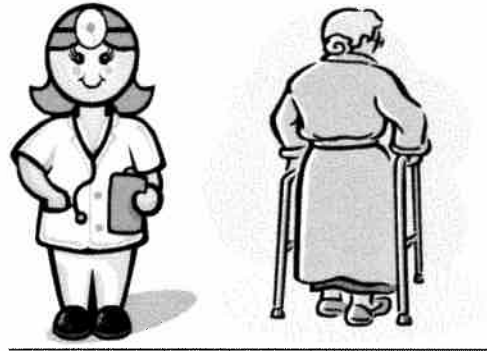


Chronic Disease Management: Tools for a Physician and Patient Based Approach



The Complex Care Program and The Personal Health File

“A worthwhile Health Care Plan for success”

Presented by:

Sylvia De Sousa, Medical Office Assistant
Dr. VanderWesthuysen, Dr. Van Wyk and Dr. Wahl
Kitimat, BC. 250-632-3135

Christine Anacleto, BSW RSW
Primary Health Care Coordinator, Care North
Kitimat, BC. 250-632-8301
Christine.anacleto@northernhealth.ca

The Complex Care Program

The complex Care Program allows for thorough assessment, monitoring and billing of patients with two or more Chronic Diseases. This program is managed with the following tool:

Complex Care Plan – Completed annually with the patients. This is a one hour appointment. The first ½ hour is with a Registered Nurse and the second ½ is with the doctor. A ½ hour follow-up is then booked annually.

Complex Care Chart – A green chart, which includes, a six year billing page and the annual complex care plan.

Colour Coded Flow Sheets – A different flow sheet for each of the Chronic Diseases a patient has is used. This allows the doctor to easily and accurately track the patient's requirements and test results. This produces the best patient care scenario.

“The Complex Care Program has evolved over the past two and a half years into a very efficient, patient centered – patient care program, which has proven to, not only have better health care outcomes for our patients, but also has been very financially viable and beneficial. A truly worthwhile business plan” – Sylvia DeSousa

The Personal Health File

The Personal Health File is a self management tool that allows the patient to play an active role in their care by providing a convenient and portable place to keep all of their medical information questions, and concerns.

The personal health file consists of a blue binder, a fridge magnet, and refillable pages divided into the following subsections.

Personal information	Healthcare Team	Allergies	Education
Appointments	Medications	Personal Goals	
Health Log	Questions/concerns	Immunizations sheet	

The Personal Health Care File is currently most widely used in Kitimat among Cancer patients and is provided through the Living Well Program, chemotherapy nurse, hospital social worker, and physician's offices.

The personal health file was originally designed by the patients of Whatcom County, Washington, in collaboration with the Pursuing Perfection Project. This current design was created by the community residents of Kitimat, B.C and staff at the Kitimat General Hospital. Additional copies may be purchased from Northern Health's Document Source. <http://documentsource.northernhealth.ca/>. The Living well program in Kitimat is able to provide these binders free of charge to patients through funding sources.

Table: GPSC Dx Codes for Complex Care Condition Combinations

ICD9 Code	Condition One	Condition Two
A414	Asthma	Ischemic Heart Disease
A428	Asthma	Congestive Heart Failure
A250	Asthma	Diabetes
A430	Asthma	Cerebrovascular Disease
A585	Asthma	Chronic Kidney Disease (Renal Failure)
A491	Asthma	COPD (with Emphysema, Chronic Bronchitis)
I428	Ischemic Heart Disease	Congestive Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease (Renal Failure)
I491	Ischemic Heart Disease	COPD (with Emphysema, Chronic Bronchitis)
H250	Congestive Heart Failure	Diabetes
H430	Congestive Heart Failure	Cerebrovascular Disease
H585	Congestive Heart Failure	Chronic Kidney Disease (Renal Failure)
H491	Congestive Heart Failure	COPD (with Emphysema, Chronic Bronchitis)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease (Renal Failure)
D491	Diabetes	COPD (with Emphysema, Chronic Bronchitis)
C585	Cerebrovascular Disease	Chronic Kidney Disease (Renal Failure)
C491	Cerebrovascular Disease	COPD (with Emphysema, Chronic Bronchitis)
R491	Chronic Kidney Disease (Renal Failure)	COPD (with Emphysema, Chronic Bronchitis)

NAME:						
	2008	2009	2010	2011	2112	2113
COMPLEX CARE Diabetes / Asthma / CRF CHF / COPD / CVA / IHD						
ICD9 -						
WEIGHT:						
HEIGHT:						
Major Complex Care Planning Visit 14033 (\$315.00) Plus...						
00100						
15300						
16100						
17100						
18100						
1. Phone Call (14039)						
2. Phone Call (14039)						
3. Phone Call (14039)						
4. Phone Call (14039)						
1. Complex Care Office Visit						
2. Complex Care Office Visit						
3. Complex Care Office Visit						
4. Complex Care Office Visit						
5. Complex Care Office Visit						
CPX #1						
CPX #2						
ALSO IF APPLICABLE:						
DIABETES MELLITUS (14050)						
CONGESTIVE HEART FAILURE (14051)						
HYPERTENSION (14052)						

Personal Health File

How to use guide for health care professionals in their promotion of this tool

1. Be familiar with the purpose to binder – listed in the introduction
2. Promote this to be taken to all health professionals visits in community & when traveling i.e. community pharmacies, massage therapists, ER, Physio, vacations, specialist appointments away
3. It is the responsibility of the patient to write in & keep up to date – information not accurate or current can be miss information and potentially harmful. Health care professionals can document only with patients permission this fosters respect.

Tab information:

Personal information – very straightforward

- Religious beliefs that may impact my health care would include i.e. Jehovah Witness not wishing blood transfusions.
- Advance Directives / Living wills– if they have one encourage them to keep a copy behind this paper

Healthcare Team

- List all they currently have and change as required

Health Information

- All medical diagnosis or conditions
- List all significant surgeries

Allergies

- List & reaction caused

Appointments

- Main purpose to track specialist appointments, making referral process easier and tracking if health insurance requires specific time between referrals
- May be used to track day to day appointments if needed

Medications

- Blue is for all prescriptions meds
- Yellow for all non prescription meds or over the counter
- Make sure the name of medication is listed as shown on bottle; how they take it i.e Venlafaxine XR 75mg one tablet daily & tick the appropriate time i.e breakfast.

Personal Goals

- Goals sheets purpose is to allow specialized clinics i.e. diabetes education, Physio, etc. and doctors to start the self management goal setting process and have linked communication with the ability to reinforce each others teaching with the patient.

Health Log

- First page address sensitive questions that patients do not like to always disclose
- Where the patient logs all their home BP, Blood glucose monitor, pedometer progress, etc
- Exercise regimes
- Asks for copies of all lab work & relevant consults reports from Dr. office

Questions / Concerns

- Space to write questions down that come to the patient at home or if other professional need clarification i.e. Home care regarding dressing changes or doctor wishing teaching done around specific medication management.

Immunization sheet

- Information on the services Public health can offer (pink) sheet
- Blue form a replica of small card used. May staple current blue card to tab.

Education Tab

- For patient to keep track of all sessions / classes attended

Fridge Magnet

- Place name in first white space
- Place permanent location of binder on second white space
- Communication link between the patient, their family and the ambulance attendants

If you choose to reproduce or change this document to more specifically meet your community needs please continue to mention the contribution of Whatcom County and include the Kitimat General Hospital Staff & community members. Thanks

Any other questions please do not hesitate to contact me.

Sincerely,



Laurel deGoeij, RN, CDE

Manager Diabetes Education & CHF Programs