Case Management Process

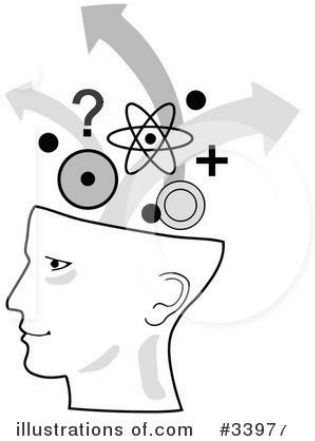
An Inter-active Overview and Application of Knowledge

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 suggested care team includes:

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

Based on the CMSA integrated Case Management; A manual for Case Managers by Case Managers

How the team works – supporting one another to serve the patient

- The medical and behavioral case managers support each other with respective experiences
- Nonclinical staff assists with coordination activities that do no 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

Based on the CMSA integrated Case Management; A manual for Case Managers by Case Managers

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.

AHRQ
https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

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**
- M**anage 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

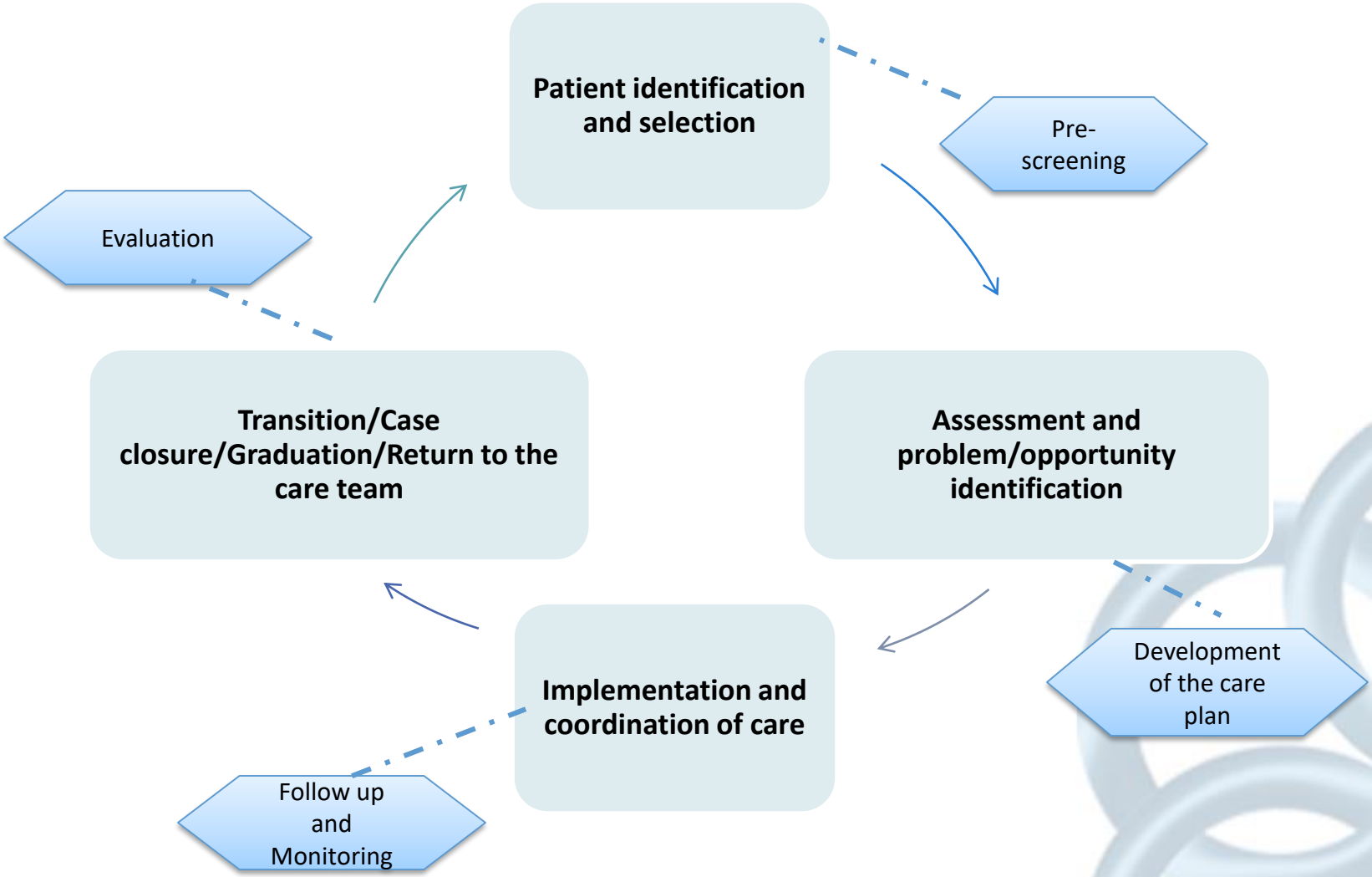
The goals of case management are:

