Care Management – for Nursing

This specific process will be used for patients being transferred from the CHW for care coordination to the nurse for care management support.

Topics covered:

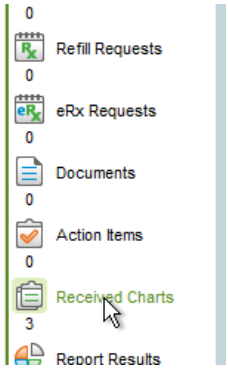
General Workflow

1. Registry report is run (monthly).
2. CHW reviews chart, communicates with usual provider and/or care management nurse to determine goals. CHW follows up with patients to assess some care coordination needs and develops/updates care plan. CHW follows up with patient to assess some care coordination needs and begins to develop/update care plan. CHW forwards Care Management encounter to Nurse.
3. Nurse reviews chart, care plan and goals. Nurse:
   i. Addresses clinical questions and triage needs
   ii. Reviews medical and medication history with patient
   iii. Assists with transitions between levels of care
   iv. Provides additional education and disease prevention information
4. Nurse tracks (daily) metrics into Care Management Log:
   i. Date of initial follow-up
   ii. Date of next follow-up (based on patient need/at minimum next month)
   iii. Status of care plan:
      a. Started
      b. Declined
5. Nurse submits chart to patient's Usual Care Provider.

Creating & Documenting a Care Management Plan

Review the Patient Chart

1. Pull the patient's chart in EHR. You must go to received charts on the right hand menu to view. Double-click the patient chart to open.



2. Review the following information to get an understanding of the patient:
    a. Patient's problem list
    b. Medication list
    c. Open orders in the lower right hand box
    d. Last visit note
    e. Recent patient messages
3. Notice any items that require follow-up and notate on ACM checklist.

Communicate with Members of the Care Team

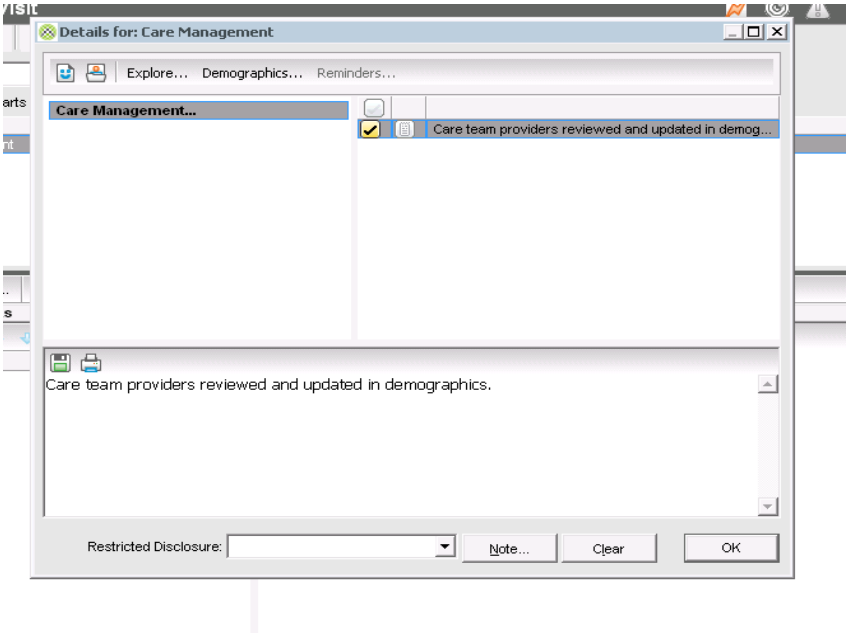
- Make one attempt to contact the patient's usual provider by phone, face-to-face, or patient message to get a better understanding of the patient's needs and prioritization of goals.
- Review outstanding referrals with CHW staff, if applicable

Contact the Patient

- Contact the patient by phone.
    - If patient responds, and is open to continue with care management visit, continue to the EHR documentation.
    - If patient responds, but is not interested in participating right now, document in chart (patient words), create care plan, and send to the patient with a letter.
        i. Ask if patient would like to be contacted in a few months to check-in. Document the follow-up date on the Care Management Checklist.
    - If patient does not respond after first contact, make 2 more attempts. If there is no contact after the 3rd attempt, continue the care plan using the information documented in the chart and send it to the patient with a letter. Track the number of calls on the Care Management Checklist.

