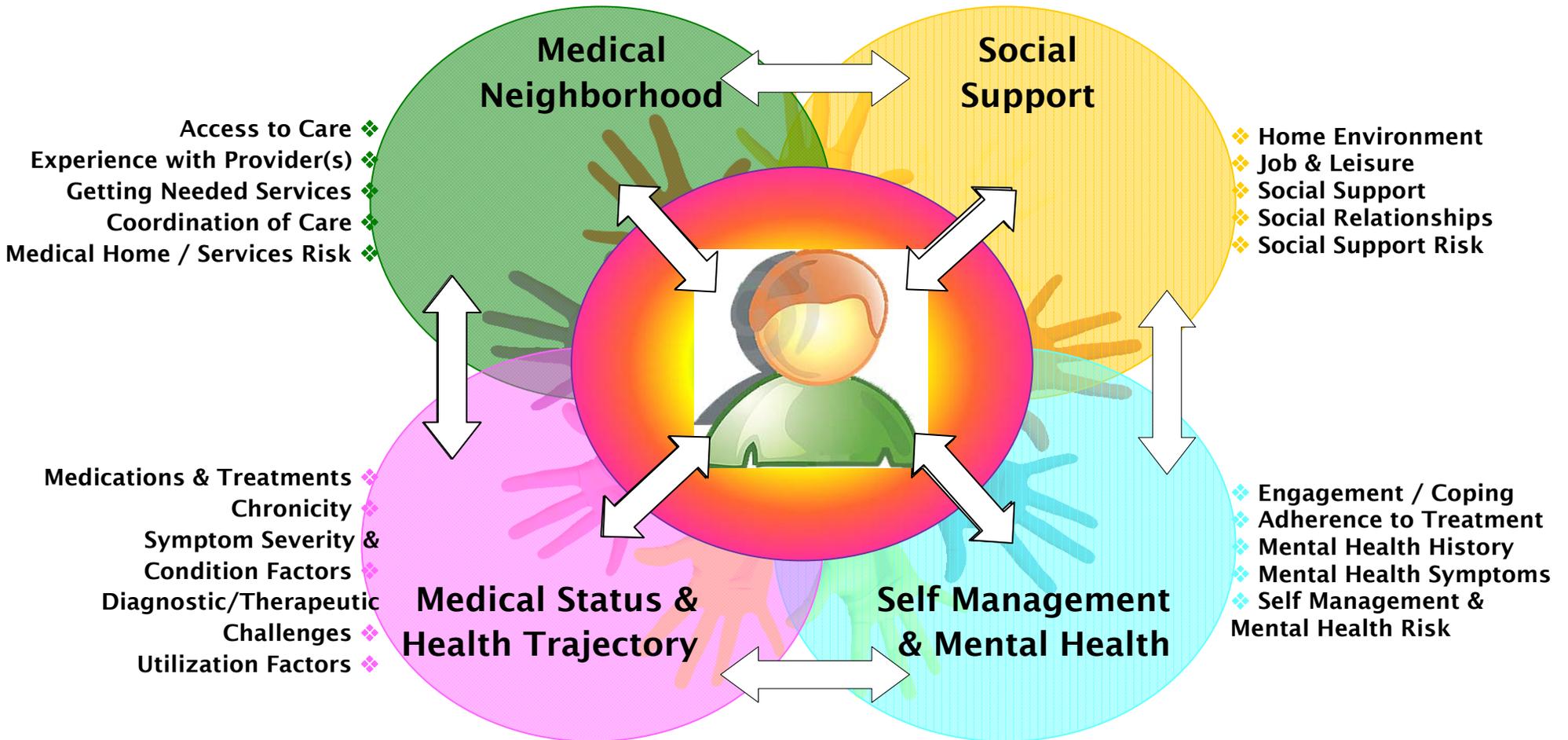


# RN Care Manager Assessment: The 4 Domains



The Team = Patient, Providers, RN Care Manager, patient's support network

Social Support Domain			
TOTAL SCORE =	Success Matrix		
<p><i>Consider the following:</i></p> <ul style="list-style-type: none"> <li>▪ <i>Basic needs such as food, safe and adequate housing</i></li> <li>▪ <i>Place of residence</i></li> <li>▪ <i>Do they live alone? With others? Have a pet?</i></li> <li>▪ <i>Caregivers</i></li> <li>▪ <i>Community support/resources</i></li> <li>▪ <i>Support network and interpersonal skills</i></li> <li>▪ <i>Leisure activity participation</i></li> </ul> <p><i>All areas with a 1 or greater should be flagged for possible goal development, further assessment and interventions</i></p>	<b>Home Environment</b>		
	0	Stable housing; able to maintain independent living	Safe and consistent living situation
	1	Stable housing with support of others (family, facility, other)	
	2	Unstable housing (no support, living in shelter, etc)	
	3	No satisfactory housing; immediate change necessary	
	<b>Job &amp; Leisure</b>		Economic stability and participation in leisure activities
	0	Has job and participates in leisure activities	
	1	Has job; no participation in leisure activities	
	2	Unemployed now for at least 6 months and participates in leisure activities	
	3	Unemployed now for at least 6 months and no participation in leisure activities	
	<b>Social Support</b>		Social and living situation that allows support for chronic and acute health needs
	0	Assistance readily available	
	1	Assistance generally available; possible delays	
	2	Limited assistance available	
	3	No assistance available at any time	
	<b>Social Relationships</b>		Social skills that will lead to connectedness/personal relationships
	0	No social disturbance	
	1	Mild social dysfunction; interpersonal issues	
	2	Moderate social dysfunction such as not able to initiate or maintain	
	3	Severe social dysfunction; disruptive or in isolation	
	<b>Social Support Risk</b>		Financial resources to meet basic needs, appropriate and consistent living arrangements, personal support with optimized relationships for the foreseeable future
	0	No risk for of need for changes in living situation, social relationships and support or job/leisure	
	1	Mild risk	
	2	Risk of need in the foreseeable future	
	3	Risk now -> intervene	

## Medical Neighborhood - Medical Home & Access to Services Domain

TOTAL SCORE =		Success Matrix	
<p><i>Consider the following:</i></p> <ul style="list-style-type: none"> <li>▪ <i>Access to and relationship with providers</i></li> <li>▪ <i>Coordination of care with services such as:</i> <ul style="list-style-type: none"> <li>▪ <i>Specialists</i></li> <li>▪ <i>Behavioral health</i></li> <li>▪ <i>Home health</i></li> <li>▪ <i>PT/OT other rehab services</i></li> </ul> </li> <li>▪ <i>Utilization management (auths)</i></li> <li>▪ <i>Communication between providers</i></li> <li>▪ <i>Is needed safety equipment in place and used</i></li> <li>▪ <i>Are there barriers to getting services, medications, DME, etc</i> <ul style="list-style-type: none"> <li>▪ <i>Transportation</i></li> <li>▪ <i>Scheduling</i></li> <li>▪ <i>language</i></li> </ul> </li> <li>▪ <i>Medication management:</i> <ul style="list-style-type: none"> <li>▪ <i>medication use/hx, barriers to taking medications</i></li> <li>▪ <i>Medication reconciliation</i></li> <li>▪ <i>Medication management</i></li> <li>▪ <i>Polypharmacy?