Section 11
Care Management Services

The Alliance Care Management (CM) team works with members to provide services and supports to improve and/or maintain health and quality of life. CM services include: complex case management for adults and pediatric members, care coordination, and preventive health education, including chronic disease self-management.

The CM multidisciplinary team consists of experienced nurses, medical social workers, care coordinators, and health educators, who collaborate with the PCP and specialty providers to provide coordinated care through the Patient Centered Medical Home (PCMH). The team's main focus is to improve quality of life through the promotion of realistic self-care goals and management of chronic health conditions. CM services are voluntary and available to all eligible Alliance members at no cost to them. Members who do not wish to participate in the program can opt out at any time.

The team works with members and their PCPs by:

- **Facilitating** safe connections between the PCP and the member
- **Educating** members on a variety of health-related topics, including appropriately navigating the health care and social systems
- **Empowering** members to take charge of their own health care needs
- **Linking** members to available community resources

Complex Case Management

The Alliance Complex Case Management team partners with the PCP and specialists to support members in managing their acute or chronic condition(s). This may include intense coordination of resources from the multidisciplinary team to ensure the member regains optimal health or improved functionality. Individualized person-centered care plans are created with the involvement of the care team and member. The support may include services that address emotional, physical, and social support needs.

The Complex Case Management Team collaborates with you as the PCP to provide the following services:

- Comprehensive assessments
- Promotion of the PCMH by fostering the member-PCP relationship
- Care coordination
- Promotion of self-management through engagement
- Linkage to community and social support resources
- Creation of mutually-agreed upon care plans, including targeted interventions

- Engagement of members telephonically and in-person
- Support across the health care continuum

What is suitable for referral to Complex Case Management Services? *(Note: this is not an all-encompassing list):*

Chronic Illness	Catastrophic Diagnosis	Medical Issues
Poorly-controlled chronic illness or new/worsening complications (i.e. asthma and diabetes)	Complex injuries	Complicated wounds
Obesity/bariatric patients	HIV/AIDS (new diagnoses and unlinked)	Stroke with complications
Medication reconciliation	End-of-life	New or worsening debilitating disease (i.e. Multiple Sclerosis, Parkinson's Disease)
Multiple hospital admissions (excludes cancer)		Seizure disorder with complications
Palliative care		

What is not suitable for referral to Complex Case Management Services? *(Note: this is not an all-encompassing list)*:

- Members with other health care coverage
- Members with violent, or abusive behaviors
- Members who are unable to be reached or who refuse to participate
- Members in long-term care

Basic Case Management

Basic Case Management is provided by PCPs. Case Management, as defined by the California Department of Health Care Services (DHCS), is "guiding the course of resolution of a personal medical problem (including the problem of the need for health education, screening or preventive services) so that the recipient is brought together with the most appropriate provider at the most appropriate times, in the most appropriate setting." It is essentially a program that enables providers and caregivers to identify members with ongoing health care needs, so that an effective plan may be developed that enables the efficient use of health care resources -- with a goal of achieving the best possible health outcomes.

Four requirements are necessary for the basic case management system to function:

- Members receiving basic case management must be assigned to a PCP.

- Through prior authorization, PCPs will refer members directly to all necessary services, with the exceptions of Emergency, Limited Allied Services (Medi-Cal line of business only), OB-GYN and certain family planning services that qualify for self-referral.
- PCPs in either individual or group practice — and in private and/or public settings — will be geographically located throughout Santa Cruz, Monterey and Merced counties to facilitate members' access to health care services.
- The objectives of a good case management plan are:
    - To foster continuity of care -- as well as good relationships -- between providers and members.
    - To coordinate the care of Alliance members so that satisfactory health outcomes are achieved.
    - To contribute to a decreased use of hospital ERs as a source for non-emergency, first contact and urgent medicine by our members.
    - To reduce the incidence of members' unnecessary self-referral to specialty providers.
    - To discourage medically inappropriate use of pharmacy and drug benefits by our members.
    - To facilitate members' understanding and use of disease-prevention practices and early diagnostic services.
    - To provide a structure within which our providers can manage members' health care services in a manner that ensures a high quality of care delivered in a cost effective manner.

For complete details on physician case management responsibilities, please see Policy 404-1313 - Primary Care Provider Responsibilities in Case Management and the Promotion of Primary Care Medical Home.

Care Coordination

The Care Coordination Team assists members with less complex, non-clinical needs by providing:

- Referrals and coordination with community resources and services, including other Case Management programs, Local Education Agencies, Regional Centers, etc.
- Follow-up care with specialists, including referrals for ancillary services and Durable Medical Equipment (DME)
- Assistance with making appointments and retrieval of medical records
- Appointment reminders and linkage to transportation resources

For information or referrals to Care Management Services, including Complex Case Management and Care Coordination, please call the Case Management Line at (800) 700-3874 ext. 5512.

Case Management Support for Members with Disabilities or Special Needs

Children with Special Health Care Needs

The Alliance pediatric Case Management team helps members and their parents/guardians with obtaining the care and services that are needed. Case Management and Care Coordination support are offered to all members who are enrolled in the CCS program.