Documenting in the EHR

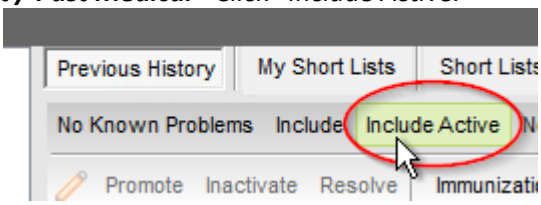
1. *Review Reason for Visit (previously documented by CHW)–*
    a. Select "Care Management". Click OK. You may come back to check the box next to "Care Team providers reviewed and updated in demographics" after update is completed.
    b. If a "Transition of Care" has occurred include that as a reason for visit.



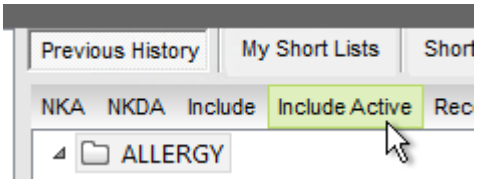
2. *Patient Words – Document if the encounter was done face-to-face or by phone.*

Review Patient History (Problem List & Medical History)

1. ***History: Problem List / Past Medical*** *- Click "Include Active."*



2. ***History: Allergies*** *- Ask the patient about any allergies and if accurate click "Include Active." If inaccurate, update and then choose "Include Active."*



3. ***History: Medication*** *- Ask the patient about any medications including over-the-counters, herbal therapies, supplements and vitamins. Ensure doses and frequency is accurate. If the medication list is accurate chose "Include Current." Click "Reconcile."*
    a. *Remember to document if the patient is not taking any over-the- counter medications, herbals or supplements.*

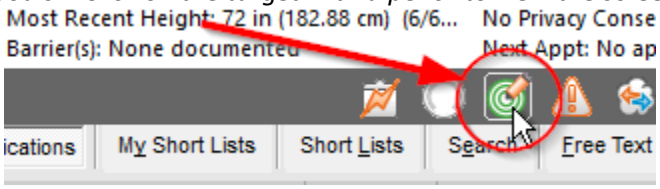
b. *If the patient reports not taking medications as prescribed include how the patient is or is not taking medications in the "Patient Words" section. Review last refill dates and make sure all medications are up to date.*

Reviewing the Current Care Plans and Goals

This care plan must:

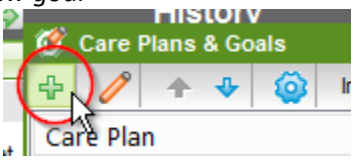
- **Incorporate patient preference and functional/lifestyle goals**
- **Identify treatment plans & goals, including a self-management plan.**
- **Assess and address potential barriers to meeting goals by creating a care plan**

