CASE MANAGEMENT TOOLS:
ENGAGING PATIENTS AS PARTNERS IN CARE

September 19, 2017

Chinle Service Unit Diabetes Program
Navajo Area Indian Health Service
Miranda Williams
Krista Haven
CHINLE SERVICE UNIT

Canyon de Chelly, Chinle, AZ

Pinon Health Center

Chinle Comprehensive Healthcare Facility

Tsaile Health Center
CHINLE SERVICE UNIT

- Chinle Service Unit is a federally run Indian Health Service site with 60 bed hospital and 3 ambulatory health care centers.
- Population: Almost 37,000 Native Americans in 17 chapters (communities) in the central part of the Navajo Nation.
- Approximately 180,000 outpatient visits annually.
Chinle has embraced the Patient Centered Medical Home model, including team-based care.

Teams consist of primary care providers, health techs (medical assistants), nurses, health coaches, care managers, Native Medicine, pharmacist, integrated behavioral health team, and dietitian in clinic.

DM clinical interventions (4500+ DM patients)
  - Focused on primary care with complex needs
  - Includes consultation for in-patients, limited ED/Urgent Care
The aim of the Chinle Diabetes Program is to support the well-being of our community through the introduction of education in self-management care to prevent diabetes, manage the progression of diabetes, and address other chronic diseases. Our goal is to enhance the systems of care for the patient while utilizing a consistent cultural approach.
SELF-MANAGEMENT

- Patient’s health largely depends on their own behaviors
  - Lifestyle issues (diet, exercise, and sleep), taking medications, checking home blood sugars, getting preventive screenings, foot and eye exams, immunizations, and tobacco/alcohol cessation

- Ultimately, patients have to take care of themselves: SELF-MANAGEMENT

- Health care personnel can provide support (SMS), education (SME)

- In our program we have added health coaching which supports lifelong learning
AADE SELF-CARE BEHAVIORS

- Being Active
- Healthy Coping
- Healthy Eating
- Monitoring
- Problem Solving
- Reducing Risks
- Taking medications
TOOLS

- Provide diabetes education using motivational interviewing strategies: Ask, Tell Ask, Brainstorming, Teach Back, Brief Action planning
- Enhance understanding by addressing language and health literacy barriers
- Provide culturally sensitive communication
  - Certified Navajo interpreters
- Promote shared decision making and collaborative relationship with providers
DIABETES HEALTH COACHES: PRIMARY ROLES

- Help patients change behavior (SMS and SME)
  - Understanding readiness for change
  - Recognizing and addressing behavioral barriers
  - Teaching skills of problem solving, realistic goal setting and action planning
  - Utilizing Healthy Heart, Balancing Your Life in Diabetes, Lifestyle Balance curriculum
- Provide care coordination and follow-up
## CASE MANAGEMENT

<table>
<thead>
<tr>
<th>Case Management:</th>
<th>Goal:</th>
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<tbody>
<tr>
<td>Pre-DM Patients</td>
<td>Educate pre-DM patients with handouts and Wellness Center and nutrition referrals</td>
</tr>
<tr>
<td>Newly Diagnosed DM patients</td>
<td>Engage new DM patients in care, support their personal journey with DM, educate them about DM and its management (AADE self-care behaviors), and treat with lifestyle interventions and medications</td>
</tr>
</tbody>
</table>
| Primary Care – DM patients with an A1C, B/P, or Statin Use | Goals:  
A1C below 8  
Blood pressure below 140/90  
Statin Use for patients that have risk factors and/or >40  
To decrease cardiovascular risk |
| Inpatient - DM Patients                               | Influence patients to use their care teams for follow-up and introduce Diabetes team       |
| ER/UC – DM patients                                   | Influence patients to use their care teams for care and introductions to DM team           |
| Case Management of High risk, High cost patients (eg, A1C>11, alcohol abuse, frequent hospitalizations) | Determine what are the behavior barriers/drivers that cause patients to be high risk, then intervene, utilizing intensive case management for 3 months.  
Bahozhoo care model |
PATIENT STORY

- 83 year old male with diabetes and recent hospitalization and skilled nursing facility
- Admission for NSTEMI and new systolic heart failure (both high risk conditions for readmission)
- Discharge on 11 daily meds, most new to patient, three not on Chinle formulary
- Has a new medical equipment need (nebulizer)
- Presents with new dizziness that he thinks is medication related
- Provider playing catch up, risk for patient being confused, many unanswered questions regarding what the patient needs

