Care Management

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CHPW Care Management

- **Focused on the whole person:** Assessing physical, behavioral and social needs and coordinating care with providers and community agencies
- **Interdisciplinary team:** Case Managers (Registered Nurses, Licensed Social Workers, Licensed Mental Health Professionals), Licensed Dieticians, Clinical Care Coordinators (LPN, BSW), Community Health Workers, Non-clinical support staff, Medical Directors (Physical & Behavioral Health), and Pharmacist collaborate to support the needs of the member
- **Data driven:** uses real-time, predictive and pattern analysis to identify members
- **Member-centric:** care plans designed to address member priorities and concerns
- **Community-based:** integrated with community health centers (CHCs) and resources
- **Regionally focused:** regional teams to best support member needs

Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation (CMSA).

Care Management Process

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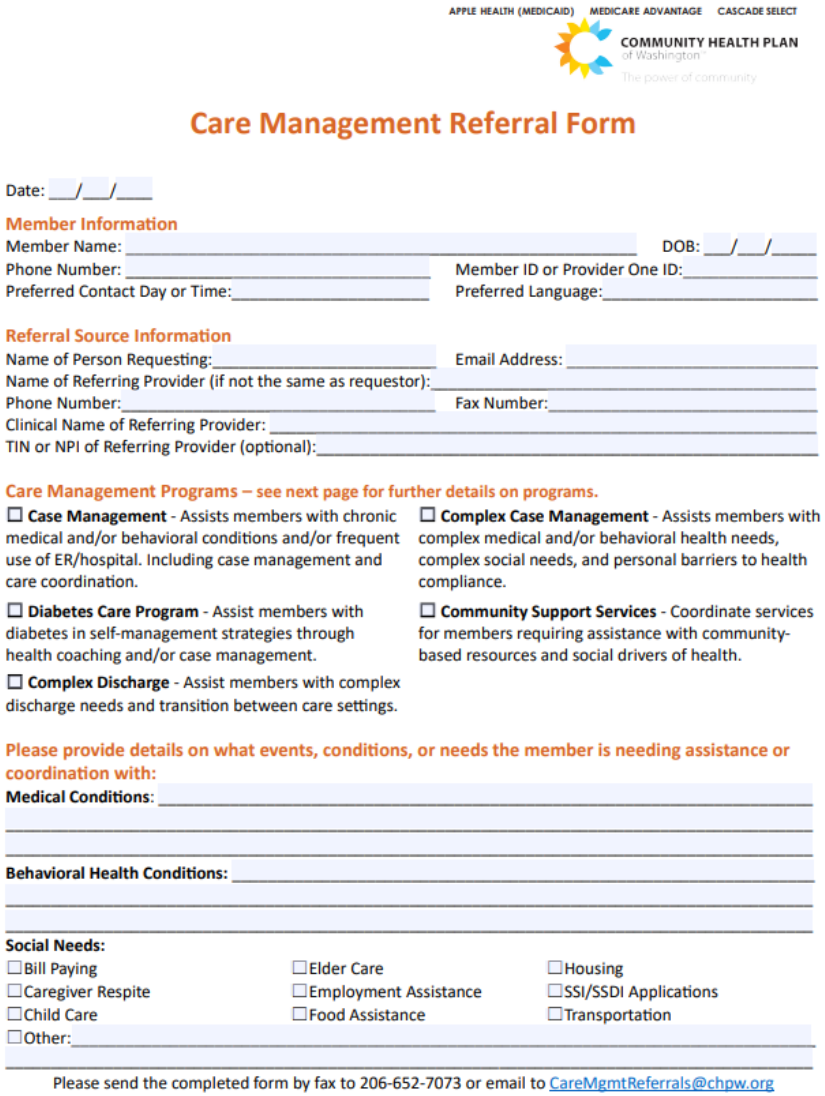
Referrals

CHPW Care Management Referral Form

- Available on the CHPW website under Provider Center
- https://www.chpw.org/wp-content/uploads/content/provider-center/Care-Management-Referral-Form.pdf
- Submitting a referral form is helpful but not required to request care management services

Referrals, questions, share information:

- Email: caremgmtreferrals@chpw.org
- Phone: 866-418-7004 (Medicaid/Cascade Select) or 866-418-7005 (Medicare)
- Fax: 206-652-7073
- Monitored Monday – Friday during business hours



APPLE HEALTH (MEDICAID) MEDICARE ADVANTAGE CASCADE SELECT

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Care Management Referral Form

Date: ___/___/___

Member Information

Member Name: _____ DOB: ___/___/____

Phone Number: _____ Member ID or Provider One ID: _____

Preferred Contact Day or Time: _____ Preferred Language: _____

Referral Source Information

Name of Person Requesting: _____ Email Address: _____

Name of Referring Provider (if not the same as requestor): _____

Phone Number: _____ Fax Number: _____

Clinical Name of Referring Provider: _____

TIN or NPI of Referring Provider (optional): _____

Care Management Programs – see next page for further details on programs.

☐ **Case Management** - Assists members with chronic medical and/or behavioral conditions and/or frequent use of ER/hospital. Including case management and care coordination.