1. *Care Plan and Goals – Click on the target with a pencil to view the screen.*



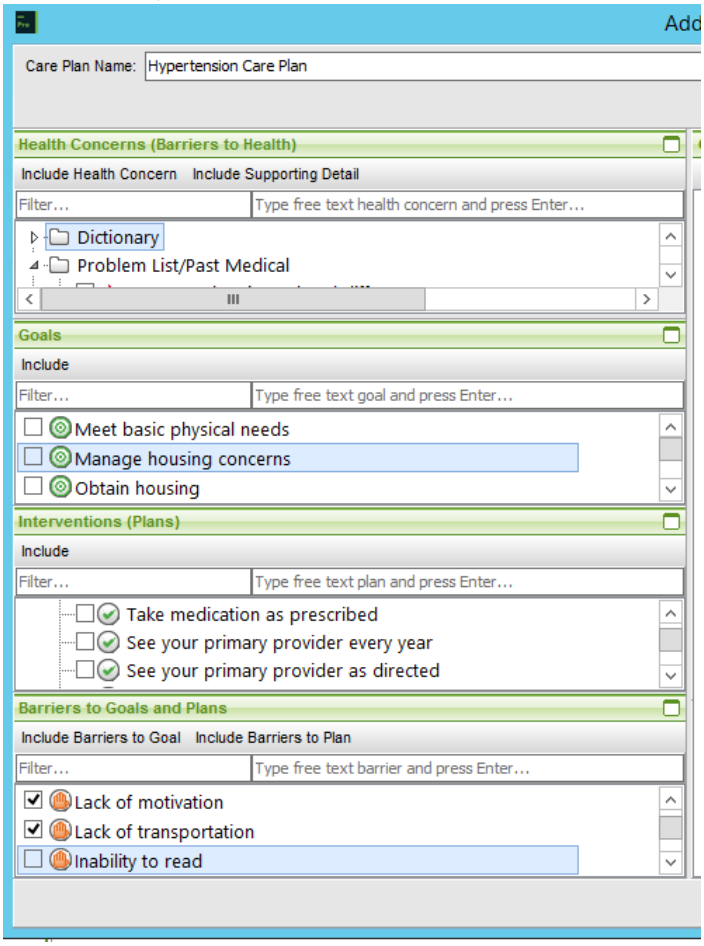
Functional & Lifestyle Goals

2. *Review the current goals and ask the patient how they are doing with achieving these goals. If additional goals are needed, make functional/lifestyle goal **based on the items identified for follow-up in the chart review (problem/medical) or open items**. You can support in brainstorming and then create a plan to reach the patient's goal.*
3. *Click the "+" sign to add a new goal*

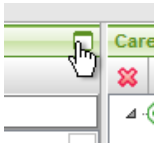


4. *Review each section of the Care Plan, as follows:*
    a. Care Plan Name: Create a name for the Care Plan or select on from the dropdown menu.
    b. Health Concerns: Select the diagnosis (es) that you are creating goals for by checking the box (es) and clicking "Include Health Concern". Diagnoses that may be secondary to the main diagnosis can be added by highlighting the primary diagnosis and clicking "Include Supporting Detail.
    c. Goals: Check the box (es) for the goals related to the Health Concerns identified by the patient and click "Include".
    d. Interventions (Plans): With the **Goal** highlighted, check the box (es) for the intervention related to the goal and click "Include".
    e. Barriers to Goals and Plans: With the **Goal** or **Intervention (Plan)** highlighted, check the box (es) for the barrier related to Goal or Plan and click "Include Barriers to Goal" or "Include Barriers to Plan".

5. *Once Care Plan is reviewed, click "OK".*

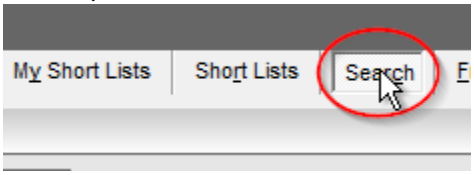


Tip: Expand each screen by clicking the window icon on the right hand corner of the section.

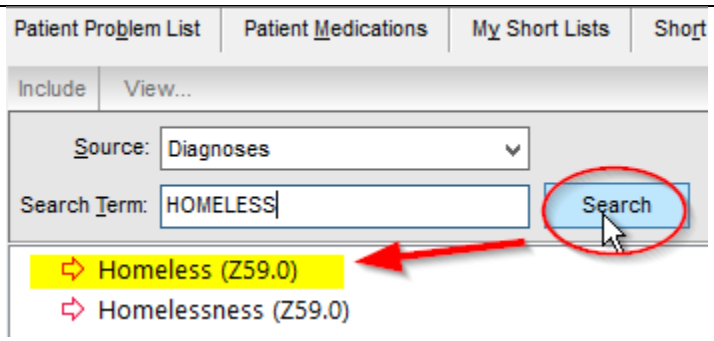


Tip: If the patient is experiencing homelessness and the diagnosis is not listed:

a. Go to the "Assessment/Plan" section of the chart and click on "Search."



b. In the "Search Term" field type "HOMELESS" and click "Search."
c. Double click on "Homeless (Z59.0)" to include it in the encounter.



