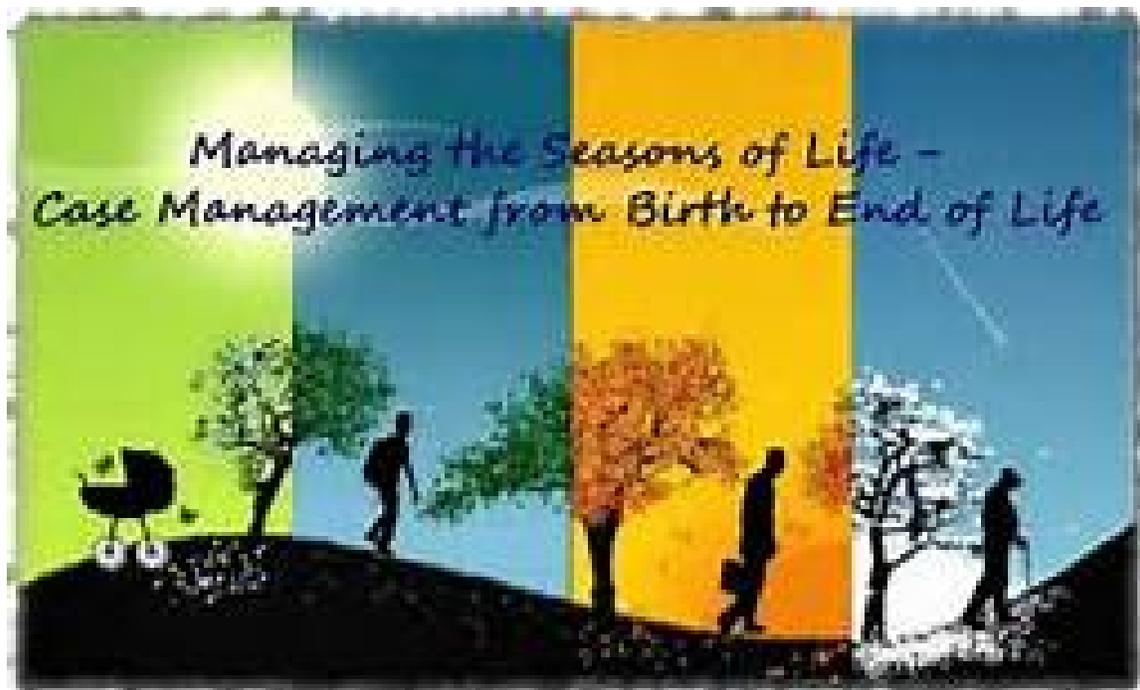


2017 Complex Case Management Program Description



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Group Health Cooperative of South Central Wisconsin Complex Case Management Program Description

POPULATION ASSESSMENT (Element A)

GHC-SCW uses data at its disposal (such as claims, encounters, labs, pharmacy, and utilization management etc.) to assess and identify the needs of its member population. The organization considers its assessment results and reviews its case management structure, processes and resources internally and externally and updates them to meet the needs of its membership if indicated by the analysis. The population assessment report is presented annually to the Clinical and Service Quality Committee.

GHC-SCW's assessment identifies populations and subpopulations that may need complex case management. Subpopulations such as children and adolescents may need particular support because they are still growing physically, mentally and emotionally, and may have special needs for complex case management when they face medical or behavioral challenges. Individuals with disabilities and individuals with SPMI are included as they may have particularly acute needs for care coordination and intense resource use.

GHC-SCW's population assessment includes:

- Commercial HMO population (all ages)
- Members covered by federal or state programs (Medicaid HMO all ages)
- Members covered by Marketplace HMO (all ages)
- Members with multiple chronic conditions or severe injuries (all ages)
- Members of Non- English ethnic or racial groups (all ages)
- Members of African American, Asian, Hispanic and identified as “other” race
- Children and adolescents (members 0–17 years of age)
- Individuals with disabilities (all ages)
- Individuals with serious and persistent mental illness ; SPMI (all ages)

The reports below identify the specific population and/or subpopulations GHC-SCW monitors annually to meet the above requirements.

- Ethnicity/Race/Age Report ENR0003060: identifies age groups, sex, and ethnic groups/race within our commercial HMO membership.
- Population Assessment All Episode by MEG v2.6
- Population Assessment - Inpatient by MEG v2.6
- Population Assessment - ER by MEG v2.6
- Patient Risk LOH Merged Commercial HMO - 201610 Crosstab
- Patient Risk LOH Merged Medicaid - 201610 Crosstab

PROGRAM DESCRIPTION (Element B)

The philosophy of GHC-SCW's Complex Case Management Program was adopted from the Case Management Society of America's definition. "Case management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

Complex Case Management consists of seven processes:

- 1) Member Identification & Selection
- 2) Case Assessment
- 3) Care Plan Development/Update
- 4) Care Plan Implementation
- 5) Care Plan Monitoring and Evaluation
- 6) Case Discharge
- 7) Cost Savings Calculations and Rates

Processes 1 thru 6 are modeled directly after the Case Management Society of America's (CMSA), *Standards of Practice for Case Management*. Process 7 is implemented as a means of determining the financial impact of the program.

GHC-SCW's overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring and follow-up.

In accordance with NCQA standards, GHC-SCW considers complex case management to be an opt-out program: all eligible members have the right to participate or to decline to participate.

GHC-SCW offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in other GHC-SCW disease management programs.

The Complex Case Management Program description is reviewed and approved annually by the Clinical and Service Quality Committee (CSQC).

OBJECTIVES

- To proactively identify members who have multiple or complex medical and/or psychosocial needs or who are at risk of developing complex needs during an acute episode of illness
- To provide early intervention for members appropriate for complex case management to prevent recurrent crisis or unnecessary hospitalizations
- To support and reinforce physician recommended treatments and therapies.
- To strengthen members interactions with their health care providers
- To assist members in navigating the health care delivery system

- To serve as a liaison to community resources regarding options and services not covered by the benefit plan
- To assist members to better understand their individual health care benefits
- To support members individualized learning needs related to their health management
- To improve quality of life, functional status and overall health
- To facilitate communication among the member, their families and care givers, health care providers, the community and the health plan in an effort to enhance cooperation while planning for and meeting the health care needs of the member
- To allocate resources and maximize the available benefits
- To track and report episodes of illness at the member and aggregate level for the purpose of identifying trends, and measuring medical outcomes and financial impact
- To increase member and provider satisfaction through the collaboration, coordination and management of health care resources
- To collaborate with clinic staff and the primary care physician and/or specialist in the development and communication of the member's self-management plan
- To function as an educator for members, the healthcare team and the community regarding the case management process and specific health care issues
- To serve as an advocate for the member, family and caregiver
- To partner with providers, members, care management and the community in assisting the member to reach maximum achievable medical potential and maximum independence

GHC-SCW's Complex Case Management (CCM) program is led by a Medical Director and Care Management Department Manager and is supported by a Case Manager Team Leader along with a team of dedicated Registered Nurses and Social Workers who work as case managers. The organization encourages and assists case managers to obtain professional certification through the Commission for Case Manager Certification; CCMC. Currently, the department has 7 Certified Case Managers including the department manager.

Evidence used to develop the program (Factor 1)

1. Established clinical practice guidelines for conditions such as Heart Disease, Diabetes, Depression, Substance Abuse, and Cancer from the following recognized sources: American Heart Association, American Diabetes Association, National Alliance on Mental Illness; NAMI, American Psychiatric Association, and the National Comprehensive Cancer Network.
2. Established chronic care guidelines from the Case Management Society of America's (CMSA) Case Management Adherence Guidelines (CMAG) for COPD, Diabetes, Breast Cancer, Pain and Depression.
3. Wisconsin Department of Health guidelines are used for management of high risk OB members
4. CMSA *Standards of Practice for Case Management*

Criteria for identifying members who are eligible for the program (Factor 2)

1. To be considered for Medical Complex Case Management, members must possess valid GHC-SCW healthcare insurance coverage for their medical services and meet at least two of the following criteria:
 - A. Be under active care of more than 2 specialty providers;
AND/OR
 - B. Have multiple hospital admissions (more than 2 in past six months) **or** multiple Emergency Room visits (more than 3 in past six months);
AND/OR
 - C. Have suffered a life threatening event or received a life threatening diagnosis
AND/OR
 - D. Per the case managers discretion it is determined case management would benefit the member due to the complexity of services needed
2. Members' with prolonged hospital stays who are at risk for severe complications and/or repeat hospitalizations at the Case Manager's discretion as high cost cases
3. To be considered for Complex Case Management for mental health and/or SUD, all members must possess valid GHC-SCW healthcare insurance coverage for mental health services and meet the following criteria:
 - A. Have an acute diagnosis of substance abuse or dependence, major depressive disorder, personality disorder, psychosis, bipolar, schizophrenia, or autism;
OR
 - B. Readmission for inpatient mental health within 30 days;
OR
 - C. Any of the following criteria:
 - i. Two or more ER visits within six months with mental health related diagnosis, **OR**
 - ii. Two or more hospitalizations within 12 months with mental health related diagnosis, **OR**
 - iii. Diagnosis impacts ability to perform Activities of Daily Living (ADL)
4. Other criteria which may be met:
 - A. The member requires many resources, such as home health care services or durable medical equipment, in order to return home or remain at home.
 - B. The member is at high risk for readmission to the hospital.
 - C. The member needs extensive interpretation of his health coverage, or the rules for obtaining medical services.
 - D. The member needs information about alternative funding sources or referrals to community based services.
 - E. There is a cost effective alternative to the member's current level of care.
5. Criteria which will not be considered for enrollment
 - A. Member is Fee for Service
 - B. Member is not competent to consent to care management
 - C. Member is currently enrolled in Hospice Services
 - D. Member has a PPO coverage

Services offered to individuals (Factor 3)

The Case Manager contacts the member and/or caregiver telephonically and/or onsite. The Case Manager may provide or offer services to the member directly or may arrange for services to be provided by other entities including, but not limited to:

- Care Coordination, including arranging appointments, acting as a liaison between specialists and their PCP, and creating referrals to community resources.
- Medication reconciliation, including medication education with the member and referring to GHC-SCW Clinical Pharmacist Program.
- Case management plan development with performance goals in which the member will achieve self-management and demonstrate improved adherence

Program goals (Factor 4)

GHC-SCW's Complex Case Management Program identified the following goals which will ultimately assist the organization to reduce costs and add value to members:

- Members will be able to obtain access to quality care and appropriate services through coordination of care of their health care needs.
- Case managers will provide support and education to the members in order to reach their maximum achievable health potential and independence
- The member or caregiver will be self-empowered to know what steps to take if their medical condition changes.
- The members' personal evaluation and experience with the program will be rated ≥ 3.0 for both the Patient Activation Measure (PAM) and the Complex Case Management Satisfaction Survey.

How case management services are integrated (Factor 5)

Case Managers may make referrals for members in the program to appropriate resources based on member assessment or need. GHC-SCW's Case Management program integrates with the following areas or services to assist member engagement in their health and well-being when member is no longer in need of case management.

- A. The Disease Management program provides continued educational materials to members who may be diabetic, have COPD, heart failure, asthma, etc. to keep members engaged in their condition maintenance. Members are automatically enrolled in this program via claims information syncing with diagnosis and labs performed.
- B. GHC-SCW's Wellness program provides classes or coaching sessions to interact as a group or one on one. Classes and sessions are designed by individuals who understand both health care and education. Case Managers may assist members in accessing these integrated services.
- C. GHC-SCW's Utilization Management collaborates with Case Management assisting in referrals and updating case managers on in-patient stays members with complex diagnoses, catastrophic events, or repeat hospitalizations.
- D. Case Managers may refer members to GHC-SCW's integrated Primary Care Behavioral Health (PCBH) program to meet with a PCBH consultant while at a physician appointment or work with GHC-SCW's mental health department and UR to facilitate needs.
- E. GHC-SCW Case Managers may work together with Palliative and/or end of life services as needed and help with transition of care.
- F. GHC-SCW Case Managers refer members to outside community resources for assistance with financial needs, transportation, housing, and non-covered services such as home care assistance

- G. Case Managers may refer members to GHC-SCW's integrated Clinical Pharmacy Program.
- H. Case Managers may refer members to after- hour services such as, *NurseConnect* or *Virtuwell* for obtaining quality care while avoiding unnecessary or inappropriate use of ERs.

IDENTIFYING MEMBERS FOR CASE MANAGEMENT (Element C)

Member identification is the initial process of Complex Case Management which consists of GHC-SCW's commercial HMO members and Medicare HMO (Badger Care) members. The following GHC-SCW products are excluded from this program: PPO and Medicare Select members. The goal is to assist qualified HMO members with multiple or complex conditions/ comorbidities in obtaining access to quality care and appropriate services through coordination of care, and to provide support to members navigating the health care system; see Policy CM.MED.039 –Appendix C.

During this identification process, referral sources are used to establish criteria to recognize a potential Complex Case Management opportunity. The following are examples of data sources used by complex case management staff in this process: claims and encounters (hospital, ER and Inpatient data) pharmacy claims, health risk assessments, disease management reports, Complex Case Management referrals, McKesson Risk Management tool, and the electronic medical record.

Through these specific reports, GHC-SCW identifies complex case management individuals who may have a mental or physical disability or a chronic condition. GHC-SCW Case Managers then coordinate with appropriate resources, community services or county services to address the needs of our members throughout the continuum of his/her care.

