Partnership HealthPlan of California Presents:

Fundamentals of Case Management & Care Plan Development for ECM Providers

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Learning Objectives

By the end of this presentation participants should be able to:

1.	Describe the ECM care management process
2.	State the purpose of assessment in the ECM care management model
3.	Describe key competencies of ECM care management documentation
4.	Develop an individualized care plan meeting the ECM criteria

Content

- ECM Care Management Purpose
- ECM Individualized Care Plan (ICP) Process
  - Step 1: Assessment Components
  - Step 2: Developing the Care Plan
  - Step 3: Implementing the Care Plan
  - Step 4: Coordinating the Care Plan
  - Step 5: Monitoring Progress of the Care Plan
  - Step 6: Evaluating of the Care Plan
- ECM Care Management Tips: How to Build Rapport During Assessment
- Knowledge Check

Why Enhanced Care Management (ECM)?

A member who qualifies for ECM is at the highest risk for poor health outcomes and often interacts with multiple areas of the health care delivery system.

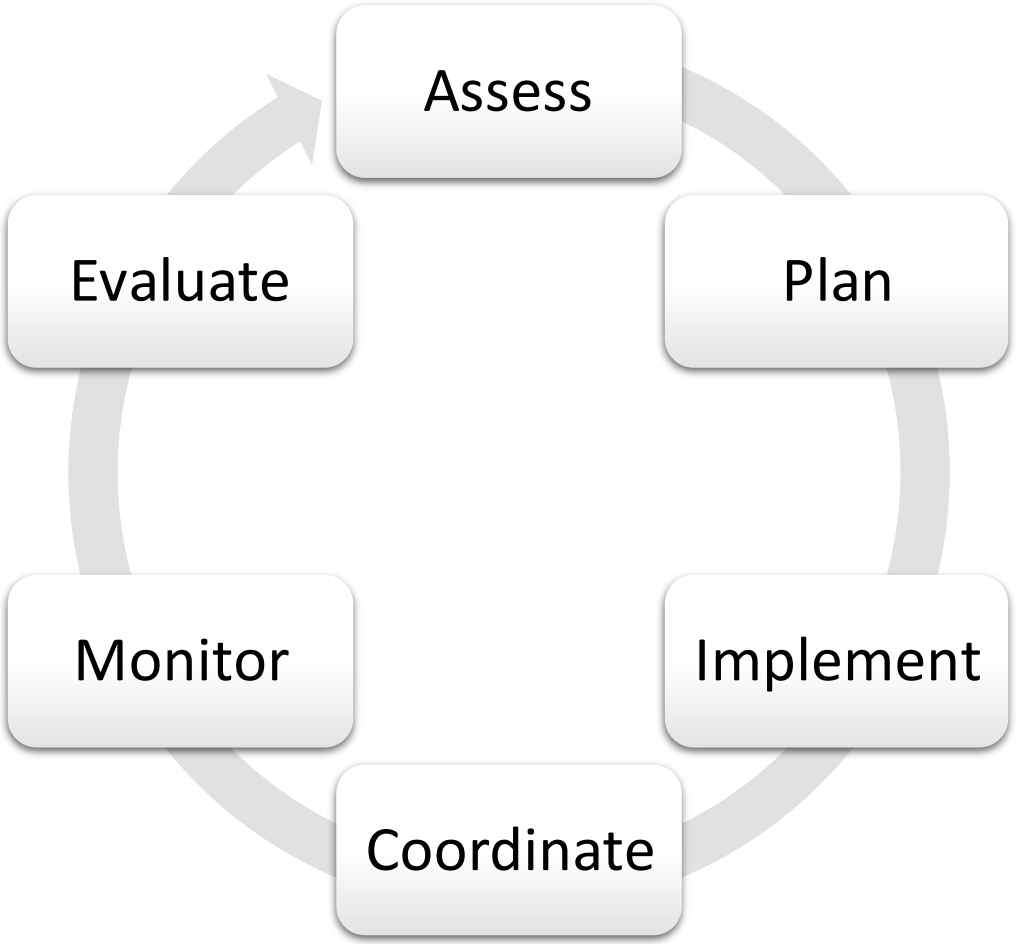
The purpose of the ECM benefit is to improve the quality of life and health outcomes for these vulnerable members by:

- Systematic coordination of care
- Comprehensive care management approach
- A whole-person approach
- Promotion of self-management
- Linkages & referrals in the community
- A ***"Lead Quarterback"*** to help the member navigate and coordinate needs – regardless of payer or setting.

