Care Management Resource Guide for CarePartners of Connecticut

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CarePartners of Connecticut
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1 Integrated Care Management

Overview of Integrated Care Management Model

As Americans live longer, many develop multiple chronic health conditions that require complex and coordinated care. More than 125 million Americans have at least one chronic health condition and 60 million have more than one chronic health condition. Many of these patients are elderly and are often less healthy, confused by their treatments and medications, and overwhelmed by paperwork. By 2025, the cost to manage the care of this population with chronic conditions is expected to reach $1.07 trillion.

Health plans continue to add programs to manage medical costs while improving outcomes. These programs include inpatient utilization management (UM), population management, and, most recently, integrated health care management. The CarePartners of Connecticut Care Management department adopted the Integrated Care Management Model to address the increasingly complex care needs of our members.

The guiding principles of this model include:

- The Care Manager, Primary Care Provider (PCP), interdisciplinary care team specialists, and member interacting as a team
- Use of the most current evidence-based guidelines to manage geriatric patients with multiple chronic conditions, avoid redundant services, and prevent avoidable admissions
- A focus on developing geriatric expertise, with a strong commitment to medication adherence, fall prevention, advanced life planning, and other issues that are challenges for seniors
- A standardization of the member experience across the entire CarePartners of Connecticut population
- Measurement of standard outcome/process metrics across the network
- Coordination of the efforts of all health care providers, including hospitals, emergency departments, specialty clinics, rehabilitation facilities, home care agencies, hospice programs, and social service agencies
- Smooth transitions between sites of care, with an intensive focus on transitions in and out of hospitals
- Education and support of family caregivers
- Facilitation of access to community resources

The CarePartners of Connecticut Integrated Care Management Model is designed to improve transitions and coordination of care using:

- Early identification of high-risk members through Enterprises Segmentation and Stratification (ESS)
- Clinical guidelines
- Care Managers as educators and coaches
- Member self-management of chronic illness

Using a team approach, the model aims to increase member self-management and decrease avoidable admission/readmission to the hospital for complex and chronic members who can be managed in their home. Ongoing support through telephonic care management can reinforce member education, and the use of self-management tools can reduce avoidable admissions that are prevalent in this population. The CarePartners of Connecticut Care Manager works with each identified member, the PCP, and other members of the care team to create a member-focused plan of care.

To be successful, medical groups must be expert in managing members with multiple chronic and complex conditions.

Required components of the Integrated Care Management program include:

- Transitions management - discharge planning/care coordination (for additional information, referto Chapter 4, Transitional Intervention
- Chronic illness management (for additional information, refer to Chapter 3, Rising Risk Chronic Illness Management Program
- Complex care management (for additional information, refer to Chapter 2, Complex Program
- Care Management - One Care Manager for every 850 members, coordinating with the PCP to manage the top 10 to 15% of members who drive a significant portion of the cost and utilization trend
- Inpatient UM
- Provider engagement and performance management, including:
  - Actionable data to medical groups and PCPs to facilitate management
  - Dashboards to monitor trends against benchmarks and best practice
  - Clinical collaboration and consultation to manage both individual members and targeted populations to improve outcomes
  - Joint efforts to identify opportunities and execute on initiatives to improve quality
  - Identification and engagement of both preferred and “best-in-class” providers

CarePartners of Connecticut Enterprise Segmentation and Stratification

CarePartners of Connecticut employs an Enterprise Segmentation and Stratification (ESS) process to target and prioritize members for care management intervention. The process incorporates over 220 member variables (17 clinical and non-clinical data sources and 25 billion data points). Machine Learning (ML) models support the segmentation and stratification analysis and provide predictive inputs in assessing patients future level of risk.

All CarePartners members are segmented based on their clinical and social needs. There are seven segments ranked in the order of increasing illness, and 26 sub-segments. Once segmented, members are stratified using a Clinical Complexity Score (CCS) to rank order members based on recent utilization, reducible utilization, and Social Determinants of Health (SDOH). The CCS is defined on a 0 to 10-point scale, with 0 indicating no identified needs and 10 indicating the most complex member need profile.

The following table illustrates the populations and how this model targets these populations:

CCS 6 – 10	Complex members, many of whom have chronic diseases with multiple co-morbidities	• Individualized care planning, including: • Psychosocial issues • Careful management of care transitions • Frequent face-to-face interactions • Home and nursing home visits
CCS 3-5	Chronic disease and other variables that increase the risk for admission	• Early intervention • Closely monitor and manage conditions • Develop individual care plans • Manage admissions and transitions of care
CCS 0-2	Rest of the population mainly healthy, increasing risk over time	• Preventative care • Annual health assessment • Ongoing monitoring for change in health status

CarePartners of Connecticut Care Manager

Care Managers should have a professional license in a health care field with initial geriatric certification or the equivalent commitment to staff development (e.g., Guided Care Certification). In addition, Care Managers should obtain at least five continuing education units (CEU) per year related to geriatric care management. For additional information, refer to specific program chapters for role competency requirements.

The Care Manager ratio for the Integrated Care Management Model for CarePartners of Connecticut physician practices is 1 Care Manager for every 850 members. Included in the 1:850 ratio is the assumption that complex members will be managed by a Complex Care Manager with a panel of no more than 80 complex members. The 1:850 ratio does not include Care Manager resources for managing Inpatient UM activities.

The number of required Care Managers and how those Care Managers are deployed to provide adequate staffing to meet the Complex, Chronic, and Transitions Care Management member needs depends on the size of the CarePartners of Connecticut physician group panel.

The following examples demonstrate how to determine the breakdown and needs of the group:

- *Example #1* - A physician group practice has 4,000 CarePartners of Connecticut members. To meet the 1:850 ratio, this practice needs 5 Care Managers (4,000 / 850 = 4.7). Assuming that the top 3.5% of the members are complex, the group would be managing 140 complex members (4,000 x 0.035).

  To maintain the Complex Care Manager ratio of 1:80, 2 Care Managers would be dedicated to complex member management. The remaining 3 Care Managers would be available to manage the remaining 15% of high-risk members (12.5% x 4,000 = 500), who would be a mix of chronic and transitions.

- *Example #2* - A physician group practice has 1,500 CarePartners of Connecticut members. To meet the 1:850 ratio, this practice needs 1.8 Care Managers. Assuming that the top 3.5% of the members are complex, the group would be managing 52.5 complex members (1,500 x 3.5% = 52.5).

  The 0.8 of a Care Manager could manage the complex members and the 1.0 of a Care Manager would have the remaining case load of high-risk members (12.5% x 1,500= 187), who would be a mix of chronic and transitions.

2 Complex Program

Population Description

The Complex Program targets the top 3 to 4% of membership that are at the highest risk for readmission. These frail members often suffer from chronic and/or multiple co-morbid conditions, as well as psychosocial issues that put them at risk.

Members are identified for the Complex Program in one of the following ways:

- Based on the Enterprise Segmentation and Stratification process
- Based on the Daily Census Report
- After meeting ad hoc admission criteria

For additional information, see CarePartners of Connecticut Care Management Complex Member Identification - Data Sources.

Overview of Complex Program

The Complex Program uses the latest clinical guidelines and educational material to manage members with multiple chronic conditions, co-morbidities, and co-existing functional impairments. This program also aims to improve overall medical care delivery, outcomes, and psychosocial support from family, friends, community outreach programs, and home healthcare providers. Constantly moving members toward healthier living, the issues addressed in the program include those related to education, transportation, access to healthcare providers, clinical evaluations, needs assessments, and disease management.

The Complex Program achieves its goals through a partnership between a Care Manager, a member, and a Primary Care Provider (PCP)/Treating Provider. Members who agree to participate in the program are assessed for geriatric conditions and psychosocial issues that could impact quality of life and medical cost. These issues include, but are not limited to, the following:

- Cultural and linguistic needs/limitations
- Caregiver resources
- Social Determinants of Health
- Functional status with activities of daily living
- Clinical history
- Mental health status, including cognitive functions
- End-of-life planning and goals of care
- Health plan coverage eligibility and benefits
- Geriatric condition management
- Medication adherence and reconciliation
- Fall risk

These assessments can be either face-to-face member interactions or through telephonic care management. Care Managers use the assessment results in collaboration with the member to create a member-centered plan that includes:

- Member-identified and prioritized problems, goals, and interventions
- Schedule for follow-up with specific time frames
- Documentation of barriers with a solution-focused plan

Member action plans are available to the member/family for continued reference. The care plan is a working tool that will change and adapt as member needs arise or resolve and should include assessment and referral for palliative care and/or hospice needs as appropriate.

Care Manager Adherence to the Complex Program

Adherence to the program's treatment plan and identified goals is monitored through specific measures identified and discussed during interaction with the member. For additional information, see Chapter 10, Policies.

Education and Disease Self-Management

Education and disease self-management focuses on the disease process or condition and the steps that the member can take to help control the progress of the chronic condition and to manage symptoms. As part of the education, how the members' co-morbid conditions, lifestyle, and cultural needs effect their chronic disease is also discussed. Using a teach-back communication method to confirm that the member understands what he/she has learned can help improve health literacy. This teach-back technique involves asking members to verbally state, in their own words (i.e., teach back), what they learned from their health care provider. Teach-back is one of the 11 top evidence-based patient safety practices endorsed by the following groups: The National Quality Forum, American Academy of Family Physicians, American College of Surgeons, American Hospital Association, American Nursing Association, and Joint Commission. Additional information regarding teach-back principles is available on the following Web site: *Agency for Healthcare Research and Quality*.

Evidence-based educational materials that CarePartners of Connecticut has vetted can be shared with members. CarePartners of Connecticut has a list of these materials that is available on request.

Complex Care Manager Roles and Competencies

Roles

The Care Manager's role includes:

- Comprehensive care management and care coordination for a panel of frail elderly patients that includes the following services
  - Providing comprehensive geriatric assessment
  - Developing and communicating (with member, caregiver, and PCP/Treating Provider/ health care team) a comprehensive care plan based on evidence-based best practice for chronic illness
  - Collaborating with interdisciplinary care team members, when necessary
  - Ensuring that the member Action Plan is available to the member, family, and other care providers
  - Providing proactive management and follow-up (home visits and telephone calls) according to the care plan

- Managing and coordinating all transitions of care for complex members, including:
  - Communicating the care plan to all providers in all settings of care (i.e., emergency department, hospital, rehabilitation facility, nursing home, home care, specialty care)
  - Assuring that relevant providers receive timely clinical data for care treatment decisions in all care settings (i.e., emergency department, hospital, rehabilitation facility, nursing home, home care, specialty care)
- Providing direct caregiver support, as needed
- Facilitating member and caregiver access to community resources relevant to members' needs, including referrals to transportation programs, Meals on Wheels, senior centers, chore services, etc.
- Incorporating self-care and shared decision-making in all aspects of member care

For additional information regarding the Care Manager's role in managing the complex population, see Appendix B, Complex Care Manager Role.

Competencies

The Care Manager's competencies include demonstrating:

- Ability to be a creative problem solver
- Advanced clinical experience
- Advanced understanding of geriatric conditions
- Understanding of goals, medications, exercise, and diet related to chronic illness and common geriatric conditions
- Ability to work with all stakeholders to improve patient quality of life
- Understanding of CarePartners of Connecticut benefits and how to help members use these benefits appropriately
- Understanding of member benefits external to CarePartners of Connecticut
- Understanding of appropriate resource utilization of internal specialists (Social Worker, Palliative Care, Dementia Care, Behavioral Health, Pharmacy)
- Understanding of Motivational Interviewing and the ability to incorporate into practice
- Understanding of teach-back principles and the ability to incorporate these principles into practice
- Ability to facilitate goals of care discussions and assist with end-of-life planning

Annual Evaluation of Complex Care Management

For information regarding CarePartners of Connecticut process metrics specifications, refer to Appendix C, Process Metric Specifications.

3 Rising Risk Chronic Illness Management Program

Population Description

The Rising Risk Chronic Illness Management Program focuses on the next 3.5 to 10% of members identified as having a geriatric condition and/or specific chronic illness (e.g., heart failure, chronic obstructive lung disease, Type 2 diabetes) that places them at higher risk for admission in the next six months. Other conditions include (but are not limited to): falls, incontinence, impaired cognition, polypharmacy/medication adherence issues, behavioral health issues, psychosocial concerns, and other syndromes that contribute to the risk of avoidable admissions.

Members are identified for the Rising Risk Chronic Illness Management Program using one of three ways:

- Based on the Enterprise Segmentation and Stratification process
- Based on the Daily Census Report
- After meeting ad hoc admission criteria

Overview of Rising Risk Chronic Illness Management Program

The Rising Risk Chronic Illness Management Program uses the latest clinical guidelines, member educational materials, motivational interviewing, and self-management support strategies to educate, counsel, and empower members and their caregivers to play a more central role in managing their health. Members who agree to participate in the program are assessed for geriatric conditions and the ability to self-manage their chronic illness and, subsequently:

- Individualized action plans are co-developed to assist members in making lifestyle and necessary behavioral changes to manage their conditions
- Members are coached to follow an action plan when they have symptoms (i.e., adjust medications, initiate a call to their Primary Care Provider (PCP)/Treating Provider, make physician office appointments, and follow their medication regimen)
- Members are coached to make appropriate life-style changes such as modifying diet, stopping smoking, participating in exercise, losing weight

To achieve these objectives, the Rising Risk Chronic Illness Program conducts telephonic assessments and care management, uses community resources, skilled home care interventions, and other identified needed interventions. Some members may also benefit from a referral to palliative care for assistance with goals of care discussions and symptom management. Evidence-based educational materials that CarePartners of Connecticut has vetted can be shared with members. CarePartners of Connecticut has a list of these materials that is available on request.

During telephonic care management, motivational interviewing techniques and health coaching is used to:

- Help members follow their treatment plans set in place by their PCP and specialists
- Help members relate these plans to their personal goals
- Help members overcome barriers to effective treatment.

Adherence to the Rising Risk Chronic Illness Program

Adherence to the program's treatment plan and identified goals is monitored through specific measures identified and discussed during each phone call to the member, repeat hospitalization or emergency room visits, and reports from the home care nurse.

Chronic Care Manager Roles and Competencies

Roles

The Care Manager's role includes:

- Conducting comprehensive clinical and social geriatric focused assessment that identifies:
  - Health and social service needs that were not met
  - Barriers to treatment, such as financial needs, lack of transportation, untreated symptoms of depression, and inadequate social support that could impede quality of life
  - Member's and/or caregiver's confidence level in managing his/her chronic condition
- Developing a comprehensive care plan in collaboration with member and/or caregiver to ensure optimum disease/condition management that promotes self-management practices and improves continuity of care:
  - Partnering with member and PCP/Treating Provider to develop member-centric Plan of Care
  - Ensuring that the member Action Plan is available to member, family, and other care providers
  - Collaborating with interdisciplinary care team members, when necessary
  - Facilitating referrals to other team members and community-based providers/resources to meet the specific needs of the member/caregiver, including referrals to clinical social work, clinical pharmacist, behavioral health, specific PCP/Treating Provider follow-up for medical assessment/management, palliative care, disease-specific programs (pulmonary rehabilitation, biometric monitoring), transportation programs, meals on wheels, senior centers, chore services, etc.
- Providing support, coaching, and self-management skills for member to assist the member/caregiver in understanding and following his/her physician's plan of care and the importance of making lifestyle changes needed to improve their health:
  - Using disease-specific, evidence-based teaching models to support member education
  - Incorporating motivational interviewing in health coaching technique to strengthen the member's motivation for and commitment to change

Competencies

The Care Manager's competencies include:

- Communicating effectively with team members to identify members at risk for readmission who are appropriate for the Chronic Illness Program
- Demonstrating the ability to work with PCPs/Treating Providers and members to create a member-specific care plan to promote member self -management of chronic disease and/or conditions
- Demonstrating the ability to work with all stakeholders to improve patient quality of life and end-of-life planning
- Having knowledge of disease-specific community resources and their capability for providing care

- Demonstrating an advanced ability to evaluate a member's capacity to meet his/her self-care needs and demonstrating that the member's goals and preferences are incorporated into the care plan
- Demonstrating an understanding of evidenced-based treatment strategies for chronic diseases and/or conditions
- Demonstrating an understanding of health coaching principles, including:
  - Strategies to evaluate member's and/or caregiver's confidence level in managing chronic conditions
  - An understanding of motivational interviewing techniques and ability to incorporate into practice
  - An understanding of Teach-Back principles and ability to incorporate into practice
- Demonstrating an understanding of geriatric condition management
- Demonstrating an understanding of appropriate use of resources such as internal consultants (social worker/ palliative care) and external disease-specific vendors

For additional information regarding Care Manager roles, refer to Appendix D, Chronic Care Manager Role.

4 Transitional Intervention

Population Description

This chapter describes the members in the top 20% of the population at risk who may need their transition managed. These members have had a hospitalization or admission to a skilled nursing facility (SNF), putting them at greater risk for readmission due to the disruptions caused by the hospitalization. Within an inpatient event, there can be ensuing changes in medications, deconditioning, decline in health status, and other related challenges for geriatric members. These changes can make transitioning to home a challenge.

The members who are managed and reported in transitions reporting include:

- Members identified as Transition Risk on the *Daily Census Report*
- Members who fail the post-discharge phone call due to lack of knowledge or lack of confidence in their self-management abilities
- Members identified for Complex or Chronic programs but who are not enrolled in either program

The transitions of the members who are enrolled in Complex or Chronic programs will be managed by their Complex or Chronic Care Managers. In addition, these members will not be reported as transitions, as this would result in double counting.

Members are identified for the Transitional Intervention in one of three ways:

- Based on the ESS High-Risk Member Report[1]
- Based on the Daily Census Report[1]
- Ad hoc referral based on a hospital, SNF, or community-based Care Manager's concerns regarding a member's ability to successfully transition home due to a limited understanding of the following:
  - The reason for his/her hospitalization
  - Ability to manage medication administration
  - Signs or symptoms that warrant calling his/her Primary Care Provider (PCP)/Treating Provider
  - A treatment regimen

The screening for a "transitions" intervention includes, at a minimum, a standardized phone call assessing the member's confidence in his/her ability to manage his/her post-discharge needs.

1 Examples of specific triggers for a transitions assessment include hospital admissions for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), a fall, or a previous readmission.

Transitional Intervention Overview

After a member is identified for Transitional Intervention, a Care Manager conducts a transition of care assessment and identifies member-specific needs in such areas as:

- Medication adherence
- Fall risk
- Lack of understanding of red and yellow flags of worsening condition
- Self-management deficits
- Psychosocial deficits

The Care Manager collaborates with the member to identify a Plan of Care to address identified needs. The Care Manager continues to oversee the overall Plan of Care to support a successful transition. This is achieved through a series of phone calls lasting up to 45 days, during which the Care Manager re-assesses member needs and determines if the risks are being mitigated by coaching, hands-on help from family or community support, and whether the member's ability and confidence to self-manage his/her care has improved.

In an effort to prevent readmission, the Care Manager reinforces the signs and symptoms that warrant a call or visit to the PCP/ Treating Provider or the Care Manager. In addition, the Care Manager identifies other parties/ community resources, e.g., Visiting Nurse Association (VNA) vetted programs, a hospital program, Area Agencies on Aging, clinical pharmacist, clinical social worker to address members' specific needs.

The members' readiness for self-management is measured using objective questions, including "confidence" in the ability to manage care and the ability to "teach back" understanding of medication regimes, symptom identification, and action plans. Members are ready to be discharged when the above measures indicate an ability to self-manage. Members not independent within the 45-day time frame should be referred for enrollment in the Complex or Chronic Illness Program.

Care Manager Roles and Competencies

Roles

The Care Manager's role includes:

- Managing and coordinating member transitions of care
- Communicating the care plan to providers in all settings of care (i.e., emergency department, hospital, rehabilitation facility, nursing home, home care, specialty care)
- Proactive managing members and follow-up according to the Plan of Care
- Providing direct caregiver support, as needed
- Facilitating patient and caregiver access to community resources relevant to members' needs, including referrals to transportation programs, Meals on Wheels, senior centers, chore services, etc.
- Developing member self-care skills and use of shared decision making in all aspects of patient care planning

Competencies

The Care Manager's competencies include demonstrating:

- The ability to communicate effectively with team members to facilitate successful transitions of care and prevent readmission
- Knowledge of Complex and Chronic Program criteria to enable member referral appropriately
- An understanding of referral responsibilities regarding community resources
- An understanding of levels of care and SNF benefits
- An understanding of a member's denial process and appeal rights
- The ability to actively participate in relationship building with external providers
- An understanding of and ability to identify member psychosocial needs vs. medical needs, and the ability to identify associated the CarePartners of Connecticut benefits
- An understanding of geriatric condition management
- An understanding of appropriate resource utilization of consultants as available (e.g., social worker/ palliative care, pharmacy)

5 Medical Management

Overview

CarePartners of Connecticut Integrated Care Management Model relies on a foundation of strong medical management principles that require infrastructure for, and management of, the delivery of health care services to our members across the continuum. Medical management is led by a Medical Director and relies on preferred provider networks with systematic means of communication. The Care Manager also plays an important role in the medical management team.

Key tenets for medical management infrastructure include:

- Medical Director:
  - Full-time preferred, but varies on size of group
  - Responsible for applying Medicare coverage criteria in case of a dispute with a provider
- Plan for hospital inpatient management, including identification of daily rounder, e.g. Primary Care Provider (PCP) and/or Hospitalist
- 24-hour medical coverage
- Access to inpatient medical record system
- Plan for preferred provider relationships, especially skilled nursing facilities (SNF) and home health providers, also including Acute Rehabs, and Long-Term Acute Care (LTAC)
- Plan for SNF management, including dedicated physicians or nurse practitioner (NP) rounders at preferred SNFs (see Guiding Principles of Rounding in Skilled Nursing Facilities below)
- Plan to impact Emergency Department utilization
- Integrated Care Management program for high risk members
- Plan for regular Medical Management meetings

Guiding Principles of Rounding in Skilled Nursing Facilities

The overall aim of this program is to assist the member/caregiver in navigating the transitions of care while providing a structure to ensure high-quality outcomes. The guiding principles of this program include:

- Identified MD/NP rounders who will actively participate in the short-term management of CarePartners of Connecticut's members while in a preferred SNF. MD/NP rounders will:
  - Conduct a face-to-face admission assessment within 24 to 48 hours of admission
  - Actively participate in the interdisciplinary discharge planning process
  - Provide 24/7 call coverage with communication processes in place to ensure coordination of plan of care
  - Provide a minimum of weekly rounds, as well as any additional necessary rounds
- The medical group will identify a subset of preferred facilities in their geographic area that meet defined quality and performance standards. The medical group will:
  - Direct at least 80% of their admissions to this subset of preferred facilities.

  - Develop systems/processes for regular communication and, at a minimum, meet annually with preferred SNFs to share data/clinical outcomes
- The group Care Manager will:
  - Actively participate in oversight and management of members in the SNF
  - Inform hospitals and others of their preferred facilities to facilitate appropriate referral
  - Actively participate in the care planning and interdisciplinary discharge planning process
  - Identify and follow up on any readmissions to the acute setting or other quality events

CarePartners of Connecticut believes a successful SNF Rounding Program is based on these principles. For additional information, refer to Appendix E, Skilled Nursing Facility Rounding Program.

Meetings

Medical Management Meetings

Medical management meetings are a vital means of communication for the medical group and Care Managers to regularly discuss members care, whether inpatient or outpatient. To facilitate effective management of the high-risk population, interdisciplinary meetings with the PCP are recommended. These meetings serve many purposes, including:

- Developing concurrent plans of care that use a team approach to manage specific high-risk members
- Identifying obstacles to effective care and developing mitigation strategies
- Creating a learning environment by evaluating outcomes, conducting case reviews, facilitating discussion, and providing constructive, respectful feedback
- Improving effectiveness of the Care Management role by providing clinical input for individual member-centric plan of care
- Improving process and outcome of care
- Monitoring group performance
- Identifying opportunities for improvement
- Developing strategies to manage populations
- Developing strategies to work with preferred SNFs and homecare agencies
- Providing information regarding regulatory changes, provider updates, and topics from the CarePartners of Connecticut Medical Directors meetings

The following actions can maximize the effectiveness of Medical Management meetings:

- Co-developing the agenda with a broad focus on medical management
- Creating an environment that facilitates discussion and learning
- Establishing clear expectations, roles, and responsibilities of all participants
- Developing an annual plan for medical management with goals and priorities, and incorporating metrics and reporting
- Integrating quality metrics, monitoring, and reporting

NOTE: Minutes, attendees, and utilization decisions/recommendations must be recorded at these meetings.

Attendees at these meetings should include the following:

- Group Medical Director
- PCPs/Treating Providers
- Hospitalist, if appropriate
- SNF rounder, e.g., physician/NP
- Care Managers from all programs
- Ad hoc attendees
  - Preferred SNF or Home Care representative
  - Specialists
  - Hospital Care Management
  - CarePartners of Connecticut representatives

At a minimum, full group meetings must occur on a monthly basis, while best practice is ongoing communication between the Group Medical Director/Group Leader/PCP/Treating Provider and Care Manager to provide updates and discuss individual issues. In addition, the Group Medical Director/Group Leader is responsible for communicating with PCPs/Treating Providers as necessary.

Quality Meetings

Quality meetings with peer-protected minutes and attendees documented are required on a monthly basis. Agenda topics for these meetings can include:

- Annual discussion of CarePartners of Connecticut *Quality Initiative Work Plan*
- Sentinel events reported to the CarePartners of Connecticut Quality department

Inpatient Notification Management

Acute inpatient level of care determinations rely on the use of a nationally recognized standard (e.g., CarePartners of Connecticut uses InterQual) for acute hospital admissions. Long term acute care (LTAC), acute inpatient rehabilitation (AIR), SNF admissions and home health care services are guided by Centers for Medicare & Medicaid (CMS) definitions for each level of care.

6 Externally Managed Groups

Overview

"Externally managed" means that CarePartners of Connecticut designated another entity (an Integrated Delivery Network (IDN) or Medical Group) to perform certain functions on its behalf; however, responsibility and accountability for the functions being performed remain with CarePartners of Connecticut. CarePartners of Connecticut's externally managed network is comprised of IDNs. These IDNs are networks consisting of medical groups in risk arrangements with CarePartners of Connecticut. The IDNs and medical groups are delegated for implementation and management of the Integrated Care Management Program.

