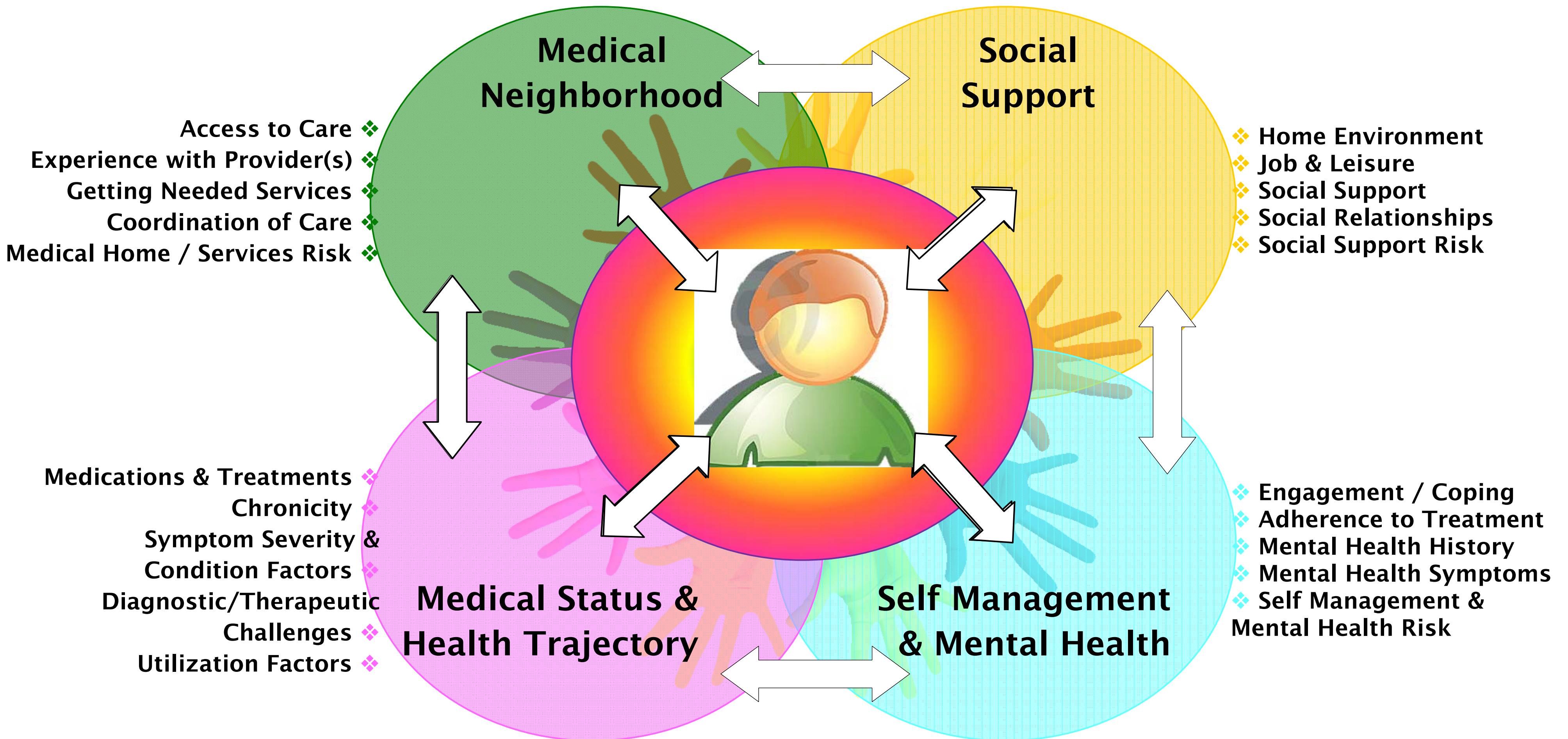
RN Care Manager Assessment: The 4 Domains



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

Humboldt IPA PRIORITY CARE Domain Assessment Adapted from Care Oregon The 5 Domains and INTERMED Complexity Grid LAN02/2011

Social Support Domain

<table>
<tr><td colspan="3">TOTAL SCORE =</td><td>Success Matrix</td></tr>
<tr><td></td><td colspan="3">Home Environment</td></tr>
<tr><td rowspan="24">Consider the following:

▪ Basic needs such as food, safe and adequate housing
▪ Place of residence
▪ Do they live alone? With others? Have a pet?
▪ Caregivers
▪ Community support/resources
▪ Support network and interpersonal skills
▪ Leisure activity participation

