CTC – Best Practice Sharing

Care Management (NCM Rebranded) Documentation

Structured Data and Reportable Process

EHR: Athena Health
CM Comprehensive General Assessment

### Risk Assessment:

- **CM Visit:** for [ ] , patient accompanied by family member , [ ] has not [ ] been treated in the ER/inpatient hospital ___ times in the last year , history of leaving the hospital against medical advice , noncompliance with hospital routines/regulations  ___ notes

### Living Situation: [see social history for additional info]:

- in a private residence , assisted living facility , has home health or VNA support , hospice , homelessness , problem with lack of adequate food / water , problem with utilities , problem with medical bills , problem with medication affordibility , problem with rent/mortgage / housing  ___ notes

### Medical History of Patient/Family: [see social history for additional info]:

- **BMI Classification:** [ ] , losing weight: ____ lbs , weight staying the same , gaining weight: ____ lbs , psychiatric , metabolic , pulmonary , neurologic , gastrointestinal , genitourinary , musculoskeletal , other risk factors(s) , history of renal failure: , long-term dialysis , ↑ substance abuse/use [ ] , no history of substance abuse , other high risk behaviors  ___ notes

### Family/Social/Cultural:

- family notes , major family conflict/disturbance  ___ notes

### Language/Communication:

- language / communication normal , language / communication barriers , difficulty reading/writing , lack of medical understanding  ___ notes

### Functional Ability

#### Hearing: [see social history for additional info]:

___ notes

#### Vision: [see social history for additional info]:

___ notes

#### Activities of Daily Living:

- able to bathe with limited or no assistance , able to control urination and bowels , able to dress with limited or no assistance , able to feed self with limited or no assistance , able to get out of chair or bed with limited or no assistance , able to groom with limited or no assistance , able to toilet with limited or no assistance , unable to bathe without assistance , unable to dress without assistance , unable to control urination and bowels , unable to feed self without assistance , unable to get out of chair or bed without assistance , unable to groom without assistance , unable to toilet without assistance  ___ notes

#### Instrumental Activities of Daily Living:

- able to do house work with limited or no assistance , able to grocery shop with limited or no assistance , able to manage medications with limited or no assistance , able to manage money with limited or no assistance , able to prepare meals with limited or no assistance , able to use the phone with limited or no assistance , unable to do house work without assistance , unable to grocery shop without assistance , unable to manage medications without assistance , unable to manage money without assistance , unable to to prepare meals without assistance , unable to use the phone without assistance  ___ notes
### Falls Risk (see falls screening for additional info):
- No frequent falls while walking, no fall in the past year, no fall since last visit, no dizziness/vertigo, fall(s) in the past ___ yr, fall(s) since last visit___ day, frequent falls while walking, dizziness/vertigo, fear of falling, injury with fall ___

### Home Safety:
- Unsafe flooring hazards, unsafe stairs, no unsafe gas appliances, working smoke/CO detectors, wears protective head gear for biking/high velocity, use of seat belts, practicing ‘safer sex’, no vision or hearing loss while driving, no fire arms, has hand bars in the bathroom/shower, good lighting in the home, reviewed sun protection, unsafe stairs, unsafe flooring hazards, unsafe gas appliances, no smoke/CO detectors, does not wear protective head gear for biking/high velocity, does not use seat belts, not practicing ‘safer sex’, vision or hearing loss while driving, number of motor vehicle accidents ___ year, fire arms, does not have hand bars in the bathroom/shower, poor lighting in the home ___

### Durable Medical Equipment (DME):
- Wheelchair, cane, walker, grab bars, shower/tub lift, transfer board, tpn or iv infusion pump, urinary catheters, cpap, nebulizer, adjustable commode/raised toilet seat, hospital bed, pressure mattress, hofer

### Other
- Oxygen needs: oxygen ___ and/or ___

### Adherence:
- Compliant with follow-up visits, compliance with oral medication is good, understands effect of concurrent medications, understands potential side effects, understands missed doses, problems with compliance with oral medication, does not understand effect of concurrent medications, does not understand potential side-effects, does not understand missed doses ___

### Nutrition/Dietary Compliance:
- Understands role of diet as primary therapy, eats mostly healthy diet, limiting salt intake, sufficient intake of fruits/vegetables, low fat diet, limiting alcohol intake, hypoglycemic awareness, not ready for diet changes, doesn’t follow any kind of diet plan, not limiting salt intake, diet high in fat content, not limiting alcohol intake, does not understand role of diet as primary therapy, hypoglycemia unawareness, family/friends provide support for meals, food banks/community resources ___

### Lifestyle Changes:
- Motivated to continue lifestyle changes, exercises regularly, exercises ___ times/week, exercises for ___ minutes/day, running (>30 min/day), swimming (>30 min/day), bicycling (>30 min/day), weightlifting (>30 min/day), not motivated to continue lifestyle changes, current smoker not wishing to stop, does not exercise regularly ___

