GUIDE TO THRIVING AT THE DOC
2017-2018 Edition

BASIC CLINIC INFORMATION

CLINIC CONTACT INFO

Duke Outpatient Clinic (DOC)
4220 N Roxboro Road
Durham, NC 27704

Main clinic number: 919-471-8344
Fax number: 919-477-3110
Fax number (refills): 919-477-5435

Door codes (all doors from waiting room to clinic area): 2-4-3-1

IMPORTANT PHONE NUMBERS

Faculty

Medical Director & Clinic Group A Leader, Lynn Bowlby, MD	919-970-4559 (p), 774-991-0041 (c)
Clinic Group B Leader, Dani Zipkin, MD	919-970-8947 (p)
Clinic Group C Leader, Larry Greenblatt, MD	919-660-9047 (o), 919-970-0496 (p)
Medical Director of Behavior Health, Greg Brown, MD	919-970-2532 (p), 847-927-0832 (c)
Ambulatory Chief Resident Dinushika Mohottige	919-970-6767 (p)
Teal Side Preceptor Room	919-660-9024
Lavender Side Preceptor Room	919-660-9023

Staff

Administrative Director Lisa Lowe-Hall	919-660-3064 (o), 919-970-0211 (p)
Amy Pollok, SAM	919-471-0459
Front Desk	919-660-9007 (or 9006 or 0919)
Financial Care Counselor	919-477-0829 (o); 919-471-9475 (o)
Social Worker, Jan Dillard	919-471-0084 (o), 919-970-4530 (p)
Clinical Pharmacist, Holly Causey	919-477-5904 (o), 919-970-3532 (p)
Clinical Pharmacy Assistant	919-660-9058
Nurse Manager Brenda Mutisya	919-660-9057 (o), 919-970-5178 (p)
Nurse Triage	919-660-9016
Nursing Pager	919-970-3624 (970-DOCHelp) (p)
HomeBASE Care Manager, Marigny Bratcher	919-309-6562
Medical Records, Carolyn Lawrence	919-660-9045
Laboratory, Angela Wilson	919-471-0546
Scheduling Hub, Rita Clark	919-479-2454
Scheduling Hub, Rita Maynor	919-479-2464
DHTS Help Desk:	919-684-2243

Hospital Transfer
DRH ER Triage: 919-470-4000 ext 1
Duke Transfer Center: 919-681-3440

Hours and Parking
Clinic hours are 8am to 5pm.

The DOC is located on the second floor of the Durham Medical Center building on 4220 N Roxboro Rd. Enter through the front door and exit through the side door. You must leave the building by 6:30pm, or alarms will go off and the clinic will get charged a big fee! Please park at the side or back of the building so that patients can park in the front.

Copy/Fax machines
- One located between the teal/lavender side nursing stations
- Another is located in medical records, no code needed
- Nursing can help you make copies

Late Policy for Patients
- Patient are considered late if they arrive >20 minutes after their scheduled appointment
- Patients arriving less than 20 minutes late will be seen
- Patients who are elderly, rely on others for transportation, are in the HomeBase program, or have an issue that requires urgent medical attention will also be seen regardless of when they arrive
- If a patient is >20 minutes late:
    - Nursing staff may ask you it you're willing to see the patient, but the general goal is to see everyone who walks in to clinic
    - If you're able, see the patient
    - If you're behind or have other people waiting, feel free to see others first, then see the late patient
    - If you really don't think you'll have time, nursing staff may add the patient to someone else's schedule or schedule them for a later appointment in the day

COMMON CLINIC TASKS

A CHECKLIST TO COMPLETE DURING A PATIENT VISIT

The majority of your patient care note can actually be completed prior to the end of the visit. The following "checklist" highlights the different steps you should take during the visit in the "visit navigator" section of each patient's chart. Note that **bolded** items **must** be completed prior to discharging a patient from the visit. You may use ".dazfu" or ".daznewtemplate" for a follow up or new visit respectively.

1. **Document and/or review the "Chief Complaint"**
2. **Review documented "Allergies"** (be sure to "mark as reviewed")
3. **Review and update the patient's "Problem List"** (be sure to "mark as reviewed")
4. Review and revise patient history (PMH, PSH, family, social)
5. **Review, reconcile, and refill patient medications under the "Medications" tab**
6. **Review and update the "Healthcare Maintenance" tab**
7. **Record a diagnosis (or multiple diagnoses) for the visit under "Visit Diagnoses"** (note: you can "push" problems from the "Problem List" section into "Visit Diagnoses" by clicking on the small arrow next to each problem). Do NOT put 'health maintenance' as the first visit diagnosis, as we can't bill visits that way.
8. **Document HPI**
9. **Order any additional tests or referrals under "Meds and Orders"** (everything you order must be "associated" with a visit diagnosis)
    a. PEND orders until you know who you're signing out with, so orders and referrals can link with correct attending.
10. Document assessment and plan (note: use .DIAGMED to pull in each visit diagnosis with attached orders)
11. **Document a follow up in the "follow-up" section, specifically in the "For:" field** (for example, "f/u in 2-4 months with PCP for HTN management")
12. Route your note to the attending you signed out with (also in the "follow-up" section)
13. **Write patient instructions in the "Patient Instructions" section** (see Smart Phrases below)

Print the "After-Visit Summary (AVS)" and hand it directly to the patient

FILLING OUT FORMS

Partnership Folders

All paperwork needing attention is placed in partnership folders. You are responsible for addressing items in folder each time you're in clinic; please be conscientious of needs of patients when not in clinic, which can include essentials such as diabetic supplies or home care orders. After completing, please place the form in the Medical Records bin. Occasionally, if a partnership has no members in clinic for a few weeks, you'll be asked to help with forms for their patients. Dr. Bowlby can help with any paperwork—they are lots of different types and it is complex! Dr. Zipkin will provide additional instruction on managing the folders during admin sessions during ambulatory weeks.

Types of Forms

There are many types of forms that need to be completed; please ask your attending or more senior residents to help you with forms that are new to you. All forms need to be copied and sent to medical records before returning them to patients.

For questions about paperwork or obtaining records at the DOC, contact Carolyn Lawrence in Medical Records or discuss with your attending.

Remember: Do not make copies of the patient's information or discuss patient care with family members unless you have permission, as HIPAA rules dictate. Document any verbal or written permission you have received.

Disability Forms

Disability forms from insurance companies will be placed in your PP folder. These will be photocopied for the patient's chart. If it is a new disability form, it should be completed by the resident *who most recently saw the patient* or the PCP, whoever knows the patient best. These forms and decisions are often complex, so please speak with your attending or the Ambulatory Chief Resident. If it is a renewal form and continues to be appropriate, old forms may be available for reference in the patient's file kept in Medical Records.

FL-2 Forms
These are required for Medicaid patients transitioning from living at home to a skilled nursing facility (temporarily, e.g., for low-intensity rehab) or rest home (i.e., more or less permanently, barring a dramatic change in home circumstances); placement depends on there being an available bed at a facility accepting Medicaid. They are also used to access funds to help a patient remain in their home in lieu of placement.

Health care power of attorney/advanced directive (HCPOA) forms
These forms may be completed by the patient and signed in front of any notary. Gloria Manley, financial counselor, is the notary for DOC or the patient may use their own. Patient should provide a copy to DOC to be scanned in to their record, and a Care Coordination Note and FYI flag entered, as well as the relevant additions to the Problem List. Forms are available in each exam room in the manila folder. You may also refer patients to Jan as needed to discuss HCPOA/Advance Directives, to ensure understanding of the process and the content.

Outside Medical Records
Outside medical records can be requested if patient completes a "Release of Medical Information" form, found in the file drawers at the workstation. When the records arrive, they will be placed in your PP folder prior to filing in the patient's chart. If you need the medical record to be scanned, let Carolyn know.

Work excuses
Use pre-printed form in clinic located in the file drawers at the workstations, or available templates in Maestro letters section (under "communication" tab. *Do not use prescription pads.*

Other miscellaneous folder Items
FYI items will come through from pharmacies and insurance companies and outside providers all the time. With each item, your job is to determine the medical necessity of following up, or simply documenting in an encounter that it was received to notify the care team, or signing it and returning to medical records to scan into the medical record.

MANAGING PATIENTS WHEN NOT IN THE CLINIC

Away from Clinic
- Check your Maestro Care inbasket daily
- If you are going on vacation and will not be able to do so, ask a member of your provider practice to cover for you

DOC AFTER-HOURS TELEPHONE HOME CALL COVERAGE
- Call is 5pm to 8am Monday-Friday and then all day/night Saturday and Sunday
- During regular work hours, calls are handled directly by clinic staff
- On the first Monday of your call week, call the Duke Operator to check in
- Carry your pager at all times including on the weekend
- The paging operator will page you first; if you cannot be reached, they will page the back-up attending
- Touch base with your attending in the middle of the week to discuss how the week is going
- Do not hesitate to call your attending. They get worried if they don't hear from you every once in a while.
- Call / email / page Dr. Bowlby if you have questions or problems with your call experience
- Document all significant telephone encounters in Maestro

HOW TO MANAGE COMMON CALLS
Acute Complaints

- Your role is to triage, not necessarily to solve or treat problems. Decide whether the issue is urgent or not.
- Urgent: Active suicidal ideation, cardiac chest pain, mental status change, vomiting/diarrhea with no PO intake for > 24 hrs.
    - Call your attending to review the case and decide whether patient needs to go to ED vs urgent care (Duke Urgent Care is open 8A-8P 7 days/week).
    - If patient is having active suicidal ideation or needs substance abuse detox, consider directing them to Durham Center Access at 309 Crutchfield St (919-560-7305).
    - It is patient's responsibility to call 911 or arrange their own transportation
    - If patient is going to ED, call the hospital and explain the reason for ED visit
- Not urgent
    - Suggest possible home treatment options or refer for an acute care visit in the upcoming days.
    - If an urgent appointment is needed, send an inbasket message to the front desk supervisor to make the appointment for the next day.

Medication needs

- Routine medication refills: Tell patient to call their pharmacy and have the pharmacy fax a request to DOC. Do not order the refill yourself.
- Urgent medication refill: If you determine that you can safely refill on review of records and discussion with patient, either call the pharmacy directly or generate a medication refill encounter thru Maestro (preferred).
- Urgent refill but patient has not been seen in past 6 months: Provide a one month supply and set up a follow-up appointment as above

PRESCRIBING DRUGS

HOW TO MAKE PRESCRIPTION DRUGS AFFORDABLE

- Use generics whenever possible
- GoodRx smartphone app provides coupons for many medications; useful for uninsured patients
- Large chains (Walmart, Costco, Kmart, Target, Harris Teeter, Kroger) have $4-5 generic prescription drugs; some require a small annual fee
- Harris Teeter dispenses free generic antibiotics and oral DM meds for $4.95/year
- Coupons: http://www.needymeds.org/coupons.taf?_function=list&letter=A
- Mail order: https://www.rxassist.org/docs/rxoutreachfrm.pdf or https://xubex.com/BMLIntro.aspx
- For some plans (including Medicaid), Maestro Care alerts you when you order a non-formulary medication
- Ask the pharmacist to walk you through pre-authorizations
- Ask social worker for additional recommendations

Patient Assistance Programs (PAP)

- Certain brand-name prescription drugs can be obtained directly from pharmaceutical companies
- Check rxassist.org to see if a medication is covered under a PAP
- Determine whether need for medication assistance is long-term or not
- Type '.docfreemedspap' in patient instructions and/or ask a nurse to explain to patient what to do.
    - Patient calls 684-9563 to speak with a pharmacy tech at the Duke Specialty pharmacy, to initiate the screening process.
    - Patient brings prescription for 90 day supply with 3 refills to the PAP staff at Duke Specialty Pharmacy (Duke Cancer Center)
- Email Pharmacy-Grp_PAP@dm.duke.edu with patient name, MRN and medication. CC the attending. Pharm Tech will email you the application to complete and have the attending sign. Then send back to tech.
- Call physician line (684-9276) with questions
- PAP delivers 3 months of medications to patient home or Duke Specialty Pharmacy

Senior PharmAssist-Patients with Medicare

- Phone number: 919-688-4772
- Website: http://www.ncdoi.com/SHIIP/SHIIP_County_Sites.aspx
- Counseling service and prescription assistance program
- Reviews medications, fills pillboxes, covers premiums and copays
- Available to patients >60 years old
-

Patient Has Medicaid Only

- Send prescriptions to Gurley's Pharmacy (919-688-8978, 114 West Main St) or Josef's Pharmacy (919-680-1540, 3421 N Roxboro Rd)
- No copay if unable to pay
- Pharmacy delivers medications and can fill pill box (blister packs) for patient

NC MedAssist:-Uninsured Patientslong-term solution

- Refer patient to SW
- E-prescribe to NC MedAssist prescription for 90-day supply with 3 refills
- Set medication formulary for low-income uninsured NC residents
- Ships medications to patient for free
- Website: http://medassist.org/available-medications/

Duke Hospital Sponsorship: short-term solution for patients without insurance

- Refer patient to SW
- One-time support for medications
- Not available for insured patients who just need copay assistance

Medicare and Medicaid Difficulty with Drug Coverage

In some cases, Medicare and Medicaid may not cover a drug you think should be covered, or the cost of the drug is higher than it usually is for the patient.

Medicare

1. Check if there are generic, over-the-counter or less expensive brand name drugs that are equally as effective
2. Call 1-800-MEDICARE (1-800-633-4227) or visit www.cms.gov/MedPrescriptDrugApplGriev/13_Forms.asp to find out what the barrier is, eg prior authorization, step therapy requirements, quantity/dosage limits
3. Request a "coverage determination" if the pharmacist or plan tells you one of the following:
    a. A drug you believe should be covered isn't covered
    b. A drug is covered at a higher cost than you think it should be
    c. The patient has to meet a plan coverage rule (such as prior authorization) before they can get the drug
    d. The plan believes the patient does not need the drug.
4. Request a coverage determination with an "exception" if:
    a. You think the plan should cover a drug that is not on the formulary because the other treatment options on the formulary will not work
    b. You believe the patient cannot meet one of the plan's coverage rules, such as prior authorization, step therapy, or quantity or dosage limits
    c. You think the plan should charge a lower amount for a drug on the plan's non-preferred drug tier because the other treatment options in the plan's preferred drug tier will not work for your patient
5. Wait 72 hours for a determination
6. If the patient cannot wait 72 hours, call or write to the plan to request a decision within 24 hours, letting the know that the patient's life or health may be at risk
7. Refer patient to Senior PharmAssist (919-688-4772) for financial assistance and assessment of alternative prescription plans

Medicaid

- Visit http://www.ncdhhs.gov/dma/pharmacy/PDL.pdf or call 866-246-8505 to find out what the barrier is, eg prior authorization, step therapy requirements, quantity/dosage limits
- Complete prior authorization form OR submit required information via email OR call for prior authorization
- Submit prior authorization requests to 866-246-8507 (fax), nc.providerrelations@acs-inc.com, or ACS State Healthcare, P.O. Box 967, Henderson, NC 27537-0967
- PA requests are typically answered within 24 hours, if not immediately.
- Pharmacy can issue a 72 hour supply while waiting for PA determination.
- For more information, go to http://www.ncmedicaidpbm.com/

PRESCRIPTION REFILLS

- For routine refill requests, patients should ask their pharmacist to fax requests to (919) 477-3110
- Your partnership's RN will refill many prescriptions by protocol
- If patient has not been seen in >1 year, they may receive a 30 day refill but must be seen in clinic for future refills
- Narcotic (schedule II) prescriptions require a written monthly prescription by a medical provider

PROCEDURES

For some procedures, you must obtain written informed consent from the patient on the pre-printed consent forms available at the nursing work stations. Procedures that need BOTH a consent form AND a "time out" include skin biopsies, joint aspirations and injections, and I&Ds. Include a brief description of the procedure in your clinic note.

