

# **Lutheran Family Health Center Health Home**

## **Care Plan Training**

### **Section I: Chronic Health Conditions**

#### **Care Plan for Asthma Management**

##### **Problem/Issue:**

The patient lacks an effective Action Plan for self-managing asthma.

##### **Goal:**

The patient will develop an effective asthma self-management plan as reflected by:

- a. Consistent attendance to PCP and specialty appointments
- b. Compliance with “Asthma Action Plan” as developed in collaboration with asthma provider
- c. Compliance with medication regimen including appropriate use of inhalers and nebulizer
- d. Identification of asthma triggers and development of strategies to minimize exposure to allergens and irritants
- e. Reduction of ED visits associated with asthma exacerbation
- f. Smoking Cessation

##### **Interventions:**

CM will assist the patient to assess the impact of asthma on family relations, work / school adjustment, recreational activities, emotional well-being, life goals and aspirations, in order to develop motivation for behavior change.

CM will assist the patient to identify his/her top 3 asthma related health concerns, to prioritize behavior change goals, and to develop change strategies

CM will promote behavior change using Motivational Interviewing to resolve treatment ambivalence, elicit change talk and enhance the patient’s experience of self-efficacy

CM will help the patient/care giver process emotional upset associated with asthma diagnosis and will assist the patient/care giver to articulate fears, concerns and questions to be discussed with the provider.

CM will address “low expectations” for asthma control that compromise patient self-management efforts

CM will schedule primary care / specialty and lab appointments, will conduct appointment confirmation calls and will follow-up on broken appointments to enhance appointment compliance.

CM will maintain ongoing communication, case conferencing and collaborative care planning with medical and / or behavioral health providers.

CM will provide education on the proper use of inhalers/nebulizer using teach back method

CM will assist the patient/care giver to develop strategies to take medication as prescribed at home, work or school

CM will conduct a home visit to assess for environmental triggers and will assist the patient to develop a plan to minimize exposure to allergens and irritants

CM will teach patient how to monitor asthma control using Peak Flow ratings

CM will assist the patient to articulate fear concerning the initiation of an exercise regimen and will teach the patient how to prevent exercise induced asthma attacks

CM will assist the patient to understand the impact of tobacco use on health, will help the patient identify smoking triggers and develop strategies for managing smoking urges including NRT.

CM will assist the patient to assess current stress level, stress triggers and stress reduction practices, and will help the patient replace negative self-soothing practices with positive stress reduction alternatives (exercise, yoga, meditation, deep breathing, visualization, etc)

CM will assist the patient to identify warning signs of worsening health condition and will collaborate with care team to support the development of a relapse prevention plan to reduce risk of re-hospitalization.

CM will assist the patient to obtain a free cell phone for use in emergency situations

## **Care Plan for Management of Diabetes**

### **Problem/Issue :**

The patient lacks an effective Action Plan for self-managing diabetes

### **Goal:**

The patient will develop an effective diabetes self-management plan as reflected by:

- a. Achieving A1c < 7
- b. Consistent attendance to PCP and specialty appointments
- c. Compliance with medication regimen
- d. Healthy eating habits
- e. Daily exercise regimen
- f. Achievement of weight loss goal
- g. Smoking cessation
- h. Development of healthy stress reduction practices to reduce dependence on “emotional eating” for self-soothing
- i. Reduction of ED visits associated with uncontrolled diabetes

### **Interventions:**

CM will assist the patient to assess the impact of diabetes on family relations, work / school adjustment, recreational activities, emotional well- being, life goals and aspirations, in order to develop motivation for behavior change.

CM will assist the patient to identify his/her top 3 diabetes related health concerns, to prioritize behavior change goals, and to develop change strategies

CM will promote behavior change using Motivational Interviewing to resolve treatment ambivalence, elicit change talk and enhance the patient’s experience of self-efficacy

CM will help the patient/care giver process emotional upset associated with diabetes diagnosis and will assist the patient/care giver to articulate fears, concerns and questions to be discussed with the provider.

CM will schedule primary care / specialty and lab appointments, will conduct appointment confirmation calls and will follow-up on broken appointments to enhance appointment compliance.

CM will maintain ongoing communication, case conferencing and collaborative care planning with

medical and / or behavioral health providers.

