CARE MANAGEMENT TOOLKIT

Created by and for Care Managers

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MICHIGAN CENTER FOR CLINICAL SYSTEMS IMPROVEMENT
www.miccsi.org

Mi-CCSI Care Management Guidelines Toolkit

Tool 1: Sample Consent – Participating in CM Services

*Information Page and **CONSENT** for Case Management services*

Patient's Name: _____DOB:_____

Dr. _____ recommended you for case management services.

Healthcare today can be confusing, especially when dealing with a chronic illness. And each individual comes with a unique situation and personal set of goals and ideas. Case Management is a process used to determine and coordinate the appropriate aspects of individualized care.

The goal of *case management* is to help you manage your health and bring about a better quality of life. As your "case" or care manager, I will be working with you and Dr. _____ to identify your healthcare needs and set up a plan of care that is right for you.

Case management is patient-centered and voluntary. If you decide to participate, it will be important for me to learn more about what is important to you. Together, we can explore various treatment options and decide how to proceed. As your advocate, I will be in communication with your healthcare team so that we are all on the right (same) track. (Your organization may want to include who is on the healthcare team in this section).

I will also be in regular contact with you to check how your plan is working and, with your input, make changes if needed. As your health improves and you gain confidence with your own self-management, case management services will no longer be necessary.

We offer case management as a service to our patients, but your insurance company may require a copayment for this. (This can be checked out before proceeding.)

[ ] I agree to participate in Case Management services.

Signature: _____ Date: _____

CM Name: _____Phone Number:_____

Tool 2: Advance Beneficiary Notice (ABN)

If a patient has original Medicare and the doctor, other health care provider, or supplier thinks Medicare probably (or certainly) won't pay for items or services, they may give the patient a written notice called an "Advance Beneficiary Notice of Noncoverage" (ABN). However, an ABN isn't required for items or services that Medicare never covers.

For detailed information and ABN templates, go to:
https://www.medicare.gov/claims-and-appeals/medicare-rights/abn/advance-notice-of-noncoverage.html

Tool 3: Interview Guide – Initial Meeting

Introduction of CM Service

Greet patient:

- Your name, title, and role
- Ask if the patient has time available and for permission to conduct an initial intake interview

Explore the patient's understanding of the reason for the referral to care management:

- In your words, explain the reasons you have been referred for care management services
- Thank the patient for sharing
- Ask permission to explain your understanding of the referral; validate and review any misunderstandings

Explore any barriers, social or financial, that might impact the patient's ability to participate in care management:

- If there are copayments for CM services, will this impact the decision to participate?
- Will there be any issues, such as time or transportation that will impact their ability to participate?

Explore the Patient's Knowledge of the Condition or Situation

Example Condition Intake Assessments Below

Chronic Disease Assessment:
Diabetes

- Management of diabetes can be very difficult. How is it going for you? Explore:
    - Taking your medications regularly and at the prescribed times
    - Usual eating pattern
    - Blood glucose testing
    - Usual activity routine
- You've identified a number of challenges with your diabetes routines. Which would you see as a priority?
- Which would you like to talk about first?
    - On a scale of 1-5, how confident are you that you can make adjustments or changes with your (medication routine, diet, activity, blood sugar testing):
        - _____(First choice)
        - _____ (Second choice)
- If the patient has priorities different from those that are high risk:
    - I'd like to share some concerns the provider/care manager has identified as a priority. Could we take a few minutes to review that?
    - After sharing:
        - What are your thoughts about this information?

Cardiac Risk Reduction Assessment:

Smoking Cessation

- Validate current status. Your chart indicates that you smoke.
    - Can you share with me your smoking routine?
    - Share with me your understanding of the tie between smoking and diabetes/heart disease.
    - If there is knowledge lacking or misunderstood:
        - Could I take a few minutes to review some information that has been researched and identified as health risks?
    - If the information is accurate and/or you have been provided permission to share:
        - Have you ever considered quitting?
    - If the answer is yes:
        - As you and I work together, we will include this in the plan of care.
    - If the answer is no:
        - Thank you for being honest. As we work together, I will check in to see if your decision has changed, and when you are ready, we can review options or steps to start with.

Elevated Blood Pressure

- When I say you have high blood pressure, what does that mean to you?
- Information check-in:
    - Share with me your understanding of the tie between elevated blood pressure and heart disease:
        - Have you and Dr. _____ set a target for your blood pressure? Y N
          If no – this is a f/u action for the care manager
    - Share with me your ideas of what you can do to help your blood pressure stay in control (provide the patient with the values the physician has targeted for this patient – e.g., below 130/90).
    - One way to be aware of your values is to take your blood pressure at home. Would you be willing to do this? Y N
        - If yes, establish a plan for home BP monitoring and tracking

Depression Assessment:

Screening

- Complete a PHQ-9
    - You completed this test, called the PHQ-9. Based on the results, the provider completed an assessment to determine if you have depression. The PHQ9 screening test and assessment indicate you do have (Mild, Moderate, or Severe Depression).
    - **If question 9 is a 1, 2, or 3, ask about suicide thoughts, plans, actions, and prevention. Consult with provider and if available psychiatric supervisor/consultant.**
    - No positive screening indicators of suicide:
        - Share with me your understanding of the diagnosis of depression
    - If the patient's description is accurate:
        - Review the provider treatment plan

Treatment Options

- Treatment plan includes starting new anti-depressant medications:
    - Review the patient's understanding of the medications
        - How they work
        - Possible side effects and concerns
        - Anticipated time before they reach full effectiveness
- Treatment plan includes counseling:
    - Review the patient's understanding of the counseling process
        - Goals
        - What to expect
        - Contact information and referral process

Medication Reconciliation (all patients, all conditions, and at all touch points):

- Let's take some time to check our clinic information and make sure the medications are written correctly
- It's hard for most of us to take our medications every day. How are you doing with_____?
    - Check each medication for dosage, timing, route, and number of times taken in the last week
    - Address any discrepancies

Shared Decision Making:

Brainstorm range of options

- What is currently working well?
    - Is the patient interested in hearing options that have worked for other patients? Y N
- If yes, share options/ideas
- What else does the patient think might be helpful?

Are there key barriers to care?

- Financial
- Social
- Behavioral
- Lack of support
- Readiness to change/engagement
- Other

Where would the patient like to start with the plan of care?

- Define
- Brainstorm multiple solutions
- Evaluate pros and cons
- Does the patient need information to help make the plan?
- Identify priority goals for the plan of care
- Identify parts or steps of the plan to prioritize
- Choose and define the beginning steps
- Rate the importance and confidence level of each plan item

Visit Closure

- Remind patient of any outstanding tests or follow-up actions
- Complete care plan and review
- Set up next call or face-to-face appointment

Tool 4: Follow-up Visit/Call to Initial Interview/Introduction

Introduce yourself: Recap who you are and your relationship with the provider, your role, and the care management service.

