Cal MediConnect Care Coordination & Quality Improvement Program Effectiveness (CCQIPE)

L.A. Care HEALTH PLAN

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Lesson 1 of 30

Welcome

00:37

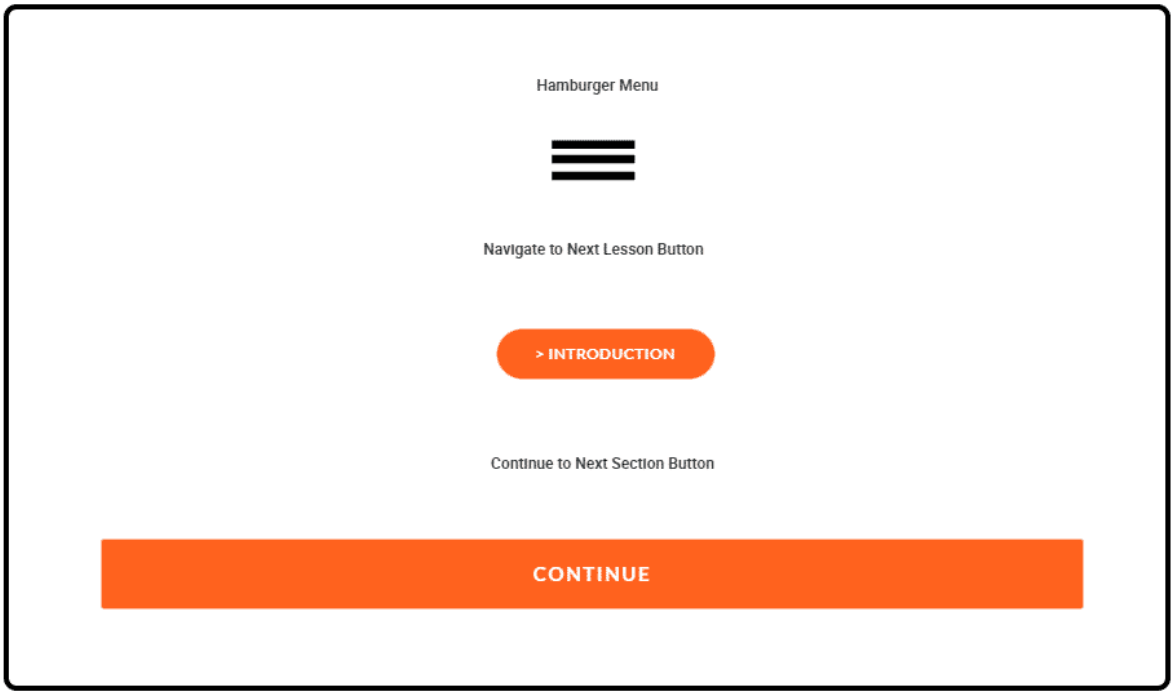
Welcome to CMC Cal MediConnect Care Coordination & Quality Improvement Program Effectiveness (CCQIPE)

We have a great deal of important information to cover, so let's get started. My name is Rob and my name is Janet, we will be your hosts during this course.

Located in the upper left hand corner you will find what we call the hamburger menu. You can track your progress, and see what topics you need to complete. You can always revisit pages you have previously completed. But you can not skip ahead in the training without interacting with all the content of each page.

The course is designed with an automatic bookmark mechanism. When you return to the course you will continue from your automatic bookmark.

Below is an image of the navigation buttons and icons used in this presentation. If you do not see the CONTINUE button it means you have not completed the lesson or you need to simply scroll down the page.

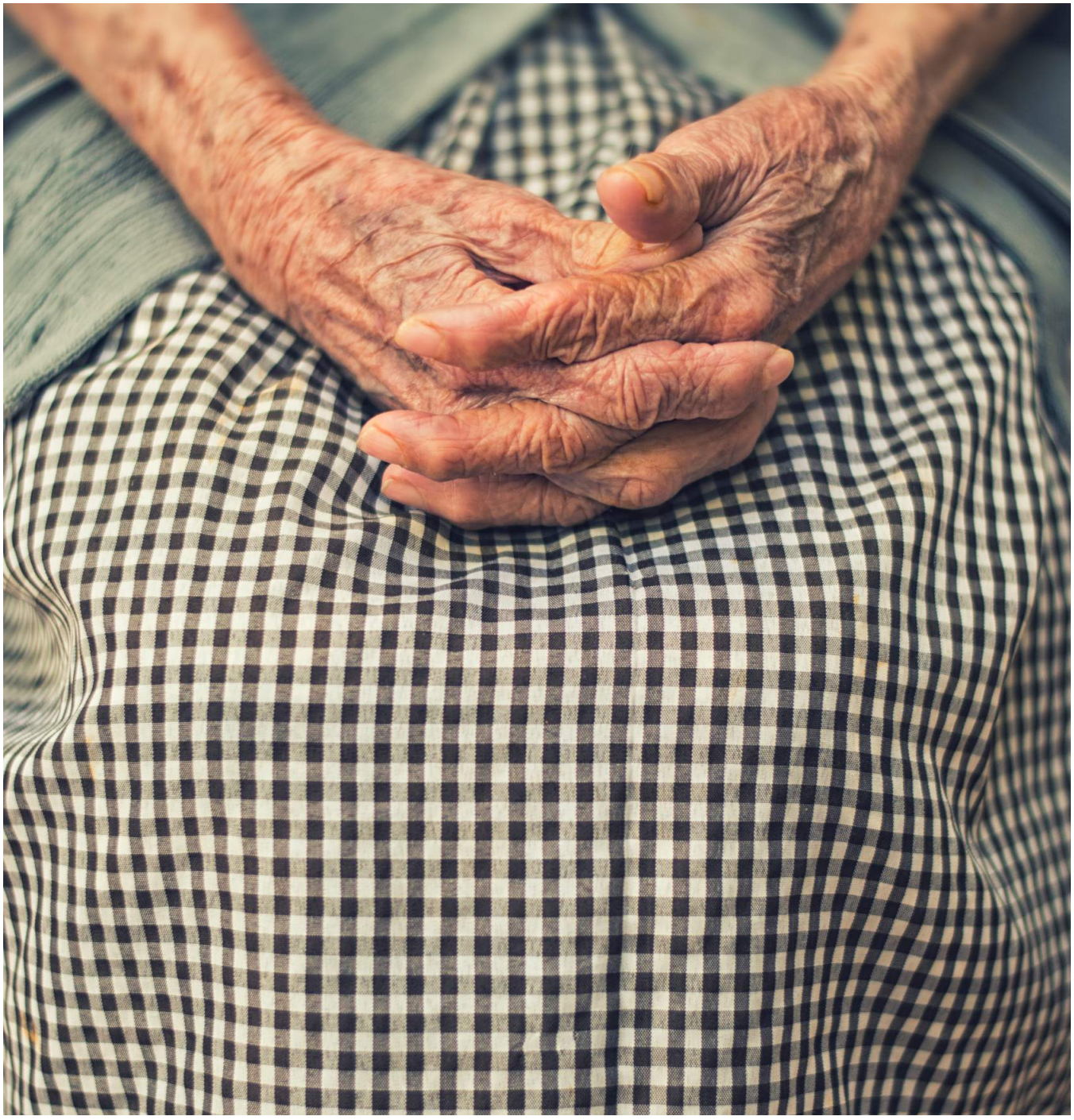


Navigation Buttons

Introduction

> INTRODUCTION

Introduction



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Welcome to Care Coordination & Quality Improvement Program Effectiveness (CCQIPE)

The Care Coordination model is a phrase that means the approach and process used to manage the health and social needs of Cal MediConnect members. The objective is that you will be familiar with each of the components of the Care Coordination model:

- Goals and how they are measured
- Staff and Care Management roles
- What is an ICT and ICP – and more detail on those is provided in a separate training module specific to them
- How the provider network and specialized services fit in
- What are the clinical practice guidelines used
- The role and detail about the Health Risk Assessment
- How MLTSS fits in
- What is the care coordination model's communication network
- How the Care coordination model performs and the measurements used to determine effectiveness
- Member protections

CMC Care Coordination

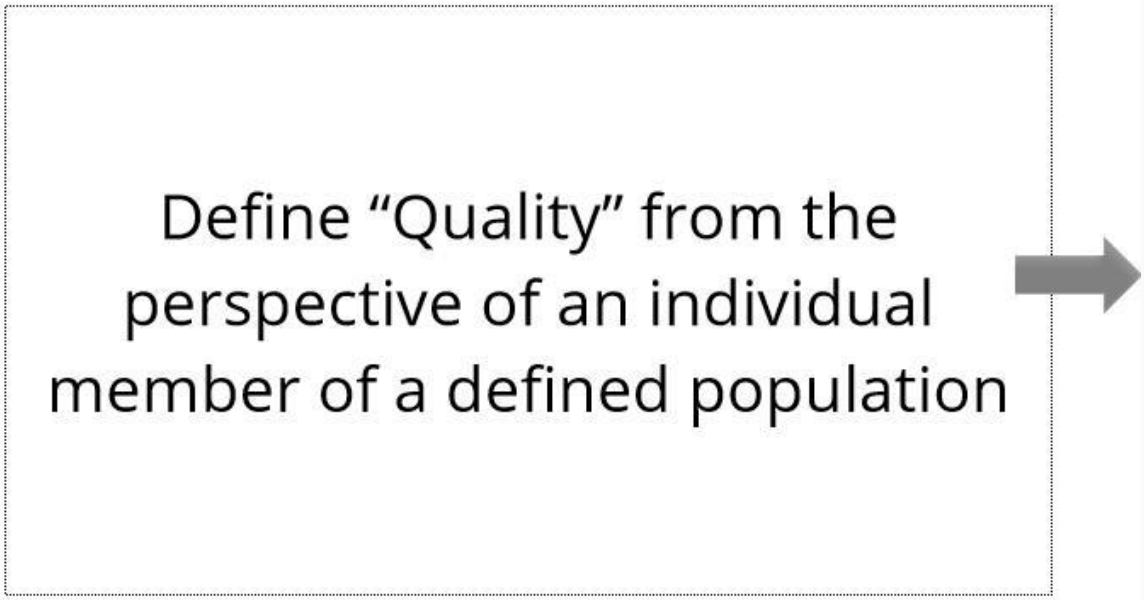
> CARE

CMC Care Coordination Goals

Our health plan will be rated on how well we meet our expected goals and quality of care for CMC members. The goal of LA Care is to help improve care, reduce health disparities, improve transitions among care settings while meeting the health and functional needs of members as well as to enable to direct their care and live independently in their homes and communities. Take a moment to review the Triple aim model below (the model has been updated to the quadruple aim to include provider satisfaction).

