CHAPTER 13:

Care Management

Review/Revised: 01/18, 01/19, 01/20, 06/20, 1/21

CARE COORDINATION

13.0 HEALTH RISK ASSESSMENT (HRA)

Care coordination begins with a comprehensive health assessment of the beneficiary's medical, psychosocial, cognitive, functional, behavioral health, and social determinant needs. This comprehensive assessment, called the Health Risk Assessment (HRA), documents the beneficiary's perception of his/her health care needs. Initial HRAs are conducted with beneficiaries within ninety (90) days of enrollment with Health Choice Pathway. Reassessments are completed on an annual basis. Health Choice Pathway uses the HRA results, as well as claims information, as a mechanism for risk identification.

13.1 INDIVIDUALIZED CARE PLAN (ICP)

The contents of the HRA have a direct impact on the development of the beneficiary's Individualized Care Plan (ICP). The ICP is member centric and focused. Health concerns and gaps in care are incorporated in the ICP to ensure the document is a living care plan. Ideally the ICP is developed with the beneficiary and those involved in his/her care planning process and support network. For beneficiaries who did not complete the HRA, the ICP is developed by review of claims information and gaps in care.

Elements used in developing the ICP include but are not limited to: (a) the beneficiary's initial health risk assessment scores, (b) the beneficiary's health care preferences (c) goals and objectives for maximizing wellness (d) identification and availability of additional resources both through the health plan as well as the community and (e) cultural/linguistic preferences. The ICP is developed from conversation with the beneficiary and appropriate providers, comprehensive clinical assessments completed by the PCP or other providers, risk stratification, and targeted responses from the HRA.

The beneficiary receives a copy of their ICP in the mail. Primary Care Providers and other Interdisciplinary Care Team members will receive the ICP either through secured email, fax or via mail.

13.2 INTERDISCIPLINARY CARE TEAM (ICT)

The Interdisciplinary Care Team (ICT) is comprised of a Health Choice Pathway HRA nurse, care manager, behavioral health care manager, pharmacy representative, medical director, and the beneficiary. The beneficiary's PCP, and as appropriate, ancillary and specialty care providers who

are involved in the beneficiary's chronic medical and/or behavioral health conditions are encouraged to attend.

Each beneficiary is given the opportunity to participate in an ICT conference. Beneficiaries are encouraged to participate in the development and reassessment of their care plan to promote health literacy and self-management of their chronic conditions.

Beneficiaries and all participants in the ICT receive a copy of the ICP for review prior to the meeting. Members of the ICT are notified of the meetings via telephonic outreach, mail, email and/or face-to-face interactions. Feedback and discussion pertaining to the identified goals and interventions will take place during the ICT. The beneficiary's care plan will be reviewed and updated based on recommendations during the ICT meeting.

13.3 CARE AND DISEASE MANAGEMENT PROGRAMS

Health Choice Pathway utilizes a risk stratification process to review and analyze each beneficiary's health care needs. Member risk stratification for health complications and/or hospitalizations has been automated and uses a modified Charlson Comorbidity Index to ensure accurate identification of our beneficiaries as high, moderate, or low risk .

Moderate and high risk beneficiaries are referred to a Care Management (CM) program. The Care Manager provides intensive, personalized care management services and goal-setting for members who have complex physical, behavioral or social determinant needs who may require a wide variety of resources to manage health and improve quality of life. The CM program supports members with multiple chronic conditions and/or specialty medications.

For beneficiaries with chronic conditions, Health Choice Pathway offers disease management programs that may include Diabetes, Congestive Heart Failure, COPD, high risk OB, and others. . Health Choice Pathway also has special programs for more unique cases such as transplants, medication therapy management, and behavioral health conditions.

13.4 PROVIDER REFERRALS

Provider referrals are encouraged. Please complete the Care Management Referral Form located on our website. Completed referral forms and any pertinent medical documentation should be faxed to the Care Management Department at: (480) 317-3358.