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Owner:	*Pamela Bourdganis: Clinical Specialist Performance Improvement*
Policy Area:	*Integrated Health Care*
References:	*NCQA QI9*

Complex Case Management

POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to promote effective complex case management services for enrollees/members (adults, children and youth) with multiple behavioral health and/or medical needs that require a wide variety of resources to manage and improve quality of life. Services are provided in a collaborative manner and assess, plan, implement and coordinate care to assist enrollee/members in regaining optimum health and/or improved functional capability in a safe, supportive environment and in a cost-effective manner – utilizing appropriate providers within appropriate time frames.

PURPOSE

The purpose of this policy is:

1. To improve the health status and quality of life of enrollee/members with multiple complex medical, behavioral, and/or substance use disorders (SUD).
2. To decrease inpatient admissions, Emergency Department (ED) visits and to improve participation in outpatient behavioral/medical health services to avoid any gaps in treatment.
3. To improve the enrollee'/member' self-management skills by increasing adherence to evidence-based practices delivered by service providers – i.e. peer advocates, Clubhouses, available IT resources (myStrength), etc.
4. To provide intensive, personalized case management services to include goal-setting and implementation utilizing person-centered principles.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWIHN Board, DWIHN Staff, Contractual Staff, Access Center, Network Providers, Crisis services vendor, Credentialing Verification Organization (CVO).
2. This policy serves the following populations: Adults, Children, I/DD, SMI, SED, SUD, Autism.
3. This policy impacts the following **contracts/service lines**: MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund.

KEYWORDS

1. Access Center
2. Acuity Level
3. Biopsychosocial Assessment
4. Care Connect 360
5. Care Management Technologies (CMT
6. Complex Case Management (CCM)
7. Consent to Share Information
8. Co-Occurring Disorders (also known as Co-occurring Issues or Conditions
9. Coordination of Care
10. Cultural Competence
11. Health Risk Assessment (HRA
12. Integrated Health Care
13. Integrated Plan of Service (IPOS
14. Linguistic Competence
15. Level of Care Utilization System (LOCUS)
16. Medicaid Health Plan (MHP)
17. MI Care Connect:
18. myStrength
19. Pre-Paid Inpatient Health Plan
20. Primary Health Care

STANDARDS

1. At least annually, Detroit Wayne Integrated Health Network (DWIHN) performs an assessment of the characteristics and needs of the entire population including adults, children/youth and relevant subpopulations. The assessment will include, but is not limited to, the following characteristics – age, gender, race/ethnicity, language preference, primary and co-morbid conditions, i.e. medical and/or behavioral health categories (SED, SMI, I/DD, SUD, Autism); and eligibility categories included in Medicaid Supplemental Security Income (SSI), etc.
2. As a result of the population assessment and consideration of relevant characteristics, the Director of Integrated Care in collaboration with the Chief Medical Officer will use this information to:
    a. Develop, assess, and re-design the Complex Case Management (CCM) program on an annual basis;
    b. Review and update the CCM resources (e.g. staffing ratios, clinical qualifications, job training, external resource needs and contacts, etc.) to address enrollee/member needs, as necessary;
    c. Review and update the CCM processes (e.g. cultural competency, program inclusion criteria, etc.);
    d. Assess enrollee/members' CCM needs and adjust procedures to facilitate linking enrollee/members

with CCM services that meet their needs.

3. Enrollee/Members will be identified for the DWIHN Complex Case Management Program (CCM) based on the following criteria:
    a. The services geared towards adults aged 18 years and older will meet the following criteria:
        1. High frequency of Emergency Department usage;
        2. Multiple chronic medical/behavioral health conditions – i.e., congestive heart failure, chronic obstructive pulmonary disease, bipolar disorder, schizophrenia, major depression, and SUD concerns;
        3. Multiple psychiatric and/or medical inpatient admissions;
        4. Gaps in service – no PCP visit within one year; for those with behavioral health concerns, limited outpatient psychiatric follow-up and adherence to medications.
    b. Children/youth will meet the following criteria in order to be considered for CCM services. They will:
        1. Be diagnosed with Serious Emotional Disturbance (SED);
        2. Range between the ages of 2 – 21 years (those enrollee/members in this cohort that are aged 18 – 21 are typically specially designated as youth with learning disabilities, court ward status, I/DD, etc);
        3. Have increased ED visits as well as multiple behavioral/medical health admissions and/or
        4. Have gaps in service and/or care; and
        5. Be diagnosed with asthma.
    c. Enrollee/members considered for participation in the DWIHN CCM will be pulled monthly by Information Technology (IT) from demographic and socioeconomic data, claims information, pharmacy claims, encounters, and utilization management data obtained through MHWIN, Care Connect 360, and other available electronic databases.
        1. Referrals can be made by DWIHN Utilization Management, Care Coordinator and other internal staff; externally by the multiple service providers within the DWIHN network.
        2. Additional referrals can be made by medical health plans, hospital discharge planners, court systems, and self-referral via family or the enrollee/member themselves.
4. A Complex Case Management (CCM) assessment will be completed for each enrollee/member involved in CCM. Within the CCM assessment will be embedded the WHO-DAS and PHQ9; both are evidenced-based tools that will provide measurable outcomes throughout an enrollee/member's participation in the program.
    a. WHO-DAS measures quality of life and covers six domains of functioning including cognition, mobility, self-care, getting along with others, life activities and participation.
    b. The PHQ9 is used for screening, diagnosing, monitoring and measuring the severity of depression.
5. A Plan of Care will be developed utilizing person-centered practices and will include the needs identified in the CCM assessment. It will include measurable goals, expectation of completion date, strengths, the enrollee/member's priorities and any barriers to success.
6. All communications, assessments and plans of care will be located within the DWIHN electronic record.
7. Complex Case Management (CCM) services will be delivered within the philosophical principles of integrated care. Some examples include:

a. Referral to Medical Health Plan Disease Management programs that will provide educational materials to enrollee/members to keep them engaged in the management of their medical/behavioral health condition.

b. Wellness and self-management programs such as smoking cessation, personal action toward health (PATH), Wellness Recovery Action Plan (WRAP), and Whole Health Action Management (WHAM) and the online myStrength tools are further options to support enrollee/members in working towards their goals.

