Care Management: Five Step Process

Management/Intervention and Case Closure

12.12.12

MiPCT Master Trainers

Objectives

- Identify the five step Care Management Process

Objectives

- Outline care management interventions
- Identify when it is appropriate to close a case

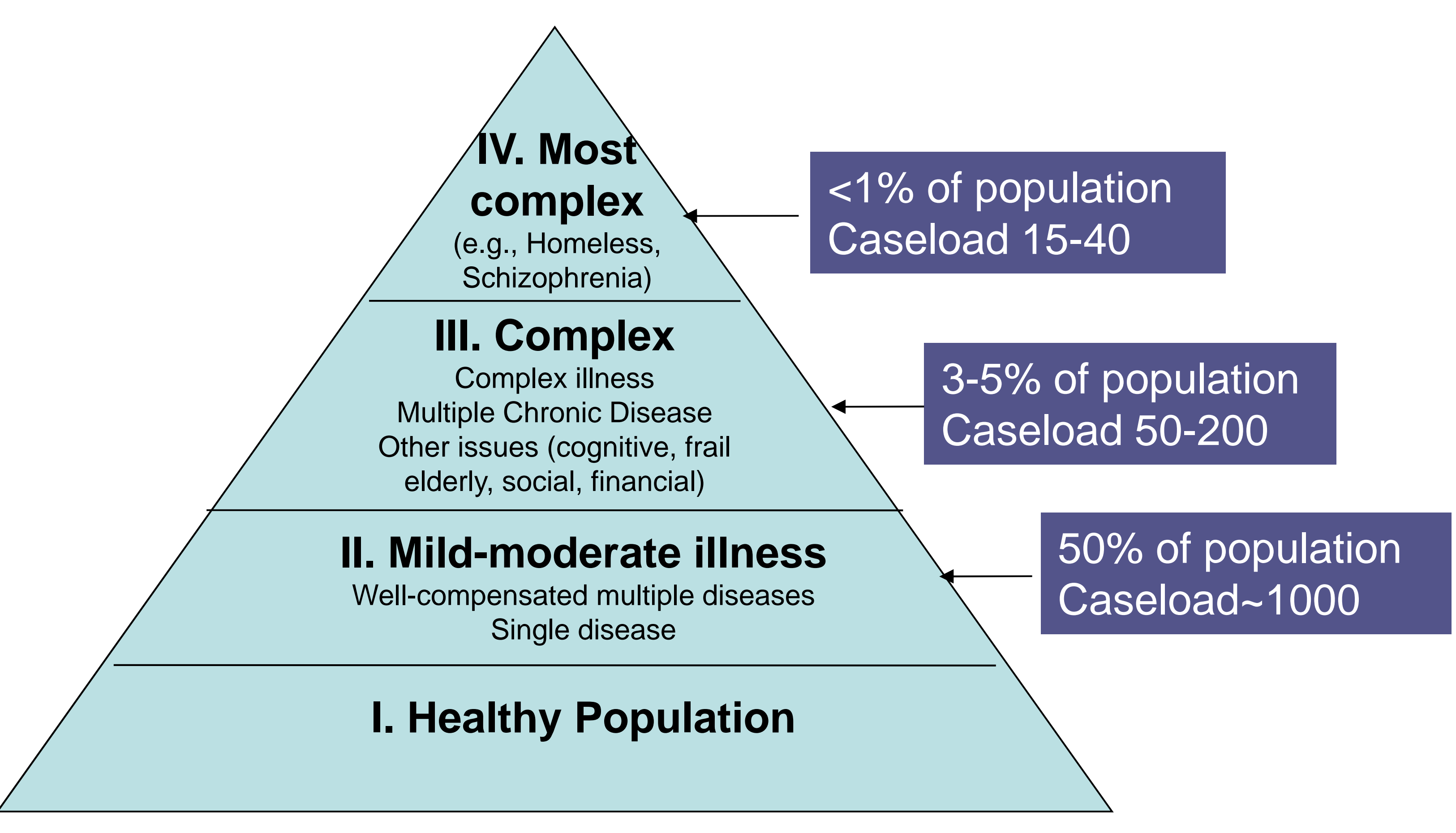
Critical steps in Care Management

1. Identification of patients
2. Screening
3. Enrollment
4. Management
5. Case Closure

Goals of Care Management

- Improve patient's functional health status
- Enhance coordination of care
- Eliminate duplication of services
- Reduce the need for unnecessary, costly medical services

Managing Populations: Stratified approach to patient care and care management



Potential Populations

- Multiple comorbidities
- Frequent ER visits and/or hospitalizations
- CKD
- Special Needs plan
- Acute medical conditions (post hospital discharge)
- Co-morbid diabetes conditions
- Elderly with psychosocial
- High risk pregnancy – with socioeconomic barriers
- Peds with special needs
- Insulin titration/management
- ECF/subacute rehab

Screening

- Claims review
- Medical record review
- Clinical condition
- Assessing resource utilization

Enrollment

- High complex patients
- High moderate patients
- Transition of Care
- CHF, COPD

Management

- Assessment/reassessment
- Medication reconciliation
- Goal setting (short/long term)
- Self Management support
- Care coordination in the medical neighborhood

Enrollment

- Patient consents to participate
- Comprehensive assessment
- Development of a care path
  - Assess and identify barriers to treatment plan
    - Variety of assessment tools
  - Setting Client specific goals
  - Determining the follow up plan
- Documentation of enrollment: date, consent and CM signature

Management

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Michigan Primary Care Transformation Project
Advancing Population Management