All areas with a 1 or greater should be flagged for possible goal development, further assessment and interventions</td><td>0</td><td>Stable housing; able to maintain independent living</td><td rowspan="4">Safe and consistent living situation</td></tr>
<tr><td>1</td><td>Stable housing with support of others (family, facility, other)</td></tr>
<tr><td>2</td><td>Unstable housing (no support, living in shelter, etc)</td></tr>
<tr><td>3</td><td>No satisfactory housing; immediate change necessary</td></tr>
<tr><td colspan="3">Job & Leisure</td></tr>
<tr><td>0</td><td>Has job and participates in leisure activities</td><td rowspan="4">Economic stability and participation in leisure activities</td></tr>
<tr><td>1</td><td>Has job; no participation in leisure activities</td></tr>
<tr><td>2</td><td>Unemployed now for at least 6 months and participates in leisure activities</td></tr>
<tr><td>3</td><td>Unemployed now for at least 6 months and no participation in leisure activities</td></tr>
<tr><td colspan="3">Social Support</td></tr>
<tr><td>0</td><td>Assistance readily available</td><td rowspan="4">Social and living situation that allows support for chronic and acute health needs</td></tr>
<tr><td>1</td><td>Assistance generally available; possible delays</td></tr>
<tr><td>2</td><td>Limited assistance available</td></tr>
<tr><td>3</td><td>No assistance available at any time</td></tr>
<tr><td colspan="3">Social Relationships</td></tr>
<tr><td>0</td><td>No social disturbance</td><td rowspan="4">Social skills that will lead to connectedness/personal relationships</td></tr>
<tr><td>1</td><td>Mild social dysfunction; interpersonal issues</td></tr>
<tr><td>2</td><td>Moderate social dysfunction such as not able to initiate or maintain</td></tr>
<tr><td>3</td><td>Severe social dysfunction; disruptive or in isolation</td></tr>
<tr><td colspan="3">Social Support Risk</td></tr>
<tr><td>0</td><td>No risk for of need for changes in living situation, social relationships and support or job/leisure</td><td rowspan="4">Financial resources to meet basic needs, appropriate and consistent living arrangements, personal support with optimized relationships for the foreseeable future</td></tr>
<tr><td>1</td><td>Mild risk</td></tr>
<tr><td>2</td><td>Risk of need in the foreseeable future</td></tr>
<tr><td>3</td><td>Risk now -> intervene</td></tr>
</table>

Medical Neighborhood - Medical Home & Access to Services Domain

TOTAL SCORE =	Success Matrix

Consider the following:

- *Access to and relationship with providers*
- *Coordination of care with services such as:*
  - *Specialists*
  - *Behavioral health*
  - *Home health*
  - *PT/OT other rehab services*
- *Utilization management (auths)*
- *Communication between providers*
- *Is needed safety equipment in place and used*
- *Are there barriers to getting services, medications, DME, etc*
  - *Transportation*
  - *Scheduling*
  - *language*
- *Medication management:*
  - *medication use/hx, barriers to taking medications*
  - *Medication reconciliation*
  - *Medication management*
  - *Polypharmacy?*
- *Knowledge/understanding of medications, diagnoses, treatments, etc.*

All areas with a 1 or greater should be flagged for possible goal development, further assessment and interventions

Score	Description	Success Matrix
Access to Care		
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	
Experience with Provider(s)		
0	No problems with health care providers	Collaborative, mutually acceptable doctor-patient relationship; Client satisfied with care; Adherence to treatment plan/interventions
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	
Getting Needed Services		
0	Practioners and health care settings readily accessible; money for Rx and medical equipment	Capable of getting appt, minimized appt conflicts and number of visits; Able to buy/get meds, equipment, needed services; Appropriate referrals
1	Some difficulties in getting appts / needed services	
2	Routine difficulties in coordinating/getting appts / services	
3	Inability to coordinate / get appts / needed services	
Coordination of Care		
0	Complete provider communication with good coordination of care	All providers involved in care and are aware of and coordinating services they are providing with others working with the patient. Record system interconnectivity
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	
Medical Home, Medical Services Risk		
0	No risk of impediments to coordinated physical and mental health	Stable access and support for health needs from trusted providers; widespread communication among providers for the foreseeable future
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

Perform readiness assessment & document "score"

Change Preparation:
- *Desire:*
- *Ability:*
- *Reasons:*
- *Needs:*

Change Implementation:
- *Commitment:*
- *Activation:*
- *Trying:*

Consider the following:

- *Self efficacy - influence over one's own motivation, thought processes, emotional states and patterns of behavior*
- *Identify/Note accomplishment and strengths related to health, access and self care management*
- *Identify and note any positive health behaviors*
- *Mental health history and risk for*
- *PHQ-9*

All areas with a 1 or greater should be flagged for possible goal development, further assessment and interventions

Engagement / Coping / "Change Talk"

Score	Description	Success Matrix
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 Willingness and demonstrated change behaviors
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	

Adherence/Resistance to Treatment

Score	Description	Success Matrix
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	

Mental Health History

Score	Description	Success Matrix
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	

Mental Health Symptoms **PHQ-9**

Score	Description	Success Matrix
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)	

Self Management & Mental Health Risk

Score	Description	Success Matrix
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	

<table>
<tr><th colspan="4">Medical Status and Health Trajectory Domain</th></tr>
<tr><td colspan="3">TOTAL SCORE =</td><td>Success Matrix</td></tr>
<tr><td></td><td colspan="3">Chronicty</td></tr>
<tr><td rowspan="19">VR-12; Pain Impact, ADLs and instrumental ADLs

