



SERVICE COORDINATION CASE MANAGEMENT

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Overview

While the provision of health care services and the exercise of professional medical judgment is the purview of treating physicians and other health care providers, service coordination (case management) is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet a member's health care needs using communication and all available resources to promote quality outcomes.

Service coordination emphasizes continuity of care for members through the coordination of care among physicians and other providers. Proper care coordination occurs across a continuum of care, addressing the ongoing individual needs of a member rather than being restricted to a single practice setting.

'Ohana's service coordination system is build around the individual member, their goals, desired outcomes and service needs. 'Ohana (the Plan) will use a patient-centered, holistic, service-delivery approach to coordinating member benefits across all providers and settings.

Core principles of 'Ohana's service coordination system include the following:

- *Care Will Be Person- and Family-Centered* – The desired goals and outcomes of the member and his/her family will be placed foremost in the care planning and management process, with service coordinators acting as their advocates within the plan and across the health care continuum.
- *Service Delivery Will Be Holistic and Comprehensive* – The assessment and care planning process will integrate the member's medical, behavioral, social, and functional needs. Service delivery also will include active coordination across payers, state agencies and other relevant community-based programs, as appropriate.



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- *Care Will Be Culturally Relevant* – ‘Ohana recognizes the critical importance of culturally appropriate assessment and treatment. Attitudes and preferences regarding care options and the role to be played by family members can differ significantly depending on a member’s culture. Service coordinators will be drawn from each of the major cultural groups represented on the islands and will be attuned and responsive to differences in communication, patterns of health risks, culturally related health beliefs and barriers to care within the Anglo, Chinese, Filipino, Hawai’ian, Japanese and Korean cultures.
- *Information Systems and Technology Will Facilitate the Delivery of Care* – From initial contact and assessment through care planning and monitoring, the service coordination process will be supported by systems that capture all critical information, provide the tools to support continuity of care during the transition and facilitate active oversight of implemented care plans.

Service Coordinators

Upon enrollment into ‘Ohana, each member will be assigned to a service coordinator (case manager) who will perform an initial intake screening, a health and functional assessment (HFA) and assist in planning and coordinating the member’s care. All members will receive an initial letter containing contact information for their service coordinator.

The service coordinator will make initial contact with the PCP during the HFA/care-planning process and will provide contact information to the physician and office staff. Providers can also contact ‘Ohana’s service coordination unit to access these services via the Provider Hotline.

Service coordinator responsibilities for all members will include:

- Coordinating a team of decision makers to



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develop the care plan, including the PCP, other providers as appropriate, the member and others as determined by the member, including family member, caregivers and significant others;

- Conducting health and functional assessments;
- Developing the care plan based upon results of the assessment;
- Monitoring progress with Early Periodic Screening and Diagnostic Testing (EPSDT) requirements;
- Coordinating services with other providers, such as Medicare, the Hawai'i Department of Health (DOH) programs excluded from QUEST Expanded Access (QExA), Medicare Advantage plans, other managed-care-organization (MCO) providers, Zero-To-Three, Healthy Start, mental health and developmental disabilities or mental retardation (DD/MR) providers at DOH;
- Utilizing compiled data received from member encounters to ensure that the services being provided meet member needs;
- Facilitating access to services; and
- Providing assistance in resolving any concerns about care delivery or providers.

In addition to the above, service coordinator responsibilities for nursing-facility-level-of-care (NF LOC) members will include:

- Completing NF LOC assessments (form 1147) and submit to PCP for signature and review; and send form to the State of Hawai'i Department of Human Services (DHS) or its designee for a functional eligibility determination;
- Providing options counseling regarding institutional placement and home- and community-



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based services (HCBS) alternatives; and

- Assisting members in transitioning to and from nursing facilities/residential-care facilities.

Health and Functional Assessment

Upon enrollment, 'Ohana will conduct a face-to-face health and functional assessment (HFA) to determine the health and functional capability of each QExA member and the appropriate strategies and services to best meet his/her needs. 'Ohana will also conduct annual HFA and NF LOC re-assessments. If a member's condition changes before his or her annual reassessment, the service coordinator will meet with the member and prepare an updated HFA and Hawai'i DHS Form 1147 (if applicable).

The HFA will factor in the health status of each member, including the following:

- Intake
- Activities of daily living/independent activities of daily living
- Cognition
- Communication and sensory
- Mood and psychosocial
- Behaviors
- Medical conditions
- Health-related services
- Medications
- Medical stability
- Social supports
- Home environment
- Strengths and preferences

Hawai'i DHS Form 1147 - Nursing Facility Level of Care

If a member is in the non-NF LOC category, but appears to meet the NF LOC standard, the service coordinator either will complete the DHS Form 1147 (if she/he is a registered nurse) or make a referral for an LOC assessment to be performed. The form, when



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completed, will be forwarded to the member's primary care provider (PCP) for signature and submitted in accordance with DHS policies and procedures.