ECM Care Management Domains

Medical Care (Physical Health)	Mental Health / Substance Use Disorder	Oral Health	Social Determinants of Health (SDOH) & Community Supports	Long-Term Support Services (LTSS)

ECM Care Management Process



STEP 1: ECM Assessment Components

ECM assessments should:

- Identify strengths
- Identify risk
- Identify needs and/or deficits
- Involve others – an interdisciplinary approach
- Gather details to help create the ECM Individualized Care Plan (ICP)

STEP 1: ECM Assessment Components

Medical Care (Physical Health) & Oral Health
Health Risk Assessment (HRA)
Staying Health Assessment (SHA)

Assessments that address physical health & medical needs should include:

- Current / past medical conditions
- Chronic conditions
- Medication list (active)
- Hospitalizations / ED visits in previous 6 months (Collective Medical)
- Primary Care Provider / Specialists involved in care
- Oral health needs
- Durable Medical Equipment (DME) needs
- Activities of Daily Living (ADLs)
- Cultural & linguistic barriers to care

STEP 1: ECM Assessment Components

Mental Health / Substance Use Disorder
Patient Health Questionnaire 9 or 2 (PHQ-9 / PHQ-2)
DAST - 10
AUDIT - C

Assessments that address mental health and/or substance use disorder needs should include:

- Screening for Depression
- Identification of risk
- Conditions / Treatments (medication, therapy, etc.)
- Treatment adherence
- Providers or care gaps

STEP 1: ECM Assessment Components

Social Determinants of Health (SDOH) & Community Supports
PREPARE (Protocol for Responding to and Assessing Patient's assets, Risks and Experiences)
PEARLS / ACES (life events check-list)

Assessments that address SDOH & Community Supports should include:

- Housing stability
- Transportation
- Family / Caregiver Support
- Financial stability
- Food resources
- Community linkages

STEP 1: ECM Assessment Components

Long-Term Support Services (LTSS)
Health Risk Assessment (HRA)
Mini-Cog
Advanced Care Planning

Assessments that address LTSS should include:

- Cognition and memory status
- Caregiver supports and/or needs
  - In-Home Support Services (IHSS)
  - Community Based Adult Services (CBAS)
- Involvement with other programs & Services
  - MSSP
  - ICF/DD Waiver
  - Regional Center
- Advance Care Planning: Code Status, Advance Directive, Living Will, POLST, Durable Power of Attorney
- Identification of Authorized Representative

ECM Assessment Recommendations

- Health Risk Assessment
- PHQ-2/9
- DAST-10 / AUDIT-C
- PREPARE
- Advanced Care Planning

STEP 2: Developing the Care Plan

ECM requires that the member have an Individualized Care Plan (ICP). The purpose of the ICP is to:

- Create a member-centric, individualized plan
- Promote independence and self-management
- Establish specific goals and actions to meet the member's needs. These goals are identified during the ECM assessment process
- Considers inputs and approvals from the member, their caregiver(s), and/or providers to support multidisciplinary collaboration
- Identify timelines to benchmark progress towards goals

STEP 2: Developing the Care Plan

What Makes an Individualized Care Plan (ICP) Good?

- Written goals that are ***SMART*** (Specific, Measureable, Achievable, Relevant and Time bound)
- Goals are ***PRIORITIZED*** by the member; the member sets the pace for what gets addressed first
- The plan is ***SHARED*** with the member, their caregiver, the provider(s) and appropriate agencies who are working to support the goals and actions.

