

Care Co-ordination Manual

**ADMINISTRATION OF
CARE COORDINATION FOR PATIENTS
AND
UTILIZATION MANAGEMENT
IN THE IPA**

LinkedIPAs: SEMNet, UHPNet, HMINet & U4IPA

Care Coordination Manual



Patient/Physician Cooperatives

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CHAPTER ONE: GENERAL INFORMATION

I. INTRODUCTION TO THE ADMINISTRATION OF CARE COORDINATION

Improving Health Care Through Patient Care Coordination

According to the National Priorities Partnership in 2008, the promise of our healthcare systems is to provide members with access to healthcare that is safe, effective and affordable. To improve patient care and results, we must fundamentally change the ways in which we deliver care, which requires a focused and combined effort on the part of patients, healthcare professionals, healthcare organizations, community members, suppliers, payers, government organizations and other stakeholders. Care coordination is at the core of this combined effort.

II. GENERAL INFORMATION ABOUT LinkedIPAs

Linked IPAs is the management organization for your IPA (SEMNet, UHPNet, HMINet, and U4IPA) through which care coordination happens. As a Care Coordinator, you are an integral member of a team of participating providers whose goal is to improve the health outcomes of its patients while eliminating duplication or overuse of health care services. Linked IPAs have contracts with the following health plans which include bonus provisions for improved patient health outcomes:

1. Wellcare
2. Bravo
3. Universal Healthcare
4. New Era Life Insurance
5. Senior Patient Association and Patient/Physician Cooperatives

In our striving to be an Accountable Care Organization, Linked IPAs has set our standards for care coordination according to the current federal guidelines outlined by the National Quality Forum in 2010. Our hope is to provide the highest standards of care by addressing patient care coordination directly and without delay. We have grown from 80 to 520 physicians over a period of 15 years and we have been successful in our attention to improved communication and coordination of services within our IPAs.

In 2010-11, the open enrollment for the Medicare Advantage Plans will result in a few thousand new enrollments for PCPs in Linked IPAs. The health plans with whom we contract have some of the best benefits being offered to seniors, especially Wellcare, Universal Healthcare and Bravo. In addition to these Medicare Advantage Plans, we have a commercial plan from Patient/Physician Cooperatives underwritten by New Era Life that is exclusive for our IPA and should result in about 10,000 new patients for our participating providers over the next few years.

The need for care coordination in our population is great and our goal is to gracefully meet this challenge. As our Care Coordinator, we welcome you and your commitment to meeting this goal.

III. CARE COORDINATION VALUES

The values of Care Coordination are: trust, family and person-centered philosophy, diversity, integrity, quality, creativity, advocacy, collaboration and leadership. The Care Coordinator's core philosophy is characterized by a commitment to partnering with the person, family members, caregivers, providers and other support persons and organizations in the community in a dynamic collaborative process to achieve the best health outcomes for the patient.

Linked IPAs' Care Coordination system results in an environment that is supportive of the person while remaining respectful of the need to conserve health care resources.

The Care Coordinator's activities are supported by:

- Computerized record-keeping and communications systems that are the basis for electronic health record management, data tracking, reporting and communications.
- Quality improvement, which is accountable for customer satisfaction activities, for ongoing evaluation of activities and for ensuring that effective quality indicators are the basis for ongoing measurement and quality reporting.

All staff members engaged in care coordination bring commitment, ethical practices, accountability, preparation, accuracy and creativity to a uniquely collaborative environment. Care coordinators are primarily nurses and health workers with broad community expertise and who have expertise in local social service systems.

IV. CARE COORDINATION GOALS

Care Coordination is fundamental to ensuring positive health outcomes for patients. The Care Coordinator acts on behalf of Linked IPAs to ensure that patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care by:

- identifying at-risk patient members for the purpose of:
 - reducing preventable emergency department visits
 - reducing hospital re-admission rates
 - achieving improved individual health outcomes through:
 - **Connecting** members with the health care network and supporting them as they navigate through it
 - **Coordinating** services for health plan members to achieve positive individual-level health outcomes
 - **Assuring** collaborative planning and improvement of our health care system
- reducing the risks of injury and harm by striving to ensure a culture of prevention and safety
- soliciting and carefully considering feedback from all patients (and their families when appropriate) regarding their health care experiences.

V. CARE COORDINATION OBJECTIVES

Care coordination ensures that all of the patient's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient's caregivers, and works with the patient to make sure that s/he gets the most appropriate treatment, while ensuring that health care is not accidentally duplicated. This process improves the quality of care as well as patient satisfaction.

For care coordination to be successful in the Health Plan, the following criteria must be met:

OBJ-1. The Care Coordinator effort must be led by the primary care provider's office. The objectives are as follows:

1. The primary care physician is directly responsible for care coordination but may choose to appoint a registered nurse or physician's assistant to perform the Care Coordinator's Duties.
2. The Care Coordinator will be trained in and is responsible for:
 - a. conducting patient assessments
 - b. service planning
 - c. patient coordination and referral
 - d. patient follow-up/monitoring and
 - e. patient education/counseling

Note: The Care Coordinator's primary responsibility is the Care Coordinator duties. They may be used secondarily as clinical relief or to provide medical care. If the health plan patient volume warrants the necessity of a full time Care Coordinator then this individual will spend 100% of their time on Care Coordinator duties. Certain variances to this policy will be allowed. However, in these instances, the plan and justification from the primary provider must be reviewed and approved by the Medical Group Coordinator appointed by the Quality Assurance Committee.

OBJ-2. There must be a commitment to teamwork among the patient's health care providers, i.e., a coordinated effort concerning:

1. Follow-up on missed appointments
2. Management of referrals and interventions as needed
3. Counseling, including referral, discharge information and home follow-up with patients.

OBJ-3. Systems must be put in place and utilized with the intention of preventing acute health crises while protecting the patient's health. Here are some examples:

1. It is strongly recommended that tracking systems be established where the Care Coordinator is notified of any problems at the time of occurrence. For example, if a patient does not keep her prenatal appointment, the Care Coordinator should be notified the day of the scheduled appointment so that the necessary tracking can be accomplished. Likewise, if the attending physician or nurse determines a need for a patient to be referred to a specialist, the Care Coordinator should be notified at the time of the appointment so that the referral appointment can be made and the recipient notified before leaving the clinic or office.

2. It is also strongly recommended that problems or concerns noted by anyone serving the patient be tracked electronically in the EMR, written in red or otherwise highlighted in the patient's physical file. This will enable others to see problem areas quickly and take whatever action is necessary.

CHAPTER TWO: ELEMENTS OF CARE COORDINATION

I. CARE COORDINATOR DUTIES

The duties as Care Coordinator are many and varied. They serve a vital role in ensuring that patients receive early, continuous and appropriate care and case management.

Care Coordinator responsibilities include, but are not limited to, ensuring that:

- A. Intake procedures are performed at the initial visit,
- B. A Comprehensive Health Assessment is performed on each patient,
- C. Service plans are developed,
- D. Linking with Services Occurs, through the activities of:
 1. Referring,
 2. Coordinating
 3. Educating
 4. Supporting and
 5. Advocating
 6. Monitoring and Evaluating
- E. Face-to-face Encounters are respected
- F. Documentation Takes Place

NOTE: This does not mean that the Care Coordinator has to actually perform these activities in all cases, but rather, to make sure that they are done: e.g., a clerk in the clinic may make the initial telephone call after a missed appointment.

