

CASE MANAGEMENT REFERRAL OVERVIEW FOR CLINIC STAFF

Referring patients for plan level case management

Case management is a process that promotes a patient’s access to care, the containment of costs, the enhancement of quality services and products, the identification of alternative care plans, the increase of a patient’s awareness of his disease and the facilitation of the members empowerment over his disease. A case manager’s role is advocacy, assessment and coordination of care between multiple providers and the member.

What is Case Management?

Catastrophic Case Management	<ul style="list-style-type: none"> ➤ Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes ➤ Evaluates the patient’s biopsychosocial needs across the continuum ➤ Longer-term interventions ➤ Goal: Supporting the patient/provider relationship.
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Other Definitions

Care Coordination	<ul style="list-style-type: none"> ➤ Short-term interventions based on a specific episode of care or need; e.g.: <ul style="list-style-type: none"> ○ Requests for prior authorization of certain elective surgical procedures reviewed for possible areas of influence prior to the procedure being performed ○ Frequent admissions to hospitals or emergency rooms will be referred for assessment for other programs such as catastrophic case management or disease management ○ Data mining to illuminate enrollees that require coordination of care between disparate specialties and their PCP. ➤ Goal to ensure patients are engaged with their PCP before and after a specific health care event.
Disease Management	<ul style="list-style-type: none"> ➤ Specific interventions around a particular diagnosis; goal to help patient self-manage their disease process. Current programs include Diabetes and Asthma.
Utilization Management	<ul style="list-style-type: none"> ➤ Prior Authorization of certain high-cost, high-volume or procedures that are potentially experimental. ➤ Utilization data review

Who can Refer?

- Clinic referral coordinator
- Primary care provider or staff
- Specialist provider
- Hospital
- Member and/or family
- Plan customer service
- High risk report at the plan level

Who is appropriate for Plan-level Case Management?

- Patients with complex or chronic care needs
- Patients with complex discharge planning needs
- Patients with needs that are beyond the available clinic resources

For example:

- Spinal cord or head injury with significant neurological deficits requiring assistance in coordinating rehabilitation services and community resources
- Neonates: Premature babies or those with a congenital anomaly requiring extensive post-hospital services and family education to learn to manage independently
- Respiratory failure with new ventilator dependence
- Medically complex or fragile condition with co-morbidities requiring assistance in breaking down access barriers
- Child or Adolescent Residential Treatment Center Admissions
- Transplant
- Suicide Attempt

How can I make a Referral to Case Management:

- Complete the attached Community Health Plan CM Referral Form and fax to (206) 652-7073
- Phone customer service 1-800-440-1561

What happens when I make a referral?

- A case manager will contact the referral source within one (1) business day after receiving the referral. The conversation will focus on the reason for the referral, and a request for documentation and medical records may be made.
- The referred member's information and documentation will be reviewed by the case manager and an attempt will be made to contact the member directly for a full assessment.
- Once contact with the patient is made, the case manager will complete the assessment to identify if there is a potential for:
 - quality improvement of the patient's health outcomes

- A coordinated plan of care

The member will be offered plan level case management services at that time and *if* the member agrees, the patient will be opened to plan level case management. If the member does not agree, then CM services cannot be offered.

What reasons would a patient not be opened for plan level case management?

- Inability of the case manager to contact the member after multiple (three or more) phone calls and a written request for contact.
- Member does not meet the above criteria.
- Member does not want a case manager involved in their care.

The referral source will be contacted if a case is not opened for plan level case management services.

What to expect while a member is open to plan level case management.

- Once the member has been opened to case management, an introductory letter will be sent to the patient and to the primary care provider.
- A collaborative care plan will be completed that includes input from the providers involved in the member's care, the plan level case manager and the member.
- A copy of this care plan is shared with the patient and the patient's identified primary care provider.
- The member will be followed by the case manager until the treatment plan is completed and the member is able to be managed at the primary care level.
- Monthly summary reports to the ED or Medical Director of the PCP clinic are available at the CHP FTP website.

Why is a case closed to plan level case management?

- The member is no longer eligible with the plan.
- The member is stable and all the interventions of the case manager have been completed.

What happens after a case is closed to plan level case management?

- A letter closing the case to plan level case management will be sent to the primary care provider and the patient.
- A satisfaction survey will be mailed out to the patient for evaluation of case management services.

How can I make a referral again?

- Complete the attached Community Health Plan CM Referral Form and fax to (206) 652-7073
- Phone customer service 1-800-440-1561