</i></li> </ul> </li> <li>▪ <i>Knowledge/understanding of medications, diagnoses, treatments, etc.</i></li> </ul> <p style="color: red; font-weight: bold; margin-top: 20px;"><i>All areas with a 1 or greater should be flagged for possible goal development, further assessment and interventions</i></p>	<b>Access to Care</b>		
	0	Adequate access to care	Medical and mental health insurance benefits, access to "close" provider, translation services, providers willing to see client
	1	Some limitations; refer to barriers above	
	2	Difficulties in accessing care; refer to barriers above	
	3	No adequate access to care; refer to barriers above	
	<b>Experience with Provider(s)</b>		Collaborative, mutually acceptable doctor-patient relationship; Client satisfied with care; Adherence to treatment plan/interventions
	0	No problems with health care providers	
	1	Negative experience with providers (either personally or family member)	
	2	Dissatisfaction or distrust; multiple providers for same condition	
	3	Repeated major conflicts with providers, distrust of doctors; Frequent ER visits/admissions; Preferred provider out of plan	
	<b>Getting Needed Services</b>		Capable of getting appt, minimized appt conflicts and number of visits; Able to buy/get meds, equipment, needed services; Appropriate referrals
	0	Practitioners and health care settings readily accessible; money for Rx and medical equipment	
	1	Some difficulties in getting appts / needed services	
	2	Routine difficulties in coordinating/getting appts / services	
	3	Inability to coordinate / get appts / needed services	
	<b>Coordination of Care</b>		All providers involved in care and are aware of and coordinating services they are providing with others working with the patient. Record system interconnectivity
	0	Complete provider communication with good coordination of care	
	1	Limited provider communication and coordination of care; Has PCP that coordinates medical and mental health services	
	2	Poor provider communication and coordination of care; no routine PCP	
	3	No communication and coordination of care among providers; evidence of ER use for non-urgent health needs	
	<b>Medical Home, Medical Services Risk</b>		Stable access and support for health needs from trusted providers; widespread communication among providers for the foreseeable future
	0	No risk of impediments to coordinated physical and mental health	
	1	Mild risk of impediments to care such as insurance restrictions, distance to services, limited provider communication or coordination	
	2	Moderate risk of impediments to care, such as potential loss of insurance, inconsistent providers, communication barriers, poor care coordination	
	3	Severe risk of impediments such as little no insurance, resistant to communication, disruptive processes that lead to poor coordination	

