Complex Care Management Guidelines

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INTRODUCTION

This document is a guide to help you prepare, refine, and train for the complex care management of individuals with multiple chronic conditions, limited functional status, and/or psychosocial needs. There are links or website references to numerous resources and tools that can be adapted as you build or test changes for your organization's care management program. All of the resources used are in the public domain and are free to use.

"CM Process-Prescreening" (tool #7 in the Care Management Guidelines Toolkit) is an example of how complex care management fits within the wider patient-centered medical home as it relates to other efforts for population, disease, or case management. The Case Management Society of America's Standards of Practice was used as the foundation for the care management process. Go to www.cmsa.org and search for the Standards of Practice to review the full standards.

General Approach to Care Management

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SOURCES

These guidelines are based on the following sources and input:

- The Mi-CCSI Clinical Model Workgroup. This group included care mangers, physicians, and administrators with responsibility for patient care, care management, and the supervision of care managers.
- Mi-CCSI member and non-member training session attendees' input and evaluations. Go to www.miccsi.org for more information about the Mi-CCSI training program.
- Practice experience with the Multi-Payer Advanced Primary Care Practice Demonstration in the Michigan Primary Care Transformation Project (MiPCT). For more information about MiPCT, go to www.mipct.org.
- Review of literature related to complex care management and its components. See "Foundational Resources" list below.
- The COMPASS project, a multi-disciplinary collaborative care model supported by a Health Care Innovation Grant program funded by the Centers for Medicare & Medicaid Services (CMS).
- Public domain material from a variety of sources, including Blue Cross Blue Shield of Michigan (BCBSM) plans, Priority Health Plan, CMSA, and the California Healthcare Foundation, among many others.

The guidelines, related materials, and all updated materials/versions can be found on the Mi-CCSI website: www.miccsi.org. These materials are free to use by any member provider organization or individual care manager that has completed the Mi-CCSI training program. If sections are used in internal materials, we ask that these be attributed to Mi-CCSI; they can be reprinted freely with our permission.

Foundational Resources

- Robert Wood Johnson Foundation: The Synthesis Project. "Care Management of Patients with Complex Health Care Needs."
- National Coalition on Care Coordination report. "The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses." By Randall Brown, PhD, Mathematica Policy Research.
- Institute for Healthcare Improvement (IHI). "Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs."
- Agency for Healthcare Research and Quality (AHRQ). Go to www.ahrq.gov/ for various resources and materials.

SUMMARY OVERVIEW

The key elements of complex care management:
Leadership, organization support, practice teams, and flexibility

Identify Patients

When available, work with a health plan partner that can identify candidate patients via a predictive risk tool. With this information, refine the patient list based on clinician and practice team input, functional status, patient activation, and social support.

In the absence of a health plan partner, try a simple risk algorithm using existing data from payers' pay for performance reports or, if available, the organization's or practice's registry tool. Refine the patient list in the same manner described above. The American Academy of Family Physicians (AAFP) has developed a risk stratification tool you may find helpful. Titled "AAFP RSCM Rubric," it can be found at www.aafp.org. Throughout the selection process, keep in mind the need to progress from high risk/safety issues to complex to moderate interventions.

Recruit and Enroll Patients

A patient must agree to enroll in a care management program. This is required by the federal, state, and private insurers within Michigan. To review the BCBSM billing documentation guidelines, go to www.mipct.org and search for billing guidelines. Priority Health billing and documentation guidelines can be found at www.priorityhealth.com. For CMS requirements, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf. Also, search under chronic care management services.

Benefit plan limitations, payment considerations, and other factors may enter into the decision to enroll a patient in care management. Best methods for enrollment will evolve over time. Many complex patients may not be engaged in their own care due to social, financial, or behavioral health conditions or limitations. These limitations will be essential for the patient population attributed to your practice or physician organization. Having a strategic plan for managing these limitations is another key component in the care manger's assessment and care plan development process.

The use of shared decision approaches — to engage patients by asking them for input — may assist your teams with engagement barriers. With training and support, this process will improve over time. See the "Interview Guide-Initial Meeting" tool in the Care Management Guidelines Toolkit as an example.

Patient recruitment and enrollment into care management services is a practice process, and it works best when the physician and patient discuss the reasons for enrollment and referral to the care manager. A warm hand-off and introduction from the physician has been reported as a best practice, shown to improve patient response and consideration of the referral to care manager services.

Consider educating care teams about shared decision making and its value. AHRQ has a number of engagement tools for care teams and patients. You can locate this information on their website at www.ahrq.gov/, and search patient engagement.

Assess, Screen, and Stratify

Develop an initial intake and assessment process that includes establishing an initial care plan with defined goals and interventions; identify any critical care needs. For many of the fee-for-service billing codes, the assessment must include at least one in-person, face-to-face visit that includes at least 30 minutes of patient and care manager interaction. A comprehensive assessment with an accompanying plan of care, to include patient goals, should be reviewed and updated at each care manager and patient billable service interaction.

