Care Management

COMMUNITY HEALTH PLAN
of Washington™

Overview

- CHPW Care Management Teams
  - Team Scopes
  - Behavioral Health Experience
- Care Coordination Best Practices
- Regional Resources
- Contact Information

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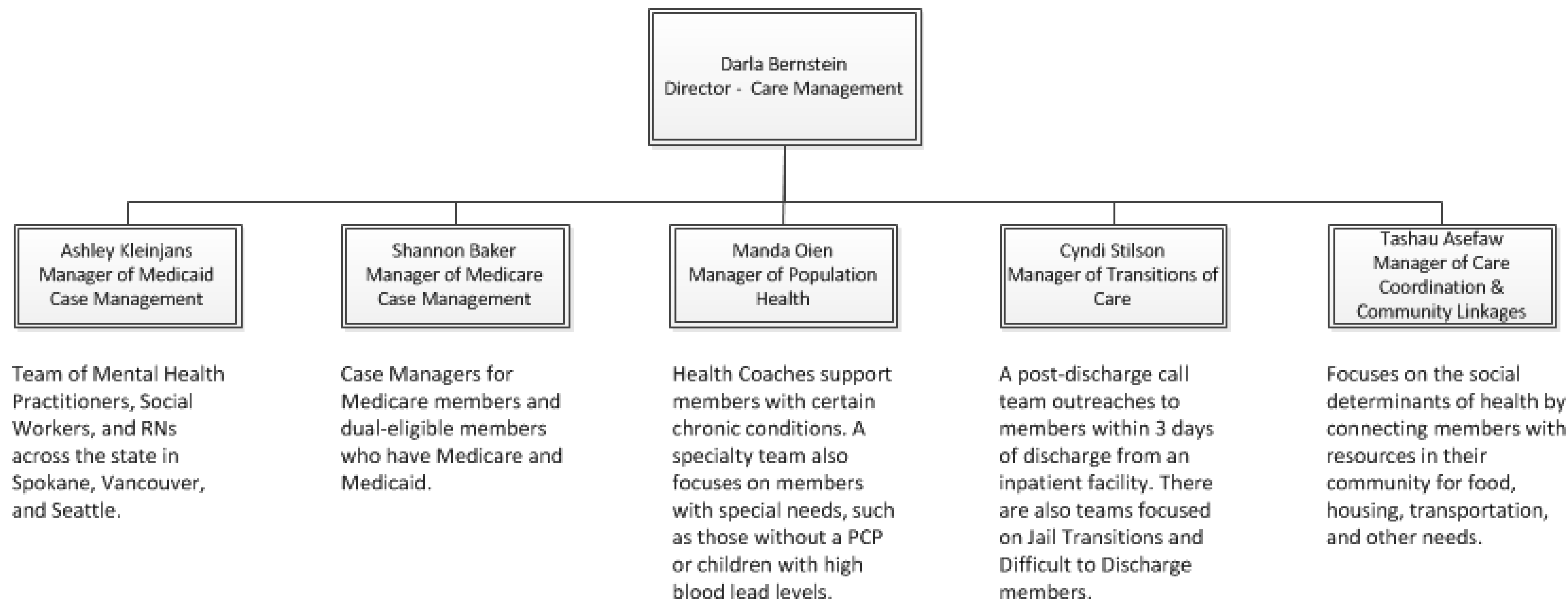
Care Management



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Transitions of Care

Transitions of care (TOC) provides proactive support to members as they move from one level of care to another. The team is staffed by medical and behavioral nurses, pharmacists, and social workers.

Program Functions:

- Ensure coordination of services and prevent unnecessary readmissions or complications
- Provide jail transition services
- Support transfers to rehab, skilled, and long-term care
- Coordinate with health homes and care teams
- Ensure home health and DME are in place
- Verify appointments with PCPs and care providers, and coordinate transportation
- Confirm member has correct medications and is able to get to the pharmacy
- Assist members/caregivers in understanding care plans
- Provide referrals to case management and other community-based programs and services

