Small Rural Hospital Transition (SRHT) Project Guide
A Rural Hospital Guide to Improving Care Management: 2019 Update

Louise Bryde, Principal
Carla Wilber, Sr. Consultant

NATIONAL RURAL HEALTH RESOURCE CENTER

STROUDWATER

Webinar Objectives

Increase understanding of hospital care management best practices

Gain insight into care management roles and staffing needs, utilization review and discharge planning

Develop care management capabilities and competencies in order to transition successfully from fee-for-service (FFS) reimbursement to value-based payment

Background

- This updated *Care Management Guide* was developed to provide rural hospital executive and management teams with generally accepted best practice concepts related to Case Management and Care Management. We hope this Guide provides opportunities to improve Case Management performance within the hospital setting and to increase knowledge and understanding of Care Management functions in the continuing national transition from traditional fee-for-service reimbursement to a value-based, population-health-focused reimbursement environment.

- The Guide is also designed to assist State Offices of Rural Health Directors, Flex Program Coordinators, and Network Directors to gain a better understanding of Hospital Case Management (CM) best practices, so they may develop educational training to further assist rural hospitals with CM performance improvement.

Focus of the Guide

The Guide focuses on two broad areas of Case Management/Care Management:

- Current best practices and recommendations for process improvement in hospital-based Case Management, particularly related to roles and responsibilities and staffing needs for Utilization Review, Discharge Planning and Transitions of Care, Swing Bed Coordination, Core Measure management, and Clinical Documentation improvement
- An overview of the Care Management capabilities and competencies an organization must develop or procure to support successful transition from fee-for-service (FFS) reimbursement to a value-based payment environment

Population Health Transition Framework
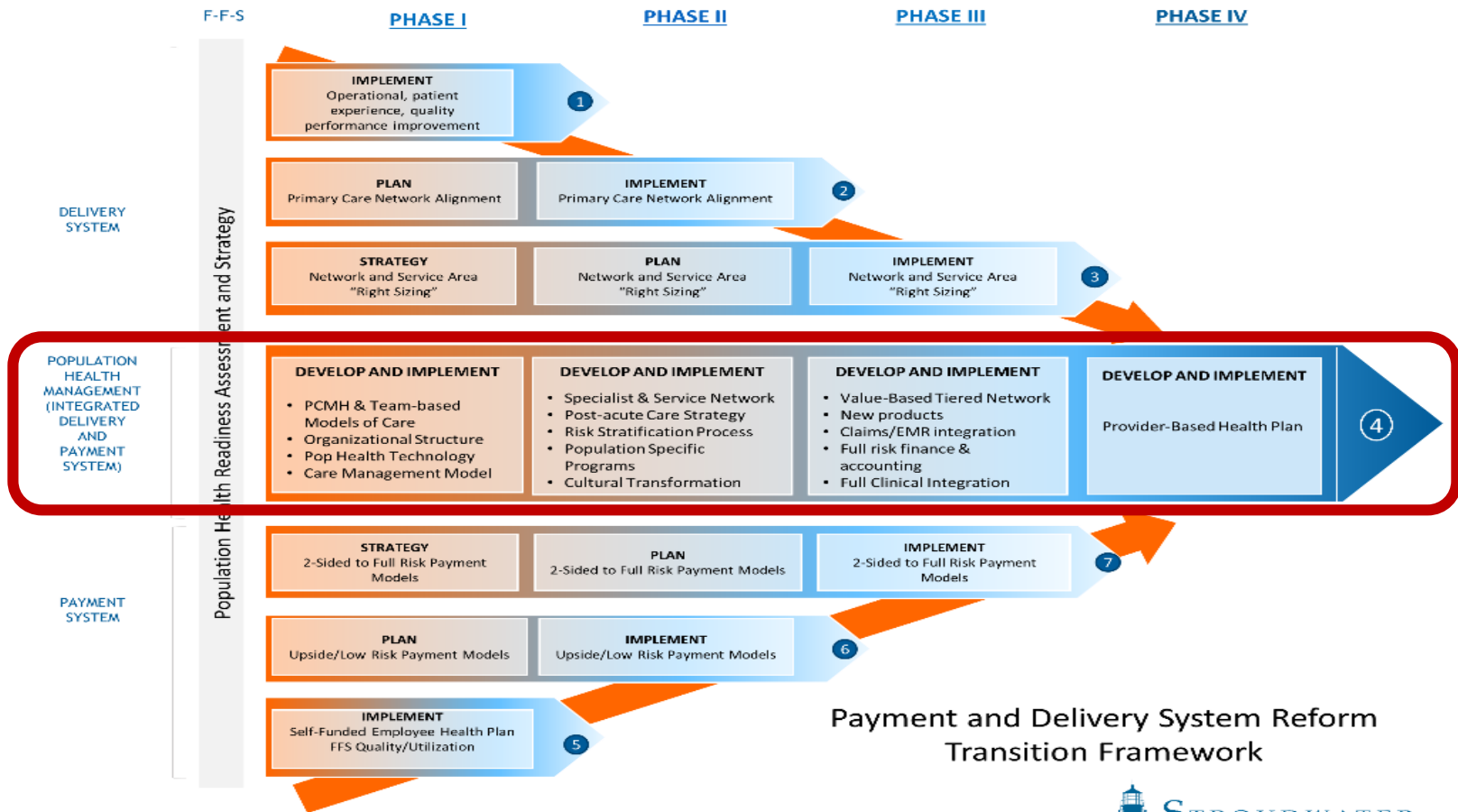
- A strategic framework designed to assist organizations in transitioning from a payment system dominated by the fee-for-service payment model to one dominated by value-based payment models