### Advanced Care Planning (see social history for additional info): respite care, palliative care, hospice ___
<table>
<thead>
<tr>
<th>Co-morbidities:</th>
<th>None, DM labs up to date, noncompliant with lab testing, Non-smoker, Hypertension, BP usually runs</th>
<th>goal is</th>
<th>Elevated lipids (cholesterol), LDL usually runs</th>
<th>goal is less than</th>
<th>Coronary Artery Disease (CAD), Smoker, Other</th>
<th>add'l notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complications:</td>
<td>previous hospitalizations: related to DM, diabetic nephropathy, Kidney Microalbumin test</td>
<td>goal is less than 30 ug/g</td>
<td>kidney disease CKD stage</td>
<td>diabetic neuropathy, diabetic retinopathy, diabetic gastroparesis</td>
<td>no diabetic complications</td>
<td>add'l notes</td>
</tr>
<tr>
<td>weight</td>
<td>weight gain/loss: ___ lbs, unintentional weight loss &gt;5% body weight, obese, morbidly obese</td>
<td>add'l notes</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Glucose Monitoring</td>
<td>presents</td>
<td>meter/log book, reports frequency of blood glucose monitoring:</td>
<td>noncompliant with home glucose monitoring, knows desired target range for blood glucose, normal range of home blood sugars (in the low 100s), improved since last visit, worsened since last visit, home blood sugar range high with readings</td>
<td>no hypoglycemia, hypoglycemia unawareness, knows blood glucose and A1C, unchanged since last visit, knows meaning of A1C test, hypoglycemia, usually poorly controlled, home blood sugar range low (below 70)</td>
<td>add'l notes</td>
<td></td>
</tr>
<tr>
<td>Food and Nutrition Knowledge Behaviors</td>
<td>eating meals regularly</td>
<td>eating snacks regularly</td>
<td>more of a grazer</td>
<td>good utilization of carbohydrate counting, reads food labels and uses labels to make appropriate food selections, verbalizes relationship between food, physical activity and medications on blood glucose levels, does not comply with diabetic diet, need to address night eating habit, depression: accompanied by: eating more, depression: accompanied by: eating less, doesn't follow any kind of diet plan, medically or professionally supervised program: weight loss amount: diet: Weight Watchers, uses carbohydrate counting for flexible insulin dosing</td>
<td>add'l notes</td>
<td></td>
</tr>
<tr>
<td>Medications:</td>
<td>treated with</td>
<td>Metformin, GLP-1, SGLT-2, DPP-4, sulphonylurea, insulin injections</td>
<td>insulin pump therapy, compliant with medications, noncompliant with medications, side effects from medications</td>
<td>add'l notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Care: seeing eye doctor yearly, not seeing eye doctor yearly</td>
<td>checking feet regularly</td>
<td>not checking feet regularly</td>
<td>Diabetic foot exam within 12 months, Due for diabetic foot exam, Dental Exam</td>
<td>add'l notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity/Exercise</td>
<td>Exercising</td>
<td>uses home bike ___ time per week, walks ___ times per week, exercise habits: planning to begin exercise, exercise None, exercise habits: exercise inhibited by condition</td>
<td>add'l notes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Preventive Medications and Immunizations**

<table>
<thead>
<tr>
<th>taking aspirin daily</th>
<th>not taking aspirin daily</th>
<th>aspirin therapy not indicated</th>
<th>On</th>
<th>Statin Therapy</th>
<th>on</th>
<th>Up to date on Pneumonia Vaccine</th>
<th>No recent Pneumonia Vaccine</th>
<th>Up to date on Flu Vaccine</th>
<th>No Recent Flu Vaccine</th>
<th>add'l notes</th>
</tr>
</thead>
</table>

**Summary**

Nurse care Manager, 06-26-2017

Hospital D/C followup

Performed by xxxxxxxxxxxxx, NCM, **

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**Reason for Visit**

1) CM: Care Management (Initial / Change in Level), 2) CM: High Risk (Level 5)

Met with patient and son XXXXXXXXXX to introduce myself and advise of care management opportunities available in our office

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**Assessment & Plan**

BARRIER ASSESSMENT

The following barrier(s) were found:

- does not take medication(s) as prescribed

Possible barriers to care interfering with treatment goals were assessed.

The following barriers(s) were found:

- does not understand disease process

The patient/family self-management abilities are affected by:

- no limitations
medical assessment

- Provided CM: DEVELOPED CARE PLAN (pcmh)
- Provided CM: BARRIER(S) TO CARE REVIEW
- Provided MM: MEDICATION REVIEW/RECONCILIATION
- Order patient follow up phone call

Tickler – Preset follow-up reminder and alarm for regular touch points as defined by our risk stratification. Triggered by High Risk (Level XX) reason for visit

Patient Goals

Pt states he wants to remain in home. He refuses any services at this time including meals on wheels. Pt will use the walker for safety reasons and elevate his legs more often.

