Alignment Healthcare

Alignment Healthcare Centers work with Primary Care Providers (PCP) to co-manage members who need additional support in managing their chronic conditions. You may refer your patient per the criteria outlined below. **If you have questions you may reach our Chronic Disease Management line by phone at (844) 460-2554, by fax at (844) 460-2555 or email them at cdm@ahcusa.com. You may also contact your local care center listed below.**

Patient Last Name	Patient First Name	Patient Middle Name
Patient Date of Birth	Patient Health Plan ID	Patient Telephone
Referring PCP Name	Referring PCP Number	Referring PCP Fax

ALIGNMENT HEALTHCARE CENTER LOCATION

Cary Care Center
103 Baines Court Suite 100B
Cary, NC 27511
(919) 803-4820

Garner Care Center
Timber Commons in Southeast 868
Timber Dr.
Garner, NC 27529
(919) 803-4820

New Bern Ridge in East Raleigh
2610 New Bern Ave.
Raleigh, NC 27610
(919) 803-4820

Wake Forest Care Center
UNC REX at Wakefield
11200 Governor Manly Way Suite 205
Raleigh, NC 27614
(919) 803-4820

Please select all that apply. Referrals to multiple programs are welcome.

Jump Start Assessment

Initial/annual comprehensive health evaluation available annually to all members at no cost; HEDIS gap closure; referral to chronic care

- ☐ All members 1x per year

Anticoagulation

- ☐ Current Rx for Coumadin or Warfarin
- ☐ Bridging with Lovenox

Chronic Obstructive Pulmonary Disease (COPD)

- ☐ Patient on oxygen
- ☐ FEV 1 < 80 unless referral for "at risk"
- ☐ Hospitalization for COPD within past 12 months

Congestive Heart Failure (CHF)

- ☐ CHF with NYHA Class III or IV
- ☐ EF < 50%
- ☐ Hospitalization for CHF within past 12 months

Chronic Kidney Disease (CKD)

- ☐ CKD Stage III, IV, and V
- ☐ CKD within 24 urine protein > 4gm/day or equivalent by urine spot protein/creatinine ratio
- ☐ Hospitalization for CKD/ESRD within past 12 months

Diabetes Management

- ☐ HgBA1c > 9%
- ☐ Clinically significant recurrent Hypoglycemia
- ☐ Insulin starts
- ☐ Hospitalization for diabetes within past 12 months

Fall Prevention

- ☐ Patient with unsteady gait
- ☐ Apparent fall risk
- ☐ Fall-related hospitalization within past 12 months

Hypertension

- ☐ Non-Diabetic: systolic BP>180
- ☐ Diabetic: systolic BP>160
- ☐ DBP >100 for both

Pre-Op Clearance

- ☐ Upcoming elective surgery with general or spinal anesthesia (except CABG)

Post-Hospitalization

- ☐ Member due for hospital discharge, or discharged within previous 72 hours

Other:

- ☐ Complex psychosocial or symptom management
- ☐ Additional support to co-manage patient
- ☐ Advance care planning
- ☐ Wound care
- ☐ Not sure, but member may benefit

Please specify:

_____

_____

This back page is provided simply to offer you additional information on our Chronic Disease Management (CDM). Please do not refer to a specialist; please refer to us first, and we will manage or integrate the care of a specialist as appropriate.

Anticoagulation

Alignment Healthcare	PCP
✓ Coumadin clinic: blood draws, adjust medications	✓ Communicate to Alignment Healthcare Center: anticoagulation initiation, frequency, dosage, duration, change in therapeutic target range and discontinuation ✓ Report if there is a scheduled procedure or disruption in dosing schedule

Chronic Obstructive Pulmonary Disease (COPD)

Alignment Healthcare	PCP
✓ Determine COPD progression ✓ Treatment plan ✓ May include remote home-monitoring	✓ Co-manage the patient ✓ Coordinate vaccinations (influenza, pneumonia) with CDM

Congestive Heart Failure (CHF)

Alignment Healthcare	PCP
✓ Evaluate CHF progression ✓ May include remote home-monitoring	✓ Defer management to CDM ✓ Address acute symptoms and coordinate with AHC ✓ If consultation desired, refer to CDM first

Chronic Kidney Disease (CKD)

Alignment Healthcare	PCP
✓ Treatment plan	✓ Communicate with PCP ✓ Manage CKD stages I and II ✓ Refer microurine and urinanalysis to CDM

Diabetes Management

Alignment Healthcare	PCP
✓ In-person education and counseling ✓ Insulin management ✓ Arrange all major treatment related to diabetes ✓ Frequent clinic visits (2-3 times per week) for members with poorly controlled diabetes, until optimal control is achieved	✓ Co-manage the patient ✓ Defer medication and treatment management to chronic disease management ✓ If blood draw performed, do not need to analyze sample for HgBA1c

Fall Prevention

Alignment Healthcare	PCP
✓ Physical exam with special attention paid to lower extremities, balance, and vision ✓ Review footwear ✓ Review medications ✓ Home safety evaluation	✓ Report falls to chronic disease management ✓ Communicate risks to chronic disease management

Hypertension

Alignment Healthcare	PCP
✓ Remote home-monitoring	✓ Respond to progress notes with relevant medical history ✓ Do not adjust medications

Jump Start Assessment

Alignment Healthcare	PCP
✓ 45-60 minute comprehensive evaluation ✓ Review past and current medical history ✓ On-site lab, including blood and urine collection ✓ Medication review, including OTC and vitamins/supplements	✓ Review JSA notes for follow up instructions for PCP and member. Encourage member to attend JSA and Chronic Disease Management Program if applicable

Pre-Op Clearance

Alignment Healthcare	PCP
✓ Perform full pre-operative evaluation, including medication review	✓ Communicate with PCP ✓ Co-manage the patient

Post-Hospitalization

Alignment Healthcare	PCP
✓ Coordinate and assist Member/caregiver in navigating post-hospitalization plans ✓ Arrange follow-up care (with transportation or home visit)	✓ Routine visit for low-risk discharge

Other

Alignment Healthcare	PCP
✓ Per PCP request, help co-manage patient	✓ Communicate with PCP ✓ Co-manage the patient

A member may be discharged from the active Chronic Disease Management Program if they have met the program and/or personal goals. They will receive on-going monitoring from the Alignment Healthcare Center as clinically indicated. The PCP will be notified at point of admission and discharge.