1. Pelvic exams:
    a. Let your nurse or CMA/CNA know in advance so he/she can get the patient ready
    b. Order the tests you want before performing the exam
    c. Commonly ordered tests: Pap with reflex HPV testing, gonorrhea, chlamydia, gram stain, trichomonas
2. EKGs: place the order in Maestro, but be sure to let your nurse or CNA know because it doesn't automatically pop up in their system
3. Spirometry: simple spirometry can be ordered same-day or as a future nursing visit, and is done by the CMA/CNA (note: you can also order formal PFTs by placing an order for "Ambulatory Referral for Pulmonary Function Testing" in Maestro)
4. Nebulizer treatments
5. IV fluids: for short duration only
6. Cryotherapy for skin lesions
7. Skin biopsies
8. Joint aspirations and injections
9. Incision and drainage
10. Suture/staple removal
11. PPD placement
12. Injections: includes vitamin B12, Depo-Provera, vaccinations, ketorolac, ceftriaxone, insulin, and others—see appendix for full list of medications

SCHEDULING (FOLLOW-UP) APPOINTMENTS

- **During a clinic visit:**
    - **Scheduling a follow up MD appointment**: go to the "Wrap-Up" tab -> "Follow-up" section -> "For: " text box where you can type a return appointment time (e.g., "2-4 months with Dr. Smith"). Always specific a time range to give schedulers leeway.
    - **Scheduling a pharmacist, DOC PT, or group visit (DM, HTN, Pain):** go to the "Wrap-Up" tab -> "Follow-up" section -> "Check Out Note: " box and type your request. Examples "Follow-up with Pharmacist 1:1 for insulin titration in 2-3 weeks," "Follow-up with DOC PT," "Schedule with HTN group"

- **At any time:** send an InBasket message to the "P DUKE OUTPATIENT SCHEDULING [10372]." This option should start popping up after typing "P DUKE OUT" in the "To:" field. Use the "Patient Lookup" button to add the relevant patient.
- **Patients can schedule** by calling the scheduling hub at (919) 471-8344 (extension 1) during business hours to request an appointment (they should be encouraged to ask for you by name)

SENDING LETTERS TO PATIENTS

- If you are asked to write a letter to a patient, please review it with an Attending (if possible the one who you precepted the patient with or who has seen them recently).
- You may notify patients of lab results by using letters.
- Select the "letters" tab (it may be hidden if you don't use it frequently). Select recipient at the top. Compose the letter (right click to make selected text editable to get rid of extraneous stuff in lab results)
  → **(1) ROUTE** or **(2) SEND the letter**
    - Click "route" to send the letter to your medical records pool or designated person (route to Lawrence, Carolyn) who will mail the letter to the patient (preferred) and the attending who reviewed the letter with you.
    - Click "send" to print letters and then have someone send them. To print later, go to Letters tab in Chart Review.

MEDICAL RESOURCES FOR PATIENTS AT DOC

GROUP CLASSES

- **DM2 class:**
  - Day/Time: two Fridays each month from 1:30-3:00 pm
  - Brief description: multidisciplinary education and support group run by a clinical social worker and a clinical pharmacist/diabetes educator. Also includes 1:1 MD visit for med titration.
  - How to refer your patients: Type "DM Group" in the "Check-out note" box if in a clinic visit.
- **HTN class:**
  - Day/Time: every 4th Monday from 10:00-11:30am
  - Brief description: provides education on BP goals, diet, monitoring, stress reduction. Also includes 1:1 pharmacist visit for med titration.
  - How to refer your patients: Type "HTN Group" in the "Check-out note" box if in a clinic visit.
- **PAIN class (Prevent And Intervene NOW):**
  - Day/Time: every other Thursday of each month from 1-2 pm
  - Brief description: chronic pain education and support. Explains origin of pain, strategies for coping and adapting, and provides support.
  - How to refer your patients: Type DOC PAIN Group in the "Check-out note" box if in a clinic visit or message Jan Dillard if not in a visit.

For all group visits: Be sure to discuss with your patient and let them know of the referral.

CLINICAL PHARMACY SERVICES

What is a Clinical Pharmacist Practitioner (CPP)? *A CPP is a pharmacist with specialized training who can independently provide drug therapy management and implement pre-determined drug therapy through a collaborative practice agreement under the supervision of a licensed physician.* Holly's supervising physicians are: Dr. Lawrence Greenblatt, Dr. Patrick Hemming, Dr. Daniella Zipkin and Dr. Lynn Bowlby.

One-on-one pharmacy visits for DM2, HTN, anticoagulation, smoking cessation, and difficult med rec/education. A clinical pharmacist practitioner will meet with patients and can titrate hypertension and diabetes medications. This is a great way to add an additional visit between MD visits with the PCP for patients who need frequent visits / close monitoring. They can also do difficult med recs and educate patients (ensure patient knows to bring all their home medications with them). Finally, they do pain management (see pain section).

Specify in your clinic note what you are expecting from the pharmacist. In the "Check Out Note" box ask for a 1:1 with pharmacist in x amount of time (e.g., 1-2 weeks). In patient instructions, type ".docpharmreferral"

Staff

- Clinical pharmacist practitioner Holly Causey (PharmD, BCACP, CPP, CDE) is the head CPP
- Dinah Harris, CPhT is present every day and assists Holly
- Ben Smith (PharmD, BCACP is present once a week (Monday AM)
- Lisa Bendz (PharmD) is present twice per month (Tues AM)
- Rotating pharmacy residents and students

PHYSICAL THERAPY

A variety of physical therapy services are available throughout the health system, including outpatient PT/OT, speech, gait and balance training, mobility evaluations for motorized wheelchairs and other assistive devices, cardiac and pulmonary rehab, vestibular rehab (for vertigo), and aquatic therapy.

Services Provided

The DOC has on-site physical therapy on Mon PM, Tues/ Thurs AM, for both scheduled appointments and informal consultation. Conditions treated on site include:

- Neck pain
- Back pain
- Knee injuries

- Shoulder injuries
- Pre-surgical management
- Post-surgical management
- Sports rehabilitation
- Arthritis conditions
- Traumatic injuries
- Overuse/repetitive injuries

For questions, email or InBasket Melissa Carvalho, or Dr. Bowlby (a former practicing PT herself!). For referrals to PT, just write DOC PT in the follow-up section of the visit navigator in Maestro. Erik can see patients regardless of insurance status.

DOC ANTICOAGULATION CLINIC

Joint nurse-pharmacist anticoagulation service for patients on warfarin

Referral Process

- Resident and attending identify patient to be enrolled in the anticoagulation clinic.
- Patients who are new to warfarin have an initial 30-45min appointment with pharmacy
- Subsequent visits with pharmacy are 15mn
- Once a patient reaches therapeutic level at 2-3 consecutive visits, s/he is assigned to follow up with RN
- Patients who are new to DOC but are already on warfarin follow up with RN

During the Anticoagulation Appointment

- POC INR test (POCT6003)
- Collect patient-reported dose of warfarin, missed doses, dietary changes, EtOH, other drug changes, signs of bleeding or unusual bruising, other acute issues.
- If INR $\geq$5, the patient is sent to the lab for INR by phlebotomy (LAB320)
    - Patients may leave if no clinically significant bleeding AND no s/s concerning for bleeding (eg headache) AND can provide a reliable phone number
    - If no s/s concerning for bleed but no reliable phone number, patient must stay for INR results or return in 3-4 hours for results
    - If s/s concerning for bleed, pharmacist or RN notifies a physician to evaluate need for acute appointment or ED transfer

INR Checks at Home

- Home health agency checks INR
- Results are faxed, called in, or emailed to the clinic (attn. Holly Causey)
- Charge nurse notifies pharmacist if not therapeutic or RN if therapeutic

INR Checks During Physician Appointment

- MD may want to check an INR outside of the designated anticoagulation clinic time due to clinical changes, transportation difficulties, etc.
- RN or LPN checks POC INR
- MD is responsible for adjusting warfarin and ensuring follow-up with the anticoagulation service

Follow-up

- All patients should have INR checked at least monthly
- If INR is at goal and has been at goal for $\geq$2 visits, follow up in 4 weeks
- If INR is not at goal, adjust dose and recheck in 1-2 weeks
- If INR is at goal x1, recheck in 1-2 weeks.
- Poor follow-up:
    - If patient has 3 no-shows, they are referred back to their PCP for further management
    - TAGTEAM (Team Approach Geared Towards Effective Anticoagulation Management): Challenging patients are discussed once a month at the DOC leadership meeting. Providers review the cases and make recommendations for further management.

Contacting patients who are overdue for INR check

- Anticoagulation provider (pharmacist or RN) sends a notification to DOC front desk via inbasket message to let them know the patient should be contacted 3 times on different days and at different times
- DOC staff documents each telephone call attempt as a telephone encounter
- After the third attempt, the encounter is forwarded to anticoagulation provider
- Provider sends a letter to the patient
- If no response is received within 1 week, a second letter is sent requesting that the patient contact the clinic to make an appointment
- If no response within 2 weeks of the second letter, provider is notified
- Provider documents that the patient is no longer active in anticoagulation clinic and sends a message to PCP and medical director

BEHAVIORAL HEALTH CONSULTANTS

- Who: Ashley Cyr and Joy Long (as well as Jan Dillard). All are LCSW.
- What they do:
    - Provide consultation to PCP for patients whose problems are related to behavior (for both physical health and mental health)
    - Targeted Counseling
    - Brief visits (20-30 minutes)
    - Develop treatment plans
    - Teach self-improvement techniques (wellness/self-management)
    - Schedule follow up if needed
    - Refer to specialty mental health as needed
    - Document in Maestro
- Common reasons for referral:
    - Chronic disease management (e.g., hypertension, diabetes, headaches, chronic pain)
    - Wellness (e.g., sleep, healthy eating, smoking cessation)
    - Adjustment to new diagnosis (e.g., STIs, cancer)
    - Dementia, cognitive impairments, I/DD (Intellectual/Developmental Disabilities)
    - Fatigue without medical etiology
    - Socio-emotional problems (e.g., bereavement, marital problems)
    - Parenting and behavioral problems in kids of patients
    - Typical psych complaints (e.g., mood disorders, ADHD, substance abuse, psychosis)
- How to make the behavioral health consult as effective as possible:
    - Identify patient behavior issue
    - Ensure willingness for patient to see BHC
    - Warm handoff – face to face introduction
    - Monitor and support patient progress with tx plan
    - Continue to refer to Jan as usual for broader social work needs, comprehensive assessment and long term counseling
    - If you are not sure whether to refer to BHC, do it anyway and they will sort it out

PSYCH CONSULTATION

The DOC has two Med-Psych attendings who specialize in medically complex psychiatric patients, and are available to see patients with several types of conditions.

- Patients MUST be referred by their PCPs (no self-referrals)
- The following patients can be referred directly for clinical assessment:
    - Patients with Schizophrenia or Bipolar disorder **without** a current psychiatrist
    - Patients with depression or an anxiety disorder **without** psychiatrist AND have been hospitalized or seen in the ER psychiatrically within the past 3 months
- The following patients should be scheduled during Med/Psych preceptor time (Mon PM, Tues PM, Wed AM and Fri AM):

    - Patients with Schizophrenia or Bipolar disorder who have a psychiatrist BUT their psychiatric illness is interfering with their ability to manage their medical illnesses
    - Patients with depression or an anxiety disorder who have a psychiatrist AND have been hospitalized or seen in the ER for a psychiatric diagnosis within the past 12 months
    - Patients with depression or an anxiety disorder who have not responded to or not tolerated medication trials per the DOC Depression Management Algorithm
    - Patients with substance abuse, personality disorders or other psychiatric issues whose psychiatric illness is interfering with their ability to manage their medical illness
    - Patients with suspected psychiatric illness but unclear psychiatric diagnosis
- Once patients are psychiatrically stable, their care will be transferred back to their PCP
- Please do not utilize Med-Psych consultation for patients with routine depression without first attempting treatment through the depression treatment algorithm
- If there are ever any questions about the appropriateness of referrals, please feel free to page or call Dr. Brown in real time

DOC SPECIALIST VISITS

- Several specialists see patients at the DOC. This may be an easier location for patients, and these clinicians are familiar with the DOC patient population. Request a specialist clinic visit by asking for the relevant specialist clinic in the "Check-out note" box after a patient visit.
- The following specialists see patients at the DOC on certain days:
    - Endocrinology clinic (Wednesday afternoons)
    - Hepatology clinic (with Dr. Muir)
    - Cardiology clinic
    - Physical Therapy (Thursdays)
    - Weight loss (with Dr. Westman). For motivated patients, his comprehensive clinic (next door to the DOC) teaches the low-carb (i.e., ketogenic / Atkins) diet and has successfully had many patients control their diabetes and even reduce / eliminate their insulin requirement.
    - Pulmonary clinic

MEDICATIONS AVAILABLE IN CLINIC

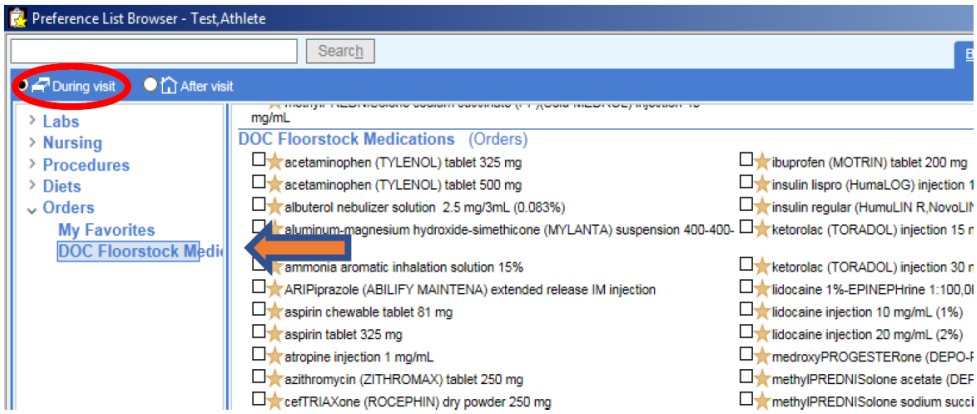
Allergy	Diphenhydramine 25mg capsule Epinephrine (Epi-Pen) 0.3mg syringe
Antibiotics	Azithromycin 250 mg tablet Ceftriaxone 250mg and 500mg vial (IM) Metronidazole 500 mg tablet Neomycin/Polymyxin/Bacitracin ointment Penicillin G 2.4 million units/4mL
Cardiology	Aspirin 81mg chewable tablets Aspirin 325mg tablets Atropine sulfate 1mg/mL vial Clonidine 0.1mg and 0.2mg tablets Furosemide 20mg tablet Hydralazine 50mg tablet Metoprolol 25mg tablet Nitroglycerin 0.4mg tablet
Endocrinology	Cosyntropin 0.25mg vial Dexamethasone 4 mg/mL vial Dextrose 50%, 50mL vials Glucagon 1mg kit vial Glucose 40% gel 31g tube Insulin lispro (Humalog) 100 units/mL Insulin regular (Humulin R) 100 units/mL

	Methylprednisolone sodium succinate (solu-medrol) 40 mg/mL and 125 mg/mL Methylprednisolone acetate (depo-medrol) 40 mg/mL Prednisone 20mg tablet
Gastroenterology/Nausea	Docusate Sodium (Colace) syrup 100mg/10mL Magnesium, aluminum, simethicone (Mag-Al Plus XS) Ondansetron ODT 4mg tablet Promethazine 25mg tablet and 25mg/mL1 mL vial
Hematology	Epoetin Alfa (Procrit) 10,000 units/mL Phytonadione (vitamin K) 5mg tablet
Pain or anti-inflammatory	Acetaminophen 325mg and 500mg tablets Colchicine 0.6 mg tablet Ibuprofen 200mg tablets Ketorolac 15 mg/mL and 30mg/mL Sumatriptan 25 mg tablet
Psychiatric/Substance Abuse	Aripiprazole (Abilify Maintena) 300 mg syringe and 400 mg syringe Naloxone 2 mg/2mL vial Naltrexone (Vivitrol) 380 mg vial
Pulmonary/Respiratory	Albuterol 2.5mg/3mL inhalation ampule
Reproductive	Etonogestrel (Nexplanon) 68mg implant Medroxyprogesterone acetate (Depo-Provera)150 mg Testosterone cypionate (Depo-testosterone)
Vaccines	Hepatitis A vaccine Hepatitis B vaccine Human Papillomavirus 9-valent(Gardasil) Influenza virus vaccine Pneumococcal 13-valent conjugate (Prevnar) Pneumococcal 23-valent conjugate (Pneumovax) Tetanus, Diphtheria- Td (Decavac) vaccine Tetanus, Diphtheria, Pertussis (Boostrix)
Miscellaneous	Ammonia aromatic inhalant 2% ampule Carbamide Peroxide Otic Soln 6.5% Cyanocobalamin (vitamin B12) 1000mcg/mL Hylan G-F 20 (Synvisc-One) 8mg/mL Lidocaine 1% and 2% injections Lidocaine with epinephrine 1% Silver nitrate applicator stick Silver sulfadiazine cream 25mg tube Thiamine 100mg/mL Triamcinolone acetonide (Kenalog) 40mg/mL Tuberculin PPD skin test

Ever Wondered How to Quickly Find which Medications and Vaccinations We Have at the DOC?

