The Practice of Care Coordination and Case Management in the Drug Medi-Cal Organized Delivery System

Elizabeth Stanley-Salazar, BSN, MPH
California Institute of Behavioral Health Solutions

1

Welcome and Introductions

Lightning Introductions

- State Your Name
- Your Job Title
- Your Agency Name
- Level of Care

2

Course Objectives

- Gain an understanding of Care Coordination and Case Management in the Waiver environment.
- Describe how coordination of care and case management activities can lead to improved patient outcomes and experience of care.
- Describe the key components of case management and who should perform these functions in your agency
- Identify at least one care coordination or case management workflow to develop further in your agency
- Identify barriers to full implementation of Care Coordination and Case Management services and develop strategies to reduce or eliminate these barriers.

3

The Context of Care Coordination

- Health care is siloed - health and wellness are not
- Access to care can be difficult - access to multiple systems of care can be impossible
- Care systems and providers may believe they can't care about what they can't care for
- Leads to poor health outcomes, poor experience of care

4

Why make care coordination a priority?

Happier clients/ patients	Patients and families hate it that we can't make this work.
Fewer problems	Poor hand-offs lead to delays, lapses in care, adverse med effects, and other problems that may be dangerous to health.
Less waste	Enormous waste is associated with duplicate testing, unnecessary referrals, and failed transitions from hospitals, EDs, & nursing homes.
Happier & fulfilled workforce	Clinical practice and counselling will be more rewarding.
Better Outcomes	Clients get healthier when their whole health needs are being met

5

Prepaid Inpatient Health Plans (PIHP) i.e. Fresno County Behavioral Health Division

- The PIHP (county AOD authority) is responsible for developing a ***structured approach to care coordination to ensure that beneficiaries successfully transition*** between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.
- The PIHP shall ***ensure that beneficiaries have access recovery supports and services*** immediately after discharge or upon completion of an acute care stay, with the ***goal of sustained engagement and long-term retention in SUD and behavioral health treatment***.
- The PIHP shall enter into a memorandum of understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS.
- Case Management is a required service (benefit) within the DMC-ODS Waiver

6

What is the difference between Care Coordination and Case Management?

7

Coordination of Care for the Treatment of Chronic Disease

Integrated Care is the routine and systematic coordination of health and behavioral health services in order to achieve improved health outcomes; improved patient satisfaction, and to reduce overall healthcare costs.

Care Coordination is the deliberate organization of patient care and treatment activities and the sharing of information among multiple providers to ensure that all areas of need identified are addressed.

Fresno County Provider Manual

8

Case Management Services - Method of Meeting Care the Goals of Coordination required by DMC-ODS Special Terms and Conditions

Case Management is defined in the Medi-Cal 2020 section 1115(a) Medicaid Demonstration Special Terms and Conditions (STCs) as:

a service [benefit]to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services

As Defined by National Center for Quality Assurance

a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for option and services to meet comprehensive, medical, behavioral and social needs of clients and their families while promoting quality, and cost effective outcomes.

9

When Implemented, Case Management Will Enhance the Scope of Addictions Treatment and the Recovery Continuum *(SAMHSA TIP 27 -1998)*

- Provides the client a single point of contact for multiple health and social services systems
- Is client driven and driven by client need
- Provides advocacy by acting in the patient's best interest
- Case management is community-based
- Case management is culturally sensitive
- Case management is flexible, pragmatic, and anticipatory
- Assists the client with needs generally thought to be outside the realm of substance abuse treatment
- Helps the client navigate & obtain community resources, & integrate into the community after discharge from inpatient or residential services

10

National Committee for Quality Assurance Standards

Case management programs connect people who have complex health care and social needs to services and providers and track their care over time.

- Identify people who are in need of case management services;
- Target the right services to people and monitor their care and needs over time.
- Develop personalized, patient-centered care plans;
- Monitor people to ensure care plan goals are reached and to make adjustments as needed;
- Manage communication among providers and share information effectively as people move between care settings, especially when there are transitions from institutional settings;
- Build in consumer protections to ensure people have access to knowledgeable, well-qualified case management staff;
- Keep personal health information safe and secure.

11

What are the components of case management services under the STC?

- Comprehensive **assessment** and periodic reassessment of individual need for case management services;
- **Transition** to a higher or lower level of substance use disorder (SUD) care;
- Development and periodic revision of a **client care plan** that includes service activities;
- **Monitoring service delivery** to ensure beneficiary access to service and the service delivery system;
- **Monitoring the beneficiary's progress;**
- Patient **advocacy,** linkages to physical and mental health care, **transportation**, and retention in primary care services; and,
- Shall be consistent with and shall not violate **confidentiality** of alcohol or drug patients as set forth in 42 CFR Part 2

12

How One Earlier Adopter Has Defined Case Management

13

Los Angeles County Provider Manual Definition of Case Management

Case Management is a patient centered service that is intended to complement clinical services to address areas in an individual's life that may negatively impact treatment success and overall quality of life.

Case Management offers support services to increase self-efficacy, self-advocacy, basic life skills, coping strategies, self-management of biopsychosocial needs, benefits and resources, and reintegration into the community.

14

Case Management Checklist of Core Functions (examples of activities)

Connection

- establishing and maintaining benefits including transferring benefits from previous county of residence
- link beneficiary to community resources and services

Coordination

- facilitate necessary transitions in SUD levels of care by coordinating and forwarding necessary treatment documentation
- coordinate care with health clinics and providers, mental health providers to ensure a whole person approach
- coordinate social services activities with state, county and community entities
- coordinate with criminal justice entities - probation and courts

15

Case Management Checklist of Core Functions (continued)

Communication

- Communicate face to face or by phone with physical health and mental health providers
- Communicate face-to-face or by phone with all service partners
- Advocate for patients with health/social service providers. County and community partners, and others in the best interest of the client

16

Case Study and Exercise

17

Who Can Provide Case Management Services?

