Clinical example (template format)

Patient encounter

- Patient: John, a 65-year-old man recently diagnosed with congestive heart failure (CHF).
- Health condition: John's CHF requires ongoing management, including medication adjustments, lifestyle modifications, and regular follow-up visits.
- Challenges: John is overwhelmed by the complexity of his treatment plan, struggles with medication adherence, and faces transportation barriers to medical appointments.

Psychologist's role

Initiating visit

- John is referred by his physician to a clinical psychologist for emotional support and coping strategies related to his CHF diagnosis.
- The psychologist conducts an in-depth assessment, discussing John's medical history, symptoms, and psychosocial factors.
- During this visit, the psychologist identifies John's need for additional support in managing his CHF.

PIN services initiation:

- The psychologist establishes a care plan that includes PIN services.
- The psychologist explains the role of a patient navigator (auxiliary personnel) who will assist John in navigating his health care journey.
- The patient navigator will work under the psychologist's general supervision.

Patient navigator's role responsibilities:

- Medication adherence (10 minutes): The patient navigator educates John about his CHF medications, emphasizing the importance of consistent adherence. They provide reminders, pill organizers, and connect John with pharmacy services.
- Transportation assistance (10 minutes): Recognizing John's transportation challenges, the patient navigator arranges transportation services for his medical appointments. They coordinate with community resources or volunteer programs.
- Coordination with specialists (15 minutes): John's CHF management involves multiple specialists (cardiologist, dietitian, and physical therapist). The patient navigator ensures seamless communication among these providers.
- Emotional support (15 minutes): John experiences anxiety related to his diagnosis. The patient navigator provides emotional support, addressing his fears and concerns.
- Access to social services (10 minutes): The patient navigator connects John with local resources for housing, utilities, and food assistance. They address social determinants of health (SDOH) needs.

Billing and documentation:

- For the initiating visit the psychologist bills CPT Code 96156; Health behavior assessment or re-assessment, which includes health-focused clinical interviews, behavioral observations, and clinical decision-making.
- The psychologist bills for PIN services incident-to their services using HCPCS code G0023 (60 minutes per calendar month).
- The patient navigator's time spent with John is documented in the patient's record.

Outcome

John receives personalized support, improves medication adherence, attends follow-up appointments, and experiences reduced anxiety. The collaborative efforts of the psychologist and patient navigator enhance John's overall well-being and quality of life.

Case Examples

Patient Name

DOLLIE BARTON

Date of Birth

03/03/1901

Encounter Type

Initiating Physician Visit

Reason for Visit

Patient with middle-stage Alzheimer's disease is seeking assistance with obtaining help at home, care coordination, and support for activities of daily living. Patient's stated reason: "We're looking at. Trying to get some help around the house. And we just don't really know. The first steps about doing that."

Medical Complexity

Low

DX/TX Significantly Limited by SDOH?

Yes

Diagnosis / ICD-10 Codes

G30.9

Alzheimer's disease unspecified

Z63.6

Dependent relative needing care at home

Z55.6

Problems related to health literacy

Z59.82

Transportation insecurity

SOAP Notes

Subjective

Patient and son on call. Son is historian. Main concern is seeking help around the house and guidance on first steps for obtaining assistance. Patient has a diagnosis of Alzheimer's disease, currently in middle stages per son. Denies other medical conditions.Not currently taking any medications; previously prescribed medication for dementia but not taking it.

Patient lives with spouse, who is the main caretaker. Patient is able to feed self, but ability to bathe and dress self is questionable. Not able to cook or clean. Transportation to appointments provided by spouse or adult child. Current care team includes PCP, neurologist, and gynecologist.

Prior History of Surgery:
- Not mentioned

Past Medical History:
- Alzheimer's disease (middle stage)

Current Medical Conditions:
- Alzheimer's disease

Current Medications:
- None currently
- Previously prescribed medication for dementia, not taking

Current Known Drug Allergies:
- Not mentioned

Current Care Team:
- PCP
- Neurologist
- Gynecologist

Objective

No objective notes.

Assessment

Patient has a diagnosis of Alzheimer's dementia, currently in the middle stages. Lives with husband, who is the main caretaker. Patient is able to feed herself but may have difficulty with bathing and dressing. Not currently taking any medications. Family is seeking help around the house and support with care needs. No explicit social risk factors such as financial constraints, food insecurity, housing instability, or transportation barriers were identified during this encounter.

G0136: Standardized SDOH screening administered and reviewed by physician (5 minutes, direct-to-patient). Findings discussed and incorporated into care plan; results documented in record.

G0506: Extensive CCM assessment performed to inform comprehensive 12-month care plan for G30.9, Z63.6, Z55.6, Z59.82—high-risk profile. Uploaded plan to chart and obtained verbal consent. Work exceeds standard 99203 E&M requirements.

Plan

Treatment Plan:
The patient was determined to be suitable for advocacy services based on a diagnosis of Alzheimer's dementia in the middle stage, with increasing needs for assistance at home and support for activities of daily living. Consent for advocacy services was obtained, and an advocate visit has been scheduled for the upcoming Friday at 3:00 p.m. The advocate will further assess needs and coordinate care as appropriate.