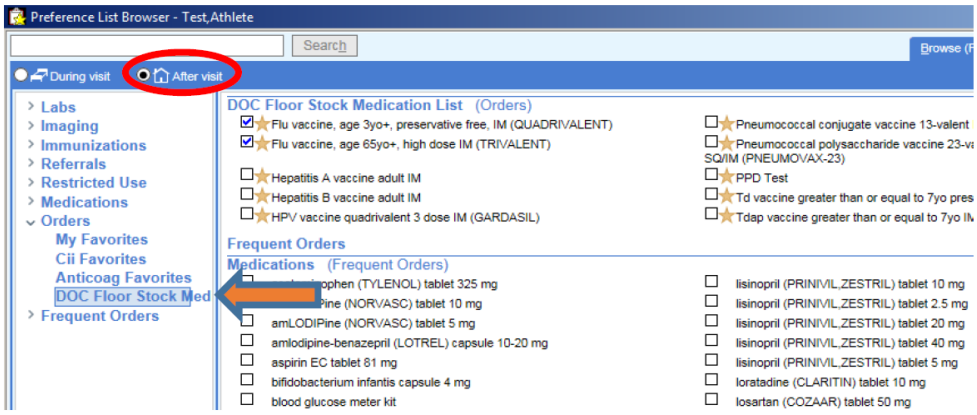
There are two lists: one is outpatient (for vaccines) and one is inpatient (for all medications to be given at bedside out of our cabinet/fridge)

Floorstock Meds



For floorstock meds, please make sure that you select the bed icon. You will then see the "DOC Floorstock Medications" List

Vaccines

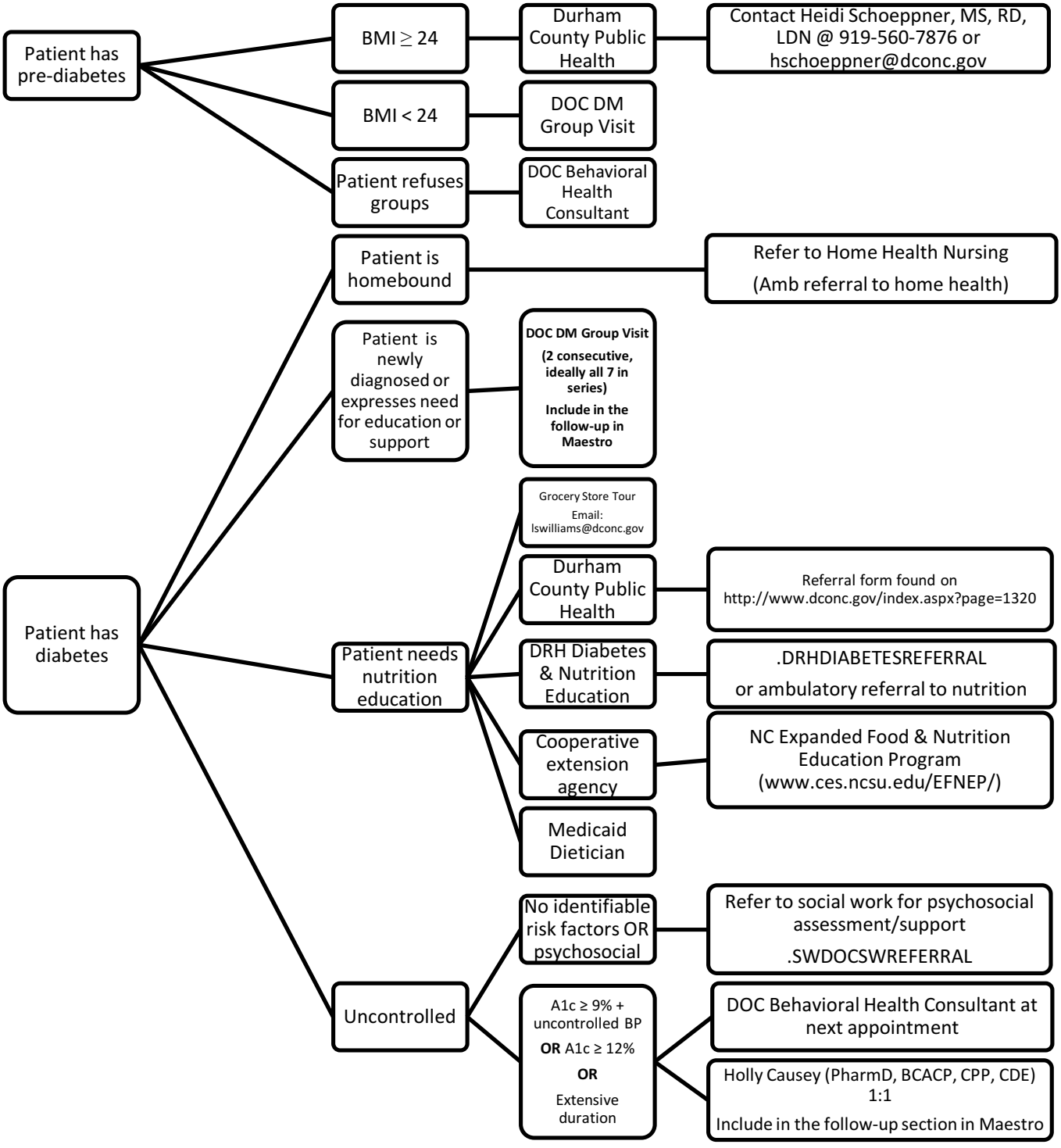


For vaccinations, please select the home icon. You will then see the "DOC Floorstock Medications" List

Infusion Center Orders: Brenda, nurse manager will assist you!

- Call first to set up appointment: 919-681-0645
- Location: 2A in Duke South
- Make sure to draw a type and screen the day BEFORE the infusion visit (if you are ordering PRBCs)
- Be sure to be on your pager in case you get called for clarification
- Steps on Maestro:
    - Select: **Patient Station** and **locate your patient**
    - Select: **More activites** (bottom left of your screen)
    - Select: **Encounters** (first option on the pop-up menu option)
    - Select: **New** (on the bottom left)
    - Select: **Orders Only encounter**
    - Then in your new encounter select: **Orders**
    - Then you must select: **orders for later** on the top menu option (last on the right)
    - It will then ask you to designate a location: Select **DUH**
    - You will be directed to another screen and select: order sets and open **Adult Blood administration** (or designated medication e.g. IV iron) and **enter desired orders**
    - **Sign** orders

DIABETIC PATIENT RESOURCES



MEDICAL RESOURCES OUTSIDE OF DOC

OUTPATIENT REFERRALS

These are generally ordered by typing "ambulatory referral [blank specialty]." A few specific referrals

- Driving Evaluation
  - Laura Juel, OT
- Incontinence
  - Males -> Urology
  - Females UroGyn
  - PT for stress incontinence: "Amb Ref PT" and indicate UroGyn PT
- **Ophthalmology for low income/Medicaid**

  For screenings: http://www.dukehealth.org/events/lions_club_eye_screenings/20120418 There are regular free vision and glaucoma screenings offered. These are usually posted on the bulletin board in the lobby.

  For uninsured patients with eye disease: Duke Eye Triage nursing suggests patient make an early morning appointment with the Comprehensive Service at Duke Eye/Erwin Road; # is 681-0896. Patient will be asked to sign a financial agreement but can say they cannot afford to pay. If the MD thinks they need a Consult, a fellow will see the pt. that same day.

  For patients whose insurance does not cover glasses (e.g. Medicaid, the uninsured), refer to social work for help filling out the following applications:
  - http://www.onesight.org/na/ Network of providers (including Sears Optical and Target that will provide free glasses)
  - www.**neweyesfortheneedy.org**/us/us.html Will provide a voucher; must apply through SW if unable to get glasses through OneSight.
  - http://www.firmoo.com/free-glasses.html (just pay shipping)
- Wheelchair evaluation
  - Laura Juel, OT

DIRECT ADMISSIONS, ED EVALUATIONS, AND URGENT CARE

Duke Regional Hospital
3643 North Roxboro Street, Durham, NC 27704

Preferred for patients with routine exacerbations of chronic conditions who probably will not require a procedure or surgical intervention not available at DRH.

Direct admissions: Reserved for patients who require admission for management of a known diagnosis and are stable for admission to the floor. Page hospitalist managing admissions at 970-9050 or call the Assistant Chief Resident (919) 470-5150 and give patient's name, MRN and reason for admission. The patient should proceed to Admissions via car or ambulance as appropriate. Call the admitting team and give brief history, reason for admission and plan; also complete a note in Maestro. The clinic nurses should be made aware of the plan.

ED evaluation: Ask the clinic charge nurse or nurse you are assigned for assistance with calling 911. Call (919) 470-5345 and ask to speak with the ED attending/resident/charge nurse about the incoming patient, giving a brief history and reason for ED evaluation. Complete a note in Maestro. If you have to leave clinic before the ambulance arrives, make sure you sign out to a resident/attending who will assume responsibility for the patient.

Duke University Hospital
2301 Erwin Road, Durham, NC 27710

Direct admissions: Call the Assistant Chief Resident at DUH (970-1010); otherwise as above.

ED evaluation: Call 684-8111 (Duke); otherwise as above.

Urgent Care

1. Duke Urgent Care South
   5716 Fayeteville Road, Durham, NC 27713
   919-525-3967
2. Duke Urgent Care Croasdaile
   1821 Hillendale Road #24-A, Durham, NC 27705
   919-338-4355
3. Duke Urgent Care Brier Creek
   10211 Alm Street #1200, Raleigh, NC, 27617

RADIOLOGY

All radiology services are offsite, many next door at the Medicine-Pediatrics clinic located in the Duke Health Center on Roxboro Rd. Front desk staff schedules all imaging studies. Imaging should be ordered during the patient's visit (if possible) and should be ordered in Maestro Care – remember to link the order to a diagnosis in Maestro Care.

HOME VISIT PROGRAM

One time: The DOC offers a one-time in-home consultation service for our patients by a team: usually a resident, the Ambulatory CR, pharmacist and SW. These visits generally take place once monthly. Indications for referral include: difficulty completing thorough med rec in clinic, follow-up of acute illness, caregiver stress assessment, frequent falls, non-adherence, suspected abuse/neglect, or needs assessment. If you have a patient who you feel is appropriate, send a staff message to Jan Dillard in Maestro using .SWDOCHOMEVISITREFERRAL in the message to provide more information as to what your specific concerns are. You can walk down to Jan's office and give her a heads-up as well, particularly if you feel the need is urgent.

Ongoing in-home medical care: Just For Us, a home-based primary care program offers in-home medical services to Durham's seniors and adults with disabilities who have barriers to routine primary care services in the traditional office setting. Medical team includes a physician, an advanced practice provider, SW, OT, phlebotomist. Patients are expected to continue care relationship with their primary care provider, and to see that provider at least once per year for chronic care and for acute needs that cannot be addressed in the home. For more information or to refer a patient, contact the Just for Us office at (919) 956-5386 or talk to Jan Dillard.

DENTAL CARE (FREE OR LOW-COST)

Check Jan's door for copies of lists.

For patients with Medicaid

May receive dental treatment from any dentist enrolled in NC Medicaid Program and willing to provide dental care to Medicaid recipients. Providers who have a "Y" indicated in the "Accepting New Patients" column may be more likely to accept new Medicaid recipients, but patients should confirm this by contacting the provider:
http://www.ncdhhs.gov/dma/dental/dentalprovlist.pdf

For those with Medicare or no insurance (Sliding Fee Scale)

- Lincoln Community Health Center Dental Clinic: Eligibility for sliding fee scale discounts based on the number of people in family and total family income, but patients are served regardless of ability to pay.
- Needy Meds Free Clinic List: Lists Free and Low Cost Clinics offering health care at no cost, for a small fee, or on a sliding scale.

For those with Medicare or no insurance

- SNDA (Student National Dental Association) CAARE Clinic: Includes cleanings, non-surgical periodontal treatment, simple restorative work, and simple extractions for patients without dental insurance.

- Donated Dental Care: Donated dental care to people who are disabled, medically compromised, or elderly and who have no financial resources with which to pay for their extensive dental care needs. Does not provide emergency care or routine cleanings.
- Samaritan Health Center : Comprehensive medical and dental care to the homeless and underserved of Durham, regardless of their ability to pay. Must apply.
- Baptist Men's Medical/Dental Bus: Patients targeted through this ministry include people without insurance, the impoverished, Hispanic and other ethnic groups, migrant workers, fair workers, the homeless, elderly, and more.
- North Carolina Missions of Mercy: Services provided to adults with income less than 200% of the Federal Poverty Level Guidelines.
- Dental SHAC (Student Health Action Coalition): Free, student run for those in Orange County who cannot afford care elsewhere—services include screenings, cleanings, restorative procedures, extractions and emergency care.

For those with Medicare who require medically necessary dental treatment

- Drs. Patterson, Kendell, Frost, Bechtold, and Sacco, PA
- UNC-Chapel Hill, Maxillofacial Surgeon

OBSTETRICS

ALL newly pregnant patients:
Scan current medications for possible teratogens, prescribe prenatal vitamins, assess and counsel as needed re: cessation of smoking/alcohol and/or other drugs, and assess for safety/support at home.

If your newly pregnant patient is high-risk:
Enter referral to Duke Obstetrics/Maternal Fetal Medicine (type in 'high-risk')

If your newly pregnant patient is not high-risk and has Medicaid or is uninsured:
Can direct them to the Durham County Health Department (located at 414 E. Main St; (919) 560-7882), which is also where the area Women, Infants and Children (WIC) nutrition program is based. Consider asking Marigny Bratcher for one-time follow-up to ensure patient has connected with that clinic.

SMOKING CESSATION OPTIONS

NC Quit Line: (Packets are available in the black folders in the exam rooms or can insert smartphrase into discharge papers)

Breath of Life: Free stop smoking program offered to individuals, community and worksite groups and organizations in Durham County. Series features five classes that assess readiness to quit smoking, preparation, quitting methods and tips to successfully remain a non-smoker. Additional resources and educational materials are provided for each participant. Contact, (919) 560-7765

DOC Quit At Duke Smoking Cessation Program
Comprehensive evaluation to determine which treatments will be most effective
Evidence-based medications — often combination medications or adaptive treatment
The option of several evidence-based behavioral treatments
Long-term phone-based "check-ups"
Access to research studies
919-613-QUIT

ALZHEIMER DISEASE SUPPORT (AND OTHER CHRONIC CONDITIONS OF LATER LIFE)

The Duke Family Support Program: In addition to resources for families, as providers you can email, call or schedule an in-person consultation with a social workers for help with your questions about elder care.
http://www.geri.duke.edu/service/dfsp/index.htm

CANCER-RELATED SUPPORT

Information packet is available in the Green Folder in the exam rooms

Duke Cancer Patient Support Program (DCPSP): free services/resources to help support patients and their loved ones throughout their experience with cancer. Services—individual, couple, and family therapy; Support groups; Self-image resources; Volunteer companionship and peer support. http://www.dukehealth.org/cancer/support-services/cancer-patient-support/about

Cornucopia: free support services to patients with cancer and their loved ones—peer support and support groups, education, connection to resources, massage, yoga and acupuncture! http://www.cancersupport4u.org/

MEDICAL SUPPLIES

All requests for medical supplies for patients with Medicare require an attending signature.

