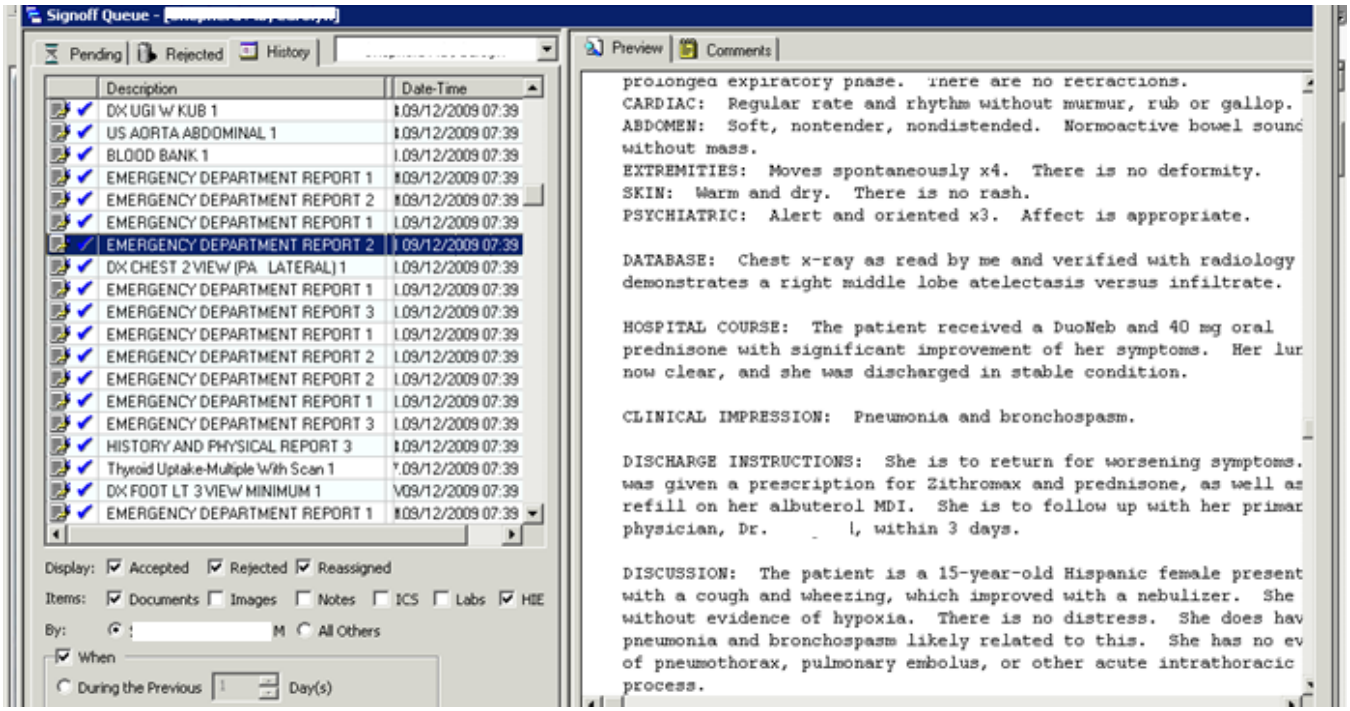
PPC 3: CARE MANAGEMENT
Element E Continuity of Care

Item 1: Identifies patients who receive care in facilities

We have built several interfaces electronic interfaces which allow us to see when patients go to the Emergency Department, or when they are admitted to care. This information comes into a product we elected to use call the Physician Approval Queue. The data comes into our medical record immediately after it the notes are dictated/transcribed into an electronic format. This is usually done in less than one hour. We call patients who have been to the ER to assure appropriate follow up. Since we continue to admit the majority of our patients to the hospital, follow them in the hospital as their PCP and discharge them, we are able to set up follow up and medication reconciliation at the time of discharge for the majority of our patients. If our patients are hospitalized out of X or at a hospital system that we don't interface with we do not get this information. However, over 80% of our admissions are at one of the 4 hospitals we have electronic interfaces with. In order to increase the coverage for our patients at other facilities, we will run our connectivity through X RHIO and our community will be one of two beta sites with data exchange starting in June 2010. At this time we will get closer to 95% of our patient data for other facilities.



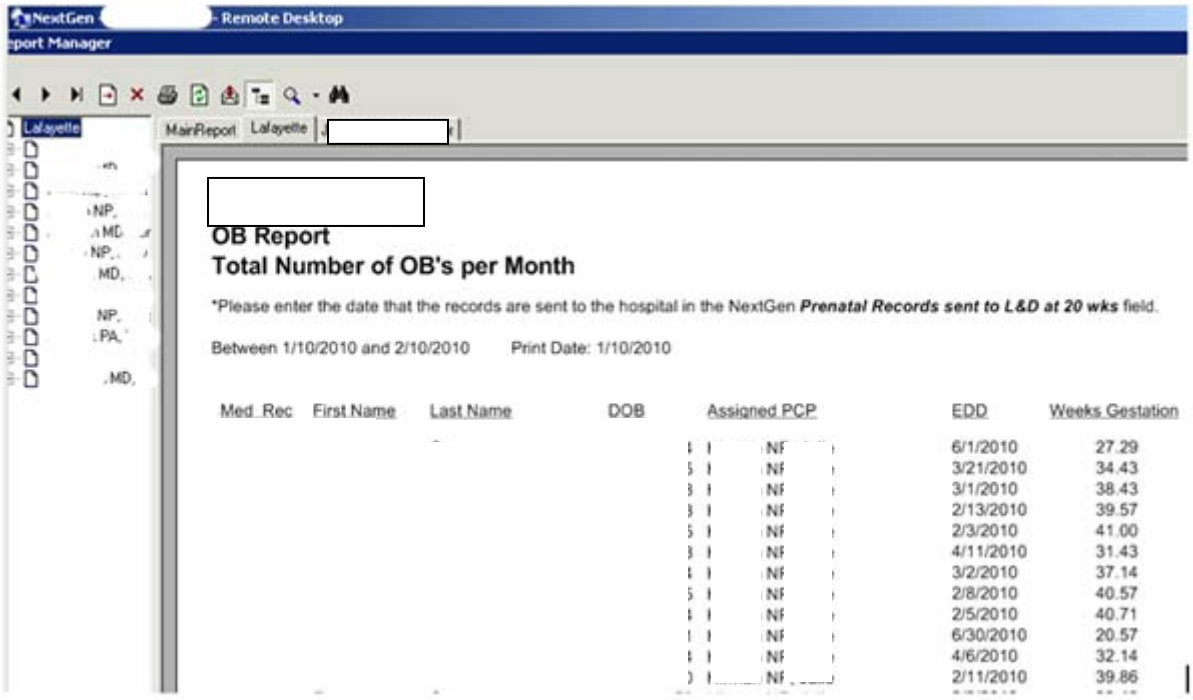
The screen shot above shows multiple hospital entries which is how our primary care providers are notified of patients accessing care at the hospitals and other health care facilities. Shown are examples of Emergency Department reports, History and Physicals, imaging studies and Op reports as well as test results.

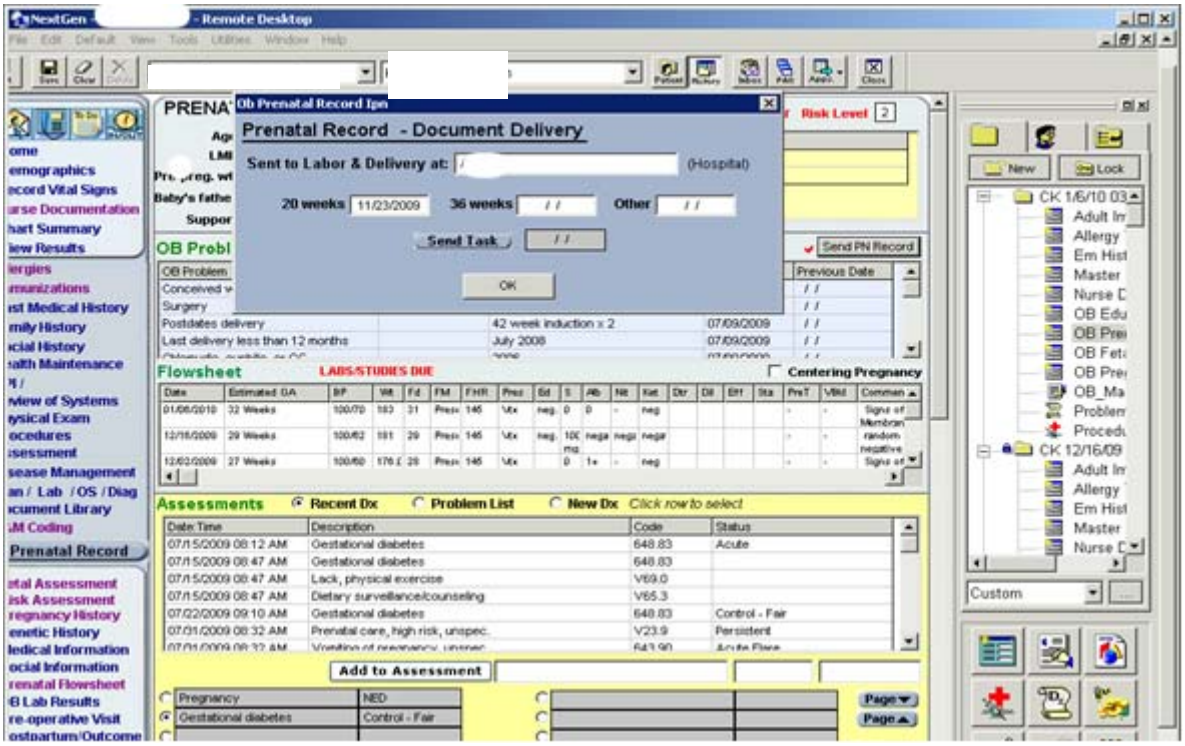
Item 2: Systematically sends Clinical information to facilities

We are able to run reports of patients who are ready to deliver, and proactively send the records to the hospital to be sure they are there for delivery. Also for patients with unplanned admissions,

using our EHR we can access our complete medical record for any patient being seen in the hospital or the Emergency Department through a Web portal.

This is a screen shot of the report that we run out of our EMR to send information to the hospital. It notifies our Medical Records staff on when to send updated records to our hospital partners for delivery preparation.





EMERGENCY TRANSFER OF PATIENTS FROM CHC-A
Clin334

Author(s): Xxxx, MD
Quick Reference: N
Scope: All medical staff and office technicians.
Responsible Director(s): Medical Director, Assistant Medical Directors
Approval/Date: 8/3/98

DESCRIPTION:
Safe and efficient transfer of patients needing emergency care not available at CHC-A occurs frequently. Effective transfer of important information about the patient's condition must occur to insure maximum continuity of care.

PURPOSE:
This procedure lists the steps necessary for efficient, continuous care at the time of emergent transfer of a CHC-A patient to another institution.

PROCEDURE:
- When a provider makes the decision that a patient needs to be transferred by ambulance to another institution she/he will ask a staff person to call 911 to get an ambulance team in route.
- If the patient's condition allows the provider should notify the appropriate receiving institution of the patient's condition prior to transfer. If this cannot be done prior to transfer it must be done once the patient is on the way to the hospital.

A Hospital		**B**		**C**	
ER	(xxx) xxx-xxxx	ER	(xxx) xxx-xxxx	ER	(xxx) xxx-xxxx

- The information to be relayed to the emergency dispatcher includes:
    1. Clinic address (not necessary when calling 911) and where in the clinic the patient is.
    2. Status of the patient and diagnoses.
    3. If known, institution to which the patient should be transferred.
    4. Name of the provider in charge.

