HERITAGE PROVIDER NETWORK

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AFFILIATED MEDICAL GROUPS

CARE COORDINATION PROGRAM 2018

Approval Signature:

_____ __02/28/2018_____

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Introduction

Heritage Provider Network's (HPN), Care Coordination (CC) program anticipates and addresses our member's needs in a safe, timely, effective, efficient, and respectful manner
HPN performs an annual Population Health Assessment which assesses the characteristics and needs of our population and relevant subpopulations that includes: children, adolescents, individuals with disabilities, individuals with serious and persistent mental illness (SPMI) which drives the characteristics and components of the CC program. Necessary updates are made, when appropriate, to the care management processes to align with these findings and members' needs. The foundation of the CC program is nationally recognized evidenced based guidelines or clinical practice guidelines that guide the team in meeting the member's needs and preferences. These guidelines are reviewed and modified where appropriate when coordinating care of vulnerable beneficiaries and also reviewed every two years by the HPN CS UM Committee.
The core of the CC program is a seasoned, expertly trained cross-functional interdisciplinary team (ICT) with appropriate administrative and clinical staff to perform care coordination of services and benefit functions which describes contingency plans used to address ongoing continuity of critical staff. A central point of contact is responsible for seamless service delivery of preventive, diagnostic, therapeutic, and chronic management services through a collaborative effort by interdependent professionals; paraprofessionals and ancillary personnel. CC uses an organizational design with empowered teams, to implement informational, technological, and evidence based solutions customized to the member's preferences, needs and values. The CC team continuously stabilizes or reduces the burden of illness and disability by focusing on the health and wellbeing of our members, while respecting their ability to make choices and have individual preferences.

The CC Team uses proactive processes to identify, coordinate and evaluate appropriate high quality services which may be required on an ongoing basis. Members who require ongoing, extensive services will receive medically necessary care in the most cost-efficient and least restrictive settings. CC coordinates resources and creates appropriate cost-effective treatment alternatives and sites of service for catastrophically, chronically ill or injured members on a case by case basis to achieve realistic treatment goals. The CC program is evaluated and updated annually and approved by the Utilization Management Committee.

Care Coordination Program Goals

The goals of the Care Coordination Program are that the program:

1. Assess our member population to ensure that our care management processes address our membership needs.
2. Provide the education and resources so members are able to self-maintain their condition or diseases processes.
3. Provide culturally appropriate care throughout the healthcare continuum.
4. Provide the member's with Patient Rights information as to the services available to them on behalf of HPN, our staff and our contractual relationships with the Health Plans and the member's right to not participate or dis-enroll from the program and/or services provided.

5. Provide care coordination that helps members: navigate the healthcare system in a safe and effective manner; is cost effective, and meets the need of the members.
6. Coordinate care to ensure the member has access to all services available to them, i.e. IHSS, CBAS, MSSP and any community based services.
7. Develop a care plan that is member centric and identifies the goals that are based on the member's preferences, needs and level of involvement.
8. Identify the barriers to members being compliant with their treatment plan and initiate interventions or resources to overcome those barriers.
9. Develop interventions to the goals that members can achieve.
10. Identify members at risk of care transitions.
11. Reduce unplanned ER and hospital admissions by providing the necessary education, resources and support to the member.
12. Identify measures of program effectiveness and annually assess the metrics to determine if the program has met them.
13. Define the staffing needs of the program and ensure that the staffing meeting the requirements of the program.
14. Provide the initial and ongoing training to staff to ensure there is compliance to the goals of the program.

Interdisciplinary Care Team Composition (ICT)

The ICT is composed of the following: the member, their primary caregiver/family (if applicable), the Primary Care Physician, a Medical Director, and Nurse Care Manager/Care Coordinator. The extended team may include any of the following: consulting physicians, SNFists, hospitalists, home health providers, facility discharge planning staff, pharmacists, ancillary providers, data analysts, health plan staff, social worker, team coordinator, and others, such as, IHSS Social Worker, MSSP Coordinator, IHSS provider(with member approval), MSSP, CBAS, or LTC Providers if members approves, as applicable to member needs.

CC Member Competencies

CC team members will have complementary competencies to quickly and effectively produce the following results:

1. Coordinate and clearly document the management of high-quality cost-effective services to meet the member's healthcare goals.
2. Apply benefits appropriately and coordinate with health plan staff to flex benefits.
3. Monitor care which is easily accessible with no access barriers to contracted eligible benefits.
4. Promote early and intensive diagnostic and treatment interventions in the least restrictive setting.
5. Apply approved Utilization Management (UM) decision criteria to the management of complex and chronic cases.
6. Comply with approved time frames and standards for timeliness of UM decision-making.
7. Provide accurate and up-to-date information to providers regarding clinical practice guideline criteria and member information.

8. Collaborate with the Specialty Providers when developing the ICP to include those necessary specialized services
9. Create individualized care coordination plans (ICP) which are revised as the member's healthcare preferences and needs change and incorporates an interdisciplinary approach in meeting those needs and preferences
10. Use multidisciplinary clinical, rehabilitative and support services.
11. Arrange a broad spectrum (comprehensive) and appropriate resources for members who will include preventive, medical, mental health, social, translation and linguistic services with coordination through a central point of contact with seamless transition across care settings, care providers and services.
12. Deliver highly personalized care management services to promote appropriate utilization of services in all settings.
13. Grant adequate attention to member satisfaction through the evaluation and improvement of the care management process.
14. Improve member's health status by developing prioritized measureable goals identified and stratified by the member.
15. Promote member independence and self-management to improve the member's health status through improved mobility, functional status, and improved quality of life perception
16. Uphold strict rules of confidentiality.
17. Provide ongoing care management program analysis and development.
18. Encourage collaborative collegial approaches to the care management process.
19. Evaluate to ensure that providers stay current and practice within mandated and recommended guidelines.
20. Promote the care management program's viability and accountability.
21. Protect member rights and encourage member responsibility.

A Model of Care training has been developed to ensure compliance to all care coordination requirements. All staff is required to complete the Model of Care Training at new hire orientation and annually. Failure to complete this training will lead to disciplinary action up to and including termination.

Member selection

Members are accepted into the CC program after assessment by the care management and coordinating staff. Members enrolled with any of HPN's affiliated groups are eligible for review. Members can be referred for assessment by providers contracted with our groups, member or caregivers, or through data mining of clinical and utilization management data, care gap analysis, pharmacy, utilization management, health plan referrals, hospital discharge data, or health risk assessments, claims data (See Appendix A for flowchart assessment). Same day assessments are available upon request by inpatient Care Manager/Care Coordinator's or hospitalists providing care to members in the emergency room and inpatient facility.

Members assessed and found not to be eligible for inclusion in the CC program will be forwarded to the appropriate disease or care management program sponsored by HPN's affiliated groups, contracted

health plans, or other community services available to the member or referred back to their primary care provider. Members are given the right to decline participation or disenroll from case management programs and services.

Member Rights

Members are asked if they wish to participate in the program and services offered by the Care Coordination Program and they are told they have the right to disenroll from the program at any time. Since each member is assigned a point of contact, this person is responsible for managing their care and services and any requests for changing their services would go through them.
A goal of the program is to ensure that the member has contact with their Primary Care Provider when making healthcare decisions and to be able to discuss any options.

The member is informed of any care management-related services available, even if a service is not a covered benefit. Our goal is to provide any and all services necessary to mitigate any unnecessary ER visits for hospitalizations.

All member identifiable data and medical information is kept confidential. Only those individuals identified as providing care or part of the care management process would have access to the member's information. HPN and its affiliate medical groups have policies and procedures in place to ensure security, privacy and confidentiality of the member's information.