GHC-SCW receives multiple reports for member identification into Complex Case Management. The review and evaluation of reports weekly, monthly or annually assist with the identification of members for complex care management services. The reports reviewed include, but are not limited to:

1. Claims or encounter data identifies members with conditions that match the eligibility criteria.
 - A. Weekly Claim encounters for Diabetes: 2100006638 - EDG ICD-9 MU N_C47 DIABETES
 - B. Weekly Claim encounters for CHF: 2100006774 - EDG ICD-9 MU A_C23 ICD-9 HEART FAILURE
 - C. Weekly Claim encounters for COPD: 2100006632 - EDG ICD-9 MU N_C225 COPD
 - D. Weekly Claim encounters for SUD: 2100006785 - EDG ICD-9 MU N_C606 ALCOHOL OR DRUG DEPENDENCE
 - E. Weekly Claim encounters for depression: 2100006665 - EDG ICD-9 MU N_C613 MAJOR DEPRESSION
 - F. Claims with Sentinel Diagnosis – MUM0003050
 - G. High Frequency Emergency Room Patients – MUM0026050
2. Hospital admission/discharge data identifies members with multiple conditions requiring frequent inpatient stays affecting cost ratio.
 - A. Hospital Census of Current Inpatients is received daily. This report lists the names of members currently admitted and identifies which member has had a previous admission within the 30 days previous to the current admission. The report includes the names of facilities, member, date of admission and actual length of days, diagnosis, attending provider, primary insurer, etc. : MUM0002010--Hospital Census -- Current Inpatients.pdf
 - B. Hospital Readmissions within 30 days of Medical Discharge Report – MUM0025050
 - C. Facility Readmissions within 30 days of Mental Health Discharge – MUM0011050
 - D. Recently Discharged Members with NICU Bed Days – MUM0004020

3. Pharmacy data provides a report of medications identified as indicating high risk.
 - A. The Top 50 Refills: reports name and quantity of medications, member's name, prescribing pharmacist: Top-50 fills detail.xls
 - B. Epic members: member's medication lists, dosages, changes, etc. is seen on line
 - C. Claims data on use of J-Codes and high cost medications
4. Numerous reports from the UM system which identify members with multiple conditions, multiple hospitalizations, high frequency of ER visits, and pending referrals to numerous specialists.
 - A. Prior Authorization review
 - B. Concurrent review
 - C. MUM0026050--High Frequency Emergency Room Patients. All HMO Hospital Readmission data identifies member, facility, date of service, diagnosis, etc.
 - D. MUM0011050--Facility Readmissions within 30 Days of Mental Health Discharge. Identifies member, facility, diagnosis, date of admission, provider, etc.
 - E. MUM0007010--All Pended Referrals. Identifies members, diagnosis, requesting to, referred by, facility, etc.
 - F. MUM0025050-Facility Readmission within 30 days of Medical Discharge. Identifies member, facility, diagnosis, date of admission, etc.
 - G. McKesson Risk Manager Tool: Patient List Report and Likelihood of Hospitalization (LOH) Merged report to identify members by diagnoses, risk stratification by costs, gaps in care, ER and admit visits.
 - H. Cave Tool Red Alert System Reports: These reports calculate the members' CNI (Care Need Index) change. ;details about the patients in these reports identify their *Risk Panel, Age, Line of Business, PCP*, and whether the member currently has coverage with GHC
5. Data collected by purchasers – *This is not applicable as GHC-SCW does not receive clinical data from purchasers.* If the employer supplies information to GHC we will analyze such data to see if there are any members that qualify for Complex Case Management.
6. GHC-SCW may use data self-reported by the member or caregiver.
 - A. Case Managers may receive information from a member regarding their HRA results or other clinical information or receive information from their caregiver to begin the CM process. Health Needs Assessments (HNA) are completed by Community Care Department for Badger Care HMO Members and are shared with Case Managers as appropriate.
7. GHC-SCW uses data provided by practitioners, such as electronic health record (EHR) data, if available, to determine eligibility criteria and the need for Case Management.
 - A. PCPs can submit Case Management messages if they have a member who may qualify for possible case management as the medical or behavioral health condition is identified.
8. Non Epic practitioners: Data is collected through the UM process as stated in #1-4 above.

Seven chronic conditions have been identified for the primary focus for complex case management: Congestive Heart Failure (CHF), COPD and/or Asthma, Cancer, Diabetes, High Risk OB, Depression and Substance Use Disorder (SUD). The diagnoses have been identified through claims encounters, pharmacy data and emergency room (ER) visits as primary, reoccurring diagnoses.

The determination of eligibility involves an in-depth evaluation of the member's condition by assessing relevant, comprehensive information and data gathered in the numerous data bases (EHRs), member's coverage as well as their use of resources.

ACCESS TO COMPLEX CASE MANAGEMENT (Element D)

To minimize the time between identifying a member's need and receiving the appropriate services, GHC-SCW has multiple avenues for members to be considered for case management services including, but not limited to:

1. GHC-SCW Case Managers review referrals from NurseConnect as they have assessed a member's health concern telephonically who might benefit from CCM.
2. GHC-SCW Case Managers review referrals from Disease Management which report members who are receiving mailings specific to chronic health conditions
3. GHC-SCW Case Managers review referrals from hospital discharge planners who have identified members who have complex conditions requiring immediate case management and special needs.
4. GHC-SCW Case Managers review referrals from UM activities which assist with the identification of members who may benefit from case management. The data includes, but is not limited to, ambulatory care conditions, diagnoses and readmission rates.
 - A. MUM0026050-High Frequency Emergency Room Patients
 - B. MUM0011050-Facility Readmissions within 30 Days of Mental Health Discharge
 - C. MUM0007010-All Pended Referrals
 - D. MUM0025050-Facility Readmission within 30 days of Medical Discharge
5. GHC-SCW Case Managers review referrals from members or caregivers (Appendix V)
6. GHC-SCW Case Managers review referrals from internal practitioners, mental health practitioners, and external specialists. (Appendix V).
7. Transition of Care (TOC) is defined as individuals who are in acute or active medical or behavioral health services who need continual services perhaps due to a change of insurance. The Case Manager ensures the coordination and continuity for these members to receive ongoing medical and/or behavioral health services through the continuum of care.

Information regarding the referral process and participation in GHC-SCWs Complex Case Management Program is communicated to both members and practitioners in a variety of ways, including but not limited to:

- GHC-SCW's website on the Internet ghcscw.com
- Internally to GHC staff on the Intranet.
- Member, practitioner, and staff electronic communications and postal mailings.
- GHC-SCW Provider Newsletter "Practitioner Update" provided bi-annually.
- GHC-SCW Member Newsletter "Housecall" provided quarterly.
- GHC-SCW Case Management brochure available in the Primary Care Clinics where members receive care

CASE MANAGEMENT SYSTEMS (Element E)

GHC-SCW facilitates Complex Case Management by providing the necessary tools and information to help case managers do their jobs effectively; see Policy CM.MED.039 –Appendix C.

- The EPIC electronic case management system GHC-SCW uses has operational algorithmic logic such as scripts and other prompts to guide the case managers through assessment and ongoing management of enrolled members. The clinical basis of these prompts and scripts are developed by using evidence-based clinical guidelines or algorithms from published care plans and other resources meeting NCQA standards, which assist the case managers in conducting initial assessments and ongoing complex care management
 - a. Nursing Diagnosis Handbook, Betty J. Ackley, Gail B Ladwig Mosby, Ninth Edition
 - b. Care Plans, 7th Edition, Elsevier Mosby.
- Clinical Practice Guidelines are embedded throughout the assessment tool in the system for Cancer, Diabetes, CHF, COPD, depression, pregnancy, and SUD when specific questions are addressed with the member.
- The system includes automated features that provide accurate documentation for each entry (record of actions or interaction with members, practitioners or providers) and use automatic date, time, and user stamps.
- The system includes features to set prompts and reminders for next steps or follow-up care to facilitate care planning and management

CASE MANAGEMENT PROCESS (Element F)

GHC-SCWs Complex Case Management Process addresses all of the following, which is also documented in the Complex Case Management policy CM. MED. 039 (Appendix C):

1. Initial Assessment of members' health status
 - A. During initial telephonic (or face to face) assessment, the case manager will evaluate the member's health status and screen for the presence or absence of the specified comorbidities. The Initial Assessment also includes member's self-reported health status and information on the event or diagnosis that led to the member's eligibility for complex case management.
2. Documentation of Clinical History including Medications
 - A. The Clinical History Summary and Medication History documentation reports the member's clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages). The documented treatment history goes back to the onset of the condition that qualified them for complex case management.
3. Initial Assessment of Activities of Daily Living
 - A. During the initial assessment, the case manager will evaluate functional status related to activities of daily living, such as eating, bathing and mobility. The case manager takes into consideration the amount of time it may take the member to perform such tasks as member indicates they can manage these ADLs.

4. Initial assessment of behavioral health status
 - A. During the initial assessment, the case manager will evaluate behavioral health status, including cognitive function, the member's ability to communicate and understand instructions, the member's ability to process information about an illness, mental health conditions, and substance use disorders. The assessment of the member and caregiver is important as this assists the Case Manager in establishing a personalized care plan.
5. Initial assessment of psychosocial issues
 - A. During the initial assessment, the case manager will evaluate psychosocial status, such as:
 - i. Beliefs and concerns about the condition or treatment.
 - ii. Perceived barriers to meeting treatment requirements.
 - iii. Access, transportation, and financial barriers to obtaining treatment.
6. Initial Assessment of Life Planning Activities
 - A. The Life Planning Questionnaire, which is completed by the Case Manager during the first month after a member accepts Case Management, assesses whether members have completed life planning activities such as wills, living wills or advance directives and health care powers of attorney. If a member does not have expressed life-planning instructions on record, the case manager determines if such a decision is appropriate. If a life planning activity is not appropriate such as in pediatric cases, the case manager records the reason in the case management system. The Case Manager provides life-planning information (e.g., brochure, website) to all members in complex case management if an activity is appropriate.
7. Evaluation of Cultural and Linguistic Needs
 - A. During the initial assessment, the case manager will evaluate culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. It includes consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs as appropriate.
8. Evaluation of Visual and Hearing Needs
 - A. During the initial assessment, the case manager will evaluate visual and hearing needs and preferences to identify potential barriers to effective communication or care.
9. Evaluation of Caregiver resources
 - A. During the initial assessment, the case manager will evaluate the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan).
10. Evaluation of available benefits
 - A. During the initial assessment, the case manager will evaluate the adequacy of health benefits regarding the ability to fulfill a treatment plan. The assessment goes beyond checking insurance coverage and includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

11. Evaluation of community resources

- A. During the initial assessment, the case manager will evaluate the member's eligibility for community resources that supplement those for which the organization has been contracted to provide. These may include community mental health, disease management, wellness organizations, palliative care programs, and other national or community resources.

12. Individual Case Management Plan and Goals

- A. The personalized case management care plan meets member needs and includes:
 - i. prioritized goals;
 - ii. time frame for reevaluation;
 - iii. resources to be utilized, including the appropriate level of care;
 - iv. planning for continuity of care, including transition of care and transfers;
 - v. collaborative approaches to be used, including level of family participation
- B. Prioritized goals consider member and caregiver needs and preferences. Time frames for reevaluation are specified in the case management care plan. The care plans are sent to the member/provider via mail and updated periodically with the member/providers. The use of the PAM survey at the initial opening of the case also assists the case manager to know what the member may know about his/her medical or behavioral health condition and will be used in making prioritized goals.

13. Identification of barriers

- A. The complex case management process identifies and addresses barriers to receipt of care or participation in the case management plan. These could include the member's lack of understanding, motivation, cultural or spiritual beliefs; visual or hearing, psychological impairment, any financial needs, insurance issues or transportation problems.

14. Referrals to available resources

- A. The case manager facilitates member referrals to other health organizations and/or community resources when appropriate. The Case Manager remains in contact with the member and/or vendor to verify if the referral was utilized by the member.

15. Follow-up Schedule

- A. The complex case management policy and procedure includes a schedule for follow-up communication that includes, but is not limited to, counseling, referrals to disease management or a health resource, member education, self-management support, and determining when follow-up is not appropriate.

16. Development and Communication of Self-Management Plan

- A. The complex case management policy and procedure specifies a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). The self-management plan is mutually agreed upon by the case manager and member/caregiver. This plan will allow the member/caregiver to be engaged in their health and will enable them to take control of their own care.

17. Assessing Progress

- A. The complex case management care plan includes an assessment of member's progress towards overcoming barriers to care and meeting treatment goals. The complex care management process includes reassessing and adjusting the care plan and its goals as needed with the member. Accomplishments are acknowledged when the member/caregiver meets a goal so new a new goal can be established mutually.

INITIAL ASSESSMENT (Element G)

Each case file contains evidence that GHC-SCW completed the 11 factors listed, according to its complex case management procedures. Documentation to meet the factors includes evidence that the assessments were completed and documentation of the results of each assessment.

GHC-SCW Case Managers complete the initial assessment within 30 calendar days of the member opting in to the Case Management Program unless the delay was due to circumstances beyond GHC-SCWs control, including, but not limited to:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, e-mail or fax.
- Natural disaster.

Case Managers must document the reason for the delay and actions/attempts he/she has taken to complete the assessment including telephone, letter, email or fax.

Complex case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days. A new assessment will be performed after discharge if the member is eligible for complex case management.

The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining eligibility, if the information is related to the current episode of care (e.g., health history taken as part of DM or during a hospitalization).

CASE MANAGEMENT – ONGOING MANAGEMENT (Element H)

Each case file contains evidence that the organization completed the five factors listed below, according to its complex case management procedures in Element F.

- Development of case management plans, including prioritized goals, that take into account member and caregivers' goals, preferences and desired level of involvement in the complex case management program
- Identification of barriers to meeting goals and complying with plans
- Development of schedules for follow-up and communication with members
- Development and communication of member self-management plans
- Assessment of progress against case management plans and goals, and modification as needed.

NCQA reviews initial assessments and ongoing management within a random sample of up to 40 complex case management files selected from active or closed cases that were open for at least 60

calendar days during the look-back period. GHC-SCW may exclude files from review that meet the following criteria:

1. Eligible members whom cannot be located or contacted after three or more attempts across a 2-week period, thus failing to complete the assessment within the first 30 calendar days after eligibility, through at least two of the following mechanisms:
 - A. Telephone
 - B. E-mail
 - C. Letter
 - D. Fax
2. Eligible members enrolled in complex case management for less than 60 calendar days during the look-back period.

Files that meet these criteria and are inadvertently included in GHC-SCW's file review are scored NA for all factors. NCQA reserves the right to confirm that the files met the criteria for an NA score.

EXPERIENCE WITH CASE MANAGEMENT (Element I)

GHC-SCW analyzes complaints and inquiries to identify opportunities to improve member satisfaction at least annually. The analysis considers quantitative and qualitative data to identify patterns of member comment; the report is presented to the CSQC.

GHC-SCW obtains and analyzes member feedback using satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.

Feedback and complaints from members and practitioners are received through the following:

1. Complex Case Management Member Survey (Appendix U) was developed by GHC-SCW to gain information on member/or caregiver satisfaction with the program. This survey is sent to members upon case closure.
2. The Patient Activation Measure is a tool which assesses member knowledge, skills and confidence for self-management. The survey is conducted with members upon opening and prior to closing the case to determine areas of knowledge that may need additional support. The PAM (Appendix M) also assists in evaluating the effectiveness of the program.
3. GHC-SCW's Insurance Operations /Member Services department tracks and analyzes member complaints about the health plan. A Complaint and Appeals report is annually prepared documenting the number of complaints broken out by specific categories or departments including Care Management. The report is presented to the Clinical and Service Quality committee each year to review patterns and stated goals.