CM will assist the patient/care giver to develop strategies to take medication as prescribed and will address fear associated with insulin injection

CM will arrange appointment with Nutritionist to discuss grocery shopping, food preparation, and portion control

CM will explore the patient's understanding of the importance of reducing consumption of sugar, starch high fat foods and of eliminating sugary drinks to improve health outcomes

CM will explore the patient's understanding of the importance of increasing consumption of high fiber foods including good fruits and vegetable to improve health outcomes.

CM will encourage the patient to maintain a food journal for review with the care team

CM will refer the patient to the Nurse/Diabetes Educator for glucometer training, will assist the patient to obtain supplies needed for glucose monitoring and will encourage the patient to maintain daily glucose monitoring log for review with care team.

CM will assess the patient's ability to identify the symptoms of a worsening health condition i.e. hypoglycemia, diabetic ketoacidosis and hyperglycemic coma and the steps to take when these conditions occur.

CM will explore the patients understanding of the importance of checking feet for cuts, bruises or sores on daily basis.

CM will monitor the completion of annual eye exam

CM will assist the patient to understand the impact of tobacco use on health, will help the patient identify smoking triggers and develop strategies for managing smoking urges including NRT.

CM will assist the patient to assess current stress level, stress triggers and stress reduction practices, and will help the patient replace negative self-soothing practices with positive stress reduction alternatives (exercise, yoga, meditation, deep breathing, visualization, etc)

CM will assist the patient to identify warning signs of worsening health condition and will collaborate with care team to support the development of a relapse prevention plan to reduce risk of re-hospitalization.

CM will assist the patient to obtain a free cell phone for use in emergency situations

## **Care Plan for Management of Congestive Heart Failure**

### **Problem/Issue:**

The patient lacks an effective Action Plan for self-managing CHF

### **Goal:**

The patient will develop an effective CHF self-management plan as reflected by:

- a. Consistent attendance to PCP and specialty appointments
- b. Compliance with medication regimen
- c. Adherence to low sodium diet
- e. Daily weight monitoring
- f. Daily checking of feet, ankles, legs and stomach for swelling

- f. Daily exercise
- g. Smoking cessation
- h. Understanding of “Heart Failure Zones” and development of CHF Action Plan to reduce unnecessary ED visits and preventable hospitalizations

**Interventions:**

CM will assist the patient to assess the impact of CHF on family relations, work / school adjustment, recreational activities, emotional well-being, life goals and aspirations, in order to develop motivation for behavior change.

CM will assist the patient to identify his/her top 3 CHF related health concerns, to prioritize behavior change goals, and to develop change strategies

CM will promote behavior change using Motivational Interviewing to resolve treatment ambivalence, elicit change talk and enhance the patient’s experience of self-efficacy

CM will help the patient/care giver process emotional upset associated with CHF diagnosis and will assist the patient/care giver to articulate fears, concerns and questions to be discussed with the provider.

CM will schedule primary care / specialty and lab appointments, will conduct appointment confirmation calls and will follow-up on broken appointments to enhance appointment compliance.

CM will maintain ongoing communication, case conferencing and collaborative care planning with medical and / or behavioral health providers.

CM will assist the patient/care giver to develop strategies to take medication as prescribed

CM will arrange appointment with Nutritionist to discuss low sodium diet, grocery shopping, food preparation, and portion control

CM will explore the patient’s understanding of the importance of establishing a low salt/low fat diet to improve health outcomes

CM will encourage the patient to maintain a food journal for review with the care team

CM will explore the patient’s understanding of the importance and how to of daily weight monitoring and will encourage the patient to maintain a daily weight log

CM will explore the patients understanding of the importance of checking feet, ankles, legs and stomach for swelling on a daily basis.

CM will assist the patient to identify fears, concerning the initiation of an exercise regimen (exercise induced heart attack)for discussion with the medical provider

CM will encourage the patient to develop a realistic exercise plan in collaboration with medical provider and will assist the patient to develop two new strategies for increasing exercise.

CM will assist the patient to understand the impact of tobacco use on health, will help the patient identify smoking triggers and develop strategies for managing smoking urges including NRT.