DIABETES SUPPLIES

Medicaid: formulary is limited; order generic glucometer and testing strips, and print out so patient can obtain from local medical supply store
Medicare: Patients have option of ordering from diabetic supply companies; patients would need to call company of their choosing; form is faxed to the DOC and placed in your PP folder for you to complete and an attending to sign. Can ask Carolyn Lawrence in Medical Records for help as well.
Uninsured: Walmart Relion brand has 50 strips for $9.

DURABLE MEDICAL EQUIPMENT

Simple equipment
Enter it as an order, but select 'Print' to produce a hard copy that the patient can take to a medical supply store.

Motorized chair
Generally, no scooters or Hoveround; only electric chairs
Steps to order:
1. Appointment with MD (AKA Face to Face) Face to Face- Resident uses smart phrase and/or documents trouble/inability to walk in the home or frequent falls, attending signs that note, and that is the attending who signs all further documentation (7 element form)—45-day window to complete the medical provider face 2 face and signing/concurrence of the therapy wheelchair evaluation.
2. Refer to PT/OT Wheelchair Evaluation (can be before or after Face to Face); if evaluation agrees with need for power device, same attending signs her note. There is no time limit on the OT evaluation, it can be far ahead of the face to face visit.
3. Paper work packet- signed by same attending then fax back to the vendor.

CPAP/BIPAP

Diagnosing OSA
The order is called "Ambulatory Referral to Sleep Studies." Within the order, you can choose routine polysomnography (will be your choice most of the time), CPAP titration (if the patient already has a diagnosis of OSA in the past 10 years and needs their device setting adjusted), or Home Sleep Test (only choose this if you are fairly certain the patient has OSA and they have a reliable home and social situation to be able to complete the test at home). As part of the order, you can also automatically request a referral to pulmonary or neurology clinic if the test is positive.

Treating OSA
Once the diagnostic sleep study and subsequent titration study have been done, with recommendations for treatment and settings, enter an order for 'CPAP Machine' in Maestro, click the 'Qty-1, External' link and then the 'Click to add text' behind it, and then use the dot-phrase .DOCCPAPORDER. Write in recommended pressure (from titration study), and print out copy of order AND sleep study results (which must be attached). We have forms for some agencies in the orange 'Respiratory Services' folder in the Forms drawers in each work area. Leave in the medical records bin with a note indicating which agency patient has selected, for it to be faxed to and/or the form for that agency. **If the patient has Medicare, get an attending to co-sign the order and the form;** Medicare requires an attending signature (and NPI) for durable medical equipment.

Two agencies that Dr. Ambrose Chiang in the Pulmonary Clinic recommends are: Sheepless Nights (in Garner, NC; fax: (919) 662-2739) and Advanced HomeCare (ph: (919) 852-0052). Two others that Carolyn Lawrence in Medical Records suggested are: Kight's Medical (in Morrisville, NC; fax: (919) 878-4411) and Apria Healthcare (also in Morrisville, NC; fax: (919) 380-1185).

Troubleshooting OSA
If a patient has had a prior sleep study confirming a diagnosis of OSA, it remains "good" for 10 years; all they would need, if they are attempting to re-start CPAP use, is to have a recent titration study. Dr. Chiang and his PA

Steve Taxman in the Pulmonary Clinic are skilled at helping patients who are having difficulty using CPAP/BiPAP. This can be an indication for referral.

HOME O2

1. If patient had assessment (documented O2 saturation <88% while walking/sleep study w/titration, print a copy of the note where this was documented. Enter an order for 'Oxygen' in Maestro, click the 'Qty-1, External' link and then the 'Click to add text' behind it, and then use the dot-phrase .DOCHOMEOXYGEN. Write in the qualifying readings, relevant diagnoses, and required statements (see Documentation above); sign, and print. Copy all of this text from the order into the assessment and plan of a Progress Note that lists hypoxia as a problem, which must also be attached.
2. Does patient have a provider preference? If no preference, can provide them with a list of choices or just choose—Lincare, Adult and Pediatric Specialists, Apria and Active Healthcare are frequently used. If they have private insurance, specific providers may be preferred.
3. Complete the form (orange respiratory services folder in the drawers at each nurse's station) for the provider chosen.
4. Fax (or place in Medical Records basket) the form and assessment, along with demographic/insurance information, to the provider.

We have forms for some agencies in the ORANGE 'Respiratory Services' folder in the Forms drawers in each work area. Leave in Partnership Folder or medical records basket with a note indicating which agency patient has selected, for it to be faxed to and/or the form for that agency.

If the patient has Medicare, get an attending to co-sign the order and the form; Medicare requires an attending signature (and NPI) for durable medical equipment including home oxygen. Medicare also requires documentation in the medical record; the easiest way to do this is copy the text from the order into a note in Maestro, either in a Progress Note for an existing encounter or a separate Documentation or Orders Only encounter.

Medicare Requirements for Home Oxygen
Testing must be performed with the patient in a chronic stable state (i.e., values from ED cannot be used): 1) As an outpatient: within 30 days prior to initial certification, 2) For patient transitioning from hospital stay to home: within two (2) days prior to discharge from an inpatient hospital stay to home, 3) For a patient in a skilled nursing facility or hospice: within 30 days prior to initial certification
Patient's chart notes must document the following:

- Documentation of patient's hypoxia-related condition and his/her condition should improve with oxygen therapy
- Documentation that other treatments have been tried and deemed insufficient (e.g., medications, inhalers, etc.)

Qualifying Saturation Test Results:

	#1 At Rest	**#2 During Exercise**	**#3 Overnight** (e.g., during sleep study)
Context	Patient tested on room air at rest	Patient tested while walking	Patient tested while sleeping
Threshold for medical necessity	SpO2 ≤ 88%	All three must be documented: a) SpO2 on room air at rest b) SpO2 on room air during exercise – must be ≤ 88%	Oxygen must be measured for at least two hours; desaturation to ≤ 88% for at least 5 minutes.

		c) SpO2 **on oxygen** during exercise – must show improvement	
Notes	If > 88% and you think patient would benefit from O2, go to **#2**		Will not qualify patient for portable O2.

Note: For **#2**, all three readings must be from the same testing session.

ENSURE

It is a two-step (two form) process to get Medicaid to cover Ensure. In the Medicaid system, it is DME. One is specific to oral nutritional supplements, the other is a general Prior Approval form. The medical justification must be documented in the medical record as well.

Policy with key points highlighted: "Examples of conditions that may indicate a need for oral nutrition products include, inborn errors of metabolism, such as phenylketonuria (PKU) or galactosemia; history of prematurity, very low birth weight (VLBW), or low birth weight (LBW); cystic fibrosis; human immunodeficiency virus (HIV); necrotizing enterocolitis (NEC); short bowel syndrome; cleft lip or cleft palate; central nervous system disorders resulting in dysphagia; and Crohn's disease. Oral nutrition products are considered medically necessary when all of the following conditions are met: a) There is a documented diagnosis in which caloric or dietary nutrients cannot be safely or adequately consumed, absorbed, or metabolized; and b) oral nutrition product is an integral component of a documented medical treatment plan and is ordered in writing by the treating physician. Medical necessity of the oral nutrition product is substantiated by documented physical findings, and laboratory data if available, that demonstrate malnutrition or risk of nutritional depletion. If a nutritional assessment is ordered, it must be conducted by a licensed dietitian/nutritionist (LDN) or registered dietitian (RD). The prescriber may also order a feeding or swallowing evaluation by a licensed therapist (SLP-CCC or OTR/L) which must be maintained within the health record as supporting documentation to substantiate medical necessity. Must submit a new Oral Nutrition Product Request Form and CMN/PA every six months with documentation supporting the effectiveness of the oral nutrition supplementation.

Note: Oral nutrition products are not covered when medical necessity is not established, or when they are used as convenient food substitutes."

CARE MANAGEMENT AND HOME HEALTH SERVICES

CARE MANAGEMENT

HomeBASE care Our first major Redesign work, one year of planning, program began 2014

- HomeBASE is a program whose goal is to reduce ED utilization via better connection to coordinated primary and specialty care, with a focus on better health coping in our patients.
- Marigny Bratcher (Manson in Duke system) is the RN Care Manager for the DOC HomeBASE program.
- Criteria: patient should have 6 or more Emergency Department visits in a 3 month period, with some ongoing use of the ED.
- Referral: send the patient's name and MRN to Marigny via email, inbasket or by stopping by her office (in the lobby behind copier).

Marigny is also available for one-time case management interventions for non-HomeBASE patients. Examples include: referral to outside medical case management agencies, follow up phone calls requiring clinical skill, complex history gathering from outside Duke system. To request, contact Marigny with the intervention you would like. If you don't exactly what the situation needs that's ok too! We can figure it out together.

HiDOC Second major Redesign project, program began Jan 2017.

- **Hi intensity Primary Care**
- Provides more on site medical care for acute illnesses

Duke Connected Care and DukeWELL

Duke Connected Care (DCC) is an Accountable Care Organization (ACO) that manages population health for patients with traditional Medicare or Cigna insurance in the general Duke service area. DukeWELL is a free care management program that assists in providing DCC's care management services. DukeWELL also manages other populations, including qualifying patients with Duke Basic/Select insurance, specific Medicare Advantage insurance plans, and others.

To identify if a patient qualifies for DCC or DukeWELL services: Look for the "DukeWELL: Y" notation in the patient's chart. This is located in the top banner beneath their MRN and CSN.

DukeWELL or DCC may identify a patient and contact you for input on potential opportunities to improve care. You may also refer directly via an ambulatory referral to DukeWELL. Include the reason for referral in the comments section.

Services include:

- Free RN home visits (limited to DCC Medicare patients)
- Care coordination
- Patient outreach and engagement
- Appointment reminders and coordination
- Transportation assistance
- Medication access assistance
- Skilled nursing facility transition coordination
- Coordination with Duke Home Health and Hospice
- Quality measure gap closure (may include outreach to patient and/or provider)
- Telephonic RN disease management education and coaching
- Virtual specialist and clinical pharmacist rounds (geriatrics, CKD, and DM)

NPCC – Kenya Gomez is the DOC Care Manager

Northern Piedmont Community Care (NPCC) is the umbrella for two networks: Durham Community Health Network (for Durham county) and Community Care Partners (for Vance, Warren, Person, Franklin and

Granville counties). NPCC promotes wellness to strengthen the self-care capacity of its Medicaid members and their families.

With an interdisciplinary staff of professional and paraprofessional providers, NPCC has focused its efforts and energies on the development of community-based care/disease management that supports the integration and collaboration of the various patient delivery systems within the community. The staff of NPCC deliver at-risk social work services, service coordination, access support, education and nutrition counseling.

HOME HEALTH AND PERSONAL CARE SERVICES

HOME HEALTH SERVICES

What: Skilled and unskilled services provided in patients' homes: RN, PT, OT and speech therapy (skilled) and medical social work, in-home aide, and short term OT (unskilled).

Who: Patients with Medicaid for whom you can certify that it would be in the best interests of the patient to have the service at home; patients with Medicare who are homebound (requires considerable and taxing effort to leave home AND only leaves home for things such as medical visits, family visits, religious services, haircuts); some patients with private insurance; uninsured patients enrolled in Duke Charity Care (Duke Home Health only)

How: 1) Discuss referral with the patient. Does patient have a provider preference? If patient wants a referral list, SW can provide that. Must document that they were given the chance to choose and have a referral list to consider. Extensive list of agencies: http://www.homeandhospicecare.org/directory/index.html. Frequently used agencies are:

- Duke Home Care & Hospice (must inform patient of financial relationship, i.e., that Duke owns and operates DHCH, and document that this information was provided)
- Others: Liberty Home Care, Intrepid, WellCare, Amedisys

2) Complete Amb Referral to Home Health. Be sure to document patient's preferred provider.

3. Complete Order and Certification for Home Health Services ("face to face") using the dot phrase given in the referral.

4. If the patient already has home health in place and you want to add a service, you can call the providing agency to give a verbal order and have your note with the written order sent to the agency.

PERSONAL CARE SERVICES

- What: Hands-on assistance by a paraprofessional aide with Activities of Daily Living (ADLs). NC recognizes 5 ADLs: (1) Bathing, (2) Dressing, (3) Mobility, (4) Toileting, (5) Eating (NOT cooking/cleaning). Patient must need at least partial assistance with 3 of 5 ADLS or total assistance with 1 or 2 of them.
- Who: Patients with Medicaid; patients with Medicare who are also receiving a home health skilled service; some patients with private insurance. Also available for out-of-pocket cost.
- **Patients with Medicaid:**
    - To determine whether your patient qualifies, use the Personal Care Services (PCS) screening tool, which can be found in the attending room folders. This tool uses information on 1) why the patient thinks they need an aide, 2) their ability to perform ADLs, and 3) whether they are ambulatory.
    - If you can legally attest that patient qualifies, complete Personal Care Services (PCS) Request for Services form (MUST include diagnoses AND ICD-10 codes) and fax to Liberty. Form is available at http://info.dhhs.state.nc.us/olm/forms/dma/dma-3051-ia.pdf (instructions at http://info.dhhs.state.nc.us/olm/forms/dma/dma-3051-tips.pdf.) In downtime, form is available in the BLUE folder in the exam rooms
    - *If patient has services, but needs additional hours*: complete above form including pg 2 "Change in status" and fax to Liberty.
- **Patients with Medicare/private insurance:** When ordering Home Health skilled service, also order In-Home Aide as needed. Otherwise, must pay out of pocket.
- **Patients who plan to pay out of pocket:** Patient contacts provider; directory of available providers: http://www.homeandhospicecare.org/directory/index.html

Incomplete forms will be rejected, causing delay in starting services. Reference instructions as needed, or ask Jan for help in completing forms correctly.

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH ACCESS

If any patient needs help connecting to mental health resources, refer to social work (Jan Dillard) for assistance. HomeBASE Care Manager (Marigny Manson) is an RN who follows the clinic's high-utilizing patients; she is also available for short-term care coordination. See HomeBase section. Financial Counselors & Referral Coordinators (Gloria Manley and Diane Bullock) can also help with referrals.

Patients with Private Insurance
Contact behavioral health customer service for the patient's insurance (on insurance card) for pre-certification and to locate an in-network provider.

Patients with Medicare
Directory of available providers: http://www.medicare.gov/physiciancompare/search.html

Patients with Medicaid or no insurance
- Contact local management entity (LME): http://www.ncdhhs.gov/mhddsas/lmeonblue.htm.
    - 24-hour access for regular and crisis referrals
    - LME refers patient to an appropriate community provider
    - Services include therapy, group therapy, medication management, case management
- If a patient with Medicaid knows a provider that accepts Medicaid, they can self-refer
- **Durham, Wake, Johnston and Cumberland counties**
    - Patient or provider + patient calls Alliance Behavioral Health at 800-510-9132 (line is open 24/7)
    - Screening over the phone (~15-20 minutes) for insurance information, contact information, primary concern, a safety screening, drug/alcohol use
    - Patients can use the same number during mental health crises
    - Use .ALLIANCEREFERRAL in patient instructions
- **Other counties**
    - Orange, Person and Chatham counties: call Cardinal Innovations (800-939-5911).
    - Franklin, Granville, Halifax, Warren and Vance counties: call Five County Area Program (877-619-3761).
    - Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, and Wilson Counties: call Eastpointe (800-913-6109).

MENTAL HEALTH CRISES

- If a patient has a mental health, substance abuse, or developmental disabilities service provider, they should contact that provider first.
- If a patient does not already have a mental health provider, consider sending them to the Durham Recovery Response Center (formerly Durham Center Access/DCA). DRRC is a place for emotional crisis or substance abuse detox. It is run by Recovery Innovations and located at 309 Crutchfield St (919-560-7305). It is open 24/7/365.
- If you don't think the patient is safe to get to DRRC by themselves, you can call 919-428-0819 for the Mobile Crisis Team. The mobile crisis team can meet the patient in a safe location (eg home, school, workplace, doctor's office, etc.) and/or take them to DRRC.