- 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)**

Philosophy and Guiding Principles

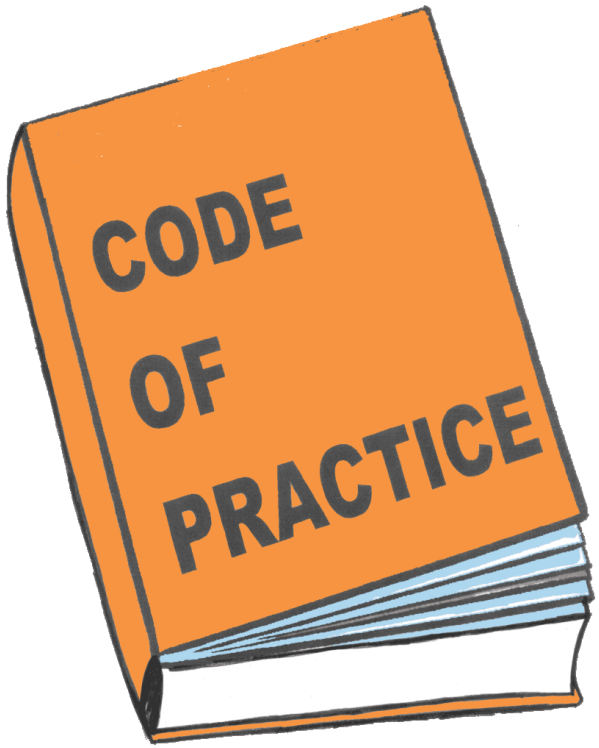
- Patient-centered, comprehensive, and holistic
- Collaboration, coordination, communication
- Facilitate self-determination through advocacy and education
- Promote evidence-based care, safety, wellness
- Integrate behavioral change principles and cultural competency
- Assist with navigating health care system
- Pursue professional competence and excellence

Case Management – It's a Process



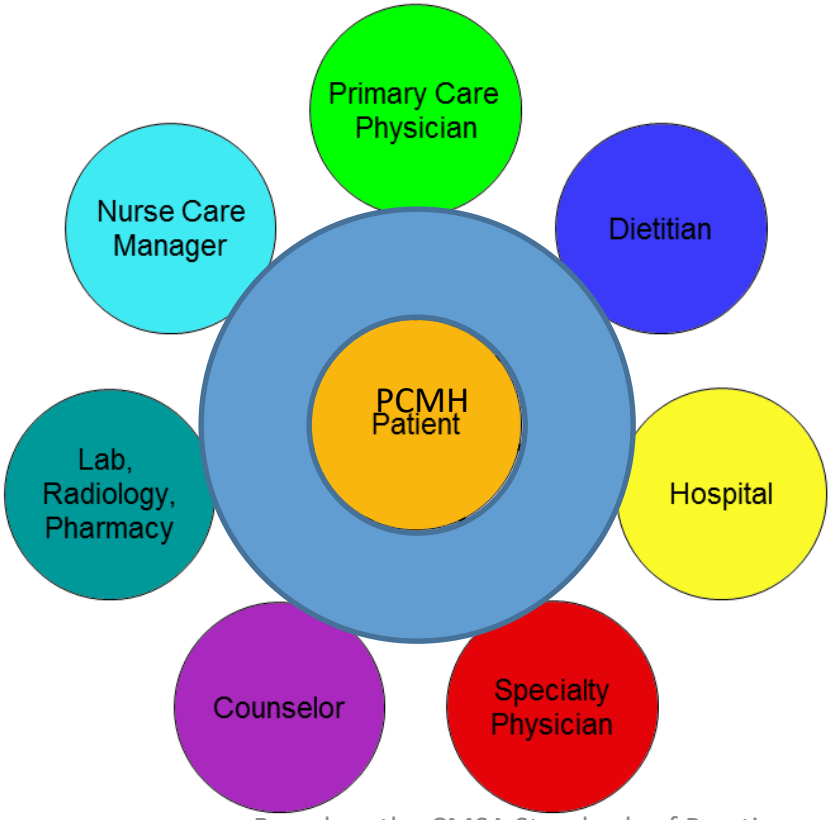
Standards of Practice

A. Patient Selection
B. Assessment
C. Problem/Opportunity Identification
D. Planning
E. Monitoring
F. Outcomes
G. Termination/Return to Care Team
H. Facilitation, Coordination, Collaboration
I. Qualifications For Case Managers
J. Legal
K. Ethics
L. Advocacy
M. Cultural Competency
N. Resource Management and Stewardship
O. Research and Research Utilization



Care management within the system

- Where care management occurs
- Examples of care management



What is missing from this diagram?

How would care management benefit?

Based on the CMSA Standards of Practice for Case Management

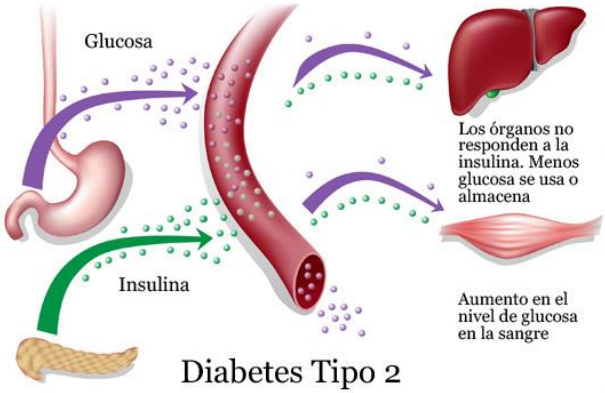
Care Management
Primary Care Practice

- 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

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 goal(s)?	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,	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	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	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