Importance of Patient Preference

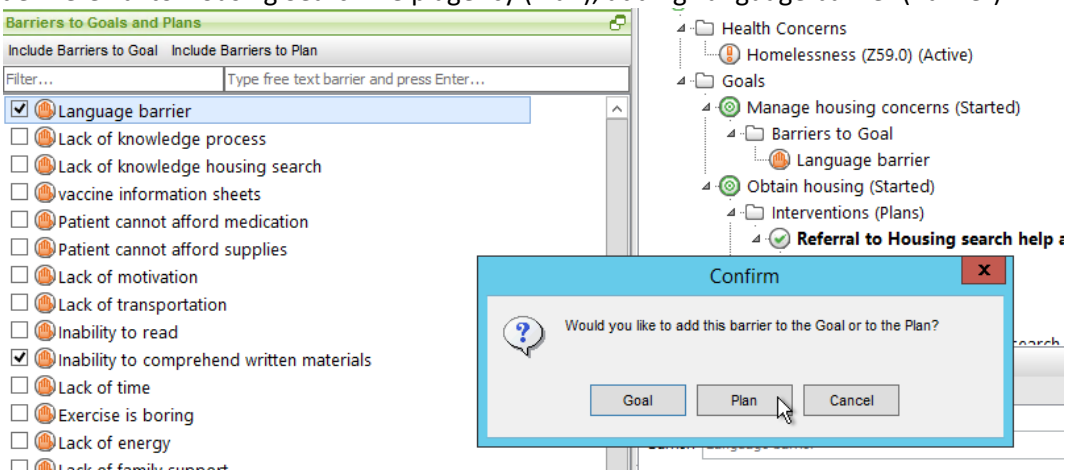
Patients should be provided an opportunity to decide on ways that they would like to meet their goals and which interventions can be prioritized now versus in the future. The nurse will document this in the Intervention (Plan) comments.

- For each goal, identify:
  1. Status
     a. Started – Patient is starting goal today or has already started goal.
     b. Suspended – Patient would like to revisit foal at a later time.
     c. Abandoned – Patient no longer wants to work towards goal or has made not steps to work towards goal
     d. Met – Patient considers goal as accomplished
  2. Start Date (end Date, if applicable)
  3. Patient Engagement – Pick the option closes to the patient's current level of engagement:
     a. Avoiding change
     b. Considering change
     c. Preparing for change
     d. Making the change
     e. Maintaining the change
  4. Goal Type – Most goals should patient goals, specify goal type:
     a. Patient
     b. Provider
     c. Collaborative Goal
- For each plan, identify progress on plan.

Addressing Barriers & Other Interventions

Confirm the interventions identified previously with the patient. If barriers have been identified for specific plans or goals, with the **Goal** or **Intervention (Plan)** highlighted, check the box (es) for the barrier related to Goal or Plan and click "Include Barriers to Goal" or "Include Barriers to Plan".

