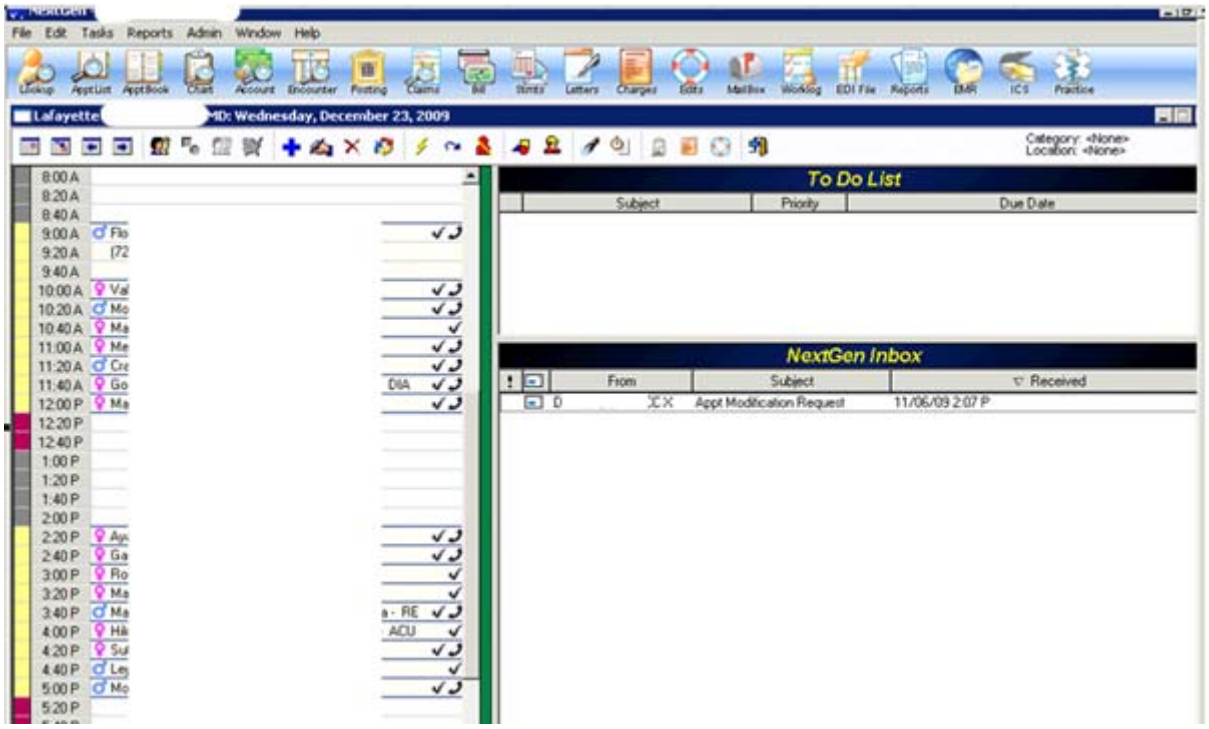
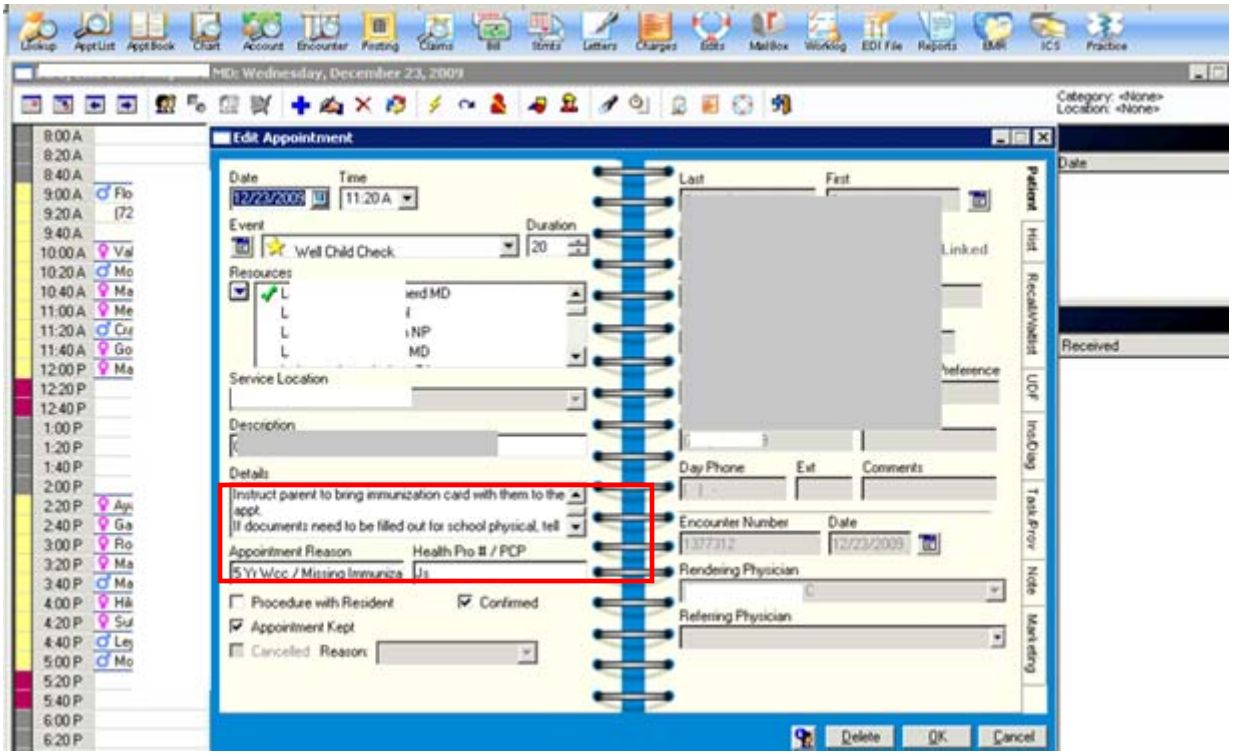
PPC 3: CARE MANAGEMENT
Element C: Practice Organization

Item 1: Phone Schedule

The telephone icon indicates that the front desk staff has called the patient to remind them of their appointment and assess for changes in phone/address/financial status, etc.



There is decision support built in to assure that the person who calls the patient reminds them of important information such as bringing their immunization card, or come fasting, etc. These prompts are built in to our electronic practice management system.



Item 2: Standing Orders

The following documents have been developed for support staff (nurses and medical assistants) so that they can assist Providers in giving care to our patients. We relieve it is impossible to provide "all and only" indicated care with out the use of a team approach. It is our focus to have the staff work at the "top of their license" to assure excellent and timely service to patients and to maximize access.

Preventive Services:

Standing Orders for Immunizations to be given by the nurse or medical assistant:

From our Provider Manual (updated 1/09):
Management Plans
1. Immunization Protocol: Immunization status is assessed at every clinic visit.
    a) CONTRAINDICATIONS:
        (1) If history of anaphylaxis to a vaccine in past or
        (2) If temp > 100.5°F *or*
        (3) If nursing assessment indicates severe illness, **DO NOT IMMUNIZE**.
    b) Infants and children: The most recent CDC schedule recommendations for childhood immunizations. These serve as standing orders for the administration of the vaccines.

Nursing Protocol for taking prenatal history and risk assessment
Sec1.1_Prenatal History & Risk Assessment Guide Instructions (Updated: 12-03)

PRENATAL HISTORY AND RISK ASSESSMENT GUIDE INSTRUCTIONS

These instructions include brief descriptions of terms that may be confusing or simpler language that may be easier for the patient to understand.

Complete ONLY the items marked with ***italics*** to assist the provider with history taking.

Key
1. Family means anyone in the patient's immediate family, for example, parents, siblings, children.
2. If patient denies any history of an item mark "-"
3. If patient reports history of or present problem with an item mark with a check mark.
4. If patient is unsure of an item write "DK" for doesn't know.