- A Licensed Practitioner of the Healing Arts (LPHA) or an AOD certified or registered counselor may provide case management services.
- The individual providing case management services must be linked, at a minimum, to a DMC certified site/facility.

18

What Are the Knowledge, Skills and Attitudes Needed to Provide Case Management Services ?

- Understand models & theories of addiction and other problems related to SA
- Describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems
- Recognize the importance of family, social networks, community systems, and self-help groups in the treatment and recovery process
- Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits
- Understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities
- Value of an interdisciplinary approach to addiction treatment

19

Where Can Case Management Services be Provided?

Case management services can be provided in the following settings as long as the services are affiliated with a DMC certified location:

- DMC provider sites
- County locations
- Regional centers
- In alternative settings as outlined and approved in the county implementation plans (including field-based services)

Each county as the PIHP is responsible for determining the design of delivery, the rates and which entity monitors the case management activities

20

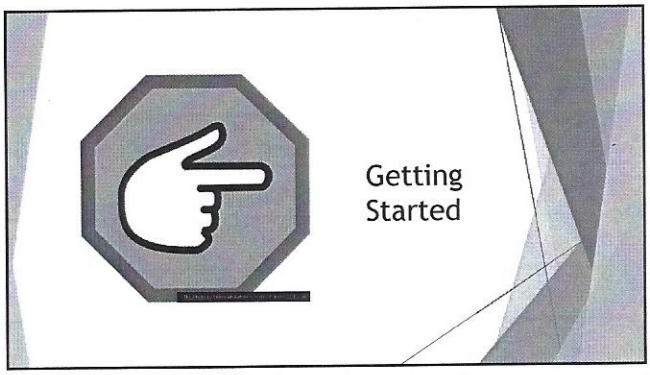
How Can Case Management Services Be Delivered?

Case management can be delivered to a client in the following ways:

- Face-to-face
- By telephone
- By telehealth

If case management services are provided in the community, the provider delivering the service must be linked to a DMC certified site / facility.

21



22

The Phases of Case Management

1. engagement and relationship building;
2. information collection and assessment;
3. planning and prioritizing client needs;
4. allocation, development and negotiation of resources;
5. implementation of a plan;
6. monitoring of the plan; and.
7. review of the plan, case closure or reassessment.

23

Case Management Tasks

Orient	Orient the client and engage in TX and CM
Verify or enroll in	Verify or enroll in Medi-Cal and link to benefit assistance
Assess	Assess need for case management support
Provide	Provide clinical justification
Add	Add case management objectives and interventions to treatment plan
Update	Update utilization review data
Process	Process release of information for CM services

24

Case Management Tasks Continued

Link	Link to Primary Care for prevention as well as treatment services
Refer and link	Refer and link to Medication Assisted Treatment
Support	Support Care Transitions
Refer and link	Evaluate, refer and link to HIV and/or Hepatitis C services
Coordinate	Coordinate medical care
Refer and link	Evaluate, refer and link for dental care

25

Case Management Tasks Continued

Evaluate, refer and link	Evaluate, refer and link for tobacco cessation
Evaluate, refer and link	Evaluate, refer and link to mental health services
Evaluate, refer and link	Evaluate, refer and link for domestic violence services
Coordinate	Coordinate criminal justice needs and requirements
Evaluate, refer and link	Evaluate, refer and link for social services
Evaluate, refer and link	Evaluate, refer and link for family needs
Evaluate, refer and link	Evaluate, refer and link for housing assistance

26

Case Management Tasks Continued

Evaluate, refer and link	Evaluate, refer and link for transportation
Evaluate, refer and link	Evaluate, refer and link for vocational assistance and employment
Evaluate, refer and link	Evaluase, refer and link for educational assistance & skill development assistance
Conduct	Conduct monitoring of activities and achievement of objectives
Participate in	Participate in Care Team meetings and huddles
Advocate	Advocate for client
Assist	Assist with transition to next Level of Care and Recovery Support

27

Documentation & Billing

28

What Requirements Must Be Met for Case Management Services to Be Eligible for Reimbursement?

- The beneficiary is Medi-Cal eligible
- The beneficiary resides in the county
- The beneficiary meets established medical necessity criteria
- The initial medical necessity determination must be performed by a medical director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA)
- Services are delivered by a qualified provider and linked to a DMC-certified site / facility

29

Case Management Services in the Client's Treatment Plan

Case management services must be indicated on the client's treatment plan or the services may not be eligible for DMC reimbursement

The Case Management component of the treatment plan should:

- Identify and prioritize the client's case management needs
- Describe the client's resources and reasons client cannot provide for themselves
- Describe the planned linkages to activities and resources to meet the client's case management needs.

30

Case Management Services Updates in the Treatment Plan

When the treatment plan is updated and/or the need for case management services changes, the case management component also needs to be updated

Updates may include:

- Contact history with the client
- Results of actions taken by the client and case manager
- Other relevant case management success, challenges, barriers, and interventions

31

Documentation Shall Include:

- The client's name, identification number and preferred language
- The purpose of the case management service
- Description of how the service relates to the treatment plan
- Date of the service
- Actual start and end time of the service
- Typed or printed name of the LPHA or AOD counselor who performed the service, their signature, and the date the service was documented
- Whether the service was provided in-person, by telephone, or in the field. If field-based, also include the location the service was provided and how confidentiality was ensured.

32

Documentation Time

Did you know?

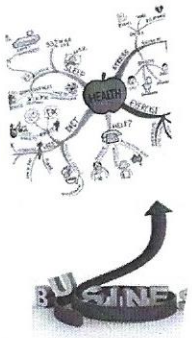
The time a Medical Director, LPHA or AOD counselor spends on case management activities can include documentation time and is DMC reimbursable.

- Record completion of progress notes, case management notes, treatment plans, continuing services justifications, and discharge documentation including the following:
  - Client's name
  - Date of the original service
  - Date documentation was completed
  - Start and end times of the documentation activity
  - The Medical Director, LPHA, or AOD counselor's typed/legibly printed name, signature and date.