Integrated Care Management Program

The CarePartners of Connecticut Care Management department adopted the Integrated Care Management Model to:

- Address the increasingly complex care needs of members
- Ensure a consistent member experience throughout the CarePartners of Connecticut network

For additional information regarding the Integrated Care Management Model, refer to Chapter 1, Integrated Care Management, as well as other chapters in this guide.

To achieve external management status, IDNs or Groups must demonstrate adoption of the Integrated Care Management Model components and must cooperate with all CarePartners of Connecticut requirements as outlined in this guide. CarePartners of Connecticut's staff are available to groups who want to achieve external management status. IDNs/ Groups that want external management status must satisfy the requirements outlined in Appendix F, Integrated Delivery Network Deliverables.

Program Requirements (Specifications)

The Integrated Care Management Model for externally managed programs requires leadership of a Medical Director and Care Management Leadership staff. Externally managed IDNs/Groups must meet and maintain policies and procedures consistent with the CarePartners of Connecticut Care Management program. This includes, but is not limited to, the specific requirements of:

- CarePartners of Connecticut Care Management Resource Guide
- Centers for Medicare & Medicaid (CMS) Manual
- CMS Chronic Care Improvement Plan (CCIP)
- CMS Star requirements

Integrated Care Management Capabilities

The Integrated Care Manager is embedded within the medical group setting and has the ability to:

- Use assessment tools to create detailed care plans for targeted members
- Create an individual care plan to be shared with Primary Care Provider (PCP)/Treating Provider and care team
- Create an individual action plan to be reviewed with the enrolled member
- Engage and coach member in self-management of chronic disease
- Use community resources to augment care plan
- Apply discharge criteria
- Demonstrate supporting systems to document care plans, track action steps, due dates, and member utilization activity
- Demonstrate a capability to integrate care plans into members electronic medical record (EMR)
- Perform utilization care management
- Ensure adherence to CarePartners of Connecticut payment policies
- Ensure adherence to InterQual or equivalent criteria for inpatient utilization
- Ensure adherence to CMS criteria for skilled nursing facilities (SNF) and home health agency (HHA) utilization management (UM)
- Identify opportunities to mitigate iatrogenic conditions or delays in care that may adversely impact quality
- Facilitate discharge planning/transition of care program for those admissions not enrolled in Integrated Care Management programs
- Identify members who may be appropriate for referral to Integrated Care Management programs
- Utilization review may be telephonic for acute setting; however, Care Management for SNF members is preferred to be on site.

CarePartners of Connecticut Responsibilities and Oversight

Responsibilities

CarePartners of Connecticut will fulfill the following responsibilities:

- Identifying high-risk/high-cost members, including:
  - Producing daily census report
  - Providing ongoing predictive modeling reporting
  - Providing data from Health Risk Assessment/Health Survey
- Supporting the development of the Care Management role, including:
  - Providing competencies/sample job descriptions for Care Managers
  - Providing best practice “seminars” for Care Management Leadership for both clinical and regulatory requirements
  - Sharing geriatric seminar opportunities for Care Management continuing education units (CEU)
- Reporting outcome metrics to facilitate performance monitoring, including:
  - Admissions and Readmissions trend reports

- Oversight, including ensuring that the provider organization is meeting program specifications as outlined herein
- Performing fast-track appeals overturn rate/staff
- Maintaining Organizational Determination process, Notice of Denial of Medical Coverage (NDMC), and member appeal data

Oversight

CarePartners of Connecticut's oversight process includes meeting with the CarePartners of Connecticut Medical Director and/or additional members of the CarePartners of CT team on both a quarterly and as needed basis to review the performance of program reporting and utilization. In addition, as part of the oversight process, the CarePartners of Connecticut team performs regularly scheduled site visits to each IDN to review program and performance metrics, and to perform record reviews or discuss summary results of record reviews done in advance of meeting.

Annual evaluation of external management functions is conducted using documentation including, but not limited to:

- Meeting minutes
- Chart reviews
- Policy and procedure reviews
- Audits
- Integrated Care Management program metrics

The externally managed groups are expected to supply documentation sufficient to meet CarePartners of Connecticut and accreditation and regulatory requirements.

Integrated Delivery Network Responsibilities

- Identified medical and care management leadership
- Administrative processes with accountability for completion of the end-to-end processes
- Workflows for all Care Manager functions
- Quality Improvement (QI) process and structure, including participating in CarePartners of Connecticut's QI work plan for CMS
- Medical group performance evaluation and improvement plan
- Compliance and regulatory guidelines and criteria and associated processes and workflow
- Benefit management - provide information updates and educational resources to group/Care Managers
- Orientation, education, and training
- Communication regarding product and regulatory changes
- Collaboration and support

For additional information, refer to Appendix G, Integrated Delivery Network Responsibilities.

External Operations

All externally managed medical groups are required to follow CarePartners of Connecticut's policies in accordance with the CMS rules and regulations. For additional information, refer to Chapter 9, Operations.

Communication

CarePartners of Connecticut's team will offer informational IDN webinars/conference calls throughout the year. Representation from each IDN is expected to participate to ensure that important information and updates are received. The IDN leadership is responsible for disseminating updated information to their respective Care Managers.

Education and Training

Leadership at each IDN is responsible for training and developing their Care Management staff. This includes orientation and training new staff regarding CarePartners of Connecticut's policies and procedures.

Provider Performance Management

Provider Performance Management is a critical function within CarePartners of Connecticut that helps provider groups succeed in our value-based care risk model while providing quality care to our members. It is a consultative approach helping CarePartners of Connecticut providers manage medical expenses and improve outcomes, sharing information to assure best practice standards are being met. This includes the following:

- Create a transparent and collaborative relationship, optimal experience for the member and provider across the externally managed network
- Collaborate with providers and case management teams sharing processes to align full HMO network.
- Conduct a joint review of cost and utilization data to understand drivers of performance
- Data-driven identification of group-specific opportunities for improvement, identify network trends, develop strategies to address areas of opportunity using Evidence-based Practice and Best Practice guidelines
- Develop innovative clinical programs/interventions to implement with groups in partnership with Care Management, Risk Adjustment, Provider Performance, Medical Directors, Product Strategy, Contracting and Product Strategy
- Recommend strategies to improve performance, improve member outcomes based on data analysis, alignment of group and network priorities.
- Collaborate with provider groups to identify priorities, create an action plan, implement interventions, work with provider performance to monitor action plans with the goal of improving performance
- Measure and monitor interventions

7 Geriatric Condition Management

Geriatric Conditions

The prevalence of geriatric conditions, such as dementia and falling, are similar to those of chronic diseases in older adults and are associated with physical and psychosocial disability. Although prevalent, geriatric conditions are not part of healthy aging and potentially can be prevented or treated. Individuals impacted by various geriatric conditions can experience decline in activities of daily living and decline in overall well-being.

In geriatric care management, it is essential to assess the individual as a whole using a multifaceted approach, with the goal of promoting independent function and wellness. To prevent or minimize further decline in functional and cognitive functioning, screening and assessment for common geriatric conditions should be conducted to identify those who can benefit from care management intervention. Although there are numerous conditions that are common in the geriatric population, CarePartners of Connecticut identified the following conditions for assessment and intervention by Care Managers.

Falls

According to the Centers for Disease Control and Prevention (CDC), falls are the leading cause of death in individuals who are 65 years and older. In addition, falls are the most common cause of non-fatal injuries and hospital admissions related to trauma (for additional information regarding falls, see *Important Facts about Falls* on the CDC Web site). Fall prevention is a joint responsibility between the primary care provider (PCP)/Treating Provider and Care Manager. CarePartners of Connecticut recommends certain elements be included in a member's physical exam to screen for fall risk and to treat potential causes.

Incontinence

Urinary incontinence in the elderly is not considered a condition of normal aging; however, it is common, and the prevalence of incontinence increases with age. Multi-factorial causes include age-related factors, co-morbid conditions, medications, and functional and cognitive impairments. Because urinary incontinence is often under-diagnosed and under-treated, it is essential to assess for this condition because of the significant associated morbidity and quality of life impact.

PCPs/Treating Providers should conduct active case finding and screening for incontinence in elderly men and women to determine the cause of incontinence and the appropriate treatment approach.

Cognition

The risk for age-related cognitive decline increases with age. Decline in cognition/memory often leads to poor treatment compliance, safety, decision-making, and psychosocial well-being. A decline in cognition directly impacts quality, cost, and utilization. Screening and identification of cognitive decline in the early

stages can identify those individuals who may require a change in their medical treatment plan and/or those who may be at risk of developing delirium or functional impairments.

Care management staff is required to use the Six-Item Screener to screen for potential cognitive decline for members enrolled in the chronic or complex programs. The Six-Item Screener is quick (less than five minutes), easy to administer, and validated for telephonic use. It has a sensitivity of 88.7% and specificity of 88%.

A positive screen is determined by two or more misses on the Six-Item Screener. After a positive screen is identified, a Care Manager is expected to notify the PCP/Treating Provider for recommended follow up. This notification should be completed via fax, phone call, or electronic health record, and documented accordingly. (For additional information regarding the Six-Item Screener assessment, refer to Appendix H, Six Item Screener Information.)

Follow up with the PCP/Treating Provider to determine the etiology or whether the cognitive decline is reversible is imperative for the appropriate treatment planning. Effective interventions (i.e., community groups, community supports, long-term care planning, advance directives) can be implemented by the Care Manager to assist the individual and his/her caregiver in dealing with the consequences of cognitive decline. (For additional information regarding process metrics and outcome reporting, refer to Appendix C, Process Metric Specifications.)

Dementia Care Consultation Program

The Dementia Care Consultation program is coordinated between CarePartners of Connecticut and local community resources. Dementia Care Consultants have expertise directly related to dementia, as well as additional training

Dementia care consultation is an in-depth, personalized service for individuals and families facing the many decisions and challenges associated with Alzheimer's disease or related dementias. The goal of the Dementia Care Consultation program is for each family to develop an understanding of a dementia diagnosis; make plans to maximize the independence of the person with memory loss; secure needed resources; and develop strategies for the best possible symptom management and communication.

Any member who has or cares for someone with concerns regarding memory or cognitive changes can be referred to this program; formal diagnosis is not needed. Refer to Dementia Care Consultant Referral Guide for more information. Use Dementia Care Consultation Referral Form and email to CarePartners of Connecticut mailbox: cm cpct@cartpartnersct.com.

To complete the initial consultation, the Dementia Care Consultant contacts the identified caregiver by phone or in person within two weeks. During this consultation, the following areas can be assessed:

- Exploration of diagnosis (if there is one) and caregiver/member understanding ofthe diagnosis
- Presenting symptoms and behaviors
- Level of functioning: activities of daily living (ADL) and instrumental activities of daily living (IADL)
- Level of structure and engagement
- Safety concerns, e.g., driving, wandering, financial, home safety
- Supports, services, and respite
- Approach to care
- Caregiver capacity to provide needed care
- Future planning needs

In addition, the Dementia Care Consultant can offer assistance related to:

- Education about the disease process

- Connection to local community programs and services
- Discussions and recommendations related to:
  - Management of challenging behaviors
  - Communication
  - Approach to care
  - Accessing and introducing new services
  - Safety concerns
  - Future care planning
  - Recommendations provided to caregiver, care manager, and PCP/Treating Provider

The Dementia Care Consultant either emails or faxes written feedback highlighting the assessment and areas discussed to the referring Care Manager. The Care Manager is responsible for sharing this information with member's PCP/Treating Provider. In addition, the Dementia Care Consultant sends a personalized care plan to the caregiver. This care plan outlines the recommendations and any resources that were discussed during the assessment. Follow-up is provided until the identified needs are met.

NOTE: Caregivers can be re-referred at any time. The Dementia Care Consultant is also available to consult on cases as needed.

Depression

Although depression is common later in life, it is not a normal part of aging and can be treated. Depression has been found to have an adverse effect on the course and outcome of individuals with chronic conditions, such as arthritis, chronic obstructive pulmonary disease (COPD), asthma, cardiovascular disease, cancer, diabetes, and obesity. If left untreated, depression can impact an individual physically and psychosocially, and can often lead to increased health care costs and decreased quality of life.

Screening older adults for depression is recommended and, when present, a collaborative care approach to improve condition management is recommended. This approach should involve the PCP/Treating Provider, mental health specialists, and other providers. You can use measures from the Patient Health Questionnaire (PHQ) to determine if the individual is exhibiting depressive symptoms, i.e., “little interest or pleasure in doing things”, “feeling down, depressed, or hopeless”. For additional information and assessment tools, use the following resources:

- *American Psychiatric Association Practice Guidelines*
- *The Geriatric Depression Scale (GDS)*

Medication Adherence

There are numerous reasons why an individual might not follow through on medication regimen, including inability to pay for medication, lack of knowledge regarding the need for the medication, and poor health literacy or cognition problems. An individual's inability to adhere to his/her treatment plan often leads to increased health care costs and decreased quality of life. Member-centered care plans should include assessment for medication adherence barriers or risk factors.

For additional information on assessment of medication adherence and tips on effecting change in the individual, use the resources available at *Case Management Society of America (CMSA)*

Hearing

According to the *National Institute on Deafness and Other Communication Disorders (NIDCD)*, hearing sensitivity declines progressively with age. Disabling hearing loss affects:

- 2% of 45 to 54-year-old adults
- 8.5% of 55 to 64-year-old adults
- 25% of 65 to 74-year-old adults
- 50% of adults who are 75 or older

It is estimated that less than one in three (30%) of adults aged 70 and older who could benefit from hearing aids have never used them. A significant impact of declining hearing sensitivity is the lack of the ability to understand speech, which can have a significant effect on quality of life. Depression, anger, loss of self-esteem, and social isolation are often associated with hearing loss.

A hearing loss assessment can assist in identifying those in need of treatment. To access a hearing loss screening tool, use *Hearing Screening in Older Adults*.

Advanced Life Planning/Goals of Care

The aim for Advanced Illness management (Serious Illness Management) is to improve the quality of care as life comes to an end by providing care that matches what the member wants. To achieve this goal, efforts directed towards members, providers, and clinicians are needed. Members need to be able to express what matters most to them as they decline, and providers/clinicians need to be able to conduct and document these conversations so that members' wishes are honored when necessary.

In addition, members need an opportunity to express what matters most to them in the context of their cultural beliefs. Opportunities for these conversations should be created when members are well and should be reviewed as disease processes progress. The first step in this process is asking members what is important to them should a sudden event, medical or trauma. Family and provider participation in the conversation is very important. The second step in the process is members identifying a Health Care representative with whom they have spoken, and who can honor their wishes should the member become unable to speak for themselves.

Some members may remain relatively healthy the rest of their lives; however, for those high-risk frail elders who are identified for care management, subsequent conversations to are necessary to uncover their understanding of their diseases, as well as the explanation from the provider about hopes and worries given the progress of their condition. Increasing functional decline is a significant indicator for the need to conduct a serious Illness conversation. Depending on the individual circumstances, a MOLST order set may be appropriate to ensure that members' wishes are clearly documented to ensure that these wishes will be honored when necessary.

Advance Directives documentation has two parts:

- The Health Care Representative is a person who is authorized in writing to make any and all health care decisions on the member's behalf including the decision whether to withhold or withdraw life support systems.
- A Living Will is a document that states a member's wishes regarding any kind of health care they may receive.
- For additional information, refer to *Connecticut Department of Social Services - Advance Directives*

The CarePartners of Connecticut's Advanced Illness initiative, Voice Your Choice, is a way to:

- Encourage members to express their wishes
- Create an open dialog with clinicians when members are well so that all members of the team,

including family members, are able to participate in planning for the management of illness as it advances to its conclusion, resulting in high member satisfaction and high quality of care at end of life

- Goals of Care is another way to express what matters most to a member/family and helps guide future conversations about prognosis and plans of care. These kinds of ongoing conversations with all the stakeholders will promote treatment plans that match members' wishes and promote living well.

Palliative Care

Palliative care is comprehensive medical care to treat the symptoms and stress of serious illness. Palliative care consultation and services can benefit members with chronic disease or life-threatening illness who do not have a prognosis of less than six months but who need improved symptom management to improve quality of life and decrease the risk for readmission.

A palliative care consultation is also a good option when discussions regarding goals of care have been difficult to initiate with a member. In this situation, a palliative care specialist works collaboratively with the PCP/Treating Provider and the member to initiate these difficult discussions and to integrate goals of care into the member's treatment plan.

NOTE: Members can continue to receive treatment for their disease while receiving the support and expertise of a Palliative Care team. This option might appeal to members who are not ready to forgo treatment, but who need additional end-of-life care and support. Members who move into the final stage of a terminal illness with a life expectancy of less than six months can transition to hospice care for medical services, emotional support, and spiritual resources.

For additional information and resources regarding palliative care, use the following resources:

- *Connecticut State Department of Public Health – Palliative Care Resources*
- *Connecticut Department of Social Services - Advance Directives*

Hospice Care

Hospice care is considered the model for quality compassionate care for people with life-limiting illness. Hospice is a Medicare benefit available to those members with a terminal illness and a life expectancy of less than six months. In addition to helping to manage the emotional challenges involved in caring for a dying family member, hospice services also support family members.

Hospice is provided by an interdisciplinary care team focused on providing comfort and improving the quality of life for its members. Members who elect hospice have chosen to forgo additional curative means of treatment.

According to the National Hospice and Palliative Care Organization, an estimated 1.5 to 1.6 million patients received hospice care in 2013 and approximately 84% of those patients were 65 years of age or older. The growth of this age group will drive the growth in hospice utilization to support quality end-of-life care

8 Behavioral Health / Substance Use Disorders

Overview

CarePartners of Connecticut supports the inpatient Behavioral Health needs of members in conjunction with the Primary Care Provider's (PCP) Health Care Team.

Clinical Management for Inpatient and Intermediate Levels of Care

To assist in coordinating care and discharge planning, the CarePartners of Connecticut or PCP Health Care team may contact the facility periodically during an admission. Clinical management is focused on the member's discharge planning needs and readmission prevention. Facilities are expected to proactively communicate with CarePartners of Connecticut or the PCP Health Care Team as appropriate, regarding the member's admission, including medication reconciliation and health information exchange to inform treatment planning during the admission and post-discharge plans.

Accessing Outpatient Behavioral Health and/or Substance Use Disorder Treatment

- The PCP and their Health Care Team should assist in coordinating all outpatient specialty care, including outpatient behavioral health care.
- A representative from the PCP can call CarePartners of Connecticut for assistance searching for contracted services, if needed.
- The PCP and Health Care Team should assist in coordinating all outpatient psychological and neuro-psychological testing.

Transitions Program

The Transitions Program provides telephonic care management to members who have been hospitalized for behavioral health treatment and are returning home. Eligibility is open to members who are at risk for readmission, as evidenced by:

- A recent psychiatric readmission
- A history of noncompliance either with outpatient services or taking medication as prescribed
- Ineffective self-management
- Co-occurring conditions that can make self-management more challenging
- Enrolled members are followed through their 45-day post-hospitalization period, and telephonic support is provided to attend aftercare appointments and complete their provider's recommendations for care. Care management goals include:
- An assessment and review of the discharge plan and the member's/caregiver's ability to follow the plan

- Support of the member/caregiver to follow through on outpatient specialty services and adhere to the medication directions prescribed by his/her provider
- Education regarding the member's condition
- Conversations with the member and caregiver regarding the coordination of care
- Identification of barriers to successfully follow the treatment plan

Sources of referrals to the program include:

- CarePartners of Connecticut-contracting and non-contracting facilities with psychiatric inpatient services
- CarePartners of Connecticut Care Managers working with members with both psychiatric and medical issues
- Providers who are currently working with members diagnosed with a psychiatric disorder and who have assessed their patient to be at risk for an inpatient hospitalization

Substance Use Disorder Support

Transition support to members who have been recently hospitalized for substance use disorder treatment and are returning home, or who have been identified by an outpatient provider as needing support around substance use, sobriety, and recovery is available.

Appropriate referrals include members with a substance use disorder, as evidenced by, but not limited to:

- A recent detoxification on a medical unit, hospitalized due to a medical condition during which substance use was identified, or hospitalized for medical problems that were caused or worsened by substance abuse
- Ineffective self-management
- Co-occurring conditions that can make self-management more challenging

Members are provided with telephonic support to attend aftercare appointments and complete their provider's recommendations for care on their road to recovery. Care management goals include:

- An assessment and review of the discharge plan and the member's/caregiver's ability to follow the plan
- Support of the member/caregiver to follow through on outpatient services and adhere to the medication directions prescribed by his/her provider
- Education regarding the member's condition
- Conversations with the member and caregiver regarding the coordination of care
- Identification of barriers to successfully follow the treatment plan

Sources of referrals to the program include:

- CarePartners of Connecticut-contracting and non-contracting facilities with psychiatric inpatient services
- CarePartners of Connecticut Care Managers working with members with a substance use disorder
- Providers who are currently working with members diagnosed with a substance use disorder and who have assessed their patient to be at risk for an inpatient hospitalization or other potential concerns regarding their substance use

A licensed clinician is available to members, family members, and providers for assistance with substance abuse resources, support, information, and assistance navigating the complex treatment options for sobriety and recovery. Single consultations or short-term support is available as a transition into more intensive Care Management

9 Operations

This chapter provides a brief overview of some operational tasks and links to operational policies and procedures that you will need to create or use as daily workflows.

Daily Census Report

The Daily Census Report is a working tool that will help Care Managers identify high risk, high priority inpatient members who will benefit from more immediate care management, and transition of care oversight. The report:

- Provides a snapshot of all CarePartners of Connecticut members with inpatient status, e.g., acute medical, skilled nursing facility, rehabilitation, behavioral health, and future elective admissions.
- Flags members with Complex, Chronic/Tier 2 status to allow the Care Manager to quickly prioritize their daily case load for intervention*
- Provides information on how to report coordination of benefits (COB)/subrogation cases and cases being considered for bridging*

End Stage Renal Disease

CarePartners of Connecticut receives the End Stage Renal Disease notification from the Centers for Medicare and Medicaid Services (CMS) identifying members who have been reported by the dialysis center as meeting the criteria for end stage renal disease. CarePartners of Connecticut provides groups a monthly End Stage Renal Disease Log with the information provided by CMS. If the group is aware of end stage renal disease members under their care who are not on the CMS list, the expectation is that the group will work with the dialysis center to ensure proper notification to CMS. Neither CarePartners of Connecticut nor the medical group has the opportunity to correct errors on the end stage renal disease report.

Health Risk Assessment/Health Survey

- Gives CarePartners of Connecticut a snapshot of actual/potential health needs of newly enrolled Medicare Advantage members
- Performed by newly enrolled members who answer a health risk assessment survey on the telephone, online, or on paper
- Results are sent to Primary Care Providers (PCP)/Treating Provider as appropriate and, if Care Manager flags are triggered, a Care Manager referral can be generated, and a Care Manager will be notified

*will be added

Hospice Log

CarePartners of Connecticut creates a monthly Hospice Log based on information reported to CMS by the hospice agency. The purpose of the log is to notify CarePartners of Connecticut of all member hospice elections, revocations, and deaths.

Hospice election information is necessary for proper claims adjudication and for tracking network and group hospice utilization and length of stay.

Care Managers are expected to review the Hospice Log for accuracy and then update and return it to CarePartners of Connecticut.

Institutional Log

The CarePartners of Connecticut Institutional Log uses information from CMS to identify members who are residents in long-term care facilities. CMS uses the information included in the Minimum Data Set (MDS) that is reported by Medicare-certified skilled nursing facilities to determine long-term institutional status. CarePartners of Connecticut members residing in a long-term institution for 90 days prior to the payment month are classified as long-term institutional status. CarePartners of Connecticut members remain in long-term institutional status until they have been discharged to the community for a period longer than 14 days. A long-term institutional status is determined for CarePartners of Connecticut members and added as a factor in risk-adjusted payments.

Care Managers are expected to:

- Review and update the *Institutional Log* by adding new long-term institutional members (with the date that they became custodial) to the list and returning the updated list to CarePartners of Connecticut.
- Regularly review custodial member's records for episodes of treatment in place, which qualify as skilled level of care. These episodes must be recorded with the Health Plan, and the SNF is obligated to seek reimbursement for them.

  NOTE: For a sample of the letter template, refer to Appendix J, Custodial Skilled Episode Letter.

- Manage Part B requests for their custodial members.

Managing Self Audits

CarePartners of Connecticut has an expectation that self-audits of clinical documentation at the management and peer level will be performed with the goal of improving member care and service. The audits will be completed quarterly, and results reported quarterly to CarePartners of Connecticut. An example of a self-audit tool is in Appendix L. This tool assesses the completion and quality of the documentation for the Complex and Chronic Member assessments and ongoing care management.

High Risk Report*

The High-Risk Report (see Appendix O, ESS High Risk Member Report) is a working tool that will identify the top 10% of the group's high-risk members for Care Managers. The report flags members with a Complex (Tier 1) or Chronic (Tier 2) status based on an aggregate of indicators (for a list of the high-risk definitions, see Appendix O, High Risk Member Report - Stratification). A Care Manager will be able to quickly identify these members to begin immediate interventions, with the goal of reducing the risk of readmission while working to provide members the highest quality of life possible.

*will be added

The report also provides the probability of an admission within the next six months based on the indicators. The High-Risk Report is updated monthly with new members appearing in bold blue. Inpatient utilization is based on ten months of claims and a two-month preregistration look back

Transplants

The medical group is responsible for ensuring that the transplants are performed at a CarePartners of Connecticut-contracted and Medicare-approved transplant facility. After the member is admitted, the group manages the inpatient care of transplants for the member. For a listing of CarePartners of Connecticut Medicare-approved transplant facilities, please visit CarePartners of Connecticut Medicare-Approved Facilities.

Evidence of Coverage

For information regarding evidence of coverage, refer to the CarePartners of Connecticut plan documentation.

Referrals

The Referral Authorization Request Form must be used to refer CarePartners of Connecticut HMO members to an out-of-network specialist. CarePartners of Connecticut members are encouraged to see specialists within the network. If a HMO member requests to see a specialist outside of the network and the PCP's treatment decision is that the member can access the same care within the network, then the member should be informed that he/she has the option to contact CarePartners of Connecticut to request an organization determination. For additional information regarding the organization determination process, refer to Grievances, Organization Determinations, and Appeals.

To view the Referral Authorization Request Form as well as additional information, refer to CarePartners of Connecticut plan documentation.

