Medication Referrals

MHSI / Northern MN Network

May 3, 2012

Duluth, MN

Demographic Insight

- Among MHSI patients:
  - 86% are below 100% FPL
  - 87% are uninsured
  - 70% identify as migrant farmworkers
  - 13% are hypertensive
  - 10% are diabetic

Source: 2011 UDS Report

MHSI Prescription Options

- “Big-box” pharmacies
- $10 Self-Pay plan (at participating pharmacies)

Migrant Health Service Inc
Quality Healthcare for Farmworkers

APPROVED MEDICATIONS & MAXIMUM QUANTITY
(Pharmacist: Please circle all medications dispensed)

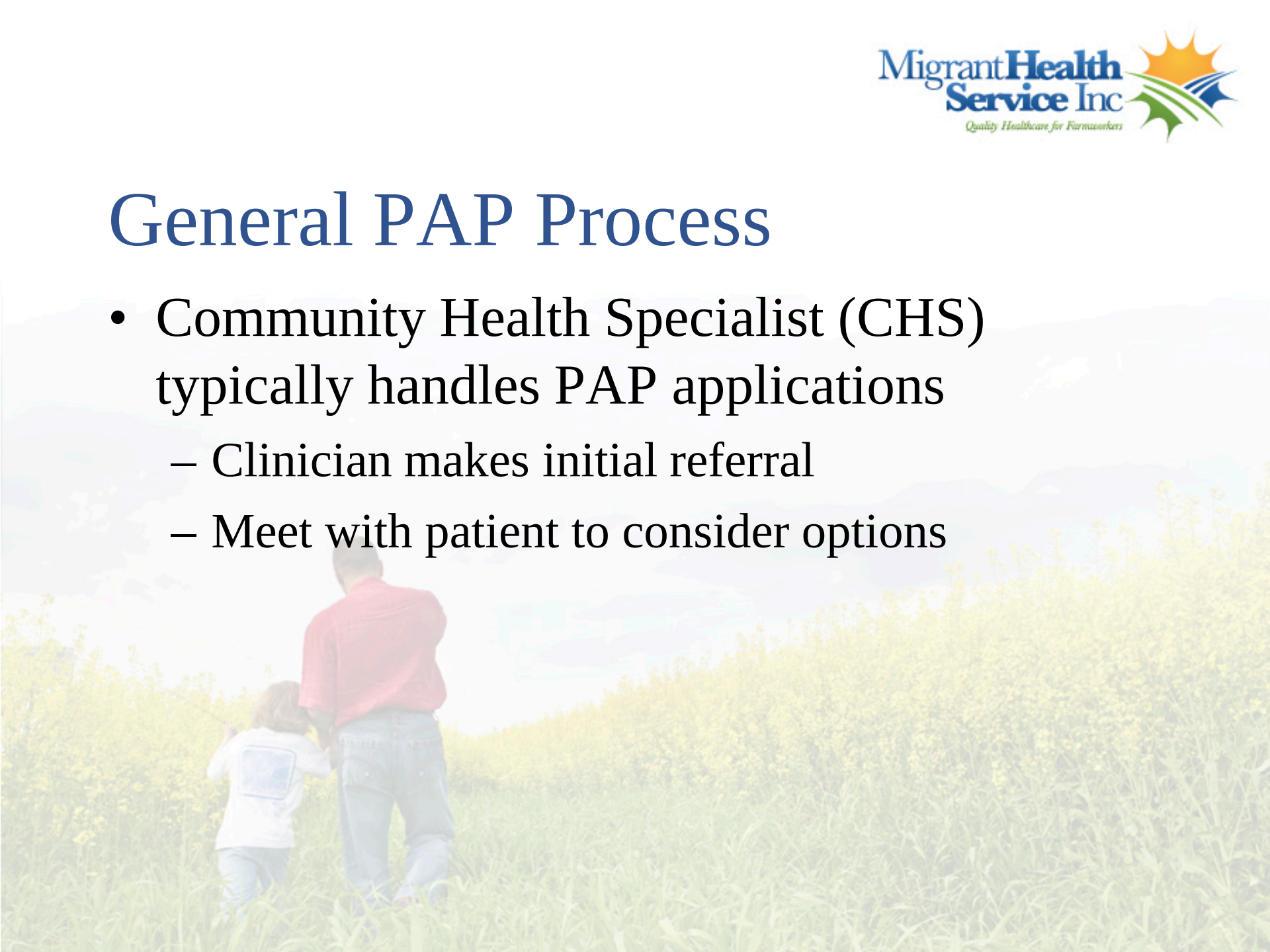
- ☐ Alendronate [4]
- ☐ Allopurinol [30]
- ☐ Alprazolam (no CR, ODT) [60]
- ☐ Amitriptyline [30]
- ☐ Amlodipine [30]
- ☐ Amoxicillin caps [40]
- ☐ Amoxicillin liquid [150mL]
- ☐ Atenolol [60]
- ☐ Atenolol/chlor. [30]
- ☒ Azithromycin [6]
- ☐ Benazepril tab [30]
- ☐ Buspirone [30]
- ☐ Captopril [60]
- ☐ Carbamazepine [60]
- ☐ Cephalexin caps [40]
- ☐ Ciprofloxacin tabs [20]
- ☒ Citalopram tab [60]
- ☐ Clonazepam [30]
- ☐ Cyclobenzaprine [30]
- ☐ Digoxin [30]
- ☐ Doxycycline [60]
- ☐ Enalapril [30]
- ☐ Estradiol [30]
- ☐ Fluconazole tabs [7]
- ☐ Fluoxetine [30]
- ☐ Furosemide tabs [60]
- ☐ Gabapentin [60]
- ☐ Glimepiride [30]
- ☐ Glyburide [30]
- ☐ HCTZ [30]
- ☐ Hydroxyzine Pam. [30]
- ☐ Ibuprofen [30]
- ☐ Ketoconazole Cr. [30]
- ☐ Latanoprost sol.[2.5mL]
- ☐ Levothyroxine [30]
- ☐ Lisinopril [30]
- ☐ Lisinopril/HCTZ [30]
- ☐ Losartan [30]
- ☐ Losartan/HCTZ [30]
- ☐ Lovastatin [30]
- ☒ Metformin [60]
- ☐ Metformin ER [30]
- ☐ Metoprolol (no ER) [60]
- ☐ Miconazole Cr./supp [100 mg / #7]
- ☐ Naproxen [60]
- ☒ Omeprazole cap [30]
- ☐ Oxybutynin tab [60]
- ☐ Pantoprazole [30]
- ☐ Paroxetine [30]
- ☐ Penicillin VK tab [30]
- ☐ Permethrin Cr. [60 gm]
- ☐ Prenatal Plus [60]
- ☐ Propanalol [30]
- ☐ Quinapril [30]
- ☐ Ramipril [30]
- ☐ Ranitidine [60]
- ☐ Sertraline [30]
- ☒ Simvastatin [30]
- ☐ SMZ/TMP [20]
- ☐ Terbinafine tabs [14]
- ☐ Tramadol [60]
- ☐ Trazodone [30]
- ☐ Triamterene/HCTZ [30]
- ☐ Triamcin. Cr./Oint [30 gm]
- ☐ Warfarin tab [30]

MHSI Prescription Options

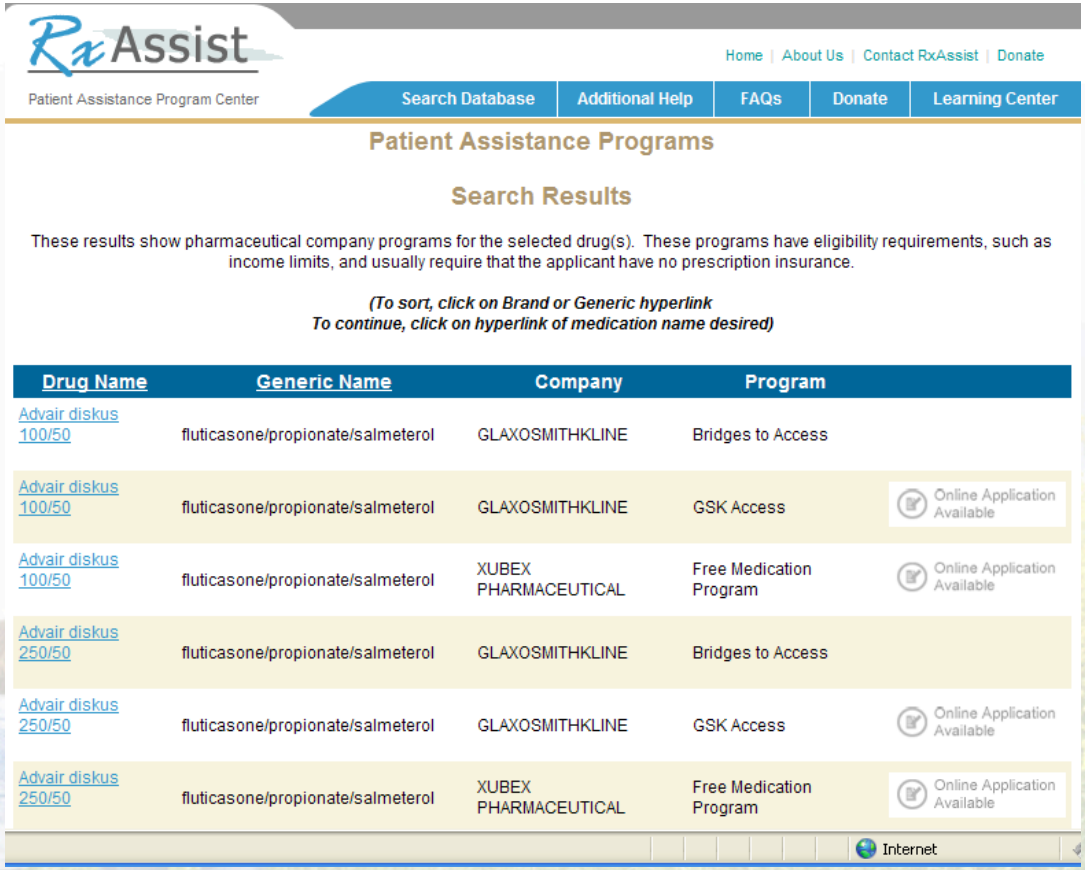
- “Big-box” pharmacies
- $10 Self-Pay plan (at participating pharmacies)
- Vouchers (at participating pharmacies)
- Patient Assistance Programs (PAPs)

General PAP Process

- Community Health Specialist (CHS) typically handles PAP applications
  - Clinician makes initial referral
  - Meet with patient to consider options



RxAssist.org



RxAssist
Patient Assistance Program Center

Home | About Us | Contact RxAssist | Donate

Search Database | Additional Help | FAQs | Donate | Learning Center

Patient Assistance Programs

Search Results

These results show pharmaceutical company programs for the selected drug(s). These programs have eligibility requirements, such as income limits, and usually require that the applicant have no prescription insurance.

(To sort, click on Brand or Generic hyperlink
To continue, click on hyperlink of medication name desired)

Drug Name	Generic Name	Company	Program	
Advair diskus 100/50	fluticasone/propionate/salmeterol	GLAXOSMITHKLINE	Bridges to Access	
Advair diskus 100/50	fluticasone/propionate/salmeterol	GLAXOSMITHKLINE	GSK Access	Online Application Available
Advair diskus 100/50	fluticasone/propionate/salmeterol	XUBEX PHARMACEUTICAL	Free Medication Program	Online Application Available
Advair diskus 250/50	fluticasone/propionate/salmeterol	GLAXOSMITHKLINE	Bridges to Access	
Advair diskus 250/50	fluticasone/propionate/salmeterol	GLAXOSMITHKLINE	GSK Access	Online Application Available
Advair diskus 250/50	fluticasone/propionate/salmeterol	XUBEX PHARMACEUTICAL	Free Medication Program	Online Application Available

Internet

RxAssist.org

Program Details
GLAXOSMITHKLINE
Bridges to Access
Advair diskus 250/50 (fluticasone/propionate/salmeterol)

CONTACT INFO

Address: PO Box 29038
Phoenix, AZ 85038-9038

Phone: 1-866-728-4368 Provider Phone:

Fax: Website: Bridges to Access

ELIGIBILITY

Eligibility Info:

- NOTE: Patients who need immediate assistance, should have their advocate call the phone number above for prescreening. Advocates who call for a prescreening need to use an application that can be found on the GSK website: http://www.bridgestoaccess.com/forms/enrollment_forms.jsp
- Patient do not need to be US Citizens, but must be a resident of the United States. The Patient must meet financial eligibility criteria based on the federal poverty level, adjusted by household size. Patient must not be eligible for prescription drug benefits through any private or public insurer/payer/program.

