HERITAGE PROVIDER NETWORK

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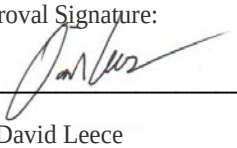
AFFILIATED MEDICAL GROUPS

POPULATION HEALTH MANAGEMENT PROGRAM

2018

Approval Signature:



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Date

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Population Health Management

Heritage Provider Network's Population Health Management approach to Care Management provides member-centric care coordination and care management for a large and diverse population of patients. The size and complexity of the HPN network requires multiple programs and approaches designed to accommodate the needs of a population that has wide variation in age, geography, resources, benefits and culture.

The overall goals of the Population Health Program focus on the Triple Aim Health Care Delivery Model.

1. Improve the health of the population
2. Improve the experience for each individual
3. Reduce the overall cost of care

Population Health Assessment

Heritage Provider Network and its affiliates conduct an Annual Population Assessment to determine the characteristics and needs of its member population and relevant subpopulations including the needs of children and adolescents, individuals with disabilities, and individuals with serious and persistent mental illness. The Population Health Assessment is intended to contribute to the maintenance and improvement of the health and well-being of the population, including the reduction of any identified disparities.

Heritage Provider Network Inc. and its affiliates will use analysis of the interrelated conditions and factors that influence the health of populations over the life course to identify current and evolving systematic variations in their patterns of occurrence, and apply the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations. The collection, monitoring and evaluation of population data allows for the development of targeted interventions for specific patient populations, and provides actionable data upon which program planning and service delivery may be developed.

Member Centered Care

The Care Management approach to delivering care is person and/or member-centered. By putting individuals first, we ensure every member has access to the highest quality of life as defined by individual preferences. We allow members and their legal representative to facilitate care or treatment decisions, inclusive of when a member is incapacitated and unable to do so.

Advance Directive materials are provided annually to each member informing them of their right to accept or refuse treatment; how to complete an advance directive; how to implement that right; and, their right to file a complaint with the State of California.

We allow them direct access to practitioners, and allow the member to choose a primary care practitioner without interferences. We allow women direct access to in-network women health specialists for routine and preventive health care services.

The Programs are a free service offered to all our patients. Information is provided to each member in writing, by web, in person or by telephone on the type of services available, how they may become eligible to participate, how to use the services, and how to opt in and opt out.

Program Services

Due to the size and diversity of our population, there are multiple potential avenues for care coordination and management for eligible members. Our medical groups offer the following services and more depending on the needs of their population:

1. High Intensity Care Management to include:
    a. Inpatient Care
    b. Transitional Care
    c. Ambulatory Care
    d. Telephonic
    e. In Person
    f. Home Based Care
    g. Telemonitoring/Biometric Monitoring
2. Complex Care Management
    a. Inpatient Care
    b. Transitional Care
    c. Ambulatory Care
    d. Telephonic
    e. In Person
    f. Home Based Care
    g. Telemonitoring/Biometric Monitoring
3. Disease Specific Care Management (Monthly)
    a. Anticoagulant Clinics
    b. Diabetic Clinics
    c. Cardiology Clinics
4. Self-Management
    a. Online and Print Tools
5. Palliative Care Management
6. Hospice Care Management
7. Services and resources that support beneficiaries who are frail, disabled or near the end of life

Medical Leadership

The oversight of the HPN Population Health Program falls under the leadership of the HPN Quality Chair. The Medical Director will ensure that all regulatory and accreditation standards are met by the group. Annually, during the Quality Improvement / Utilization Management Committee (QI / UM Committee), existing physicians within the practice are encouraged to discuss the program and allow feedback.

The HPN QI Committee will review the current program, relevant policy and procedures, patient program educational material, clinical practice guidelines, reports and trending, inclusive of patient and provider satisfaction surveys, and will make recommendations for program enhancements. Existing physicians within the practice are encouraged to discuss the program and allowed feedback.

The HPN QI Committee meets at least quarterly. The written program description and policies will be distributed and readily available for physician review. Practitioners will be provided with written information about the program that includes instructions on how to use services and how the group works with a practitioner's patients in the program.

