Chronic Pain Visit Planner Summary - Annual Overview

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Visit Type	Overview / Purpose	Q1	Q2	Q3	Q4	Sub-Totals
Quality of Life Assessment:	**Semi-Annual Assessment:** • Measure baseline or progress in 5 areas • Record stored in "Patient Registry" to manage patient's chronic medical condition • Information developed will assist in the development of patients annual plan of care	0	1	0	1	2
Functional Assessment:	**Semi-Annual Assessment:** • Measure of 5 core functional issues/components (R.O.M., grip, pinch, strength, etc.) • Record stored in "Patient Registry" to manage patient's chronic medical condition • Information developed will assist in the development of patients annual plan of care	1	0	1	0	2
Physiological Assessment:	**Diagnosis of Chronic Pain:** • Is pain neuropathic, muscle, inflammatory or mechanical compressive? • Is pain acute or chronic? • Determine co-morbidities and how they impact chronic pain condition	0	0	0	1	1
Nutrition Assessment:	**Annual Assessment:** • Measure of patient diet and eating habits • Record stored in "Patient Registry" to manage patient's chronic medical condition • Information developed will assist in the development of patients annual plan of care	1	0	0	0	1
Quality of Life Visits:	**Patient Self Management:** Helping patients to build goals, develop action plans and facilitate long term self-care management techniques is a core component of the Quality of Life Visit. Discussion of contributing factors and barriers to treatment.	3	3	3	3	12
Medication Management Visits:	**Quarterly Visits for Medication Management:** • Review adherence/compliance with medication therapies • Modify medication management plan as necessary • Provide Medication Counseling	3	3	3	3	12
Physiological Visits:	**Semi-Annual Visit:** • Comprehensive Examination & Physical • Patient Adherence to Medical Plan Review • Specialist Referrals and Plan of Care Development	1	0	1	0	2
Nutrition Visits:	**Quarterly Review of Nutrition Goals:** • Nutrition therapy for Chronic Pain • Diet planning for reduction of pain symptoms *(The Serotonin Power Diet - Book)* • Nutrition Management - Planning for weight loss by Health Coach Team	1	0	1	0	2
Interventional Therapies Visits:	**Visits as medically appropriate:** • Interventional therapies should only be used in conjunction with an integrated treatment plan that includes pharmacologic, functional and behavioral therapies and management	0	0	0	0	0
Functional Visits:	**When Exercise is Medicine:** • Address patient's ability to improve function • Utilize "Exercise" protocol for improvement in function • Build "Wii Fit" program for patient self-care management	3	3	3	3	12
Patient Education Visits:	**Understanding My Condition:** • Group Education Classes • Activity Counseling • Lifestyle Modification - Self-Care Management	1	1	1	1	4
	Total Quarterly & Annual Visits	**14**	**11**	**13**	**12**	**50**

