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

## 2023

**Case Management/Care Coordination, Complex Case Management & Disease Management 2023 Program Evaluation**

**Signature Page**

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# 2023
# Case Management Program Evaluation

## Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors, senior management and the Quality Improvement Health Equity Committee (QIHEC), the Health Care Services 2023 Case Management Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the Case Management (CM) program activities, which include care coordination, care management, complex case management and disease management.

The processes and data reported covers activities conducted from January 1, 2023 through December 31, 2023.

## Membership and Provider Network

The Alliance products include:

- Medi-Cal Managed Care: serving beneficiaries eligible through one of several Medi-Cal programs, including Temporary Assistance for Need Families (TANF), Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

- Alliance Group Care (commercial product): an employer-sponsored plan providing low-cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Covered services are provided to beneficiaries via Alliance's direct network or one of Alliance's contracted provider networks. In 2023, The Alliance's contracted provider networks included

Alameda Health System (AHS), Children First Medical Group (CFMG), Community Health Center Network (CHCN), and Kaiser Permanente. The below figures show membership trends throughout 2023.

**Figure 1a. 2023 Membership - by Category of Aid**

| Category of Aid Trend | | | | | | | |
|---|---|---|---|---|---|---|---|
| Category of Aid | Dec 2023 | % of Medi-Cal | Independent (Direct) | AHS (Direct) | CFMG | CHCN | Kaiser |
| Adults | 52,174 | 15% | 10,629 | 9,872 | 790 | 22,025 | 8,858 |
| Child | 101,634 | 29% | 8,380 | 9,382 | 32,231 | 33,788 | 17,853 |
| SPD | 30,848 | 9% | 10,020 | 4,407 | 1,148 | 13,052 | 2,221 |
| ACA OE | 119,669 | 35% | 19,524 | 36,581 | 1,231 | 47,077 | 15,256 |
| Duals | 40,976 | 12% | 24,440 | 2,463 | 1 | 9,784 | 4,288 |
| LTC | 135 | 0% | 134 | 1 | - | - | - |
| LTC-Dual | 951 | 0% | 950 | - | - | - | 1 |
| Medi-Cal | 346,387 | | 74,077 | 62,706 | 35,401 | 125,726 | 48,477 |
| Group Care | 5,622 | | 2,164 | 842 | - | 2,616 | - |
| **Total** | **352,009** | **100%** | **76,241** | **63,548** | **35,401** | **128,342** | **48,477** |
| Medi-Cal % | 98.4% | | 97.2% | 98.7% | 100.0% | 98.0% | 100.0% |
| Group Care % | 1.6% | | 2.8% | 1.3% | 0.0% | 2.0% | 0.0% |
| | | *Network Distribution* | *21.7%* | *18.1%* | *10.1%* | *36.5%* | *13.8%* |
| | | | % Direct: | 40% | | % Delegated: | 60% |

**Figure 1b. 2023 Membership - by Age Group**

| Age Category Trend | | | |
|---|---|---|---|
| | Members | | |
| Age Category | Jan 2022 | Jan 2023 | Dec 2023 |
| Under 19 | 101,615 | 104,152 | 104,062 |
| 19 - 44 | 109,198 | 120,648 | 121,694 |
| 45 - 64 | 61,651 | 69,127 | 72,612 |
| 65+ | 30,709 | 35,887 | 53,641 |
| **Total** | **303,173** | **329,814** | **352,009** |

**Figure 1c. 2023 Membership – by Provider Network**

| Network Trend | | | | | | |
|---|---|---|---|---|---|---|
| | Members | | | % of Total (ie.Distribution) | | |
| Network | Jan 2022 | Jan 2023 | Dec 2023 | Jan 2022 | Jan 2023 | Dec 2023 |
| Independent (Direct) | 57,046 | 53,870 | 76,241 | 18.8% | 16.3% | 21.7% |
| AHS (Direct) | 58,927 | 66,052 | 63,548 | 19.4% | 20.0% | 18.1% |
| CFMG | 32,689 | 33,741 | 35,401 | 10.8% | 10.2% | 10.1% |
| CHCN | 109,878 | 126,433 | 128,342 | 36.2% | 38.3% | 36.5% |
| Kaiser | 44,633 | 49,718 | 48,477 | 14.7% | 15.1% | 13.8% |
| **Total** | **303,173** | **329,814** | **352,009** | **100.0%** | **100.0%** | **100.0%** |

**Figure 1d. 2023 Membership – by Provider Network (Delegated vs. Direct Trend)**

| Delegation vs Direct Trend | | | | | | |
|---|---|---|---|---|---|---|
| | Members | | | % of Total (ie.Distribution) | | |
| Members | Jan 2022 | Jan 2023 | Dec 2023 | Jan 2022 | Jan 2023 | Dec 2023 |
| Delegated | 187,200 | 209,892 | 212,220 | 61.7% | 63.6% | 60.3% |
| Direct | 115,973 | 119,922 | 139,789 | 38.3% | 36.4% | 39.7% |
| **Total** | **303,173** | **329,814** | **352,009** | **100.0%** | **100.0%** | **100.0%** |

In 2023, The Alliance membership increased by 22,195 members by year-end. The largest membership increase was seen in the population age 65 and older. The Alliance direct network experienced the largest membership gains, with an increase of 19,867 members by the end of 2023. This trend aligns with increases in Medi-Cal Enrollment overall, including dual-eligible members and Long-Term Care members receiving custodial level of care in Skilled Nursing Facilities in January 2023.

## Case Management Program Scope and Structure

### *CM Program Scope*

The Alliance provides person-centered case management services through multidisciplinary teams that address medical conditions, behavioral, functional, and psychosocial issues occurring throughout the continuum of care, including in between medical office visits. 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, and the overall health care delivery systems (including physicians, hospitals, and the various payer sources).

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

### *CM Program Structure*

The structure of the CM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of The Alliance health care delivery network and community resources. Additionally, the structure is designed to enhance communication and collaboration on CM issues that affect all departments and disciplines within

the organization. The CM Program is evaluated on an on-going basis for efficacy and appropriateness of content by The Alliance staff and oversight committees.

***Responsibility, Authority and Accountability / Governing Committee***

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 19-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of The Alliance programs and is responsible for approving the Quality Improvement, Utilization Management and Case Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to The Alliance Chief Medical Officer (CMO) and the Quality Improvement Health Equity Committee (QIHEC) and provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management and Case Management Programs. Utilization Management oversight is the responsibility of the QIHEC. Utilization Management and Case Management activities are the responsibility of The Alliance Health Care Services staff under the guidance of the Medical Director for Care Management, the Medical Director for Utilization Management, and the Senior Director, Health Care Services, in collaboration with The Alliance CMO.

***Committee Structure***

The Board of Governors appoints and oversees the QIHEC, the Peer Review and Credentialing Committees, and the Pharmacy and Therapeutics Committee (P&TC) which, in turn, provide the authority, direction, guidance, and resources to enable The Alliance staff to carry out the Quality Improvement, Utilization Management and Case Management Programs. Committee membership consists of provider representatives from The Alliance contracted networks and the community, including those who provide health care services to populations served by The Alliance (for example: Seniors and Persons with Disabilities, Dual-eligible members, and members with Chronic conditions).

The QIHEC provides oversight, direction, makes recommendations, and has final approval of the UM and CM Programs. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates.

QIHEC charters a sub-committee called the Utilization Management Committee (UMC), which meets at least once every 2 months. UMC serves as a forum for The Alliance to evaluate current CM activities, processes, and metrics, including case management/care coordination, complex case management, transitional care services, population health, integration of medical and behavioral health, regulatory compliance, and oversight for delegated CM activities. The UMC also evaluates the impact of CM programs on key stakeholders in other departments, including Compliance, Member Services, and Grievance and Appeals. Input from UMC members is included in continuous CM program monitoring, evaluation, and design of interventions.

In 2023, the UMC had 10 meetings. The 2022 CM Program Evaluation and 2023 CM

Program Description and Workplan were presented for review and approval at the March 31, 2023 QIHEC meeting, and documented in the minutes for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Senior Director of Quality Management, external physicians, and key organizational staff.

***Integration of Medical and Behavioral Health***

Effective April 1, 2023, Behavioral health was insourced by the Alliance. CM participated in the planning for the insourcing with the Director of BH services, and in the training of new BH staff in CM processes and practices. This has allowed for further integration of behavioral and medical health within the Alliance. The Alliance provides access to mental health services for the Medi-Cal and Commercial membership in several ways:

- Basic mental health care needs are provided by Primary Care Providers
- Medi-Cal members with "mild to moderate" impairments in mental, emotional, or behavioral functioning were referred to the contracted behavioral health delegate, Beacon Health Options (Beacon) through 3/31/23. Effective 4/1/23, the Medi-Cal members were referred to the Alliance's network for behavioral health care.
- Medi-Cal members diagnosed with a severe persistent mental health disorders and Substance Use Disorders are carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- Commercial members accessed mental health/SUD benefits through the contracted BH delegate, Beacon Health Options (Beacon) through March 31, 2023. Effective April 1, 2023, commercial members were referred to the Alliance's network for behavioral health care.

Increasing access to care and increasing utilization was a primary driver of the Alliance's decision to insource the management of behavioral health services. The Behavioral Health Program includes a care coordination program staffed by licensed clinicians and behavioral health navigators.

- The mental health team consists of 4 licensed clinicians and the ABA team consists of 3 licensed clinicians.
- The clinical teams are supported by 5 behavioral health navigators.
- A behavioral health manager was hired in Q4 2023 to further support the growth and visibility of the behavioral health program at the Alliance.
- The Alliance behavioral health program operates under the leadership of a Senior Director of Behavioral Health and Medical Director.

***Involvement of senior-level physician and behavioral healthcare practitioners***

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

Currie, Ph.D., Senior Director, Behavioral Health Services, provides leadership to behavioral health care at the Alliance, further supporting the integration of behavioral health care with medical care. Together, the senior-level physician and behavioral health practitioners are involved in the CM program by:

- Establishing CM policies (for medical and behavioral healthcare services)
- Reviewing and consulting on complex CM cases (for medical and behavioral healthcare services)
- Participating in various clinical and stakeholder committees (including UMC and QIHEC)
- Evaluating the overall effectiveness of the CM Program (for medical and behavioral healthcare services)

***Case Management Resources***

The Alliance CM Department is staffed with physicians, nurses, social workers, and non-clinical support staff, including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2023 CM Program Description.

In 2023, the CM leadership structure was designed to meet the needs of the program and the staff, including Enhanced Care Management and Community Supports:

- 1.0 FTE Medical Director of Case Management
- 1.0 FTE Senior Director, Health Care Services
- 1.0 FTE Director, Social Determinants of Health
- 1.0 FTE Manager, CM
- 1.0 FTE Supervisor of CM
- 1.0 FTE Non-Clinical Supervisor of CM
- 1.0 FTE Lead CM
- 1.0 FTE Clinical Manager, Enhanced Care Management (ECM)
- 1.0 FTE Supervisor of Community Supports (CS)

With insourcing Behavioral Health in April 2023, additional leadership was added to support Behavioral Health case management:

- 1.0 FTE Senior Director, Behavioral Health Services
- 1.0 FTE Manager, Behavioral Health

The adequacy of case management resources is continuously evaluated to ensure appropriate staffing levels to manage programmatic changes and workload volumes, accounting for variations in members' health status and complexities of coordination of care needs. For example, in 2024, the Community Supports team will transition to the Long-Term Services and Supports Director, allowing for continued expansion and optimization of Community Supports services.

***Delegated Case Management***

The Alliance delegates case management (CM) activities to contracted health plan, provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between The Alliance and delegated groups specify the responsibilities of both parties, including:

- the functions or activities that are delegated;
- the frequency of reporting on those functions and responsibilities;
- how performance is evaluated; and
- corrective action plan expectations, if applicable.

The Alliance conducts pre-contractual evaluations of delegated functions to ensure a delegates' abilities to meet standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with CM department, and other departments, to conduct the annual delegation oversight audits. When delegation occurs, The Alliance requires the delegated entity to comply with the NCQA standards and present quarterly reports of services provided to Alliance members. The Alliance's Compliance Department completes an annual performance evaluation of delegated CM operations. Results of the annual evaluation, and any audit results, are reviewed by the Compliance and Delegation Oversight Committee, and shared with the delegates.

In 2023, Alliance delegated CM activities to the following entities:

**Figure 2. Delegated Entities (CM activities only)**

| **Delegate Name** | **Provider Type** | **Delegated Activity-** Care Coordination/Case Management | **Delegated Activity-** Complex Case Management |
|---|---|---|---|
| Kaiser | Health Maintenance Organization (HMO) | Yes | Yes |
| CHCN | Managed Care Organization (MCO) | Yes | No |
| Beacon / College Health IPA* (through 3/31/23) | Managed Behavioral Healthcare Organization (MBHO) | Yes | Yes |

*In April 2023, Mental Health/Behavioral Health services were insourced into The Alliance and Beacon/College Health IPA was a delegate only through March 31, 2023. Efforts in Q1 2023 were focused on transitioning the impacted members from Beacon to The Alliance.

## Case Management Information Systems

The CM Department uses a clinical information system, TruCare®, as the case management platform. TruCare® is a member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with algorithmic clinical intelligence and best practices to guide case managers through assessments, development of care plans, and ongoing management of members. The system includes assessment templates to drive consistency in the program. Care plans are generated within the system and are individualized for each member and include short and long-term goals, interventions, and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; record actions or interactions with members, caregivers, and providers; and create automatic date, time, and user stamps. To facilitate care planning and management, the clinical information system includes features to set prompts and reminders for next steps or follow-up contact. Optimization of TruCare® continued into 2023, including improving assessments to automatically trigger care plan elements (including problems, goals, interventions, and barriers). Thorough vetting processes are established between clinical and IT teams to ensure any enhancements and upgrades to the platform are amenable to all system users. System optimization and upgrades are ongoing as standard practices, including staff training to ensure competence in using the platform and alignment on best practice workflows.

## 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, as well as medical and behavioral healthcare specialty societies and/or Alliance Clinical Practice Guidelines.

## Case Management Process

***Case Management Referral and Identification***

The Alliance's Care Management program adopts a person-centered design, ensuring all care management activities align with members' needs, preferences, and goals. Members are identified as candidates for care management services through a variety of data sources and referrals. This includes, but is not limited to:

- Health Risk Assessment (HRA)
- Health Information Forms/Member Evaluation Tool (HIF/MET)
- Data sources such as Utilization reports and Admission, Transfer and Discharge (ADT) Feeds

- Population Health Reports - *In 2023, the Population Health initiatives at the Alliance were strengthened and further integrated into ongoing Alliance care management identification activities. A stratification of member acuity was developed, ranging from low-risk members who may need health promotion/education, to the highest risk, most vulnerable members needing full wraparound Enhanced Care Management services.*
- Self-referrals from members/authorized representatives
- Direct referrals from provider networks
- Internal referrals (including Utilization Management, Member Services, Appeals and Grievance, Leadership)
- Predictive modeling

The HRA and HIF/MET processes are essential components of the care management process, allowing members to self-report their health care needs and goals.

***Health Risk Assessments (HRA)***

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

- 45 days of enrollment for members identified as high-risk.
- 105 days of enrollment for members identified as lower-risk.

The Alliance outreaches to SPD members to administer the HRA and to develop a Care Plan. SPD members are re-assessed annually on the anniversary month of their enrollment. The responses from the HRA may result in the members being re-stratified as high risk or low risk (for some members, risk-level based on their HRA responses may be different from their earlier stratification based on the stratification tool/data). In addition, the HRA includes specific Long-Term Services and Supports (LTSS) referral questions. These questions are intended to assist in identifying members who may qualify for and benefit from LTSS services. These questions are for referral purposes only and are not meant to be used in stratifying members as high risk or low risk. After completion of the HRA, the Alliance develops Individualized Care Plans (ICPs) for members found to be high risk and coordinates referrals for identified LTSS, as needed.