Staff Role

Care Management Staff are divided into four major categories:

1. Plan administrative staff (employed or contracted)
2. Provider network (employed or contracted)
3. Interdisciplinary Care Team {ICT} (employed or contracted)
4. Management staff (employed or contracted)

Specialized Network

HPN offers our Care Management Program members the opportunity to receive quality health care coverage combined with social support services. By effectively coordinating care, providing specialized support services, and respite care for families and caregivers (as applicable), HPN provides eligible members with important advantages and provides a structured care coordination model. These advantages include access to:

1. A primary care provider (PCP)
2. A care manager
3. An ICT team - team of nurses, specialists, and a support services coordinator, work with the member (and family members or caregivers, if applicable) to develop an individualized plan of care to specifically address the needs of the member
4. 24-hour access to an on-call health care professional and active involvement of the member in decisions concerning his or her health care
5. Care Coordination with:
    a. Medical specialists (e.g., cardiology, nephrology, psychiatry, geriatric specialists, pulmonologists, immunologists, etc.)
    b. Behavioral and mental health specialists (e.g., drug counselors, clinical psychologists, etc.)
    c. Nursing professionals (e.g., registered nurses, nurse practitioners, nurse managers, nurse educators, etc.)
    d. Allied health professionals (pharmacists, physical therapists, occupational specialists, speech pathologists, laboratory specialists, radiology specialists, etc.)

Patient Criteria

HPN systems focus on identifying members that have the most need for the specialized services our programs provide. This will range from members with complications from multiple chronic conditions to frail seniors needing assistance with resources. Enrollment in programs is based on each member's risk stratification, medical profile, referrals by providers and care team members, and individual member needs and preferences. Members in Special Needs Plans, Dual Demonstrations, and other specific populations will be enrolled in programs specific to the member's needs and regulatory requirements.

Clinical Practice Guidelines

The Population Health Program has been developed using nationally recognized evidence-based guidelines (i.e. Milliman Care Guidelines) and nationally approved Clinical Practice Guidelines. Individualized patient intervention strategies and goals are developed in collaboration with all treating physicians and consistent with nationally accepted guidelines.

The Clinical Practice Guidelines adopted for the Disease Management program are consistent with the incidence and prevalence of targeted disease and conditions relevant to our population (e.g. Health Failure, Depression and Diabetes).

Our Practice guidelines are reviewed and approved at least every 2 years. Updates in the adopted guidelines will initiate a change or modification to relevant Program documentation. If no changes are made to the guidelines, annual review and approval will be documented within the meeting minutes.

Clinical Practice Guidelines are distributed to providers by posting them on the networks website or through provider web portals. If changes or revisions are made a notice will be sent to the practitioner by blast fax.

Training Program

The organization provides practitioners with written information about the various Population Health Programs that includes instructions on how to use the services. Training is provided upon hire or contract, and annually thereafter throughout all levels of the care delivery system. There is a formal orientation and training program for all new staff involved in the Programs. All existing staff will be assessed by the Medical Director, and/or his designee to ensure proper and consistent execution of the program. Documentation is maintained for all staff orientation, training and assessment activities.

Methodology may be:

1. Face to Face
2. Interactive (web-based, audio-video conference)
3. Self-study (printed materials, electronic media)

Education for providers, employed and contracted staff shall include and not be limited to:

1. Advance Directives
2. Population Health Program
    a. SNP Model of Care
    b. High Risk
    c. Complex Care
    d. Disease Management Program(s)
3. Identifying Member's Special Needs
4. Coordination of Medicare and Medi-Cal benefits for the dual members
5. Coordination with County Programs for specialty mental health services and substance abuse prevention programs
6. Assisting members to obtain services funded by Medicare or Medicaid, when assistance is required.
7. Cultural Competency
8. Disability Training
9. Long Term Services and Support programs (LTSS)

MOC Training for Personnel and Provider Network

HPN's developed Population Health Management Program training model is provided annually to HPN affiliated medical groups and staff members. Trainings are conducted annually for all staff members and relevant downstream providers. The employee sign in sheets are maintained at the Medical Groups.

Patient Education

Member educational material will be available in print, and on-line:

1. Integrated into clinical management system
2. Consistent with best practice recommendations
3. Designed to meet State and/or Federal cultural competency requirements
4. Available in different learning modalities: written pamphlets and web based
5. Available in different languages
6. Reviewed on an annual basis for appropriateness and accuracy
7. Designed to encourage patient self-management and monitoring and assistance available to self-direct care
8. Information on available treatment options, supports, and/or alternative course of care.
9. The material provided will be on his or her conditions and care options.

