DOORWAY INFORMATION FACT SHEET

Mi-CCSI Center for Clinical Systems Improvement

Patient Name	Judy A. Toody	**Patient DOB**	2/13/1955
Case Type	Diabetes Depression SDOH HF HTN HL-LDL Hyperlipidemia	**Visit Type**	Office Visit
Visit Reason	Overdue Diabetes Visit		

ASSESSMENT PLAN

Type II Diabetes Hypertension	Refer to RNCM for evaluation and self-management Repeat A1C in 3 months
Depression	Refer to LMSW for recurrence of depression Restart Paxil on lower tapering dose. Monitor side effects to maximize adherence

VITAL SIGNS

Height (ft & in)	5'1"	**Weight (lbs)**	220
BMI	42	**Pulse/min**	74
BP	165/90		

LAB VALUES

A1c	10.7	Previously 8.5 prior to starting Lantus. Discontinued metformin upon initiation of the Lantus

SCREENING RESULTS

PHQ9	12 (0 on #9)	Previously 10 – prescribed Paxil SR 25 daily
GAD7	4	Within normal
SODOH	Positive for transportation	Referral to referral coordinator

ALLERGIES

NKA

MEDICATION LIST

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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**
Paxil	10mg am and 5 mg pm x2 weeks Titrating to 10 mg bid thereafter	**Depression**

ACTIVE PROBLEMS

Depression
Diabetes Mellitus, Type 2
Dyslipidemia
Heart Failure
Hypertension

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Simulation Preparation

You are a new member of the Primary Care Team. The team includes several physicians, three advanced practice providers (APPs), a care manager, a social worker, pharmacist, a dietician, 2 medical assistants for each provider and registration staff.

Roles: This Care Team

Medical Assistant (MA) - Rotating days. Each MA FTE is assigned to a provider pod at 4 days a week. Responsibilities include rooming the patient to prepare for the provider visit. This involves preparing the chart, rooming the patient and preparing for the provider examination, conducting screenings to include social barriers with the SDOH questionnaire, depression screening with the PHQ2, Anxiety screening with the GAD 7 and conducting a medication history.
One day a week the MA is dedicated to population health management. This involves reviewing the registry list for "gaps in care/health maintenance needs" and for patients with a gap in care, addressing the gap in care at the time of a visit, and/or telephonically outreaching to the patients on the list to remind them of overdue tests, and if needed, schedule them for an office visit.

RN Care Manager (RNCM) -In the organization, the RN Care Managers are assigned to high risk patients. High Risk patients are identified as having one or more uncontrolled chronic diseases with one or more out-of-scope measurement for the conditions of diabetes (A1C>9, elevated LDL, elevated BP, missed eye exam, missed foot exam), Hypertension (B/P> 140/90) and Heart Failure (> 1 inpatient admission or ED visit in past 6 months). The RN Care Manager also conducts post-discharge calls for patients admitted with a chronic condition complication or an elective admission that may result in complications of a chronic condition.
The RN Care Manager works with the patients on resolving high risk issues, on self-management action plan development, care coordination, and where knowledge deficits are identified, provision of education.

Behavioral Health Specialist/LMSW (BHS/SW) – The LMSW's are assigned to patients identified as having moderate to severe depression or anxiety and those that screen positive on the Social Determinants for behavioral or safety issues. Screening results for the SODOH, PHQ9 and GAD7 are entered into the EMR by the MA. The provider confirms diagnosis and determines if a referral to the LMSW is needed.
Patients referred to the LMSW will have a comprehensive assessment to further evaluate the condition(s) and determine the need for enrollment into depression/anxiety collaborative care (if available), care management for the depression/anxiety, education, brief treatment or referral to specialist/practitioners outside the practice.

Pharmacist- The pharmacist in the organization are assigned to high risk patients with conditions of chronic disease, polypharmacy, on high risk medications, or with complicated regimens. The pharmacists are also referred patients to conduct a Comprehensive Medical Review (CMR) to assist the provider with medication management recommendations.

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Case Study Facts

The Patient:

Judy Toody is a 65-year old white woman with a BMI of 42 and a history of heart failure, diabetes, hypertension, and dyslipidemia. She was diagnosed with Heart Failure (HF) about 11/2 years (18 months) ago. Up until about 6 months ago, her symptoms for the HF were well-controlled and her BP was within the appropriate range (128/76). She has a history of depression. Her last PHQ9 (6 months ago) was 10, of which the provider prescribed Paxil CR 25 mg. per day.

Population Health; Patient Identification:

- 7 Days ago, the MA reviewed the gap in care registry
- Judy Toody is identified as having needed follow-up. She is overdue for her planned care diabetes visit and A1C test.
- In review of the medical record, the MA identifies Judy "no showed" for her last 2 appointments. This is unusual for Judy.

Patient Identification; Population Health Pre-visit Planning

- To address the gaps in care, the MA places a call to Judy to schedule an appointment. Demonstrating care and concern, the MA brings up the missed appointments. Judy admits she has not been "very on top of things" since her husband died 6 months ago. In addition, her car has been acting up and he always fixed it in the past. It is not currently running but her sister is willing to take her shopping and to appointments. The MA expresses empathy and inquires if Judy's sister would be available and willing to bring her into a doctor office visit. Judy says she would if it is on a Thursday before 3. The appointment is scheduled.

Day of visit - MA Visit Preparation

- The MA reviews Judy's chart (Doorway Fact Sheet)
- MA preps Judy's chart.
    - Notes Judy is overdue for an A1C.
    - Completes a Point of Care (POC) A1C. (The office's Health Maintenance protocol has standing orders that allow the MA to do a Point of Care A1C prior to the patient seeing the provider).
    - MA starts the visit with the patient
        - Obtains the patient's vital signs (BMI, B.P., and has Judy remove her socks and shoes for the monofilament foot exam)
        - Judy's B/P is **165/90**
        - POC A1C- today it is **10.7**
        - PHQ9 screening score is **12** (#9 suicide question is 0)

Provider Visit

- The Primary care physician conducts the diabetes planned care visit. During the visit, Judy reports she stopped the Paxil on her own related to side effects of feeling restless and not being able to sleep. The provider reviews the elevated BP and A1C findings with Judy and inquires on what her thoughts are on this - what might be the reasons for the changes? Judy shares she has not been able to concentrate and has been missing medication dosages. This has been since her husband died, she's been struggling emotionally, pulling away from friends and family. She hasn't gotten out much.

- Based on the findings the provider creates the medical plan of care:
  - Restart Paxil at 10 mg in the morning 5 mg in the evening and tapering up to 10 mg 2X a day in 2 weeks. Referral to the LMSW for depression management
  - Have the referral coordinator follow-up on the transportation issues
  - Warm handover today to the RN CM to address chronic disease management needs, medication adherence concerns, and self-management
  - Add Judy to the Team conference Roster scheduled in 1 week – notify extended team of plans to review her case – be prepared to share their findings.

Key Simulation Actions Assessment and Care Planning

Introducing the concept of TBC

- Describing and obtaining permission

Starting the assessment

- Establish patient knowledge, ability, and interest
- Starting the assessment
  - Key areas of focus with open-ended questions

- Creating the action plan
- Follow up and monitoring

Create the SBAR (as a team)

- Situation
- Background
- Assessment
- Recommendations