PHC ECM Care Plan Requirements

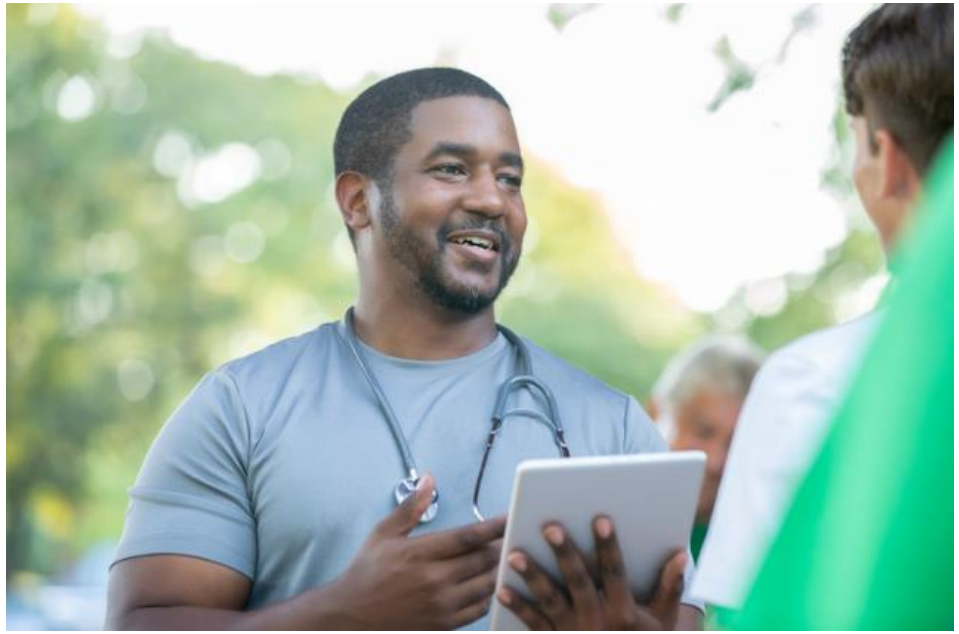
- Member demographics & Population of Focus
- ECM care management components must be addressed:
  - Medical
  - Mental Health / SUD
  - Oral Health
  - Social Determinants of Health & Community Supports
  - LTSS
- The Individualized Care Plan **MUST** be uploaded to Collective Medical & accompany the TAR to PHC.

STEP 3: Implementing the Care Plan

Key steps when implementing the ECM Individualized Care Plan (ICP)?

- The ICP ***MUST*** be uploaded into Collective Medical.
- A copy of the ICP and ROI must also accompany the TAR to PHC for authorization of ECM services.
- Review and document frequently! As part of PHC's Utilization Review processes, nurses will be reviewing the ECM ICP for progress towards stated goals.
- As part of PHC's oversight & monitoring of the ECM benefit, audits of care plans will occur. PHC ECM staff will be partnering with ECM providers to develop future oversight activities! – STAY TUNED!

STEP 4: Coordinating the Care Plan



Key steps when coordinating the ECM Individualized Care Plan (ICP)?

- Multidisciplinary collaboration & communication is key! The member may have multiple case managers involved – but ECM is the ***LEAD*** Care Manager
- Used closed-loop communication
- Documentation should be objective, time stamped, timely, limit abbreviations (use sparingly)
- Anticipate that things may not go as planned; come up with a "Plan B"

STEP 5: Monitoring Progress of the Care Plan

How to monitor progress of the ECM Individualized Care Plan (ICP)?