RISK LEVEL 2
1. **Genetic diseases** - Examples include chromosome abnormalities, Down's Syndrome, Cystic Fibrosis
2. **Congenital Heart disease** - Any heart defect the patient may report
3. **Hemoglobinopathy** - Examples include any blood disorders, Sickle cell anemia
4. **Chronic Renal Disease** – Problems that the patient has with their kidneys. This does not include bladder infections.
5. **Hypertension** – high blood pressure, if patient reports this write down any medications they are taking for this
6. **DM** – diabetes, problems with blood sugar
7. **Heart disease severe (NYHA class > I)** – any symptoms that patient may have that affect daily living, an example may be arrhythmias or fatigue (weakness) or shortness of breath
8. **Thyroid disease**

9. **Asthma –** ask patient what medications they are using for this
10. **Seizure disorder –** convulsions or epilepsy, ask the patient and document what medications they are using for this.
11. **Alcohol or illicit drug use –** cocaine, marijuana, etc…
12. **Physical or sexual abuse now –** ask if patient feels safe in current relationship
13. **Prior preterm or postdates delivery –** if patient has had prior pregnancies did she deliver before 37 weeks or after 40 weeks
14. **Infant >4kg** (8.8lbs) **or LGA** (large for gestational age)
15. **Infant <2.5kg** (5.5lbs) **or SGA** (small for gestational age)
16. **Uterine or cervical anomaly –** abnormal pap smear (cone biopsy. Incompetent cervix)mk, unusually shaped uterus
17. **IV or HBV** (hepatitis or liver problems) **infection**

RISK LEVEL 1

1. **Birth defects –** congenital anomaly, examples include deafness, blindness
2. **Multiple births –** twins
3. **Hearing loss in infancy –** deafness developed after birth, if baby was born deaf that is considered a birth defect
4. **HPV** (genital warts) **or HSV** (herpes simplex virus)
5. **Chlamydia, syphilis, or GC –** history of any STDs
6. **Lung disease, hx –** examples include emphesema, COPD
7. **Heart disease mild (NYHA class I) –** patient's symptoms have no affect on their daily living and they only have symptoms with moderate exertion, an example may be mitral valve prolapse
8. **Prior thromboembolic disease –** Examples include blood clot, stroke, heart attack, DVT, pulmonary embolism
9. **Mental illness, on meds –** depression, bipolar disorder, anxiety, post traumatic stress disorder
10. **Hospitalization**
11. **Surgery**
12. **Eating disorder –** bulimia, anorexia
13. **Atopic dermatitis** (skin rash), **allergic rhinitis** (seasonal allergies), **food allergies**
14. **Hx of physical or sexual abuse –** ask if anyone has ever hit, kicked, or slapped patient
15. **Cigarette use**
16. **Multiparity –** how many live births has patient had
17. **Sab, trimester 1 (≥3) –** miscarriage < 12wks, if patient has had more 3 or more this puts her at greater risk
18. **Sab, trimester 2 (≥2) –** miscarriage between 12-28 wks, if patient has had 2 or more this puts her at greater risk
19. **Delivery in last 9 months, or hx of preterm labor**
20. **Fetal or neonatal death –** did baby die in womb after the 3rd month of pregnancy or in the first 4 weeks of life
21. **Prior postpartum hemorrhage –** abnormally heavy bleeding after delivery
22. **Hx of PIH, pre-eclampsia or eclampsia –** high blood pressure with swelling or even seizures during or after past deliveries
23. **Hx GDM –** gestational diabetes, diabetes only during pregnancy

24. **Prior LTCD –** low transverse caesarian delivery, ask patient where her scar is from last c-sections, if bikini line scar patient is at little risk, if the scar is chest to groin the provider needs to do further assessment
25. **Obese (BMI > 29)**
26. **Underweight (BMI < 19.8)**
27. **Migraine –** does patient have problems with severe headaches

Medication Refills:

Nursing Protocol for Group A Strep
Sec2.4 Strep A Throat Culture (10-09)

GROUP A: STREP THROAT CULTURE

ASSESSMENT

- Document Allergies
- ***Any change in symptoms (fever, chills or severe abdominal pain) since seeing provider***.

TREATMENT

- **Children < 27 kg**
  - Penicillin V 250mg TAB 1 PO BID x 10 days **or**
  - Amoxicillin 40mg/kg in divided doses tid x 10 days (for children >3 months and < 40kg).
    - If over 5 years old use 250mg TID in either chewable or liquid forms.
  - If worried about poor compliance, can give single IM injection of Bicillin LA 0.6 million if provider in office. Observe for 30 minutes after injection for possible anaphylaxis.
- **Children ≥ 27 kg and Adults**
  - Penicillin V 500mg TAB 1 PO BID x 10 days **or**
  - If worried about poor compliance, can give single IM injection of Bicillin LA 1.2 million units for adults or larger children if provider in office. Observe for 30 minutes after injection for possible anaphylaxis.
- **If allergic to Penicillin:**
  - Children: Ery ped (EES) 40mg/kg/day in divided doses BID x10d (Max dose is 3.2G/day PO)
  - Adults: E-Mycin 333mg TID x10d (Max dose of 2G/day)

PATIENT EDUCATION

- Continue medication even after symptoms have improved for a full 10 day course.
- No school or work until on antibiotics for at least 24 hours.
- Push fluids (tea, water, sports drinks, juice). Adults should be encouraged to take 2-3L per day especially when febrile.
- Pain/fever reliever (e.g., Ibuprofen or Acetominophen dosed for age)
- Gargle with saline
- Lozenges
- Rest
- Discard or boil toothbrush after 48 hours of antibiotic treatment
- If any family members/contacts develop sore throat and/or fever within 2 weeks, treat presumptively
- Notify provider if not improving with antibiotics

CALL BACK FOR APPOINTMENT WITH PROVIDER IF:

- High temperature >104 or does not improve after 24 hours of medication.
- Signs of allergy to antibiotics: rash, swelling, difficulty breathing

DOCUMENT ALL OF ABOVE IN MEDICAL RECORD
AND SEND "FYI" TASK TO PROVIDER WHO ORIGINALLY ORDERED LAB.

Order Tests:

Nursing Protocol for Urinary Tract Infection
Sec3.6_Urinary Tract Infection (Updated: 6-08)

UNCOMPLICATED URINARY TRACT INFECTION

Definition of Complicated: pregnant, male, child, ill-appearing, fever, nausea, vomiting, flank pain, recurrent infection. For any of the above, contact provider.

SUBJECTIVE

- Frequency, urgency, dysuria, hematuria, pyuria
- Fever and chills, nausea or vomiting
- History of recurrent or previous bladder infections
- History of previous urinary tract surgery, renal stones or other problems
- Document allergies to medications, other medical problems such as diabetes…
- Document last menstrual period and contraceptive method for women

OBJECTIVE

- Document vital signs and absence of fever
- Check for no CVA tenderness
- Check the abdomen is non-tender and bowel sounds are normal
- Urine analysis for leukocytes and hematuria (Urine culture only if recurrent or complicated UTI)
- Spin urine for provider to check prior to presenting patient.
- Present patient to provider

APPRAISAL: Cystitis 595.0 or Urinary Tract Infection 599.0

PLAN

EDUCATION:

- Prevention: Urinate frequently, completely empty bladder, increase fluid intake
- Prompt treatment to prevent pyelonephritis and permanent kidney damage
- How to take medication, stress importance of finishing meds even after symptoms clear
- For female patients, encourage good perineal hygiene and void after intercourse if related to intercourse.

TREATMENT:

- Non pregnant patients: If treating based on symptoms and microscopy, Bactrim DS 1po bid x 3d #6.
- If symptoms are severe Pyridium 100mg 1 po TID x 2d.

