blue california
Promise Health Plan

Policy Title: Coordination of Care		POLICY #: 10.2.29 Line of business: Medi-Cal	
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Department Head: Mirela Albertsen, UM Senior Director		**Date: 3/23/21**	
Medical Services/P&T Committee: (If Applicable) **Susan Fleischman** **Promise CMO**		**Date: 4/6/21**	

OVERVIEW

The Care Management Program is an ongoing, interdisciplinary program committed to the effective and efficient coordination of care and services for members with high costs of health care, multiple diagnoses, and/or chronic conditions. The intent of the program is to promote appropriate use of resources for provision of cost-effective quality care.

PURPOSE

To ensure that Utilization Management (UM) is based on the integration of clinical, contracting and financial services in order to provide optimum health care with the most appropriate resources available, and to delineate a process that identifies individuals with chronic conditions, illnesses, injuries or multiple diagnoses at risk of a catastrophic event resulting in permanent or lifelong disabilities.

Responsibility:

1. The Board of Directors has the overall responsibility for the Care Management Program through the Medical Services Committee (MSC), who assumes responsibility for implementation of the program.
2. MSC actively directs, participates in, and is accountable for the Care Management Program.
3. Administration will provide the support, personnel, resources and equipment necessary to maintain the integrity and effectiveness of the Care Management Program.

Goals & Objectives:

The goal of the Care Management Program is to efficiently and effectively ensure and facilitate the provision of appropriate medical care and services to Blue Shield of California Promise Health Plan (Blue Shield Promise) members with high risk/complex medical needs. The Care Management Program identifies individual members in need of care management through diagnostic/symptomatic categorization, case finding, and referrals.

Blue Shield Promise recognizes the importance of care management in a continuous and coordinated manner. The Primary Care Physician (PCP) is responsible for Basic Comprehensive Medical Care Management for his/her assigned members. The PCP provides all basic medical care needed for his/her member and coordinates referrals to specialist, ancillary services, and linked services as needed.

Care Management of the identified individual will:

1. Ensure the most favorable outcome to care managed members.
2. Coordinate and document high-quality cost-effective services to care management members.
3. Ensure that the care management process is utilized requiring extensive and ongoing medical care and to obtain appropriate care rendered through the most efficient use of benefit coverage resources.
4. Provide strong links to related programs available to Blue Shield Promise members within the county, state, federal and/or community programs.

POLICY

Blue Shield Promise has a formal process in place to identify individuals who may have (a) complex care need(s) and may benefit from care management. This may include members with chronic illness, injury and/or multiple diagnoses, or members who are at risk for catastrophic events resulting in lifelong disabilities and who require multidisciplinary care/services, which may or may not result in full or potential recovery, may be referred into care management.

This care management process facilities active communication and information exchange among all treating health care professionals.

Blue Shield Promise utilizes a broad strategy for care management to enable members and providers to achieve the best possible outcomes for each unique member with multiple or severe chronic conditions.

Blue Shield Promise monitors members' care needs and takes action to facilitate the coordination of their care through arrangements with community and social service programs. Blue Shield Promise allows members who are incapable of making decisions concerning their health care due to mental or physical incapacity to have a representative who is permitted to make such decisions for them.

Blue Shield Promise helps members access network providers that participate in both Medicare and Medicaid programs or providers that accept Medicaid patients.

Blue Shield Promise members helps members obtain services funded by either program when assistance is needed.

Blue Shield Promise members are not discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

Program Structure:
In compliance with NCQA UM 1 Criteria, the Blue Shield Promise Care Management Program ensures the following program structure which contains the following components: Basic Comprehensive Care Management, High Risk/Complex Care Management, Targeted Care Management, and Out of Network/Coordination of Care, Outpatient Care Management, and Linked Services Care Management. These components work closely together to provide members with quality, coordinated, and continuous care.

