Case Management/Care Coordination, Complex Case Management & Disease Management Program Program Evaluation

2021

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2021
Case Management
Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Care Services 2021 Case Management Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the Case Management (CM) program activities, which include care coordination, care management, complex case management and disease management.

The processes and data reported covers activities conducted from January 1, 2021 through December 31, 2021.

Membership and Provider Network

The Alliance products include Medi-Cal Managed Care beneficiary's eligible thorough one of several Medi-Cal programs, e.g. TANF, SPD, Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan serviced by The Alliance which provides low-cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County. The Alliance provides services to IHSS workers through the commercial product, Group Care.

Figure 1 2021 Trended enrollment by network and age group

Current Membership by Network By Category of Aid							
Category of Aid	Dec 2021	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	43,077	15%	9,049	8,992	671	16,519	7,846
Child	98,150	34%	8,232	8,820	29,714	33,435	17,949
SPD	26,450	9%	8,318	4,115	1,058	10,946	2,013
ACA OE	102,264	35%	16,029	33,514	1,130	38,210	13,381
Duals	20,964	7%	8,190	2,255	-	7,490	3,029
Medi-Cal	290,905		49,818	57,696	32,573	106,600	44,218
Group Care	5,823		2,470	894	-	2,459	-
Total	**296,728**	**100%**	**52,288**	**58,590**	**32,573**	**109,059**	**44,218**
Medi-Cal %	98.0%		95.3%	98.5%	100.0%	97.7%	100.0%
Group Care %	2.0%		4.7%	1.5%	0.0%	2.3%	0.0%
	Network Distribution		*17.6%*	*19.7%*	*11.0%*	*36.8%*	*14.9%*
			% Direct:	**37%**		**% Delegated:**	**63%**

Age Category Trend				
	Members			
Age Category	Dec 2019	Dec 2020	Nov 2021	Dec 2021
Under 19	91,641	97,399	100,206	100,408
19 - 44	78,271	93,280	104,239	105,212
45 - 64	54,210	57,679	60,571	60,685
65+	24,709	27,231	30,135	30,423
Total	**248,831**	**275,589**	**295,151**	**296,728**

For 2021, The Alliance membership increased, as seen in Figure 1, to about 297 thousand members, from 275 thousand members in 2020. This trend is in alignment with the increase in Medi-Cal Enrollment in California in 2021 and suspension of disenrollment due to the Covid Public Health Emergency.

Medical services are provided to beneficiaries through one of the contracted provider networks. Currently, The Alliance provider network includes:

Figure 2 Provider Network by Type and Enrollment

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment in Network
Direct-Contracted Network	Independent	52,288	17.6%
Alameda Health System	Managed Care Organization	58,590	19.7%

Children First Medical Group	Medical Group	32,573	11.0%
Community Health Clinic Network	Medical Group	109,059	36.6%
Kaiser Permanente	HMO	44,218	14.9%
TOTAL		296,728	100%

The percentage of members within each network has been relatively steady from 2020 to 2021, varying by less than 1%

The Alliance offers a comprehensive health care delivery system, including the following scope of services:

- Basic care management
- Care Coordination
- Care Management
- Complex Case Management
- Transitions of Care
- Health Homes

Delegation

The Alliance delegates CM activities to contracted health plan, provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between The Alliance and delegated groups specify the responsibilities of both parties: the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre- contractual evaluation of delegated functions to assure capacity to meet standards and requirements.

The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with other respective departments to conduct the annual delegation oversight audits. When delegation occurs, The Alliance requires the delegated entity to comply with the NCQA standards and present quarterly reports of services provided to Alliance members. The Alliance's Compliance Department is responsible for the oversight of delegated activities and completes an annual performance evaluation of delegated case management operations. Results of the annual evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee.

The Alliance shares the performance of CM activities with several delegates. The Alliance's CM delegates, as of the date of this document, are the following:

Figure 3 – 2021 the Alliance Delegated Network

2021 Alliance Delegated Network			
Provider Network/Delegate	**Provider Type**	**Delegated Activity- Care Coordination/CM**	**Delegated Activity- Complex Case Management**
Kaiser	HMO	Yes	Yes
CHCN	MCO	Yes	No
Beacon	MBHO	Yes	Yes

Delegation vs Direct Trend								
	Members				% of Total (ie.Distribution)			
Members	Dec 2019	Dec 2020	Nov 2021	Dec 2021	Dec 2019	Dec 2020	Nov 2021	Dec 2021
Delegated	154,621	168,412	183,640	185,850	62.1%	61.1%	62.2%	62.6%
Direct	94,210	107,177	111,511	110,878	37.9%	38.9%	37.8%	37.4%
Total	**248,831**	**275,589**	**295,151**	**296,728**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Overall, the network was sufficient to meet the needs of The Alliance membership and provider network through 2021. In 2021 there were ongoing improvements in the level of oversight, monitoring, reporting, and training of delegates to ensure they met the regulatory standards and Alliance requirements.

Program Structure

The structure of the CM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of The Alliance health care delivery network and community resources. Additionally, the structure is designed to enhance communication and collaboration on CM issues that affect all departments and disciplines within the organization. The CM Program is evaluated on an on-going basis for efficacy and appropriateness of content by The Alliance staff and oversight committees.

Responsibility, Authority and Accountability/ Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 12-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of The Alliance programs and is responsible for approving the Quality Improvement, Utilization Management and Case Management

Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to The Alliance Chief Medical Officer (CMO) and the Health Care Quality Committee (HCQC) and provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management and Case Management Programs. Utilization Management oversight is the responsibility of the HCQC. Utilization Management and Case Management activities are the responsibility of the Alliance Health Care Services staff under the direction of the Medical Director for Care Management and Special Programs and the Senior Director, Health Care Services in collaboration with the Alliance CMO.

Committee Structure

The Board of Governors appoints and oversees the HCQC, the Peer Review and Credentialing Committee (PRCC) and the Pharmacy and Therapeutics Committee (P&TC) which, in turn, provide the authority, direction, guidance, and resources to enable The Alliance staff to carry out the Quality Improvement and Utilization Management and Case Management Programs. Committee membership is made up of provider representatives from The Alliance contracted networks and the community including those who provide health care services to Seniors and Persons with Disabilities (SPD) and Chronic conditions.

The HCQC Committee provides oversight, direction, makes recommendations, and has final approval of the UM and CM Programs. Committee meeting minutes are maintained summarizing committee activities and decisions and are signed and dated.

HCQC charters a sub-committee, the Utilization Management Committee (UMC) which meets at least once every 2 months (8 meetings in 2021,) serving as a forum for the Alliance to evaluate current CM activities, processes, and metrics. The UMC also evaluates the impact of CM programs on other key stakeholders within various departments and when needed and assesses and plans for the implementation of any needed changes.

The 2020 CM Program Evaluation and 2021 CM Program Description were developed and presented for review and approval at the March 18, 2021 HCQC meeting and documented in the minutes, for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Senior Director of Quality Management, external physicians, and key organizational staff.

In 2021 the UM Subcommittee of HCQC has continued to support the focus on CM activities, oversight for delegated CM activities, case management/care

coordination, complex case management, transitions of care, population health, integration of behavioral health and medical as well as regulatory compliance.

Evaluation of the level of involvement of senior-level Physician and Behavioral healthcare practitioners

The Board of Governors delegates oversight of Quality and Case Management functions to The Alliance Chief Medical Officer (CMO). The CMO provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Case Management Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development.

During 2021 Dr. Aaron Chapman, a psychiatrist, and Medical Director of Alameda County Behavioral Health Care Services, actively participated in the HCQC meetings and provided clinical input ensuring policies and reports considered behavioral health implications.

Program Scope and Structure

The Alliance promotes case management services through multidisciplinary teams that address member specific medical conditions, behavioral, functional, and psychosocial issues whether in a single health care setting or during the member's transitions of care across the continuum of care. Case management activities are performed telephonically. The underlying premise of the program is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems, and the various payer sources.

The comprehensive case management program is established to provide case management processes and procedures that enable the Alliance to improve the health and health care of its membership. Members from all Alliance health products are eligible for participation in the program. Alliance products include Medi-Cal and Alliance Group Care. The fundamental components of Alliance case management services encompass: member identification and screening; member assessment; care plan development, care plan implementation and management; evaluation of the member care plan; and closure of the case. The structure of comprehensive case management is organized to promote quality case management, client satisfaction and cost efficiency using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

Case Management Resources

The Alliance CM Department is staffed with physicians, nurses, social workers, and non-clinical support staff including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2021 CM Program Description.

The assignment of work to the team, whether working on site or remotely for both clinical and non-clinical activities, is seamless to the process. In 2020, in response to the Covid 19 pandemic and public health requirements, the CM department transitioned to fully working from home, and have continued to do so throughout 2021. Staff were provided equipment, remote connectivity, and policies to follow to successfully work from home while maintaining full functionality and meeting regulatory requirements. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

In 2021, the leadership structure in the CM department is designed to meet the needs of the program and the staff:

- Medical Director of Case Management
- 1.0 FTE Manager
- 1.0 FTE Supervisor of CM.
- 1.0 FTE Lead CM.

The department was successful in hiring and retaining Complex Case Managers in 2021.

Delegated Case Management

As describe in the section above for Delegated Activities, The Alliance provides health services to our members through a partially delegated network.

For care management and complex case management (CCM), The Alliance delegates basic care management and care coordination to network providers. Currently, the Alliance only delegates complex case management to Kaiser (a NCQA-accredited entity) which represents a small proportion of its total membership.

Behavioral Health CM activities are delegated to and managed by the contracted managed behavioral health vendor (MBHO), Beacon Health Strategies.

The Compliance Department is responsible for the overall performance of the internal and external audits of delegates. CM Department staff are responsible for the review and reporting of the CM components of the annual process which includes standards and file review. The Compliance Department is responsible for finalizing the audit findings and issuing required corrective actions. All audit findings are reported into the Compliance Department and the HCQC.

In 2021, the CM staff conducted annual audits on the four (4) delegates. The threshold for CM audit compliance is 90%. For entities that do not meet the threshold, CM may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2021 were:

- One (1) group passed the CM audit (≥ 90.0%), 2 had findings and required corrective actions.

Figure 4 the Alliance Network – 2021 Annual Audit Score

Delegate	Provider Type	Delegated Activity- CM	2021 Audit Results	Corrective Action Required
Kaiser	HMO	X	No deficiencies found	None
CHCN	Medical Group	X	Deficiencies found, Corrective Action Plan Required	Yes: No documentation of member outreach, evaluation, and PCP collaboration
Beacon/College Health IPA (CHIPA)	Vendor-BH	X	Deficiencies found, Corrective Action Plan Required	Yes: No documentation of PCP collaboration and did not include review of clinical documentation

Additionally, the CM team is responsible for ongoing monitoring activities including review of the delegated entities annual work plans/evaluations, and semi- annual reporting.

Recommend Actions/Next Steps

For 2022, there is an opportunity to continue to improve the oversight of delegated CM activities. The CM Department leadership continues to develop a robust level of delegate oversight and performance monitoring. The activities include dedicated staff, monitoring activities, performance management, delegate feedback and CM training. In Q4 2022, Behavioral Health for members with Mild to Moderate illness will be insourced back into AAH, rather than delegating to Beacon/CHIPA. This will improve the integration of BH with medical care, particularly care coordination functions.