8. Criteria for discontinuing Complex Case Management (CCM) services include enrollee/member:
   a. Having reached maximum benefit from CCM services and is able to safely return to outpatient service providers;
   b. Having met or partially met the majority of identified short-term goals;
   c. Declines further services;
   d. Unable to reach member after 3 or more outreach contacts;
   e. Enrollee/member requires a higher level of care – i.e, enrollee/member: is inpatient with an anticipated length of stay greater than 30 days; is incarcerated for longer than 30 days, requires hospice services, etc.
9. The effectiveness of Complex Case Management Services (CCM) will be reviewed using the following parameters:
   a. Decreased ED visits;
   b. Decreased gaps in service related to PCP and/or CMH visits;
   c. Adherence to medications as evidenced by pharmacy claims;
   d. Decreased inpatient psychiatric and/or medical health admissions;
   e. Decreased cost for services due to decreased usage of higher end services;
   f. Outcomes derived from evaluation of the PHQ9 and WHO-DAS tools embedded in the CCM Assessment;
   g. Satisfaction surveys completed by the enrollee/member guardian;
   h. Enrollee/member complaints regarding CCM services.
10. A Periodic Review will be completed at the time that Complex Case Management (CCM) services are ending and/or are being discontinued.
    a. Customer Satisfaction Survey will be provided to enrollee/member for completion – outcome data will be collected from the surveys.
    b. All individuals involved in enrollee/member's care will be notified of the discontinuation of CCM services including the primary care physician and behavioral health provider.
    c. Enrollee/member's next steps will be clearly identified and appropriate referrals made to ensure continuity of care.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

A sample of CCM cases will be audited quarterly for compliance with CCM process. CCM care coordinators will be expected to score 90% or greater on case audit scores. CCM case coordinator scoring less than 90% on case review will be counseled one on one on missing items and expectation will be that on next audit, CCM case coordinator cases will score 90% or greater.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY AND REFERENCES

RELATED POLICIES

1. Assessment Policy
2. Complex Case Management Procedure
3. Eligibility and Screening Policy
4. Referral, Coordination and Integration of Care Policy

RELATED DEPARTMENTS

1. Claims Management
2. Clinical Practice Improvement
3. Customer Service
4. Information Technology
5. Integrated Health Care
6. Legal
7. Managed Care Operations
8. Quality Improvement
9. Recipient Rights
10. Substance Use Disorders
11. Utilization Management

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

Complex Case Management Procedure.pdf
Complex Case Management Program Description - UPDATE 1-19.docx

Approval Signatures

Approver	Date
Dana Lasenby: Chief Clinical Officer	09/2019

Origination:	*02/2019*
Effective:	*02/2019*
Last Approved:	*02/2019*
Last Revised:	*02/2019*
Next Review:	*02/2020*
Owner:	*Tina Forman: Director of Integrated Health Care*
Policy Area:	*Integrated Health Care*
References:	

Complex Case Management Procedure

PROCEDURE PURPOSE

To provide guidelines for the delivery of enrollee-focused, integrated Complex Case Management (CCM) services.

EXPECTED OUTCOME

Deliver intensive and integrated Complex Case Management services:

- To support enrollees as they learn to self-manage some of their daily challenges
- To ensure integration of medical and behavioral health services to support holistic treatment
- To encourage use of outpatient medical and behavioral health services in an effort to reduce overuse of higher-end services

PROCEDURE

1. CCM Manager receives referrals from the various referral sources – i.e., monthly IT data pulls from within MHWIN, referrals from community mental health agencies (CMH), hospitals, DWIHN Utilization Management, self-referrals, etc.
    a. Criteria for Identifying Members Who are Eligible for the Program:
        1. The DWIHN Complex Case Management program has general eligibility criteria for adults and children/youth. For adults, these include any of the following:
            i. Member is an active consumer of outpatient behavioral health services with a disability designation of SMI, DD/IDD and/or SUD as evidenced by at least one visit within the last quarter with DWIHN provider AND
            ii. 1 or more of the following chronic medical health conditions: Hypertension, Diabetes, Asthma, COPD, heart Disease, and Obesity AND
            iii. 10 or more visits to the ED in the last 6 months OR
            iv. Evidence of 1 or more gaps in services, including but not limited to: absence of primary or specialty medical care visits within the last 12 months or gaps in medication refills for behavioral health and/or medical chronic conditions AND
            v. Willingness to actively participate in the program for at least 90 days
        2. Criteria for children/youth are as follows:

i. Must be Diagnosed with Serious Emotional Disturbance (SED) and seen for services at a DWIHN provider at least once in last quarter AND

ii. Should range between the ages of 2-21 years (those enrollees in this cohort that are aged 18-21 are typically specially designated as youth with learning disabilities, court ward status, I/DD, etc.) AND

iii. Diagnosed with chronic asthma AND

iv. 4 or more ED visits related to asthma or behavioral health in the last 12 months OR

v. Gaps in services/care- including but not limited to: absence of primary care visit within the last 6 months and gaps in refilling prescriptions for asthma controller medication and/or behavioral health medication AND

vi. Willingness of enrollee/member and or parents/guardian to actively participate in the program for at least 90 days.

b. CCM Manager will reach out to the referring service provider to gather clinical information and discuss the barriers to successful care within 14 days of receipt of the referral.

1. If the case does not meet criteria for CCM, then Manager will discuss with referral source and provide written documentation as to why the case was not accepted for CCM services. If the referral source is the enrollee and/or guardian, the reason for not opening the case in CCM will be provided; however, in both instances, efforts will be made to guide enrollee/referral source to the appropriate services and community resources. Written documentation of the decision and any referrals/community resources offered will be included in his/her MHWIN record. Any letters or mailings will be uploaded into MHWIN and case will be closed noting that enrollee did not meet criteria for CCM services.
2. If the case is appropriate for CCM, Manager will reach out to the enrollee to schedule an introductory meeting/discussion to describe CCM services. There will be instances when the service provider/referral source will assist in scheduling the initial meeting/discussion.

c. Introduction to services can occur telephonically.

1. CCM Manager will contact enrollee at the appointed time and introduce CCM services.
2. Following the description of CCM services, if enrollee declines services, a letter will be sent to him/her and to the individual making the initial referral indicating that services were declined. This letter will then be uploaded into MHWIN.
3. If CCM services are accepted, then an introductory letter, Agreement to Participate, Consent to Share Information form, and Enrollee Bill of Rights will be mailed to him/her. CCM Manager will explain each form and answer questions/concerns during the phone interaction.
    i. Enrollee will be asked to send signed documents back in the enclosed self-addressed envelope.
4. CCM Manager will offer to complete CCM Assessment during this call or schedule a different appointment date and time at enrollee's convenience as long as it is within the first 30 days of having met criteria for CCM services. CCM Manager will encourage a face-to-face meeting to complete the assessment – either at the offices of the service provider or another safe setting agreeable to enrollee and any other support individuals that he/she has asked to participate.

d. Introduction to services can occur in a face-to-face meeting.

