Care Coordination Institute
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Complex Care Management and Care Transitions Programs

The Care Coordination Institute's Complex Care Management Program ("CCM", "Care Mangement" or the "Program") is a program that targets specific populations. Care Managers assist patients with multiple or complex conditions to obtain access to care and services, as well as coordinate their care in order to meet health goals and improve outcomes. CCM is provided to patients who have experienced an event or diagnosis requiring the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. It is a collaborative process of assessment, planning, facilitation, care coordination and evaluation. The CCM Program provides advocacy for options and services to meet the comprehensive medical, behavioral, psychological, social and spiritual needs of a patient and the patient's family/caregiver, while promoting quality and cost-effective outcomes. Since CCM is considered an opt-out program, all eligible patients have the right to participate or decline participation. The Care Transition Program focuses on evaluating and coordinating post-hospitalization needs for patients who may be at risk of readmission.

The goal of Care Management is to help identify patients in need of care management services and refer eligible patients to the appropriate programs. Through the CCM programs, the patient should regain optimum health or improved functional capability. The CCM resource strives to serve as an advocate to the patient and ensures that the patient receives the appropriate level of care in the appropriate setting. Together, the CCM team and the patient will work toward and continually monitor progress against the goals of the plan of care. In addition, the CCM staff is focused on continuously improving patient satisfaction and engagement in their care by providing education and patient-centered support. The program will balance the needs of the patient and family with the efficacious and cost-effective use of resources.

The goals of the program include:

- Reducing avoidable admissions for acute care
- Reducing emergency room visits
- Reducing re-admissions
- Improving clinical outcomes
- Increasing patient quality of life and overall satisfaction

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- Reducing duplication of services and avoidable cost

A. Services

The scope of services provided to the patient includes:

1. Assessment of health status
2. Education on the CCM program and their condition
3. Development of a care plan with goals, barriers and self-management goals
4. Assessment of progress against the care management plans for the patient, treatment plans, and evaluation of adherence
5. Prescribed treatment, interventions or regimens
6. Regularly scheduled contact with the Care Manager based on acuity
7. Assistance in navigating and collaborating with health plans, other practitioners, community resources and vendors regarding treatment plans
8. Supporting transitional care between inpatient and other facility or home
9. Discussion with interdisciplinary team to review treatment plan and discuss interventions

B. Evidence-based Care

Table 1.1: Evidence-Based Guidelines	
Condition	**Evidence-Based Guidelines**
Diabetes	ADA Standards of Medical Care in Diabetes 2020. *The Journal of Clinical and Applied Research and Education*.
Congestive Heart Failure (CJF)	2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure
Chronic Obstructive Pulmonary Disease	Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease 2020 Report.
Asthma	NHLBI National Asthma Education and Prevention Program, Third Expert Panel on the Diagnosis and Management of Asthma. Expert Panel Report 3: Guidelines for the Diagnosis and Management of

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	Asthma. Bethesda (MD): National Heart, Lung, and Blood Institute (US); 2007 Aug.
Hypertension	AAFP/ACP Pharmacologic Treatment of Hypertension in Adults Aged 60 Years or Older to Higher Versus Lower Blood Pressure Targets 2017
Hyperlipidemia	AHA/ACC Guideline on the Management of Blood Cholesterol-2018

The Care Managers use evidence-based clinical guidelines approved by the Care Coordination Institute (CCI), the Prisma Health Network's Quality and Care Delivery Committee (QCDC), and best practices by the Case Management Society of America, as well as guidelines built into the care coordination platform to conduct assessments, build care plans, identify interventions and suggest patient education. Guidelines/best practices built into the platform include HEDIS, NCQA, 5-Star, Care Management Care Pathways, America Diabetes Association and GOLD standards. Care Managers use decision support tools via Care Coordination Platform and EPIC, such as electronic reminders, alerts, and order sets. In addition, patients are provided with education resources based on the above guidelines to promote self-care and engagement in their own health. Care Managers also receive best practice training in motivational interviewing to support patient outcomes (see Table 1.1 above).

