ACO Accelerated Development Learning Session

Baltimore, MD
November 17–18, 2011

Module 1B: Care Delivery—Primary Care and Care Redesign

November 17, 2011
1:30–3:30 p.m.

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David Eitrheim MD:
Bio and Disclosure

- Family physician: Mayo Clinic Health System–Red Cedar in Menomonie, WI
- Co-chair of MCHS ACO Clinical Transformation Team
- Wisconsin Academy of Family Physicians Vice President, PCMH committee chair and Family Physician of the Year in 2004
- Menomonie Family Practice Rural Training Track Residency site director 1995–2003
- Clinical Assistant Professor University of Wisconsin and University of Minnesota Medical Schools
- Graduate of Augsburg College, University of Minnesota–Duluth School of Medicine and Sioux Falls Family Practice Residency program
- Team leader of MCHS–Red Cedar Provider/Nurse Clinic Efficiency Team
- Nothing to disclose

Goals and Objectives

- Understand the business case for improving clinic office efficiency in primary care
- Understand the team care concept in the Patient-centered Medical Home
- Create a charter to develop a Clinic Primary Care Provider/Nurse Efficiency Team

Situation

"In few other sectors of the economy is the highest-level professional responsible for the majority of production, customer service, and clerical work."

SGIM Blue Ribbon Panel Report. 2007. "Redesigning the Practice Model for General Internal Medicine: A Proposal for Coordinated Care." *J Gen Intern Med* 22:400–109.

"Family physicians spend 40% of their day doing something that someone else should be doing."

Quote from Terry McGeeney—
President and CEO of TransforMED

Background:
The 15-minute Office Visit

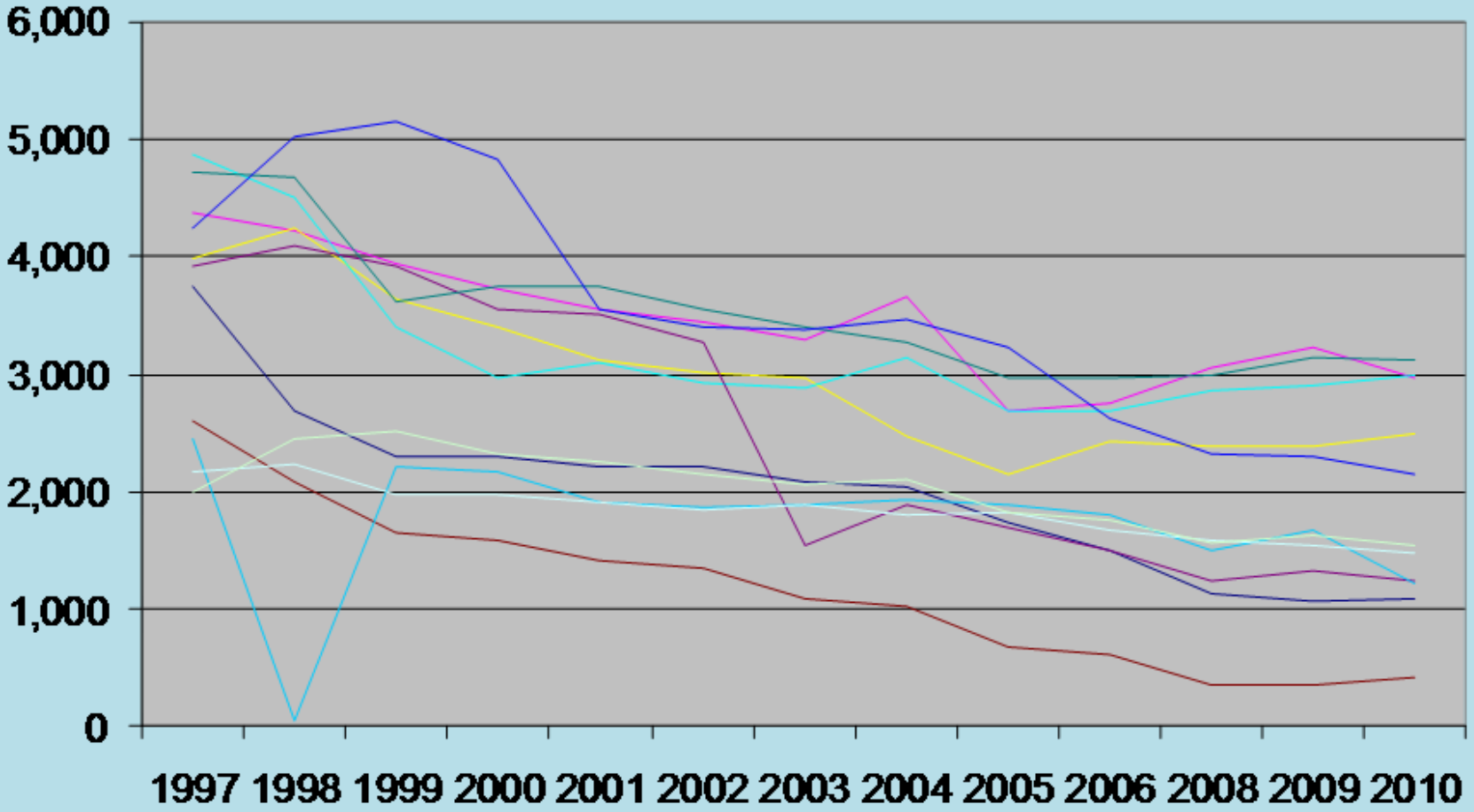
- Nurse tasks in rooming a patient 24 years ago:
  1. Weight
  2. Blood pressure
  3. Chief complaint

The 15-minute Office Visit Today

The 15-minute Office Visit Today

- Nurse tasks when rooming a diabetic patient today:
  - Weigh patient.
  - Take and record BP, pulse, temperature if needed, O2 sat if needed, LMP if applicable, and reasons for visit.
  - Record tobacco use and offer cessation counseling.
  - Review and update all allergies and medications listed on the Current Medication List and see if refills are needed.
  - Counsel preventive services and give appropriate immunizations, help schedule pap, mammogram, lipid testing, and colonoscopy.
  - Diabetic care includes doing annual diabetic foot exam and recording information that is used by our diabetic registry. Review diabetic knowledge assessment worksheet and provide education or make needed referrals to the dietician or diabetic educator.
  - Provide and review patient education materials.
  - Print diabetic scorecard and review with patient.

Clinic Visits by Provider 1997–2010



Primary Care:
Too Much To Do and Too Little Time

- Forty-two percent of primary care physicians report not having adequate time to spend with their patients.
  - Center for Studying Health System Change. Physician Survey. http://CTSonline.s-3.com/psurvey.asp.
- It takes 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients, plus 10.6 hours to manage all chronic conditions adequately.
  - Yarnall, K.S., K.I. Pollak, T. Ostbye, K.M. Krause, and J.L. Michener. 2003. "Primary Care: Is There Enough Time for Prevention?" *Am J Public Health* 93:635–641.
  - Ostbye, T., K.S. Yarnall, K.M. Krause, K.I. Pollak, M. Gradison, and J.L. Michener. 2005. "Is There Time for Management of Patients with Chronic Diseases in Primary Care?" *Ann Fam Med* 3:209–214.

It Only Takes a Minute…

- Toyota
  - "A minute here, a minute there and pretty soon you are talking real money."
- Primary Care
  - "A minute here, a minute there and pretty soon you are talking real burnout."

The Business Case for Change

- Primary care providers and nurses struggle to complete all the expected clinic tasks
- Not happy with their work/life balance
- Less willing to participate in improvement efforts
- Performing suboptimally on many measures of quality
- Result—Patients do not always receive exceptional care

Assessment

- The way we do office visits must change:

Physician Centered
to
Patient & Team Centered

Recommendation: Team Care

- Appropriate delegation of tasks
- Standard work flow
- Previsit planning
- Postvisit planning

Team Care:
MCHS—RC Office Efficiency Timeline

- 3/2007: Development of two-nurse team
- 3/2008: Team charter and goals
- Ongoing: Frontline solutions
- 1/2011: Provider and nurse survey
- 3/2011: Build protocols, new work flows, and work descriptions
- 7/2011: Diffusion

Team Care Principles: The Business Case

- Team-oriented (less physician-centric)
  - Patient-centered Medical Home model
    - NCQA-PPC 3C: Plan and Manage Care—Care Management (MUST PASS)
  - The Triple Aim
- Patient perspective: Care will be…
  - More accessible
  - More planned and less reactive
  - Performed by the most appropriate member of the healthcare team

Team Care Principles: Lessons From Dentistry

- Providers
  - Concentrate on patient's reason for visit
  - Handle complex medical tasks
- Nurses
  - Work to the full extent of their license
  - Have full ownership of certain medical tasks
- Team
  - Work off of protocols to improve workflow, consistency (for cross coverage), and reliability

Team Care: What Can Be Done?

- Path of least resistance? Let the physician do it all.
- Can nurses refill medications from a physician-directed protocol?
- Can nurses order lab work under the direction of a physician?
- Can nurses do a diabetic foot exam?
- Can nurses fill out forms that are signed by the physician?
- Can nurses educate (or “coach”) patients about their medical condition or health needs?
- Can nurses leap tall buildings in a single bound?

Team Care Principles: Benefits of Efficiency

- The efficient office practice needs to make sense in our current fee-for-service environment and future physician payment reform environments such as Accountable Care Organizations

Primary Goal of Efficiency Team

- Make provider and nurse work lives easier
- Staff satisfaction measures: stratified by provider and nurse
  - Satisfaction with clinic workflow (38/100)
  - Overtime or length of workday (36/100)
  - Ability to provide quality of care (61/100)

Primary Value
"The Needs of the Patient Come First"

Team care can improve value of patient care

- Higher performance in quality measures
- Improve cost structure via increased clinic efficiency and less overtime
- Improve patient satisfaction via improved access and more coordinated care

Quality measures

- Diabetes All or None performance
- Colon cancer screening

Patient satisfaction measures

- Provider visits

Appropriate Delegation of Tasks: Initial Survey

- Each part of the office visit should be done by the most appropriate employee.
- All team members are empowered to work to the fullest level of their abilities and training.
- Minimize physician tasks that are in the skill set of others.
- New work descriptions for nursing: Physicians and rooming nurses asked, **“What are you currently doing in clinic that can be done by someone else?”**

Adequate Time for Nursing Tasks

- Efficient practices ensure that the physician is the slowest link in the clinic visit process.
- An overburdened rooming nurse will lead to the physician doing tasks that should be done by others.
- Clinic physician: Nurse ratio of 1:1 no longer an option.
- Nurses are more fulfilled in their work when engaged as an important part of the team and each clinic visit.