1. CCM Manager will meet with enrollee, advocate, and/or service provider to describe array of services within CCM.
2. The meeting can be scheduled at the service provider's offices or in a safe environment that is convenient for enrollee and his/her advocates.
3. Following explanation of services, if enrollee declines services, he/she will be asked to sign a statement that he/she is not interested in the services. This will be uploaded into the MHWIN enrollee record; the record will indicate that CCM services were declined and thus case closed.
4. If enrollee and/or his/her representatives agree to CCM services, the Agreement to Participate and the Consent to Share Information forms will be explained and signed accordingly.
5. After explaining the Enrollee Bill of Rights, a copy will be provided to him/her. If he/she is in agreement, the CCM Assessment will be completed on that day. Otherwise, another face-to-face appointment will be scheduled to complete the assessment within the required 30 days following identification as a candidate for CCM services.
6. All completed and signed documents are to be uploaded into MHWIN.

e. If CCM Manager is unable to make contact with consumer - despite support from the service provider - to make introductions to CCM program, outreach efforts are to continue via telephone and mail.
    1. Attempts to reach enrollee by phone should occur one time weekly for the first 30 days.
    2. Within the initial 30 days of outreach, a letter should be sent to him/her describing the reason for the outreach.
    3. Should these outreach efforts be unsuccessful, an additional two attempts for the next 30 days should be made.
    4. If these final outreach attempts are unsuccessful, then a letter closing the case should be sent to the enrollee and referral source. The letter must include the following:
        i. The reason for closing the case
        ii. The date of the case closure.
        iii. A statement indicating that CCM Care Coordinators will make check-in phone calls within several weeks to ensure that enrollee does not require any additional support.
        iv. Enrollee will also be informed that he/she can contact CCM program to institute services whenever the need arises.
f. The CCM Assessment mirrors the integrated biopsychosocial assessment; embedded into the CCM Assessment are two tools – one that screens for depression (PHQ9) and the other measures quality of life and overall functioning (WHO-DAS). These tools will be used to assess outcomes over the course of CCM service delivery.
    1. The CCM Manager will complete the CCM Assessment in an effort to initiate engagement and to allow an opportunity for enrollee to recognize more than one member of the CCM team in case of emergencies or need for coverage – all in an effort to increase his/her comfort and eliminate the feeling of "another new worker" should the assigned CCM Care Coordinator not be available.
    2. The enrollee will be encouraged to invite any support individuals that would make him/her more comfortable in completing the CCM Assessment.
    3. It will be recommended that the service provider be part of the CCM Assessment process, if

possible.

g. The CCM Manager will also complete a Safety and/or Crisis Plan with enrollee and his/her advocates (as part of the assessment process), if appropriate.
    1. The purpose of these plans will be discussed with the enrollee, as will the difference between the Safety/Crisis Plans.

h. When the CCM Assessment is completed, the Manager will refer the enrollee to one of the CCM Care Coordinators to initiate services.
    1. CCM Care Coordinator will reach out to the service provider and enrollee to introduce him/herself and schedule a time to begin services.
    2. CCM Care Coordinator and enrollee will discuss the needs identified in the CCM Assessment that should be addressed as part of the Plan of Care.
    3. Person-Centered principles will be incorporated in the planning process – allowing enrollee to choose the location, individuals to invite, date and time.
    4. The Plan of Care is completed with needs identified prioritized according to enrollee choice; if safety concerns are identified, these will take precedence over the enrollee's other prioritized goals.
        i. It will be up to enrollee's team to explain why safety concerns need to be addressed in addition to the goals that he/she has identified – even though these were concerns that he/she had not considered as important.
        ii. Referral to Crisis/Safety Plan would be important at this point.
    5. Depending on enrollee need, the CCM Care Coordinator will make outreach calls as warranted and support the service provider in linking him/her to necessary community resources.
    6. Depending on enrollee's needs, CCM Care Coordinator provides education, follow-up after referrals are made and self-management support.
    7. Date and time for next telephone or face-to-face contact will be established with enrollee at the end of each contact and documented in MHWIN.
    8. The CCM Care Coordinator will be reaching out to enrollee either telephonically or face-to-face depending on enrollee need and preference – approximately 1-3 times per week initially. It is hoped that as enrollee progresses, the contact between enrollee and CCM Care Coordinator will decrease as enrollee's needs are being met as enrollee is linked to appropriate services and resources.
    9. The referral to Peer Advocates, Clubhouse settings, myStrength (interactive web and mobile application that will support consumer in learning to self-manage co-occuring conditions) and other evidenced-based programming is encouraged with enrollee agreement and involvement of the service provider.
    10. CCM Care Coordinator will review areas of CCM Assessment and the Plan of Care on a monthly basis and make adjustments/changes as necessary. All team members involved in this enrollee's care and the enrollee are to be made aware of any changes and should be in agreement.
    11. All interactions with the enrollee, provider and referral contacts are documented in MHWIN Once initial assessments are completed, a summary of each section of assessment will be

documented in MHWIN.

i. If the CCM Care Coordinator is unable to reach enrollee when initially assigned to him/her or after completion of the Plan of Care, outreach efforts will begin. Please refer to ***Section e.*** for outreach process.

j. Once it is agreed by the team that enrollee has reached maximum benefit from the CCM services and/or the severity of need has decreased, transitioning the enrollee to other services will be discussed with him/her as well as the date that CCM services will end.

1. It is important to note that it is not necessary for all goals on the Plan of Care to have been met; as long as enrollee's condition has stabilized and linkage to services and community resources has been made.

i. A Discharge Summary is completed when CCM services are ending. Enrollees engaged in CCM services for 90 days need to be discussed with Manager as far as status of unmet goals and whether he/she can be transitioned to case management, supportive or other community services that can support him/her to continue work on outstanding goals. At this point, it will be determined whether continued CCM services are warranted. Each case will be reviewed on an individual basis.

ii. Criteria for discontinuing CCM services include:

a. Outreach efforts have not been successful.

b. As noted, enrollee has reached maximum benefit from the services and is safe to return to outpatient providers and/or community resources.

c. Enrollee declined the services during any part of the process.

d. Enrollee was admitted to an inpatient facility and it is known that his stay in the facility will exceed 30 days.

e. Other extenuating circumstances that can be discussed within the CCM team.

iii. Ending services in CCM involves notifying the enrollee and service provider via telephone followed up with a letter that includes the reason for discontinuing services.

a. A Satisfaction Survey will also be enclosed in the letter discontinuing services – enrollee will be encouraged to complete and return in a self-addressed envelope to measure success of the services provided.

iv. Enrollees and their service providers will be informed that he/she will remain on a "check-in" list and monitoring telephone calls will be made at intervals to ensure continued progress.

v. Case will be closed in MHWIN. Documentation will include the reason for discontinuing CCM services.

