CARE MANAGEMENT PROGRAM DESCRIPTION 2026

Contents

Overview

CountyCare **members drive their own health and health care**. CountyCare's Care Management (CM) Program supports members by augmenting patient-centered medical homes with multidisciplinary care management teams. Members, providers, and the care management teams work together to help members achieve their goals using evidenced-based care and coalescing personalized services and supports around each member. CountyCare has responsibilities to provide access to services, resources for a continuum of care ranging from care coordination function through complex care management.

Care Management Program Services

The CM Program offers levels of service:

- **Care Coordination** is episodic and is offered to all members as the need arises to assure that episodes of care go smoothly. Low risk members usually do not require service but may access it as needed. Moderate risk members may partner with Care Coordination to develop skills and use healthcare more efficiently and effectively.
- **Care Management** is offered to high-risk members or moderate risk , typically with comorbidities and social needs, who would benefit from a longer-term, more intense partnership to help develop skills, use healthcare more efficiently and effectively, and access additional resources for improved health.
- **Complex Care Management** is offered to a subset of high- risk members who have complex needs, crossing multiple domains, typically in situations where the timing of activities and integration of many players is essential for success. Members must be willing to engage in care management as evidenced by their completion of a care plan.
- **Extension of care management include Community resource Navigators that address member engagement and social determinants of health**

Care Management Program Methodology & Philosophies

Due to economic and social inequities within the Cook County service area, CountyCare members may have limited access to non-health resources that significantly impact health. Therefore, the CM Program takes a **broad view of the inputs that contribute to health**, including housing, food, education and training, safety, income security, transportation, and overall wellness. These considerations are incorporated into care plans as indicated on an individual basis, and driven by member choice, strengths, capacities, and priorities Using motivational interviewing techniques, trauma informed skills and person centered practices. Care Managers help members pinpoint goals, assess their readiness to act, and identify small, short-term steps (often within larger over-arching goals) that can be successfully achieved.

To address systems gaps, the CM Program bridges the historic system divide between **physical and behavioral health care, as well as both formal and informal community-based supports** through integrated and comprehensive assessments and tailored interventions.

In addressing systems gaps and providing high quality care to members, CM Program staff have a robust capacity to **receive, use, analyze and share time-sensitive, actionable data** among members, providers, and other resources. Collective Medical Technology provides an enterprise-wide platform that integrates real time admission, discharge, and transfer (ADT) data. This process also integrates claims data, predictive modeling scores and other indicators, and standardizes assessments, facilitating both a rounded view of an individual member and trend spotting at the population level. Additional technology includes an internally developed case management application called Case Management Information System (CMIS) serving as a centralized repository for key populations and selected metrics.

CM Program policies, protocols and requirements reside in the **Care Management Program Manual**, which is maintained on the CountyCare website at http://www.countycare.com/carecoordination. The Manual is continually updated and serves as the authoritative reference for the Care Management Program. The Manual is frequently referenced throughout this Program Description. Other references of interest are the **Population Health Program Description,** the **Quality Improvement Plan** (both available internally) as well as the **Member Handbook** and the **CountyCare Website** itself at http://www.countycare.com.CountyCare makes resources readily available to members, CMP staff and providers.

Provider-Based Care Management

On the provider side of the CountyCare-member relationship, CountyCare puts the member's **primary care provider at the center**. All members are encouraged to select a primary care provider (PCP) and to maintain a schedule of (at least) annual visits, so that the PCP can know the member and learn – over time – how best to organize and provide care.

This approach fits within the solid CountyCare strategy as a **provider-led and provider-governed health plan**; CountyCare's providers are intimately connected to members and can best speak to their needs. Providers also are sensitive to the ways system demands impact their ability to efficiently deliver care, helping CountyCare to find the optimal balance among competing needs. CountyCare's largest partner is an Accountable Care Organization (ACO), Medical Home Network (MHN), also provider-led and provider governed. Strong partners for this model also include Access Community Network, Ambulatory and Community Health Network of Cook County and Division of Specialized Care for Children.

Care management is most effective when operating within provider practices. CountyCare utilizes a delegated care model through Care Management Entities (CMEs), or entities delegated by CountyCare to carry out the activities and services of care management and care coordination to its members. About half our CM Program staff are embedded directly into practices and other clinical settings, or Care Management Entities (CME). Thus, the provision of CM Program services is not separate from the functioning of the provider sites themselves. The remaining staff – organized in CMEs that serve multiple providers – typically assign staff to a

specific cohort of providers so that they can develop the relationships necessary to facilitate effective integration among providers and services. Please see Appendix A for a map of current CountyCare CMEs.