Case Management Processes and Information Sources

Case Management Information Systems and Sources

The CM Department utilizes a clinical information system, TruCare, as the case management platform. TruCare is a member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with the use of algorithmic clinical intelligence and best practices to guide case managers through assessments, development of care plans, and ongoing management of members. The system includes assessment templates to drive consistency in the program. Care plans are generated within the system and are individualized for each member and include short and long-term goals, interventions, and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; record actions or interactions with members, caregivers, and providers; and create automatic date, time, and user stamps. To facilitate care planning and management, the clinical information system includes features to set prompts and reminders for next steps or follow-up contact.

Evidence-based clinical guidelines are available to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the Alliance will involve board certified specialists in the development of the appropriate guidelines, as well as medical and behavioral healthcare specialty societies and/or Alliance Clinical Practice Guidelines.

In July 2019, the CM Department conducted a comprehensive review of standard CM workflow using Lean Management principles. This included reviewing the functionality of the TruCare system. In 2020/2021, Casenet, the corporate parent of TruCare, worked in collaboration with CM and AAH IT

leadership to optimize and improve the functionality of the TruCare system. 2021 optimization was not fully completed, and work will continue into 2022.

In 2021, CM Department collaborated with Senior Leadership to align Disease Management criteria with the Population Health initiatives. The enhancements made were based on the Population Health initiatives, leading to a strengthening of the Disease Management Program in 2021.

The Alliance Health Care Services Departments area continues to review and update existing policies and workflows to address regulatory changes based on specific criteria. This includes any internal and delegate training or regulatory reporting needs.

Care Coordination and Case Management Processes

There are five (5) distinct levels/areas of Care Management to match the members identified risk level as described below:

- **Basic Case Management** or Low Risk level is provided by the Primary Care Physicians and their staff with a Network Provider Group's Care Management support.
- **Care Coordination/Service Coordination** or Moderate Risk level is provided at the Provider Group level, supporting the Primary Care Provider (PCP). AAH CM provides support to the PCP to coordinate care.
- **Targeted** Care Management is supported by The Alliance Care Management staff with designated community TCM programs.
- **Complex** Care Management is provided by The Alliance Care Management staff, consistent with NCQA Standards.
- **Specialty Programs** such as Transitions of Care, Continuity of Care, and Health Homes

Basic Care Management

The Primary Care Provider (PCP) is responsible for Basic Care Management for his/her assigned members and is supported by the Provider Group CM team. The PCP is responsible for ensuring that members receive an initial screening and health assessment (IHA), which initiates Basic Medical Care Management. The PCP conducts an initial health assessment upon enrollment, and through periodic assessments provides age-appropriate periodic preventive health care according to established, evidence-based, preventive care guidelines. The PCP also makes referrals to specialists, ancillary services, and linked and community services as needed based on the member's Individual Care Plan (ICP). When additional care management assistance is needed, the PCP works with the Provider Group's CM department to facilitate coordination. For member enrolled in the Direct Network, the PCP works with the Alliance CM or UM teams to facilitate coordination.

Care Coordination

Care coordination is provided by the Provider Group CM staff for members needing assistance in coordinating their health care services. This level of CM may include ambulatory case management, referral coordination and/or focused disease management programs. For members in need of care coordination along the continuum of care, including arrangements for linked and carved out services, programs, and agencies, the Alliance CM team provides assistance using non-clinical staff, Health Navigators, with extensive training in facilitation and coordinating services both internally and with outside agencies. Health Navigators manage most of the care coordination, continuity of care, and low risk transitions of care cases. They also make referrals to Beacon, Alameda County Public Health, community resources, etc.

Targeted Care Management

The Alliance facilitates, and coordinates care for eligible members (including the Medi-Cal SPD and Expansion population) through Targeted Case Management (TCM) services. Alliance staff follow preset guidelines and collaborates with primary care providers when necessary to determine eligibility for TCM services. Members may be referred to receive TCM services through the Alliance or through the most appropriate contracted community partner.

Members eligible for TCM services have generally been identified as moderate or high risk. Once a member is identified and referred for TCM, they are assigned to an Alliance Case Manager, who takes responsibility for screening, referrals, care planning, and all other care coordination activities. Members are matched to a Case Manager who is specialized based on the prominence of medical or behavioral health needs. Though there is one assigned "lead," the support and expertise of other Case Managers may be harnessed to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those Members who are multiply diagnosed with medical, functional, cognitive, and psychosocial conditions.

Complex Case Management

Complex Case Management (CCM) is provided to members who meet the criteria for CCM. Members meeting criteria for CCM have conditions where the degree and complexity of illness or conditions is typically severe, the level of management necessary is typically intensive and the number of resources required for member to regain optimal health or improved functionality is typically extensive.

Complex Case Management is a collaborative process between the Primary and/or Specialty Care Providers, member, and Care Manager, who provide

assistance in planning, coordinating, and monitoring options and services to meet the member's health care needs.

Disease Management

The Alliance CM Disease Management (DM) program is integrated with the Quality Management Department and Population Health initiatives to provide interventions for members with targeted chronic illnesses. The Population Health initiative has identified target diagnoses affecting the Alliance membership at a disproportionate rate and/or with significant utilization. In 2021, the DM program worked with children and adult members with Asthma and adult members with Diabetes. Multiple approaches were taken to enhance the service, ranging from identification of members with the disease, ensuring standard work was employed related to the level of acuity of the member and their disease. The program worked with community partners: Asthma Start, for children with asthma, and a variety of community programs to provide services for members with diabetes. The planning for the launch of CalAIM Community Supports occurred in 2021, and Asthma Remediation as a Community Support was chosen to further support members with Asthma.

Population Health Initiative

In 2021, the Population Health initiatives at the Alliance were strengthened and further integrated into ongoing Alliance work with members. A stratification of member acuity was developed, ranging from low-risk members who may need health promotion/education to the highest risk, most vulnerable members needing full wrap around Health Homes Program services. The CM interventions performed at each acuity level were identified, and the foci of CM work has been further targeted to the acuity level of the members.

Figure 5 Volume of CM cases in Population Health Target Diagnoses in 2021

Dx	Numbers with Disease State in the last 12 months	Care Coordination (Currently Enrolled)	Transitions of Care (Currently Enrolled)	Complex Case Management (Currently Enrolled)	Health Homes
CAD	6039	33	39	8	162
CHF	3637	27	41	15	160
Cervical CA	328	0	1	0	7
Lung CA	277	0	4	0	2

Emphysema	3358	28	33	11	147
ESRD	908	11	14	3	34
Schizophrenia	3216	22	19	1	65
Sickle Cell Disease	119	0	0	0	0
Hepatitis C	1077	10	10	0	21
Tuberculosis	125	1	0	0	5
SUD	8516	53	55	10	197
Asthma	23904	82	76	15	305
Breast CA	1060	3	4	0	5
Hyperlipidemia	37217	69	57	14	305
Hypertension	39894	98	120	28	489
Diabetes	21016	55	80	19	325
Obesity	29342	36	56	9	200
Pregnancy	6472	6	3	0	11
Gingivitis	999	1	3	2	10
Burns-1st degree	416	3	1	0	4
Tobacco	12225	53	64	10	194
Total Unique Members any DX	200145	591	680	145	2648

The highest volume of members with the Population Health target diagnoses are served by the Health Homes program (HHP), which is to be expected, since the HHP serves the highest risk, most vulnerable members. The next highest is those members receiving Care Coordination, which reflects the volume of work assisting significant numbers of members to navigate the health care system. Complex CM is typically involved when members have multiple diagnoses, some of which are part of those targeted by the Population Health initiative.

Specialty Programs

Transitions of Care

In November 2019, the Transitions of Care (TOC) Program was enhanced. TOC is provided to members who meet the criteria of hospital discharge. The level of management necessary and the number of resources required for the member to regain optimal health or improved functionality varies, thereby involving any individual or combination of the Case Management disciplines: Nurse Case Managers, Social Workers or non-clinical staff, Health Navigators.

For 2020/2021, the Transitions of Care Program included the hospitals of the Alameda Health System, and expanded to also include any Alliance member hospitalized with COVID-19 (including members who are delegated to CHCN). There was improved collaboration between CM, Utilization Management (UM) and Pharmacy.

For 2021, the Transitions of Care Program expanded to include collaboration with Pharmacy for the high-risk Transitions of Care members described above.

For 2022, the Transitions of Care Program plans to expand beyond the three (3) current hospitals and to incorporate further collaboration between Utilization Management (UM), Pharmacy and CHCN to further meet the member's health care needs.

Case Management Processes

Health Risk Assessments

The Alliance arranges for the assessment of every new Senior and Person with Disabilities (SPD) member through a process that stratifies all new members into an assigned risk category based on self-reported or available utilization data. Based on the results of the health risk stratification, the Alliance administers a Health Risk Assessment (HRA) survey to all newly enrolled SPD members within:

- 45 days of enrollment identified as at high health risk.
- 105 days of enrollment as a lower risk.

The Alliance outreaches to SPD members to administer the HRA and to develop a Care Plan. SPD members are re-assessed annually in the month of their enrollment. The responses from the HRA may result in the members being re-classified as higher or lower risk. (For some members, this HRA based re-classification may be different from their earlier classification based on the stratification tool.) In addition, the HRA includes specific Long-Term Services and Supports (LTSS) referral questions. These questions are intended to assist in identifying members who may qualify for and benefit from LTSS services. These

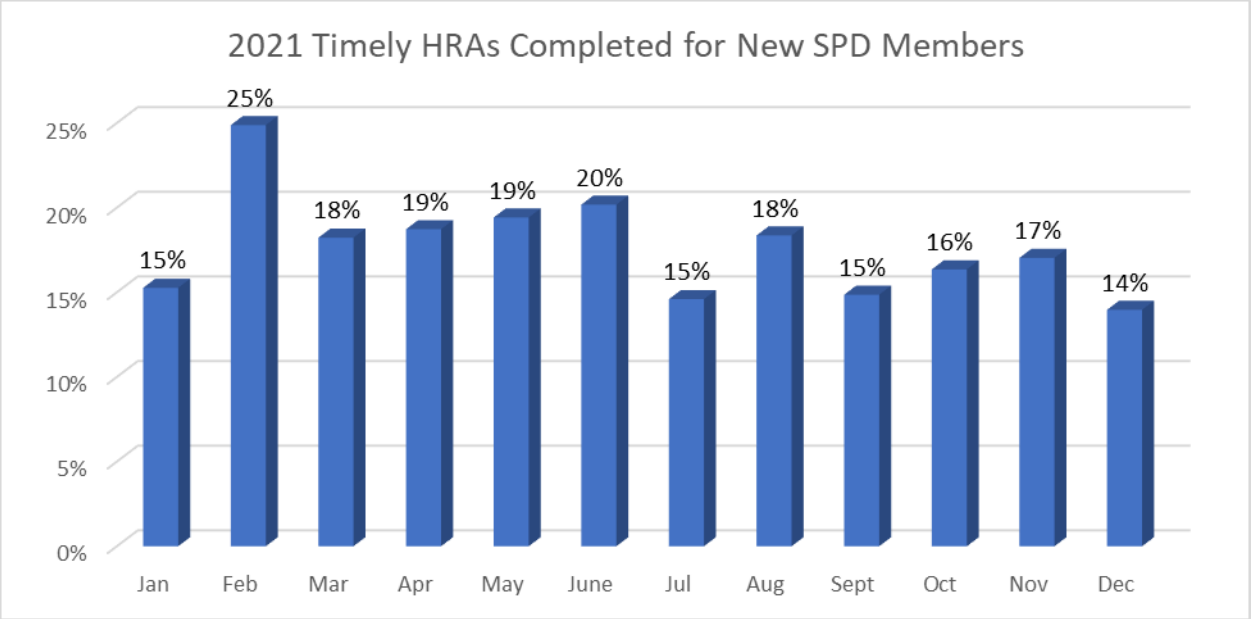
questions are for referral purposes only and are not meant to be used in classifying high and low risk members. After completion of the HRA, the Alliance develops Individualized Care Plans (ICPs) for members found to be at higher risk and coordinate referrals for identified LTSS, as needed.

