CTC – Best Practice Sharing

Care Management (NCM Rebranded) Documentation

Structured Data and Reportable Process

EHR: Athena Health

CM Comprehensive General Assessment

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 addt'l 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 affordibilty , problem with rent/mortgage / housing addt'l 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 , f substance abuse/use [ ] , no history of substance abuse , other high risk behaviors addt'l notes

family/ social/ cultural: family notes , major family conflict/disturbance addt'l notes

language / communication language / communication normal , language / communication barriers , difficulty reading/writing , lack of medical understanding addt'l notes

Functional Ability

Hearing: (see social history for additional info): addt'l notes

Vision: (see social history for additional info): addt'l notes

Activities of Daily Living: able to bathe with limited or no assistance , able to contol 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 contol 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 addt'l 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 addt'l 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 year ___ , fall(s) since last visit___ , frequent falls while walking , dizziness/vertigo , fear of falling , injury with fall addt'l notes

Home Safety: no unsafe flooring hazzards , no unsafe stairs , no unsafe gas appliances , working smoke/CO detectors , wears protective head gear for biking/high velocity , use of seatbelts , 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 hazzards , unsafe gas appliances , no smoke/CO detectors , does not wear protective head gear for biking/high volocity , does not use seatbelts , not practicing 'safer sex' , vision or hearing loss while driving , number of motor vehicle accidents ___ , fire arms , does not have hand bars in the bathroom/shower , poor lighting in the home addt'l notes

Durable Medical Equipment (DME): wheelchair , cane , walker , grab bars , shower / tub equipment: , adjustable commode / raised toilet seat , hospital bed , pressure mattress , hoyer lift , transfer board , tpn or iv infusion pump , urinary catheters , cpap , nebulizer: , advanced respiratory needs: oxygen and/or addt'l notes

other

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 addt'l notes

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 addt'l notes

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 addt'l notes

Advanced care planning (see social history for additional info): respite care , palliative care , hospice addt'l notes

CM Diabetes

CM Diabetes

DM

Co-morbidities: None , DM labs up to date , noncompliant with lab testing , Non-smoker , Hypertension , BP usually runs [ ], goal is [ ] , Elevated lipids (cholesterol) , LDL usually runs [ ], goal is less than [ ] , Coronary Artery Disease (CAD) , Smoker , Other addt'l notes

Complications: previous hospitalizations: related to DM , diabetic nephropathy , Kidney Microalbumin test [ ], goal is less than 30 ug/g , kidney disease CKD stage [ ] , diabetic neuropathy , diabetic retinopathy , diabetic gastroparesis , no diabetic complications addt'l notes

weight weight gain/loss: ___ lbs , unintentional weight loss >5% body weight , obese , morbidly obese addt'l notes

Glucose Monitoring presents [ ] meter/log book, , reports frequency of blood glucose monitoring: [ ] , 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 [ ] , 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) addt'l notes

Food and Nutrition Knowledge Behaviors eating meals regularly [ ] , eating snacks reguarly [ ] , more of a grazer , 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 addt'l notes

Medications: treated with [ ] , Metformin , GLP-1 , SGLT-2 , DPP-4 , sulphonylurea , insulin injections [ ] , insulin pump therapy , compliant with medications , noncompliant with medications , side effects from medications addt'l notes

Self Care: seeing eye doctor yearly , not seeing eye doctor yearly , checking feet regularly [ ] , not checking feet regularly , Diabetic foot exam within 12 months , Due for diabetic foot exam , Dental Exam [ ] addt'l notes

Activity/ Exercise Exercising [ ] , uses home bike ___ time per week , walks ___ times per week , exercise habits: planning to begin exercise , exercise None , exercise habits: exercise inhibited by condition addt'l notes

Preventive Medications and Immunizations taking aspirin daily , not taking aspirin daily , aspirin therapy not indicated , On , Statin Therapy , on intensity statin} , Up to date on Pneumonia Vaccine , No recent Pneumonia Vaccine , Up to date on Flu Vaccine , No Recent Flu Vaccine addt'l notes

Summary

Nurse care Manager, 06-26-2017

Hospital D/C followup

Performed by xxxxxxxxxxxxxx, NCM, **

In this example, there are 2 reasons for visit. 1) triggers the Assessment Templates that will generate as part of the visit, as well as our own custom order with CM results. 2) triggers the preconfigured followup reminder between scheduled visits.

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

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/RECON
- 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

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Table 1: Examples of Potentially Significant Risk Factors

Clinical Diagnoses, Behavioral Health, Special Needs	Potential Physical Limitations	Social Determinants	Utilization/Claims Data	Clinician Input (Personal Knowledge)
– Any chronic disease, particularly one that is not in control or at desired goal – Chronic pain – Substance abuse (alcohol/drug/tobacco) – Terminal illness – Advanced age with frailty – Multiple co-morbidities – Pre-term delivery of newborn – Child, youth, or adult with special needs – Anxiety, schizophrenia, bipolar, depression, or other behavior affecting health – Dental health – Dementia/Alzheimer's disease	– Non-ambulatory – Needs Assistance with Activities of Daily Living (ADLs) – Severely diminished functional status – Declining eyesight – Extreme weakness or fatigue – At risk for falls	– Lack of financial or family support that impacts care – Unemployed – No health insurance – Low health literacy – Unsafe home environment – Homeless – Lives alone and needs assistance with ADLs – Transportation for health care appointments is difficult – Language barriers	– Frequent hospitalizations (particularly heart failure, GI disorders, and pneumonia) – Frequent office, ER, or urgent care visits – Multiple providers – Hospital readmission within 30 days – Major procedure in last year – Chronic kidney disease – Brain trauma – Expensive medications	– Polypharmacy – Patient is taking several medications that may not all be needed and/or could have potential for interactions – High-risk medications – Non-compliant with treatment plan – Confusion with medications or following the treatment plan – Recent move to long-term facility or other transition of care – Spouse (who was the caregiver) recently deceased – Lack of engagement in care plan – Low confidence or ability for self-management – Answer to the question: Is this patient at higher risk for dying within the next year?

