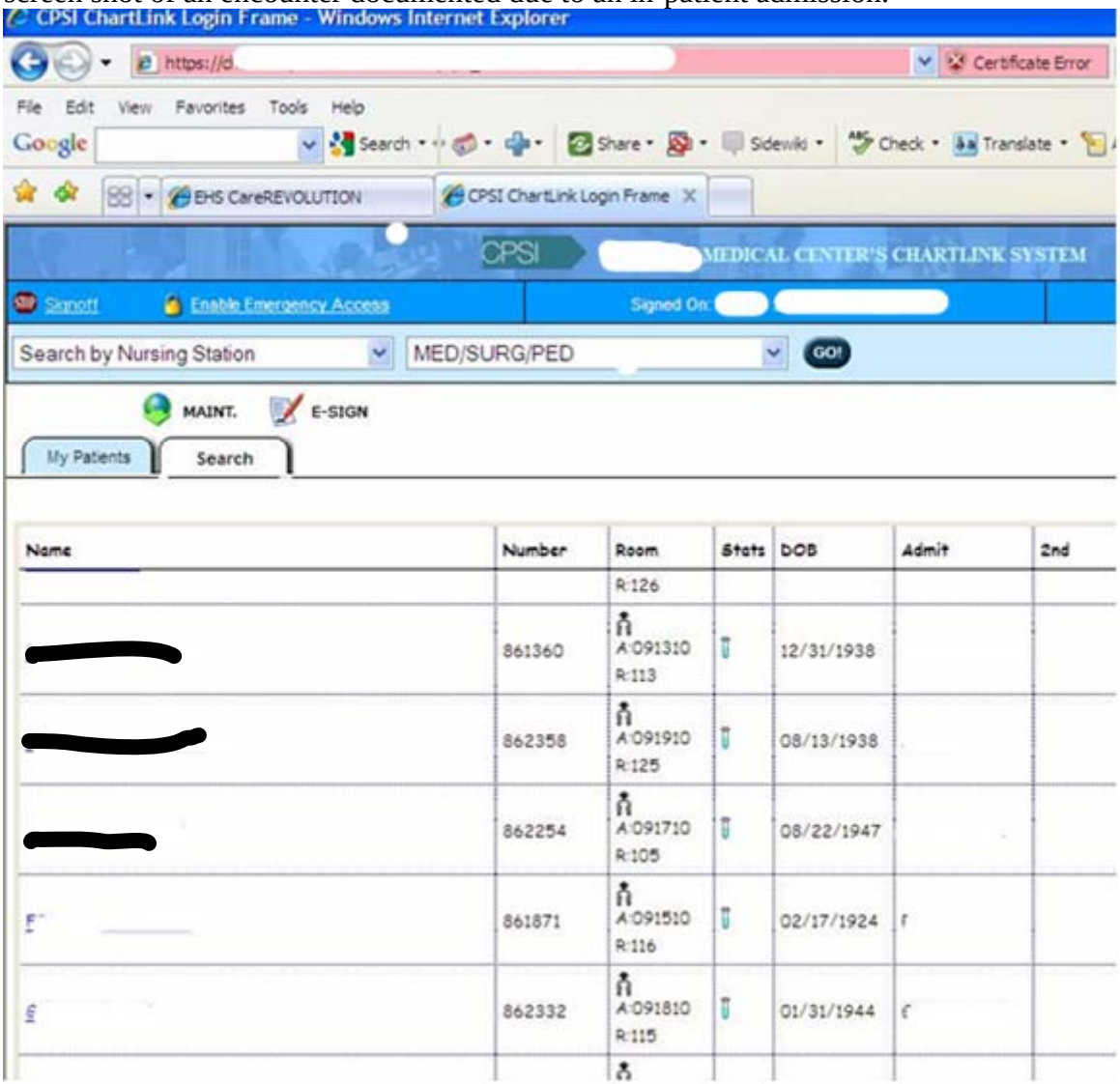
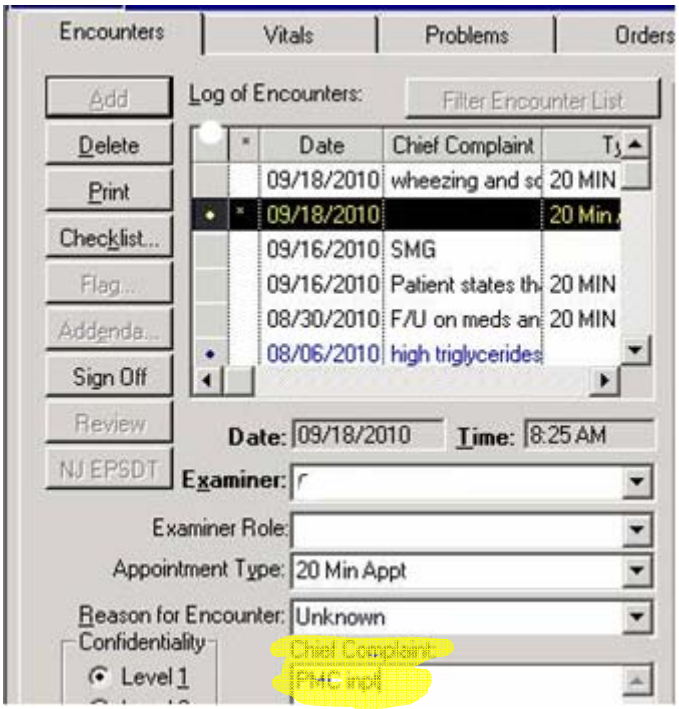
PPC 3: CARE MANAGEMENT
Element E Continuity of Care

