Partnership HealthPlan of California

CARE COORDINATION PROGRAM DESCRIPTION

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PROGRAM PURPOSE

To define the scope of services provided by Partnership HealthPlan of California's (Partnership's) Care Coordination Department.

INTRODUCTION

Partnership HealthPlan of California's Care Coordination Department offers case management services to any plan member with care management needs who is willing to participate, and for whom Partnership is either the primary source of coverage or for whom Partnership may be responsible for the benefit, such as members eligible for California Children's Services (CCS). Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the member's health and wellness needs. It is characterized by advocacy, communication, and resource management, while promoting quality and cost-effective interventions and outcomes. These services assist Partnership in ensuring that we are fulfilling our mission to help the members and the communities we serve be healthy.

DEPARTMENT OBJECTIVES & GOALS

The objectives and goals of Partnership's Care Coordination Department are to:

- Educate members about the resources available to them through their plan benefits and how to use these resources to optimize their wellness
- Assist members in understanding their health conditions and support members in becoming proficient in gaining/maintaining their optimum health and functionality
- Provide support for members with chronic illness
- Facilitate timely access to care and efficient delivery of health care services, supplies, and equipment
- Promote communication between the member, member's supports (i.e., caregiver, guardian, or other concerned parties), providers, community resources, and long-term support systems
- Connect members to resources within their communities to support and to assist them in self-management of their health and well-being
- Collaborate with multidisciplinary health agencies and non-profit partners to link members to available community resources, where accessible
- Minimize gaps between healthcare settings by coordinating transitions across the healthcare continuum of age, coverage, service type, and location
- Improve member and provider satisfaction
- Provide education to members, providers, and community-based organizations about case management services offered by Partnership and encourage referrals when needs or barriers are identified

Care Coordination is not intended to replace or be a substitute for the physician's management of a member's medical conditions. Partnership staff works collaboratively with the practitioner to coordinate clinical and support services for members to decrease the potential for fragmentation of care.

Services offered through Partnership's Care Coordination Department are available to eligible members, and outreach efforts may target a particular population depending on regulatory requirements and identified population needs. The following are examples of populations who may benefit from Care Coordination:

- Members new to the health plan who require expedited care
- Children diagnosed with a California Children's Services (CCS) eligible condition
- Medi-Cal Partnership eligible enrollees who are designated by aid code as Seniors or Persons with Disabilities (SPD) and who may be at risk for an adverse outcome without an Individualized Care Plan (ICP)
- Children with Special Health Care Needs (CSHCN)
- Children and adults with developmental disabilities in collaboration with the California Regional Centers
- Members identified as connected to the Genetically Handicapped Persons Program (GHPP) who require assistance and support
- Members who are chronically ill or who have multiple complex medical conditions
- Members preparing for an organ transplant
- Members who require assistance accessing community-based programs and/or services
- Members who are in a pivotal place with their healthcare needs due to transition across settings (e.g. acute hospital stay to home), across age groups (e.g. transition from pediatric to adult care), or across benefit structures (e.g. exhausting home health benefits or transitioning from curative care to hospice care)
- Members who have difficulties navigating the healthcare community
- Members who have cognitive or communication deficits that require an advocate to help them communicate their health care needs
- Members challenged with efficiently managing their health within Partnership's managed care network
- Members involved in child welfare and foster care

SCOPE OF SERVICES

The Care Coordination Department offers a variety of evidence-based services and interventions to coordinate care for members. Our team of Nurse Case Managers, Medical Social Workers, and Health Care Guides help to ensure services are coordinated for the member across the healthcare continuum. Taking the member's, or their caregiver's, needs and preferences into account when communicating, the staff in the Care Coordination Department uses evidence-based practices such as Motivational Interviewing and principles from Dialectical Behavioral Therapy (DBT) to ensure that the member's goals are at the center of an Individualized Care Plan (ICP). With the use of these member engagement techniques, the team is able to assist the member in enhancing their autonomy and reaching their desired goals and outcomes. During the course of participation, goals and interventions are routinely identified and evaluated by Partnership's Care Coordination staff to track the member's progress. Goals and interventions may be added and/or closed as care needs resolve. In accordance with Department of Health Care Services (DHCS) regulations and Partnership's policies, Partnership Care Coordination staff shall ensure there is no duplication of case management services or care coordination when actively working with a member; facilitating warm hand-offs with appropriate providers/agencies if such duplication is identified.

