13. Care Management

13.1 Overview for all Healthfirst Members

Medical Management brings added value to our members by providing proactive and comprehensive care management and outreach for those diagnosed with high-risk conditions, illnesses, and special situations and needs. Our collaborative process of assessment, planning, facilitation, and advocacy—coupled with a comprehensive portfolio of programs—helps our members better manage their overall health and well-being and navigate the complexities of the healthcare system.

Care Management encompasses a variety of clinical, outreach, and educational programs that cover:

- Behavioral Health Care Management
- Complex Care Management Program
- Care Coordination Programs
- HIV
- Healthy Mom/Healthy Baby

OB High Risk Program

Members may self-refer or be referred from provider referrals such as their PCP or from utilization data sources for Care Management. Members are screened for care management to receive case management and/or care coordination by the Healthfirst interdisciplinary care team. Care Managers and Care Coordinators will work with members and their families, PCPs, other attending providers, facilities, and other service providers to assess, plan, coordinate, monitor, and evaluate the member's level of function and to support and empower the member in their heathcare decisions to improve their quality of life. After an initial assessment, care plans are developed that include interventions to educate, monitor, and evaluate both the member's and the caregiver's ability to maintain their optimal level of function and wellness in the community. These Care Management programs are member-centric and are focused on the most efficient and effective way to support the member's goals. The member's care plan is an organized map of problems, goals, and interventions that are managed proactively with the member and their interdisciplinary care team to meet the individual needs of the member. The Healthfirst Care Management Team provides ongoing care management services when there is an identified need for case management and/or care coordination.

Healthfirst is committed to increasing the quality of life and decreasing mortality and morbidity in all members through a dedicated care/case management approach.

Healthfirst Model of Care (MOC) for Medicare Special Needs Plans

The Healthfirst Model of Care is the framework for a comprehensive and collaborative care management delivery system to promote, improve, and sustain member health outcomes across the care continuum in accordance with the requirements set forth by the Centers for Medicare & Medicaid Services. The program provides primary, specialty, and acute medical care services and Medicaid-covered long term care services where applicable. It coordinates these services to address acute medical needs and to manage chronic conditions while allowing members to remain safe and secure in their own homes. The goals of the Model of Care consist of:

- Improving access to essential medical, mental health, long term care, and social services
- Improving access to affordable care
- Ensuring coordination of care through an identified point of contact
- Ensuring seamless transitions of care across healthcare settings, providers, and health services

- Enhancing access to preventive health services
- Assuring appropriate utilization of healthcare services
- Improving beneficiary health outcomes across the continuum of care
- Maintaining member at home at the highest functional level possible for as long as possible

These goals are accomplished via:

- The administration of an initial and annual comprehensive health-risk assessment and the development of an individualized care plan;
- Assignment of members with complex medical and psychosocial needs to a case manager; provision of an adequate network of providers who can meet the special needs of the membership;
- Effective collaboration with an interdisciplinary care team; training of stakeholders on the MOC effective analysis of data toward meeting goals; and ongoing identification of process improvements with designated stakeholders, as well as communication of the results to same.

Interdisciplinary Care Team

Healthfirst assigns an interdisciplinary care team to each member in care management which plays an important role in the development and implementation of a comprehensive individualized plan of care for each member. Members of the interdisciplinary care team may include some or all of the following:

- Primary care physician
- Nurse practitioner, physician's assistant, mid-level provider
- Social worker, community resources specialist
- Registered nurse
- Restorative health specialist (physical, occupational, speech, recreation)
- Behavioral and/or mental health specialist (psychiatrist, psychologist, licensed social worker, drug or alcohol therapist)
- Board-certified physician
- Dietitian, nutritionist
- Pharmacist, clinical pharmacist
- Disease management specialist
- Nurse educator
- Pastoral specialists
- Caregiver/family member
- Preventive health/health promotion specialist

The interdisciplinary care team works together to manage each member's care by performing duties including some or all of the following:

- Develop and implement an individualized care plan with the member/caregiver
- Conduct care coordination meetings on a regular schedule
- Conduct face-to-face meetings

- Maintain a web-based meeting interface
- Maintain web-based electronic health information
- Conduct case rounds on a regular schedule
- Maintain a call line or other mechanism for beneficiary inquiries and input
- Conduct conference calls among plan, providers, and beneficiaries
- Develop and disseminate newsletters or bulletins
- Maintain a mechanism for beneficiary complaints and grievances
- Use email, fax, and written correspondence to communicate

Initial and annual assessments are analyzed to determine the need for add-on services and benefits. These needs are incorporated into the individualized care plan for each member.

