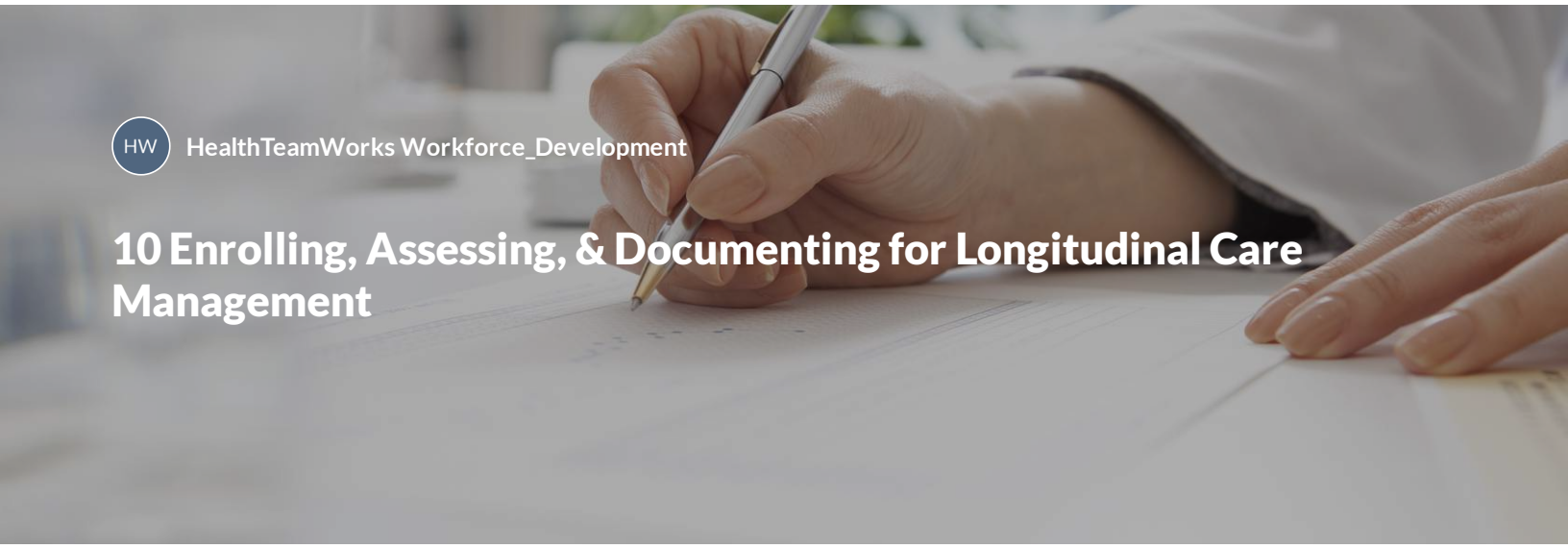

HW HealthTeamWorks Workforce_Development

10 Enrolling, Assessing, & Documenting for Longitudinal Care Management

Lesson 1 of 13

Introduction & Learning Objectives

HW HealthTeamWorks Workforce_Development

01:02

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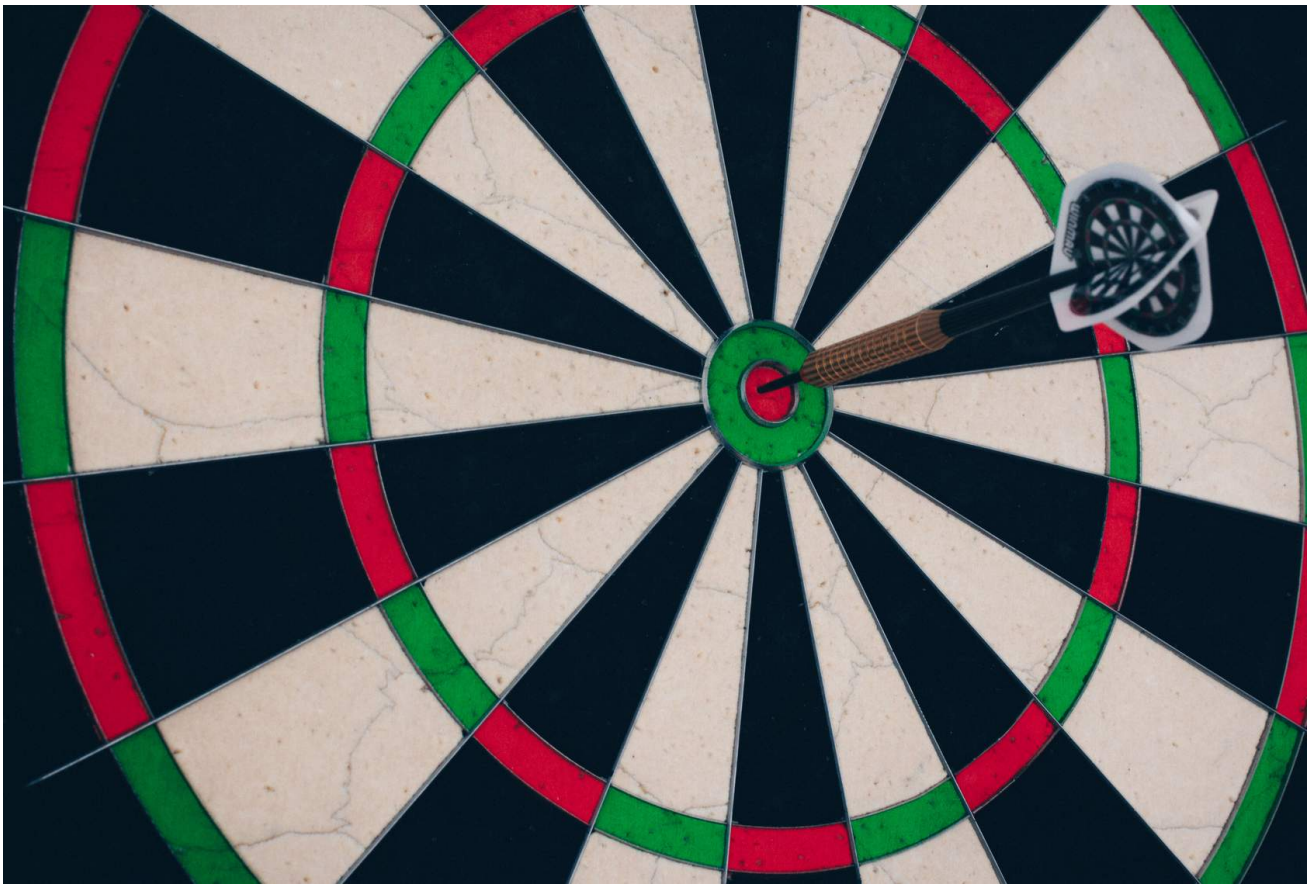