All members are treated courteously and respectfully by the staff. All member complaints are investigated immediately by the Quality Improvement Department.

Member Expectations

It is expected that Members will:

1. Follow the mutually agreed care plan/management plans/treatment plan offered by the Interdisciplinary Care Team (ICT) which includes the PCP.
2. Provide the CC staff with information necessary to carry out our services.
3. Notify the CC staff if they wish to dis-enroll from the program.

Member Assessment and Documentation

The **CC** team uses evidence-based clinical guidelines and algorithms, as well as, member goals and preferences, to conduct assessment and management of the member. A holistic assessment is performed to include all aspects of the member (spiritual, physical, social, economic and psychological). In some instances a Health Risk Assessment (HRA) is provided by the designated Health Plan. If an HRA is not received from the Health Plan, then HPN will perform a Clinical Social Assessment (CSA).

The Clinical Social Assessment (CSA) includes:

1. The care management procedures to address the member's right to decline participation or dis-enroll from the care coordination program, ICP development and updates and from participating in the ICT meetings;
2. Identifying and describing the medical and health conditions impacting the members as well as ongoing assessments of the member, including condition specific issues;
3. Documentation of clinical history, including medications (dosage and frequency) and adherence and any comorbidities
4. Initial assessment of mental health status which includes depression screening as appropriate and cognitive functions (ability to communicate, understand instructions and process information about their illness, alert and oriented x4), psychosocial issues and their health literacy deficits and, health behaviors
5. Initial assessment of life-planning activities (advance directives, member's desire to maintain their independence and current daily activities or remain in their home;
6. Initial assessment of activities of daily living;
7. Evaluation of medication adherence (STARS Measures); When medication adherence is identified as a risk, an assessment will be performed and any interventions will be documented.
8. Evaluation of cultural and linguistic needs, barriers, preferences or limitations; (language needs, preferences and limitations)
9. Evaluation of visual and hearing needs, preferences or limitations
10. Evaluation of caregiver resources and involvement;
11. Evaluation of available benefits within the organization
12. Evaluation of community resources;
13. Evaluation of social status;
14. Evaluation of environmental factors (factors outside of the body that affect a member's wellbeing, for example: quality of air, food and water supply or their exposure to hazardous materials.
15. Evaluation of the living conditions (circumstances of a member's life – shelter, food, clothing safety, access to clean water, etc.). ;
16. Evaluation of the fall risk factors (STARS Measures);
17. Evaluation of compliance to recommended preventive screenings (STARS Measures);
18. Identification of participation in community resources and social services (LTSS and appropriate home and community based services (BH, IHSS, CBAS, MSSP, personal care services and nutrition programs;
19. All carved out and linked services will be coordinated, and referrals will be made to the appropriate community resources and other agencies.
20. Identification of any add-on services and benefits;
21. Assessment of social determinants of health, i.e. employment status, social network, history of substance abuse, etc.
22. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals
23. Development of a care (care management) plan (SMART prioritized goals) with the primary care physician, healthcare providers, and member participation;
    a. If beneficiary refused CM or was unable to be reached, there is documentation of review of enrollee medical records and any available clinical data to develop the IC
24. Identify limitations and barriers to meet goals or comply with the care plan (i.e. non-compliance or

deficits that pose potential challenges for the member.

25. Development of a schedule for follow-up and communication with members;
26. Development, communication, and documentation of member self-monitor and self-management plans.
27. Identification of the need to provide other activities or services to assist member in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health or functional status; Educational material on his or her conditions and care options.
28. If a members is admitted to a Hospital or facility:
    a. The member's pre-admission or baseline status will be documented
    b. The initial set up of services needed after discharge including but not limited to medical care, medication, DME, identification of integration of community based LTSS programs.
    c. The initial coordination of care, as appropriate, with the member's caregiver, other agencies as well as ensuring the member's care coordinator contact information is documented and available for hospital/care providers.
    d. The information for making follow up appointments will be documented and provided to the member/caregiver.
    e. Any SNF placement will be documented within 72 hours from date of the request.
    f. A medication reconciliation will be performed and documented within 30 days of a hospital discharge and at least annually
29. Educational material on his or her conditions and care options;
    a. Self-directed care options and assistance available to self- direct care; and
    b. Available treatment options, supports, and/or alternative courses of care.

Information is documented as to the date, time and actions taken for each member by each **CC** team member interacting with that member. Documentation is completed in HPN's and affiliate groups' system. The care coordination/care management plan drives the prompts for follow-up.

Risk Stratification

Each member entered into the **CC** program will be risk stratified into appropriate levels of care so interventions are provided that meet the member's needs (Appendix B). The initial stratification using HPN's Clinical Social Assessment (CSA) or the health plan generated Health Risk Assessment (HRA) or Hierarchical Code Conditions (HCC) and/or other data will be done within 72 hours of acceptance into **CC**. Milliman guidelines are utilized in the development of the condition specific care plans and interventions, as well as member individualized goals and preferences.

The CC program uses three risk stratification levels - Low, Medium, and High and they are defined as follows:

Low – The following Activities may be completed by the care coordinator/care manager, social worker or other healthcare professional. (Member self-maintained monitoring):

1. The HPN's Clinical Social Assessment (CSA) or health plan completed HRA for Special Needs Program (SNP)/Cal MediConnect (CMC)/Comprehensive Care Management (CCM) and/or other assessments are performed at least annually.
2. Condition specific assessment and condition detail, as well as assessment of the member individualized goals and preferences, are performed at least annually. The care plan is developed and revised in collaboration with the member and Interdisciplinary care team (ICT) quarterly, if needed, but at least annually.
3. Care may be coordinated with external entities (i.e. Department of Social Services, Medicaid) when necessary.
4. Referral for health coaching/disease management, as needed.
5. Surveillance calls for chronic disease management, such as Congestive Heart Failure. Review for potential status changes such as: ER visits, hospitalizations, Case Management/ICT follow up (including ICT meeting and care plan update) with member/caregiver is at least annually and when there are any health status changes.

Moderate - The following Activities which may be rendered by the care coordinator/care manager, social worker or other healthcare professional. (Member Needs Ongoing Education):

1. The HPN's Clinical Social Assessment (CSA) or health plan completed HRA for Special Needs Program (SNP)/CalMediConnect (CMC/Comprehensive Care Management (CCM) and/or other assessments are performed at least annually.
2. Condition specific assessment and condition detail, as well as member individualized goals and preferences, are performed at least annually for members who have the top 3 HCC conditions or renal failure (primary condition assessed).
3. Care may be coordinated with external entities (i.e. Health Plans, DSS, DHCS, Medicaid) when necessary.
4. Referral for disease management as needed.
5. Follow up calls for chronic disease management, such as Congestive Heart Failure. Follow up calls for potential status changes such as ER visits, hospitalizations, Case Management/ICT follow up (including ICT meeting and care plan update) with member/caregiver is at least semi-annually and when there are any status changes.

High - The following Activities will be rendered by a nurse (Member not stable or being stabilized):

1. The HPN's Clinical Social Assessment (CSA) or health plan completed HRA for Special Needs Program (SNP)/CalMediConnect (CMC)/Comprehensive Care Management (CCM) and/or other assessments are performed at least annually.
2. The HPN CSA for Acute or SNF admissions done upon discharge from facilities.

3. Condition specific assessment and condition detail, as well as member individualized goals and preferences, are performed at least annually for members who have the top 3 HCC conditions or renal failure (primary condition assessed).
4. Perform condition detail assessment for major condition at least semi- annually.
5. Develop and revise the plan of care in collaboration with ICT at least quarterly or as needed.
6. Care may be coordinated with external entities (i.e. Health Plans, DSS, DHCS, Medicaid) when necessary.
7. Referral for disease management.
8. Follow up calls for chronic disease management, such as Congestive Heart Failure and for potential status changes such as ER visits, hospitalizations, Case Management/ICT follow up (including ICT meeting and care plan update) with member/caregiver is at least semi-annually or as needed and when there are any status changes.