The plan of care and related implementation plan serve as the framework for encounters. The care manager should review the goals to determine continued relevance, importance, and progress. Two key factors should be reviewed at each encounter:

- Treat-to-target: Are we progressing to the clinical evidence-based goals agreed upon by the provider, patient, and care manager?
  - If not, what are the barriers prohibiting the progress?
  - Is there opportunity to overcome the barrier(s)? If not, move on. Time spent on ineffective actions does not add value to the patient, health care system, or payer.
- Need for treatment intensification: If the patient care and/or outcomes are not progressing, is there a need to alter medications, consultation, and/or the goals?

Meanwhile…

Create a Systematic Approach

Care managers need to identify, assess, and engage larger numbers of patients and providers over time. Expand the program systematically by adding targeted subsets of patients and engaging practice sites or providers over a defined period (e.g., X per month). Many patients with multiple conditions will present with complex conditions and/or issues that are difficult to manage with traditional approaches and single-disease clinical guidelines. However, guidelines are evolving to accommodate more complex patients.

For example, the Medicare and Medicaid PACE programs, the University of Washington TEAMcare model, and the University of Indiana GRACE model offer approaches. Soon to be released for public review is the COMPASS Care model, which has been tested and demonstrated with eight different partners across the nation, including Mi-CCSI partners, Lakeshore Health Network, Mercy Health Physician Partners, and Spectrum Health Medical Group. All of these models utilize a multidisciplinary approach to manage patients with multiple conditions and complex needs. Details of each program can be found at:

PACE: www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html,
GRACE: http://graceteamcare.indiana.edu/home.html
TEAMcare: www.teamcarehealth.org/

Consider the Care Model

Later in this document, approaches to complex patients, including conditions and patient characteristics that have responded to care management approaches, are discussed.

Define the Care Manager Role

The distinction between case management and care management has been an ongoing debate that still lacks clarity. National organizations offer the following definitions:

National Committee for Quality Assurance (NCQA)
"Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effectiveness."

Case Management Society of America (CMSA)
"Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes."

Centers for Medicare & Medicaid Services (CMS)
CMS provides a description of the tasks and expectations of care management rather than a definition. The following are the expectations of care management.

Chronic care management services — at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements (for the patient):

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

Robert Wood Johnson Foundation (RWJF)
Via synthesis report 19 (conducted by Thomas Bodenheimer, MD, and Rachel Berry-Millet of the Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California, San Francisco), RWJF provides a more distinct definition and offers some clarity in differentiating case management from care management. The synthesis report contains the following definitions:

Care Management – "Care management is a set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aim of improving patients' health status and reducing the need for medical services. The goals of care management are to improve patients' functional health status, enhance coordination of care, eliminate duplication of services, and reduce the need for expensive medical services."

> ***Case Management*** – "Case management often refers to a limited set of episodic services assisting patients and families in navigating the health care and social service systems with cost reduction as its primary goal."

As pointed out in the RWJF synthesis report, it is beneficial to also differentiate between disease management and population management. All of these terms are being used interchangeably in the context of case and care management, and it is helpful to establish clarity and standard language when using the terms.

> "Care management can also be contrasted with disease management and population management. Disease management tends to target one disease, while care management focuses on individuals who often have multiple chronic conditions. Population management emphasizes care and prevention required to improve the health of populations rather than of individuals, which requires stratifying the population into different risk groups depending on disease severity and choosing the best approach for each risk group."

Provide Care Management Training

Develop a plan for training that includes shadowing internal experts; 1:1 mentoring; patient engagement and communication tools; and approaches such as motivational interviewing, behavioral activation, and care transitions support training.

Mi-CCSI can assist with developing or conducting this training. Introductory level training includes workflow development and use, the history of primary care delivery models, self-management support, communication skills (intra-disciplinary and patient), introduction to motivational interviewing, transitions of care management, and review and application of the case management process using the CMSA standards of practice as a guideline.

Mi-CCSI also offers advanced training options: behavioral activation and problem-solving, collaborative care, managing depression in the PCP setting, use of PHQ testing, health care literacy and diversity, applications in care management and care plan development, and care management sustainability related to billing and coding, to mention a few. We continue to assess training and mentoring needs and develop training as appropriate.

Manage and Follow Patients

To do this effectively, consider including in the training program the following:

- Care transitions
- Patient engagement and activation
- Ongoing outreach and care coordination
- Case conferences — simple (with the primary care physician) and, when available, complex (with a multidisciplinary team)
- Ongoing communication and planning with PCPs

PATIENT IDENTIFICATION AND RISK STRATIFICATION

Narrative

Develop internal algorithms and/or a set of criteria to identify patient candidates. (MiCCSI can provide input for this.)

