Case Management & Care Coordination

Trusted Health Plan

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

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Case Management Program

Trusted's Case Management Program design is based on the Case Management Society of America's (CMSA) Standards of Practice for Case Management (2010).

Trusted uses nationally recognized evidence-based clinical practice guidelines.

Case Management

According to CMSA guidelines, Case Management is a collaborative process of:

* Assessment
* Planning
* Facilitation
* Care Evaluation
* Coordination
* Advocacy

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Staffing

Case Management Team Approach:

* Three teams
  - Each Team is comprised of
    * Two Case Managers
    * One Care Coordinator per team supports the CM with member outreach and administrative functions
* One Behavior Health Case Manager
* Social Worker

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Case Management Resources

Community Partners

- Momeas Program
- Impact DC
- Breathe DC
- HOV (Healing our Village)
- Mary's Center
- YWCA
- DC Farmers Market
- Southeast Family Enhancement
- Bread for the City
- DC Police Department
- Far Southeast Collaborative
- East of the River Collaborative
- DC Office on Aging
- Andromeda Transcultural Health
- LAYC-Job-Corps
- Coalition for the Homeless
- DC Cancer Consortium
- UDC & GW Nutrition Collaborative
- Mayor of Latino Affairs
- Telemundo
- America Diabetes Association
- DC Childcare Services Division
- Ethiopian Community Center
- DC Office on Employment Services
- The Community Partnership for the Prevention of Homelessness
- Department of Transportation-Car Seat Presentation
- The Pregnancy Center
- Aids HealthCare Foundation
- Us Helping Us

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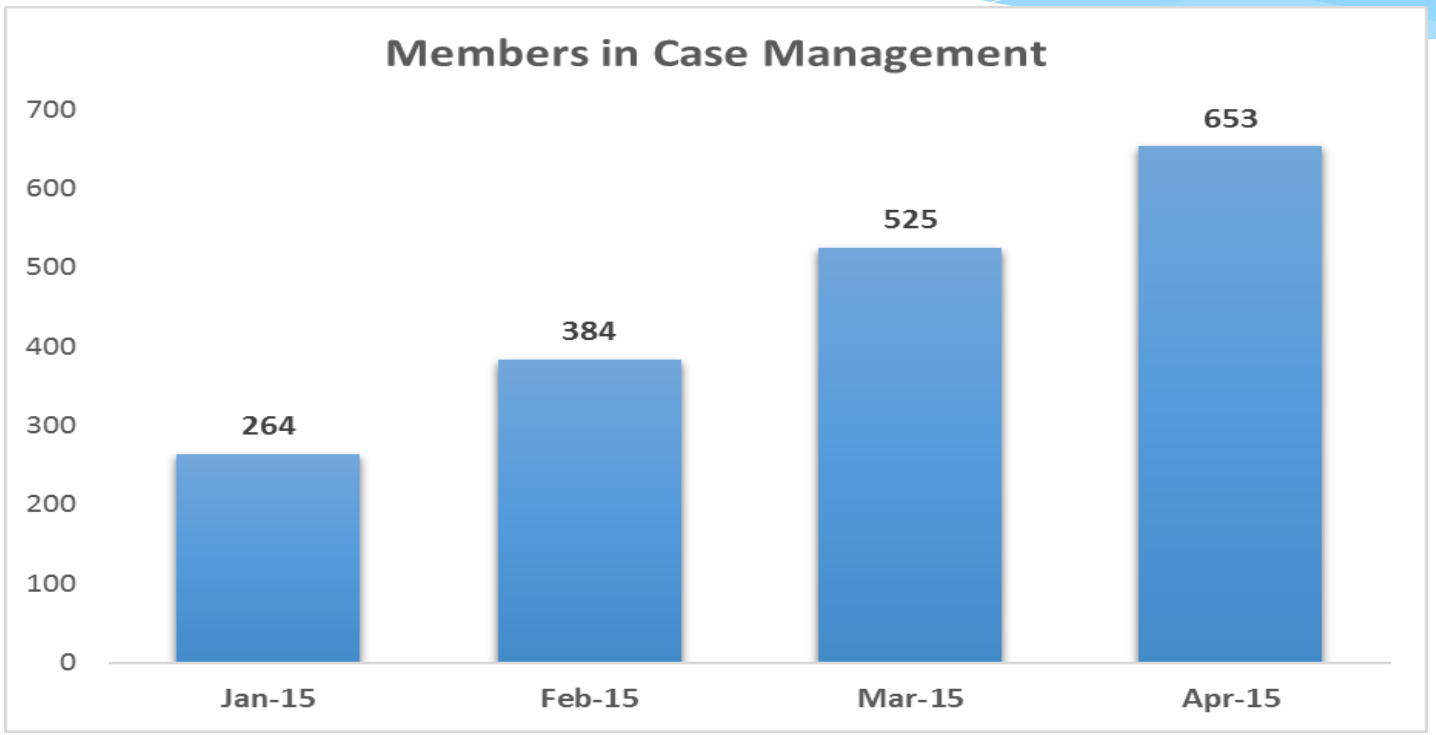
Cultural Competency

* Interpreter Services and Translations to members who do not speak and/or understand English
* Free onsite interpreter services (home/hospital/ physician office)
* On-site Multi-Lingual Care Coordination Staff
* Language Line Services for telephonic language interpretation of over 170 languages
* Multi-Cultural Community Partners
* Translation of written documents

Case Management



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Eligibility Criterion

Eligibility Criteria

* Any member with serious, chronic and/or complex conditions that are persistent, or substantially disabling or life threatening that require treatments and services across a variety of domains of care (medical and/ or social) is eligible for case management.
* Members that have frequent ED visits (3+ in six months) or unplanned hospitalizations or non-compliant with Disease Management.
* Members that exhibit the need for help navigating the system to facilitate the appropriate delivery of care and services.

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Identification of Members

Multiple Sources

* Members identified through our predictive modeling platform "Care Analyzer" which utilizes an expansive algorithm to identify at risk. The system is developed and maintained by the Johns Hopkins Bloomberg School of Public Health.
* Self Referrals, Physician Referrals, NurseLine Referrals
* New Member Initial Health Assessments
* Provider and Practitioner Data bases, HEDIS results
* Data collected from Utilization Management
* Pharmacy, Hospital Discharges, ED visits, etc…

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Case Management Enrollment

Enrollment Process

* Case Manager contacts member/caregiver and offers the member enrollment in the Case Management Program.
* Member/caregiver has the right to **"opt out"** of the program.
* If member/caregiver accepts, case manager completes the appropriate disease specific Case Management Assessment tool which is used to preliminarily stratify the member in Care Connect.

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Tracking of Enrollment

Case Management Tracking

Case Management status for members is documented in Care Connect. The initial assessment is completed within 30 days of being identified as eligible.

* **Referred (New):** Member has been referred for CM screening assessment
* **In -Process:** CM screening has been completed and member has been determined **eligible** for case management.
* **Fully Engaged:** Case Manager contacted member to enroll in the program, member has consented and an assessment is completed within 30 days of referral date.

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Stratification Levels

Stratification levels are based on at least one of six categories:

* Medical Needs
* Mental Health Needs
* Provider and Access Issues
* Psychosocial Issues
* ER/Inpatient Utilization
* Education Needs

Members are stratified as “low”, “medium” or “high” intensity.

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Interventions

Low intensity

* Members with no significant barriers or compliance issues.
* Example: Newly diagnosed pre-diabetic. No ER/hosp visits.
* Intervention: Angela developed Plan of Care, and invited member for face-to-face at the Health and Wellness Outreach Center. She provided member two hour educational session, answered all of the member's questions and showed member how to use glucometer.
* Care Plan will be reviewed if status changes (ER/IP/Dx)

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Interventions

Medium intensity

* Members with moderate complexity of needs and/or barrier to optimal care.
* Example: Pediatric member with Asthma, recent ER visit.
* Intervention: Katherine spoke with member's mother and determined that member had not received inhaler medication. In addition to developing care plan and explaining need for mother to take member to PCP, Kathryn referred the member to Breathe DC for a home visit and Impact DC for additional consultation. Plan of Care to be reviewed quarterly or upon condition change (ER/IP/Dx)

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Interventions

High intensity

* Member has high intensity needs and significant barriers to care and/or compliance problems.
* Example: Member with HIV T-cell count < 500, depression, non compliant with meds.
* Intervention: Gregory utilized the "Red Carpet program" to assist member for PCP visit within 5 days, referred to Social Worker for housing support, referred to Beacon for depression. Gregory contacts member at least weekly until member becomes stable.
* Plan of Care will be updated at least monthly and as needed.

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Trusted Brings To Life:

Member Centric Complex Case Management

Team

Collaboration

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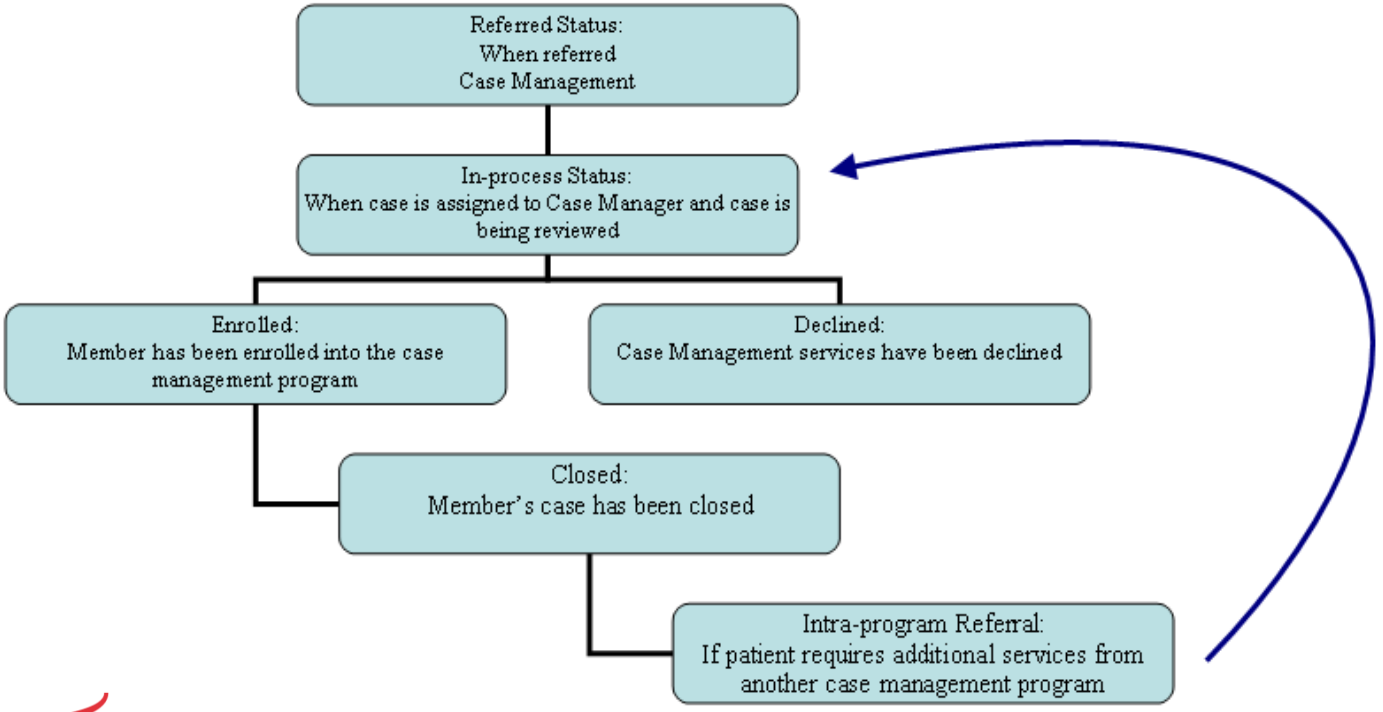
Case Management Participation Status



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Disease Management

* Disease Management assists members make effective health care choices for self management of their chronic conditions.

* Trusted has implemented two Disease Management programs: Pediatric Asthma and Diabetes.

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Trusted Health and Wellness Outreach Center

Trusted has located its Case Managers for Diabetes, HIV/AIDS and Cancer, Obstetrics, EPSDT, L.A.N.E. and Social Worker at the Trusted Health and Wellness Outreach Center, located at:

3732 Minnesota Ave. NE.

Washington, DC 20019

They are supported by Outreach Care Coordinators, Nutritionist, Pharmacist, Diabetes and Asthma Educators, Disease Management programs, and the Quality team.

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Case Management Face to Face Visits

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Case Management Results

Measurable results for Trusted's CM Program:

* 2014 vs 2013 reduced ER visits per thousand by 25%
* 2015 YTD increased members in CM by over 100%
* 100% of members in CM have a Plan of Care initiated

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Case Management / Quality Integration

* Trusted has a company wide Quality Improvement Plan (QIP); which focuses on improving health outcomes.
* Case Management integrates with the QIP utilizing the following approach:
  * Identifying and Closing Gaps in Care
  * Providing Care Coordination Services
  * Enrolling members in Case Management as appropriate

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Case Management / Quality Integration

The following HEDIS measures are utilized by the QIP as proxy indicators to evaluate the efficacy of Trusted CM programs

Adult Access to Preventive/Ambulatory Svcs (20-44)
Cervical Cancer Screenings
Adolescent Well-Care Visits
Annual Dental Visit (total)
Asthma Medication Ratio (total)
Breast Cancer Screening
Children's and Adolescents Access to PCP(12-24mths)
Children's and Adolescents Access to PCP(25mths-6yrs)
Children's and Adolescents Access to PCP(7yrs-11yrs)
Children's and Adolescents Access to PCP(12yrs-19yrs)
Comprehensive Diabetes Care(HBA1C Testing)
Follow-up After Hosp for Mental Illness(7 days)
Follow-up After Hosp for Mental Illness(30 days)
Lead Screening in Children
Medication Mgmt for People with Asthma(75%)
Plan All Cause Readmissions (Total - <65yrs)
Prenatal and Postpartum Care(Timeliness of Prenatal Care
Prenatal and Postpartum Care(Postpartum Care)
Well-Child Visits in 1st 15 months(6 or more visits)
Well-Child Visits 3-6 Years
CBP- Controlled High Blood Pressure (HYBRID ONLY)

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Case Management

Q & A

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