CONNECTED CARE DATA TEMPLATE

Member Tier – Display SMI Tier 1, 2, or 3 (plus historical activity to show changes in tier)

Member Demographics

Member name, address, phone number, DOB, MC400 Member ID, MA Recipient Number

Member Engagement Status

Status = Consent, Enrolled, Passive- UTR, Passive-Opt out; date provided

Other Needs:

☑ Needs TTY Line/Language Line

☑ English not primary language Primary Language: _____

Lead Physical and Behavioral Health Staff

UPMC Health Plan: name of HP staff CCBH: name of CCBH staff

Member Contacts

Primary caregiver, Community Case Manager/CTT , CCBH Contact ; Personal Wellness Advocate Display: category, contact name, relationship, phone number(s)

Primary Care Provider on Record

Behavioral Health Provider on Record

Chronic Medical Conditions

Behavioral Health Diagnoses

Inpatient Utilization

Admission date, discharge date, LOS, facility, admit diagnosis (exclude D&A) Display rolling 12 month period

Emergency Department Utilization

Admission date, facility, diagnosis (exclude D&A) Display rolling 12 month period

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Care Coordination Triggers and Interventions

Behavioral Health Needs	Result	Community Care Most Recent Date	Result	Health Plan Most Recent Date
PHQ2 Screening				

Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Member outreach for depression		
☑ Coordination of care for depression		
☑ Educational materials provided for depression		

Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Crisis recovery plan in place		
☑ Educated on Resolve		

Physical Health Needs (self-identified)	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Asthma		
☑ COPD/Emphysema		
☑ Diabetes		
☑ Heart Disease		
☑ Heart Failure		
☑ High Blood Pressure		
☑ High Cholesterol		
☑ Kidney Failure		
☑ Memory Problems		
☑ Sickle Cell		
☑ Other		
☑ Poor/Very Poor Health Status		

Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Member enrolled in case management (excl. EPSDT, MTM)		
☑ Educational materials provided to address DM needs		
☑ Member has self-management plan		
☑ Has symptom response plan for physical health		
☑ Educated on 24/7 nurse advice line		

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Medical Home/Access to Care Needs	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Does not see PH Provider regularly		
☑ Does not see BH Provider regularly		

Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Facilitate PCP assignment		
☑ Coordinate care with PH provider due to insufficient follow-up		
☑ Facilitate behavioral health provider assignment		
☑ Coordinate care with BH provider due to insufficient follow-up		

Transportation	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Has transportation needs		

Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Provided transportation resources		

Emergency Department Visits	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Has frequent ED Visits		

Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Assessed regarding frequent ED use		
☑ Facilitate provider communication		

Inpatient Admissions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Has frequent PH Readmissions		
☑ Has frequent BH Readmissions		

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Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Assessed regarding PH hospital admissions		
☑ Assessed regarding BH hospital admissions		
☑ Referral to Mobile CM		
☑ Enrolled in Transitions Program		
☑ Member has post-discharge follow up appointment with provider		
☑ Assessed for referral to more intensive BH treatment programs		
☑ Reviewed crisis plan		

Medication Concerns	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Physical Health Medication compliance issue		
☑ Behavioral Health Medication compliance issue		
☑ Difficulty obtaining medication		
☑ Antipsychotic adherence post hospital discharge		
☑ Antipsychotic compliance issue		
☑ Medication compliance issue due to side effects		
☑ Lack of understanding related to medication use		

Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Medication reconciliation completed		
☑ Medication intervention by pharmacist during review		
☑ Referral to pharmacy for non-compliance issue		
☑ Contacted provider for non-compliance issue		
☑ BH provider gave instructions on managing symptoms		

Support Needs	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Inadequate caregiver support		
☑ ADL/IADL needs		

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Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Provided education regarding caregiver support needs		
☑ Assist member with obtaining community resources for caregiver support needs		
☑ Referral to mobile CM or SW for caregiver support needs		
☑ Provided education regarding ADL/IADL needs		
☑ Assist member with obtaining community resources for ADL/IADL needs		
☑ Referral to mobile CM or SW for ADL/IADL needs		
☑ Assist member with care coordination for ADL/IADL needs		

Environmental/Safety Needs	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Safety issued identified in home		
☑ Homeless		
☑ Inadequate housing		
☑ Possible domestic violence		
☑ Fall Risk		
☑ Lives alone		

Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Provided education regarding environmental safety issue		
☑ Assist member with obtaining community resources for environmental safety issue		
☑ Referral to mobile CM or SW for environmental safety issue		
☑ Assist member with care coordination for environmental safety issue		
☑ Referral to homeless shelter or program		
☑ Provided education for possible abuse		
☑ Assist member with obtaining community resources for possible abuse		
☑ Referral to mobile CM or SW for possible abuse		

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☑ Assist member with care coordination for possible abuse		
☑ Assist member in developing a safety plan		
☑ Coordinate home safety assessment for fall prevention		
☑ Coordinate medication review for fall prevention		
☑ Provided education for fall prevention		
☑ Assist member with care coordination for fall prevention		

Lifestyle Issues	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Tobacco use		
☑ Nutritional need		
☑ Overweight		
☑ Exercise need		

Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Referral for tobacco cessation		
☑ Referral to weight loss program		
☑ Referral to nutrition program		
☑ Referral to exercise program		

Miscellaneous Issues	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Communication/literacy needs identified		
☑ Member has advanced directive		
☑ Member has power of attorney		

Interventions	Community Care Most Recent Date	Health Plan Most Recent Date
☑ Referred to appropriate community resources for communication/literacy needs		
☑ Assisted with coordination of care for communication/literacy needs		
☑ Mailed advanced directive information to member		

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Integrated Care Team Activity		
Date	Activity With	Note

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