The frequency of the Care Manager/Care Coordinator follow up should meet the minimum contact within each stratification level. More follow up may be required, i.e., care management at the High Level may require daily, bi-weekly, weekly, bi-monthly, monthly, and quarterly or annual follow up (See Appendix B for additional details).

Care Plan Generation

The **CC** team develops the care plan which is shared with, acknowledged, and endorsed by the member, member care givers, the member's Primary Care Physician (PCP), professional staff providing services to the member, and the **CC** team. The HRA or CSA will be used to develop the care plan. The care plan will address member specific goals and preferences, as well as active social, psychological, and health issues present. It will also identify who the member has designated to be involved in the care plan generation and the level of involvement of his or her caregivers or medical providers. Our holistic approach ensures that the identified issues will have associated plans of care with specific designation of the CC's members primarily responsible for implementation of the care plan as well as secondary or tertiary professionals also responsible for care plan implementation. The member and associated care givers are intricate members of the **CC** team and will be encouraged to actively participate in care plan implementation. The care plan will identify resources available as a contracted health plan benefit, as well as community or other resources available to assist in care plan implementation. It is important that member self-management plans are built into the care plan and how that is to be effectuated and communicated. The care plan will be located in the member medical record/file and will be available in alternative formats and in the member's preferred written or spoken language (the Health Plan will provide the necessary translation services to do so) If the member is unable to contact and HPN does not receive an HRA from the Health Plan, the CC team is to contact the PCP and obtain any information (History & Physical, labs, etc.), claims information, authorizations, etc. to develop a plan of care.

Designating responsible provider

The primary care physician and a participating provider or Interdisciplinary care Team (ICT) members will be identified for each active care issue within the care plan. All ICT team members will have responsibility for care plan implementation for the specific identified issue. For the D-SNP and CMC members, the Primary Care Provider:

1. Is an integral member of/ active participant in the Interdisciplinary Care Team (ICT) is the primary source of assessment information, care plan development and member interaction within the ICT.
2. Will participate in regular case conferences for member with complex healthcare needs and/or complex transition issues.
3. Is primarily responsible for determining what medical services the member needs.
4. Is the primary leader of the healthcare team involved in the coordination and direction of services for the member.
5. Will complete an Initial Health Assessment (IHA) within 120 days of enrollment and an Initial Health Education Assessment (IHEBA) on all CMC members.
6. Will identify all appropriate providers and facilities to meet the member's healthcare needs.
7. Will provide direct communication to the member/family.
8. Will maintain all reports on services delivered to the member by the ICT in the PCP medical record as well as the care management file in the Medical Group.

Careful and precise communication amongst the member, care givers, designated responsible provider(s), and CC team is required to effectively develop and implement effective care plans. The designated provider(s) may or may not be a licensed healthcare professional. The designated provider(s) will never be assigned responsibilities for tasks outside the scope of their professional designation, demonstrated competencies, or agreed upon duties.

Care Plan Execution

The care plan will be implemented and monitored so that it is consistent with the member's acuity scoring. The member's acuity may change over time. A critical component of the care plan is the intermittent Clinical Social Assessments (CSA) or health plan generated Health Risk Assessment (HRA) of the member's physical, psychosocial, and functional needs. The assessment(s) can be performed face-to-face, telephonic, electronic or by mail. To achieve this, the information/data collected from the CSA or HRA is evaluated to determine individual member's needs and assists with development of a Care Plan within 10 business days of CSA or HRA completion and enrollment into CC or other group care program.

The **CC** Care Manager/Care Coordinator reviews the CSA or HRA results to identify members who are at risk for chronic or catastrophic medical conditions and then uses this data to stratify members based on complexity and severity of any existing disease processes or conditions and their risk for hospitalization. The CSA or HRA results are shared with the **CC** team members in their ICT meetings and the information is provided via the HPN Care Management system (patient's care plan) for coordination of care and development and implementation of an individualized care plan Care plan implementation requires the **CC** Care Manager/Care Coordinator use these guidelines to evaluate the members:

1. Evaluation of clinical and psychosocial information through review of CSA or HRA results, interviews with the member or family/caregiver, review of medical information, and communication with the member's physician(s) and other assigned professionals, when applicable. Problems identified in the initial health risk assessment (HRA) are addressed in the individualized care plan (ICP) when available.
2. Identification of current and potential problems/limitations/barriers and care needs based on the initial assessment that would require a need for referrals to resolve any physical or cognitive barriers to access.
3. Identification of the need for facilitating communication among the member's health care providers, including mental health and substance abuse providers. Evaluation of the need to develop an individual plan of action, which includes the physician(s) treatment plan, member/caregiver preferences and goals, and any appropriate community-based services and care facilities.

Care Plan implementation may be limited to arranging temporary home visits after a hospital discharge, or it may serve to integrate long term health care, nursing home, social services, hospice and community services such as: CBAS, IHSS, LTSS, MSSP, meal assistance, senior transportation, community education, and wellness classes. Care plan interventions, implementation notes and ongoing evaluation will be documented in the system and shared with the member, caregiver, and associated providers of care, as needed to meet the goals of the care plan(s). The Care Plan and member needs and health status are re-evaluated on a regular basis and updated as member's health status changes to ensure that the Care Manager has the most current physical, psychosocial, and functional information for effective, timely and continuous member care coordination.

To achieve member oriented goals the following procedures are followed utilizing evidence-based clinical guidelines or algorithms. (i.e.: Milliman Chronic Care Guidelines), as well as the member's preferences and personal goals for self-maintenance. The Care Manager/Care Coordinator identifies and documents the following information, including information from the assessment process in the members care record, and takes this information to the ICT review within 30 working days of the HRA or CSA completion**:**

1. Members of the Interdisciplinary Care Team (ICT) currently involved in the member's care, including Specialty.
2. Physical care needs – what care is the member receiving and what else may be needed such as home health care, home infusion, consultations and diagnostic reports from network specialists, etc.
3. Claims, encounters, prescription and other clinical data were reviewed and used to build the individualized care plan.
4. Equipment and supplies – are the services in place or being requested appropriate to the member's needs; are or will they be provided by a participating provider; should purchase of DME or supplies be considered.
5. Caregivers and other sources of social support that provide physical, emotional, and spiritual assistance.
6. Alternative benefits or financial resources the member has access to or requires to meet his/her needs.

7. Available community resources –what resources is the member accessing now, if any; what might he/she need for additional support such as DHCS/state Programs, meals assistance, transportation services, etc.
8. Member's cultural and linguistic needs or requirements.
9. Member's healthcare preferences and prioritization of goals.
10. Intervention prioritization - what needs to be done, what is urgent, what is a long term intervention?
11. The need for more complex care coordination, such as discharge planning.
12. If the member is a CSNP – assist in verifying the Chronic diagnosis for Special Needs members.. The assessment is specific to the member's disease state and the care plan is specific to those disease states,

The Care Manager/Care Coordinator will identify specific individual problems or concerns, in collaboration with the Interdisciplinary Care Team to establish the course of action for prioritized goal setting to meet the member's needs and preferences. Each problem will have at least one goal and one intervention with documented barriers, if they exist. The Care Manager/Care Coordinator documents each problem in the care plan. For CCM and CMC Members, the initial assessment and care/plan goals are completed within 30 days of enrollment into case management.