A. INTAKE PROCEDURES / OPENING A PATIENT TO CARE COORDINATION

Because the health plan limits the patient's freedom of choice to the contracted provider network, certain things must be explained to the patient at the initial visit. Intake procedures are as follows:

1. Designate a Care Coordinator to Serve the Patient
 - The member's primary care physician's office will designate a Care Coordinator within the first 10 days of enrollment, if the patient is a PPC member and within the first 90 days if the patient is a member of other affiliated Health Plans.

- They must update Care Coordinator assignment in the EMR system.
 - The Care Coordinator will send a “Welcome to Care Coordination / Case Management Letter” (see Welcome to Care Coordination letter (.doc) in the Attachments section). The letter will be sent to the member within the first 10 days of enrollment with the name and phone number of their Care Coordinator.
 - The purpose of the letter is to tell the patient that you will be coordinating their care and that you will make sure she or he will get all the care she or he needs. It lets the recipient know that you are their Care Coordinator and that she or he can contact you anytime. You must reinforce these roles with the patient in a face-to-face meeting, on the initial visit.
- Note: For patients who choose to opt-out of Care Coordination services:
 - A member has the right to refuse care coordination services. If this happens, document the refusal in the member's Care Coordination File and contact the member in one year to re-offer services.
 - After entering an initial Patient Health Assessment Form into the member's EMR, document the member’s refusal for care coordination services.
 - The member will remain as an open care coordination case and the Care Coordinator listed in his or her EMR will be notified by Patient/Physician Cooperatives if there is change in health status (hospitalization, ER visit, etc.).
 - If the care coordinator is notified of a change in condition, the Care Coordinator will contact the member and re-offer care coordination services

2. Explain the benefits and services available through the primary provider network.

- Explain that services must be obtained through the primary care physician and the specialists and diagnostic service providers in order for the health plan to cover the maximum amount for care.
- Provide information regarding location of facilities, hours of service, and locations and telephone numbers for after-hour urgent care and emergency care.

3. Use the following forms of written information (see Attachments section):

a. Welcome to Care Coordination Letter (Attachment B).

b. Agreement to Receive Care, (Attachment D) and obtain the patient's signature on this form.

c. Patient's Rights and Responsibilities, (Attachment C)

d. Authorization for Release of Medical Information form, (Attachment H) The Care Coordinator will assist the member to establish and authorize a Release of Information between PPC and any other appropriate parties.

4. Provide pamphlets regarding available services, healthy life-styles and counsel the patient on importance of self-care.

5. Ascertain if he or she has third party insurance other than the coverage provided under the IPA contracted health plans. If he or she does:

a. Obtain the name of the insurance company, address, phone number, policy number. If possible, ascertain from the patient what type of coverage the policy provides.

b. Verify the information with the insurance company and/or health plan and record all information in the file. Some of this information may be available from the Plan Administrator of the health plan. It is vital that this type of information be gathered at the beginning of care as you may have to request a third party coordination of benefits.

B. COMPREHENSIVE HEALTH ASSESSMENT

1. A Comprehensive Health Assessment must be completed within the first 90 days of member enrollment. This Assessment MUST be face-to-face.

2. Use the Patient Health Assessment Record.doc or LTCC (.pdf) as the tool to complete the Assessment (see attachments F or G, respectively). **These forms meet the Medicare requirements for a health risk assessment so should be used as the tool to complete the member's health assessment for Patient/Physician Cooperatives.

Again, the Assessment MUST be completed within 90 days of enrollment and face-to-face.

Document in the member's EMR that the comprehensive health assessment was completed and the tool that was used to complete it. Any changes must be documented.

- If a Comprehensive Health Assessment has been completed within the past 6 months and a hard copy is obtained, the Care Coordinator can review the most recent Comprehensive Health Assessment face-to-face with the member and update the patient's EMR accordingly. In this way, the previously completed document can be used as the tool to complete the Comprehensive Health Assessment.

ALL fields must be completed or marked as "not applicable" in the assessment tool in order for the assessment to be included as complete.

C. SERVICE PLANNING

Creating an individualized patient Plan of Care is one of the most important Care Coordinator duties. Without a specific document delineating the plan of care, important medical issues are likely to be neglected. The ultimate purpose of the Plan of Care is to guide all who are involved in the care of the patient to provide appropriate treatment to ensure optimal health outcomes. A caregiver unfamiliar with the patient should be able to find all the information necessary to care for the patient in the Plan of Care.

The first step in creating a Plan of Care is accurate and comprehensive assessment. Regular assessments should be performed as often as the patient's status demands. In general, the plan must be based on the

results of the Patient Health Assessment and on the physician's treatment protocol. To facilitate follow-through with the Plan of Care, please use the Care Coordinator Service Certification form (see Attachments section).

The Service Certification and Plan of Care must be maintained in the individuals' EMR and/or physical medical records. **For purposes of Quality Assurance Assessment, the IPA will from time to time conduct random audits of patient records. The Plan of Care documentation are critical factors in the QA Assessment process.**

During the time the Plan of Care is being developed and after it is completed, contact is required as frequently as is indicated. Each contact with the patient should be documented. The dates of the face-to-face encounters will be accepted on the Care Coordinator Service Certification Form, rather than total details of each visit if protocols dictate. The level of involvement with the patient will vary depending upon: (1) the number and complexity of problems; (2) the availability of caregivers/services within the area; (3) counseling and support necessary to the patient and (4) the patient's ability to follow the service plan.

Components of the Plan of Care include: 1) a completed and/or updated Patient Health Assessment Record (see attachments section) where the elements of the Plan of Care are identified and formulated; 2) coordination with the various providers, including but not limited to: the physicians within the medical team, insurance providers, patient support specialists, home service providers and family caregivers, as well as community support organizations; 3) electronic appointment tracking and documentation.

It is suggested that a system be formulated within the clinic so that the Care Coordinator has access to patient records immediately after an appointment, missed or kept, so that appropriate action can be taken. It might also be helpful if the Care Coordinator keeps a "tickler file system" or other time management system as a backup. The tickler system would also prove useful in documenting treatment commitments from referral physicians, ensuring that appointments to other services are kept, and in tracking per-inpatient and outpatient visits. This is best accomplished through the use of Electronic Medical Records filing systems.

1. Initial services are complete when, at a minimum, the following tasks have been accomplished:

- The client's identifying and demographic information has been recorded;
- The Patient Health Assessment Record has been completed, problems identified and any necessary referrals have been made;
- Special program referrals have been made or the client's active participation in special programs is confirmed or completed;
- Client education sessions are completed or planned and appropriate referrals have been made;

- Input from the medical care provider has been solicited;
 - Information has been obtained so that follow-up and tracking can be accomplished.
- a. Services Planning Based on the Patient Health Assessment - IPA contracted Health Plans require a medical risk assessment, a requirement which the Patient Health Assessment fulfills (see Attachment F). Patient Health Assessments are to be completed only by a certified health professional, including a physician, nurse or physician's assistant. As a Care Coordinator, you are to familiarize yourself with the completed Patient Health Assessment along with the medical notes to assist patients with receiving care, services and referrals to specialists, if needed. If protocols are established for someone other than the Care Coordinator to make referrals, then such protocols should be followed. However, you, as Care Coordinator, still have the responsibility of ensuring that such referrals are noted in the patient's file and ensuring that treatment comments are recorded.