Institute for Healthcare Improvement Triple Aim Initiative

Click the gray arrow below for an overview of the Triple Aim Initiative.



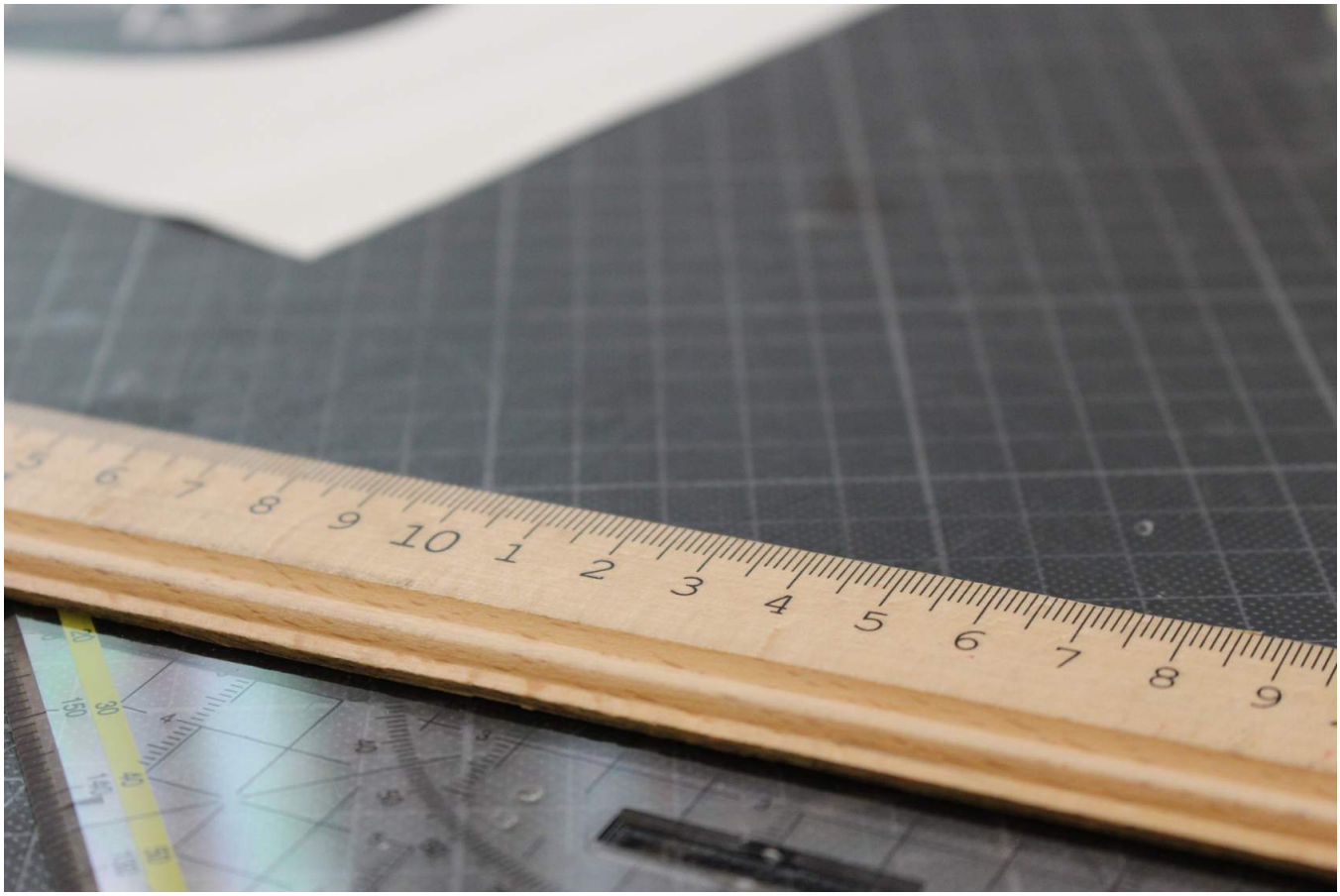
Summary

The goal is to help improve care, reduce health disparities, improve transitions among care settings while meeting the health and functional needs of members – and enabling them to direct their care, and live independently in their homes and communities.

CMC Program Measurable Goals

> MEASURABLE

CMC Program Measurable Goals



The Care Coordination model meets the specialized needs of Dual Eligible members through a member centered approach that provides for:

1. Systematic identification of members with special needs through several methods at the time of enrollment

2. Thorough assessment of individualized member needs during initial outreach calls

3. Referral to various programs, such as care management, disease management, social services, community based organizations

4. Referrals through the initial health assessment process

CMC Program Measurable Goals

Please take a moment to review CMC Program's 7 Measurable Goals.

Step 1

Goal 1

Improving access to essential services, such as medical, mental health, substance use, social services and supports including home and community based services

Step 2

Goal 2

Improving access to affordable care

Step 3

Goal 3

Assuring appropriate utilization of services

Step 4

Goal 4

Improving coordination of care through an identified point of contact

Step 5

Goal 5

Improving seamless transitions of care across healthcare settings, providers and health services

Step 6

Goal 6

Improving access to preventive health services

Step 7

Goal 7

Improving beneficiary health outcomes

Complete the content above before moving on.

CMC Program Measurable Outcomes

> OUTCOMES

CMC Program Measurable Outcomes

The Model enables the measurement of specific outcomes to gauge effectiveness. Performance is measured annually or more frequently as defined by the measure.

Measures are established by CMS, DHCS or defined by L.A. Care's Quality Improvement program, and they are performed according to our Plan, Do, Study, Act model of improvement of a continuous quality cycle so there will be Corrective Action Plans and Interventions. Analysis will be by multidisciplinary team and approved by appropriate quality committees

For Goals not met – Quality Committees will perform root cause analysis to establish causal relationship for compliance with identified measures.

Summary

Please review CMC Measurable Outcomes listed below:

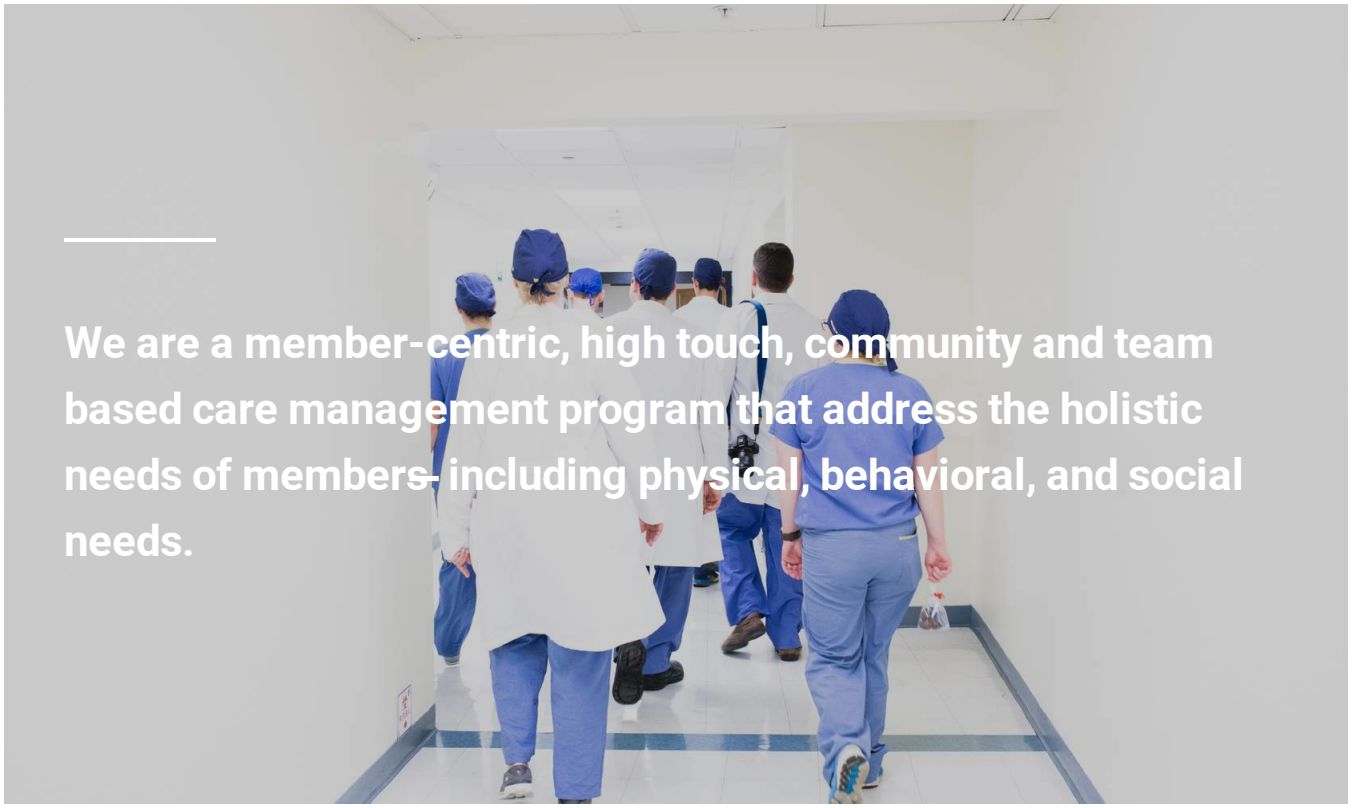
- Performance is measured annually
- Measurable goals may be analyzed more frequently as defined by the measure
- Established by CMS, DHCS or defined by L.A. Care's Quality Improvement program
- Measured using the Plan, Do, Study, Act model of improvement
- Corrective Action Plans and Interventions
- Continuous quality cycle
- Analyzed by multidisciplinary team and approved by appropriate quality committees
- Goals not met – Quality Committees will perform root cause analysis to establish causal relationship for compliance with identified measures

