Michigan Institute for Care Management & Transformation

MICMT Complex Care Management Course

Care Management Five Step Process

Learning Objective

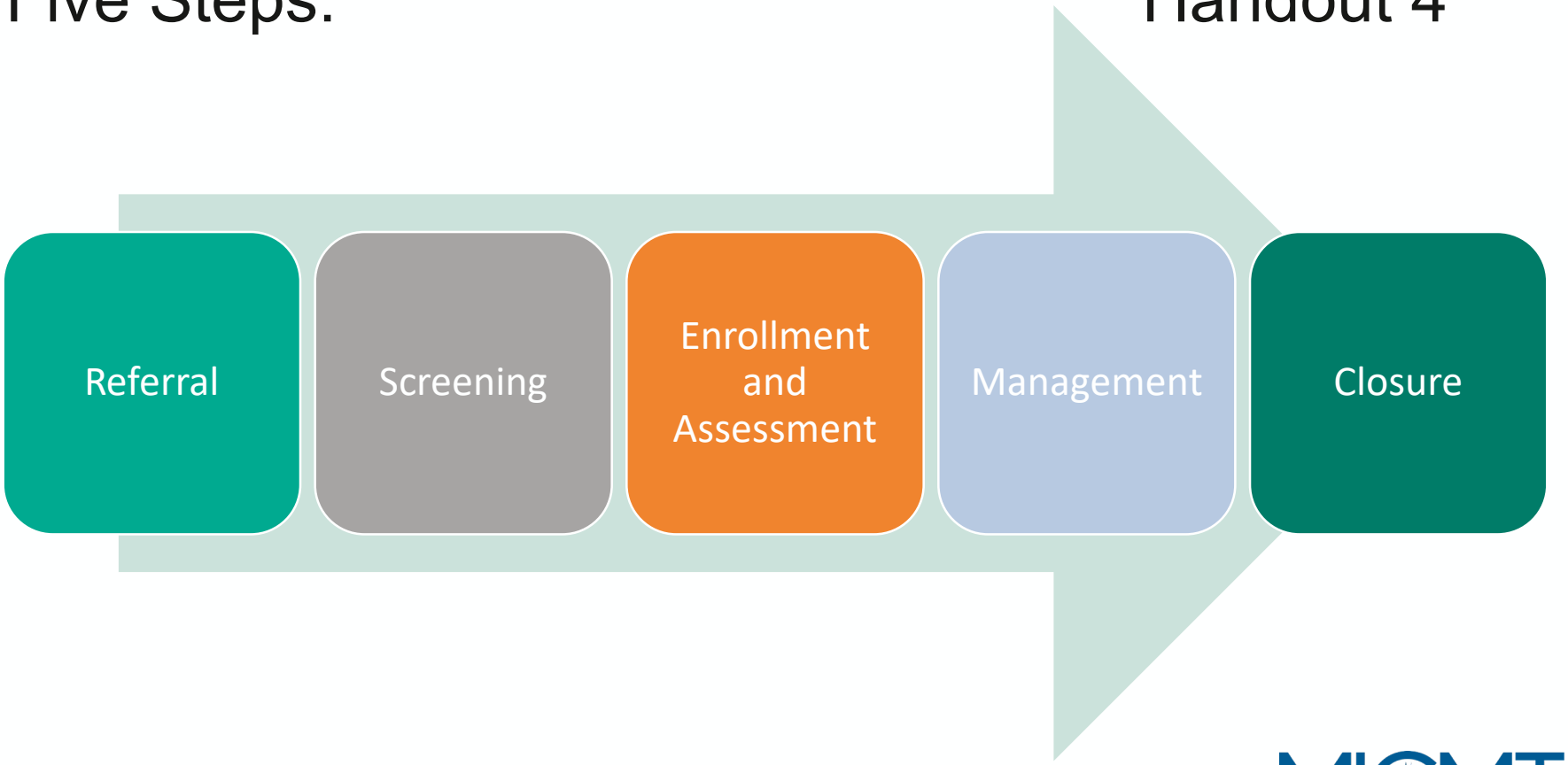
- Relate key work which is completed in each step of the five step care management process

Care Management Process 5 Step Process and Key Work

Care Management Process

Five Steps:

Handout 4



Step 1:
Referral into Care Management

Referral into Care Management

It is important to manage your referral processes!!!

Work with your practice team to assure the population you work with is directly related to practice and PO metrics

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A1c control, BP control, ED Utilization, Inpatient Utilization

Referral into Care Management

Proactive Patient Identification

- Risk Stratification →
  - look for high risk patients to impact utilization measures
- Registry lists →
  - identify 'lost to follow up' patients to support improving quality measures such as A1c and BP
  - Develop a criteria with the provider that could become a standing order for referral

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Passive Patient Identification

- Referrals from physicians
- Standing orders based on patient parameters

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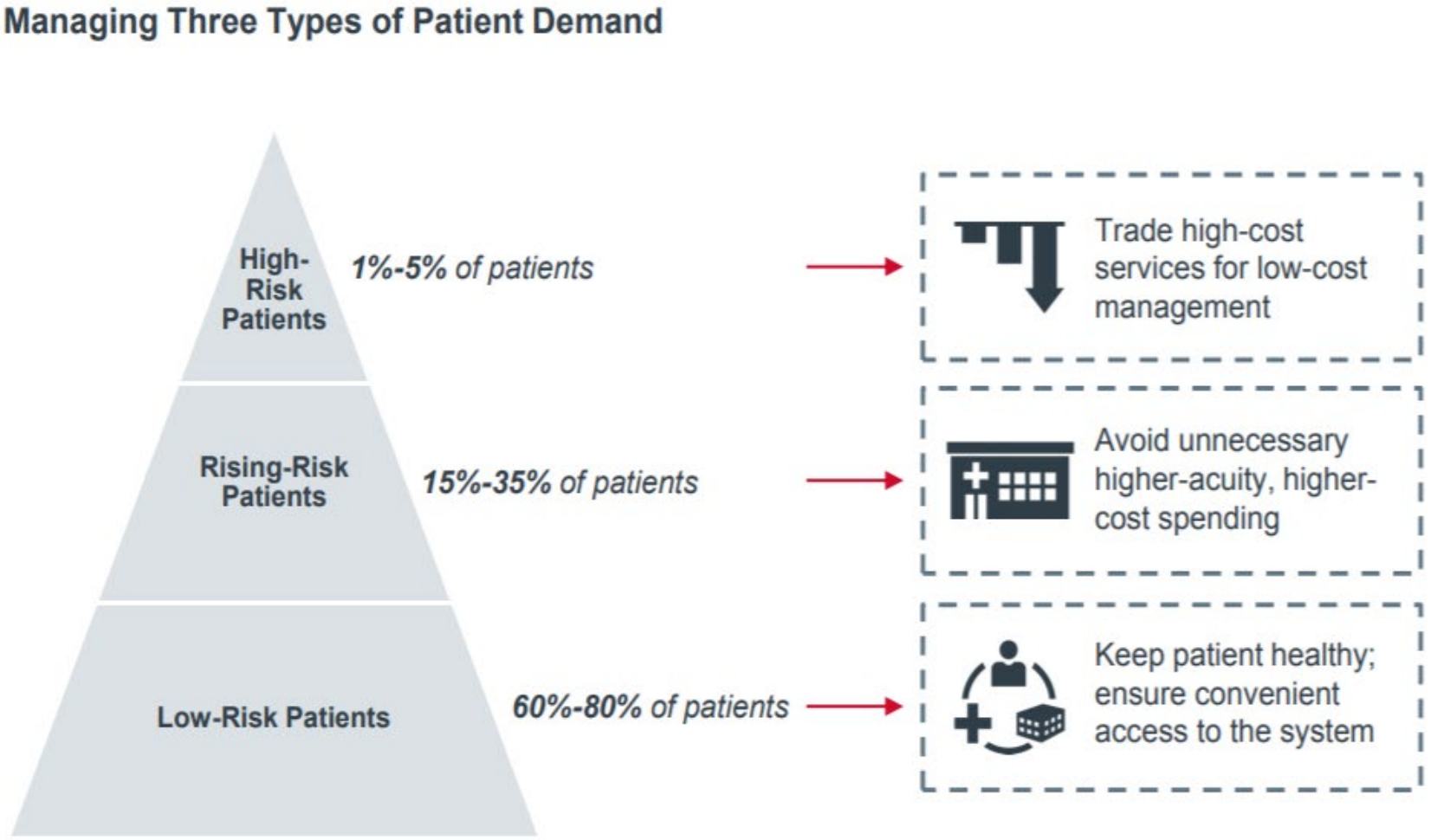
Risk Stratification

Risk stratification is ideally an intentional, planned and proactive process carried out at the practice level to effectively target clinic services to patients.

