

Population Management at Community Health Plan of Washington
Medicare Advantage Special Needs Plan
Model of Care 2011



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Introduction

Community Health Plan of Washington has specialized in Medicaid managed care since 1996. Today, we serve approximately 180,000 beneficiaries of Washington's Healthy Options program. We serve an additional 60,000 low-income Washington residents through the state's Basic Health program, the state's Children's Health Insurance Program, and the General Assistance - Unemployable program. In total we manage the care of roughly 260,000 low-income beneficiaries through our contracts with the state of Washington.

CHPW is an affiliate of Community Health Network of Washington, an affiliation of 19 Community Health Centers (CHCs) across the state of Washington, all of which are Federally Qualified Health Centers (FQHCs). As safety net providers, the CHCs take all comers, including managed care, fee-for-service and uninsured patients. In 2004, these CHCs collectively recorded serving 200,000 uninsured patients, 215,000 Medicaid patients, and 27,000 Medicare beneficiaries, roughly one-third (i.e.; 9,000) of whom were dually eligible for Medicaid. Over the past several years, the number of Medicare beneficiaries seeking care at the CHCs has increased on average between 15 and 20% per year.

Based on our mission of providing quality health care to the underserved, our tenure in serving Medicaid beneficiaries, and our strong connection to the CHCs we remain uniquely positioned to serve Dual-Eligible beneficiaries and high risk populations

We are acutely aware that dual-eligible beneficiaries in the state of Washington have relatively comprehensive health insurance coverage with no out-of-pocket responsibility through Original Medicare and fee-for-service Medicaid. Thus, it was challenging to design a SNP benefit package that offers beneficiaries better value than Original Medicare. Thus, when we entered the market in 2007 we implemented a new concept based on an enhanced service approach: the Patient Navigator (PN) model. The SNP model of care for 2010 is in many ways a natural extension of our ongoing efforts at population management.

We believe that this concept has distinguished us from both Original Medicare and our SNP competitors, and affords beneficiaries and their families with a unique and highly valuable improvement in their Medicare experience. We essentially changed our competitive position from one based on supplemental benefits (i.e.; rebate allocation) to one based on medical management infrastructure (i.e.; patient centered care). As such, we are the first SNP in Washington State available in 26 counties across the state and are adding two additional counties to bring the total to 28.

Our system of care, to be outlined in detail below, reflects pertinent clinical expertise and staff structures to support quality care for this population. Our processes of care meet or exceed the goals and objectives for initial and periodic assessment, care and case management, and process/outcome measures to evaluate our performance.

Below we detail our Population management plan as relevant to the SNP Model of Care that has been in place since 2007, our first year serving Medicare beneficiaries as a Medicare Advantage Organization and precede the layer in the Model of Care 2010 requirements.

Through 2009, for our SNP product, the work of the Patient Navigators remained unique in its content and value. Patient Navigators (now Integrated Care Management Specialists or ICMS)

assist our dually-eligible SNP members understand and access Medicaid-only benefits which, in Washington, are paid for by the State in a highly uncoordinated fee-for-service environment.

In 2010 we are continuing a mandatory supplemental dental benefit to our SNP. While Medicaid covers dental in Washington, market research indicated that dually-eligible beneficiaries faced difficulty finding dentists who would accept the Medicaid fee schedule. We have devoted a significant portion of our rebate toward providing a comprehensive dental benefit with a \$1,200 annual limit, believing that doing so will provide alternative care and open access to dental care and help improve the overall health of this special needs population.

Description of the SNP Specific Target Population

MA Contract Name: Community Health Plan of Washington
MA Contract Number: H5826 - 005
Type of Dual-eligible SNP: Full Dual-Eligible

(We are not serving beneficiaries with end-stage renal disease [ESRD] unless they are diagnosed with ESRD after they have enrolled.)

Goals and Objectives

The CHPW SNP will offer services to all SNP beneficiaries that will serve to:

1. Improve access to medical, mental health and social services
2. Improve access to affordable care
3. Improve coordination of care through the primary care team
4. Improve seamless transitions of care across healthcare settings and providers
5. Improve access to preventive health services
6. Assure appropriate utilization of services
7. Assure cost effective health services delivery
8. Improve beneficiary health outcomes
 - a. Reduce hospitalizations and SNF placements
 - b. Improve self-management and independence
 - c. Improve mobility and functional status
 - d. Improve pain management
 - e. Improve quality of life as self-reported
 - f. Improved satisfaction with health status and health services

Community Health Plan of Washington will assure that these goals have measurable outcomes, and that a mitigation plan is developed should any individual member or the population not meet the goals and objectives. All action plans or care plans developed for SNP beneficiaries will include activities that are indicated by Evidence Based Practice (social work, nursing and/or medicine) for that beneficiary's medical or social needs.