Nursing Positions

- Three new Care Coordination nursing positions.
- Job description similar to current clinic RN/LPN with additions of:
  - **Previsit planning**
  - Daily huddle(s)
  - Support for CPOE
  - Nurse-only visits and care/case management (RN functions)
  - Will evolve as group work continues

Nurse Advice Line Changes

- Increased NAL RN staffing during clinic hours
- Designated med refill phone line
- **Med refill protocols**
  - Look for last visit
  - Rx enough to last until next reasonable visit
  - Schedule patient for office visit
- Message center support for providers
- Triage of **symptom-based calls**
- Protocols that support discharged hospital patients and minimize unnecessary readmissions (i.e., CHF)

Expanded Runner Role

- Transition to Clinic Assistant role
- Job duties to include…
  - Supply management (exam and procedure rooms)
  - Equipment management
  - Information management (WIRs)
  - Faxing
- **KANBAN system**

Standard Work Flow: Rooming Nurse

- Chart prep (EMR included)
- Reconcile current med and allergy list
- Tobacco use discussed and counseling offered
- **Preventive medicine measures** counseled and ordered
  - Mammography, pap, colon CA screens
  - Immunizations
- Additional tasks determined by team
- “Owned” by nursing
- CPOE data entry when needed

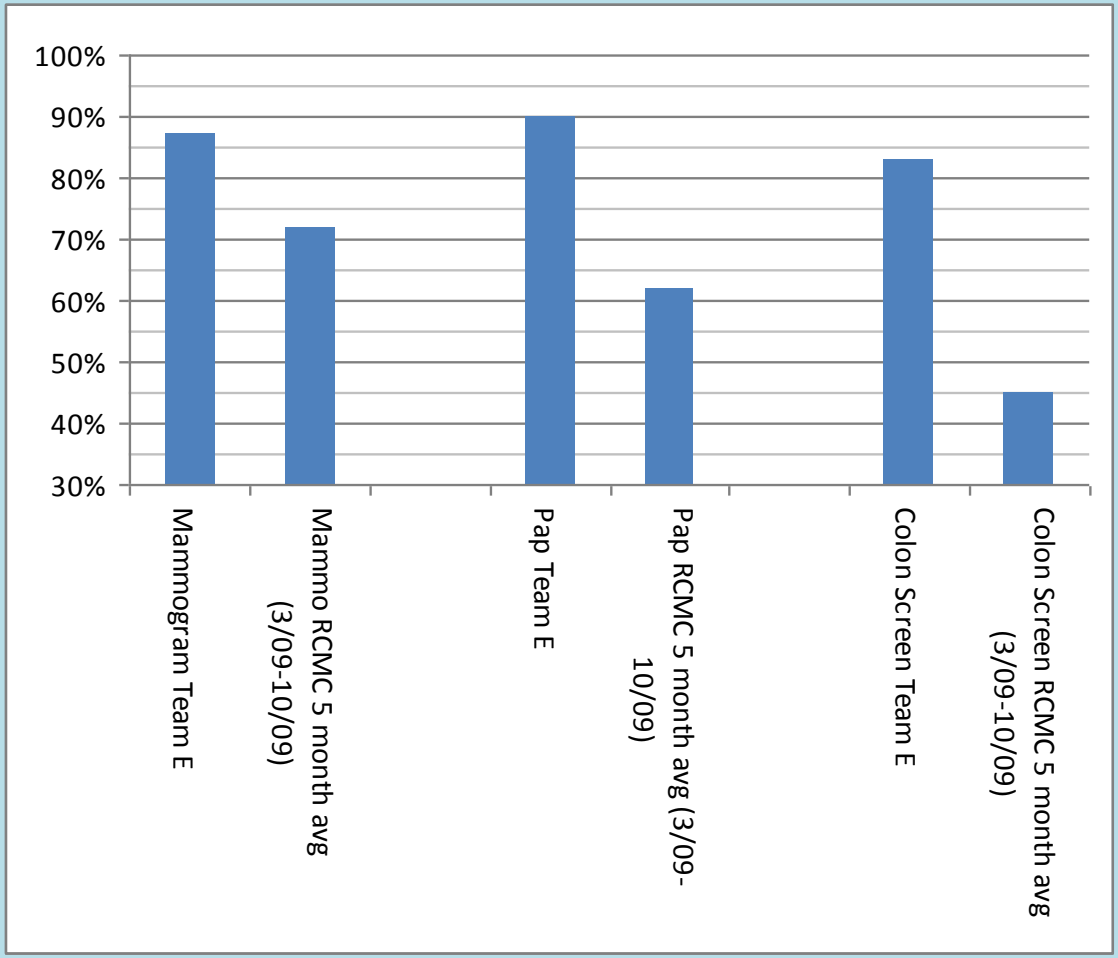
Standard Work Flow: Medication Refills

- All medications ideally should be refilled together for up to one year
- Nurses refill medications under physician protocol
- Efficient processes are vital
  - Med refills are a significant source of phone calls and should not be consuming a large amount of physician time
  - Dedicated med refill phone line

Standard Work Flow: Preventive Services

- **Ownership:** Physician vs. nurse vs. appointment staff vs. automated computer-generated reminders
- Keeping patients up to date on their preventive services
  - Patient centered
  - Rewarded under fee for service but also under physician payment reform initiatives

Team Care Results: Cancer Screening



Standard Work Flow:
Nursing Tasks in Diabetic Care

- Update data in diabetic registry
- Perform annual diabetic foot exam
- Schedule diabetic eye exams
- Diabetic Scorecard printed and reviewed

Standard Workflow: Paperwork

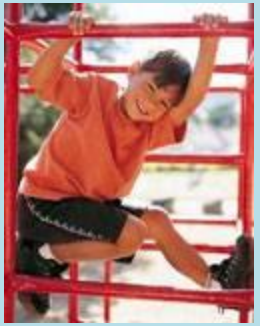
- HELP!!
- Physicians need nurse or other office staff to help with forms: FMLA, disability, leave of absence, prior authorizations, child-care exam, immunization records, etc.
- Nursing can dictate letters or add enclosures to letters that provider dictates.

Standard Workflow: Patient Coaching

- Nursing staff or physician can find good patient education materials: handouts or websites
- Depart summary or care plan
- Nursing staff can run their own health maintenance programs (for example, pedometer program)

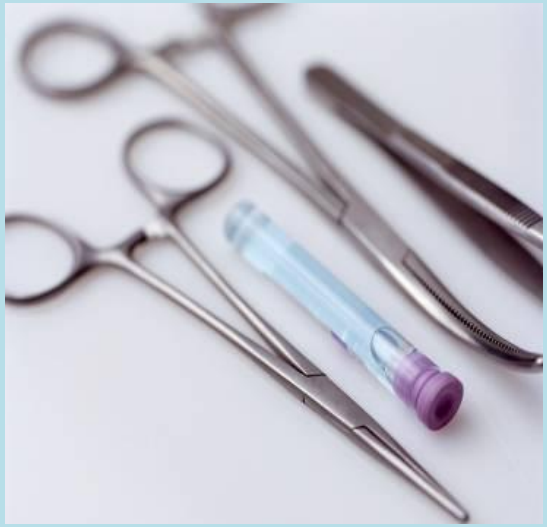
Standard Workflow: Well Child Care

- Nursing time > physician time
  - History
  - Vital signs including weight and height measurements
  - Developmental screening
  - Autism screening
  - Vision and hearing testing
  - Immunizations
- All fall on nursing staff ➔ help is needed to stay on time



