SIM PCMH Initiative Affinity Groups

Care Manager and Care Coordinator Visit Documentation: What and How? Adult

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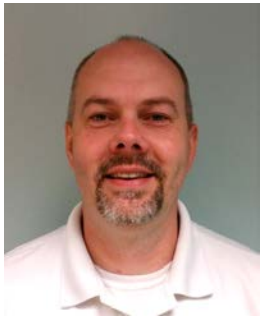
The Michigan Care Management Resource Center

August 2nd, 2017

Michigan Care Management Resource Center
Affinity Group Support Staff

Marie Beisel, Introductions



Scott Johnson - Group Facilitator

Lauren Yaroch - Questions

Judy Avie – Participant Facilitator

SIM PCMH Affinity Groups

The care manager and coordinator affinity group facilitates networking and promising practice sharing across the state. This group is open to all Initiative care managers and coordinators offering an opportunity for peer to peer learning. Collaboratively, care managers and care coordinators will identify areas of interest, topic focus, and prioritize challenges. Outcomes include:

- "What works"
- "What has been tried and does not work"
- Shared learning
- Identification of best practices
- Identify educational needs

Care Manager and Coordinator Learning Credits

One hour of SIM PCMH Longitudinal Learning Credit will be earned per each hour of participation in the Affinity Groups.

- Participants must register with their complete information to earn credit, anonymous participants will not earn Learning Credits.
- To obtain Longitudinal Learning Credit participants must join sessions “live” (in real-time).

Instructions for Obtaining a Certificate of Completion

To receive a certificate of completion for the “Care Manager and Care Coordinator Visit Documentation: What and How?” Affinity group

1. Attend and participate in the entire Affinity Group
2. Check inbox for email from MiCMRC for “SIM PCMH Affinity group Evaluation”
3. Follow instructions in the e-mail: Attest to completing the Affinity Group, complete the evaluation and submit. This step generates an email to you containing the certificate of completion

For technical assistance please e-mail:

micmrc-requests@med.umich.edu

Care Manager & Care Coordinator Participant Commitment:

Attendees participating in a variety of ways during the interactive virtual meeting

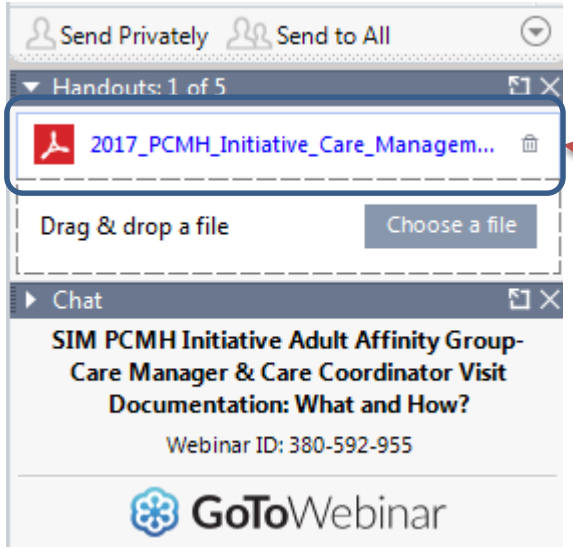
- Posting questions, verbally sharing experiences and lessons learned, responding to polls
- Completion of post meeting evaluation
- Attendee contact information will be shared with the group to promote networking
  - Example: in addition to the contact information, sharing information such as area of expertise
- Completion of a brief survey to identify future high priority Affinity Group meeting topics.

Housekeeping: Webinar Toolbar Features

Collapse Toolbar

Raise Your Hand

Ask a Question



Access PDF Versions of documents

Use question box at any time for your questions or comments. If we are unable to answer some of the questions we will take the question back and respond either by e-mail or submission of your question to SIM