What can we do differently to improve care to complex patients?
“THIS CARE IS DIFFERENT”
HOW WE HOPE PATIENTS TALK ABOUT THEIR EXPERIENCE

- There is a team helping me and they all seem to know what they’re doing
- They care about me and what I want
- They are easy to get a hold of
- My appointments are better – things really get done
- They’ve taught me so that I can now really take care of myself
- They helped me get through one of the hardest periods of my life
- I am on more meds but I understand them better
- They listen
- I feel better
## Tools for Case Management of Complex High Risk Patients

<table>
<thead>
<tr>
<th>Scale-up Challenges</th>
<th>Ideas to Overcome the Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>Identified case manager and coach to develop and test enhanced care model – new roles</td>
</tr>
<tr>
<td>Space</td>
<td>Identified a room in which to provide enhanced care model</td>
</tr>
<tr>
<td>Training</td>
<td>Identified case management and coaching training for team</td>
</tr>
<tr>
<td>Risk/need assessment forms</td>
<td>Identifying assessment tools for risk stratification and to identify needs/barriers</td>
</tr>
<tr>
<td>Care coordination with outside hospital</td>
<td>Partnering with inpatient case managers to develop process for assessment and care planning before discharge</td>
</tr>
<tr>
<td>Case management documentation</td>
<td>Building templates for assessment and care plans to assure consistency</td>
</tr>
</tbody>
</table>
INTERVENTION

- Key principles:
  - Use of Patient Activation Measure (PAM) – concept/measurement of increasing activation in self-managed care
  - Patient centeredness – challenge always!
  - Broad view of health – beyond medical (biopsychosocial) and with attention to traumatic life experiences/lifecycle, home assessment
  - Team care – coordination, training up of staff (not traditional assembly line), physical space critical (team rooms)
  - Complex care – with excellent primary care access and stronger coordination of specialty input, availability to patient
    - Fast appointments and ID card for patients
    - Flag in the EHR if the patient is in the hospital – call the BHLC team
  - Risk stratification of patients with assessment tool
## INTERVENTION

<table>
<thead>
<tr>
<th>Activity/Staff Member</th>
<th>Hospital</th>
<th>Home Visit</th>
<th>Visit #1</th>
<th>4-6 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity/Staff Member</strong></td>
<td>* Contact with hospital staff for risk assessment – nurse case manager * Contact with patient to introduce our awareness of hospitalization and the program</td>
<td><strong>Public Health Nurse/Health Coach</strong></td>
<td>Health coach to coordinate care with the case manager and update care plan</td>
<td><strong>4-6 weeks</strong></td>
</tr>
<tr>
<td><strong>Clinical Assessment and activity</strong></td>
<td>* Severity and appropriateness for BHLC * Key elements of medical record to PCP (admit, specialist consultation, key tests, discharge summary)</td>
<td>Assess home environment, self-management, introduce the program, identify key questions or issues for Visit #1, and build rapport</td>
<td>* Update medication list * Order medical equipment * Internal and external referrals * Assess patient goals and barriers</td>
<td>Select primary DOMAINS area Identify patient goal</td>
</tr>
</tbody>
</table>
BAA HÓZHÓPROCESS

Patient admitted to outside hospital

Nurse care coordinator and hospital case manager learn patient needs

Care plan made with patient before discharge

Early contact with team after discharge through home visit or clinic visit

Follow up by phone call, clinic visit or home visit by patient preference and complexity

Motivational interviewing and brief action planning used to help patient reach goals

Patient priorities determine care plan at each visit and documented in EHR

Holistic assessment of patient needs and barriers using standard tools

Patient has regular appointments – as frequent/seldom as needed

Coach and case manager are accessible to patients between visits

Referrals to additional needed services coordinated

Care plan tracked to assure goals are met
Your Care Team
Matthew Werito, Health Coach
Phone: 928-674-7896
Email: matthew.werito@ihs.gov

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

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

Chinle Comprehensive Healthcare Facility
Drawer PH
Chinle, AZ 86503

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

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

https://phr.ihs.gov
Empowering Patients
Transforming care

Our goal is to hear you say

"There is a team helping me and they all seem to know what they’re doing”

"They care about me and what I want”

"They are easy to get a hold of”

"My appointments are better – things really get done”

"They’ve taught me so that I can now really take care of myself”

"They listen”

"I feel better”

What does your Team do for you

Nurse Care Coordinator

♦ Communicates with outside hospital case managers to develop your care plan
♦ Provides care coordination for complex issues
♦ Assure that your wishes and your care plans are carried out.

