PPC 2: PATIENT TRACKING AND REGISTRY FUNCTIONS
Element F: Use of Systems for Population Management

Item 1: Patients needing pre-visit planning

At the start of every afternoon session, an appointment slot is blocked for team huddles. During the huddle, teams pre-visit plan for afternoon patients and any patients with appointments the next morning. The following table is a tool to help staff identify pre-visit planning tasks in order to facilitate their appointments.

Huddle Goal:	Same Day Patient Needs	Tasks that are due	Managing Flow	Managing Demand	Planned Care: Registries Immunization, Prenatal	Chart Retirement	Huddle Leadership
Nurse	Look for opportunities to provide nursing support (i.e., education for asthma pts). Present complicated triage to provider. Task front desk when help is needed. Support MA identified areas of need.	Discuss with provider questions related to future tasks.	Know potential places for double books if necessary. Communicate acute pod factors to team and plan for response and communicate to all necessary personal (i.e. GV coverage, equipment failure, IT issues, staff shortages, etc.)	Review schedule for opportunities to off load patient appt to nurse visits. Review future schedule to communicate identified demand issues and plan for management of issues.	Coordinate planned care needs w/ECS & clinician (ORDC Question: what is new nurse role in planned care delivery?). Share outcomes data w/team.	Assist MA in entry of HM data	Assure huddle occurs and is productive.

<table>
<tr>
<td>Back up</td>
<td>Set up procedures, identify (w/provider) missing results/reports needed for current visit and task OT to obtain, assure cancer screening forms available, educational forms in chart for OBs, WCCs…. Review PCP assignment & look for opportunities to trade patients to their PCP. Check immzs (w/provider). Anticipate (w/provider) planned/preventive care needs. Release of information authorization form for new patients.</td>
<td>Anticipate (w/provider) future tasks for current day pts (e.g., usual FU visits for PP, WCC, NB, delayed immz; med RFs that will be needed;). Ask appropriate staff to help call recalls if needed (i.e., scheduler, office techs…) Share med RF requests w/clinician (preferably to approve for 12 months). Share task clarifications w/clinician.</td>
<td>Identify (w/clinician) possible pt bottlenecks (e.g., pts having special needs) and devise mgmt plan (w/NTM, clinician & ECS). Anticipate doing labs or immz.s before provider sees pt. Check with clinician re: particular info he/she wants to see entered in EMR. Review scheduled procedures to assure that all rooms and equipment are reserved.</td>
<td>Review registry (w/clinician) to identify patients who need appts; task to OT to schedule. Look at two-week extended schedule weekly to assure accuracy (e.g., is provider on-call or taking PTO?). Coordinate internal referrals.</td>
<td>Review registries each week with clinician. Review pain registry to assure timely and appropriate med RFs.</td>
<td>Identify charts for which MA can do data entry</td>
<td>Communicate concerns directly to team members; remind clinician of special circumstances; perform huddle tasks even in absence of clinician</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Be sure all unretired charts are in pods. Assure all loose documents are data entered prior to pt visit. For all OB charts that need faxed, verify all OB labs are data entered, and if not entered, take to the pod for data entry.</td>
<td>Assure that all charts requested by pod staff are available by huddle.</td>
<td>Bring rejected release of records for provider review. Return to the provider all incomplete data entry results.</td>
<td>Print 2 week schedules for review at huddle time to anticipate demand needs</td>
<td>Assist with organization of the papers in the charts to assure all chart are orderly and easily reviewed.</td>
<td colspan="2">Assure stickers are on all charts. Assure that all charts have NextGen Transition sheets. Send charts to Xxxx once chart retired by provider. Assure that retired charts do not come to huddle. Data enter patient info on NextGen Transition sheets as needed.</td>
</tr>
</table>

