

Care Coordination – for CHWs

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General Workflow

1. Registry report is run (monthly).
2. CHW reviews chart.
3. CHW reviews current care plan. If patient is not receiving nurse care management services, CHW will develop a new care coordination plan with patient.
4. CHW communicates with usual provider and/or nurse care manager to understand patient need.
5. CHW:
 - i. Screens patients due for social determinant of health assessment
 - ii. Supports care management needs & updates care coordination plan
 - iii. Connects and assesses need for community resources and social supports with provider and nurse care manager (if applicable)
 - iv. Provides patient education and disease prevention information (if applicable)
 - v. Measures progress to goals and works with care team to modify, as needed
 - vi. Ensures consistent access to services
6. CHW 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
7. CHW sends chart to Care Management nurse for review.

Creating & Documenting a Care Coordination Plan

Review the Patient Chart

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

Communicate with Members of the Care Team

- Make one attempt to contact the patient's usual provider or care management nurse (if assigned) by phone, face-to-face, or patient message to get a better understanding of the patient's needs and prioritization of goals.
- Review most recent care plan with care management nurse (if assigned)

Contact the Patient

- Contact the patient by phone.
 - If patient responds, and is open to participating, continue to the SDOH assessment.
 - If patient responds, but is not interested in participating right now, create a care plan using the information documented in the chart and send to care management nurse. Document that patient is not interested in patient words.
 - 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, create a 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.

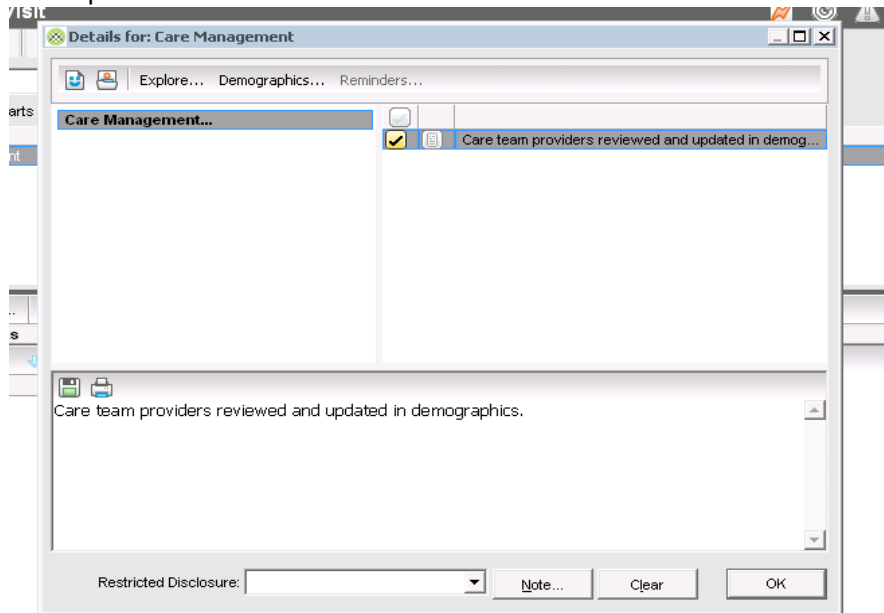
Complete the Social Determinant of Health Assessment

- Review the questions of the SDOH questionnaire with the patient over the phone and document the responses in the Care Management Checklist.
- As you go through the assessment, address any interventions that can be put in place and notate any referral/social supports provided in the checklist for CHWs.
- Use patient education statements in CHW shortlist to document any specific supports or referral information provided (if available). Supports can also be document as notes in Patient Words.

Documenting in the EHR

1. Reason for Visit –

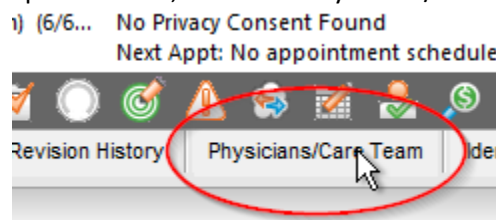
- a. Select “Care Management”. Click OK. You will come back to check the box next to “Care Team providers reviewed and updated in demographics” after update is completed.



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

3. Demographics – Update the care team providers.

- a. In the Demographics screen, click the “Physicians/Care Team” tab.