Health Coach

♦ Engages you as partner in managing your own health
♦ Develops care plans with you
♦ Helps you navigate the healthcare system to get what you need
♦ Available to you if issues to address

Questions

Call us:

Have any questions about medications, instructions, equipment

Need medication refills

Appointments with your Provider

Dressing supplies

Medical equipment

Referral for therapy, Specialists, etc.
## NAH Care Management Screening Tool

### Socio-Economic

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Points</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>Financially Solvent</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>No Expendable Resources/Uninsured</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Low Income</td>
<td>1</td>
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</table>

1=Public Assistance Dependent; 2=No Public Assistance

### Educational Level (Poor Health Literacy)

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Points</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>High School Graduate or Above</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>Some High School or GED</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>&lt;8th Grade</td>
<td>1</td>
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</table>

Cognitive Functioning
0=No Impairment; 1=Minimal to Moderate Impairment; 2=Severe Impairment

### Medications & Medical Health (Polypharmacy/Problem Medications & Problem Do)

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No medication assistance needed or 0-2 meds</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>Some medication assistance needed or 3-4 meds</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Extensive medication assistance needed or &gt;5 meds</td>
<td>1</td>
</tr>
</tbody>
</table>

Add 1 point for each chronic disease
- Heart Disease
- Hypertension
- Pneumonia
- TKA/THA (post op)
- CAD (post op)
- Diabetes
- Dementia
- Lung Disease
- Current Tobacco Use
- Chronic Pain
- Congestive Heart Failure
- Kidney Disease
- Cancer
- Obesity
- Stroke
- Pneumatic Pneumonia
- ED visits (25 in last 6 months)
- Readmission w/146 (2 pts)
- Readmission w/105 (1pt)
- Other:
- Other:

Add 1 point for each category of medication
- Anti-coagulants
- Insulin

### Mental Health (Psychological/Psychiatric)

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Points</th>
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<tr>
<td>0</td>
<td>No mental health history</td>
<td>1</td>
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<tr>
<td>1</td>
<td>Past mental health history</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Current mental health and/or current ETCH/drug abuse history</td>
<td>1</td>
</tr>
</tbody>
</table>

1=With Treatment; 2=No Treatment

### Total Score

0 = Full Cooperation
1 = Limited Cooperation (Provide Health Engagement Survey)
2 = Uncooperative (Provide Health Engagement Survey)

### Adherence Potential

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Points</th>
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<tbody>
<tr>
<td>0</td>
<td>0-1</td>
<td>1</td>
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<tr>
<td>1</td>
<td>2-3</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>&gt;5</td>
<td>1</td>
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</table>

1=Low Risk; 2=High Risk

### Psychosocial Stressors

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Points</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>Personal Injury/Illness</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>Insurance Issues</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Relating to God</td>
<td>1</td>
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</table>

### Support (Physical Limitations)

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No assistance needed</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>Some degree of assistance needed</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Extensive assistance needed</td>
<td>1</td>
</tr>
</tbody>
</table>