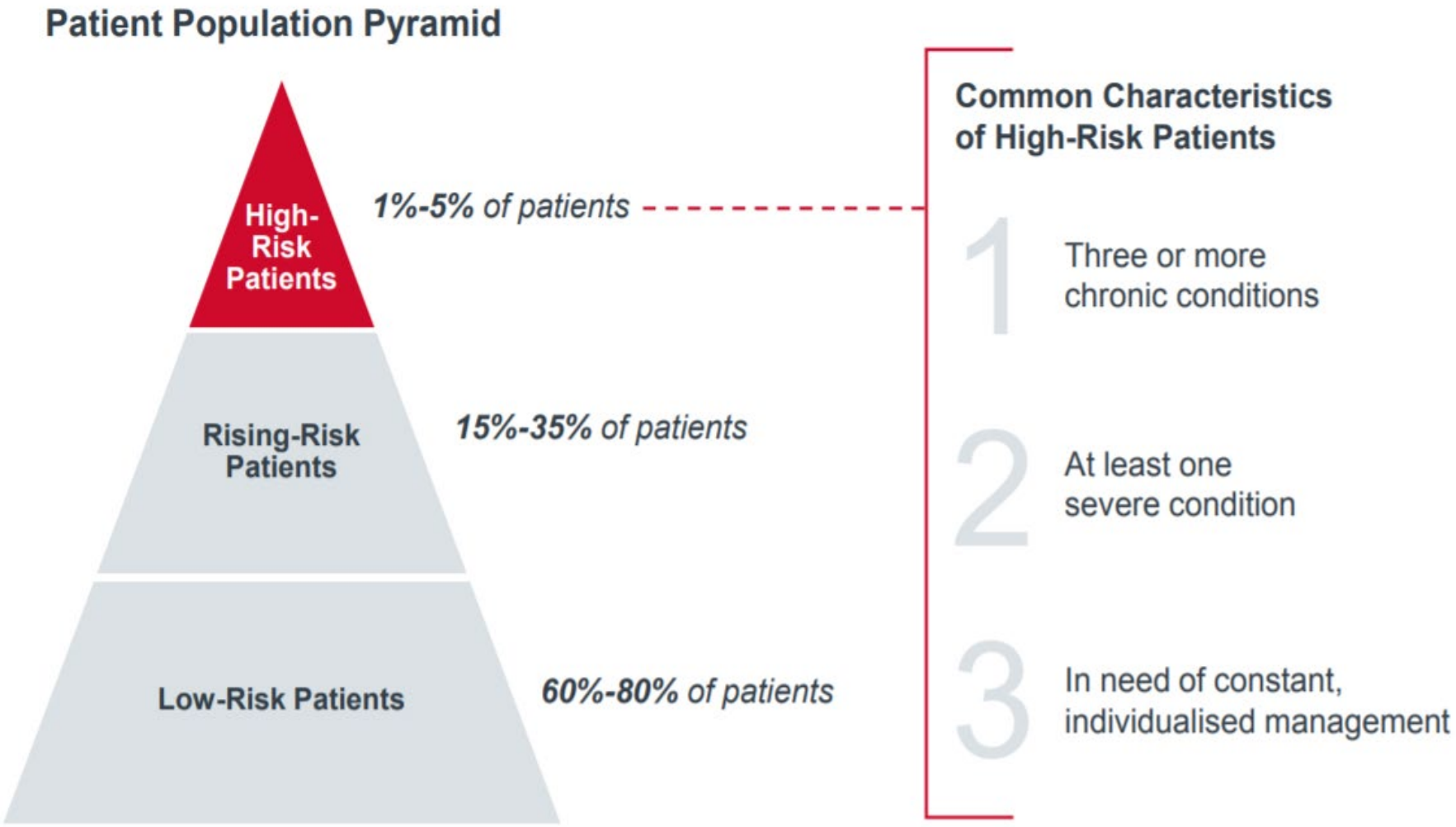
http://www.njafp.org/sites/ethos.njafp.org/files/risk_strat_peskin_distribution_final.pdf

The Risk Pyramid

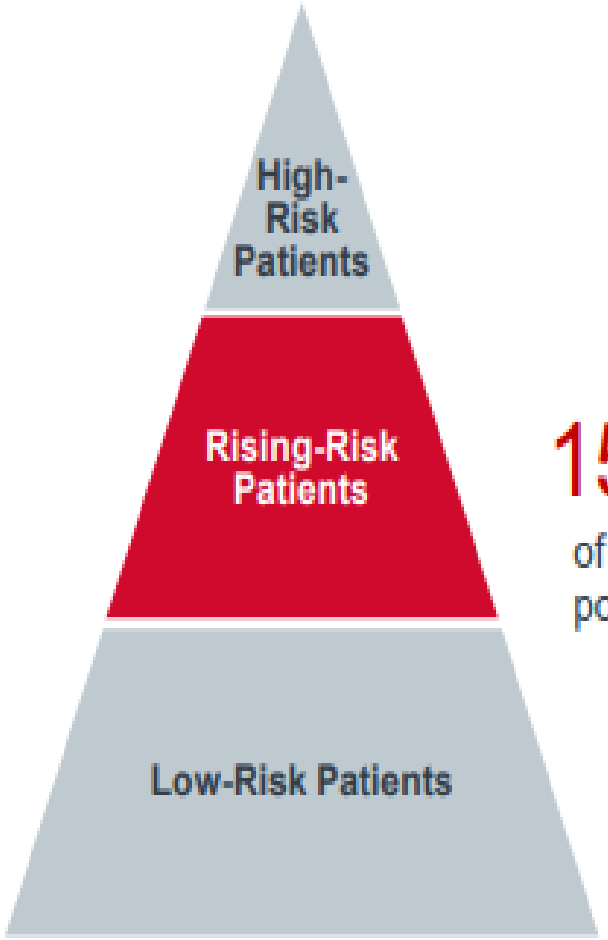


SOURCE: “Mind the Gap", The Advisory Board Company.
https://www.advisory.com/-/media/Advisory-com/Research/PHA/Research-Study/2017/Mind-the-Gap-Managing-the-Rising-Risk-Patient-Population.pdf

High Risk – the Initial Focus!



Rising Risk – yearly 18% of rising risk escalate to high-risk when not managed



15%-35%

of your patient population is rising risk

Key Characteristics of Rising-Risk Patients

1. Patient has 1 to 2 well-managed chronic diseases
2. Symptoms not severe and can be ignored
3. Patient has co-occurring psychosocial risk factors

SOURCE: Addressing the Needs of Your Rising-Risk Patients 2017 https://www.advisory.com/research/population-health-advisor/research-briefings/2018/addressing-the-needs-of-your-rising-risk-patients

How does your office risk stratify?

