Gold Coast Health Plan℠
A Public Entity

2019 Care Management Program Description

Care Management
Program Description

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I. STRUCTURE AND ORGANIZATION

POPULATION HEALTH FRAMEWORK FOR CARE MANAGEMENT

The Population Health (PH) Framework is an interdisciplinary structure that utilizes data from across the healthcare continuum to support and align GCHP's efforts to achieve positive health outcomes for defined populations.

It is a practical and customizable method that is designed to guide and organize Care Management in its effort to guide education and develop programs in order to best meet the needs of the GHCP community. Integration into the Population Health framework will allow Care Management to plan effective engagement strategies, improve existing programs, and demonstrate the results of resource investments. The framework encourages an approach to integrate continuous evaluation and improvement into routine program operations.

CARE MANAGEMENT PROGRAM PURPOSE & GOALS

Guiding principles at Gold Coast Health Plan include collaboration, advocacy, self-care management, and empowerment in decision-making, education, informed choice, and anticipation of needs, linkage with community resources, and assisting the member to navigate the health care system.

- Assess for and address member needs across the continuum of care
- Facilitate improvement in the health status and quality of life of members with both complex and non-complex medical needs
- Assist members in understanding their health condition and support them become self-advocates
- Assist members in navigating the health care system to minimize gaps in care, facilitate optimization of available benefits and timely access to care and services
- Collaborate with external stakeholders such as multidisciplinary health agencies and non-profit partners, to link members to community resources where accessible
- Work collaboratively with the member, physician, and other individuals in the member's care team to develop and implement a plan of care that meets the member's stated needs
- Improve member and provider satisfaction

Care Management is not intended to replace or substitute physician's management of member's medical conditions.

IDENTIFICATION AND REFERRAL

Population Identification

The organization collects, integrates, and assesses member data to identify target populations.

Data sources may include:

1. Medical and/or behavioral claims/encounters
2. Pharmacy Claims
3. HIF/MET
4. Laboratory Results
5. Health Appraisal results
6. Electronic Health Records
7. Advanced data sources may include, but are not limited to:
   - Regional immunization registries (CAIR Registries)
   - Integrated data warehouses between providers, practitioners, and the organizations

These data sources will be evaluated to develop actionable interventions to meet the care needs of targeted populations.

Referrals

Referrals for Care Management originate from a variety of internal and external sources. Members may self-refer, or may be referred by another member of their care team including caregivers, Primary Care Providers, Specialists, Hospital Case Managers, or other community partners.

II. PROGRAM STRUCTURE

GCHP offers Care Management services as a part of Care Coordination; which also includes Basic Case Management (provided by members' primary care physician), Utilization Management, Discharge Planning and Transitions of Care. Care Management utilizes person centered planning and collaboration with the member to address member's stated health and/or psychosocial needs, this process may or may not include the development of an Individualized Plan of Care (IPC). Interventions are tailored in response to the member's assessed needs or stated goals. Throughout the care management process, the member's needs will be reassessed and adjustments will be made as needed to provide the appropriate level of care.

Non-Complex Care Management

Level One:

Members identified as Level One are the lowest risk members in Care Management. Their needs are generally resolved within 30 days of identification, the primary focus is to ensure these members are well connected to their primary-care providers.

Members who may be considered for Level One include:

- New Member Health Information Forms (HIF/MET)
- Access to care:
    - Primary and/or Specialty Care
    - Behavioral Health Therapy (BHT)
    - Early Periodic Screening Diagnostic Treatment Services (EPSDT)
    - Well-coordinated members of the CCS population,
    - Members co-managed through Beacon
- Those needing assistance with:
    - Well managed chronic disease
    - IHSS, Denti-Cal, Transportation, etc.
    - Ancillary Services or DME covered by Medi-Cal
    - Prescriptions
    - Simple Transitions of Care
- Requests for Continuity of Care
- Education for resources available in their area/community

Interventions for members identified as Level One are determined through assessment/survey to identify his/her primary care management needs. Based on the member's stated goals and needs, CM staff will assist the member in gaining access to necessary resources and supports, this process may or may not include developing an Individualized Care Plan.
Typical interventions provided for Level One members may include, but are not limited to:

- Emotional Support/ Active Listening
- Coordination of Services (Appointments, Referrals, DME, etc.)
- Medication Reconciliation
- Collaboration with County/Community Agencies

Level Two:

Members identified as Level Two may have an emerging risk of disease or disease exacerbation, a newly diagnosed chronic illness, or a routine pregnancy. They may benefit from education and resources tailored to their condition along with a contact within the care management department should questions arise.
Members at Level Two may include those requiring assistance with:

- Chronic Pain
- Chronic Disease Management
- Routine Pregnancy

Members managed at this level will be provided with Health Education resources supporting lifestyle management to maximize health and wellness and mitigate effects of chronic disease. This process may or may not include the development of an Individualized Care Plan.
Interventions provided for these members may include, but are not limited to:

- Emotional Support/ Active Listening
- Coordination of Services (Appointments, Referrals, DME, etc.)