Provider	Review patients coming in. Help nurse and back up strategize flow and anticipate patients needs. Request ER or lab reports as necessary for office tech to request. Let office techs and nurse know of any potentials for double books if absolutely necessary. Review PCP assignments, look for opportunities to trade patients to their PCP. Review OB charts. Review charts for missing info (labs, history and reports). Look at referrals to outside sources to put in referral to RCM	Bring any task questions to the CHC-Al Team for clarification.	Identify patients that require a lot of time (elderly, patients who always have multiple complaints…).EG: Strategize ways to get history with MA, get refills done, perhaps see next patient before if here early and has quick.needs. Let office techs and nurse know of any potentials for double books.	Look for opportunities to create capacity (a patient that will have a very quick appointment and could be double booked…) Double check for blockings for vacations, meetings, on-call one and two weeks out are accurate and communicate if changes needed.	Review a different registry each week. Look for patients who need to be seen vs. patients who need phone calls. Check that medications are refilled, Request pt be called patient if unsure. Identify patients who need self management goals and hand off to ECS. For recurrent problems, refer to site peer review. Need legible and complete notes to be able to anticipate needs. Identify new and follow up diabetics to be scheduled for early am appointments for fasting lipids (need annually). Look at referrals to outside sources to put in referral to RCM	Identify charts to be retired on a daily and weekly basis.	See Back-up, above. Arrive on time and participate in huddle daily

Office Techs	Update pt address/phone as needed. Review patient discounts and update as needed. Review patient appts and determine all appts that will need paperwork distributed at time of check-in (e.g. asthma questionnaires, registration form, records release forms for new pts, etc.) Review schedule for chronic no show/late pts and inform provider of pt issue.	Bring any task questions to the CHC-A Team for clarification. Solicit any work from providers. OT to make sure that they sent no-show letters from previous session.	Alert provider of pts scheduled that are chronic no shows, chronic late patients or patients who are traditionally disruptive or disrespectful. Inform team of any concerns that came up with reminder calls day before. Communicate with team to anticipate any special needs for scheduled group visits.	Review the schedule the day for unbooked appt slots and high acuity schedule. Communicate with, MA, COM and NTM to strategize management of supply and demand. During call backs remind pts to bring in meds and immunization records.	
ECS	Review schedule ahead of huddle time. Know which patients you need to discuss with team. eg: Chronic care, OB and high risk patients.	Discuss urgent, same day tasks with Team.	Review coverage issues, group visit coverage, scheduling conflicts. Remind about availability of CMs/BHPs going in to see patients before PCP when backlogged.	Review for teams, on a regular basis, variety of options for when to use CMs/BHPs. Review with Team OB patients who have delivered.	Identify planned care patients coming in that day. Review CDSMPand other ECS group schedules and patient referral criteria and recruit from daily schedules.

Financial Screener	Look at people who need to be screened this day. Give Z-pay status information to provider to help encourage patient to finish screening. Provider to inform F.S. when the patient needs help getting financial information. Prepare any rate sheets that can be identified ahead of time. Share problem patients with the rest of the pod. Look for difficult patients or chronic no-show patients who might be seen and who could use help with screening. Bring list of paycodes.	Consider using to track patients rescreening dates. Then this can be done before expiration and decrease time spent on Z-pay.	Manage screening schedule to be sure that patients are screened appropriately. Strategize what to do if other pods need screener coverage. Which patients must be screened-how will we get them done as a minimum.	Consider offering patients to be pre-screened over the phone or mail in info. Look ahead at pre-books and verify they are coming in. Consider group FS visits for high demand times, such as August school physicals, flu season. Strategically control number of new patients that can be accommodated by the clinic.	Prescreen for group visits. Put registered patients into recall systems.		
RCM	Review the schedule and notify the CHC-A/ops team on pod if need to meet with scheduled pt. Give papers to MA/Front Desk that patient needs to sign. Notify provider of patients that chronic no show for referrals. Review with FS Dept or Front Desk if pt data is not up to date (e.g. paycode).	Notify providers when closing a referral because of lack of pt compliance or unable to locate a referral provider for services.	If bottle necks are present, let the office techs know that you could see the patient before the provider to optimize use of wait time.	Notify team of any changes in status for outside resources, ie: imaging.	Attend group visits if appropriate. Use the opportunity to set up eye referrals, perhaps bring eye specialists to the fairs.		
Everyone	Communicate directly; share concerns and successes; come prepared to problem-solve and serve						
	"EDUCATING OURSELVES ABOUT WHAT OUR PATIENTS WANT AND NEED!"						

