Care Management: Five Step Process

Referral, Screening and Enrollment

12.5.12

MiPCT Master Trainers

Objectives

- Identify each step of the 5 step care management process.
- Review common modalities for care management referral.
- Discuss case screening and patients that qualify for care management.
- Review conditions that will benefit from care management
- Review enrollment into Care Management process

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

Critical steps in Care Management

Identification of patients/Referral

Screening

Enrollment

Management

Case Closure

Care Management Process

Referral sources

- Targeted populations
- MiPCT list
- Providers
- ER/Discharge lists
- Health Care Team Members
- Gaps in Care Report
- Registry

Care Management Process

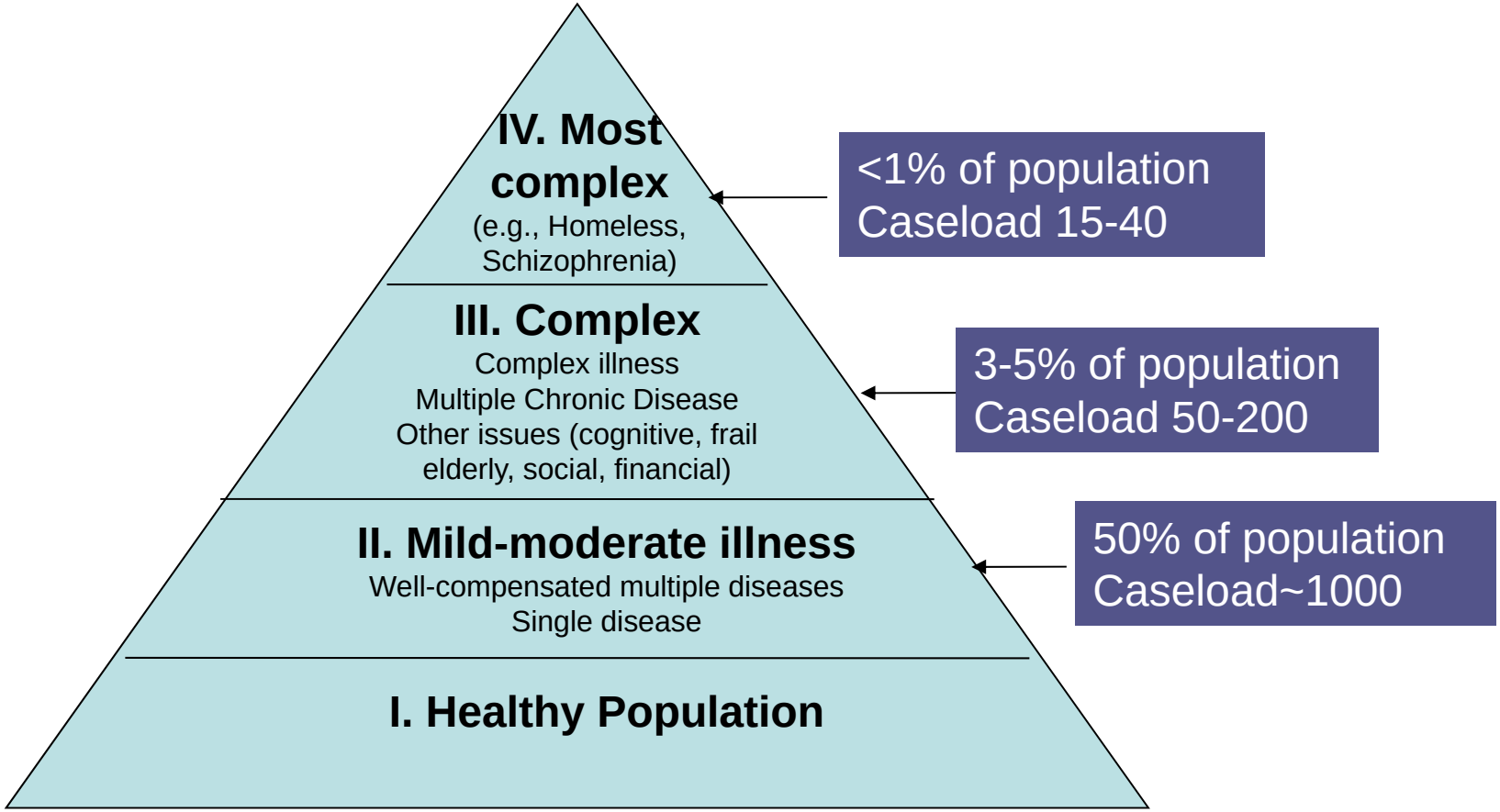
Referral

- Not everyone referred will benefit from CM

Screening

- Medical record review
- Claims history
- Clinical condition
- Resource utilization
- Hospital record
- Registry

Managing Populations: Stratified approach to patient care and care management



When do I screen?

- Hospitalized patients: within 24-48 hours
- High risk, claims or record: 10 business days
- High-moderate risk: 10 business days
- Review patient case
- Discovery of information

Chronic Illness in America

- More than 125 million Americans suffer from one or more chronic illnesses and 40 million limited by them.
- Despite annual spending of nearly $1 trillion and significant advances in care, one-half or more of patients still don't receive appropriate care.
- Gaps in quality care lead to thousands of avoidable deaths each year.
- Best practices could avoid an estimated 41 million sick days and more than $11 billion annually in lost productivity.
- Patients and families increasingly recognize the defects in their care.

Common Chronic Conditions

- CHF
- COPD