Severe Chronic Condition:
One that is persistent and substantially disabling or life-threatening that requires treatments and services across a variety of domains of care to ensure the best possible outcomes for each unique member. These conditions may include, but are not limited to the following:

1. Life threatening conditions
2. Conditions that cause serious disability without necessary being life threatening
3. Conditions associated with severe consequences, conditions affecting multiple organ systems
4. Conditions that carry a risk of serious complications
    a. Severe and chronic conditions that are prevalent in the care management population, and those for which continuity and effectiveness of care can be targeted to improve care include, but are not limited to:
        i. COPD
        ii. Cardiovascular conditions (i.e. brain aneurysm, brain tumor, paraplegia, quadriplegia, MS, CVA, Guillain Barre, Reyes, ALS, Alzheimer's)
        iii. Motor vehicle accident
        iv. Multiple trauma (i.e. fractured skull, closed head injury, 3rd degree burns, amputations)
        v. Cancer
        vi. Poly pharmacy or prescription of high-risk medications (i.e. Coumadin, Vancomycin, TPN)
        vii. Member requiring drug monitoring for:
            1. Tolerance and reaction to the medication
            2. Compliance with health care appointments
            3. Compliance with surveillance blood work
            4. Prescription refills

Levels of Care Management:

1. Basic Comprehensive Care Management- a function delegated to the PCP assigned to provide the member's care. In general, the care management function is fulfilled by the PCP, who forms a medical relationship with the member and directly cares for the member's primary care needs. When the member's condition warrants an examination or treatment by a specialist, the PCP refers the member to the appropriate specialist. Consultation between the PCP and the specialist ensues. Once the consultant's report is received, the PCP confers with the member and a plan of further treatment is devised. The PCP, assisted as necessary by the Care Management staff for his group, facilitates the new treatment parameters, tracks, and documents the results and therefore meets the member's healthcare needs in a planned, timely and high-quality fashion. Additional information related to basic care management services related to the Initial Health Assessment can be located in the following policy: Initial Health Assessment Oversight, Policy # 70.1.1.14.

    Basic Case Management services are provided by the PCP, in collaboration with Blue Shield Promise and shall include:
    a. Initial Health Assessment (IHA)
    b. Initial Health Education Behavioral Assessment (IHEBA)
    c. Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet member care needs.
    d. Direct communication between the provider and the member/family.
    e. Member and family education, including healthy lifestyle changes when warranted.

f. Coordination of carved out and linked services, and referral to appropriate community resources and other agencies.

2. High-Risk/Complex Care Management- is defined as monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside the Plan's provider network. The Care Management staff plays a key role in assisting the PCP with his/her care management duties. Prior authorizations are processed and tracked. Out of area or additional services or contracts are researched, implemented, and followed for appropriateness and timeliness. Assistance with arranging these services is provided. Concurrent review for early discharge planning includes levels of care (SNF, Home Care, etc.), care management screens and concurrent quality case finding, and intervention is an important case management activity. Consistent interaction with the PCP/attending is the basis of a successful case management program. High risk/Complex cases are followed on a continual and coordinated basis and are a central element to high quality and cost-effective care. Members may be referred to high risk/complex case management by the PCP/attending physician, member services, QM or Medical Director upon review of quality data, and UM or Medical Director upon review of utilization cases, UM data (i.e. claims/encounter date by specific ICD10/CPT codes, hospital discharge data, pharmacy data, data collected through the UM management process, etc. as per NCQA PHM 5 standards). The care management nurses within Blue Shield Promise Health plan perform the care management function and are able to perform at both the basic and high risk/complex levels of care management/ these nurses will provide the oversight of the care management functions within the plan. The following targeted diagnoses (ICD-10 numbers inclusive) are referenced as a means of identification for persons requiring ongoing or intermittent medical intervention. Contract Medical Groups/IPAs are NOT delegated to manage Complex Care Management of Blue Shield Promise Health Plan members.

3. Targeted Care Management (TCM) Services- Blue Shield Promise is responsible for determining whether a member requires TCM services and must refer members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services. Blue Shield Promise shall be responsible for coordinating the member's health care with the Targeted Care Management provider and for determining the Medical Necessity of diagnostic and treatment of services recommended by the Targeted Care Management provider that are Medi-Cal Covered Services for members receiving TCM services specified in Title 22, CCR, Section 51351. If members under age twenty-one (21) are referred to and not accepted for TCM services, the TCM Care Manager shall ensure the members have the access to services comparable to EPSDT TCM services.
    a. TCM persons eligible to receive TCM services shall consist of the following Medi-Cal beneficiary groups:
        i. Persons who have language or other comprehension barriers and
            1. Are unable to access or appropriately utilize services themselves
            2. Have demonstrated noncompliance with their medical regimen
            3. Are unable to understand medical directions because of language or other comprehension barriers; or
            4. Have no community support system to assist in follow-up care at home.
        ii. Persons who are 18 years of age and older who:
            1. Are on probation and have a medical and/or mental condition; or