Patient Selection
Aligning Risk with Services



CM Process
Patient Identification

Objectives

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

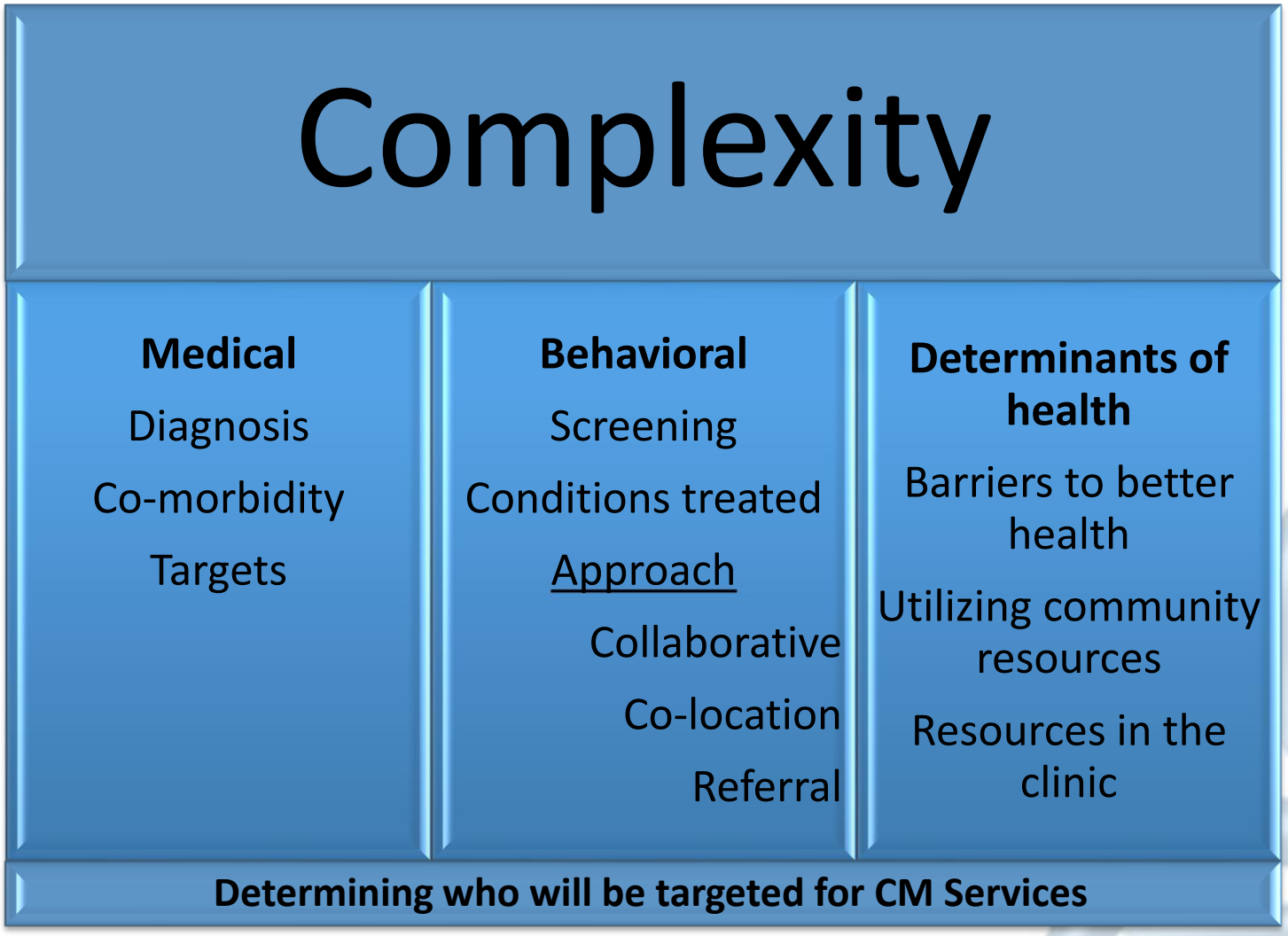
Care/case Managers: Patient Identification Process

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



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

Based on payer requirements outlined in the BCBSM Payment Guideline and PH website

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?

Based on the CMSA Standards of Practice for Case Management

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

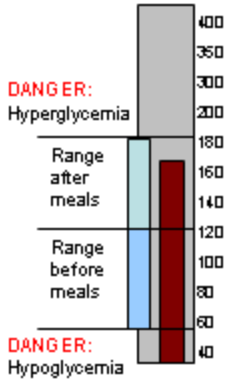
CM Process – Patient Identification Prescreening

Objectives

- Review prescreening process

Applying the Care Management Process

Prescreening



Pre-screening

- Pre-screening (see page 18 & 19 in the CM Toolkit)
  - Most current data
    - Sources
      - » Medical Record of Primary Care, inpatient and specialist
      - » Registry or EMR registry like reports
      - » Payer reports
  - Provider input and approval
    - Sources
      - » PCP, Specialist, and other care team members
  - Patient & Care Giver Interview
      - » Patient knowledge of disease/situation
      - » Most up-to-date information
      - » Desire to work with the care manager
        - Participate in self-management
          - Willingness
          - Ability

Pre-screening - In Practice

After receiving the referral
(see pages 2,3, and 4 – CM Toolkit)

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

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

Your Mission: Create an elevator speech

Pre-screening Video

- http://www.improvingchroniccare.org/index.php?p=Planned_Care_Visit:_The_Provider_Point_of_View&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
- Documentation requirements

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

- Serves as the framework for CM services
  - 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

The Case/Care Manager 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

Common Attributes of Successful Care Models

- Interdisciplinary primary care models show positive outcomes and may have broad application. Chad Boult and Darryl Wieland (Johns Hopkins) distilled features associated with more effective primary care for older adults with chronic illnesses. They are:
  1. Comprehensive assessment of health conditions, treatments, behaviors, risks, supports, resources, values, preferences;
  2. Evidence-based care planning and monitoring to meet the patient's health-related needs and preferences;
  3. Promotion of patients' and family caregivers' active engagement in care;
  4. Coordination, communication among all engaged in a patient's care, especially during transitions from hospital.
- Bodenheimer, Berry-Millett identified characteristics of more successful programs:
  1. Selecting patients with complex needs but not those with illness so severe that palliative or hospice care would be more appropriate than care management;
  2. Using specially trained care managers on multidisciplinary teams that include physicians; emphasizing person-to-person encounters, including home visits;
  3. Coaching patients and families in self-care and recognize problems early to avoid expensive care;
  4. Relying on informal caregivers in the home to support patients.

