Children's Mercy
INTEGRATED CARE SOLUTIONS

Longitudinal Care Management

MANUAL

Longitudinal Care Management is an effective strategy for mitigating risk and improving health outcomes for patients experiencing complex clinical, mental and/or psychosocial issues. Longitudinal Care Management supports families in coordinating care across clinicians, settings, conditions and navigating the healthcare system. This process optimizes outcomes for patients and families while controlling costs and is a requirement of our contract with Blue KC.

9/30/24

Table of Contents

What is Longitudinal Care Management (LCM)?

- Patients experiencing **complex clinical, mental or psychosocial issues** impacting their health outcomes
- Supporting families in **coordinating care across clinicians, settings, conditions,** and navigating the health care system
- Optimizing outcomes for patients and families while controlling costs
- **Documented activity with care plan, goals, family, and provider engagement**
- Effective strategy for **mitigating risk** and improving health outcomes
- **Not a one time phone call** or for help with scheduling appointments
- **Beyond visit based diagnosis and treatment**

Care Management Program Levels

		Longitudinal Care Management (LCM)	
Level 1 Outreach Monitoring	**Level 2 Transitional Care**	**Level 3 Care Management**	**Level 4 Intensive Care Mgmt**
• Basic Needs • Addressing gaps in care	• Short term care management to ensure a smooth transition	• Chronic conditions • High risk conditions	• Multiple complex conditions poorly managed • Frequent hospitalizations
MINIMUM Contact Frequency			
1x every 3 months	1x per month x2 months	1x every 2 months	1x per month

All programs are voluntary.

Why is LCM Important?

Kids & families do better when we collaborate

Keeping kids healthy is good for our community

Better coordinated care leads to reduced overall costs

Primary Care First Care Management

The Blue KC Primary Care First Program is based upon a program established by the Centers for Medicare and Medicaid Service (CMS). A Primary Care First Delivery Interventions Guide was developed to provide common care delivery model intervention definitions, descriptions of the value of care delivery activities, and provide useful resources. Within this guide, there is a section on Care Management that includes additional information on risk stratification and care management.

Risk Prioritization Logic & Communication

Risk Prioritization Algorithm Objectives

1. To identify and prioritize the highest risk patients that would most benefit from & be targeted for longitudinal care management (LCM) services.
2. To increase awareness of high risk patients, so practices can support warm hand-off referrals to either centralized or decentralized (i.e. within a practice) care navigation services.

Risk Prioritization Algorithm Inputs

The algorithm was designed based on 4 key inputs, including risk score, acute utilization (inpatient admissions, ED visits), chronic condition complexity, and the presence of "critical" social needs.

Risk Score

The risk score is defined based on the patient's age, gender, medical diagnoses, and prescription medication history over the prior 24 months. Risk scores are presented as relative risk ratios based on an average patient with a risk score of 1.0. In other words, a patient with a risk score of 2.0 is expected to be twice as costly, and a patient with a risk score of 0.9 is expected to be 10% less costly. For the risk prioritization algorithm, a patient is placed into one of the following categories based on their risk score.

Risk Score Category	
Extremely High	10 or above Risk Score
Very High	>=5 and <10 Risk Score
High	>=2 and <5 Risk Score
Moderate	>=1 and <2 Risk Score
Low	>=0 and <1 Risk Score
None	No Risk Score

Acute Utilization

Acute utilization is evaluated based on the total number of acute utilization points in the prior 12 months, where each inpatient admission counts as 3 points and each ED visit counts as 1 point. Only non-delivery and non-newborn admissions are included in acute utilization points. All ED visits are included. For the risk prioritization algorithm, a patient is assigned into one of the following categories.

Acute Utilization Points	
In the previous 12 months, acute utilization points are totaled where each ED visit counts as 1 point and every inpatient admission counts as 3 points.	
Acute Utilization Category	
High	7 or more Acute Utilization Points
Moderate	4 to 6 Acute Utilization Points
Low	1 to 3 Acute Utilization Points
None	0 Points

Chronic Condition Complexity

Chronic condition complexity is based on chronic condition classifications defined by AHRQ (Agency for Healthcare Research and Quality) databases. A chronic condition is considered a 'complex chronic condition' (i.e. a progressive condition that is associated with deteriorating health with a decreased life expectancy in adulthood) when 1 or more ICD-10 diagnoses associated with the patient are considered 'progressive' diagnoses as defined by Kaiser Permanente Washington Health Research Institute. For the risk prioritization algorithm, a patient is assigned into one of the following categories based on the number of chronic conditions and number of complex chronic conditions. For counting purposes, a complex chronic condition counts as both a chronic condition and a complex chronic condition.

