Section 5B – Case Management Services:

Case Management Overview

Chinese Community Health Care Association's (CCHCA) Case Management (CM) program is designed provide a comprehensive system focusing on coordination of care, services and resources needed by the member throughout the continuum of care. The CM program seeks to coordinate Health Plan benefit and services available to the member to develop individualized care to the meet the members needs with collaboration and input from their PCP.

The overall goal of the CM program is to facilitate the organization and sequencing of appropriate health care and social services in the most individualized and person centered way to promote an optimal outcome.

Enrollment in the CM program is voluntary.

The identification of members for CM is through prospective, concurrent and retrospective review of data collected from Utilization Management (UM), the authorization process, inpatient concurrent review and discharge planning. Referrals are accepted from a multitude of avenues for members with high-risk medical conditions and/or other care needs:

- Member
- Member representative
- PCP or specialist
- Health Plan
- Internal CCHCA staff

The CM referral form can be found on the CCHCA website.

Upon identification, the Case Manager will reach out to the member to conduct an assessment to assist in determining the member's needs to include but not limited to; specialty care, home health, rehabilitative services and medical equipment required.

In some cases the Case Manager will develop an individualized care plan (ICP) with input from the member, member's representative and PCP. The ICP will identify the following elements:

- Problem and problem severity
- Goals identified as lifelong, long term, mid-range and short term
- Interventions
- Barriers to meeting the goals

The Case Manager may close or discharge the member when:

- The member and/or member's representative decide the goals have been achieved or the member is no longer willing to participate in the CM program
- ICP goals have been achieved
- The member is no longer eligible for services. For example, moves out the service area.

Transitions of Care

CCHCA's Transition of Care (TOC) program focuses on member's transitioning from various health care settings to include but not limited to:

- Discharged from the acute or skilled nursing facility (SNF) setting
- Members that have had a recent ER visit
- Members that have had 2 or more ER visits in a 3 month rolling period

The TOC program provides support and continuity of care for the member, re-establishing the member back to his/her medical home (PCP).

Upon discharge from the above, the Case Manager attempts to reach the member to conduct an assessment to identify needs. During the assessment process, the member may be identified as a candidate for case management services and enrolled in the CM program.

Health Homes

The Health Homes Program may be offered to member with complex needs and chronic conditions who may benefit from enhanced care management and coordination.

The Health Homes benefits aims to:

- Increase coordination between medical and behavioral health services
- Create an infrastructure to support multi-system coordination and care delivery
- Address homelessness/unstable housing of eligible members

The Health Homes Program provides 6 core services

- Comprehensive case management
- Care coordination
- Health promotion

- Comprehensive transitional care
- Individual and family support
- Referral to community and social support, including housing

Eligibility requirements

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in at least one of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

To enroll the Health Plan may identify the member needs and reach to him/her directly, providers can refer to the member to the Health Plan and the member can speak with their physician regarding enrollment.