Elements to include in Care Plan:
Coordination & Visit Planning:

- Confirm and document the list of current medical providers (PCP, neurologist, gynecologist) and ensure up-to-date contact information is available.
- Review and clarify the patient's current medication list, including any dementia medications that were prescribed but are not being taken.
- Assess the need for and coordinate in-home support services to assist with activities of daily living (ADLs), such as bathing, dressing, and household tasks.
- Explore options for respite care or caregiver support for the primary caregiver (husband) and family.
- Coordinate transportation resources for medical appointments as needed, considering current reliance on family members.

Immediate Actions:

- Schedule and confirm the upcoming advocate visit for Friday at 3:00 p.m., ensuring all relevant family members and caregivers are informed.
- Request that the family prepare a list of all current providers and any prescribed medications (including those not currently taken) for the next visit.
- Initiate assessment of home safety and support needs, focusing on dementia-related risks and the patient's ability to perform ADLs.
- Begin gathering information on local resources for in-home care, dementia support services, and caregiver support groups.
- Identify any immediate gaps in care or safety concerns that require urgent attention during the next advocate visit.

Complex Needs:

- Ongoing monitoring and support for Alzheimer's dementia, with attention to progression and evolving care needs.
- Support for the primary caregiver, including assessment of caregiver burden and connection to respite or support services.
- Evaluation of the patient's ability to perform ADLs and need for increasing assistance as dementia progresses.
- Coordination of transportation and appointment scheduling to reduce caregiver strain and ensure continuity of care.
- Assessment of home environment for safety and suitability as dementia advances.
- Additional needs to be addressed as identified by the advocate.

Patient Name

BILLIE JONES

Date of Birth

01/23/34

Encounter Type

Initiating Physician Visit

Reason for Visit

Patient requires assistance with care coordination, including obtaining test results, managing multiple chronic conditions (type 2 diabetes, hypertension, asthma, high cholesterol, overactive bladder, IBS), medication reconciliation, and durable medical equipment (walker) needs. Patient expresses difficulty navigating the healthcare system and communicating with providers. Medical complexity is moderate due to multiple chronic conditions and polypharmacy.

Medical Complexity

Moderate

DX/TX Significantly Limited by SDOH?

Yes

Diagnosis / ICD-10 Codes

E11.9

Type 2 diabetes mellitus without complications

E78.5

Hyperlipidemia unspecified

J45.909

Unspecified asthma uncomplicated

K58.9

Irritable bowel syndrome without diarrhea

N32.81

Overactive bladder

Z96.651

Presence of right artificial knee joint

I10

Essential (primary) hypertension

K21.9

Gastro-esophageal reflux disease without esophagitis

Z60.2

Problems related to living alone

Z60.4

Social exclusion and rejection

Z55.6

Problems related to health literacy

SOAP Notes

Subjective

This 76yo female Expressed frustration with not receiving test results in a timely manner and difficulty communicating with previous providers. Reports issues with medication side effects and a desire for better medication management. The pt has been waiting for results from blood work after a month. She has talked to a pharmacist to help her understand her medications. Another concern is that she feels she is taking acid reflux medication unnecessarily. She would like to stop it if possible. She has not reflux symptoms
Had renal u/s in Jan/Feb and never got the results. She had to leave that doctor. She is seeing another doctor in hopes of reviewing her results.
Needs assistance obtaining a new walker due to right knee replacement and ongoing mobility issues. Relies on transportation services for appointments.

Prior History of Surgery:
- Right knee replacement (with revision for retained bone fragments)
- Remote right arm surgery (impingement/fracture)

Past Medical History:
- Asthma (uses inhalers and nasal sprays)
- Type 2 diabetes (on insulin and oral meds)
- Hypertension
- High cholesterol
- Overactive bladder
- Irritable bowel syndrome (on Linzess)

Current Medications:
- Lantus insulin
- Oral diabetes medication
- Amlodipine
- Oxybutynin
- Linzess
- Pantoprazole (denies reflux symptoms)
- Nasal sprays (for asthma/allergies)
- Over-the-counter mucus relief

Current Known Drug Allergies: lisinopril, angioedema

Objective

No objective notes.

Assessment

Patient does not drive and relies on insurance and public transportation (Metro) to attend medical appointments. No other social risk factors such as financial constraints, food insecurity, housing instability, or social isolation were identified during the encounter. Has to elicit help from the pharmacist to explain her medications. Her doctors don't explain things well. No language barrier noted.

G0136: Standardized SDOH screening administered and reviewed by physician (5 minutes, direct-to-patient). Findings discussed and incorporated into care plan; results documented in record.

G0506: Extensive CCCM assessment performed to inform comprehensive 12-month care plan for E11.9, E78.5, J45.909, K58.9, N32.81, Z96.651, I10, K21.9, Z60.2, Z60.4, Z55.6—high-risk profile. Uploaded plan to chart and obtained verbal consent. Work exceeds standard 99204 E&M requirements.