CM staff is responsible for ensuring the Individualized Care Plan is completed, shared with the Member and PCP, and is accompanied by relevant community and health resources. For Members whose completed HRA results in a final stratification of Low Risk, CM staff review Member HRA responses to identify Member needs (i.e., resources for transportation, in home support services (IHSS), durable medical equipment (DME), food resources). The CM staff generates the standardized low risk care plan, attaches the relevant resources, and prepares it for mailing. For Members whose completed HRA results in a final stratification of High Risk, clinical CM staff outreach to the Member and

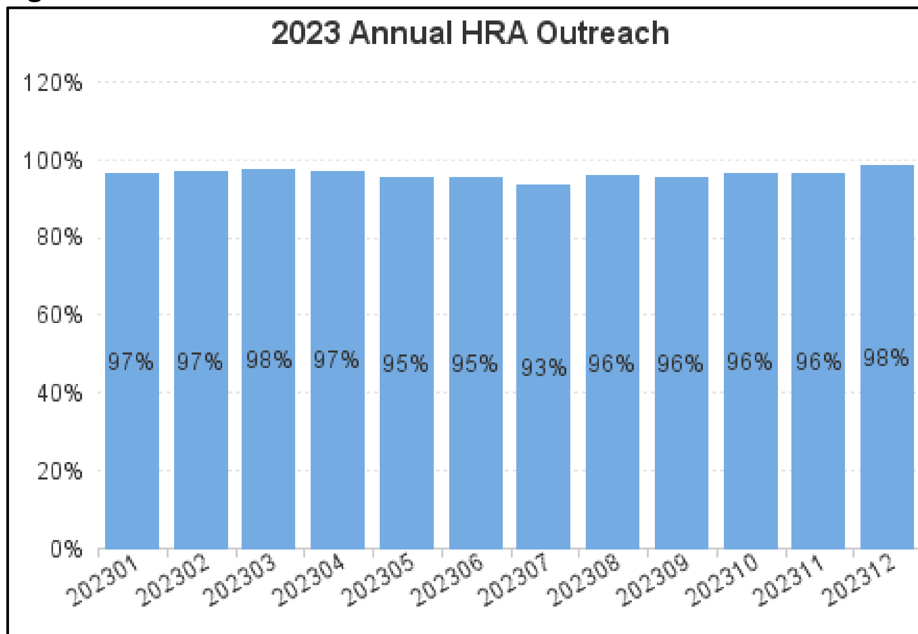
reviews Member HRA responses with the member to identify Member needs. The CM staff generate the standardized high-risk care plan and include additional health education resources and materials based on the conversation with the Member. If the member remains Unable to Contact (UTC), a standardized care plan is sent to the member. This is sent to members, even if they do not complete the HRA and return it to the plan.

Copies of the care plans, for both High Risk and Low Risk members, are mailed to the Member, the Primary Care Provider, and the Delegate Group if applicable.

The Alliance uses Interactive Voice Response (IVR) calls to remind and encourage Low Risk Members to complete an HRA. The Alliance's internal IT team makes Interactive Voice Response (IVR) calls to members. These IVR calls are made to members so that the Alliance can give members every opportunity to complete the HRA and have the results acted upon by the CM department. High Risk Member receive calls from CM staff to remind and encourage completion of the HRA.

Below figures show 2023 HRA outreach and completion rates for the SPD population.

**Figure 3. HRA Outreach for SPD Members**




The average outreach rate for 2023 was 96%, reflecting the engagement of the Alliance IT team's IVR to assist with the HRA process by reminding members to return HRAs in a timely manner.

**Figure 4a. New HRA completion for SPD Members**

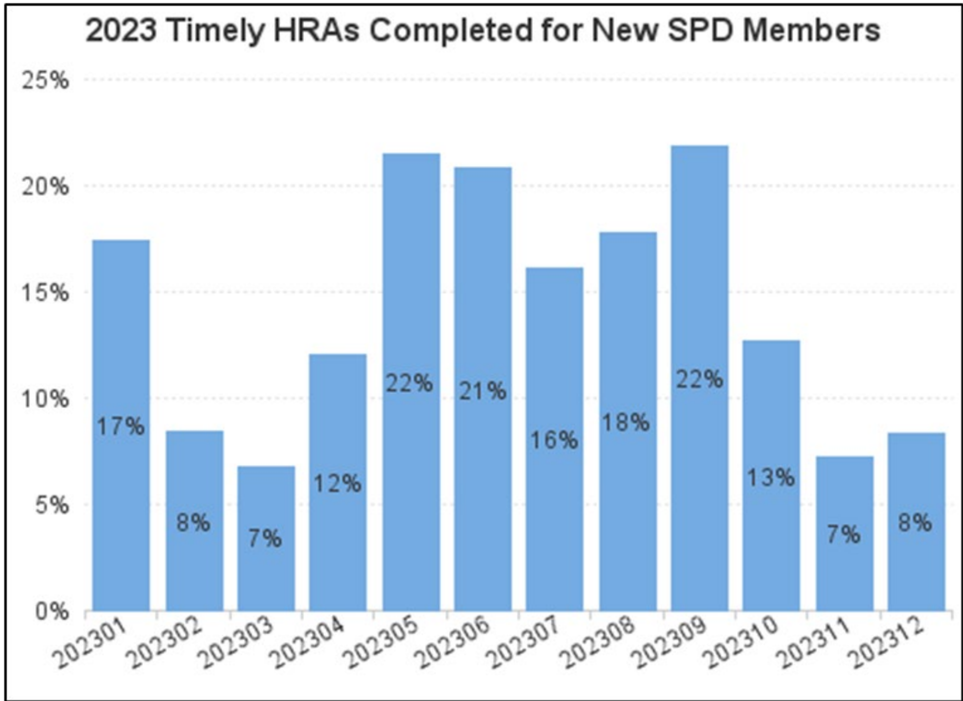
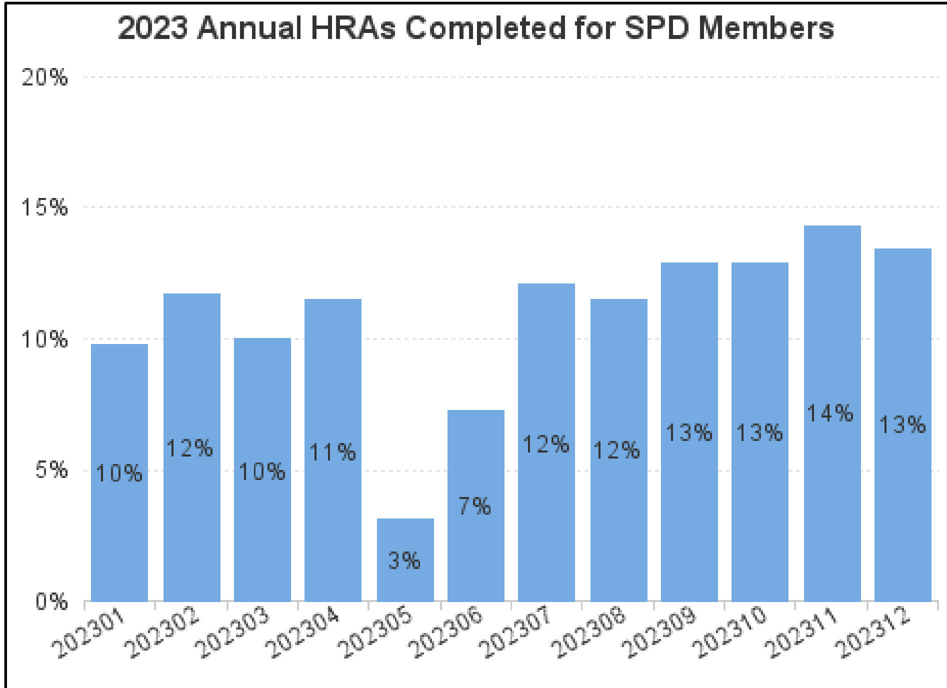



**Figure 4b. Annual HRA completion for SPD Members**




In 2023, the average combined completion rate for new and annual HRAs was 12%, representing a 2% decrease compared to the 14% completion rate in 2022. In 2023, the highest monthly completion rate was 22%.

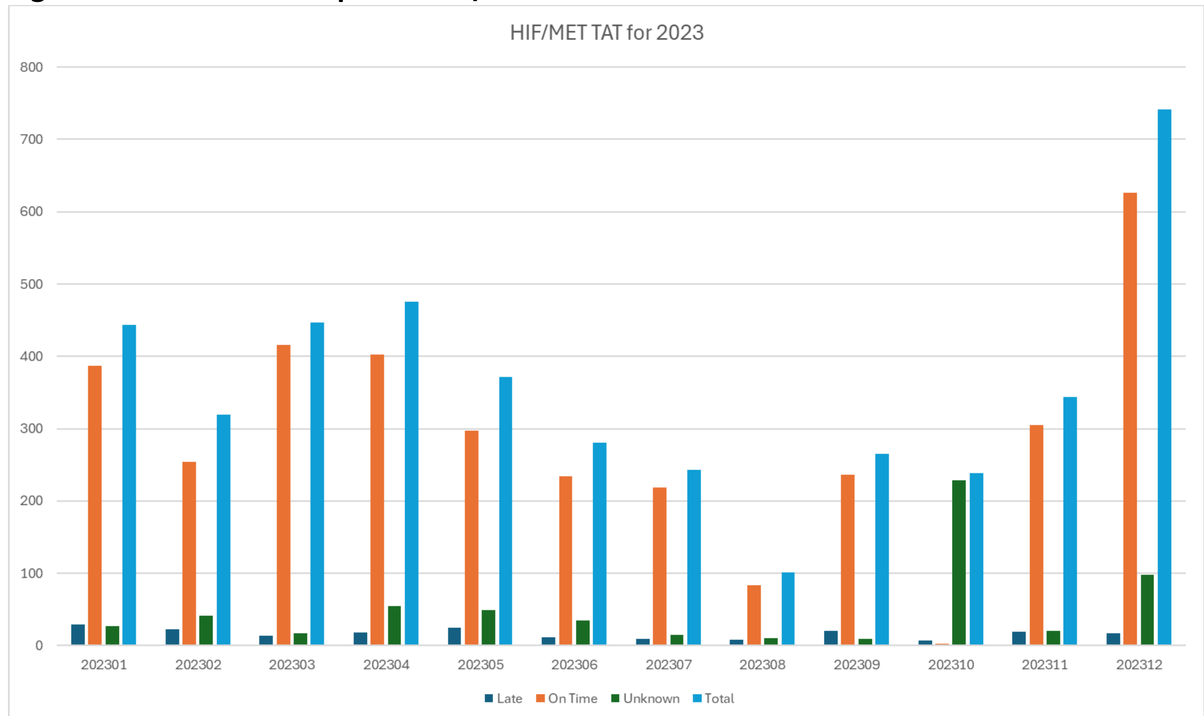
***Health Information Forms/Member Evaluation Tools (HIF/MET)***

The Alliance arranges for the assessment of every new member to the Alliance, and for members returning to the Alliance after a gap in coverage (with the Alliance) of 6 months or more. The HIF/MET is a brief federal initial screening requirement that is used to identify general member needs and to determine if a new member requires expedited care upon joining or returning to the Alliance.

HIFMETs are mailed in the new member packet for any member not stratified as a Senior and Persons with Disability (SPD). The responses from the HIF/METs are entered into the Case Management system of record (TruCare). Monthly reports are run to identify any positive responses to inform members' assigned PCPs of the results. PCPs provide follow up, as necessary.

The Alliance uses Interactive Voice Response (IVR) calls to encourage members to complete the HIF/METs. The Alliance's internal IT team makes the IVR calls to members so that the Alliance can give every opportunity to complete the HIF/MET and have the results acted upon by the members' assigned PCP.

**Figure 5. 2023 Total Completed HIF/METs**




In 2023, we saw an increase in HIF/METs through the end of Q1. Q4 showed a sharp increase in HIF/METs as members were no longer assigned to Anthem past October 1, 2023. The Q4 spike is likely related to members preparing for the Anthem Transition on January 1, 2024.

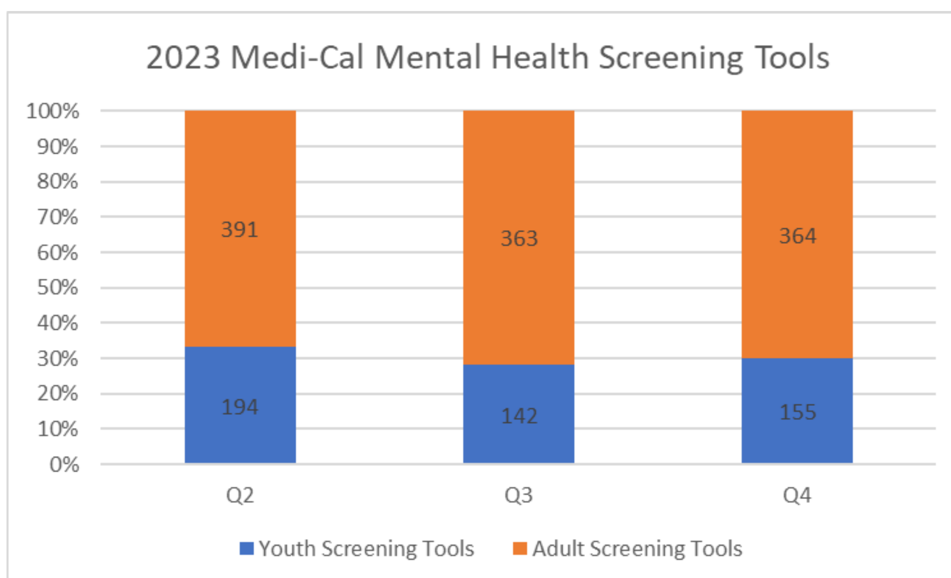
***Referral Assignment***
All CM referrals are reviewed by the CM Lead who makes daily assignments, considering referral data, pre-existing or historical CM cases, type of request, and acuity of request. The CM Lead verifies the appropriate CM staff to support the member (including Health Navigators, Social Workers, or Nurses) and assigns to corresponding CM staff. Members are deemed ineligible if the member's Alliance eligibility is inactive, the member has expired, or is receiving duplicative services.

***Behavioral Health CM Referrals***
Also in 2023, as part of increased efforts to integrate BH and medical services, the Alliance worked closely with ACBHCS to identify members who may benefit from co-management of medical and behavioral health services and/or specialty and non-specialty mental health services. The Behavioral Health (BH) Department maintained the relationship with ACBHCS to ensure eligible Medi-Cal members receive services through the ACBHCS linked mental health programs. The focus of the activities is to ensure contracted providers continue to identify and refer members with serious persistent mental health/SUD conditions to the appropriate ACBHCS programs, as well as to facilitate coordination activities for co-existing medical and behavioral health disorders to assist with their treatment access and follow-up care.

DHCS issued a No Wrong Door policy in December 2022, which required AAH and ACBHS to utilize a standardized screening tool between both entities to determine which system of care Medi-Cal members are referred into. The Alliance and ACBHCS worked to implement the DHCS required age-appropriate screening and care transitions tools that went into effect on January 1, 2023. AAH and Beacon participated in joint meetings with ACBHCS through March 31, 2023. After insourcing, The Alliance continued regular meetings with ACBHCS to facilitate coordination of care and identify potential duplication of services.

The graph below represents the number of adult and child DHCS MH screening tools that were completed by the Alliance Q2-Q4 2023 for Medi-Cal.

**Figure 6. 2023 Medi-Cal Mental Health Screening Tools**




***Care Coordination/Care Management Services and Supports***
Upon identification and receipt of appropriate care management referrals, the Alliance provided the following Care Coordination and Care Management services and supports in 2023. Service categories are aligned with the DHCS Population Health Management (PHM) Policy Guide that governs the Alliance's PHM Strategy.

- **Basic Population Health Management** (replaces DHCS' "Basic Case Management" requirements, includes Care Coordination and Disease Management, also includes Basic Case Management delegated to CHCN)
- **Care Management Programs:**
  - Complex Care Management (CCM)
  - Enhanced Care Management (ECM)
  - Targeted Case Management (TCM)
- **Transitional Care Services**
- **Specialized Services:**
  - Continuity of Care
  - Community Supports
  - Transportation

Also in 2023, after the insourcing of BH services, the care management teams worked on integration efforts between medical and behavioral health services, including:

- Enhancing CCM outreach to the chronically ill.
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams.
- Continued efforts toward improving communication between the primary care physician and behavioral health providers.

- Attendance by the Alliance's behavioral health team at the Interdisciplinary Care (IDT) Team meetings to collaborate, advise, refer, and provide additional insight into medical CCM cases.

Below is a summary of care management cases managed in 2023, categorized by target diagnoses identified as part of the population health management strategy.

