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

2022

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Signature Page

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- Progress on Optimization of TruCare
- Further Refinement of TOC process
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- Improvement Opportunities
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I. Background

Alameda Alliance for Health (the Alliance) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to citizens most in need in Alameda County. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for Alameda County residents and reflects the cultural and linguistic diversity of the community. In addition, Alliance providers, employees, and Board of Governors live in areas that the health plan serves.

The Alliance provides health care coverage to over 300,000 children and adults through the Medi-Cal and Group Care programs. Alliance Members choose from a network of over 1,700 doctors, 17 hospitals, 68 community health centers, and more than 200 pharmacies throughout Alameda County. Through active partnerships with healthcare providers and community partnerships, Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan Members.

The Alliance offers an array of care management services to support a collaborative patient and provider treatment process and to improve the health of the Member population.

Comprehensive case management is one such Alliance service offering that assists Members and providers in aligning effective healthcare services and appropriate community resources. The activities of the comprehensive case management program support Alliance Members and providers to attain the highest level of functioning available to the Member in relation to their overall health condition. The Alliance oversees and maintains the following case management services in the comprehensive case management program:

- Health Risk Assessments
- Basic Case Management
- Care Coordination/Service Coordination
- Complex Care Management
- Transitions of Care
- Specialty Programs
- Continuity of Care

This comprehensive case management program description includes a discussion of program scope, objectives, structure and resources, population assessment, clinical information systems, care coordination and case management services, and individual program descriptions for each of the three case management services that comprise the comprehensive case management program.

II. Purpose and Scope

The purpose of the Alliance comprehensive case management program is to provide case management processes and structures to a Member who has complex health issues. Case management is defined by the Case Management Society of America as:

"a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes."

The Alliance promotes case management services through multidisciplinary teams that address Member specific medical conditions, behavioral, functional, and psychosocial issues 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, 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 through the use of collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

III. Goals and Objectives

A. Goals

The overall goal of the comprehensive case management program is to support the mission of making high quality health care services accessible and affordable to the Alliance Membership. In doing so, more specific goals for the program include:

- To maximize the quality of life and promote a regular source of care for patients with chronic conditions
- Improve Member engagement as active participants in the care process.
- Support the foundational role of the primary care physician and care team to achieve high-quality accessible, efficient health care.
- Coordinate with community services to promote and provide Member access to available resources in the Alliance service area.
- Provide support, education, and advocacy to Members in collaborative communications and interactions.
- Engage the provider community as collaborative partners in the delivery of effective healthcare.

- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards.

B. Objectives

The comprehensive case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.
The Health Care Quality Committee (HCQC) and Utilization Management Committee (UMC) are have authority and responsibility for the review and assessment of the CM program performance against objectives during the annual program evaluation, and if appropriate, provide recommendations for improvement activities or changes to objectives. The objectives of the comprehensive case management program are stated to support concrete measurements that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to the Alliance Membership. The objectives of the program include:

- Promote appropriate utilization of services for Members enrolled in case management.
- Achieve and maintain Member's high levels of satisfaction with case management services as measured by Member satisfaction rates.
- Improve functional health status and sense of well-being of comprehensive case management Members as measured by Member self-reports of health condition.

IV. Program Oversight and Staff Responsibility

A. Health Care Quality Committee (HCQC)

The HCQC Committee provides oversight, direction and makes recommendations, and final approval of the UM Program. Committee meeting minutes are maintained summarizing committee activities and decisions and are signed and dated. A full description of the HCQC Committee responsibilities can be found in the most recent Quality Improvement Program Description.

The HCQC provides the external physician involvement to oversee The Alliance QI and UM Programs. The HCQA includes a minimum of four (4) practicing physician representatives. The UM Committee include in its Membership physicians with active unrestricted licenses to practice in the State of California. The composition includes a practicing Medical Director Behavioral Health and/or a Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed.

The HCQC functional responsibilities for the CM Program include:

- Annual review and approval of the CM Program Description.
- Oversight and monitoring of the CM Program, including:
  - Define the strategies direction for population health.
  - Define the goals and measures to the target population.
  - Assist in identifying the target population along with programs/services to be provided.
  - Recommend policy decisions.
  - Oversight of interventions to the provision of the programs and services.
  - Recommend necessary actions.

B. The Utilization Management Committee

The Utilization Management Committee (UMC) is a sub-committee of HCQC. The UMC promotes the optimum utilization of health care services, while protecting and acknowledging Member rights and responsibilities, including their right to appeal denials of service. The sub-committee is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to Members.

UM Committee Structure

The UM Committee is a sub-committee, of the HCQC which reports to the full Board of Governors. The HCQA supports the activities of the UM Committee and reviews and approves the UM activities and program annually. Reporting through the HCQC integrates CM activities into the Quality Improvement system.

Authority and Responsibility

The HCQC is responsible for the overall direction and development of strategies to manage the UM program including but not limited to reviewing all recommendations and actions taken by the UM Committee.

The Quality Oversight Committee has delegated authority to the UM Committee for certain UM functions.

This delegation of authority is pursuant to the annual review and approval of the Case/ Care Management Program, CM Policies/Procedures, CM Clinical Criteria, and other pertinent CM documents such as the CM Delegation Oversight Plan.

UM Committee Membership

The UMC is chaired by the Chief Medical Officer. Members of the UM Committee include:

- The Alliance Chief Analytics Officer
- The Alliance Medical Directors, UM

- The Alliance Medical Director, CM
- The Alliance Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement
- The Alliance Senior Director, Pharmacy & Formulary
- The Alliance Senior Director, Health Care Services
- The Alliance Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director of Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Director of Social Determinants of Health
- The Alliance Manager, Healthcare Analytics
- The Alliance Manager, Case Management
- The Alliance Manager, Enhanced Care Management
- The Alliance Managers, Utilization Management
- The Alliance Manager, Grievance & Appeals

UMC Voting Privileges

For the purposes of voting at the UM Committee, only physician and Director level Members of the UM committee may vote.

UMC Quorum

A quorum is established when fifty one percent (51%) of voting Members are present.

UMC Meetings

The UMC meets at least quarterly but as frequently as necessary. The meeting dates are established and published each year.

UMC Minutes

All meetings of the UM Committee are formally documented in transcribed minutes which include discussion of each agenda topic, follow-up requirements, and recommendations to the HCQC. All minutes are considered confidential. Draft minutes of prior meetings are reviewed and approved by the UMC with noted corrections. These minutes are then submitted to the HCQC for review and approval.

UM Committee Functions

The UM Committee is a forum for facilitating clinical oversight and direction. The UMC purpose is to:

- Improve quality of care for the Alliance Members.
- Evaluate and trend enrollment data for medical and behavioral health services provided to

Alliance Members and benchmarks for care management program utilization.

- Provide a feedback mechanism to drive quality improvement efforts.
- Increase cross functional collaboration and provide accountability across all departments in Medical Services.
- Provide mechanism for oversight of delegated CM functions, including review and trend CM reports for delegated entities to identify improvement opportunities.

UM Committee responsibilities are to:

- Maintain the annual review and approval of the CM Program & Evaluations, CM Policies/Procedures, CM Criteria, and other pertinent UM documents such as the CM Delegation Oversight Plan.
- Participate in the utilization management/ continuing care programs aligned with the Program's quality agenda.
- Review and analysis of utilization data for the identification of trends
- Assist in monitoring performance of CM activities and recommend appropriate actions when indicated.
- Review and provide input into the annual CM effectiveness reports, i.e. Experience with the CM experience, Annual Performance Evaluations.

The UMC reports to the HCQC and serves as a forum for the Alliance to evaluate current UM activities, processes, and metrics. The UM committee also evaluates the impact of CM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes.

V. Staff Resources

The Case Management and Disease Management Department in the Alliance is responsible for comprehensive case management program and activities. A department of multi-disciplinary staff administers the comprehensive case management program. (The organizational chart in Appendix A displays the reporting relationships for key staff responsible for comprehensive case management activities at the Alliance.)

The following are the primary staff with roles and responsibilities in the implementation of the comprehensive case management program:

I. **Chief Medical Officer**

The Chief Medical Officer (CMO) is the designated Board Certified in his/her specialty and California licensed physician with responsibility for development, oversight, and implementation of the comprehensive case management program. The CMO provides guidance for all clinical aspects of the program. The CMO serves as the chair of the HCQC and makes periodic reports to

the HCQC regarding comprehensive case management program activities and the annual program evaluation. The CMO works collaboratively with the Alliance network physicians to continuously improve the services that the comprehensive management program provides Members and providers.

II. **Medical Director**

The Medical Director of CM, a licensed physician, provides clinical leadership and stewardship to the Case and Disease Management programs and staff. The Medical Director provides guidance to clinical program design and clinical consultation of Members enrolled in the case and disease management programs. The Medical Director works collaboratively with the Alliance network physicians to continuously improve the services that the case and disease management programs provide Members and providers.

III. **Senior Director, Health Care Services**

The Senior Director of Health Care Services, a Licensed Clinical Social Worker, provides operational leadership to the Case and Disease Management programs and staff. The Senior Director provides additional guidance to the programs' designs with a focus on analytics, operations, and regulatory adherence. The Senior Director also ensures the collaboration of the programs with other internal and external stakeholders. The Senior Director provides leadership for case management accreditation and regulatory activities. The Senior Director works with the Director to carry out program goals.

IV. **Director of Social Determinants of Health**

The Director of Social Determinants of Health provides operational leadership to the Case and Disease Management, Community Supports and Enhanced Care Management programs and staff. The Director provides guidance to the various programs with a focus on analytics, operations, and regulatory adherence. The Director assists with collaboration of the programs with other stakeholders. The Director develops the programs' goals and operationalizes processes needed to successfully commence and complete the desired goals.

V. **Manager, Case Management and Disease Management**

The Manager of Case and Disease Management provides daily oversight over the comprehensive case management program. Under the supervision of the Director of Social Determinants of Health, the scope of responsibilities of the Manager of Case and Disease Management includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and HCQC.

VI. **Clinical Manager of Enhanced Care Management**

The Clinical Manager of Enhanced Care Management is responsible the provision of daily oversight of components of the case management program, including programs between the

Alliance and contracted Community Based Organizations (CBOs). Under the supervision of the Director of Social Determinants of Health, the scope of responsibilities of the Clinical Manager of Enhanced Care Management includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and HCQC.

VII. **Supervisor of Case Management and Disease Management**

The Supervisor of Case and Disease Management provides daily oversight over the comprehensive case management program. Under the supervision of the Manager of Case Management and Disease Management, the scope of responsibilities of the Supervisor of Case and Disease Management includes supervision of department staff; allocation and management of program resources; and accountability for the quality of care and services.

VIII. **Lead Case Manager**

The Lead Case Manager (CM) is a licensed California registered nurse, who acts as a daily resource to the case management, social work, and navigator staff. Under the supervision of the Manager of CM/DM, the scope of responsibilities of the Lead CM are to assist in identifying and resolving issues impeding the daily delivery of consistent CM services to meet regulatory and quality requirements, escalate issues unable to be resolved to upper leadership, carry a caseload of members, and assist in the coaching of staff in the standard work of the department.

IX. **Complex Case Manager**

The Alliance uses licensed California registered nurses in the role of the Complex Case Manager. The Complex Case Manager provides case management services for health plan Members with highly complex medical conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's disease conditions. Working within a multi-functional team, the Complex Case Manager coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes. The Alliance uses staffing guidelines to assign caseloads to each Complex Case Manager. Caseload assignments are made with the following considerations: current case load size; acuity level of case load; characteristics of Members, primary care provider, health plan product; and relevant case management responsibilities.

X. **Social Worker**

The Alliance employs Medical Social Workers to assist in the provision of services for Members enrolled in one of the comprehensive case management programs.

The Medical Social Worker is also responsible for coordinating medical, social and or behavioral health care needs with Alliance CM teams. Under general supervision from the Manager, Case and Disease Management, the Medical Social Worker is responsible to meet the day-to-day care coordination needs among assigned case management teams. Occasionally, the Social Worker may be required to support delegated Provider Group teams with care coordination and community resources.

XI. **Health Navigator**

Under guidance from the Case Management Manager or the Clinical Manager, Enhanced Care Management, the Health Navigator supports clinical staff through the completion of components of case management, disease management, and wellness/health maintenance programs. The Health Navigator provides the Member with individualized, patient-centered support and education to assist and guide the Member across the continuum of the healthcare delivery system. The Health Navigator works with the Complex Case Manager to perform follow up case management activities and coordinate care and services for the Member with providers and community resources. The Health Navigator also coordinates care for Members not admitted to the complex case management program.