C. Care Management Systems

CCM documentation is within the care coordination platform. All documentation in the platform automatically records the staff, date, and time of interaction with the patient. It also contains automated prompts and flags to remind Care Managers to take action. Additionally, the care coordination platform and algorithms are based on evidence-based guidelines and best practices. Communication with providers is accomplished through telephone encounters in the electronic health record (EHR) or via fax or telephone for providers using EHR's not accessed by CCMs.

D. Eligibility Criteria

Using Milliman's MedInsight risk stratification tool, eligible patients are proactively identified for care management which pulls in clinical, utilization, readmission, emergency department usage, hospital discharge, pharmacy and claims/billing. In addition to identifying patients through eligible criteria, referrals are also made through the Condition Management program, discharge planners, utilization management analysis,

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the Nurse Hotline and payers. Patients are also referred into the program from providers or the patient and family/caregiver themselves. Care Managers will review data from these sources to identify patients as eligible. When a patient is identified as eligible, they are stratified based on their risk score. This stratification identifies the level of intervention.

Criteria for identifying patients who are eligible for the program includes:

I. Frequent ED visits
II. Multiple hospital admissions
III. Life threatening event or diagnosis
IV. Risk of readmission within 30 to 90 days
V. Complexity of services needed
VI. Poor or no social support
VII. Noncompliance to treatment plan
VIII. Duplication of services
IX. Poor quality of life
X. Unmet needs identified

A patient is not eligible for Care Management if:

I. Long term care residents
II. Referred to hospice
III. Transplant
IV. High risk obstetrics
V. Any agreed upon exclusions

The CCM Department has determined graduation and discharge criteria. The graduation criteria are used when moving a patient from a high-touch intervention to a lower-touch intervention, graduating them from the program or transitioning them to Condition Management. The discharge criterion includes:

I. The majority of Care Management goals have been met
II. Expiration
III. Eligibility (based on referral criteria or contracts)
IV. Geography

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V. Hospice
VI. Long term care
VII. Transplant

The discharge criteria will be reviewed at the beginning of the program with the patient/caregiver. The graduation criteria are discussed at length with the patient/caregiver in terms of the patient's individual goals. Discharge from the program, graduation from a risk level or transition to Condition Management will be documented in the patient's record. The patient and or family/caregiver will be notified of the change verbally within 5 business days. If the Care Manager is unable to let the patient/family know verbally, then they will mail a letter and/or email the patient through the patient portal. This communication is documented in the care coordination platform.

E. Interventions

Intervention strategies are based on the level of risk or the severity of the condition. These interventions are tied to alerts and triggers for the Care Manager within the care coordination platform. The intervention strategies will be adjusted as the patient is re-evaluated or assessed against their care plan. The CCM program has established a timeline for interventions as noted in the Table 1.2. The use of these strategies varies on the risk level of the patient.

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Table 1.2 Interventions	
Intervention Level	**Contact Schedule**
High Criteria Guidelines: • New enrollment or not progressing with goals • Recent ED or inpatient utilization • Missed appointments • Poor or no social support/unstable social situation • Barriers & unmet needs • Noncompliance • Establishing care with multiple new providers • Receiving Home Health services or STR (weekly contact with appropriate staff after first contact with patient)	Twice Weekly / 1-2 Times Weekly First call being to patient within 3 days, post discharge or ED visit (if applicable)
Medium Criteria Guidelines: • Progressing with goals/barriers being resolved • Increased compliance with appointments • Decreased ED or inpatient utilization • Improved compliance	Every 2-4 Weeks
Low Criteria Guidelines: • Meeting 80% goals or minimum barriers • Good support system • No missed appointments • No ED or inpatient utilization	Every 1-2 Months

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F. Resourcing/Case Load

Staffing ratios are based on acuity of the members assigned to each Care Manager. Approximate RN Care Manager Ratios are one nurse per 100 high-risk acuity members and a compliment of moderate acuity members of which are also supported by a health coach and a social worker. Staffing ratios are also based on geography, patient satisfaction, performance outcomes, and complexity of patient population, changes in volume of patient cases and whether a patient is part of a bundled payment program. The care coordination platform reports on the level of productivity to monitor the effectives of the established ratio. In the event that a Care Manager's case load becomes excessive, the Care Coordination Institute will reassign the case load based on geography, while seeking to ensure continuity for patients.