CMC Care Management

> CARE

CMC Care Management

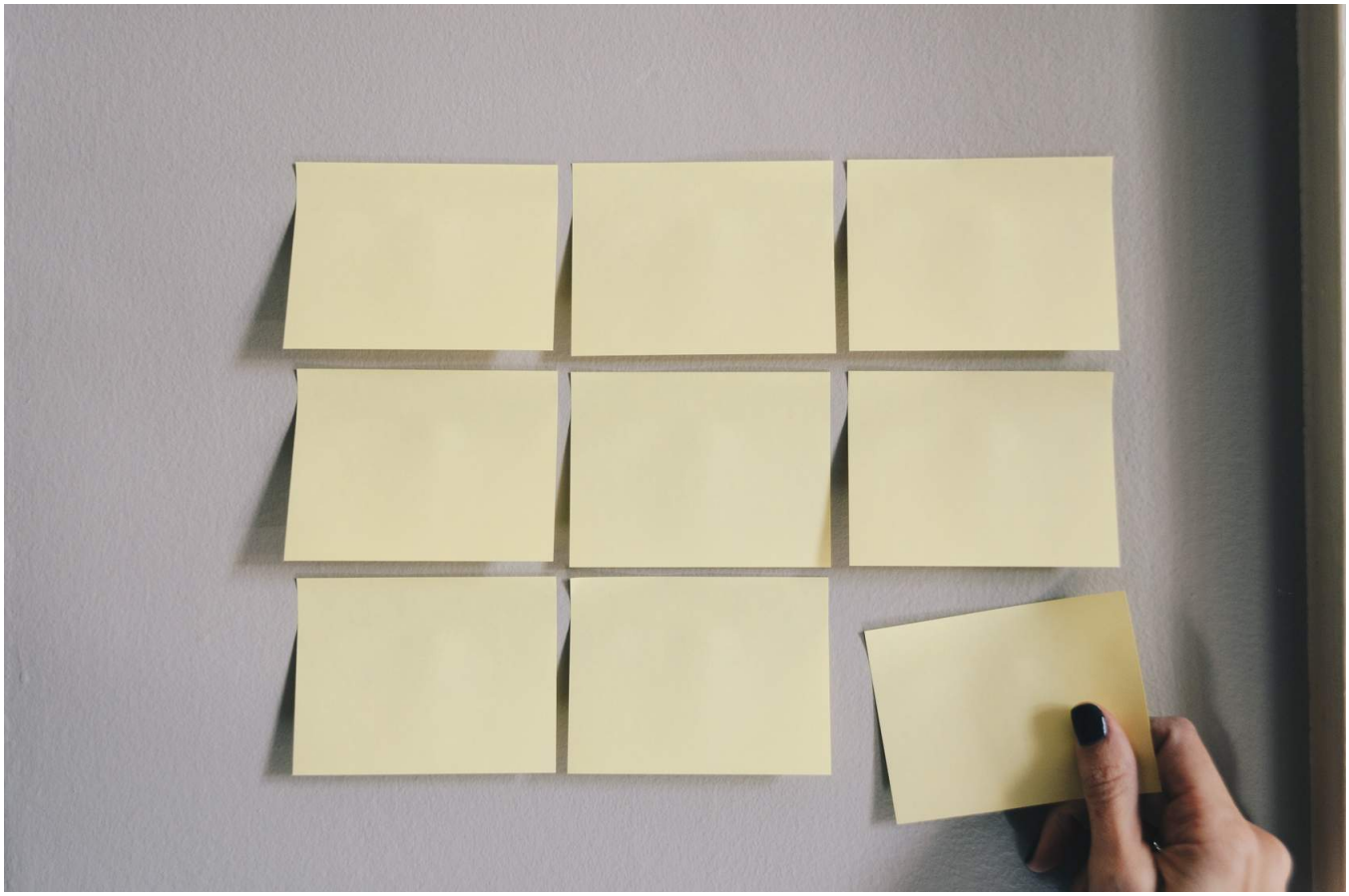
Who We Are



Member Centric

> MEMBER CENTR...

Member Centric Care Management Process



Member Centric Care Management Process

Member identification and engagement are completed through various means.

Click the Start button to review the Member Centric Care Management Process.

Step 1

Health Risk Assessment (HRA):

Member self-reported and scoring is done based on responses to questions. Stratified based on score either Low, Moderate and High. Various reports are used for predictive modelling to identify potential members for care management services.

Step 2

Individualized Care Plans

Individualized Care Plans are developed based on member HRA and CCM assessment. Based on member's response, SMART goals are set (S=Specific, M=Measurable, A=Attainable, R=Realistic, T=Timely).

Step 3

Interdisciplinary Team

Evaluate current care plan and goals and recommend other interventions as needed based on identified barriers or member concerns.

Step 4

Communication and Education

Communication and Education occur related to Care plan SMART goals and the interdisciplinary care teams input (Social worker, BH Specialist etc.)

Step 5

Care Coordination and Advocacy

Care Manager delegates and assures care coordination is carried out to meet the identified goals in a timely manner. Through this process, member advocacy is present.

Step 6

Transition of Care Management

Facilitates transition of care between different settings in a timely manner based on member's holistic status.

Step 7

Evaluation of Care Management Plan and Follow Up

Addresses effectiveness of the interventions to meet member centric goals (Goals met or not met, create new goals or close case).

Step 8

Termination of Care Management Services

Once goals are met and member is able to manage care, Care management services are ended with mutual consent.

Summary

Member Centric Care Management Process is a methodology that is composed of nine interwoven processes. Member Centric Care Management Processes are composed of the following:

- Member Identification and Engagement
- Assessment - HRA and Case Management Assessment
- Individual Care Plan
- Interdisciplinary Care Team
- Communication and Education
- Care Coordination and Advocacy
- Transitions of Care
- Evaluation of Care Management Plan and Follow Up
- Termination of Care Management

Complete the content above before moving on.

Health Risk Assessment (HRA)

> HRA

Health Risk Assessment (HRA)

HRA is a standardized self-reported screening tool conducted with each member upon enrollment.

Who gets an HRA – and When?

Every CMC member is offered a face-to-face HRA upon enrollment.

An Initial comprehensive HRA is offered to every CMC member within the first 45 days of enrollment, an annual reassessment (HRA) is done within 12 months of the last HRA or more often based on the member needs or change in health status.

To ensure an HRA is completed for each member, if a member cannot be reached, L.A. Care follows up with a written form and self-addressed stamped envelope for completion by the member. A follow up call to the member confirm receipt of the mailing.

Summary

L.A. Care will maintain an assessment process that will:

1. Assess each new enrollee's risk level and needs based on an interactive process such as telephonic or face-to-face communication. The HRA can also be mailed
2. Address the care needs and coordinate the Medicare and Medi-Cal benefits across all settings
3. Review historical Medicare and Medi-Cal utilization data
4. Follow time frames for reassessment
5. Develop the initial Individualized Care Plan (ICP) using the HRA responses

What Does The HRA Assess?

> ASSESSMENT

What Does The HRA Assess?

The HRA screens for a full range of needs and supports – to ascertain an individualized view of the member's needs.The HRA screens for:

- Health status including chronic health conditions/health care needs
- Clinical history
- Mental health, substance use disorder and cognitive status
- Activities of daily living (ADLs)/ Instrumental activities of daily living (IADLs)
- Medication review
- Health Literacy
- Living situation
- Caregiver support
- Continuity of care needs
- Fall risk
- Social determinants of health

This tool, along with other resources, is used to develop the Individualized Care Plan (ICP).