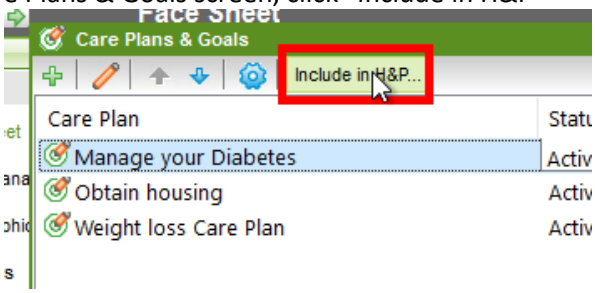
Ex. Under Referral to Housing Search Help agency (Plan), adding Language barrier (Barrier)



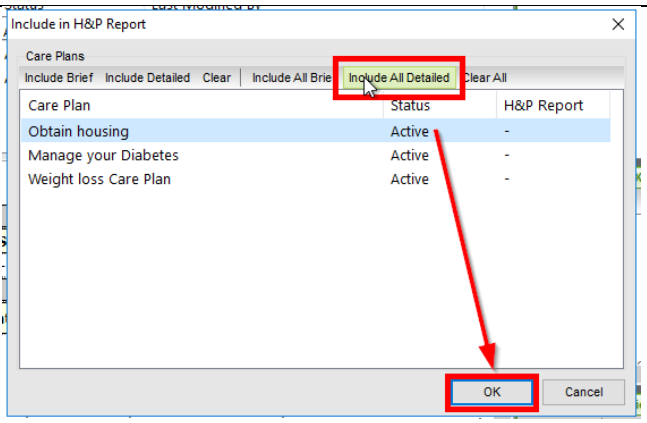
Review the interventions to ensure that plans have been addressed appropriately:

- **All patients should have a self-management plan**. The plan can include "Maintain a blood sugar log" or other self-management plans. In the "Comments" field document if the patient has the necessary equipment, understands frequency of testing and when to notify the provider.
- All **patients who are prescribed medications** should have "Take medications as prescribed" with patient compliance, understanding and need for refills addressed and documented in the "Comments" section.

1. *Update the Care Plan to be included in today's Encounter (please do not include Behavioral Health care plans)*
    a. In the Care Plans & Goals screen, click "Include in H&P"



    b. Click "Include All Detailed". Click OK.