2. Complex Case Management Manager and Care Coordinator Expectations:

a. The CCM team will meet on an every other week basis to go over any team concerns and to conduct team case reviews
Agendas, sign-in sheets, as well as minutes will be completed for each of the CCM Team meetings and will be made available to the team members.

b. On alternate weeks when the CCM team does not meet, the team will meet with the Director of Integrated Health Initiatives to address any major concerns related to process and to make

adjustments in service delivery and to provide updates on team functions.

c. Case reviews will occur outside of meetings as appropriate and necessary.

d. Documentation will be completed in the time frames required – i.e., CCM Assessment, Crisis and/or Safety Plans must be completed within 30 days enrollee was identified as a candidate for CCM services; Plan of Care will be completed within two weeks following the CCM Assessment.

    1. Chart notes are to include outreach efforts and any activities that support enrollee's progress.
    2. All correspondence and/or signed documents are to be uploaded into enrollee's MHWIN record within 24 hours.

e. CCM Manager and Care Coordinators will work together to develop community resource book to include information regarding the various MHP benefits, guardianship processes and terms, motivational interviewing according to population – i.e., children/youth; individuals with SUD, MI, I//DD. Develop skills to enhance cultural competence – i.e., various ethnic backgrounds, LGBTQ population, etc. Other relevant resources include processes for specialized residential services as well as the process for referral for placement; available children's services along with information related to the foster care system; SUD providers with various programs available for different populations. Collection of community resources will be an ongoing process with special care to ensure that the resources are current and still active.

f. Explain CCM services clearly and concisely to various referral sources – will develop a short "cheat sheet" that describes services, criteria, referral process, etc.

PROCEDURE MONITORING & STEPS

Who monitors this procedure:	Tina Forman/Director of Integrated Health Care
Department:	Integrated Health Care
Frequency of monitoring:	At least annually
Reporting provided to:	IPLT and QISC
Comments: This was transferred from a MS Word Procedure that originated 12/8/2016, Rev Dates: 12/25/17. This Procedure is associated/attached to the Complex Case Management Policy.	

Attachments:

Approval Signatures

Approver	Date
Tina Forman: Director of Integrated Health Care [AS]	02/2019
Tina Forman: Director of Integrated Health Care [AS]	02/2019

INTEGRATED HEALTH CARE INITIATIVES
COMPLEX CASE MANAGEMENT
PROGRAM DESCRIPTION

Introduction

The Case Management Society of America defines Case Management as a collaborative process that includes an assessment, planning, facilitation, and advocacy. It explores options and services to meet an enrollee's identified needs with the ultimate goal of promoting high quality, enrollee-friendly and cost-effective outcomes. The Detroit Wayne Mental Health Authority (DWMHA) utilizes the Institute for Healthcare Improvement's (IHI) "Triple Aim" as a framework. The Triple Aim was developed as an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which they call the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations; and
- Reducing the per capita cost of health care.

The Detroit Wayne Mental Health Authority (DWMHA) Complex Case Management program will be available to children/youth and adults who are eligible for the Medicaid, dual eligible members with both Medicaid and Medicare and including MI Health Link, SED and/or Autism Waiver benefits. Enrollees involved in this program can carry the designation of severely mentally ill (SMI), intellectually/developmentally disabled (I/DD), have a substance use disorder (SUD), be severely emotionally disabled (SED) or receiving services under the autism benefits available through Medicaid. However, participation in Complex Case Management will not be dependent upon the health benefit available to the enrollee.

The ultimate goal of DWMHA's Complex Case Management (CCM) Program are to:

- Improve medical and/or behavioral health concerns and increase overall functional status as well as improve overall quality of life as evidenced by a 10% improvement in PHQ-9 score for those enrollees with depression and/or a 10% improvement in mental or physical related quality of life scores on the WHO-DAS
- To provide early intervention for members appropriate for complex case management to prevent recurrent crisis or unnecessary hospitalizations as evidenced by 10% reduction in Emergency Department (ED) usage and/or 10% reduction in inpatient admissions.
- To facilitate communication among the enrollee/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 by sharing the enrollee/member's individualized plan of care 100% of the time.
- To serve as a liaison to community resources regarding options and services not covered by the benefit plan as evidenced by a 10% improvement in mental or physical health related of life scores on the WHO-DAS.

- Improve adherence to medications as well as outpatient treatment including appointments by supporting and reinforcing the treatment plan as evidenced by a 20% decrease in ED use and /or inpatient admissions in the 90 day period following enrollment.
- Gain skills for self-management of conditions utilizing MyStrength and other informational technology tools as evidenced by reports showing increased participation in the use of self-management tools.
- Enrollees/members will be able to access community resources and will obtain a better understanding of the medical and/or behavioral health diagnoses they carry as evidenced by at least 1 documented BH visit each month following admission into the program and completion of an annual physical at the medical provider if not previously present during the last year.
- 80% or greater member satisfaction scores for enrollee/members that have completed the program.

The Nine Phases of Complex Case Management

1) Population Assessment
2) Member identification and selection
3) Complex Case Management Assessment
4) Plan of Care Development/update
5) Plan of Care Implementation
6) Plan of Care Monitoring and Evaluation
7) Case Discharge
8) Transition to other care
9) Measure effectiveness of the program – i.e., outcomes and cost savings

The first seven are modeled directly from the Case Management Society of America Standards of Practice for Case Management (CMSA, 2016). The last two are implemented to ensure safe transitions between levels of care and to determine the effectiveness of DWMHA'S CCM program.

The reason to initiate CCM services is to support enrollees to sustain/maintain optimum health and/or functional capacity in the most appropriate setting and in a cost-effective manner. It involves comprehensive assessment of the member's situation, determination of available benefits and resources, and development and implementation of a Plan of Care that includes needs identified in the initial CCM Assessment, monitoring of progress towards those goals and eventual transition back into outpatient service provider/community care.

In accordance with an enrollee's right to choose, as well as NCQA standards, DWMHA considers Complex Case Management to be an opt-out program. That is, eligible enrollees have the right to participate or to decline. DWMHA offers a variety of programs to its enrollees and does not limit

eligibility to one complex condition or to enrollees already participating in other DWMHA health management programs.

The DWMHA CCM program is led by the Director of Integrated Health Care Initiatives and overseen by the Medical Director. The Director of Integrated Health Care Initiatives will report CCM program practices and outcomes to the Improving Practice Leadership Team (IPLT), and the Quality Improvement Steering Committee (QISC). Complex Case Management services will be delivered by licensed and limited licensed masters and bachelors level social workers, counselors, limited license psychologists, and/or nurses. Complex case management care coordinators will have a minimum of 5 years working with persons with behavioral health conditions and/or complex medical conditions.

Evidence Used to Develop the CCM Program

There is significant evidence to inform the use of CCM to improve the health outcomes for persons with complex medical and behavioral health conditions. For example, a 2013 article published in *The Journal of Emergency Medicine* found that complex case management strategies were effective in reducing the number of emergency department visits amongst a high utilizer population (Kumar & Klein).

