



Care Management

Empowering Patients to Make Better Healthcare Decisions

Our Care Management program is a patient-centered and team-based approach for supporting the most high-risk patients assigned by the payers to Catalyst Health Network members. Includes care coordination, patient care gap assessment, chronic disease support, and healthcare navigation.



Programs

Transition of Care (TOC) - The goal is for the safe and timely transfer of consumers from one level of care to another, or from one type of setting to another. The focus is on educating patients and families to address root causes of poor outcomes and avoid preventable re-hospitalizations.

Emergency Services (ES) - The goal is to decrease frequent emergency department use for avoidable conditions. The opportunity is to educate patients on access to care options, appropriate emergency department utilization, and provider services.

Quality Improvement (QI) - The goal is to provide effective, equitable, patient-centered care in a safe, efficient, and timely manner. The care team assists in identifying patients with open gaps and closing individual gaps in care through a systematic process of identification.

Care Management (CM) - The goal is to link individuals with illnesses/chronic conditions with appropriate educational services and resources in a cohesive and rational way to efficiently maximize health outcomes. It is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs



through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.

Disease Management (DM) - The goal is to improve the quality of life for individuals by preventing or minimizing the impact of a disease or chronic condition. Focus is to provide health coaching for behavior change with use of advanced information technology, and by caring for the whole person, rather than for an individual disease.

Medication Management through StellusRx - The goal is to work to optimize the medication management of patients to optimize health care outcomes. This includes consultation with a pharmacist regarding medication-related questions and the ability to optimize drug therapy and improve therapeutic outcomes for patients in partnership with their physician.

*** Populations served in our Care Management programs are found in our specific program policies.*

Care Management programs are evaluated by different stakeholders and reviewed by CHN Leadership on a quarterly basis. Additionally, clinical guidelines are reviewed annually by the members of the Quality committee and Medical Directors to determine if any program design changes are needed.

How does it work?

- Patients are referred to a program(s)
- Outreach is performed to enroll in the program
- Informed consent is obtained
- Care Plans and/or assessments are completed, program specific.
- SMART Goals are established and agreed upon with the patient and/or caregiver
- Interventions correlate with the goals and associated health outcomes
- Quality measures are reviewed and updated
- Resources and Education are provided
- Outcomes are tracked
- Followed up on goals or action items is based on agreed upon patient and/or family/caregiver needs and wants
- Continuous assessment is performed while enrolled in the program(s)
- Reassessment occurs when a change in condition occurs



Ongoing collaboration with patients and other members of the multidisciplinary team occurs while enrolled in the program(s). The provider is notified after each interaction with the patient and notes are documented based on the preference of the provider. Patients are discharged from any of our programs when the patient has reached their patient-specific goals, the patient activates the termination, the patient and/or family have been empowered through the case management relationship, or when a patient can advocate independently for health service needs based on reported outcomes.

Your Care Team

Care Managers - Coordinates continuity of care for patients, often as a liaison between the patient's family and healthcare organization, ensuring that the proper treatment is administered at the appropriate time to maximize health and well-being while also minimizing the need for hospitalization. The Care Manager is an active registered nursing and strives to promote self-managed care and the use of healthcare resources in the most cost-effective way possible. Care Managers work with patients of all ages and conditions, but primarily focusing on a specific population such as persons at a high-risk level or with multiple chronic conditions.

Care Coordinators - Assists with the care coordination of patient care under the direction and supervision of the Care Manager. The Care Coordinator assists members by providing support, education, and assistance in the prevention and/or maintenance of their health and wellness state by assisting with member treatment plan compliance collaborative coordination to reduce waste and inefficiency, and by assisting the patient to complete quality and/or preventative testing and exams, increasing their quality of life. Care Coordinators have healthcare-related experience or a degree in an allied health related field.

Social Workers - Supports individuals and their families through difficult times and ensures that vulnerable people, including children and adults, are safeguarded from harm. Their role is to help improve outcomes in people's lives by evaluating the psychosocial and emotional needs of members with ongoing and/or situational medical concerns through coaching, education, and support for low acuity emotional needs. They coordinate referrals, assist with discharge planning and serve as a liaison with the community resources (food stamps, childcare, and health care).



Social Workers have a master's degree in social work and hold a current LCSW or LMSW license.

Behavioral Health Care Manager- Supports the mental and physical health care of patients related to admission of psychological and behavioral care. Their role is to track the treatment and monitor patients for changes in clinical symptoms, support medication management in relation to the patient's diagnosis, and provide patient education and resources to the patient's needs.



CHN Quality – Care Management

Catalyst Health Network participates in Commercial value-based contracts. Quality measures and goals are based on contractual obligations for performance in Commercial value-based contracts. These measures may include quality of care, utilization patterns, and cost-effectiveness measures.

Quality activities supported by Care Management align with the measurable goals outlined in the payer and/or client contracts. Additional goals specific to the individual networks and overall company vision are established for further performance improvement. Goals are patient-centered and are measured through use of evidence-based guidelines.

For all quality goals, strategies are designed and implemented to improve process and outcomes. Policies, workflows, job aids, and other resources support strategies and goals while aiming to focus on the patient as a “whole” by addressing barriers to care.

How it works:

- Patients are referred to program by payer reporting
- Payer reporting is validated by Care Team to determine if quality measure(s) are incomplete
- If quality measure(s) are closed, the Care Team will gather required information to submit to the payer to close the measure(s)
- If quality measure(s) are incomplete, outreach is performed to enroll in the program and assist with closing the open measure(s)
- Informed consent is obtained
- Care Plans and/or assessments are completed, program specific.
- Quality measures are reviewed and updated
- SMART Goals are established and agreed upon with the patient and/or caregiver
- Interventions correlate with the goals and associated health outcomes
- Resources and Education are provided
- Outcomes are tracked
- Follow up on goals or action items is based on agreed upon patient and/or family/caregiver needs and wants



Referral Management

Through the utilization of the LeadingReach platform, Catalyst Health Network members are supported with the referral management process and can expect ongoing monitoring and follow-up for focused specialty referrals.

The focused specialty referrals were selected based on their association with high levels of cost, utilization and long-term clinical impact. By focusing on these areas, we expect to see increased ASC utilization, lower ER utilization and decreased acute admits/readmits.

Focused Specialty List:

- Orthopedics
- Oncology
- Cardiology
- Pulmonologist
- Gastroenterology
- Endocrinology
- Nephrology
- Neurology
- Urgent Referrals

With this approach we will have a greater impact on both patient experience and total cost of care, for patients with the highest needs.

Your Referral Team

Referral Coordinators - Coordinates follow up aspects of the referral process from the time the referral is sent to receiving consult notes, to ensure comprehensive patient care between the patient, physician, specialty office, and primary care office.