Standard Workflow: Procedures

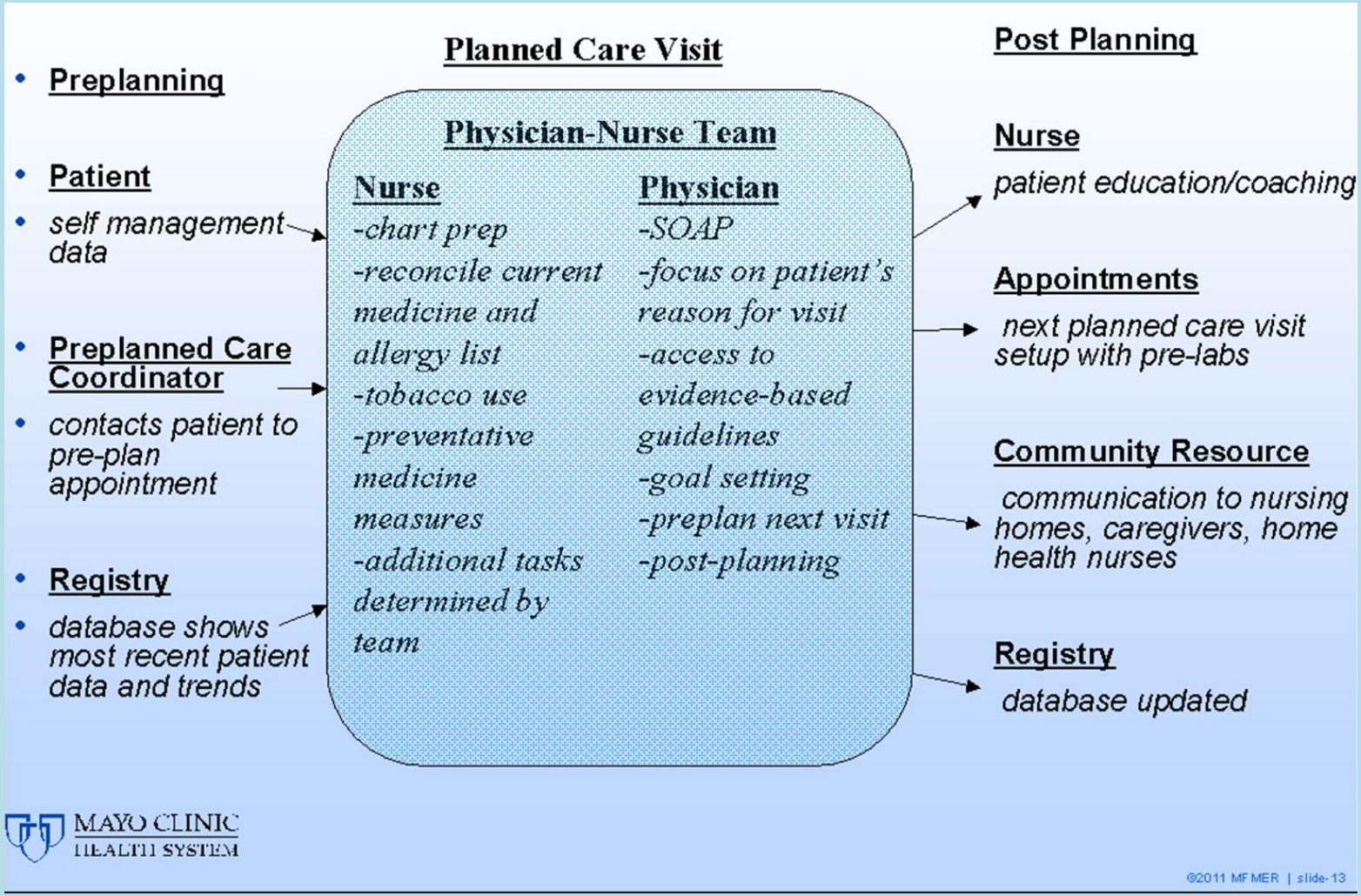
- All procedures scheduled for 15 minutes
- Procedures performed same day as office visit: no rescheduling
- Thorough prep by nursing minimizes physician time in performing procedure



First Patient Rooming

- The first two patients of the morning and afternoon are scheduled at the same time with the next 15-minute appointment slot set as a hold time
- Patients arrive at different times even when they have the same appointment time
- Start on time ➔ Stay on time

Planned Care Model



Previsit Planning

- Patients want to discuss and ask questions about lab work and test results at their clinic visit
- Physicians are more efficient when they have all the information that they need at a visit
- Preplanning the upcoming chronic care visit prevents rework before the next visit
- Techniques such as goal-setting and motivational interviewing lead to better outcomes
- It takes a team

Previsit Planning: Patient Responsibilities

- Work on goals established at last visit
- Bring self-management data to visit and act on data that are out of range (blood pressure, blood glucose, peak flows, diet and exercise, etc.)

Previsit Planning: Care Coordination Nurse

- Letter or phone call to patient instructing patient to do the following…
  - Update current medication list
  - Pre-labs: Preorder labs to be done right before clinic visit per protocol (if not already ordered)
  - Health maintenance measures: mammogram and colon cancer screening
  - Special enclosures: Autism screen, asthma control test, DOT or history form
  - Self-management data: Bring home BPs, glucose, weight, exercise log, peak flows, etc. to appointment

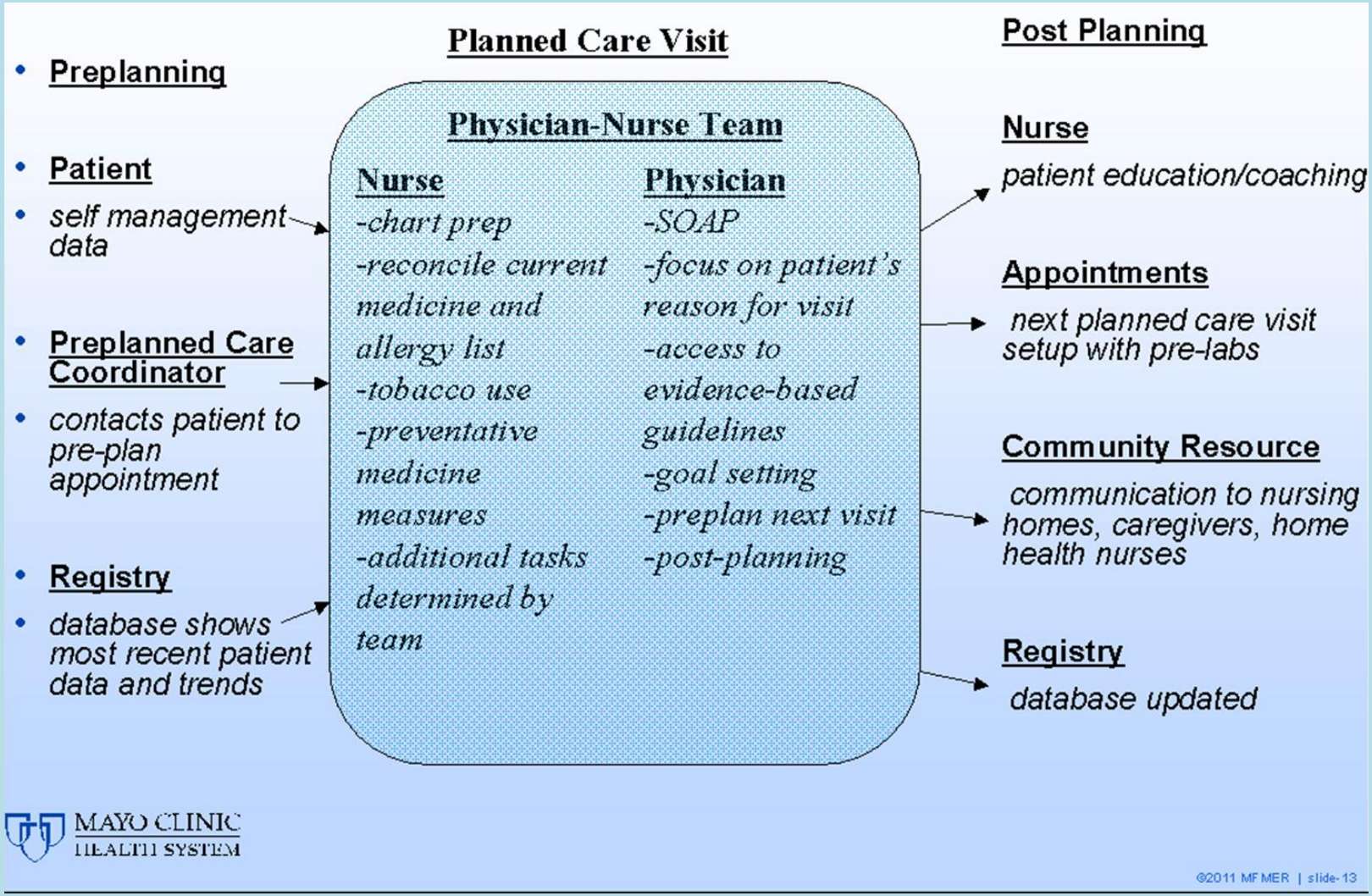
Standard Work Flow: Physician

- Focus on patient's agenda or reason for visit
- Access to evidence-based guidelines/Mayo library
- Goal-setting with motivational interviewing
- Set up postplanning

Postvisit Planning: Physician

- Additional orders: Labs can usually be added to blood drawn before planned care visit (lab stores blood for 6 days)
- Follow-up planner order sheet
- Preplan or schedule next visit

