GUIDE TO THRIVING AT THE DOC

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INTRODUCTION

THE BASICS
Duke Outpatient Clinic (“DOC”)
4220 N Roxboro Rd (2nd floor of the Durham Medical Center building)
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

HOURS AND PARKING
Clinic hours are 8am to 5pm. Enter through the front door and exit through the back 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.

IMPORTANT PHONE NUMBERS (P=PAGER, M=MOBILE)
Medical Director & Clinic Group A Leader, Lynn Bowlby, MD…., 919-660-9048, m. 774-991-0041
Clinic Group B Leader, Dani Zipkin, MD……………………………………………..919-970-8947
Clinic Group C Leader, Larry Greenblatt, MD…………................919-660-9047, p. 919-970-0496
Medical Director of Behavior Health, Greg Brown, MD…………………………………….919-970-2532
Ambulatory Chief Resident (Aparna Swaminathan)………………………………………….919-970-9823
Teal Side Preceptor Room…………………………………………….919-660-9024
Lavender Side Preceptor Room………………………………………………919-660-9023
Clinic Operations Director……………………………………………………………919-660-9044
Front Desk………………………………………………………………………919-660-9007; 919-660-9006; 919-660-9010
Financial Care Counselor…………………………………………………………….919-477-0829; 919-471-9475
Social Worker, Jan Dillard………………………………………………………919-471-0084, p.919-970-4530
Clinical Pharmacist, Holly Causey………………………………………………….919-477-5904, p. 919-970-3532
Clinical Pharmacy Assistant……………………………………………………….919-660-9058
Nurse Manager…………………………………………………………………………919-660-9057
Nurse Triage………………………………………………………………………………919-660-9016
Nursing Pager…………………………………………………………………………….p. 919-970-3624 (970-DOCHelp)
HomeBASE Care Manager, Marigny Manson…………………………………………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

COPY MACHINES
- One located in the waiting room next to the cubicles, the code is taped to the machine
- 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 if 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.
MAESTRO CARE

HOW TO SCHEDULE AN APPOINTMENT
- Make a follow-up appointment by indicating a return appointment time range in the follow up section (using the “For:” field) in the visit navigator in Maestro (for example, “2-4 months with PCP)
- Patients can call the scheduling hub at (919) 471-8344 (extension 1) during business hours to request an appointment (should be encouraged to ask for you by name)
- To request an appointment for your patient, send an InBasket message to the “FRONT DESK POOL,” which will pop up when you type “P DUKE OUTPATIENT” in the “to” field. Be sure to include the patient’s name, MRN, time frame requested, reason for appointment, and person with whom they should be scheduled

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

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.
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)
14. **Print the “After-Visit Summary (AVS)”** and hand it directly to the patient

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
  o 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
• Letters to patients: Select recipient at the top → compose letter (right click to make selected text editable to get rid of extraneous stuff in lab results → (1) ROUTE or (2) SEND the letter
  o Click “route” to send the letter to your medical records pool or designated person, who will mail the letter to the patient (preferred).
  o Click “send” to print letters and then have someone send them. To print later, go to Letters tab in Chart Review.

See Dr. Zipkin for extra tips!

Epic InBasket
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
  o 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.
  o If you notify 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.

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

<table>
<thead>
<tr>
<th>Name of template</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAZANNUAL</td>
<td>Template for an annual visit</td>
</tr>
<tr>
<td>DAZFU</td>
<td>Template for a follow-up visit</td>
</tr>
<tr>
<td>DAZNEWTEMPLATE</td>
<td>Template for a patient who is new to the DOC</td>
</tr>
<tr>
<td>DAZHOSPITALFU</td>
<td>Insert this template into the “HPI” section of your new or follow-up note if the visit is a hospital follow-up appointment</td>
</tr>
<tr>
<td>DOCGROUPDM</td>
<td>Template for DM group visit</td>
</tr>
</tbody>
</table>
### Templates to Use in Your HPI

<table>
<thead>
<tr>
<th>Name of template</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAZHPIDM</td>
<td>HPI info for a routine diabetes visit</td>
</tr>
<tr>
<td>DOCASTHMASEVERITY</td>
<td>HPI info for routine asthma visit</td>
</tr>
<tr>
<td>DOCCOPDSEVERITY</td>
<td>HPI info for routine COPD visit</td>
</tr>
<tr>
<td>DOCNDRDISCUSSION</td>
<td>To document DNR discussion in HPI</td>
</tr>
<tr>
<td>WEIGHTLOSSSSURGERY</td>
<td>For patients who present for flu of weight loss attempt in preparation for bariatric surgery</td>
</tr>
</tbody>
</table>