Out-of-State Benefit

The CarePartners of Connecticut Out-of-State Benefit for HMO members provides coverage of urgent and emergent events occurring outside the State of Connecticut. Events and post-acute care services related to the out-of-state episode of care are managed by the designated Care Manager. When a medical group or PCP provides a referral for care/services outside of the state, it is the medical group's responsibility to manage any related subsequent events and services. For additional information, refer to the CarePartners of Connecticut plan documentation.

CarePartners of Connecticut PPO members have access to out-of-state care based on their plan benefits.

Prior Authorization

For a current list of procedures, services, medication, and items requiring prior authorization, refer to CarePartners of Connecticut plan documentation.

Payment Policies and Financial Programs

For CarePartners of Connecticut Terms and Conditions and Reimbursement Grid, refer to the CarePartners of Connecticut plan documentation.

Quality Assurance and Improvement

CarePartners of Connecticut continuously evaluates the quality of care in all health care settings that it serves and advocates for improvement when necessary. For standards and guidelines, refer to the CarePartners of Connecticut plan documentation:

- *Quality Improvement Member Grievance Report Form*
- *Quality Improvement Occurrence Report Form*

Observation Program

Care Managers are encouraged to use the observation status when the member's problem related to an inpatient facility is reasonably expected to resolve within 48 hours. For detailed information on this program, refer to the CarePartners of Connecticut's *Provider Manual, Observation Program*.

Grievances, Organization Determinations, and Appeals

CarePartners of Connecticut members have the right to file both appeals and grievances, or to request organization determinations related to their care. A grievance is when a member is dissatisfied with the quality of care received. An organization determination is a decision made by the Plan that is based on a request by the beneficiary/authorized representative (including a physician) to pay for goods or provide services. The request for an organization determination can be the result of: 1) a disagreement with the Treatment Team or 2) a request for coverage by the Plan. If a negative organization determination is reached, a member has the right to appeal that decision.

Treatment Team Definition

A Treatment Decision is a decision between the provider (Treatment Team) and a beneficiary/authorized representative without the Plan's direct involvement. The Treatment Team may be comprised of, but not limited to, the member's PCP, Medical Group Director, group nurse practitioner (NP), office nurse, Care Manager.

NOTE: All Care Managers, both for internally and externally managed groups, are considered part of the Treatment Team and are not acting on behalf of the Plan.

As a member of the Treatment Team, a CarePartners of Connecticut Care Manager participates in making treatment decisions/recommendations for members. If a member agrees with a treatment decision, the Care Manager should document the discussion/rationale in the medical record.

If the member disagrees with the treatment decision, the Care Manager should document the discussion/ rationale for the decision in the medical record, and offer the member the opportunity to contact CarePartners of Connecticut to request an organizational determination (for example, an acute inpatient member requests a discharge to acute rehabilitation, and the treatment team recommends sub- acute level of care).

NOTE: It is not necessary for the Care Manager or medical group representative to notify CarePartners of Connecticut.

If a member is exhausting his/her SNF, acute inpatient rehabilitation, or long-term acute care hospital benefit, the Care Manager is required to notify the member/member's authorized representative and the facility of the impending benefit exhaustion 15 calendar days prior to the date the coverage will end. The Care Manager is also required to complete and fax the *CarePartners of Connecticut Extended Care Exhaustion of Benefit Notification Form* to the Precertification department. This form enables the Care Manager to communicate specific information relative to the member's benefit exhaustion to the

Precertification department.

After receiving the form, the Precertification department uses the information to generate the *Notice of Denial of Medical Coverage and Payment* (NDMCP) and then faxes it to the facility to be delivered to the member. In addition to serving as the formal Plan notification to the member of benefit exhaustion, the *NDMCP* provides the member with his/her appeal rights and the process to request an organization determination if the member disagrees with the benefit exhaustion.

For additional information on the extended care exhaustion and benefit notification process, refer to the following resources:

- *Extended Care Exhaustion of Benefit Notification Form*
- *Instructions for Extended Care Exhaustion of Benefit Notification Form*

For additional information on appeals and grievances, refer to the CarePartners of Connecticut plan documentation.

Member Service Referrals

Member Service department staff members are trained regarding the Integrated Care Management model and Care Manager functions. They have been trained regarding what qualifies as areas of concern that may indicate the need for Care Manager involvement.

While answering calls in the Call Center, based on caller statements, a Member Service department staff member may identify a member who is in potential need of Care Manager outreach. The staff member will offer to forward the information to the Care Management department. When the caller agrees, the information is sent via email. Then, a Care Management department staff member reviews the medical group information.

NOTE: When the member belongs to an externally managed medical group, the information is forwarded via email to the appropriate medical group contact.

Pharmacy

For information on CarePartners of Connecticut pharmacy benefits, refer to CarePartners of Connecticut's *Prescription Drug Coverage*.

Home Health

Home health services do not require prior authorization; however, the Care Manager will have clinical conversations with the home health agency (HHA) to ensure that the member's goals are being achieved. Notification for these services is required. Refer to the *Home Health Payment Policy* in the Provider Resource Center.

Part B Notification

Part B notification refers to services that SNFs' rehabilitation services provide for CarePartners of Connecticut custodial members. A notification is required, and the appropriate Care Manager will assess the requester's clinical rationale and ensure that member goals are being met. Refer to the *Skilled Nursing Facility Payment Policy*

Medication Reconciliation

CarePartners of Connecticut requires a comprehensive medication reconciliation for all CarePartners of Connecticut HMO members. This is to support the standardization of best practice across the network and increase the focus on avoidable admissions and readmissions, while addressing regulatory requirements of the Centers for Medicare & Medicaid Services (CMS).

The required documentation and/or coding must be completed within 30 days of patient discharge from an acute or non-acute inpatient facility to the community.

We must be able to review the member's discharge medications and the member's current outpatient medications in the documentation. Notification of completed medication reconciliation, as well as any identified concerns, must be shared with the member's PCP/Treating Provider.

Documentation

One or a combination of the following evidence meets the criteria for best practice documentation:

- Notifications that the medications prescribed or ordered upon discharge were reconciled with the current medications
- A medication list in a discharge summary that is present in the outpatient chart and evidence of reconciliation with the current medications conducted by a registered nurse, clinical pharmacist, or prescribing practitioner (e.g. nurse practitioner, physician assistant, or physician)
- Notation that no medications were prescribed or ordered upon discharge

NOTE: The date of member's discharge must be noted. In addition, a signature (electronic or written) of the clinician who completed the medication reconciliation must be included.

Medication reconciliations can be performed only by a registered nurse, clinical pharmacist, or prescribing practitioner (e.g. nurse practitioner, physician assistant, or physician).

Coding

- NCQA HEDIS rules for this measure: Medication reconciliations (using approved codes) must be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse.
- Medical Providers: The submissions of transitional care management codes (TCM) 99495 or 99496 are appropriate and reimbursable. The submission of reporting code 1111F is also appropriate but not reimbursed.
- Care Management: If care managers are completing medication reconciliation post-discharge and coding is inappropriate or not applicable, documentation in accordance with specifications described above are required.
- Home Care Agencies: The submission of CPT code 1111F in combination with code G0299 on the same claim will comply with NCQA HEDIS measure requirements. Code G0299 confirms that a registered nurse completed the medication reconciliation.
- Audit: Verification is subject to audit by CarePartners of Connecticut.

COB/Subrogation

For information, refer to the Daily Census Report for more information.

Use of Out-of-Plan Providers

Infrequently, a member of the Care Management team will need to facilitate an admission to a non-contracted facility (i.e., SNF, Long-Term Acute Care, Acute Inpatient Rehabilitation) or a non-contracted home health care agency. In this instance, they will determine the appropriate level of care, then instruct the

provider to notify the CarePartners of Connecticut Precertification Operations Intake department by submitting the appropriate Inpatient Notification Form. Following discharge, the provider can bill CarePartners of Connecticut at the same billing rate as traditional Medicare. For home health care, the Care Manager should request that the provider submit a Home Health OR Part B Services Notification Form with their plan or care and supporting documentation.

Carve-Outs

If there is the need for a medication carve-out at SNFs the CarePartners of Connecticut Contract Manager assigned to SNFs should be contacted. The Contract Manager should be notified of key elements, e.g., Care Manager name and number, member name, member ID; for medication carve outs, include the drug name, dosage, frequency, duration, member's weight.

If there is the need for DME from a non-contracted provider, the Contract Manager assigned to DME should be contacted, with the request and key demographics referenced above.

Call CarePartners of Connecticut Provider Services (1-888-341-1508 to contact both Contract Managers.

Additional Resources

Non-covered Items/Equipment List

For information on non-covered items/equipment, refer to the resources below:

- National Coverage Determinations - For a listing Medicare National Coverage Determinations (NCDs), access the Medicare Coverage Center on the CMS website click on NCDs under Spotlight
- Medicare Coverage Database - To access the Medicare Coverage Database, go to the Medicare Coverage Center on the CMS website and click on Medicare Coverage Database under Spotlight. Then click on Search. You can search for both NCDs and LCDs in this database
- Medicare Online Manual System - To access the CMS Online Manual System, go to the CMS website. The Medicare Benefit Policy Manual (pub 100-2) includes coverage instructions that are not included in NCDs (e.g., skilled nursing guidelines). The Medicare Managed Care Manual (pub 100-16) provides general Managed Care benefit information in Chapter 4 (benefits). The Medicare NCD Manual (pub 100-3) includes all Medicare NCDs

Quality Improvement Organization Fast-Track Appeal

Quality Improvement Organization (QIO) is designated by CMS to serve as the designated QIO for the CarePartners of Connecticut service. QIO receives appeal requests from members who disagree with the *Notice of Discharge* that they have received. In the hospital or other acute level-of-care settings, the *Important Message No. 2* (*IM No. 2*) serves as the *Notice of Discharge.* SNFs, Comprehensive Outpatient Rehabilitation Facilities (CORF), and Home Health Agencies (HHA) use the *Notice of Medicare Non Coverage* (NOMNC).

1. When QIO receives a call within the required time frame after the delivery of the *IM No. 2* or NOMNC, QIO activates the fast-track appeal process.
2. After the process has been initiated, QIO notifies the Appeals and Grievances department at CarePartners of Connecticut. The Appeals and Grievances department representative then contacts the appropriate facility or provider to request that a copy of the *Notice of Discharge* be faxed to him/her.

3. An Appeals and Grievances Analyst determines if the notice was issued correctly and contacts the appropriate Care Manager to obtain the *Discharge Summary document*.
4. The Care Manager must return the completed *Discharge Summary* document to the Appeals and Grievances department within two hours of being notified by the Analyst or by the end of business that day, whichever comes first. This information is used to write the letter which goes from the Health Plan to the facility/provider. A copy is also mailed to the member's home on record and to the PCP's office. The acute setting letter is the *Detailed Notice of Discharge* (DNOD). The SNF/HHA letter is the *Detailed Explanation of Non-Coverage* (DENC).
5. The member's medical record from the hospital or the SNF is sent directly to QIO. The SNF and HHA record are sent to CarePartners of Connecticut for review before Appeals and Grievances forwards it to the QIO.
6. If the *Notice of Discharge* is upheld, QIO notifies the provider, the member, and CarePartners of Connecticut. If the notice is overturned, QIO notifies the provider, the member, and CarePartners of Connecticut.

On occasion, the group's Care Manager performs a clinical reinstatement before the QIO decision has been rendered. When done, this halts the fast-track appeal process. For additional information, refer to the following resources:

- *Hospital Discharge Summary Form*
- *Hospital Discharge Summary Form Instructions*
- *SNF/HHA/CORF Discharge Summary Form*
- *SNF/HHA/CORF Discharge Summary Form Instructions*
- *HMO Reinstatement of Services*

10 Policies

Complex Care Management Policies

Population Assessment

Purpose

The purpose of this policy is to ensure a process to provide ongoing assessment of the needs of the general population on, at minimum, an annual basis to adjust the procedures to facilitate linking members with care management services that meet their needs.

Policy

CarePartners of Connecticut will review the population at least annually to assess the characteristics and needs of its member population and relevant subpopulations. This assessment will be used to review and update care management processes and resources to address member needs.

Procedure

The CarePartners of Connecticut Management Team, in conjunction with analysts from the Actuarial department, routinely reviews information about the CarePartners of Connecticut population. These reviews determine eligibility for care management services in the Clinical Data work group and ad hoc meeting with the CarePartners of Connecticut Medical Director and management teams. Characteristics of specific population include, but are not limited to:

- Ethnicity
- Custodial members
- Hospice members
- Members with:
  - Multiple chronic conditions
  - Psychiatric diagnoses
  - Geriatric conditions

CarePartners of Connecticut Care Management Complex Member Identification - Data Sources

Purpose

The purpose of this policy is to identify data sources used to identify potential members for CarePartners of Connecticut care management.

Policy

- On a monthly basis, members will be identified as candidates for complex care management using the ESS process.

- To reflect preregistration data and high-risk indicators that apply to members, members will be identified on the *Daily Census Report* and the *ESS High Risk Report.*
- Members will be identified by providers or other care managers during utilization management and discharge planning process.

Procedure

1. The Population Health Analytics team analyzes data related to member identification. CarePartners of Connecticut medical and pharmacy claims history are gathered on a monthly basis to produce population segmentation with risk scoring.
2. The clinical parameters for complex care are identified and reviewed monthly by the CarePartners of Connecticut Care Management leadership team and Medical Director.
3. Identified members comprise a list of potentials members for care management. A greater number of members will be identified than will be able to be assigned.
4. When the member is an inpatient, the Care Manager will screen the member for an evaluation.
5. When the member is an outpatient, the Care Manager will prioritize the evaluation of members based on their risk.
6. Daily Census data is available through the CarePartners of Connecticut Precertification department.

Access to Care Management

Purpose

The purpose of this policy is to ensure that members meeting the criteria for complex care management services are referred to the program by multiple sources in a timely way.

Policy

The CarePartners of Connecticut network uses multiple sources for referral to complex care management services, including, but not limited to:

- Claims data
- Information gathered through the utilization management (UM) or discharge planning process
- Information gathered through the member's involvement with other programs or services provided (i.e., enrollment in the congestive heart failure program)
- Member or caregiver self-referral
- Provider referral

Procedure

1. Claims data is reviewed on a monthly basis to determine if a member meets the criteria for the complex care algorithm.
2. Daily reports that identify all members with an open preregistration and their associated risk factors are sent to Care Managers. These reports are used to identify and prioritize the completion of the initial assessment by the Care Manager.
3. Members and/or caregivers can make a self-referral to the program, either by contacting the Plan, their providers, and/or Care Manager. Providers can also make ad hoc referrals for complex care management programs. Information about the programs is available to members, caregivers, and providers in a variety of mediums including, but not limited to, the Internet, mailings, and medical management meetings.

4. The Plan maintains a file that indicates the source of member referrals. The CarePartners of Connecticut management team and Medical Director routinely analyze this file.

Care Management Systems

Purpose

The purpose of this policy is to assure that the assessment and management of members is based on evidence-based decision support tools that minimize management variability. Documentation is maintained in an electronic system that provides automatic documentation of member, provider, and caregiver interactions and reminders for the care plan.

Policy

The CarePartners of Connecticut Network uses a Care Management System that does the following:

- Uses evidence-based clinical guidelines/algorithms and logic scripts to assess and manage Complex Care Management patients
- Includes automatic documentation of staff member's ID, and is date- and time-stamped with each interaction with members, providers, or practitioner involved in the care
- Includes automated prompts for follow-up with reminders for next steps as required by the care plan

Procedure

The Care Manager will use evidence-based and standardized tools to complete the following:

- Minimize treatment variability
- Improve health outcomes
- Reduce health care costs
- Increase patient involvement and adherence

Care Management Process

Purpose

The purpose of this policy is to establish a standardized process to assess the needs of each member referred to the program and to develop an effective and individualized member care plan.

Policy

The initial assessment covers a broad scope of health-related topics. Members and Care Managers explore these topics to identify the member's achievable health goals and opportunities to improve self-management of health conditions, as well as influence health-related behavior for optimal health and identify member-centric goals. The Care Manager will complete all activities involved in the member initial assessment period within 30 days of the receipt of a new care request or assignment of a direct referral.

The following are the components of an initial assessment:

- Health status and any condition-specific issues
- Clinical history, including medications
- Daily living activities
- Mental health and cognitive status
- Life planning activities
- Cultural, linguistic, visual, and hearing needs, preferences, or limitations

- Caregiver resources and involvement
- Benefits within the organization and from community resources
- Self-management ability

The process creates an individualized care management plan with the following:

- Provides prioritized goals that consider the member's and caregiver's goals, preferences, and desired level of involvement in the care management plan
- Provides a time frame for re-evaluation
- Identifies resources to be used, including appropriate level of care
- Includes planning for continuity of care, including transitions of care and transfers
- Provides collaborative approaches to be used, including family participation
- Provides educational materials that encourage member self-management
- Evaluates member social needs and personal preferences that drive activities to support the care management plan

The process identifies the following:

- Available resources for member referral as part of benefits or other health organizations and a follow-up process to determine whether members act on referrals
- Barriers to member receiving or participating in the care management plan
- A follow-up plan and schedule
- Development and communication of a member self-management plan

The process assesses member progress against the care management plan, including the following:

- Overcoming barriers to care
- Meeting treatment goals
- Maintaining self-management
- Maintaining the desired level of involvement in care management activities

Measuring the Effectiveness of the Care Management Program

Purpose

The purpose of this policy is to:

- Identify at least three measures that validate the effectiveness of the care management program across its entire population or subset of the population
- Ensure that these measures have significant and demonstrable bearing that enables the appropriate intervention that would result in significant improvement of the population

Additionally, based on the results of the measurement and analysis of care management effectiveness, the organization will do the following:

- Implement at least one intervention to improve performance
- Re-measure to determine change in performance

Policy

The CarePartners of Connecticut network measures care management activities that have significant influence in the improvement of the health of its membership. The measures may include, but are not limited to:

- Fall risk
- Medication adherence
- Advance Directives
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Readmission reduction
- Member satisfaction

Based on the results of the identified measures, the organization identifies opportunities for improvement and implements measures to improve performance, thereby improving the health of its population.

Procedure

The organization measures the effectiveness of its care management program using three measures. For each measure, the organization does the following:

1. Identifies a relevant process or outcome
2. Uses valid methods that provide quantitative results
3. Sets a performance goal
4. Clearly identifies measure specifications
5. Analyzes results
6. Identifies opportunities for improvement, if applicable
7. Develops a plan for intervention and re-measurement

11 Outcomes and Measures

Reporting Requirements

Integrated Care Management Reporting metrics for the Integrated Care Management Program include Process Metrics. Data tracking and reporting requirements are received for the CarePartners of Connecticut Membership enrolled in Care Management Programs. These standards provide the ability to identify and track opportunities for improvements in the delivery of the Integrated Care Management Program. These requirements may vary from year to year, based on changes in the needs of the populations, organizational priorities and changes in CMS regulations/requirements.

For additional information, refer to Appendix C, Process Metric Specifications.

	Complex Care Management	Tier 2/Chronic Management	Transitions Management	Wellness
Process Metrics	• Quarterly Process Metrics (including Goals of Care) • Cognitive Screening Process Metrics (separate report)	• Quarterly Process Metrics (including Goals of Care) • Cognitive Screening Process Metrics (separate report)		
	Monthly/Member Level Variable Report Monthly Member Level PHQ2 Referral Report	Monthly Member Level Variable Report Monthly Member Level PHQ2 Referral Report	Monthly Member Level Variable Report	Monthly Member Level Variable report

Monthly Process Metrics (Complex, Tier 2/Chronic, Transitions, Wellness)

This reporting file provides CarePartners of Connecticut with a monthly data feed for all members who have a new or changed disposition code for the Complex, Chronic, Transition, or Wellness program within the reporting month.

Reporting Objectives

The objectives of these reports include:

- Tracking referral source into Complex, Chronic
- Reconciling status of members sent to the Integrated Delivery Network (IDN)/Medical Groups on the CarePartners of Connecticut Complex and Chronic Tier 2 Lists
- Allowing CarePartners of Connecticut to know which members are enrolled in Integrated Management Programs
- Allowing CarePartners of Connecticut to track duration of members enrollment in programs
- Measuring Goals of Care completion and responses
- Measuring cognitive screening completion and action taken on positive screen

Monthly Member Level Patient Health Questionnaire 2 Referral Report for Centers for Medicare & Medicaid Services Chronic Condition Improvement Plan (CMS CCIP)

The objective for the Patient Health Questionnaire 2 (PHQ2) reporting is to ensure that members who are enrolled in the High-Risk Care Management Programs receive timely screenings both at the time of initial enrollment and subsequent intervals. CarePartners of Connecticut reviewed the effect that behavioral health comorbidities have on the management of chronic obstructive pulmonary disease (COPD) and found that members with COPD and behavioral health comorbidities have higher morbidity, utilization, and cost than members with COPD alone. Further, undetected and untreated behavioral health conditions among members with COPD can be barriers to effective treatment, exacerbate existing conditions, and negatively impact outcomes.

The goal is to track and improve the rate of PHQ2 screening for members with COPD, and track results of positive screens so members can receive appropriate diagnosis and treatment for depression and become better equipped to self-manage their chronic condition. The schedule for PHQ2 screening will be at the time of initial assessment, and any subsequent PHQ2 screening followed by referral to PCP/Treating Provider and or BH for positive PHQ2 results.

Quarterly Process Metrics

This reporting is conducted on members in the Complex Care Management Program. Reporting should include all members who have agreed to participate and have a disposition code of ENROLLED ACTIVE.

Reporting Objectives

The objectives of this report include ensuring that:

- Members who are newly enrolled in the Complex Care Management Program receive timely assessments, care plans, and actions plans
- The initial assessment is completed within 30 days of being assigned to a Care Manager
- Members with a completed Depression Screen
- Members with Goals of Care answered
- Members are screened for declining cognitive function and action is taken

Other Reporting

CarePartners of Connecticut reserves the right to require reporting mandated by the Centers for Medicare & Medicaid (CMS). CarePartners of Connecticut strives to give as much notice as possible for CMS-required changes.

Frequently Asked Questions Regarding Reporting

Q Should members who are referred to the Complex Care Management Program and who are subsequently determined to be ineligible for this program still be counted in the denominator for the process metrics?

A No. Only include those members who meet the definition during the time period measured.

The definition is all CarePartners of Connecticut members who had a new case opened that remained

open for 60 days during the reporting period. If a member is deemed ineligible or is discharged from the program before 60 days, do not include him/her in the denominator.

Q Should I only report on members identified via reporting provided by CarePartners?

A No. Regardless of referral source, include all eligible members in your Complex Care Management Program reporting.

Q Is it possible that the same members will be on the CarePartners of Connecticut list every month or is the list refreshed so that only new members appear?

A The top 3.5% of complex members appear on the list every month. There is an indicator for members who are appearing on the report for the first time. The date that the member was first identified on the report is also listed.

Q Is it possible for members to drop off the *High-Risk Report* from month to month?

A The report identifies the top 3.5% acute members. Since the cutoff of 3.5% is somewhat inexact, it is possible for a member who is hovering at that point to not appear on the list in subsequent months. We expect that you will evaluate each new member on the list to determine if he/she is appropriate for your Complex Care Management Program. If he/she is appropriate, we expect that he/she would remain in your Complex Care Management Program as long as he/she meets your criteria, regardless of whether or not he/she appears on the list in subsequent months.

Q What happens to members who are eventually closed when they are no longer complex?

A We ask that you report discharge dates on the *Member Level Data Report*.

APPENDIX

A Inclusion Criteria for Ad Hoc Referrals to Complex and Chronic

The following illustrates the inclusion criteria for ad hoc referrals to Wellness, Complex and Chronic Care Management.

Ad Hoc Referral/ Case Guideline Tool		revised June 2020
Wellness	**Chronic**	**Complex**
Members who do not meet Complex or Chronic Criteria but are in need of Care Management for assistance with self-management or knowledge deficits related to : • Functional decline • Disease management • Medications • Nutrition/ Diet • Community Resources • Specialist Resources	1+ chronic conditions (CHF, COPD, Diabetes, ESRD, Parkinson's, etc.) **WITH** self-management deficits: • IADL and/or 1 ADL deficit • Medication adherence • Exercise/ diet OR 1+ chronic conditions **AND** 2 or more of the following: • 1+ admit in 6 mo • Medication adherence concerns • Altered mental status with teachable care giver • Living alone • 1-2 falls in 6 months • 7+ medications • Age 85+ • Psychosocial concerns • Community resource needs	Catastrophic Injury (stroke, brain injury) OR 2+ chronic conditions with multiple ADL/ IADL deficits OR Cognitive Impairment and living alone OR New Oncology Dx OR 2+ Chronic Conditions **AND** 2 or more of the following: • 2+ admits in 6 mo • Medication adherence concerns • Altered Mental Status • Living alone • 3+ falls in 6 months • 10+ medications • Age 85+ • Psychosocial concerns • Community resource needs

Revised June 2020

If the member has an aggregate of needs that fall outside these clinical guidelines, the Care Manager's clinical judgment should prevail.

B Complex Care Manager Role

The table on the following pages describes the Complex Care Manager's role.

