

Who are we?

Where are we located?

And.....how many of us
are out there?

Lakeshore Family Care

601 W. Savidge
Spring Lake, Michigan 49456
231-672-3100

- **Three Primary Care Physicians**
- **Dr. Paul Haight , D.O.**
- **Dr. Timothy Kval ,D.O.**
- **Dr. Gregory Stempky ,D.O.**

3 Physicians
3 Clinical Employees
4 Clerical Employees
1 Health Coach
1 Midlevel Employee
1 Office Manager

Lakeshore Family Care is part of a Primary Care Network in Muskegon, Michigan. The physician practice network is owned by Trinity Health's Mercy Health Partners Mission Organization. The MHP Primary care Network includes 14 primary care practices, 3 OB/GYN practices, and 1 geriatric specialty practice. The PCN employs 59 primary care physicians, 10 OB/GYN providers and 4 geriatric specialty physicians.

Total Patients in practice 3100

▪**Total Diabetic Patients 300**

Background

The Teamlet (little team) Model of Primary Care as stated by Dr. Thomas Bodenheimer, M. D., suggests that primary care has an obligation to distinguish between acute care and chronic care for the purpose of optimal care.

Acute care is immediate care without life-long treatment. Chronic care on the other hand, is care for a chronic illness that is life-long and requires regular monitoring.

“Teamlet “ can be described as all primary care practices developing a team approach to chronic care. The team for each patient consists of a primary care physician, a clinician and a health coach. In its fullest expression , implementation of the Teamlet encounter involves a pre-visit with the health coach, a visit including both the clinician and the health coach, a post-visit with the health coach.

Our Objectives

- 1.To establish a Teamlet model that conforms to the needs of our practice and its demographics.
- 2.To provide optimal care for all patients in a Patient Centered Medical Home atmosphere.
- 3.To utilize a registry (WellCentive) that updates information on all patients with the capability of “alerting” us to patient needs BEFORE they become a problem.
- 4.Using PDSA’s (Plan, Do, Study, Act) to develop a sound protocol for primary care physicians, medical assistants , clerical staff and health coaches.
- 5.To train all members of our practice in the delivery of this system.
- 6.To become a proactive practice as opposed to a reactive practice.

Transforming
from.....

.....Acute to Chronic
Care

The Basis For Change

The fifteen minute acute care visit is fundamentally flawed in caring for anyone with a chronic health condition.

Why? It is inherently REACTIVE instead of PROACTIVE.

Dr. Thomas Bodenheimer , of Family and Community Medicine, University of California, San Francisco, states “During a fifteen minute visit, primary care physicians cannot provide acute, chronic, and preventive care while building meaningful relationships with their patients and managing multiple diagnoses according to a host of evidence-based guidelines.”

Simply stated, “Research findings show that the central institution of primary care – the 15 minute physician visit – can no longer accomplish what society expects.”

Acute Care (reactive) *Visit*

-How it should work-

- 38 y/o female with UTI symptoms
- No co-morbidities
- Brief history and physical exam
- Check UA dip
- Prescribe meds
- discharge

Acute Care Visit

-Why it really doesn't work-

- 38 y/o female with UTI symptoms.
- With multiple co-morbidities:
 - diabetes, hypertension, hyperlipidemia
- PCP spends time reviewing chart for previous labs, then tries to assess overall health in a more labor intensive history and physical exam.
- Check UA, treat chief complaint and superficially address co-morbidities.

Problems with Acute/Reactive Practice

- Treated the UTI, and...
- Sometimes ordered needed labs (after searching multiple pages for previous labs results), and ...
- occasionally adjusted BP, DM, Cholesterol meds.
- And, spent 10 to 15 extra-minutes doing this.
- BUT, often MISSED opportunities for:
 - *nephropathy screen*
 - *immunization updates (pneumovax, tetanus, flu)*
 - *diabetic foot exam*
 - *referral for annual retinal exam*
 - *referral for diabetic education*
 - *setting self management goals*

What's the point?

More difficult for one person (usually PCP) to collect (find), review and analyze all the data.

Leads to missed opportunities for screening and intervention.

Patients are often not ready to accept new information or interventions that they see as not being pertinent to their chief complaint.

(remember, they were here for a UTI, not diabetes or HTN)

AND, more time spent with these patients backs up lobby wait time.

More directly - this is the point!

- ...Ultimately, this system results in a backed up health care system fraught with bad outcomes (e.g. MI, stroke, renal failure) that we need to *react* to.
- This costs everyone **more money** spent in unplanned, heroic interventions, usually with **worse outcomes** for the patient.

What do we do?

- The challenge is to change from a *reactive* to a ***proactive*** system.
- We want to create a system that is able to follow individual patients with chronic conditions *proactively* to avoid bad outcomes, or at least be able to plan interventions rather than react to them.

Building a Chronic Care (*Proactive*) System

- At its most basic level, the chronic care system is built on regularly scheduled visits for the sole purpose of reviewing and monitoring one or a few, chronic illnesses.
- It also uses the team approach to collect, record, and track data.
- This system is housed in a new clinic referred to as a “**Patient Centered Medical Home**” with its own set of additional, new designs.

Benefits of the Proactive Practice

Team approach to chronic disease care lifts burden off PCP, making them more efficient, decreasing other patients' lobby time (less of a back-up or more access).

Regularly scheduled visits provide the framework to easily and closely monitor chronic illnesses (i.e. checking renal function twice yearly in hypertension and diabetes) with less opportunity to miss essential screening / interventions.

Provides more time for patients and care-givers to discuss chronic illnesses in detail and to start or adjust therapies accordingly.

(remember, now they're here for diabetes, but we can note and address a UTI)

Also, scheduling future labs and visits at the previous visit can reduce wasted, non-reimbursed staff and PCP time.

Empowering Your Patients

1. *Organization*
2. *Tenacity with compassion*
3. *Understanding cultural diversities*
4. *Listen, Listen, Listen – Document, Document, Document*
 - A. *Everything is a clue to reaching your patient*
 - B. *Be inspirational not confrontational*



Clerical, Phones, Greetings, Chart Preparation.



