VENTURA COUNTY
HEALTH CARE PLAN

Complex Case Management Policy and Procedure

2024

VENTURA COUNTY HEALTH PLAN (VCHCP)
COMPLEX CASE MANAGEMENT PROGRAM POLICY AND PROCEDURE

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Mission Statement

The mission of Case Management is to empower members to take control of their health care needs across the continuum of care by coordinating quality health care services and the optimization of benefits through a realistic, cost-effective, and timely care management plan. The value of case management will be evidenced by best practices and quality outcomes that contribute to the optimal health, function, safety, and satisfaction of our members.

Ventura County Health Care Plan (VCHCP) delivers case management services that are member-centric, collaborative, supported by evidence-based care, and integrated with other VCHCP programs to facilitate improved member outcomes, enhanced member satisfaction, and optimal resource utilization.

The principles upon which the mission is based are:

- Provide Case Management services that contribute to the optimal health and satisfaction of our members.
- Foster member empowerment through advocacy and education.
- Address identified gaps in member care and engage and collaborate with the care team to close gaps.
- Provide optimal value and quality through the delivery of case management services that are evidence-based.

POLICY STATEMENT

Ventura County Health Care Plan (VCHCP) shall establish a Complex Case Management (CCM) Program to promote the coordination of care and services provided to members with complex conditions. This includes members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

The program is evidence-based utilizing Milliman Chronic Care Guidelines' latest edition, Case Management Standards and technical research and literature from professional entities such as the Case Management Society of America.

VCHCP's CCM program is an opt-out program, and all eligible members have the right to participate or decline participation. Verbal consent is obtained prior to formally enrolling the member into the Complex Case Management Program. This consent is to be documented, clearly indicating the primary source for the verbal consent, date, and time of the consent. In obtaining verbal consent from a secondary source, the Case Manager uses the following hierarchy of representatives who can provide the consent, in the order listed, and must document the reason the member was unable to provide consent:

- Legal Guardian (including parents if the member is a minor)
- Health Care Power of Attorney
    - Spouse
    - Adult children
- Other close family members or next of kin

- Companions, significant others, or close friends

At the time of receipt of the verbal consent, the Case Manager explains the process for signing then returning the written agreement to the member or member representative. This discussion is documented in notes as well. Once the signed written agreement is received, the Case Manager documents in notes its receipt, method of receipt, name of person who signed and the date of the signature.

Oversight of CCM activities, policies and procedures is provided by the Plan's Medical Director, who is available for case consultation upon request by Case Management staff, and the Utilization Management Committee (UMC).

SCOPE OF VCHCP'S COMPLEX CASE MANAGEMENT PROGRAM

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, facilitation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. *Case Management Society of America website: http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx*

Target Population

VCHCP has defined the scope of its CCM program and has identified the following members in the following situations as those who would most benefit from its services:

- High Risk Diabetics (uncontrolled, hard to control, multiple co-morbidities)
- Transplants
- High Risk Asthmatics (uncontrolled, hard to control, multiple co-morbidities)
- End Stage Renal Disease (ESRD)
- More than $20,000 inpatient claims within a 90-day period
- 3 or more ER visits within one month
- More than 4 inpatient hospitalizations within a 6-month period
- Multiple chronic conditions that are not controlled (e.g. cancer, COPD, diabetes, asthma)
- High Risk Social Needs (lack of caregiver/family support, financial issues)- this gets identified during intake screening (no report generated)
- Traumatic Brain Injuries
- Spinal Cord Injuries
- Poly-pharmacy usage (12 or more different prescriptions in a 60-day period; >= $20,000 paid pharmacy claims within 30 days)

VCHCP CCM Program Services

As Members are identified for the Plan's complex care management program, services are provided according to the specific needs of the Member. Services offered include but are not limited to:

- Assessment including review of medical, psychosocial, and functional history and current status.
- Disease specific assessments
- Barrier identification and intervention
- Member specific care plans, including individualized goals and interventions.
- Self-management plans
- Care coordination, including transitions of care assessment and post inpatient care follow- up.

- Coordination with behavioral health
- Evaluation and assistance with community and support systems
- Social work support as prior authorized by the Plan's Utilization Management for needed resources.
- Targeted education
- Follow-up contacts to assess progress and track member specific care plans.
- Preventive health reminders
- Medication management, such as assisting with barriers to filling prescriptions, medication refill monitoring, medication reconciliation, and coordinating specialty drug deliveries.

