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(12) **United States Design Patent** (10) **Patent No.:** **US D857,718 S**
Merkin (45) **Date of Patent:** **** Aug. 27, 2019**

(54) **DISPLAY SCREEN OR PORTION THEREOF WITH COMPLEX CASE AND DISEASE MANAGEMENT GRAPHICAL USER INTERFACE**

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(**) Term: **15 Years**

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Related U.S. Application Data

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(51) **LOC (12) Cl.** **14-04**

(52) **U.S. Cl.**
USPC **D14/486**

(58) **Field of Classification Search**
USPC D14/485-495; D20/11; D21/324, 325
(Continued)

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(57) **CLAIM**

I claim the ornamental design for a display screen or portion thereof with complex case and disease management graphical user interface, as shown and described.

DESCRIPTION

FIG. 1 is a view of a display screen or portion thereof with complex case and disease management graphical user interface of my new design;

FIG. 2A is a partial view of a display screen or portion thereof with complex case and disease management graphical user interface of my new design, the partial view of FIG. 2A showing an upper part of the design;

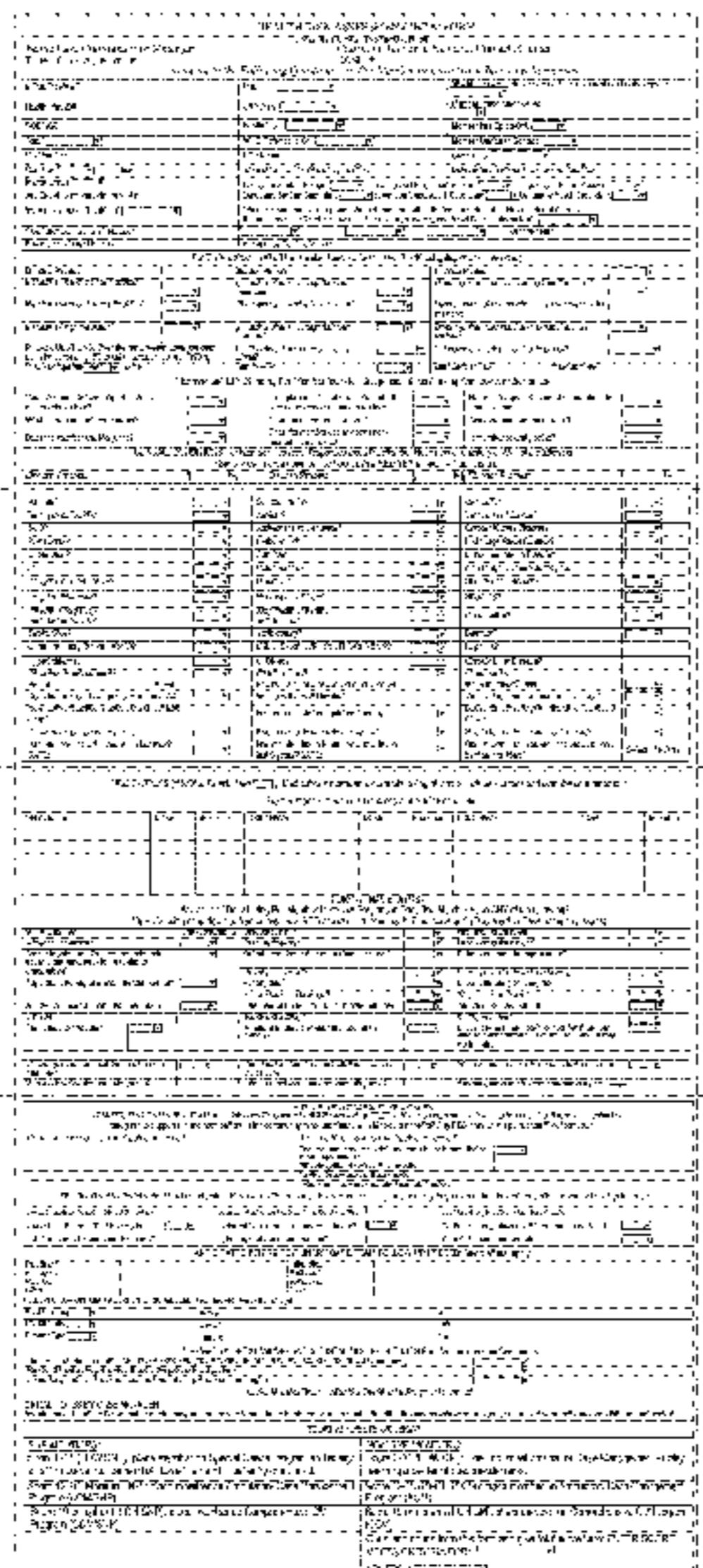
FIG. 2B is a partial view of the display screen or portion thereof with complex case and disease management graphical user interface of my new design, the partial view of FIG. 2B showing a middle part of the design that borders the partial view of FIG. 2A at the bottom of the partial view of FIG. 2A;