**Figure 7. Volume of CM cases in Population Health Target Diagnoses in 2023**

| Diagnoses | Numbers with Disease State in the last 12 months | Care Coordination (Currently Enrolled) | Transitional Care Services (Currently Enrolled) | Complex Case Management (Currently Enrolled) | Enhanced Care Management (Currently Enrolled) |
|---|---|---|---|---|---|
| **CAD** | 7900 | 65 | 58 | 12 | 209 |
| **CHF** | 5202 | 56 | 71 | 9 | 246 |
| **Cervical CA** | 444 | 3 | 1 | 0 | 8 |
| **Lung CA** | 407 | 5 | 3 | 1 | 8 |
| **Emphysema** | 4683 | 41 | 43 | 9 | 183 |
| **ESRD** | 1232 | 28 | 15 | 4 | 62 |
| **Schizophrenia** | 3867 | 24 | 40 | 2 | 118 |
| **Sickle Cell Disease** | 118 | 0 | 0 | 0 | 2 |
| **Hepatitis C** | 879 | 3 | 11 | 0 | 21 |
| **Tuberculosis** | 217 | 0 | 0 | 0 | 5 |
| **SUD** | 9607 | 75 | 102 | 9 | 386 |
| **Asthma** | 16180 | 66 | 50 | 8 | 347 |
| **Breast CA** | 1312 | 11 | 7 | | 15 |
| **Hyperlipidemia** | 47672 | 184 | 108 | 17 | 462 |
| **Hypertension** | 49637 | 239 | 173 | 27 | 749 |
| **Diabetes** | 26211 | 138 | 97 | 16 | 404 |
| **Obesity** | 30275 | 128 | 74 | 11 | 406 |
| **Pregnancy** | 6129 | 19 | 48 | 2 | 43 |
| **Gingivitis** | 7285 | 17 | 6 | 2 | 51 |
| **Burns-1st degree** | 422 | 3 | 4 | | 7 |
| **Tobacco** | 9607 | 75 | 102 | 9 | 386 |

| Total Unique Members any DX | 500199 | 2196 | 1693 | 246 | 7593 |
|---|---|---|---|---|---|

The highest volume of members with a Population Health target diagnoses are served by Enhanced Care Management (ECM), representing the most vulnerable members with complex physical, social, and emotional risk factors. The next highest volume are those members receiving Care Coordination, representing the volume of work assisting members to navigate the health care system. Transitional Care Services are provided to members transitioning between settings of care, including those discharging from a hospital to a skilled nursing facility or to a home. Complex CM (CCM), the lowest volume of enrolled members, is an opt-in program for members with multiple and/or complex health conditions, requiring member consent and participation in care planning and goal setting to appropriately self-manage their conditions. If a member declines Complex CM, the member is offered care coordination services.

Each CM service category, and its impacts, are further evaluated below.

**Basic Population Health Management**

Basic Population Health Management (BPHM) is available to all The Alliance members, regardless of risk tier, and includes ensuring access to primary care, care coordination, navigation and referrals across health and social services (including Community Supports), information sharing and referral support infrastructure, services provided by Community Health Workers (CHWs) under the new CHW benefit, wellness and preventions programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children.

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

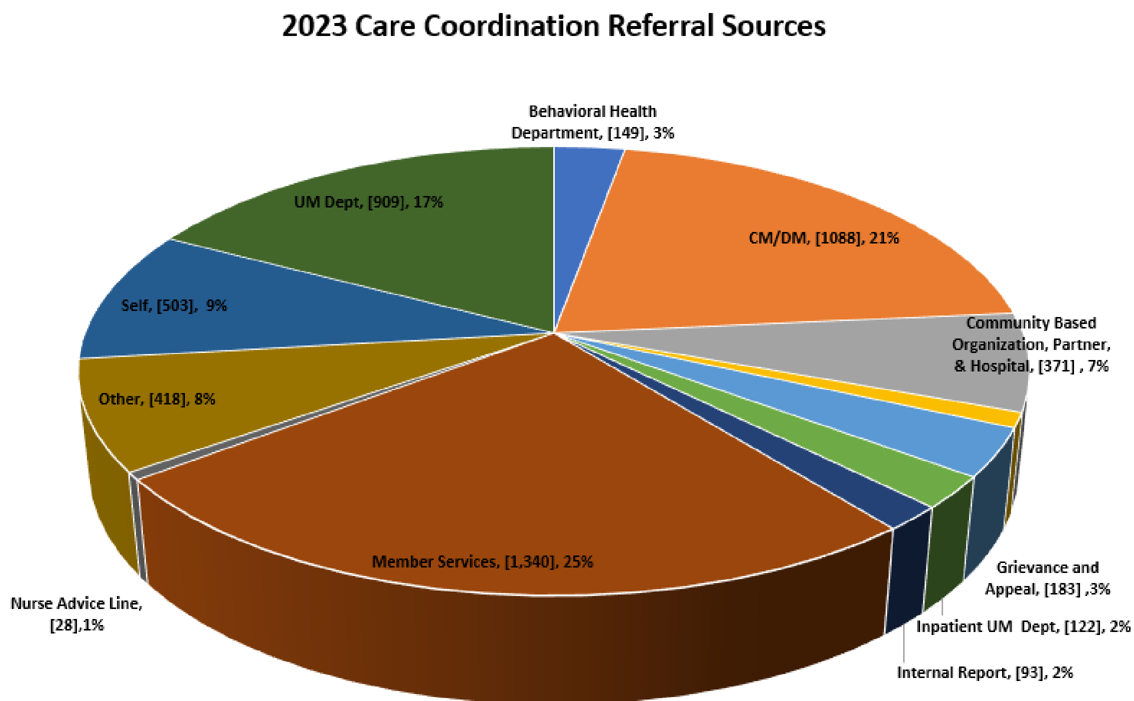
**Care Coordination – Medical Services**

Care coordination is provided by the CM staff for members needing assistance in coordinating their health care services. Interventions may include referral coordination, focused disease management programs, and/or making arrangements for linked and carved-out services, programs, and agencies. The Alliance uses non-clinical staff called Health Navigators to support care coordination. Health Navigators have extensive

training in facilitation and coordinating services both internally and with outside agencies (for example: Alameda County Public Health and other community resources). They are equipped to manage most care coordination cases, including those involving access to care and continuity of care.

Below figures show 2023 Care Coordination program outcomes by referral source, open/active volumes, and case closure reasons.

**Figure 8. 2023 Care Coordination Program by Referral Source**

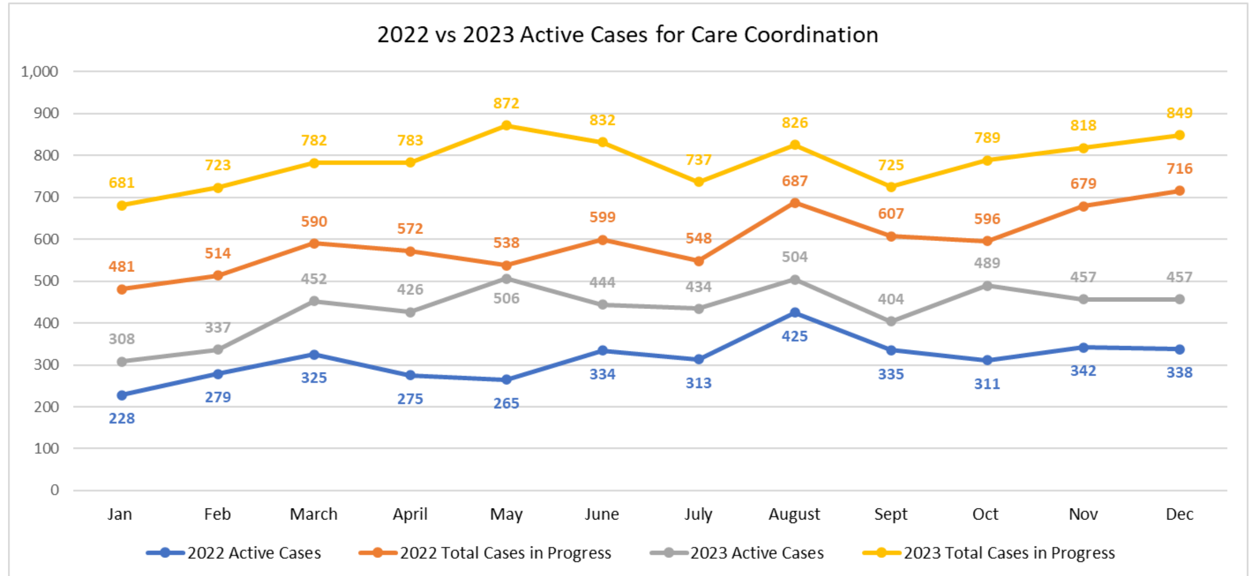



In 2023, the top three referral sources for Care Coordination cases were Member Services (1340 referrals), CM/DM department (1088 referrals), and the UM Department (909 referrals).

- The Member Services Department is the top referral source leading to care coordination cases because Member Services is the main entry point for members contacting the Alliance. Member Services also processes exempt same-day grievances, referring to CM for any care coordination needs related to grievances that cannot be resolved by a member services representative on the same day of the member's call.
- CM/DM referrals are comprised of referrals for members being referred within the care management team (for example, a nurse may refer care coordination tasks to a health navigator), thus demonstrating the collaboration among the team and the resulting continuity of care management support to members.

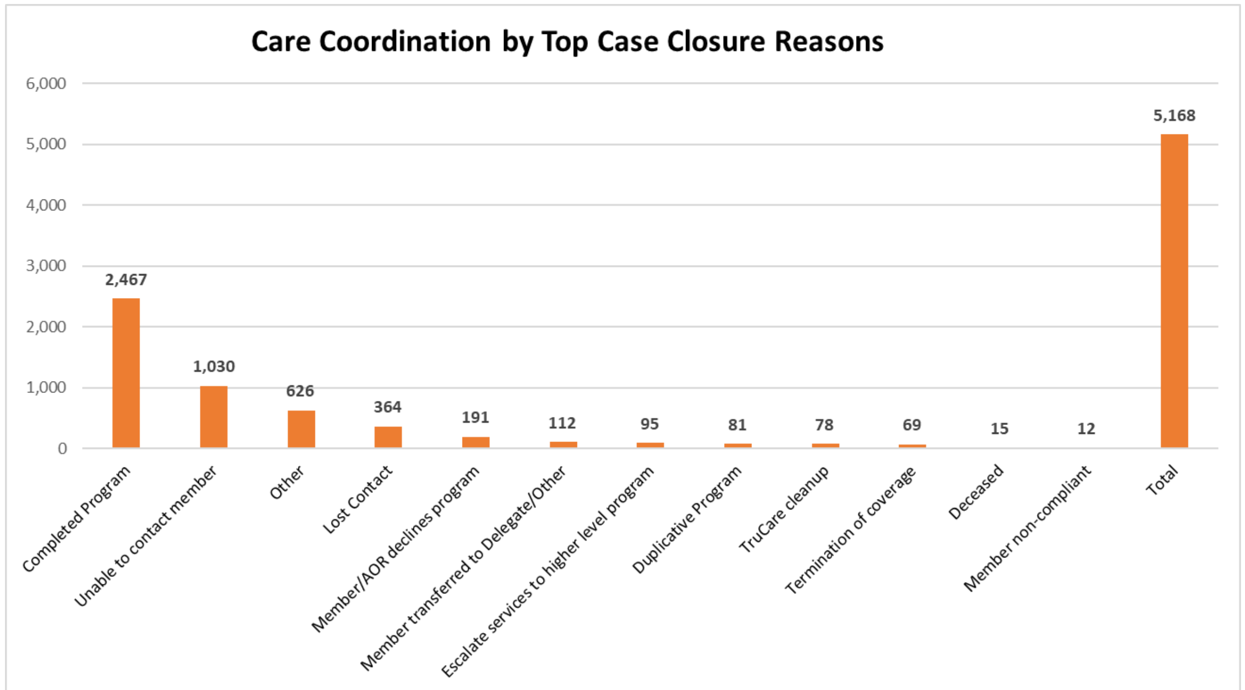
- The UM Department is a top referral source leading to care coordination cases showing the essential collaboration between UM and CM teams. Common referrals from UM include support with accessing and navigating care with in-network providers and facilitating continuity of care with out-of-network providers, when appropriate.

**Figure 9. 2022 vs. 2023 Care Coordination Program by Active Cases**




In 2023, there was a monthly average of 434 open/active care coordination cases. This was a year-over-year increase of 120 cases per month, compared to the monthly average of 314 open/active care coordination cases in 2022.

**Figure 10. 2023 Care Coordination Program by Case Closure Reason**



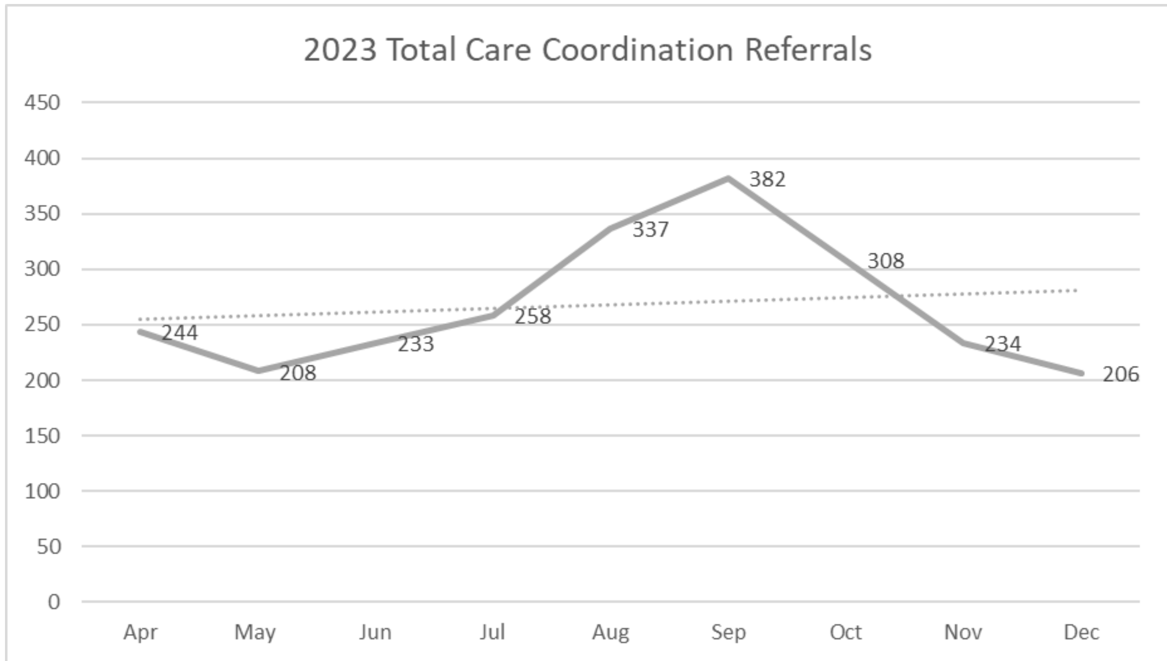

In 2023, the top three reasons for case closure were Completed Program (2,467 cases), Unable to Contact Member (1,030 cases), and Other (626 cases). Cases closed with reason of "Other" including free text by staff describing case closure reasons that could have been categorized by other options in drop-down menu. This presents an opportunity for retraining CM staff and updating the drop-down menu options. Leadership is considering removal of "Other" as an option, as many cases would have fit into more appropriate closure categories.

While nearly 20% of cases were closed due "unable to contact" member, it should be noted that when a referral is made from other departments or data sources besides member "self-referral," the member is not expecting a phone call from CM, and therefore, less likely to respond to contact attempts (including voicemails and letters).

**Care Coordination – Behavioral Health Services**

The Alliance received an average of 147 care coordination referrals. These are referrals from PCPs, and mental health clinicians and members themselves requesting assistance with coordination of behavioral health care. The graph below represents referrals for behavioral health and autism-related services.