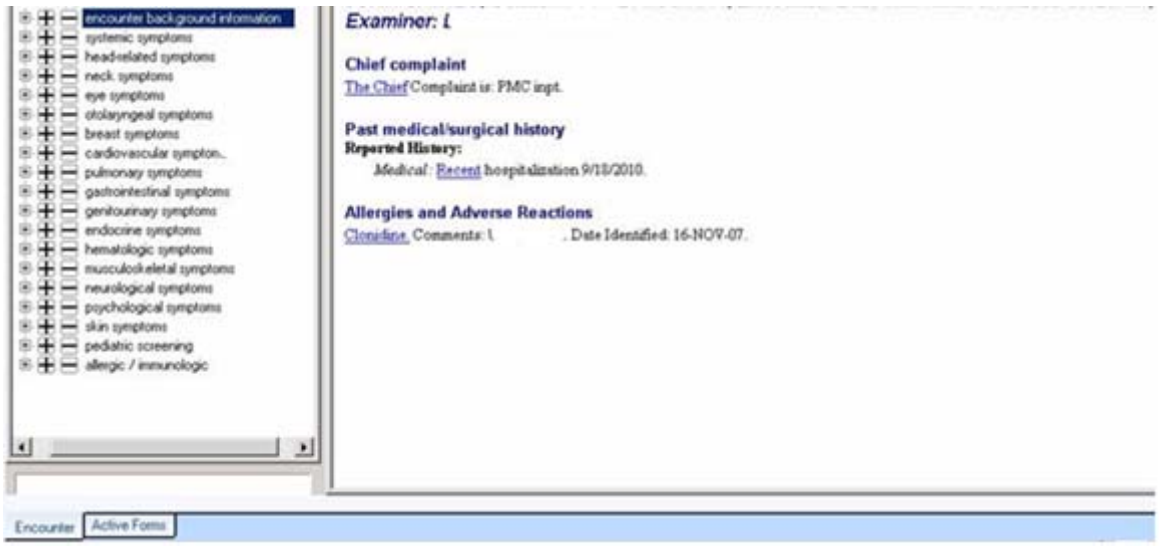
Item 1: Identifies patients who receive care in facilities

We have the ability to look up in-patients at our local hospital. This function is web-based and is reviewed each morning to see which patients are being followed by our providers at the hospital.

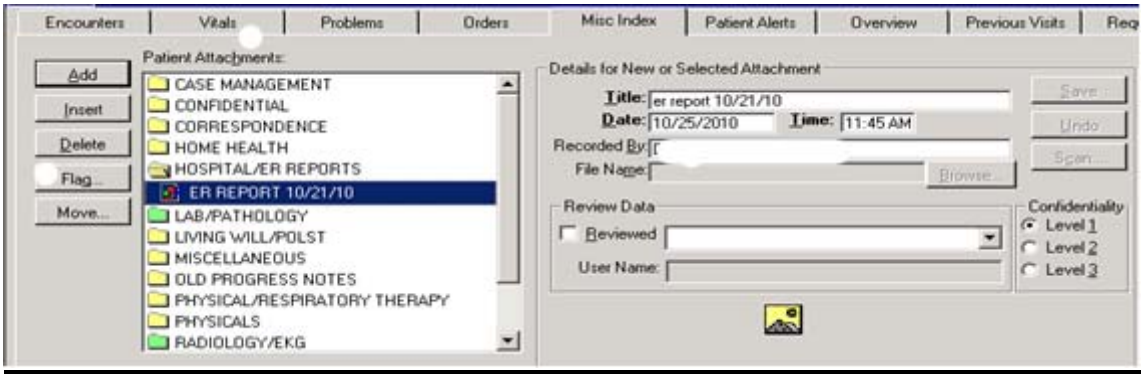
The daily review of the inpatients at the local hospital allows us to open an encounter within our EMR that is flagged to the PCP here. That is helpful because not all patients are direct admission from the clinic and could be admitted by a community on-call doctor. This allows us to alert PCPs that they have a patient in the hospital. Here is a screen shot of an encounter documented due to an in-patient admission.

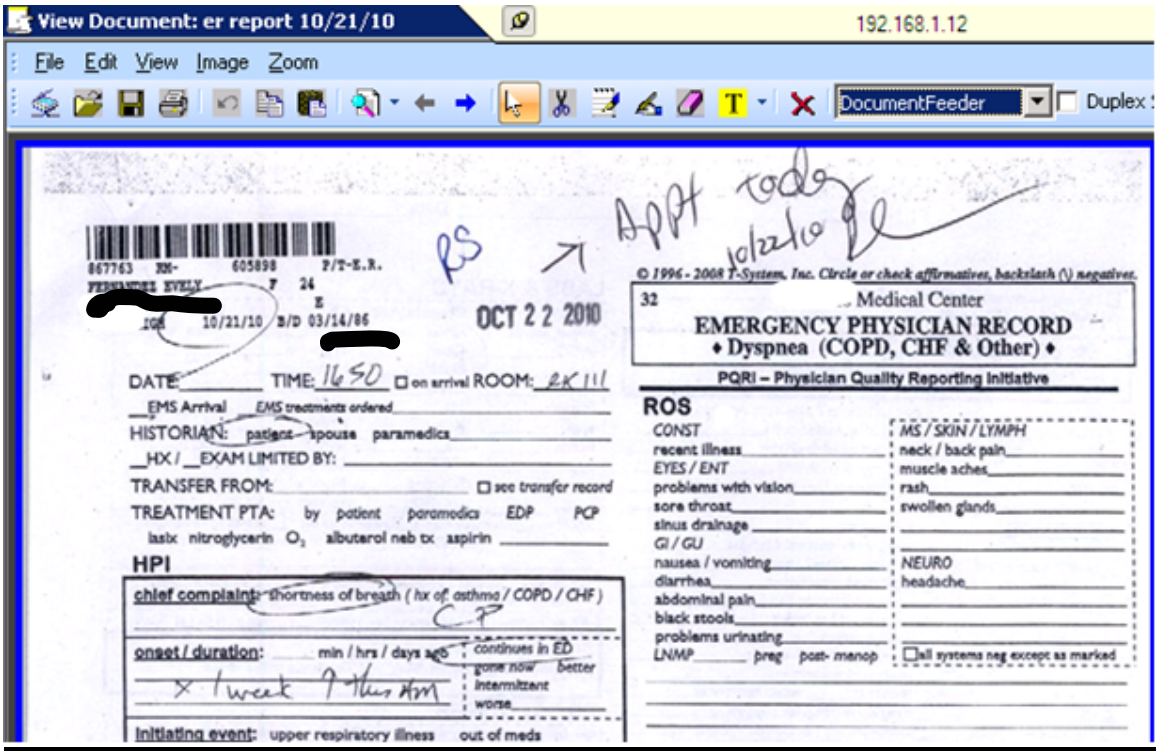






Our local hospital also sends paper ER reports each morning that are distributed to PCP's here so they know which patients utilized the ER. These are also scanned into our medical record. The screen shots shows it filed in the electronic chart under Misc/Index/Hospital ER Reports/ER Report 10/21/10 and the scanned document linked to it.





Item 2: Systematically sends clinical information to facilities

Patients may be transferred via ambulance directly from our clinic or maybe directed via a phone call to go to the emergency room. The following policy outlines the steps used for patients going to the emergency room.