Description of Complex Care Manager		
Key concepts for the Complex Care Manager role include: • Manage the complex member through all levels of care (acute, home, facility, etc.). • Use the Complex Care Manager's clinical judgment regarding where best to complete the initial Complex Assessment **NOTE:** Only a subset of members require a home visit • Develop close working relations hips with community resources, preferred facilities, preferred providers, and other supportive services • Ensure that motivational interview techniques are used and assessment of the member and/or caregiver's confidence in managing the member's care is addressed • Ensure appropriate care plans are in place and regular follow-up are provided to track member's progress in adherence to his/her physician's treatment plan In addition, the Complex Care Manager is responsible for: • Working as a team with the member, Primary Care Provider (PCP), and other providers to manage members identified for chronic care management • Ensuring that member needs are met in a time efficient manner		
Essential Function	**Description**	**Tools/Workflow**
Comprehensive Assessments		
	Use clinical judgment to determine the most appropriate setting to complete the assessment	
	Formal assessments that address both medical and psychosocial issues and required community supports	Complex Assessment
Create Evidence-Based Plan of Care (POC) and Member Action Plan		
	• Develop POC based on assessment results and member goals • Solicit PCP and/or Treating Provider input, as needed, to complete initial assessment within 14 to 21 days • Complete all open initial assessments within 30 days of assignment	Complex Program Workflows
	• Develop and distribute Action Plan to the member with instruction and the Chronic Care Manager's contact information • Mail a copy of the Action Plan to PCP and/or Treating Provider	Action Plan templates
Ongoing Proactive Management and Members/Caregiver Coaching		
	• Open complex cases should be followed according to member need, but at a minimum contact member on a monthly basis to monitor engagement and adherence, identify new areas of concern or problems, and assess need to revise the POC **NOTE:** The intensity and frequency of interactions will be m ember specific and will be based on their current Action Plan and any change in status.	Use of clinical judgment to prioritize cases and interventions

	Communication with the member's practitioner about the member's health conditions and treatments	
	Provide ongoing coaching to meet member goals	• Member Action Plan • Diagnosis-specific education material mailed • Motivational interview/coaching tips and tools

Description of Complex Care Manager		
Community Resource Development/Coordination of Care		
	• Coordinate services/information among providers/caregivers • Participate at PCP/Treating Provider appointment when indicated	
	Refer to and consult with skilled home health care or community services/resources to facilitate management of member needs and goals **NOTE:** This can include specific vendors for tele-health monitoring, oxygen therapy, disease management programs at community hospital, disease-specific organizations, or at Area Agencies on Aging	• List of community agencies/ resources • Best Practice Metrics
Ongoing Health Coaching	• Assessment of member and caregiver's ability to self-manage • Ongoing health coaching with emphasis on assessing member and/or caregiver's ability to follow physician treatment plans • Complete weekly updates with focus on progress to goals and eliminating barriers to care	
Facilitate Transitions of Care		
	Develop close working relationships with a limited number of preferred providers, skilled nursing facility (SNF) rounders, and facility Care Managers	Each group/integrated delivery network (IDN) identifies preferred network and sets expectations regarding transitions of care and collaboration of "handoffs"
	Upon admission to a facility: • Communicate member goals, pertinent history and potential barriers to facility Care Manager • Proactively reach out to the family/caregiver to identify member/family concerns/expectations • Communicate with the Visiting Nurses Association (VNA) either before the member is discharged or during the first visit	• Transition of Care Workflow and Assessment tools • Preferred Provider SNF/HHC educational presentation on model and transitions of care
	Upon discharge: • Assume responsibility for post-discharge follow-up • Focus on medication reconciliation • Chose to use non-clinical staff to make post discharge for follow up phone calls (this is optional) • Choose to perform a joint home visit with VNA or NP to ensure that the member has made a safe transition (this is optional)	• Transition of care assessment tool • Contacts/relationships with community-based agencies • Guidelines for pharmacy/mental health/SW/palliative care

C Process Metric Specifications

The following illustrates sample Process Metric Specifications, which may vary from year to year, based on changes in the needs of the populations, organizational priorities and changes in CMS regulations/requirements.

2019 Process and Outcome Metric Reporting Requirements

	Complex Care Management	Tier 2/Chronic Management	Transitions Management	Wellness
Process Metrics	Quarterly Process Metrics Including Goals of Care Cognitive Screening process metrics (separate report)	Quarterly Process Metrics Including Goals of Care Cognitive Screening process metrics (separate report)		
	Monthly Member Level Variable Report Monthly Member Level PHQ2_Referral report	Monthly Member Level Variable Report Monthly Member Level PHQ2_Referral report	Monthly Member Level Variable Report	Monthly Member Level Variable Report

Introduction

The reporting metrics for the Integrated Care Management Program include both process and outcome metrics. Data tracking and reporting are required for the entire CarePartners of Connecticut membership enrolled in care management programs. Standard reporting requirements will provide the ability to identify and track opportunities for improvements in the delivery of the Integrated Care Management Program. Outcome measures will demonstrate effectiveness of programs and opportunities for improvement.

I. Process Metrics: Complex Member and Goals of Care Quarterly Report

A. Reporting Objective

The objective of the complex member quarterly report is to ensure that members who are newly enrolled in the Complex Care Management Program receive timely assessments, care plans and actions plans. Note: It is expected that members who are identified on the CarePartners of Connecticut Monthly High Risk (Complex and Tier 2/Chronic) reports will 1) be assigned to a Care Manager within 30 days, 2) have a completed initial assessment, care plan and action plan within 30 days of being assigned to a Care Manager, 3) be asked about goals of care during the first 60 days of enrollment into the Complex program and 4) receive a depression screening.

B. Quarterly Process Metrics

Quarterly process metrics are reported on Complex members who have a disposition code of ENROLLED - ACTIVE. The report should include:

1. Numerator for each metric and total denominator (Please note, total denominator for percent of Complex and Chronic/Tier 2 Members with documented goals of care differs from the denominator for the remainder of the goals of care metrics.; (Please see Specifications section for specifics)
2. Percentage of Complex Members with a completed Initial Assessment within 30 days of case assignment to care manager

3a. Percentage of Complex and Chronic/Tier 2 Members with documented answers to Goals of Care question

3b. Of the Complex / Chronic Tier 2 Members who are enrolled
   - Percent of Complex Members with a documented Longevity goal

- Percent of Complex Members with a documented Function goal
- Percent of Complex Members with a documented Comfort goal
- Percent of Complex Members who did not wish to answer

4. Percentage of Complex Members with a documented Care Management Plan
5. Percentage of Complex Members who have received a Member Action Plan
6. Percentage of Complex Members who have received a Depression Screen

C. Specifications

1a. Denominator for calculating percentages for all metrics (except metrics for specific member answers to Goals of Care question – see below), includes the following:

a) Members who are Enrolled active in Complex and Chronic Tier 2 care management program regardless of referral source

b) Members who hit their 60th day of enrollment during the reporting period (i.e. If member is enrolled active in Q1 buts hits 60th day during Q2, then the member should only be included in the Q2 report)

c) Members with a current disposition code of Enrolled - Active as of last day of the reporting period

d) Members who have been in program for at least 60 days (since date member became enrolled active)

1b. Denominator for calculating percentages for specific member answers to Goals of Care question is the total number of Complex members with goals of care specified

NOTE: Given the definition of the denominator (1a and 1b), those members that were open at least 60 days and discharged before the last day of the quarter are exempt from quarterly reporting

2. Multiple medical groups can either be rolled up to the IDN level or reported individually
3. File Format

Variable Name	Value Description	Type	Length	Values
IDN	Name	Char	10	
MED_GROUP	IDN total in separate line, next line Med group IPA number	Char/Num	3	123
QUARTER		Char	2	Q1
YEAR		Char	4	2013
Total_Complex	Number of Complex members who agree to participate or are enrolled in Complex program and hit 60th day during reporting period (Denominator)	Num	10	
NUM_INITIAL_ASSESS	Number of Complex members with a completed Initial Assessment within 30 days of case assignment to Care Manager	Num	10	
PCT_INITIAL_ASSESS	Percentage of Complex members with a completed Initial Assessment within 30 days of case assignment to Care Manager	Num	4	100%
NUM_COGC	Number of Complex members with Goals of Care specified	Num	10	
PCT_COGC	Percentage of Complex members with Goals of Care specified	Num	4	100%
NUM_COLONGEVITY	Number of Complex members with documented Longevity goal	Num	10	
PCT_ COLONGEVITY	Percentage of Complex members with documented Longevity goal	Num	4	100%
NUM_COFUNCTION	Number of Complex members with documented Function goal	Num	10	
PCT_COFUNCTION	Percentage of Complex members with documented Function goal	Num	4	100%
NUM_COCOMFORT	Number of Complex members with documented Comfort goal	Num	10	
PCT_COCOMFORT	Percentage of Complex members with documented Comfort goal	Num	4	100%
NUM_COPDNWTA	Number of Complex members with documented Patient does not wish to answer	Num	10	
PCT_COPDNWTA	Percentage of Complex members with documented Patient does not wish to answer	Num	4	100%
Total_Chronic	Number of Chronic members who agree to participate or are enrolled in Chronic program and hit 60th day during reporting period (Denominator)	Num	10	
NUM_CHGC	Number of Chronic members with Goals of Care specified	Num	10	
PCT_CHGC	Percentage of Chronic members with Goals of Care specified	Num	4	100%
NUM_CHLONGEVITY	Number of Chronic members with documented Longevity goal	Num	10	
PCT_ CHLONGEVITY	Percentage of Chronic members with documented Longevity goal	Num	4	100%
NUM_CHFUNCTION	Number of Chronic members with documented Function goal	Num	10	
PCT_CHFUNCTION	Percentage of Chronic members with documented Function goal	Num	4	100%
NUM_CHCOMFORT	Number of Chronic members with documented Comfort goal	Num	10	
PCT_CHCOMFORT	Percentage of Chronic members with documented Comfort goal	Num	4	100%
NUM_CHPDNWTA	Number of Chronic members with documented Patient does not wish to answer	Num	10	
PCT_CHPDNWTA	Percentage of Chronic members with documented Patient does not wish to answer	Num	4	100%
NUM_CARE_PLAN	Number of Complex members with a documented Care Management Plan	Num	10	
PCT_CARE_PLAN	Percentage of Complex members with a documented Care Management Plan	Num	4	100%
NUM_MEMBER_ACTION	Number of Complex members who have received a Member Action Plan	Num	10	
PCT_MEMBER_ACTION	Percentage of Complex members who have received a Member Action Plan	Num	4	100%
NUM_DEPRS_SCREEN	Number of Complex members who have received a Depression Screening	Num	10	
PCT_DEPRS_SCREEN	Percentage of Complex members who have received a Depression Screening	Num	4	100%

4. File naming convention:
   The preferred format is a tab delimited text file with the following naming convention:
   CPCT_Complex_Mbr_Quarterly_Q#_yyyy_XXX.txt
   Please substitute the 'XXX' with the medical group number or IDN name.
   The second preference for file format is an Excel file with the same naming convention (.xls).

D. Definitions

1. Initial Assessment
2. Depression screen: PHQ-2
3. Goals of Care: 1) Members who respond to Goals of Care question and 2) Members who report goal of Longevity, Function or Comfort or Members who did not wish to answer
4. Care Management Plan: Medical and behavioral plan for managing and monitoring the member's condition
5. Member Action Plan: Member-centric document created and sent to member

II. Process Metrics Quarterly Cognitive Screening report separate file

A. Reporting Objective

The reporting objective is to perform dementia screening on all new Complex and Tier 2 members and measure the incidence of positive screens that lead to PCP, MSW or Dementia Care Consultant referrals.

A second objective is measure caregiver strain for those members who have positive screen and to measure completion of Goals of Care discussion for all members with positive screening.

B. Quarterly Cognitive Screen Process Metrics

Quarterly process metrics are reported on Complex and Tier 2 (chronic) members who have a disposition code of ENROLLED - ACTIVE. The report should include:

1. Numerator for each metric and total denominator (Please note, total denominator for percent of Complex or Chronic/Tier 2 Members with documented completed cognitive screens differs from the denominator for the remainder of the cognitive screen metrics.; (Please see Specifications section for specifics)
2. Number and percentage of Complex members with completed Cognitive Screen
3. Number and percentage of Complex members with positive screen
4. Number and percentage of members with positive screen with referral to PCP or medical provider
5. Number and percentage of members with positive screen with referral to MSW
6. Number and percentage of members with positive screen with referral to Dementia Care Consultant
7. Number and percentage of members with positive screen with completed Goals of Care
8. Number and percentage of members with positive screen with completed Caregiver Strain
9. Repeat same measures for Tier 2/Chronic members

C. Specifications

1a. Denominator for calculating percentages for all metrics (except metrics for specific actions made as a result of a positive cognitive screen - see below), includes the following:

   a) Members who are Enrolled active in Complex and Chronic Tier 2 Care management program regardless of referral source
   b) Members who hit their 60th day of enrollment during the reporting period (i.e. If member is enrolled active in Q1 but hits 60th day during Q2, then the Member should only be included in the Q2 report)
   c) Members with a current disposition status of Unassigned or disposition code of Enrolled - Active as of last day of the reporting period
   d) Members who have been in program for at least 60 days (since date member became enrolled active)

1b. Denominator for calculating percentages for Positive Cognitive screen with referrals or Goals of care or caregiver strain completed is the number of Complex and Chronic members with a Positive Cognitive Screen.

NOTE: Given the definition of the denominator (1a and 1b), those members that were open at least 60 days and discharged before the last day of the quarter are exempt from quarterly reporting

2. Multiple medical groups can either be rolled up to the IDN level or reported individually
3. File Format

Variable Name	Value Description	Type	Length	Values
IDN	Name	Char	10	
MED_GROUP	IDN total in separate line, med group IPA number in next line	Char/Num	3	123
QUARTER		Char/Num	2	Q1
YEAR		Num	4	2016
Total_Complex	Number of Complex members who agree to participate or are enrolled in Complex program and hit 60th day during reporting period/Denominator	Num	10	
NUM_COM_COG_SCR	Number of Complex members who have a completed Cognitive screen	Num	10	
PCT_COM_COG_SCR	Percentage of Complex members who have a completed Cognitive screen	Num	4	100%
NUM_COM_POS_SCR	Number of Complex members who have a positive Cognitive Screen (2 or more questions missed)	Num	10	
PCT_COM_POS_SCR	Percentage of Complex members who have a positive Cognitive screen (2 or more questions missed)	Num	4	100%
NUM_COM_REF_MED_PROV	Number of Complex positive screens referred to medical provider (PCP, neurologist, geriatrician)	Num	10	
PCT_COM_REF_MED_PROV	Percentage of Complex positive screens referred to Medical provider (PCP, neurologist , geriatrician)	Num	4	100%
NUM_COM_REF_SW	Number of Complex positive screens referred to Social Work	Num	10	
PCT_COM_REF_SW	Percentage of Complex positive screen referred to Social Work	Num	4	100%
NUM_COM_REF_DCC	Number Complex positive screens referred to Dementia Care Consultant	Num	10	
PCT_COM_REF_DCC	Percentage of Complex positive screens referred to Dementia Care Consultant	Num	4	100%
NUM_COM_GOC	Number of Complex positive screens with completed Goals of Care	Num	10	
PCT_COM_GOC	Percentage of Complex positive screens with completed Goals of Care	Num	4	100%
NUM_COM_CGS	Number of Complex positive screens with completed Caregiver Strain	Num	10	
PCT_COM_CGS	Percentage of Complex positive screens with Completed Caregiver Strain	Num	4	100%
Total_Chronic/Tier2	Number of Chronic/Tier2 m embers who agree or are enrolled in Chronic/Tier2 program and hit 60th day during the reporting period/ Denominator	Num	10	
NUM_CH_COG_SCR	Number of Chronic/Tier2 members who have a completed Cognitive screen	Num	10	
PCT_CH_COG_SCR	Percentage of Chronic/Tier2 members who have a completed Cognitive screen	Num	4	100%
NUM_CH_POS_SCR	Number of Chronic/Tier2 members who have a positive Cognitive screen (2 or more questions missed)	Num	10	

4. File naming convention:

   The preferred format is a tab delimited text file with the following naming convention:
   Quarterly_COGNITIVE_Q#_yyyy_IDN.txt
   Please substitute the 'XXX' with the medical group name of IDN name,
   The second preference for file format is an xls with the same naming convention (.xls).

D. Definitions

1. Cognitive Screen: 6 Item Screener: Cognitive Screen (used with permission): Christopher M. Callahan, MD, Frederick W. Unverzagt,, PhD, Siu L. Hui, PhD, Anthony J. Perkins, MS, and Hugh C. Hendrie, Mb, ChB: Medical Care: Volume 40, Number 9, Pp 771-781 ©2002 Lippincott Williams & Wilkins, Inc. Please insert this statement into your Documentation system.
2. Positive Screen: 2 or more questions are missed
3. Referral to PCP (medical provider) documentation in system expect this for all positive screens
4. Referral to MSW and / or Dementia Care Consultant documentation in system this is as indicated by assessment
5. Goals of care as documented in system
6. Caregiver Strain as documented in system

III. Process Metrics: Monthly Metrics for Complex, Tier 2/Chronic, Transition Management and Wellness

A. Reporting Objectives

The monthly member level process metrics report will provide CarePartners of Connecticut a monthly data feed for all members who have a new disposition code for either the Complex, Tier 2/Chronic, Transitions or Wellness programs within the reporting month. The report also allows CarePartners of Connecticut to:

1. Track referral source for members enrolled in Complex, Tier 2/Chronic programs
2. Reconcile members' status, as identified on the CarePartners of Connecticut High Risk Complex and Tier 2/Chronic lists, which are sent monthly to the IDN/ Medical Groups
3. Identify which members are enrolled in Integrated Care Management Programs
4. Track duration of members' enrollment in programs

B. Specifications

1. File format

As of January 2021, highlighted fields are the only fields that will need to be completed

Note: The file is sent on a monthly basis and includes all members who have a new disposition code for the Complex, Tier 2 /Chronic Transitions or Wellness Programs within the reporting month.

Variable Name	Type	Length	Format	Values	Description
CPCT_MID	Char	9			CPCT Member ID
DATE_CASE_ASSIGNED	Date	8	DDMONYY*		Date the data is loaded and available to CM
REF_DATE	Date	8	DDMONYY		Date the file is received from THP or ad hoc referral received
REF_SOURCE	Char	50		TMP MEMBER REPORT	Complex or Tier 2
				DM PROGRAM	DM Program (Complex to Tier 2 or Tier 2 to Complex)
				UM PROGRAM	Referred via discharge planning or transition of care
				MEMBER OR CAREGIVER	
				PRACTITIONER	
PROGRAM_REFERRED	Char	50		COMPLEX	
				TIER2	
PROGRAM_FOCUS_REFERRED				CHF	
				COPD	
				NOT CLASSIFIED	
PROGRAM_ENROLLED	Char	50		COMPLEX	
				TIER2	
				TRANSITIONS	
				WELLNESS	Those members that have opted into Custom Care and do not meet Complex or Tier 2 criterial
PROGRAM_FOCUS_ENROLLED				CHF	
				COPD	
				NOT CLASSIFIED	
DATE_MBR_AGREED	Date	8	DDMONYY		Date the member agrees to participate (begin/schedule assessment)
DATE_ASSESSMENT_COMPLETE	Date	8	DDMONYY		Date initial assessment completed, and initial care plan generated
DISPOSITION_CODE	Char	50		ENROLLED T ACTIVE	Assessment complete and initial care plan generated
				ENROLLED T DISCHARGED	
				MEMBER DECLINED	
				UNABLE TO CONTACT	
				CLINICALLY NOT APPROPRIATE	
				MIN REQUIREMENT NOT MET	i.e. custodial, hospice, unable to communicate
				INELIGIBLE	i.e. deceased, termed with the plan
DISPOSITION_DATE	Date	8	DDMONYY		Only changes when disposition is updated

2. File naming convention: The preferred format is a tab delimited text file with the following naming convention: **CPCT_Member_Level_Detail_XXX_MonYR.txt**.
   Please substitute the 'XXX' with the med group number or the IDN name. The second preference for file format is an Excel file with the same naming convention (.xls).
3. Report is required to be sent to CarePartners of Connecticut every month (See Section IV. Report Submission Schedule for 2021 IDN Reporting Schedule
4. Report file format must match exactly
5. Use of Disposition Codes: Pre-enrollment disposition status should only be used to relay why a member was not enrolled in a program:
   - CLINICALLY NOT APPROPRIATE
   - INELIGIBLE
   - MEMBER DECLINED
   - MIN REQUIREMENT NOT MET
   - UNABLE TO CONTACT
6. For an enrolled member, with a disposition status of ENROLLED – ACTIVE, a disposition status of ENROLLED – DISCHARGED should be used if the member is discharged from the program, regardless of the reason
7. Transitions reporting: ENROLLED – ACTIVE disposition and enrolled date, then, at time of discharge, ENROLLED-DISCHARGED followed by discharge date
8. Wellness reporting: Enrolled active same as above, only discharge if moving to Complex or Tier 2 level of CM or member opt out after being enrolled

IV. Patient Health Questionnaire – PHQ2

A. Reporting Objectives

The objective for the PHQ2 reporting is to ensure that members who are enrolled in the High-Risk Care Management Programs receive timely screening both at the time of initial enrollment and subsequent intervals. CarePartners of Connecticut reviewed the effect that BH comorbidities have on the management of COPD and found that members with COPD and BH comorbidities have higher morbidity, utilization and cost than members with COPD alone. Further, undetected and untreated BH conditions among members with COPD can be barriers to effective treatment, exacerbate existing conditions and negatively impact outcomes. The goal is to track and improve the rate of PHQ2 screening for members with COPD and track results of positive screens so members can receive appropriate diagnosis and treatment for depression and become better equipped to self-manage their chronic condition(s). The schedule for PHQ2 screening will be at time of initial assessment and any subsequent PHQ2 screening followed by referral to PCP and / or BH for positive PHQ2 results.

B. Specifications

- File format:

Patient Health Questionnaire-2 PHQ2				
Variable Name	**Type**	**Length**	**Values**	**Value Description**
TMP_MID	Char	9		TMP Member ID
POINT_OF_SURVEY	Char	8	INITIAL	Initial assessment or subsequent PHQ2 surveying
			Or	
			Re surve	
POSITVE_SCORE	Char	3	Yes	Score of 3 or more
			No	Score less than 3
REFERRAL_ TO_PCP	Char	3	YES/NO	
REFERRAL_TO_BH			YES /NO	

- File naming convention: The preferred format is a tab delimited text with the following naming convention: **CPCT_POS_PHQ2_Referral_XXX_MonYR.txt** or .xls
- Reporting population: Complex and Tier 2 / Chronic members with enrolled active status and have a completed assessment; or have had a repeat PHQ2 during the reporting month. CarePartners of Connecticut will identify who has COPD and being managed.
- Please substitute the "XXX" with the medical group number or the IDN name. The second preference for file format is an Excel file with the same naming convention (.xls).
- Report is required to be sent to CarePartners of Connecticut following the schedule below.
- Report file format must match exactly.

IV. Report Submission Schedule

Monthly Reporting		**Quarterly Reporting**	
Reporting Month	**Due Date**	**Reporting Quarter**	**Due Date**
January 2021	February 9, 2021	Q1 2021	April 18, 2021
February 2021	March 9, 2021		
March 2021	April 13, 2021		
April 2021	May 11, 2021	Q2 2021	July 18, 2021
May 2021	June 8, 2021		
June 2021	July 13, 2021		
July 2021	August 10, 2021	Q3 2021	October 17, 2021
August 2021	September 14, 2021		
September 2021	October 12, 2021		
October 2021	November 9, 2021	Q4 2021	January 16, 2022
November 2021	December 14, 2021		
December 2021	January 11, 2022		

D Chronic Care Manager Role

The table on the following pages describes the Chronic Care Manager's role.

Description of Chronic Care Manager		
Key concepts for the Chronic Care Manager role include: • Provide education and health coaching to help members with chronic illness address disease symptoms effectively and improve self-management skills • Ensure that motivational interviewing techniques are used and assessment of the member and/or caregiver's confidence in managing the member's care is addressed • Ensure appropriate care plans are in place and regular follow-up are provided to track member's progress in adherence to his/her physician's treatment plan • Provide access to a wide range of community services to address the full spectrum of member needs, such as tele-health monitoring, behavioral health care, life planning, and pharmacy assistance programs for medications In addition, the Chronic Care Manager is responsible for: • Working as a team with the member, primary care provider (PCP), and other providers to manage members identified for chronic care management • Ensuring that member needs are met in a time efficient manner		
Essential Function	**Description**	**Tools/Workflow**
Comprehensive Assessments		
	Formal assessments that address both medical and psychosocial issues and required community supports	Chronic Illness Assessment (CIA) and Disease Specific Assessments (e.g., Chronic Obstructive Pulmonary Disease (COPD), heart failure)
	Assess member's readiness/ commitment to change through completion of the appropriate assessment	Training regarding behavior change assessment
Create Evidence-Based Plan of Care (POC) and Member Action Plan (AP)		
	• Develop POC based on assessment results and member goals • Solicit PCP and/or Treating Provider input, as needed, to complete initial assessment within 14 to 21 days • Complete all open initial assessments within 30 days of assignment	Chronic Program Workflows
	Using motivational interview and coaching techniques, work with the member and/or caregiver to develop an action plan that focuses on self- management of his/her disease (including symptom management), and enhances his/her active participation in medical care and decision-making	Action Plan templates

Description of Chronic Care Manager		
Coaching Members and Caregivers		
	Provide the following: • Information on wellness and self- management of chronic conditions • Education and information about preventive health issues and recommended medical testing • The importance of complying with recommended treatments • Communication with the member's practitioner about his/her health conditions and treatments	• Welcome letter/action plan provided to member and PCP/Treating Provider • Diagnosis-specific education material mailed • Motivational interviewing/coaching tips and tools
Community Resource Development/Coordination of Care		
	Consult with the PCP, specialists, subject matter experts, and/or pharmacist for medication literacy and/or adherence, as needed	
	Refer to and consult with skilled home health care or community services/resources to facilitate management of member needs and goals **NOTE:** This can include specific vendors for tele-health monitoring, oxygen therapy, disease management programs at community hospital, disease-specific organizations, or at Area Agencies on Aging	• List of community agencies/resources • Best Practice Metrics
Ongoing Health Coaching	• Assessment of member and caregiver's ability to self-manage • Ongoing health coaching with emphasis on assessing member and/or caregiver's ability to follow physician treatment plans • Complete weekly updates with focus on progress to goals and eliminating barriers to care	

E Skilled Nursing Facility Rounding Program

Rounders manage and care for patients in the long term and post-acute setting with a focus on enhancing quality and functional status to promote positive outcomes.

The Rounder has a consistent presence in the facility and transparent collaboration with an interdisciplinary team to identify strengths, weaknesses and barriers that need to be addressed in order to optimize discharge outcomes, identify mutual goals and deliver comprehensive care.

