



2011 UCare for Seniors Case Management Requirements
Updated 3/16/2011

According to the Case Management Society of America (CMSA), Case Management Model Act of 2009, “Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes”.

UCare requires that case management for *UCare for Seniors* members is performed by a Minnesota licensed registered nurse (RN). UCare contracts with the following entities to provide case management for *UCare for Seniors* members: Allina, Essentia, Fairview Physicians Associates, MMSI, and North Clinic.

UCare provides case management for all UCare members not affiliated with one of the above listed care systems

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Purpose and Focus of Case Management	<p>The <u>purpose</u> of case management for <i>UCare for Seniors</i> members is to encourage and support healthy behaviors and to reach the wellness level they desire to achieve; maintain members in their choice of living environment; and support the establishment of primary care and a healthcare home.</p> <p>The <u>focus</u> of case management is on members with acute, complex medical needs, typically of short term duration (3-6 months).</p>
Screening for Case Management	<p><i>UCare for Seniors</i> members are identified for case management through internal and external referrals and through a risk assessment process that consists of reviewing the following:</p> <ul style="list-style-type: none">◆ Enrollment reports.◆ Senior Health Profile results (PRA Survey, Frailty Scale, Depression Scale).◆ Disease Management reports.◆ Impact Pro (predictive modeling).◆ Medical records.◆ Daily admissions report.

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<p>Suggested Triggers for Case Management Screening/Opening -Utilization</p>	<p>Level of care transitions: acute, skilled, or custodial:</p> <ul style="list-style-type: none"> ◆ Emergency Department utilization (Impact Pro). <ul style="list-style-type: none"> ○ 2 or more ED visits in 6 months. ○ 3 or more ED visits in 12 months. ◆ Admission to a Skilled Nursing Facility (SNF) or Physical Rehabilitation unit within the past 12 months (daily electronic report). ◆ Inpatient hospital admission (daily electronic report).
<p>Suggested Triggers for Case Management Screening/Opening - Diagnosis</p>	<p>Members with one or more of the following diagnoses* should be screened for case management:</p> <ul style="list-style-type: none"> ◆ Cardiac (heart failure, coronary artery disease). ◆ Diabetes (Type I and Type II). ◆ Chronic Obstructive Pulmonary Disease (chronic bronchitis, emphysema or both). ◆ Depression. <p>*Not an inclusive listing.</p>
<p>Suggested Triggers for Case Management Screening/Opening -Risk</p>	<ul style="list-style-type: none"> ◆ Probability of inpatient admission of 70% or greater (Impact Pro). ◆ Probability of repeated admissions (PRA score) 0.4 or higher (Senior Health Profile). ◆ Frailty Scale score of 0.5 or higher (Senior Health Profile). ◆ Score of 2 or higher on Depression Scale (Senior Health Profile).
<p>Suggested Triggers for Case Management Screening/Opening -Referrals</p>	<p>Referrals for case management services may come from a variety of sources, including but not limited to:</p> <ul style="list-style-type: none"> ◆ Internal sources. ◆ Primary Care Providers (PCP)s. ◆ Hospital social workers/discharge planners. ◆ Family members/caregivers. ◆ Other external sources.
<p>Initial Telephonic Assessment</p>	<p>The Case Manager (CM) should initiate a telephonic assessment for all members deemed to be “at risk” by meeting one of the case management triggers listed above, with the inclusion of professional judgment.</p>
<p>Telephonic Assessment Form</p>	<p>The CM will complete the <i>UCare for Seniors</i> Telephonic Assessment form to gather information or will complete an assessment form that has been approved by UCare.</p>