Goals and Objectives of the VCHCP CCM Program

- Help eligible members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner.
- Proactively identify and comprehensively assess the physical, behavioral, cognitive, functional, and social needs of members and provide early intervention for members eligible for CCM services.
- Develop a comprehensive care plan, with input from the member and/or caregiver, and by working with the member to complete a planned and prioritized set of interventions tailored to the individual needs of the member and his or her family/support system.
- Provide high quality, integrated, culturally competent CCM services to eligible members, including but not limited to coordination and management of healthcare resources, allocating resources and maximizing available benefits, and serving as a liaison to community resources regarding options and services not covered by the benefit plan.
- Encourage members to take action to improve their overall quality of life, functional status, and health outcomes such as assisting members to follow treatment plans and coordinating health services appointments.

Population and Subpopulation Assessment

Annually, VCHCP conducts an assessment of its member population and relevant subpopulations and subsequently reviews and updates its CCM services and resources to address member needs, if necessary.

The assessment of the member population includes the collection and analysis of the multiple data points across the entire enrolled population. Data collected includes:

- Plan or census data to identify cultural and linguistic characteristics.
- Age/sex distribution
- Top inpatient diagnoses
- Top outpatient diagnoses
- Top inpatient procedures
- Top readmission diagnoses
- High-cost related inpatient/outpatient diagnoses and procedures
- Top pharmacy utilization
- Grievance and appeals trends.

Based on the analysis conducted on the full membership, VCHCP also assesses the needs of special populations within the membership population to identify key subpopulations that may benefit from population health management.

Once complete, health plan staff review the findings against the current CCM program to determine if adjustments need to be made to program processes or resources. Adjustments to program processes may include but are not limited to: modification to CCM identification criteria; modification to program materials to meet language needs, reading levels, or cultural preferences; enhancements to initial assessments forms to accommodate additional co-morbidities or condition-specific issues; or adoption of additional evidence-based clinical guidelines or algorithms to better manage selected conditions. Adjustments to program resources may include, but not limited to staffing ratios, clinical qualifications, job training, identification of external resources and contacts, or cultural competency training.

Case Management Services Integration with Other Services Received by the Member
Integration of case management services with other services the member is receiving occurs in several ways. The key component for integrating case management services is the initial assessment that identifies the key players involved with the member that not only includes clinicians and other professional team members, but the caregivers and other important family members and friends involved in the member's care. From there, the Case Manager can begin to identify the points where coordination of care is needed to remove barriers and assist the members with reaching their health care and self- management goals. Other examples where VCHCP integrates case management services are outlined below.

- **Ventura County Health Care Agency Affiliation**
  VCHCP is unique in that there is a "sister" relationship with the Ventura County Health Care Agency (HCA) Clinics and Ventura County Hospital: All entities are part of the Ventura County Health Care Agency and are under the administrative management of the HCA Director. The system is integrated with all health care employees, including primary care physicians and specialists, nurses, and VCHCP clinical staff, under the umbrella of the Health Care Agency. This overall structure helps to pool resources and prevent duplication of services.

- **Care Collaboration with Health Care Agency Clinics and Ventura County Hospital**
  The Ventura County Health Care system is based on a medical home model where the HCA clinics serve as a medical home for affiliated patients. Members can choose their primary care physicians and many services, such as specialist care, labs, and educational classes, that are located onsite at the HCA clinics. The HCA clinics have their own case managers located onsite who are available to VCHCP case managers to work together to coordinate care for members with complex needs. Additionally, hospital-based case managers coordinate with VCHCP case managers/VCHCP discharge planner-concurrent review nurse for care transition needs and prevention of unplanned readmissions through dialoguing on the member's status and coordinating needed services and follow up care.

- **Electronic Medical Record Access**
  For members whose primary care physicians are affiliated with the HCA clinics, Cerner is the electronic medical record system for the clinics and the hospital, where outpatient and inpatient services are documented and tracked. VCHCP case managers and Medical Directors have viewing access to Cerner and can observe the outpatient and inpatient services for their assigned case managed members. When coordinating care at the clinics and hospitals, VCHCP

case managers have real time access to a common medical record and can effectively dialogue with the member's clinical team regarding the member's plan of care. Additionally, clinic providers can send Treatment Authorization Requests through Cerner to VCHCP. This helps to efficiently facilitate authorization for VCHCP members, prevent loss of the request, and facilitate timely specialty services for the member.

CASE MANAGEMENT SYSTEMS

Tracking of the CCM cases including Intake Assessment, identification for CCM, development of the initial assessment and care plan, and ongoing management are completed within the QNXT CM module and MCG Cite of Care Standalone module. This requires entries in both QNXT and MCG Cite of Care.