Practitioners or the ICT staff provides Population Health education to the patient, family and/or caretaker. Population Health education may include one or more of the following elements:

1. Disease pathophysiology
2. Signs and symptoms and appropriate actions
3. How to report changes in condition to the PCP
4. Medication management
5. Laboratory tests results
6. Health weight BMI maintenance
7. Smoking cessation;
8. Encouraging physical activity
9. Healthy eating and exercise
10. Managing stress
11. Avoiding risky drinking
12. Identifying depressive symptoms
13. Community resources for continuing education and support
14. Other, as required

Member Self-Management Tools

The HPN and its affiliates will provide self-management tools to help members' stay healthy and reduce risk. They will be in language that is easy for the member to understand, and in their own language. The tools will be made usable for members with special needs, including vision and hearing impaired.
HPN self-management tools include:

1. Health weight BMI maintenance
2. Smoking cessation
3. Encouraging physical activity
4. Healthy eating and exercise

5. Managing stress
6. Avoiding risky drinking
7. Identifying depressive symptoms

Diabetes Education and Training Program

Diabetes education and training will ensure that the member can properly use their medication, equipment, and supplies. Diabetic education will be done on an outpatient basis by an appropriately licensed or registered health care profession, who is legally authorized to provide the training. Instruction of the training will be retained in the member's medical records. The training will demonstrate that the diabetic member and their families will gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.

Program Steps

1. Introductory letters
2. Telephonic Communication
3. In-person visit
4. Website

Introductory information will include information and contact numbers for the Program, as well as passive verbal consent for program participation. Distribution of a Population Health Program information starts when the patient receives the general awareness welcome letter that introduces some of the components of the program and the concept of Population Health (Care Management). This is followed by a disease-specific mailing within 30 days which includes:

1. Information about care coordination and condition monitoring, including self-management of chronic disease.
2. Description of services included
3. Explanation of how a patient is identified as eligible for our program
4. Information encouraging goal setting and appropriate lifestyle modification around exercise and smoking (as applicable)
5. Encouragement to work with their practitioner and ICT staff to develop and adhere to a Population Health care plan
6. Encouragement to call a physician and/or ICT staff with a focus on behavioral modification, overall assessment of other health conditions as they relate to Population Health and overall health, goal setting, and problem solving.

Coordination of Medicare and Medicaid Coverage

HPN helps to coordinate Medicare and Medicaid benefits for dual eligible members when necessary and as directed per plan contract with a goal to provide the best integrated care for members. HPN medical groups maintain knowledge regarding dual benefits and but will refer members back to their health plan when appropriate. These two programs are the D-SNPs and the Cal MediConnect.

C-SNP

HPN and the affiliated medical groups will assist in verifying a Chronic (C) diagnosis for Special Needs Plan (SNP) members. When notified by the Health Plan, an appointment with the member's PCP or a specialist will

be scheduled to verify diagnosis within 30 days of enrollment. Confirmation of a chronic diagnosis is relayed to the health plan per contractual requirements.

Integrated Communications

HPN and each of its PPGs have integrated and extensive communication systems necessary to implement the SNP care coordination requirements:

The **Electronic Medical Records** integrates documentation of care management, care planning, and input from the interdisciplinary care team, transitions, assessments and authorizations.

The **Customer Call Center** is staffed with associates trained to assist with enrollment, eligibility and coordination of benefit issues and questions for our Population Health Program members.

The **Provider Portal** securely communicates Health Risk Assessment results and new member information to SNP delegated medical groups.

The **Member Portal** provides member access to online education, programs, and the ability to create a personal health record. (Not available at this time)

Member and Provider Communications such as member newsletters, educational outreach, provider updates and provider online news are distributed by mail, phone, and fax or online.

Complex Case Management (CCM)

As an integral part of their Population Health Program, HPN provides coordinated services for members with complex, multiple chronic and high risk conditions. In alignment with the overall program, the goals of the CCM Program focus on the triple aim; improved health for the member, an excellent member experience, and reduced overall costs. Members enrolled in PH Complex Case Management Program may benefit from services that include telephonic care management; ambulatory care management; home visits and care coordination.

Population Assessment

HPN recognizes the importance of identifying members that could receive the most benefit from the various Population Health Programs and thus performs an annual population health assessment. This assessment will include the entire population in order to identify all subpopulations that may benefit from a Population Health Program intervention. HPN will assess:

1. The characteristics and needs of its member population and relevant subpopulations
2. The needs of children and adolescents
3. The needs of individuals with disabilities
4. The needs of individuals with serious and persistent mental illness (SPMI)

The governing committee will conduct an annual review of complex case management processes and resources to address member needs. Based on their review, the committee will make recommendations or modifications to the overall Population Health Program.

