CASE MANAGEMENT:
PRACTICING POPULATION HEALTH TO ENGAGE PATIENTS AS PARTNERS IN CARE

Krista Haven RN, MSN, CCM, CDE
Diabetes Nurse Specialist
Chinle Comprehensive Health Care Facility, Chinle AZ
WHO WE ARE

- **Diabetes Program**
  - 3 coordinators, 1 administrator, 1 lead health coach, 14 health coaches, 1 data manager, 1 nurse improvement specialist, 1 clinical consultant
  - Administratively housed in Public Health, Population Health
  - Accreditation (2018) by American Diabetes Care and Education Specialists (ADCES)

- **Collaborations within the Chinle Service Unit (CSU) for diabetes clinical care and prevention**
  - Primary care (adult, pediatrics, SCOB, case management), podiatry, optometry, dental, nutrition, integrated behavioral health, in-patient, Office of Native Medicine, mobile health unit, adolescent/school health, Wellness Center, HPDP, public health nursing

- **Community partnerships**
  - Schools, Chinle Navajo Nation Special Diabetes Program for Indians (SDPI), Navajo Nation Health Education, Community Health Representatives
Define case management and health coaching, and how case management programs may improve patient-centered clinical services, primary care infrastructure and population health.

Describe how team members can be mentored to develop case management skills.

Discuss how to identify high risk patients in a population, including those with a diagnosis of diabetes, utilizing tools such as RPMS: ICare, and Audit analytics.
High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual’s health and wellness needs across settings and through sustained relationships with patients, families, and communities.
More than addressing
“What is the matter with you?”
WHOLE PERSON CARE

More than addressing “What is the matter with you?”

Also, addresses "What matters to you?"
TEAM BASED CARE

Courtesy of the Medical Center Archives of New York Presbyterian/Weill Cornell Medicine
EQUITABLE CARE


https://resistancetraining.wordpress.com/2016/06/28/the-equity-kids/
THE VISION OF RELATION-BASED CARE: “THIS CARE IS DIFFERENT.”
- HOW WE HOPE PATIENTS TALK ABOUT THEIR EXPERIENCE

- There is a team helping me and they all seem to know what they’re doing
- They care about me and what I want
- They are easy to get a hold of
- My appointments are better – things really get done
- They’ve taught me so that I can now really take care of myself
- They helped me get through one of the hardest periods of my life
- I am on more meds but I understand them better
- They listen
- I feel better
MEDICAL HOME MODEL: PRIMARY CARE BASED

Navajo Hogan

http://www.foma.org/patient-centered-medical-home.html
WHAT IS HIGH-QUALITY PRIMARY CARE?

- The definition of high quality primary care was based on the following concepts:
  - integrated, whole-person health;
  - interprofessional care teams;
  - foundational, sustained relationships between the care team and patients and families;
  - the critical role of communities in providing primary care;
  - the importance of equitable access to primary care; and
  - the diversity of settings and modalities used to deliver primary care.

Health Coaching helps patients build the knowledge, skills, and confidence required to manage their chronic conditions and improve their health. Health coaches empower patients to play a central role in clinical encounters and to engage in self-management activities at home, work, and schools, where they spend most of their lives.

Philosophy

- Health coaching is built on a relationship
- Health coaching frequently helps patients understand provider advice
- Patients may or may not be ready for changes, and coaching meets them where they are
- Health coaching can help patients be involved in the clinical decisions

https://cepc.ucsf.edu/health-coaching
"Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes."

**Philosophy**
- When an individual reaches the optimum level of wellness and function, everyone benefits
- Case managers triangulate between patients/caregivers, providers, and the organization of health services to maximize benefits
  - Explicit advocacy (and equity) role for patients/caregivers within the health system
  - Knowledge of how the health system works and how it might best serve a patient and their needs
- Bridge communication between patients and provider(s)

[What Is A Case Manager | Case Management Society of America (cmsa.org)](http://www.cmsa.org)
Diabetes is a common, complex medical problem with population prevalence of 21.6% in Chinle.

http://www.foma.org/patient-centered-medical-home.html
MEDICAL HOME MODEL: PRIMARY CARE BASED

Navajo Hogan

We can identify cohorts of patients who will benefit from special attention. Examples are patients with new onset DM, elevated A1c, or on insulin.