QNXT

The QNXT care management system supports the case referral process. The QNXT platform is a customized commercially available product through Trizetto/Cognizant, Inc., and is the information and processing system within VCHCP for claim, utilization management and case management. QNXT is the electronic documentation system utilized by VCHCP for clinical and non-clinical documentation. Clinical documentation includes processing treatment authorization requests (TARS), documenting inpatient concurrent reviews and discharge planning, and documenting episodic case management (ECM) activities, such as care plans and related activities. Non-clinical documentation includes member eligibility information, member call tracking, and claim payment.

VCHCP case managers have access to all clinical and non-clinical documentation as they coordinate care and services. They can review eligibility status, review documented member calls into Member Services, and observe claim status. Additionally, UM clinical staff have access to the case management documentation to review to support TAR processing or inpatient discharge planning activities. Non-clinical staff, such as Member Services, can see system flags that indicate that a member is in case management and can alert or confer with the case manager as needed as part of resolving member issues.

The Case Manager creates the *candidate record* and case ID in the QNXT CM module after reviewing medical records/clinical information. The Plan's case manager conducts three (3) or more attempts to contact the member for *intake assessment* which involves verifying member demographics, and determines if member is eligible candidate for CCM, within 30 calendar days after creation of the candidate record. Once the member is determined to meet criteria for CCM, the case record and Initial Assessment is completed within the MCG Cite of Care module. Automatic documentation of staff ID, and the date and time of any action on the case is captured in both the QNXT CM and MCG Cite of Care modules.

MCG Cite of Care Stand Alone Program

The CCM nurse utilizes the MCG Cite of Care Stand Alone program which includes evidenced- based clinical guidelines or algorithms to conduct assessment and management of members identified for CCM. Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurs is tracked in the MCG Cite of Care Program. The automated prompts for follow-up, as required by the case management plan, are available in the MCG Cite of Care Program. When the Case Manager opens her screen, the list of cases due that day are presented in her queue.

- **Evidence-based clinical guidelines or algorithms to conduct assessment and case management process:** MCG Cite of Care Stand Alone includes condition specific evidence based clinical guidelines and algorithms. Clinical guidelines and algorithms accessible through the MCG Cite of Care Stand Alone include Complex Case Management and Frail Elderly guidelines that provide a system-based approach to assess the medically complex patient. The condition-specific self-management guidelines provide a stratified approach to managing the chronic disease population. The case management process and documentations are performed in the MCG Cite of Care Stand Alone. MCG Stand Alone also includes nursing-based guidelines to address issues such as skin integrity, mobility, and safety. The MCG Cite of Care Stand Alone includes embedded/automated prompts and scripts that guide the Case Manager through conducting an interactive initial assessment and ongoing monitoring and case management of the member's condition. Based on the member's responses from the initial assessment, MCG Cite of Care automatically creates a list of problems and goals in a drag to prioritize functionality. The member and Case Manager choose the appropriate customized member centered problems/goals and choose interventions from a disease specific drop-down list based on MCG. As the Case Manager follows the member over time, he/she has access to condition/disease-specific interactive assessment to monitor the member and assist with identifying additional problems, goals, and interventions via MCG's drag to prioritize functionality. Case notes related to activities not reflected in the system are documented in a notes field with no text limits. Once cases are closed, the components of the care plan are closed with goals documented as met or not met. Case closure reasons are documented in QNXT via a drop box option, with additional information documented in the intervention notes and case notes field in MCG Cite of Care Stand Alone.
- **Automatic documentation of the staff member's ID and date, and time of action on the case or when interaction with the member occurred:** The MCG Cite of Care Stand Alone automatically stamps the member's/case file with the user's ID and time/date of entry. The stamp can be viewed on notes and on several fields within the program. Additionally, MCG Cite of Care Stand Alone has a screen that tracks access to the case management module by user ID, date, time, and the component accessed.
- **Automated prompts for follow-up, as required by the CCM plan:** The MCG Cite of Care Stand Alone has a mechanism for the Case Manager to set automated reminders and prompts for follow-up to monitor the care plan and follow up with members, caregiver, practitioners/providers, and other contacts.

Complex Case Management Communication

- **Case Management**
  VCHCP case management staff communicate between and among themselves to ensure coverage, continuity, and quality of care. The case managers are co-located. All case managers have access to the QNXT CM module for screening and MCG Cite of Care Stand Alone to facilitate communication and continuity of care. In addition, the case managers use email, phone, and instant messaging to communicate with one another.