Population Health Transition Framework

➢ The **Delivery System** portion of the framework addresses the imperative to transform the current "sick care" model to a "health and wellness care" model, as the organization moves from FFS to value-based reimbursement.

➢ The **Payment System** section of the framework addresses the national imperative to proactively transition reimbursement from FFS to value-based payment.

➢ The **Population Health Management** row is the "backbone" and represents the elements (infrastructure, processes, resources, programs) required to create an integrated delivery/payment system able to support and succeed in a value-based reimbursement environment.

What Is Care Management and Why Is It Important?

- Care Management utilizes systems, science, incentives and information to:
  - Improve medical practice
  - Assist consumers and their support system to become engaged
  - Provide a collaborative process designed to manage medical/social/mental health conditions effectively
- The overall goal is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.
- Care Management is crucial to guiding and educating patients with complex healthcare needs through a complex healthcare delivery system.

Source: "Care Management Definition and Framework." Center for Health Care Strategies. December 28, 2016. Accessed July 01, 2019. http://www.chcs.org/resource/care-management-definition-and-framework/

Care Management Framework

Care Management Components	Definition	Tools / Strategies
Identification **Stratification** **Prioritization**	Identification, stratification, and prioritization should be used to identify consumers at the highest risk who offer the greatest potential for improvements in health outcomes. Programs should incorporate clinical and non-clinical sources of information to identify consumers who will most benefit from care management.	• Health risk assessments • Predictive models (algorithm–driven model that uses multiple inputs to predict high-risk opportunities for care management) • Surveys (e.g., Patient Health Questionnaire 9, Short Form 12) • Case finding (e.g., chart reviews, surveys) • Referrals (from member, provider, community)
Intervention	Interventions should be tailored to meet individual consumer need, respecting the role of the consumer to be a decision maker in the care planning process. Interventions should be designed to best serve the consumer, be multi-faceted, improve quality and cost effectiveness, and ensure coordination of care.	• Evidence-based practices • Interactive care plan, developed based on consumer-set priorities • Multidisciplinary care teams • "Go to" person • Medical home • Physical/behavioral health integration • Specialized patient engagement (e.g., self-management training)
Evaluation	Evaluation should include systematic measurement, testing, and analysis to ensure that tailored interventions improve quality, efficiency, and effectiveness. Careful and consistent evaluation will build the evidence base in terms of what works for complex and special need populations.	• Program evaluations • Rapid-cycle micro experiments (e.g., continuous quality improvement, testing, and program adjustments) • Representative measures of quality (e.g., HEDIS, CAHPS) • Representative measures of cost (e.g., ROI calculations)
Payment/Financing	Payment/financing should be aligned to support improvements in care management by rewarding consumers and providers for participating in interventions/evaluations and establishing accountability for quality and cost.	• Pay for performance at multiple levels (e.g., health plan, provider, and consumer level) • Share in program savings (gainsharing) • Case management/medical home payments

- Outlines and defines the key components of a comprehensive care management program and provides examples of tools and strategies that can be utilized to effectively meet the needs of patients with complex and special needs

What Is Case Management?

- The Case Management Society of America (CMSA) defines Case Management as a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.

  - Involves the timely coordination of quality services to address a client's specific needs in a cost-effective and safe manner, in order to promote optimal outcomes

  - The professional Case Manager serves as an important liaison and facilitator among the client, family or family caregiver, the interprofessional health care team, the payer, and the community

Hospital Case Management Best Practices

- Having organized routines and processes in place is crucial to an effective and efficient hospital Case Management (CM) program, as well as maintaining thorough records.

- Ideally, roles and responsibilities of Case Management are assigned to a clinician due to their background and versatility with any of the duties, as well as their experiences working together with physicians.

- Allocation of roles and responsibilities among the CM staff will vary depending on facility size.

  - For example, in rural hospitals where the UR and discharge planning positions are held by two people, both often have other duties such as core measure tracking and abstracting for Centers for Medicare and Medicaid Services (CMS), reporting, and follow-up telephone calls.