If your organization has access to claims data, there are several off-the-shelf, claims-based tools that produce a prospective risk score based on some combination of the following: demographics, utilization, diagnoses, medication/prescription fill information, existence of co-morbidities, and previous costs. These tools provide objective, replicable (albeit limited) methods. Therefore, it is important to refine the list of identified patients using other inputs (see the "Resources" list below).

In the absence of claims data, see the "CQC Complex Care Management Toolkit Resource" located in the Care Management Guidelines Toolkit. This is taken from the California Quality Foundation and is located at: www.calquality.org/storage/documents/CQC_ComplexCareManagement_Toolkit_Final.pdf. A basic list should include age, hospital/emergency department utilization, volume of medications, and key diagnoses, with out-of-scope, evidence-based measures.

Keep in mind:

- No approach/algorithm will be perfect. Start simple with the data you have readily available, or build a panel through PCP or post-discharge referrals only.
- Looking at the data coupled with clinical review (i.e., care team reviewing charts, PCP clinical assessments, or asking the PCPs) seems to yield the best results.
- There will be high-risk patients who are not identified using your approach. Use multiple methods to identify high-risk patients to help mitigate this risk.
- Other methods for patient identification include direct referrals from PCPs, other care managers, or health plans, as well as identification at significant care transitions.
- There will be patients identified by your approach who do not need a high-risk intervention. Further stratification and assessment should help to make these distinctions.

Resources

- Risk stratification tool (CalOptima) at: www.calquality.org/storage/documents/meteor/1.4.1CalOptima_RefinementProcess.pdf
- Identification and stratification tool (MemorialCare) at: www.calquality.org/storage/documents/meteor/1.2.1MemorialCare_PatientIdentificationRiskStratification.pdf
- Vulnerable Elders Survey (VES-13) - instrument and information at: www.rand.org/health/projects/acove/survey.html

- "Predicting the Financial Risks of Seriously Ill Patients." By Stuart Levine, MD, et al. Paper published on the California HealthCare Foundation (CHCF) website at: www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PredictiveModelingRiskStratification.pdf
- AAFP Risk-stratified Care Management at: www.aafp.org/practice-management/pcmh/initiatives/cpci/rscm.html

PATIENT SCREENING AND ASSESSMENT

Narrative

Transitions of Care

Transitions of care is a subset of care management that is independent from patient enrollment into care management services. In the context of this document, this primarily refers to the transition from hospital to home and the primary care physician practice. The actions and interventions of transitions of care, via the post-discharge follow-up call, should include the following: assess risk and safety; determine the patient's understanding and ability to complete the discharge plan; conduct medication reconciliation; and coordinate follow-up care such as the primary care post-discharge follow-up appointment, specialist appointments, treatments, and procedures. During the transitions of care follow-up, the care manager should screen the patient's status and ability to determine appropriateness for enrollment into care management.

Assessment

After patients are identified as potential candidates for care management services, consider stratifying them into different levels of interventions and outreach intensity. Use one or more of the following lists of criteria:

High Risk – Level 1: (Contact weekly, up to 4 weeks, pending stability and needs of the patient)

- Current/recent admission
- High prospective score on predictive model
- 2 or more chronic conditions with an out-of-scope value, social determinate issue, financial issue, or other factor affecting decisions/health care
- Complex behavioral health condition (mental illness) and an out-of-scope behavioral health factor
- Dual eligibility (Medicare and Medicaid) and out-of-scope or complex issues
- Provider identified; without intervention of a care manager, the patient would progress in complexity and/or result in hospitalization/ER visit(s)

High Moderate Risk – Level 2: (Contact every 1-3 months, pending stability and needs of the patient)

- Moderate/high prospective score on predictive model
- High-cost claims (provided by payers)
  Co-morbid disease management conditions (e.g., DM, Heart Failure, COPD, CAD, CVA, PVD)

Conduct patient assessments at the onset of enrollment and update them over time. For care managers it is important to be efficient AND effective; this means 1-3 contacts with patients over time to make a full assessment. In addition:

- Consider utilizing or developing a tool to assess social support, functional status, health assessment scores, and patient activation. Examples of tools already developed are:
  - Patient Centered Assessment Method (PCAM) at: www.pcamonline.org/about-pcam.html
  - Patient Activation Measure® (PAM) at: www.insigniahealth.com/products/pam-survey
- Capture psychosocial factors. They are difficult to capture in an algorithm, but they are a significant predictor of utilization. They should be included in any screening process.
- Apply clinical input. For example, send a PCP his/her list of candidate patients and ask the physician:
  - "Identify patients who you would not be surprised if they were in the emergency department or hospital in the next 6 months."
  - Or for Medicare patients, the above question and: "Identify patients who you would not be surprised if they became seriously ill or died in the next 12 months."
- Use a "no wrong door" approach. Your referral and stratification processes will not be 100% accurate, so build flexibility and expectations into your system so that staff can move patients into the program that best suits their needs.