- **Behavioral Health**
  Behavioral health is assessed as part of the Initial Assessment and Care Plan for the member. If behavioral health needs are identified, the VCHCP case manager provides members with information on how to access behavioral health care through Optum, the contracted behavioral health vendor for VCHCP, and will securely e-mail the member information to the Optum clinical liaison as an alert that the member has been referred. VCHCP case managers review monthly

claim reports from Optum to assess if the member is receiving care, and if claims are not present, will verify with the member if they have connected with a provider in the Optum network. Any access barriers are coordinated by the VCHCP case manager through the Optum clinical liaison either through phone call or e-mail.

- **Tertiary Care**
  For cases involving tertiary care, VCHCP case managers work collaboratively with the VCHCP Inpatient Review UM nurse to coordinate care and discharge planning. They also work with tertiary providers for ambulatory service coordination and will liaison with HCA clinic staff, including the onsite clinic case managers, as needed.

- **Disease Management Program**
  The VCHCP case managers also coordinate the Disease Management program. All members stratified as High Risk for Disease Management are assessed for CCM. If the criterion is not met, the member is managed at the Disease Management level, and coordinated through the Disease Management process. Disease management documentation is maintained in the Quality App. At any point, if the member's condition changes, the VCHCP case manager can reassess the member and move the member to CCM if indicated.

- **Sirona/Carenet Health (Nurse Advice Line)**
  Sirona/Carenet Health is the VCHCP Nurse Advice Line. VCHCP receives a report listing the member calls, the call reason, and resolution which is incorporated into the daily Utilization Management (UM) report distributed to the entire VCHCP Medical Management team. This report is reviewed by the Case Manager to determine if the member may be a candidate for CCM or if a CCM member has accessed the Nurse Advice Line. If a member is in CCM, the VCHCP case manager will follow up with the member regarding the nurse advice line call. Additionally, if a member was directed to an urgent care or ER, the VCHCP case manager can contact the member for follow up to obtain additional information.

IDENTIFICATION OF MEMBERS FOR COMPLEX CASE MANAGEMENT

VCHCP has developed systematic processes to proactively identify members who may be appropriate for CCM services. This process includes the use of multiple data sources, including VCHCP's claim payment and medical management system (QNXT) to ensure comprehensive data mining to identify eligible members for the CCM Program. For each data source, VCHCP has established criteria and frequency of identification.

Hospital Discharge Data

VCHCP receives daily hospital census reports that include admits and discharges. Included in the discharge data are resource needs for discharge planning that would identify members who could benefit from CCM services.

- Criteria: A weekly systematic inpatient discharge report is generated using data from the QNXT UM module. This report has information on admitting diagnosis, discharge diagnosis, services codes and relevant discharge notes that may indicate high dollar DME, tertiary level of care, ventilator care, and others.
- Frequency of identification: Daily

Claims Data

Hospital Inpatient Data

VCHCP Claim data is queried to identify key hospital admissions by frequency and high dollar.

- Criteria (ONE of the following): >4 inpatient hospitalizations in last 6 months, greater than $20,000 in paid inpatient claims in past 90 days, readmission within past 30 days.
- Claims data is the universe of medical claims data in VCHCP's QNXT system (claims processing system).
- The claims data is queried to identify >4 inpatient hospitalizations in last 6 months and greater than $20,000 in paid inpatient claims in past 90 days.
- Claims data is loaded into Inovalon HEDIS Software and the software identifies readmissions within past 30 days, using the Plan All-Cause Readmissions (PCR) HEDIS Measure
- Frequency of identification: Monthly

Diagnoses Specific Data

VCHCP Claim data is queried to identify outpatient and inpatient data by specific diagnoses as noted under target population.

- Frequency of identification: Monthly

Emergency Room Data

VCHCP Claim data is queried to identify frequent emergency room visits for medical management. An additional query of emergency room behavioral health related diagnoses is conducted to assess opportunities for behavioral health and medical coordination of care.

- Frequency of identification: Monthly

Pharmacy Data

VCHCP receives pharmacy data from pharmacy vendor Express Scripts. The data includes prescription data obtained at contracted pharmacy and pharmacy claims.

- Claims data includes pharmacy and medical.
- Frequency of identification: Monthly

Data Collected Through the UM Management Process

VCHCP conducts prior authorization for selected services and concurrent review on members who are in the process of receiving an ongoing course of treatment. Information from these utilization management processes is stored in the QNXT UM module.

- Frequency of identification: Monthly

Complex Case Management Referral Sources

Members who experience a critical event or diagnosis should receive timely CCM services. To minimize the time between identification of member needs and member receipt of CCM services, VCHCP uses multiple avenues/referral sources to consider members eligibility for CCM. Each referral source is informed of the VCHCP CCM program, which members would benefit from the program, and how to initiate a referral. Referrals from VCHCP internal departments can be systematically routed through QNXT. Referral sources and how the referral source is informed of the CCM program include, but are not limited to:

Disease Management (DM) Program

- Method of notifying DM staff about the CCM Program:

- During the new VCHCP DM employee orientation and during Medical Management staff meetings, information about the VCHCP CCM program is presented by either DM or CCM management staff.

