to the country are huge. From a study that has been replicated in tune -- 2012 they have grown 2.3 -- I am sorry almost doubled since 2007. The cost are honest, it is important and we need to manage this more efficiently.

People with diabetes we have to consider health literacy we know this related to any chronic disease will affect the way people understand the disease condition, the way they manage, self care behaviors and also we as providers have to also get a better understanding of the disparities that we observe for people with diabetes. As we know folks of different ethnic cities and populations are affected with more [Indiscernible] that are tougher to treat and suffer early mortality from the disease. It is important that we understand.

I was stunned the estimates ranging from 15%-40% of people who have diabetes had very low level of health literacy. It is a one size does not fit all to approach for management for people who have this disease. Some of the issues that we face in chronic disease management in primary care, of course we have many. It is kind of discouraging, but in primary care we often see patients and healthcare providers that are disengaged from the care process. The patients sense this they are passive, we have often times and -- as healthcare providers adopted a materialistic healthcare approach everything centers around us as the provider and not as the patient.

Another thing I see a lot and over the many years I've been in the business, we suffer from clinical inertia, we make incorrect assumptions about the patient, this means we tolerate very high hemoglobin A1C for a long time. We make assumptions about the patients like I would assume currently -- incorrectly that the patient cannot do self in Jackson's -- self injections with the insulation. -- Insulin. Of course we know the chronic disease management they take holidays from their disease they do not always follow the care prescribed to them.

Other issues it is fine to find a good provider that patients connect with. We suffer from patients who are either under insurance -- underinsured or do not have insurance or do not -- or are not citizens of the country. This exit difficult for chronic disease management. Specific things that I see, during a single visit we are often rushed, distracted, overwhelmed with the number of patients that have to be seen in a short period of time. Often we have little time for more than one problem that it patients want to come in and discuss. Chronic disease like diabetes you cannot talk about just one problem it affects everything. You talk to people about pain conditions, depression, other mental health issues, hypertension, neuropathy all of the other complications.

It is really hard to fit that into a 10-15 and a visit.

-- Minute visit. Why you would see things like patients being frustrated? Our focus may not be the same focus that the patient has. Often patients think we do not listen to what we are saying. We look rushed, we have a poor understanding of what the patient is dealing with and where they come from. Many patients feel like we are not respecting them and not valuing their input into the healthcare visit. It is again, no wonder that we do not reach their goals of care. Many patients take disease managed holidays, they do not lose weight, metrics are not met, they become disengaged, not motivated and they take breaks from there care.

A lot of things affect the patient's understanding of the disease and the approach to the disease. Engine six and extra and six factors. -- intrinsic and extrinsic Factors. You have to break down the barriers and deal with where the patient is. Many of them have limited knowledge about diabetes, they may be limited and physical capabilities, poor vision, they cannot ambulate as well, they have health literacy issues and it affects their self efficacy for behavior change.

Some of the extrinsic factors are financial resources, deficiencies, inadequate family support and limited access to care. I know many patients they have waited for 2-3 months to get into see someone at the clinic. Access to care is limited even who have -- even to those who have good insurance but they cannot get and. -- Get in. Team-based care, people benefit from a team approach, the ideal situation. People with diabetes benefit from intensive patient education regarding the disease, treatment, self manage, even with advanced therapies.

Again the principle of the team-based care, notice where the patient is? They should be in the center. Traditionally for the past 20-30 years the healthcare provider has been in the middle and we forced the patient to work around us. Team-based care is a operation, sharing goals, clear roles in the process, effective communication. Developing mutual trust, of course having better measurable processes and outcomes.

Communication is key. I like the book called everything you need to know in life you learned in kindergarten. It teaches the basics, I do not want to sound insulting, we have to go back to effective communication. Being nice, demonstrate respect, anticipate rather than waiting for patients to ask, get a sense of where they are coming from? I cannot make enough of a statement, if he do not establish trust and do not have the relationship built on trust they will never follow you to the next step and they will not be engaging care and outcomes will never be optimize.

I am lucky because of the University of Maryland medical center we have a team-based care approach to the patients. I work and what I call utopia. We have the necessary team people who are there all of the time. To help her approach the chronic disease management plan for our patients. A patient can come in and see me and maybe one hour before they see me, they met with the dietitian or they may be afterwards with the podiatrist or foot checks it is fortunate I have that. We offer a lot of classes, group support systems, we have one-stop shopping. Healthcare providers who see patients in the same clinic so they do not have to go all over the campus.