Income at or below: Single 250 % FPL

Couple 250 % FPL

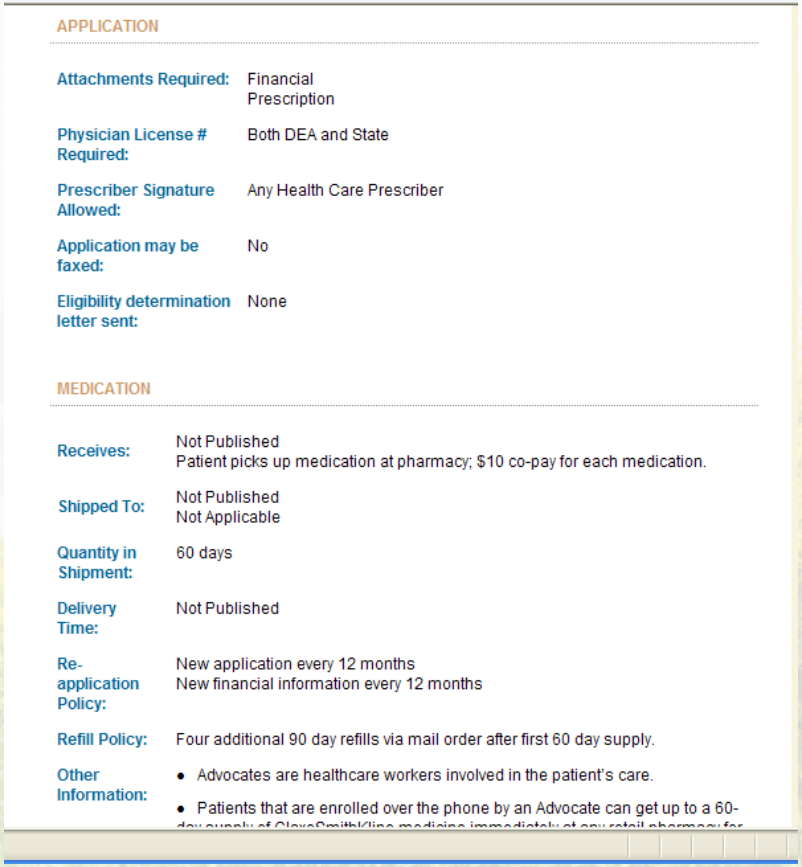
Federal Poverty Level Calculator

Application Forms & Instructions
The following documents are provided in interactive PDF format, allowing you to type information directly into the form.

Apply by mail application

Print-friendly version of this page

Internet



APPLICATION

Attachments Required:	Financial Prescription
Physician License # Required:	Both DEA and State
Prescriber Signature Allowed:	Any Health Care Prescriber
Application may be faxed:	No
Eligibility determination letter sent:	None

MEDICATION

Receives:	Not Published Patient picks up medication at pharmacy; $10 co-pay for each medication.
Shipped To:	Not Published Not Applicable
Quantity in Shipment:	60 days
Delivery Time:	Not Published
Re-application Policy:	New application every 12 months New financial information every 12 months
Refill Policy:	Four additional 90 day refills via mail order after first 60 day supply.
Other Information:	• Advocates are healthcare workers involved in the patient's care. • Patients that are enrolled over the phone by an Advocate can get up to a 60-

General PAP Process

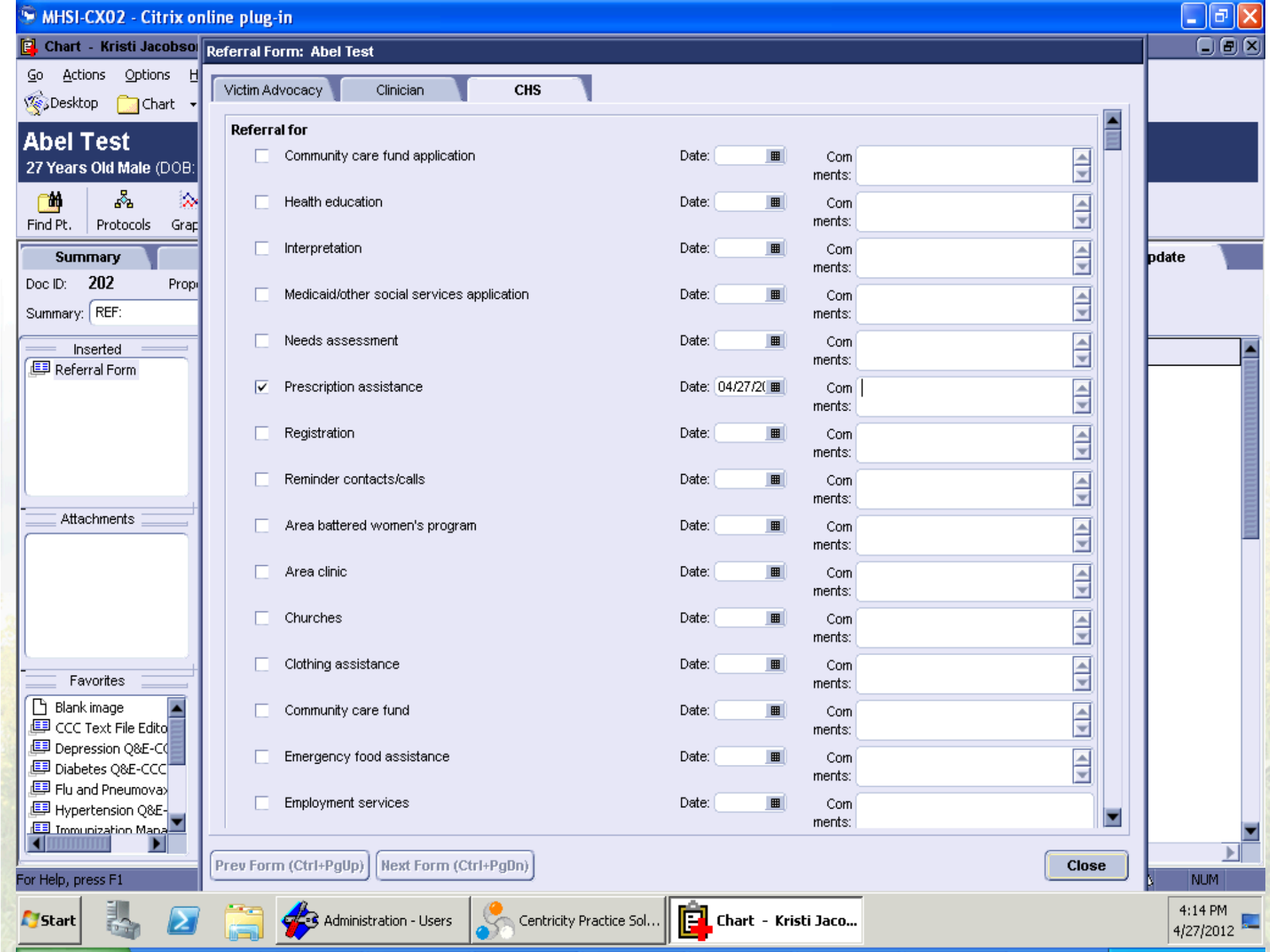
- Community Health Specialist (CHS) typically handles PAP applications
  - Clinician referral
  - Meet with patient to consider options
  - Get necessary scripts and financial documents
  - Complete paperwork on patient's behalf
  - Contact company for refill requests
  - Notify patient and arrange med pickup

Challenges

- Paper records
- Time-consuming process
- Refills for a migrant population

System improvements

- Referral form created in EMR


MHSI-CX02 - Citrix online plug-in
Chart - Kristi Jacobso
Go Actions Options H
Desktop Chart
Abel Test
27 Years Old Male (DOB:
Find Pt. Protocols Grap
Summary
Doc ID: 202 Prop
Summary: REF:
Inserted
Referral Form
Attachments
Favorites
Blank image
CCC Text File Edito
Depression Q&E-C
Diabetes Q&E-CCC
Flu and Pneumova
Hypertension Q&E-
Immunization Mana
For Help, press F1
Referral Form: Abel Test
Victim Advocacy
Clinician
CHS
Referral for
Community care fund application Date: Comments:
Health education Date: Comments:
Interpretation Date: Comments:
Medicaid/other social services application Date: Comments:
Needs assessment Date: Comments:
Prescription assistance Date: 04/27/2(Comments:
Registration Date: Comments:
Reminder contacts/calls Date: Comments:
Area battered women's program Date: Comments:
Area clinic Date: Comments:
Churches Date: Comments:
Clothing assistance Date: Comments:
Community care fund Date: Comments:
Emergency food assistance Date: Comments:
Employment services Date: Comments:
Prev Form (Ctrl+PgUp)
Next Form (Ctrl+PgDn)
Close
pdate
NUM
Start
Administration - Users
Centricity Practice Sol...
Chart - Kristi Jaco...
4:14 PM
4/27/2012

System improvements

- Referral form created in EMR
- Staff education
- Site-specific workflows

	From	To	Location	Start Date	Expire		Message
	Jane Hines LPN	Jane Hines LPN	C25	02/07/2012		N	Pt. due in June to order another 6 months of L
	Jane Hines LPN	Jane Hines LPN		02/13/2012		N	Pt. due for Mammog. and pap, was a no show
	Jane Hines LPN	Jane Hines LPN		03/16/2012		N	reorder, Januvia, Actos and Lipitor mid June.
	Jane Hines LPN	Jane Hines LPN		03/16/2012		N	reorder Tricor mid June
	Jane Hines LPN	**Jane Hines LPN**		**03/16/2012**		**A**	**Reorder Pap Meds mid May. pt. picked up**
	Jane Hines LPN	Jane Hines LPN	C25	04/03/2012		\	Pt's Levemir Flexpen expires in Sept., she know
	Jane Hines LPN	Jane Hines LPN	C25	04/12/2012		N	Order Lipitor and Actors after 5/31/12. Pt. picke

Pt's Levemir Flexpen expires in Sept., she knows to come in and apply then. I have completed PAP apps for ProAir inhaler and Singulair as of today.....good for 12 months. Pt. knows this.

