

THE RHODE ISLAND INTEGRATED CARE PROGRAM FOR MEDICARE AND MEDICAID ELIGIBLE (MME) AND MEDICAID-ONLY ELIGIBLES

CARE MANAGEMENT OVERVIEW

Overview

The mission of the Integrated Care Program is to transform the delivery system through purchasing person-centered, comprehensive, coordinated, quality health care and support services that promote and enhance the ability of Medicaid-only and Medicaid/Medicare eligible (MME) recipients to maintain a high quality of life and live independently in the community.

Care management is a critical component of this strategy. EOHHS will build upon, improve and integrate with current Care Management programs to better meet the needs of the target population. Care should be less fragmented and more person-centered; care managers should strive to better communicate across settings and providers; and members should have greater involvement in their care management.

Overall Philosophy

Optimal care management requires a combination of three basic types of activities:

1. A set of “high-touch,” person-centered, care management activities requiring direct interaction with the recipient and the care team
2. Data collection, analysis, interpretation, and communication of data to the care team
3. Monitoring and quality assurance of care management activities

EOHHS believes that for certain individuals, person-centered care management activities are optimally delivered when functionally and, where possible, physically integrated into a multi-disciplinary, primary care-based practice team with the capacity to support this function. The Integrated Care program will develop over time to improve access to on-site, integrated care management services to the greatest extent possible.

Key Care Management Strategies and Goals:

In order to maximize the effectiveness of care management activities, EOHHS supports the following strategies and goals for the care management component of the Integrated Care program:

Improve member health and quality of life:

- Measurably improve the quality of care, health outcomes and quality of life for members
- Ensure involvement of members and their families in the care management process
- Promote effective and ongoing health education and disease prevention activities
- Provide and coordinate support for Family Caregivers

Decrease care fragmentation:

- When possible provide the maximum physical and functional integration of care management services with the primary site of health care for the member. For many individuals, the primary site of care should be the site most appropriate to coordinate care given the needs of a particular member.
- Facilitate access to timely, appropriate, accessible, and person-centered physical and behavioral health care, long term care services and supports (LTSS), and community-based resources
- Increase communication and coordination of care across all components of the care team.
- Identify duplication of care management efforts for complicated members and identify a Principal Care Manager for each.

Optimize resource utilization:

- Reduce Emergency Room visits, avoidable hospitalizations, and avoidable nursing home admissions and days

Components of Care Management Process

Below is a list of components of care management which will be included in the Integrated Care Program with the goal of promoting “high-touch,” person-centered, care management activities:

1. Comprehensive Needs Assessment

The Managed Care Organization (MCO) and the Coordinated Care Entity (CCE) will ensure the completion of a Comprehensive Needs Assessment (CNA) on new members. The goal of the CNA is to identify a members’ care management needs in order to determine a member’s care needs and develop a care plan. The CNA will be conducted by a healthcare professional.

2. Plan of Care to Address Needs Identified

In collaboration with the member, their family/caregivers, other involved agencies, and the health care team, the care manager will develop a care plan. The plan should include short and long-term care management goals, and specific actionable objectives. If the site of care management is not the primary care provider, linkages to the member’s primary care provider (PCP) should be included in the care plan. The care plan should be culturally appropriate and consistent with the abilities and desires of the member and/or caregiver. Understanding that members’ care needs and circumstances change, the care manager must periodically evaluate the care plan to update and/or change it to accurately reflect the member’s needs. The frequency of this periodic update will vary by member.

3. Coordination of Care/Implementation of the care plan

The lead care manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the plan. This includes making referrals, coordinating care, promoting communication, ensuring continuity of care, and conducting follow-up. Implementation

of the member's care plan should enhance his/her health literacy while being considerate of the member's overall capacity to learn and (to the extent possible) assist the member to become self directed and compliant with his/her plan of care. Critical components of the care coordination/implementation process include:

- Referral tracking and follow-up
- Serve as a “communication hub” in the coordination of care between primary care, specialty care, behavioral care, institutional care, LTSS and end of life care.
- Communication and referral to the Community Health Team or community-based resources
- Support transitions from hospital to community or nursing facility to community
- Member education and self-management support
- Collaboration and integration with the Care Team
- Utilization of behavior change techniques and motivational interviewing practices
- Coordination of medication management with a pharmacist
- Referral as appropriate to end-of-life services and supports

4. Transitional Care Planning

The care management process shall include 24-hour care management and support during transitions across care settings. This includes a transitional care program that provides onsite visits with the care manager upon discharge from the hospitals, nursing homes, or other institutional setting. Care managers should assist with the development of discharge plans and ensure the completion of medication reconciliation. Transitional care should reflect Rhode Island's best practices in hospital transitions of care, by requiring MCOs and CCEs to incorporate best practices and lessons learned from Money Follows the Person and the Nursing Home Transitions program.