Member Self-Direction Option

If a member is NF LOC and living at home or in the community, or is non-NF LOC but appears to meet the Hawai'i NF LOC standard, the service coordinator will review the consumer- or surrogate-directed care option with the member and his/her family. If the member expresses an interest in this option, he/she will complete a self-assessment form during the HFA. The purpose of the self-assessment is to determine whether or not a member is capable of directing his/her own care. If a member is not capable, then he/she can appoint a surrogate to fill this role.

At the conclusion of the face-to-face assessment, Service Coordinators will have the ability to review a preliminary care plan with recommended services, service units and corresponding budgets with each member. If the care plan includes any of the qualifying services under self-direction – Personal Assistance Levels I or II; Attendant Care; and/or Respite Care – the service coordinator will inform the member of the availability of the self-direction option for those services.

A member's rights and responsibilities under self-direction include:

- Designating an (unpaid) surrogate, at the member's option;
- Recruiting/selecting self-direction providers, including qualifying family members and friends;
- Instructing 'Ohana to arrange for a criminal history/background check of the potential provider, at their option (and funded out of their budget);
- Limitations on who may serve as a provider and the number of hours per week providers may work;



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- Defining provider duties, instructing/training/supervising and evaluating providers;
- Reviewing and approving provider time sheets; and
- Terminating and changing providers at any time.

'Ohana Health Plan's duties under self-direction include:

- Providing face-to-face training on self-direction to the member/surrogate;
- Assisting the member/surrogate to develop interview questions and screen/interview non-family member applicants and develop/execute a service agreement outlining the roles and responsibilities of the member and provider (the coordinator himself/herself will provide this assistance);
- Ensuring a choice of providers are offered to members who are considering a spouse as provider;
- Defining service units (hours of care) within allowable weekly parameters;
- Arranging for/assuring potential providers receive a TB test and complete CPR and first aid training;
- Developing a back-up plan within the larger care plan addressing how the member will receive services in the event his/her provider is unavailable;
- Collecting/reviewing timesheets and paying providers in a timely manner;
- Reviewing services documented on timesheets for conformance to care plan and approving for payment;



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- Performing other payroll functions, including withholding applicable local/state/federal taxes;
- Reviewing and verifying the results of criminal history/background checks; and
- Coordinating services not covered under self-direction.

Care Plan Development

A care plan will be developed by the service coordinator for each QExA member in collaboration with the member's PCP. The service coordinator will obtain existing care plans for each member, as applicable. The care planning process will begin at the time of the initial HFA. Based on the results of the HFA and subsequent consultation with the member's providers and existing case managers (if applicable), a comprehensive care plan will be developed.

Care Plan Components

At a minimum, all care plans will include information regarding:

- Member goals and desired outcomes;
- Current medical conditions and associated medically necessary services;
- Other service needs and authorized service units/budgets; and
- Medications and medication management.

Care plans for persons meeting the NF LOC or with complex needs will be lengthier and more detailed than plans for the remaining populations. Care plans for persons receiving home- and community-based services, including persons with paid family caregivers, will include back-up plans in the event a service provider becomes unavailable.

Interdisciplinary Care Team

The greater complexity of an “average” care plan for a member with special health care needs may be evident in the creation of an interdisciplinary care team (ICT). The ICT could include PCP/other providers, family members, caregivers, cultural leaders, others that a member designates. If such a team is assembled, the member or designee will be invited to attend any meetings held by the team. (Homebound members will be given the option of having the meetings occur in their homes).

Reviewing Care Plans

Upon completion, the care plan will be signed and dated by the service coordinator and the member, his or her representative and any surrogate..

Updating Care Plans

Care plans for non-complex members will be reviewed and updated:

- When significant events occur in the life of a member, to include but not limited to the death of a caregiver, change in health status, change in living arrangement, institutionalization and change in provider (if the provider change affects the care plan); or
- Annually if a review and update has not occurred because of the occurrence of a significant event.

Care plans for members at NF LOC must be revised, as needed, every 90 days.

Service coordinators will be responsible both for managing the services included in the member’s care plan and coordinating/interacting with providers and case managers to ensure the member is receiving all medically necessary services, regardless of payer source. This will include assisting with the scheduling of



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appointments and advocating on behalf of members with identified service needs falling outside of the QExA capitated benefit package.

The Service Coordinator will provide updates to the PCP concerning any changes in the member's health or significant developments that may require a change in the member's care plan.

Obstetrical Care

In support of obstetrical (OB) care, the Plan has adopted Guidelines of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG). These clinical practice guidelines are based on valid and reliable clinical evidence.