CHC-B
Board Policy & Procedure Manual

Subject: Emergency Transfer of Patients Page3of 16

Purpose: To provide for efficient, continuous care for patients who require emergency room treatment.

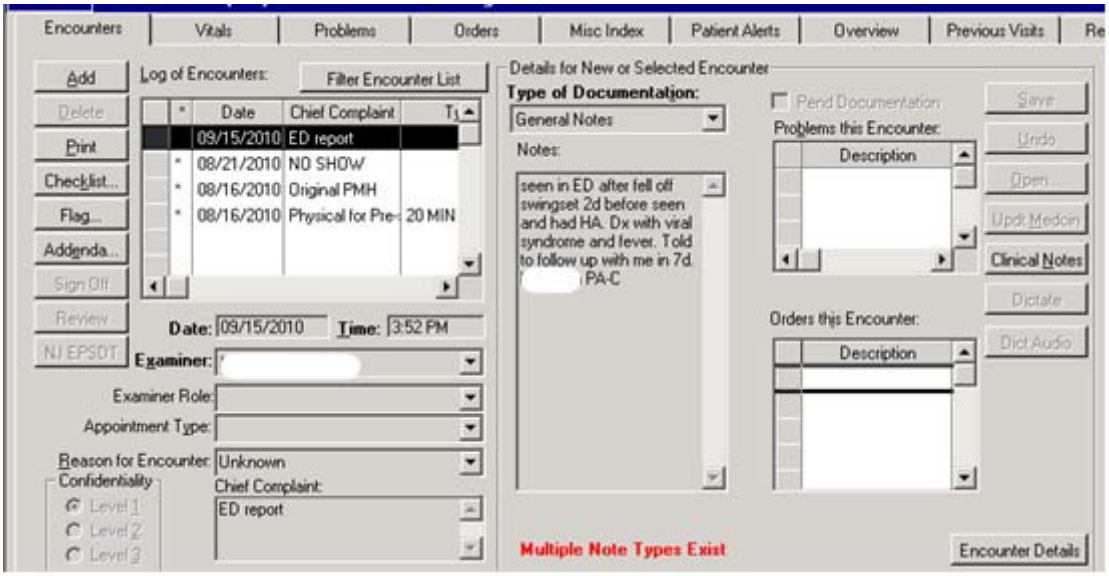
Policy: Staff will ensure effective transfer of important information about the patient's condition at the time of emergent transfer of a CHC-B patient to another facility or when directing a patient to go to the emergency room.

Procedure(s):

1. When a provider makes the decision that a patient needs to be transferred by ambulance to another facility, he/she will instruct a staff person to call 911 to get an ambulance team in route.
2. If the patient's condition allows, the provider or designated staff member should notify the appropriate receiving facility of the patient's condition prior to the transfer. If necessary, this may be done once the patient is on the way to the emergency room.
3. When a provider or a staff person doing telephone triage instructs a patient to go to the emergency room, the provider or designated staff member should notify the appropriate receiving facility of the patient's condition as soon as possible.
4. Written information important to the patient's status will be made available to the ambulance team or will be faxed to the emergency room. Depending on the situation, information provided should include but is not limited to:
    a. The progress note should be completed detailing the events of the clinic visit.
    b. Any medication given during the visit must be recorded in the progress note.
    c. When pertinent, a copy of the problem list and medication list including known allergies.
    d. Results of ongoing monitoring of the patient (vital signs should be checked and recorded every 15 minutes while waiting for the ambulance).
    e. Any lab work done during the visit or recent lab work that may be pertinent.
5. The provider is responsible for notifying appropriate family members of the transfer of a patient from CHC-B to another facility.

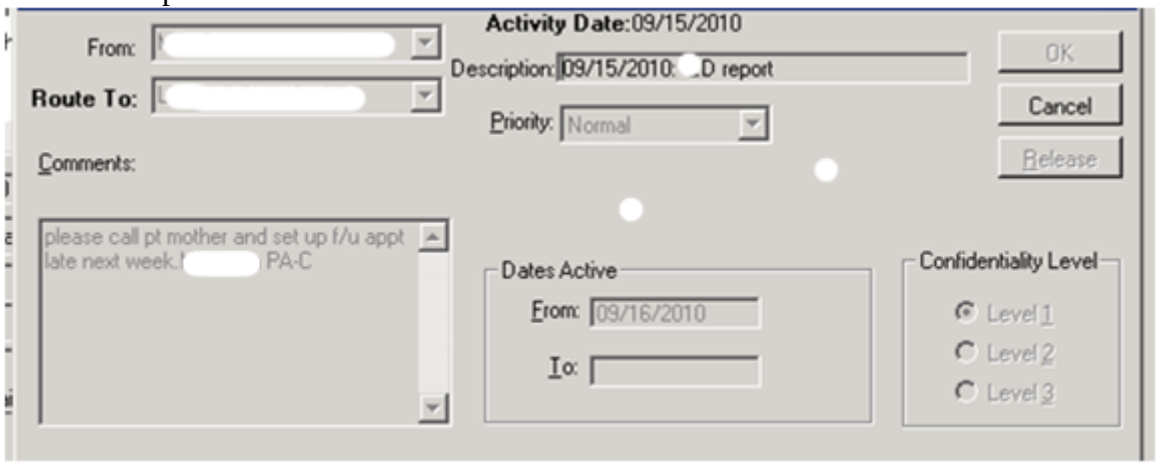
Item 3. Reviews information from facilities to determine patients who require proactive contact outside of patient-initiated visits or who are at risk for adverse outcomes

Each morning, we pick up the paperwork in our in-box at the local hospital. This would include ER reports, discharge summaries, lab, x-ray and other services provided at the hospital. These papers are distributed to the patient's PCP here. Consults and other results received via the mail are also distributed to the patient's PCP. As necessary, each PCP then opens an encounter in our EMR, enters a note, updates problem lists, and enters orders and/or consults. As necessary, this encounter would be flagged to staff for follow up. Here is an example of an encounter note for ER follow up.