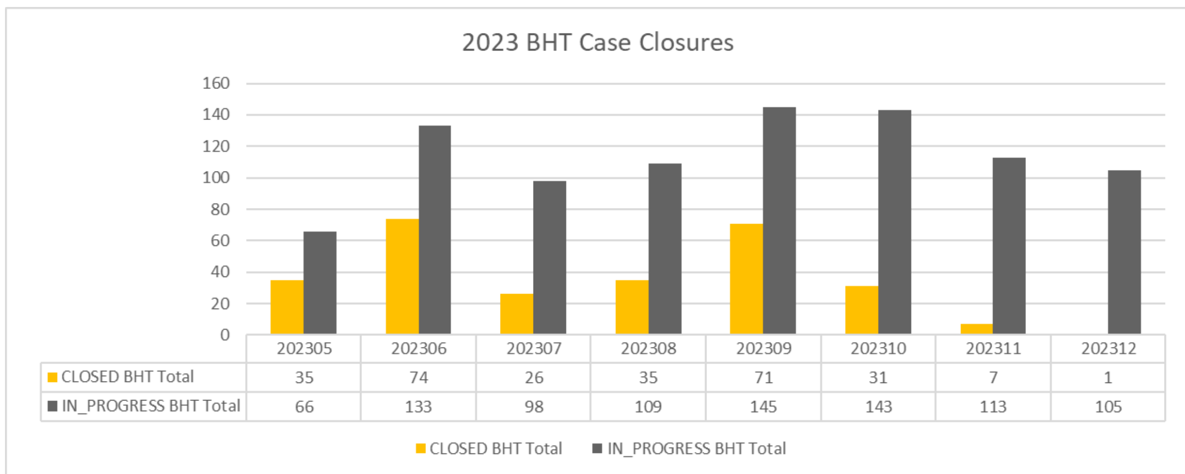
**Figure 11. 2023 Total Care Coordination Referrals**




When the Alliance insourced behavioral health treatment/applied behavioral analysis and related diagnostic assessments from Beacon, the care coordinators inherited a backlog of members waiting for connection to care. These were mostly members with developmental delay referred for diagnostic evaluations and related treatments. Locally and nationally, there has been a significant increase in the numbers of children identified and later diagnosed with developmental delays, mostly autism. The number of treatment providers has not grown at a comparable rate. This has resulted in longer than expected wait times for access to care. As a result, the Alliance has a high-touch care coordination program to support the members and their families in accessing care. In addition, the Alliance has taken action to increase network capacity. The care coordination program has also increased communication with primary care providers to keep them abreast of the status of referrals.

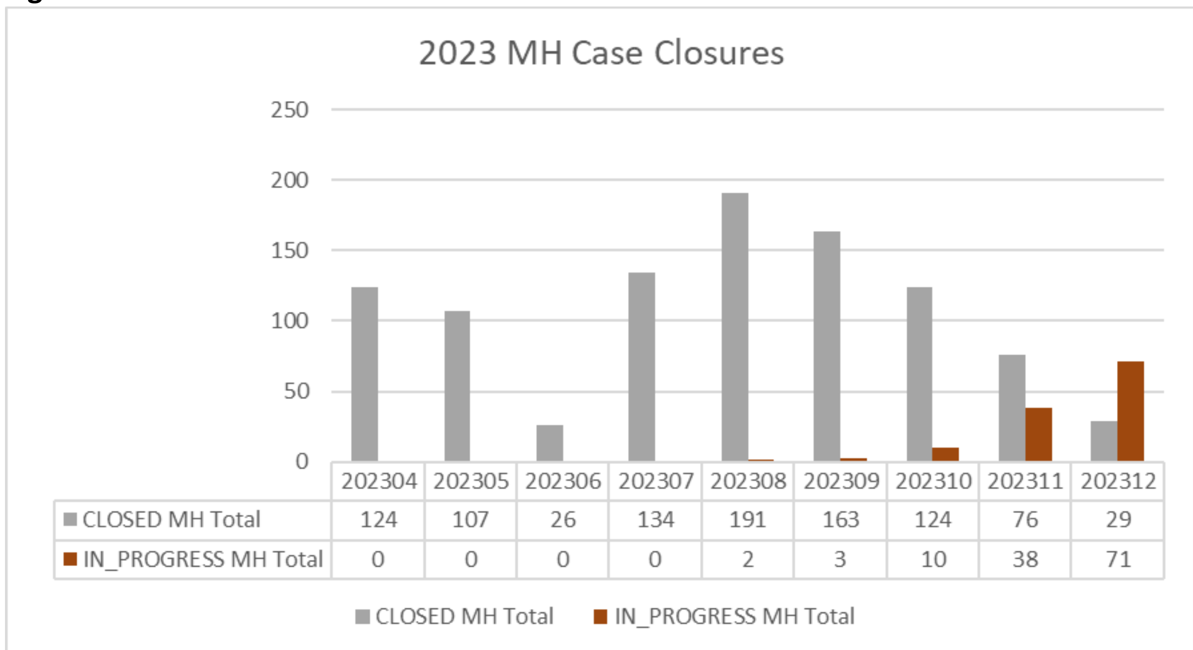
The graphs below represent the number of cases open in each month and the number that are successfully closed.

**Figure 12. 2023 BHT Case Closures Volumes**




| | 202305 | 202306 | 202307 | 202308 | 202309 | 202310 | 202311 | 202312 |
|---|---|---|---|---|---|---|---|---|
| CLOSED BHT Total | 35 | 74 | 26 | 35 | 71 | 31 | 7 | 1 |
| IN_PROGRESS BHT Total | 66 | 133 | 98 | 109 | 145 | 143 | 113 | 105 |

**Figure 13. 2023 MH Case Closure Volumes**

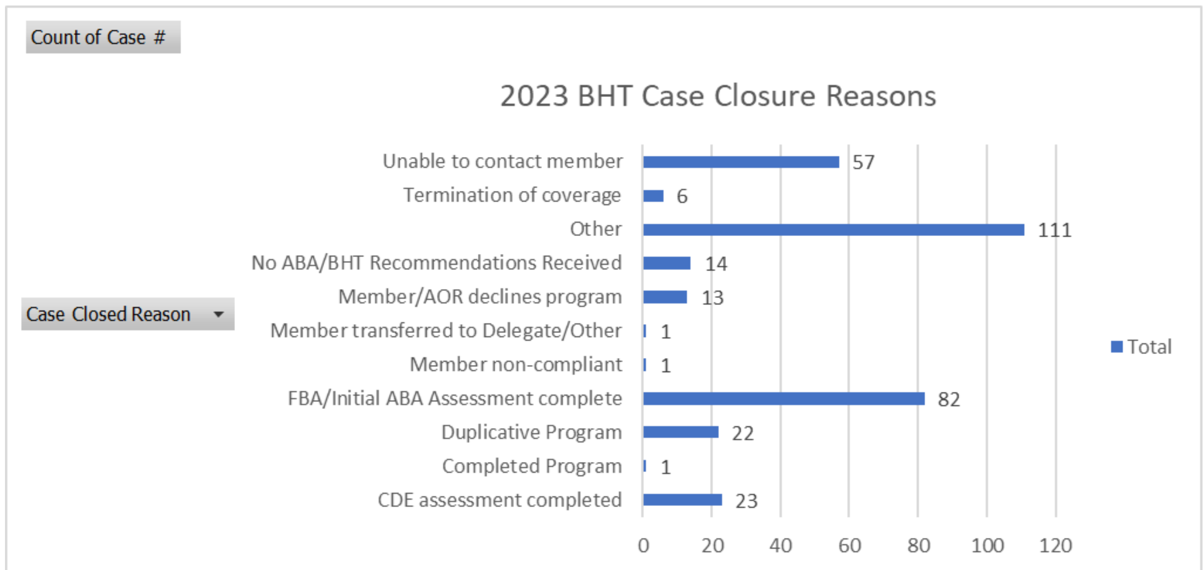


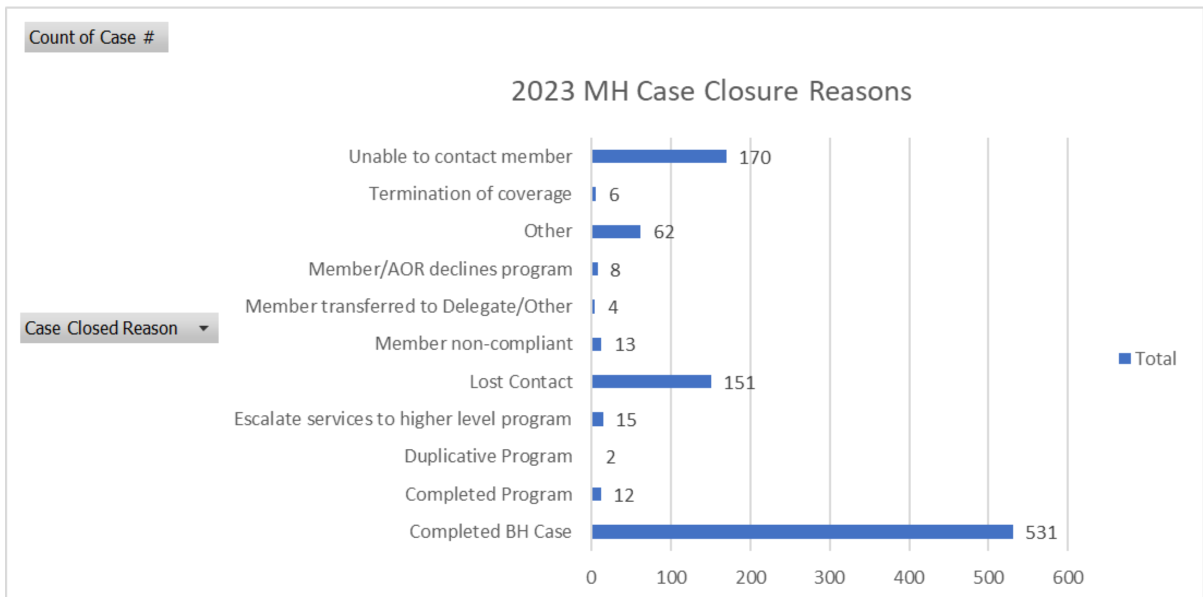

| | 202304 | 202305 | 202306 | 202307 | 202308 | 202309 | 202310 | 202311 | 202312 |
|---|---|---|---|---|---|---|---|---|---|
| CLOSED MH Total | 124 | 107 | 26 | 134 | 191 | 163 | 124 | 76 | 29 |
| IN_PROGRESS MH Total | 0 | 0 | 0 | 0 | 2 | 3 | 10 | 38 | 71 |

The challenges in connecting members to care is reflected in the ratio of closed to in progress cases, particularly with the BHT cases. The mental health care coordination team has been able to close cases more readily. However, the uptick in care coordination referrals is noted in the Q32023.

The graph below represents case closure reasons for both the mental health and BHT/ABA care coordination cases.

**Figure 14. 2023 BHT & MH Case Closure Reasons**




Cases are predominantly closed because the member has been successfully connected to care. It is noted that there is a significant number of BHT/ABA case closure reason categorized as other. This category was initially utilized in our case coordination program until more specific case closure reasons were developed and implemented.

In addition to the focus on reducing barriers to accessing mental health services, the Alliance behavioral health team is committed to facilitate coordination of care between mental health and primary care providers. To enable coordinated care, we deployed the Mental Health Initial Evaluation and the Mental Health Coordination of Care Update forms on our provider portal. These forms are designed to be an efficient and secure process whereby Mental Health providers log into the Alliance provider portal after evaluating a member to then enter the presenting problems, their findings and diagnosis

as well as their treatment plan with the mental health treatment modalities they recommend. The Mental Health provider is also provided information about the member's Primary Care Physician and the pharmacy information including all the medications the member has received from prescribers. The Mental Health provider is also able to include a message to the Primary Care Physician and make referrals to other mental health providers and to Alameda County Behavioral Health for specialty mental health services. This new mental health treatment report will help the Alliance connect mental health providers with co-treating providers and Primary Care Physicians to establish coordinated care that integrates behavioral and physical health care.

**Disease Management**

The Alliance Disease Management (DM) program is an Alliance Case Management and Health Education collaboration. Disease Management provides interventions for members with targeted chronic conditions. Interventions include case management for higher risk members and health coaching, care coordination and condition self-management education for lower risk members. The Alliance Population Health Assessment identified asthma for children and diabetes for adults as priority diagnoses affecting the Alliance membership at a disproportionate rate and/or with significant utilization. The Alliance Disease Management program collaborates with community partners, such as Alameda County Public Health's Asthma Start Program for children with asthma, and hospital-based Diabetes Self-Management Training (DSMT) programs to provide services for members with diabetes.

**Figure 15. Members Served for Disease Management Services**

| Disease Management Services | Members Served |
|---|---|
| Asthma Start - Child care-management, health education and asthma remediation | 128 |
| Diabetes - Health Coaching | 17 |
| Diabetes - Diabetes Self-Management Training (DSMT) | 497 |

With the release of the Population Health Management Policy Guide in 2023, additional work was done to expand disease management services to include cardiovascular disease and depression by 2024.

***Basic Population Health Management (including Care Coordination for Medical and Behavioral Health Services and Disease Management) - Recommended Actions for 2024:***

- Increase engagement in care coordination for medical services by continuing efforts to find alternative contact information for members through Electronic Health Records (EHR), PCP clinics, and Community Health Record (CHR)
- Work with Healthcare Analytics department to further enhance population analysis and program interventions to evaluate program efficacy
- Work with IT department to identify additional opportunities to automate processes administrative CM processes

- Further solidification of case coordination processes for behavioral health services to increase efficiency and uniformity of practice
- Further collaboration with Alameda County Behavioral Health to ensure member's needs are met across systems of care
- Further collaboration Alameda County Office of Education to coordinate school-based services
- Initiate bi-directional coordination of care between physical health and mental health providers, including deployment of PCP referral to Mental Health Web Form, enabling PCPs to communicate more completely the needs of the members they refer for mental health services that can be passed on to the Mental Health Provider to enhance their evaluation
- Behavioral Health Treatment/Applied Behavioral Health Treatment plan deployed on the Alliance Provider Portal to enable Autism Service Providers to submit their assessments and treatment plans securely, that can then be shared with referring pediatricians and PCPS.
- Continued identification of data sharing pathways between PCPs and Behavioral Health Practitioners
- Increase member engagement into Alliance Disease Management programs through member mail and call campaigns and provider education

**Care Management Programs: Complex Case Management (CCM)**

Complex Case Management (CCM) is an opt-in program, provided to members who consent to participate. It is a collaborative process between the Primary and/or Specialty Care Providers, member, and Care Manager; and the Care Manager's role is to support the member with person-centered planning, coordinating, and monitoring options and services to meet the member's health care goals.

Members meeting criteria for CCM may have conditions in which the degree and complexity of illness or conditions is severe, the level of management necessary is intensive, and the number of resources required for member to regain optimal health or improved functionality is extensive. Eligibility criteria are subject to change, based on findings from the population needs assessment and/or community and stakeholder committees, but typically support Members with at least one of the following clinical features:

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

A clinician (CM nurse or social worker) may deem a member eligible for CCM if they feel a member could benefit from CCM services. The Alliance also employed proactive strategies to identify members meeting criteria for CCM.

**Predictive Model Application**

The Alliance uses a predictive model application, CareAnalyzer, to aggregate utilization data (including behavioral health and pharmacy data) to identify members who may be at risk and could benefit from CM interventions. CareAnalyzer's unique analytic approach stems from the integration of The Johns Hopkins University Adjusted Clinical Group (ACG) System, a comprehensive set of predictive modeling tools based on series of mutually exclusive, health status categories defined by morbidity, age, and sex. ACGs offer a person-focused method of categorizing patients' illnesses; over time, each person develops numerous conditions, and based on the pattern of these morbidities, the ACG approach assigns each individual to a single ACG category. The Johns Hopkins Resource Utilization Bands (RUBs) were added to the data sets to improve the sensitivity and specificity of the member data. In addition, the tool was enhanced to capture the Relative Risk Score (RRS) to apply predictability to the data. The enhancement identifies current and predictive changes based on utilization data.