Now that you have identified the best candidates for LCM, the next step is to start the enrollment and assessment process. In addition to that, ensuring that you have clear, accurate documentation of encounters with the patients is crucial. In this

course, you will learn about the administrative and documentation steps to take when guiding a patient through the enrollment process so that you can begin the really fun work.

Learning Objectives

Following the completion of this course, the learner should be able to:

- Define key considerations of enrollment into a longitudinal care management program.
- Identify the necessary components of a comprehensive assessment for enrollment into longitudinal care management.
- Create a template for documentation that can be immediately introduced into your practice or organization.

Administrative Details about Enrollment in Longitudinal Care Management

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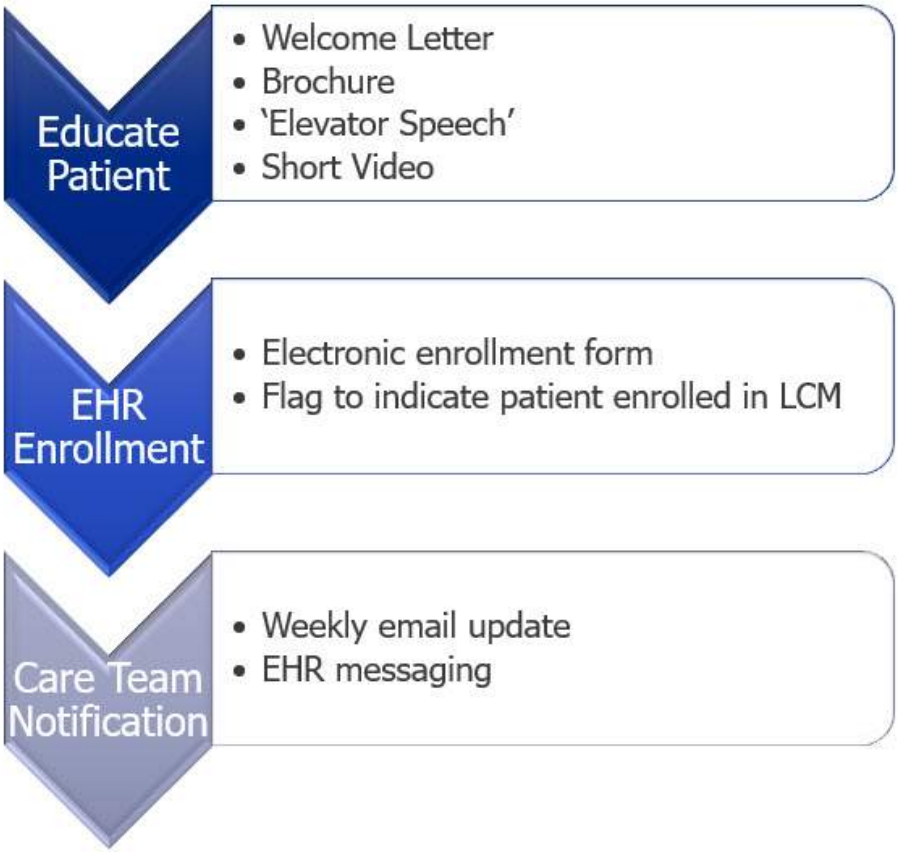
04:02

Click to Play Audio

Once the patient has decided to enroll in LCM, there are a few important administrative details that should not be overlooked.

First, develop a process for educating the patient about the program. There are a few different ways this can be done, and it may be helpful to develop several options, as many people benefit from an approach that combines different learning methods.



- Create a welcome letter that is provided to every patient at the time of enrollment. This letter should describe the program, what the patient can expect to receive by participating, as well as some general information about time commitment and requirements. This way they have the information in writing that you have already previously discussed.

- A brochure is helpful to give to a patient that is unsure about whether or not to participate. It should be simple, provide basic information about what the program entails, what the patient will receive by participating, and the time commitment involved. Be sure to emphasize the program requires active participation and isn't just something that "happens to you". It requires engagement and a willingness to make some lifestyle changes and work toward meaningful goals that will improve their health and quality of life.

- Many Care Managers get pulled in to an office visit when a patient is identified that may benefit from LCM. For this, you will want to have an "elevator speech" ready.

- Other times, you may identify that a patient would benefit from LCM when looking at the high-risk list of patients or reviewing a disease registry. In these cases, you will most likely be making a "cold call". Cold calls are probably the most difficult method to engage and educate a patient about LCM, as the patient is not there in the office and reacting to lab work, change in health status, or their PCP encouraging them to participate. For these types of calls, it's extremely valuable to have the support of the primary care provider before contacting the patient and have permission to say that their PCP asked you to reach out to invite them to participate in the program. Having the provider's support will go a long way toward chances of the patient engaging.