- Written information important to the patient's status will be copied by an available staff person to send with the patient in the ambulance
    1. The progress note should be completed relating the events of the clinic visit. Any medication given during the visit must be recorded in the progress note.
    2. When pertinent, a copy of the problem list and the medication flow sheet including known allergies should be included in the information sent with the

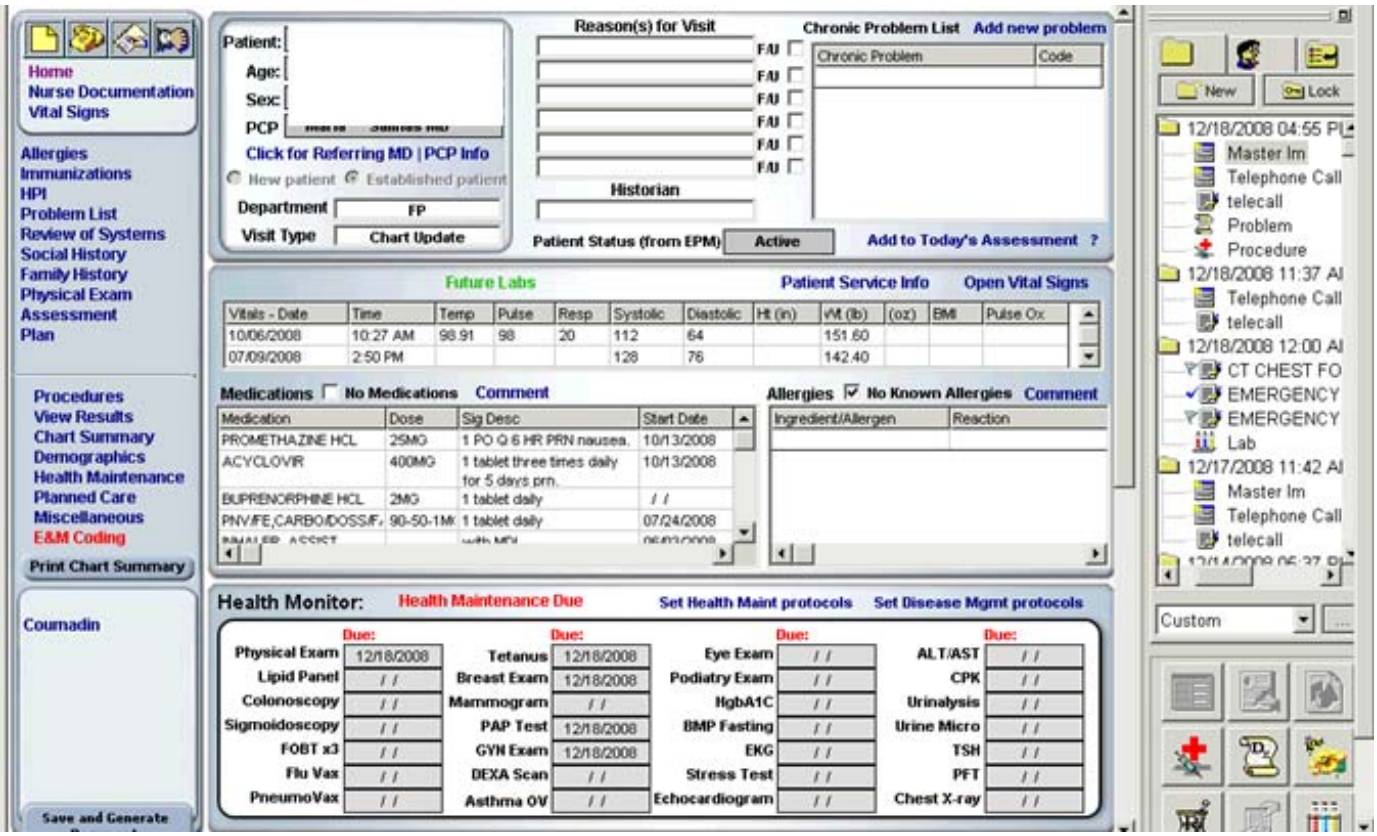
patient.

3. Results of ongoing monitoring of the patient (vital signs should be checked and recorded every 15 minutes while waiting for transfer team to arrive).
4. Any lab work done during the visit should be included in information copied.

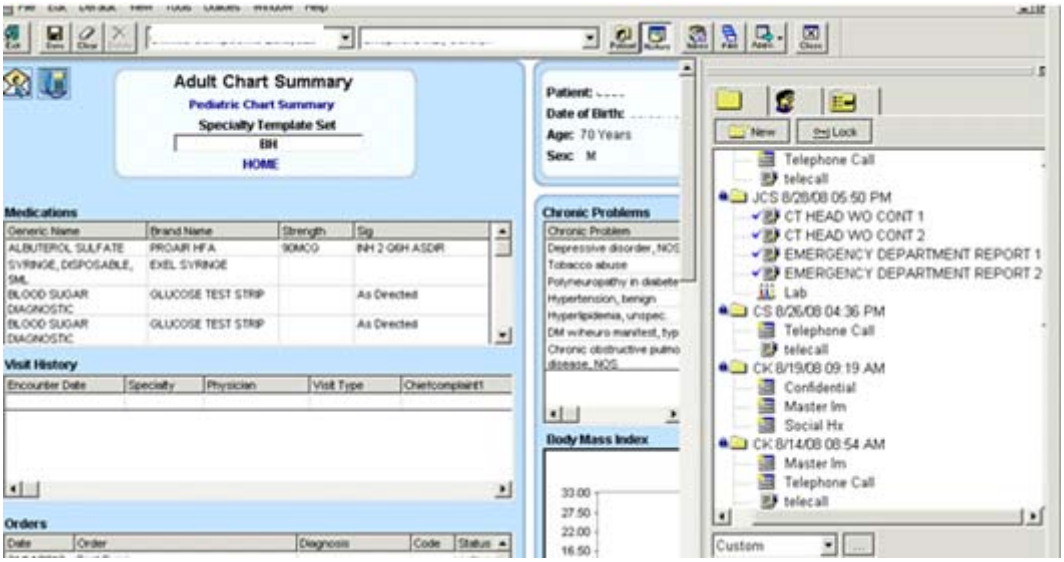
- The provider in charge is responsible for deciding what medical interventions are appropriate while awaiting transfer team. These may include:
    1. Oxygen
    2. IV
    3. EKG
    4. Medication
- The provider is responsible for notifying appropriate family members of the transfer.

REVIEW DATES:

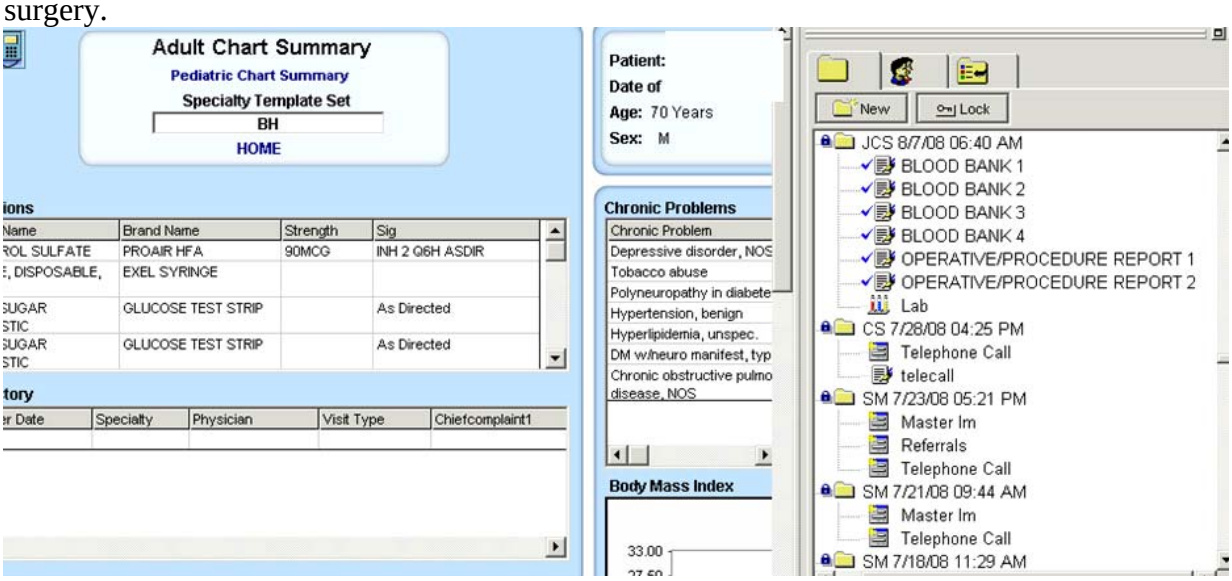
- 8/3/98



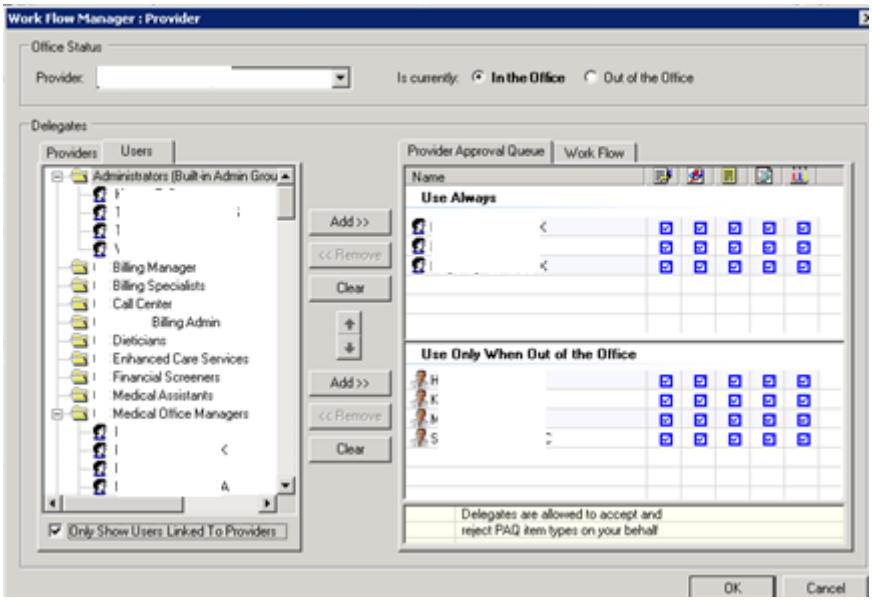
Another example of ER visit with CT results done at the Emergency Department in the record.



Example of operative report and blood bank results coming in for the patient on the day of surgery.