CM staff is responsible for ensuring the Member Care Plan is completed and shared as well as providing any community or health resources. For Members who completed the HRA with a final stratification of Low Risk, CM staff review the HRA responses to identify Member needs, i.e. resources for transportation, IHSS, and Food Banks. The CM staff generates the care plan, attaches the resources, and prepares it for mailing. If the member remains Unable to Contact, (UTC,) CM Staff will create a standardized care plan based on the needs identified from the initial data used to stratify the Member. The Alliance generates the standardized high-risk care plan because there are additional health education resources and materials that can be provided to members even if they do not complete the HRA. All copies of the care plans are mailed to the Member and Primary Care Provider as well as to the Provider Group for potential care coordination needs. A HRA letter and resources are sent to the Member; a copy of the Care Plan is sent to the Primary Care Provider for care coordination.

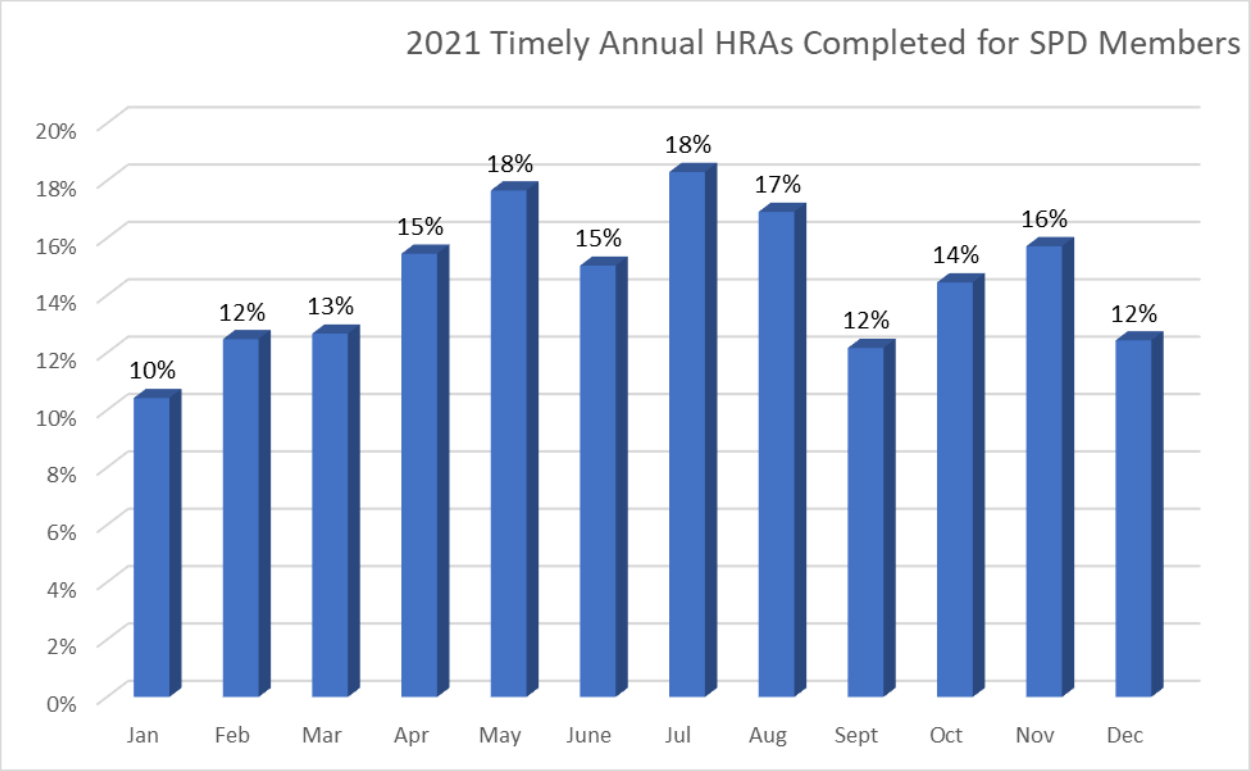
The Alliance uses Interactive Voice Response (IVR) calls to encourage members to complete an HRA. In 2021, the Alliance shifted from contracting with a vendor to the Alliance's internal IT team, to make Interactive Voice Response (IVR) calls to members. These IVR calls are made to members so that the Alliance can give members every opportunity to complete the HRA and have the results acted upon by the CM department.

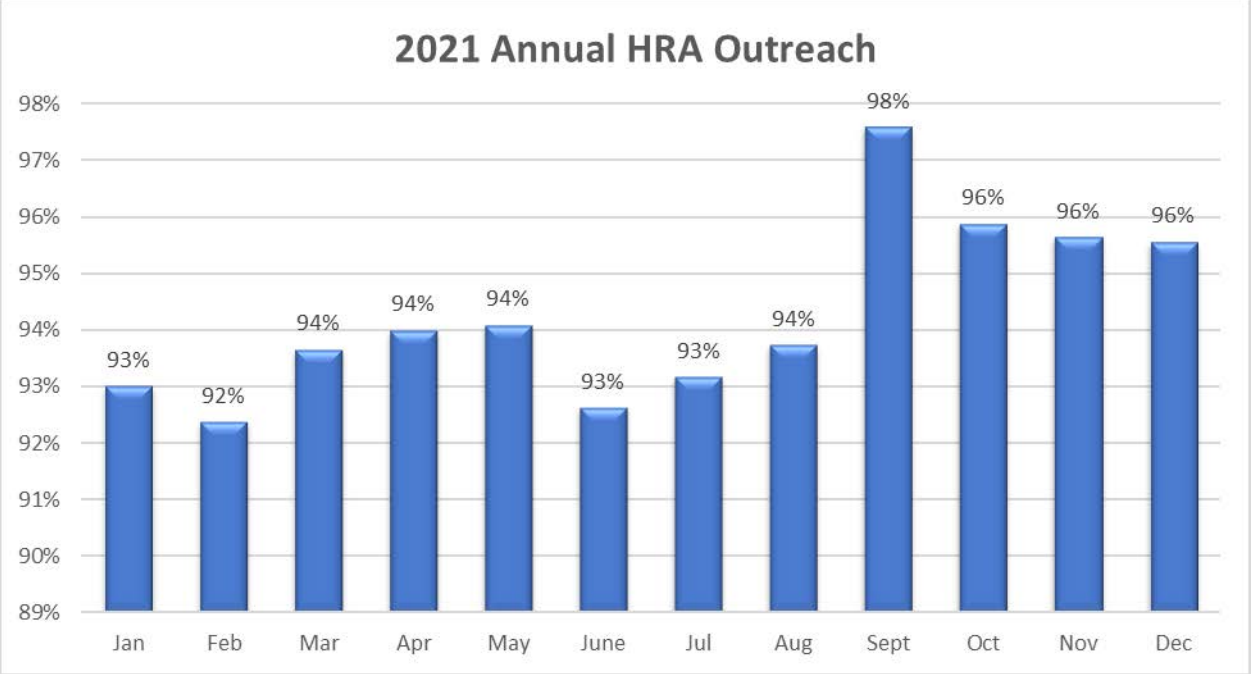
In collaboration with Healthcare Analytics, a HRA dashboard was created in 2018, to track compliance of outreach attempts and timely completion of the HRA for the SPD population, and this tracking continued in 2021.

New HRA completion for SPD Members



Annual HRA completion for SPD Members





The outreach rates for 2021 remained consistently above 90%, reflecting the engagement of the vendor to assist with the HRA process, to remind members to

return HRAs timely. The completion numbers increased in 2021, but never going above 25%. Because this remains low, there will be further evaluation in 2022 to identify any opportunities for improvement.

CM Referral and Identification

Members are identified as candidates for care management services through a variety of data sources and referrals. This includes:

- Self-referrals
- Direct referrals from provider networks
- Internal referrals, e.g. UM, Member Services, Appeals and Grievance, Leadership
- Predictive modeling, e.g. Care Analyzer

The Alliance's Care Management program emphasizes that the CM aligns with the members' needs. The four (4) primary level trigger areas used to determine CM identification:

- Health Risk Assessment (HRA),
- Data sources such as Utilization, Predictive Modeling, Admission, Transfer and Discharge (ADT) Feed
- Population Health Reports
- Direct referrals to care management.

The goal of the Health Risk Assessment (HRA) is to gather member self-reported information to proactively identify members who may have high risk needs and therefore need prioritized engagement into CM for further assessment. The HRA information is used as a starting point to develop an Individualized Care Plan (ICP) with the member, which is shared with an Individualized Care Team (ICT). Conducting the HRA is a requirement for Medi-Cal SPD lines of business.

The Alliance utilizes a predictive model application, CareAnalyzer, to aggregate utilization data and identify members who may be at risk and could benefit from CM interventions. Using CareAnalyzer, along with claims and authorizations, the HealthCare Analytics Department generates a monthly Population Health Report. Staff review the data and prioritize outreach to the top 1% on the Population Health Report.

Direct referrals into Care Management are received from multiple sources, such as the staff from disease management, utilization management, hospitals, Provider Groups, the Primary Care Provider (PCP), Specialist or from the member, members' family or caregiver. Additional internal departments may

refer based on their involvement with certain member situations, e.g. Grievance and Appeals, Member Services, Compliance, and Leadership.

CM cases identified through the data sources or referral sources cited above are reviewed by the CM triage nurses, taking into consideration the known information about the case from claims history, medical records that may be on file for UM purposes, and Member Services call history. The triage nurse verifies member appropriateness for CCM and if appropriate opens a case in the CM information system and assigns a case manager. Members are deemed ineligible if the member is not on the Plan, has died, is receiving duplicative services or is in a long-term care facility.

Predictive Model Application

As stated above, The Alliance utilizes a predictive model application, CareAnalyzer, to aggregate utilization data to identify members who may be at risk and could benefit from CM interventions. CareAnalyzer's unique analytic approach stems from the integration of The Johns Hopkins University Adjusted Clinical Group (ACG) System, a comprehensive set of predictive modeling tools.

In 2017, the CM department collaborated with the Information System team to enhance the data stratification to target members for outreach. Adjusted Clinical Group, or ACGs, are the building blocks of The Johns Hopkins ACG System methodology. ACGs are a series of mutually exclusive, health status categories defined by morbidity, age, and sex. They are based on the premise that the level of resources necessary for delivering appropriate healthcare to a population is correlated with the illness burden of that population. ACGs are a person-focused method of categorizing patients' illnesses. Over time, each person develops numerous conditions. Based on the pattern of these morbidities, the ACG approach assigns each individual to a single ACG category. By adding the Johns Hopkins Resource Utilization Bands (RUBs) to the data sets, the team hoped to improve the sensitivity and specificity of the identified member data. ACGs were designed to represent clinically logical categories for persons expected to require similar levels of healthcare resources (i.e., resource groups). However, enrollees with similar overall utilization may be assigned different ACGs because they have different epidemiological patterns of morbidity.
In addition, the tool was enhanced to capture the Residual Risk Score (RRS) to apply predictability to the data. The enhancement identifies current and predictive changes based on utilization data.