Chronic Condition Complexity Category	
Very High	10 or More Chronic Conditions OR 2 or More Complex Chronic Conditions
High	5 to 9 Chronic Conditions OR 1 Complex Chronic Condition
Moderate	3 to 4 Chronic Conditions
Low	1 to 2 Chronic Conditions
None	No Chronic Conditions

Although not currently used within the existing risk prioritization algorithm, each chronic condition is associated with one primary body system and each patient has a total count of chronic condition "body systems". These chronic condition body systems are presented in the risk prioritization report.

Critical Social Need Identifier

A patient is identified as having a "critical social need" if the patient has one of the following diagnoses related to employment, transportation, housing, or food insecurity in the past 4 months.

SDOH Needs Indicator Definition		
Set to "Yes" if presence of one of the following SDOH diagnosis codes in past 4 months.		
SDOH Category	**SDOH Dx Code**	**SDOH Dx Description**
Employment	Z56.0	Unemployment unspecified
	Z56.1	Change of job
	Z56.2	Threat of job loss
Transportation	Z59.82	Transportation insecurity
	Z91.89	Other specified personal risk factors not elsewhere classified
Physical Environment / Housing / Food Insecurity	Z58.6	Inadequate drinking-water supply
	Z58.81	Basic services unavailable in physical environment
	Z59.00	Homelessness unspecified
	Z59.01	Sheltered homelessness
	Z59.02	Unsheltered homelessness
	Z59.10	Inadequate housing
	Z59.11	Inadequate housing environmental temperature
	Z59.12	Inadequate housing utilities
	Z59.19	Other inadequate housing utilities
	Z59.41	Food insecurity
	Z59.48	Other specified lack of adequate food
	Z59.5	Extreme poverty
	Z59.6	Low income
	Z59.7	Insufficient social insurance and welfare support
	Z59.811	Housing instability, housed, with risk of homelessness
	Z59.812	Housing instability, housed, homelessness in past 12 months
	Z59.819	Housing instability, housed unspecified
	Z59.86	Financial insecurity
	Z59.87	Material hardship

https://www.kpwashingtonresearch.org/application/files/5915/6685/2221/consensus-definitions-for-medical-complexity.pdf

Risk Prioritization Algorithm

The risk prioritization algorithm uses the above inputs to define four risk priority groups. Each risk priority group combines two to three inputs to define a targeted patient population. The rank of each group is used to prioritize patients. In other words, the "Critical SDOH Need Identified & High Risk" group is prioritized first since it has rank of 1, followed by the "High Utilization & High Risk" group. Within each risk priority group, patients are ranked by descending risk score.

Rank	Risk Priority Group Name	Criteria
1	Critical SDOH Need Identified (within last 4 Months) & High Risk	- SDOH Needs Indicator = Yes AND - Risk Score Category = High, Very High, OR Extremely High
2	High Utilization & High Risk	- Acute Utilization Category = High AND - Risk Score Category = High, Very High, Extremely High, OR None
3	Moderate Utilization, High Risk, and High Chronic Condition Complexity	- Acute Utilization Category = Moderate AND - Risk Score Category = High, Very High, OR Extremely High AND - Chronic Condition Complexity Category = High, Very High
4	No Utilization, Very High Risk, & High Chronic Condition Complexity	- Acute Utilization Category = None AND - Risk Score Category = Very High OR Extremely High AND - Chronic Condition Complexity Category = High, Very High

Patient Exclusions: *Cancer (Malignant Neoplasms), Transplant*
These patients are excluded because many of the care programs associated with these conditions already have dedicated care management programs.

IMPORTANT: The risk prioritization algorithm runs on a monthly basis to help identify and prioritize patients for longitudinal care management services. Please note, the patients on the list are simply potential targets for LCM services and may be outreached throughout the course of the year!

Risk Prioritization Communication Process

The monthly output of the risk prioritization algorithm includes patient demographics, the attributed PCP practice & provider, the patient's next scheduled visit with the attributed practice, whether the patient is a new/existing patient, the risk prioritization input characteristics, and a set of reference attributes (highest cost diagnosis, paid costs) for each patient.

How Distributed: Via Secure Email from sqlreportnotification@cmpcn.org
When Distributed: Last Friday of the Month
Distribution List: Communicated to Practice's Designated Care Management Contact(s) or as Directed by Practice.

Want to Add/Remove Email Contact? Please Let Your Network Rep Know.