- Cardiac with co-morbidities
- Chronic Kidney Disease
- Asthma
- Mental illness – with co morbidities & frequent ER/hospitalizations
- Autoimmune conditions
- Diabetes with co-morbid conditions
- Premature births
- Peds with special needs
- High risk pregnancy – with socioeconomic barriers
- Chronic Pain
- Cancer
- Sickle Cell

Characteristics of Patients who would benefit from Complex Care Management

- 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/functional
- High risk pregnancy – with socioeconomic barriers
- Peds with special needs
- Insulin titration/management
- ECF/subacute rehab
- Infusion Medications

If you are hybrid……

- Newly diagnosed with a chronic condition
- Support for self management of an existing chronic condition.
- Chronic condition with GAPS in care
- Time limited needs related to their condition
- Inappropriate utilization (ER, primary care sensitive)
- Care Coordination between multiple providers
- Functional impairment/limited support

Screening

- Not every patient referred or identified will benefit from care management.
- Transitions of Care-
  - Post hospital, ER, subacute care, ECF
  - > 2 visits in the last 12 months
- High utilization
- High cost cases
- Co-morbid conditions
- New diagnosis/changes in treatment

Screening (cont.)

- Hospitalization hx over the last year
- Significant medical events
- Provider hx over the last year
- Advanced Directives, POA

High risk

- Post discharge from hospital
- Predictive modeling (scores on MiPCT list)
- Condition specific
  - CHF
  - COPD

What makes a high cost case

- Consider patient's clinical status, in relation to high cost
  - Hospital utilization
  - ER utilization
  - High tech radiology
  - Infusion medications
  - Specialty care
  - ECF /Rehab placement
  - Cancer Treatment
  - Organ transplant

Priority Chronic Conditions for consideration

- CHF
- COPD
- Discussion?