Details

From: **Jane Hines LPN** Date Sent: **03/16/2012** Start Date: **03/16/2012** Priority: **Norm**

To: Time Sent: **11:09 AM** Attached To: **Chart Summary for**

Subject:

reorder Tricor mid June

	Mirella Lopez	Belinda Morin		03/22/2012		F From some changes for Ethnicity on the Registration side. The options have been
	Jaime Mattson, FNP	Belinda Morin		04/09/2012		Check next week about Lantus on PAP program
	Jaime Mattson, F	**Belinda Morin**	**F40**	**04/10/2012**		**[Notify patient when Lantus comes in and he will come in next week when**

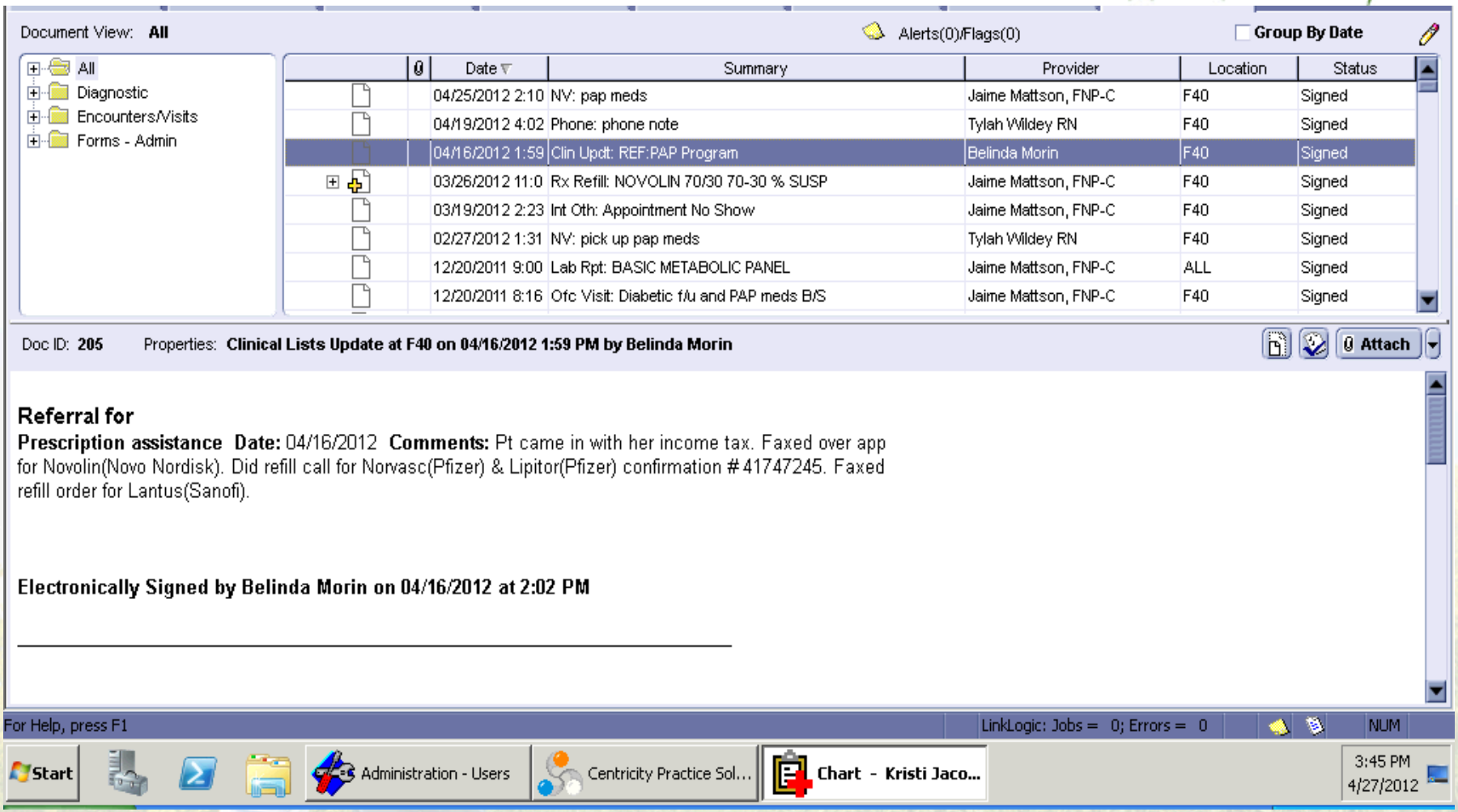
Details

From: **Jaime Mattson, FNP-C** Date Sent: **04/09/2012** Start Date: **04/09/2012** Priority: **Normal**

To: **Belinda Morin** Time Sent: **3:42 PM** Attached To: **Desktop**

Subject:

Check next week about Lantus on PAP program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Alerts(0)/Flags(0)
Group By Date
All
Diagnostic
Encounters/Visits
Forms - Admin
Date
Summary
Provider
Location
Status
04/25/2012 2:10 NV: pap meds Jaime Mattson, FNP-C F40 Signed
04/19/2012 4:02 Phone: phone note Tylah Wildey RN F40 Signed
04/16/2012 1:59 Clin Updt: REF:PAP Program Belinda Morin F40 Signed
03/26/2012 11:0 Rx Refill: NOVOLIN 70/30 70-30 % SUSP Jaime Mattson, FNP-C F40 Signed
03/19/2012 2:23 Int Oth: Appointment No Show Jaime Mattson, FNP-C F40 Signed
02/27/2012 1:31 NV: pick up pap meds Tylah Wildey RN F40 Signed
12/20/2011 9:00 Lab Rpt: BASIC METABOLIC PANEL Jaime Mattson, FNP-C ALL Signed
12/20/2011 8:16 Ofc Visit: Diabetic f/u and PAP meds B/S Jaime Mattson, FNP-C F40 Signed
Doc ID: 205
Properties: Clinical Lists Update at F40 on 04/16/2012 1:59 PM by Belinda Morin
Attach
Referral for
Prescription assistance Date: 04/16/2012 Comments: Pt came in with her income tax. Faxed over app for Novolin(Novo Nordisk). Did refill call for Norvasc(Pfizer) & Lipitor(Pfizer) confirmation # 41747245. Faxed refill order for Lantus(Sanofi).
Electronically Signed by Belinda Morin on 04/16/2012 at 2:02 PM
For Help, press F1
LinkLogic: Jobs = 0; Errors = 0
NUM
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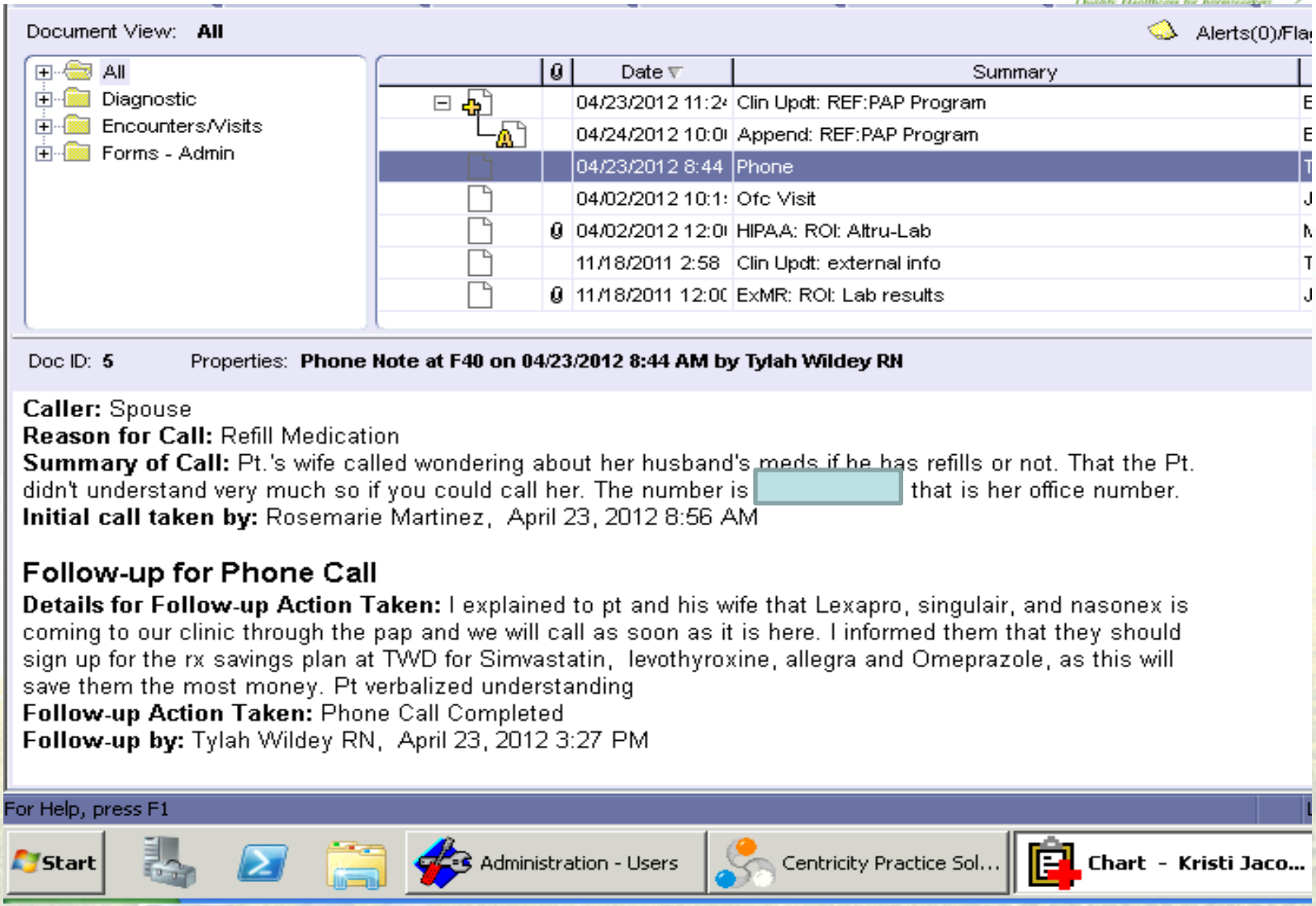
Administration - Users
Centricity Practice Sol...
Chart - Kristi Jaco...
3:45 PM
4/27/2012


Document View: All
Alerts(0)/Fla
All
Diagnostic
Encounters/Visits
Forms - Admin
Date
Summary
04/23/2012 11:2
Clin Updt: REF:PAP Program
04/24/2012 10:0
Append: REF:PAP Program
04/23/2012 8:44
Phone
04/02/2012 10:1
Ofc Visit
04/02/2012 12:0
HIPAA: ROI: Altru-Lab
11/18/2011 2:58
Clin Updt: external info
11/18/2011 12:0
ExMR: ROI: Lab results
Doc ID: 5
Properties: Phone Note at F40 on 04/23/2012 8:44 AM by Tylah Wildey RN
Caller: Spouse
Reason for Call: Refill Medication
Summary of Call: Pt.'s wife called wondering about her husband's meds if he has refills or not. That the Pt. didn't understand very much so if you could call her. The number is that is her office number.
Initial call taken by: Rosemarie Martinez, April 23, 2012 8:56 AM
Follow-up for Phone Call
Details for Follow-up Action Taken: I explained to pt and his wife that Lexapro, singulair, and nasonex is coming to our clinic through the pap and we will call as soon as it is here. I informed them that they should sign up for the rx savings plan at TWD for Simvastatin, levothyroxine, allegra and Omeprazole, as this will save them the most money. Pt verbalized understanding
Follow-up Action Taken: Phone Call Completed
Follow-up by: Tylah Wildey RN, April 23, 2012 3:27 PM
For Help, press F1
Start
Administration - Users
Centricity Practice Sol...
Chart - Kristi Jaco...

Final thoughts

- Goal is to meet increasing need for assistance in obtaining medications
  - Get creative!
  - Better EHR documentation ➔ Better communication between staff
    - "Hit by a bus" theory
  - Kudos to nurses/CHS for keeping track of what options are available in individual cases!

