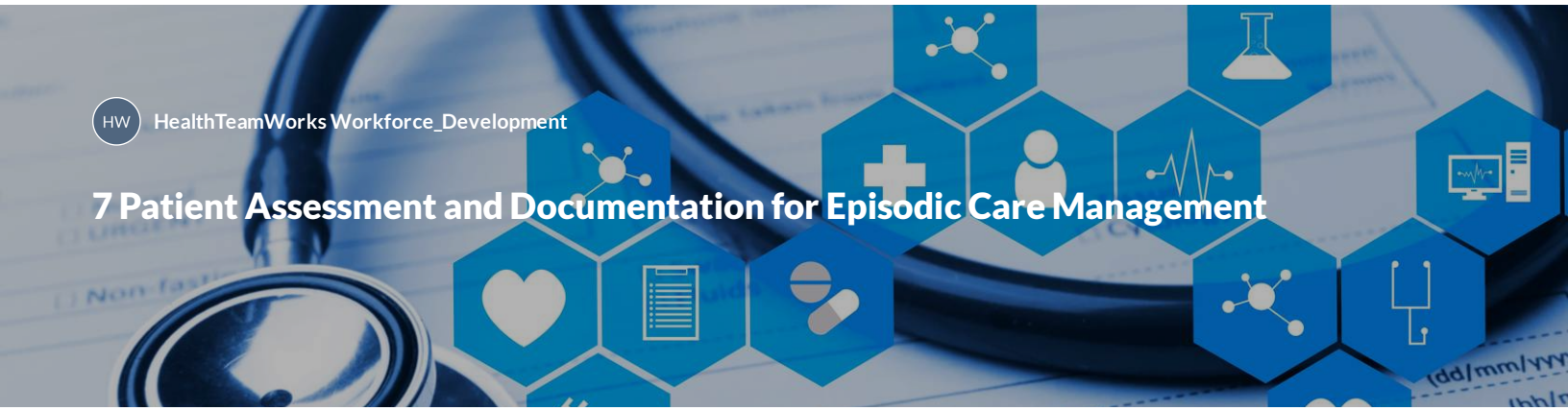

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7 Patient Assessment and Documentation for Episodic Care Management

Introduction and Learning Objectives

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01:00

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How do you know if a patient is a proper candidate for ECM? It is important to be sure that you are maximizing the necessary time and resources required for delivering the best care to your patients enrolled in care management. Once you have chosen who to enroll, how do you assess the needs of the patient and keep track of their progress? In this course, you will learn the steps to follow and receive recommendations for documenting encounters with patients in ECM.

Learning Objectives

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

- Accurately recall the four steps of working with patients for episodic care management.
- Outline tactics to ensure effective communication with providers.
- Identify successful strategies for assessing patients over the telephone.