Strategy	Description	Care Manager example strategy
Basic	**No clear risk assigned** to the full population of patients.	Review lists of patients from registries – diabetics, asthmatics, and Payer with Provider. Providers can risk stratify based on their patient knowledge. CMs can supplement with screenings (SDOH, depression, etc.) *Remember that each patient the provider reviews with you means a G9007 billable code!
Intermediate	**Hospital discharges risk stratification** no internal process that assigns risk.	Strategy to use inpatient admissions risk score. Care manager and office staff share work based on discharged risk score.
Advanced	**Automatic method** of assigning risk to the entire population.	Standing referral to Care Management protocol based on risk score.

Care Manager Risk Stratification Tools

1. **Incentive program patient lists**
   - Lists have a column that describes # of hospitalizations / ED visits, comorbidities, etc.
   - Discussing patients is a good 1st step that is also billable!
2. **Social Determinants of Health Screenings**
   - A strong predictor of readmission is social isolation – so knowing whether or not a patient has social support can help inform the best approach to supporting that patient*.
3. **Patient Activation Screenings**
   - Patient Activation Measure (PAM) by Insignia, other patient activation tools.
4. **Behavioral Health Screenings**
   - PHQ-9 and other mental health screenings.

*https://www.sciencedirect.com/science/article/abs/pii/S1071916406007421

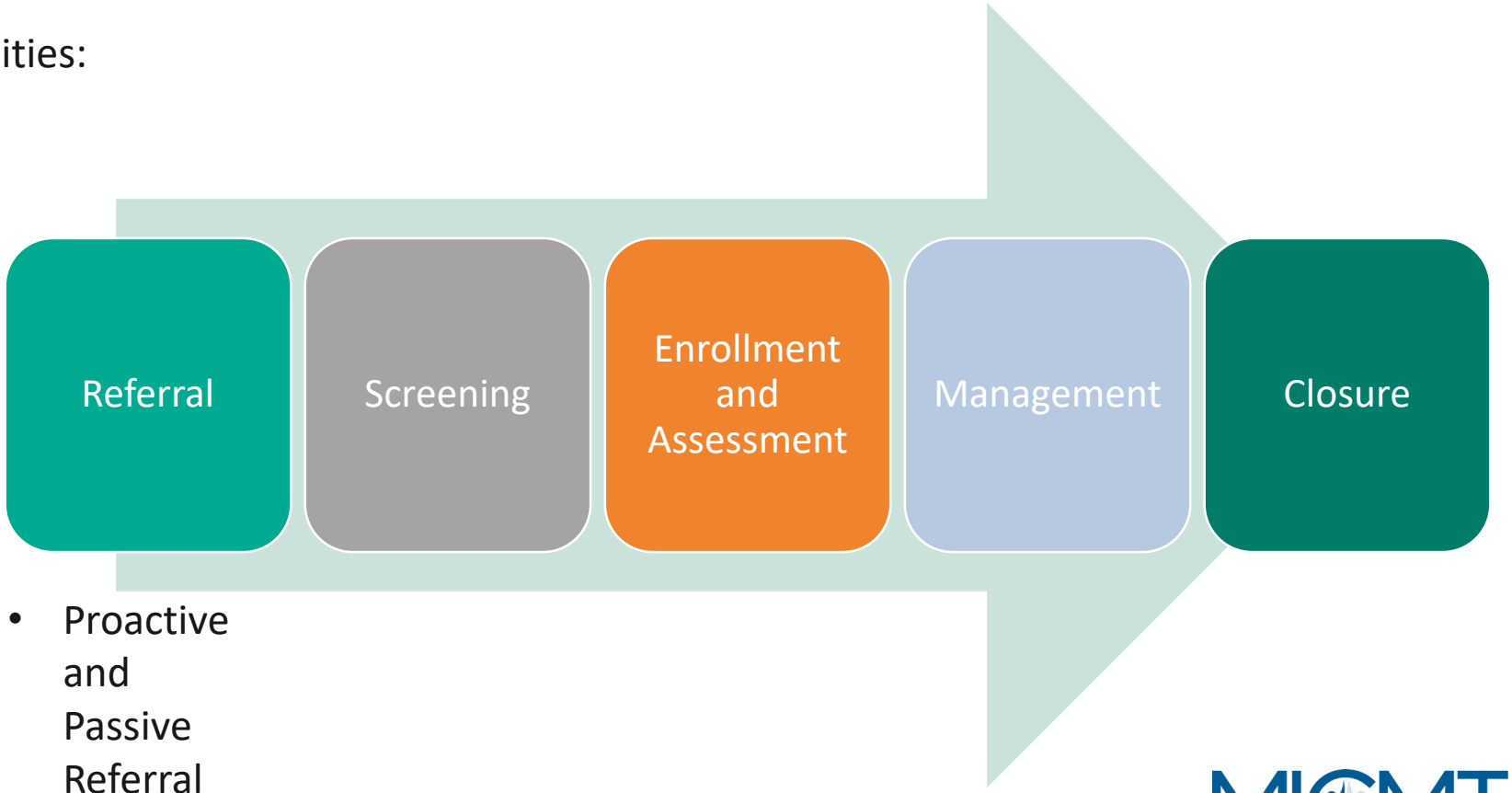
Post Hospitalizations: Risk of Readmission

High-Risk Patients	Moderate-Risk Patients	Low-Risk Patients
Admitted two or more times in the past year Unable to Teach-Back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home	Admitted once in the past year Moderate degree of confidence to carry out self-care at home, based on Teach Back results	No hospital admissions in the past year High degree of confidence and can Teach-Back how to carry out self-care at home

http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionsfromHospitaltoHomeHealthCareReduceAvoidableHospitalizations.aspx

Care Management Process

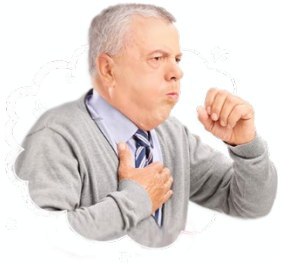
Billing Opportunities:



Key Items:

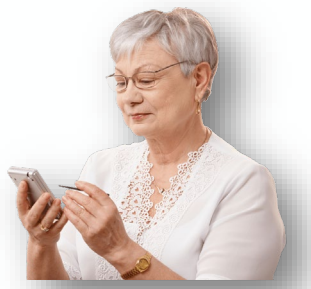
- Proactive and Passive Referral processes

Case Study



Mr. B – High Risk

- 83 years old
- Increasing symptoms of fatigue, weakness, SOB
- Hospitalized 3 months ago, HF exacerbation
- History of HTN, CAD, MI
- Temporarily living with daughter
- Unsure about his medications
- Feeling low
- High salt diet
- Worried about living arrangements
- Wants to be in own home
- Trouble sleeping
- Requires assistance with ADLs



Mrs. A – Rising Risk

- 70 years old
- Has type II diabetes for last 10 years without complication
  - Recently started on insulin
  - blood sugar out of control
- HTN – BP controlled with medication

Step 2:
Screening

Screening

- Screenings give patient context and support development of the patient Care Plan

Types of Screening

- Social Determinants of Health
- Social Support Structures:
  - home environment, social relationships
- Limitations and barriers:
  - what's keeping the patient from being a good steward of their health
- Physical/emotional/cognitive functioning
- Self-care ability:
  - health understanding, health literacy, engagement, confidence
- Behavioral Risk:
  - Anxiety, depression, stress, mental health symptoms

What are Social Determinants of Health (SDOH)?

Social Determinants of Health:

- What are Social Determinants of Health
- How do Social Determinants of Health impact a person's overall health and well-being
- How Social Determinants of Health can be evaluated
- What resources exist
- The care manager's role in addressing Social Determinants of Health

What are Social Determinants of Health?

