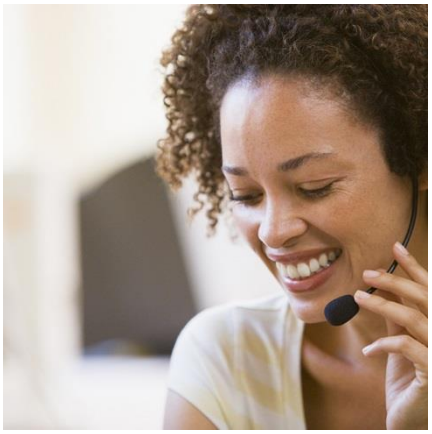
Case Management

Improving health and ensuring cost-effective, quality care through engagement and care coordination.



What is Case Management? Case Management is a clinical team approach for members who have complex medical and behavioral conditions. We assess members' health and help them plan and coordinate treatment in collaboration with their healthcare provider. Case Management can help reduce costs by coordinating care smoothly and effectively.

How is Case Management beneficial to the member?

Case Management helps the member and his or her family to:

- Improve health outcomes
- Improve experience of care
- Promote access to appropriate and cost-effective care

How are members identified for Case Management?

In the coordinated care approach, our integrated care management system identifies members using:

- Utilization Review process that shows high-cost diagnoses or procedures and complex inpatient care needs
- Readmission risk assessments that identify which members might need transition of care services
- Predictive Modeling that identifies high-risk, high-utilizing and non-adherent members who would benefit from Case Management

Members may also be referred to Case Management through:

- Health Advocacy activities
- Wellness Coaching, Condition (Disease) Management and/or Employee Assistance Program referrals (if applicable)
- Utilization Review activities
- Referral by plan, provider, community agency or self

What happens when a member is referred to Case Management?

Upon referral to Case Management, we contact the member to explain the program benefits and answer questions. Working with the care manager, the member participates in an assessment of needs and in the creation of their care plan. This plan includes personalized goals and interventions that guide the member toward improved quality of life, health outcomes and access to care.

What are the care manager's responsibilities?

The care manager uses evidence-based care guidelines throughout the Case Management process. The care manager's responsibilities include:

- Assessing health status, health literacy and barriers to improvement, including behavioral, social and economic challenges
- Developing SMART (Specific, Measurable, Attainable, Realistic, Timed) goals with the member to maintain or improve health status and prevent future complications
- Establishing an engagement strategy with the member that may include text messages, telephone or email contacts and in-person coaching groups
- Educating and coaching the member to adopt healthy behaviors, and providing feedback that promotes quality outcomes
- Coordinating care by facilitating communication among the members of the care team, including the member, providers, family members, community supports, etc.
- Assisting members in efficient utilization of plan benefits and access to all appropriate health and supportive resources
- Empowering the member to engage in a productive relationship with their providers
- Monitoring the member's condition and progress in reaching their health goals, and appropriately adjusting the care plan

What are the care managers' qualifications?

Our care management team consists of licensed clinicians and engagement specialists, and may also include pharmacy technicians and provider specialists. Many of our licensed clinicians hold advanced certifications in specialty areas. Additionally, all staff is trained to use motivational interviewing techniques.

How does the Case Management program produce cost savings?

The Case Management program produces cost savings by promoting the right care, at the right time, in the right place.

Care managers coach members to manage their chronic conditions to prevent unnecessary inpatient admissions and emergency room (ER) events.

Members receive support for a successful recovery after hospital discharge, thus helping prevent readmissions.

Examples of ways we achieve savings include:

- Avoiding expensive services by transitioning to more cost-effective care
- Avoiding services that are not medically necessary
- Identifying mental health conditions that need intervention and support
- Identifying high-risk, high-cost members and reaching out to engage them in collaborative case management services for enhanced outcomes
- Avoiding hospital admissions, ER visits and medical complications by educating members, monitoring progress and coordinating with providers for early intervention
- Transitioning care to in-network providers where possible
- Negotiating discounts with providers when in-plan care is not available

When is a member discharged from the program?

A member is discharged from the program when:

- He or she can self-manage their condition effectively
- Personal health goals are met
- The member decides to leave the program
- He or she no longer meets health plan eligibility criteria

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