IDENTIFICATION AND REFERRALS

The Care Coordination Department utilizes a variety of approaches to screen and identify members who may benefit from Case Management Services. These activities include:

- Internal reports, such as the Monthly Utilization Report, Monthly Pediatric Case Finding Report, Weekly Hospital Discharge Report, HEDIS Outreach Campaign List, etc.
- Review of referrals sent to the Care Coordination Department Help Desk email by both internal and external parties
- Heath Information Form (HIF)/Member Evaluation Tool (MET)
- Health Risk Assessment (HRA) Form
- Pediatric Health Risk Assessment (PHRA) Form
- Reports based on Fee-for-Service (FFS) Claims Data provided by the State, etc.
- Risk stratification reports, including but not limited to, the Population Health Management (PHM) Service Risk Stratification and Segmentation (RSS)

Referrals for Case Management Services originate from a variety of both internal and external sources. Members are commonly referred for Case Management from Partnership's internal departments such as Member Services, Pharmacy, Utilization Management, Population Health Management, Enhanced Health Services, Behavioral Health, and/or Grievance. Externally, members may self-refer, or they may be referred by their caregivers, Primary Care Providers (PCPs), Specialists, Hospital Case Managers/Discharge Planners, and/or County or Community Partners such as Public Health Nurses, Medical Therapy Programs, Grant Programs, or Home Visiting Program Providers, etc.

Referrals for Case Management can be sent to the department directly via email, phone, Partnership's member portal, or the Provider website referral form. Members, providers, caregivers and/or community partners can contact the Care Coordination department directly to make a referral. Each referral sent to the department is reviewed by Care Coordination staff who, based on the information received upon intake, will identify the initial needs of the member and route the member to the appropriate team for case assignment.

PROGRAM STRUCTURE

Care Coordination services are based upon the acuity of the member's needs. Using a scale of one to five, the member's acuity determines the level of care coordination intervention. A member's acuity may be adjusted during the course of case management services as goals are met or additional barriers are encountered.

BASIC POPULATION HEALTH MANAGEMENT

Acuity Level One:

Members with Acuity Level One are the lowest risk members receiving services in Care Coordination. Their needs are generally resolved within 30 days of identification and the primary focus is to ensure these members are well-connected to their primary care providers or specialists who may be acting as primary care providers. Members assigned Acuity Level One include those referred through or requiring assistance with:

- New Member Health Information Forms (HIFs)

- Access to Care:
    - Primary or Specialty Care,
    - Specialty Mental Health Services (SMHS)
    - Substance Use Disorder (SUD) services
    - Early Intervention
    - Developmental Services (DD)
    - Behavioral Heath Therapy (BHT),
    - Early Periodic Screening Diagnostic and Treatment (EPSDT) services
    - Transportation to/from Medi-Cal covered services
- Those needing assistance with and needing closed loop referrals to:
    - County social service agencies and waiver agencies for In-Home Support Services (IHSS) and other home- and community-based services (HCBS)
    - Medi-Cal Dental
    - CalFresh, Women, Infants and Children (WIC), Meals on Wheels, etc.
    - Ancillary Services or Durable Medical Equipment (DME) covered by Medi-Cal
    - Prescriptions
    - Services provided by Community Health Workers (CHWs), peer counselors, and local community organizations
    - Transitioning to a new primary care or specialty provider, including pediatric members preparing to transition from pediatric to adult care
    - Arranging routine screening appointments, such as those monitored through Healthcare Effectiveness Data and Information Set (HEDIS) measures
    - Education for resources available in their area/community (housing, transportation, support groups, etc.)
    - Connecting to Enhanced Care Management (ECM)[1] and Community Supports (CS)[2]
- CCS member's annual re-assessment, risk review, and documentation to support redetermination of medical eligibility
- Members requesting to see out-of-network providers where an established relationship exists (Continuity of Care)

Interventions:

Members identified as an Acuity Level One will be assessed to identify their primary care coordination needs. Based on the member's stated goals, Care Coordination staff will assist the member in gaining access to necessary resources and supports. Typical interventions provided under Acuity Level One include, but are not limited to:

- Navigation and coordination of services (appointments, DME, transportation, etc.)
- Collaboration with county/community agencies
- Ensuring that the member has ongoing source of care that is appropriate and timely to meet the member's needs
- Closed loop referrals to physical health, mental health, oral health and/or community resources
- Linkages to other public benefit programs including but not limited to CalWorks, CalFresh, WIC,

[1] For further information on ECM, refer to Partnership policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
[2] For further information on CS, refer to Partnership policies MCAP7003 CalAIM Community Supports (CS) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

Supplemental Nutrition Program, Early Intervention Services, Supplemental Security Income (SSI), etc.

Care Coordination staff work to help members overcome barriers to health and wellness care. When a member's barriers cannot be resolved promptly, Care Coordination staff create an Individualized Care Plan (ICP) to assist the member in achieving health and wellness goals. Throughout the course of the case, Care Coordination staff will reassess the assigned acuity level for the case and make adjustments as needed to provide the right level of care at the right time, including escalation to Complex Case Management (CCM) or the Enhanced Care Management (ECM) benefit when warranted.

