MiPCT Care Management Path - 5 Step CM Process

Risk Stratification, Admission and Non Admission Care Path

Purpose: This document presents a suggested process, which may be altered as needed to fit your practice/Physician Organization.

Step One: Patient Identification

Patient Identification – Step 1 in the 5 step process. Patients to consider for Care Management

Moderate: (Verify MiPCT Eligibility)

Patient with single chronic condition
Or multiple conditions that are stable with out-of-scope measures within evidence based care (such as AHRQ, MQIC guidelines)
Pts recently DC from the hospital related To new diagnosis or complications of the patients chronic condition(s)
Pts with complex issues that are resolved but would benefit from education & Self-management support

Complex: (Verify MiPCT Eligibility)

Recent DC from acute care facility
Pts with high risk predictive model score
Pts with multiple chronic conditions
Pts with mod. Risk predictive model score
Pts with high cost – evidence by payer claims report or other available resources
Pts with high utilization of admissions/ER
Pts with barriers that impact their ability to manage their care (social, financial, behavioral)

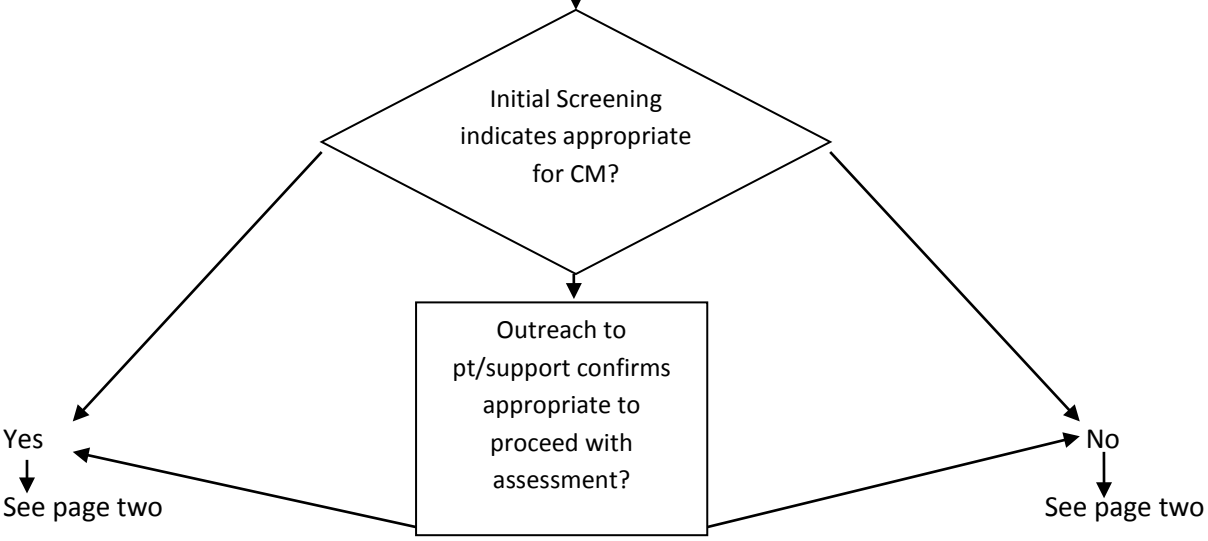
Step Two: Screening

Screening – Once pts are identified as potential candidates for CM services, the CM reviews:

Medical Records Data Utilization Reports Inpatient records Specialist reports PCP Input

*Determine if the patient meets eligibility for CM service guidelines. Eligibility considerations may include, but are not limited to the following:

- Ability of the patient or caregiver to self-manage the care
- Situation/condition can be addressed/resolved by CM interventions
- Patient engaged and agreeable to CM Services
- CM facilitates care coordination to a community resource or other provider who can best manage the patient



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Yes

Step Three: Initiate Assessment – (follow 5 step process # 4)

(The following are suggestions – check with your organization for specific assessment tool being used)

Considerations:

Moderate	High (Moderate +)
✓ Disease specific	✓ Comprehensive
✓ Develop Care plan & goals	✓ Develop Care plan & goals
✓ Self- management	✓ Self-management
✓ Barriers/coordination	✓ Barriers/coordination
✓ Med reconciliation	✓ Med reconciliation
✓ Preventive health	✓ End of life planning
✓ Cult/linguistic sensitive	✓ Safety/risk management
✓	✓ Primary Care sensitive

No

Reasons

- ✓ No Needs
- ✓ Patient Refusal
- ✓ Unable to contact (3 attempts 3 different times, 3 different days)
- ✓ Not MiPCT eligible

Actions

- ✓ Inform PCP of no needs or refusal
- ✓ Complete documentation supporting the decision
- ✓ Inform patient/care provider

Assessment confirms enrollment into CM appropriate?

Yes

No

Develop Individualized Plan of Care and provide patient with a copy

Step Four: Follow-up and Management/Monitor

Follow up per appropriate guidelines and identified needs of the patient as outlined by the Care Manager's Practice/Physician organization leadership

Monitor progress:

- Update goals (short and long-term) per intervals as indicated by the plan of care and organization
- Identify barriers and progress to meeting goals at each interaction
- Revise the individualized plan of care as indicated

Provide and coordinate interventions as needed

Close gaps in care

Update the status in the medical record as indicated

Update the severity/date as indicated

Annual assessment note must be completed q 12 months

Periodic visits, progress, and updates per care plan and patient progress

Review progress with member goals and barriers at each interaction

Update care plan and goals with each interaction

Address goals and barriers to establish goals at each interaction

Follow documentation requirements as indicated by the Care Manager's Practice/Physician organization leadership

No

Pt ready for case closure?

Yes

Step Five: Case Closure

**See addendum "Spectrum Health Case Closure Standard Work Activity Sheet" for an example.

Discuss case closure with PCP/team as established within the Care Manager's Practice/Physician organization leadership

. Suggestions:

- If patient meets case closure criteria document status of case and patient goals within the medical record or EMR
- Update the status in the appropriate episode – closure reasons as outlined by the Care Manager's Practice/Physician organization leadership