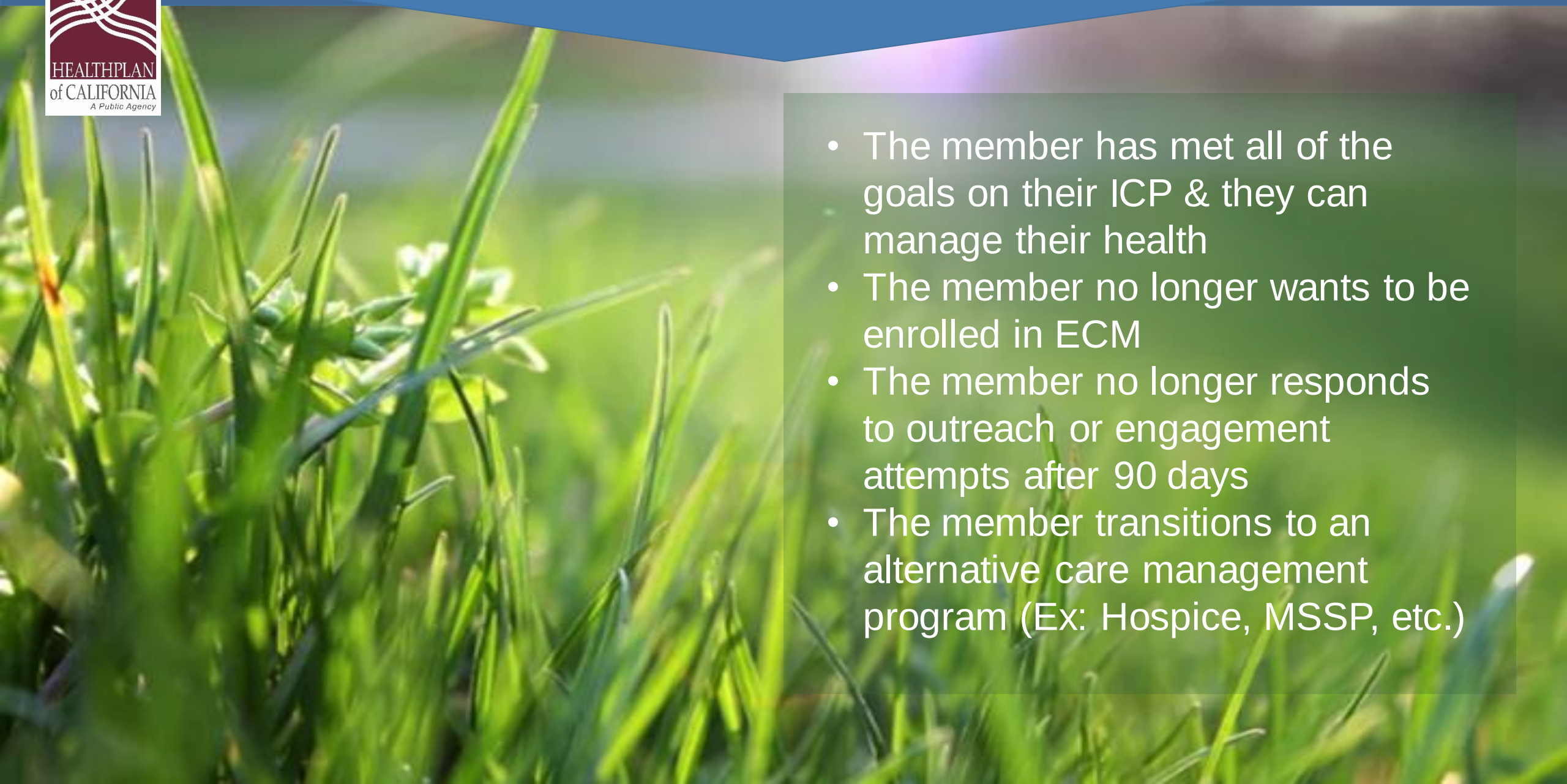
- Is progress being made toward the goals?
- Is the member responding to your engagement efforts? Action items?
- Is the member engaged in their progress?
- Document progress in the Individualized Care Plan

STEP 6: Evaluating the Care Plan

How to evaluate the ECM Individualized Care Plan (ICP)?

- Are all the goals complete? Have new goals been identified or created?
- Have new barriers been identified? New action items created?
- Again: Is the member engaged in their progress?
- Is the member better served through another Care Management Program / Benefit? (Example: Hospice, MSSP, etc.)