FIG. 2C is a partial view of the display screen or portion thereof with complex case and disease management graphical user interface of my new design, the partial view of FIG. 2C showing a middle part of the design that borders the partial view of FIG. 2B at the bottom of the partial view of FIG. 2B; and,

FIG. 2D is a partial view of the display screen or portion thereof with complex case and disease management graphical user interface of my new design, the partial view of FIG. 2D showing a lower part of the design that borders the partial view of FIG. 2C at the bottom of the partial view of FIG. 2C.

The broken line made up of single-length dashes, showing a display screen in each view, forms no part of the claimed design. The broken lines made up of alternating long and short dashes, showing borders between the partial views, forms no part of the claimed design.

1 Claim, 5 Drawing Sheets



HEALTH RISK ASSESSMENT (HRA) FORM
Nurse Case Coordinator or Manager: _____ Date of this Assessment: _____
Case # _____
Answers to the Following Questions Are For Member or Care Giver Interview Responses:
MEMBER NAME: _____
DOB: _____
Address: _____
City: _____
State: _____
ZIP: _____
Phone: _____
Fax: _____
Email: _____
Language Spoken at Home: _____
Language Understood: _____
Language Read: _____
ALLERGENS (Name, Dose, Rx): _____
RECENT HOSPITALIZATION: _____
CLINICAL CONCERNS: _____
Emergency Contact Person: _____
FOLLOW-UP: _____
CLINICAL CONCERNS FOR MEMBER INTERVIEW RESPONSES: _____

(58) **Field of Classification Search**
 CPC G06F 3/048; G06F 3/0481; G06F 3/04817;
 G06F 3/0482; G06F 3/0483; G06F
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 G06F 3/0486; G06F 3/0488; G06F
 3/04886; G06F 9/4443; G06F 10/06;
 G06F 16/248; G06F 17/211; G06F
 17/212; G06F 19/3418; H04H 20/12;
 G06Q 20/00; H04L 12/2801; H04L 67/10
 See application file for complete search history.

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FIG. 1

HEALTH RISK ASSESSMENT (HRA) FORM
 TRANSCARE HEALTH SERVICES, INC.
 Case Coordinator or Manager Contact Number: _____

Name Case Coordinator or Manager: _____
 Date of this Assessment: _____

ANSWER TO THE FOLLOWING QUESTIONS FOR THE MEMBER OR Caregiver Interview Responses

MEMBER INFO: Name: _____ DOB: _____ Gender: _____
 Race: _____ Ethnicity: _____
 Address: _____
 Phone: _____
 Email: _____

PHYSICAL HEALTH: Current Health Status: _____
 Chronic Conditions: _____
 Medication Management: _____
 Mobility: _____
 Vision: _____
 Hearing: _____
 Cognitive Function: _____
 Falls: _____

MENTAL HEALTH: Depression: _____
 Anxiety: _____
 Stress: _____
 Substance Use: _____
 Social Support: _____

FUNCTIONAL STATUS: Activities of Daily Living (ADL) Interview Responses: _____
 Instrumental Activities of Daily Living (IADL): _____
 Mobility: _____
 Vision: _____
 Hearing: _____
 Cognitive Function: _____
 Falls: _____

TRANSPORTATION ISSUES: Member Interview Response: _____
 Transportation Issues: _____

UTILIZATION PATTERNS: Member Interview Response: _____
 Utilization Patterns: _____