### Templates to Use in Your “Objective”

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

### To Use in Your Assessment and Plan

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

### Behavioral Health-Related Smartphrases

<table>
<thead>
<tr>
<th>Name of template</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFGAD7</td>
<td>Validated, widely-used 7-item anxiety screening tool</td>
</tr>
<tr>
<td>FFPTSDSCREEN</td>
<td>2-item validated PTSD screening tool (from the VA)</td>
</tr>
<tr>
<td>DOCPHQ2</td>
<td>Brief depression screen</td>
</tr>
<tr>
<td>PHQ9</td>
<td>Full PHQ-9 in compact format</td>
</tr>
<tr>
<td>DAZPHQ9FLOW</td>
<td>Pulls PHQ-9 flowsheet into note</td>
</tr>
<tr>
<td>DOCETOHAGEQUESTIONS</td>
<td>CAGE questionnaire for alcohol abuse</td>
</tr>
<tr>
<td>DOCAUDITC</td>
<td>3-item standard alcohol abuse screening</td>
</tr>
<tr>
<td>DOCAUDIT</td>
<td>10-item standard alcohol abuse screening (more accurate)</td>
</tr>
<tr>
<td>DOCDAST10</td>
<td>10-item drug abuse (prescription or otherwise) screening</td>
</tr>
<tr>
<td>DOCACESCORE</td>
<td>Calculator for adverse childhood events</td>
</tr>
<tr>
<td>NC41CRISISLINE</td>
<td>Phone number for Durham Center Access Crisis Line and Suicide</td>
</tr>
</tbody>
</table>
**Templates for Patient Instructions**

<table>
<thead>
<tr>
<th>Name of Template</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAZLOWCARBREC</td>
<td>Dr. Zipkin’s brief recommendations for low carb diet</td>
</tr>
<tr>
<td>DOCDIETADVISOR</td>
<td>Includes “my plate” and table of glycemic index of common foods</td>
</tr>
<tr>
<td>DOCLOWGLYCEMIC</td>
<td>Table of glycemic index of common foods</td>
</tr>
<tr>
<td>DOCEXERCISEOPTIONS</td>
<td>Options for daily exercise</td>
</tr>
<tr>
<td>DOCQUITSMOKINGHOTLINE</td>
<td>Smoking cessation hotline</td>
</tr>
<tr>
<td>DOCMEDLINEPLUS</td>
<td>Instructions for patient on how to get information from Medline Plus</td>
</tr>
<tr>
<td>DOCCASTHMACTIONPLAN</td>
<td>Asthma action plan</td>
</tr>
<tr>
<td>DOCDEPRESSIONSELFECAREPLAN</td>
<td>Behavioral interventions for depression</td>
</tr>
<tr>
<td>DOCDIABHYPOGLYCEMICMAINSTRUCTIONS</td>
<td>Instructions re: hypoglycemia for patients on insulin</td>
</tr>
<tr>
<td>DOCDIABIINSULININSTRUCTIONS</td>
<td>Instructions re: diabetes care if taking insulin</td>
</tr>
<tr>
<td>DOCDIABORALINSTRUCTIONS</td>
<td>Instructions re: diabetes care if taking oral meds</td>
</tr>
<tr>
<td>DOCDIABSLIDINGSCALEINSTRUCTIONS</td>
<td>Instructions re: insulin sliding scale</td>
</tr>
<tr>
<td>DOCEMERGENCYPSYCHMEDS</td>
<td>For patients who have a psychiatrist and are requesting meds</td>
</tr>
<tr>
<td>NARCOTICEDUCATIONBASIC</td>
<td>Low literacy information about narcotics</td>
</tr>
<tr>
<td>NARCOTICEDUCATIONFULL</td>
<td>Information about narcotics</td>
</tr>
<tr>
<td>DOCOPIOIDVIDEOPATIENTEDUCATION</td>
<td>12 patient education videos regarding opioids</td>
</tr>
<tr>
<td>DOCGROUPSERVICES</td>
<td>Explains the group visits (DM, HTN and pain)</td>
</tr>
<tr>
<td>DOCMYCHART</td>
<td>Explains MyChart and how to install</td>
</tr>
<tr>
<td>DOCPACEREFERRAL</td>
<td>Information for YOU (not patient) about PACE (program of all-inclusive care for the elderly) and referral instructions</td>
</tr>
<tr>
<td>DOCBRIEFMENTALHEALTHREFERRALTO-ALLIANCE</td>
<td>For patients with Medicaid or without insurance who need to connect with substance abuse, mental health, or developmental disability services</td>
</tr>
<tr>
<td>DOCHEALTHINSURANCEEXCHANGE</td>
<td>Information about signing up for the exchanges</td>
</tr>
<tr>
<td>DOCMEDICAIDTRANSPORTATION</td>
<td>How to get free transportation if you have Medicaid</td>
</tr>
<tr>
<td>DOCPHARMREFERRAL</td>
<td>Information regarding what a clinical pharmacist will do and what to bring to an appointment with pharmacy</td>
</tr>
<tr>
<td>DOCADVANCEDDIRECTIVES</td>
<td>Instructions re: what AD are and where to find the appropriate forms</td>
</tr>
</tbody>
</table>

**Social Work-Related Templates**

<table>
<thead>
<tr>
<th>Name of Template</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFHOUSINGSCREEN</td>
<td>Standard screening tool looking for risk factors for unstable housing and homelessness (from the VA)</td>
</tr>
<tr>
<td>DOCSWREFERRAL</td>
<td>Use when referring a patient to DOC social worker (use in the text of an InBasket message to Jan Dillard)</td>
</tr>
<tr>
<td>SWFREEMEDSAP</td>
<td>Info for patient on how to apply for patient assistance program to get medications sponsored</td>
</tr>
<tr>
<td>DOCCANIMANAGEMONEY</td>
<td>Info for patient about how to become his or her own payee if he/she currently has a representative payee</td>
</tr>
</tbody>
</table>
| DOCAIRCONDITIONERLETTER         | Letter documenting a patient’s need for electricity, heating, or
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.

