



Promise Health Plan

POLICY & PROCEDURE Medical Services

Policy Title: Complex Case Management Process

Policy No: 70.4.1.1

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Department Head:

Date:

Medical Services/P&T Committee:

Date:

P&P Committee:

Date:

Department(s):

CCM

PURPOSE:

The purpose of this policy is to describe the processes Blue Shield Promise Health Plan utilizes to identify potential members for Complex Case Management (CCM, the Blue Shield Promise Case Management System for documentation, comprehensive member assessment and follow-up communication process and notification and coordination with the member's Primary Care Provider (PCP). This is in accordance with NCQA Standards Q.I.7 and SNP 1.

POLICY:

Identification Process:

The CCM Department through prospective, concurrent, or retrospective review will identify members who have experienced a critical event(s) or diagnosis requiring extensive use of resources needing assistance to facilitate appropriate delivery of care and services to optimize outcomes. Blue Shield Promise utilizes multiple data sources to identify members for enrollment in Complex Case Management, including electronic and referral identification sources. Administrative data reports are reviewed on a minimum of a monthly basis, identification via referrals are done concurrently.

Electronic identification sources include but are not limited to the following:

- Claims Data
- Encounter Data
- Hospital Discharge Data
- Pharmacy Data
- Laboratory Data
- Impact Pro Data

Referral identification sources include but are not limited to the following:

- Discharge Planner (Inpatient Case Manager)
- Member Self-Referral

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- Provider Referrals
- Internal Care 1st Department Referrals
- 24 hour Nurse Advice Line
- Health Risk Assessment (HRA)
- Health Information Form (HIF)

Complex Case Management Software Application:

Blue Shield Promise Health Plan utilizes McKesson Care Enhance Clinical Management Software (CCMS) as the primary application to support Complex Case Management functions and workflow. CCMS provides the tools and functionalities for a comprehensive approach to case management. This includes the ability to stratify members based on risk/acuity, then CCMS provides automated reminders to the Case Manager for timed member contact. The frequency of the follow-up is automatically predetermined in CCMS in accordance with the assigned stratification level. CCMS is an integrated approach to member management and improves communication among the inter-disciplinary team to optimize outcomes.

CCMS automatically populates date, time and Case Manager's name with every entry/documentation by the Case Manager.

CCMS provides evidence-based clinical guidelines and customizable functions to create assessments for the management of distinct populations. CCMS has flexible solutions to create workflows and automated functions to manage the high-risk/complex members.

Clinical Guidelines:

CCMS is pre-loaded with a multitude of evidence based assessments for the most disease states. These assessments are called Care Strategies in CCMS. In addition Blue Shield Promise uses the following guidelines in development of assessments and management:

- National Heart, Lung, and Blood Institute (NHLBI) National Education and Prevention Program (NAEPP), Expert Panel Report 3(EPR3): Guidelines for Diagnosis and Management of Asthma 2007
- Global Initiative for Chronic Obstructive Lung Disease, 2016
- Heart Failure Society of America Comprehensive Heart Failure Practice Guideline
- ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults
- American Diabetes Association
- Agency for Healthcare Research and Quality
- Center for Disease Control (CDC)
- MCG Care Guidelines, 2018, 22nd Edition, Online CareWebQI version 9.4 Content Version 21.1
- Regulatory Agency Guidelines
- NCQA Guidelines

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PROCEDURE: Eligibility/ Selection Criteria for CCM:

The following criteria meet the definition of complex case management:

1. Major Organ Transplant
2. Major Trauma
3. Multiple chronic conditions that significantly impair members' health
4. 3 or more Admits within a 12 Month Period
5. Readmission with Thirty (30) Days with the Same/Similar Diagnosis/Condition
6. Polypharmacy Utilization Consisting of >30 Prescriptions per Quarter
7. Diagnosis of cancer requiring multiple modalities of treatment with complex coordination of care across multiple disciplines
8. Members with disabilities requiring special care
9. Members with emotional or mental health issues
10. Chronic illnesses that result in high utilization

Chronic Conditions that Qualify for Complex Case Management

1. Diabetes
2. Renal Failure
3. Hypertension
4. COPD, Pneumonia, Asthma, Respiratory Failure, Pulmonary HTN, Emphysema, Chronic Bronchi
5. CHF, Cardiomyopathy, CAD, Arrhythmias,
6. SLE, Rheumatoid Arthritis
7. Diseases of Musculo Skeletal System: Multiple Sclerosis
8. Parkinson's Disease, Alzheimers, Advanced Dementia
9. Cirrhosis of Liver / Chronic Liver Disease
10. Pressure Ulcers
11. HIV/AIDS
12. Metastatic Cancer
13. Severe, persistent mental illness
14. Spinal injuries

Member Enrollment Process:

1. Identify members eligible for Complex Case Management as outlined above either concurrently or on a minimum of a monthly basis through data reports.
2. The Complex Case Manager is sent an electronic referral in CCMS for each identified member to evaluate for CCM. The CCMS nomenclature for this process is called "Review".