INDICATED INTERMEDIARY CARE TEAM'S LOW OF NEED: _____

MEMBER UNDERSTANDING AND SATISFACTION (PROCESSES FOR MEMBER INTERVIEW): _____

ADDITIONAL COMMENTS: _____

SCORES: _____

MEMBER NOTES BY CASE MANAGER: _____

SCORING MEETS CRITERIA:

SNP MEMBERS: Score 5-11 (LOW SNP): place member in Special Needs Program and assign to SNP coordinator once HRA, Care Plan and initial entry completed.	NON-SNP MEMBERS: Score 0-4 (LOW CM): Does not meet criteria for Case Management - only referring provider of outcome decision.
SCORE 12-15 (MEDIUM SNP): place member in Interim Case Management Program (ICM).	SCORE 16-19 (MEDIUM CM): place member in Interim Case Management Program (ICM).
SCORE 20 or Higher (HIGH SNP): place member in Comprehensive CM Program (CCM-SNP).	SCORE 20 or Higher (HIGH CM): place member in Comprehensive CM Program (CCM).

Enter the grade from this form and give total score here: ENTER SCORE MEETS CRITERIA FOR: _____

ACTIVITY: _____

HEALTH RISK ASSESSMENT (HRA) FORM	
Name Case Coordinator or Manager: _____ Date of this Assessment: _____	
DEMOGRAPHIC INFORMATION: Case Coordinator or Manager Contact Number: _____ CASE #: _____	
Answers to the Following Questions Are Per Member or Care Giver Interview Responses:	
MEMBER NAME:	LOB: []
Health Plan ID#	SNP Plan: []
DOB/AGE:	Health Plan: []
Sex: []	WHO Referred to CM: []
PCP NAME:	PCP Number: []
Contacted: [] Date: []	Date of Last Office Visit with your PCP: []
Marital Status: []	Language Spoken Primary: [] Language Understood Primary: [] Language Read Primary: []
ALLERGIES (if none indicate N/A): []	Language Spoken Secondary: [] Language Understood Secondary: [] Language Read Secondary: []
WHAT IS YOUR ETHNICITY: []	What are your living arrangements who do you live with? (If Member is Homeless Refer to Social Worker) (if the answer is HOMELES, address in a care plan and request Social Worker intervention): []
CULTURAL LINGUISTIC NEEDS:	[] Other/Needs: []
Emergency Contact Person:	Emergency Contact Number: []
PSYCHO-SOCIAL STATUS Per Member Interview Responses (Specify using drop down or free boxes)	
Disease Process:	Disease Process: []
Member's view of their own health?	Does member attend activities outside the home? []
Member's view of their quality of life?	Name/number of person who manages healthcare for member: []
Member's Cognitive status?	Does member have good psycho-social support system? []
PHQ-2 QUESTIONS: Over the last 2 weeks, have you often been bothered by: (YES to either question, fu with PHQ-9)	2. Feeling down, depressed, or hopeless? []
PHQ9 Completed [] Date: []	Date Sent To PCP: [] (if Blank = N/A)
Lifestyle and Life Planning Per Member Interview Responses (Specify using drop down or free boxes):	
Does the member have any life planning documents in place?	If life planning is in place, indicate which type of process member has in place [] Request a copy of document for member's file from member []
What is the member's code status?	Does the member use alcohol? [] Does the member use tobacco? []
Does the member use Marijuana?	Does the member use any other non-prescribed narcotics? [] Is member sexually active? []
CLINICAL CONDITIONS Per Member Interview Responses Does the Member Have now or a history of ANY of the following? (Specify using drop down or free boxes): Any RED YES answer = 1 point each:	
Disease Process:	Disease Process: []