  - Ideally, these key individuals are placed within the same department organizationally.

Clinical Documentation Improvement

- More recently, CDI staff are frequently being added to the Case Management team to provide increased education/training for UR staff, reflecting the importance of thorough and accurate provider documentation.

- Improving accuracy and completeness of clinical documentation can reduce compliance risks, minimize a health care facility's vulnerability during external audits, and provide insight into quality of care and patient safety issues.

- Strong clinical documentation that appropriately captures the patient's medical status including co-morbidities, along with efficient coding, can improve revenue per discharge

- Additional information on Clinical Documentation Improvement (CDI) is available online at:

  - http://www.ahima.org/topics/cdi

  - https://en.wikipedia.org/wiki/Clinical_documentation_improvement

Hospital Case Management Staffing

In general, CM staffing should be based on average daily census (including acute, observation, and swing bed) and the overall scope of responsibilities of the CM team.
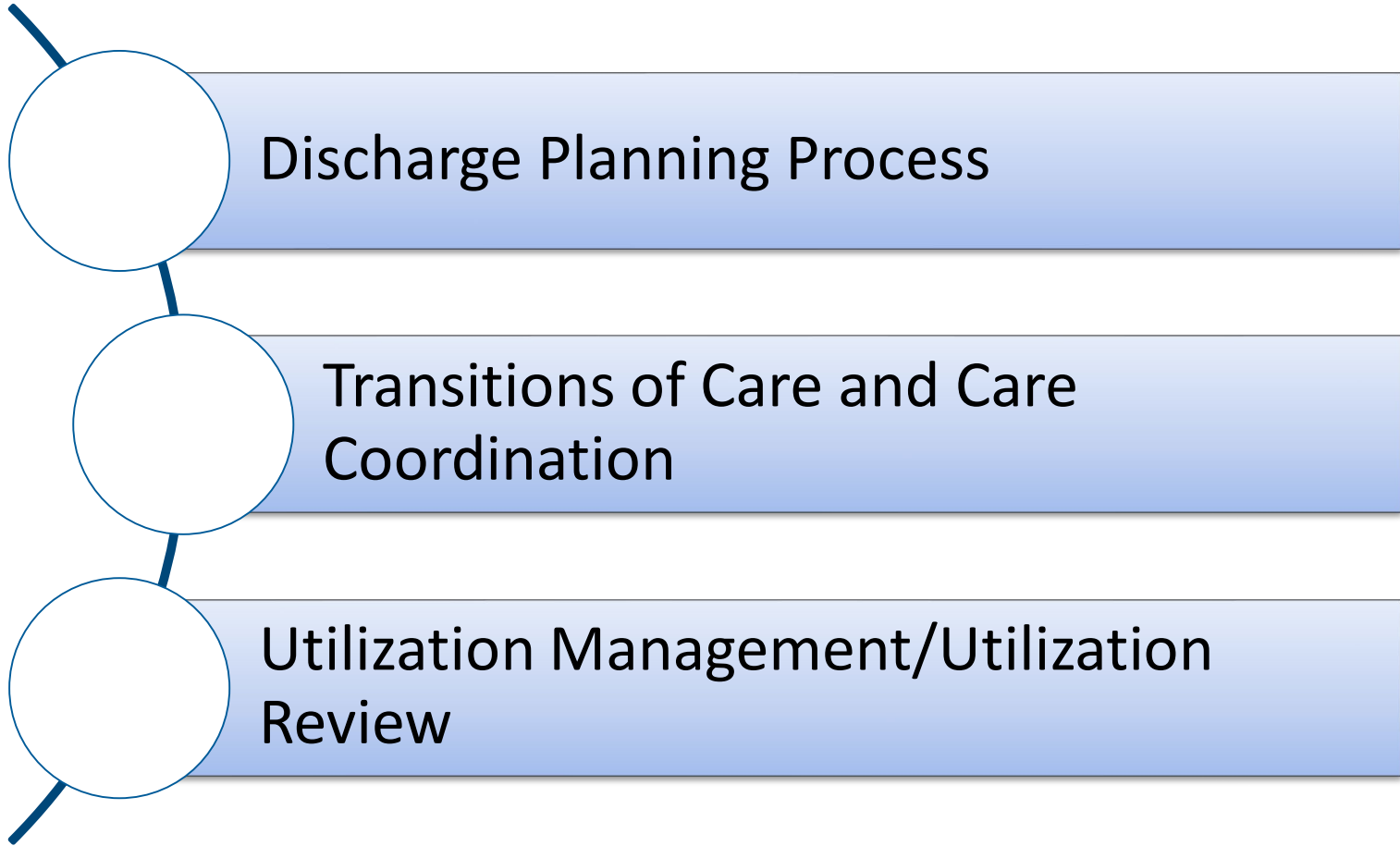
- If a SW is not available, then the registered nurse (RN) Case Manager may assume the medically-related social service responsibilities.