Communication & Action Requested:

Subject: Longitudinal Care Management (LCM) Risk Prioritization Patient List
Content: Attached is a monthly "**Longitudinal Care Management Risk Prioritization Patient List**" for your practice. The patients included on this list are attributed to your practice and have been identified with two or more high risk factors (i.e. high risk score, high ED/Inpatient utilization, chronic condition complexity, and/or significant SDOH needs).

If your practice is participating in centralized LCM services, the patients on this list may be contacted to engage in Longitudinal Care Management. If your practice is performing LCM, please use this list to prioritize outreach & perform Longitudinal Care Management.

Please review the list and take the following actions as applicable.

- **Patients with Upcoming Visits with Your Practice:** Patients with scheduled visits over the next month are highlighted yellow. Please consider messaging the provider to potentially refer the patient for LCM services. To refer the patient for centralized LCM service, submit the e-form at https://www.cmics.org/cmreferral.
- **Request to Not Perform LCM Services:** If a patient is on the list for which your practice does not want any centralized longitudinal care management performed, complete this request using the following form: https://www.cmics.org/exclusion.
- **Feedback:** General feedback regarding the risk prioritization algorithm? Please email LCM@cmics.org or contact your CMICS network representative.

Please review scheduled appointments and message providers to help to support warm handoffs to longitudinal care management services! The success of the connection and value of LCM services is greatly enhanced with your referral and recommendation!

Example Risk Prioritization Report Output

CMICS Member ID	First Name	Last Name	Date of Birth	Gender	Phone Number	Attributed Practice Name	Attributed Provider	Next Appointment at Attributed Practice
						LEAWOOD PEDIATR	NAGY, MARY	
						LEAWOOD PEDIATR	STEIN, KAITLIN	
						LEAWOOD PEDIATR	SPEROPOULOS, AUNDRIA	
						KU PEDIATRICS	LEWIS, MICHAEL	03/18/2024

Status	Risk Stratification Month Added	LCM Risk Category	Risk Score Category	Risk Score	Acute Utilization Category	Acute Utilization Points	# of Admits	# of ED Visits
Existing	202309	Risk Priority Group 4: (No	05-Very High	5.80	00-None	0	0	0
Existing	202309	Risk Priority Group 3 (Mo	02-High	4.52	04-Moderate	4	1	1
Existing	202309	Risk Priority Group 3 (Mo	02-High	4.89	04-Moderate	5	1	2
Existing	202309	Risk Priority Group 4: (No	10-Extremely High	19.02	00-None	0	0	0

Chronic Condition Category	# Chronic Conditions	Chronic Conditions	# Complex Conditions	Complex Chronic Conditions	# Body Systems	Chronic Condition Body Systems
10-Very High	5	Chronic Fatigue|Condu	2	Other Nervous Syst	4	Cardiac|Metabolic|M
05-High	5	ADHD|Anxiety Disorder	0		2	Mental Health|Neur
10-Very High	10	ADHD|Anxiety Disorder	0		6	Dermatological|Endo
10-Very High	12	ADHD|Anxiety Disorder	1	Cerebral Palsy	6	Dermatological|Men

SDOH Need Indicator	SDOH Employment	SDOH Transportation	SDOH Phys Env Housing Econ	Highest Cost Diagnosis	Highest Cost Diagnosis Description	Highest Cost Diagnosis $ Value	Total Paid Medical Cost	Total Paid Rx Cost	Total Paid Cost
No	No	No	No						
No	No	No	No						
No	No	No	No						
No	No	No	No						

Chart Review/Clinical History

The goal of the chart review is to gain information on recent utilization, patient's status, SDOH needs, upcoming appointments, gaps in care, and demographic information that may assist in outreaching the family.
Areas to review:

Innovaccer-Integrated Care Solutions Population Health Platform

- Contact info and email
- Acute Utilization & Notes
- Gaps in Care/Recommended Care
- Lab Tests
- Diagnostic Imaging

Internal EHR

- Demographics
- Utilization
- Medications

Cerner My Patient Connections EHR

- Visit List
- Demographics
- Insurance
- Documents from recent visits

Outreach Process

At least three attempts are made to outreach a family.

- Calls should be made on different days of the week and different times of day.
- Email may also be used to contact a family but should exclude PHI.
- Document each attempt to contact a family.