Assessment

- 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 while assessing:
  - **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

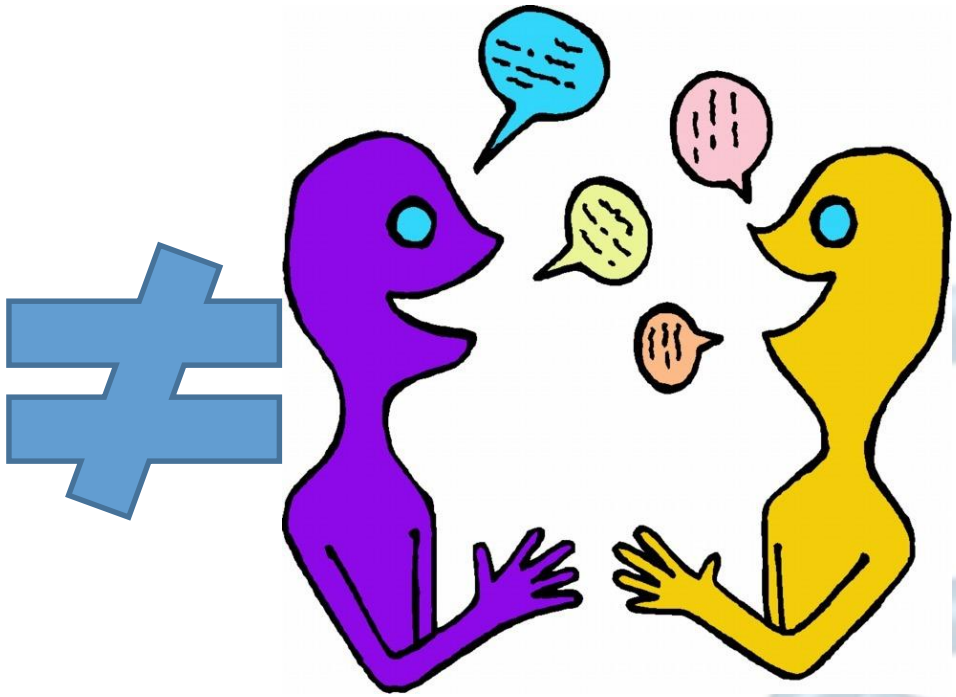
Commission of Case Management http://www.cmbodyofknowledge.com/content/case-management-knowledge-2

Assessment and the Care Coordinator

- Partners with the Care Manager to:
  - Jointly create and **manage the individualized plan of care** with the patient/family, care team and community based organizations, that outlines the patient's **current and longstanding needs** and **goals for care** and **addresses coordination needs and gaps in care**

Capturing the Information

- It is about engaging with the patient



Assessment Application

Review the packet titled, “Persona for MiCCSI Package”

- Review of case studies
- Assigning cases to small groups

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

Group Sharing

Shared questions for each category:

Health status_____

_____

Psychosocial status_____

_____

Knowledge/ability/desire_____

_____

Cultural and or linguistic needs_____

_____

Psychosocial Assessment Approach

- Establishing Cultural and Linguistic Needs
  - Cultural awareness and competence
  - Linguistic awareness and competence

- Social Determinants 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

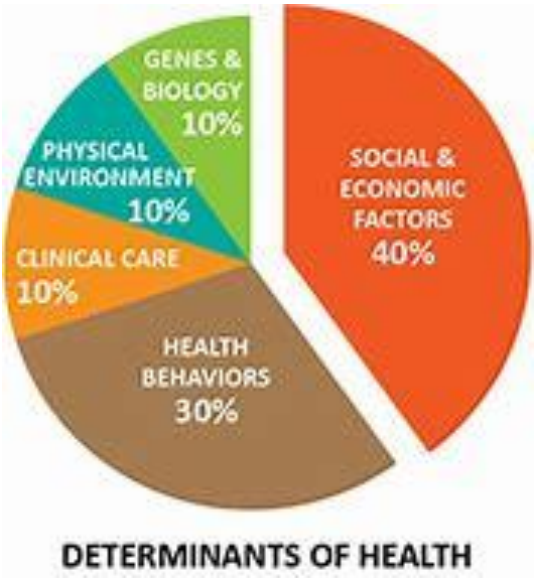
- The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels
- The social determinants of health are mostly responsible for health inequities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