- If the hospital employs hospital (house) Supervisors for evenings, nights, and weekends, consider training the Supervisors to perform Utilization Review, which allows for an in-house resource available 24 hours a day, seven days a week, enhancing typical Monday through Friday UR support.

- Regardless of the size of the hospital and number of staff, all Case Management duties must be consistently provided to support facility operations.

- See the *CM Guide* pages 11-12 for additional recommendations.

Improvement Opportunities for Care Management & Case Management

What hospitals should consider when the goals are to improve health and reduce total cost of care:

- ✓ Data Analytics and Predictive Modeling
  - Identification of patient needs, high-risk populations
- ✓ Care Coordination
  - ✓ Discharge Planning
  - ✓ Care Transitions
- ✓ Patient Engagement/Collaboration
  - Develop a plan of care in partnership with patient/family
- ✓ Utilization Review/Management
- ✓ Performance Measurement

Core Hospital CM Responsibilities

Discharge Planning Process

Transitions of Care and Care Coordination

Utilization Management/Utilization Review

Discharge Planning Process

STROUDWATER

- The discharge planning CoP (and Section 1861(ee) of the Act on which the CoP is based) provides for a four-stage discharge planning process (see graphic on following slide):

  ➤ Screening all inpatients to determine which are at risk of adverse health consequences post-discharge without appropriate discharge planning

  ➤ Evaluation of the post-discharge needs of inpatients identified in the first stage, or of inpatients who request an evaluation, or whose physician requests one

  ➤ Development of a discharge plan if indicated by the evaluation or at the request of the patient's physician

  ➤ Initiation of the implementation of the discharge plan prior to the discharge of an inpatient.

Discharge Planning Process

1
- Screen patients

2.
- Assess post-discharge needs

3.
- Develop discharge plan

4.
- Implement discharge plan
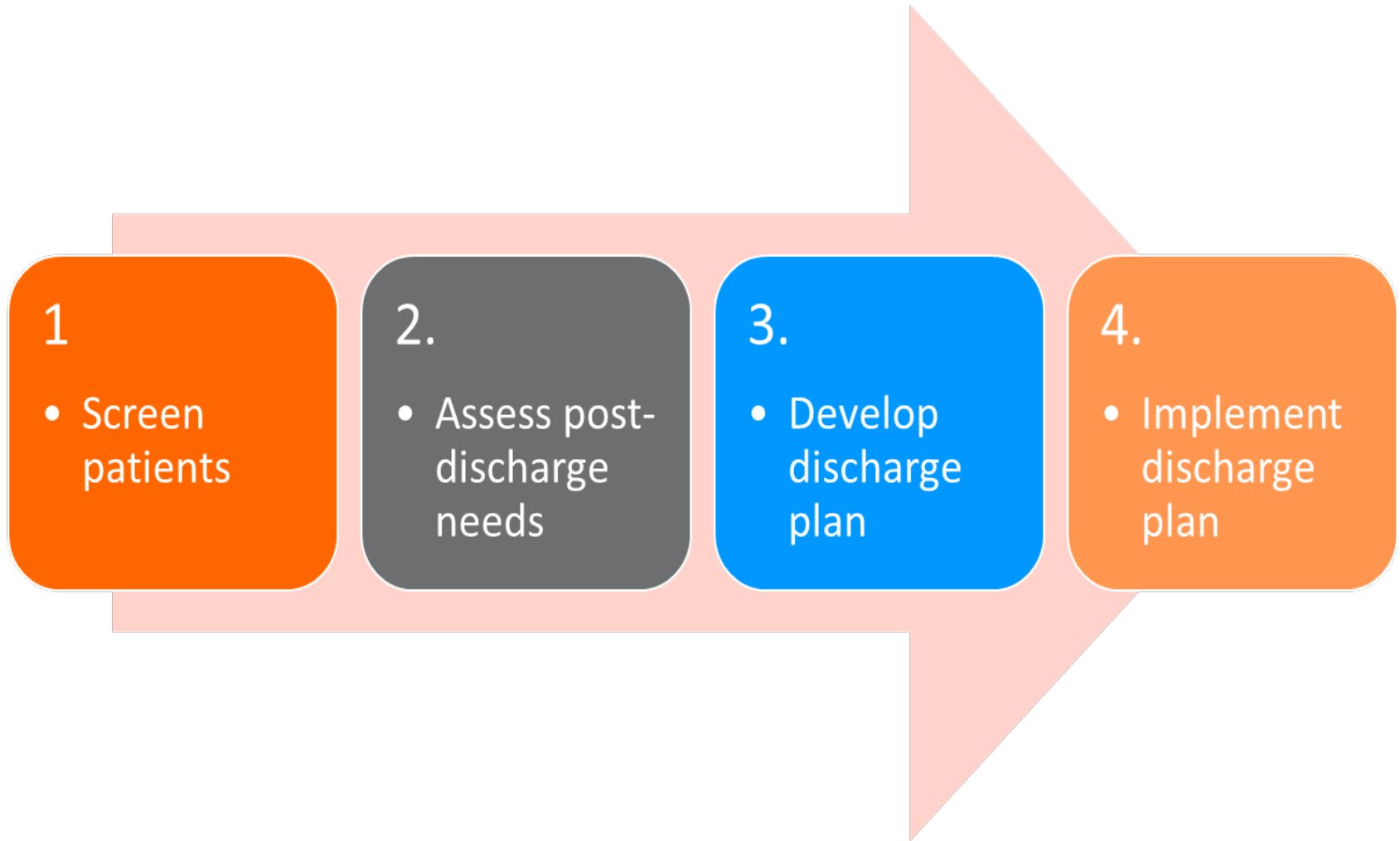
Discharge Planner Responsibilities