The DWMHA CCM Program was developed based on evidence-based guidelines from various sources including medical and behavioral healthcare specialty organizations. The following is a list of organizations that have been reviewed to increase knowledge with regard to clinical practice guidelines, chronic care guidelines as well as to research case management practice:

1. American Heart Association, American Diabetes Association, National Alliance on Mental Illness; (NAMI), the Substance Abuse and Mental Health Services Administration (SAMHSA), the American Psychiatric Association (APA) , and the National Comprehensive Cancer Network, and National Heart, Lung and Blood Institute.
2. The Michigan Center for Clinical Systems Improvement's Complex Care Management Guidelines.
3. Case Management Society of America's (CMSA) Case Management Adherence Guidelines (CMAG) for chronic conditions.
4. Robert Wood Johnson Foundation: The Synthesis Project. "Care Management of Patients with Complex Health Care Needs."
5. Institute for Healthcare Improvement (IHI). "Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs.
6. CMSA Standards of Practice for Case Management
7. DWMHA's clinical guidelines

Population Assessment:

DWMHA recognizes the importance of analyzing membership data to assure that our programs and services meet the diverse needs of the enrollees we serve. We use this information to create topic and language appropriate materials, establish partnership with other organizations serving ethnic

communities, inform our vendors about specific ethnic and cultural needs; and develop competency training that staff must attend annually.

Enrollee who will be referred to participate in the CCM program will be adults and children/youth with the designation of severely mentally ill (SMI), intellectually/developmentally disabled (I/DD), substance use disorders (SUD), severely emotionally disturbed (SED) and autism. The population is typically eligible for Medicaid, Medicaid and Medicare including MI Health Link, SED waiver, and/or the Autism waiver benefit. Review of the statistics from Michigan Department of Health and Human Services (MDHHS) reveal that the following medical/behavioral health conditions are equally and/or more prevalent within Wayne County versus the entire State of Michigan. The 2017 population of Wayne County was 1.75 million people and had a median household income of $42,043 (US Census). According to the Robert Wood Johnson County Health Rankings, Wayne County is ranked 83/83 in overall health outcomes.

Health/Social Factors	Michigan	Wayne County
Adult Obesity	31%	34%
Severe Housing Problems	17%	23%
Adult Smoking	21%	23%
Children Eligible for Reduced Price Lunch	47%	61%
Preventable hospital stays per 1,000 members	56	71
% Diabetic Medicare Enrollees that received HBA1C	86%	82%
Sexually Transmitted Infections per 100,000	447.2	804.3

Based on the population assessment obtained from DWMHA data (enrollment, encounters and claims) from 2016-2017, of the 58,864 individuals with Medicaid enrolled in DWMHA's behavioral network, the population is broken into the following categories:

1) Racial Breakdown:
    a. African American: (27,782) 47.20%
    b. Caucasian: (17,461) 29.66%
    c. 2 or more races: (7,748) 13.16%
    d. Other race: (3,041) 5.17%
    e. Asian: (216) 0.37%
    f. Native American, Alaskan Native, Native Hawaiian or other Pacific Islander: (146) 0.25%
    g. Unreported: (2,470) 4.20%
2) Ethnic Breakdown:
    a. Not of Hispanic or Latino origin: (49,557) 84.19%
    b. Cuban: (26) 0.004%
    c. Mexican: (873) 1.48%
    d. Other Hispanic or Latino: (462) 0.78%
    e. Puerto Rican (333) 0.57%

f. Specific origin not specified: (1,438) 2.44%
g. Unreported: (5,175) 10.49%

3) Age Breakdown:
    a. 0-17 years: (13,963) 23.72%
    b. 18-64 years: (42,584) 72.34%
    c. 65 and older: (2,317) 3.94%
4) Sex Breakdown:
    a. Female: (27,305) 46.39%
    b. Male: (31,545) 53.59%
    c. Unreported: (14) 0.02%
5) Disability Designation:
    a. SED: (10,902) 18.52%
    b. SMI: (29,108) 49.45%
    c. Mild to Moderate MI: (789) 1.34%
    d. I/DD: (9,279) 15.76%

The top 5 behavioral health conditions for the adult and child combined population are mood disorders, schizophrenia and other psychotic disorders, developmental disorders, anxiety disorders and Attention - deficit conduct and disruptive behavioral disorders. The top 5 chronic medical conditions are hypertension, diabetes, COPD, asthma, and heart disease.

English is the primary language spoken by our members. Of those whose primary language is not English, 58% speak Arabic as their primary language, 36% speak Spanish as their primary language, 2% Bengali as their primary language and 4% all other languages combined.

When these figures are analyzed, Wayne County has a significant number of members who carry multiple chronic behavioral and medical conditions as compared to the State in its entirety. Possible reasons are related to the behavioral health diagnoses that may or may not be treated consistently that often result in decreased PCP follow-up, poor diet and overall physical health/care. The need for continued education to members who are being cared for in behavioral health settings cannot be over-emphasized. Accessibility of medical care for members with limited transportation resources should also be considered. The "one-stop shopping" concept is an important one – services for medical and behavioral health should optimally be available in one location so that needs can be addressed while the enrollee is engaged in care.

Criteria for Identifying Members Who are Eligible for the Program

1) The DWMHA Complex Case Management program has general eligibility criteria for adults and children/youth. For adults, these include any of the following:
    - Member is an active consumer of outpatient behavioral health services with a disability designation of SMI, DD/IDD and/or SUD as evidenced by at least one visit within the last quarter with DWMHA provider **AND**

- 1 or more of the following chronic medical health conditions: Hypertension, Diabetes, Asthma, COPD, Heart Disease, and Obesity **AND**
  10 or more visits to the ED in the last 6 months **OR**
- Evidence of 1 or more gaps in services, including but not limited to: absence of primary or specialty medical care visits within the last 12 months or gaps in medication refills for behavioral health and/or medical chronic conditions **AND**
- Willingness to actively participate in the program for at least 90 days

2) Criteria for children/youth are as follows:
   - Must be Diagnosed with Serious Emotional Disturbance (SED) and seen for services at a DWMHA provider at least once in last quarter **AND**
   - Should range between the ages of 2-21 years (those enrollees in this cohort that are aged 18-21 are typically specially designated as youth with learning disabilities, court ward status, I/DD, etc.) **AND**
   - Diagnosed with chronic asthma **AND**
   - 4 or more ED visits in the last 12 months OR
   - Gaps in services/care- including but not limited to: absence of primary care visit within the last 6 months and gaps in refilling prescriptions for medical and/or behavioral health conditions **AND**
   - Willingness of enrollee/member and or parents/guardian to actively participate in the program for at least 90 days.

Enrollees appropriate for DWMHA CCM often have complex medical conditions, behavioral health issues, co-occurring substance use disorders and psychosocial needs that could result in exacerbation of fragile medical status.