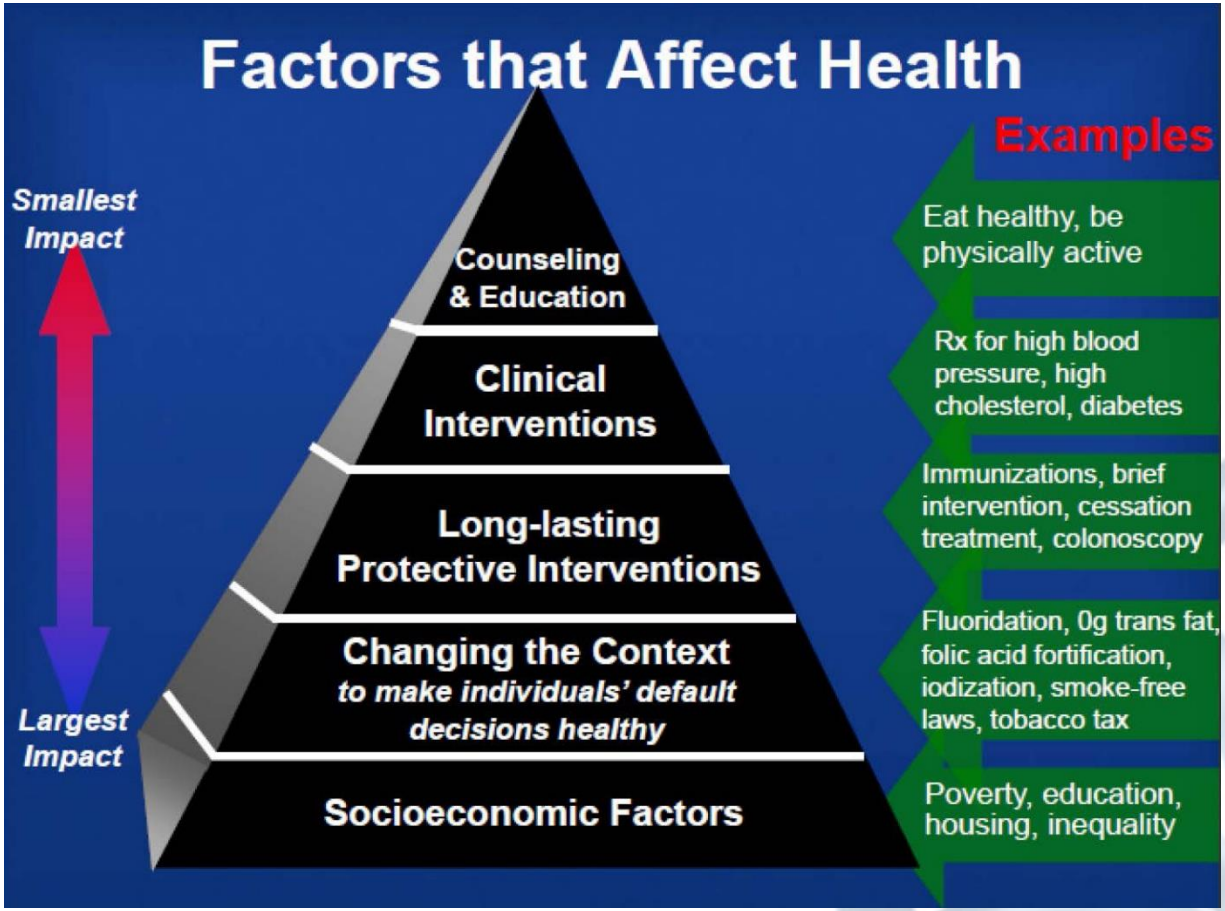
Psychosocial Assessment Determinants of Health

The determinants of health include:

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

According to the Center for Disease Control





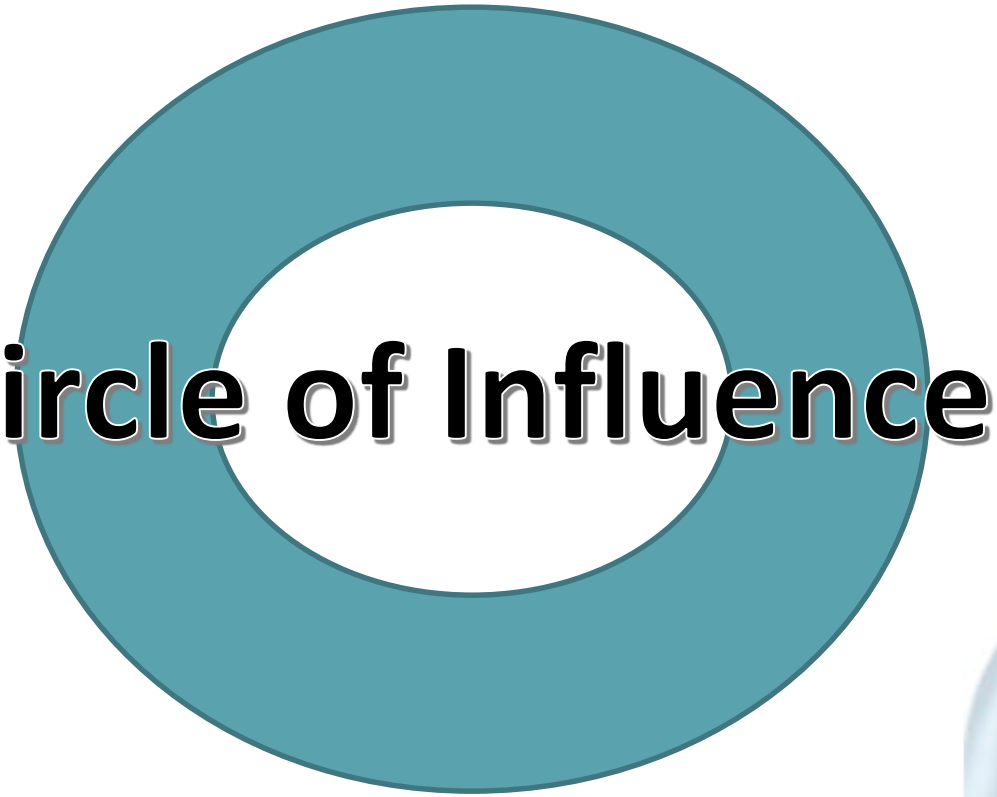
- # Social Determinants of Health
- https://www.youtube.com/watch?v=I7iSYi3ziTI

Why do they keep telling me what to do without asking me why I'm not doing the things they told me to do last time?

Why isn't the patient's care improving? We've provided education, a care plan, prescriptions and recommendations. What's missing?