Full Integration Care Management System (FICMS)

> FICMS

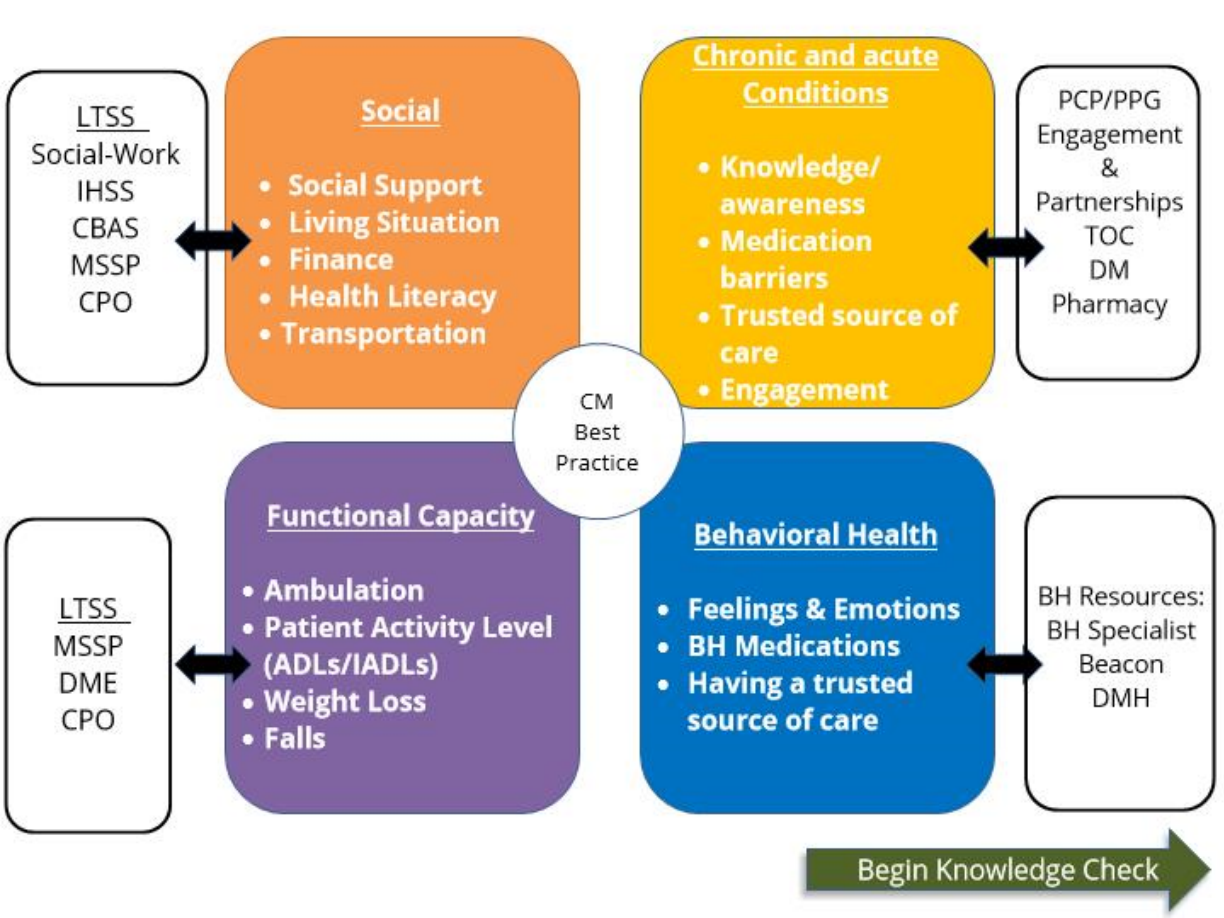
Full Integration Care Management System (FICMS)

The HRA, CM assessment and care planning process utilizes the Full Integration Care Management System (FICMS). By reviewing and addressing member's HRA responses, these four quadrants are explored further through the CM assessment using the FICMS method of individualized care. This model assists the member and nurse to prioritize which barriers to obtaining optimal wellness in whatever disease state may be present.

It is the care manager who takes the lead role and collaborates with the interdisciplinary team members and develops the professional relationship with the member/family/caregiver to implement agreed upon goals to manage health care needs. The team's goal is to engage and empower the member/family/caregiver on how to manage their care and utilize their health care services appropriately.

In the next section we will examine the FICMS model created by Dr. Amezcua.

Click the play button on the media player for a review and Knowledge Check of FICMS.



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Who Conducts An HRA?

> CONDUCTS

Who Conducts An HRA?

The two groups conduct the Health Risk Assessment:

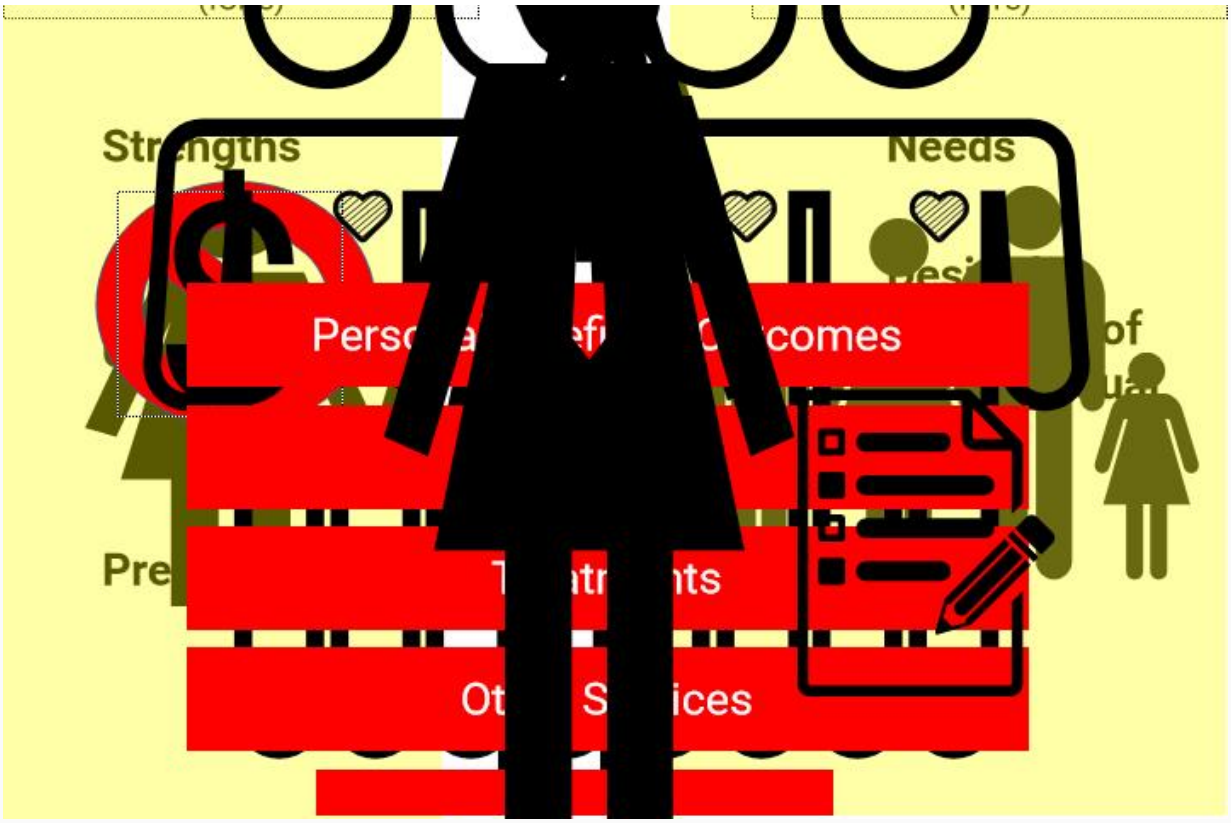
- Customer Solution Center (CSC) personnel
- Credentialed personnel who are knowledgeable conduct face-to-face HRAs.

Person Centered Planning

> PERSON

Person Centered Planning

Click the play button on the player below to view Person Centered Planning process.



Complete the content above before moving on.

Summary

The ICT is a dynamic and person centered plan of care is maintained by the Health Plan or its delegates:

- Comprehensive input from the member, member's caregiver/designee, Primary Care Provider (PCP), specialists and other service providers in accordance with the member's wishes.
- Identifies the member's strengths, capacities, and preferences
- Provides additional care options, including transitioning from a nursing facility to the community.
- Identifies the enrollee's long term care needs and the resources available

Basis for ICP

> BASIS FOR ICP

Basis for Individual Care Plan (ICP)

What information is used to develop the ICP?