Figure 6 - 2021 Care Analyzer data for Disease Management and Care Management Services

Care Analyzer	01/2021	02/2021	03/2021	04/2021	05/2021	06/2021	07/2021	08/2021	09/2021	10/2021	11/2021	12/2021
Asthma	1139	1064	2813	939	8792	N/A	263	1423	3244	715	163	7206
Diabetes (Excluding CCM)	2439	6405	5357	3913	13990	N/A	9122	1747	1706	1705	1564	1418
CCM (Diabetes + Non-Diabetes)	608	867	871	886	911	N/A	958	946	996	984	1024	1009
Care Coordination MCAL/Medicare members	90	103	111	132	133	N/A	118	116	127	131	133	134
Percentage of CCM												
5%	30	43	44	44	46	N/A	48	47	50	49	51	50
3%	18	26	26	27	27	N/A	29	28	30	30	31	30
1%	6	9	9	9	9	N/A	10	9	10	10	10	10

Figure 6 above shows the number of members identified by CareAnalyzer algorithm for potential candidates for CCM services in 2021. The top volumes were in Diabetes, averaging about 4500 per month, followed by Asthma at around 2500 per month.

Members are identified as candidates for CCM through a variety of data sources and referrals. The Population Health Report is one of the data sources. The criteria are determined using Care Analyzer data plus utilization history. The Care Analyzer data includes Member claims, including those for behavioral health, and pharmacy claims. The scores, together with the utilization history, provide a listing of Members who are most at risk. The criteria are subject to change at least annually but typically address Members with at least one of the following clinical features:

- Complex diagnoses such as End-Stage Renal Disease (ESRD), Chronic Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD)
- High risk scores
- Multiple comorbidities
- Multiple Emergency Department (ED) visits in a year
- Multiple hospitalizations in a year

CM uses the Care Analyzer report and added the combination of co-morbidities (Diabetes, Renal Failure, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD)), inpatient admissions (greater than three (3)) and emergency room visits (greater than four (4)) in the prior six (6) months as additional criteria, based on staff experience with identifying at risk members. If a member has any combination of three (3) of the above filters, then the member is outreached by a Health Navigator, with a goal to enroll appropriate members in CCM.

With the changes made to filter the Population Health Report, in 2021, the case management team outreached to the members who meet criteria described above. (0.1% to 7.9%, depending on the month)

Review of the number of members outreached versus potential members to outreach, has led to improvement in the process of converting members to CCM from the Population Health Report. This process has been prioritized in 2022 for integration within the system of record (TruCare) for process automation.

Transitions of Care

In November 2019, Transitions of Care program was enhanced, piloting at the Alameda Health System (containing 3 hospitals), with the plan for further expansion in 2020. The criteria for Transitions of Care is a discharge from an inpatient stay from AHS hospitals, or (as of 2020,) a discharge from any hospital following a hospitalization for Covid. Continued collaboration is ongoing to prevent duplication of work by other Transitions of Care Programs.

The Admission, Transfer, Discharge (ADT) data from hospitals is used to identify members who are candidates for TOC, as well as referrals from the Inpatient Nurses. Upon discharge from the hospital, the members listed on the reports are entered into the Clinical Information System as a referral. The referral source is listed as 'Internal Report'. Prior to CM staff assignment, the referrals are reviewed by a triage nurse to evaluate medical history and utilization history from various data sources including the hospital discharge summary. The triage nurse makes a recommendation during the assignment process as to which CM team member role is appropriate to receive the referral. In collaboration with IT, CM automated referrals into the system of record, TruCare, to streamline the referral process.

The onset of COVID-19 in 2020, delayed the expansion of the TOC Program to other hospitals. Instead of expanding to more hospitals, CM expanded the criteria to include every Alliance member discharged from any hospital with a diagnosis of COVID-19 into the TOC Program. This list of members included members assigned to our delegates (including CHCN). This continued in 2021.

Further planning regarding expansion of the TOC Program to more hospitals into 2022 is ongoing. The goal is to expand to include 25% more members into the TOC Program by the end of 2022. This 2021 goal was not met due to continued public emergency of COVID-19. This has further delayed TOC program expansion. Instead, the Alliance Case Management Department focused efforts to establish relationships with the local hospital ambulatory teams. This

was done to mitigate and work collaboratively to provide the best appropriate care for our members.

The complex case management criteria includes specific diagnoses, including mental health diagnoses as well as other complex psychosocial needs. The CM workflow requires that every member referred for case management also be screened for Complex Case Management (CCM). If the member meets criteria, CCM is offered to that individual (even if the member is first enrolled in the TOC Program).

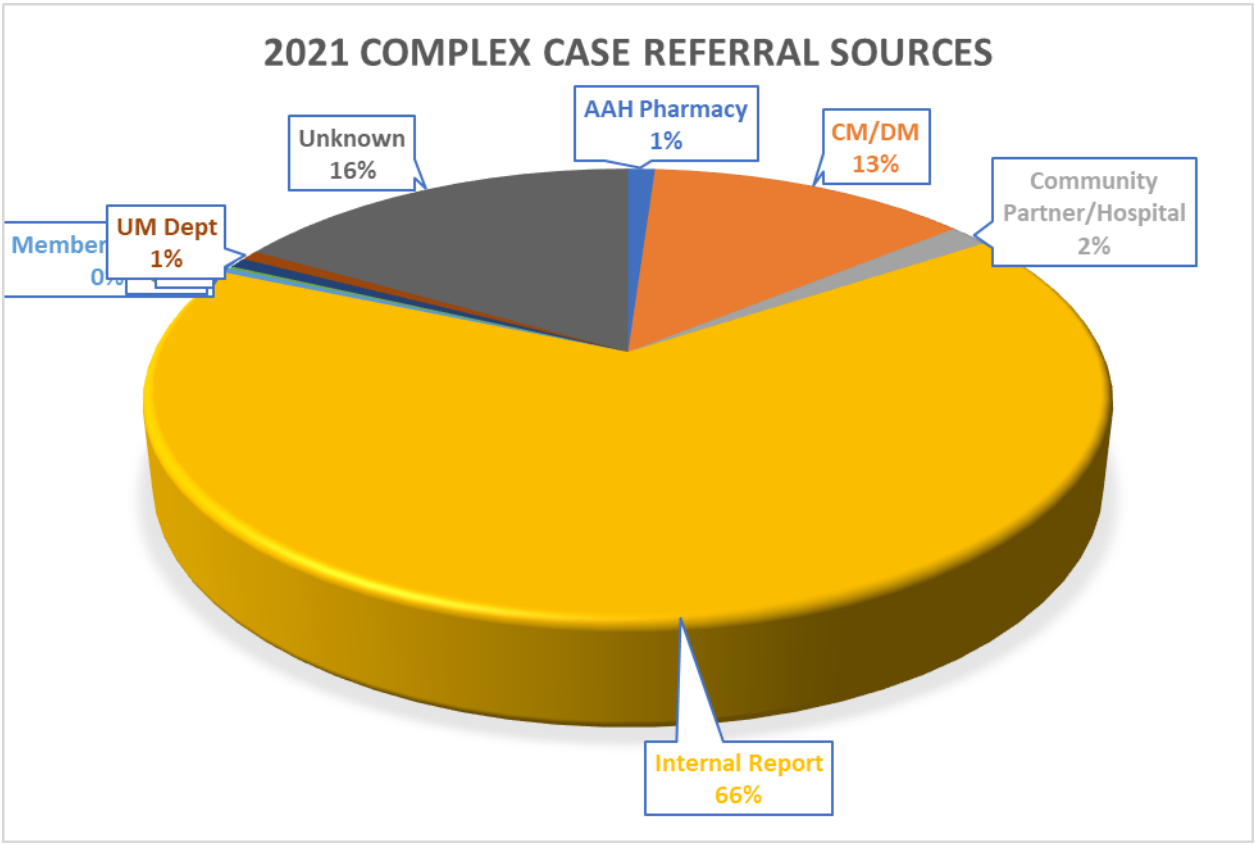
Methodology:

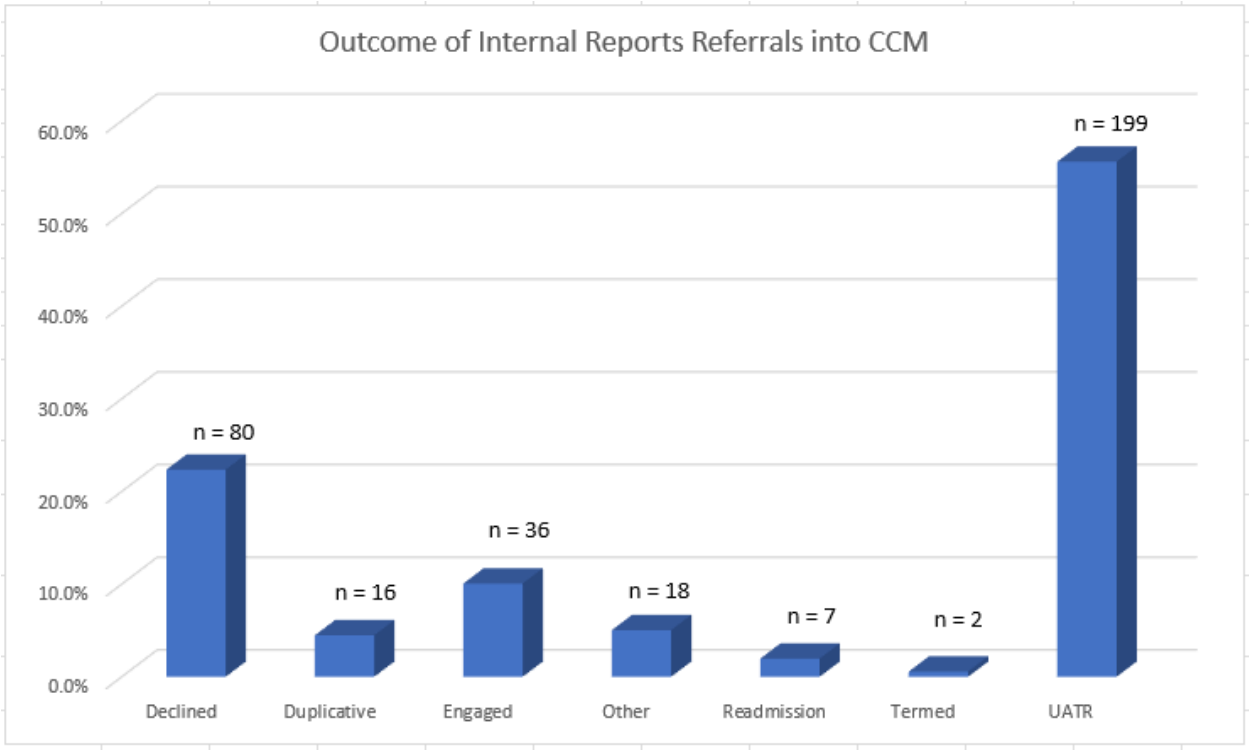
Using the Case Management Aging report, CCM cases created in 2021 were pulled and separated based on sources. Sixty-Six (66) percent (358 out of 538) of CCM cases came from an Internal Report. Including the Transitions of Care (TOC) Program, the Internal Report category includes the ADT Feed and the Population Health Report.