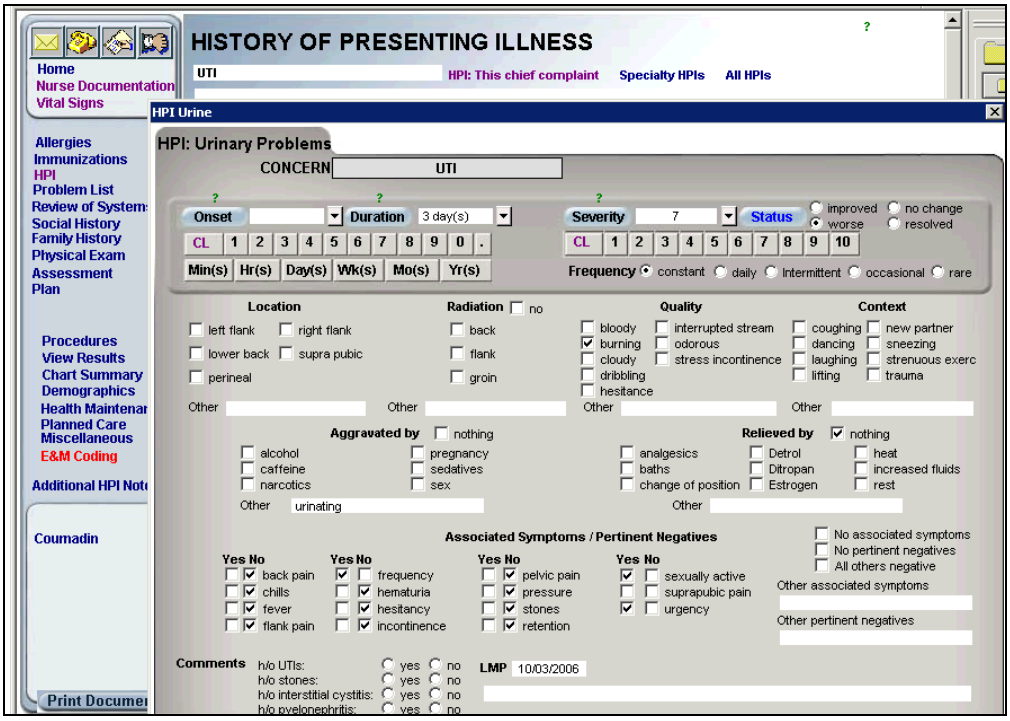
- Pregnant patients: amoxacillin 250mg po tid, nitrofurantoin 100 mg BID, or cephalexin 500 mg po BID to QID; each of these drugs given for three to seven days.

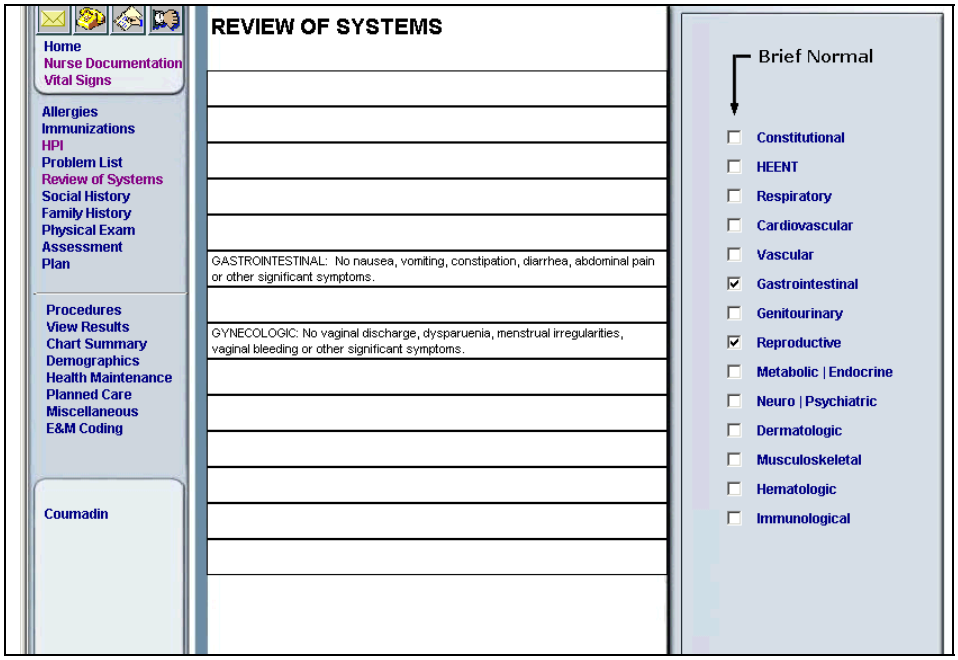
CALL BACK FOR APPOINTMENT WITH PROVIDER IF

- Worsening with signs and symptoms of pyelonephritis including, flank pain, fever, chills, vomiting, malaise
- Not improving with medication

DOCUMENT ALL OF ABOVE IN MEDICAL RECORD AND HAVE PCP COSIGN

NextGen Nurse Documentation for Urinary Tract Infection:





Pe Abdomen

Home
Nurse Documentation
Vital Signs
Allergies
Immunizations
HPI
Problem List
Review of Systems
Social History
Family History
Physical Exam
Assessment
Plan
Procedures
View Results
Chart Summary
Demographics
Health Maintenance
Planned Care
Miscellaneous
E&M Coding
Coumadin
Print Document

Constitutional | Head | Face | Eyes | Ears | Nose | Mouth | Throat
Neck | Thyroid | Lymphatic | Breast | Respiratory | Thorax | Cardiovascular
Vascular | Abdomen | Genitourinary | Rectal | Skin | Hair
Back | Spine | Musculoskeletal | Extremities | Neurological | Psychiatric

Abdomen — Obese ○ No ◉ Yes — Normal

Inspection ☑ Normal
Appliance(s) ☐ None
Abdominal muscles ☐ Normal
Auscultation ☐ Normal
Percussion ☐ Normal
Anterior palpation ☑ Normal
CVA tenderness ☑ None
Umbilicus ☐ Normal
Abdominal reflexes ☐ Normal

☐ Tenderness
☐ Liver enlarged Down cms ☐ Crosses Midline
☐ Spleen enlarged Down cms ☐ Crosses Midline
☐ Positive for hepatojugular reflux
☐ Hernia Present
☐ Positive Murphy's sign
☐ Palpable mass present
☐ Ascites