Resources

Examples of tools:

- Assessment and stratification tool (Humboldt)
- Identification and stratification tool (MemorialCare)
- Mi-CCSI stratification tool

PATIENT MANAGEMENT (STRUCTURAL CONSIDERATIONS)

Narrative

Use continual process improvement methods to develop levels within your complex care program that vary based on severity of illness and other key factors (e.g., social support) and different levels of outreach frequency and intensity (e.g., telephone vs. in person). Some patients may be able to self-manage well with only telephone support, while others will need face-to-face visits in the home or at the clinic. Frequency of contact will vary based on the patient's complexity, conditions, and where they are in the process of care management. Newly enrolled patients require much more frequent interaction than patients who have learned to self-manage and whose conditions or circumstances have shown improvement.

Consider at a high level how your complex care program will be structured. Based on results from Medicare Coordinated Care Demonstration projects, these elements were found to be part of successful programs:

- In-person contact with patients. (This is also supported in various literature searches conducted by Mi-CCSI).
- Timely information about hospital and emergency room admissions (i.e., Admission Discharge Transfer [ADT] notification process). Currently, practices and/or systems are principally using internal system alerts and data; the limitations of this process affect timely access to critical information. For an overview of a Health Information Exchange (HIE), go to: www.healthit.gov/providers-professionals/health-information-exchange/what-hie. If the practice does not have an HIE, there should, at minimum, be a process for accessing admission and discharge information within its own system.
- Close coordination between the care manager and PCP
- Coordination of transitions of care and close follow-up subsequent to an admission/discharge (such as follow-up with specialists, with the PCP, home care, durable medical equipment)
- Patient self-management support and activation, including medication education
- Social support, including advice or direct connections to community resources that may assist patients in a variety of areas. Suggested resources include:
    - Michigan Department of Community Health at: www.michigan.gov/mdch
    - Michigan PACE Programs at: www.michigan.gov/mdch/0,4612,7-132-2945_42542_42543_42549-87437--,00.html
    - United Way 211 programs at: www.hwmuw.org/211onlinedatabase
    - Area Agency on Aging of Western Michigan at: http://aaawm1.tru-m.com/?utm_campaign=Area+Agency+on+Aging&utm_source=google&utm_medium=ppc&utm_term=%2Barea+%2Bagency+%2Baging&utm_content=1325121x531752173981718319

Care Manager Models

Complex care manager programs are typically offered in one or a combination of the following models:

Embedded Care Manager
This model contains most of the recommended elements listed above. Complex care managers are assigned to one or more dedicated practice sites and are located on site. This model promotes close coordination with primary care, but may not work well if patients are not concentrated in a few practices. A determining factor would be the number of patients with complex issues within the practice setting.

Centrally Located Care Management
Complex care managers are located at a central office and provide care to multiple practice sites. This model may not work as well as models that integrate care management with primary care upfront, but it simplifies the distribution of care manager resources across multiple sites.

Care Coordinator
A care coordinator may be an MA, LPN, or other clinical team member who functions within their defined scope of practice and is located at the practice site. This individual is supported by and accountable to a complex care manager who is centrally or regionally located. This model supports the on-site daily availability of the care coordinator for referrals and resource allocation, yet offers flexibility for managing multiple sites by the complex care manager. The case load for the complex care manager supported by a care coordinator can potentially be doubled (from 50 patients up to 100 patients).

Levels of Care Management

Some organizations have differentiated care manager services into levels. The levels may represent a certain licensure (e.g., RN vs. LPN), or the purpose of the care manager service (e.g., patient self-management support vs. care coordination and complex care planning for health improvement actions). The different levels used in the MiPCT model in Michigan are described below.

Complex Care Manager
These managers provide care management and care coordination for adult and pediatric patients with complex illness, in the primary care setting, under minimal supervision. In partnership with the primary care practice leadership team, they lead care management within the team through process improvement and workflow redesign, also providing assistance with training and delegating to other members of the team. The managers serve in an expanded health care role to collaborate with specialists, members of the health care team, and patients/families to ensure the delivery of quality, efficient, and cost-effective health care services. Complex care managers assesses, plan, implement, coordinate, monitor, and evaluate all options and services with the goal of optimizing the patient's health status. They also integrate evidence-based clinical guidelines, preventive guidelines, and protocols in the development of individualized care plans that are patient-centric, promoting quality and efficiency in the delivery of health care.