SPIROMETRY

Sawtooth Mountain Clinic's Journey

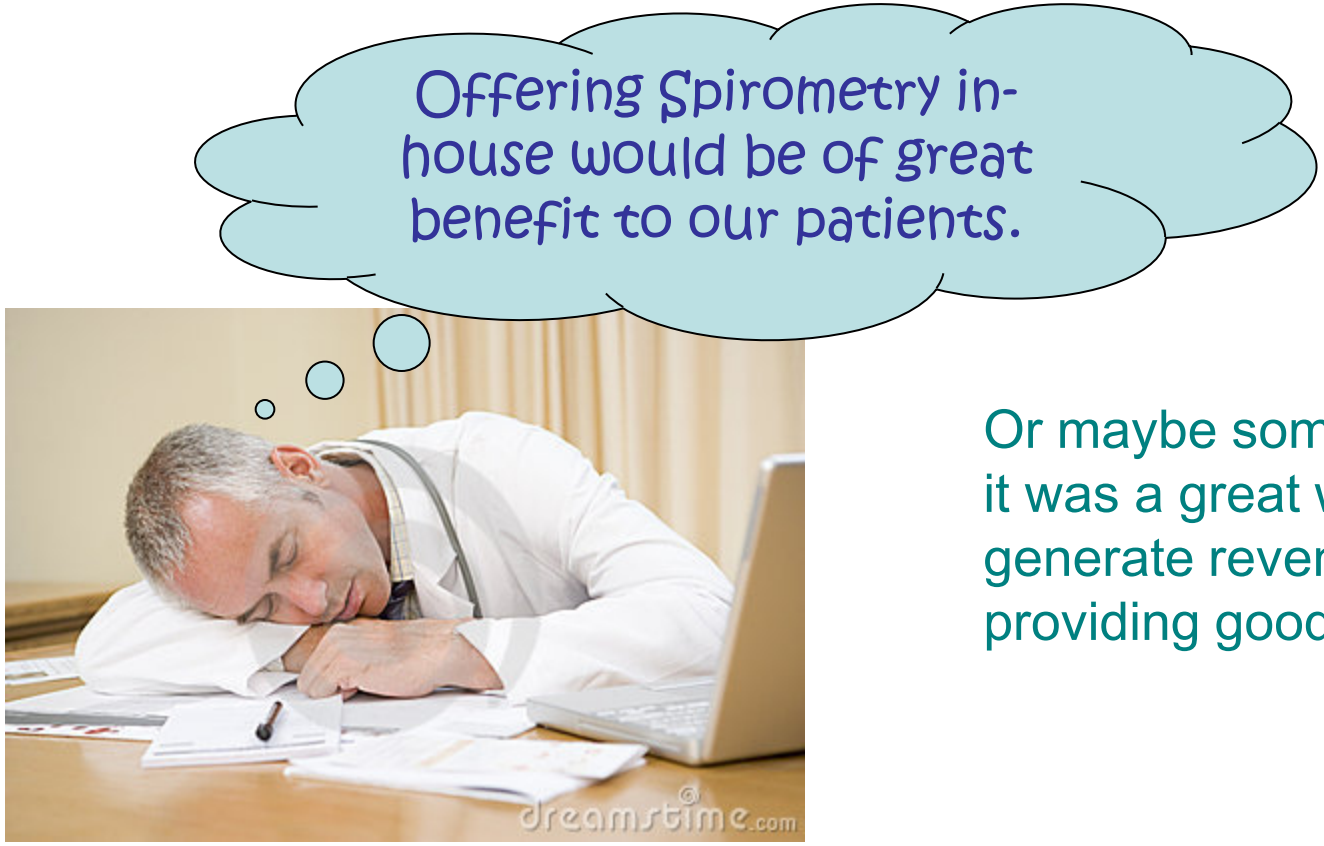
One fine day…

While lunching in a grassy meadow…

Patients of SMC may have had the following conversation:

Somehow, that great thought made its wayto the Providers at SMC.

- Or maybe it came to them in a dream.



Or maybe someone realized it was a great way to generate revenue while providing good care…

Regardless of its origin, we decided to pursue it.

Spirometry is so cool!

Spirometry, please.

Spirometry, spirometry, spirometry!

- Our nurses were a little skeptical—sometimes the thought of adding one more thing to do is, well, overwhelming.

But our doctors said: "Spirometry is essential to accurately diagnose asthma and COPD. It provides a tool to help assess how well controlled those diseases are and to demonstrate the effectiveness of therapy. By performing this service in clinic, we make it more convenient for the patient, improve our revenues, and can easily integrate the data into our record. This is a standard of care that is EASY to achieve." --Paul Terrill

Who can argue with that kind of a statement???

So we began our search for the perfect spirometry unit.

Our first attempt didn’t exactly work….

- Our first Spirometry unit was provided by Welch Allyn.
- It looked nice.
- It sounded nice.
- But it didn’t interface.
- Sorry, Welch Allyn.

Our next attempt was a perfect fit…

- Midmark had everything we wanted.
- AND it interfaced beautifully.

Full-speed ahead!

We were adviced to gather a core team of nurses to be our *“Spirometry Team”.*

We were told the quality of the test is *best* if it is performed an expert.

So, we gathered a team of four nurses to become *experts*.

the learning curve...

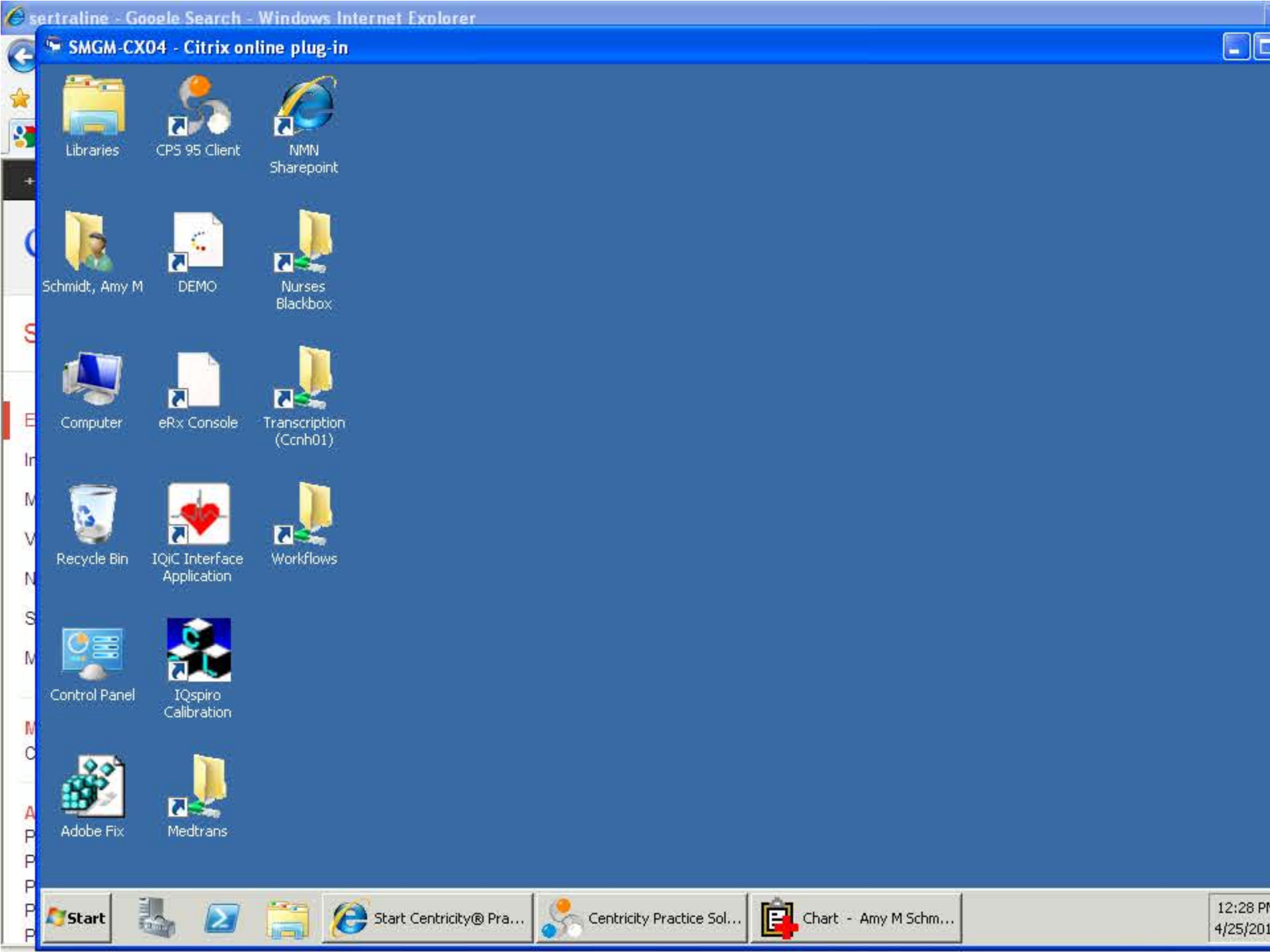
- Our core team spent an afternoon watching video tutorials on how to administer a Spirometry test.
- We felt pretty confident after these videos—they were very thorough.
- But we wanted a little more….

- Amy attended a certification course at the U of M put on by NIOSH.
- This was an intense two-day course focused on accurate administration of Spirometry tests, comprehension of results and care of equipment.
- When Amy returned, she shared the information with the rest of her team.

Meanwhile…

- Patty, our EMR Super-user was working hard on the computer end of things.
- The interfacing process went relatively smoothly.

Here's what she came up with…

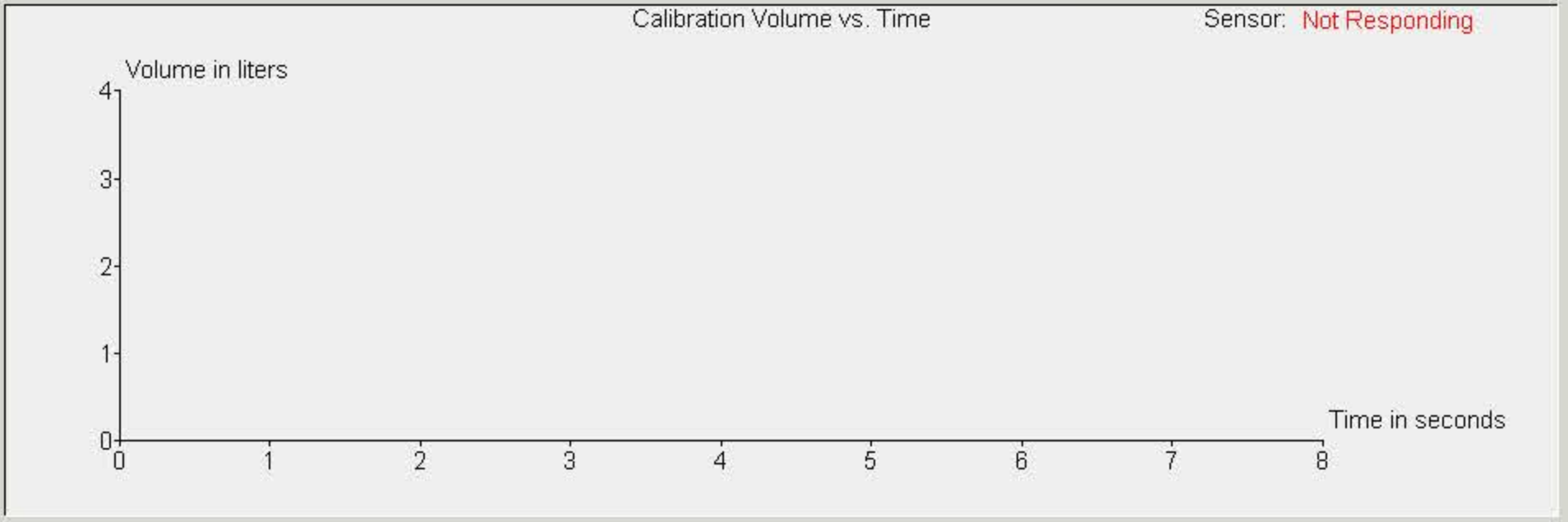

sertraline - Google Search - Windows Internet Explorer
SMGM-CX04 - Citrix online plug-in
Libraries
CPS 95 Client
NMN Sharepoint
Schmidt, Amy M
DEMO
Nurses Blackbox
Computer
eRx Console
Transcription (Ccnh01)
Recycle Bin
IQiC Interface Application
Workflows
Control Panel
IQspiro Calibration
Adobe Fix
Medtrans
Start
Start Centricity® Pra...
Centricity Practice Sol...
Chart - Amy M Schm...
12:28 PM
4/25/201

Spirometry Calibration

Date		Sensor ID			
Performed By		Sensor SN			
Syringe Volume	ml.	Temperature	deg. C		
Syringe S/N		Accepted Pumps			
Pressure	mmHg	Avg. Volume	liters		
Corr. % Change		Correction			