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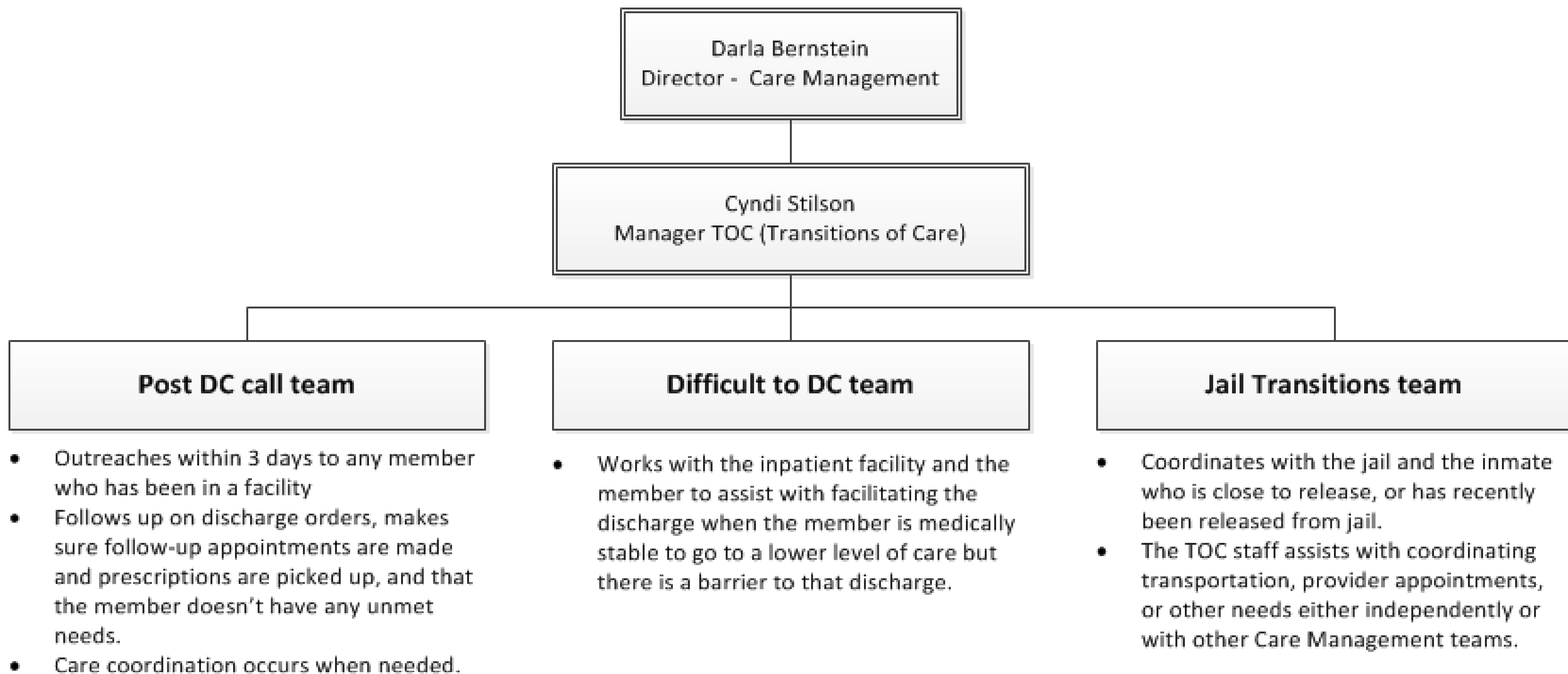
Transitions of Care



- Outreaches within 3 days to any member who has been in a facility
- Follows up on discharge orders, makes sure follow-up appointments are made and prescriptions are picked up, and that the member doesn't have any unmet needs.
- Care coordination occurs when needed.

- Works with the inpatient facility and the member to assist with facilitating the discharge when the member is medically stable to go to a lower level of care but there is a barrier to that discharge.

- Coordinates with the jail and the inmate who is close to release, or has recently been released from jail.
- The TOC staff assists with coordinating transportation, provider appointments, or other needs either independently or with other Care Management teams.

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Care Coordination & Community Linkages

CHPW's Care Coordination and Community Linkages (CCCL) **addresses the social determinants** that have an impact on member health.

This team of **community-based workers, social workers and medical assistants** provides support to internal team members (case managers) as well as members, providers and caregivers.

The locally-based team works closely with Community Health Centers (CHCs) to **identify regional resources, connect the member to those services,** and ensure continued support and access.

Services include coordinating housing, transportation, food, and assistance in getting appointments and care.