33

Examples of Treatment Planning and Event Documentation Using Fresno Guidelines

34



The Business Case for Case Management

IMPROVED CASE MANAGEMENT AND CARE COORDINATION NOT ONLY MAKES GOOD SENSE FOR

CLIENT OUTCOMES

BUT MAKES GOOD SENSE FOR YOUR

BOTTOM LINE

35

Fresno County Rates and HCPCS for Outpatient Services *HealthCare Common Procedure Code*

CP	Encounter	M	M	Unit of Service	Interim Rate
H0004	Individual Counseling	U7		15 minute increments	$36.79
H0005	Group Counseling	U7		15 minute increments	$36.79
H0006	Case Management	U7		15 minute increments	$35.00
G9008	Physician Consultation	U7		15 minute increments	$153.60
H2010	Additional Medication Assisted Treatment	U7		15 minute increments	$153.60
H0004	Recovery Services - Individual Counseling	U6	U7	15 minute increments	$33.30
H0005	Recovery Services - Group Counseling	U6	U7	15 minute increments	$33.30
H0006	Recovery Services - Case Management	U6	U7	15 minute increments	$33.30
T1012	Recovery Monitoring	U6	U7	15 minute increments	$33.30

36

Managing Case Management = Defining and Monitoring Caseload and Productivity

One Program Example: Caseload of 40 clients

Calculate Productivity Goals & Expectations =

- *Minimum = 384 minutes a day (6.4 hours or 80% productivity)*
- *Maximum = 420 minutes a day (7 hours of work)*

Identify & Monitor Quality Assurance Metrics

- *Weekly Productivity Reports*
- *Were all clients assessed for case management services?*
- *Was treatment plan initiated?*
- *Completed linkages?*
- *Unduplicated clients served*
- *Average number of units (15 minute increments)*

37

Every Client Will Not Need The Same Level of Case Management Service - How do we plan for this?

Table 1: Examples of Potentially Significant Risk Factors

Clinical Diagnosis, Behavioral Health, Special Needs	Potential Physical Limitations	Social Determinants	Utilization/Claims Data	Clinical Judgment (Personal Knowledge)
- Any chronic disease, particularly one that is not in control or at desired goal - Chronic pain - Substance abuse (alcohol/drug/tobacco) - Terminal illness - Advanced age with frailty - Multiple co-morbidities - Preterm delivery or newborn - Crisis, youth, or adult with special needs - Anxiety, schizophrenia, bipolar, depression, or other behavior affecting health - Dental health - Dementia/Alzheimer's disease	- Non-ambulatory - Needs Assistance with Activities of Daily Living (ADLs) - Severely diminished functional status - Declining eyesight - Extreme weakness or fatigue - At risk for falls	- Lack of financial or family support that impacts care - Unemployed - No health insurance - **Low health literacy** - Unsafe home environment - Homeless - Lives alone and needs assistance with ADLs - Transportation for health care appointments is difficult - Language barriers	- Frequent hospitalizations (particularly heart failure, GI disorders, and pneumonia) - Frequent office, ER, or urgent care visits - Multiple providers - Hospital readmission within 30 days - Major procedure in last year - Chronic kidney disease - Brain trauma - Expensive medications	Polypharmacy - Patient is taking several medications that may not all be needed or could have potential for interactions - High risk medications - Non-compliant with treatment plan - Confusion with medications or following the treatment plan - Recent trips to long-term facility or other transitions of care - Spouse (who was the caregiver) recently deceased - Lack of engagement in care plan - Low confidence or ability for self-management - Answer to the question, Is this patient at higher risk for dying within the next year?

The Future: Chronic Care Risk Stratification Model - American Academy of Family Physicians

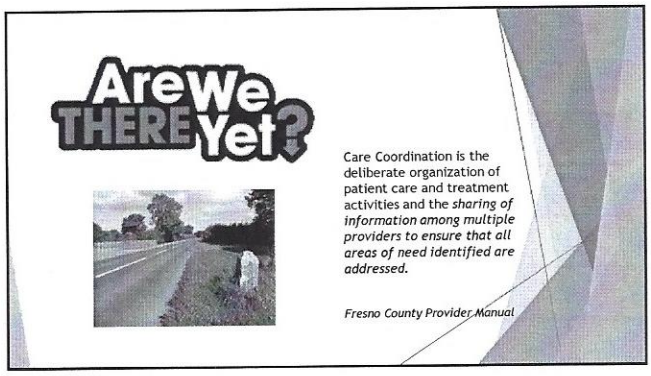
38

How can the AAFP framework be used to plan workload and/or structure the case management benefit?

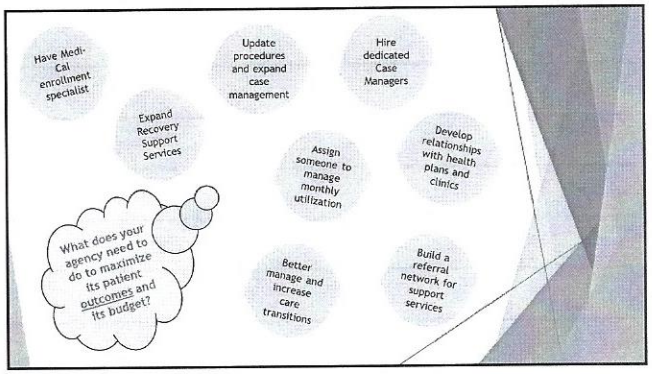
Risk Score	Minutes of Case Management per Month
1	420
2	420
3	840
4	1260
5	1680
6	2100

- A client is assessed and assigned a risk score of 1 to 6 based on domains of need
- Clients with a SUD diagnosis will fall within the range of 3 through 6
- Clients with a score of 6 are likely to be hospitalized in an acute psychiatric or general hospital, leaving risk scores 3, 4 and 5 to be most commonly encountered in the context of SUD treatment