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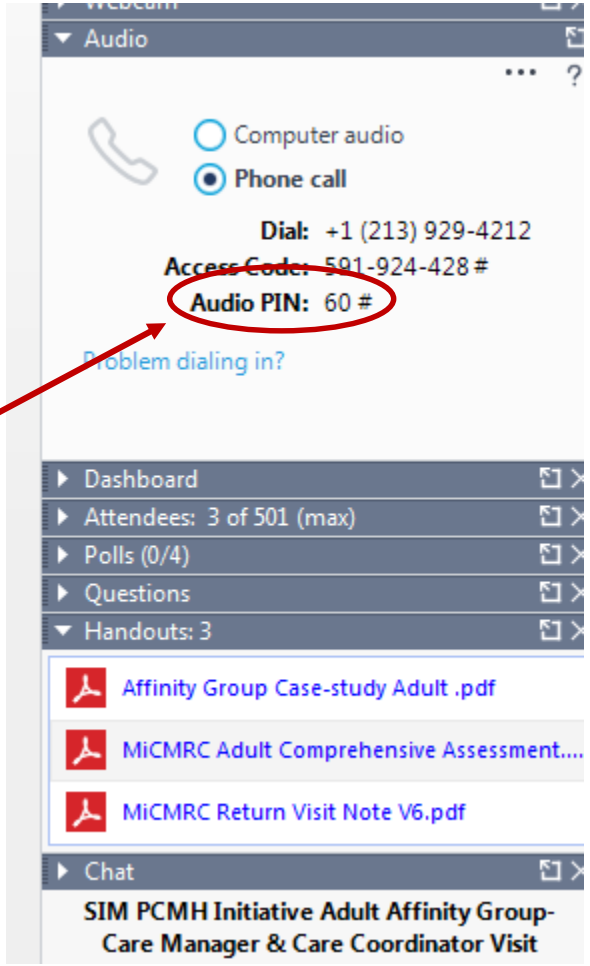
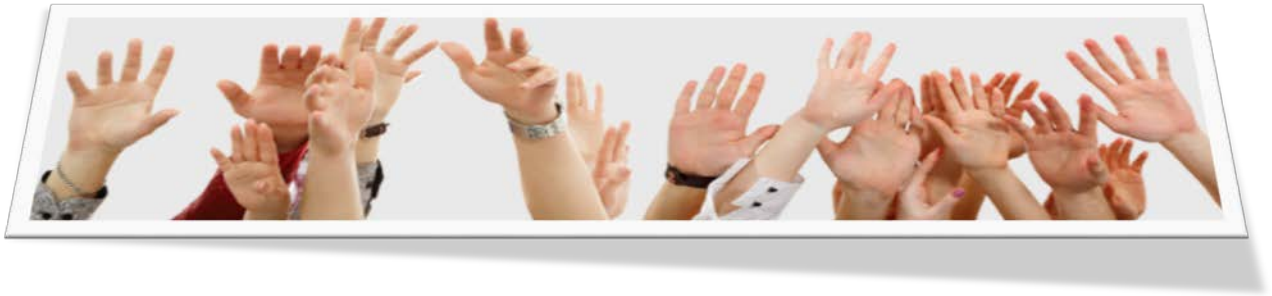
If you did not enter your audio pin when first dialing in please input it now to allow for unmuting of your phone



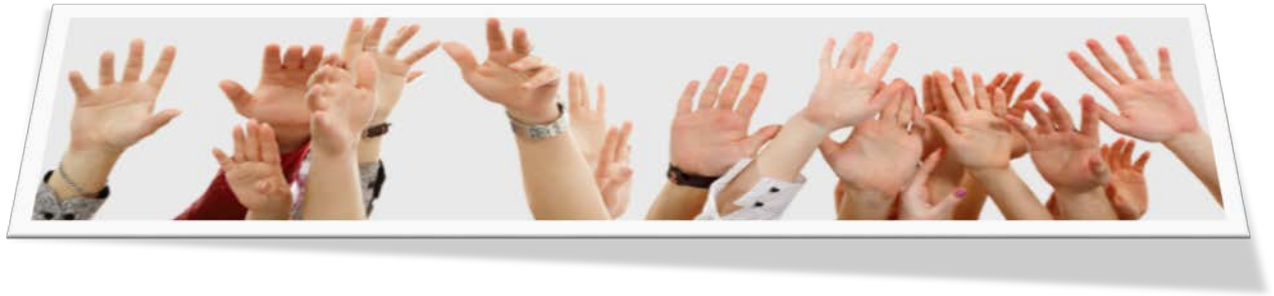
- How long have you been in care management, less than 1 year, 2 to 3 years, 4 or more

- Provide one question you would like to get answered about documentation – type into question box



- Raise your hand if you find documentation challenging

- Raise your hand if you would like to share a specific challenge



- Raise your hand if you have found a solution or had success in the challenges mentioned

Let’s pause a moment for any questions or comments.