**Population Health Report**

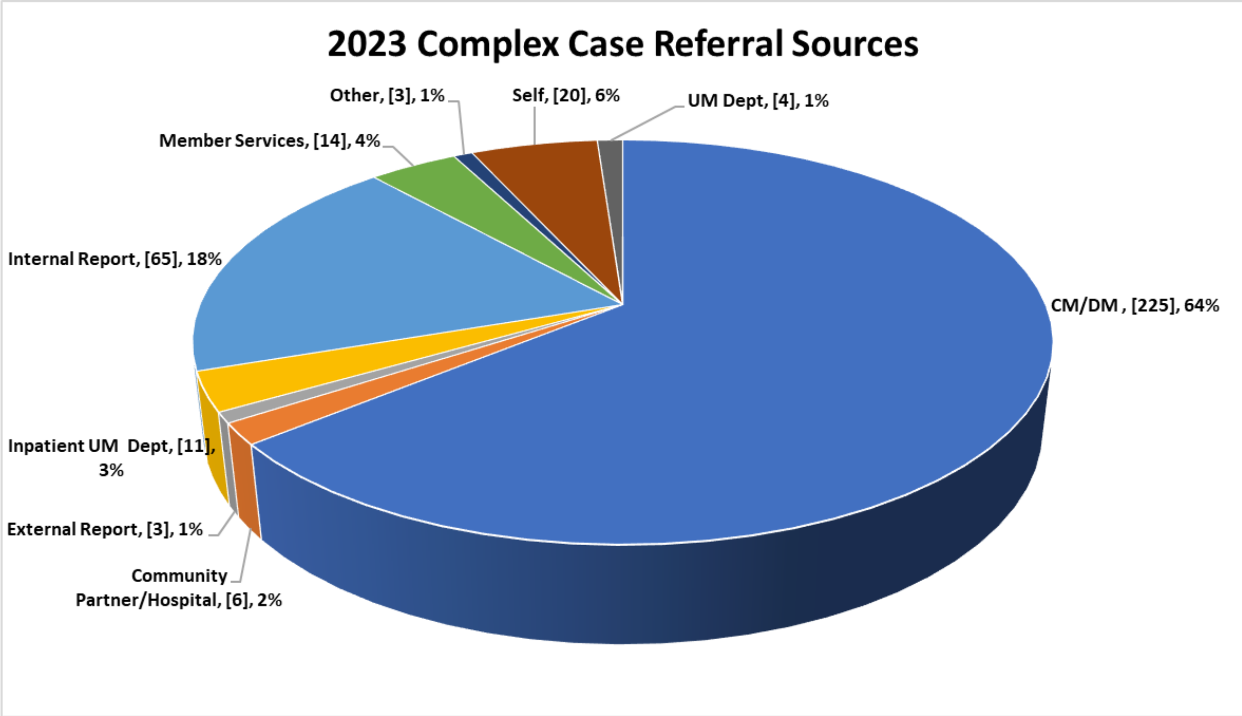
CM also worked with Healthcare Analytics to develop a Population Health Report based on claims, utilization data and the predictive modeling application, CareAnalzyer. Members identified on the report were contacted and offered CCM services.

In 2023, 166 members were identified to meet criteria for CCM and contacted by a non-clinical team member to offer CCM. Of those contacted, 11 members (about 7%) consented to participate in CCM.

The CM Department monitors CCM referral sources, case volumes and outcomes, and staff operational metrics to assess the effectiveness of the program, as well as, to identify patterns for potential program and process improvements.

The below chart shows members referred to Complex Case Management, categorized by referral source.

**Figure 16. 2023 Complex Case Management – Referrals by Source**

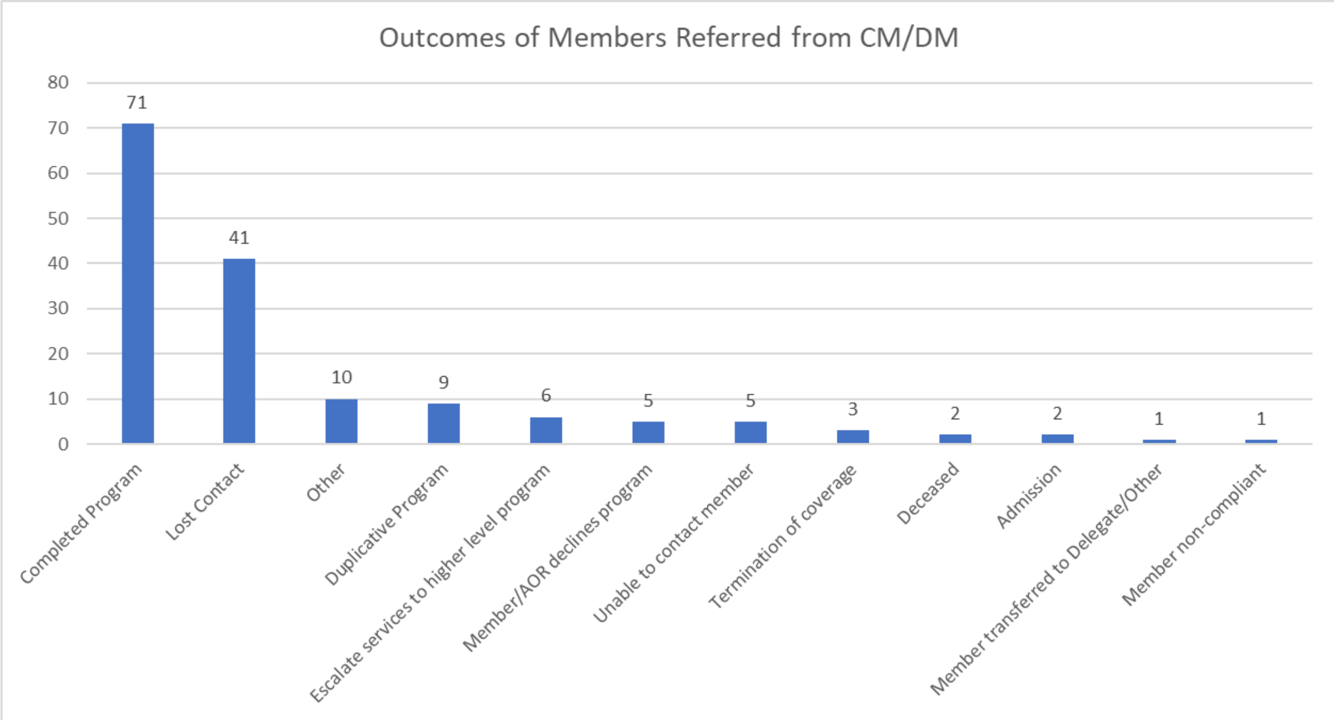



Referrals into CCM increased from 193 referrals in 2022 to 352 referrals in 2023, for a total increase of 159 cases. This may be attributed to increasing the CCM productivity standard for RN Complex Case Managers, encouraging more members to participate in CCM.

For 2023, the top three referral sources were CM/DM (225 referrals), Internal Report (65 referrals), and Self (20 referrals).

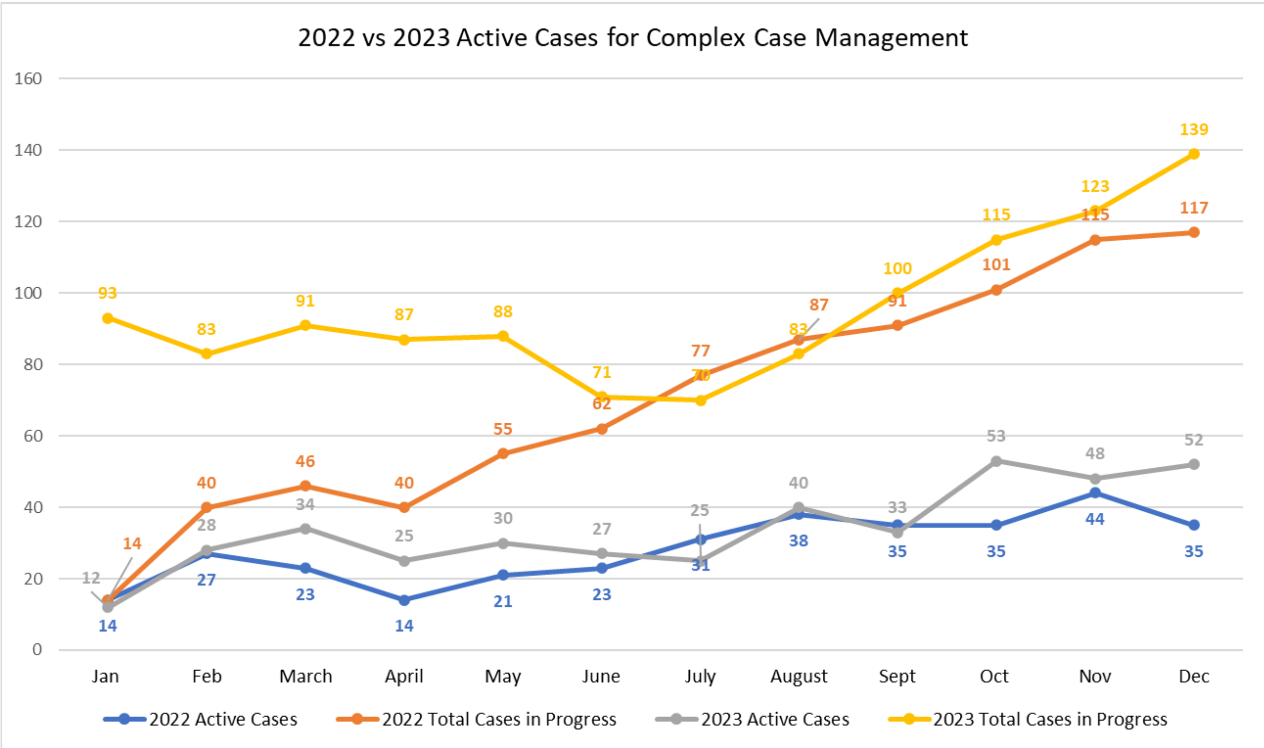
Some cases managed as care coordination may have indicators for CCM, but cannot be enrolled in CCM until the member consents. After member consent is received, a referral is made to enroll in Complex Case Management. In 2023, CM continued to monitor CCM productivity standard for CCM RNs, providing coaching sessions to practice motivational interviewing skills to increase consent from members to participate in CCM. This resulted in more CM staff referring members to CCM from a lower level-of-care CM program, like care coordination. The below table shows outcomes of members referred from lower-level CM interventions to CCM.

**Figure 17. Outcome of Members Referred from CM/DM**




In 2023, the CM/DM team was the largest source of CCM referrals. This means the members were already working with the CM/DM team and agreed to the more intensive case management program. Of the total CCM referrals, 32% of members completed the program and 18% lost contact with staff. The other 50% of cases were closed for reasons including (but not limited to): escalating to a high level of care, the member was already enrolled in a more intensive case management program, or the member/AOR declined the program.

**Figure 18. 2022 vs. 2023 CCM Active Cases**



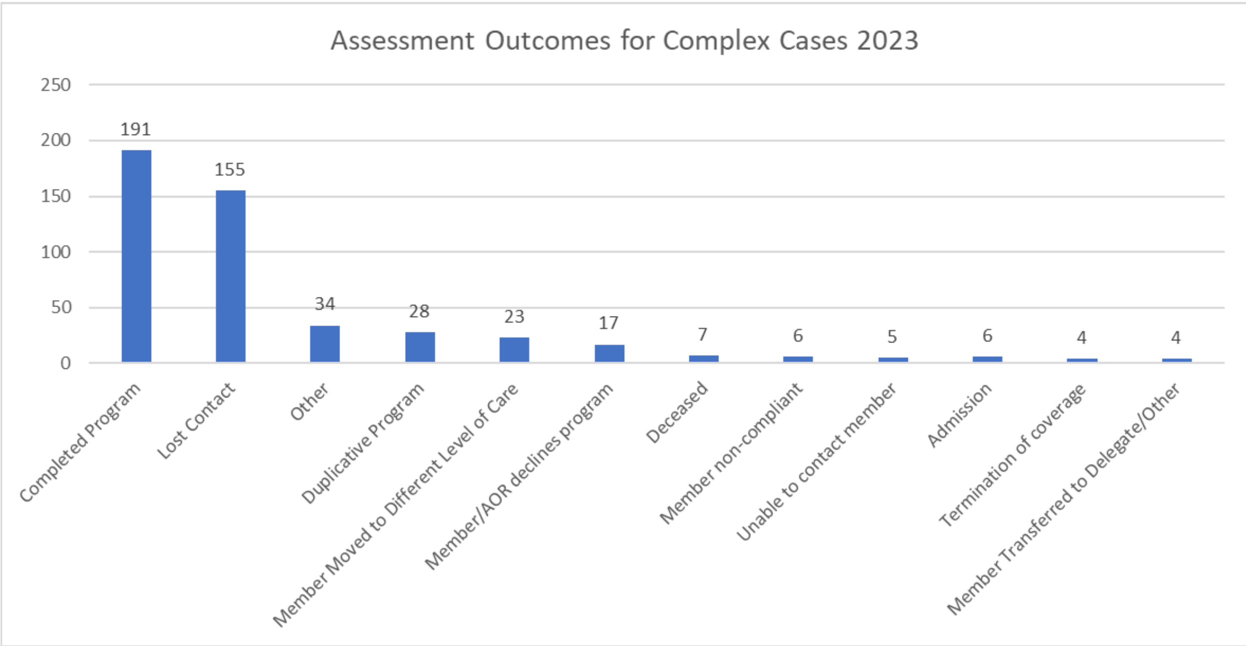

In 2023, there was a monthly average of 34 open/active CCM cases. This was a year-over-year increase of 6 cases per month, compared to the monthly average of 28 open/active CCM cases in 2022.

There has been improvement in identification and engagement of members with potential need for CCM from the Internal Reports. Referral and identification from internal staff continues to be the largest driver for CCM enrollment, indicating the importance of continued staff training to increase referrals into CCM. Monthly CCM productivity standards have promoted increased identification of and engagement of members into CCM.

To evaluate the effectiveness and quality of CCM interventions, CCM assessment and Interdisciplinary Care Team presentations were evaluated for outcomes and completion timeliness. Case closures outcomes and staff operational metrics were also evaluated.

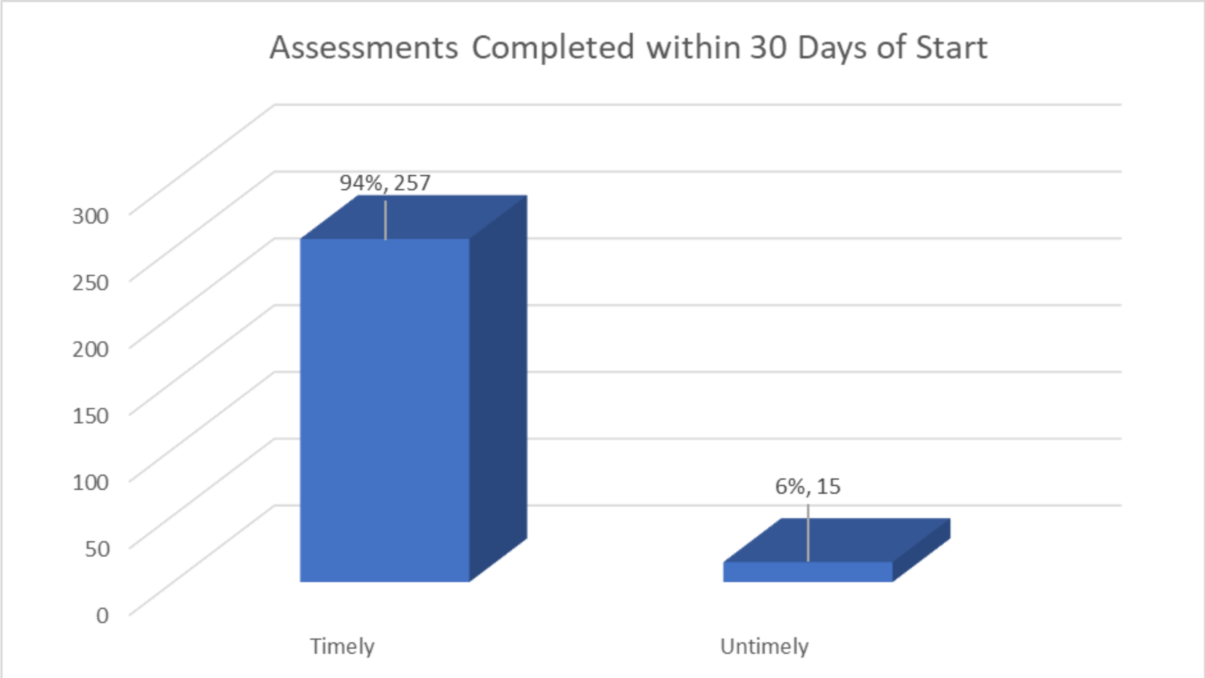
The below figures show CCM assessment trends in 2023:

**Figure 19a. 2023 Assessment Outcomes for Complex Cases**




In 2023, 70% of CCM assessments were completed, compared to 56% in 2022. Unable to reach rates decreased to 2% in 2023, compared to 19% in 2022.

**Figure 19b. 2023 Assessment Completion Timeliness**




In 2023, a total of 272 assessments were completed. This was an increase from 199 total completed assessments in 2022. Out of the 272 completed assessments, 257 were started within 30 days, meeting the timeliness goal at 95.0%. Of the 15 assessments that did not get completed within 30 days, all 15 were completed (100%) within 60 days. Assessments that were not started within 30 days were due to care coordination needs taking priority to starting the assessment, and difficulty re-engaging the member.