Patient Health Assessment tools may vary, but generally, low-risk patients receive care from primary care physicians. Patients who are high-risk generally receive care from a specialist. Coordination with the hospital is a must in that you are required to send records to the scheduled hospital prior to admission so that they are available to the staff as well as the physician. If an automated medical record system does not exist, check with hospital personnel to find out when and to whom to send the records. IPA personnel will review to determine if these records were actually available to the physician and nursing staff in the hospital prior to admission.

- b. Psychological and Social Needs Assessment - The psychological and social needs assessment is done by a mental health specialist. If a patient appears to need or requests any services in the area of mental health they should be referred to Member Services Representatives of the Health Plan. The Plan will in turn work closely with the Care Coordinator and the primary care physician so that the primary care physician can see that the patient's whole health history and care are well-managed.

PRENATAL AND POSTPARTUM SERVICE PLANNING

Make certain that every pregnant patient selects a pediatrician who is contracted with the respective health plans as soon as possible and BEFORE delivery. Failure to do this may result in penalties by actions of the Quality Assurance Committee in the compensation of the physicians in charge of the pregnant patient's care, the primary care physician and the OB physician .

Ensure that each pregnant patient is scheduled for postpartum/family planning services. Discuss with the patient the need to begin pediatric care for the baby and arrange an appointment. Pediatric referrals should be documented clearly in the record. Assist the patient in locating routine community services which are available to her and the newborn. Provide materials on parenting and well baby care and review such material with the patient.

Some hospitals practice early release. If a mother is released from the hospital prior to 36 hours

post delivery a home visit must be accomplished for the propose of assessing both the mother and infant. A registered nurse must make the home visit within 5-7 days after discharge. Retain a copy of the home visit record in the patient's medical record.

D. LINKING WITH SERVICES

The objective of linking is to ensure that the patient receives the special health services to which they are entitled. Linking includes five essential activities: referring, coordinating, educating, supporting, and advocating.

1. Referring Activities

- Become knowledgeable about care providers, available services, and choices. Learn the various social programs' eligibility criteria and identify contact point for each agency or specialist's office. It may be helpful to maintain a list of care providers for referral agencies.
- Assist the patient to complete the necessary application forms and obtain releases of information or other pertinent information required by the referral agencies.
- Confirm that the patient has a primary medical provider; if not, assist the family in locating one in the IPA community.
- Link the patient with appropriate and needed services. This may be as simple as making a single referral or as complicated as arranging transportation, temporary lodging, respite care or securing the funding needed for the services, etc...
- Review and clarify recommendations of the care coordination plan with the patient.

1A. PHYSICIAN REFERRALS

- The Care Coordinator is responsible for referring the patient for health care that is not within the scope of practice of the primary care physician. If protocols are established for someone other than the Care Coordinator to make referrals, then such protocols should be followed. However, you, as Care Coordinator, are responsible for ensuring that such referrals are noted in the patient's file, that appointments are kept, and that treatment commitments are recorded.
- **ALL REFERRALS ARE TO BE MADE TO PHYSICIANS CONTRACTED WITH THE IPA DEPENDING ON THEIR RESPECTIVE HEALTH PLANS. IF THE SPECIALIST IS PAID BASED ON CAPITATION PRIOR AUTHORIZATION FROM THE IPA IS NOT REQUIRED. IF THE REFERRAL IS TO A CONTRACTED PHYSICIAN WHO IS PAID FEE-FOR-SERVICE THEN PRIOR AUTHORIZATION IS REQUIRED IN EACH CASE. IF THE PATIENT IS REFERRED TO A PHYSICIAN OR FACILITY OUTSIDE OF THE CONTRACTED PHYSICIANS AND FACILITIES OF IPA THEN APPROVAL OF THE RESPECTIVE SPECIALIST GROUP WHO IS BEING PAID FOR THOSE SERVICES MUST BE OBTAINED IN ADVANCE.**
- **FOR EXAMPLE: IF A REFERRAL IS MADE TO A CARDIOLOGIST WHO IS NOT IN THE CONTRACTED GROUP AND IT IS AN IPA PATIENT, the in-network cardiologist MUST OKAY THE REFERRAL.**

- Examples of referrals and appropriate action that should be taken are as follows:
 - **EXAMPLE 1:** A woman is receiving care from her primary care physician. The physician discovers an obstetrical problem and feels it is wise to have a perinatal specialist see the woman to determine if she will require special OB medical services. The physician documents in the medical record to refer the patient to a Complications Clinic. You, as Care Coordinator, will ensure that the appropriate appointment is made, records are copied and mailed, assistance is provided with transportation as needed, and ensure that the appointment is kept or follow-up initiated. After the patient receives one or maybe two visits at the Comp Clinic and the Comp Clinic determines that the patient may continue to receive care through the primary provider, ensure that treatment comments from the Comp Clinic are received. If, on the other hand, the IPA determines that the patient should continue to receive all of the remainder of her care at the Comp Clinic, ensure that treatment comments from the Comp Clinic agent at the Comp Clinic takes responsibility for care coordination.
 - **EXAMPLE 2:** Occasionally a patient will develop a problem which is not clear in nature. Referrals of this nature are made to providers, such as cardiologists, endocrinologists, dentists, geneticists, neurologists, etc. When the physician recommends such a referral, you are to ensure that an appointment is scheduled and obtain treatment comments for the medical record.
 - **EXAMPLE 3:** It is your responsibility to ensure that the patient is referred to and receives counseling as needed (i.e., nutritional counseling for pregnant women, substance abuse counseling for substance abusers, etc.). Coordination between yourself and the counselor can facilitate your duties.

2. Coordinating Activities

- Coordinate services to prevent duplication and promote continuity of care.
- Facilitate communication between service providers to set common goals and identify responsibilities of the individuals involved. Obtain a signed release of medical information (See Attachments Section) yearly from the patient.
- Act as a liaison between the IPA, other tertiary centers and local providers. Reports from specialty providers are obtained and shared with designated agencies/providers as indicated in the patient's Plan of Care. Review, clarify and follow-up on any clinic recommendations.
- Help coordinate medical and educational recommendations by taking part in the Plan's Quality Assurance Committee and when appropriate, participating on the multidisciplinary Medical Care Team.
- Promote continuity of care between the hospital and the home by participating in discharge planning.

3. Educating Activities

- Provide general information to patients, their families and providers about the patient's health condition, diagnosis and treatment options which will allow them to make informed decisions.
- Provide instruction on special care techniques pertinent to the patient's condition.
- Provide instruction on the importance of receiving early and continuous care-- especially prenatal care and chronic disease management—on following the physician's advice and on practicing healthy lifestyles.
- Provide information to the patient and family on how to access services.
- Assist the patient and families to learn how to coordinate the patient's care.
- Educate the patient and family on role and importance of a medical home and preventive care.
- Educate the patient and family on importance of maintaining medical and educational records.

4. Supporting Activities

Support is one of the most important activities the Linked IPAs Care Coordinator will provide. Often families and professionals are so engrossed in learning the specialized aspects of the patient's care that little time is spent dealing with the emotional feelings that are ongoing for families. Beyond knowledge, families need the opportunity to express, clarify and receive validation for their feelings. Often the frequency and duration of services the LinkedIPAs Care Coordinator provides depends more on the family functioning and ability to cope than on the severity of the patient's illness.

