Standardization & Reporting:

Why is standardization important?

Community Care Networks are responsible for the delivery of targeted care management services that will improve quality of care while containing costs. In order to measure the impact/effectiveness of care management (CM), there must be consistent standards of documentation across all networks.

What is expected of the Care Manager and how are CM activities measured?

The Care Managers in each CCNC network and certain partnering agencies, provide a variety of services in the form of population management and direct care management. CCNC is working dynamically with networks to establish priorities that identify recipients who are most likely to benefit from care management interventions. Once identified, recipients who agree to participate should have clear documentation of a comprehensive health assessment (CHA), conditions/problems, interventions, goals and other care management activities recorded in the CCNC Care Management Information System (CMIS).

For the purpose of measuring outcomes, patients are considered care managed if their CM status is Heavy or Medium during the reporting period.

CMIS documentation for these patients should also include:

- one or more documented goals
- a comprehensive health assessment (within the 12-month reporting period.)
- one or more documented tasks per week / month

Patients who fall within the identified cohort are followed for CCNC program evaluation / reporting. Data is analyzed for meaningful trends in quality, cost, utilization and CM activity.

Implementation:

PRIORITY POPULATIONS

CCNC has been, and will continue to be, in a continuous state of revisiting and refining our information support, our processes, and our interventions as we develop new tools and resources (e.g. analytics) to better manage our population and prioritize our care management activities. CM efforts should be aimed at impacting priority populations:

- **Patients in the hospital** – our transitional care program is a priority approach to finding impactable people at a highly impactable moment

- **Patients on the TREO Priority Population List (PPL)** – this is our “go-to” report for targeted care management efforts for the Medicaid population

- **Real-time referrals** from the Primary Care Physician, Emergency Department, or other community providers

- **Other Data Reports** (e.g., Case ID Reports, Inpatient Visit Report, ED Visit Report, Care Alerts, etc.)
CCNC Care Management Standardized Plan

Expectations for Hospitalized Patients

- Hospitalized patients already flagged as meeting “CCNC Priority” or “CCNC Screening” should receive Transitional Care.

- Any/all hospitalized ABD patients should be assessed for Transitional Care Management (TCM).

- Non-ABD hospitalized patients - at a minimum, those with conditions targeted by our CCNC chronic disease initiatives - should be assessed for TCM.

- At the point a CM encounters a patient in the hospital; other predictive factors about their risk of readmission (certain medications, fragility, social supports, etc) are going to overshadow the importance of any historical claims indicator. A primary goal of our transitional care is to prevent the patient from being flagged with a CCNC Priority indicator.

SUGGESTIONS for workload distribution of PPL Patients — listing of all non-dual enrollees (ABD and Non-ABD) who have spent more in hospital (inpatient/ED/readmissions) services in the past year than would be expected given their clinical risk group (CRG).

- PPL patients flagged as LME Priority indicator or designated as Quadrant 2 patients - engage LME and network behavioral health resources
- PPL patients flagged as Quadrant 4 patients - engage LME and network behavioral health resources
- PPL patients aged 0-5 – engage CC4C Case Managers
- PPL patients with Palliative Care indicator – engage network palliative care resources
- PPL patients with greater than 19 narcotic fills during the 12 month reporting period – engage Network Pharmacist and/or Chronic Pain Initiative resources
- PPL patients with Polypharmacy indicator - engage Network Pharmacist
- PPL patients with HTN who also appear on the HTN Case ID with poor med adherence – engage patient in the HTN Self-Management module

ADDITIONAL SUGGESTIONS for Prioritizing Patients within the PPL List:

- PPL patients who have had their most recent potentially preventable activity in the past 6 months should be a priority for CM services
- PPL patients flagged as newly enrolled should be a priority for CM services
- PPL patients deferred due to being “well-linked” should still be evaluated for appropriate use/volume/cost of services, effective coordination of care, avoidance of duplication, etc.
- PPL patients with CM status of “deferred” or “inactive” should be a priority for CM services

The CCNC Priority and Screening flags eliminate the need to complete the CCNC screening tool in CMIS or spending additional time doing claims review to see if the patient “qualifies” for Care Management.
Action Steps:

- During a brief/initial evaluation period, view the patient snapshot, Comprehensive Health Assessment (CHA), and/or hospital data, if available. Your goal is to obtain enough information to determine if the patient is impactable and initiate contact with the patient.