pain - Quality of Life Assessment Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Objective Baseline Measure: PHQ-9 - Patient Health Questionnaire (9 questions)	**Used to determine severity of depression:** *A provisional diagnosis is determined (5 categories)* • Minimal symptoms • Minor depression • Major depression *(mild)* • *M* ajor depression *(moderately severe)* • *M* ajor depression *(severe)*
Objective Baseline Measure: SF-36 *(8 domains of health)*	**Quality of Life Measures - 8 Core Domains:** • Physical functioning • Role limitations due to physical health • Bodily pain • General health perceptions • Vitality • Social functioning • Role limitations due to emotional problems • Mental health
Objective Baseline Measure: PSOCQ (Pain Stages of Change Questionnaire)	**Four Scales: • Pre-contemplation • Contemplation • Action • Maintenance** • It is important to assess the patient's potential readiness to accept "change" • Patient triage for "Pre-Contemplative" includes consideration of change in medication management or behavioral referral • Patient triage for "Action" includes referral for functional and behavioral therapies
Objective Baseline Measure: PACIC - Patient Assessment of Chronic Illness Care (20 questions)	**Five Core (Medical Practice) Competencies:** • Patient Activation • Delivery System Design/Decision Support • Goal Setting • Problem-solving • Follow-up/Coordination • Information is measured 2x annually to improve quality of delivery of patient care services
Objective Baseline Measure: Berlin Sleep Questionnaire (10 Questions)	Three Categories of Risk (Sleep Apnea): Patients can be classified into High Risk or Low Risk based on their responses to the individual items and their overall scores in the symptom categories. Results determine need for specialty referral or patient education. Up to 60% of pain patient population has sleep disorder comorbidity that impacts the patients ability to improve quality of life scores.
Patient Plan of Care Development:	**Utilization of Assessment Information:** • Specialist Referrals • Goal Setting, Action Planning & Self-Care Management • Development of plan of care for co-morbidities
Quality of Life Patient Goal Setting:	**Utilization of SF-36 Assessment Information:** • Development of Goals based on 8 core domains • Discussion of Goals with Licensed Clinical Social Worker • Implementation Planning for Goal Setting
Quality of Life Action Planning:	Working with Patient Goals: • Breaking down barriers to improvement in health • Coordinating care improvement with support groups and family • Creating a "Want vs. Need" patient care environment - the pain patient must "want" to be involved in care process.
Specialist Referrals:	**Utilization of Assessment Findings (Managing Patient Referrals):** • PHQ-9 Score (severity of depression determines potentials for behavioral health referral) • BMI assessment determines need for additional sleep evaluation • Quality of Life assessment determines need for additional visits with Quality of Life Health Coach
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w/behavioral background • Licensed Clinical Social Worker and/or Psychologist • CPT Code 90804 or 96152 (provider specific) documentation requirements

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	0	1	0	1	2

Chronic Pain - Functional Assessment Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Physical Therapist - Medical Evaluation:	**Assess safety of exercise program:** • Assess physical condition and limitations of the patient. • Assist in the determination of biological mechanisms of pain • Review MD/LCSW clinical report findings to determine is patient is candidate for physical therapy
Functional Evaluation (Use Computerized Toolset):	**Measure Functional Capabilities:** • Range of Motion, Grip, Pinch, Muscle Weakness/Strength, Pain Intolerance • Use computerized toolset for objective baseline clinical measures for the above • Utilize baseline objective clinical findings for development of functional care plan, store clinical data findings in CDMS
Neurological & Musculoskeletal Special Tests:	**Special Tests:** • Perform special tests to rule in or rule out if neuropathic pain is present • Perform special tests to rule in or rule out if mechanical/compressive pain is present • Perform special tests to rule in or rule out if inflammatory/muscle pain is a component of the patients overall pain condition
Health Coach Introduction:	**Movement Improvement is different than Physical Therapy:** • Reframe "Physical Therapy" as "Movement Improvement" how it is different and fun • Discussion with patient about "Physical Therapy" failures, and new approach to functional improvement • Health Coach introduction should include how entire team is available just for you, the patient
Activities of Daily Living:	**Patient Limitations (ADL): (20 questions)** • Questionnaire used to determine ADL limitations • Questionnaire results used to develop plan of care based on patient needs • ADL goal setting built into patient's written plan of care
Working with the Wii Fit System:	**Getting Started:** • Measurement and Goal Setting • How to use the system • How does the system help?
Understanding Exercise:	**Developing an Exercise Plan:** • Moving your bodies joints, every day, every way • Building an attainable movement program • Exercise is not possible for me, what now?
Specialty Referrals:	Health Coach Referrals: • While the "Health Coach" cannot perform MDM, they can provide recommendations for additional services to MD/NP/LCSW • "Health Coach" is the front line for patient management of condition, strong relationship is built between health coach and patient • "Health Coach" should report to PSPI team members any discussions about activities detrimental to care plan
Patient Home Exercise Discussion:	**The Importance of Home Exercise:** • Wii Fit Program • Helping the patient with maintaining a chronic pain journal • Discussion with patient "Movement Improvement" opportunities
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w/functional assessment training background • Nurse Practitioner (under MD Supervision) or MD Supervisor • CPT Code 99212 or 99213 clinical documentation requirements *(Chronic Medical Condition Management Criteria)*

