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Overview

Denver Health, Colorado’s and Region VIII’s largest safety net health care system, is an essential health care provider and a major corporate contributor to the well-being of the State of Colorado. Denver Health is an integrated care system and contributes to personal, community and public health and includes Rocky Mountain Regional Trauma Center, community health clinics, school-based health clinics, city’s detox facility, correctional care and the 911 system for the City and County of Denver.

Denver Health Medical Plan, Inc. (DHMP) is an entity of the Denver Health and Hospital Authority (DHHA) and is a full service health insurance plan licensed by the State of Colorado. Established in 1997, DHMP offers a full spectrum of health care services for managed care members through its principle service network at Denver Health and Hospital Authority and a variety of contracted services external to Denver Health. Current membership is comprised of a variety of lines of business including Medicaid, Child Health Plan Plus (CHP+), commercial plans, Health Exchange and Medicare.

The Mission Statement of Denver Health Medical Plan, Inc. (DHMP)

To provide quality, accessible and affordable healthcare services in the Denver area. In partnership with our providers we continually seek to improve the health and well-being of our members by:

- Promoting wellness and disease prevention
- Providing access to culturally diverse comprehensive health services
- Enabling members to play an active role in their health care
- Delivering our services with responsibility and respect to all

DHMP’s Complex Case Management (CCM) Program has been designed to support the mission of DHMP by enhancing the quality of patient management and satisfaction, to promote continuity of care and cost effectiveness through the integrating and functions of case management. The CCM program is available to any individual enrolled into any of the Denver Health Medical Plan insurances plans.

The CCM program provides intensive, personalized case management services and goal-setting for members who have complex medical needs and require a wide variety of resources to manage health and improve quality of life. Services are provided in a collaborative process that assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet an individual’s health needs, using communication and available resources to promote quality, cost-effective outcomes.

2014 Program Updates and/or Changes

Each year, based upon the evaluation and review of member satisfaction and effectiveness data, DHMP, Inc. will make updates and/or changes to the Complex Case Management process to address member needs, if necessary. Evaluation results will be shared with staff and staff training will be provided to ensure understanding of any programmatic changes to the current process for the upcoming year.
In reviewing data from October 1, 2012 to September 30, 2013, the CCM program found areas of improvement to the CCM process that would improve coordination of care and services to members. Updates and/or changes to the CCM program and process include but are not limited to the following:

- Revise and expand program criteria for inclusion to include more clinical diagnoses and conditions (e.g. cancers, diabetes, trauma, complex medical conditions)
- Incorporate the use of predictive analytic reports from Guiding Care™ to increase program enrollment, including Commercial members
- Improve outreach to providers to increase direct referrals to the CCM program (e.g. emails, newsletters, clinic presentations)
- Implement a new process to incorporate Nurse Advice Line data to ensure member needs are being met following contact with health information line
- Incorporate clinically based goals into the ongoing case management process, including staff training to improve clinical knowledge and understanding of conditions and use of those goals in the self-management action plan (SMAP)
- Incorporate use of patient education materials into ongoing case management process to reinforce clinical education and teaching
- Update Initial Comprehensive Assessment to include questions that will identify and address available community resources for all lines of business, including commercial
- Expand the current process to address readmission rates, including implementation of a post-discharge call within 72 hours for all lines of business
- Provide transition letters to members of all lines of business who are admitted to inpatient hospital setting to identify those who may benefit from CCM services
- Update Effectiveness Review script to include evaluation of the self-management tool (SMAP)

**Population Assessment**

At least annually, DHMP performs an assessment of the characteristics and needs of the entire member population and relevant subpopulations. The assessment will include, but is not limited to, the following characteristics:

- Age
- Race/Ethnicity
- Language Preference
- Nature and extent of carved out benefits
- Eligibility categories included in Medicaid managed care
- Special Needs Plan (SNP) enrollees
- Diagnoses distribution (including mental health diagnoses)
- Risk scoring (by predictive modeling software)

As a result of the assessment and consideration of relevant characteristics, the Case Management Leadership Team will use this information to:

- Design and define the programs included in complex case management
• Review and update the complex case management processes (e.g. cultural competency, program inclusion criteria, etc.) to address member needs, if necessary.
• Review and update complex case management resources (e.g. staffing ratios, clinical qualifications, job training, external resource needs and contacts, etc.) to address member needs, as necessary.
• Assess the complex case management needs of members and adjust procedures to facilitate linking members with complex case management services that meet their needs.