MEASURING EFFECTIVENESS (Element J)

GHC-SCW annually measures the effectiveness of its complex case management program by tracking at least three measures from the following tools to assess the programs' effectiveness:

- 1) Patient Activation Measure (Appendix M) **trending** of three questions re: "Member Activation"
- 2) Complex Case Management Member Survey (Appendix U) trending of "Overall Satisfaction"

For each measure, GHC-SCW:

- Identifies a relevant process or outcome,
- Uses valid methods that provide quantitative results,
- Sets a performance goal,
- Clearly identifying measure specifications,
- Collecting data and analyzing results,
- Identifying opportunities for improvement, when applicable

ACTION AND RE-MEASUREMENT (Element K)

Based on the results and analysis of complex case management effectiveness and satisfaction, GHC-SCW will:

- Implement at least one intervention to improve clinical performance, if applicable
- Implement at least one intervention to improve member satisfaction, if applicable
- Re-measure results to determine impact on performance., if applicable
- Re-measure results to determine impact on member satisfaction, if applicable

The evaluation of the PAM and Complex Case Management Surveys are presented annually to the CSQC committee. Recommended interventions for areas of improvements are discussed and approved. Results of the satisfaction survey are shared with the Case Managers and if interventions are necessary, the Case Manager develops an improvement process to increase the particular performance or satisfaction measure.

TRANSITION TO OTHER CARE

GHC-SCW helps our members transition their care/services under the following circumstances:

1. **Exhaustion of benefits** - policy CM.MED.012 addresses when a member has exhausted his/her benefits and how GHC-SCW provides options and alternatives that are available for either medical and/or behavioral health services.
2. **Transitioning from pediatric care to adult care**- policy MED. QM. 015 defines the process to facilitate transitioning health care services from child to independent, adult-oriented primary care for all youth, both with and without special health care needs.
GHC-SCW suggests complete transfer from a pediatric model to an adult primary care model by age 22 for all HMO plan members. GHC-SCW will assist with the transfer process including helping to identify an adult provider, sending medical records and communicating with the adult provider about the unique needs of individual patients as indicated.
3. New members to GHC who are in active treatment with a non-plan provider

APPENDIX A
STEP 7 – COST SAVINGS CALCULATIONS AND RATES

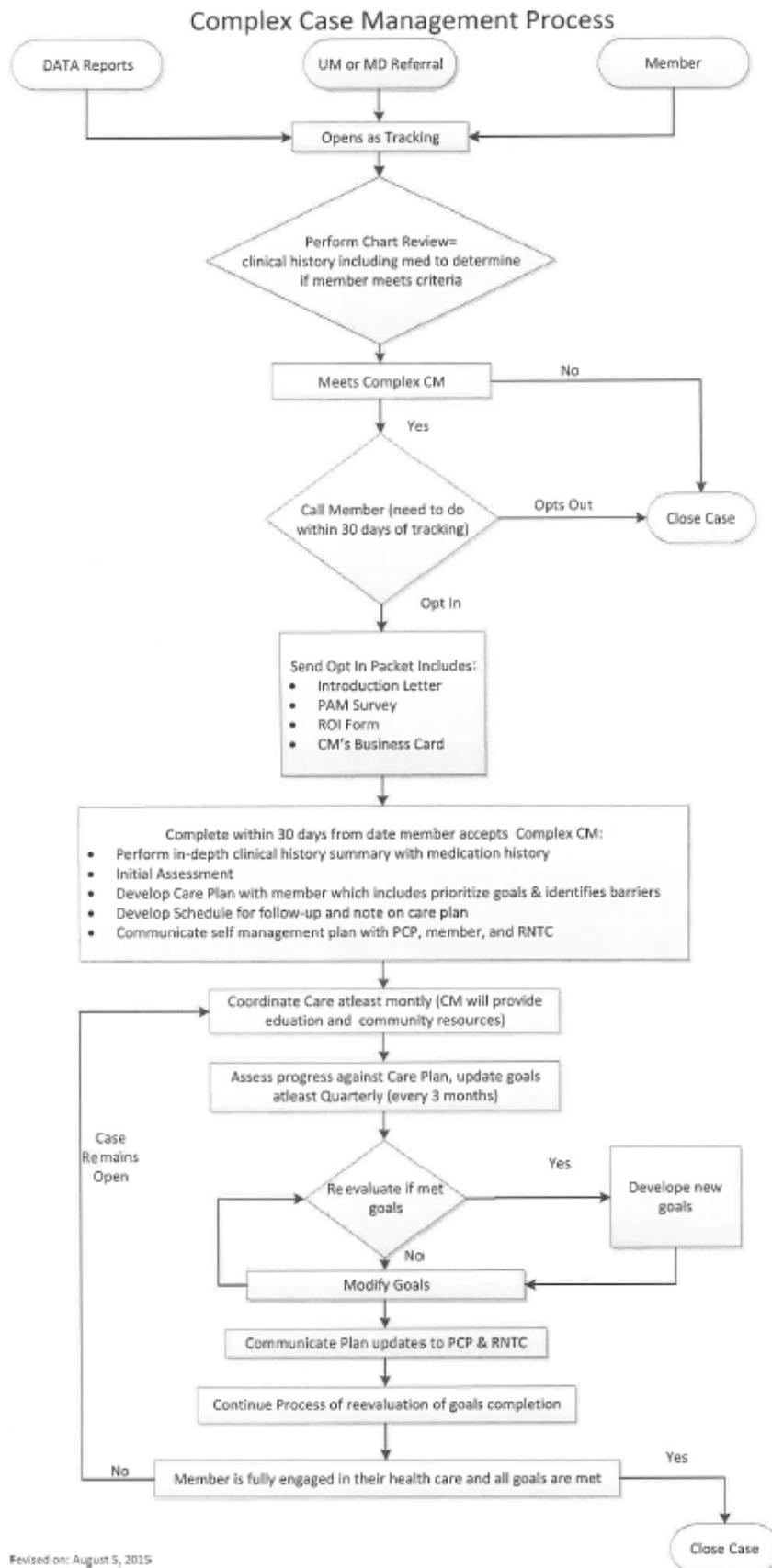
Cost savings is used to identify complex case management savings opportunities and to calculate the savings which are a result from actions taken by the member with guidance from the Case Manager. Cost savings calculations may be realized by changing an existing plan of care, thus cost savings are a way to measure the impact of case management from a monetary viewpoint. Cost savings are also a way to measure the ROI for GHC-SCW's Case Management program.

1. Examples of situations where a treatment option or alternative service exist include, but are not limited to:
 - Steering a member from an out-of-network facility to an in-network facility
 - Diverting inpatient admissions to outpatient services
 - Steering members to the most cost effective, in-network facilities for diagnostic services, procedures or therapies
 - Avoidance of ER visits by arranging member to see PCP or go to Urgent Care
2. Complex case management costs are evaluated and documented monthly or with scheduled review of the case record by the Utilization Management staff. The complex case managers work collaboratively with the Utilization Management staff to review claims– this includes but is not limited to:
 - Time saved by PCP or patient care staff.
 - Compliance represented with Decreased Emergency Department visits
 - Compliance represented with decreased In-patient stays
 - Decreased use of specialty care referrals/visits
3. The complex case management program understands that it may be difficult to measure cost savings, and thus, has begun using the McKesson Risk Manager tool beginning in March 2015. The McKesson Risk Manager Tool utilizes claims to generate data about the member including, but not limited to:
 - The likelihood of re-hospitalization
 - Number of Acute care visits member has experienced in past year
 - Number of hospitalizations member has had in past year
 - The amount of claims billed for prior year and as-to-date for current year

The complex case manager is able to use this data to assist in determining qualified candidates for the case management program. GHC-SCW will also use this data to look at the person's "Risk Management Score (i.e., very high, high, moderate, low, very low) pre-case management and then also post-case management to determine the effectiveness of the care plan goals and cost savings.

GHC-SCW also works with the GHC-SCW Reinsurer to obtain price reductions which assist in lowering claims costs when a member has to be treated out of network.

APPENDIX B CASE MANAGEMENT FLOW SHEET



Revised on: August 5, 2015

APPENDIX C
CASE MANAGEMENT POLICY & PROCEDURE



APPROVAL as appropriate:

Board _____ Exec Dir _____
Med Dir _____ Other Dir/Mgr _____

REVIEWED BY LEGAL COUNSEL
Yes ___ No ___ Date: x
Name: x

POLICY STATUS: Approved Pending

Policy and Procedure

Title: Complex Case Management
Author: L. Behl, RN and E. Jenson, RN **Div/Dept/Serv Area:** Medical Services/Care Mgmt
Volume: VI **Number:** CM.ADM.039 **Date of Issue:** 4/07 **Page 1 of 10**
Formerly A2a.085 (5/08)/CM.039 (7/12) NCQA Standard: QI 5

PURPOSE:

The purpose of this policy is to document the guidelines underlying the appropriate utilization of Complex Case Management by Group Health Cooperative of South Central Wisconsin (GHC-SCW).

POLICY:

1. The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.
2. In accordance with NCQA standards, GHC-SCW considers complex case management to be an opt-out program: all eligible members have the right to participate or to decline to participate.
3. GHC-SCW offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in other GHC-SCW disease management programs.

PROCEDURE:

1. GHC-SCW Case Management Department uses data at its disposal (i.e., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, data supplied by the member, caregiver or practitioner, and demographics) to identify the needs of its population annually. Care Management staff assess the characteristics and needs of its member population and relevant subpopulations on an annual basis. Updates are made as needed to the case management processes and resources as necessary.

2. Identification of members for Complex Case Management services is accomplished through methods and tools that may include (but not limited to):
 - a. Claims and encounter data
 - b. Hospital discharge data
 - c. Pharmacy data
 - d. Data collected through the utilization management (UM) process.
 - e. Data supplied by purchasers
 - f. Data supplied by member or caregiver
 - g. Data supplied by practitioners

3. GHC-SCW has multiple avenues for members to be considered for Complex Case Management services including (but not limited to):
 - a. Health information (Nurse Connect) line referral;
 - b. Referral from Disease Management;
 - c. Referral from hospital discharge planners;
 - d. Data gathered from UM activities;
 - e. Referrals from practitioners;
 - f. Transition of Care to GHC-SCW insurance (members who are in acute or active medical/behavioral services);
 - g. Members identified through data analysis and subsequent reports.

4. To be considered for Medical Complex Case Management, members must possess valid GHC-SCW Healthcare coverage for their medical services and meet at least two of the following criteria:
 - a. Be under active care of more than 2 specialty providers;

AND/OR

Have multiple hospital admissions (more than 2 in past six (6) months) **or** multiple Emergency Room visits (more than 3 in past six (6) months);

AND/OR

Have suffered a life threatening event or received a life threatening diagnosis

AND/OR

Per the Case Managers Discretion. Due to the complexity of services needed by the member, it is determined Case Management would benefit the member.
 - b. Members with prolonged hospital stays are high dollar cases who are at risk for severe complications and/or repeat hospitalizations. These members, at Case Manager's discretion, may be selected for complex case management.

5. To be considered for Complex Case Management for mental health and/or SUD, all members must possess valid GHC-SCW Healthcare coverage for their mental health services and meet the following criteria:
 - a. Have an acute diagnosis of substance abuse or dependence, major depressive disorder, personality disorder, psychosis, bipolar, schizophrenia, or autism;

OR

Readmission for inpatient mental health within 30 days;

OR

Any of the following criteria:

 - iv. Two or more ER visits within six months with mental health related diagnosis, **OR**
 - v. Two or more hospitalizations within 12 months with mental health related diagnosis, **OR**
 - vi. Diagnosis impacts ability to perform Activities of Daily Living (ADL)

6. Other criteria which may be met:

- a. The member requires many resources, such as home health care services or durable medical equipment, in order to return home or remain at home.
 - b. The member is at high risk for readmission to the hospital.
 - c. The member needs extensive interpretation of his health coverage, or the rules for obtaining medical services.
 - d. The member needs information about alternative funding sources or referrals to community based services.
 - e. There is a cost effective alternative to the member's current level of care.
7. Criteria which will not meet enrollment criteria
- a. Member is Fee for Service
 - b. Member is not competent to consent to care management
 - c. Member is currently enrolled in Hospice Services
 - d. Member has a PPO coverage
8. Once the potential member has been identified the case manager will initiate a case record within the EPIC Case Management System as follows:
- a. Select member through Member inquiry under the Epic Tab. Select Case tab. Select New button
 - b. Select TRACKING as case type. An individual may be kept open in tracking for no more than 30 days.
 - c. Enter case manager's name.
 - d. Enter primary diagnosis under Roster (i.e., Cardio Vascular, OB/GYN, Pulmonary, Cancer...)
 - e. Enter affiliated diagnoses and procedure codes.
9. Document where the Case Management Referral originated from.
- a. Select Contact tab. Select Add Contact button. Select "Message" in Contact type. Type "CM Request" before date in Summary box. Document where referral for CM originated (i.e. data report, practitioner, UM referral...)
 - 1) Example: CM received referral for case management services from PCP.
10. Perform a quick chart review of member's history to determine if they meet Case Management criteria. Document this under Contacts.
- a. Select "Chart Review" in Contact type. Type "CM Decision – Chart Review" before date in Summary box. Document a short narrative stating if member meets criteria or not with reasoning included.
 - 1) Example: Member has a diagnosis of COPD and CHF. Member sees cardiology, pulmonology, and health psychology. Member has been hospitalized 2 times in past six months for COPD exacerbation. Member qualifies for Case Management services.
11. If a member does not meet criteria, Case Manager must notify the referring source, PCP, and RN team coordinator.
- a. Under In Basket, Select New Msg. Select "Case Manager". Type in PCP and RNTC in the To box. Subject is "Case Management." Select your patient. Write a message to the PCP to notify that the member does not meet criteria for case management. Select and copy this text. Select Accept button to send message.
 - b. Select Contacts tab in the member's Case. Select "Care Coordination" in Contact Type. Type "Care Coordination" before date in Summary box. Paste MD message.
 - 1) Change Case type under Case Summary tab to 'Did not meet criteria.' Select Close Case.
 - 2) Lastly, select Review & Accept.