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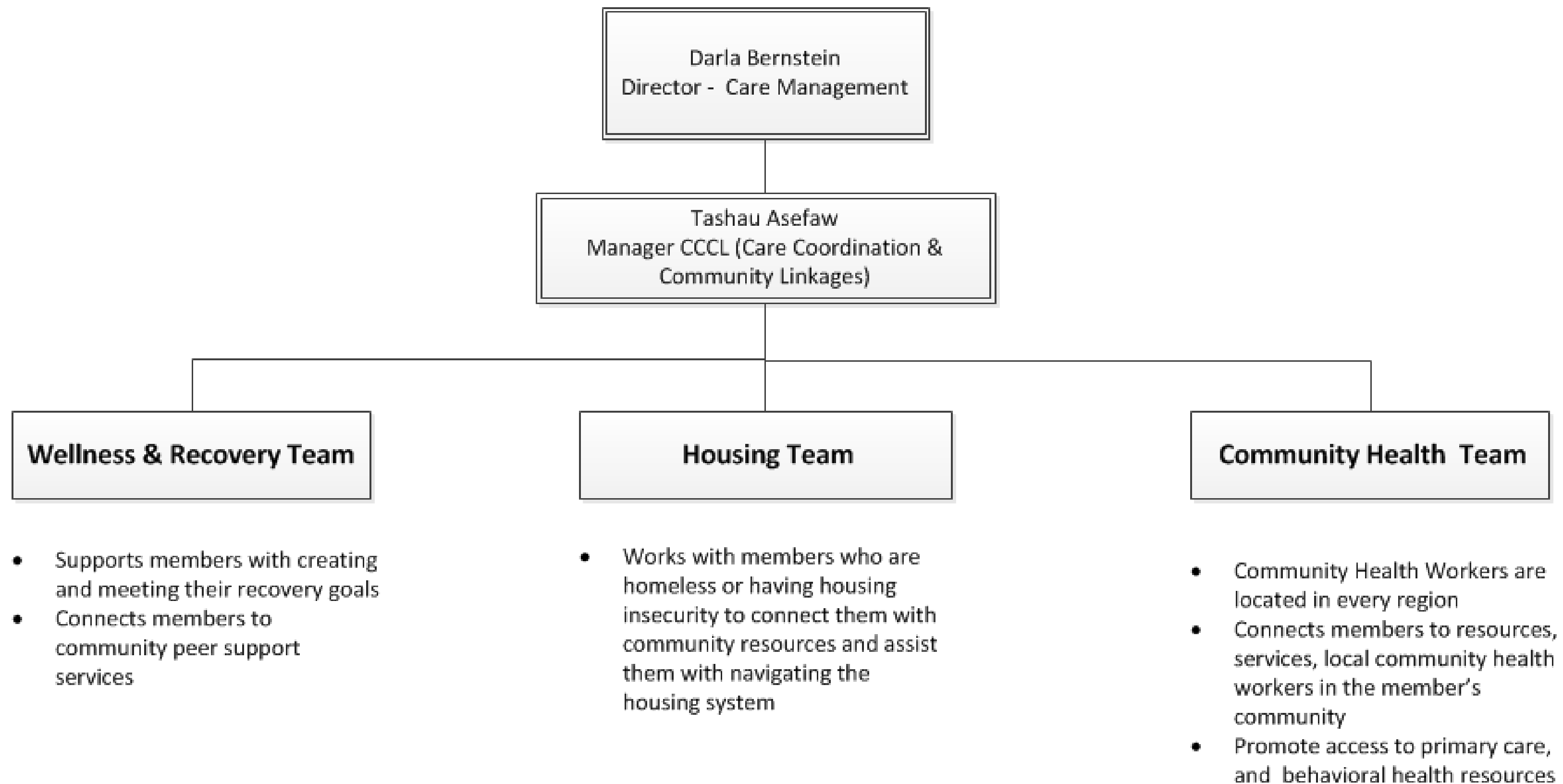
Care Coordination and Community Linkages



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Case Management

CHPW's case management (CM) programs work with members, caregivers and care teams to develop and manage a plan of care that ensures access to quality care and the social support they need. These programs address the needs of our most complex and vulnerable members.

CHPW case management is:

- **Focused on the whole person:** teams include medical and behavioral CMs working side-by-side to support the complete needs of members
- **Data driven:** uses real-time, predictive and pattern analysis to identify members
- **Consumer centric:** care plans designed to address member priorities and concerns
- **Community-based:** fully integrated with community health centers (CHCs) and resources

