	# 702	Care Management Program X Policy ☐ Standard Operating Procedure

Date of Inception:		11/30/2014	**CEO Approval:**				
Current Approval Date:		08-07-2023	**CMO Approval (If Required):**				
Operational Scope:	Board Directors ☐	Admin ☐	PF ☐	CC / QM ☐	Rights ☐	RCM ☐	ERS ☐
H/S ☐	IHS ☐	IT/IDS ☐	Sec / Safety ☐	Environmental ☐	Facilities ☐	☐	Agency ☒

702 Policy

Provider Health (Provider) supports and promotes the health and safety of service participants through a comprehensive Care Management Program focused on assisting members, their families, and support systems in managing health and behavioral health conditions more effectively.

702.1 Scope

To establish operating protocols for Provider Care Management and Care Coordination activities, including coordination with Clinical Care Teams and any involved Managed Care Organization (MCO) Care Management personnel.

702.2 Procedure

I. Program Structure

A. Identification and Assignment of Risk Groups

Provider uses a data analytics platform, alerts from the Health Information Exchange and a risk-vetting process within each campus to identify service participants with the highest costs, greatest needs and/or those who would most benefit from support through the Care Management Program. Risk Groups include:

1. Provider High Risk Registry
2. Groups with enhanced risk due to utilization of high-cost settings and/or emergent at-risk conditions and lifestyle factors with limited ability to self-manage
3. Individuals with preventive healthcare needs
4. Pregnant women
5. Individuals requiring more targeted chronic condition management
6. Individuals whose outcomes are lower than expected

B. Care Manager

1. Provider assigns one (1) Care Manager for an assigned caseload of approximately 90 service participants on the Provider High Risk Registry.

4.2 C

2. The Care Manager is responsible for oversight, coordination, and direct intervention with all individuals on the High-Risk Registry across all Provider clinic facilities.
3. The Provider Care Manager coordinates with involved MCO Care Managers to maximize information sharing and reduce overlap and duplication in services between the programs.
4. The Lead Care Manager must be licensed as a Behavioral Health Professional (BHP) MSW, RN, MA, etc. and is assisted in their role by additional Care Managers and Integrated Care Coordinators at each clinic facility. These individuals have a BA/BS in behavioral health related fields. They also closely coordinate with the MCO Care Managers assigned to each site who have a variety of behavioral health related educational credentials. 4.2 A

C. Integrated Care Coordinator (ICC)
1. Provider assigns one (1) Integrated Care Coordinator to each Provider integrated clinic/practice site. The ICC is responsible for a short-term caseload of approximately 20 service participants with enhanced risk and limited self-management skills.
2. The ICC serves as an added resource to the assigned primary case manager to facilitate individual engagement and follow-up in care, understand and implement post-discharge/post-visit medical orders and to coordinate more specialized post-discharge/post-visit placements (including skilled nursing centers, home health, and residential settings).
3. The ICC may also interact with involved MCO Care Managers for participants with enhanced risks who are also identified by the MCO Care Management Program.

CI. MCO Care Managers
1. The MCO Care Management Program uses predictive modeling, health risk assessment and utilization data to identify the top tier of high-risk/high-cost members with serious mental illness and assign them to an MCO Care Manager. Current priority groups for MCO care management include:
    a. Pregnant women
    b. Transplants
    c. Hepatitis C
    d. HIV/AIDS
    e. Hemophilia
2. MCO Care Managers are co-located at Provider Facilities and act as consultants to the Clinical Care Team for complex cases and MCO priority groups.
3. On a quarterly basis, MCO Care Managers conduct and present a case analysis including current information on health status and follow-up for routine and specialty care, identifying strategies to improve coordination between involved providers and ensuring successful transitions of care from institutional settings.
4. For priority risk groups such as pregnant women, MCO Care Managers establish defined communication protocols to support improved care coordination between Provider Clinical Care Teams and specialty providers.

II. Program Operations

A. Care Management Role
The Provider Care Manager supports the overall effort of the Clinical Care Team for persons on the High-Risk Registry by ensuring effective communication among team members, development of tailored integrated service plans and serving as a team consultant on evidence-based strategies for clinical, medical, family, environmental and social interventions, as applicable.

1. Uses clinical tools, conducts assessments of High-Risk members and reviews member specific health information/data to determine an approach to resolving member issues and/or meeting needs,
2. Actively participates in developing a comprehensive care management plan that addresses identified clinical/medical needs including need for specialty care and environmental support (e.g., DME), level of health literacy and activation, community and family support resources and all involved providers.
3. Coordinates implementation of the plan with the Clinical Care Team, including establishing defined follow-up points and monitoring of outcomes of any interventions and referrals.
4. Systematically tracks treatment response and monitoring High Risk members (in person or by telephone) for changes in clinical symptoms and treatment side effects or complications.
5. Supports hospital transitions in collaboration with other team members.
6. Provides member, family and caregiver education about common behavioral health, medical and substance abuse disorders and the available treatment and resource options.
7. Develop and implement self-management plans for members who have achieved their treatment goals and are soon to be transitioned from the High-Risk Registry. 4.2 B

B. Integrated Care Coordinator Role
Copa Integrated Care Coordinators participate as a member of the Clinical Care team for members assigned to other risk groups, including pregnant women and participants on court ordered treatment.

1. When an ADT alert is transmitted for a member of a risk group, the ICC works directly with the Clinical Coordinator and Care Manager to ensure specialized supports and services (e.g., DME, specialist appointments) are arranged and provided.
2. Provides enhanced support to complex members or individuals who are not progressing as expected by participation in primary care/specialist appointments and supporting transitions from the hospital.
3. In collaboration with the assigned primary case manager, facilitates treatment plan changes for members, tracks member follow-up on referrals and monitors gaps in preventive care and wellness services.

C. Coordination and Communication with MCO Care Managers
MCO Care Managers are co-located at Provider facilities and participate in service planning and complex case staffings as needed.

1. MCO Care Managers conduct quarterly case reviews and present findings and recommendations to the Clinical Care Team.

2. MCO Care Managers are invited to participate in weekly Provider Integration Meetings for review of the PCP caseload and other complex service participants.
3. MCO Care Managers are outreached by the Provider Care Manager to coordinate services and share information for individuals on the Provider High-Risk Registry.
4. MCO Care Managers define a coordination protocol for certain risk groups and monitor follow up by the Clinical Care Team telephonically or by email.