- c. Select Patient Care Coordination Note in Patient's chart under SnapShot tab. At the top of the new screen, again, select Patient Care Coordination Note. Type short note stating reasoning for not enrolling into CM. Select Accept.
 - 1) Example: Member was referred to CM Services on 1/1/15. Member found ineligible for CM. Case Closed on 1/1/15.
12. If member meets criteria, contact member to offer enrollment into Complex Case Management program. Document as follows:
- a. Select Contacts tab. Select Add Contact button. Select "Offer of Case Management" in Contact type. Type "CM Offer" before date in Summary box. Call member and offer CM using the Offer of Case Management script.
 - b. If member speaks a different language than English, use the Pacific Interpreter Language Line to assist in calling member and offering case management. Document the interpreter's name and number in the Contact field.
13. If member agrees to case management, set appointment to meet with or to call member to complete the initial assessment within 2 weeks.
- a. In the Offer of Case Management contact comment, use Smart Phrase .cmscript and complete *** fields
 - b. Write a "Case Manager" message to PCP and RN team coordinator informing him/her that their client has accepted CM Services. Select and copy this text. Select Accept button to send message
 - 1) Select Contacts tab in the member's Case. Select "Care Coordination" in Contact Type. Type "CM MD Msg" before date in Summary box. Paste MD message. Select Accept.
 - c. Add self to Client's Patient Care team. Select member through member inquiry. Select "Case Managed" under Patient types. Select Accept. This will make the demographics bar in the chart turn green.
 - d. In patient's chart, select Snapshot, click on Patient Care Team, select '+ Add me' button, enter relationship as 'GHC Case Manager.' Select Accept. Select Close.
 - e. In patient's chart, under SnapShot tab, click on Patient Care Coordination Note. At the top of the new screen, again, select Patient Care Coordination Note. Type short note stating member has accepted CM Services. Select Accept.
 - 1) Example: Member enrolled in Case Management on 1/7/15. Case Manager: _____ (CM Name) and Phone: _____.
 - f. In Member's case, select Notes tab. Select New Note. Choose "CM Enrollment" as Note Type. Type "cm enroll" into Smart Text box. Select CM Enrollment. Complete the "Enrollment to Case Management Questionnaire". Type CM Enrollment Questionnaire and date completed in Note Summary. Accept Note. This must be done the same day as acceptance to program.
 - g. Continue on to Step 16
14. If the member elects to "Opt Out" of the program invitation, the case manager will complete the case record as follows:
- a. In the Offer of Case Management contact comments, use Smart Phrase .cmscript and complete *** fields stating member "is not" interested. Delete the last sentence stating an assessment will be done.
 - b. Select Notes tab. Select New Note. Choose "CM Enrollment" as Note Type. Type "cm enroll" into Smart Text box. Select CM Enrollment. Complete the "Enrollment to Case Management Questionnaire" noting the last answer as member stating no to services. Type CM Enrollment Questionnaire and date completed in Note Summary. Accept Note.

- c. Under In Basket, Select New Msg. Select “Case Manager”. Type in PCP and RNTC in the “To” box. Subject is “Case Management.” Select your patient. Write a message to the PCP to notify that the member opted out of case management. Select and copy this text. Select Accept button to send message.
 - d. Select Contacts tab in the member’s Case. Select “Care Coordination” in Contact Type. Type “CM MD Message” before date in Summary box. Paste MD message.
 - e. Change Case type under Case Summary tab to ‘Opt Out.’ Select Close Case.
 - f. Lastly, select Review & Accept.
 - g. Select Patient Care Coordination Note in Patient’s chart under SnapShot tab. At the top of the new screen, again, select Patient Care Coordination Note. Type short note stating member opted out of CM. Select Accept.
 - 1) Example: Member was offered CM Services on 1/1/15, but decided not to participate. CM Case Closed 1/1/15. _____ (CM name).
15. If the case manager has not successfully contacted the member after three (3) attempts within a two week time period using the following schedule, the case manager will close the case.
- a. Day 1: Call client. Leave voicemail. Document this under the Contact tab.
 - 1) Select “Phone Message” as Contact type. Type “Phone Message” before date in summary box. Document what was said on voicemail. Document a letter has been sent to member.
 - 2) Select Case Summary tab. Select Review Date as 4 days from this date.
 - b. Day 4: Call client. Leave voicemail. Document this under the Contact tab.
 - 1) Select “Phone Message” as Contact type. Type “Phone Message” before date in summary box. Document what was said on voicemail.
 - 2) Select Notes tab. Select New Note. Select Letter as type. Use Smart Phrase .cmsecondoffer. Complete the phone number extensions and e-mail address. Type “2nd Attempt at Contacting Member” and date in summary box. Select Print text button. Select Accept.
 - 3) If member is Spanish speaking, use the Smart Phrase .cmsecondoffersp.
 - 4) Select Case summary tab. Select Review date as 7 days from this date.
 - c. Day 11: Call client. Leave voicemail. Document this under the Contact tab.
 - 1) Select “Phone Message” as Contact type. Type “Phone Message” before date in summary box. Document what was said on voicemail. Document a letter has been sent to member.
 - 2) Select Case Summary tab. Select Review Date as 3 days from this date.
 - d. Day 14: Close Case using the following steps:
 - 1) Under contacts, select “Case Review” in Contact type. Type “Case Review” before date in Summary box. Document “Member has not been able to be reached and therefore the case will be closed.”
 - 2) Under the Summary tab, change case type to ‘Lost to Follow Up.’ Select Close Case. Select Review and Accept
 - 3) Select Patient Care Coordination Note in Patient’s chart under SnapShot tab. At the top of the new screen, again, select Patient Care Coordination Note. Type short note stating member was lost to follow up. Select Accept.
 - a) Example: Member was referred to CM Services on 1/1/15. CM ____ (name) unable to locate member through multiple PC and Letter attempts. CM Case Closed 1/16/15.
16. Once the member elects to “Opt In” to the program, this is the official start date of the case. The case manager will complete the case record as follows:
- a. In the Case, under Case Summary tab, Select the appropriate case type (i.e., Opt In-Medicaid, Opt In-GHC Prime, Opt In-Medicare).

- b. Select Notes tab. Select New Note. Choose “Letter” as Note Type. Select Smart Text “CM Enrollment Letter”. Complete all **** variables in the letter and make additions as necessary. Personalize as needed. Type “CM Enrollment Letter” and date completed in Note Summary. Accept Note. Select Print Text. Choose Apum2 for GHC-SCW letterhead.
 - c. Mail Enrollment letter in a Care Management envelope that includes the Patient Activation Measure Tool. Include an “Authorization To Release Information” form as well and a pre-paid return envelope with the case manager’s initials written below “Care Management”. Enclose a business card for the member’s convenience.
17. Document a Clinical History Summary and Medication History Note.
- a. Case manager will complete a thorough review of client’s history using information from GHC, UW Health, Dean/St. Mary’s, and Meriter charts. CM can also obtain information about client’s services received in past and present by looking through the Referrals tab and Claims tab. Document information obtained.
 - 1) Select Notes tab. Select New Note. Type Clinical History Summary as Note type. Type “cm clinical” into Smart Text box. Select CM Clinical History Summary. Document information obtained. Type “Clinical History Summary” and date completed in Note Summary box. Accept Note.
 - b. Complete a thorough medication history.
 - 1) Select New Note button. Select Medication History as the note type. Medication History Summary may be copied from patient’s EpiCare Chart.
 - a) Under Chart review, select tab Misc Rpts. Copy the Medication History Summary and paste into the Note. Type “Medication History” and date completed in Note Summary field. Accept Note.
 - c. Accept case record.
18. PAM measurement tool maybe returned via US mail to the case manager in the interim and should be entered into the case record as follows:
- a. Select Notes tab. Select New Note. Choose “CM PAM Survey” as Note Type. Type “cm pam” into Smart Text box. Select CM PAM Survey. Complete the “Patient Activation Measure Tool Questionnaire”. Type CM PAM Survey and date completed in Note Summary. Accept Note
 - b. Give a copy of survey to Administrative Assistant to document and score.
 - c. If after two weeks from sending the PAM Survey, CM has not received results yet, CM to call client and complete PAM over the phone.
 - 1) If member chooses to complete via phone, document as above and print a copy of the completed questions and submit to Administrative Assistant to document and score.
19. Case manager will call member at agreed upon time to complete the Initial Assessment within 30 days and edit the Case Record as follows:
- a. Select Notes, select New Note Button. Choose Note Type “CM Initial Assessment”. In the blank note, type Smart Phrase ‘cminitialassessment’. Complete questions with member. In the summary field, type “CM Initial Assessment” and completed date. Accept Note.
 - b. Set new appointment time with member to follow-up and review proposed care plan. Inform the member that you will take their responses to the questionnaires and draft a care plan. The care plan will be reviewed at the follow-up appointment. Enter this date in the Review Due field on the Summary tab of the Case Record. Accept Case.

20. The case manager will contact the member at the agreed upon time, then create a custom care plan with the member. The Care plan consists of personalized, measurable goals; progress member is making to achieve goals, and barriers which may hamper member from achieving goals. The barriers identified are areas in which the Case Manager provides education, resources, and support in order for member to overcome these and achieve their goals. Once the care plan has been agreed upon between the case manager and the member, the case manager will enter the care plan into the case record as follows:
- a. Select Notes, select New Note Button, and change Note Type to “CM Care Plan”. Choose SmartText ‘CM CARE PLAN’. Complete the Care Plan. In the summary field, type “Initial Care Plan and completed date”.
 - b. Additional goals or new goals for Updated Care Plans can be added using SmartPhrase, “.cmaddgoal”. Each identified goal should have associated barriers to achieving the goal listed. Case Management interventions should focus on steps to remove or reduce these barriers thus making the goal more achievable.
 - c. Offer a copy of the agreed upon Care Plan to the member.
 - d. Send a copy via Case Manager message to PCP and RN Team Coordinator for Staff Model members. For non-staff models, notify member’s Clinic Care Team and discuss involvement; send Care Plan if desired.
 - 1) Under In Basket, Select New Msg. Select “Case Manager”. Type in PCP and RNTC in the “To” box. Subject is “Care Plan.” Select your patient. Write a message to the PCP to notify any changes in member’s care and paste the Care Plan into the note. Select and copy this message. Select Accept button to send message
 - 2) Under Contacts, select “Care Coordination” in contact type. Type “CM MD Message” before date in summary box. Paste Case Manager message. Select Accept.
 - e. Select Patient Care Coordination Note in Patient’s chart under SnapShot tab. At the top of the new screen, again, select Patient Care Coordination Note. Type short note under CM enrollment note stating member’s goals. Select Accept.
 - 1) Example: : Member enrolled in Case Management on 1/7/15. Case Manager: _____ (CM Name) and Phone: _____. Goals: Member is to complete 1 PT appt by ____ (date).
 - f. In Case Summary tab, set priority time to agreed frequency of contact with member. Must be once a month or more frequent.
21. Complete the Life Care Planning questionnaire within 30 days of member opting-in to the CM program. Enter into the case record as follows:
- a. Select Notes tab. Select New Note. Choose “CM Life Care Plan” as Note Type. Type “cm life” into Smart Text box. Select CM Life Care Plan. Complete the “Life Care Plan”. Type CM Life Care Plan and date completed in Note Summary. Accept Note
 - b. If member expresses interest in completing the documents, provide member with GHC website for Honoring Choices. <https://www.ghcscw.com/be-well/health-resources/honoring-choices-wisconsin>.
 - c. If member reports he/she has already completed these documents, encourage member to bring them to their clinic to be scanned into their chart.
22. The following need to be completed by 30 days after acceptance to Case Management:
- a. Enrollment Questionnaire, Clinical History Summary, Medication History, PAM Survey, Life Care Planning Questionnaire, Initial Assessment, Care Plan, Adding self to the Care Team and changing EPIC demographic bar to green, notifying PCP and RN Team Coordinator.
 - b. A letter must be sent to the PCP and RN Team Coordinator when client enrolls into Case Management. A second letter to PCP and RN Team Coordinator must be sent when Care Plan is

established. Additional documentation to the PCP and RN Team Coordinator must be completed when there are changes to the care plan, needing care coordination, and also every month following CM Follow-up with client.

23. A Case Review Due message will appear in the case manager's in-basket approximately 24-72 hours before the due date of the follow-up call to the member. Case Managers can also run a report in their dashboard of upcoming Cases Due within the next 7 days. Lastly, Case Managers may utilize their outlook calendars to set reminders of scheduled appointments and phone calls due.
24. Prior to contacting member monthly, the case manager will conduct and document a chart review of events since last contact. Document this under Contacts tab.
 - a. Select "Chart Review" in Contact type. Type "CM Review" before the date in summary box. Document information. Select Accept.
25. At least once a month, the Case manager will document updates, review medication, assess progress against care plan and create short term goals to demonstrate member's self-management goals that are aligned with the care plan between visits. This is the member self-management plan under QI 5. Document this under Contacts tab.
 - a. Select "Patient Contact" in Contact type. Type "CM Follow Up" before the date in summary box. Use Smart Phrase .cmfollowup. Complete the documentation. Select Accept.
 - b. After each of these contacts with the member, the Case Manager will send a Case Manager message to the PCP and Care Team to notify of any changes in the care plan, updates in medications, and other pertinent information the clinical team needs to be aware of.
26. The Case Manager will complete Medication Reconciliations with member as needed.
 - a. The CM will check medications during the initial assessment and ongoing contacts. The case manager will provide education from Web MD, an URAC Accreditation website. CM will document this under Notes.
 - 1) Select New Note button. Select "CM Medication Review" as the note type. Use the smart phrase '.cmmedreview.' Complete the documentation. If there is a discrepancy in the medication list and member's report, contact the member's Care Team via Case Manager Message or Phone to report changes. Document this contact under Contacts tab as "Care Coordination".
27. After each contact with the member, the case manager will set a new appointment time with the member to follow-up at an agreed upon time. This is entered under the Case Summary tab.
 - a. Under Review Due field, select next date. Select Review & Accept button. Member contacts are determined between the Case Manager and the member but must occur at least monthly with care plan modifications made as needed or at least every three months.
28. At least every 90 days, a Case Review must be completed with client.
 - a. Call client on agreed upon time. Discuss goals (new, completed, and no longer relevant) and progress of goals. Document this under the Contacts tab.
 - 1) Select Case Review in contact type. Type "Case Review" before date in summary box. Type smart phrase ".cmcasereview." Complete documentation. Select Accept.
 - b. When a Case Review is completed with client, there is no need for a CM Follow Up that month.