<table>
<thead>
<tr>
<th>Documentation Purpose (when completed outside of patient visit)</th>
<th>Encounter Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication refill</td>
<td>Medication Refill Encounter</td>
</tr>
<tr>
<td>Documenting a phone conversation</td>
<td>Telephone Encounter</td>
</tr>
<tr>
<td>Ordering a referral</td>
<td>Orders Only Encounter OR</td>
</tr>
<tr>
<td></td>
<td>In Basket message to the Referral Pool</td>
</tr>
</tbody>
</table>

ORDERING AN OUTPATIENT BLOOD TRANSFUSION
Infusion Center Orders (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:
  o Select: Patient Station and locate your patient
  o Select: More activities (bottom left of your screen)
  o Select: Encounters (first option on the pop-up menu option)
  o Select: New (on the bottom left)
  o Select: Orders Only encounter
  o Then in your new encounter select: Orders
  o Then you must select: orders for later on the top menu option (last on the right)
  o It will then ask you to designate a location: Select DUH
  o 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
  o Sign orders

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.)

<table>
<thead>
<tr>
<th>Visit “flavor”</th>
<th>Brief description (including objectives for visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Complete review of past medical history, social history, family history, plus thorough review of 10+ systems</td>
</tr>
<tr>
<td>Return</td>
<td>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.</td>
</tr>
<tr>
<td>Acute</td>
<td>Patient-made appointment to address a particular problem</td>
</tr>
</tbody>
</table>
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 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 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Housing Z59.0</td>
<td>also refers to unstable housing</td>
</tr>
<tr>
<td>Financial Difficulties Z59.8</td>
<td>e.g., transportation, clothing</td>
</tr>
<tr>
<td>and Dependent for Transport Z74.8</td>
<td></td>
</tr>
<tr>
<td>Problems with Literacy Z55.0</td>
<td>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.</td>
</tr>
<tr>
<td>Lack of Adequate Food Z59.4</td>
<td></td>
</tr>
<tr>
<td>Adult Maltreatment T74.91XA</td>
<td>includes ONGOING adult physical, sexual, psychological abuse, and neglect (i.e., domestic violence, elder abuse)</td>
</tr>
<tr>
<td>Cognitive Impairment Z94.9</td>
<td>including memory problems, not rising to level of dementia</td>
</tr>
<tr>
<td>Ineffective Self Health Management V49.89</td>
<td></td>
</tr>
<tr>
<td>Underdosing of medications due to financial hardship Z91.120</td>
<td></td>
</tr>
<tr>
<td>History of Childhood Maltreatment Z62.819</td>
<td></td>
</tr>
<tr>
<td>Lives in a Group Home Z59.3</td>
<td></td>
</tr>
</tbody>
</table>
MEDICAL RESOURCES IN THE CLINIC

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 below for full list of medications

MEDICATIONS AVAILABLE IN CLINIC

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Diphenhydramine 25mg capsule Epinephrine (Epi-Pen) 0.3mg syringe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics</td>
<td>Ceftriaxone 250mg and 500mg vial (IM), 500mg premix (IV) Neomycin/Polymyxin/Bacitracin ointment Penicillin G 2.4 million units/4mL</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Aspirin 81mg chewable tablets Aspirin 325mg tablets Atropine sulfate 1mg/mL vial Clonidine 0.1mg, 0.2mg, and 0.6mg tablets Furosemide 20mg tablet Hydralazine 50mg tablet Metoprolol 25mg tablet Nitroglycerin 0.4mg tablet</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Cosyntrropin 0.25mg vial Dextrose 50%, 50mL vials Glucagon 1mg kit vial Glucose 40% gel 31g tube Insulin lispro (Humalog) 100 units/mL Insulin NPH (Humulin N) 100 units/mL Insulin regular (Humulin R) 100 units/mL Methylprednisolone sodium succinate (solu-medrol) Methylpresnisolone acetate (depomedrol)</td>
</tr>
</tbody>
</table>

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Last revised: 29 June 2016
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>Prenisone 20mg tablet&lt;br&gt;Docusate Sodium (Colace) syrup 100mg/10mL&lt;br&gt;Magnesium, aluminum, simethicone&lt;br&gt;Ondansetron ODT 4mg tablet&lt;br&gt;Promethazine 25mg tablet and 25mg/mL</td>
</tr>
<tr>
<td>Hematology</td>
<td>Epoetin Alfa (Procrit) 10,000 units/mL&lt;br&gt;Phytonadione (vitamin K) 5mg tablet</td>
</tr>
<tr>
<td>Pain or anti-inflammatory</td>
<td>Acetaminophen 325mg and 500mg tablets&lt;br&gt;Ibuprofen 200mg tablets&lt;br&gt;Ketorolac 30mg/mL</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Albuterol 2.5mg/3mL inhalation ampule</td>
</tr>
<tr>
<td>Reproductive</td>
<td>Etonogestrel (Nexplanon) 68mg implant&lt;br&gt;Medroxyprogesterone acetate (Depo-Provera)&lt;br&gt;Testosterone cypionate (Depo-testosterone)</td>
</tr>
<tr>
<td>Vaccines</td>
<td>Hepatitis A vaccine&lt;br&gt;Hepatitis B vaccine&lt;br&gt;Human Papillomavirus Quadrivalent (Gardasil)&lt;br&gt;Influenza virus vaccine&lt;br&gt;Pneumococcal 13-valent conjugate (Prevnar)&lt;br&gt;Pneumococcal 23-valent conjugate (Pneumovax)&lt;br&gt;Tetanus, Diphtheria- Td (Decavac) vaccine&lt;br&gt;Tetanus, Diphtheria, Pertussis (Boostrix)</td>
</tr>
</tbody>
</table>
| Miscellaneous           | Ammonia aromatic inhalant 2% ampule<br>Carbamide Peroxide Otic Soln 6.5%
<br>Cyanocobalamin (vitamin B12) 1000mcg/mL<br>Hylan G-F 20 (Synvisc-One) 8mg/mL<br>Lidocaine 1% and 2% injections<br>Lidocaine with epinephrine 1%<br>Silver nitrate applicator stick<br>Silver sulfadiazine cream 25mg tube<br>Thiamine 100mg/mL<br>Triamcinolone acetonide (Kenalog) 40mg/mL<br>Tuberculin PPD skin test |