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	1	0	1	0	2

Chronic Pain - Physiological Assessment Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Assessment for Chronic Pain:	**Patient Assessment:** • Pain onset and progression of condition should be documented (classification of patient STEP 1 - 5) • History of sleep & diet is essential to understanding the chronic pain condition • Location, intensity, quality, duration and character of pain condition should be measured and recorded in CDMS
Co-Morbidities - Risk Factors:	**Patient Risk Factors & Co-Morbidities:** • Utilize SOAPP-R Questionnaire to determine risk category (high, moderate, low) for addiction • Assessment of mental status as cognitive impairment will be more difficult to treat • Review of "Quality of Life" questionnaires to determine if other risk factors are present
Functional Assessment:	**Patient Exam:** • Identification of significant areas of impairment or disability • Establish specific functional outcome goals within a care plan • Measure the effectiveness of the care plan or treatment interventions
Physical Examination:	**Patient Physical Exam:** • Exam should include neurological and musculoskeletal "Special Tests" based upon presenting condition • In the event the injury is work related OREBORO Musculoskeletal Exam questionnaire should be administered • Comprehensive review of functional assessment information, behavioral assessment information, and other diagnostic studies
Laboratory Evaluation:	**Patient Diagnostics:** • While there is no diagnostic test for "Chronic Pain" appropriate imaging is an important component of the diagnostic workup • Urine Drug Testing (UDT) should be ordered for all "High Risk" patients utilizing controlled substances as a component of care • UDT Quantitative Testing Protocol should be implemented for all "Positive" patient findings as appropriate (when not expected)
Specialist Referrals:	**Specialty Referral Management:** • Radiological (Imaging) and neurological (EMG/NCV) specialist referrals for STEP III chronic pain patients and higher • Addiction Medicine Specialist referral when SOAPP-R questionnaire score is high risk • Interventional Pain Specialist as appropriate, Integrated Chronic Care Program (ICCP) should provide optimal care without intervention
Medical Condition Co-Morbidities:	**Patient Education (Review & Discussion):** • Obesity (see nutrition education visits and plan of care development) • Depression (see PHQ-9 scores) referral based on severity of score • Sleep (BMI over 30 and Berlin score determines need for OSA assessment, therapies and management)
Integrated Care Team / Patient Education:	**Introduction to Integrated Care Team:** • How the integrated care team works together • The benefits for the patient of the Integrated Care Team • Discussion of how Chronic Pain is a complex multi-faceted condition, it requires multiple types of expertise to benefit the patient
Importance of Compliance / Self-Care Management:	**Patient Involvement in Care:** • Discussion of importance of patient involvement in their care • Why the patient will need to see a team of care specialist on a regular basis • Rewards to compliance, penalties for non-compliance
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w medical condition training • Nurse Practitioner (under MD supervision) or MD Supervisor • CPT Code 99212 or 999213 documentation requirements *(Chronic Medical Condition Management Criteria)*