29. Update Care Plan as needed, but must be done at least every 90 days (in conjunction with Case Review). Document under Notes tab.
 - a. Copy the previous plan. Choose Add Note, and then select “CM Care Plan Update” as type. Paste care plan into note. Edit the fields as necessary including changing the date of the plan. The case manager may add new goals with smartphrase “.cmaddgoal.” Type “Updated Care Plan” and date in the Summary box. Accept note.
30. Inpatient Admissions sometimes occur while a member is being actively case managed.
 - a. The Case Manager should assist the UM RN and Inpatient Discharge Planner with coordinating care as needed including discharge planning with family or assisting with identifying community resources to be put in place upon discharge.
 - b. The Case Manager will follow-up 0-72 hours after discharge to complete a follow-up phone call with member indicating medication changes, assess progress, and coordinate discharge recommendations. Document this under Contacts.
 - c. A Case Manager message should be sent to the PCP and Care Team if further orders or referrals need to be submitted or reviewed.
31. When member is approaching discharge from Case Management, CM will provide member with a PAM survey. Review survey with member to note areas where further assistance may still be needed. If there are areas identified requiring additional attention, then discuss with member to keep case open to focus on these areas.
32. The case manager will close (dis-enroll) a case record when a member is eligible for discharge from the Complex Case Management program as outlined in the GHC-SCW Complex Case Management Program Description. The following entries will be made to the case record prior to closure of the record:
 - a. Create a new Contact in the Contacts tab. Select Patient Contact as type. Type “Patient Contact” before date in summary box. Document the conversation discussing closure with the member in contacts. Select accept.
 - b. Update the Care Plan to show achievement of goals or rationale for closing prior to completion of goals. Document this under notes as “CM Updated Care Plan.”
 - c. Notify PCP and RNTC via Case Manager Message that member has been dis-enrolled from case management. Copy and paste this message in a “Care Coordination” Contact.
 - d. Complete PAM survey with member under the Note tab in Case. Print a copy of completed PAM survey and submit to Care Management Administrative Assistant for record keeping.
 - e. If the patient has expired, the case manager will send a Complex Case Management Condolence card to the member’s family at the address on the member record.
 - f. For all other categories of disenrollment aside from patient’s expiration, the case manager will write a Case Review Note stating why the case is being closed.
 - 1) Under contacts, select “Case Review” as type. Type “Case Review” before date in summary box. Use Smart Text .cmcasereview and complete areas noting completion of goals and reasoning why case is being closed.
 - g. Select the Notes tab, select New Note, select note type “letter”, Choose SmartText “CM DISENROLLMENT LETTER” and complete all *** variables in the letter. Personalize as needed. Select Print Text onto GHC-SCW letterhead. Accept Note.
 - h. Enclose CCM Patient Satisfaction Survey with disenrollment letter, and place letter in mail. Have letter and Satisfaction survey translated if necessary.
 - i. Select the Summary tab and click Close Case. Select Review and Accept

- j. In the Member's chart, under Snap Shot, select box titled "Patient Care Team." Then choose "X-END" button next to your name on the Care Team. Select Close.
 - k. Under Patient Care Coordination Note, edit note to state why CM is closing case.
 - 1) For example: CM Case is closed on 5/1/15 due to lost to follow up.
 - 2) CM Case is closed on 5/1/15 due to member entering hospice care (or loss of insurance)
 - 3) CM Case Closed on 5/1/15 due to member's goals being completed/obtained.
 - l. Go to Member Inquiry for patient. Under Patient types, delete 'Case Managed.' Select Accept button.
33. If, at any time during the Complex Case Management process, a case manager is unable to contact a member at a scheduled follow-up time, the case manager will make two more attempts to reach the member within 2 weeks using the following schedule:
- a. Day 1: Call client. Leave voicemail. Document this under the Contact tab.
 - 1) Select "Phone Message" as Contact type. Type "Phone Message" before date in summary box. Document what was said on voicemail. Document a letter has been sent to member.
 - 2) Select Case Summary tab. Select Review Date as 4 days from this date.
 - b. Day 4: Call client. Leave voicemail. Document this under the Contact tab.
 - 1) Select "Phone Message" as Contact type. Type "Phone Message" before date in summary box. Document what was said on voicemail.
 - 2) Select Notes tab. Select New Note. Select Letter at type. Use Smart Phrase .cmcontactorcloselatter. Complete the phone number extensions and e-mail address. Type "Contact or Close Letter" and date in summary box. Select Print text button. Select Accept.
 - 3) Select Case summary tab. Select Review date as 7 days from this date.
 - c. Day 11: Call client. Leave voicemail. Document this under the Contact tab.
 - 1) Select "Phone Message" as Contact type. Type "Phone Message" before date in summary box. Document what was said on voicemail. Document a letter has been sent to member.
 - 2) Select Case Summary tab. Select Review Date as 3 days from this date.
 - d. Day 14: Close Case using the following steps:
 - 1) Under contacts, select "Case Review" in Contact type. Type "Case Review" before date in Summary box. Document "Member has not been able to be reached and therefore the case will be closed."
 - 2) Under the Summary tab, change case type to 'Lost to Follow Up.' Select Close Case. Select Review and Accept
 - 3) Under Note tab. Select New Note. Select Letter as type. Use Smart Text "CM Disenrollment Letter." Complete the information indicating why member is being disenrolled from CM. Accept Note. Print Text.
 - 4) Select Patient Care Coordination Note in Patient's chart under SnapShot tab. At the top of the new screen, again, select Patient Care Coordination Note. Type short note stating member was lost to follow up. Select Accept.
 - a) Example: Member was referred to CM Services on 1/1/15. CM ____ (name) unable to locate member through multiple PC and Letter attempts. CM Case Closed 4/16/15.

APPENDIX D CM.039 ATTACHMENT

Contacts Types:

- 1) Care Coordination: Includes Consult with clinics, doctors, specialists and nurses; Consult with community resources; consult with vendors; Consult with family
- 2) Messages: My Chart messages, email messages, staff messages, Case Manager messages
- 3) Phone message: When patient leaves the CM a message or any message the CM leaves for patient. Also used for vendors and providers
- 4) Chart Review: To be used prior to every patient contact to summarize patient care that has transpired but especially for determining eligibility for Case Management.
- 5) Patient Contact: For telephone, face to face visits with the patient (ie inpatient or at doctor's office). Use the .cmfollowup template as a guide to documentation (Required monthly).
- 6) Case Review: To document discussion of goals and their progress or lack thereof. Should be done once every 90 days when doing Case review note and when closing case.
- 7) Offer of Case Management: Use the .cmscript and tweak to demonstrate when member accepts or declines Case Management Services.

Contact Summary Types:

- 1) CM Request: use with message or order asking for case management
- 2) CM Decision: use for initial chart review for determining if member meets criteria for Case Management.
- 3) CM Offer: Use with the "Offer of Case Management" contact (Use .cmscript)
- 4) CM F/U: Use for monthly review with patient (Use .cmfollowup)
- 5) CM MD Message: Use when sending Case Manager message to MD re: member

Note Types:

- 1) Letter: Enrollment, disenrollment, Second attempt to Contact, Contact or Close and any other letter that is mailed out to the member by the CM. Document in the summary tab description of letter.
- 2) Clinical History Summary: Use the CM Clinical History Summary from "smart text field".
- 3) CM Care Plan: Initial Care Plan. Include measurable goals, barriers and be sure to make patient centered. Use patient name as a standard practice. List time frame for goal completion. Must be measurable.
- 4) CM Care Plan Update: Copy in old care plan and tweak as needed. Update goals, identify new barriers and summarize member progress. Document date updated
- 5) Medication History: This information can be obtained from the chart, McKesson and from member. This should include even discontinued medications.
- 6) CM Medication Review: To be used when member has had medications changed or when reviewing medications with member. Use smart phrase to complete.
- 7) CM Initial Assessment: Use smart phrase. If unable to complete at one sitting can place in contacts and when completed transfer to notes for time/date stamping purposes.
- 8) CM Enrollment: Enrollment to Case Management questionnaire. To be completed after member has been contacted to offer case management. Must be done same day as Offer of Case Management Contact.

- 9) CM Life Care Plan: To be completed within thirty days of opting in to Case Management. Refer member for assistance if needed to complete forms.
- 10) CM PAM survey: Filled out when case is opened and when case is closing. Turn in to Melissa Frick and let her know if it is an opening or a closing survey.
- 11) CM MH ENROLLMENT: Enrollment to Mental Health Case Management questionnaire. To be completed after member has been contacted to offer case management. Must be done same day as Offer of Case Management Contact.
- 12) CM SUD ENROLLMENT: Enrollment to Substance Abuse Case Management questionnaire. To be completed after member has been contacted to offer case management. Must be done same day as Offer of Case Management Contact
- 13) General: Anything that does not fit anywhere else. Good use of this is for listing contact information such as numbers and names of people on care team. Use summary tab to identify the contents of the general tab note.

Smart Phrases:

- 1) .cmmedreview
- 2) .cmfollowup
- 3) .cminitialassessment
- 4) .cmaddgoal
- 5) .cmscript
- 6) .cmsecondoffer or .cmsecondoffersp or .cmsecondofferpg (for Spanish or pregnant members)
- 7) .cmcontactorcloselatter
- 8) .cmcasereview

Smart Texts:

- 1) CM ENROLLMENT LETTER
- 2) CM DISENROLLMENT LETTER
- 3) CM CARE PLAN
- 4) CM CLINICAL HISTORY SUMMARY
- 5) CM ENROLLMENT
- 6) CM LIFE CARE PLAN
- 7) CM PAM SURVEY
- 8) CM MH ENROLLMENT
- 9) CM SUD ENROLLMENT

Smart Links:

- 1) .me (adds in your name)
- 2) T+30 (in date field adds date of 30 days from today)
- 3) .name (adds member full name)
- 4) .fname (brings in patient first name)
- 5) .meds (for current medications)

APPENDIX E
PRENATAL CASE MANAGEMENT PROCESS

- A. Goal of Prenatal Case Management
 - a. To assist GHC-SCW prenatal clients to deliver full-term babies without complications, thus, decreasing the likelihood of NICU admissions and decrease in insurance cost
- B. Who will be called/referred
 - a. Any member who is being followed by Perinatology at St. Mary's
 - b. Any member who is being followed by UW OBGYN or GHC-SCW with the following circumstances:
 - i. Drug or ETOH usage during pregnancy
 - ii. HTN, prenatally or preeclampsia
 - iii. History of fetal abnormality/demise
 - iv. Psychological issues
 - v. Chronic illness
 - vi. Multiple births
 - vii. Heavily noncompliant with appointments/follow-up
 - viii. To Case Manager's discretion
- C. How Case Managers will receive referrals
 - a. Check in-patient hospital list daily
 - b. Receive print-out of members who tested pregnant monthly
 - c. MD or UR referrals
- D. Case Management follow-up
 - a. Once receive referral, will have 30 days to reach out and have member accept services
 - b. Once member accepts services, Case Manager will follow Case Management policies/protocols for managing members throughout pregnancy (ie. f/u intervals, documentation...)
 - c. Once mother delivers baby, Case Management will continue to follow-up with member until their 6 week appt with OBGYN to assure birth control and other common health concerns have been addressed. At this time, Case Management will close the case unless one of the following:
 - i. Member is Diabetic and needs f/u with PCP
 - ii. Member has Post-partum depression or other physical/mental need
 - iii. Infant needs Case Management – New case will be opened for infant

APPENDIX F
NICU/Premature Babies Case Management Process

- A. Goal of NICU/Premature Babies Case Management
 - a. To assist GHC-SCW parents of premature/NICU admission babies to decrease complications following stay in NICU by coordinating services and assist with accessing resources
- B. Who will be called/referred
 - a. All infants born under the age of 32 weeks gestation
 - b. Any infant born between 32 and 40+ weeks gestation will be reviewed for the following circumstances:
 - i. Uncontrolled hypoglycemia
 - ii. Respiratory distress syndrome requiring respiratory management >24 hours
 - iii. Diagnosis of SGA or IUGR
 - iv. Congenital anomalies
 - v. Feeding abnormalities
 - vi. Consistent hypothermia >24 hours
 - vii. Sepsis
 - viii. Isoimmunizations/hyperbilirubinemia not resolved by phototherapy
 - ix. Neurological disorders
 - x. To Case Manager's discretion
 - c. Any infant born to a mother known for drug abuse or any infant whom tested positive for drugs/alcohol
 - d. Any infant born who sustained a traumatic birth injury
- C. How Case Managers will receive referrals
 - a. Check in-patient hospital list daily
 - b. Receive NICU weekly D/C list
 - c. MD or UR Referrals
- D. Case Management follow-up
 - a. Once receive referral, will have 30 days to reach out and have member accept services
 - b. Once member accepts services, Case Manager will follow Case Management policies/protocols for managing members (ie. f/u intervals, documentation, coordinating with outside agencies...)
 - c. Case Manager will address or discuss with family mental health needs for coping with situation of baby in NICU and provide assistance and referrals as needed
 - d. Case Manager will follow baby until:
 - i. Family is no longer interested in program
 - ii. Family is lost to follow-up
 - iii. Baby has achieved care plan goals

**APPENDIX G
SECOND METHOD TO CONTACT LETTER**

DATE

MEMBER NAME
ADDRESS

Dear Member

I have been trying to contact you by phone about the Case Management program at Group Health Cooperative, but have been unsuccessful. Our program is free and voluntary for any of our members. Areas which a Case Manager may be able to help you with would be:

- Connecting to resources in the community that may be able to assist with medical bills, co-pays, support, and assistance.
- Assisting you with communicating your family's needs and questions to your health care team.
- Helping you understand changes in your care.
- Interacting and consulting with other members of your healthcare team (specialists, helping to find a PCP at GHC, therapies, etc.)
- Helping to explain options related to treatment
- Evaluating the effectiveness of any pain and symptom management to make sure you are comfortable
- Evaluating any needs for home health and medical equipment when necessary
- Providing your family with self-management support and education
- Providing education related to your disease, treatment, medications, and self-care.

Here is a link to the Case Management Society of America's website which discusses what Case Management involves nationally.

<http://www.cmsa.org/Consumer/FindaCaseManager/WhatisaCaseManager/tabid/276/Default.aspx>

I hope this information is helpful to you. If you have any further questions, please do not hesitate to e-mail or call me. Both my e-mail and voicemail are confidential and no one else will see/hear it besides me. I can be reached Monday-Friday, 8 a.m. to 5 p.m. at 608-662-4982. If I do not hear from you, I will try calling you next week.