Lesson 2 of 10

The Timing of Outreach for Episodic Care Management

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01:13

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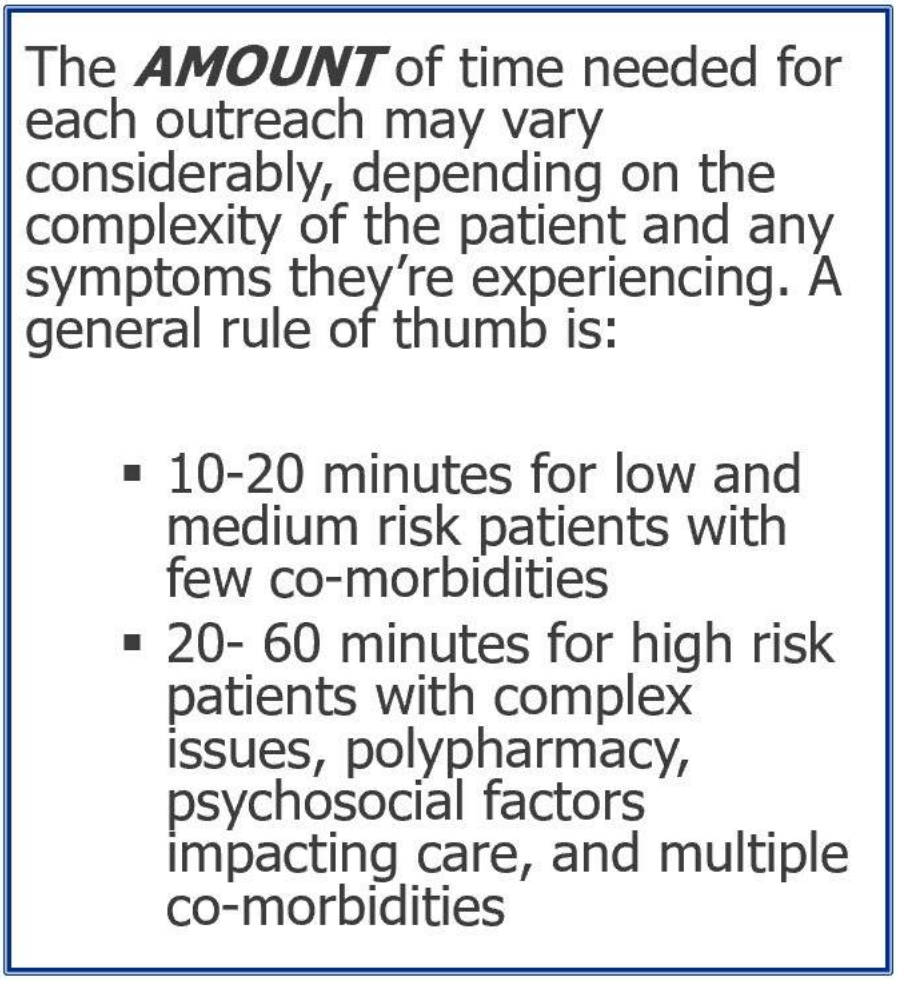
Before we dig into all of the details of how to conduct outreach, it's helpful to have an idea of how long an outreach might take and how soon you need to contact the patient.



- [ ] For timing, any patient discharged from the hospital or skilled nursing facility (SNF) should be contacted within 24-48 hours of discharge if at all possible. These patients are the most vulnerable to adverse events related to medication, follow up, services, etc.
- [ ] Patients who were seen in the ED should receive follow up within 2-7 days of discharge. Use your clinical judgment on this, look at the reason they were seen in the ED and their risk level, this will help you determine the best timing and prioritize your workload.
- [ ] For acute and miscellaneous issues, these patients are typically referred from within the practice and you should outreach as soon as you receive the referral, or, per your practice protocol.
- [ ] Remember: There will always be outliers, patients that require significant coordination, but these cases will be less frequent.

The Four Steps of Episodic Care Management

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00:50

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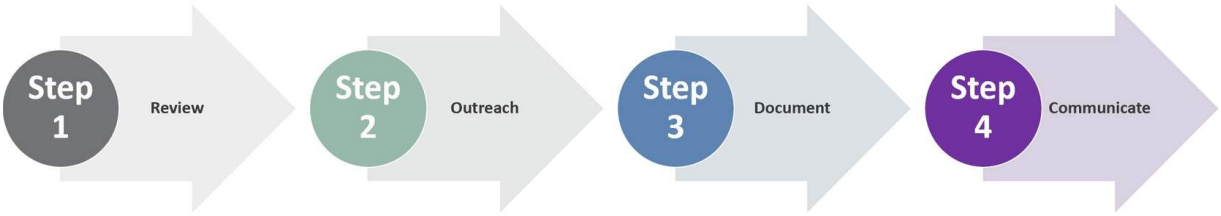
When working with patients for episodic care management (ECM), there are 4 key steps to follow, with important processes within each step. The Four Steps are:



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. **Document** – this encompasses the details that need to be documented from the outreach and assessment
4. **Communicate** – this is the communication that needs to take place with the patient's different care providers

In the following modules, we will take a deeper look at each step.