Patient Instructions

Instructed pt to contact NCM with any questions or concerns. NCM will call patient to f/u and patient agreed to monthly calls.

Discussion Notes

GOAL: To monitor patient and continue to improve patient safety in the home and further discuss options and resources to assist him with living independently.

CARE PLAN:

* Patient education and engagement
* High Risk Assessment (Quarterly)
* Appropriate monitoring for warning signs
* Interventions for unhealthy lifestyles / habits
* Links to community resources to enhance patient education, self-management, or special facilities.

TEAM/PLANNED CARE:

* Follow up with monthly phone calls to patient.
* Contact information for NCM given to patient for any further issues or questions.
* Referrals, as appropriate

CARE MANAGEMENT FOLLOW-UP VISIT: 3 Months

History of Present Illness

CM Comprehensive General Assessment

Risk Assessment:

Patient reports for high risk evaluation, patient accompanied by his son, and has been treated in the ER/inpatient hospital 7 times in the last year. Pt reports in a private residence. Pt reports lives with spouse and has 3 supportive children. Pt reports language / communication normal.

Functional Ability

Patient reports unable to do house work without assistance and unable to grocery shop without assistance but reports able to prepare meals with limited or no assistance. Pt reports able to bathe with limited or no assistance, able to control urination and bowels, able to dress with limited or no assistance, able to feed self with
limited or no assistance, able to get out of chair or bed with limited or no assistance, able to groom with limited or no assistance, and able to toilet with limited or no assistance. Pt reports fall(s) in the past year 2 and fall(s) since last visit 0. Pt reports walker (rolling walker), shower / tub equipment: chair, and adjustable commode / raised toilet seat.

other

Patient reports problems with compliance with oral medication: ___ and does not understand potential side-effects. Pt reports not motivated to continue lifestyle changes. Pt reports family/friends provide support for meals.

Procedure Documentation
Fall Risk Assessment
Have you had any falls in the last year? yes _____ 2

MISSING CARE TEAM !!!! Note to self
We developed our CM definitions and protocols for Risk based on the following AAFP guidelines:

**Risk-Stratified Care Management and Coordination**

**Table 1: Examples of Potentially Significant Risk Factors**

| Category | Potential Physical Characteristics | Social Determinants | Utilization/Claim Data | Clinician Input |
|----------|-----------------------------------|---------------------|------------------------|-----------------
| Noncompliance | Lack of family or family support that impacts care | Heavy drinking | Our policy in place | No chart comments |
| Unemployment | Frequent hospitalizations (particularity heart failure, GI disorders, and pneumonia) | Frequent office, E/R, or urgent care visits | Our policy in place | No chart comments |
| No health insurance | High-risk medications | High-risk medications | Our policy in place | No chart comments |
| No financial support | Noncompliance with treatment plan | Noncompliance with treatment plan | Our policy in place | No chart comments |
| Unhealthy lifestyle | Complacency with medications or following the treatment plan | Complacency with medications or following the treatment plan | Our policy in place | No chart comments |
| Hospital readmission within 3 days | Recent move to long-term facility or other transition of care | Recent move to long-term facility or other transition of care | Our policy in place | No chart comments |
| Any chronic disease | Spouse (who was the caregiver) recently deceased | Spouse (who was the caregiver) recently deceased | Our policy in place | No chart comments |
| Death of a family member | Low confidence or ability to self-manage | Low confidence or ability to self-manage | Our policy in place | No chart comments |
| Mental Health | Access to the question Is the patient at higher risk for dying within the next year? | Access to the question Is the patient at higher risk for dying within the next year? | Our policy in place | No chart comments |