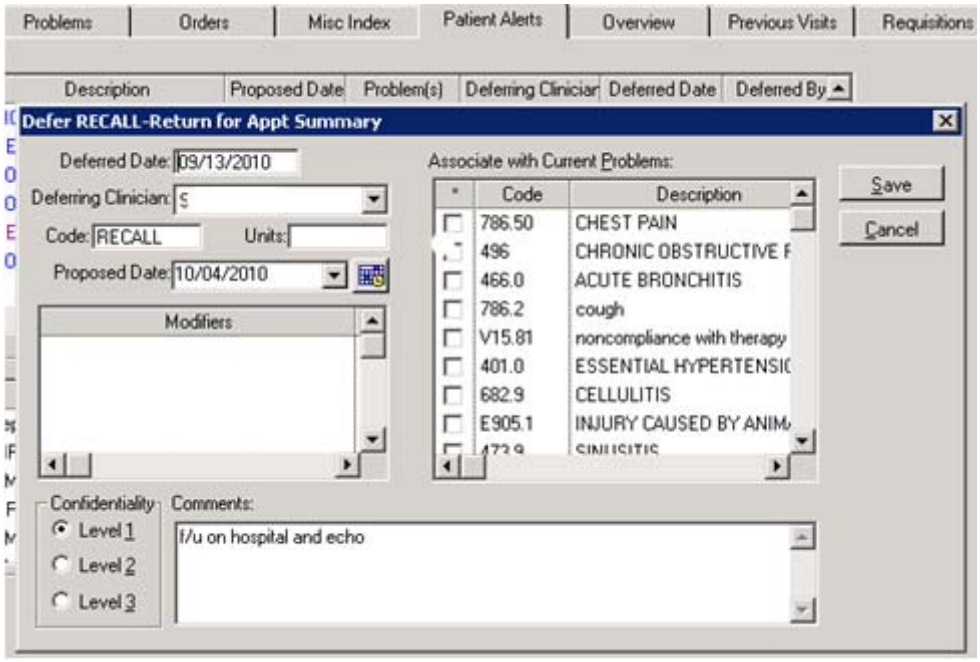
Item 4. Contact patients after discharge from facilities

Each day, staff review flags created by the PCP's and contacts patients who need follow up appointments or referrals. Here is the flag created by the provider after reviewing the above ER report:



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

Each day as results and discharges are reviewed, providers make comments as to necessary follow-up. Staff then notify patients and providers enter deferred orders for future care and/or testing. Here is an example of an echo required after hospital discharge, with follow-up orders entered, and patient notification documented.



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

PROCEDURES

Patient Name: [redacted]
Chart No: [redacted]
Phone: [redacted]
Age: 49 yrs

Date 1st Visit: 09/28/2006
Date Latest Visit: 10/04/2010
Examining Clinician:

Date Ordered	Description	CPT Code	ICD9 Code	Associated Problem	Date Performed
09/13/2010	ECHO EXAM OF HEART	93307	786.50	- Chest Pain	09/13/2010

Order Comments: appt. for mon 9/13/10 @ 10am dmarez pt notified dmarez

Order Results Comments: heart enlargement most likely secondary to uncontrolled bp. pt needs to stop smoking and comply w/ meds. pt w/ poor compliance leaves hospital and er against medical advice (AMA). Heart has good function but already presents w/ problems w/ the blood filling phase. Given uncontrolled bp and chest pain, patient needs to see cardiologist. some other changes most likely secondary to lung problems due to smoking. appt if she needs for explanation. anyway, pt needs appt w/ new pcp within 2 wks. 9-21-10 MLS
pt notified 9-29-10 j

Due to our rural location and very limited coverage by large group insurance plans, we do not consistently work with other disease or case management organizations. We provide lots of patient support internally, coordinate referrals to resources, and assist patients with removal of barriers to their care. We do provide worker's compensation care for many area businesses and work with their RN case managers to coordinate care for those patients. This policy outlines some of the assistance that we provide to patients:

CHC-B
Board Policy & Procedure Manual

Subject: Community Collaboration Page6of 16

Purpose: To encourage a spirit of collaboration with other community resources in order to provide comprehensive care to the patients of the CHC-B.

Policy: Providers, patient facilitators, pharmacy technicians, outreach workers, and dental staff will all work together to provide patients with information regarding services available to meet the patients basic physical, emotional, and spiritual needs.

Procedure(s):

1. Physical Needs- Generally providers will be the party responsible for assessing overall health needs as part of the office visit; however, needs may become obvious to other staff, who will then need to bring these needs to the attention of the provider.
2. Providers, medical assistants, nurses, or patient facilitators will work with specialty providers to obtain medical consultation when needed according to referral policy.
3. Providers, pharmacy technicians, medical assistants, nurses, and patient facilitators will work with patients to obtain necessary medications utilizing any of the following resources:
    a. In house dispensary
    b. Compassionate drug programs of pharmaceutical companies
    c. Salvation army funds
    d. Ministerial Alliance funding
    e. Social Services

1. Patient facilitators, medical assistants, nurses, providers, outreach and dental staff will be responsible for assisting patients in receiving appropriate dental care utilizing the following resources:
    a. CHC-B Dental Clinic
    b. Friends of Man funding

a. Any staff may become aware of a patient with physical needs outside of their direct health needs. CHC-B needs to try to address these needs for our patients as well.

1. Patients facilitators, medical assistants, nurses, providers, and outreach workers will work with patients to identify resources for housing, food, and clothing including:
    a. Xxxx Housing Authority
    b. Food pantry at Xxxx Church
    c. Clothing closet at Xxxx Church
    d. Homeless Shelter
    e. WIC
    f. Social Services
    g. Ministerial Alliance funding
2. Psychological Needs

a. Providers will be primarily responsible for identifying the psychological needs of patients and family; however, other staff may identify needs or patients and family may reveal needs to them that have not been discussed with the provider. In this case, the staff member needs to discuss these needs with the provider involved in order to facilitate appropriate care. Local referral sources included:

1. Providers at CHC-B

2. Xxxx Mental Health
3. Xxxx, counselor
4. Xxxx Care
5. Xxxx Medical Center
6. Xxxx

b. Providers, medical assistants, nurses, or patient facilitators may be confronted with patients who express suicidal ideation. The following guidelines should be followed in handling such a threat:

1. Involve a provider (medical or mental health) if possible.
2. Do not leave the patient unattended.
3. If the patient is at home, see if there is anyone with him/her, if not, obtain the patients current location and try to keep the patient on the phone, while another person contacts the police to go to the patients home.
4. If the patient is in the clinic and no provider is available, call 911. Do not attempt to detain the patient if he/she tries to leave, just get a description of the patient and observe how they leave and in what direction they go and contact the police.
5. If a provider is available in the clinic, he/she will assess the patient and either contact mental health or refer to the emergency room as needed.