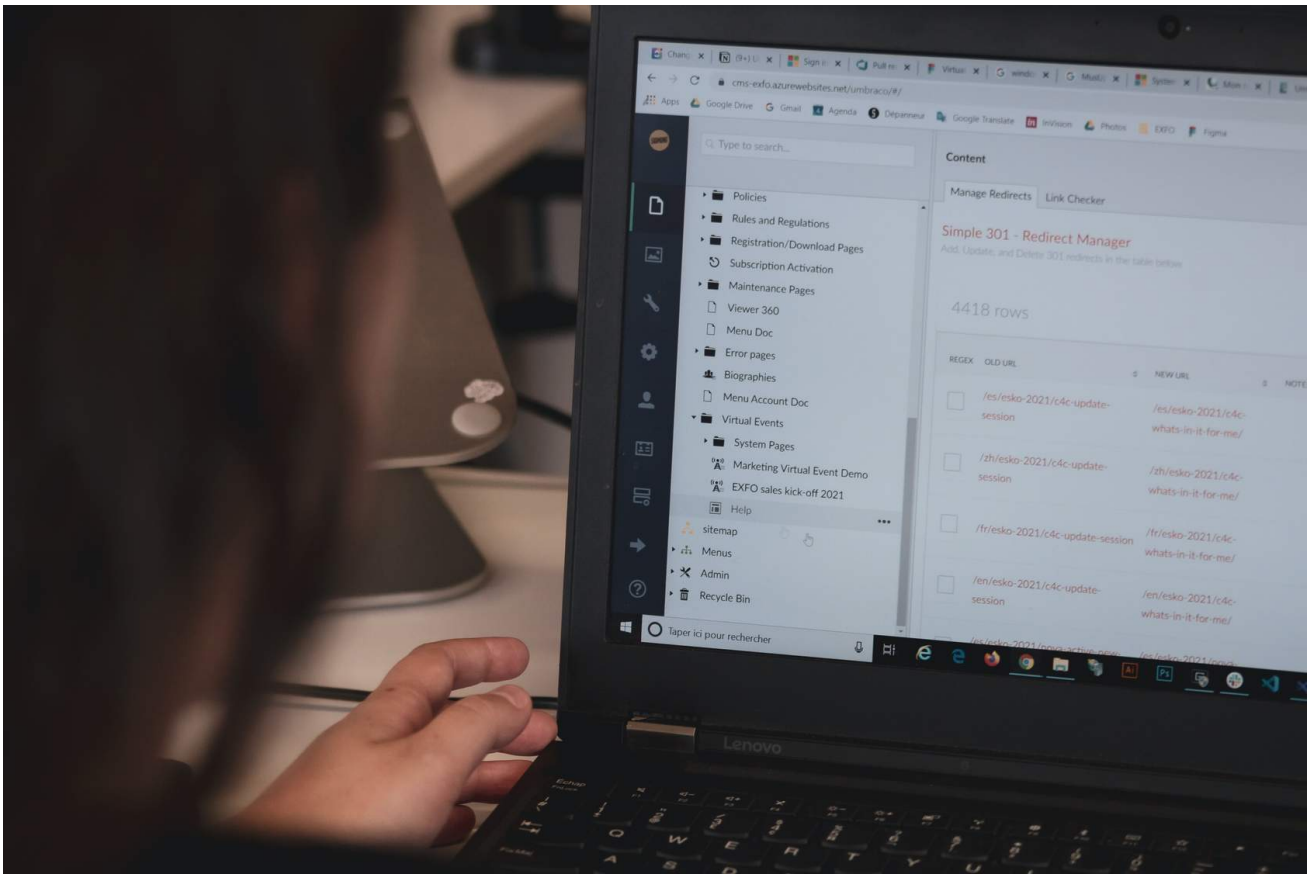
- A short video about LCM is a great way to teach patients about the program. It's especially helpful if you have a large population that's challenged with literacy. This is something that can be shared at the time of an office visit on a tablet or computer, or it can even be available on the practice website if this is an option.

Next, it's important to have a process within the EHR to officially "enroll" the patient in LCM (and later, when they have completed the program, "graduate" from LCM). This process ideally includes two things:

- An electronic enrollment "form" that's embedded in the EHR. You may need to work with your IT team or the EHR vendor to develop this. Depending on the reporting capability of your EHR, reports can be created for the enrollment form, thereby allowing you or leadership to run reports of individuals that are currently enrolled in the program. This can serve to help with monitoring metrics for the CM program.

- A method to "flag" the patient in the EHR so that anyone in the practice that opens the patient's chart will easily recognize that they are currently enrolled in the longitudinal care program.

And last, it's helpful to develop a standardized process for notifying the care team that the patient is enrolled in LCM. This will ensure continuity of care for the patient. Talk with the practice team to develop a process for this. Some practices do this as a weekly email update from the Care Manager, others choose to simply send a notification through the EHR. And other practices have indicated that they share this information at a weekly care team conference.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Content
Manage Redirects
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Simple 301 - Redirect Manager
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Registration/Download Pages
Subscription Activation
Maintenance Pages
Viewer 360
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Virtual Events
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Marketing Virtual Event Demo
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Menus
Admin
Recycle Bin
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Lesson 3 of 13

Educating Patients about LCM

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02:42

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There are several key pieces of information to share when educating patients about the LCM program.

What LCM is and How Can it Help

Whenever possible, tailor this information to the patient's individual needs. If the patient is dealing with a lot of psychosocial concerns, advise them the program can help them meet those needs. Develop an "elevator speech" that includes your main

talking points or core messages about the program and leave room or space for individual information.

Time Commitment

This includes how often you will make contact, how much time they will need to spend on their own, and how long patients are typically in the program based on their needs.

Engagement Details

You will also want to talk about when and how contact occurs. The frequency of contact may vary throughout an engagement with more frequent "visits" in the beginning as the patient is learning the process and you are learning about the patient. You may also want to meet face to face initially then move to telephonic contacts once the patient has gained confidence around self-management. In between visits you may also engage via email, text messaging, and or patient portal.

Remember, patients have a choice to engage or not engage in LCM. When you explain the program during your initial interaction, try to incorporate what you already know about the patient's history or circumstances to put things in a framework that they can relate to, and hopefully then make the decision to engage.

For example:

If you know John has had 4 hospitalizations for Heart Failure in recent months, and he's the sole caregiver for his wife with dementia, he most likely wants to avoid hospitalizations. So, use this information as context to help him move forward with the decision. You can explain the program will help him learn to manage the condition, so he can avoid hospitalization as much as possible. Also, advise you may also be able to help with some resources to reduce his caregiving burden.