Step 1: Review

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03:08

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Before calling the patient, complete the following. You will want to prepare by gathering some background information before outreaching to the patient. This includes a review of several key areas:

- [ ] Start with a records review

  - Review the patient's health history to understand co-morbid issues that may complicate recovery.
  - Look at the discharge diagnosis and status of the patient at discharge. Review the provider discharge summary. You will refer back to this information when you call the patient to determine if they are stable or deteriorating since discharge.
  - Review the discharge disposition and if new services or equipment were ordered.

- [ ] Next, review the patient's medications.

  - Compare medications listed in the discharge summary to discharge medication list the patient received. Make note of any discrepancies which will be addressed during the patient call.
  - Second: compare the discharge medication list with the record of medications in primary care. Once again, note any differences, as this will need to be reviewed with the primary care physician and resolved.
  - Also, make note of any potential problems that the patient could have with the medication. This includes:
    - Discontinued medication
    - Dose change on any medication
    - High-risk medications with the potential to cause adverse safety events if taken incorrectly (e.g. Coumadin)
    - Medications with complicated instructions. For example, a medication with different morning and evening doses.

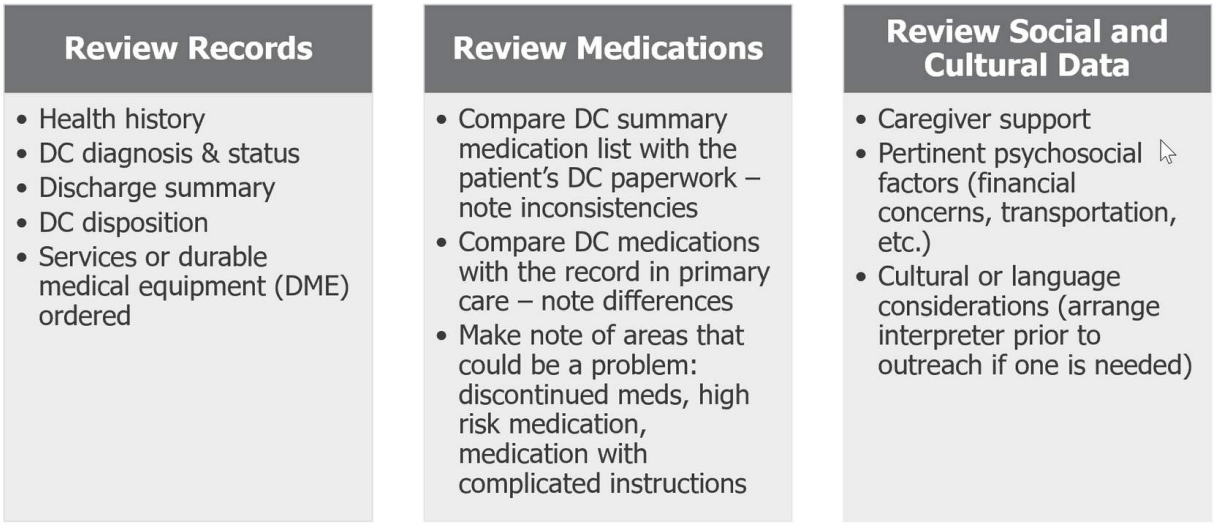
Key Takeaway: Medications have the potential to cause serious harm if taken incorrectly. Any changes to a patient's medication regimen requires close attention from the Care Manager.

☐ Finally, review social and cultural data

- Is the patient is independent, or do they have a caregiver? If a caregiver is involved, include the caregiver in the outreach if possible, as many caregivers manage details like medications, nutrition, ADL's, etc.
- Review other social data that's available. It's helpful to know ahead of time if there are financial concerns, issues with getting to and from appointments, unstable housing, etc. Details like this can have a big impact on a patient's ability to adhere to a treatment plan.
- Review any cultural/spiritual data. This will inform your care and help to prepare for outreach (e.g. if an interpreter is needed).