Benefits of a Hybrid Provider Lead Model

This arrangement has multiple benefits, listed below.

- CM Program staff reach members at the **point of service**, enabling them to integrate medical treatment plans into overarching care plans, and ensure that relevant non-medical considerations and resources that may impact treatment adherence are considered.
- Providers and CM Program staff are **jointly accountable** for process and outcome measures, facilitating an integrated – and jointly-owned - response to performance improvement opportunities.
- Because conditions that present as medical often have **behavioral or social root causes**, integrated CM Programs increase the possibility that root causes are recognized and addressed.
- For providers without a designated care management, the CountyCare internal team is responsible for support directly to these provider groups including up to onsite opportunities.

Because data are aggregated by CME and shared across the enterprise, **all system members can see where progress is being made and what areas need attention**. Success strategies and resources are shared in monthly webinars, and individual Provider Group/CMEs participate in monthly “deep dives” into performance and operational issues.

In addition to its delegates, CountyCare fosters relationships that contribute to the success of its CM Program, such as with behavioral health entities, cross-agency initiatives in food or housing security, resources to support specific population segments such as pregnant people, or relationships that encourage member self-management such as with the Canary Telehealth Program for managing chronic diseases. CountyCare works collaboratively with the State in the development of new approaches to complex challenges inherent in caring for our population. Please see the CountyCare Population Health Program Description for more information about CountyCare’s other relationships. Coupling an internal CM team for supports programs for specialized population or programs enhanced and supports the provider-based model.

Health Equity in Care Management

Health equity in case management involves ensuring that all individuals, regardless of their background, have access to the resources, care, and support they need to achieve optimal health outcomes. Key attributes of health equity in case management include:

1. **Cultural Competence**: Understanding and respecting diverse cultural, social, and linguistic backgrounds to provide personalized care. This includes using trauma-informed,

non-stigmatizing communication when discussing personal or sensitive topics, including sexual orientation or gender identity questions that support care planning. Care managers explain why information is requested, ensure members feel safe and respected, and honor member preferences regarding what they choose to share.

2. **Access to Care**: Ensuring that all members have access to appropriate healthcare services, including those who face financial, geographic, or systemic barriers to care. Case managers work to connect individuals with the services they need, even if they face obstacles like lack of transportation, insurance, or language barriers.
3. **Individualized Care Plans**: Developing care plans tailored to each person's unique needs, considering social determinants of health (such as income, education, and housing) that may impact their health and ability to access care.
4. **Advocacy**: Actively working on behalf of clients to ensure they receive the care and services they are entitled to, advocating for resources and services that address health disparities.
5. **Health Literacy Support**: Providing education and resources in ways that are understandable, ensuring that all individuals, regardless of their education or language skills, can make informed decisions about their care.
6. **Eliminating Disparities**: Identifying and addressing any disparities in health outcomes by targeting underserved populations, ensuring equitable distribution of resources, and reducing barriers to care.
7. **Community Collaboration**: Collaborating with community organizations, healthcare providers, and local resources to enhance support systems and improve health outcomes, particularly for vulnerable populations.
8. **Respect for Autonomy**: Empowering individuals to actively participate in their care, respect their choices, and support them in making decisions that align with their values and preferences.
9. **Privacy and Protection of Sensitive Data**: CountyCare maintains strong protections around access to and use of sensitive member information. Such data are used only for appropriate purposes (e.g., coordinating care, improving quality, identifying disparities) and are never used for underwriting, benefit decisions, or any impermissible purpose. Members are notified of these protections when such data are collected.

Incorporating these attributes into case management ensures that care is fair, accessible, and responsive to the diverse needs of all individuals, contributing to the reduction of health disparities and promotion of health equity.

Care Management Program Goals

The overarching goal of the CM Program is to help members direct their own care to achieve an optimal level of wellness through experiences that are empowering, respectful, efficient, and effective. The breadth, intensity and duration of CM Program services varies by member need and desire.

CM Program goals that apply to members across the spectrum of intensity include:

- Members proactively manage their own health to gain or regain optimal functional

capability.

- Members receive the right care, at the right time, and in the most appropriate location.
- Members understand and confidently manage their conditions.
- Members understand and effectively use their health care services.
- Members experience respect and choice. They are met in their own 'cultural space', rather than having to learn medical or insurance culture.
- Members maintain their health insurance coverage.

