

Case Management Process

An Inter-active Overview and
Application of Knowledge





Introduction

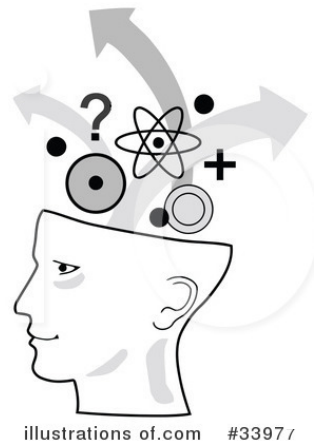
Care Management Process

- Review the processes of case management
- Review the goals and definitions associated with case management
- Identify key criteria to consider for each case management process
- Discuss how social, behavioral and medical status impact patient care planning and care management services



Pre-test Process

- Assessing current knowledge
 - In small groups share ideas on each of the pre-test questions
 - The goal – understanding current state, developing rapport with others, and exploring others points of view





Starting with Definitions and Terms

Actions

- Case management
- Care management
- Care coordination

Roles – A care team may include:

- Case/care manager (Behavioral – Medical)
- Care Coordinator
- Care Navigator
- Community Health Worker
- Health coach
- Pharmacist
- Medical Director





Team Approach

Support One Another To Serve the Patient

- Medical and behavioral case managers support each other with respective experiences
- Non-clinical staff assists with coordination activities that do not require clinical expertise
- Pharmacy assist with medication review and reconciliation
- CHW can be the eyes and ears of the case manager and become peer supports for the patient
- Medical directors guide the team by advising best practice, evidence-based care and act as a liaison with other providers





Case Management

A Verb

Case 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.

Based on the CMSA Standards of Practice for Case Management





Care Management

According to the Commission for Case Manager Certification (CCMC)

- A **healthcare delivery process** that helps achieve **better health outcomes** by anticipating and **linking clients** with the services they need more quickly. It also helps **avoid unnecessary services** by **preventing medical problems** from escalating.

Robert Wood Johnson Definition:

- **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.**





Care Coordination

A Verb

Care coordination involves:

- deliberately organizing patient care activities
- sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care

This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.





Case Manager

Definition

A healthcare professional who is responsible for **coordinating the care** delivered to an assigned group of **patients based on diagnosis or need**.

Case managers work with people to get the healthcare and other community services they **need, when they need** them, and for the **best value**.

Other Responsibilities

- Patient/family education
- Advocacy
- Delays management
- Outcomes monitoring and management





Care Coordinator

According to the State Innovation Model Care Coordinators:

Determine with the care team, the patient's needs for coordination, including physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations and need for support services.

- **Knowledge about community resources..... coordinate these services that may help support patients' health and wellness or meet their care goals**
- **Manage the individualized plan of care** with the patient/family, care team and community based organizations,...**current and longstanding needs and goals for care and addresses coordination needs and gaps in care**
- Ongoing **maintenance, which includes monitoring, following up and responding** to changes in the patient's individualized plan of care
- **Facilitate transitions of care**
- **Support self-management goals to promote patient health**
- **Align resources**
- Identify **gaps in care and communicate recommended tests/services** to the patient. Provide additional resources to under insured patients.
- Demonstrate administrative skills to **organize, evaluate, and present information**
 - See insert SIM Care Coordinator Role





Case Management Goals

The goals of case management are:

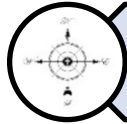
- Improve patients' functional health status
- Enhance coordination of care
- Eliminate duplication of services
- Reduce the need for expensive medical services. (This may be new to ambulatory care approaches)



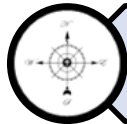


CMSA

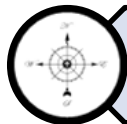
Philosophy and Guiding Principles



Patient-centered, comprehensive, and holistic



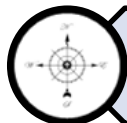
Collaboration, coordination, communication



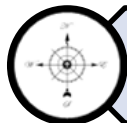
Facilitate self-determination through advocacy and education



Promote evidence-based care, safety, wellness



Integrate behavioral change principles and cultural competency



Assist with navigating health care system

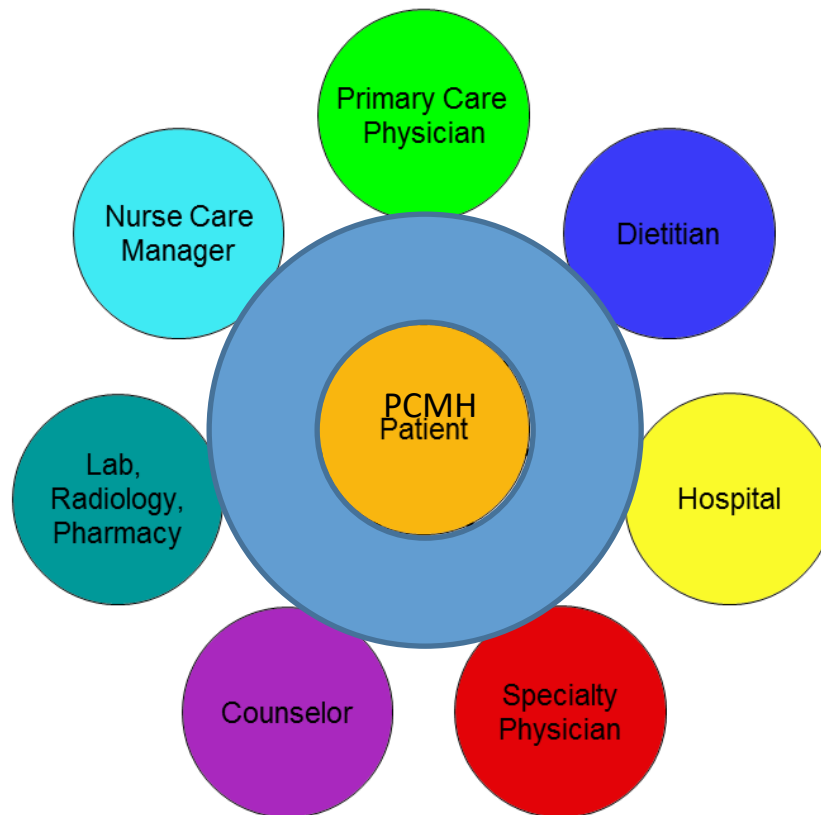


Pursue professional competence and excellence



Care management within the system

- Where care management occurs
- Examples of care management



What is missing from this diagram?