Confirm availability and amount of time: The last time we met/talked I agreed to call you at this time. Is this still and good time? Yes. Proceed. No. Reschedule. I have about 30 minutes for the call/visit. Does this work for you? Yes. Proceed. No. Adjust time to meet the patient's availability.

Review agenda: At our last visit/call we discussed_____. I would like to review _____ at this time. Is there anything you would like me to include in the agenda that I haven't mentioned? Yes. Add to agenda. No. Proceed.

Update changes: Since we last met/talked have you had any changes, visits, or other care that would be important for the healthcare team to know about? Examples would be a visit with a specialist, changes in medications, urgent care visit, ER, or hospitalization. No. Proceed. Yes. Review the event and notify the provider.

Review the plan of care: Each time we speak, I will be referencing the plan of care we began. Do you have your copy available? Yes. Proceed. No. I'll read through my copy, and I'll send/provide you with another copy after the visit/call.

Determine actions for plan of care based on the following:

- Making progress – goals not fully met – continue with current plan of care
- Making progress – goals not fully met – needs adjusting – agree on changes and provide an updated copy
- No progress – determine if goals need changing – make changes – provide an updated copy
- No progress – patient not interested – hold – discuss continuation with PCP

Reconcile medication: Ask the patient to locate their medication list or pill bottles. Conduct the medication reconciliation process. Use open-ended questions. Normalize and provide an environment where patients can be open/honest when they have not taken medications directly as prescribed. Any discrepancies? No. Proceed to next steps. Yes. Follow up with the physician/provider to determine next steps.

Review or conduct screening as appropriate: Specific to the condition(s) the patient has, conduct screening to obtain current status. Examples: PHQ9 for depression, Blood Sugars or A1C for diabetics, Blood Pressure for HTN, Fluids/weights for heart failure.

Review results of the screening:

- Improvement – acknowledge and explore reasons for success – continue
- Same – use behavioral activation and problem-solving to begin positive forward movement

- Worse – explore reasons, use BA and PST, follow up with the PCP to determine need to treatment adjustments

Close the call: Review call and actions. Determine interval for next visit/call. Thank patient for time and commitment to their health. If the plan of care changed, provide a new copy to the patient at the visit, through a portal, or via mail.

Tool 5: Initial Assessment Template

Simple Patient Assessment – Talking Points

Pt Identification

Reason for Referral:

Screen/Assess

Current Status: *What is going on today? Patient's concerns; Cognition, VS, Wt/BMI, latest lab work*
How are you feeling? Physical, psychological, sleep, appetite, affect/mood, comfort, sensory impairments

Pertinent History: *Comorbid conditions; recent hospitalizations?*

Other Providers/Specialists: *Who/why? Scheduled appointments?*

Medications: *What/Why? (Check med rec) Are there issues (adherence, side effects, and financial barriers)?*

Life Style: *What is going on at home? ADL needs/problems? ("Food, clothing, shelter"), using DME? Smoking?*
Issues with transportation, job, childcare, stresses, support persons, employment/insurance coverage
Does patient have an ACP?

Literacy/Readiness to Change/Educational Opportunities:

Plan

PLAN OF CARE based on Patient's Understanding and Agreement:

Desired Outcome/s: *"_____as evidenced by…"* **(These are the SMART Goals) Patient-Centric Goals**

Problems: *What is keeping patient from achieving desired outcome?*

Actions: *What can be done to solve problems identified above? (These can be patient ideas or evidence based.)*
Who will be responsible for these actions? (Patient and/or Case Manager?)

Barriers: *What, if anything, stands in the way of accomplishing above-stated actions? (Can these be mitigated?)*

Care Coordination Needs: *Referrals, services, community resources, a different level - care management*

Knowledge Deficits/Teaching Needs: *What patient education was provided, and what was the patient's understanding of that education? (Use of teach-back)*

Evaluate

Progress Toward Goals: *Ongoing monitoring of the effectiveness of the Plan of Care (changes may be needed)*

Follow-up/Monitor: *When/how: Call or visit? What will be discussed/the goal for that interaction? Assess progress toward goals, use of treat-to-target, and assessing the need for treatment intensification*

Case Review with PCP: *Communication with PCP and/or other members of team as needed*

- *Pt making progress – anticipate discontinuing CM services and returning monitoring to care team*
- *Pt not progressing – identify barriers and review:*
  - *Need for treatment intensification*
  - *Pt engagement indicates timing for CM ineffective*
  - *Care needs have changed – need for other level of services/care management, etc.*

Based on the case review recommendations, continue follow-up/monitoring or prepare and/or proceed to case closure process

Tool 6: Letter Templates

Template a.
Outreach Phone Script and Protocol Sample

Before Calling:

- Check HIPPA document; allowed to leave voicemail?
- Do they still qualify? If the month has changed over, check insurance; if they have had another appointment, double-check labs.

If NO pick-up:

If detailed message IS permitted according to HIPPA document, leave voicemail:

Staff: "Hi my name is _____. I am calling from _____ about the _____ Care Management program. We sent you a letter about the care management program in the mail, and I was just calling to see if you got the letter, if you were interested in participating, or if you had any questions. In any case, even if you are not interested or did not receive the letter, please give me a call back at _____."

If message IS NOT permitted according to HIPPA document, hang up.

In either case, document your call in the medical record (paper or the electronic health record).
"Called patient re: Care Management on (date); left voicemail asking for call back."

If the patient picks up:

Staff: "Hello, my name is _____ and I'm calling from _____. Is this (patient's name)?"

Response: If yes, proceed.

Template b.
Program Introduction Template

Dear _____

We are writing to tell you about a new care management program that you qualify for at _____.

Care management can help improve the health of patients like you who have diabetes, _____, and/or heart disease. We want to offer this program to patients who might need extra help managing these health problems.

This care management program allows you to work closely with a care manager, who is a nurse or social worker. The care manager can assist you in figuring out ways to make changes to your health, ensure that all your care providers understand your needs, and help you deal with some of the stresses that may be interfering with getting better. Your primary care provider (PCP), _____ , would like you to consider this program, although it is voluntary. This program is in addition to the care you receive from your PCP, who will still be your main provider.

If you have any questions about care management or if you are interested in scheduling your first appointment with a care manager, please call_____ at _____. They can tell you more about the program and schedule your initial interview if you are interested. If we do not hear from you, we will call you within two weeks to follow up and see if you would like to schedule an appointment.

Thank you for considering this new program, and for choosing _____.

Sincerely,

CM name, credentials
Phone/Address

Template c.