Size (cm) X X X — Location — Characteristic

Comments

OK CANCEL

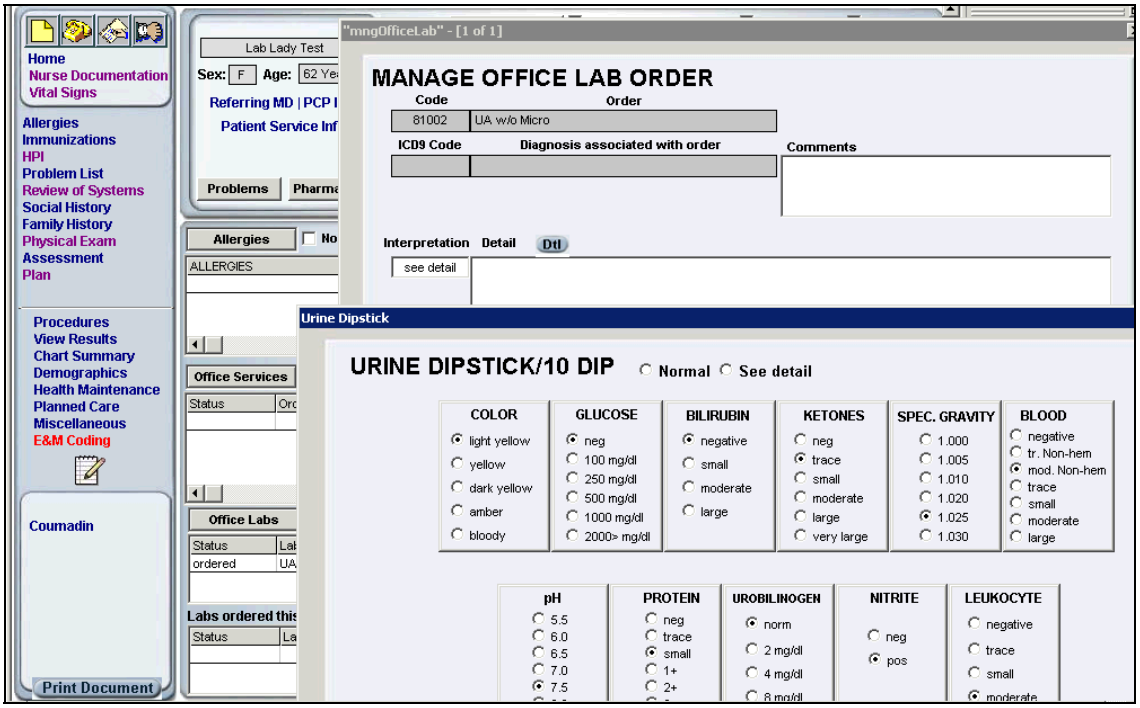
Physical Exam Summary

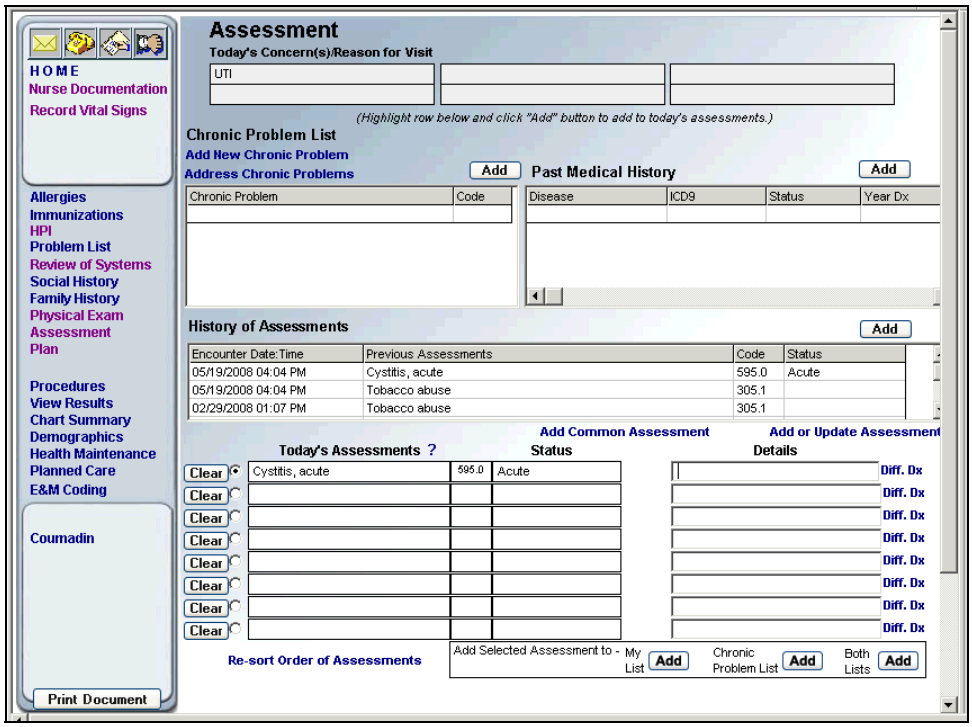
CONSTITUTIONAL: Alert, cooperative, no apparent distress, well nourished.

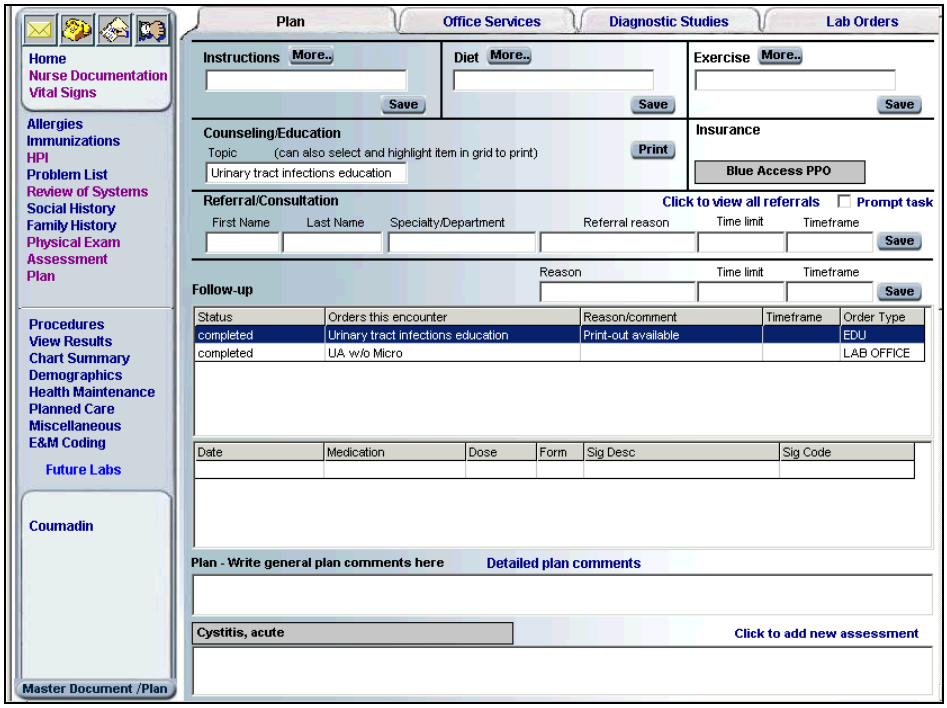
ABDOMEN: See document for details.

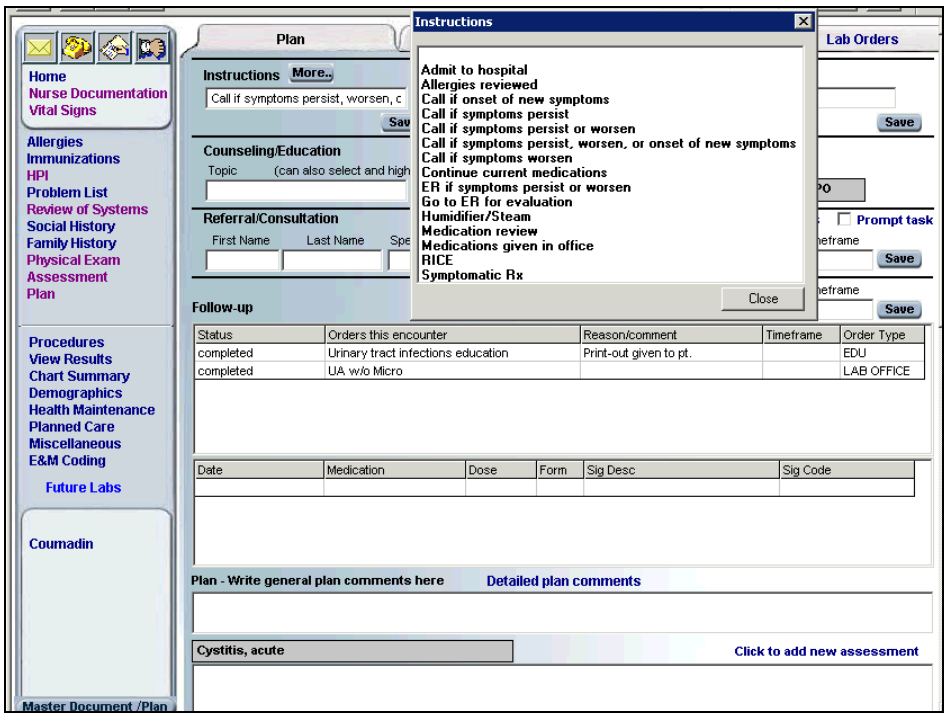
Brief Normal

☑ Constitutional
☐ Head | Face
☐ Eyes | VisionScreening
☐ Ears | Audiometry
☐ Nose | Mouth | Throat
☐ Neck | Thyroid
☐ Lymphatic
☐ Breast
☐ Respiratory | Thorax
☐ Cardiovascular
☐ Vascular
☐ Abdomen
☐ Genitourinary
☐ Rectal
☐ Skin | Hair
☐ Back | Spine
☐ Musculoskeletal
☐ Extremities
☐ Neurological
☐ Psychiatric