Development of Goals

1. After identifying the member's problems and concerns using information obtained from the member, ICT team members, caregivers, CSA or HRA, and the members risk profile; the Care Manager/Care Coordinator collaborates with the member/caregiver and the ICT, and the member, to establish measurable prioritized goals to meet the member's needs/preferences and develop interventions required to meet the goals. The previously identified problems will drive goal statements and facilitate the direction in which the member/caregiver participates in the care plan.

2. Goals should be aimed at improved member health/mental status, be individualized, and prevention/reduction of transitions of care through improved:
    a. independence and self-management
    b. mobility and functional status
    c. pain and symptom management
    d. quality of life perception
    e. satisfaction with health status and healthcare services

3. Goals should be <u>specific</u>, <u>measurable</u>, <u>aligned</u> and <u>directly linked</u> to the identified problems using focused charting. Prioritized goals address acute and immediate clinical, psychosocial and financial needs and delineate activities to sustain health improvements, optimal health status, or provide optimal support at the end of life. Prioritized goals also define the criteria for graduation (see Appendix D) or case closure for non SNP members.

4. The Care Manager/Care Coordinator develops goals that are member driven (what is important to the member) and should be "**SMART**"

   Specific – clear with target result that must be achieved by the member
   Measurable – measurable with criteria that indicate how the result will be quantifiable. Some examples of measurability dimensions are quantity, frequency, quality, etc.
   Achievable – realistic, clinically appropriate, member driven, and credible (Care Manager/Care Coordinator , Medical Director, member or provider believes and is confident that he/she has the ability to attain the goal).
   Results-oriented – stated in terms of an outcome that must be achieved and requires focused interventions and effort.
   Time bound – time bound by a specific timeframe by which the goal must be achieved. Deadline focuses attention and effort on achieving the goal results.

5. A goal should be able to be well supported:
   a. Based on member's documented preferences, assessment(s) and problems.
   b. All care team members are aware of the goal and understand their role in achieving it (member/family/provider)
   c. All care team members agree with the goal(s) and are committed to achieving it (them).
   d. The Care Manager/Care Coordinator documents the goals in the member's record.
   e. Each goal is documented as met or not met when evaluated.

Development of Interventions

1. Each problem and its associated goal(s) has identified barriers, if any, and interventions that are required to achieve the goal. The Care Manager/Care Coordinator will document the specific type of barrier, if any, and intervention, date established and the date completed.

2. Each intervention is either acted on at the time the Care Manager/Care Coordinator is establishing the Care Plan or is scheduled for follow up.

3. Specific Care management intervention activities are based on member preferences, appropriateness, availability, and accessibility of medical, psychosocial and financial resources. These may include:
   a. Interventions provided for the member to achieve specific member/caregiver goals.
   b. Referrals to other programs (internal and external)
   c. Description of services specifically tailored to the member's needs including add on services and benefits.
   d. Skills training interventions structured with incremental time frames as appropriate to achieve educational and self- management goals.
   e. Discharge goals established to target optimal health condition and prevent re-admissions.
   f. Development and communication of self-management plan for the member and/or her/his family.

g. Educational material on the member's conditions and care options, which include self-directed care options and assistance available to self-direct.
h. Information on how to access available LTSS, including IHSS services, if applicable.

4. The Care Manager/Care Coordinator will indicate the priority of the interventions based on the urgency of the problem or issue, and what is important to the member and/or his family/representative. Documentation will include the schedule for follow up and communication with the member and/or his/her representative based on the member's acuity level and clinical judgment of the Care Manager/Care Coordinator.

5. Once the Care Manager/Care Coordinator has identified the problems, barriers, interventions, and goals, agreement is reached with the member and the care team in implementing the Care Plan. The Care Plan and its approval are documented in the member's record, and a letter of participation with the Care Plan and any amendments is sent via US mail to the member and the primary care provider, indicating the members/caregivers agreed participation in the plan of care. The member will have an opportunity to review the care plan and make any amendments to the plan. Any modifications will be addressed with the ICT and the care plan modified accordingly. A new copy of the Care Plan will be sent to the member and Primary Care Provider.

Supporting the Care Plan through Resource Identification and Benefit Management

1. A care plan may include a recommendation for alternative resources/services. Alternative community-based resources, i.e. meals, transportation, carve-out services, etc., should always be used if available for non-covered services.

2. The Care Manager/Care Coordinator reviews the member's benefits and alternative resources, including community-based resources, to determine how to best support the Care Plan. In some instances the member may not have benefits to cover services required to support an alternative care plan. The Care Manager/Care Coordinator determines what alternative funding such as secondary coverage, third party liability, community-based resource, etc. may be available.

3. The Care Manager/Care Coordinator provides continuity over the continuum of care for members with complex conditions or illnesses. When a member has multiple conditions and/or providers, the Care Manager/Care Coordinator has a key role in coordinating the member's care and providing continuity of the communication between providers/professionals.

4. The Care Manager/Care Coordinator's established relationship and rapport with the member and/or their representative and provider(s) help facilitate not only care coordination, but also opportunities for the Care Manager/Care Coordinator to identify, develop and recommend alternative treatment services.

5. The Care Manager/Care Coordinator helps the member obtain services that they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage and community-

based resources. The Care Manager/Care Coordinator reviews each program's rules and benefit structure to provide appropriate care coordination within the program.

Implementation of the Care Plan

1. Working with the member and/or member's representative and the ICT, the Care Manager/Care Coordinator implements the activities and interventions in the Care Plan.

2. The Care Manager/Care Coordinator ensures that:
    a. The care plan contains services and interventions which are consistent with the member's health care needs, health plan medical policies, provided by appropriate service providers, and the member's benefits or, if no benefits are available, accessible through alternative funding or community resources.
    b. The care plan addresses the appropriateness, level, frequency, duration and effectiveness of the treatment plan and includes interventions to address any specific issues such as assessing for language or culturally based barriers to utilization of local community based resources.
    c. The care plan includes interventions, which support the functions of service coordination and monitoring.
    d. Referrals are made to available contracted service providers (whenever possible), vendors, Health Plan programs or resources. These may include a referral to Disease Management, Behavioral Health Depression Programs or other health care professionals, or programs. These referrals will be discussed with the Interdisciplinary Care Team (ICT) and documented appropriately.
    e. Referrals are made to any appropriate community resources such as disease specific or other support groups and resources, and when appropriate and how these services are coordinated in to the care management process

3. Care management reviews are conducted among peers to promote discussion of care management issues, improve continuity of care, and identification and resolution of barriers to care plan development.

4. The process also allows a forum for the Care Manager/Care Coordinator to learn of new technologies, identify best practice standards, facilitate care across the continuum, and combine successful care management interventions.

Monitoring and Evaluating the Care Plan

1. The Care Manager/Care Coordinator continually monitors the quality of care, services and products delivered to the member to determine if the goals are being met or if any new problems have developed. The frequency for review of the care plan is at minimum annually, or upon change of health status. Our software system provides, the date and time of the action and

automatic prompts for follow-up that are entered after every interaction with the member/caregiver.

2. Through ongoing assessment, using the system assessment tools and risk profiles the Care Manager/Care Coordinator determines with the help of the ICT team, whether the goals continue to be appropriate and realistic, and what interventions may be implemented to achieve or enhance positive outcomes.