***Complex Cases Open >90 days***

An essential component of CCM is involvement of the Interdisciplinary Care Team (IDT). Members' cases are presented to the IDT at IDT Rounds to elicit insight from multiple disciplines, ensuring comprehensive problem-solving to achieve the most optimal health outcomes. IDT Rounds are held bi-weekly and using the Daily Aging Report. So that staff meet the deadline to present a case at IDT Rounds by the $90^{th}$ day the case is open, staff are notified of cases that are open at the 60-day mark, ensuring the case is ready to be presented before the $90^{th}$ day deadline. The timeliness of case managers presenting cases during IDT Rounds was evaluated, pulling data from all cases that had been open for 90 days or more.

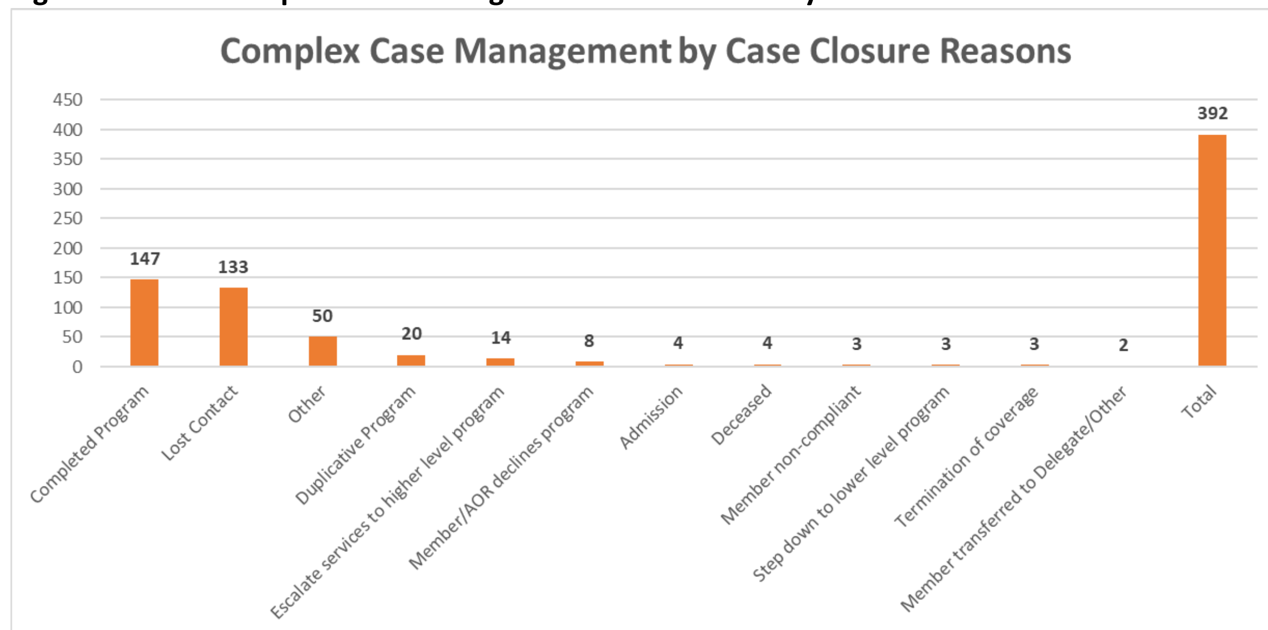
**Figure 20: 2023 Results for IDT Rounds**

| Complex Cases ≥ 90days | Outcome of IDT | % of Timely IDT based on Report |
|---|---|---|
| 0 | No IDT | 0% |
| 18 | Timely | 100% |
| 0 | Untimely | 0% |

In 2023, 18 CCM cases were identified to be open for at least 90 days, and 100% of cases were presented at IDT meetings within 90 days of the case being opened.

Upon completion of care plan goals, including addressing all barriers, case closure is discussed with members to ensure they feel prepared to self-manage their health. The below figure shows CCM case closure reasons.

**Figure 21. 2023 Complex Case Management Case Closures by Reason**




In 2023, the top three reasons for case closure were Completed Program (147 cases), Lost Contact (133 cases), and Other (50 cases). Cases closed with reason of "Other" including free text by staff describing case closure reasons that could have been categorized by other options in drop-down

menu. This presents an opportunity for retraining of CM staff and updating the drop-down menu options.

There was increase in case closure reason "Completed Program" to 147, compared to 67 in 2022. This continues to show 2023 had both a higher volume of CCM cases and higher rate of program completion (31% in 2022, 38% in 2023). Lost contact case closure reason continues to be addressed via multiple telephone attempts and sending member a "Lost Contact" Letter.

The Alliance maintains operational performance measures for the complex case management program to maximize member health, wellness, safety, satisfaction, and cost efficiency while ensuring quality care. The Alliance selects measures that have significant and demonstrable bearing on the entire complex case management population or a defined subpopulation. The Alliance annually measures the effectiveness of its complex case management program based on the following performance goals and corresponding measures:

**Figure 22. 2023 CM Performance Measures**

| | Goal | Measure | Measurement | Performance Goal | 2023 Rate | Goal Met? |
|---|---|---|---|---|---|---|
| **#1** | Achieve and maintain high level of satisfaction with CM services. | Member Satisfaction Rates | High level of satisfaction with CM services | 90% | 100% | Yes |
| **#2** | Improve member outcomes | All-Cause readmission Rate | Readmission rates for all causes for members in CCM with admission within 6 months of enrollment in CCM | *Report in development* | | N/A |
| **#3** | Improve member outcomes | Emergency Room Visit Rate | ER rates for members enrolled in CCM | *Report in development* | | N/A |
| **#4** | Achieve optimal member functioning. | Health Status | % of members in CCM responding that their health status improved because of CCM | 90% | 100% | Yes |

Of the four measures, two had an established benchmark. For 2023, CM continued to achieve the goal of achieving and maintaining high level of satisfaction with CM services at 100%. Also, 100% of members in CCM responded that their health status had improved because of CCM. Reports are being developed to evaluate the remaining two measures.

In summary, for 2023, the following strategies resulted in an increased volume of members engaged in CCM and increased identification of members for the program:

- Continued review and revisions of the Population Health Report and the CM Daily Aging Report
- Department trainings to improve consistency in member outreach, improving the staff process to offer services to members and streamlining documentation in the electronic system of record.
- Continued collaborative efforts with hospital partners to identify eligible members, including implementing alternatives to member outreach
- Continued review of productivity standard with a goal of increasing outreach to members who may be eligible for CCM.
- Staff identifying members they are already working at a lower level of care for CCM through increased training for staff on proper identification
- Motivational interviewing of members to assist in staff gaining more information that could qualify member for CCM and to assist in increasing member consent into CCM program

***Complex Case Management - Recommended Actions for 2024:***

- Continue to identify, implement, and evaluate different avenues to continue to increase member engagement.
- Continue SMART goal for:
    - Collaborative efforts with partnered hospitals
    - Productivity standard of Complex member outreach and engagement
    - Obtaining accurate member contact information.
    - Continue the use of the CHR and PCP for alternate phone numbers for member engagement

**Care Management Programs: Enhanced Care Management (ECM)**

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. ECM coordinates all care for Members who receive it, including across the physical and behavioral health delivery systems. ECM offers comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

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

The ECM program has evolved since its transition from the Health Homes Program (in 2021).

- In January 2022, The Alliance successfully launched ECM for homeless, high utilizer, and Serious Mental Health (SMI)/Substance Use Disorder (SUD) populations of focus.

- In September 1, 2022, Alameda County Behavioral Health (ACBH) became an ECM Provider.
- In January 2023, the Alliance launched programs to support two new ECM populations of focus (Adults Living in the Community at Risk for Institutionalization & Adult Nursing Facility Residents Transitioning to the Community).
- In July 2023, after DHCS re-structured ECM to further breakdown eligibility criteria for children and youth, The Alliance onboarded ECM providers to specifically support the children and youth populations.

As of 12/31/2023, the ECM program had served 1,341 members at the 24 ECM sites in Alameda County. The below table shows the number of members served in each Population of Focus.

**Figure 23a. 2023 ECM Populations of Focus Enrollment**

| ECM Populations of Focus | | Adults | Children & Youth |
|---|---|---|---|
| 1 | Individuals Experiencing Homelessness | 115 | 140 |
| 2 | Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly "High Utilizers") | 486 | 116 |
| 3 | Individuals with Serious Mental Health and/or SUD Needs | 171 | 45 |
| 4 | Adults Living in the Community and At Risk for LTC Institutionalization | 198 | |
| 5 | Adult Nursing Facility Residents Transitioning to the Community | 2 | |
| 6 | Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition | | 30 |
| 7 | Children and Youth Involved in Child Welfare | | 38 |
| | **TOTAL** | **972** | **369** |
| | **COMBINED TOTAL** | **1341** | |

Also in 2023, the ECM team worked diligently to assist with network expansion as the final two (2) Populations of Focus went live on January 1, 2024 (Justice Involved and Birth Equity). The Alliance is also incorporating Street Medicine into ECM in alignment with DHCS' APL.

**Figure 23b. ECM Populations of Focus – Implementation Dates**

| ECM Populations of Focus | | Adults | Children & Youth |
|---|---|---|---|
| 1a | Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experience Homelessness | ✓ | |
| 1b | Individuals Experience Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness | ✓ | ✓ |
| 2 | Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly "High Utilizers") | ✓ | ✓ |
| 3 | Individuals with Serious Mental Health and/or SUD Needs | ✓ | ✓ |
| 4 | Individuals Transitioning from Incarceration | Go-Live January 1, 2024 | |
| 5 | Adults Living in the Community and At Risk for LTC Institutionalization | ✓ | |
| 6 | Adult Nursing Facility Residents Transitioning to the Community | ✓ | |
| 7 | Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition | | ✓ |
| 8 | Children and Youth Involved in Child Welfare | | ✓ |
| 9 | Birth Equity Population of Focus | Go-Live January 1, 2024 | |

In 2023, many ECM providers continue to have challenges understanding authorizations and requirements for ECM. The Clinical Manager of ECM has leaned in to assist with process improvements, restructuring and engaging every ECM provider in regular meetings. With the current staff of five (5) Health Navigators, two registered nurses and a Physician Champion, the CM Medical Director, the team is renewing collaboration and further developing relationships with the ECM providers to understand their capacity to support additional members. ECM program graduation will be a focus area in 2024, providing additional insight/education to providers on various programs (lower levels of case management services, Community Supports services, etc.) and working towards increasing enrollment (and graduation) of members enrolled in ECM.

***Enhanced Care Management - Recommended Actions for 2024:***

- Continue to develop, train, and maintain the ECM Provider network, in preparation for further expansion to support all ECM populations of focus.
- Provide consistent/routine monthly in-person and virtual provider audits and respective in-services to ensure ECM compliance and optimal use of ECM benefits.
- Work closely with ECM providers in monthly IDT meetings to provide guidance with the ECM graduation process.

## Care Management Programs: Targeted Case Management (TCM)

Targeted Case Management is provided to members by Local Governmental Agencies (LGAs). The Alliance facilitates access to TCM for eligible members by ensuring referrals are appropriately made to the LGAs, so they can evaluate members for TCM services. Alliance staff follow preset guidelines and collaborate with primary care providers when necessary to identify members eligible for TCM services.

Members eligible for TCM services have generally been identified as moderate or high risk. Once a member is identified and referred to an LGA for potential TCM, they are assigned to an Alliance

Case Manager, who ensures screening, referrals, care planning, and all other care coordination activities are coordinated between the member, their providers, the LGA, and The Alliance. Data exchange occurs between the Alliance and the various TCM LGAs, to ensure non-duplication of services. Collaboration with the LGA also ensures members who are no longer eligible for TCM are appropriately linked with alternate resources to support any ongoing health needs.

**Transitional Care Services**

The Alliance's Transitions of Care (TOC) Program has evolved since its inception in 2019. The TOC care model had always provided support to members at hospital discharge, using any individual or combination of the Case Management disciplines: Nurse Case Managers, Social Workers or non-clinical staff, Health Navigators. In 2022, the Alliance redesigned the TOC care model to align with DHCS' Transitional Care Services (TCS), as described in the Population Health Management Policy guide.

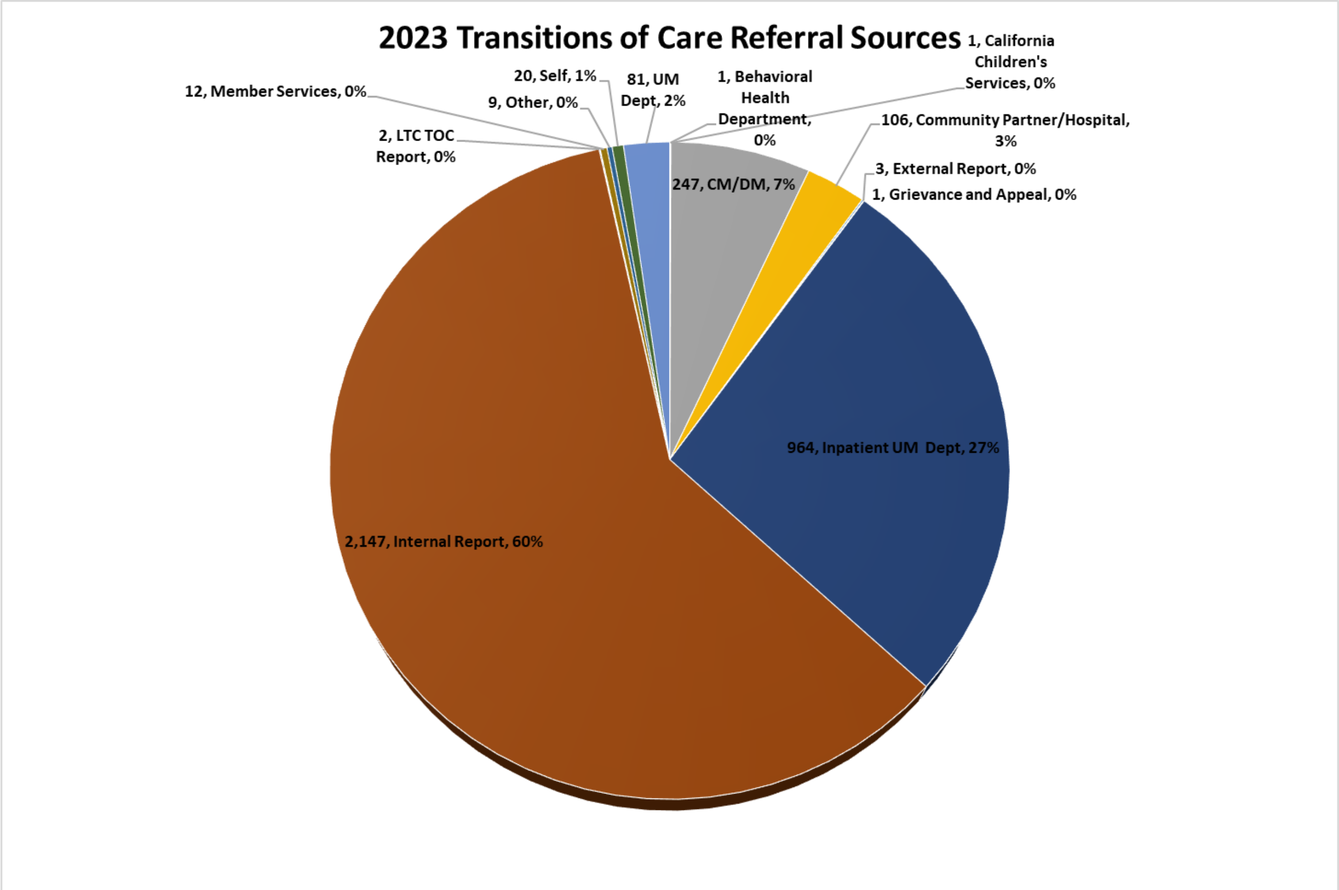
In January 2023, The Alliance implemented TCS for all high-risk members transitioning from one setting or level of care to another. These transitions include, but are not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings. The Alliance has established partnerships with hospitals and network providers, like Alameda Health Systems (AHS), to effectively implement TCS, ensuring members have access to supports across the continuum from admission to discharge.

Also, in 2023, the Alliance prepared for the expanded requirement of providing TCS to all members, regardless of risk stratification, starting January 2024.

The Alliance delegates TCS to CHCN for members assigned to the CHCN network – these members are supported via CHCN's Care Transitions Registered Nurse (CTRN) program. The CM team provides oversight and monitoring of the delegated TCS activities to ensure compliance with all DHCS requirements.

The below data represents TCS outcomes in 2023, including referral sources, case volumes, and case closure reasons.

