Indicate client’s quality flag (s)

|  |  |  |  |
| --- | --- | --- | --- |
|  | High Utilization of Medical Inpatient/Emergency Room (4+Inpatient/ER) |  | No Outpatient Medical Visit |
|  | Preventable Hospitalizations – Adult Diabetes |  | No Diabetes Monitoring for Individuals with Diabetes |
|  | Preventable Hospitalizations – Adult Dehydration |  | No Diabetes Screening for Individuals on Antipsychotics |
|  | Preventable Hospitalizations – Adult Asthma |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Interventions: annual physical exam** | Date | Date | Date | Date |
| Medical staff at the clinic provided physical |  |  |  |  |
| Medical staff at the clinic checked weight, blood pressure, lab and physical exam status |  |  |  |  |
| Refer to medical providers on-site |  |  |  |  |
| Refer to medical providers off-site |  |  |  |  |
| Review results of labs or physical exam |  |  |  |  |
| Follow-up with abnormal physicals |  |  |  |  |
| Educate clients on the benefits of regular exams |  |  |  |  |
| Motivational interviewing to promote an annual outpatient medical visit (i.e. physical exam) |  |  |  |  |
| Assist in scheduling physicals |  |  |  |  |
| Provide reminders for physicals |  |  |  |  |
| Provider transportation for physicals |  |  |  |  |
| Peer support |  |  |  |  |
| **Interventions: reduce high utilization of inpatient/ER services** |  |  |  |  |
| Evaluate risks and causes of high utilization |  |  |  |  |
| Incorporate health coordination into mental health treatment plan |  |  |  |  |
| Educate about importance of using a primary care provider and adhering to medical treatment |  |  |  |  |
| Review health issues in sessions and follow-up with health coordination |  |  |  |  |
| Use “teach back” method to reduce high utilization of inpatient/ER services |  |  |  |  |
| Motivational interviewing to reduce high utilization of inpatient/ER services |  |  |  |  |
| Assist in scheduling physicals |  |  |  |  |
| Provide reminders for physicals |  |  |  |  |
| Arrange transportation for physicals |  |  |  |  |
| Peer support |  |  |  |  |
| Referral to: Nutrition programs |  |  |  |  |
| Referral to: Exercise programs |  |  |  |  |
| Referral to: Case management |  |  |  |  |
| Referral to: Home Health Services |  |  |  |  |
| **Interventions: promote annual diabetes screening/monitoring** |  |  |  |  |
| Order, review or follow-up on lab results |  |  |  |  |
| Clinic - medical professional reviews and signs-off on lab results |  |  |  |  |
| Follow-up on any abnormal lab results |  |  |  |  |
| Review results of lab tests with client and develop or review follow-up plan |  |  |  |  |
| Educate clients on benefits of lab monitoring |  |  |  |  |
| Motivational interviewing to promote annual diabetes screening/monitoring |  |  |  |  |
| Schedule lab appointments for clients |  |  |  |  |
| Provide transportation to labs |  |  |  |  |
| Provide reminders |  |  |  |  |
| Peer support |  |  |  |  |
| Refer to another medical provider to order labs |  |  |  |  |