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

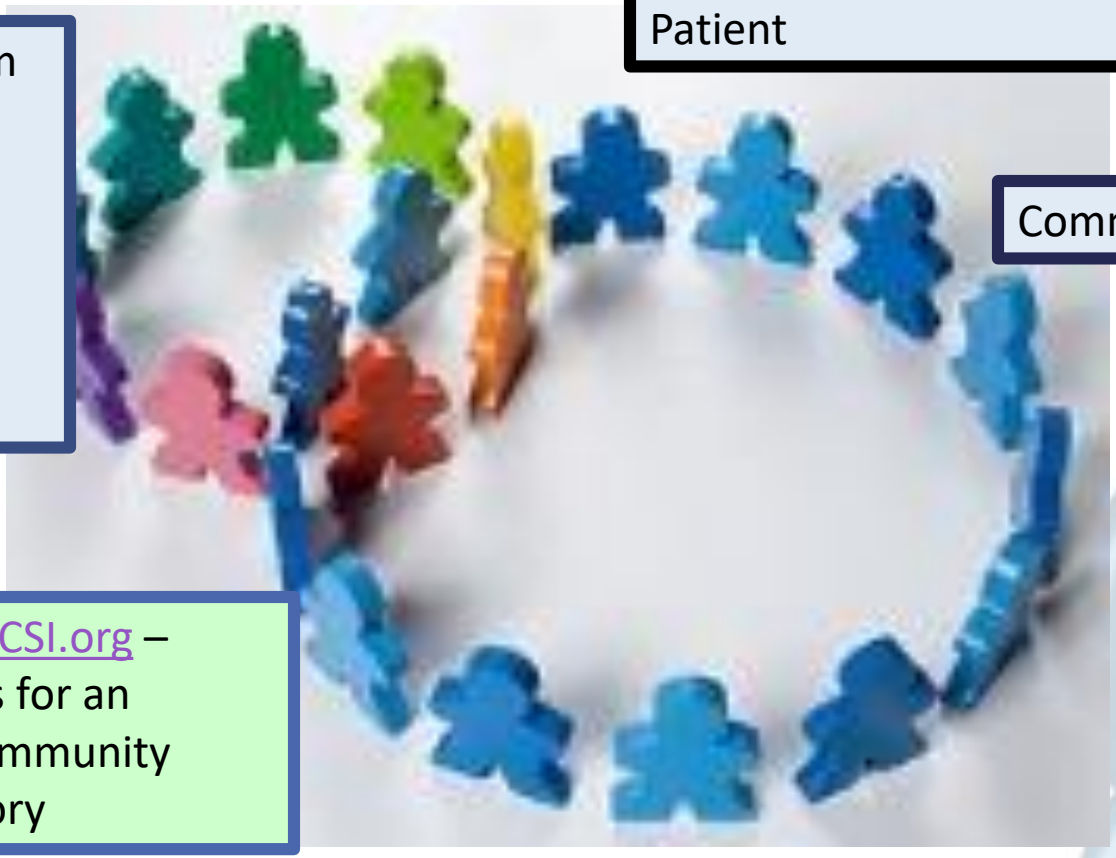
Care Management
Impact on Determinants of Health

- For health care to deliver on its promise of improved health and better quality of life, a renewed commitment by all stakeholders is required to ensure that each person has the opportunity to participate knowledgably and effectively in their care to the extent they are able.

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

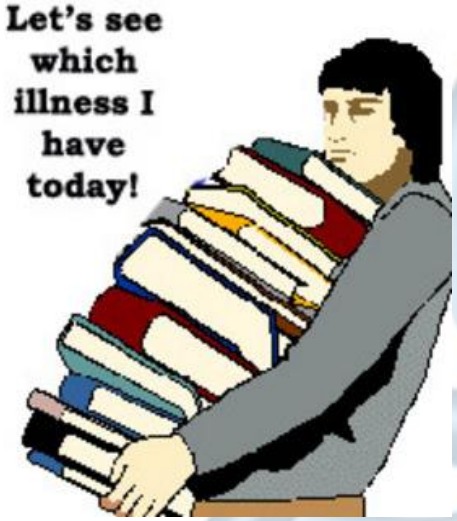
Go to www.MiCCSI.org – under resources for an example of a community resource directory

Screening for Social Determinants

- Review State Innovation Model
  - Concepts
  - Tool (see insert in training book)

- Review CPC+
  - Concepts
  - Position on State tool

Assessment – Disease Management



Assessing Patient Knowledge

- What does the patient already know about their condition or disease?
- What are the patients goals? (Health and other)
- What do you as the care manager understand about the condition or disease?

Definition of Disease Management

CCMC definition of disease management:

A system of coordinated healthcare interventions and communications for populations with chronic conditions in which patient self-care efforts are significant. It supports the physician or practitioner/patient relationship. The **disease management plan of care** emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the **goal of improving overall health**.

Disease Management In Practice

- Identify the source used for each condition
  - 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.micmrc.org

Considerations
Disease Management

- 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

Care Management and Care Coordination Focus of Disease Management

Disease Management

- Assess the patient's knowledge and ability to manage the disease
  - Identify knowledge and ability gaps and barriers - opportunity for education and care coordination
- Assess the patient's readiness and confidence
  - How confident are they?
  - How interested are they?
- Review the clinical plan of care
- Based on knowledge, desire and ability, determine self-management goals to support the clinical plan of care and the patient's self-management action plan

Based on the CMSA Standards of Practice for Case Management

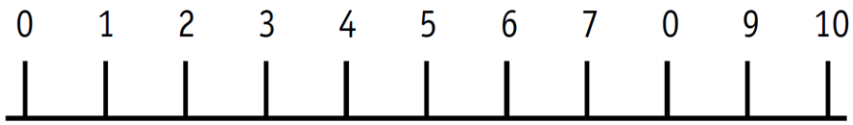
Assessing Readiness and Confidence

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

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
    - Using the readiness ruler assess the persons readiness
    - Using the ruler concept, assess the persons confidence in carrying out the plan
- Others in the group
  - Observe the response of the patient to the caregivers approach
  - Observe the caregivers use of the ruler and or open-ended questions
- Review your experience as the CM/CC, patient and observers
  - How did it go?
  - How do you see this working in the practice of care management?