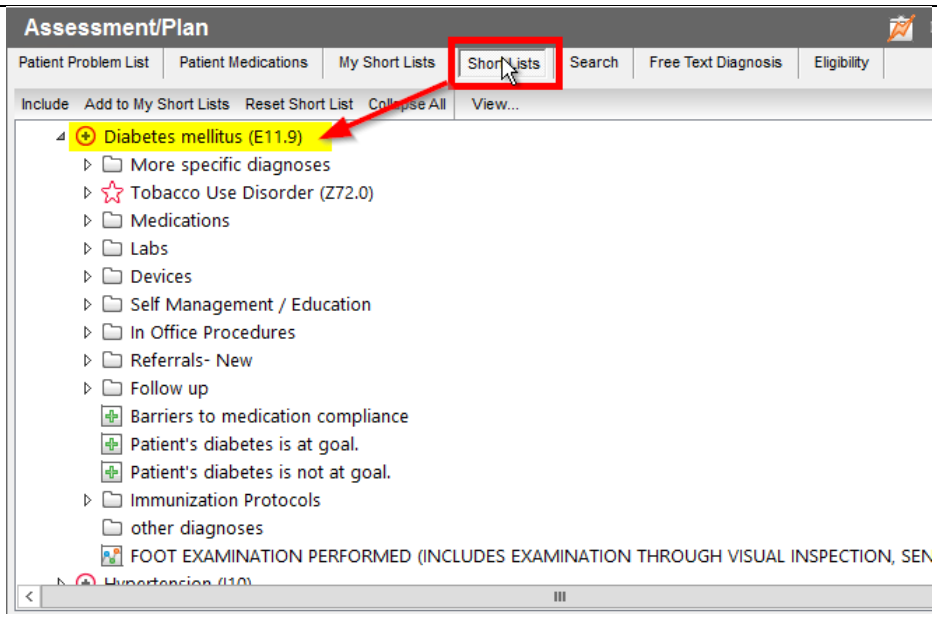


Providing Patient Education & Updating Treatment Plan

- **For patients experiencing homelessness** - The nurse/CHW is responsible for tracking any patient who is experiencing homelessness until housed and stable. Once the patient is housed and stable, resolve the diagnosis by going to patient's face sheet. Click once on the diagnosis to highlight it and right click on it. Chose the option "Resolve."
- **For patients with Diabetes Mellitus** – Review the chart for compliance with the following recommendations:
    a. Diabetes Education visit with RN – **yearly**, if patient is interested
    b. Influenza vaccine – **yearly**
    c. Pneumococcal vaccine once with booster in – **Within 5 years**
    d. Lab work:
        i. Urine microalbumin: creatinine ratio – **yearly,** unless abnormal
        ii. Non-fasting lipid panel - **yearly**
        iii. Basic Metabolic Panel (BMP) – **yearly**
        iv. HGBA1C every 3 months if last HGBA1C was 7.0 or greater
        v. HGBA1C every 6 months if last HGBA1C was less than 7.0

If the patient is due for any of the listed orders, go to "Assessment and Plan" and use the "Short Lists" for "PCMH" and then "Diabetes mellitus". Click on the appropriate order for the needed care to include in the note. Discuss with the patient the plan to complete any order included in the note.

- **For patients in the MAT program**
    - Provide Narcan Education
    - Schedule/Order Urine Toxicology Testing



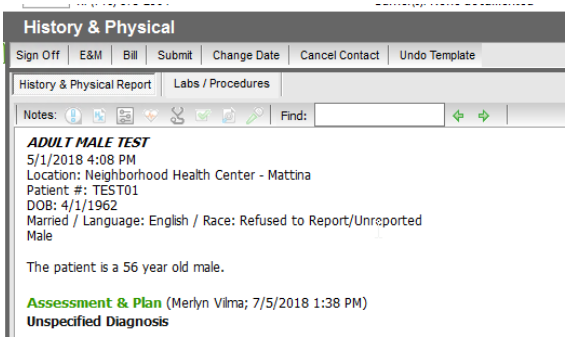
- Refer to the population care management protocol for other specific items for follow-up along with timelines for each item.

Setting up a schedule for Follow-up

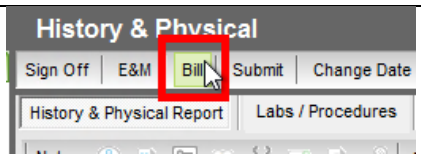
- Be sure to make a plan on when you will either call the patient back to check-in on progress or participate in the next office visit at the health center
- Document in the appropriate "Plan." Also document the plan for follow-up on the "Follow-up" tracking sheet located in P:\Clinical Info\Nursing\Advanced Care Management.
- If the patient states they would not like care management support, include a goal specific to the person and document the decline of support by selecting the appropriate dropdown of Patient Engagement. Offer the patient to check-in in 3-6 months and document in the plan.

Provide the written care plan to the patient / family / caregiver

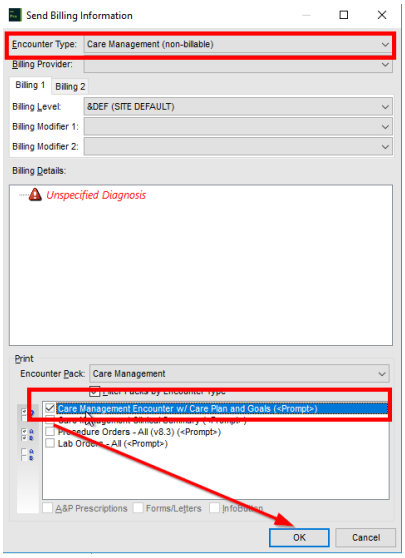
1. *Submit the encounter to the usual provider and provide treatment plan in writing to patient/family/care giver*
    a. In the History & Physical Screen, review the information that you've included in the encounter.



    b. Click "Bill".