Acuity Level Two:

Members with Acuity Level Two have emerging risk of disease/disease exacerbation, and/or a newly diagnosed chronic illness. They benefit from health education and resources tailored to their condition along with a contact within the care coordination department should questions arise. Members assigned Acuity Level Two include those referred through or requiring assistance with:

- Maintenance of chronic conditions like diabetes, asthma, or mild to moderate mental illness
- High Risk Infant Follow Up (HRIF)
- Identified case management needs resulting from Population Health Management screenings

Interventions:

Members managed at an Acuity Level Two will be provided with Health Education resources supporting lifestyle management to maximize health and wellness, and to mitigate effects of chronic disease. Interventions provided for members with Acuity Level Two may include, but are not limited to:

- Emotional Support/ Active Listening
- Reinforcement of health maintenance screening and care
- Referrals to disease prevention/management programs, Population Health interventions, or Healthy Living classes
- Referrals to community support groups
- Coordination of Services (appointments, referrals, DME, medical supplies, etc.)
- Review of health education materials

Members in this acuity may require more intensive interventions should their condition warrant it or if the member requests additional support.

TRANSITIONAL CARE SERVICES (TCS)

Acuity Level Three:

Transitional Care Services [3] focus on members who are transitioning across settings including, but not limited to, discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC) settings or across benefit structures (e.g. exhausting residential treatment service benefits for

[3] For further information on TCS, refer to Partnership policy MCCP2034 Transitional Care Services (TCS).

substance use disorder, or transitioning from curative care to hospice care). These members are vulnerable to lost information across the care continuum, fragmented care, may have difficulty navigating the health care system, or may need support ensuring a transition plan is executed as intended. Members considered Acuity Level Three may come from any source; however, the most common sources of referral are:

- Hospital Case Managers/Discharge Planners or Social Workers
- Weekly Hospital Discharge reports
- Admission, Discharge, and Transfer (ADT) feeds
- Other Care Coordination programs
- Referrals from Partnership's Utilization Management team

Interventions:

Case Management activities for members tiered at Acuity Level Three ensure the member reconnects with primary care, specialty care (when needed), DME, pharmacy, and/or community resources that will support health and wellness following a transition of care. Upon referral to the Care Coordination department, staff will conduct an assessment and review any applicable medical documentation such as a discharge summary, plan of care, medical records, etc. Care Coordination staff will develop an ICP supporting the member's successful transition along the care continuum and provide education, advocacy and reinforcement for the transition plan. A copy of the ICP shall be made available to the member, their parent(s)/caregiver, and/or authorized representative. Typical interventions utilized during Transitional Care Services include, but are not limited to:

- Review of Discharge Summary/Plan
- Identification of ongoing care team roles and members
- Coordination of outpatient services (appointments, medication reconciliation, referrals, transportation, food banks, Community Supports, etc.)
- Ensuring necessary prior authorizations are in place (e.g. home health, medical supplies, DME, etc.)
- Coordination with hospitals and/or discharge planners to support the discharge plan, the member, and ensure no delays or gaps in care
- Ensuring members with Substance Use Disorder (SUD) and/or mental health needs receive treatment prior to discharge
- Closed loop referrals to ensure no gaps in care
- Assistance with accessing programs such as Long Term Support Services (LTSS), WIC Program, IHSS, or other social supports
- Ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, emergency departments (EDs), LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, service providers, and county/community agencies to facilitate safe and successful transitions while reducing duplication of efforts
- Motivational Interviewing to build on resiliencies
- Emotional Support/ Active Listening

If the member is receiving CCM or ECM, the member's existing assigned case manager is responsible for providing all Transitional Care Services. The interventions for Transitional Care Services are tailored in response to the member's assessed needs or stated goals. Members receiving Transitional Care Services, but not currently enrolled in either CCM or ECM, who are exhibiting ongoing, unresolved and/or complex care needs shall be referred to either Partnership's CCM program or to a contracted Enhanced Care Management

(ECM) provider for intensive care coordination support.

COMPLEX CASE MANAGEMENT (CCM)

Complex Case Management focuses on meeting the needs of the most fragile members through clinical intervention(s) and case management services. These may be members with multiple chronic medical conditions, or they may have fragmented care, have difficulty navigating the health care system, or have other challenges that threaten to compromise their well-being if not supported through an ICP.

Acuity Level Four:

These members require intensive support available through clinical and non-clinical case management activities and interventions, but are not otherwise eligible or decline to participate in Medi-Cal's Enhanced Care Management (ECM) benefit. Examples of members commonly enrolled in CCM are those with at least one CCS-eligible condition along with social support needs (in pediatric cases), and members who have two or more chronic conditions (in adult cases). Alternatively, these members may have mental illness or substance use disorders or other challenges that threaten to compromise the member's well-being if not supported through an ICP. Cases in this tier may reflect more than one recent hospitalization within the past 2 months or multiple emergency department visits relating to the eligible conditions. These cases have high risk of declining function, hospitalization, or readmission if appropriate interventions are not in place. Members assigned Acuity Level Four are often identified by:

- New Member Health Risk Assessments (HRAs) for new SPDs or CCS members
- Medical Therapy Programs/Units
- Hospital Discharge Planners or Social Workers
- Primary Care or Specialty Providers
- Internal case-finding reports (Monthly Utilization Report, Monthly Pediatric Case Finding Report, etc.)
- Care Coordination Help Desk email review
- Other internal Care Coordination services and activities
- Other internal departments (Utilization Management Inpatient Rounds, Quarterly Grievance Review, Provider Relations, etc.)
- Meetings with external organizations (Hospital Case Management Rounds, CCS county meetings, County Mental Health departments, Community-Based Organization collaborations, etc.)
- Risk stratification reports

Interventions:

The primary focus of case management for members tiered at Acuity Level Four is to help members regain optimum health or improved functional capacity in the right setting and in a cost-effective manner by coordinating both clinical, non-clinical, and social determinants of health (SDOH) needs for members with complex needs. For those members with clinically complex needs, the Partnership Care Coordination staff shall also provide community connections, social supports, and integration with long-term support services. Care Coordination staff will perform a comprehensive assessment evaluating the member's medical, psycho-social, mental, emotional, and behavioral needs. The member and Care Coordination staff member will develop an ICP. Care Coordination staff will collaborate with the member to identify prioritized goals and select interventions/behaviors intended to meet these goals. Together with Partnership Care Coordination staff, the member, their parent/caregiver and/or authorized representative will work collaboratively to

overcome identified barriers to meeting the identified and prioritized goals. Typical interventions utilized during Complex Case Management include, but are not limited to:

- Personalized assessments
- Individualized Care Plan (ICP)
- Motivational Interviewing to build on resiliencies
- Emotional Support/ Active Listening
- Transitional Care Services for tailored support across settings, benefit structure, or programs.
- Disease specific management support and education (e.g. Asthma, Diabetes, End-Stage Renal Disease, Cardiovascular Disease, Sickle Cell Anemia, Cystic Fibrosis, etc.)
- Teach-back techniques to promote health and support lifestyle choices based on healthy behavior
- Coordination of Services (appointments, referrals, DME, transportation, medical supplies, etc.)
- Closed loop referrals to address the needs of physical health, mental health, substance use disorder, oral health, developmental health, palliative care, Community Supports, and/or community agencies
- Identification of barriers to established goals or treatment plan adherence
- Review for medical necessity of complex services such as Pediatric Shift Nursing or Residential SUD Treatment Services
- Collaboration with the multi-disciplinary care team to ensure the member's care needs are expedited as well as reducing duplication of efforts amongst care team members
- Assistance and support in accessing programs such as LTSS, IHSS, WIC, or other social supports.

Interventions are tailored in response to the member's assessed needs or stated goals. A copy of the ICP is provided to the member's provider(s) and to the member, the member's parent/caregiver and/or authorized representative to facilitate collaboration and joint agreement on goals of care. The individualized care plan and corresponding goals are routinely evaluated to evaluate progress, update when necessary, and adjust the member's assigned acuity when appropriate or when requested by the member. Interdisciplinary case conferences may be scheduled with identified individuals from the member's care team, internal Partnership staff, and external community level-partners and/or the member, their parent/caregiver and/or authorized representative to review the goals of the ICP and to support the member in achieving identified goals.

Acuity Level Five:

Members with Acuity Level Five are the highest risk members in Complex Case Management and they require more involvement than can be provided through telephonic forms of case management. These members experience extraordinary barriers to care, such as communication challenges, cognitive barriers, capacity issues, or a severely fragmented provider/health care delivery system and often require an onsite assessment(s) or multi-disciplinary conferences to meet their needs. Members considered for Acuity Level Five will be reviewed by a clinical supervisor for approval, with specific goals described for the face-to-face meeting.

Interventions

Acuity Level Five is distinguished from other acuities in that it includes all the interventions for other acuity levels as well as a face-to-face interaction between the case manager and the member/member's representative for one or more visits. This interaction may take place in the member's home, but more optimally occurs in a provider's office. These meetings are pre-scheduled and may include the member/member's representative, clinical member(s) of the care team with non-clinical support as appropriate to the case, the provider and/or specialist, ancillary provider(s) such as members of the Medical Therapy Unit or therapists, and other

individuals who are part of the member's multidisciplinary care team. Note: not all multidisciplinary care team meetings require a face-to-face visit; however, this intervention may be leveraged when the case complexity or communication challenges require extraordinary efforts for collaboration.

CARE COORDINATION PROCESS

When referred for Care Coordination, members are advised that these services are voluntary and the member is not required to participate. All case documentation of assessments, interventions, activity, and the member's ICP will be stored in the Care Coordination Department's Case Management software system. The Care Coordination team will also document each instance when a member declines to participate in case management or when they cannot be reached after multiple attempts, through multiple means of contact.

The guiding principles for Partnership's case management services are identifying a member's goals of care and the barriers to meeting those goals, and then choosing interventions designed to overcome the barriers. When the identified goals are met, the case will be closed unless new goals, barriers, or needs are identified. At any time during the course of receiving services, if the member's status or needs change, the case will be evaluated by the assigned Partnership Care Coordination staff member to determine acuity level appropriateness. Members who experience a change in condition, where their needs cannot be met by Partnership's Care Coordination programs and services, will be screened and directed to other available services within, or external to, Partnership when appropriate (e.g. Enhanced Care Management benefit).

