





Management Can Work and the Michigan Center for Clinical Systems Improvement Care Management Toolkit.

**Responsibilities:** Integrated Healthcare Specialist or Care Manager II or III will fulfill the policy as written.

**Definitions:**

- A. Integrated Healthcare Specialist: Registered Nurse (RN), Licensed Master Social Work (LMSW).
- B. Care Manager II or Care Manager III: Licensed Master Social Work (LMSW), Limited License Psychologist (LLP), Licensed Professional Counselor (LPC), or Registered Nurse (RN) is required.

**Procedure:**

- A. Potential members will be identified by various means, including:
  - 1. Review of IP admissions and/or ED claims
  - 2. SWMBH Utilization Management referral
  - 3. SWMBH Customer Service referral
  - 4. Community referral
  - 5. Provider referral
  - 6. MHP/CO/HIDE-SNP/DSNP referral
- B. Potential members will be eligible if they have complex medical, behavioral and/or psychosocial needs. While members may be eligible based on broader complex needs. The target population includes individuals with one or more of the following:
  - 1. One or more behavioral health diagnosis
  - 2. Two or more psychiatric inpatient admission in the past 12 months
  - 3. High/trending emergency department use
  - 4. Any chronic medical diagnoses that complicates care or treatment plans (especially chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) or diabetes mellitus (DM) based on population analysis)
  - 5. A combination of inpatient admissions and/or high emergency department use with a less severe mental illness
  - 6. Withdrawal management or SUD treatment admissions in the past 12 months
  - 7. Chronic medical conditions with SUD treatment, withdrawal management or residential treatment in the last 12 months
  - 8. Race will be considered to address any racial disparities identified by population analysis.
  - 9. A behavioral health diagnosis of schizophrenia will weigh heavily on eligibility based on population analysis.
- C. SWMBH's case manager (CM) will document in SmartCare (electronic health record).
- D. Initial Paperwork will be requested and/or completed with the member.
  - 1. Request member signature on State of Michigan Behavioral Health Consent form (MDHHS 5515).
    - a. This form is mailed to member upon identification as a potential participant.
    - b. If member refuses to sign a MDHHS 5515 after confirming his/her understanding of its usefulness, the CM will discuss the use of this form 1 more time at the next CCM contact.



2. Electronic Communication Consent
  - a. This form is mailed to member upon identification as a potential participant.
  - b. It is optional but required if the member would like to communicate anything related to care via electronic means (i.e. text, facetime, email).
- E. Services to members include but are not limited to:
  1. Disease specific education
  2. Referrals to medical providers
  3. Referrals to behavioral health providers
  4. Referrals to dental, vision and other providers
  5. Referrals and support entering into community opportunities (i.e. volunteering, job assistance, etc.)
  6. Referrals to community resources for transportation, food, and housing stability
- F. Program Goals:
  1. To connect members with behavioral health providers for long-term mental health treatment 100% of the time that a member sets this goal.
  2. To decrease inpatient hospitalizations significantly during CCM and post CCM.
  3. To decrease emergency department admissions significantly during CCM and post CCM.
- G. SWMBH integrates care for CCM members by collaborating with community mental health providers, community partners, integrated care organizations and medical providers. We communicate and advocate for member needs such as routine testing, preventative treatment, dental care and other specialty services. We do this through phone calls, faxes, emails, and educating and empowering our members.
- H. Complete the CCM assessment to include all National Council for Quality Assurance (NCQA) CCM assessment items listed below. The CM will ask both open and closed ended questions to complete the assessment and then will use clinical knowledge to draw and document a conclusion for each section based on the data or information collected.
  1. Assess members' health status including condition-specific issues, comorbidities, self-reported health status, and presenting diagnosis or event that led to identification for CCM and current medications.
  2. Document clinical history including past hospitalizations and major procedures, significant past illnesses and treatment history and past medications.
  3. Assess and document activities of daily living including bathing, dressing, going to the toilet, transferring, feeding and continence.
  4. Assess Behavioral Health status:
    - a. Cognitive
      - i. Ability to communicate and understand instructions.
      - ii. Ability to process information about an illness.
    - b. Mental health conditions
    - c. Substance use disorders
  5. Assess social determinants of health including economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.