We are very fortunate. The patients of course love this. We think this is one of the reasons why we have good outcomes in care. We try to keep the patient and the center of the team. -- In the center of the team and we function as a good team we tried to for to each other, we try to read each other's notes so we always know where the patient is in the process of treatment. Many ways we try to facilitate the visit. Everything is designed to try to optimize the experience with the patient, the best thing that we did several years ago is a shared EMR system patients will respond better if they know you can read the note that the dietitian wrote about them so you're not repeating the same information, you do not make assumptions you base it on a diary they put in for the patient., -- And part of getting patients -- hooking up in the system, they engage through the patient portal for the access.

E-mailing questions for us, refills of medications, helping the patient feel engaged. Foster communication and helps the fostering of team communication as well.

So let me just describe to you quickly a couple of patients. These are real patients that I see, I just saw this gentleman last week. A 58-year-old African-American male with type II diabetes. He is

not controlled his A1C is not controlled it is a .6%. I can see that his rates and insulin coverage is not optimize and his finger sticks are out of range and he is not taking them as often as he should. He has had lots of interactions with the healthcare team, he had liver transplant, he suffers from heart failure. He tries to sit away from me and said that instead of sitting up that the disc -- up at the desk. This gentleman actually told me that I was one of the first providers who ever laid a finger on him when I examined him.

Patients will tell you sad stories if you listen carefully. This first visit, he evaluated me, he asked me at the end of the visit, how long I plan to be there. He was used to turnover rate of care -- of healthcare providers.

So I had him make a follow up a point that he sees me every three. He brings his meters to his visits, he shares his result he understands I read them and engage in care and make decisions about his care based on the information that he brings to me. We look at the medication list each visit, I help coordinate care with him, referring him to diabetes classes, dietitian, visits over the next year his A1C has dropped and he was could -- considered optimize. Together with a good team that works and listens and develops a relationship and clear communication and getting a sense of where the patient came from? We got him or engage in this care and obviously improve his goals.

I think motivational interviewing goes a long way. Business -- this next case illustrates how you listen to the patient, develop a system and engage with the patient in a meaningful while -- meaningful way and reach a agreement to a action plan that the patient helps to formulate. It cannot be my plan it has to be a plan that Jane and the patient joins in together. In the page -- case of Ernestine when I first met her she had diabetes for 16 years. Frustrated with her weight her A1C was not in a good range. It was 7.9%. Herby oh my -- her BMI was obese, she was sick of treating her diabetes and the routine. She did not test her sugars and frankly in the back of my mind, why are you here?

Again you have to be careful, that has to be be bubble over your head. What I said to her I can understand a lot of my patients are frustrated with the disease I empathize with you. You may not be ready to engage in good self-management at home, exercise and losing wealth and seen the providers, or maybe one thing that I can clearly see you are interested in. Let's decide on a change that you can make. Maybe we will go for that and will be happy if you can meet at one goal.

Ernestine was interested in developing a action plan, for example which she said she could commit to, they be not walking on the treadmill, she did, to stay more act div, make better food choices and she agreed to contest her glucose at least daily. If it was weekly, it was more often that she was doing at the time. That was a good plan, to bring her back into the fold and engage in her care.

She saw the dietitian again so she could read labels on learn about portions, better food choices. She had support group activities that were of interest to her, group diabetes education class. Again just with a little bit of engagement I got her to commit to her plan, I did the one thing that people with diabetes who are overweight are interested in. Jumpstarting her weight loss plan so

instead of -- she clearly needed medication augmentation I chose medication [Indiscernible] that would help augment and jumpstart weight loss plan through the way and weapon is an -- and mechanism of how the drug worked. That was of interest to her., You can see through two simple examples, connecting with the patient, techniques of team management and communication and empathizing. Can offers some major redesigning of the healthcare system for the patient.

It is very simple it is not require a bit complex transition of care. Clearly you can see even with a really optimize healthcare system team approach I have at my particular facility, it is still the healthcare provider touched that can make the difference . So thank you for your time and attention I think that was my last slide? I included some references for review, I believe we are taking questions at the end but I bet Ava wants me to pass the ball back to you.

Yes please.

The challenges that you brought up that really segues perfectly into the work of that Tanishah Nellom is doing in Columbia South Carolina.

Tanishah Nellom or is a -- is a Care Improvement Specialist. I'm sorry -- I am trying to advance the slides.

Tanisha I will pass this off to you.

Do I advance my own slides?

Yes .