Out of office procedure for covering and re-assigning the electronic information inboxes:



1. Workflow manager PAQ/Workflow Inbox
    a. USE ALWAYS:
        i. NTM, CMDs, AMDs, CDs, COT, COMs, Medical Records should be attached to all providers at their sites in the Use Always section of the table.
        ii. Medical records will work the PAQ for providers who get a lot of inappropriate work from the hospitals. Medical records will reassign these documents to PCPs.
        iii. Providers should never change this "Use Always" section.
    b. OUT OF OFFICE:
        i. Set always if out more than 5 business days.
        ii. Providers will set up Out of Office with other providers from their site and pod or in the case of OB's,--other OB partners. Providers are expected to have their PAQ and tasks completed when they plan to be out of office, this may not be possible in the event of emergency leaves.
        iii. Ops will assign a buddy in collaboration with the provider who is taking arranged leave. The "buddy" is the lead provider who will be responsible for both the PAQ and the Tasks. Sites will define the process for notifying buddies of abnormals. This may include having the buddy-provider do the primary review or having a nurse review the PAQ/Tasks depending on site workflow. Buddies will be listed on the "daily" sheets to assist the NTMs in identifying the needed Buddy.
        iv. If leave is 1 week or less, only abnormals need be addressed. If leave is greater than one week, then all PAQ and Tasks should be managed.
2. What should be the process when looking at someone else's PAQ?
    a. Nursing :
        i. Per nursing protocols, review the lab, treat per protocol, document in the chart, and then accept the lab.
        ii. Review and reassign all other labs not falling under the nurse protocols.
        iii. A report will be available to monitor the work of non-clinicians who have signed off tasks.
    b. Providers
        i. When providers take leave, they should designate a buddy, notify operations and sign out all important follow up using the SBAR methodology (see a.

ii. Providers should monitor the PAQ and the tasks for their buddy who is out of office.
iii. Buddies will task PCPs for significant new problems or changes in treatment plan.
iv. If greater that 5 business days, then both the normals and the abnormals should be addressed.

Provider Handoff process from the Provider Manual:

G. Provider Hand-Off

Full-time (FT) and Part-time (PT) Provider Hand-off Expectations

1. Studies	All providers regardless of FTE status are expected to document in the EHR a clear plan for timely F/U of the results of studies that are anticipated to be significantly abnormal (e.g., ordered for a patient with high-risk symptoms or conditions). This expectation includes but is not limited to all studies ordered "stat." Depending on the situation, a PT provider may do the F/U at a time they are not scheduled to be at work, or they will make clear arrangements with another provider who agrees to be responsible for following up the urgent results. This plan will be clearly documented in the EHR. (see "Warm hand offs," below).
2. Piles of paper	The provider will review and sign off on non-critical results and reports within 72 hrs of receipt; if a PT provider is not scheduled to be in clinic at least once every 72 hrs, the NTM will review all incoming paper results for abnormals and will discuss them with any available "consulting" provider to determine if they need to be addressed sooner than provider's next shift in the clinic. This consulting provider will initial & date the paper as "OK to wait" OR will document in the EHR a F/U plan.
3. Inbox/PAQs	Unless scheduled to be out of office >72 (see below), all providers regardless of FTE status will check their e-mail (Outlook) Inbox, NG Inbox and PAQ at least once every 72 hrs and respond appropriately to the information found therein.
4. Warm hand offs for F/U	Whenever a provider orders a lab or study that she anticipates may be critically abnormal but for which she will not be available to do timely F/U, she will give a "warm hand off" to a receiving provider according to _____ standards for hand-off communication. She will document in the EHR who agreed to be the receiving provider and a brief outline of the plan for managing likely result scenarios (e.g., "If X-ray shows fracture, appt on X date with PCP to cast; if no fracture, refer to physical therapy").
5. Meeting information	All providers regardless of FTE status are responsible for the information posted in the minutes of important meetings. Providers will read the minutes of meetings they have missed within 1 calendar week of having received them. The meeting organizer or designee will e-mail minutes within 1 calendar week of the day on which the meeting occurred.
6. Scheduled out of office >72 hours (e.g. vacation, CME, sick leave, FMLA...)	Any provider regardless of FTE status who will be away from clinic for more than 72 hrs (except for a 4-day holiday weekend like Thanksgiving) must discuss coverage with her podmates and, possibly, site mgmt staff. The provider will negotiate an explicit commitment from those who will cover incoming clinical information while she is gone. The resulting coverage plan will be posted in writing at the provider's desk, noted in an "Out of Office" automated e-mail response in Outlook, and (eventually) noted in NG's "Out of Office" feature when it becomes available.
7. Mandatory training	All providers regardless of FTE status will attend mandatory trainings, unless physically unable to do so (e.g., out-of-town or sick). An example is required EHR training. Leadership staff will keep "mandatory" designations to a minimum.
8. Care mgmt requiring multiple providers	The PCP is responsible for documenting a patient care mgmt plan that involves multiple providers. The plan will explicitly state who is involved and what role each agreed to play. PT providers are still responsible for care mgmt plan and collaboration with other providers for coverage when they at not available.

Abbreviations

EHR	Electronic health record	NTM	Nurse team manager	PTO	Paid time off
FTE	Full-time equivalent	PAQ	Provider Approval Queue	Mgmt	Management
F/U	Follow up	PCP	Primary care provider	NG	NextGen

Principles of Clinical Practice (P.3)
Revised 01/2009

Item 4: Contacts patients after discharge from facilities

OB Pregnancy Outcome Process

First thing in the morning
Login to Meditech
Run simple rounds report – Print

(on Mondays run both Discharge report and the rounds report)

When using the Discharge report look up every woman in OBIX to see if she had a delivery (even if there isn't a mom-baby pair because the baby may be in the NICU.)

Login to the Tellurian Server
Open Crystal Viewer and run the *Delivery Report for ECS*

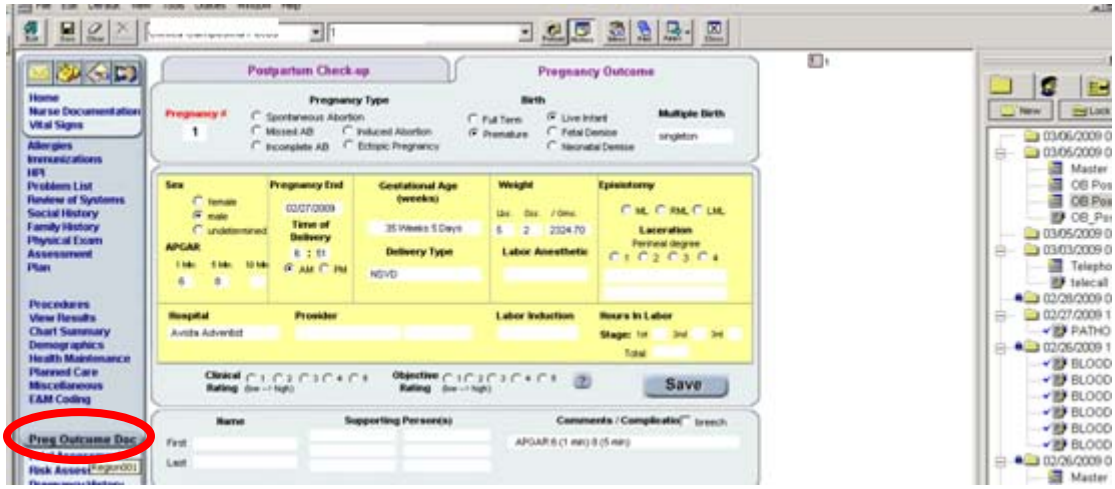
Look to see if any of the patients have been entered already in NextGen and cross off rounds report.

Note: If a provider has entered the information be sure you complete anything they missed (usually breastfeeding). Make sure the baby chart is filled out.

Open OBIX and search for all the patients that have not been previously entered.
Print the OBIX Delivery Report on each mother.

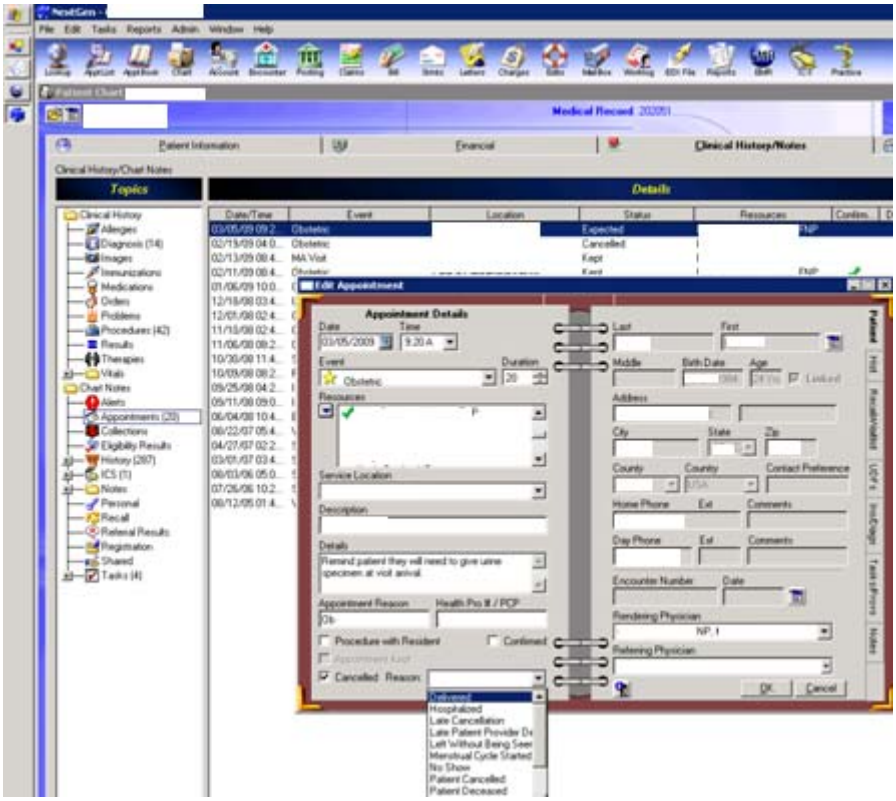
Go to Meditech and look up baby information – Feeding type, Blood Type, Head circumference, length and write each baby's info on the mother's delivery report.

Login to NextGen and end the pregnancy and put in breastfeeding information
Concatenate the report on the mother's chart – See below on where to print the Pregnancy outcome document.



(if you see any problems on the mothers chart like multiple rows for the same pregnancy number email or task Xxxx to fix it.)
Open baby's chart and add birth history –

Look up each patient in the EPM – Clinical history notes, and appointments and cancel any ob appointments they may have. – reason – delivery



Send email to the team on deliveries (name and dob). Be sure patient has appropriate follow up at CHC-A.

Next day:
Check the *Delivery Report for ECS* the next day to ensure that you have not left out any data.. Fix if you did.

Other items:
If you are going to be gone find a person to do your day and notify Xxxx too.

Case managers are responsible for ending pregnancies from SAB's etc. Whenever you see a patient that has had one, please end it.

If a provider has entered the information be sure you complete anything they missed (usually breastfeeding). Make sure the baby chart is filled out.

If any OB patient on your pod delivers at another hospital – track down all the information and end the pregnancy. We must have all the information even if they don't deliver with CHC-A. And it is easier for you to get it right after the delivery than it will be next January when we must have it for UDS. Also, in the meantime we will be able to give better patient care with accurate delivery information.