Diabetes is a common, complex medical problem with population prevalence of 21.6% in Chinle.

http://www.foma.org/patient-centered-medical-home.html
MEDICAL HOME MODEL: PRIMARY CARE BASED

Health coaches can help patients learn about diabetes care and overcome barriers to diabetes care. They share language and culture, and live in the community.

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http://www.foma.org/patient-centered-medical-home.html
# Social Determinants of Health for Diabetes

F. Hill-Briggs, Diabetes Care, 2021

<table>
<thead>
<tr>
<th>Socioeconomic Status</th>
<th>Neighborhood and Physical Environment</th>
<th>Food Environment</th>
<th>Health Care</th>
<th>Social Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>Housing</td>
<td>Food Security</td>
<td>Access</td>
<td>Social Cohesion</td>
</tr>
<tr>
<td>Income</td>
<td>Built Environment</td>
<td>Food Access</td>
<td>Affordability/Quality</td>
<td>Social Capital</td>
</tr>
<tr>
<td>Occupation</td>
<td>Toxic Environmental Exposures</td>
<td>Food Availability</td>
<td></td>
<td>Social Support</td>
</tr>
</tbody>
</table>
Health coaches, providers, and medical assistants create a care team. This is the basic unit of support for patients. The team may grow, depending on the patient.
Navajo Hogan

Health coaches build rapport with their patients. Over several visits, a relationship develops and trust grows. The care team benefits.

http://www.foma.org/patient-centered-medical-home.html
Because the team helps make care needs and goals explicit, health coaches can help patients navigate their way toward success. They help patients stay on track, get their medications, and connect patients with other services. This is the essence of case management or care coordination.
The coaches provide an additional pathway to access. They help patients communicate with their provider or set appointments.

http://www.foma.org/patient-centered-medical-home.html
# DIABETES CASE MANAGEMENT COHORTS

<table>
<thead>
<tr>
<th>Case-Management</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Diabetes</td>
<td>Educate pre-DM patients with updated handouts and wellness center and nutrition referrals</td>
</tr>
<tr>
<td>Newly Diagnosed (Best Practice)</td>
<td>Engage new DM patients in care, support their personal journey with DM, educate them about DM and its management (ADCES self-care behaviors), and treat with lifestyle interventions and medications</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Utilize motivational interviewing, self management, goal setting, and educate patients about DM with a focus on A1C &lt; 8, Blood pressure &lt; 140/90, Statin use for patients that have risk factors and/or &gt;40 to decrease cardiovascular risk</td>
</tr>
<tr>
<td>Inpatient/Emergency/Urgent Care</td>
<td>Influence patients to use their care teams for follow-up and introduce Diabetes Health Coach model-of-care</td>
</tr>
<tr>
<td>Teen/Pediatric clinic</td>
<td>Healthy Habit and SMART goal setting</td>
</tr>
<tr>
<td>ADCES patients</td>
<td>Glycemic control and risk reduction</td>
</tr>
</tbody>
</table>
BEST PRACTICE PROJECT
**Target Population:** Patients with new onset DM ages 30-60, residing in a CSU community, A1c > 8% at the time of diagnosis

- Primary goal is to achieve A1c < 8%
- Annual cohorts since 2015

**Background:** Early glycemic control is associated with improved diabetes outcomes; providing an opportunity to alter the trajectory of DM morbidity.

- In one study, the authors estimated a 7-fold mortality benefit for a 1% reduction of A1c in Y1-10 with diabetes compared to Y11-20 with diabetes (18.8% reduction vs. 2.7% reduction)¹.