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	0	0	0	1	1

Chronic Pain - Nutrition Assessment Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Nutrition Assessment:	**Key Indicators:** • Current BMI/goal BMI • Discussion of developing reasonable goals for BMI • Discussion of diet plan to achieve goals
Your Environment:	**Understanding how your environment impacts your weight:** • Sleep Patterns (hours of sleep per night & quality of sleep) • Stress/Environmental Issues (loud noise, work environment, cleanliness) • Housing Quality (age of housing, current condition, etc.)
Food Allergies:	**Dietary Limitations:** • Religious Limitations (kosher diet, etc.) • Food Allergies (peanuts, wheat, etc.) • Ethnic Preferences (recipes with heavy carbohydrates)
Current Eating Patterns:	**Typical foods eaten, CHO, protein, fat, fruit/vegetables, restaurant food):** • Breakfast (beverages, quantities, etc.) • Lunch (typically eaten at restaurant, prepared, etc.) • Dinner (what time of day do you eat dinner?)
Family & Work Support:	**Understanding Family/Support Groups :** • Your Weight History • Family History (how many overweight, underweight) • Do you work in an environment that supports food?
Dietary Discussion:	**Patient Nutrition Counseling:** • Primary Dietary Issues to Discuss/Review • Foods/Ideas to Emphasize • Foods to Limit/Foods to Avoid
Nutrition Assessment Key Findings:	**Patient Education Referral & Planning:** • Referral to Sleep Specialist • Referral to Chronic Pain Nurse Educator • Referral to other specialists for obesity management (interventional procedures)
Patient Motivation:	**Patient Nutrition Management:** • Develop assessment of patients ability to follow recommendations • Develop assessment of patients ability to understand recommendations • Develop assessment of patients history at following clinical plan of care *(High risk, Moderate risk, Low risk)*
Commencement of Patient Education:	**Nutrition Education Information:** • Commence Discussions in regards to patient nutrition journal • Provide educational handouts, discuss follow up with nutrition groups • Establish Nutrition Education Visit Plan of Care
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w/nutrition training background • Nurse Practitioner (under MD Supervision) • CPT Code 99212 or 99213 documentation requirements

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
		1	0	0	0	1

Chronic Pain - Quality of Life Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Patient Education / Goal Setting:	**Health Coach Activities:** • Description of the Chronic Pain disease process and treatment options • Goal-setting to promote health, and problem-solving for daily living • Preventing, detecting and treating acute complications
Action Planning:	**Development of Patient Action Plans for Care Management:** • Prevention (through risk reduction behavior), detection and adherence to treatments for chronic medical conditions/complications • Incorporation of appropriate nutrition management • Incorporation of physical activity into lifestyle
Self Care Management:	• Utilizing medications (if applicable) to optimize therapeutic effectiveness • Patient awareness of culturally appropriate community resources/support for persons with Chronic Pain and their families and ability to access community resources • Psychosocial adjustment of Chronic Pain to daily life
Community Resources:	**Community Programs:** • Programs that are complimentary to patient care and education should become part of the "Standard of Care" within the practice • Programs that are designed to enhance a patient's ability to self-manage Chronic Pain. • Integrate spiritual programs as a component of compliance and education
Health Coach QoL Activities:	**Improvement Opportunities:** • Patient needs discussion as it relates to reinforcement of amount of time required for improvement in condition • Health Coach team should be available for patient, not single provider • Health Coach should focus primarily on simple easy to attain goals, ideally one at a time, vs. many goals
Review Quality of Life Measures:	**Quality of Life Measures:** • Utilize the findings developed with patient from the SF-36 toolset. • These findings should provide opportunities to develop personal health goals, and quality of life improvement opportunities. • Long term patient self-care management should also be coordinated
Self Management Support Training:	**Patient Self-Care Management:** • Self-management support is the care and encouragement provided to people with chronic conditions and their families to help them understand their central role in managing their chronic pain condition • Assist patient to make informed decisions about care, and engage in healthy behaviors
Review Quality of Life Questionnaires:	**Review of Objective Assessment Tools:** • PACIC, PSOCQ, Berlin Sleep, PHQ-9, are questionnaires that are administered in the "Quality of Life" assessment visit. • Findings from these assessments are to be utilized by the "Health Coach" to facilitate improvement in overall quality of life. • Discussion with patient of how the information will be used to enhance quality of life, restore function and reduce pain
References:	**Chronic Medical Condition/Disease Management References & Guidelines:** • Institute for Clinical Systems Improvement (extensive research) • American Pain Society (extensive research and tools available) • Improving Chronic Care (Chronic Medical Condition Management)
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w/behavioral training background • Licensed Clinical Social Worker and/or Psychologist • CPT Code 90804 or 96152 (provider specific) documentation requirements