CM will assist the patient to assess current stress level, stress triggers and stress reduction practices, and will help the patient replace negative self-soothing practices with positive stress reduction alternatives (exercise, yoga, meditation, deep breathing, visualization, etc)

CM will assist the patient to identify warning signs of worsening health condition and will collaborate with care team to support the development of a relapse prevention plan to reduce risk of re-hospitalization.

CM will assist the patient to obtain a free cell phone for use in emergency situations

## **Care Plan for Management of Hypertension**

### **Problem/Issue:**

The patient lacks an effective Action Plan for self-managing Hypertension

### **Goal:**

The patient will develop an effective Hypertension self-management plan as reflected by:

- a. Blood pressure goal achieved
- b. Consistent attendance to PCP and specialty appointments
- c. Compliance with medication regimen
- d. Adherence to low sodium diet
- e. Achievement of weight loss goal
- f. Development of daily exercise regimen
- g. Smoking cessation
- h. Reduction/elimination of alcohol
- i. Development of healthy stress reduction practices

### **Interventions:**

CM will assist the patient to assess the impact of hypertension on family relations, work / school adjustment, recreational activities, emotional well- being, life goals and aspirations, in order to develop motivation for behavior change.

CM will assist the patient to identify his/her top 3 hypertension related health concerns, to prioritize behavior change goals, and to develop change strategies

CM will promote behavior change using Motivational Interviewing to resolve treatment ambivalence, elicit change talk and enhance the patient's experience of self-efficacy

CM will help the patient/care giver process emotional upset associated with hypertension diagnosis and will assist the patient/care giver to articulate fears, concerns and questions to be discussed with the provider.

CM will schedule primary care / specialty and lab appointments, will conduct appointment confirmation calls and will follow-up on broken appointments to enhance appointment compliance.

CM will maintain ongoing communication, case conferencing and collaborative care planning with medical and / or behavioral health providers.

CM will assist the patient/care giver to develop strategies to take medication as prescribed

CM will arrange appointment with Nutritionist to discuss low sodium diet, grocery shopping, food preparation, and portion control

CM will explore the patient's understanding of the importance of establishing a low salt/low fat diet to improve health outcomes

CM will encourage the patient to maintain a food journal for review with the care team

CM will assist the patient to identify fears, concerning the initiation of an exercise regimen (exercise induced heart attack) for discussion with the medical provider

CM will encourage the patient to develop a realistic exercise plan in collaboration with medical provider and will assist the patient to develop two new strategies for increasing exercise.

CM will assist the patient to obtain supplies needed for daily blood pressure monitoring and will encourage the patient to maintain BP results log for review with care team.

CM will assist the patient to understand the impact of tobacco use on health, will help the patient identify smoking triggers and develop strategies for managing smoking urges including NRT.

CM will assist the patient to understand the impact of alcohol use on health, will help the patient identify drinking triggers and develop strategies for managing drinking urges.

CM will assist the patient to assess current stress level, stress triggers and stress reduction practices, and will help the patient replace negative self-soothing practices with positive stress reduction alternatives (exercise, yoga, meditation, deep breathing, visualization, etc)

CM will assist the patient to identify warning signs of worsening health condition and will collaborate with care team to support the development of a relapse prevention plan to reduce risk of re-hospitalization.

CM will assist the patient to obtain a free cell phone for use in emergency situations

## **Care Plan for Management of Obesity**

### **Problem/Issue:**

The patient lacks an effective Action Plan for self-managing obesity

### **Goal:**

The patient will develop an effective obesity self-management plan as reflected by:

- a. Achievement of realistic weight loss goal – BMI<30
- b. Consistent attendance to PCP and specialty appointments
- c. Compliance with medication regimen
- d. Development of healthy eating habits
- e. Development of daily exercise regime
- f. Reduction of alcohol intake and elimination of sugary drinks
- g. Smoking cessation
- h. Development of healthy stress reduction practices to reduce dependence on “emotional eating” for self-soothing
- i. Participation in weight loss support group

### **Interventions:**

CM will assist the patient to assess the impact of obesity on health status, family relations, work / school adjustment, recreational activities, self-concept and emotional well-being, in order to develop motivation for behavior change.