- **Social determinants of health are the conditions in which people are born, grow, live, work and age.**
- They include factors such as:
  - Socioeconomic status
  - Education
  - Neighborhood and physical environment
  - Employment
  - Social support networks
  - Access to health care

SDOH Domains

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

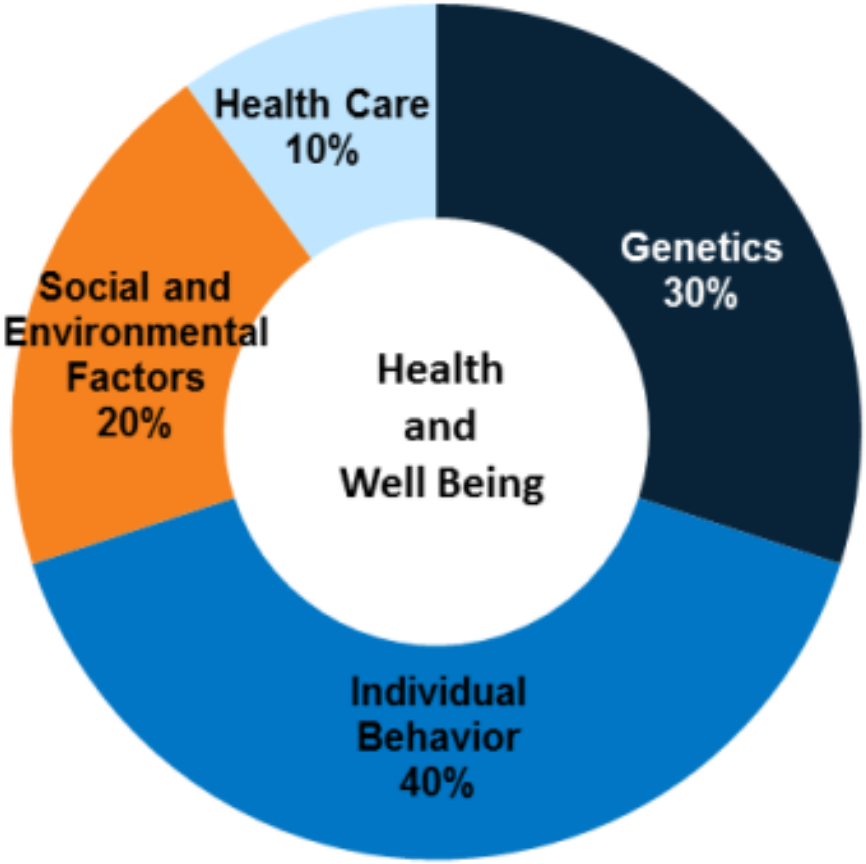
SDOH Examples:

Patient:
Mr. W does not understand the instructions on his pill bottle for his CHF. He ends up in the hospital due to taking his medication incorrectly.
Mrs. H calls an ambulance and is taken to the ER for a low blood sugar reaction because she has no transportation to get to her primary care office.
Mrs. A's son is hospitalized for an acute asthma exacerbation. The family has been unable to pay for heat this month and it is December.

How do SDOH Impact Health?

SDOH and the Triple Aim

Social Determinants Impact on Health



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

KFF
HENRY J KAISER FAMILY FOUNDATION

How to identify SDOH

Identifying a SDOH Need

1. Screening options:
   - Screen all patients once per year with their annual visit.
   - Screen patients from specific program, SIM, Priority.
   - Screen all patients referred to care management.
2. Probing questions to get to the root cause of the barriers to receiving care

Screening Tool

- SIM Suggested SDOH Screening tool:

SIM SDOH Domains	
Healthcare	Family Care
Food	Education
Employment & Income	Transportation
Housing & Shelter	Personal and Environmental Safety
Utilities	General If yes, would you like to receive assistance with any of these needs? Are any of these needs urgent?

To access SIM suggested SDOH screen tool – MICMT Care Management Reference Guide

Screening Process

The process is different at each office. Investigate:

- Who initiates the SDOH screening tool in your office?
- Where does the screening tool go once it is completed by a patient?
- Who addresses a positive screen?
- Who provides the resource, and how?
- Who follows up on the resources provided?

SDOH within the Comprehensive Assessment

- Baseline for both the medical **and** *social needs*
  - Patient's typical day
  - How the patient functions in their daily life
  - Identify family/caregiver support
  - Ability of caregiver to carry out necessary tasks
  - Patient and caregiver needs and wellbeing
  - Clarify patient's preferences regarding community participation and goals of care

- Prioritize risks through Maslow's Hierarchy of Needs
  - Provides an ordered structure to needs for the clinical team
  - Prioritize interventions

Health Literacy

The Facts:

- **90 million adults**, nearly half of the adult population, lack literacy skills needed to understand and act on health information and health system demands

- **12% of U.S. adults** have the health literacy proficiency to perform complex health tasks such as using a table to calculate an employee's share of health insurance costs

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http://www.iom.edu/~/media/Files/Activity%20Files/PublicHealth/HealthLiteracy/HealthLiteracyFactSheets_Feb6_2012_Parker_JacobsonFinal1.pdf

AMA Health Literacy

Adverse Childhood Experiences (ACES)

- Are intense and frequently occurring sources of stress children may suffer
- Prolonged stress in childhood has life-long consequences for health and well-being. It can disrupt early brain development and compromise nervous and immune systems
- 10 types of childhood trauma measured in the ACE Study
  - Five are personal
    - Physical, verbal, or sexual abuse
    - Physical or emotional neglect
  - Five are related to other family members
    - Parent who's an alcoholic
    - Mother who's a victim of domestic violence
    - Family member in jail
    - Family member diagnosed with a mental illness
    - Disappearance of a parent through divorce, death or abandonment
- **As the number of ACEs increases, so does the risk for unfavorable outcomes**

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https://www.cdc.gov/violenceprevention/acestudy/about_ace.html

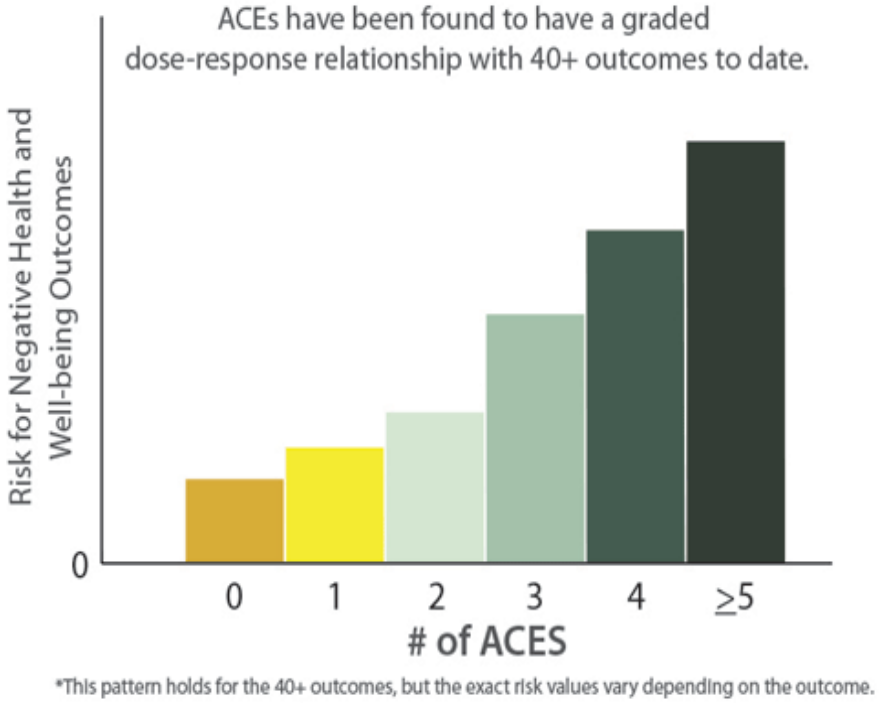
ACES

ACES can have lasting effects on….

