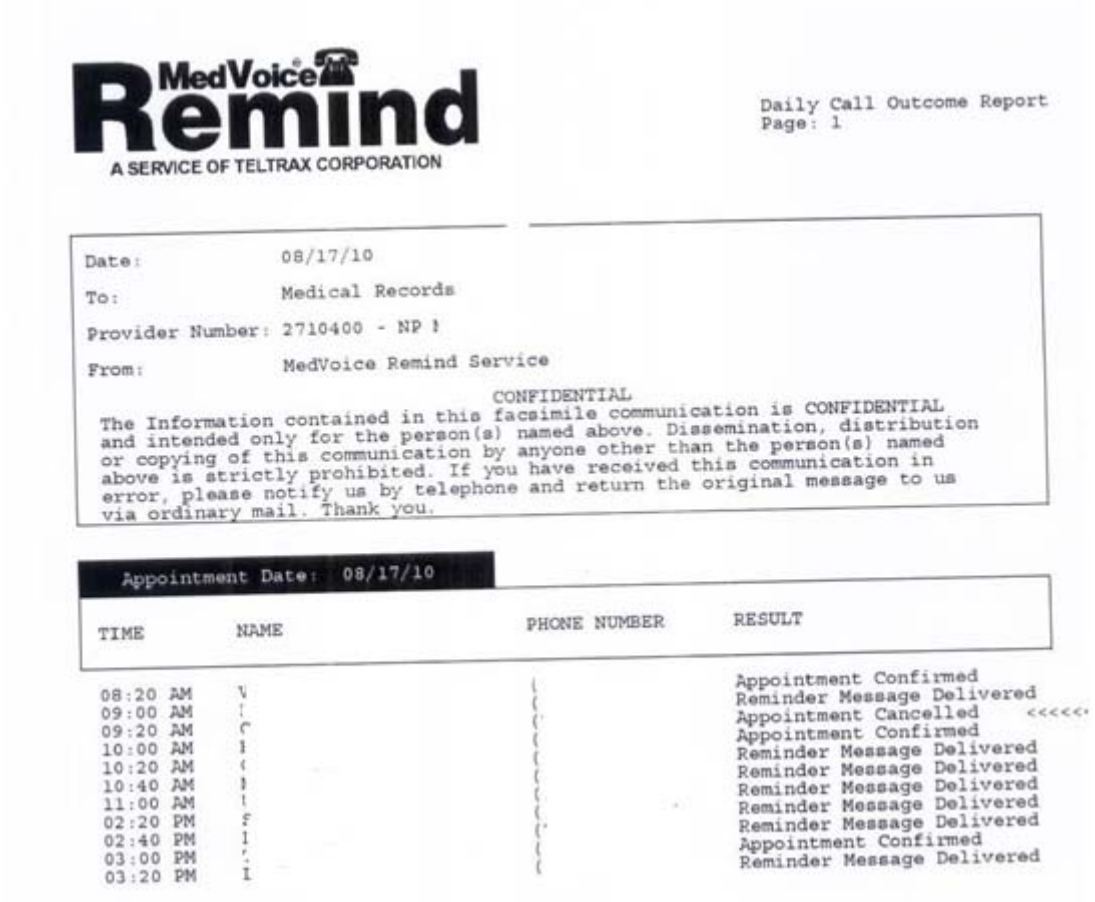
PPC3: Care Management
Element C: Practice Organization

Item 1. Non-physician staff reminds patients of appointments and collect information prior to appointments.

To remind patients of their appointments, we utilize a company called MedVoice. Patients are reminded to bring all their medication, their IZ records, and to let us know if they have new contact information or insurance. Patients can press buttons to confirm or cancel appointment.

We receive confirmation back from MedVoice as to appointment confirmed, delivered message, cancelled appointments, or unable to deliver message. Plans for the day are made accordingly.