FIG. 2A

Asthma?	<input type="checkbox"/>	Schizophrenia?	<input type="checkbox"/>	CANCER?	<input type="checkbox"/>
Emphysema/COPD?	<input type="checkbox"/>	Anxiety?	<input type="checkbox"/>	What kind of Cancer?	<input type="checkbox"/>
SOB?	<input type="checkbox"/>	Alzheimer's or Dementia?	<input type="checkbox"/>	Chronic Kidney Disease?	<input type="checkbox"/>
Pneumonia?	<input type="checkbox"/>	Parkinson's?	<input type="checkbox"/>	End Stage Renal Disease?	<input type="checkbox"/>
Depression?	<input type="checkbox"/>	Arthritis?	<input type="checkbox"/>	Is this member on Dialysis?	<input type="checkbox"/>
MI?	<input type="checkbox"/>	Osteoporosis?	<input type="checkbox"/>	If on Dialysis, where do they go?	<input type="checkbox"/>
Congestive Heart Failure?	<input type="checkbox"/>	Diabetes?	<input type="checkbox"/>	Urinary tract infection?	<input type="checkbox"/>
Irregular HR/Angina?	<input type="checkbox"/>	Neuropathy? Where?	<input type="checkbox"/>	HIV/AIDS?	<input type="checkbox"/>
Hypertension (HTN)?	<input type="checkbox"/>	Amputation of a limb?	<input type="checkbox"/>	Constipation?	<input type="checkbox"/>
Enter last known B/P	<input type="checkbox"/>	Which Limb?	<input type="checkbox"/>	Diarrhea?	<input type="checkbox"/>
Stroke/CVA?	<input type="checkbox"/>	Retinopathy?	<input type="checkbox"/>	Hepatitis?	<input type="checkbox"/>
Coronary Artery Disease (CAD)?	<input type="checkbox"/>	IBS/ULCERATIVE COLITIS/CHRON'S?	<input type="checkbox"/>	Chronic Liver Disease?	<input type="checkbox"/>
Hypertipidemia?	<input type="checkbox"/>	GI Bleed?	<input type="checkbox"/>	Other Issues	<input type="checkbox"/>
Peripheral Artery Disease?	<input type="checkbox"/>	GERD/ Ulcers?	<input type="checkbox"/>	Is the member Obese?	<input type="checkbox"/>
Height:	<input type="checkbox"/>	BMI by Calculator (www.bmi-calculator.net)	<input type="checkbox"/>	What is the member's current pain level?	<input type="checkbox"/>
Weight:	<input type="checkbox"/>	Where is the PAIN located?	<input type="checkbox"/>	Does member take pain medication on regular basis?	<input type="checkbox"/>
Does the member have acute or chronic PAIN?	<input type="checkbox"/>	Is member on Anticoagulation Therapy?	<input type="checkbox"/>	Had Tetanus shot in the last 10 years?	<input type="checkbox"/>
How many medications does the member take daily?	<input type="checkbox"/>	If so, on an anticoagulation program?	<input type="checkbox"/>	Does member take all medications as ordered by their providers?	<input type="checkbox"/>
Checked for polypharmacy issues:	<input type="checkbox"/>	Has member had a Pneumovax shot in the last 5 years? DATE:	<input type="checkbox"/>	Select (if NO 1 pt)	<input type="checkbox"/>

FIG. 2B

MEDICATIONS (if NONE Check Here): Medications member is currently taking at home, include vitamins and over the counter drugs:
Greater than 12 meds chart in notes and notify PharmD/MD:

DRUG NAME	DOSE	How often	DRUG NAME	DOSE	How often

FUNCTIONAL STATUS -
Activities of Daily Living Per Member interview Responses Does The Member Have ANY of the following?
(Specify using drop down or free boxes: Any RED answer = 1 point each IF not corrected: (Document in Case notes any issues))

Visual impairment?	Yes - corrected w/ <input type="checkbox"/>	Difficulty bathing?	Incontinent of the bowel? <input type="checkbox"/>
A hearing impairment?	<input type="checkbox"/>	Difficulty dressing?	Incontinent of the bladder? <input type="checkbox"/>
Speech impairment? That interferes with their ability to communicate? (1pt - if unable to communicate)	<input type="checkbox"/>	Difficulty transferring from one surface to another?	Difficulty or unable to prepare meals? <input type="checkbox"/>
Any difficulty walking or maintaining their balance?	<input type="checkbox"/>	Difficulty feeding self?	Difficulty or unable to do housekeeping? <input type="checkbox"/>
Any falls in the last 6 months, how many have they had? <input type="checkbox"/>	<input type="checkbox"/>	Feeding tube?	Difficulty shopping or buying food? <input type="checkbox"/>
Device used to ambulate? <input type="checkbox"/>	<input type="checkbox"/>	Feeding tube is it old or new?	Where is the weakness? <input type="checkbox"/>
		Weakness of the extremities that interfere with their self care or mobility?	Assistance or CARE GIVER? <input type="checkbox"/>
		A manual or electric wheelchair or scooter for mobility?	If YES, how often? <input type="checkbox"/>
			is it used for in home mobility or outside? if member uses an electric wheel chair or scooter where did they get it? Select <input type="checkbox"/>
Was Hospice discussed with this member or the caregiver? <input type="checkbox"/>		Was Palliative Care discussed with this member or the caregiver? <input type="checkbox"/>	Was a Palliative Care or Hospice evaluation ordered? <input type="checkbox"/>
Who was Hospice discussed with (name)? <input type="text"/>		Who was Palliative Care discussed with (name)? <input type="text"/>	If ordered, name and telephone number of agency <input type="text"/>