**MED/PSYCH CONSULTATION**

- **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 who do not have a psychiatrist AND have been hospitalized or seen in the ER psychiatically within the past 3 months
- The following patients should be scheduled during Med/Psych preceptor time (Mon/Tues/Wed PM, Thurs 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 (see below)
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: INITIATING ANTIDEPRESSANT TREATMENT WITH SERTRALINE***

<table>
<thead>
<tr>
<th>Start</th>
<th>Suspected Depression: Administer PHQ-9 (.phq in maestro)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &gt; 9:</td>
<td>TREAT Depression and START Sertraline 50mg Daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 weeks</th>
<th>Tolerating, no Side Effects:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &gt; 9:</td>
<td>INCREASE Sertraline to 100mg daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 weeks</th>
<th>PHQ-9 &gt; 9:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &gt; 9:</td>
<td>INCREASE Sertraline to 200mg daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 weeks</th>
<th>PHQ-9 &gt; 9:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &gt; 9:</td>
<td>CONTINUE Sertraline 200mg daily AND AUGMENT with Bupropion XL (Table 3) OR Mirtazapine (Table 4)</td>
</tr>
</tbody>
</table>

Intolerable side effects:
STOP sertraline AND SWITCH to Venlafaxine XR (Table 2) OR Bupropion XL (Table 3)

**TABLE 2: SWITCHING TO OR AUGMENTING WITH VENLAFAXINE XR**

<table>
<thead>
<tr>
<th>Start</th>
<th>SWITCH to or AUGMENT with Venlafaxine XR 37.5mg daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &lt; 9:</td>
<td>CONTINUE Venlafaxine XR 75mg daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 weeks</th>
<th>Tolerating, no side effects:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &gt; 9:</td>
<td>INCREASE Venlafaxine XR to 75mg daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 weeks</th>
<th>PHQ-9 &gt; 9:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &gt; 9:</td>
<td>INCREASE Venlafaxine XR to 150mg daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 weeks</th>
<th>PHQ-9 &gt; 9:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &gt; 9:</td>
<td>INCREASE Venlafaxine XR to 225mg daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 weeks</th>
<th>PHQ-9 &gt; 9:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If on Venlafaxine Monotherapy:</td>
<td></td>
</tr>
<tr>
<td>CONTINUE Venlafaxine XR 225mg daily AND AUGMENT with Bupropion XL (Table 3) OR Mirtazapine (Table 4)</td>
<td></td>
</tr>
</tbody>
</table>

If on 2 antidepressants:
CONTINUE Venlafaxine XR 225mg daily AND seek psychiatric consultation (Med/Psych SUPERVISION)

Intolerable side effects:
STOP Venlafaxine AND SWITCH to Bupropion XL (Table 3)

**TABLE 3: SWITCHING TO OR AUGMENTING WITH BUPROPION XL**

<table>
<thead>
<tr>
<th>Start</th>
<th>SWITCH to or AUGMENT with Bupropion XL 150mg daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &lt; 9:</td>
<td>CONTINUE Bupropion XL 150mg daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 weeks</th>
<th>Tolerating, no side effects:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &gt; 9:</td>
<td>CONTINUE Bupropion XL 150mg daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 weeks</th>
<th>PHQ-9 &gt; 9:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 &gt; 9:</td>
<td>CONTINUE Bupropion XL 150mg daily</td>
</tr>
</tbody>
</table>

If on Bupropion monotherapy:
STOP Bupropion AND SWITCH to Venlafaxine (Table 2)

If on 2 antidepressants:
STOP Bupropion AND SWITCH to Mirtazapine (Table 4)

*Depending on $4 formularies, other SSRIs such as Fluoxetine or Citalopram can be substituted for Sertraline for uninsured patients.
**INCREASED Bupropion XL to 300mg daily**

CONTINUE Bupropion XL 150mg daily

<table>
<thead>
<tr>
<th>4 weeks</th>
<th>PHQ-9 &gt; 9:</th>
<th>CONTINUE Bupropion XL 300mg daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 weeks</td>
<td>PHQ-9 &lt; 9:</td>
<td>CONTINUE Bupropion XL 300mg daily</td>
</tr>
</tbody>
</table>

If on Bupropion monotherapy:
CONTINUE Bupropion XL 300mg daily AND AUGMENT with Mirtazapine (table 4)

If on 2 antidepressants:
CONTINUE Bupropion XL 300mg daily seek psychiatric consultation (Med/Psych SUPERVISION)

