Care Management



Overview

- CHPW Care Management Teams
 - Team Scopes
 - Behavioral Health Experience
- Care Coordination Best Practices
- Regional Resources
- Contact Information



Care Management

Darla Bernstein Director - Care Management

Ashley Kleinjans Manager of Medicaid Case Management

Team of Mental Health Practitioners, Social Workers, and RNs across the state in Spokane, Vancouver, and Seattle. Shannon Baker Manager of Medicare Case Management

Case Managers for Medicare members and dual-eligible members who have Medicare and Medicaid. Manda Oien Manager of Population Health

Health Coaches support members with certain chronic conditions. A specialty team also focuses on members with special needs, such as those without a PCP or children with high blood lead levels. Cyndi Stilson Manager of Transitions of Care

A post-discharge call team outreaches to members within 3 days of discharge from an inpatient facility. There are also teams focused on Jail Transitions and Difficult to Discharge members. Tashau Asefaw Manager of Care Coordination & Community Linkages

Focuses on the social determinants of health by connecting members with resources in their community for food, housing, transportation, and other needs.



Transitions of Care

Transitions of care (TOC) provides proactive support to members as they move from one level of care to another. The team is staffed by medical and behavioral nurses, pharmacists, and social workers.

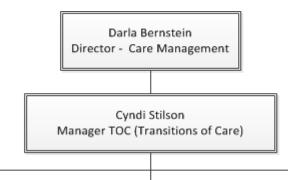
Program Functions:

- Ensure coordination of services and prevent unnecessary readmissions or complications
- Provide jail transition services
- Support transfers to rehab, skilled, and long-term care
- Coordinate with health homes and care teams
- Ensure home health and DME are in place
- Verify appointments with PCPs and care providers, and coordinate transportation
- Confirm member has correct medications and is able to get to the pharmacy
- Assist members/caregivers in understanding care plans
- Provide referrals to case management and other community-based programs and services





Transitions of Care



Post DC call team

- Outreaches within 3 days to any member who has been in a facility
- Follows up on discharge orders, makes sure follow-up appointments are made and prescriptions are picked up, and that the member doesn't have any unmet needs.
- Care coordination occurs when needed.

Difficult to DC team

 Works with the inpatient facility and the member to assist with facilitating the discharge when the member is medically stable to go to a lower level of care but there is a barrier to that discharge.

Jail Transitions team

- Coordinates with the jail and the inmate who is close to release, or has recently been released from jail.
- The TOC staff assists with coordinating transportation, provider appointments, or other needs either independently or with other Care Management teams.



Care Coordination & Community Linkages

CHPW's Care Coordination and Community Linkages (CCCL) addresses the social determinants that have an impact on member health.

This team of community-based workers, social workers and medical assistants provides support to internal team members (case managers) as well as members, providers and caregivers.

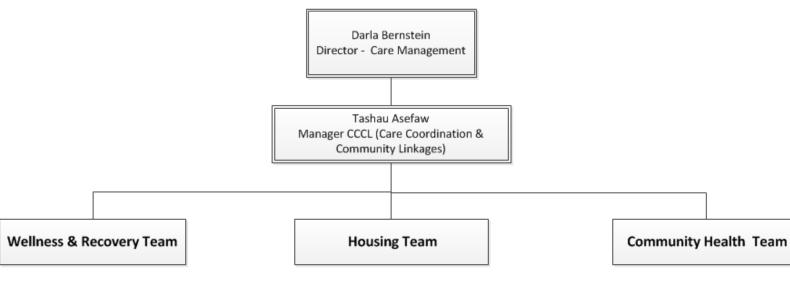
The locally-based team works closely with Community Health Centers (CHCs) to identify regional resources, connect the member to those services, and ensure continued support and access.

Services include coordinating housing, transportation, food, and assistance in getting appointments and care.





Care Coordination and Community Linkages



- Supports members with creating and meeting their recovery goals
- Connects members to community peer support services

Works with members who are homeless or having housing insecurity to connect them with community resources and assist them with navigating the housing system

- Community Health Workers are located in every region
- Connects members to resources, services, local community health workers in the member's community
- Promote access to primary care, and behavioral health resources



Case Management

CHPW's case management (CM) programs work with members, caregivers and care teams to develop and manage a plan of care that ensures access to quality care and the social support they need. These programs address the needs of our most complex and vulnerable members.