In certain instances, Partnership staff may close a case before completing the ICP or achieving the goals listed on the ICP. Examples of scenarios where Care Coordination may be discontinued include:

- Member is no longer responsive to outreach efforts after 45 calendar days and multiple attempts
- The member requests to have their case closed or expresses they no longer wish to participate in services
- Member is obtaining case management services through another agency that are duplicative of the services through Partnership
- The member is referred to an alternative program or service that better meets the needs of the member
- Member loses Medi-Cal eligibility and/or is no longer assigned to Partnership
- Continued inappropriate (derogatory, profane, abusive) behaviors towards Partnership staff with no improvement after documented attempts to address behaviors
- Cases closed to Care Coordination may be re-evaluated if the member's condition, or desire to participate, changes

PROGRAM SUPPORT

The Care Coordination department is supported by a team of leaders and administrative staff within the department. Leadership within the department provides supervision of staff & programs and evaluates program activities & outcomes; ensuring compliance, oversight, support and guidance for evidence-based case management and care coordination activities in alignment with Partnership policies, Department of Health Care Services (DHCS) regulations and National Committee for Quality Assurance (NCQA) standards. The leadership and administrative support staff in the Care Coordination department also network and facilitate meetings with providers, community partners, and government agencies, to share information about Partnership's Care Coordination programs and referral pathways, and to answer questions and promote collaboration of efforts to reduce/avoid duplication of services.

ENHANCED CARE MANAGEMENT (ECM) BENEFIT

Partnership shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible members. The ECM benefit is unique and distinct from the care management services or programs offered by Partnership. ECM is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of the highest need and/or highest cost members who meet the Population of Focus criteria established by DHCS. ECM is high-touch, person centered and occurs primarily in the community where the member lives and/or seeks care and focuses on systematic coordination of services through a single lead case manager.

Partnership members may not be simultaneously enrolled in any of Partnership's Care Coordination programs and ECM. However, upon assessment of the member's needs and after obtaining the member's agreement to participate, Partnership's Care Coordination department may refer the member to an ECM provider for services. Conversely, ECM providers may refer a member to one of Partnership's Care Coordination programs for support if indicated, or at the expressed desire by the member. For more information about the ECM benefit, see Partnership policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).

TEAM ROLES AND RESPONSIBILITIES

Chief Health Services Officer-RN: Responsible for the executive management and operational leadership of the following Partnership Health Plan of California Health Services departments: Utilization Management (UM), Care Coordination (CC), Population Health Management (PHM), Health Equity, and associated initiatives under CalAIM. This position provides executive leadership in organizing the health plan's operations and interdepartmental communication, and participates in goal setting and strategic organizational planning in the development of new business lines and programs.

Senior Director of Care Management-RN: The Senior Director of Care Management (CM) is responsible for setting and carrying out the overarching strategic direction and goals of the Care Coordination and Utilization Management departments. This position maintains and oversees proper delivery, coordination and execution of all related services and activities to improve the health outcomes of members. This role oversees and manages a large team of clinical and non-clinical staff while working in cross-collaboration with Medical Directors and other senior departmental leaders.

Director of Care Coordination - RN: Provides oversight of all Care Coordination programs and services to improve the health of Partnership members in every office location. Works with the Chief Medical Officer, Senior Director of Care Management, and Associate/Regional Directors to meet organization and department goals and objectives while developing and tracking measurable outcomes (e.g. financial, clinical, qualitative, etc.) of department staff, programs and services. Works collaboratively with identified Health Services staff to ensure appropriate integration of Partnership, DHCS, and NCQA guidelines, policies, and procedures.

Associate Director of Care Coordination - RN: Under direction from the Director of Care Coordination, manages and provides direction to the Care Coordination (CC) Department Managers and Supervisors for all services. Responsible for establishing and maintaining reports that will support the efficacy of department activity and producing a summary at least annually, or upon request, of CC program activities with

documentation of department services, member outcomes, return on investment, and quality improvement activities. A key component of this position is the enhancement and refinement of existing programs, and enthusiastic innovation in the development, management, integration, and refinement of new and existing programs.

Associate Director of Clinical Integration Under direction from the Director of Care Coordination, manages and provides direction to the Care Coordination (CC) department's Clinical Integration team's Managers, Supervisors, and Individual contributors. A key component of this position is the enhancement and refinement of existing programs, and enthusiastic innovation in the development, management, integration, and refinement of new and existing programs. The Associate Director of Clinical Integration identifies and communicates opportunities aligned with strategic initiatives, market, stakeholder, and regulatory needs. This position is a critical intersection of identification and intake of clinical, regulatory, and business needs from internal and external stakeholders across Care Coordination programs, and serves to align expected outcomes, plan roadmaps, and oversee alignment and execution of deliverables in collaboration with Care Coordination leaders and internal departments. This position works closely with Care Coordination's operational leaders, Associate Directors of Care Coordination and their regional case management teams, as the design and deliverable branch to support operations and department growth and performance. This Associate Director leads a multi-functional team responsible for the department's reporting, policy development and compliance, program development and associated deliverables, as well as the Care Coordination training team.