Enrollment Letter Template

(To be used after the patient meets with the CM and agrees to CM services)

Dear_____

I am writing to welcome you into the care management program at _____. Together, you the patient, your provider _____, and I the care manager will work closely together to figure out ways to make changes to your health. We will assess your needs and strengths and look for ways to better your health.

At our initial meeting we started putting together a plan of care. This plan will guide us in determining if we are making progress or if we need to make adjustments. Please be prepared to review this plan each time we meet or speak on the phone.

What you can expect at each call:

- Review of medications
- Review of the plan of care
- Evaluation of _____ screening tests, blood sugars, weights, etc.

At the end of each visit/call we will discuss next steps, which include actions you will take and actions the care team will take. We will also set up the next call/visit.

I'm looking forward to partnering with you. Please let me know if you have any questions. Our next call/visit is scheduled to occur on _____ (date).

Respectfully,

CM Name
Phone/email portal address

Template d.
Update Letter

Dear _____

I am writing to update you on the progress you've made so far with your health using the care management service.

As a team, we have been working on a care plan to improve your _____condition(s). The current levels indicate that you are (choose 1) making good progress, holding steady, your care is getting more concerning.

Your results: (use evidence-based and agreed upon intervals by PCP, CM, and patient)
PHQ trending at *1 month* intervals
A1C trending at *3 month* intervals
BP trending at *1 month* intervals

Based on the results and progress, the team at _____ would like you to continue to participate in the care management service. If you have any questions about this, please call me. If I do not hear from you, I will plan to call you at our scheduled call/visit on_____.

Respectfully,

CM Name
Phone/email portal address

Template e.
Unable to Reach Letter

Dear _____,

On ##/##/##, you completed an assessment as part of our care management program for patients with complex medical conditions. You spoke with a care manager a few times to follow up, the last of which was on ##/##/##. I would like to continue working with you regarding the health concerns you and your primary care provider have identified to create a personal health care plan for you.

I have tried to contact you by phone to discuss your health care plan, but have not been able to reach you. Please call me at (###) ###-#### to let me know if you would like to continue receiving services through our care management program.

You can also call (Clinic Name) at (###) ###-#### to update your contact information.

Respectfully,

CM Name
Phone/email portal address

Template f.

Case Closure Letter - Graduation

Dear_____,

Congratulations on your great accomplishment! We have been working together since _____(date). Together, we created a plan of care to improve your healthcare. Over the last few months you have been able to maintain the goals we agreed on and have been able to achieve this with minimal support from the team.

The plan is to now graduate you from the care management services and have you return to the clinic for regular monitoring.

The self-management action plan is for you to review and use to maintain your health goals. If you find this is isn't going well and you would like to review questions or concerns with the care manager, please use the contact information provided on the self-management action plan.

Your healthcare team congratulates you on your success!

Respectfully,

CM Name
Phone/email portal address

Template g.

Case Closure Letter – Unable to Reach

Dear _____,

On ##/##/## I sent you a letter asking you to call or visit the clinic to follow up on the care management services. I have tried to call you on _____ (dates).

As I have not heard from you, your care team has decided it best to discontinue the care management services offered to you.

This does not impact your care with the practice. You will continue receiving care from _____ clinic.

If you would like to have the care management services restarted, please discuss this with your provider at the next scheduled visit.

I wish you the best,

CM Name
Phone/email portal address

Tool 7: CM Process – Prescreening

Chart Review for Eligibility – Prescreening

1. Medical Screening Examples by Condition

Clinical Lab Values and Diagnoses
Check for evidence of substantial chronic disease in poor control. Example: Lab Values A1C (>8); BP (SBP >160, DBP>100); LDL (>100 for CVD or >130 for DM).

Screening Coronary Artery Disease
CAD (aka ischemic, aka atherosclerosis if related to coronary arteries), view patient's most recent cardiology consult and look for the following: cardiac catheterization, stent, CABG, h/o STEMI (ST segment Elevation Myocardial Infarction) or Non-STEMI. If you find any of this language, YES (patient qualifies). If not present, you may need to conference with the PCP to request clarification of diagnosis. If unable to obtain cardiac consult, NO (patient does not qualify).

Heart Failure
If HF (aka cardiomyopathy), view patient's most recent cardiology consult and look for the following: 2D echocardiogram, CHF, and/or heart failure or ejection fraction. If ejection fraction <50% then YES, if greater than 50% NO.

Cerebrovascular Accident
If CVA (aka stroke), view most recent neurology consult or MRI report and look for the following: CVA, chronic infarcts. If present, YES. If DM, be sure that patient has one of the following to confirm: diabetes diagnosis, A1C >8, currently on DM medications.

COPD
If chronic obstructive pulmonary disease, view the patient's record for recent admissions, ER, or urgent care visits. Related to bronchitis or other complications associated with COPD? If yes, review medications and treatment plans from all providers involved in the patients care. Review the chart for the COPD Action plan. One in place? If yes, review the action plan with the patient to determine understanding and ability to follow. Would this patient benefit from CM services? If yes, begin enrollment process. If no action plan in place, review with the PCP and determine if CM services are appropriate. If yes, begin enrollment process.

2. Behavioral Health Screening

Depression Screening
Check most recent PHQ-9 results (if applicable). If >9, YES. If <9, NO. If there are no PHQ-9 results for the patient in EMR, mail a questionnaire to the patient or complete one over the phone with them to see if they qualify.

Anxiety Screening
Check to most recent GAD-7 results (if applicable). If $\geq$ 10 possible anxiety. Confirm with further evaluation. If anxiety confirmed, YES.

Substance Use
Review the substance use screening tools supported within your organization. Examples may be:
Audit (Alcohol Use Disorders Identification Tool). A score of 8 or more indicates harmful drinking.
Cage Aid. A score of 1 or more indicates a positive screening.
DAST- 20. A score of 20 indicates a positive screening requiring further evaluation.

3. Patient's Current Insurance Eligibility

Check the patient's insurance for the name of the payer.

- Does the payer have products that cover the service of care management? YES. Proceed to next step.
- Is the payer product included in the care management service coverage? YES. Proceed with next steps for enrollment.
- If the patient does not have insurance coverage, is the patient willing to self-pay? YES. Proceed to next steps.
- NO to any of the above requires discussion within the healthcare system or practice to determine how non-coverage for care management service eligibility will impact the practice.

4. Active Outreach

- Send a CM introduction letter to those who qualify. (Optional). Describe the why. Patients qualify based on such decisions of diagnoses, lab values, PHQ-9, AND insurance.
- Next steps. Start calling patients around one week after sending letter to assess if they have questions or would like to schedule an appointment for care management.