This review process is basically the same for any patient you're working within ECM, whether it's an inpatient discharge or referral for an acute or miscellaneous issue.

You may need to make some minor modifications to the process for patients referred from within the office (e.g., a patient referred for an acute issue may not have a "discharge summary" or discharge medications, but it is still important to review the record, medications, and social data).



Lesson 5 of 10

Step 2: Outreach

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04:46

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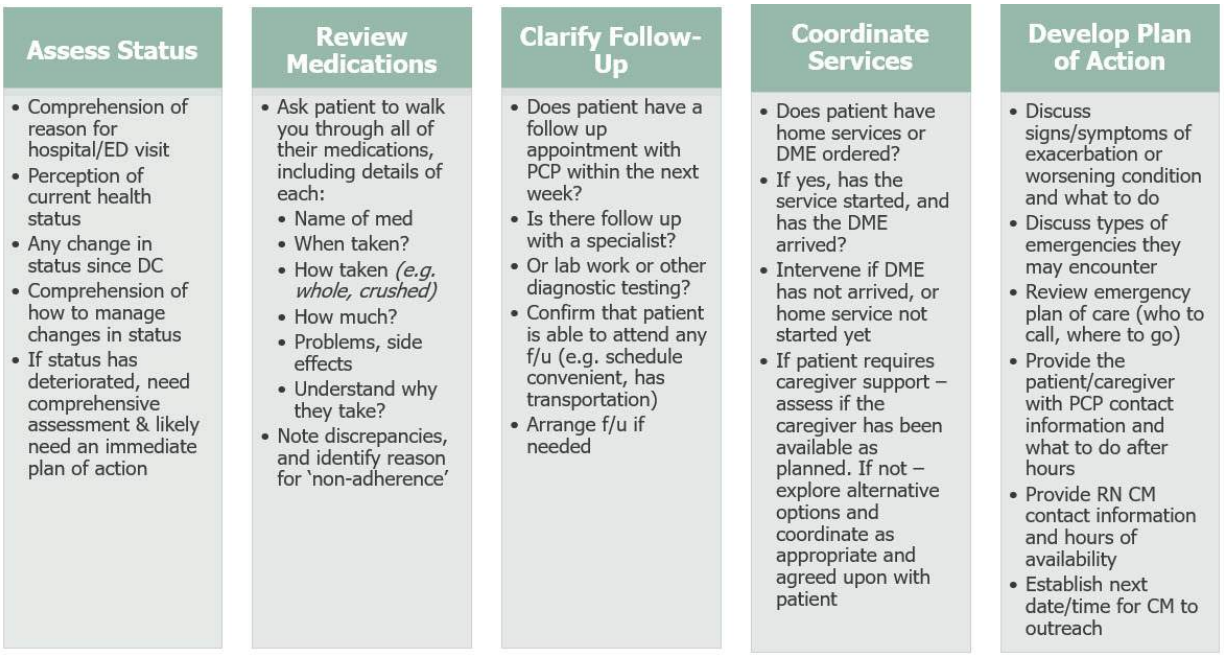
During the call, complete the following:



Now let's move on to Step 2, the Outreach. If you're new to Ambulatory Care Management, it's helpful to use a script for the outreach until you've established a routine. We have provided an example of a script that you can tailor to your own style of speaking and interacting with a patient. Remember, the script is only meant to be a guide! You still have to adapt to each unique patient's circumstance and allow the conversation to be guided by the patient's needs.

A few other helpful things to consider when calling a patient, and before you immediately dive into asking how they're doing:

- Establish rapport by introducing yourself and the reason for the call. Ask if it's a good time to talk and reschedule if it's not a good time.

- If English is not the patient's preferred language, schedule a time to call back with an interpreter. Patients with a language barrier are especially vulnerable to poor outcomes.
- Ask the patient to have the following handy for your conversation: discharge paperwork, all medications, and any supplements/home remedies. If they don't have it close by, explain that you can wait while they get it.

