IHA Care Manager Outreach Call:

1. **Plan for your call/decide if good attempt to make:**
    a. Review list of diagnoses.
    b. Review medication list.
    c. Last 2 PCP notes.
    d. Look at ER records in past year – high utilizer?
    e. Look at Hospital records – Frequent admissions in past year?
2. **Warm Greeting:**
    a. Key Phrases:
        i. I am a nurse here in the office that can come alongside you to provide resources, education, and proactive outreach as you manage and improve your health.
        ii. Dr. _____, thought that you could benefit from working with me.
        iii. We will talk about steps and goals that are important to you.
        iv. I am an extra layer of support here for you in the office.
        v. Working with me doesn't require a lot of extra time, I will make periodic phone calls to you and also will see you when you are coming in to see your PCP.

Patient declines Care Management:

b. Ok. Thank you so much for your time. If you change your mind in the future, please let your PCP know that you would like to work with Care Manager.

Patient agrees to Care Management:

3. **Set stage for the call:**
    a. To get started, I need about 20 – 30 minutes of your time to complete my assessment and get to know you better. Do you have time to do this today? What would be a good time for me to call you back?
4. **Patient perspective:**
    a. I reviewed your chart, but could you tell me what concerns you have about your health?
    b. What is the hardest thing for you about managing your health?
5. **Complete Comprehensive Assessment –**
    a. If patient doesn't have time to complete entire assessment, just do portion of assessment prioritizing the med reconciliation.
6. **Review plan of care and discuss goals:**
    a. Earlier in the call you shared that you were concerned about this. Let's talk about this more.
    b. What steps can you take to address your concern of _____?
    c. In the next 3 – 6 months, what is something you would like to work on to improve your health?
7. **Wrap – Up:**
    a. Review goals
    b. Ensure they know when they will see physician next
    c. Plan : CM

IHA Care Manager HICM Outreach Call

Steps 1 and 2 are the same as above.

Patient declines Care Management:

- **a.** Ok. Thank you so much for your time. If you change your mind in the future, please let your PCP know that you would like to work with Care Manager.
- **b.** Update HICM Panel.

Patient Agrees to Care Management:

8. **Discuss HICM program (See HICM scripting).**
    - **a. Key phrases:**
        - i. There are a couple of things that need to be done to get started with this program.
            1. My assessment – 20-30 minutes of time to get to know you better. If patient willing to come in, good to schedule FTF.
            2. Wellness Visit – This can be done at next office visit dependent on your office set-up with Wellness visit.
            3. Home Visit (see home visit instructions).
                a. Pharmacist will review your medications and make sure there are no interactions and that you are taking medications appropriate and safe for your age and conditions.
                b. Nurse Practitioner and CM come to Provide on resources
                c. Whole Goal is to do assessment through eyes of how to ensure you can live safely in your home as long as possible.
9. **Set stage for the call:**
    - b. I would like to get started with my assessment. It will take about 20 – 30 minutes to complete. Do you have time to do this today? What would be a good time for me to call you back?
10. **Patient perspective:**
    - a. I reviewed your chart, but could you tell me what concerns you have about your health?
    - b. What is the hardest thing for you about managing your health?
11. **Complete Comprehensive Assessment –**
    - a. If patient doesn't have time to complete entire assessment, just do portion of assessment prioritizing the med reconciliation.
12. **Review plan of care and discuss goals:**
    - a. Earlier in the call you shared that you were concerned about this. Let's talk about this more.
    - b. What steps can you take to address your concern of _____?
    - c. In the next 3 – 6 months, what is something you would like to work on to improve your health?
13. **Wrap – Up:**
    - a. Review goals
    - b. Ensure they know when they will see physician next
    - c. Plan : CM

Follow-up Encounter

2. **Plan for your call/visit (See pre-visit planning document and chart checklist):**
    a. Review Goals.
    b. Review your last plan and intervention page.
    c. PCP notes since last time you interacted with patient.
    d. Review telephone communication summary.
    e. Check where you are at with Comprehensive or TOC Assessment.
    f. Pick top 2 priorities for your encounter today.
    g. Top 1 topic to provide education on today.

3. **Warm Greeting:**
    a. Hello, this is _____, your care manager calling from Dr. _____ office.
    b. Ok, to leave general message requesting call back if appropriate.

14. **Set stage for the call:**
    a. I wanted to spend about 10 minutes with you today. Is this a good time to talk?****
    b. Tell agenda – I want to hear from you about your questions and concerns, discuss how your goals are going, and talk with you more about your CHF.

15. **Patient Perspective:**
    a. What concerns or questions do you have today or what has come up over the month?
    b. When we talked last, you had planned to work on _____. How is this going? What things have gotten in your way of accomplishing your goal?

16. **Care Manager led discussion:**
    a. Discuss goals.
    b. Complete assessment or portion of assessment if needed.
    c. Do relevant review of system or assessment of situation.
    d. Answer questions.
    e. Advance Care Planning Discussion.
    f. Provide education on one topic.
    g. Review plan of care with patient (clarify medications, specialist appts, testing, labs, barriers patient is having).
    h. Set new goal if needed – have full discussion.
        i. Earlier in the call you shared that you were concerned about this. Let's talk about this more.
        ii. What steps can you take to address your concern of _____?
        iii. In the next 3 – 6 months, what is something you would like to work on to improve your health?

17. **Wrap – Up:**
    a. Review goals
    b. Ensure they know when they will see physician next
    c. What is your plan for follow-up?