MedVoice Remind
A SERVICE OF TELTRAX CORPORATION

Daily Call Outcome Report
Page: 1

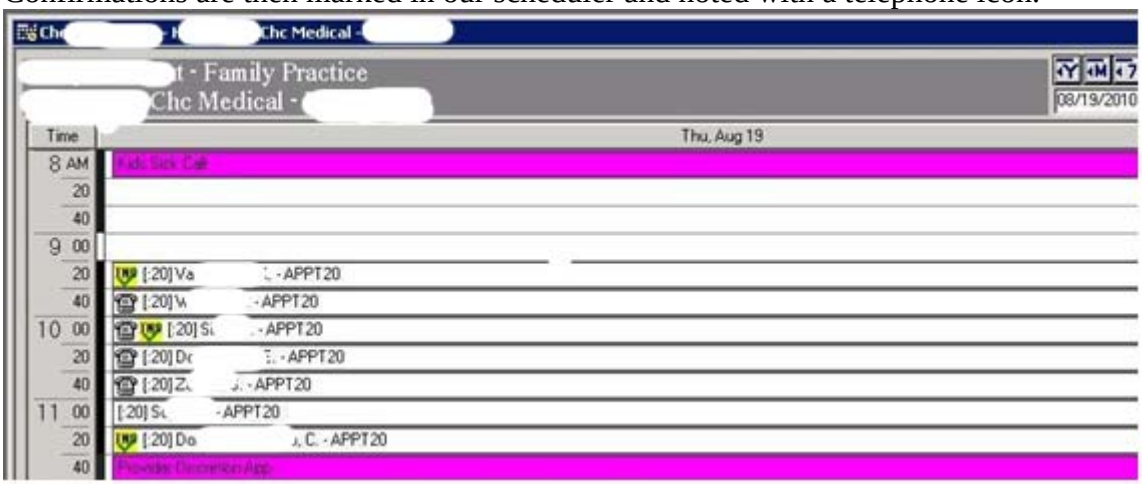
Date: 08/17/10
To: Medical Records
Provider Number: 2710400 - NP 1
From: MedVoice Remind Service

CONFIDENTIAL
The Information contained in this facsimile communication is CONFIDENTIAL and intended only for the person(s) named above. Dissemination, distribution or copying of this communication by anyone other than the person(s) named above is strictly prohibited. If you have received this communication in error, please notify us by telephone and return the original message to us via ordinary mail. Thank you.

Appointment Date: 08/17/10

TIME	NAME	PHONE NUMBER	RESULT
08:20 AM			Appointment Confirmed
09:00 AM			Reminder Message Delivered
09:20 AM			Appointment Cancelled <<<<<
10:00 AM			Appointment Confirmed
10:20 AM			Reminder Message Delivered
10:40 AM			Reminder Message Delivered
11:00 AM			Reminder Message Delivered
02:20 PM			Reminder Message Delivered
02:40 PM			Appointment Confirmed
03:00 PM			Reminder Message Delivered
03:20 PM			

Confirmations are then marked in our scheduler and noted with a telephone icon.



As part of the huddle to prepare for the day, staff would determine if patient contact or collection of information is necessary prior to the appointment. For example, if a patient has not had fasting labs that are due, staff might call the patient to ask them to come in early in the am for those labs or reschedule the appointment for an early morning slot.

Item 2. Non-physician staff executes standing orders for medication refills, order tests, and deliver routine preventive services.

We have standing orders as follows:

CHC-B
STANDING ORDERS

Standing orders may be executed by any medical assistant, LPN, RN, trained patient facilitator, or any other health center staff functioning in the preceding capacity.

For CHC-B patients with **diabetes**, the following labs are needed:

1. Hemoglobin A1c 3-4 times a year, at least three months apart.
2. Blood sugar at every visit.
3. Fasting lipid panel at least once a year.
4. Complete metabolic panel at least twice a year.
5. If the most recent microalbumin is negative and more than 12 months old, or if the patient has never had a microalbumin done, obtain a urine specimen this visit for protein, and if negative, also test for microalbumin.
6. Foot exam twice a year.