- Provide emotional support and counseling when a patient is initially diagnosed, during family crisis, or for grief counseling.
- Provide support to help the family reach the goals outlined in the Care Coordination Plan of Care.
- Support patients and families in the decisions they make regarding the patient's care.
- Refer families to support groups.
- Encourage utilization of support persons or entities already established with the family.

5. Advocating Activities

- Become familiar with eligibility criteria, application processes and appeal procedures for programs and agencies.
- Become knowledgeable about the laws and regulations applying to the care of persons with special healthcare needs.
- Provide resources to the patient and family on legal rights and services.
- Act as a patient and family advocate to work toward removing barriers in accessing care.
- If necessary, participate with the patient and family in negotiations to secure services.
- Assist the patient and family to gain skills in problem solving and self advocacy.

6. Monitoring and Evaluating Activities

Monitoring and evaluating refers to the responsibility of the LinkedIPAs Care Coordinator to follow-up with the patient, family and providers. This involves periodic reassessment and modification of the Service Plan to address new concerns. Evaluation is a critical piece of the care coordination process. Periodically, the LinkedIPAs Care Coordinator and the patient review the care plan and evaluate it to ensure that the expected outcomes were met.

A. Patient Monitoring

- Ensure that patients keep scheduled appointments.
- Ensure that appropriate-follow-up is accomplished on missed appointments, including the face-to-face encounters.
- It must be documented in the record that at least two separate attempts—either telephone call, home visit or letter—have been made to get the patient back for care.
- Missed appointments should be highlighted in the file with either a missed appointment stamp or by specific notation in either the patient's EMR or in the patient's physical file using a different color ink or using a highlighter. Follow-up attempts should also be differentiated in the file.
- Before any record is closed, ensure that all documentation is appropriately signed and dated.
- Review records to ensure that all required forms and documentation are complete and on file.
- Alert referral specialists, if needed, for any documentation lacking on their part, such as referral treatment comments and a discharge summary for any hospitalizations.
- A closed patient record consists of the Care Coordinator Service Certification, care coordination documentation, signed forms, medical information from all involved in the patient's care and the hospital discharge summary.

Remember that other staff can perform these functions; however, the Care Coordinator must be sure all of these tasks are completed.

B. Evaluation Activities

- Follow-up to decide if the patient/family has received the services as noted on the Care Coordination Service Plan. For example, medical and educational plan, follow-through with referrals, appropriate educational services, etc.
- Monitor the patient's progress in reaching the outcomes/goals as designated in the Care Coordination Service Plan.
- Evaluate the plan of care using the following as a guide:
 - Was the patient's expected outcomes met and the problems resolved?
 - When did the patient achieve the expected outcome?

- How realistic was the expected outcome?
- Were the coordinator's interventions effective?
- How instrumental were the interventions in assisting the patient to achieve the outcome?
- What happened when the intervention was not congruent with the expected outcome and/or the patient's plan?
- What variables influenced the attainment of the expected outcome?
- Why were outcomes not attained? Wrong problems/needs identified?
- Interventions not appropriate? The care plan was incomplete? Team members did not complete their responsibilities?
- What changes are needed in the plan?
- Where should the coordinator and patient or family refocus their efforts?
- Is the coordinator no longer needed by the patient?
- Can the record be closed?
- Is the patient or family comfortable notifying the coordinator if new concerns arise?

Update and modify the Care Coordination Service Plan as needed. If the expected outcomes have been met, the LinkedIPAs Care Coordinator has the option of closing the case.

E. RESPECTING THE VALUE OF FACE-TO-FACE ENCOUNTERS

- The Care Coordinator must have at a minimum of one interview with each patient. This is a minimum number and more are to be done if needs indicate.
- If possible, these sessions should coincide with the days that the patient obtains services to avoid extra trips to the facility.
- If no face-to-face visits are accomplished, documentation must be presented as to why the visit was not accomplished.

F. DOCUMENTATION

Care Coordination activities can either be recorded on the Care Coordinator Service Certification, in the Progress Notes or on the Service Plan depending on program protocols. Below are some acceptable samples of documentation from client encounters. Please remember that the review staff will look at the total record for supporting documentation.

For topics covered in addition to or for problems noted and resolution, a brief description should be documented. It is acceptable to use commonly used abbreviations.

Example 1: A client enters your system and on the initial intake. A health assessment is done and a service plan is formulated. Your documentation for the first visit would be the Patient Health Assessment, the creation of the Plan of Care, and documentation. The second face-to-face encounter occurs with no additional problems noted. Before the third face-to-face visit, the client calls and needs assistance with transportation. Documentation would be "Patient called with transportation problem. Arranged for community van to pick up". Then the third encounter should take place as indicated.

Example 2: For those recipients who enter care late in their pregnancy, the Care Coordinator should

cover as much as is feasible in the first encounter. The chart should contain documentation as to what is covered and that the patient entered care late. On subsequent visits, the Care Coordinator should meet with the client, emphasizing education, pre-admission to the hospital, family planning, etc.

II. DEFINITIONS

"Antepartum Care" means all usual prenatal services including, but not limited to: the initial visit at the time pregnancy is diagnosed, initial and subsequent histories, care coordination, risk assessments, physical exams, recordings of weight and blood pressure, fetal heart tones, lab work appropriate to the level of care including hematocrit and chemical urinalysis, and any additional services required for high risk women.

"Capitated Fee" means the reimbursement fee paid to the providers for patient recipients who meet the requirements of the program. This fee is a lump sum amount that is paid to the provider who in turn pays subcontractors who provided services to the particular recipient. The amount paid to each subcontractor is a negotiated amount agreed upon between the provider and the subcontractor.

"Care Coordination" means a management of care including recruitment, outreach, assessment, service planning, assisting the recipient in arranging for appropriate services including, but not limited to, transportation, ensuring continuity of care, education, counseling, and follow-up and monitoring to ensure services are delivered.

"Delivery" means vaginal delivery (with or without episiotomy and with or without forceps), or cesarean section delivery, hospitalization, assistant surgeon services, and professional services such as anesthesiology.

"Dropout" means a patient recipient who began care with the primary provider but is no longer receiving care from the provider. Reasons for dropouts may include recipients who move from a health plan county into another county.

"Emergency Services" means covered services normally provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health or the health of the fetus in jeopardy; (2) serious impairment of bodily functions; or (3) serious dysfunction of any organ or part of the body.

"Exemption for Good Cause" means a recipient has been exempted from receiving care from the primary provider based on medical necessity, travel hardship. (See Section 6 - Exemption Procedures for further information).

"Exemption for Third Party Liability" means that the recipient is still restricted to receiving care through the primary provider, but all providers of service will bill their claims fee-for-service. Claims are to be billed to the third party carrier prior to Health Plan being billed. (See Section 6 - Exemption Procedures for further information.)

"Family Planning Tracking" means informing recipients in face-to-face interviews of available family, planning services.

"Fee-for Service" means the services that can be billed directly to the Trust through the standard billing procedures of the provider.

"Health Plan Recipient" means those patients who reside in the health plan location and are certified for the health plan and receive services under the health plan.

"Health Plan Service Area" means the geographic location in which the primary provider serves and in which the Health Plan recipient resides.