L.A. Care uses the following to develop the ICP:

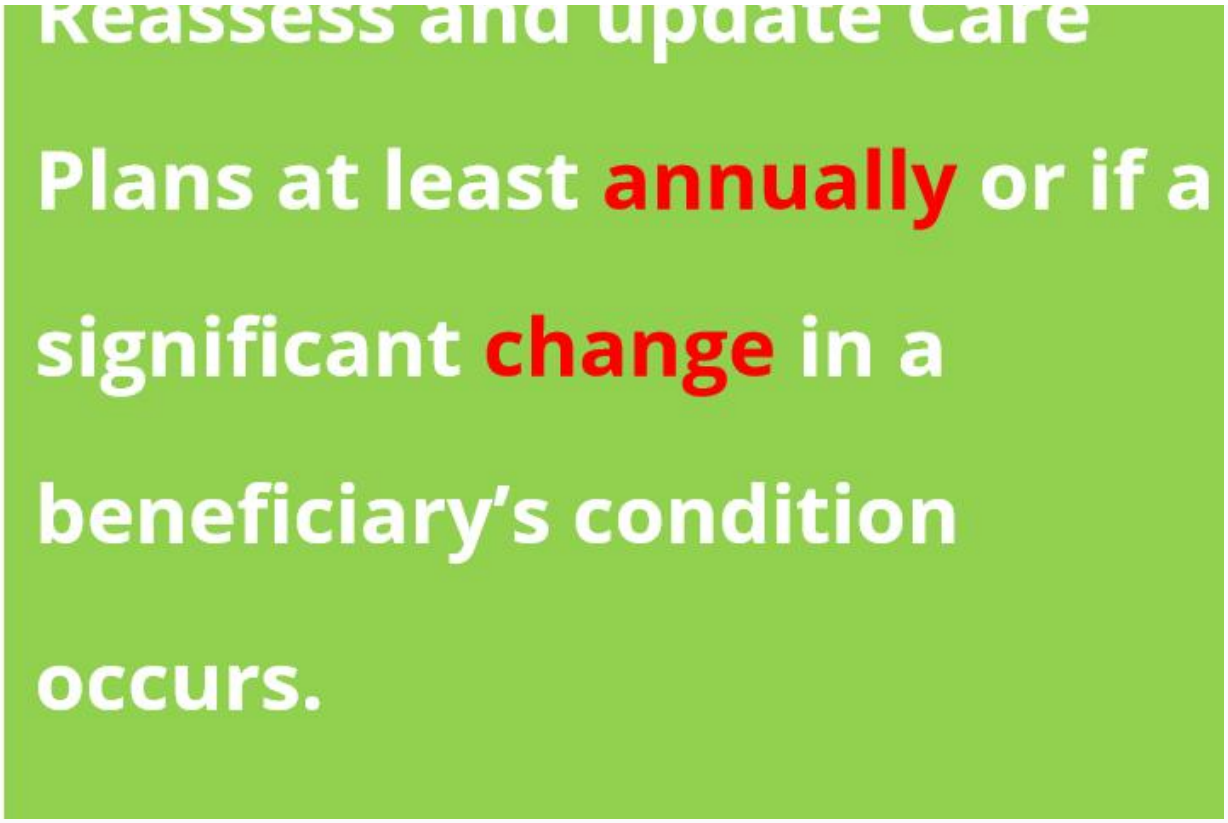
- Health Risk Assessment
- Member information provided during care management planning to identify any necessary assistance and accommodations, including:
    - Educational material on conditions and care options
    - Information on how family members and social supports can be involved in care planning, as member chooses
    - Self-directed care options and assistance available
    - Information on accessing available MLTSS, including IHSS services if applicable
    - Available treatment options, supports, and/or alternative courses of care
    - Ability to opt out of the ICP process

Individualized Care Plan (ICP) Timing

> ICP TIMING

Individualized Care Plan (ICP) Timing

For an overview of Individualized Care Plan (ICP) Timing click the forward button located on the media player below.



Summary

1. The ICP must be developed within 30 working days from the date of HRA completion.
2. ICP must be developed within 3 months of enrollment date regardless of HRA completion.
3. Reassess and update Care Plans at least annually or if a significant change in a beneficiary's condition occurs.

We will now move to the actual care plan and go over it in some detail.

Member Centered Individualized Care Plan (ICP)

> ICP

Member Centered Individualized Care Plan (ICP)

The ICP is a dynamic and person centered plan of care:

- Includes comprehensive input from the member, member's caregiver, Primary Care Provider (PCP), specialists and other providers in accordance with member's wishes
- Identifies the member's strengths, capacities, and preferences; provides additional care options, including transitions to a different setting
- Identifies the enrollee's long term care needs and the resources available

ICP Essential Elements

The ICP identifies needs for the following:

- Appropriate involvement of caregivers
- Access to primary care, specialty care, durable medical equipment, medications, mental health and substance abuse providers, or other needed health services, including access and assignment to a Medical Home
- Services to optimize member health status, including assisting with self-management skills or techniques, health education, and other modalities
- Coordinated care across all settings, including outside the provider network and to ensure appropriate discharge planning

As mentioned in previous modules, the ICT meeting is the avenue for linkages and referrals to be identified and discussed in the care plan. The care plan documents the need for referrals to appropriate community

resources and other agencies for services outside the scope of responsibility of the managed care health plan, including but not limited to:

- Mental health and behavioral health
- Personal care
- Housing
- Home-delivered meals
- Energy assistance programs
- Services for individuals with intellectual and developmental disabilities

Summary

ICP Essential Elements

1. Health care needs including the medical, social, behavioral and functional factors relevant to the member's current health care status
2. Individualized measurable goals ("SMART" goals)which take into account the member's goals and preferences
3. Appropriate involvement of caregivers
4. Access to primary care, specialty care, durable medical equipment, medications, mental health and substance abuse providers, or other needed health services, including access and assignment to a Medical Home
5. Services to optimize member health status, including assisting with self-management skills or techniques, health education, and other modalities

6

Coordinated care across all settings, including outside the provider network and to ensure discharge planning

ICP Goals

> ICP GOALS

ICP Goals

Now we move to the actual goals of the Individualized Care plan.

First, the plan must contain prioritized goals that consider the member / caregiver goals, preferences and desired level of involvement in the ICP. This ensures ongoing member engagement in the plan.

The goals are :

- Determined and documented by the Care Manager and the appropriate ICT team members
- Considerate of member/ caregiver preferences and needs, including advanced directives or the desire to maintain independence, current daily activities or home
- Self-managed goals (member activities that help them manage their health)
- Aligned with long-term care needs and available resources

ICP Goals

Click the Start button below to review the ICP Goals.

Step 1

Prioritization of Goals

Goals are prioritized considering the member/caregiver goals, preferences and desired level of involvement in the ICP.

Step 2

Care Managers Assessment

Care Managers will use health data to assess if member goals are being met. The data for assessment is gleaned from the following sources:

I. Utilization data

II. Preventive health outcomes

III. HRAs

IV. Pharmacy data

Step 3

ICP Update

The ICP is updated as necessary, reflecting if goals are met or not met.

Step 4

Managing Barriers

Care Managers are responsible for managing any barriers to the member meeting identified goals or complying with the ICP.

Summary

ICP Goals consist of four processes:

Prioritization of Goals

Care Managers Assessment

ICP Update

Managing Barriers

Complete the content above before moving on.

ICP Review by ICT Personnel

> REVIEW

ICP Review by ICT Personnel

There are expectations around some time-frames for the ICP. The care plan will be reviewed and revised (at a minimum):

- At least annually
- Upon notification of change in member status. This is usually health status but may be a social change that impacts the ICP.

The ICP is reviewed during ICT meetings and on an ongoing basis:

- In accordance with scheduled follow-up on member goals
- The frequency of needed ongoing updates will likely depend on routine and non-routine reviews and revisions, including required updates when members are not meeting their ICP goals

Summary

The ICP is reviewed during ICT meetings.

- In accordance with scheduled follow-up on member goals
- Update frequency may change in response to routine and non-routine reviews and revisions, including required updates when members are not meeting their ICP goals

ICP Maintenance

> MAINTENANCE

ICP Maintenance

Click the ICP Maintenance title below for an overview of ICP Maintenance.

Individualized Care plans are maintained in a HIPAA compliant electronic format within the L.A. Care Information Systems Department. Alternatively, the ICP can be stored in a PPG Information Systems Department for a period of 10 years from the last date of creation.

The L.A. Care or PPG information system is accessible to the multidisciplinary team members and is maintained in accordance with industry practices such as being protected from destruction and secured for privacy and confidentiality.

In the next module we will review the Interdisciplinary Care Team.

Interdisciplinary Care Team

> ICT TEAM

About The “Interdisciplinary Care Team”

In the following module we will review four components of the Interdisciplinary Team. The components we will examine are:

- Interdisciplinary Care Team (ICT) Definition
- ICT Process: Who, where, how…?
- Purpose of ICT
- Frequency of Meeting

ICT Definitions

Key to understanding the ICT are the words "collaborate" and "multidisciplinary". Remember the member is at the center and the team consists of all care and service providers regardless of specialty.

What is ICT?

- ICT is a collaborative, multidisciplinary team.
- ICT analyzes and incorporates the results of the initial and annual health risk assessment into the care plan.
- ICT develops a collaborative Individualized Care Plan (ICP) and annually updates the member’s ICP.
- ICT manages the medical, behavioral, social and functional needs of each member.
- ICT communicates the ICP to all caregivers for care coordination.

- ICT coordinates with and facilitates referrals to the appropriate resources, medical, behavioral health or home and community based providers, i.e. MLTSS.

ICT Roles

1. The member is at the center of the care planning process and may choose to include clinical or non-clinical staff and/family or caregivers.

2. The member may also choose to exclude participants as part of their right to self-direct care. Possible ICT members include:

Members can choose members of their ICT.
For example, their caregivers can be a member of the team.