Contact information for other county teams:
https://www.ncdhhs.gov/assistance/mental-health-substance-abuse/crisis-services

DOMESTIC VIOLENCE SERVICES

- Refer to SW
- If patient declines SW referral, give info for Durham Crisis Response Center 24 hour crisis line (919-403-6562 (English), 919-519-3735 (Spanish)) and document refusal.
- Services:
    - Free legal clinic
    - Safety Planning
    - Support groups
    - Information and case management
    - Sexual assault services

- Specialized safety programs
- Emergency shelter
- Counseling
- Hospital response
- Community outreach, education and training
- Rape prevention education

SOCIAL WORK AND ACCESS TO CARE

CLINICAL SOCIAL WORK

- Jan Dillard, social worker
- HomeBASE Care Manager (Marigny Bratcher): RN who follows the clinic's high-utilizing patients; she is also available for short-term care coordination. See HomeBase section above.
- Financial Counselors & Referral Coordinators (Gloria Manley and Sophia Navarro)
    - Assist patients with insurance-related questions and financial arrangements
    - Manage patient referrals
    - Meet with patients without insurance who might be eligible for Duke charity care.

Social Work Services

- **Safety assessments and referrals**/reports: SI, HI, domestic violence, abuse/neglect.
- Brief **behavioral interventions** at the time of appointment with the medical provider
- **Assess patient** using tools such as PHQ-9 and MoCA
- **Comprehensive psychosocial assessments** and chart review: obtain detailed work history, substance use history, mental health history, funding, emotional support, coping strategies and personal strengths/resources, ability to access medications and medical services.
- **Individual and Group Counseling/Psychotherapy** in may areas, including: depression, anxiety, adjustment to illness, expression of suicidal/homicidal ideation, altered cognitive status, trauma, substance abuse, patient and family education, grief, medication adherence, caregiver stress, crisis pregnancy
- Home visits (1-2 per month)
- Brief crisis intervention and psychosocial support.
- Assistance with legal issues: guardianship, power of attorney, impending release from prison, criminal issues, divorce and custody issues, undocumented immigrants, children in foster care system.
- Increase access to medications: NC MedAssist, Pharmacy Assistance Program at DUHS, community resources.
- Refer to local community resources for help with housing, food, mental health, substance abuse, developmental disabilities resources, legal aid, case management, job finding, etc..
- Help patients identify and locate programs for which they may be eligible: Medicaid, Medicare, SSI, SSDI, food stamps
- Answer questions about provider-ordered home health and personal care service referrals and assist patient with selecting a provider.
- Monthly Home visits with the DOC home visit team
- Discussion of healthcare power of attorney and advanced directives
- **Provide support to the team**, and referrals as needed, particularly with regard to managing the response to the challenges of healthcare.

How to Refer to Social Work

- Best way is tostop by Jan's office
- or send her an InBasket message, email, phone message or page
- In the body of in-basket message, use .SWDOCSWREFERRAL and complete template
- If you have time and Jan is available, stop by her office to give her a heads-up

MEDICAL TRANSPORTATION

A flyer containing all of the information below is in the SW door.

Medicaid

Patient can call any of the following for free Medicaid Access transportation 8a-5p

- Durham County Department of Social Services, 919-560-8607
- Orange County Public Transportation, 919-245-2871
- Person County Area Transport, (do not dial 1) 336-503-1178

- Vance, Granville, Franklin, Warren Counties KARTS (Kerr Area Rural Transportation System), 800-682-4329
- Franklin County, 919-496-5721
- Wake County Human Services 919-212-7000 option 2, then option 1

No Medicaid
Small fee per trip
- American Red Cross in Durham County: 919-489-6541; 8:30am-4pm; starts at $10/round trip
- Orange Public Transportation: 919-245-2008; 8am-4pm; cost varies depending on circumstance
- Person Area Transport: 336-597-1771; 8:30am-5pm; $10 to Duke, $2 local
- Vance, Granville, Franklin, Warren Counties KARTS (Kerr Area Rural Transportation System): 800-682-4329; weekdays 5am-7:30pm, Saturdays 8am-5pm; $4-8 depending on length of trip
- Wake County TRACS: 919-212-7005; Monday-Friday 7am-12pm and 1-6pm; cost varies depending on destination, starting at $2

Transportation for cancer treatment
American Cancer Society Road to Recovery: 800-227-2345

HOW TO MAKE BASIC CARE AFFORDABLE AND ACCESSIBLE

If your patient has barriers to care (eg vision, hearing, literacy, cultural and religious beliefs/practices, emotional barriers, desire and motivation to learn, physical and cognitive limitations, language, lack of resources, history of prior trauma, competing priorities), document them and get help addressing them from the SW staff, including Jan Dillard and the financial counselors & referral coordinators (Gloria Manley and Diane Bullock).

Subsidized health insurance via the affordable care act
Uninsured patients who have an income can be referred to a navigator working with Project Access of Durham County (PADC) to help them apply for subsidized coverage during open enrollment for the federal health insurance exchange.

North Piedmont Community Care (NPCC) / Durham Community Health Network (DCHN)
- NPCC serves Durham and five rural counties north of the Triangle. The unit serving Durham is called the Durham Community Health Network (DCHN).
- Patient population: patients who have been hospitalized or are using healthcare resources inefficiently, patients with heart failure or diabetes, patients with Medicaid (automatically enrolled)
- Services:
    - Health education
    - Coordination of community resources
    - Opioid safety
    - Palliative care
    - Transitions of care for hospitalized Medicare recipients
    - In-home assessments with information relayed back to the referring provider
    - Referral to mental health services
- Contact NPCC (919-620-8034) for more information

NC breast and cervical cancer control program (for the uninsured)
- Covers breast cancer screening for women 50-64yo
- Covers cervical cancer screening for women 18-64yo
- Covers cancer treatment and full Medicaid if diagnosed

Duke Charity Care
- Application process:

    - Patients must first apply for NC Medicaid and be denied. The only patients who do qualify for Medicaid in NC are low income AND ≥65yo, visually impaired, disabled with inability to work for ≥12 months, OR parenting a child ≤19yo.
    - Patient must bring letter of denial
- Services that qualify for financial assistance or financial hardship are limited to:
    - **Emergent Services** without which the patient's health (or unborn child's health if patient is pregnant) could reasonably be expected be placed in serious jeopardy. These services are limited to those provided in the ED.
    - **DUHS Physician Approved Services** are services that are non-emergent but necessary and appropriate to prevent serious deterioration in the health of the patient from injury or disease. Often follow up services for care originating in the Emergency Department is included. DUHS Physician approval is required prior to the service being provided.
- Application for coverage of prescription medications is separate.
- Some specialty services (eg elective ortho) may not be available.
- Refer patient to a financial care counselor for help applying.

The DOC Fund
Provides resources (medications, medical supplies, transportation, etc.) to patients on a case-by-case basis. Used for short-term needs. Refer to Jan Dillard, LCSW to request.

Durham Medical Respite Program
- What: medical respite for homeless patients with acute medical needs
- Who: homeless patients who need home-like environment to recover from acute illness or prep for a procedure
- How: If at DOC, send an inbasket message to Julia Gamble, who will review the case. If on inpatient rotation, ask your PRM to refer the patient to Chrissie Moody, the complex care PRM at DUH.

RESOURCES FOR ESSENTIAL DAILY NEEDS
Below are lists of resources for food, shelter, clothing, etc.
- Durham County: http://www.blessdurham.org/wp-content/uploads/2011/07/DURHAM-RESOURCES-MASTER-LIST.pdf
- Wake County: http://www.mentalhealthadvocacyinc.org/raleigh-resource-guide
- Orange County: http://www.needhelppayingbills.com/html/orange_county_assistance_progr3.html
- Vance, Granville, Henderson, Warren and Halifax counties: http://issuu.com/hendersondispatch/docs/mhrd__11_mini-tab__in_seq_?viewMode=presentation&mode=embed

Non-Medical Transportation
- Durham County
    - DATA Fares and Schedules: 919-485-RIDE (7433)
    - DATA ACCESS for people with disabilities: 919-560-1551, press 1; requires completion of an application, medical provider's signature
    - Durham Center for Senior Life: 919-688-8247 ext.103; transportation to congregate meal at Senior Center; free
- Orange Public Transportation: 919-245-2008; 8am-5pm; cost varies depending on circumstance
- Person Area Transport: 336-597-1771; 8:30am-5pm; $10 to Duke, $2 local
- Vance, Granville, Franklin, Warren Counties KARTS (Kerr Area Rural Transportation System): 800-682-4329; weekdays 5am-7:30pm, Saturdays 8am-5pm; $4-8 depending on length of trip
- Wake County TRACS: 919-212-7005; Monday-Friday 7am-12pm and 1-6pm; cost varies depending on destination, starting at $2

CONTROLLED SUBSTANCES

DOC Pain group provides education and support to patients with pain. The clinical pharmacist administers pain contracts with patients and meets monthly with them.

INITIATING NARCOTICS

What patients

- Failed to respond to 2-3 OTC analgesics and/or NSAIDS within a reasonable time period.
- Failed other pharmacologic therapies, eg steroid injections, nerve block
- Failed non-pharmacologic therapies, eg PT, rehab, TENS units

Contraindications

- Active substance abuse
- History of substance abuse (relative)
- Uncontrolled psychiatric disorder
- Chaotic home environment with difficult medication management (consult SW)
- Full body pain, fibromyalgia, chronic headaches, vague pain, or no diagnosis
- Positive screen for any illicit drugs in the past 3-6 months.

What to do before initiating narcotics

- Specify the cause of the pain
- Document intensity of the pain, current and past treatments, coexisting diseases, effect of pain on physical and psychological function, history of substance abuse, negative urine drug screen
- Discuss and document risks and benefits of controlled substances
- Consider referring to social work for a psychosocial assessment to identify risk factors
- Refer patient to DOC PAIN Group for education and support

Medication choice & dosing

- Scheduled doses (vs PRN) if patient has continuous or frequently recurring pain
- Short-acting narcotics: tramadol, oxycodone
- Long-acting narcotics: if patient requires frequent short-acting narcotics, replace with long-acting narcotics
    - MS Contin
    - Methadone (max dose at DOC is 40mg QD)
    - Do NOT use oxycontin because it is expensive and can be abused more easily
- Breakthrough short-acting narcotics:
    - No need for patients on methadone
    - 30 pills per month for patients on MS Contin

Follow-up visits

- MD should see patient every 1-4 weeks initially; every 3 months once pain control is stable
- Document intensity, location, duration, aggravating and alleviating factors, effect of pain on function
- Document opioid-related side effects, aberrant drug-related behaviors
- No refills for early, lost or stolen meds.
- Additional short-acting pain medication can be prescribed when deemed appropriate by an attending when there is an acute need.

PAIN CONTRACTS

When to start

- Patient has been on the same stable dose of a particular narcotic for $\geq$3 months
- Patient has been seen at DOC at least once before
- Nothing sketchy on the NC Controlled Substances Reporting System (aka the NC database)
- Nothing sketchy in North Carolina Department of Correction Public Access Information System (http://webapps6.doc.state.nc.us/apps/offender/search1).

- Patient passes Mayo drug screen x1

First narcotic prescription
- Get a blank agreement from Holly's office or one of the preceptor rooms
- Review agreement with patient
- Explain to the patient that s/he will need to follow up every 3 months and provide urine samples upon request
- Educate patient about side effects; differences between physical dependence, tolerance and addiction; risk of developing physical dependence, tolerance and/or addiction; and potential for cognitive impairment. MD, PharmD, LPN or RN can do this.
- Both provider and patient sign the agreement
- Duke UDS
- Give patient first prescription at this visit.
- In the 'Follow-up' section of Visit Navigator, under 'Check-out instructions,' type "Pharm CII on or before [30 days from date of Rx]."
- Return signed agreement to Holly's office along with 3 future 30d prescriptions for the prescribed opioid

Follow-up visits
- All visits: pharmacist evaluates pain, functioning, adverse effects, and potential for misuse
- Visit #2: review the Controlled Substances Agreement in detail.
- Visit #3: after the initial 3 prescriptions have been used, a request for refills will be placed in your partnership folder. Print out 3 new 30d prescriptions, place them in the file, and return to Holly's office.
- Yearly: pharmacist or PCP must review the pain contract with the patient
- No refills for chronic pain medications during acute care visits
- If a prescription is lost or stolen, do NOT supply a new prescription. Police report will not change this.
- Drug screening
    - UDS q3-4 months for compliance (Mayo) and illicit substances (Duke); Mayo should be sent at least 1-2x per year
    - Serum drug levels is used in rare cases, usually anuria.

Violations
- Terminate contract if pt exhibits aberrant behavior on multiple occasions (document each in chart):
    - Multiple missed appointments
    - Prescriptions from another provider
    - Taking medications inappropriately
    - Repeatedly contacting PCP or clinic for refills
- Terminate contract immediately if:
    - Forged prescriptions
    - UDS screen for illicit substance (including THC) or non-prescribed controlled substance (including benzodiazepine)
    - Mayo UDS results negative for prescribed narcotic
    - Mayo UDS results inconsistent with dosing
- If narcotics are discontinued, this should be clearly documented in the problem list

Reinstatement of pain contract
- This is a decision that is made on an individual basis after at least 6 months
- Patient must attend PAIN group or substance abuse treatment
- No reinstatement if patient has been violent
- Must be approved by attending

BENZODIAZEPINES
- Use of non-addicting medication such as SSRI's is preferred for anxiety.
- Referral to psychiatry for use of benzodiazepines is preferred.
- Prescribe short-acting benzodiazepines (eg lorazepam) for 3 months maximum; for continued use, psychiatry needs to prescribe

- NO alprazolam (Xanax)
- Consider long-acting benzodiazepines after discussion with patient and signing a pain contract

Drug Screens commonly used & available at Duke Outpatient Clinic

In-House

1. Toxicology (Drug) Screen, Urine
    a. Order in Maestro: LAB6266
    b. Results same day
    c. Tests for: amphetamines, barbiturates, benzodiazepines, Cocaine, opiates, THC

2. Toxicology (Drug) Screen, Serum
    a. Order in Maestro: Lab678
    b. Results same day
    c. Tests for acetaminophen, salicylate, ethanol
    d. Do not recommend using

3. Methadone (dolophine), serum confirmation – can use if methadone not detected in either of the Mayo drug screens
    a. Order in Maestro: Lab6655
    b. Not detected unless 25 ng/mL → if negative, consider calling LabCorp for verification (their limit of detection is a total daily dose of 25 mg)
    c. Results back within 48 business hours
    d. This is run through LabCorp in Burlington, NC

4. 10 Panel Drug Screen
    a. Order in Maestro: Lab7797
    b. Tests for: methadone, propoxyphene, amphetamine, barbiturates, benzodiazepines, cocaine, opiates, THC, methamphetamines, PCP,
    c. Would recommend this for a patient that you want a broader illicit substances screen than the typical UDS
    d. Of note, methadone confirmation is 250 ng/mL

Send -Out

1. Mayo Drug Screen, urine
    a. Order in Maestro: Pain Clinic Survey, Urine Lab (Lab9486)
    b. Results back in approximately one week since this is a send out

2. Mayo Serum Drug Screen
    a. Order in Maestro: Gen Code Commercial Lab – Blood; in the comments: insert Mayo serum/plasma panel 9 drug screen FDS9R
    b. Results back in approximately one week since this is a send out

Cannot do the RAPIDDRUG Screens since these require special equipment that we do not have.