The measurable outcomes and goals are detailed in the section on Performance and Outcome Measurement. (Pages 14-15)

Staff Structure & Care Management Roles

Key staff responsible for the programs:

Christopher Mathews, MD – Senior Vice President and Chief Medical Officer

Verni Jogaratnam, MD –Medical Director

Deborah Tanabe, RN, CPHQ – Director, Care Management

These roles (with some variations) were existent in 2007 at the initiation of the SNP, or were formed during the first year of operation. All staff interact with SNP beneficiaries (and all other MA beneficiaries and all other health plan beneficiaries) to provide coordinated care. The key roles involved are:

Medical Directors:

Provide management oversight and active guidance for Utilization Management (UM), Case Management (CM), Population Management (PM), Disease Management (DM) and Care Coordination (CC) practices at Community Health Plan. Ensure that CHPW is compliant with regulatory and contractual obligations. Ensure that Clinical Guidelines and prior authorization requirements are reviewed annually and recommendations for additions, deletions and changes are made to Medical Management Leadership team (MMLT) and the Utilization Sub Committee.

Director/Managers:

Assure alignment of various Care Management functions (UM, CM, PM, DM, and CC [which includes ICMS]) with organizational strategic direction, goals, measures and initiatives. Assure cost-effective and appropriate use of health care services by planning, designing, implementing and evaluating continuity of care programs.

Utilization Management staff:

Review and assess services requiring prior authorization, ensuring that established indicators and criteria are met before determinations are made. Requests that do not meet criteria due to medical necessity issues are brought to the Medical Directors for decision.

Nurse Case Managers:

Facilitate effective and appropriate use of health care services by: identifying high risk and high cost patients with complex medical and/or psychosocial needs, assessing treatment options and opportunities and designing treatment plans to improve the quality and efficacy of care; integrating and coordinating the expertise and support of other professionals, family members, community agencies, and providers across the health care continuum; achieving optimal clinical and quality outcomes by effectively managing care and resources; and, serving as a liaison to centers and center staff regarding case management.

Disease Managers:

Perform review, screening and management of potential disease management cases in the diseases currently offered via the DM Program at Community Health Plan. Complete assessments, plan of care, identify resources and goals with beneficiary and family involvement. Assist in resource development for complex

cases. Assist center medical directors, primary care providers and managed care coordinators in case management of complex outpatient cases using CHPW Case Management Process and Disease Management Process guidelines. Refer complex cases identified during the Disease Management process to Case Management or Care Coordination. Act as an internal consultant to other departments on Disease Management and clinical resource issues.

Integrated Care Management Specialist (ICMS):

The primary purpose of the population management program is to serve a risk stratified population to include Medicare Advantage Special Needs Plan (SNP) beneficiaries by assisting the beneficiary to engage in managed care services and fully leverage all care providers and the member in key interventions. ICMS Staff provide assessment, education and assistance with the coordination of services related to health, community, entitlement and psychosocial needs. See Attachment 1.

Administrative Roles:

Enrollment, Eligibility, Marketing, Claims Processing, Customer Service and other administrative departments will operate as per CHPW Policy & Procedure and CMS contracting requirements for any and all SNP beneficiaries as they would for any other CHF/CHPW enrollee.

Primary Care Provider Team:

The beneficiary's PCP team will be notified on all transitions of care or major medical issues as needed, invited to participate in the SNP Rounds, and will be provided a full spectrum of plan level care management resources to support the needs of the member / patient.

Interdisciplinary Care Team (ICT)

Composition & Interventions

All high risk members at CHPW to include the Special Needs Population are assigned to an ICT of board certified primary, ancillary, behavioral health and specialty care providers. The membership may include physicians and other licensed practitioners, social workers, integrated care management specialists behavioral / mental health practitioners working together to formulate a care plan and perform care management functions as appropriate.

These interventions include the following based on individualized need; active involvement of the individual or caregiver, regular care coordination meetings, meetings with the primary care providers team acting in close coordination with the ICT, case rounds and multiple modes of communication as defined in the description of the communication network.

Provider Network having Specialized Expertise & Use of Clinical Practice Guidelines & Protocols

We do not differentiate the SNP provider and pharmacy networks from the other Medicare lines of business served by CHPW in our service area. If a provider serves our Medicare Advantage member, they serve all of them equally. We do not discriminate against those enrollees with special needs.