Or if you know Jane, a forty-year-old patient working full-time may be worried about the time commitment involved in LCM, let them know you will strategize the best way to work together with the least impact on their work schedule. Maybe it's touching base by text or lunchtime phone calls for check-ins.

Be creative and innovative with your approach and meet patients where they are.

Lesson 4 of 13

The 5 Steps of Longitudinal Care Management

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01:21

Click to Play Audio

When completing the initial outreach and enrollment for LCM, there are 5 key steps to follow, and important processes within each step. This process is similar to the steps you learned in the Episodic CM course, with the addition of a new step for care planning.

1. **Review** – this will encompass all the details that need to be reviewed prior to outreaching to the patient
2. **Outreach** – this encompasses the outreach and assessment of the patient
3. **Care Plan** – this is the personalized care planning that you will do with the patient to ensure they have an actionable plan with goals that align with their values
4. **Document** – this encompasses the details that need to be documented from the outreach and assessment
5. **Follow up** – this is the communication that needs to take place with the patient's different care providers, and any coordination or referrals that need to be completed.

The following modules will provide details for each step.

Lesson 5 of 13

Step 1: Chart Review

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05:05

Click to Play Audio

Before meeting with the patient for the first time, whether in person or over the phone, prepare for the visit by gathering some background information. This includes a chart review of several key areas that we call domains. This chart review is not to be confused with the quick chart review completed to determine if the patient may be a candidate for LCM. This chart review is more in depth, and you will want to take notes on pertinent areas for exploration when you meet with the patient.

Reviewing the chart and assessment in specific domains will ensure that you capture all of the pertinent information needed to effectively work with the patient. Each of these domains combined, cover the many facets of a patient's health, lifestyle, and circumstances that impact their overall functioning and outcomes. One helpful tip might be to develop your documentation around these domains of care.

1. **Chronic Conditions:** Start by looking at the patient's chronic conditions, diabetes, COPD, heart failure, multiple sclerosis, etc., to understand the different conditions the patient has, and how these conditions or treatment may interact with one another. Also, look at the patient's health history so you have an idea of all co-morbid issues. For example, if a patient has both Heart Failure and Kidney disease, you will need to be aware of the plan of care from both the cardiologist and the nephrologist, if they're involved.

2. **Medications and Adherence:** Review the medications and make note of any areas you see potential concern (e.g., high-risk medications, meds with complicated instructions). Most likely you won't be able to fully assess adherence until you outreach to the patient, but make note if you see anywhere in the record indicating the patient has poor adherence, this will need to be explored in depth.

3. **Mental Health:** It's important to understand if the patient is diagnosed with any mental or behavioral health conditions, or if there are underlying untreated symptoms. Undiagnosed and/or untreated mental/behavioral health conditions can adversely impact an individual's ability to adhere to a treatment plan, and ultimately impact outcomes.

4

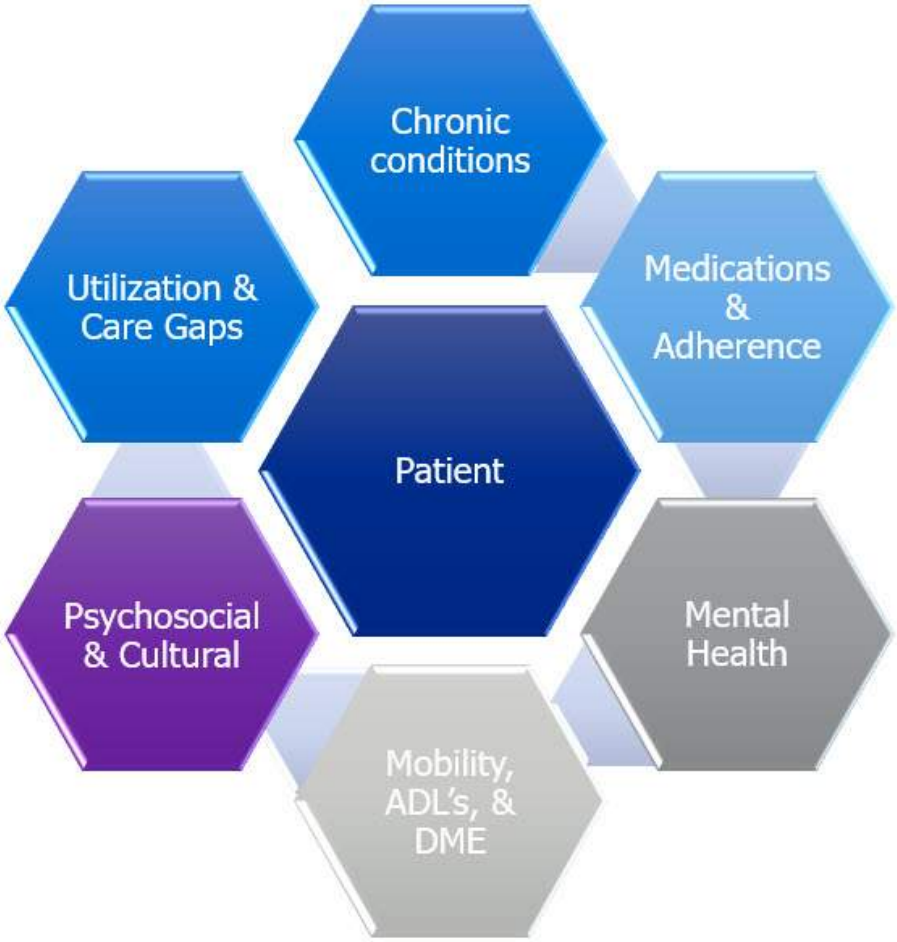
Mobility, Activities of Daily Living (ADLs), & Durable Medical Equipment (DME): It's helpful to understand the patient's ability to get around and complete their activities of daily living. Do they require assistance? If so, is there a capable person to assist? For example, if an elderly patient requires full assistance for all ADL's or Instrumental Activities of Daily Living (IADLs), and their only support is a spouse who is frail, this will require some deeper investigation and possible coordination of care. Be sure to assess for safety concerns here too. Inquire about falls, other safety events, and if the patient has a "Life Alert" if you believe this is indicated.