Item 2: Patients needing clinician review or action

CHC-A has many population management tools that are used throughout the organization to help patients get the services they need. The following audit tools are used to contact patients who need certain services:

1. List of patients with hypertension whose last blood pressure was greater than 140 over 90

UDS Hypertension Measures

Actual Query Code	Denominator	Numerator

2008	Denominator	Numerator	Last BP < 140/90	Last BP >= 140/90	Last BP >= 140 and < 90	Last BP < 140 and >= 90	Last BP Is Null	Audit
2009	Denominator	Numerator	Last BP < 140/90	Last BP >= 140/90	Last BP >= 140 and < 90	Last BP < 140 and >= 90	Last BP Is Null	Audit

2009 UDS Hypertension Last BP >= 140/90

Summary - Back to UDS Hypertension -Export to excel

TOTAL
192

Detail

last_name	first_name	dob	Visit Count in Reporting Year	bp_systolic	bp_diastolic	race	Site	Pod	primarycare_prov_name
		1960	20	178	108	Hispanic (White)			
		1948	5	164	90	Hisp(White)			MD,
		1954	2	151	99	White			PA,
		1961	3	146	92	Hispanic			MD,

2. List of patients in need of certain immunizations

UDS Childhood Immunizations Measures

2009	Denominator	Summary	Missing
Additional Data	2009 VZV (Varicella) Exlusion List		

Missing Total - Back to UDS Immunizations Home

Total
383

2009 Summary Detail

last_name	first_name	dob	Site	Pod	Up To Date	Not Up To Date
		/1/2007	[illegible]	[illegible]		DTaP,Hepatitis B,HiB,IPV,MMR,pneumococcal conjugate,VZV,
		20/2007	[illegible]	[illegible]	DTaP,Hepatitis B,HiB,mmr,VZV,	IPV,pneumococcal conjugate,
		4/2007	[illegible]	[illegible]	mmr,VZV,	DTaP,Hepatitis B,HiB,IPV,pneum conjugate,
		26/2007	[illegible]	[illegible]	DTaP,Hepatitis B,IPV,mmr,pneumococcal	HiB,
		24/2007	[illegible]	[illegible]	DTaP,Hepatitis B,HiB,IPV,mmr,VZV,	pneumococcal conjugate,
		20/2007	[illegible]	[illegible]		DTaP,Hepatitis B,HiB,IPV,MMR,pneumococcal conjugate,VZV,

Item 3: Patients on a particular medication

We can run a list of any patient on any medication including active medications or inactive (hx of use of the medication) using the EHR reporting tool in NextGen. The following screen shot is a report of all patients who started Coumadin after 6/1/09. I am not displaying the demographic data but could on any report.

Patient

Pat Zip	Brand Name	Generic Name	Start Date
06	COUMADIN	WARFARIN SODIUM	10/23/2009
06	COUMADIN	WARFARIN SODIUM	12/19/2009
27	COUMADIN	WARFARIN SODIUM	08/29/2009
27	COUMADIN	WARFARIN SODIUM	10/28/2009
29	COUMADIN	WARFARIN SODIUM	09/03/2009
29	COUMADIN	WARFARIN SODIUM	11/11/2009
04	COUMADIN	WARFARIN SODIUM	06/11/2009
02	COUMADIN	WARFARIN SODIUM	08/17/2009
29	COUMADIN	WARFARIN SODIUM	09/01/2009
01	COUMADIN	WARFARIN SODIUM	11/09/2009
34	COUMADIN	WARFARIN SODIUM	09/08/2009
27	COUMADIN	WARFARIN SODIUM	12/10/2009
27	COUMADIN	WARFARIN SODIUM	01/13/2010
41	COUMADIN	WARFARIN SODIUM	08/04/2009
41	COUMADIN	WARFARIN SODIUM	09/04/2009
26	COUMADIN	WARFARIN SODIUM	08/10/2009
21	COUMADIN	WARFARIN SODIUM	11/23/2009
03	COUMADIN	WARFARIN SODIUM	06/19/2009
03	COUMADIN	WARFARIN SODIUM	08/18/2009
03	COUMADIN	WARFARIN SODIUM	10/30/2009
03	COUMADIN	WARFARIN SODIUM	11/19/2009
21	COUMADIN	WARFARIN SODIUM	08/26/2009
21	COUMADIN	WARFARIN SODIUM	08/28/2009
04	COUMADIN	WARFARIN SODIUM	08/11/2009
04	COUMADIN	WARFARIN SODIUM	08/24/2009
04	COUMADIN	WARFARIN SODIUM	11/13/2009
02	COUMADIN	WARFARIN SODIUM	09/17/2009
02	COUMADIN	WARFARIN SODIUM	09/24/2009
26	COUMADIN	WARFARIN SODIUM	12/08/2009
21	COUMADIN	WARFARIN SODIUM	06/12/2009
21	COUMADIN	WARFARIN SODIUM	10/16/2009
21	COUMADIN	WARFARIN SODIUM	09/21/2009