Best Regards,

Case Manager's Name
Case Manager
Group Health Cooperative of South Central Wisconsin
Phone Number
E-mail address

APPENDIX H
SECOND METHOD TO CONTACT - SPANISH

Estimado MEMBER,

He intentado ponerme en contacto con usted sobre el programa *Case Management* (Manejo de Casos) aquí en Group Health Cooperative, pero no he tenido éxito. Todos los miembros de nuestra cooperativa pueden usar este programa voluntario y sin costo. Puede que un asesor en este programa le ayude con los siguientes asuntos:

- Conectándole con recursos comunitarios que tal vez le ayudarán con cuentas médicas, co-pagos, apoyo y asistencia.
- Ayudándole a comunicar con su equipo de atención médica sobre las necesidades de su familia y sus preguntas.
- Ayudándole a entender cambios en su atención médica.
- Interactuando y consultando con otros miembros de su equipo de atención médica sobre atención por especialistas, ayuda para escoger un proveedor de atención primaria, terapias etc.
- Explicando las opciones relacionadas con el tratamiento.
- Evaluando la eficacia del manejo de dolores y síntomas a fin de asegurar su comodidad.
- Evaluando sus necesidades con respecto al equipo médico y equipo médico en casa, según sea necesario.
- Entregándole apoyo y educación para ayudarle a manejar su propia salud.
- Entregándole educación sobre su enfermedad, tratamiento, medicamentos y maneras de cuidarse.

Encontrará abajo el enlace al sitio de web de la *Case Management Society of America* (solamente disponible en inglés). Este sitio explica en qué consiste *Case Management* (Manejo de Casos) a nivel nacional.

<http://www.cmsa.org/Consumer/FindaCaseManager/WhatisaCaseManager/tabid/276/Default.aspx>

Espero que esta información sea útil para usted. Si tiene más preguntas, no dude en enviarme un correo electrónico o llamarme. Tanto mi correo electrónico como mi sistema de mensajes de voz son confidenciales y ninguna persona excepto yo verá o escuchará su mensaje. Usted puede ponerse en contacto conmigo de lunes a viernes, 8:00 am-5:00 pm, al 608-662-****. Si no nos ponemos en contacto antes, intentaré llamarle la semana que viene.

Atentamente,

CM NAME

Asesora de Casos

Group Health Cooperative of South Central Wisconsin

Teléfono:

APPENDIX I
SECOND METHOD TO CONTACT – PREGNANCY

DATE

MEMBER NAME
MEMBER ADDRESS

Dear MEMBER,

I have been trying to contact you by phone about the Case Management program at Group Health Cooperative, but have been unsuccessful. Our program is free and voluntary for any of our members. Areas which a Case Manager may be able to help you with would be:

- Providing education related to your pregnancy, labor and delivery, medications, and self-care.
- Assisting with needs after delivery such as coordinating care of newborn if needed
- Connecting to resources in the community that may be able to assist with medical bills, co-pays, support, and assistance.
- Assisting you with communicating your needs and questions to your health care team (PCP, OBGYN, specialists).
- Helping you understand changes in your care.
- Interacting and consulting with other members of your healthcare team (specialists, helping to find a PCP at GHC, therapies, etc.)
- Helping to explain options related to testing, treatment, labor and delivery
- Evaluating any needs for home health and medical equipment when necessary
- Providing your family with self-management support and education

Below is a link to the Case Management Society of America's website which discusses what Case Management involves nationally.

<http://www.cmsa.org/Consumer/FindaCaseManager/WhatisaCaseManager/tabid/276/Default.aspx>

I hope this information is helpful to you. If you have any further questions, please do not hesitate to e-mail or call me. Both my e-mail and voicemail are confidential and no one else will see/hear it besides me. I can be reached Monday-Friday, 8 a.m. to 5 p.m. at 608-662-EXT. If I do not hear from you, I will try calling you next week.

Best Regards,

CASE MANAGER
Case Manager
Group Health Cooperative of South Central Wisconsin
608-662-EXT
****@ghcscw.com

APPENDIX J
OFFER OF CASE MANAGEMENT SCRIPT

Spoke to (Member Name) and explained case management in the following way:

The Case Management Program serves members who have complex medical and/or mental health needs by assigning a Case Manager to provide additional support and help with coordination of your medical care.

As your Case Manager I would work with you and your health care team in a variety of ways, for example:

- *Assisting you with communicating your needs and questions to your health care team.*
- *Helping you understand changes in your care.*
- *Interacting and consulting with other members of your healthcare team*
- *Helping to explain options related to treatment*
- *Evaluating the effectiveness of any pain and symptom management to make sure you are comfortable*
- *Discussing advanced care planning with you and your family/caregivers*
- *Evaluating your need for home health and medical equipment when necessary*
- *Providing you with self-management support and education*
- *Providing education related to your disease, treatment, medications, and self-care.*

Participation in the Case Management Program is free and voluntary. You or your family members may stop the program at any time.

As your Case Manager, I will contact you several times over the next few months. Our first meeting will be for an initial one hour assessment. During our subsequent telephone interviews, we will discuss your current medical concerns. I will work with you, your family members and your physician to develop a personalized care plan which would include short and long term goals. This personalized care plan will provide you and your family with resources and options based on your needs, and assist you in making informed healthcare decisions. I will continue to contact you periodically to update your care plan, provide educational and social support to you and your family and answer any questions you may have about your care plan.

Based on the program as described, (Member Name) ***is/is not*** interested in participating in this program.

Agreed to speak on *** date/time *** for completion of initial assessment.

APPENDIX K ENROLLMENT QUESTIONNAIRES

Enrollment to Case Management

Member must meet criteria #1 or at least 2 items under criteria #2.

1. **Does Member have an Acute Life Threatening Illness?** (YES or NO)
2. **What alternative criteria does member meet for case management?** (>2 Hospitalizations in 6 months, >2 Specialists involved in Patient Care, >3 ED visits in 6 months, None)

Is the member in a hospice setting? (YES or NO)

Is the member a fee for service patient? (YES or NO)

Is the member competent to consent to case management? (YES or NO)

Have you reviewed the risks and benefits of case management? (YES or NO)

Has the patient opted into case management? (YES or NO)

Enrollment to Mental Health Case Management

Member must meet criteria #1 or #2 or any of #3

1. **Does member have acute dx of psychosis, schizophrenia or autism?** (YES or NO)
2. **Was member readmitted for Inpatient Mental Health within 30 days?** (YES or NO)
3. **What alternate criteria does member meet for Case Management (Mark all that apply - must meet all 3 for MH CM)?** (2 or more ER visits in 6 months, 2 or more hospitalizations in 12 months, Condition impacts ability to perform ADLs, None)

Is the member in a hospice setting (If member answers yes - not eligible for Case Mgmt)? (YES or NO)

Is the member a fee for service patient (If member answers yes - not eligible for Case Mgmt)? (YES or NO)

Is the member competent to consent to case management (Member is not competent if durable POA active)? (YES or NO)

Have you reviewed the risks and benefits of case management? (YES or NO)

Has the patient opted in to case management? (YES or NO)

Enrollment to Substance Abuse Disorder Case Management

1. **Does member have an Acute Life Threatening Illness?** (YES or NO)
2. **Does the member meet criteria for SUD Case Management (Mark all that apply - must meet 3 to qualify for CM)?** (2 or more ER visits in 6 months, 2 or more hospitalizations in 6 months, Axis IV condition present, Dx of substance abuse or dependence, Utilizing external SUD services)

Is the member in a hospice setting (If member answers yes - not eligible for Case Mgmt)? (YES or NO)

Is the member a fee for service patient (If member answers yes - not eligible for Case Mgmt)? (YES or NO)

Is the member competent to consent to case management (Member is not competent if durable POA active)? (YES or NO)

Have you reviewed the risks and benefits of case management? (YES or NO)

Has the patient opted in to case management? (YES or NO)

APPENDIX L
CM ENROLLMENT LETTER

Dear Member:

It was a pleasure speaking with you regarding our case management program here at Group Health Cooperative of South Central Wisconsin.

As we discussed during our phone conversation, my role as a case manager is to work collaboratively with you and your health care team to coordinate and obtain the most appropriate health care services. This program is both free and voluntary.

I look forward to talking with you further during our next phone contact which we agreed would be on "Day", "Date" at "Time". The purpose of that call will be to become better acquainted which will then assist us to develop a personalized care plan with goals designed to meet your specific health care needs. After that assessment, I will continue to contact you periodically to check in, coordinate care as needed, assist with resources and provide support for you.

Prior to our next phone conversation there are a couple forms I would like for you to complete.

- 1) GHC-SCW adheres to Federal guidelines related to release of medical information to family members, guardians and or caretakers. Please identify who you give permission for the case manager to release medical information to, and then put their name and contact information on the enclosed **Authorization to Release Medical Information** form.
- 2) The **Patient Activation Measure (PAM)** is a tool we use to assist us in identifying which areas of your healthcare where you may need additional information. There is no right or wrong answer so please fill this out as honestly as you can.

Upon completion please return both forms in the enclosed postage paid envelope. If you desire, the PAM can be completed over the phone to help with any questions you may have.

If you have any concerns about this or have any issues to discuss, please call me at (608) 662-XXXX between the hours of 8:00 AM to 5:00 PM. Enclosed is a copy of my business card for your convenience.

Sincerely,

CM Name
Case Manager

Enclosures:
PAM Survey
Release of Information Authorization Form
Case Manager Business Card

**APPENDIX M
PAM SURVEY**

PATIENT ACTIVATION SURVEY

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think others want you to say.

If the statement does not apply to you, circle N/A.

1. When all is said and done, I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2. Taking an active role in my own health care is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3. I am confident I can help prevent or reduce problems associated with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4. I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5. I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6. I am confident that I can tell a doctor concerns I have even when he or she does not ask	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7. I am confident that I can follow through on medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8. I understand my health problems and what causes them	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9. I know what treatments are available for my health problems	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10. I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
11. I know how to prevent problems with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
12. I am confident I can figure out solutions when new problems arise with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
13. I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

APPENDIX O
CLINICAL HISTORY SUMMARY, MEDICATION HISTORY, MEDICATION REVIEW

CLINICAL HISTORY SUMMARY:

Referral Source Type: (OPTIONS: Health Information Line, Disease Management Referral, Discharge Planner Referral, UM Referral, Member or Caregiver Referral, Practitioner Referral, Data Report, McKesson Risk Manager)

Clinical History Summary:

1. **Disease Onset:** ***
2. **Key Events:** ***
3. **Treatment or procedures previously done:** ***

Completed By: Case Manager's Name

MEDICATION HISTORY:

Document medication information obtained from the EpicCare Chart Medication History Summary Report or information obtained from Non-GHC EPIC users (St. Mary's, UW, Meriter). Include all medications member is currently taking and ones which have been discontinued.

MEDICATION REVIEW (.cmmedreview)

Name of Medication:

Purpose of the medication and how it will help Member's health:

How often med should be taken:

What time of day to take this medication:

Problems with following prescribed treatment (cost, education, member's lifestyle etc):

What side effects to watch for:

Precautions to take:

When to call my doctor:

**APPENDIX P
INITIAL ASSESSMENT**

Initial Clinical Assessment

1. Verify member demographics to ensure all data is current and correct.

Verified: {YES/NO :15728}

If yes, send updated information to Member Services

2. Obtain permission from member to interview for assessment: {YES/NO :15728}

Current health problems (Factor 1)

1. What are your current health concerns?

Current Health problems: DIABETES-

Lowering A1C to below or around 7% has been shown to reduce microvascular complications of diabetes and, if implemented soon after the diagnosis of diabetes, is associated with long-term reduction in macrovascular disease.

Is your most recent A1C below 7%? {YES/NO :15728} Current level: ***

Guidelines suggest that adults should perform muscle-strengthening activities that involve all major muscle groups > 2 days/week.

Do you partake in any doctor approved exercise? {YES/NO :15728}

How often would you say you exercise? ***

Epidemiological analyses show that a blood pressure >115/75 mmHg is associated with increased cardiovascular event rates and mortality in individuals with diabetes.

Is your current BP above 115/75? {YES/NO :15728}

Current B/P: ***

Guidelines indicate that diabetic clients should have LDL cholesterol <100 mg/dL.

Is your current LDL below 100 mg/dl? {YES/NO :15728}

Current LDL: ***

For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations.

Have you ever had your feet screened by a doctor? {YES/NO :15728}

Do you have any issues with your feet? {YES/NO :15728}

-If yes, what? {N/A or other:13656::"N/A"}

Do you need a screening scheduled? {YES/NO :15728}

Patient's with diabetes should have an annual comprehensive eye examination by an ophthalmologist or optometrist.

Have you had an eye exam in the last year? {YES/NO :15728}

Do you have any issues with your eyes? {YES/NO :15728}

If yes, please describe: {N/A or other:13656::"N/A"}

A patient-centered approach should be used to guide choice of pharmacological agents. Considerations include efficacy, cost, potential side effects, effects on weight, comorbidities, hypoglycemia risk, and patient preferences.

Can you tell me what diabetic medications you are currently taking? {YES/NO :15728}

If yes, what? {N/A or other:13656::"N/A"}

Are you taking insulin? {YES/NO :15728}

If yes, type and method of delivery: {N/A or other:13656::"N/A"}

Nutrition therapy is recommended for all people with type 1 and type 2 diabetes as an effective component of the overall treatment plan.

Have you ever met with a Registered Nutritionist to discuss your diabetes? {YES/NO :15728}

Are you on a diabetic diet? {YES/NO :15728}

If yes, please explain:

What is your current weight? ***

Do you weigh yourself regularly? {YES/NO :15728}

How often do you weigh yourself? Daily, weekly? ***

Current Health Problems: CARDIAC-

Do you have a blood pressure below 140/90? {YES/NO :15728}

What is current level? ***

Diuretic-based antihypertensive therapy has been shown to prevent Heart Failure in a wide range of target populations. ACE inhibitors and beta blockers are also effective in the prevention of Heart Failure.

Are you currently taking any medications for Heart Failure? {YES/NO :15728}
If yes, can you tell me the names of your heart medications? {N/A or other:13656::"N/A"}

Because sodium intake is typically high in the general population, clinicians should consider some degree (eg, <3 g/d) of sodium restriction in patients with CHF for symptom improvement.

Have you met with a Registered Nutritionist to discuss sodium restrictions? {YES/NO :15728}

Are you currently on a sodium restricted diet (DASH diet)? {YES/NO :15728}

Exercise training in patients with Heart Failure is safe and has numerous benefits.

Do you participate in any physician endorsed exercise at least 2 times weekly? {YES/NO :15728}

It is critical that patients are involved with self-care to improve overall successful outcomes.

Do you understand the following self-care concepts and when to call your physician? Edema/Water weight? {YES/NO :15728}
Shortness of breath? {YES/NO :15728}
The importance of weighing yourself every day and reporting any weight fluctuations that occur to your physician? {YES/NO :15728}

Current Health Problems: COPD-

A history of smoking is the most common risk factor for developing COPD.