3. The Complex Case Manager receives an automated “reminder” in CCMS identifying the member for “review”. Upon receipt of the “review” the Complex Case Manager is required to complete the following steps:
 - a. Review member information in CCMS, including pharmacy and claims data, previous hospitalizations, current and previous notes and assessments, if applicable.
 - b. Contact member telephonically to explain the CCM Program
 - c. If member agrees, mail the Member Bill of Rights and Consent to Case Management form.

Case Management Evaluation Process:

1. The Complex Case Manager initially contacts the member to explain their role, the process for using the case management services, how the member became eligible to participate and their ability to opt in/opt-out. If the member agrees to participate he/she is required to sign and return Consent for Case Management/Authorization for Release of Medicaid Information. After this is received the Complex Case Manager conducts the comprehensive CM Risk Evaluation Assessment. This assessment is required to be conducted with every member identified for potential enrollment in CCM. The questions within this assessment were developed to capture the critical information to develop an effective care plan. The Risk Evaluation Assessment is periodically reviewed and updated to meet the needs of this distinct population and in accordance with regulatory requirements. The assessment is done as expeditiously as the member’s condition requires, but no later than 30 calendar days from the date that the member was identified as eligible for complex case management services and the assessment is completed within 60 days of identification. This assessment questions were created to illicit the following information below but is not limited to:
 - a. Member’s right to decline participation or disenroll from CM programs and services offered by the organization
 - b. Initial assessment of member’s health status, including condition-specific issues
 - c. Documentation of clinical history, including medications
 - d. Initial assessment of activities of daily living (ADL)
 - e. Initial assessment of behavioral health status, including cognitive functioning, substance abuse disorders, mental health conditions.
 - f. Initial assessment of social determinants of health
 - g. Initial assessment of life planning activities
 - h. Evaluation of cultural and linguistic needs, preferences or limitations
 - i. Evaluation of visual and hearing needs, preferences or limitations
 - j. Evaluation of caregiver and community resources
 - k. Evaluation of available benefits
 - l. Development of a case management plan, including long/short-term/prioritized goals that take into account the member’s or responsible party’s/caregiver goals, preferences and desired level of involvement in the case management plan.
 - m. Identification of barriers to meeting goals or complying with the plan

- n. Facilitation of member's referrals to resources and follow-up process to determine whether members act on referrals
- o. Development of a schedule for follow-up and communication with the member
- p. Development and communication of self management plans members
- q. Process to assess progress against the case management plans for members.

Primary Care Provider Notification Process

1. After the member is enrolled in Complex Case Management their PCP is notified in writing which includes an explanation on the services of the CCM Program and Case Manager contact information (for more detailed information refer to PCP Introduction to CCM Letter Attachment "A")
2. The PCP will periodically receive written correspondence from the Complex Case Manager with a clinical status update on their member
3. The Complex Case Manager is required to telephonically contact the member's PCP when there is a change in member condition and/or to coordinate care/services when applicable

Member Stratification Level

1. Upon completion of the initial CM Risk Evaluation Assessment the Case Manager is required to determine the acuity level of member. There are 3 distinct levels for Complex Case Management. The member is asked the following questions to determine qualification for the most appropriate stratification level. Each question has a specific criteria value and a threshold score is pre-determined for each level.

High Level CCM:

- Readmission within 30 days of previous acute discharge with similar diagnosis
- ER visits with similar diagnoses, 3 or more with 30 days
- Unplanned hospital admission x3 within last 6 months with same or similar medical condition

Medium Level:

- Does member have 4 or more chronic conditions
- Medication related issues with potential for adverse outcomes
- Complex ambulatory treatment plan
- Does member have lack of knowledge related to medical condition(s)

Low Level:

- Does member have a lack of knowledge related to medical condition(s)
- Does member not understand sign and symptoms of their exacerbation of their chronic condition(s)
- Does member require assistance with access and/or coordination of care/services