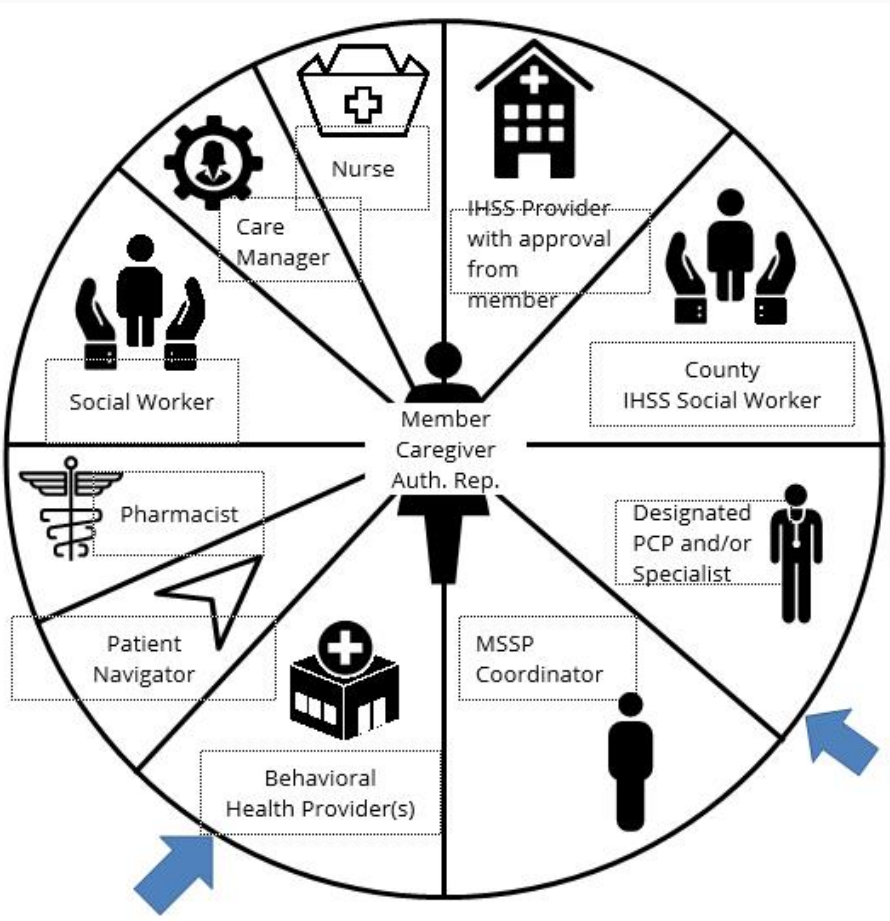
The ICT is comprised of individuals diverse in clinical expertise to address the needs of the targeted population. The L.A. Care part of the team consists of Medical Directors, Registered Nurse Care Managers, Nurse Practitioners, Clinical Pharmacists, Social Workers, Health Educators, Registered Dietitians, Transition of Care Nurses, and non-clinical support staff (i.e. Care Coordinators and Health Navigators, Health Promoters, Translators and Interpreters).

Ad hoc members of the team may include additional program staff members and representatives from various operational areas including team members from Utilization Management, CBAS, Long Term Care Team, Managed Long Term Support and Services, Medicare Operations, Customer Solutions Center, Claims and Provider Network Operations and/or representatives from community-based organizations. Behavioral health experts, social services specialists and/or other health care specialists are available when the member's need is identified through the HRA.

The ICT also includes participation of PCPs, members and/or caregivers whenever feasible.

The wheel below illustrates the general types of ICT members. ICTs may include all or only some of these members. Click the forward button on the media player for an animated overview of the general types of ICT members.

Utilization Management, CBAS, Long Term Care Team, Managed Long Term Support, and Services Unit, Medicare Operations, Customer Service, Claims and Provider Network Operations, and representatives from community-based organizations.



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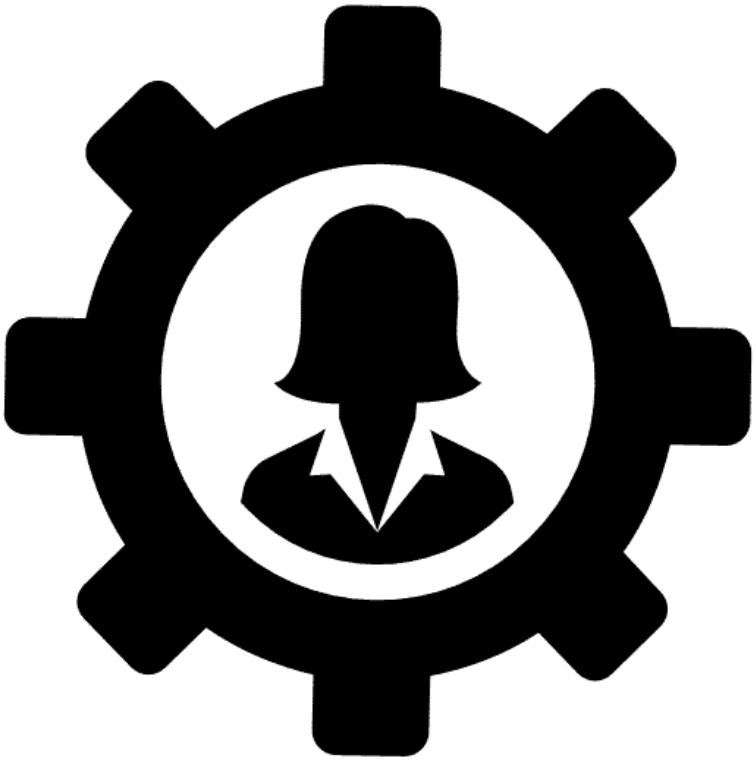


ICT Lead (Care Manager, Care Coordinator, Team Leader)

ICT Lead

The Care Manager is the Team Leader, responsible for coordinating the member's care as well as organizing the ICT. The Care Manager is presenting the member's case to the team in response to:

Step 1

Member

Member or provider requests

Step 2

HRA Feedback

Negative events or needs identified via the Health Risk Assessment (HRA)

Step 3

Other Assessments

Other previous assessments such as medical, MLTSS (IHSS, CBAS, MSSP), nursing facility and Behavioral Health assessments.

The Care Manager assigned to the members' risk level (High, Moderate or Low) is the responsible lead of the ICT presentation.

Step 4

Change in Condition

Transitions in care or a change in the member's condition.

Summary

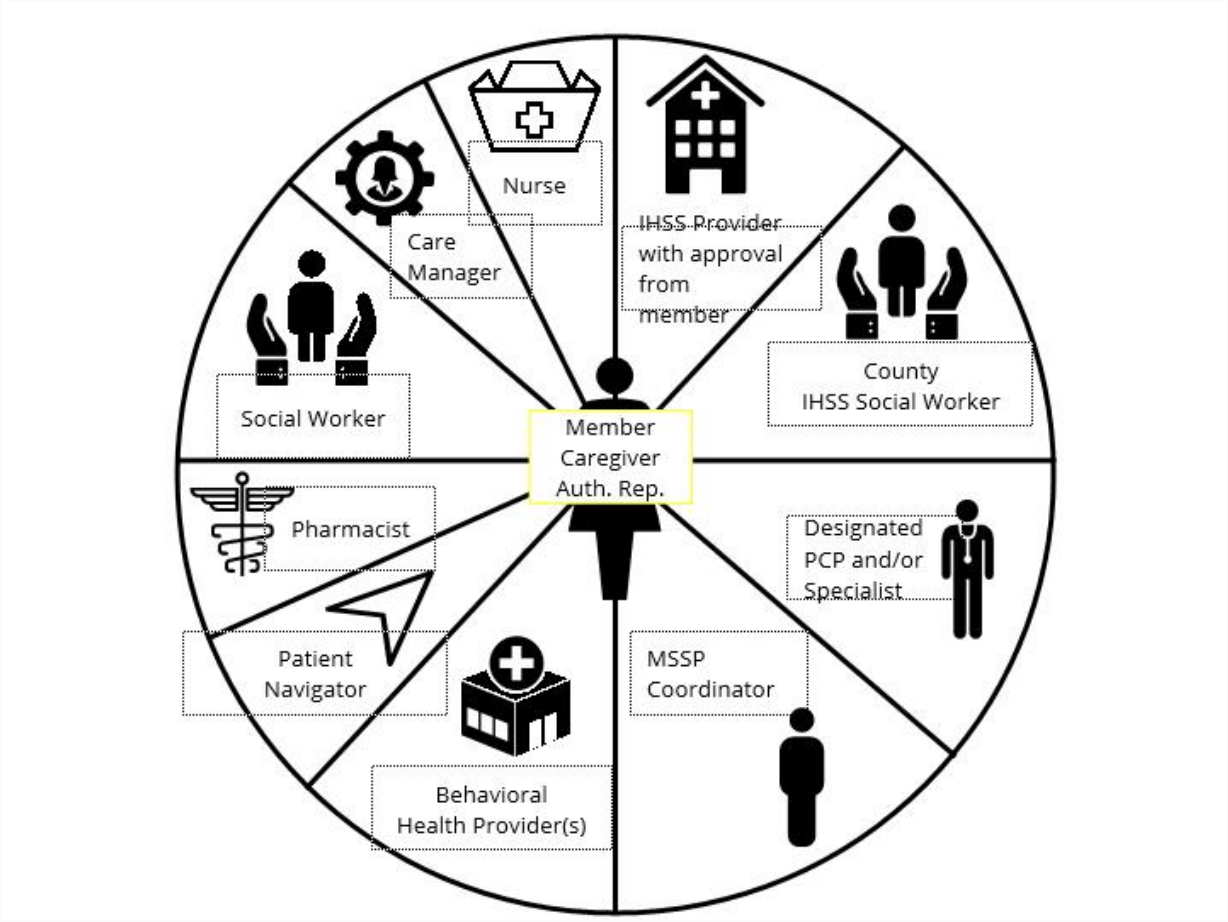
The Care Manager is the leader of an ICT presentation. As the leader, the Care Manager is responsible for choosing the other ICT members (based on member and provider requests), presenting the needs revealed in the HRA, and other assessments such as the Nursing Assessment, MTSS, ITSs, CBAS, MSSP, nursing facility and Behavioral Health assessments.