CONTROLLED SUBSTANCES SCHEDULES

Schedule	1	2	3	4	5	6 (NC)
Substance	Heroin	Cocaine (illicit) Codeine Fentanyl Hydrocodone	Buprenorphine Butalbital ± aspirin (Fiorinal)	Benzodiazepines (i.e. diazepam, lorazepam, etc)	Cough syrups with codeine 10-12	Marijuana, Tetrahydrocannbinols, Synthetic Cannabinoids

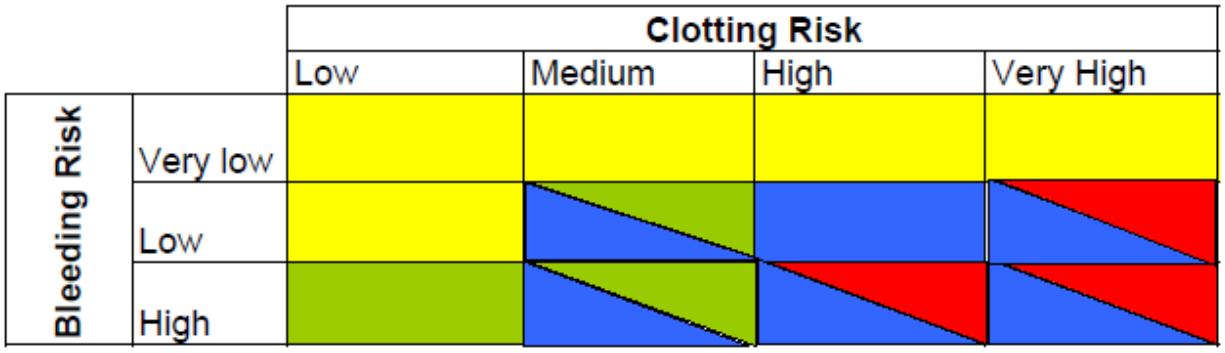
		Hydromorphone Meperidine Methadone Methylphenidate Morphine Oxycodone Pentobarbital	Codeine +APAP (tablet form) Dronabinol Ketamine Oxandrolone Testosterone	Butorphanol Carisoprodol Lorcaserin Midazolam Phenobarbital Phentermine Tramadol Zaleplon Zolpidem	mg/5mL Lacosamide Pregabalin	
Potential for Abuse	++++	++++	+++	++	+	
Accepted Medical Use	No	Yes	Yes	Yes	Yes	----
Prescription Required	----	Yes	Yes	Yes	Yes/No	----
Quantity Limit	----	None	180 days	180 days	None	----
Telephone Prescribing	----	No	Yes	Yes	Yes	----
Electronic Prescribing	----	No	No	No	No	----
Refills Allowed	----	No	5 refills within 6 months		No restriction	----

Notes:
APAP+Butalbital+Caffeine (Fioricet) is a non-scheduled substance.

Prepared by Holly Causey, PharmD, BCACP, CPP, CDE; version 2/15/17
Reviewed by Mackenzie Dolan, PharmD Candidate; version 2/15/17

CLINICAL ALGORITHMS

BRIDGING (PAUSING) ANTICOAGULATION



Yellow
Continue warfarin except for low risk ortho and GYN. In those cases may let therapeutic level drift to 1.3 – 1.5
Green
DC warfarin 4 days prior to procedure and restart day of procedure
Blue
DC warfarin 4-5 days prior to procedure. • Start LMWH 12-36 hours after the last dose of warfarin held • If in-patient, consult with coag service 970-2DVT. • If outpatient restart LMWH 12-24 hours post procedure with warfarin and confirmation with person doing the procedure. • **Warning:** Once a day dosing of LMWH may have higher peaks. creatinine and weight should be avaiable. Q 12 h dosing is recommended
Red
Consult with coag clinic. Call 2 weeks in advance for elective consults. Patient will be seen by PA or PharmD. For emergent consults call 668-6688. If limited availability, call 684-5350 and speak to the attending.

Source: Duke Medicine Clinical Practice Guideline for the Management of Anticoagulation Therapy in the Ambulatory Setting. January 2009.

BLEEDING RISK	CLOTTING RISK
Very Low Risk of Bleeding • All dental procedures including multiple extractions • Skin biopsies • Skin tag removals • Cataract extraction • Mohs Surgery	**Low Risk of Clotting** • AF, without prior CVA/TIA or other thromboembolic event
Low Risk of Bleeding • Low risk GYN * • Low risk ortho (without surgery into a bone) • Diagnostic endoscopy with no biopsy • EGD – no biopsy • Flex sig – no biopsy • Cysto – no biopsy • Colonoscopy without biopsy • ERCP without endoscopic sphinceterotomy • Biliary/pancreatic stent without endoscopicsphincterotomy	**Medium risk of Clotting** • AF with age >65 and/or DM and/or CAD and/or HTN • Mechanical aortic valve in SR without HF, without prior thromboembolism • Prior DVT > 3 months ago without other high risk features
High Risk of Bleeding • Polypectomy • Biliary spincterotomy • Pneumatic or bougie dilatation • PEG placement • EUS guided FNA • Laser ablation and coagulation (GI, urology) • Treatment of varicies • Diagnostic endoscopy or EGD with potential biopsy • Cysto with potential biopsy • Flex sig or colonoscopy with biopsy • Percutaneous image guided aspiration/biopsies • Percutaneous image guided drainage procedures • Other invasive surgeries	**High Risk of Clotting** • AF with prior CVA/TIA • Heart failure (EF <20%) • Mitral stenosis • Bileaflet (St. Jude) mitral valve with AF or heart failure without prior thromboembolism • Aortic mechanical heart valve with prior thromboembolism • DVT/PE > 3 months ago with high risk features
* Office procedures, colposcopy, cervical and endometrial bx, LEEP, IUD insertion, I&D, diagnostic hysteroscopy, cystocoscopy, endometrial ablation. NOTE: For epidurals or regional anesthetics – discuss with surgery and/or anesthesia. Active cancer patients: discuss with oncology	**Very High Risk of Clotting** • Multiple mechanical heart valves • Non bileaflet (eg., STARR-Edwards) mechanical heart valves • Bileaflet (St. Jude) mitral heart valve with AF and heart failure or prior embolism • DVT/PE within past month with multiple risk factors

DEPRESSION MANAGEMENT ALGORITHM

Always offer counseling to your patients who suffer from depression. Talk to the Med-Psych attending for help determining whether they should be seen by a Med-Psych resident at DOC or by a psychologist or psychiatrist outside of DOC.

Table 1: Inititing Antidepressant Treatment with Sertraline

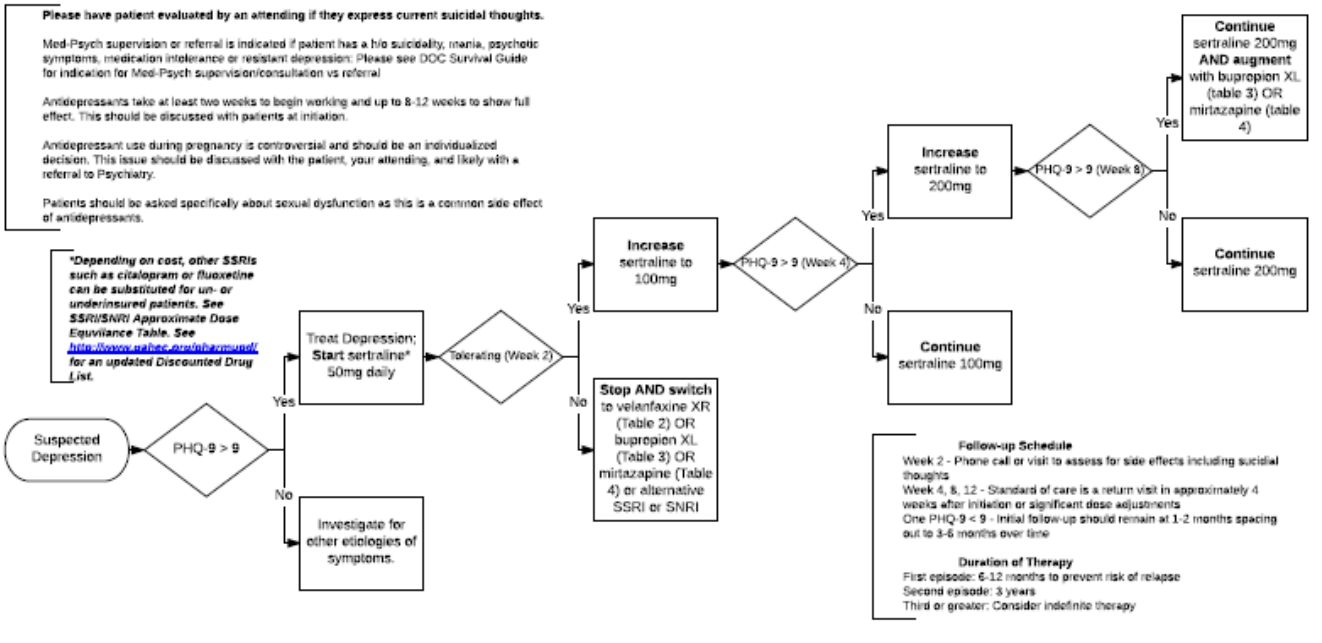
Please have patient evaluated by an attending if they express current suicidal thoughts.

Med-Psych supervision or referral is indicated if patient has a h/o suicidality, mania, psychotic symptoms, medication intolerance or resistant depression. Please see DOC Survival Guide for indication for Med-Psych supervision/consultation vs referral

Antidepressants take at least two weeks to begin working and up to 8-12 weeks to show full effect. This should be discussed with patients at initiation.

Antidepressant use during pregnancy is controversial and should be an individualized decision. This issue should be discussed with the patient, your attending, and likely with a referral to Psychiatry.

Patients should be asked specifically about sexual dysfunction as this is a common side effect of antidepressants.



Follow-up Schedule
Week 2 - Phone call or visit to assess for side effects including suicidal thoughts
Week 4, 8, 12 - Standard of care is a return visit in approximately 4 weeks after initiation or significant dose adjustments
One PHQ-9 < 9 - Initial follow-up should remain at 1-2 months spacing out to 3-6 months over time

Duration of Therapy
First episode: 6-12 months to prevent risk of relapse
Second episode: 3 years
Third or greater: Consider indefinite therapy

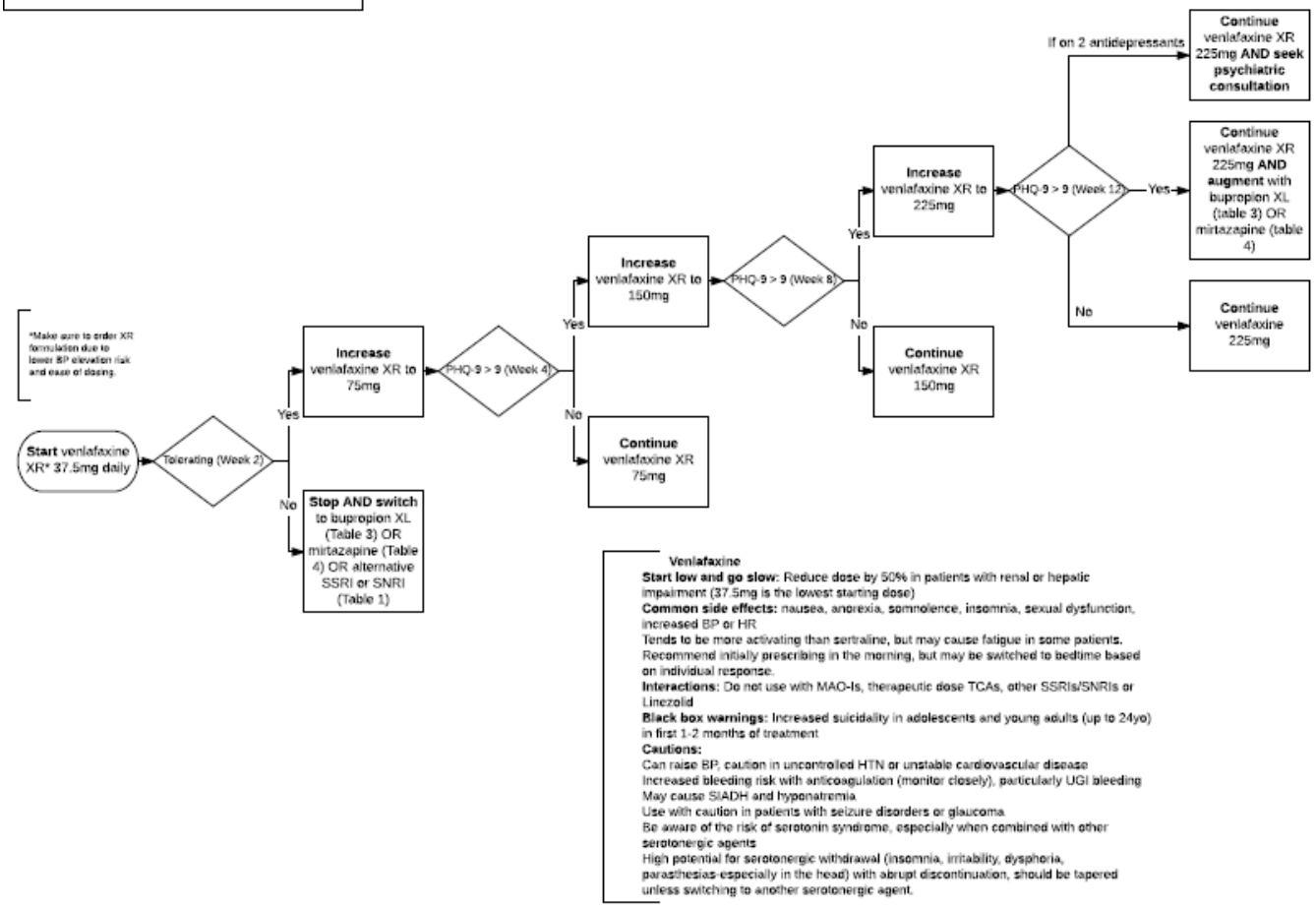
Sertraline
Start low and go slow: elderly patients, patients with cirrhosis, or those sensitive to medications (e.g. severe anxiety) can start at 25mg daily and titrate up as tolerated
Common side effects: nausea, diarrhea, insomnia, fatigue, sexual dysfunction
Inform patients that medication causes insomnia in some patient and drowsiness in others and can be taken in the morning or at bedtime depending on individual response.
Interactions: Do not use with MAO-Is, therapeutic dose TCAs, other SSRIs/SNRIs, Linezolid, Pimozide, Disulfiram
Black Box warnings: Increased suicidality in adolescents and young adults (up to 24yo) in first 1-2 months of treatment
Cautions:
Increased bleeding risk with anticoagulation (monitor closely), particular UGI bleeding
May cause SIADH and hyponatremia
Use with caution in patients with seizure disorders, glaucoma, or uric acid nephropathy
Be aware of the risk of serotonin syndrome, especially when combined with other serotonergic agents
Potential for serotonergic withdrawal (insomnia, irritability, dysphoria, parasthesias-especially in the head) with abrupt discontinuation, should be tapered unless switching to another serotonergic agent.

Approximate Dose Equivalents

SSRIs					
Sertraline (Zoloft)	25mg	50mg	100mg	150mg	200mg
Citalopram (Celexa)	5mg	10mg	20mg	40mg	
Escitalopram (Lexapro)	2.5mg	5mg	10mg	20mg	
Fluoxetine (Prozac)	10mg	20mg	40mg	60mg	80mg
Paroxetine (Paxil)	10mg	20mg	40mg	60mg	
Paroxetine CR (Paxil-CR)	12.5mg	25mg	37.5mg	50mg	75mg
Fluvoxamine#	50mg	100mg	150mg	200mg	300mg
SNRIs					
Venlafaxine	37.5mg	75mg	112.5mg	150mg	225mg
Desvenlafaxine		50mg		100mg	
Duloxetine^	30mg	60mg	90mg	120mg	

*Always monitor for drug-drug interactions. Table does not take into account dose reductions based on renal and/or hepatic impairment or for specific populations, e.g. geriatric patients. Always check the need for dose adjustments for your patients.
#Recommend avoiding use, defer to Psychiatry for this.
^Data do not demonstrate significant benefit above 60mg for depression or pain.

Table 2: Switching to or Initiating with Venlafaxine XR



Venlafaxine

Start low and go slow: Reduce dose by 50% in patients with renal or hepatic impairment (37.5mg is the lowest starting dose)

Common side effects: nausea, anorexia, somnolence, insomnia, sexual dysfunction, increased BP or HR

Tends to be more activating than sertraline, but may cause fatigue in some patients. Recommend initially prescribing in the morning, but may be switched to bedtime based on individual response.