Identifying Members for Case Management

Member lists are refreshed on a monthly basis to identify potentially eligible members. Members identified as potentially eligible are automatically referred for additional assessment and management. Physicians may also refer a member to our program by using a 1-800 hotline number, on a routine or urgent basis. Sources for member identification may include, but are not limited to:

1. Data supplied by member, caregiver and health plans
    a. Health Risk Assessments
    b. Self-Referral
2. Data supplied by practitioners
    a. Electronic Health Record Data
    b. Clinical Care Gaps
    c. Referrals
3. Claims or Encounter Data.
4. Hospital or Discharge Data.
    a. Concurrent review data
    b. Hospital admission data
5. Data collected through UM process, case management process or care management process.
    a. Prior authorization data
6. Data from health management, wellness or health coaching program.
7. Pharmacy data
    a. Medication compliance
    b. Clinical Care Gaps
8. Laboratory results
    a. Chronic condition monitoring
    b. Clinical care gaps

Access to Case Management

HPN provides multiple avenues for clinicians, members and caregivers to refer members for care management services; they may include, but are not limited to:

1. Disease Management Referral
2. Discharge Planner Referral
3. Social Worker Referral
4. Utilization Management Referral
5. Member or Caregiver Referral
6. Practitioner (primary or specialist)
7. Health Information line Referral
8. Health Plan Referral

Care Management Systems

Operating within HIPAA regulations, HPN and its affiliates, integrate member information from multiple systems that allow disease management, care management, utilization management and health information-line staff to access relevant clinical information. Current enterprise systems include used are not limited to:

1. NextGen® Electronic Medical Record
2. MZI (E Z-CAP®, EZ-CARE®, EZ-NET®)
3. Heritage Connect

4. Internally developed care coordination and management systems (q.ube)

Links are created between all systems to allow coordination of care and support to ensure that the care is appropriate and delivered at the proper time. Facilitating timely access to member records is fundamental to the success of health promotion and Population Health Programs. Integrated information allows us to offer interventions that match the severity of the condition.

The care management computer data systems will automatically document staff member's ID, date and time of action on the case or when interaction with the member occurred. In all systems, the ICT staff has access to the member's health information electronically to facilitate care and documentation for the provision of seamless care.

To assure timely care management follow-up, the computer data system is required to provide automatic prompts for frequency of ICT staff communication and referrals. The acuity score derived from the Health Risk Assessment and progress towards the goals in the care plan determines the frequency of follow-up. The ICT staff uses the acuity score to set the automated prompts for follow-up in the care management system.

Interdisciplinary Care Team (ICT)

The Interdisciplinary care team assigned to the member may consist of clinicians and allied professionals with specialized expertise providing care through the life continuum. They provide support to individuals to facilitate improved behavior, motivation, confidence, decision-making skills, and knowledge and awareness of their disease and self-management.

The Interdisciplinary care team will minimally include:

1. Medical expert; Primary Care Physician and/or assigned provider
2. Mental health and/or behavioral health expert; Psychiatrist and/or psychologist
3. Social Services expert; Licensed social worker
4. Enrollee/caregiver/designated surrogate

Other care team members may include;

1. Pharmacist
2. Nursing professional
3. Restorative therapist
4. Nutrition specialist
5. Medical specialist
6. Pastoral specialist
7. Health educator
8. Disease management specialist
9. County IHSS social worker
10. MSSP coordinator, if enrolled in MSSP
11. CBAS provider if enrolled in CBAS
12. IHSS provider with approval from the IHSS enrollee/caregiver/designated surrogate
13. Other professional staff within the provider network

Services of the Interdisciplinary Care Team

The Medical Groups must assign each beneficiary to an interdisciplinary care team (ICT). The team may be comprised of employed or contracted practitioners. The ICT will be person-centered: built on the enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and

cultural competence, and dignity. Each ICT will have a composite of members that are knowledgeable on key competencies including, but not limited to: person centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles.

The Roles of the team are to:

1. Review HRA's, if provided by the health plans, to determine member's appropriateness for a Population Health Program such as complex case management, high risk, special programs, services and benefits.
2. Analyze and incorporate the results of the initial and annual health risk assessment in to the care plan.
3. Collaborate to develop and annually update an individualized care plan for each beneficiary.
4. Manage the medical, cognitive, psychosocial, and functional needs of beneficiaries.
5. Communicate to coordinate the care plan
6. Provide logs of cases reviewed and presented

The participation of the beneficiary/caregiver/designated surrogate is desired whenever possible. The ICT staff must document:

1. The process for having the beneficiary/caregiver/designated surrogate on the team in written individualized care plan.
2. The enrollee/caregiver/designated surrogate participation when it occurs.