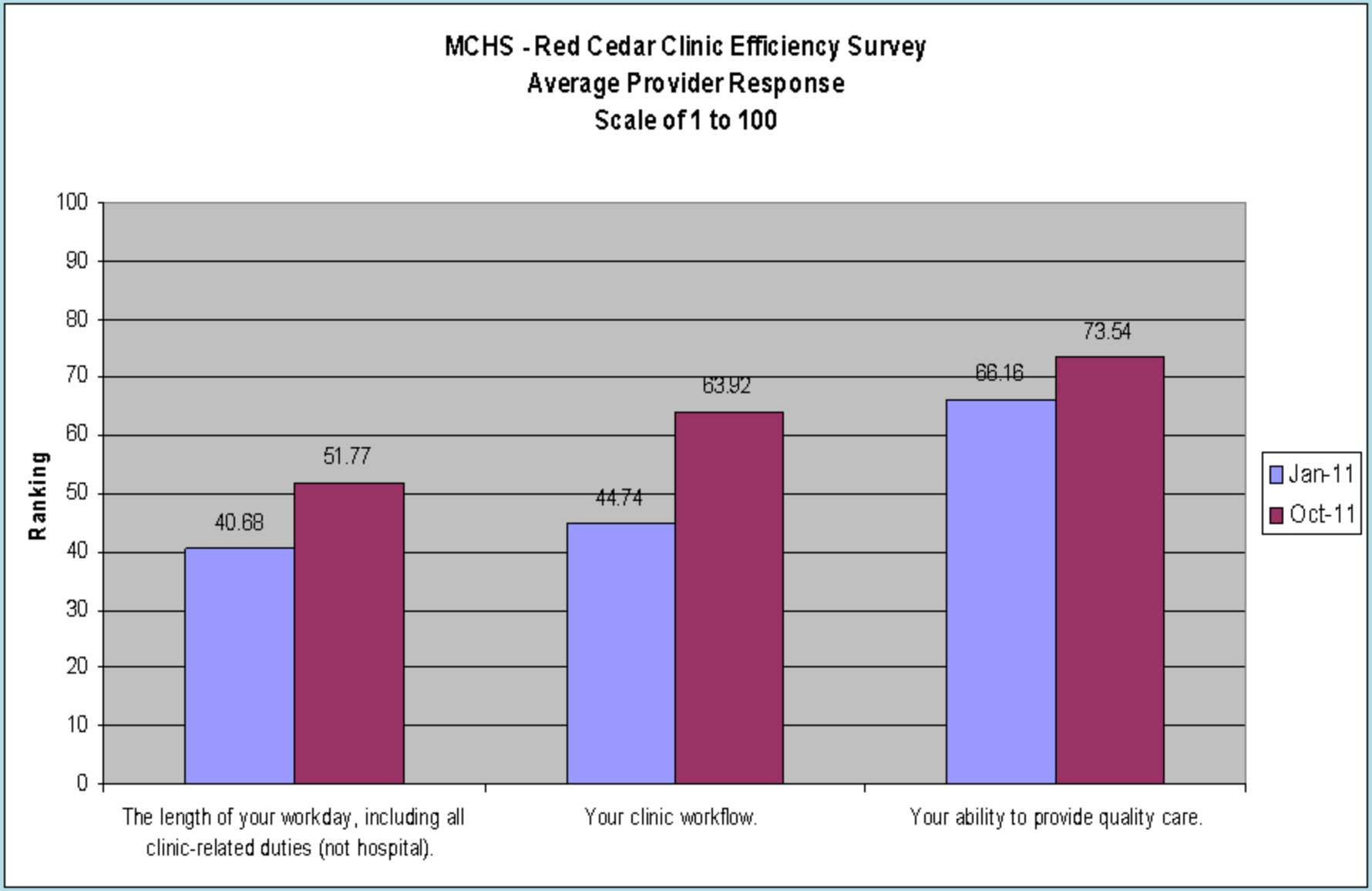
Planned Care Model



Team Care Satisfaction

- Physician can focus visit on patient's reason for visit.
- Nursing isn't overwhelmed and does more interesting and challenging work.

- Patient receives higher quality care, more time with nursing staff, and a more focused time with his or her physician. Access to primary care physician is improved.



CPOE and the Efficiency Dilemma

- Efficiency is a safety issue
- Data entry is not a good use of physician time
- Meaningful use criteria:
  - Medication refill CPOE can be performed by any “licensed healthcare professional”
  - Lab and x-ray orders do not require CPOE

Future of Office Efficiency

- Improved EMR functionality
- Patient portal
- EMR growing pains with promise of a better future

Team Project

- Create a charter to develop a clinic provider/nurse efficiency team

What Is Primary Care?

- Personal physicians—family physicians, general internists, and general pediatricians
- Work closely with nurse practitioners and physician assistants
- Patient's entry into the health care system and the medical "home" for ongoing, personalized care
- PCPs need a vast amount of medical knowledge
- 94 percent of people surveyed want a personal physician who knows about their problems

Grumbach, K., et al. 1999. "Resolving the Gatekeeper Conundrum: What Patients Value in Primary Care and Referrals to Specialists." *Journal of the American Medical Association* 282(3):261–266.

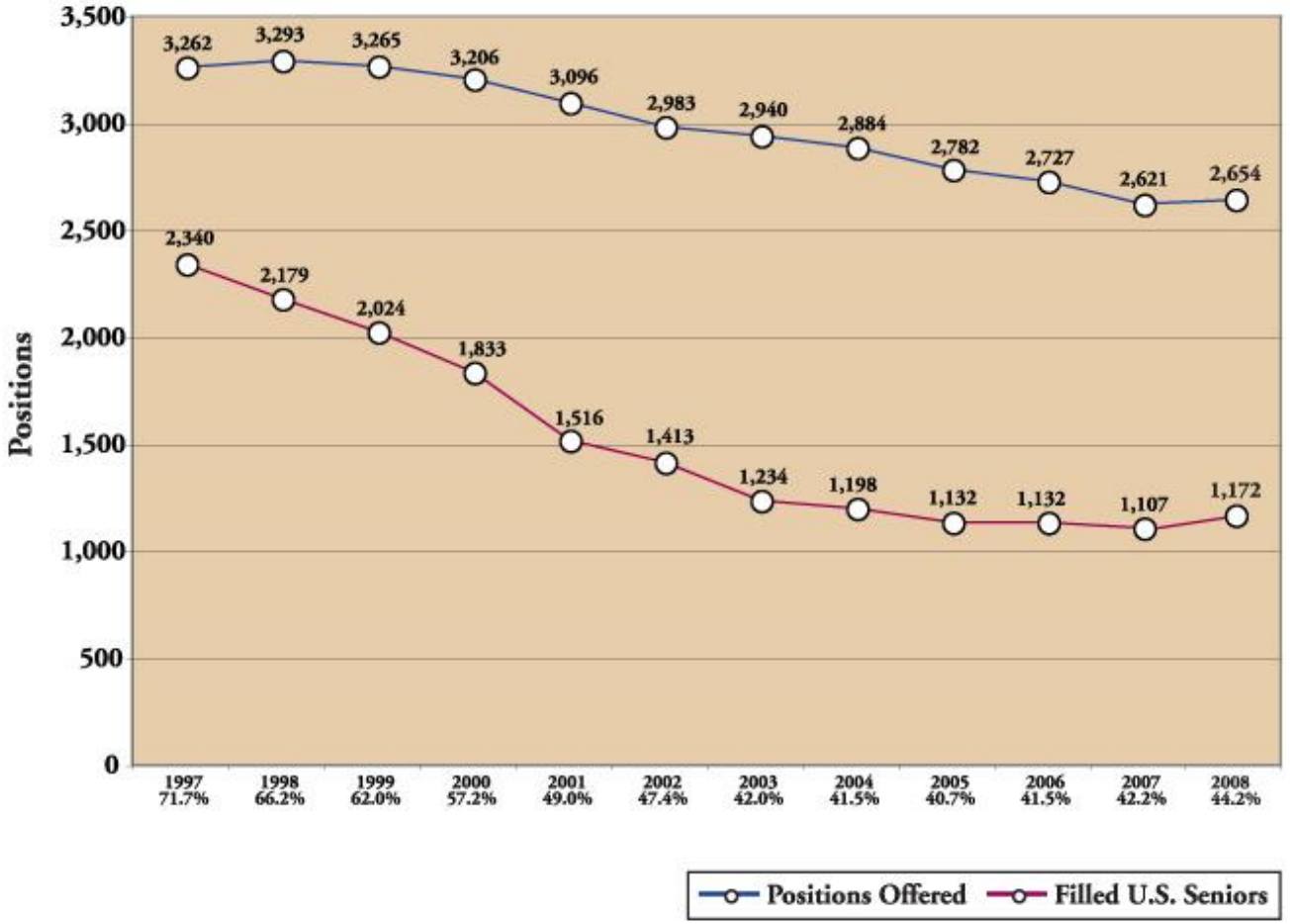
Threats to Primary Care

- From 1997 to 2005, the number of U.S. medical school graduates entering family medicine residencies dropped by 50 percent.
- In 1998, 54 percent of internal medicine residents planned careers in primary care rather than specialty medicine; by 2004, only 25 percent entered primary care. In 2009, only 247 residency positions were offered in primary care internal medicine, a decrease of 328 percent from 1999.
- The primary care–specialty income gap is growing. Over a 35- to 40-year career, the difference in income results in a $3.5 million gap, on average, between the "return on investment" for primary care physicians and that for subspecialists.
- Lower incomes and a stressful work life.

Sepulveda, M. J., Bodenheimer, T., and Grundy, P. 2008. "Primary Care: Can It Solve Employers' Health Care Dilemma?" *Health Affairs* 27(1):151–158.

Steinbrook, R. 2009. "Easing the Shortage in Adult Primary Care — Is It All about Money?" *New England Journal of Medicine* 360:2696–2699.

New Physicians Graduate, But Not in Family Medicine



Primary Care: Costs and Quality

- Dozens of studies show lower health care costs and improved quality.
- People with a PCP rather than a specialist as a personal physician had 33 percent lower annual health care spending and 19 percent lower mortality; cost and mortality data were adjusted for age, sex, ethnicity, health insurance status, reported diagnoses, and smoking status.

  Franks, P., and K. Fiscella. 1998. "Primary Care Physicians and Specialists as Personal Physicians: Health Care Expenditures and Mortality Experience." *Journal of Family Practice* 47(2): 105–109.

- States with more PCPs per capita had lower per capita Medicare costs and higher quality care. States with more specialists per capita had lower quality care and higher per capita Medicare expenditures.

  Baicker, K., and A. Chandra. 2004. "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care." *Health Affairs* 23:w184–w197 (published online 7 April 2004).

Primary Care and the Patient-centered Medical Home

- One strategy—investing in primary care has been adopted by the health systems of virtually every developed country except the United States.
- Primary care has the potential to contain health care costs, particularly by reducing ambulatory care–sensitive hospital admissions, emergency department visits, and inappropriate specialty consultations.
- Patient-centered Primary Care Collaborative: www.pcpcc.net

Current State in Primary Care

- Does your organization need to redesign the office practice of primary care physicians and their staff?
- Are you loading too much onto primary care physicians without enough nursing and staff support?
- Are you still operating with the traditional one nurse to one physician ratio?
- Has the longer process of rooming a patient, CPOE, disease management strategies, and quality reporting led to your primary care physicians seeing fewer patients?
- Are primary care practices producing quality results that the organization can be proud of?
- Is your primary care staff "emotionally exhausted" at the end of the day?

Future State of Primary Care

- Under fee for service, primary care was the “feeder” to specialists who provided hospital and surgical services that reimbursed well.
- Under an ACO, primary care provides comprehensive and continuous care that is more cost-effective than specialty care.
- Is your ACO paying lip service to the value of primary care or is it the glue that holds patient care together?
- Is primary care important enough in your new ACO structure that you will invest in primary care by adding primary care providers and nurses and actively improve their efficiency and quality of care?
- Will specialists (the PCMH neighborhood) play a different role in your ACO?

Team Discussion

- What is the current and future state of primary care in your organization?
- Does your organization need to redesign the office practice of primary care physicians and their staff?