- The next step is **PATIENT ENGAGEMENT** using motivational interviewing (MI) techniques.

- Once patient engagement is secured, initiate the **Comprehensive Health Assessment (CHA)**. The **CHA** is a working document about the patient’s past and current medical, behavioral, and social history and should be updated as new information is obtained. It serves as the patient’s health record, allows the CM to identify and open conditions, and is the single care plan that stays with the patient as he or she moves from one area of the state to another or across eligibility programs. Any CCNC staff member should be able to review a CHA and feel secure that they are aware of pertinent medical information that will assist them in providing services to the patient.

- Following initiation of the CHA, NEXT STEPS in the Care Management process include:
  - Document **Tasks and Interventions**
  - Determine **Follow up / Monitoring frequency**
  - Assign Patient-Centric **Goals**
  - Assign **Case Status** (level of intensity)

**Documentation in CCNC Case Management Information System (CMIS)**

- CMIS is a secure, web-based system for the management of its enrollees that is a user-built, patient-centric, electronic record of care management activities.
- CMIS contains standardized health assessments, care plans, screening tools, disease management, health coaching modules, and workflow management features
- ALL care management activities, interventions, tasks, progress toward goals, etc., are documented in CMIS.
- CCNC staff will use CMIS to assess the impact of care management. Therefore, it is **imperative** that:
  - (a) care managers utilize the standardized processes defined in this plan to document in CMIS their involvement with the individuals receiving care management services; and
  - (b) that the documentation be consistent across CCNC networks and other programs using CMIS for care management documentation
- CMIS is for reporting both individual and population level information
- CMIS enables the CM to assess, plan, implement, and evaluate patient care management through use of the following modules:
  - Accessing claims data and other clinical and patient-centric data
  - Case Assignment
  - Patient Assessment and Care Planning
  - Medication Management
  - Secure Messaging System
- CMs are to perform regular periodic status and goal reviews (in CMIS) every **90** days, at a minimum, while the patient is being care managed at **Heavy** or **Medium** status.
CCNC Care Management Standardized Plan

CCNC MEDICATION MANAGEMENT

The process of gathering, organizing and sharing with community-based providers, medication use information from multiple sources (including the patient, medical chart, prescription fill history, and discharge instructions) in order to identify and resolve urgent/emergent duplications, interactions, possible adverse events, poor adherence or other suboptimal medication-taking behavior(s).

A. MEDICATION LIST

WHO: This task may be performed by a Licensed Practical Nurse, non-nurse CM (Care Manager), pharmacy technician, or other personnel with adequate skill competency as determined by the Network in conjunction with the CCNC Pharmacy Program. While an RN-CM can perform this task, the intent is for other staff to complete this step of the medication management intervention

WHAT: 1. Compile a set of medication lists by source, including but not limited to:
   *a. Discharge instructions from hospital/facility, if applicable
   *b. PCP Chart/EHR
   *c. Fill History (Pharmacy Home/CMIS)
   *d. Patient Report (non-clinical CMs can write down the list per patient report, as it is a necessary part of the Information the RN or Pharmacist will need to do the next step in the process. This is not a Patient/Caregiver Interview - see B1 below).
   e. Specialist(s) Chart(s)/EHR(s)
   f. Home care-based service provider
   g. Retail Pharmacy

   2. Hand off list to RN-CM and/or Network Pharmacist for Medication Reconciliation and/or Medication Review.

B. MEDICATION RECONCILIATION (This step must be completed for all patients being care managed at heavy or medium status, including Transitional Care patients.)