For CHC-B patients with **hypertension**, the following labs are needed:

1. Complete metabolic panel at least twice a year.
2. Fasting lipid panel at least once a year.

For CHC-B patients with **COPD:**

1. Baseline Spirometry in patients with COPD and then every 1-2 yrs.

2. Pulse oximetry on every visit for patients with COPD.

For CHC-B patients with **Asthma:**

1. Pulse oxometry and Peak flows on every visit for asthma.
2. Spirometry at baseline and then every 1-2 yrs.

For CHC-B patients who are here for their 1 and 2 year old well child exams:

1. Lead Screenings to be done at 1 and 2 years.

For CHC-B patients with **Depression**:

1. PHQ-9 on all patients between the ages 18 and 64, annually with well exam.
2. Geriatric depression scale in patients 65 and older, annually.
3. Twice a year for the following diagnosis:
    a. DM, HTN, CAD, Chronic pain, those on mood altering drugs (anticonvulsants or antidepressants)
    b. If two consecutive scores less than 5, ok to do it annually.

Health Fair Labs

CBC, TSH, PSA, CMP, and fasting Lipid panel. These specific health fair labs do not have to be ordered by a provider, and may be done as long as the patient has been seen in the last three years by a CHC-B Provider.

Immunization:

Influenza vaccination each flu season, unless contraindicated.
Pneumovax for all patients over age 65 yrs if not contraindicated. Based on CDC recommendations for patients under age 65 yrs.

xxxx 4-16-09

_____ _____

Signed by xxxx, MD
Medical Director of CHC-B

Item 3. Non-physician staff educates patients/families about managing conditions.

This practice uses a team approach to manage patient care. All staff has received formal Motivational Interviewing training and have participated in frequent role playing activities to improve skills for interacting with patients. Patient Facilitators/Medical Assistants are responsible for addressing self management goal setting at each visit. This includes finding out what is important to the patient, assessing and coaching to remove barriers, and documenting a confidence level. PF's and providers refer patients to other resources within our center and to community resources (many of which, CHC-B has been instrumental in starting).
Since 2008, we have had grants for Health Coaches, SBIRT Health Educator, and a Registered Dietician. Here are excerpts from our work plan for one of these grants:

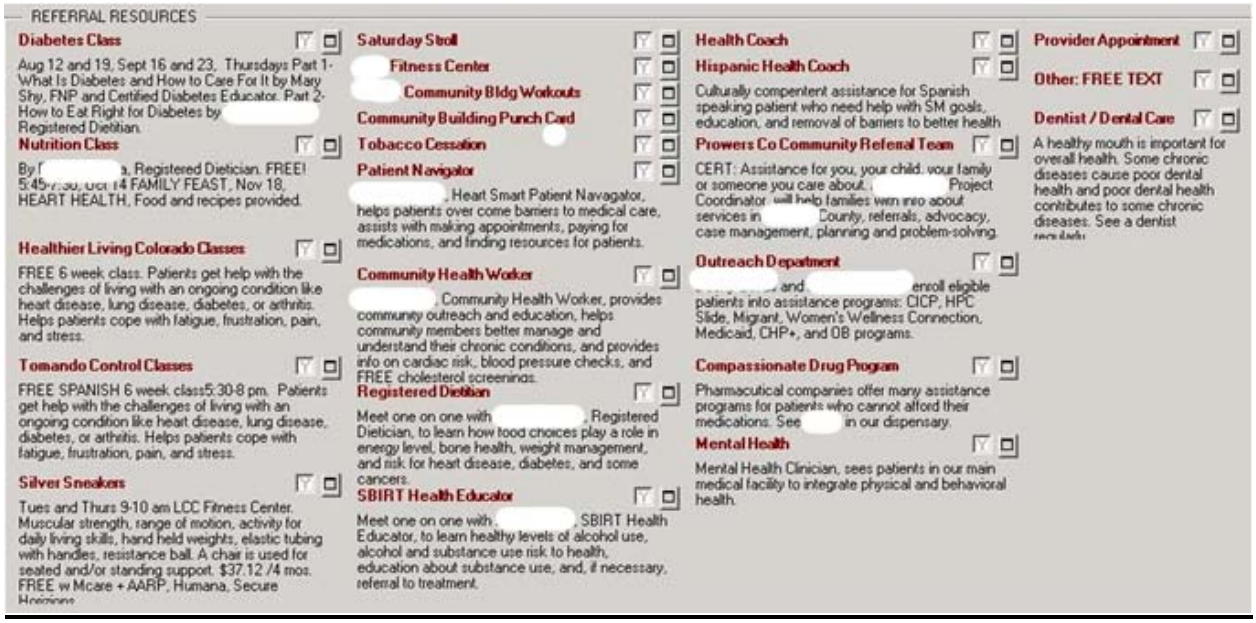
Work Plan: FY08/09	
Goal 1:	**CHC-B patients diagnosed with CVD will have their symptoms managed.**