**Table 2: Risk Categories and Levels using Diabetes Example Case**

<table>
<thead>
<tr>
<th>Category</th>
<th>Primary Prevention (Low Resource Use) Goal</th>
<th>Secondary Prevention (Moderate Resource Use) Goal</th>
<th>Tertiary Prevention (High Resource Use) Goal</th>
<th>Catastrophic/Complex (Extremely High Resource Use) Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>No known diagnosis or potential risk factors</td>
<td>No known diagnosis or potential risk factors</td>
<td>No known diagnosis or potential risk factors</td>
<td>No known diagnosis or potential risk factors</td>
</tr>
<tr>
<td>Step 2</td>
<td>Healthy</td>
<td>Healthy</td>
<td>Healthy</td>
<td>Healthy</td>
</tr>
<tr>
<td>Example of using uncontrolled progression of diabetes</td>
<td>Blood pressure and lipids, but still within normal parameters</td>
<td>Blood pressure and lipids, but still within normal parameters</td>
<td>Blood pressure and lipids, but still within normal parameters</td>
<td>Blood pressure and lipids, but still within normal parameters</td>
</tr>
<tr>
<td>Example of Case Care Considerations for patients with uncontrolled progression of diabetes</td>
<td>Preventive screenings and immunizations</td>
<td>Preventive screenings and immunizations</td>
<td>Preventive screenings and immunizations</td>
<td>Preventive screenings and immunizations</td>
</tr>
<tr>
<td>Identifying Disease Burden and Determining Health Risk Status</td>
<td>Is the patient healthy, with no chronic disease, risk factors?</td>
<td>Is the patient healthy, but at risk for a chronic disease, potential risk factors?</td>
<td>Does the patient have one or more chronic diseases, with significant risk factors but is stable and at treatment goal?</td>
<td>Does the patient have multiple chronic diseases, significant risk factors, complications, and/or complex care needs?</td>
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**Level 1: Primary Prevention**

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<tr>
<th>Goal</th>
<th>CARE PLAN SUGGESTIONS</th>
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<tbody>
<tr>
<td>1.</td>
<td>Prevent, detect, treat, and manage disease risk factors</td>
</tr>
<tr>
<td>2.</td>
<td>Prevent cancer, heart disease, stroke, and diabetes</td>
</tr>
<tr>
<td>3.</td>
<td>Prevent illness and injury</td>
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**Level 2: Primary Prevention**

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**Level 3: Secondary Prevention**

<table>
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<th>Goal</th>
<th>CARE PLAN SUGGESTIONS</th>
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<tbody>
<tr>
<td>1.</td>
<td>Prevent, detect, treat, and manage disease risk factors</td>
</tr>
<tr>
<td>2.</td>
<td>Prevent cancer, heart disease, stroke, and diabetes</td>
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<tr>
<td>3.</td>
<td>Prevent illness and injury</td>
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</table>

**Level 4: Tertiary Prevention**

<table>
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<th>Goal</th>
<th>CARE PLAN SUGGESTIONS</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Prevent, detect, treat, and manage disease risk factors</td>
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<tr>
<td>2.</td>
<td>Prevent cancer, heart disease, stroke, and diabetes</td>
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<tr>
<td>3.</td>
<td>Prevent illness and injury</td>
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</table>

**Level 5: Catastrophic Care**

<table>
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<th>Goal</th>
<th>CARE PLAN SUGGESTIONS</th>
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<tr>
<td>1.</td>
<td>Prevent, detect, treat, and manage disease risk factors</td>
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<td>2.</td>
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<tr>
<td>3.</td>
<td>Prevent illness and injury</td>
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**CARE PLAN SUGGESTIONS**

- Preventive screenings and immunizations
- Patient education and engagement
- Early detection
- Early intervention
- Early treatment

**TEAM/PLANNED CARE**

- Group visits
- Home monitoring
- Health coaching
- Referrals

**CARE PLAN SUGGESTIONS**

- Preventive screenings and immunizations
- Patient education and engagement
- Early detection
- Early intervention
- Early treatment

**TEAM/PLANNED CARE**

- Group visits
- Home monitoring
- Health coaching
- Referrals

**CARE PLAN SUGGESTIONS**

- Preventive screenings and immunizations
- Patient education and engagement
- Early detection
- Early intervention
- Early treatment

**TEAM/PLANNED CARE**

- Group visits
- Home monitoring
- Health coaching
- Referrals

**CARE PLAN SUGGESTIONS**

- Preventive screenings and immunizations
- Patient education and engagement
- Early detection
- Early intervention
- Early treatment

**TEAM/PLANNED CARE**

- Group visits
- Home monitoring
- Health coaching
- Referrals

**CARE PLAN SUGGESTIONS**

- Preventive screenings and immunizations
- Patient education and engagement
- Early detection
- Early intervention
- Early treatment

**TEAM/PLANNED CARE**

- Group visits
- Home monitoring
- Health coaching
- Referrals
CM Order - Risk Stratification / CM Reporting:

Results

<table>
<thead>
<tr>
<th>Risk:</th>
<th>Low (Level 1-2)</th>
<th>Medium (Level 3-4)</th>
<th>High (Level 5-6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
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<tr>
<td>Reason, if</td>
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<td></td>
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<tr>
<td>no CM:</td>
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<tr>
<td>Closed Date</td>
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<td>mm/dd/yy:</td>
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<td></td>
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</table>

Status:

<table>
<thead>
<tr>
<th>Reason, if</th>
<th>CM Not Appropriate</th>
<th>Goals Met</th>
<th>Pt DC from Practice (SNF)</th>
<th>Pt Expired</th>
<th>Pt Refused</th>
<th>Unable to contact X3</th>
</tr>
</thead>
<tbody>
<tr>
<td>no CM:</td>
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