* Bupropion XL can be given as 300mg daily or 150mg BID

**TABLE 4: AUGMENTING WITH MIRTAZAPINE**

<table>
<thead>
<tr>
<th>Start</th>
<th>AUGMENT with Mirtazapine 15mg QHS</th>
<th>Intolerable side effects:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 weeks</td>
<td>Tolerating, no side effects: CONTINUE Mirtazapine 15mg QHS</td>
<td>If augmenting Sertraline or Venlafaxine: STOP Mirtazapine AND SWITCH to Bupropion (Table 3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 weeks</th>
<th>PHQ-9 &gt; 9:</th>
<th>CONTINUE Mirtazapine 15mg QHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 weeks</td>
<td>PHQ-9 &lt; 9:</td>
<td>CONTINUE Mirtazapine 30mg QHS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 weeks</th>
<th>PHQ-9 &gt; 9:</th>
<th>CONTINUE Mirtazapine 45mg QHS AND seek psychiatric consultation (Med/Psych SUPERVISION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 weeks</td>
<td>PHQ-9 &lt; 9:</td>
<td>CONTINUE Mirtazapine 45mg QHS</td>
</tr>
</tbody>
</table>
# CDC Vaccination Timelines

## Figure 1. Recommended adult immunization schedule, by vaccine and age group

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>AGE GROUP</th>
<th>19-21 years</th>
<th>22-26 years</th>
<th>27-49 years</th>
<th>50-59 years</th>
<th>60-64 years</th>
<th>≥ 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>1 dose annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap)</td>
<td>Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>2 Doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Female</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Male</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoster</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td>1 or 2 doses</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (polysaccharide)</td>
<td>1 or 2 doses</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>1 or more doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

Tdap recommended for women if contact with <12 month old child, Either Td or Tdap can be used if no infant contact

No recommendation

## Figure 2. Vaccines that might be indicated for adults based on medical and other indications

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>INDICATION</th>
<th>Pregnancy</th>
<th>Immuno-suppressing conditions (including human immunodeficiency virus [HIV] [CD4+ T lymphocyte count])</th>
<th>HIV infection [HIV] [CD4+ T lymphocyte count] ≤ 200 cells/μL</th>
<th>≥ 200 cells/μL</th>
<th>Men who have sex with men (MSM)</th>
<th>Heart disease, chronic lung disease, chronic anemia</th>
<th>Asplenia* (including splenectomy and persistent complement component deficiencies)</th>
<th>Chronic liver disease</th>
<th>Diabetes, kidney failure, end-stage renal disease, receipt of hemodialysis</th>
<th>Health-care personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>1 dose TIV annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>Contraindicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Female</td>
<td>3 doses through age 26 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Male</td>
<td>3 doses through age 26 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoster</td>
<td>Contraindicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td>1 or 2 doses</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (polysaccharide)</td>
<td>1 or more doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

Contraindicated

No recommendation
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.

The DOC has on-site physical therapy on Thursdays (8am-5pm), 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 Erik Carvalho, PT, DPT (physical therapist at DOC on Thursdays) or Dr. Bowlby (a former practicing PT herself!). For referrals to Erik, just write Erik, PT in the follow-up section of the visit navigator in Maestro. Enter the order “Amb Ref PT” for referrals to UroGyn PT or to Laura Juel, OT for wheelchair or driving evaluation. Erik can see patients regardless of insurance status.

DIABETES- AND HYPERTENSION-RELATED SERVICES AT THE DOC
Consider referring your patient with diabetes or hypertension to:

- Individualized visit with Holly Causey, PharmD, BCACP, CPP, CDE
- Diabetes mellitus group: a multidisciplinary diabetes education and support group that meets at the DOC every other Friday from 1:30-3pm
  - Education from clinical social worker and clinical pharmacist/certified diabetes educator
  - Patients also meet one-on-one with a resident physician, who may make changes to their medication regimen
  - Type “DM group” in the follow-up section of the visit navigator
- Hypertension group: a multidisciplinary hypertension education and support group that meets at the DOC every other Monday from 10-11:30am
  - Education regarding BP goals, diet, monitoring, stress and coping, etc.
  - Patients also meet one-on-one with a pharmacist
  - Type “HTN group” in the follow-up section of the visit navigator
- Endocrinology clinic at DOC
- Ambulatory Referral to Nutrition

Please refer to the next page for a flowsheet on available resources for patients with diabetes.
CLINICAL PHARMACY SERVICES

STAFF
- Clinical pharmacist practitioner Holly Causey (PharmD, BCACP, CPP, CDE)
- 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

REFERRING YOUR PATIENT TO THE PHARMACIST

WHEN
- General medication therapy management (MTM), including medication reconciliation for complex patients
- Diabetes and hypertension group visits
- Diabetes and hypertension individual visits under special circumstances
- Initiation of anticoagulation with warfarin or NOACs
- Patients who have difficulty managing anticoagulation medications
- CII (narcotic) refills for patients on a Controlled Substances Agreement (aka pain contract)
- Smoking cessation counseling

HOW
- In patient instructions, type '.docpharmreferral' to explain the referral and what to bring to the visit.
- To refer to a group visit, type ‘DM group’ or ‘HTN group’ in the follow-up section at the end of the visit