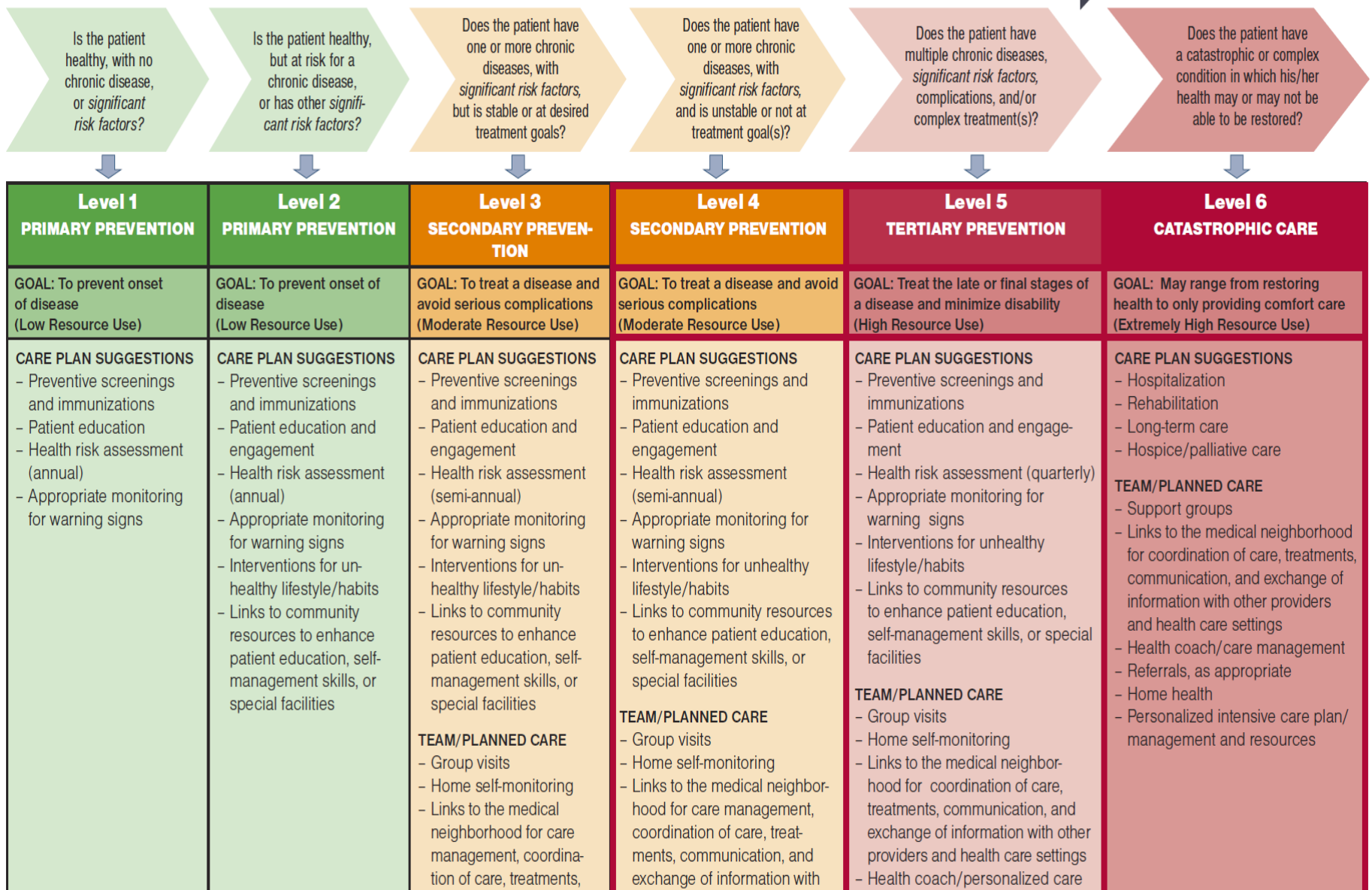


Care Management Primary Care Practice

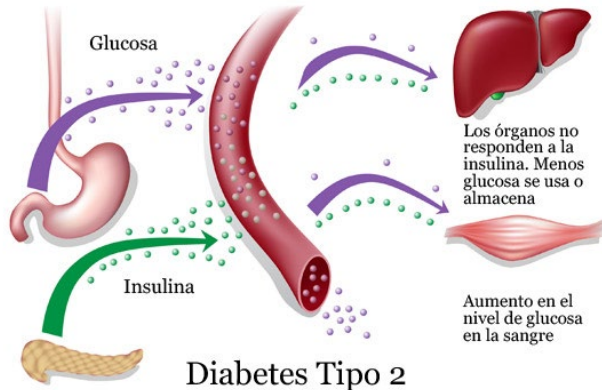
- AAFP Risk-Stratified Care Management and Coordination
 - Discuss:
 - What care management services happen in each of the levels
 - Who can provide the care management services in each of the levels?
 - How does this fit into the team-based care model?



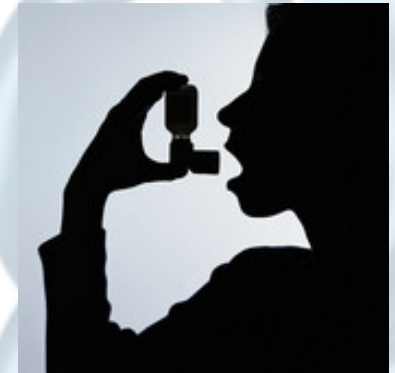
Identifying Disease Burden and Determining Health Risk Status



Patient Identification



Nicola Nightstalker



CM Process

Patient Identification

Objectives

- Review patient identification strategies
- Discuss eligibility considerations
- Identify key referral sources
- Examine pre-screening processes



Care/case Managers: Patient Identification Process



Who will receive care/case manager services, care coordinator services, community health workers, others? What are the qualifying values for this decision?





Practice Setting Considerations

- Population Management – Who we serve
- Reimbursement Method – How we get paid
- Team Structure and available healthcare disciplines (RN, MSW, NP's) – Who is on the team
- Care Setting (PCP Practice, Specialist, Central)
 - What is the structure (centralized, independent, system, etc.)



Key Identification Components

Complexity

Medical

Diagnosis

Co-morbidity

Targets

Behavioral

Screening

Conditions treated

Approach

Collaborative

Co-location

Referral

Determinants of health

Barriers to better health

Utilizing community resources

Resources in the clinic

Determining who will be targeted for CM Services





Eligibility and Reimbursement

- Team and organization position
 - Care/case management and care coordination for all
 - Care/case management and care coordination for those that have coverage/benefit
- Payer requirements (BCBSM, Priority Health, State, National)
 - Active coverage
 - One or more conditions requiring and warranting care management services and have potential to improve the patient's wellbeing and functional status
 - A referral for CM services from the Provider
 - Patient agrees to actively participate in the care plan





Care Management Functions

Care coordination

- The deliberate organization of patient care activities between two or more participants... (AHRQ, 2007).

Self-management

- The care and encouragement provided to people with chronic conditions and their families to help them understand their role in managing their illness, make informed decisions about care, and engage in healthy behaviors

http://www.improvingchroniccare.org/index.php?p=SelfManagement_Support&s=39

Education/teach

- to cause or help ... to learn how to do something by giving lessons, showing how it is done, etc
- (Meriam Webster <http://www.merriam-webster.com/dictionary/teach>)





Practice Level Population Management

(Group Activity)

Describe the location of the clinic/clinics you will be working in.

Age	Prevalent diseases & status
Income	Primary language
Ethnicity	Resources – community, specialist, technical
Religion	Rural vs Urban

In your group share with one another what you know about the patient population of the clinic(s) you will be serving.

Pertinent to your role, what will be your primary function?

- Care coordination
- Education
- Self-management support

Brainstorm and share examples of the functions





Referral to Care/Case Manager and Care Coordinator Sources





Referral Source

Brainstorming Exercise – Shout out!

