Care Management Learning Activities: Patient Assessment and Care Planning		
Relevant PCMH Concepts	**Care Management and Support (CM)** The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.	**Knowing and Managing Your Patients (KM)** The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports the population needs and provision of culturally and linguistically appropriate services.
Relevant PCMH Competencies & Criteria	<u>Competency A: Identifying Care Managed Patients</u> The practice systematically identifies patients who may benefit from care management. o *CM01 (Core)*: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria): A. Behavioral health conditions B. High cost/high utilization C. Poorly controlled or complex conditions D. Social determinants of health E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver. <u>Competency B: Care Plan Development</u> For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates	<u>Competency A: Collecting Patient Information</u> The practice routinely collects comprehensive patient data and uses the data to understand patients' backgrounds and health risks. o *KM02 (Core)*: Comprehensive health assessment includes (all items required): A. Medical history of patient and family B. Mental health/substance use history of patient and family C. Family/social/cultural characteristics D. Communication needs E. Behaviors affecting health F. Social functioning G. Social determinants of health H. Developmental screening using a standardized tool (NA for practices with no pediatric population under 30 months of age) I. Advance care planning (NA for pediatric practices) o *KM03 (Core)*: Conducts depression screenings for adults and adolescents using a standardized tool. o *KM04*: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement 2+) A. Anxiety B. Alcohol use disorder C. Substance use disorder

Relevant PCMH Competencies & Criteria	patient preferences and lifestyle goals documented in the patient's chart. ○ *CM04 (Core)*: Establishes a person-centered care plan for patients identified for care management. ○ *CM05 (Core)*: Provides a written care plan to the patient/family/caregiver for patients identified for care management. ○ *CM06*: Documents patient preference and functional/lifestyle goals in individual care plans. ○ *CM07*: Identifies and discusses potential barriers to meeting goals in individual care plans. ○ *CM08*: Includes a self-management plan in individual care plans.	D. Pediatric behavioral health screening E. Post-traumatic stress disorder F. Attention deficit/hyperactivity disorder G. Postpartum depression ○ *KM05*: Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners. <u>Competency D: Medication Management</u> The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers. ○ *KM14 (Core)*: Reviews and reconciles medications for more than 80 percent of patients received from care transitions. ○ *KM15 (Core)*: Maintains an up-to-date list of medications for more than 80 percent of patients. ○ *KM16*: Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers. ○ *KM17*: Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.
Learning Objectives (with relevant IPEC Core Competencies)	○ Communicate information with patients, families, community members, and health team members in a form that is understandable, avoiding discipline-specific terminology when possible (CC2). ○ Engage diverse professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific health and healthcare needs of patients and populations (RR3). ○ Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among health and other professionals and with patients, families, and community members (TT6). ○ Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services and programs (VE5).	
	1) As an introduction to primary care-based interprofessional care, student teams will:	

