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 LMSWs 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 is assigned to complete a comprehensive medication review (CMR) for all patients on high risk medications, with a complicated medication regimen, or when multiple chronic conditions are present. The pharmacist is also consulted when medication-related problems are identified or suspected (e.g., access issues related to cost or lack of insurance coverage, patient non-adherence, medication administration counseling, drug-drug interactions, etc.) and when the team is in need of guidance related to treatment options.

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DOORWAY INFORMATION FACT SHEET

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Case Study Facts

Group Breakout: Outreaching to the Patient Breakout

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 1 and 1/2 years (18 months) ago. Up until about 6 months ago, her symptoms of 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. The call took 20 minutes **(98967-BCBS, PH no code)**

Information on the Patient representing a Planned Visit

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)

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Group Breakout: Introducing TBC Concepts to the Patient Breakout

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 **(calls GoBus-possibly 99497 depends on time end of month)**
  - Referral to Pharmacist and BHS in next 3-5 days to conduct the CMR
  - 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**.(G9007 or G9008 Priority Health-depends on who is there and if G9008 was previously done)**

Provider treatment plan notes

Referral Follow-up

- A note is sent to the extended team (RNCM, Pharmacist, and LMSW)
  - Dr Jones is finishing up with Judy Toody in room #2. He is asking to have the RNCM come into the room today for a warm handoff. Are you available to come in 5"? He'd like to introduce you. Referral reason is to work with her on her high A1C and B/P. She is here for an overdue diabetes check. She is having trouble remembering her meds and seems confused about them since her husband died. She stopped her metformin when we started her on Lantus and not sure she wants to restart it. She also stopped the Paxil soon after she started it due to restlessness and trouble sleeping. **(RN visit G9002 or G9001 if comprehensive – pending how your system manages this with multi-disciplinarians)**
  - Referring her to the pharmacist to complete a CMR within the next week. Please outreach to Judy, she can be reached on her cell phone anytime between 9 a.m. and 9 p.m. Doctor reviewed this with Judy and she is anticipating a call. **(Pharmacist phone call that took 25 minutes-98968)**
  - He's referring to the LMSW for depression management. Please outreach to Judy for the depression management. Dr. reviewed the importance, and she is expecting a call. BHCM calls patient to set up visit. **(BHCM Telehealth visit-G9002 or G9001 if comprehensive. Reminder: BCBSM- allows multiple use of G9001)**

Group Breakout: Establishing Patient Knowledge and Desire

Referral to the Care Manager

- Warm handover today to the RN CM to address chronic disease management needs, medication adherence concerns, and self-management
- Care manager review with the patient her understanding of why she was referred and what area(s) the patient would like to begin addressing
- Care manager (assuming it is diabetes), assist the patient in identifying where she would like to start

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