- 1. What case finding sources will be available to you?**
- 2. How will you create your caseload?**



Referral Sources

The winners are:



- **PCP and Care team**
- **Registry**
- **Payer (claims) reports**
- **Specialist**
- **Hospital notifications, staff/care managers**
- **Home care**
- **Payer care management team**
- **Other facilities such as rehab, skilled nursing, long-term acute care**

Who is missing?



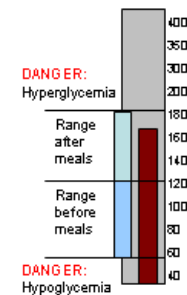


Creating Your Caseload

- By attrition
 - as patients come into the clinic
- Active outreach
 - Cold calls
 - Partnering with community
 - Hospital discharge planners
 - Specialist
 - Home health services
 - Community agencies
 - Skilled facilities
 - Neighborhood associations



CM Process – Patient Identification Prescreening



Objective

- Review prescreening process



Pre-screening

Pre-screening Actions to Identify Needs

- Most current data
 - Sources
 - » Registry or EMR registry like reports
 - » Payer reports
 - » Medical Record
- Provider input and approval
- Patient & Care Giver Interview



In Practice

After receiving the referral

- **Introduce** role
 - Engagement and clarity on the reasons and goals of services
- **Advise** on potential self-pay/co-pay
 - Benefits vary from payer and products
- **Identify needs** are appropriate for services
 - Validate need and focus of CM and CC services
- **Link** your role to others on the **team**
- Obtain **permission**

****Describing the role, **obtaining permission** and reviewing with the patient potential payment options **may not fall into one of the CM billable codes****



Your Mission: Create an elevator speech





Describing The Role

- At your table
 - Describe to one another your role on the team
 - Use the information in the tool kit as a starting place and include the following in your description:
 - Connection to others on the care team
 - Value to the patient
 - What the patient can expect from the service
 - The patients role
 - Timeline of your involvement



Pre-screening Video

- [http://www.improvingchroniccare.org/index.php?p=Planned Care Visit: The Provider Point of View&s=218](http://www.improvingchroniccare.org/index.php?p=Planned%20Care%20Visit%3A%20The%20Provider%20Point%20of%20View&s=218)

Observe:

- Team approach
- Introduction of the CM role
- Use of data





CM Process

The Patient Assessment





Assessment Objectives

Review the case management process of assessment (includes problem/opportunity identification as identified in CMSA Standards and by the CCMC)

- Pertinent information to include in the assessment
- Code and documentation requirements
- Problem/Opportunity Identification for the care plan





Assessment: Key Components

The case/care manager completes the comprehensive **health** and **psychosocial assessment**, taking into account the cultural and linguistic needs of each patient

- The framework to meet patient needs and define the key components of the care plan
 - Defines the desired outcome(s) of the CM intervention/service
- Aids to prioritize needs
 - Risk and safety first
 - Knowledge (gaps), Ability (self-management skills), and Desire (engagement)
 - Barriers followed by plan(s) to reaching outcomes



Assessment Process

- Using standardized assessment tools and checklists, the case/care manager gathers information through face-to-face and telephonic contact



Commission of Case Management <http://www.cmbodyofknowledge.com/content/case-management-knowledge-2>





Attributes of Successful Care Models

Interdisciplinary primary care models show positive outcomes and may have broad application. Chad Boulton and Darryl Wieland (Johns Hopkins) distilled features associated with more effective primary care for older adults with chronic illnesses.

- **Comprehensive assessment of health conditions, treatments, behaviors, risks, supports, resources, values, preferences;**
- Evidence-based care planning and monitoring to meet the patient's health-related needs and preferences
- Promotion of patients' and family caregivers' active engagement in care
- Coordination, communication among all engaged in a patient's care, especially during transitions from hospital





The Assessment: Involves the collection of information about a patient's situation similar to those reviewed during screening, however to **greater depth**. This information may include:

Past and current health conditions

- service utilization
- socioeconomic and financial status
- insurance coverage
- home condition and safety
- availability of prior services
- physical/emotional/cognitive functioning
- psychosocial network system
- self-care knowledge and ability
- readiness for change

This information assists in creating a “picture” of the patient status and helps determine the CM interventions and care plan



Assessment Purpose

Two primary goals:

- **Identifying** the patient's **key problems** to be addressed, as well as **individual needs** and **interests**
- **Developing** a comprehensive case/care management **plan of care** that addresses these problems and needs

Additionally, the case manager seeks to **confirm or update the patient's risk** (category) based on the information gathered

Commission of Case Management <http://www.cmbodyofknowledge.com/content/case-management-knowledge-2>



Conducting the Assessment

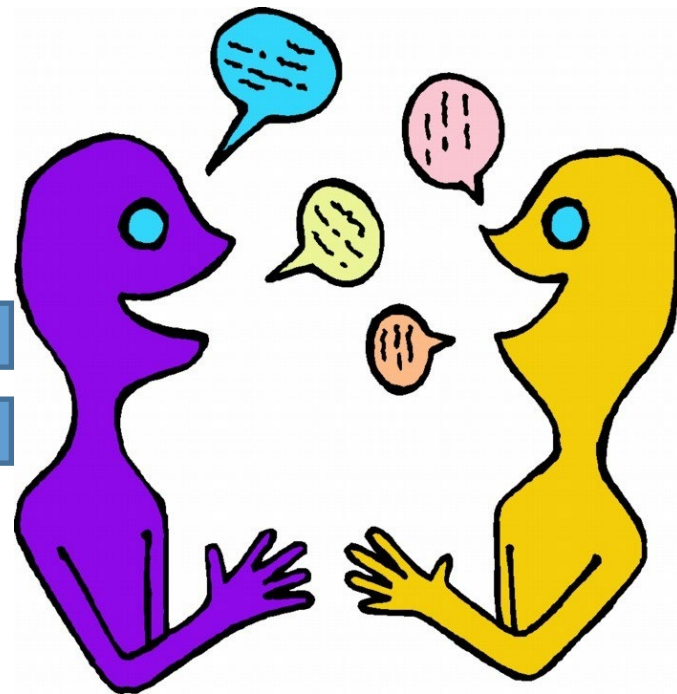
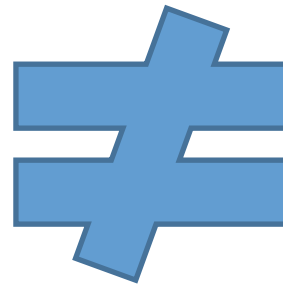
Identify what credentials are required to bill the comprehensive assessment

- **Priority Health: Qualified Health Professional**
 - QHP is a RN, Certified NP, PA, LMSW, Psychologist (LLPs and PhDs), CDE's, Registered Dieticians, Masters Trained Nutritionist, Clinical Pharm., and Respiratory Therapist
- **BCBSM: Licensed Care Team**
 - Act within their scope of licensure, certification, or authorization by the Physician, Physician Assistant or Advanced Practice Nurse



Capturing the Information

- It is about engaging with the patient





Assessment Questions

- Develop an open-ended question for each component of the assessment you could use to obtain critical information from the patient
- Remember we are establishing an understanding of the following:

- Health Status
- Psychosocial Status/Needs
- Patient Knowledge/Awareness/Ability
- Cultural and Linguistic Needs

****Be prepared to share your responses with the group**





Psychosocial Assessment Approach

- Establishing Cultural and Linguistic Needs
 - Cultural awareness and competence
 - Linguistic awareness and competence
- Social Needs Assessment
 - Resources in the community
 - Practice team ability to assess
 - Knowledge of resources
 - Tracking the use and ability to meet needs



Psychosocial: Cultural and Linguistic Needs

Agency for Health Research and Quality

Linguistic Competence: Providing readily available, culturally appropriate **oral and written language services to limited English proficiency**

Examples

Bilingual/bicultural staff

Trained medical interpreters

Qualified translators

Cultural Competence: A set of **congruent behaviors, attitudes, and policies** that come together in a system or agency or among professionals that **enables effective interactions in a cross-cultural framework.**

Cultural and Linguistic Competence: The **ability** of health **care providers** and health care organizations to **understand** and **respond effectively** to the **cultural and linguistic needs** brought **by the patient** to the health care encounter.