MANAGEMENT OF POTASSIUM:
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

<table>
<thead>
<tr>
<th>Creatinine</th>
<th>Potassium 2.7-2.9</th>
<th>Potassium 3.3-3.4</th>
<th>Potassium 3.5-3.9</th>
<th>Potassium 5.6-5.9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>&lt; 1.5</strong></td>
<td>40 meq bid x 2 days, in addition to current dose. Then long term dose increase of 30 meq’s daily</td>
<td>40 meq bid x 1 day, in addition to current dose. Then long term dose increase of 20 meq’s daily</td>
<td>Consider long term dose increase of 20 meq’s daily</td>
<td>Re-check in 1 week if increasing diuretic</td>
</tr>
<tr>
<td><strong>1.5-2</strong></td>
<td>40 meq bid x 2 days, in addition to current dose. Then long term dose increase of 20 meq’s daily</td>
<td>40 meq bid x 1 day, in addition to current dose. Then long term dose increase of 10 meq’s daily</td>
<td>Long term dose increase of 10 meq’s daily</td>
<td>Re-check in 1 week if increasing diuretic</td>
</tr>
<tr>
<td><strong>2-2.9</strong></td>
<td>40 meq daily x 2 days, in addition to current dose. No long term dose increase</td>
<td>40 meq daily x 1 day, in addition to current dose. No long term dose increase</td>
<td>20meq x 1 day, in addition to current dose. No long term dose increase.</td>
<td>Re-check in 1 week if increasing diuretic</td>
</tr>
<tr>
<td><strong>&gt;3</strong></td>
<td>Notify Attending</td>
<td>Notify Attending</td>
<td>20 meq x 1 day, no increase in chronic dose</td>
<td>Re-check in 1 week if increasing diuretic</td>
</tr>
</tbody>
</table>

Labs should
- Follow up labs 4 days
- Follow up labs 7 days
- Follow up labs 7-10 days
- Follow routine monitoring if no

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

**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 ≥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 ≥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:
  o If patient has 3 no-shows, they are referred back to their PCP for further management
  o 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
## Bridging Warfarin

<table>
<thead>
<tr>
<th>Clotting Risk</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very low</td>
<td></td>
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<td></td>
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<tr>
<td>Low</td>
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<tr>
<td>High</td>
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</table>

### 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 available. 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.

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## Bleeding Risk

<table>
<thead>
<tr>
<th>Very Low Risk of Bleeding</th>
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<tbody>
<tr>
<td>- All dental procedures including multiple extractions</td>
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<tr>
<td>- Skin biopsies</td>
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<tr>
<td>- Skin tag removals</td>
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<tr>
<td>- Cataract extraction</td>
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<tr>
<td>- Mohs Surgery</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Risk of Bleeding</th>
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</thead>
<tbody>
<tr>
<td>- Low risk GYN *</td>
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<tr>
<td>- Low risk ortho (without surgery into a bone)</td>
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<tr>
<td>- Diagnostic endoscopy with no biopsy</td>
</tr>
<tr>
<td>- EGD – no biopsy</td>
</tr>
<tr>
<td>- Flex sig – no biopsy</td>
</tr>
<tr>
<td>- Cysto – no biopsy</td>
</tr>
<tr>
<td>- Colonoscopy without biopsy</td>
</tr>
<tr>
<td>- ERCP without endoscopic sphincterotomy</td>
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<tr>
<td>- Biliary/pancreatic stent without endoscopic sphincterotomy</td>
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<table>
<thead>
<tr>
<th>High Risk of Bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Polypectomy</td>
</tr>
<tr>
<td>- Biliary sphincterotomy</td>
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<tr>
<td>- Pneumatic or bougie dilatation</td>
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<tr>
<td>- PEG placement</td>
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<tr>
<td>- EUS guided FNA</td>
</tr>
<tr>
<td>- Laser ablation and coagulation (GI, urology)</td>
</tr>
<tr>
<td>- Treatment of varices</td>
</tr>
<tr>
<td>- Diagnostic endoscopy or EGD with potential biopsy</td>
</tr>
<tr>
<td>- Cysto with potential biopsy</td>
</tr>
<tr>
<td>- Flex sig or colonoscopy with biopsy</td>
</tr>
<tr>
<td>- Percutaneous image guided aspiration/biopsies</td>
</tr>
<tr>
<td>- Percutaneous image guided drainage procedures</td>
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<tr>
<td>- Other invasive surgeries</td>
</tr>
</tbody>
</table>

* Office procedures, colposcopy, cervical and endometrial bx, LEEP, IUD insertion, I&O, diagnostic hysteroscopy, cystoscopy, endometrial ablation.

**NOTE:** For epidurals or regional anesthetics – discuss with surgery and/or anesthesia. Active cancer patients: discuss with oncology.

## Clotting Risk

<table>
<thead>
<tr>
<th>Low Risk of Clotting</th>
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<tbody>
<tr>
<td>- AF, without prior CVA/TIA or other thromboembolic event</td>
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<table>
<thead>
<tr>
<th>Medium Risk of Clotting</th>
</tr>
</thead>
<tbody>
<tr>
<td>- AF with age &gt;65 and/or DM and/or CAD and/or HTN</td>
</tr>
<tr>
<td>- Mechanical aortic valve in SR without HF, without prior thromboembolism</td>
</tr>
<tr>
<td>- Prior DVT &gt; 3 months ago without other high risk features</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>High Risk of Clotting</th>
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</thead>
<tbody>
<tr>
<td>- AF with prior CVA/TIA</td>
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<tr>
<td>- Heart failure (EF &lt;20%)</td>
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<tr>
<td>- Mitral stenosis</td>
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<tr>
<td>- Biologic (St. Jude) mitral valve with AF or heart failure without prior thromboembolism</td>
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<tr>
<td>- Aortic mechanical heart valve with prior thromboembolism</td>
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<tr>
<td>- DVT/PE &gt; 3 months ago with high risk features</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Very High Risk of Clotting</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Multiple mechanical heart valves</td>
</tr>
<tr>
<td>- Non-bioprosthetic (eg., STARR-Edwards) mechanical heart valves</td>
</tr>
<tr>
<td>- Bioprosthetic (St. Jude) mitral heart valve with AF and heart failure or prior embolism</td>
</tr>
<tr>
<td>- DVT/PE within past month with multiple risk factors</td>
</tr>
</tbody>
</table>
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