Moderate Risk Care Manager

These managers provide care management and care coordination for adult and pediatric patients with mild to moderate illness, under minimal supervision. In partnership with the primary care practice leadership team, they lead population management within the team through process improvement and workflow redesign, providing assistance with training and delegating to other members of the team. They collaborate with members of the health care team to empower patients to manage their chronic conditions, and assist patients who are at risk for developing chronic conditions to minimize these risks. These managers serve in an expanded health care role to collaborate with PCPs and patients to ensure the delivery of quality, efficient, patient-centered, and cost-effective health care services. They assess, plan, implement, monitor, and evaluate the delivery of individualized patient care with the goal of optimizing the patient's health status. These managers also provide self-management support and patient education services.

Hybrid Care Manager

In Michigan, the majority of provider groups have identified care management as a service provided to patients that should ebb and sway between complex and moderate care needs. In addition, these practices did not have sufficient population to justify having both types of care managers. The preference was to have a care manager role that provides both complex and moderate care management services. The hybrid care manager was created to meet this request.

Resources

- "The Promise of Care Coordination Models" – Summary of models that decrease hospitalizations and improve outcomes for Medicare beneficiaries at: www.mathematica-mpr.com/our-publications-and-findings/publications/the-promise-of-care-coordination-models-that-decrease-hospitalizations-and-improve-outcomes-for-beneficiaries-with-chronic-illnesses
- "Evaluation of Medicare Coordinated Care Demonstration Projects," by D. Peikes at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Schore_Fourth_Eval_MCCD_March_2011.pdf

PATIENT MANAGEMENT

Narrative

Take a broad, interdisciplinary approach to building your complex care team. Build on what you have and align with the needs of the patients you are managing.

- Typical care teams consist of a nurse care manager who has responsibility for the care management of a patient in partnership with the patient's PCP. Support from a social worker, behavioral health specialist, and other care providers (e.g., respiratory therapist, occupational therapist, physical therapist) can be utilized as necessary.
- The "right" care manager / patient ratios will evolve over time as your program matures.
- The ratios will vary based on your population and acuity levels. Panels tend to be larger with commercial patients than with Medicare or Medicaid patients due to complex issues such as multiple chronic conditions, care coordination, and social issues.
- A common ratio seen in complex care programs is one care manager per 200 commercial patients, or one care manager per 50-60 highest-acuity patients. Analyze the particular needs of your population by looking at top diagnoses and top causes for admission to determine the need for added specialty support. For example, frail elders or homebound patients might need a respiratory therapist for COPD or home health support.
- If fully dedicated behavioral health and social work resources are not available, work with these types of organizations or, if they exist in the system, departments to designate an individual to be your complex care program's point of contact.
- Consider using one dedicated medical director (or physician advocate/champion) for the program who can work with a number of care teams and contribute clinical oversight and guidance, especially for case review and triage. This may be more effective than having a series of part-time physicians per team. (Note that this aligns with multidisciplinary models if psychiatry and/or potentially other specialists are involved. Examples of these models are the TEAMcare, DIAMOND, and GRACE models.

Promote face-to-face interaction between care managers and their patients.

- The first care management visit is ideally face-to-face; if possible, a warm handoff should be arranged from the PCP. The PCP should explain to the patient the importance and value of the care manager program.
- If management is primarily by telephone for lower acuity patients, initiate the relationship with a scheduled physician clinic visit. Another option would be to attend a PCP visit with the patient to build a foundation for the relationship.
- If care managers are centrally located, designate certain times and days of week where they can visit practice sites on a rotating basis to meet with patients and providers in person, and/or have a care navigator who is part of the care team.

Emphasize patient self-management techniques and include the patient's support system.

Care Transitions – Transitions of Care (TOC) Support

- Use hospital or HIE alerts for notification of emergency department (ED) or hospital admissions (preference is real time or near real time).
- Conduct a daily admissions and ED census review with relevant parties to ensure that important, nonclinical information is transferred from one provider to another.
- Review the admission and ED list to identify patients that would benefit from care manager follow-up regarding issues related to medical management (not access to care, as this is a team issue).
- Contact patients 24-48 hours post discharge.
- Conduct a comprehensive medication reconciliation that includes all prescribers, over-the-counter and homeopathic/supplement remedies, and any means of administration (oral, topical, drops, suppository, respiratory, etc.). An example can be found on the AHRQ web-site. See the AHRQ Brown Bag method of medication reconciliation for a best practice approach.
- To facilitate safe and smooth care transitions, some provider organizations have employed:
    - Inpatient care managers or hospitalist coordinators to conduct daily inpatient reviews; meet with hospitalists, any independent physicians, specialists, or surgeons; facilitate care; educate and manage patients; and ensure that follow-up care is arranged.
    - Associate medical directors with inpatient responsibilities to conduct daily inpatient discharge rounds with care managers and hospitalists, and to conduct weekly phone rounds with skilled nursing facility (SNF) staff.
    - Communication standards and protocols from the hospitalist to the PCP.