- Review of disease signs/ symptoms
- Medication Reconciliation
- Referrals to community support groups,
- Referrals to disease prevention/management programs or Healthy Living classes
- Education regarding the management of their condition(s)

Members may be advanced to a higher level of care management should their condition warrant it or if the member requests additional support.

Complex Care Management

Level Three:

These members are vulnerable to fragmented care, may lack social supports, have difficulty navigating the health care system, have mental illness or substance use disorders, fragile housing, a poorly managed chronic disease, or other challenges that threaten to compromise the member's well-being if not supported through Care Management. Members considered Level Three may come from any source however the most common sources of referral are:

- Member Health Information Form (HIF/MET)
- Newly identified SPDs or CCS members which may include T-21
- Hospital Discharge Planners or Social Workers
- Physicians or specialty care providers
- County Programs such as Whole Person Care, Nurse/Family Partnership, Medical Therapy Programs, other grant programs, or Public Health Nurse referral
- Community Partner program referrals
- Foster Care
- Regional Centers
- Other internal departments or programs

Care Management for Level Three members is focused on providing community connections, social supports, and integration with long-term support services. CM staff will perform a comprehensive assessment evaluating medical, psychosocial, emotional, and behavioral needs. The member and CM staff will develop an Individualized Care Plan (ICP) that addresses both medical and Social Determinants of Health (SDH) concerns. CM staff will collaborate with the member to identify prioritized goals and select interventions/behaviors intended to meet these goals. Together, the member and CM staff will work throughout the care management process to overcome barriers to meeting these goals and achieving the health/wellness outcome(s) identified by the member.

Typical interventions utilized during the CM process for Level Three members may include, but are not limited to:

- Personalized Assessments
- Motivational Interviewing
- Emotional Support/ Active Listening
- Review of disease signs/ symptoms
- Coordination of Services (Appointments, Referrals, DME, food banks, homeless shelters, etc.)
- Referral to and collaboration with county/ community agencies to provide support and reduce duplication of efforts
- Assistance with accessing programs such as Long Term Support Services (LTSS), Women, Infants, and Children (WIC) Program, or other social supports.

Level Four:

Members at Level Four typically have one CCS-eligible condition along with social support needs (in pediatric cases), or two or more chronic conditions (in adult cases). Members at this level may reflect a recent hospitalization within the past 6 months or multiple emergency department visits relating to the eligible conditions. These members may also have communication challenges, cognitive barriers, capacity issues, and/or a severely fragmented provider/health care delivery system. Level Four members have a high risk of declining function, hospitalization or readmission if appropriate interventions are not in place.

Level Four members are often identified by:

- Member Health Information Form (HIF/MET)
- Newly identified SPDs or CCS members which may include T-21
- CCS county partners or Medical Therapy Programs/Units
- Hospital Discharge Planners or Social Workers

- Primary Care or Specialty Providers
- Other Internal Departments
- External Collaborative Meetings with community partners

The primary focus of care management for members at this level is the coordination of clinical services for medically complex cases. In addition, care management efforts will also address the provision of community connections, social supports, transitions across age/developmental milestones, and integration with long-term support services. CM staff will perform a comprehensive assessment evaluating medical, psycho-social, emotional, and behavioral needs. The member and CM staff will develop an Individualized Care Plan (ICP) that addresses both medical and Social Determinants of Health (SDH) concerns. CM staff will collaborate with the member to identify prioritized goals and select interventions/behaviors intended to meet these goals. Together, the member and CM staff will work throughout the care management process to overcome barriers to meeting these goals and achieving the health/wellness outcome(s) identified by the member.

Typical interventions utilized during Complex Care Management include, but are not limited to:

- Personalized Assessments
- Motivational Interviewing
- Emotional Support/ Active Listening
- Review of disease signs/ symptoms
- Coordination of Services (Appointments, Referrals, DME, etc.)
- Collaboration with the multi-disciplinary care team to ensure the member's care needs are expedited as well as reducing duplication of efforts amongst care team members
- Referral to and collaboration with county/ community agencies
- Assistance with accessing programs such as LTSS, WIC, or other social supports.

