Purpose:
The purpose of the Riverside Physician Network ambulatory case management program is to ensure that medically necessary care is delivered in the most cost-efficient setting for members who require extensive or ongoing services. The evidence used to develop the case management program is derived from Milliman Chronic Care Guidelines and the program will be focused on the delivery of cost-effective, appropriate healthcare services for members with complex and chronic care needs.

Goals:
1. Case managers will coordinate individual services for members whose needs include ongoing medical care, home health/hospice care, rehabilitation services, and preventive services.
2. Case managers will work collaboratively with all members of the healthcare team, including discharge planners at the affiliated hospitals and case management staff at the contracted health plan.
3. The Medical Director/Associate Medical Directors and Utilization Management (UM) Committee members will be involved in overseeing these case management functions.
4. Proactive clinical and administrative processes are implemented to identify, coordinate, and evaluate appropriate high quality services which may be delivered on an ongoing basis.
5. The case management process will be directed at coordinating resources and creating appropriate cost-effective alternatives for catastrophically, chronically ill, or injured members on a case by case basis to facilitate the achievement of realistic treatment goals.

Policy:
Riverside Physician Network’s case management program will accomplish the following:
1. Coordinate cost-effective services.
2. Monitor care which is easily accessible with no access barriers as related to the Member's available benefits.
3. Apply benefits appropriately and coordinate with health plan staff to flex benefits.
4. Promote early and intensive treatment intervention in the least restrictive setting.
5. Provide accurate and up-to-date information to providers regarding member evaluations.
6. Create individualized treatment plans which are revised as the member's healthcare needs change utilizing evidenced based clinical guidelines to conduct assessment and management.

7. Utilize multidisciplinary clinical, rehabilitative, and support services.

8. Arrange broad spectrum appropriate resources for members and assure integration with all services the member is receiving.

9. Deliver highly personalized case management services.

10. Grant adequate attention to member satisfaction.

11. Uphold strict rules of confidentiality.

12. Provide ongoing case management program analysis and development.

13. Annually implement at least one intervention for improvement & re-measure following analysis of case management effectiveness.

14. Encourage collaborative collegial approaches to the case management process.

15. Promote the case management program's viability and accountability.

16. Protect member rights and encourage member responsibility.

Procedures:

A. Care Management Process/Services Offered

1) Referrals to case management may be made through multiple avenues for consideration of services such as practitioners, discharge planners, other hospital staff, employers, health plan staff, health plan disease management referrals, community resources such as social workers, and members/care givers.

2) Data sources that can be used to identify members for case management may include claims or encounter data, hospital discharge information, pharmacy data (if available), lab results, and data collected through the UM process, if applicable.

3) Riverside Physician Network’s website will be used to communicate how practitioners may refer and members self refer into the program.

4) The referral is made to Riverside Physician Network’s case manager who is a licensed staff member and is educated, trained, and experienced in the case management process.

5) The “Ambulatory Case Management Form” will be utilized to initiate a referral, see the “Case Management Program Referral Forms” P&P.

6) The case manager obtains eligibility information on the member and notifies the referral source of the member's eligibility status for involvement in the case management program.

7) An initial assessment must be completed as expeditiously as the member's condition requires but no later than 30 days from the date of the determination that a member is eligible for case management services. The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining the member’s eligibility for case management if the information is related to the current episode of care (health history taken as part of DM or during a hospitalization).

8) If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is still eligible for case management.

9) If the member does not appear to be eligible, the case manager guides the referral source to an alternate method for managing the member's care.

10) Member has the right to decline participation or to disenroll from case management program and services.
1. Case management initial assessments must clearly describe assessment results for each factor below, even if the factor is not applicable. If not applicable the notes must include why. The following will be assessed:
   a. Member’s right to decline participation or to disenroll from case management program and services
   b. Member’s health status, including condition-specific issues
   c. Documentation of treatment history including current/past medication schedules and dosages; procedures such as surgery, PT and radiation treatment; treatment history should go back at least to the onset of the condition that qualified the member for case management
   d. Initial assessment of activities of daily living
   e. Initial assessment of behavioral health status, including cognitive functioning
   f. Initial assessment of life planning activities, in situations where a life planning activity is not appropriate, documentation about the situation should be recorded.
   g. Evaluation of cultural and linguistic needs, preferences or limitations
   h. Evaluation of adequacy of care giver resources and evaluation of available benefits
   i. Evaluation of visual and hearing needs, preferences or limitations
   j. Evaluation of available benefits within the organization and from community resources
   k. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals
   l. Evaluation of member psychosocial needs and personal preferences (i.e., transportation, shelter, food, concerns about condition or treatment, access, religious affiliations, or any financial barriers to obtaining treatment).

2. Once the assessment is completed by the case manager, it will be reviewed by an RN or MD. Date, time, and signature in the Notes section of the ACE computer system will be annotated to verify review of each patient assessment.

3. If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the member’s family or caregiver.

4. Access to appropriate individual, Riverside Physician Network and community based resources are reviewed.

5. The case manager develops a plan of care which includes:
   a. Long and short term goals which will be first identified during the initial assessment and listed in order of priority to consider the member’s and caregiver’s goals, preferences and desired level of involvement in the case management plan:
      o Time frames for re-evaluation
      o Resources to be utilized, including the appropriate level of care
      o Planning for continuity of care, including transition of care and transfers
      o Collaborative approaches to be used, including family participation
   b. Identification of barriers to meeting goals or complying with the plan such as members’ lack of understanding, motivation, financial need, insurance issues, transportation problems, or cultural needs, preferences or limitations
   c. Development of a schedule for follow-up and communication with the member
d. Development and communication of self management plans for members

e. Assessment of progress against case management plans and goals and
modification of them as needed.

6. The case manager monitors the progress of the implemented plan of care. In lieu of
automation, manual prompts will be used for documentation of dates and times an
interaction occurred with the member and for when follow up is required by the plan of
care.

7. The case manager serves as a resource throughout the implementation of the
plan and makes revisions in the plan as it is appropriate.

8. The case manager also coordinates appropriate educational sessions and
encourages the member's role in self-help.

9. Progress toward the member's achievement of treatment plan goals is
monitored in order to determine an appropriate time for the member's discharge from the
case management program.

B. Satisfaction with Case Management

1. Riverside Physician Network will annually evaluate satisfaction with its case
management program by obtaining feedback from members and analyzing complaints
and inquiries.

2. Riverside Physician Network will measure the effectiveness of its case management
program using three measures. For each measure, it will:
   - Identify a relevant process for outcome
   - Use valid methods that provide quantitative results
   - Set performance goals and have clearly identified measure specifications
   - Analyze results
   - Identify opportunities for improvement, if applicable
   - Develop a plan for intervention and re-measurement, if applicable

C. Population Assessment

1. At least annually the Case Management Policy & Procedures will be reviewed
and updated as needed. Included in this review will be an annual assessment of
the characteristics and needs of Riverside Physician Network’s member
population/subpopulation which will include assessing the needs of children
and adolescents; assessing the needs of individuals with disabilities; and,
assessing the needs of individuals with serious persistent mental illness.
Specifics for annual assessments are detailed in Utilization Management
Work Plan and Semi-Annual reports.

2. Processes & resources will be updated as needed to address individual needs.

3. Characteristics of specific populations will be considered when revising the
program. Some examples of relevant population characteristics could include
nature and extent of carved out benefits, types of special needs categories,
race/ethnicity, and language preferences.