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Milestone Process

1. The selected Stratification Level determines the automated schedule for member contact/follow-up communication. This is referred to Milestones in CCMS
2. CCMS automatically sends the Complex Case Manager a Reminder notification when the member needs to be contacted as associated with the timed milestone as attributed to the specific stratification level.
3. The automated Milestone reminders for member communication is as follows:
 - a. High Level: Every 14 days
 - b. Medium Level: Every 30 days
 - c. Low Level: Every 60 days
4. The purpose of the timed Milestone member contact is to reassess the member's condition as compared to the previous assessment.
5. Each Milestone has a specific assessment referred to in CCMS as the Intervention Interview Assessment. This assessment is to determine if the member accessed care since the last member contact. The questions can be categorized as follows:
 - a. ER visits
 - b. Hospitalization
 - c. Hospital Readmission
 - d. Change in clinical condition
 - e. At Risk for admission/ER
6. Depending on the answers to the Intervention Interview Assessment and additional information elicited during member contact the Complex Case Manager can re-stratify the member to either a higher or lower stratification level.

Case Management Plan

1. The Risk Evaluation Assessment completed with the initial member contact has automated functions to develop an individualized care plan based on the member's responses to specific questions
2. The automated care plan generated populates specific Problems, Interventions and Goals. It is the Complex Case Manager's responsibility to initially review the Problems, Interventions and Goals and adjust or modify them as indicated to appropriately address the member's needs.
3. Problems, Interventions and Goals to meet member/caregiver needs can be manually selected at the discretion of the Complex Case Manager at any time when indicated.
4. The Complex Case Manager is required to do the following for each Goal and Intervention:
 - a. Determine target date and actual date for each goal/intervention completion
 - b. Document progress/status
 - c. Document member compliance with achievement
 - d. Select Variance Reason if goal/intervention not fully achieved
5. The Complex Case Manager is required to utilize the Treatment/Case Management Plan Module in CCMS to document the following:

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- a. Identify member and caregiver barriers to meeting Goals, Problems and Interventions
- b. Assessment of member and caregiver progress to case management plans and specific Problems, Interventions and Goals and documentation of modification as needed
- c. Assessment of member progress to self-management plans
- d. Member/caregiver participation level in case management program

Inpatient Care Coordination

1. When a member enrolled in CCM is admitted to a hospital or Skilled Nursing Facility (SNF) the respective Complex Case Manager receives notification via an automated Admission Reminder in CCMS
2. The Complex Case Manager tracks the clinical progression of the member through documentation in CCMS by the Inpatient Case Manager
3. The Complex Case Manager's level of involvement required while the member is hospitalized is discussed and coordinated with the Inpatient Case Manager
4. Upon discharge the respective Complex Case Manager receives notification via an automated Discharge Reminder in CCMS.

Multi-Disciplinary Coordination

1. The Complex Case Managers can work collaboratively with additional staff for a multi-disciplinary approach to optimize member outcomes.
2. The Case Management Team meets twice weekly to review all hospitalized members and selected complex case managed members and discuss members needing post hospital discharge coordination of care/service
3. The resource staff available to the Complex Case Manager includes but not limited to the following:
 - a. Social Workers
 - b. Pharmacists
 - c. Case Managers
 - d. Medical Director

Person-Centered Planning for all Beneficiaries:

Upon the enrollment of a beneficiary, will provide, a Person-Centered Planning and treatment approaches that are collaborative and responsive to the beneficiary's continuing health care needs. Person-Centered Planning will include identifying each beneficiary's preferences and choices regarding treatments and services, and abilities. Ensure the participation of the beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services. Ensure that beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

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Population Assessment

On a minimum of an annual basis Blue Shield Promise assesses the characteristics of all members to determine if there is a need to address a specific population or subpopulation. This information along with the monthly evaluation of Complex Case Managed member acuity utilized to determine current Complex Case Management resources to ensure appropriate staffing ratios in order to meet the needs of the members.

Reports used for population assessment for all lines of business include but not limited to the following;

- Age and gender breakdown
- Language percentage breakdown
- Utilization statistical reports by line of business including;
 - Acute admissions
 - Acute readmissions
 - ER visits
 - Bed days
- Health Risk Assessment acuity tiering
- Health Risk Assessment Quantitative Analysis

Based on these reports the Complex Case Management processes will be reviewed and updated on an annual basis to ensure the program is adequately addressing member needs.

Termination of Member from Complex Case Management

The Complex Case Manager appropriately terminates case management services based upon industry standard established case closure guidelines.

Identification of reasons for case management termination, such as:

1. Achievement of targeted outcomes
2. **Maximum benefit reached**
3. Change of health setting
4. Loss or change in benefits
5. **Client refuses**
6. Death of the client

REFERENCES/AUTHORITIES:

Care 1st Blue Shield of California CCM Program Description, 2017