



PATIENT: Test client (Brandi)  
DATE OF BIRTH:  
DATE: 10/22/2014 1:44 PM  
VISIT TYPE: Medication Management with Psychotherapy

**INDIVIDUALIZED ACTION PLAN**

Program name: CARE  
Admission date:  
Effective date of initial IAP: 10/22/2014  
Next review date: 04/22/2015

**GOALS, OBJECTIVES AND INTERVENTIONS**

**Goal 1: I want to loose weight (new)**

- Objective: Brandi will continue to walk daily and try to make healthy eating choices. Brandi will see an eye doctor with CM assistance, meet with CNP, PCP, RN, and CM to address medical concerns.

- Intervention: CM will coordinate eye exam, coordinate PCP appointments to ensure regular medical check ups occur, and communicate with nursing staff to follow up on health assessment needs.

-- Intervention: CM will meet with Brandi weekly to assess activity level and encourage daily walking routine. Will assist with educating on healthy eating options while on a budget.

- Intervention: CM will coordinate lab appointments to ensure Brandi follows through with provider orders. Will participate in PCP appointments to discuss diabetic concerns and reinforce PCP orders.

-- Intervention: CM will coordinate a second opinion from a dentist in order to rule out delusional thinking from Brandi. Will coordinate with CNP to ensure psychiatric symptoms are being managed.

- Intervention: CM will meet with Brandi weekly to talk about her medical delusions. Will offer support, listening, and support reality based facts.

**GOAL 1 DETAILS:**

Start date: 10/22/2014  
Target date: 04/22/2015

Assessed need: Heath Home

Identified problem: yes

Desired outcomes: I want to loose weight to help with my diabetes.

Individual's strength/skills: Depression is being manage. Consistent with medication. Follows up with PCP. Tests her glucose levels consistently.

Supports and resources: BMS CM, BMS RN, PCP, Med pack, diabetic educator, CNP

Potential barriers: Mental health symptoms, financial limitations, transportation limitations.

Progress: new

OBJECTIVE 1:

Start date: 10/22/2014

Target date: 04/22/2015

INTERVENTION(S)/METHOD(S)/ACTION(S)

Modality: Case management

Frequency: weekly

Type of provider: Case Manager

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TRANSITION/DISCHARGE CRITERIA

Others participated in the development of this plan:

Health History Completed 4/16/14

Brandi reports following for medical care at Community Health and dental with Community Oral Health. Dr. Britton for vision, and last appointment was 2 years ago. Due for diabetic eye exam. She is due for her annual physical and for dental care. She is diabetic and manages with diet as well as medication. Checks her glucose level daily. Given blood sugar log tracker today. Medical history includes surgery for appendectomy in 1996 and left breast biopsy in 2002 for non hodgkins lymphoma. Also history of Scarlet fever, Guillian Barres Syndrome, Arthritis in fingers and feet. Food sensitivity to horse radish, turnips, mustard, gluten. Past alcohol use, and reports sobriety for 9 years. B/P 132/74, LDL at 182 (11/12/13), and BMI 34.1 in obese category. She quit smoking 5 years ago. Education with discussion on risk factors with being overweight with diabetes, and importance of preventative health care and maintenance of diabetes and weight. Hand out for healthy nutrition and activity tips given. Nutrition education given. Brandi sets weight loss goal, plans to eat better and increase activity for weight reduction, blood sugar control, and reduction of overall cholesterol. PHQ-9 depression screen with minimal depression results. Follows with BMS provider for mental health.

#### Suggestions for HH goals

- 1- Coordinate eye exam and dental exam following up with any orders.
- 2- Annual physical
- 3- Follow up with checking glucoses pt teaching as necessary
- 4- Pt teaching regarding healthy food choices for Diabetes diagnosis and lipid levels
- 5- Pt teaching regarding increased activity for Diabetes, and BMI