Agenda

- Discuss the key differences in Care Management and Care Coordinator roles, and how this affects documentation

- Review Patient Consent, Initial Comprehensive Assessment, and Follow up Visit Documentation

Key roles of the Care Manager

- **Complete comprehensive assessment** of patient's health conditions, treatments, behaviors, risks, supports resources, values, preferences and overall service needs. This can be done in coordination with other members of the care team
- **Develop comprehensive, individualized care plans**; coordinate services required to implement the plan; provide continuous patient monitoring to assess the efficacy of the plan; periodically re-evaluate and adapt the plan, as necessary
- **Ensure patients have timely and coordinated access** to medically appropriate levels of health and support services and continuity of care
- **Provide a range of client-centered services** that link patients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible
- **Conduct medication reconciliation**
- **Promote patient's and family caregiver's active engagement in self-care**
- Coordinate and communicates with all professionals engaged in a patient's care, especially during transitions from the hospital
- Assist with advance directives, palliative care, hospice and other end-of-life care coordination

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Key Roles of the Care Coordinator

- **Jointly creates and manage the individualized plan of care** with the patient/family, care team and community based organizations, that outlines the patient's current and longstanding needs and goals for care and addresses coordination needs and gaps in care
- **Contribute to ongoing maintenance**, which includes monitoring, following up and responding to changes in the patient's individualized plan of care
- **Support self-management goals** to promote patient health
- Align resources with patient and population needs
- Demonstrate administrative skills to organize, evaluate, and present information clearly both verbally and in written communication; **maintain documentation according to practice specifications**
- **Demonstrate knowledge about community resources** by providing information on the availability of and, if necessary, coordinate these services that may help support patients' health and wellness or meet their care goals

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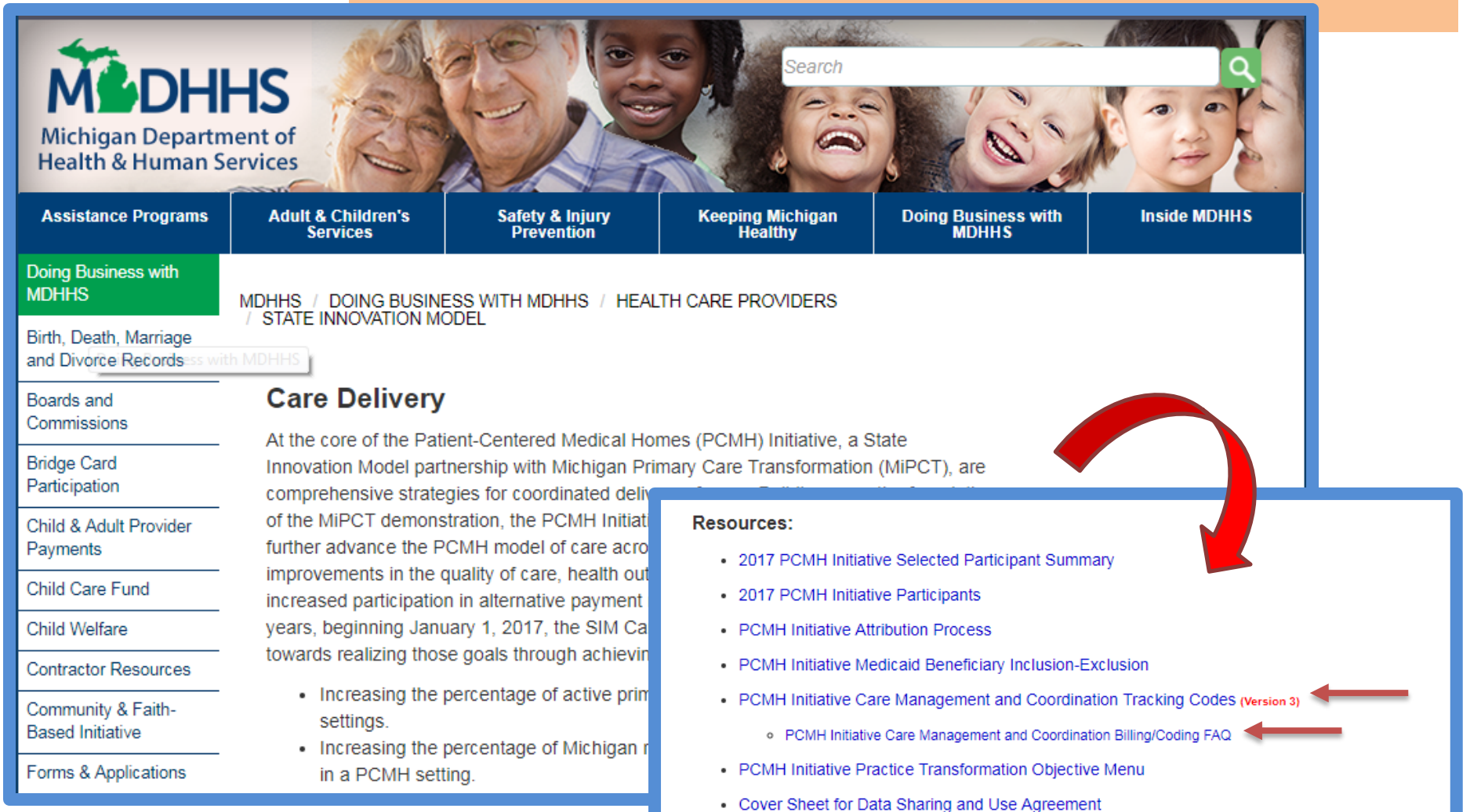
SIM PCMH General Requirements