Mayo Clinic Preliminary Proposal

Project Name:

Brief Project Description *(What will this project do?) (255 characters):*

Business Need *(Problem or Opportunity Statement / Background of Need)*

Project Value– Quantitative and Qualitative Metrics of Success

Objective	Metrics/Measurements
Primary Goal:	
Secondary Goal:	

Project Scope *(elements that are in & out of scope)*

Project Team

Project Governance

Role *(Abbreviate as applicable)*	Name(s)	A	R	C	I	V	D
Sponsor/Champion							
Process Owner/Team Leader							
Team Members							

Please contact a member of the EPMO with any questions – http://mayoweb.mayo.edu/planning/epmo.html

Deliverables:

Clinic Provider/Nurse Efficiency Team: Steps in Development of Charter

- Determine brief description of project and team membership
- Articulate the business case for improving office efficiency
- Develop team goals
- Determine and measure metrics for improvement
- Conduct survey of PCPs and nurses
- Deliverables with timelines:
  - New workflows and work descriptions
  - Build physician-directed protocols
  - Diffusion

Team Project #1: Team Description

- Create a brief description of the clinic provider/nurse efficiency team
  - What will this project do?
- Determine clinic provider/nurse efficiency team membership
- Begin entering this information into your team charter

Team Project #1: Team Description
What This Project Will Do…

- Improve the support of the existing provider/nurse teams to maximize staff satisfaction and optimize their function
- Improve safety, quality of care, patient and staff satisfaction, and regulatory and billing compliance
- Improved clinic efficiencies will be gained by
  - Empowering all members of the healthcare team to work together
  - Using the highest level of their licensure and abilities
  - Improving continuity of care and transitions

Team Project #1: Team Description
Team Membership

- Chief Administrative Assistant (sponsor/champion)
- Physician (process owner/team leader) and nurse from two-nurse team
- Physician and nurse from one-nurse team
- Director of Quality Improvement
- Clinic Director of Nursing
- Clinic Nursing Director of Primary Care
- Clinic Nurse Advice Line Director
- When hired, added three Care Coordination nurses
- EMR physician liaison/expert when needed

Team Project #1: Team Description
Team Exercise

- Create a brief description of the Clinic Provider/Nurse Efficiency Team
- Determine Clinic Provider/Nurse Efficiency Team membership
- Begin entering your data into the team charter
- Question: What will this project do?
- Question: How will each team member contribute to the development of increased clinic efficiency in primary care practices?

Team Project #2: Business Case

- Create the business case for improving clinic efficiency in the primary care practice focusing on the provider/nurse team

Team Project #2: Business Case
Problem or Opportunity Statement/Background of Need

- Currently, primary care providers and nurses at Mayo Clinic Health System-Red Cedar struggle to complete all the expected clinic tasks within any given clinic day.
  - Providers and nurses are not happy with their work/life balance
  - Are less willing to participate in improvement efforts and are performing suboptimally on many measures of quality
- In this overtaxed, busy, and uncoordinated environment, patients do not always receive exceptional care.
- Transitioning toward a more team-oriented (less physician-centric) Patient-centered Medical Home model of outpatient care will
  - Improve value by increasing measurable quality of care and
  - Reduce the overall cost of care through improved efficiency
- From a patient perspective care will be more accessible, more planned, and less reactive, and be performed by the most appropriate member of the healthcare team.
- Under newer models of healthcare reimbursement (such as Accountable Care Organizations):
  - Improved clinic practice efficiency and appropriate use of preventive services will be fiscally rewarded
  - Additional support will be necessary to aid providers who will require additional time to implement CPOE and meet meaningful use criteria

Team Project #2: Business Case
Team Exercise

- Create a business case for the development of a Clinic Primary Care Provider/Nurse Efficiency team and enter it into your charter. (Problem/opportunity statement and background of need.)
- Question: Is your business case strong enough to pay for additional nursing personnel to help support primary care?

Team Project #3: Develop Goals/Identify Measures

- Project value: Determine quantitative and qualitative metrics for success
  - Set primary and secondary goals
  - Create metrics or measurements of success

Team Project #3: Develop Goals/Identify Measures Quantitative and Qualitative Metrics of Success

- Objective: All provider/nurse teams who choose to participate in this project will seek to attain the following goals:
  1. Primary goal: Improve provider/nurse satisfaction via improved work/life balance
     - Staff satisfaction measures: Satisfaction with workflow, length of workday, and ability to provide quality of care (stratified by provider and nurse)
  2. Secondary goal: Improve value via higher performance in quality measures; improve cost structure via increased clinic efficiency and less overtime; improve patient satisfaction via improved provider access and more coordinated care
     - Quality measures: Diabetes All or None performance; colon cancer screening
     - Patient satisfaction measures: Provider visits

Team Project #3: Develop Goals/Identify Measures Primary Goal of Efficiency Team

- Make provider and nurse work lives easier
- Staff satisfaction measures: stratified by PCP and nurse
  - Satisfaction with clinic workflow
  - Overtime or length of workday
  - Ability to provide quality of care

Team Project #3: Develop Goals/Identify Measures "The Needs of the Patient Come First"

Team care can improve value of patient care

- Higher performance in quality measures
- Improve cost structure via increased clinic efficiency and less overtime
- Improve patient satisfaction via improved access and more coordinated care

Quality measures

- Diabetes All or None performance
- Colon cancer screening

Patient satisfaction measures

- Provider visits

Team Project #3: Develop Goals/Identify Measures Team Exercise

- Project value: Determine quantitative and qualitative metrics for success
  - Set primary and secondary goals
  - Create metrics or measurements of success
- Question: Is your primary goal to help patients, help providers and nurses, or improve revenue and cut waste?
- Question: Can you recommend metrics in several domains?
  - Staff satisfaction
  - Patient experience or satisfaction
  - Quality of care
  - Cost of care

Team Project #4: PCP/Nurse Survey

- Create an initial survey for clinic primary care providers and nurses
  - Length of workday
  - Clinic workflow
  - Ability to provide quality care

Team Project #4: PCP/Nurse Survey
Satisfaction Level: Length of Workday

- Including all clinic-related duties (not hospital)

Very Dissatisfied — Very Satisfied

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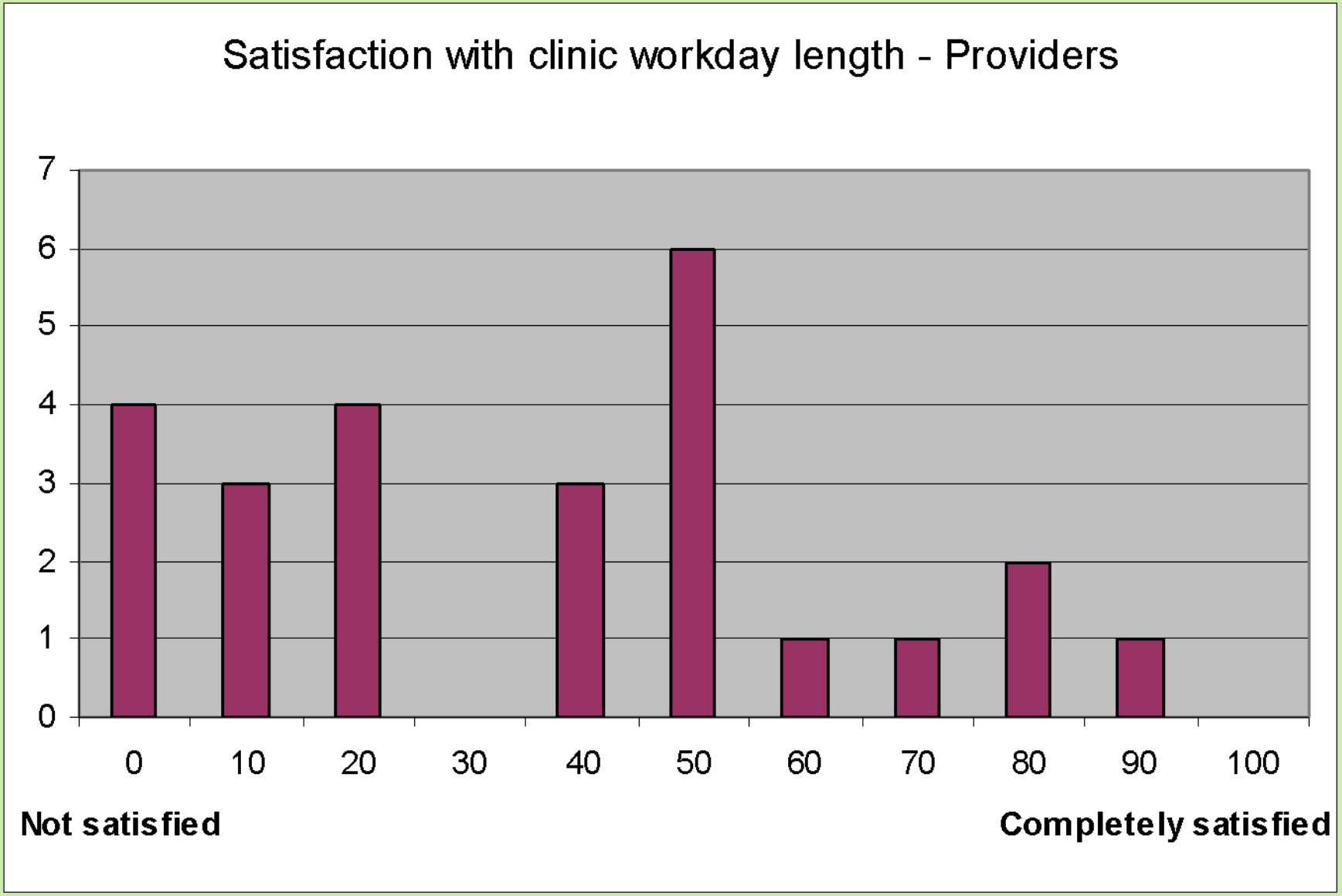