5. Initial Health Assessment (IHA) with Care Manager

- Send a message or schedule a case review with the physician to inform them of the appointment and the patient's qualifying criteria.
- Confirm the patient is appropriate to enroll into care management service.
- Obtain permission from the patient to enroll them into care management services, document this in the medical record, and/or obtain signature on an enrollment agreement form.
- Add the patient to the care manager's caseload in the organization's CM Tracking System or in a manual tracking tool.
- If the patient would like a reminder call for IHA, call them the business day before the appt.

6. For IHA No-Shows . . .

- Attempt to call the patient up to three times on different days and times. Consider sending an additional letter. If still no response, review this with the provider to determine appropriateness for case closure. If yes, remove from list.
- If there is no accurate address or phone number in the EMR, review the schedule to see if the patient is scheduled for an appointment within the next few months. Request the front desk staff to notify the care manager regarding when the patient comes into the clinic; try to meet with the patient to review the CM service and determine interest in proceeding.

Tool 8: Day in the Life	Day and Week in the Life of a Care Manager		
Day/Time	**Monday**	**Tues – Thursday**	**Friday**
		Weekly Activity	
Weekly	Case review (with each PCP in the office). Determine day and time with each provider.	Address any carry over from previous day needing completion. Work previous day follow-up into the proceeding day's schedule.	Review outstanding issues not resolved: work into the upcoming week's schedule, review patient "list" for potential candidates for CM, and allocate time to review and screen charts into the next day/week. Review the upcoming week's schedule to determine workload based on anticipated visits and calls.
		Daily	
8 a.m. (Start of Day)	Review admission/discharge/transfer data (ADT) • ID high risk/safety issues • Determine who on the team will f/u with which patients newly discharged. • If scheduled is over taxed, which patients require follow-up today; which patients can wait until the following day? • Any patients from previous week that did not receive a call? If yes, follow up today.	Review admission/discharge/transfer data (ADT) • ID high risk/safety issues • Determine who on the team will f/u with which patients newly discharged. • If schedule is over taxed, which patients require follow-up today; which patients can wait until the following day?	Review admission/discharge/transfer data (ADT) • ID high risk/safety issues • Determine who on the team will f/u with which patients newly discharged. • If schedule is over taxed, which patients require follow-up today; can someone else on the team assist; can any of the patients wait until Monday for a f/u call?
Before starting the day's work	Review caseload and ID patients you are monitoring and are due for a call this week (see monitoring guidelines).	Review caseload and ID patients you are monitoring and are due for a call this week (see monitoring guidelines).	Review caseload and ID patients you are monitoring and are due for a call this week (see monitoring guidelines).

	Have prepared and review at each call: • Measures/condition being monitored • The current treat-to-target status • The current treat-to-target goal • Current utilization of ER - hospital –specialist - other • Current medications	Have prepared and review at each call: • Measures/condition being monitored • The current treat-to-target status • The current treat-to-target goal • Current utilization of ER - hospital –specialist - other • Current medications	Have prepared and review at each call: • Measures/condition being monitored • The current treat-to-target status • The current treat-to-target goal • Current utilization of ER - hospital –specialist - other • Current medications
Throughout the day	Prepare for face-to-face visits planned for the day. Review the schedule and be prepared for newly identified cases that may occur throughout the day. If possible, complete a face-to-face introduction. Between visits, complete the post-discharge calls and monitoring calls. Target 6 – 8 calls per day.	Prepare for face-to-face visits planned for the day. Review the schedule and be prepared for newly identified cases that may occur throughout the day. If possible, complete a face-to-face introduction. Between visits, complete the post-discharge calls and monitoring calls. Target 6 – 8 calls per day.	Prepare for face-to-face visits planned for the day. Review the schedule and be prepared for newly identified cases that may occur throughout the day. If possible, complete a face-to-face introduction. Between visits, complete the post-discharge calls and monitoring calls. Target 6 – 8 calls per day.
End of Day	Review progress of the day's work. • Outstanding f/u post-discharge calls • Outstanding monitoring calls • Pts unable to reach after 3 calls on 3 different days and at different times, requiring a "Sorry I missed you letter"	Review progress of the day's work. • Outstanding f/u post-discharge calls • Outstanding monitoring calls • Pts unable to reach after 3 calls on 3 different days and at different times, requiring a "Sorry I missed you letter"	Review progress of the day's work. • Outstanding f/u post-discharge calls • Outstanding monitoring calls • Pts unable to reach after 3 calls on 3 different days and at different times, requiring a "Sorry I missed you letter" • New issues needing attention prior to leaving for the day (f/u with PCP, specialist, PharmD, MSW, etc.) • New patients enrolled and requiring Intro to CM letter

	• New issues needing attention prior to leaving for the day (f/u with PCP, specialist, PharmD, MSW, etc.) • New patients enrolled and requiring Intro to CM letter Establish a plan to work in outstanding CM activities.	• New issues needing attention prior to leaving for the day (f/u with PCP, specialist, PharmD, MSW, etc.) • New patients enrolled and requiring Intro to CM letter Establish a plan to work in outstanding CM activities.	Establish a plan to work in outstanding CM activities.

Miscellaneous Activities and Considerations
What is the plan for emergent issues that arise?
Does the care manager have the ability to add patients to the day's schedule? If not, who do you coordinate this with to determine if a patient can be seen the same day?
What values or conditions do the physicians consider urgent or emergent? What is the preferred method to communicate this information (via the MA, Instant Message, knock on the door)?
What is the expectation to build the caseload? I.e., how many new patients per week? Per year? What is the maximum caseload?
What are the billing code productivity expectations per day? How do you keep track of the number of codes billed in a day/week/month to determine If you are meeting the productivity expectations?
As you build the caseload, how will you keep up with monitoring and tracking? Is there something built into the EMR? Do you track it manually? What is the plan?

Tool 9: Motivational Interviewing Tools

a. Basics of MI

Accessed from:

http://homeless.samhsa.gov/Resource/Motivational-Interviewing-Open-Questions-Affirmation-Reflective-Listening-and-Summary-Reflections-OARS-32840.aspx

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Motivational Interviewing: Open Questions, Affirmation, Reflective Listening, and Summary Reflections (OARS)

Author(s):
Homelessness Resource Center (HRC)

Tags:
Evidence-based practice | motivational interviewing

Description: Motivational Interviewing provides a foundation for assisting individuals with developing the rationale for beginning change in their lives. This resource provides basic information about the principles on communicating using motivational interviewing.

Content: Motivational Interviewing: The Basics, OARS
(Adapted from handouts by David Rosengren and from Miller & Rollnick, Motivational Interviewing, 2nd Edition, 2002)

Motivational Interviewing is an "empathic, person-centered counseling approach that prepares people for change by helping them resolve ambivalence, enhance intrinsic motivation, and build confidence to change." (Kraybill and Morrison, 2007)

Open questions, affirmation, reflective listening, and summary reflections (OARS) are the basic interaction techniques and skills that are used "early and often" in the motivational interviewing approach.

