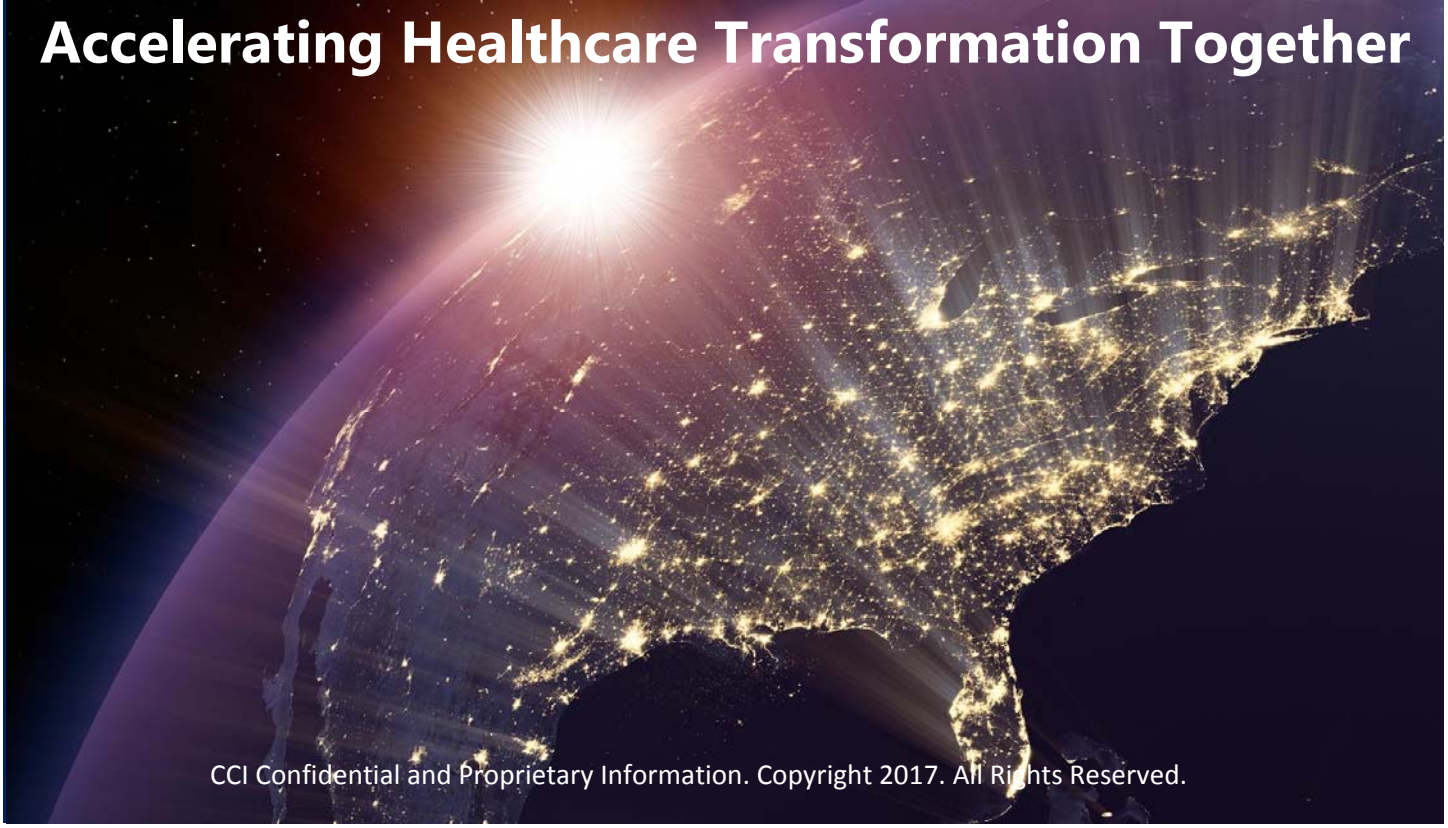
CARE COORDINATION INSTITUTE

CARE MANAGEMENT PROGRAM

Accelerating Healthcare Transformation Together



Program Description – *6.2017 Version, pending revision*

Care Management (CM) is a program that targets specific populations. Care Managers assist patients with multiple or complex conditions to obtain access to care and services, as well as coordinate their care in order to meet health goals and improve outcomes. CM is provided to patients who have experienced an event or diagnosis requiring the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. It is a collaborative process of assessment, planning, facilitation, care coordination and evaluation. The CM Program provides advocacy for options and services to meet the comprehensive medical, behavioral, psychological, social and spiritual needs of a patient and the patient's family/caregiver, while promoting quality and cost-effective outcomes. Since CM is considered an opt-out program, all eligible patients have the right to participate or decline participation. The Care Transition Program focuses on evaluating and coordinating post-hospitalization needs for patients who may be at risk of readmission.

Objectives

The goal of Care Management is to help identify patients in need of care management services and refer eligible patients to the appropriate programs. Through the CM programs, the patient should regain optimum health or improved functional capability. The CM resource strives to serve as an advocate to the patient and ensures that the patient receives the appropriate level of care in the appropriate setting. Together, the CM team and the patient will work toward and continually monitor progress against the goals of the plan of care. In addition, the CM staff is focused on continuously improving patient satisfaction and engagement in their care by providing education and patient-centered support. The program will balance the needs of the patient and family with the efficacious and cost-effective use of resources.

The goals of the program include:

I. Reducing avoidable admissions for acute care
II. Reducing emergency room visits
III. Reducing re-admissions
IV. Improving clinical outcomes
V. Increasing patient quality of life and overall satisfaction
VI. Reducing duplication of services and avoidable cost

Services

The scope of services provided to the patient includes:

I. Assessment of health status
II. Education on the CM program and their condition
III. Development of a care plan with goals, barriers and self-management goals
IV. Assessment of progress against the care management plans for the patient, treatment plans, and evaluation of adherence