CHPW has a Credentialing Program that meets the standards for accreditation by the National Committee for Quality Assurance (NCQA). The CHPW Credentialing Program sets forth the

criteria, standards and processes to select and retain qualified health care providers in order to promote the quality of care to beneficiaries. The Program also includes the structure and oversight responsibilities for any credentialing activities that may be delegated to another provider group or health care organization.

Specialty Care Monitoring and Network Adequacy Monitoring are in place to identify possible gaps in our specialty care network. Provider Relations Coordinators (PRC) use a combination of the Open County Assessment Form, GeoAccess reporting using targeted distance standards and services utilization data to assess network inadequacies. Once a gap has been identified, the PRC will develop a county action plan consisting of a targeted contracting strategy. Recommendations will be presented to the Provider Contracting and Credentialing Manager and the Vice President of Provider Relations for approval.

Network adequacy will be measured by the distance a member has to travel to access care from a provider. The distance standard for members living in urban areas will be one (1) provider per every ten (10) miles; rural areas will be one (1) provider per every 25 miles. The CHPW standard is that 90% of our members will have access to care from a provider within the distance standard. Access will be monitored on a quarterly basis.

CHPW Members must be referred by their PCP for all medically necessary services beyond the scope of the PCP, or when complications of treatment necessitate the opinion of a specialist. Exceptions to this process are those services for which a member can self-refer.

Emergency services or urgently needed services require no referral or pre-authorization. If an emergent service is required after business hours, it is expected that all medically necessary services will be rendered and the Specialist will contact the PCP to communicate the reason for the visit.

Clinical Expertise

If the existing network does not include the clinical expertise to fully meet the special needs of the target population, or if there is no network provider with the required clinical expertise within a 25 mile radius of the beneficiary's home address, then CHPW will make all reasonable accommodations to ensure that the beneficiary's health care is provided as needed, and will arrange appropriate access to non-contracted specialists.

Evidence based guidelines are reviewed and disseminated annually via the web to all credentialed practitioners. The Integrated Care Team reviews records from the primary care provider's office for selected enrollees as identified at the case management rounds.

Use of Non-Network Specialists

If the existing network does not include sufficient specialists to fully meet the special needs of the target population, or if there is no network specialist within a 25 mile radius of the beneficiary's home address, then CHPW will make all reasonable accommodations to ensure that the beneficiary's health care is provided as needed, and will arrange appropriate access to non-contracted specialists.

Model of Care Training for Personnel & Provider Network

All new primary care providers receive an on-site orientation by a Contracting Associate and a Credentialing Administrator. A portion of the orientation addresses the Model of Care Resources available to providers through various sources, such as the CHP website and the provider manual. Topics cover the model of care, including but not limited to: referral management; utilization management and prior authorization; case management and disease management; pharmacy management, and member rights & responsibilities.

The following is a listing of topics covered, in-depth, as part of the population management model for plan level staff. Documentation of participation is achieved via meeting minutes. Oversight of the training is provided by the Director of Care Management and the Medical Director.

Overall CHPW Information

- Mission – Vision – Values
 - Community Health Network of Washington
 - Community Health Plan
 - Medical Management
- Community Health Plan/Network
 - Personnel, Benefits, Phone lists, Departments
 - Orientation to building
 - Departments within Community Health Plan
 - Location of Community Health Centers (CHC)
 - Roster of CHCs
 - List of back lines for CHCs
- Confidentiality
- Integrity Training
- Security

HR & Benefits

- Benefits
- HR New Employee Orientation
- Work place policies and procedures
 - Timekeeping
 - Attendance
 - Sick Call

Insurance Industry

- Managed Care Organization (MCO) & managed care features (referrals, Part D formulary, etc.)
- Social Security
- Medicare (A-B-C-D / aka Medicare 101 & 102)
- Medicaid wrap-around coverage
- Assist w/insurance & financial functions & coordinate w/ SHEBA
- Maintaining SSA & Medicaid eligibility paperwork
- Serve as primary Plan contact for Medicare Advantage SNP beneficiaries.
- Assist w/insurance functions & referrals
- Provide beneficiary education regarding participation in a managed care health plan, including information on the health care team, referrals, authorizations, part D formulary, and benefit administration.

Conduct ongoing outreach
Assist with applications maintenance of Federal and State entitlement benefits.
Develop and maintain thorough understanding of Medicare and Medicaid benefits.
Develop and maintain thorough understanding of managed care principles and Plan services, entitlement programs and applicable systems.

Resources & Referrals

CHC resources

Community Resources & facilitate involvement

Pt advocacy groups

Charities

Hospices

Other Home Care providers

Other organizations in community

○ Meals

○ Etc

Dentists

Volunteer & donation services (DME, volunteer transportation & respite)

Assist with the coordination of transportation services.

Develop and maintain regional resource list

Facilitate involvement of community organizations

Coordinate with insurance ombudsman

Identify and act as liaison to other assigned community case workers.

Women's Health

Preventive Services

Specialty Care

Interpreter line & how to use

Community Health Plan of Washington Departmental Interface & Workflow Coordination

Case Management interface and referral process

Disease Management interface and referral process

Utilization Management

Referrals

Prior Authorizations

Customer Service

Policies & Procedures

Transfers & Duties differentiation

Training

Eligibility & Enrollment

Provider Relations

Appeals & Grievances process

CHC Interface

Barriers to health care & how to overcome

Coordination of Health Care Services & referrals for cancer & chronic diseases

Help finding & making appointments w/PCP & specialists

Develop strong working relationship and work in collaboration with primary care provider and clinic staff.

Coordinate with clinic/PCP

▪ Facilitate appt if needed

▪ Communicate needs determined from assessment

How to work with health care team to coordinate access to primary care and specialty care providers (including dental providers)
Assist in coordination of health care services
Anticipate, identify, and help overcome barriers within health care system.

Paraprofessional Skills Development

Cultural Competency & Interpreter Services
Crisis intervention & escalation procedures
Phone etiquette
Prescription Drug Assistance Programs
Advance Directives
Dementia, Delirium, Depression & Anxiety
Personality Disorders
Motivational Interviewing
Participate in staff development and Beneficiary Navigator Program activities

Documentation

Documentation (electronic & paper backup)
Consent to Coordination of Care (opt out language)
Health Risk Appraisal completion
Maintain caseload as assigned.
Maintain documentation according defined standards
Assessment – Telephonic/Mail

- Coordinate with HRA
- Home environment issues and other treatment barriers
- Social support system & contact information
- Next or first appointment with PCP

Documentation of calls in Jiva system
Production standards

Health Risk Assessment

MA-SNP enrollees will be screened using a Health Risk Assessment (HRA), reviewed by an interdisciplinary team. The HRA tool currently in use is the PraPlus as developed and licensed by Johns Hopkins University. This validated tool captures medical, psychosocial, functional and cognitive input and includes health history as well.

We will provide these services through the following process:

- Members will receive an HRA within the first 90 days of enrollment and annually thereafter. We currently use an initial mailed version and follow up with telephonic outreach.
- ICT Rounds, manually analyses all available data and input that will determine member's category of SNP (routine, frail/elderly, multiple chronic conditions, end of life), risk level or acuity (high, moderate or low), and what actions for team members to take in the provision of coordinated care (medical, mental health, social services, and education re: health risks and care options.)
- Staff will provide CM, DM and/or ICMS services as needed, develop an integrated and comprehensive action plan (plan of care), clarify member preferences for Personal Representatives, and obtain necessary Releases of Information for all referrals as needed. Staff will: advocate, inform and educate members; facilitate access to community services; triage care needs; facilitate or authorize access to services; and, obtain

consultation and diagnostic reports as needed.

Integrated Care Plan Creation and Management

CHPW will use the initial HRA derived member risk score and combine that information with a predictive, claims-derived risk score to establish the initial stratification of members. Every member has an ICP created, whether they are reached and assessed or not. ICP's are created using information from claims, Medicare HCC and MMR risk values, practitioner reported information and member assessments.

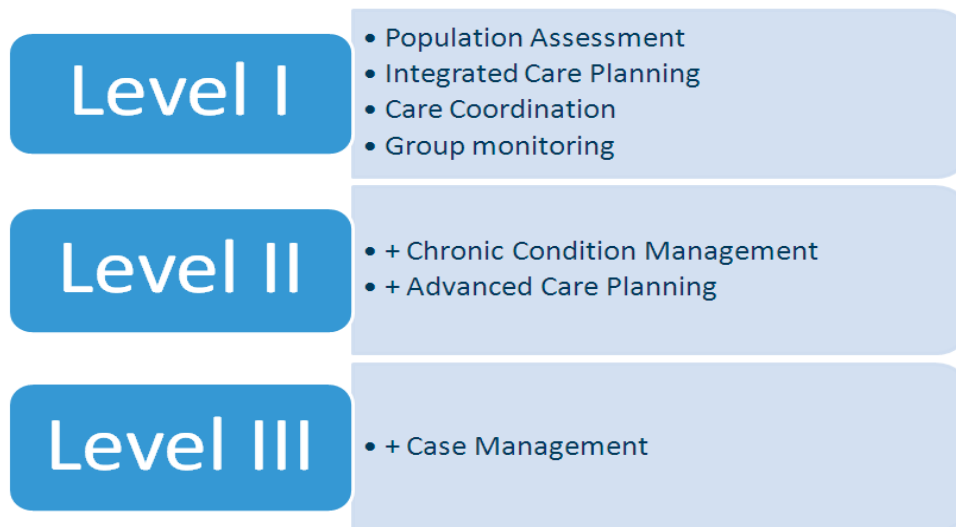
ICPs will be comprehensive and incorporate best practices for chronic conditions as well as psychosocial needs. The ICP will be shared with the member and their PCP or other designated providers.

The complexity of the ICP will match the member's stratification level, as summarized below.

- Level I: Care Coordination
- Level II: Care Coordination and Chronic Condition Management
- Level III: Complex Case Management

The member stratification process incorporates: Claims based predictive modeling risk scores, HRA risk scores, Utilization Management information, member reported information, practitioner reported information, and experienced clinical decision-making using multiple specialties where appropriate. In addition to initial stratification, we review, monitor for changes in condition, and re-stratify members to ensure that resources are focused appropriately throughout your population.

Summarized Stratification Levels

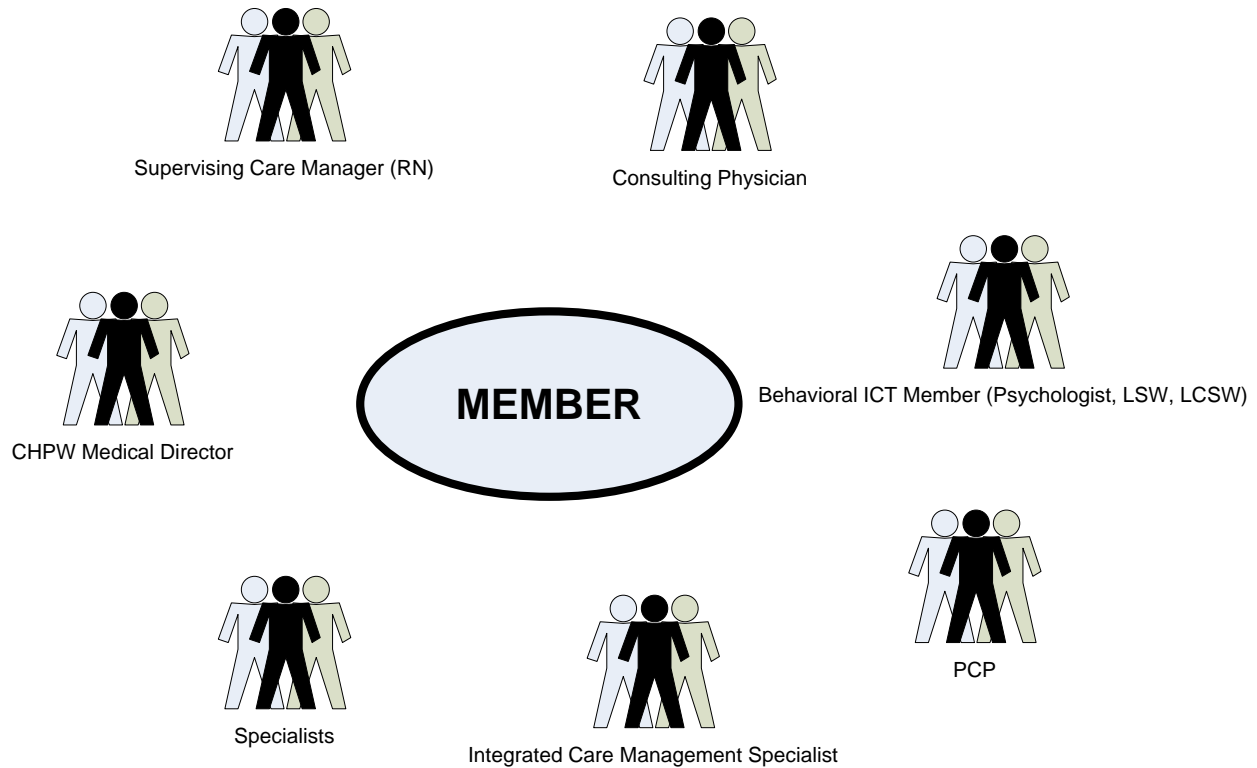


Interdisciplinary Care Team (“ICT”) and Care Coordination

CHPW will integrate internal and external resources to create an Interdisciplinary Care Team to care for each member. A dedicated Health Integrated care management specialist (ICMS) will coordinate care and communications with other members of the team. CHPW's internal team

includes RNs, behavioral health clinicians and medical and behavioral physicians. The extended team would include the PCP and other specialists.

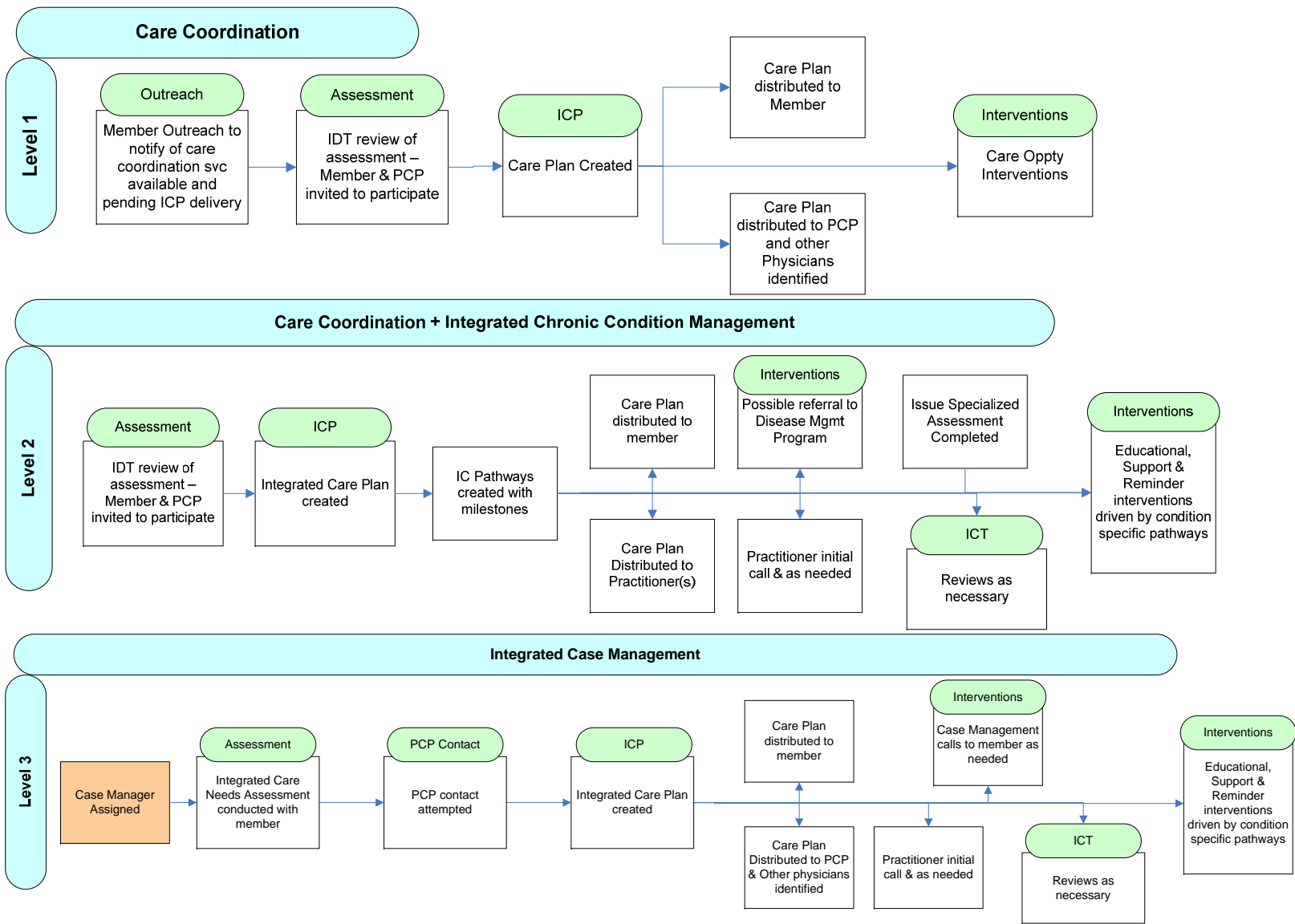
The program will use well developed internal processes and systems to track tasks, consultations by other members of the ICT, and all PCP and practitioner communications (letters, clinical alerts, and care gap notifications).



The ICT will make use of a tool set for assessing and managing members through various levels of acuity. Beneficiary management is supported by a diverse set of assessments designed specifically for medical, behavioral and psychosocial issues. These assessments, in addition to clinician judgment, will drive the identification of specific problems or challenges, the setting of goals, and creation of appropriate interventions to be delivered. These components are critical elements to care plan content and serve for managing beneficiaries to better health and outcomes. The assessments focus on:

- Empowering members to contribute as much as possible to their own care
- Capturing accurate information about members and their conditions to track outcomes
- Ensuring that appropriate medical, behavioral and social resources are utilized when members have needs

Beyond the initial HRA score, claims based predictive risk scores and other gathered information will be used to establish the appropriate stratification level. The intent is to use three (3) levels of stratification for this program with the third level of management, Complex Case Management. The illustrations below outline the basic pathways intended for initial stratification and management for members at each level following initial HRA assessment and stratification.



Clinical and administrative oversight by manager will:

- Ensure implementation of the Model of Care;
- Assess licensure and competency of staff;
- Assure statutory and regulatory compliance;
- Monitor contractual services (through Provider Relations);
- Evaluate the Model of Care;
- Monitor the Interdisciplinary Team (IDT);
- Assure timely and appropriate delivery of services;
- Ensure staff follow clinical practice guidelines where applicable;
- Ensure staff facilitate seamless and timely transitions in care settings for members; and
- Audit documentation and facilitate pharmacy reviews as needed.

Frail/disabled beneficiaries (FD), beneficiaries with multiple chronic illnesses (MCI), and beneficiaries near the end of life (EOL) are all provided for in our company-wide population management model of care for all beneficiaries regardless of line of business. FD, MCI and EOL are all identified in a number of ways:

- Through predictive modeling algorithms used to identify beneficiaries with special health care needs (ESHCHN) – with a special case management process (Complex Case Management; CCM) followed for all beneficiaries.
- Through regular ICMS staff contact with all SNP beneficiaries (unless the beneficiary has specifically opted out of receiving these services) to determine if frailty, disability, chronic illnesses or end of life status is detracting from their quality of life and creating difficulties in managing their health care.
- Through systematic monitoring of hospitalizations with concurrent review and discharge planning to ensure coordination of care that can include home care, hospice, alternative living arrangements, or other care needs.
- Through annual or semi-annual review of Hierarchical Condition Categories (HCC) and verification that the beneficiaries are being treated for this condition, or if not, that the PCP is aware that this is a previously reported condition for the beneficiary.

We also include Medicare beneficiaries in all of our HEDIS, CAHPS, and other Quality Improvement programs and projects. Specific Quality Improvement Projects are in development for the Medicare population. Medicare beneficiaries are also included in all company performance and health outcome measures.

Individualized Care Plan

An individualized care plan is improved based on the determination of the ICT working from the initial health risk assessment, claims, pharmacy, hospitalization and risk stratification data. Individual health care preferences are incorporated based on input from the member or primary care team.

A written plan is being developed based on our current experience as to the best methods of communication with members. For the most part these are telephonic when feasible for high risk enrollees and via mail to enrollees at lesser risk at this point in time. The frequency of review is based upon predictive modeling of prospective risk and re reviewed annually at the minimum. The documented care plan is maintained in an electronic, HIPAA compliant, integrated care management system. Limited access to the frontline provider network is in the formative stages via the care management system.

Integrated Case Management Specialists (ICMS) coordinate the transition of members from one care setting to the next, see attachment 1, and generate referrals to the following CHPW programs based on the individualized care plan:

- The enrollees primary care team
 - Case Management or Care Coordinators for:
 - Complex medical care requiring clinical coordination,
 - Hospice,
 - Long Term Acute Hospitalization,
 - Inpatient Rehabilitation,
 - SNF-A Rehabilitation,
 - Out of State / Out of Network, and
- Exceptions to Benefit
- Disease Management for:
 - Disease specific services (i.e., Diabetes, Asthma, and future programs as they become available)
- Utilization Management (per desk procedures)
- Entitlement for SSI, SSDI, and other coordination efforts (per desk procedure)
- External referrals to any non-CHPW program, with beneficiary permission, as needed.

Communication Network

Please see the attachment detailing the communication infrastructure.

ICMS staff, and all other CHPW staff serving SNP beneficiaries, will communicate via letter, fax, and phone with the beneficiary's PCP and any relevant specialists. Copies of Health Risk Appraisals, Care Plans and Action Plans, and any relevant beneficiary assessment information will also be communicated to the beneficiary's PCP to coordinate care. Care conferences for complex needs are an integral component of the model of care.

ICMS Staff, and all other CHPW staff serving SNP beneficiaries, in any situation where any reasonable person would believe that the beneficiary was in some form of danger, will escalate care to: a Manager or Director or Medical Director; a Clinical Care Coordinator; any licensed Care Management staff; any licensed Case Management staff; or, other clinical staff or manager, based upon perceived need and/or concern about medical and/or psychiatric clinical needs.