For the purposes of the PCMH Initiative, care management and coordination services are "the application of systems, science, incentives, and information to improve clinical practice and assist patients and their support system to become engaged in a collaborative process designed to manage medical, social, and/or behavioral health needs more effectively."

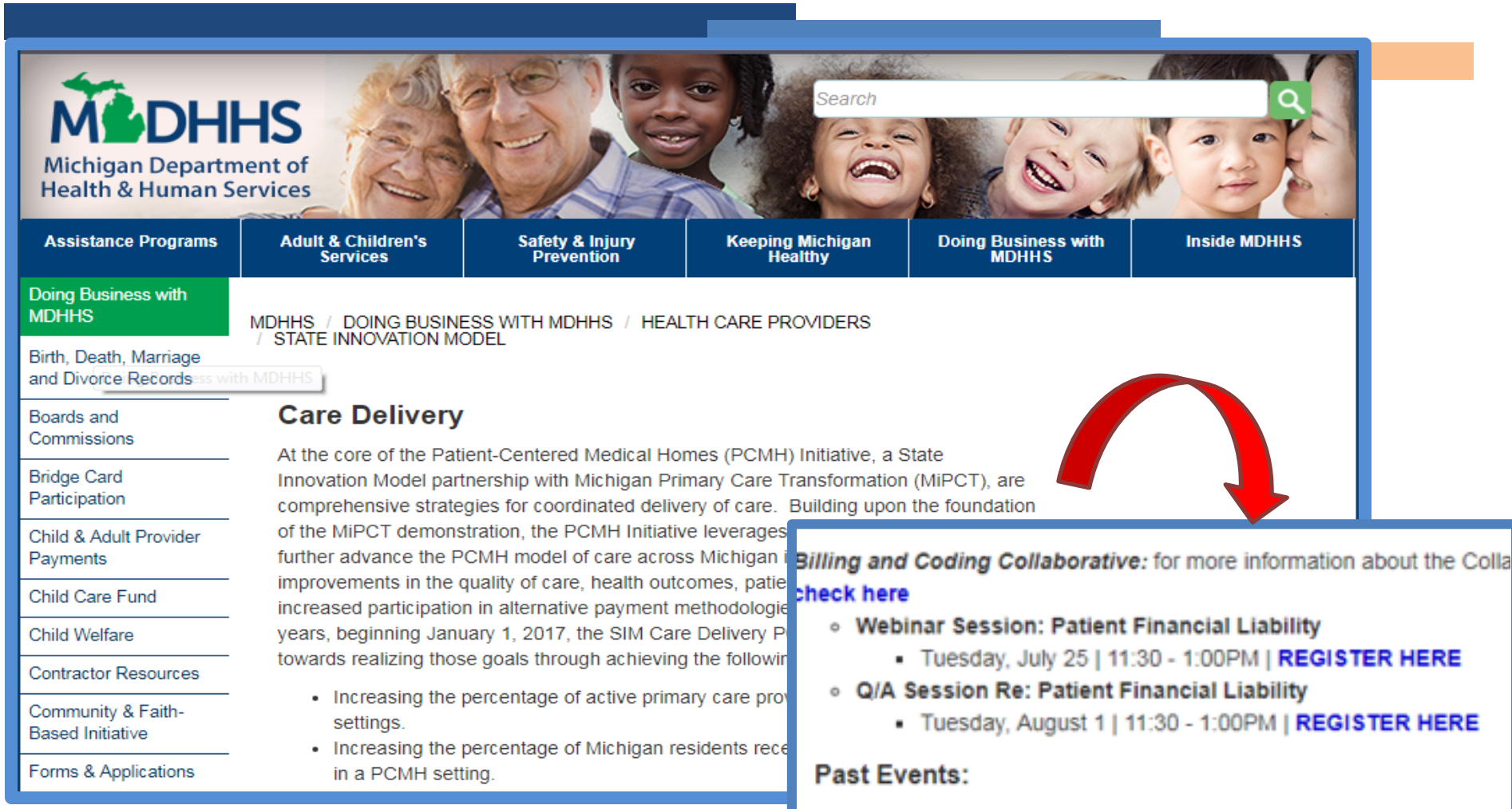
- It includes services such as (but it not limited to):
  - Comprehensive assessment of the patient's medical, functional, and psychosocial needs
  - System-based approaches to ensure timely receipt of all recommended preventive care services
  - Medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications
  - Management of care transitions between and among health care providers and settings, including referrals to other providers, follow-up after emergency department visits, and discharges from inpatient settings
  - Coordination of care with and linkages to home and community-based service providers. o (The level of intensity of care management will vary based on the needs of the patients, as to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.)