OARS: Open Questions

Open questions invite others to "tell their story" in their own words without leading them in a specific direction. Open questions should be used often in conversation but not exclusively. Of course, when asking open questions, you must be willing to

listen to the person's response.

Open questions are the opposite of closed questions. Closed questions typically elicit a limited response such as "yes" or "no." The following examples contrast open vs. closed questions. Note how the topic is the same, but the responses will be very different:

- Did you have a good relationship with your parents?
- What can you tell me about your relationship with your parents?

More examples of open questions:

- How can I help you with ___?
- Help me understand ___?
- How would you like things to be different?
- What are the good things about ___ and what are the less good things about it?
- When would you be most likely to___?
- What do you think you will lose if you give up ___?
- What have you tried before to make a change?
- What do you want to do next?

OARS: Affirmations

Affirmations are statements and gestures that recognize client strengths and acknowledge behaviors that lead in the direction of positive change, no matter how big or small. Affirmations build confidence in one's ability to change. To be effective, affirmations must be genuine and congruent.

Examples of affirming responses:

- I appreciate that you are willing to meet with me today.
- You are clearly a very resourceful person.
- You handled yourself really well in that situation.
- That's a good suggestion.

- If I were in your shoes, I don't know if I could have managed nearly so well.
- I've enjoyed talking with you today.

OARS: Reflective Listening

Reflective listening is a primary skill in outreach. It is the pathway for engaging others in relationships, building trust, and fostering motivation to change. Reflective listening appears easy, but it takes hard work and skill to do well. Sometimes the "skills" we use in working with clients do not exemplify reflective listening but instead serve as roadblocks to effective communication. Examples are misinterpreting what is said or assuming what a person needs.

It is vital to learn to *think* reflectively. This is a way of thinking that accompanies good reflective listening. It includes interest in what the person has to say and respect for the person's inner wisdom. Listening breakdowns occur in any of three places:

- Speaker does not say what is meant
- Listener does not hear correctly
- Listener gives a different interpretation to what the words mean

Reflective listening is meant to close the loop in communication to ensure breakdowns don't occur. The listener's voice turns down at the end of a reflective listening statement. This may feel presumptuous, yet it leads to clarification and greater exploration, whereas questions tend to interrupt the client's flow. Some people find it helpful to use some
standard phrases:

- So you feel…
- It sounds like you…
- You're wondering if…

There are three basic levels of reflective listening that may deepen or increase the intimacy and thereby change the affective tone of an interaction. In general, the depth should match the situation. Examples of the three levels include:

- **Repeating or rephrasing**: Listener repeats or substitutes synonyms or phrases, and stays close to what the speaker has said
- **Paraphrasing**: Listener makes a restatement in which the speaker's meaning is inferred
- **Reflection of feeling**: Listener emphasizes emotional aspects of communication through feeling statements. This is the deepest form of listening.

Varying the levels of reflection is effective in listening. Also, at times there are benefits to over-stating or under-stating a reflection. An overstated reflection may cause a person to back away from their position or belief. An understated reflection may help a person to explore a deeper commitment to the position or belief.

OARS: Summaries

Summaries are special applications of reflective listening. They can be used throughout a conversation but are particularly helpful at transition points, for example, after the person has spoken about a particular topic, has recounted a personal experience, or when the encounter is nearing an end.

Summarizing helps to ensure that there is clear communication between the speaker and listener. Also, it can provide a stepping stone towards change.

Structure of Summaries

1) Begin with a statement indicating you are making a summary. For example:

- Let me see if I understand so far…
- Here is what I've heard. Tell me if I've missed anything.

2) Give special attention to **Change Statements**. These are statements made by the client that point towards a willingness to change. Miller and Rollnick (2002) have identified four types of change statements, all of which overlap significantly:

- **Problem recognition**: "My use has gotten a little out of hand at times."
- **Concern**: "If I don't stop, something bad is going to happen."

- **Intent to change**: “I’m going to do something, I’m just not sure what it is yet.”
- **Optimism**: “I know I can get a handle on this problem.”

3) If the person expresses ambivalence, it is useful to include both sides in the summary statement. For example: “On the one hand…, on the other hand…”

4) It can be useful to include information in summary statements from other sources (e.g., your own clinical knowledge, research, courts, or family).

5) Be concise.

6) End with an invitation. For example:

- Did I miss anything?
- If that’s accurate, what other points are there to consider?
- Anything you want to add or correct?

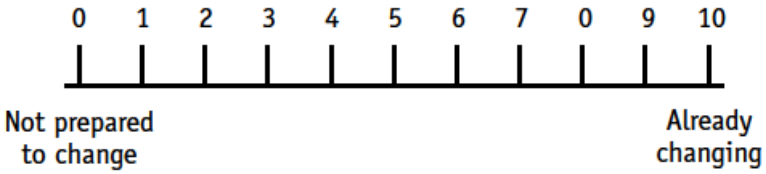
7) Depending on the response of the client to your summary statement, it may lead naturally to planning for or taking concrete steps towards the change goal.

b. Readiness Ruler

READINESS RULER

Below, mark where you are now on this line that measures your change in _____.

Are you not prepared to change, already changing or somewhere in the middle?



Source: adultmeducation.com

READINESS-TO-CHANGE RULER

The Readiness-to-Change Ruler is used to assess a person's willingness or readiness to change, determine where they are on the continuum between "not prepared to change" and "already changing", and promote identification and discussion of perceived barriers to change. The ruler represents a continuum from "not prepared to change" on the left, to "already changing" on the right.

The Readiness-to-Change Ruler can be used as a quick assessment of a person's present motivational state relative to changing a specific behavior, and can serve as the basis for motivation-based interventions to elicit behavior change. Readiness to change should be assessed regarding a very specific activity such as taking medications, following a diet, or exercising, since persons may differ in their stages of readiness to change for different behaviors.

ADMINISTRATION

1. Indicate the specific behavior to be assessed on the Readiness-to-Change Ruler form. Ask the person to mark on a linear scale from 0 to 10 their current position in the change process. A 0 on the left side of the scale indicates "not prepared for change" and a 10 on the right side of the scale indicates "already changing".

2. Question the person about why he or she did not place the mark further to the left, which elicits motivational statements.

3. Question the person about why he or she did not place mark further to the right, which elicits perceived barriers.

4. Ask the person for suggestions about ways to overcome identified barriers and actions that might be taken.

SCORING

A score above 5 shows that the person is willing to consider change and should be supported and encouraged.