"Home Follow-up Visit" means a visit by a registered nurse and/or a mental health professional to the residence of a recipient after being discharged from the hospital or alternative program. The home visit should generally be done within five days, but no more than seven days, after the recipient is discharged from the hospital. Home follow-up visits generally include a home assessment, physical assessment, education to the mother regarding self care, newborn care, and danger signals, scheduling of follow-up visit if a visit has not already been scheduled, and scheduling of a family planning visit for the mother if one has not already been scheduled/received.

"Postpartum Care" means in-hospital visits, office visits and/or home visits by a physician, midwife or registered nurse with experience or credentials in obstetrics or pediatrics following delivery for routine care through the end of the month of the 60-day postpartum period.

"Subcontract" means any written agreement between the primary provider and another party for any services necessary to fulfill the requirements of the Provider Agreement.

"Urgent Care" means care for patients that is not an emergency but cannot wait until an appointment can be made with their primary care physician and is at a time of day or on a date when their PCP's office is closed. The care is to be at the designated "URGENT CARE CENTER" of Linked IPAs.

ATTACHMENTS BIBLIOGRAPHY

A. CARE COORDINATOR SERVICE CERTIFICATIONS

The Care Coordinator Service Certification has been developed to facilitate tracking of services received by patients. Complete instructions for completion are included in the Care Coordinator Manual since it is the responsibility of the Care Coordinator to ensure accuracy and completeness.

B. WELCOME TO CARE COORDINATION LETTER

This letter is to be mailed upon notification of the patient's having signed up with a primary care physician and has been identified for Care Coordination Services.

C. PATIENT'S RIGHTS AND RESPONSIBILITIES

It is the responsibility of the Care Coordinator to ensure that each patient receives a copy of this form and that the patient understands the information conveyed. This form was designed to assist the patient in remembering key points about the Program.

D. AGREEMENT TO RECEIVE CARE

It is the responsibility of the Care Coordinator to ensure that each patient is given a copy of this form, the patient understands the information stated, and that a signed copy is maintained in the patient's file.

E. CARE COORDINATION ENCOUNTER GUIDE

One of these tools must be utilized for keeping track and monitoring during face-to-face visits. The actual tool does not have to be kept in the patient record if it is a template.

F. PATIENT HEALTH ASSESSMENT RECORD

This form was developed for use in conducting health assessments upon hospital admission. This is an example of a form acceptable for use when conducting the Patient Health Assessment in a clinic setting as well. It may only be conducted using this form by a **certified health professional**.

F.1. HEALTH ASSESSMENT RECORD WORKSHEET

This form is to be used to aid the interviewer in filling out the Patient Health Assessment Record.

G. COMPREHENSIVE MEDICAL ASSESSMENT

This form is to be used in lieu of the Patient Health Assessment Record when a certified health professional is not present to conduct the patient interview or when more comprehensive detail is required. It is in .pdf format.

H. AUTHORIZATION TO RELEASE MEDICAL INFORMATION FORM

This form is to be filled out when a request of medical records is made to complete care coordination activities. It must be renewed by the patient annually.

I. THE HEALTH PLAN'S GRIEVANCE SYSTEM

This document is included to aid the Care Coordinator in resolving conflicts and in care coordination so that the needs of the patient are met.

J. QUALITY ASSURANCE SYSTEM

This document is provided so that the Care Coordinator may educate herself on the policies and procedures of LinkedIPAs Quality Assurance System, as well as understand and be encouraged to participate in this system.

ATTACHMENT A: CARE COORDINATOR SERVICE CERTIFICATION

These step-by-step instructions have been formulated to assist you in completing the Care Coordinator Service Certification. It is imperative that this form be completed accurately and in its entirety. If at any time you have questions concerning this form please contact the Quality Assurance Coordinator.

Each instruction corresponds to the question number of the service plan.

1. The recipient's Health Plan number is:
2. The hospital date is to be represented numerically with the year first, month second, day last. If the month or day is a single digit, please put a zero in the first blank. EXAMPLE:
2011/01/08 = January 8, 2011
3. This is the site name (office) from which the care coordinator operates. If you do not know the appropriate code to use, contact your primary care physician.
4. Print the recipient's name in last name, first name, middle initial order.

LAST _____ FIRST _____ MIDDLE _____

5. The recipient's date of birth is to be represented numerically with the year first, month second, day last. If the month or day is a single digit, please put a zero in the first blank of that section.
EXAMPLE: 2009/01/08 = January 8, 2009. DOB _____
6. The recipient's SERVICE AREA code is to be listed. This is the five digit ZIP code in which the recipient lives.
7. Race? W=White; B=Black; H=Hispanic; NA=Native American A=Asian; O=other is to be utilized. It is not necessary to write the word.
8. Risk status categories include High, Low and Medium. Indicate the risk status at the initial appointment and include a brief description of reason for high or medium risk. This risk status is the medical and/or psychosocial risk.
9. Explanation:
10. Record whether vitamins or a prescription for vitamins were given and the date it was done.
11. If vitamins or a prescription was given on more than one occasion record the first date.
12. The certification does not have to state whether vitamins or a prescription was given.
13. This number should reflect the total number of prenatal visits including the initial visit and visits to OB specialists.
14. The answer should reflect if services were actually received and the date. DO NOT include referrals only.
15. This is for referral to specialists.

16. If the patient has been referred to a specialist write the reason--indicate whether an inpatient stay was incurred and the number of days.
17. If more than one stay was incurred and they were for different reasons: indicate the number of days by each reason and then the total.
18. Indicate whether a pre-delivery outpatient visit was incurred.
19. If there was more than one outpatient visit indicate the number of visits by each reason and then the total.
20. If educational or self-help classes are available and arrangements are made for attendance, check yes. If classes are not available and you only make a referral, check no.

Yes	No
-----	----
21. Have prior records of the patient been sent to Primary Care Physician?

Yes
No
22. The provider number of the health care provider is to be indicated.
23. Has a home visit been accomplished? The date should reflect the date the home visit was done.

Yes	No	Date
-----	----	------
24. If for some reason a home visit could not be accomplished, but attempts were made, indicate yes and the dates of the attempts. Yes No Date
25. This question is for a scheduled visit and the date should reflect the appointment date. Check yes if you make a referral, including arranging an appointment, for medical care. Yes No
26. This section is to be used for summary of all care coordination activities. Please number and date each individual encounter with the patient or action taken on behalf of that patient (e.g. assistance with transportation). If protocols are in place to utilize another form for recording of case coordination activities, the form can be utilized and placed in the patients record. Such variances though must be approved by the Quality Assurance Director.

ATTACHMENT B: WELCOME TO CARE COORDINATION LETTER

**Welcome to the Care Coordination/Case Management Program of
Patient/Physician Cooperatives!**

You have access to local care coordination/case management to make sure you get the services and supports you need. A Care Coordinator can help you:

- Arrange your annual visit to your doctor;
- Better understand your health;
- Locate a medical specialist; and
- Arrange for other needed health care services.

Patient/Physician Cooperatives has an agreement with _____ to provide Care Coordination for our members. This service is provided at no cost to you.

My name is _____. I will be your local Care Coordinator for Patient/Physician Cooperatives.

My address is:

My phone number is:

The health benefit plan you have chosen is:

I will be contacting you shortly for an initial visit but please feel free to contact me with any questions and/or concerns that you might have.

Thank you!

This is a voluntary service. You may choose not to have this service if you wish at any time. This will not affect your health care coverage through Patient/Physician Cooperatives. Members are assumed to be in the program unless they decline participation.