Thank you everyone for listening. I were like to say that James -- Jane's talk was a perfect introduction. I am addressing healthcare professionals literacy. I know sometimes we get caught up in the healthcare bubble that everything is going to be perfect. We will give recommendations to our patients and they will go home and do everything. If not they are not compliant. What we consider rarely, there are other determinants that have a deciding factor as to how a patient is going to be able to perform those self care and self disease management once they are outside of the hospital facility.

And so we have to consider, economic stability, education level, social and community contacts. Do they have families? Do they understand the disease? What are the myths that they have? Healthcare access will they have to wait six meet -- six weeks for a appointment? Do they have transportation? And the neighborhood, we suggest people walk more get out and exercise. Do they live in a neighborhood with no sidewalks, playgrounds or parks? We do not consider these would we make recommendations, we have to have more of a focus of what the social determine its are.

And so, when we look at what the culturally competent provider has or what these skills they presents they usually embrace cultural diversity. Many people from different backgrounds are looking at healthcare differently . Do they have a Ms. Trust -- Ms. Trust -- mistrust for

healthcare? Their cooking habits? Prepare for language barriers? You cannot say -- they did not speak English, that is not excuse that we should rely on when we look at being culturally competent. We need to build a better report with patients. The gentleman example that Jane gave was the perfect example of what building Representative or with a patient can do in improving outcomes. Understand how the social determine it can impact -- determinants that impact the patients. Do you have electricity? You have refrigerated medication, do you have a refrigerator?

This can be a determine it -- deterrent when you consider outcomes, we communicate it does not mean that we communicate well. If we communicate effectively we want to make sure we are being understood and that the patient absorbs the information that we give to them. It is useful for them. And my example later will be based on nutrition. A lot of patients are getting a lot of nutritional information they can repeat back, but if they do not have the food options in the stores at the shop in, that is good communication that they understand, that they cannot apply it to their lives. It is not useful information.

And so effective communication that is useful communication information can help patients better manage their health and prevent adverse drug events and emergency department visits that we to readmissions. Over all improving the health outcomes which is what we want in the end. And so, coming down to the local problem.

I work for the QI I'll -- QIO for South Carolina I have a hard fill your nurse that was expressing -- heart failure nurse that was expressing a lot of frustration about her patients and the sodium restrictions. They are not compliant, she does not understand because she is giving education, the patients respond well they understand the information and come into the follow-up visits. As part of the new care transition program, the patients were given nutritional tools to guide the food choices. And yet they are still seeing negative outcomes tied to disease self-management once the patient is discharged back into the community.

And so while we are having this conversation, I know and Kerry will discuss this more, Columbia South Carolina since in this 29203 has the highest rate of amputations in the country, very low social economic status. Many residents in the community -- there are several Family Dollar, Dollar General stores in the community where the patients were reporting to shop. The hard to fill your nurse was not familiar with the products in the store. Some of the store -- corrector six -- some of the characteristics, they accept SNAP benefits and they have low prices, they attract a lot of people in the area directly around the hospital.

Our work in the public health, I work in the care transition I have been waiting for the social deterrent of health for the healthcare transition, this was a educational moment that could turn into something bigger.

I suggested the nurse practitioner visit the stores, familiarize herself with the inventory and learn about what is the patient buying from the store? What are the options? Can they eat within the nutritional restrictions from the store? I felt it was an opportunity to walk the walk, practice what you preach. Can you eat a full day, three meals per day, maybe a snack for under 1500 Villa grams of sodium if this is the store you have to shop that?

And so her challenge was to craft a full day's menu from a local discount store for less than six dollars which is the average SNAP benefits for the day and under 1500 mg of sodium.

What we discovered, there are no fresh food items, there is a lot of processed foods with high sugar and sodium, and canned meat products. There were some good things, there were some sodium free vegetables, salt free crackers, there were two enough -- tuna packed in water. What comes from the conversation is that, heart failure nurse could not plan a full day's mail for under 1500 mg of sodium and even cheating on the budget.

She now has in her mind, for some of her patients she sends it -- sends them out with a impossible task, she did learn there are better food options available at the stores. As an outcome from this experience, which was a eye opener for the practitioner, leaving the healthcare bubble where the patient will be compliance became -- because we gave them the tools to go out and see what it is like to operate in the real world with some of the social determinants as structure for what your actions can be.