Source: adultmeducation.com

c. Motivational Interviewing - Tips For Focusing

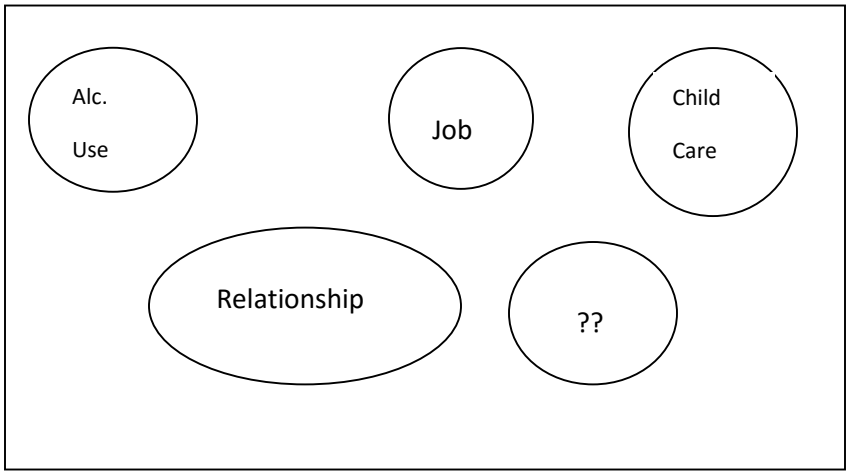
(Or guiding to a target behavior that is important to the client)

Focusing in Motivational Interviewing helps you to guide the client to choose a target behavior for focus during the MI session. The target should be something identified by the client, often with some guidance by the practitioner. Generally it is something about which they are considering making a behavior change, and they are feeling two ways about changing it (i.e., not sure whether they want to or can).

If the target is not clear and apparent, here are a few ways you can help guide a client to a target behavior:

1) **Evoke (draw out) from the client directly:** Ask the *client* what seems most important for them to look at or change in their life at present. E.g., "What area of your life do you feel you might want to work on to stay on track with your goals?" "What have you been considering changing in your life to help you move forward?" OR "What have you been struggling with changing in your life...maybe even something you're not sure you *want* to change?" OR "Which of these rules of the program seems like it will be the most difficult for you?"

2) **Provide a menu**: "Of all the things you mentioned, your housing, your relationship with your partner and staying clean and sober, which seems the most important to work on at the moment?" NOTE: A visual "bubble chart" works very nicely with this approach. Remember to ask what you might have missed (??) and add a bubble if needed. NOTE: The idea with the bubble chart is to NARROW the focus. "Which one seems the hardest or most important to work on right now", vs. use it to check in on all of the areas! You can also use this with need areas that come to light during an assessment or intake process.



3) **Suggest** something that seems important to them and see if they want to talk about it. E.g., "It sounds like you're not sure whether or not you want to move out of your current living situation. Would it be okay if we talk about that a bit?"

Once a target has been identified, make it **transparent**, i.e., "Let's talk more about that, if you don't mind." OR "If it's okay, let's look at that more closely. *Note that client free will (autonomy) is always present, as the target is identified by the client, though we may provide some guidance.*

Tool 10: SMART Goals

Being SMART with Your Goals!

By Edward Leigh, MA

At the beginning of the New Year, people enthusiastically talk about their resolutions / goals. Goals are critical in our lives, both at work and at home. Not having goals is like going on a driving trip without directions. Would you plan a vacation trip without having a destination? Unfortunately, many people / organizations do not achieve their goals. This is because their goals are not SMART. No, I am not questioning their intelligence; I am referring to an acronym that describes the attributes of an effective goal. SMART stands for these five characteristics:

- **Specific**: A clear concrete goal has a much greater chance of working versus a vague goal. For example, "We need to improve interdepartmental communication" is too general. A better goal would be "We need to improve communication through employee training in the next three months." This could then be broken down into specific communication topics, such as listening skills and email correspondence.
- **Measurable**: Determine criteria for achieving your goal so you could measure your progress to attain your objective. This allows us to track our progress. In other words, identify markers that will determine when you have reached your goals. For example, a hospital may say, "We need to see more patients." That is a poorly defined goal that cannot be measured. A more effective goal is, "We need to increase the number of patients we see by 10% within the next twelve months." We now have a measurable objective; the measure being the percentage of patients seen from the present moment to the given moment in the future. We can calculate this very easily, based on the recorded number of patients visiting the hospital.
- **Attainable**: Always set goals that have a fair chance to be met; the key word here is realistic. I am not saying you should set "easy" goals that are not challenging. Rather, you are encouraged to set difficult ones as long as they're practical. Your goals should be challenging enough to make you stretch, but not so far that you break. People rarely achieve significant goals by sitting contently in their comfort zone.
- **Relevant**: The goal must be pertinent for you. The goal has to mean something to you. You need an emotional connection with the goal. Without this you will have difficulties finding the motivation to drive your efforts. For example, asking the human resources department to enhance the organization's computerized infrastructure would be irrelevant. We are working with the wrong department. The HR department deals with people issues, the IT department deals with computer matters.
- **Time sensitive**: Any functional goal must have a clear timeframe of when it should start and/or when it should end. Without having a timeframe specified, it is practically impossible to say if the objective is met or not. A goal without a deadline is simply a dream. Set a realistic yet challenging deadline for accomplishment.

SMART Goal Example Many people have goals of taking off weight, so we will use the SMART goal setting technique to plan our weight reduction strategy.

Goal: Shed 25 pounds in six months through weight checks every two weeks at the gym.

SMART characteristics:

- Specific: shed 25 pounds
- Measurable: weight checks every two weeks at gym
- Attainable: taking off 25 pounds in six months is realistic (and healthy!)
- Relevant: Taking off weight is certainly significant for a number of reasons such as improved health and appearance
- Time-Sensitive: Six-month period

You can only be truly SMART with goals by writing them down. It is does not matter whether you write them by hand in a notebook or type them into a computer, the important thing is “get it writing.”

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Toolkit B: Predictive Modeling Tools

Tool B1 – VES-13

VES-13

1. Age _____

SCORE: *1 POINT FOR AGE 75-84*
3 POINTS FOR AGE ≥ 85

2. In general, compared to other people your age, would you say that your health is:

- ☐ Poor,* *(1 POINT)*
- ☐ Fair,* *(1 POINT)*
- ☐ Good,
- ☐ Very good, or
- ☐ Excellent

SCORE: *1 POINT FOR FAIR or POOR*

3. How much difficulty, on average, do you have with the following physical activities:

	No Difficulty	A little Difficulty	Some Difficulty	A Lot of Difficulty	Unable to do
a. stooping, crouching or kneeling?	☐	☐	☐	☐ *	☐ *
b. lifting, or carrying objects as heavy as 10 pounds?	☐	☐	☐	☐ *	☐ *
c. reaching or extending arms above shoulder level?	☐	☐	☐	☐ *	☐ *
d. writing, or handling and grasping small objects?	☐	☐	☐	☐ *	☐ *
e. walking a quarter of a mile?	☐	☐	☐	☐ *	☐ *
f. heavy housework such as scrubbing floors or washing windows?	☐	☐	☐	☐ *	☐ *

*SCORE: 1 POINT FOR EACH * RESPONSE IN Q3a THROUGH f . MAXIMUM OF 2 POINTS.*

4. Because of your health or a physical condition, do you have any difficulty:

a. shopping for personal items (like toilet items or medicines)?

