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SECTION 9: CARE COORDINATION

INTEGRATED CARE COORDINATION

HPSJ provides a comprehensive suite of care coordination services that offers a continuum of care, including standard care management, complex case management, disease management, and social services. HPSJ views care coordination as collaboration between the Member, the Providers, and the health plan with the goal of ensuring high-quality cost-effective care.

The specific goals of care coordination programs are (1) to achieve efficient and effective communication between Members and Providers, and (2) to utilize appropriate resources which enable Members to improve their health status and self-management skills.

HPSJ's care coordination programs provide a consistent method for identifying, addressing, and documenting the health care and social needs of Members along the continuum of care. Once a Member has been identified for Case Management or disease management, a nurse will work with the Member to:

- Complete a comprehensive initial assessment
- Determine benefits and resources available to the Member
- Develop and implement an individualized care plan in partnership with the Member, Providers, and family or caregiver
- Identify barriers to care
- Monitor and follow up on progress toward collaborative care management goals

COMPLEX CASE MANAGEMENT (CCM)

Complex Case Management (CCM) consists of coordinated care services provided to Members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the health care system to facilitate appropriate delivery of care and services. CCM promotes behavior change through self-management education in order to reduce the exacerbation of chronic illness and the related costs.

CCM addresses the Member's social, physical, and behavioral health needs in order to maximize disease prevention and promote Member wellness in a high-quality, cost-effective manner. This may involve coordination of care, assisting Members in accessing community-based resources, providing education on self-management, improving adherence to medication and other treatment regimens, or any of a broad range of interventions designed to improve the quality of life and functionality of Members. HPSJ's CCM programs are designed to improve communication between Members and Providers and to make efficient use of the available health care and community-based resources.

Members are identified for the CCM program through the analysis of Encounter Data, utilization

data, claims, and pharmacy reporting. PCPs or Specialists can refer Members with complex health care and coordination needs to this program by calling (209) 942-6352. Members can also self-refer to this program.

DISEASE MANAGEMENT PROGRAMS

HPSJ actively works to improve the health status of Members and intervenes to help Members and Providers manage chronic conditions. HPSJ offers disease management programs for three chronic conditions:

- Asthma
- Diabetes
- Congestive heart failure

Members are identified for these programs through detailed analysis of claims, Encounter Data, pharmacy and utilization data. Members can be referred to the program by Providers or they can self-refer.

Asthma Disease Management Program

Members enrolled in the Asthma Disease Management Program receive educational materials regarding asthma triggers, appropriate use of asthma medications, condition monitoring and appropriate use of inhaler and nebulizer devices. High-risk Members receive individualized Case Management.

The case manager works with the Provider and the Member in order to develop a care plan for the Member. The case manager also follows up with the Member to ensure progress with the care plan. To refer a Member to the Asthma Disease Management Program or for more information, contact the Disease Management Department at (888) 318-7526.

Diabetes Disease Management Program

Members enrolled in the Diabetes Disease Management Program receive educational materials to empower them with the knowledge of the disease condition, their medications, and the importance of screening tests such as HgA1c, kidney functions, blood lipids, and blood pressure. High-risk Members receive individualized Case Management. The Case Manager works with the Provider and the Member to develop a care plan for the Member and follows the Member's progress with the care plan. To refer a Member to the Diabetes Disease Management Program or for more information, please call the Disease Management Department at (888) 318-7526.

Congestive Heart Failure Disease Management Program

Members enrolled in the Congestive Heart Failure Disease Management Program receive educational materials on monitoring weight, salt intake, reading nutrition facts labels, checking blood pressure, and medication regimen. High-risk Members receive individualized Case Management. To refer a Member to the Congestive Heart Failure Disease Management Program or for more information, please call the Disease Management Department at (888) 318-7526.

TRANSGENDER PROGRAM

HPSJ's transgender program is a relatively new covered benefit for Members under Medi-Cal. HPSJ has and will continue to perfect the program as more resources are identified, trained, and contracted.

However the basic elements are in place and available to support Providers:

- Identification and criterion for transgender Members
- PCPs trained to address the special needs of transgender candidates within the Service Area and in surrounding/adjoining areas
- Training events for Provider's offices in transgender special needs and support
- Specialists in the Service Area and surrounding areas for transgender care and support
- Hospitals specializing in the surgical needs of transgender Members
- Continuing dialogue with transgender advocates about support, programs, and initiatives regarding this benefit

Providers and Members are able to access information about the transgender program by calling the Care Management Department at (209) 942-6352.

SOCIAL SERVICES

HPSJ's Social Work Services team conducts Member needs assessments and based on assessment findings, can assist with:

- Transportation via Dial-A-Ride or van services
- Durable medical equipment (DME) evaluations
- Housing and In-Home Support Services (IHSS) referrals
- Food and Utility resources
- Maternal child/adolescent health resources and education
- Mental health resources

For questions or printed information about Social Services or community resources, please call (209) 942-6320 or (888) 936-7526.

CENTERS OF EXCELLENCE

HPSJ has contracted with several Hospitals that provide specialty services with outstanding clinical results. These "Centers of Excellence" offer Members and Providers options for special cases demanding clinical expertise. One such example is HPSJ's relationship with Shriner's Hospital in Sacramento for pediatric burn cases as well as pediatric orthopedics. For more information about Centers of Excellence and services for special clinical cases, contact the UM Department at (209) 942-6320.