5

Psychosocial & Cultural: You will want to understand the many factors impacting the individual's life and circumstances – housing, transportation, finances, access to care, insurance, family/friends, overall support (think about Maslow's hierarchy of needs). This information will provide significant clues into needs for coordination and or additional support. Also, look at any cultural/spiritual data available. This will inform your care and help to prepare for outreach (e.g., if an interpreter is needed, you will want to arrange this prior to the outreach).

6

Utilization and Care Gaps: Explore the patient's recent utilization and gaps in care. This includes how many hospitalizations or ED visits they've had in the last year or two. Review their adherence to appointments – do they come in for regular care for chronic conditions, or do they use the ED and hospital more often? Also, do they have any care gaps, like overdue for preventive screenings (mammogram, colonoscopy), immunizations, or chronic care visits?



These domains, combined, will provide a comprehensive view of the patient's current health, lifestyle, and circumstances thus, providing you with excellent clues as to where to get started in your work together. Keep in mind that any patient beginning LCM will be experiencing a barrier in at least one of these domains. The more domains with barriers, the more complex your work will be.

For the seriously complex/complicated patients, it is especially important to keep Maslow's hierarchy of needs in mind as you begin the care planning process.

Step 2: Outreach

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07:29

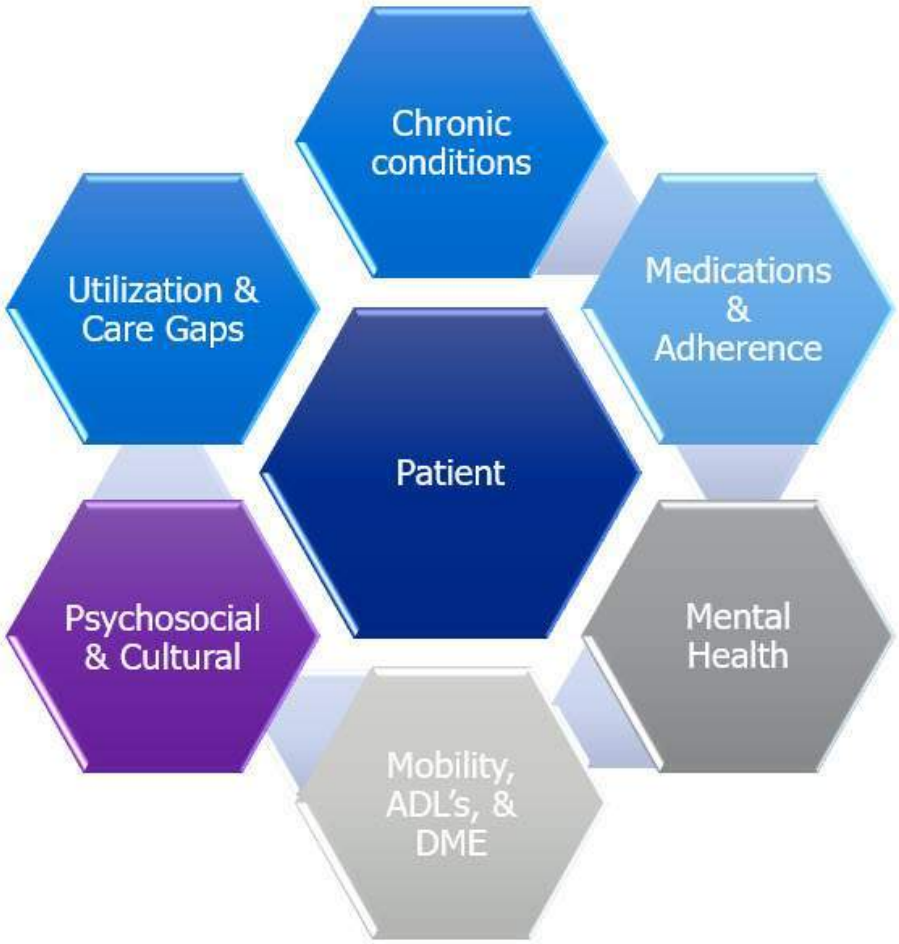
Click to Play Audio

If you're new to Ambulatory Care Management, this will be a very different assessment than what you may have done in the past. For nurses that served in an acute care setting like a hospital, an assessment was comprised of a head to toe evaluation that included auscultation, inspection, palpation, etc. For Medical Assistants now serving in a Care Management role, their previous experience with assessments may have included taking vitals and weights.

In an Ambulatory Care Management setting, your assessment is a conversation, exploring the 6 domains of the patient. It's helpful to use a script, or a guide until you've established flow and gain confidence in covering all material. We have provided a sample script you can tailor and use for your initial outreach for LCM. It's only meant to be a guide! You will have to adapt to each unique patient's circumstances and follow the flow of the conversation based on their needs. There are always key data points to gather, but allow the patient's unique situation to help drive the conversation.

Continue to use the 6 domains that were used for the chart review for your assessment. This will help you stay focused and organized as you work with the patient. If it makes sense to re-order these domains, feel free to do that! The order is less important than the domains themselves. This is meant to be a guide and help to provide a framework you can tailor for your unique practice and style.

Start by talking with the patient about their Chronic Conditions. Explore their knowledge by determining if they know what conditions they have and the trajectory for the condition, or the long-term impact on their health. Determine what they are currently doing or not doing, but know they need to do for self-management. Find out if they're experiencing any concerning symptoms such as chest pain, shortness of breath or other symptoms relative to their conditions.



- Asses their understanding of how to manage any changes in status, where to go for help or self-management tactics. For example, does the patient with heart failure comprehend basic principles of managing the condition to avoid exacerbation?