XII. **Health Assessment Coordinator**

Under the guidance of the Manager of Case and Disease Management, Health Assessment Coordinator is responsible for the non-clinical support of the Health Risk Assessments (HRAs) for Members identified as Low Risk. The Health Assessment Coordinator is responsible for the final processing of completed HRAs and providing the preventive health and community resources identified from the Member responses. Fulfillment also includes sending the HRA letter and resources to the Members and the Care Plans to the PCPs. The Health Assessment Coordinator is also responsible for the management of mailings and data entry of hardcopy documents received (HRAs and HIFs/METs) for entry into the clinical information system.

VI. Population and Member Needs Assessment

The Alliance routinely assesses the characteristics and needs of the Member population, including relevant subpopulations. Alliance analyzes claims and pharmacy data, as well as enrollment and census data to obtain the population characteristics of its total Membership. Population characteristics for Member participation in the comprehensive case management program include:

- Product lines and eligibility categories
- Language and subpopulations
- Race and ethnicity
- Age
- Gender
- High volume diagnoses
- Results of Health Risk Assessments (HRA)

- Chronic and co-morbid medical conditions
- Laboratory Reports
- Internal department data sources
- Utilization history

To effectively address Member needs, after the collection of Member population data, the CM Medical Director, Senior Director of Health Care Services, and Manager of Case Management and Disease Management analyze and review the data to determine any necessary updates to the processes and resources of the comprehensive case management program.

The information gathered in this process is used to further define and revise the program's structure and resources, including the following types of factors:

- Department staffing – by analyzing the data the Alliance revises staffing ratios and roles, for example adding nurse Case Managers versus social workers when the level of higher risk Members increases in the program.
- Evidence-based guidelines – as the mix of condition types increases the Chief Medical Officer assists in identifying clinical guidelines to be used in creating care plans for Members.
- Member materials – Alliance uses data, Case Manager feedback and patient satisfaction information to identify new types of materials or revise materials to support language and cultural needs.

VII. Case Management Clinical Systems

A. Clinical Information Systems

Delivery and documentation of case management services directly provided by Alliance staff is accomplished through a clinical information system. Alliance uses 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; records actions or interactions with Members, care givers and providers; and 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.

B. Clinical Decision Support Tools

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. Clinical guidelines are reviewed and approved by the UMC and HCQC.

VIII. Care Coordination and Case Management Services

The Alliance oversees and maintains the following case management services in the comprehensive case management program:

- **Health Risk Assessments** clinical processes are managed by the Alliance Care Management Department including High Risk HRAs and Care Planning, as well as Low Risk care plan development, with communication to Member and Provider.
- **Basic Case Management** for Low Risk level is provided by the Primary Care Physicians and their staff with a Network Provider Group's Care Management support. In the case of Direct Network Providers, the Alliance Case Management program provides Basic Case Management services.
- **Care Coordination/Service Coordination f**or Moderate Risk level is provided at the Provider Group level or The Alliance, supporting the PCP.
- **Specialty Programs** such as Transition of Care, Continuity of Care. Transitions of Care is provided by The Alliance Care Management staff for Members with a recent hospitalization. The level of management necessary is dependent upon the degree and complexity of illness or conditions to regain optimal health or improved functionality.
- **Complex Care Management** is provided by The Alliance Care Management staff for Members with conditions where the degree and complexity of illness or conditions is typically severe, the level of management necessary is typically intensive and the amount of resources required for Member to regain optimal health or improved functionality is typically extensive**.**
- **Enhanced Care Management (ECM)** The Alliance has developed and oversees a network of ECM Provides providing in-person comprehensive multidisciplinary care coordination and care management for the ECM target populations. The same network of teams also provides care for Members identified by the Alliance as high risk/high cost and/or meeting the ECM benefit criteria as defined by DHCS.
- **Community Supports (CS)** The Alliance is providing six Community Supports services as part of the CalAIM initiative: 1) Housing Transition Navigation, 2) Housing Deposits, 3) Housing Tenancy and Sustaining Services, 4) Recuperative Care, (Medical Respite) 5) Medically Tailored/Medically Supportive Meals, and 6) Asthma Remediation. The aim of the services is to address social drivers of health and provide cost effective, appropriate alternatives in lieu of higher-level services.

A. Health Risk Assessment

To ensure that the appropriate level and quality of care is delivered to newly enrolled, non-dual Seniors and Persons with Disabilities (SPD), the Alliance makes every effort to identify each Member's individual

medical and resource needs. On July 11, 2017, Department of Health Care Services issued a new All Plan Letter for Requirements for Health Risk Assessments of MediCal Seniors and Persons with Disabilities. This revised APL supersedes the existing notification and clarifies the Plan's responsibilities for the early identification of Members who need early intervention and care planning to prevent adverse outcomes. The new guidance also requires development of a process for utilizing the standardized LTSS referral questions to identify and ensure the proper referral of Members who may qualify for and benefit from LTSS services. 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.

The Alliance utilizes a standardized HRA questionnaire to identify member care needs and provide early interventions for Members at higher risk for adverse outcomes. The questions are focused at medical care needs, community resource needs, the appropriate level of caregiver involvement, timely access to primary and specialty care needs, identification of communication of care needs across providers as well as identifying any activities or services to optimize a Member's health status including a mental health screener. In addition to the standardized HRA questions, the DHCS LTSS questionnaire is completed to identify whether a beneficiary is experiencing risk factors that make them a candidate for LTSS services that will help keep them in their home and community.

The Alliance arranges for the assessment of every new SPD Member through a process that stratifies all new Members into an assigned risk category based on self-reported or available utilization data as either High Risk or Low Risk. 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 High Risk.
- 105 days of enrollment as Low Risk.

The Alliance CM Department works in collaboration with the two vendors, KP LLC to send out the forms, and the Alliance IT Department for interactive voice calls to encourage members to return the HRAs to complete the HRA process. CM Staff are responsible for the outreach and assessment for Members who are initially stratified as high risk. Designated vendors for mailing and phone call are responsible for the initial outreach process for Members stratified as low risk.

High Risk Members are referred to Complex Case Management team for completion of the HRA, review of the HIF/MET when available, development of a care plan and completion of care coordination. For Members initially identified as Low Risk, a vendor performs the initial outreach to complete the HRA. Vendors submit the outreach report to AAH every month including those HRAs who have scored as Low Risk either by HRA scoring or are initially scored as Low Risk but are Unable to Contact (UTC) and complete the HRA. The responses from the HRA may result in the Members reclassification of Members as higher or lower risk. (For some Members, this re-classification based on the HRA may be different from their earlier classification based on the stratification tool.) Members re-classified/scored as High Risk are routed to the CCM team for review and processing. The HRA and LTSS Questionnaire can be found in Appendix F and G.

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 and the final stratification is Low Risk, a CM staff will review the HRA responses to identify Member needs, i.e. resources for transportation, IHSS, food banks. The CM staff will generate the Care Plan, attach the resources, and prepare for mailing. If the Member remains UTC, CM staff will create a standardized care plan based on the needs identified for the initial data used to stratify the Member. The Alliance has chosen to generate the standardized high-risk care plan because this care plan includes additional health education resources as well as health education materials. 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.

SPD Members are re-assessed annually in the month of their enrollment. All HRAs are reviewed for needs provided by a Social Worker, with member is identified as Low Risk or High-Risk Member.
For High Risk Members, the assigned Care Manager is responsible for ensuring the HRA is completed and the Care Plan updated accordingly. For Members identified as Low Risk Members, The Alliance uses utilization data to re-stratify Members. The Alliance follows the process outlined above for interventions based on the UTC Members. The CM team will create a standardized high-risk care plan and follow the communications activities to Member and PCP. For Members that are re-stratified from Low to High based on the annual re-assessment activities, a report will be sent to the CCM team for CM Nurse assignment, assessment, and development of a Care Plan. If the member continues to be stratified as Low Risk in the annual re-assessment, the member is provided a standardized care plan and informed of the availability of CM as needed.

B. Case Management

Case Management will be provided using a combination of staffing models:

- Care team approach comprised of a RN Complex Case Manager, Health Navigator and Social Worker working together to manage a group of Members with complex and care navigation needs.

- Extended care teams to support specific needs of the care teams. The extended team members work across teams providing additional support and interventions as needed. The extended care team includes Medical Director, pharmacy, behavioral health, nurse liaison community care and health education.

Care teams are assigned specific roles on the team to address the needs of the Members. The CM Nurse will serve as the medical lead for the team. The role of the CM Nurse is to ensure the CM assessments and follow-up is completed in a timely manner. The CM Nurse will communicate the outcomes of each assessment with the other team Members to ensure the team is knowledgeable on care needs and understands their role in the care plan. The teams are directed by defined workflows between the team Members. Communication is key to the effectiveness of the program. The team meets daily to discuss the needs and expectations for the day.

Extended Care Team Members are consultants to the core care team. As needed, the CM Nurse will coordinate care team discussions to address identified care needs. This may include medication reconciliation or adherence issues, behavioral health concerns, social determinates of health best managed using community resources, or health literacy issues.

Care teams also serve as sources to identify and refer Members to the Enhance Care Management (ECM) and Community Supports (CS) programs.

1. Basic Case Management Services

Basic Case Management services are made available to Alliance Members (including the Medi-Cal SPD and Medi-Cal Expansion population) when appropriate and medically indicated.

Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and out of plan services are considered basic case management services.

Basic Case Management services are provided by the primary care provider, in collaboration with the Alliance, and include the following elements:

- Initial Health Assessment (IHA)
- Initial Health Education Behavioral Assessment (IHEBA)
- Identification of appropriate providers and facilities (such as medical rehabilitation, and support services) to meet Member needs.
- Direct communication between the provider and Member, family and/or caregiver.
- Member, caregiver and/or family education, including healthy lifestyle changes when warranted.
- Coordination of carved out and out of plan services, and referral to appropriate community resources and other agencies.

2. Initial Health Assessment and Behavioral Risk Assessment

The PCP schedules with the Member and performs an Initial Health Assessment (IHA) and an Individual Health Education Behavioral Assessment (IHEBA). The IHA includes a history and physical evaluation sufficient to assess the acute, chronic, and preventive health needs of the Member. The IHEBA includes a series of age specific questions to evaluate risk factors for developing preventable illness, injury, disability, and major diseases. The PCP and/or the office staff are responsible for identifying and arranging for care needs. This includes referrals to the various linked and carved out County and State programs. For medical services that are needed but managed through The Alliance, providers are responsible for contacting and arranging for UM or CM servicers to meet the identified needs.

C. Care Navigation (Case Management/Care Coordination)

The Alliance oversees and maintains the following case management services in the comprehensive case management program:

1. Case Management/Care Coordination

Alliance Case Management staff maintains procedures to assist Members who are unable to secure and coordinate their own care because of functional, cognitive, or behavioral limitations, or the complexity of the community-based services. Members are assigned to a Case Manager, Social Worker or Health Navigator to assist with short-term assistance with care coordination. Members, during program enrollment, will also be assessed for long-term care needs provided through Complex Case Management and Disease Management.

The Alliance facilitates, and coordinates care for eligible Members (including the Medi-Cal SPD and MediCal Expansion population) through Case Management services. Alliance staff follows preset guidelines and collaborates with Primary Care Providers when necessary to determine eligibility.

Members eligible for care management/care coordination services have generally been identified as low or moderate risk and meet the following criteria:

- Suffer from one or more acute or chronic conditions.
- Require case management services that are less intensive than services provided in CCM.
- Have medical, functional, and/or behavioral health conditions that require extra support but generally demand fewer resources to achieve or maintain stability than do Members enrolled in more intensive case management programs.
- Care requires moderate coordination with several providers involved.
- Member and/or caregiver education is needed to support self-management skills and strategies. Once available resources are accessed, successful self-management is achievable with moderate intensity of care coordination services.
- Issues may be acutely destabilized and time-limited OR chronic, ongoing but stable.

Once a Member is identified and referred for care coordination/case management, they are assigned to an Alliance lead Case Management unit to take responsibility for screening, referrals, care planning, and all other care coordination activities. Members are matched to the Case Management staff that is specialized based on the prominence of needs. Though there is one assigned "lead," the support and expertise of other units 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.