3. As part of the monitoring process, the Care Manager/Care Coordinator contacts the member or the member's authorized representative and provider(s) at established timeframes based on the:
    a. The engagement of members and/or their representatives to play an active role in designing their care plan; and
    b. Need for specific interventions and/or the Care Manager/Care Coordinator's judgment.
    c. The frequency for updating the individualized care plan, in response to routine and non-routine reviews and revisions, including required updates when members are not meeting their individualized care plan goals or at a minimum frequency as defined by the member's acuity level. If the Care Manager/Care Coordinator determines the frequency needs to be decreased or increased, he/she should modify the acuity level of the case, document the change and discuss this with the ICT

4. As the Care Manager/Care Coordinator monitors the Care Plan and the progress towards meeting the goals, he/she evaluates the need for modification. The Care Manager/Care Coordinator may base the assessment of progress on information obtained from the member or member's representative, family members, attending physician, professional and caregivers, Interdisciplinary Care Team members and risk profiles.

5. If progress is not being made toward meeting the goals, the ICT should reassess the case to identify any barriers to meeting the established goals or complying with the Care Plan. These barriers may include:
    a. Insufficient information.
    b. Member or member's representative not willing to participate in case management.
    c. Lack of member or family/caregiver readiness to change.
    d. Lack of communication between member and his family or providers or other psychosocial concerns.
    e. Lack of advance directives.
    f. Ineffective strategy for managing after hour's care or care transitions.
    g. Unidentified or un-manageable psychosocial issues with the member and/or his family or caregivers.
    h. Lack of rapport between the member and the Care Manager/Care Coordinator or the attending provider(s) and the Care Manager/Care Coordinator.
    i. Lack of resources for non-covered benefits/services.

6. When barriers are identified the Care Manager/Care Coordinator is responsible for addressing the barriers. Barriers can be discussed at the case reviews (ICT's) or at any time with the member/caregiver and/or primary care provider/medical director(s).

7. As the care plan is monitored and evaluated it may need to be revised. Revisions to the care plan should be considered whenever there is:
    a. A significant change in the member's condition, treatment plan, prognosis, or their support systems.
    b. Difficulty in meeting the goals.
    c. Case review by the unit manager or medical director with a request to revise the care plan.
    d. Changes are noted in the clinical, psychosocial, or financial status.
    e. The member is not making progress towards goals and objectives.
    f. The member is not adhering to the agreed upon care plan.
    g. Qualities of care, access or other issues with a provider are noted.

8. If modification to the Care Plan is required, the Care Manager/Care Coordinator continues to work with the member's ICT team to modify the care plan as appropriate and guide the member toward health and wellness, rehabilitation or adaptation and self-care, or when needed, acceptance of an end of life condition.

9. The Care Manager/Care Coordinator documents all care plan activities. Throughout the management of the care coordination, the Care Manager/Care Coordinator encourages the member and their family to make choices, to experience a sense of achievement and/or control, and to modify or continue participation in the treatment process.

10. The Care Manager/Care Coordinator documents the achievement of goals and the date, and notes which goals were not achieved through care management interventions and why. Members graduate from the program as they become capable to self-monitor and manage their care and have not had any inpatient admission(s) for three months, unless the member is in a Special Needs Program (SNP) or in the Cal MediConnect Program (CMC) then the member is placed on a lower level of care and followed up is performed as needed.

The Interdisciplinary Care Team (ICT)

The ICT will coordinate the delivery of services and benefits to every member when a need is demonstrated or one is requested and is in accordance with the member's functional needs as assessed in the care plan and integrates medical, behavioral health and LTSS needs.

The ICT will convene when:

1. Any member who has an Initial Care Level of "High"
2. Notified by the Care Manager of any member who has undergone a care transition such as a change in level of care, an unplanned admission, ,(ER, psychiatric, SNF or acute) etc.
3. Any member who has been identified by the ICT pharmacist as high risk via the Medication

Therapy Management (MTM) program.

4. Any member who has experienced a significant change in health status.
5. Any member and/or case manager experiencing barriers to achieving goals requiring ICT support.
6. Any member whose assessment identifies needs requiring support of the ICT.

Documentation and Timeframe of the Interdisciplinary Care Team meetings will be:

1. Conducted on CMC eligible members – who have been enrolled for at least 60 days.
2. Conducted within the necessary timeframe to meet member needs but no later than 90 days after the occurrence of one of the demonstrated need criteria.
3. When a member demonstrates a need for an ICT, the ICP or member notes will document the dates, participants, notes and action plan discussed during ICT.
4. When upon assessment a case manager determines a member does not meet demonstrated need criteria or is not truly High risk despite meeting demonstrated need criteria, the case manager will document in the Individualized Care Plan (ICP) or member notes the explanation for not conducting an ICT.
5. ICTs are member centric and dynamic and may meet as needed to manage members at all risk levels.

Transitions of Care

The CC program also monitors and coordinates care when the member moves or transitions from one level of care to another, i.e. home to ER or home to hospital or hospital to skilled nursing facility whether planned or unplanned. The CC Program identifies members who are at risk of transitions by analyzing the utilization management data on a monthly basis and focusing on those individuals. Of significant importance is that the Special Needs Members need to be closely monitored for transitions of care because it is important to provide a seamless delivery of care across the health continuum. A provider network with specialized expertise will collaborate with the ICT and contribute to a enrollee's ICP to provide necessary specialized services.

The Transitions of Care process is used to guide the Care Manager in obtaining the documentation necessary to ensure seamless care delivery in one business day. In most instances our concurrent review process monitors and assists in this coordination through communication with the member, the member’s family and the PCP. The inpatient review nurse communicates with the discharge planner and care manager when appropriate to coordinate the member’s care. The member/caregiver/family is provided with available treatment options, supports, and/or alternative courses of care and are ensured access to appropriate community resources. The focus is on providing services in the least restrictive setting and transitions between the facilities and community. Data is collected on all transitions of care and analyzed on an annual basis to determine if there are areas of the process which need improvement.

Of particular importance is the mitigation or management of planned or unplanned hospital admissions and admissions to acute or long-term care facilities. HPN requires that all its contracted hospitals and long term facilities report admissions **within one (1) business day**. A goal of HPN is to minimize the number of unplanned admissions by working with our contracted hospitals and long term facilities in the notification process. The Provider will be notified of the hospital or ED admission **within one (1) business day of the admission.**

SNF and Sub-acute Care Facilities – HPN and its affiliated medical groups will place a patient in the SNF or Sub-Acute Care Facility within 72 hours from the request. If placement exceed the 72 hours, HPN and its affiliated medical groups will coordinate with the hospital to facilitate discharge as soon as possible to the most appropriate level of care based on medical necessity and incorporate the patient's preferences when medically appropriate.

The Care Manager (CM) is the point of contact for the member. The Care Manager will notify the members and/or their caregivers of the personnel responsible for supporting them through transitions between any two settings. The CM is to communicate with the member/caregiver/family and educate him/her within **five (5) days of discharge** on the importance of working with their PCP in preventing unplanned transitions of care and where appropriate, the new plan of care due to changes in the member's health status Data is analyzed on a scheduled basis regarding ED visits and unplanned admissions to determine the drivers of these admissions and what can be done to decrease them. All transitions are tracked as to their status including the timing of information exchange. Any quality improvements to the process are identified and interventions are implemented.

Once the Care Manager has been notified of a member's admission to an acute or skilled facility, s/he must determine if this was a planned (elective) or unplanned admission.

If unplanned, the Care Manager must determine why this admission occurred, what was the driver behind the admission so that interventions can be put in place to prevent this from occurring again.

If planned, the Prior Authorization Department would have notified the Care Manager in advance of the admission that this member was to have an elective procedure. The Care Manager then is responsible for educating and preparing the member for what can be expected preoperatively, during and after this planned procedure or surgery before the event.

For example:
If the member was to have knee replacement surgery, the Care Manager may have scheduled an appointment with the physical therapy department so the member can see and discuss the post-surgical physical therapy treatments, prior to the surgery being done, to allow the member to understand the process and to reduce anxiety of the member.