c. Providers, medical assistants, nurses, and patient facilitators may be involved with patients needing alcohol or drug rehabilitation. Patients may request treatment or providers may suggest treatment to the patient. Patient facilitators and medical assistants should generally not offer treatment to patients. The following are resources for alcohol and drug treatment:

1. xxxx
2. xxxx Medical Center
3. Alcoholics Anonymous
4. xxxx
5. Drug Free Communities
6. Partnership for Progress

3. Spiritual Needs

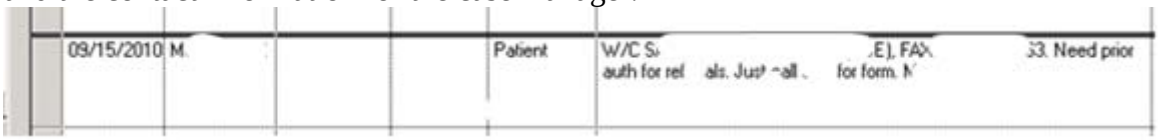
a. All have spiritual needs. Staff should inquire when it seems appropriate whether patients would like involvement of spiritual counsel or support and contact any of the following resources:

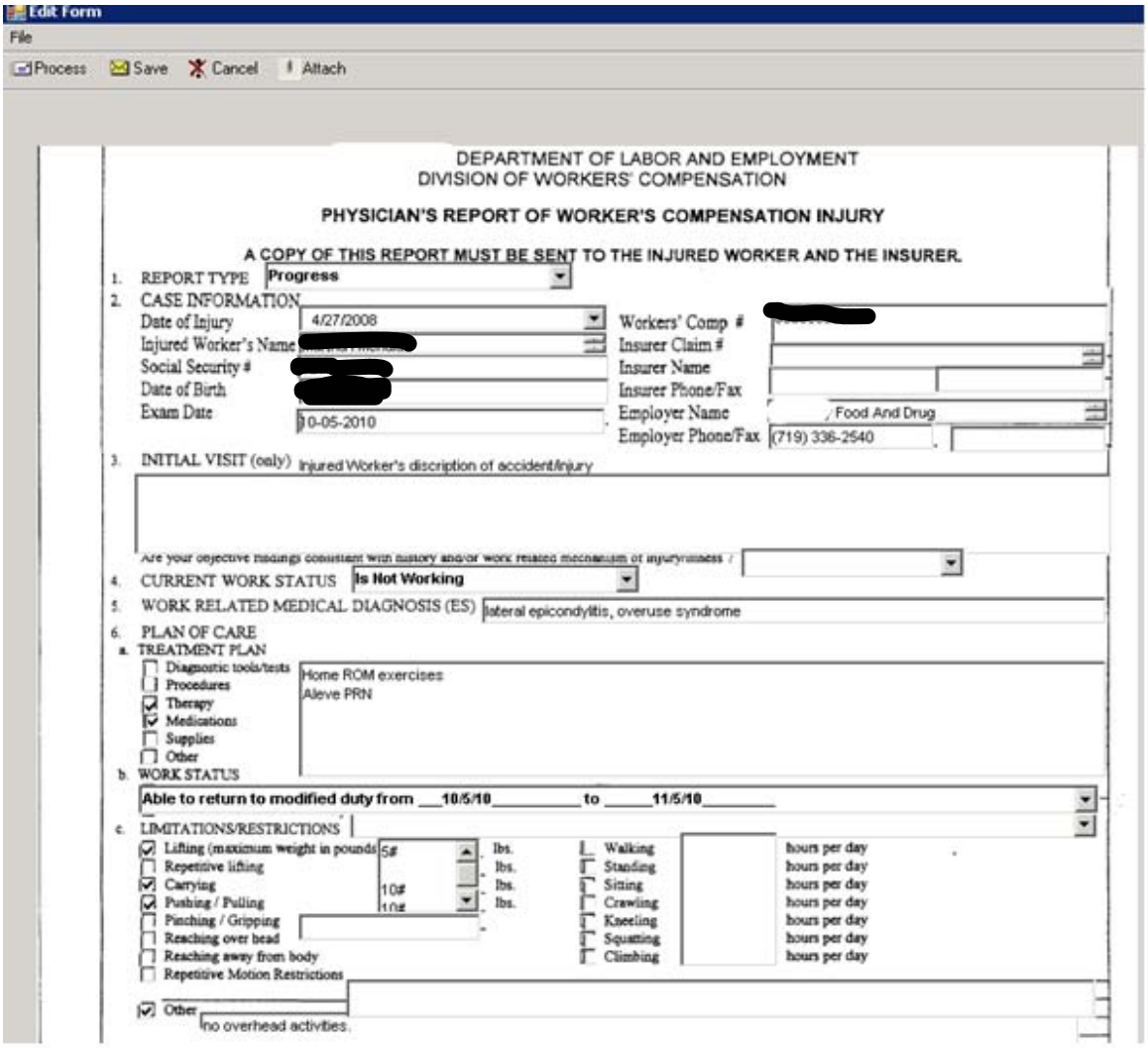
1. Hospital chaplain on call
2. Area churches
3. Other spiritual resources as indicated by patient

4. Quality of Services

a. Providers, patient facilitators, medical assistants, nurses, dental staff, pharmacy technicians, and outreach workers need to constantly evaluate the quality of the interactions and outcomes with referral sources and report any areas of concern to the medical director or administrative officer.

Here is an example of a patient with a work comp case manager and some of the coordination of care that occurs. First, a pop-up alert so staff know patient is work comp and the contact information for the case manager.





A form sent to the case manager following each visit:

Item 7 Communicates with patients/families receiving ongoing disease management or high risk case management.