The requirement for the education and experience level of the ICT will be determined by the needs of the Member. For Members identified as high risk, ICT staff will have substantial training regarding medical, LTSS, and behavioral health services. Also depending on the needs of the Member, the duties of the care coordinator may include:

1. Direct communication between the provider and Member/family;
2. Member and family education;
3. Coordination of carved-out and linked services, and referrals.
4. Promotion of co-location of service delivery, particularly for Members with receiving specialty mental health or chronic substance use disorder services.
5. Intense coordination of resources to meet ICP goals;
6. With Member and PCP input, development of an ICP specific to individual needs and updating of these plans at least annually.
7. Person-Centered Planning.
8. Assessment of clinical risks and needs
9. Enhanced self-management training and support
10. Frequent Member contact
11. Set up the ICT
12. Case rounds and ICT meetings as needed
13. Refer beneficiaries to community resources or other agencies for needed medical or social services or items outside the Plan's responsibilities, in cooperation with the respective agencies (SB 1008)

14. Facilitate communication among a Member's medical care, LTSS and behavioral health providers when appropriate (SB 1008).
15. Engage in other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status. (SB 1008)
16. Facilitate timely access to primary care, specialty care, medications, and other health services needed by the Member, including referrals to address any physical or cognitive barriers to access. (SB 1008)

The Care Management Process

The Care Management process is a roadmap towards success for each member. Although each step may provide some value on its own, it is the completion of the entire journey that ensures each member with their best chance at successful self-management and a healthier life. Care Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive needs of the member and their family while promoting quality and value.

The HPN Care Management Process includes the following:

1. Initial assessment of member's health status, including condition-specific issues
2. Documentation of clinical history, including medications
3. Initial assessment of the activities of daily living
4. Initial assessment of behavioral health status, including cognitive functions
5. Initial assessment of psychosocial issues
6. Initial assessment of life-planning activities
7. Evaluation of cultural and linguistic needs, preferences or limitations
8. Evaluation of visual and hearing needs, preferences or limitations
9. Evaluation of caregiver resources and involvement
10. Evaluation of available benefits
11. Evaluation of community resources
12. Development of an individualized case management plan, including prioritized goals, that considers the member's and caregiver's goals, preferences and desired level of involvement in the case management plan.
13. Identification of barriers to a member meeting goals or complying with the plan
14. Facilitation of member referrals to resources and follow -up process to determine whether members act on referrals
15. Development of a schedule for follow –up and communication with members
16. Development and communication of member self-management plans
17. A process to assess members' progress against case management plans for members

The Initial Assessment

The Initial Assessment is an integral step in the Care Management Process. All members eligible for care management will receive a completed assessment no later than 30 calendar days from the date the member is identified as eligible or their enrollment date or sooner if the member's condition requires. Information for the assessment may be derived from encounters occurring up to 30 calendar days prior to the member's

enrollment if the information is relevant to the current episode of care, for example physician, specialist, concurrent review or relevant notes from another program. The assessment may be a team effort, with components completed by members of the care team in collaboration with the member, member's family or caregiver. If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the member's family or caregiver. Assessment results for each factor must be clearly documented in the assessment or notes, even if a factor does not apply to the member. Data for the assessment may be gathered verbally or in writing.
If complex case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment will be performed after discharge if the member is still eligible for complex case management.

A member may be excluded from the assessment requirement, only if the member is enrolled in the case management program but cannot be located or contacted after the medical group has made 3 or more documented attempts across a 2 week period within the first 30 calendar days after identified as eligible. The medical group will document all attempts to contact the member, either by phone; letter e-mail or fax.

Assessments will include the following elements:

1. Initial assessment of member health status, including condition-specific issues
2. Documentation of clinical history, including medications
3. Assessment of the activities of daily living
4. Assessment of behavioral health status, including cognitive functions
5. Assessment of psycho-social issues
6. Evaluation of cultural and linguistic needs, preferences or limitations
7. Evaluation of visual and hearing needs, preferences or limitations
8. Evaluation of caregiver resources and involvement
9. Evaluation of available benefits
10. Evaluation of available community resources
11. Assessment of life-planning activities

Individualized Care Plan

The ICT staff use information from several sources including the care management assessment process to develop a comprehensive and individualized care plan in collaboration with the member/caregiver.
Problems and objectives addressed in the ICP may include

1. Medical, nursing or behavioral health needs (rehabilitation, pain management or depression)
2. Treatment support(e.g. dietary needs during therapies)
3. Triggers or areas of risk for members with uncontrolled chronic conditions
4. Individual educational needs
5. Clinical care gaps in care identified by plan or HPN data(e.g. poor medication compliance or missed appointments)
6. Functional limitations or safety issues(e.g. fall risk)
7. Identified personnel who will develop the Care Plan with input from the member
8. Specific services and benefits appropriate for the member
9. Preferences for care
10. Add on services and benefits and services for frail and vulnerable beneficiaries