Risk Stratification
Using risk assessment information to guide care manager and care coordinator interventions

Risk Stratified Care Management

AAFP defines risk stratified CM as:

- The **process of assigning a health risk status** to a patient, and **using the patient's risk status** to direct and improve care.
- The goal of RSCM is to help patients achieve the best health and quality of life possible by preventing chronic disease, stabilizing current chronic conditions, and preventing acceleration to higher-risk categories and higher associated costs.

Rationale of Risk Stratification

According to the CCMC ***The Stratifying Risk Phase*** involves the classification of a client into one of three risk categories –

- Low
- Moderate
- High

Stratifying risk aides in determining the appropriate level of intervention

- Based on the client's situation and interests

Stratifying risk allows the implementation of targeted risk category-based interventions and treatments

- Enhance the client's outcomes

Current State
(Group Activity)

- **Discuss in your groups how your teams could categorize patients into risk or level of service. See pages 35, 36, 37 in the CM toolkit**
  - **How could this assist in determining the level of service (such CM, care coordinator, behavioral health specialist, etc..)**
  - **How would this help in determining frequency of monitoring and follow up?**
  - **Be prepared to share your conclusions with the group**
  - **See page 35, 36, 37 in the CM Toolkit for examples**

Care Management Process
Planning Phase of CM

Care Planning Process

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

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**

Assessment & Care Plan Michigan Payer Positions

Michigan Commercial Payer Criteria (BCBSM & PH)

- 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 30 minutes

Next Steps

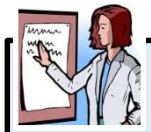
- What to do with all this information?
  - Documenting the assessment
  - Creating the care plan

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

Focus of CM and CC Services

Ask Yourself

- "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)

CM Assessment & Care Planning

- Using your case study
    1. Identify key areas to include in the initial assessment
        1. What are the drivers for this case (medical, behavioral, social)?
        2. What are the primary quality and risk/safety concerns?
        3. What do you anticipate the patients main concerns/needs/desires will be?
        4. What financial issues will likely contribute to the complexity?

Creating the Care Plan

In your group

1. From your initial assessment (focusing on the key areas of medical, behavioral and social complexities) develop an initial care plan

Example:

Long-term goal: Asthma in control as evidenced by no ER visit within the next 12 months

Short-term goal: Establish patient confidence in medication management as evidenced by:

- Identifying patient confidence using the confidence ruler
- Ability to complete a return demonstration of inhaler use accurately to this CM by end of visit today

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 regiment** 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

Implementation in Action

Share ideas on how care coordination impacts patient care and how the roles of the care team can stay involved and updated on the care plan and implementation process

- How and when will you communicate changes with the:
  - Patient
  - PCP, BH Specialist/Social Worker, Care Coordinator, Pharmacists
  - Specialist and others outside of the medical home (home care, Inpatient discharge planners, etc..)
- How could a team conference with core care team members be constructed?

Care Coordination to Prevent Unnecessary Services

In your groups discuss how care coordination and implementation responsibilities could benefit your assigned case.

- What members of the team would act as the facilitator/organizer for each care coordination opportunity?

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)

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

Evaluation

Patient needs

Patient's health condition

Ability for self-care

Review

Follow Up Phase

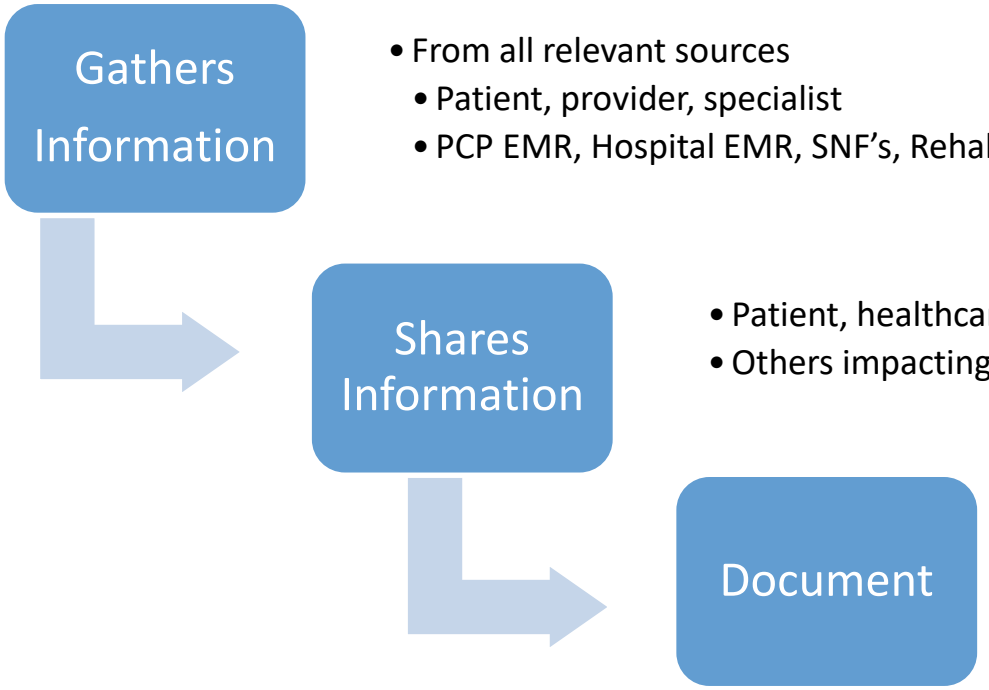
Monitoring

Knowledge of condition and treatment regimen

Outcomes of the implemented treatments and interventions

Reassessment

Follow Up Responsibilities



These activities are repeated at frequent intervals as needed

Following-up may indicate the need for a minor modification or a complete change in the case management/patient plan of care

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
      - PHQ self-score/todays score
      - 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

Implementation: Follow-up and Monitoring

Billing Opportunities

- 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

Definition: Care Transitions

Care Transitions

- Moving a client/patient across the health and human services continuum or levels of care depending on the client's health condition and the needed services/resources
- Examples:
  - Hospital to home, Hospital to Skilled Nursing Facility, PCP to Specialist
- Your ideas: Examples of care transitions specific to provider delivered care/case management within the primary care practice team

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!