- Begin the discharge planning on admission (review nursing documentation within 24 hours if possible)

- Complete a discharge planning assessment

- Review advance directives unless done by social worker or patient advocate

- Facilitate interdisciplinary huddles

- If possible, round with provider

- Begin post-acute care planning early, focusing on patient/family/caregiver goals and treatment preferences
  - DME needs
  - LTC/HHA/Hospice

- Communicate with family/caregivers, if needed, to ensure clarity around discharge plan

Discharge Planning Tools

- Examples of available tools include:
  - Medicare's "Your Discharge Planning Checklist,"
  - Agency for Healthcare, Research and Quality's (AHRQ) "Taking Care of Myself: A Guide for When I Leave the Hospital,"
  - Consumers Advancing Patient Safety (CAPS) "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient Toolkit"

Transitions of Care

- The term "care transitions" refers to the movement of patients between health care settings/facilities (inpatient and outpatient, home with home health, nursing facilities and practitioners including PCP and specialists) as their condition and care needs change during a chronic or acute illness.

- Effective management of care transitions is a priority.

  - CMS expects hospitals to focus on preventing readmissions.

  - PPS hospitals pay a penalty if their avoidable hospital readmission rates are above a threshold established by CMS

  - There is a potential decrease in patient satisfaction.

  - High preventable readmission rates are costly to payers and may deter potential partners or affiliations.

What Is Community Care Coordination?

> At the Rural Care Coordination and Population Health Summit held in May 2019, the participants modified a Community Care Coordination definition provided by Stratis Health and adopted the following definition:

- Community Care Coordination is "a collaboration among health care professionals, clinics, hospitals, specialists, pharmacies, mental health, community services, and other resources working together to provide person-centered coordinated care."

Community Care Coordinator

STROUDWATER

- To provide seamless transitions of care, care coordinators are highly effective when working alongside the healthcare team. Care coordinators assume many roles and can assist in numerous areas, including but not limited to:
  - ➢ Culturally competent and linguistically appropriate care
  - ➢ Appointment scheduling and follow-up
  - ➢ Health education/Patient self-management support
  - ➢ Patient navigation/Care transitions/Referrals support
  - ➢ Care management
  - ➢ Medication management
  - ➢ Transportation assistance
  - ➢ Translation services
  - ➢ Program eligibility and enrollment assistance
  - ➢ Linkages to other community-based or social services

Post-Discharge Follow-up

STROUDWATER

- Best practice recommendation is for post-discharge follow-up calls to occur 24-48 hours post discharge and then weekly for 30 days.
- In addition, at a minimum, weekly follow-up calls should take place for patients with chronic diseases and/or if the patient is at risk for readmission.
  - Caller can become the liaison between the patient and their PCP/other providers
  - Some hospitals create extra support by involving a social worker
  - Findings from the follow-up calls are shared with the patient's providers
- Implementation of *Personal Health Records* (PHR) has also proven to be effective. Patients use their PHR to document and track information about the care they receive across care settings.
- Hospitals have also implemented Care Transition Intervention models, such as Dr. Eric Coleman's model.

Utilization Management/Utilization Review

STROUDWATER

- The term "Utilization Management" (UM) is often used interchangeably with "Utilization Review" (UR).
    - No single accepted definition for UM in the literature, although key elements of *medical necessity* and *appropriateness of care* are common across multiple definitions
- URAC defines UM as "the evaluation of medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health plan benefits, sometimes called UR."
- UM/UR involves review of care based on a determination of medical necessity.

Goals and Objectives of UM/UR

- Primary goals and objectives are to:
  - ➢ Provide appropriate care at the appropriate time in the most appropriate setting for the appropriate length of time to achieve optimal outcomes
  - ➢ Ensure that the patient is being admitted or initially placed in the correct level of care based on the patient's needs
  - ➢ Ensure ongoing care/length of stay are medically appropriate, in accordance with the Payer's relevant regulations/requirements for the services rendered and relevant standard treatment guidelines

Three Types Of Utilization Management

- *Prospective Review, also referred to as Prior Authorization or Pre-Certification,* refers to requests for approval of future planned medical care and services in order to reduce or eliminate services determined to be unnecessary.