PCP's

Patient
Patient Centered Medical Home

Medical Assistant
Vital Signs, Documentation



Self Management Plan = HC
Referrals = HC, Clerical
Tools & Scheduling = HC
Community Resources = HC
Follow-Up = HC

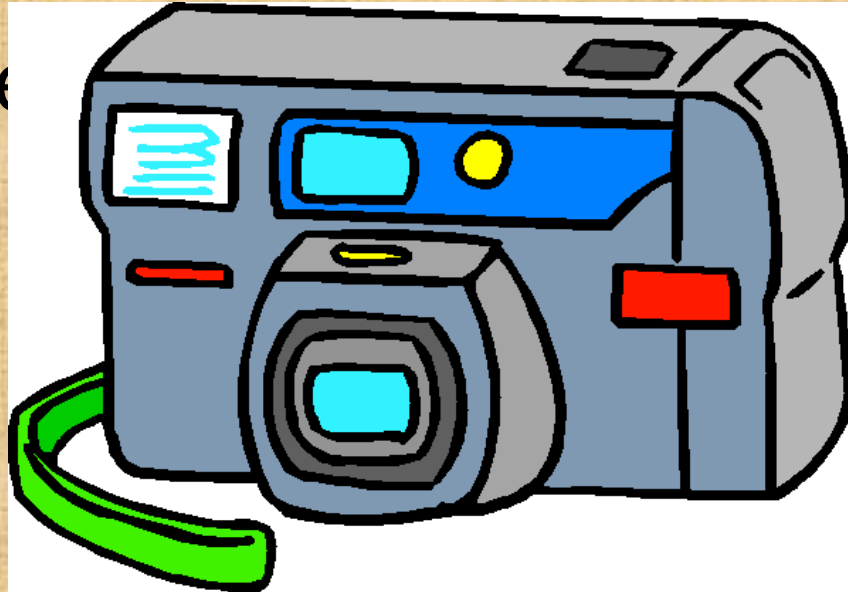
Health Coach



In the beginning...

■

We de



orm

Patient Name: _____ D.O.B. _____ Provider: _____

Date of pre-visits phone call: _____ Phone Number: _____

Notes, comments and agenda for upcoming visit: _____

Appointment Date: _____

A, B, C's

Latest HBA1c _____ Date: _____

Latest Blood Pressure _____ Date: _____

Latest Cholesterol _____ Date: _____

Latest HDL _____ LDL _____ Date: _____

Latest Triglycerides _____ Date: _____

Latest Micro Albumin _____ Date: _____

Immunizations and Appointments:

Last Flu Shot _____

Last Pneumovax Shot _____

Last Tetanus Shot _____

Last Retinal Exam _____

Last Dental Appt _____

DM Ed Class _____

Non-Smoker - Chew Tobacco - Smoker - Amt. _____

LAB FORM – NOCH - Mercy - Patient - Other

Diabetic Foot Exam
With Monofilament
Line



Depression Screening: Over the past two weeks have you often been bothered by:

- 1. Little interest or little pleasure in doing things? YES or NO (Yes to either question, give patient
- 2. Feeling down, depressed or hopeless? YES or NO PHQ9 questions and give to Doctor)

Self-Management Plan and Goals: _____

Health coach Signature: _____ Next Visit: _____ / _____ / _____ Time: _____

Post Call or Follow-up: Date: _____ Time: _____

Review of Meds: _____

Evaluate SMG Successes/Failures/Modifications _____

Health Coach Signature

Pre-Visit Call



Patient Name: _____ D.O.B. _____ Provider: _____

Date of pre-visits phone call: _____ Phone Number: _____

Notes, comments and agenda for upcoming visit: _____

This pre visit call can serve all kinds of purposes. The self-management goals are on the snapshot page and notes concerning the patient, medicines, families and background give you several areas to open a friendly phone visit. Trust and compassion are important. For example: Hi Susan, this is Phil from Dr. Scapal's office, just calling with some reminders. By the way, how is your dog Maggie recovering?



Pre-Visit Call

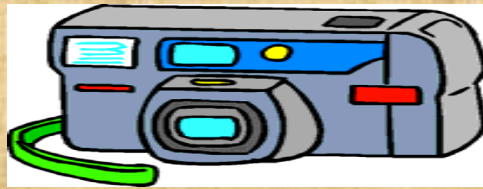


Patient Name: Susan Doereme D.O.B. 1/25/1958 Provider: Dr. Sterile Scaple
Date of pre-visits phone call: August 12th, 2009 Phone Number: 321-555-5555
Notes, comments and agenda for upcoming visit: Called Susan today and asked if she had any needs. She Expressed her medications were up-to-date. She was reminded that she needs fasting blood work done one week prior to her next diabetic visit. We confirmed that her upcoming visit was on the 29th of August @ 9:00 a.m. She was Also reminded to bring in her glucose monitor. A lab order was given to the patient directly.

Health Coach Signature: Philip A. Cappelleri

Typical Chronic Disease Patient Visit

- Patient walks in and is greeted by clerical staff: name, address, insurance and reason for visit are all confirmed. Diabetic patients know they are here for a diabetic visit prior to their appointment.
- Chart is prepared for M.A. by the clerical staff and placed in primary care physician's mailbox.
- M.A. Greets the patient and escorts them to a room.
 - "Rooming takes place" Patient is asked to remove shoes and proceed to scale
 - Patient has height and weight recorded.
 - Patient returns to room and blood pressure, pulse and temperature are taken and recorded.
 - M.A. confirms current medication regiment (medication, dose, frequency, side affects)
 - M.A. informs patient to remove socks for diabetic foot exam with each visit.
 - M.A. informs patient that the Health Coach will be in to see them to discuss their chronic illness, their labs and pre-doctor information.
 - M.A. proceeds to health coach, with chart to inform him/her that the patient is ready.