PCMH Services

Complex Care Management ***Functional Tier 4***	All Tier 1-2-3 services plus: ▪ Home care team ▪ Comprehensive care plan ▪ Palliative and end-of life care
Care Management ***Functional Tier 3***	All Tier 1-2 services plus: ▪ Planned visits to optimize chronic conditions ▪ Self-management support ▪ Patient education ▪ Advance directives
Transition Care ***Functional Tier 2***	All Tier 1 services plus: ▪ Notification of admit/discharge ▪ PCP and/or specialist follow-up ▪ Medication reconciliation
Navigating the Medical Neighborhood ***Functional Tier 1***	▪ Optimize relationships with specialists and hospitals ▪ Coordinate referrals and tests ▪ Link to community resources

Prepared Proactive Healthcare Team
Engaging, Informing and Activating Patients

PCMH Infrastructure

Health IT
- Registry / EHR registry functionality *
- Care management documentation *
- E-prescribing (optional)
- Patient portal (advanced/optional)
- Community portal/HIE (adv/optional)
- Home monitoring (advanced/optional)

Patient Access
- 24/7 access to decision-maker *
- 30% open access slots *
- Extended hours *
- Group visits (advanced/optional)
- Electronic visits (advanced/optional)

Infrastructure Support
- PO/PHO and practice determine optimal balance of shared support
- Patient risk assessment
- Population stratification
- Clinical metrics reporting

*denotes requirement by end of year 1

P O P U L A T I O N   M A N A G E M E N T

CM Interventions will include:

- Acute management
- Transition management
- Chronic Management/Clinical Monitoring
- Clinical guidelines
- Identification of problems
  - Active
  - Managed
  - Resolved
- Collaboration with treatment team
- Collaboration with medical neighborhood

Management Interventions (cont.)

- Identification of barriers to the plan of care
  - Resources at home
  - Literacy
  - Socio-economic
- Medication Reconciliation/intervention
- Coordination of services/resource utilization/ Home care/DME
- Gaps in Care: Disease specific
- Behavioral health needs
- Pain Management
- Safety Management
- End of Life Planning/Advanced Directives
- Preventive care
  - Adult immunizations, Preventive Services
- Self Management support
  - written plan

Definition

- Medication reconciliation is the process of comparing a patient's medication list to all of the medications that the patient has been taking.

- It's a National Patient safety goal (NPSG) from the Joint Commission (TJC) that entails reviewing all medications a patient takes after a health care transition.

When to do Medication Reconciliation

- TJC defines the implementation expectations are,

  "At a minimum, any time the medication orders are rewritten and any time the patient changes service, setting provider or level of care"

- The full scope of the safety goal is across the continuum of care

A Three Step Process

According to IHI, mediation reconciliation is a three step process

- **Verification** – collecting an accurate medication history
- **Clarification** – ensuring that the medications and doses are appropriate
- **Reconciliation** – documenting every single change and making sure it 'squares' with all the medication history

When to Perform Medication Reconcialtion

- At EVERY transition of care, including in patient care settings
- Upon Discharge from any facility (Acute Inpatient, SNF, Rehabilitation facility, etc.)
- After Discharge
- At each appointment with a provider
- In the Emergency Department

Sample Goals

- Short term goals
  - Participation in case management
  - Medication adherence/understanding
  - Teach back of critical elements
  - Support system/resources/functional status/safety
  - PCP appointment (post discharge)
  - Access (who to call?)
  - Develop a self management plan
- Long term goals
  - Patient demonstrates a basic understanding of conditions
  - Prevents exacerbations/minimized/reduced
  - Identification/management of co-morbid conditions
  - Preventive care
  - Adherence to treatment plan
  - Care Coordination/ongoing
  - Accessing
  - Self Management

How will we know it's working? Measurement

MiPCT Metric documents

- www.mipctdemo.org
- http://mipctdemo.wordpress.com/resources/mipct-documents-and-presentations/12-month-metrics-final/

How will we know it's working? MiPCT Metrics - example

Adult and Pediatric Chronic and Preventive Care Measures
Diabetes Measures: (ages 18-75 years with type 1 or 2 diabetes)
1. Diabetes: A1C Test + Control A1c > 9 = Control A1c < 8
2. Diabetes: LDL-C Test + LDL-C Controlled < 100 mg/dl
3. Diabetes: BP <140/90
4. Diabetes: Retinal Eye Exam
5. Diabetes: Nephropathy Screen or Evidence of Nephropathy
6. Persistent Asthma: Self-Management Plan or Asthma Action Plan (ages 5-50)
7. Hypertension: Controlled BP <140/90 (age 18-85)
Cardiovascular Disease Measures: (ages 18-75)
8. Cardiovascular Disease: Blood Pressure Management <140/90 mmHg
9. Cardiovascular Disease: LDL Cholesterol Management <100 mg/dl
10. Obesity: Adult Weight Screening (Meaningful Use)
11. Tobacco: Assessment and Cessation Intervention (Meaningful Use)
12. Breast Cancer Screening (ages 40- 69)
13. Cervical Cancer Screening (ages 21-64)
14. Colorectal Cancer Screening (ages 50-75)
15. Chlamydia Screening (Women ages 16–24)
16. Childhood (age 2) Immunization*
17. Adolescent (age 13) Immunizations*
18. Well Child Visits:15 Months, 3-6 years and 12-21 years

* A MCIR report may count for this measure if the practice routinely checks patient's immunization status with visits and periodically generates lists of patients due for services in order to do outreach

Referral/Case Finding

Screening

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Case Closure

Case Closure

- Patient leaves the practice/relocates
- Patient expires.
- Patient is not actively working on/or unable to set goals
- Patient declines care management
- Goals have been achieved—transfer to moderate care

Questions?

- Next webinar
  - January 9, 2012 at 2:00pm