Alliance-based Health Navigators, Social Workers or Case Managers are responsible for the following services:

- Screening and enrollment
- Comprehensive clinical assessment
- Development and implementation of a "service plan."

- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon assessment and care plan.
- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

2. Targeted Case Management Services

The Alliance facilitates, and coordinates care for eligible Members (including the Medi-Cal SPD and Medi-Cal Expansion population) through targeted case management (TCM) services. Alliance staff follows 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 and meet the following criteria:

- Suffer from one or more acute or chronic conditions.
- Require case management services that are less intensive than services provided in CCM.
- Have medical, functional, and/or behavioral health conditions that require extra support but generally demand fewer resources to achieve or maintain stability than do Members enrolled in more intensive case management programs.
- Care requires moderate coordination with several providers involved.
- Member and/or caregiver education is needed to support self-management skills and strategies. Once available resources are accessed, successful self-management is achievable with moderate intensity of care coordination services.
- Issues may be acutely destabilized and time-limited OR chronic, ongoing but stable.

Once a Member is identified and referred for TCM, they are assigned to an Alliance lead Case Management staff member to take responsibility for screening, referrals, care planning, and all other care coordination activities. Members are matched to the Case Management unit that is specialized based on the prominence of medical or behavioral health needs. Though there is one assigned "lead," the support and expertise of other units 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.

For Members who are already connected to services through a community social service, or behavioral health provider, the responsibilities of lead Case Manager will fall to that agency. Generally, TCM services are delegated to the external agency with demonstrated expertise in the referred Member's most pressing needs. For example, Members who require primary support for developmental disabilities are referred to community partners such as Regional Center of the East Bay for the provision of TCM services.

Lead Case Manager, whether Alliance-based or community-based, is responsible for the following services:

- Screening and enrollment
- Comprehensive clinical assessment
- Development and implementation of an Individualized Care Plan ("ICP") also referred to as a "service plan."
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon assessment and care plan.
- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

If a Member receives TCM services as specified in Title 22 CCR Section 51351, the Alliance is responsible for coordinating the Member's health care with the TCM provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM provider that are covered services by the Alliance.

For Members under age of twenty-one (21) not accepted for TCM services, the Alliance ensures Member access to services comparable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) TCM services as well as California Children Services (CCS) for case management for Members with a qualified CCS condition.

D. Special Programs

The Alliance maintains several programs to assist Members with specific or targeted program needs. Those programs include:

- Transitions of Care
- Care Coordination for Members receiving continuity of care (CoC) with non-contracted providers.
- CCS
- Enhanced Care Management (ECM)
- Community Supports
- Major Organ Transplants

1. Transitions of Care

Alliance Case Management staff maintains procedures to assist Members who were recently discharged from the hospital. Members are assigned to a Case Manager, Social Worker or Health Navigator to assist with short-term assistance with care coordination. Members, during program enrollment, will also

be assessed for long-term care needs provided through Complex Case Management and Disease Management.

Once a Member is identified and referred for care coordination/case management, they are assigned to an Alliance lead Case Management unit to take responsibility for screening, referrals, care planning, and all other care coordination activities. Members are matched to the Case Management staff that is specialized based on the prominence of needs. Though there is one assigned "lead," the support and expertise of other units 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.

Lead Case Manager, whether Alliance-based or community-based, is responsible for the following services:

- Enrollment
- Evaluation of post-discharge needs in association with TOC bundle.
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon evaluation.
- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

2.Continuity of Care with Out-of-Network Providers

When The Alliance's network is unable to provide necessary services covered under the Plan to a particular Member, The Alliance must adequately and timely cover these services out of network for the Member, until services are completed or the Member can be safely transitioned back into The Alliance medical home. Continuity of Care may be provided for one of the following situations:

- Newly enrolled
- SPD, Newly Enrolled
- Members with terminated providers
- Medical Exceptions Requests for Newly Enrolled Medi-Cal Enrollees

The Alliance's UM Department is responsible for the initial care determinations related to CoC situations. Once the CoC is approved, the Member is referred to Case Management for the identification of any care needs. One month prior to the termination of the CoC arrangement, CM staff contact the Member and treating Provider to ensure communication of the transition to all parties and identify any ongoing care needs. CM staff will also obtain any necessary information to share with the assigned PCP/Provider Group on the ongoing care coordination needs. Case Management staff are responsible for ensuring care is continued with out of network providers. The CM staff ensure the coordination of

services with the Primary Care Providers and Specialists. A full description of the various CoC programs in found in the relevant UM Policies.

2. California Children Services

The Alliance participates in the identification and referral of eligible children to the California Children Service Program. California Children's Services (CCS) is a statewide program that assists children and youth:

- With a chronic, disabling, or life-threatening CCS eligible medical condition
- In need of specialty medical care
- Meeting income requirements (See Eligibility, below)
- Age birth to 21

Referred children are screened for eligibility criteria and referred to a specialized contracted CCS provider. As the program is limited to providing services to children under the age of 21 years, The Alliance has developed a program to identify and provide care coordination of services for children in CCS whose needs are not covered with the CCS program, and who are nearing 21 years of age and aging out of pediatric health care services. As CCS children age out of the system, staff will assist with the transitions to appropriate adult specialists in a collaborative manner to protect the individual and ensure age appropriate care is provided.

The CCS Program is coordinated through the UM department, including the Out of Plan RN, and the Case Managers provide coordination of care in collaboration with the UM department as needed to ensure that all needs are met.

3. Enhanced Care Management (ECM)

ECM offers comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members as part of the CalAIM initiative, with the overarching goals of:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

ECM service includes:

- Outreach & Engagement
- Comprehensive Assessment & Care Plan
- Enhanced Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Member & Family Supports

- Coordination of & Referral to Community & Support Services

4. Community Supports Services

Community Supports (CS) services are provided as part of the CalAIM initiative that include a variety of services not typically covered by managed care plans. These services are intended to provide additional cost-effective support to members in lieu of higher-level services. In 2022, the Alliance is providing six CS services:

Housing Navigation

Housing Deposits

Housing Tenancy and Sustaining Services

Recuperative Care (Medical Respite)

Medically Tailored/Medically Supportive Food

Asthma Remediation

Each CS service has eligibility criteria and specific services provided per CS service, following the DHCS requirements.

5. Major Organ Transplants

In 2022, Major Organ Transplants (MOT) are being carved back into the Plan from FFS Medi-Cal. This uniquely vulnerable set of members are provided focused Case Management services throughout the care continuum, from pre-transplant to post-transplant. The CM program works closely with Centers of Excellence providing the transplants to ensure comprehensive, wrap around services throughout. The Alliance program is a collaboration between the UM and CM department as well as other Alliance departments. The full program is described in the UM policies and procedures.

E. Complex Case Management

Complex Case Management services are made available to Alliance Members (including the Medi-Cal SPD and Expansion population) with chronic and complex medical conditions. Complex case management services are offered through the Alliance Complex Case Management program and a limited number of primary care provider entities. Complex Case Management includes at a minimum the following elements:

- Case Management services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- Intense coordination of resources to ensure Member regains optimal health or improved functionality.

- With Member and PCP input, development of care plans specific to individual needs and updating at least annually.

IX. Case Management Program Description

A. Case Management

1. Identifying Members for Case Management

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

Data Sources
Aggregate data is processed or reviewed to identify Members with CCM triggers

- The predictive model, CareAnalyzer, includes claim and encounter data, pharmacy data, and health risk assessment data, as well as data supplied by the State of California (as purchaser for Medi-Cal) which may include claims data and service authorizations;
- Provider Groups provide registry data and supplemental reports (e.g., Catastrophic Medical Condition reports for Genetic Conditions, Neoplasms, organ/tissue transplants, and multiple traumas and provides data regarding Members with HIV/AIDS and ESRD)
- Inpatient census reports
- Hospital discharge reports
- Health Risk Assessments (HRA)
- Readmission Report
- Laboratory Results
- Opiate Utilization Report

Referral Sources

Individual Members may be referred by:

- Medical Management/Internal referrals, e.g. UM, Disease Management, Health Information Line, Member Services, Appeals and Grievance, Leadership
- Direct referrals from Discharge Planners
- Self-referrals, e.g. Members, Caregivers
    - Instructions for self-referral and the phone number are provided in the Member handbook and on the Alliance website. In addition, Member Services and Health Navigators explain the process for self-referral when appropriate.

- Practitioners/provider network referrals, e.g. PCPs, Specialists, Medical Group Medical Directors
    - Instructions for referral and the phone number are documented in the provider manual and notified through Provider update communications.

- Predictive modeling, e.g. Care Analyzer

The 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 CM and if determined as appropriate then a case is opened in the care management information system and assigned to a Case Manager. Members are deemed ineligible if the Member is not in the Plan, has died, is receiving duplicative services, or is in a long-term care facility.

2. Case Management Process

The Alliance maintains policies and procedures for case management services. Case management procedures and processes include:

A. Intake

When a Member is identified, or a referral is received for case management, the Alliance staff enters the referral into the care management system and coordinates case management services with the Member's PCP.

B. Identification of Care Needs

The PCP in collaboration with Alliance Utilization Management and Case Management staff identify appropriate providers and facilities to meet the specific health condition needs of the Member to ensure optimal care delivery to the Member.

C. Communication with Member

The PCP communicates directly with the Member to meet Member specific health care needs, and includes family, caregivers, and other appropriate providers in the case management process. The PCP facilitates the participation of the Member, and any family, friends, and professionals of their choosing, to participate in any discussion or decisions regarding treatments, services, support, and education. The PCP in collaboration with Alameda Utilization Management and Case Management staff ensures that the Member receives all necessary information regarding treatment and services so that the Member makes informed choices regarding case management, prioritized goals, and interventions.

D. Coordination of Services

The PCP in collaboration with Alliance Case Management staff facilitate linkages between Members and community organizations to enhance access to community resources and ensure Members can utilize these resources. Utilization Management and Case Management staff coordinates access to community services, monitor service delivery, advocate for Member needs, and evaluate service outcomes.

E. Monitoring of PCP Services

Alliance Case Management staff monitor the Member's condition, responses to case management interventions, and access to appropriate care. The Alliance ensures the PCP

performs the necessary activities of case management services such as the IHA and the IHEBA and identification of appropriate healthcare services.

F. Identification of Barriers to Care

Alliance Case Management staff monitor barriers to care such as a Member's lack of understanding of condition, motivation, financial or insurance issues and transportation problems. The Case Management staff identify interventions to reduce or resolve Member specific healthcare barriers.

G. Case Closure

The PCP in collaboration with Alliance Case Management staff terminate case management services for Members based on established case closure guidelines. The criteria for case closure include:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care
- Determination by the Case Manager that the member is unable to appropriately and actively participate in the program

B. Targeted Case Management

1. Identifying Members for Targeted Case Management

Alliance Case Management staff facilitates services to Members eligible for targeted case management services to Regional Center of the East Bay (RCEB), community partner such as Community Based Adult Day Centers (CBAS) or other local government health program. The Alliance identifies Members that may be eligible for targeted case management services through admission review, concurrent review processes, provider referral, or at the request of the Member.

2. Targeted Case Management Process

The Alliance maintains policies and procedures for targeted case management services. Targeted case management procedures and processes include:

A. Referral

When a Member is identified, or a referral is received for targeted case management, the staff enters the referral or prior authorization into the care management system and coordinates case management services with the RCEB as appropriate.

B. Documented Assessment

The TCM partner assesses the Member's health and psychosocial status to identify the specific needs of the Member.

C. Development of Comprehensive Service Plan

The TCM partner develops a comprehensive service plan to include information from the Member assessment as well as Member input regarding preferences and choices in treatments, services, and abilities. The Regional Center or local government health program in collaboration with Alliance utilization and Case Management staff assist Members with accessing services identified in the service plan. The Regional Center or a local government health program periodically reviews with the Member progress toward achieving goals identified in the service plan.

D. Coordination of Services

The TCM partner in collaboration with Alliance Case Management staff facilitate linkages between Members and community organizations to enhance access to community resources and ensure Members can utilize these resources. Utilization management and Case Management staff coordinates access to community services, monitor service delivery, advocate for Member needs, and evaluate service outcomes.

E. Crisis Assistance

The TCM partners in collaboration with Alliance Case Management staff coordinate and arrange crisis services or treatment for the Member when immediate intervention is necessary or in situations that appear emergent in nature.