- Make note of any specialists involved in care, and be sure this is documented in the EHR

Next, discuss Medications and Adherence. If you're meeting face to face, several days before the appointment prompt them to bring in ALL medications they're taking. While this can be a time-consuming task if they have a lot of medications, it is extremely important and enlightening. Often, a thorough assessment at the time of enrollment in LCM reveals significant discrepancies in the medications prescribed and what the patient is actually taking. This can be due to patient choice, finances, confusion, or even multiple specialists prescribing the same medication at different doses. Yes, this has happened! A patient in LCM had 4 different doses prescribed for the same medication by her PCP and 3 specialists. The patient even had multiple bottles of this medication in different doses and did not know which one to take, so she was alternating her dose on different days! Be sure to cover the following:

- Review each medication, including the name of the med, how much they take (dose on bottle and number of pills taken), how they take it (crushed, swallow with water, etc.), any problems or side effects, and assess their understanding of why they take the medication.

- If noted that patient is not taking (or inappropriately taking) something that's prescribed, identify the reason for non-adherence

Move on to Mental Health. Explore any significant mental or behavioral health history. Per your practice protocol, you may also want to complete a depression screen, and possibly even a substance misuse screening. Keep in mind mental and behavioral health can feel "touchy" to patients. Be sure to put into context the connection between mental and emotional health and our physical health, to put the patient at ease. It also helps to explain you ask the same of everyone you work with, so they don't feel singled out.

Transition to discussing Mobility, ADL's, & DME. Cover any safety concerns the patient or caregiver has and find out if they have any additional DME not noted in the EHR. During this assessment, inquire if they're using the DME, and how they're using it. This can potentially uncover concerns or identify reasons for exacerbations or worsening of what was an otherwise relatively stable condition. For example, a COPD patient with recent frequent exacerbations and visits to the ED has perhaps received a new nebulizer they are using incorrectly. It is also important to make note of any DME the patient may need based on your assessment, you will circle back around to this in Step 5: Communication.

Next, assess the Psychosocial and Cultural domain. A validated social needs screening tool is particularly helpful for this segment. It guides you through specific questions to identify common social needs that impact health outcomes. Additionally, clarify if the patient has any special cultural or spiritual considerations of note. Sometimes this can feel like an awkward thing to address. By saying "It's important to me that I provide care in a way that feels safe for you. Is there anything you would like me to know so that I can best serve you?" If the patient doesn't understand what you mean, prompt them by asking what special cultural, religious or spiritual customs inform their decisions about healthcare. If the patient DOES have special customs, be sure to note this so it can be documented in the appropriate place in the EHR so the entire care team has access to this information.

Finally, the 6th domain, Utilization, and Care Gaps. In this domain, discuss any overdue preventive or chronic care needs, colonoscopy, mammogram, overdue A1C or other lab work, and determine the patient's willingness to complete. Utilization does not need to be addressed unless you note an inappropriate pattern, like frequent ED use or inpatient hospitalizations for ambulatory sensitive conditions. If this is the case, ask open-ended questions to understand the root cause such as no transportation to get to PCP, thereby causing the patient to "put off" going to the doctor despite a worsening condition.

Additional items to consider:

- Moving through these different "domains" of the assessment should be a smooth and natural process. There's no need to point out to the patient that you're moving into a different portion of the assessment. Just

make it an easy and natural conversation.

- Make notes throughout your assessment, highlighting items you know will need to be followed up on (e.g., identified needs like DME for safety or mobility, referrals that may need to be made, follow up or communication with a specialist, etc.)

Once you have completed the assessment you will seamlessly move into care planning.

Lesson 7 of 13

Step 3: Care Plan

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01:29

Click to Play Audio

Step 3 in the LCM process is the care plan. We will cover care planning in depth in Collaborative Care Planning, so we will just touch on a few key highlights here as a primer.

The care plan should be patient-focused, centering on the patient's ideas and wishes. Talk about what they are willing and ready to do to manage their health.

Concerns & Motivators

My health concerns are:

Getting healthy matters to me because:

My Goals:

Date Set	Patient Goal (short & long term)	Action Steps	Tools/ Resources	Confidence	Planned Follow up
Example 3/3/19	*Remember to take medications*	*1. Download Rx reminder app 2. Set up personal info in app 3. Set up daily medication reminders*	*Medication Reminder App*	*8*	*3/10/19*

Confidence Scale

Not confident — Somewhat confident — Very Confident

1 2 3 4 5 6 7 8 9 10

Once you have established a plan of action, document it on a patient-centered care plan template, and both the Care Manager and the patient will sign it. Make a copy and give it to the patient, with instructions to keep it somewhere at home that will remind them to stay focused.

Also, make a copy available in the EHR so the entire care team has access.

If the outreach, assessment and care plan are completed over the phone, mail, send a copy of the care plan to the patient along with any ancillary materials they might need such as educational pamphlets, appointment cards, or anything that you previously discussed.

Before ending the visit, thank the patient/caregiver for their time, and re-state the plan, both what they are accountable to complete and what you are accountable to complete. (e.g., they need to do the steps on their care plan and you need to follow up on any care coordination type things like referrals or arranging appointments, etc).

This concludes Steps 2 & 3 - the Outreach and Care Planning portions of your LCM encounter. Next, we'll look at the documentation of your work!

Step 4: Document

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03:00

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By following the six domains as you assess the patient and documenting your findings, you will keep your process consistent across each step. It's also helpful to have a documentation template in the EHR that includes each of the six domains, to ensure pertinent details aren't missed.

Items to document include:

- Level of patient engagement – this can be done using the Patient Activation Measure (PAM) or another activation measurement tool. Additional information on patient activation and engagement will be covered in Establishing the Patient Relationship.
- Areas of concern – this should include the items on which you will be following up. These can be incorporated into the plan of care.
- Plan of care – this is not to be confused with the patient's care plan. The patient's personalized care plan is written in their own words with their own stated goals. As the Care Manager, you likely have some bigger and longer-term goals that you are keeping in mind as you work with the patient and this is where you will want to document that information.