1=Limited Support; 2=No Support or Lives Alone

### Final Score

LOW 0-15
MEDIUM 16-20
HIGH ≥21

02-17-2016
# NEMT PROVIDERS

## Service Address and Phone Numbers for All Active NEMT Providers

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Street Line 1</th>
<th>Street Line 2</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Business Phone Number</th>
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</thead>
<tbody>
<tr>
<td>1ST CLASS SHUTTLE EXPRESS</td>
<td>STE. # 204</td>
<td>2450 S. 4TH AVE.</td>
<td>YUMA</td>
<td>AZ</td>
<td>85364</td>
<td>(928) 373-2527</td>
</tr>
<tr>
<td>24, 7 AMBULATORY SERVICES</td>
<td>4717 W CALATRAVA LN</td>
<td>PO BOX 3994</td>
<td>TUCSON</td>
<td>AZ</td>
<td>85742</td>
<td>(520) 838-4277</td>
</tr>
<tr>
<td>3TURKEY INGENUITY</td>
<td>HWY 191, OAK #12</td>
<td>9324 E RAIN TREE DR</td>
<td>CHINLE</td>
<td>AZ</td>
<td>86503</td>
<td>(928) 714-8495</td>
</tr>
<tr>
<td>A &amp; N SERVICES, LLC</td>
<td>SUITE 110</td>
<td>1614 N. FIRST STREET</td>
<td>SCOTTSDALE</td>
<td>AZ</td>
<td>85260</td>
<td>(480) 634-5965</td>
</tr>
<tr>
<td>A FRIENDLY CAB, LLC</td>
<td>SUITE # 308</td>
<td>1921 S ALMA SCHOOL RD</td>
<td>FLAGSTAFF</td>
<td>AZ</td>
<td>85004</td>
<td>(928) 774-4444</td>
</tr>
<tr>
<td>A HELPING HAND TRANS</td>
<td>SUITE # 114</td>
<td>2942 N 24TH ST</td>
<td>MESA</td>
<td>AZ</td>
<td>85210</td>
<td>(480) 374-0361</td>
</tr>
<tr>
<td>A MAN TRAN</td>
<td>2476 W. CEZANNE CIRCLE</td>
<td>2020 E BROADWAY RD # 131</td>
<td>TUCSON</td>
<td>AZ</td>
<td>85741</td>
<td>(520) 327-3714</td>
</tr>
<tr>
<td>A PLUS MEDICAL TRANSPORT</td>
<td>SUITE D220G</td>
<td>11225 N. 28TH DR</td>
<td>PHOENIX</td>
<td>AZ</td>
<td>85004</td>
<td>(480) 966-8377</td>
</tr>
<tr>
<td>A.R.T. Medical Trans</td>
<td>SUITE # 103</td>
<td>2501 E HAZELWOOD ST</td>
<td>PHOENIX</td>
<td>AZ</td>
<td>85016</td>
<td>(480) 326-2165</td>
</tr>
<tr>
<td>ACCURATE MEDICAL TRANSPORT</td>
<td>13 OR 6191</td>
<td>2885 PAPEETE DR</td>
<td>PHOENIX</td>
<td>AZ</td>
<td>85016</td>
<td>(480) 300-0544</td>
</tr>
<tr>
<td>ALLSTATE MED LLC</td>
<td>SUITE D220G</td>
<td>630 N FRESCO ST</td>
<td>PHOENIX</td>
<td>AZ</td>
<td>85025</td>
<td>(602) 336-0000</td>
</tr>
<tr>
<td>ALRAHMA CARE TRANSPORT</td>
<td>1760 W 36TH ST</td>
<td>1401 S. 6TH AVE.</td>
<td>PHOENIX</td>
<td>AZ</td>
<td>85225</td>
<td>(602) 357-9916</td>
</tr>
<tr>
<td>AMERICAN CAB</td>
<td>SUITE # 312</td>
<td>4040 E MCDOWELL RD</td>
<td>PHOENIX</td>
<td>AZ</td>
<td>85016</td>
<td>(602) 357-9916</td>
</tr>
<tr>
<td>AMORE SHUTTLE &amp; SEDAN SRV</td>
<td>13 OR 6191</td>
<td>2885 PAPEETE DR</td>
<td>TUCSON</td>
<td>AZ</td>
<td>85004</td>
<td>(480) 966-8377</td>
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<tr>
<td>ANDERSON TRANSPORT</td>
<td>13 OR 6191</td>
<td>2885 PAPEETE DR</td>
<td>TUCSON</td>
<td>AZ</td>
<td>85004</td>
<td>(480) 966-8377</td>
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<tr>
<td>APACHE TAXI LLC</td>
<td>2501 E HAZELWOOD ST</td>
<td>PHOENIX</td>
<td>KIRTLAND</td>
<td>NM</td>
<td>87417</td>
<td>(505) 592-9540</td>
</tr>
<tr>
<td>ARIZONA MEDICAL TRANSIT</td>
<td>SUITE D220G</td>
<td>6450 E GOLF LINKS RD</td>
<td>TEMPE</td>
<td>AZ</td>
<td>85221</td>
<td>(480) 804-1166</td>
</tr>
<tr>
<td>ARIZONA SENIOR TRANSPORT</td>
<td>SUITE D220G</td>
<td>6450 E GOLF LINKS RD</td>
<td>TUCSON</td>
<td>AZ</td>
<td>85792</td>
<td>(520) 792-0944</td>
</tr>
<tr>
<td>ARROW TRANSPORT, LLC</td>
<td>HWY 264</td>
<td>1 MAIN STREET</td>
<td>HOTELLLA</td>
<td>AZ</td>
<td>85364</td>
<td>(928) 373-2527</td>
</tr>
<tr>
<td>ARROWHEAD COMMUNITY TRANS</td>
<td>HWY 264</td>
<td>1 MAIN STREET</td>
<td>CHANDLER</td>
<td>AZ</td>
<td>85224</td>
<td>(928) 266-1275</td>
</tr>
<tr>
<td>ASSISTED LIVING MINGT</td>
<td>SUITE 103</td>
<td>14807 N 73RD ST.</td>
<td>SCOTTSDALE</td>
<td>AZ</td>
<td>85260</td>
<td>(480) 922-3299</td>
</tr>
<tr>
<td>AZ EZ RIDE LLC</td>
<td>7450 N. THORNTWOOD RD.</td>
<td>14807 N 73RD ST.</td>
<td>TUCSON</td>
<td>AZ</td>
<td>85741</td>
<td>(520) 579-7652</td>
</tr>
<tr>
<td>AZ HARMONY MEDICAL TRANSPORT</td>
<td>2310 W MEGAN ST</td>
<td>1921 S ALMA SCHOOL RD</td>
<td>CHANDLER</td>
<td>AZ</td>
<td>85004</td>
<td>(928) 774-4444</td>
</tr>
<tr>
<td>AZ MED TRANSPORTATION</td>
<td>STE 101</td>
<td>1921 S ALMA SCHOOL RD</td>
<td>TONALEA</td>
<td>AZ</td>
<td>85004</td>
<td>(928) 209-6986</td>
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<tr>
<td>B.E.S.T. TRANSPORTERS,</td>
<td>MILE POST 358 HWY 160</td>
<td>1 MILE SOUTH</td>
<td>TONALEA</td>
<td>AZ</td>
<td>85004</td>
<td>(928) 209-6986</td>
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# Medical Home Teams

