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SECTION 9: CARE COORDINATION

PROVIDER RESPONSIBILITIES FOR CARE COORDINATION

All primary care Providers including FQHC 's are responsible for basic care management, care coordination, and health education functions for their Members who are engaged in primary care. For Members who have been assigned to a PCP but have not yet engaged in their care, or have been lost to follow-up, the PCP is responsible for establishing or reestablishing the physician-patient relationship, through outreach attempts to the Member.

INTEGRATED CARE COORDINATION

Health Plan provides a comprehensive suite of care coordination services that offers a continuum of care. These services include:

- Complex Case Management
- Standard Care Management
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- Disease Management
- Social Services

Health Plan views care coordination as a collaboration between the Member, Providers, and Health Plan. Our common goal is to ensure 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.

Health Plan's care coordination programs provide a consistent method to identify, address, and document 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 an 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, as appropriate to the Member's needs
- 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.

Health Plan's CCM program is 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 analysis of assessment information including HIF/MET and HRA information, authorization data, claims and encounter data, and pharmacy reporting.

PCPs or specialists can refer Members with complex health care and coordination needs directly to the Case Management team by calling (209) 942- 6352 or (888) 318-7526. Case Management team Members will take all available information and reach out to Members as quickly as possible. Members can also self-refer to this program by calling the Case Management number above.

DISEASE MANAGEMENT PROGRAMS

Health Plan actively works to improve the health status of Members and intervenes to help Members and Providers manage chronic conditions. Health Plan offers disease management programs for five
(5) chronic conditions:

- Asthma
- Diabetes
- Congestive Heart Failure (CHF)
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression

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

Asthma 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 Member and Provider 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 Health Plan's Disease Management Department at (888) 318-7526.

Diabetes Management Program

The diagnosis of diabetes has evolved from physician recognition of typical symptoms to detection of ambient hyperglycemia. The definition of excessive plasma glucose levels after an overnight fast and/or oral glucose tolerance test (OGTT), and recently, the measurement of glycated hemoglobin (HbA1c) informs that diagnosis. Evolving screening techniques have uncovered a higher prevalence of diabetes and the enormity of its impact on public health. Testing has identified individuals at high risk for the development of diabetes and pregnant women whose fetus are at increased risk for mortality and morbidity.

The 2020 National Diabetes Statistics Report, a periodic publication of the Centers for Disease Control and Prevention (CDC), informed that 10.5% of the US population has diabetes.

Diabetes

Total: 34.2 million people have diabetes (10.5% of the US population)
Diagnosed: 26.9 million people, including 26.8 million adults
Undiagnosed: 7.3 million people (21.4% are undiagnosed)

Prediabetes

Total: 88 million people aged 18 years or older have prediabetes (34.5% of the adult US population) 65 years or older: 24.2 million people aged 65 years or older have prediabetes. Given these statistics, Health Plan is compelled to continue to focus attention and resources through the Diabetes Management Program on the promotion of our Members well-being. The program equips Members with the tools needed to better understand, monitor, and manage their diabetes to improve their quality of life. Educational materials empower Members with the knowledge of their 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 (CHF) Management Program

Heart failure (HF) remains a major cause of mortality, morbidity, and poor quality of life. More than 6 million adults in the United States have heart failure, according to the Centers for Disease Control and Prevention. Heart failure is a serious condition that has no cure, but the effects can be

mitigated by medications, lifestyle changes, and some devices and procedures. Research about heart failure (HF) has made major progress in recent years. More knowledge is now available regarding biomarkers and imaging, management of comorbidities, and the mitigation of difficulties encountered in care coordination which can help many people have a higher quality of life. For these reasons, Health Plan has selected CHF as a condition of focus for the Case Management team.

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.

Chronic Kidney Disease (CKD) Management Program

Patients with CKD must manage numerous medical treatments and lifestyle changes that strain their adherence to treatment. Helping CKD patients remain treatment adherent and engaged with their care team is critical for improving their treatment, outcomes, and quality of life.

When CKD is managed inefficiently, this chronic condition is associated with decreased quality of life, greater morbidity and mortality, and higher costs. Health Plan risk stratification includes all high risk and emerging risk individuals with disease stage 2-4. There is a need for the early identification and enrollment of CKD Members in a disease management (DM) program to reduce disease progression, preserve or improve patient quality of life, and decrease costs associated with the disease.

Members enrolled in the Chronic Kidney 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 kidney functions (GFR) and monitoring their HbA1c and blood pressure. High-risk Members receive individualized case management. The case manager works with the PCP and the Member to develop a care plan for the Member and follows the Member's progress with the care plan. The PCP will receive a written plan of care from the case manager along with the invitation to provide feedback and inform the case manager on areas the PCP would like emphasized during case management efforts. To refer a Member to the Chronic Kidney Disease Management Program or for more information, please call the Disease Management Department at (888) 318-7526.

Chronic Obstructive Pulmonary Disease Management Program

Chronic Obstructive Pulmonary Disease (COPD), was the fourth leading cause of death in the United States in 2018.1 Almost 15.7 million Americans (6.4%) reported that they have been diagnosed with COPD.2 Many adults with risk factors for COPD have depressed pulmonary function without clinical manifestations of the disease, and so the actual prevalence may be higher.

COPD can be difficult to manage. When managed inefficiently, it is a chronic condition associated with decreased quality of life, greater morbidity and mortality, and higher costs.

Age-adjusted deaths in 2019 amongst US men were 40.5 per 100,000 in 2019 and 34.3 per 100,000 among US women in 2019[4]. Health Plan has targeted COPD as a chronic condition worthy of a focused effort for the Health Plan's Case Management team. On a monthly basis, Health Plan identifies and stratifies high-risk individuals with COPD to offer proactive measures to reduce the incidence and severity of symptoms which may have an impact on the decrease of inpatient and outpatient utilization associated with this condition.

Members enrolled in the Chronic Obstructive Pulmonary Disease Management Program receives educational materials regarding managing triggers such as first and secondhand smoke, and pollution, appropriate use of 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 to develop a care plan for the Member and follows the Member's progress with the care plan. To refer a Member to the Chronic Obstructive Pulmonary Disease Management Program or for more information, please call the Disease Management Department at (888) 318-7526.

TRANSGENDER SERVICES

Transgender services are a covered benefit for Medi Cal Members. Health Plan continues to work with community partners to offer guidance, support and local resources to provide the best possible culturally sensitive care.

The basic elements available to support Providers caring for transgender Health Plan Members are:

- Identification and criterion for transgender Members
- PCPs training to address the special needs of transgender candidates within the Health Plan service area and 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

Providers and Members can access information and available resources through Health Plan's transgender program by calling the Care Management Department at (209) 942-6352.

SOCIAL SERVICES

The primary mission of the social services department is to enhance human well-being and help meet basic and complex needs of all people with a particular focus on those who are vulnerable, oppressed and living in poverty.

Our team includes behavioral health and social work coordinators/navigators, case managers and leadership to ensure the following:

- Timely Access
- Coordination of Care
- Quality of Care
- Support Linkages

Health Plan's Social 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

Health Plan has contracted with several hospitals that provide specialty services with outstanding clinical results. These "Centers of Excellence" offer Health Plan Members and our network Providers options for special cases demanding clinical expertise. One such example is Health Plan'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.