- Members appropriate for referral:
  - Members with medical and psychosocial needs impacting their compliance with disease management and health improvement including increasing severity of condition, safety issues, decreasing functional status, new behavioral health issues, need for caregiver resources.
- Instructions given for how to initiate a referral:
  - The list of members enrolled in the DM programs is housed in the Quality App. The DM nurse screens members who are identified as potentially meeting criteria for high-risk diabetes and asthma. If members are identified as potential candidates for CCM, the DM nurse refers the member to the Case Manager who creates the candidate record to determine if the member meets CCM criteria. The Case Manager completes an Intake Assessment to make this determination.

Discharge Planners

- Method of notifying about the CCM Program:
  - At the time of contracting with hospitals, written information about the VCHCP CCM program is provided via the Provider Manual. This information is updated and distributed annually and whenever significant changes are made to the CCM program via mail or email. Notification of the sections updated or added is included with the distribution. The hospital is responsible for ensuring all discharge planning staff are appropriately trained on the CCM program and understand criteria for members appropriate for referral as well as how to initiate a referral.
- Instructions given for how to initiate a referral:
  - Hospital discharge planning staff are instructed to contact the VCHCP Concurrent Review Nurse or VCHCP Case Manager to initiate referral. The VCHCP Concurrent Review Nurse/VCHCP Case Manager can confirm if the member has an open CCM case and work with Discharge Planner to coordinate care plan. If a case is not open, the Concurrent Review Nurse/VCHCP Case Manager will confirm member demographics and clinical information to initiate referral through the QNXT module and assist with care coordination, as appropriate.

Utilization Management

- Method of notifying about the CCM Program:
  - During new employee UM orientation and during UM staff meetings, information about the VCHCP CCM program is presented by either UM or CCM management staff.
- Members appropriate for referral are presented at part of the orientation and annual training.
- Instructions given for how to initiate a referral:
  - UM staff will enter and route the referral via email notification to CCM staff.

Member or Caregiver

- Method of notifying about the CCM Program:
  - Information regarding the VCHCP CCM program is included in member materials supplied to the member following enrollment. Information is also distributed in newsletters at least annually.
- Members appropriate for referral:

    - Member materials state if the member believes they have special health care needs they may benefit from case management services.
- Instructions given for how to initiate a referral:
    - Members and caregivers are instructed to contact Member Services and request a referral for CM services. Member Services staff will notify CM by phone or by email of the requested referral to CM.
    - Members can also self-refer to the program online via the Member website at vchealthcareplan.org and click on the box labeled "Request Case Management or Disease Management".

Practitioners

- Method of notifying about the CCM Program:
    - Information regarding the VCHCP CCM program is included in provider materials that are supplied to practitioners at time of contracting and published annually in the provider newsletter sent via email or fax. The Provider Manual is updated and distributed annually and whenever significant changes are made to the CCM program via mail or email. Notification of the sections updated or added is included with the distribution.
- Members appropriate for referral:
    - Provider materials describe the members appropriate for referral to case management.
- Instructions given for how to initiate a referral:
    - Physicians are instructed to contact the VCHCP Case Manager to initiate referral. The VCHCP Case Manager can confirm if the member has an open CCM case and work with Physician to coordinate the care plan. If a case is not open, the VCHCP Case Manager will confirm member demographics and clinical information to initiate referral through the QNXT module and assist the Physician with care coordination, as appropriate.

CCM staff evaluates referrals from each source to determine eligibility for the CCM program based on criteria. This is completed by a VCHCP Case Manager. Members are not identified as eligible for the CCM program until the Intake Assessment is complete. Members who do not meet eligibility criteria may be referred to alternative programs including Episodic CM or one of the disease management programs, as applicable.

PROCEDURE

INTAKE ASSESSMENT

1. Members are identified as potentially eligible for CCM through the system or referral processes noted above. When a member is identified as potentially eligible for CCM, a referral for an intake assessment is manually entered in the QNXT CM module. This entry creates a candidate record.

2. The Case Manager makes three or more attempts within 30 days to contact the member to complete an intake assessment using at least two mechanisms for contact (e.g. telephone, regular mail, and fax).

3. A Case Manager conducts the Intake Assessment. The following information is captured/verified:
    - Member demographic information,

- Current clinical information
- Reason the member was referred for CCM.