Health (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)

Behaviors (smoking, alcoholism, drug use)

Life Potential (graduation rates, academic achievement, lost time from work)



https://www.cdc.gov/violenceprevention/acestudy/about_ace.html

ADDRESSING SDOH

Addressing SDOH – Community Linkages

Practices

- Have a Community Resource binder (paper or online). It is a PCMH capability.
- Use online resources such as the MI Bridges, Michigan 2-1-1.
- Connect the patient with the resource.
- **Follow up** to check patient used the resource.
- Document linkages in the medical record.

Community Linkages

- Creating sustainable, effective linkages
- Between the clinical and community settings
- To improve patients' access to preventive and chronic care services
- By developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live
- These linkages connect clinical providers, community organizations, and public health agencies

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

Community Linkages - GOALS

- Coordinating health care delivery, public health, and community-based activities to promote healthy behavior

- Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services

- Promoting patient, family, and community involvement in strategic planning and improvement activities

- Collaborations between clinical, community, and public health organizations offer a win-win scenario for participating organizations, clinical teams, and patients

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https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

Patient	Care Team	Community Linkage
Mr. W **Did not understand the instructions on his pill bottle for his CHF**. He ends up in the hospital due to taking his medication incorrectly	Mr. W is referred and called by the **primary care practice pharmacist** for medication reconciliation and medication management	The practice has an established relationship with **the local pharmacy who provides bubble packs** for Mr. W. The pharmacist ensures Mr. W. receives the bubble packs and that this intervention works for him and he is satisfied
Mrs. H **Calls an ambulance for a low blood sugar reaction** no transportation to get to her primary care office	Mrs. H is followed by the Primary Care Practice **Medical Assistant or Community Health Worker** and is provided with transportation resources	The **practice has a relationship with the 3 local transportation providers** in the area. The appropriate one is referred. Follow up is done by the MA/CHW to ensure the service happened and the MA/CHW ensures the patient was satisfied with the outcome
Mrs. A's son is hospitalized for an **acute asthma exacerbation** unable to pay for heat this month and it is December	Mrs. A is referred to **the social worker** at the primary care practice who assists Mrs. A with utility resources	The practice has a connection with a local resource. The contact person, known to the social worker, agrees to provide the resource. Follow up is done with the patient to ensure closure of need and to assess patient satisfaction with the outcome

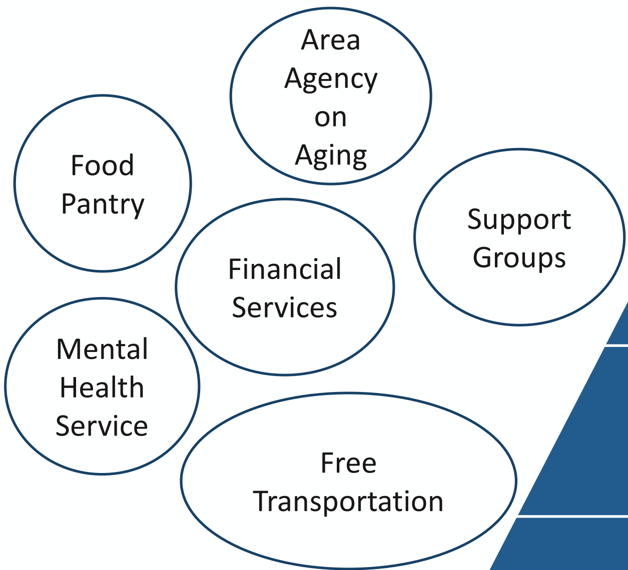
Addressing SDOH – Individualized Plan of Care

Document Needs for Ongoing Support

- Social needs that can't be addressed with a community resource today
- Focus on barriers that can be addressed now
- Self-management goals related to addressing social needs can be a way of documenting progress

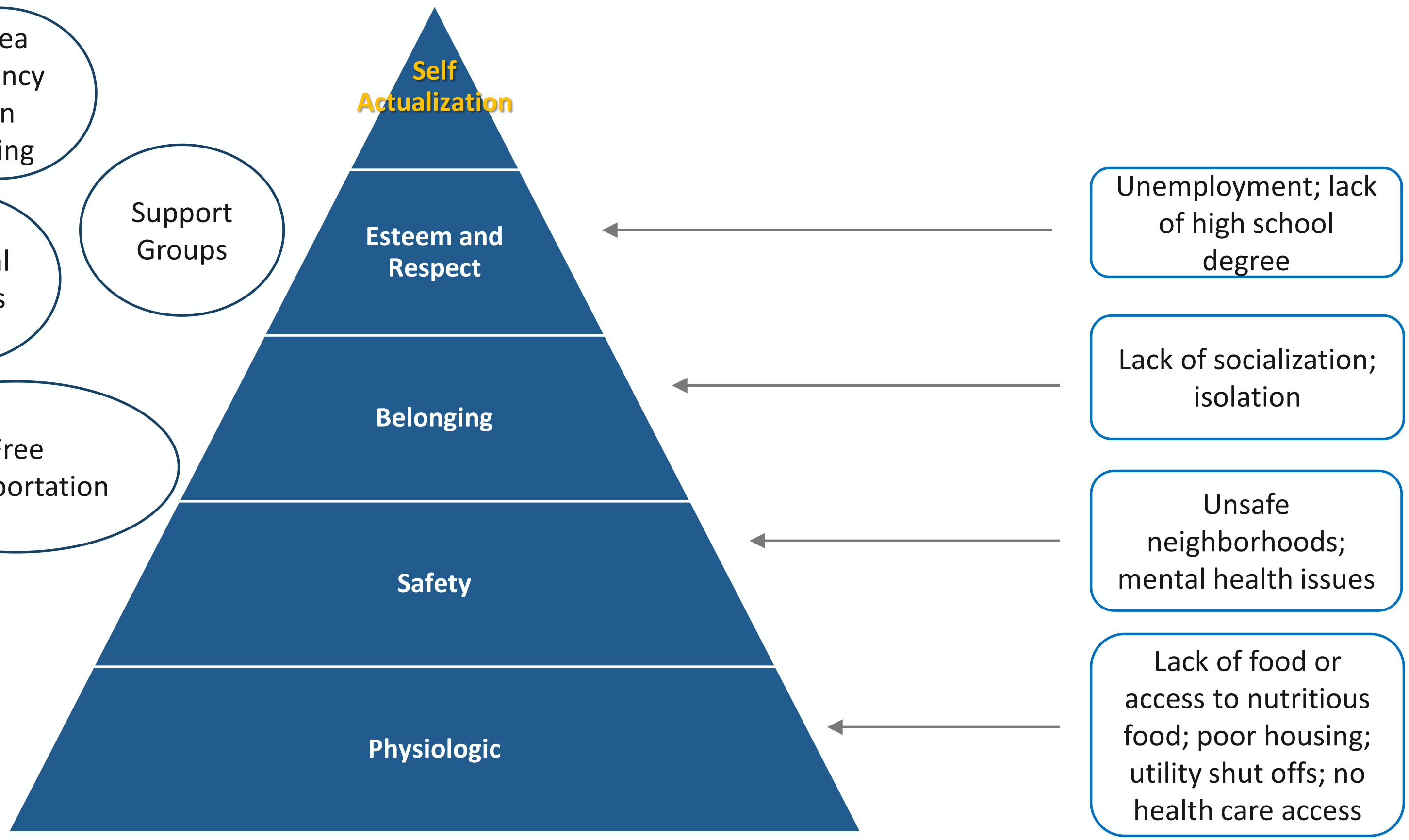
SDOH – Prioritization & Organization

Community-based Interventions



Maslow's Hierarchy

Risk Assessment



If basic needs are not met patients will not have the desire/ability to engage in health care discussions

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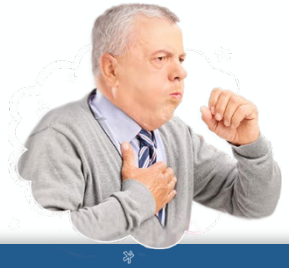
Adapted from: Beck, A.F., Henize, A.W., Kahn, R.S., Klein, M.D. (2015, October). A road map to address the social determinants of health through community collaboration. *Pediatrics,* 136(4) Retrieved from, http://pediatrics.aappublicati...