2. Have exhibited an inability to handle personal, medical, or other affairs; or
3. Are under public conservatorship of person and/or estate; or
4. Have a representative payee; or
5. Are in frail health and in need of assistance to access services to prevent institutionalization.

iii. High-risk persons means those persons who have failed to take advantage of necessary health care services, or do not comply with their medical regimen or who need coordination of multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, substance abuse or because they are victims of abuse, neglect, or violence, including, but not limited to, the following individuals:

1. Women, infants, children, and young adults to age 21
2. Pregnant women
3. Persons with Human Immunodeficiency Virus, Acquired Immune Deficiency Syndrome
4. Persons with reportable communicable disease
5. Persons who are technology dependent. Solely for the purposes of the TCM Services program, "technology dependent persons" means those persons who use a medical technology, embodied in a medical device, that compensates for the loss of normal use of a vital body function and require skilled nursing care to avert death or further disability.
6. Persons with multiple diagnoses who require services from multiple health/social service providers
7. Persons who are medically fragile. Solely for the purposes of the Targeted Care Management Services program, "medically fragile persons" mean those persons who require ongoing or intermittent medical supervision without which their health status would deteriorate to an acute episode.

b. TCM services means carved out Medi-Cal services as specified in Title 22, CCR, Section 51351 as follows:

i. TCM services shall include at least one of the following service components:

1. A documented assessment identifying the beneficiary's needs. The assessment shall support the selection of services and assistance necessary to meet the assed needs and shall include the following, as relevant to each beneficiary:
    a. Medical/mental condition
    b. Physical needs, such as food and clothing
    c. Social/emotional status
    d. Housing/physical environment
    e. Familial/social support system
    f. Training needs for community living
    g. Educational/vocational needs
2. Development of a comprehensive, written, individual service plan, based upon the assessment specified in subsection B.1.a. above. The plan shall be developed in consultation with the beneficiary and/or developed in consultation with the beneficiary's family or other social support system. The plan shall be in writing and, as relevant to each beneficiary, document the following:

a. The nature, frequency, and duration of the services and assistance required to meet identified needs.
b. The programs, persons and/or agencies to which the beneficiary will be referred.
c. Specific strategies to achieve specific beneficiary outcomes
d. Care manager's supervisor's signature

3. Implementation of the service plan includes linkage, consultation with, and referral to providers of service. The Case Manager shall follow-up with the beneficiary and/or provider of service to determine whether services were received and whether the services met the needs of the beneficiary. The follow-up shall occur as quickly as indicated by the assessed need, but still shall not exceed (30) days from the scheduled service.
    a. Assistance with accessing the services identified in the service plan includes the following:
        i. Arranging appointments and/or transportation to medical, social educational and other services.
        ii. Arranging translation services to facilitate communication between the beneficiary and the Case Manager, or the beneficiary and other agencies or providers of service.
4. Crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary.
    a. For the target populations defined in Section III.A.3, crisis assistance planning shall be restricted to non-medical situations.
5. Periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified, or discontinued. The review or reinvestigation shall be:
    a. Completed at least every six months
    b. Conducted by the Care Manager in consultation with the beneficiary and/or in consultation with the beneficiary's family or social support system, and
    c. Approved by the Care Manager's supervisor
    d. Any modifications to the plan of service shall be made in writing and become an addendum to the plan of service.
6. BSCA Promise Social Services team also identifies and manages members for managed long term support services. Please refer to Social Service Policy # 70.27.1.3 for additional information.

4. Out of Network Care Management/Coordination of Care – the Blue Shield Promise Case Management staff (qualified and appropriately licensed health professionals) will manage and track out-of-network emergency room visits and hospitalizations for members and arrange transfer to an in-network facility/hospital as soon as the member is stable for transfer in order to ensure continuity of care for the Ambulatory Care setting to inpatient care and vice versa as indicated. The Blue Shield Promise care management staff will collaborate efforts with their providers according to the contractual

agreements. A Blue Shield Promise physician is closely involved in the out-of-network care management process. When required cases are referred to a board-certified physician for the specialty area to assist in making determination of medical appropriateness. Blue Shield Promise will implement and maintain procedures to monitor quality of care provided in an inpatient setting to its members, and maintain procedures for monitoring the coordination of care provided to the member, including but not limited to coordination of discharge planning from inpatient facilities, and coordination of all medically necessary services both within and outside of the Blue Shield Promise provider network. Blue Shield Promise will arrange care outside of the network when network practitioners are unavailable or inadequate to meet a member's medical needs.