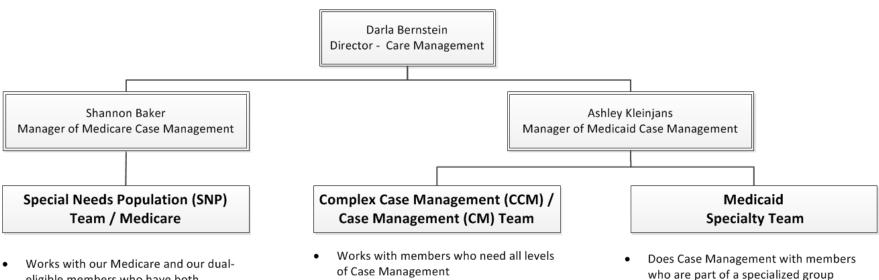
CHPW case management is:

- Focused on the whole person: teams include medical and behavioral CMs working side-by-side to support the complete needs of members
- **Data driven:** uses real-time, predictive and pattern analysis to identify members
- Consumer centric: care plans designed to address member priorities and concerns
- Community-based: fully integrated with community health centers (CHCs) and resources





Case Management



- eligible members who have both Medicare and Medicaid
- The members may need Complex Case Management, Case Management or Care Coordination
- of Case Management
- Offers integrated case management, with team members who have a mixture of behavioral health and physical health backgrounds
- Regional coverage with at least one Case Manager in every region
- This includes team members who have behavioral health background, such as experience with recovery, WISe, adolescent psych and trauma-informed care for children.

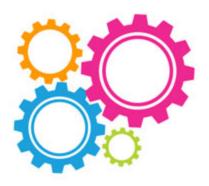


Population Health



Population Health Management (formerly Disease Management) programs address:

- Keeping members healthy
- Managing members with emerging risk
- Improving safety and health outcomes
- Managing multiple chronic illnesses



CHPW's programs:

- Use multiple data sources (claims, HRAs, and electronic health records) to identify members
- Stratify populations to find highest impact members
- Target relevant and key conditions (diabetes, asthma, and COPD)
- Screen, refer, and coordinate related behavioral health needs as well as medical
- Provide health coaching and selfmanagement support community HEALTH PLAN of Washington™

Population Health



Health Coaches

 The Health Coaches work with our members who have Asthma, COPD, and/ or Type 2 Diabetes to encourage healthy lifestyle changes and support better chronic condition management.

Specialty Team

- The Specialty Team focuses on specific populations with specific health needs, outside of chronic conditions.
- Currently this team is involved with coordinating care for children with high blood lead levels and getting members in to see their PCP if they're overdue.



CHPW Behavioral Health Experience

- Case Management nurses with experience, including:
 - Adolescent psychiatry
 - Trauma-informed care for children
 - Physical healthcare for incarcerated children
 - Correctional health care
 - Mental Health for at-risk youth
- Case Management behavioral health professionals with experience including:
 - Children's behavioral health
 - WISe
 - CLIP referral
 - Juvenile justice (including drug court and probation)
 - Recovery
- Care Coordination and Community Linkages Wellness & Recovery Coordinator who is a certified peer and recovery coach



Care Coordination Best Practices

- Shared Care Plans
- Member/Patient Driven
- Recovery Oriented Principles
- Trauma Informed Care
- Cultural Sensitivity



Care Coordination Principles

- One lead care coordinator identified for each person (health care provider or health plan)
- Multidisciplinary team approach individualized to each person's needs with agreed upon roles and responsibilities
- Routine information-sharing within privacy laws
- Connects individuals to health care, social services, and community resources
- Focuses on individuals with complex needs
- Strives to enhance or supplement current efforts and reduce duplication of work.



Additional Regional Resources

- Each region of the state has unique resources to help support members around care coordination
- CHPW coordinates with these resources by having a regional presence with at least a Regional Manager, Community Health Worker and Case Manager; along with supportive team members throughout the state.



Contact Us

Program specific staff can be reached by phone and email:

- Case Management: 866-418-7004 or Case.Management@chpw.org
- SNP Case Management: 866-418-7005 or Case.Management@chpw.org
- Care Coordination & Community Linkages: 866-418-7006 or <u>CareCoordCommLinkage@chpw.org</u>
- Population Health: 866-418-7008 or <u>PopHealthRequests@chpw.org</u>
- Transitions of Care: 866-418-7009 or <u>TOCRequests@chpw.org</u>

