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Case Closure

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MiPCT CM Preliminary Concepts

- Plan of care preparation
  - Why was the patient referred for Care Management?
  - What Long Term goals/targets do you hope to meet/achieve with this patient while s/he is receiving care management?
- Plan for regular conferencing with PCP/Team
- Patients identified as able to self-manage: Develop A Self Care Plan prior to case closure.
- Transitioning patient from Care Management to Practice Management.
  - What does it look like to return patient to the Practice team?
  - Leave door open for future care management

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Transitioning Care Managed Patients

- PO/Practice definition: PCP will no longer have responsibility for this patient. Examples include:
  - Patient meets Hospice criteria
  - Patient requires Nursing home placement where PCP is not primary or patient requires custodial care
  - Patient moves to another practice
  - Home-based program, i.e. Visiting Physician, Priority Health Home Base Primary Care
  - Patient expired

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Active Patients – meeting goals

- Goals are met per patient's plan of care or provider decision
- Reinforce gains made. Patient is able to teach back self-management skills using self-care plan
- Patient demonstrates continued engagement with PCP
- Provider agreement to close
- Return to team care

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Inactive Patient Process

- Patients referred for Care Management are contacted with the intent to provide MiPCT Care Management service. In the event that the patient is not reached initially, the following process is followed.
- 1. Call patient 3 different times of day and days of week. If unable to reach the patient after three calls notify provider.
- 2. Mail Unable to Reach Letter and wait 2 weeks for patient to call back.
- 3. If no call is received from the patient within 2 weeks from the date the “Unable to Reach” letter was mailed, the case is closed to Care Management and returned to Practice team care.

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Active Patients - not engaged in meeting goals

- Prior to recommending case closure, Consider the following engagement activities:
- 1. Attempt to identify/confirm and utilize patient key motivator to improve their health i.e. Motivational Interviewing – what is important to the patient ?
- 2. Once key patient motivator is identified:
  - Discuss lack of patient progress meeting health goal(s)
  - If patient/CM and provider agree to continue – establish target date to reassess patient engagement
  - Reassess at target date
  - If no gain on goals, discuss closing case with PCP/recommend case closure at next care conference.
  - Leave door open for future partnering with patient.

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Case closure Steps

Establish agreement to close each case

At Care Conference:

- PCP agrees to close case to Care Management.
- Patient returned to practice team care

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Documentation of case closure

- Document in EMR particulars of case closure and CM end date
- Use one of the following reasons for case closure
  - Hospice
  - Custodial care-nursing home
  - Transferred to another PCP
  - Expired
  - Unable to reach
  - Lack of readiness for further care management and/or self 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