Making the call:

1. First, assess the patient's status. Assess their comprehension of the reason for hospitalization/ED (or, if an acute issue, the reason they were referred for CM):

   - Ask them their perception of how they're doing now noting any change in status, or concerning symptoms.
   - Asses their understanding of how to manage changes in status; where to go for help, or self-management tactics (e.g., HF patient comprehends basic principles of managing the condition to avoid exacerbation).
   - If the patient's condition appears to be worsening, triage the issue and establish a plan.

2. Next, review medications with the patient

   - Talk with the patient about the medications that they're taking. It's important to go through 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 also assess understanding of why they take the medication
   - If the patient is in Episodic Care Management (ECM) for recent discharge, compare what the patient has reported to you with the discharge medication list:
     - Clarify any discrepancies
   - If noted that patient is not taking (or inappropriately taking) something that's prescribed, identify the reason

3. Third, clarify follow-up appointments that are scheduled. Validate that the patient is able to attend the appointment as scheduled and if not, offer to re-schedule at a time that works.

   - If an appointment(s) was not set up with the PCP at the time of discharge, explain the importance of follow up in terms the patient will understand, and offer to schedule. If the patient is agreeable to you scheduling for them, make sure you circle back around and communicate the date/time.
   - After a hospital discharge (DC), patients should (ideally) be seen within a week, 10 days at the most.
   - Also, check to see if lab work or other diagnostic testing has been ordered and that patient understands when/where to go for it. Reschedule if needed.

4. The fourth thing to complete with the patient is to assess and coordinate for services. If the patient had home services or DME ordered, has the service started and the equipment arrived?

   - If something is missing, intervene and work to coordinate, keeping the patient informed.

- Also, assess to see if the patient needs caregiver support and if this person(s) has been available as planned.
    - If issues are identified, explore other options and arrange as indicated.

5 And the last piece of this outreach segment is to develop a plan of action with the patient:

- Review signs and symptoms (s/s) or worsening condition and what to do (who to call, where to go).
- Discuss types of emergencies they may encounter and review the plan for this (e.g., where to go at different times of day, who to call, and when it's appropriate to go to the ED).
- Provide contact information for both the PCP and yourself. Explain hours of availability and how to reach the practice after-hours.
- If the patient will need further outreach, establish the next date/time of contact and ask the patient to put it on their calendar or in a place where they will see and not forget.

Step 3: Document

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01:40

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Step 3 is the documentation for your outreach and assessment. At a minimum, documentation should include the following:

- [ ] Track the number of attempts it took to reach the patient. If you were unable to speak with the patient and left a message, document details of instructions you provided in the message.
- [ ] The reason the patient is in Episodic Care Management and the source of the referral if they were referred for an acute or miscellaneous issue.
- [ ] Information about their current health status noting any concerns. Include lab results if pertinent. Note changes to medication and/or discrepancies identified in the medication list.
- [ ] Follow-up appointment dates for the primary care provider, specialists and diagnostic testing such as imaging or labs.
- [ ] New orders for home care, durable medical equipment or other community services.
- [ ] Information about the patient's comprehension of their current health status. As well as their self-management plan and degree of activation.
- [ ] Make note of your follow-up responsibilities and be sure to schedule this using whatever process you follow to keep track of your patients.

Key Information to Document

- Call attempts
- Reason for providing ECM (DC from hospital/ED/SNF, Acute issue, Miscellaneous issue) & referral source
- Current health status, recent labs if indicated
- Changes in medications or discrepancies
- Follow-up appointments, diagnostic testing
- Changes to normal baseline of care (new service, DME, etc.)
- Patient's self-management plan and comprehension
- Follow-up for CM to make

On busy days it is tempting to put documentation off until later in the day. Don't let yourself fall into this trap. Your documentation, and ultimately your patients, will suffer. Key things will be missed and this could lead to an adverse safety event. Finish your documentation before moving on to the next patient.