Regardless if the hospitalization was planned or unplanned, the PCP must be notified of the admission within one business day. Next, the Care Manager must obtain the care plan from the receiving facility so that care can be coordinated upon discharge. A copy of all facilities' care plans are to be reviewed and scanned into the care management system to be used for member care coordination. If for some reason

the Care Manager is unable to obtain a care plan from the facility, it should be documented in care file in the member's case notes. Depending on the facility, a discharge treatment plan with the discharge medications may be available for review. The member's medications and reviewed and reconciled with the member or the member's family during the transitions of care.

Program Value

Care Coordination (CC) produces value by focusing time, attention, talent, and resources on the small percentage of members who are not well served by the current health delivery system. By identifying and providing additional clinical, administrative, and community services the members in the **CC** program will experience improved quality of life and more effective, productive use of healthcare resources. Participating providers derive value by accessing and utilizing additional clinical care management services to coordinate care plan development and implementation without incurring additional expense or inconvenience. The Health Plans derive value by confirming that their most needy members have their care needs accurately identified and addressed using evidence based guidelines in addition to community resources, while encouraging the member/caregiver participation in their own care processes.

Program Metrics

The HPN Care Coordination (CC) Program will be measured at least annually to determine its effectiveness. The following are the elements that may be measured using the following parameters:

1. % eligible members enrolled in the program, defined as # of members in **CC** /# of eligible members
2. Length of stay in the **CC** program, average LOS and median LOS
3. # of Emergency Room encounters by **CC** members which ended in a non-admission
4. # of Emergency Room encounters by **CC** members which ended in an admission
5. # of Urgent Care encounters by **CC** members
6. # of hospital admission per thousand which were not prior authorized by **CC** members
7. # of non-prior authorized hospital admissions of **CC** members with < 1 day LOS per thousand
8. # of non-prior authorized admissions per thousand transferred from another facility
9. # admissions per thousand **CC** members per Care Manager/Care Coordinator and physician director
10. # of transitions of care per event.
11. Admission Length of Stay both average and median
12. Identify the drivers of Emergency Room and Hospital utilization by **CC** members.
13. # of active **CC** members per Care Manager/Care Coordinator
14. # of outbound calls per week by Care Manager/Care Coordinator
15. # of hospice conversions
16. # of **CC** office visits, home visits, SNF visits by provider
17. % of active **CC** members for CSNP, DSNP and CMC with updated and complete care plan
18. % of completed ICT Meetings for the CSNP and DSNP.
19. % of Members satisfied with the CC Program by obtaining feedback from members and analyzing member complaints.

Benchmarks and/or thresholds are established for each metric and if any metric does not meet the established benchmark/threshold, one or more interventions will be developed and implemented with timeframes for re-measurement.

Continuous Quality Improvement

The **CC** team uses the Plan / Do / Study / CC method of quality improvement. Member identification, assessment, stratification, monitoring, communication, care plan generation, care plan implementation are reviewed and revised annually or as needed to improve quality and performance. **CC** members, family members, and caregivers complete satisfaction surveys (see Appendix E) to provide insight into improvement opportunities. Referring providers are surveyed as well to gain insight into effective activities and to identify improvement opportunities. Member complaints are collected and assessed to identify areas of improvement so that interventions can be implemented immediately.

The Care Coordination Program is reviewed annually to ensure that the content meets the evidence used to develop the program. Member materials are assessed to determine the consistency with current evidence and that they are cultural and linguistically appropriate. All staff training materials are reviewed to determine if they are consistent with current evidence. If any discrepancies are found, immediate action is taken to correct or modify the processes, materials or content.

Staff Requirements

The Staffing of the CC Program entails both licensed and non-licensed personnel. The care management is performed by Care Managers who are licensed LVNs and RNs and non-licensed staff who are CC Coordinators. Other staff include: Licensed Medical Directors, Social Workers, and Pharmacists. The number of each category of staff depends on the number and acuity of the membership to be managed.

Job descriptions have been developed that clearly outline the level of education and experience required to meet the member's risk level individual needs (e.g., communication, cognitive, or other barriers) and for the staff to perform the tasks for nurses, coordinators, other ICT members, and/or social workers.

1. Processes clearly delineate the workflows and details as to what level of staff interact with member. These workflows will be approved by the affiliated medical group's Medical Director. The levels of contact are clearly delineated for the various roles and functions of the staff assigned to each member.

2. Staff licenses are verified within 90 days of hire and monthly to ensure they are current using primary sources for verification.

3. Staff are monitored for any sanctions leveled against them as well as any

complaints from providers or members/caregivers/family members.

4. Depending on the circumstances, sanctions, complaints or quality issues, the issues will be investigated according to the potential quality and leveled accordingly. Each level is assigned a corrective action that will be implemented and documented.

Staff Training

1. All staff members will receive the following training at orientation and annual updates, where appropriate:
    a. Confidentiality of Member Information
    b. Education on the evidence based clinical practice guidelines
    c. Focus on Member Centered Care while providing a safety net of services to better manage patient care.
    d. Independent Living Philosophy
    e. Least Restrictive Setting
    f. Understanding the Patient's needs
    g. Cultural and Linguistic Training
    h. Disability Literacy Training
    i. Advance Directives
    j. Team Concept of working together to provide the safety net of services.
    k. Timeframes for all Initial Contact and continued outreach
    l. Patient Needs Assessment, Stratification and Care Planning
    m. ICT identification and meetings
    n. Care Transitions
    o. Abuse and Neglect Reporting
    p. Graduation for non-SNP/CMC members
    q. IHSS, CBAS, MSSP, LTSS - Service Monitoring; Self-Direction of Services; Behavioral Health and Chemical Dependency (How to identify needs and how to obtain services)
    r. Dementia Care and Alzheimer's Disease (How to identify needs and how to obtain services)
    s. Pharmacy and Part D Services
    t. Hospice and Palliative Care –
    u. Medication Reconciliations, Disease Programs, i.e. Diabetes, CHF
    v. Transportation
    w. Homebound Programs
    x. Home Health Services

y. Social Services
z. Value Added Services – Community Centers, Meals on Wheels
aa. Model of Care Training