6. Assess and educate regarding life-planning activities, such as a wills, living wills or advance directives and health care powers of attorney. Request documentation if the member has advance life-planning documents that are pertinent to the program (e.g. guardianship paperwork or DPOA).
7. Evaluate cultural and linguistic needs, preferences or limitations such as family traditions related to illness death and dying, health literacy and health care treatments discouraged or not allowed for religious or spiritual reasons. All identified needs will be addressed.
8. Evaluate visual and hearing needs, preferences or limitations. All identified needs will be addressed.
9. Evaluate caregiver resources, e.g. family involvement in and decision making about the care plan. All identified needs will be addressed.
10. Evaluate available benefits and determination whether the available resources will be adequate to fulfill the treatment plan. i.e. CMH, Medicaid, Medicare, PACE, disease management, palliative care, etc.
11. Evaluate the need for available community resources.
  - a. Examples: community mental health, employee assistance program, transportation, housing, disease management, wellness organizations, palliative care programs, other national or community resources
12. Develop an individualized case management plan:
  - a. Prioritized patient-centered goals
  - b. Time frame for reevaluation of goals
  - c. Resources to be utilized, including appropriate level of care.
    - i. It is likely that many times the level of care established when doing the LOCUS will not be heavily weighed into the case management plan for CCM – regardless of LOCUS level of care, CCM will provide access to care, coordination of care and other supports.
  - d. Planning for continuity of care, including transition of care and transfers
  - e. Collaborative approaches to be used including level of family, partners and friends' participation
13. Identify barriers to receiving or participating in a case management plan. e.g. language or literacy level, access to reliable transportation, understanding of a condition, motivation, financial or insurance issues, cultural or spiritual beliefs, visual or hearing impairment, psychological impairment.
  - a. Documentation that barriers were assessed will be included, even if none were identified.
  - b. Determine if the member understands his or her conditions, treatment and is willing to participate in case management.
14. Facilitate needed referrals to other health organizations when appropriate.
  - a. Referral facilitation may be completed by:
    - i. Warm referral – CM makes the referral call with the member
    - ii. Coached referral – CM provides information and instruction to member.
    - iii. Any other method as needed for individual members
15. Develop a communication schedule and follow up as needed in the following areas. This will be documented in electronic health record and/or CCM tracking sheet.



- a. Counseling
  - b. Follow-up after referral to a disease management program
  - c. Follow-up after referral to a health resource
  - d. Member education
  - e. Self-management support
  - f. Determining when follow-up is not appropriate
16. Work with member to develop their self-management plan. This will be communicated verbally. It will be available in writing as needed or requested by member. It will include member agreed upon goals that may include:
- a. Performance of ADLs and iADLs
  - b. Self-administration of medication and medical procedures
  - c. Management of medical equipment
  - d. Maintenance of prescribed diet or another regimen
  - e. Weight, blood sugar or other checks at regular frequencies
17. Assess members' progress with overcoming barriers to care and to meeting treatment goals and assess for and adjust the care plan and goals as appropriate.
- I. Ongoing Management will continue for active members with a completed initial assessment. Case Management plans will be developed, barriers identified, and schedules will be agreed upon for follow-up communication with the members. The CM and member will work together to develop an appropriate self-management plan and work toward and reevaluate all goals when appropriate.
- J. Completion of CCM Program
1. Active members will be considered "graduates" of CCM based on some or all of the following items:
    - a. Self-management goals are complete
    - b. Case management goals are complete
    - c. Member experiences decreased inpatient and emergency department utilization
    - d. Member is active and engaged with healthcare providers.
  2. Closure/graduation will be agreed upon by the CM and member prior to completion of the program. The CM will provide the member with a verbal plan for continued disease management (e.g. continuing annual preventive care with PCP and behavioral health medication reviews as ordered). This may be available in writing per participant request.
- K. Withdrawal from CCM
1. Participation can be withdrawn in one of these ways:
    - a. Member's stated refusal to participate
    - b. Member voluntarily withdraws prior to completion.
    - c. Member becomes unable to verbalize needs or participate in person-centered planning.
    - d. The CM becomes unable to reach or engage member. Attempts to contact the member, within reason, will be made over a two-week period through at least two of the following mechanisms:
      - i. Telephone
      - ii. Direct mailing
      - iii. Email (if member has signed electronic consent)



iv. Fax (if member has signed electronic consent)

**Effectiveness Criteria:**

1. Inpatient admission utilization 6 months prior to CCM, during CCM and 6 months post CCM will be analyzed.
2. Emergency Room utilization 6 months prior to CCM, during CCM and 6 months post CCM will be analyzed.

**References:**

National Council Quality Assurance Standards – QI 8 Complex Case Management

Michigan Center for Clinical Systems Improvement Complex Care Management Guidelines

<https://www.miccsi.org/wp-content/uploads/2016/01/Complex-CM-Guideline-Final-Version-pdf.pdf>

Michigan Center for Clinical Systems Improvement Care Management Toolkit <https://www.miccsi.org/wp-content/uploads/2016/01/Mi-CCSI-S-Vos-Care-Mgmt-Guidelines-Toolkit-Final-version-2-2016.pdf>

<https://www.miccsi.org/wp-content/uploads/2016/01/Mi-CCSI-S-Vos-Care-Mgmt-Guidelines-Toolkit-Final-version-2-2016.pdf>

Relias Here's How Complex Case Management Can Work <https://www.reliasmedia.com/articles/142399-heres-how-complex-case-management-can-work>

**Attachments:** None