Enrollees should have medical complexity as described above that is compounded by related psychosocial, health and behavioral needs such as treatment adherence, care coordination, educational and/or community resource needs.

It will be important to coordinate with Medical Health Plans (MHP)/Integrated Care Organizations (ICO) to ensure that the enrollees/members referred to DWMHA for CCM services are not receiving these same services through the MHP or ICO.

<u>Services Offered</u>

1. Services available to members in CCM will include:
   a. Care Coordination to support/assist enrollee in arranging appointments.
   b. Coordination of care between medical and behavioral health providers.
   c. Referrals to community resources – i.e., MDHHS for financial assistance or redetermination of benefits, referral for specialized residential services, etc.

d. Education and promotion of self-management, including DWMHA's online self-management tool MyStrength, in order to empower enrollee/members to take a more active role in their health.
e. Assistance to enrollees to help them to better understand their behavioral health and medical benefits.
f. Support enrollee's adherence to the care plan
g. Advocacy to ensure appropriate referral and services are received.
h. Appropriate and timely communication with enrollees, practitioners and hospitals.
i. Medication reconciliation, including medication education with the enrollee.
j. Systematic approach to assessing, planning and provision of case management services to improve health outcomes.

2. Enrollees in Complex Case Management will have a CCM Assessment from which enrollee needs will be determined; this will then lead to the development of the Plan of Care. The Plan of Care will be developed utilizing person-centered principles. The enrollee will be able to identify supports, family, and advocates that he/she would like to attend. The Complex Case Manager as well as the service provider, behavioral/medical health personnel will be part of this meeting when available and appropriate and part of enrollee's support team.

Technological Tools Used to Identify Enrollees for Complex Case Management

Enrollees for CCM will be identified from data supplied from multiple available sources, including**:**

1. **MHWIN**: This is the primary transactional system used by DWMHA for analysis of revenue, cost, and utilization trends for individuals served by the DWMHA network. Within this system enrollee demographics and encounters are the primary sources of data.
2. **ProAct/Relias Population Health Tool:** This is a population health tool that uses Medicaid claims and pharmacy data provided by MDHHS and runs it through complex algorithms to identify enrollee/members that flag HEDIS and other compliance and quality metrics signaling a potential need for CCM intervention.
3. Enrollees are identified from data sharing or care coordination meetings in conjunction with medical health plan (MHP) partners, through the Community Outreach of Psychiatric Emergencies (COPE) and community service providers, guardians, and members.
4. **Utilization management** monthly reports

Access to Complex Case Management

1. The DWMHA Complex Case Management team may receive referrals for services electronically, telephonically or by written communication. A referral form has been developed and was distributed to the various referral sites as well as available on the DWMHA website.

2. Referrals can be made by practitioners/providers, enrollees or their caregivers, UM staff, Customer Service staff, Access Center staff, hospital discharge planners, health plan case managers/disease managers.

3. CCM staff will review the following reports proactively to identify enrollees who might benefit from CCM in an effort to minimize the time between identifying an enrollee's needs and them receiving appropriate services:
    - UM Inpatient Admission Report
    - UM report of 3 or more inpatient admissions in the last 6 months of enrollees with an SUD condition.
    - Pharmacy report of adults with schizophrenia who have not refilled their antipsychotic medication for at least 80% of the last 12 months and who has also had 10 or more ED visits in the last quarter.
    - Children with chronic asthma and at least 4 visits to the ED in the last year

4. The DWMHA Complex Case Management team will provide education and written communication to providers on a regular basis. The quarterly MI Health Link roundtable meetings, monthly quality operations meetings, and bi-monthly substance use disorder provider meetings can be used as a forum to disseminate information regarding Complex Case Management.
5. The Member Handbook, which is sent to every enrollee upon initiation into DWMHA, includes a description of complex case management and information on how to access these services.
6. The Provider Manual includes information about complex case management and how to make a referral.
7. Information for enrollees as well as practitioners/providers is available on the DWMHA website and can be obtained by calling customer service.

Complex Case Management Process

The Complex Case Management program is voluntary and is provided at no cost to the member. A member must give verbal and/or written consent for enrollment in this program. The program is most successful with participation of the member's family, caregivers and/or other support systems. The CCM program will use a standardized case management process for all of its assigned members and consists of several key areas including but not limited to:

- Comprehensive Initial Assessment of enrollee/member as listed below;
- Development of an individualized care plan with enrollee and or caregiver, significant other, family, with a copy shared with the enrollee;
- Facilitation of enrollee referrals to resources;
- Self-Management Plans;
- Assessment of progress towards needs identified in the Plan of Care.

Complex Care Coordinators provide ongoing case management for as long as the enrollee has identified needs and expresses willingness to receive support and services from the program, up to 120 days. Complex Care Coordinators maintain at least monthly contact, although may be more frequent especially in the beginning, to address and meet varying enrollee needs. Generally, Complex Care Coordinators provide the following to all enrollees enrolled in the program:

a. Support to the enrollee's adherence to care plans to improve health complexities;
b. Advocacy to ensure appropriate services and resources are received;
c. Education and promotion of self-management in order to empower enrollees to take a more active role in their health;
d. Coordinated and seamless integration of complex services and/or special needs;
e. Appropriate and timely communication with enrollees and/or caregivers, providers/practitioners, and hospitals;
f. Systematic approach to assessing, planning and provision of case management services to improve health outcomes;
g. Referrals to appropriate medical, behavioral, social and community resources to address enrollee needs.

The Complex Case Management Manager will review the referrals and reach out to the service provider/referral source in an effort to gather clinical information to determine enrollee's appropriateness for CCM services. The clinical information can include the integrated biopsychosocial assessment, Individual Plan of Service and any other relevant assessments (nursing assessment, history and physical, etc.).

If the enrollee does not meet criteria for Complex Case Management, the referral source and/or enrollee will be informed by written or verbal communication. However, his/her concerns will be discussed and information and resources provided as appropriate.

If the enrollee meets the identified requirements to participate in Complex Case Management, the DWMHA CCM Manager will reach out to the service provider/referral source and determine the best way to reach out to the enrollee. It may be that the enrollee would be more comfortable having the service provider make the initial contact and/or appointment for CCM staff to introduce the CCM services. The introductory information can be relayed to enrollee telephonically or face-to-face. The recommendation will be for a face-to-face meeting, as long as enrollee is agreeable. This meeting can occur at the service provider's offices or in a safe, public environment of enrollee's choice.