<table>
<thead>
<tr>
<th>Department</th>
<th>Team</th>
<th>Care Coordinator</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>Sage</td>
<td>Betty Standford, LPN P (928) 674-7895 F (928) 674-7701</td>
<td>David Goldberg, MD Nurit Harari, MD Lawrence Gau, MD Britney Click, NP</td>
</tr>
<tr>
<td></td>
<td>Yucca</td>
<td>Freddie Brown, RN P (928) 674-7773 F (928) 674-7701</td>
<td>Sayumi De Silva, MD Andrea Cuff, NP Jacqueline Salig, ANP Steven Williams, MD Regina Szczesniak, MD Abdul Jall, MD Ronny Santosa, MD</td>
</tr>
<tr>
<td>Family Practice</td>
<td>Cedar</td>
<td>Henry Samson, RN P (928) 674-7898 F (928) 674-7702</td>
<td>Gail Ratko, FNP John Tisdale, MD Joseph Salay, MD MaryClaire O’Neill, MD</td>
</tr>
<tr>
<td></td>
<td>Juniper</td>
<td>Yvonne Harp LPN P (928) 674-7749 F (928) 674-7702</td>
<td>Andrew Baker, MD Victoria Rose, MD Jessica Weeks, MD Stephen Neal, MD</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Morning Mist</td>
<td>Caphia J., RN P (928) 674-7405 F (928) 674-7458</td>
<td>Joseph Salay, MD William Flood, MD</td>
</tr>
<tr>
<td></td>
<td>Sunbeam</td>
<td>Keithetia C., RN P (928) 674-7066 F (928) 674-7458</td>
<td>Annie Moon, CPNP Brandon Ko, PNP Jill Moses, MD, MHP Nurit Harari, MD John Tisdale, MD</td>
</tr>
<tr>
<td></td>
<td>Rainbow</td>
<td>Jay A., RN P (928) 674-7840 F (928) 674-7458</td>
<td>Sayumi DeSilva, MD Robert Solomon, MD M. Colgan, MD</td>
</tr>
</tbody>
</table>

In the event that a Care Coordinator cannot be contacted, in Tsailie please call Dorothea Begaye, SCN at (928) 724-3679.