The care plan includes prioritized goals that consider the member's and caregivers' goals, preferences and desired level of involvement in the care management plan. The care plan will include a list of barriers to the member meeting their goals or complying with the plan. It will include a follow up schedule for communications re-evaluation and planning for continuity of care, including transitions in care. This schedule may be part of an automated system in the medical groups care management platform. The follow up plan includes a schedule for follow up that may include counseling, referrals to other appropriate programs, education and self-management support. The care plan is only successful if there is frequent re-evaluation against the member's progress and goals. Care plans are updated frequently to meet the member's current needs and outcomes. These updates are in collaboration with the member and family, and revisions are provided to all parties.

Ongoing Care Management

Care Management is an ongoing process that is designed to meet the individual needs and goals of the member and adapts to changes in the member's condition, needs and preferences. Based in the member's initial assessment and their stated goals and concerns, an individualized care plan is developed for each member. The care plan includes prioritized goals that take into account the preferences and desired level of involvement for the member and caregiver. The care plan includes identification of any barriers to meeting these goals and plans to resolve them, if possible. Communication schedules and plans for follow up are documented in each plan. Care plans are re-evaluated, modified or changed in order to continue to be relevant for the member and their goals and needs.

Experience with Case Management

The Medical Groups will evaluate satisfaction with the Population Health Program annually and PRN through:

1. Obtaining feedback from members via satisfaction surveys; and
2. Analyzing member complaints and inquiries

We will make every effort to address patient and provider concerns. If we are unable to resolve complaints internally, we will refer the Patient to the Health Plan's Customer Service and provide them with the toll-free telephone number. Member complaints will be leveled, tracked and trended.

Patient and provider complaints and outcomes will be tracked and reported to the HPN Quality Committee on a quarterly basis. An analysis of member complaints will be completed on an annual basis. Patient adverse events will be reported to the network risk manager within 24 hours of identification and the Health Plan.

Measuring Effectiveness of Care Management

Annually, HPN will select a minimum of three measures that identify a relevant process or outcome in which to evaluate the effectiveness of the Population Health Program. The three measures with goals and clearly identified measure specifications for the network will be developed. Measure selection will not be exclusive by product or product line. Data collected will not be health plan specific. Process measures will be evidence-based, based on the best scientific evidence, professional standards or expert opinion. The Medical Groups will use valid methods to provide quantitative results, collect data and analyze results and identify areas of improvement.

Based on the results of the measurement and analysis of PHP effectiveness and satisfaction, each medical group will identify, implement and re-measure to determine the impact, at least:

1. One intervention to improve clinical performance
2. One intervention to improve member experience

Disease Management

The HPN Disease Management Programs are designed to support the practitioner-patient relationship and plan of care through the emphasis on prevention of exacerbation and complications through usage of evidence based practice guidelines and patient education and empowerment. Several of HPN Disease Management Programs are Pharmacist led. HPN has determined that these Disease Management Programs will be pharmacist led with collaboration with the Medical Director and member's PCP and Specialist (where appropriate). As members of the health care team, pharmacists can provide education, as well as screening and medication monitoring services.

The various disease management programs offered include all information and interventions calculated to help members with or at risk for chronic conditions to regain or improve optimum health functional capability in the right setting and in a cost effective manner through the following:

1. Condition monitoring (including self-monitoring and medical testing)
2. Adherence to treatment plans (including medication adherence)
3. Medical and behavioral comorbidities (e.g. cognitive deficits, physical limitations)
4. Addressing health behaviors, psychosocial issues
5. Providing for depression screening
6. Providing information about the patient's condition to caregivers who have the patients consent
7. Encouraging patients to communicate with their practitioners about their health conditions and treatment
8. Providing resources are utilized to achieve goals and include how the DM Program meets objectives and goals, functional areas and their responsibilities, reporting relationships for departmental staff.

The programs include:

1. Development of disease registries utilizing information from all data and referral sources
2. Identification of members at least monthly (data refresh rate)
3. Distribution of Program information (including eligibility and participation options) via mail, fax, email, website, or telephonically
4. Comprehensive initial and ongoing assessments
5. Development and implementation of treatment plans and interventions with performance goals, utilizing clinical practice guidelines and disease stratification
6. Development and implementation of DM self-management plans/tools
7. Monitoring member chronic disease self-management, wellness and preventive health status, relevant medical test results and managing co-morbidities, lifestyle issues and medications
8. System integration, coordination and collaboration with and referrals to and from other Population Health Programs.