Complex Case Management

As discussed above, the CM Department aids members identified as needing assistance in navigating the health care system or in coordinating their health care services. The CM Department monitors referral sources and program activities to assess the effectiveness of the program as well as to identify patterns for potential educational opportunities.

The following data shows the referral sources of the Complex Case Managed members


2021 COMPLEX CASE REFERRAL SOURCES
AAH Pharmacy 1%
CM/DM 13%
Community Partner/Hospital 2%
Unknown 16%
UM Dept 1%
Member 0%
Internal Report 66%



Quantitative Analysis:
An analysis of CCM and population health as referral source reveals the following:

- Overall, for 2021, 66% of CCM cases were identified from the Internal Reports.
- CM/DM referral type is defined as CM department refers to other CM team members. For 2021, 13% of the referrals were these internal referrals.
- CM continued to have difficulty engaging members from the Internal Reports in the CCM program, with only 10% of potential cases successfully engaged in the program. (This is down from 20% in 2020.)
- Most cases identified through the Internal Reports were Unable to Reach (UATR) or Declined, while some Engaged in the program.

Qualitative analysis:

There has been improvement in identification and engagement of members with potential need for CCM from the Internal Reports, but there remains room for improvement:

- There were members identified as very high cost but did not appear on the Internal Reports, as might be expected.
- There were members identified on the Internal Reports but not successfully engaged.

In 2021, there were multiple initiatives to improve internal structures and processes. They included:

- Continued review and revisions of the Population Health Report and the CM Daily Aging Report

- Department trainings to improve consistency in outreaching members, talking to members and documentation in the electronic system of record.
- Launching collaborative efforts with hospital partners to discuss identifying and implementing alternatives to member outreach.
- Launching a productivity standard with a goal of increasing Complex member outreach.

Through discussion and feedback, the following has been identified as possible contributing factors resulting in low volume of members engaged in CCM and identifying members for the program:

- Reports pull from different sources and yield different results.
- "Cold calling" members on the Population Health Report continues to be less effective in engaging members in the program.
- Inaccurate contact information.

2022 Recommendations

- Continue to identify, implement, and evaluate different avenues to attempt to improve member engagement.
- Set SMART goal for:
    - Collaborative efforts with partnered hospitals
    - Productivity standard of Complex member outreach and engagement
    - Obtaining accurate member contact information.
    - Evaluating the use of the CHR for member engagement
- Findings will be collected and submitted as part of the 2022 CM program evaluation.

Figure 7 - 2021 CM Care Coordination Program by Referral Source

Care Coordination	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
AAH Pharmacy	0	1	5	2	0	0	1	0	2	1	0	1
Behavioral Health Program	0	1	2	2	0	1	0	0	1	0	2	1
California Children's Services	0	1	0	0	1	1	0	0	0	0	0	0
CM/DM	56	49	54	43	49	41	37	47	57	32	34	36
Community Partner/Hospital	28	24	30	35	15	21	26	15	23	16	16	21
Compliance Dept	5	1	1	2	0	0	1	1	3	1	1	6
Grievance and Appeal	7	3	6	3	3	19	15	10	3	6	6	3
Health Education	0	0	0	0	0	0	0	0	0	0	0	0
Internal Report	13	16	10	19	15	15	11	8	14	17	17	2
Member Services	75	66	80	77	70	83	67	99	63	78	51	59
Nurse Advice Line	3	4	5	3	4	0	4	1	1	2	2	0
Other	2	1	6	4	2	1	1	1	0	2	0	1
PCP/Specialty Provider	0	1	2	2	2	1	0	0	0	1	0	0
Provider Services Dept	0	1	0	0	0	0	0	0	0	0	0	0
Self	10	9	19	11	17	15	25	22	40	33	32	37
UM Dept	25	24	44	30	32	42	34	49	37	31	49	59
Total	**224**	**202**	**264**	**233**	**210**	**240**	**222**	**253**	**244**	**220**	**210**	**226**

Analysis of 2021 show the top three referral sources for Care Coordination cases are:

1) Member Services at 868
2) CM/DM at 535
2) UM Department at 456

Referrals from PCP/Specialty Providers remain low and represent an opportunity to work with the Physicians/Physician Offices on the services for improving care coordination.

Figure 8 - 2021 CM Care Coordination Program by Active Cases

Care Coordination	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
ACTIVE CASES												
New Cases	238	194	274	235	214	246	231	287	258	252	233	254
Total Cases In Progress	610	567	641	618	567	517	503	552	537	509	458	489
Total Assessments Completed w/in 30 Days of Referral	12	3	5	4	2	7	23	12	9	8	6	5
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral / Total Referrals)	5%	1%	2%	2%	1%	3%	10%	5%	4%	4%	3%	2%

Figure 8 above describes the Active case activities by the number of new Care Coordination cases and the total open cases in program.

The data in Figure 8 shows the number of assessments completed and the timeframe for completing the assessment.

Though the Care Coordination Assessment to identify care coordination needs was developed in Q4 of 2020, it is not used often due to perceived lack of utility. In 2022, re-education will be provided to the CM team, and monitoring its use and efficacy.

Figure 9 - 2021 CM Care Coordination Program by Case Closure

Care Coordination	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
CASE CLOSURE BY CLOSURE REASONS												
Admission	0	0	0	0	0	0	0	0	2	0	0	0
Already in Program	5	6	6	2	1	0	5	3	5	10	3	9
Completed Program	43	31	47	40	40	31	41	48	38	28	25	39
Condition stable with no further Case Management needs	64	43	46	54	51	59	67	79	81	79	79	62
Condition stable with no further Disease Management needs	1	0	1	0	0	1	0	1	0	0	0	0
Deceased	0	0	2	1	2	0	1	2	1	0	0	1
Duplicate member record	0	1	2	2	1	0	0	2	0	0	0	0
Duplicative Program	5	2	5	4	5	3	2	2	7	1	2	2
Escalate services to higher level program	5	9	15	19	12	15	8	7	7	9	4	11
Inappropriately identified for program	0	0	1	2	2	0	1	0	1	0	0	0
Lost Contact	14	27	27	29	34	14	22	38	24	39	19	29
Member/AOR declines continued case management services	0	0	0	0	0	0	0	0	1	5	0	6
Member/AOR declines program	4	2	4	6	6	3	4	8	6	3	3	1
Member/Caregiver refuses services	1	0	0	1	0	2	1	0	0	0	0	0
Member declines continued Case Management services	3	2	0	1	0	2	4	2	1	0	0	0
Member declines continued Disease Management services	0	0	0	3	2	1	0	0	0	0	0	0
Member Ineligible	4	3	9	5	5	2	3	5	4	0	0	0
Member non-compliant	0	0	0	0	3	1	0	0	3	0	0	2
Member transferred to Delegate/Other	8	3	7	5	6	9	4	2	4	7	5	5
New case open	2	2	0	0	0	5	3	3	2	0	1	2
Other	20	21	26	23	40	40	27	23	44	44	23	35
Readmission	2	1	5	3	3	2	1	3	1	0	2	1
Referred to Disease Management	0	0	0	0	0	1	0	0	0	0	0	0
Step down to lower level program	0	0	0	0	0	0	0	0	0	1	0	0
Termination of coverage	0	1	3	1	7	3	3	4	1	4	4	3
TruCare cleanup	0	0	0	0	0	0	0	0	0	0	0	0
Unable to contact member	56	46	52	64	76	51	41	41	47	54	53	31
Total	237	200	258	265	296	245	238	273	280	284	223	239

As noted in Figure 9, the top three reasons for case closure were:

1) Condition Stable with no further need for CM at 764 members
2) Unable to Contact at 612 members
3) Completed Program at 451 members.

Condition Stable with no further need for CM and Completed Program are similarly defined reasons for case closure, warranting further refinement of the data tool and clearer definitions of the reasons for case closure, including understanding the "Other" category.

Plan for 2022

Continued efforts to improve reporting process to accurately depict Referrals, Active Cases and Case Closure numbers.

Complex Case Management

Complex Case Management (CCM) is provided to members who meet the criteria for CCM.

Members are identified as candidates for CCM through a variety of data sources and referrals. A full description of the data sources is included in the CM Program description.

Figure 10 – 2021 Complex Case Management – Referrals by Source

Complex	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
AAH Pharmacy	0	0	2	1	3	0	0	0	0	0	0	0
CM/DM	13	13	16	15	25	26	11	12	7	2	9	3
Community Partner/Hospital	1	1	1	2	1	2	0	0	2	2	1	0
Internal Report	9	12	20	27	58	127	5	2	13	54	67	24
Member Services	0	0	0	0	0	1	0	0	0	1	0	1
Other	0	1	0	0	1	0	0	0	0	0	0	0
Self	0	0	0	1	1	0	2	0	1	1	0	0
UM Dept	2	1	0	0	1	1	0	1	0	0	0	0
Total	**25**	**28**	**39**	**46**	**90**	**157**	**18**	**15**	**23**	**60**	**77**	**28**

For 2021, the top three referral sources were:

1) Internal Report at 418
2) CMDM at 152
3) Community Partners/Hospitals at 13.

It is noted that the referrals to CCM are low overall. This is an opportunity to evaluate and improve the CCM intervention and stakeholder communication about the CM program. This may also include working with the Physicians/Physician Offices and the UM department on the services available to members through complex case management.

Figure 11 2021 CCM Active Cases and Case Assessments Rates

Complex	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
ACTIVE CASES												
New Cases	21	23	44	44	80	141	20	20	30	59	77	28
Total Cases In Progress	64	50	81	100	145	220	146	90	84	109	123	68
Total OptOut Assessments	0	2	0	0	12	5	1	0	2	6	15	4
Total Assessments Completed w/in 30 Days of Referral	6	10	11	12	11	21	7	4	7	10	8	6
Active Participation Rate % (Total Assessments Completed w/in	24%	36%	28%	26%	12%	13%	39%	27%	30%	17%	10%	21%

Figure 11 above describes the 2021 Active case activities by the number of new cases, (587) the total open cases in program (1,280) and the number of cases in which the members was identified and referred but opted not to engage in the program, (47).

In addition, the data in Figure 11 monitors the number of assessments completed and the timeframe for completing the assessment from the referral. This value is created based on the assessments completed within 30 days of referral over the number of referrals. This part of the report does not reflect the required timeframes, which is 30 days from the time of identification of CCM, so it will be retired as a metric.

The current process is that the Case Manager attempts to begin the initial assessment in the first contact call. An initial assessment is performed as expeditiously as the Member's condition allows (and may be completed by multiple calls) but must be created/initiated within 30 calendar days and completed within 60 days from date of identification. Barriers to completing the full CCM assessment include the member's ability to participate in a long assessment conversation, and difficulty with maintaining contact with the member over more than one call. Strategies to improve this will be required.

Methodology for Data Validation:
Using the Daily Aging Report, all cases referred and created in 2021 were pulled to identify the assessment status. CCM assessments completed were pulled and evaluated for timeliness.