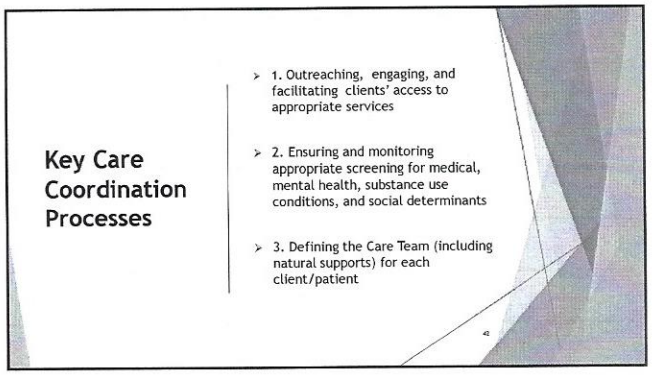
39


Are We THERE Yet?
Care Coordination is the deliberate organization of patient care and treatment activities and the *sharing of information among multiple providers to ensure that all areas of need identified are addressed.*
Fresno County Provider Manual

40


Have Medi-Cal enrollment specialist
Update procedures and expand case management
Hire dedicated Case Managers
Expand Recovery Support Services
Assign someone to manage monthly utilization
Develop relationships with health plans and clinics
What does your agency need to do to maximize its patient outcomes and its budget?
Better manage and increase care transitions
Build a referral network for support services

41


Key Care Coordination Processes
1. Outreaching, engaging, and facilitating clients' access to appropriate services
2. Ensuring and monitoring appropriate screening for medical, mental health, substance use conditions, and social determinants
3. Defining the Care Team (including natural supports) for each client/patient

42

Key Care Coordination Processes

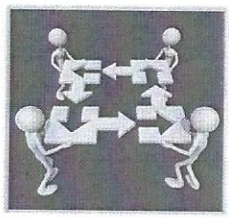
- 4. Ensuring and monitoring consent to share clinical information
- 5. Supporting client self-management
- 6. Ensuring and communicating shared care plan goals among client/patient and providers (primary care, mental health, and substance use providers)
- 7. Conducting multidisciplinary clinical care conferences

43

Key Care Coordination Processes

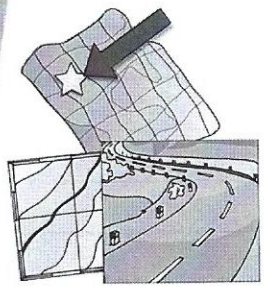
- 8. Ensuring and monitoring routine medication reconciliation and compliance
- 9. Facilitating and following up on referrals
- 10.Monitoring transitions in care

44



Care Coordination in DMC-ODS

45



A Road Map for Enhancing Care Coordination Capacity

46

Outreach and Engagement

- Outreaching, engaging, and facilitating clients' access to appropriate services
- Goal: Clients Get Access To The Services They Need
- Milestones:
  - Knowledge of which providers and services your clients commonly use and need or serve people who need your services
  - Have initiated relationship with these providers - developing understanding of how to access their services and how they can access yours
  - Clear protocols for facilitating access for shared or potentially shared clients
  - Develop Care Coordination Agreements

47

Comprehensive Screening

- Ensuring and monitoring appropriate screening for medical, mental health, substance use conditions, terms & conditions of probation, housing, employment and social needs
- Goal: Knowledge Of Clients Needs And Goals
- Milestones:
  - Agreed upon comprehensive screening tool and process developed
  - Procedures for addressing screening results in place
  - Comprehensive screening fully integrated into intake, care and treatment planning, updates and follow-up

48

Defining the Care Team

- Defining the Care Team (including natural supports) for each client/patient
- Goal: Knowledge And Recording Of All Client's Care Providers
- Milestones:
  - Process in place for identifying care providers
  - EHR infrastructure in place to record and easily see client's care team
  - Contingency documentation and contingency plan for non-EHR environment

49

Sharing Information

- Ensuring and monitoring consent to share clinical information
- Goal: Ability To Share Information As Needed With All Members Of Care Team
- Milestones:
  - Release of information form and process developed flexible enough for clients' care teams
  - Mechanism established for easily tracking if in place and current
  - Procedure for regularly updating releases in place

50

Client Self-Management

- Supporting client self-management
- Goal Client Is Able To Engage In Recommended Self-care Activities
- Milestones:
  - Mechanism in place for identifying client *self-care* goals, motivators, and support needs, and integrating into care plan
  - Procedure in place for regularly checking in with client and modifying plan and actions as needed
  - Resources in place for supporting client self-care goals
    - Self-management workshops, peer groups

51

Shared Care Plans

- Ensuring and communicating shared care plan goals among client/patient and providers (primary care, mental health, and substance use providers)
- Goal: All Members Of Care Team Are Aware Of High-Level Whole Health, Person -- Centered Care Goals
- Milestones:
  - Process in place for developing whole health person-centered (WHPC) care plan
  - Protocols and tools in place for sharing high level WHPC goals with care team and updating as needed
  - EHR capable of recording and making easily visible client's WHPC care plan

52

Multidisciplinary Care/Case Conferences

- Conducting multidisciplinary clinical care conferences
- Goal: Multidisciplinary Providers Coordinate Care
- Milestones:
  - Regular intra-agency meetings with multidisciplinary providers to conduct caseload review
  - Regular inter-agency meetings with multi multidisciplinary providers to conduct caseload review
  - Multidisciplinary "huddles" to discuss upcoming client visits and proactively address whole health care needs

53

Medication Reconciliation

- Ensuring and monitoring routine medication reconciliation
- Goal: Avoid Medication Errors Such As Omissions, Duplications, Dosing Errors, Drug Interactions
- Milestones:
  - Staff trained and standard process in place for routinely gathering high quality up-to-date medication list
  - Standard process in place for adequate reconciling of medication list
  - Medication reconciliation conducted at every transition in care (change in setting, service, practitioner, level of care)