- ☐ YES → Do you get help with shopping? ☐ YES * ☐ NO
- ☐ NO
- ☐ DON'T DO → Is that because of your health? ☐ YES * ☐ NO

b. managing money (like keeping track of expenses or paying bills)?

- ☐ YES → Do you get help with managing money? ☐ YES * ☐ NO
- ☐ NO
- ☐ DON'T DO → Is that because of your health? ☐ YES * ☐ NO

Continued

Risk-Stratified Care Management and Coordination

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Table 1: Examples of Potentially Significant Risk Factors

Clinical Diagnoses, Behavioral Health, Special Needs	Potential Physical Limitations	Social Determinants	Utilization/Claims Data	Clinician Input (Personal Knowledge)
– Any chronic disease, particularly one that is not in control or at desired goal – Chronic pain – Substance abuse (alcohol/drug/tobacco) – Terminal illness – Advanced age with frailty – Multiple co-morbidities – Pre-term delivery of newborn – Child, youth, or adult with special needs – Anxiety, schizophrenia, bipolar, depression, or other behavior affecting health – Dental health – Dementia/Alzheimer's disease	– Non-ambulatory – Needs Assistance with Activities of Daily Living (ADLs) – Severely diminished functional status – Declining eyesight – Extreme weakness or fatigue – At risk for falls	– Lack of financial or family support that impacts care – Unemployed – No health insurance – Low health literacy – Unsafe home environment – Homeless – Lives alone and needs assistance with ADLs – Transportation for health care appointments is difficult – Language barriers	– Frequent hospitalizations (particularly heart failure, GI disorders, and pneumonia) – Frequent office, ER, or urgent care visits – Multiple providers – Hospital readmission within 30 days – Major procedure in last year – Chronic kidney disease – Brain trauma – Expensive medications	– Polypharmacy – Patient is taking several medications that may not all be needed and/or could have potential for interactions – High-risk medications – Non-compliant with treatment plan – Confusion with medications or following the treatment plan – Recent move to long-term facility or other transition of care – Spouse (who was the caregiver) recently deceased – Lack of engagement in care plan – Low confidence or ability for self-management – Answer to the question: Is this patient at higher risk for dying within the next year?

Table 2: Risk Categories and Levels using Diabetes Example Case

CATEGORY	PRIMARY PREVENTION (Low Resource Use) GOAL: To prevent onset of disease		SECONDARY PREVENTION (Moderate Resource Use) GOAL: To treat a disease and avoid serious complications		TERTIARY (High Resource Use) GOAL: To treat the late or final stages of a disease and minimize disability	CATASTROPHIC/COMPLEX (Extremely High Resource Use) GOAL: May range from restoring health to only providing comfort care
Stage	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**Level 6**
	No known diagnoses or complex treatments	No known diagnoses but demonstrates warning signs or potentially significant risk factors	Has diagnosis, but stabilized or in control; potentially significant risk factors	Has diagnosis and/or complex treatment, and at higher risk for complications or potentially significant risk factors	Has diagnosis, complex treatment, and complications or potentially significant risk factors– goal is to prevent further complications	• Very severe illness or condition and potentially significant risk factors • End-of-life care • Premature baby (May have high costs with limited or no opportunity for improvement, stabilization, or cost control)
Example of using uncontrolled progression of diabetes	• Healthy	• Blood glucose and lipids rising, but still within desired parameters • BMI elevated • Smoker	• Diagnosed with type 2 diabetes, blood sugar, and lipids brought within desired parameters • Married, family involved	• Blood sugar and lipids not within desired parameters, and financial situation impacting negatively • Lives alone • One ER visit and one hospitalization in past year	• Has diabetes with early renal disease, coronary artery disease, failing eyesight, and lives alone • Three ER visits and two hospitalizations in past year • Dual eligible Medicaid/Medicare • Needs Assistance with Activities of Daily Living (ADLs)	• Diagnosed with lung cancer • Recent myocardial infarction • Progression to ESRD with renal dialysis • Amputation of one leg • Blind • Lives in nursing home
Example of Care Plan Considerations for patient with uncontrolled progression of diabetes	✓Preventive screenings and immunizations ✓Patient education and engagement ✓Appropriate monitoring for warning signs ✓Health risk assessment (annual) ✓Care plan that includes smoking cessation counseling and program offered		✓Preventive screenings and immunizations ✓Patient education and engagement ✓Appropriate monitoring ✓Health risk assessment (semi-annual) ✓Care plan with smoking cessation counseling and program offered ✓Team/planned care ✓Group visits ✓Health coach ✓Referrals as appropriate, such as social services ✓Community resources ✓Home self-monitoring		✓Preventive screenings and immunizations ✓Patient education and engagement ✓Appropriate monitoring ✓Health risk assessment (quarterly) ✓Intensive care management plan and resources ✓Smoking cessation ✓Group visits ✓Health coach ✓Home health	✓Hospitalization ✓Rehabilitation ✓Long-term care ✓Hospice ✓Home health ✓Individualized intensive care management and coordination ✓May or may not conduct preventive screenings ✓Health risk assessment, as appropriate

