Care Spectrum Plus
COORDINATED CARE FOR ALL

Chronic Care Business Requirement Assessment

Scenario 1: Referral from Primary Care Provider

Mr. C is a 55 year old Caucasian male with a primary diagnosis of diabetes with co-morbidities of hypertension, obesity, and depression. Mr. C's is retired, has insurance coverage via his retirement benefits but benefits are limited and he has a large monthly premium and high deductible. He is low-income, living alone, and although has a car it is often unreliable. His most recent A1c is 12.3 and has shown increasing negative trends for the last six months. His BP is 155/90 and his BMI consistently 38. He missed his last two appointments. His Primary Care Provider is Dr. Know.

Dr. Know wishes to refer Mr. C for Chronic Care Management for assistance in identifying Mr. C's needs and help him better manage his chronic conditions.

NOTE: The following work flow processes are generally consistent for all referral sources with the exception of case finding data sources.

Discuss and provide responses.

Referral and Eligibility Work Flow Process

- Please describe the referral process for Dr. Know and his staff.
- Please describe the referral process from other sources excluding case finding data source (refer to scenario 2 on page 5 for the case finding data source work flow process)
- How are referrals generated and communicated?
- Where referrals are documented (electronic, registry, other means)?
- Who receives the referral?
- Who checks and how do you check eligibility and where is this documented?
- What happens when a patient is not eligible?

What types of data/information do you wish to monitor/report as efficiency (process) measures to surveil staff consistency and performance and measures of success for outcome expectations associated with this process?

Recommendation: The following is recommended for system documentation for at least minimum reporting referrals information.

- Referral Source: (Refer to flow chart for referral source options)
- Date of Referral:
- Referral Reason
- Referral Assigned To:
- Referral Date:
- Meets Eligibility: (Refer to flow chart for eligibility requirements)

Documents:

- Referral Form
- Referral Policy/Protocol
- Eligibility Policy/Protocol

Intake Work Flow Process

- What individuals are involved in the intake process? Please provide title(s) for each.
- What is needed to prepare for the intake? (For example, review of medical record, patient participation agreement, intake assessment and data entry system, other assessment tools, etc).
- How soon after the referral will contact be made with patient to initiate the intake process? Please establish an expected response time
- What are the protocols for patient contacts? How many attempts are acceptable before closing the case as contact not made? Where are contacts documented and notification to referral source(s) when referral is closed due to reason "Contact unsuccessful"
- What setting as acceptable to conduct the intake process take plan and by whom?
- What is the method of intake (telephone, face-to-face, online completion, self-directed form completed by patient)
- What domains does the intake assessment process include *(Please indicate):*
    - ✓ Medical History
    - ✓ Medications
    - ✓ Current Self-Management Practice
    - ✓ Social History/Support (primary caregiver, risk factors, environmental, financial, family structure, cultural preferences)
    - ✓ Mental Health/Substance Abuse History
    - ✓ Lifestyle Habits/Preferences
    - ✓ Patient Goals (What are they interested in working on)
    - ✓ Cognitive Abilities
    - ✓ Care Team Contacts (Other Providers involved in patient care)
- Where is the intake assessment information stored for data collection and reporting?
- What staff is involved in review of the assessment information?
- Does/should the primary care provider obtain an assessment summary? If so, how is this generated and communicated? Where is this communication documented?

What types of data/information do you wish to monitor/report as efficiency (process) measures to surveil staff consistency and performance and measures of success for outcome expectations associated with this process?

Documents:

- Intake Assessment(s) (i.e., risk assessment, PAM, PHQ, etc?)
- Intake Assessment Policy/Protocol
- Home Visit Policy/Protocol
- Patient Communication Policy/Protocol

Risk Stratification Work Flow Process:

- What tool(s) are used to determine risk level?
- How soon after intake do you expect the risk stratification to be completed?
- Who receives communication of the risk level and how?
- Where is the risk level documented?
- What staff is involved in the risk stratification process?
- Are all patients managed according to risk or only certain risk levels (e.g., high risk)?
- At what point is the patient considered enrolled in the program and assigned a care manager?
- How are cases assigned?
- What is the case load (Refer to staffing model for recommended case load)
- Where is the identified case manager documented for care team purposes?

