

Subject: Case Management Program

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By definition, case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communications and available resources to promote quality, cost-effective outcomes (CMSA. 2007).

Goals:

- I. To improve quality and continuity of care as the member moves through the healthcare system.
- II. To provide personalized care in an impersonal system.
- III. To ensure cost-containment by eliminating or reducing unnecessary utilization of resources.
- IV. To assist providers in managing complex patients thereby improving outcomes and providers' satisfaction with their professional responsibilities.
- V. To facilitate interdisciplinary care coordination for identified members, which may include (but not limited to) supplying appropriate educational materials to members and providers, assisting with access to preventive care, and linking both members and providers to community provided support systems as appropriate.
- VI. To provide early identification of complex and/or potentially catastrophic cases to coordinate care, and promote communication between PCP and other healthcare providers.
- VII. To ensure that that dignity, confidentiality, and issues related to the members' medical, social, and quality of life issues are respected and considered.

Case Manager's Roles

- I. Coordinator - Including assessor (gathering all relevant data), planner (best treatment plan or approach) and facilitator (actively promoting communication between providers on the health care team).
- II. Facilitator - understands and accesses appropriate benefits with negotiation of services including benefits, rates, and treatment plans.
- III. Liaison - including between members, providers, the medical management team, and community resources.
- IV. Advocate - supports, educates and empowers the member in making appropriate

decisions and follow through.

- V. Evaluator of quality of care and cost containment.

Policy:

- I. Case management should not be confused with managed care. Case management refers to member-focused strategies to coordinate care. Managed care refers to system level strategies employed by purchasers of health services to influence aggregate utilization levels of various types of services in order to maintain quality and control costs. Managed care arrangements are not designed to address member level care coordination, as case management does.
- II. Case Management is a collaborative and multidisciplinary process that coordinates quality resources and facilitates flexible individualized treatment goals in conjunction with the physician. It provides cost effective options for select individuals with complex medical or behavioral needs.
- III. Case Management is the process of planning, coordinating, screening and evaluating processes throughout the member's total episode of illness, which includes but is not limited to preadmission, concurrent and post discharge interventions. This process may include special services for those who need help navigating the system to facilitate appropriate delivery of care and services.
- IV. Case Management is an essential component of the framework for quality improvement activities. This system works concurrently and always intervenes at the process level of member care.
- V. Case management helps members regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.
- VI. Systems
 - A. THA utilizes case management systems that support evidence-based clinical guidelines or algorithms to conduct assessments and provide management.
 - B. THA's case management database automatically documents the case manager's ID, date and time action on the case is taken or interaction with the member has occurred.

- VII. Identifying Members for Case Management
 - A. THA utilizes data to identify members for case management
 - 1. Claim or encounter data
 - 2. Hospital discharge data
 - 3. Eligibility categories
 - 4. Pharmacy data
 - 5. Data collected through the Utilization Management process when Applicable
 - B. Trigger List for identification for case management
THA case managers utilize a trigger list to focus identification on members that may need case management services but do not fall into the above categories. An example would be diagnosis specific case management, transplants, etc.
 - C. Access to case management referral may come from multiple avenues including:
 - 1. Member services referral
 - 2. Disease management programs
 - 3. Hospital discharge planners
 - 4. Member self referral
 - 5. Practitioner referral
- VIII. Case Management Process
 - A. The case management plan includes a schedule for follow-up that includes but is not limited to counseling, referrals to disease management, education and self management support.
 - 1. Development of case management plans, including long-term and short term goals.
 - 2. Identification of barriers to meeting goals or complying with the plans.
 - 3. Development of schedules for follow-up communication with members.
 - 4. Development and communication of member self-management plans.
 - B. The case management plan includes an assessment of the member's progress toward overcoming barriers to care and meeting treatment goals. The case management process includes reassessing and adjusting the care plan and its goals as needed.
- IX. Measuring Effectiveness
 - A. THA annually evaluates the effectiveness of both the Quality Improvement and Utilization Management programs of which Case Management is a part.
 - B. Measuring effectiveness allows THA to identify opportunities for improvement, determine action and remeasurement as needed.

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Reference: 2008 NCQA HP Standards and Guidelines QI 7

Formulated: August 12, 2002

Revised: January 2006

Revised: July 2008

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