Manager of Clinical Integration: Under direction of the Associate Director of Clinical Integration, leads and supports the Clinical Integration team in the enhancement and refinement of existing programs and the development, management, integration and refinement of new and existing programs. The Manager of Clinical Integration will ensure successful implementation of Care Coordination programs including working closely with Care Coordination's operational leaders and internal and external stakeholders to establish expected outcomes, plan roadmaps, and oversee alignment and execution of deliverables. The Manager of Clinical Integration will directly oversee and support the clinical integration team consisting of supervisors and individual contributors across the training team, program and project roles, and the business and data analysts.

Manager of Regulatory Performance CC - RN: Plans, manages and evaluates clinical department and/or Partnership delegate(s) performance and compliance under DHCS and NCQA regulations. Responsibilities include annual DHCS Medical Audits for Care Coordination, delegation oversight and monitoring activities for applicable providers and entities, and on-going stewardship of NCQA activities to support Partnership's continued NCQA Accreditation.

Manager of Care Coordination - RN: Licensed clinician who leads and supports the department leadership in the development, implementation and evaluation of Partnership's clinical case management services. Collaborates with Supervisor(s) to oversee the department activities and provides guidance to manage these functions to enhance cost effectiveness, ensure compliance with applicable state and federal regulations, and to fulfill all contractual requirements.

Supervisor of Case Management - RN: Licensed clinician who provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best clinical expertise and sound judgment (and in consultation with providers and staff), designs and implements

high-quality, cost-effective care plans to enable members to achieve maximum medical improvement. Assists in determining appropriateness, quality and medical necessity of treatment plans.

Supervisor of Case Management – LVN: Provides daily oversight, leadership, support, training and direction of both non-clinical staff and clinical staff within scope of licensure. Supports and assists the Team Manager in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Designs and implements high quality, cost-effective care plans to enable members to achieve health goals.

Non-Clinical Supervisor: Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers and staff), provides daily oversight, leadership, support, training and direction of non-clinical staff. Supports and assists the Team Manager and other Case Management Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics.

Social Worker Supervisor - LCSW/MFT: Provides daily oversight, leadership, support, training and direction to assigned staff. Supports and assists departmental leadership in developing and maintaining a cohesive team with a high level of productivity, accuracy and quality to achieve Partnership goals and business objectives.

Nurse Case Manager I - RN: Licensed registered nurse who initiates and coordinates a multidisciplinary team approach to case management with members, health care providers, Partnership's Chief Medical Officer or physician designee, and with any patient-identified health care designee. The Nurse Case Manager will collaborate, assess, plan, facilitate, evaluate, and advocate in order to meet the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes. The Nurse Case Manager will assist members to become empowered to accept and self-manage their condition(s). This position may be assigned cases requiring case management, review of complex treatment authorization requests, disease management, or special initiative programs.

Nurse Case Manager II - RN: In addition to the Nurse Case Manager I duties, the Nurse Case Manager II has a higher level of experience, evaluates special requests, assists with benefit interpretation, serves as a liaison between the line staff and the supervisor, assists with training activities, participates in audit activities and shows initiative by suggesting improvements to department processes.

Behavioral Health Clinical Specialist – LCSW or LMFT: Licensed Practitioner of the Healing Arts (LPHA)[4] who develops, implements, and coordinates medically necessary treatment services within Partnership's Health Services for adults and children with behavioral health and/or substance use disorder needs. Collaborates and coordinates care as part of the multidisciplinary team to evaluate and advocate for the medical, behavioral and psychosocial needs of the member while promoting quality and cost-effective outcomes.

[4] Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

Social Worker I: Provides a range of social work services in collaboration with Partnership staff to meet the psychosocial and care coordination needs of members. Responsible for the assessment and care coordination of the psychosocial needs of members, families and/or caregivers to help promote positive coping skills, reduce the risk of premature institutionalization, assist individuals in maintaining independence in the community and increase stabilization of social determinants.

Social Worker II: In addition to the Social Worker I duties, the Social Worker II serves as a liaison between the line staff and the supervisor, proactively identifies strategic partnerships and/or community-based activities to enhance psychosocial supports to members and/or families, and fosters professional working relationships with providers and/or community-based agencies on behalf of Partnership.

Health Care Guide I/ CC: In collaboration with Care Coordination team members, this position provides support and guidance to members referred to the Care Coordination department for Case Management services and programs. The Health Care Guide (HCG) I works closely with members, families, providers, community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner, while connecting members to available internal and external resources.

Health Care Guide II/ CC: In addition to the Health Care Guide I duties, the Health Care Guide II exercises a higher degree of judgment, discretion, initiative and independence when working with members, families, providers, community agencies and/or the interdisciplinary team.

Quality and Training Supervisor: Under the direction of the Care Coordination Management team, this position is responsible for the design and structure of the Care Coordination department's quality and training program. Organizes and implements identified training opportunities to department staff, maintains accurate records of standard training materials, and conducts presentations on Partnership Care Coordination activities and programs to internal and external stakeholders alike.

Care Coordination Training Specialist: In collaboration with the Quality & Training Supervisor, the CC Training Specialist develops training program courses and materials in accordance with Partnership policies & procedures and coordinates, conducts, and implements assigned training modules. The CC Training Specialist supports new and ongoing training and staff support needs within the Care Coordination department and collaborates with other department leaders to support departmental referral volumes, caseload distributions, systems and operational workflows.

Health Services Analyst I: Performs routine and ad-hoc reporting and data management for internal and external users; assists in maintaining reporting systems within the department. Prepares, analyzes, reports, and manages data used for both plan-wide and regional decision making for evaluating performance in key quality measures and the effective use of health plan resources on a routine and ad hoc basis. Works collaboratively with departments company-wide to identify data needs, develop and maintain data queries and tools, and complete accurate reporting to support performance and process improvements.

Care Coordination Business Analyst: Designs, produces, and analyzes Care Coordination Department operational data in support of department objectives and goals. Works closely with business users and Configuration department to write business requirements, test plans, implementation plans, and other project documentation. Utilizes knowledge of numerous applications, databases, information systems, statistical tools and analytical principles to monitor and analyze information related to department operations. May assist Care Coordination Senior Program Manager on more complex projects.

Clinical Advisor-RN: Under guidance from the CC Manager of Regulatory Performance, the Clinical Advisor is responsible for drafting, editing, reviewing, auditing, tracking, monitoring and maintaining policies and procedures for Partnership HealthPlan of California. Alongside designated organizational leadership, ensures compliance with governing rules, regulations, and/or accreditation standards. Reviews both draft and final All Plan Letters (APLs) and/or regulatory changes and supports leaders with the research, planning, implementation and/or operational readiness submissions across the organization. The Clinical Advisor may support new and ongoing training and staff support needs within the Care Coordination department through the translation of regulatory requirements to operational training, and assist the Care Coordination leadership team on necessary audits and projects.

Policy Analyst: Responsible for drafting, editing, reviewing, auditing, tracking, monitoring and maintaining policies and procedures for Partnership HealthPlan of California. Alongside designated organizational leadership, ensures compliance with governing rules, regulations, and/or accreditation standards. Reviews both draft and final All Plan Letters (APLs) and/or regulatory changes and supports leaders with the research, planning, implementation and/or operational readiness submissions across the organization.

Senior Program Manager: To develop, implement, improve, and manage assigned programs. In addition to the Program Manager II duties, the Senior Program Manager is a leadership role, has a higher level of education/experience, more autonomy, exercises independent judgment, and provides coaching and guidance to less experienced program managers.

Program Manager I: To develop, implement, improve, and manage assigned programs. The Program Manager I is responsible for the overall success for the assigned program(s) and their role extends beyond completion of individual tasks. Programs are ongoing, which may include aligned projects and requires strategic planning and continuous improvement efforts after program startup.

Program Manager II: To develop, implement, improve, and manage assigned programs. In addition to the Program Manager I duties, the Program Manager II has a higher level of experience, more autonomy, exercises independent judgement, and conducts business analysis and program analytics. Programs are ongoing, which may include aligned projects and requires strategic planning and continuous improvement efforts after program startup.

Project Coordinator I: Provides routine and ad hoc reporting for key Health Services activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports and facilitates structured file and record management.

Coordinator I: Provides coordination and administrative support to department managers. Performs a variety of general clerical duties, including data entry and report generation, and develops forms and presentations. Distribution of referrals to department staff as directed.

Coordinator II: Coordinates assigned departmental projects and provides complex administrative support to senior management. Develops, implements and monitors processes, tools, and systems for collecting, tracking and managing information required for monitoring performance and deadlines. Develops and produces reports. In addition to the Coordinator I duties, the Coordinator II gives presentations, training, and guidance to internal Partnership audiences. The Coordinator II also monitors inventory control processes, reporting schedules, and regulatory deadlines. Distribution of referrals to department staff as directed.

Customer Service Representative, CC: Responds to member and provider inquiries regarding case management telephonically. Ensures that callers' questions and/or problems are resolved or are directed to the appropriate person for resolution and/or entered as a referral for case management while providing the highest level of customer service.

Administrative Assistant I: Provides direct administrative assistance and support to the department leadership. Manages calendars, organizes meetings, and prepares documentation and written correspondences. Interfaces with other Partnership department Administrative Assistants to organize meetings and activities, responds to requests, and maintains department policies and files.