Home
Nurse Documentation
Vital Signs
Allergies
Immunizations
HPI
Problem List
Review of Systems
Social History
Family History
Physical Exam
Assessment
Plan
Procedures
View Results
Chart Summary
Demographics
Health Maintenance
Planned Care
Miscellaneous
E&M Coding
Coumadin
Print Document
Lab Lady Test
Sex: F Age: 62 Ye
Referring MD | PCP
Patient Service Inf
Problems
Allergies
ALLERGIES
Office Services
Status
Office Labs
Status
ordered
Labs ordered this
"mngOfficeLab" - [1 of 1]
MANAGE OFFICE LAB ORDER
Code
Order
81002
UA w/o Micro
ICD9 Code
Diagnosis associated with order
Comments
Interpretation
Detail
Dtl
see detail
Urine Dipstick
URINE DIPSTICK/10 DIP
Normal
See detail
COLOR
light yellow
yellow
dark yellow
amber
bloody
GLUCOSE
neg
100 mg/dl
250 mg/dl
500 mg/dl
1000 mg/dl
2000> mg/dl
BILIRUBIN
negative
small
moderate
large
KETONES
neg
trace
small
moderate
large
very large
SPEC. GRAVITY
1.000
1.005
1.010
1.020
1.025
1.030
BLOOD
negative
tr. Non-hem
mod. Non-hem
trace
small
moderate
large
pH
5.5
6.0
6.5
7.0
7.5
PROTEIN
neg
trace
small
1+
2+
UROBILINOGEN
norm
2 mg/dl
4 mg/dl
NITRITE
neg
pos
LEUKOCYTE
negative
trace
small


HOME
Nurse Documentation
Record Vital Signs
Allergies
Immunizations
HPI
Problem List
Review of Systems
Social History
Family History
Physical Exam
Assessment
Plan
Procedures
View Results
Chart Summary
Demographics
Health Maintenance
Planned Care
E&M Coding
Coumadin
Print Document
Assessment
Today's Concern(s)/Reason for Visit
UTI
(Highlight row below and click "Add" button to add to today's assessments.)
Chronic Problem List
Add New Chronic Problem
Address Chronic Problems
Add
Chronic Problem
Code
Past Medical History
Add
Disease
ICD9
Status
Year Dx
History of Assessments
Add
Encounter Date:Time
Previous Assessments
Code
Status
05/19/2008 04:04 PM
Cystitis, acute
595.0
Acute
05/19/2008 04:04 PM
Tobacco abuse
305.1
02/29/2008 01:07 PM
Tobacco abuse
305.1
Add Common Assessment
Add or Update Assessment
Today's Assessments ?
Status
Details
Clear
Cystitis, acute
595.0
Acute
Diff. Dx
Re-sort Order of Assessments
Add Selected Assessment to -
My List
Add
Chronic Problem List
Add
Both Lists
Add


Plan
Office Services
Diagnostic Studies
Lab Orders
Home
Nurse Documentation
Vital Signs
Allergies
Immunizations
HPI
Problem List
Review of Systems
Social History
Family History
Physical Exam
Assessment
Plan
Procedures
View Results
Chart Summary
Demographics
Health Maintenance
Planned Care
Miscellaneous
E&M Coding
Future Labs
Coumadin
Master Document /Plan
Instructions More..
Save
Diet More..
Exercise More..
Counseling/Education
Topic (can also select and highlight item in grid to print)
Print
Urinary tract infections education
Insurance
Blue Access PPO
Referral/Consultation
Click to view all referrals
Prompt task
First Name
Last Name
Specialty/Department
Referral reason
Time limit
Timeframe
Follow-up
Reason
Status
Orders this encounter
Reason/comment
Order Type
completed
Urinary tract infections education
Print-out available
EDU
UA w/o Micro
LAB OFFICE
Date
Medication
Dose
Form
Sig Desc
Sig Code
Plan - Write general plan comments here
Detailed plan comments
Cystitis, acute
Click to add new assessment


Instructions
Admit to hospital
Allergies reviewed
Call if onset of new symptoms
Call if symptoms persist
Call if symptoms persist or worsen
Call if symptoms persist, worsen, or onset of new symptoms
Call if symptoms worsen
Continue current medications
ER if symptoms persist or worsen
Go to ER for evaluation
Humidifier/Steam
Medication review
Medications given in office
RICE
Symptomatic Rx
Close
Plan
Lab Orders
Call if symptoms persist, worsen, c
Counseling/Education
Referral/Consultation
Follow-up
completed
Urinary tract infections education
Print-out given to pt.
UA w/o Micro
Plan - Write general plan comments here
Detailed plan comments
Cystitis, acute
Click to add new assessment

Home
Nurse Documentation
Vital Signs
Allergies
Immunizations
HPI
Problem List
Review of Systems
Social History
Family History
Physical Exam
Assessment
Plan
Procedures
View Results
Chart Summary
Demographics
Health Maintenance
Planned Care
Miscellaneous
E&M Coding
Future Labs
Coumadin
Master Document /Plan

Plan | Office Services | Diagnostic Studies | Lab Orders

Instructions More..
Save

Diet More..
Save

Exercise More..
Save

Counseling/Education
Topic (can also select and highlight item in grid to print)

Insurance
Blue Access PPO

Referral/Consultation
Click to view all referrals
Prompt task

First Name	Last Name	Specialty/Department	Referral reason	Time limit	Timeframe

Save

Follow-up

Reason	Time limit	Timeframe

Save

Status	Orders this encounter	Reason/comment	Timeframe	Order Type
completed	Urinary tract infections education	Print-out given to pt.		EDU
completed	UA w/o Micro			LAB OFFICE

Date	Medication	Dose	Form	Sig Desc	Sig Code
05/19/2008 04:04 PM	BACTRIM DS	800-160MG	TABLET	1 tablet twice daily	TAB 1 BID
05/19/2008 04:04 PM	PYRIDIUM	100MG	TABLET	1 tablet three times daily for two days	TAB 1 TID

Plan - Write general plan comments here
Detailed plan comments

Cystitis, acute
Click to add new assessment

PATIENT: Lab Test
DATE OF BIRTH: 10/10/1945
AGE: 62 Years
VISIT DATE: 05/19/2008 4:04 PM
VISIT TYPE: Chart Update
Document Generated By:
Date: 05/19/2008 4:35 PM

Reason(s) for visit
1. UTI Severity level is 7. Duration 3 day(s). The patient describes it as burning. It occurs constantly. The problem is worse. Symptom is aggravated by urinating. Denies relieving factors. Associated symptoms include frequency, urgency, sexually active. Pertinent negatives include back pain, chills, fever, flank pain, retention, hesitancy, incontinence, pelvic pain, pressure, stones, hematuria. Additional information: LMP: 10/03/2006 .

Allergies:

Review of Systems
Gastrointestinal: No nausea, vomiting, constipation, diarrhea, abdominal pain or other significant symptoms.
Gynecologic: No vaginal discharge, dyspareunia, menstrual irregularities, vaginal bleeding or other significant symptoms.

Vital Signs

Time	Temp F	Pulse	Resp	Pulse Ox	BP-Sys	BP-Dias	Height	Weight	BMI	Position	Site
4:05 PM	98.80	74	16		112	68	64.00	145.00	24.89		

Physical exam
Constitutional: Alert, cooperative, no apparent distress, well nourished.
Abdomen: Abdomen is obese. symmetric, no distention, soft, nontender, no organomegaly, no masses, no hernias,
no CVA tenderness,

Assessment
Cystitis, acute (595.0), Acute

Medications new, active or stopped as of this visit:

Brand Name	Dose	Sig Desc	Start Date	Stop Date
Bactrim Ds	800-160mg	1 tablet twice daily	05/19/2008	05/30/2008
Pyridium	100mg	1 tablet three times daily for two days	05/19/2008	05/30/2008

Office Labs

Status	Ordered	Order	Completed	Interpretation	Value
completed	05/19/2008	UA w/o Micro	05/19/2008	See detail	Color: light yellow. Glucose:

neg. Bilirubin: neg. Ketones: tr. Dipstick Gravity: 1.025. Blood: mod. Non-he pH: 7.5. Protein: sml. Urobilinogen: norm. Nitrite: pos. Leukocyte: mod.

