

Management and Support Policy

Purpose:

_____ are committed to reducing cost and improving outcomes in partnership with patients who have complex, costly and difficult to manage health conditions and/or who have social or behavioral conditions that may interfere with their ability to receive appropriate care

Policy:

Identify, stratify, and offer case management to patients with complex, costly and difficult to manage health conditions and/or who have social or behavioral conditions that may interfere with their ability to receive appropriate care.

1. Identify patients with complex, costly and difficult to manage health conditions and/or who have social or behavioral conditions that may interfere with their ability to receive appropriate care.
 - a. Behavioral health conditions
 - i. Patients seen by medical providers will receive a PHQ-9 screening.
 1. Individuals who scored moderate/severe depression (15 or higher on the PHQ-9 screening) or affirmation of suicidal ideation (1 or more on question 9) will be referred to _____
 2. Behavioral health care management will be done in conjunction with _____ Medical Social Worker
 - a. Referrals for case management may be made through case management or through Electronic Health Record (EHR)
 - b. For more information, see Joint Suicide Screening/Intervention Policy and Process
 - ii. All patients with a diagnosis of depression will be included in risk stratification process.
 - b. High cost/high utilization
 - i. Patients will be identified by high visit volume if they have greater than X visits.
 1. All patients identified as high utilization based on high visit volume will be included in risk stratification process.
 - ii. Additional patients will be identified for follow-up using a quarterly report from _____ of the top 20 cost patients (High Cost Utilization Report)
 1. The High Cost Utilization Report will be presented in Case Management Committee quarterly for case management follow-up with patients.
 - c. Poorly Controlled or Complex Conditions (Diabetes)
 - i. Patients who have poorly controlled diabetes and are newly diagnosed or newly motivated will be referred to _____ Diabetes Program; "Self-Management Through Education" for diabetes self-management education and case management using EHR. (Please see associated SMTE referral policy)
 - ii. Patients with A1c between 8-10% will be included in risk stratification process.
 - d. Social determinates of health (uninsured)
 - i. During the check-in process Patient Registration will identify patients who are uninsured or have no insurance on file. Patients without insurance coverage will be offered the opportunity to speak with the benefits coordinator or ___ representative to obtain coverage.
 1. Bi-annually Patient Registration/Health Information Technology will use the EMR to run a report to identify uninsured patients. ___ staff will provide outreach for patients without health insurance.
 - ii. Patients with diagnosed substance abuse conditions will be included in the risk stratification process.

2. Case management referrals happen in a variety of ways, and ___ and ___ are committed to providing case management in a variety of ways. See attached Case management process flow and identified types of case management service providers and services offered.
3. Risk stratification will occur utilizing the iCare system.
 - a. Patients will be identified in the risk stratification process by the combination of risk factors including:
 - i. All patients with a diagnosis of depression.
 - ii. All patients identified as high utilization based on high visit volume.
 - iii. Patients with A1c between 8-10%.
 - iv. Patients with diagnosed substance abuse conditions.
 - b. Patients with X or more risk factors will be offered care management support.
 - i. Care management support will be assigned through Case Management Committee, or by EHR referral.
 - ii. Staff providing care management will work with patients to make care plans and goals and document them appropriately.
 - iii. Conditions necessitating removal from care management:
 1. Lost to follow-up
 - a. Including inability to contact patient after 3 attempts, or
 - b. Moved from local area)
 2. Decline care management
 - a. Patient will be offered the opportunity to resume/receive care management if they choose
 3. Deceased
 4. Care management goals attained

Care Management Providers, Eligibility, Referral, and Services

Case Management Providers (hospital follow-up)	CHN (Hospital)	Patient Navigator	CDE	MSW (Hospital)
Who is eligible	Elders 55+ w/ or w/o chronic conditions	Chronic illness- end stage, cancer	Pre diabetic, diabetic patients, heart disease, obesity, eating disorders, liver, kidney	Sees all people, a lot of social issues.
How are patients referred for services	Self-referral, referrals from case management, in house, and outside	Case management, self-referrals, cancer report, field nursing	EHR referrals, direct and in house referrals, Case management, hospital referrals.	In-house referrals, outside referrals.
What services are provided	Case management, medication delivery and med box refills, physical assess- limited, wound care, DME delivery, welfare check, hospital admits, and D/C follow up.	Help to identify barriers to care- cost, transportation, lifeline phones, hospital charities. Hospital follow up. Referral follow up.	Medication and device education, nutrition and medication management, identification of resources and needs, case management. Facility DME referrals for shoes, eyeglasses and dentures. Field nursing.	Case management, hospital visits, protective custody hospitalization advocacy, transports, advanced directives, power of attorney, funeral request, continuity of care- post d/c planning & F/U - after care (hospital, home health, PCS), crisis management

Care Management Process Flow