Because we provide the majority of case management, we use our Collaborative Team to communicate with patients for planned care. Here are excerpts from that work plan:

Work Plan:	
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.**
Intermediate Objective:	**By June 2010, 65% of CVD patients will have a blood pressure less than 140/90, 45% will have an LDL value less than 100 and 65% will have a documented self-management plan.**
Short-term Objective:	**By June 2009, 60% of CVD patients will have a blood pressure less than 140/90, 40% will have an LDL value less than 100 and 60% will have a documented self-management plan.**

Process Objectives (activities)	***Time Frame***			
	Q1 Jul. – Sept.,	*Q2* *Oct. – Dec.,*	*Q3* *Jan. – Mar.,*	*Q4* *Apr. – Jun.,*
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*	*X*	*X*	*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*	*X*	*X*	*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*	*X*	*X*

Work Plan:	
Goal 3:	**Most CHC-B patients will be screened for cervical, breast, colon, prostrate and oral cancer per age and gender clinical protocols.**
Long-term Objective:	**By June 2011, 65% of CHC-B women patients age 21 – 64 will have had a PAP in the previous 3 years, 65% of women patients over age 50 will have a mammogram in the previous 2 years, 50% of patients over 50 will have a colonoscopy within the previous 10 years, 65% of men over 50 will have a PSA in the previous 2 years and 90% of dental patients receiving an oral comprehensive exam will be screened for oral cancer.**
Intermediate Objective:	**By June 2010, 60% of CHC-B women patients age 21 – 64 will have had a PAP in the previous 3 years, 60% of women patients over age 50 will have a mammogram in the previous 2 years, 40% of patients over 50 will have a colonoscopy within the previous 10 years, 60% of men over 50 will have a PSA in the previous 2 years and 85% of dental patients receiving an oral comprehensive exam will be screened for oral cancer.**
Short-term Objective:	**By June 2009, 55% of CHC-B women patients age 21 – 64 will have had a PAP in the previous 3 years, 55% of women patients over age 50 will have a mammogram in the previous 2 years, 30% of patients over 50 will have a colonoscopy within the previous 10 years, 60% of men over 50 will have a PSA in the previous 2 years and 80% of dental patients receiving an oral comprehensive exam will be screened for oral cancer.**

Process Objectives (activities)	***Time Frame***			
	Q1 Jul. – Sept.,	*Q2* Oct. – Dec.,	*Q3* Jan. – Mar.,	*Q4* Apr. – Jun.,
1) The Cancer Prevention Specialist will review screening reports and begin contacting patients lacking required screening to arrange for completion. Resources will be utilized to hurdle any barriers including lack of insurance, transportation, etc. to ensure participation.	*X*	*X*	*X*	*X*
2) The Cancer Prevention Specialist will manage special event clinics such as women's wellness clinics during national breast cancer awareness month, PSA screening clinics, breast self-exam training and Bring a Loved one to the Doctor clinics.	*X*	*X*	*X*	*X*

Work Plan:	
Goal 5:	**CHC-B patients with diabetes will delay the onset of debilitating symptoms as long as possible.**
Long-term Objective:	**By June 2011, the average HgA1c for CHC-B diabetic patients will be 7.0 or lower, at least 80% of diabetic patients will have two HgA1c's per year at least three months apart and 70% will have documented self-management goals.**

Intermediate Objective:	**By June 2010, the average HgA1c for CHC-B diabetic patients will be 7.4 or lower, at least 75% of diabetic patients will have two HgA1c's per year at least three months apart and 65% will have documented self-management goals.**
Short-term Objective:	**By June 2009, the average HgA1c for CHC-B diabetic patients will be 7.8 or lower, at least 70% of diabetic patients will have two HgA1c's per year at least three months apart and 60% will have documented self-management goals.**

Process Objectives (activities)	***Time Frame***			
	Q1 Jul. – Sept.,	*Q2* *Oct. – Dec.,*	*Q3* *Jan. – Mar.,*	*Q4* *Apr. – Jun.,*
3) The Patient Navigator will review electronic health record reports showing the HgA1c of CHC-B patients diagnosed with diabetes and whether there is a self-management goal present on at least a monthly basis.	*X*	*X*	*X*	*X*
4) Patients with a last recorded HgA1c over 8.0 will be called and encouraged to schedule an appointment with their provider if they have not been seen in the past six months. Any that have not met the criteria of two HgA1c's per year at least three months apart will be encouraged to schedule to have an HgA1c completed.	*X*	*X*	*X*	*X*
5) Patients that do not have a documented self-management goal will be referred to the Health Educator who will work with the provider and patient to cause a self-management goal to occur.	*X*	*X*	*X*	*X*

Work Plan:	
Goal 6:	**CHC-B patients with indications of tobacco, alcohol, or drug utilization will be provided the opportunity for treatment.**
Long-term Objective:	**By June 2011, 60% of CHC-B patients over age 17 will be screened for tobacco, alcohol or drug utilization, 70% of those scoring in the at-risk area will be provided a brief intervention by the SBIRT Screener and 60% of those provided a brief intervention will be referred for treatment.**
Intermediate Objective:	**By June 2010, 50% of CHC-B patients over age 17 will be screened for tobacco, alcohol or drug utilization, 60% of those scoring in the at-risk area will be provided a brief intervention by the SBIRT Screener and 60% of those provided a brief intervention will be referred for treatment.**
Short-term Objective:	**By June 2009, 40% of CHC-B patients over age 17 will be screened for tobacco, alcohol or drug utilization, 50% of those scoring in the at-risk area will be provided a brief intervention by the SBIRT Screener and 50% of those provided a brief intervention will be referred for treatment.**

Process Objectives (activities)	Time Frame			
	Q1 Jul. – Sept.,	*Q2* *Oct. – Dec.,*	*Q3* *Jan. – Mar.,*	*Q4* *Apr. – Jun.,*
6) The SBIRT Screener will be trained by Peer Assistance Services, the grantor of the SBIRT program, in the use of a screening instrument, brief intervention and the process for referral. CHC-B medical support staff will be trained how to conduct a brief screen of patients over age 17 for tobacco, alcohol or drug utilization.	*X*	*X*	*X*	*X*
7) The medical support staff will do a brief screen of patients over age 17. Patients presenting at risk on the brief screen for tobacco, alcohol, or drugs will be referred to the SBIRT Screener for a more intense screening to determine need and if cooperative, the SBIRT Screener will refer to the provider and/or Health Educator for tobacco treatment and one of the two local drug treatment organizations for alcohol or drug abuse treatment.	*X*	*X*	*X*	*X*
8) The SBIRT Screener will refer patients screened who are demonstrating symptoms of depression to the Depression Coordinator for referral to the on-site mental health worker	*X*	*X*	*X*	*X*

Our Health Coaches work with patients to set goals & remove barriers to achieving goals. Here is an example of that conversation:

The Chief Complaint is: SMG set HC.

Counseling/Education

- Discussion of education and counseling on Physical Activity: Reviewed benefits of physical activity and role in health. Exploration of patient-driven reasons for change. Edu ation on strategies to incorporate physical activity into lifestyle. Assisted patient in identifying barriers and formulating strategies to overcome barriers
- Patient goals -Use pedometer according to goal:

The patient states that the level of confidence is a _7__ on a one to ten scale that they will be able to acheive this goal.

