

Provision of Care in Community Case Management

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POLICY:

I. Case Management Services:

The Community Case Management Program provides a range of case management services to existing or potential Lutheran Healthcare patients in order to achieve the “Triple Aim” of better patient experience, better patient outcomes, and reduced health care expenditures. The program targets high risk patients diagnosed with chronic health conditions, including mental illness, HIV/AIDS, and/or chemical dependency disorders, whose fragile health status may be compromised by destabilizing biopsychosocial factors

As a member of the Brooklyn Health Home, and as specified by CMS, Community Case Management provides five core services, which include the following case management activities:

- (1) comprehensive care management
- (2) care coordination and health promotion
- (3) comprehensive transitional care/follow-up;
- (4) patient and family support
- (5) referral to community and social support services.

The provision of a core service may involve face to face patient contact, mailings, phone calls, electronic communication and /or case conferencing with medical, behavioral health, chemical dependency or other social service providers. Active, ongoing and progressive engagement with the patient, and progress toward achieving case management goals are documented in the case management record. Care/Case Managers are expected to provide at least one of the five core services per patient, per month to meet minimum billing requirements, but more intensive contact is often required to effectively engage the patient, to address unmet social service needs and to achieve behavior change goals. (See Brooklyn Health Home Program Manual, Procedure B)

In recognition of service area demographics, the program strives to provide culturally and linguistically competent services to reduce barriers to accessing care and to enhance care delivery. The program actively recruits bilingual, bicultural staff; and provides cultural diversity training to achieve these objectives.

Case Management services are available on a daily basis and most staff work at least one evening per week to accommodate the scheduling needs of patients. The hours of operation are Monday-Friday, 9 a.m. to 5 p.m. with services offered until 7pm at some sites, some days a week.

II. Staffing Pattern and Case Management Roles:

The department’s leadership team includes the Assistant Vice President of Community Case Management who is responsible for program development, fiscal management and administrative oversight; and the Director of Panel Management, who is responsible for daily operations, clinical training and staff supervision. A Care Manager Supervisor assists the Program Director with record review.

The multidisciplinary case management team includes Care Managers, Nurse Case Managers, Social Work Case Managers, and Community Health Workers. Case Management teams are embedded across nine Family Health Center sites, to maximize patient contact, and

to promote communication and coordinated care planning among providers and case management staff.

Care Managers use a coaching style, informed by the principles and techniques of Motivational Interviewing, to motivate high risk patients with chronic health conditions to make lifestyle behavior changes that will increase adherence to their medical care plan resulting in improved health outcomes and thus quality of life. The Care Manager meets with the patient to conduct an evaluation and to develop a care plan. The Care Manager elicits from the patient, his/her own ideas about how change can be accomplished, and augments the patient's ideas about change, when necessary, by offering a list of change options based on provider recommendations. The Care Manager maintains contact with the patient between provider appointments to monitor and affirm the patient's progress in achieving change goals, and to offer ongoing support and encouragement.

Care Managers are expected to understand the basic facts of chronic diseases and chronic disease management, but do not function as disease educators. The Care Manager evokes and explores the patient's thoughts and feelings about his or her illness, clarifies the patient's understanding of the information communicated by medical providers, and communicates gaps in understanding, misperceptions, patient concerns and patient questions to the provider. Whenever possible, and if the patient and the provider are in agreement, the Care Manager will attend the medical appointment with the patient in order to enhance his or her understanding of the patient's health conditions and of the provider's treatment recommendations.

The Social Work or Nurse Case Manager plays a pivotal role in outreaching and engaging high risk patients who present with complex medical and/or psychiatric comorbidities. Patients who present with complex medical conditions are assigned to the Nurse Case manager. Patients with salient behavioral health issues are assigned to the Social Work Case Manager.

In providing intensive case management services, the Case Manager addresses those functional deficits that impact the patient's ability to care for self and participate in treatment, including deficits in affect regulation and impulse control, as well as deficits in social and self-care skills. Psychosocial stressors which compromise the patient's emotional stability, and increase the risk of decompensation and re-hospitalization are also targeted for resolution. Unmet social service needs are addressed and barriers to accessing medical and or psychiatric care are resolved.