Step 4: Communicate

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01:24

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The last step in this process is communicating to keep pertinent players informed of the patient's care.

For all cases, you will need to communicate with the patient's PCP, keeping them informed of the status and care, and working to resolve any issues.

When communicating with the PCP, keep these things in mind:

1. It's ideal if you can "route" your documentation through the EHR directly to the PCP. If your EHR does not have that capability, send a note with a summary.

2 Find out how your providers like to receive information (e.g., minimal details or all details).

3 List key points/concerns/request at the top of the documentation. This helps the provider triage the many messages they receive in a day.

Depending on patient circumstances and needs, you may also need to communicate with:

- Specialist
- Home care
- DME Provider
- Pharmacy

In ALL of these communications, it's important to organize your thoughts before reaching out.

For this, the SBAR method of communication (situation, background, assessment, and recommendation) is helpful. The Solutions Center Resource Library contains an SBAR tool to use if you aren't familiar with this technique.

Tips for Telephonic Assessment

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02:16

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With the exception of patients referred to you at the time of an office visit, the majority of encounters care managers have with patients for episodic care management are conducted over the phone. This is because most patients identified for ECM are identified from a hospital discharge or ED visit.

Therefore, it will be important to work on some skills for telephonic assessment! If you have come from the bedside nursing arena and have not had much experience working with patients on the telephone, these may be new skills to work on.

- [ ] First – invest in a good headset. Your neck, shoulders, and head will thank you!
- [ ] Keep some different references close by, available to use if needed in a pinch. Google is okay, but sometimes you need a good medication handbook or a medical dictionary.
- [ ] Having clinic protocols like EBG's or care pathways can be handy, too.
- [ ] As mentioned earlier, use a script when you're first getting started in this role. It will help you establish a solid method and technique.
- [ ] Use open-ended questions. This allows the patient to elaborate in their own words what they're experiencing. Yes/no questions don't help you get to the level of detail needed.
- [ ] LISTEN very closely. Not just to the words your patient is saying, listen to the speech and breathing pattern. Sometimes, you can identify if a patient is exacerbating with HF or COPD just by listening closely to their speech and breathing.
- [ ] Remember, context and non-verbal cues don't translate over the phone. Use your voice to convey kindness, caring, compassion.
- [ ] Let the patient know how much time you'll need on the phone. This allows them to decide if this is a convenient time and you'll avoid being rushed.
- [ ] Document during the call and finish up as soon as you're done!
- [ ] Establish a flagging system or some kind of method to follow up on outstanding items. Sticky notes and random pieces of paper often get lost in the shuffle!

Test Your Knowledge

Question

01/05

What are the four steps to follow when assessing a patient for ECM?

- Outreach
  Communicate
  Research
  Analyze

- Review
  Outreach
  Document
  Communicate

- Review
  Outreach
  Document
  Research

- Review
  Document
  Test
  Huddle

Question

02/05

When assessing a patient over the phone, it is recommended that you ask open-ended questions that allow the patient to elaborate in their own words.

- [ ] True
- [ ] False

Question

03/05

When communicating with the PCP regarding a patient's ECM plan, it is best to...

- ◯ Tell the MA the information and tell them to tell the PCP.
- ◯ Email the PCP an extensive, detailed report with all of the information that you have documented.
- ◯ Route documented encounters through the EHR to the PCP
- ◯ Walk to the PCP's office and tell them directly.

Question

04/05

How quickly should outreach be conducted after you receive an in-practice referral to ECM?

- ◯ When you get to it.
- ◯ Per practice protocol
- ◯ Immediately
- ◯ Within 7 days

Question

05/05

When documenting a patient encounter, what is the KEY information that you should include? (Choose all that apply.)

- [ ] The number of call attempts
- [ ] The name of the employer of the patient's spouse
- [ ] The current health status of the patient
- [ ] A list of the patient's family members

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.