2021 Results:

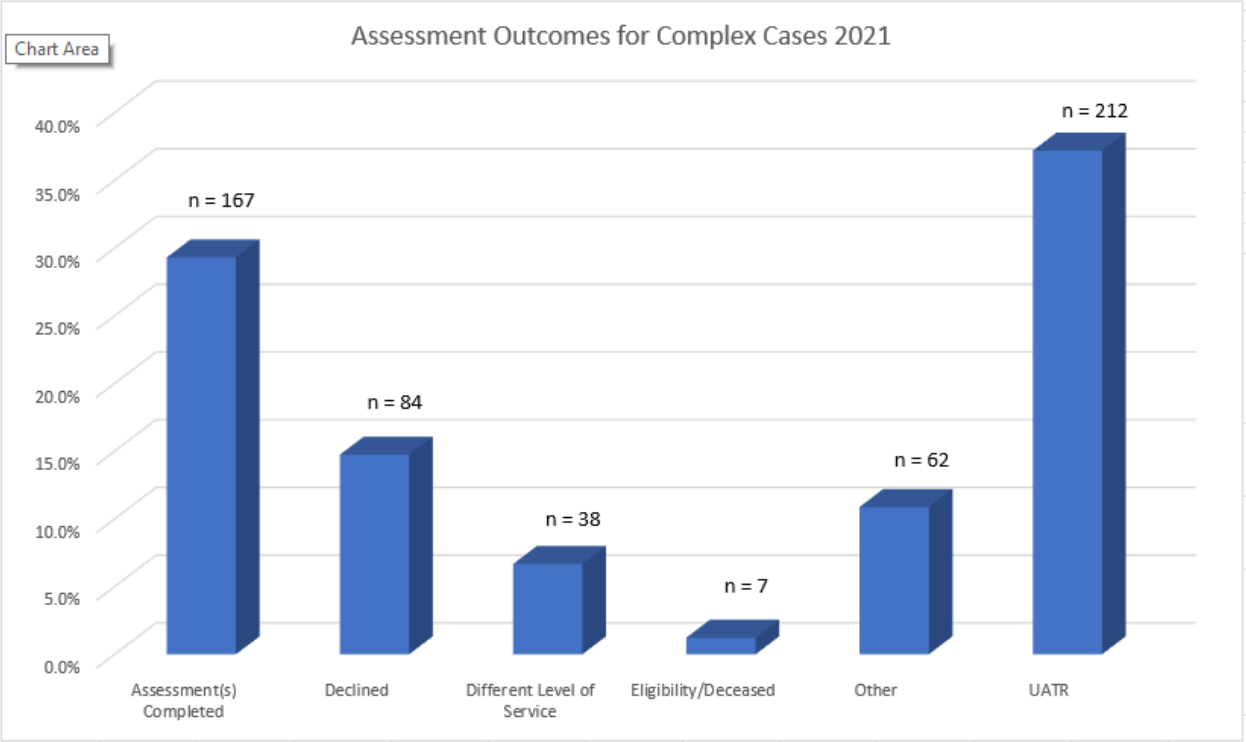
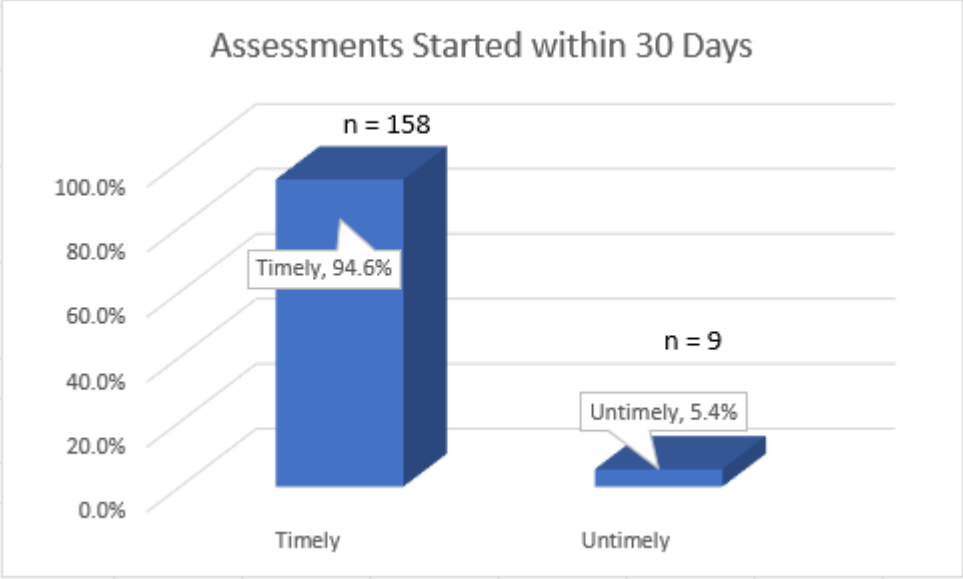
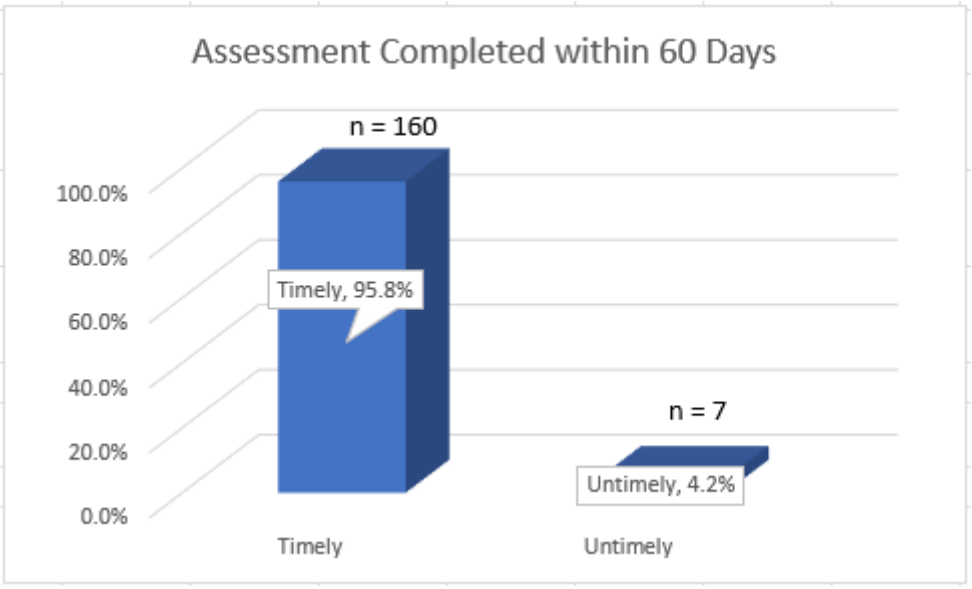


Chart Area
Assessment Outcomes for Complex Cases 2021
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
n = 167
n = 84
n = 38
n = 7
n = 62
n = 212
Assessment(s) Completed
Declined
Different Level of Service
Eligibility/Deceased
Other
UATR


Assessments Started within 30 Days
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
n = 158
Timely, 94.6%
n = 9
Untimely, 5.4%
Timely
Untimely



Quantitative Analysis:
An analysis of CCM assessment timeliness shows the following:

- Out of 167 assessments (up from 23 in 2020), 158 were started within 30 days and only nine (9) were started after the 30-calendar day timeframe, at 94.6%.
- Out of 167 assessments, 160 were completed within 60 days and only seven (7) were completed after the 60-calendar day timeframe, exceeding the goal at 95.8%.

Qualitative analysis:
The following provides a qualitative analysis of CM assessment timeliness from both the quantitative analysis of CCM Aging Report, and the outcome of chart review and case review feedback with staff:

- The assessments that were not started within 30 days were due to care coordination needs taking priority to starting the assessment and difficulty re-engaging the member.
- The seven assessments that were not completed within 60 days were due to members who were challenging to re-engage to complete the assessment.

During 2020, CCM standard of work was created, and staff were trained. In 2021 a productivity standard was implemented to encourage staff to engage members and offer CCM. This had a positive outcome, with the number of CCM assessments completed in 2021 increasing to 167, from 23 during 2020. There continues to be ongoing problem-solving discussions within the CM team regarding CCM cases and further refinement and system optimization for the system of record, TruCare, to streamline the process of recording the CCM assessment.

Interdisciplinary Care Team **(IDT)**

Case Management evaluated timeliness of presenting to Interdisciplinary Care Team (IDT) Rounds for cases that were open for 90 days or more.

Methodology:

Review all cases that have been open for 90 days or more, regardless of case type.

IDT Rounds are held bi-weekly, and using the Daily Aging Report, staff are notified of cases that are open at 60 days or more, to prepare to present the case at the next IDT meeting. Upon notification, all cases are logged within the Complex Case Log.

CM identified 22 CCM cases (open for at least 90 days) from the Complex Case Log (and validated with the Daily Aging Report).

2021 Results:

Complex Cases ≥ 90 days	Outcome of IDT	% of Timely IDT based on Report
0	No IDT	0%
19	Timely	95%
1	Untimely	5%

Every CCM case open for 90 days or more was presented at IDT meeting. Of the one (1) case that was not presented timely, this occurred because the case was incorrectly closed before all team members were able to complete their interventions with the member.

This led to 95% of timely IDT presentation (up from 86% in 2020 and 19% in 2019). The successful improved process will be continued into 2022.

Figure 12 - 2021 Complex Case Management Case Closures by Reason

Complex	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
Admission	0	0	0	0	0	0	0	0	0	1	3	0
Already in Program	1	0	0	0	2	4	1	0	0	1	0	0
Completed Program	3	1	2	2	6	7	2	5	7	7	3	2
Condition stable with no further Case Management needs	2	0	3	1	2	5	4	5	5	5	2	1
Condition stable with no further Disease Management needs	0	0	0	0	0	0	0	0	0	0	0	0
Deceased	1	0	0	0	1	0	2	0	2	1	1	0
Duplicate member record	0	0	2	0	0	0	0	0	0	0	0	0
Duplicative Program	1	1	4	1	2	5	4	2	1	1	4	1
Escalate services to higher level program	0	5	3	5	4	4	1	2	0	1	0	0
Inappropriately identified for program	0	0	0	0	2	3	0	0	1	0	0	0
Lost Contact	5	0	2	4	10	11	12	12	3	14	13	7
Member/AOR declines program	0	1	1	3	11	13	3	0	3	9	16	3
Member/Caregiver refuses services	0	0	0	2	5	3	1	0	0	0	0	0
Member declines continued Case Management services	1	0	0	1	0	0	1	1	0	0	0	0
Member Ineligible	1	0	0	0	0	0	0	1	0	0	0	0
Member non-compliant	1	0	0	2	0	1	0	1	0	1	1	2
Member transferred to Delegate/Other	0	1	0	0	0	0	0	0	1	0	0	0
New case open	0	0	0	0	0	1	0	0	1	1	1	1
Other	4	0	1	2	4	9	4	0	3	3	5	0
Readmission	0	0	1	1	0	1	2	1	1	0	0	0
Step down to lower level program	1	0	0	0	0	0	2	2	3	0	1	2
Termination of coverage	0	0	0	0	1	0	0	0	0	0	1	0
TruCare cleanup	0	0	0	0	0	0	0	0	0	0	0	0
Unable to contact member	16	4	6	11	16	27	37	4	3	18	32	13
Total	37	13	25	35	66	94	76	36	34	63	83	32

As noted in Figure 12, the top three reasons for case closure in 2021 were:

1) Unable to Contact (187)
2) Lost Contact (93)
3) Member/AOR Declined the Program (63)

Recommended Interventions/Next Steps for 2022:

An opportunity to continuously improve the quality oversight of the current CM processes has been identified. This will be accomplished by internal monitoring of CM/CCM files on a periodic basis. This also includes reviewing and revising the standardized reports focused on monitoring of CM activities: referral management, outreach, case closure and PCP communications. Strategies to address the Unable to Contact issues will need to be developed.

