Alliance Health

Provider Practice Transformation Academy

Step-By-Step Guide to Working with Members as a CMA/AMH+

Alliance has created a step-by-step guide to walk care management organizations through how to start working with a member. For ease of use, the table below outlines the steps for Jiva users separately than the steps for those using a clinically integrated network (CIN) or other care management (CM) platform.

Using JIVA	Using Other CM Platform or CIN
1. Panel Assigned to Provider: • Load 834 data into Jiva and assigned to provider agency as the provider-led care management entity.	**1. Panel Assigned to Provider:** • Alliance drops an 834 (beneficiary) file on your sFTP site. • CM entity loads the file into your CM platform.
2. Assign Members to CM Caseload: • JIVA admin/supervisor logs into Jiva and all the members will show as list. • JIVA admin/supervisor assigns each member to a care manager (creating caseload). • The members will show on the assigned CM dashboard and my member list, and to do List with initial activity.	**2. Assign Members to CM Caseload:** • Clinical supervisor assigns members to care managers based on the instructions from their care management platform.
3. Care Manager Begins Work to Engage Member • **Opts out:** document in activity - unsuccessful with reason. • Triggers episode close. • Document each engagement attempts as interaction. • **Engages** -> Begin TP CM comprehensive assessment. • **Unable to contact:** episode: unsuccessful; status: hold. • Outreach activity scheduled for three months; can be rescheduled by provider staff.	**3. Care Manager Begins Work to Engage Member** • Care manager begins engagement work. ◦ If a member opts out during engagement, document in member record. ◦ Document each engagement attempt. ◦ If member engages, care manager begins assessment and care planning. ◦ If unable to contact member, outreach activities should be schedules to try again in 3-6 months.
4. TP CM Comprehensive Assessment • Assessment may take several visits to complete. • Completed assessment “triggers” a care plan to be developed.	**4. TP CM Comprehensive Assessment** • The assessment and plan may take several visits to complete. • If the assessment does not trigger a care plan in your platform, the care manager will need to create one.
5. Develop Care Plan/ISP • Review care plan goals and SELECT from populated Interventions for goals agreed to by member. • Review the care plan with the member. • Share completed goal with others on care team (permissions needed in Jiva). • If interventions can be assigned to CM extender, assign to them.	**5. Develop Care Plan/ISP** • Review the care plan with the member. • Member selects goals they would like to work on. • If interventions can be assigned to CM extender, assign to them.
6. Ongoing Team Responsibilities • Make sure that one visit per month meets one of the six health home criteria:	**6. Ongoing Team Responsibilities** • Make sure that one visit per month meets one of the six health home criteria:

Continued

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1. Comprehensive care management 2. Care coordination 3. Health promotion 4. Comprehensive transitional care/follow-up 5. Patient and family support 6. Referral to community & social support/services • Make appropriate referrals and close the referral loop – make sure the member followed through and there is documentation to show the result of referral. • Use NCCare360 for tracking community referrals. • Document interactions, contacts, visits with the members based on care plan activities/interventions.	1. Comprehensive care management 2. Care coordination 3. Health promotion 4. Comprehensive transitional care/follow- up 5. Patient and family support 6. Referral to community & social support/services • Make appropriate referrals and close the referral loop – make sure the member followed through and there is documentation to show the result of referral. • Use NCCare360 for tracking community referrals (this may have to be a separate application from the CM platform). • Document interactions, contacts, visits with the members based on care plan activities/interventions.
7. Care Manager & Extender Responsibilities: • Work towards closing the member's gaps in care. • If referral is for another level of service – work with the receiving service line doing a warm handoff. • CM to conduct reassessments and unmet health related needs screenings, when triggering events occur. • Make efforts to engage members at regular intervals set by agency. ◦ Reassign your panel members who were unable to be engaged initially to care managers to attempt engagement again. • If member is hospitalized, the care manager follows up while the member is in the hospital and works with the facility staff and member on a ninety day post discharge transition plan (90 Day PDTP). • Manage transitions to care, which may include: ◦ Member opts out / disengages during or after care plan development ◦ Member moves out of Alliance catchment area ◦ Member requests different CM or CM provider • As a team, monitor your ADT alerts and ensure members with any admissions, discharges or transfers are followed up according to care management requirements. • ADT alert will be on TO DO List as separate episode.	**7. Care Manager & Extender Responsibilities:** • Work towards closing the member's gaps in care. • If referral is for another level of service – work with the receiving service line doing a warm handoff. • CM to conduct reassessments and unmet health related needs screenings, when triggering events occur. • Make efforts to engage members at regular intervals set by agency. • As a team, monitor your ADT alerts and ensure members with any admissions, discharges or transfers are followed up according to care management requirements. • If member is hospitalized, the care manager follows up while the member is in the hospital and works with the facility staff and member on a ninety day post discharge transition plan (90 Day PDTP). • Manage transitions to care, which may include: ◦ Member opts out / disengages during or after care plan development ◦ Member moves out of Alliance catchment area ◦ Member requests different CM or CM provider
8. CM Supervisor Responsibilities: • Use daily huddles or clinical staffings to assist care managers with member engagement. • Engage clinical consultants to advise and guide on complex member cases or scenarios. • Use supervisory reports to monitor and track engagement status and billing trends.	**8. CM Supervisor Responsibilities:** • Use daily huddles or clinical staffings to assist care managers with member engagement. • Engage clinical consultants to advise and guide on complex member cases or scenarios. • Use supervisory reports (or dashboard in your platform) to monitor and track engagement status and billing trends. • On a routine basis set by your agency, reassign your panel members who were unable to be engaged initially to care managers to attempt engagement again.