Call Script

	**Call answered:** Hello, my name is Lindsay. I am a Care Navigator calling on behalf of (PCP Name) about (child's name). • What is your name? Are you her/his parent or guardian? • For security purposes can you please verify (child's name) DOB and address? • (PCP name) shared (child's name) has a chronic or complex condition you are managing and wanted me to see if I may be able to assist. • I'd like to ask you a few questions about (child's name) and your family to see how I may be able to help.
	**Voicemail:** Hello, my name is Lindsay. I'm a Care Navigator calling on behalf of (PCP Name/Practice). I want to share information regarding care management support available to you. Please give me a call back at (phone number). Thank you!
	**Email:** Hello, I am a Care Navigator reaching out on behalf of (PCP Name/Practice). I want to share information regarding care management support available to you for your child's healthcare needs. Please contact me via email or phone with any questions. If you are not interested in care management at this time, please let me know. Thank you!

Assessment

- Name/Age/DOB
- PCP
- Address/Phone
- Secondary insurance
- Household information (who lives in the home)
- Diagnoses
- Utilization
  - ED visits, hospitalizations, ambulatory care
  - Including physical and mental health
- Medications
- Current care providers and services
  - Home care, therapy, DME, etc.
- Education status and recent attendance
- Cultural preferences
- Depression Screening
  - PHQ for patients ≥ 12
  - PSC for patients <12
- Barriers to care
- Primary concern of parent
- Option to enroll in Longitudinal Care Management
  - If agreeable, follow-up plan

Clinical History/Chart Review

Pre-Assessment Documentation Example:

Referral received 3.11.24 via Blue KC Risk Prioritization report. Susie is a 14yo (DOB: 4/2/2009) female with past medical history of pneumonia, hypoxemia, dysphagia, congenital malformations, failure to thrive, and epilepsy. PCP is Mickey Mouse with ABC Pediatrics. Home address is 123 Main, KCMO.

Utilization: *High inpatient utilization with 6 inpatient stays in the last year for C-diff, pneumonia, epilepsy, and cough. 1 ER visit and 3 UC visits noted. Per CMH EHR, followed by Cardiology, Rehabilitation, and Pulmonology. Upcoming appointments: Cardiology on 3.19.14, Rehab 4.2.14, and Pulmonology 6.5.14.*

Medications: *Albuterol PRN, clobazam, clonazepam, Epi pen, esomeprazole, Flovent, gabapentin, levetiracetam, ondansetron PRN, valproic acid.*

Gaps in care: *Annual well child checks and pneumococcal vaccine per Innovaccer. Per claims, last well child check completed 5.23.22.*

SDOH: *No SDOH needs identified in chart review.*

Assessment Documentation Example:

Patient identified through Blue KC Risk Prioritization report. Assessment completed with parent, Joe Smith at 816-111-2222 on 3.24.24 at 1530. Parent confirmed address at 123 Main, KCMO and provided email address of joesmith@acb.com. Susie lives with both biological parents and 2 younger siblings. Susie is in 8th grade at ABC Middle School.

Parent reports Susie was recently hospitalized and is struggling to get back to baseline and has missed a lot of school due to recent illness and hospitalization. The family is unclear on the next steps for Susie's healthcare and feels overwhelmed with all the providers and appointments. Susie did not receive her ABC medical equipment post discharge and was not able to fill all her prescriptions. Family is aware of upcoming appointments but can't recall dates, times and locations. Depression Screen completed with no new needs identified.

Care Navigator offered Longitudinal Care Management services to support the family during this difficult time. Parent is agreeable.

Barriers to care are transportation and general coordination of health care needs.

The primary concern of the parent is coordinating transportation for follow-up appointments, getting needed equipment and medications, and getting Susie back to school.

The following goals were set with the parent:

- *Parent will contact ABC equipment company to inquire about needed supplies*
- *Parent will contact ABC pharmacy to request delivery and automatic refills*
- *Parent will contact ABC school to request a meeting with the counselor*
- *Parent will utilize natural supports to assist with transportation to appointments*

Next Steps: *Care Navigator will follow-up with parent in two weeks to assess progress on goals and provide ongoing support navigating the health care system.*

Care Plan (Recommendations and Goals)

Update each time contact is made or attempted

- Include barriers, interventions, goals, next steps, and plan for follow-up
- Goal ownership and due dates
- Ongoing updates
- Sample below

Patient Name: Susan Smith	**Patient DOB:** 12/21/2007	**Date:** 9/18/2023
Date Opened in CM: 9/18/2023	**CM Name:** Cori Paschang	**CM Phone:** 816-601-4534