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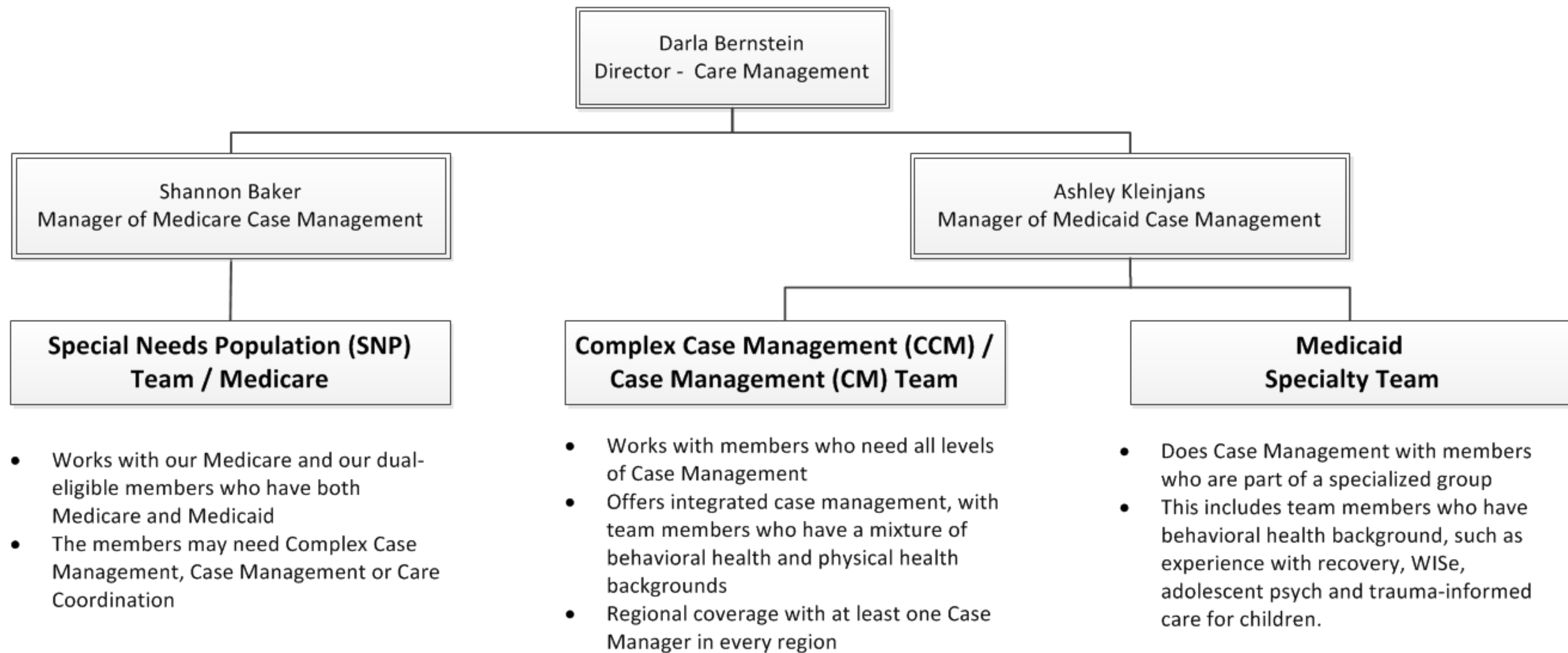
Case Management



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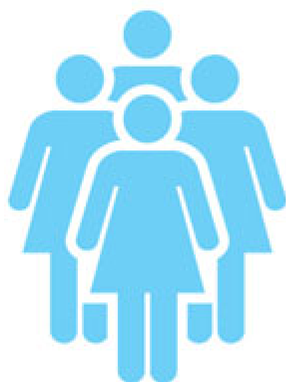
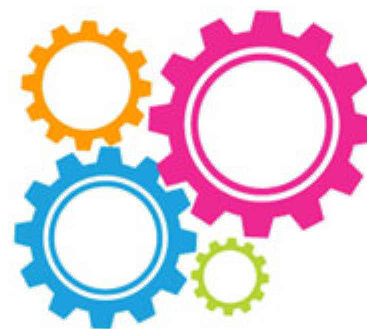
Population Health