Like the Care Manager, the Case Manager, uses a guiding style, informed by the principles and techniques of Motivational Interviewing, to motivate patients with complex medical and psychiatric conditions to make lifestyle behavior changes that will improve health outcomes. However, Motivational Interviewing is supplemented with other, psycho-educational, ego supportive and cognitive-behavioral approaches to treatment. Health education is also provided by the Nurse Case Manager. Given the physical and emotional fragility of this high risk population, Case Managers also conduct ongoing risk assessment and safety planning.

Like the Care Manager, the Case Manager initially meets with the patient to conduct an assessment and develop a care plan. The Case Manager maintains regular face to face or

phone contact with the patient between provider appointments to enhance treatment compliance, and to track and affirm patient progress in achieving change goals.

Community Health Workers function as the department's "Feet on the Street", or emergency response team, in crisis situations. The Community Health Worker may be deployed at a moment's notice for outreach to re-engage patients who have missed appointments, to check on a fragile patient, to communicate a critical test result, to pick up a prescription, or to gather information needed by the Care/Case Manager or medical provider to inform the bio-psychosocial assessment of the patient. Within the context of the home visit, the Community Health Worker is able to observe first-hand how living conditions and family dynamics impact on the patient's emotional adjustment and health condition, and frequently plays an important role in developing family and/or other community supports for the patient's recovery. The ability of the multilingual Community Health Worker team to communicate with patients and families in their first language deepens understanding, enhances engagement, and promotes compliance. With deep roots in the community, the Community Health Worker brings an intimate knowledge of cultural dynamics and community resources to case management activities.

The Community Health Worker also plays a pivotal role in addressing the unmet social service needs that have been identified by the patient's Care/Case Manager. For example, the Community Health Worker may escort the indigent patient to the local HRA office, as well as assist the patient to fill out applications to obtain Public Assistance, Food Stamps and/or Medicaid coverage. The reluctant or fearful patient may be escorted to a medical, behavioral health or chemical dependency appointment by the Community Health Worker. The hands-on-help that the Community Health Worker provides in meeting the patient's concrete social service needs, and the relationship building that occurs in the time spent together in the community, often strengthens the patient's alliance with the health care team and enhances the patient's ability to obtain and maintain ongoing care within our Family Health Center system.

III Referral and Case Assignment:

Patients who meet Health Home, LFHC, and/or LMC network case management eligibility criteria, as outlined below, qualify for services, and should be referred to Community Case Management.

Eligibility criteria:

1. Medicaid or Dual Medicaid/Medicare
2. Recurrent ED and/or hospital admissions/readmissions.
3. One chronic health condition with risk for developing another.
4. LFHC Patient within the past 2 years.
5. Unmet biopsychosocial service needs that impact on access to care and treatment compliance.

Exclusion Criteria:

1. Patients who are currently in long term residential placement such as a nursing home, adult home, Chemical Dependency or Behavioral Health Treatment Program are not eligible for the program's case management services.
2. Patients who are currently receiving intensive case management services from another agency or Health Home programs are not eligible for the department's case management services.

All referrals will be vetted by Brooklyn Health Home for eligibility before formal case management is initiated.

Community Case Management has developed several referral protocols. Patients identified as high risk by inpatient case management staff, or inpatient medical providers are referred directly to the Program Director for vetting through Brooklyn Health Home. Patients with severe mental illness, identified as high risk by inpatient or outpatient Behavioral Health staff are also referred to the Program Director for vetting. At risk patients identified by primary care providers and referred to on site case management staff are referred by the designated Care/Case Manager to the Program Director for vetting. Referrals are made using the appropriate referral form (see Appendix A). Once Brooklyn Health Home clearance is obtained, the Program Director assigns the patient to the appropriate Care/Case Manager for follow-up. Case assignments are made taking into account the patient's primary care service site, age, gender, ethnicity, language, diagnosis and social service needs.