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Opening to Case Management	<p>Members are opened to case management based on assessment, data collected, and professional judgment.</p> <ul style="list-style-type: none"> ◆ If the member accepts case management, the CM will develop a plan of care with member input. See POC below. ◆ If the member declines case management, the CM will send a follow-up letter with CM contact information and resource/educational material as appropriate. ◆ If the CM is unable to reach the member via phone after two attempts, the CM will send a letter explaining the CM role and request a callback from the member to complete the assessment.
Plan of Care	<p>If the member accepts case management, the CM will develop a plan of care. The POC should be developed in collaboration with the member, the PCP, and where appropriate, the member's family or authorized representative. The POC should be developed based on assessment data, identified needs, and desired member outcomes. The CM should document and include the following on the POC:</p> <ul style="list-style-type: none"> ◆ Identified needs/problems. ◆ Agreed-upon member goals. ◆ Goal target dates. ◆ Treatment and care interventions. ◆ Follow-up plan to evaluate outcomes (specify an evaluation date). ◆ Goal achievement dates. <p>The CM should document and communicate assessment findings and POC to key stakeholders such as the member's PCP, other community providers, and family/caregivers when applicable.</p> <ul style="list-style-type: none"> ◆ The CM has the lead responsibility for creating, implementing, and updating the care plan. ◆ The POC should be kept in the member's case management record and be retrievable when necessary.
Care Plan Form	<p>The CM must use the <i>UCare for Seniors</i> Care Plan form approved by UCare or a care plan form that has been approved by UCare.</p>
Service Coordination	<p>The CM will initiate referrals and coordinate care as appropriate, and assist members with getting access to providers for specific health care needs that require follow-up. The CM will ensure continuity of care and integration of services through arrangements with community and social service programs as appropriate. Referrals may include but are not limited to:</p>

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	<ul style="list-style-type: none"> ◆ Referrals to the PCP and/or other specialists as needed. ◆ Clinic appointments for preventive care and/or condition. ◆ Medication management and related follow up. ◆ Home Care Services. ◆ Durable Medical Equipment (DME). ◆ Utilization of UCare’s Disease Management programs where appropriate, or referral of members to other appropriate disease management programs. ◆ Education of member and/or family/caregiver on health/wellness strategies; and illness prevention related to their diagnosis/condition. ◆ Support services, community groups, or associations related to their condition or need (e.g., stroke or Alzheimer support groups, Meals on Wheels, safe driving resources, Diabetes Association, adult day care).
Ongoing Monitoring	The CM must monitor the effectiveness of the care plan, revising as necessary to meet the member’s needs. The CM will document and maintain communication with the member, primary care provider, and other community providers, as applicable.
PCC/PCP Contact	The CM will send a copy of the POC or a summary to the member’s PCC/PCP; and will maintain communication with the primary care provider.
Transition Management	The CM will facilitate member's placement and discharge needs during transitions: hospital to home etc., if applicable.
Evaluation	<p>The CM will evaluate the following:</p> <ul style="list-style-type: none"> ◆ Member’s progress in achieving agreed upon goals within established time frames. ◆ When and if the member’s condition has stabilized and case management is no longer appropriate. ◆ Impact of the plan of care on the member’s desired level of health and /or wellness.
Outcomes	The CM will document and communicate member outcomes with the member, PCP, other community providers, and family/caregiver as appropriate.
Advance Directives	The CM must document that they addressed or discussed advance directives with the member, or that an advance directive is culturally inappropriate for the member.

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Case Closure	<p>The CM will close the case to case management when one or all of the following occurs:</p> <ul style="list-style-type: none"> ◆ Member goals are achieved. ◆ Member's condition has stabilized. ◆ CM determines that case management services will no longer promote the plan of care or positively impact member outcomes. ◆ Member terminates case management services.
Documentation	<p>The CM must keep a roster of open and closed case management cases. The CM must keep a case management record to include the following:</p> <ul style="list-style-type: none"> ◆ Assessments and screening information. ◆ Plan of care. ◆ Services and interventions. ◆ Evidence of ongoing monitoring. ◆ Contacts with primary care provider, other members of the interdisciplinary care team. ◆ Outcomes and evaluations.
Caseload Ratios	<p>Due to the telephonic nature of case management, UCare suggests that case managers should be able to manage 50-75 open active cases, and complete up to 200 screenings per month.</p>
Policies and Procedures	<p>All UCare delegates are required to have policies and/or procedures that support all the above stated requirements.</p>