IP Student Learning Activities **(Students will complete one or more of these activities)**	a) Work with the practice to identify a complex patient who would benefit from interprofessional care, utilizing the practice's defined protocol and/or factors listed above in **CM Competency A – Criterion CM01**; and b) Review the patient case as a team and conduct a **MOCK** pre-visit brief to define profession-specific roles in assessment and care planning. Care should be taken to select a patient whose health status and needs are an appropriate match for the composition of the student team. For example, if a dental student is on the team, a patient with health problems that include oral health or a strong connection to oral health should be selected. 2) *ADVANCED*: Student teams will conduct a comprehensive health assessment for a patient. This assessment may or may not be part of a complex patient visit (see #3 below). Students will: a) Participate in a **team brief** to define visit roles and objectives prior to engaging the patient; b) Conduct the adult comprehensive assessment, which includes all of the required items as outlined above in **KM Competency A – Criteria KM02 & KM03**. Additional behavioral health and/or oral health screenings (as noted in criteria **KM04** & **KM05)** may also be provided; and c) **Debrief** to reflect on team performance. 3) *ADVANCED*: Student teams will interview and examine a patient, according to the practice's established protocols, and involving the patient/family/caregivers as appropriate. The visit may take place at the practice site, in the patient's home, or another site deemed appropriate by the practice, and will include: a) Identification of a complex patient, per the practice's defined protocol and/or factors such as those listed in **CM01**, and medical record review; b) A **team brief** to define visit roles and objectives; c) A comprehensive health assessment (found in **KM02 – KM05)**, to include *social determinants of health* **(KM02-G)**, or other focused assessment; d) A medication management review, per **KM Competency D**; e) Person-centered care planning, featuring **CM Competency B – Criteria CM04-CM08**; f) Preparation of a report/presentation of the team's assessment, recommendations and care plan; and g) A **team debrief** to reflect on team performance.
IP Student Learning Assessment	1) The student team will conduct the mock pre-visit brief in the presence of a facilitator, who will give written feedback to the student team on how well they addressed and participated in key components of the brief. 2) *ADVANCED*: The debriefing on student team performance will include written feedback to the students on areas of strength and needed improvement. 3) *ADVANCED*: The student team will present their assessment, recommendations, and care plan to appropriate members of the practice team, possibly including the patient and/or family/caregivers. Following this presentation, the student team and facilitator will utilize the TeamSTEPPS Debrief Checklist (see ***Resources*** below) to facilitate the team's reflection of its performance.

Resources	○ Care Management and Support: ▪ Develop a Shared Care Plan (AHRQ: The Academy, n.d.) - *Examples of Shared Care Plans* ▪ Guidelines for SOAP (University of Kansas Medical Center, 2012) ▪ Motivational Interviewing for Better Health Outcomes (SAMHSA-HRSA CIHS, 2011) ▪ Motivational Interviewing Reminder Card (Case Western Reserve University, n.d.) ▪ Self-Management Support (AHRQ, 2014) ▪ TeamSTEPPS: SBAR (AHRQ, n.d.) ▪ The Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) Tool (National Association of Community Health Centers, 2016) ▪ Video: Coaching Patients for Successful Self-Management (CA Health Care Foundation, 2008) ▪ Video: What is Motivational Interviewing? (IHI Open School, n.d.) ○ Knowing and Managing Your Patients: ▪ 10 Questions to Ask Your Family (Utah Department of Health, n.d.) ▪ A Framework for Patient-Centered Health Risk Assessments: Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries (CDC, 2011) - *Sample Health Risk Assessment, pp. 43-50* ▪ Conduct Brown Bag Medicine Reviews: Tool #8 (AHRQ Health Literacy Universal Precautions Toolkit, 2015) ▪ Depression Screening Tool, Adolescents: PHQ-9 Modified for Teens ▪ Depression Screening Tools, Adults: PHQ-9, PHQ-2, Geriatric Depression Scale ▪ Alzheimer's Disease and Healthy Aging: Advance Care Planning (CDC, 2017) ▪ Birth to 5: Watch Me Thrive! (DHHS: Administration for Children & Families, 2017) ▪ Bright Futures Resources, Tools and Guidelines (American Academy of Pediatrics, n.d.) ▪ Consider Culture, Customs, and Beliefs: Tool #10 (AHRQ Health Literacy Universal Precautions Toolkit, 2015) ▪ Family Health History Resources for Health Professionals (CDC, 2016) ▪ Help Patients Remember How and When to Take Their Medicine: Tool #16 (AHRQ Health Literacy Universal Precautions Toolkit, 2015) ▪ Keep ME Well Online Health Risk Assessment (Maine DHHS/CDC, n.d.) ▪ NIDA Drug Screening Tool (National Institute on Drug Abuse, n.d.) ▪ Talking With Your Older Patient: Understanding Older Patients (National Institute on Aging, 2017) ○ IPEC Core Competencies (2016) ○ NCQA PCMH Standards and Guidelines (2017) ○ TeamSTEPPS Debrief Checklist