Table 2: Risk Categories and Levels using Diabetes Example Case

CATEGORY	PRIMARY PREVENTION (Low Resource Use) GOAL: To prevent onset of disease		SECONDARY PREVENTION (Moderate Resource Use) GOAL: To treat a disease and avoid serious complications		TERTIARY (High Resource Use) GOAL: To treat the late or final stages of a disease and minimize disability	CATASTROPHIC/COMPLEX (Extremely High Resource Use) GOAL: May range from restoring health to only providing comfort care
Stage	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	No known diagnoses or complex treatments	No known diagnoses but demonstrates warning signs or potentially significant risk factors	Has diagnosis, but stabilized or in control; potentially significant risk factors	Has diagnosis and/or complex treatment, and at higher risk for complications or potentially significant risk factors	Has diagnosis, complex treatment, and complications or potentially significant risk factors– goal is to prevent further complications	• Very severe illness or condition and potentially significant risk factors • End-of-life care • Premature baby (May have high costs with limited or no opportunity for improvement, stabilization, or cost control)
Example of using uncontrolled progression of diabetes	• Healthy	• Blood glucose and lipids rising, but still within desired parameters • BMI elevated • Smoker	• Diagnosed with type 2 diabetes, blood sugar, and lipids brought within desired parameters • Married, family involved	• Blood sugar and lipids not within desired parameters, and financial situation impacting negatively • Lives alone • One ER visit and one hospitalization in past year	• Has diabetes with early renal disease, coronary artery disease, failing eyesight, and lives alone • Three ER visits and two hospitalizations in past year • Dual eligible Medicaid/Medicare • Needs Assistance with Activities of Daily Living (ADLs)	• Diagnosed with lung cancer • Recent myocardial infarction • Progression to ESRD with renal dialysis • Amputation of one leg • Blind • Lives in nursing home
Example of Care Plan Considerations for patient with uncontrolled progression of diabetes	✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring for warning signs ✓ Health risk assessment (annual) ✓ Care plan that includes smoking cessation counseling and program offered		✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring ✓ Health risk assessment (semi-annual) ✓ Care plan with smoking cessation counseling and program offered ✓ Team/planned care ✓ Group visits ✓ Health coach ✓ Referrals as appropriate, such as social services ✓ Community resources ✓ Home self-monitoring		✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring ✓ Health risk assessment (quarterly) ✓ Intensive care management plan and resources ✓ Smoking cessation ✓ Group visits ✓ Health coach ✓ Home health	✓ Hospitalization ✓ Rehabilitation ✓ Long-term care ✓ Hospice ✓ Home health ✓ Individualized intensive care management and coordination ✓ May or may not conduct preventive screenings ✓ Health risk assessment, as appropriate

Identifying Disease Burden and Determining Health Risk Status

Is the patient healthy, with no chronic disease, or *significant risk factors?*	Is the patient healthy, but at risk for a chronic disease, or has other *significant risk factors?*	Does the patient have one or more chronic diseases, with *significant risk factors,* but is stable or at desired treatment goals?	Does the patient have one or more chronic diseases, with *significant risk factors,* and is unstable or not at treatment goal(s)?	Does the patient have multiple chronic diseases, *significant risk factors,* complications, and/or complex treatment(s)?	Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?
Level 1 PRIMARY PREVENTION	**Level 2 PRIMARY PREVENTION**	**Level 3 SECONDARY PREVENTION**	**Level 4 SECONDARY PREVENTION**	**Level 5 TERTIARY PREVENTION**	**Level 6 CATASTROPHIC CARE**
GOAL: To prevent onset of disease (Low Resource Use)	**GOAL: To prevent onset of disease (Low Resource Use)**	**GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)**	**GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)**	**GOAL: Treat the late or final stages of a disease and minimize disability (High Resource Use)**	**GOAL: May range from restoring health to only providing comfort care (Extremely High Resource Use)**
CARE PLAN SUGGESTIONS – Preventive screenings and immunizations – Patient education – Health risk assessment (annual) – Appropriate monitoring for warning signs	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (semi-annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (semi-annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach – Referrals, as appropriate	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (quarterly) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach/personalized care plan/management and resources – Referrals, as appropriate – Home health	**CARE PLAN SUGGESTIONS** – Hospitalization – Rehabilitation – Long-term care – Hospice/palliative care **TEAM/PLANNED CARE** – Support groups – Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach/care management – Referrals, as appropriate – Home health – Personalized intensive care plan/management and resources

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CM Order - Risk Stratification / CM Reporting: