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

2024

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I. Background

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

The Alliance provides health care coverage to over 300,000 children and adults in Alameda County through the Medi-Cal and Group Care programs. Through active partnerships with healthcare providers and community partnerships, the Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan Members.

The Alliance offers an array of care management services to support a collaborative patient and provider treatment process, and to improve the health of the Member population. The comprehensive case management program assists Members and providers in aligning effective healthcare services and appropriate community resources. The activities of the comprehensive case management program support Alliance Members and providers to attain the highest level of functioning available to the Member in relation to their overall health condition. The CM Program ensures parity between medical/surgical care and behavioral health care throughout all structures and functions. The Alliance oversees and maintains the following case management services in the comprehensive case management program:

- Health Risk Assessments
- Basic Population Health Management (inclusive of Care Coordination and Disease Management)
- Complex Case Management (CCM)
- Enhanced Care Management (ECM)
- Targeted Case Management (TCM)
- Transitional Care Services
- Specialized Services (including Community Supports, Continuity of Care, California Children's Services, Major Organ Transplants, and Transportation)

This comprehensive case management program description includes a discussion of program scope, objectives, structure and resources, population assessment, clinical information systems, care coordination and case management services, and monitoring and oversight processes that ensure quality assurance of CM program interventions.

II. Program Purpose and Scope (including Goals and Objectives)

The purpose of the Alliance comprehensive case management program is to provide case management processes and structures to Members who may have complex health needs. Case management is defined by the Case Management Society of America (CMSA) as:

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

The Alliance 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.

Goals for the CM program include:

- Maximize the quality of life and promote a regular source of care for patients with chronic conditions
- Improve Member engagement as active participants in the care process
- Improve health, including behavioral health, outcomes
- Support the foundational role of the primary care physician and care team to achieve high-quality, accessible, and efficient health care
- Coordinate with community services to promote and provide Member access to available resources in the Alliance service area
- Provide person-centered support, education, and advocacy to Members in collaborative communications and interactions
- Engage the provider community as collaborative partners in the delivery of effective healthcare
- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards

Objectives of the CM program are stated to support concrete measurements that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to the Alliance Membership. The objectives of the program include:

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

III. 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.

A. Board of Governors

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.

The QIHEC and UMC are responsible for the review and assessment of the CM program performance against objectives during the annual program evaluation, and if appropriate, provide recommendations for improvement activities or changes to objectives.

B. Quality Improvement Health Equity Committee (QIHEC)

The QIHEC provides oversight, direction, makes recommendations, and has final approval of the CM Program. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates. A full description of the QIHEC Committee responsibilities can be found in the most recent Quality Improvement Program Description.

The QIHEC provides the external physician involvement to oversee The Alliance QI and UM Programs. The QIHEC includes a minimum of four (4) practicing physician representatives with active, unrestricted licenses to practice in the State of California. The composition includes the Senior Director of Behavioral Health and/or a Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized

criteria, development of policies and procedures, and case review, as needed.

The QIHEC functional responsibilities for the CM Program include:

- Annual review and approval of the CM Program Description
- Annual review and approval of CM Policies and Procedures
- Oversight and monitoring of the CM Program, including:
  - Define the strategies direction for population health
  - Define the goals and measures to the target population
  - Integration of medical and behavioral health activities
  - Assist in identifying populations at high-risk for poor health outcomes, along with potential programs/services to be provided
  - Recommend policy decisions
  - Oversight of interventions to the provision of the programs and services
  - Recommend necessary actions

C. Utilization Management Committee (UMC)

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

UM Committee Membership

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

- The Alliance Chief Analytics Officer
- The Alliance Medical Director, UM
- The Alliance Medical Director, CM
- The Alliance Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement
- The Alliance Senior Director, Pharmacy
- The Alliance Senior Director, Health Care Services
- The Alliance Senior Director, Behavioral Health
- The Alliance Senior Director, Healthcare Analytics
- The Alliance Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director, Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Director, Social Determinants of Health
- The Alliance Director, Utilization Management
- The Alliance Director, Long-Term Supports and Services (LTSS)
- The Alliance Manager, Case Management

- The Alliance Clinical Manager, Enhanced Care Management
- The Alliance Manager, Utilization Management
- The Alliance Manager, Long-Term Care (LTC)
- The Alliance Manager, Grievance & Appeals

UMC Voting Privileges
For the purposes of voting, only physician and Director-level members of the UMC may vote.

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

UMC Meetings
The UMC meets at least once every 2 months, but as frequently as necessary. The meeting dates are established and published each year.

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

UMC Functions
The UMC is a forum for facilitating clinical oversight and direction. Its purpose is to:

- Improve quality of care for the Alliance Members
- Evaluate and trend enrollment data for medical and behavioral health services provided to Alliance Members and benchmarks for care management program utilization.
- Provide a feedback mechanism to drive quality improvement efforts.
- Increase cross-functional collaboration and provide accountability across all departments in Health Care Services.
- Provide mechanism for oversight of delegated CM functions, including review and trend CM reports for delegated entities to identify improvement opportunities
- Identify behaviors, practices, patterns, and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of providers and network
- Maintain the annual review and approval of the CM Program & Evaluations, CM Policies/Procedures, CM Criteria, and other pertinent CM documents such as the CM Delegation Oversight Plan.
- Review and analysis of utilization data for the identification of trends
- Assist in monitoring performance of CM activities and recommend appropriate actions when indicated.

The UMC also evaluates the impact of CM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes.

D. Staff Resources

The Alliance's Case Management Department (see Appendix A) is responsible for comprehensive case management programs and activities. The Behavioral Health Department (see Appendix B) is responsible for behavioral health case management activities, including triage, referral, and participation on the multi-disciplinary case management teams. The following are the primary staff with roles and responsibilities in the implementation of the comprehensive case management program:

Chief Medical Officer

The Chief Medical Officer (CMO) is the designated Board Certified in his/her specialty and California licensed physician with responsibility for development, oversight, and implementation of the comprehensive case management program. The CMO provides guidance for all clinical aspects of the program. The CMO serves as the chair of the HCQC and makes periodic reports to the HCQC regarding comprehensive case management program activities and the annual program evaluation. The CMO works collaboratively with the Alliance network physicians to continuously improve the services that the comprehensive management program provides Members and providers.

Medical Director

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

Senior Director, Health Care Services

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

Senior Director, Behavioral Health Services

The Senior Director, Behavioral Health Services is a licensed Psychologist and is responsible for the overall Behavioral Health department operations, staff training, and coordination of services between departments. The Senior Director's management responsibilities include:

- Develop and maintain the Behavioral Health (BH) Program in collaboration with the Senior Medical Director of Quality and the CMO.

- Coordinate BH activities with the Quality, UM, Case Management, Member Services Departments, as well as other Alliance units.
- Maintain compliance with the regulatory standards.
- Maintain professional collaboration with Alameda County Behavioral Health Care Services (ACBHCS) to coordinate care and care transitions across behavioral health care systems.
- Coordinate interventions with the Senior Medical Director and the CMO to address under and over utilization concerns when appropriate.
- Develop and monitor data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies.
- Monitor for consistent application of utilization criteria by BH staff, for each level and type of UM decision.
- Monitor for consistent application of Triage and Referral criteria by BH staff for each type of behavioral health service

Director, Social Determinants of Health

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

Director, Long Term Services and Supports

The Director of Long-Term Services and Supports provides operational leadership to the Long-Term Services and Supports and Community Supports programs and staff. The Director provides guidance to the various programs with a focus on analytics, operations, and regulatory adherence. The Director assists with collaboration of the programs with other stakeholders. The Director develops the programs' goals and operationalizes processes needed to successfully commence and complete the desired goals.

Manager, Case Management and Disease Management

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

Manager, Behavioral Health

The Manager of Behavioral Health is responsible for the daily oversight of the care coordination program for behavioral health. This includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and HCQC. This position was newly created in Fall 2023 to further support the care coordination efforts within Behavioral Health.

Clinical Manager of Enhanced Care Management

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

Supervisor of Case Management and Disease Management

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

Non-Clinical Supervisor of Case Management and Disease Management

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

Supervisor of Community Supports

The Supervisor of Community Supports provides daily oversight over the Community Supports services. Under the supervision of the Director of Long Term Services and Supports, the scope of responsibilities of the Supervisor of Community Supports include supervision of department staff; allocation and management of program resources; and accountability for the quality of care and services.

Lead Complex Case Manager, Nurse

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

Complex Case Manager, Nurse

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

Enhanced Care Management, Nurse

The Alliance uses licensed California registered nurses in the role of the Enhanced Care Management, Nurse. The Enhanced Care Management nurse provides collaborative assistance for Enhanced Care Management (ECM) providers. The ECM nurse participates in regular interdisciplinary team rounds with each ECM provider clinic site and offers clinical support and recommendations to ECM providers to assist with members enrolled in ECM. The ECM nurse also assists with clinical review for ECM authorizations.

Community Supports, Nurse

The Alliance uses licensed California registered nurses in the role of the Community Supports, Nurse. The Community Supports nurse provides collaborative assistance for Community Supports (CS) providers. The CS nurse participates in regular meetings with each CS provider and offers clinical support and recommendations to CS providers to assist with members receiving CS. The CS nurse assists with clinical review for all CS authorizations requiring a clinical review. If members need continued services past an expired authorization, the CS nurse reviews all requests and corresponding justification to determine whether services can be appropriately continued.

Social Worker

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

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

Health Navigator

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

Community Supports Coordinator

Under guidance from the Supervisor of Community Supports, the Community Supports Coordinator works with Community Supports providers to process authorizations into AAH's information system of record. The Community Supports Coordinator works with the Medical Director and Supervisor to perform follow up management to meet specific turn-around times for authorizations. They also assist with coordination of weekly meetings with Community Supports providers and facilitate communication to meet appropriate authorization regulatory requirements.

Transportation Coordinator

Under guidance from the Manager of Case Management or the Supervisor of Case Management the Case Management Coordinator supports the case management department through assisting with ensuring that members receive transportation as needed to all covered services, acting as a coordinator between providers, the Transportation Vendor, members and AAH staff.

Case Management Coordinator

Under guidance from the Manager of Case Management or the Supervisor of Case Management the Case Management Coordinator supports the case management department through assisting with administrative duties. The Case Management Coordinator providers the member with individualized, patient-center support and assistance to help guide the member across the continuum of the healthcare delivery system.

Health Assessment Coordinator

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

Behavioral Health Triage Specialist

Under guidance from the Senior Director of Behavioral Health, Behavioral Health Triage Specialists provide the behavioral health case management components for members to enables integration of physical and behavioral health to address the member's whole person health needs.

The Alliance uses California Licensed Clinical Social Workers, Licensed Marriage and Family Counselors and Licensed Psychologists in the role of the Behavioral Health Triage Specialist. The Behavioral Health Triage Specialist provides case management services for health plan Members with highly complex behavioral health conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within a multi-functional team, the Behavioral Health Triage Specialist coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

Behavioral Health RN Case Manager

Under guidance from the Senior Director of Behavioral Health, Behavioral Health RN Case Managers provide the behavioral health case management components for members to enables integration of physical and behavioral health to address the member's whole person health needs. Additionally, the Behavioral Health RN Case Manager participates in the multi-disciplinary case management team when there are psychiatric conditions impacting the members health outcomes to ensure psychiatric conditions are addressed in coordination with physical health conditions.

The Alliance uses California Licensed registered nurses who have specialized in psychiatric/mental health nursing in the role of the Behavioral Health RN Case Manager. The Behavioral Health RN Case Manager provides case management services for health plan Members with highly complex behavioral health conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within a multi-functional team, the Behavioral Health RN Case Manager coordinates with the Member,

Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

Applied Behavioral Analysis (ABA) Analyst

Under guidance from the Senior Director of Behavioral Health, the ABA Analyst provides the behavioral health therapy/Applied Behavioral Analysis (ABA) case management components for members to ensure member under the age of 21 who need ABA services for the treatment of Autism or other developmental conditions receive medically necessary services.

The Alliance uses Board Certified Behavioral Analysts (BCBA) in the role of the ABA Analyst. The ABA Analyst provides case management services for health plan Members with Autism or other developmental conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within the behavioral health team the ABA Analyst coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

Behavioral Health Navigator

Under the guidance of the Senior Director of Behavioral Health, the Behavioral Health Navigator is responsible for the non-clinical support of the Alliance Behavioral Health Department. The Behavioral Health Navigator is responsible for the non-clinical support of members who need assistance in accessing the behavioral health services they need. The Behavioral Health Navigator supports the Behavioral Health Department's clinical staff in following through on referrals and services to ensure member health care needs are met. The Behavioral Health Navigator is also responsible for the management of mailings and data entry of hardcopy documents received for entry into the clinical information system.

Liaisons

Liaisons are members of the care management team who have subject matter expertise with the population and/or entity they are assigned to. Liaison names and contact information are shared with DHCS, and their roles and responsibilities are as follows:

- California Children's Services (CCS) Liaison: serves as the primary point of contact responsible for the CCS members' care coordination. CCS liaisons must receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS Children
- Foster Care Liaison: has expertise in Child welfare services, County Behavioral Health Services, and ensures appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend meetings of the Child and family teams, in

accordance W&I section 16501(a)(4); Ensure Covered services are closely coordinated with other services, including social services and Specialty Mental Health Care Services; Act as a resource to ECM Providers providing services to Child welfare-involved Children and youth, provide technical assistance to Contractor and ECM Provider staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with County and community partners; Coordinate with foster care liaisons for other Medi-Cal managed care plans to notify them when Members cross county lines and/or change managed care plans; Serve as a family advocate.

- Justice-Involved (JI) Liaison: support correctional facilities, pre-release care management providers, and/or ECM providers in the re-entry planning process
- Regional Center Liaison: coordinate with each RC operating within Contractor's Service Area to assist Members with Developmental Disabilities (DD) in understanding and accessing services, and to act as a central point of contact for questions, access and care concerns, and problem resolution
- Dental Liaison: be available to Medi-Cal dental Providers to assist with referring the Member to other Covered Services, including but not limited to, laboratory services, and pre-admission physical examinations required for admission to an outpatient surgical service center, or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services)
- In-Home Support Services (IHSS) Liaison: day-to-day liaison with county IHSS agency; sufficiently trained on IHSS assessment and referral processes and providers, and how the Alliance and PCPs can support IHSS eligibility applications and coordinate care across IHSS, medical services, and long-term services and supports; includes training on IHSS referrals for Members in inpatient and SNF settings as a part of Transitional Care Service requirements, to support safe and stable transitions to home and community-based settings

IV. Population and Member Needs Assessment

The Alliance routinely assesses the characteristics and needs of the Member population, including relevant subpopulations. The Alliance analyzes available enrollment and census data, in combination other data sources, including but not limited to:

- Product lines and eligibility categories
- Language and subpopulations
- Race and ethnicity
- Age
- Gender
- High volume diagnoses
- Results of Health Risk Assessments (HRA)
- Chronic and co-morbid medical conditions
- Laboratory Reports

- Internal department data sources
- Utilization history (including claims and authorizations for medical, behavioral, and pharmacy services)

To effectively address Member needs, after the collection of Member population data, the CM Medical Director, Senior Director of Health Care Services, Senior Director of Behavioral Health, Director of Social Determinants of Health, and Manager of Case Management and Disease Management analyze and review the data to determine any necessary updates to the processes and resources of the comprehensive case management program. The information gathered in this process is used to further define and revise the program's structure and resources, including the following types of factors:

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

V. Case Management Clinical Systems

A. 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.

B. Clinical Decision Support Tools

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

VI. Case Management Services

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

- Health Risk Assessments
- Basic Population Health Management (inclusive of Care Coordination and Disease Management)
- Complex Case Management (CCM)
- Enhanced Care Management (ECM)
- Targeted Case Management (TCM)
- Transitional Care Services
- Specialized Services (including California Children's Services, Community Supports, Continuity of Care, Major Organ Transplants, and Transportation)

To effectively deliver case management services, 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 various 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
- Self-referrals from members/authorized representatives
- Direct referrals from provider networks
- Internal referrals (including Utilization Management, Member Services, Appeals and Grievance, Leadership)
- Predictive modeling

After members are identified as candidates for care management, they are aligned to the appropriate case management service. Each service component is described in further detail below.

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

For members stratified as lower risk, members receive the HRA questionnaire via mail, and also receive interactive voice calls encouraging them to return the questionnaire to complete the HRA process. For members stratified as high-risk, CM staff initiate outreach to the member to attempt completion of the HRA over the phone. The responses from the HRA may result in the reclassification of Members as higher or lower risk (for some members, risk-level based on their HRA responses may be different from their earlier stratification based on the stratification tool/data). 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.

SPD members are reassessed annually in the month of their enrollment. All HRAs are reviewed by a Social Worker, whether a member is identified as Low-Risk or High-Risk, to determine needs or any changes in condition. For High-Risk Members, the assigned Care Manager is responsible for ensuring the HRA is completed, and the Care Plan updated accordingly. For Members identified as Low-Risk, the Alliance uses utilization data to re-stratify Members. Members that are re-stratified from Low to High-risk based on annual re-assessment activities are referred to a CM Nurse for further assessment and development of a Care Plan. If the member continues to be stratified as Low-Risk in the annual re-assessment, the member is provided a standardized care plan and informed of the availability of CM as needed.

B. Care Team Roles and Responsibilities

Case Management services are provided using a combination of care teams:

- The core care team is comprised of an RN Complex Case Manager, Health Navigator and Social Worker, working together to manage a group of Members with complex and care navigation needs.
- The extended care team supports specific needs of the core care team. The extended care team members work across functional areas to provide additional support and interventions, as needed. The extended care team may include Medical Directors, pharmacy, behavioral health, utilization management, long-term care and health education.

Care teams are assigned specific roles to address the needs of Members. The CM Nurse will serve as the medical lead for the team. The role of the CM Nurse is to ensure the CM assessments and follow-up are completed in a timely manner. The CM Nurse will communicate the outcomes of each assessment with the other team Members to ensure the team is knowledgeable on care needs and understands their role in the care plan. The Behavioral Health Triage Specialist or the Behavioral Health RN Case Manager is engaged in the Care Team when behavioral health conditions are identified. The teams are directed by defined workflows and serve as sources to identify and refer Members to other programs, including Enhance Care Management (ECM), Community Supports (CS), and behavioral health services. Communication is key to the effectiveness of the program, with the care team meeting daily to discuss member needs and expectations.

Extended Care Team Members are consultants to the core care team. As needed, the CM Nurse will coordinate care team discussions to address identified care needs. This may

include medication reconciliation or adherence issues, behavioral health concerns, social determinates of health best managed using community resources, or health literacy issues.

C. Basic Population Health Management Services

Basic Population Health Management (BPHM) is available to all 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.

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

- Initial Health Assessment (IHA) (including a history and physical evaluation sufficient to assess the acute, chronic, and preventive health needs of the Member)
- Identification of appropriate providers and facilities (such as medical rehabilitation, and support services) to meet Member needs.
- Direct communication between the provider and Member, family and/or caregiver.
- Member, caregiver and/or family education, including healthy lifestyle changes when warranted.
- Coordination of carved out and out of plan services, and referral to appropriate community resources and other agencies.

Care Coordination

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

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

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

Once a member is identified and referred for care coordination, they are assigned to an Alliance lead Case Management unit for screening, referrals, care planning, and all other care coordination activities. Members are matched to the Case Management staff that is specialized based on the prominence of needs. Though there is one assigned "lead," the support and expertise of other units may be harnessed to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those Members who are diagnosed with medical, functional, cognitive, and psychosocial conditions. Health Navigators, Social Workers or Case Managers are responsible for the following services:

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

Disease Management

The Alliance has four disease management programs as a part of the overall Population Health Management strategy. Disease Management (DM) programs provide health education interventions, seek to close care gaps, and focus on improving equity and reducing health disparities. Disease Management programs aim to improve the health

status of its participants through assessment, support with adherence to treatment plans, health coaching, and care coordination.

All program interventions are based on data-identified patient needs and are developed using evidence-based practice guidelines and care pathways. Members are identified for engagement by claims, pharmacy, and lab data and direct referrals from Alliance staff, physicians, and community partners. Current Alliance Disease Management programs address the following conditions:

- Diabetes
- Cardiovascular Disease
- Asthma
- Depression

The Alliance Disease Management (DM) Programs will:

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

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

Alliance Disease Management Programs

Disease state	Program name	Criteria	Key program offerings	Member outreach
Asthma	**Asthma Remediation Services**	Alliance Medi-Cal members ages 0-18 with poorly controlled asthma.	Asthma education, tools, and home modifications to improve asthma management.	Letter and telephonic outreach
Asthma	**Happy Lungs**	Members 18 years or younger with lower-risk asthma and their caregivers.	Opportunity to engage in pediatric asthma case	Educational letter and an invitation to engage in pediatric

Disease state	Program name	Criteria	Key program offerings	Member outreach
			management services.	asthma services.
Asthma	**Living Your Best Life with Asthma**	Members 19 years or older with lower risk asthma.	Opportunity to receive Alliance care management, health coaching, health education, care coordination or other services based on need.	Educational letter with an invitation to engage with the Alliance for additional resources.
Diabetes	**Living Your Best Life with Diabetes**	Members 19 years and older with diabetes.	Opportunity to receive Alliance care management, health coaching, health education, care coordination or other services based on need.	Members identified at lower risk will receive an educational letter and an invitation to engage with diabetes management programs. Members identified with diabetes at a higher risk of worsening outcomes will also receive an outreach call.
Hypertension	**Living Your Best Life with a Healthy Heart**	Members aged 18 – 85 years or older with high blood pressure.	Opportunity to receive Alliance care management, health coaching, health education, care coordination or other services based on need.	Educational letter and an invitation to engage with the Alliance for additional resources. Members identified with high blood pressure at a higher risk will also receive an outreach call.

Disease state	Program name	Criteria	Key program offerings	Member outreach
Depression	**Birthwise Wellbeing**	Members between the ages 18-50 who are pregnant, or have given birth within the past year	Opportunity to receive assessment, care coordination to access behavioral health services, and perinatal health education services.	An educational flyer in the Alliance Baby Steps packet of educational materials for a healthy pregnancy. Members identified as higher risk for depression may also receive an outreach call.

Identification and Screening

Disease Management (DM) services at the Alliance are provided to all Alliance members with a diagnosis of diabetes, asthma, hypertension, or depression who meet the age criteria specified in the above table and are identified as eligible based on clinical, pharmacy and utilization data or direct referral.

Members are identified for program eligibility through one of the following:

a. Monthly report from HealthCare Analytics department utilizing claims, encounter, and pharmacy data. The report is further risk stratified according to the program criteria (see below).
b. Health Risk Assessment (HRA) for Medi-Cal Seniors and Persons with Disability (SPD). Members are identified as eligible with the appropriate age and diagnoses eligible for the DM program, and have a score calculated from HRA answers that may impact the member's health. The list of members meeting these criteria will be provided to the Intake Department for further processing.

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

The Alliance informs practitioners about the DM programs and how to refer members through multiple methods, including, Provider Services educational material, Alliance webpage, and Provider bulletins. The communication methods describe how to use disease management services and how the Alliance works with their patients enrolled in

DM. Training and/or targeted communications for key referral sources such as the CM department, UM department, Member Services, Hospital Discharge planners occur at least annually.

Information needed for a DM referral includes:

a. Referral or data source (name, affiliation, and contact information).
b. Date referral received by Intake. If secondary referral, document initial contact information and date.
c. Member information
d. Reason for referral
e. Diagnosis (asthma, diabetes, hypertension, or depression)
f. Level of urgency
g. Additional information, as necessary.

DM Risk Stratification

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

    1. **High Risk Diabetes:** Eligible age members with diagnosis of diabetes and other comorbidities and potentially significant risk factors, such as history of hospital or ER admission.
    2. **Moderate Risk Diabetes:** Eligible age members with diabetes and identified gaps in care. Members with a diagnosis of diabetes will be initially classified as Moderate Risk and referred to the Health Navigator to determine appropriate risk stratification.
    3. **Low risk Diabetes:** Eligible age members with diagnosis of diabetes and who do not fall into the high or moderate risk category.
    4. **High Risk Asthma:** Eligible age members identified with pediatric asthma, ER and hospital utilization, and asthma medications. Members with a diagnosis of asthma will be classified as High Risk and referred for outreach and follow up..
    5. **Low Risk Asthma:** Eligible age members not in the high-risk category.
    6. **High Risk Hypertension:** Eligible age members with at least one hypertension medication in the last year or whose blood pressure was not adequately controlled as defined by HEDIS Controlling High Blood Pressure (CBP) measure and frequent inpatient, emergency room visits or readmissions. Members with a diagnosis of hypertension will be classified as High Risk and referred to the Health Navigator for appropriate follow up and interventions.
    7. **Low Risk hypertension:** Eligible age members with a diagnosis of hypertension and at least one hypertension medication in the last year or whose blood pressure was not adequately controlled as defined by HEDIS Controlling High Blood Pressure (CBP) measure.

8. **High Risk Perinatal Depression:** Eligible age members identified as pregnant or having given birth within the past year and who have a prescription for anti-depressants or anti-psychotic medications in the past year. Members with a diagnosis of depression will be classified as High Risk and referred for outreach and follow up.
9. **At Risk Perinatal Depression:** Age-eligible members identified as pregnant or having given birth within the past year, not in the high-risk category.

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

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

Upon receipt of the necessary information for a referral, the CM/DM designee documents the referral into Clinical Information System. Members assigned to a delegate entity that provides Disease Management will be referred to the delegate. If the member is no longer eligible for services, the case should be closed and the reason for case closure will be marked as transitioned to a lower level of care, or Other.

Enrollment

1. High-Risk and Moderate-Risk Programs. Referrals will be assigned to staff based on existing caseload and specialization.
    a. Case Managers (CMs) and Health Navigator staff assigned to the case will outreach to members for further engagement regarding disease management program enrollment and/or update the member's existing Care Plan with the new information.
    b. Case Management will document one of the following programs member is enrolled into, by opening an appropriately corresponding case:
        i. DM – Diabetes High Risk
        ii. DM – Diabetes Moderate Risk/Navigator
        iii. DM – Hypertension

2. Low Risk Programs: Members identified for the Low-Risk programs will be counted as enrolled by sending the appropriate DM low-risk Letter.

Assessment

1. Upon engagement from the member, staff will complete the appropriate intake assessment within the Clinical Information System.
2. Procedures for conducting assessments are addressed in *CM-001, CCM Identification, Screening, Assessment and Triage Policy*. Along with assessment questions regarding

co-morbidities, cognitive deficits, psycho-social issues, depression, physical limitations and health behaviors, additional questions specific to the disease management condition have been added to the DM High Risk assessments.

DM Plan Development and Management

1. The steps in developing the Care Plan involve:
   a. Development of case management goals, including prioritized goals
   b. Identification of barriers to meet the goals and complying with the plans
   c. Development of schedules for follow-up and communication with members
   d. Development and communication of member self-management plans
   e. Assessment of progress against CCM plans and goals, and modifications as needed

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

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

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

DM Case Evaluation and Closure

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

High Risk Program enrollees will be evaluated for closure to DM services using *CM-003, Policy and Procedure, Complex Case Management Plan Evaluation and Closure Evaluation and Closure criteria.* Diabetes DM Program enrollees will also be evaluated for closure to DM services using CM-003 P&P criteria.

All closure actions will be documented in the Clinical Information System. At the time of case closure, a satisfaction survey, and a case closure letter if appropriate will be sent.

D. 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. Complex Case Management includes at a minimum the following elements:

- Case Management services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- Intense coordination of resources to ensure Member regains optimal health or improved functionality.
- With Member and PCP input, development of care plans specific to individual needs and updating at least annually.

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

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

Identification of Eligible Members

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 (see Appendix D) are subject to change, based on findings from the population needs assessment and/or community and stakeholder committees. Criteria are developed under the guidance of the Chief Medical Officer, and routinely, but no less than annually, evaluated to ensure Members at high-risk of poor health outcomes receive the appropriate level of care management support. Typically, CCM supports 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
- Mental Health diagnosis
- Complex Psychosocial Needs (i.e., Homelessness)

Referral Process

Referrals to CCM can be made by members, caregivers, practitioners/providers (including PCPs and Specialists), hospitals or facilities, and internal departments (including UM, Member Services, Disease Management, Behavioral Health, and Grievance & Appeals). A CM clinician (nurse or social worker) may also deem a member eligible for CCM if they feel a member could benefit from CCM services.

The Alliance also employs proactive strategies to identify members meeting criteria for CCM, including but not limited to:

- 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*
- Inpatient census reports
- Hospital discharge reports
- Health Risk Assessments (HRA)
- Readmission Report
- Laboratory Results
- Claims and pharmacy data
- Admission, Transfer, Discharge (ADT) report

Program Interventions

Members referred for CCM are reviewed by CM triage nurses, taking into consideration the known information about the case from claims history, medical records that may be on file for UM purposes, and Member Services call history. The triage nurse verifies Member appropriateness for CM, and if determined as appropriate then a case is opened in the care management information system and assigned to a Case Manager. If the Member does not meet criteria for complex case management, the Member may be referred to the other Alliance program for coordination of care, assistance in managing risk-factors, referral to community services or assistance in identifying a primary care practitioner. Members are deemed ineligible if they do not have active Alliance eligibility or are receiving another duplicative CM service.

The Alliance considers a member enrolled in case management when they are given a program overview and provides verbal or written consent to program enrollment. The encounter establishing eligibility is tracked in the Clinical Information System as a CCM Consent Note. The Member may opt out of CCM services at any time during the process. Members who make the decision to opt out of CCM are offered the opportunity to enroll

again into CCM upon request or by outreach from The Alliance upon a new triggering event.

Once a member is enrolled in CCM, the Case Manager is responsible for the following services:

A. Identification of Care Needs

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

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

An initial assessment is performed as expeditiously as the Member's condition requires (and may be completed by multiple calls), but always within 30 calendar days of the Member becoming eligible. At the time of the assessment, the Case Manager obtains consent to participate in the complex case management program and information about the Member's primary care practitioner, identifies short-term and long-term needs and initiates the care plan. If the Member declines complex case management services, the Member may be referred to the community services or assistance in identifying a primary care practitioner.

As part of the General Assessment, the Case Manager reviews and documents the member's clinical history, including disease onset; key events such as acute phases; inpatient stays; treatment history; and current and past medications, including schedules and dosages. All clinical documentation is collected and stored in a secure clinical information system and is organized in structured templates to facilitate efficient access and use of information. Assessment components are further detailed below, and information gathered in the assessment is used to identify care gaps and potential barriers to care.

- **Assessment of Activities of Daily Living** – evaluates Member functional status related to activities of daily living such as eating/feeding, bathing, dressing, going to the toilet, continence, transferring, and mobility.
- **Assessment of Behavioral Health Status Including Cognitive Functions** – evaluates mental health status, including psychosocial factors, cognitive functions, and depression; also includes evaluation of the member's ability to communicate, understand instructions, and their ability to process information about their illness. An alcohol and drug use screen are also included in the assessment, and

referrals are made to the behavioral health Triage Specialists or behavioral health RN Case Managers to collaborate with the Complex Case Management Team for Members, as needed.

- **Assessment of Social Determinants of Health –** evaluates for social determinants of health barriers, which are economic and social conditions that affect a wide range of health, functioning and quality of life outcomes and risks that may affect a member's ability to meet their health goals; assessment includes questions on:
    - Current living situation, such as homelessness
    - Issues related to obtaining or using medications.
    - Transportation issues in meeting healthcare needs
    - Overall financial concerns that impacts member's well-being

- **Assessment of Life-Planning Activities** – evaluates member preferences about healthcare and treatment decisions that may impact their care, including life planning activities (including wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life Sustaining Treatment (MOLST or POLST forms); life planning materials can also be mailed, as appropriate (e.g., advance directive)

- **Evaluation of Cultural and Linguistic Needs, Care Preferences or Limitations** – determines communication methods best suited for the Member, cultural and linguistic needs, care preferences or limitations; also includes assessment of any personal, religious, cultural preferences or any cultural restrictions to consider in a their care

- **Evaluation of Visual and Hearing Needs, Preferences or Limitations** – determines any visual and hearing needs, preferences or limitations, including details such as use of hearing aids and eyeglasses

- **Evaluation of Caregiver Resources and Involvement** – determines any family and/or caregiver involvement in decision-making about the member's care

- **Evaluation of Health Plan Benefits and Community Resources** – determines access to resources that may impact care, including caregiver, community, transportation, and financial resources delivered by local, county, and state agencies as well as disease-specific organizations, ECM, CS, and philanthropic groups to provide services such as community mental health, transportation, wellness organizations, palliative care programs, and nutritional support. United Way, Meals on Wheels and the American Cancer Society are examples of programs with available assistance.

B. Care Plan Development

Following the initial assessment, the Case Manager and/or Social Worker develops an Individualized Care Plan (ICP), consisting of goals and interventions. Case Managers must develop an ICP within 30 calendar days of completing an initial assessment. The Case

Management staff incorporate information from the initial assessment, as well as other assessments such as Health Risk Assessments, Pharmacy profile, specialized assessments, such as PHQ-9 or PHQ-2, that may be included in the Initial Assessment, HRA and Health Information Form/Member Evaluation Tool.

The Care Plan includes a personalized Person-Centered planning and treatment approach that is collaborative and responsive to meet Member specific health care needs. The ICP is a comprehensive, individualized, interdisciplinary action plan that includes varying types of goals such as clinical milestones, pain management, addressing care gaps, and Member self-management. The Person-Centered approach involves the development of the care management plan with Member input regarding preferences and choices in treatments, services, and abilities. Working with the Member, the Case Manager or Social Worker establishes and documents a set of prioritized goals.

Case Managers establish care plan goals with the following characteristics:

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

barriers. Barriers may be assessed at the individual goal level (such as limited transportation to physical therapist) or at the case level (such as Member is in denial about prognosis).

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

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

Care plans also assess the level of care settings, i.e., home health, custodial care, adult, or child day care. Case Managers or Social Workers determine the appropriate setting, education and training required, and community network resources required to achieve a desired level of functioning/independence. In some cases, a specialist, or multiple specialists, in lieu of the Member's PCP, best positioned to provide the most appropriate care. In these situations, the care manager discusses this option with the Member's PCP and the specialist(s) and arranges for a standing referral to the specialist(s). The care manager notifies the Member that he/she will have direct access to the managing specialist for a specific period.

C. Identification of Barriers to Care

The CM identifies and addresses the Member's beliefs and concerns about their condition and any perceived or real barriers to their treatment such as access, transportation, and financial barriers to obtaining treatment. The Care Plan identifies barriers to care and interventions to reduce or resolve Member specific healthcare barriers. Additionally, cultural, religious, and ethnic beliefs are assessed that may impact the condition being managed. Based on the assessment of these psychosocial issues, interventions may be modified. Examples of such issues include:

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

D. Communication with Member

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

The Case Manager arranges follow-up interactions with members to review progress towards their care plan goals, including but not limited to, counseling, referral to disease management, education, or self-management support. The Case Manager also evaluates whether previously identified barriers to goals are impeding progress and may work with members to adjust their care plan and goals, as needed.

E. Coordination of Services

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

F. Monitoring of PCP Services

Alliance Case Management staff monitor the Member's condition, responses to case management interventions, and access to appropriate care. The Alliance ensures the PCP performs the necessary activities of case management services such as the IHA and identification of appropriate healthcare services.

G. Case Closure

The PCP in collaboration with Alliance Case Management staff terminate case management services for Members based on established case closure guidelines. For Members that do not meet the closure criteria with 90 calendar days of enrollment, the Case Management staff will present the case to the Inter-Disciplinary Care Team (ICT) to evaluate whether established goals are appropriate, and if additional goals are needed or referrals to additional services are warranted. The criteria for case closure include:

- Goals met
- Interventions not successful/All resources exhausted

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

Inter-Disciplinary Care Teams

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

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

ICTs are held bi-weekly to discuss complex care planning, and to provide support and direction to the dedicated care teams.

E. Enhanced Care Management (ECM)

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 SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

The Alliance has contracted with community-based agencies to deliver Enhanced Care Management (ECM). The purpose of the program is to build community infrastructure to improve integration, reduce unnecessary utilization of health services and improve health outcomes. The ECM providers include both clinic-based CBOs and social agencies (see Appendix H), and serve the below Populations of Focus:

1. Adults & Children/Youth Experiencing Homelessness
2. Individuals At Risk for Avoidable Hospital or ED Utilization
3. Individuals with Serious Mental Health and/or SUD Needs
4. Individuals Transitioning from Incarceration
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) with Additional Needs Beyond the CCS Condition
8. Children and Youth Involved in Child Welfare
9. Birth Equity Population of Focus

ECM service includes:

- Outreach & Engagement
- Comprehensive Assessment & Care Plan
- Enhanced Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Member & Family Supports
- Coordination of & Referral to Community & Support Services

Program activities focus on transitioning from a fragmented and siloed approach provided by various health delivery systems, county/community programs and health plans to an integrated county-wide program focused on accessible shared health information, effective linkages to county resources, and access to high quality community case management services. The Alliance maintains regular communication and coordination with contracted ECM providers to ensure optimal delivery of ECM services, providing clinical consultative and liaison support to navigate the managed care plan.

F. 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.

Identification of Eligible Members

Alliance staff follow preset guidelines and collaborate with primary care providers when necessary to identify members eligible for TCM services. The Alliance identifies Members that may be eligible for targeted case management services through admission review, concurrent review processes, provider referral, or at the request of the Member. Members eligible for TCM services have generally been identified as moderate or high risk, and meet the following criteria:

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

Referral Process

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. The LGA determines eligibility for TCM and assigns a Lead Case Manager to support the member once deemed eligible. For Members under the age of twenty-one (21) who are not accepted for TCM services, the Alliance ensures Member access to services comparable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) TCM services as well as California Children Services (CCS) for case management for Members with a qualified CCS condition.

Program Interventions

When enrolled in TCM, the LGA Lead Case Manager is responsible for the following services:

- **Screening and enrollment**: determines eligibility and obtains member consent to services
- **Comprehensive clinical assessment:** assesses the Member's health and psychosocial status to identify the specific needs of the Member, including

identification of barriers to care such as Member lack of understanding of condition, motivation, financial or insurance issues and transportation problems

- **Development and implementation of an Individualized Care Plan ("ICP") also referred to as a "service plan":** includes information from the Member assessment as well as Member input regarding preferences and choices in treatments, services, and abilities
- **Care coordination activities:** including facilitating communication, referrals, treatment/service authorizations, collaborating with Alliance Utilization and Case Management staff to assist Members with accessing services identified in the service plan
- **Crisis assistance:** collaborating with Alliance Case Management and Behavioral Health staff to coordinate and arrange crisis services or treatment for Members when immediate intervention is necessary or in situations that appear emergent in nature
- **Maintenance of comprehensive, written records:** including assessments, service plans and documentation of service delivery, provider communications, member interactions, etc.
- **Periodic review and evaluation of cases, including case closure, as appropriate**

Oversight

Alliance Case Management and Behavioral Health staff monitor the Member's condition, responses to case management interventions, and access to appropriate care. The Alliance ensures the TCM LGA performs the necessary activities of TCM services. 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.

G. Transitional Care Services

Alliance Case Management staff maintains procedures to assist Members who transition 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 support across the continuum from admission to discharge.

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.

Regardless of risk level, members are assigned to a Case Manager, Social Worker, or Health Navigator to provide transitional care support throughout their hospitalization, and after they leave the hospital. Members are also assessed for ongoing care management needs provided through Complex Case Management, Enhanced Care Management, Disease Management, or other available resources.

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

- Enrollment
- Ensuring completion of the discharge risk assessment
- Ensuring completion of the discharge document (containing lead case manager's name and contact information) and share with appropriate parties
- Evaluation of post-discharge needs in association with TOC bundle.
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon evaluation.
- Clear documentation of service(s) provided, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

H. Specialized Services

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

- California Children Services (CCS)
- Community Supports
- Continuity of Care (CoC) with Out-of-Network providers
- Major Organ Transplants
- Transportation

California Children Services

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

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

Referred children are screened for eligibility criteria and referred to a specialized contracted CCS provider. As the program is limited to providing services to children under the age of 21 years, The Alliance has developed a program to identify and provide care coordination of services for children in CCS whose needs are not covered with the CCS

program, and who are nearing 21 years of age and aging out of pediatric health care services. As CCS children age out of the system, staff will assist with the transitions to appropriate adult specialists in a collaborative manner to protect the individual and ensure age-appropriate care is provided.

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

Community Supports Services

Community Supports (CS) services include a variety of services not typically covered by managed care plans. These services are intended to provide additional cost-effective support to members in lieu of higher-level services. In 2024, the Alliance is providing twelve (12) CS services:

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

Each CS service has eligibility criteria following the DHCS requirements. The Alliance has contracted with Community Based Organizations (CBOs) to provide the CS services, including the Alameda Health Care Services Agency (HCSA,) for housing services and Asthma Start, medical respite providers (Lifelong, Cardea Health, and BACS,) and Project Open Hand for Medically Tailored/Supportive Meals. HCSA infrastructure includes a community health record, and the Alliance uses it as a tool for managing members through the continuum. The goal of the collaboration is to ensure targeted Members and providers can access intensive, community-based care management services from anywhere in the care continuum, providing the “right care-right place-right time”. The program outcomes focus of providing services that will:

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

The Alliance maintains regular communication and coordination with contracted CS providers to ensure optimal delivery of CS services, providing clinical consultative and liaison support to navigate the managed care plan.

Continuity of Care (CoC) with Out-of-Network Providers

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

- Mandatorily enrolled from Medi-Cal FFS or another managed care plan
- Members with terminated providers
- Medical Exceptions Requests for Newly Enrolled Medi-Cal Enrollees
- Newly enrolled with active course of treatment

The Alliance's UM Department is responsible for the initial care determinations related to CoC situations. Once the CoC is approved, the Member is referred to Case Management for the identification of any care needs. The Case Management program engages in activity that monitors and assesses continuity and coordination of clinical care. Individual registered nurses work closely with the Member, the physicians and any other associated healthcare delivery organization involved in the case, to provide timely, quality-based care meeting the needs of the individual member. The CM staff ensure the coordination of services with the Primary Care Providers and Specialists. A full description of the CoC process can be found in the relevant UM Policies.

Major Organ Transplants

In 2022, the Major Organ Transplants (MOT) benefit was carved-in to the Alliance, from Medi-Cal Fee-for Service. This uniquely vulnerable member population is provided focused Case Management services throughout the care continuum, from pre-transplant to post-transplant. The CM program works closely with Centers of Excellence providing the transplants to ensure comprehensive, wraparound services to support members throughout their transplant care.

Transportation Services

Transportation services are covered benefits, including:

- Emergency
- Non-emergency medically necessary (NEMT)
- Non-medical transportation (NMT)

The Alliance contracts with a vendor, ModivCare (formerly called LogistiCare), to provide NEMT and NMT. The day-to-day operational monitoring of NEMT and NMT utilization is performed by Case Management staff, in collaboration with ModivCare. Specifically, CM staff 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 align with the requirements of APL 22-008 for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT). A full description of the process is defined in the most recent policies on transportation services.

The Alliance is also responsible for the provision of NMT and NEMT to eligible children under the age of 21 to access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, (now called Medi-Cal for Kids and Teens). The Alliance provides appointment scheduling assistance and necessary transportation, including NEMT and NMT, to and from medical appointments for the medically necessary covered services. The Alliance is not responsible for providing non-medical transportation to and from the services that are carved-out, including dental services. AAH follows DHCS All Plan Letter 19-010 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment of Services for Medi-Cal Members Under the Age of 21.

VII. Case Management Monitoring and Oversight

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

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

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

A. Program Effectiveness

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

Complex Case Management Performance Measurement

The Alliance maintains performance measures (see Appendix E) for the complex case management program to maximize Member health, wellness, safety, satisfaction, and cost efficiency while ensuring quality care. The Alliance selects measures that have significant and demonstrable bearing on the entire complex case management population or a defined subpopulation. The Alliance CM leadership staff annually evaluates the measures of the effectiveness of its complex case management program

based on the following performance goals and corresponding measures (also see Appendix E):

1. Achieve and maintain high levels of satisfaction with CM services.
Measure One - Member Satisfaction Rates

2. Improve Member outcomes
Measure Two - All-Cause Admission Rate
Measure Three – Emergency Room Visit Rate
Measure Four – Percentage of Eligible Members enrolled in CCM
Measure Five – Care Management for High-Risk Members after Discharge
Measure Six – Percentage of members enrolled in ECM

3. Achieve optimal Member functioning.
Measure Seven – Health Status Rate

4. Use of Appropriate Health Care Services
Measure Eight – Use of Services (Primary Care)

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

1. Identifies a relevant process or outcome.
2. Uses valid methods that provide quantitative results.
3. Sets a performance goal.
4. Clearly identifies measure specifications.
5. Analyzes results.
6. Identifies opportunities for improvement, if applicable
7. Develops a plan for intervention and re-measurement.

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

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

identified, the CM leadership team will develop an intervention action plan to improve measurement performance and subsequently re-measure performance to assess effectiveness of the intervention.

Member Experience with Case Management

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

Annual CM Program Evaluation

The Chief Medical Officer, the Senior Director, Health Care Services, and the Director or Manager of Case and Disease Management collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of Member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the UMC and QIHEC for review and feedback. The UMC and QIHEC make recommendations for actions and/or interventions to improve program performance, as appropriate.

Annual CM Workplan

Each year, the Alliance establishes objectives and priorities based on findings from the Annual Program Evaluation and outlines a strategic workplan for the coming year. The workplan incorporates goals, measures, anticipated completion timeframes, and responsible parties, and is maintained throughout the year to monitor progress towards goals and adjust goals, as necessary. The CM workplan is reviewed and approved by the UMC and QIHEC annually.

Delegation of 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 2024, the Alliance delegates Care Coordination to the following entity:

Delegate	Provider Type	HRA	Care Coordination	CCM	DM
CHCN	Managed Care Organization	No	X	No	No

The Alliance is responsible for ensuring delegated entities deliver quality, cost-effective services. In all delegated arrangements, oversight and evaluation are maintained through the following activities:

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

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

B. Summary of Program Enhancements in 2024:

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 Analysis 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

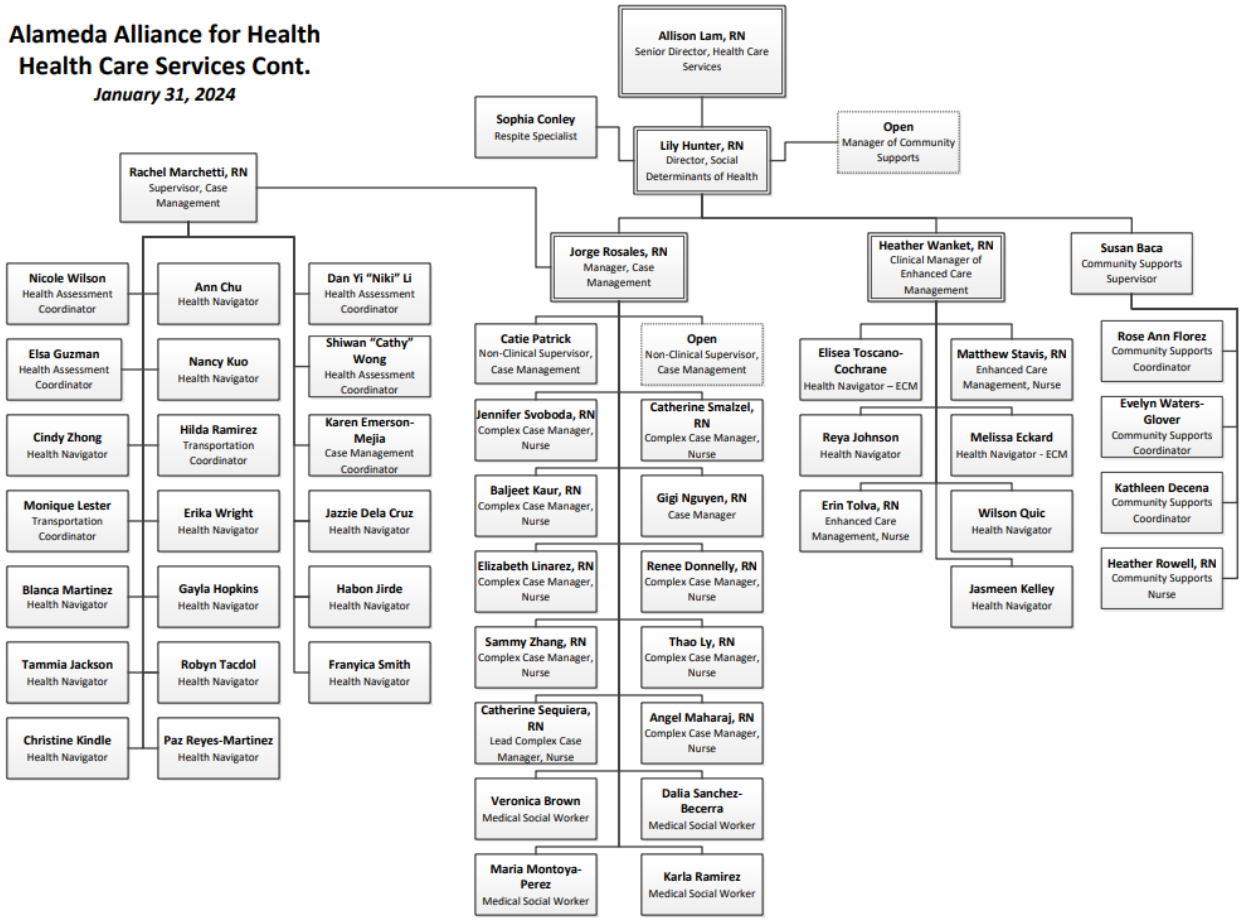
Member Satisfaction with CM:

- 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

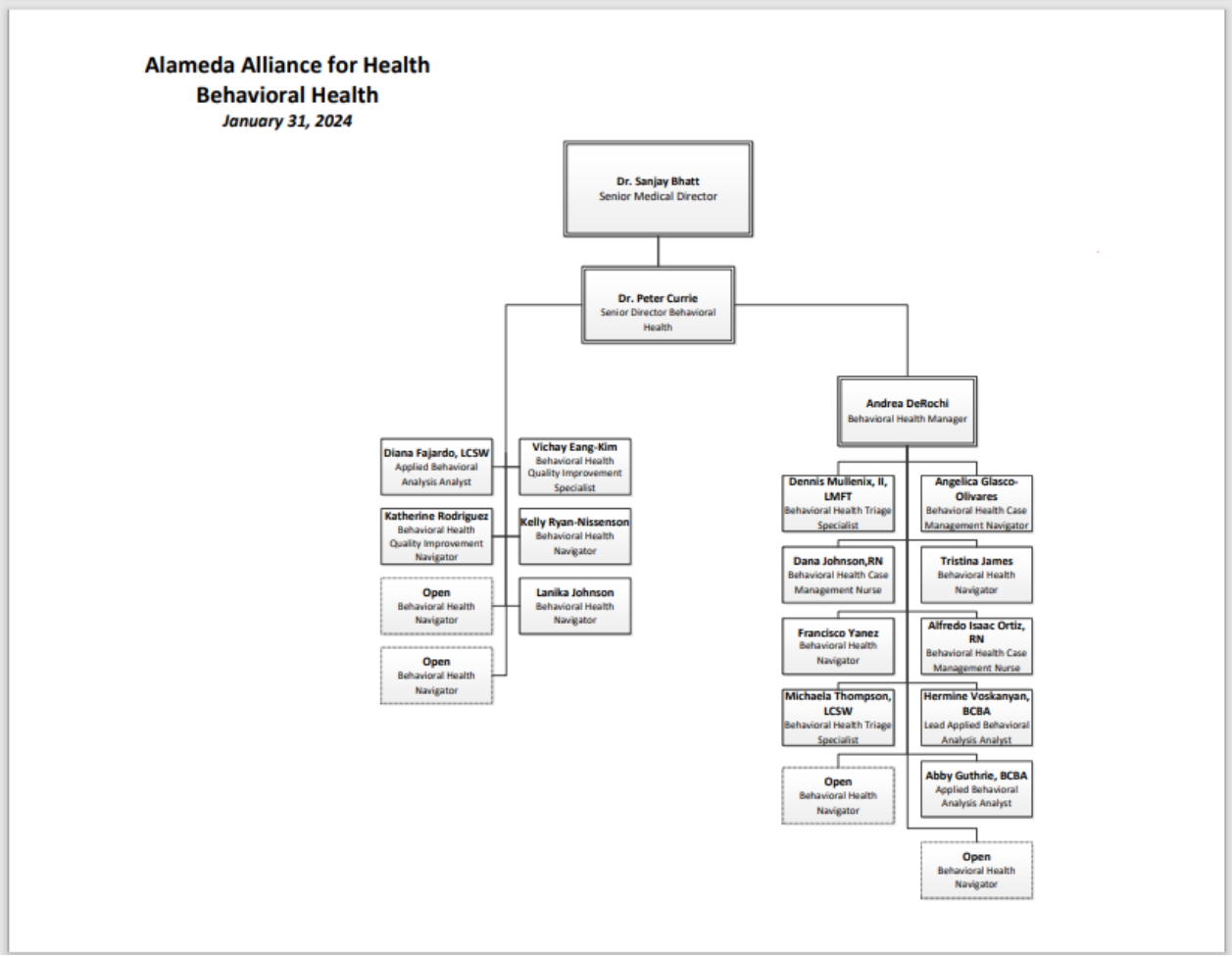
Delegated Case Management:

- 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

Appendix A – Case Management Department Organization Chart



Appendix B – Behavioral Health Department Organization Chart



Appendix C – Clinical Practice Guidelines

The Alliance recommends its provider network follow the most current versions of Clinical Practice Guidelines, as found on the Alliance Provider Website and detailed below:

Preventive Care Guidelines

Preventive Care

For Alliance members 21 years of age and under, the Alliance adheres to the most recent Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care. This is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. The full periodicity schedule is found here.

