Care Management Process: CMHRP Workflow (revised September 1, 2019)

Identification / Referral

Referral Process

Automated
- ADT
- Data:
  - CareImpact/VH information
  - Claims Data

Manual
- User Entry > Searches for/Add temporary member → Create OB Episode & add a “Referral”

Temporary Members: If patient record is not found in VirtualHealth, user creates Temporary Member record to begin documentation. CCNC/VH intends to develop logic to update record during nightly feed if member data is available within CCNC data warehouse.

Eligibility Determination, Outreach & Assessment

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- New “referral” generates task reminders for OB Department:
  - Assign Pregnancy CM (immediately)*
  - Outreach to Member (CM engages member within 3 business days)
- Document Pregnancy Due Date in Medical History.
- Enter Pregnancy Risk Screening Form (RSF); scan & upload original RSF document (if available) into patient VH documents.
- User assigns self as Primary CM (or collaborates with Complex CM to determine who is primary) and Pregnancy Care Manager
- Reaches out to Member:
  - Successful (see below)
  - Unsuccessful (continue outreach efforts)

Member Agrees to CM Services

- Document Member acceptance of services by selecting “opt in” on Interaction Tracker. This moves member’s Episode Status into “Engaged”
- The following autogenerated tasks are triggered:
  - Complete CNA-OB*
  - Create/Review CP*

* = Tasks automatically closed by system once completed

For any ADT referrals or if the Pregnancy Risk Screening is not available, user:
- Completes Brief Pregnancy Assessment or begins CNA-OB.

Member declines services or user is unable to reach after multiple attempts:

- CM documents all attempts in Interaction Tracker
- CM documents member refusal using Interaction Tracker;
- Informs referral source
- Episode Closure: Episode Status should be set to “Decline” or “Unable to Reach”

See CMHRP Step by Step Documentation Guide for further details.

END
Care Planning and Monitoring

- CM collaborates with member to develop, prioritize & complete Care Plan:
  - Needs
  - Problems
  - Goals
  - Barriers
  - Interventions

Care Plan Signed

- Creates task reminder for the primary CM (Due date = Next scheduled Intervention)
- Once Care Plan is signed by the member, the Episode Status automatically updates to “Managed”

Ongoing Monitoring, Assessment and Evaluation of Member Needs & Goals

- CM documents ongoing interventions within Care Plan;
- Continues assessing (Any new needs identified are documented in CNA-OB);
- Document interactions in the Interaction Tracker.

* 13 Needs pre-populate from CNA-OB
* Manually enter all other identified needs
* Needs should be associated with specific Episodes
* Always have one need with a “managed problem status”
* Always have one managed goal for each managed need
* Always have a target date that aligns with engagement level

If at any point during the CM process the member’s OB Episode should need closure, then consult the CMHRP Step by Step Documentation Guide for additional guidance.
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Assessment and Follow Up

CM makes any necessary referrals prior to closure:
- Document interventions in Care Plan / Interaction Tracker
- Prior to closure ensure the member is linked with needed resources

Correspondence to Referral Source
- CM notify referral source (letter, call, in-person) of closure

Case Closure

Closure of Care Plan, Tasks & Episode
- SEE CMHRP Step by Step Documentation Guide (step 13)
- Care Manager closes all pending tasks associated with episode
- Care Manager assigns Care Plan needs as “Graduated” or “Declined”
- Episode Status should move to “Graduated”
Additional information pertaining to the Case Management Process:

“The process through which case managers provide health and human services to clients/support systems consists of several phases that are iterative, cyclical, and recursive rather than linear and that are applied until clients’ needs and interests are met. The phases of the process are Screening, Assessing, Stratifying Risk, Planning, Implementing (Care Coordination), Following-Up, Transitional Care), Communicating Post Transition, and Evaluating.”

Above excerpt and below graphic were taken from the Commission for Case Manager Certification (CCMC) Body of Knowledge. More information can be found at https://www.cmbodyofknowledge.com/content/introduction-case-management-body-knowledge