Patient

Procedure | Allergy | Sorting | Totals | Templates | Diagnosis | Filter | Columns | Patient | Medication | Laboratory | Provider

Select Medication | Medication Filter

Filter

Field	Operator	Value
Brand Name	Equal	Coumadin
Generic Name	<none>	
Dose	<none>	
Dose Desc	<none>	
Route Desc	<none>	
Med Cat Desc	<none>	
Start Date	On or After	06/01/2009
Stop Date	<none>	__/__/____
Last Refill Date	<none>	__/__/____

Active/Inactive: All | Number of Medications: Less Equal 10 | Clear Medication

Detail | Summary | Report List | Add Sub Report

Options | Head/Foot | Save | OK | Cancel

Start | NextGen | NextGen EMR: Graciel... | NextGen -

We also have a registry of all our patients on anti-coagulation therapy for population based management.

Coumadin Registry

Medium Risk

Last Name	First Name	DOB	Last Visit	Initiated	Duration	Goal INR	High Risk	INR Date	INR Result	Dose Date	Weekly Dose	Return Visit	Return Lab
[illegible]	[illegible]	[illegible]948	12/3/09	06/01/2004	lifelong	2.50 to 3.50	No	12/3/09	2.70	12/4/09	75.00		01/04/2010
								10/7/09	2.90	12/3/09	75.00		
								6/8/09	2.50	10/8/09	75.00		

Indication — Alerts — Comments

V43.3 Status, heart valve replacement NEC

Last Name	First Name	DOB	Last Visit	Initiated	Duration	Goal INR	High Risk	INR Date	INR Result	Dose Date	Weekly Dose	Return Visit	Return Lab
[illegible]	[illegible]	[illegible]953	11/30/09	//	lifelong	2.00 to 3.00	No	11/30/09	2.70	12/1/09	49.00	01/04/2010	
								10/5/09	1.80	11/30/09	49.00		
								8/24/09	1.60	10/6/09	49.00		

Indication — Alerts — Comments

394.9 Disease, mitral valve NEC/NOS

Low Risk

Last Name	First Name	DOB	Last Visit	Initiated	Duration	Goal INR	High Risk	INR Date	INR Result	Dose Date	Weekly Dose	Return Visit	Return Lab
[illegible]	[illegible]	[illegible]954	10/20/09	//	3 months	2.00 to 3.00	No						

Indication — Alerts — Comments

435.9 Transient ischemic attack, unspec.

Wednesday, January 6, 2010 — **High Risk:** INR > 3.5 or < 2.0 or High Embolic Risk — **Medium Risk:** Last INR > 30 days — **Low Risk:** INR >= 2.0 and <=3.5 and Last INR < 30 days

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www.[illegible]

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Item 4: Patients needing reminders for preventive care

CHC-A has a list of patients who have not received a pap test in the last 3 years that can be run by each site to make sure women have an up-to-date pap test.

UDS PAP Measures

PAP Query System

2009	Denominator	Numerator	Audit

Audit Summary - Back to UDS PAP Home

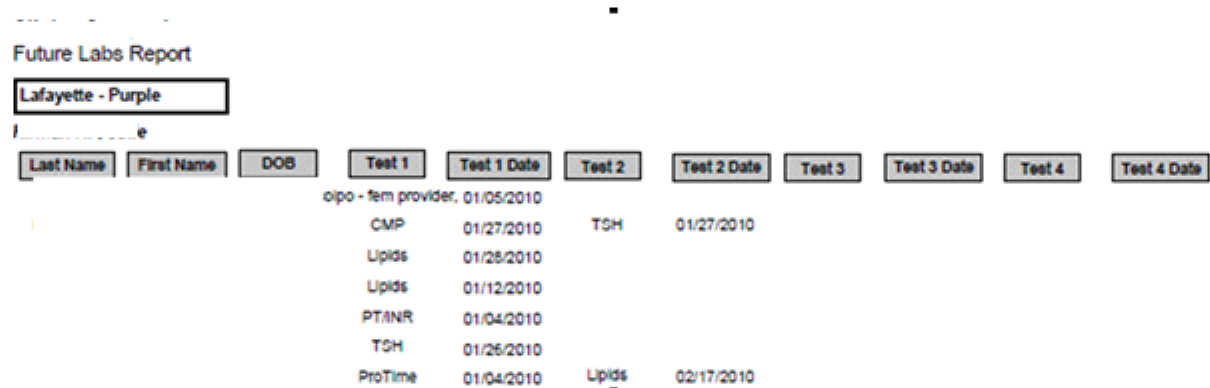
1970

2009 Audit Detail

last_name	first_name	DOB	PCP	Pod	Site

Item 5: Patients need reminders for specific tests

We have a report that allows us to call patients about future labs coming up in the next 30 days.