Previous Calibration

Date		
Pressure		mmHg
Temperature		deg. C
Avg. Volume		liters
Correction		



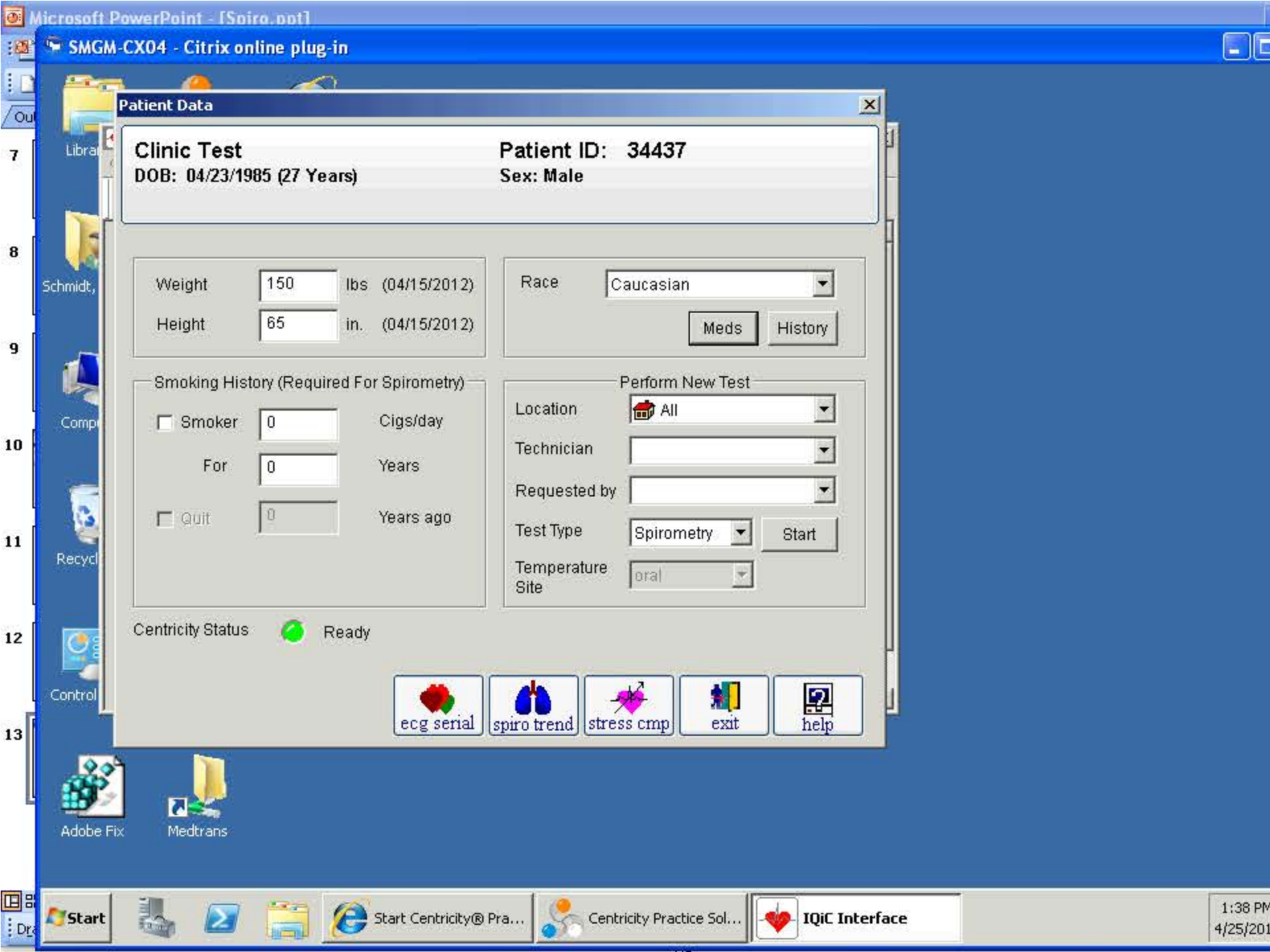
To begin calibration, click on New. Enter the data for Performed By, Syringe Volume, Syringe S/N, Pressure and Sensor SN.
Then press Start to begin calibrating.

Print | Verify | New Cal | Start Cal | Settings | Help | Exit

Start | Start Centricity® Pra... | Centricity Practice Sol... | Midmark IQspiro C... | 1:39 PM 4/25/2012

Slide 11 of 13 | Default Design

start | Inbox - Microsoft Out... | Citrix XenApp - Logge... | clonidine - Google Se... | Microsoft PowerPoint ... | SMGM-CX04 - Citrix o... | 1:42


Microsoft PowerPoint - [Spiro.ppt]
SMGM-CX04 - Citrix online plug-in
Patient Data
Clinic Test
DOB: 04/23/1985 (27 Years)
Patient ID: 34437
Sex: Male
Weight 150 lbs (04/15/2012)
Height 65 in. (04/15/2012)
Race Caucasian
Meds
History
Smoking History (Required For Spirometry)
Smoker 0 Cigs/day
For 0 Years
Quit 0 Years ago
Perform New Test
Location All
Technician
Requested by
Test Type Spirometry
Start
Temperature Site oral
Centricity Status Ready
ecg serial
spiro trend
stress cmp
exit
help
Adobe Fix
Medtrans
Start
Start Centricity® Pra...
Centricity Practice Sol...
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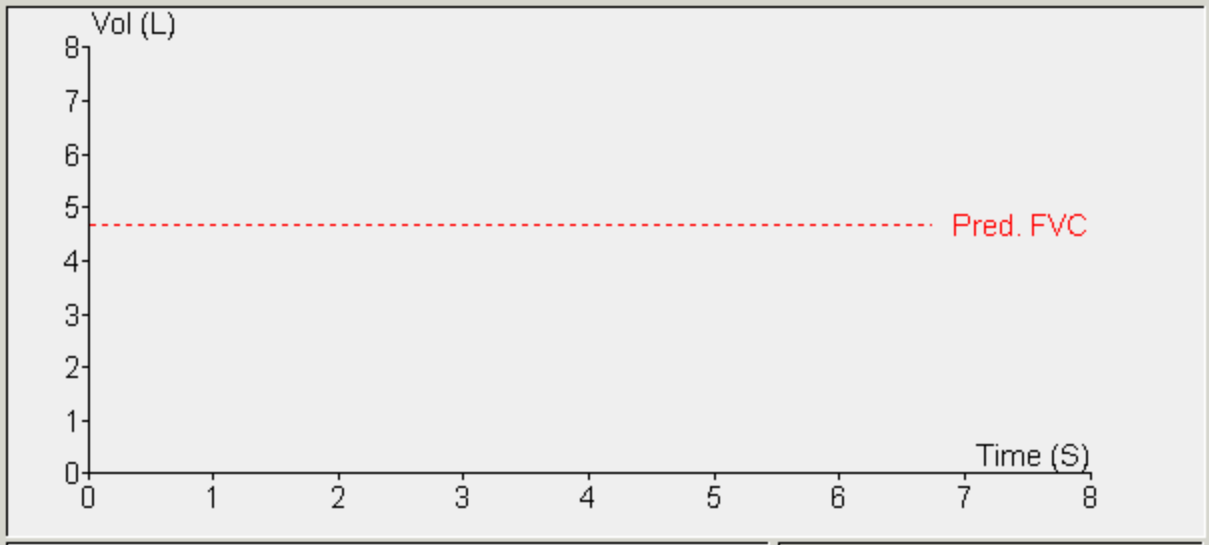
4/25/201

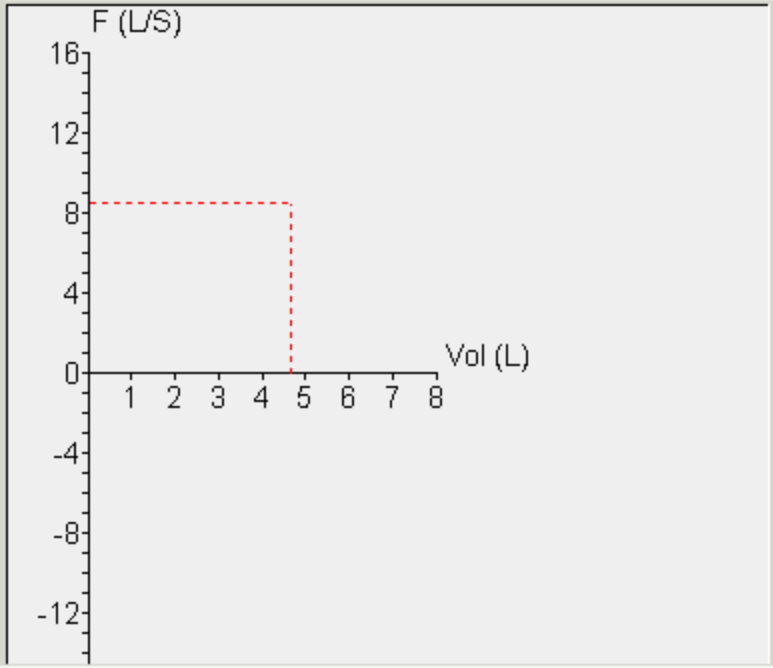
icrosoft PowerPoint - [Spiro.ppt]
SMGM-CX04 - Citrix online plug-in

Spirometry for Clinic Test, 34437



FVC Test

Meas.	Pred.	Actual	% Pred.
FVC			
FEV1			
FEV1/FVC			
FEF25%			
FEF50%			
FEF75%			
FEF25-75%			
PEF			
Exp. Time			
V ext.			
FIVC			



Pre-Bronchodilator
No tests yet

Prev | Next

Accept | Reject

Best

Pre | Post

Start New Test

FVC | VC | MVV

Sensor: Searching ....

Pre-BD	Attempt(s)	Accepted	Matches
FVC	0	0	0
VC	0	0	
MVV	0	0	
Post-BD	**Attempt(s)**	**Accepted**	**Matches**
FVC	0	0	0
VC	0	0	
MVV	0	0	

Delete Rejected Tests

Cal | Test Data | Settings | Help | Exit

Start | Start Centricity® Pra... | Centricity Practice Sol... | IQiC Interface
1:38 PM
4/25/2012

metry for Clinic Test, 34437

Vol (L)

8
7
6
5
4
3
2
1
0

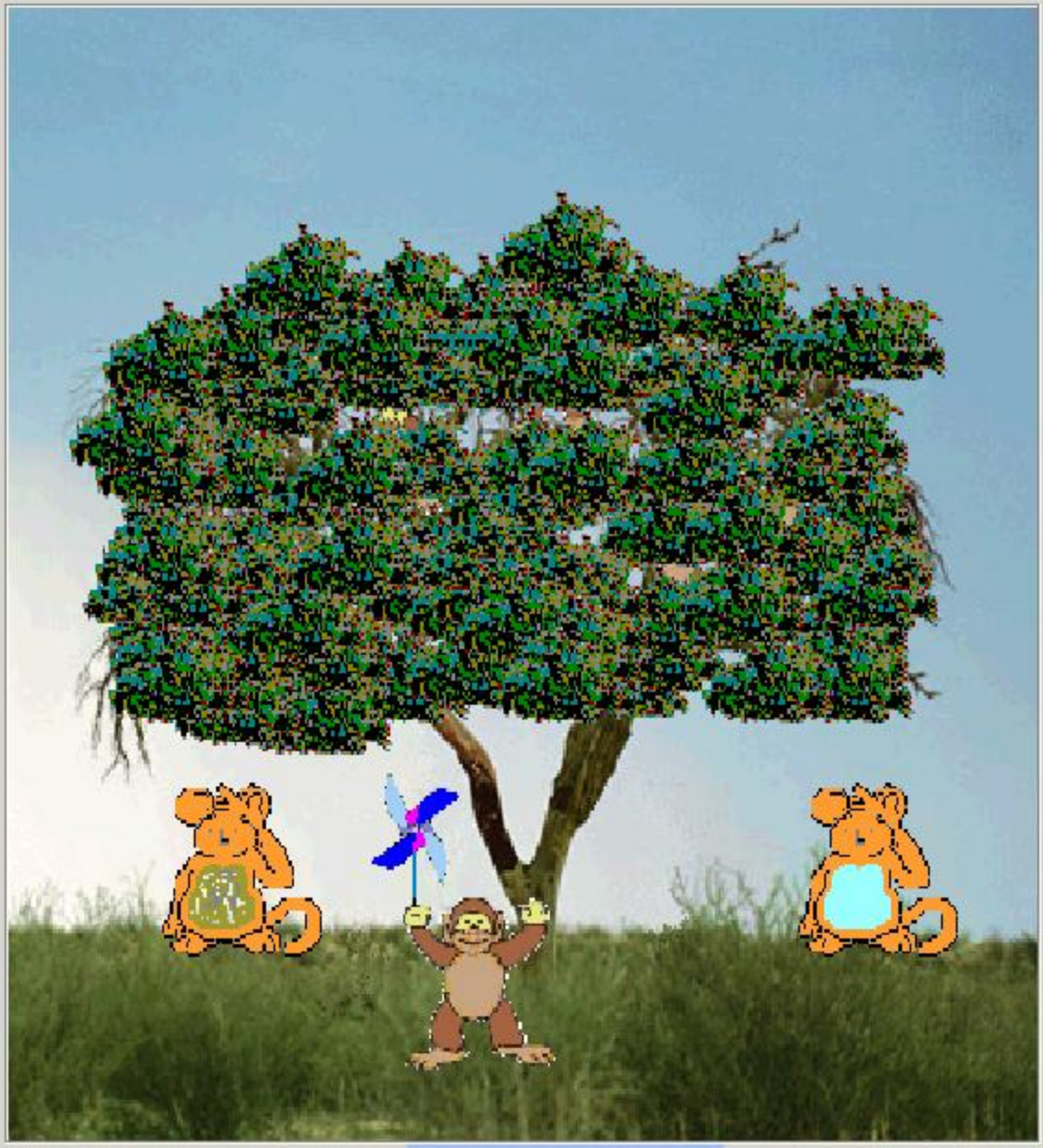
0 4 8

F (L/S)

16
12
8
4
0
-4
-8
-12
-16

1 2 3 4 5 6

Spirometry Incentive Display



Stop

Start when Ready....