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
- 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.
- Call physician line (684-9276) with questions
- PAP delivers 3 months of medications to patient home or Duke Specialty Pharmacy

SENIOR PHARMASSIST
- 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: LONG-TERM SOLUTION FOR PATIENTS WITHOUT INSURANCE
- Refer patient to SW
- Print 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

**DIFFICULTIES GETTING PRESCRIPTION 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 is usually 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

**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/
CARE MANAGEMENT AND ACCESS TO CARE

HOMEBASE CARE
- 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.

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)

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 Sophia Navarro).

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:
  o Health education
  o Coordination of community resources
  o Opioid safety
  o Palliative care
  o Transitions of care for hospitalized Medicare recipients
  o In-home assessments with information relayed back to the referring provider
  o Referral to mental health services
- Contact NPCC (919-620-8034) for more information

NC BREAST AND CERVICAL CANCER CONTROL PROGRAM
- 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:
  o 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.
  o Patient must bring letter of denial
- Services that qualify for financial assistance or financial hardship are limited to:
  o 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.
  o 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.

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 Gay Bonds, the complex care PRM at DUH.

RESOURCES FOR ESSENTIAL DAILY NEEDS
Below are lists of resources for food, shelter, clothing, etc.
- Wake County: http://www.mentalhealthadvocacyinc.org/raleigh-resource-guide

**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

**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
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 and print out Order and Certification for Home Health Services form (i.e., use .DOCHOMEHEALTHFACETOFACEDOCUMENTATION dot-phrase in note or letter). Attending must sign.
3) For Duke Home Care: no additional documentation is needed. Order can be faxed to 919-471-5509/866-209-8370.
   For other agencies: complete referral form for that provider. The form and order are faxed to provider with demographic information (address, phone number, insurance) and H&P.
4) Leave original forms in Partnership folder or place in medical records tray to be scanned into the record (and findable later).

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:
      o 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.
      o 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
      o 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
If any patient needs help connecting to mental health resources, refer to SW for assistance.

CLINICAL SOCIAL WORK STAFF
- Jan Dillard, social worker
- HomeBASE Care Manager (Marigny Manson): 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.

HOW TO REFER TO SOCIAL WORK
- Stop by Jan’s office or send her an InBasket message
- In the body of the message, use .SWDOCSWREFERRAL and complete template
- If you have time and Jan is available, stop by her office to give her a heads-up

SOCIAL WORK DUTIES
- Safety assessments and referrals/reports: SI, HI, domestic violence, abuse/neglect.
- 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.
- Counseling: 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
- Individual and group treatment of mental illness and substance abuse
- 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.
- 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. Home visits with the DOC home visit team
- Discussion of healthcare power of attorney and advanced directives

BEHAVIORAL HEALTH CONSULTANTS
- Who: Ashley Cyr and Joy Long (as well as Jan Dillard)
- 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:
  o Chronic disease management (e.g., hypertension, diabetes, headaches, chronic pain)
  o Wellness (e.g., sleep, healthy eating, smoking cessation)
  o Adjustment to new diagnosis (e.g., STIs, cancer)
  o Dementia, cognitive impairments, I/DD (Intellectual/Developmental Disabilities)
  o Fatigue without medical etiology
  o Socio-emotional problems (e.g., bereavement, marital problems)
  o Parenting and behavioral problems in kids of patients
  o Typical psych complaints (e.g., mood disorders, ADHD, substance abuse, psychosis)
- How to make the behavioral health consult as effective as possible:
  o Identify patient behavior issue
  o Ensure willingness for patient to see BHC
  o Warm handoff – face to face introduction
  o Monitor and support patient progress with tx plan
  o Continue to refer to Jan as usual (see above)
  o If you are not sure whether to refer to BHC, do it anyway and they will sort it out

OTHER MENTAL HEALTH RESOURCES

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
  o 24-hour access for regular and crisis referrals
  o LME refers patient to an appropriate community provider
  o 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 CRISSES
- 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 (e.g., home, school, workplace, doctor’s office, etc.) and/or take them to DRRC.

Contact information for other county teams:

**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
CONTROLLED SUBSTANCES

DOC PREVENT AND INTERVENE NOW (PAIN) GROUP
- Time: Thursdays 1:00-2:00pm
- Leaders: Jan Dillard, LCSW and a chronic pain management specialist
- Who to refer: any patient with chronic pain, especially patients at risk for substance abuse who are being considered for pain contract; patients currently on pain contract; patients who have violated a pain contract; patients who want more information about pain contracts
- How to refer: in ‘follow-up’ section of visit navigator
- Program:
  - 4-weeks on understanding and managing chronic pain
  - 4-weeks on understanding medications and addressing the risks of substance use/abuse related to chronic pain; required for patients who have violated their pain contracts and want to re-establish one

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

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
REINSTALLMENT 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
- Consider long-acting benzodiazepines after discussion with patient and signing a pain contract

URINE DRUG SCREENS

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: Gen Code Commerical Lab O/T ; in the comments: insert Mayo UDS
   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

CONTROLLED SUBSTANCES SCHEDULES
Schedule 1:
• Heroin

Schedule 2:
- Must have written prescription from the provider except in emergency situations
- Opium and opiate, codeine, fentanyl, hydrocodone, hydromorphone, morphine, methadone, oxycodone, oxymorphone,
- Methylphenidate (Ritalin)
- No prescriptions may include refills.
- Patient photo ID required at retail.