Interactions: Do not use with MAO-Is, therapeutic dose TCAs, other SSRIs/SNRIs or Linezolid

Black box warnings: Increased suicidality in adolescents and young adults (up to 24yo) in first 1-2 months of treatment

Cautions:

Can raise BP, caution in uncontrolled HTN or unstable cardiovascular disease

Increased bleeding risk with anticoagulation (monitor closely), particularly UGI bleeding

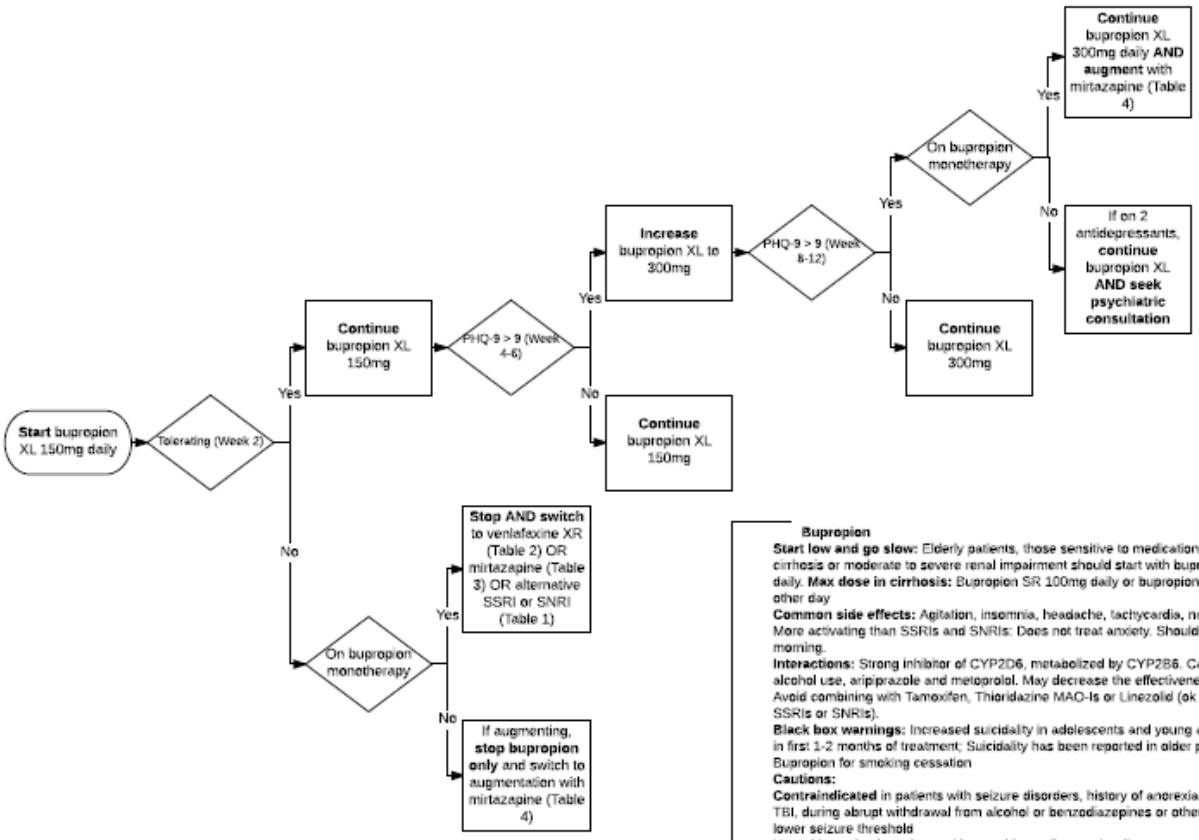
May cause SIADH and hyponatremia

Use with caution in patients with seizure disorders or glaucoma

Be aware of the risk of serotonin syndrome, especially when combined with other serotonergic agents

High potential for serotonergic withdrawal (insomnia, irritability, dysphoria, paresthesias-especially in the head) with abrupt discontinuation, should be tapered unless switching to another serotonergic agent.

Table 3: Switching to or Initiating with Bupropion XL



Bupropion

Start low and go slow: Elderly patients, those sensitive to medications and those with cirrhosis or moderate to severe renal impairment should start with bupropion SR 100mg daily. **Max dose in cirrhosis:** Bupropion SR 100mg daily or bupropion XL 150mg every other day

Common side effects: Agitation, insomnia, headache, tachycardia, nausea

More activating than SSRIs and SNRIs: Does not treat anxiety. Should be taken in the morning.

Interactions: Strong inhibitor of CYP2D6, metabolized by CYP2B6. Caution with heavy alcohol use, aripiprazole and metoprolol. May decrease the effectiveness of codeine. Avoid combining with Tamoxifen, Thioridazine MAO-Is or Linezolid (ok to combine with SSRIs or SNRIs).

Black box warnings: Increased suicidality in adolescents and young adults (up to 24yo) in first 1-2 months of treatment; Suicidality has been reported in older patients using Bupropion for smoking cessation

Cautions:

Contraindicated in patients with seizure disorders, history of anorexia or bulimia, serious TBI, during abrupt withdrawal from alcohol or benzodiazepines or other conditions that lower seizure threshold

Use with caution in patients with unstable cardiovascular disease or uncontrolled HTN

Hypersensitivity reactions including SJS, anaphylaxis and delayed hypersensitivity resembling serum sickness have been reported rarely

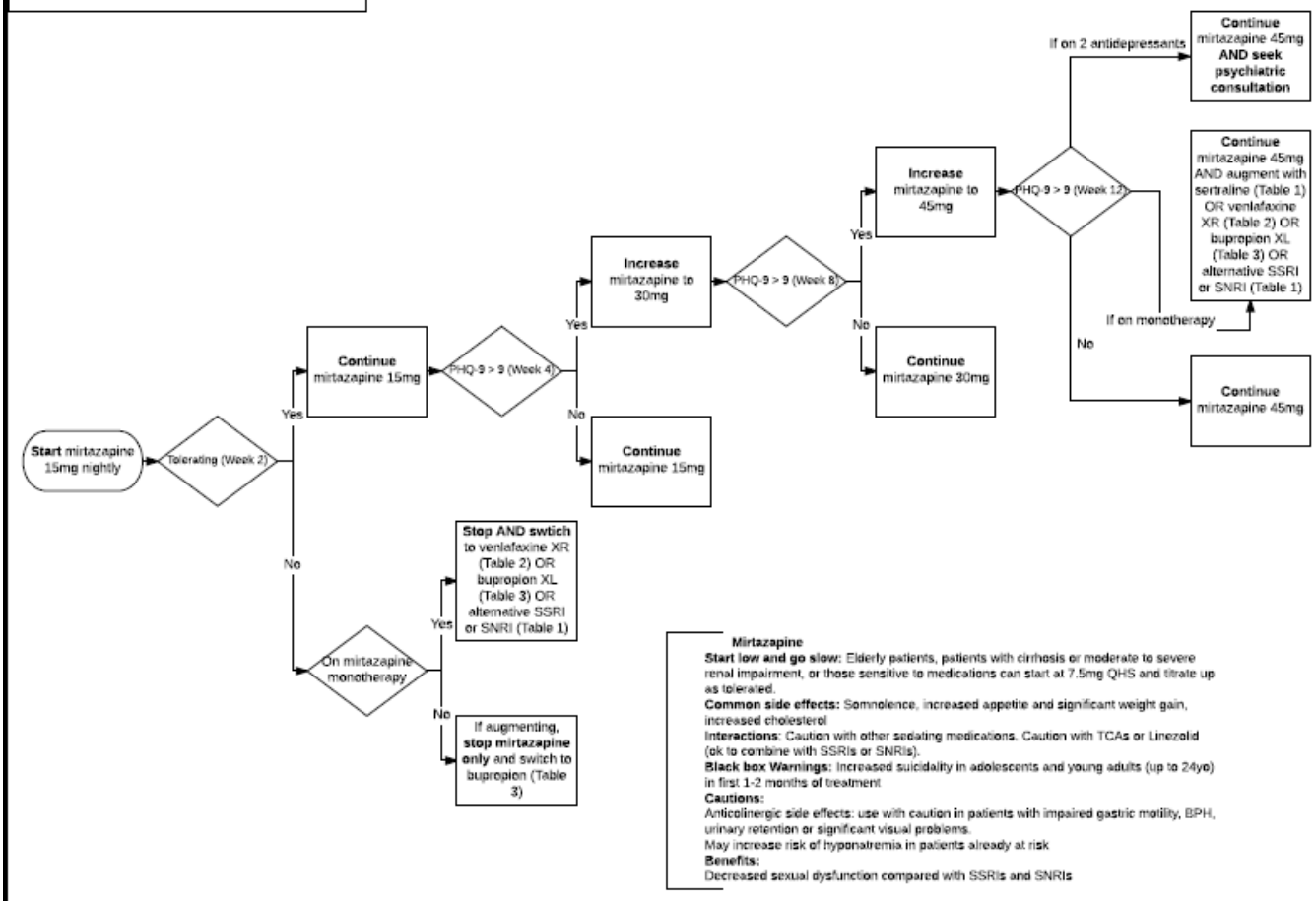
Bupropion is not generally effective for treating anxiety disorders

Benefits:

Weight neutral to some weight loss

Decreased rates of sexual dysfunction compared with SSRIs and SNRIs

Table 4: Switching to or Initiating with Mirtazapine



POTASSIUM MANAGEMENT

Under the Clinical Pharmacist Practitioner agreement at the DOC, our clinical pharmacist Holly Causey can manage potassium in patients with clinical conditions receiving diuretic or other anti-HTN meds.

Table 1: Potassium replacement

Creatinine	Potassium 2.7-2.9	Potassium 3 – 3.2	Potassium 3.3-3.4	Potassium 3.5-3.9	Potassium 5.6-5.9
< 1.5	40 meq bid x 2 days, in addition to current dose. Then long term dose increase of 30 meq's daily	40 meq bid x 1 day, in addition to current dose. Then long term dose increase of 20 meq's daily	Consider long term dose increase of 20 meq's daily	Re-check in 1 week if increasing diuretic	Hold x 2 days then decrease dose by 50%
1.5-2	40 meq bid x 2 days, in addition to current dose. Then long term dose increase of 20 meq's daily	40 meq bid x 1 day, in addition to current dose. Then long term dose increase of 10 meq's daily	Long term dose increase of 10 meq's daily	Re-check in 1 week if increasing diuretic	Hold x 2 days then decrease by 50%
2-2.9	40 meq daily x 2 days, in addition to current dose. No long term dose increase	40 meq daily x 1 day, in addition to current dose. No long term dose increase	20meq x 1 day, in addition to current dose. No long term dose increase.	Re-check in 1 week if increasing diuretic	Hold x 2 days then decrease by 75%
>3	Notify Attending	Notify Attending	20 meq x 1 day, no increase in chronic dose	Re-check in 1 week if increasing diuretic	Notify Attending
Labs should include BMP	Follow up labs 4 days	Follow up labs 7 days	Follow up labs 7-10 days	Follow routine monitoring if no med changes	48 hours

Notify Attending MD for K+ < 2.7 or > 5.9. For K+ > 6.5, recommend emergency treatment, including an EKG.

ADDITIONAL TREATMENT CONSIDERATIONS:

- Dietary counseling. Review foods high in potassium that patient should consume or avoid.
- Hyperkalemia symptoms: listlessness, mental confusion, weakness, paresthesias
- Hypokalemia symptoms: fatigue, myalgia, weakness, and cramping
- Patients with any cardiac history and/or taking digoxin are considered high risk.
- If patient taking K+ salts such as LiteSalt or NuSalt, or NSAIDs, recommend discontinuation.
- If patient is prescribed spironolactone or an ACEi/ARB with hyperkalemia (K+ ≥ 5.6) on no potassium supplementation, instruct patient to hold the medication for 2 days then resume at half dose. If patient is taking a potassium supplement as well as spironolactone or an ACEi/ARB, instruct patient to hold medication for one day and follow above recommendations for holding potassium supplement.

References:

Asheville Cardiology Associates. Potassium Protocol
UK Renal Association. Clinical Practice Guidelines: Treatment of Acute Hyperkalemia in Adults. July 2012.

VACCINATION SCHEDULE (CDC)

https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf

Figure 1. Recommended immunization schedule for adults aged 19 years or older by age group, United States, 2017

Vaccine	19–21 years	22–26 years	27–59 years	60–64 years	≥ 65 years
Influenza[1]	1 dose annually				
Td/Tdap[2]	Substitute Tdap for Td once, then Td booster every 10 yrs				
MMR[3]	1 or 2 doses depending on indication				
VAR[4]	2 doses				
HZV[5]				1 dose	
HPV–Female[6]	3 doses				
HPV–Male[6]	3 doses				
PCV13[7]	1 dose				
PPSV23[7]	1 or 2 doses depending on indication				1 dose
HepA[8]	2 or 3 doses depending on vaccine				
HepB[9]	3 doses				
MenACWY or MPSV4[10]	1 or more doses depending on indication				
MenB[10]	2 or 3 doses depending on vaccine				
Hib[11]	1 or 3 doses depending on indication				

Recommended for adults who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended for adults with additional medical conditions or other indications

No recommendation

Vaccine	Pregnancy[1-6,9]	Immuno-compromised (excluding HIV infection)[3-7,11]	HIV infection CD4+ count (cells/μL)[3-7,9-11]		Asplenia, persistent complement deficiencies[7,10,11]	Kidney failure, end-stage renal disease, on hemodialysis[7,9]	Heart or lung disease, chronic alcoholism[7]	Chronic liver disease[7-9]	Diabetes[7,9]	Healthcare personnel[3,4,9]	Men who have sex with men[6,8,9]
			< 200	≥ 200							
Influenza[1]	1 dose annually										
Td/Tdap[2]	1 dose Tdap each pregnancy	Substitute Tdap for Td once, then Td booster every 10 yrs									
MMR[3]	contraindicated	1 or 2 doses depending on indication									
VAR[4]	contraindicated	2 doses									
HZV[5]	contraindicated				1 dose						
HPV–Female[6]		3 doses through age 26 yrs									
HPV–Male[6]		3 doses through age 26 yrs			3 doses through age 21 yrs						3 doses through age 26 yrs
PCV13[7]		1 dose									
PPSV23[7]		1, 2, or 3 doses depending on indication									
HepA[8]		2 or 3 doses depending on vaccine									
HepB[9]		3 doses									
MenACWY or MPSV4[10]		1 or more doses depending on indication									
MenB[10]		2 or 3 doses depending on vaccine									
Hib[11]		3 doses post-HSCT recipients only			1 dose						

Recommended for adults who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended for adults with additional medical conditions or other indications

Contraindicated

No recommendation

USING MAESTRO CARE (EPIC)

Troubleshooting
Helpdesk: (919) 684-2243, choose option #5
Maestro "Super Users" at DOC: Dr. Bowlby & Dr. Zipkin

MAKING YOUR ENCOUNTER MORE EFFICIENT

- Order items on the left hand column for better function during all encounters
- Move diagnoses between History, Problem List, and Visit
- **Review Flowsheets** (vitals, diabetes detail)
- **Common Diagnosis buttons:** populate these for easy use for routine healthcare maintenance orders
- **Orders favorites:** Go to Epic menu → preference list composer → Patient Care Tools
- Medication prescribing: delete END DATE, make sure quantity is correct, refills for 30 or 90 day supply.
- Be aware that we CANNOT discontinue meds in the system, must add that on as a note to the pharmacy when you do a new Rx.
- Uploading images: Take a photo using the Epic Haiku app (ask a resident or attending to show you how). It will automatically upload to the "Media" tab of the patient's chart. Copy and paste the image into your note
    - To get Haiku on your phone, go to https://intranet.dm.duke.edu/sites/MaestroCare/Mobile/SitePages/Home.aspx
- **Speed buttons** for check out in the 'follow up' section

See Dr. Zipkin for extra tips!

EPIC INBASKET

You are responsible for your patient panel and following up on all tests ordered on your patients. When you are on a busy service, new patient questions will be routed to other people in your partnership group. However, tests you ordered from clinic will still result to you. No one is necessarily double checking how you handle your test results, so make sure you act in timely manner, and if you need help be sure to ask!

When you need help with something and want to route an encounter to your nurse, please refer to the partnership map to know who your team nurse is (Group A is Amber Walters, Group B is Diana (Glenda) Wamsley, Group C is Johna Weilacher) and put that nurse in the routing field.