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	3	3	3	3	12

Chronic Pain - Medication Management Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Assess patient adherence:	**Understanding Patient Motivations:** • Assess the patient's knowledge of his/her condition and his/her expectations for treatment. • Assess the patient's medication administration process. • Assess the patient's barriers to adherence.
Medication Management Key Points:	**Patient Medication Management:** • For "High Risk" patients (see findings from SOAPP-R) monthly UDT studies should be ordered and reviewed • For "Moderate Risk" patients (see findings from SOAPP-R) UDT studies should be ordered and reviewed at the direction of MD • Overall goal of treatment care plan is to reduce dependence on Class II narcotics and convert to combination medication therapies
Medication Management for Related Conditions (Co-Morbidities):	**Related Condition Medications: *(review of contraindications)*** • Anti-Inflammatories • Anti-Depressants • Anti-Convulsants
On-Going Management of Medications:	**On-Going Medication Management Care:** • When diversion is suspected, refer to "Mental Health" and/or Health Coach Team before considering patient discharge • Integrated care approach objective is to reduce dependence on medications as a core component of care • Utilize medications as a compliance tool for all care components, non-compliance may require medication care plan modification
Medication Management Visit Frequency:	**Modification to Medication Plan of Care:** • Patient visits should be regular when new medications are added to plan of care (weekly). • Regular visits should be scheduled at least every three to six months • More frequent visits may be necessary if treatment goals are not achieved.
Chronic Pain Follow-Up:	**Chronic Pain Follow Up:** • For recreational drug positive findings on UDT studies, implement clinical policy that includes referral to substance abuse provider • Do not discontinue medication management patient care without attempt to implement program, or referral to substance abuse • Medications may be reduced in the event of non-compliance with program, although do not discontinue care for legal protection
Maintain Treatment Goals:	**Nutrition/Physical Activity:** • Work with individual patient to set realistic goals. • When patient is not compliant review with patient the need for compliance as it impacts improvement in overall pain condition • Continually review patient action plans, goals set, and patient's self-care management of condition
Coordinate Action Planning with Health Coaches:	**Care Coordination:** • Coordinate Care with Quality of Life Health Coach Team • Coordinate Care with Functional Health Coach Team • Coordinate Care with Patient Education and Counseling Health Coach Team
Patient Non-Adherence to Medication Management Plan:	Interventions to enhance medication adherence should be directed at risk factors or causes of nonadherence. Interventions may include simplifying the medication regimen, using reminder systems, involving family or caregivers in care, involving multiple disciplines in team care, providing written and verbal medication instructions, setting collaborative goals with patients, and providing education about medications (including potential adverse effects) and about Chronic Pain in general
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w/medical condition training • Nurse Practitioner (under MD supervision) or MD Supervisor • CPT Code 99212 or 999213 documentation requirements *(Chronic Medical Condition Management Criteria)*