Future Labs Report

Lafayette - Purple

Last Name	First Name	DOB	Test 1	Test 1 Date	Test 2	Test 2 Date	Test 3	Test 3 Date	Test 4	Test 4 Date
			olpo - fem provider,	01/05/2010						
			CMP	01/27/2010	TSH	01/27/2010				
			Lipids	01/28/2010						
			Lipids	01/12/2010						
			PT/INR	01/04/2010						
			TSH	01/26/2010						
			ProTime	01/04/2010	Lipids	02/17/2010				

Item 6: Patients needing reminders for follow-up visits such as for a chronic condition

CHC-Ally Important Conditions Registries and Workflows

CHC-A Planned Care Registries were developed to create a proactive system of care designed to best address our patients and conditions. We also wanted to create a system of care that aligns everything towards a common aim. We have used the Plan-Do-Study-Act (PDSA) quality framework to implement the registries and workflows at each of our four sites.

The planned care registries pull data directly from our Electronic Health Record (EHR). In the EHR, we have developed templates for each of our planned care conditions that help guide the patient team through a patient visit using evidence based standards of care.

The workflows for each of the planned care conditions were developed in our Office Redesign Committee, spearheaded by a Provider Champion for each condition.

Diabetes Registry, Workflow and Ruler:

Diabetic Registry

High Risk

Last Name	First Name	DOB	Visit	BP Sys	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
			12/16/2009	106	70	Never			12/16/09	11/11/2009	101		
Group Visit	No												
												11/10/2009	10.00
			10/05/2009	120	80	Never		10/8/09	3/2/09	05/27/2009	0		
Group Visit	No												
												12/18/2009	11.60
												10/05/2009	11.00
												05/26/2009	11.70
			12/11/2009	130	82	Former		10/27/09		11/11/2009	0		
Group Visit	No												
												10/27/2009	7.70
			11/30/2009	138	80	Never		11/30/09		09/24/2009	107		
Group Visit	No												
												11/30/2009	7.00
												09/18/2009	7.50
			11/20/2009	136	78	Never	1/16/09	8/10/09	2/27/09	01/23/2009	46		
Group Visit	No												
												11/20/2009	7.50
												07/23/2009	7.60
												04/17/2009	9.50
			12/22/2009	110	74	Never	12/3/08	8/17/09	2/3/09	08/18/2009	77		
Group Visit	No												
												12/22/2009	8.10
												08/17/2009	7.00

12/29/2009
Developed by
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High Risk: Last A1c >= 7 **Medium Risk**: Last A1c > 5 Months **Low Risk**: Last A1c <7 and < 5 Months

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Diabetes Registry Workflow

Aim: To provide quality evidence-based care to our patients with Diabetes.

Aim: To maintain a comprehensive and accurate registry of our patients with Diabetes in order to perform appropriate and timely care.

Diabetes Registry Measures:	Average A1c	% of patients with two A1cs in the last 12 months	% of patients with last BP < 130/80	% of patients are current smokers	% of patients have an annual foot exam	% of patients with an annual self-management goal documented
	% of patients have A1cs < 7%		% of patients with last LDL < 100		% of patients have an annual eye exam	