- Move folders up and down per your preferences (use the wrench)
- Involve the nursing team where appropriate. They can contact patients on your behalf if needed.
- **Patient Calls:** click "QuickNote" to bounce back to nurse, or "Enc" to document your portion of the call. Do not use "comment", as this doesn't go anywhere.
- **Patient advice request:** click "Reply to pt," or "MyChtEnc". Route if needed. Clicking on "tel call" creates a new encounter.
- **Results:** click "Rslt Release" to release the results in MyChart (if patient has MyChart). Click "Letter" to populate a letter with the results, and then route the letter to the medical records pool so they can send the letter to the patient. Click "result note" to comment and route to nurse for help
    - Please note that abnormal results for HIV, GC, Chlamydia, and Syphilis are to be sent to Molly Jarvis. She collects them and reports to the health department for us. This is in addition to you notifying the patient and treating them.
- **Rx request:** click "EditRx," or "Approve All." If you want to enlist nursing help, click "Enc," or "QuickNote."
- **Referral message:** Right click, reply to all or reply to sender
- **CC'd charts:** Specialists route their notes to you, as the patient's PCP. These are mostly FYI.
- **Staff Messages:** This is like email, except harder to figure out who is sending and who is copied. These messages are not recorded in the patient's chart.
- **Patient station (icon on topmost banner of Epic):** Click on this to start any new encounter or go into an existing open encounter, whether routed to you or not.

- **Orders only encounters:** For times when a patient needs to return for blood work outside an encounter; make all orders "future", even if being done that same day.

VISIT TYPES

Although from a scheduling/administrative perspective there are officially only two basic visit types (**new patient visits** defined by Medicare as not having been seen at the DOC for 3 years; and **returns**), there are actually many different visit "flavors," which we encourage you to use *explicitly* (e.g., bringing patients with uncontrolled chronic illness back for prepared chronic disease-focused visits at regular intervals, outside of acute visits). Doing so can help you avoid becoming overwhelmed by having to address every issue at every visit, or being purely reactive. Of course, the realities of patients' lives force us to be opportunistic as well, taking care of what we can when patients present to clinic, regardless of reason (e.g., refills, health maintenance, interrupted workups for potentially concerning complaints, etc.)

Visit "flavor"	**Brief description (including objectives for visit)**
New	Complete review of past medical history, social history, family history, plus thorough review of 10+ systems
Return	Second official visit type; but actually fall into many subtypes. Can be to follow up on acute complaints not able to be addressed in a single visit; or in follow-up of prepared chronic illness visit, at whatever interval/frequency is required.
Acute	Patient-made appointment to address a particular problem
Annual	Although the evidence for the benefit of these is mixed, can provide a set-aside opportunity to catch up specifically on health maintenance, update history, and address patient self-management goals and goals of care. It can also be a good time for completing PHQ-9 (depression) and AUDIT (EtOH) screening. Of note, Medicare has a very specific Annual Wellness Visit format, reimbursed separately.
Chronic illness	PREPARED visits focused on one or more chronic conditions that a patient may be struggling to get under control. Verbally contract w/ patients before setting these up that these visits will be to address their chronic condition(s). In reality, care cannot easily be compartmentalized, but it can provide both you and the patient some time/space/clarity to establish a plan for the next 12 months, to-dos, etc.
Group	In conjunction with weekly PAIN, diabetes or hypertension group visits
Home	A multidisciplinary team (resident, Ambulatory Chief Resident, pharmacist, social worker) can visit a patient's home to identify/address potential barriers to health
Hospital follow-up	Use the .DAZHOSPFU template within your note. Main purposes are to: a) assess condition s/p hospitalization, and patients' understanding of why they were hospitalized and what they can do to avoid re-hospitalization; b) complete to-dos from discharge summary; c) ensure any medication changes made on discharge have in fact been implemented w/o adverse events; d) address any urgent issues; and e) schedule them soon (< 6 weeks) to return to their assigned PCP.
Paperwork	To enable completion of a particularly time-consuming form (e.g., FMLA), or one that requires a provider assessment (e.g., FL-2)
Procedure	New this year, staffed by Larry Greenblatt and intended to be where patients can be "referred" for joint/bursa injections, cryotherapy, even punch biopsies, etc. in clinic

DOCUMENTATION OUTSIDE A VISIT

Maestro Care has specific documentation pathways that vary based on whether you are documenting information **during** a patient visit versus **outside of** a patient visit. The following table highlights the workflow for a few different types of documentation outside of a patient visit in Maestro Care.

*Documentation Purpose (when completed **outside** of patient visit)*	*Encounter Type*
Medication refill	Medication Refill Encounter

Documenting a phone conversation	Telephone Encounter
Ordering a referral	Orders Only Encounter **OR** In Basket message to the Referral Pool

DOCUMENTATION OF PSYCHOSOCIAL NEEDS

A third, emerging priority will be to better understand the impact of social determinants of health on the needs of our patients – which requires better documentation. The following list was compiled after extensive discussion:

Code	**Notes**
Lack of Housing Z59.0	also refers to unstable housing
Financial Difficulties Z59.8 and Dependent for Transport Z74.8	e.g., transportation, clothing
Problems with Literacy Z55.0	1-question screen: "How confident are you filling out medical forms by yourself?" Screening for health literacy is also a PCMH (primary care medical home) REQUIREMENT.
Lack of Adequate Food Z59.4	
Adult Maltreatment T74.91XA	includes ONGOING adult physical, sexual, psychological abuse, and neglect (i.e., domestic violence, elder abuse)
Cognitive Impairment 294.9	including memory problems, not rising to level of dementia
Ineffective Self Health Management V49.89	
Underdosing of medications due to financial hardship Z91.120	
History of Childhood Maltreatment Z62.819	
Lives in a Group Home Z59.3	

SMARTPHRASES

Note: To insert the smartphrases below into your note or patient instructions, each phrase must be preceded by a period ("."). For example, to insert a template for a follow-up visit, start typing ".dazfu" and choose the smartphrase you're looking for from the drop-down menu that pops up.

TEMPLATES FOR CLINIC NOTES

Name of template	**Description**
DAZANNUAL	Template for an annual visit
DAZFU	Template for a follow-up visit
DAZNEWTEMPLATE	Template for a patient who is new to the DOC
DAZHOSPITALFU	Insert this template into the "HPI" section of your new or follow-up note if the visit is a hospital follow-up appointment
DOCGROUPDM	Template for DM group visit
DOCGROUPHTN	Template for HTN group visit
DOCSARHANDOFF	Template for SAR handing patient off to intern
DOCNEWFEMALEUNDER50	Template for new female patient under age 50
DOCNEWMALEUNDER50	Template for new male patient under age 50

HPI

Name of template	**Description**
DAZHPIDM	HPI info for a routine diabetes visit
DOCASTHMASEVERITY	HPI info for routine asthma visit
DOCCOPDSEVERITY	HPI info for routine COPD visit

DOCDNRDISCUSSION	To document DNR discussion in HPI
WEIGHTLOSSSURGERY	For patients who present for f/u of weight loss attempt in preparation for bariatric surgery

EXAM AND PROCEDURES

Name of template	Description
LASTWT(3)	Quick trend of weights
LASTTEMP(3)	Quick trend of temperatures
LASTBP(3)	Quick trend of BPs
LASTPULSE(3)	Quick trend of pulses
LASTDM(3)	Quick trend of diabetes data
DOCDIABFOOTEXAM	To document a diabetic foot exam (including monofilament)
LGKNEEINJECTION	Template for knee injection procedure
LGSHOULDERINJ	Template for shoulder injection procedure

ASSESSMENT AND PLAN

Name of template	Description
DIAGMED	Pulls in all orders as linked to diagnoses, with nicely formatted area for writing your thoughts
DOCDMGOOD	Include in the a/p for a patient who has DM and all parameters are in order
DOCDMUNCONTROLLED	Include in the a/p for a patient with uncontrolled DM
DOCLBPUNCOMPLICATED	Text for the a/p about management of uncomplicated lower back pain
DOCACCLIPIDS	Text for the a/p about using the new ACC lipid guidelines
LGDRYSKIN	Text for the a/p about management of xerosis
DOCHOMEHEALTHFACETOFACEDOCUMENTATION	Order and certification for home care services (include in your progress note)
HOMEHEALTHSETUP	Info for YOU (not the patient) on how to order home health

BEHAVIORAL HEALTH

Name of template	Description
FFGAD7	Validated, widely-used 7-item anxiety screening tool
FFPTSDSCREEN	2-item validated PTSD screening tool (from the VA)
DOCPHQ2	Brief depression screen
PHQ9	Full PHQ-9 in compact format
DAZPHQ9FLOW	Pulls PHQ-9 flowsheet into note
DOCETOHCAGEQUESTIONS	CAGE questionnaire for alcohol abuse
DOCAUDITC	3-item standard alcohol abuse screening
DOCAUDIT	10-item standard alcohol abuse screening (more accurate)
DOCDAST10	10-item drug abuse (prescription or otherwise) screening
DOCACESCORE	Calculator for adverse childhood events
NC41CRISISLINE	Phone number for Durham Center Access Crisis Line and Suicide Prevention Line
SUICIDERISK	Suicide risk assessment
DOCCRISISSERVICES	List of crisis resources
DOCSLEEPHYGIENE	Sleep hygiene instructions

PATIENT INSTRUCTIONS

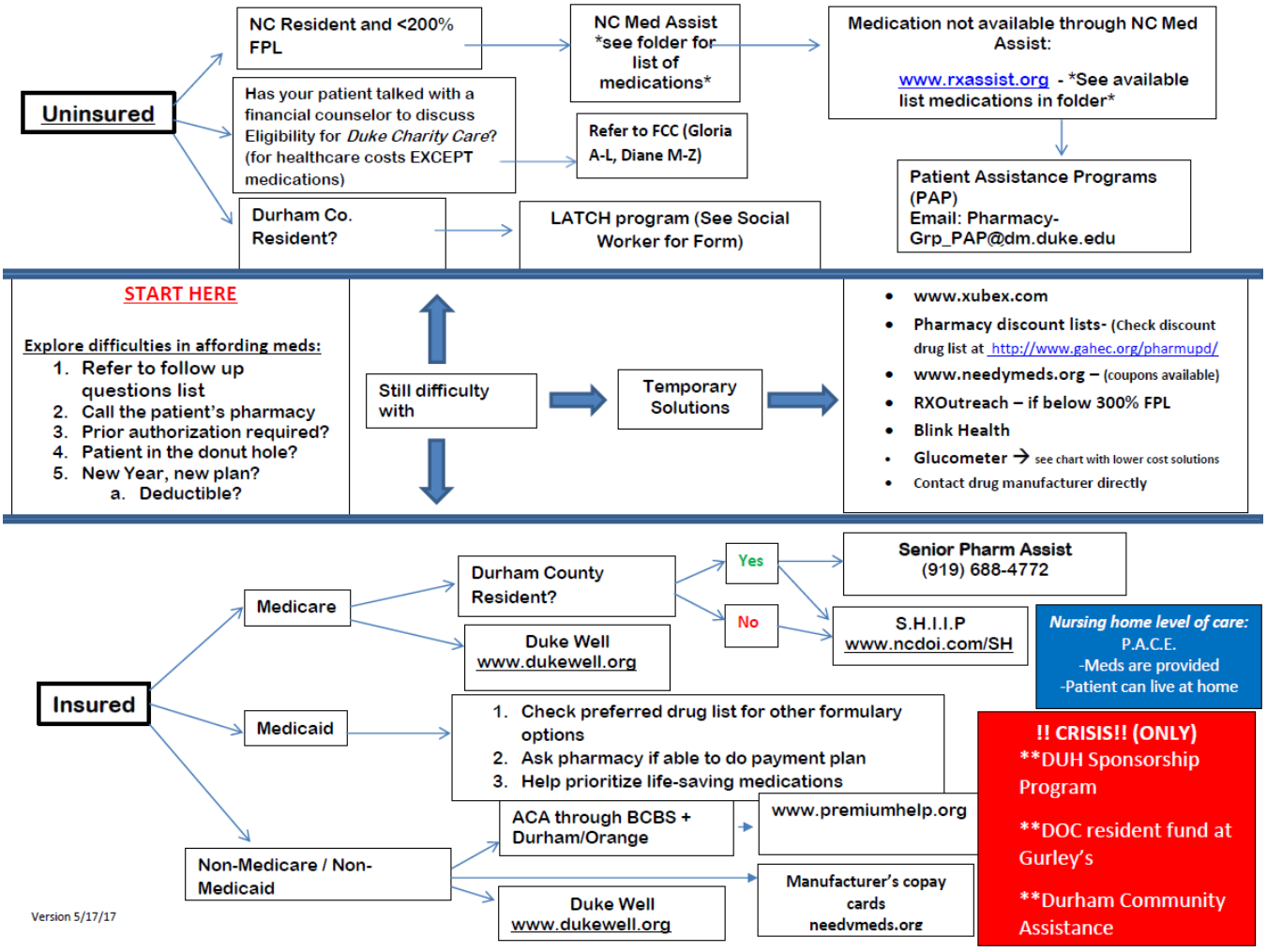
Name of template	Description
DAZLOWCARBREC	Dr. Zipkin's brief recommendations for low carb diet
DOCDIETADVISOR	Includes "my plate" and table of glycemic index of

	common foods
DOCLOWGLYCEMIC	Table of glycemic index of common foods
DOCEXERCISEOPTIONS	Options for daily exercise
DOCQUITSMOKINGHOTLINE	Smoking cessation hotline
DOCMEDLINEPLUS	Instructions for patient on how to get information from Medline Plus
DOCASTHMAACTIONPLAN	Asthma action plan
DOCDEPRESSIONSELFCAREPLAN	Behavioral interventions for depression
DOCDIABHYPOGLYLCEMIAINSTRUCTIONS	Instructions re: hypoglycemia for patients on insulin
DOCDIABINSULININSTRUCTIONS	Instructions re: diabetes care if taking insulin
DOCDIABORALINSTRUCTIONS	Instructions re: diabetes care if taking oral meds
DOCDIABSLIDINGSCALEINSTRUCTIONS	Instructions re: insulin sliding scale
DOCEMERGENCYPSYCHMEDS	For patients who have a psychiatrist and are requesting meds
NARCOTICEDUCATIONBASIC	Low literacy information about narcotics
NARCOTICEDUCATIONFULL	Information about narcotics
DOCOPIOIDVIDEOPATIENTEDUCATION	12 patient education videos regarding opioids
DOCGROUPSERVICES	Explains the group visits (DM,HTN and pain)
DOCMYCHART	Explains MyChart and how to install
DOCPACEREFERRAL	Information for YOU (not patient) about PACE (program of all-inclusive care for the elderly) and referral instructions
DOCBRIEFMENTALHEALTHREFERRALTO-ALLIANCE	For patients with Medicaid or without insurance who need to connect with substance abuse, mental health, or developmental disability services
DOCHEALTHINSURANCEEXACHANGE	Information about signing up for the exchanges
DOCMEDICAIDTRANSPORTATION	How to get free transportation if you have Medicaid
DOCPHARMREFERRAL	Information regarding what a clinical pharmacist will do and what to bring to an appointment with pharmacy
DOCADVANCEDDIRECTIVES	Instructions re: what AD are and where to find the appropriate forms

SOCIAL WORK

Name of template	**Description**
FFHOUSINGSCREEN	Standard screening tool looking for risk factors for unstable housing and homelessness (from the VA)
DOCSWREFERRAL	Use when referring a patient to DOC social worker (use in the text of an InBasket message to Jan Dillard)
SWFREEMEDSAP	Info for patient on how to apply for patient assistance program to get medications sponsored
DOCCANIMANAGEMONEY	Info for patient about how to become his or her own payee if he/she currently has a representative payee
DOCAIRCONDITIONERLETTER	Letter documenting a patient's need for electricity, heating, or air conditioning
DOCHOMEVISITREFERRAL	Use when referring patient for a home visit by the DOC team

HOW TO HELP PATEINT WHO CANNOT AFFORD MEDICATIONS



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