Additional goals that more frequently apply to members with higher levels of need – particularly those in Complex Care Management - include:

- Members with multiple care and service providers receive care and services that are timely, integrated, comprehensive, organized, and consistent.
- Members obtain appropriate resources across the entire spectrum of service: medical, behavioral, and community-based resources as needed.
- Members identify and use their strengths, resources, and informal supports.
- Members experience small successes leading to large change over time.

Finally, system goals are forwarded, either directly or indirectly, by effective CM Program services:

- Population characteristics, needs and trends are identified.
- Prevention, early detection, and effective management is facilitated, avoiding harm and waste.
- Provider gaps are identified, enabling the network to be improved in breadth or quality.
- Data allows evidence-based evaluations and decisions.

Evidence-Based Program

CountyCare develops its **Complex Case Management system** using **evidence-based clinical guidelines, algorithms, and validated assessments** to ensure risk identification and care planning align with best practices. These tools are **embedded in automated systems** to support real-time decision-making.

Management Definition and Framework

CountyCare has adopted the care management components, definitions, and strategies established by The Center for Health Care Strategies (CHCS) as its framework for the health plan's Case Management process. CountyCare's Case Management program is built on these guiding principles, applying data, evidence-based practice, and member engagement to improve outcomes for Medicaid members with complex needs. Members are identified and stratified using predictive modeling, health risk assessments, and referrals from providers and community partners to target those at highest risk. Interventions are person-centered and multidisciplinary, integrating physical, behavioral, and social supports through individualized

care plans that promote member self-management. Program effectiveness is evaluated through quality and cost metrics such as HEDIS and ROI, with results used in rapid-cycle quality improvement. CountyCare aligns payment and accountability with performance and population health goals to ensure coordinated, cost-effective, and equitable care[1].

Evidence-Based Assessments

Care Management Entities (CMEs) use standardized, research-backed assessments to evaluate Enrollees' needs and risks:

- **PHQ-9:** Screens and monitors depression.
- **GAD-7:** Assesses anxiety severity.
- **DAST-10:** Identifies substance use risk.
- **AUDIT:** Screens for alcohol use disorder.
  These tools are **integrated into CountyCare's care management systems** to ensure consistent, evidence-based interventions.

Clinical Guidelines and Algorithms

CountyCare incorporates **clinical guidelines and predictive algorithms** to stratify Enrollees and optimize care management. These methodologies are **embedded in the Care Management Information System (CMIS)** to drive informed decision-making and improve health outcomes. CountyCare remains committed to using validated, evidence-based tools to enhance care quality and meet **NCQA standards**.

[1] hHYPERLINK "http://www.chcs.org/media/Care_Management_Framework.pdf"ttp://www.chcs.org/media/Care_Management_Framework.pdf

Member Choice

Members engage in all programs – from the simplest Care Coordination to Complex Care Management – by choice. Members may opt in or out at any time and can also negotiate the extent of the services they wish to receive. Choosing to opt out of a program does not impact member coverage or eligibility for other services. Please see the Member Handbook for member communications regarding choice.

Care Management Program as the "Face of CountyCare"

CM Program staff are the primary face of CountyCare to our members. The quality of CM Program interactions with members determines **whether members trust CountyCare** for advice, support, and services. CM Program staff recognize that **members are drivers of their own health**, and are experts of their own experience, and are to be respected and supported as leaders of their health care teams.

CM Program staff also deliver services in a culturally competent manner, using readily understood language rather than healthcare jargon, being sensitive to:

- communication styles
- religious and cultural beliefs
- member readiness, confidence, and motivation
- potential trauma history
- medical literacy
- any other factor that may impact the member's ability to optimize their health.

CMEs recruit staff who reflect the communities they serve, but who are also open to ongoing learning about cultures and experiences that are not their own. Please see the Care Management Program Manual for cultural competency requirements.

Care Management Program as CountyCare's Integrative Tool

CountyCare's CM Program is the most significant tool in the health care system's arsenal for assuring delivery of a complex set of services in a timely and seamless manner.

In addition to applying effective assessment, motivational interviewing, and care management clinical skills, it is necessary for CM Program staff to understanding and integrate meaningful objective information into practice. This means an ability to **aggregate, review, and distill key information** from multiple **member-level** sources: member self-reports, provider notes, clinical treatment plans, demographic data, and prior screens, assessments, and care plans.