0.0 liters 0 %

VC Test

	Pred.	Actual	% Pred.

eady

tempt(s)	Accepted	Matche
0	0	0
0	0	
0	0	

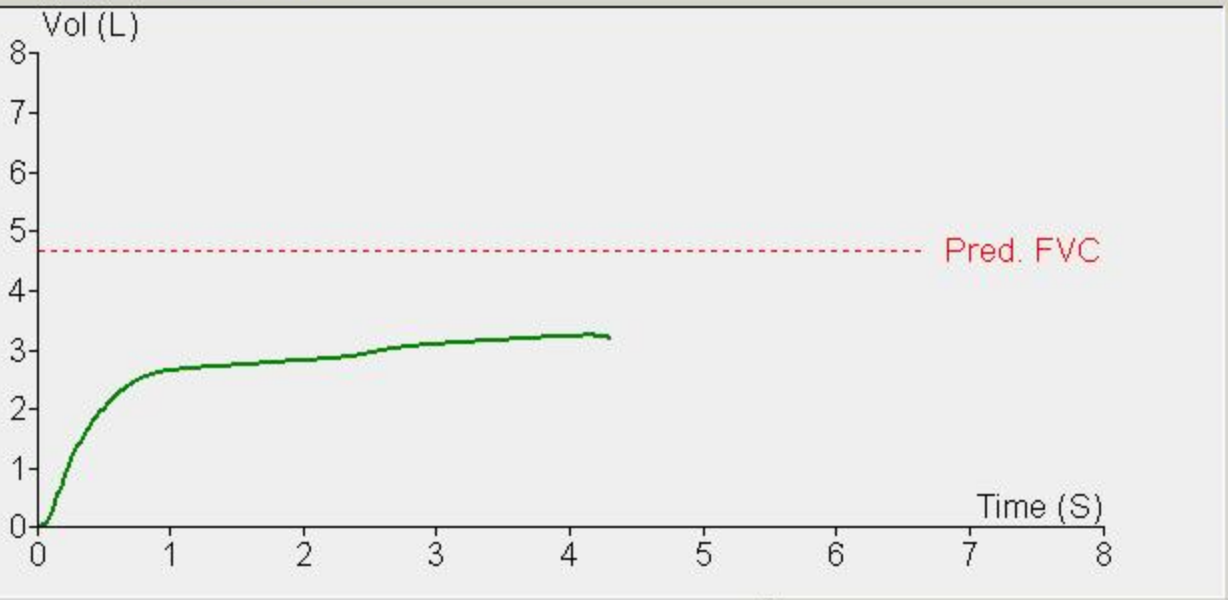
tempt(s)	Accepted	Matche
0	0	0
0	0	
0	0	

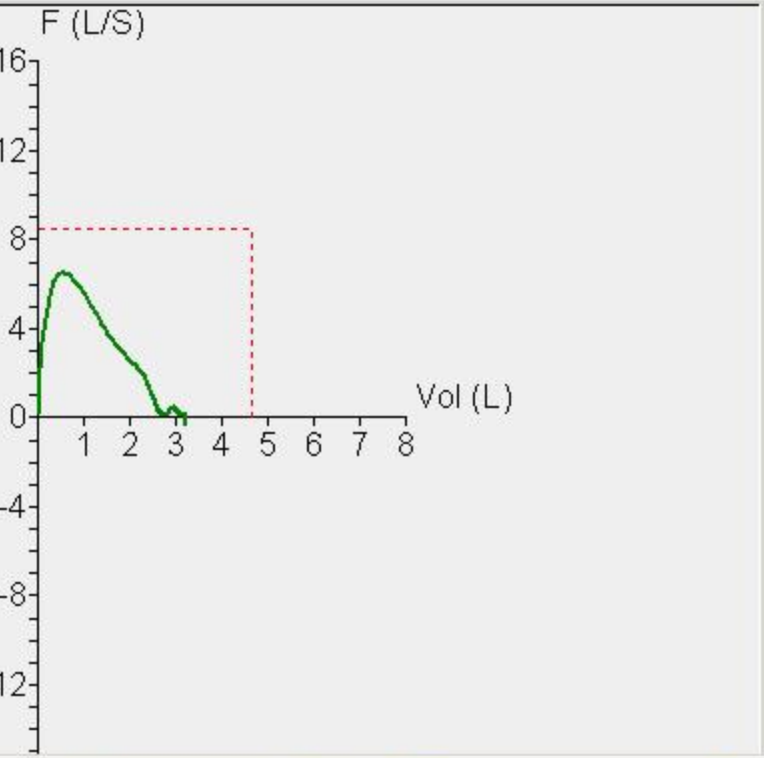
ed Tests

Help

Exit

metry for Clinic Test, 34437





Pre-Bronchodilator
Test 3 of 3

Prev | Next

Accept | Reject

Best

Pre | Post

Start New Test

FVC | VC | MVV

FVC Test

Meas.	Pred.	Actual	% Pred.
FVC	4.68	3.24	69 %
FEV1	3.99	2.66	67 %
FEV1/FVC	85 %	82 %	97 %
FEF25%	7.97	6.51	82 %
FEF50%	4.76	3.70	78 %
FEF75%	2.01	1.58	78 %
FEF25-75%	4.48	3.33	74 %
PEF	8.58	6.59	77 %
Exp. Time	---	4.08	
V ext.	---	0.06	
FIVC	4.68	---	

Blow out longer.

Sensor: Ready

Pre-BD	Attempt(s)	Accepted	Matche
FVC	3	3	0
VC	0	0	
MVV	0	0	
Post-BD	**Attempt(s)**	**Accepted**	**Matche**
FVC	0	0	0
VC	0	0	
MVV	0	0	

Delete Rejected Tests

Cal | Test Data | Settings | Help | Save Review

3:33 PM

ooth Mountain Clinic

atient Name: Clinic Test
atient ID: 34437

DOB(Age): 04/23/1985(27)
Sex: Male

Report Type: Spirometry Report
Report Date: 04/25/12 15:30:59

echnician: Schmidt RN, Amy M
eviewed By: Sampson MD, Michael R [m

Review Date:
Predicteds: Crapo

Perform Pre-BD | Perform Post BD | Settings | Bronchodilator

Summary | FVC Graphs | MVV Graphs | VC Graphs

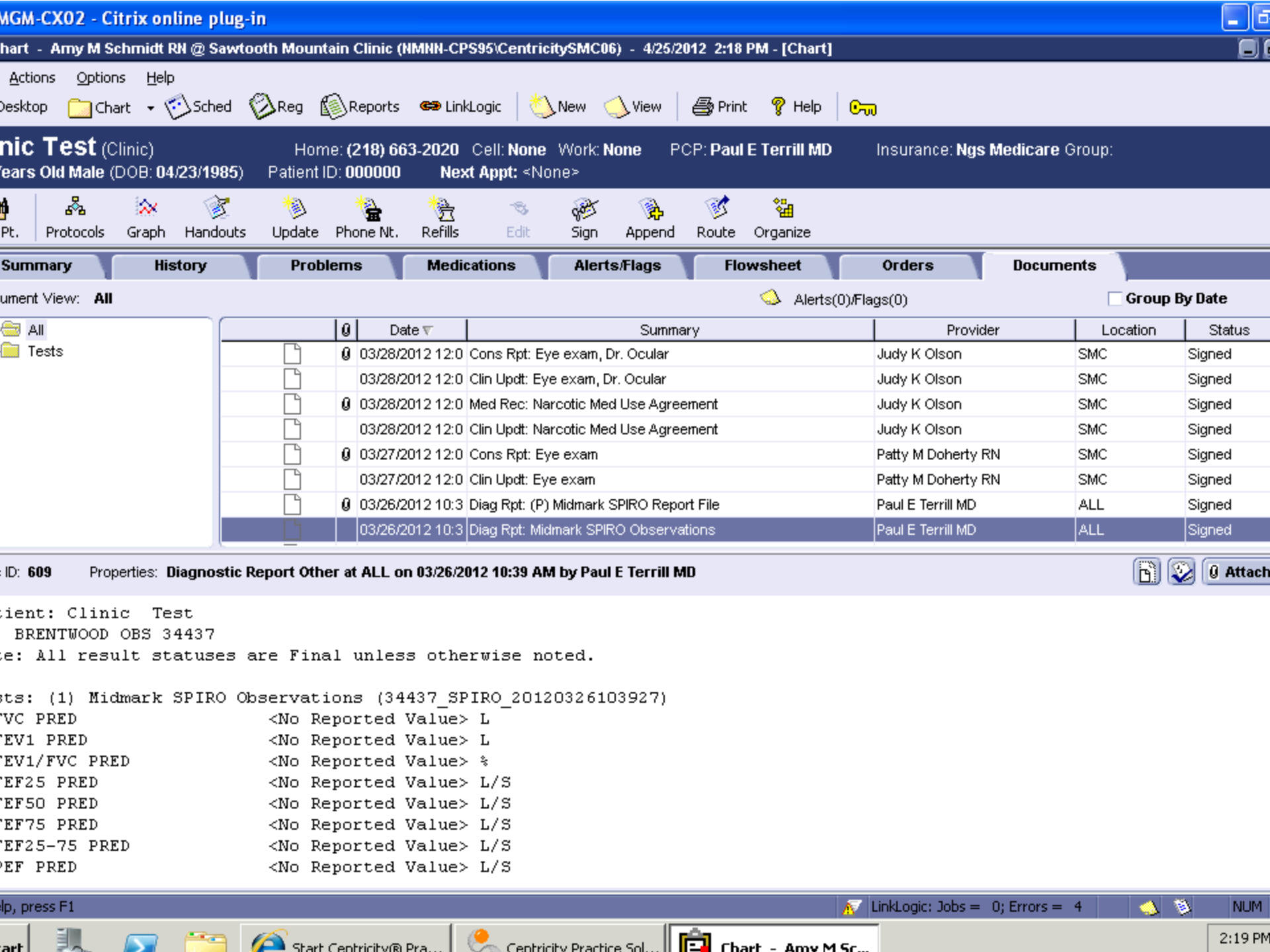
	Units	Predicted	Pre Actual	Pre % Pred.	Post Actual	Post % Pred.	% Change
FVC	L	4.68	3.49	75 %			
FEV1	L	3.99	2.90	73 %			
FEV1/FVC	%	85 %	83 %	98 %			
FEF25%	L/S	7.97	6.87	86 %			
FEF50%	L/S	4.76	3.66	77 %			
FEF75%	L/S	2.01	1.42	70 %			