Plan

Status	Order	Timeframe
completed	Urinary tract infections education	

Home
Nurse Documentation
Vital Signs
Allergies
Immunizations
HPI
Problem List
Review of Systems
Social History
Family History
Physical Exam
Assessment
Plan
Procedures
View Results
Chart Summary
Demographics
Health Maintenance
Planned Care
Miscellaneous
E&M Coding
Coumadin
Print Document

EVALUATION AND MANAGEMENT CODING

New Patient
Established patient

Visit Type: Chart Update

Decision Making Level:

Risk Table

- Straight Forward
- Low Complexity
- Moderate Complexity
- High Complexity

☐ Counseled > 50% of time and documented content

Code Check: 99211
Additional EM Code:
Click to Save Code(s)

Code(s) submitted

Calculated Code	Submitted Code
	99211

Calculated code overwritten

Print Patient Plan

Assessment Template Dx Codes

1	595.0	Cystitis, acute
2		
3		
4		

Sign Off

Other Codes

OV New	OV Est	Consult	On Call for PCP	NH Comp	NH Subseq	Dom New	Dom Est	House New	House Est
99201	99211	99241	99050	99304	99307	99324	99334	99341	99347
99202	99212	99242	99051	99305	99308	99325	99335	99342	99348
99203	99213	99243	99058	99306	99309	99326	99336	99343	99349
99204	99214	99244			99310	99327	99337	99344	99350
99205	99215	99245				99328		99345	

Calculated Hx Level: 2
Expanded Problem Focused

History of Present Illness

HPI1	5	CC1	CC6
HPI2	0	CC2	CC7
HPI3	0	CC3	CC8
HPI4	0	CC4	
HPI5	0	CC5	
HPI6	0		

Past, Fam, Soc Hx

Medical Hx	
Family Hx	
Social Hx	

Review of Systems

General	0	Neuro	0
Eyes	0	Psych	0
ENT	0	Endocrine	0
Cardio	0	Hematology	0
Resp	0	Allergy	0
Gastro	1	Musc	0
GU	1	Skin	0

TOT HPI 5 TOT CC 0 TOTAL PFSH 0 TOTAL ROS 2

Calculated PE Level: 1
Problem Focused

Physical Exam

General	2	1	Neck	0	0	Abdomen	3	1	Integ	0	0	Resp	0	0
Eyes	0	0	Cardio	0	0	Musc	0	0	Psych	0	0	GU	0	0
ENMT	0	0	Breast	0	0	Neuro	0	0	Lymph	0	0			

TOTAL PE SYSTEMS 2 2 0 TOTAL PE BULLETS 5 0 5 0

Item 3: Managing chronic conditions

The diabetes workflow indicates the role of each staff member in the care of our Diabetes population. The Diabetes Planned Care Ruler is used by our Front Desk and Case Management staff as a guide with out Diabetes Registry for making sure our Diabetes patients get the services they need. We also have workflows for addressing our Prenatal and ADHD populations.

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 have A1cs < 7%	% of patients with two A1cs in the last 12 months	% of patients with last BP < 130/80 % of patients with last LDL < 100	% of patients are current smokers	% of patients have an annual foot exam % of patients have an annual eye exam	% of patients with an annual self-management goal documented
	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 Clinical 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 counseling	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 months	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 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 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 4 assessment scores (2 parent, 2 teacher)	% 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 with med f/u within 30 days	% of pts started meds % 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.					
	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.		
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.					
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.					

Item 4: Coordinate care with external case management

Disabilities population: explain partnership with Xxxx. For pts w/ diabetes who are disabled, they are case managed by Xxxx.

The organization partners with our managed care organization to case manage high risk patients.

XYZ PATIENT NAVIGATOR PILOT PROGRAM

Ops763.1
Author(s): Xxxx
Quick Reference: N
Scope: Med Recs, Front Desk, ECS, Call Center, Providers, MAs, COM/COT
Responsible Director(s): Operations, ECS, Clinical
Approval/Date: 5/27/09

DESCRIPTION: This procedure describes the process for incorporating XYZ Patient Navigator into our Clinical care of XYZ patients. The program aims to improve the quality of care received by Medicaid's highest need, highest cost fee-for-service patients by better coordinating physical health, mental health, and substance abuse services. Patient Navigators from XYZ (one for each site) will provide case management services both within and outside of the clinic for a selection of patients. The CDs are the Operations contact and the ECS Case Managers are the Mental Health contacts, and the Nurses are the Clinical contacts. Patient Navigators should also have regular interaction with CHC-A's Referral Case Manager (RCM) so that it is clear who will work on the logistics for referrals of XYZ Patient Navigator patients (RCM or XYZ or Patient Navigator).

PURPOSE: Patient Navigators will work with patients to provide additional training and education about self care, track medically necessary activities, attend medical visits, etc.

PROCEDURE:

Identifying patients as part of the program

1. XYZ will send CHC-A Project Manager the list of participating patients.
2. CHC-A Project Manager will compare the list against established patients and determine how many are new and how many are established.
3. CHC-A Office Tech will verify all patients on the list are active members of XYZ by checking pay code eligibility via the Web Portal. Office tech will make a list of patients that are not XYZ and share that with CD and XYZ Patient Navigator.
4. CHC-A Office Techs will complete the mini-reg and enter PCP for new patients on the XYZ list that have an active XYZ pay code.
5. For established patients OTs will enter the "XYZ Patient Navigator" Referral into the Plan template on NextGen and immediately mark that the referral is "completed" (that way it will not show up on the open referral report).
6. Operations will only do mini-registration on new patients when they are told by Patient Navigator (Via form in attachment section) that the patient is actually interested in being a CHC-A patient and receiving case management from the Patient Navigator.

   Instructions for Mini-registration
   - Click the appointment book, right click on the appointment.
   - Click on view person, enter all fields in red plus all UDS fields that are needed
   - Click on status field and select active.
   - Click on UDS tab and use the drop down menu to select correct status on each box.

- Click on Relations tab.
- Click on Norton button and then click "New."
- Enter name and click "find". If name is found double click on name. If name is not found click new and add relationship.
- Click on insurance button to the appropriate payer, after it has been verified.
- Click on Norton button and then click "New."
- Type in the first letter of the insurance you are adding to account.
- Add patient's insurance ID, leave the effective date blanks, enter expiration date (tomorrow's date).
- Enter co-pay amount if applicable
- Click "Okay" to save changes
- Close the insurance listing box. Click OK on patient information screen
- Click on Account button and yes on confirm creation of account
- On Family Info click on Norton Button then New enter family size, patients annual income, verify and effective date as today and expiration date as one year from today.
- Click on chart. You will be asked if you are sure you'd like to create a chart, click "OK".
- You must enter privacy notice information at this time. Click OK and then close all open windows.

<u>Instructions for adding a referral</u>

- Create a "new encounter" and choose "chart update" as the visit type
- Click on the "Plan" template on left hand side of the screen
- Under the "Referral/Consultation" heading click in the blank field titled "Specialty Department"
- From the pull down menu choose "XYZ Pt. Navigator" and press save
- Click "cancel" when asked to select task recipients
- You will see the referral has moved down under the "Follow up" heading. Double click on the referral
- Click on the "completed" box and then press "save" then "close"

<u>Instructions for removing a referral</u>

- Open the referral & document in the comment box that the patient will no longer be case managed via ICM. NextGen will not allow the deletion of a referral.

Registry and Appointment Schedules

7. Designated Operations staff will print the XYZ Pt. Navigator Registry every two weeks and put on Patient Navigators work space (to be determined by the CD/COM) in designated folder
8. This same staff member will also run a scheduling report (MWF) containing each provider's appointment schedule for two days (Monday's report will include Monday & Tuesday; Wednesday's report will include Wednesday & Thursday, Friday's report will include Friday and Monday). This report will also include the payer that was listed at the last encounter. These reports will also be put on the Patient Navigator's workspace in the designated folder
9. The Patient Navigator will be able to identify all XYZ patients (not just the high risk ones from the list) and be able to provide case management as appropriate.
10. If in this process the Patient Navigator decides that they would like an additional XYZ patient to appear on their registry, then they can ask an Office Tech to add in the referral per the instructions above.
11. Patients who have a referral to this program will also be added to the ECS integration report.