ICT Meeting

> ICT MEETING

ICT Meeting

To review ICT Meeting click the forward button located on the media player below.



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Summary

ICT Meetings are an avenue to:

- Discuss complex needs
- Identify linkages to home and community-based services
- Follow-up on utilization, level of care issues and/or specialized services needs
- Track types and numbers of referrals made
- Communicate with all stakeholders

When Does ICT Meet?

When does ICT Meet?

- Initially to review/modify/approve the ICP and at least annually thereafter
- When there is an acute change in the member's condition, including social condition
- At the request of the member
- When the member experiences a Transition of Care event

ICT Responsibilities

> ICT RESPONSI...

ICT Responsibilities

The ICT has many responsibilities – all of which drive member care.

Please review the list of ICT responsibilities below.

1. Analyze and incorporate the initial and annual HRA results into an Individualized Care Plan (ICP)

2. Collaborate on the development and annual update of each member's care plan (as mentioned, the Care Manager is the lead in this effort)

3. Communicate coordinated care plans across all settings

4. Coordinate the member's medical /cognitive / psycho-social /functional needs and communicate back to the member/caregiver and PCP

5. Assess and address identified social service barriers to achieving ICP goals

6. Assess members for access to long-term care services and supports enabling them to remain in their homes and communities as long as possible

7. Coordinate ICP integration addressing medical and social needs

8. Engage members to self-direct their care

9. Provide and support person-centered care coordination and planning

10. Identify community-based resources as needed and make referrals

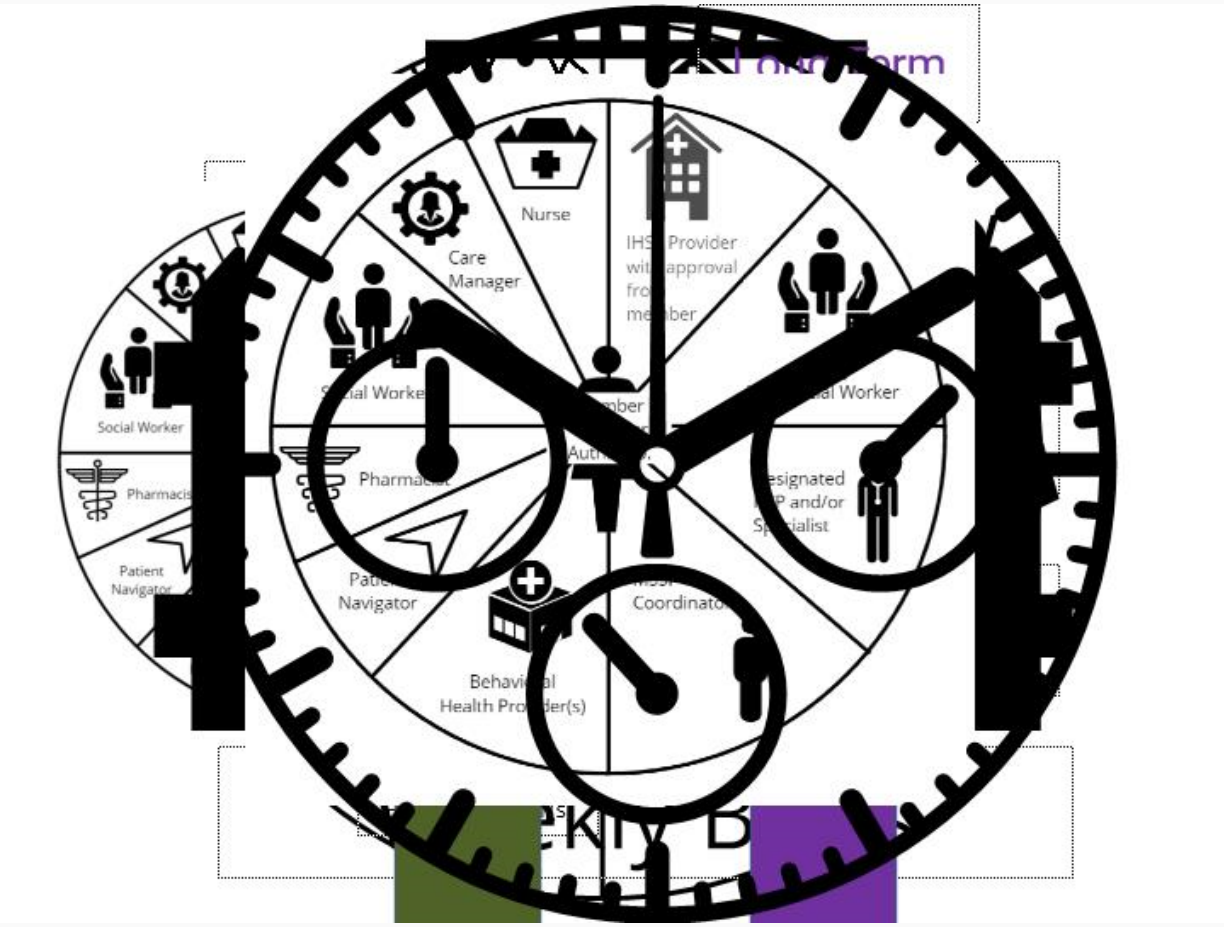
11. Assist with measuring effectiveness and extent to which care is managed

ICT Timing Requirements

> ICT TIMING

ICT Timing

Click the timer below for a brief overview of ICT Timing Requirements.



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The ICT works closely with contracted practitioners and agencies in the identification, assessment, referral and implementation of appropriate health care management interventions for eligible adults with special health care needs, including the provision of care coordination, linkages with county resources, and access to community and state waiver programs.

ICT members work collaboratively with the PCP, hospital discharge planners, specialty practitioners, ancillary practitioners, community and state resource staff. The Care Managers, in concert with the health care team, focus on coordinating care and services for members whose needs include preventive services, ongoing Medical care, rehabilitation services, behavioral health, home health, MLTSS and hospice care. These may include services that may not be covered benefits, such as Meals-On-Wheels, housing services and services offered through Independent Living Centers, Senior Centers and Area Agencies on Aging.

When is ICT and ICP supposed to happen?

ICT and ICP occur in the following time-frames:

1. Initial ICP is due within **30 calendar days** of the initial Health Risk Assessment (HRA) completion.

2. ICPs are discussed with the ICT **20 calendar days** after the completion of the ICP

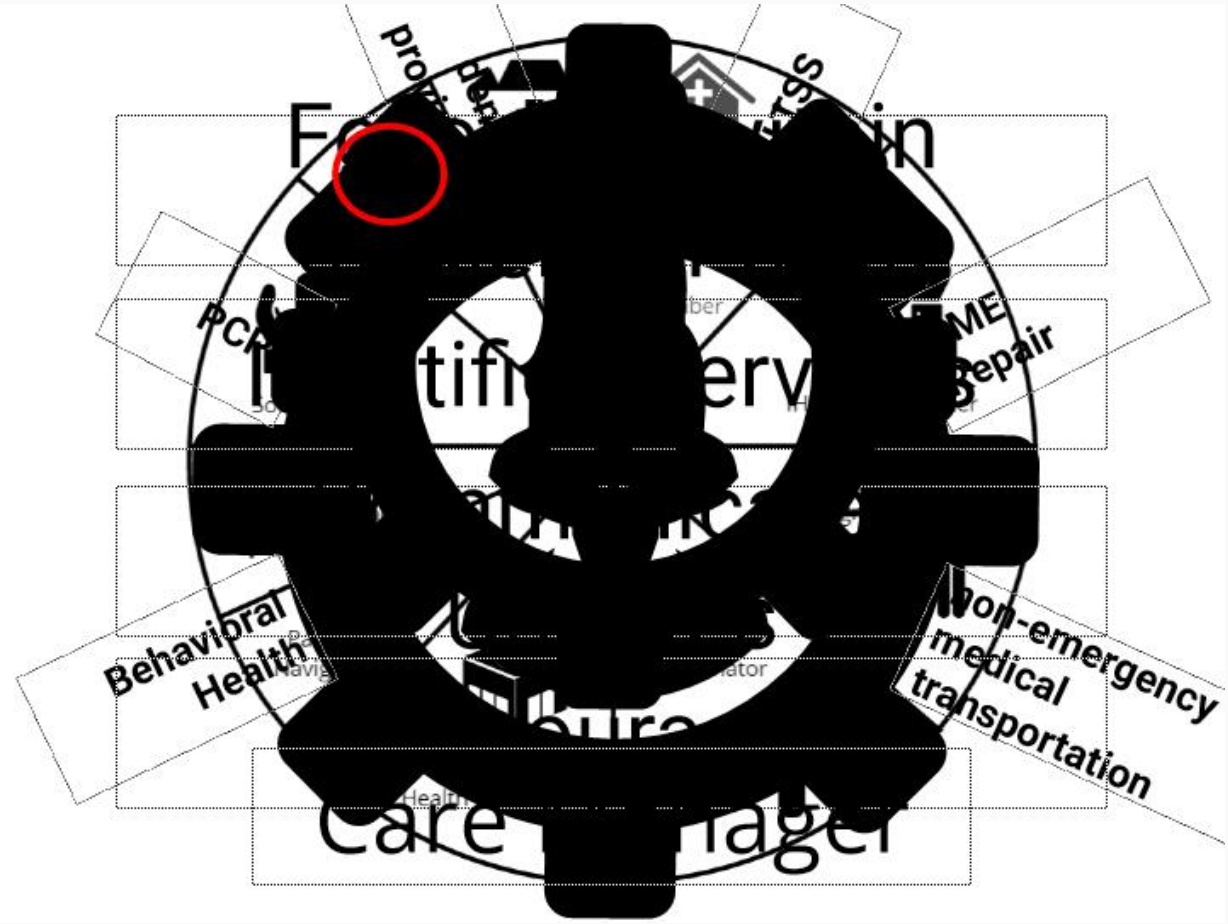
Once the ICT and ICP are in place, a copy of the ICT recommendations and ICP can be made available to the member, the member's legal representative, PCP and/or other pertinent providers by request.