SIM PCMH General Requirements

- All care management services provided by a participating provider and reported using the tracking codes above should be documented in an electronic care management and coordination documentation tool accessible to all members of a care team
- The tool must be either a component of an EHR, or able to communicate with an EHR, to ensure pertinent care management and coordination information is visible to care team members at the point of care
  - SIM aligns with the documentation criteria as defined by these commercial payers. The documentation guidelines we discuss today, meet the SIM expectations for documentation.



For more information on Affinity groups, care manager and care coordinator roles and requirements, tracking codes, and the SIM PCMH Initiative go to: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491_76092_77452---,00.html

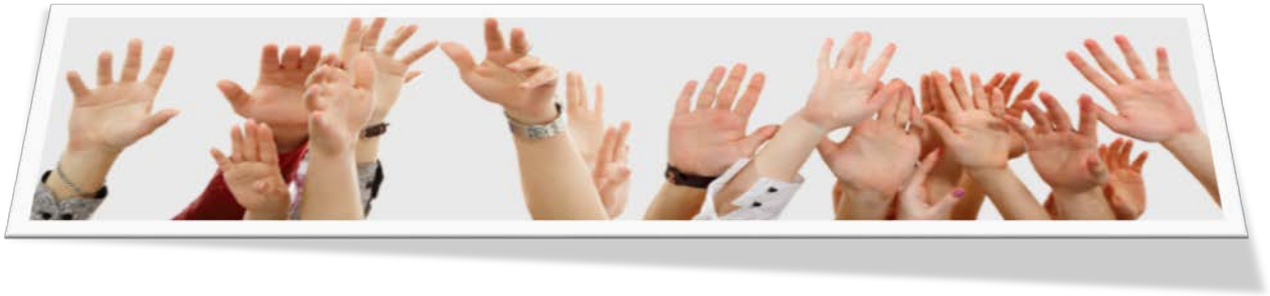


SIM PCMH Billing and Coding Collaborative

To support SIM PCMH Initiative practices and POs in understanding G and CPT care management and coordination code requirements for Medicare patients, as well as care management and tracking codes for Medicaid patients. The collaborative will: ☐Support participants in Billing/Coding related issues for Care Management (CM) / Care Coordination (CC) ☐Build an understanding of CM/CC code requirements

- Does your practice have care management documentation templates?