F. Monitoring of Regional Center or a Local Government Health Program Services

Alliance Case Management staff monitor the Member's condition, responses to case management interventions, and access to appropriate care. The Alliance ensures the TCM partner performs the necessary activities of targeted case management services such as performing a documented assessment and developing an individual comprehensive service plan.

G. Identification of Barriers to Care

Alliance Case Management staff monitor barriers to care such as Member lack of understanding of condition, motivation, financial or insurance issues and transportation problems. The utilization management and Case Management staff identify interventions to reduce or resolve Member specific healthcare barriers.

H. Case Closure

The PCP in collaboration with Alliance Case Management staff terminate targeted case management services for Members based on established case closure guidelines. The criteria for case closure include, but not limited to:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care
- Determination by the Case Manager that the member is unable to participate in the program appropriately and actively.

IX. Complex Case Management Program Description

A. Identifying Members for Complex Case Management

1. Criteria

Criteria for identifying Members for complex case management are developed under the guidance of the Chief Medical Officer. Routinely, but no less than annually, the Alliance evaluates the criteria and its staff resources to determine if there are sufficient staff to provide complex case management to those Members who are at high-risk and are potential participants in the complex case management program.

The criteria are determined using the DST Care Analyzer data plus utilization history. The DST CareAnalyzer 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 generally 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 the previous six (6) months

- Multiple hospitalizations in the previous six (6) months
- Mental Health diagnosis
- Complex Psychosocial Needs (i.e. Homelessness)

In addition to the above medical criteria, Members must also meet the following qualifications to be eligible for complex case management:

- Member is eligible with the health plan on the date Case Management staff reviews program eligibility
- Member can be contacted
- Member expresses interest in program enrollment and provides consent.

2. Data Sources

The Alliance uses the following data sources to continuously identify appropriate Members for participation in complex case management:

- Claims and pharmacy data (CDPS and PerformRx) from the data warehouse and analyzed by the Health Care Analysts.
- Members are identified monthly from this data source Data from Admission, Transfer, Discharge (ADT) report, generated by various community hospitals
- UM data from preauthorization and concurrent review Data from purchasers (Medi-Cal and Commercial)

Information provided to Alliance from Members, caregivers and community-based programs that support the Member, Data from Member Health Risk Assessment, Data from practitioners (Referral and Medical Records)

3. Referrals to Complex Case Management

There are multiple referral avenues for Members to be considered for Complex Case Management services. Services are available to all Alliance Members who meet the general criteria for case management, regardless of specific line of business. Referral sources include:

A. Health Information Line referral

Alliance has mechanisms in place to gather information from the phone-based health information line, the AAH Nurse Advice Line, to identify Members who are eligible for complex case management. CM staff receive daily activity reports from the health information line vendor, and they assign Members to staff for CM services as appropriate.

b. DM program referral

The Disease Management staff have criteria to assist them in identifying high-risk Members for case management.

c. Hospital discharge planner referrals

The Alliance has relationships with discharge planners at hospitals in the provider network and they will refer to case management Members they believe are at high risk.

d. UM referral

The Utilization Management program identifies Members in need of case management at admission, discharge, and concurrent review.

e. Member, caregiver, and practitioner referrals

The Member Services Department receives calls from Members, caregivers and practitioners and refers them to case management based on either a request by the caller or if the nature of the call indicates that the Member would benefit from the service. At least annually, Members and Providers are informed about their ability to make referrals in the Provider and Member newsletters.
With the update to the member portal, Members and caregivers are now able to directly refer to Case Management for CM services.

f. Community-based referrals

The CM department may receive referrals for case management from community organizations/partners such as hospitals, CCS, etc.

g. Behavioral health referrals

The CM department may also receive referrals for case management services from the behavioral health delegate, Beacon.

4. Date of Eligibility for Complex Case Management

Members identified or referred for Complex Case Management are reviewed for health plan enrollment and eligibility prior to beginning a general assessment. The Alliance considers a Member eligible for case management once a Member is provided a program overview and provides verbal or written consent to program enrollment. The encounter establishing eligibility is tracked in the Clinical Information System as a CCM Consent Note.

B. Complex Case Management Process

The Alliance Complex Case Management Program uses a systematic approach to patient care delivery and management. Primary steps of the Alliance complex case management process include: Member identification and screening; Member assessment; care plan development, implementation, and management; evaluation of the Member care plan; and closure of the case.
The Alliance maintains policies and procedures for the complex case management process. Complex case management procedures and processes include:

1. Referral & Screening

When a Member is identified, as described in Section IX.A ("Identifying Members for Complex Case Management") or a referral is received for case management, the CM staff enters the referral into the care management system and verifies Member health plan enrollment and eligibility. After health plan eligibility is confirmed the staff submits the referral. The Case Manager then screens and determines program eligibility in complex case management or other appropriate programs by performing the initial screening assessment with the oversight of the Medical Director. If the Member does not meet criteria for complex case management, the Member may be referred to the other Alliance program for coordination of care, assistance in managing risk-factors, referral to community services or assistance in identifying a primary care practitioner. Appendix C & D contain the 2022 Case Management Criteria and Screening Checklist to assist clinical teams in consistency in assessment for CCM services.

2. Assessment of Health Status

The Case Manager (and with periodic collaboration with a Social Worker) conducts a Comprehensive Assessment of the Member health, behavioral, functional, and psychosocial status specific to identified health conditions and comorbidities. The assessment also includes:

- Screening for presence or absence of comorbidities and their status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the Member's identification for complex case management.
- Assessment of current medications, including schedules and dosages.

At the time of the assessment, the Case Manager obtains consent to participate in the complex case management program and information about the Member's primary care practitioner, identifies short-term and long-term needs and initiates the care plan. If the Member declines complex case management services, the Member may be referred to the community services or assistance in identifying a primary care practitioner.

3. Documentation of Clinical History Including Medications

As part of the General Assessment, the Case Manager reviews and documents Member clinical history, including disease onset; key events such as acute phases; inpatient stays; treatment history; and current and past medications including schedules and dosages. All clinical documentation is collected and stored in a secure clinical information system and is organized in structured templates to facilitate efficient access and use of information.

4. Assessment of Activities of Daily Living

The Case Manager or Social Worker evaluates Member functional status related to activities of daily living such as eating/feeding, bathing, dressing, going to the toilet, continence, transferring, and mobility. The Case Manager or Social Worker collects this information in the General Assessment and uses the information to determine barriers to care and to identify issues to include in the Member care plan.

5. Assessment of Behavioral Health Status Including Cognitive Functions

During the General Assessment and ongoing evaluations as appropriate, the Case Manager or Social Worker evaluates Member mental health status, including psychosocial factors, cognitive functions, and depression. The Case Manager or Social Worker also completes an alcohol and drug use screen as part of the General Assessment. As part of the assessment of cognitive and communication limitations, the Case Manager or Social Worker assess the member's ability to communicate, understand instructions, and their ability to process information about their illness. Referrals are made to behavioral health clinicians for case management Members that meet specified criteria.

6. Assessment of Social Determinants of Health

The Case Manager or Social Worker assesses for social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality of life outcomes and risks that may affect a Member's ability to meet case management goals. As part of the assessment the following are being assessed by Case Managers or Social Workers:

- Current living situation, such as homelessness
- Issues related to obtaining or using medications.
- Transportation issues in meeting healthcare needs
- Overall financial concerns that impacts member's well-being

7. Assessment of Life-Planning Activities

Member preferences about healthcare and treatment decisions may impact the care plan. The General Assessment and case management process includes an assessment of Member life planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life Sustaining Treatment (MOLST or POLST) forms. The Case Manager or Social Worker (SW) documents situations when life-planning activities are not appropriate, and mails appropriate information (e.g., advance directive) to Member when needed.

8. Evaluation of Cultural and Linguistic Needs, Care Preferences or Limitations

Communication issues can compromise effective healthcare for the Member. To identify communication methods best suited for the Member, cultural and linguistic needs, care preferences or limitations are assessed by the Case Manager or Social Worker during the General Assessment. The Case Manager or Social Worker assesses whether there are any personal, religious, cultural preferences or any cultural restrictions to consider in a plan of care with the member. The CM or SW also assesses the member's ability to communicate, understand instructions, and their ability to process information about their illness.

9. Evaluation of Visual and Hearing Needs, Preferences or Limitations

To ensure an appropriate care plan and healthcare needs are effectively met, Member visual and hearing needs, preferences or limitations are assessed by the Case Manager or Social Worker during the

General Assessment. In the event Case Managers or Social Workers identify impairment, details such as use of hearing aids and eyeglasses, or any future known surgery will be provided to assist in the development of care planning.

10. Evaluation of Caregiver Resources and Involvement

The Case Manager or Social Worker evaluates caregiver resources such as family involvement and decision making about the Member's individualized care plan. The Case Manager or Social Worker collects this information in the General Assessment and uses the information to determine barriers to care and to identify issues to include in the Member Care Plan.

11. Evaluation of Health Plan Benefits and Community Resources

The Intake Coordinator verifies Member health benefits, and the Case Manager or Social Worker assesses resources impacting care including caregiver, community, transportation, and financial resources. When indicated for the Member, the Case Manager or Social Worker accesses local, county, and state agencies as well as disease-specific organizations, ECM, CS, and philanthropic groups to provide services such as community mental health, transportation, wellness organizations, palliative care programs, and nutritional support. United Way, Meals on Wheels and the American Cancer Society are examples of programs with available assistance.

12. Development of Individualized Person-Centered Case Management Plan

The Care Plan includes a personalized Person-Centered planning and treatment approach that is collaborative and responsive to meet Member specific health care needs. The Person-Centered approach involves the development of the care management plan with Member input regarding preferences and choices in treatments, services, and abilities. Working with the Member, the Case Manager or Social Worker establishes and documents a set of prioritized goals.

These goals are incorporated into the care plan which also includes:

- Timeframe for re-evaluation
- Resources to be used in meeting the goals and addressing the Member's needs.
- Plans for addressing continuity of care needs, transitions, and barriers.
- Involvement of the family and/or caregiver in the plan
- Educational needs of the Member
- Plans for supporting self-management goals.

The Case Manager or Social Worker facilitates the participation of the Member, and any family, friends, and professionals of their choosing, to participate in any discussion or decisions regarding treatments, services, support, and education. The Case Manager or Social Worker ensures that the Member receives all necessary information regarding treatment and services so that the Member makes informed choices and input regarding care management, prioritized goals as high, medium or low, and interventions. The Case Manager or Social Worker includes the Member in appropriate and regular updates to the care management plan that occur at a minimum on an annual basis.

13. Identification of Barriers to Goals or Compliance with Plan of Care

The CCM procedures address barriers to care such as Member lack of understanding of condition, motivation, language, financial or insurance issues and transportation problems. The Care Plan identifies barriers to care and intervention actions to reduce or resolve Member specific healthcare barriers.

The Case Manager or Social Worker addresses the Member's beliefs and concerns about their condition and any perceived or real barriers to their treatment such as access, transportation, and financial barriers to obtaining treatment. Additionally, cultural, religious, and ethnic beliefs are assessed that may impact the condition being managed. Based on the assessment of these psychosocial issues, interventions may be modified. Examples of such issues include:

- Beliefs or concerns about the condition or treatment.
- Perceived barriers to meeting treatment requirements.
- Access, transportation, and financial barriers to obtaining treatment.

14. Facilitation of Member Referrals to Resources and Follow-up Process

The Care Plan includes follow-up to reduce or eliminate barriers for obtaining needed health care services. The case management process facilitates linkages between Members and community organizations to enhance access to community resources and ensure Members can utilize these resources. Case Management staff coordinate access to community services, monitor service delivery, advocate for Member needs, and evaluate service outcomes. A directory of community resources is available to Case Managers and Social Workers as they work with Members, caregivers, and providers. Case Management and Disease Management department staff regularly compile and document resources available in Alameda County and update the directory when necessary.

15. Development of Schedule for Follow-up and Communication

The Care Plan includes a schedule for follow-up that includes, but is not limited to, counseling, referral to disease management, education, or self-management support. Complex case management workflows and processes specify when and how the Case Manager or Social Worker follows up with a Member.

16. Development and Communication of Member Self-Management Plan

The Case Manager provides the Member or Member caregiver(s) instructions and/or materials to assist the Member with self-management of his or her complex medical condition. The development and communication of a self-management plan includes Member monitoring of key symptoms, activities, behaviors, and vital statistics as appropriate (i.e., weight, blood pressure and glucose levels). The Case Manager documents oral or written communication of self-management activities provided to the Member or caregiver(s).

