DOORWAY INFORMATION FACT SHEET

Mi-CCSI Center for Clinical Systems Improvement

Patient Name	Judy Toody	**Patient DOB**	2/13/1955
Diagnosis	Diabetes – A1C 10.7 Depression – PHQ-9 HF – managed HTN – BP 165/90 HL – LDL 254	**Visit Type**	Office Visit
Referral Reason	Diabetes and BP uncontrolled		

You are an RN care manager in a primary care office. You work with a team that includes several physicians, three advanced practice providers (APPs), a pharmacist, a social worker, a dietician, and a group of medical assistants and registration staff. You recently started as the care manager in the practice and are beginning to receive referrals from other care team members in situations where they feel your expertise would be helpful.

You receive an electronic message from the medical assistant regarding Judy, who was in the office last week for a well visit. In her message, the medical assistant writes:

> *"Can you please outreach to Judy to speak with her about her A1C and BP, indicating she is struggling with her diabetes and HTN. The provider asked to have a referral to the Nurse Care manager and SW'er. She was in for a well visit and is having a lot of trouble remembering to take her medications. I think her BP and lipids are probably elevated because she hasn't been taking her medications regularly since her husband died about 6 months ago. The SW'er is going to continue to work with her on adherence barriers related to the depression diagnosis, the provider would also like to involve you. She seems to be confused about her diabetes medications, so the provider asked for a referral to you. She mentioned to me that she stopped taking her metformin when we started her on Lantus and is expressing hesitancy about restarting metformin." She was in 6 month's ago and started on Paxil. Related to side effects, she spontaneous stopped the medication for her depression and stopped her metformin for the diabetes on her own.*

You go through the process of reviewing Judy's chart and learn the following objective information. Judy is a 65-year old white woman with a BMI of 42 and a history of heart failure, diabetes, hypertension, depression, and dyslipidemia. She was diagnosed with HF about a year and a half ago and up until about 6 months ago, her symptoms were well-controlled and her BP was within the appropriate range. In the recent office visit, her A1C is 10.7%, her BP is 165/90, and her LDL-C is 254. She also screened positive for depression with a PHQ-9 score of 12 and you can see that I've also placed a referral to the social worker.

After looking at Judy's problem list, list of active medications, and social history, you decide that you will start off by completing a virtual call to begin the assessment with the patient. Your goal will be to assess Judy's level of understanding regarding her diagnosis, what her goal is, and identify any problems to speak with the physician about, following your encounter with Judy. Based on the note from the MA, you will plan to focus primarily on Judy's diabetes and hypertension, review treatment options, and come up with a plan to improve her safety and risk, ideally getting her BP in control and eventually, her diabetes to target.

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ALLERGIES

NKA

MEDICATION LIST

Drug	Dosage	Indication
Carvedilol 25 mg	Take 1 tablet by mouth twice daily	**Heart Failure**
Furosemide 20 mg	Take 1 tablet by mouth once daily in the morning	**Heart Failure**
Lantus Solostar (100 units/mL)	Inject 20 units subcutaneously once daily in the evening	**Diabetes**
Lisinopril 10 mg	Take 1 tablet by mouth once daily	**Hypertension**
Metformin 1000 mg	Take 1 tablet by mouth once daily	**Diabetes**
Pravastatin 20 mg	Take 1 tablet by mouth once daily	**Hyperlipidemia**
Omeprazole	Take 1 capsule by mouth once daily	**Unknown**
Paxil 20 mg	Take 1 capsule by mouth once daily	**Depression**

ACTIVE PROBLEMS

Depression
Diabetes Mellitus, Type 2
Dyslipidemia
Heart Failure
Hypertension