Screening

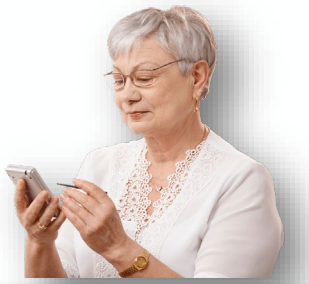
Mr. B

- Medical record
- PCP
- Patient story
- SDOH screening
- Hospital discharge report
- Care giver support - patient's daughter



Mrs. A

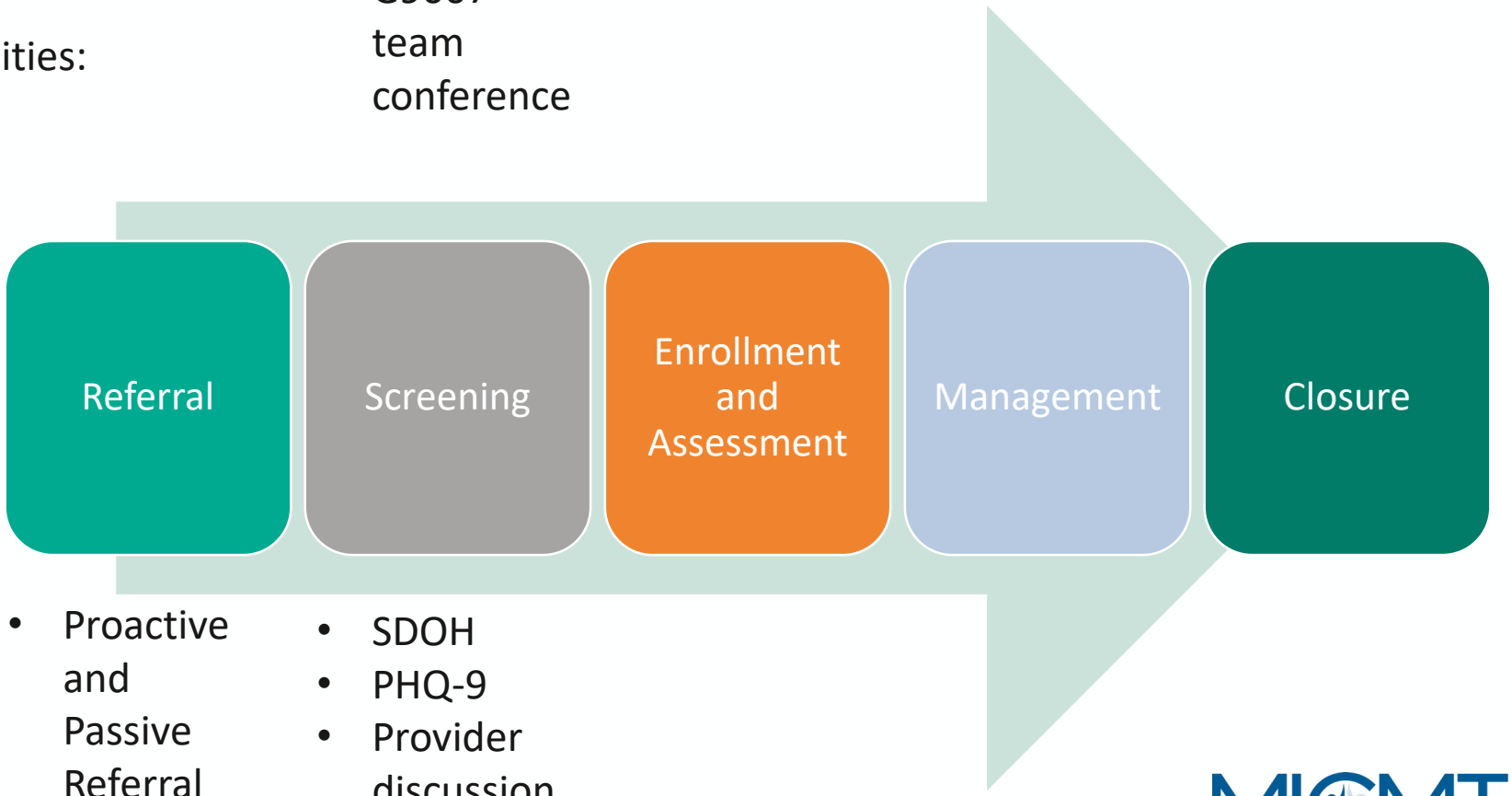
- Medical record
- PCP
- Patient story
- SDOH screening
- Care giver-spouse



Care Management Process

Billing Opportunities:

- G9007 team conference



Key Items:

- Proactive and Passive Referral processes
- SDOH
- PHQ-9
- Provider discussion

Step 3:
Enrollment and Assessment

Provider Discussion

Why have the Provider discussion?

- Speaking with the provider is an excellent way to determine whether or not the patient would be appropriate for care management.
  - Provider often has knowledge of patient's circumstances - psychosocial, readiness for change
  - Provider input saves time!

- Your role – initiate the conversation.
  - State why you think the patient may benefit from care management services
  - Identify possible care management services and team members

Determination for Care Management

- Patient would benefit from care management services but a determination made to not enroll
- Consider options to offer support for patient
  - Link to community resources
  - Reaching out to the patient's health care plan care manager

For Medicaid Managed Care – see contact list for the plan's care management services	**Blue Cross Health and Wellness, call 800-775-2583**

Engagement

- What is it?
- How do you achieve it?
- Resources
  - eLearning and topic page

Enrollment: Patient Engagement Strategies

- Warm handoff from PCP is best
- If warm handoff is not possible
  - Quick Tools
    - CM elevator speech or greeting face to face in office
    - CM Phone script
    - Care Management Flyer
    - Care Management Brochure
  - Building a trusting relationship
  - Assess patient's readiness

Enrollment: Patient Engagement

- Getting started:
  - Ask patient/caregiver:
    - “Dr. Smith asked me to contact you. He thinks you may benefit from a service we offer.”
    - “My name is Beth, a nurse with Dr. Smith’s office. He wanted me to call you regarding a service to help you manage your diabetes.”
    - “Dr. Smith asked me to call you about the concerns you have about your health.”

Enrollment: Comprehensive Assessment

- The Comprehensive Assessment is billed through the G9001 code.
  - Note that a G9001 code doesn't *have* to be the first code billed for a patient. It is the code for the comprehensive assessment.
- Physician discussion G9007

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Enrollment: Assessment

- Use information from screenings to develop a understanding of the patient's self-care ability.
- Organize information into a (SWOB) analysis
  Strengths / Weaknesses / Opportunities / Barriers
  - **Strengths** → behaviors / social structures / attributes that support the patient being a self-manager of their own health
  - **Weaknesses** → behaviors / social structures / attributes that do not support the patient self-managing their health
  - **Opportunities** → things the patient wants to accomplish that the care manager can leverage to help the patient avoid negative health outcomes or high cost events
  - **Barriers** → things the care manager can help diminish, like a positive on a SDOH screen

Organizing Screening Info to Develop a Care Management Plan

Strengths

behaviors / social structures / attributes that support the patient being a good steward of their own health.

Weaknesses

behaviors / social structures / attributes that do not support the patient to be a good steward of their health.

Opportunities

things the patient wants to accomplish that the care manager can leverage to help the patient avoid negative health outcomes or high cost events.