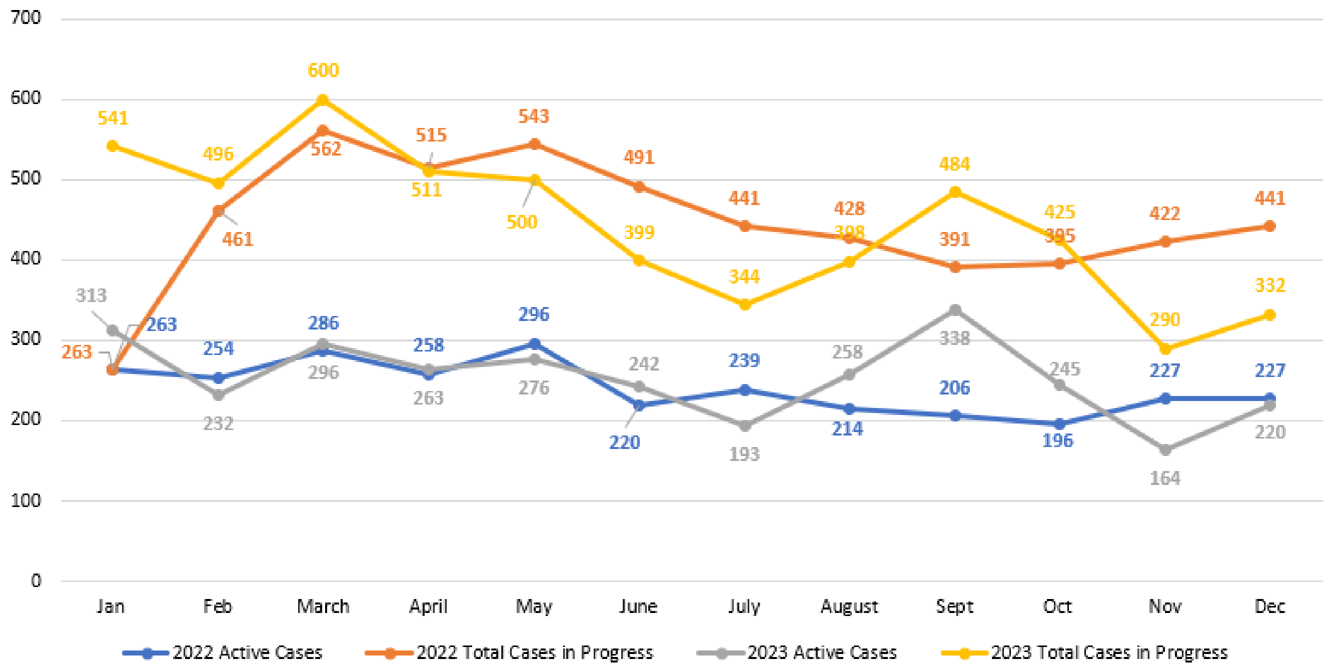
**Figure 24. 2023 Transitional Care Services Referrals**




In 2023, the top three sources of TCS referrals were Internal Report (2,147 cases), the Inpatient UM Dept (964 cases), and CM/DM (247 cases).

The Internal Reports refer to the ADT Feed, in which cases are created automatically via ADT data received from hospitals who have agreed to provide ADT. The significant increase in TCS referrals is due to implementation of the DHCS requirement for all members stratified as high-risk.

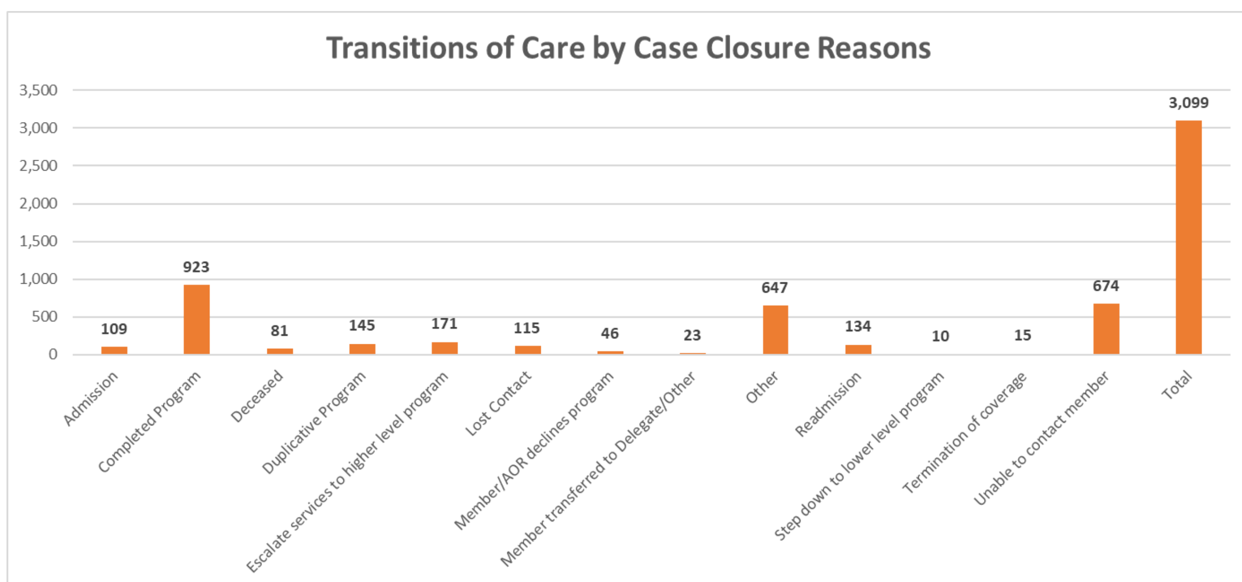
**Figure 25. 2022 vs. 2023 Transitional Care Services Active Cases**




In 2023, there was a monthly average of 253 open/active CCM cases. This was a year-over-year decrease of 13 cases per month, compared to the monthly average of 240 open/active TCS cases in 2022. The decrease from 2022 to 2023 was due to new requirements from DHCS beginning in 2023, including that TCS in 2023 was only required for members stratified as high risk. CM updated workflows of its previous Transitions of Care (TOC) pilot to comply with these formalized TCS requirements.

The higher volume of TCS cases in Q1 2023 was related to supporting ECM providers with training and reminders to deliver Transitional Care Services to members enrolled in ECM. The ECM team worked with various ECM providers to ensure they were able to identify ECM members who had been hospitalized. Once ECM providers understood how to track and manage their members who were hospitalized, they were able to effectively deliver TCS, thus stabilizing the TCS referral volume noted in the remainder of 2023.

**Figure 26. 2023 Transitional Care Services Case Closures**




In 2023, the top three (3) reasons for TCS Case Closure were Completed Program (923 cases), Unable to Contact Member (674 cases), and Other (647 cases). Cases closed with reason of "Other" including free text by staff describing case closure reasons that could have been categorized by other options in drop-down menu. This presents an opportunity for retraining of CM staff and updating the drop-down menu options.

The number of members who completed TCS increased year-over-year to 923 cases, compared to 794 cases in 2022. In 2023, the CM team implemented member outreach while the member was still in the hospital, likely contributing to this increase in successful outcomes.

***Transitional Care Services - Recommended Actions for 2024:***

- Continued efforts to improve member engagement rate will continue in 2024 via finding alternate phone numbers through CHR, and PCP office.
- Increased partnerships with hospital systems.
- Increased partnerships with PCP offices in collaborating on TCS, particularly post discharge appointments.
- Increased focused on specific TCS populations such as OB and FFS Medicare Part A members.

***Specialized Services***

***Continuity of Care***

The CM Department collaborates with the UM Department and Member Services on facilitating members' timely access to care and any appropriate continuity of care. CM is responsible assisting members who are redirected to In-Network Providers after their continuity of care period ends and assisting members whose initial request did not qualify for continuity of care. Continuity of Care referrals are sent to CM via direct referrals from UM and Member Services. The UM department also identifies and refers members to CM

who have exhausted a benefit, who are aging out of a benefit (i.e., California Children Services), or have needs beyond those provided by partner agencies. CM supports these members with access to alternate resources.

In Q4 2023, the Alliance worked with DHCS and other managed care plans to prepare for the transition of about 100,000 members into The Alliance, due to The Alliance becoming a single-plan county. The Alliance effectively executed the specialized Continuity of Care requirements for this transitioning population, proactively outreaching to providers and members, when appropriate.

***Community Supports***

Community Supports (CS) services were initiated as part of CalAIM and include a variety of services not typically covered by managed care plans. These services were intended to provide additional cost-effective support to members in lieu of higher-level services. In 2023, the Alliance provided eleven (11) CS Services:

- Housing Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Recuperative Care (Medical Respite)
- Medically Tailored Meals/Medically Supportive Food
- Asthma Remediation (for children under 19 years of age)
- Environmental Accessibility Adaptations (Home Modifications)
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care & Homemaker Services
- (Caregiver) Respite Services

The below table shows the number of members receiving Community Supports in 2023.

**Figure 27. Number of Members Receiving Community Support Services**

| CS Service Type | CS Providers | Members Served | Number of Authorizations |
|---|---|---|---|
| **Housing Deposits** | Healthcare Service Agency (HCSA) | 241 | 406 |
| **Housing Tenancy and Sustaining Services** | Healthcare Service Agency (HCSA) | 1594 | 1648 |
| **Housing Transition/Navigation Services** | Healthcare Service Agency (HCSA) | 870 | 968 |
| **Medically-Supportive Food/Medically Tailored Meals** | Project Open | 734 | 922 |
| | Healthcare Service Agency (HCSA) - Recipe 4 Health | 823 | 1447 |

| | | | |
|---|---|---|---|
| **Asthma Remediation** | Health Care Service Agency (HCSA) - Asthma Start | 182 | 189 |
| **Community Transition Services/Nursing Facility Transition to a Home** | East Bay Innovation (EBI) | 4 | 5 |
| **Environmental Accessibility Adaptations** | East Bay Innovation (EBI) | 0 | 6 |
| **Nursing Facility Transition/Diversion to Assisted Living Facilities** | East Bay Innovation (EBI) | 10 | 15 |
| **Personal Care/Homemaker Services** | 24 Hour Home Care | 81 | 130 |
| **Recuperative Care/Medical Respite** | Cardea Health | 120 | 134 |
| | Adeline Lifelong | 76 | 92 |
| | Bay Area Community Services (BACS) | 24 | 27 |
| **Respite Services** | 224 Hour Home Care | 1 | 2 |

The Alliance continued to work with the current providers of the current services, and onboarded new providers and new services in 2023. Significant effort was made to further expand the CS services that the Alliance offers, and to prepare for further network expansion of the current CS services in Jan 2024. The CS team met regularly with all CS providers, discussing utilization, member support/cases and building rapport with the CS provider network. Oversight and monitoring began in 2023 with the providers who had been contracted with the Alliance for 12 months (or more).

***Community Supports - Recommended Actions for 2024:***

- Transition the operational oversight of Community Supports to LTSS Director
- Launch the last two CS services (Short-Term Post-Hospitalization Housing and Day Habilitation Programs) by January 1, 2025.
- Continue to broaden CS provider network, as appropriate.
- Increase staff where appropriate as department expands to better meet needs of members and providers.

- Continue to build relationships with billing to assist providers with receiving timely payments.
- Continue to work with Analytics to further enhance a dashboard for CS services
- Continue development of accurate and reliable closed loop referral process with Community Supports providers, in alignment with the DHCS requirement by January 1, 2025; establish mechanism for CS providers to confirm members are being serviced after authorizations have been issued
- Provide training to all CS providers to promote best practices while working with our members and to continue to build rapport with CS providers

***Transportation***

Ensuring access to adequate and timely transportation to medical appointments is an essential care management intervention to address this social determinant of health barrier. In 2023, the Alliance's dedicated CM Transportation Coordinators provided oversight and management of the Transportation benefit. Specifically, they assumed responsibility for obtaining completed Physician Certification Statement (PCS) forms prior to coordinating Non-Emergency Medical Transportation (NEMT), collaborating with the vendor management department to ensure that Transportation processes aligned with the requirements of APL 22-008 for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT).

Additionally, the Alliance continued to monitor the performance of its transportation subcontractor, ModivCare, in the provision of the Transportation benefit by conducting weekly joint operational meetings, quarterly joint operational meetings (JOM), weekly grievances meetings, weekly potential quality issue (PQI) meetings, and other ad-hoc meetings as needed. The below figure show ModivCare's key performance indicators.

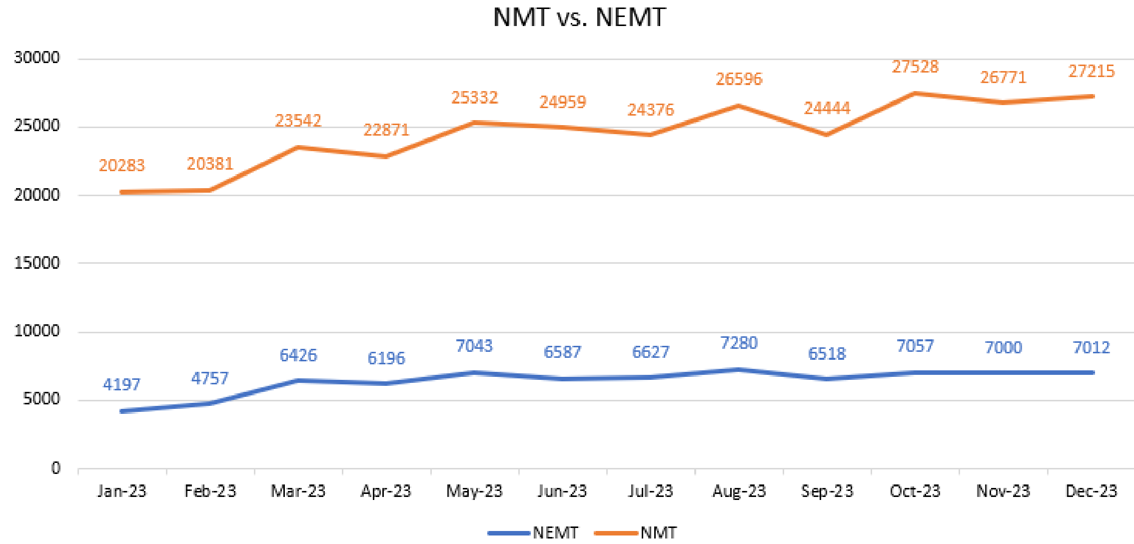
**Figure 28. ModivCare Key Performance Indicators**

| | Description | | 1st QTR Total | 1st QTR Average | % of Total | 2nd QTR Total | 2nd QTR Average | % of Total | 3rd QTR Total | 3rd QTR Average | % of Total | 4th QTR Total | 4th QTR Average | % of Total | YTD | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Members | Members Served | Number of unique members utilizing transportation | | 2,207 | | | 2,468 | | | 2,621 | | | 2,747 | | 2,511 | 2,511 |
| | Enrollment | Total number of eligible members | | 344,985 | | | 359,293 | | | 352,593 | | | 352,225 | | | |
| Advance Notice | Same Day Trips | Trips scheduled with less than 24 hr notice | 875 | 292 | 1.5% | 1091 | 364 | 1.6% | 1755 | 585 | 2.5% | 3819 | 1273 | 5.7% | 2.9% | 7,540 |
| | Standing Orders | Standing Order Trips | 33066 | 11022 | 55.2% | 40932 | 13644 | 60.0% | 41220 | 13740 | 59.8% | 37406 | 12469 | 55.9% | 57.8% | 152,624 |
| Utilization | Utilization Rate | Transportation utilization rate (completed trips/total enrollment) | | 5.8% | | | 6.3% | | | 6.5% | | | 6.3% | | 6.25% | |
| Call Center | Calls Received | Measures number of Reservations calls received | 9,565 | 3,188 | | 9,465 | 3,155 | | 9,978 | 3,326 | | 8,588 | 2,863 | | 3,133 | 37,596 |
| | Average Hold Time | Average hold time should be less than 3 min for 90% of calls | | 0:00:44 | | | 0:00:39 | | | 0:00:32 | | | 0:00:20 | | 00:34 | |
| | Service Level | Goal: 80% of calls answered within 30 seconds | | 82.0% | | | 83.9% | | | 73.6% | | | 88.5% | | 82.0% | |
| Timeliness | On Time Performance* | Goal: 90% on time for all legs | | 77.7% | | | 84.2% | | | 89.5% | | | 91.1% | | 85.6% | |
| | Will Call On Time | Goal: 90% on time for Will Call Legs | | 97.6% | | | 98.0% | | | 98.5% | | | 98.6% | | 98.1% | |

The below figure shows total NMT vs. NEMT trip volume in 2023.