For more information on children with special health care needs, please see Policy 405-1106 - Children with Special Health Care Needs (CSHCNs).

Individuals with Disabilities

The Case Management team coordinates services and helps members obtain the equipment they need.

Members with Developmental Disabilities: Medi-Cal

During the Initial Health Assessment performed when enrolling new children into your practice, providers will identify those who have, or are at risk of acquiring, developmental delays or disabilities; this includes signs and symptoms of intellectual disability, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to intellectual disability or requiring treatment similar to that required for individuals with intellectual disability. Additionally, developmental screening is a part of each well-baby and well-child visit.

A *developmental disability* is a disability attributable to an intellectual disability, cerebral palsy, epilepsy, autism, or other conditions similar to an intellectual disability that originates before the age of 18 years, is likely to continue indefinitely, and constitutes a significant handicap for the individual. A *developmental delay* is impairment in the performance of tasks or the meeting of milestones that a child should achieve by a specific chronological age.

The Alliance is required to cover all medically necessary and appropriate developmental screenings, primary preventive care, diagnostic and treatment for members who (a) have been identified or are suspected of having developmental disabilities; and (b) are at high risk of parenting a child with a developmental disability. The Alliance works to ensure that members with developmental disabilities receive all medically necessary screening, preventive, and therapeutic services as early as possible and determines medical necessity for covered services.

Such members are referred to the appropriately funded agency, such as the Local Education Agencies (LEA), the San Andreas Regional Center (SARC) in Santa Cruz and Monterey Counties, and the Central Valley Regional Center (CVRC) in Merced County. SARC and CVRC are part of a statewide system of locally-based regional centers that offer supportive services programs for California residents with developmental disabilities. Regional centers provide intake and assessment services to determine client eligibility and needs and work with other agencies to provide the full range of early intervention services. Local regional centers can provide specific information on the services available in the member's service area. Services include respite day programs, supervised living, psychosocial and developmental services, and specialized training.

Members with developmental disabilities are linked to a PCP, who provides them with all appropriate preventive services and care, including necessary Early Periodic Screening, Diagnosis, and Treatment

(EPSDT) services. Preventive care is provided per the current guidelines of the American Academy of Pediatrics and the United States Preventive Services Task Force for Adults. PCPs are required to provide or arrange for medically necessary care to correct or ameliorate developmental disabilities and provide/arrange for all medically necessary therapies and items of durable medical equipment within the scope of their practices. For those necessary services that are beyond the scope of their practices, PCPs should make the necessary referrals and coordinate with the appropriate funding agency.

PCPs should collaborate in the development of a child's IEP (the school district's Individualized Education Plan), IFSP (the Regional Center's Individual Family Service Plan), or IPP (the Regional Center's Individual Program Plan), when applicable. PCPs should monitor and coordinate all medical services with Regional Center Staff, when applicable.

Contact information for the local regional center field offices in Santa Cruz, Monterey and Merced Counties are:

SARC Santa Cruz Field Office	SARC Monterey Field Office	CVRC Merced Field Office
1110 Main Street Watsonville, CA 95076 Tel. (831) 900-3737 Fax (831) 728-5514	1370 South Main Street Salinas, CA 93901 Tel. (831) 900-3636 Fax (831) 424-3007	3172 M Street Merced, CA 95348 Tel. (209) 723-4245 Fax (209) 723-2442

For additional information about patients with developmental disabilities and the use of regional centers, please see the following policies:

Policy 405-1304 - Developmental Disabilities - Services to Plan Members.

Policy 405-1302 - Early Intervention Services.

Coordination of Care: Medi-Cal and Alliance Care IHSS

As a PCP, you are part of the interdisciplinary team supporting the member's medical, as well as psychosocial and environmental needs. Screening, preventive, and medically necessary and therapeutic services that are covered benefits will continue to be covered by the Alliance.

The Alliance will continue to provide for normally covered medical services for members receiving services related to CCS, from San Andreas Regional Center (SARC), Central Valley Regional Center (CVRC), or the Early Start Program and will coordinate with the PCP and the designated center to assist with the development of a care plan, or in meeting the care plan that has been developed.

The Alliance maintains Memoranda of Understanding (MOU) with the Santa Cruz County Health Services Agency, Monterey County Health Services Department, and Merced County Department of Public Health. The MOU is an agreement between the Alliance and a division of the county Health Services Agency that delineates how the two entities will coordinate the provision of covered and/or public health services, as appropriate. The MOU also delineates the roles and responsibilities of each agency related to specific public health services.

Health Education and Disease Management Programs

The Alliance is committed to improving access to affordable health care for our members. To accomplish this, the Alliance offers innovative programs to help members achieve healthier outcomes. These programs are managed by a multidisciplinary team comprised of experienced health educators who assist members with techniques to stay healthy and to understand and manage chronic disease/s, including enrollment in the Alliance Health Education and Disease Management Programs. Detailed information about these services is provided in Section 12 and 13 of this manual.

For information or referrals to the Alliance Health Education and Disease Management Programs, please call the Health Education Line at (800) 700-3874 ext. 5580.