Care Manager Involvement in the ICT

> CARE MANAGER

Care Manager Involvement in the ICT

Click the Care Manager icon below for an animated overview of Care Manager involvement in the ICT.



Complete the content above before moving on.

Care Managers facilitate care coordination among the ICT members such as; the PCP and other providers, e.g. behavioral health, non-emergent medical transportation, DME repair, dental providers, MLTSS, etc:

- Care Managers incorporate outcomes of the intervention into the ICP.
- Care Managers ensure ICT team follow-up within 5 calendar days for member linkage to appropriate service / provider.
- Care Managers identify services and member health care outcomes, that are shared with the ICT team and PCP during the ICT planning discussions.
- Care Managers communicate ICP changes to the ICT and PCP in writing or by telephone.
- Care Managers encourage members to discuss the changes with the PCP during the next scheduled visits.
- Care Managers coordinate services for urgent or emergent care needs such as home safety assessments, medication reconciliations, home oxygen requirements, continuity of care with out-of-network providers, etc. Urgent or emergent care needs identified prior to scheduled ICT discussions are reviewed directly with the PCP or the Medical Director within 1 business day of identification.
- Case Managers incorporate outcomes of the intervention into the ICP.

Provider Involvement in the ICP

> PROVIDER INV...

Provider Involvement in the ICP

All respective care providers are involved in the development of the ICP. These may include, but not limited to the following:

1. Primary Care Provider

2. Specialty Providers (including SNF)
3. Behavioral Health Providers or contracted Behavioral Health Care Vendor
4. MLTSS Providers (MSSP)
5. IHSS provider, upon member consent
6. Home and Community Based Providers (CBAS)
7. Others (Regional or Specialty Care Centers)

Information can be exchanged via mail, facsimile, telephone, secured email, and through the LA Care provider portal as appropriate.

Care Management ICP/ ICT Responsibility Matrix

> ICP ICT MATR...

Care Management ICP/ ICT Responsibility Matrix

The following matrix lists the requirements and responsibilities for both the ICP and the ICT:

Risk Level	ICP Requirement and Responsibility	ICT Requirement and Responsibility
Low and moderate	ICP is required PCP/PPG	If a need for an ICT is demonstrated during clinical review, or if the member requests one, an ICT is required PPG CM is the lead
High/Complex	ICP is required L.A. Care CM	ICT required L.A. Care CM is the lead
High/Complex	ICP is required L.A. Care CM	ICT required L.A. Care CM is the lead
*Default Low= Member enrolled with no HRA	ICP is required within 3 months from the date of enrollment. PPG	Required to offer an ICT "when a need is demonstrated" or if the member requests one.

1 ICT should be offered to all beneficiaries regardless of risk level or HRA completion.

2 LA Care performs outreach to members for the first 45 days of effective enrollment to complete the HRA.

3 After 45 days the PPG will begin reaching out to members in order to complete the HRA.

4 Members who consent to complete an HRA will be warm transferred to the LA Care Customer Solution Center at **855-810-9724**.

Oversight

> OVERSIGHT

Oversight

L.A. Care Health Plan will monitor delegated entities' compliance through analysis of reports and audits as well as through monitoring activities in accordance with L.A. Care Utilization Management Delegation and Oversight policies and procedures.

Resources and Partners

> RESOURCES

Resources and Partners

Care Management is all about knowing available resources and networking in order to assist the member in connecting with the right services based on their unique medical needs. It is also about being able to engage and empower the members to learn how to manage their own health and access available resources.

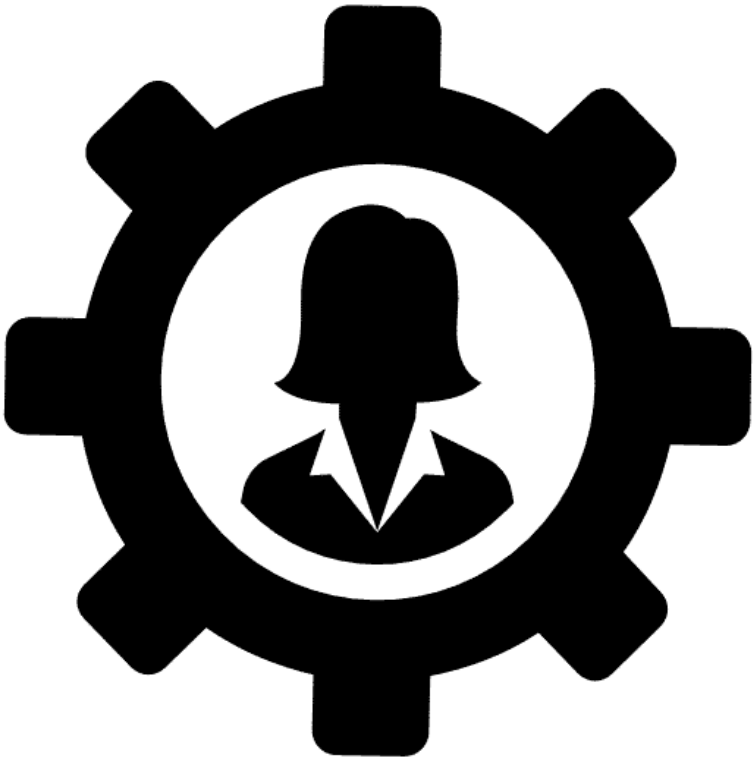
Many of these resources can also be utilized to address issues and concerns identified in the HRA findings. Please review the list of available resources below:

- PCP
- Participating Provider Group
- Family Resource Centers.
- Managed Long Term Services and Supports
- Home and Community Based services
- Disease Management Programs
- Behavioral Health Programs
- Substance Use Programs
- Community Transitions

For Member Transitions Due to Provider Termination

> TERMINATION

For Member Transitions Due to Provider Termination



Care Manager

When a provider has termed, the member is assigned to another provider within the same practice unless the member requests otherwise. L.A. Care Care Managers assist members during these transitions to new providers.

When a Provider terminates from L.A. Care's network, Care Management does the following:

- Coordinates with UM and PNO to identify termination dates
- Monitors utilization data for 6 months prior to transition to ensure needs are accurately evaluated and to minimize unplanned or unnecessary care transitions
- Assists with identification of needed providers/facilities, i.e. ICF for developmentally delayed, rehabilitative facilities for traumatic brain injuries, etc.

When Member Transitions To New Providers

L.A. Care's Care Management executes the following processes for new providers:

- Identifies providers from Member assessments, clinical reports, ICP discussions and/or utilization data
- Confirms all members of the ICP are aware of the new provider
- Ensures the new provider is provided with ICT participation information as well as with the ICP as defined by policy
- Ensures new the provider receives appropriate training as defined by policy.

For All Member Transitions

The Care Manager or ICT members:

- Assists the member or responsible party in transitioning any necessary clinical information including the medication reconciliation
- Updates the Individualized Care plan to reflect the applicable provider, facility and/or services
- Shares the ICP with the ICT, member and caregiver

Authorities

> AUTHORITIES

Authorities

These are the governing bodies and references to Cal MediConnect's

ICT and ICP requirements:

- Dual Plan Letter 15-001 Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans

- Dual Plan Letter 16-002 Continuity of Care
- Dual Plan Letter 17-001 Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect
- DHCS, CMS, & L.A. Care Contract (3 Way Contract) section 2.8
- Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements
- California-Specific Reporting Requirements under Medicare-Medicaid Capitated Financial Alignment Model
- Medicare Managed Care Manuals
- CMS Guideline

References

> REFERENCES

References

1. L.A. Care California Dual Eligible Demonstration Model of Care
2. L.A Care Utilization Management/Care Management Program
3. Your L.A. Care provider representative Cal MediConnect Provider Manual
4. L.A. Care provider portal

Thank you for completing **Care Coordination and Quality Improvement Program Effectiveness (CCQIPE)** instructional. To exit the tutorial click the **Exit Course** button below.

EXIT COURSE