G. Transitions of Care

The facility's Interdisciplinary Care Team (IDT) attended by the Transitions Coordinator, manages care transitions, identifies problems that may result in unplanned transitions and strives to prevent unplanned readmissions. The IDT makes a special effort to coordinate care and support patients through the transitions from one level of care to a higher or lower acuity level, as well as between care providers. To achieve this, care transitions procedures are monitored, measured, reported and analyzed by the appropriate Quality and Care Design Committee (QCDC) at least semi-annually.

The Transitions Coordinator initiates the ambulatory plan of care and sets goals with the patient and family/caregiver. Additionally, the coordinator ensures that the appropriate referrals to providers or social services/community resources have been scheduled. The Hospital Case Manager, Transitions Coordinator and IDT communicate with the patient and/or responsible party about the expectation of patient involvement in the care transition process and changes to the patient's health status. This is communicated verbally and is documented in the patient's record. The Transitions Coordinator educates the patient on the transition process and identifies the necessary steps to transition between care settings. The Transitions Coordinator and Ambulatory Care Manager provide the patient with ongoing educational information regarding how to maintain health and remain in the least restrictive setting and reduce their risk of hospitalizations and unplanned transitions with on-going reinforcement during care management activities. In addition, the Transitions

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Coordinator and Ambulatory Care Manager perform a huddle at the bedside with the patient and family/caregiver at discharge.

H. Stakeholder Engagement

The Care Manager collaborates with the health plans and their programs, practitioners, and vendors regarding the care and treatment plan, as indicated, as well as consistently keeping Primary Care Provider (PCP) informed of patient status through documentation in the EHR or communication with specialists, as appropriate. The Care Manager may also attend ambulatory practice huddles to discuss patients as appropriate.

The Care Manager assesses the patient, develops a care plan, identifies barriers to care, community resources to leverage, as well as engages the patient in their health goals. In developing this plan, the Care Manager and the patient define goals that the patient/caregiver feels are feasible and that will help the patient improve their health status. The goal is to have the patient feel as though they have assisted in developing the plan and increase their level of confidence to self-manage.

The Care Manger will address with the patient:

a. Monitoring and problem solving
b. Medication administration
c. Skills and strategies to manage signs or symptoms
d. Diet and physical activity
e. Coping with emotions (anxiety, depression, etc.)
f. Reducing unhealthy behaviors (smoking, alcohol, etc.)
g. Importance of keeping provider appointments as scheduled

Care Managers provide patients education and tools which promote self-management. These resources are accessed via Health Wise, an online library of health education materials, self- management tools and shared decision-making support mechanisms. These resources facilitate shared decision-making and enable the patient to make informed decisions about their health. If there is a caregiver, the Care Manager will include them in the discussion, ensuring that the caregiver is able to provide the support required by the care plan. The Care Manager will assess the burden on the caregiver as well.

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Caregiver-supporting activities include:

I. Healthcare tasks (monitoring vitals, arranging for follow-up care, follow-up appointments, assisting with medical equipment, etc.)
II. Medication Management
III. Household Management

About the CCI

The Care Coordination Institute (CCI), an independent entity of Prisma Health, enables integrated delivery systems and provider networks (CINs/ACOs) to be successful in implementing true population health. Using a patient-centric, provider-led approach to care transformation, the CCI supports providers and care teams with their efforts to:

- Improve patient outcomes and patient experience;
- Drive clinical integration and care coordination;
- Reduce the total costs of care.