☐ **Complex Case Management** - Assists members with complex medical and/or behavioral health needs, complex social needs, and personal barriers to health compliance.

☐ **Diabetes Care Program** - Assist members with diabetes in self-management strategies through health coaching and/or case management.

☐ **Community Support Services** - Coordinate services for members requiring assistance with community-based resources and social drivers of health.

☐ **Complex Discharge** - Assist members with complex discharge needs and transition between care settings.

Please provide details on what events, conditions, or needs the member is needing assistance or coordination with:

Medical Conditions: _____

Behavioral Health Conditions: _____

Social Needs:

☐Bill Paying ☐Elder Care ☐Housing

☐Caregiver Respite ☐Employment Assistance ☐SSI/SSDI Applications

☐Child Care ☐Food Assistance ☐Transportation

☐Other: _____

Please send the completed form by fax to 206-652-7073 or email to CareMgmtReferrals@chpw.org

CM Engagement

- Gather information to understand the member's clinical needs & treatment plan
  - Request clinical records, review ProviderOne, Health Risk Assessment, Arcadia, Express Scripts, Jiva, etc.
- Contact with the member within 5 days
- The Case Manager will complete an assessment & create a care plan with the member
- Ongoing follow up with the member & care team to achieve goals in the care plan
  - Frequency of contact is based on the member's needs

Closing a Case

- Goals have been met
- Member chooses to opt out of CM services
- The member does not adhere to the plan and unable to engage in the plan of care
- Unable to reach the member after multiple attempts
- The members expires
- Change in eligibility with CHPW

Care Management Teams

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Care Management Teams

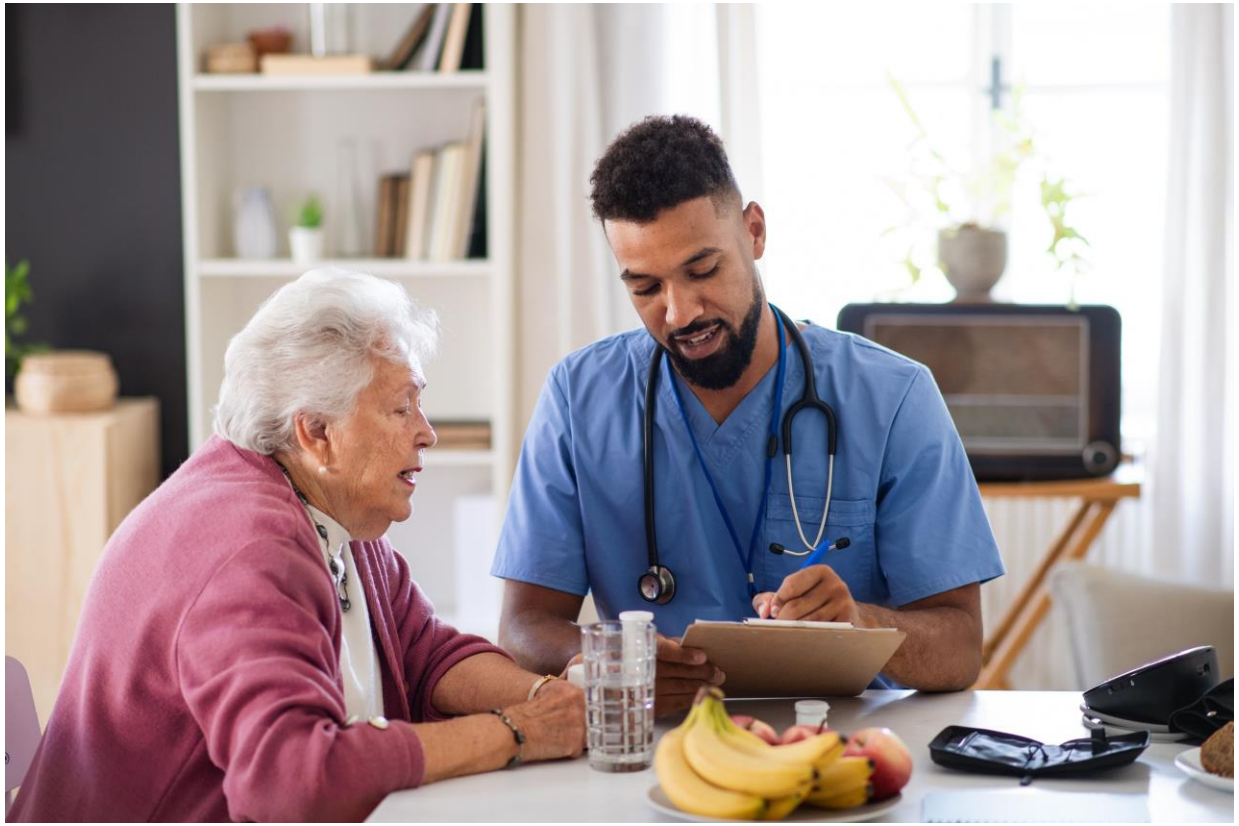
Medicare (MA & DSNP)	Special Programs	Community Support Services	Wellness & Chronic Condition Programs	Medicaid