IV. Evaluation and Care Planning:

Community Case Management recognizes that comprehensive biopsychosocial evaluation provides the foundation for informed care planning. A brief "Initial Assessment" is conducted to determine the patient's appropriateness for program services. This evaluation is used to identify basic case management needs across multiple domains (Medical, Mental Health, Substance Use, Housing, Financial, Entitlements, Legal, Support Services). An evaluation of the patient's functional status, the "FACT-GP" is also completed at this time. The FACT-GP is repeated on an annual basis and at case closing, and provides a measure of patient progress over time. As rapport is established with the patient and within the first month of program participation, evaluation activities continue. The "Patient Self-Assessment" is conducted by Care Managers to identify health concerns, to assess health education needs and to identify preliminary health behavior change goals and change strategies. Nurse and Social Work Case Managers also conduct a more in depth, more detailed "Risk Stratification Assessment", prior to developing the Coordinated Care Plan. Patients who express suicidal or homicidal ideation are referred to onsite behavioral health staff or to the psychiatric ED for further evaluation.

Evaluation occurs initially and as needed while case management continues, and takes place in a variety of contexts. In addition to conducting face to face interviews with the patient, the Care/Case Manager may also interview significant others, as well as consult with the patient's

medical, behavioral health, chemical dependency and social services providers when a release form has been signed.

Comprehensive evaluation culminates in the development of the Coordinated Care Plan (CCP). The Coordinated Care Plan provides the foundation and direction for ongoing case management activities. The CCP identifies the patient's strengths, limitations, stage of change, presenting problems across multiple domains, expected case management outcomes, and interventions to be employed by Care/Case Managers to achieve case management goals. The CCP, which is documented in DASHBOARD, Brooklyn Health Home's electronic medical record, can be reviewed and revised by any provisioned member of the patient's Care Team.

Community Case Management recognizes that effective care planning is a patient driven process. It requires active collaboration between the patient, the provider when possible, and the Care/Case Manager to identify and prioritize those problems, which the patient is ready and willing to work on.

V. Communication and Care Plan Coordination:

The department recognizes that case management plays a critical role in assisting patients to transition between alternate levels of care, and in coordinating communication between inpatient and outpatient providers. Initial contact with the patient and introduction to case management services may occur while the patient is hospitalized. In such cases, the Case/Care Manager meets with the high risk patient prior to discharge to develop a working alliance with the patient, to conduct a brief evaluation of case management needs and to participate in discharge planning. The relationship developed with the patient on the inpatient unit, provides a bridge to outpatient care. The Case/Care Manager may expedite the referral to chemical dependency, behavioral health and/or primary care services as needed and establishes ongoing communication with involved outpatient providers. Case/Care Managers working with medically compromised or emotionally unstable patients on an outpatient basis may also initiate the referral to inpatient services when emergency care is required to stabilize the patient.

Case/Care managers track transitions in care by notifying providers of hospital admissions within 24 hours of admission, when admission information is available. When able to obtain the reason for admission from inpatient case management staff, this information is shared with the primary care provider. Case/Care Managers also support transition in care by providing follow-up for hospital discharges. Case/Care Managers contact high risk patients within 48 hours of hospital discharge to assess discharge status, to confirm follow-up appointments and to identify and resolve barriers to accessing outpatient care. Concerns about the patient's health or questions regarding medication are communicated to the care team at this time.

Case/Care Managers also play a role in care coordination by providing Pre-Visit Planning for high risk patients. On the day prior to an outpatient appointment, the Case/Care Manager calls the high risk patient to confirm the appointment, reviews the medical record to determine if outstanding specialty appointments or lab tests need to be scheduled, and communicates review results to the medical provider.

Communication and coordinated care planning between Case/Care Managers, medical providers and behavioral health clinicians within the LFHC network also occurs within the

context of daily “huddles” and case conferences, and is supported by shared access to several electronic medical records including Allscripts, the inpatient case management record; eCW, the LFHC medical record and DASHBOARD, the Brooklyn Health Home electronic medical record. DASHBOARD enables provisioned members of the patient’s care team, including primary care physicians, psychiatrists, nurse practitioners, social workers and psychologists to review and make recommendations regarding the patient’s case management care plan.

Tracking patient’s movements across the continuum of care, beyond the Lutheran Healthcare network is facilitated by the department’s access to Healthix, a regional health information exchange which generates alerts when patients are admitted to or discharged from other health care facilities within the exchange network. The department’s access to PSYCKES, a web based Medicaid data base, allows the Care/Case Manager to review the patient’s history of inpatient and outpatient treatment, within New York State over the past 5 years. Such information is used to inform comprehensive evaluation and care planning.

