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SAPC: CASE MANAGEMENT MODEL OF CARE OVERVIEW

Substance Abuse Prevention and Control (SAPC) understands that individuals with substance use disorders (SUD) frequently have co-morbid conditions, face barriers in access to primary care, and require extensive wrap around services. As individuals are enrolled in treatment services, different interventions/supports will likely be required to ensure individual needs are met with the appropriate level of service.

To effectively address this spectrum of service needs, SAPC is considering a comprehensive, highly-flexible, community-based care coordination approach that will organize a system of care for every SAPC enrollee requiring case management services. This approach is not “business as usual” for SAPC – it aims to build on existing Los Angeles County and community/partner experience providing integrated, coordinated, managed care for complex Medi-Cal populations. The SAPC model of care is an enhanced and comprehensive program that includes wrap-around services specific to individuals with SUD, reflects nationally recognized best practices, and is informed by stakeholders.

For purposes of this document, the following definitions are utilized to describe Care Management, Care Coordination and Case Management. Although there is potential for overlap between some of these functions, it is important to understand the distinct functions described, particularly for the roles requiring a certain level of clinical judgment (i.e. care management), and determine the level of need and staffing required to meet those needs.

CARE MANAGEMENT

Care management programs apply systems, science, incentives, and information to improve medical practice and help patients manage medical conditions more effectively. The goal of care management is to improve patient health status and reduce the need for expensive medical services. The principal challenge is finding effective ways to change clinician and patient behavior.¹

Care management in the outpatient setting is typically performed by a registered nurse (RN) or an individual with a bachelor’s degree of science in nursing (BSN), certified substance use counselors, and licensed practitioners of the healing arts (LPHAs). The level of education, experience and training this professional has can change the scope of the position. An RN is preferred because there is frequently a level of clinical assessment or judgment required. An RN Care Manager can work independently with patients to set self-management goals to improve health, triage health issues and help the patient manage certain chronic diseases such as substance use disorder, seizures, coronary artery disease and diabetes.

According to research findings presented at a 2004 Princeton Health Industry Forum by Robert Mechanic, care management refers to the more intensive care provided to patients considered to be high-risk based on high-risk of inpatient admission, emergency room utilization, medical

¹ <http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Improving-Care-Complex-Patients.pdf>

decompensation, behavioral health decompensation, or relapse.² It encompasses both referral/transition management and clinical services such as monitoring, self-management support and medication review and adjustment. Whereas in most practice panels, a large percentage of the patients will at some point be referred or hospitalized and need care coordination services, only a small subset of the most acutely or chronically ill patients will benefit from care management services.

CASE MANAGEMENT

The role of the case manager is broader than health care. The case manager addresses the other social determinants of health and assists patients with things like housing, domestic violence, food assistance, etc. The Case Management Society of America defines case management as “a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes”. For the purposes of individuals living with SUDs, case managers are an important part of a multi-disciplinary provider team. Case managers help manage transitions from inpatient, residential and long-term treatment to outpatient and community-based care, helping individuals move effectively from one level of care to another within the substance use service continuum.

CARE COORDINATION AND NAVIGATION

Care coordination is the cornerstone of many healthcare redesign efforts, including primary and behavioral healthcare integration. It involves bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care. Research shows that care coordination increases efficiency and improves clinical outcomes and patient satisfaction with care.¹

Care Coordinators manage/coordinate referrals, interactions with specialists, (i.e. making appointments, getting reports back). A Care Coordinator could be a non-licensed staff member with good attention to detail and communication skills.

The following characteristics define Care Coordination:

- Links patients with community resources to facilitate referrals and respond to social service needs
- Integrates SUD, mental health, and specialty care into care delivery through co-location or referral protocols
- Tracks and supports patients when they obtain services outside a specific location or practice
- Follows-up with patients within a few days of an emergency room visit, hospital discharge, or discharge from a residential facility
- Communicates test results and care plans to patients/families³

² Mechanic R. *Will Care Management Improve the Value of U.S. Health Care?* Background Paper for the 11th Annual Princeton Conference, May 20 – 21, 2004 [Accessed: January 3, 2007]; Available from: <http://healthforum.brandeis.edu/research/pdfs/CareManagementPrincetonConference.pdf>.

³ <http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Improving-Care-Complex-Patients.pdf>

NAVIGATION: A COMPONENT OF CARE COORDINATION

Navigation is a component of Care Coordination. Patient navigation refers to the assistance offered to patients in “navigating” through the complex health-care system to overcome barriers in accessing quality care and treatment (e.g., arranging financial support, coordinating among providers and setting, arranging for translation services, etc.). In the SAPC model, navigators also emphasize a patient-centric model— a navigator is someone who understands the patient's fears and hopes, and who removes barriers to effective care by coordinating services and increasing a patient's chances for sustained recovery and quality of life.⁴

TIERED APPROACH TO CARE

Case Management Services will be provided as a tiered benefit, divided by acuity/complexity of the patient. Acuity and complexity will be based on American Society of Addiction Medicine (ASAM) Criteria and additional criteria such as homelessness, emergency room and inpatient utilization, justice involvement, and foster system involvement.

Patients would be risk stratified into those requiring:

- A) Care Management (Highest Acuity/Complexity)
- B) Case Management
- C) Care Coordination (Lowest Acuity/Complexity)

The most complex patients, for example those with high medical and SUD needs, would likely be tiered into the Care Management group; while, individuals who require navigation services and linkage but have stable medical and SUD needs would be designated to receive care coordination services.

SERVICE PROVIDERS

Services will be provided by a spectrum of providers and will likely involve the following. Suggested roles are in parentheses:

- Health Plans and Managed Care Organizations (Care Management)
- Community Based Mental Health, SUD and other Specialty Providers (Case Management, Care Coordination)
- Community Based Organizations (Case Management, Care Coordination)
- County based Mental Health, SUD, Case Management, Public Health and other services (Care Management, Case Management, Care Coordination)
- County based Primary Care Providers (Care Coordination)
- FQHCs and Community Clinics (Care Coordination)
- Community based Primary Care Providers (Care Coordination)

⁴ <http://www.integration.samhsa.gov/workforce/care-coordination>

TIME LINE FOR IMPLEMENTATION

It is expected that existing service providers will likely provide all three levels of service with support from the health plans as clinically indicated in the initial start-up phase of the program.

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