	Actions					
Operations	Print off Diabetes registry and workflow the first Tuesday of every month.					
Front Desk	Review registry for last visit, blood pressure, eye exam, foot exam, lipids, and A1c.					
	Visit	**Blood Pressure**	**Eye Exam**	**Foot Exam**	**Lipids**	**A1c**
	If more than six months, make appointment. Otherwise, review Blood Pressure, Lipids and A1c for follow-up guidelines.	If blood pressure <130/80 use other risk factors to determine follow up needs. If BP Systolic is >130 or BP Dyastolic is >80 follow up at least every month.	Add patients without eye exam in the last 12 months to wait list for eye clinic. Contact patient when slot opens with date of clinic.	If no foot exam in the last 12 months, schedule an appointment.	If LDL <100 use other risk factors to determine follow up needs. If LDL >100 but <130 follow up should be at least every three months. If LDL >130 follow up should be at least once a month.	If Hgb A1c > 9, follow up every month. If Hgb A1c >7 but <9 follow up should be at least every 3 months. If HgbA1c <7 follow up should be every three to six months
Case Manager	Review registry for risk stratification, tobacco, and self-management goal. **Note:** For patients who do not have information populated in the flowsheet, CM will open NextGen and determine if patient is actually a diabetes patient. Alert CHC-AI team to patients on huddle report.					
	Tobacco	**Self-Management**	**Group Visits**			
	If current smoker, review for tobacco cessation counseling. Advise patient to quit at next contact.	Monitor patients on registry for annual goal. Responsible for connecting with patient to set goal when in for a visit.	Determine which patients/providers do groups. Coordinate DM group visits for pod by doing the following: • Determine provider availability • Denise's schedule availability • Coordinate with NTM on support staff availability • BHP schedule availability Call pts and schedule for DM GV as needed.			
Provider	Review the flowsheet every visit and enter any new data. Review registry for any patients for which there are concerns and patients who are MOGE. Provide information to CM.					
MA	Review the flowsheet every visit and enter any new data. Responsible for patients on registry who are in for visit today.					

Nurse	Reviews copy of registry given by CM to ensure all follow-up has been completed and is accurate.

Last Name	First Name	DOB	Visit	BP Syst	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
Diabetes Planned Care Ruler			If more than six months, make appt. Otherwise, see BP, LDL & A1c rules	If above 130, appt every month	If above 80, appt every month	If current smoker, CM to review for Tobacco Cessation counselin g	If not within one year, put on list for DM Eye Exam GV	If not within one year, CM to set goal with patient	If not within one year, make appt	If not within one year, make appt	If above 130, appt every month. If 100-130, appt every 3 month s	If not within 3 months, make appt (6 months okay if last value less than 7.0)	If above 9, appt every month. If 7.0 - 9.0, appt every 3 months . If below 7.0, appt every 6 months

Prenatal Registry and Workflow:

Prenatal Registry

Last Name	First Name	DOB	Last Visit	EDD	Wks at Visit	PN +	Primary Insurance	Preg End Date	Preg End Type	Current Wks Gest	CP	Risk Level	High Risk Problems
			11/22/09	12/5/09	38	No	F Slic			43		2	Preterm or postdates delivery, prior
Antenatal Management Plan:			9/22/09: elevated 1hr GTT - 3hr scheduled - 9/28/09 pt arrived to 3hr appt and had not followed regimen - rescheduled for 10/7/09 nutritionist appt at that time also 3hr GTT normal 10/6 - pt declining flu shot										
			12/16/09	12/7/09	41		N Slic			43		2	
Antenatal Management Plan:			post-term 12.12.2009: biwkly NST; induce next wk if pt willing; cervix not favorable today										
			12/1/09	12/16/09	37		Medicaid FQ	12/2/2009	Delivered	42	Y	2	Abortion, previous, 2nd trimester Alcohol or illicit drug dependence
Antenatal Management Plan:			Gestational HTN (9/14) *baseline 24 hr urine, PIH panel, previous PIH 6/09 WNL KF										
			12/21/09	12/27/09	39		Medicaid FQ			40			
Antenatal Management Plan:			Per records from previous provider - pelvimetry completed and proven to 6lb6oz and placenta was posterior without previa or abruption as of 5/13/09 Pt would like to breastfeed, had trouble w/ previous child, would like additional support. 10/29/09 11/12/09 tubal form signed and sent to med recs										

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Developed By

Prenatal Registry Workflow

Aim: To provide quality evidence-based care to our prenatal patients.

Aim: To maintain a comprehensive and accurate registry of our patients who are pregnant in order to perform appropriate and timely care.

Prenatal Registry Measures/Goals:						
	% low birth weight	% pregnant teens	% breastfeeding at delivery	% of prenatal patients who smoke	% of smokers who quit	% of smokers who quit and decreased
	% entry of care in 1st trimester	% post partum return	% of prenatal patients who use ETOH	% of prenatal patients who use drugs	% of prenatal patients with nutritional risk	% of prenatal patients with psychosocial risk
	% entry of care in 3rd trimester	% infant return	% of ETOH users who quit	% of drug users who quit	% of with nutritional risk resolved	% of with psychosocial risk resolved

Actions

***All staff who learn of a termed pregnancy are responsible for notifying their Pod Case Manager via a task**

Operations

Print off Prenatal registry and workflow the first and third Tuesday of every month. COMs give registry to front desk.