VI. Termination of Case Management Services:

Participation in case management services is voluntary. Enrolled patients may discontinue services at any time, and/or request transfer to another Health Home program that better meets their case management needs. Case management services will be discontinued when individual case management goals have been achieved and new goals have not been identified, or if the patient is lost to contact, is placed in residential care or is incarcerated. The decision to close a case is always made in consultation with the Program Director.

VII. Training, Supervision and Competency Assessment:

Community Case Management recognizes the role of regular training and supervision in developing the core competencies required to provide effective case management services, and in monitoring compliance with best practice and regulatory standards. Upon hire, Care/Case Managers participate in intensive, on-hands, orientation program that provides an opportunity to “shadow” experienced case management staff, to develop necessary computer skills and to role play simulated patient encounters. Competency assessment is conducted at the end of the orientation period to ensure that required skills have been successfully acquired. (See Case/Care Manager/Patient Advocate and the Community Health Worker Competency Assessment Appendix B)

Training continues within the context of weekly team meetings. Didactic presentations and interactive role play are used to cultivate patient engagement skills and to develop expertise in Motivational Interviewing. Case scenarios are used to teach the essentials of assessment and care planning. Individual case presentations are regularly scheduled, either in-house or by Brooklyn Health Home to illustrate and explore effective vs. less effective case management interventions. The completion of an on-line training program in Motivational Interviewing is required, and staff are encouraged to participate in pertinent external trainings.

Individual supervision is provided on a weekly basis for case management staff working with high risk patients with complex medical and/or psychiatric co-morbidities. Training is provided in motivational interviewing, ego-supportive and cognitive-behavioral approaches to case management, as well as in risk assessment and safety planning. Individual supervision with other Care Management staff is also scheduled on an as needed basis to address skill deficits and/or other learning needs.

Performance evaluation is conducted on an annual basis, at which time, competency is assessed, learning needs are identified and improvement plans are developed.

PROCEDURE:

A. See the linked Power Point Training Modules listed below for description of procedural steps for the provision of Core Case Management Services:

1. Community Case Management Patient Tagging in eCW



Microsoft PowerPoint
Presentation

2. Hospital Admissions, The “Huddle” and documentation.



Microsoft PowerPoint
Presentation

3. Hospital Discharge Report: Appointment Confirmation Call and CTM-15 Survey



Microsoft PowerPoint
Presentation

4. Pre-Visits Planning

a. Pre-Visit Planning Spreadsheet



Microsoft PowerPoint
Presentation

b. Creating CPCI PVP Report



Microsoft PowerPoint
Presentation

b. Chart Review Instructions for PVP Planning



Microsoft PowerPoint
Presentation

c. Documenting PVP in Telephone Encounter



Microsoft PowerPoint
Presentation

e. Posting Alerts in Provider Progress Note



Microsoft PowerPoint
Presentation

5. Documenting 5 Week Follow-up



Microsoft PowerPoint
Presentation

6. Patient Self-Assessment and Self-Management Plan



Microsoft PowerPoint
Presentation

7. Miscellaneous Case Management Support



Microsoft PowerPoint
Presentation

8. Health Home Eligibility, Dual Documentation Requirement for CCM and Patients Consented into Health Home, and Health Home Core Services



Microsoft Excel
97-2003 Worksheet

- B. See Brooklyn Health Home's Power Point DASHBOARD Training Module for procedural details regarding documentation of Encounters, Progress Notes and Care Plans in Brooklyn Health Home's DASHBOARD.**



Microsoft PowerPoint
Presentation

- C. See Brooklyn Health Home's Policy and Procedure Document regarding for Health Home patients.**



Adobe Acrobat
Document

Appendix A Referral Forms

Behavioral Health Referral Form



Community Case
Management Referra

Inpatient Case Management Referral Form



Community Case
Management Referra

Congestive Heart Failure Referral Form



CCM Referral form
CHF.docx

FHC Sites Referral Form



CCM Referral
Form_FHC sites.docx

Appendix B

Case/Care Manager/Patient Advocate Competency Assessment



Microsoft Excel
97-2003 Worksheet

Community Health Worker Competency Assessment



Microsoft Excel
97-2003 Worksheet