Note where the responsibility and accountability are in this statement





Value of Cultural Competence

Relationship Building

- Language & Communication
- Negotiation – Win/Win





Social Determinants of Health

- The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels
- The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries



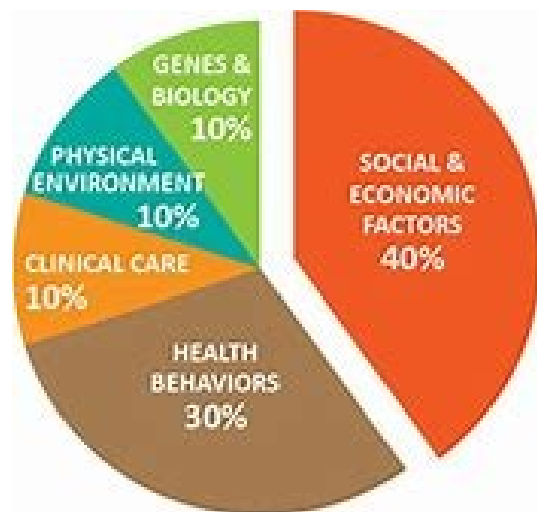
Psychosocial Assessment Determinants of Health

The determinants of health include:

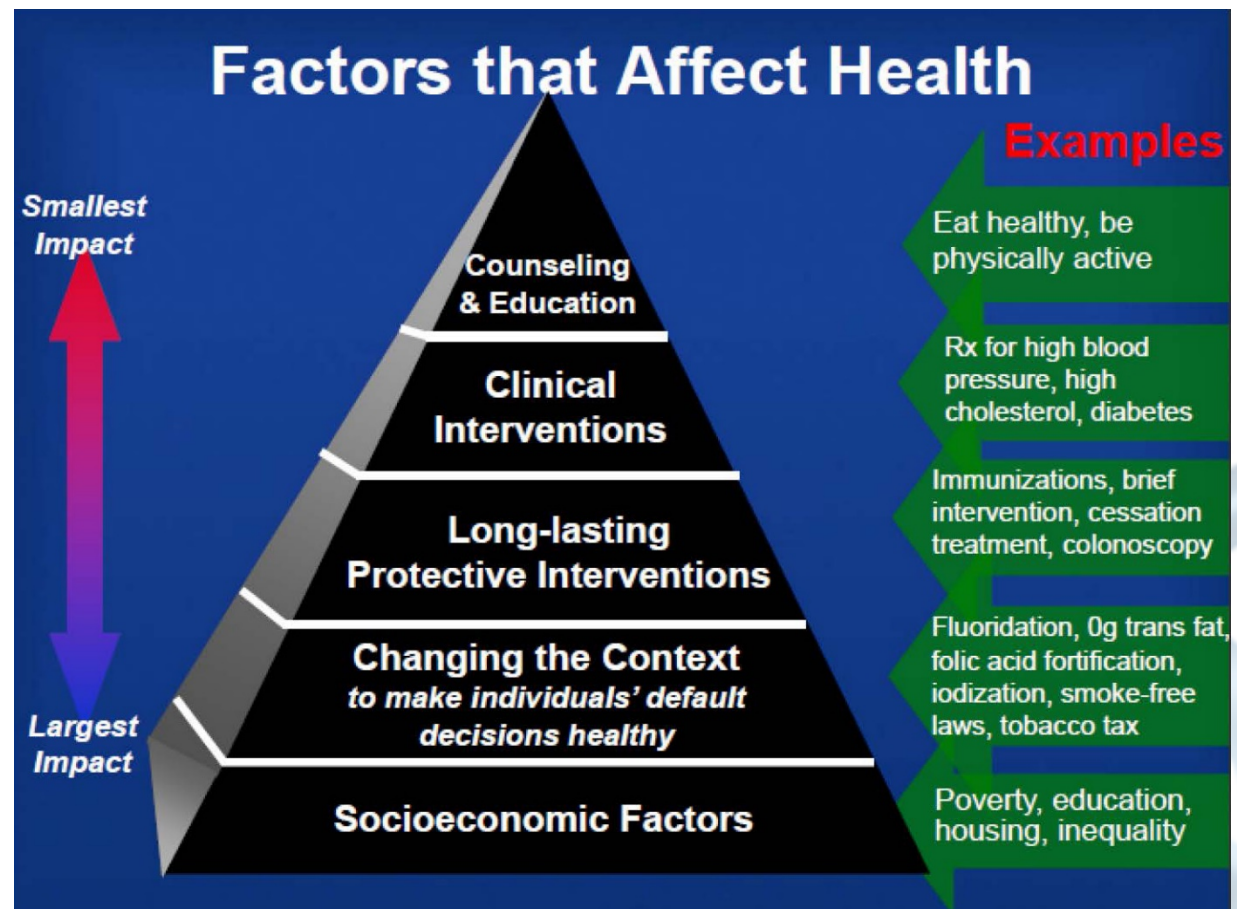
- Social and economic environment
- Physical environment
- Person's individual characteristics and behaviors