- What types of CM templates does your documentation system include?



- Raise your hand if you have updated or modified your care management documentation templates

- Raise your hand if you would like to discuss successful updates or modifications.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Initiation of Care Management (Comprehensive Assessment) G9001

Description: Comprehensive Assessment and Care Plan Development with Patients, Prior to Enrollment in Care Management (and annually thereafter)

Subset of similar required documentation fields across payers.

- Patient's Agreement and consent to Engage/Participate in Care Management
- Patient's Level of Understanding of his/her condition and Readiness for Change
- Risk Factors: Physical Status, Emotional Status
- Perceived Barriers to Treatment Plan and Unmet Needs
- Comprehensive assessment results and detailed, individualized care plan

Case Study

Dr. James asks you to meet with Mr. Bowers during his office appointment to work with his chronic condition control

- **Medical Record information**: Mr. Bowers a 75 y/o male has diagnosis of heart failure, type II diabetes, COPD, depression, rheumatoid arthritis and HTN. In last 6 months he was hospitalized twice for HF. He is widowed, lives alone and has a daughter

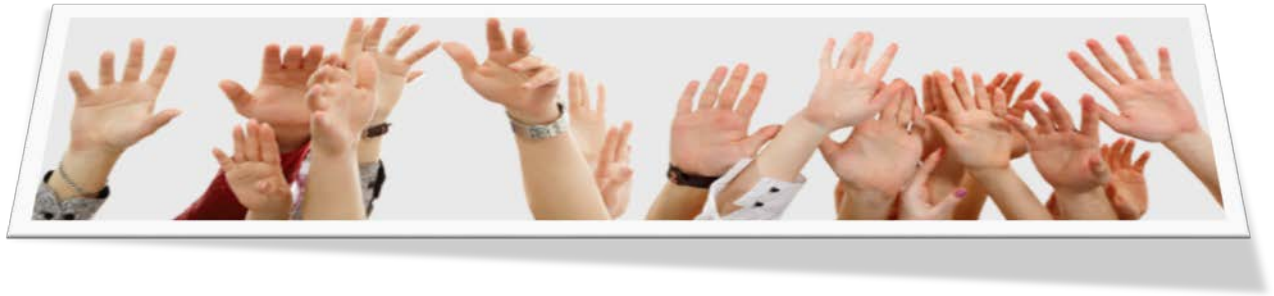
- You meet with Mr. Bowers to explain CM services, gain his consent and start initial assessment

- **Assessment information**: Bowers states since losing his wife it is difficult to care for himself. He relied on his wife for managing of his chronic conditions. His arthritis makes it difficult at times to shower, prepare meals, drive and open medication bottles causing him to miss medications and appointments. He has lost 7-pound in 3 months and has little desire to eat, no cooking skills and does not socialize outside the home. Daughter's time is limited. A neighbor helps occasionally with transportations and meals.

- Where do you document patient consent?

Example Documentation

Type of visit:	○ Phone	◉ Face-to-face	
Visit duration in minutes:	○ 5-10	○ 11-20	○ 21-30
	◉ 31-60	○ >60	
Consent for care management:	○ Yes	◉ Verbal consent	
	○ Declined		



- Raise your hand if you document patient's Level of Understanding of his/her condition and Readiness for Change

Example Documentation

Level of understanding:	Mr. Bowers has been hospitalized twice in six months due to exacerbation of his CHF. He has reduced level of understanding on the importance of managing his disease. In the past he has relied on his wife to manage his care, including medications, meal prep and transportation.
Readiness for Change	Mr. Bowers has demonstrated a willingness to change through acceptance needing assistance for daily activities and management of his heart failure. Mr. Bower is fearful of being placed in a nursing facility, however he wants to remain in his own home.