Goals and Objectives
The goal of the program is to help members regain optimum health or improved functional capacity in the right setting, utilizing the right providers, in the right time frame and in a cost-effective manner. It involves comprehensive assessment of a member’s condition to include but not limited to determination of the available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring and follow-up. More specifically, the goals established for the Complex Case Management program for 2014 include:

*Improve Self-Management*
• At least 75% of Commercial members in CCM will demonstrate improvement in self-management.

*Increase Member Satisfaction*
• At least 75% of Commercial members in CCM will express satisfaction of a 4 or 5 with the question “How helpful was your CM in helping you understand your health better?”

*Reduce Inpatient Re-admissions*
• Reduce total readmissions for Commercial to 5%.

Criteria for Inclusion in Complex Case Management
The following criteria are used to determine which members will benefit from the CCM program. Program criteria were established to provide the opportunity to participate in complex case management for members with a variety of complex conditions. Factors distinguishing complex case management typically include a degree of complexity of illness or condition that severe, level of management that is intensive and requiring an extensive amount of resources to obtain optimal health or improved functioning. Eligibility will start the date the member is identified as being eligible for CCM services, although, enrollment occurs when the member has provided consent to receive services. CCM is a voluntary program, so only members who agree and consent to the program are enrolled.

CCM program criteria are two pronged – risk factor/s and complex social needs. Members should have medical complexity that is compounded by related psychosocial, health behavioral needs.

Members with one or more of the following risks:
• Acute health care needs, diagnoses, or hospitalizations
• Complex medical issues and/or comorbidities
• Poorly controlled disease states
• Frequent admissions (3 within 3 months)
• Multiple Emergency Department (ED) visits (> 4 ED visits/rolling 3 months)
• Predictive modeling identified risk level

AND one or more of the following needs:
• Adherence to treatment (meds, visits, behavior change, diet etc.)
• Care Coordination (facilitate communication between providers, appointment making, transportation, specialty visits)
• Patient Education and Activation
• Community Resources (to identify, refer and access care for members
• No PCP visit in 6 months

Complex Case Management Process

The Complex Case Management program is voluntary and is provided at no cost to the member. A member must give verbal and/or written consent for enrollment in this program. The program is most successful with participation of the member’s family, caregivers and/or other support systems.

The CCM program will use a standardized case management process for all of its assigned members and consists of several key areas including but not limited to:

• Comprehensive Initial Assessment of member’s health
• Development of an individualized care plan
• Facilitation of member referrals to resources
• Follow-up and communication with members
• Self-Management Plans
• Assessment of progress against case management plans for members

Case Managers provide ongoing case management for as long as the member has identified needs and expresses willingness to receive support and services from the program. Case Managers maintain at least monthly contact, although may be more frequent, to address and meet varying member needs. Generally, case managers provide the following to all members enrolled in the program:

• support members adherence to care plans to improve health complexities
• advocacy to ensure appropriate services and resources are received
• education and promotion of self-management in order to empower members to take a more active role in their health
• coordinated and seamless integration of complex services and/or special needs
• appropriate and timely communication with members, practitioners, and hospitals
• systematic approach to assessing, planning and provision of case management services to improve health outcomes
• referrals to appropriate medical, behavioral, social and community resources to address member needs
Case Management Systems

The Complex Case Management program uses a customizable population care management software platform from Altruista Health, Inc. Altruista Health, Inc. provides software tools, data analytics and support services to help streamline clinical and administrative processes. Its products for health plans include GuidingCare™ for Health Plans, a member-centric web-based care management system designed to improve health outcomes and reduce avoidable costs for at-risk populations. Guiding Care™ system includes many features that provide the necessary tools and information to help case managers do their jobs effectively. Those features include but are not limited to:

- **Risk Stratification and Predictive Modeling** - an integrated predictive modeling engine using imbedded algorithms driven by evidenced-based guidelines and diagnosis-based risk methodology to automatically stratify patients by level of severity.

- **Identifying Care Gaps** – GuidingSigns™ has more than 300 clinical care, behavioral health and medication-related evidence-based indicators help identify gaps and other opportunities to improve member health.

- **Integration of Health Information Systems** – GuidingCare™ supports improved clinical decision-making and reporting with seamless data integration.

- **Up-to-date Case Management Framework** – superior clinical content based on the Milliman Care Guidelines are updated annually to effectively guide the daily workflow of clinical staff.