Rounding Model

- Supported by close collaboration between all members of the Care Team
  - The Care Team includes
    - Facility team
    - Primary Care Physician/Provider
    - Rounder
    - Care Manager - CPC / Primary Care
    - Community providers – as appropriate
  - Member and family engagement whenever possible

Role of CarePartners of Connecticut (CPC) Rounder

Aligned with CPC Program

- Employed, contracted, designated by medical group, SNF, or CPC
- Must be aligned with CPC SNF Collaborative Management Program
  - Nurse Practitioner with a collaborating Physician
  - Physician
- Complete an admission history and physical within 48 hours
  - Conduct medication reconciliation
  - Responsible for the plan of care while at the facility, follow up, and acute change in status
  - Start discharge planning, identify and communicate functional goals required for safe transition to next level of care
- Engage in advance directive discussions, address goals for care ongoing
- Attend family meeting scheduled within 72 hours
- Participate in weekly Care Team conferences /family meetings with discussion related to members progress towards goals, barriers, community supports
- Weekly patient visits for routine evaluations pertaining to presenting diagnosis
- Provide “first call” coverage 24/7/365
  - Return calls within 15 minutes of receipt
  - Answering service weekends/after hour
  - Follow treat-in-place protocols

- Discharge planning
  - Discharge visit no more than 48 hrs. from discharge with detailed notes highlighting changes at facility, PCP follow up items, pertinent labs and any concerns that would impact success in community setting
  - Provide prescriptions for medications /narcotics/ DME, skilled home health services
  - Write discharge order, document discharge plan
  - Ensure PCP follow up is in place (5-7 days after discharge) – include in order

Role of the Care Manager

Responsible for monitoring and coordinating care in partnership with the other members of the Care Team

- Collaborate/communicate with the Care Team in initial and continual reviews of care plan, goals, length of stay, discharge plan
- Participate in weekly Care Team conferences and all family meetings
- Communicate anticipated discharge/estimated length of stay during Care Team conferences/family meetings
- Facilitate communication between the Care Team and the PCP/Provider
- Review medical record to ensure documentation supports plan of care
- Assist Facility Care Management with discharge planning, identifying preferred providers
- Verify PCP visit scheduled within 5-7 days of discharge
- Communicate level of payment (i.e. 1A, 1B, L2) and discharge date to CPC
- Post discharge follow-up call within 48 hours to reinforce understanding of discharge plan, PCP visit, services/equipment in place
- Follow member in the community as appropriate

Role of the Physician Group

- Identify MD facility rounder who will manage or co-manage members in collaboration with the CPC Rounder
- Develop support systems for coverage and communication to ensure continuity of care
- Leverage group medical management meetings to discuss/review SNF cases
- Ensure Care Team access to physicians on a timely basis
- Group Medical Director takes active role in ensuring appropriate and timely post discharge follow-up care
- Participate in regular meetings and forums to monitor quality and outcomes of SNF rounding program

Role of the Facility

- Communicate and collaborate with Rounder and Care Manager on admission - member status, teaching needs, initial goals for treatment and tentative discharge destination and supports
- Initiate family contact to validate prior level of function, discuss expected course of treatment, tentative discharge plan, potential barriers and support system
- Facilitate initial family meeting within 72 hours of admission and weekly thereafter with participation of the Care Manager and Rounder
- Address and document goals of care and code status at first family meeting, facilitate ongoing discussions as needed
- Facilitate weekly Care Team conferences which can include the family meeting

- Communicate with Rounder and Care Manager regarding any concerns about medical management / level or plan of care / discharge plan
- Achieve team consensus for plan of care and discharge plan, ensure documentation supports plans as well as highlights noted progress/barriers and team decisions
- Arrange for home visit if needed to assess home environment, support system
- Schedule PCP follow-up visit prior to discharge, within 5-7 days of discharge date
- Validate/arrange transportation for PCP follow-up visit after discharge
- Make needed referrals to ancillary services as members transition to the community
- Provide a discharge summary to PCP prior to follow-up visit, best practice within 2 business days of discharge
- Timely update of the Admission/Discharge/Transfer notification system, e.g. Patient PING
- Provide a discharge summary to PCP prior to follow-up visit, best practice is within 2 business days of discharge

F Integrated Delivery Network Deliverables

The table on the following page describes Integrated Delivery Network (IDN) deliverables required for IDN/Groups seeking status to be externally managed.

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/SIGN OFF
General Administrative				
Secure Gateway	Secure gateway for communication confirmed between IDN and CPC			
	CPC provided with credentials for EMR access. If EMR is not available, alternative method of data transfer has been secured and implemented			
User Agreement for CPC Support Materials	Signed user agreement for CPC support materials			
Attestations	Signed attestations-IDN will follow requirements outlined by:			
	1) CPC Care Management Resource Guide and subsequent changes/updates			
	2) CMS			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/SIGN OFF
Infrastructure				
IDN Responsibilities	Understanding of oversight responsibilities (see attached Oversight Responsibilities of the Integrated Delivery Network (IDN) document)			
Organizational Structure of IDN	Copy of organizational structure			
	IDN and group Care Management contact information			
Roles and Responsibilities	Define for Medical Management, i.e. Medical Directors and PCPs			
	Define for Care Management Leadership			
Care Managers Staffing	Staffing plan and budget outline			
	Staffing statement and acknowledgment of staffing ratio as 1:850 members, not including UM			
Annual CEU requirements (5) in Geriatric Content for Care Managers	Course descriptions and attestation of completion			
Medical Director/Primary Care Provider Communication and Performance	Workflow to ensure information from CPC Medical Directors' meeting is cascaded to staff as appropriate			
	Mechanism to ensure performance reporting received from CPC is distributed to practice leadership, others as appropriate			
	Workflow for review of CPC utilization performance reporting, i.e. Group Level Days reports and utilization charts			
	Ability to profile physicians and provide feedback on individual performance			
	Incentives for actions needed to achieve goals (i.e., managing transitions, improving length of stay)			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/ SIGN OFF
Integrated Care Model Management				
Complex Care Management Program				
Complex Care Management Program Description	Program admission criteria			
	Ad hoc referral criteria			
	Referral workflow for each potential referral source, i.e. CPC Complex list, Ad hoc, acute care case manager, etc.			
	Identify Complex Clinical Practice Guidelines, CHF and COPD			
	Describe management of this population - initial and ongoing			
Complex Care Manager Description	Complex CM Job Description			
	Complex CM Competencies			
	Describe Complex CM integration with other team members. i.e., PCP, other CMs			
	Plan for embedding CM into PCP office setting: % of time in PCP office			
	Completion of Guided Care or comparable training for Complex CM			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/ SIGN OFF
Integrated Care Model Management				
Complex Care Management Program				
Complex Care Management Program specifications for documentation in approved care management system	Initial Complex assessment completed within 30 days of referral to a Complex Care Manager. *Assessment to include, but not be limited to, the following components:* - Member health status including condition specific - Clinical History with medications - Initial assessment of activities of daily living (ADLs) - Initial assessment of independent activities of daily living (IADLs) - Initial assessment of mental health status, including cognitive function - Evaluation of cultural and linguistic needs with preferences and limitations - Evaluation of visual/hearing needs with preferences and limitations - Evaluation of care giver resources and involvement - Evaluation of available benefits from community resources - Assessment of life-planning activities - Assessment of progress to defined member goals			
	Complex Program Care Plan and Action Plan Requirements to include, but not be limited to: - Care Plan with prioritized goals for member and CM - Plan to provide Care Plan to PCP - Action plan created with member - Plan to provide Action Plan to member - Identification for barriers to meeting goals and adherence with plans - Plan for scheduled follow-up and communication with member			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/ SIGN OFF
Chronic (Rising Risk) Care Management Program				
Chronic (Rising Risk) Care Management Program Description	Program admission criteria			
	Ad hoc referral criteria			
	Workflow for identifying members with chronic illness and/or geriatric conditions, i.e., end of life, dementia, falls, incontinence			
	Referral workflow for each potential referral source, i.e. CPC Chronic list, Ad hoc, acute care case manager, etc.			
	Identify clinical guidelines for, at minimum - CHF, COPD, Falls, CAD/CHF			
	Describe management of this population - initial and ongoing			
Chronic (Rising Risk) Care Manager Description	Chronic CM Job Description			
	Chronic CM Competencies			
	Describe Chronic CM integration with other team members, i.e., PCP, other CMs			
	Plan for embedding CM into PCP office setting: % of time in PCP office			
	Demonstrate completion of training in Chronic Care or comparable training for Chronic CMs			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/ SIGN OFF
Chronic (Rising Risk) Care Management Program specifications for documentation in approved care management system	Required Chronic Assessment completion once referral to Chronic Care Manager. *Assessment to include, but not be limited to, the following components:* - Member health status including specific chronic conditions - Clinical History with medications - Initial Assessment of activities of daily living (ADLs) - Initial Assessment of independent activities of daily living (IADLs) - Initial assessment of mental health status, including cognitive function - Evaluation of cultural and linguistic needs with preferences/limitations - Evaluation of visual/hearing needs with preferences/limitations - Evaluation of care giver resources and involvement - Evaluation of available benefits from community resources - Assessment of life-planning activities - Assessment of progress to defined member goals - Monitoring and self-management of chronic disease(s) - Active coaching on chronic disease management			
	Chronic Program Care Plan and Action Plan Requirements: - Care Plan with prioritized goals for member and CM - Plan to provide Care Plan to PCP - Action plan created with member - Plan to provide Action Plan to member - Identification for barriers to meeting goals and adherence with plans - Plan for scheduled follow-up and communication with member			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/ SIGN OFF
Transitions of Care				
Initiatives to Manage Transitions of Care	Identify tool used for risk stratification of members			
	Criteria for post-discharge call completion			
	Determine CM responsible for post discharge follow up calls, i.e., UM, Complex Chronic, or other			
	Process for post-discharge telephone calls - first call required within 48 hours of discharge from a facility, confirm PCP visit scheduled within five (5) to seven (7) days of discharge			
	Screening call script for initial call			
	Identify who is responsible for scheduling PCP appointment if needed and how member is made aware of appointment			
	Plan to address appointment access issues			
	Workflow to confirm appointment attended and next steps if member missed or rescheduled			
	Criteria for referral to transitions program, i.e., member verbalizes low confidence, member has other care needs			
	Criteria for referral to Complex or Chronic program or if needs persist past 30-45 days of Transition program			
Transitions Program specifications for documentation in approved care management system	Transition assessment, care plans, action plans and interventions with goal of member/caregiver independence in 30-45 days. Required to address, but not limited to: - Readmission risk - Medication adherence - Fall Risk - Understanding of 'red' and 'yellow' flags - Self management deficits - Psychological deficits			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/ SIGN OFF
Care Management Software System and Reporting				
Care Management Software System	Identify CM software system			
	Provide for review of high-level business requirements			
	Document final IT specifications			
	If needed, timeline for IT build, including anticipated completion date			
	Integration of software system via demonstration of ICMM assessments			
	Assessments demonstrate integration of clinical practice guidelines			
Monthly Metrics Reporting	Understanding of metrics reporting requirements for monthly reporting			
	Understanding of appropriate reporting file formats for monthly reporting			
Quarterly Metrics Reporting	Understanding of metrics reporting requirements for quarterly reporting			
	Appropriate file format implemented for quarterly reporting			
	Knowledge of quarterly outcome metrics reporting schedule			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/SIGN OFF
Medical Management				
Medical Management Software System				
Leveling software	Confirm leveling software access (InterQual or Milliman)			
Medical Management Administrative Processes				
Hospital(s)	Determine and communicate to CPC for profile, if utilized			
Specialists	Criteria for identification as preferred provider (inclusion in referral circle)			
	Listing of specialists chosen, communicate / distribute to office staff and others as needed; workflow to update			
	Workflow to communicate referral to specialist			
	Workflow to communicate referral to member and make appointment			
	Workflow to submit referral to CPC for claims payment - see "General office-based operations for CPC product management"			
	Workflow to confirm report received from specialist post visit			
Preferred Provider	Criteria for inclusion by category, i.e. SNFs, HHAs			
	Listing of preferred providers; workflow to update			
	Workflow for communication of preferred providers to members and other providers			
Emergency Room Management	Plan to measure and improve member access to PCP office or encourage use of alternate site of care for non-emergent care			
	Develop/expand relationships with hospitalists at hospital(s)			
	Workflow for notification of members in the ER			
	Plan to address ER frequent fliers			
Pre-surgical Management	Identify members scheduled for elective surgeries			
	Plan for pre-surgical outreach to support plan of care			
	Identify criteria for outreach			
	Plan to review optimal surgical pathway, i.e., preparation required, course of inpatient stay			
	Plan to review optimal post-acute care pathway with identification of home/community support available, preferred providers if required			
Rounding Management	Establish medical group/IDN rounding team, i.e., PCP/Med Dir, Case Mgr, Advanced Practice Professional			
	Designate rounders to manage members undergoing inpatient care with associated workflows			
	Designate rounders to participate in servicing provider huddles/IDTs, internal utilization management meetings, with associated workflows			
Behavioral Health Management	Workflow for managing referrals to BH services			
	Criteria and workflow for warm hand-offs, appointment scheduling, follow-up			
	Specific plan for focusing on members with depression, anxiety, substance abuse and chronic mental illness			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/SIGN OFF
Medical Management				
General office-based operations for CPC product management **Please note need for referral submission to CPC is dependent on plan type**	Understanding of Managed Medicare basics			
	Workflow to ensure physician documentation supports coding			
	Process to identify provider learning opportunities, plan to deliver re-education			
	Understanding of Health Risk Assessment (HRA) completion at member onboarding			
	Workflow when members with potential needs are identified			
	Understanding of Prior Authorization requirements			
	Workflow for submission to CPC			
	Workflow for managing referrals to preferred provider circle and subsequent monitoring of leakage			
	Process to review member and provider utilization of preferred provider circle			
	Monitoring for leakage			
	Process to identify provider/member learning opportunities, plan to deliver re-education			
	Workflow for submission of required referrals to CPC for claims payment			
	Process to review claims submitted without required referral			
	Process to communicate concern to CPC			
	Process to identify provider/member learning opportunities, plan to deliver re-education			
	Understanding of Treatment Decisions			
	Process to discuss and communicate outcomes to members			
	Understanding of fast-track appeal rights			
	Role of office in providing information			
	Timeframe for submission			
	Understanding of and process for communicating organizational determination rights to members			
	Role of office in providing information			
	Timeframe for submission			
	Understanding of appeal rights after the issuance of an organizational determination			
	Schedule and plan for Medical Management and Quality Committee meetings			
Training Plan developed and delivered for above topics	IDN Medical Director			
	Group / Pod Medical Director			
	PCPs			
	Office Staff			
	Care Management staff			
	Record of competencies achieved as a result of trainings			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/SIGN OFF
Medical Management				
Care Manager Role in Utilization Management/Medical Management				
Utilization Mgmt Care Manager Description	UM CM Job Description if dedicated position or indicate other location			
	Describe UM CM competencies or indicate other location			
Utilization Mgmt and Level of Care review	Workflows for utilization management and level of care review, i.e., process to review daily census report, inpatient/outpatient notification, notes/documentation			
	Describe integration with other team members, i.e., PCP, other CMs			
Acute Inpatient Hospital Level of Care	Understanding of medical levels of care and associated workflow for management			
	Understanding of Behavioral Health levels of care and associated workflow for management			
	Confirm access to inpatient electronic record or alternate process to review of clinical information			
	Understanding of InterQual criteria or comparable used by facility			
	Use/understanding of CPC payment policies			
	Process for huddle discussion with facility Case Management as needed for level of care determinations			
	Process to include facilitate peer-to-peer discussion between hospital clinicians and PCP/IDN Medical Director, or CPC physician as needed			
	Understanding and workflow for documentation and communication of treatment decision			
	Understanding of Hospital Fast Track appeal vs. Organization Determination vs. Appeal			
	Provider, Case Management, CPC and Member roles			
	Workflow for discharge planning with warm handoff to next level of care / ambulatory or community care			
	Understanding of preferred provider use			
	Understanding of managing transitions of care and post discharge follow up visit			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/SIGN OFF
Medical Management				
Care Manager Role in Utilization Management/Medical Management				
SNF Skilled and Custodial Inpatient Management	Understanding of SNF and LTC levels of care and associated workflow for management			
	Confirm access to electronic record or alternate process for review of clinical information			
	Use/understanding of CMS level of care criteria for SNF			
	Use/understanding of CPC SNF payment policies			
	Process for huddle discussion with SNF staff as needed for level of care determinations			
	Process to include facilitate peer-to-peer discussion between SNF staff and PCP/IDN Medical Director, or CPC physician as needed			
	Understanding and workflow for documentation and communication of treatment decision			
	Understanding of SNF Fast Track appeal vs. Organization Determination vs. Appeal			
	Provider, Care Management, CPC and Member roles			
	Workflow for Discharge Planning to next level of care, i.e. home with/without services or LTC			
	Understanding of preferred provider use			
	Understanding of managing transitions of care and post discharge follow up visit			
	Custodial LTC management - demonstrates understanding of Part B benefit			
Acute Inpatient Rehab (AIR) and Long-Term Acute Care (LTAC) Level of Care	Understanding of LTAC and AIR levels of care and associated workflow for management			
	Confirm access to electronic record or alternate process to review of clinical information			
	Use/understanding of CMS level of care criteria for LTAC and Acute Inpatient Rehab level of care			
	Use/understanding of CPC AIR and LTAC payment policies			
	Process for huddle discussion with facility Case Management as needed for level of care determinations			
	Process to facilitate peer-to-peer discussion between facility physician and PCP/IDN Medical Director, or CPC physician as needed			
	Understanding and workflow for documentation and communication of treatment decision			
	Understanding of Hospital Fast Track appeal vs. Organization Determination vs. Appeal			
	Provider, Case Management, CPC and Member roles			
	Workflow for Discharge Planning to next level of care, i.e. SNF or home with/without services			
	Understanding of preferred provider use			
	Understanding of managing transitions of care and post discharge follow up visit			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/SIGN OFF
Medical Management				
Care Manager Role in Utilization Management/Medical Management				
Home Health Care Management	Understanding of Home Health Care disciplines and associated workflow for management			
	Confirm access to electronic record or alternate process to review of clinical information			
	Use/understanding of CMS level of care criteria			
	Use/understanding of CPC payment policies			
	Process for huddle discussion with Home Health staff as needed for plan of care determinations			
	Process to facilitate peer-to-peer discussion between home health staff and PCP/IDN Medical Director, or CPC physician as needed			
	Understanding and workflow for documentation and communication of treatment decision			
	Understanding of HHA Fast Track appeal vs. Organization Determination vs. Appeal			
	Provider, Case Management, CPC and Member roles			
	Understanding of preferred provider use			
	Understanding of available extended care options if needed, i.e. hospice care, outpatient care, community resources			
Out of Area/ State	Understanding of Out of Area/State process; what qualifies as emergent/urgent care			
	Ability to educate members/providers in facilitating self-management when traveling out of state			
	Ability to educate members of importance of notifying PCP of any Out of State care received so follow-up care can be coordinated			
Out of Network (OON)	Process to review services for a HMO member which may require referral to an OON provider			
	Verify services cannot be provided by a CPC in-network provider			
	Referral form must be prepared and approved by PCP and group/IDN authorized reviewer or CPC Medical Director			
Other Care Manager responsibilities	Understanding and process for monthly log verification and submission of updates, i.e., custodial, ESRD, hospice and death			
	Ability to navigate/review CMS manuals/website, LCDs/NCDs			
	Ability to navigate CPC website			
	Understanding and workflow for verifying CPC member eligibility			
	Use/understanding of CPC payment policies as appropriate			
	Understanding of CPC contacts - who and what dept to use as needed			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/SIGN OFF
Medical Management				
Care Manager Role in Utilization Management/Medical Management				
Training Plan developed and delivered for above topics	Group Care Managers			
	Other staff as appropriate			
	Record of competencies achieved as a result of trainings			
Medical Group Profile Information	Document Identified preferred providers:			
	SNF			
	Home care			
	Other			
	Complete Medical Group Profile (one for each group)			
Screen shot required from approved Care Management system:	*Sample Inpatient Notification* Required components include: Member Name Member DOB Member Age Member CPC ID# Admitting Hospital Name Admitting Diagnosis Admission Date Actual Discharge Date Admit Type Description Admit Status Description Admission Class PCP Name			

DELIVERABLES CATEGORY	END POINT DELIVERABLE	TIME FRAME	STATUS	COMPLETION DATE/SIGN OFF
Medical Management				
Screen shot required from approved Care Management system:	*Sample Outpatient Authorization* Required components include: Member Name Member DOB Member Age Member CPC ID# Provider/Vendor Name Diagnosis Start Date End Date Number of visits Service Type PCP Name			
Screen shot required from approved Care Management system:	Sample Notification/Authorization Note Name DOB Sex Sample Authorization Note CPC Member ID Event date: admission to Acute Inpatient, Acute Rehab, LTAC, SNF Current Living Situation: Where was member living? Home, assisted living, Nursing Home: Custodial Prior Level of Function Caregiver detail: Who, how many hours and name address, phone or email contact? Advance Directives type Prior Services: services at the home prior to admission, VNA, Elder services, private pay help Co Morbidities Admit type: Acute Inpatient, Acute Rehab, LTAC or SNF Discharge Plan: what is the plan following this admission, e.g. : home with services, SNF DC plan goal: e.g. Return to independence, walk xxyy feet, climb xxyy stairs Who this plan has been discussed with: PCP, Facility, Family			

G Integrated Delivery Network Responsibilities

The table on the following page describes Integrated Delivery Network (IDN) responsibilities.

Task	IDN Responsibility	IDN Process
Administrative processes with accountability for completion of the end-to-end process		
Response to Custodial/ESRD/Hospice logs	IDN intercedes as necessary to facilitate completion of these administrative processes.	.
Claims payment processes with timely resolution of claims discrepancies		
Timely submission of authorization/notification logs to facilitate claims payment		
Identifies cases for potential "bridging" review, or other medical claims review triggers		
Process and structure		
Facilitate/support development and implementation of Quality Improvement Plan with documented monthly Quality Improvement meetings	IDN oversight and provides opportunity for sharing of "Best Practice" QI plans.	
Submission of Quality events		
Identified medical group leadership is available to care managers for clinical consultation/review		
Medical group identifies and develops collaborative relationship with selected referral circle and monitors utilization trends and leakage		
Compliance with regulatory guidelines and criteria and associated processes and workflows		
CMS policies and procedures: provide training, support and oversight for all regulatory processes	IDN will monitor trends and patterns and work collaboratively with CPC to develop action plans as needed. IDN is responsible for oversight, training and support of their provider network and will work with CPC to monitor compliance to CMS policies, identify trends and patterns and develop and monitor action plans as needed. IDN will demonstrate ability to use CMS manuals	
Monitor performance to identify trends/patterns and opportunity for improvement in process or outcome and develop specific action plans as needed		
Specific compliance tasks: x Member requests, organizational determinations, and appeals x Fast track appeals and clinical reinstatements associated with NOMNC; x Member non-compliance issues;	IDN will identify a contact person to act as an intermediary to facilitate Organizational Determinations and appeal processes. Internal audits will be used to assess compliance with standards and provide direct feedback to the groups and IDNs on program outcomes.	.
Benefit Management: provide informational updates and educational resource to groups and care managers		
Specific updates include: x Annual changes in CPC Evidence of Coverage (EOC), Summary of Benefits, prior authorization, and referrals; x CMS coverage guidelines; x Access to CMS website	IDN will provide updates and changes to their network.	

Task	IDN Responsibility	IDN Process
Orientation, education and training		
New group training and ongoing record reviews	IDN responsible for clinical training and competencies (via record reviews) of all providers in its network.	
Ongoing education and training to meet compliance or regulatory requirements/standards	Assess competency of all Care Managers on hire and annually	
Provide Floater Holiday coverage	IDN is aware of CarePartners Floater Holidays and early close days. Provides voice mail coverage messages for these times.	
Annual CEUs in Geriatric Content	IDN maintains records of CM staff annual CEUs in Geriatric content (5 CEU annually)	
Communication		
Facilitate communication between CPC and individual groups/care managers regarding changes or updates in process, administrative, coverage, compliance, or business policies	IDN CM leadership will participate in CPC MP IDN Webinars and convey information to IDN medical groups and Care Managers.	
Collaboration and Support		
Collaborate with CPC and medical group/care managers to:	IDN will participate and collaborate with CPC staff monthly and quarterly for IDN steering meetings.	

H Six Item Screener Information

This appendix contains the following information regarding the Six Item Screener:

- Six Item Screener Primary Literature
- Six Item Screener Assessment
- Six Item Screen Workflow
- Example of Provider Notification via Fax

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Six-Item Screener to Identify Cognitive Impairment Among Potential Subjects for Clinical Research

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OBJECTIVE. To design a brief cognitive screener with acceptable sensitivity and specificity for identifying subjects with cognitive impairment

DESIGN. Cohort one is assembled from a community-based survey coupled with a second-stage diagnostic evaluation using formal diagnostic criteria for dementia. Cohort two is assembled from referrals to a specialty clinic for dementing disorders that completed the same diagnostic evaluation.

SETTING. Urban neighborhoods in Indianapolis, Indiana and the Indiana Alzheimer Disease Center.

PATIENTS. Cohort one consists of 344 community-dwelling black persons identified from a random sample of 2212 black persons aged 65 and older residing in Indianapolis; cohort two consists of 651 subject referrals to the Alzheimer Disease Center.

MEASUREMENTS. Formal diagnostic clinical assessments for dementia including scores on the Mini-mental state examination (MMSE), a six-item screener derived from the MMSE, the Blessed Dementia Rating Scale (BDRS), and the Word List Recall. Based on clinical evaluations, subjects were categorized as no cognitive impairment, cognitive impairment-not demented, or demented.

RESULTS. The mean age of the community-based sample was 74.4 years, 59.4% of the sample were women, and the mean years of education was 10.1. The prevalence of dementia in this sample was 4.3% and the prevalence of cognitive impairment was 24.6%. Using a cut-off of three or more errors, the sensitivity and specificity of the six-item screener for a diagnosis of dementia was 88.7 and 88.0, respectively. In the same sample, the corresponding sensitivity and specificity for the MMSE using a cut-off score of 23 was 95.2 and 86.7. The performance of the two scales was comparable across the two populations studied and using either cognitive impairment or dementia as the gold standard. An increasing number of errors on the six-item screener is highly correlated with poorer scores on longer measures of cognitive impairment.

CONCLUSIONS. The six-item screener is a brief and reliable instrument for identifying subjects with cognitive impairment and its diagnostic properties are comparable to the full MMSE. It can be administered by telephone or face-to-face interview and is easily scored by a simple summation of errors. (Med Care 2002; 40:771–781)

Scientists interested in enrolling older adults in clinical research studies often seek to identify subjects with cognitive impairment as an initial assessment in the consideration of more specific

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inclusion or exclusion criteria. Excluding subjects with cognitive impairment may be desirable when the study relies on self-reports of functioning, mood, health-related quality of life, or health services utilization as outcome measures. Other investigators may adjudge that adherence to specific self-care behaviors, study protocols, or other complex tasks require intact cognitive function. Scientists studying dementing disorders often seek to efficiently screen a large numbers of subjects in a first-stage assessment to identify those patients most likely to meet criteria for dementia in a second-stage assessment. Despite the frequent goal to efficiently identify older adults with cognitive impairment or identify those with a high probability of dementing disorders, there is no consensus on how to best balance the need for accuracy with limited resources and time.