Plan

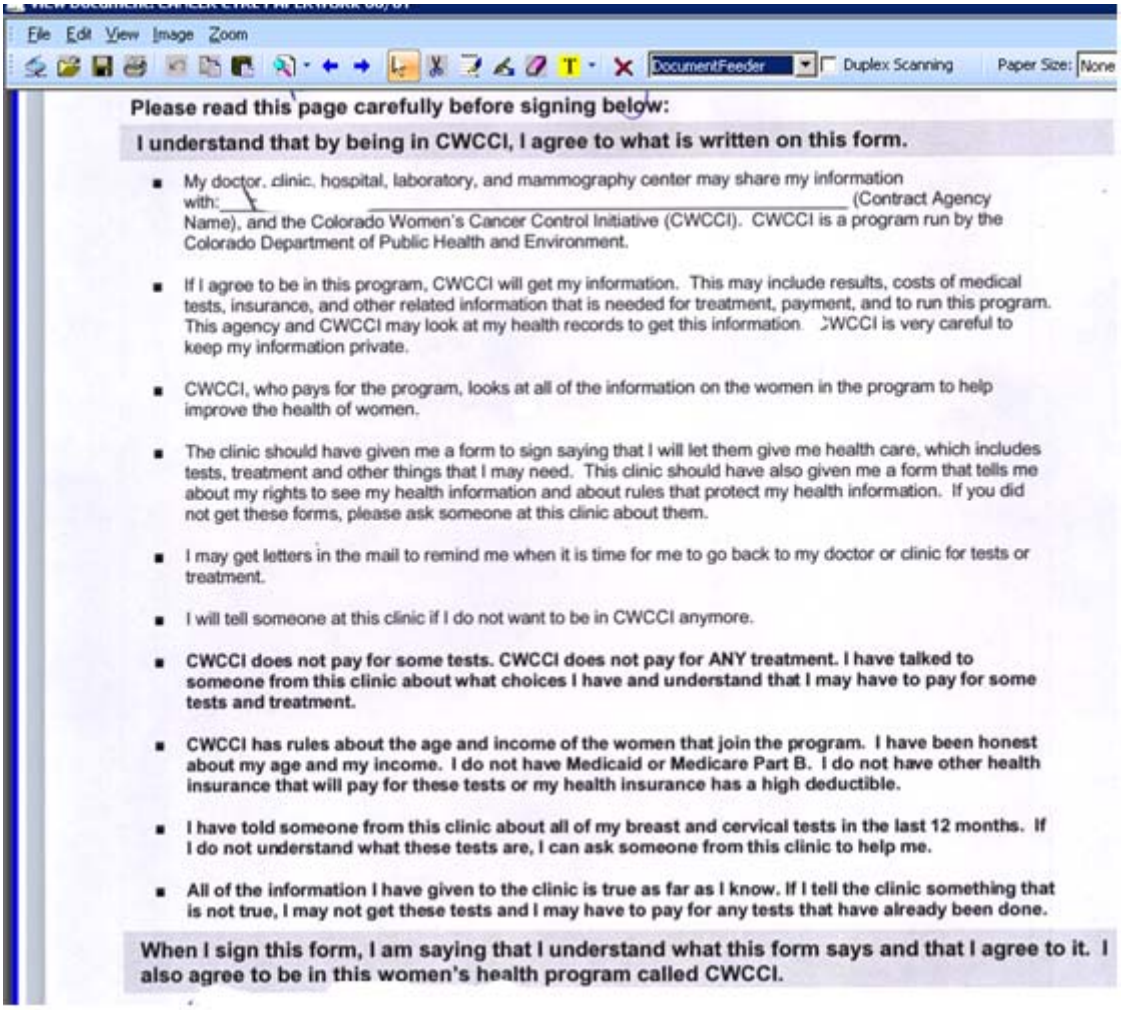
Pt will check her schedule at work and join us for Saturday stroll. She will make small goals for herself until she can reach 10,000 steps on her pedometer.

Notes

Electronically signed by: M a, Health Coach.

Item 8 Communicates with case managers for patients receiving ongoing disease management or high risk case management

We case manage patients for the Women's Wellness Connection which involves enrollment, scheduling, tracking, referrals and follow up for women who qualify for free cancer screenings. This information is all submitted to the Women's Wellness Connection. Here is an example of that agreement with a patient:



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Please read this page carefully before signing below:

I understand that by being in CWCCI, I agree to what is written on this form.

- My doctor, clinic, hospital, laboratory, and mammography center may share my information with: _____ (Contract Agency Name), and the Colorado Women's Cancer Control Initiative (CWCCI). CWCCI is a program run by the Colorado Department of Public Health and Environment.
- If I agree to be in this program, CWCCI will get my information. This may include results, costs of medical tests, insurance, and other related information that is needed for treatment, payment, and to run this program. This agency and CWCCI may look at my health records to get this information. CWCCI is very careful to keep my information private.
- CWCCI, who pays for the program, looks at all of the information on the women in the program to help improve the health of women.
- The clinic should have given me a form to sign saying that I will let them give me health care, which includes tests, treatment and other things that I may need. This clinic should have also given me a form that tells me about my rights to see my health information and about rules that protect my health information. If you did not get these forms, please ask someone at this clinic about them.
- I may get letters in the mail to remind me when it is time for me to go back to my doctor or clinic for tests or treatment.
- I will tell someone at this clinic if I do not want to be in CWCCI anymore.
- **CWCCI does not pay for some tests. CWCCI does not pay for ANY treatment. I have talked to someone from this clinic about what choices I have and understand that I may have to pay for some tests and treatment.**
- **CWCCI has rules about the age and income of the women that join the program. I have been honest about my age and my income. I do not have Medicaid or Medicare Part B. I do not have other health insurance that will pay for these tests or my health insurance has a high deductible.**
- **I have told someone from this clinic about all of my breast and cervical tests in the last 12 months. If I do not understand what these tests are, I can ask someone from this clinic to help me.**
- **All of the information I have given to the clinic is true as far as I know. If I tell the clinic something that is not true, I may not get these tests and I may have to pay for any tests that have already been done.**

When I sign this form, I am saying that I understand what this form says and that I agree to it. I also agree to be in this women's health program called CWCCI.