Complex Care Management Programs

Complex Care Management Programs target members diagnosed with high-risk conditions, illnesses, special situations or needs and emphasize outreach, education, and intervention through collaboration with each member's healthcare team, including PCPs, hospitals, specialists, home care, DME companies, etc. Our highly trained team of nurses works by telephone with the interdisciplinary care team to address and enforce compliance, educate members about managing their condition, coordinate care, select services, and educate/inform members of available treatment options.

Care Coordination Management Programs

Care Coordination Management Programs target members requiring assistance, synchronization, and support in obtaining care and emphasize outreach and education in handling and dealing with chronic conditions or sudden unexpected acute illness. Care management is effectuated by collaborating with each member's healthcare team, including PCPs, hospitals, clinics, specialists, home care, DME companies, etc. Our highly trained team of nurses works by telephone in clinics, in emergency rooms, and on units at several of our participating hospitals in collaboration with the interdisciplinary care team to address and enforce compliance, educate members about managing their condition, coordinate care, select services, and educate/inform members of available treatment options.

HIV

Healthfirst is committed to increasing the quality of life and to decreasing mortality and morbidity in the HIV/AIDS population. Emphasis of the program is based on member assessment and coordination of care with the PCP, infectious disease clinic, immunologist, or HIV specialist provider. The goal is member education, coordination of medical care to help prevent opportunistic infections, and early identification of behavioral health and/or community resource needs. This program was developed in accordance with HIV/AIDS clinical practice guidelines published by the AIDS Institute, New York State.

Healthy Mom/Healthy Baby

Healthfirst has implemented member education programs and care management programs focused on pregnancy and newborn care. All pregnant women enrolled in these programs are sent educational materials endorsed by the American Congress of Obstetricians and Gynecologists (ACOG). These include information about prenatal care, fetal development, nutrition, preterm labor, and vaccinations. ~~Please contact the obstetrical case manager at **1-888-394-4327** regarding all pregnant Healthfirst members under your care so they can receive these educational materials~~. Members identified as "high-risk" are followed by a registered nurse for education, outreach, and prenatal and post-natal care. Healthfirst offers an incentive program to encourage prenatal care. Please see Section 14 for details.

Healthy Mom/Healthy Baby provides ~~care management and~~ outreach services for all obstetrical members. The program is designed to improve outcomes for mothers and newborns (with an emphasis on member outreach and education) and links the member and her family with appropriate providers and community resources to ensure that she receives needed services and to identify any obstacles to care. Part of the Healthy Mom/Healthy Baby program is that ~~The Obstetric Care Management~~ staff proactively contacts identified members to perform initial and ongoing comprehensive risk assessments, to encourage early and continuous prenatal care. to develop a prenatal plan of care and to coordinate that care, to encourage and/or provide HIV testing and counseling with clinical recommendation, and to coordinate post-partum and newborn care. The standard of care for Healthy Mom/Healthy Baby follows the New York State Law 85.40, PCAP Guidelines.

Specific program components include:

- Identifying pregnant members
- Assessment of members to identify high-risk pregnant members
- Providing community outreach services through affiliated hospitals and clinics
- Educating members by telephone and through literature mailed out to members
- Assessing pregnant members for risk factors and complications
- Coordinating care in collaboration with the member's obstetrical provider for high-risk pregnancies

Important: Please refer pregnant women under your care who meet these diagnostic criteria, as well as any other high-risk Healthfirst obstetrical members, to the Care Management program by calling 1-888-394-4327 or faxing a referral to 1-646-313-4603.