54

Linkage and Effective Referrals

- Facilitating referrals
- Goa. Referrals Are Tracked And Followed Up To Ensure Care Received
- Milestones:
  - Formal referral protocols developed and shared with key partner agencies
  - Capacity in place to track referrals and include referral reports in HER or secondary system if no EHR available
  - Process in place to support client in successfully completing a referral and following up to ensure success
  - Navigation protocols included in case management services
  - Use of Peer Navigators

55

Transitions in Care

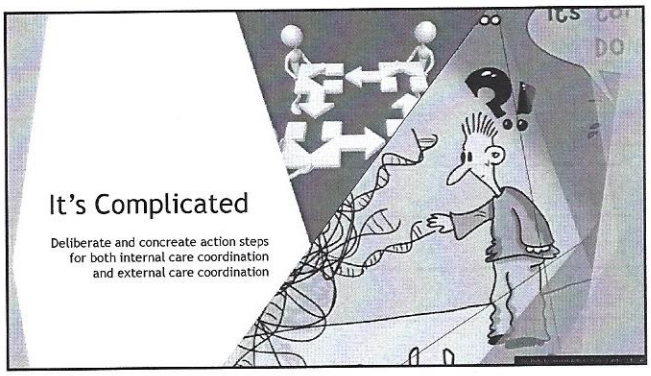
- Monitoring transitions in care
- Goal: No One Fails To Successfully Transition In Care
- Milestones:
  - Process in place to identify clients being transitioned into your services and making sure transition is successful
  - Process in place for supporting transitions out of your services and making sure transition is successful

56

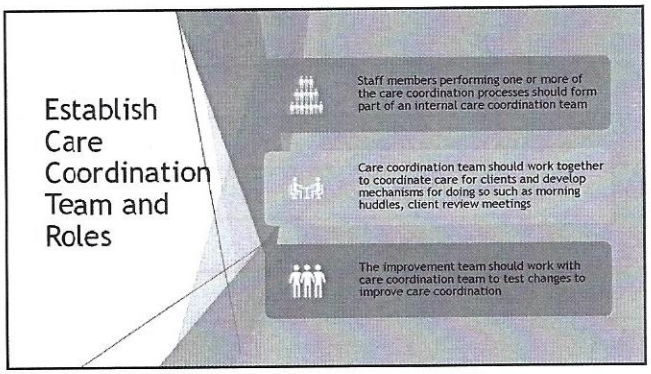
Care Coordination Registry *an organized system to collect uniform data for a defined population, one use is to help improve care for patients with chronic disease*

- Entering clinical information into caseload registry tool
- Goal: Up-to-date Care Coordination Needs And Information Are Readily Available In Registry Tool
- Milestones:
  - Registry functions developed and in place
  - Staff trained and routinely entering data in registry
  - Registry review of population indicators routine part of care planning

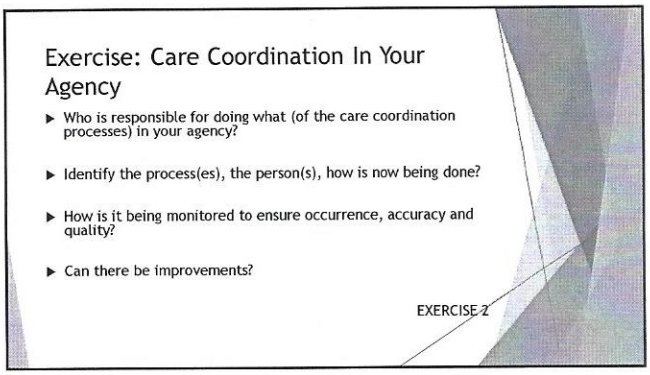
57


It's Complicated
Deliberate and concreate action steps for both internal care coordination and external care coordination

58


Establish Care Coordination Team and Roles
Staff members performing one or more of the care coordination processes should form part of an internal care coordination team
Care coordination team should work together to coordinate care for clients and develop mechanisms for doing so such as morning huddles, client review meetings
The improvement team should work with care coordination team to test changes to improve care coordination

59


Exercise: Care Coordination In Your Agency
Who is responsible for doing what (of the care coordination processes) in your agency?
Identify the process(es), the person(s), how is now being done?
How is it being monitored to ensure occurrence, accuracy and quality?
Can there be improvements?
EXERCISE 2

60

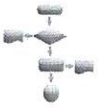
Care Coordination Process Analysis *Example*

Process	Who/How Being Done	Sharing the Information Internally & Externally
Consents to share clinical information	Intake staff collects at intake; primary counselor collects at time of treatment plan; case manager collects at referral	Where are the consents found? How can we easily know a consent is in place?
Screening for medical, mental health, substance use conditions, and social determinants	Intake staff collects intake information; counselor/LPHA collect during assessment; case manager collects during interview; new conditions	Who is responsible to ensure all needs are being addressed or deferred?

EXERCISE 2

61

Workflow Example – Referrals Out



- Start - who generates the referral?
  - Clinician or care manager
- What is provided to the client?
  - Contact information and procedure for making appointment
- What is needed from client?
  - Signed consent to exchange info

62

Workflow Example – Referrals Out

- Anything sent to other provider?
  - Referral report - reason for referral, treatment goals, contact info to send report back
- What follow-up? Confirmation completed? Results? Report from provider?
  - Care coordinator follows up with client and agency to see if appointment made and completed
  - Care coordinator makes arrangements to help client make appointment if needed (transportation)
  - Care coordinator follows up with agency to get report on results and enters in EHR

63

Let's Review Action Item Options

- ✓ Review list of key care coordination processes and develop a table saying who and how each is currently being done and what will be done in future
- ✓ Develop flowcharts for some of the processes - identify gaps and areas for improvement

64

Example of Care Coordination Tasks

- ✓ At the end of every week a supervisor reviews the charts for all clients coming in the next week who require care coordination and identifies services needed internally and externally
- ✓ At the beginning of the week, there is a meeting of care coordination team, care coordinator shares info about who coming in and what they need

65

Action Item Options

- ✓ Identify internal care coordination team members
- ✓ Determine mechanisms for coordinating care internally - method (meetings, emails, huddles) and frequency (weekly, daily)