If you chose not to participate in the Care Coordination/Case Management Program, you may call Patient/Physician Cooperatives at 1-866-549-4199 or contact me at the phone number above and ask to be removed from the service. You may also write us at:

**Patient/Physician Cooperatives
P.O. Box 1838
Splendora, TX 77372**

Patient/Physician Cooperatives: 1-866-549-4199

ATTACHMENT C: PATIENT'S RIGHTS AND RESPONSIBILITIES

Patient's Rights:

1. You have the right to receive quality and accessible care.
2. You have the right to receive bona fide emergency care from any provider.
3. You have freedom to choose where to receive services within the guidelines, terms and conditions of your Health Plan.
4. You have the right to receive care which is proper for your risk status.
5. You have the right to file a grievance with your care coordinator and receive prompt review of your case if you are not satisfied with an aspect of care you are receiving under the program. If you are not satisfied with the recommendation of action taken by your care coordinator, you may request that the primary provider review your case. If you are not satisfied with the recommendation or action taken by the primary provider, your case can be appealed by The Quality Assurance Committee.

Patient Signature: _____ Date: _____

Special Rights or Benefits accrue to members of the Patient/Physician Cooperatives. As a Cooperative Member, you have the following rights:

1. To participate in member-owner meetings and other Co-op forums.
2. To attend Co-op sponsored educational events.
3. To attend all pre-voting discussions and all votes held for the member-owners.
4. To run for the Board of Directors and serve on Board Committees (after having had training approved by the PPC).
5. To access financial, strategic planning and governance information.
6. To propose agenda items to the Board, to review minutes from the board meetings.

Member Signature: _____ Date: _____

Patient's Responsibilities:

1. You are responsible for receiving all your care only from providers in the Health Plan's IPA Program. Your care coordinator will provide you of a current list of our physician members to whom you may go for health care services. The Health plan will not pay for your care if you do not receive your care from a participating provider.
2. You are responsible for making every attempt to keep appointments and interviews with the Care Coordinator.
3. You are responsible for abiding by the service plan of care that you and your Care Coordinator set up under the direction of a physician.
4. You are responsible for keeping your Care Coordinator informed when you move, when your Health Plan eligibility changes, when your medical condition changes, or when you decide not to participate in the program.
5. You are responsible for keeping your Care Coordinator fully informed regarding changes in your medical condition.

Patient Signature: _____ Date: _____

As a Member of the Patient/Physician Cooperatives, certain responsibilities accrue:

1. To be accountable, dependable and professional in all of your interactions with other Co-Op members, clients and their families.
2. To abide by the Cooperatives' values towards other members, clients and their families.
3. To maintain client and patient/member confidentiality.
4. To actively participate in the overall well-being of the members of the Patient/Physician Cooperatives.
5. To attend Co-op meetings and activities, including voting.
6. To serve on and participate in committees (after having been given training approved by the PPC)
7. To promote a positive business presence in the community (after having been given training/guidelines approved by the PPC).
8. To educate oneself about Co-op governance, structure, operations and patient/member care.
9. To maintain good standing by being current on member dues, current on contracts with your physician and current on payments to the group health insurance, if applicable.

Member Signature: _____ Date: _____

ATTACHMENT D: AGREEMENT TO RECEIVE CARE

Welcome to Care Coordination. We wish to provide you with the best care possible. Please help by doing these things:

1. Keep all appointments and come for medical checkups as recommended.
2. Attend patient education classes if ordered.
3. Take vitamins and nutritional supplements regularly as recommended. Take prescription medications as ordered by your doctor.
4. After primary treatment is completed, attend checkups and aftercare as follows: call your care coordinator if you cannot keep an appointment and ask for help with transportation if you need it.
5. Fill in the address and phone number where you can be reached:

Phone Number Address

6. I have been given a copy of the Patient's Rights and Responsibilities under the Health Plan. I understand my part and wish to be actively involved in my care. I am willing to work closely with my care coordinator and follow the plan developed for my health.

Patient's Signature: _____ **Date:**
____/____/____

ATTACHMENT E: CARE COORDINATION ENCOUNTER GUIDE

FIRST ENCOUNTER

1. Explain benefits of Health Plan's IPA Program.
2. Provide information on after hours care, location of facilities and hours of service. Explain your role and how you can be contacted.
3. Obtain signature on Agreement to Receive Care, release of information and telephone number where patient can be reached.
4. Provide written information and explanation regarding the grievance procedures and a copy of the Patient Rights and Responsibilities (See Attachment C). Obtain recipient's signature on Agreement to assure she has received information.
5. Provide information and counsel recipient on importance of early and continuous care.
6. Ensure that any medications that were provided contain instructions and inquire if they are being taken. Encourage that the medications be taken as prescribed.
7. Ensure referral to educational classes, counseling services.
8. If you are a certified medical professional, perform the Comprehensive Health Assessment (See Attachment F).
9. If you are not a certified medical professional, perform the LTCC Form (See Attachment G)
10. Develop a service plan for coordinating total care according to medical and social risk assessment and psychosocial needs.

SECOND ENCOUNTER

1. Update the Patient Health Assessment and Plan of Care.
2. Encourage enrollment in education classes as appropriate or needed.
3. Provide information about family planning and assist with consent forms as appropriate.
4. If undergoing prenatal care, discuss labor and delivery process. Advise patient which hospital to deliver at, encourage pre-admission to scheduled hospital, assess transportation needs to scheduled hospital and assist as appropriate, etc.
5. Emphasize the need for pediatric care. Provide information as appropriate as to available services.

THIRD ENCOUNTER

1. Update the Patient Health Assessment and Plan of Care.
2. If patient is pregnant, ensure preparation for childbirth, i.e., transportation, hospital site, procedures to follow, pre-admission, home preparations, etc.
3. Re-emphasize information about services available for the newborn through the first year of life.
4. Re-emphasize the availability of family planning services.

AS NEEDED

1. Follow-up on missed appointments to clinic/other referral agencies. Make notes on service plan.
2. Update health assessment and service plan as needed.