Staff must also gather and integrate relevant information at the **system level**:

- System-generated member data, such as Predictive Modeling risk score, utilization, claims, prior authorizations, ADT alerts, call logs, HEDIS measures and other quality indicators
- CountyCare benefits, resources, and processes
- Government and community-based resources of potential service to members, including other providers, schools, or informal sources of support.

CM Program staff must be **problem-solvers**, acting on their own initiative to discern key barriers or ambiguities, and pursuing solutions until resolved to the satisfaction of the member.

No single CM Program staff person can know everything; staff must also be **able to garner information and guidance from colleagues**. CM Program staff typically develop a network of field- based connections and knowledge that is invaluable when shared.

CountyCare augments these information gathering skills with **monthly webinars** that review resources and processes, introduce new resources – both within CountyCare and from the broader community – discuss CME performance and its improvement, highlight best practices, and serve as a platform for sharing expertise across the enterprise.

CountyCare also maintains **a resource page** specifically for the use of CM Program staff at www.CountyCare.com/carecoordination. The Care Management Program Description, a constantly updated Program Manual (which serves as the source of truth for current performance processes and standards), and a variety of other resources, including prior webinars, are posted at this site, and are frequently referenced.

Care Management and the Member Journey

When members engage in Care Management or Complex Care Management, they are typically embarking on a journey. At the start of the journey, **information is gathered and culled** to discern the key drivers for forward progress. Team members are identified and brought on board. Through active listening and motivational inquiry, CM Program staff assist the member to prioritize goals, identify barriers and discern a path forward by identifying a series of small, achievable steps. At this stage, members may be quite overwhelmed and are best helped by significant activity and support from CM Program staff.

At the next stage of the journey **services are put into place**. The member receives initial services and takes initial actions toward the new goals. Staff may continue to provide significant support, accompanying the member to appointments, arranging for transportation, clarifying confusing treatment plans, or researching more specific needs.

Once a member's situation has stabilized - services are engaged and proving helpful - the member journey can **shift its focus to self-management skill development**. Do members know how to raise clinical concerns? Make appointments? Get transportation? Update their address? Maintain their insurance coverage? Recognize when additional help is needed and know whom to call to

get it? CM Program staff still assist but enable members to do more and more for themselves as their stress levels decline and they are ready to empower themselves through learning.

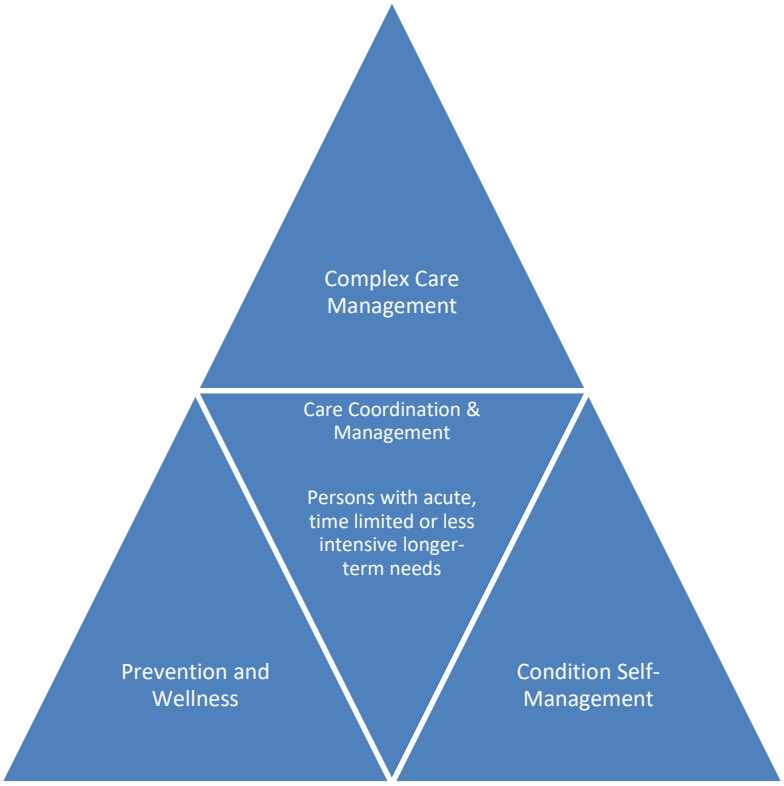
Finally, there comes a time when members are ready to **"graduate"** from Care Management**.** They have the skills required to optimize their use of the health care system and they know how to ask for more help should they need it.