According to the Center for Disease Control

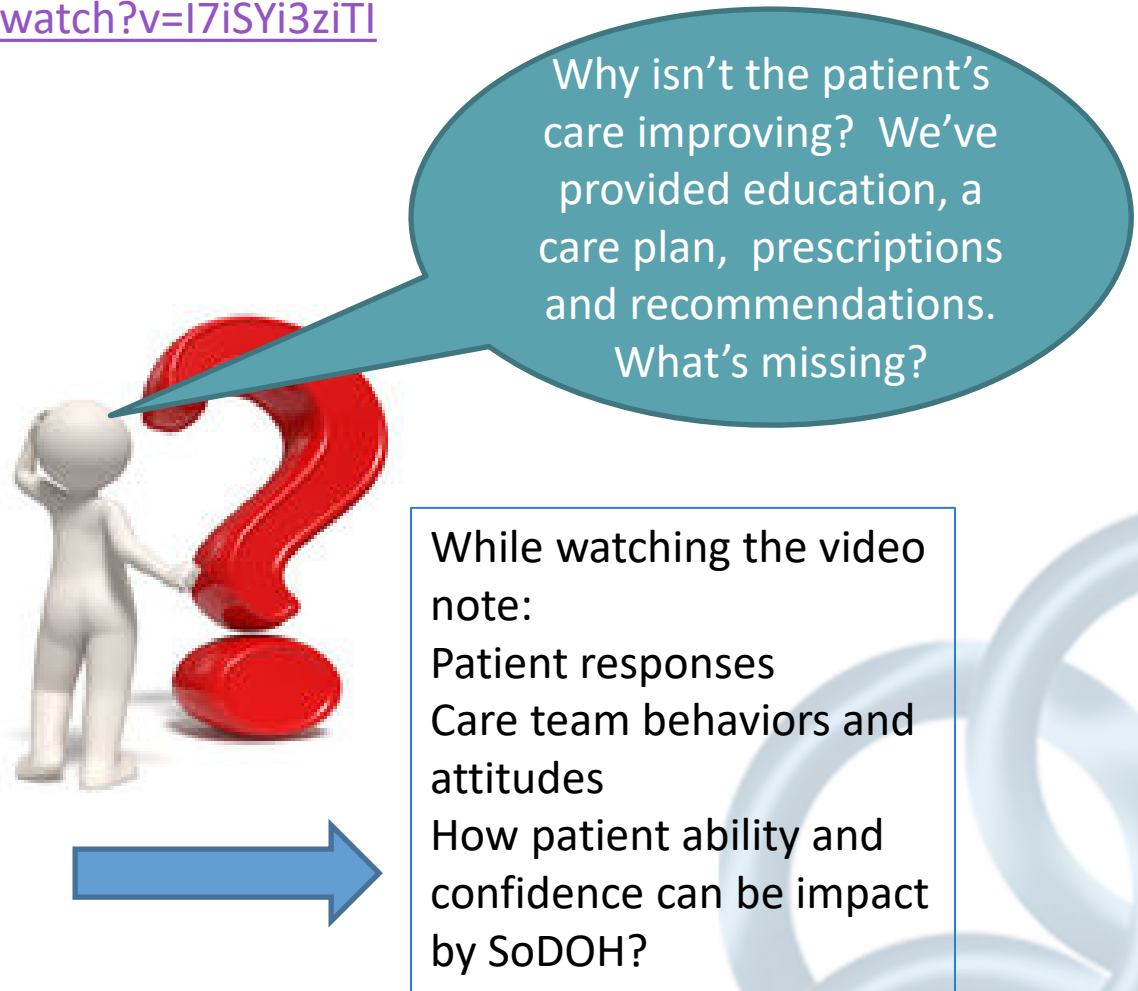


DETERMINANTS OF HEALTH



• Social Determinants of Health

- <https://www.youtube.com/watch?v=I7iSYi3ziTI>

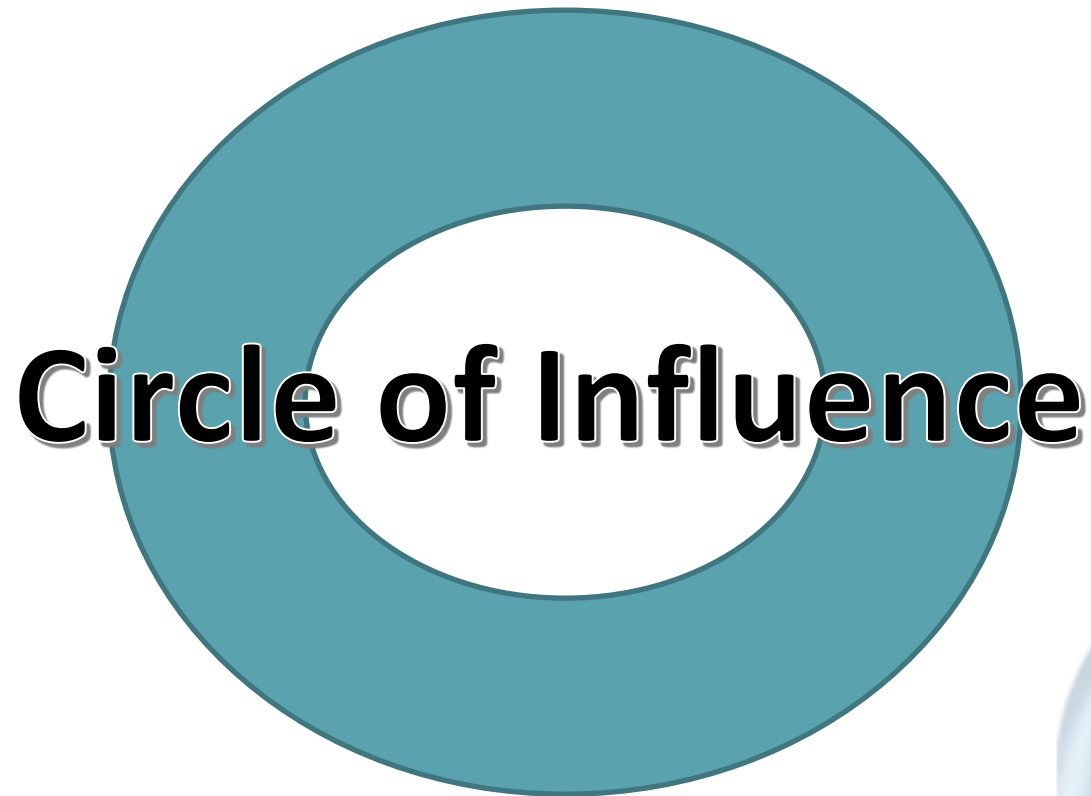


While watching the video note:
Patient responses
Care team behaviors and attitudes
How patient ability and confidence can be impact by SoDOH?





Psychosocial Assessment



Understand and acknowledge the patients limits and your abilities to impact determinants of health



Knowledge of Community Agencies

- Who are they and what do they do?

Health Care Team

- Primary care
- Specialist
- **Community agencies**
- Health care workers

Patient

Community

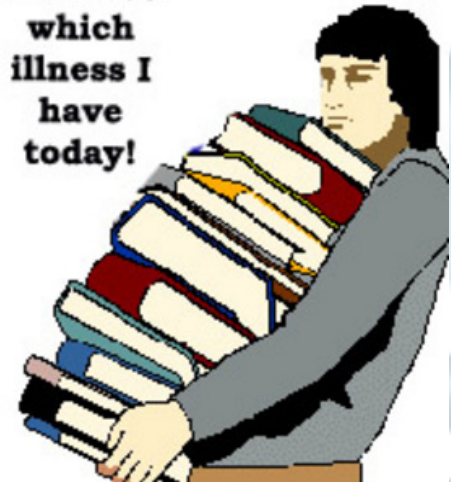
Go to www.MiCCSI.org –
under resources for an
example of a community
resource directory



Medical Assessment Disease Management



Let's see
which
illness I
have
today!





Assessing Patient Knowledge

- What does the patient already know about their condition or disease?
- What are the patients desire and ability? (Health and other)
- What is your level of understanding about the condition or disease?