CM will assist the patient to identify his/her top 3 weight related health concerns, to prioritize behavior change goals, and to develop change strategies

CM will promote behavior change using Motivational Interviewing to resolve treatment ambivalence, elicit change talk and enhance the patient’s experience of self-efficacy

CM will schedule primary care / specialty and lab appointments, will conduct appointment confirmation calls and will follow-up on broken appointments to enhance appointment compliance.

CM will maintain ongoing communication, case conferencing and collaborative care planning with medical and / or behavioral health providers.

CM will arrange appointment with Nutritionist to discuss grocery shopping, food preparation, and

portion control

CM will explore the patient's understanding of the importance of reducing consumption of sugar, starch high fat foods and of eliminating sugary drinks to improve health outcomes

CM will explore the patient's understanding of the importance of increasing consumption of high fiber foods including good fruits and vegetable to improve health outcomes.

CM will encourage the patient to maintain a food journal for review with the care team

CM will assist the patient to identify a weight loss support group and will monitor impact of participation on recovery status

CM will assist the patient to explore the pros and cons of bariatric surgery if recommended by the care team

CM will assist the patient to identify health concerns and fears associated with the initiation of an exercise regimen for discussion with the medical provider

CM will encourage the patient to develop a realistic exercise plan in collaboration with PCP and will monitor compliance with same

CM will assist the patient to conduct a Decisional Balance exercise to explore/resolve ambivalence over initiating exercise regimen

CM will assist the patient to identify two new strategies for increasing exercise

CM will monitor physical therapy follow-up

CM will assist the patient to understand the impact of tobacco use on health, will help the patient identify smoking triggers and develop strategies for managing smoking urges including NRT.

CM will assist the patient to understand the impact of alcohol use on health, will help the patient identify drinking triggers and develop strategies for managing drinking urges.

CM will assist the patient to assess current stress level, stress triggers and stress reduction practices, and will help the patient replace negative self-soothing practices, with positive stress reduction alternatives (exercise, yoga, meditation, deep breathing, visualization, etc)

### **Care Plan for Management of a Substance Use Disorder**

#### **Problem/Issue:**

The patient lacks an effective Action Plan for self-managing alcohol and/or drug use disorder

#### **Goal:**

The patient will develop an effective substance use disorder self-management plan as reflected by

- a. Ability to verbalize the impact of alcohol/substance abuse on health status
- b. Acceptance of chemical dependency diagnosis and of referral to appropriate level of care (detox/IOP/rehab/residential)
- c. Establishment of quit date or harm reduction goal
- d. Development of relapse prevention plan including Self-help involvement
- e. Development of non-narcotic pain management strategies and reduction of ED visits associated with drug seeking behavior
- h. Development of healthy stress reduction practices to reduce dependence on alcohol/drugs for self-soothing

**Plan/Interventions:**

CM will provide educational materials on the disease concept of addiction to challenge false myths and negative stereotypes and will assist the patient to process shame and guilt associated with substance use disorder diagnosis

CM will provide pt. with educational materials regarding the impact of alcohol/substance use on identified health conditions.

CM will assist the patient to identify the pros and cons of continued alcohol/substance utilizing the Decisional Balance sheet to enhance motivation for abstinence

CM will utilize Motivational Interviewing techniques to motivate the patient to accept referral to the appropriate level of care and will coordinate the referral to detox, rehab or IOP treatment as needed.

CM will maintain ongoing communication, case conferencing and collaborative care planning with chemical dependency providers

CM will assist the patient to understand how addictive attitudes and behaviors result in drug seeking behavior and compromises medication management

CM will assist the patient to identify and practice non-narcotic pain management strategies in collaboration with medical provider

CM will assist the patient to identify drinking/drug use triggers and to develop strategies for managing urges / averting relapse.

CM will provide education regarding addiction and 12 Step programs to patient/ family members/care givers, and will provide meeting lists for local AA/NA/CA/Al-Anon/Al-Anon/Al-Ateen meetings.