17. Process to Assess Progress

The Case Manager or Social Worker continuously monitors and reassesses the Member's condition, responses to case management interventions, and access to appropriate care. The case management plan includes an assessment of the Member progress toward overcoming barriers to care and meeting treatment goals. The complex case management process includes reassessing and adjusting the care plan and its goals, as needed.

18. Case Closure

The Case Manager terminates case management services for Members based on established case closure guidelines. The criteria for case closure include:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care
- Determination by the Case Manager that the member is unable to participate in the program appropriately and actively

19 Patient Safety

The Alliance CCM process provides opportunities along the continuum of care to identify and address potential risks for medical errors and ensure patient safety. The CCM program includes the following activities to ensure and enhance Member safety:

- Completion of a comprehensive general assessment that supports proactive prevention or correction of patient safety risk factors.
- Active management of transitions of care to ensure that the Member's health condition will not be placed at risk for an unsafe situation that may result in a negative outcome.
- Care plan development that ensures individualized access to quality, safe, effective, and timely care.
- Monitoring of information exchanges across the provider continuum to ensure safety, prevent medical errors, and support effective continuity of care. Review of medication regimen to monitor drug utilization, interactions and side-effects that compromise patient health and safety
- Patient advocacy to ensure the care plan is followed by all providers. Annual evaluation of satisfaction with the complex case management program.

20. Member Engagement and Consent/Member Right to opt Out of CCM

Engagement CCM services are performed telephonically. An outbound engagement call is placed to the Member to offer CCM services and obtain Member consent. Member consent is a program requirement. Case Managers are responsible for fully explaining the program and benefits of the program to assure that the Member is making an informed decision.

If the Case Manager or Social Worker is unable to contact a newly assigned Member, the Case Manager or Social Worker sets a task in the care management system to attempt a second and third call in the next two days, at different times of day. If the Member is not reached following these three attempts, an Unable to Contact letter is sent to the Member, to explain the CCM program and to invite the Member to call the Case Manager or Social Worker to engage in services. All contact attempts and the letter are documented in the case management system.

If the Case Manager or Social Worker is able to contact the Member and obtain consent to participate, the Case Manager may begin the initial CCM assessment, or may schedule an assessment appointment based on the Member's availability and preference.

If the Member is contacted and declines to participate, the Member's wishes are respected. The CCM program is based on active participation. The Member may opt out of CCM services at any time during the process. Members who make the decision to opt out of CCM are offered the opportunity to enroll again into CCM upon request or by outreach from The Alliance upon a new triggering event.

21. Initial Assessment

The Member is sent a welcome letter that describes the services and introduces the Case Manager and describes the interdisciplinary care team management concept. Members are advised of their rights in selecting care team participants.

The Case Manager or Social Worker may begin the initial assessment in the first contact call. An initial assessment is performed as expeditiously as the Member's condition requires (and may be completed by multiple calls), but always within 30 calendar days of the Member becoming eligible (i.e. date identified by triage nurse as eligible for complex case management or date identified from a report that Member meets CCM criteria).

22. Individualized Care Plan

Following the initial assessment, the Case Manager and/or Social Worker develops an Individualized Care Plan (ICP), consisting of goals and interventions. The Case Management staff incorporate information from the initial assessment, as well as other assessments such as Health Risk Assessments, Pharmacy profile, specialized assessments, such as PHQ-9 or PHQ-2, that may be included in the Initial Assessment, HRA and Health Information Form/Member Evaluation Tool.

The ICP is crucial to the success of care management activities. The ICP is a comprehensive, individualized, interdisciplinary action plan that includes varying types of goals such as clinical milestones, pain management, addressing care gaps, and Member self-management. The development and communication of the self-management goals refer to the instruction or materials provided to Members or their caregivers to help them manage their condition. These activities are suggested by the Member or the Member's primary caregiver in consultation with the care manager to support the Member's management of their condition, when appropriate. These are components of the care plan and do not require a separate plan. Member self-management activities include, but are not limited to:

- Maintaining a prescribed diet.
- Charting daily readings (e.g., weight, blood sugar).
- Changing a wound dressing as directed.

Case Managers may also set goals for themselves, such as following up with a family Member to discuss a transportation barrier.

Case Managers must develop an ICP within 30 calendar days of completing the Initial Assessment or within 30 calendar days of HRA completion.

Case Managers establish care plan goals with the following characteristics:

- Goals are relevant to the Member's condition with identified goals driving optimally coordinated care.
- Goals take into consideration the Member's or primary caregiver's goals and preferences, and desired level of involvement. These goals must be:
    - **Specific** - usually defining a maximum of four behaviors or measurable outcomes.
    - **Measurable** - so that it is easily understood when the goal is achieved.
    - **Achievable** - it does no good for the patient or for the manager to set unrealistic or unachievable goals. This is an invitation to frustration and disappointment for all involved parties.
    - **Relevant** - are the chosen goals the ones for which the greatest value can be achieved for the time, resources, energy expended?
    - **Time-dimensioned** - Is there a realistic timeframe in which the goal can be achieved?
- Goals are prioritized. A complex case may have many goals toward regaining optimal health or improved function, therefore each goal is prioritized against other goals for dependencies. The Alliance designates goals on a scale of 1 to 10. 1 = High, 10 = Low.
- Goals have specific time frames for re-evaluation. Members with complex health concerns require ongoing assessment and management. When establishing a goal, the Case Management staff sets a specific date for follow-up on progress toward that goal. Upon re-evaluation the goal may be on track, may require revision, or may no longer be appropriate due to changes in condition or circumstance. When a goal is retained as is or revised the Case Management staff establishes a next follow-up date in the case management system.
- Goals have identified resources to be utilized, including the appropriate level of care when applicable.
- Goals include documentation of any collaborative approaches to be used, including family participation, to achieve the goal. Goals have an assessment of barriers. Barriers may be assessed at the individual goal level (such as limited transportation to physical therapist) or at the case level (such as Member is in denial about prognosis).

Care plans assess the level of care settings, i.e. home health, custodial care, adult, or child day care. Case Managers or Social Workers determine the appropriate setting, education and training required, and community network resources required to achieve a desired level of functioning/independence. The Case Manager or Social Worker approves available add-on benefits and services for vulnerable Members such as disabled or those near end-of-life.

In some cases, a specialist, or multiple specialists, in lieu of the Member's PCP, best positioned to provide the most appropriate care. In these situations, the care manager discusses this option with the Member's PCP and the specialist(s) and arranges for a standing referral to the specialist(s). The care manager notifies the Member that he/she will have direct access to the managing specialist for a specific period.

23. Ongoing Management

The Case Management staff establish a communication schedule with the Member and/or Member representative, that is appropriate for Member's condition and to which the Member will commit. The Case Management staff will establish the communication plan in the case management system which will prompt the Case Management staff to keep the communication schedule. All Member contact will be tracked in the system, and each contact and case note will include a unique identifier for the Case Management staff, along with the date and time of contact or case note entry. Interdisciplinary care team Members are noted in the case management system where care team meetings are scheduled and documented.

Case Management staff make referrals for care and services, and follow-up with Member and/or practitioners to assure the Member has acted on referrals. Some referrals are prompted by the assessment.

The Case Manager or Social Worker assesses the Member's progress toward individual goals through regular interaction with the Member and diligence in reviewing additional information that becomes available, such as a preauthorization request, ER visit, hospital admission, call to the health information line, or other information provided by a practitioner or family Member. Goals are adjusted as appropriate. When a top priority goal is achieved or eliminated, then other goals are evaluated and moved up to a higher priority.

The Case Management staff closes the case when criteria are met as defined in Section B.18 Case Closure. For Members that do not meet the closure criteria with 90 calendar days of enrollment, the Case Management staff will present the case to the Inter-Disciplinary Care Team (ICT) to identify the established goals are appropriate, and if additional goals are needed or referrals to additional services are warranted.

24. Case Management Integration

Complex Case Management staff cannot be effective working apart from the formal and informal circle of care that surrounds the Member. The Case Management staff integrates CCM program activities with all Members of the Interdisciplinary Care Team (ICT). CCM care plans are made available to the Member or Member representative and the ICT. Request for care plans from individuals other than the Member, Member representative, and ICT participants require consent of the Member or authorized representative. The Case Management staff collaborates with other licensed professionals on the care team, such as a social worker, clinical pharmacist, and health plan medical directors, and with external professionals in addition to the PCP such as specialty care practitioners. When indicated, the Case Management staff builds a co-management plan with a specially trained Behavioral Health Case Manager, Carve-Out Service CM team, a CM from a Community Based Organization, (CBO) or a CM from an Organ Transplant Center of Excellence (COE). The Case Management staff continually plans for the Member's developing and future needs, which includes ongoing interaction with other Alliance programs such as Disease Management.

25. Inter-Disciplinary Care Teams

The ICT is a team of healthcare professionals from various professional and care management disciplines who work together to manage the physical, psychological, and social needs of the Members. The ICT is always comprised of the CM Nurse, the PCP and the Member or caregiver. Internal ICTs are held to review care plans and provide guidance to the CM team caring for the Member. For CM, the core ICT is comprised of the CM Medical Director, Manager of CM and DM, the assigned CM. Ad hoc Members of the team may be invited to attend based on the needs of the Member. This includes Pharmacy, Social Worker or Behavioral Health Specialist. Formal ICTs are held with invitations to the Member/Member Caregiver and PCP/Specialist as needed.

ICTs are held bi-weekly to discuss complex care planning as well as provide assistance and direction to the dedicated care teams.

XI. Community Based Integration

As part of the CalAIM initiative, the Alliance has partnered with community-based agencies to provide both the Enhanced Care Management (ECM) benefit and Community Supports (CS). The purpose of the program is to build community infrastructure to improve integration, reduce unnecessary utilization of health services and improve health outcomes. AAH has contracted with Community Based Organizations (CBOs) to provide the ECM and the CS services. The ECM providers include both clinic-based CBOs and social agencies (see appendix I for full list.) CS Partners include the Alameda Health Care Services Agency (HCSA,) for housing services, Asthma Start, medical respite providers (Lifelong, Cardea Health, and BACS,) and Project Open Hand for Medically Tailored/Supportive Meals. HCSA infrastructure includes a community health record and AAH uses it as a tool for managing members through the continuum. The goal of the collaboration is to ensure targeted Members and providers can access intensive, community-based care management services from anywhere in the care continuum, providing the “right care-right place-right time”. The program outcomes focus of providing services that will:

- Improve physical and behavioral health outcomes.
- Improve Quality of Life
- Enhance PCP and Member experience with the Health Plan.
- Enhance the efficiency and effectiveness of service delivery.

The program activities focus on transitioning from a fragmented and siloed approach provided by various health delivery systems, county/community programs and health plans to an integrated county-wide program focused on accessible shared health information, effective linkages to county resources, standardized approach to allocation of limited housing resources and access to high quality community case management services.

The target populations of focus for the ECM benefit and CS services programs are based on the DHCS definitions of eligibility for each (a combination of complex chronic illnesses, health care utilization, and other high risk factors like homelessness, mental illness and other social determinants of health (SDOHs).)

The Alliance has dedicated clinical and non-clinical staff to participate in the planning and development of Alliance activities for ECM and CS in partnership with community providers/agencies. Staff works at developing mechanisms to identify Members and provide services to meet the overall goals. The processes are defined in CM Policies and Procedures.

XII. Disease Management

The Alliance has two dedicated disease management programs based on patient population needs and prevalence. The Pediatric Asthma and Adult Diabetes Disease Management programs aim to improve health status of its participants by fostering self-management skills and providing support and education. Programs provide education, chronic care management, patient activation and coordination of care. All programs interventions are based on data-identified patient needs and are developed using evidence-based practice guidelines and care pathways. Members are identified by claims, Pharmacy, and lab data as well as direct referrals from physicians or community partners.

- Pediatric Asthma – Serves Members who under 19 years old and identified with asthma based on clinical, pharmacy, and utilization data or direct referral.

- Adult Diabetes – A Member living with diabetes if they are > 21 years or older and identified based on clinical, pharmacy and utilization data or direct referral.

A full description of the Disease Management program activities is listed in Appendix H.

XIII. Case Management Monitoring and Oversight

The Alliance utilizes several activities to monitor and oversight CM program activities and staff performance.