**Intervention:**

- Assign a health coach to every patient in the target population
- Early engagement, support, and case management in team-based primary care with emphasis on diabetes education, self-management support, and outreach
- Additional options for education and support from Nutrition, the Wellness Center, Integrated Behavioral Health, Office of Native Medicine

¹ M Lind, Diabetes Care, 2021
WHAT DO WE NEED TO DO TO BE SUCCESSFUL?

- Provide comprehensive primary care
  - Education about lifestyle
  - Prescribe and monitor medications
  - Self-management support with motivational interviewing and assessment for readiness to change
  - Track glycemic control
  - Screening and evaluation for prevention and early detection of complications

- Support individuals with new onset diabetes to accept this diagnosis
  - Recognize the emotional burden of the diagnosis
  - Build trust

- Help newly diagnosed become and remain our “partners in care”
  - Fragmented care to continuity
  - Understand the health system and engage with primary care
  - Case management to track visits and keep the primary care relationship going
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Health coaching can play a central role in the aims of comprehensive primary care for people with diabetes.

Coaching provides emotional support and helps build trust for primary care.

We added a case management role in support of continuity and navigation.
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THE FIRST SIX YEARS TAUGHT US....

....we could be successful

- **Evaluation:**
  - Comparison of glycemic control for the first three cohorts to similarly selected patients from the three years preceding the QI project

- **Results:**
  - The Best Practice participants
  - Achieved an average A1c 1.0% lower (p<0.001)
  - More likely to achieve A1c <8% (58% vs. 42%, p=0.013)
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  - Achieved an average A1c 1.0% lower (p<0.001)
  - More likely to achieve A1c <8% (58% vs. 42%, p=0.013)

.....COVID affected this vulnerable population

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**Rate of A1c<8% after Y1 in the program**

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-pandemic</th>
<th>Pandemic</th>
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<tbody>
<tr>
<td>2016</td>
<td>55%</td>
<td>35%</td>
</tr>
<tr>
<td>2017</td>
<td>56%</td>
<td>48%</td>
</tr>
<tr>
<td>2018</td>
<td>53%</td>
<td>48%</td>
</tr>
<tr>
<td>2019</td>
<td>56%</td>
<td>48%</td>
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<tr>
<td>2020</td>
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<tr>
<td>2021</td>
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</table>

11% lower rate of A1c<8%
LESSONS FROM THE BEST PRACTICE

- Data driven
- Patient engagement and self-management
- Care team
- Continuity
- Care coordination
- Access
MENTORSHIP: WHO ARE OUR COACHES?

- Local Navajo tribal members – bicultural and bilingual
- Variable educational backgrounds:
  - High school grads
  - College graduates: health promotion, nutrition
  - Medical assistant
- Non-licensed professionals
- Selected for experience, ability and potential
- Trained on the job with a competency-based curriculum
TRAINING DIABETES HEALTH COACHES

- Extensive orientation with curriculum
  - Shadowing
- Ongoing support
- Competencies
  - Competency based career advancement
TRAINING DIABETES HEALTH COACHES

- Motivational Interviewing
- Brief action planning
- Ask-tell-ask
- Teach back strategies
- Shared decision making
- Empathic listening
- Culturally sensitive communication
- Case management skills
- Electronic Health data tools
# ADCES: Level One/Two Career Path for Diabetes Educators

## Level One Characteristic:
Level 1 includes community healthcare workers and other non-professional healthcare providers who have little expertise in diabetes education and/or management, but provide and/or support healthcare services to individuals with diabetes. This level includes, but is not limited to, health promoters, health educators, and community health workers.

## Level One Definition:
This level comprises healthcare workers who do not have a clinical background, but who nonetheless work with persons with diabetes in supportive or clinical environments.

## Domain One: Pathophysiology, Epidemiology, and Clinical Guidelines of Diabetes
**Competency:** Demonstrates familiarity with pathophysiology, epidemiology, and clinical guidelines consistent with diabetes care for a provider level one.

