UCare Medicare Case Management Requirements
Updated January 2022

UCare supports and follows the guidelines for the standards of practice from the Case Management Society of America (CMSA) which include but are not limited to assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes".

UCare contracts with the following entities to provide case management for UCare Medicare members: Essentia, Fairview Physicians Associates, Fairview Partners, North Clinic, and North Memorial Clinic.

UCare provides case management for all UCare members not affiliated with one of the above listed care systems. UCare provides NCQA Complex Case management to eligible members. This function is not delegated to care systems.

UCare Medicare	
Purpose and Focus of Case Management	The purpose of case management for UCare Medicare members is to encourage and support healthy behaviors and to reach the wellness level they desire to achieve; to coordinate services across the continuum of healthcare to meet their health and social service needs; maintain members in their choice of living environment; and support the establishment of primary care and a healthcare home. The focus of case management is on members with acute, medical needs, typically of short term duration (3-6 months).
Screening for Case Management	UCare Medicare members are identified for case management through internal and external referrals and through a risk assessment process that consists of reviewing the following: ◆ Enrollment reports ◆ Matrix (Health Risk Assessments) ◆ Disease Management reports ◆ Medical records ◆ Daily admissions report

UCare Medicare	
Suggested Triggers for Case Management Screening/Opening **-Utilization**	Level of care transitions: acute, skilled, or custodial: ◆ Emergency Department utilization ○ 2 or more ED visits in 6 months ○ 3 or more ED visits in 12 months ◆ Admission to a Skilled Nursing Facility (SNF) or Physical Rehabilitation unit within the past 12 months (daily electronic report). ◆ Inpatient hospital admission (daily electronic report).
Suggested Triggers for Case Management Screening/Opening **- Diagnosis**	Members with one or more of the following diagnoses* should be screened for case management: ◆ Cardiac (heart failure, coronary artery disease) ◆ Diabetes ◆ Chronic Obstructive Pulmonary Disease (chronic bronchitis, emphysema or both) ◆ Depression *Not an inclusive listing.
Suggested Triggers for Case Management Screening/Opening **-Referrals**	Referrals for case management services may come from a variety of sources, including but not limited to: ◆ Internal sources. ◆ Primary Care Providers (PCP) ◆ Hospital social workers/discharge planners ◆ Family members/caregivers ◆ Other external sources
Initial Telephonic Assessment	The Case Manager (CM) should initiate a telephonic assessment for all members deemed to be "at risk" by meeting one of the case management triggers listed above, with the inclusion of professional judgment.
Telephonic Assessment Form	The CM will complete the UCare Medicare Telephonic Assessment form to gather information or will complete an assessment form that has been approved by UCare.

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Opening to Case Management	Members are opened to case management based on assessment, data collected, and professional judgment. ◆ If the member accepts case management, the CM will develop a plan of care (POC) with member input. (See POC below). ◆ If the member declines case management, the CM will send a follow-up letter with CM contact information and resource/educational material as appropriate. ◆ If the CM is unable to reach the member via phone after two attempts, the CM will send a letter explaining the CM role and request a callback from the member to complete the assessment.
Plan of Care (POC)	If the member accepts case management, the CM develops a person-centered POC. The POC should be developed in collaboration with the member, the PCP, and where appropriate, the member's family or authorized representative. The POC should be developed based on assessment data, identified needs, and desired member outcomes. The CM should document and include the following on the POC: ◆ Member identified needs/problems. ◆ Agreed-upon member goals. ◆ Goal target dates. ◆ Treatment and care interventions. ◆ Follow-up plan to evaluate outcomes (specify an evaluation date). ◆ Goal achievement dates. The CM should document and communicate assessment findings and POC to key stakeholders such as the member's PCP, other community providers, and family/caregivers when applicable. ◆ The CM has the lead responsibility for creating, implementing, and updating the care plan. ◆ The POC should be kept in the member's case management record and be retrievable when necessary.
Care Plan Form	The CM uses the UCare Medicare Care Plan form (on the UCare.org website) or a care plan form that has been approved by UCare.
Service Coordination	The CM initiates referrals, coordinates care as appropriate, and assists members with obtaining access to providers for specific health care needs which require follow-up. The CM ensures continuity of care and integration of services through arrangements with community and social service programs as appropriate.

UCare Medicare	
Service Coordination Cont.	Referrals may include but are not limited to: ◆ Referrals to the PCP and/or other specialists as needed. ◆ Clinic appointments for preventive care and/or condition management. ◆ Medication management and related follow up. ◆ Home Care Services. ◆ Durable Medical Equipment (DME). ◆ Utilization of UCare's Disease Management programs where appropriate, or referral to other appropriate disease management programs ◆ Education of member and/or family/caregiver on health/wellness strategies; and illness prevention related to their diagnosis/condition. ◆ Support services, community groups, or associations related to their condition or need (e.g., Stroke or Alzheimer support groups, Meals on Wheels, safe driving resources, Diabetes Association, adult day care).
Ongoing Monitoring	The CM monitors the effectiveness of the care plan, revising as necessary to meet the member's needs. The CM documents and maintains communication with the member, primary care provider, and other community providers, as applicable.
PCC/PCP Contact	The CM sends a copy of the POC or a summary to the member's PCC/PCP; and maintains communication with the primary care provider.
Transition Management	The CM maintains a "UCare Transition of Care Log" (found on the UCare website) on members experiencing a transition of care. The log is to be updated within 1 business day of notification of each transition. The PCP is notified using the "Transition of Care Notification to the Primary Care Physician" for each transaction.
Evaluation	The CM evaluates the following: ◆ Member's progress in achieving agreed upon goals within established time frames ◆ When and if the member's condition has stabilized and case management is no longer appropriate ◆ Impact of the plan of care on the member's desired level of health and /or wellness
Outcomes	The CM documents and communicates member outcomes with the member, PCP, other community providers, and family/caregiver as appropriate.
Advance Directives	The CM documents they addressed or discussed advance directives with the member, or that an advance directive is culturally inappropriate for the member.

UCare Medicare	
Case Closure	The CM closes the case when one or all of the following occurs: ◆ Member goals are achieved. ◆ Member terminates case management services. ◆ Member dis-enrolls from UCare or transitions to a non-delegated care system.
Documentation	The CM keeps a roster of open and closed case management cases. The CM also keeps a case management record to include the following: ◆ Assessments and screening information ◆ Plan of care ◆ Services and interventions ◆ Evidence of ongoing monitoring ◆ Contacts with primary care provider, other members of the interdisciplinary care team ◆ Outcomes and evaluations
Caseload Ratios	Due to the telephonic nature of case management, UCare suggests that case managers should be able to manage 50-75 open active cases and complete up to 200 screenings per month.
Policies and Procedures	All UCare delegates are required to have policies and/or procedures that support all the above stated requirements.