More advanced transitions of care go beyond acute care to primary care transitions. Consider the next level of transition, which is from hospital to SNF and, if applicable, back to the primary care office. These transitions will require engaged leadership, developing relationships, and being explicit about expectations to ensure high-quality care at the SNF.

- Schedule quarterly meetings (with the SNF's administrator, director of nursing, physical therapists, discharge planners, etc.) to build relationships, improve communication, discuss cases, and improve transition processes.
- Consider assigning a care manager with responsibility for SNF patients.
- Develop a SNF dashboard with measures such as admission rates, readmission rates, ED visit rates, appeals, grievances, and member satisfaction. Display the performance of other SNFs used.

Care Conferences for Patient Management

Use virtual or in-person multidisciplinary care conferences to facilitate communication among all providers caring for a patient, identify additional resources needed, discuss care level transitions within the complex care program, and modify the individualized care plan as necessary.

- Include complex care managers, social workers, PCPs, medical directors/physician champions, specialists, behavioral health specialists on an as-needed basis. The benefit of including specialists is that they can help educate the team and build competencies. (This

aligns with the TEAMcare and/or COMPASS model. See details by visiting https://www.icsi.org/health_initiatives/compass_mind_and_body_health/)

- Reach out to PCPs in advance of case conferences to invite them to attend. Explain the purpose of the conference, and ensure them they are not "losing" control of their patient.
- Hold the conferences on a biweekly or monthly basis for 1.5-2 hours each (could be weekly depending on patient counts and complexity).
- If possible, rotate the locations of the meetings among practice sites to engage different providers, or hold them in a central location.
- Consider requiring the care managers to use a formal process for reporting such as the "SBAR" format (Situation, Background, Assessment, and Recommendation). For a sample format, go to the MiCCSI website and search for care management training tools – SBAR reporting tool.

Provider organizations have found it helpful to expose care managers to the concepts of advance health care planning and make resources available internally. This promotes meaningful conversations with patients when considering their wishes regarding end-of-life care and selecting a surrogate decision maker.

CARE MANAGER AND CARE TEAM ROLES AND TRAINING

Narrative

Develop a complex care manager job description and set of expectations that includes the following key components:

- As the manager of the patient's care, take the initiative in collaborative relationships to coordinate care manager services with physicians and patients; delegate, direct, and coordinate in a leadership role.
- Set the expectation that care managers have a dual role. They must function as an advocate to manage patient needs and maintain contact with the PCP. PCPs must be able to see the notes from care manager discussions.
- Prioritize support for patients currently in the hospital or ED, or currently in the discharge process. Care transitions are critical life moments when patients develop or lose trust in the system.
- For the patients the care manager has enrolled into CM services, daily work includes the following:
    - Triage incoming phone calls
    - Check upcoming appointments for potential patients to meet and recruit them
    - Check upcoming appointments for existing patients to meet them face-to-face
    - Conduct intake visits
    - Place recruitment and outreach calls
    - Coordinate care
    - Handle pre-visit planning

Some programs have found it more efficient to have an unlicensed individual handle administrative tasks such as making appointments, under the direction of the care manager, rather than use valuable nurse care manager time. This is a team process, which requires thought and the development of workflows.

Hiring a Care Manager

When hiring care managers, use a case scenario interview approach and involve a team in the interview process.

- Use case competencies in the interview process. Give several case studies to candidates about one week before the interview. Then use those case competencies to drive questions and discussion in the interview. There are no right or wrong answers, but this helps to assess candidates' critical thinking and their mindset. It also helps to tailor the training if they are hired.
- Involve a team of people in the interview process, such as peers, direct managers, upper management, clinic managers, and other nurses.
- Inquire about the candidates' understanding of the role and the reason they are pursuing the position.

- Assess the individual's ability to independently conduct care management with minimal direction and oversight, yet value the importance of working within multiple levels of team members.

Training

Develop and offer training modules over time for new and existing care managers that include the following components.

- Provide orientation training that covers basics, such as case management software/EMR, how to enroll a patient, and how to conduct an intake and assessment.
- Provide motivational interviewing training, behavioral activation training, care transitions training, and proactive planning and management over a period of time, but within the first 3 months.
- Provide 1:1 support and training for the first 3 months. For example, each week have a care manager or leader sit down to review cases with the trainee.
- Have trainees shadow content experts in the first couple of weeks after hire, such as disease management leads, diabetes educators, and congestive heart failure clinic leads.
- Have trainees shadow more experienced care managers according to their strengths. Have them complete an intake and routine follow-up call, home visit, clinic visit, and/or hospital visit together.
- Meet 1:1 with each of the department heads that interface with the complex disease program. Discuss how the departments interact and mutual expectations.
- Partner a new care manager with a mentor over the course of 3-6 months, so the new arrival has a dedicated resource. It might be necessary to bring in temporary resources to assist the mentor during this period.
- Ramp up the responsibilities and caseload of the care manager over time. For example, have the new care manager be responsible for only recruitment phone calls and scheduling intake visits during the first couple weeks. Do not have the trainee be responsible for on-call for the first 3 months; only do home visits with peers during that time.
- Orient the care manager to the workflow and processes within the care team setting.
- Define how the care manager role fits within the team functions.