V. Prescribed treatment, interventions or regimens
VI. Regularly scheduled contact with the Care Manager based on acuity
VII. Assistance in navigating and collaborating with health plans, other practitioners, community resources and vendors regarding treatment plan
VIII. Supporting transitional care between inpatient and other facility or home
IX. Discussion with interdisciplinary team to review treatment plan and discuss interventions

Care Management Systems

CM documentation is within the Caradigm platform. All documentation in Caradigm, records the staff, date, and time of interaction with the patient. Caradigm also contains prompts and flags to remind Care Managers to take action. Additionally, Caradigm's platform and algorithms are based on evidence-based guidelines and best practices. Communication with providers is accomplished through telephone encounters in the EMR or via fax or telephone for providers using EMR's not accessed by CMs.

Evidence-based Care

The Care Managers use evidence-based clinical guidelines approved by the Care Coordination Institute (CCI), Quality and Care Model Committee and best practices by the Case Management Society of America, as well as guidelines built into the Caradigm Platform to conduct assessments, build care plans, identify interventions and suggest patient education. Guidelines/best practices built into Caradigm include HEDIS, NCQA, 5-Star, Care Management Care Pathways, America Diabetes Association and GOLD standards. Care Managers use decision support tools via Caradigm and EPIC, such as electronic reminders, alerts, and order sets. In addition, patients are provided with education resources based on the above guidelines to promote self-care and engagement in their own health. Care Managers also receive best practice training in motivational interviewing to support patient outcomes. See Evidence-Based Guidelines in the attached Appendix.

Eligibility Criteria

Using Milliman's MedInsight 2015, eligible patients are proactively identified for care management which pulls in clinical, utilization, readmission, emergency department usage, hospital discharge, pharmacy and claims/billing. In addition to identifying patients through eligible criteria, referrals are also made through the Disease Management program, discharge planners, utilization management analysis, caregiver/patient referral, the Nurse Hotline and payers. Patients are also referred into the program from providers or the patient and family/caregiver themselves. Care Managers will review data from these sources to identify patients as eligible. When a patient is identified as eligible, they are stratified based on their risk score. This stratification identifies the level of intervention.