****Note: Staffing subject to change based upon program need and organizational growth.***

CARE COORDINATION PROGRAM QUALITY MONITORING AND OVERSIGHT

Partnership's programs have been developed using evidence from a number of resources, including but not limited to, evidence-based clinical practice guidelines and resources that have scientifically supported evidence of the effectiveness of services that improve health outcomes. Examples include:

Patient-Centered Management of Complex Patients Can Reduce Costs Without Shortening Life, Sweeney L., Halpert A., Waranoff J; The American Journal of Managed Care. 2007:13:84:92

The Playbook (2017). Institute for Healthcare Improvement. Retrieved from https://www.bettercareplaybook.org/.

Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home, American Academy of Pediatrics; Pediatrics. 2011; DOI: https://doi.org/10.1542/peds.2011-0969.

CMSA's Integrated Case Management - A Manual for Case Managers by Case Managers, Frasier, K., Perez, R., Latour, C. (2017). Retrieved from https://cmsa.org/education/.

Searching for a business case for quality in Medicaid managed care, Healthcare Management Review. 2008. vol. 33, issue 4, pg. 350-360. DOI: doi: 10.1097/01.HCM.0000318772.59771.b2.

Not less than annually, Partnership's Care Coordination Department reviews population assessment data to ensure the department programs reflect current member needs. Member identification sources and referral practices are updated to ensure the member subpopulations with greatest need are offered care coordination services.
Vulnerable populations such as children, adolescents, members with disabilities, and mentally ill members are assessed along with the available community resources. Care Coordination programs are developed and refined to ensure that these services are coordinated to reduce duplication of effort while providing Care Coordination for those members who do not have access to appropriate alternatives. Revisions to the programs are made as necessary to continue to address the members' changing needs, or as required by Partnership's contract with California's Department of Healthcare Services (DHCS) and/or National Committee for Quality Assurance (NCQA) standards and guidelines.

Program quality is monitored through clinical audits performed monthly on randomly selected cases to ensure adherence to program guidelines and to support and guide care coordination staff toward best practices.
Monthly and annual utilization reports are used to evaluate program efficacy. Members participating in select programs are surveyed for satisfaction with case management services after their case is closed or annually, if the member remains open to that program for greater than 18 months. No less than annually, Care Coordination leadership reviews grievances filed by members enrolled in care coordination. The information garnered from the audits, reports, surveys, grievances, and anecdotal data is taken into consideration in revising the program offerings to better meet the needs of Partnership's population.

PROVIDER AND MEMBER SATISFACTION

Partnership conducts satisfaction surveys with both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the CC program. The responses to the

survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results, as well as any plans for corrective action, are reviewed and/or developed in conjunction with the Quality/Utilization Advisory Committee (Q/UAC). Corrective actions that were in place are evaluated at the time of the next annual survey unless the committee feels an expedited time frame needs to be implemented.

ANNUAL PROGRAM EVALUATION

The overall effectiveness of Care Coordination programs and/or services are evaluated at least annually and reviewed by Q/UAC and the Physician Advisory Committee (PAC). The results of these evaluations are shared not less than annually with the Population Health Management and Quality and Performance Improvement departments as part of Partnership's overall Population Health and Quality Strategies. Information regarding the Care Coordination annual program evaluation or program performance may be provided to members or practitioners upon request. Partnership's Care Coordination services and referral information are published to Partnership's website and member portal as well as in the member and provider newsletters.

PROTECTED HEALTH INFORMATION

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specification as described in 45 Code of Federal Regulations Parts 160 and 164-HIPAA Privacy Rule-as of April 14, 2003. The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer and has implemented a comprehensive program that includes "Notice of Privacy Practices" sent to ALL members, implementation of a confidential toll-free complaint line available to Members, providers and Partnership staff, and Business Associate Agreements with all Partnership vendors, extensive training of internal staff and external providers, and policy and procedures around documentation of complaints of violations.

STATEMENT OF CONFIDENTIALITY

Confidentiality of provider and member information is ensured at all times in the performance of CC activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that is maintained in the QI files.
- CC documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Q/UAC and Credentials meeting minutes and agendas, QI and Peer Review reports and findings, CC reports, or any correspondence or memos relating to confidential issues where the name of a provider or member is included.
- Confidential documents are electronically archived and stored on protected drives, or paper documents are stored in locked file cabinets with access limited to authorized persons only.
- Confidential paper documents are destroyed by shredding when no longer in use.

NON-DISCRIMINATION STATEMENT

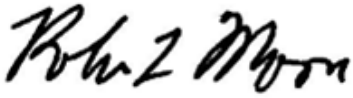
Partnership complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Partnership will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, Partnership will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

Partnership provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries.
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership members according to regulatory timeframes, and into other languages or alternative formats as indicated in the member's record or upon request. Material formats include audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735- 2929 or 711]

CARE COORDINATION PROGRAM APPROVAL

Robert Moore, MD, MPH, MBA 	2/19/2025
Quality/Utilization Advisory Committee Chairperson	*Date Approved*

Steven Gwiazdowski, MD 	3/12/2025
Physician Advisory Committee Chairperson	*Date Approved*

Kim Tangermann 	4/23/2025
Board of Commissioners Chairperson	*Date Approved*