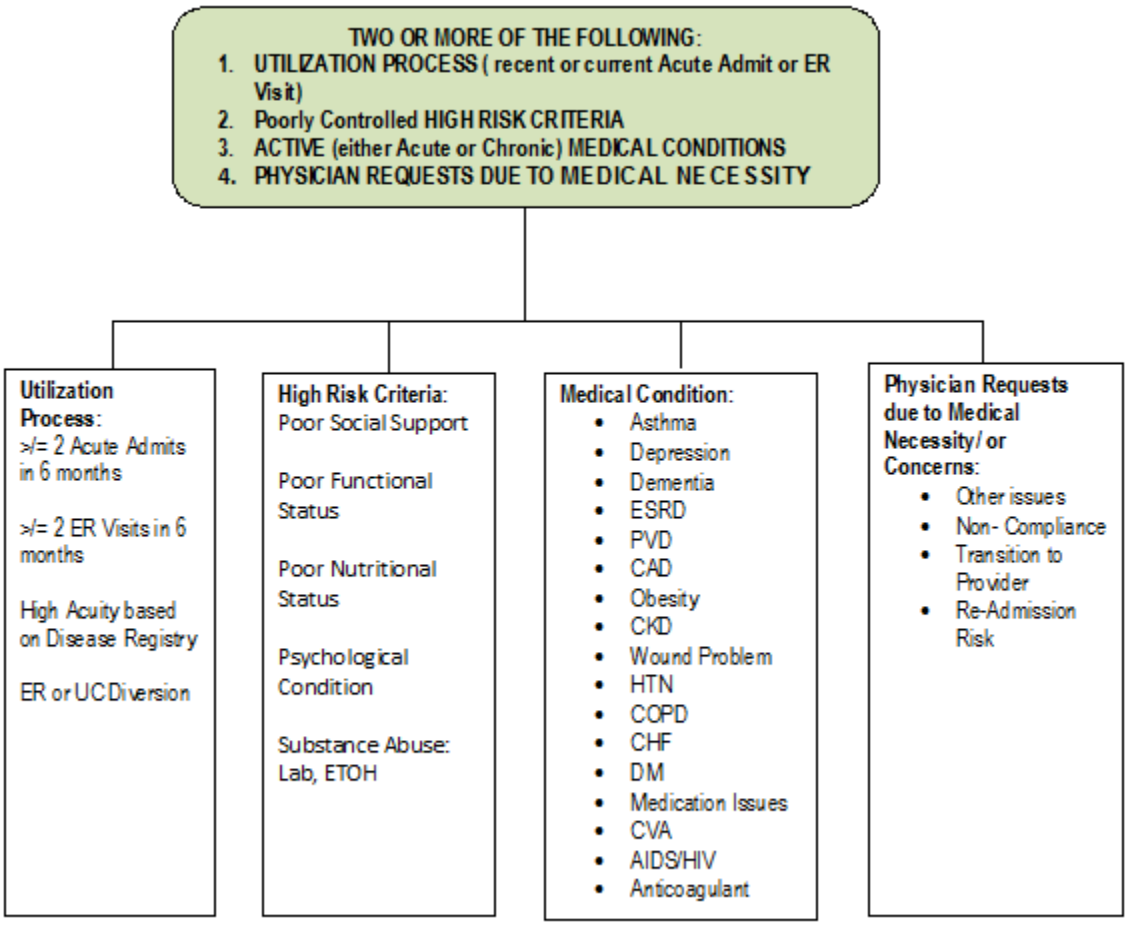
Overall, HPN and its affiliated medical groups' train and review clinical and nonclinical staff. Training addresses education about conditions, clinical practice guidelines, and clinical pathways relevant to the program; behavioral change models that can be used to provide self-management support to patients; goal setting; and cultural competence

2. All staff require ongoing monitoring and feedback as to their performance through patient satisfaction scores, percentage of completed care plans with patient goals met, etc.

APPENDICES

Appendix A – High Risk Care Coordination Management

HIGH RISK CARE COORDINATION MANAGEMENT

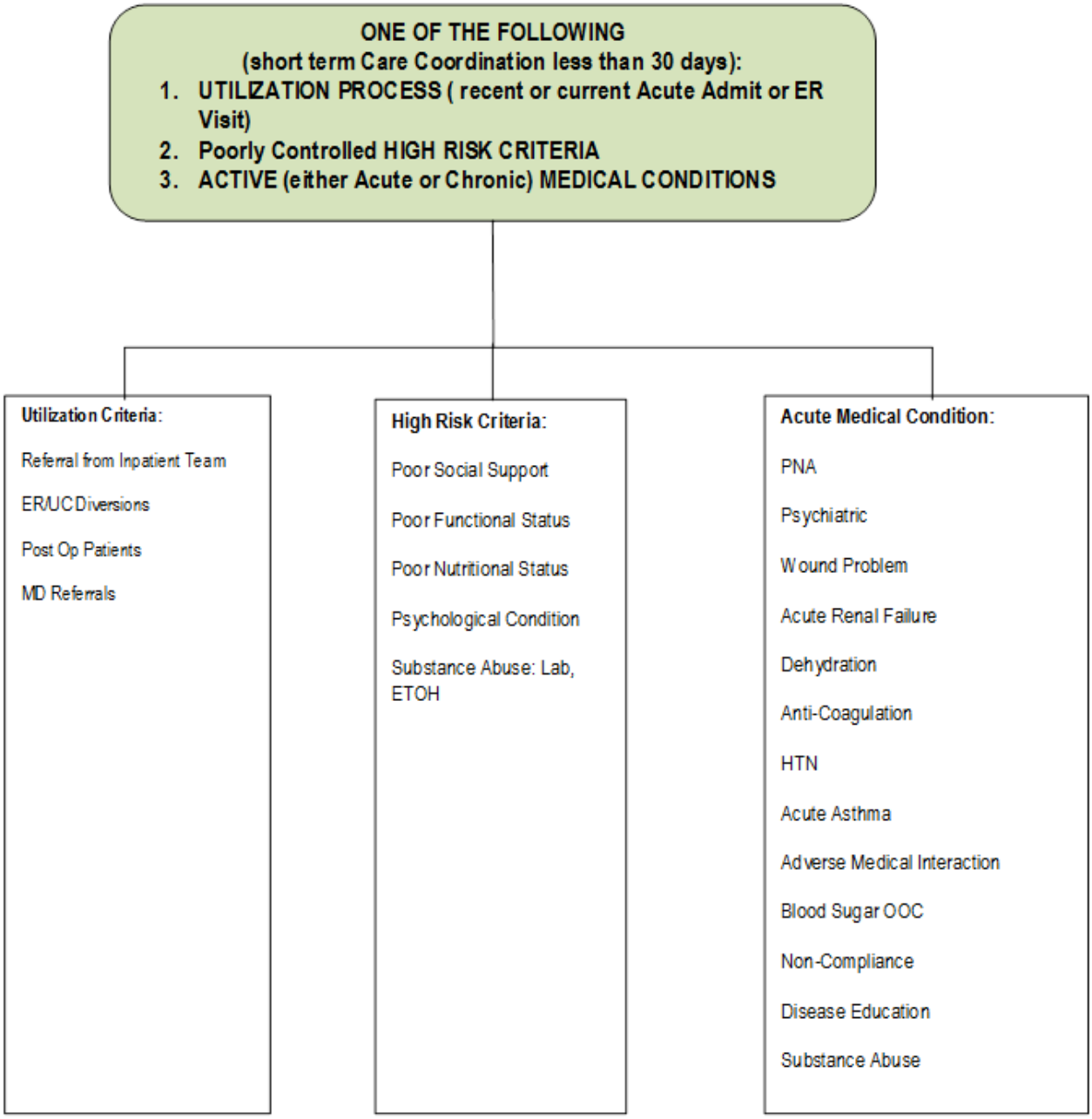


Appendix B – High Risk Acuity Level Grid

HIGH RISK ACUITY LEVEL GRID						
Verbiage used depends on group policy	**Medical Complexity**	**Social Support**	**Functional Status**	**Lifestyle issues**	**Nutritional Status**	**Psychological Status**
HIGH	1. Daily symptoms from medical conditions. 2. Recent medical problem exacerbations 3. Medical problems severely affecting other dimensions 4. Member clearly frustrated with current medical care, treatment plan and/or access 5. Recent Hospitalization	1. Dysfunctional family/friend support systems 2. Little or no contact or interaction with other people or community resources	1. Little to no mobility with little or no Caregiver support 2. Little to no transportation resources for travel to buy food or to doctor's appointments.	1. Daily poor lifestyle choices that effect health status 2. Alcohol abuse 3. Smoking 4. Medication Non-Compliance 5. High risk sexual behavior	1. No coordinated plan of meal preparation 2. Daily poor food selection (fatty foods, fast foods, sodas, fried foods, etc.) 3. Limited or no knowledge of nutritional effects on medical problems	1. Poor or absent coping mechanisms 2. Clearly depressed or negative attitude 3. Hopelessness
MODERATE	1. Frequent symptoms 2.Medical problems frequently affect other dimensions of member welling being 3. Member has occasional difficulty with medical care treatment plan and/or access	1. Limited family/friend support 2. Limited contact or interaction with other people or community resources.	1. Limited mobility with limited Caregiver support 2. Limited transportation resources for travel to buy food or doctor's appointments	1. Frequent poor lifestyle choices that effect health status 2. Alcohol abuse 3. Smoking 4. Medication Non-Compliance 5. High risk sexual behavior	1. Occasional support with meal preparations. 2. Frequent poor food selections 3. Some knowledge of nutritional effects on medical problems	1. Minimal coping mechanisms 2. Some signs of depressed or negative attitude 3. Minimal hope for future improvement.
LOW	1. Occasional symptoms 2. Medical problems occasionally affect other dimensions of members well being 3. Member comfortable with current care treatment plan and/or access	1. Good family/friend support 2. Good Caregiver support or no caregiver support needed at all 3. Frequent contact and interaction with other people/community.	1. Good mobility with little or no need for Caregiver 2. Good transportation resources for travel to buy food and to doctor's appointments.	1. Few to no poor lifestyle choices that affect health status	1. Regular support with food preparation 2. Good food selection 3. Good knowledge of nutritional effects on medical problems	1. Good coping mechanisms 2. Positive attitude 3. Positive outlook on life and health