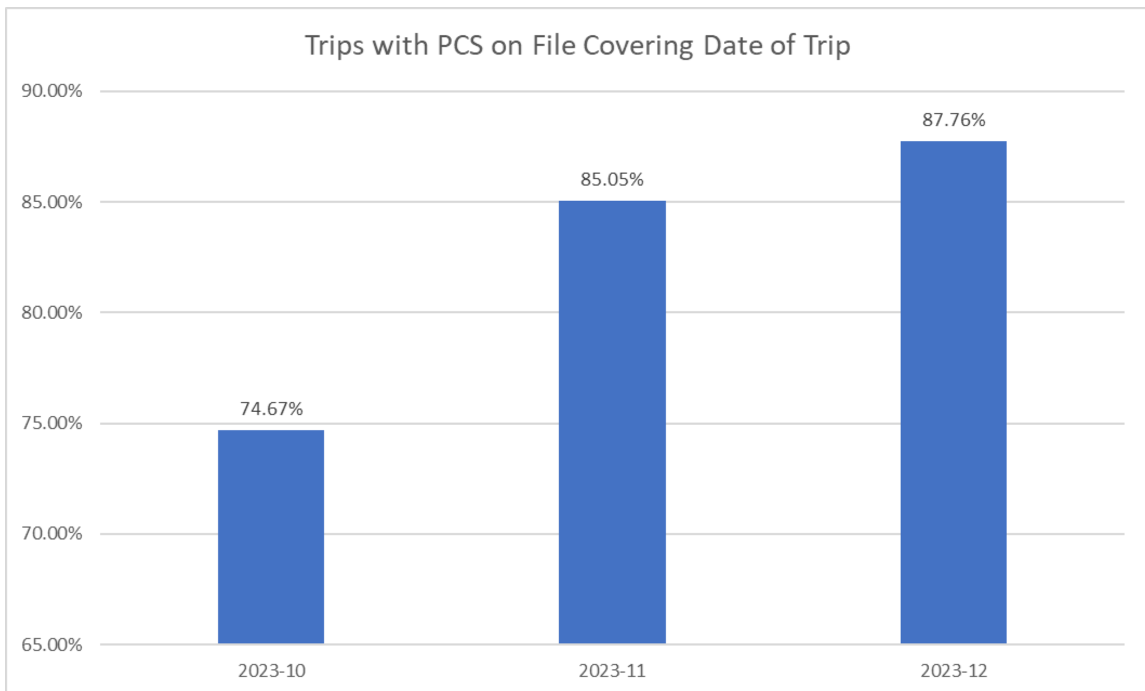
**Figure 29. Total NMT vs. NEMT trip volume**

| NMT vs. NEMT | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 |
| NEMT | 4197 | 4757 | 6426 | 6196 | 7043 | 6587 | 6627 | 7280 | 6518 | 7057 | 7000 | 7012 |
| | 17.14% | 18.92% | 21.44% | 21.32% | 20.88% | 21.36% | 21.38% | 21.49% | 21.05% | 20.40% | 20.73% | 20.49% |
| NMT | 20283 | 20381 | 23542 | 22871 | 25332 | 24959 | 24376 | 26596 | 24444 | 27528 | 26771 | 27215 |
| | 82.86% | 81.08% | 78.56% | 78.68% | 78.25% | 79.12% | 78.62% | 78.15% | 78.95% | 79.60% | 79.27% | 79.51% |




In 2023, ModivCare scheduled a monthly average of 6,392 NEMT trips and 24,525 NMT trips. Around 6% of Alliance members utilized the transportation benefit, with the top reason for transportation continuing to be transport to dialysis for members with End Stage Renal Disease.

**Figure 30. NEMT trips with PCS on file**




In 2023, the Alliance completed the insourcing of the acquisition of Physician Certification Statement (PCS) forms, previously done by the Alliance's transportation subcontractor, Modivcare. The insourcing included creation and hiring of a new position, transportation coordinators. CM leverages its relationships with PCP offices and dialysis centers to ensure timely completion of PCS forms. The Alliance worked with its analytics department to better track PCS compliance, defined as having a valid PCS form on the day of a member transportation trip. Figure 31 shows compliance hovering around 88% by end of 2023, up from an estimated 30%-50% compliance when PCS was still managed by the transportation subcontractor.

***Coordination with Compliance Department***

The Alliance CM Department works closely with the Compliance Department to prepare for regulatory audits. In April 2023, the department participated in DHCS' annual audit. There were two findings related to the care management program:

1) A repeat finding related to The Alliance not ensuring required Physician Certification Statement (PCS) Forms were on file for members receiving Non-Emergency Medical Transportation (NEMT) services. The CM department implemented DHCS' recommendation to ensure policies and procedures for obtaining and maintaining PCS forms in members' files and worked with the transportation vendor to reinforce requirements.
2) The Alliance did not ensure members' behavioral health treatment plans contained all required elements. The finding involved Beacon Health Options, given delegation of behavioral health treatment services through March 2023. With the insourcing of BH services in April 2023, the behavioral health department implemented DHCS'

recommendation to ensure members' behavioral health treatment plans contain all the required elements.

To maintain the integrity of The Alliance's CM processes, ongoing auditing and monitoring of key operational functions will continue, ensuring compliance with all federal, state, regulatory, contractual and accreditation standards.

## Member Satisfaction with the CM Process

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

The Alliance's goal is to obtain a 90% or greater overall satisfaction with the CCM program. Satisfactory results are defined as those that fall under the following categories:

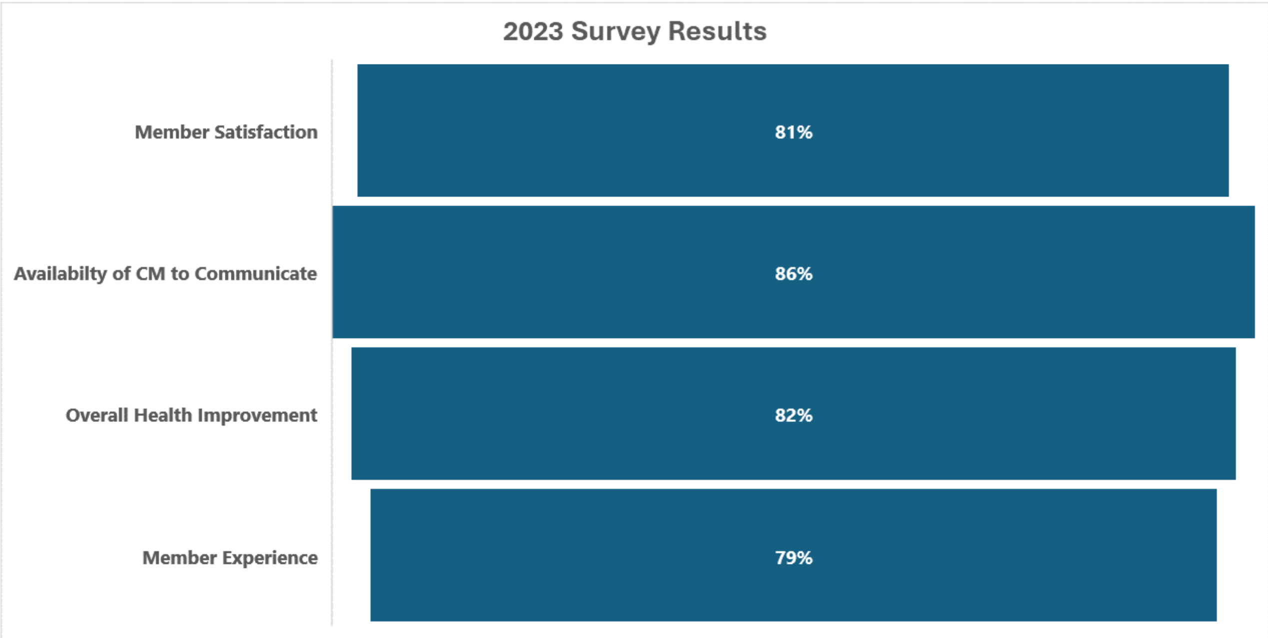
- Very Satisfied
- Much Improved
- Always True
- Highly Likely

**Figure 31. 2023 CM Member Satisfaction Survey Questions**

| Member Satisfaction |
|---|
| Are you satisfied with the amount of time spent with your care manager throughout the program?<br>How satisfied were you with the care manager listening to and understanding your concerns?<br>How satisfied were you with the information you received in managing your health? |
| **Availability of CM to Communicate** |
| When you called with questions about your health care needs, were you able to speak to your care manager? |
| **Overall Health Improvement** |
| Are you able to better manage your health condition since receiving care management services?<br>Please rate how much the Alliance Program helped your overall health and well-being. |
| **Member Experience** |
| How do you rate your overall experience with the Alliance Program?<br>How likely are you to recommend the services of this organization to your family and friends? |

In 2023, CM Department received a total of 14 surveys. Below are the results:

**Figure 32. 2023 CM Member Satisfaction Survey Results**




The overall satisfaction rate was 82%, thus not meeting the goal of 90%.

Member experience is also assessed by reviewing grievances filed against Case Management. Below are grievances filed in 2023:

**Figure 33. 2023 Complaints Filed Regarding CM Process**

| Total Non-Exempt Grievances Against CM | G&A Decision – In Favor or Member | G&A Decision – Neutral | G&A Decision – In Favor of Plan |
|---|---|---|---|
| 38 | 23 | 15 | 0 |

In 2023, there were 38 non-exempt grievances against CMDM, with 23 grievances resolved in the members' favor. Notable trends included:

- Members dissatisfied with turnaround time for returning member calls
- Members dissatisfied with ability to assist in changing decision by a provider office

***Member Satisfaction with CM - Recommended Actions for 2024:***

- Increasing the return rate of satisfaction surveys. Satisfaction surveys are attached to case closure letters, which are sent to all members who complete their CM case. CM will work on ensuring members are educated that they will receive a survey upon case closure to increase return rate.
- Continue educating members on care management process, including establishing communication plan with member and establishing mutually-agreed upon scheduled calls
- Continue educating members on effective strategies for working with provider offices, including setting realistic expectations about provider treatment protocols

## Evaluation of Delegated Case Management Activities

The Compliance Department is responsible for monitoring and tracking the overall performance of delegates, including completion of annual audits. CM department staff review the CM components of the annual audit, which includes a review of delegates' policies and procedures and member case files. The CM team also reviews the delegated entities' annual work plans/evaluations, and semi-annual reporting. The Compliance Department is responsible for finalizing the audit findings. For entities that do not meet thresholds, a corrective action plan may be issued and tracked to ensure adequate resolution of the deficiency. All audit findings are reported to the Compliance Committee and the QIHEC.

In 2023, the Compliance Department conducted annual audits on the 2 delegates with delegated CM responsibilities. The threshold for CM audit compliance was 90%. In 2023, delegate audit results for CM activities included:

- Kaiser passed the CM audit (≥ 90.0%)
- CHCN had findings and required corrective actions.

**Figure 34. 2023 Delegate Annual Audit Results (CM components only)**

| **Delegate Name** | **Provider Type** | **Delegated Activity-** Care Coordination/Case Management | **Delegated Activity-** Complex Case Management | **2023 Audit Results** | **Corrective Action Required** |
|---|---|---|---|---|---|
| Kaiser | Health Maintenance Organization (HMO) | Yes | Yes | No deficiencies found | None |
| CHCN | Managed Care Organization (MCO) | Yes | No | 1 finding File Review (91% score) *This is a preliminary finding* | Retraining of staff already addressed in 2022 audit. |
| Beacon / College Health IPA (through 3/31/23) | Managed Behavioral Healthcare Organization (MBHO) | Yes | Yes | No audit* | No audit* |

*In April 2023, Mental Health/Behavioral Health services were insourced into The Alliance and Beacon/College Health IPA was a delegate only through March 31, 2023. Efforts in Q1 2023 were focused on transitioning the impacted members from Beacon to The Alliance.

**NOTE:** Calendar year 2023 was the last year Kaiser Permanente remained a delegate with The Alliance. Kaiser Permanente contracted directly with the Department of Health Care Services

(DHCS), effective January 2024. In 2023, Kaiser and The Alliance worked together to prepare for this transition to ensure minimal disruption in care to the impacted membership.

***Delegated Case Management - Recommended Actions for 2024:***

- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance's key performance indicators.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

## Conclusion

Overall, the 2023 CM Program continued to develop into an effective program, maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The CM program activities have met most of the established targets, including a reduction in regulatory findings. The Alliance leadership has played an active role in the CM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements. To ensure that the Alliance used a comprehensive approach to designing the CM program structure, practicing physicians provided input through QIHEC. The CM program continues to analyze internal benchmarks to further enhance progress and provide quality service to the Alliance membership.

***CM Program Recommendations for 2024***

As a result of the 2023 program evaluation, opportunities for improvement have been identified and will be incorporated into the 2024 CM Program and Work Plan. A summary of process improvement opportunities is noted below:

***Operational Efficiency and Compliance***

***Basic Population Health Management (including Care Coordination for Medical and Behavioral Health Services and Disease Management):***

- Increase engagement in care coordination for medical services by continuing efforts to find alternative contact information for members through Electronic Health Records (EHR), PCP clinics, and Community Health Record (CHR)
- Work with Healthcare Analytics department to further enhance population analysis and program interventions to evaluate program efficacy
- Work with IT department to identify additional opportunities to automate processes administrative CM processes
- Further solidification of case coordination processes for behavioral health services to increase efficiency and uniformity of practice

- Further collaboration with Alameda County Behavioral Health to ensure member's needs are met across systems of care
- Further collaboration Alameda County Office of Education to coordinate school-based services
- Initiate bi-directional coordination of care between physical health and mental health providers, including deployment of PCP referral to Mental Health Web Form, enabling PCPs to communicate more completely the needs of the members they refer for mental health services that can be passed on to the Mental Health Provider to enhance their evaluation
- Behavioral Health Treatment/Applied Behavioral Health Treatment plan deployed on the Alliance Provider Portal to enable Autism Service Providers to submit their assessments and treatment plans securely, that can then be shared with referring pediatricians and PCPS.
- Continued identification of data sharing pathways between PCPs and Behavioral Health Practitioners
- Increase member engagement into Alliance Disease Management programs through member mail and call campaigns and provider education

***Complex Case Management:***

- Continue to identify, implement, and evaluate different avenues to continue to increase member engagement.
- Continue SMART goal for:
    - Collaborative efforts with partnered hospitals
    - Productivity standard of Complex member outreach and engagement
    - Obtaining accurate member contact information.
    - Continue the use of the CHR and PCP for alternate phone numbers for member engagement

***Enhanced Care Management:***

- Continue to develop, train, and maintain the ECM Provider network, in preparation for further expansion to support all ECM populations of focus.
- Provide consistent/routine monthly in-person and virtual provider audits and respective in-services to ensure ECM compliance and optimal use of ECM benefits.
- Work closely with ECM providers in monthly IDT meetings to provide guidance with the ECM graduation process.

***Transitional Care Services:***

- Continued efforts to improve member engagement rate will continue in 2024 via finding alternate phone numbers through CHR, and PCP office.
- Increased partnerships with hospital systems.
- Increased partnerships with PCP offices in collaborating on TCS, particularly post discharge appointments.
- Increased focused on specific TCS populations such as OB and FFS Medicare Part A members.

***Community Supports:***

- Transition the operational oversight of Community Supports to LTSS Director
- Launch the last two CS services (Short-Term Post-Hospitalization Housing and Day Habilitation Programs) by January 1, 2025.
- Continue to broaden CS provider network, as appropriate.
- Increase staff where appropriate as department expands to better meet needs of members and providers.
- Continue to build relationships with billing to assist providers with receiving timely payments.
- Continue to work with Analytics to further enhance a dashboard for CS services
- Continue development of accurate and reliable closed loop referral process with Community Supports providers, in alignment with the DHCS requirement by January 1, 2025; establish mechanism for CS providers to confirm members are being serviced after authorizations have been issued
- Provide training to all CS providers to promote best practices while working with our members and to continue to build rapport with CS providers

***Quality Improvement***

***Member Satisfaction with CM:***

- Increasing the return rate of satisfaction surveys. Satisfaction surveys are attached to case closure letters, which are sent to all members who complete their CM case. CM will work on ensuring members are educated that they will receive a survey upon case closure to increase return rate.
- Continue educating members on care management process, including establishing communication plan with member and establishing mutually-agreed upon scheduled calls
- Continue educating members on effective strategies for working with provider offices, including setting realistic expectations about provider treatment protocols

***Delegated Case Management:***

- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance’s key performance indicators.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance’s Population Health Management strategy