- The health coach enters the room and greets the patient and any significant others in the room
- Informational and motivational interviewing takes place and is key to a successful visit
- A B C's are discussed from lab results
 - First time visit patient is asked what they know about each value, importance, etc



Appointment Date: _____

Latest HgA1c _____ Date: _____

Latest Blood Pressure _____ Date: _____

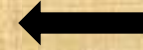
Latest Cholesterol _____ Date: _____

Latest HDL _____ LDL _____ Date: _____

Latest Triglycerides _____ Date: _____

Latest Micro albumin _____ Date: _____

Non-Smoker – Chew Tobacco – Smoker – Amt: _____



Listen

Encourage

Inspire

- The health coach enters the room and greets patient and significant others in the room
- Informational and motivational interviewing takes place and is key to a successful visit
- A B C's are discussed from lab results
- First time visit patient is asked what they know about each value, importance, etc

Appointment Date: August 24th, 2009

Latest HgA1c 7.2 H \downarrow .2 Date: 8/10/09
 Latest Blood Pressure 127/79 C Date: 8/24/09
 Latest Cholesterol 149 C Date: 8/10/09
 Latest HDL 50 LDL 79 Date: 8/10/09
 Latest Triglycerides 130 Date: 8/10/09
 Latest Micro albumin 0.4 Date: 8/10/09
 Non-Smoker – Chew Tobacco – Smoker – Amt: 0



Listen
 Encourage
 Inspire



Immunizations Appointments:

Latest Flu Shot _____

Last Pneumovax Shot _____

Last Tetanus Shot _____

Most Current Retinal Exam _____

Most Current Dental Appt. _____

Diabetic Ed. Class (YES OR NO) _____

LAB FORM – NOCH – MERCY – PATIENT – FAXED

Immunizations Appointments:

Latest Flu Shot 10/12/2008 (due)

Last Pneumovax Shot 04/15/2006

Last Tetanus Shot Undocumented

Most Current Retinal Exam 01/12/2008 (Negative) due

Most Current Dental Appt. Yearly or Bi-yearly

Diabetic Ed. Class (YES) OR NO) 10/18/2005 Refresher
?

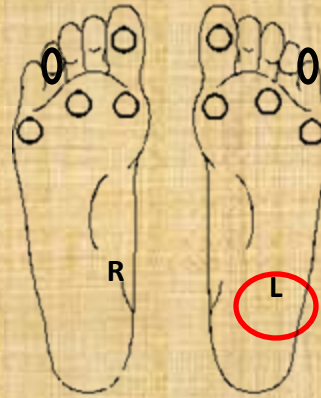
LAB FORM – NOCH – MERCY – PATIENT – FAXED

Diabetic Foot Exam:

With Monofilament Line



*Good sensation in right foot.
Left foot has good sensation in 1st
digit, but no sensation in 5th digit or
pads of left foot.
Pressure sore on heel of Left foot.*



- Means No Feeling
+ Means Feeling

Depression Screening:

PHQ2: Over the past two weeks have you often been bothered by:

1. Little Interest or little pleasure in doing things? YES or NO
2. Feeling down, depressed or hopeless? YES or NO

PHQ9 to follow if there is a positive answer to either of these questions

Self-Management Plan and Goals:

Patient was seen today, and one self management goal was to walk 3 to 5 times weekly for 30 minutes and she is very confident that she will accomplish this task. She also selected counting carbs using a carb counter and cutting her carb in-take in half. She is very confident she can accomplish this task as well. Finally patient has agreed to bring in her glucose monitor with every visit. Her long range goal is to continue losing weight and bring her hemoglobin A1c below 7.0.

Note to me: Post call because patient was told to D.C. lisinopril and add Benicar 40 mg. Patient also was instructed to increase dose of metformin to 1000 mg 2 X daily from current dose of 500 mg 2X daily. Ask how patient is tolerating the change.

Health coach Signature: _____ Next Visit: _____ / _____ / _____ Time: _____

Post Call Follow-Up

Post Call or Follow-up:

Date

Needed or Not Needed

Review of Meds:

Evaluate SMG Successes/Failures/Modifications

Health Coach Signature

If the doctor feels a follow up call is not needed, than only a pre-call would be made prior to patient's next visit.

If the doctor suggests a follow up call is needed, you then begin to scribe why. For example: Hi Susan, during your last visit doctor discontinued Lisinopril and put you on Benicar 40 mg. daily and discontinued your Mevacor and added Lipitor 40 mg daily. How are you doing with those med changes?

Or if the health coach and/or doctor feel the patient is not a good SMG candidate the call can be used just to make sure the patient has a) began a process regarding the goals they set, b) are having success or barriers, and c) if necessary making modifications to help them achieve success. (Listen, listen, listen)

Patient Name: James Borderline D.O.B. 12/25/1919 Provider: Dr. Kval
 Date of pre-visits phone call: 06/25/2009 Phone Number: 100-555-5512
 Notes, comments and agenda for upcoming visit: James needs no medications, was reminded to bring in his glucose monitor and also reminded to get his fasting labs done 1 week prior to his next diabetic visit. He is having no side effects from change of metformin dose.

Appointment Date: August 20th, 2009

A, B, C's		Immunizations and Appointments:						
Latest HBA1c	8.5 \downarrow 3.1	Date:	11/01/2009	Last Flu Shot	10-24-2008	Due		
Latest Blood Pressure	129/79	Date:	11/03/2009	Last Pneumovax Shot	Undocumented			
Latest Cholesterol	180	Date:	11/01/2009	Last Tetanus Shot	8-15-2001			
Latest HDL	45	LDL	88	Date:	11/01/2009	Last Retinal Exam	6-05-2008	Due
Latest Triglycerides	145	Date:	11/01/2009	Last Dental Appt	8-30-2009			
Latest Micro Albumin	0.4	Date:	11/01/2009	DM Ed Class	Scheduled for 11/01/2009			

Non-Smoker - Chew Tobacco Smoker - Amt. 6 cig PD

LAB FORM NOCH - Mercy - Patient - Other

Diabetic Foot Exam
 With Monofilament
 Line



right foot has no sensation on digits or on the pads of the feet. Left foot has good sensations on digits and pads, however the left heel has a pressure sore that needs attention.. Feet are extremely dry.

Depression Screening: Over the past two weeks have you often been bothered by:

1. Little interest or little pleasure in doing things? YES or NO (Yes to either question, give patient
2. Feeling down, depressed or hopeless? YES or NO PHQ9 questions and give to Doctor)

Self-Management Plan and Goals: James has committed to the following self management goals. He will walk 3 to 4 miles 3 times a week and is extremely confident he will accomplish this task. He will cut his carb intake in half and will record the amount of carbs he is eating on a daily basis and is confident that he will accomplish this task. He will get his fasting labs done for the next visit and we will visit his progress at that time.

Health coach Signature: Philip A. Cappelleri Next Visit: 1 / 29 / 2010 Time: 9:30 a.m.

Post Call or Follow-up: Date: 9/20/2009 Time: 11:30 a.m.