If you have any questions or problems contact Xxxx at x109 or office xxx-xxx-xxxx or cell xxx-xxx-xxxx

CHC-A
Position Description

CASE MANAGER

Department: Medical **Date Updated: September 2009**
Reports to: COM **Location: Xxxx**

OVERALL PURPOSE:
To uphold CHC-A's mission to serve the medically underserved by providing the highest level of continuously improving quality medical care, health education and preventive services possible, while 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: Provide case management, follow up, support services and counseling to planned care patients and their providers.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

(1) Prenatal Plus program

- Understand requirements and expectations of PN+ Program

- Identify all OB patients on Medicaid and screen for eligibility
  - Print and go through OB Medicaid Report weekly
  - Attend INPs and distribute PN+ Assessments
- Complete comprehensive intakes on all eligible patients
  - Pull aside at/after INP
  - Schedule individual appointments
- Provide continuity care throughout pregnancy in collaboration with pod CM, BHP and PCP
  - Use OB Medicaid Report to track when PN+ patients are coming in
  - Notify pod CM of upcoming visits
  - Assist pod CM in seeing PN+ patients as needed
  - Encourage maximum number of visits
- Confirm all data has been entered correctly and completely in the EMR
  - Audit PN+ Intake Templates in the EMR
  - Fill in missing information with help from pod CM
- Ensure that shadow charts are complete

    - Create and stock blank shadow charts
    - Audit pod CM shadow charts for completeness
- Ensure that completed shadow charts are turned in to supervisor for billing

(2) Brief behavioral health interventions (lower-acuity patients) on pods as needed

- Brief solution-focused counseling
- Depression (PHQ score 14 or below)
- Stress management and relaxation techniques
- Crisis intervention, including agency reporting, as long as it is within CM scope of practice
    - Domestic violence
    - Child abuse & neglect
    - Suicidal ideation
    - Teen confidentiality
- Pregnancy decision counseling
- Facilitate transfer of higher-acuity patients to BHP
- Referrals to community resources as per Resource Cards

(3) Facilitation of patient Group Visits as needed

- Preparation of group materials for education and activities
- Facilitation of patient-group discussions
- Provide Health education:
    - Anticipatory Guidance (pediatric and adult well care)
    - Basic diagnosis-specific education for Planned Care diagnoses
    - Chronic disease self-management skills
    - Self management goal setting

() Demonstrates knowledge of the principles of growth and development over the life span.

(5) Responsible for being timely with attendance.

OTHER DUTIES AND RESPONSIBILITIES:

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

SUPERVISION: No

SCOPE OF AUTHORITY:

- Provide resource coordination, follow up, patient education, and self-management education services to patients and to serve as a consultant to medical staff.
- Request support from professional staff when required.

Progress is reviewed quarterly and results are measured and formally evaluated annually.

POSITION QUALIFICATIONS:

A. Education / Experience

1. Two years college with 5 years equivalent work experience in case management, crisis intervention and client-centered counseling **OR** BA degree in Human Services field.

2. Experience in maternal child health preferred.

B. Knowledge, skills and abilities:

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

PRINCIPAL WORKING RELATIONSHIPS:

- Other pod members and site employees
- Patients
- Outside contacts such as community, other healthcare providers

MATERIALS AND EQUIPMENT DIRECTLY USED:

- *Medical supplies and equipment*
- *Computer*
- *Telephone*

WORKING ENVIRONMENT / PHYSICAL ACTIVITIES:

- *Usual office environment.*
- *Ability to travel from clinic to clinic as required.*
- *Evening or weekend work may be required.*

Process sheet for attending NICU discharge conferences for our babies discharged from the NICU.

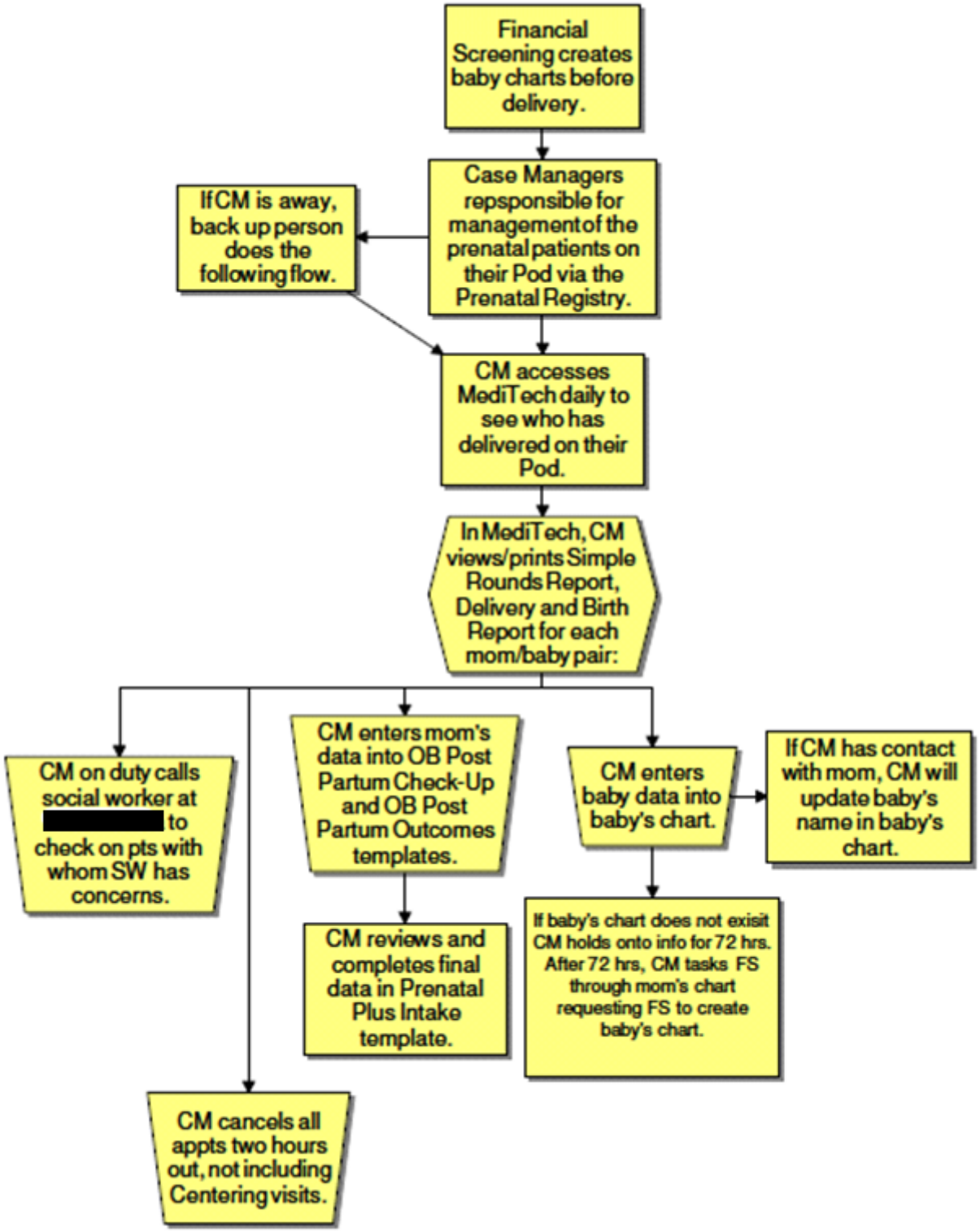
NICU – CHC-A Guidelines

Weekly the X Social Worker, xxxx, is going to the NICU weekly case conference.

1. Case review of CHC-A babies in the NICU in relation to risk factors, infant attachment issues, feeding issues, parenting concerns and discharge planning.
2. Have NICU staff keep copy of discharge paperwork for weekly meetings so xxxx can attach baby's name to Mom's name.
3. When have baby's name, have X front desk staff create EHR chart for baby so providers can enter information and/or notes on the baby prior to discharge if needed.
4. Communicate information from the meeting to the Mom's PCP.
5. Send data on baby to Director, ECS for Synagis program.

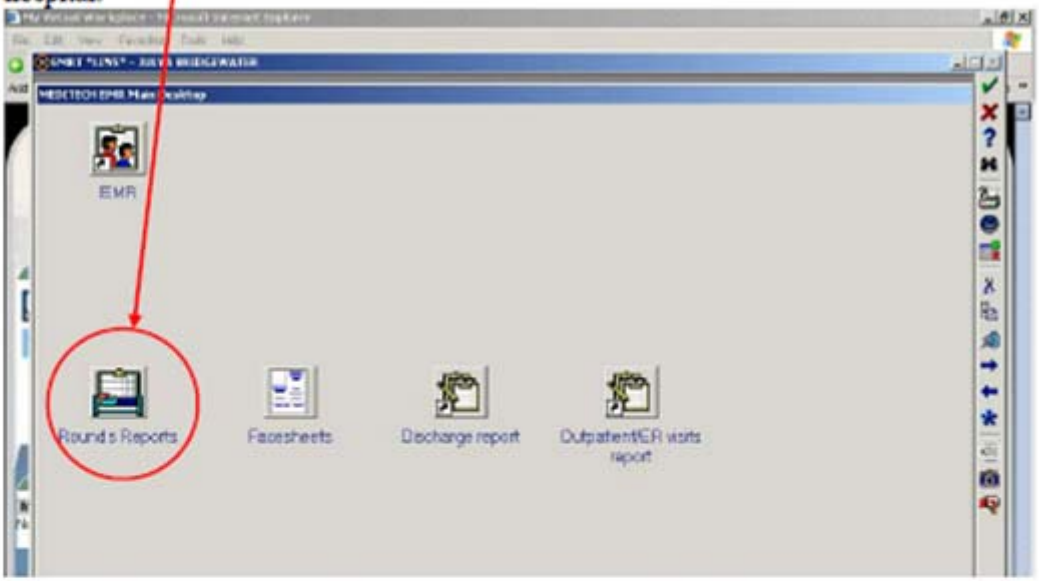
Item 5: Provides or coordinates follow-up care to patients/families who have been discharged

Flow diagram for process of follow up for most common admission and discharge:

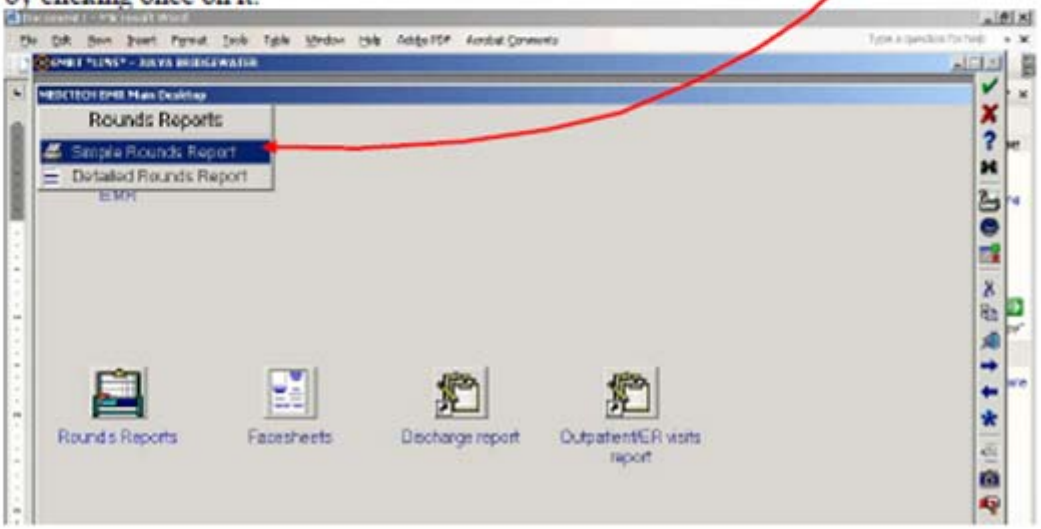


Below are two pages from a 15 page rounding report that we generate to determine who is in the hospital and who is being discharged for follow up. Our Case Managers use this tool to follow our patients and we have been granted access to the system which covers our most common sites of admission.

Click on the Rounds Reports icon in order to get the list of patients currently at the hospital.



This will open a drop-down menu in the top left corner. Select the Simple Rounds Report by clicking once on it.



Item 6: Coordinates care with external disease management or case management organizations as appropriate

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's 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

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

B. Knowledge, skills and abilities:

- Excellent verbal and written communication skills in English and Spanish required.
- Ability to flourish independently and in a team management system
- Sensitivity to low income, ethnic minority community
- 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.