Team Project #4: PCP/Nurse Survey
Satisfaction Level: Clinic Workflow

Very Dissatisfied

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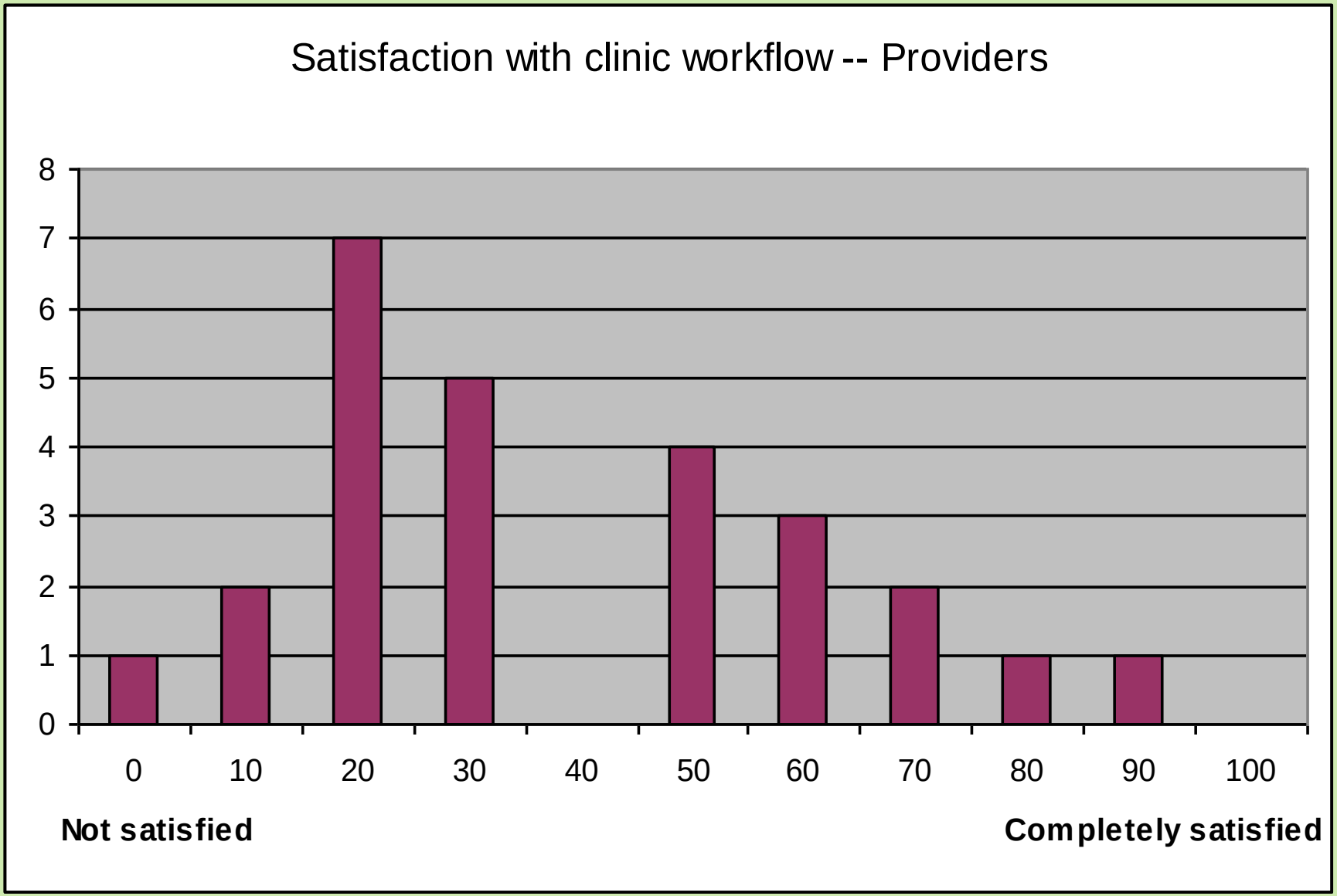
Very Satisfied



Team Project #4: PCP/Nurse Survey
Satisfaction Level: Ability to Provide Quality Care

Very Dissatisfied

Very Satisfied

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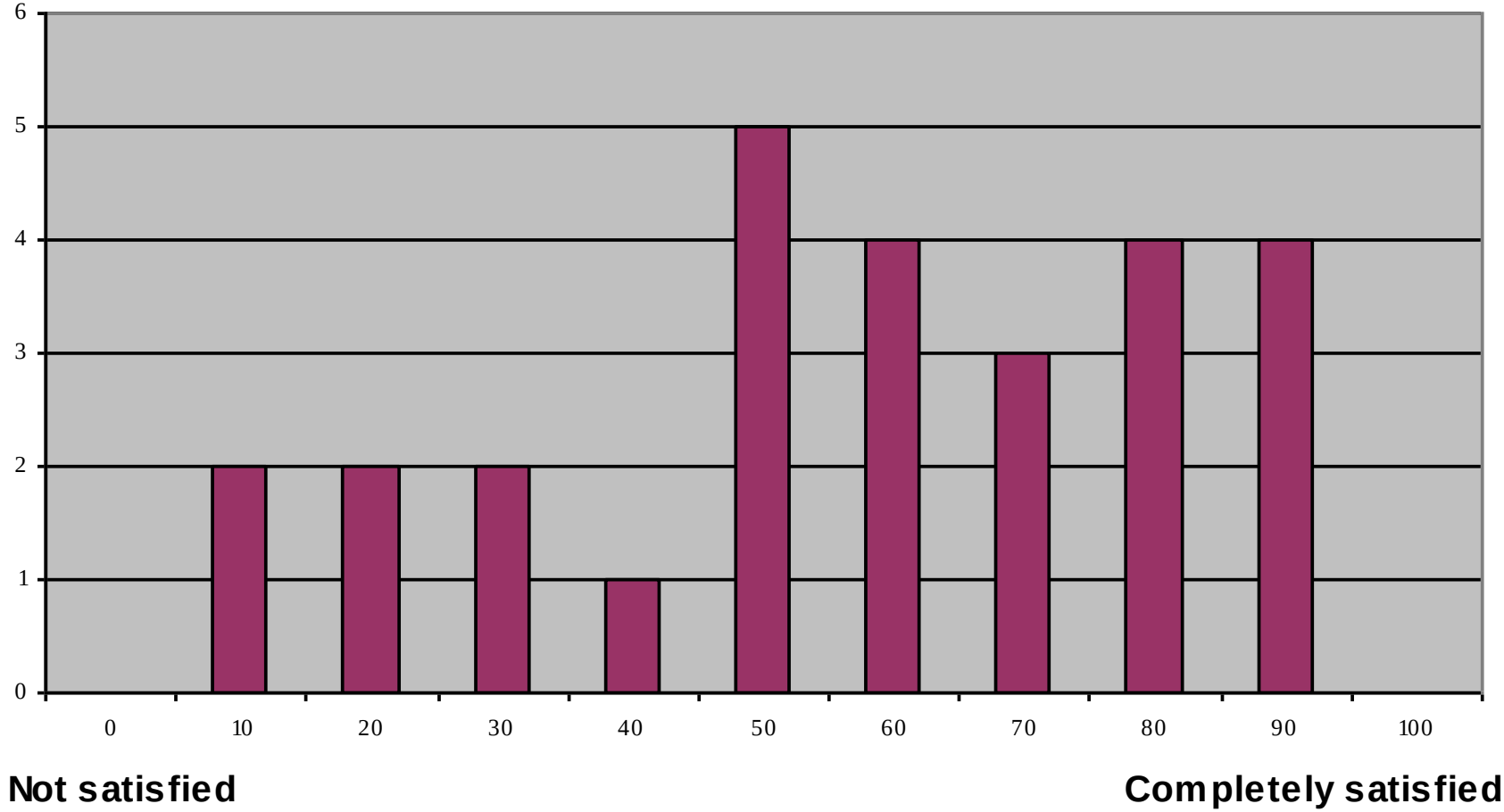
Satisfaction with ability to provide quality care - Providers



Team Project #4: PCP/Nurse Survey Activities/Tasks

- What activities/tasks do you currently complete with most patients that could be performed by someone other than you?

Team Project #4: PCP/Nurse Survey Team Exercise

- Create an initial survey for primary care providers and nurses.
- Question: How does each survey question contribute to improving clinic efficiency or supply a metric for improvement?
- Hint: Short surveys get higher response rates.

Team Project #5

- Determine the scope of the Clinic Provider/Nurse Efficiency Team. (What is in and out of bounds?)

Project Scope:
Elements That Are In and Out of Scope

- In-bounds
  - Any clinic workflow process that improves provider/nurse efficiency, teamwork, and value of care
- Out-of-bounds
  - EMR issues
  - One-team solutions
  - Hospital, ER, UC workflow processes
- Compatible with Meaningful Use requirements

Project #5: Team Exercise

- Determine the scope of the Clinic Provider/Nurse Efficiency Team. (What is in and out of bounds?)
- Question: Will you try to solve EMR issues as part of improving workflow?
- Question: Can efficiency solutions occur for individual provider/nurse teams or will they need to be solutions for all teams?

Team Project #6

- Deliverables
  - New work flows
  - New work descriptions
  - Physician-directed protocols
  - Diffusion
  - Timelines

Project #6: Team Exercise

- Establish new work flows that are more efficient
- Establish new work descriptions that support those work flows
- Build physician-directed protocols
- Create a diffusion strategy
- Timelines

Questions and Discussion

Tools Follow

POLICY

Certain medications may be refilled by nursing staff in a prompt, uniform, and safe manner. Nurses may refill medications per this protocol when working with any provider. They may refill for their own provider's patients when the provider is out of the clinic as well. With all refills completed per this protocol, the provider will be notified of refills done by nursing staff using a system worked out by the provider/nurse team.

PROCEDURE

I. Access the patient's medication list in the electronic medical record verifying full name and date of birth. Verify that the patient is within the designated provider's practice.

II. If the medication that is being requested to be refilled is on the medication list as a prescription which was written by a provider, nurses may refill using the following guidelines:

A. CHRONIC MEDICATONS – a medication that is provider prescribed to treat or manage a long-standing disease process

1. Last annual visit/medication review one year or more – refill 90 days and assist patient in scheduling an appointment.
2. Last annual visit/medication review 3 – 9 months – refill medications one month past when exam would be due and remind the patient when an appointment is due.
3. Last annual visit/medication review three months or less – refill medications for one year.