<table>
<thead>
<tr>
<th>Lifespan</th>
<th>Self Assessment Initial/Date</th>
<th>Mentor Assessment Initial/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identifies and refers high risk and/or patients with unstable diabetes to diabetes care providers</td>
<td></td>
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<tr>
<td>2. Encourages use of family and community support systems</td>
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<tr>
<td>3. Identifies support systems</td>
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</tr>
</tbody>
</table>
**PEER EVALUATION CHECKLIST:** CHRONIC DISEASE/DIABETES HEALTH COACH PEER EVALUATION

**EMPLOYEE NAME:** ___________________________________ **Title:** __________________________ **Clinic:** ___________________________

**Average Score:** ___________ (Supervisor to determine) **Evaluator’s Name:** __________________________

**Instruction Key:**
- Includes:
  - R = Role play education
  - F = Clinic observation/participation
  - D = Demonstration in case study discussion

**Evaluation Key:**
- Includes:
  - R = Role play education
  - D = Demonstration in case study discussion
  - V = Verbal

**Validation of Competency**

<table>
<thead>
<tr>
<th>Education Level Key</th>
<th>Evaluation Key</th>
<th>Date</th>
<th>Initials</th>
<th>Evaluation Key</th>
<th>Education Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = Novice</td>
<td>O = Observation</td>
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<tr>
<td>PR = Practitioner</td>
<td>RD = Return Demonstration</td>
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<tr>
<td>P = Preceptor</td>
<td>V = Verbal</td>
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</tbody>
</table>

**Peer evaluation**

Pre-plans and meets with care team for action plan for each patient
Introduces self to patient in a culturally competent manner
Attempts to build trust/rapport with respectful communication
Uses motivational interviewing skills to determine patient barriers
Directs patients to the 7 self-care behaviors for setting goals: Healthy eating, being active, monitoring, taking medication, problem solving, risk reduction, and healthy coping
Articulates correct diabetes language and examples to describe diabetes pathophysiology and management
Set a goal with the patient and set a time for follow-up
Communicates patient information in a clear manner with other members of the diabetes care team
After visit follow-up done with the patient in a timely manner

**Peer evaluation for Duties**

- Insulin start
- Newly diagnosed diabetes
- Glucometer use
- Low blood sugar prevention and treatment
- General nutrition
- Pre-DM education
- Medication review

**Name:** ___________________________________ **Initials:** __________________________ **Signature:** __________________________

**Suggestions/Comments:**
_________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________________
# List of Community Resources

### For Children

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Location/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Grief Support</td>
<td>123 Main St, Anytown, USA, (555) 123-4567</td>
</tr>
<tr>
<td>Early Learning Center</td>
<td>456 Anytown Ave, Anytown, USA, (555) 789-0123</td>
</tr>
</tbody>
</table>

### For Youth

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Location/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Development Council</td>
<td>789 Main St, Anytown, USA, (555) 345-6789</td>
</tr>
</tbody>
</table>

### For Families

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Location/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Support Services</td>
<td>123 Anytown Road, Anytown, USA, (555) 456-7890</td>
</tr>
</tbody>
</table>

### For All Ages

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Location/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Center</td>
<td>567 Anytown Ave, Anytown, USA, (555) 890-1234</td>
</tr>
</tbody>
</table>

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## Resources for Healthcare

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Available at various locations throughout the community.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Provided by local therapists and counselors.</td>
</tr>
<tr>
<td>Nutrition Services</td>
<td>Offered at community centers and clinics.</td>
</tr>
</tbody>
</table>

## Resources for Education

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Counseling</td>
<td>Provided by local universities and colleges.</td>
</tr>
<tr>
<td>Career Planning</td>
<td>Services offered by local employment agencies.</td>
</tr>
</tbody>
</table>