WHO: Optimally, this intervention should be performed by an RN with appropriate clinical training and adequate skill competency as determined by the Network in conjunction with the CCNC Pharmacy Program. Network Leadership may delegate this intervention to those with professional degrees and/or licensed professionals who possess appropriate clinical training and adequate skill competency (unless excluded by their scope of practice as defined by their licensing entity). All medication reconciliations performed by a non-RN must be approved by the supervising RN or Network Pharmacist.

WHAT:
1. Patient and/or Caregiver Interview takes place in the home, clinic, or via telephone, using the Medication List to enhance drug use information gathering. *Critical Med List sources are D/C instructions, PCP Chart, Fill History and Patient Report.
2. At a minimum, this is the process of identifying duplications and/or discrepancies between the medications lists and other sources (e.g. fill history, patient interview, PCP chart) arising from uncoordinated care or patient non-adherence

C. MEDICATION REVIEW - COMPREHENSIVE

WHO: Medication Review may be performed by a Pharmacist or PCP

WHAT: In-depth global review of the medication regimen and drug use history to identify complex problems. Review includes all aspects of medication management, including: cost-effective medications, duplications, side effects, contraindications, interactions, allergies, adverse event identification, and evidence-based recommendations. Process is initiated by referral from CM or PCP (not limited solely to transitional care patients).

The CM should serve as a liaison between PCP, pharmacist and patient/family as needed.
CCNC Care Management Standardized Plan

Transitional Care Model / Real-Time Inpatient Referrals:

Our transitional care program continues to be a priority approach to finding impactable people—at a highly impactable moment. At the point a CM encounters a patient in the hospital; other predictive factors about their risk of readmission (certain medications, fragility, social supports, etc) are going to overshadow the importance of any historical claims indicator. A primary goal of our transitional care is to prevent the patient from ending up on the Treo PPL.

Key Components of the Transitional Care Model
- Face-to-Face Patient Encounters
- Patient Self-Management Notebook / Patient Education
- CCNC Medication Management
- Follow-Up Calls and Contact
- Follow-Up with PCP or specialist in a timely manner

FACE-TO-FACE PATIENT ENCOUNTERS
- **Hospital** – Networks are expected to have embedded Care Managers in large-volume hospitals to interact with the hospital team (Hospitalists, Discharge Planning, Pharmacy, Palliative Care, etc.) to facilitate optimal hospital stay that includes discharge planning at the time of admission. The CM should visit the patient at bedside and begin engagement; as well as ensure processes are in place for a smooth and timely discharge. CM should ensure discharge instructions/discharge medication list, other necessary documents are readily available.

- **Home Visit** - Patients at high-risk for a failed transition should receive a home visit within 3 business days of discharge with the priority intervention being medication management, beginning with “medication reconciliation”. Additional home visits and/or join PCP visits are often needed to facilitate optimal care management.

- **Practice and Community Encounters with the Patient** - Although a home visit is considered the best method of providing a thorough assessment of both the patient and their home environment, there are times when it may be more appropriate (or as a supplement to the home visit) to have a face-to-face encounter with the patient in the community or at the provider office. The patient should be instructed to bring all their medication bottles with them so that the medication reconciliation can take place.

CCNC MEDICATION MANAGEMENT (refer to Medication Management section of this document)

PATIENT SELF-MANAGEMENT NOTEBOOK / PATIENT EDUCATION

- **Self-Management Notebook**
  - Provide individualized patient education and assist the patient with implementation of the Self-Management Notebook as appropriate. This notebook serves as a personal health record for the patient and a communication tool with PCP, specialty providers, and other healthcare services to facilitate continuity of care. Document the overall content of education, (e.g., side-effects of meds and when to report), and include name(s) of CCNC Patient Education tool(s), if used, along with patient’s response to teaching.

- **Red Flags**
  - Provide patient and family education on “red flags” that could indicate a complication or exacerbation, requiring a call to the doctor, CM, or other in-home service provider to prevent potential ED visit/readmission.
  - Utilize Motivational Interviewing techniques, “teach-back”, and other evidence-based patient education strategies for optimal outcomes.