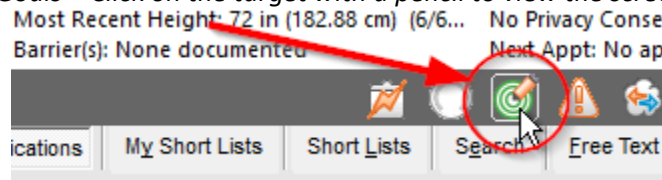
- b. Ask the patient who the Usual Caregiver is and verify it is accurate.
If it is not accurate, send a patient message to the front desk supervisor at the site the patient is usually seen with the updated information.
- c. Ask the patient about any referral or additional providers involved in the patient’s care and verify the care team is accurate.
If a provider needs to be added use the plus sign to add a provider and chose “Add Caregiver.”

Developing & Reviewing Care Plans and Goals

This care plan must:

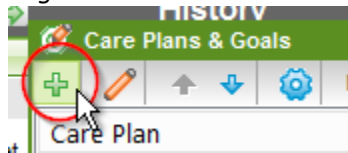
- Incorporate patient preference and functional/lifestyle goals
- Identify treatment plans & goals, including a self-management plan.
- Assess and address potential barriers to meeting goals by creating a care plan

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



Functional & Lifestyle Goals

2. Ask the patient to make functional/lifestyle goal **based on the items identified for follow-up in the chart review or social determinant of health assessment**. 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. Address each section of the Care Plan, as follows:

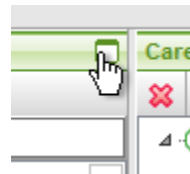
- d. Care Plan Name: Create a name for the Care Plan or select on from the dropdown menu.
- e. Health Concerns: Select the diagnosis (es) that you are creating goals for by checking the box (es) and clicking "Include Health Concern". Diagnoses that may be secondary to the main diagnosis can be added by highlighting the primary diagnosis and clicking "Include Supporting Detail".
- f. Goals: Check the box (es) for the goals related to the Health Concerns identified by the patient and click "Include".
- g. Interventions (Plans): With the **Goal** highlighted, check the box (es) for the intervention related to the goal and click "Include".
- h. 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 complete, click "OK".

The screenshot shows a care plan interface for 'Hypertension Care Plan'. It is divided into several sections, each with a filter and a list of items:

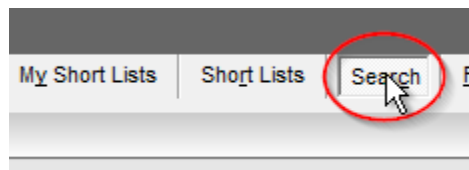
- Health Concerns (Barriers to Health):** Includes a filter and a list with 'Dictionary' and 'Problem List/Past Medical'.
- Goals:** Includes a filter and a list with 'Meet basic physical needs', 'Manage housing concerns', and 'Obtain housing'.
- Interventions (Plans):** Includes a filter and a list with 'Take medication as prescribed', 'See your primary provider every year', and 'See your primary provider as directed'.
- Barriers to Goals and Plans:** Includes a filter and a list with 'Lack of motivation', 'Lack of transportation', and 'Inability to read'.

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.

Note: For other diagnoses (Diabetes, etc.) , click Patient Problem List and double click the appropriate diagnosis.

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 CHW will document this in the Intervention (Plan) comments.

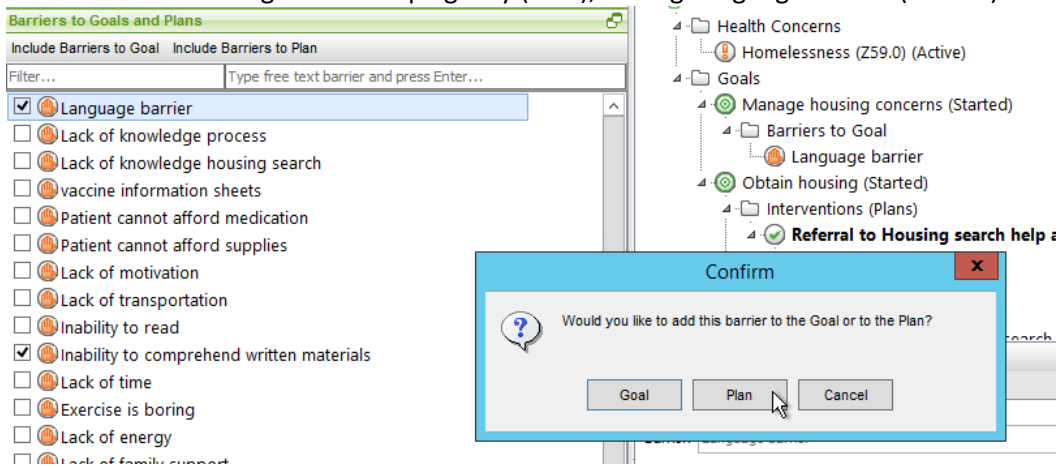
- For each goal, identify:
 1. Status
 - a. Started – Patient is starting goal today or has already started goal.
 - b. Suspended – Patient would like to revisit foal at a later time.
 - c. Abandoned – Patient no longer wants to work towards goal or has made not steps to work towards goal
 - d. Met – 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