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<thead>
<tr>
<th>Department</th>
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<td>Family Practice/</td>
<td>White Corn</td>
<td>Velma Colbert, RN P (928) 725-9735 F (928) 725-9546</td>
<td>Judy Brown, PA Kati Padilla, FNP</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Blue Corn</td>
<td>Gena Shorty, RN P (928) 725-9743 F (928) 725-9546</td>
<td>Donald McLaren, MD</td>
</tr>
<tr>
<td>Adult/</td>
<td>Yellow Corn</td>
<td>Elizabeth Klein, RN P (928) 725-9608 F (928) 725-9546</td>
<td>Bowman Tzeng MD Theresa Lupton, FNP</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>Red Willow</td>
<td>Mandy Lopez, RN P (928) 725-9599 F (928) 725-9546</td>
<td>Sean Meade, MD Kristen Burholder, MD</td>
</tr>
</tbody>
</table>

In the event that a Care Coordinator cannot be contacted in Pinon, please call Gerlinda Silversmith, SCN at (928) 725-9625.

## Case Managers

<table>
<thead>
<tr>
<th>Department</th>
<th>Case Manager</th>
<th>Phone &amp; Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult/Specialty</td>
<td>Annie Ward, RN, CNS Aggie Davis, HT</td>
<td>P: (928) 674-7271 P: (928) 674-7750 F: (928) 674-7706</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>Lisa G. Jim BSN, RN</td>
<td>P: (928) 674-7055/7596 F: (928) 674-7501</td>
</tr>
<tr>
<td>Surgery/Specialty</td>
<td>Trina Mathes, RN</td>
<td>P: (928) 674-7589 F: (928) 674-7627</td>
</tr>
</tbody>
</table>
How Do I...???

... Contact my Diabetes Health Coach?
Internal Medicine Diabetologists: 928-674-7124; 928-674-7798

... Contact my Behavioral Health Coach?
Contact: 928-674-7770
Andie Sanchez: 928-674-7739

... Contact my Nutritionist?
928-674-7734 or 928-674-7801

... Contact my Case Manager?
Sage Team: Betty Stanford 928-674-7695
Yucca Team: Fred Brown 928-674-7770

... Refill my medications?
Refill hotline: 1-888-674-7038
Call at least 24 hours in advance. You will need:
- Your chart number
- Your prescription number

Pharmacy Hours:
Mon-Wed 8a-7p, Thurs 1p-9p, Fri 8a-6p
Closed Federal Holidays and Weekends

... Get help with transportation to my appointment?

Care Express 866-513-9922
Dien Home Care 505-863-3482
Native Resources Development 888-847-6674
NIAAA Transportation Services 888-951-9800
505-863-9811

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Thank you for coming in today!
Internal Medicine: 928-674-7069

My next appointment: _______________________
Call in ________ weeks to set up an appointment _______

MY PRIMARY CARE TEAM

Sage Team
- Brittany Dick, NP
- Lawrence Gault, MD
- David Goldberg, MD
- Naat Harari, MD
- Amanda Gelman, MD

Yucca Team
- Andrea Guff, NP
- Seyumi De Silva, MD
- Jacqueline Selig, NP
- Steven McSavoy, MD
- Katherine Padilla, NP
- Powell/Szczesniak (HEAL)

MY NEW MEDICINES


CHANGES TO MY OLD MEDICINES


What To Do and Where To Go next...

- Labs
- Pharmacy (1-888-674-7038)
- Physical Therapy (Rehab): 928-674-7223
- Radiology: 928-674-7337
- Mamogram X-ray
- Ultrasound CT Scan
- Specialty Clinic (928-674-7044) to make appointment with:
  - Colon Health Screening
  - Colonoscopy (Go to Specialty Clinic)
  - EGD Test (Bring sample to lab)
  - Women's Health Clinic: 928-674-7056
  - Annual Exam: Appointment Only
  - Walk-In: M/W/Th 8am-11am & 1pm-3pm
    - Fri 8am-3pm
  - A Referral was made for