For example, a diabetic patient with an A1C of 12.3% might have their first two goals focused on getting into a habit of checking their blood sugar and remembering to take their medications. These are great goals, and you will work with them toward more advanced goals as they achieve success. But you will likely have a larger end goal in mind for this patient; for example, a goal to get A1C to less than 8.0% within 12 months.

Helpful tip for documentation:

Documentation should be thorough AND concise. You need enough information to capture an accurate picture of the patient and, for the sake of your own efficiency as well as the efficiency of the care team members that read your notes and keep the narrative to only what is necessary.

As you progress in your experience with LCM, you may find there are common concerns identified that can be incorporated into the template as "checkboxes". This will save significant time with documentation, especially as the panel size grows. With checkboxes, there is less need for narrative. That said, you may still want a small amount of narrative in these areas, to flesh out unique details for the patient.

For example – in the 4th domain – Mobility, ADLs, & DME – you could include a standard set of checkboxes to document the type of DME that the patient uses plus a small space for free text, to document the patient's adherence to using the DME. So a patient with a c-pap but is not using it due to "discomfort & claustrophobia" would be documented by a checkbox for the equipment (c-pap) and a free text entry of "not using d/t discomfort and claustrophobia."

Step 5: Communicate

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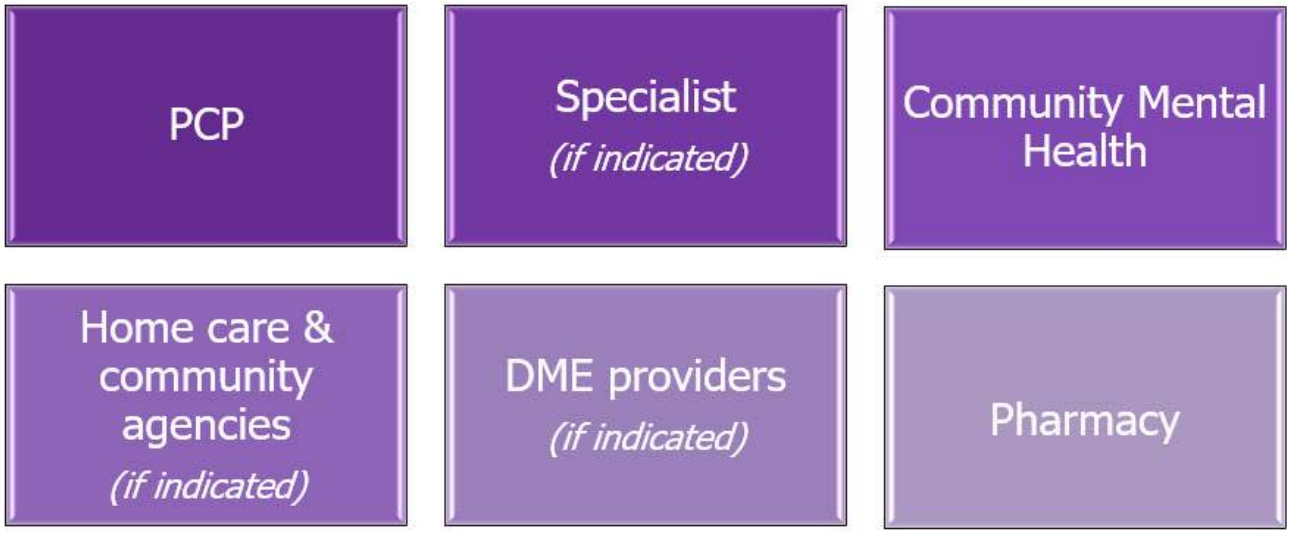
01:49

Click to Play Audio

The last step in this process is communicating to coordinate needs and to keep pertinent care team members informed of patient status. Remember, the care team extends beyond the walls of your practice. This may include specialists, mental/behavioral health, home care or other community agencies, DME providers, and the pharmacy, to name a few.

Communication will need to be tailored to the pertinent audience. For standard outreach to an LCM patient without extenuating concerns, you will most likely only need to communicate within the primary care practice. However, if needs are identified that will be addressed outside the practice, specialist, home care, etc., you will need to tailor the communication to that agency.

Communication with the PCP after LCM encounters varies from practice to practice. Some practices have the Care Manager route all encounters with patients in LCM to the provider for status updates. Other practices determine this is only necessary if there's a concern and provider intervention is needed. It's important to talk with the providers in your practice and establish a process based on their preferences.



With ALL of these communications, it's important to "get your ducks in a row" before reaching out. One approach is the SBAR method of communication (situation, background, assessment, recommendation), this is helpful in organizing your thoughts too.

SBAR: Situation-Background-Assessment-Recommendation

Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

Template: SBAR

S	**Situation:** What is the situation you are calling about? • Identify self, unit, patient, room number. • Briefly state the problem, what is it, when it happened or started, and how severe.	
B	**Background:** Pertinent background information related to the situation could include the following: • The admitting diagnosis and date of admission • List of current medications, allergies, IV fluids, and labs • Most recent vital signs • Lab results: provide the date and time test was done and results of previous tests for comparison • Other clinical information • Code status	
A	**Assessment:** What is the nurse's assessment of the situation?	
R	**Recommendation:** What is the nurse's recommendation or what does he/she want? Examples: • Notification that patient has been admitted • Patient needs to be seen now • Order change	

Click this link to download an SBAR template.