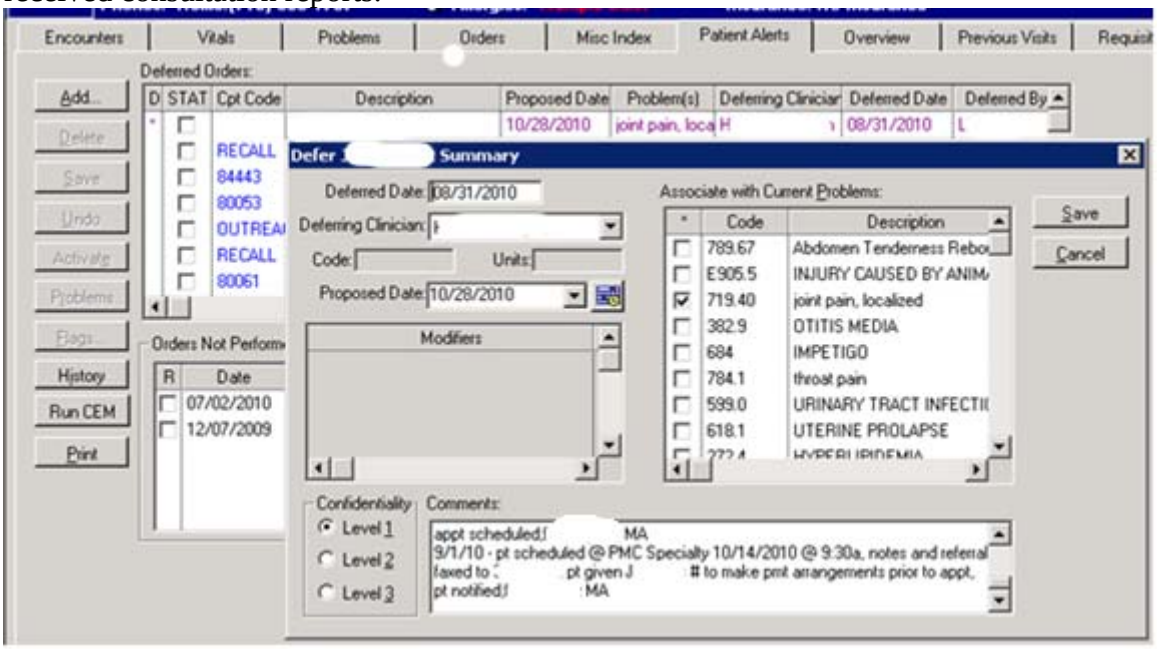
Item 9 For patients transitioning to other care, develops a written transition plan in collaboration with the patient and family

This occurs when our providers deliver care in our local hospital in conjunction with the case manager there. Our providers also work jointly with our local nursing home case managers and the site manager of the assisted living facility across the street from us.

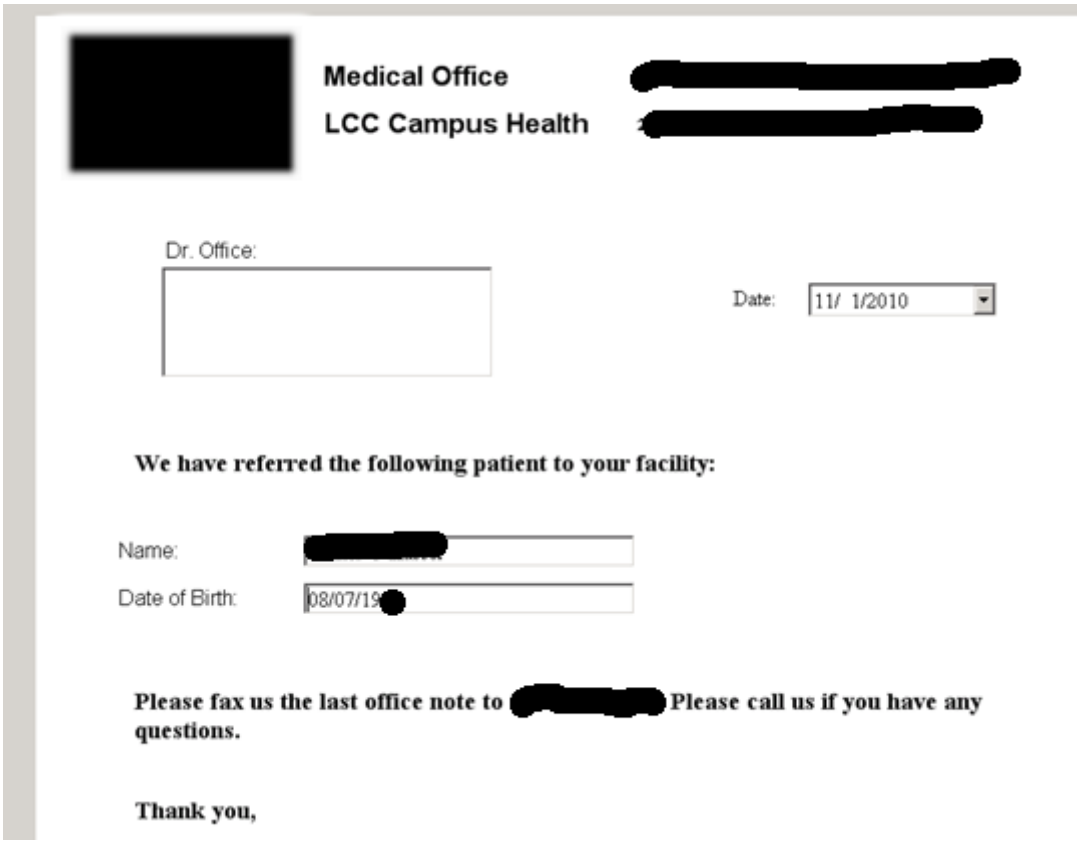
Item 1O Aids in identifying a new primary care physician or specialists or consultants and offers ongoing consultation

For specialty care and consults, we utilize our EMR for ordering and tracking purposes. The provider will enter the order for the type of specialty care required. Staff makes the appointment, sends the necessary records, notifies the patient, and assists with finding options for payments.

After the order is entered, our EMR will queue it back into the provider organizer if results are not attached within 60 days. Staff will contact patients and/or the specialist to find out the outcome. Letters are sent to follow up with specialists if we have not received consultation reports.



Here is a sample of the letter sent to specialists to request the note:



[redacted]

Medical Office [redacted]

LCC Campus Health [redacted]

Dr. Office:

Date: 11/ 1/2010

We have referred the following patient to your facility:

Name: [redacted]

Date of Birth: 08/07/19[redacted]

Please fax us the last office note to [redacted] **Please call us if you have any questions.**

Thank you,