Promote face-to-face interaction between members of the care team to build strong relationships and trust and to facilitate communication about patients. Utilize routine, in-person, multidisciplinary case conferences. Co-locate care managers in primary care offices, or make sure care managers are present at primary care offices at regular intervals.

Create a system for internal sharing of best practices and peer support. This increases internal consistency, facilitates purposeful cross-fertilization, and supports care managers.

- Recognize burn-out and staff fatigue. Provide support for your staff, just as you provide care to your patients and their caregivers.

- Implement weekly huddle calls (15-30 minutes in length) with the complex care team to discuss what is going well, what is not going well, and what barriers management can break down so that care managers can focus on their patients.
- Train care teams **i**n effective facilitation and communication skills and role clarification. Use scenarios and case-based learning (i.e., case scenario examples and responses).

PHYSICIAN AND OFFICE STAFF ENGAGEMENT

Narrative

Identify a physician champion or medical director to pave the way in conversations with physicians to recruit them to participate in the program. Solicit input from physicians and care management staff in the development of the program.

The organization's leadership and physician champion should meet face-to-face with providers to educate them on the plan for a complex care program.

- Share information about how complex care programs have worked in other geographical regions. Share with the physician the problems/issues driving a need for change and the purpose and current state that require a vision of the end state; also share a roadmap with milestones of how you will get there.
- Discuss one or more of that physician's patients as examples. Prod physicians to think about what it would mean to have a care manager involved in their patients' care as a way of demonstrating how the program can be of value to them. Come prepared with talking points. They are likely to be curious about how the high-risk patients were identified. Give them the opportunity to make referrals themselves.
- Elicit the providers' and care teams' input and thoughts on how care management will work in their practice. Providers will want to be engaged in different ways. For some, a 1:1 conversation will work, whereas others may prefer a group discussion.
- Practice respectful listening in these conversations.
- Review the financial implications and impact on the practice delivery model.
- Start with high-volume providers.
- No matter how many times you have spoken with a provider regarding your program, always start from the beginning.

After you have a list of candidates for your complex care program, engage the practice in refining the target list of patients. Ask the physician to rank the patients on the list. Which are the best candidates for care management, and which are the least? (If applicable, ask the office manager to confirm whether the patient attribution using claims is correct.)

Maintain partnership and communication between the complex care manager and the PCP by:

- Utilizing virtual case conferences; invite PCPs to attend, either in person or on the phone
- Ensuring that PCPs have access to notes from care manager appointments
- Considering co-location or designated times for the care manager to be on site

Share successes internally with physicians, office staff, and care management staff so they see progress. Anecdotes and case studies can build support and enthusiasm.

PATIENT ENGAGEMENT AND ENROLLMENT

Narrative

Have the physician office staff lead recruitment of patients into the program, rather than any central IPA (independent physician association) staff or the physician. Patients grow concerned when they receive a call from the physician, and they associate office staff with the practice.

- Introduction to the program by the PCP/PCP's office staff improves enrollment and trust in the program.
- An initial call by the PCP's office, followed by a letter on the physician office's letterhead, then followed by a call from the care manager to enroll the patient is a good starting point for recruitment. However, this may require testing and refinement.
- Be flexible because patients may prefer different approaches to enrollment and outreach.
- Consider using an "enrollment specialist" instead of the care manager to make the initial recruitment call and schedule the first visit.

Stagger outreach to patients for recruitment to smooth out demand for intake and assessment of these patients. Give office staff a list of 5-15 patients at a time, for example. After the physician's office reaches out to the patient, follow up very soon after to enroll or the patient will forget.

Words matter. Involve patients in your communication strategy.

- Solicit feedback from patients on your program's logo, name, recruitment process, and materials, such as enrollment letters. For example, Humboldt learned that calling "Priority Care" a service, rather than a program, appealed more to patients.
- Get continual feedback from patients.
- Train patients to be a part of team meetings.

Changes to Try

Develop an intake process that includes these key components:

- Conduct an initial assessment.
- Establish an initial care plan and identify goals using a patient-centered approach.
- Identify any critical care plan needs and initiate action.

The initial visit is very important to build a relationship, identify strengths and barriers, and establish the trust of the patient as a key partner and team member in the process. Have it face-to-face as a home visit or at the hospital or clinic, for example.

Reinforce patient self-care and self-management, especially through motivational interviewing.

- Set short-term and long-term goals.
- Pay attention to the patient's emotional well-being and look for anger and hopelessness.
- Demonstrate empathy, listen to the patient, and validate the patient's feelings and concerns; these are effective interventions in and of themselves.

