Clinical Case Management Process in the Military Health System
Recovery Care Coordinator (RCC) Course

August 2019
MHS High Reliability Operating Model

“Medically Ready Force...Ready Medical Force”
MHS-level Clinical Communities

“Medically Ready Force...Ready Medical Force”
Distribution of Illness Burden in the Direct Care Population

* Time Period July 2017-July 2018
Characteristics of the Case Management Population

Typically smallest percent of the population driving the largest utilization and spend

Likely had a recent hospitalization, significant exacerbation of chronic condition, or an acute/catastrophic event

Medically fragile and have significant care coordination needs

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Continuum of Population Health

Population Health Resource:
Monitors HEDIS metrics and identifies Pop Health Initiatives at the enterprise level. Identifies patients with gaps in care and referrals to appropriate resources

Utilization Management/Discharge Planning if hospitalization. Immediate D/C needs coordinated appropriate referrals are made

- Generally Healthy
  - Compliant with preventative care
  - IBI below 1
- Lifestyle modification indicated
- Labs indicate incipient risk of Chronic condition
- IBI of 1-2
- Been diagnosed with one or more chronic condition
- Heavy Utilizer of Healthcare system
- Potential Hospitalization
- Borderline instability
- IBI of 2-5
- Medically Acute
  - Likely hospitalized
  - Multiple chronic conditions
  - Medically fragile
  - IBI of 5 or above
- Previously in CM and referred to DM
  - Is unstable
  - Has one or more chronic condition
  - Heavy Utilizer of Healthcare system
  - IBI of 2-5
- Previously in DM
  - Ongoing Lifestyle modification indicated
  - Presence of chronic disease possible however patient independent in self management
  - IBI of 1-2

Health Awareness/preventative
Early Stage/Prevention/pre-breakdown Health Coaching
DM
CM
DM
Post-breakdown Health Coaching

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CASE MANAGEMENT IN THE MHS
Role of the Case Management in the MHS

Case Management Definition:

- 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
The Goal Of Case Management

- The goal of complex CM is to help members regain optimum health or improved functional capability, in the right settings, and in a cost-effective manner. It involves a comprehensive assessment of the patient’s condition; determination of available benefits and resources; and development and implementation of a CM plan with performance goals, monitoring, and follow-up. The military case manager’s primary role is as an advocate for the patient and his/her family/caregiver within the MHS. Case Management is not focused on a specific disease, but rather takes a holistic approach to comprehensive management.

- There are many ways a patient would be identified for Case Management:

  - Command Referral
  - Self Referral
  - Post-discharge referral
  - PCM referral
  - Specialist Referral
  - High utilization list
  - Case Management Screening Registry

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Nursing Process

“Medically Ready Force...Ready Medical Force”
Case Management Process

"Medically Ready Force...Ready Medical Force"
Case Management Engagement Process

No wrong door for CM referrals

Attribution
- Patient attributed to an MTF

Identification
- CM Screening Registry
- PCM, Specialist, other provider or self referrals
- Recent hospitalization
- High utilizer lists

Engagement
- Patient is contacted by a CM if appropriate
- Care Plan implemented and goals continually reassessed until patient is compliant in self-management and case is closed

Assessment
- CM assessment completed
Sample of Case Management Screening Registry

The Case Management Screening Registry is an algorithm-based registry, which uses the Random Forrest Model for analysis. It serves as a standardized way to identify patients who should be screened to determine if they might benefit from Case Management and reduce the possibility that a direct care patient in need of Case Management may be missed.

- Once the algorithm identifies a patient for screening, they will appear on the Case Management Screening Registry in Carepoint.
- Since Case Management is contingent on patient need, rather than a particular diagnosis, the registry is not condition-specific.
- An MTF Case Manager will follow up, assess and determine if the patient is eligible for and interested in Case Management.

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Sample of Case Management Tri-Service Work Flow (TSWF) Form

- Case Managers use the Case Management TSWF form found in AHLTA to document elements of their engagements with patients.

- This form allows for minable data elements to be extracted to provide insight into the patient population and reflect the impact of Case Management at the population level.
Harnessing the Power of Data

Through the collection and analysis of data extracted from program specific codes, clinical documentation, systems and registries, we have been successful in identifying a baseline of clinical and engagement demographics of the patient population at a programmatic level.

From there we are able to trend month/month and quarter/quarter to monitor the success and engagement of the programs. This data empowers our ability to measure outcomes of programmatic enhancements, return on value, improved patient outcomes and patient satisfaction.
Medical Management Reporting

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Key To Success

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Identifying the Level of Illness and Wellness of the Population

• Every month an Illness Burden Index Score (IBI) is calculated for every beneficiary in the MHS independent of their health or level of engagement with the health care system. The IBI is calculated based on a number of variables called Adjusted Clinical Groupers (ACG’s), developed by a Johns Hopkins proprietary algorithm.

• ACGs are a series of mutually exclusive, health status categories defined by morbidity, age, and sex. They are based on the premise that the level of resources necessary for delivering appropriate healthcare to a population is correlated with the illness burden of that population.

• The IBI Score is one way we identify and align resources to provide the most appropriate level of support at the right time, in the most cost effective setting.

• Those individuals with an IBI of 1.0 or below are generally healthy, while those with an IBI of 1.0 or higher likely have incipient risk for chronic illness, have been diagnosed with a chronic condition or have had some type of medical event yielding high utilization of services and cost.