Management staff and auditors monitor cases for timeliness of screening, triage, assessment, and care planning in compliance with CM/CCM policies and procedures. Triage nurses, Case Managers, and all internal ICT Members are provided with timely feedback (both positive and negative). Retraining and the disciplinary process are employed as indicated by monitoring.

Internal reports developed to monitor CM/CCM activities for case referrals by source, open active cases, cases open by number of days, timeliness of triage and assessments, timeliness of Member contacts, timeliness of care plan development, PCP contact for care planning purpose, and case closure activities.

Monitoring and oversight activities are the responsibility of CM management. Monitoring occurs monthly with reporting to the UMC and HCQC on a quarterly basis.

XIV. Program Effectiveness

The Alliance is committed to continuous program improvement. Care Management leadership seeks to improve the CCM program through several formal processes.

A. Complex Case Management Performance Measurement

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 CM leadership staff annually evaluates the measures of the effectiveness of its complex case management program based on the following performance goals and corresponding measures:

1. Achieve and maintain high levels of satisfaction with CM services.

Measure One - Member Satisfaction Rates

2. Improve Member outcomes

Measure Two - All-Cause Admission Rate

Measure Three – Emergency Room Visit Rate

3. Achieve optimal Member functioning.

Measure Four – Health Status Rate

4. Use of Appropriate Health Care Services

Measure Five – Use of Services (Primary Care)

A full description of the measures, goals, methodology and sources is available in Appendix E – 2022 Performance Measures.

For each of the performance measures, the Alliance completes the following procedures to produce annual performance measurement reports:

1. Identifies a relevant process or outcome.

2. Uses valid methods that provide quantitative results.

3. Sets a performance goal.

4. Clearly identifies measure specifications.

5. Analyzes results.

6. Identifies opportunities for improvement, if applicable

7. Develops a plan for intervention and re-measurement.

Performance measurement involves the use of quantitative information derived from a valid methodology that considers the numerator and denominator, sampling methodology, sample size calculation, and measurement period. The measure is relevant to the target population so appropriate interventions result in a significant improvement to the care or health of the population.

With data analytic support from the Healthcare Analytics, the CM Medical Director, Senior Director of Health Services, Director of Social Determinants of Health and Manager of Case and Disease Management in collaboration with the Chief Medical Officer establish a quantifiable measures and performance goal for each measure that reflects the desired level of achievement or progress. The team will identify measure specifications to ensure that reliable and valid measures can be produced with available analytic capabilities and data resources. Annually the data is compiled, and results reviewed against performance goals. The team completes the evaluation using qualitative and quantitative analysis to identify opportunities to improve performance on the measures and improve the overall effectiveness of the CM program. When opportunities to improve a measure are identified, the CM leadership team will develop an intervention action plan to improve measurement performance and subsequently re-measure performance to assess effectiveness of the intervention.

B. Experience with Case Management

An annual assessment of Member experience with the CM program is conducted. Member satisfaction is evaluated using a Member survey upon discharge from CCM. Any Member complaints received regarding CCM are also used, whether the complaint was made during the case or submitted with the post-discharge survey. Formal quantitative and qualitative analyses are conducted using trended data over time, identification of opportunities, barrier analysis, development of interventions for implementation, and plans for re-measurement. The Experience with CM Process report is presented to the UM Committee for review and approval.

XV. Annual Complex Case Management Program Evaluation

The Chief Medical Officer and the Director or Manager of Case and Disease Management collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of Member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet

the needs of the population. The results of the annual program evaluation are reported to the UMC and HCQC for review and feedback. The UMC and HCQC make recommendations for corrective action interventions to improve program performance, as appropriate. The Senior Director of Health Care Services is responsible for implementing the interventions under the oversight of the Chief Medical Officer.

XVI. Delegation of Case Management Activities

The Compliance Department is responsible for the overall performance of the internal and external audits of delegates. CM Department staff is responsible for the review and reporting of the CM components of the annual process which includes a file review to evidence compliance with the activities. The Compliance Department is responsible for finalizing the audit finding and issuing required corrective actions. All audit findings are reported into the Compliance Department and the HCQC. The CM team is responsible for ongoing monitoring activities including review of the delegated entities annual work plans/evaluations, and semi- annual reporting.

For HRAs, care management, care coordination, CCM and disease management, The Alliance may delegate these services to network providers. The Alliance delegates the following services to contracted providers:

Delegate	Provider Type	HRA	Care coordination/ CM	CCM	DM
Kaiser	HMO	X	X	X	X
CHCN	Managed Care Organization	No	X	No	No
Beacon/College Health IPA (CHIPA)	MBHO	No	X	X	No

Alliance is also responsible for ensuring the delivery of quality, cost effective services. Through all delegated arrangements, oversight and evaluation are maintained through the following activities:

1. Evaluation of the delegate's abilities to perform case management functions prior to delegation in accordance with all regulatory requirements and accreditation standards.
2. Review of required reports monthly, quarterly, semi-annually, and annually, or as defined by the delegate's contract.
3. Annual delegation review

When a Provider Group is identified as interested in performing a delegated function, the CM team performs a pre-delegation review to ensure the entities can perform the functions in compliance with the regulatory and accreditation standards. When delegation occurs, the CM team works with Provider Relations to create an appropriate delegation agreement which requires the delegated entity to comply with the regulatory and accreditation requirements to evidence. The oversight of a delegated activity includes regular reporting of CM services provided to Alliance Members. (e.g., monthly, quarterly, semi-annually, or annually).

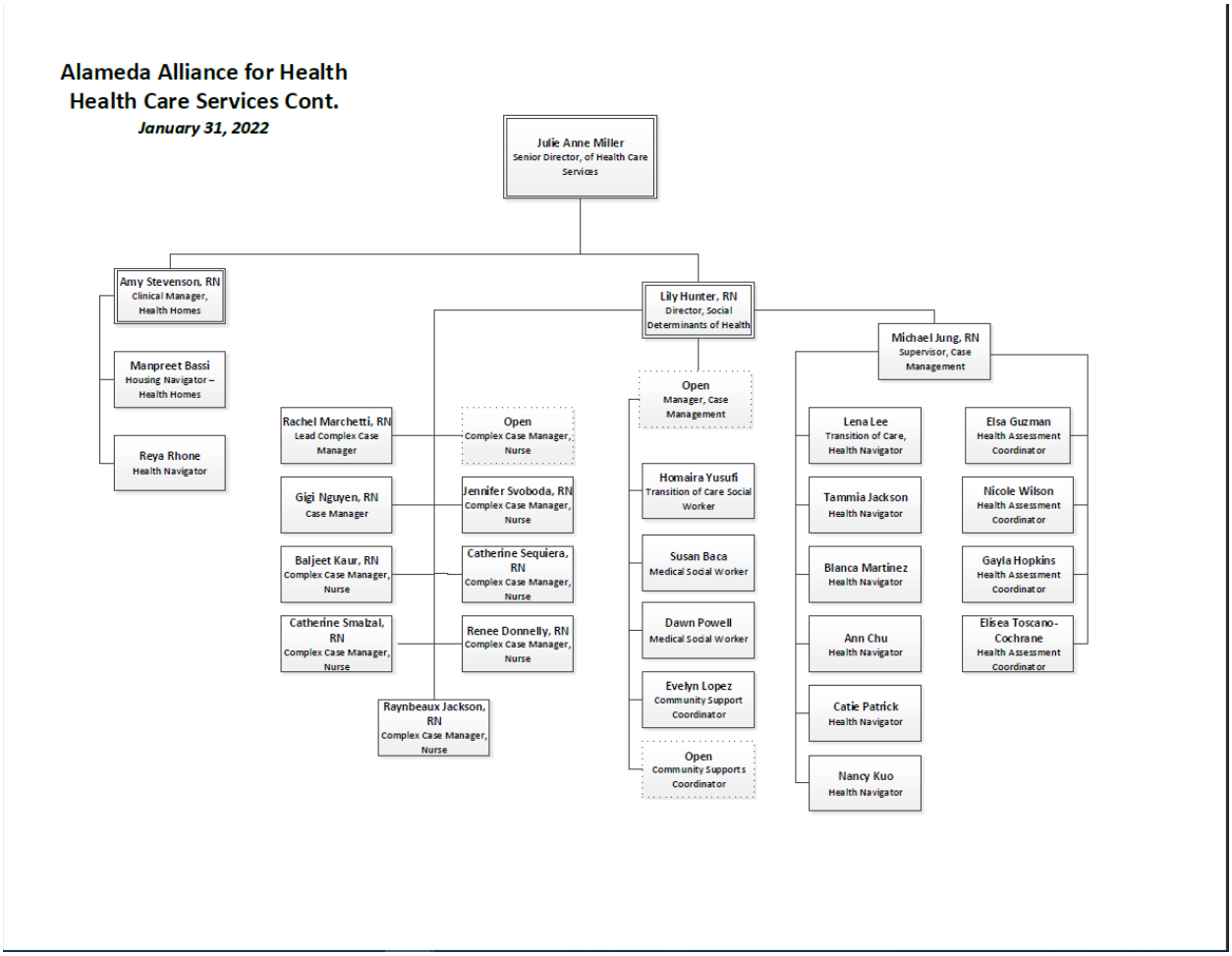
The Alliance's CM Management Team is responsible for the oversight of delegated activities and will participate in the annual performance review. Results of the annual evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee.

All delegation is conducted in accordance with Alliance's delegation policies and procedures, assuring consistent, thorough oversight and evaluation of delegated case management activities.

2022 Improvement Opportunities Summary:

- Continue to redesign the CM program to focus on key CM activities, monitoring through the UM Committee and HCQC.
- Ensure information systems reflect reporting needs for compliance monitoring and oversight, both internal and external.
- Continue to identify appropriate performance measures and goals for CM and develop monitoring reports for the measures.
- Maintain and expand the ECM program with community-based collaborations.
- Maintain and expand the Community Supports services with community-based partners.
- Complete the transition for enrolled Health Homes and Whole Person Care (AC3) members into CalAIM Enhanced Care Management (ECM) and Community Supports, launched on January 1, 2022.
- Continue the development of focused services for vulnerable populations, such as Oncology, Major Organ Transplant and ESRD/Dialysis.
- Develop educational program for PCPs and Network Provider Groups
- Enhance reporting and analysis of CM activities focused on member experience with CM.
- Continue to enhance the Palliative Care Program
- 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.

APPENDIX A: Case Management Organization Chart



APPENDIX B: Clinical Care Guidelines

TruCare 4.7 Disease Specific Content References

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Cancer

- NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) https://www.nccn.org/professionals/physician_gls/default.aspx. The NCCN Guidelines are copyrighted by the NCCN. All rights reserved. NCCN Guidelines and illustrations (including algorithms) may not be reproduced in any form for any purpose without the express written permission of the NCCN. *(AAH 2018 QI Clinical Practice Guidelines).*

Preventive Health Guidelines

The following guidelines were approved by the Health Care Quality Committee of Alameda Alliance for Health (Alliance) in August 2017. The Alliance recommends its provider network follow the most current versions of the following preventive guidelines. The Alliance recognizes that these guidelines are continually updated; therefore, providers need a reasonable amount of time for implementation of any updates:

- **Asymptomatic Healthy Adults**

For Asymptomatic Healthy Adults, the Alliance follows the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services of the U.S. Preventive Services Task Force (USPSTF), specifically USPSTF Grade "A" and "B" recommendations for providing preventive screening, testing and counseling services.

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

- **Members Under 21 Years of Age**

For members under 21 years of age, the Alliance adheres to the most recent American Academy of Pediatrics (AAP)/Bright Futures age-specific guidelines and periodicity schedule for preventive services. Search for "Periodicity Schedule" at: www.aap.org

- **Perinatal Services**

For pregnant members, the Alliance provides perinatal services according to the most current standards or guidelines of the American College of Obstetrics (ACOG). http://www.acog.org/

- **Immunizations**

For all members, the Alliance provides immunizations according to the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) Immunization Schedules.

- Child and Adolescent Immunization Schedule: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
- Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

Appendix C – 2022 Criteria for Case Management

The overall goal of complex case management is to help Members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the Member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

The Alliance offers a variety of programs to its Members and does not limit eligibility to one complex condition or to Members already enrolled in the organization's CM programs.