Care Transitions
PCMH View

- **13.0 Coordination of Care**
- Goal: Patient transitions are well-managed and patient care is coordinated across health care settings through a process of active communication and collaboration among providers, patients and their caregivers

In Practice: Transitioning Patients

Prepare the Patient

- Provide Written Overview of Care Plan
  - Date of Last Labs/Tests and Results
  - Next Date Labs/Tests are Due
  - Next Date for Follow-up Care – who, how to contact, and location
  - Patient Goals of Treatment
  - Self-management Goals – Relapse prevention plan
  - Medications
  - Other
- Provide List of Providers to include:
  - Specialist Contact Information and Location
  - New Primary Coordinating Provider Contact Information
  - Care Manager Contact Information
  - Due Date for Next Appointment(s)

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

Review of Goals

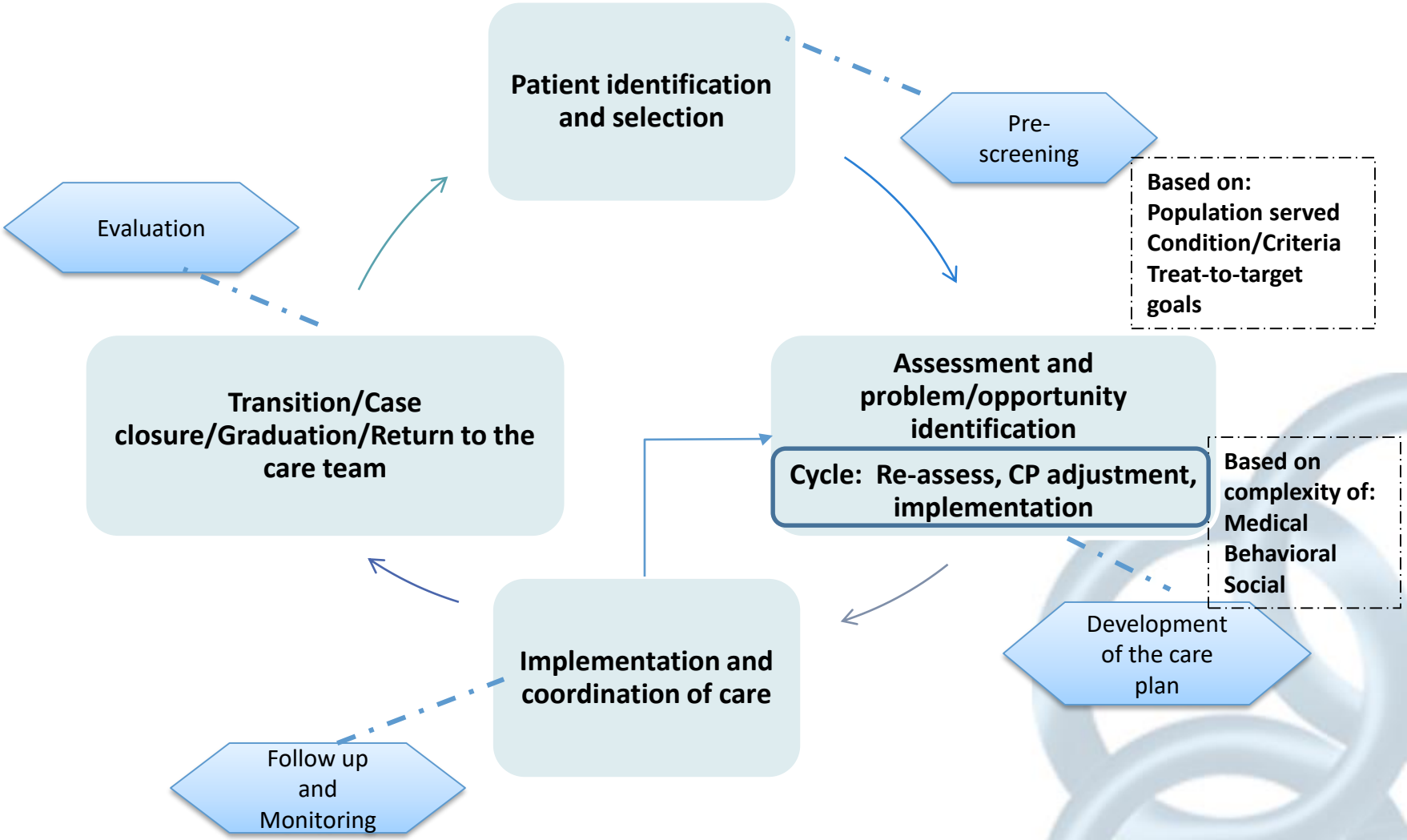
1. Improve patients' functional health status
2. Enhance Coordination of Care
3. Eliminate duplication /unnecessary/avoidable services
4. Reduce the need for expensive medical services

Case Management Process Billing Guide

Case Management Process	**Billing (Priority Health and BCBSM)**
• Patient Identification/Pre-screening	• No payment
• Assessment/Care Planning – Care Coordination	• G9001, G9008
• Implementation (follow-up and monitoring) – Care Coordination	• G9002, CPT phone codes, G9007 – 99487, 99489
• Case closure/Evaluation	• 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