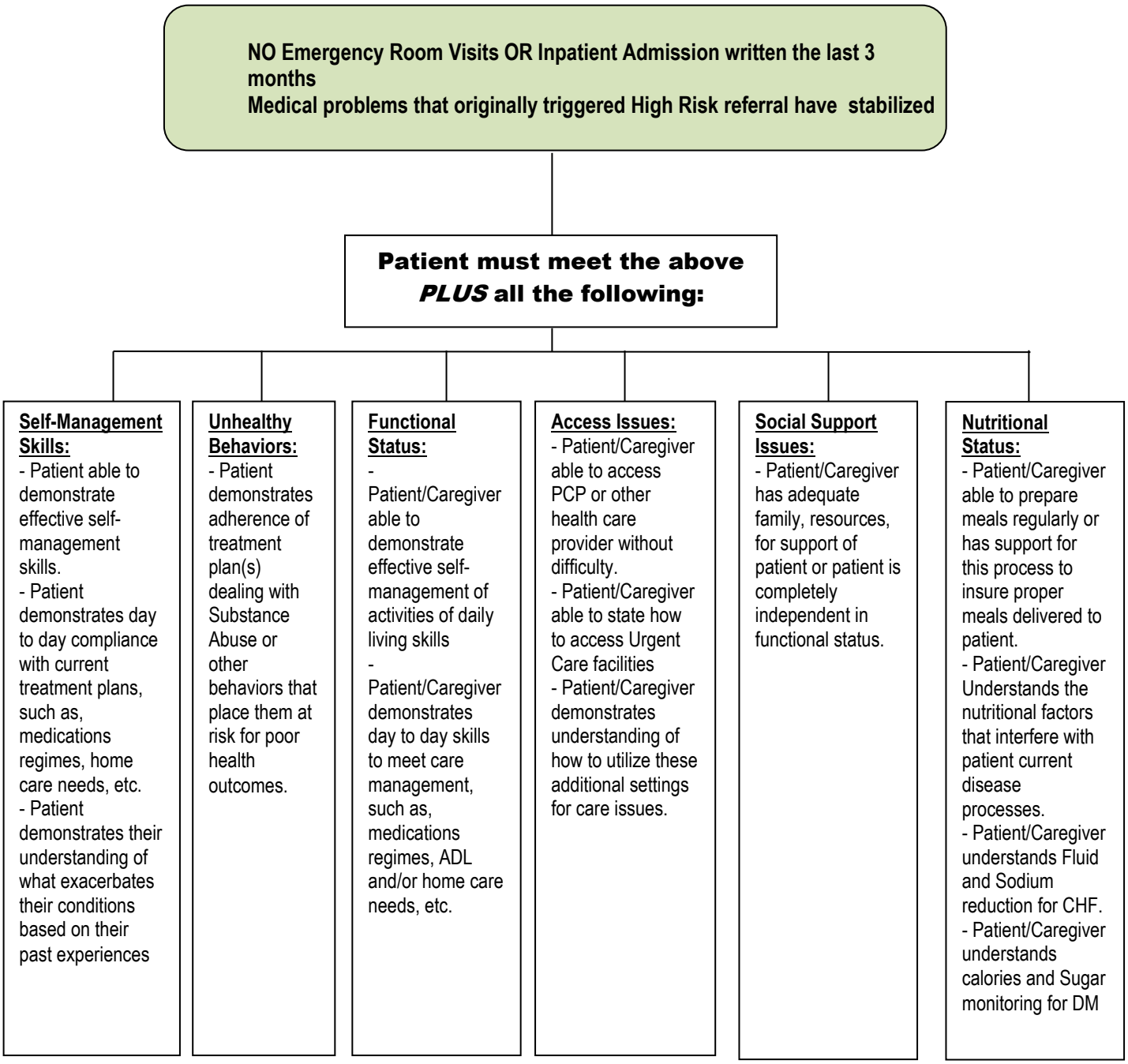
Appendix C – Transitional Care Coordination Management

TRANSITIONAL CARE COORDINATION MANAGEMENT



Appendix D – High Risk Discharge Process

High Risk Discharge Process



Appendix E – Member Satisfaction Survey

Your Opinion Is Important To Us! Since you are periodically contacted by **CC** Nurse Care Manager/Care Coordinator's we would like to know how satisfied you are with the service. Please complete this very brief survey so that we know how we are doing and if there is something that needs improvement. This survey is confidential. Once you complete the survey please return it in the enclosed ***Business Reply Envelope*** provided for your convenience, NO POSTAGE REQUIRED.

1. I know the name of my Nurse Care Manager/Care Coordinator
   _____ Yes ____ No

   If you checked "Yes", what is the Nurse's Name? _____

2. My Nurse Care Manager/Care Coordinator returns my calls within 24-48 hours.

   _____ Very Satisfied _____Satisfied _____ Dissatisfied _____Not Applicable

3. My Nurse Care Manager/Care Coordinator explained that she/he or another staff person is available to assist me 24 Hours a day every day of the week, including weekends and holidays.

   _____ Very Satisfied _____Satisfied _____ Dissatisfied _____Not Applicable

4. My Nurse Care Manager/Care Coordinator makes me feel free to tell her/him how I feel about the service I receive (d).

   _____ Very Satisfied _____Satisfied _____ Dissatisfied _____Not Applicable

5. My Nurse Care Manager/Care Coordinator explained that I can call her/him anytime when I am not feeling well.
   _____ Very Satisfied _____Satisfied _____ Dissatisfied _____Not Applicable

   . When my Nurse Care Manager/Care Coordinator was not in the office, another staff member gave me assistance.
   _____ Very Satisfied _____Satisfied _____ Dissatisfied _____Not Applicable

6. My Nurse Care Manager/Care Coordinator is sensitive to my cultural background.
   _____ Very Satisfied _____Satisfied _____ Dissatisfied _____Not Applicable

7. I am satisfied with the care management services and feel that they are/were beneficial.
   _____ Very Satisfied _____Satisfied _____ Dissatisfied _____Not Applicable

9. How satisfied are you with the way the Nurse Care Manager/Care Coordinator has obtained your input with your treatment plan?
   _____ Very Satisfied _____Satisfied _____ Dissatisfied _____Not Applicable

1. How satisfied are you when your Nurse Care Manager/Care Coordinator discussed life style modification changes such as diet, exercise, not smoking, not drinking, medications, and self-management skills to help your health improve.

   _____ Very Satisfied _____Satisfied _____ Dissatisfied _____Not Applicable

   Comments (Optional):
   _____

   THANK YOU! Please return by _____ (Date)