While Denver Health is an integrated system, case managers utilize various documentation systems to ensure assessments, care plans and case management information from DHMP is available to all providers within the health care system. Guiding Care™ is the primary case management documentation system for the CCM program, although, case manager’s provide additional summary notes on the Care Coordination Documentation Template, self-management action plans (SMAPs) and any other pertinent information on hospital approved forms that are stored electronically. Case managers primarily use two systems in the delivery of case management services:

- **Electronic Document Manager (EDM)** - a commercially-produced system that stores electronic medical records. This system is used by Denver Health Medical Center.

- **Lifetime Clinical Record (LCR)** - a commercially-produced web-based tool used by Denver Health Medical Center to store patients’ clinical information (e.g. lab results, visit history, medication profile, problem list, etc.) in an electronic format.

All care providers within the Denver Health system, therefore, have access to up-to-date case management documentation and services provided to members. This facilitates collaboration with health care providers in a more effective manner.

Evidence Basis for CCM Program

The Complex Case Management (CCM) Program was developed based on evidence-based guidelines from various sources including medical and behavioral healthcare specialty societies. These guidelines
not only helped to establish the care management processes, but also the content of the programs (disease specific guidelines).

The CCM program design was based on the Case Management Society of America’s (CMSA) *Standards of Practice for Case Management, 2010 revision*, which are the voluntary practice guidelines for the case management industry. Specifically, the CCM program uses a client-centric, holistic approach, encourages self-determination and self-care, integrates behavioral change science and principles, links with community resources and assists with navigating the health care system –within the framework of cultural competence and professional excellence. The program also promotes quality outcomes and has established periodic assessments to measure and track the outcomes.

The roles of the Complex Case Managers are consistent with those outlined in the guidelines: assessment, care planning, communication and coordination, education, empowering and advocacy. The program also follows the case management process detailed in the guidelines: member identification and selection, assessment and problem/opportunity identification, development of care plan, implementation of interventions, and evaluation of progress and termination of the case management process.

The CCM Program also uses the following clinical practice guidelines to guide patient education related to specific disease states:

**Asthma**
*Guidelines for the diagnosis and management of asthma*
National Heart Lung and Blood Institute
[www.nhlbi.nih.gov/guidelines/asthma/asthqdln.htm](http://www.nhlbi.nih.gov/guidelines/asthma/asthqdln.htm)

**Depression**
*Clinical practice guidelines for the diagnosis and treatment of depression*
American Psychiatric Association
[http://psychiatryonline.org/guidelines.aspx](http://psychiatryonline.org/guidelines.aspx)

**Diabetes**
*Clinical practice recommendations for the treatment of diabetes*
American Diabetes Association

**Heart Failure**
Guidelines for the diagnosis and management of heart failure
American College of Cardiology Foundation/American Heart Association
[http://circ.ahajournals.org/dgi/reprint/CIRCULATIONAHA.109.192065](http://circ.ahajournals.org/dgi/reprint/CIRCULATIONAHA.109.192065)

**Hypertension**
Guidelines on the prevention, detection, evaluation and treatment of high blood pressure
National Heart Lung and Blood Institute

**Obesity**
Prevention and Treatment of Childhood Overweight and Obesity
Member Satisfaction and CCM Effectiveness

At least annually, DHMP will evaluate the Complex Case Management program. The purpose of the evaluation is to determine the effectiveness of the program, identify areas of improvement, and outline interventions for the following year. The evaluation process includes, but is not limited to the following:

- CCM Satisfaction Survey results (member satisfaction)
- Member/Provider complaints

The Case Management Leadership team will review the results of the program evaluation and determine appropriate interventions to address opportunities for improvement, if applicable. The team will consider both qualitative and quantitative data to identify patterns in feedback. Feedback will be specific to the complex case management program and services.

Confidentiality

Individuals engaged in the Complex Case Management Program activities shall maintain confidentiality of all member information and any other information developed or presented as part of the Program. DHMP protects the confidentiality of member information in such a manner that is consistent with divulging or collecting only enough information from the member, subscriber, or appropriate healthcare provider that is necessary to conduct business activities. Activities and documents that are part of the CCM Program are considered confidential and are maintained in compliance with legal requirements.

Denver Health Medical Plan, Inc. has written policies and procedures to protect a member’s personal health information (PHI). The Case Management Department collects only the information necessary to conduct case management services or certify the admission, procedure or treatment, length of stay, frequency and duration of health care services. DHMP is required by law to protect the privacy of the member’s health information. Before any PHI is disclosed, we must have a member’s written authorization on file. Within the realm of utilization review and case management, access to a member’s health information is restricted to those employees that need to know that information to provide these functions. A full description of DHMP’s Notice of Privacy Practices may be found on our website at: http://www.denverhealthmedicalplan.com/Privacy.aspx