B ANTIDEPRESSANTS

1. If patient has been on the medication long term, (greater than one year), refill using chronic medication guidelines.
2. If the patient has been on the medication less than one year, refill for one month and the patient should consult with their provider by phone call or preferably an appointment.

C. SLEEP MEDICATIONS – if used on a nightly basis and was filled for 6 months previously, can refill for another 6 months, (unless due for an appointment before 6 months, in which case give refills until exam is due). Otherwise, one refill can be given and patient will need an appointment if further refills are needed.

D. NON-NARCOTIC PAIN MEDICATIONS – same as chronic medications above

E. MUSCLE RELAXANTS – one refill and assist patient in scheduling an appointment.

F. NARCOTICS, (INCLUDES TRAMADOL) – nurses do not refill.

G. ADHD MEDS – nurses do not refill.

H. WARFARIN – refill for one year if getting INR's regularly as ordered by the provider or in Anticoagulation Clinic.

III. If the medication is not on the patient's medication list as a prescription, and the provider is not available, send the request to Nurse Advice Line to handle via their protocol.

IV. The provider is to be notified of all prescription refills done by the nurse, either verbally or via the message center.

POLICY

Specific future lab orders, as part of pre-planned care, may be ordered by nursing per protocol, as designated in this policy, when certain criteria are met.

PROCEDURE

PRE-VISIT LABWORK, ORDERED by NURSING

1. Annual Lipid Profile (12 hour fast)
   a. Diagnosis – Dyslipidemia , Hypercholesterolemia, Hypertriglyceridemia, Elevated LDL Cholesterol, Low HDL Cholesterol
   b. Medications

      Statins
      Simvastatin (Zocor)
      Atorvastatin (Lipitor)
      Rosuvastatin (Crestor)
      Lovastatin (Mevacor)
      Vytorin (Simvastatin/Ezetimide)
      Pravachol (Pravastatin)

      Niacin
      Niaspan
      Niacin-SR

      Fibrates
      Gemfibrozil (Lopid)
      Fenofibrate (Tricor)
      Ezetimide (Zetia)
   c. Screen all patients over 20 years of age every 5 years

ALT – annually if on these medications
   a. Simvastatin 80 mg.
   b. Lipitor 80 mg.
   c. Crestor 40 mg.

Annual Basic Profile (8 hour fast)
   a. Diagnosis – Hypertension (when taking one of the meds listed below)
   b. Medications

      Diuretics
      Hydrochlorothiazide (HCTZ)
      Hydrochlorothiazide/Triamterene (HCTZ/Triam)
      Spironolactone (Aldactone)
      Furosemide (Lasix)
      Bumetanide (Bumex)
      Metolazone (Zaroxolyn)
      Torsemide (Demadex)

      ACE Inhibitors (may be combined with HCTZ)

Lisinopril (Zestril/Prinivil)	Enalapril (Vasotec)
Benazepril (Lotensin)	Ramipril (Altace)
Quinapril (Accupril)	Trandolapril (Mavik)
Fosinopril (Monopril)	Moexipril (Univasc)
Captopril (Capoten)	

      ARB's (may be combined with HCTZ)
      Losartan (Cozaar/Hyzaar if combined with HCTZ)
      Irbesartan (Avapro)
      Valsartan (Diovan)
      Candesartan (Atacand)
      Olmesartan (Benicar)
      Telmisartan (Micardis)
      Eprosartan (Teveten)

4. Annual PSA
   a. **All men age 50-70 should have screening PSA discussed with provider. If previously ordered annually, continue to order annually. If previously ordered every two years and previous PSA is in lower half of normal range, continue ordering every two years. DO NOT ORDER INITIAL PSA AT AGE 50.**
   b. Men with history of PSA's elevated above normal, (or 4.0), should have a Free & Total PSA Ratio
   c. Men with history of prostatectomy, brachytherapy, or radiation therapy as treatment for prostate cancer now have very low PSA's and should have a diagnostic PSA.

5. Diabetic Labs, (same as registry and Condition Summary guidelines) – indicated for:
   - Diagnosis – Diabetes Mellitus I and II
   - If on the following medications

Insulins	**Oral Agents**
Lispro (Humalog)	Glypizide (Glucotrol)
Aspart (Novolog)	Glyburide (Diabeta, Micronase)
Glargine (Lantus)	Glimepiride (Amaryl)
Detemir (Lememir)	Metformin (Glucophage)
Novolin (Humulin)	Pioglitozone (Actos)
	Glucovance
Other Injectables	Sitagliptin (Januria)
Exenetide (Byetta)	Saxagliptin (Onglyza)
Liraglutide (Victoza)	Combination agents: Metaglip, Janumet, Actoplus Met
Pramlintide (Symlin)	

   a. Annual labs include creatinine, urine microalbumin, lipid profile; (creatinine is included in fasting basic profile if on hypertension meds noted above)
   b. HgbA1c – every 6 months; If HgbA1c is greater than or equal to 8.0, do every 3 months.
   c. LDL – If <100, do annually with other lipids. If >100, do every 3 months. Order entire lipid profile, not just LDL.

6. Annual HgbA1c – diagnosis of prediabetes/impaired glucose tolerance with previous FBS, (must be fasting), of 110 or greater, **or** previous HgbA1c of 6.0% or greater

7. Annual FBS – diagnosis of prediabetes/impaired glucose tolerance with previous FBS of 100-109 **or** HgbA1c 5.7-5.9%

8. "Routine" diabetes screen – Fasting Blood Sugar
   a. Every 5 years for adults age 25-44
   b. Every 3 years after age 45

9. Annual TSH
   a. Diagnosis – Hypothyroidism, Downs Syndrome
   b. Medications – Levothyroxine
   c. Screen all women over age 50 every 5 years

10. Annual creatinine – check annually if patient is on non-steroidals, (such as Ibuprofen, Naproxen, etc.), **and takes regularly**, (daily, etc.); (Reason is that these meds can worsen kidney function.) See **addendum for complete list** of non-steroidal anti-inflammatory drugs (NSAIDS).

11. Trough drug levels, (right before next dose of medication) – **to be determined by the provider; Request that the patient holds the morning dose of these medications so that the drug trough level can be added if the provider orders it.**
   a. Carbamazepine (Tegretol) use – CBC with auto diff., ALT, basic profile
   b. Valproic Acid (Depakene, Depakote) use – CBC with auto diff., ALT
   c. Lithium use – CBC with auto diff., TSH, basic profile, UA
   d. Phenytoin (Dilantin) use – CBC with auto diff., ALT
   e. Digoxin (Lanoxin) – creatinine

12. Anticoagulation – protime monthly if on Warfarin

13. Chronic anemia – CBC with auto diff. annually

14. Methotrexate use – CBC with auto diff., ALT, every 4 months

15. Amiodarone (Pacerone) use – TSH, ALT every 6 months, chest x-ray annually

16 . Pre-op. Physical Exam – See Policy #200.01.118

06/23/11

ADDENDUM

List of NSAIDS Requiring Annual Creatinine

Generic name	Brand name
Choline and magnesium salicylates	Trilisate
Celecoxib	Celebrex
Diclofenac potassium	Cataflam
Diclofenac sodium	Voltaren, Voltaren XR
Diclofenac sodium with misoprostol	Arthrotec
Diflunisal	Dolobid
Etodolac	Lodine, Lodine XL
Flurbiprofen	Ansaid
Ibuprofen	Advil, Motrin, Motrin IB, Nuprin
Indomethacin	Indocin, Indocin SR
Ketoprofen	Actron, Orudis, Orudis KT, Oruvail
Magnesium salicylate	Bayer Select, Doan's Pills
Meclofenamate sodium	Meclomen
Mefenamic acid	Ponstel,
Meloxicam	Mobic
Nabumetone	Relafen
Naproxen	Naprosyn, Naprelan
Naproxen sodium	Aleve, Anaprox
Oxaprozin	Daypro
Piroxicam	Feldene
Rofecoxib	Vioxx
Salsalate	Disalcid
Sulindac	Clinoril
Tolmetin sodium	Tolectin
Valdecoxib	Bextra

05/19/11

Previsit Planning Letter

Dear *

#1. Your appointment with * is scheduled on * at Mayo Clinic Health System in Menomonie. Please arrive 15 minutes prior to your scheduled appointment to register.

#2. Your child's appointment with * is scheduled on * at Mayo Clinic Health System in Menomonie. Please arrive 30 minutes prior to your scheduled appointment to register and complete necessary paperwork.

#3. No tests are needed prior to your appointment.

#4. Separate from this exam, as part of your health maintenance and prevention, your provider has recommended the following blood tests be done, which have been ordered for you. These tests are NOT covered under your DOT exam and will be billed separately.

#5. As part of your health maintenance and prevention, your provider has recommended the following blood tests to be done, which have been ordered for you.

5a. (bullets . . . state lab test and what it is for)

5b. It works well if you can have your blood drawn a few days before your exam so that you and your provider can discuss the results at your visit. Since most tests require 12 hours of fasting, please do not eat or drink for 12 hours, (except for water), before coming. Ideally, you should have your blood drawn no more than 3 days prior to the appointment with your provider. You may take any of your regular medications. If it is not convenient for you to come before the day of your appointment, please arrive 60 minutes before your exam to have your blood drawn. Report to the Urgent Care registration desk on the first floor of Mayo Clinic Health System in Menomonie for this lab work. You do not need an appointment.

Lab hours:
Monday 6 a.m. – 8 p.m.
Tuesday through Thursday 6 a.m. – 6 p.m.
Friday 6 a.m. – 5 p.m.
Saturday and Sunday 9 a.m. – 3 p.m.

You may have your blood drawn at our satellite clinics in Elmwood or Glenwood City if you prefer. Their hours coincide with their clinic hours:

Glenwood City – Monday – Friday, 8:30 a.m. to 4:00 p.m.
Elmwood – Monday - Friday, 8:15 a.m. to 12:30 p.m., 1:30 p.m. to 4:00 p.m.