Schedule 3:
- Testosterone
- Dronabinol
- Pentobarbital (mixture/preparation/suppository)
- Hydrocodone/APAP (Vicodin)
- Can be written or phoned to pharmacy
- Refills permissible up to 6 months following original Rx written date

Schedule 4:
- Low potential for abuse related to the substances listed in schedule III
- Alprazolam, clonazepam, diazepam, lorazepam, midazolam, Phenobarbital, temazepam,, zolpidem, zaleplon, tramadol
- Buprenorphine
- Can be written or phoned to pharmacy
- Refills permissible up to 6 months following original Rx written date

Schedule 5:
- Low potential for abuse relative to Schedule 4’s.
- Prescriptions/Compounds:
  - Not more than 200 milligrams of codeine or any of its salts per 100 milliliters or per 100 grams.
  - Not more than 100 milligrams of dihydrocodeine or any of its salts per 100 milliliters or per 100 grams.
  - Not more than 100 milligrams of ethylmorphine or any of its salts per 100 milliliters or per 100 grams.
  - Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.
  - Not more than 100 milligrams of opium per 100 milliliters or per 100 grams.
  - Not more than 0.5 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.
- May be sold at retail without a prescription only to a person at least 18 years of age (Rx not needed – example OTC codeine cough syrup)

Schedule 6:
- No currently accepted medical use in the US or low potential for abuse in terms of risk to public health
- Marijuana
- Tetrahydrocannabinols
- Not dispensed; only used for scientific/research purposes

Methamphetamine precursors or pseudoephedrine
- Packaged in blister packs; not loose bottles
- Kept behind pharmacy counter; requires record of disposition (“log”)
- May be sold only to a person at least 18 years of age
- NC law prohibits the purchase of more than 2 packages of certain products containing pseudoephedrine (3.6 grams total), per day and more than 3 packages (9 grams total) of certain products within a 30-day period.
MEDICAL RESOURCES OUTSIDE OF THE CLINIC

DIRECT ADMISSIONS & ED EVALUATIONS

DUKE REGIONAL HOSPITAL
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
Direct admissions: Call the Assistant Chief Resident at DUH (970-1010); otherwise as above.
ED evaluation: Call 684-8111 (Duke); otherwise as above.

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.

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)

PODIATRY
Enter podiatry referral into Maestro as an order.

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

**ALZHEIMER DISEASE SUPPORT**

**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](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](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/](http://www.cancersupport4u.org/)

**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. 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](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
- Jason A Pate DDS PLLC
- Drs. Patterson, Kendell, Frost, Bechtold, and Sacco, PA
- Brent Golden, UNC-Chapel Hill, Maxillofacial Surgeon

OBSTETRICS
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 Manson for one-time follow-up to ensure patient has connected with that clinic.
And for 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.
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. Appt 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 eval.
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 .DOCHOMEORYGEN. 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:

<table>
<thead>
<tr>
<th>#1 At Rest</th>
<th>#2 During Exercise</th>
<th>#3 Overnight (e.g., during sleep study)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td>Patient tested on room air at rest</td>
<td>Patient tested while walking</td>
</tr>
<tr>
<td><strong>Threshold for medical necessity</strong></td>
<td>SpO2 ≤ 88%</td>
<td>All three must be documented: a) SpO2 on room air at rest b) SpO2 on room air</td>
</tr>
<tr>
<td>During exercise – must be ≤ 88%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) SpO2 on oxygen during exercise – must show improvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Notes</th>
<th>If &gt; 88% and you think patient would benefit from O2, go to #2</th>
<th>Will not qualify patient for portable O2.</th>
</tr>
</thead>
</table>

**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.”
DOCTORING FROM HOME (OR THE CCU)

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).
  - If 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.

PATIENT WANTS TO MAKE AN APPOINTMENT
Send inbasket message to front desk to schedule a return appointment (please refer to "How to make an appointment" in the Maestro Care section above).

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

IMPORTANT CONTACT NUMBERS:
DRH ER Triage: 919-470-4000 ext 1
Duke Transfer Center: 919-681-3440
Dr. Bowlby pager: 919-970-4559
Dr. Bowlby cell: 774-991-0041
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. 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/ADVANCE DIRECTIVE (HCPOA) FORMS
These forms may be completed by the patient and signed in front of any notary. Gloria Manley, financial counselor, and Christa Rutledge at the front desk are the notaries for DOC or the patient may use their own. Patient should provide a copy to DOC to be scanned into 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.

LETTERS
If you are asked to write any letter or other correspondence on behalf of a patient, please review it with an attending. This letter should be completed in Maestro (under ‘Communications’) and routed to the Medical Records InBasket (Duke Outpatient Clinic-MOPC MEDICAL RECORDS), and/or directly to Carolyn Lawrence.

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.
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