• CHC aligned care teams to support MA & DSNP members
  • Case Managers
  • Clinical Care Coordinators
  • Care Advocates
	• Complex Discharge
	• Carceral Transitions
	• Patient Review and Coordination (PRC) Program
		• Community Health Workers
		• Care Management Coordinators
			• Diabetes Care Program
			• Maternal Child Health Program
			• Health Homes Care Coordinators
				• Regional and Field Case Managers
				• Case Managers
				• Clinical Care Coordinators
				• Member Engagement Specialists

Medicare Team

- Serves Medicare Advantage and Dual Special Needs Plan (DSNP) members
- Most vulnerable population
- Specific requirements for DSNP members
  - All are assigned a Case Manager
  - CMS requirements for annual assessments, Individualized Care Plans and Interdisciplinary Care Team meetings
- Provide care coordination and care management services
  - Help members navigate benefits
  - Gaps in care closure
  - Health education
  - Collaboration with provider teams

Medicare Model: In-Home Assessments



Partner with high volume CHC's to provide advance practice nurse in-home assessment – newly enrolled and high risk/home bound/non-engaged MA/DSNP members:

- Capture high risk diagnoses
- Complete initial HRA
- Develop initial care plan
- Determine risk level
- Warm hand off to Care Team and PCP

Special Programs Team

- Complex Discharge
  - Complex Discharge Case Manager collaborates with the inpatient facility, community agencies, and the member to transition the member to a more appropriate care setting.
- Carceral Transitions
  - Coordinates with the jail and justice involved individual as a release date approaches to ensure continuity of care for the member.
- Patient Review and Coordination (PRC)
  - Case Managers review members with high utilization of opioids.
  - Members are restricted to one pharmacy, one hospital, and one PCP.
  - Case Managers coordinate care between members, providers, facilities, and pharmacy.

Community Support Services Team

- Community Health Workers (CHW)
  - 20 regionally based CHWs
  - Education and coordination of community resources
    - Housing
    - Transportation
    - Food insecurity
    - Peer connections
    - Assistance with applications for resources or programs
    - Assistance in scheduling appointments
  - CHWs supporting in-home assessment projects
- CM Coordinators
  - Non-clinical staff
  - Review, triage, and disseminate referrals for the department

Wellness & Chronic Condition Programs Team

Maternal Child Health (MCH)

- Case Managers assigned to high-risk pregnant members and newborn members up to 1 year old (Healthy You, Healthy Baby program)
- Provide care coordination & care management services

Diabetes Care Program

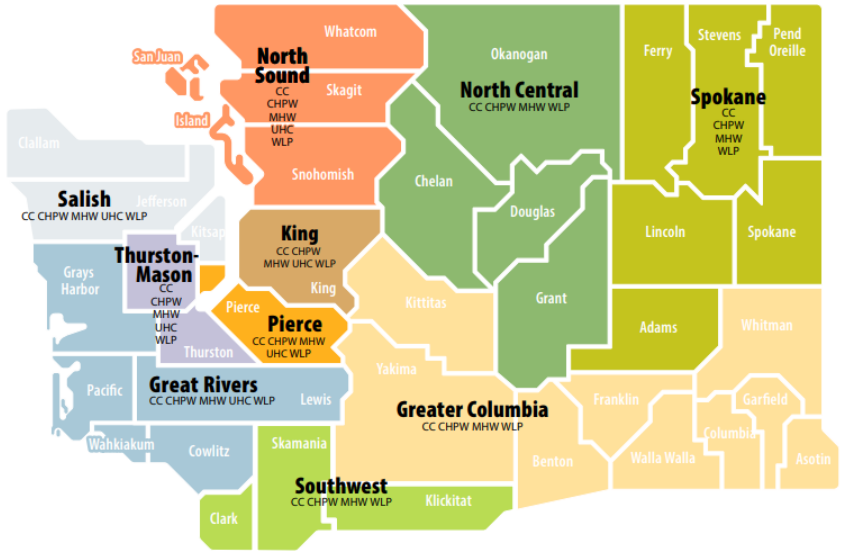
- Health Coaches (Registered Dietician) and Case Managers (Registered Nurse) working with members to empower healthy lifestyle choices and self-management diabetes
- Outreach to high-risk members
- Collaborating with Community Health Centers
- Coordinating services with community Diabetes Programs or Support Groups
- Program available to members across lines of business

Medicaid Team

- Serves Apple Health, Apple Health Expansion and Cascade Select members
- Provide care coordination & care management services
- Regionally based field staff
  - Regional and Field Case Managers
  - Provides face-to-face case management to members where telephonic engagement is a barrier
  - Attend community meetings
- Case Managers coordinate care in person or telephonically
  - Help members navigate benefits
  - Gaps in care closure
  - Health Education
  - Collaboration with provider teams

Regional Focus

- Regional Care Teams
  - Aligned with ten (10) IMC regions
  - Member and Provider facing staff
    - Care Management
    - Regional Managers
    - Sales/Marketing Account Managers
    - Provider Relations/Contracting
    - State Hospital Liaisons



https://www.hca.wa.gov/assets/free-or-low-cost/service_area_map.pdf

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