Consider:
▪ Lifestyle choices:
o Smoking
o Substance abuse
o Weight
o Activity/Exercise
▪ Chronic Diseases
▪ Learning Needs
▪ Utilization:
o Explore primary care office’s PnP
o ED use for “avoidable” complaints
o Hospitalizations
o Procedures
o Etc.
▪ Preventive Screening

All areas with a 1 or greater should be flagged for possible goal development, further assessment and interventions</td><td>0</td><td>Less than 3 months of physical symptoms/dysfunction; acute health condition</td><td rowspan="4">Patient understands illnesses and participates in treatments; patient personally engages in illness stabilization</td></tr>
<tr><td>1</td><td>More than 3 months/dysfunction or several periods of less than 3 months</td></tr>
<tr><td>2</td><td>A chronic disease</td></tr>
<tr><td>3</td><td>Several chronic diseases</td></tr>
<tr><td colspan="3">Symptoms Severity / Condition Factors</td></tr>
<tr><td>0</td><td>No physical symptoms or symptoms resolve with treatment</td><td rowspan="4">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;</td></tr>
<tr><td>1</td><td>Mild symptoms which do not interfere with current functioning</td></tr>
<tr><td>2</td><td>Moderate symptoms which interfere with current functioning</td></tr>
<tr><td>3</td><td>Severe symptoms leading to inability to perform many functional activities</td></tr>
<tr><td colspan="3">Diagnostic / Therapeutic Challenges</td></tr>
<tr><td>0</td><td>Clear diagnoses and or uncomplicated treatments</td><td rowspan="4">Clinical services available to the patient that control symptoms and prevent disease progression likely to be consistently delivered for the foreseeable future</td></tr>
<tr><td>1</td><td>Clear differential diagnoses and/or diagnosis expected with clear treatments</td></tr>
<tr><td>2</td><td>Difficult to diagnose and treat; physical cause/origin and treatment expected</td></tr>
<tr><td>3</td><td>Difficult to diagnose or treat; other issues than physical causes interfering with diagnostic and therapeutic process</td></tr>
<tr><td colspan="3">Utilization Factors</td></tr>
<tr><td>0</td><td>No unscheduled/elective admission; no ED use (past 12 months)</td><td rowspan="4">Clinical services available to patient; adherence to preventative screening measures. Patient actively participates in wellness activities to the best of their ability</td></tr>
<tr><td>1</td><td>Elective admission (1); no ED use or < 2 visits in 12 months</td></tr>
<tr><td>2</td><td>Multiple elective and/or emergent admissions >2 &< 4; ED visits >2 &< 4 in 12 months</td></tr>
<tr><td>3</td><td>Frequent elective and/or emergent admissions > 4; multiple ED visits > 4 in 12 months</td></tr>
</table>

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
LEVEL 1: total score less than 20 ▪ **Impact:** minimal involvement; focus areas wellness, health maintenance/coaching, patient education, placement assistance, etc. ▪ **Time involvement**: days or less ▪ **Clinical example:** recent inpatient stay with rapid recovery anticipated, minimal follow-up care; resolved illness or mental health illness/issues	Within one week of assessment share results with patient Develop focus areas with patient; set goals if needed. Share with provider prn. Telephonic or face to face contact at least once a month with patient. Reassess if situation changes.
LEVEL 2: total score 21 – 27 ▪ **Impact:** brief involvement; focus area disease management, patient education, placement assistance, referrals, return to work, community resources, etc. ▪ **Time involvement**: days to weeks ▪ **Clinical example:** 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	Within one week of assessment share results with patient Develop action plan. Assist patient to establish measureable goals. Share with provider if indicated. Telephonic or in-person contact as indicated for situation: ▪ If inpatient contact during hospitalization followed-by ▪ Assist with discharge needs/planning ▪ Call within 24 – 48 hours of discharge ▪ Call one week after discharge and prn then Telephonic contact at least once a month with patient. Reassess if situation changes.

LEVEL 3: total score 28 – 34 ▪ **Impact:** 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 ▪ **Time involvement**: weeks to months ▪ **Clinical example:** 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	Within one week of assessment share results with patient Develop problem list and action plan. Assist patient to establish measureable goals. Share with provider. Telephonic or in-person contact as indicated for situation: ▪ If inpatient contact during hospitalization followed-by ▪ Assist with discharge needs/planning ▪ Call within 24 – 48 hours of discharge ▪ Call one week after discharge and prn then Telephonic or in-person contact at least twice a month with patient. Reassess at timely intervals. Actively communicate with provider.
LEVEL 4: total score 35 or greater ▪ **Impact:** 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 ▪ **Time involvement**: months or longer ▪ **Clinical example:** complex, concurrent physical and mental conditions with high service use	Within one week of assessment share results with patient Develop problem list and action plan. Assist patient to establish measureable goals. Share with provider. Telephonic or in-person contact as indicated for situation: ▪ If inpatient contact during hospitalization followed-by ▪ Assist with discharge needs/planning ▪ Call within 24 – 48 hours of discharge ▪ Call one week after discharge and prn then Telephonic or in-person contact at least two to three times a month with patient. Reassess at timely intervals. Actively communicate with provider.