Type of referral: RN CM referral via EMR from the MA.

The PCP made the referral after discussion and agreement by the patient. The RN CM is working virtually from home at the time of the referral. An arrangement for a video call was scheduled for the following day.

Reason for referral: Diabetes and hypertension out of control, elevated LDL.

Referral source: PCP referral to BHS/SW and RN CM.

Significant Information from the PCP: The PCP notes indicate the following:

Reviewed results of the A1C and BP and provider assessment findings with the patient. The patient reveals her spouse became sick about 1 year ago and "things were really rough at the end". He died 6 months ago and she can't quite seem to get her life back together since. She declined to try medications but was agreeable to seeing the social worker.

The patient also had confusion about the Metformin and Lantus. She thought she was to stop the Metformin when she started the Lantus. It's not clear if she is taking her BP medication regularly.

Medical records indicate the patient was prescribed an anti-depressant 6 months ago, and spontaneously discontinued them. A note indicates the patient felt extremely restless and was having difficulty sleeping.

PCP indicates general dx of depression, hypertension uncontrolled, diabetes uncontrolled.

The patient would like to stay independent and avoid complications such as a stroke or heart attack. She would also like to reengage with her sisters. She has become very isolated and has "pulled away" from her family and friends.

Video call goals of the initial assessment:

Understanding of the patient's knowledge about your conditions
Review safety and risk concerns of the elevated blood pressure and LDL
Identify the patient concerns, desire and ability in respect to her health

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RNCM scenario

Starts from the introduction being completed at a previous visit and today's visit is about starting the assessment.

Type of referral: Virtual handover from the MA – (Completed after the PCP visit)

> **Reason for referral:** Due to B/P of 165/90 and A1C at previous visit of 10.7%. Judy had missed several appointments in the past 8-9 months. Her last A1C was 7.8% 9 months ago.

The RNCM-quickly looks through the chart to note:

Dx=Diabetes, Heart Failure, Hyperlipidemia, Hypertension, Newly added diagnosis =Depression

Screening/tests completed today unless otherwise specified: (have copies in the "chart" of results)

PHQ=12(0 on question 9)
B/P=165/90
LDL=254 9 months ago
SDOH=inconsistent transportation

Medication History-she reported not taking BP meds regularly, stopped taking Metformin when started Lantus (The MA did medication history and reported this to the PCP)

No recent ED visits, last hospitalization was 1 year ago for HF

Specialists listed on care team-cardiologist

Introduction of CM - Completed at previous visit

Virtual Face to face assessment with Judy:

Starting with open-ended questions to assess:

- **Cultural linguistic needs**
- **Health status**
- **Health function**
- **Knowledge**

Suggested starter open-ended questions
What is your understanding of why PCP referred you to me today?
What concerns/challenges do you have?
What does a day in your life typically look like?

I see that you were diagnosed with HF 1 ½ years ago and have managed that well.
How have you done that?
Other suggestions to ask:
What is you understanding of DM and how have you managed it in the past?
What is your understanding of HTN?

Ask permission to fill in gaps of knowledge

Prioritize risk and safety – what will place the patient as risk for an untoward event/ER visit/hospitalization?

Take into account patient's ability and desire

Patient agreement to CM services

Interventions:
Identified gaps in knowledge regarding HTN, Diabetes
Acknowledge the meeting with the pharmacists and the outcome of that meeting
Reinforcement of information gathered from the SW'er

Future appointments and follow up:
Video appointment with SW tomorrow for assessment
Follow up phone call with RNCM after team conference in 1 week
Reiterate at check-out she should receive updated med list, handout on blood pressure, Transportation resources and next appointments – reinforce or ask about it

Tips:

Knowledge of payer requirements for G9001

Take onto account health literacy ie the patient preferred the MA ask her the questions, she likes handouts with pictures

Be familiar with your organization's assessment templates/tools

Be conversational in conducting the assessment-seek to understand and meet where they are

Recommend use of Motivational Interviewing (MI) approach and skills such as open ended questions