There may be room to address or -- I am sorry, there is room to change the approach when it comes to nutritional recommendations. This community is working to make a nutritional tool that includes shopping with all income levels that include a better food option. In stores like these. Instead of purchasing maybe the high sodium canned soup, you purchase tuna that is vacuum sealed and assault free crackers . -- salt Free crackers. Practice what you preach, intervention for clinical staff to get experience and what is like to live in your patience shoes for a day? We had heart failure nurses, attempt the 1500 mg challenge, no one has been successful so far.

We have some of the care transition nurses travel on public transportation with some of their patients to see what is like to have appointment at a scout jeweled -- scheduled all over time that -- in a city that does not have the best public transportation system. We opened the eyes and minds of the staff, that may affect the health outcomes of their patients outside of the idea that they are noncompliant.

While we have the clinical understand -- understanding we have to get the real world experiences. This is what the community and with the committee of Terri Jowers is a part of is what we're trying to do. As providers we have to be willing to explore the unfamiliar to understand where disease adjusts his -- addressing the root cause, what is the cause of the cause of the disease?

I will turn this back over to Ava and Terru -- Terri so she can discuss more about the area and all of the work that is going on here.

Thank you so much Tanishah. And now we will pass things over to Terri Jowers director of the Healthy Columbia initiative.

[Silence]

All right.

Thank you so much would've the -- what a pleasure to be here today, Tanishah thank you for your hard work. I am Terri I am just honored to be here. I have been blessed to be with hard-working folks to the leaving by living their faith by giving back to the committee. Everyday is a good day, a great day is when we do something for someone who cannot afford to pay you back.

Before you ask, my medical expense [Indiscernible-static] and as of last week I finished my sixth end-of-life experience with loved ones. In January 2011 out of the blue I got a call from organizing [Indiscernible-static] asking me if I would be interested in a part-time job. To improve healthcare and reduce calls and underserved South Carolina. I have a whole hog type of girl, you have my head, my hands and my heart.

January 2011 we formed a vision team of [Indiscernible-static] we coded looking at hotspots areas, began organizing the map Constitution called the clear area of Columbia. [Indiscernible-static]

As Tanishah said, there are so many problems in the community, there is about 46,000 people, 30% are uninsured, 50% have Medicaid or Medicare. The cost of care is unbelievable. In 2011 it cost [Indiscernible-static]

It does have one of the highest rates of amputation in the nation, we believe most likely one of the highest rates for dialysis. It became evident that this is a community in need.

We began to work on a hopeful vision, the vision of transforming lives and communities through health. The mission uses community organizing as the model of change to build leadership to enable individuals to take actions to create healthier lives with providers and more efficiently to improve health care.

A real vision. It is outbreak of health in Columbia South Carolina, we realize this is a hopeful vision and audacious vision. We want to help patients and communities be equal partners, healthcare providers and develop plans of action and create health changes in their lives. What we would like to see is a epidemic of health.

Why committee organizing? -- Community organizing? It builds relationships, we identify, recruit and develop leaders, we take action to create change.

You will hear us talk all of the time about changing the balance, who has a balance of power in health and healthcare? [Indiscernible-static] if you speak in the language I do not understand if you make decisions about my care without me that his power over. For many patients especially in underserved areas that makes them feel victimized, helpless and hopeless to create health improvements in their lives.

So in the fall 2011 got together -- we taught 250 people, can you hear me?

We had a number of one on ones, we did 45 house meetings, talk to 750 people, we had 250 people.

Terri You are cutting in and out. Are their connections -- are there issues with your connection works

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Is that better?

Thank you.

After doing 45 house meetings, 200 members of the community came together and voted on the strategy for change, those included using the pharmacist as extenders, having community based communication workers, nurse practitioners embedded and sites in the community, developing a one-stop patient centered medical home who have a lifestyle support that may be a space for activities. The covenant on that part of Grasstops and grassroots we are willing to make changes perhaps but we need support and we need education to be able to do this.

This is what we have done. [Indiscernible-static] and beginning conversations in the community we started to do health screening events in 2012 as a way to practice our power with pain out in the community. So far we have had about 1650 health screening we go to Brown bag medication checks, we connect people to services. We have done all of this using 365 volunteers. We have a campaign to transform the education at University of South Carolina, we are opening medical homes operated by students [Indiscernible-static] and a local hospital system.