66

Assign Key Processes for Care Coordination to Team

Identify any care coordination processes not currently performing and assign someone to be responsible for that process

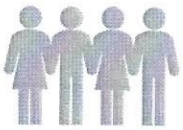
Goal is to eventually be able to perform all the key processes and make sure someone is accountable for that process

67

Action Item Options

- ✓ Identify who on the internal care coordination team will be responsible for care coordination processes not currently being performed
- ✓ Work with those responsible for quality improvement to test changes to find what works best for these new processes

68



Enhance Capacity to Coordinate Care

69

Key Tasks for Developing Tools

- Develop tools and supports needed for care coordination:
  - care coordination agreements
  - screening tools
  - medication reconciliation
  - whole health patient centered treatment planning

70

Care Coordination Agreements

- Agreements with each of the entities with which your agency coordinates care
- May be structured as a contract, memorandum of agreement, memorandum of understanding
- Lays out the parties' mutual expectations and responsibilities related to care coordination

71

Provisions Related to Coordination of Services

- Describe the process by which the parties will share medical notes/records regarding diagnosis and treatment, including prescriptions
- Include as attachments all applicable care coordination protocols (such protocols should be incorporated by reference into the Agreement)

72

Provisions Related to the Obligations of the Care Coordination Partner

Contain

- Contain a provision stating that to the extent that referred clients receive services from the other party, such individuals are considered clients of the other party as well as clients of referring agency

Specify

- Specify that the other party agrees to accept all consumers referred to it by the agency, subject to capacity limitations

Specify

- Specify whether the other party will make services available to consumers regardless of their ability to pay

73

Provisions Related to Patient Privacy and Data Sharing

Contain a provision stating each party agrees to comply with any federal or state law governing the privacy and confidentiality of the individually identifiable health information of consumers originating with either party

Specify that the parties will provide treatment planning and care coordination activities, as set forth in the care coordination agreement, in compliance with HIPAA, 42 CFR Part 2, and other applicable federal and state laws, including consumer privacy requirements specific to the care of minors

Specify that the parties will request consumers' consent for the disclosure of their health information, in accordance with state and federal laws and regulations

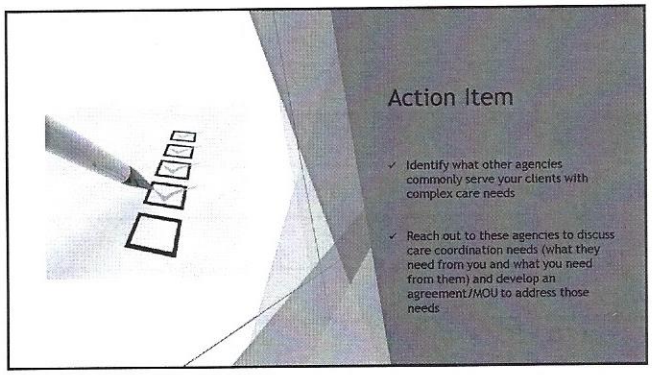
74

Provisions Related to Standards of Care

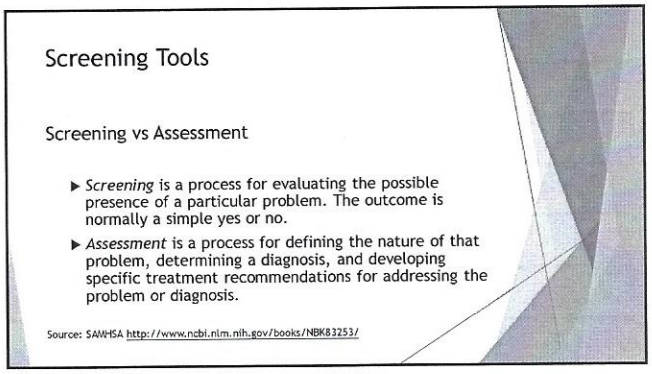
Contains assurances that the other party and each of its professionals providing services pursuant to the care coordination agreement:

- Are appropriately licensed, certified and/or otherwise qualified to furnish the services, with appropriate training, education and experience in their particular field
- Are not excluded from participating in Medicare, Medicaid and other federal health care programs
- Will furnish services in accordance with applicable federal, state and local laws and regulations

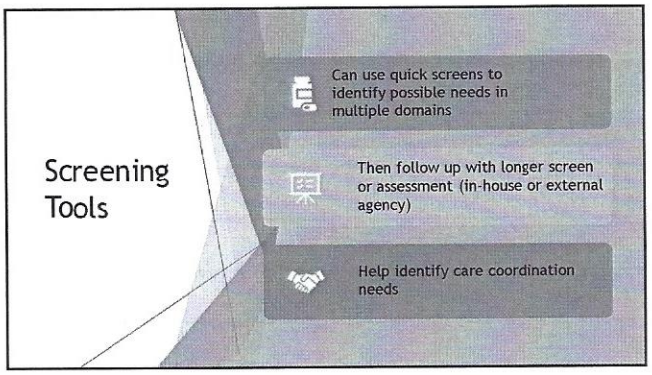
75


Action Item
Identify what other agencies commonly serve your clients with complex care needs
Reach out to these agencies to discuss care coordination needs (what they need from you and what you need from them) and develop an agreement/MOU to address those needs

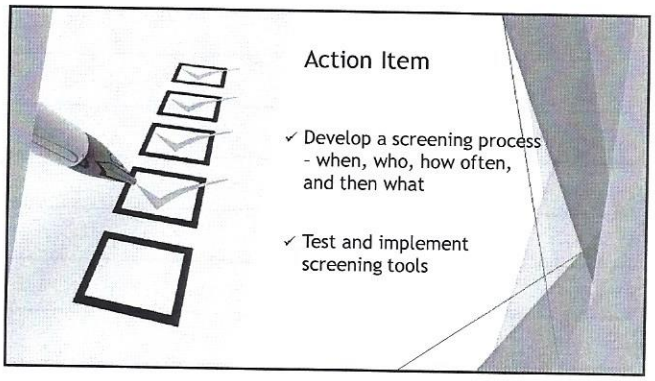
76


Screening Tools
Screening vs Assessment
Screening is a process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no.
Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.
Source: SAMHSA http://www.ncbi.nlm.nih.gov/books/NBK83253/