Reason(s) referred to CM: Pregnancy

Barriers Identified	Interventions	Goals	Owner
Patient newly pregnant and 15 years old and requires supervision/assistance for pregnancy needs	Assist patient in rescheduling appointments and keeping scheduled appointments. Patient and parent will continue to attend scheduled OBGYN appointments with Northland Obstetrics during pregnancy.	Patient attends appointments as scheduled	Patient
Patient's mother would like assistance with first and last month rent deposits to obtain more accommodating housing for family	CN will sent referral to CRS for possible community agencies that can help with deposits	Patient, family, and/or caregiver has been connected with appropriate community resources to improve social or financial support systems	CRS
Patient is not enrolled in WIC	Facilitate referral to WIC	Patient is enrolled in WIC	Caregiver
Patient on waiting list at Tri-county for therapy	CN will send mom a list of additional mental health agencies to explore for possible therapy providers	Patient connected with appropriate behavioral health services	Caregiver
Patients new born does not have insurance coverage	Provide referral/assistance with MO Healthnet Application	Patients newborn has insurance coverage	Patient

Case Closure Process

Cases will be closed when:

- The patient achieves their goals.
- The patient cannot be reached by phone or email after 3 contact attempts
- Family requests to close case
- Blue KC coverage ends
- Documentation will include closure date and reason for closure.
- Communication will be shared with the primary care provider when cases are closed and the reason for closure.

Documentation Expectations

All interactions and attempts to reach the family will be documented in the EHR.

Documentation will include:

- Date and time of outreach
- Verification of demographic information with each outreach
- Name and contact information for the person providing information
- Summary of the conversation including clinical status and diagnosis
- Plan for next steps
- Name and credentials of the Care Navigator

LCM Referral Process & Expectations

- E-Referral form located here: https://www.cmics.org/cmreferral
- You may also complete the referral form manually and email to LCM@cmics.org or fax to 1-888-670-7260.
- If you do not want a patient on your monthly risk report to be contacted, please complete the exclusion form located here: https://www.cmics.org/exclusion.
- For urgent needs or questions regarding referrals or care management activity, please call CMICS at (888) 670-7262.

Longitudinal Care Management Referral Reasons

- Multiple comorbidities
- Complex treatment regimens
- Poorly managed chronic conditions
- Technology assisted or DME dependent
- Child at risk for admission or re-admission
- SDOH needs creating barriers that limit the child from reaching optimal wellness

Care Navigation Summary Communication

Care Navigation Summary Reports from ICS to practices with active patients
Reports will be sent to the identified contact at your practice. If you have automated reports going directly to your EHR, these reports will be sent via the same process.

- At case open
  - Send "case open letter"
- Monthly
  - Send most recent note within last month (if no activity for the month, no update will be sent)
- At case close
  - Send "case closure letter"

IMPORTANT: Practice Workflow Integration Expectations
To support continuity of care and collaboration, the practice contact will add each patient's Care Navigation Summary report into the EHR message center/inbox for applicable patient and provider.

Initially, the CMICS outbound communication process will be conducted manually to develop and refine the process and confirm the need and value of automation.

Audit Process

Practices independently performing longitudinal care management will have quarterly audits. An ICS staff member will coordinate time to review your risk report and documentation to ensure protocols and procedures are followed and meet the requirements set by Blue KC. The audit tool used by the ICS staff member is shown on pages 13-14 for reference.

CMHN Blue KC LCM Audit

Practice Name	
Practice Contact	
Audit Period	
Audit Date	

Total Number of Patients Identified from Risk Report	
Total Number of Patients Identified for Contact	
Total Number of Patients Unable to Contact	
Total Number of Patients Screened & Declined Needs	
Total Number of Patients Opened in LCM	

Items Identified for Improvement:

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CMHN Blue KC LCM Audit

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Screening Outcome	Opened	Opened	Opened	No Further Needs	No Further Needs	Closed	Closed
	Screened & Opened in Case Management			Screened, No Needs Identified		Contacted & Declined LCM or Unable to Contact	
Member ID:							
Month of Identification							
Identification & Review							
Clinical history reviewed and documented							
Appropriate number of outreach attempts (3)							
Screening/Assessment							
Screening completed date							
Documentation includes name and contact information for person providing information							
Documentation includes verification of demographics							
Condition specific assessment of diagnosis							
Medication reconciliation							
Depression screening (PHQ) completed for patients ≥12 or PSC completed for <12 with BH Needs *Starting October 2024							
Interventions							
Assessed and provided community resources to the patient							
Health education provided (wellness, benefits, chronic conditions, gaps in care and behavioral health)							
Careplan Development							
Barriers to care identified and addressed							
Care Plan goals include ownership and due date							
Goal entered addressing primary concern of parent							
Follow-Up							
Developed follow-up plan							
Follow-up with patient documented within planned timeframe							
Care plan/goals progress documented							
Closure							
Documentation of reason and date for case closure							
Documentation of contact attempts prior to closing case for inability to reach							