SPECTRUM HEALTH The Medical Group	**Standard Work Activity Sheet**		
Case Closure	***Purpose:*** *Closing Cases for Care Management Services*		

Seq. No	Task Description	Key Point / Image / Measure (what good looks like)	Who	Cycle Time mm:ss
1	**For <u>transitioning patients</u>** - verify handover and recommend closure at next care conference. *If patient not transitioning, go to step 2.*	Transitioning out of primary care ie PCP will no longer have responsibility for this patient includes: • Hospice • Nursing homes where PCP is not primary or patient is custodial • Patient moves to another practice • Home-based program ie Visiting Physician, Priority Health Home-based Primary Care. • Expired Close case. Go to Step 5.	Care Mgr	
2	**For <u>inactive patients</u>** - work tickler list attempting to reach patients before recommending closure at next care conference. *If patient is active, go to step 3.*	Call patient 3 different times of day and days of week. If unable to reach, notify provider, send **Unable to Reach Letter** and give 2 weeks for patient to call back. If patient does not call back within 2 weeks, recommend close case + return to team care. Go to Step 5.	Care Mgr	
3	**For <u>active patients but not engaged in meeting goals</u>** - reattempt to identify and utilize key motivator ie Motivational interviewing-what is important to the patient- prior to recommending closure at next care conference. *If patient meeting goals, go to step 4.*	<u>1 to 3 months</u> • Work with patient using phone/face to face contacts on mutually agreed upon goals. If care coordination has been achieved and there is no further gain on goals, reiterate to the patient the benefits of care management, how care management works and review goal making/self-management concepts in an attempt to re-engage. • Discuss lack of patient progress with provider in care conference. • If patient/CM and provider agree to continue-establish target date to reassess patient engagement continuing to work with patient using Motivational interviewing. • Reassess at target date with patent/CM and provider. • If no gain on goals or "Unable to Reach"patient consistently- Discuss closing case with PCP. Discuss reasons with patient - leaving door open for future partnering or send **Unable to**	Care Mgr	

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		Reach Letter, if needed. Return to team care. Go to step 5.		
4	**For <u>active patients meeting goals</u> -** reinforce gains made, *establish self care plan (formerly known as relapse prevention plan) <u>prior</u> to closing the case*.	**Requirements -** Stable patient • Goals met per patient specific care plan or provider decision • Patient is able to teach back self management skills using self care (formerly known as relapse prevention) plan • Patient demonstrates continued engagement with PCP • Provider agreement to close • Return to team care Once the requirements are met, go to step 5	Care Mgr	
5	**Establish agreement to close each case**	At care conference: PCP agrees to close case. Return to team care (unless pt will no longer be with the practice).	Team	
6	**Document each case closure**	Document in EMR particulars of case closure Close episode of care in EMR with reason for closure use one of the following reasons: • Hospice • Custodial care-nursing home • Transferred to another PCP • Expired • Unable to reach • Lack of readiness for further care management and / or self management • Patient declined care management • Insurance change and / or transfer to payer care manager • Goals met • Highest level of function achieved-not all goals met • Not appropriate for Care management	Care Mgr	

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		Indicate in EMR CM end date.		