We have people who have stepped up to take leadership as volunteers, they are taking training and now leads lifestyle or exercise classes in their neighborhoods. It additionally we have some other projects we are working on I would love to tell you about those in -- at another time, we have a men's health team, teaching parents to help healthy meals with a good conversation. [Indiscernible-static]

Targeting high school football players who are at tremendous risk. Some of the [Indiscernible-static] we received $2.4 million CMS grant to do the nurse practitioner all micro-sites with the community health workers. We have neighborhoods who are beginning or expanding the wellness programs and we have providers who are really changing the way they are reacting and working with the patients. They are serving to think about the team approach and we are extremely excited about some of the changes that we are seeing.

Ongoing we have the health screenings and I will tell you about those in a minute, we also have ongoing leadership Trini for community members. -- Training for community members. [Indiscernible-static]

We are trying to meet the needs of the community, we see there are food [Indiscernible-static] we have folks who came up we want to be involved and we would like to create some change. We are working on a produce truck that would go to neighborhood to neighborhood that accepts EBT.

We have a rotation for third-year medical students they partner with pharmacy students, public health students and community members we go out into the communities to do screenings.

So what we have learned. It looks like -- I have missed -- I will tell you quickly what we do in the screenings. It is not that we you -- you come through and we give you a sure -- April sure, we give you information and move you to action. We do BMI, body fat percentage, we do blood pressure and random glucose, at the checkout table we listen to what the challenges are. We try to understand the barriers. What is going on in your life? We have conversations about [Indiscernible-static] and talking about ChooseMyPlate.gov . We find out what are they excited about what goals do they want to set? Around the lifestyle when movement -- what are the barriers? Do you need food? Support? We make the connections but we also in the plan of action named a support system, who will they share their action with? We have the team of folks in -- and it has been an amazing.

We have learned that access to care is much more than just getting covered. We have a primary care crisis in South Carolina, there is not enough people seeing Medicaid and Medicare patients and there are those every day. If I have to wait two months for care, that can be a problem. If I do not have transportation, if I cannot get there those are problems. Folks are struggling to manners -- to managers -- folks are struggling to manager -- manage, especially the seniors, not being able to take care of themselves, [Indiscernible-static] when people have been out to the home to talk to them wants to do education. They are still struggling.

Trust is earned, for patients to be honest with us, they have to believe that we are treating them as equals. Go to where they are, go to their neighborhood, we earn their trust in a different kind of way and they are honest . We have also learned there is power in the group. [Indiscernible-static] who can talk to you in a language that you understand, somebody that you trust and who will be there tomorrow to who -- help back you up. These folks are patients who out in the community that we have labeled as noncompliant are actually -- we need to be treating them as equals because they bring something to the table. If we want to reduce ED visits and total cost, we have to help them find the power. And to be able to create sustained [Indiscernible-static] underlies.

We still have incredible aspirations. For us this includes the community centered health home, we have a place to not just have great team care, the also have a place for healthy cooking or a farmers market or diet and exercise, what the community feels it needs. We are still working on, debased health workers, from the Healthy Columbia they are volunteers now who receive training and go out and be able to work both folks -- with folks in the home. Make calls to the transportation to figure out how to get there. We are adding a fall risk assessment to the health screening which we are excited about that. There will be simple training around us, we are always thinking about the healthy blind, -- mind and body connection.

And here is my inspiration.

[Silence]

Terri You have gone after them are you there?

Yes.

Hello?

This is Ava.

To have time for the inspirations?

Let me tell you about Ridgewood Baptist Church . The minister is a vegetarian and he holds a health and wellness as a godly principle. We have so many Healthy Columbia volunteers that have taken training and ownership. They do walking classes, better food choices and health, all kinds of things they are connected and supporting each other and the numbers are the best that we have seen.

I need to tell you about Jannie she is a [Indiscernible-static] who was taking training to be a leader. And a healthy choice and better health -- she invited me to come out to the community for a meeting, there were 15 people sitting in folding chairs under trees, some were in wheelchairs, there were altogether trying to figure out what they want to do and how they can make their neighborhood a healthier and safer place to they it. They were -- safer place to live. They were taking ownership, when it was over she decided to show me her apartment. Four years ago she was homeless and had been a crack addict. She decided to change her life, now she is a leader in her neighborhood, and inspiration to so many people . In Columbia South Carolina.

So that is a little bit of what we are doing. I realize I have covered a lot of information in the short amount of time. I hope this sparks you to think about the urgent challenges in your community and what you can do to take the time to think about those challenges and what is your inspiration to create change where you are?

And finding the people to connect with to help you do that. Thank you so much for having me it has been a blessing to be here. I have contact information here . Feel free to contact me I would be happy to talk to you further. Thank you for allowing me to be with you.