III. THE CARE MANAGEMENT PROCESS

Care management is founded upon the collaborative identification of goals, barriers to meeting those goals, and interventions designed to overcome identified barriers. When goals are met, the case will be closed unless new goals, barriers, or needs are identified during the CM process. At any time during the course of services, if the member's status or needs change, the case will be evaluated by the assigned CM staff to determine appropriate level of intervention needed.

In certain instances, cases may be closed to care management for reasons other than completion of care plan goals. Examples of reasons where care management may be discontinued include:

- Member is no longer responsive to outreach efforts after multiple attempts
- CM staff and clinical leadership agree that member is inappropriate for CM as evidenced by a lack of consistent adherence to the care plan
- Member is obtaining services through another agency that duplicates the services offered through GCHP, or is referred to another service who is better suited to meeting the needs of the member
- Member loses eligibility for GCHP coverage
- Continued inappropriate (derogatory, profane, abusive) behaviors towards the CM staff with no improvement after documented discussions regarding the need for behavioral change.

Care plans closed for reasons other than the completion of a care plan or inability to reach member must be discussed with Management prior to closing. Closed CM cases may be re-evaluated if the member's condition, or desire to participate, changes.

MEMBER PARTICIPATION AND OPTING OUT OF PROGRAM

Participation in the CM Program is free and voluntary. Members may decline services at any time, and are advised that declination of services will not otherwise affect their Medi-Cal benefits. If a member declines participation, or is unable to be reached after multiple attempts, this is noted in the case record and the case is closed.

COMMUNICATION

Care Management staff communicate with the member, health care providers and other member identified individuals of the member's health care team via written and telephonic communication.

DOCUMENTATION AND CONFIDENTIALITY

Care Management staff document clinical information and data on an ongoing, timely, accurate and concise manner, using available tools within the medical management system. All staff are responsible for keeping member information confidential in accordance with applicable federal and state laws.

SAFETY AND PROTECTION OF MEMBERS

Job aid manuals have been created to address the following member safety issues:

- Reporting Suspected Abuse and/or Neglect
- Handling Suspected Emergencies during Telephonic Contact (per JAM Crisis Call Triage and Handling)

Member Legal Issues: Care Managers will not offer legal advice in any context, and will refer members to appropriate community resources as applicable.

IV. DEPARTMENTAL STAFFING

To effectively achieve the program goals and objectives, licensed and unlicensed healthcare professionals perform care management activities under the direction of the Executive Director of Health Services and the Medical Director.

- **Care Management Manager**: Responsible for operational oversight for the department.
- **Care Management Registered Nurse (CMRN)**: Works with other team members to engage members and facilitate self-efficacy and optimal outcomes.
- **Care Management Licensed Clinical Social Worker (CMSW)**: Works with other team members to identify social determinants of heath and make appropriate referrals.
- **Care Management Coordinator (CMC)**: works with other team members to collect member specific information and coordinate care.

A written job description exists for all staff performing CM activities which are reviewed regularly.

V. QUALITY MANAGEMENT

STANDARD OPERATIONAL METRICS FOR CARE MANAGEMENT

A key operating metric for Care Management includes the quantity and quality of cases managed. This is to be measured consistently and reported on a regular basis to senior management.

CARE MANAGEMENT QUALITY CASE REVIEW PROCESS

Inter Rater Reliability training and peer review processes are in place to assess the staff's ability to consistently implement and document the correct process and maintain competencies in member management.

REFERENCES

The scope of this program description was developed using the following resources:

National Committee of Quality Assurance's (NCQA) Population Health Management Standards and Elements (2018).
Case Management Society of America's (CMSA) Standards of Practice for Case Management (2016).

VI. APPROVAL AND SIGNATURES

2018 Gold Coast Health Plan Care Management Program Description

The 2018 Gold Coast Health Plan Care Management Program Description is subject to, at a minimum, annual review and revision as necessary. The Care Management Program Description is presented and approved at the following committees:

- Utilization Management Committee

Approval Signatures:

Kathy Neal, RN, DNP
Executive Director, Health Services

4/19/19
Date of Approval

Nancy Wharfield, MD
Chief Medical Officer

4/19/19
Date of Approval

Appendix A: Health Services Organizational Chart