Documents:

- Risk Stratification Tool
- Risk Stratification Policy/Protocol

What types of data/information do you wish to monitor/report as efficiency (process) measures to surveil staff consistency and performance and measures of success for outcome expectations associated with this process?

Self-Management Planning Work Flow Process

- What staff is involved in developing the self-management plan and carrying out interventions?
- How does staff plan to engage patients/family/caregivers in process?
- Where does self-management planning take place?
- What is the expected timeliness standard for completing a self-management plan?
- Where will the self-management plan be documented?
- Who receives a copy of the plan and how?
- What is the definition of short and long-term self-management goals? Who determines the type of goals? Where are these documented?
- What is available as patient self-management tools/educational resources available for use with self-management plans? (i.e., community resources, diabetes education materials, mobile apps, etc)
- What is the process for reviewing all self-management/educational materials for consistency with adopted evidence-based guidelines?
- Do you have any gaps in self-management resources?
- How are self-management plan goals/interventions assigned to staff?

What types of data/information do you wish to monitor/report as efficiency (process) measures to surveil staff consistency and performance and measures of success for outcome expectations associated with this process?

Documents:

- Self-management plan
- Resource Guide and Index)

- Patient Educational tools and materials
- Self-management planning policy/protocol
- Evidence-based guideline Consistency Review Policy/Protocol

Self-Management Interventions Workflow Process

- What tool(s) are used to document interventions, follow-up dates, and progress?
- Where will goal progress be documented (goal met, deferred, unmet, etc)
- Where are interventions associated with self-management goals documented?
- What are the expected roles and responsibilities of the patients/families during this phase? How is this communicated and documented?
- What is the process for triggering follow-up dates with patients/families to address progress/barriers? What are contact expectations (frequency, contact methods, documentation)
- When referrals are needed who is responsible for generating referrals to community resources, health care services, social services, behavioral health services, etc?
- How are the referrals generated and documented?
- What is the process for referral management (tracking and follow-up)?
- What is the frequency expectation and communication method for reporting progress with the primary care provider or other members of the primary care team? How is the communication documented?
- How do you document contacts/encounters for the care management team (type, time spent, etc)?

What types of data/information do you wish to monitor/report as efficiency (process) measures to surveil staff consistency and performance and measures of success for outcome expectations associated with this process?

<u>Documents:</u>

- Self-Management Process – Management, Policy/Protocol
- Care Conference Policy/Protocol
- Self-management tracking and follow-up tool
- Progress report (patient and provider)
- Roles and Responsibilities Statement

Self-Management Transitions Work Flow Progress

- Please describe criteria for transitioning patients from active care management to maintenance/transitions prior to discharge?
- What is the expected duration for a patient to be in care management transitions?
- Where is the date patients are transitioned to the maintenance program documented?
- What are the expected roles and responsibilities of the care management team during this phase?
- What are the expected roles and responsibilities of the patients/families during this phase? How is this communicated and documented?
- What is the expected frequency of communication with patients/families during this phase? What type of communication is accepted?
- What are the criteria for graduating/discharging from the program?

- What information/materials are provided to patients/families about at graduation/discharge?

What types of data/information do you wish to monitor/report as efficiency (process) measures to surveil staff consistency and performance and measures of success for outcome expectations associated with this process?

Documents:

- Transition Plan Policy/Protocol
- Transition Plan

Program Discharge Work Flow Process

- Who can discharge a patient from the program?
- What is the criteria for discharge (i.e., not participating, moved out of area, graduated, etc)
- Where is program discharge documented? Date, reason
- How and by what method is program discharge communicated to providers and patients/families?

What types of data/information do you wish to monitor/report as efficiency (process) measures to surveil staff consistency and performance and measures of success for outcome expectations associated with this process?

Documents:

- Program Discharge Summary Report
- Discharge Planning Policy/Protocol

Scenario 2: Referral via Case Finding Sources

Case Finding Work Flow Process

- Please describe the data sources available for proactive/systematic case finding
- How is the data generated and received?
- Who is responsible for generating the data?
- Who receives the data?
- What frequency of reporting is expected for each data source?
- When patients are identified using case finding data sources what method(s) of communication are used to obtain acceptance from the primary care provider for care management services?

What types of data/information do you wish to monitor/report as efficiency (process) measures to surveil staff consistency and performance and measures of success for outcome expectations associated with this process?

Documents:

- Case Finding Identification Using Data Sources Policy/Protocol