Front Desk

Scheduling OB Visits	Documentation	Next Steps
Front desk reviews last date of service and schedules an OB appointment based on gestational age. **Note:** Patient's gestational age is located on the last column of the registry printout calculated up to the day the registry is printed. • Up to 28 weeks—OB apt every 4 weeks • 28-36 weeks—OB apt every 2 weeks • 36-40 weeks—OB apt every week Compare patient name with Centering Pregnancy list and will not call Centering Pregnancy patients.	Document on the registry the outcome of the call to patient (e.g. left message, scheduled appt, etc.). **Note:** Make two attempts over two different days (should be different times of the day) to contact patient and then send a letter if unable to reach patient after two attempts. Document all contact attempts and letters sent in the telephone communication template in NextGen.	Give registry to the floor BHP after all patients have been reviewed and/or contact attempts have been made and documented.

Case Manager

Review registry twice a month and update any of the below information. Review with Pod Providers in huddle.

Pt Lost to Contact	Prenatal Plus	Centering	Risk Level	Delivered	Term Date
CM to team up with Front Desk to determine any other ways to contact patient within HIPAA guidelines.	If column blank, CM to audit patient chart and document PN+ status of patient in PN+ template. If patient is PN+, CM responsible flagging PN+ status on sticky note in chart and for seeing patient at their next visit.	CM responsible for checking Centering box on every patient in a Centering group.	CM responsible for documenting risk factors on risk assessment template, related to substance abuse, smoking, nutrition and psychosocial risk factors.	CM responsible for entering mom's delivery information in the post partum and pregnancy outcomes templates, and newborn data in the baby's chart.	CM responsible for documenting in the mom's pregnancy outcome template any abortions, fetal demise, transfer of care, moved, and ectopic pregnancies.

Provider

Review the flowsheet every visit and enter any new data. Review registry for any patients for which there are concerns and patients who are MOGE. Provide information to CM.

MA

Review the flowsheet every visit and enter any new data. Responsible for patients on registry who are in for visit today.

Pod BHP	Reviews copy of registry given by CM with Pod Nurse to ensure all follow-up has been completed and is accurate.

ADHD Registry and Workflow:

ADHD Registry

High

Last Name	First Name	DOB	Last Visit	Initial Evaluation	Teacher Assessment	Parent Assessmen	Assigned PCP	Next Visit	Medication
			06/02/2009	12/31/2007	04/29/2009	04/07/2009		in 5 Weeks	
Patient Address					School Contact				Dose: Freq:
			05/15/2009	12/17/2007		10/12/2009		in 3 Weeks	Concerta
Patient Address					School Contact fax				Dose: 18 Freq: AM
			05/04/2009	12/04/2007	04/29/2009	04/20/2009		in 3 Months	Adderall
Patient Address					School Contact fax				Dose: 7.5 Freq: AM
			02/09/2009	02/09/2009	04/24/2009	02/09/2009		in 3 Weeks	Adderall
Patient Address					School Contact fax				Dose: 10 Freq: AM
			08/17/2009	08/17/2009		08/17/2009		in 6 Weeks	

High Risk = No f/u after Initial Visit or no f/u in last 3 months **Medium Risk** = Performance Score >=4 **Low Risk** = Performance <4

Tuesday, December 29, 2009

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ADHD Registry Workflow

Aim: To provide quality evidence-based care to our patients who have ADHD.

Aim: To maintain a comprehensive and accurate registry of our patients with ADHD in order to perform appropriate and timely care.

ADHD Registry Measures/Goals:	% of pts with management plan	% of pts with 2 f/u visits within 9 mos of initial visit	% of pts with 25% reduction in performance score	% of pts with 25% reduction in symptom score	% of pts prescribed meds	% of pts started meds
	% of pts with 4 assessment scores (2 parent, 2 teacher)				% of pts with med f/u within 30 days	% of pts stayed on meds for 7 mos