Plan

Treatment Plan:
The patient was determined to be suitable for advocacy services based on multiple ongoing medical needs, challenges with care coordination, and difficulty obtaining test results and equipment. Consent for advocacy services was obtained during the call, and an advocate visit has been scheduled for follow-up.

Elements to include in Care Plan:
Coordination & Visit Planning:

- Review and organize all current medications, including insulin (Lantus), oral diabetes medications, amlodipine, oxybutynin, Linzess, pantoprazole, and over-the-counter nasal sprays and mucolytics.
- Coordinate with the patient's primary care provider and specialists to obtain outstanding laboratory and imaging results, including kidney ultrasound and bloodwork.
- Assist in communication between the patient and healthcare providers regarding medication necessity, especially for medications the patient reports as unnecessary (e.g., pantoprazole for reflux without symptoms).
- Facilitate acquisition of a new walker, including necessary documentation and provider coordination, given the patient's history of right knee replacement and ongoing mobility needs.
- Support the patient in tracking and preparing for upcoming appointments, including ensuring all relevant questions and concerns are addressed during visits.

Immediate Actions:

- Contact the patient's providers to request and relay outstanding test results, particularly kidney ultrasound and recent bloodwork.
- Review the patient's medication list in detail during the advocate call to ensure accuracy and address any discrepancies or concerns.
- Discuss possible discontinuation of PPI based on the patient's denial of reflux symptoms.
- Initiate the process for obtaining a replacement walker, including gathering necessary medical documentation and coordinating with durable medical equipment suppliers.
- Communicate with the patient's care team regarding adverse reactions to previous medications (e.g., lisinopril) and ensure these are documented in the medical record.
- Explore local community resources and activities for social engagement, as the patient expressed interest in participating in neighborhood programs.

Complex Needs:

- Ongoing support for management of multiple chronic conditions, including type 2 diabetes, hypertension, asthma, high cholesterol, overactive bladder, and irritable bowel syndrome.
- Assistance with medication reconciliation and education, particularly in light of polypharmacy and previous adverse drug reactions.

- Advocacy for timely and transparent communication of test results and care plans from all providers.
- Support for mobility and fall prevention, including ensuring access to appropriate assistive devices.
- Addressing transportation needs for medical appointments, as the patient does not drive and relies on arranged transportation.
- Additional needs to be addressed as identified by the advocate.

Patient Name

MICHAEL JACKSON

Date of Birth

08/32/1943

Encounter Type

Initiating Physician Visit

Reason for Visit

The provider is not helping like i need and I are having a hard time finding other providers. I need to sign my niece up to do caregiving for me and I'm not sure how. I need help. I'm having a hard time. My dementia has gotten worse so I need the help from an advocate.

Medical Complexity

Moderate

DX/TX Significantly Limited by SDOH?

Yes

Diagnosis / ICD-10 Codes

G30.9

Alzheimer's disease unspecified

Z74.3

Need for continuous supervision

Z63.6

Dependent relative needing care at home

Z75.3

Unavailability and inaccessibility of health-care facilities

SOAP Notes

Subjective

74 y/o former musician, PMH of dementia, who presents for enrollment in advocacy services due to worsening cognitive decline and significant difficulty navigating care. The patient's niece is actively involved and attended the appointment to provide support, she assists with caregiving. The patient expresses concern that his current PCP is not adequately coordinating care, often referring out without follow-through or guidance on next steps. He describes multiple instances where diagnostics, including brain scans, are ordered but never communicated or explained. He feels unsupported and uncertain about how to manage his health, especially as his dementia progresses. The family is actively seeking a new PCP but has encountered access issues. They also request assistance with enrolling the niece as a formal caregiver and securing reimbursement or support for niece's caregiving services. The patient voices emotional distress and confusion and is requesting advocacy to assist with both medical coordination and system navigation.

The patient was informed about CHI and Chronic Care Management (CCM/CCCM) services. Patient was informed that only one practitioner may bill CCM services monthly and that they may opt out at any time.

G2211: I/my team have established a long-term relationship with this patient for ongoing care of the problems listed in the assessment and plan.

Refer to my plan of care detailed in this note.

Objective

No objective notes.

Assessment

No assessment.

Plan

The patient has been scheduled for an initial intake with health advocate.

Advocate to assist with identifying a local PCP in the County or via telehealth who can provide comprehensive, dementia-sensitive care with appropriate follow-through.

Support family in enrolling the niece as a formal caregiver via Oregon State's Family Caregiver Support Program or local Medicaid personal care options.

Provide referral to local Aging & Long-Term Support Administration (ALTSA) office for support with caregiver pay options and case management.

Assist in obtaining and reviewing past diagnostic reports, including recent brain scans, and coordinate follow-up with referring providers.

Facilitate communication between patient, caregiver, and new primary provider to establish a clear care plan and next steps.

Offer emotional and logistical support to the patient and his niece, ensuring ongoing dementia management and reducing system-related overwhelm.

Additional needs as identified by the advocate.