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	3	3	3	3	12

Chronic Pain - Physiological Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Treatment Priorities:	**Chronic Pain Patient Treatment Priorities: (Goals & Objectives)** • Enhance "Quality of Life" • Restoration of Function • Overall Pain Reduction
Targeted Physical Exam Should Include: (2x annually)	**Target Assessment Exam 2x Annually:** • Measurement of key clinical measures, record in CDMS for reporting to entire care team • Update of chart including CC. H&P, ROS, PFSH, N/M hands on exams, MDM • Discussion with patient of improvement (or lack thereof) in overall condition(s) and improvement strategies
Targeted Annual History and Physical Exam:	• Current prescribed medications, over-the-counter medications, dietary supplements and alternative therapies • Problems with adherence to therapeutic regimen • Alcohol/drug use patterns • Adjustments by the patient of the therapeutic regimen
Bio-Psychosocial Care:	**Behavioral Health Management:** • Identification of comorbid psychological disorders • Patient discussion on improvement in quality of life, restoration of function, pain symptom reduction • Review of Quality of Life Assessment measures, with potential referral to mental health specialist
Patient Perception:	**Understanding the Patient's Perception of their Condition:** • Use the *"Physical Functional Ability Questionnaire"* (FAQ5) to assist in understanding patient perceptions of condition • Work with questionnaires or measures that can be entered numerically into EMR/CDMS to graph improvement over time • Based on duration of injury (STEP I - V) discussion of time required to improvement of condition
Patient Fears/Avoidance:	**Chronic Pain Patient Fears:** • Fear of removal from program, reductions in medication • If on SSDI, fear of improvement in quality of life, how this will impact their ability to receive SSDI compensation • Fear of exacerbation of injury - discussion on how important return to normal activities impacts symptoms
Reinforcement of Integrated Care Team:	**MD Integrated Care Team Discussion:** • Primary Care Provider must support ICCP team approach through discussions with patient • PCP discussion should include review of integrated care team plan, and how important it is for improvement in condition • Remove concept of PCP as provider, replace with ICCP Team as provider of care
Chronic Pain Disease Management:	**Review and Discussion of Related Clinical Conditions:** • Discussion of related issues such as sleep apnea, weight gain, functional limitations, and other chronic medical conditions • Discussion of key clinical measures from CDMS, review with patient on how to improve individual measures • Discussion of how important patient compliance with care plan is as it relates to reducing pain symptoms
When treatment goals are not met, modify treatment based on related guideline:	**Clinical Guidelines:** • Institute for Clinical Systems Improvement Clinical Guideline for Chronic Pain • Exercise is Medicine website, guidelines for chronic pain management • MacArthur Foundation (Depression Management Toolkit)
Consider Referral to Chronic Pain Care Team or Specialists:	**Other Specialist Referrals:** • Assess the patient's knowledge of his/her condition and his/her expectations for treatment. • Assess the patient's medication administration process. • Assess the patient's barriers to adherence.

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	1	0	1	0	2

Chronic Pain - Nutrition Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Nutrition Therapy Education:	**Nutrition Education Activities:** • Implementation of gradual, realistic and culturally appropriate changes in lifestyle goals. • Foods containing carbohydrates from whole grains, fruits, vegetables, legumes and low-fat milk to be included in a healthy eating plan. • Maintaining the pleasure of eating by limiting only food choices indicated by scientific evidence.
Nutrition Patient Education & Self Management:	**Nutrition Education - Lifestyle Modification:** • Reducing total caloric intake by moderating food/beverage and limiting total fat intake. • Distributing carbohydrates evenly throughout the day to smaller meals and snacks. • Monitoring carbohydrates remains a key strategy in achieving glycemic control
Development of Nutrition Plan of Care:	**Building a Plan of Care:** • Analyze Nutrition Assessment Information • Generate Nutrition Related Problem List • Develop Nutrition Solutions
Nutrition Plan Compliance:	**Patient Compliance Goals:** • Realistic Goal Development • Nutrition education first, goals for weight loss next • Weight Management is lifestyle change, not a diet
Patient Understanding:	**Patient Compliance:** • Do you have a patient compliance issue, or a patient understanding issue • Does the patient retain information from education sessions • Is the patient engaged in the activity of just going through the motions
Development of Written Nutrition Plan of Care:	**Building the Right Nutrition Plan:** • Does the patient cook his or her own meals? • Does the patient eat at home or away on a regular basis? • Is the patient a good cook? Or does the patient eat packaged foods?
Educating Patient on Importance of Compliance:	**Why Compliance Matters:** • Quality of Life (ability to do more in life) • Social Relationships (is eating a primary social function) • Functional Capabilities (movement, function, intimacy, etc.)
Impact of Patient Social & Environment Issues:	**Patient Environment:** • Does the patients life evolve around food and eating activities • Is diet a primary importance in patients life • Assessment of Environment should be performed
Non-Compliance Management:	**When the Patient Won't Listen:** • Reinforce the consequences of non-compliance • Demonstrate the clinical impact of non-compliance • Get family members involved
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w/nutrition and/or medical condition training • Nurse Practitioner (under MD supervision) • CPT Code 99212 or 999213 documentation requirements *(Chronic Medical Condition Management Criteria)*