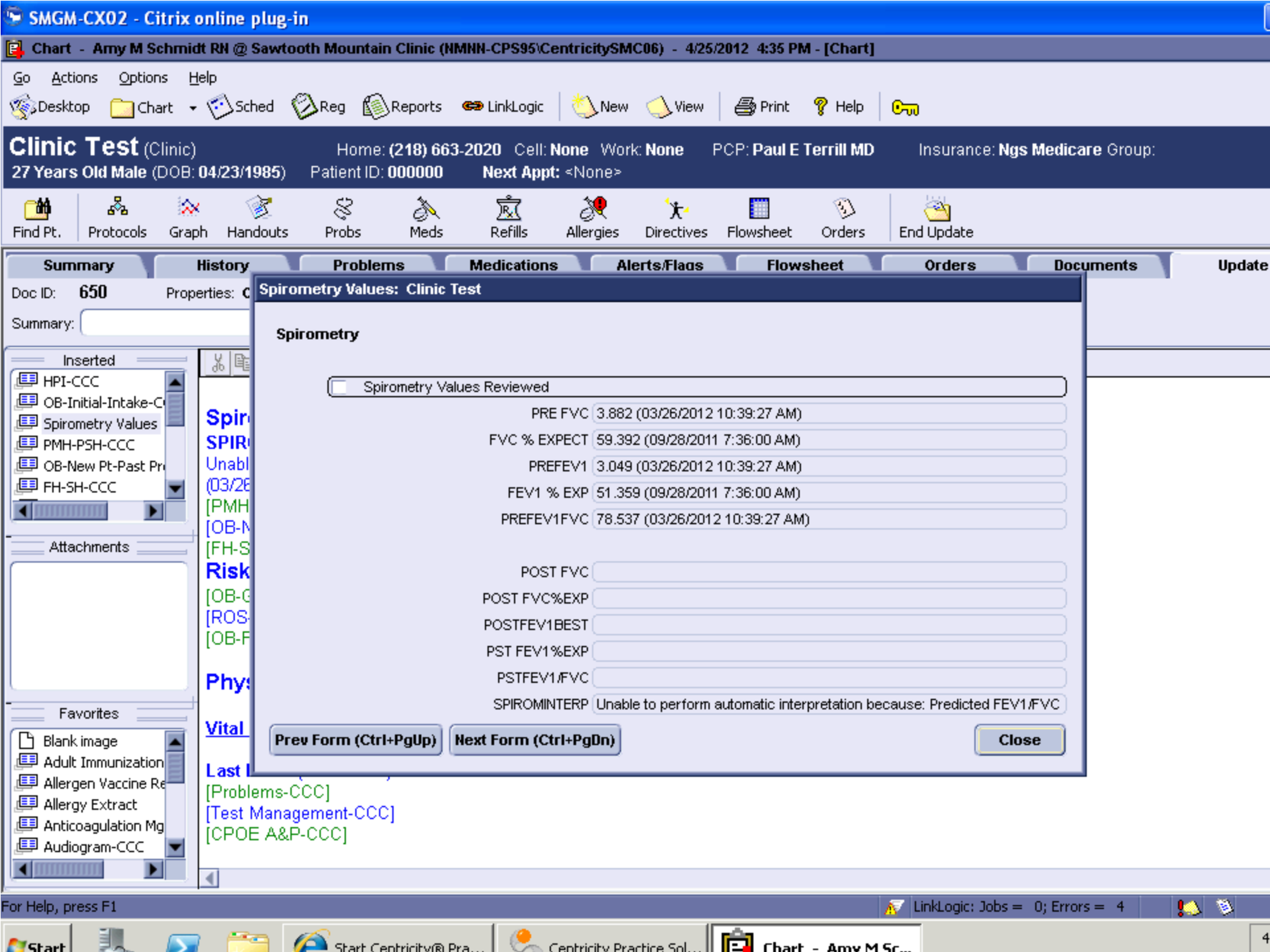
Age:	27 years	Lung Age:	57 years	Pre-BD FVC:	3 attempted, 3 accepted, 0 matches.
Sex:	Male			Post-BD FVC:	0 attempted, 0 accepted, 0 matches.
Height:	65 inches			Smoker:	No.
Race:	Caucasian			COPD Risk:	Low.

Interpretation

Mild restriction.

File | Print | Help | Exit


MGM-CX02 - Citrix online plug-in
hart - Amy M Schmidt RN @ Sawtooth Mountain Clinic (NMNN-CPS95\CentricitySMC06) - 4/25/2012 2:18 PM - [Chart]
Actions Options Help
Desktop Chart Sched Reg Reports LinkLogic New View Print Help
nic Test (Clinic) Home: (218) 663-2020 Cell: None Work: None PCP: Paul E Terrill MD Insurance: Ngs Medicare Group:
ears Old Male (DOB: 04/23/1985) Patient ID: 000000 Next Appt: <None>
Pt. Protocols Graph Handouts Update Phone Nt. Refills Edit Sign Append Route Organize
Summary History Problems Medications Alerts/Flags Flowsheet Orders Documents
ument View: All
Alerts(0)/Flags(0)
Group By Date
All
Tests
Date Summary Provider Location Status
03/28/2012 12:0 Cons Rpt: Eye exam, Dr. Ocular Judy K Olson SMC Signed
03/28/2012 12:0 Clin Updt: Eye exam, Dr. Ocular Judy K Olson SMC Signed
03/28/2012 12:0 Med Rec: Narcotic Med Use Agreement Judy K Olson SMC Signed
03/28/2012 12:0 Clin Updt: Narcotic Med Use Agreement Judy K Olson SMC Signed
03/27/2012 12:0 Cons Rpt: Eye exam Patty M Doherty RN SMC Signed
03/27/2012 12:0 Clin Updt: Eye exam Patty M Doherty RN SMC Signed
03/26/2012 10:3 Diag Rpt: (P) Midmark SPIRO Report File Paul E Terrill MD ALL Signed
03/26/2012 10:3 Diag Rpt: Midmark SPIRO Observations Paul E Terrill MD ALL Signed
ID: 609 Properties: Diagnostic Report Other at ALL on 03/26/2012 10:39 AM by Paul E Terrill MD
Attach
ient: Clinic Test
BRENTWOOD OBS 34437
e: All result statuses are Final unless otherwise noted.
sts: (1) Midmark SPIRO Observations (34437_SPIRO_20120326103927)
VC PRED <No Reported Value> L
EV1 PRED <No Reported Value> L
EV1/FVC PRED <No Reported Value> %
EF25 PRED <No Reported Value> L/S
EF50 PRED <No Reported Value> L/S
EF75 PRED <No Reported Value> L/S
EF25-75 PRED <No Reported Value> L/S
EF PRED <No Reported Value> L/S
lp, press F1
LinkLogic: Jobs = 0; Errors = 4
NUM
Start Centricity® Pra...
Centricity Practice Sol...
Chart - Amy M Sc...
2:19 PM


SMGM-CX02 - Citrix online plug-in
Chart - Amy M Schmidt RN @ Sawtooth Mountain Clinic (NMNN-CPS95\CentricitySMC06) - 4/25/2012 4:35 PM - [Chart]
Go Actions Options Help
Desktop Chart Sched Reg Reports LinkLogic New View Print Help
Clinic Test (Clinic) Home: (218) 663-2020 Cell: None Work: None PCP: Paul E Terrill MD Insurance: Ngs Medicare Group:
27 Years Old Male (DOB: 04/23/1985) Patient ID: 000000 Next Appt: <None>
Find Pt. Protocols Graph Handouts Probs Meds Refills Allergies Directives Flowsheet Orders End Update
Summary History Problems Medications Alerts/Flags Flowsheet Orders Documents Update
Doc ID: 650 Properties:
Summary:
Inserted
HPI-CCC
OB-Initial-Intake-C
Spirometry Values
PMH-PSH-CCC
OB-New Pt-Past Pr
FH-SH-CCC
Attachments
Favorites
Blank image
Adult Immunization
Allergen Vaccine Re
Allergy Extract
Anticoagulation Mg
Audiogram-CCC
Spirometry Values: Clinic Test
Spirometry
Spirometry Values Reviewed
PRE FVC 3.882 (03/26/2012 10:39:27 AM)
FVC % EXPECT 59.392 (09/28/2011 7:36:00 AM)
PREFEV1 3.049 (03/26/2012 10:39:27 AM)
FEV1 % EXP 51.359 (09/28/2011 7:36:00 AM)
PREFEV1FVC 78.537 (03/26/2012 10:39:27 AM)
POST FVC
POST FVC%EXP
POSTFEV1BEST
PST FEV1%EXP
PSTFEV1/FVC
SPIROMINTERP Unable to perform automatic interpretation because: Predicted FEV1/FVC
Prev Form (Ctrl+PgUp)
Next Form (Ctrl+PgDn)
Close
[Problems-CCC]
[Test Management-CCC]
[CPOE A&P-CCC]
For Help, press F1
LinkLogic: Jobs = 0; Errors = 4
Start
Start Centricity® Pra...
Centricity Practice Sol...
Chart - Amy M Sc...

- We do these spirometry tests on an acute need basis and as schedule labs associated with an annual visit.

- These tests can be stand-alone or done as “pre” and “post” tests with an Albuterol Nebulizer treatment between them.

So:

Was it all it was cracked up to be?

- It generates revenue (a good thing)
- It interfaced with minimal hassle (yes, please)
- It is another way to provide excellent patient care (a very good thing)
- It saves our patients a drive to Duluth (gas is SO expensive)
- And our nurses actually kind-of enjoy it! (happiness!)

EVERYBODY!!!

Questions?

Community Health Partnership of Illinois

The Patient Care Redesign Workgroup

A Patient Centered Medical Home Imitative

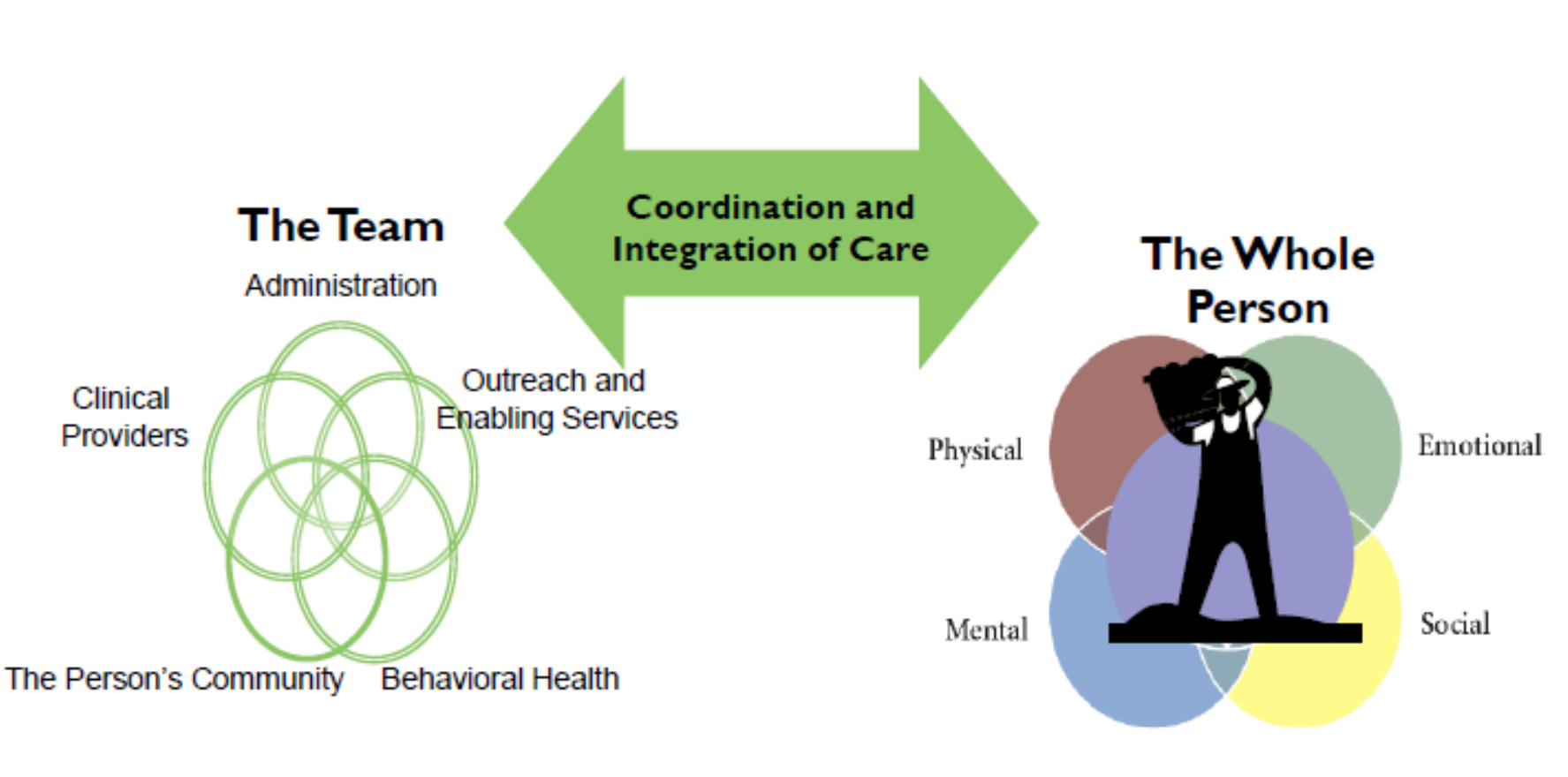
Why Patient Centered Medical Home?