Referrals that are selected for CCM are based on the following general criteria:

a. The degree and complexity of the Member's illness is typically severe.
    1. Multiple specialties involved.
    2. Level of specialty management (tertiary providers)
    3. Primary diagnosis with complication(s)
    4. Higher levels of disease staging
b. The level of management necessary is typically intensive.
    1. Multiple services needing coordination.
    2. Frequency of care management contacts needed.
    3. Large number of external care coordination services
c. The amount of resources required for the Member to regain optimal health or improved functionality is typically extensive.
    1. Multiple hospitalizations in the past 6 months
    2. Multiple ED visits in the past 6 months
    3. High cost and utilization of pharmacy

The conditions and examples below are used as guidance to assist staff and potential referral sources in identifying eligible Members through the UM processes or data captured.

1. High Risk Diabetes
    a. Criteria
        i. 2 or more comorbidities
        ii. 2 Inpatient Admits within 6 months (excluding delivery admits) OR
        iii. ≥ 3 Outpatient Emergency Department visits within 6 months

2. Cancer and possible cancer indicators:
    a. Criteria
        i. Lung, brain, head, and neck, pancreatic, liver cancer

ii. Metastatic cancer
iii. Malnutrition, dehydration, nausea/vomiting
iv. Chronic pain

3. Cerebrovascular disease:
    a. Criteria
        i. Stroke requiring intensive rehabilitation or prolonged facility admission.
4. Complex Diabetes
    a. Criteria
        i. Diabetes with heart disease, peripheral vascular disease, cerebrovascular disease, kidney failure
        ii. Type 1 diabetes with ketosis or severe complications
5. Cardiovascular disease:
    a. Criteria
        i. Heart failure
        ii. Cardiomyopathy
        iii. Cor pulmonale
6. Infectious disease:
    a. Criteria
        i. Diseases possibly indicating immunosuppression, opportunistic infection, presence of other disease, or causing encephalopathies.
        ii. Histoplasmosis
        iii. Jakob-Creutzfeldt
        iv. Leukoencephalopathy
7. Respiratory diseases:
    a. Criteria
        i. Severe asthma
        ii. Chronic obstructive pulmonary disease
        iii. Respiratory failure
8. Dementia and progressive neuro muscular disease
    a. Criteria
        i. Dementia
        ii. Amyotrophic lateral sclerosis
        iii. Bulbar palsy
9. Major organ failure:
    a. Criteria
        i. heart failure
        ii. liver failure
        iii. kidney failure
10. Preterm birth:
    a. Criteria

i. babies requiring prolonged facility admission or complex home care.

11. Trauma:
    a. Criteria
        i. severe trauma with head injury and/or requiring prolonged facility care or complex home care.
        ii. spinal cord injuries
        iii. brain injury
        iv. burns
12. Readmission:
    a. Criteria
        i. readmission to facility within 30 days of discharge due to complications or multiple admissions for same condition
13. Mental health:
    a. Criteria
        i. requests for residential treatment facilities
        ii. multiple psychiatric or chemical dependency admissions within the past 12 months
        iii. history or threat of suicide
14. Other:
    a. Criteria
        i. Any recommendation from Health Services management or direct referral from referral provider

Appendix D- REFERRAL TO COMPLEX CASE MANAGEMENT CHECK LIST

Referrals that are selected for CCM are based on the following criteria:

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

Complex Case Management Criteria

(any 3 of ANY of the following)

High Utilization:

- ER visits: greater than 4 in the past 6 months
- Acute inpatient admissions: greater than 3 admissions in the past 6 months
- Readmissions: 2 or more readmissions in past 6 months

At Risk Diagnoses:

- Cancer
- CHF
- COPD
- CVA
- Diabetes
- End Stage Renal Disease (ESRD) with or without dialysis
- Hemophilia
- HIV/AIDS
- Multiple Sclerosis (MS)
- Transplant
- Neonates who are premature, have a congenital anomaly, or cancer (If selected, this will qualify member for Complex criteria alone)
- Schizophrenia
- schizoaffective
- anxiety
- depression
- bipolar
- PTSD
- Chemical dependency/substance use

Complex Medical/Psychosocial Needs:

- Three (3) or more dependencies for ADLs
- The member reports abuse, neglect, or threat of harm to self or others (Reminder, if select: file appropriate report with protective services)
- The member does not have permanent housing
- There is no caregiver present
- Per the member, the caregiver is unreliable
- Per the member, the caregiver is not enough

Appendix E - 2022 CCM Performance Measures

#	Measure	Purpose	Indicator	Measure	Methodology	Sampling
1	Member Satisfaction Rates	Achieve and maintain high levels of satisfaction with CM services.	Member Satisfaction	90% of Member responses for the overall satisfaction with the care management	All Members in CCM for > 60 days or upon discharge.	Total number of "satisfied" or "very satisfied" respondents/Total number of respondents.
2	All-Cause Readmission Rate	Improve Member outcomes	Acute hospital readmission rate for Members enrolled in CCM	10 percentage point reduction from prior to CM enrollment	Acute care readmissions, all causes, for all Members in CCM for >60 days	Aggregate utilization reports specific to Members enrolled in CCM
3	Emergency Room Visit Rate	Improve Member outcomes	ER rates for Members enrolled in CCM	10 percentage point reduction from prior to CM enrollment	ER rate for all Members in CCM for >60 days	Aggregate utilization reports specific to Members enrolled in CCM
4	Health Status Rate	Achieve optimal Member functioning	percentage of Members who received CCM services and responded that their health status improved because of CCM services	85% of Members responses will report improvement in their perceived health status	All Members in CCM for > 60 days or upon discharge	Total number of "greatly improved" or "somewhat improved" response/ Total number of responses.
5	Use of Services	Appropriate Use of Health Care Services	PCP visits for Members enrolled in CCM per Member per year	10 percentage point increase from prior to CM enrollment	All Members in CCM for > 60 days or upon discharge	Aggregate utilization reports specific to Members enrolled in CCM

Appendix F: HRA Questionnaire

ALAMEDA Alliance FOR HEALTH

Health Survey

Member Name: _____ Alliance Member ID#: _____

Member Address: _____ Member Phone Number: ☐ Cell ☐ Home _____

1. What is your preferred language:

   ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese
   ☐ Other: _____

2. Where do you live:

   ☐ Own home ☐ Temporary housing
   ☐ Rent ☐ Homeless
   ☐ Staying with friends/family ☐ Group home
   ☐ Assisted living ☐ Other: _____

Please answer the questions on this form as best you can.

3. In general, how would you describe your health?

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Decline to answer

4. Do you know the name of your Primary Care Provider (PCP)? Your PCP is the main doctor you see for check-ups and when you have a medical problem. ☐ Yes ☐ No

5. Have you had a hard time trying to see your PCP or specialist? ☐ Yes ☐ No

6. Have you seen your PCP in the last three (3) months? ☐ Yes ☐ No

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7. Do you need to see a doctor in the next 60 days? ☐ Yes ☐ No

8. Are you under the care of any specialists? ☐ Yes ☐ No

9. Are you pregnant? ☐ Yes ☐ No

   a. If you are pregnant, are you currently seeing a doctor for this pregnancy? ☐ Yes ☐ No

10. Do you have a condition that limits your activities or what you can do? ☐ Yes ☐ No

11. Do you have chronic pain? ☐ Yes ☐ No

12. Have you been to the Emergency Room (ER) two (2) or more times in the last 12 months? ☐ Yes ☐ No

13 Have you been admitted to the hospital in the past 12 months? ☐ Yes ☐ No

14 Have you been in a Skilled Nursing Facility (SNF) in the past 12 months? ☐ Yes ☐ No

15. Do you see a doctor regularly for a chronic condition? ☐ Yes ☐ No
If yes, check all that apply:

☐ Asthma	☐ Cancer	☐ Cystic Fibrosis
☐ Diabetes	☐ Heart Problems	☐ Hepatitis
☐ High Blood Pressure	☐ HIV or AIDS	☐ Kidney Disease
☐ Seizures	☐ Sickle Cell Anemia	☐ Tuberculosis

☐ Other: _____

16. Do you take three (3) or more prescription medicines each day? ☐ Yes ☐ No

17. Please tell us the medications you are taking at this time (if any):

Name of Medication	Dose (How Much)	How Often Taken

18 Do you need help picking up your medication? ☐ Yes ☐ No

19. Do you need help taking your medicines? ☐ Yes ☐ No

20. Over the past month (30 days), how many days have you felt lonely?

- ☐ None – I never feel lonely
- ☐ Less than 5 days
- ☐ More than half the days (more than 15 days)
- ☐ Most days – I always feel lonely

21. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia? ☐ Yes ☐ No

22.

	Not at all	Several Days	More than half the days	Nearly everyday
a. Over the last two (2) weeks, how often have you had little interest or pleasure in doing things?				
b. Over the last two (2) weeks, how often have you felt down, depressed or hopeless?				

23. Have you had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No

24. Do you feel you have a problem with:

a. Alcohol use ☐ Yes ☐ No
b. Drug Use ☐ Yes ☐ No
c. Tobacco use ☐ Yes ☐ No

25. If you use tobacco or smoke, are you ready to try quitting within the next month? ☐ Yes ☐ No

26. Are you using medical equipment or supplies, such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags? ☐ Yes ☐ No
Please list _____

27. Do you need assistive devices that you do not have? ☐ Yes ☐ No
Please list _____

28. Do you need help with any of these actions?

a. Taking a bath or shower	☐ Yes	☐ No
b. Going up stairs	☐ Yes	☐ No
c. Eating	☐ Yes	☐ No
d. Getting dressed	☐ Yes	☐ No
e. Brushing your teeth or hair, or shaving	☐ Yes	☐ No
f. Making meals or cooking	☐ Yes	☐ No
g. Getting out of a bed or a chair	☐ Yes	☐ No
h. Shopping and getting food	☐ Yes	☐ No
i. Using the toilet	☐ Yes	☐ No
j. Walking	☐ Yes	☐ No
k. Washing dishes or clothes	☐ Yes	☐ No
l. Writing checks or keeping track of money	☐ Yes	☐ No
m. Getting a ride to the doctor or to see your friends	☐ Yes	☐ No
n. Doing house or yard work	☐ Yes	☐ No
o. Going out to visit family or friends	☐ Yes	☐ No
p. Using the phone	☐ Yes	☐ No
q. Keeping track of your appointments	☐ Yes	☐ No

If yes, are you getting all the help you need with these actions? ☐ Yes ☐ No

If you get help with any of the tasks listed above, who is your helper? ☐ Yes ☐ No

Name of your helper: _____

What is your relationship to the helper: _____

May we contact your helper? ☐ Yes ☐ No

Phone number of helper: _____

29. Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No

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30. Is there a family member or friend who helps you make your health care decisions or who is involved in your plan of care? ☐ Yes ☐ No

    If yes, please provide the name and relationship to you.

    Name: _____

    Relationship: _____

31. As of today, do you receive any of these services from an agency?
    a. Home Health Nurse ☐ Yes ☐ No
    b. Physical, Occupational, Speech Therapy at Home ☐ Yes ☐ No
    c. Home Care Worker ☐ Yes ☐ No
    d. Social Worker ☐ Yes ☐ No
    e. Adult Day Care Center ☐ Yes ☐ No
    f. Help with Transportation ☐ Yes ☐ No

    Other (please list): _____

32. Do you have family members or others willing and able to help you when you need it? ☐ Yes ☐ No

33. Do you need help with food? ☐ Yes ☐ No

34. Do you need help with housing? ☐ Yes ☐ No

35. Do you need help with transportation? ☐ Yes ☐ No

36. Do you need help with your heating or water bill? ☐ Yes ☐ No

37. Have you completed an Advance Directive (a form that directs your health care wishes)? ☐ Yes ☐ No

38. Can you live safely and move around easily in your home? ☐ Yes ☐ No

39. If no, does the place where you live have:

a. Good lighting	☐ Yes	☐ No
b. Good heating	☐ Yes	☐ No
c. Good cooling	☐ Yes	☐ No
d. Rails for any stairs or ramps	☐ Yes	☐ No
e. Hot water	☐ Yes	☐ No
f. Indoor toilet	☐ Yes	☐ No
g. A door to the outside that locks	☐ Yes	☐ No
h. Stairs to get into your home or stairs inside your home	☐ Yes	☐ No
i. Elevator	☐ Yes	☐ No
j. Space to use a wheelchair	☐ Yes	☐ No
k. Clear ways to exit your home	☐ Yes	☐ No

40. Have you fallen in the last month?	☐ Yes	☐ No
41. Are you afraid of falling?	☐ Yes	☐ No
42. Do you need help filling out health forms?	☐ Yes	☐ No
43. Do you need help answering questions during a doctor's visit?	☐ Yes	☐ No
44. Are you afraid of anyone or is anyone hurting you?	☐ Yes	☐ No
45. Is anyone using your money without your okay?	☐ Yes	☐ No
46. Do you sometimes run out of money to pay for food, rent, bills, and medicine?	☐ Yes	☐ No

This Health Survey is complete. Thank you!

