Subject: Case Management Referral

Objective:

I. To promote an optimal state of wellness for each individual Tuality Health Alliance (THA) member through referral to a Case Management Program that provides consistent and collaborative assessment, monitoring, and coordination of healthcare needs.

II. To ensure that all member services are provided in a timely and cost-effective manner.

Definitions:

Case Management is defined as a collaborative process that promotes quality care and cost-effective outcomes to enhance the physical, psychosocial, and vocational health of individuals. Case Management includes assessing, planning, implementing, coordinating, and evaluating health-related service options.

Case Managers are active members of an interdisciplinary team of health care providers working toward a common goal to plan appropriate patient/member care.

Policy:

I. THA staff and providers may seek Case Management intervention when furnishing care to members with conditions that may be rare, that are difficult to manage, or that result in high utilization of resources. THA staff may refer a member to THA Case Management services at any time. Criteria for Case Management referrals are listed below.

   a. Generic Criteria for Referral of Member to Case Management (includes any combination of the following):
      1. Physiological instability
      2. Inability to assume self-care due to physical dependencies and/or neurological status
      3. Mobility impairment/disability
      4. Lack of support from family or significant other
      5. History of noncompliance with medical/surgical regimen
      6. Pain management problems
      7. Complexity of diagnosis
      8. Fluctuating emotional status
      9. Involvement of several care disciplines
      10. Multiple readmissions in a short period of time
      11. Complex discharge, need for placement in a particular facility

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12. Need for intensive healthcare education
13. Death and dying, hospice care
14. Risk for prolonged hospital stay
15. Pre-existing problems accessing care

b. Service-Specific Criteria for Referral of Member to Case Management:

1. Homelessness
2. Inconsistency in medical follow-up or frequent change of PCP and missed appointments
3. Chronic illness (as listed below)
4. Exceptional Needs
5. Prematurity
6. Child abuse
7. Organ transplant
8. Multisystem failure

c. Diagnosis-Specific/Co-Morbid Condition Criteria for Referral of Member to Case Management (includes two or more chronic conditions with acute signs and symptoms):

1. Diabetes
2. Congestive heart failure
3. Coronary artery disease
4. Asthma, COPD, emphysema
5. AIDS
6. High-risk infancy
7. High-risk Pregnancy
8. Cancer
9. Renal failure
10. Multiple traumas, head injury, spinal cord injury
11. Neuromuscular disease
12. Severe burn
13. Substance abuse
14. Stroke

II. Any member who is appropriately referred to Case Management will have a documented Care Plan that assesses, implements, and evaluates the member's health outcomes.

a. The benefits of Case Management include:

1. Early screening for potential issues;
2. Coordination of an interdisciplinary approach to care;
3. Integration of service network care, from general wellness to long-term care;
4. Coordination of transitions through the service continuum;

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5. Individualized attention for the best possible outcomes.

b. Member cases/Care Plans are to be closed according to the following criteria, or when there has been no case activity for six months:
   1. Case Management has accomplished the referral goals;
   2. Case Management assessment reveals that no other Case Management referral issues exist;
   3. Significant quality issues are absent or have been otherwise externally referred;
   4. Member is no longer eligible/enrolled with THA;
   5. Member died.

References: OAR 410-141-0000: Division of Medical Assistance Programs; Definitions
OAR 410-141-0160: (PHP) Coordination and Continuity of Care
OAR 410-141-0400: (PHP) Case Management Services
Oregon Health Authority Health Plan Services Contract
Health Share RAE Participation Agreement

Formulated:	June 1996
Reviewed:	April 1999 June 2000 April 2013 September 2015 August 2017
Revised	September 2002 February 2006 July 2008 October 2010