Disease Management In Practice

- Identify the evidence based guidelines used in the clinic
 - research and review the guidelines (this serves as your core in setting goals)
 - Inquire if the evidence used is built into the medical record or registry tool
 - Determine the placement in the medical record and how the care team uses this information during the visit





In practice – professional development

- Assess your knowledge of the disease/conditions
 - Operating within your scope of practice, identify the evidence for the conditions you will be managing – become knowledgeable on
 - Key medications to manage diseases
 - Interventions and suggested guidelines for care
 - Intervals for monitoring and follow up
- Disease management assessment tips
 - See assessment example in the CM toolkit (page 4)





Resources for Disease Management

- Asthma Network
- American Diabetes
- MQIC Guidelines
- Gold Standard for COPD
- www.miccsi.org resources
 - Asthma webinar series live and recorded
 - Diabetes
 - Depression
 - Hypertension
 - Multi-morbid (COMPASS)
- www.micmt.org





Disease Management Considerations

- Health care professionals have the knowledge and expertise to assist the patient
- The actual disease manager is the patient
 - They decide, based on the information they have and their expertise upon themselves, what next steps if any they will take
- Provide information in a sense making, non-threatening approach
 - Engaging with the patient may provide opportunity for the patient to reconsider or consider new ways of managing their chronic condition



Assessing Readiness and Confidence



Assessing the Patient's Ability and Desire

- Assess the patient's readiness and confidence
 - How confident are they?
 - How interested are they?
- The patient's knowledge, desire, and ability, are key to creating a successful plan
- This information will be used to in creating the self-management action



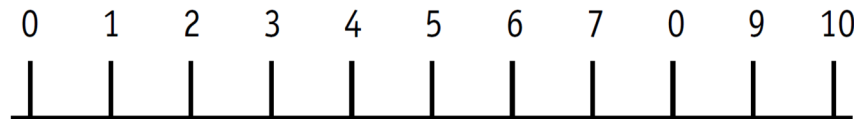


Assessing Readiness

(Page 29 CM Toolkit)

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?



Consider asking:

Why a (number provided) and not (number lower)?

We ask the lower number to promote the patients own reasons and to encourage “change talk”



Assessing Confidence

Same approach as readiness

- Ask.....
 - On a scale of 1 through 10 how confident are you in(monitoring your blood sugars/taking your medications as prescribed/exercising/.....)
 - Why a (number provided) and not (lower number)?
 - What would it take to get you to (a higher number)?



Measure it!



The Why of Assessing Health Confidence

Health confidence measures patients' level of knowledge, skills, and self-efficacy about:

- Taking an active role in their health care
- Managing their health conditions

Patient reported health confidence is a simple measure for concepts of:

- Self-care
- Self-management
- Activation
- Self-efficacy
- Productive patient-provider interaction
- Patient engagement



Care Management Process

Planning Phase of CM



Assessment to Planning

Case management plan of care

- Identifies outcomes that are measurable and achievable
- Are within a manageable time frame
- Apply evidenced-based standards and care guidelines



According to the Commission of Case Management

Planning is completed after authorization for the health and human services to be rendered has been given **by the payer source** and after the services and **resources needed have been identified**





Care Planning Process

- Objectives
 - Review the process of care plan development
 - Identify the documentation requirements

A dream
becomes a goal
when action is
taken toward
achieving it...



Assessment & Care Plan

Michigan Payer Positions

Michigan Commercial Payer Criteria (Priority Health)

- G9001 Code documentation requirements
 - Care Manager responsible for the care plan to include name and credentials
 - Patient's provider and contact
 - Date, duration and modality of contact (face-to-face or phone)
 - **Provider agreement to services**
 - **Patient agreement to services**

Also consider

- The assessment tool of your organization
- Part of this code requires face to face
- Total time must be at minimum 31 minutes



Next Steps

What to do with all this information?

- Documenting the assessment
- Creating the care plan
- Creating the self-management action plan



Planning Phase

The Planning phase establishes:

- Specific objectives
- Goals (short and long-term) within a timeframe
- Actions (treatments and services) necessary to meet a patient's needs as identified during the Assessing phase

Based on the CMSA Standards of Practice for Case Management



Planning Basics



Inputs and approvals

- Pt
- Family
- Providers



Action oriented

- Time specific
 - SMART Goals
- Incorporate multi-disciplinary input
 - Specialist
 - Other care team
 - Social Worker
 - RN
 - PT/OT
 - Pharmacist



Addresses Self-management (desire and ability)

- Is across the care continuum
- Addresses current episodes
 - ER, admits, specialist, etc..





Michigan Payer Must Have Elements Care Plan Documentation Note

❁ Demographics

- ❁ Date of visit
- ❁ Appointment duration
- ❁ CM name and credentials
- ❁ If others at the care planning – name and relationship to the patient
- ❁ Name of the patient's PCP

❁ Care plan specifics

- ❁ All diagnosis discussed
- ❁ Treatment plan
- ❁ Medication reconciliation/therapy
- ❁ Risk factors impacting the plan of care
- ❁ Unmet care
- ❁ Physical status
- ❁ Emotional status
- ❁ Community resources (if applicable)
- ❁ Readiness to change, including challenges and interventions
- ❁ Patient understanding of the care plan
- ❁ Patient level of agreement with the care plan
- ❁ Physician coordination activities and approval of the care plan





Care Plan In Practice

Ask

- “Why was the case referred/what is/are the driver(s)?”
- “What quality, risks and safety issues exist and require priority?”
- “What does the patient want to accomplish?”
- “What are the patients main concerns/worries?”

3 Processes involved:

- Planning (using the assessment)
- Validation (reviewing records, communication with care team)
- Implementation and Problem-solving (Action steps for the patient and care manager)





Self-management Action Plan

Real Play

Group Activity:

- One person takes on the role of the patient
- One person takes on the role of the care manager or care coordinator
 - Care Manager/Care Coordinator: Identify an area the patient would like to work on, “Is there something you would like to do to improve your health?”
 - Using open-ended questions
 - Get the patient to a SMART action (Specific, Measurable, Achievable, Relevant, Time bound)
 - Using the readiness ruler assess the persons readiness
 - Using the ruler concept, assess the persons readiness and or confidence in carrying out the plan





Note Example

11/13/2021

CM services approval with PCP on 10/31/2021. Patient agreement 11/7/2021

- This CM met with Jane Doe from **11:10 to 12:30 today** to complete an **initial assessment** and create a **plan of care**. In **attendance were** Jane and her spouse John. With Jane's permission, the 3 of us **discussed Jane's current diabetes outcomes** and Dr. Smith's concerns related to these values, and his recommendation for a referral to care management services.
- During the evaluation, we **reviewed Jane's current medication regimen** and **her understanding of the treatment plan**. Jane reported on a scale of **1-10 for readiness to make changes** with her care she was at a 6.
- With permission, I reviewed the **concerns and risks of a stroke** or CVA associated with elevated blood sugars along with elevated blood pressure readings. Jane was not interested in a **referral to the diabetes center** at this time, she was receptive to reviewing available **classes at the YMCA**, of which were provided.
- Jane **appeared in good spirits, appropriately dressed and manicured**. There was no evidence of cognitive impairment. She had **no difficulties transferring in/out of the chair or walking to/from** the waiting area, she was able to shake hands without any difficulties.
- The **PHQ9 Depression Screening** score was a 3. There is no noted diagnosis of depression.
- Next steps and actions were reviewed and outlined in the plan of care. We planned a telephonic review in one week between 11/20/21 and 11/27/21
- The plan of care developed by this CM'er and Jane was reviewed with the provider. The **provider is in agreement to the plan of care**.