5. Outpatient Care Management – the primary responsibility of the outpatient Care Manager is to assist members through the outpatient continuum of care in collaboration with the member's PCP. The Blue Shield Promise Outpatient Care Manager will perform reviews of outpatient members with complex medical and social problems and generate referrals to contracted ancillary service providers and community agencies when appropriate. The Care Manager will create a plan of care with the member, PCP, family and/or support system to coordinate care activities. The outpatient Care Manager works in conjunction with the Medical Director to assure complete and appropriate care.

6. Linked Services – Blue Shield Promise Care Manager acts as a resource for the plan. The Care Manager will establish relationships with liaisons at the LA Care Health Plan level and act as a hands-on Care Manager for the facilitation of referrals to special programs or as a resource to the PCP, Participating Provider Group (PPG) or Provider Case Managers. The CCS Case Manager will ensure linked services are offered to CCS eligible members and the Children with Special Health Care Needs program will perform care management for members not enrolled in the CCS Program.

Criteria for Referral to Care Management Program:

1. The Care Management process is directed at coordination and integration of care and resources for catastrophically ill or injured individuals on a case-by-case basis to facilitate quality cost-effective treatment outcomes.

2. The following conditions and health problems are examples of reasons for referral into the Care Management Program. The members may:
    a. Be frail, chronically disabled, functionally, and/or emotionally impaired
    b. Have chronic, medically complex problem(s) requiring multifaceted or costly care
    c. Be severely compromised by acute episode of illness or an acute exacerbation of chronic illness

3. Any member may be placed on care management regardless of diagnosis if they are identified as potentially high risk/complex. The following are examples of indicators for high risk/complex care management:
    a. Members who are frequent ER users
    b. Members with frequent hospital readmissions (readmits for social reasons may be handled at the high-risk/complex or basic case management level)
    c. Members who are non-compliant with Child Health and Disability Prevention periodicity visits.
    d. Members with chronic diseases who are frequent 'no shows.'
    e. Medically fragile or chronically ill members
    f. Members with catastrophic illness or trauma

g. Members with high-risk/problem prone medical
h. Members with multiple medical problems
i. Members with high cost/over utilization of resources

4. Members selection can be captured through the UM process including, precertification data, concurrent review data, prior authorization data and/or admission data; or through conditions, diseases or high-risk groups most frequently managed (i.e. spinal injuries, transplants, cancer, serious trauma, AIDS. Multiple chronic illnesses that result in high utilization).

Case Identification and Referral Process:

In accordance with NCQA PHM 5Standards, Blue shield Promise members have multiple avenues to be considered for care management services, including referral to case management by:

1. Practitioner referral (i.e. PCP, Attending Physician, Specialty Care Physician, and/or licensed physician support staff).
2. UM department, concurrent review staff, discharge planner, disease management, social services
    a. Acute inpatient hospitalizations
    b. SNF/Rehabilitation admissions/discharges
    c. Requests for referral to specialist/diagnostic testing
3. Health education, health information
4. Member Services
5. Inpatient nursing/hospital staff or inpatient discharge planners
6. PPG
7. Claims department
8. Medical Director upon review of quality or utilization data
9. Referral from community resource programs
10. Member self and/or family referral
11. Blue Shield Promise or its contracted/delegated medical groups will identify conditions for which more intensive case management is necessary
12. Routine screening and selection should be performed to identify those beneficiaries with multiple or severe chronic medical conditions who would benefit from a coordinated care management strategy.

Care Manager Role:

1. Care Management will be performed by a licensed nurse who is educated, trained and experienced in the care management process.
2. The Care Manager will be responsible for being familiar with community resources and their costs, since they serve as a resource to the Primary Care Physician (PCP)
3. The Care Manager can perform cost analysis functions as part of the case management process.
4. The Care Manager will obtain demographic, healthcare, and social data about the member being referred, from the referral source.
5. The Care Manger will be responsible for formulating a plan of care for each member in care management and will communicate the plan of care to all care providers.
6. The Care Manager will work collaboratively with all members of the health care team, including the health plan partner (delegated IPA/MG) Case Managers.
    a. The Care Manager will coordinate individual services for members whose needs include ongoing medical care, home health, hospice care, rehabilitation services, and preventive services.

b. Catastrophic care management will focus on the processes and activities to support members in the most appropriate setting.