Managing Care Transitions

HPN and its affiliates manage and/or coordinate transition of care between one care setting to another. We will identify problems that could cause a transition to a higher level of care, and where possible prevent any unplanned transitions.

HPN and its affiliates will ensure each member has a consistent point of contact person to be responsible for supporting the member through the transition. For planned or unplanned transitions, key aspects for aspects for the case manager to follow include:

1. Identifying that a planned transition is going to occur across multiple settings (i.e. acute hospital, skilled nursing facility, home health care, custodial nursing facility, rehabilitation facility, outpatient/ambulatory care/surgery center and home).
2. Ensuring that the member has support prior to, during and after the transition
3. Sharing the care plan with the member and receiving facility;
4. Notifying the member's usual practitioner of the transition;
5. Communicating with the member or responsible party about changes in the member's health status and plan of care.
6. Educating the member/caregiver on how to prevent unplanned transitions and the options that are available to them.

Communication with the member, their representative, the PCP, and receiving facility should occur within one (1) business day of transition. Care plans should be given to each person within one (1) business day of notification of the transition.

Supporting members through Transitions

The medical group will communicate with the responsible party about the care transition process as soon as possible following admission but no later than five (5) calendar days from the date of notification. This communication will include, but not limited to, and changes to the member's health status or plan of care as a result of the admission or transition. The medical group will provide the member or responsible person with the name of a consistent person they can contact during the transition process. The medical group will provide the members with information and materials specific to their transition process, needs and changes in care.

Analyzing Performance

The HPN network will maintain a monthly Care Transitions Log (for SNP enrollees) for all contracted medical groups that contains the below bulleted information. This data will be used annually to analyze each medical group's performance in meeting the care transition factors.

1. Member Name, Identifier, Health Plan and Medical Group
2. Facility Name and Type
3. Planned or Unplanned admission
4. Admit Date
5. Planned admission determination date
6. Date the PPG was notified of the admission/transition
7. Discharge Date
8. Date the PPG was notified of the discharge
9. Location member was discharged to
10. Date the Discharge plan was sent to the next care setting or member's usual practitioner
11. Date the Discharge plan was received at the next care setting or member's usual practitioner
12. Date the member was contacted and coached about the Transition Process
13. Date member was contacted and coached to health status and changes in the Care Plan

14. Date of notification of the transfer was sent to the member's usual practitioner
15. Name of person assigned to assist the member in the transition

Identifying Unplanned Transitions

HPN and its affiliates will identify unplanned transitions for the facilities within our network by:

1. Twice daily review reports of member hospital admissions within one business day of admission
2. Once daily review of reports of emergency room visits.
3. Once daily review of reports of member admissions to long-term care facilities within one business day of admission.

Analyzing & Reducing Transitions

The Medical Groups will analyze transition reports at least monthly, to identify members at risk of transitions, and will analyze all member admission to hospitals and ED visits at least annually to identify areas for improvement. Based on their findings, the Medical Groups will work to maintain members in the least restrictive community setting possible by:

1. Coordinating services for members at high risk of having a transition.
2. Educating members or responsible parties about transitions and how to prevent unplanned transitions.
3. Whenever possible, working with members to ensure that all services are provided in accordance with their wishes and Individual Care Plan in a care setting that is sensitive to the member's functional and cognitive needs, language and culture, allows for involvement of the members and caregivers, and is a care setting appropriate to the member's needs, with a preference for home and the community.
4. Implementing at least one intervention related to an identified improvement opportunity.

Dual Eligible Members

HPN recognizes that the complex needs of the dual eligible population require care management and coordination that encompasses a multi-faceted approach to health care delivery that focuses on the unique needs of this new and diverse population. Again, the goals regardless of the population focus on the triple aim; to improve the overall health of the individual, to provide an excellent patient experience and to reduce the overall cost of healthcare. Additional Dual Population requirements are noted below and are performed in conjunction to the overall Population Health Model as presented above.

Assessment and Care Planning

1. Risk Stratification
    a. HPN will use available data and mechanism or algorithm approved by the state and CMS in order to prioritize enrollees for assessment and care planning (if delegated)
2. Health Risk Assessment (HRA)
    a. The health risk assessment will be performed in accordance with all applicable Federal and State laws Welfare and Institutions Code section 14182.17 (d) (2). The HRA will be the starting point for the development of the enrollee's individual care plan. It will serve as the basis for further assessment needs that may include, but are not limited to, mental health, substance abuse, chronic conditions, reduced ADL's, dementia and cognitive status and the capacity to make informed decisions.

b. The HRA may be completed in person, by telephone or other methods as devised. HPN will use a variety of communication methods to reach the enrollee during the required timeframes for the assessment. For example, multiple documented efforts to contact the member at different times using a variety of methods (i.e. phone calls and a letter).