ICMS Staff are mandatory reporters and will escalate potential abuse or neglect calls to their manager (or other Medical Management manager or director, if manager is not on site) to facilitate joint reporting to official State abuse reporting systems within the legal timelines.

Evaluation of Communication Plan through the annual Provider Survey will help us further refine our current design.

Care Management for the Most Vulnerable Sub Populations

The Population management approach to high risk enrollees and SNP beneficiaries is a high touch service program for work with beneficiaries in most need of assistance. We provide help, teaching, coaching, and coordination for those who may not be able to do so for themselves. We identify those most in need through our Health Risk Appraisal, the PraPlus, and make referrals to our Complex Case Management (CCM) and Enrollees with Special Health Care Needs (ESHCN) programs as needed for additional case management.

Beneficiary participation in Coordination and Case Management (and all other CHPW Programs) is voluntary – a collaborative process between the beneficiary, the team, and the PCP/clinic. By coordinating with the beneficiary, CHPW can help with many aspects of the beneficiary’s healthcare needs, such as: patient and family education; facilitating communication between beneficiary and providers (e.g. specialists, therapists etc.); and helping to resolve issues if they develop.

The Complex Case Management program provides additional services and care coordination for persons having chronic and disabling conditions, including persons with special health care needs like the FD, MCI, and EOL beneficiaries in the SNP program. This includes those served in the Disease Management Program as well. SNP ESHCN beneficiaries (FD, MCI, and EOL) require a broad range of primary, specialized medical, behavioral health, and related services. SNP ESHCN has ongoing health conditions, high or complex service utilization, and low to severe functional limitations.

Community Health Plan’s Population Management services for the ESHCN population enable the Plan to identify, risk screen, track and provide Plan-level interventions for these enrollees. The Plan identifies appropriate beneficiaries through a variety of methods including: medical claims data; pharmaceutical data; health risk assessment survey results; and, program referrals from our Primary Care sites.

Services for the ESHCN population integrate ten steps:

1. Identify the beneficiaries who potentially would need the services
2. Risk Screening
3. Tracking & Scoring
4. Acuity Determination & Health Assessment
5. Collaborative Care Planning
6. Outreach/Interventions by PLCM (if needed)
7. On-going Maintenance of System
8. Reports/Dashboards
9. Increased frequency of assessment; every 6 months versus annually

10. Increased frequency of contact

Plan-level interventions include case management activities such as: assisting the individual/family in coordination of care; completing necessary “open” referrals; allowing seamless access to necessary care; and, connecting the individual/family to community resources available. Those enrollees that do not meet the selection criteria for Plan-level case management are referred to their Primary Care Provider for follow-up and collaborative care planning.

CHPW ensures that PCPs are responsible for the provision, coordination and supervision of health care to meet the needs of each enrollee, including assessment, initiation and coordination of referrals, and individualized treatment plans. CHPW assists this process by identifying beneficiaries who meet the ESHCN criteria and notifying the PCPs of this. Treatment plans are developed with enrollee participation and are coordinated with any specialists caring for the enrollee.

Performance & Health Outcome Measurement

The Strategy and Analysis Unit at CHPW shall provide quantitative analysis. Oversight accountability for monitoring, evaluation and qualitative analysis lies with the Director of Care Management and the Medical Director. All data and analysis is stored in electronic format on the primary data storage area at CHPW. The ongoing evolution and improvement of the model of care is a function of the Quality Council.

Dissemination of improvements and changes will occur via web announcements, internal training for staff and direct outreach to primary care provider staff.

Outcome Measures are as listed with performance targets set against available benchmarks. Lacking benchmarks we will use PDSA methodology and set goals as a certain percentage of improvement. Performance versus goals is reported to the Care Management Operations Forum and corrective action plans are the accountability of this forum.

Goal	Measurement
Increase access to medical, mental health & social services	Provider Services with oversight activities regarding access to care. QI third out data as self reported by the network.
Increase coordination of care with an identifiable point of contact	3% Increase in Coordination of Care. Survey enrollees for PCP and access information. Track PCP visits at time of risk stratification.
Improve transitions across settings & providers	3% Reduction in lag time to PCP notification, and lag time to appointment with PCP or Psych provider from time of discharge.
Improve access to preventive health services	3% increase in preventive health visits with the PCP team
Assure appropriate utilization	3% Reduction in ER visits
Improve health outcomes	3% Reduction in Admission Rates 3% Reduction Readmission Rates

Managing Transitions for All SNP Beneficiaries

Items to be completed by each care setting includes:

- Discharge Summary
- Medication List – Reviewed with the Members
- Follow-on appointments