Review of Meds: Nothing Needed at this time. Meds are fine and no adverse side effects

Evaluate SMG Successes/Failures/Modifications
James has expressed that he is having great success with the walking but has not documented all the carbs he is consuming. His barrier is at work he often forgets to write down what he is eating then he forgets to record it later. I suggested that he take prepared lunches for the next couple months and that he record them as they are prepared making it unnecessary to do it later. He agreed to do that and we will go over results on next dm. visit. He has lost two pounds and feels better already.

Health Coach Signature Philip A. Cappelleri 09/20/2009

Information documented – all systems go!

- Meet with doctor outside room to provide an up-to-date snap shot of patient condition and address specific needs.
- Return to office and enter vitals (WellCentive)
- Enter care
- Enter immunizations
- Schedule next visit
- Schedule referrals
- Wait for patient and scribe any doctor notes, changes in meds etc.

Doctor or M.A. escorts patient to Health Coach office.

Patient tools:

- Provide Literature
- Provide Community Resources
- Utilize Care Pamphlet
- Confirm all instructions and information.

Wellness Care Plan



*Lakeshore Family Care
610 W. Savidge St.
Spring Lake, Michigan*

*Health Coach - Phil Cappelleri
Office Phone - 231-672-3114
Office Fax - 231-672-3102*

Patient Name: _____

Provider: _____

Diabetes Self Management Pamphlet:

*“Setting a goal and not reaching that goal is not failure.....
.....not trying is failure”*

ACCEPTABLE LEVELS FOR DIABETIC PATIENTS:

Fasting Blood Sugar 70↔100

Blood Pressure <130 / < 80

Hemoglobin A1c <7

Cholesterol <200

LDL < 100

Triglycerides < 150

BLOOD SUGAR TESTING:

- I WILL TEST MY BLOOD SUGAR LEVEL _____(X'S) A DAY EVERY DAY.
- I WILL RECORD MY BLOOD SUGAR LEVELS EVERY DAY FOR TWO WEEKS PRIOR TO MY NEXT APPOINTMENT.
- I WILL TEST MY BLOOD SUGAR LEVELS 2 HOURS AFTER EATING EACH MEAL.
- I WILL TEST MY BLOOD SUGAR BEFORE I GO TO BED AND WHEN I WAKE UP.
- I WILL BRING MY GLUCOSE MONITOR INTO THE DOCTOR'S OFFICE EACH VISIT.

EXERCISE PROGRAM:

- I WILL AEROBICALLY EXERCISE _____ MINUTES A DAY _____ TIMES A WEEK.
WHAT AEROBIC EXERCISE WILL YOU BE DOING? _____
- I WILL SCHEDULE 30 MINUTES _____ (X'S) A WEEK FOR RELAXATION, VISUALIZATION AND STRESS RELIEF.
WHAT ACTIVITY? _____
- I WILL JOIN A FITNESS CLUB AND KEEP UP A REGULAR ROUTINE.
- I WILL USE THE STAIRS INSTEAD OF USING THE ELEVATOR.
- I WILL PARK MY CAR LONG DISTANCES FROM THE ENTRANCES OF STORES, FORCING MYSELF TO WALK MORE.

MEAL PLANNING:

- I WILL NOT SKIP MEALS AND ALWAYS HAVE BREAKFAST.
- I WILL FOLLOW A LOW CARBOHYDRATE EATING PLAN, COUNTING CARBS AND EATING HEALTHY.
- I WILL CONCENTRATE ON SERVING MYSELF "PORTION" SIZE HELPINGS OF FOOD.
- I WILL EAT LOW FA FOODS AND REDUCE MY FAT INTAKE BY ½.
- I WILL PREPARE MY SHOPPING LIST FOLLOWING SOUND NUTRITIONAL GUIDELINES.
- I WILL PURCHASE A DIABETIC RECIPE BOOK AND BEGIN PREPARING SOLELY DIABETICALLY SOUND MEALS.



SET REACHABLE GOALS !!!!!!!

What lies behind us and what lies before us are tiny matters compared to what lies within us”

Ralph Waldo Emerson

WEIGHT LOSS:

- I WILL READ FOOD LABELS TO MAKE SURE I AM MAKING QUALITY FOOD CHOICES TO AID IN MY WEIGHT LOSS
- I WILL KEEP A FOOD CHART TO MAKE SURE MY CALORIE INTAKE IS LESS THAN THE CALORIES I BURN EACH DAY.
- I WILL EXERCISE 4 TO 5 TIMES A WEEK FOR A MINIMUM OF _____ MINUTES PER DAY.
- BASED ON 0 – 10 SCALE, MY CURRENT DAILY ACTIVITY IS _____. I WILL INCREASE THAT ACTIVITY LEVEL TO:_____.



SMOKING:

- I WILL TALK TO MY DOCTOR ABOUT MEDICATIONS, GUM AND OR PATCHES TO HELP WITH MY CRAVINGS BY THIS DATE:_____.
- I WILL OBTAIN A LIST OF SMOKING CESSATION PROGRAMS.
- I WILL ANNOUNCE TO MY FAMILY AND FRIENDS MY QUITTING DATE OF: _____
- I WILL GET RID OF CIGARETTES AND ASHTRAYS AND MAKE MY HOME/CAR ETC., A “NO SMOKING” ZONE AS OF:_____.



PERSONAL COMMITMENTS:

- I WILL TAKE AND COMPLETE A DIABETIC EDUCATION PROGRAM.
- I WILL VISIT MY DOCTOR EVERY THREE MONTHS FOR SUCCESSFUL DIABETIC CARE.
- I WILL GET A DIABETIC EYE EXAM YEARLY.
- I WILL PRINT UP A LIST OF ALL MY MEDICATIONS, INCLUDING NAME , MEDICINE, DOSE AND FREQUENCY.
- I WILL GET A FOOT EXAM EVERY TIME I HAVE A DIABETIC VISIT
- I WILL GET AN ANNUAL DENTAL CHECK-UP
- I WILL GET A TETANUS SHOT (EVERY TEN YEARS)
- I WILL GET A PNEUMOVAX SHOT



NEXT OFFICE APPOINTMENT (S)

Follow up visit appointment: → DATE: _____
TIME: _____ a.m. p.m.

Scheduled diabetic visit: → DATE: _____
TIME: _____ a.m. p.m.