Please return to:

Alameda Alliance for Health
Case Management Department
1240 S. Loop Road
Alameda, CA 94501

If you have questions, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-free at **1.877.932.4567**
People with hearing and speaking impairments (CRS/TTY):
711/1.800.735.2929

Appendix G Long-Term Services and Supports Referral Questions

Background: In 2016, the Department of Health Care Services (DHCS) announced several strategies designed to improve referrals to Long Term Services and Supports (LTSS), including creating and releasing standardized LTSS referral questions for all Medi-Cal managed care plans (MCPs) to administer during the Health Risk Assessment (HRA) process. DHCS convened a workgroup to develop recommendations to increase the effectiveness of the questions.

The workgroup identified four different categories of risk factors: social determinants, functional capacity, medical conditions, and behavioral health conditions. These risk factors address the spectrum of challenges a beneficiary may face, reflecting a whole person approach to understanding the need for LTSS. The workgroup developed standardized LTSS referral questions to address the most directly connected risk factors. Each of the questions seeks to identify whether a beneficiary is experiencing risk factors that make them a candidate for LTSS services that will help keep them in their home and community. The questions are organized in the following two tiers and MCPs must take a holistic view of questions in both tiers to identify beneficiaries in need of follow-up assessments:

• Tier 1 contains questions directly related to LTSS eligibility criteria and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.

• Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.
The headings in italics are not part of the questions but provide the intent of the questions.
Tier 1 LTSS Questions:

Long-Term Services and Supports Referral Questions *APL 17-013 Requirements for HRA for MediCal SPD
Activities of Daily Living Functional Limitations / Instrumental Activities of Daily Living Limitations / Functional Supports (Functional Capacity Risk Factor)
Question 1: Do you need help with any of these actions? (Yes/No to each individual action) a) Taking a bath or shower b) Going up stairs c) Eating d) Getting Dressed e) Brushing teeth, brushing hair, shaving f) Making meals or cooking g) Getting out of a bed or a chair h) Shopping and getting food i) Using the toilet j) Walking k) Washing dishes or clothes l) Writing checks or keeping track of money m) Getting a ride to the doctor or to see your friends n) Doing house or yard work o) Going out to visit family or friends p) Using the phone q) Keeping track of appointments If yes, are you getting all the help you need with these actions?
Housing Environment / Functional Supports (Social Determinants Risk Factor)
Question 2: Can you live safely and move easily around in your home? (Yes/No) If no, does the place where you live have: (Yes/No to each individual item) a) Good lighting b) Good heating c) Good cooling d) Rails for any stairs or ramps e) Hot water f) Indoor toilet g) A door to the outside that locks h) Stairs to get into your home or stairs inside your home i) Elevator j) Space to use a wheelchair k) Clear ways to exit your home

Long-Term Services and Supports Referral Questions *APL 17-013 Requirements for HRA for MediCal SPD
Low Health Literacy (Social Determinants Risk Factor)
Question 3: "I would like to ask you about how you think you are managing your health conditions" a) Do you need help taking your medicines? (Yes/No) b) Do you need help filling out health forms? (Yes/No) c) Do you need help answering questions during a doctor's visit? (Yes/No)
Caregiver Stress (Social Determinants Risk Factor)
Question 4: Do you have family Members or others willing and able to help you when you need it? (Yes/No) **Question 5:** Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)
Abuse and Neglect (Social Determinants Risk Factor)
Question 6a: Are you afraid of anyone or is anyone hurting you? (Yes/No) **Question 6b:** Is anyone using your money without your ok? (Yes/No)
Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)
Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No) Tier 2 LTSS Questions:
Fall Risk (Functional Capacity Risk Factor)
Question 8a: Have you fallen in the last month? (yes/No) **Question 8b:** Are you afraid of falling? (Yes/No)
Financial Insecurity or Poverty (Social Determinants Risk Factor)
Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)
Isolation (Social Determinants Risk Factor)
Question 10: Over the past month (30 days), how many days have you felt lonely? (Check one) ☐None – I never feel lonely ☐Less than 5 days ☐More than half the days (more than 15) ☐Most days – I always feel lonely

Appendix H – Disease Management Program Activities

Disease Management (DM) services at Alameda Alliance for Health (the Alliance) are provided to all Alliance members with a diagnosis of diabetes or asthma that meet certain age criteria. The Alliance will:

- Provide disease management as an "opt-out" service meaning that all eligible members identified are enrolled unless they choose to decline participation.
- Ensure that all Alliance members are identified and stratified into appropriate levels for disease management services depending on risk.
- Provide DM services based on evidence-based guidelines and an individual assessment of gaps in care.
- Maintain documentation of program enrollment and provision of services using a Clinical Information System
- Promote DM to members and practitioners via written information about the program.

The Alliance delegates DM for a small proportion of its population. The delegates are required to follow NCQA standards.

DM Identification and Screening
Members are eligible for DM if they have a diagnosis of diabetes and are over 18 years of age or have a diagnosis of asthma and are between 5 and 12 years of age.
The Alliance informs practitioners about the DM programs through multiple methods, including but not limited to, Provider Services educational material, Alliance webpage, and Provider bulletins. The communication methods describe how to use disease management services and how the Alliance works with their patients enrolled in DM.

Training and/or targeted communications for key referral sources such as the CM department, UM department, Member Services, Hospital Discharge planners occur at least annually.
1. Members are identified for program eligibility through one of the following:
    a. Monthly report from HealthCare Analytics department utilizing claims, encounter, and pharmacy data. The report is further risk stratified into low, moderate, or high risk.
    b. Health Risk Assessment (HRA) for Medi-Cal Seniors and Persons with Disability (SPD). Members are identified as eligible with the appropriate age and diagnoses eligible for the DM program, and have a score calculated from HRA answers that may impact the member's health. The list of members meeting these criteria will be provided to the Intake Department for further processing.

Additional source or report from a source includes, but is not limited to, self-referral, caregiver, Primary Care Providers or Specialists, discharge planners at medical facilities and internal department referrals such as Utilization Management (UM), Case and Disease Management and Member Services.

Information needed for a DM referral includes:

i. Referral or data source (name, affiliation, and contact information).
ii. Date referral received by Intake. If secondary referral, document initial contact information and date.
iii. Member information
iv. Reason for referral
v. Diagnosis (asthma or diabetes)
vi. Level of urgency
vii. Additional information, as necessary.

2. Laboratory results data is used to identify diabetic members eligible for the DM program.

3. Eligible members (or parents/guardians of minors) are sent letters about the availability of diabetes DM or asthma DM program services. The letter will also inform them how to use the program, eligibility criteria and opt-in and opt out program aspects.

4. Upon receipt of the necessary information for a referral, the CM/DM designee shall document the referral into Clinical Information System. Members assigned to a delegate entity that provides Disease Management will be referred to the delegate.

5. If the member is no longer eligible for services, the case should be closed and the reason for case closure will be marked as coverage termed.

DM Risk Stratification

1. The CM/DM designee shall stratify all members directly referred to the Alliance DM services into the appropriate DM program.
2. Data reports provided to the Case & Disease Management Department monthly are already stratified into levels according to the following risk criteria:

a. High Risk Diabetes: Eligible age members with diagnosis of diabetes and other comorbidities and potentially significant risk factors, such as history of hospital or ER admission.

b. Moderate Risk Diabetes: Eligible age members with diabetes and other comorbidities and at higher risk for complications.

c. Low risk Diabetes: Eligible age members with diagnosis of diabetes and who do not fall into the high or moderate risk category

d. High Risk Asthma: Eligible pediatric age members identified with pediatric asthma, ER and hospital utilization, and asthma medications.

e. Low Risk Asthma: Eligible pediatric age members not in the high-risk category.

4. Members referred into the program: those with a diagnosis of diabetes will be initially classified as Moderate Risk and referred to the Health Navigator. Members with a diagnosis of asthma, will be classified as High Risk and will be further assigned.

5. DM referrals will be completed within the month of receipt of the request of the DM Identification and Stratification. If at any time, the CM/DM designee or the referral source believes that the case is of an urgent nature, priority will be given to the case to be completed as soon as possible.

Enrollment

1. High Risk and Moderate Risk.
    a. Referrals will be assigned to staff based on existing caseload and specialization.
    b. Case Managers (CMs) and Health Navigator staff assigned to the case will enroll the member in the specific program/level or update their existing Care Plan with the new information.
    c. Case Manager will document one of the following programs member is enrolled into:
        i. DM – Diabetes High Risk
        ii. DM – Diabetes Moderate Risk/Navigator
        iii. DM – Asthma High Risk

2. Low Risk Programs. a. Members identified for the Low Risk programs will be counted as enrolled by sending the appropriate DM Welcome Letter.

Assessment

1. After enrolling the member, staff assigned responsibility for High and Moderate programs will click on perform the assessment within the Clinical Information System using one of the pre-built assessments appropriate for the risk level.

2. Procedures for conducting assessments are addressed in *CM-001, CCM Identification, Screening, Assessment and Triage Policy*. Along with assessment questions regarding co-morbidities, cognitive deficits, psycho-social issues, depression, physical limitations and health behaviors, additional questions specific to the disease management condition have been added to the DM High Risk assessments.

3. The Asthma High Risk assessment tool has been modified to accommodate the pediatric population. As such, sections on cognitive, life planning and social use history have been omitted as not appropriate for this population.

4. The Diabetes Moderate Risk Program is designed as a short-term case management program with a focus on managing hemoglobin A1c levels.

DM Plan Development and Management

1. The steps in developing the Care Plan involve:
    a. Development of case management goals, including prioritized goals

b. Identification of barriers to meet the goals and complying with the plans

c. Development of schedules for follow-up and communication with members

d. Development and communication of member self-management plans

e. Assessment of progress against CCM plans and goals, and modifications as needed

2. Condition monitoring (self-monitoring and medical testing) and adherence to the applicable chronic disease treatment plan will be an important component of the DM Plan of Care and goals should be set accordingly.

3. The Care Plan for the Diabetes DM Program is developed from evidence-based Standards of care for Diabetes Management. Goals will be set as short-term goals defined as achievable within 30 days. Goals can be extended by another 30 days, however, at the 60 day mark the member should be reviewed at Case Rounds. At that time, the member may be referred to CCM for ongoing case management needs.

4. Referrals for additional services and resources will be made as documented in the Plan of Care. Referrals will be made as necessary and in a timely manner (within 7 business days of identifying the need) and follow up on these referrals will occur within 30 calendar days after the referral is made.

DM Case Evaluation and Closure

1. The DM program is structured where DM cases are closed either by meeting prescribed length in program criteria or by defined closure criteria.

2. High Risk Program enrollees will be evaluated for closure to DM services using *CM-003, Policy and Procedure, Complex Case Management Plan Evaluation and Closure Evaluation and Closure criteria.* CMs should aim to close the case within 6 months of enrollment allowing for 30 days of conducting the assessment.

3. Diabetes DM Program enrollees will also be evaluated for closure to DM services using CM-003 P&P criteria. However, the length of time in program should not exceed 6 months of participation in the program.

4. Low Risk Program enrollees will be considered disenrolled at the time a new DM Low Risk report is provided. If the member is no longer identified as having gaps in care, he/she will no longer be in the program.

5. All closure actions will be documented in the Care Plan as applicable and the Program Enrollment section of Clinical Information System except for Low Risk Program enrollees who will be considered automatically disenrolled as described above.

6. At the time of case closure, a satisfaction survey, and a case closure letter if appropriate will be sent.

Appendix I – Enhanced Care Management Community Based Organizations

Enhance Case Management (ECM) Sites
AHS Eastmont
AHS Highland
AHS Hayward
California Cardiovascular Consultants
CHCN Asian Health Services
CHCN Axis Community Center
CHCN La Clinica De La Raza
CHCN LifeLong Medical Care
CHCN Native America Health Center
CHCN Tiburcio Vasquez Health Center
CHCN TriCity Health Center
CHCN West Oakland Health Council
EBI
Family Bridges
Roots
Roots STOMP
Watson Wellness