7. This program will consider the member as a whole individual taking into consideration the member's medical needs, age, disability, self-determination, cultural values, and available support systems.
8. Transfer to an appropriate lower level of care will be considered when the member's clinical condition and the complexity of care/services prescribed no longer meets criteria for continued care at the current level of treatment. Level of care options include, but are not limited to, Long Term Acute Care, Subacute, Skilled Nursing, Home Health, MD home visits, Hospice, or home.
    a. Special consideration will be given to members who have had:
        i. Joint replacement surgery
        ii. Cardiac surgery
        iii. Ostomy surgery
        iv. Neurosurgery
        v. Infusion therapy (TPN, chemotherapy, anticoagulants)
        vi. No immediate family, or significant others, and who are frail
        vii. Communication barriers (i.e., disabled, language barriers)
        viii. Require special monitoring
        ix. Require long term support (i.e., tubes, catheters, wound care)
9. Transfer to appropriate service providers and/or lower level of care when a member becomes ineligible with Blue Shield of California Promise Health Plan.
10. Transition and monitoring if the member reaches the maximum allowable health plan benefit, i.e. Skilled Nursing Facility maximum 100 day stay requiring transition to custodial level of care.

Care Management Process:

Care Management will work collaboratively with all members of the health care team to develop and support care management functions, which include but are not limited to:

1. Identification and referral of high-risk members
2. Triage, within an appropriate time frame
3. Comprehensive assessment processes and formats
4. Care plan development and implementation
5. Ongoing monitoring and coordination of care needs
6. Coordination of care through arrangements with community and social services programs
7. Adherence to Care Management strategy including all of the above, but is not limited to, case finding; screening, and selection; problem assessment and identification of strengths; development of treatment or care plans with an emphasis on proactive interventions; and monitoring of care plan implementation and outcomes.
    a. This care management strategy reflects a commitment to continuity and coordination of care by:
        i. Monitoring continuity and coordination activities
        ii. Analyzing date to identify opportunities for improvement
        iii. Taking actions to bring about improvements
    b. This care management process includes multidisciplinary perspectives and treatments, as appropriate, and may involve the assessment and treatment expertise of:
        i. Primary care practitioners
        ii. Specialty care practitioners
        iii. Nurses and nurse specialists
        iv. Social workers

v. Pharmacists
vi. Occupational, speech and physical therapists
vii. Rehabilitation specialists
viii. Behavioral and mental health professionals
ix. Community based services providers and resources

c. Access to expertise from these various disciplines should be available as needed.
d. Members and their families should be involved at every step so that the care process incorporates the member's expectations and preferences and documents the member's role in achieving treatment goals.
e. Blue Shield Promise Health Plan allows members who are incapable of making decisions concerning their health care due to mental or physical incapacity to have a representative who is permitted to make such decisions for them.
f. This care management strategy integrates the participation of all those involved in the care of the member including:
    i. Primary care physicians
    ii. Medical and surgical specialists
    iii. Nurses and nurse specialist
    iv. Behavioral and mental health specialists
    v. Physical, occupational, and speech therapists
    vi. Social workers
    vii. Allied health professionals
    viii. Community based service providers

8. This program monitors care management plans for both process and outcomes for members with multiple and severe chronic conditions at the level of population, member, provider, and best practices of care.
9. All care management participants will receive:
    a. An assessment of all their medical, psychological, and social conditions
    b. The medical care needed to fully address and monitor those conditions.
        i. If the assessment identifies need for medical, psychological or social services that are outside the scope of CIS's benefit package, referrals can be made to and are coordinated with appropriate external agencies and providers to be involved in the care of the member.
            1. Individual goals should be established for the member
            2. Resources are identified
            3. Outcomes are evaluated
            4. Needs for further intervention are identified
    c. An individualized care plan will be developed that is consistent with the member's coverage and address the needs identified by the assessment. This care plan should be developed by the care management staff in conjunction with the primary care provider (or other designated member of the interdisciplinary team responsible for the member), and the member and his/her family.
        i. It should be established for a specific period
        ii. Identify target dates for reassessment of progress and/or accomplishment of desired member outcomes
10. In the event the member requires care from a specialist (Blue Shield of California Promise) or its' delegated medical groups should provide direct access to the specialist(s) in sufficient quantity, consistent with the member's care plan.
11. Communication and information exchange among the professionals involved in the care of conditions requiring multiple sources of treatment or levels of care are integral to this care management program.