- Make sure patients/families are part of the plan of care and that they understand what to expect in terms of health improvement, holding steady, or palliation.

If possible, develop a simple "flag" system in your EHR to alert the physician or medical assistant if a patient comes in who is being followed by care management, has refused care management, or cannot be reached to discuss care management. This will alert the physician to have a conversation with the patient that reinforces the availability and benefits of complex care management. Develop flyers for the physician to use to explain the program.

MEASUREMENT PLAN

Narrative

Measurement must start at the beginning, not at the end. Gather baseline data prior to starting your intervention, then chart data over time on run charts.

A comprehensive approach for measuring the effectiveness of high-risk programs is to track the total cost of care for your entire patient population. This holds you to a higher standard, but avoids the mistake of taking credit for regression to the mean for a subset of the population. (Regression to the mean is a probability term; left to themselves, things tend to return to normal or average. In the case of complex patients, some will naturally improve, especially if the highest cost cases are sampled. It is easy to attribute improvement in this population to a particular intervention, when it is actually an artifact of sampling.)

Changes to Try

Develop a measurement plan. Consider the following domains and example measures, and refine them based on your data availability.

Cost and Utilization

- Total cost of care
- Hospital and emergency department utilization (admits or bed days)
- Daytime emergency department use
- Readmission rates
- Ambulatory-care sensitive admissions

Clinical Quality

- Diabetes control, blood pressure control, LDL control (examples)
- Depression screening, such as PHQ9
- Medication adherence
- Patient experience and engagement
- Patient experience survey results, such as the CHAPS
- Functional assessment surveys, such as SF-12
- Patient Activation Measure (PAM)
- Provider and care team experience
- Provider experience survey results

Process Measures

- % of patients receiving outreach call within 48 hours of emergency department discharge or hospital admission
- % of patients with PCP visit within 7 days of discharge
- Accept/decline rates for care management services
- Time interval from referral to intake visit (specialist referrals)
- Referral origin

- Number of care manager contacts per reporting period
- Number of cases reviewed with the care team per reporting period

Finally, gather and document anecdotes and stories about your program.

NOTE: See the "Care Management Guidelines Toolkit" for examples and templates mentioned throughout this document.

RESOURCES

Agency for Healthcare Research and Quality (AHRQ): www.ahrq.gov/

American Academy of Family Physicians (AAFP): www.aafp.org

Area Agency on Aging of Western Michigan: http://aaawm1.tru-m.com/?utm_campaign=Area+Agency+on+Aging&utm_source=google&utm_medium=ppc&utm_term=%2Barea+%2Bagency+%2Baging&utm_content=1325121x531752173981718319

BCBSM Billing Guidelines: www.mipct.org

California HealthCare Foundation (CHCF): www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PredictiveModelingRiskStratification.pdf

California Quality Foundation: www.calquality.org/storage/documents/CQC_ComplexCareManagement_Toolkit_Final.pdf

CalOptima: www.calquality.org/storage/documents/meteor/1.4.1CalOptima_RefinementProcess.pdf

Case Management Society of America: www.cmsa.org

Centers for Medicare & Medicaid Services (CMS) Billing Guidelines: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf

COMPASS: https://www.icsi.org/health_initiatives/compass_mind_and_body_health/

"Evaluation of Medicare Coordinated Care Demonstration Projects": https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Schore_Fourth_Eval_MCCD_March_2011.pdf

GRACE: http://graceteamcare.indiana.edu/home.html

Health Information Exchange (HIE): www.healthit.gov/providers-professionals/health-information-exchange/what-hie

MemorialCare: www.calquality.org/storage/documents/meteor/1.2.1MemorialCare_PatientIdentificationRiskStratification.pdf

Mi-CCSI: www.miccsi.org

Michigan Department of Community Health: www.michigan.gov/mdch

Michigan PACE Programs: www.michigan.gov/mdch/0,4612,7-132-2945_42542_42543_42549-87437--,00.html

Michigan Primary Care Transformation Project (MiPCT): www.mipct.org

PACE: www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html,

Patient Activation Measure (PAM): www.insigniahealth.com/products/pam-survey

Patient Centered Assessment Method (PCAM): www.pcamonline.org/about-pcam.html

Priority Health Billing Guidelines: www.priorityhealth.com

"The Promise of Care Coordination Models": www.mathematica-mpr.com/our-publications-and-findings/publications/the-promise-of-care-coordination-models-that-decrease-hospitalizations-and-improve-outcomes-for-beneficiaries-with-chronic-illnesses

TEAMcare: www.teamcarehealth.org/

United Way 211 programs: www.hwmuw.org/211onlinedatabase

Vulnerable Elders Survey (VES-13): www.rand.org/health/projects/acove/survey.html