5. Risk Assessment/Identification of Members Who Need Care Management

The MCO and CCE must have effective systems, policies, procedures and practices in place to identify any member in need of care management services. Methods for identifying members in need of care management should include face-to-face person focused encounters, retrospective claims analysis, and real-time events like inpatient admissions, nursing home admissions, or home visits. Assessments should also include the psychosocial risk factors for institutional or hospital care. These methods should be able to anticipate that members' needs change, and have the ability to profile members as their needs and circumstances change. Any member identified as having potential care management needs will trigger referral to and notification to the appropriate care manager and ongoing care management as indicated.

The contracted MCOs and Enhanced PCCM CCE shall use their data and analytic capacities to identify the needs and risks of members; stratify members' needs according to acuity and risk for hospitalization or nursing home placement, communicate with care teams regarding high risk members, and ensure that members receive appropriate, timely and comprehensive care management services. As part of the care management process, MCOs and CCE will:

- Apply systems, science, and information to identify members with potential care management needs and assist members in accessing care management services with the goal of improving, maintaining, or slowing the deterioration of their health status and quality of life.
- Ensure the use of a multi-disciplinary team to manage the care of members needing care management and care coordination. While care management may be performed by one qualified health professional (a nurse, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, primary care site, specialists, long term care facilities, home-based services, pharmacists, community-based resources, and hospitals.

6. Analysis of Care Management Effectiveness and Appropriateness

The MCOs and CCE will be responsible for monitoring and ensuring the quality and effectiveness of care management activities in multiple ways, including through contractual arrangements with primary care providers, community health teams, or other entities providing integrated care management services. Expectations for care management activities will be developed. Each member with care management needs must have a care plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self direction.

7. Monitoring Outcomes

The effectiveness of the care management process will be measured by the review and analysis of patient outcomes. The MCOs and CCE shall develop processes to collect and submit population based measures to EOHHS annually for review. State approved measures will be used to monitor success.

Technology to support Care Management activities

The MCOs and CCE must have effective systems, policies, procedures and practices to create, refine and execute a plan of care. The MCOs and CCE shall develop integrated electronic information systems that maximizes interoperability in order to provide care managers with access to all essential data related to the member (including but not limited to: member's clinical history, diagnosis, sentinel events, urgent/on-going care need), other data sources (pharmacy, utilization) and data mining tools (predictive modeling, risk scores) to: (1) place a member into his/her appropriate care management model (for that particular date in time); (2) implement his/her care plan; (3) monitor care plan for effectiveness and appropriateness; and (4) modify the care plan to accurately reflect any change in the member's circumstances. Strong consideration should be given to the use of the state's Health Information Exchange, **currentcare**, to support information exchange, particularly around transitions of care.

Appendix: Definitions

DEFINITION OF CARE MANAGEMENT

"Care management" means a set of person-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care management emphasizes prevention, continuity of care and coordination of care, which advocates for, and links members to services as necessary across providers and settings. At a minimum, care management functions must include, but are not limited to:

1. Early identification of enrollees who have or may have special needs
2. Assessment of an enrollee's risk factors
3. Development of a plan of care
4. Referrals and assistance to ensure timely access to providers
5. Coordination of care actively linking the enrollee to providers, medical services, residential, social, behavioral, and other support services where needed
6. Monitoring
7. Continuity of care
8. Follow-up and documentation

Care management is driven by quality-based outcomes such as: improved/maintained functional status, improved/maintained clinical status, enhanced quality of life, member satisfaction, adherence to the care plan, improved enrollee safety, cost savings, and enrollee autonomy.

DEFINITION OF CASE MANAGEMENT

Case management, a component of care management, is a set of activities tailored to meet a member's situational health-related needs. Situational health needs can be defined as time-limited episodes of instability. Case managers will facilitate access to services, both clinical and non-clinical, by connecting the member to resources that support him/her in playing an active role in the self-direction of his/her health care needs.

As in care management, *case* management activities also emphasize prevention, continuity of care, and coordination of care. Case management activities are driven by quality-based outcomes such as: improved/maintained functional status; enhanced quality of life; increased member satisfaction; adherence to the care plan; improved member safety; and to the extent possible, increased member self-direction.

DEFINITION OF CARE COORDINATION

Care coordination is defined as the delivery organization of member care activities between two or more participants (including the member) involved in a members' care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required member care activities, and is often managed by the exchange of information among participants responsible for different aspects of care