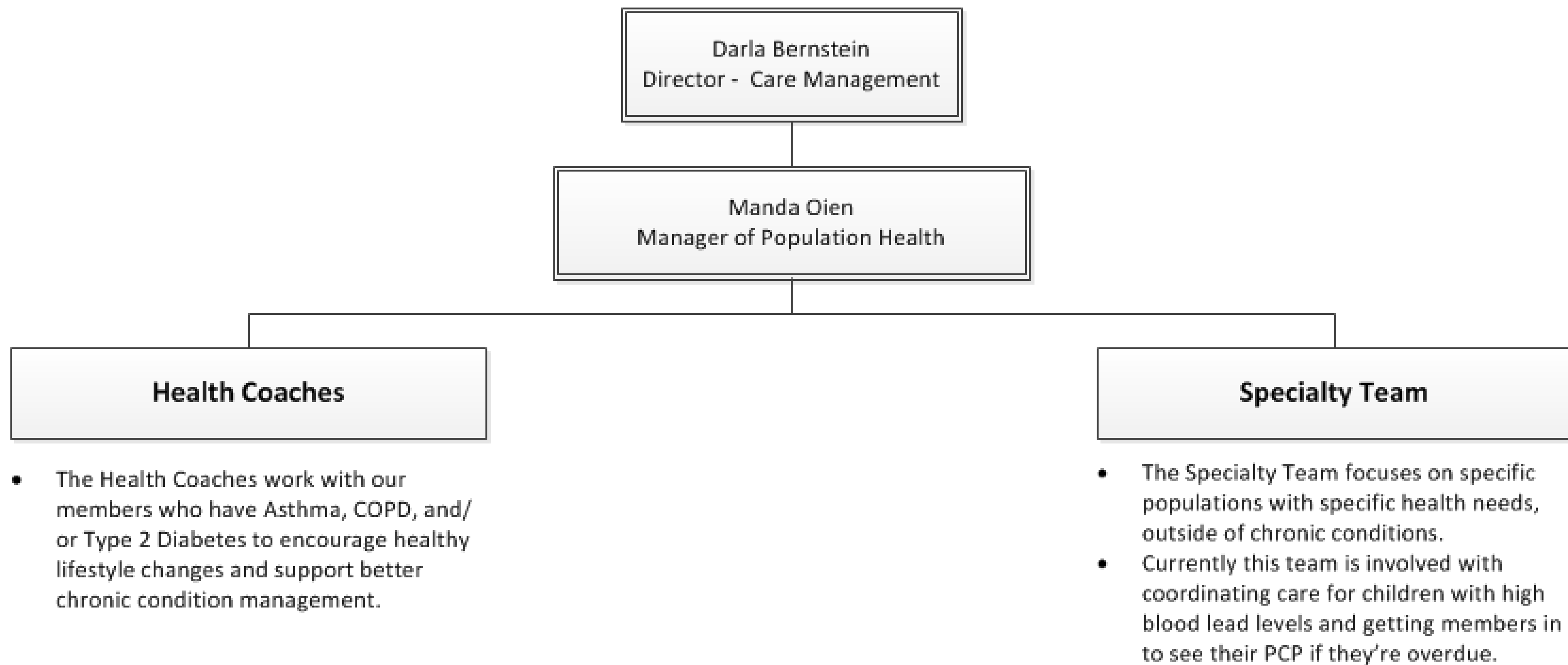
Population Health Management (formerly Disease Management) programs address:

- Keeping members healthy
- Managing members with emerging risk
- Improving safety and health outcomes
- Managing multiple chronic illnesses

CHPW's programs:

- Use multiple data sources (claims, HRAs, and electronic health records) to identify members
- Stratify populations to find highest impact members
- Target relevant and key conditions (diabetes, asthma, and COPD)
- Screen, refer, and coordinate related behavioral health needs as well as medical
- Provide health coaching and self-management support

Population Health



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CHPW Behavioral Health Experience

- Case Management nurses with experience, including:
  - Adolescent psychiatry
  - Trauma-informed care for children
  - Physical healthcare for incarcerated children
  - Correctional health care
  - Mental Health for at-risk youth
- Case Management behavioral health professionals with experience including:
  - Children's behavioral health
  - WISe
  - CLIP referral
  - Juvenile justice (including drug court and probation)
  - Recovery
- Care Coordination and Community Linkages Wellness & Recovery Coordinator who is a certified peer and recovery coach

Care Coordination Best Practices

- Shared Care Plans
- Member/Patient Driven
- Recovery Oriented Principles
- Trauma Informed Care
- Cultural Sensitivity

Care Coordination Principles

- One lead care coordinator identified for each person (health care provider or health plan)
- Multidisciplinary team approach individualized to each person's needs with agreed upon roles and responsibilities
- Routine information-sharing within privacy laws
- Connects individuals to health care, social services, and community resources
- Focuses on individuals with complex needs
- Strives to enhance or supplement current efforts and reduce duplication of work.

Additional Regional Resources

- Each region of the state has unique resources to help support members around care coordination
- CHPW coordinates with these resources by having a regional presence with at least a Regional Manager, Community Health Worker and Case Manager; along with supportive team members throughout the state.

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Contact Us

Program specific staff can be reached by phone and email:

- Case Management: 866-418-7004 or Case.Management@chpw.org
- SNP Case Management: 866-418-7005 or Case.Management@chpw.org
- Care Coordination & Community Linkages: 866-418-7006 or CareCoordCommLinkage@chpw.org
- Population Health: 866-418-7008 or PopHealthRequests@chpw.org
- Transitions of Care: 866-418-7009 or TOCRequests@chpw.org