FIG. 2C

<p>TRANSPORTATION ISSUES - Per Member Interview Responses (if NONE Check Here []): What resources are anticipated to be needed for this member/patient or caregiver to support the member/patient in the community or to coordinate with Medicaid benefits? Any RED answer = 1 point each if not corrected</p>	
<p>Community Resources(anticipated or needed):</p>	<p>Does the member have any difficulty getting to and from medical or dental appointments? Who transports the member when needed? Name of person who transports member: Telephone number of person who transports member:</p>
<p>UTILIZATION PATTERNS Per Member Interview Responses "How many Times Has the ...": (Specify using drop down or free boxes): Any RED answer > 0 = 1 point each</p>	
<p>member been to the ER in the last 3 months?</p>	<p>been to the Urgent Care in the last 3 months?</p>
<p>If went to the ER, called PCP before going?</p>	<p>Did the member go during PCP Office hours (9am - 5pm)?</p>
<p># SNF days used in benefit period (if known)?</p>	<p>Were PCP appointments available?</p>
<p>ANTICIPATED INTERDISCIPLINARY CARE TEAM/FOLLOW UP NEEDED: Select all that apply</p>	
<p>Participant: Participant: Participant: Other:</p>	<p>Participant: Participant: Participant: Other:</p>
<p>FOLLOW UP APPOINTMENTS CURRENTLY SCHEDULED (if referred upon hospital discharge):</p>	
<p>Provider Type: []</p>	<p>Name#: [] Date: []</p>
<p>Provider Type: []</p>	<p>Name#: [] Date: []</p>
<p>Provider Type: []</p>	<p>Name#: [] Date: []</p>
<p>MEMBER UNDERSTANDING AND SATISFACTION PROCESSES Per Member Interview Responses:</p>	
<p>Member Satisfaction Survey/EVALUATION OF PROGRAM (TO BE DONE ANNUALLY & WHEN CASE IS CLOSED): CM to send survey</p>	
<p>Member or Family/Caregiver understanding of this process and/or program:</p>	
<p>Assess for type of participation that can be utilized with the patient and/or the caregiver:</p>	
<p>CASE MANAGEMENT ADMISSION SUMMARY (Initial Charting):</p>	
<p>INITIAL NOTES BY CASE MANAGER (Indicate here the items/focus that you and the member/caregiver have agreed to focus on for the initial care plan on this member, this will be the basis for admission to the program, be sure to include medication reviewed with the member/caregiver)</p>	
<p>SCORING / MEETS CRITERIA?</p>	
<p>SNP MEMBERS: Score 0-11 (LOW SNP): place member on Special Needs Program and assign to SNP coordinator once HRA, Care Plan and initial entry completed. Score 12-18 (Medium SNP): place member on Ambulatory Case Management Program (ACM/SNP) Score 19 or higher (HIGH SNP): place member on Comprehensive CM Program (CCM/SNP)</p>	<p>NON SNP MEMBERS: Score 0-11 (LOW CM): Does not meet criteria for Case Management - notify referring provider of outcome/decision. Score 12-18 (MEDIUM CM): place member on Ambulatory Case Management Program (ACM) Score 19 or higher (HIGH CM): place member on Comprehensive CM Program (CCM) Count the points from this form and give total score here: ENTER SCORE MEETS CRITERIA FOR: [] ACUITY: []</p>

FIG. 2D