A patient is not eligible for Care Management if:

I. Long term care residents
II. Referred to hospice
III. Transplant
IV. High risk obstetrics

The CM Department has determined graduation and discharge criteria. The graduation criteria are used when moving a patient from a high-touch intervention to a lower-touch intervention, graduating them from the program or transitioning them to Disease Management. The discharge criterion includes:

I. The majority of Care Management goals have been met
II. Expiration
III. Eligibility (based on referral criteria or contracts)
IV. Geography
V. Hospice
VI. Long term care
VII. Transplant

The discharge criteria will be reviewed at the beginning of the programs with the patient/caregiver. The graduation criteria are discussed at length with the patient/caregiver in terms of the patient's individual goals. Discharge from the program, graduation from a risk level or transition to Disease Management will be documented in the patient's record. The patient and or family/caregiver will be notified of the change verbally within 5 business days. If the Care Manager is unable to let the patient/family know verbally, then they will mail a letter and/or email the patient through the patient portal. This communication is documented in Caradigm.

Interventions

Intervention strategies are based on the level of risk or the severity of the condition. These interventions are tied to alerts and triggers for the Care Manager within the Caradigm platform. The intervention strategies will be adjusted as the patient is re-evaluated or assessed against their care plan. The CM program has established a timeline for interventions as noted in the table below. The use of these strategies varies on the risk level of the patient.

Interventions	
Intervention Level	**Contact Schedule***
High **Criteria Guidelines:** • New enrollment or not progressing with goals • Recent ED or inpatient utilization • Missed appointments • Poor or no social support/unstable social situation • Barriers & unmet needs • Noncompliance • Establishing care with multiple new providers • Receiving HH services or STR (weekly contact with appropriate staff after first contact with patient)	**Twice Weekly / 1-2 Times Weekly** First call being to patient within 3 days, post discharge or ED visit (if applicable)
Medium **Criteria Guidelines:** • Progressing with goals/barriers being resolved • Increased compliance with appointments • Decreased ED or inpatient utilization • Improved compliance	**Every 2-4 Weeks**
Low **Criteria Guidelines:** • Meeting 80% goals or minimum barriers • Good support system • No missed appointments • No ED or inpatient utilization	**Every 1-2 Months**

*Contacts may be face-to-face (office or home visits) or telephonic based on CM discretion. Document level of acuity and schedule for follow up at every encounter. Levels of intervention are based primarily on clinical judgement that should include several or all of the criteria guidelines. Other populations may begin at Medium, if appropriate. MSSP, TOC & Bundles are high risk for the first 30 days. Other populations may begin at Medium, if appropriate.

Resourcing/Case Load

Staffing ratios are based on acuity of the members assigned to each Care Manager. Approximate RN Care Manager Ratios are one nurse per 100 high-risk acuity members and a compliment of moderate acuity members of which are also supported by a health coach. Staffing ratios are also based on geography, patient satisfaction, performance outcomes, complexity of patient population, changes in volume of patient cases and whether a patient is part of a bundled payment program. Caradigm reports on the level of productivity to monitor the effectives of the established ratio. In the event that a Care Manager's case load becomes excessive, the Care Coordination Institute will reassign the case load based on geography, while seeking to ensure continuity for patients.

Transitions of Care

The facility's Interdisciplinary Care Team (IDT) attended by the Transitions Coordinator, manages care transitions, identifies problems that may result in unplanned transitions and strives to prevent unplanned readmissions. The IDT makes a special effort to coordinate care and support patients through the transitions from one level of care to a higher or lower acuity level, as well as between care providers. To achieve this, care transitions procedures are monitored, measured, reported and analyzed by the CCI Quality and Care Model Committee at least semi-annually.