	Actions
Operations	Print off ADHD by Rendering Provider registry and workflow the third Tuesday of every month and give to the Provider.
Provider	* Review registry monthly for any patients for which there are concerns and patients who are MOGE. * Notate on registry who needs a visit and who needs a teacher questionnaire to be obtained by fax. * Determine care plan for adult patients with ADHD and transfer to high risk mental health database if appropriate. * Behavioral Health Referral as appropriate. * Give registry to CM for follow-up once registry review is complete. CM will give to FD once completed. * Review the flowsheet every visit and enter any new data.
Case Manager	* CM will schedule patients who are in an ADHD group (visit indicated by Provider on registry) and do reminder calls for group visits. * CM will communicate with school as needed for patients. * Conduct ADHD groups with provider as scheduled. * Confirm agenda of group with provider prior to group. * Determine patient status of parents participating in group. * CM to give registry to FD when finished to schedule individual patients **Note:** Email Barb Rayburn for any patients identified as MOGE or who the Provider indicated does not have ADHD.
Front Desk	Schedule individual ADHD appointment with PCP for list of patients determined by the Provider (patients not in Group Visits). Confirms appt for both group and individual appts. Gives parent Follow-up Questionnaire to complete while in waiting room UNLESS first visit, in which case Initial Assessment questionnaire should be used. Faxes teacher follow-up questionnaires as indicated by provider.
BHP	* May need to provide family therapy after consultation with provider. * Review adult patients with ADHD diagnosis with Provider. * Assist referrals to mental health center if further eval needed. * Consult with team on ADHD group curriculum.

Provider (continued):

Risk Level	**Initial Evaluation**	**Teacher Assessment**	**Follow-up Visit**
High risk--no follow-up within 1 month after initial eval OR no follow-up in > 3 mos after last follow up visit); Medium risk= performance score >= 4, Low risk = performance score <=4, be sure has follow up task at least 3 mos after last appt. Adult patients with ADHD diagnosis should be highlighted for BHP review.	If no initial eval, confirm that this patient belongs in the registry. If patient belongs in registry, have Front Desk schedule initial eval appointment with ADHD Provider Champion at the site.	If no teacher eval in last 3 months, have CM or FD fax **follow-up** teacher Vanderbilt scale to school ***(may need to get school info from parent if not in registry).*** If never any teacher eval, fax **initial** teacher Vanderbilt scale.	Ensure follow up every three month unless care individualized. Notate individualized care plans on registry.

MA	Review the flowsheet every visit and enter any new data (Vanderbilts, review medications). Responsible for patients on registry who are in for visit today. Collect Vanderbilts from patients for review by provider prior to office visit.

We have additional registries for the following conditions:

1. Asthma
2. Bipolar Disorder
3. Chronic Pain
4. COPD
5. Depression
6. Latent Tuberculosis
7. Pap Management – patients with abnormal pap tests
8. Tobacco Use

Item 7: Patients who might benefit from care management support

We have a report that is used on a daily basis by our behavioral health staff that identifies patients coming in for a visit today who are pregnant, have a chronic condition or who are a tobacco user. The behavioral health staff will provide extra support to these patients during their visit.

Appointment List - Planned Care Patients

Appt Date	Appt Time	Duration	First Name	Last Name	DOB	DX Category	First Diagnosed	Last Diagnosed
F	Misae Vela Brol FNP							
1/6/2010	8 :20	20			5/1975			
						Prenatal	12/28/2009	12/28/2009
1/6/2010	8 :40	20			29/1971			
						Depression	09/04/2009	09/24/2009
						Prenatal	05/01/2008	12/26/2008
1/6/2010	9 :00	20			13/1976			
						Prenatal	08/02/2006	12/07/2009
1/6/2010	9 :20	20			21/1988			
						Obesity	09/21/2005	09/21/2005
						Prenatal	08/04/2005	12/23/2009
1/6/2010	9 :40	20			4/1979			
						Prenatal	04/06/2007	12/29/2009
1/6/2010	10 :00	20			16/1954			
						Diabetes	07/13/2005	12/17/2009
						Hypertension	07/13/2005	12/17/2009
1/6/2010	10 :20	20			16/1985			
						Chronic Mental Health	06/13/2007	06/13/2007
						Prenatal	10/11/2006	12/04/2009
1/6/2010	11 :00	20			5/1976			
						Hypertension	12/04/2009	12/04/2009
						Prenatal	09/06/2006	12/08/2009
1/6/2010	11 :40	20			1/28/1985			
						Prenatal	11/01/2006	12/29/2009
1/6/2010	11 :40	20			3/1973			
						Chronic Mental Health	08/07/2009	09/25/2009
						Chronic Pain	01/18/2006	04/15/2008
						Depression	07/20/2005	12/03/2009
						Obesity	08/17/2006	10/08/2009
						Prenatal	05/26/2009	12/30/2009

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