2014 Best Practice- 5 Step Process Worksheet

Process Step	Care Management Activity	Notes
Step 1 : MiPCT Patient Identification-	Overall purpose: Assess and monitor risk to optimize patient outcomes, value/cost of care, and patient satisfaction (the Don Berwick IHI Triple Aim)	In this section, the PO/PHO/practice can add detail specific to their organization
Transitions in Care (TOC)		
a. Admission, discharge and transfer (ADT) daily notification	X	Source for ADT
b. Utilizes risk/acuity score to identify patient	X	Risk stratification approach
c. Review discharge list for MiPCT eligible patients	X	Distribution/use of the MiPCT MDC list
Patient Identification-Non-TOC	X	Distribution/use of the MiPCT MDC list
a. Use of prospective risk score	X	
b. MiPCT patient list; review for patients with high admission/ED utilization	X	Definition of high admission/ED
c. Identification of patients with a chronic condition such as or not limited to: (COPD, Heart Failure, Asthma, CKD, Depression, DM, Depression, and HTN)	X	List of chronic diseases and measures used to determine referral to care management
d. Target MiPCT eligible patients that "no shows"	X	
e. Physician input related to patients who could benefit from CM services	X	Process used for obtaining physician input
f. Target MiPCT patients coming into the office. CM checks MiPCT eligibility and then discusses with PCP the morning of the appointment or a day (or week) in advance of the patient's appointment	x	
Step 2- Screening	Overall purpose: Once patients are identified as potential candidates for care management services, the care manager conducts screening of	

	records to determine current status of clinical measures, social and financial determinants, and or other patient identification triggers that indicated the patient may be appropriate for care management services.	
Specific to TOC call- a. Review medical record, medication list and history, clinical discharge summary, chronic disease history, last visit note and inpatient nursing notes.	X	Access to records and location of documents
Non- TOC call screening a. Review of medical record, chronic disease history and medication list	X	Expectations of review process
Review of physician schedule for tomorrow or the next day or so to identify MiPCT eligible patients and reach out to PCP before office visit	X	Process in place within the practice
Step 3-Assessment	Overall purpose: Subsequent to reviewing patients identified as candidates for care management services and conducting the screening process the care manager proceeds with the comprehensive assessment for patients determined appropriate for enrollment into care management services. During this process, the care manager identifies patient strengths, barriers and goals to formulate the plan of care.	Location and must have inputs of the assessment tool
Assessment activities utilized for CCM or MCM patient. 1.Disease Specific	X	
2. Comprehensive assessment	X	

3. Individualized Care plan & SMART goals	X	
5. Self-management	X	
6. Barriers/coordination	X	
7. Med. Reconciliation	X	
8. Assessment of Life planning/Advance directives" witch may include End of Life planning	X	
9.Safety/risk management	X	
10.Primary Care sensitive	X	
11.Preventive Health	X	
12.Culture sensitivity	X	
13.Linguistic sensitivity	X	
14*. Additional assessments conducted*	Assessment of cognitive functioning/mental health status (member A&O x 3, appropriate conversation, fully independent in cognitive functions). Evaluation of visual and hearing needs, preferences or limitations. Evaluation of available benefits (from insurance, community resources)	List of assessments conducted within the practice, and description of who completes and records the results
3a Assessment- Not enrolled determinations or reasons to consider: a. Non MiPCT patient b. No needs identified c. Patient declined d. Not appropriate-reason e. Other - list	X	Parameters of enrollment criteria

Step 4- Follow-Up/Management	Purpose: Assess and monitor overall progress with the plan of care, treatment goals, patient centric goals and preferences to determine the need to continue with set goals and or make adjustments.	Definition of monitoring expectations to include intervals and targeted information to review
1. 1.Update Short term/Long term goals	X	
2. 2.Identify barriers & progress to meeting goals	X	
3. 3.Revise POC & self-management plan	X	
4. 4. Provide & coordinate interventions as needed.	X	
5. 5. Close gaps in care	x	
6. 5. Update status in medical record.	X	
7. 6.Update severity/date as indicate	X	
8. 7.Annual assessment note q 12 months	X	
9. 8.Periodic visits, progress, and updates per individualized plan of care	X	
10. 9.Utilize return visit documentation	X	
11. 10.Utilize new assessment template for annual follow-up	X	
12. 11.Review progress to goals with member and barriers at each interaction	X	
13. 12.Update care plan & goals	X	
14. 13.Address goals & barriers to establish goals	X	
Step 5-Case Closure	Overall purpose: Determine if the case is appropriate for continued care management	Definition of steps and expectations for case closure within the organization/practice

	enrollment and or if the patient has progressed to another state such as Hospice or return to the practice for ongoing monitoring due to meeting goals requiring care management services.	
1.Discuss case closure with PCP/team	X	
2. If patient meets case closure criteria, complete documentation identifying problems & goals met are recorded in the medical record	X	
3. Update status in appropriate episode of care in the medical record.	X	

Adapted from work group activity completed 2014 MiPCT Care Management Best Practice:
Group 1 POs-UPHP, Advantage Health Medical Group, Sparrow Medical Group, IHP, United Physicians (MCM focus)
Group 2 POs- UMHS, LHN, Spectrum Health Medical Group, IHA, HFMG, CIPA/MAG (CCM focus)