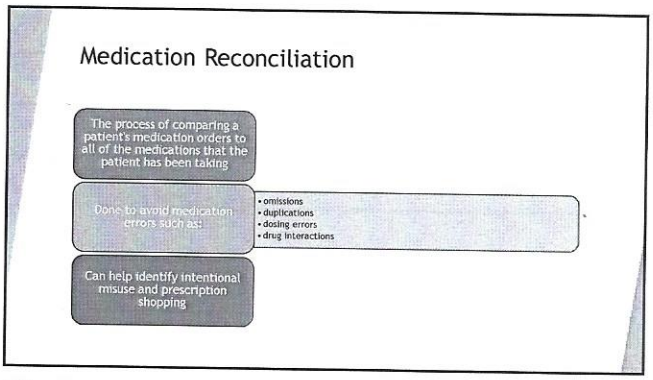
77


Screening Tools
Can use quick screens to identify possible needs in multiple domains
Then follow up with longer screen or assessment (in-house or external agency)
Help identify care coordination needs

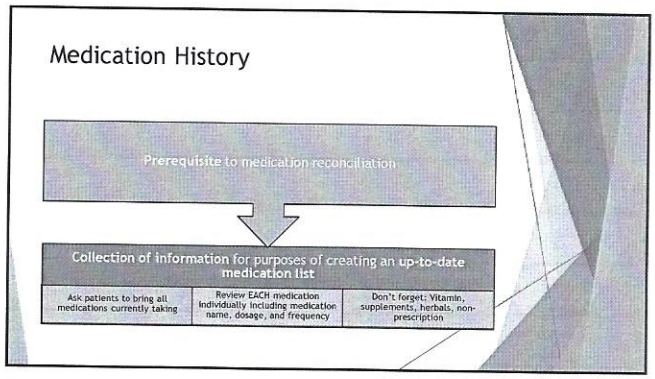
78


Action Item
✓ Develop a screening process - when, who, how often, and then what
✓ Test and implement screening tools

79


Medication Reconciliation
The process of comparing a patient's medication orders to all of the medications that the patient has been taking
Done to avoid medication errors such as:
• omissions
• duplications
• dosing errors
• drug interactions
Can help identify intentional misuse and prescription shopping

80


Medication History
Prerequisite to medication reconciliation
Collection of information for purposes of creating an up-to-date medication list
Ask patients to bring all medications currently taking
Review EACH medication individually including medication name, dosage, and frequency
Don't forget: Vitamin, supplements, herbals, non-prescription

81

Sample Medication History Interview

Did you bring your medications with you today?

What changes have there been to your medications since your last visit?

Review EACH medication individually including medication name, dosage, and frequency

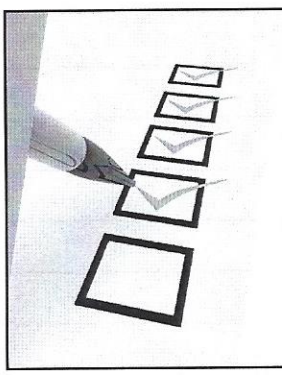
- Are you still taking _____?
- What is the dosage?
- How are you taking it? How many times per day?
- What inhalers, eye drops or topical products do you use

Vitamin, supplements, herbals, non-prescription

- What over-the-counter or non-prescription medications do you use? Anything for pain? Sleep? Allergies?
- What vitamins or supplements are you taking?

82

Action Item



- ✓ Identify who will conduct medication history and who will conduct the reconciliation
- ✓ Develop a medication history interview protocol

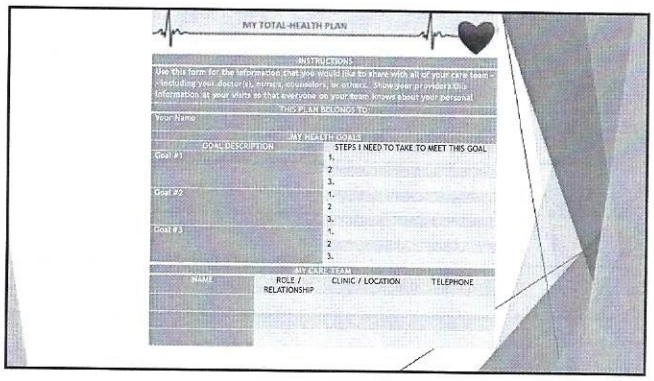
83

Patient-Centered Care Planning

Patient determines their goals that can cover all aspects of health (mental, physical, substance use, social) (whole health patient-centered care plan)

Agency then determines what they need to do support client in achieving their goals and what care needs to be coordinated

84


MY TOTAL HEALTH PLAN

INSTRUCTIONS

Use this form for the information that you would like to share with all of your care team - including your doctor(s), nurses, counselors, or others. Show your provider this information at your visits so that everyone on your team knows about your personal

THIS PLAN BELONGS TO:

Your Name

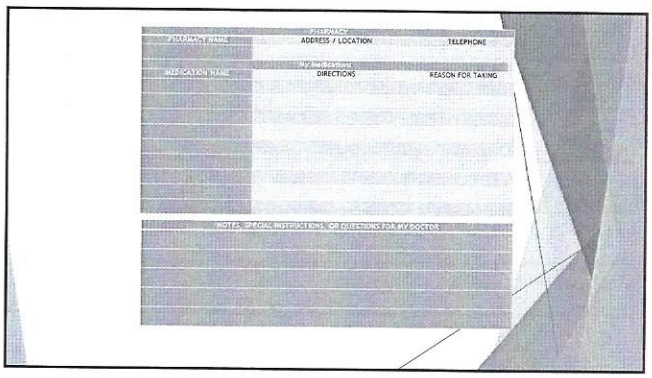
MY HEALTH GOALS

GOAL DESCRIPTION	STEPS I NEED TO TAKE TO MEET THIS GOAL
Goal #1	1. 2 3.
Goal #2	1. 2 3.
Goal #3	1. 2 3.