Are you a current smoker? {YES/NO :15728}
If yes, how much daily: {N/A or other:13656::"N/A"}

Were you a smoker in the past? {YES/NO :15728}
If yes, how much: {N/A or other:13656::"N/A"}

Pharmacological Therapy is used to reduce symptoms, exacerbations, and improve health status.

Are you currently taking any medications for the treatment of COPD or Asthma? {YES/NO :15728}
If yes, what medication/doses? {N/A or other:13656::"N/A"}

Are you using any oxygen therapy? {YES/NO :15728}
If yes, dose: {N/A or other:13656::"N/A"}

Exercise is beneficial to COPD patients to improve quality of life.

Do you participate in any form of exercise as approved by care provider? {YES/NO :15728}

Clinical guidelines state to take an Asthma Control Test (ACT) one time per year.

When was the last time you took an ACT? ***

Active identification and elimination of risk factor exposure is important at all stages of COPD

How much can you do before you get short of breath? (ex. such as walking up flights of stairs, up a hill, or on flat ground.) ***

Have you noticed your symptoms worsen with different triggers (illness, weather, activity, smoke, stress, anxiety...)? {YES/NO :15728}

If yes, explain:

Symptom distress (exacerbation) is strongly correlated with impaired quality of life

What are your symptoms of exacerbation (increased SOB, wheezing, chest tightness, cough)? ***

What things do you do that help to relieve your symptoms? ***

Current Health Problems: CANCER-

Tell me what you know about the type of cancer you have: ***

Are you currently receiving chemotherapy? {YES/NO :15728}

If yes, what medications are you taking and how much and how frequently do you take them? {N/A or other:13656::"N/A"}

If no, did you receive chemo in the past and when was the last time you received chemo? {N/A or other:13656::"N/A"}

Are you having any complications related to this therapy? {YES/NO :15728}

If yes, explain? {N/A or other:13656::"N/A"}

Radiation therapy is a common treatment regimen that can improve outcomes for patients with many cancers types.

Are you currently receiving radiation therapy? {Yes, No:16267}

There is a whole range of medications depending on the cancer type that can improve patient outcomes when taken correctly.

Are you taking any other medications for cancer? {YES/NO :15728}

If yes, what medication/dose: {N/A or other:13656::"N/A"}

Screening appointments for follow up care are essential to patients with cancer in improving survival rates.

Do you have a follow up screening appointment scheduled? {YES/NO :15728}
If yes, date, time and what kind of screening: {N/A or other:13656: "N/A"}

Adequate pain control is essential in improving quality of life for patients with cancer diagnosis of all types.

Do you participate in a pain management regimen? {YES/NO :15728}
If yes, explain: {N/A or other:13656: "N/A"}

Do you feel your cancer pain is well managed and tolerable? {YES/NO :15728}
If no, explain: {N/A or other:13656: "N/A"}

Current Health Problems: PREGNANCY-

Late prenatal care beginning in the second or third trimester or absence of prenatal care is associated with increased risk of adverse pregnancy outcomes.

When was your first medical appointment for prenatal care? ***
What trimester: ***

Who are you seeing for prenatal care? ***

Medical complications associated with multiple gestations include low birth weight, premature birth, maternal anemia, preeclampsia, placental or umbilical cord problems, and baby's abnormal position in the uterus.

Are you pregnant with more than one baby? {YES/NO :15728}
If so, how many:

Breastfeeding is promoted and supported due to the health benefits to mother and baby. Breastfeeding promotes bonding and protects infants from some infections and allergies.

What are your thoughts about breastfeeding? ***

Illnesses or conditions requiring ongoing medical care is a risk factor for adverse pregnancy outcomes

Have you had any of the following?
Gestational Diabetes: {YES/NO :15728}
Hypertension: {YES/NO :15728}
Fetal Demise: {YES/NO :15728}
Preterm labor: {YES/NO :15728}
Premature Rupture of Membranes: {YES/NO :15728}

Is there anything I have not mentioned that has affected your previous pregnancies? {YES/NO :15728}

A history of preterm delivery is a major risk factor for preterm birth and other adverse pregnancy outcomes.

Have you had a premature baby? {YES/NO :15728}

If yes, gestational age:

What, if any medical concerns did your premature baby have? ***

Current Health Problems: DEPRESSION -

Tell me about your history with depression (onset, events, past treatments...): ***

Are you being followed by a counselor or psychiatrist? {YES/NO :15728}

If yes, then who, where, and how often: ***

Side effects can occur with SSRIs, SNRIs, TCSs, MAOIs, and Atypical Antidepressants such as mirtazapine and bupropion, but can be manageable.

What medications have you tried taking for your depression? ***

Which ones have worked/not worked? ***

Are you experiencing side effects of your antidepressant medications (ex. Weight gain, change in appetite or energy)? {YES/NO :15728}

Up to 80% of those treated for depression show an improvement in their symptoms generally within four to six weeks of beginning medication, psychotherapy, attending support groups, or a combination of these treatments

An estimated 50% of unsuccessful treatment for depression is due to medical non-compliance.

Do you feel your medications have adequately addressed your mental health concerns? {YES/NO :15728}

A Balanced diet, exercise, and adequate sleep may increase overall well-being.

Tell me how you have been coping lately. ***

Have you had any thoughts of self-harm? {YES/NO :15728}

If yes, do you have a plan?

Have you had any problems with sleeping, eating, or concentrating? {YES/NO :15728}

If Yes, please describe what your concerns are: ***

2. Additional Health Concerns: NERVOUS SYSTEM, GASTROINTESTINAL SYSTEM, MUSCULAR/SKIN , VASCULAR, RESPIRATORY and OTHER ***

Medications (Factor 2)

1. What medications do you take including any over the counter medications? ***
2. Do these medications match what is in the client's GHC chart? {YES/NO :15728}
CM review chart meds with client: ***

Activities of Daily Living (Factor 3)

1. Are you independent with the following self-care activities? If not, please tell me what assistance you need in these areas:
Bathing? {YES/NO :15728}
Grooming? {YES/NO :15728}
Dressing? {YES/NO :15728}
Toileting? {YES/NO :15728}
Eating? {YES/NO :15728}
Preparing meals? {YES/NO :15728}
Driving? {YES/NO :15728}
Walking? {YES/NO :15728}
Shopping? {YES/NO :15728}
Transferring? {YES/NO :15728}
Frequent falls? {YES/NO :15728}

Behavioral Health Status/Cognitive Function (Factor 4)

1. Do you drink alcohol? {yes alcohol/ no:16236}
2. Do you smoke? {Yes, No:16270}
If yes, how much and for how long: {N/A or other:13656::"N/A"}
3. Do you use any other recreational or non-health care provider prescribed drugs? {yes drugs/ no:16237}
4. Have you ever been treated for substance abuse? {YES/NO :15728}
If yes, when, where, and for what substance: {N/A or other:13656::"N/A"}
5. How would you describe yourself emotionally? ***
6. What is your normal response when faced with a crisis? ***
7. Have you had issues with your mental health in the past (ex. Depression, anxiety...)? {YES/NO :15728}
If yes, please explain:
8. Are you currently seeing a mental health professional? {YES/NO :15728}
If yes, for what, from whom, and how often: {N/A or other:13656::"N/A"}

9. Do you feel that your mental health provider is adequately addressing your needs?{YES/NO :15728}
If no, why: {N/A or other:13656::"N/A"}

10. How is your memory (long term and short term)? ***

11. Do you have any issues expressing your thoughts, communicating with others, or getting your words out? {YES/NO :15728}
If Yes, explain: ***

12. Has anyone ever expressed problems understanding you? {YES/NO :15728}
If Yes, explain: ***

Case Manager Assessment:

1. Is member A&O x4, able to focus and shift attention, comprehends directions? {YES/NO :15728}
If no, explain:

2. Does member require prompting (cuing, repetition, reminders) during phone conversation? {Yes, No:15728}
If yes, please explain: {N/A or other:13656::"N/A"}

3. Does member seem to comprehend conversation and answer appropriately? {Yes, No:15728}
If no, explain: {N/A or other:13656::"N/A"}

Psychosocial (Factor 5)

1. Are you currently working?{YES/NO :15728}
If yes, what/where: {N/A or other:13656::"N/A"}

2. What are your interests or hobbies? ***

3. Are you able to pay all your bills? {YES/NO :15728}

4. Do you have any financial concerns? {Yes, No:16259}

5. Do you have any issues with getting transportation? {YES/NO :15728}
If yes, explain:

6. Are you able to get into the doctor when you need to or able to reach them by phone? {YES/NO :15728}
If no, explain: {N/A or other:13656::"N/A"}

7. What are your beliefs or concerns about your condition or treatment? ***

8. Is there any reason you may not be able to follow the treatment plan your doctor prescribed (ex. Mistrust of the system, med side effects, problems taking meds...)? {YES/NO :15728}

If yes, explain: {N/A or other:13656::"N/A"}

Culture (Factor 6)

1. Are there any specific religious, cultural, or family remedies/beliefs/practices I should be aware of that would help me to better work with you? {YES/NO :15728}

If yes, explain: {N/A or other:13656::"N/A"}

2. Are there any treatment or procedures that are discouraged or not allowed for religious needs? {YES/NO :15728}

If yes, explain: {N/A or other:13656::"N/A"}

3. What is the best way for the health care team to communicate with you? ***

4. Which is easier for you to understand: verbal or written info? ***

5. Do you speak and read English? {YES/NO :15728}

If no, do you prefer using a translator? {YES/NO :15728}

6. What is your preferred language? ***

Visual and Hearing Needs (Factor 7)

1. Is member hearing impaired? {YES/NO :15728}

If yes, what does member do for it?: {N/A or other:13656::"N/A"}

2. Is member visually impaired? {YES/NO :15728}

If yes, what does member do for it?: {N/A or other:13656::"N/A"}

Caregiver Resources and Involvement (Factor 8)

1. Are you a caregiver for an adult or child? {Yes, No:16258}

If yes, explain: {N/A or other:13656::"N/A"}

2. Is there a caregiver who you rely on or do you feel you need a caregiver? {YES/NO :15728}

If yes, explain: {N/A or other:13656::"N/A"}

3. Does the caregiver need training or supportive services? {YES/NO :15728}

If yes, explain: {N/A or other:13656::"N/A"}

4. Who do you consider your support network? ***

Do you feel you need additional support? {YES/NO :15728}

If Yes, what would you find helpful? ***

5. When you have a crisis situation, who do you turn to for help? ***

6. Who do you discuss your health and health care decisions with? ***

7. Do you feel safe in your home? {YES/NO :15728}

If no, explain: {N/A or other:13656::"N/A"}

Evaluation of Available benefits (Factor 9)

1. Who do you see for your primary care provider? ***

2. Do you see any health care specialists? {YES/NO :15728}

If yes, who and where:

3. Are you currently receiving any treatment/complementary medicine for your current health issues?
{YES/NO :15728}

If yes, explain:

4. Do you feel the treatments and physicians have adequately addressed your health issues? {YES/NO :15728}

If No, explain:

5. Is there any testing that you are aware of that your health care provider has ordered for you?
{YES/NO :15728}

If yes, was the testing completed? Where:

6. Are you interested in any outside resources or seeing any additional specialists? {YES/NO :15728}

If yes, explain:

7. Have you ever used any resources or specialists in the past, but are currently ineligible for them?
{YES/NO :15728}

If yes, explain:

8. Is member eligible for any outside resources or specialists? {YES/NO :15728}

If yes, explain:

9. Are these resources/specialists covered by insurance? {YES/NO :15728}

If no, explain:

10. Do you have any issues with pain? {YES/NO :15728}

If yes, are you under any treatment for this condition? {YES/NO :15728}

What do you take or do for pain if no medication is prescribed?***

Evaluation of Community Resources (Factor 10)

1. What community resources is member currently using? ***
2. What community resources could member benefit from? ***
3. Are you or your spouse military veterans? {YES/NO :15728}
If yes, are you receiving any VA benefits? {YES/NO :15728}
4. Have you ever talked to a VA representative to determine your eligibility for benefits? {YES/NO :15728}

Clinical Guidelines:

Cardiac and CHF

[https://ghcscw.com/SiteCollectionDocuments/Clinical Practice Guidelines/8 CPG 2013 ACCAHA Guideline.pdf](https://ghcscw.com/SiteCollectionDocuments/Clinical%20Practice%20Guidelines/8%20CPG%202013%20ACCAHA%20Guideline.pdf)

COPD & Asthma

[http://www.cmsa.org/portals/0/pdf/CMAG COPD.pdf](http://www.cmsa.org/portals/0/pdf/CMAG_COPD.pdf)

[https://ghcscw.com/SiteCollectionDocuments/Clinical Practice Guidelines/1 CPG Asthma Guidelines.pdf](https://ghcscw.com/SiteCollectionDocuments/Clinical%20Practice%20Guidelines/1%20CPG%20Asthma%20Guidelines.pdf)

Cancer

http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

Diabetes

[https://ghcscw.com/SiteCollectionDocuments/Clinical Practice Guidelines/7 CPG Exec Summary Standards Of Care In Diabetes.pdf](https://ghcscw.com/SiteCollectionDocuments/Clinical%20Practice%20Guidelines/7%20CPG%20Exec%20Summary%20Standards%20Of%20Care%20In%20Diabetes.pdf)

Depression

[https://ghcscw.com/SiteCollectionDocuments/Clinical Practice Guidelines/15 CPG Diagnosis Depression.pdf](https://ghcscw.com/SiteCollectionDocuments/Clinical%20Practice%20Guidelines/15%20CPG%20Diagnosis%20Depression.pdf)

[http://www.cmsa.org/portals/0/pdf/CMAG Depression.pdf](http://www.cmsa.org/portals/0/pdf/CMAG_Depression.pdf)

Substance Use

http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf

Pregnancy

<https://www.dhs.wisconsin.gov/forms/f0/f01105a.pdf>

**APPENDIX Q
CARE PLAN**

**Priority 1
Diagnosis:**

Goal	% Complete	Barriers
1.		

Comments:

**Priority 2
Diagnosis:**

Goal	% Complete	Barriers
2.		

Comments:

Care Plan established with member on {DATE} via telephone. Member agrees to expected outcomes of care plan and their related interventions. Member and Case Manager agree to {WEEK/EOW/MONTH} contacts.