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)

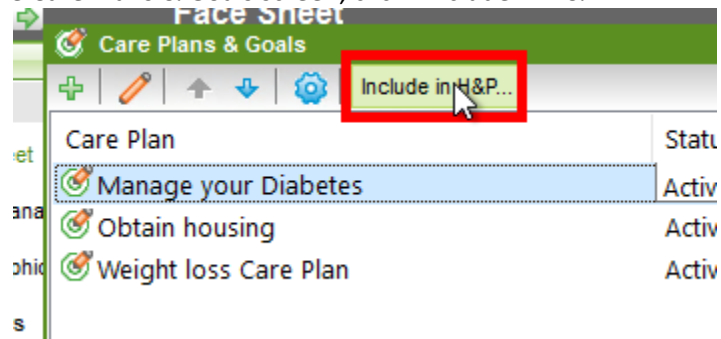


See below for interventions to be provided for the plans listed below (along with comments):

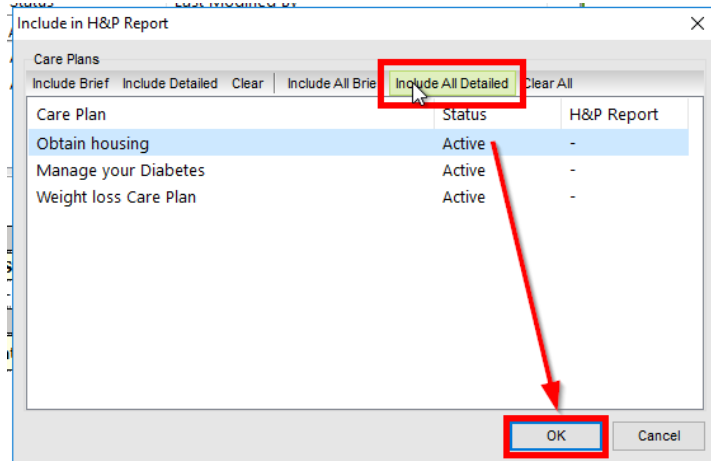
- **All patients should have “See your primary provider as directed”** with the date of the next visit documented in the “Comments” field. If the patient does not have a follow-up visit scheduled, schedule the visit as directed.
- All **patients with outstanding labs** should have “Keep your lab work appointments” with the plan to get the labs completed in the “Comments” field. If the patient declines to complete, notify the ordering provider through a patient message.
- All **patients with outstanding radiology or imaging orders** should have “Keep radiology/imaging appointments” with the plan to get the radiology/ imaging completed in the “Comments” field. If the patient declines to complete, notify the ordering provider through a patient message.
- All **patients who have multiple care providers or outstanding referrals** should “Keep appointments with recommended referrals” with the dates of all upcoming appointment noted in the “Comments” field. If the patient does not have an appointment scheduled for another care provider and should, support the patient in scheduling. Any outstanding referrals should have a documented plan to complete. If the patient declines to complete, notify the ordering provider through a patient message.

1. Include the Care Plans and Goals 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:
 - Diabetic Retinal Exam (DRE) – **yearly**
 - Podiatry Visit – **yearly**, if patient is interested
 - Nutritionist Visit – **yearly**, if patient is interested

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** - Verify
 - Seeing Behavioral Health provider
 - Confirming Narcan Education or refer to nurse for education
 - Verify Consent in Chart
 - Confirm Urine Toxicology Testing – Flag chart for nurse to complete

The screenshot shows the 'Assessment/Plan' interface. The 'Short Lists' tab is selected and highlighted with a red box. Below the tabs, there are buttons for 'Include', 'Add to My Short Lists', 'Reset Short List', 'Collapse All', and 'View...'. The main content area displays a list of short lists. The first item, 'Diabetes mellitus (E11.9)', is highlighted in yellow and has a red arrow pointing to it. The list includes various categories such as 'More specific diagnoses', 'Tobacco Use Disorder (Z72.0)', 'Medications', 'Labs', 'Devices', 'Self Management / Education', 'In Office Procedures', 'Referrals- New', 'Follow up', 'Barriers to medication compliance', 'Patient's diabetes is at goal.', 'Patient's diabetes is not at goal.', 'Immunization Protocols', 'other diagnoses', and 'FOOT EXAMINATION PERFORMED (INCLUDES EXAMINATION THROUGH VISUAL INSPECTION, SEN'. The interface also shows a scroll bar at the bottom.