Long-term Objective:	**By June 2011, 70% of CVD patients will have a blood pressure less than 140/90, 50% will have an LDL value less than 100 and 70% will have a documented self-management plan.**			
Process Objectives (activities)	**Time Frame**			
	Q1 Jul. – Sept., 2008	Q2 Oct. – Dec., 2008	Q3 Jan. – Mar., 2009	Q4 Apr. – Jun., 2009
The electronic health record will produce reports that give the blood pressure, LDL and presence of a self-management for each CHC-B patient diagnosed with CVD. The Patient Navigator will contact at least 40% of CVD patients missing any of these three indicators, encourage compliance and try to eliminate any barriers that prevent the patient from compliance. The Health Educator will contact at least 40% of CVD patients that do not have a self-management plan and attempt to negotiate one.	X			
The Patient Navigator will contact at least 50% of CVD patients missing any of these three indicators, encourage compliance, and attempt to schedule them with one of our providers if the last blood pressure is not within 140/90. The Health Educator will contact at least 50% of CVD patients that do not have a self-management plan and attempt to negotiate one.		X		
The Patient Navigator will contact at least 60% of CVD patients missing any of these three indicators, encourage compliance, and attempt to schedule them with one of our providers is the last blood pressure is not within 140/90. The Patient Navigator will refer challenging non-compliant patients to the RN Case Manager for follow-up and the RN will attempt intensive case management with these referrals. The Health Educator will contact at least 60% of CVD patients that do not have a self-management plan and attempt to negotiate one. The Health Educator will also meet with at least 10 CVD patients per month either in an individual or group setting to provide diet and exercise instruction.			X	X
Goal 4:	**CHC-B patients diagnosed with asthma will be debilitated as little as possible because of their chronic illness.**			
Long-term Objective:	**By June 2011, 90% of CHC-B patients diagnosed with asthma will be on an anti-inflammatory medication, 80% will have a baseline spirometry and 80% will have a documented self-management goal.**			
	Time Frame			

Process Objectives (activities)	Q1 Jul. – Sept., 2008	Q2 Oct. – Dec., 2008	Q3 Jan. – Mar., 2009	Q4 Apr. – Jun., 2009
1) The RN Case Manager will orient self to typical anti-inflammatory medications and their particular usage, make sure that reminders are present in the electronic records to do spirometries on asthma patients as they are seen, ensure that the spirometers are accessible and in good working condition and that needed reports are available from the electronic medical records to track these objectives.	X			
2) The RN Case Manager will review the anti-inflammatory medications being utilized by particular asthmatic patients and make recommendations as needed to the assigned provider, contact patients that do not have a baseline spirometry and attempt to get them to obtain one.		X	X	X
3) The RN Case Manager will refer any asthma patients that do not have a documented self-management plan to the Health Educator		X	X	X

Item 4. Non-physician staff coordinates care with external disease management or case management organizations.