ATTACHMENT F: PATIENT HEALTH ASSESSMENT RECORD

Patient Health Assessment Record Part I: Intake Routine

Patient's Identifying Information			
Name: Last		First	MI
DOB (mm/dd/yyyy):		SS#:	
MR#		(Note: Place Patient ID Sticker above this line if available)	
1 Date:	2 Time:	3 T:	4 P: 5 RR: 6 SpO ₂ :
7 Mode: <input type="checkbox"/> amb <input type="checkbox"/> gurney <input type="checkbox"/> w/c <input type="checkbox"/> other		8 B/P: Rt: Lt:	
9 Via: <input type="checkbox"/> referral <input type="checkbox"/> ER <input type="checkbox"/> OR <input type="checkbox"/> other		10 Height: Weight: <input type="checkbox"/> Stand. <input type="checkbox"/> Stated	
11 Admitting MD:		12 Primary Care MD:	
13 Admitting Diagnosis:			
14 Chief Complaint (per patient):			
15 Allergies: Latex: <input type="checkbox"/> balloons <input type="checkbox"/> bananas <input type="checkbox"/> NKDA <input type="checkbox"/> gloves <input type="checkbox"/> pineapple <input type="checkbox"/> mult OR <input type="checkbox"/> avocados			
17 Type of Reaction:			16 LATEX 4 or > - order latex free cart <input type="checkbox"/>
18 Valuables List: (describe jewelry, clothing, etc.)			19 Valuable envelope to Safe <input type="checkbox"/>
<input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Dentures <input type="checkbox"/> Partial/Bridge <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Refused Safe			Safe <input type="checkbox"/>
20 Nurse Signature (if other than nurse completing remainder of assessment):			
Part II: Patient History			
21 Patient History (major illnesses / operations / major injuries):			
<input type="checkbox"/> Hypertension <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Anesthesia issues <input type="checkbox"/> Heart Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Hepatitis <input type="checkbox"/> Seizures <input type="checkbox"/> None <input type="checkbox"/> Stroke <input type="checkbox"/> TB <input type="checkbox"/> Ulcer <input type="checkbox"/> Mental Disorder <input type="checkbox"/> Cardiac other <input type="checkbox"/> Respiratory other <input type="checkbox"/> Kidney Disease <input type="checkbox"/> General other			22 To OR & anesthesia issue HX; call MD <input type="checkbox"/>
23 Specify others not listed above and Surgeries:			24 Smoking & yes to MI, Pneu. CHF: give Ed. <input type="checkbox"/>
25 Alcohol/Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: Daily Amt: <input type="checkbox"/> Quit		27 Flu/Pneu if no, do Screen form <input type="checkbox"/>	
28 Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: Daily Amt: <input type="checkbox"/> Quit			
29 Admitting Diagnosis: AMI; Pneumonia, CHF: <input type="checkbox"/> Yes <input type="checkbox"/> No			
30 Vaccinations:			31 CM Flu/Pneu Referral <input type="checkbox"/>
Flu Shot within past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused			
Pneumonia Shot in past 5 years <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused			
32 Family History:			
<input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Asthma <input type="checkbox"/> TB <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney <input type="checkbox"/> Anesthesia <input type="checkbox"/> Cancer <input type="checkbox"/> Seizures <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Mental Disorder <input type="checkbox"/> None <input type="checkbox"/> Other:			
33 Psychosocial/Economic/Discharge:			
34 Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed		35 FINANCE Referral <input type="checkbox"/>	
36 Family: <input type="checkbox"/> Lives With <input type="checkbox"/> Lives Alone			
37 Lives in: <input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other			
38 Occupation: <input type="checkbox"/> Full Time <input type="checkbox"/> Part time <input type="checkbox"/> Retired <input type="checkbox"/> Other		39 SS or CM Referral <input type="checkbox"/>	

Patient Health Assessment Record (Family History cont'd)

40 Requests Visit from PPC/Cooperative Rep. <input type="checkbox"/> Yes <input type="checkbox"/> No	
41 Activity Level: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bed	
42 Suspected Abuse or Neglect: <input type="checkbox"/> Yes <input type="checkbox"/> No	43 Anxiety <input type="checkbox"/>
44 Emotional Status: <input type="checkbox"/> Cooperative <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> End of Life	
46 Concerns with Hospitalization: <input type="checkbox"/> Child Care <input type="checkbox"/> Home Life <input type="checkbox"/>	45 Grief <input type="checkbox"/>
Religious or Cultural Practices	
48 Emergency Contact: POA: <input type="checkbox"/> Yes <input type="checkbox"/> No	47 Knowledge Deficit <input type="checkbox"/>
Relationship: Phone:	
50 Nearest Relative: Relationship: Phone:	48 Spiritual <input type="checkbox"/>
51 Info. Obtained From: <input type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Other	

52 Part III: Physical Assessment

Place Check mark in areas of abnormality. If unable to assess, indicate reason.

53 Assess eyes, ears, nose for abnormality No Problem Noted

EENT	<input type="checkbox"/> impaired vision <input type="checkbox"/> glaucoma <input type="checkbox"/> hard of hearing <input type="checkbox"/> gums <input type="checkbox"/> redness	54 EENT: <input type="checkbox"/>
	<input type="checkbox"/> drainage <input type="checkbox"/> blind <input type="checkbox"/> deaf <input type="checkbox"/> teeth <input type="checkbox"/> burning <input type="checkbox"/> lesion	
	Notes	

55 Assess chest configuration, resp. rate, depth, pattern, breath sounds No Problem Noted

RESPIR-ATORY	<input type="checkbox"/> asymmetric <input type="checkbox"/> tachypnea <input type="checkbox"/> crackles Rt: <input type="checkbox"/> up <input type="checkbox"/> ow Lft: <input type="checkbox"/> up <input type="checkbox"/> ow <input type="checkbox"/> cough	56 RESPIRATORY <input type="checkbox"/>
	<input type="checkbox"/> barrel chest <input type="checkbox"/> bradypnea <input type="checkbox"/> diminished Rt: <input type="checkbox"/> up <input type="checkbox"/> ow Lft: <input type="checkbox"/> up <input type="checkbox"/> ow <input type="checkbox"/> sputm-color	
	<input type="checkbox"/> dyspnea <input type="checkbox"/> shallow <input type="checkbox"/> wheezes Rt: <input type="checkbox"/> up <input type="checkbox"/> ow Lft: <input type="checkbox"/> up <input type="checkbox"/> ow O ₂ @ ____ liters/min.	
Notes		

57 Assess heart rate, pulse, blood pressure, circulation, fluid retention No Problem Noted

CARDIOVASC	<input type="checkbox"/> tachycardia <input type="checkbox"/> irregular <input type="checkbox"/> tingling <input type="checkbox"/> edema <input type="checkbox"/> diminished pulses	58 CardioVasc <input type="checkbox"/>
	<input type="checkbox"/> bradycardia <input type="checkbox"/> murmur <input type="checkbox"/> numbness <input type="checkbox"/> fatigue <input type="checkbox"/> absent pulses	
	Notes	

59 Assess abdomen, bowel sounds, bowel habits No Problem Noted

GASTRO-INTESTIN	<input type="checkbox"/> distention <input type="checkbox"/> hypo BS <input type="checkbox"/> anorexia <input type="checkbox"/> dysphagic <input type="checkbox"/> diarrhea <input type="checkbox"/> incontinent	60 GI: <input type="checkbox"/>
	<input type="checkbox"/> rigidity <input type="checkbox"/> hyper BS <input type="checkbox"/> N or V <input type="checkbox"/> constipation <input type="checkbox"/> last BM <input type="checkbox"/> ostomy	
	<input type="checkbox"/> special diet <input type="checkbox"/> diet intolerances <input type="checkbox"/> diabetes	
Notes		61 Endocrine <input type="checkbox"/>
		62 Nutrition <input type="checkbox"/>

63 Nutritional Trigger Assessment: No Problem Noted

NUTRI-TION	<input type="checkbox"/> weight change >10lb within last month <input type="checkbox"/> decubitus – stage II or greater	64 Dietary Trigger Referral <input type="checkbox"/>
	<input type="checkbox"/> changes to appetite > 3 days <input type="checkbox"/> TPN/tube feeding/PEG tube	
	<input type="checkbox"/> N/V/diarrhea > 3 days <input type="checkbox"/> DX malnutrition, FTT or Gest DM	

Patient Health Assessment Record (cont'd)