This information is used to determine if the member is eligible for CCM. Members determined not eligible for CCM may be eligible for Disease Management, Behavioral Health Case Management, or Episodic Case Management. After the Intake Assessment, the CCM Nurse refers the member to the appropriate program.

4. The CCM identification date is the date the member is determined to meet CCM criteria based on the Intake Assessment.

5. The Case Manager creates a CCM case record in both QNXT and the MCG Cite of Care Stand Alone program and sets a date to conduct the Initial Assessment with the member within 30 days of the identification date.

CCM INITIAL ASSESSMENT

6. The Case Manager conducts the Initial Assessment and evaluation.

7. The Case Manager completes the Initial Assessment with the member via telephone. If a member is unable to communicate because of infirmity, the assessment may be completed by the Case Manager with assistance from the member's family or caregiver.

8. Information is collected from the member, caregiver, practitioner(s), and any other individuals who may hold important clinical and psychosocial information regarding the member with consent for release of information from the member or the member's authorized representative.

9. The Case Manager initiates the assessment within 30 calendar days of the member's identification date. If the assessment is unable to be completed within a single contact, the date of completion of each requirement is captured in the system.

10. The initial assessment is completed within 60 calendar days of identification unless the process is delayed due to circumstances beyond VCHCP control including:
    a. Member is hospitalized during the initial assessment period.
    b. Member cannot be contacted or reached by telephone, letter, email, or fax.
    c. Natural disaster.
    d. Member is deceased.

11. The Case Manager must document in the system the reason for any delay in completing the assessment and actions taken to complete the assessment.

12. The Case Manager documents the findings and his/her conclusion about the data or information collected for each factor in the case notes section of the member record.

13. If a required assessment topic (factor) does not apply to the member, the Case Manager enters a conclusion to address the finding and the reason the factor is not applicable to the member.

14. The Case Manager enters the following information in the MCG system as part the Initial Assessment completed with the member or the member's authorized representative:

a. Members' current health status, including:
    - Screening for presence or absence of comorbidities and their current status.
    - Member self-reported health status.
    - Information on the event or diagnosis that led to the member's eligibility for CCM.
    - Current medications, including schedules and dosages.

b. Documentation of clinical history, including:
    - Past hospitalizations and major procedures, including surgery.
    - Significant past illnesses and treatment history.
    - Relevant past medications related to the member's condition.

c. Member's functional status related to activities of daily living, including but not limited to:
    - Eating
    - Bathing
    - Dressing
    - Toileting
    - Continence
    - Transfer and mobility

d. Member's behavioral health status, including:
    - Cognitive functions
        - Ability to communicate and understand instructions.
        - Ability to process information about his/her illness.
    - Presence of depression and/or anxiety (PHQ-2) and (PHQ-9)
    - Mental health conditions
    - Substance use disorders.

e. Member social determinant of health, including:
    - Housing
    - Food insecurity
    - Access to transportation
    - Economic barriers

f. Member's life-planning activities, including:
    - Existence of will, living will, or advance directive.
    - Existence of health care powers of attorney.
    - Provisions for children if something happens to the parent or caregiver.

    If life planning activities are appropriate, the Case Manager will document the steps the member has taken and the documents in place. If the member does not have expressed life planning instructions on record, the case manager offers to provide life-planning information (e.g. brochure, pamphlet) to the member.

    For situations in which discussion of life planning activity is not appropriate, the Case Manager documents the reason in the record.

g. Cultural and linguistic needs, preferences, or limitations.
   The Case Manager assesses the member's culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. This includes:
   - Cultural health, beliefs and practices to be considered as part of the plan of care.
   - Preferred language
   - Health literacy
   - Other communication needs

h. Visual and hearing needs, preferences, or limitations to identify potential barriers to effective communication or care, including:
   - Use of hearing aids
   - Use of glasses or contacts
   - Need for large type printed materials.
   - Need for specialized telephonic equipment.

i. Caregiver resources and involvement.
   The Case Manager evaluates the adequacy of caregiver resources, including:
   - Family involvement in and decision making about care plan.
   - Adequacy of caregiver resources to meet member's needs.

j. Available health plan benefits:
   The Case Manager evaluates the benefits available to the member and makes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

k. Community resources:
   The Case Manager evaluates the member's eligibility for community resources to supplement those for which the health plan has been contracted to provide, including:
   - Community mental health
   - Transportation
   - Wellness organizations
   - Palliative care programs
   - Nutritional support
   - EAP
   - Other national or community resources, as appropriate

CCM ONGOING MANAGEMENT

15. The Case Manager develops an individualized care plan within seven (7) days of completion of the Initial Assessment. The care plan is member centric and is developed incorporating data collected as part of the initial assessment and utilizing Milliman Case Management guidelines. The care plan is documented in MCG Cite of Care Stand Alone.