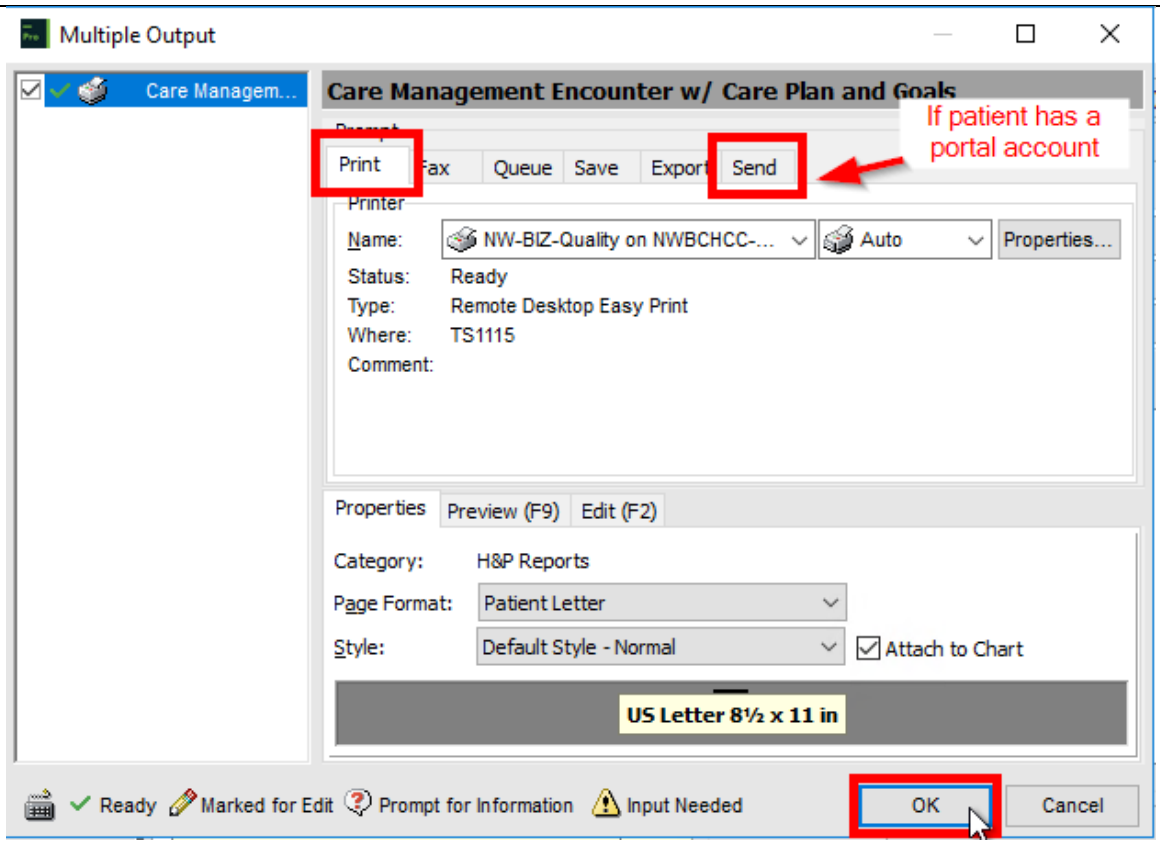


c. Change the Encounter Type to “Care Management”. Check “Care Management Encounter w/ Care Plan and Goals” and click “OK.”

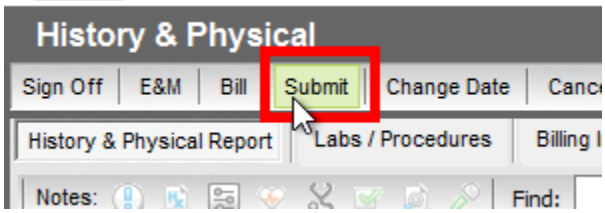


d. Encourage the patient to use the Patient Portal to obtain a copy of the care plan. If sending to portal chose “Send” and click “OK.”