Clearly, these issues are not limited to research. Clinicians faced with the resource constraints of daily clinical practice also seek screening tests, which can balance accuracy with efficiency. There are already numerous measures of cognitive impairment developed for use in clinical settings. These instruments typically range from 10 to 30 items. Most of these questionnaires have demonstrated sensitivity and specificity as an aid to the diagnosis of dementia. Unfortunately, these instruments can take from 7 to 15 minutes to complete and some require props, paper, and pencil, or other face-to-face interactions. In addition, these longer scales do not always perform with greater accuracy in comparison to shorter scales.[1] One solution to the time burdens of these longer questionnaires has been two-stage screening. For example, Lachs et al[2] have suggested using three-item recall as an initial screen for cognitive impairment followed by the Mini-Mental State Examination (MMSE) for those patients unable to recall all three items. This first-stage screen is reported to have excellent sensitivity (97%), but poor specificity (43%) which makes it useful as an initial screen to identify those subjects unlikely to have the condition.[3]

However, in some clinical trials, investigators may be more interested in optimizing specificity. For example, in the design of an ongoing multisite study of late life depression, investigators were faced with the challenge of balancing the need to exclude older adults who would be unable to provide self-reports or adhere to the protocol with the competing goal to include older adults who might have poor cognitive performance because of a treatable depression.[4] Indeed, it is often difficult to determine what magnitude of cognitive impairment renders a potential subject ineligible for meaningful participation. Many patients with mild cognitive impairment may be capable of providing self-reports and following study protocols. An overzealous exclusion of subjects with mild cognitive impairment might unnecessarily reduce the generalizability of a study. Thus, different studies would be expected to make different choices in balancing the competing needs for sensitivity and specificity.

We sought to develop a brief screen for cognitive impairment that would balance diagnostic accuracy with the logistic demands of screening a large group of subjects in an efficient manner. This report provides a detailed description of the sensitivity, specificity, and predictive value of a six-item screener for cognitive impairment among older adults. There are several advantages of this six-item screener over existing scales in addition to its brevity. First, each of the six items comes from the MMSE, which allows for comparison among the many studies utilizing this longer questionnaire. Second, the six-item screener can be administered over the telephone and it is scored simply by summing the number of errors. Third, the diagnostic performance of the scale can be varied by choosing a cut-off score to match the study goals. The six-item screener is offered as an efficient tool to identify patients with cognitive impairment either as a one-stage screen with acceptable specificity to exclude those with moderate to severe impairment, or as the first stage of a two-stage screen to identify probable cases of dementia.

Materials and Methods

Study Samples

The impetus for this study was the need for a brief cognitive screener to efficiently exclude patients with moderate to severe cognitive impairment in a multisite study of late life depression.[4] The data for this study come from two projects funded by the National Institute on Aging that are investigating the prevalence, incidence, risk factors, and treatment of dementia. The first source of subjects is a study on the prevalence of dementia among a community-based sample of black persons. The second source is from the subjects

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assembled from referrals to the Indiana Alzheimer Disease Center. Both groups of subjects complete the same clinical evaluation process by the same group of clinicians associated with the Indiana Alzheimer Disease Center. However, in the first sample, subjects are identified by a community-based screening program and in the second sample, subjects are referred to the Center. The two samples are described below followed by a description of the common clinical evaluation.

For the community-based sample, the geographic target area consisted of 29 contiguous census tracts with a total population of 82,387 and total households of 32,954 in the 1990 US Census. Black persons comprised 86% of this population, which also represents more than two-thirds of Indianapolis' elderly black population. A random sample of 60% of residential addresses was constructed by the Indianapolis Water Company using all residential addresses in the target area, and identified homes were then visited by interviewers from May 1, 1992-April 30, 1993. Patients residing in nursing homes are not included in this sample. Eligible subjects had to be (1) a resident at a sampled address, (2) black, and (3) age 65 years or older. A total of 7590 households were approached, 4915 of which did not have an eligible resident. Of the 2582 eligible persons, 2212 (85.7%) agreed to participate. These subjects were screened with the Community Screening Instrument for Dementia (CSI-D).

Details of the development, content, scoring, and psychometric properties of the CSI-D have been previously published.[5,6] Briefly, the CSI-D is composed of two parts: a 33-item scale assessing the subject's cognitive performance and a 24-item scale assessing a relative's perception of a decline in the subject's functional or social abilities. Items for the CSI-D were selected from several widely used screening instruments including the Cambridge Mental Disorders in the Elderly Examination,[7] the Mini-Mental State Examination,[8] the Dementia Rating Scale,[9] the Comprehensive Assessment and Referral Evaluation,[10] and the East Boston Memory Test.[11] The items selected test cognitive function across multiple domains but specifically exclude literacy dependent items. A discriminant function was derived in developmental work on the CSI-D to establish an empirically derived cut-off score that best differentiated between demented and nondemented with a structured clinical assessment as the gold standard. Subjects were classified into "poor," "intermediate," or "good" performance groups based on their discriminant function score. In a community prevalence study, the sensitivity of the CSI-D was 87% and the specificity was 83%.[6]

A stratified sample of the community-based subjects was selected for full clinical assessments based on their performance on the CSI-D. All subjects who scored poorly on the CSI-D were invited for clinical assessments and we also selected a 50% sample of those with intermediate performance, and a 5% sample of those with good performance. Patients aged 75 and older were over-sampled in the 5% sample so that 75% of the patients with good performance on the CSI-D would be 75 years of age or older. Rates of cognitive impairment, dementia, and Alzheimer's disease among this community-based sample have been previously published.[12,13] The impact of age, gender, education, and occupation on cognitive performance in this sample has also been previously published.[14,15] There were 351 patients selected for full clinical assessments but seven were too severely impaired to complete the standardized questionnaires. Data for the remaining 344 (98%) subjects are included here.

The second set of subjects comes from patient referrals to the Alzheimer Disease Center at the Indiana University School of Medicine. The differences in sampling strategies for these two samples are considerable and are reflected in the demographic and clinical characteristics provided in Table 1. Patients are referred to this Center both for diagnosis and for treatment and it is the only Center of its kind in Indiana. Notably, patients from this sample are not initially screened but referred by family, caregivers, or providers for evaluation. Thus, the CSI-D is not performed as the first stage assessment of the clinical sample. The clinical sample is not limited to black persons who were the focus of the community-based study described above. There were 662 subjects referred for the clinical assessment, but eleven were too severely impaired to complete the standardized questionnaires. Data for the remaining 651 (98%) subjects are included here.

Clinical Assessments

All clinical assessments of subjects from the community-based cohort were made blinded to the screening status. A geriatric psychiatrist or neurologist conducted a complete physical and

TABLE 1. Characteristics of Patient Samples

	Community-Based Sample	Alzheimer Disease Center Sample	P Value
Sample size	344	651	<0.001
Mean age (range)	74.4 (65–99)	69.6 (21–92)	<0.001
% women	59.4	57.1	<0.698
% black	100	16.1	<0.001
Mean years of education (range)	10.4 (0–16)	12.5 (0–20)	<0.001
% cognitively impaired	26.4	61.3	<0.001
% with dementia	4.3	53.0	<0.001
Mean errors on six-item screener	1.3	2.6	<0.001
Mean score on MMSE	26.1	21.7	<0.001
Mean score on Word List Recall	13.8	12.6	0.012
Mean score on Blessed Dementia Rating Scale	4.3	7.4	<0.001

neurologic examination. Cognitive assessments included the MMSE, the cognitive performance portion of the CAMDEX, and the Consortium for Establishment of Registry for Alzheimer Disease (CERAD) battery.[16] In addition to the MMSE, the CERAD battery includes the Animal Fluency Test (a measure of semantic fluency in which subjects generate as many names of animals as possible in 60 seconds), the Boston Naming Test (a 15-item test of confrontation naming of line drawings of objects), Constructional Praxis (a test of graphomotor skill in which subjects copy geometric figures), and the Word List Recall (a 10-item word list is presented three times with free recall and recognition assessed after a brief, filled interval). Where possible, a relative of the subject was also interviewed. A research nurse met with a spouse or other relative and completed the semi-structured Informant Interview. The interview provides information on the presence, duration, and severity of symptoms of memory, language, judgment and reasoning, and personality change. Informants are also asked to characterize the subject's performance of instrumental and basic activities of daily living (ADLs). The CERAD-modified version of the Blessed Dementia Scale[9] was calculated from the Informant Interview for those subjects where an informant could be interviewed. The Blessed consists of 11 items assessing memory, comprehension, shopping/money management, performance of household chores, dressing, feeding, and toileting.

On the basis of the above evaluation, participants were classified as normal, cognitive impairment-not demented, or demented. Patients were diagnosed as cognitive impairment-not demented if: (1) the informant reported a clinically significant decline in cognition; (2) the physician detected a clinically significant impairment in cognition; or (3) the participant's scores on cognitive testing fell below the 7th percentile; and if there was no clinically important impairment in the performance of activities of daily living.[17] The 7th percentile is approximately equivalent to 1.5 standard deviations (SD) below the mean, the level of impairment specified by Mayo Clinic in their criteria for mild cognitive impairment. For a diagnosis of dementia both DSM-III-R and ICD-10 criteria had to be satisfied.[18,19] On the basis on this clinical assessment, patients were dichotomized into demented and nondemented groups. Patients with dementia were then further categorized into those with and without possible or probable Alzheimer disease as defined by NINCDS/ADRDA criteria.[20] For the purposes of the current study, we focus on the diagnosis of normal, cognitive impairment-not demented, or dementia. In all tables, the cognitive impairment group includes both patients with the "cognitive impairment-not demented" diagnosis and the dementia diagnosis.

Design of Six-Item Screener

In designing the six-item screener, we sought to balance the instrument's diagnostic properties with brevity, ease of administration, and validity. Because investigators working on different projects might seek to optimize sensitivity as opposed to specificity or vice versa, we also sought

to design a screener that would allow a variety of "cut-off points." The hallmark of dementia is a deficit in short-term memory. The MMSE is heavily loaded with memory items though some are more sensitive than others. For example, temporal disorientation occurs before disorientation to place. Within temporal orientation, problems with day of the week, month, and year are rarely seen in those not experiencing dementia (high specificity). Three-object recall is the best assessment of new learning ability in the MMSE and has consistently been identified as having excellent discrimination for identification of subjects with cognitive impairment (high sensitivity). Three-object registration has more to do with language, hearing, and attention. Although registration is a necessary step in successful recall, it does not in itself discriminate well between those with and without dementia. The rest of the MMSE items tap language, attention, or praxis and while any of these may be impaired in any given patient with dementia, no one domain or item is reliably implicated, some of these items are more sensitive to education, and some require props or motor skills not assessable by telephone. Thus, we chose the three-item recall (apple, table, penny) and three-item temporal orientation (day of the week, month, year) to design the six-item screener. Notably, the three-item recall question in the CSI-D is "boat, house, and fish" consistent with prior work on this instrument.[12]

We present the sensitivity, specificity, predictive value, and area under the receiver operating characteristic (ROC) curve for the six-item screener using cognitive impairment as the gold standard and then with dementia as the gold standard. Analyses of the community-based sample analyses are weighted, with individual weights being inversely proportional to the sampling proportion in that stratum. To compare the performance of the six-item screener with the full MMSE, we present the diagnostic properties of the MMSE in this same population and report the mean scores and ranges on the MMSE, Word List Recall, and Blessed Dementia scale at each level of subject performance on the six-item screener. As noted above, approximately 2% of both sample populations could not be tested on the MMSE because of the severity of their impairment. Among the subjects adjudged to be testable, coding of responses to the MMSE required that the respondent provide the correct answer or the item was coded as incorrect. However, 21% of the community-based sample and 8% of the clinical sample either refused or could not perform the Word List Recall. Also, 53% of the community-based sample and 31% of the clinical sample did not have an informant and therefore do not have scores on the Blessed Dementia Rating Scale.

Results

Table 1 provides the clinical characteristics of the two samples. As would be expected from the differences in sampling strategy, the community-based sample consists of black persons who are older, less educated, and less likely to have cognitive impairment or dementia as compared with the Alzheimer Disease Center sample.

Tables 2 to 5 present the diagnostic properties of the six-item screener as compared with the MMSE

Table 2. Sensitivity, Specificity, and Predictive Value of Six-Item Screener Among the Community-Based Sample

Six-item Screener		Cognitive Impairment as Gold Standard				Dementia Diagnosis as Gold Standard			
Errors	N	Sens	Spec	PPV	NPV	Sens	Spec	PPV	NPV
>0	344	100.0	0.0	26.4		100.0	0.0	4.3	
>1	273	97.7	49.2	40.8	98.3	100.0	38.4	6.7	100.0
>2	190	74.2	80.2	57.4	89.6	96.8	68.6	12.1	99.8
>3	120	50.4	97.4	87.2	84.5	88.7	88.0	24.8	99.4
>4	75	27.8	99.4	93.9	79.3	75.2	95.2	40.9	98.9
>5	45	14.8	100.0	100.0	76.6	56.1	98.4	61.1	98.1
6	18	4.7	100.0	100.0	74.5	24.2	99.8	83.3	96.7

MMSE = Mini-mental state examination; Sens = sensitivity; Spec = specificity; PPV = positive predictive value; NPV = negative predictive value; ADC = Alzheimer's Disease Center.

TABLE 3. Sensitivity, Specificity, and Predictive Value of the MMSE Among the Community-Based Sample

MMSE		Cognitive Impairment as Gold Standard				Dementia Diagnosis as Gold Standard			
Score	N	Sens	Spec	PPV	NPV	Sens	Spec	PPV	NPV
<27	269	91.5	56.2	42.9	94.9	100.0	45.6	7.6	100.0
<26	241	76.5	12.9	50.4	89.6	98.4	62.5	10.5	99.9
<25	206	71.5	87.3	66.9	89.5	98.4	74.9	14.9	99.9
<24	172	53.3	92.1	70.9	84.6	98.4	83.6	21.1	99.9
<23	149	44.4	93.2	70.1	82.4	95.2	86.7	24.2	99.8
<22	123	38.9	94.8	72.8	81.2	87.1	89.1	26.3	99.4
<21	108	36.1	95.8	75.5	80.7	87.1	90.7	29.4	99.4

MMSE = Mini-mental state examination; Sens = sensitivity; Spec = specificity; PPV = positive predictive value; NPV = negative predictive value; ADC = Alzheimer's Disease Center.

using cognitive impairment or dementia as the gold standard in both the community-based and clinic-based patient populations. It must be stressed that these two instruments are being compared in the same population(s) of patients against a separate gold standard clinical diagnosis. In addition to sensitivity and specificity, we present the positive and negative predictive values. Predictive value is a property both of the sensitivity and specificity of the test and the prevalence of the disease in the population under study. A test with higher sensitivity optimizes negative predictive value whereas a test with higher specificity optimizes positive predictive value.

As demonstrated in Tables 2 to 5, the six-item screener performs well in comparison with the longer MMSE. In both populations and using either gold standard, one can identify a cut-off score on the six-item screener that would compare favorably with the MMSE in terms of diagnostic accuracy. Indeed, as a first stage screening tool among a community-based population to identify subjects with cognitive impairment the six-item screener performs at least as well as the MMSE. The six-item screener performs less well in comparison to the full MMSE when one compares the instruments in a population with a high prevalence of disease and using dementia as the gold standard. However, even in this population, one can choose a cut-off score that optimizes sensitivity and specificity. Table 6 compares the area under the ROC curves for the six-item screener as compared with the MMSE.

Table 7 compares the mean scores of three other commonly used instruments to screen for cognitive impairment with scores on the six-item screener. Mean MMSE, Word List recall, and Blessed Dementia Scale scores progressively worsen as the number of errors on the six-item screener increase. This finding is consistent across all three comparison scales and at each level of

TABLE 4. Sensitivity, Specificity, and Predictive Value of Six-Item Screener Among the ADC Clinical Sample

Six-item Screener		Cognitive Impairment as Gold Standard				Dementia Diagnosis as Gold Standard			
Errors	N	Sens	Spec	PPV	NPV	Sens	Spec	PPV	NPV
>0	651	100.0	0.0	61.3		100.0	0.0	53.0	
>1	477	93.7	59.1	78.4	85.6	96.8	53.3	70.0	93.7
>2	372	84.0	85.3	90.1	77.1	89.6	79.4	83.1	87.1
>3	306	74.2	96.0	96.7	70.1	80.6	90.9	90.9	80.6
>4	245	60.9	99.2	99.2	61.6	67.5	96.1	95.1	72.4
>5	173	43.1	99.6	99.4	52.5	49.0	98.7	97.7	65.2
6	107	26.6	99.6	99.1	46.1	30.4	99.4	98.1	55.9

MMSE = Mini-mental state examination; Sens = sensitivity; Spec = specificity; PPV = positive predictive value; NPV = negative predictive value; ADC = Alzheimer's Disease Center.

TABLE 5. Sensitivity, Specificity, and Predictive Value of MMSE Among the ADC Clinical Sample

MMSE		Cognitive Impairment as Gold Standard				Dementia Diagnosis as Gold Standard			
Score	N	Sens	Spec	PPV	NPV	Sens	Spec	PPV	NPV
<27	445	93.0	70.6	83.4	86.4	98.0	65.0	76.0	96.6
<26	393	88.2	83.7	89.6	81.8	94.5	78.1	83.0	92.6
<25	357	82.7	89.3	92.4	76.5	89.3	84.0	86.3	87.4
<24	322	77.2	94.4	95.7	72.3	84.6	90.2	90.7	83.9
<23	301	73.4	96.8	97.3	69.7	81.5	93.5	93.4	81.7
<22	279	68.9	98.4	98.6	66.7	76.8	95.4	95.	78.5
<21	261	64.9	99.2	99.2	64.1	73.0	97.1	96.6	76.2

MMSE = Mini-mental state examination; Sens = sensitivity; Spec = specificity; PPV = positive predictive value; NPV = negative predictive value; ADC = Alzheimer's Disease Center.

performance on the six-item screener. Using this table, an investigator can extrapolate mean scores on the six-item screener to corresponding scores on the longer scales if one seeks to compare levels of cognitive impairment to studies using the longer scales. As shown in Table 8, the number of errors on the six-item screener is highly correlated with performance on the other three scales.

Discussion

We propose the six-item screener as an efficient and accurate method to screen subjects for cognitive impairment. The scale was specifically developed for studies that must screen large numbers of subjects and for studies that rely on subjects' cognitive ability to participate in a complex intervention and/or provide self-reports. A specific inclusion criterion in such a study is often the requirement that a patient have the cognitive capacity to understand questions about their current symptoms, emotion, or function, and be able to follow the study protocol. Although this scale was originally conceived for use in research studies, the diagnostic characteristics are comparable to the MMSE or the Blessed Dementia Rating Scale and thus the six-item screener could also be used in clinical practice as a first stage assessment for cognitive impairment.

There are several important logistic features of the six-item screener that make it particularly well-suited for use in research studies compared with other brief screens recently developed.[21–24] First, the scale is short and unobtrusive so that it can be readily incorporated into an initial patient assessment of eligibility. The scale takes only 1 to 2 minutes to complete as compared with 7 to 15 minutes for longer scales.[8,9,24,25] Second, the scale does not include any visuospatial or motor skill tasks, it does not require any props or visual cues, and scoring requires only the simple addition of the number of errors.[21–24,26,27] Thus, the six-item screener can be easily administered by telephone or in face-to-face interviews. Third, the investigator can alter the cut-off score to match the goals of the study and the targeted population.

We have demonstrated the diagnostic characteristics of the six-item screener in a community-based sample where the screening scale used (CSI-D) was independent from the six-item

TABLE 6. Area Under ROC Curves for MMSE Compared with Six-Item Screener

	Gold Standard	Six-item screener	MMSE
Community-based sample			
	Cognitive Impairment	0.86	0.84
	Dementia	0.95	0.96
Clinical sample			
	Cognitive Impairment	0.91	0.93
	Dementia	0.92	0.95

TABLE 7. Means, Medians, and Ranges of other Screening Instruments by Number of Errors on Six-item Screener Among Community-Based Sample and Alzheimer Disease Center Sample

No. of Errors	Sample	MMSE			Word List Recall			Blessed Dementia Scale		
		Mean	Median	Range	Mean	Median	Range	Mean	Median	Range
0	Comm	28.4	29.0	17–30	16.0	16.0	7–24	3.6	3.5	3.0–7.5
	Clinical	28.9	29.0	23–30	20.0	20.0	9–30	3.7	3.0	2.8–12.0
1	Comm	27.0	27.0	17–29	14.6	15.0	5–23	4.4	4.0	3.0–11.6
	Clinical	26.9	27.0	20–29	15.9	15.0	5–28	4.9	4.0	3.0–11.5
2	Comm	25.8	26.0	16–28	12.1	12.0	4–20	3.8	3.5	3.0–14.3
	Clinical	24.8	25.0	15–28	13.1	13.0	6–24	6.4	6.5	3.0–17.6
3	Comm	22.4	25.0	10–27	10.6	12.0	0–16	3.8	3.5	3.0–10.4
	Clinical	20.6	21.0	9–27	9.3	9.0	0–22	7.3	7.0	3–14.5
4	Comm	19.4	19.0	12–24	8.6	10.0	0–14	5.1	5.5	3.0–13.8
	Clinical	18.9	20.0	5–26	8.8	9.0	0–17	8.1	8.0	3.5–16.5
5	Comm	14.4	16.0	3–23	7.1	6.0	0–13	6.8	6.0	4.4–10.5
	Clinical	14.7	15.5	4–24	5.7	5.5	0–15	9.7	9.5	3.5–18.7
6	Comm	8.9	7.5	0–21	3.3	1.0	0–9	10.2	9.4	3.9–17.1
	Clinical	10.0	10.0	0–23	4.1	3.0	0–15	10.8	10.0	4.5–22.0

Comm = community-base sample; Clinical = Alzheimer's Disease Center clinical sample.

screener described here. Notably, the six-item screener's performance is based on a gold standard diagnosis of cognitive impairment or dementia rather than its ability to predict a total score on the full MMSE. This is important because the MMSE typically performs in the range of 80% to 85% sensitivity and specificity;[28] in other words, the MMSE does not provide a gold standard for cognitive impairment or dementia. The six-item screener's performance was excellent in both of the populations studied in this report. The scale performed nearly as well as the MMSE in these patient populations and showed a high level of validity when compared with other commonly used screens for cognitive impairment.

Although the six-item screener performed well in these two populations in terms of diagnostic accuracy for identifying older adults with cognitive impairment or dementia, it is important to note the differences in the two patient populations as described in Table 1. The community-based sample is representative of urban, black older adults, but these results may not generalize to other racial groups. Subjects in the clinical sample completed the same evaluation as the community-based sample and this sample comprises both white persons and black persons. Taken together, the two samples thereby represent a fairly broad spectrum of older adults but simply combining the results of these two samples does not create a cohort necessarily generalizable to all older adults. Although our use of a community-based sample of black persons improves upon prior studies relying only on clinical samples, exploring the generalizability of our findings is an important area for future research.

Because both clinicians and researchers seek a brief and accurate method to identify patients or subjects with cognitive impairment, multiple previous investigators have reported on the sensitivity

TABLE 8. Regression Coefficients Comparing Screening Scores Versus Number of Errors on Six-Item Screener

N		Community-based Sample			Alzheimer's Disease Center Sample			
		Regression Coefficient	P Value	R^2	N	Regression Coefficient	P Value	R^2
344	MMSE	−2.4	<0.001	59.7%	651	−3.1	<0.001	75.4%
273	Word List Recall	−1.9	<0.001	35.9	599	−2.7	<0.001	64.2%
158	Blessed	0.5	<0.001	19.6%	452	1.2	<0.001	45.2%

and specificity of shorter scales. Initially, these attempts included instruments of 10-to-15 items (eg, Short Portable Mental Status Questionnaire)[25] rather than the 30-item scales such as the Mini-Mental State Examination or Blessed Dementia Scale. By the early 1980s, scientists were exploring scales as short as six items. These early efforts were limited by the use of small clinical samples of nursing home residents or medical inpatients,[3,29] and the developers were typically predicting scores on longer screening tests rather than predicting the actual clinical determination of cognitive impairment or dementia.[29–31]

In the 1990s, several authors reporting from Alzheimer Disease Research Centers were able to report on the sensitivity and specificity of a reduced item Mini-mental state examination.[23,32,33] The studies by Galasko and Fillenbaum were limited to patients with Alzheimer's disease who had been referred to the clinical center whereas the study by Wells coupled data from an Alzheimer Disease Research Center with data from the Epidemiologic Catchment Area study. Although all three of these studies demonstrated that a reduced-item Mini-mental State examination had acceptable sensitivity and specificity for identifying patients with Alzheimer's disease, the study by Wells requires the calculation of a discriminant function score and includes a total of nine items. Although limited to Alzheimer disease subjects, the studies by Fillenbaum and Galasko[32,33] have previously demonstrated that three-item recall and orientation items provide excellent discrimination for normal subjects as compared with those with cognitive impairment or Alzheimer Disease.

More recently Buschke et al,[22] reported the performance of a 4-minute, four-item, delayed free- and cued-recall test of memory impairment. The study sample included 286 volunteers recruited from physician offices and senior centers and 197 subjects from the local community identified through Medicare lists. All subjects completed a neurologic evaluation to establish a diagnosis of dementia. These authors reported a sensitivity of 86% and a specificity of 91% in diagnosing dementia using a cut-off score of 5 (range of possible scores 0–8). This level of diagnostic accuracy has not been demonstrated in an unselected community-based population. However, the primary drawback of this test for screening large research populations is the requirement that patients read a visual cue card containing the four items to be recalled, and that testing of recall be delayed from 3 to 4 minutes after reading the card. This makes completion by telephone or in-person more cumbersome.

One of the primary advantages of the six-item screener compared with the other brief cognitive screens mentioned above is its suitability for administration over the telephone. There are at least three other instruments reported in the literature that are designed specifically to assess cognitive function via telephone administration. These include the Telephone Interview for Cognitive Status (TICS),[34] the Minnesota Cognitive Acuity Screen (MCAS),[35] and the Structured Telephone Interview for Dementia Assessment (STIDA).[36] All three instruments have reported acceptable sensitivity and specificity although the MCAS and STIDA studies did not target a representative community-base sample of older adults. The primary disadvantage of these three instruments is their length. Although all three instruments eliminate items that would require props or face-to-face administration, the length of these instruments approximate that of the MMSE and thereby require 10 to 20 minutes to complete. A short-STIDA has also been described but this instrument still requires 10 min to complete and the reported specificity falls to 0.77. Each of these longer telephone assessments could readily be considered as a second-stage cognitive screen to be used in tandem for those older adults scoring positive on the six-item screener.