- *Concurrent Reviews* are performed during treatment or an episode of care, particularly for inpatient hospital and Skilled Nursing Facility stays. Concurrent review also addresses requests for approval of additional treatments or procedures during an episode of care. Expected length of stay is generally monitored as a component of concurrent review.

- *Retrospective Reviews,* performed after health care services have been delivered; assessment of appropriateness of the services, setting, and timing of care in accordance with specified criteria. Such reviews often pertain to payment and may result in claims denials.

UM/UR Best Practices

- Review demographic information on face sheets of all new admissions

- Begin evaluation based on a new admission's payer requirements (Medicare, Medicaid, commercial payers, payers with managed care, self-pay)

- Review the physician's order for patient in an inpatient bed to ensure that the order for the level of care is very clear:

  - Admit to acute or place in observation

  - OP (obs) service in an IP bed

  - Extended OP in an IP bed

- Ensure the pre-certification notification is completed and documented for payers requiring it

UM/UR Best Practices (continued)

- Determine the certification requirements for payers based on priority (prioritize based on when the information must be reported to the payer)

- Review provider documentation

- Call payer case manager as necessary or use their required electronic form or fax results of review based on payer's requirement (maintain documentation)

- Notify the provider of the certification status

- Review Medicare charts for appropriate criteria to ensure that the right patient is in the right level of care

ACO Care Management

Focusing on Hospitals/Providers Participating in an ACO or Other Value-Based Contract

Definitions:

Accountable Care Organization (ACO)

- ACOs are groups of doctors, hospitals and other health care providers who come together voluntarily to offer coordinated high-quality care to their Medicare patients.

- In general terms, an ACO is responsible for the cost and care of any defined population. Examples of ACOs include Medicare Shared Savings Program (MSSP), Next Generation, Primary Care First, as well as Medicaid ACOs, and commercial ACOs.

ACO Definitions

ACO "Members"

- All value-based contracts must identify the population for which the provider organization is accountable and identify the method for attributing or assigning the population/members defined. CMS ACO members are defined as the ACO's attributed lives.

- "The ACO model requires that each ACO have a defined patient population for which the ACO will be held accountable for both total cost of care and quality performance. There are two major methods of defining, or attributing, patient populations to ACOs: the prospective method and the performance year method."

Source: Health Affairs (Millwood). 2013 March; 32(3): 587–595. doi:10.1377/hlthaff.2012.0489.

Population Health

- Population health is defined as **the health outcomes of a group of individuals, including the distribution of such outcomes within the group.** These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.

ACO Definitions (continued)

Population Health Management

- Population Health Management proactively identifies and addresses the needs of populations of people rather than focusing episodically on individual patients when they seek or access health care services.

Risk Stratification

- The process of categorizing individuals and populations according to their likelihood of experiencing adverse outcomes, e.g., high risk for hospitalization.

Source: "CMSA's Standards of Practice for Case Management, 2016." P. 36

Population Health Management

- Developing the infrastructure and capabilities to focus on population health management is essential in a risk-based reimbursement environment, particularly for ACOs participating in two-sided risk arrangements.
  - Registries are an important tool to enable the identification, monitoring, and tracking of sub-populations of patients within and across practices to identify and proactively address gaps in care, support chronic disease management, and promote timely preventive health screenings and services
  - Examples include:
    - Addressing due/past due diabetes care for all known diabetics within a selected sub-population
    - Sending out mammogram and colonoscopy reminders to members based on age and gender criteria, per agreed upon evidence-based clinical practice guidelines
  - Proactive outreach to identified sub-populations can be done via targeted mailings, email blasts, and other communication methods

Risk-Stratifying the Population

- Hospitals and providers participating in ACOs must develop or procure the capability to risk-stratify their patient population, including:
  - Selection of risk stratification criteria and a methodology to classify members into identified risk categories- for example, low-moderate/rising-risk/high-risk categories
    - Selected risk stratification criteria should reflect the population served by the ACO
  - Generally, risk criteria include inpatient hospital and ED cost and utilization data, pharmacy cost and utilization data, pertinent diagnosis and clinical conditions data, and increasingly, key social determinants of health (SDOH) data for that population.
  - Both claims data and EHR data are important data sources in the risk stratification process, as available.
- The identified risk categories can then be correlated with defined levels of intensity of Care management services offered to the respective risk levels.

Identifying ACO Members Who Need Ongoing Care Management

- Individuals with complex medical, behavioral health/substance use disorder and/or social determinants of health needs may benefit from ongoing, longitudinal care management.