Item 7: Communicates with patients/families receiving ongoing disease management

Asthma Registry Workflow

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

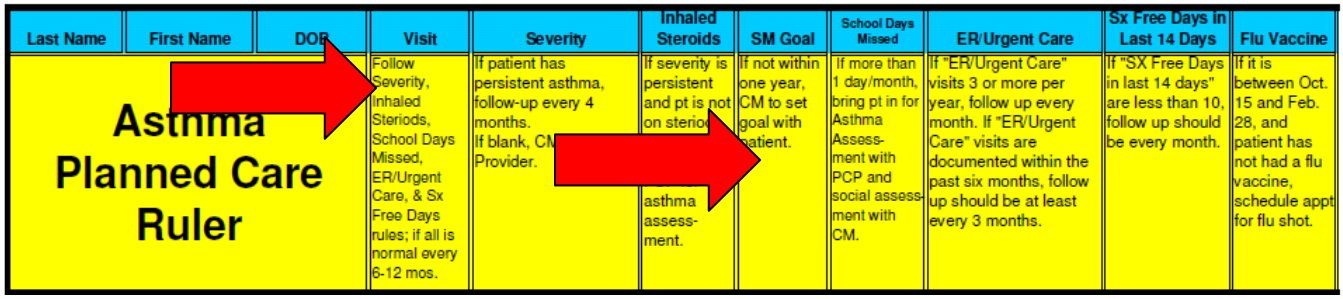
Aim: To maintain a comprehensive and accurate registry of our patients with Asthma in order to perform appropriate and timely care.

Asthma Registry Measures/Goals:	% of patients reporting symptom free days	% of patients with severity assessment Avg symptom free days in last 14 days	% of patients with Persistent Asthma on anti-inflammatory meds	% of patients with ER/Urgent Care visits documented	% of patients with influenza vaccine Avg number of school days missed	% of patients have an annual self-management goal documented

	Actions					
Operations	Print off Asthma registry and workflow the third Tuesday of every month.					
Case Manager	Review registry for last visit, risk stratification, severity, inhaled steroids, ER frequency, sx-free days and SM Goal. Note: For patients who do not have information populated in the flowsheet, CM will open NextGen (and confer with PCP if necessary) and determine if patient is actually a asthma patient. Alert clinical team to patients on huddle report.					
	High Risk	**Severity**	**Steroids**	**ER Frequency**	**SX & School Missed**	**SM Goal**
	Alert provider to patients without a documented Severity Assessment. (Provider to determine whether to assign a Severity Assessment, bring the patient in, or remove from Asthma Registry).	If Severity Assessment includes "Persistent" in description, follow up should be every three to six months.	If Severity Assessment includes "Persistent" in description and patient is not on Inhaled Steroids, schedule asthma evaluation with PCP.	If "ER/Urgent Care" visits 3 or more per year, follow up every month. If "ER/Urgent Care" visits are documented within the past six months, follow up should be at least every 3 months.	If "SX Free Days in last 14 days" are less than 10, follow up should be every month. If more than 1 day/month school missed, bring patient in for Asthma Assessment with PCP and social assessment with CM.	Monitor patients on registry for annual goal. Responsible for connecting with patient to set goal when in for a visit.
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. For patients without a Severity Assessment documented, provider determines whether to assign a Severity Assessment, bring the patient in for an Asthma Assessment, or remove the patient from the Asthma Registry. Providers to decide individually whether they want their patients with COPD also included in the Asthma Registry. Complete Asthma Action Plan and review with patient at each visit as needed.					
MA	Review the flowsheet every visit and enter any new data. Responsible for patients on registry who are in for visit today. Measure and document Peak Flow at each visit. Print Asthma Action Plan in apppropriate language for provider to complete and review with patient.					
Nurse	Reviews copy of registry given by CM to ensure all follow-up has been completed and is accurate.					
Front Desk	Schedule individual Asthma appointments with PCP for list of patients determined by the CM.					

***Contact** **to remove a patient from a registry**

This ruler shows how we use the registry and the ruler as decision support for outreach and communication with patients about their chronic disease, in this case asthma.



Item 8: Communicates with case managers for patients receiving ongoing disease management

We added the position of case manager to each of our micro-system work teams, called pods. They are full time and focused on case management of patients with ongoing disease management issues and prevention.

CHC-A

Position Description

CASE MANAGER

Department: Medical **Date Updated: September 2009**
Reports to: COM **Location: xxxx**

OVERALL PURPOSE:
To uphold CHC-A's mission to serve the medically underserved by providing the highest level of continuously improving quality medical care, health education and preventive services possible, while 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: Provide case management, follow up, support services and counseling to planned care patients and their providers.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

Prenatal Plus program

- Understand requirements and expectations of PN+ Program

- Identify all OB patients on Medicaid and screen for eligibility
  - Print and go through OB Medicaid Report weekly

    - Attend INPs and distribute PN+ Assessments
- Complete comprehensive intakes on all eligible patients
    - Pull aside at/after INP
    - Schedule individual appointments
- Provide continuity care throughout pregnancy in collaboration with pod CM, BHP and PCP
    - Use OB Medicaid Report to track when PN+ patients are coming in
    - Notify pod CM of upcoming visits
    - Assist pod CM in seeing PN+ patients as needed
    - Encourage maximum number of visits
- Confirm all data has been entered correctly and completely in the EMR
    - Audit PN+ Intake Templates in the EMR
    - Fill in missing information with help from pod CM
- Ensure that shadow charts are complete
    - Create and stock blank shadow charts
    - Audit pod CM shadow charts for completeness
- Ensure that completed shadow charts are turned in to supervisor for billing

Brief behavioral health interventions (lower-acuity patients) on pods as needed

- Brief solution-focused counseling
- Depression (PHQ score 14 or below)
- Stress management and relaxation techniques
- Crisis intervention, including agency reporting, as long as it is within CM scope of practice
    - Domestic violence
    - Child abuse & neglect
    - Suicidal ideation
    - Teen confidentiality
- Pregnancy decision counseling
- Facilitate transfer of higher-acuity patients to BHP
- Referrals to community resources as per Resource Cards

Facilitation of patient Group Visits as needed

- Preparation of group materials for education and activities
- Facilitation of patient-group discussions
- Provide Health education:
    - Anticipatory Guidance (pediatric and adult well care)
    - Basic diagnosis-specific education for Planned Care diagnoses
    - Chronic disease self-management skills
    - Self management goal setting

Demonstrates knowledge of the principles of growth and development over the life span.

Responsible for being timely with attendance.

OTHER DUTIES AND RESPONSIBILITIES:

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

SUPERVISION: No

SCOPE OF AUTHORITY:

- Provide resource coordination, follow up, patient education, and self-management education services to patients and to serve as a consultant to medical staff.
- Request support from professional staff when required.

Progress is reviewed quarterly and results are measured and formally evaluated annually.

POSITION QUALIFICATIONS:

A. Education / Experience

- Two years college with 5 years equivalent work experience in case management, crisis intervention and client-centered counseling **OR** BA degree in Human Services field.
- Experience in maternal child health preferred.

B. Knowledge, skills and abilities:

- Excellent verbal and written communication skills in English and Spanish required.
- Ability to flourish in a team management system.
- Sensitivity to low income, ethnic minority community.
- Excellent organizational skills.

PRINCIPAL WORKING RELATIONSHIPS:

- Other pod members and site employees
- Patients
- Outside contacts such as community, other healthcare providers

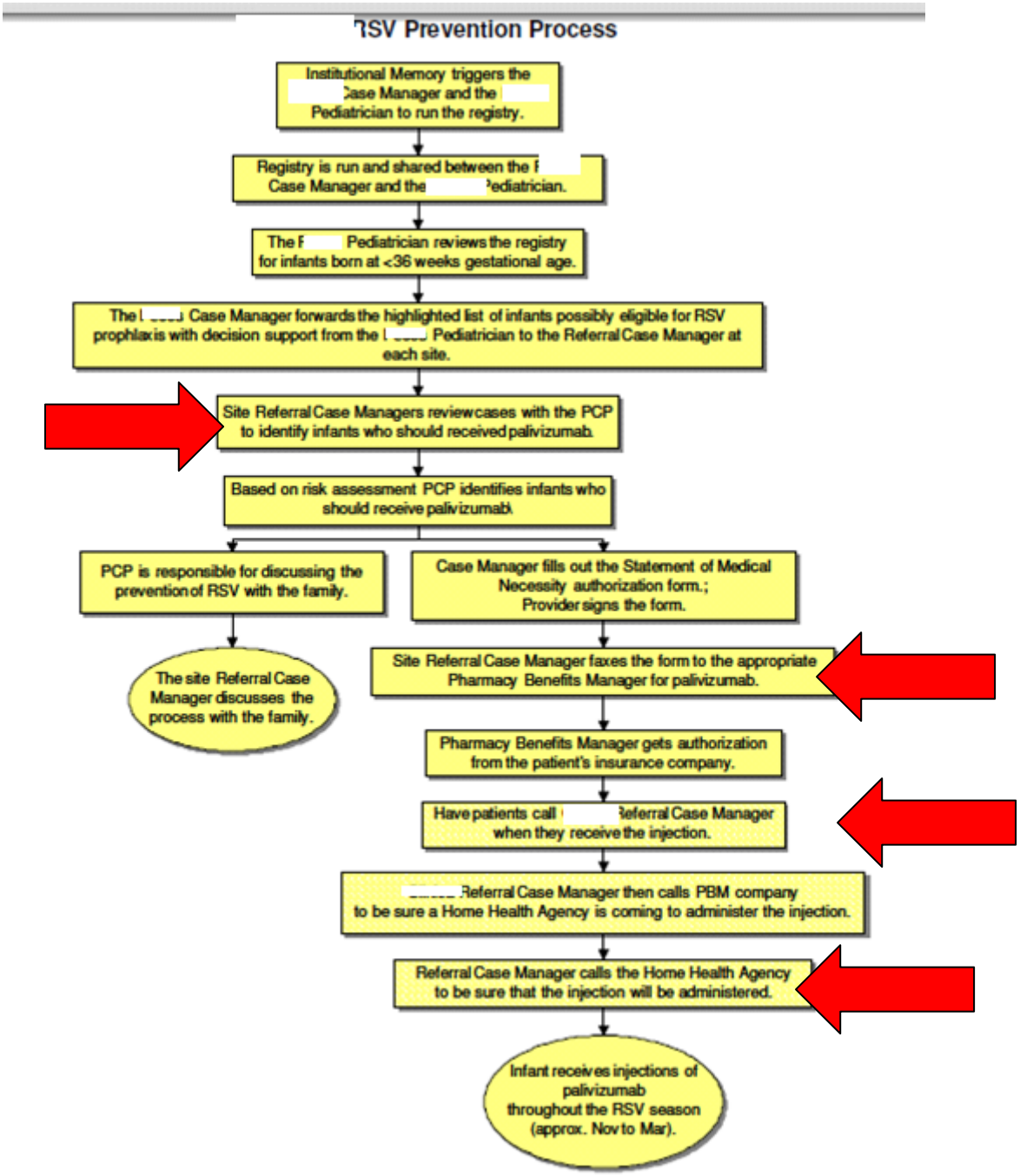
MATERIALS AND EQUIPMENT DIRECTLY USED:

- Medical supplies and equipment
- Computer
- Telephone

WORKING ENVIRONMENT / PHYSICAL ACTIVITIES:

- Usual office environment.
- Ability to travel from clinic to clinic as required.
- Evening or weekend work may be required.

Use of a planned care approach to managing infants at risk for RSV using Case Management and registries to interface with other services for patients and their families.