Conclusion

In conclusion, we have demonstrated that a brief six-item screener that can be readily administered face-to-face or by telephone has diagnostic-test characteristics comparable with the MMSE and other longer scales designed to identify cognitive impairment or dementia. Sensitivity and specificity change precipitously but predictably as one varies the number of errors used as a cut-off point. This scale, which is a subset of the full MMSE, provides investigators with an efficient and accurate mechanism to identify patients with probable cognitive impairment.

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APPENDIX A. TABLE 1. Six-Item Screener

1. I would like to ask you some questions that ask you to use your memory. I am going to name three objects. Please wait until I say all three words, then repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Please repeat these words for me: APPLE—TABLE—PENNY. (Interviewer may repeat names 3 times if necessary but repetition not scored.)

Did patient correctly repeat all three words?	*Yes*	*No*
	Incorrect	Correct
1. What year is this?	0	1
2. What month is this?	0	1
3. What is the day of the week?	0	1
What were the three objects I asked you to remember?		
4. *Apple* =	0	1
5. *Table* =	0	1
6. *Penny* =	0	1

Six-Item Screener Assessment

Six-Item Screener

Script:
I would like to ask you some questions that ask you to use your memory. I am going to name three objects. Please wait until I say all three words, and then repeat them.

Remember what they are because I am going to ask you to name them again in a few minutes.

Please repeat these words for me: APPLE—TABLE—PENNY.

(Interviewer may repeat names 3 times if necessary but repetition not scored.)

Did patient correctly repeat all three words? *Yes* ☐ *No* ☐

		Yes	No
1. What is the year?	Correct	☐	☐
2. What is the month?	Correct	☐	☐
3. What is the day of the week?	Correct	☐	☐

Before asking member to repeat the words Apple, Table, Penny, ensure that at least three minutes have passed from the time you provided these names to the member. Example: Ask additional questions such as validation of address and phone number.

What were the three objects I asked you to remember?

		Yes	No
4. *Apple*	Recall	☐	☐
5. *Table*	Recall	☐	☐
6. *Penny*	Recall	☐	☐

Six Item Screener: Number of objects missed (only choose one).

1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐ 6. ☐

Do responses indicate cognitive impairment?

Scoring: A score of greater than 2 missed indicates a need for further screening and diagnostic evaluation

Cognitive Screen Reference (Used with permission): Christopher M. Callahan, MD, Frederick W. Unverzagt, PHD, Siu L. Hui, PHD, Anthony J. Perkins, Ms, And Hugh C. Hendrie, Mb, Chb: Medical Care: Volume 40, Number 9, Pp 771–781©2002 Lippincott Williams & Wilkins, Inc

Six-Item Screener Work Flow

Six Item Screener Workflow

Step 1: Identify if member currently has a confirmed diagnosis of Alzheimer's or dementia. If yes, Six Item Screener may be skipped.

Step 2: Care Manager Introduction:

I would like to ask you some questions that use your memory. I am going to name 3 objects. Please wait until I say all 3 words, then you repeat them. Remember what the 3 objects are because I am going to ask you to name them again later.

Step 3: Care Manager to name objects and have member repeat the objects. Document if the member could not repeat any of these objects.

Apple, Table, Penny

Step 4: Care Manager will introduce and ask the next set of questions to the member:
Now I am going to ask you a few basic questions.

1. What is the year? Correct YES NO
2. What is the month? Correct YES NO
3. What is the day of the week? Correct YES NO

Care Manager will use an additional set of questions, such as verifying name, address, and phone number. Clinical and other questions are appropriate also.

Step 5: Care Manager will allow 3 minutes to pass. TIP: Care Manager to observe time started or begin timer.

Step 6: Care Manager will ask second question to member
What were the 3 objects I asked you to remember?

4. Apple RECALL YES NO
5. Table RECALL YES NO
6. Penny RECALL YES NO

Step 7: Identify how many objects were missed from Step 3 and Step 5. Only choose 1 number (1-6).

Step 8: Scoring

Do responses indicate cognitive Impairment? **A score of 2 misses or greater indicate need for further screening and diagnostic workup.**

Step 9: Notify primary care physician for recommended follow up if score indicates further assessment needed (See Step 7)
Appropriate PCP messaging: (fax, phone call, EMR)

Step 10: Consider referrals to Social work secondary to care giver strain
Appropriate messaging

Step 11: Consider referral to Dementia Care Consultant or other appropriate resource- Appropriate messaging

Step 12: Care Manager Documentation

Document results within care management documentation system.

Example of Provider Notification via Fax

Confidential Fax – Cognitive Screening Results

To:	**Date**:	**Fax #:**
Patient Name:	**DOB:**	**Member ID:**

During a routine cognitive screening, the above-named patient could not recall 2 or more of the six questions below. This indicates that your patient would benefit from further cognitive evaluation. This fax has been sent to alert you of these findings and to urge you to open a discussion with your patient and/or refer for further evaluation and treatment if indicated. Below are the results of the cognitive screening for your records.

SIX-ITEM SCREENER TO IDEN7IFY COGNITIVE IMPAIRMENT:

The member was given the names of three objects (apple, table, SHQQ\) and was asked to repeat the words and to remember them for later recall questioning (minimum of 3-minute spaced interval).

1. **What is the year? Correct: Yes☐ No☐**
2. **What is the month? Correct: Yes☐ No☐**
3. **What is the day of the week? Correct: Yes☐ No☐ What were the 3 objects I asked you to remember?**
4. **APPLE Recall: Yes☐ No☐**
5. **TABLE Recall: Yes☐ No☐**
6. **3(11< Recall: Yes☐ No☐**

SIX-ITEM SCREENER NUMBER OF MISSED QUESTIONS: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐

☐ I have encouraged your patient to discuss the results of the cognitive screening with you and/or _____
☐ And/or the additional topic of_____;
☐ Member is currently enrolled in a care management program

If you have any questions regarding this information, please contact me at the phone number below.

<User's Signature>
<User's Name>
<User's Title>
(xxx)xxx-xxxx <user extension>

Confidentiality Notice: The document(s) accompanying this fax contain confidential information. The information is intended only for the use of the intended recipient named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this telecopied information, except for purposes of returning this fax to CarePartners of Connecticut, or directly delivering this fax to the intended recipient named above, is strictly prohibited. If you have received this fax in error, please notify us immediately by telephone.

Hospice Log

The following page contains a sample of a *Hospice Log*.

IPA	MID	Last Name	First Name	DOB	HOSPICE_AGENCY	Terminal Diagnosis	Hospice Start Date	Revocation Date	Date of Death	Comments
00	S00000000	SMITH	JOHN	XX/XX/XX	Life Choice Hospice - Chestnut Hill		6/27/2014			still there
00	S00000000	APPLESEED	JOHNNY	XX/XX/XX						still there
00	S00000000	CAPONE	AL	XX/XX/XX	HealthAlliance Home Health and Hospice	mal pleural effusion	2/4/2014			still there

J Custodial Skilled Episode Letter

Sample of Custodial Skilled Episode Letter

[Member Name]
[Address]

[Date]

Dear *[Name or Member Representative]:*

We are writing to let you know the Skilled Nursing Facility services you received beginning on *[Start Date of skilled episode]* and ending on *[End Date of skilled episode]* from *[Facility Name / provider]* will be covered by your plan.

This means you are only responsible for the cost sharing amount identified under your Skilled Nursing Facility benefit. Any changes above your cost sharing amount will be paid by your plan.

How do you know what your cost sharing amount is?
Your cost sharing amount for Skilled Nursing Facility services depends on the plan you are in. The chart on the back of this letter lists the Skilled Nursing Facility cost sharing amount for each of our plans. (If you receive your benefits from a current or former employer, see your Evidence of Coverage (EOC) booklet, contact your benefits administrator or call Customer Service for benefit information.) You should receive a bill in the mail shortly with the correct cost sharing amount.

What if you already paid for services?
If you already paid for Skilled Nursing Facility servcies above your cost sharing amount and need a reimbursement, give us a call at the number below. We can help you get a reimbursement for the amount you don't need to pay.

For more information
If you have any questions, call Customer Service at 1-888-341-1507 (TTY: 711). Representatives are available Monday through Friday, 8:00am – 8:00pm. From October 1 through March 31, representatives are available 7 days a week, 8:00am – 8:00pm.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.

Sincerely,

[CarePartners of Connecticut
Or Medical Group and Skilled Nursing Facility]

2021 Skilled Nursing Facility Cost Sharing Amounts
For CarePartners of Connecticut plans*

	CarePartners Access PPO In-network	CarePartners Access PPO Out-of-network	CarePartners CareAdvantage Preferred HMO	CarePartners CareAdvantage Prime HMO	CarePartners CareAdvantage Premier HMO
Skilled nursing facility (SNF)	• $0 copay after deductible for days 1 through 20 • $178 copay per day after deductible for days 21 through 100	30% of the cost after deductible	• $0 copay per day for days 1 through 20 • $178 copay per day for days 21 through 59 • $0 copay per day for days 60 through 100	• $0 copay per day for days 1 through 20 • $160 copay per day for days 21 through 52 • $0 copay per day for days 53 through 100	• $0 copay per day for days 1 through 20 • $160 copay per day for days 21 through 44 • $0 copay per day for days 45 through 100
What You Should Know		Our plan covers up to 100 days in a SNF per benefit period.			

For more detailed information on this benefit, see your Evidence of Coverage (EOC) booklet or refer to the **For more information** section on the previous page.

Where can you find an EOC booklet?
An EOC booklet is sent to you each year in September. You can also find an EOC booklet for your plan on the Documents page of our website at CarePartnersCT.com.

***What if you receive your benefits from a current or former employer?**
If you receive your benefits from a current of former employer, your cost sharing amount may be different. Please see your Evidence of Coverage (EOC) booklet, contact your benefits administrator or call Customer Service for benefit information.

Instructions for Custodial Skilled Episode Letter

The purpose of this letter is to inform a member of the use of Skilled Nursing Facility (SNF) benefits while the member is living in a long-term care facility. CarePartners of Connecticut members, who reside in a SNF as long-term care residents, have Care Managers who perform retrospective chart reviews. At times, skilled orders/treatments are identified. The Care Manager will use this letter to inform both the member and the facility of a Medically Necessary Skilled Nursing Facility episode which is a CarePartners of Connecticut benefit. Care Manager can notify the Precertification Department of skilled episode admission and discharge dates.

Note: Care Managers who are employed by CarePartners of Connecticut will use the CarePartners of Connecticut letterhead. Care Managers employed by a medical group will send the letter on the group letterhead.

This letter will be updated annually to reflect any changes in member cost sharing.

CARE MANAGER RESPONSIBILITIES

Upon determination that use of a member's Skilled Nursing benefit is appropriate:

1. Complete letter's first sentence:

   We are writing to let you know the Skilled Nursing Facility services you received beginning on *[Start Date of skilled episode]* and ending on *[End Date of skilled episode]* from *[Facility Name / Provider]* will be covered by your plan.

2. Print letter on appropriate letterhead (CarePartners of Connecticut or medical group letterhead)
3. Send to member / AOR and cc Skilled Nursing Facility
4. Save in member record

K Institutional Log

The following page contains a sample of an *Institutional Log*.

Institutional

Group Member ID	Last Name	First Name	DOB	Facility_name	Facility_Town	Original Admit Date	Date Custodial	Discharge Date	Discharge Status	Comments
00 S00000000	MOUSE	MICKEY	5/15/1928	Disney's Home for Retired Characters	Orlando		10/19/2014			
00 S00000000	WHITE	SNOW	2/4/1938		Hollywood	10/20/2014	11/7/2014			

L CarePartners of Connecticut Audit Tool

The table on the following page provides an example of CarePartners of Connecticut's Audit tool, which may vary from year to year, based on the needs of the populations, organizational priorities, and changes in CMS regulations/requirements.

Integrated Care Management QI Record Review

IDN/Medical Group:
Reviewer:
Date of Review:

	MEMBER INFORMATION			PROGRAM INFORMATION		INITIAL ASSESSMENT					INITIAL PROBLEM LIST	INITIAL CARE PLAN			ONGOING CARE PLANNING	INITIAL ACTION	ONGOING ACTION PLAN	EVIDENCE OF INTEGRATION			CRITERIA FOR DISCHARGE					TOTAL SCORE/COMMENTS
Case #	Member name	Member ID	Medical Group	Program: Complex, Chronic, or Transitions	Program Focus: CHF or COPD	Date Case Assigned to CM	Date IA is complete	IA Completed w/in 3rd of assigned (CCM or Tier 2) or 2-7 days (Transitions)	PAM Survey complete (CCM or Tier 2)	IF case is classic data	Initial Problem List for CCM or Tier 2 identified needs for Transitions management	Prioritized Goals Consistent w/Problem list	Identification of barriers to meeting goals	Development of schedules for the communication wheel & member	Evidence of Care Plan updates.	Member Generic Goals	Action Plan Medications	Documented CP shared w/PCP	Documented AP shared w/PCP & other care members	Communication - all CM management	Self or Caregiver demonstrates competency in Self or Member Management - all CM management	AND	PAM Survey completed prior to discharge with a Level 3 or 4 (CCM or Tier 2)	AND	Less than 2 ED visits & no unplanned admissions for 6mths.	Transitions management: 30-45 days	
	0/2	0/2		0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1/2	0/1/2	0/1/2	0/1/2	0/1/2	0/1/2	0/2	0/2	0/1/2	0/2		0/2		0/2	0/2	Score Total
1																										
																										0
2																										
																										0
3																										
																										0
4																										
																										0
5																										
																										0
6																										
																										0

M Guide to CarePartners of Connecticut Audit Tool

The following is a guide to CarePartners of Connecticut's Audit tool.

MEMBER INFORMATION	ANSWER KEY
Member name	Yes or No if its documented 0=N 2=Y
0/2	
Member ID	Yes or No if its documented 0=N 2=Y
0/2	
PROGRAM INFORMATION	**ANSWER KEY**
Program: Complex, Chronic, Wellness or Transitions	Able to be identified in record :0=N 2=Y
0/2	
Program Focus: CHF or COPD	Allowing for various system variances: 0=N 2=Y
0/2	
INITIAL ASSESSMENT	**ANSWER KEY**
Date Case Assigned to CM	Clearly able to identify assigned date 0= N 2=Y
0/2	
Date IA is complete	Clearly able to see date assessment done 0=N 2=Y
0/2	
IA Completed w/in 30d of Assignment (CCM, T2, or WELL) or 2 - 7 days Transitions Management	Meets guidelines established 0=N 2=Y
0/2	
PAM survey complete (CCM or Tier 2)	Meets guidelines established 0=N 2=Y
0/2	
IF case is closed: date	Closed date available in record 0=N 2=Y
0/2	
INITIAL PROBLEM LIST	**ANSWER KEY**
Initial Problem List for CCM, T2 & WELL Identified needs for Transitions management	Is there a problem list/opportunities clearly identified recognizing various system limitations: 0=N 2=Y
0/2	
INITIAL CARE PLAN (CCM, T2 & WELL)	**ANSWER KEY**
Prioritized Goals Consistent w/Problem list	0=No Evidence of integration 1=Partially meets integration 2=goals and problems aligned
0/1/2	
Identification of barriers to meeting goals	0=No Evidence of barriers documented 1=Partially address' barriers 2=goals and barriers clear
0/1/2	

Development of schedules for f/u communication w/team & member	0=No Evidence of f/u with team or member scheduled 1=f/u with member only 2=f/u with team and mbr
0/1/2	
ONGOING CARE PLANNING (CCM, T2, & WELL)	**ANSWER KEY**
Evidence of Care Plan updates.	Signs of collaboration, new plan and goals, new interventions, tasks scheduled: 0=No evidence 1=Some partial updating noted 2= Current plan of care with updates
0/1/2	
INITIAL ACTION (CCM, T2, & WELL)	**ANSWER KEY**
Member Centric Goals	Supporting documentation that goals are member focused 0=N 1=partially addressed member focused goals 2=Y
0/1/2	
ONGOING ACTION PLAN (CCM, T2 & WELL)	**ANSWER KEY**
Action Plan Modification	Current and updated depending on each IDN/Group requirements 0=N 1=Some partial updating noted 2=Y
0/1/2	
EVIDENCE OF INTEGRATION	**ANSWER KEY**
Documented CP shared w/PCP (CCM, T2 & WELL)	This could be in different locations depending on system, looking for evidence CM discussed member problem/goals/plan example discussed at medical management meeting: 0=N 2=Y
0/2	
Documented AP shared w/PCP & other team members (CCM, T2 & WELL)	This could be a copy mailed to PCP, handed out at MM meeting etc. 0=N 2=Y
0/2	
Communication - All Management	Evidence of calls to other care team members, PCP, providers, family, member, evidence of mailings where appropriate: 0=N 1=some evidence but needs improving 2: detailed documentation of calls and contacts with team/PCP/Member/vendors
0/1/2	
CRITERIA FOR DISCHARGE*	**ANSWER KEY**
Member demonstrates competency in Self-Management Caregiver demonstrated competency in Member Management (CCM or Tier 2)	Evidence of teach back, confidence questions answered and reviewed, medication management clear. Documentation if discharged because of transition to Hospice, Custodial, no longer CPC member, or other 0=No documented evidence 1=Some evidence-partially meets 2=Evidence of member competency clear and documented CGS completed, care giver teach back evident in notes or plan of care 0=N 2=Y Criteria for discharge is only applicable for CCM, T2 and Transition cases.
0/1/2	
PAM Survey completed prior to discharge with a Level 3 or 4 (CCM or Tier 2)	0=N, 2=Y
0/2	
Less than 2 ED visits & no unplanned admissions for 6mths. (CCM or Tier 2)	0=N, 2=Y
0/2	
Transitions management: 30-45 days	0=N. 2=Y
0/2	

N Dementia Care Consultant Referral Guide

Who Can Be Referred?

A primary caregiver/decision maker of someone who is experiencing changes in memory.
A formal dementia diagnosis is not needed for referral. **

Who Would Benefit From a Referral?

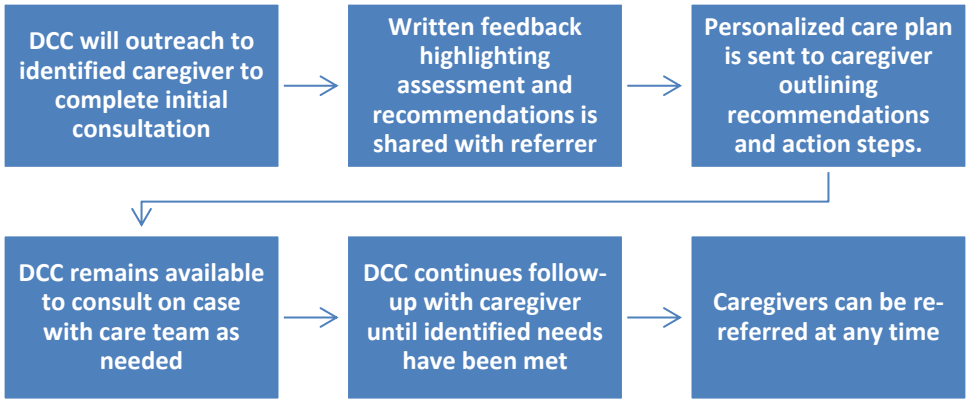
Including but not limited to those with:

Concerns Related to Changes in Memory	• Memory loss disrupting daily life or ability to care for oneself • Education needed about diagnosis or diagnostic process
Caregiver Strain	• Limited support system or respite • Difficulty accessing formal supports • Education needed about the disease process, symptoms, resources or supports
Safety Concerns (current or at risk for)	• Living alone • Driving, wandering, concerns about the physical environment or financial safety
Long Term Care Planning	• Future planning for disease progression • Discussions about when or how to increase care or transition care environments • Legal & financial planning
Behavioral Concerns	• Caregiver difficulty managing hallucinations, paranoia, delusions, agitation, etc. • Challenges related to assisting with ADL/IADL needs • Changes in communication
Accessing Support and Community Resources	• Guidance around introducing new supports or services •Assistance with decision making and accessing appropriate supports

In order to have the most productive consultation it is important that the caregiver be introduced to the referral and agrees to outreach from the dementia care consultant.

Once caregiver agrees, referral form should be completed and emailed to
cm_cpct@carepartnersct.com

What Happens After a Referral is Made?



** In some cases, a person with memory concerns may be referred to speak with a dementia care consultant. Please outreach to discuss prior to making a referral.

O ESS High Risk Report Sample

member_id	NEWLY_IDENTIFIED	FIRST_NAME	LAST_NAME	DOB	EXTERNALLY_MANAGED_GRP	pcp_ipa	PCP_FULL_NAME	PCP_LEVEL1	ccs	oppscr_amt	SEGMENT
S00****** 01	Y	MOUSE, MINNIE		MM/DD/YYYY	Y	123			8.4		ADVANCING ILLNESS
S00****** 01	Y	MOUSE, MINNIE		MM/DD/YYYY	Y	123			8.4		ADVANCING ILLNESS
S00****** 01	Y	MOUSE, MICKEY		MM/DD/YYYY	Y	123			7.8		FRAIL ELDER
S00****** 01	Y	DUCK, DONALD		MM/DD/YYYY	Y	123			7.4		ADVANCING ILLNESS
S00****** 01	Y	MERMAID, ARIEL		MM/DD/YYYY	Y	123			7.4		ADVANCING ILLNESS
S00****** 01	Y	FLINTSTONE, FRED		MM/DD/YYYY	Y	123			7.4		ADVANCING ILLNESS
S00****** 01	Y	FLINTSTONE, WILMA		MM/DD/YYYY	Y	123			7.4		ADVANCING ILLNESS
S00****** 01	Y	RUBBLE, BARNEY		MM/DD/YYYY	Y	123			7.3		ADVANCING ILLNESS
S00****** 01	Y	RUBBLE, BAM BAM		MM/DD/YYYY	Y	123			6.9		ADVANCING ILLNESS

SUBSEGMENT	funct_impair	chf	copd	TOTAL_3MONTHS	TOTAL_12MONTHS	ED_3MONTHS	ED_12MONTHS	BH_ADMITS_3MONTHS	BH_ADMITS_12MONTHS	MED_SCHED_ADMIT_3MO	MED_UNSCHED_ADMIT_3MO
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	17075	45258.77	48744.8	101762	2	2	2	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	19848.6	70013.04	105769	130661	2	5	1	0
Older Adults with Functional Impairment and Major Comorbi	1	1	1	10860.2	20726.75	22685.1	23241.9	1	3	0	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	0	0	1	4377.68	36367.36	18728	31821	3	6	0	1
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	6541.75	24437.12	8757.3	94579.7	1	5	0	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	11080.1	51723.31	12487	14029.6	3	5	1	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	0	8501.31	64485.54	17172.2	45741.4	2	7	3	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	0	0	1	25401.2	35832.02	45775.8	85337.9	2	2	3	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	46512.6	29482.05	24874.9	53057.8	2	8	3	0

Stratification – Clinical Complexity Score (CCS)

Definition

The Clinical Complexity Score (CCS) is a process to rank order all CPC members based on recent utilization, reducible utilization, and Social Determinants of Health (SDOH). The CCS is defined on a 0 to 10-point scale, with 0 indicating no identified needs and 10 indicating the most complex member need profile.

CCS Calculation

1) All members have a CCS that is updated monthly.
2) CCS calculation employs data from 5 consecutive quarters:
    - The most recently finished quarter (Q0);
    - 4 quarters prior the most recently finished quarter (Q1-Q4).

   The quarter is considered finished on a last day of the quarter. For example, Q2 2019 is finished on June 30, 2019. The data for the quarter will change over time as claims are adjudicated.
3) Machine Learning (ML) algorithm provides a one quarter forecast for four clinical variables: inpatient medical scheduled utilization, inpatient medical unscheduled utilization, inpatient behavior utilization, emergency department utilization.
4) The ML forecasts are used in the utilization-based components CCS calculation and is made for the most recently finished quarter (Q0). CCS for historic quarters (Q1, Q2, Q3, Q4) uses actual values.
5) Calculation of Paid Claims, ED visits, inpatient visits for Q0 relies on blending actual and predicted values.
6) Prediction for medical spend is made by applying the average change of total spend across three completed quarters Q1, Q2, Q3 to the most recent completed quarter Q1.

$$Q1_{actual}+MAX(0,AVG(Q2_{actual}\text{-}Q3_{actual},Q1_{actual}\text{-}Q2_{actual}))$$

   For Q1 and other historic quarters, percentile of medical spend for Segment 6 is calculated using actual Q1 medical claims.
7) Prediction for IP and ED utilization is made by applying ML forecasted values to the cost mapping file generated from historic values. A sample values for the cost mapping file are presented below:

Business	Measure	Average Visits	Members	Prob	Cost
Comm	ED	0	3739443	0.933294	$0
Comm	ED	1	204121	0.984215	$352.630
Comm	ED	3.25	63180	0.997674	$1606.67

   If ML predicted percentile of ED visit for Commercial product member is greater than 0.984215 (the percentile value from the mapping file for average visits '1') and lower or equal to 0.997674 (the percentile value from the mapping file for average visits '3.25'), then a member is predicted to have 2-3.25 ED visits with cost of $1606.67.

   Prediction for inpatient visits is made similar with ML forecasted IP visits being the maximum of forecasted medical scheduled, forecasted medical unscheduled, forecasted behavioral visits.
8) Blended medical spend, IP and ED utilization for Q0 is then calculated as follows:

$$Q0_{actual}+MAX\ (0,\ Q0_{predicted}-\ Q0_{actual})\ *(\#\ full\ months\ left\ in\ current\ quarter/3)$$

   For example, if the model is updated in October 2019 and Q0 corresponds to the third quarter of 2019, medical spend will be calculated as

Third quarter 2019_{Actual}+MAX(0,Third quarter $2019_{Predicted}$- Third quarter 2019_{Actual})*(2/3).

If the model is updated in November 2019 and Q0 corresponds to the third quarter of 2019, medical spend will be calculated as

Third quarter 2019_{Actual}+ MAX(0,Third quarter $2019_{Predicted}$- Third quarter 2019_{Actual})*(1/3).