Determination for Care Management

- Enroll patient in care management
- Documentation of reason for CM and timeline for contact

Enrollment

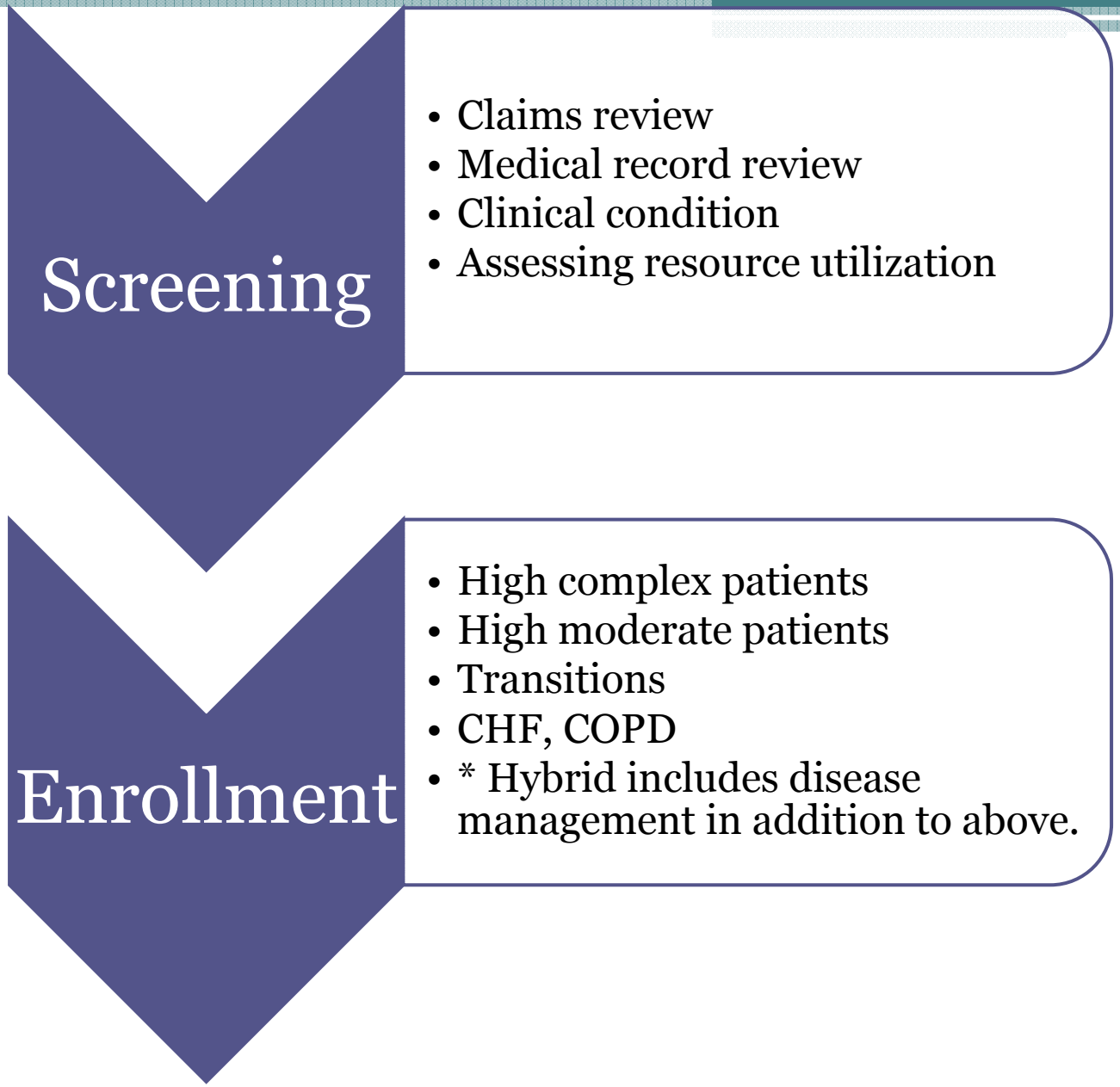
- New complex patient enrollment requires a comprehensive assessment and ongoing management on a care path
- Patient consents to participate
- Assess and identify barriers to treatment plan
- Goal setting
- Documentation of enrollment: date, consent and CM signature

Screening

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

Enrollment

- Patient consent: implied
- New patient assessment completed
- Face to face OR phone
- Within 24-48 hours (based on type of referral)


Screening
• Claims review
• Medical record review
• Clinical condition
• Assessing resource utilization
Enrollment
• High complex patients
• High moderate patients
• Transitions
• CHF, COPD
• * Hybrid includes disease management in addition to above.