Item 9: For patients transitioning to other care, develops a written transition plan in collaboration with the patient and family

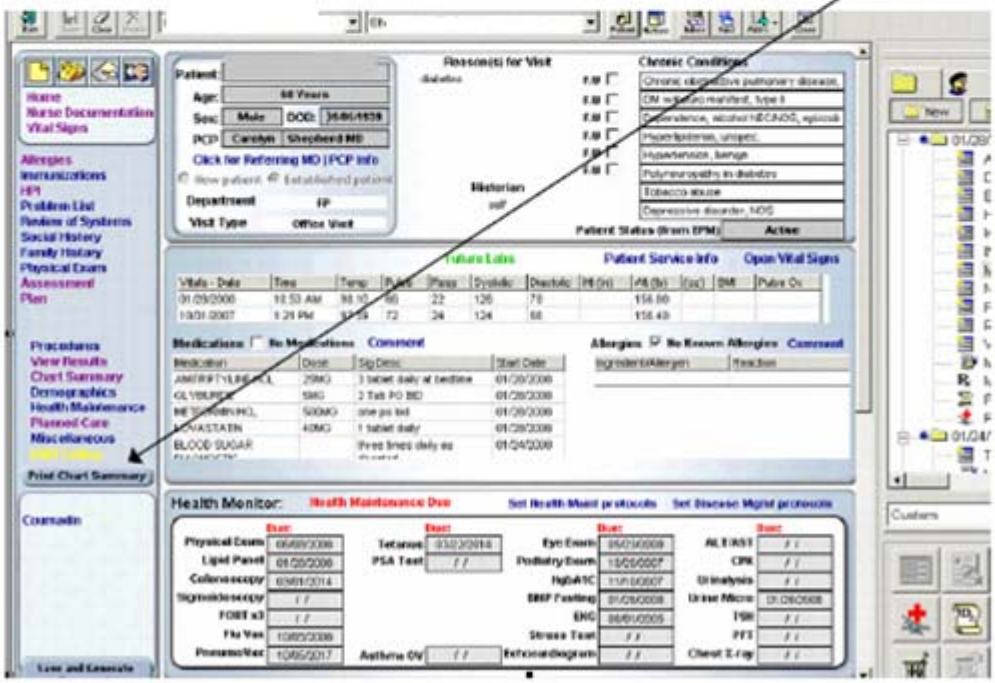
EMR QTS

Reconciling Medication Across the Continuum of Care: Chart Summary

1. For prenatal patients, use the Prenatal Record to transfer the care of these patients to another provider.

2. Patient medications must be reconciled in the following circumstances:
   - Transferring the care of a non prenatal patient from ..... to another provider (hospital, nursing home, hospice, home heath care…); communication with the next provider is documented
   - A patient leaves the organization's care; the current list of reconciled medications is provided and explained to the patient; interaction is documented
   - A patient is care terminated; the current list of reconciled medications is provided to the patient along with the termination letter; action is documented

3. Use the chart summary document to facilitate a seamless handoff in the care of the patient. In an unlocked encounter or new encounter/chart update from the **Master IM** template, click on **Print Chart Summary:**



4. **Click Save** to save the document in the history bar. **Print** Chart Summary to hand to the patient or fax to the receiving care giver.

Chart Summary

Patient:
Date of Birth:

Document Date: 02/18/2008 12:20 PM

Chronic Conditions

1. **Chronic obstructive pulmonary disease, NOS.**
2. **DM w/neuro manifest, type II.**
3. **Dependence, alcohol NEC/NOS, episodic.**
4. **Hyperlipidemia, unspec..**
5. **Hypertension, benign.**
6. **Polyneuropathy in diabetes.**
7. **Tobacco abuse.**
8. **Depressive disorder, NOS.**

Past Medical/Surgical History

Medical

Disease	ICD-9	Status	Year
Depressive disorder, NOS	311		
Upper respiratory infection, acute, NOS	465.9		
Chronic obstructive pulmonary disease, NOS	496		
Asthma, unspec.	493.90		
Disorder, synovium/tendon/bursa NOS	727.9		2005
Diverticulitis of colon, NOS	562.11		
Phase-of-life problem	V62.89		
Hyperlipidemia, unspec.	272.4		
Polyneuropathy in diabetes	357.2		
Male genital disease, other, unspec.	608.9		
Peripheral vascular disease, unspec ie claudicatio	443.9		
Hypertension, benign	401.1		
DM w/neuro manifest, type II	250.60		
Tobacco abuse	305.1		
Rhinitis, allergic cause unspec.	477.9		
Dependence, alcohol NEC/NOS, episodic	303.92		
Health check up, not pediatric	V70.0		
Gout, unspec.	274.9		

Surgical

Procedure	Outcome	Year
R inguinal hernia repair		

Diagnostics:

Date	Test	Interpretation	Result/Report
01/02/2007	Audiometry	Abnormal	Mod to severe hearing loss at high frequencies.
01/02/2007	Esophagram	Abnormal	Moderate Schatzki's ring, small sliding hiatal hernia with mod GE reflux, esophagitis
10/09/2007	EKG	No change from 9/04	NSR, Axis 60, QIII, T wave flat in III, No acute ST/T ware changes, scanned in.
01/02/2007	Chest X ray	Normal	Negative
10/20/2006	Colonoscopy	Normal	negative
08/10/2007	EKG	Normal	No acute ST TW changes.

Parity:

Family History

Family Member	Disease Detail	Age	Age Death
Brother	CAD	59 (cause of death)	1
Brother	Cocaine OD	59 (cause of death)	1

Social History

General Information:

Ethnicity: Hispanic (American Indian Or Alaskan Native).
Marital status is divorced

Tobacco:
Former Tobacco user

Allergies:
No known allergies
Date last asked: 01/28/2009.

Immunizations

Health Maintenance

TEST/EXAM	DATE OF LAST	DUE DATE	DECLINED
Physical Examination(s)			
H & P	06/08/2007	06/08/2008	
Cardiovascular Disease			
Lipid Panel		02/18/2008	
Cancer Screening			
Colonoscopy	03/01/2004	03/01/2014	
Adult Immunizations / Screening			
Influenza	10/05/2007	10/05/2008	
Pneumococcal	10/05/2007	10/05/2017	
Td	03/22/2004	03/22/2014	

Disease Management

TEST/EXAM	DATE OF LAST	INTERVAL	DUE DATE	DECLINED
Eye Exam	05/23/2007	1 Year	05/23/2008	
Podiatry Exam	10/20/2006	1 Year	10/20/2007	
HgbA1C	08/10/2007	3 Months	11/10/2007	
BMP Fasting		1 Year	02/18/2008	
EKG	08/01/2004	1 Year	08/01/2005	
Urine Microalbumin		1 Year	02/18/2008	

Medications:

Brand Name	Dose	Sig Desc	Start Date	Stop Date
Micronase	5mg 01/28/2009	2 Tab PO BID	01/28/2008	
Metformin Hcl	500mg 01/28/2009	one po bid	01/28/2008	
Amitriptyline Hcl	25mg 01/28/2009	3 tablet daily at bedtime	01/28/2008	
Mevacor	40mg 01/27/2009	1 tablet daily	01/28/2008	
Accu-chek	 02/24/2008	three times daily as directed	01/24/2008	
Allopurinol	100mg 09/24/2008	1 tablet daily	10/12/2007	
A.s.a.	325mg 10/05/2026	1 tablet daily	10/05/2007	
Quinapril Hcl	10mg 10/07/2009	1 tablet daily	10/05/2007	
Proair Hfa	90mcg 10/05/2007	2 inhaled doses every 4-6 hours as directed 10/05/2009		
Flovent	110mcg 10/05/2009	2 inhaled doses twice daily	10/05/2007	
Citalopram Hbr	40mg 10/05/2009	one po daily	10/05/2007	

Item 10: Aids in identifying a new primary care physician or specialists or consultants and offers ongoing consultation

CHC-A
Position Description

REFERRAL CASE MANAGER

Department: Medical **Date Prepared: June 2009**
Reports to: Clinic Director **Location: All**

OVERALL RESPONSIBILITIES:
To uphold CHC-A's 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 need access to specialty care.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

- Process referrals for managed care plans, specialty programs such as XCHN, Cancer Screening, to receive authorization and schedule needed appointments.
- Maintains up to date knowledge of managed care referrals process, specialty programs and state rules and regulations for Medicaid, Medicare and CHP Plus.
- Provides case management services to assure all needed information is obtained to facilitate an effective referral.
- Provides case management for all chronic diseases and preventative programs as requested.
- Updates and monitors all referrals being tracked.
- Collects data and writes reports as requested**.**
- Assist with organizational development to maintain an effective referral process.
- Provides information/training to the clinic staff in regards to changes in referral process, change in no payer source referral, and State rules and regulation changes.
- Reports to work on time and on a regular basis.
- Will work at another site as deemed necessary by the Clinic Director.
- Provides superb customer service to all customers (coworkers, out side customers).
- Assist pod case manager when demand for referrals are low.
- 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, follow up, and case management on all referral requests.

Progress is reviewed quarterly and results are measured and formally evaluated annually.

POSITION QUALIFICATIONS:

A. Education / Experience
- Bachelor's degree in the human services field.
- Or HS/GED and four years in referral processing.

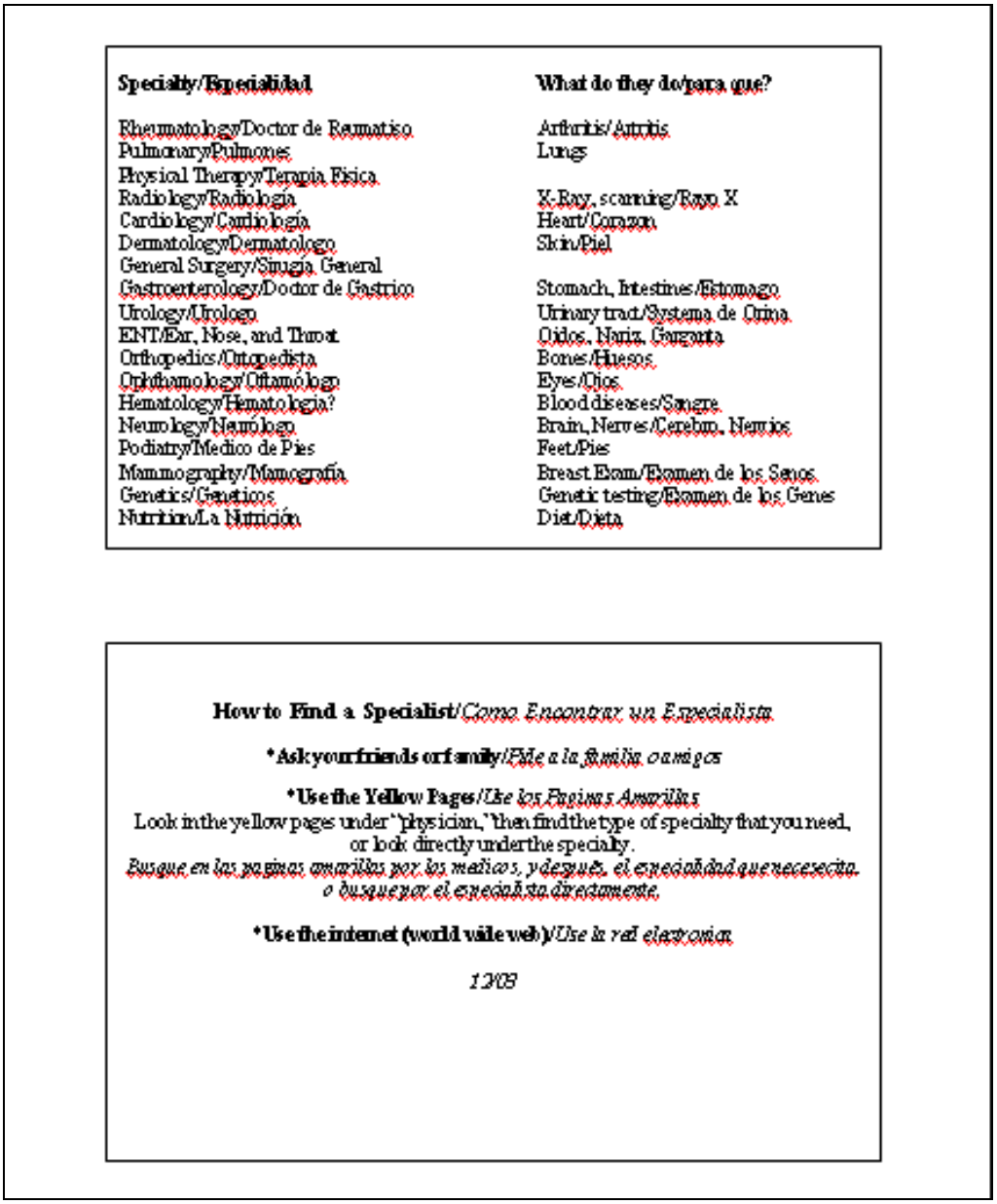
B. Knowledge, skills and abilities:
- Excellent verbal and written communication skills in English and Spanish required.
- Ability to flourish independently and in a team management system
- Sensitivity to low income, ethnic minority community
- Excellent organizational skills.
- Excellent tracking, and documentation