<u>Instructions for running the registry</u>

- See quick tips sheet in attachment section below

<u>Instructions for running scheduling report</u>

- Click on the Reports icon on the tool bar in the EPM.
- Select the appointment list for the desired clinic as report type.
- Click on XYZ Navigator Patient List.

- Click on Filter 1 tab.
- Select date range to run report
- Click OK.
- Report will run and then click print.

Patient Navigators on site

12. Patient Navigators will be self sufficient. They will have cell phones and computers. We will be providing them with an office/pod space and a telephone with an extension
13. Patient Navigators will be responsible for informing the front desk that they would like to be called when a patient checks in for their appointment
14. When appropriate/desired the Patient Navigator can join the patient in the room during their visit and afterwards continue discussions with them either in their own office or in the exam room (if this does not obstruct flow).

Communication with our team electronically

15. Patient Navigators will not have access to the EMR.
16. They will be sending Health Risk Assessments & Progress Summary forms (word documents) for both new and established patients electronically via encrypted email to all Med Recs staff & CD at the appropriate clinic.
17. The Med Recs staff will only process these documents if it is for one of their PCPs or if the Med Recs for that PCP is out of the office.
18. Med Recs will cut and paste this document as a chart update Master IM document.
19. Med Recs will then task the PCP with the Master IM document attached as an FYI

<u>Instruction for cutting and pasting Patient Navigator information into Master IM document</u>

a) Medical records staff will check their email box a minimum of twice a day
b) When a HRA document has been sent from the XYZ navigator, open attachment and enter in password (also provided by navigator)
c) Obtain the patients name and date of birth from HRA and search for patient in NextGen
d) Once in the patient's chart create a new encounter for that day by clicking the new button on the upper right hand corner of the screen
e) Once the encounter has been created click on the template icon located on the bottom right corner of the screen (three rows up and third button from the right)
f) Click on master IM to open the master IM template.
g) Enter in the following information
    1. If the patient is an established patient or new patient
    2. Department (should be FP)
    3. Visit type (should be chart update)
h) Once those three items have been entered click on the "save and generate document" button located on the bottom left corner of the screen. This will generate a document with the patients past medical history if they are an established patient and if they are a new patient the document will generate with only the patients name at the top of the document
i) If the documented has past medical history information, highlight all information listed below the black line located under the patients name and under the name of the person who generated the document.
j) Once the information has been highlighted, delete this information from the document by pressing the delete key on the keyboard.
k) Return to the HRA and click on edit from the pull down menu located at the top of the word document. Click on select all. This will highlight all the information in the HRA.
l) Click on edit again but this time select copy
m) Return to NG, click on edit, and then paste. This will transfer all information form the

word document and place it into the patients chart.

n) Click on the save button located at the top of the screen in NextGen.
o) Process complete. To add another HRA to another chart repeat steps above.
p) Send the PCP a task with Master IM document attached.

Scheduling patients

20. Since all patients will have a chart, they should not have a problem scheduling an appointment when they call the Call Center. The Patient Navigators will also coach patients to mention that they are part of the program.
21. If a patient does have a hard time scheduling an appointment then they will communicate back with their Patient Navigator who will then facilitate communication.

ATTACHMENTS:

- Add new patients & remove patients from registry form
- EMR Quick Tips Sheet -- Accessing XYZ Patient Navigator Registry

COLORECTRAL SCREENING PROCEDURE

Author(s): Xxxx
Quick Reference: Y
Scope: Clinical, Operations
Responsible Director(s): CDs, CMDs
Approval/Date: 10/02/08 updated 4/8/09

DESCRIPTION:

This procedure describes how the X Colorectal Screening program will function at CHC-A.

PURPOSE:

To assure effective and efficient management and tracking of all resources and activities utilized with the X Colorectal Screening Program.

QUICK REFERENCE:

Once the Provider refers a patient to the Referral Case Manager (RCM) for a colonoscopy, the RCM will confirm eligibility according to the X Colorectal Screening Program (XCSP). If the patient agrees to participate in the screening program, the RCM will schedule the patient for the procedure. RCM will regularly communicate referrals and share documentation with the CCM who will continue with all administrative aspects of the program (database maintenance, and billing), aside from actually communicating with the patient which will remain with the RCM.

DETAILED PROCEDURE:

Screening patients for eligibility

1. CCM reviews patient schedule in the morning to determine patients who might be eligible for XCSP at each clinic:
    - over 50 years of age
    - XICP eligible
        - Income below 250% of Federal Poverty Level
        - No insurance
        - Lawfully present in the US
    - XICP recently expired

2. CCM emails each RCM daily with a list of eligible patients including XCSP in the subject line of the email.

3. RCM gives XCSP brochure for each identified patient to appropriate Medical Assistant or Provider.

   Provider can also identify patients that are under 50 years of age who are symptomatic or have a direct family history of colorectal cancer and refer them to XCSP as appropriate.

4. If Provider determines that the patient is a good candidate for XCSP, Provider will direct patient to the RCM prior to leaving in order to proceed with referral process. RCM will schedule appointment and give bowel prep information.

5. Provider also sends RCM a task for this referral.

Determining eligibility

6. RCM will confirm eligibility and documentation depending on if RCM is able to meet with the patient at this visit. RCM can also schedule the patient on the phone to come in and do the documentation at the next visit.

   Since some Medicare patients are covered through XCSP, the distinction between Medicare A & Medicare B is provided below.
   - *Medicare A covers hospital charges*: with approval from XCSP, patients with Medicare A only (meaning they do not have Medicare B as well) can possibly get a colonoscopy covered through XCSP.
   - *Medicare B covers physician charges*: these patients would not be eligible for a colonoscopy through XCSP, but could possibly receive one through normal Clinical procedures.

7. Acceptable forms of documentation for verifying residency status are listed on the back of the affidavit.

8. RCM will get the following from patient
   a. Signed affidavit
   b. Signed E-cast consent form (then give to med recs for scanning into the EMR under “consents”)
   c. Copy of acceptable ID or driver’s license.

Scheduling colonoscopy appointment and bowel prep instructions

9. The RCM will call the appropriate specialty provider and document the call in the Nextgen referral.

10. RCM will fax the specialty provider the following:
    - Referral letter which includes a medical history
      - If referring Provider is a PA, need to have supervising Provider’s name on form as well
    - Signed Affidavit
    - Acceptable ID or Driver’s License
    - Medicare card (if applicable)

11. RCM will meet with patient to review bowel prep instructions
    a. When the provider refers a patient for a colonoscopy, the provider will include in the "comments" section of the referral that they have done the following:
       - 1.) Reviewed the patient meds and 2.) That either normal prep instructions will work OR the provider will give RCM special instructions to review with patient during bowel prep.
       - If the provider does not give such information in the task, the RCM can go and confirm with the provider whether there are any special instructions that the RCM should know about.

12. RCM will regularly send all above document to CCM along with a copy of XCSP cover sheet & signed E-cast consent form. RCM will also inform CCM of patients who refused participation.

13. CCM will re-verify patient’s eligibility based on the patient’s sliding scale.

14. CCM will enter in the data to the XCSP database (P:\Referrals\XCSP\manual & database\Eval_Tracking_CC\). If patient refuses procedure, CCM should still enter the patient in the XCSP database and document refusal.

    If it is confirmed that the patient is actually not eligible for XCSP, CCM will notify RCM immediately who will notify the patient of ineligibility for XCSP and will refer patient through normal Clinical procedure. This person does not need to be entered in the database.

15. The Specialty Provider will call the patient the day before their scheduled screening to confirm their appointment.
    - If the patient asks questions which are Clinical in nature, the RCM can send a nurse a task asking nurse to call the patient.

After screening is complete

16. Specialty Provider will notify patient of colonoscopy and pathology results (if pathology was done).

17. Specialty provider will send both CCM and Med recs of appropriate clinic colonoscopy and pathology reports.

18. CCM will send copies of colonoscopy reports to RCM's

19. CCM will communicate with specialty providers to obtain missing reports

20. CCM will enter patient data into XCSP database, E-cast, and document disclosure in the EMR PHI Log.

Certifying patients for Specialty Providers and XCSP

21. CCM will communicate with specialty providers monthly (via fax) as to patient names and dates of service for which specialty provider is billing XCSP. Upon confirmation from specialty provider CCM will complete the Certification of Verification and fax to specialty provider and XCSP.