Every member journey is unique, and the CM Program honors that uniqueness. Not every member will graduate from CM Program. Some members may return as needed over a long period of time. Others may need continuous support to live in the least restrictive manner possible. Still others may carry a stress, cognitive, emotional or disease burden that makes additional investment in new skills difficult.

Nonetheless, CM Program staff are attuned to the journey, maximizing member autonomy and skill-building, so that the member – to the fullest extent possible – is **empowered to actively pursue health and wellbeing**.

Hierarchy of Care Management Program Services

As described by diagram below, the CM Program at its most broad foundation encourages members to actively engage in healthy behavior and manage their conditions effectively. The middle of the pyramid represents those members who need some support, whether that be coordination for a single episode of care, or a longer-term partnership to put services into place and develop the skills to manage those services. At the top of the pyramid, members require an increasingly intense array of services, and may need ongoing support to maintain these services in good order.



Prevention and Wellness

CM Program staff keep wellness in view, rather than focusing solely on presenting conditions. Tools and programs available to support attention to wellness include:

- Newsletters with health tips and reminders
- Rewards program for timely preventive care
- Coordination drives to encourage school physicals or other preventive services
- A robust member portal that allows members to research resources, see a care plan, or replace an ID
- Online health tools and apps available to the member and family to track and monitor chronic diseases
- A comprehensive website that details benefits, processes, and resources
- General text-supported drives to encourage redetermination, preventive care
- Targeted text-supported drives, such as services to pregnant women and infants

For a detailed survey of health promotion activities, please see CountyCare's Population Health Management Program Description, Wellness and Prevention.

Chronic Condition Education and Management

Condition-specific education is available online, at provider offices, and through CountyCare programs such as the phone-enabled chronic condition self-management program, provided in partnership with Canary Telehealth, for adults with asthma, diabetes, hypertension, or obesity. Additionally, select CM Program staff have access to **UniteUs**, a hyperlocal online directory of resources to facilitate finding the right resource available at a time and location that is convenient for the member. UniteUs allows staff to **search out programs in the member's home community**, as may be available in such locations as WIC offices, park districts, the YMCA or community centers. Participating in a targeted chronic condition program does not impact eligibility for any other CountyCare program or service. For more information on programs offered for Adults with Chronic Conditions, please see that section of the CountyCare Population Health Management Program Description.

Care Coordination

All members are assigned to a CME upon enrollment, so an identified resource is at the ready should the need arise. In addition, CountyCare standardizes screens of all members, via text or phone to proactively identify whether a member needs additional support. Members may be directed to their CME if they call Member Services for something more than a quick question, by a provider or by medical management programs, or they may refer themselves.

Care Coordinators focus on four tasks:

1. **Screening members** to identify a range of needs form social determinants of health factor through complex care management
2. **Solving immediate, defined problems,** such as obtaining access to a service, resolving a misunderstanding, facilitating post-discharge services, or finding a needed resource
3. **Encouraging member wellness** through treatment adherence, preventive health visits and screenings, immunizations, and self-management health and wellness strategies
4. **Helping moderate-risk members** manage their conditions, use healthcare resources appropriately and develop more effective wellness strategies.

While Care Coordination addresses a broad range of member needs, some situations require additional attention to maintain continuity of care. One such instance is when a member exhausts their covered benefits, necessitating guidance on alternative options. CountyCare ensures that these members receive support by identifying available resources. Members may be identified through self-referrals, including requests for extensions of services denied due to benefit limitations, as well as through utilization data, provider referrals, and case management review. Care teams assist by connecting members to appropriate community-based and state-

funded resources.

Please see the Member Handbook for the Description of Care Coordination made available to members. Please see the Care Management Program Manual for more specific requirements, resources, and evaluation metrics associated with the Care Coordinator role.

Care Management

Care Management includes care coordination activities, but is a more intense level of service, designed around **member strengths and needs indicated by a detailed assessment**. The Care Manager collaborates with the member and the member's interdisciplinary care team (ICT), which includes all providers, services, family members and any informal supports (pastor, coach, relative) who may be engaged in supporting that member's progress. The ICT contributes to the development of a **care plan**, which prioritizes next steps per member choice, framed in such a way as to promote member success.