    Documentation includes, at a minimum, the following components:
    a. Prioritized goals taking into consideration the member's and caregivers' goals, preferences, and desired level of involvement in the plan.

- After completion of the assessment, the Case Manager works with the member and/or caregiver to determine the top three to four issues the member would like to work on or have assistance with. These issues will be formulated as High Priority goals.
- Once High Priority goals are identified, the Case Manager works with the member and/or caregiver to identify additional issues the member would like to work on or have assistance with. These issues will be formulated into Lower Priority goals and can be further ranked to determine priority as stated above.
- Goals are prioritized as High Priority or Low Priority. If there are multiple goals under these prioritizations, each goal is further ranked (1, 2, 3…) in order of priority of completion/attainment.
- The Case Manager documents in the intervention section the members' or caregiver's input regarding their (members') goals in MCG Cite of Care Stand Alone system.

b. Specific timeframes for reevaluation of the established goals to determine member progress, need to modify/revise, or completion.

c. Resources the member may need to support goal attainment, including level of care.

d. Plan for continuity of care, including transition of care and transfers between settings, as appropriate and the method of communication.

e. Collaboration is needed to support the care plan and the approaches to be used to promote collaboration, including the level of family, significant others and social support participation.

16. The Case Manager works with the member/authorized representative to identify, document, and address barriers to the member's ability to meet goals or comply with the care plan. Barriers assessed may include, but are not limited to:
    a. Language or literacy issues
    b. Lack or limited access to reliable transportation.
    c. Member's lack of understanding of a condition
    d. Member's lack of motivation
    e. Financial or insurance issues
    f. Cultural or spiritual beliefs
    g. Visual or hearing impairment
    h. Psychological impairment

    If there are no barriers identified, the Case Manager affirmatively documents in the care plan that barriers were assessed and no barriers were identified.

17. The Case Manager documents in the care plan any resources to be used. If referrals to other resources or health organizations are appropriate, the Case Manager:
    a. Facilitates the member referral to other organizations when appropriate by contacting the PCP regarding medical referrals, providing information to the member on how to make contact for behavioral health referrals, and mailing or emailing contact and educational information to the member for other types of referrals to outside resources.

b. The Case Manager schedules follow-up with the referral to determine whether the member has acted on the referral by setting a follow up action in MCG Cite of Care to call or e-mail the member to confirm the member made contact. Follow up to confirm that the member has contacted the referral resource will be scheduled by the Case Manager at minimum 7 calendar days after the member was provided with the resource information. In the case of a medical referral(s) from the PCP, the Case Manager monitors the referral through QNXT and/or calls the PCP office to confirm the referral was provided to the member.

   The care plan includes a schedule for follow-up that includes, but is not limited to, the following referral types:
   - Counseling
   - Follow-up after referral to a DM program
   - Follow-up after referral to a health resource
   - Member education
   - Self-management support

   Follow-up may not be appropriate in all situations. If follow-up is not appropriate, this will be documented as part of the care management plan.

18. The Case Manager communicates the member self-management plan upon completion of the care plan verbally via telephone. The information provided includes the instructions or materials provided to the member or the caregiver to help them manage the member's condition. The emphasis is to shift the focus in patient care from members receiving care from a practitioner or care team to the member providing care for him or herself, as appropriate. Documentation of the self-management plan includes:
    a. Specific self-management action(s) the member will take.
    b. How the self-management action was communicated to the member.
    c. Evidence the member agreed with the self-management action.
    d. Follow-up and subsequent contact to confirm if the member followed through with the self-management action. If an action needs to be adjusted, the adjustment will be documented in the care plan.

19. The Case Manager assesses the member's progress toward overcoming barriers to care and meeting the treatment goals identified in the care plan using an agreed upon schedule. The Case Manager considers the following criteria to determine the frequency of contact.
    a. Severity of current condition
    b. Availability of family or caregiver support
    c. Impact on safety
    d. Cognitive ability of member to initiate contact.
    e. Severity of member compliance issues.

    Once the next follow-up date is identified in the MCG Cite of Care Stand Alone system, the case management software prompts staff to follow-up on the next scheduled contact. This is accomplished with the use of mandatory fields for the next scheduled contact and a daily reminder or task list.

20. The Case Manager uses the following criteria to evaluate whether the case should be closed:
    - Goals met.
    - Created in error.

- Duplicate
- Ineligible for benefits
- Member declined.
- Member expired.
- Member not compliant
- Transition to Behavioral Health
- Transition to Episodic Case Management
- Transition to Disease Management
- Unable to contact member after three attempts within a two-week period.
- VCHCP is secondary payor.