PRINCIPAL WORKING RELATIONSHIPS:
- Other pod members and site employees
- Patients
- Outside contacts such as community, other healthcare providers
- Other referral case managers within the organization

MATERIALS AND EQUIPMENT DIRECTLY USED:
- Fax
- Computer
- Telephone

WORKING ENVIRONMENT / PHYSICAL ACTIVITIES:
- No risk of exposure to blood borne pathogens.
- Usual office environment.
- Ability to travel from clinic to clinic as required.
- Evening or weekend work may be required.

Education card for patients who prefer to find their own specialists:



Specialty/Especialidad	**What do they do/para que?**
Rheumatology/Doctor de Reumatico	Arthritis/Artritis
Pulmonary/Pulmones	Lungs
Physical Therapy/Terapia Fisica	
Radiology/Radiologia	X-Ray, scanning/Rayo X
Cardiology/Cardiologia	Heart/Corazon
Dermatology/Dermatologo	Skin/Piel
General Surgery/Sirugia General	
Gastroenterology/Doctor de Gastrico	Stomach, Intestines/Estomago
Urology/Urologo	Urinary tract/Systema de Orina
ENT/Ear, Nose, and Throat	Oidos, Nariz, Garganta
Orthopedics/Ortopedista	Bones/Huesos
Ophthamology/Oftamólogo	Eyes/Ojos
Hematology/Hematologia?	Blood diseases/Sangre
Neurology/Neurólogo	Brain, Nerves/Cerebro, Nervios
Podiatry/Medico de Pies	Feet/Pies
Mammography/Mamografía	Breast Exam/Examen de los Senos
Genetics/Geneticos	Genetic testing/Examen de los Genes
Nutrition/La Nutrición	Diet/Dieta

How to Find a Specialist/*Como Encontrar un Especialista*

***Ask your friends or family**/*Pide a la familia o amigos*

***Use the Yellow Pages**/*Use los Paginas Amarillas*
Look in the yellow pages under "physician," then find the type of specialty that you need, or look directly under the specialty.
Busque en las paginas amarillas por los medicos, y despues, el especialidad que necesecita. o busque por el especialista directamente.

***Use the internet (world wide web)**/*Use la red electronica*

12/08

Sample letter for communication when arranging specialty care for patients with cancer:

CHC-A

A Commitment Today For Good Health Tomorrow!

Monday, Tuesday, December 20, 2011
Dear, xxxx Clinic

Thank you for agreeing to _____ on _____.
Patient has been instructed to bring in any x-ray she may have had.

Please send bill to:
CHC-A
Attention: xxxx
xxxxxx
xxxx, XX xxxxx

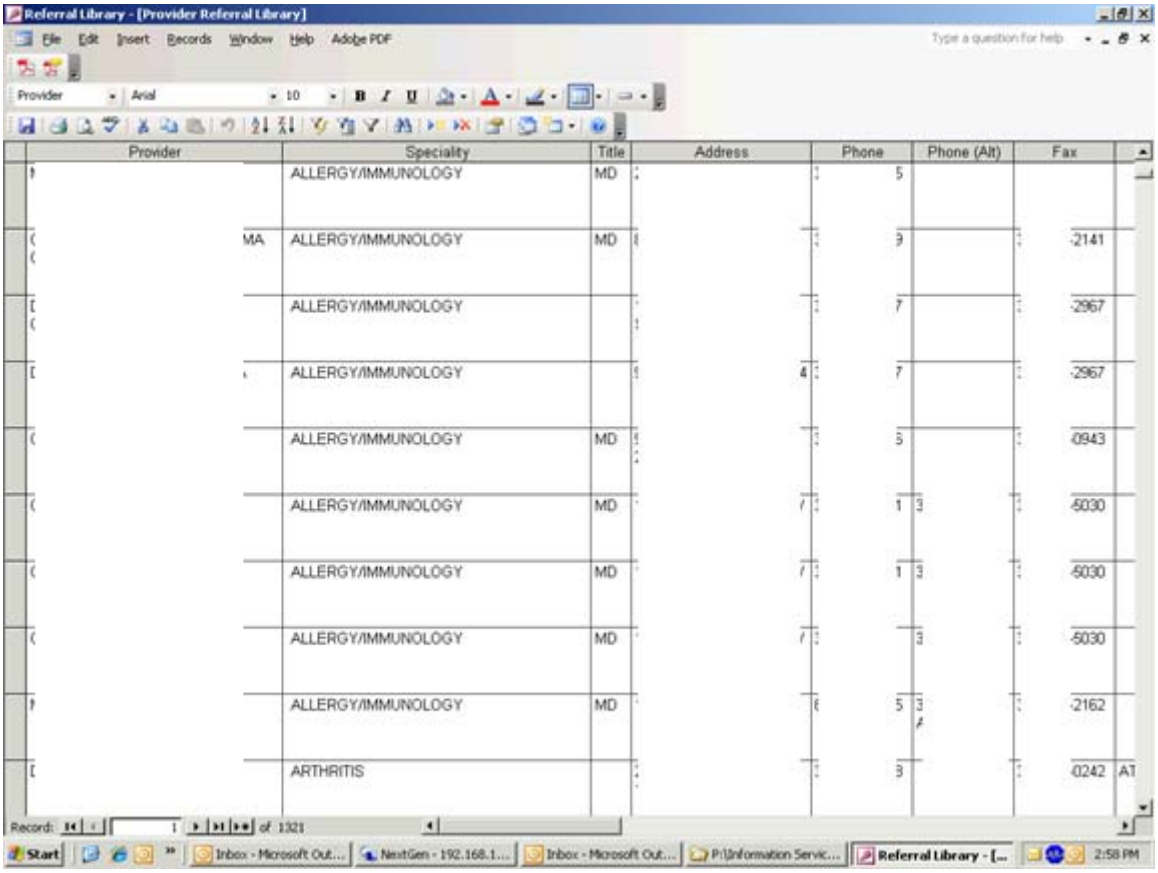
You will be reimbursed at the rates as designated by our contract with Xxxx. If additional services are needed, please contact xxxx at xxx-xxx-xxxx Ext. 284, before they are scheduled or performed. CHC-A is not responsible for any other charges unless xxxx has approved them.

Thank you for your continued support in helping us to provide needed medical services to the medically underserved.

Yours truly,

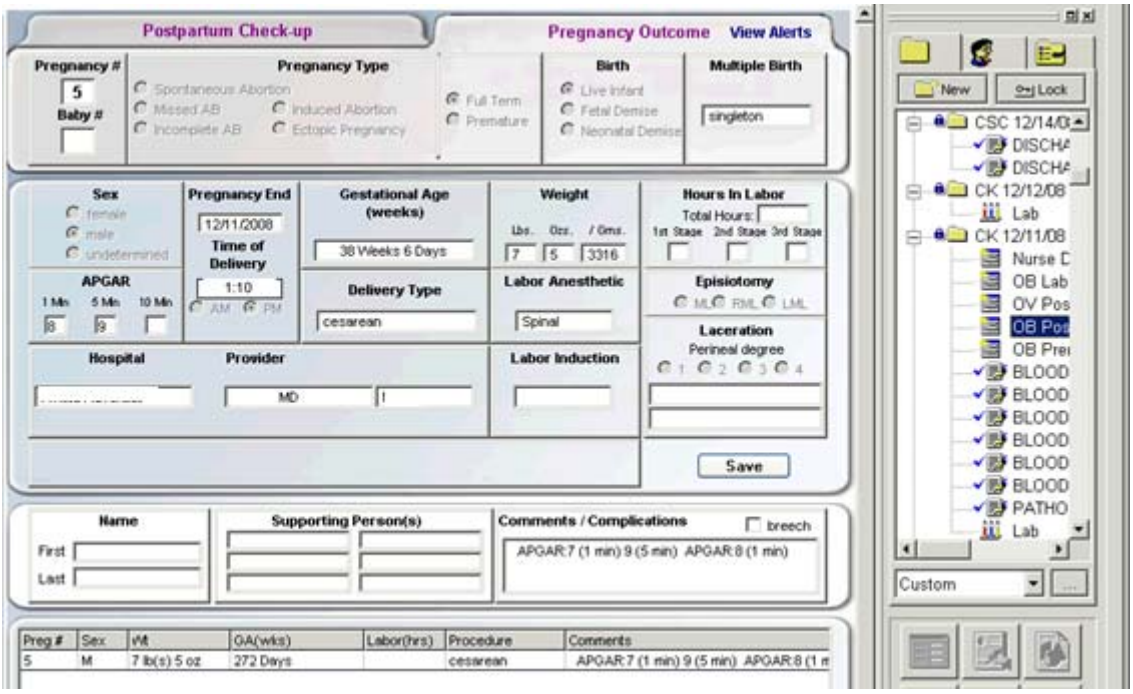
_____
Referral Case Manager
xxx-xxx-xxxx ext 241
101 xxnd Ave

We store our referral resources of specialists who will see uninsured and under-insured patients in a data base. We have over 1300 resources listed. Below is a screenshot of the data base used to help find referrals.



Patient Example of Care Management PPC 3:

We will use this patient as an example of how these procedures work in our system for patients. This patient delivered at 1:10 in the afternoon on 12/11/08. The delivery was documented in our electronic medical record on the same day as delivery by our case managers who had accessed the hospital EMR to look for admissions and discharges. The patient wasn't discharged until 12/14. The discharge summary appears in our EMR on the same day of discharge, and we review any follow up needed when we sign off on the record in the EMR. The case manager proactively contacts the patient and schedules the patient to come back for her post-natal care.



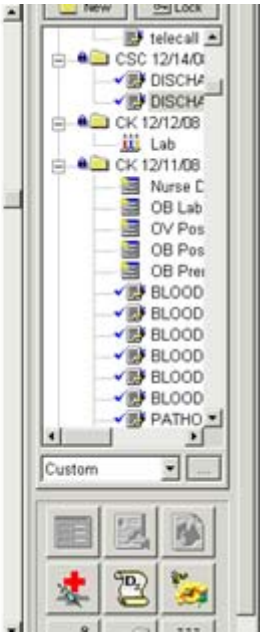
This is the discharge note dictated by one of our physicians-Dr. xxxx. We were alerted to the patient's narcotic issues by Dr. xxxx's note, and we were aware that a report to Social Services had been made by the hospital.