For travel and other issues please follow up with:
- Sage Team: 928-674-7061 (Savannah)
- Yucca Team: 928-674-7894 (Tammy)
- Eye Exam/Optometry: 928-674-7100
- JVN / Diabetic Eye Exam (Same day or walk in)
- Dental Clinic: 928-674-7152
- Shingles Vaccine Clinic - Date: ________
- Other: ________
# LIST OF COMMUNITY RESOURCES

## For Children
- **Asian Center Global United School**
  - Program: Community Lunch Program
  - Hours: Monday-Friday, 11:45am-12:15pm
  - Contact: 312-744-0080
- **Family Service Agency**
  - Program: Youth Services
  - Contact: 312-744-0080

## For Personal Needs
- **Wheaton Family Health Care**
  - Services: Primary Care, Mental Health
  - Hours: Monday-Friday, 9am-5pm
  - Contact: 630-769-6600
- **Ymca of Greater Chicago**
  - Program: Family Ymca
  - Contact: 312-744-0080

## For Food
- **Chicago Public Schools Food & Nutrition Services**
  - Program: Summer Food Service Program
  - Contact: 312-744-0080
- **Feeding America**
  - Program: Mobile Pantry
  - Contact: 1-800-565-4333

## For Assistance
- **Chicago Parent Link**
  - Program: Parenting Support Programs
  - Contact: 312-744-0080
- **Social Security Administration**
  - Program: Disability Benefits
  - Contact: 1-800-772-1213

## For Health
- **American Red Cross**
  - Program: Blood Donations
  - Contact: 1-800-733-2767
- **Chicago Park District**
  - Program: Youth Sports Clinics
  - Contact: 312-744-0080

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**Updated: 6.27.2017**
**PATIENT ACTIVATION MEASURE PAM-13 (DRAFT)**

Below are some statements that people sometimes make when they talk about their health. Please tell us how much you agree or disagree with each statement as it applies to you personally. Your answers should be what is true for you and not just what you think others want you to say.

If the statement does not apply to you, check N/A

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am the person responsible for taking care of my health</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Taking care of myself is the most important thing I can do for my health.</td>
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<tr>
<td>I know I can help prevent or reduce problems related to my health.</td>
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<tr>
<td>I know what each of my prescribed medications do for me.</td>
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<tr>
<td>I can tell whether I need to go the doctor or whether I can take care of a health problem myself.</td>
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</tr>
<tr>
<td>I can tell my doctor worries I have even when he or she does not ask.</td>
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<tr>
<td>I know that I can follow directions on medical instructions I may need to do at home</td>
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</tr>
<tr>
<td>I understand my health problems and what causes them</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>I know what treatment (medications, surgery, physical therapy, etc.) are available for my health problems.</td>
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<tr>
<td>I have been able to keep up with healthy changes, like eating right or exercising</td>
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</tr>
<tr>
<td>I know how to keep problems from happening with my health</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can figure out ways to fix new problems</td>
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</tbody>
</table>
“EUROQUAL” VISUAL ANALOG SCALE

from worst to best on a continuous 0 to 100 point scale.

- We would like to know how good or bad your health is **TODAY**.
- This scale is numbered from 0 to **100**.
- **100** means the **best** health you can imagine.
- 0 means the **worst** health you can imagine.
- Mark an **X** on the scale to indicate how your health is **TODAY**.
- Now, please write the number you marked on the scale in the box below.

**YOUR HEALTH TODAY =**
CAHPS Patient Satisfaction Question

Date: ________________

Using any number from 0-10, where 0 is the worst provider possible, and 10 is the best provider possible, what number would you use to rate this provider?

1 → 2 → 3 → 4 → 5 → 6 → 7 → 8 → 9 → 10
PATIENT STORY

- Patient admitted to outside hospital with foot infection needing urgent amputation
- Patient was upset with plan of care and intended to leave hospital against medical advice
- Hospital case manager called Chinle care coordinator
- Had prior relationship with health coach
- Care coordinator arranged for patient to talk by phone with health coach and then staff native healer
- Patient decided to stay in the hospital and continue health care
- Baa Hózhó team and hospital continued to collaborate on care
Miranda Williams, BS
CSU Diabetes Program Coordinator
Office #: 928-674-7806
Email: miranda.Williams@ihs.gov

Krista Haven, RN, BSN, CDE
CSU Diabetes Improvement Specialist
Office #: 928-674-7736
Email: krista.haven@ihs.gov