Self Management and Mental Health Domain			
TOTAL SCORE =	Success Matrix		
<p>Perform readiness assessment &amp; document "score"</p> <p><i>Change Preparation:</i>  <i>Desire:</i>  <i>Ability:</i>  <i>Reasons:</i>  <i>Needs:</i></p> <p><i>Change Implementation:</i>  <i>Commitment:</i>  <i>Activation:</i>  <i>Trying:</i></p> <p><i>Consider the following:</i></p> <ul style="list-style-type: none"> <li>▪ <i>Self efficacy - influence over one's own motivation, thought processes, emotional states and patterns of behavior</i></li> <li>▪ <i>Identify/Note accomplishment and strengths related to health, access and self care management</i></li> <li>▪ <i>Identify and note any positive health behaviors</i></li> <li>▪ <i>Mental health history and risk for</i></li> <li>▪ <i>PHQ-9</i></li> </ul> <p><i>All areas with a 1 or greater should be flagged for possible goal development, further assessment and interventions</i></p>	<b>Engagement / Coping / "Change Talk"</b>		
	0	Ability to manage stresses/life and health challenges	Stress reduction and problem solving capabilities; reduction in substance misuse/abuse/dependency; treatment that controls mental health symptoms
	1	Restricted coping skills, such as need for control, illness denial, irritability	
	2	Impaired coping skills such as, non-productive complaining or substance abuse but without serious impact on medical condition, mental health or social situation	
	3	Minimal coping skills -> destructive behaviors, such as substance dependence, psychiatric illness, self-mutilation, suicide attempts	Willingness and demonstrated change behaviors
	<b>Adherence/Resistance to Treatment</b>		
	0	Interested in receiving treatment and willing to actively participate/cooperate	Documented adherence associated with health stabilization and/or outcome improvement
	1	Some ambivalence but willing to cooperate with treatment	
	2	Considerable resistance and non-adherence; hostility or indifference to providers and/or treatments	
	3	Active resistance to important medical care	
	<b>Mental Health History</b>		
	0	No history of mental health problems/conditions	Screening and follow-up for potential recurrent psychiatric symptoms in place; support structure for mental condition treatment and follow-up by appropriate providers in place
	1	History of mental health problems/conditions now resolved; no effects on daily function	
	2	Mental health conditions with clear affects on daily function (needing medications, therapy, day treatment, etc.)	
	3	Psychiatric admissions and or persistent effect on daily function	
	<b>Mental Health Symptoms PHQ-9</b>		
	0	No mental health symptoms	Mental health symptoms improvement/stabilization; appropriate mental health provider involvement; social/environmental support in place; mental health symptoms do not interfere with general medical treatment/outcomes
	1	Mild symptoms (problems with concentration/felling tense, etc.) that do not interfere with current function	
	2	Moderate mental symptoms (anxiety, signs of depression, mild cognitive impairment) that interfere with functioning	
	3	Severe psychiatric symptoms and or behavioral disturbances (violence, self-inflicted harm, delirium, criminal behavior, psychosis, mania)	
	<b>Self Management &amp; Mental Health Risk</b>		
0	No mental health concerns	Stabilized mental conditions; ready access and availability of services; health improvement associated with consistent treatment adherence; reduction in client "crises" (personal, social, health)	
1	Risk of mild worsening of mental health symptoms such as stress, anxiety, feeling blue, substance abuse		
2	Moderate risk of mental health disorder requiring additional mental health care; moderate risk for treatment resistance/non-adherence		
3	Severe risk for psychiatric disorder requiring frequent ED visits and/or inpt admissions; risk of treatment refusal for serious disorder		