The Transitions Coordinator initiates the ambulatory plan of care and sets goals with the patient and family/caregiver. Additionally, the coordinator ensures that the appropriate referrals to providers or social services/community resources have been scheduled. The Hospital Case Manager, Transitions Coordinator and IDT communicate with the patient and/or responsible party about the expectation of patient involvement in the care transition process and changes to the patient's health status. This is communicated verbally and is documented in the patient's record. The Transitions Coordinator educates the patient on the transition process and identifies the necessary steps to transition between care settings. The Transitions Coordinator and Ambulatory Care Manager provide the patient with ongoing educational information regarding how to maintain health and remain in the least restrictive setting and reduce their risk of hospitalizations and unplanned transitions with on-going reinforcement during care management activities. In addition, the Transitions Coordinator and Ambulatory Care Manager perform a huddle at the bedside with the patient and family/caregiver at discharge.

Stakeholder Engagement

The Care Manager collaborates with the health plans and their programs, practitioners and vendors regarding the care and treatment plan, as indicated, as well as consistently keeping Primary Care Provider (PCP) informed of patient status through documentation in Caradigm or communication with specialists, as appropriate. The Care Manager may also attend ambulatory practice huddles to discuss patient care plans as appropriate.

CM assesses the patient, develops a care plan, identifies barriers to care, community resources to leverage, as well as engages the patient in their health goals. In developing this plan, the Care Manager and the patient define goals that the patient/caregiver feels are feasible and that will help the patient improve their health status. The goal is to have the patient feel as though they have assisted in developing the plan and increase their level of confidence to self-manage.

The Care Manager will address with the patient:

I. Monitoring and problem solving
II. Medication administration
III. Skills and strategies to manage signs or symptoms
IV. Diet and physical activity
V. Coping with emotions (anxiety, depression, etc.)
VI. Reducing unhealthy behaviors (smoking, alcohol, etc.)
VII. Importance of keeping provider appointments as scheduled

Care Managers provide patient education and tools which promote self-management. These resources are accessed via Healthwise, an online library of health education materials, self-management tools and shared decision making support mechanisms. These resources facilitate shared decision-making and enable the patient to make informed decisions about their health. If there is a caregiver, the Care Manager will include them in the discussion, ensuring that the caregiver is able to provide the support required by the care plan. The Care Manager will assess the burden on the caregiver as well.

Caregiver-supporting activities include:

I. Healthcare tasks (monitoring vitals, arranging for follow-up care/appointments, assisting with medical equipment, etc.)
II. Medication Management
III. Household Management

Appendix

Evidence-Based Guidelines	
Condition	**Evidence-Based Guidelines**
Diabetes	Cefalu et al. "American Diabetes Association: Standards of Medical Care in Diabetes - 2015." *The Journal of Clinical and Applied Research and Education: Diabetes Care* 38.Supplement 1 (2015): S1-S94. Print.
Congestive Heart Failure	Yancy et al. "2013 ACCF/AHA Guideline for the Management of Heart Failure: Executive Summary: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines." *Circulation* 128.16 (2013): 1810-852. Print.
Chronic Obstructive Pulmonary Disease	From *the Global Strategy for the diagnosis, Management and Prevention of COPD*, Global Initiative for Chronic Obstructive Lung Disease (GOLD 2015. Available from: http://www.goldcopd.org/.
Asthma	National Asthma Education and Prevention Program, Third Expert Panel on the Diagnosis and Management of Asthma. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Bethesda (MD): National Heart, Lung, and Blood Institute (US); 2007 Aug. Available from: http://www.ncbi.nlm.nih.gov/books/NBK7232/
Hypertension	James PA et al. 2014 Evidence-based guideline for the management of high blood pressure in adults: Report from the panel members appointed to the Eighth Joint National Committee (JNC 8). JAMA Dec 18, 2013. (http://dx.doi.org/10.1001/jama.2013.284427)
Hyperlipidemia	Stone NJ, Robinson J, Lichtenstein AH, Bairey Jr, Watson K, Wilson PWF. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2013;00:000-000.