Respectfully submitted – **Sue Smith BSN, RN**



Self Management Interview

- Planned Care Visit: The Self-management Interview : Improving Chronic Illness Care



Observe and be prepared to share:

- Tools used by the Care manager
- Follow-up plan





Care Management Process

Implementation
Care Coordination



Implementation Planning

- According to the Commission for Case Management
 - The Implementing phase centers on:
 - **Execution of the specific case management activities and interventions that are necessary for accomplishing the goals** set forth in a patient's case management plan of care. This role is commonly known as care coordination.





Case Manager Implementation Responsibilities

- Organize
- Secure
- Integrate
- Modify (as needed)

.....the health and human services and resources necessary to meet the client's needs and interests





Implementation

The care manager shares information on an ongoing basis with the:

- Client/patient
- Client's/patient's support system
- Healthcare providers/clinicians
- Insurance company/payer
- Community-based agencies
- Medical Neighborhood





Tips

Implementation and Problem Solving

Documentation includes:

- Creating and updating the patient's written case management plan of care: documentation of ongoing agreement with plan, including agreement with any changes or additions
- Evidence of supplying the patient with information and resources to make informed decisions
- Awareness of maximizing of patient outcomes and goals (treat-to-target)
- Compliance with payer expectations
 - Documentation
 - Reevaluation and redefining long and short-term goals





CM Process

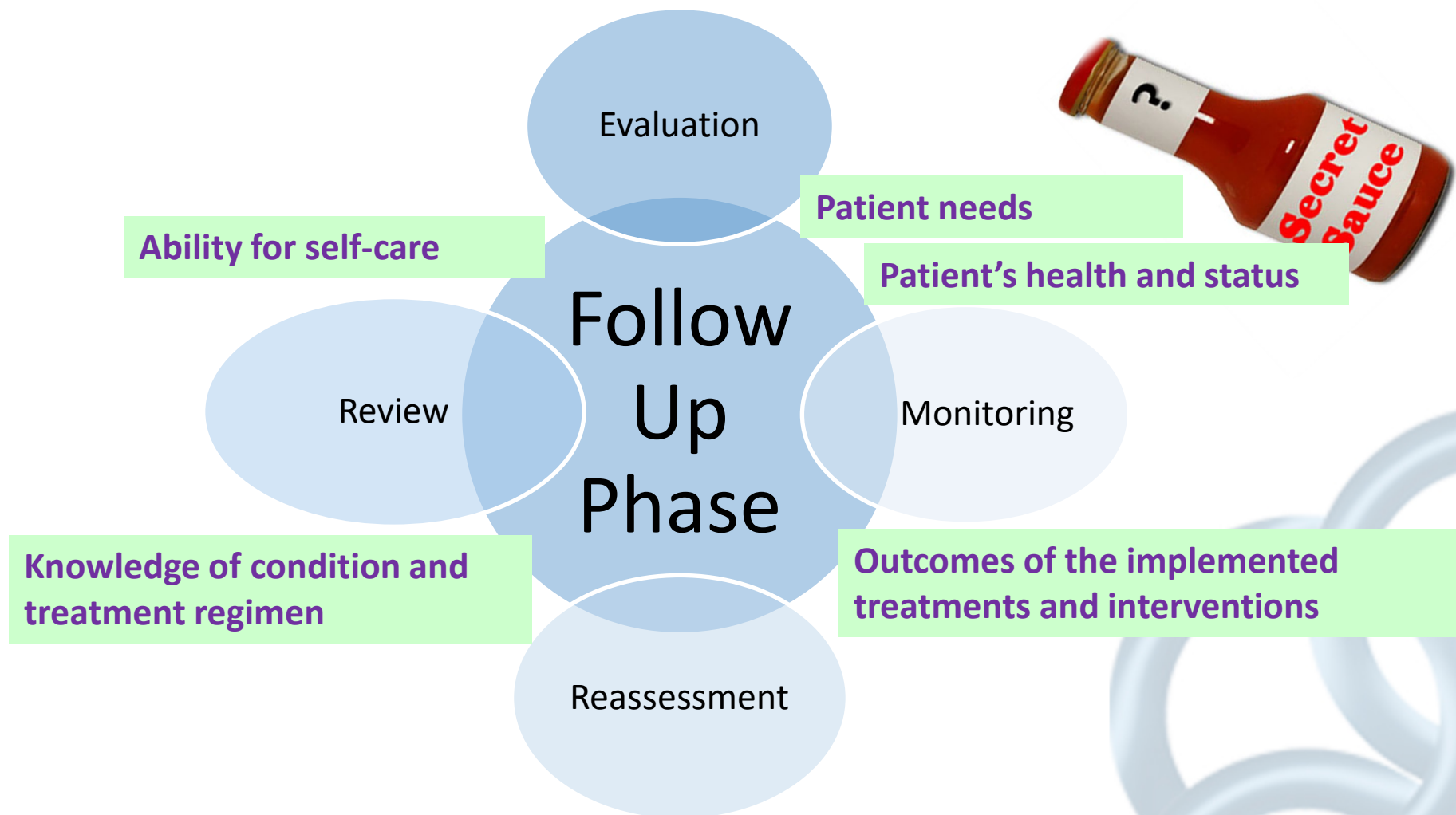
Follow-up Phase

(Between Implementation and Closure)

Blue Prints to Success
Monitoring Progress



The case manager's primary objective is to evaluate the appropriateness and effectiveness of the case management plan and its effect on the client's/patient's health condition and outcomes





Follow-up in Action

Using the Care Plan as a guideline, collect information

- Use the Agenda Setting technique
 - We have 15 minutes today, what 2 things do you want to cover? I would like to cover these 2 items (state the items – such as progress in goals, screening values such as PHQ)
 - Before we get started, has anything changed or is there information you think I should know about since we last spoke?
 - Been to ER, in the hospital, seen specialist
 - Changes in prescribed medications
 - Taking any new homeopathic or over the counter medications
 - Monitoring progress to the clinical and self-management plan of care
 - Treat-to-target measures
 - A1C/Blood sugar diary - Medical
 - PHQ self-score/todays score - Behavioral
 - Self-management goals (activity, diet, social, etc...)





Lack of Progress to Goals

Consider:

- Need for treatment intensification – review options with the provider
 - revise plan of care and provide a copy to patient
- Determine if frequency of contact needs to be adjusted
 - Self-care plan in place and in phase of preparing for closure
 - New risk/safety issue





Billing Opportunities

Follow-up and Monitoring

G9002 (face to face encounter with patient)

G9007 (care conference with provider)

- CPT Phone Codes
 - 98966 (5-10 min)
 - 98967 (11-20 min)
 - 98968 (21-30 min)



Monitoring Frequency Guidance

New or change in
treatment plan

New or change in
medications

Risk or safety
issues

Patient progressing
to self-
management

Preparing patient
for graduation and
return to clinic for
monitoring



Relapse Prevention/Graduation

Preparing for Discharge/Case Closure from CM Services

Throughout the follow up phase

Measure and assess the client's response to the plan of care to:

- Demonstrate ongoing collaboration
 - Verify the plan of care continues to be appropriate
 - Measure the patient's progress or lack of to goals
 - Establish patient triggers and ability to identify circumstances that alter the plan of care in preparation for self-care/monitoring
- When it is apparent the patient, provider, and care manager identify the patient is ready for discharge or case closure, proceed with finalizing the “Relapse Prevention” steps





Preparing a Relapse Prevention Form

(See example in training book)

- Note the tool “CM Relapse Prevention Guideline”
 - What conditions could this tool be used for?
 - How would a “relapse prevention” tool benefit triple AIM (cost, quality, and satisfaction)?
 - How can you fit relapse prevention planning with patients into standard work?