Thank you for joining us for the wonder for -- wonderful presentation and we will open the lines up for questions. You can type your question into the chat feature or by pressing 14 on your telephone.

We will start with the questions in the queue. I think this one is for Jane, on 60 min. a story was noted about the care that male and females receive for chronic decisions -- conditions. Regarding the type I and type II diabetes?

I saw this as well, we have known for years there are many differences with the way we metabolize drugs, alcohol, and the whole bit. I thought they did a good job point out the difference with Ambien. In terms of the way we metabolize achievements with people with type I and type II with the gender differences. Is not the crust of the issue, type I and type II diabetes is treated differently . The main treatment for the type I the top allies is the insulin is different from somebody with type II, type II has insulin resistance it takes more insulin to break -- bring down their sugar. I will not go on. I hope I address that radical it. -- That question adequately .

The differences in specificity as well -- ethnicity as well is noted for the metabolize them in the drugs as well program we need to know the populations of people, many Asians for example in certain areas lack the enzyme that can completely break down alcohol. There are lots of things like this. Thank you for the question I hope I addressed it.

We have another question, have you found [Indiscernible] to be a winning treatment? Even though it has associated weight loss address -- effects . I love [Indiscernible] it is a injectable medication it is a test -- a tough sell to get people to inject daily which is not medication. It does stimulate weight loss, there are several others as well . I really like the drug, unfortunately in the diabetes world and for any chronic disease one of the things that it takes the kind of drugs we use for the patients unfortunately is financial resource. [Indiscernible] is expensive if you do not have insurance, if you have insurance and is not a prior authorization you are fortunate to get the medication. That yes I do love Betoza.

I think we have one final question from any suggestion on how to assess the effectiveness on patient and family engagement?

Yes to the EMR we see the patients engage through electronic medical records and search for information and look for the lab results and request refills and that type of thing. That is one engagement you can directly measure. Another direct minister it -- measure, they bring in their diabetes logs and food logs, they look actively for participation and response, sadly so many get negative responses from is. When you see the glycemic control improving, you know that you are reaching them . I am sure there are tools, self efficacy tools you can use. I am sorry I do not have these, there are ways you can look at that, the simple way is to take notes of the kinds of interaction you have with the patients and the way they participate in care and take their medications and that kind of thing.

Thank you the next question is for Tanishah. Have any other steps been taken to increase access to healthier food?

Yes. And Terri was speaking on this, she said they are working to have a food truck with fresh produce and food and -- that has been donated from churches. And also this would be in partnership with some of our local government that would take EBT cards or SNAP benefits and more of a two for one exchange so there is a value of purchasing fresh fruits from the trucks than to go to the stores where you can get the not so fresh food items and processed food. With the higher sodium and salt and sugar contents.

Also a map of where there are food stands in the community. Up and down that one of the main streets through this zip code there are maybe 5-6 different fruit stands that are active in the spring and summer. Most of the fall it is pretty warm year-round, there can be fresh fruits and vegetables purchase. We are trying to increase the awareness of the community members for the healthier food options that are currently available as well as provide new ways to access the food best the healthier food items and make the better food choices in the community. We want to make the goals realistic and address the issues, nutritional issues that are happening in the neighborhood so they are -- it is useful information and can be immediately applied to the real life.

Tanishah that we have another question for you, how do you manage self-care -- measure self-care behavior?

In multiple ways, we have several hospitals, federally qualified health centers them a that are working on care transitions together in some instances and separately. Those are all measured independently. I collect a lot of data on the measures. For the self-care, the measures vary from are you able to get transportation? Or are you able -- if available, will you be able to get to your appointment? Do you need assistance with everyday routine parts of your life and self-care? So we can work to make sure there is home health or hospice referral, the measures vary from facility to facility. It is basically -- we create a standard to identify the people who are qualified for services.

How many of the people are provided the service versus the number who are qualified? A lot of different ways of measurements. Nothing standard in the community as we introduce care transition we introduce with the idea it is not a standard one-size-fits-all which I think it has been successful. We do not provided measures the community did it has helped us be a very successful here in South Carolina.

I want to thank you once again to all of the speakers. We have run out of time we will to wreck the rest of the questions to the speakers and get back to the participants directly.

We will leave you with useful resources and to get connected and the listserv. We have office hours next Wednesday from 2 PM to 3 PM. March 11 we will have the March COP call and lastly please check out the CMS website.

We will see you next week for office hours.

[Event Concluded]