9) Opportunity Values are calculated as a sum of ED and inpatient paid claims for the last 4 finished quarters. The claims are removed from the calculation if any of the following conditions is satisfied:
    - Revenue code: 114, 116, 124, 126, 905, 906 or 911;
    - CPT code: H0010, H0011, H0015, H0019, H0037, H0037HH, H2015, S9485TG, 1001, 1002;
    - Service types: Acute Treatment Services/Level 3.7, Enhanced Acute Treatment Services, Clinical Stabilization Services/Level 3.5, Dual Diagnosis Acute Residential Treatment, RRS, Community Based Acute Treatment, Intensive Community Based Acute Treatment, Community Crisis Stabilization, Community Support Program. The following service types were also removed for commercial and CPC members: Psychiatric Inpatient, Detox, SUD Acute Residential Treatment, Psychiatric Acute Residential Treatment.

Opportunity values are then grouped into Low, Moderate and High categories based on their percentile within a subsegment:

- Low: member`s opportunity value is less or equal to 75th percentile;
- Moderate: member`s opportunity value is greater than 75th percentile and less or equal then 90th percentile;
- High: member`s opportunity value is greater than 90th percentile.

10) CCS composition for most recently finished quarter (Q0) is outlined in the table below.

CCS Element	Weight	Data Input	Comment
Total Paid Claims	20%	100% if >=98 percentile of blended paid claims 75% if >=94 percentile of blended paid claims 50% if >=90 percentile of blended paid claims 25% if >=85 percentile of blended paid claims	Forecast is made for one quarter only. Use blended formula.
Inpatient Utilization	15%	100% if 2+ blended IP visits	Forecast is made for one quarter only. Use blended formula.
ED Utilization	10%	100% if 2+ blended ED visits	Forecast is made for one quarter only. Use blended formula.
Opportunity Value	10%	100% if (Opportunity Value>=$4k) 50% if (Opportunity Value>$1k)	Utilization cost for last 4 finished quarters.
Medical Chronic Comorbidities	10%	100% if (3+ conditions) OR (1+ high risk condition) OR (1+ catastrophic condition) 50% if (2+ conditions not in high	The value is fixed and will not vary by quarter.

		risk/catastrophic group) 25% if (1 condition not in high risk/catastrophic group)	
Behavioral Health Chronic Comorbidities	10%	100% if SPMI=1 OR High MH: (Mental_Health=1) AND (BH admits in Q0 or Q1 or Q2 or Q3 or Q4>=1) 50% if Mod MH: (Mental_Health=1) AND (Rx claim count in Q0 or Q1 or Q2 or Q3 or Q4>=3) OR (Mental_Health=1) and (Count of CNS fills in Q0 or Q1 or Q2 or Q3 or Q4>=2) 25% if Low MH: (Mental_Health=1)	SPMI flag is fixed and will not vary by quarter. MH flag will vary by quarter.
Substance Use Disorder Indicator	10%	100%: (SUD_ Alcohol or Opioid or Other=1) AND (ATS37 for Q0 or Q1 or Q2 or Q3 or Q4>=1) 100%: (SUD_ Alcohol or Opioid or Other =1) AND (CSS35 for Q0 or Q1 or Q2 or Q3 or Q4>=1) 50%: (SUD_ Alcohol or Opioid or Other =1) AND (ED Visit for Q0 or Q1 or Q2 or Q3 or Q4>=1) 25%: (SUD_ Alcohol or Opioid or Other =1)	The value will vary by quarter.
Composite SDOH Risk #1	6%	100% if SDoH Composite #1 Econ and Housing Instability =1	The value will vary by quarter.
Composite SDOH Risk #2	6%	100% if SDoH Composite #2 Low Health Literacy=1	The value will vary by quarter.
Composite SDOH Risk #3	3%	100% if SDoH Composite #3 Access Limitations=1	The value will vary by quarter.

11) CCS calculation for quarters Q1, Q2, Q3, Q4 shifts input data by one quarter back dynamically. For example, for quarter Q1: predicted values and Q0 values are replaced with Q1 data, Q1 values are replaces with Q2 data and so on.
12) CCS scores are recalculated in each data refresh monthly. Since each data refresh updates claims and medical history information, quarterly CCS scores may differ from the last iteration.

Daily Census Report Sample

ADMISSIONS TAB

Daily Census as of Sep 14, 2020

Member ID	Member Name	Member DOB	Member Age	Facility Name	Facility Type	Facility In/Out of network	Place Of Service
S00****** 01	MOUSE, MINNIE	MM/DD/YYYY	**	NORTHEAST HOSPITAL CORP INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	MOUSE, MINNIE	MM/DD/YYYY	**	MT AUBURN HOSPITAL - IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	MOUSE, MICKEY	MM/DD/YYYY	**	BETH ISRAEL DEACONESS MED-INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	DUCK, DONALD	MM/DD/YYYY	**	MT AUBURN HOSPITAL - OUT PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	MERMAID, ARIEL	MM/DD/YYYY	**	SOUTH SHORE HOSP - IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	FLINTSTONE, FRED	MM/DD/YYYY	**	LOWELL GENERAL HOSP - IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	FLINTSTONE, WILMA	MM/DD/YYYY	**	BETH ISRAEL DEACONESS PLYMOUTH	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	RUBBLE, BARNEY	MM/DD/YYYY	**	NEVILLE CENTER AT FRESH POND	SKILLED NURSING FACILITY	Contracted	Skilled Nursing Facility
S00****** 01	RUBBLE, BAM BAM	MM/DD/YYYY	**	BETH ISRAEL DEACONESS MED-INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	BUNNY, BUGS	MM/DD/YYYY	**	BETH ISRAEL DEACONESS NEEDHAM	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	FUDD, ELMER	MM/DD/YYYY	**	SOUTH SHORE HOSP - IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	BEAR, FOZZIE	MM/DD/YYYY	**	UMASS MEMORIAL MED CENTER-INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	EAGLE, SAM	MM/DD/YYYY	**	LOWELL GENERAL HOSP - IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	SCROOGE, EBENEZER	MM/DD/YYYY	**	NEVILLE CENTER AT FRESH POND	SKILLED NURSING FACILITY	Contracted	Skilled Nursing Facility
S00****** 01	BROWN, CHARLIE	MM/DD/YYYY	**	Brigham & Womens Hospital		Non Contracted	Inpatient Hospital
S00****** 01	BOOP, BETTY	MM/DD/YYYY	**	BETH ISRAEL DEACONESS MED-INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	PICKLES, ANGELICA	MM/DD/YYYY	**	South Shore Hospital		Non Contracted	Inpatient Hospital
S00****** 01	DUCK, DAFFY	MM/DD/YYYY	**	BETH ISRAEL DEACONESS NEEDHAM	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	COYOTE, WILE E.	MM/DD/YYYY	**	BETH ISRAEL DEACONESS NEEDHAM	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	BEAR, YOGI	MM/DD/YYYY	**	SANCTA MARIA NURSING FACILITY	SKILLED NURSING FACILITY	Contracted	Skilled Nursing Facility
S00****** 01	LEGHORN, FOGHORN	MM/DD/YYYY	**	NEVILLE CENTER AT FRESH POND	SKILLED NURSING FACILITY	Contracted	Skilled Nursing Facility
S00****** 01	TENTACLES, SQUIDWARD	MM/DD/YYYY	**	MT AUBURN HOSPITAL - IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital

Daily Census as of Sep 14, 2020

Diagnosis	Bed Type	Admission Type	Procedure Name	Requested Admission Date	Admission Date	Days In	Discharge Date	Admission Status	Case Number
Diverticulitis of large intestine without perforation or abscess without bleeding	Surgical	Scheduled	LAPS COLCT PRTL W/COLOPXTSTMY LW ANAST	10/15/2020	10/15/2020	-31			**********
Splenomegaly, not elsewhere classified	Surgical	Scheduled	LAPS SURG SPLENC	9/15/2020	9/15/2020	-1			**********
Dyspnea, unspecified	Medical	Urgent/ Emergent		9/11/2020	9/11/2020	3	Aug 31, 2020		**********
Weakness	Medical	Urgent/ Emergent		9/11/2020	9/11/2020	3			**********
Unspecified injury of head, initial encounter	Medical	Urgent/ Emergent		9/11/2020	9/11/2020	3			**********
Pneumonia, unspecified organism	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4	Aug 28, 2020		**********
Chronic obstructive pulmonary disease with (acute)	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4			**********
Alzheimer's disease, unspecified	SNF Level 1B	Scheduled		9/10/2020	9/10/2020	4			**********
Chronic obstructive pulmonary disease with (acute)	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4	Aug 28, 2020		**********
Gastrointestinal hemorrhage, unspecified	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4			**********
Chronic atrial fibrillation, unspecified	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4			**********
Urinary tract infection, site not specified	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4			**********
Dyspnea, unspecified	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4			**********
Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery	SNF Level 1B	Scheduled		9/10/2020	9/10/2020	4			**********
Hypertensive emergency	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4			**********
Unspecified fall, initial encounter	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4			**********
Pneumonia, unspecified organism	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4			**********
Postprocedural hemorrhage of a digestive system organ or structure following a digestive system procedure	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4			**********
Viral pneumonia, unspecified	Medical	Urgent/ Emergent		9/10/2020	9/10/2020	4			**********
Postprocedural hematoma of a circulatory system organ or structure following a cardiac catheterization	SNF Level 1B	Scheduled		9/10/2020	9/10/2020	4			**********
Other mechanical complication of other urinary catheter,	SNF Level 1B	Scheduled		9/10/2020	9/10/2020	4			**********
Localized swelling, mass and lump, unspecified lower limb	Surgical	Urgent/ Emergent	EXC B9 LES MRGN XCP SK TG T/A/L > 4.0 CM	9/9/2020	9/9/2020	5			**********

Daily Census as of Sep 14, 2020

PCP Name	PCP Group ID	PCP Group Name	PCP Phone Number	# Acute Admits	Last Acute Admit Date	30 Day Acute Readmission	CCS (Clinical Complexity Score)
**********	**********	**********	**********			N	Tier 2/Chronic
**********	**********	**********	**********			N	
**********	**********	**********	**********			N	Tier 3
**********	**********	**********	**********	2	05/24/2020	N	Tier 2/Chronic
**********	**********	**********	**********			N	Tier 2/Chronic
**********	**********	**********	**********			N	Tier 2/Chronic
**********	**********	**********	**********	1	01/20/2020	N	Tier 2/Chronic
**********	**********	**********	**********	2	08/27/2020	N	Tier 3
**********	**********	**********	**********			N	Complex
**********	**********	**********	**********	1	08/24/2020	Y	Tier 2/Chronic
**********	**********	**********	**********			N	Tier 3
**********	**********	**********	**********			N	Tier 3
**********	**********	**********	**********	2	07/31/2020	N	Tier 2/Chronic
**********	**********	**********	**********			N	Tier 3
**********	**********	**********	**********			N	Tier 2/Chronic
**********	**********	**********	**********	1	07/08/2020	N	
**********	**********	**********	**********	8	08/06/2020	N	Tier 2/Chronic
**********	**********	**********	**********			N	Tier 3
**********	**********	**********	**********			N	Tier 3
**********	**********	**********	**********	2	08/21/2020	N	Tier 2/Chronic
**********	**********	**********	**********	1	04/27/2020	N	Tier 3
**********	**********	**********	**********	1	05/01/2020	N	Tier 3

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Daily Census Report (cont.)

DISCHARGES TAB

Member ID	Member Name	Member DOB	Member Age	Facility Name	Facility Type	Facility In/Out of network	Place Of Service
S00****** 01	MOUSE, MINNIE	MM/DD/YYYY	**	BETH ISRAEL DEACONESS NEEDHAM	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	MOUSE, MINNIE	MM/DD/YYYY	**	LOWELL GENERAL HOSP - IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	MOUSE, MICKEY	MM/DD/YYYY	**	NORTHEAST HOSPITAL CORP INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	DUCK, DONALD	MM/DD/YYYY	**	LIFE CARE CENTER OF PLYMOUTH	SKILLED NURSING FACILITY	Contracted	Skilled Nursing Facility
S00****** 01	MERMAID, ARIEL	MM/DD/YYYY	**	NEW ENGLAND BAPTIST HOSP IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	FLINTSTONE, FRED	MM/DD/YYYY	**	BETH ISRAEL DEACONESS MED-INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	FLINTSTONE, WILMA	MM/DD/YYYY	**	BANE JOHN SCOTT, LLC	SKILLED NURSING FACILITY	Contracted	Skilled Nursing Facility
S00****** 01	RUBBLE, BARNEY	MM/DD/YYYY	**	BETH ISRAEL DEACONESS MED-INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	RUBBLE, BAM BAM	MM/DD/YYYY	**	BETH ISRAEL DEACONESS PLYMOUTH	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	BUNNY, BUGS	MM/DD/YYYY	**	LOWELL GENERAL HOSP - IN PT	HOSPITAL ACUTE CARE	Contracted	Skilled Nursing Facility
S00****** 01	FUDD, ELMER	MM/DD/YYYY	**	HATHORNE HILL CENTER	SKILLED NURSING FACILITY	Contracted	Skilled Nursing Facility
S00****** 01	BEAR, FOZZIE	MM/DD/YYYY	**	BETH ISRAEL DEACONESS MED-INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	EAGLE, SAM	MM/DD/YYYY	**	SOUTH SHORE HOSP - IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	SCROOGE, EBENEZER	MM/DD/YYYY	**	BRIGHAM & WOMENS FAULKNER HOSP	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	BROWN, CHARLIE	MM/DD/YYYY	**	SKILLED NURSING FAC@NORTH HILL	SKILLED NURSING FACILITY	Contracted	Skilled Nursing Facility
S00****** 01	BOOP, BETTY	MM/DD/YYYY	**	BETH ISRAEL DEACONESS MILTON	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	PICKLES, ANGELICA	MM/DD/YYYY	**	NORTHEAST HOSPITAL CORP INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	DUCK, DAFFY	MM/DD/YYYY	**	SOUTH SHORE HOSP - IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	COYOTE, WILE E.	MM/DD/YYYY	**	BETH ISRAEL DEACONESS PLYMOUTH	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	BEAR, YOGI	MM/DD/YYYY	**	MT AUBURN HOSPITAL - IN PT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital
S00****** 01	LEGHORN, FOGHORN	MM/DD/YYYY	**	NEW ENGLAND BAPTIST HOSP IN PT	HOSPITAL ACUTE CARE	Non Contracted	Inpatient Hospital
S00****** 01	TENTACLES, SQUIDWARD	MM/DD/YYYY	**	BETH ISRAEL DEACONESS MED-INPT	HOSPITAL ACUTE CARE	Contracted	Inpatient Hospital

Diagnosis	Bed Type	Admission Type	Procedure Name	Requested Admission Date	Admission Date	Days In	Discharge Date	Discharge	Days Since Discharge	Case Number	PCP Name
Malignant neoplasm of appendix	Surgical	Scheduled	COLCT PRTL W/RMVL	9/8/2020	9/8/2020	1	9/9/2020		5	**********	**********
Weakness	Medical	Urgent/ Emergent		9/5/2020	9/5/2020	4	9/9/2020		5	**********	**********
Fracture of unspecified part of neck of left femur,	Medical	Urgent/ Emergent		9/3/2020	9/3/2020	6	9/9/2020		5	**********	**********
Aftercare following joint replacement surgery	SNF Level 1B	Urgent/ Emergent		9/3/2020	9/3/2020	7	9/10/2020		4	**********	**********
Unilateral primary osteoarthritis, right knee	Surgical	Scheduled		9/2/2020	9/2/2020	2	9/4/2020		10	**********	**********
Chest pain, unspecified	Medical	Urgent/ Emergent		9/2/2020	9/2/2020	7	9/9/2020		5	**********	**********
Unspecified atrial fibrillation	SNF Level 1B	Scheduled		9/2/2020	9/2/2020	6	9/8/2020		6	**********	**********
Heart failure, unspecified	Medical	Urgent/ Emergent		9/1/2020	9/1/2020	6	9/7/2020		7	**********	**********
Unilateral primary osteoarthritis, right knee	Surgical	Scheduled		9/1/2020	9/1/2020	2	9/3/2020		11	**********	**********
Unilateral primary osteoarthritis, right knee	Surgical	Scheduled	ARTHRP KNEE	8/31/2020	8/31/2020	1	9/1/2020		13	**********	**********
Malignant neoplasm of bladder, unspecified	SNF Level 1B	Scheduled		8/31/2020	8/31/2020	8	9/8/2020		6	**********	**********
Paroxysmal atrial fibrillation	Medical	Scheduled	UNCLASSIFIED DRUGS	9/1/2020	8/31/2020	3	9/3/2020		11	**********	**********
Acute pulmonary edema	Medical	Urgent/ Emergent		8/31/2020	8/31/2020	2	9/2/2020	Unknown	12	**********	**********
Pneumonia, unspecified organism	Medical	Urgent/ Emergent		8/31/2020	8/30/2020	9	9/8/2020		6	**********	**********
Syncope and collapse	SNF Level 1B	Urgent/ Emergent		8/29/2020	8/29/2020	12	9/10/2020		4	**********	**********
Disorientation, unspecified	Medical	Urgent/ Emergent		8/29/2020	8/29/2020	2	8/31/2020	Unknown	14	**********	**********
Acute cystitis without hematuria	Medical	Urgent/ Emergent		8/29/2020	8/29/2020	2	8/31/2020	Unknown	14	**********	**********
Cellulitis, unspecified	Medical	Urgent/ Emergent		8/29/2020	8/29/2020	2	8/31/2020	Unknown	14	**********	**********
Pneumothorax, unspecified	Medical	Urgent/ Emergent		8/29/2020	8/29/2020	4	9/2/2020	Unknown	12	**********	**********
Dizziness and giddiness	Medical	Urgent/ Emergent		8/28/2020	8/28/2020	4	9/1/2020	Unknown	13	**********	**********
Unilateral primary osteoarthritis, right hip	Surgical	Scheduled	ARTHRP	8/28/2020	8/28/2020	1	8/29/2020		16	**********	**********
Pneumonia, unspecified organism	Medical	Urgent/ Emergent		8/28/2020	8/28/2020	7	9/4/2020		10	**********	**********

PCP Group ID	PCP Group Name	PCP Phone Number	# Acute Admits	Last Acute Admit Date	30 Day Acute Readmission	CCS (Clinical Complexity Score)
1	**********	**********	1	06/30/2020	N	Tier 3
1	**********	**********			N	Tier 3
1	**********	**********			N	Tier 3
1	**********	**********	1	09/01/2020	N	Tier 2/Chronic
1	**********	**********			N	Tier 3
1	**********	**********	2	07/22/2020	N	Complex
1	**********	**********	2	08/27/2020	N	Tier 2/Chronic
1	**********	**********	1	03/11/2020	N	Tier 2/Chronic
1	**********	**********	1	09/01/2020	Y	Tier 2/Chronic
1	**********	**********	3	08/31/2020	Y	Tier 2/Chronic
1	**********	**********	1	01/30/2020	N	Tier 2/Chronic
1	**********	**********	1	12/04/2019	N	Tier 2/Chronic
1	**********	**********	7	08/31/2020	Y	Complex
1	**********	**********	1	08/30/2020	Y	Tier 3
1	**********	**********			N	Tier 3
1	**********	**********	2	08/29/2020	Y	Complex
1	**********	**********	3	08/29/2020	Y	Tier 3
1	**********	**********	1	08/29/2020	Y	Tier 3
1	**********	**********	1	08/29/2020	Y	Tier 2/Chronic
1	**********	**********			N	Tier 3
1	**********	**********	1	08/28/2020	Y	Tier 3
1	**********	**********			N	Tier 2/Chronic

Updated 12/30/2020

Q Daily Census Report Guide

Daily Census Report Guide

Overview

The Daily Census Report is a working tool that will help Care Managers identify high risk, high priority inpatient members who will benefit from more immediate care management and transition of care management. The report provides a snapshot of all CarePartners of Connecticut members with current medical admissions (acute, skilled nursing facility (SNF), and rehabilitation), future elective, and current behavioral health admissions in the CarePartners of Connecticut system. The report prioritizes members with Complex, Tier 2/Chronic status to allow the Care Manager to quickly prioritize their daily caseload for intervention.

The report is also intended to improve operational efficiency, as it contains a discharge date field and blank Admission Status field which will allow the external Care Manager to document the member's discharge date or admission status (i.e. change to observation or never admitted), and then email the report back to the CPC. Because the report is provided in Excel format, users may also manipulate the format to accommodate other needs, such as creation of a daily census or use for weekly management meetings.

The Daily Census Report is scheduled for email delivery daily (Weekdays ONLY). Please do not send questions to the email address on the auto-generated email.

Selection Criteria

The Admissions sheet of the report includes all open events in the CPC system

- Any open cases (on date of report run) awaiting final determination from IDN or CPC UM
- Includes future elective events
- Includes events with discharge date in CPC system awaiting final determination from IDN or CPC
- Includes Behavioral Health events: will appear at time of notification and stay on report until the IDN or CPC Behavioral Health dept closes case with discharge date
- Includes Out of Area events: will appear at time of notification and stay on report until the IDN or CPC UM dept closes case with discharge date

The Discharges sheet of the report includes all closed/completed events within the last 31 days.

- Includes events reviewed by IDN **AND** CPC (Externally Managed and Internally Managed)

Excludes Cancelled event

Report Details

Field Name	Field Description
Member ID	Member ID
Member Name	Member Full Name
Member DOB	Member Date of Birth
Facility Name	Facility Name **Note:** Out of Area events are reviewed internally
Place of Service	Place of Service Description (examples: Inpatient Hospital, Skilled Nursing Facility, Inpatient Psychiatric Facility) **Note:** Mental Health (Inpatient Psychiatric Facility) events are reviewed internally
Diagnosis	Primary Diagnosis Description (Long Name)
Bed Type	Bed Type Code Name (examples: Medical, Surgical, SNF Level 1B)
Admission Type	Scheduled or Urgent/Emergent
Procedure Name	Primary Procedure Description (Long Name)
Received Date	Inpatient Notification Received Date
Requested Admission Date	System Request Admit date
Admission Date	System Actual Admission Date
Days In	Member Admission Date minus day report is ran
Discharge Date	System Discharge Date **OR** Used by External groups for sending information back to Tufts Health Plan **Note:** Discharge date on admissions sheet may have been obtained from clinical, EMR, or entered by facility via portal and need to be confirmed to close out the event
Admission Status (Admissions Sheet only)	Used by External groups for sending information back to Tufts Health Plan
	Leave blank (if member still in)
	Fill in discharge date or SDC – Surgical Day Center OBS - Observation for LOC change
	Never admitted (examples: ER only, cancelled admission)
	Notes for Clarifying/Correcting Data on the Report
Discharge Status (Discharges Sheet only)	System Discharge Disposition
Days Since Discharge (Discharge Sheet only)	Count from System Discharge date to day report is ran
Case Number	Authorization Number
PCP Name	System Case PCP Provider Full Name
PCP Group ID	System Case Provider Group ID
PCP Group Name	System Provider Group Name
PCP Phone Number	System PCP Phone Number
# Acute Admits	Number of admits to an Acute Facility within the last 12 months (Excludes Electives)
Last Acute Admit Date	Last Admission Date to an Acute Facility (Excludes Electives)
30 Day Acute Readmission	Y or N if this Acute Admission is a 30-day readmission from a previous Acute Admission (Excludes Electives)
CCS (Clinical Complexity Score)	Clinical Complexity Score (Tier 3, Tier2/Chronic, Complex)
	Tier 3: Clinical Complexity Score 0-2. Members can agree to participate in Proactive Programs (programs intended to prevent events that have not occurred yet)
	Tier 2/Chronic: Clinical Complexity Score 3-5. The member was identified as being in the top 3.5 – 10% for risk of an acute inpatient admission within the next 6 months. Members can agree to participate in Responsive Programs (programs intended to stabilize members and prevent chaotic care pattern)
	Complex (Tier 1): Clinical Complexity Score 6-10. The member was identified as being in the top 3.5% for risk of an acute inpatient admission within the next 6 months. Members can agree to participate in Intensive Programs (programs intended to reduce chaotic pattern of IP and ED utilization)

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Using the report

I. For Daily Management of Inpatient Members

- Care Managers should check the report first thing each morning to identify new, high- priority admissions. The report will be delivered daily (Weekdays ONLY)
- The report is sorted by Admission Date to allow the Care Manager to quickly identify new admissions.
- The CCS (Clinical Complexity Score) and Admitting Diagnosis columns will provide information to allow the Care Manager to quickly assess clinical severity and priority of the member.
- The Care Manager will synthesize the content of this report to prioritize their workload and determine whether to reach out to hospital Care Managers for individual members.

II. For Creating Weekly Management Meeting Census Reports

Because the report is in Excel format, Care Managers can use this format to create weekly management reports or census reports.

III. For Sending Discharge Date/Disposition to CPC

Care Managers will use the report to document discharge dates or other admission status by adding the information directly in the Discharge Date or Admission Status field and will **email discharge dates to CPC at a minimum of three times per week.** Sending discharge dates or up to date admission status on a timely basis will make the report more manageable, accurate, and will expedite claims payment.

Updating the report

Enter the discharge date if applicable, in the Discharge Date field or case status into the Admission Status field. Admission status field can be used to correct inaccurate information for accurate payment. Changes in admission status may be one of the following:

- SDC
- OBS
- Never admitted [ER only, cancelled admission, etc.]
- Clarifying/Correcting Data on the Report, Delay Days, Custodial status,
    - o It is the responsibility of the facility to pre-register the case, however, to clarify or correct information on the report that is inaccurate type the accurate information in the appropriate column and/or write a clarifying note in the admission status field. (example: to correct dates for levels of care, to notify CPC a SNF member is becoming custodial or to identify delay days with identification of responsible party or that case is a coordination of benefit case). See next pages for Bridging policy

End of Month

By the first day of the new month give discharge date or note that member is “Still in” to CPC and the End of Month procedure will be completed.

Returning the report to CPC

1. Save the document with the IDN name or # and today's date.
2. Attach the updated document to your secure email. Using the secure domain name between CarePartners of Connecticut and your IDN will ensure the email is secure.
3. In the subject line type your IDN name or #.
4. Email the edited document to the following email address to assure correct payments: CPCTCaseCloseOut CPCTCaseCloseOut@carepartnersct.com

END OF DOCUMENT