Identifying Disease Burden and Determining Health Risk Status

Is the patient healthy, with no chronic disease, or *significant risk factors*?	Is the patient healthy, but at risk for a chronic disease, or has other *significant risk factors*?	Does the patient have one or more chronic diseases, with *significant risk factors*, but is stable or at desired treatment goals?	Does the patient have one or more chronic diseases, with *significant risk factors*, and is unstable or not at treatment goals?	Does the patient have multiple chronic diseases, *significant risk factors*, complications, and/or complex treatment(s)?	Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?
Level 1 PRIMARY PREVENTION	**Level 2 PRIMARY PREVENTION**	**Level 3 SECONDARY PREVENTION**	**Level 4 SECONDARY PREVENTION**	**Level 5 TERTIARY PREVENTION**	**Level 6 CATASTROPHIC CARE**
GOAL: To prevent onset of disease (Low Resource Use)	**GOAL: To prevent onset of disease (Low Resource Use)**	**GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)**	**GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)**	**GOAL: Treat the late or final stages of a disease and minimize disability (High Resource Use)**	**GOAL: May range from restoring health to only providing comfort care (Extremely High Resource Use)**
CARE PLAN SUGGESTIONS – Preventive screenings and immunizations – Patient education – Health risk assessment (annual) – Appropriate monitoring for warning signs	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (semi-annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (semi-annual) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach – Referrals, as appropriate	**CARE PLAN SUGGESTIONS** – Preventive screenings and immunizations – Patient education and engagement – Health risk assessment (quarterly) – Appropriate monitoring for warning signs – Interventions for unhealthy lifestyle/habits – Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** – Group visits – Home self-monitoring – Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach/personalized care plan/management and resources – Referrals, as appropriate – Home health	**CARE PLAN SUGGESTIONS** – Hospitalization – Rehabilitation – Long-term care – Hospice/palliative care **TEAM/PLANNED CARE** – Support groups – Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings – Health coach/care management – Referrals, as appropriate – Home health – Personalized intensive care plan/management and resources

11/12

Tool B3 - MemorialCare – Identification and Risk Stratification of High-Risk Patients

Monthly queries extract data from the data warehouse and stratify patients into seven high-risk categories and scores using the following methodology. The patients in these categories are entered as candidates for case management:

- **High ER Utilization** (Total ER visits in rolling 12 months prior to report run date)
    - 1-5 visits = 1 point
    - 6 to 10 visits = 2 points
    - 11 to 15 visits = 3 points
    - 15+ visits = 4 points
- **Elder and Frail**
    - Age >/= 65 years with ANY of the following conditions: COPD, CHF, CKD, Asthma, Brain Injury, DM, or Stroke
    - AND an acute admission to an inpatient facility with LOS > 5 days = 1 point
- **Chronic Kidney Disease Stage**
    - Stage 4 = 1 point
    - Stage 5 = 2 points
- **Major Organ Transplant(s)**
    - Transplant date within 2 years = 2 points
    - Transplant date more than 2 years = 1 point
- **Traumatic Brain Injury (TBI)**
    - Date of injury (DOI) less than 1 year = 2 points
    - DOI more than 1 year = 1 point
- **High Costs**
    - Total cost < $30K = 1 point
    - Total cost between $30K and $60K = 2 points
    - Total cost between $60K and $90K = 3 points
    - Total cost > $90K = 4 points
- **Readmits**
    - Readmit within 3 months from run date = 2 points
    - Readmit within 3-12 months from run date = 1 point
    - In addition to traditional referral sources (PCP, Health Plan, etc.), patients are also identified and referred during specific points of care (i.e., ER and hospitalization).

The case managers receive these candidates and conduct an assessment for triage using the Risk Stratification Tool (see below). Patients with multiple ER visits or those with complex conditions are also immediately referred as a candidate for case management and follow the enrollment and intake process.

CQC Complex Care Management Toolkit Resource – Shared with permission from MemorialCare 2.

Risk Stratification Tool
Maximum Possible Score 19

1) Current Age

0-18	0
19-75	1
76+	2

2) Current Risk Score

At risk for hospitalization/ER visits/deterioration of ADLs	4
Catastrophic medical diagnosis	2
Independent with ADLs	1
Institutionalized patient	5
Moderate risk for deterioration of ADLs	3

Tool B4 - CQC Complex Care Management Toolkit Resource

Tips for Identification of High-Risk Patients

Many provider organizations have developed their own risk algorithms using data elements that are readily available. The following summarizes learning from multiple organizations on the elements to include in an algorithm to identify high-risk patients.

Ideal inputs:

- Utilization triggers
- Clinical information – disease type, disease burden, co-morbidities
- Patient activation/motivation
- Clinical input

Drill Down (key elements in bold):

- Utilization –
  - Total cost
  - **Hospitalizations**
  - **Emergency department utilization**
  - Pharmacy data, including specific classes and **volume of prescriptions**
  - Use of durable medical equipment (DME), such as wheelchairs
- Demographic information – **age** and gender
- Conditions and priority of conditions – likely different among senior vs. commercial populations
  - **Key diagnoses to consider**: Chronic obstructive pulmonary disease, congestive heart failure, chronic kidney disease, cancer (including stage if possible), hemophilia, end stage renal disease (ESRD), coronary artery disease (CAD), HIV/AIDS transplant, hypertension, depression, obesity, chronic pain, anxiety, chemical dependency
  - Existence of multiple co-morbidities
  - Behavioral health diagnosis (key for individual prediction)
  - Lab values, such as HbA1c

These components are typically not available in data systems, but are found to be highly useful to stratify patients once identified:

- Social support (key for individual prediction) – homelessness, live alone, lack of family support
- Risk assessment / functional status, such as a health risk assessment, or the Vulnerable Elders Survey (VES-13)
- Patient activation or readiness for change, as measured by the Patient Activation Measure (PAM), for example
- Clinical input – Orient physicians to think about a patient's risk differently. For example, you might ask:
  - Identify patients who you would not be surprised if they were in the emergency department or hospital in the next 6 months.
  - 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.
  - Ask about social or behavioral concerns. For example, for members with >8 medications: do they have social or behavioral risk factors?

About Mi-CCSI: The Michigan Center for Clinical Systems Improvement (Mi-CCSI) is a non-profit collaborative member organization comprised of health systems, physician organizations, a behavioral health system and payers.

Our Mission: Mi-CCSI supports its stakeholders, the healthcare community and the communities of which they serve to:

- Display models that deliver better care for individuals, improved population health, and lover cost
- Promotes initiatives supporting clinical integration
- Facilitate payment redesign

Vision: Mi-CCSI will lead healthcare transformation through collaboration

What We Do: Mi-CCSI works with stakeholders directly to:

- Facilitate the training and implementation of collaborative care models
- Promote best practice sharing including regional, state and national initiatives
- Support workgroups and collaborative in support of initiatives, including evidence review
- Strengthen measurement and analysis of quality improvement efforts
- Assist in developing payment to sustain models of improvement

Support of This Toolkit: A workgroup consisting of field experts in case management assisted in the development and review of the documents created to support the provider delivered care manager. We would like to give special thanks and acknowledgement to this workgroup.

Workgroup Members:

- Chair – Susan J. Vos BSN, RN Program Director Mi-CCSI
- Workgroup Advisors
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As stated in our mission, Mi-CCSI supports transformation through collaboration.

- Users of this document are key contributors and identifiers for continued development and evolving needs for transformational work. Please contact us with any ongoing needs or tools you would like included in this toolkit.
- If you have identified a tool that others could benefit from, are willing to share as a best practice and have permission from your practice/organization to be included in this toolkit please forward it to sue.vos@miccsi.org

Best Regards,

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