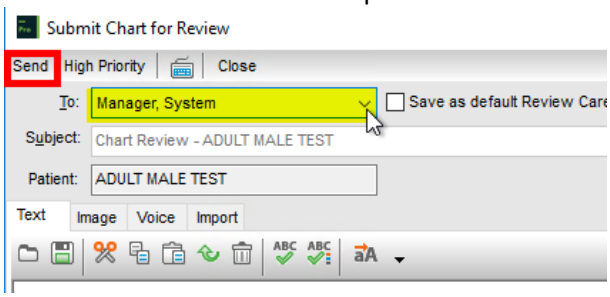
2. If the patient does not have a portal account and is not interested in having an account, print the care plan. If printing chose “Print” and use the drop down box to pick the appropriate printer and click “OK.”
3. Mail or hand the care plan to the patient.



a. Return to the History & Physical screen where you can submit the encounter to the Usual Provider for sign off. Click "Submit."



b. Choose the Usual Provider from the drop down box and click "Send".

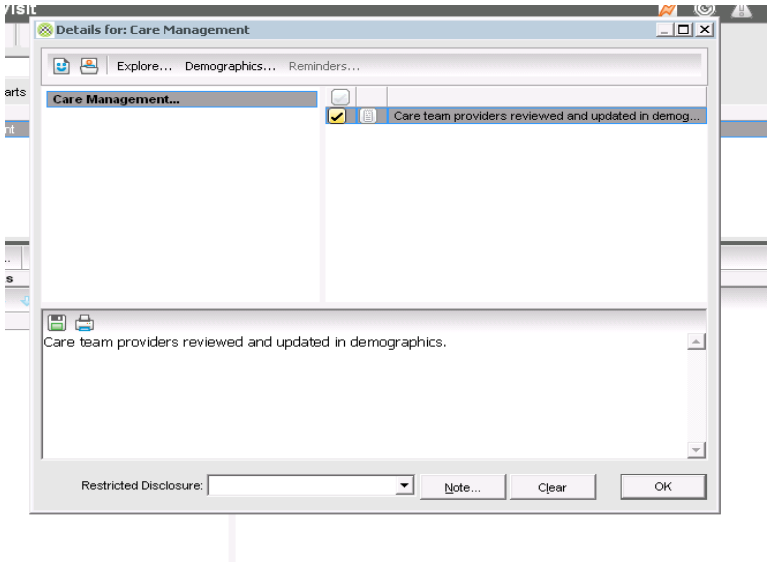


Document Follow-Up Encounter to Initial/ Previous Care Plan

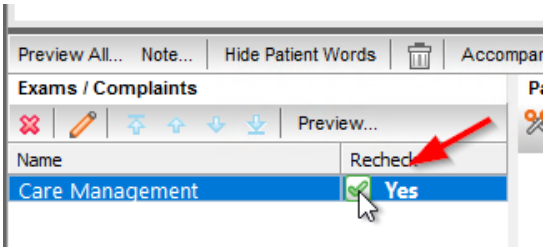
All patients must be contacted within 1-2 days of the documented follow-up date.

1. Reason for Visit –
   a. Select "Care Management". Click OK. You will come back to check the box next to "Care Team providers reviewed and updated in demographics" after update is completed.

b. If a “Transition of Care” has occurred include that as a reason for visit.



c. In the Exams / Complaints list, check the “Recheck” box since this is a follow-up check.



Care Plan is Integrated Across Setting of Care

Upon signature by a provider, the Care Management Encounter is automatically electronically sent to the local Qualified Entity (QE) HEALTHeLINK as a standard C-CDA. This Care Management Encounter document is visible to over 400 plus participating health care providers in WNY and Statewide through the SHIN-NY including hospitals, emergency rooms, specialists, community based organizations, and other primary care practices.

Tracking Metrics & Follow-Up

1. Nurse will also document the following in the patient registry report:
    a. Date of initial follow-up
    b. Date of next follow-up (based on patient need/ no more than 90 days from the date of this care plan)
    c. Status of care plan:
        i. Completed
        ii. Declined