Case Management Process Case Closure

Transitioning



Objectives

- Review the goals of care management
- Identify triggers for case closure
- Review the process of care transitions
- Discuss the transitioning process in PDCM



Provider Delivered CM

Case closure/transition triggers

Your Thoughts?

Discuss in your groups

What are the triggers you will use to determine when a case should be closed/transitioned from your service?





Case Closure Triggers

- Hospice
- Custodial/Long-term Care
- Transferred to another PCP
- Expired
- Maximized Level of Function
- Unable to Reach
- Lack of Engagement
- Readiness to Change Indicates Not Ready
- Transferred to Another Care Manager
- Patient Declines
- Goals Met!





Managing Inactive Patients

- Attempts to contact 3 different times and days (Standard of Practice for CM)
 - Patient unresponsive to outreach
- Closure Process Options to consider
 - PCP agreement
 - Follow up letter
 - Closure letter
 - In-person notification at next appointment



Managing Active – Not Engaged

- Patients attend appointments, respond to phone calls – not making gains on goals
 - Determine if the goals are realistic/attainable
 - Validate the care plan goals are in alignment with the patients goals
- Consistently unable to reach
 - Reassess “Readiness to Change”
 - Use your OARS/MI techniques
 - No progress – follow case closure steps



Active – Meeting Goals

- Identified by:
 - Care Coordination/clinical stabilization achieved
 - Utilization/high cost resolved
 - Maximum function achieved
 - Chronic disease(s) in control or maximum control attained
- Next Steps:
 - Finalize relapse prevention planning
 - Assist PCP team with transition/re-entry to PCP team for monitoring
 - Congratulate the patient – Goals met!
 - Prepare the patient for transitioning out of care management services



Discontinuing Services

- Steps to Take:
 - Leave the door open for future CM
 - Provide the patient with CM contact information
 - Establish an agreement with the PCP and patient
 - Document case closure in the medical record





Case Management Process Billing Guide

Case Management Process

- Patient Identification/Pre-screening
- Assessment/Care Planning
 - Care Coordination
- Implementation (follow-up and monitoring)
 - Care Coordination
- Case closure/Evaluation

Billing (Priority Health and BCBSM)

- No payment
- G9001, G9008
- G9002, CPT phone codes, G9007
 - 99487, 99489
- G9002, CPT phone codes, G9007

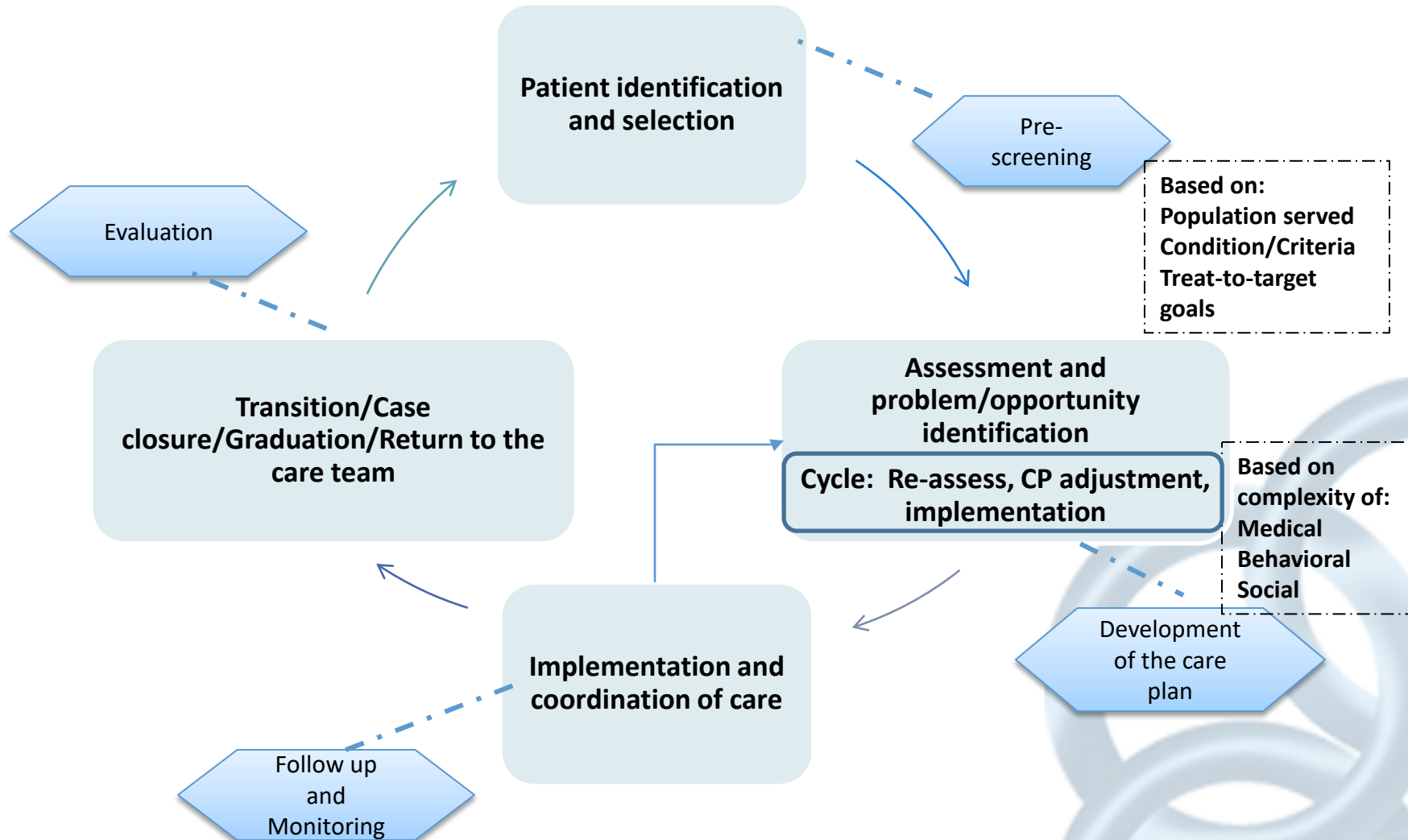
*Transition of Care (TCM) is part of patient identification. It sits alongside of the CM process. Billing codes used are dependent upon the insurance type and product.

Medicare – TCM codes

Commercial - (BCBSM/Priority Health) G9002 or CPT phone codes and TCM codes



Case Management – It's a Process



Resources

- The Integrated Case Management Manual pgs. 46-49
- CMSA Standards of Practice for CM
- Commission for Case Management Certification Body of Knowledge
- Robert Wood Johnson Foundation Synthesis Report 19 conducted by Thomas Bodenheimer, MD & Rachel Berry-Millet of the center for Excellence in Primary of Care Department of Family & Community Medicine, University of California-San Francisco
- WWW.Miccsi.org
- www.priorityhealth.org (search CM codes)
- www.micmrc.org (search billing)



Thank You!

Questions