REFFERAL APPOINTMENTS:

- 1) _____
DATE: _____
TIME: _____
- 2) _____
DATE: _____
TIME: _____
- 3) _____
DATE: _____
TIME: _____

NOTES: _____

NEXT OFFICE APPOINTMENT (S)

Follow up visit appointment: → DATE: September 25th, 2009 F U Blood Pressure
TIME: 3:00 a.m. **(p.m.)**

Scheduled diabetic visit: → DATE: December 26th, 2009
TIME: 9:00 **(a.m.)** p.m.

REFFERAL APPOINTMENTS:

- 1) Diabetic Education Class NOCH
15346 Kentwood Ave. Grand Haven DATE: October 15th, 2009
321-555-5555 TIME 9:00 a.m.
- 2) Eye Exam @ Shoreline Eye Clinic
1150 Sherman Ave. DATE: September 12th 2009
321-555-5432 TIME: 2:30 p.m.
- 3) _____
DATE: _____
TIME: _____

NOTES: This is the spot used for the patient or the health coach to copy down the doctors instructions. For example: "Discontinue Lisinopril and start Benicar 40 mg. 1 x daily p.m. Reduce Metformin from 1000 mg 2 x daily to 500 mg. 1 x daily with largest meal. ****Please make sure to get fasting labs done, 1 week prior to next Diabetic Visit.

End of visit.....Here is the tally

Patient wait time in waiting room..typically 0 to 1 min.
Patient time “rooming”typically 3 to 6 min.
Health coach with patient (patient based) 10 to 45 min.

Meeting with doctor outside room typically 1 min.
Doctor in room with patient.....typically 6 to 7 min.
..... 2 min.

Patients don't mind staying in the clinic longer if they're with someone spending productive time (not just sitting in the lobby or the exam room).



Just the Facts In Black and White

Average charge for an office visit	\$ 75.00
Average charge for a cmp	\$111.00
Average charge for a hgA1c	\$ 53.00
Average charge for a lipid profile	<u>\$ 70.00</u>

Average charge for a diabetic office visit with labs: \$309.00

There are and estimated 32 million DIAGNOSED diabetics.

Approximately over 60 percent of those or 19.2 million are not controlled.

Four office visits at \$309.00 = \$1236.00 yearly for each uncontrolled diabetic.

Imagine the savings if we could bring 75% of those 19.2 million diabetics under control

Not to mention.....

.....This year – in April, May, June, July and August

There were, on average , 40 diabetic visits per month to the ER at Mercy/Hackley Hospitals.

The average cost of an ER visit was \$1500.00 per visit

The five month total of actual charges was \$224,000.00.....

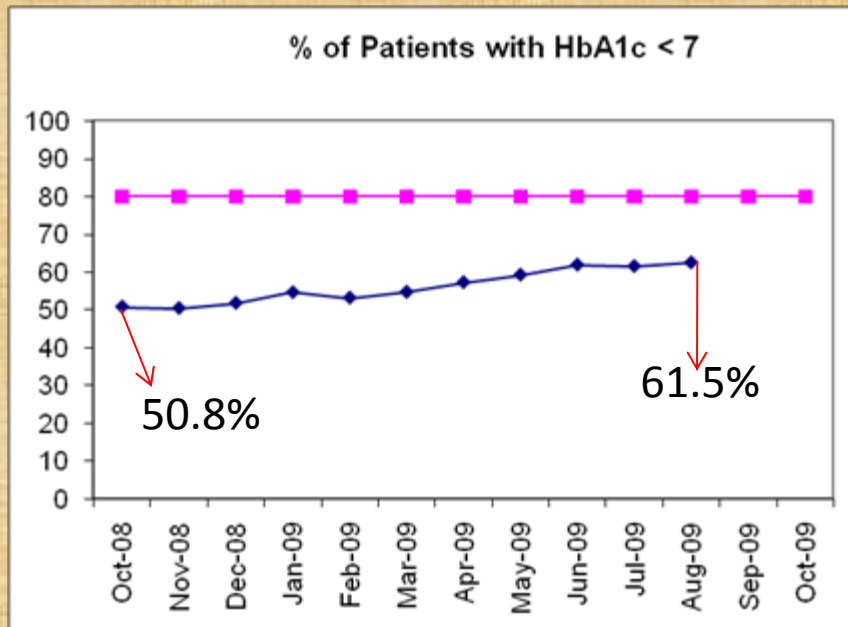
Or \$536,000.00 extrapolated over a twelve month period.

Imagine cutting that number by 75%

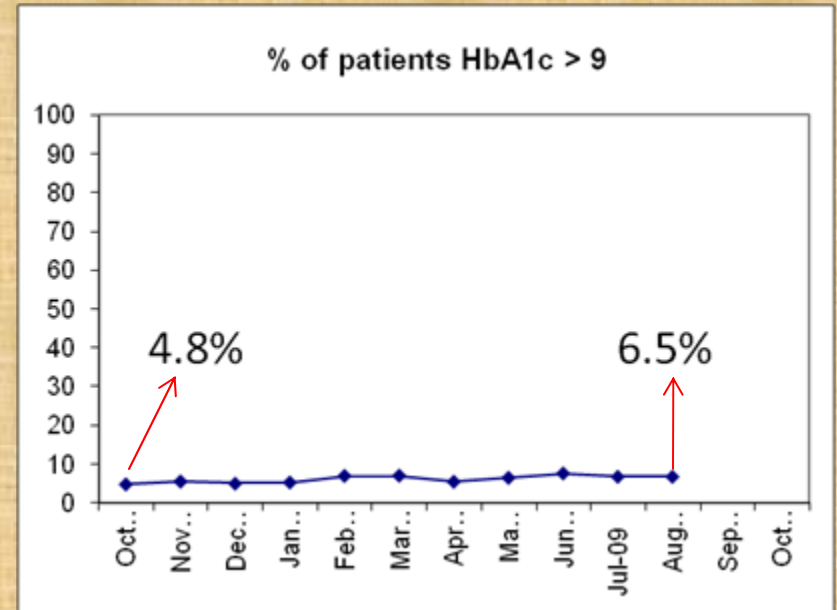
At Lakeshore Family Care,
and Norton Family Care,
and in health coach
programs across the state,
It is our mission.....
And we are having success
reaching those goals!