PHC ECM Discharge Criteria



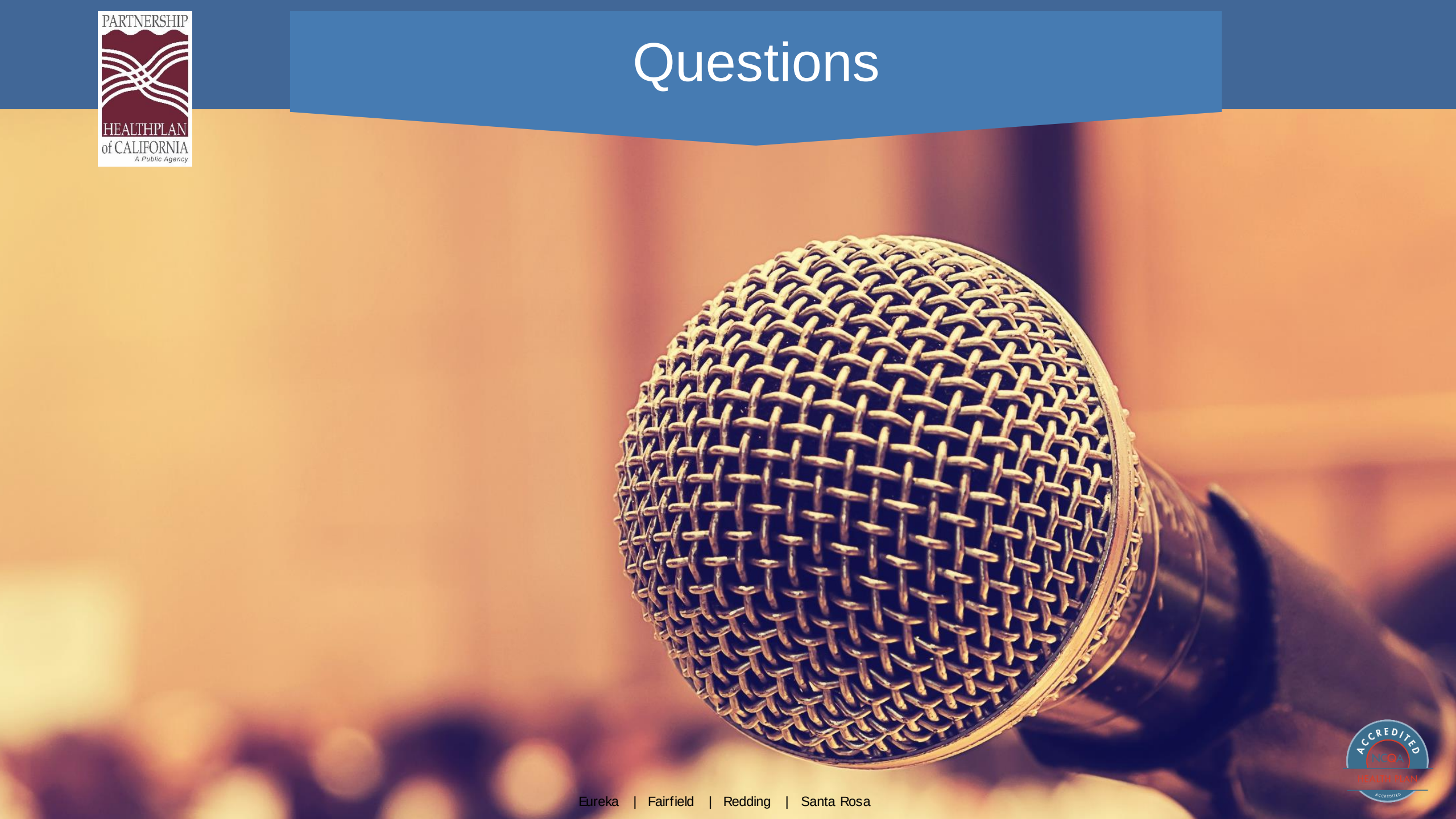
- The member has met all of the goals on their ICP & they can manage their health
- The member no longer wants to be enrolled in ECM
- The member no longer responds to outreach or engagement attempts after 90 days
- The member transitions to an alternative care management program (Ex: Hospice, MSSP, etc.)

ECM Care Management Tips: How to Build Rapport During Assessment

- Use Motivational Interviewing techniques
  - Open-ended questions
  - Reflection
- Active listening – seek understanding
- Be aware of body language, non-verbal communication queues
- Conduct assessment in an appropriate environment (ex: safe, confidential, etc.)
- Be cognizant of member's time / attention – don't try and complete questions in all one sitting
- Focus attention on member (not cell phone, notes, laptop, etc.)
- Frame assessment questions as part of conversation – don't simply just read off list of questions. It helps to memorize/review assessment questions beforehand.
- Be prepared, document as you go.

You only get one chance to make a 1st impression!

Questions



Upcoming Events

- ECM Training Series (Medical 101, Behavioral Health 101, etc.):
  - Medical Model Care Navigation, June 13 from 1-2 p.m.
  - Behavioral Health Care Navigation, July 22 from 10-11 a. m.
  - Dental Health Care Navigation, August 12 from 11 a.m.- noon
  - Long-Term Support Services Care Navigation, September 21 from 11 a.m.- noon

- Provider Relations ECM Roundtable Discussions
  - May 26 from 12-1 p.m.
  - June 9 from 12-1 p.m.
  - June 23 from 12-1 p.m.

Contact Us

Questions?

Contact us: ECM@partnershiphp.org

Links/Resources

- PHC MCCP2032 CalAIM ECM Policy
- PHC ECM ROI
- PHC ECM CARE PLAN TEMPLATE
- Assessment: ADULT HRA (PHC)
- Assessment: PEDIATRIC HRA (PHC)
- Assessment SHA
- Assessment PHQ-9/PHQ-2
- Assessment DAST-10
- Assessment AUDIT-C
- Assessment PREPARE