MY CARE TEAM

NAME	ROLE / RELATIONSHIP	CLINIC / LOCATION	TELEPHONE

85


PHARMACY

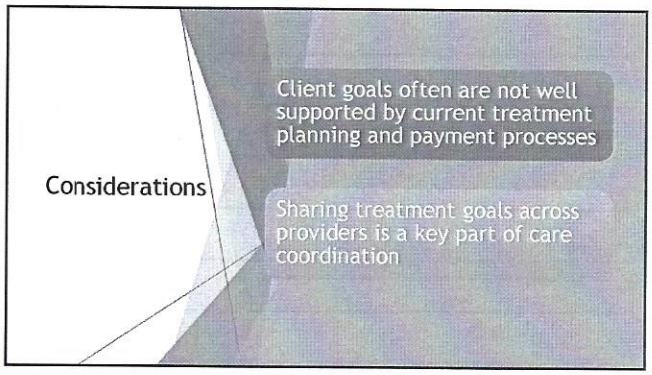
PHARMACY NAME	ADDRESS / LOCATION	TELEPHONE

My Medications

MEDICATION NAME	DIRECTIONS	REASON FOR TAKING

NOTES, SPECIAL INSTRUCTIONS, OR QUESTIONS FOR MY DOCTOR

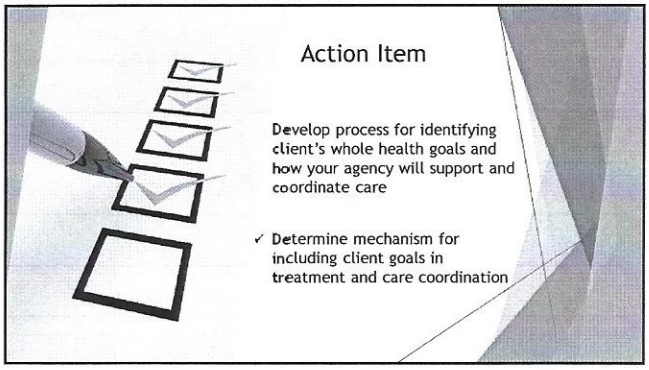
86


Considerations

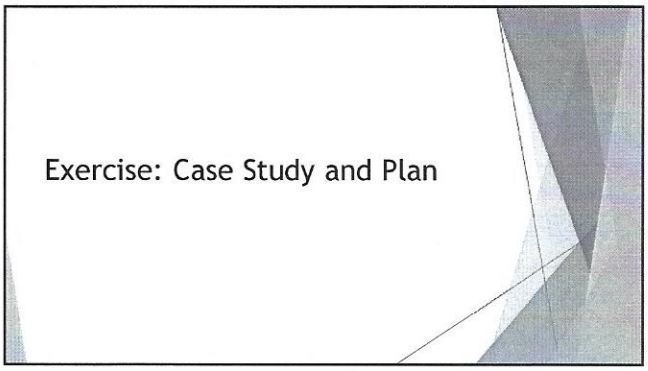
Client goals often are not well supported by current treatment planning and payment processes

Sharing treatment goals across providers is a key part of care coordination

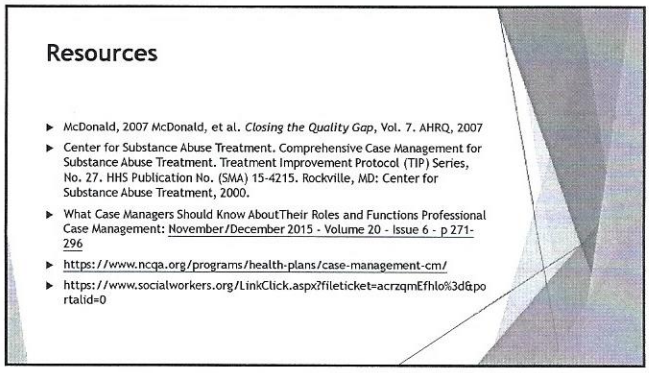
87


Action Item
Develop process for identifying client's whole health goals and how your agency will support and coordinate care
✓ Determine mechanism for including client goals in treatment and care coordination

88


Exercise: Case Study and Plan

89


Resources
McDonald, 2007 McDonald, et al. Closing the Quality Gap, Vol. 7. AHRQ, 2007
Center for Substance Abuse Treatment. Comprehensive Case Management for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 15-4215. Rockville, MD: Center for Substance Abuse Treatment, 2000.
What Case Managers Should Know AboutTheir Roles and Functions Professional Case Management: November/December 2015 - Volume 20 - Issue 6 - p 271-296
https://www.ncqa.org/programs/health-plans/case-management-cm/
https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3d&portalid=0

90

Resources

- Center for Substance Abuse Treatment. Comprehensive Case Management for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 15-4215. Rockville, MD: Center for Substance Abuse Treatment, 2000.
- Fundamental of Case Management Practices: Skills for Human Services (Fifth Edition), Summers, Nancy. Boston, MA. 2016
- California Institute of Behavioral Health Solutions. Strengths Based Case Management, Rich Goscha PhD, https://www.cibhs.org/strengths-model-case-management
- What Case Managers Should Know About Their Roles and Functions Professional Case Management: November/December 2015 - Volume 20 - Issue 6 - p 271-296
- Closing the Quality Gap, McDonald, 2007 McDonald, et al., Vol. 7. AHRQ, 2007
- Case Management Under the Drug Medical Organized Delivery System FAQ
- https://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver/DMC_ODS_Case_Management_FAQ_06.30.16.pdf
- National Center for Quality Assurance Standards
- https://www.ncqa.org/programs/health-plans/case-management-cm/

91