- How do you document Risk Factors: Physical Status, Emotional Status- type into question box

Example Documentation

Mobility Status, Activities of Daily Living and Physical Rehabilitation

Patient/Other reports:

Has the patient been referred for physical rehabilitation? ○ Yes ◉ No

Level of assistance with Activities of Daily Living:
- ☑ Independent
- ☐ Requires total care

Assistance required with:

☑ Bathing	☐ Toileting
☐ Dressing	☑ Medications
☑ Meals	☑ Housekeeping
☐ Laundry	☑ Transportation
☑ Shopping	☐ Finances
☑ Appointments	
☐ Other:	

General hygiene: ○ No problem ○ Poor

Regular exercise: ○ Yes ○ No

Physical limitations: ◉ Yes ○ No

Describe Fur

Comments:

Mr. Bower has limited functional ability secondary to arthritis which has led to difficulty opening medication bottles, meal prep, showering and the ability to drive

How does the patient cope with life events and daily stress? (Check all that apply.)
- ■ Keeps it to him/herself
- ☐ Talks to family
- ☐ Talks to friends
- ☐ Prays
- ☐ Talks to a professional
- ☐ Support group
- ☐ Internet resources

Is the patient involved in community activities, groups, social events, or volunteering? ○ Yes ◉ No

If yes, describe:

What has the patient previously done for enjoyment or recreation?

Is (s)he able to engage in these activities now? ○ Yes ○ No

Does the patient report having adequate support? ○ Yes ◉ No

If no, what support is desired?

Mr. Bower wishes to remain in his own home and is fearful of being placed in a nursing facility

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- How do you document Perceived Barriers to Treatment Plan and Unmet Needs- type into question box

Example Documentation

Barriers Identified:	Mr. Bowers is not able drive at this time, requires assistance with medications, does not cook, lack of consistent caregiver
Interventions to Address Barriers:	Contact meals on wheels for food assistance, and local pharmacy for delivery options/medication packaging. Home health aide to assist with ADLs Contact local senior center for transportation assistance as well as socialization

SELF-MANAGEMENT ACTION PLAN

Asthma	☐ Yes	☐ NA
Short Term Goal and Target Date:		
Long Term Goal and Target Date:		
CAD	☐ Yes	☐ NA
Short Term Goal and Target Date:		

Questions or comments around Consent and the Comprehensive Assessment-type into question box

Case Study

Follow up: you have called and met with Mr. Bowers frequently over the next three months

- He has not been hospitalized since starting in care management
- Links to community resources have been successful, homecare aid helps with shower and meal prep, pharmacy is blister packing meds, local seniors service is providing transportation and socialization
- More frequent office visits with CM has allow him to learn about and manage his chronic conditions.
- He states at latest visit he is read to discuss advanced directives.

Individual Face-to-Face Visit G9002

Description: Individual face-to-face care management intervention visits

Subset of similar required documentation fields across payers.

- Updated Status on Patient's Medical Condition
- Focused discussion pertinent to the patients Care Plan progress, changes
- Any revisions to the Care Plan Goals, Interventions, and Target Dates

- Where do you document a patient follow up including a updated status on patients medical condition?

Example Documentation

Cardiovascular:

- [x] No problem
- [ ] Edema
- [ ] Fatigue
- [ ] Pallor
- [ ] Hx DVT
- [ ] Chest pain / angina

Characterize chest pain / angina: Mr. Bowers does not indicate any current chest pain/angina

Other: N/A

Comments: Mr. Bower states that since working with the care manager and the help from outside resources he has learned much more about how to manage his disease which has kept Mr. Bowers out of the hospital for the past three months since he began working with his CM

How do you document Care Plan progress, changes and any revisions to the Care Plan Goals, Interventions, and Target Dates-type into question box

Example Documentation

Re-evaluation of Plan of Care and Progress Toward Goals Achievement:

Follow-up planned and time frame:	Mr. Bowers at this time remains in his home with the support of local community services and pharmacy support for his medications. Will continue to follow up with Mr. Bowers monthly. Mr. Bowers would like to discuss more about advance directives at his next visit.
Level of understanding:	Mr. Bower states he is managing his chronic condition much better thanks to the increase in support. Because of the previous meetings with his CM he now has a better understanding of his disease and how to manage it more effectively.

Example Documentation

CHF ■ Yes ☐ NA

Short Term Goal and Target Date: Meet with care manager to discuss advance directive paperwork at next visit

Long Term Goal and Target Date: Case manager will meet with Mr. Bowers once a month to check in on progress

HTN ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Medication Therapy ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Osteoporosis ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Questions or comments

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