There are very few health plans participating in rural southeast Xxxx that provide disease management or case management. There were also few resources available for patients. Through grants and with much buy-in from our providers, CHC-B has created its own Prevention & Chronic Care Team. Some of these positions below are full time and some are employees who wear several hats and have responsibility for coordinating case management for special programs or teaching classes. Then next screen print shows the resources that we are involved in. Patient lists are generated for each resource and staff make calls to remind patients of classes, remove barriers, and continue motivating the patient to utilize the resource.


REFERRAL RESOURCES
Diabetes Class
Aug 12 and 19, Sept 16 and 23, Thursdays Part 1- What Is Diabetes and How to Care For It by Mary Shy, FNP and Certified Diabetes Educator. Part 2- How to Eat Right for Diabetes by Registered Dietitian.
Nutrition Class
By , Registered Dietician. FREE! 5:45-7:30, Oct 14 FAMILY FEAST, Nov 18, HEART HEALTH, Food and recipes provided.
Healthier Living Colorado Classes
FREE 6 week class. Patients get help with the challenges of living with an ongoing condition like heart disease, lung disease, diabetes, or arthritis. Helps patients cope with fatigue, frustration, pain, and stress.
Tomando Control Classes
FREE SPANISH 6 week class5:30-8 pm. Patients get help with the challenges of living with an ongoing condition like heart disease, lung disease, diabetes, or arthritis. Helps patients cope with fatigue, frustration, pain, and stress.
Silver Sneakers
Tues and Thurs 9-10 am LCC Fitness Center. Muscular strength, range of motion, activity for daily living skills, hand held weights, elastic tubing with handles, resistance ball. A chair is used for seated and/or standing support. $37.12 /4 mos. FREE w Mcare + AARP, Humana, Secure
Saturday Stroll
Fitness Center
Community Bldg Workouts
Community Building Punch Card
Tobacco Cessation
Patient Navigator
, Heart Smart Patient Navagator, helps patients over come barriers to medical care, assists with making appointments, paying for medications, and finding resources for patients.
Community Health Worker
, Community Health Worker, provides community outreach and education, helps community members better manage and understand their chronic conditions, and provides info on cardiac risk, blood pressure checks, and FREE cholesterol screenings.
Registered Dietitian
Meet one on one with , Registered Dietician, to learn how food choices play a role in energy level, bone health, weight management, and risk for heart disease, diabetes, and some cancers.
SBIRT Health Educator
Meet one on one with , SBIRT Health Educator, to learn healthy levels of alcohol use, alcohol and substance use risk to health, education about substance use, and, if necessary, referral to treatment.
Health Coach
Hispanic Health Coach
Culturally compentent assistance for Spanish speaking patient who need help with SM goals, education, and removal of barriers to better health
Prowers Co Community Referal Team
CERT: Assistance for you, your child, your family or someone you care about. , Project Coordinator, will help families learn into about services in County, referrals, advocacy, case management, planning and problem-solving.
Outreach Department
and enroll eligible patients into assistance programs: CICP, HPC Slide, Migrant, Women's Wellness Connection, Medicaid, CHP+, and OB programs.
Compassionate Drug Program
Pharmaceutical companies offer many assistance programs for patients who cannot afford their medications. See in our dispensary.
Mental Health
Mental Health Clinician, sees patients in our main medical facility to integrate physical and behavioral health.
Provider Appointment
Other: FREE TEXT
Dentist / Dental Care
A healthy mouth is important for overall health. Some chronic diseases cause poor dental health and poor dental health contributes to some chronic diseases. See a dentist