The Plan contracts with participating providers for OB care that includes OB as well as Certified Nurse Midwife services. The OB or Midwife must complete the **Prenatal Notification** Form in the **Forms** section of this manual at the first prenatal visit and fax the completed form to the Plan's OB department. Upon receipt, the Plan will give comprehensive authorization for prenatal, delivery and post-partum care.

If a pregnant member is entering the Plan in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal services the day before enrollment, the health plan will be responsible for providing continued access to the prenatal care provider (whether contract or non-contract) through the postpartum period.

If a pregnant member is receiving care from a non-participating provider, the Plan will make special arrangements to reimburse the provider for the member's care though the postpartum period. The provider is required to provide the most appropriate and highest level of quality care for pregnant women.

Authorizations for OB Care

The OB physician or Midwife must complete the Prenatal Notification Form in the Forms section of this manual at the first prenatal visit and fax the completed form to the Plan's OB department to obtain an authorization for OB



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care.

Initial OB Visit

All new members who are pregnant or who become pregnant while on the Plan should be encouraged to see their OB physician for their initial visit within 14 calendar days.

OB Physician Functioning as the PCP

The OB physician may function as the PCP during the pregnancy and may request referrals and authorizations for that member during her pregnancy. An OB physician can also function as a PCP, in general.

Lead-Level Screening

‘Ohana provides service coordination services to all eligible children with blood lead levels (BLL) equal to or greater than 10mcg/dl. These services include all basic service coordination services and those services that directly relate to assisting a member who has an elevated lead level, i.e. education, assistance in obtaining lead abatement, coordination of testing of siblings, scheduling of appointments and coordination of transportation, etc.

The method of identification for members with elevated lead levels is through a monthly report from contracted laboratories and from the Plan’s exam.

Disease Management Programs

The Disease Management (DM) program proactively identifies members with certain chronic diseases and educates members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and appropriate medication management. The program also focuses on educating the provider with regards to the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of members, improve health outcomes, and decrease medical costs. In addition, ‘Ohana makes available to providers and members general information regarding health conditions



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on 'Ohana's website at: www.ohanahealthplan.com.

Ohana's DM program incorporates culturally appropriate interventions, including but not limited to taking into account the multilingual, multicultural nature of the member population.

The program's focus is on educating members and their caregivers regarding the standards of care for chronic diseases, specific triggers to avoid, appropriate medications and interventions that exist in their communities. The service coordinator/disease management health education specialist also educates the member on appropriate action plans, preventing reoccurrences and all measures that will decrease the likelihood of adverse outcomes.

Additionally, the program also focuses on providing technical support and educational opportunities for the provider to ensure the provider is utilizing the most current and nationally recognized standards of care for chronic diseases and current treatment recommendations. Intervention and education will improve the quality of life of members, improve health outcomes and decrease medical costs.

Ohana's DM program covers some of the most commonly managed disease states that are also prevalent in Hawai'i today:

- Coronary Artery Disease
- Diabetes
- Obesity Management
- Depression
- Smoking Cessation

In the Disease Management Programs:

- Members are stratified according to the severity



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of their diseases.

- 'Ohana emphasizes the prevention of exacerbation and complications of diseases;
- 'Ohana incorporates culturally appropriate interventions, including but not limited to taking into account the multilingual, multicultural nature of the member population. Members receive culturally appropriate educational mailings and have the opportunity to request additional educational material specific to their condition or needs.
- Members who are stratified in the most high-risk categories receive more intensive follow-up by their service coordinator and disease management health education specialist.
- All members also receive periodicity letters to remind them of the preventive health care they need.
- Members receive flu and pneumonia reminders.
- Members receive newsletters that feature articles related to diabetes, coronary artery disease, depression, obesity and other chronic conditions.
- Providers receive clinical practice guidelines based on nationally-recognized evidence-based guidelines.
- Providers receive newsletters that feature articles regarding the latest treatment guidelines.

While 'Ohana employs proactive and programmatic methods to identify members for enrollment into the DM program, providers may also directly refer members to the program.

If you would like to refer your member to the program please complete the Service Coordination/Disease



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Management referral form available on our website, www.ohanahealthplan.com or call Customer Service, 1-888-846-4262 and ask for the Disease Management department.

Member and Provider Access to Case and Disease Management

If you would like to refer your 'Ohana patients to either or both of these programs, you may:

- 1) Call the Care Management Referral Line at 1-888-846-4262 Monday through Friday,
or
- 2) Complete the Care Management Referral Form and fax to the number listed on the form.

Members may self-refer or receive referral by a provider to the program (s) utilizing:

Care Management toll free line, 1-888-846-4262, TTY/TTD available in unit. If a 'Ohana Member would like to speak with a nurse after hours or on weekends, they may contact 'Ohana's Nurse Advice Line at: 1-800-919-8807. TTY/TTD Nursing Advice Line: 1-800-955-8770