Discharge from Case Management:

1. Discharge from care management will be based on medical necessity.
2. A member will be discharged from the care management program when the following discharge criteria are met:
   a. His/her medical condition is no longer considered to be in a life-threatening state.
   b. He/she has met his/her medical necessity goals and has returned to the level of optimum functioning no longer requiring use of the case management benefit.
   c. The responsible practitioner and team will ascertain, based on member progress and compliance with the treatment plan, that the member may safely return to self-maintenance.
   d. Member is able to effectively self manage their healthcare and disease state.
3. Member terminates from the plan.
4. Member expires
5. Member refuses further case management services.

Documentation will be made, at appropriate intervals, of the progress toward goal and of the outcome of the case management interventions prior to the patient being discharged from care management (i.e. return to home, home health follow-up, admission to a SNF, etc.).

In accordance with NCQA PHM 5, the Care Management documented process addresses:

1. Member's right to decline participation or disenroll from CM programs and services offered by the organization
2. Initial assessment of members' health status, including condition-specific issues. (During initial assessment, Care Managers evaluate member's health status specific to identified health conditions and likely co-morbidities, e.g. high-risk pregnancy, and heart disease, for members with diabetes).
3. Documentation of clinical history, including medications. (Care Management procedures document members' clinical history, including disease onset; key events such as acute phases; and inpatient stays, treatment history and current and past medications).
4. Initial assessment of activities of daily living (ADL). (Care Management procedures evaluate members' functional status related to ADLs such as eating, bathing and mobility).
5. Initial assessment of mental health status, including cognitive functioning. (During the initial assessment, Care Managers evaluate members' mental health status, including psychosocial factors and cognitive functions such as ability to communicate, understand instructions and process information about their illness).
6. Initial assessment of life planning activities. (The care management assessments addresses life planning issues such as wills, living wills or advance directive and health care powers of attorney).
7. Evaluation of cultural and linguistic needs, preferences, or limitations. (The care management plan includes an assessment of cultural and linguistic needs, preferences, or limitations).
8. Evaluation of caregiver resources. (During the initial assessment, Care Managers evaluate caregiver resources such as family involvement in decision making about the care plan).
9. Evaluation of available benefits. (The care management plan includes an assessment of members' eligibility for health benefits and other pertinent financial information regarding benefits).
10. Development of a care management plan, including long and short-term goals. (The care management plan identifies short and long term goals, timeframe for reevaluation, resources to be utilized, including the appropriate level of care, planning for continuity of

care, including transition of care and transfers, collaborative approaches to be used, including family participation).

11. Identification of barriers to meeting goals or complying with the plan. (The care management procedures address barriers to care such as members' lack of understanding, motivation, financial need, insurance issues or transportation problems).
12. Development of a schedule for follow-up and communication with the member. (The care management plan includes a schedule for follow-up that includes, but is not limited to, counseling, referrals to disease management or education or self-management support).
13. Development and communication of self-management plans for members (The self-management plan includes, but is not limited to, members' monitoring of their symptoms, activities, weight, blood pressure and glucose levels).
14. Processes to assess progress against the care management plans for members. (The care management plan includes an assessment of members' progress toward overcoming barriers to care and meeting treatment goals. The case management process included reassign and adjusting the care plan and its goals, as needed).

* A assessment of cultural needs, preferences or limitations addresses health care treatments or procedures that are religiously or spiritually discouraged or not allowed, and/or family transitions related to illness, death and dying.

Program Evaluation:

1. The Medical Services Committee will evaluate the Care Management Program at least annually.
    a. The annual evaluation will be directed toward the identification of components of the program that need to be instituted, altered, or deleted.
    b. Recommendations resulting from the annual review shall ensure that the program is ongoing, comprehensive, efficient, and cost effective in the improvement of the member's care and related services.
2. Recommendations resulting from the annual review will be evaluated and approved by the Medical Services Committee and the Board of Directors, as appropriate.

Delegations:

Adherence to these standards will be monitored in several ways, including but not limited to:

- Monthly/Quarterly Reports
- Annual UM Delegation Oversight Audit (70.24.91 UM Delegation and Monitoring)
- Joint Operating Meetings (JOMs)

REFERENCES

DHCS Contract Exhibit A Attachment 11
LA Care Contract
Title 22, CCR, Section 5135
NCQA PHM 5