HEALTH CENTER
PREVENTION & CHRONIC CARE TEAM
HEALTH EDUCATOR
INTERNAL/EXTERNAL
TEAM LEAD
SELF-MANAGEMENT, DIABETES CLASSES, NUTRITION CLASSES, BMI'S, COMMUNITY EVENTS
DIABETES EDUCATOR
INTERNAL/EXTERNAL
FREE CERTIFIED DIABETES EDUCATION, INSULIN PUMP EDUCATION
COMMUNITY HEALTH WORKER
EXTERNAL
HEART WELLNESS SCREENS, HEALTHIER LIVING COLORADO
PATIENT NAVIGATOR
INTERNAL
PLANNED CARE FOR BLOOD PRESSURE, LDL GOALS, FLU, IZ, CASE MANAGEMENT, HBA1C'S
WOMENS WELLNESS CASE MGR
INTERNAL/EXTERNAL
FREE PAPS & MAMMOS
HISPANIC HEALTH COACH
INTERNAL
SELF MGMT, HEALTHIER, MORE ACTIVE LIVING & TOMANDO CONTROL
IMMUNIZATION COORDINATOR
INTERNAL/EXTERNAL
CHILDHOOD IZ MGMT
HEALTH DISPARITIES COORDINATOR
INTERNAL/EXTERNAL
COMMUNITY FACILITATOR FOR HEALTH DISPARITIES, & HISPANIC HEALTH COACH
COLORECTAL PT NAVIGATOR
INTERNAL
FREE COLONOSCOPY
HEALTH COACH
INTERNAL/EXTERNAL
SELF MGMT, ACTIVE LIVING, SILVER SNEAKERS, HEALTHIER LIVING COLORADO CLASS
SBIRT SCREENER
INTERNAL
TOBACCCO, DRUGS, ALCOHOL SCREEN, BRIEF INTERVENTION AND REFERRAL
HEALTH COACH
INTERNAL/EXTERNAL
SELF MGMT, HEALTHIER ACTIVE LIVING, BEST BUYS LISTS, SOCIAL MEDIA

• CLASS	• INSTRUCTOR	• CLASS INFORMATION	• NEXT CLASS DATES
• **DM Class I**	• xxxx, NP Drxxx (dental)	• **Thursday 6:00-7:30 pm:** Basic diabetes information including the disease process, medications, and routine testing. Dr. Xxxx will show a 10 minute video and have a discussion on periodontal disease.	• **June 10, 2010**
• **DM Cass II**	• xxxx, RD, MS	• **Thursday 5:45-7:30 pm:** How to eat for diabetes! Food and recipes provided.	• **June 17, 2010**
• **Nutrition Class**	• xxxx, MS, RD	• **Thursday 5:45-7:30 pm:** Topics rotate around chronic diseases. Classes are centered around learning how to eat well for chronic diseases.	• May 13, 2010**: Family Feast** June 10, 2010**: Meals in Minutes**
• **Fresh Start**	• xxxx, BA	• **TBA:** Smoking Cessation class. "Tackle tobacco once and for all".	• **TBA**
• **Silver Sneakers**	• xxxx	• **Tuesday & Thursday 9:00am- 10:00am @ LCC Fitness Center** -Exercise to music is designed to increase muscular strength, range of movement, and activity for daily living skills. Hand-held weights, elastic tubing with handles, and a ball are offered for resistance. A chair is used for seated and/or standing support. Patients who have Medicaid, AARP, Humana, and Secure Horizons may be eligible for FREE membership. All other patients it is $37.12 for 4 months.	• **Every Week: Tuesday and Thursday 9:00 - 10:00**
•	•	• **HEALTHIER LIVING XXXX**	•
• **English Class**	• xxxx	• **TBA:** The class meets once per week for six weeks; each session is 2.5 hours long. This program is designed to help people with the challenges they face who either have a chronic condition or live with someone who does. Helps participants cope with fatigue, frustration,	• **TBA**

		pain, and stress.	
• **"Tomando Control" Spanish class**	• xxxx	• **Tuesday: 5:30- 8:00 pm**: This healthier living class provides the same information as above; with bilingual instructors and a focus on the Hispanic/Latino Culture.	• **May 18- June 22, 2010**
•	•	•	•