MDC: MiPCT Dashboards

Population

Membership

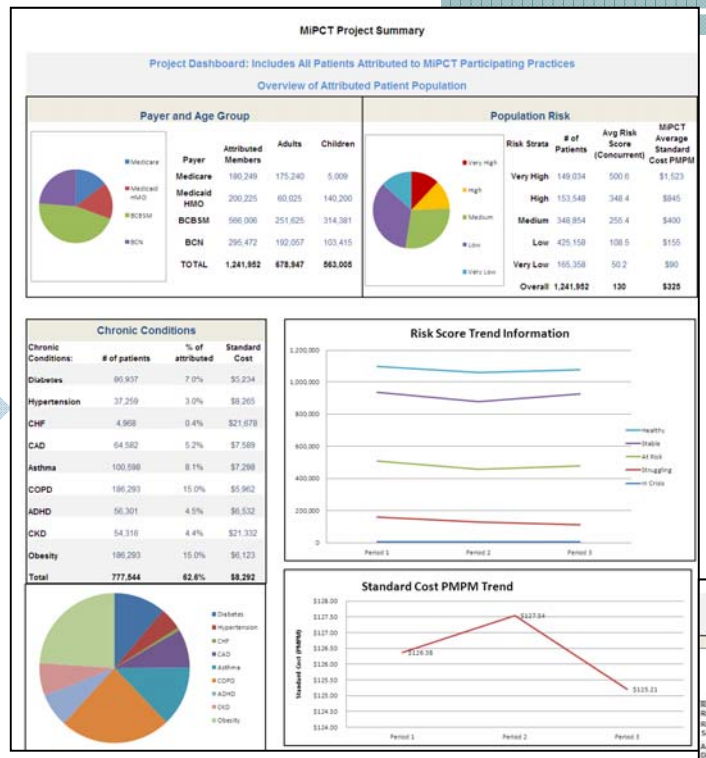
- **Attributed members by Payer**

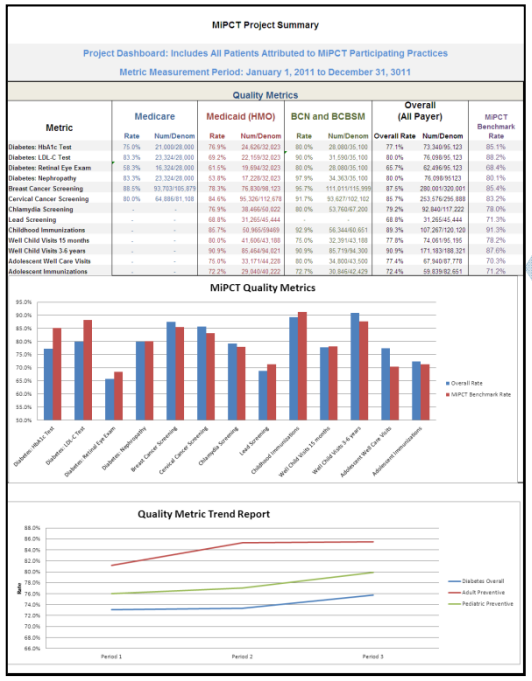
Risk Information

- **# of members by Risk Level**

Population Information

- **# patients by Chronic Condition (Asthma, CKD, CHF, etc)**





Quality Measures

Screening and Test Rates

- **Diabetes tests, Cancer Screens, etc**

Prevention

- **Immunization Rates, Wellness Visits, etc.**

Comparison to Benchmarks

Utilization Measures

Rates

- **ED Use, Admissions, Re-admissions, etc**

Comparison to Benchmarks