Medical Status and Health Trajectory Domain			
TOTAL SCORE =	Success Matrix		
<p><b>VR-12; Pain Impact, ADLs and instrumental ADLs</b></p> <p><i>Consider:</i></p> <ul style="list-style-type: none"> <li>▪ <i>Lifestyle choices:</i> <ul style="list-style-type: none"> <li>○ <i>Smoking</i></li> <li>○ <i>Substance abuse</i></li> <li>○ <i>Weight</i></li> <li>○ <i>Activity/Exercise</i></li> </ul> </li> <li>▪ <i>Chronic Diseases</i></li> <li>▪ <i>Learning Needs</i></li> <li>▪ <i>Utilization:</i> <ul style="list-style-type: none"> <li>○ <i>Explore primary care office's PnP</i></li> <li>○ <i>ED use for "avoidable" complaints</i></li> <li>○ <i>Hospitalizations</i></li> <li>○ <i>Procedures</i></li> <li>○ <i>Etc.</i></li> </ul> </li> <li>▪ <i>Preventive Screening</i></li> </ul> <p><i>All areas with a 1 or greater should be flagged for possible goal development, further assessment and interventions</i></p>	<b>Chronicty</b>		
	0	Less than 3 months of physical symptoms/dysfunction; acute health condition	Patient understands illnesses and participates in treatments; patient personally engages in illness stabilization
	1	More than 3 months/dysfunction or several periods of less than 3 months	
	2	A chronic disease	
	3	Several chronic diseases	
	<b>Symptoms Severity / Condition Factors</b>		
	0	No physical symptoms or symptoms resolve with treatment	Stabilized illness parameters with appropriate support for continued treatment in place; activated illness progression prevention measures; rehabilitation for functional impairment and appropriate level of personal/equipment support and residential care;
	1	Mild symptoms which do not interfere with current functioning	
	2	Moderate symptoms which interfere with current functioning	
	3	Severe symptoms leading to inability to perform many functional activities	
	<b>Diagnostic / Therapeutic Challenges</b>		
	0	Clear diagnoses and or uncomplicated treatments	Clinical services available to the patient that control symptoms and prevent disease progression likely to be consistently delivered for the foreseeable future
	1	Clear differential diagnoses and/or diagnosis expected with clear treatments	
	2	Difficult to diagnose and treat; physical cause/origin and treatment expected	
	3	Difficult to diagnose or treat; other issues than physical causes interfering with diagnostic and therapeutic process	
	<b>Utilization Factors</b>		
	0	No unscheduled/elective admission; no ED use (past 12 months)	Clinical services available to patient; adherence to preventative screening measures. Patient actively participates in wellness activities to the best of their ability
	1	Elective admission (1); no ED use or < 2 visits in 12 months	
	2	Multiple elective and/or emergent admissions >2 &< 4; ED visits >2 &< 4 in 12 months	
	3	Frequent elective and/or emergent admissions > 4; multiple ED visits > 4 in 12 months	

# Priority Care Domain Assessment Risk Stratification/Leveling and Interventions

After conducting the Domain Assessment score each variable (0 – 3) and then total all areas.  
Maximum score = 57

