[redacted] **Job Aid**

Subject: CM Initial Outreach Prep & Scripting

Prepared by Director of Patient Care and Care Coordination [redacted] | **10/24/2022**

JOB AID PURPOSE:

This job aid provides additional detail to support preparation steps to consider prior to the CM Initial Outreach, in addition it provides sample scripting to follow during the CM initial Outreach development of the Care Management Value Statement prior to an Initial Outreach to the patient.

SUMMARY:

Preparation for the CM Initial Outreach should include review of the patient's health history to develop a CM Value statement that would reflect 'value' to the patient and be a reason for them to engage in Care Management. This CM Value Statement is a preliminary value statement and will evolve during conversations that engage the patient to define value and priorities.

Encounter Preparation Process:

Care Management Dashboard - Risk Scores

- Review patient detail
  - chronic conditions that contribute to risk score
  - ED/Hospital discharge that contributes to risk score/ review ED/Hospital detail
- Note these in patient chart in HPI CM_IniitalHPI (Screenings will not be completed in Initial Outreach)

Patient Chart - areas to consider

- Problem List - is this accurate based on what you know of this patient
  - Last update of Problem List
  - Are diagnosis present in non-Center based care such as ED, Hospital discharge, specialty consults that are not included in Problem List
  - When appropriate, send note or Patient Case to PCP to add diagnosis to problem list

- Medication List
  - New medications
  - Complex medication regimen
  - Refill history review - absence of refill may indicate struggle with adherence

- Does problem list and medication list appear consistent
  - Are medications present on med list without correlating diagnosis on problem list, for example metformin daily with no diagnosis for diabetes

- PCP visits
  - Regular visits with PCP - this may vary based on PCP and health complexity (minimum of 3-4/ yr)
  - Note chief complaint or key concerns at PCP visit, this may inform initial CM priorities
  - No Show or Cancellation history - may indicate struggling with adherence
  - PCP recommended follow-up that has not happened
  - Explanation: patients who do not come in regularly for chronic disease care may be struggling with effective engagement and adherence with their care
- Care Team Notes
  - HC, CDE (if applicable)
  - Specialty care or other notes reflecting potential value for Care Management

- Social History - note any positives or gaps in screening
    - Screening history - review last date to prevent duplication if done within previous 2 wks
        - Depression screening history; Last PHQ-2 or 9. Date_____. Score____
        - Is a positive score ≥10 (PHQ-9) reflected in problem list?
        - GAD-7 screening history: Is a positive GAD-7 ≥10 reflected in problem list
        - Determine best method to provide PHQ-9 / GAD-7 / Audit C screens
    - Tobacco / Substance use: Last screen Date____ Results _____
    - Support network or lack of support system
    - Indication of financial / housing challenge

CM VALUE STATEMENT:

Based on your review summarize what may be a CM Value Statement, consider any chart notes or knowledge of patient care that would reflect what is important to the patient.

Consider that this is a preliminary CM Value Statement to encourage patient to engage in care management - again something that is important to the patient whenever indication of this is present.

Develop a preliminary CM VALUE STATEMENT:

CM Script:

When outreaching to patients regarding enrollment in CM, it's important to provide foundational information, share the value of CM support as part of an integrated care team, invite and actively listen to the patient's perspective of current health status. The following provides sample scripting for the conversation. However, because engagement is built on trusted relationships the conversation should flow based on what the patient is sharing and details needed to inform a decision to enroll, rather than reading a prescribed scripting.

Sample Scripting:

We are expanding services our team provides to include Care Management. This is a program that expands your care team to ensure that your healthcare needs are met and supports you to improve your health. This program can help you to (include patient specific CM value statement):

- *improve your diabetes control*
- *guide you to improve your activity tolerance*
- *help you take your medications regularly*

If patient seems to be unclear of priorities, consider Quality of Health Assessment - to help prioritize
In general, how would you rate your health?

Excellent -1; Very Good - 2; Good-3; Poor-4; Very Poor – 5

What do you think would help to improve how you rate your health? (Note: This can guide or re-direct the value statement for CM).

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Care Management is no additional cost to you but an opportunity for a regular - weekly, biweekly, or monthly contacts with me, your care manager, to help you improve the quality of your health and address health needs that are important to you. We do this by identifying goals that are important to you and set up an action plan.
I help by keeping you accountable to your goal and action plan.

Examples:

- *Care Management is a program that can help you take your medications on a regular basis which in turn can improve the status of your COPD.*
- *Care Management is a program that can help you get better control of your blood pressure. (or other poorly controlled chronic condition)*
- *Care Management is a program that can help you address obstacles to you achieving optimal health for you.*

Text Macro Options for messaging:

CM_PortalOutreach: PATIENT NAME

XXXX recently launched a Care Management program to provider our patients with additional support on their journey to achieving optimal health. Your provider PROVIDER NAME feels you could benefit from this program. We tried to reach you today via telephone but were unsuccessful. We will try again within the next week. Feel free to give us a call at CGRN PHONE NUMBER, ext #### to discuss how this could help you achieve your health goals.

CGRN NAME, Care Guide RN

CM_PhoneOutreach: PATIENT NAME

This is CGRN NAME, from [redacted] CENTER NAME. I was hoping to talk with you about a new program we are offering to our patients that PROVIDER NAME feels would be a good fit for you. Feel free to give me a call back at NUMBER, Ext #### or I will try again to reach you at a more convenient time.

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CM Outreach Preparation Check List:

Care Management Risk Stratification Dashboard Review

- Risk Score _____
- Contributing Diagnosis _____
- ED visits in previous 6 mos: _____
- IP Admits, last 12 mos: _____
- Additional factors: _____
- Provider or CGRN notes:_____

Patient Chart Review:

- Problem List
  - Additional chronic conditions:_____
  - Other: _____

- Medication List
  - Complex poly pharmacy: Yes____ No _____
  - Key complex Rx that increase risk: _____
  - Chemotherapy _____ Started_____
  - Refill History: Consistent _____ Appears sporadic: _____
    Known financial challenges with Rx _____
  - Other: _____
- Does problem list and medication list appear consistent
  - Consistent: _____ Inconsistencies: _____

- PCP visit Review
  - Regular visits: monthly_____ q3-4 mos_____ 2-3 / yr _____
    Sporadic_____ No shows and/or cancelations in past yr _____

  - Chief complaint or key concerns at PCP visits _____
  - Key areas of struggle or non-adherence: _____
  - Other _____
- Care Team Review
  - HC, CDE Goals/Notes _____
  - Specialty care Notes: _____

- Social History Review:
  - SDOH date: _____ Positives: _____Needs update: Yes / No
  - PHQ-2/9 date: _____. Score: _____ Needs update: Yes / No
  - GAD-7 date: _____. Score: _____ Needs update; Yes/ No
  - Tobacco / Substance use: Last screen Date_____. Results _____
  - Support network or lack of support system
  - Indication of financial / housing challenge Date_____. Results _____

CM VALUE STATEMENT (PRELIMINARY): _____

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Initial Outreach Summary:

What is important to you that Care Management could help you with?_____

Health Status Results: *In general, how would you rate your health?* _____
Excellent -1; Very Good - 2; Good-3; Poor-4; Very Poor – 5
What do you think would help to improve how you rate your health? _____

Do you have any questions about Care Management and what it is? _____
Is Care Management something you would be interested in or would like to try? _____
What day and time in the next week that can work for you? _____