CM will provide education regarding addiction as a family disease/co-dependency/enabling/detachment

**Care Plan for Management of a Behavioral Health Disorder****Problem/Issue:**

The patient lacks an effective Action Plan for self-managing a behavioral health disorder

**Goal:**

The patient will develop an effective behavioral health disorder self-management plan as reflected by

- a. Ability to understand the relationship between emotional stability and health status.
- b. Understanding of the symptoms, causes and consequences of mental illness
- c. Acceptance of behavioral health diagnosis and of referral to treatment to stabilize psychiatric concerns.
- d. Compliance with Behavioral Health appointments and psychotropic medications
- d. Development of a relapse prevention plan to minimize the risk of decompensation and reduce the frequency of unnecessary ED visits/ hospitalizations
- e. Development of a Safety Plan to manage suicidality/homicidality and reduce the frequency of unnecessary ED visits / hospitalizations
- h. Development of healthy stress reduction practices and adaptive problem solving skills

**Plan/Interventions:**

CM will provide educational materials on mental illness to the patient and family member/caregiver to challenge false myths and negative stereotypes.

CM will assist the patient to process shame, anxiety, guilt and depression over the diagnosis and need for treatment.

CM will provide education on the role of pharmacotherapy in stabilizing mental health symptoms.



CM will use Decisional Balance exercise to identify the pros and cons of complying with medication regimen.

CM will refer the patient for Behavioral Health treatment and will maintain ongoing communication, case conferencing and collaborative care planning with behavioral health providers.

CM will assist the patient to submit an SSI/SSD application

CM will conduct ongoing Risk Assessment and Safety Planning with patient

CM will assist the patient to assess current stress level, stress triggers and stress reduction practices, and will help the patient replace negative self-soothing practices, with positive stress reduction alternatives (exercise, yoga, meditation, deep breathing, visualization, etc)

### **Care Plan for Management of a Tobacco Use Disorder**

#### **Problem/Issue:**

The patient lacks an effective Action Plan for self-managing tobacco use disorder

#### **Goal:**

The patient will develop an effective tobacco use disorder self-management plan as reflected by

- a. Ability to verbalize the impact of tobacco abuse on health status
- b. Establishment of quit date or harm reduction goal
- c. Development of relapse prevention plan including use of NRTs
- h. Development of healthy stress reduction practices to reduce dependence on smoking for self-soothing

#### **Plan/Interventions:**

CM will provide pt. with educational materials regarding the impact of tobacco use on identified health conditions.

CM will assist the patient to identify the pros and cons of continued tobacco use utilizing the Decisional Balance sheet to enhance motivation for abstinence

CM will assist the patient to identify smoking triggers and to develop strategies for managing urges / averting relapse

CM will encourage the patient to discuss RT with PCP

CM will assist the patient to assess current stress level, stress triggers and stress reduction practices, and will help the patient replace negative self-soothing practices, with positive stress reduction alternatives (exercise, yoga, meditation, deep breathing, visualization, etc) to replace dependence on smoking for stress reduction

### **Care Plan for Management of HIV**

#### **Problem/Issue:**

The patient lacks an effective Action Plan to self-manage HIV

#### **Goal:**

The patient will develop an effective Action Plan for self-managing HIV as reflected by

- a. Compliance with provider appointments and prescribed medications
- b. Reduction of HIV viral load and increase in T-cell count
- c. Consistent use of condoms when sexually active
- d. Elimination of opiates and other drugs
- e. Development of healthy diet, exercise, sleep and stress reduction practices

**Plan/Interventions**

CM will provide HIV educational materials to counteract hopelessness and will assist the patient to process shame, guilt, anxiety and depression over the diagnosis

CM will assist the patient to develop strategies for achieving medication compliance, will help the patient understand how medication non-compliance can result in the HIV virus becoming medication resistant and will provide ongoing monitoring

CM will monitor appointment compliance and track progress in reducing HIV viral load and in increasing T-cell count

CM will assist the patient to understand how unprotected sex and needle sharing create opportunities for reinfection and will role play asserting self with intimate partners and drug using peers

CM will assist the patient to understand how tobacco, alcohol, opiate and/or other drug use can further compromise the functioning of the patient's immune system.

CM will offer a referral to a chemical dependency treatment program and provide a Self-help meeting list

CM will help the patient to understand the importance of developing healthy diet, exercise, sleep and stress reduction practices and will explore any obstacles to the development of healthy self-care practices.

