
Overview

The Centers for Medicare and Medicaid Services are contracted with 'Ohana Health Plan to provide comprehensive, cost-effective managed care health services to enrolled members.

Case management emphasizes continuity of care for the members through the coordination of care among physicians and other providers. Case management is not an episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single practice setting.

- The Case Management team is comprised of specially qualified nurses who assess the member's risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the treatment plan.
- Case Managers work collaboratively with Primary Care Physicians (PCPs) serve as the principal case manager and to coordinate or of care for the member and expedite access to care and needed services. The Plan's Case Management team also serves in a support capacity to the PCP and assists in coordinating care actively linking member to providers, medical services, residential, social and other support services, as needed. The Plan's Case Management team adheres to the Case Management Society of America (CMSA) standards of practice.
- The Plan has incorporated case management programs that manage members with specific health care needs such as catastrophic diseases, chronic illnesses or complex and transplant. The physician may request case management services for any of the Plan members.

Case Management Process

The Case Management process illustrates the formation of one seamless Case Management Program and begins with Member identification, and follows the Member until discharge from Case Management. 'Ohana's philosophy is that these programs are an integral management tool in providing a continuum of care for our Members. The Case Management process is as follows:

- Member Identification
- Member Stratification
- Member Evaluation
- Member Planning
- Member Service Facilitation
- Member Advocacy

Members are discharged from the Case Management program when one or more of the following reasons occur:

- 80% of goals are met;
- Non-adherence to CM Treatment plan or Medical plan;
- Termination from the plan;
- Member request to be discharged from program;
- Death

Case Management Program

In accordance with each contractual agreement, the health Plans offer Case Management services to adult members with chronic illnesses. In addition, 'Ohana's Case Management services also provide HIV/AIDS Case Management.

'Ohana's Case Management Program is composed of the following categories of eligibility:

- Catastrophic – head injury, near drowning, burns, etc.
- Complex – multiple co-morbidities or multiple intricate barriers to quality health care i.e. HIV/AIDS

- Transplantation – organ failure, donor matching, post-transplant follow-up
- Special Needs Population – developmentally delayed, etc.
- Long Term Care – medically frail
- Elderly

Member Access to Case Management

'Ohana Members have access to Case Management at any time. The Member can self refer or receive referral by a provider to the program (s) using:

Health information line referral; 24-hour nursing line; or Case Management toll-free line, TTY/TTD available in unit.

Case Management Queue: 1-888-505-1201

TTY/TTD: 1-888-505-1194

24 hour Nursing Line: 1-800-919-8807

TTY/TTD 24 hour Nursing Line: 1-800-955-8770

'Ohana's Case Management programs are "opt out" programs.

Disease Management Program

The Disease Management Program proactively identifies members with certain disease states and provides education for these members and/or their caregivers to empower them to make behavior changes to ensure the choices they make will improve their health and reduce the complications of their disease. In addition, the program educates members and their caregivers regarding the standards of care for these disease states, triggers to avoid and to ensure they are receiving the appropriate medications for the specific conditions.

The program also focuses on educating the provider with regards to the standards of care and current treatment recommendations for the individual disease management conditions. Intervention and education will improve the quality of life of members, improve

health outcomes and decrease medical costs.

The Disease Management Program offers the following disease states to Medicare members:

- Asthma
 - COPD
 - Diabetes
 - CHF
 - CAD
 - Obesity
 - Hypertension (HTN)
 - HIV/AIDS
- Members are stratified according to the severity of their disease.
 - Outreached members receive educational mailings and have the opportunity to request additional educational materials specific to their condition or needs.
 - Qualifying members receive telephonic intervention by a disease management nurse. The nurse conducts a telephonic disease management comprehensive assessment and provides education regarding the disease process.
 - Members receive newsletters that feature articles related to specific disease states to provide further education and awareness for members.
 - Providers receive Clinical Practice Guidelines based on nationally-recognized evidence-based guidelines.
 - Providers receive newsletters that feature articles regarding the latest treatment guidelines.