Once the CCM staff has made contact with the enrollee, CCM services including the array and benefit of services will be described. The enrollee will be informed that it is his/her choice to participate; that current services will be maintained; that CCM complements the services already in place; and that the proposed services are provided at no additional cost to him/her. If enrollee declines to participate, either a letter indicating the decision not to participate (if conversation is telephonic) or a signed statement declining services (if face-to-face) will serve as documentation of that decision. Either

document will be uploaded into his/her chart within the MHWIN system. Enrollee will be provided with contact information to access CCM services should he/she decide to participate in the future.

Upon agreement to participate in CCM services via a face-to-face meeting, the CCM staff will review the Welcome Letter, the Agreement to Participate and Consent to Share Information forms for enrollee signature. Enrollee Bill of Rights will also be explained and a copy provided for his/her records. If he/she is in agreement, the CCM staff will complete the CCM Assessment at that time. If the enrollee does not agree, then an alternate date and time will be scheduled at his/her convenience; however, it will need to be within 30 days of the date enrollee was identified as a candidate for CCM. If the time frame required is not met, documentation as to why must be included in the enrollee's MHWIN record – potential reasons could include inability to reach him/her, enrollee illness, etc.

If the introduction to services is telephonic and enrollee agrees to participate, then the Welcome Letter, Agreement to Participate, the Consent to Share Information, and Enrollee Bill of Rights will be sent via mail, including a self-addressed envelope for return to CCM staff.

Once a case is opened, the CCM Care Coordinator will reach out to the service provider/referral source and/or the enrollee within 7 days of receiving the case. Based on the completed CCM Assessment, the CCM Care Coordinator will then work with service provider and enrollee to complete a Plan of Care. This Plan of Care will be developed utilizing person-centered principles – giving the enrollee an opportunity to identify individuals who will be invited to participate; he/she will also identify the date, time, and location for either face-to-face or telephonic meeting. The individuals identified as members of the team will be invited to the meeting on the date and time chosen by the enrollee; they will be notified of the meeting either telephonically, through secure email, or through regular U.S. mail.

The Plan of Care will be enrollee-focused, in that he/she will prioritize goals to be addressed. However, if safety concerns exist, other team members may make these a priority with efforts to show enrollee possible negative consequences if not addressed. The Plan of Care will include action items for specific team members to assist with and/or enrollee to self-manage with support or independently. The goals need to be measureable and time-limited. Barriers will also be documented and addressed. Once the Plan of Care is completed, a copy will be made available for each team member. These can be handed out following the Plan of Care Meeting or can be sent out by mail/secure email. If team members have access to MHWIN, they can also review the Plan of Care within the electronic record.

The Plan of Care will be reviewed with enrollee and identified team members on a monthly basis to assess progress and/or the need to make adjustments. The Plan of Care will be updated as necessary and a copy of the amended plan will be provided to enrollee and team members in the same way described above.

The CCM Care Coordinator will reach out to enrollee either telephonically or face-to-face depending on enrollee need and preference – approximately 1-3 times per week initially. It is hoped that as time

progresses, the contact between enrollee /member and CCM Care Coordinator will decrease as he/she becomes more connected and needs are slowly resolving. Dates for follow up are tracked in MHWIN and presented to care coordinator in his/her work queue. All documentation will be entered in or uploaded to MHWIN.

Process for Outreach

If efforts to contact enrollees to introduce CCM services, complete the assessment and/or Plan of Care are not successful, it is required that CCM staff attempt outreach as noted below:

1. Contact enrollee telephonically one time per week for 30 days
    a. A letter should also be sent to him/her at this time indicating that efforts are being made to reach him/her. Within the letter, the enrollee will be offered the opportunity to contact the CCM program staff should he/she decide to accept or return to services.
    b. All efforts to contact enrollee will be documented in MHWIN.

Outreach to referral sources, identified emergency contacts and/or family members will also be attempted prior to closing a case. Additionally, efforts will be made to reconnect with enrollee by checking in MHWIN to determine if there have been any hospital admissions or if there are any upcoming appointments with service providers. There may be opportunities when medical health plans can assist in locating enrollees/members – either through PCPs and/or through specialized teams and programs that differ at each health plan.

DWMHA CCM Assessment would address the following:

Enrollees/Members' Health Status

- The assessment includes enrollee's self-reported health status and information on the event or diagnosis that led to his/her eligibility for complex case management.

Clinical History including Medications

- This section reports the enrollee's clinical history (e.g., condition 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 him/her for complex case management

Activities of Daily Living

- The WHO-DAS assessment tool is embedded in the CCM Assessment. This tool evaluates quality of life and overall functional status.

Behavioral Health Status

- The PHQ9 assessment tool is also embedded in the CCM Assessment and evaluates the behavioral health symptoms being reported by the enrollee

Psychosocial Issues

- Beliefs and concerns about the condition and/or treatment
- Perceived barriers to meeting treatment require
- Access, transportation, and financial barriers to obtaining treatment

Life Planning Activities

- The Life Planning Questionnaire, as part of the initial assessment, assesses whether he/she has completed life-planning activities such as wills, living wills or advance directives and health care powers of attorney. If an enrollee/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 enrollees in CCM if it is appropriate.

Cultural and Linguistic Needs

- CCM care coordinators will evaluate cultural and linguistic characteristics which may present potential barriers to effective communication or care, and/or acceptability of specific treatments. This section of the assessment includes consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs as appropriate.

Visual and Hearing Needs

- Identify potential barriers to effective communication or care.

Caregiver resources

- Evaluate the adequacy of caregiver resources (e.g., family involvement and level of support)

Available benefits

- Evaluate the adequacy of health benefits regarding the ability to fulfill a Plan of Care. The assessment goes beyond checking insurance coverage and includes a determination of whether the resources available to the enrollee/member are adequate to fulfill the Plan of Care.

Community Resources

- Evaluate the enrollee'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.

Individual Case Management Plan and Goals

The personalized Plan of Care meets enrollee's needs and includes:

- Prioritized goals, time frame for reevaluation;
- Resources to be utilized, including the appropriate level of care;
- Planning for continuity of care, including transition of care and transfers;
- Collaborative approaches to be used, including level of family participation;
- Prioritized goals consider enrollee and caregiver needs and preferences;
- Time frames for reevaluation are specified in the case management care plan.

Identification of Barriers

- Identifies and addresses barriers to receipt of care or participation in the Plan of Care. These could include the enrollee's lack of understanding, motivation, cultural or spiritual beliefs; visual or hearing, psychological impairment, any financial needs, insurance issues or transportation problems.

Referrals to Available Resources

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

Follow-up Schedule

- Schedule for follow-up communication that includes, but is not limited to, counseling, referrals to disease management or a health resource, enrollee education, self-management support, and determining when follow-up is not appropriate.

Development and Communication of Self-Management Plan

- The complex case management policy and procedure specifies a process for communicating the self-management plan to the enrollee or caregiver (i.e., verbally, in writing). The self-management plan is mutually agreed upon by the case manager and enrollee/caregiver. This plan will allow the enrollee/caregiver to be engaged in his/her health and care.