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## Additional Resources

<table>
<thead>
<tr>
<th>Program</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meals on Wheels</td>
<td>(555) 123-4567</td>
</tr>
<tr>
<td>Fuel Assistance</td>
<td>(555) 789-0123</td>
</tr>
<tr>
<td>Energy Assistance</td>
<td>(555) 345-6789</td>
</tr>
</tbody>
</table>

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## Contact Information

- **Office of Community Services**: 123 Main St, Anytown, USA, (555) 456-7890
- **Healthcare Services**: 567 Anytown Ave, Anytown, USA, (555) 890-1234
- **Education Services**: 987 Main St, Anytown, USA, (555) 123-4567

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**Updated**: 3.7.2017
Medical Home Teams

<table>
<thead>
<tr>
<th>Department</th>
<th>Team</th>
<th>Care Coordinator</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>Sage</td>
<td>Kristin St. Germaine, RN</td>
<td>David Goldberg, MD</td>
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<tr>
<td></td>
<td></td>
<td>Case Manager (Detailed)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Savannah Beggay,</td>
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<td></td>
<td></td>
<td>Care Coordinator</td>
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<tr>
<td></td>
<td></td>
<td>P (928) 674-7061</td>
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<td></td>
<td></td>
<td>Cell (928) 221-9456</td>
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<td>Vacant, Care Coordinator</td>
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<td></td>
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<td>P (928) 674-7886</td>
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<td>Cell (928) 380-8895</td>
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<td></td>
<td>David Goldberg, MD</td>
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<td>Sayumi De Silva, MD</td>
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<td>Jacqueline Selig, ANP</td>
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<td></td>
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<td>Leslie Stewart, MD</td>
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<td>Putherry Vs, MD</td>
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<td>Donald Miles, MD</td>
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<td></td>
<td>Yucca</td>
<td>Regina Fuller RN Case</td>
<td>Sayumi De Silva, MD</td>
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<td></td>
<td></td>
<td>Manager</td>
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<td></td>
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<td>P (928) 674-7002</td>
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<td>Cell (928) 380-8137</td>
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<td></td>
<td></td>
<td>Samantha Honyumpeiwua,</td>
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<td>Care Coordinator</td>
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<td>P (928) 674-7894</td>
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<td>Cell (928) 380-5204</td>
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<td></td>
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<td>Tommy Roane,</td>
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<td>Care Coordinator</td>
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<td>P (928) 674-7895</td>
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<td></td>
<td>Cedar</td>
<td>Vacant RN Case Manager</td>
<td>John Tisdale, MD</td>
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<td></td>
<td>P (928) 674-7928</td>
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<tr>
<td></td>
<td></td>
<td>Lena Lewis, MD</td>
<td>Joseph Selay, MD</td>
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<td>Care Coordinator</td>
<td>Jonathan Powell, MD</td>
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<td>P (928) 674-7919</td>
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<td>Cell (928) 380-8124</td>
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<td>Colleen Beggay HT, Care C</td>
<td>John Tisdale, MD</td>
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<td>Joseph Selay, MD</td>
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<td>Juniper</td>
<td>Heidi Ekon, RN</td>
<td>John Tisdale, MD</td>
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<td>P (928) 674-7896</td>
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<td>Cedelinda Todechines, RN</td>
<td>Joseph Selay, MD</td>
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<td>Care Coordinator</td>
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<td>P (928) 674-7762</td>
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<td>Cell (928) 380-8126</td>
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<td>Candelma Jim,</td>
<td>John Tisdale, MD</td>
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<td>Care Coordinator</td>
<td>Joseph Selay, MD</td>
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<td>P (928) 674-7885</td>
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In the event that a Care Coordinator cannot be contacted, please call Shavonna White at (928) 674-7458

Updated 10/20/2022
Your Care Team
Matthew Werito, Health Coach
Phone: 928-674-7896
Email: matthew.werito@ihs.gov

Wilma Hunter-Pine, RN, Nurse care coordinator
Phone: 928-674-7754
Email: wilma.hunterpine@ihs.gov

Internal Medicine
Primary Care Provider
Appointment desk
928-674-7069

Chinle Comprehensive Healthcare Facility
Drawer PH
Chinle, AZ 86523

Baa Hózho’ó Care
Engaging Patients as Partners in care

Personal Health Record
What is the Personal Health Record?
The Indian Health Service Personal Health Record (PHR) can help you access your health information. You can track medications and lab results, contact your health care provider, and much more - all from the privacy of your personal computer and mobile device.