For asymptomatic healthy adults and pregnant women, the Alliance follows the current U.S. Preventive Services Task Force (USPSTF) A and B Recommendations for providing clinical preventive services. Current recommendations are found here.

Immunizations

The Alliance covers immunizations according to the immunization schedules recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC) and other medical associations. The child and adult immunization schedules are found here.

Perinatal Guidelines

The Alliance provides perinatal services for pregnant members according to the most current standards and guidelines of the American College of Obstetrics and Gynecology (ACOG). Current guidelines are found here.

Mental and Behavioral Health Services

The Alliance uses the following externally validated criteria for provision and effective management of Behavioral and Mental Health services:

1. Milliman Clinical Guidelines. Current guidelines found here.
2. Level of Care Utilization System (LOCUS). Current guidelines found at the American Association for Community Psychiatry (AACAP).
3. Child and Adolescent Level of Care Utilization System (CALOCUS). Current guidelines found at the American Academy of Child and Adolescent Psychiatry (AACAP).
4. Early Childhood Service Intensity Instrument (ECSII). Current guidelines found at the American Academy of Child and Adolescent Psychiatry (AACAP).
5. APA Board Guidelines for Autism Spectrum Disorders. Current guidelines found here APA-Approved Standards and Guidelines.

Tobacco Cessation Guidelines

1. Alameda Alliance for Health Tobacco Provider Guide
2. U.S. Department of Health and Human Services – Treating Tobacco Use and Dependence Guidelines: 2008 Update

Appendix D – Complex Case Management Criteria

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

Complex Case Management Criteria

(any 3 of ANY of the following)

High Utilization:

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

At Risk Diagnoses:

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

Complex Medical/Psychosocial Needs:

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

Appendix E – CCM Performance Measures (2024)

	Goal	Measure	Measurement	Performance Goal	2023 Outcome	Goal Met in 2023?
#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	90%	*N/A - Report in development*	
		Emergency Room Visit Rate	ER rates for members enrolled in CCM	90%	*N/A - Report in development*	
		Percentage of Eligible Members enrolled in CCM	The number and percentage of members eligible for Complex Care Management (CCM) who are successfully enrolled in the CCM program	Establishing baseline in 2024	N/A – new measure for 2024	
		Care Management for High-Risk Members after Discharge	The number and percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge	Establishing baseline in 2024	N/A – new measure for 2024	
		Percentage of members enrolled in ECM	The number of members who are enrolled in ECM out of the total number of enrolled members in the Alliance	Establishing baseline in 2024	N/A – new measure for 2024	
#3	**Achieve optimal member functioning**	Health Status	% of members in CCM responding that their health status improved because of CCM	90%	100%	Yes
#4	**Use of Appropriate Health Care Services**	Use of Services (Primary Care)	Percentage of members who had at least one primary care visit within a 12-month period	Establishing baseline in 2024	N/A – new measure for 2024	

Appendix F – Health Risk Assessment (HRA) Questionnaire

ALAMEDA Alliance FOR HEALTH

Health Survey

Member Name: _____ Alliance Member ID#: _____

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

1. What is your preferred language:
   ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese
   ☐ Other: _____

2. Where do you live:
   ☐ Own home ☐ Temporary housing
   ☐ Rent ☐ Homeless
   ☐ Staying with friends/family ☐ Group home
   ☐ Assisted living ☐ Other: _____

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

3. In general, how would you describe your health?
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Decline to answer

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

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

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

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7.	Do you need to see a doctor in the next 60 days?	☐ Yes	☐ No
8.	Are you under the care of any specialists?	☐ Yes	☐ No
9.	Are you pregnant?	☐ Yes	☐ No
	a. If you are pregnant, are you currently seeing a doctor for this pregnancy?	☐ Yes	☐ No
10.	Do you have a condition that limits your activities or what you can do?	☐ Yes	☐ No
11.	Do you have chronic pain?	☐ Yes	☐ No
12.	Have you been to the Emergency Room (ER) two (2) or more times in the last 12 months?	☐ Yes	☐ No
13	Have you been admitted to the hospital in the past 12 months?	☐ Yes	☐ No
14	Have you been in a Skilled Nursing Facility (SNF) in the past 12 months?	☐ Yes	☐ No
15.	Do you see a doctor regularly for a chronic condition?	☐ Yes	☐ No

If yes, check all that apply:

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

☐ Other: _____

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

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

Name of Medication	Dose (How Much)	How Often Taken

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

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

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

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

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

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22.

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

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

24. Do you feel you have a problem with:
    a. Alcohol use ☐ Yes ☐ No
    b. Drug Use ☐ Yes ☐ No
    c. Tobacco use ☐ Yes ☐ No

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

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

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

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

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

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

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

Name of your helper: _____

What is your relationship to the helper: _____

May we contact your helper? ☐ Yes ☐ No

Phone number of helper: _____

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

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

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

    Name: _____

    Relationship: _____

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

    Other (please list): _____

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

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

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

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

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

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

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

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

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

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

This Health Survey is complete. Thank you!

Please return to:

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

If you have questions, please call:

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

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Appendix G – Long-Term Services and Supports Referral Questions

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

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

• Tier 1 contains questions directly related to LTSS eligibility criteria and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.
• Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.
The headings in italics are not part of the questions but provide the intent of the questions.

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

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

Appendix H – ECM Providers

ECM Contracted Providers	ECM Sites
HCSA – Alameda County Behavioral Health	ACBH
Alameda Health Systems (AHS)	AHS Eastmont
AHS Highland	AHS Highland
AHS Hayward	AHS Hayward
Bay Area Community Services (BACS)	BACS
California Cardiovascular Consultants	California Cardiovascular Consultants
California Children's Services (CCS)	CCS
CHCN	Asian Health Services
	BACH - Liberty
	BACH - Mowry
CHCN Axis Community Center	La Clinica – San Antonio
CHCN La Clinica De La Raza	La Clinica - Transit Village
CHCN LifeLong Medical Care	LifeLong – Downtown Oakland
	Lifelong – East Oakland
	Lifelong – Howard Daniel
	Lifelong – Trust Center
	Lifelong – West Berkeley
CHCN Native America Health Center	Native America Health Services
CHCN Tiburcio Vasquez Health Center	Tiburcio Vasquez Health Center
CHCN West Oakland Health Council	West Oakland Health Council
East Bay Innovations (EBI)	EBI
Full Circle	A Better Way
	Alameda Family Services
	Alternative Family Services
	East Bay Agency for Children
	Fred Finch Youth and Family Services
	Lincoln Family Services
	Stars. Inc
	West Coast Children's Clinic
Institute on Aging (IOA)	IOA
La Familia	La Familia
MedZed	MedZed
Roots Community Health Center	Roots Community Health Center
Seneca Family Services	Seneca Family Services
Titanium Health Care	Titanium Health Care