**Section II Other Psychosocial or Unmet Social Service Needs****Care Plan for Domestic Violence****Problem/Issue:**

**The patient is a victim of Intimate Partner Violence**

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**Goal:**

The patient will understand her rights and options as a victim of intimate partner violence

The patient will develop a Safety Plan

The patient will obtain safe housing for self- and minor children

**Interventions:**

CM will conduct a safety assessment and assist the patient to develop a Safety Plan

CM will educate the patient regarding her rights and options

CM will refer the patient to Safe Horizon or other domestic violence shelter

CM will refer patient to Family Justice Center for legal representation

CM will educate patient regarding the role of the Mandated Reporter and will initiate SCR reporting with regard to the presence of minors in the

**Problem/Issue:**

**The patient is unable to maintain ADLs, including medication management without assistance**

**Goal:**

In- home nursing and/or homemaker services will be arranged in an effort to support continued residence in the community

The patient will accept referral for inpatient nursing/rehabilitative care

The patient will enlist family/caregiver support for the implementation of the wellness self-management plan to maintain continued residence in the community

**Plan/Interventions:**

CM will collaborate with medical provider to coordinate the application for in-home medical care/ nursing care and/or home maker services

CM will contact APS to request safety assessment and will develop safety plan in collaboration with patient, providers and care givers

CM/CHW will conduct regular home visits to assess health status/safety issues

**Problem/Issue:**

The patient lacks stable housing due lack of financial resources/ due to family conflict/ is homeless/is in rental arrears/is facing eviction/needs special housing accommodation because of disability

**Goal:**

The patient will obtain/maintain appropriate, stable housing situation

**Plan/Interventions:**

CM will coordinate submission of 2010E housing application

CM will coordinate submission of NYCHA housing application

CM will refer patient to shelter

CM will coordinate referral to Supportive Housing program

CM will refer patient to HRA for "One Shot Deal" to address rental arrears

CM will assist patient to identify low cost housing alternatives

CM will refer pt. to services for the visually impaired/physically challenged to obtain appropriate housing accommodations

CM will assist the patient to submit application for Public Assistance through HRA

CM will refer/escort the patient to legal services/Housing Court to appeal eviction

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**Problem/Issue:**

**The patient lacks adequate health coverage**

**or**

**The patient has Medicare but does not have prescription coverage**

**Or**

**The patient is not eligible for Medicaid or Medicare due to income level restrictions**

**Goal:**

The patient will obtain health insurance and prescription coverage

**Interventions:**

CM will assist the patient to submit an application for Medicaid/Medicare

CM will refer patient to Health Exchange Navigator for assistance in obtaining health coverage

CM will coordinate submission of a MAP application

CM will provide list of pharmacies that provide low cost prescriptions

CM will collaborate with pharmacy and prescribing provider to identify alternative medications when prescribed medications are not covered by the patient's insurance plan.

**Problem/Issue**

**The patient has unmet transportation needs**

**Or**

**The patient is unable to travel to appointments independently due to physical disability/mental health condition**

**Goal:** The patient will obtain dependable transportation and/ or escort to appointments

**Plan/Interventions:**

CM/CHW will coordinate submission of an Access-A-Ride/Logisticare application

CM/CHW will make transportation arrangements prior to appointments and/ or will teach patient/caregiver to make such arrangements on their own

CM/CHW will escort patients to appointments when necessary or will enlist the support of family member/caregiver

CM will refer patient for Behavioral Health service to address travel phobia

**Problem/Issue**

**The patient lacks financial stability, has no stable source of income/ is unemployed/is under employed/ is unemployable due to severity of functional deficits or in job jeopardy/has been denied SSI benefits.**

**Or**

**The patient is unable to manage his/her finances without assistance**

**Goal:**

The patient will secure entitlement income

The patient will secure/maintain stable employment

The patient will accept a rep-payee to manage monthly income.

**Plan/Interventions:**

CM will assist the patient to submit an application for Public Assistance

CM will assist the patient to submit an SSI/SSD application

CM will refer the patient for legal representation to appeal denial of SSI/SSD application

CM will refer the patient to EPRA/NADAP/VESID/ICD/Good Will Services for job training and/or job placement

CM will assist the patient to develop a resume and initiate job search activities

CM will assist the patient to obtain a rep-payee to manage monthly income.

CM will assist the patient to develop a relapse prevention plan tailored to work place stressors