If you have had this bloodwork done at another locaton outside of the Mayo Clinic Health System, **or** if you believe this bloodwork is not needed, you may chose to **not** have this done. Discuss this with your healthcare provider at your upcoming appointment.

#6. Separate from the problem that you are seeing your provider for, as part of your health maintenance and prevention, your provider has recommended the following blood tests be done. They have been ordered for you.

#7. If you are currently taking **(insert drug name)** (Carbamazepine (Tegretol), Valproic Acid (Depakene, Depakote), Lithium, Phenytoin (Dilantin), Phenobarbital, or Digoxin), please take your morning dose of this medication **after** your blood has been drawn in case your healthcare provider wants to check a medication blood level.

#8. Our records show that you are due for a mammogram. If you have not already scheduled this, you can call our radiology department at 715-233-7228 and they can assist you in getting an appointment scheduled

#9. Our records show that you may be due for colon cancer screening. Enclosed is information on this. You may discuss this further with your nurse or provider at your upcoming appointment.

#10. Enclosed is the current medication list that we have on record for you.
- Review this list for accuracy and make note of any corrections or additions.
- Please bring this updated medication list, as well as medication bottles, including all over the counter medications and herbal supplements, with you to your appointment.

#11. According to our records, you are not taking any prescription medications. Please bring bottles of all over the counter medications and herbal supplements that you may currently be taking.

#12. Enclosed is the Medical Examination Form. Please complete the highlighted areas and bring with you to your appointment.

#13. As part of the 18 and 24 month healthcheck exam, your provider does a screening for autism. Please complete the enclosed form and bring with you to your appointment.

#14. To assist us in assessing how well your asthma is currently controlled, please complete the enclosed Asthma Control Test and bring with you to your appointment.

#15. To assist us in assessing how well your child's asthma is currently controlled, please complete the enclosed Asthma Control Test and bring with you to your appointment.

If you have concerns about your insurance coverage, please contact your insurance company prior to services being rendered. If you would like an estimate of our charges, (fee estimate), please contact our business office at 715-233-7607.

#16. Thank you for letting Mayo Clinic Health System in Menomonie be involved with your health care. Please do not hesitate to contact us at **(Pre-visit Planner's phone number)** if you have any questions.

Sincerely,

Enclosure(s)

07/14/11

CLINIC ROUTE SLIP

2221 Stout Road
Menomonie, WI 54751
715-235-5531

01154485

FOLLOW-UP PLANNER ORDER SHEET

** PLEASE GIVE TO SCHEDULER BEFORE LEAVING CLINIC TODAY **

Date	Provider	Chart	Time	MSR

Patient PN	Illness Date	Injury Date	Birth date	Age	Sex

Responsible Party / Address	*N/A charges do not require HIPAA info*	Injury Type AA AP OA WC	Home Phone / Work Phone

Insurance	LMP Date	Injury State WI MN ____	Follow Up: ____ week(s) ____ month(s) ____ year(s)

Diagnosis
1. 3. 5.
2. 4. 6.

PE BP
Follow-up Health Check
Diabetes Lab

Follow-Up Appointment Type

Planned Care Visit regarding: _____ ❑ Physical Exam

❑ 1 week ❑ 1 month ❑ 3 months ❑ 6 months ❑ 1 year ❑ Other: _____

Follow-Up Labs

Date (if different than date of follow-up appointment): _____.

Write number of diagnosis next to lab test.

Hematology
- ____ CBC
- ____ CBC with Manual Differential
- ____ Ferritin
- ____ Hemoglobin
- ____ Hemogram
- ____ Lead with demographics Mayo 15070
- ____ ESR

Chemistry Profiles
- ____ Basic Metabolic Profile
- ____ Comprehensive Metabolic Profile
- ____ Hepatic Function Profile
- ____ Lipid Panel

Oncology
- ____ PSA - Screen

Coagulation
- ____ Protime/INR

General Chemistry
- ____ ALT
- ____ BUN
- ____ Creatinine
- ____ Glucose Fasting
- ____ Potassium Level
- ____ Sodium Level

Endocrinology
- ____ Hgb A1C
- ____ Glucose 2 Hr. Post Glucola
- ____ Microalbumin Random Urine
- ____ TSH

Urinalysis
- ____ UA - Office Dip
- ____ UA (microscopic, if indicated)
- ____ Culture Urine

Drug Level

Name of Drug: _____

Other:

_____ _____

Follow-Up X-rays

Date (if different than date of follow-up appointment): _____.

❑ Mammogram (Screening). Previous: _____ (date) _____ (location) Implants: ❑ Yes ❑ No
❑ Bone Density
❑ Other:

Therapy Referral

Date of Injury/Onset/Surgery: _____ ❑ Motor Vehicle Accident ❑ Employment/WC ❑ None ❑ Other

❑ Red Cedar CP & PR
❑ Other: _____
❑ Evaluate and Treat
Diagnosis: _____
Special Instructions: _____

✓ all that apply	Next Available	Other
Physical Therapy		
Occupational Therapy		
Speech Therapy		
Massage Therapy		

Physician Referral

Okay to leave message: ❑ Yes ❑ No

Location: _____
Diagnosis: _____
Referral Specialty: _____
Provider Name: _____

✓ all that apply	Next Available	Other
Referral Appointment		

Other Follow-Up Appointments

Diagnosis: _____

✓ all that apply	Next Available	Other
Nurse		
Dietician		
Diabetic Educator		
Behavioral Health		

_____ _____ _____
Physician Signature Date Time

2015031

Narcotics for Chronic Pain or ADHD Medications

You have been prescribed a narcotic pain or attention deficit hyperactivity disorder (ADHD) medication. The Drug Enforcement Agency has specific narcotic pain medication dispense and use regulations that must be followed.

Mayo Clinic Health System is committed to helping you use your medications properly and fully explaining the medication refill process.

Please remember the following when using or requesting refills of narcotic or ADHD medications:

1. Do not share or give your medication to someone else. It is illegal.
2. Medication that is lost or stolen will not be replaced. It is your responsibility to keep your medications in a safe place.
3. If you call for a refill of your medication, expect it within 48 hours. It is best to call Monday through Thursday for a refill. If you call on Friday, it will be refilled by the end of the next Monday (or the next business day).
4. Refills will not be done on weekends or holidays over the phone, so plan accordingly.
5. Many narcotic pain relievers and most ADHD medications require a written prescription that must be picked up in the clinic. If someone other than the patient picks up the prescription, the name and relationship to the patient must be communicated prior to picking up the prescription. Anyone picking up a prescription must show a photo ID. Prescriptions can also be mailed to your pharmacy.
6. You can request three separate ADHD medication prescriptions for three months of refills. Each prescriptions will include different pick up and start dates. It is recommended that you bring all three prescriptions into your pharmacy within five days of receiving the prescription. Please ask your pharmacist to explain when you need to pick up the next two months' medication.
7. Your health care provider will let you know when he/she needs to see you back for a clinic appointment. Most patients with ADHD should be seen every six months. Patients who take narcotic pain relievers may need to be seen more frequently.
8. Do not take street drugs or drink excessive alcohol with any of these medications. Your provider may request a drug screen to be performed if these concerns exist.
9. Some providers will have you sign a *Narcotic Contract* for narcotic pain medications. Be sure to read and understand this contract.

Narcotics for Acute Pain

You have been prescribed a narcotic medication for your pain. The Drug Enforcement Agency has specific narcotic pain medication dispense and use regulations that must be followed.

Mayo Clinic Health System is committed to helping you use your medications properly and fully explaining the medication refill process.

Please remember the following when using narcotics or requesting refills:

1. Do not share or give your medication to someone else. It is illegal.
2. Medication that is lost or stolen will not be replaced.
3. Refills will not be completed over the phone.
4. You must schedule an appointment with a health care provider to request a refill. Ideally, this should be your primary care provider. If your pain is a result of a surgery or other medical problem that is managed by another provider, please schedule an appointment with him/her.
5. Call 715-233-7777 to schedule an appointment. Many providers offer same day appointments. The telephone line opens at 7 a.m. Same day appointments are available on a first come, first serve basis.

906-612 | 8.11

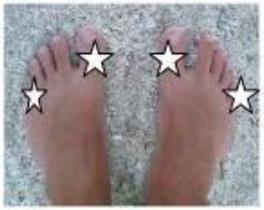
Patient Name _____ **Birthdate** _____

Diabetic Foot Exam

(This sheet should not stay in the chart. Please throw after dictation)

1. History – ask the following questions and **document in patient's words**
   - Do you have numbness or tingling in your feet? Yes/No
     Describe -
   - Do you have pain in your feet? Yes/No If yes, rank on scale of 1-10
     Describe the location and character of their pain.
   - Are your feet cold? Yes/No

2. Monofilament Exam – document as presence or absence of sensation
   - Dorsum of the 1st and 5th toes
     Right – Present/Absent **Left** – Present/Absent
   - Distal arch of the plantar aspect of the foot
     Right – Present/Absent **Left** – Present/Absent



3. Pulses – present or absent. If any pulse is not palpable, obtain Doppler.
   - Dorsalis pedis **Right** – Strong/Weak/Doppler **Left** – Strong/Weak/Doppler
   - Posterior tibial **Right** – Strong/Weak/Doppler **Left** –Strong/Weak/Doppler

4. Capillary Refill – blanche great toe on each foot and document number of seconds
   Right - ____ seconds **Left** - ____ seconds

5. Skin integrity (R.N. or Provider only) – assess color and skin temperature
   - Erythema or pallor –**Right**– present/absent **Left** – present/absent
   - Temperature –**Right** **Left**
   - Callous formation – **Right** – present/absent **Left** – present/absent
   - Breaks in the skin, ulcerations, rashes
     Right – describe if present
     Left – describe if present

02/03/2010

The Best Tool of All:
The Physician/Nurse Team

Module 1B: Care Delivery—Primary Care and Care Redesign

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