- Completion of Care Needs Screening tools and Comprehensive Assessment tools, analysis of patient/member health care utilization and cost data, and patient/member risk stratification scores are utilized to identify individuals who would potentially benefit from ongoing care management services and support.

- See Appendix F in the *CM Guide* for a sample Comprehensive Assessment Tool and sample health screening tools.

Building an ACO Care Management Program

STROUDWATER

- Developing, implementing, and/or managing a comprehensive care management program are essential activities for any ACO, including Medicare ACOs, Medicaid ACOs, or commercial payer ACOs.

- According to the Agency for Healthcare Research and Quality (AHRQ), care management has emerged as a leading strategy to manage the health of populations. "Care management is organized around the principle that appropriate interventions for individuals within a given population will reduce health risks and decrease the cost of care."

Building an ACO Care Management Program

- A newly formed ACO must make key strategic and tactical decisions regarding its Care Management Program, including:
  - "Buy versus build" decisions, such as contracting with a third party for CM services versus building a program internally
  - Determination of ACO Care Management model, including:
    - Creation of centralized Care Management staff versus embedding care managers within individual Primary Care practices or Primary Care clinics or a hybrid model
    - Telephonic Care Management services versus face-to-face services or a combination
  - Determination of Care Management program goals and objectives and key performance metrics
  - Determination of the Care Management organizational structure and composition of Care Management staff
  - Selection of a Care Management electronic platform to house and manage care management-related assignments and documentation

ACO Care Management Staff Roles & Responsibilities

- Rural hospitals and clinics are often part of a larger healthcare system which may be participating in an ACO arrangement or the rural hospital may directly participate in an ACO.
  - Roles and responsibilities to perform Care Management functions and services at the local level will be based on the Care Management model selected by the ACO entity.
  - Important for organization to clearly define CM roles and responsibilities across the ACO entity.
- Unless the ACO has contracted with an outside party to perform Care Management functions on its behalf, ACO Care Management staff will typically have primary responsibility to perform core components of the Care Management process.
  - Work under the direction of identified ACO leadership, including regular ongoing access to physician leadership for medical direction and clinical oversight.

ACO Care Management Core Responsibilities

- Identify and engage ACO members in active Care Management via referrals to CM and via pro-active outreach to identified high- and rising-risk members with modifiable risk

- Perform a *Comprehensive Assessment* using standardized screening and comprehensive assessment tools

  - Utilize effective communication skills including active listening, motivational interviewing, and use of open-ended questions

  - See **Appendix F** for suggested resources regarding motivational interviewing

Source: Case Management Society of America. Standards of Practice for Case Management; Section VII. Components of the Case Management Process. Little Rock, AK. Revised 2016; accessed at cmsa.org

ACO Care Management Core Responsibilities
(continued)

- Prepare a member-centric *Case Management Plan of Care* in collaboration with member and their family/caregiver(s) and other members of the interdisciplinary care team

- Monitor and periodically follow-up with members receiving Care Management services, per established policies and procedures
  - Assist member to identify and address any barriers and update Care Management *Plan of Care,* as indicated

- Work with member and their family/caregiver(s) to determine appropriate timing of completion of Care Management services, per established case closure criteria and processes

- Assist with/perform care coordination and facilitate transitions of care, when members access care across multiple providers and/or across the ACO care continuum
  - Develop and implement standardized processes, workflows, and tools across the ACO entity to maximize efficient, timely coordination of care/transitions of care and to minimize gaps or duplication of services

ACO Utilization Management

Total Cost of Care is a critical metric for organizations participating in risk arrangements, particularly two-sided risk arrangements

ACO entity must periodically analyze and review cost and utilization data by service type, by diagnosis codes, by provider, and by provider type to identify patterns and trends and opportunities to reduce costs and utilization

Inpatient admission & readmission rates, ED visit rates, and total costs for pharmacy are critical ACO performance metrics

ACO Utilization Management (continued)

The ACO entity must implement standardized processes and procedures to collect, analyze, and report cost, quality, and utilization data on a regular, periodic basis.

- Must include timely sharing of results with ACO providers and staff

Many risk arrangements include quality performance thresholds which must be met for the ACO to receive quality bonuses or achieve shared savings.

- Essential for providers and staff to be aware of the ACO's quality metrics and performance targets and to align day-to-day clinical operations with achievement of the ACO's quality targets

CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

CHRONIC DISEASES IN AMERICA

6 IN 10
Adults in the US have a **chronic disease**

4 IN 10
Adults in the US have **two or more**

THE LEADING CAUSES OF DEATH AND DISABILITY
and Leading Drivers of the Nation's **$3.5 Trillion** in Annual Health Care Costs

Source: CDC.gov, accessed 10/28/19 https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

Medicare Chronic Care Management (CCM) Program

- CCM services are designed to address the complex needs of Medicare beneficiaries suffering from multiple chronic conditions.