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	1	0	1	0	2

Chronic Pain - Behavioral Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Depression Care Process:	**Care Overview:** • Depression Recognition & Diagnosis • Understanding the Behavioral Health Patient Education Process • Discussion of Treatment Options
Depression Evidence Based Guidelines:	**Management Tools for Treating Depression:** • Utilize CDMS (Chronic Disease Management System) to record key clinical indicators • Patient Assessment Questionnaires for progress reporting • Utilize Clinical Guidelines and Depression Toolkit from Macarthur Foundation
Patient Monitoring:	**Response to Treatment:** • Compliance with Treatment Plan • Improvements in Symptoms and Function • Modify Treatment as appropriate
Depression Screening:	**Overview of the Screening Process:** • Thorough Interview and Examination • Diagnostic Criteria explored, depression diagnosis confirmed/not confirmed • Rule out other causes of depression symptoms
Evaluate for depression: (PHQ-9)	**Identification and Management of Depression:** • Depression diagnosis is an important aspect of Chronic Pain care. • Self-administered or professionally administered instruments, such as PHQ-9, are useful adjuncts to the clinical interview in the identification of depression.
Recognition Tools - Clinician Memory Aids:	**Overview of Memory Aids:** • Patient mood and function interview questions • DSM-IV Criteria for Depression Interview Questions • Suicide Risk Questions
Challenges in Monitoring Depression:	**Key Treatment Challenges:** • Educating and recruiting the patient as a partner in treatment. • Treat long enough. (Patients often take 6 to 10 weeks to respond.) • Follow outcomes and adjust treatment as needed. Consider consultation if patient is not improving.
Working with the Cycle of Depression:	• Behaviors - decreased physical or social activity, decreased productivity, alcohol or drug use • Stressors - Medical Illness, work or family problems • Physical Problems - pain, low energy, poor sleep, poor concentration • Thoughts & Feelings - negative thoughts, low self-esteem, sadness, hopelessness,
Depression Care Managers Role:	**Behavioral Health (Depression) Care Management:** • Educates patients and their significant others • Engages patients in treatment • Provides proactive follow-up, tracks clinical responses with PHQ-9
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w/behavioral background • Licensed Clinical Social Worker and/or Psychologist • CPT Code 90804 or 96152 (provider specific) documentation requirements