When should I use the Personal Health Record?
The PHR is a tool that provides you with timely access to your health information. It is not a substitute for meeting with your health provider. If you are experiencing a medical emergency, call 911 or go immediately to the closest emergency room.

https://phr.ihs.gov

Chinle Comprehensive Health Care Facility
Population Health: “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.”

- Traditionally the domain of public health
- Impacted by the local social determinants of health
- Important for health equity
- More recently, primary care is embracing population health for their empaneled patients

Quadruple aim

- Enhancing patient experience
- Improving population health
- Reducing cost
- Improving the work life of health care providers

1. D Kindig, Health Affairs, 2015
2. T Bodenheimer, Annals of Family Medicine, 2014
People without chronic disease or risk factors

People with Renal Failure (RF) or Chronic Disease (CD) and low utilization of resources

People with CD or RF and moderate utilization

People with CD or RF and high utilization

People at end of life (25)
RPMS UTILIZATION

- Active users, living, CSU communities
- Histogram (frequency distribution) of ER visits in past year
- Histogram of hospital or transfers in past year, exclude birth and delivery
- Crosstab by number of ER and hospital/transfers
CHRONIC CONDITIONS

- DM
- HTN
- Heart disease or MI
- COPD
- Arthritis
- Depression
- Kidney disease
- Stroke
- Cancer
- Asthma

- Developmental delay
- Disability
- SA/Etoh abuse
  - Etoh lab value, withdrawal dx, abuse dx
- Prior trauma
- IPV positive
- Depression/anxiety
- Morbid obesity (BMI>35)
CASE MANAGEMENT: ICARE REGISTRY

Currently:
- Asthma
- COPD
- HIV/AIDS
- Diabetes
- Hypertension
- CVD Known
- CVD At Risk
- Obese
- Pre-DM Metabolic Syndrome
- Tobacco Users (Smokers)
- Pregnant
- Glaucoma
- End Stage Renal Disease
- Chronic Kidney Dis NOS
- Chronic Kidney Dis Stg 1
- Chronic Kidney Dis Stg 2
- Chronic Kidney Dis Stg 3
- Chronic Kidney Dis Stg 4
- Chronic Kidney Dis Stg 5

Future possibly to add:
- Acquired Hypothyroidism
- Acute Myocardial Infarction
- Depression
- Alzheimer's Disease, Related Disorders, or Senile Dementia
- Anemia
- Heart Failure
- Atrial Fibrillation
- Hip / Pelvic Fracture
- Benign Prostatic Hyperplasia
- Hyperlipidemia
- Cancer, Colorectal
- Cancer, Endometrial
- Cancer, Breast
- Osteoporosis
- Cancer, Lung

Future possibly to add:
- Rheumatoid Arthritis / Osteoarthritis
- Cancer, Prostate
- Stroke
- Cataract
- Schizophrenia and Other Psychotic Disorders
- Autism Spectrum Disorders
- Hepatitis C (already have a Change Request)
DM AUDIT TOOL

- RPMS for criteria
- Make a registry
- iCare panel
- Pull into excel
- Chart review new diagnosis
- Assign to the health coaches
- Case management