**0 = none; no need to act**

**1 = mild; need for monitoring and/or prevention**

**2 = moderate; need for action and development of action plan**

**3 = severe; need for immediate action and development of action plan**

Level description	Interventions
<p><b>LEVEL 1: total score less than 20</b></p> <ul style="list-style-type: none"> <li>▪ <b>Impact:</b> minimal involvement; focus areas wellness, health maintenance/coaching, patient education, placement assistance, etc.</li> <li>▪ <b>Time involvement:</b> days or less</li> <li>▪ <b>Clinical example:</b> recent inpatient stay with rapid recovery anticipated, minimal follow-up care; resolved illness or mental health illness/issues</li> </ul>	<p>Within one week of assessment share results with patient</p> <p>Develop focus areas with patient; set goals if needed. Share with provider prn.</p> <p>Telephonic or face to face contact at least once a month with patient.</p> <p>Reassess if situation changes.</p>
<p><b>LEVEL 2: total score 21 – 27</b></p> <ul style="list-style-type: none"> <li>▪ <b>Impact:</b> brief involvement; focus area disease management, patient education, placement assistance, referrals, return to work, community resources, etc.</li> <li>▪ <b>Time involvement:</b> days to weeks</li> <li>▪ <b>Clinical example:</b> coming out of recent high cost healthcare activity, recent inpatient stay with anticipated persistent need for support to prevent delayed/pronged recovery or poor outcome</li> </ul>	<p>Within one week of assessment share results with patient</p> <p>Develop action plan. Assist patient to establish measureable goals. Share with provider if indicated.</p> <p>Telephonic or in-person contact as indicated for situation:</p> <ul style="list-style-type: none"> <li>▪ If inpatient contact during hospitalization followed-by</li> <li>▪ Assist with discharge needs/planning</li> <li>▪ Call within 24 – 48 hours of discharge</li> <li>▪ Call one week after discharge and prn then</li> </ul> <p>Telephonic contact at least once a month with patient.</p> <p>Reassess if situation changes.</p>

<p><b>LEVEL 3: total score 28 – 34</b></p> <ul style="list-style-type: none"> <li>▪ <b>Impact:</b> standard care management involvement; patient needs in multiple domains, action plan development indicated by variable scores of 2 or 3, assistance to patient to understand illness and health system, assistance with providers, referrals, placement, systematic development and completion of action plan</li> <li>▪ <b>Time involvement:</b> weeks to months</li> <li>▪ <b>Clinical example:</b> persistent use of inpatient and outpatient services, poorly treated mental health co morbidity in the face of medical and or mental illness/needs, chronic general medical illnesses</li> </ul>	<p>Within one week of assessment share results with patient</p> <p>Develop problem list and action plan. Assist patient to establish measureable goals. Share with provider.</p> <p>Telephonic or in-person contact as indicated for situation:</p> <ul style="list-style-type: none"> <li>▪ If inpatient contact during hospitalization followed-by</li> <li>▪ Assist with discharge needs/planning</li> <li>▪ Call within 24 – 48 hours of discharge</li> <li>▪ Call one week after discharge and prn then</li> </ul> <p>Telephonic or in-person contact at least twice a month with patient.</p> <p>Reassess at timely intervals. Actively communicate with provider.</p>
<p><b>LEVEL 4: total score 35 or greater</b></p> <ul style="list-style-type: none"> <li>▪ <b>Impact:</b> extended care management involvement as in Level 3 however problems are persistent, complex and multiple with long-term high service use or anticipated risk for; patient needs in multiple domains, action plan development indicated by variable scores of 2 or 3, assistance to patient to understand illness and health system, assistance with providers, referrals, placement, systematic development and completion of action plan</li> <li>▪ <b>Time involvement:</b> months or longer</li> <li>▪ <b>Clinical example:</b> complex, concurrent physical and mental conditions with high service use</li> </ul>	<p>Within one week of assessment share results with patient</p> <p>Develop problem list and action plan. Assist patient to establish measureable goals. Share with provider.</p> <p>Telephonic or in-person contact as indicated for situation:</p> <ul style="list-style-type: none"> <li>▪ If inpatient contact during hospitalization followed-by</li> <li>▪ Assist with discharge needs/planning</li> <li>▪ Call within 24 – 48 hours of discharge</li> <li>▪ Call one week after discharge and prn then</li> </ul> <p>Telephonic or in-person contact at least two to three times a month with patient.</p> <p>Reassess at timely intervals. Actively communicate with provider.</p>