65 Assess urine frequency, control (Gyn – assess bleeding, discharge, pregnancy)					
<input type="checkbox"/> No Problem Noted					
GU & GYN	<input type="checkbox"/> dysuria <input type="checkbox"/> hesitancy <input type="checkbox"/> nocturia <input type="checkbox"/> foley <input type="checkbox"/> menopausal <input type="checkbox"/> discharge				
	<input type="checkbox"/> frequency <input type="checkbox"/> incontinent <input type="checkbox"/> hematuria <input type="checkbox"/> urostomy <input type="checkbox"/> LMP <input type="checkbox"/> pregnancy				
	Notes			66 GU & GYN	<input type="checkbox"/>
67 Assess orientation, LOC, speech, strength, grip, etc. <input type="checkbox"/> No Problem Noted					
NEURO	<input type="checkbox"/> confused <input type="checkbox"/> sedated <input type="checkbox"/> pupil/Lt. Non-react <input type="checkbox"/> vertigo <input type="checkbox"/> tremors <input type="checkbox"/> unsteady				
	<input type="checkbox"/> comatose <input type="checkbox"/> lethargic <input type="checkbox"/> aphasic <input type="checkbox"/> headaches <input type="checkbox"/> numbness <input type="checkbox"/> paralyzed				
	<input type="checkbox"/> semi-comatose <input type="checkbox"/> pupil/Rt. Non-react <input type="checkbox"/> slurred speech <input type="checkbox"/> seizures <input type="checkbox"/> tingling <input type="checkbox"/> grips – weak				
Notes			68 NEURO	<input type="checkbox"/>	
69 Assess mobility, joint function, skin color, turgor, integrity <input type="checkbox"/> No Problem Noted					
MUSCLE & SKIN	<input type="checkbox"/> appliance <input type="checkbox"/> swelling <input type="checkbox"/> diaphoretic				
	<input type="checkbox"/> prosthesis <input type="checkbox"/> skin color <input type="checkbox"/> hot <input type="checkbox"/> flushed				
	<input type="checkbox"/> deformity/atrophy <input type="checkbox"/> poor turgor <input type="checkbox"/> cool				
	<input type="checkbox"/> drainage <input type="checkbox"/> moist <input type="checkbox"/> skin ulcer				
Notes			70 MS Referral	<input type="checkbox"/>	
			Skin Issues or Wound Care Referral	<input type="checkbox"/>	
NORTON SCALE	71 Norton Scale (Skin Risk Assessment)				
	<i>Physical Condition</i>	1 Very bad	2 Poor	3 Fair	4 Good
	<i>Mental Condition</i>	1 Stupor	2 Confused	3 Apathetic	4 Alert
	<i>Activity</i>	1 Bed	2 Chair Bound	3 Walk Help	4 Ambulant
	<i>Mobility</i>	1 Immobile	2 Very Limited	3 Slightly Limited	4 Full
	<i>Incontinence</i>	1 Doubly	2 Usually/Urine	3 Occasional	4 Not
	72 Notes	If 14 or less, evaluate appropriateness for Plan of Care			73 Total Score
				74 SKIN	<input type="checkbox"/>
FUNCTN	75 Functional Trigger Assessment:				
			76 Usual ADL	77 Admit ADL	78 Total Score = Usual+Admit
	Code:	79 OT feeds self/dressing/ADLs			
	4 = 100% of care	80 PT gait/transfers			
	3 = 75% of care	81 ST swallow/expression/comprehension			
	2 = 50% of care		82 ADL	<input type="checkbox"/>	83 FUNCTION
1 = 25% of care		Referral to Phys. Med. if change			
0 = N/A (acute time limited condition)					

Patient Health Assessment Record (cont'd)

FALL RISK	94 Fall Risk (Risk Assessment)			
	85 <input type="checkbox"/> Level I		86 <input type="checkbox"/> Level II – <i>Has two or more of the following risk factors</i>	
	Any patient <input type="checkbox"/> age > 65			
	<input type="checkbox"/> history of falls (immediate or within the past 3 months)			
	<input type="checkbox"/> taking fall related medications (hypnotics, analgesics, psychotropics, anti hypertensive, diuretic, laxative)			
	<input type="checkbox"/> moderate to severe physical impairment (includes mobility or visual/hearing deficits)			
	<input type="checkbox"/> occasional or frequent cognitive impairment		97 FALL RISK II <input type="checkbox"/>	
88 Pain Assessment				
PAIN	89 Pain score = 90 <input type="checkbox"/> numbers (A) 91 <input type="checkbox"/> faces (B) 92 <input type="checkbox"/>		93 Pain Goal:	
	FLACC (C)			
	94 Location:		95 <input type="checkbox"/> Unable to give	
	96 Onset:			
	97 Variations:			
	98 Quality: <input type="checkbox"/> ache <input type="checkbox"/> dull <input type="checkbox"/> sharp <input type="checkbox"/> stabbing <input type="checkbox"/> throbbing <input type="checkbox"/> cramping <input type="checkbox"/> burning <input type="checkbox"/> shooting <input type="checkbox"/> pressure			
	99 Aggravates: <input type="checkbox"/> light <input type="checkbox"/> dark <input type="checkbox"/> movement <input type="checkbox"/> lying down <input type="checkbox"/> other:			
	100 Relieves: <input type="checkbox"/> eating <input type="checkbox"/> quiet <input type="checkbox"/> cold <input type="checkbox"/> heat <input type="checkbox"/> other:			
101 Medications:		102 PAIN <input type="checkbox"/>		
103 Effects of pain: <input type="checkbox"/> NV <input type="checkbox"/> sleep <input type="checkbox"/> appetite <input type="checkbox"/> activity <input type="checkbox"/> relations. <input type="checkbox"/> emotions				
104 Home Medications (list medication, dose and frequency, and last dose taken)				
MEDS.	105 Medication:	106 Dose:	107 Frequency:	108 Last Dose:
	109 <input type="checkbox"/> refer to printed NH med list with last dose identified		110 <input type="checkbox"/> refer to cont. med sheet with last dose identified	
111 Disposition of Medications: <input type="checkbox"/> did not bring <input type="checkbox"/> to pharmacy <input type="checkbox"/> family to take home				
112 Medication sheet faxed to pharmacy: <input type="checkbox"/> Yes				

Patient Health Assessment Record (cont'd)

113 Treatment Summary / Plan:

SUMMARY	114 General	115 Referrals	116 Plan of Care: Choose top 3 priorities for Plan of Care			
	<input type="checkbox"/> latex cart	<input type="checkbox"/> CM/SS Ref.	<input type="checkbox"/> Anxiety	<input type="checkbox"/> CardioV.	<input type="checkbox"/> GU/Gyn	<input type="checkbox"/> Infect.
	<input type="checkbox"/> valuables	<input type="checkbox"/> Finance Ref.	<input type="checkbox"/> Grief	<input type="checkbox"/> GI Upper	<input type="checkbox"/> Skin	<input type="checkbox"/> Other
	<input type="checkbox"/> smoking ed.	<input type="checkbox"/> Nutrition Ref.	<input type="checkbox"/> Know. Def	<input type="checkbox"/> GI Lower	<input type="checkbox"/> ADL	
	<input type="checkbox"/> flu/pneu scr.	<input type="checkbox"/> Wound Ref.	<input type="checkbox"/> Spiritual	<input type="checkbox"/> Endo.	<input type="checkbox"/> Fall	
		<input type="checkbox"/> Phys M Ref.	<input type="checkbox"/> Resp.	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Pain	

117 NOTES:

118 Date: _____ **119 Time:** _____ **120 RN Signature:** _____