Lesson 10 of 13

Communicating Concerns to the Physician

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01:36

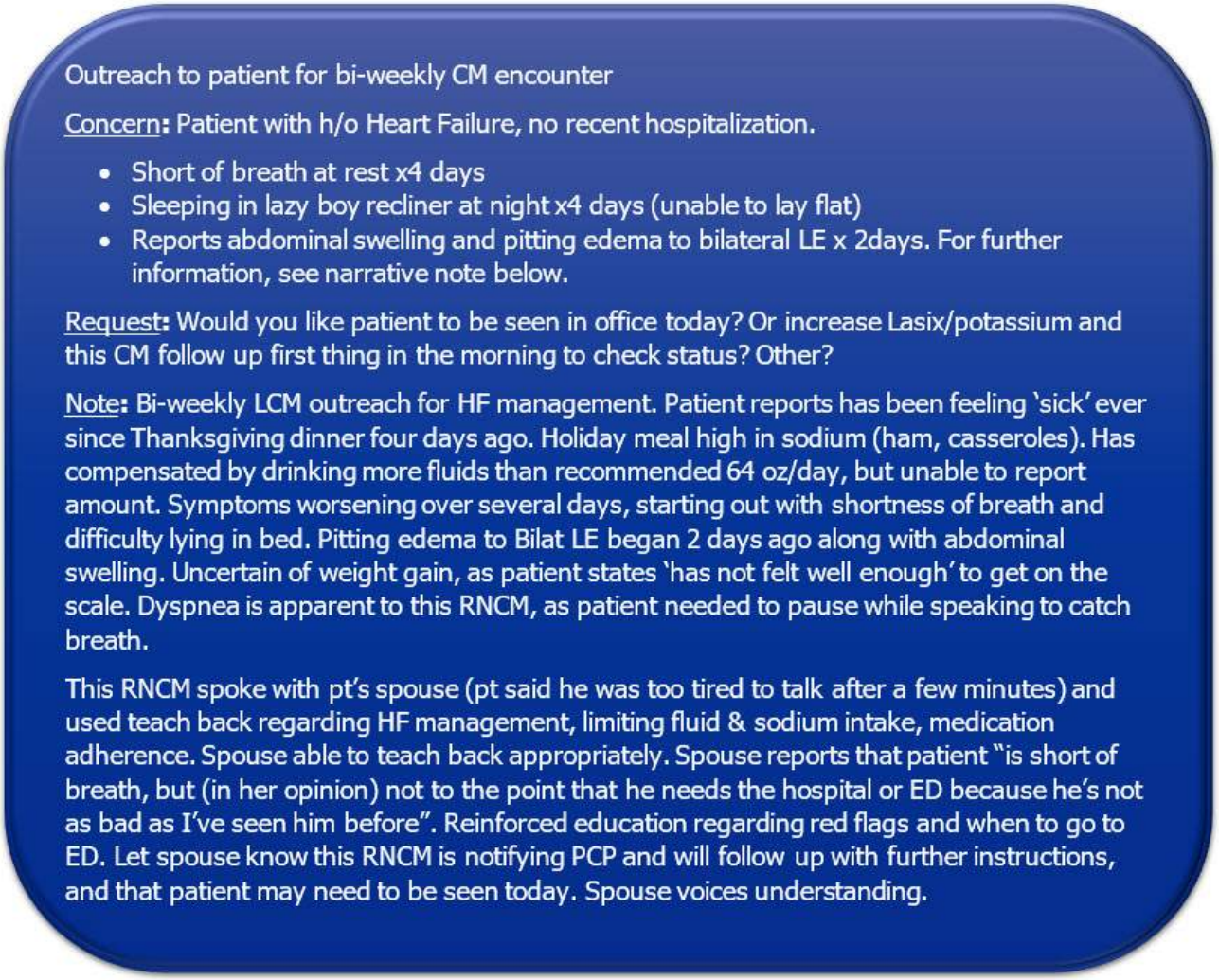
Click to Play Audio

When communicating a concern to the primary care physician (PCP), it's imperative to keep the information and request(s) concise & direct. Rambling narrative notes with multiple paragraphs and questions/concerns/requests buried within the paragraphs are not helpful for busy providers and will most likely be missed. Many Care Managers (and providers) find it extremely helpful is to use the following format:

- Reason for contact with patient
- Concern identified
- Request
- Narrative note

By placing the narrative note at the end, the provider then has the choice to read the full narrative of what transpired on the outreach contact. This additional narrative provides further details, but many providers do not desire this level of detail.

For example – in a follow up LCM outreach, the CM discovers the patient is short of breath and has abdominal swelling and pitting edema in both lower extremities. Following the process noted above, the CM will document in this way:



As you can see from this example, the information captured in the concern and request adequately inform the PCP to determine on next steps. The narrative note creates a bigger picture of status and documents your intervention (education with spouse and plan to notify PCP). This adequately covers all bases and gives the provider the option to read the Note, while still satisfying the legal requirements for documentation.

Test Your Knowledge

Question

01/05

Looking at the list below, what are key considerations when enrolling a patient in LCM? (Choose all that apply.)

- [ ] Notifying the care team
- [ ] Specialty provider communication
- [ ] EHR enrollment documentation
- [ ] Patient Education

Question

02/05

Meeting the patient where they are and addressing their concerns is the best way to engage and increase chances of success.

- True
- False

Question

03/05

The 5 Steps of LCM enrollment are:

- Review
  Outreach
  Care Plan
  Graduation
  Follow Up

- Review
  Outreach
  Care Plan
  Document
  Follow-up

- Outreach
  Assessment
  Care Plan
  Follow Up
  Graduation

- Enrollment
  Follow Up
  Graduation
  Care Plan
  Research

Question

04/05

What are some of the components of a comprehensive assessment for LCM? (Choose all that apply.)

- [ ] Chart Review
- [ ] Conversation with the patient
- [ ] Cold Calls
- [ ] The 6 Domains of the Patient

Question

05/05

The 6 Domains of the Patient are:

1. Chronic Conditions
2. Medication Adherence
3. Mental Health
4. Psychosocial & Cultural
5. Mobility
6. Utilization & Care Gaps

- ◯ True
- ◯ False

Activity Instructions

Practical application of what you are learning helps with skill development and retention. We have created an activity that will guide you in that type of application.

- [ ] Visit https://www.healthteamworks.org/resource/essentials-care-management-activities-and-resources.
- [ ] Find and download the activity assigned for this course.
- [ ] Complete the activity. You are encouraged to work with your team to complete the activity.
- [ ] Email the completed activity to caremanagement_nachc@healthteamworks.org.

- [ ] Make sure to add the Course Activity Title you are submitting and your full name to the Subject Line of your email.
- [ ] You will receive feedback on your completed assignments.

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