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	0	0	0	0	0

Chronic Pain - Functional Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Physical Activity Education:	**People with Chronic Pain should perform:** • Discuss limited exercise activities based upon functional assessment and "Exercise is Medicine" condition guideline • Discuss with patient on "Movement Improvement" activities to assist in overall functional improvement • Discuss incorporating exercise and movement into self-care management goals
Simple Exercise Strategies (Getting Started):	**Incorporate 10 minutes of increased activity into every day:** • Use stairs instead of elevator. • Park car away from building entrance and walk. • Walk to do errands.
Planning for Activities:	**Overcome Barriers to improvement:** • Self-monitor activity performed using pedometer, time record and/or journal. • Be consistent. • Have alternative activities for inclement weather.
Exercise is Medicine:	**Utilize Exercise is Medicine Medical Condition Protocols:** • Suggested exercise protocol for chronic pain patients • Suggested exercise protocol for balance and gait issues • Suggested exercise protocol for neurological impairment medical conditions
Utilizing the Wii Fit System:	**Creating Patient Profile:** • Using the patient measurement capabilities • Demonstration of Wii Fit games and challenges • Closed loop training (discussion on how fun that can be)
Manual Therapies:	**Massage Therapy:** • Lower Extremity manipulation (used to increase local circulation) • Nerve Decompression Therapies (to relieve pain) • Upper Extremity Manipulation therapies (to provide opportunities for movement improvement)
Complimentary Therapies:	**Quality of Life Therapies:** • Yoga (used to improve quality of life) • Chiropractic (reduction of medical condition symptoms) • Low weight bearing aquatic therapies (used to improve muscle strength) excellent for fibromyalgia patient population
Gait & Balance Training:	**What is Gait & Balance Training:** • Posture Improvement (assists in enhancing quality of life) • Reduce risk of falling (reduces fear of exercise) • Improve or maintain independence (optimizes potentials for improvement in medical condition)
Compression Therapies:	**Reduces Symptoms of Condition:** • Manual Lymphatic Drainage • Compression Therapy Pumps/Systems • Enhance localized circulation
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w/rehabilitation/exercise training • Nurse Practitioner (under MD supervision) • CPT Code 99212 or 999213 documentation requirements *(Chronic Medical Condition Management Criteria)*

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	3	3	3	3	12

Chronic Pain - Patient Education Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Patient Education:	**Interactive Patient Experience:** • Diet/Nutrition Activities - Lifestyle modifications • Exercise/Movement Activities - Setting Goals and maintaining them • Sleep Hygiene - key component of pain reduction
Patient Goal Setting Discussions:	**Health Coach - Coordinating development of "Reasonable Patient Goals"** • Functional Goals (see "Activities of Daily Living" questionnaires for clinical guidance) • Quality of Life Goals (see quality of life questionnaires for clinical guidance) • Comorbid condition goal setting (weight, diet, sleep hygiene, etc.)
Patient Action Planning Discussions:	**Action Planning Implementation:** • Commence with removal of patient barriers for action planning • Health Coach coordinates all "Action Planning" for patients medical condition, plans are established and reported to MD • Design "Patient Action Plans" that focus on improvement in quality of life, i.e., attending movie with children, etc.
Patient Self-Management Discussions:	**Discussion of Home Education (Self-Care Management) Opportunities:** • Patient education discussions on how to implement self-care management objectives • Education sessions on the importance of maintaining a chronic pain patient journal • Education activities on available community support groups and resources available to patient *(You are not alone)*
Community Resources:	**Community Support Groups:** • Faith based community resources - introductions to these programs can be very beneficial to modify lifestyle • Food co-op programs • Build networking opportunities within patient population
Integrated Care Team Coordination of Care:	**Care Coordinator Activities:** • Health Coach coordination of care activities - CDMS - Chronic Disease Management System implementation • Health Coach is in supportive role to MD/NP/LCSW for all care activities, expands resources and improves care programs • 3 - part visit process (Pre - Intra - Post) is utilized for each visit. Data collection, delivery of services, patient education reinforcement
Understanding My Condition:	**Patient Education Should Include *(Delivered by Health Coach)*:** • Comprehensive education about their condition(s) • On-going discussions about their medications, and the importance of following care plan • Providing resources and discussions about interventional procedure options
Reframing the Chronic Pain Condition:	**Pain is the 5th Vital Sign:** • Pain is a symptom, not the condition • Focus of education should be on enhancing quality of life and restoring function, then reducing pain • Try to remove "Pain" from the discussion, reframe conversation to patient lifestyle, etc.
Patient Focus Groups:	**Patient Research/Understanding Care:** • Discuss the patient's understanding of available options for treating pain • Discuss and determine how chronic pain influences changes in lifestyle and function • Understand the patient's perspective of the provider's and care team roles
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w/nutrition and/or medical condition training • Nurse Practitioner (under MD supervision) • CPT Code 99212 or 999213 documentation requirements *(Chronic Medical Condition Management Criteria)*

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	1	1	1	1	4