Barriers

things the care manager can help diminish, like a positive on a SDOH screen.

1. Patient Goals

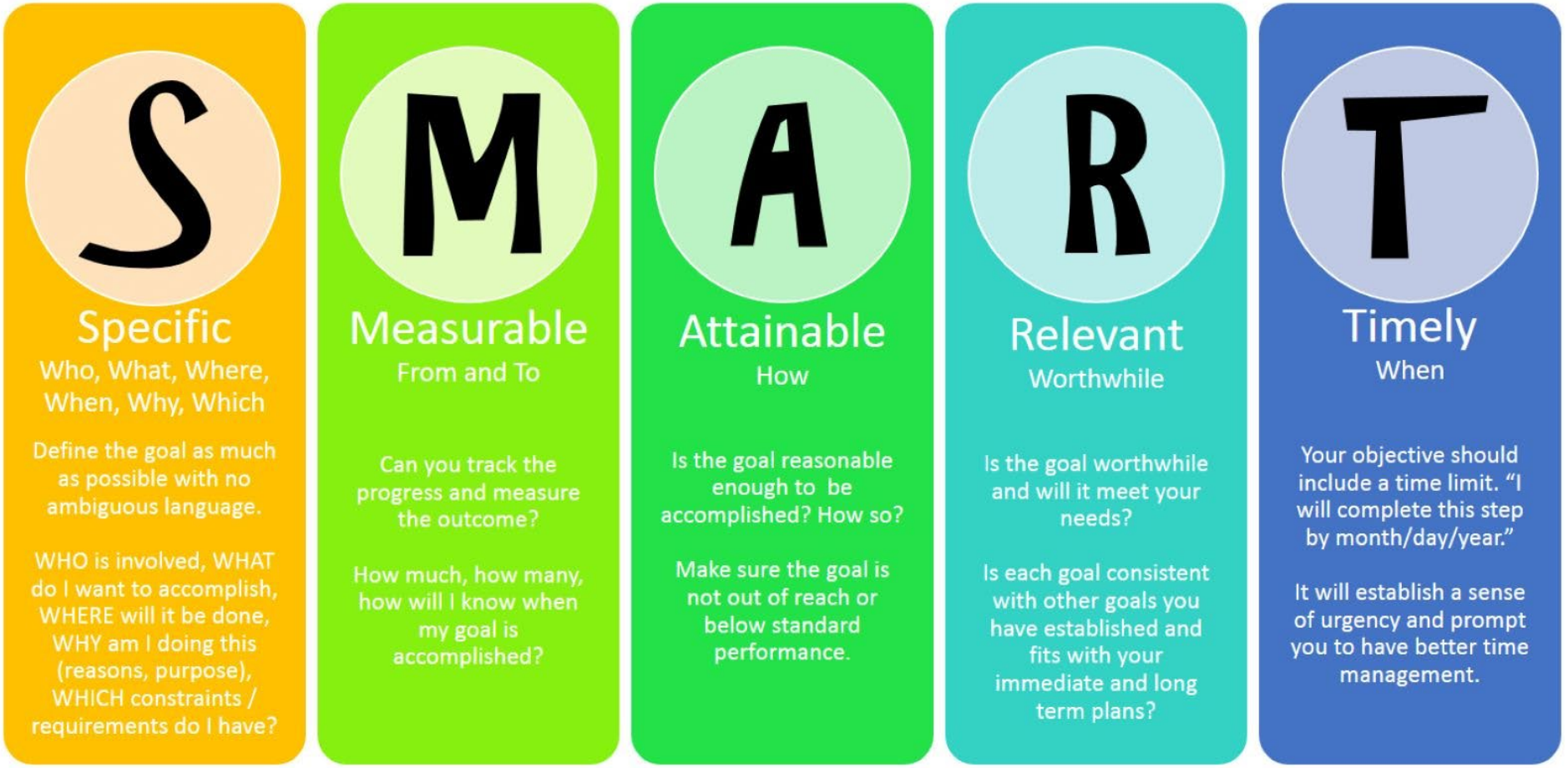
- Goals come from the patient's perceived opportunities, with the care manager helping to reduce barriers.
- Align with the provider's care plan goals and the outcomes that our programs seek to improve (A1c, BP, ED utilization, IP utilization)

2. Follow Up Plan

- Determine how frequently you will see the patient face to face and how often you will do phone check-ins.

Clinical foundation → provider discussion, med rec, clinical history, problem list, utilization history

SMART Goals check handout



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Enrollment/Assessment - Activity 5

Mr. B – in person

- Document consent
- Level of understanding
- SDOH – positive screen
  - Transportation
  - Home environment
- Self care ability
- Support network
- Why patient unable to sleep
- Diet
- Depression screening
- Medication reconciliation

Mrs. A - phone

- Document consent
- Level of understanding
- SDOH – no needs
- Support network
- Depression screening
- Medication reconciliation
- Self care ability
- Diet, behavior/lifestyle

Care Management Process

Billing Opportunities:

- G9007 team conference

- G9001
- Potentially other billing codes, as needed.

Key Items:

- Proactive and Passive Referral processes

- SDOH
- PHQ-9
- Provider discussion

- SWOB analysis
- SMART goals
- Follow up plan

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Step 4:
Management

Management

The initial follow up care plan is based on:

1. The perceived level of support the patient might need to accomplish their goals.
   - Does the patient need episodic or longitudinal care management?

2. Whether the bulk of the screening and risk observations landed in the
   - “Strengths / Opportunities” side
   - “Weaknesses / Barriers” side

Episodic vs. Longitudinal Management

Episodic

- Otherwise stable patients going through TOC
- Newly unstable chronic condition
- Short-term, goal oriented

Longitudinal

- Combination of multiple comorbidities
- Complex treatment regimens
- Behavioral and social risks
- Ongoing relationship

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Plan of Care – Patient Goals and Follow up

The patient goals and follow up plan are derived from:

- Conversations with the provider about the patient
- Conversations with the *patient* to develop goals
- Screenings:
  - Social Determinants of Health
  - Social Support Structures:
    - home environment, social relationships
  - Limitations and barriers:
    - what's keeping the patient from being a good steward of their health
  - Physical/emotional/cognitive functioning
  - Self - care ability or Patient Activation Level:
    - health understanding, health literacy, engagement, confidence
  - Behavioral Risk:
    - Anxiety, depression, stress, mental health symptoms

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Management – Plan of Care and Goals

Mr. B

- Comprehensive Plan of Care -Longitudinal
  - Collaboration with physician office team members, specialists, community agencies/resources, health plan care manager
  - When to call the PCP office

Mrs. A

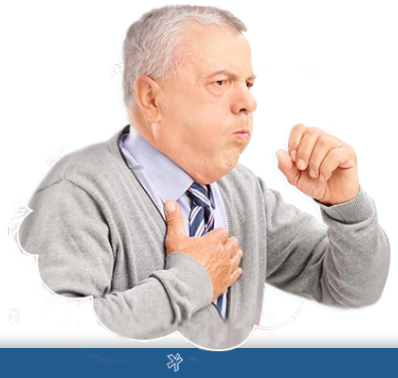
- Short-term episodic care
  - Diabetes action plan

What are some short and long term goals for each patient?