Approximately 60 pts on average fit the criteria
<table>
<thead>
<tr>
<th>Provider</th>
<th>% Met</th>
<th># Patients in Denominator</th>
<th># Patients in Numerator</th>
<th>2022 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM: BP &lt;140/90</td>
<td>79.7%</td>
<td>138</td>
<td>110</td>
<td>Jan-Jun BP&lt;140/90 79.7% 57.0%</td>
</tr>
<tr>
<td>DM: A1c&lt;8</td>
<td>47.8%</td>
<td>138</td>
<td>66</td>
<td>Jul-Dec BP&lt;140/90 57.0%</td>
</tr>
<tr>
<td>DM: Nephropathy</td>
<td>79.7%</td>
<td>138</td>
<td>110</td>
<td>Jan-Jun Nephropathy 79.7% 43.7%</td>
</tr>
<tr>
<td>DM: Retinopathy</td>
<td>54.3%</td>
<td>138</td>
<td>75</td>
<td>Jul-Dec A1c&lt;8 47.8% 0.0%</td>
</tr>
<tr>
<td>DM: A1c&gt;9</td>
<td>32.6%</td>
<td>138</td>
<td>45</td>
<td>Jan-Jun Retinopathy 54.3% 41.2%</td>
</tr>
<tr>
<td>DM: Statin Therapy</td>
<td>96.3%</td>
<td>109</td>
<td>105</td>
<td>Jul-Dec Retinopathy 41.2%</td>
</tr>
</tbody>
</table>

**Should be less than 16.8%**

- Jan-Jun A1c>9 32.6% 16.8%
- Jul-Dec A1c>9 16.8%
- Jan-Jun Statin 96.3% 56.8%
- Jul-Dec Statin 56.8%
### Chinle Service Unit (Chinle, Pinon, Tsaile) 5 year comparison

Audit Years: 2017 to 2021

<table>
<thead>
<tr>
<th>BLOOD SUGAR CONTROL</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1c &lt; 7.0</td>
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<tr>
<td>A1c 7.0-7.9</td>
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<tr>
<td>A1c 8.0-8.9</td>
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<tr>
<td>A1c 9.0-9.9</td>
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<tr>
<td>A1c 10.0-10.9</td>
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<tr>
<td>A1c ≥ 11.0</td>
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<td>Not Tested or No Valid Result</td>
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<tr>
<td>A1c &lt; 8.0</td>
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<tr>
<td>A1c &gt; 9.0</td>
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</table>

### BLOOD PRESSURE CONTROL - Based on 1 value or mean of 2 or 3 values

<table>
<thead>
<tr>
<th>BP category</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;140/&lt;90</td>
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<td>140/90 - &lt;160/&lt;100</td>
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<tr>
<td>160/100 or higher</td>
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<tr>
<td>BP category undetermined</td>
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<tr>
<td>If age ≥ 60, &lt;150/90</td>
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</table>

### HYPERTENSION

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
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</thead>
<tbody>
<tr>
<td>Diagnosed ever</td>
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<tr>
<td>Diagnosed hypertension &amp; mean BP &lt;140/90</td>
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</tbody>
</table>
1. In the last 6 months, did you contact this provider’s office to get an appointment for an illness, injury, or condition that needed care right away?
   - Yes
   - No

2. In the last 6 months, when you contacted this provider’s office to get an appointment for care you needed right away. How often did you get an appointment as soon as you needed?
   - Never
   - Sometimes
   - Usually
   - Always

(Insert 2a: During your appointments within the last 6 months, how often did you feel that your concerns were adequately addressed? Never/Sometimes/Usually/Always).

(Insert 2b): Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you see a specialist for a particular health problem? (CAHPS 20):

(Insert 2c): In the last 6 months, did the provider seem informed and up-to-date about the care you get from specialists? (CAHPS 21)
The principles and attributes of high quality primary care
- We described the multi-faceted Medical Home Model
- The importance of teams and relationships

The role of health coaching and their integration into the primary care team
- The contribution of health coaches to care in a Medical Home
- The importance of competencies for a para-professional workforce
- Extending the coaching role (and competencies) to include focused case management
- Having tools for health coaches to use when they apply case management functions

Principles of population health in primary care
- Using the Electronic Health Record to support the design and/or tracking of population health efforts
AHÉHEE’