22. CCM will keep reports that list names and dates of service along with referral form, affidavit, license, colonoscopy form and pathology reports for each patient.

23. XCSP will perform regular audits at CHC-A to confirm that each patient has met the eligibility criteria and had the procedure done. Once these audits have been completed, paper documentation for XCSP billing can be purged after it has been 5 years since the patient has last been seen (See CHC-A Process: How long do we keep financial files).

24. If RCM is contacted by patient because they have received a bill, RCM will make a copy of the bill (leaving the original with the patient) and will fax bill to CCM. CCM will call the specialty provider to inform them that patient has been incorrectly billed and the bill should instead be sent to XCSP.

Billing XCSP for Bowel prep

25. CCM will create encounter in patient chart and attach the XCSP payer code (CHC-A Colorectal).

26. By the 15th of the following month, CCM will send Statement of Screening Services: Bowel Prep. XCSP will process and send payment.

27. Once XCSP payment is received, accounting will notify CCM. CCM will then confirm receipt of all prep material and follow up with XCSP for any outstanding balances.

28. CCM will enter payments into NextGen encounters and XCSP Database.

Billing XCSP for CCM time

29. clarify process with Jennifer

30. By the 15th of the following month, CCM will send forms to XCSP (giving finance a copy) in order to bill for CCM salary, benefits, and other expenditures while attaching any relevant documentation.

- Payroll Summary (get from ADP)
- Benefits Summary (get from ADP)
- CCM invoice (get from finance)

If patient needs follow up care

31. Specialty provider will contact patient's Provider to inform of a potential cancer case.

32. RCM will communicate cancer case with CCM who will contact XCSP Treatment Case Navigator to notify them of cancer case.

33. XCSP Treatment Case Navigator will work with CCM, RCM and Clinical Providers to organize cancer treatment and payment for patient.

RCM site-to-site coverage

- If ever an RCM, CCM, or program manager has a forthcoming absence, they will identify another staff member to fulfill that role and notify the CHC-A XCSP team via e-mail (See CHC-A Procedure: Site to Site coverage-not yet approved).

- If an RCM is away from the office and a provider would like to refer a patient for colorectal screening, the provider will task the RCM to follow up with the patient upon returning to the office. If the referral is urgent, the provider will notify the covering RCM(s) to complete the referral (See CHC-A Procedure: Site to Site coverage-not yet approved).

Notes:

- CCM is responsible for attending Patient Navigator calls and representing issues/comments from RCMs. If there is an additional concern or interest the RCM is welcome to join the call. RCM will be informed of information via summary notes from CCHN.
- Questions regarding billing or procedure, contact CCM or Project manager.

XCSP FORMS

Referral Forms

All located in P:\Referrals\XCSP\XCSP referral forms
English Data collection form
English unsigned affidavit and acceptable IDs
Spanish affidavit (refer to English for acceptable IDs
English and Spanish patient prep form
E-cast consent form Spanish and English

Billing Forms

Certification of Verification (P:\Referrals\XCSP\billing forms)
Statement of Screening Services: Bowel Prep (P:\Referrals\XCSP\billing forms\statement of screening serv bowel prep)
Billing for XCSP Case Manager (P:\Referrals\XCSP\billing forms\billing for XCSP case manager)

Database

XCSP Database (P:\Referrals\XCSP\Eval_Tracking_CC\)

Relevant Procedures

Site to Site Coverage
How long do we keep financial files?
Referral Case Manager Procedure

REVIEW DATES: 10/02/2008

CHC-A

Position Description

Colorectal Case Manager

Department: Medical **Date Prepared: October 2007**
Reports to: Operations analyst/Project manager **Location: Admin w/travel to clinics**

OVERALL RESPONSIBILITIES:
To uphold CHC-A mission to serve the medically underserved by providing the highest level of continuously improving quality medical care, health education and preventive services possible, embracing the values of:

- Service to Others
- Creativity
- Diversity
- Excellent Teamwork
- Do the Right Thing
- Make CHC-A a Great Place to Work

This job exists to: Assure an effective and efficient process is available for patients who are eligible for the X Colorectal Screening Program (XCSP) as funded through the University of X Cancer Center, Division of Cancer Prevention & Control. Since this position is funded through a state grant, the funding is only guaranteed through June 2008. Funding beyond this date is funding is likely, but not guaranteed.

ESSENTIAL DUTIES AND RESPONSIBILITIES:
Outreach & Recruitment

- Collaborates with XCSP in mailings informing patients of XCSP.
- Regularly attends team huddles to promote XCSP and answer any staff questions.
- Knowledge of national and state outreach efforts as they relate to colorectal cancer.
- Outreach in the community (attending fairs and coalition meetings).
- Ensures English and Spanish literature and promotional materials is available in each clinic.

Referral assistance

- Maintains up to date knowledge of XCSP referral process, program rules, and eligibility guidelines.
- Provides support to Referral Case Managers in obtaining all needed information for an effective referral.
- Assist with organizational development to maintain an effective referral process.
- Provides information/training to the clinic staff in regards to changes in XCSP referral process.
- Assist Referral Case Manager and Pod Case Manager when demand for XCSP referrals are low.

Administrative duties

- Pulls daily reports of patients with scheduled appointments and informs PCP of XCSP eligible patients.
- Communicates with Referral Case Managers about each referral and completes any administrative paperwork, allowing Referral Case Manager more time for patient interaction.
- Collects all colonoscopy reports from specialty providers and distributes them appropriately
- Is the go-to-person for updates on status of referrals, eligibility, and follow-up as it relates to XCSP
- Tracks and bills for all patients who receive screening through XCSP.
- Communicates with billing to ensure payments on accounts from XCSP.
- Communicates with specialty providers regarding collaborations on XCSP colorectal screenings.
- Enters, updates, and monitors all referrals in NextGen and Access databases.
- Reviews and exports the database to XCSP as requested.
- Collects data on eligibility of patients compared to actual number of screening and writes reports as requested**.**

Other

- Regularly informs Operations Analyst/Project Manager on outreach efforts and referral tracking.

- Reports to work on time and on a regular basis.
- Will work at each of the four clinics and administration building.
- Provides superb customer service to all customers (coworkers, out side customers).
- Request support from professional staff when needed.

OTHER DUTIES AND RESPONSIBILITIES:

- Maintains a safe work environment.
- Performs other duties and responsibilities, as required.

SUPERVISION: No

SCOPE OF AUTHORITY:

- Provide resource coordination, outreach, and support to Referral Case Managers for X Colorectal Screening Program referral requests.
- Progress is reviewed quarterly and results are measured and formally evaluated annually.

POSITION QUALIFICATIONS:

A. Education / Experience

1. Bachelor's degree in the human services field.
2. Or HS/GED and four years in referral processing.

B. Knowledge, skills and abilities:

1. Excellent verbal and written communication skills in English and Spanish required.
2. Ability to flourish independently and in a team management system
3. Sensitivity to low income, ethnic minority community
4. Excellent organizational, tracking, and documentation skills.

PRINCIPAL WORKING RELATIONSHIPS:

- Referral Case Managers at each clinic
- Operations analyst/ Project Manager
- Other pod members, site employees, and providers
- Patients
- X Colorectal Screening Program staff
- Outside contacts such as community or other healthcare providers

MATERIALS AND EQUIPMENT DIRECTLY USED:

- Fax
- Computer
- Telephone

WORKING ENVIRONMENT / PHYSICAL ACTIVITIES:

- No risk of exposure to Blood borne pathogens.
- Usual office environment with sitting, walking, standing, stooping.
- Ability to travel from clinic to clinic in own vehicle.
- Sufficient vision to read documents and computer screen.
- Oral and auditory capacity enabling interpersonal communication as well as communication through automated devices such as email and telephone
- Lifting up to 10 pounds