PRIMARY CARE PHYSICIAN:

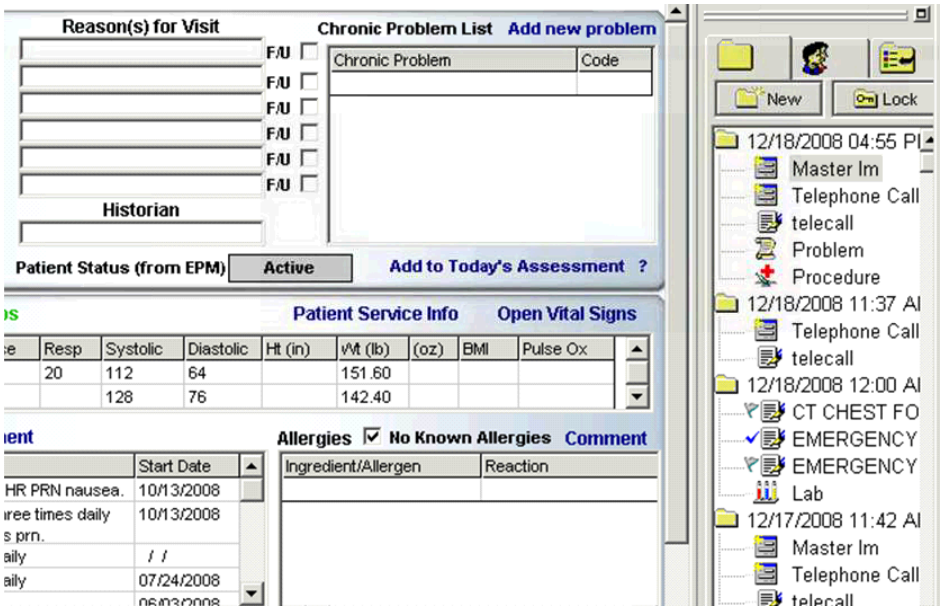
DISCHARGE DIAGNOSES: Fibromyalgia, chronic opioid use, asthma, smoker, elevated blood pressure and lower extremity pain.

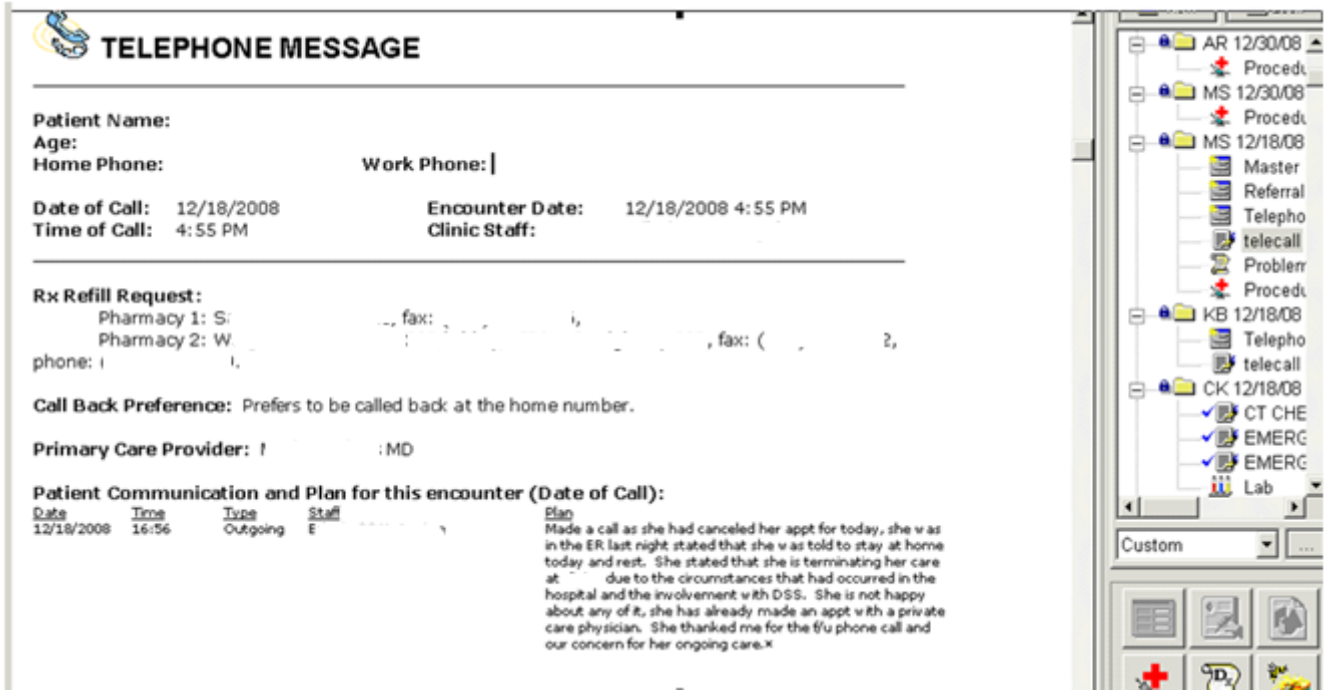
HISTORY AND HOSPITAL COURSE: This is a 33-year-old G3, P3 female who presented not in labor for a repeat cesarean section, which she underwent on December 11, 2008, with the birth of a viable baby boy at 13:10 in the afternoon who was appropriate for gestational age, Apgars are 8 and 9. His birth weight was 3345 grams. She did have a low transverse cesarean section. In her postpartum course she did have an On-Q pump placed for pain control as she has had a history of fibromyalgia and Sweet's syndrome which was being treated during her pregnancy with Subutex, who is buprenorphine. Before this pregnancy she does have a longstanding history of morphine use. She did require some intravenous (IV) morphine for pain control but for the 24 hours before discharge has been able to tolerate Percocet and ibuprofen with reasonable pain control. On the day of discharge her hematocrit is noted to be 33.6. She will be discharged on iron. Her blood pressure was ranging 143/97 to at times normal. This is stable. However, she reports a previous history of hypotension. She does not have any associated headaches or leg swelling. She is postpartum at this point. I suspect that she either has acute elevated blood pressure due to pain or she could have a very mild and resolving postpartum onset of preeclampsia. She does have a history of preeclampsia with her other 2 pregnancies.

DISCHARGE MEDICATIONS:
1. Percocet #120 which I calculated would be a maximum dose for the first week, then tapering down to half maximum dose until she has 2-week followup with her psychiatrist. She should not receive any further Percocet unless deemed so by her PCP.



Based on concerns of the nurse caring for the patient in postpartum, the Department of Social Services was contacted. The patient then went to the emergency room seeking more narcotics.
This patient was then seen in the emergency room on 12/17 at 12:00 AM in the morning. There was a notification in the providers Approval Queue that came in at 12:00 AM on 12/18.





TELEPHONE MESSAGE

Patient Name:
Age:
Home Phone: **Work Phone:**

Date of Call: 12/18/2008 **Encounter Date:** 12/18/2008 4:55 PM
Time of Call: 4:55 PM **Clinic Staff:**

Rx Refill Request:
Pharmacy 1: S fax:
Pharmacy 2: W , fax: (
phone:

Call Back Preference: Prefers to be called back at the home number.

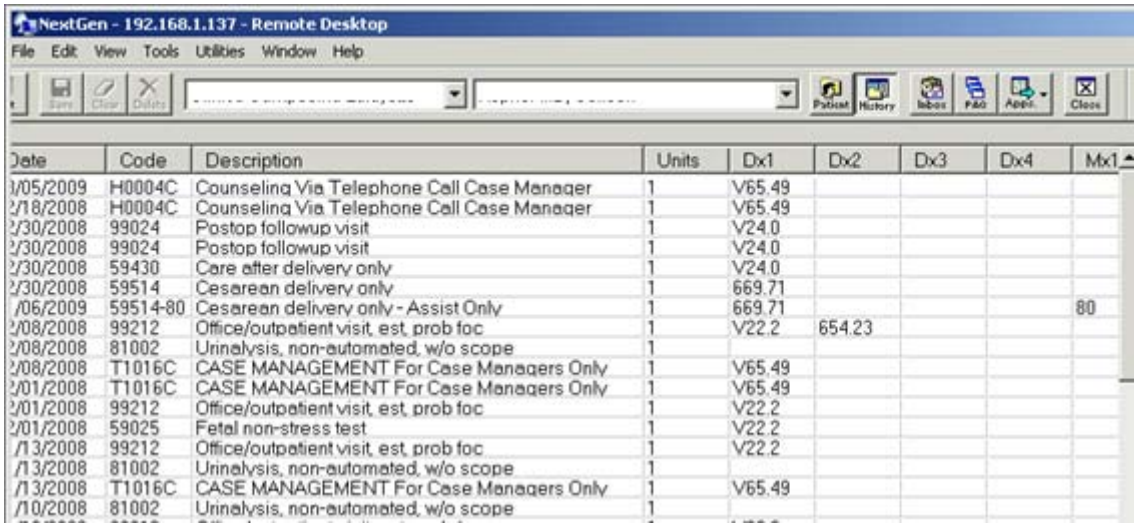
Primary Care Provider: MD

Patient Communication and Plan for this encounter (Date of Call):

Date	Time	Type	Staff	Plan
12/18/2008	16:56	Outgoing	E	Made a call as she had canceled her appt for today, she was in the ER last night stated that she was told to stay at home today and rest. She stated that she is terminating her care at due to the circumstances that had occurred in the hospital and the involvement with DSS. She is not happy about any of it, she has already made an appt with a private care physician. She thanked me for the f/u phone call and our concern for her ongoing care.x

AR 12/30/08 Proced
MS 12/30/08 Proced
MS 12/18/08 Master Referral Telepho telecall Problem Proced
KB 12/18/08 Telepho telecall
CK 12/18/08 CT CHE EMERG EMERG Lab
Custom

This patient continued to get contacts from the Case Managers, the last one being 3/5/2009 to be sure she and the baby were getting care.



NextGen - 192.168.1.137 - Remote Desktop

File Edit View Tools Utilities Window Help

Date	Code	Description	Units	Dx1	Dx2	Dx3	Dx4	Mx1
3/05/2009	H0004C	Counseling Via Telephone Call Case Manager	1	V65.49				
2/18/2008	H0004C	Counseling Via Telephone Call Case Manager	1	V65.49				
2/30/2008	99024	Postop followup visit	1	V24.0				
2/30/2008	99024	Postop followup visit	1	V24.0				
2/30/2008	59430	Care after delivery only	1	V24.0				
2/30/2008	59514	Cesarean delivery only	1	669.71				
/06/2009	59514-80	Cesarean delivery only - Assist Only	1	669.71				80
2/08/2008	99212	Office/outpatient visit, est, prob foc	1	V22.2	654.23			
2/08/2008	81002	Urinalysis, non-automated, w/o scope	1					
2/08/2008	T1016C	CASE MANAGEMENT For Case Managers Only	1	V65.49				
2/01/2008	T1016C	CASE MANAGEMENT For Case Managers Only	1	V65.49				
2/01/2008	99212	Office/outpatient visit, est, prob foc	1	V22.2				
2/01/2008	59025	Fetal non-stress test	1	V22.2				
/13/2008	99212	Office/outpatient visit, est, prob foc	1	V22.2				
/13/2008	81002	Urinalysis, non-automated, w/o scope	1					
/13/2008	T1016C	CASE MANAGEMENT For Case Managers Only	1	V65.49				
/10/2008	81002	Urinalysis, non-automated, w/o scope	1					

The billing module shows that the patient was contacted for patient care follow up and case management five separate times in the two months of her pregnancy.