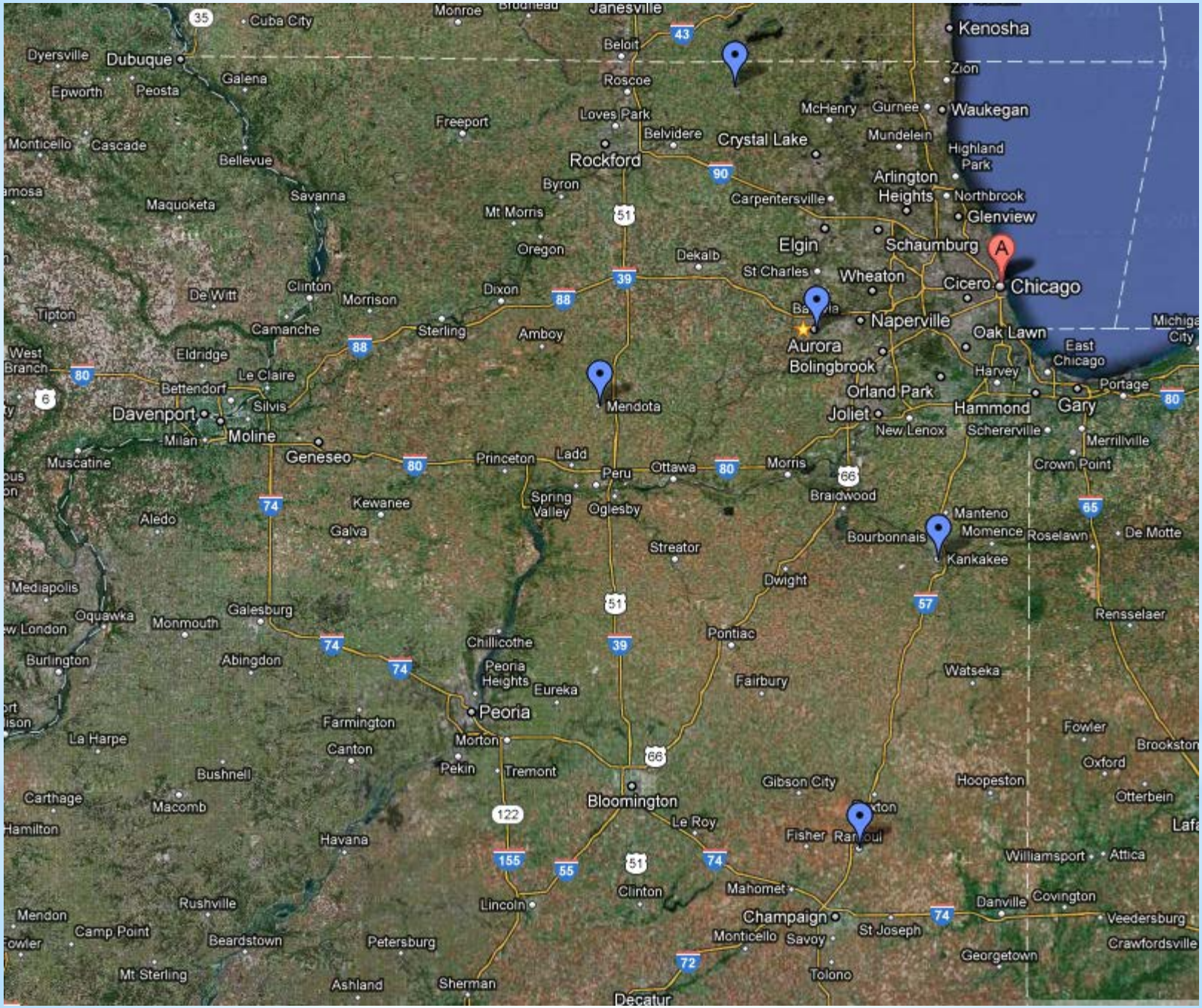
A PCMH puts patients at the

center of the health care system, and provides primary care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”

(American Academy of Pediatrics)

CHP – “Un Hogar de Salud”




Kenosha
Janesville
Monroe
Cuba City
Dyersville
Dubuque
Galena
Epworth
Peosta
Beloit
Roscoe
Zion
Waukegan
McHenry
Gurnee
Loves Park
Freeport
Belvidere
Crystal Lake
Mundelein
Highland Park
Monticello
Cascade
Bellevue
Rockford
Byron
Arlington Heights
Northbrook
Glenview
Maquoketa
Savanna
Mt Morris
Carpentersville
Oregon
Elgin
Schaumburg
Dekalb
St Charles
Wheaton
Cicero
Chicago
De Witt
Clinton
Morrison
Dixon
Tipton
Camanche
Sterling
Amboy
Naperville
Oak Lawn
Aurora
Bolingbrook
East Chicago
West Branch
Eldridge
Le Claire
Harvey
Portage
Bettendorf
Silvis
Mendota
Orland Park
Hammond
Gary
Davenport
Joliet
New Lenox
Schererville
Milan
Moline
Geneseo
Princeton
Ladd
Merrillville
Muscatine
Peru
Ottawa
Morris
Crown Point
Kewanee
Spring Valley
Oglesby
Braidwood
Aledo
Galva
Manteno
Bourbonnais
Momence
Roselawn
De Motte
Streator
Kankakee
Dwight
Mediapolis
Oquawka
Galesburg
Monmouth
Rensselaer
Chillicothe
Pontiac
Burlington
Abingdon
Peoria Heights
Eureka
Fairbury
Watseka
Peoria
Farmington
Fowler
La Harpe
Morton
Canton
Brookston
Pekin
Tremont
Oxford
Bushnell
Gibson City
Hoopeston
Carthage
Macomb
Bloomington
Otterbein
Le Roy
Hamilton
Havana
Fisher
Williamsport
Attica
Clinton
Mahomet
Rushville
Lincoln
Danville
Covington
Mendon
Champaign
Veedersburg
Camp Point
Beardstown
Petersburg
Monticello
Savoy
St Joseph
Crawfordsville
Georgetown
Mt Sterling
Ashland
Sherman
Tolono
Decatur

* HRSA's supplemental funding for quality improvement and medical home initiative

  * **Focus on:**
    - **Plan and Manage Care: U**se evidence-based guidelines for preventive, acute and chronic care management for chronic, frequent and behavior-based conditions, including medication management
    - **Track and Coordinate Care:** Track and coordinate tests, referrals and transitions of care

  * **Accomplish by:**
    - Hire Patient Care Resource Specialist
    - Assemble Patient Care Redesign Workgroup
    - Medical Director will chair group

Grant Guidelines:

* Choose 2 of 6 clinical domains/initiatives
* Implement plan for development, tracking, assessing and reporting of the measure for compliance monitoring
* Submit a mid-term progress report
* Submit a final report
* Develop a project maintenance plan for continuation post grant funding termination

Project staffing

* Representation required by each clinical site (5 locations)
* Medical staff only: either CNA, MA, LPN, RN or provider
* Initial meeting guidelines: once a month via teleconference; in person every 3 months

Meeting guidelines continued:

* Required to check e-mail a minimum of every 48 hrs.
* Required to respond to e-mails within 72 hrs.
* Pre-work items circulated via e-mail based on the action items/steps agreed upon during each meeting
* Always determine next meeting date and next meeting agenda before meeting adjournment

Goals of the Patient Care Redesign Workgroup

* Redesign and update our paper health record documents
* Identify top 3 health conditions of focus
* Create evidence-based care guidelines for patients with a top health condition of focus
* Integrate our chart design with our electronic health record
* Submit Notice of Intent for PCMH recognition

Progress so far

* Our new health record documents will be implement at all clinics on May 7, 2012
* We have identified three health measures to track for improved outcomes and compliance: Pap smear compliance, immunization compliance, and diabetes control
* We have aligned our new paper chart documents with the data/content of their complementary electronic versions
* We have identified the need to improve our current system of referrals tracking and follow-up of diagnostic tests in order to standardize practices across all clinic sites.

Conclusion:

* The PCMH initiative and grant was a great opportunity and incentive for us to reorganize our current practices, policies and procedures to align with standardized goals/methodologies for health care centers providing care in high risk communities
* Our medical teams have managed to improve their working relations in lieu of the miles of highway and walls of individual practices that were separating our clinics

THANK YOU!

NCQA's Patient Centered Medical Home (PCMH) 3 Year Demo Project

Scenic Rivers Health Services
Bigfork Clinic Site
Provider/Staff Introduction Meeting
January 25, 2012

What is the NCQA PCMH Demo Project?

- CMS (Center for Medicare/Medicaid Services) funded project, assisting FQHC's (Federally Qualified Health Center) to get on board with a Patient Centered Medical Home
- NCQA (National Committee for Quality Assurance) working with CMS FQHC's to achieve level 3 NCQA recognition
- CMS will reimburse FQHC's based on their Medicare populations on a quarterly basis in an effort to assist with implementation costs

Who is in the demo project?

- 500 FQHC's across the United States
- Only one FQHC chosen in Minnesota, that being SRHS, Bigfork
- Why Bigfork?
  - Met criteria for Medicare Patients
  - Rural Area Need - limited healthcare facilities in Bigfork area
  - Other FCHC's declined project

What is a Patient Centered Medical Home (PCMH)?

- **The American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA) developed seven core principles that define a Medical Home:**
- 1) ***Personal Medical Provider*** — patients have a single physician or medical provider overseeing and facilitating their health care
- 2) ***Clinician Directed Medical Practice*** — a team of health care professionals supports the patient's personal physician or clinician
- 3) ***Whole Person Orientation*** — all aspects of each patient's care are managed, not just conditions directly related to the physician's medical specialty

What is a Patient Centered Medical Home (PCMH)? Cont..

- 4) ***Coordinated/Integrated Care*** — hospital, home health agency, nursing home, and public/private community-based program care is monitored and results are tracked via disease registries, electronic medical records (EMRs), and other forms of information exchange
- 5) ***Quality and Safety*** — using evidence-based medicine and clinical decision-support tools, personal physicians/providers actively engage patients and their families with information about their conditions and options for care
- 6) ***Enhanced Access*** — Medical Homes offer non-traditional office hours and multiple communication channels to ensure patients/families have access to the support they need
- 7) ***Payment*** — Medical Home clinics can be recognized within their communities for the services they provide, which exceed the typical clinic-patient relationship

Expectations

- ***CHANGE*** **will occur**
- **Remain in demo for duration of project (3 years)**
- **Cooperate with evaluation contractor**
- **Participants comply with stated Terms and Conditions**
- **Complete semi-annual surveys (NCQA)**
- **Comply with random audits if required**
- **Achieve Level 3 NCQA recognition by end of 3rd year in demo project**

SRHS Bigfork PCMH Team

- Jeff Scrivner – Project Director
- Cathy Sellers – Clinical Support
- Nancy Mault – Project Coordinator
- Carmen Heinecke – HIT/EMR/PM Support
- Jessica Furey – Clinical Support
- Linda Buckingham – Clinical Support
- Additional team members to be brought in at appropriate times, i.e Julie Procopio – Health Information Support, Barb Beyer – Account Mgmt Support, additional medical providers for clinical support

NCQA PCMH Standards

- Enhance Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Provide Self-Care Support and Community Resources
- Track and Coordinate Care
- Measure and Improve Performance

NCQA Medical Home Standards Emphasis

- Emphasis on patient-centeredness and patient experience of care
- Reinforces incentives for Meaningful Use (HIT)
- Focuses attention on aspects of primary care that improve quality and reduce costs
- Based on advances in evidence and changes in practice capability

How To Get Started

- Project Director and Project Coordinator will review all Standards (6) and Elements (28)
- Determine areas currently meeting criteria
- Determine areas needing further implementation or refinement
- Develop outline for PCMH team
- Meet with PCMH team February 8th
  - Develop guidelines for progression of project
- Meet with Providers/Staff February 15th
  - Introduce guidelines

Questions?