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

Setting up a schedule for Follow-Up

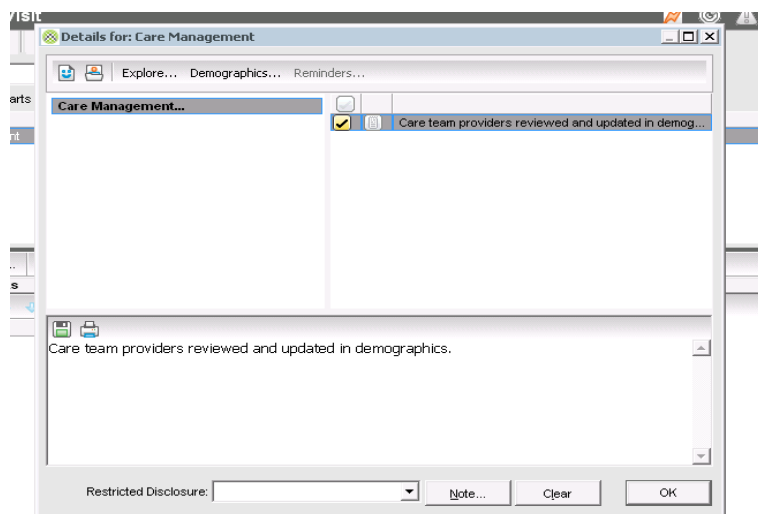
- Be sure to make a plan on when you will either call the patient back to check-in on progress or participate in the next office visit at the health center
- Document in the appropriate “Plan.” Also document the plan for follow-up on the “Follow-up” tracking sheet located in P:\Risk Stratification.
- If the patient states they would not like further 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 months and document in the plan.

Document Follow-Up Encounter to Initial/ Previous Care Plan

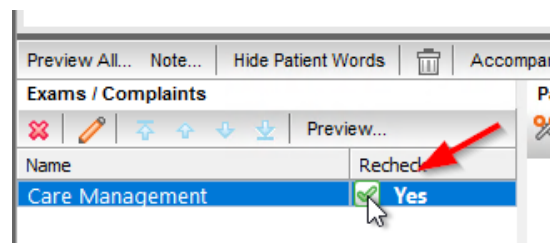
Every initial Care Plan that is created should have a plan for when you will follow-up with the patient which needs to be documented in the appropriate tracking spreadsheet found in P:\Community Health Worker\CH - Care Coordination

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.



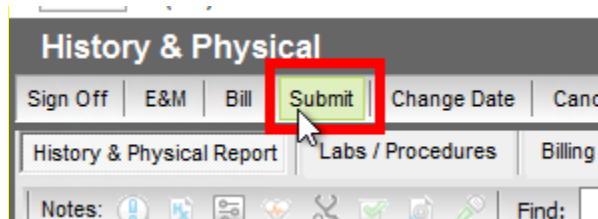
2. *Patient Words – Document if the encounter was done face-to-face or by phone.*
3. *Follow previous steps to update care team, demographics, history, functional/lifestyle goals and treatment plan, schedule follow. Document next follow-up date in tracking sheet.*

Sending the Care Management Note to Nurse

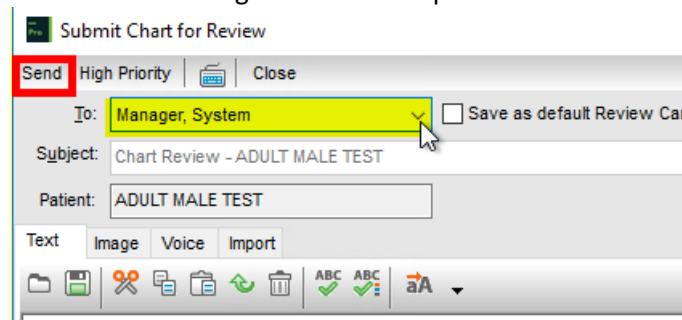
Patients may need additional follow-up from the Care Management Nurse for Medication Reconciliation and clinical follow-up. Use the following script to prepare the patient for the additional follow-up:

“Thank you for sitting/speaking with me today about some of our follow-up items. A nurse will be reach out to you in the next day or two to follow up on [insert items]. In the meantime, if you have any question, please give me a call at [extension number].”

1. Return to the History & Physical screen where you can submit the encounter to the Care Management Nurse for review.



2. Choose the Nurse Care Manager from the drop down box and click “Send”.



Tracking Metrics & Follow-Up

1. CHW will also document the following in the patient registry tracking form:
 - 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. Started
 - ii. Declined