**APPENDIX R
MONTHLY FOLLOW UP**

Care Management Follow Up Questionnaire:

Data:

- 1) Review physician appointments and treatment changes
- 2) Medication changes
- 3) New symptoms/problems
- 4) Changes in support systems/housing/transportation
- 5) Member feelings and understanding of health
- 6) Member status toward goal progression

Additional Information:

Recent test results: ***

Assessment:

CM Impression of members understanding

CM Identification of areas to focus on

CM Education provided

CM Medication Review needed (place in notes)

Plan:

- 1) CM agreed upon action plan (include follow up contact date)
- 2) Member self-management plan

**APPENDIX S
CASE REVIEW**

Case Review – Done every three months

Member's existing goals and member's reported progress towards goals:

New goals decided by CM and member:

Goals completed or no longer relevant:

CM's assessment of member's progress towards goals (new and old) and care plan:

**APPENDIX T
DISENROLLMENT LETTER**

DATE

MEMBERS NAME
ADDRESS

Dear @NAME@:

You have been dis-enrolled from the Complex Case Management Program at Group Health Cooperative of South Central Wisconsin (GHC-SCW). The purpose of this letter is to explain that disenrollment occurred because {CM DISENROLLMENT REASONS:14083}.

It has been our sincere pleasure to serve you. If you have any questions or would like to discuss re-enrollment in the program at any time in the future, please contact the GHC-SCW Care Management Department at (608) 257-5294.

The *Patient Satisfaction Survey* is a tool we use to evaluate our Complex Case Management Program at GHC-SCW. Your feedback is an essential part of this process and is helpful for identifying areas where changes and improvements are needed. Would you please complete the enclosed survey and return it in the enclosed postage paid envelope? Thank you in advance for taking the time to offer this valuable feedback. Helping us to improve the Complex Case Management Program benefits everyone and truly makes us “Better Together”.

Sincerely,

@ME@
Case Manager

Enclosures:
CM Program Patient Satisfaction Survey

**APPENDIX U
PATIENT SATISFACTION SURVEY**



Case Management Program Patient Satisfaction Survey

If you would like to receive a copy of this survey in Spanish or Hmong, or would like to receive mail in Spanish or Hmong in the future, please call GHC of South Central Wisconsin's Member Advocate-Bilingual at (608) 661-7215.

Si a usted le interesa obtener una copia de esta encuesta en español, o desea recibir correspondencia en español en el futuro, por favor llame a GHC of South Central Wisconsin al (608) 661-7215.

Yog tias koj xav tau tsab ntawv no sau ua ntawv Hmoob los sis koj xav kom tom ntej no GHC of South Central Wisconsin xa ntawv rau koj no kom sau ua ntawv Hmoob, thov koj hu rau tus txhais lus Chueshee Xiong xov tooj yog (608) 257-9700 extension 1373.

In order to continuously improve the quality of Group Health Cooperative of South Central Wisconsin's Case Management Program, we need your feedback. Please take a few minutes to complete this survey and return it in the enclosed, postage-paid envelope. Your answers are strictly confidential.

Please fill in the circle that is the best response – only one circle per statement.

1. I am the: Member Family Caregiver

2. Do you know your Case Manager's name?
 Yes No Comment:

<u>Select your satisfaction level with the following areas.</u>	<u>Very Dissatisfied</u>	<u>Dissatisfied</u>	<u>Satisfied</u>	<u>Very Satisfied</u>
3. I feel knowledgeable in what my insurance coverage means to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. My Case Manager helped me get the right care I needed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I feel that my goals were heard and understood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. The Case Manager helped me to better understand my medical condition(s).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I was able to reach or get ahold of my Case Manager when needed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I feel better prepared, now that I have worked with a Case Manager, guiding me through the health care system.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How I would rate my overall satisfaction with GHC's Case Management Program?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Any comments I wish to add:

APPENDIX V
REFERRAL FORM



COMPLEX CASE MANAGEMENT REFERRAL FORM

As a GHC-SCW Provider, you may identify a GHC-SCW patient who could benefit from Complex Case Management. With Complex Case Management (CCM), a RN or SW case manager performs an assessment, coordination of resources and ongoing communication with the provider to facilitate quality care and individual treatment plans.

We are presently offering CCM for patients with the following diagnosis:

- | | | |
|--------------|------------------------|------------------------------|
| Diabetes | Cancer | Behavioral Health Conditions |
| CHF | High Risk Pregnancy | Chronic Pain |
| Asthma /COPD | Substance Use Disorder | |

There are many reasons patients are selected by us for CCM; below are a few examples:

- Frequent Hospitalizations
- Frequent Emergency Room or Urgent Care visits
- Medically complex patients

REFERRAL TO COMPLEX CASE MANAGEMENT

FAX TO: 608-662-4910

or

MAIL TO: GHC-SCW Case Management, 1265 John Q. Hammons Dr. Ste.200, Madison, WI 53717-1962

Referral Source: Provider Office Other _____

Referring Source:

Name _____
Telephone Number _____
Fax Number _____

Member:

Name: _____
Telephone Number _____
Date of Birth _____

Referring Physician, NP or PA Name: _____

Reason for Referral: (Please Be Specific)

**APPENDIX W
COMMUNICATION WITH THE CLINICS**

Case Managers receive referrals for Case Management from Utilization Review, Data Reports (UW ER Report, Inpatient Census, McKesson Risk Manager), PCP or Specialists, and Caregivers/members. When a Case Manager opens a case in TRACKING, the Case Manager is reviewing the member’s chart and determining if they meet criteria. During the TRACKING time, the Case Manager is also attempting to contact the member to offer services. This is done through multiple phone calls and letters. The Case Manager has 30 days to reach the member. At this time, the only way to know if a member is being considered for Case Management is the Red “M” on the heading of the Member Inquiry tab.

MRN: 247624 GHCTEST, FRAULEIN	M	DOB: 03/29/1968 Age: 47 year old
----------------------------------	----------	-------------------------------------

The Case Manager attempts to contact the member through multiple phone calls and a letter sent to the member’s home. If the Case Manager does not receive a response from member within the 30 days of being opened in the TRACKING status, member’s case is closed due to lost to follow up. If the member does not wish to participate in Case Management or if the Case Manager cannot reach member, the Case Manager records this under the Patient Care Coordination Note. The Case Manager sends a Case Manager Message to referring source and/or PCP reporting member has declined CM Services or member was unable to be located by CM through multiple attempts.

📄 Patient Care Coordination Note

Jenson, Erica Thu Oct 1, 2015 10:49 AM
Fraulein was offered CM Services on 9/1/15, but decided not to participate. CM Case Closed 9/1/15. - Erica Jenson, RN

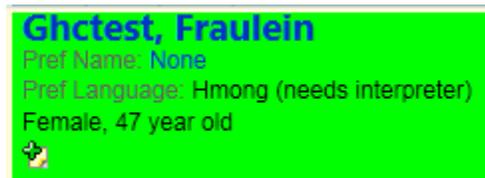
OR

Fraulein was referred to CM Services on 9/1/15. CM Erica Jenson, RN unable to locate member through PC and letter attempts. CM Case Closed 10/1/15.

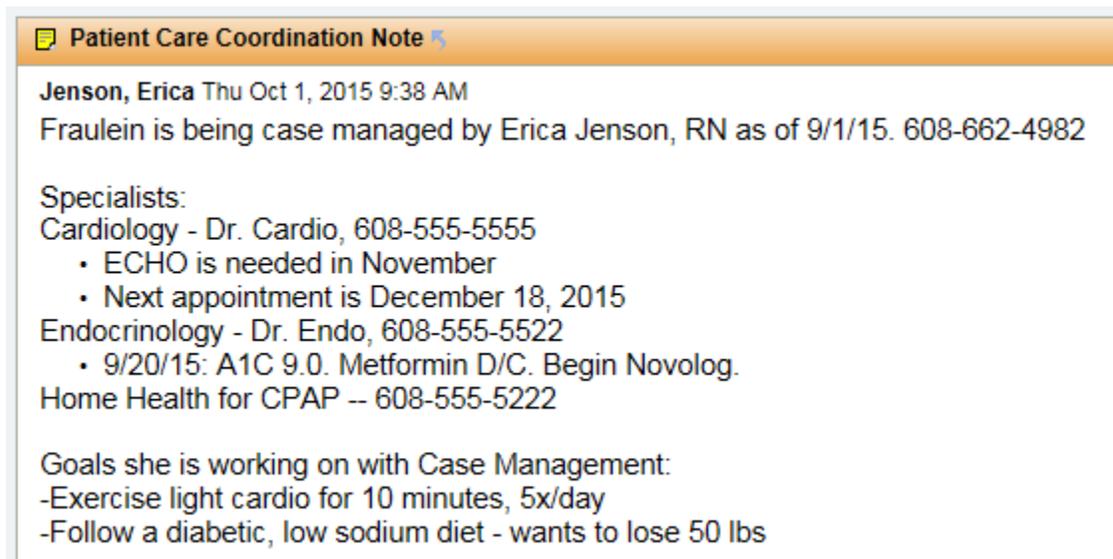
Once contact is made with the member and the member agrees (Opts-In) to Case Management, the Case Manager will add him/herself to the Patient Care Team on the SnapShot of the member’s chart.

⚙️ Patient Care Team	
PCPs	Type
Dowd Pac, Ivy	General
Other Patient Care Team Members	Relationship
Jenson, Erica	GHC Case Manager

The Case Manager will also change the heading of the member's chart to green by adding "Case Managed" to the Patient Types under the Demographics section in the Member Inquiry tab.



Finally, the Case Manager will add their contact information, specialists the member is seeing, care plan goals, and other pertinent information (emergency plans, special instructions...) to the Snapshot under the Patient Care Coordination Note.



After member agrees to Case Management, a Case Manager Message is sent to the member's PCP and RNTC indicating the member has been offered CM Services and has accepted.

The next message sent to the PCP is when the Case Manager and member devise a care plan with set goals. The goals are added to the Patient Care Coordination Note (See above) and a Case Manager Message is sent to the PCP and RNTC.

After each contact with the member, the Case Manager sends a Case Manager message to the PCP and RNTC updating them with pertinent information and updates to the goals. For example, if member's goal is to obtain Comp Med Services for assistance with pain due to a diagnosis of Cancer. The case manager sends a message to the PCP indicating that member has completed this goal and is participating in the Oncology Care Comp Med Program. The Case Manager would also send a message if the opposite: The member has not yet made an appointment for Acupuncture. Can you please address this at the next office visit next week?

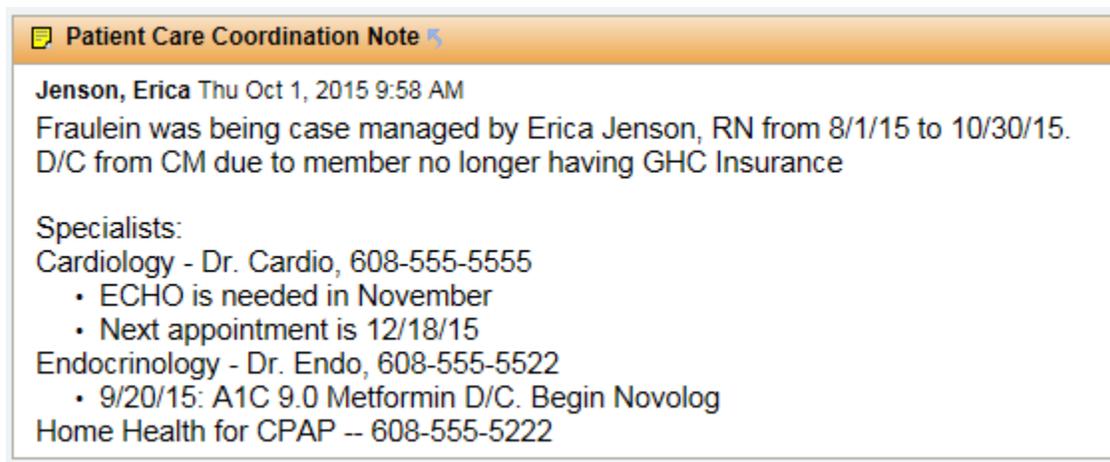
The Case Managers will also receive messages from the PCP and RNTC with requests/information for the Case Manager to follow up on during the next phone conversation with the member. When the Case Manager discusses this request/information with the member, the Case Manager messages the

PCP and RNTC with the information obtained. This communication between the PCP/RNTC/CM is recorded in the Case Manager's notes.

Case Managers also contact the specialists to inform them of the Case Managers involvement in care. This is done through telephone calls. If Case Manager receives a phone call from a specialists with information about the member or a request by the specialist for the PCP/RNTC/CM to follow up on, again, the Case Manager will add it to the Patient Care Coordination Note and send a Case Manager Message to the PCP/RNTC. Again, the coordination of care between specialist, PCP, and CM is recorded in the CM's notes.

If there is a message that the PCP/RNTC receives from the CM, at this time, the PCP/RNTC may record this information under a Tele encounter in the chart so that it is accessible to the care team and for further reference.

When a member has been discharged by Case Management, a Case Manager Message is sent to the PCP and RNTC reporting member has been d/c and the reasoning why (lost to follow up, enrolled in hospice, loss of insurance, met goals...). The Case Manager also reports this on the Patient Care Coordination Note. The Case Manager removes self from Patient Care Team and removes green bar.



When a Key Quality of Care Indicator has occurred, The Care Management department (Case Managers and Utilization Management) immediately contacts Quality Management to notify them of the occurrence.

APPENDIX X QUALITY MANAGEMENT

Quality Management - Key Quality of Care Indicators

The case manager plays a critical role in identifying quality of care issues and helping to avert adverse events whenever possible to promote a successful outcome for the patient.

The following quality of care indicators serve as a guide for the case manager when working with the member and healthcare team, in addition to serving as criteria for tracking and evaluating quality of care issues.

Whenever a quality of care indicator is identified, the case manager refers the case to the Medical Director for review. Further evaluation may include the Peer Review Committee and forwarding to the appropriate Quality Directors of Hospitals or Health Care Facilities.

Key Quality of Care Indicators:

Adverse Events: An Adverse Event is an untoward event with a less-than-optimal outcome.

- a. Unplanned hospital readmission within 10 days of a hospital medical discharge and within 30 days of a hospital mental health discharge;
- b. Unplanned return to the operating room during the same hospital admission;
- c. Unanticipated in-hospital deaths;
- d. Trauma or injury suffered while in a health care facility/practitioner office/HMO site:
 - 1) Surgery on wrong body part
 - 2) Surgery on wrong patient
 - 3) Loss of function not related to illness or condition
 - 4) Rape in 24-hour care facility
 - 5) Suicide in 24-hour care facility
 - 6) Infant abduction or discharge to wrong family
 - 7) Hemolytic transfusion reaction related to wrong blood type of incompatible blood products.