- At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional is required in order to bill Medicare for the service **(CPT 99490).** Moderate or complex medical care, up to 60 minutes of clinical staff time must be recorded for billing purposes **(CPT 99487).**

- In addition to physician offices, CCM services can be provided by FQHCs, RHCs, and CAHs.

- The following healthcare professionals can bill for CCM services:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Certified Nurse Midwives
  - Clinical Nurse Specialists

- Services include:
  - Utilizing EHR to record patient health information
  - Development of a comprehensive care plan
  - Access to care and care continuity (24/7)
  - Comprehensive care management
  - Transitional care management

99490: $43.13   99487: $95.51
* For RHC: G0511

Source: Medicare Learning Network: Chronic Care Management

Medicare Transitional Care Management (TCM) Program

STROUDWATER

- TCM services are designed to prevent hospital readmissions by providing seamless care when a patient is discharged from an inpatient facility (hospital) to community-based care (clinic)

- Providers may conduct the following TCM components beginning at the day of discharge up to 30 days:
  - Interactive contact within 2 business days of discharge
  - Certain non face-to-face services
  - Face-to-face visit within either 7-14 calendar days of discharge

- Moderate complexity & face-to-face visit within 14 calendar days of discharge **(CPT 99495)**

- High complexity and face-to-face visit within 7 calendar days of discharge **(CPT 99496)**

- These health care professionals may furnish TCM services:
  - Physicians (any specialty)
  - Physician Assistants
  - Nurse Practitioners
  - Certified Nurse Midwives
  - Clinical Nurse Specialists

- May provide TCM services beginning the day of the beneficiary's discharge from an inpatient hospital settings (SNF, Acute Care Hospital, etc.) and after inpatient discharge, the beneficiary must return to their community setting (home, assisted living, etc.)

| 99495: $170.67 | 99496: $240.71 |

Source: Medicare Learning Network: Transitional Care Management

Medicare Behavioral Health Integration Services

- Behavioral Health Integration (BHI) services are considered an effective strategy to improve mental or behavioral health outcomes for Medicare beneficiaries.

- Medicare makes payment to physicians and non-physician practitioners for BHI services over a calendar month service period. BHI services include Psychiatric Collaborative Care (CoCM) services and General BHI services.

- **CPT codes 99492, 99493, and 99494** are used to bill for monthly services furnished using the Psychiatric Collaborative Care Model (CoCM).

- CoCM care team members include:
  - *Treating (billing) practitioner:* A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically, primary care, but may be of another specialty (e.g., cardiology, oncology)
  - *Behavioral Health Care Manager*: A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight & direction of billing practitioner
  - *Psychiatric Consultant:* A medical professional trained in psychiatry and qualified to prescribe full range of medications
  - *Beneficiary:* is considered a member of the care team

Medicare Behavioral Health Integration Services (continued)

CoCM Service Components

- Initial assessment by the primary care team (billing practitioner and behavioral health care manager).

  - Initiating visit (if required, separately billed)

  - Administration of validated rating scale(s)

- Care planning by the primary care team, jointly with the beneficiary, with care plan revision for patients whose condition is not improving adequately.

  - Treatment may include pharmacotherapy, psychotherapy, and/or other indicated treatments

- Behavioral health care manager performs proactive, systematic follow-up using validated rating scales and a registry.

- Regular case load review with psychiatric consultant.

Source: Medicare Learning Network: Behavioral Health Integration Services, May 2019

Presenter Bios

Carla Brock Wilber, Senior Consultant, is an accomplished nurse administrator with an extensive background in critical care, education, and emergency services. Carla came to Stroudwater from Wake Forest Baptist Health-Lexington Medical Center, where she was Director of Enterprise Excellence. Carla earned her Doctorate of Nursing Practice from George Washington University, where she was a member of the Sigma Theta Tau International Honor Society of Nursing. She holds a Master of Science in Nursing Leadership from East Carolina University, a BS in Nursing from Winston-Salem State University, and an associate degree in nursing from Davidson County Community College.

Contact Carla at 336-425-3837 or cwilber@Stroudwater.com.

Louise Bryde, Principal, joined Stroudwater in 2013 and brings to the firm more than 30 years of experience in healthcare management and clinical operations. She has a proven record of accomplishments in developing and executing initiatives to enhance access and improve quality and value of healthcare delivery in both the public and private sectors. At Stroudwater, she focuses on population health, strategic planning and operational improvement, and models of care, including Patient-Centered Medical Home and Team-Based Care initiatives. Louise Bryde holds a Bachelor of Science degree in Nursing from the University of Virginia and a Master of Health Administration degree from Georgia State University. She is a member of the American College of Healthcare Executives and is an NCQA Patient-Centered Medical Home Certified Content Expert.
Contact Louise at 770-206-9160 or lbryde@Stroudwater.com.