Assessing Progress

The complex case management care plan includes an assessment of enrollee'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 enrollee. Accomplishments are acknowledged when the enrollee/caregiver meets a goal. New goals can be established as appropriate.

Each case file will demonstrate evidence that DWMHA's CCM Program has completed the 11 factors listed within the Quality Standards related to Complex Case Management. Documentation that the factors were assessed and needs addressed must be clear.

As previously indicated, the WHO-DAS and PHQ9 tools are embedded within the CCM assessment. These tools measure quality of life for the enrollee and will be conducted at the start of CCM services and every month thereafter as the Plan of Care is reviewed. In addition to the WHO-DAS and PHQ9, members will be evaluated on whether or not they achieved their identified goals for the CCM program.

Process for Closing Cases from Complex Case Management

CCM cases are closed for the following reasons and in the following manner:

- Enrollee/guardian could not be reached to introduce CCM services despite numerous outreach attempts via telephone and/or mail
- Enrollee achieved maximum benefit from CCM and can return to outpatient service providers' care - i.e., case management, supports coordination, day program, Clubhouse, etc.
- Enrollee/guardian has decided to discontinue CCM services – this can occur at any point in the process
- Following completion of CCM Assessment and Plan of Care, unable to contact enrollee/guardian despite multiple attempts at outreach either by telephone, mail, and/or both
- Enrollee requires a higher level of care – i.e., inpatient with expectation of hospital stay greater than 30 days, or incarceration lasting longer than 30 days. Enrollee can return to CCM services after discharge, if applicable
- Death of the enrollee

As part of discontinuing CCM services, the CCM Care Coordinator will complete a Discharge Summary to assess enrollee's progress/situation at closing. A letter will be sent to the service provider and enrollee informing them of discontinuation of services. Transition of care needs will be addressed to ensure continuity of care including connecting enrollees with services that will continue to support and assist him/her. A Satisfaction Survey will be included with the closure letter. Enrollee will be encouraged to complete the survey and mail it back to DWMHA utilizing the self-addressed, stamped envelope. The survey will be utilized as part of the data gathering process to assess CCM services.

Assessing the Overall CCM Program

The overall goal of the DWMHA CCM program is to ensure members are appropriately connected to their medical providers, improve their ability to self-manage their health, improve the mental and physical health related quality of life and overall satisfaction with their healthcare.

Monthly CCM member assessment

- Changes in WHO-DAS & PHQ9 scores for adults
- Attainment of goals identified in CCM (% complete for each goal)

CCM will be measured quarterly against the following benchmark for participating members:

- 10% improvement in PHQ 9 scores for members with depression
- 10% improvement in mental or physical health related quality of life
- Completed at least 2 visits with behavioral health provider
- Completed at least 1 visit with primary care provider if not seen within the last year

CCM will be measured every 6 months against the following benchmark for participating members:

- 10% reduction in Emergency department usage
- 10% reduction in inpatient hospital admissions
- 80% or greater member satisfaction scores for members that have completed the program
- Completed at least 1 visit with primary care doctor

The CCM leadership team will review the results of above and determine appropriate interventions to address opportunities for improvement, if applicable. The team will consider qualitative and quantitative data to identify patterns in feedback.

Data from the CCM program will be presented to the IPLT and QISC at least annually.

References

Behl. (2015). 2016 Complex Case Management Program Description. Retrieved from https://www.ghcscw.com/SiteCollectionDocuments/Provider_Handbook/Complex_Case_Management_Program_Description.pdf

Craig C, Eby D, Whittington J. Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011.

Kumar, G.S. & Klein, R. (2013). Effectiveness of Case Management Strategies in Reducing Emergency Department Visits in Frequent User Patient Populations: A Systematic Review. *The Journal of Emergency Medicine.* http://dx.doi.org/10.1016/j.jemermed.2012.08.035

Complex Care Management Guidelines. (2015). Michigan Center for Clinical Systems Improvement. Retrieved July 20, 2018 from: https://www.miccsi.org/wp-content/uploads/2016/01/Complex-CM-Guideline-Final-Version-pdf.pdf

Guidelines

American Diabetes Association
www.diabetes.niddk.nih.gov

American Heart Association
www.heart.org

American Lung Association
www.lung.org

American Psychiatric Association
https://www.psychiatry.org/

Case Management Adherence Guidelines for COPD, Diabetes, and Depression
http://www.cmsa.org/

Case management Society of America
http://www.cmsa.org/

National Alliance on Mental Illness
http://www.nami.org/

National Comprehensive Cancer Network
https://www.nccn.org/

Audit Tool - Complex Case Management

QI	Element	Description	Met (1)/Not Met (0)
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Initial assessment of member health status, including condition-specific issues and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Documentation of clinical history, including medications and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Initial assessment of the activities of daily living and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Initial assessment of behavioral health status, including cognitive functions and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Initial assessment of psychosocial issues and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Evaluation of cultural and linguistic needs, preferences or limitations and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Evaluation of visual and hearing needs, preferences or limitations and completes assessment within 30 calendar days of identification.	
9	G	Review of complex case management files demonstrates that DWMHA follows its documented processes for: Evaluation of caregiver resources and involvement and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Evaluation of available benefits and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Evaluation of available community resources and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Assessment of life-planning activities and completes assessment within 30 calendar days of identification.	
9	H	Review of DWMHA's complex case management files that demonstrates that DWMHA follows its documented processes for: 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 and completes assessment within 30 calendar days of identification.	
9	H	Review of DWMHA's complex case management files that demonstrates that DWMHA follows its documented processes for: Identification of barriers to meeting goals and complying with the plans and completes assessment within 30 calendar days of identification.	
9	H	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Development of schedules for follow-up and communication with members and completes assessment within 30 calendar days of identification.	
9	H	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Development and communication of member self-management plans and completes assessment within 30 calendar days of identification.	
9	H	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Assessment of progress against case management plans and goals, and modification as needed and completes assessment within 30 calendar days of identification.	
		Total	**0**

Audit Tool - Complex Case Management

QI	Element	Description	Met (1)/Not Met (0)
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Initial assessment of member health status, including condition-specific issues and completes assessment within 30 calendar days of identification.	
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9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Initial assessment of psychosocial issues and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Evaluation of cultural and linguistic needs, preferences or limitations and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Evaluation of visual and hearing needs, preferences or limitations and completes assessment within 30 calendar days of identification.	
9	G	Review of complex case management files demonstrates that DWMHA follows its documented processes for: Evaluation of caregiver resources and involvement and completes assessment within 30 calendar days of identification.	
9	G	Review of DWMHA's complex case management files demonstrates that DWMHA follows its documented processes for: Evaluation of available benefits and completes assessment within 30 calendar days of identification.	
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