FOLLOW-UP CALLS AND CONTACT

- **Timely Follow-up**
  - Ensure patient has a follow-up appointment with PCP/specialists quickly after discharge.
  - Assess for potential barriers to patient attending the appointment and assist with planning, transportation, etc. to facilitate completion of appointment.
  - Transitional care follow-up should continue for a minimum of 30 days.

Documentation standards for transitional patients

- When documenting the Transitional Care process, use appropriate TC interventions/tasks
- As you continue to work through the Transitional Care Model, document the interventions named above as you accomplish them. The goal is to include all interventions named above during the transition period
- The transitional period only applies to period from hospital admission through 30 days post discharge.
CASE STATUS

Case Status defines the intensity level of care management needs for THE PATIENT and must reflect direct service with the patient. Activities not directly related to a patient centered intervention, e.g., tasks related to engaging the patient, SHOULD NOT be counted toward case status requirements.

Intense Care Management - Heavy
- One or more documented patient-centric goals with at least 1 documented and completed task per week or 4 per month, at a minimum

Intense Care Management – Medium
- One or more documented patient centric goals with at least 1 documented and completed task per month.

Care Management - Light (Patient Maintenance)
- Patient has been referred to an outside agency and CM monitors to assure that linkage occurred.
- Maintenance of stable conditions/problems, and/or
- Population Management Services, e.g., resolution of health care access issue or mailings directed at program initiatives/prevention, etc.
- Minimum of 1 or more documented tasks per year (but not more than 2 per quarter)

Care Management – Pending
- Period when newly identified patients are being assessed to determine level of care management required.
- Pending Status should not be used for more than 30 days.* If no decision re: CM needs has been made within this time frame, the patient's status should be changed to “deferred.”[*Patients with extended hospital stays (e.g. NICU babies, severe trauma, etc.) may stay in pending status longer than 30 days or status may be updated.]

Care Managers are required to schedule a pending task for all patients who have a Care Status of Heavy, Medium, Light or Pending.

Care Management - Deferred
Following patient assessment and/or Care Management, it may be appropriate to set status as deferred, if one of the following reasons apply:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-linked</td>
<td>Patient assessment reveals no care management needs at this time because patient is well-linked to medical home and/or other services.</td>
</tr>
<tr>
<td>Identified Needs/Goals Have Been Met</td>
<td>Identified needs/goals for patient have been resolved as a result of CCNC CM activity. CM is no longer providing CM services. (One should select this reason only if CM services have been provided previously.)</td>
</tr>
<tr>
<td>Unable to Contact (at least 3 documented attempts)</td>
<td>CM has attempted contact at different times/different days/different ways and been unsuccessful.</td>
</tr>
<tr>
<td>Is Not Adherent to Care Plan or Goals</td>
<td>CM has made multiple attempts to help patient set and work towards meeting goals without success due to patient unwilling or unable to adhere to care plan. User should select this after she/he has attempted to work with the patient and has notified the PCP of the circumstances resulting in deferral for this reason. (This is not based upon PCP request to defer.)</td>
</tr>
<tr>
<td>Refused Services</td>
<td>Pt verbalizes he/she does not want CM services at this time or refuses referral for linkage.</td>
</tr>
<tr>
<td>Rolled Off</td>
<td>Patient is not enrolled with Medicaid. CCNC does not currently offer CM services to this population.</td>
</tr>
<tr>
<td>Does Not Qualify for CM at this time</td>
<td>Patient does not qualify for CM services at this time due to living facility (e.g: institution), enrollment status (Straight Medicaid, CA I) or other circumstances that prohibit pt/family from setting goals.</td>
</tr>
<tr>
<td>PCP Recommends Deferral</td>
<td>Pt is deferred at PCP’s request/recommendation.</td>
</tr>
<tr>
<td>Deceased</td>
<td>Deceased</td>
</tr>
</tbody>
</table>

Care Management - Inactive
- System-assigned case status for all patients with no CCNC care management contact, or new enrollee