Management - Interventions

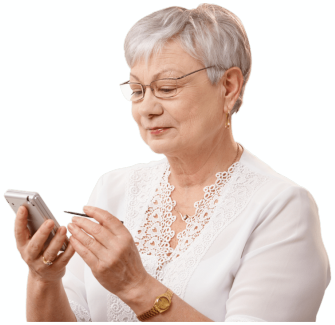
Mr. B

- Team members:
  - Pharmacist
  - SW
  - Dietitian
- Heart Failure action plan
  - Daily weights
  - When to call the PCP



Mrs. A

- Team members:
  - Diabetic educator
  - Patient and husband teach back on insulin use
- Diabetes action plan
  - When to call the PCP



Management: Assessing Progress

- Determine the cadence of follow up visits based on:
  - Reassessment of patient's SWOB analysis – including re-screenings on a regular basis, progress with meeting SMART goals
  - If patient's identified needs met
  - Health status and outcomes

[64] http://www.cmbodyofknowledge.com/content/case-management-knowledge-2

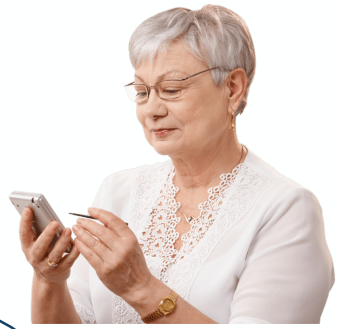
Management
Follow up

Mr. B

- Long-term longitudinal
- Weekly to start
  - Daily weights
  - Dietary changes
- Follow up on transportation

Mrs. A

- Short-term Episodic
- Weekly to start
  - Follow up on insulin use
  - Blood sugar monitoring



What next?

Care Management Process

Billing Opportunities:

- G9007
- G9001
- Potentially other billing codes, as needed.
- All billing codes

Key Items:

- Proactive and Passive Referral processes
- SDOH
- PHQ-9
- Provider discussion
- SWOB analysis
- SMART goals
- Follow up plan
- Re-screen
- Actively work to reduce barriers
- Support goal progress

Step 5:
Case Closure

Case Closure

- Reasons for case closure:
  - Patient has met their goals and is discharged from care management services
  - Patient moves out of region/state
  - Patient expires
  - Patient is admitted to hospice care

Note:

- Be sure primary care physician is in the loop for case closures. This conversation is another potential billing opportunity (G9007)
- Discussion with patient (G9002)

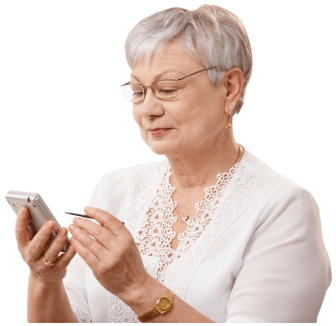
Case Closure

Mr. B

- Not appropriate for case closure, PCP in agreement
  - Chronic condition symptoms and exacerbations ongoing
  - SDOH barriers exist

Mrs. A

- Appropriate for case closure and PCP in agreement
  - Understands use of insulin
  - Blood sugars in control



Care Management Process

Billing Opportunities:

- Referral: G9007
- Screening: G9001; Potentially other billing codes, as needed.
- Enrollment and Assessment: All billing codes
- Management: G9007
- Closure

Key Items:

- Referral: Proactive and Passive Referral processes
- Screening: SDOH; PHQ-9; Provider discussion
- Enrollment and Assessment: SWOB analysis; SMART goals; Follow up plan
- Management: Re-Screen; Actively work to reduce barriers; Support goal progress
- Closure: Confirm with PCP

Reference Guide

Care Manager Introduction Phone Script

Care Management Explanation Flyer

SIM SDOH Screening Script Example

Michigan Community Resources

Michigan Medicaid Health Plan Contact Information

MDHHS Community Mental Health Services Programs

ACES Resiliency Screening

Michigan 2-1-1 Informational Guide

SIM SDOH Screening Tool

Health Literacy

- **Agency for Health Research and Quality**
  - http://www.ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/index.html
  - http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2.html

- **US Department of Health and Human Services Health Literacy**
  - http://health.gov/communication/literacy/

ACES – recorded webinar

- **SIM PCMH Initiative Pediatric Office Hours: ACES and SDOH Screening**

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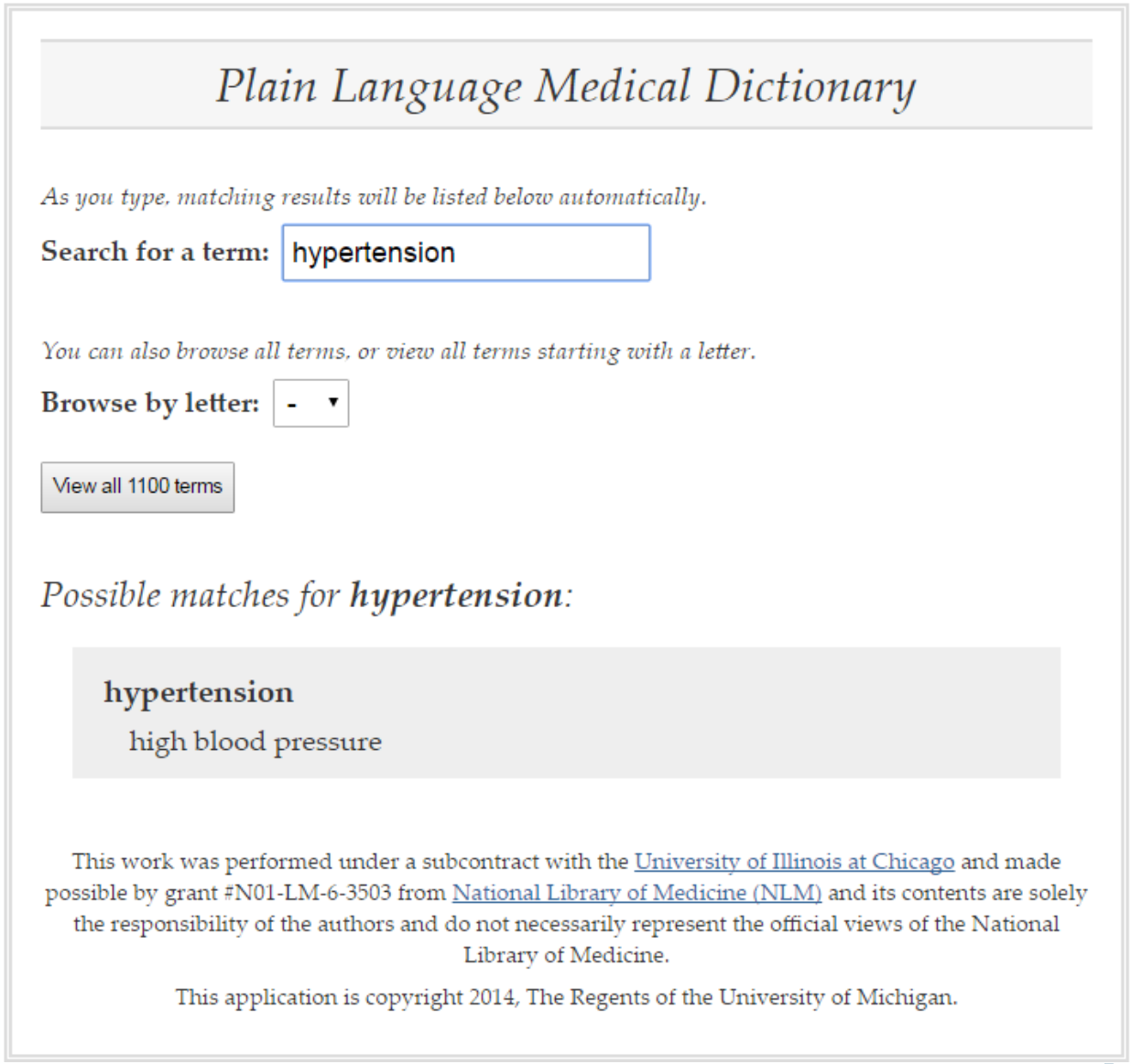
ACCESS THROUGH MiCMRC.org https://micmrc.org/webinars/pediatric-office-hours-aces-and-sdoh-screening



http://www.lib.umich.edu/taubman-health-sciences-library/plain-language-medical-dictionary