Proof is in the “puddin”

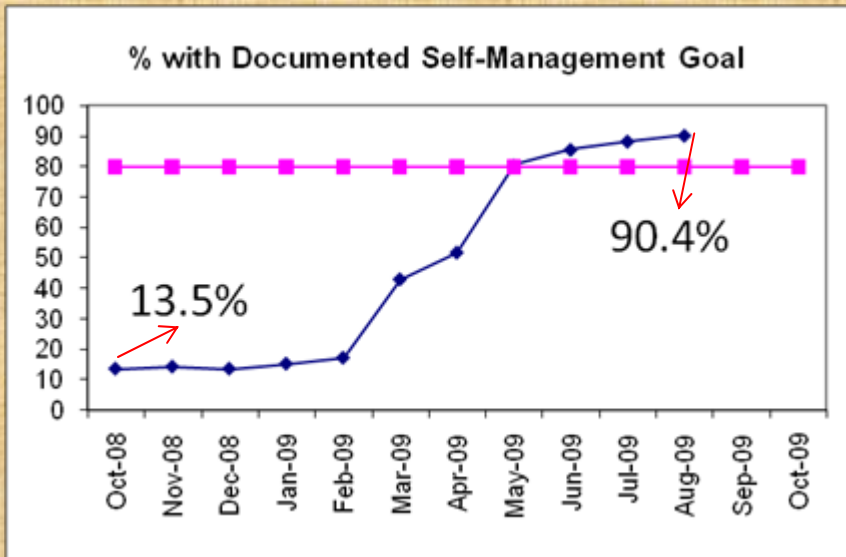
(Or as stated in the clinical world)
Functional and Clinical Outcomes