3. An individualized care plan (ICP) will be developed for each enrollee:
    a. Within thirty (30) days of HRA completion or within 30 to 135 days if no HRA is available.
    b. If the member is identified as high-risk and/or has not completed the HRA – the time to complete the HRA is not to exceed 90 calendar days from enrollment. The PCP will be encouraged to outreach to members and to schedule visits.
    c. If there is no HRA and the enrollee is stratified as Low Risk, the ICP is developed within 135 calendar days of the enrollee's effective date.
    d. If an HRA is partially completed, it will be treated as complete and the ICP is developed within 30 working days/45 calendar days of the HRA completion date
    e. The assessments are then analyzed to determine the need for add-on services and benefits; access to appropriate individual, carved out linked services and community-based resources and are included in the care plan.

3. Reassessments will be conducted at least annually, within 12 months of the last assessment, or as often as the health of the enrollee requires.

For all enrollees, the assessment process will at a minimum identify:

1. Referrals to appropriate LTSS and home and community-based services, such as behavioral health, IHSS, CBAS, MSSP, personal care services, and nutrition programs.
2. Caregivers and authorized representatives who may be involved in the individual care plan per the enrollee's approval.
3. The need for facilitating timely access to primary care, specialty care, DME, medications, and other health services needed by the enrollee, including the need for referrals to resolve any physical or cognitive barriers to access.
4. The need for facilitating communication among the Member's health care providers, including mental health and substance use providers when appropriate
5. The need for providing other activities or services needed to assist enrollees in optimizing their health or functional status, including assisting with self-management skills or techniques, health education, and other modalities to improve health or functional status.
6. The appropriate level of care management for the enrollee

Care Coordination

HPN care coordination and management services will be available to all enrollees. These services will reflect a member-centered, quality and value based approach. These care coordination services will

1. Follow the beneficiary's direction about the level of involvement of his or care caregivers and medical providers
2. Span medical and LTSS care systems, with a focus on transitions between service locations
3. Consider behavioral health needs and coordinate with county services
4. Develop individualized care plans with enrollees
5. Be performed by nurses, social workers, primary care providers and other medical services and professionals as needed

Individual Care Plan

Case Management is an ongoing process that is designed to meet the individual needs and goals of the member and adapts to changes in the member's condition, needs and preferences. Based in the member's initial assessment and their stated goals and concerns, an individualized care plan is developed for each member. The care plan includes prioritized goals that take into account the preferences and desired level of involvement for the member and caregiver. The care plan includes identification of any barriers to meeting these goals and plans to resolve them, if possible. Communication schedules and plans for follow up are documented in each plan. Care plans are re-evaluated, modified or changed in order to continue to be relevant for the member and their goals and needs.

Interdisciplinary Care Team

HPN will offer enrollees an Interdisciplinary Care Team which will be built around the individual needs of the enrollee and ensure the integration of the member's medical, behavioral health, and LTSS care. Teams may include the enrollee, family members and other caregivers, designated primary physician, nurse, case manager, social worker, patient navigator, county IHSS social worker, IHSS providers, MSSP coordinator, pharmacist, behavioral health service providers, and other professional staff within the provider network. The ICT will be person-centered: built on the enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity. The enrollee can choose to limit or disallow altogether the role of the IHSS providers, family members and caregivers on the team. The ICT will have a composite of members that are knowledgeable on key competencies including, but not limited to: person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles.

Communications

The HPN network Customer Service Representatives will provide these additional services to the dual enrollees:

1. Toll Free services line
2. Upon request, make available to enrollees information including, but not limited to, the following:
    a. The identity, locations, qualifications, and availability of providers by phone, written materials, and Internet website
    b. Registry for assisting IHSS recipients in finding eligible providers
    c. Enrollees' rights and responsibilities
    d. The procedures available to an enrollee and provider to challenge any denials
    e. How to access language assistance services and written materials in threshold languages.
    f. Information on all medical group services and information on how to contact their health plan
    g. Information on how to contact the health plan for information on changing plans or opting out.

Complex Case Management

HPN coordinates services for members with complex conditions and help them access needed resources. The Complex Case Management Process incorporates all elements of the Population Health Program Model and Special Needs Model

Care Transitions

HPN uses processes to manage care transitions, to identify problems that could cause transitions, and wherever possible prevents unplanned transitions. HPN and affiliates follow the Population Health Program Model and Special Needs Model and maintain tracking logs per required guidelines.