21. Cases are assessed for potential closure at least every 90 calendar days. Upon case closure, a case closure letter is mailed to the member and practitioners/providers stating the case is closed, the reason the case is closed, and how to contact VCHCP to re-open the case, as appropriate.

22. If case management stops while a member is admitted to a facility and the stay is longer than 30 days, a new assessment must be performed after discharge if the member is still eligible for CCM. For shorter stays, a specific assessment targeted at the member's clinical condition that caused the hospitalization is conducted and the care plan revised as appropriate.

23. When conducting ongoing management of care plans, the Plan's Case Manager makes three or more attempts to contact the member within the 14 calendar days of either side of the date or date range for follow up that is specifically documented as part of the CCM Plan. "Best-effort attempt" is defined as at least three (3) documented attempts in fourteen (14) calendar days to contact the member or member's authorized representative. At least two of the following mechanisms for contact are used: telephone, regular mail, e-mail, fax.

24. The ongoing assessment contains the same elements of the initial assessment as identified under the Initial Assessment section. However, updated information is gathered to reflect the status of the members regarding each problem identified at the time of the initial assessment. New problems may be identified and documented during the ongoing assessment.

CCM EVALUATION

Evaluation refers to the ongoing follow-up and evaluation of the CCM Plan to assess the impact of case management services. Evaluation occurs over specific time frames and is a continuous process. Evaluation occurs at an individualized and case-specific level, or otherwise as suggested by specific case management program guidelines.

The Case Manager conducts ongoing communication with the member/family and with the physician and other health care team members. This process is important for appropriate and timely revision of the plan and implementation of new interventions and treatment.

CCM CASE MATURITY/DURATION

Case duration is an integral part of the complex case management process. It provides a method to evaluate case management interventions and outcomes. Duration parameters help to ensure the process is focused on achieving the CCM Plan goals. Case duration is dependent upon the member's needs.

Generally, the average case duration for a VCHCP Complex Case Management case is less than six (6) months. Case management documentation is required to support outlier cases. Case management consultation with the VCHCP Medical Director may be recommended for cases that exceed the average case duration.

SATISFACTION WITH COMPLEX CASE MANAGEMENT

Member satisfaction with the CCM program is evaluated at least annually by obtaining member feedback and analyzing member complaints. This is accomplished through:

1. ***Member survey***
    a. A CCM Satisfaction Survey is conducted at the time of case closure for all members who have been enrolled in the complex case management program.
    b. Survey results are reviewed annually through the UM Committee. At a minimum the Survey tool includes questions regarding:
        - Satisfaction with case management received.
        - Satisfaction with the case manager

2. ***Analyzing member complaints***
    a. Member Complaint and Grievance data is evaluated quarterly via the QM Committee to identify any issues or trends related to dissatisfaction with the CCM process.

MEASURING EFFECTIVENESS

VCHCP annually measures the effectiveness of the CCM program using two data sources: the CCM Member Satisfaction Survey, and evaluation of Member Complaint and Grievance data. Based on the data provided by these two data sources, VCHCP identifies potential opportunities for process improvement. In addition, VCHCP reviews inpatient admissions, ER visits and Plan All-Cause Readmission Rate to measure effectiveness of the CCM Program. These results are incorporated into the PHM Effectiveness analysis.

The evaluation of the effectiveness measures is presented annually to the QM and UM Committee. Recommended interventions for areas of improvement are discussed and a timeframe for reevaluation is determined based on the severity of impact on the program, although the minimum timeframe for re-evaluation is annually.

Related Documents:

1. Case Management Consent Form
2. Case Management Welcome Letter
3. Case Management Closure Letter
4. Educational Materials

Version History:
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Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/11/21	Yes	Faustine Dela Cruz, RN	Updated MCG to 24th Edition and MCG References on Complex Case Management- Self Care https://careweb.careguidelines.com/ed24/index.html
2/17/22	Yes	Faustine Dela Cruz, RN	Annual Review; Updated attachment 4 - with Milliman Chronic Care Guidelines (25th Edition) on Summary of Guidelines Development Policies and Procedures; Removed attachment 5 – Complex Care Management Reference. This is no longer available in MCG.
8/11/22	Yes	Faustine Dela Cruz, RN; Meriza Ducay, RN	Updated the CM and episodic CM member survey questions to make it simpler. Added QR code.
2/2/2023	Yes	Faustine Dela Cruz, RN; Meriza Ducay, RN	Added Carenet Health to Nurse Advise Line

2/8/2024	Yes	Faustine Dela Cruz, RN	Updated to meet NCQA Requirements.