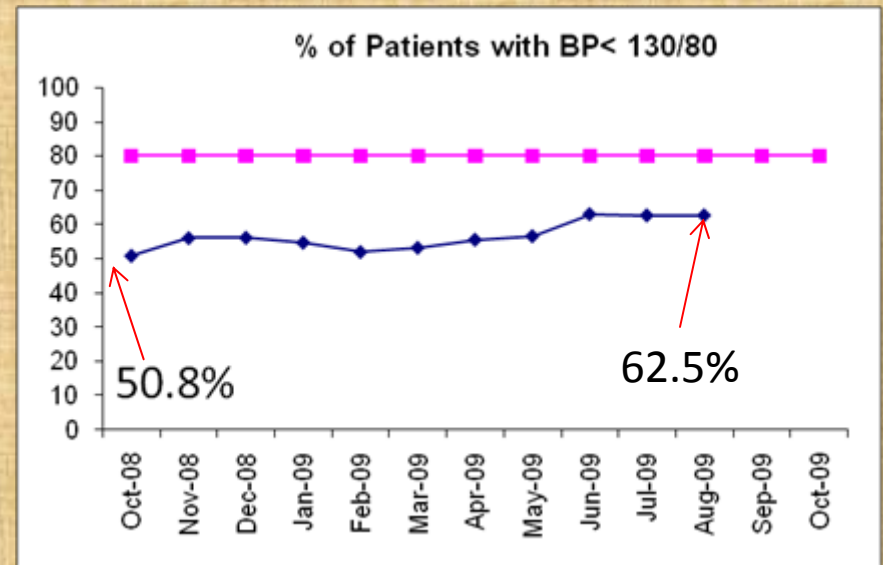
10.7 % Increase



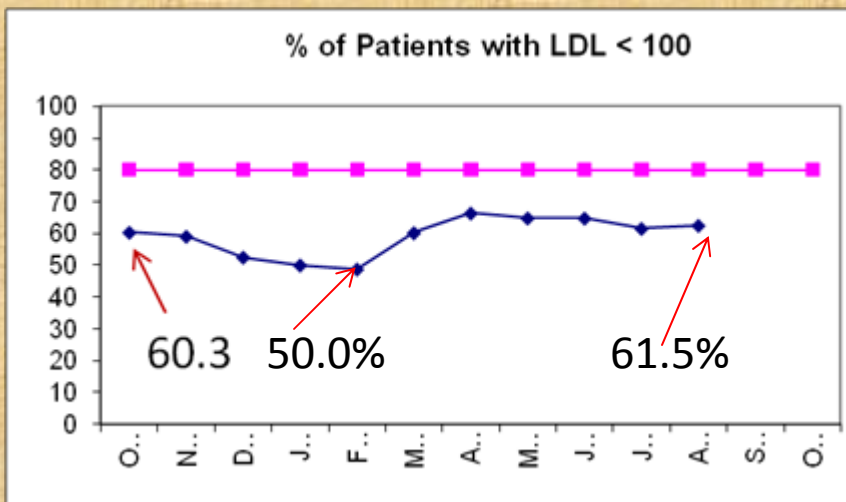
1.7 Increase



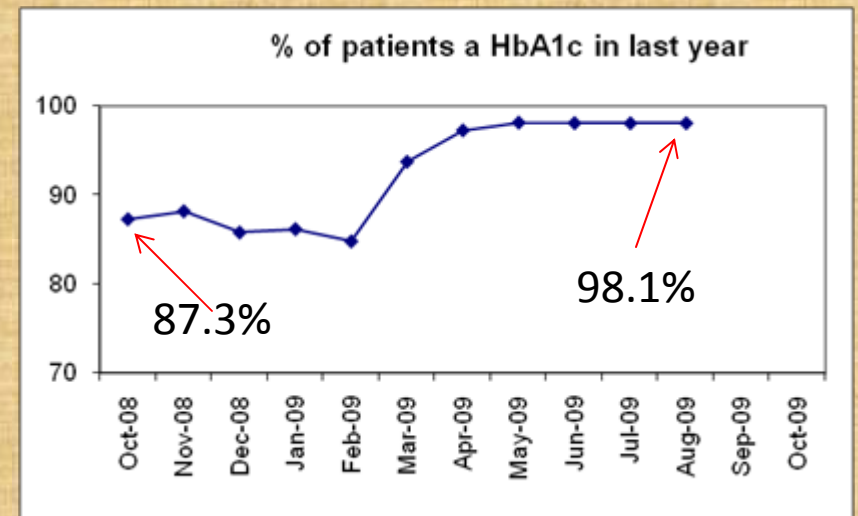
76.9% Increase



11.7% Increase

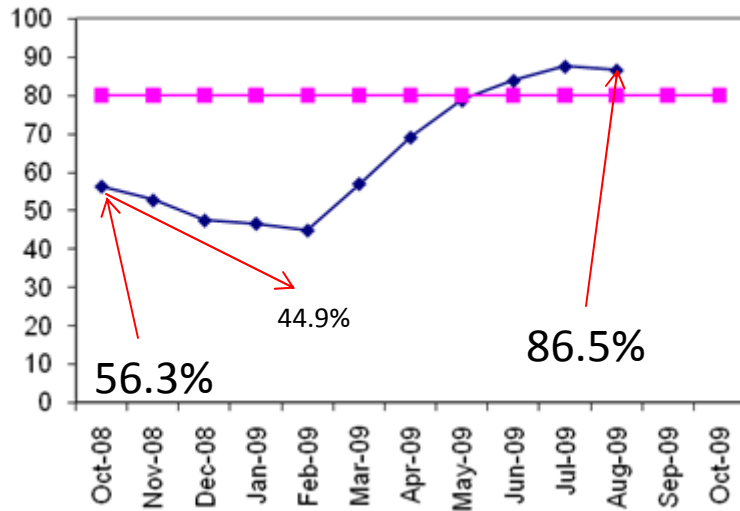


11.5% Increase



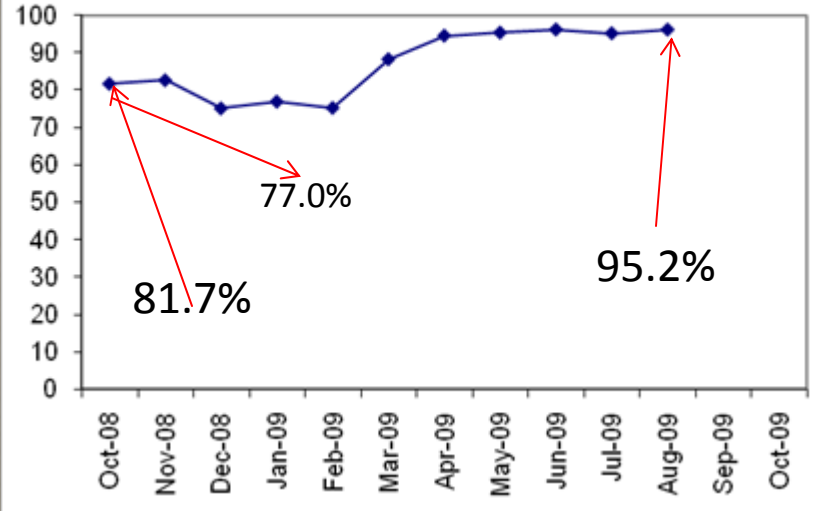
10.8% Increase

% of Patients with Foot Exam



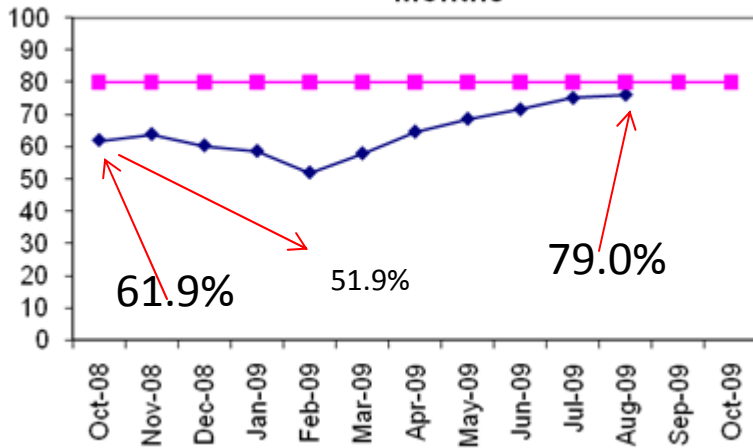
32.2% Increase

% of patients a LDL in last year



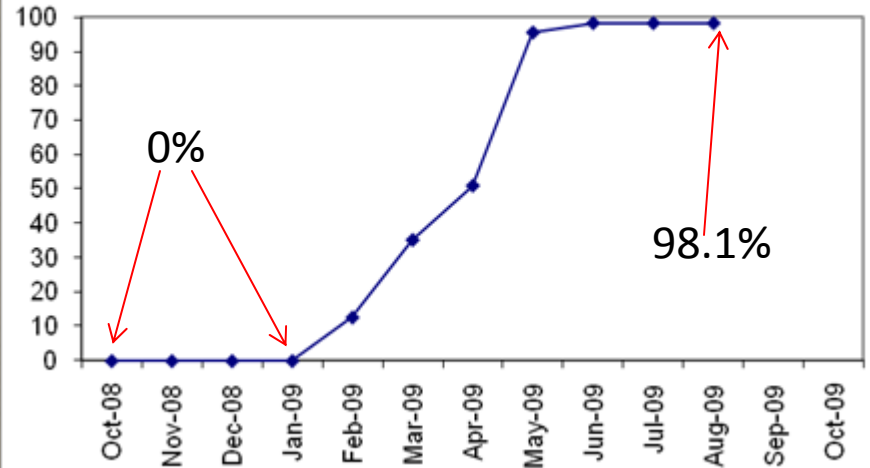
13.5% Increase

% of pts Micro albumin Screen in last 12 months

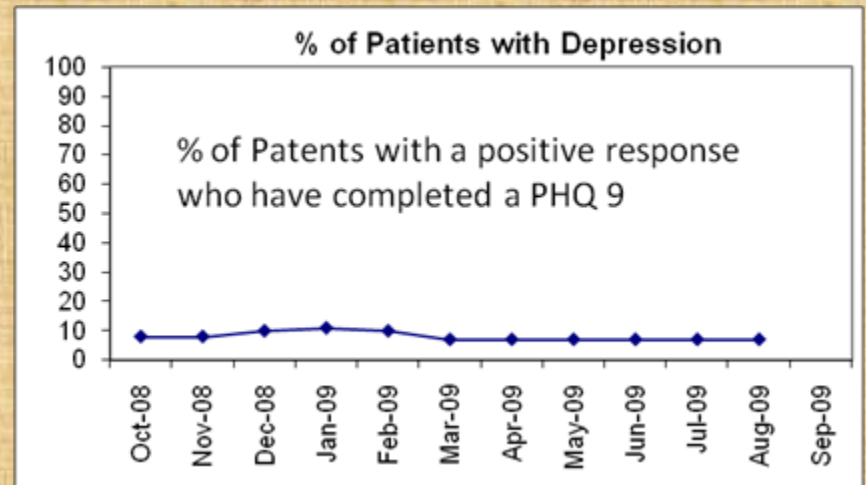
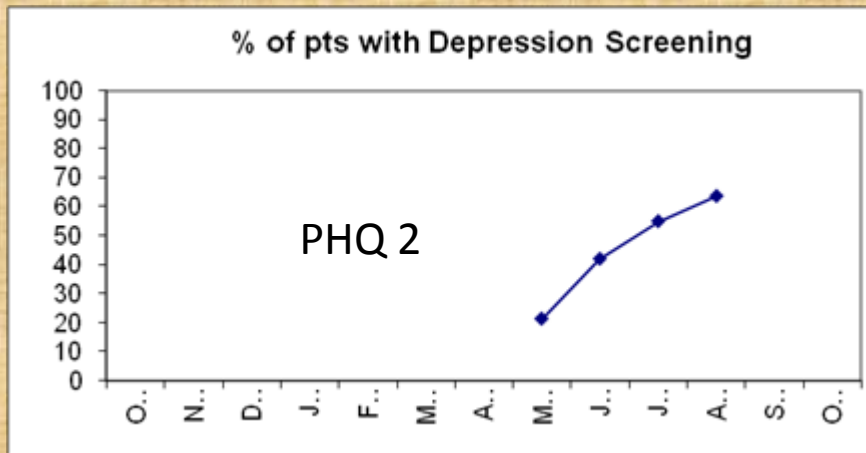


27.1% Increase

% of pts w/ Tobacco Assessment



98.1% Increase

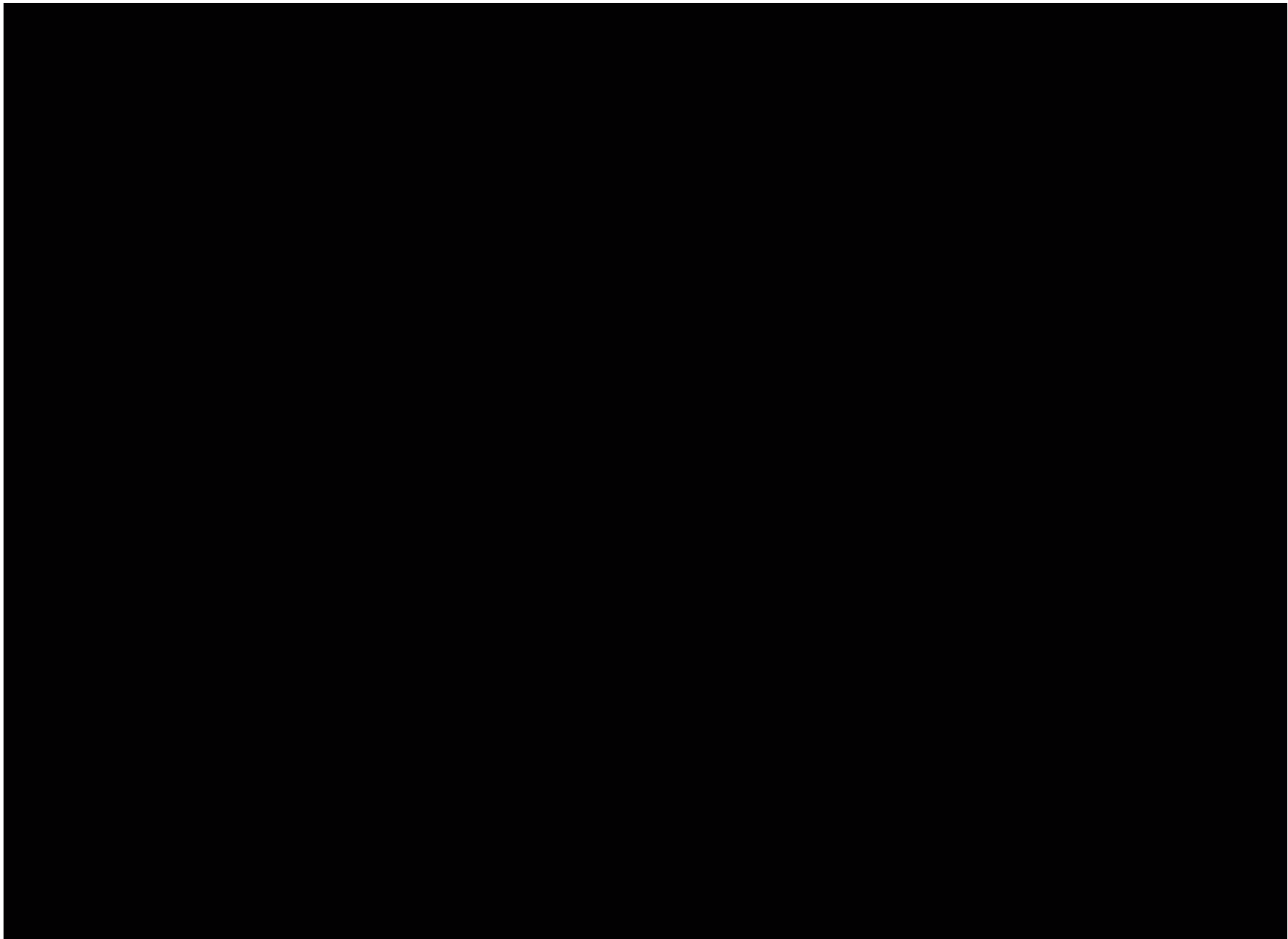


In conclusion:

- ✓ We have streamlined our office visits for diabetic patients.
- ✓ We have provided a consistent tracking program to address success and barriers.
- ✓ The average time spent for patients with our PCP's is 7-8 minutes.
- ✓ The PCP's see more patients each day.
- ✓ The patients have expressed extremely positive comments.
- ✓ Compliance and lab measures have all steadily improved.
- ✓ Diabetic patients spend less and less time with Health Coach as they become less dependent and learn more and more about self-management goals and controlling their chronic illness.
- ✓ The success of the program allows us to now consider incorporating CHF as the next chronic disease to add to the Health Coach population.

Statistical information has affirmed the successful direction of our mission.

The real proof, however, is gauging the positive affect the program has on staff and patient alike.





Questions



Thanks for listening!
Any Questions?