Performance Measures

The Alliance maintains performance measures for the complex case management program to maximize member health, wellness, safety, satisfaction, and cost efficiency while ensuring quality care. The Alliance selects

measures that have significant and demonstrable bearing on the entire complex case management population or a defined subpopulation. The Alliance annually measures the effectiveness of its complex case management program based on the following performance goals and corresponding measures:

Figure 13 – CM Performance Measures

	Goal	Measure	Measurement	Performance Goal	2021 Rate	Goal Met?
#1	Achieve and maintain high level of satisfaction with CM services.	Member Satisfaction Rates	High level of satisfaction with CM services	90%	85.6%	No
#2	Improve member outcomes	All-Cause readmission Rate	readmission rates for all causes for members in CCM with admission within 6 months of enrollment in CCM	Report in development	19.0% overall, not specific to CCM	NA
#3	Improve member outcomes	Emergency Room Visit Rate	ER rates for members enrolled in CCM	Report in development	Not Available	NA
#4	Achieve optimal member functioning.	Health Status	% of members in CCM responding that their health status improved because of CCM	90%	85.7%	No
#5	Use of Appropriate Health Care Services	Use of Services	Improvement in measures of office visits within Alliance Network	Report in development	Not Available	NA

Figure 13 captures the 2021 Performance Measures. Of the five measures, two had an established benchmark.
For 2021, CM continued to achieve the goal of achieving and maintaining high level of satisfaction with CM services at 85.6%
The overall all cause readmission rate was reported at 19.0%, but this is not specific to the CCM population. It is noted that most measures are not specific to members enrolled in CCM. With the assistance with the Analytics department, a report is being developed to identify the readmission rate for members who are enrolled in CCM. This report will also include Emergency Room Visit Rates for members enrolled in CCM (Performance Measure #3).
The member surveys showed that 85.7% of members in CCM responded that their health status had improved because of CCM.
In collaboration with, Analytics a report is being developed to evaluate the use of appropriate Health Care Services by measuring office visits for members receiving CM services.

Assessing Members Experience with the CM Process

On an annual basis, CM evaluates member experience with the CCM Program by obtaining member feedback with the use of satisfaction surveys and continuous monitoring of member complaints. The information obtained assists Alameda Alliance in measuring how well their complex case management program is meeting member's expectations and identifying areas for improvement.

The goal of the Complex Case Management Program is to obtain a 90% or greater overall satisfaction with the CCM program.
Satisfactory results are defined as those that fall under the following categories:

- Very Satisfied
- Much Improved
- Always True
- Highly Likely

In 2021, CM Department received a total of 11 surveys.

Figure 14 – 2021 Survey Results

	N	%	Sample Size	Goal Met?
Member Experience Criteria	Very Satisfied			
Time Spent with CM	9	81%	11	N
CM Understands Concerns	9	81%	11	N
Information to Manage Health	5	45%	11	N
Overall Experience	8	72%	11	N
Member Experience Criteria	Moderately Satisfied			
Information to Manage Health	2	19%	11	N
Overall Experience	1	9%	11	N
Member Experience Criteria	Slightly Satisfied			
Information to Manage Health	2	19%	11	N
Member Experience Criteria	Moderately Dissatisfied			
Overall Experience	1	9%	11	N
Member Experience Criteria	Very Dissatisfied			
Time Spent with CM	2	19%	11	N
CM Understands Concerns	2	19%	11	N
Information to Manage Health	2	19%	11	N
Overall Experience	1	9%	11	N
Member Experience Criteria	Much Improved			
Better Manage Health Condition	5	45%	11	N
Overall Health & Well-Being	7	64%	11	N
Member Experience Criteria	Improved			
Better Manage Health Condition	3	27%	11	N
Overall Health & Well-Being	2	19%	11	N
Member Experience Criteria	Somewhat Improved			
Better Manage Health Condition	2	19%	11	N
Member Experience Criteria	Same			
Better Manage Health Condition	1	9%	11	N
Overall Health & Well-Being	2	19%	11	N
Member Experience Criteria	Always True			
Ability to Speak to CM	6	54%	11	N
Member Experience Criteria	Usually True			
Ability to Speak to CM	1	9%	11	N
Member Experience Criteria	Neutral			
Ability to Speak to CM	4	36%	11	N
Member Experience Criteria	Highly Likely			
Recommend CM Services	8	72%	11	Y
Member Experience Criteria	Likely			
Recommend CM Services	3	27%	11	Y

Of the eleven surveys returned; the combined satisfaction was 85.6%%.

Another way to assess member experience is through review of the filed complaints against Case Management:

Figure 15 – 2021 Complaints Filed Regarding CM Process

Grievances Filed Against	Access to Care		Other		Quality of Service	Total
	Lack of Telephone Accessibility	Delay in Referral	Misc.	Discrimination / Sensitivity	Poor Provider / Staff Attitude	
Case Management	44	9	22	1	10	87

There was a total of 87 complaints for 2021. There were 44 complaints related to Lack of Telephone Accessibility, typically regarding reaching a specific staff member. The call volume had also increased in 2021, coinciding with the increase in membership. CMDM worked in 2021 to improve the telephone accessibility issue by changing the daily staffing plan to assign one person to answer the phones and triage/transfer as indicated. There were 10 complaints with Quality of Service – Provider/Staff Attitude, primarily the Provider. Strategies included staff assignment re-organization, customer service communication and member engagement training, which provided to all staff. The live answer rate was increased by 10% in 2021, and complaints will be monitored ongoing to determine efficacy in reducing the number of complaints.

Recommended Interventions/Next Steps for 2022:

In 2022, there is an opportunity to ensure the CM Department:

- Review and revise the process on how CM initiates and collects the satisfaction survey to continue to increase the response rate.
- Identifies CM performance measures, goals, and benchmarks.
- Collaborates with Health Care Analytics to ensure the performance measures can be captured and reported semi-annually.

Special Programs

Transitions of Care

Health Care Delivery Systems are challenged with reevaluating their hospital's transitional care practices to reduce 30-day readmission rates, prevent adverse events, and ensure a safe transition of patients from hospital to home. Successful transitional care programs include a "bridging" strategy with both pre-discharge and post-discharge interventions, often including a dedicated transitions coordinator involved at multiple points in time. The key strategies of a Transitions of Care (TOC) program include patient engagement, use of a dedicated

transitions coordinator, and facilitation of communication with outpatient providers. These strategies have the aim of improving patient safety across the continuum of care and require time and resources.

In 2019, the Alliance revamped the existing TOC program to better support partner hospital efforts when Alliance members transition out of the facility to home. With the collaboration of IT, a new way of identifying members was created through a report called the Admission, Discharge, Transfer (ADT) Feed sent from various hospitals. The TOC pilot program continued into 2021 with Alameda Health Systems (containing 3 local hospitals). With the arrival COVID-19 in 2020, the TOC program expanded to include any member discharged from any hospital with a diagnosis of COVID-19, and it continued into 2021.

Figure 16 - 2021 Transitions of Care Referrals

Transitions of Care	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
AAH Pharmacy	0	0	0	1	0	0	0	0	0	0	1	0
Behavioral Health Program	0	0	1	0	0	0	0	0	0	0	0	0
California Children's Services	0	1	0	0	0	0	1	0	0	0	0	0
CM/DM	30	21	32	37	27	17	26	12	11	8	8	9
Community Partner/Hospital	38	26	14	18	8	15	12	14	28	12	17	11
Compliance Dept	0	0	0	0	0	0	0	0	0	0	0	1
Grievance and Appeal	0	0	0	0	0	0	0	0	0	1	0	0
Health Education	0	0	0	0	0	0	0	0	0	0	0	0
Internal Report	208	194	193	226	210	181	192	173	178	202	161	207
Member Services	1	1	0	1	0	0	1	1	1	1	0	0
Nurse Advice Line	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	0	0	0	1	1	0	0	0	0	1
Self	0	0	0	0	0	0	1	0	0	0	0	0
UM Dept	52	22	18	26	15	11	13	54	32	20	24	29
Total	330	265	258	309	260	225	247	254	250	244	211	258

With the resurgence of the TOC Program, Figure 16 shows the top three sources of referrals were:

1) Internal Report at 2325
2) UM Dept at 316
3) CM/DM at 238

The Internal Reports refer to the ADT Feed and the COVID-19 Report.

Figure 17 – 2021 Transitions of Care Active Cases

Transitions of Care	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
ACTIVE CASES												
New Cases	281	246	261	264	220	237	211	267	240	248	241	260
Total Cases In Progress	584	560	538	507	476	478	427	480	465	484	479	487
Total OptOut Assessments	2	0	0	0	1	3	2	3	2	1	1	1
Total Assessments Completed w/in 30 Days of Referral	82	81	84	88	103	81	57	86	81	52	72	58
Active Participation Rate % (Total Assessments Completed w/in 30 Days of Referral /	25%	31%	33%	28%	40%	36%	23%	34%	32%	21%	34%	22%

The data noted in Figure 17 shows a stabilization in TOC cases throughout 2021. The Active Participation Rate is calculated from the total assessments completed within 30 days of referral and the total referrals.

Analysis shows that some assessments were not completed because the corresponding referrals were declined because they were duplicate referrals, or the member was already enrolled in another CM program.

Re-education of the Transitions of Care program and completion of the TOC assessment is recommended for 2022, to improve the Active Participation Rate % score.

Figure 18 – Transitions of Care Case Closures

Transitions of Care	202101	202102	202103	202104	202105	202106	202107	202108	202109	202110	202111	202112
CASE CLOSURE BY CLOSURE REASONS												
Admission	0	0	0	0	0	0	0	0	7	8	1	2
Already in Program	6	1	1	1	1	0	3	2	3	2	1	0
Completed Program	31	35	29	17	35	29	26	21	39	54	41	47
Condition stable with no further Case Management needs	32	24	34	28	16	26	22	23	27	20	29	18
Condition stable with no further Disease Management needs	0	1	0	0	0	1	0	0	0	0	0	0
Deceased	5	7	5	7	0	0	1	1	5	2	4	4
Duplicate member record	0	0	1	1	0	2	0	4	0	0	0	0
Duplicative Program	5	7	5	6	7	4	7	6	5	4	4	6
Escalate services to higher level program	9	9	17	16	19	21	9	19	12	5	13	8
Inappropriately identified for program	2	0	1	2	0	1	0	1	1	0	0	0
Lost Contact	21	26	23	16	19	29	25	33	21	22	22	20
Member/AOR declines continued case management services	0	0	0	0	0	0	0	0	0	1	1	0
Member/AOR declines program	3	6	4	3	5	5	0	6	9	4	0	3
Member/Caregiver refuses services	1	2	3	5	3	3	2	0	0	0	0	0
Member declines continued Case Management services	3	3	1	2	1	5	3	0	0	0	0	0
Member declines continued Disease Management services	0	0	0	0	0	1	0	0	0	0	0	0
Member Ineligible	2	7	3	2	2	3	1	7	1	0	0	0
Member non-compliant	0	0	0	0	1	0	0	0	0	0	1	0
Member transferred to Delegate/Other	2	5	2	2	1	0	1	1	1	1	1	4
New case open	0	1	0	0	0	0	1	5	5	5	2	1
Other	12	32	24	28	25	23	19	36	18	22	20	18
Readmission	16	25	36	37	26	31	25	33	22	26	34	22
Step down to lower level program	1	0	0	0	0	0	0	2	1	0	0	0
Termination of coverage	1	1	1	0	0	0	1	0	1	3	2	3
TruCare cleanup	0	0	0	0	0	0	0	0	0	0	0	0
Unable to contact member	118	91	105	78	74	78	68	55	51	67	76	66
Total	**270**	**283**	**295**	**251**	**235**	**262**	**214**	**255**	**229**	**246**	**252**	**222**

As noted in Figure 18, the top three (3) reasons for TOC Case Closure in 2021were:

1) Unable to Contact Member (927)

2) Completed Program (404)
3) Readmission (333)

Efforts to improve the connect rate with members as they transition out of hospitals is needed. Discussions with AHS case management and transitions leadership about how to engage members before discharge is underway to develop strategies during the hospital stay. Using the Community Health Record to identify points of contact for members will be explored as well

Continuity of Care

The CM Department collaborates with the UM Department and Member Services on the management of the continuity of care program. CM is responsible for assisting members who have been approved to see providers outside of the network and need to be transitioned back in network after the Continuity of Care period has ended as well as members for whom Continuity of Care conditions have not been satisfied (ex. out of network provider not accepting Medi-Cal rates.) CM is notified of the need to assist members back in network via a report developed by HealthCare Analytics which captures data from the UM authorization. Staff also assist members based on direct referrals into the care coordination program, such as from UM staff who make referrals needed as a result of the Authorization Review process.

The UM department takes the leadership for assisting members who have exhausted a benefit or who are aging out of a benefit, i.e. California Children Services, or have needs beyond those provided by partner agencies. The UM Department coordinates these services through the care coordination referral process and identifies members who are aging out of CCS eligibility to ensure that they transition to appropriate providers, or other needs, and refers to CM as needed for further assistance to ensure that members receive the services required. Further work on these processes will occur in 2022.

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Alliance is responsible for ensuring Members who are eligible to receive LTSS services are identified and referred. The CM Department works with UM department to refer members who may benefit from LTSS for services. The UM Out of Plan (OOP) RN performs the initial assessment and referral into the appropriate Community Based Adult Services (CBAS) center. The OOP RN also provides re-assessments and re-authorization and refers to the CM department for additional services not provided at the CBAS center as needed.

INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH

Behavioral health is managed through delegation to Beacon Health Options, the MBHO. The behavioral health practitioners are involved in key aspects of the delegate's UM/CM program ensuring BH focus in policies and procedures, aligning the medical necessity guidelines with medical necessity guidelines and participation in the UM committee meetings. The MBHO dedicates a clinical team to assist in the co-management of the activities.

In 2021, the teams worked on efforts crossing the medical and behavioral health services which included:

- Enhancing CCM outreach to chronically ill
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams.
- Continued efforts toward improving communication between the primary care physician and behavioral health providers.
- Attendance by Beacon at the Interdisciplinary Care (IDT) Team meetings to collaborate, advise, refer, and provide additional insight into CCM cases.

A full description of the MBHO UM and CM Program and Evaluation can be found in the HCQC minutes.

In 2022, the services for members with Mild/Moderate Behavioral Health issues will be insourced back to the Alliance, which will help with further integration of BH and medical care.

HEALTH HOMES PROGRAM:

The state funded Health Homes Program for chronic physical conditions started in July of 2019, and members with serious mental illness (SMI,) were added in January of 2020 in Alameda County. Since July of 2019 and continuing through 2021 the Alliance employed a network of community-based care management entities (CB-CME's) to integrate primary, acute, and behavioral health care services (SMI beginning in January 2020) as well as community based needs (ex. housing) for the highest risk Medi-Cal enrollees. The HHP includes six core services, delivered through the managed care system: 1) Comprehensive care management; 2) Care coordination; 3) Health promotion; 4) Comprehensive transitional care; 5) Individual and family support; 6) Referral to community and social support services.

The primary program goal is to achieve improved health outcomes for eligible members by providing them additional supportive ("wrap around") care via the plan's network of CB-CME organizations. In 2021 Alameda Alliance

simultaneously helped build and oversee the capacity of CB-CME's to address the needs of the population and orchestrate reporting of encounter data and program results.

In 2021 the HHP (and the associated Whole Person Care (WPC) services through the Alameda County Health Care Services Agency (HCSA)) was integral to the planning for the transition to the CalAIM Enhanced Case Management (ECM) benefit, as well as the Community Support services to be provided by AAH, effective 1/1/2022. Members who were receiving HHP services on 12/31/2021 will "grandfathered" into the ECM services benefit on 1/1/2022. Members receiving housing support from HCSA WPC on 12/31/2021 were "grandfathered" into the housing bundle of the CalAIM Community Supports offered by AAH on 1/1/2022.

Health Homes Patient Characteristics (enrollment criteria)

Eligibility Requirement	Criteria Details
1. Chronic condition criteria (*Must meet at least one of the above to be enrolled.)	· **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR · **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR · **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR · **Asthma**

2. Acuity/Complexity criteria (*Must meet at least one of the above to be enrolled.)	· Has at least 3 or more of the HHP eligible chronic conditions; OR · At least one inpatient hospital stay in the last year: OR · Three or more emergency department visits in the last year; OR · Chronic homelessness.

Staff in 2021 included a Clinical Program Manager, a Health Navigator, a Housing Navigator, and a Physician Champion, the CM Medical Director. Work also had begun on AAH CM team to become an internal CB-CME, however, this work was placed on hold with the planning for the CalAIM Enhanced Care Management (ECM) benefit noted above, which was launched 1/1/2022. Work shifted to planning and preparing the Alliance CB-CME network to transition to the new ECM benefit structure and Community Supports services. This included training and re-certifying the AAH CB-CME network as new ECM Providers, and successfully identifying & transitioning all HHP and WPC enrolled members into ECM on 01/01/2022, and WPC members receiving housing services into the housing bundle of Community Supports.

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Program Outcomes: As of 12/31/2021, the HHP program had served 980 members at the 17 CB-CME sites in Alameda County:

CB-CME Site	Members Served in HHP in 2021
AHS Eastmont	52
AHS Highland	84
AHS Hayward	37
California Cardiovascular Consultants	113
CHCN Asian Health Services	61
CHCN Axis Community Center	24
CHCN La Clinica De La Raza	50
CHCN LifeLong Medical Care	161
CHCN Native America Health Center	52
CHCN Tiburcio Vasquez Health Center	72
CHCN TriCity Health Center	76
CHCN West Oakland Health Council	16

EBI	28
Family Bridges	19
Roots	95
Roots STOMP	10
Watson Wellness	30
Total Members Served	**980**

Next Steps in 2022

Continue to develop, train, and maintain the AAH ECM Provider network in preparation for additional Populations of Focus coming into CalAIM on January 1, 2023.

Launch Alameda County Behavioral Health (ACBH) as an ECM Provider to provide network expansion for SMI/SUD Population of Focus on July 1, 2022

Continue to develop and train new ECM providers in preparation for expansion of CalAIM populations of focus on January 1, 2023.

Coordination with Regulatory Compliance

The Alliance CM Department works closely with the Compliance Department in preparation for regulatory audits. In 2021, the department participated in DHCS and DMHC regulatory audits. The DHCS audit identified the following findings:

- The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members.
    - HRA tracking was refined in 2021. HRAs were sent out within the required timeframes, and Interactive Voice Response (IVR) calls were made to low-risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls were made by CM staff on high-risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log was kept to ensure that the required timelines were met, and close monitoring of the adherence to requirements was implemented.

- The plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.
    - This finding related to UM staff not making referrals to CM for coordination of care for EPSDT. UM staff were trained on identifying members who need coordination of care for EPSDT services from PA requests and referring members to CM.

- The plan did not ensure the completion of ICPs for members enrolled in CCM.
    - CM staff were re-trained on standard work for ICPs and revised the CM Aging report to capture completion of ICPs. Monitoring is ongoing.

- The plan did not ensure the development of care plans in collaboration with the PCP
    - Staff were retrained on development of care plans in collaboration with PCP and revised the Daily Aging Report to capture the date the care plan letter was sent to the PCP. Monitoring is ongoing.

- The plan did not conduct periodic evaluations to ensure the provision of CCM based on members' medical needs. The plan did not implement procedures for monitoring time frame standards or maintain monthly contact with members.
    - AAH developed a workflow to maintain regular contact with members, developed a Complex Criteria Checklist to ensure that the continuation of CCM is based on medical needs, trained staff, and revised the Aging Report to monitor adherence to requirements.

- The plan did not ensure that IDT assessments were included in the updating of the members' care plans.
    - AAH revised the CCM case log to monitor timely entry of IDT round note into TruCare, developed a workflow to include IDT in updated Care Plans, and monitors adherence.

The interventions include processes for ongoing monitoring and reporting to mitigate further regulatory deficiencies.

Recommended Interventions/Next Steps for 2022:

To ensure the effectiveness of the internal CM process, Alliance CM Department will conduct ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. Alliance CM Department will implement a monitoring program for the early identification of potential compliance risks.

In addition, the program includes an opportunity to provide quality oversight of the current CM processes. This is accomplished by internal monitoring of CM files on a periodic basis.

Conclusion

Overall, the 2021 CM Program continued to develop into an effective program, maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The CM program activities have met the established targets or are developing strategies to meet targets. The Alliance leadership has played an active role in the CM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements. To ensure that AAH used a comprehensive approach to the CM program structure, practicing physicians provided input through the UM Committee and subcommittees.

CM Program Recommendations for 2022

As a result of internal performance monitoring performed in 2021, opportunities for improvement were identified and will be incorporated into the 2022 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Focus on key CM activities, monitoring through the UM Committee and HCQC.
- Revise the CM staffing model to address operational needs.
- Ensure information systems are accurate reflections of reporting needs for compliance monitoring and oversight, both internal and external.
- Identify appropriate performance measures and goals for CM and develop monitoring reports of performance toward the measures. This includes developing CM related activities to address improvement with the measures.

- A key focus in 2022 is the implementation of the CalAIM Enhanced Care Management benefit, Community Supports services, and Major Organ Transplant. This will include iterative process improvements in the structure, the planning for expansion of additional ECM and CS providers, and additional providers to focus on additional populations of focus and additional Community Supports services.
    - Work with the Alliance Project Management Office and all relevant Alliance departments to:

  Launch the CalAIM ECM benefit and Community Supports services.
  Expand the ECM provider network for current needs
  Plan for the additional Populations of Focus in ECM in 2023
  Identify and plan for additional Community Supports services.
  Launch Major Organ Transplant initiative to insource from FFS Medi-Cal

- Develop educational program for PCPs and Network Provider Groups on identification of members in need of CM/CCM, referral processes and engagement with CM team on management of ICPs and IDTs.
- Enhance reporting and analysis of CM activities focused on member experience with CM.
- Develop process for implementing activities addressing improved member experience with CM, including analysis of a member survey and member complaints.
- In collaboration with the Compliance Department, develop a department program focused on monitoring internal compliance and quality review of CM department operations.
- Revise the continuity of care program to accurately reflect CM involvement and activities, including regulatory reporting and CCS program.
- Continue to enhance the Palliative Care Program in collaboration with Alameda Health Systems.
- Enhance delegation oversight activities for CM, Care Coordination, CCM, and TOC.
- Collaborate with Health Care Analytics on identifying enhancements to the predictive model algorithm to improve the identification of appropriate members for CCM.
- Continue internal auditing of cases for Care Coordination, CCM and TOC.