Care Managers work with the member to ensure that:

- All providers are aligned in their expectations and plans
- The member understands the condition(s) and the treatment plans
- The member has thought through what the treatment plan requires and has identified any barriers to adherence
- Goals are prioritized and broken down into small enough steps that they can be successfully attained
- The care plan considers the whole person – not just the condition – and therefore addresses wellness opportunities or barriers that the member may not think of as "health- related"

Care Managers are expected to facilitate skill development, so that members develop confidence to handle routine health concerns on their own and know how to reach out for assistance when needed. However, there is no time limit to the care management relationship, and members may stay engaged in Care Management for as long as they wish.

Please see the Care Management Program Manual for more specific requirements, resources, and evaluation metrics associated with the Care Management role, including processes and content related to screening, assessments, and care plans.

There is a **universal referral form** on the CountyCare website, and phone numbers are given for members who wish to bypass the form or in cases of urgency of referral. This tool is available to refer to care management or care coordination at any level of acuity or complexity.

Complex Care Management

Complex Case Management (CCM) is a specialized approach to managing healthcare for individuals with multiple, serious, and often chronic health conditions that require coordinated care across various healthcare providers, services, and settings. It focuses on high-risk patients who have complex medical, social, or behavioral health needs and require a personalized,

comprehensive plan to navigate their care effectively. The goal is to improve health outcomes, enhance the quality of life, and reduce the need for unnecessary or emergency healthcare services.

Key Elements of Complex Case Management:

1. **Patient-Centered Care**: A tailored care plan is developed around the individual's unique medical, emotional, and social needs, preferences, and goals.
2. **Multidisciplinary Collaboration**: Case managers work with a team of healthcare professionals (doctors, nurses, social workers, mental health providers, etc.) to coordinate care and ensure all aspects of the patient's health are addressed.
3. **Chronic Disease Management**: Many patients in complex case management have long-term conditions like diabetes, heart disease, cancer, or multiple chronic illnesses that require ongoing monitoring and treatment.
4. **Care Coordination**: The case manager ensures that the patient receives the right care at the right time, avoids duplication of services, and reduces the risk of hospital readmissions. This involves organizing appointments, medications, treatments, and follow-ups.
5. **Health Education and Self-Management**: Educating patients about their conditions and treatment options, and empowering them to take an active role in managing their health and making informed decisions.
6. **Social Determinants of Health**: Addressing factors like housing instability, food insecurity, or lack of transportation that can impact the patient's ability to follow medical advice or access needed care.
7. **Advocacy**: Advocating for the patient within the healthcare system, ensuring they receive all the resources and support they need and are treated fairly and respectfully.
8. **Continuous Monitoring and Support**: Regular follow-up with patients to monitor progress, reassess needs, and adjust care plans accordingly.

Common Populations Served:

- Patients with multiple chronic diseases
- Individuals with severe mental health or behavioral health conditions
- Patients recently discharged from the hospital who need close follow-up
- People with complex, high-cost conditions like cancer, organ transplants, or trauma recovery

Goals of Complex Case Management:

- **Improve health outcomes** by ensuring effective treatment and care coordination.
- **Reduce healthcare costs** by preventing unnecessary hospitalizations and emergency room visits.
- **Enhance patient satisfaction** by providing more personalized, comprehensive care.

- **Increase patient engagement** by involving individuals in the management of their own care.

Overall, complex case management is designed to address the multifaceted needs of high-risk patients through collaboration, coordination, and proactive care to improve both their health and quality of life.

Members may be referred for Complex Care Management by medical management observations arising from utilization review, Member or Nurse call lines, a Care Management assessment, or any other system touchpoint at which it appears a member may need extensive support. Other sources of referral are discharge planners, providers, members, caregivers, or their families.

Potential eligibility for Complex Care Management is systemically identified by an **assessment of member risk level** or by **predictive modeling score**, which is built on member demographics and medical and pharmacy claims.

Additional consideration includes programs overall identified needs any medical, social, chronic condition or utilization pattern (under or over) may trigger potential eligibility for Complex Care Management, such as:

- Assessment or screening identifies member as high risk for complication or adverse outcome
- Significant change in condition or risk
- Exacerbation of chronic condition requiring intensive care management intervention
- Behavioral health crisis or exacerbation
- Complex discharge

The following populations **must be offered Care coordination, not complex care management:**

- Level 3 (high risk) FHP/ACA/ICP members
- Dual-eligible adult members enrolled in the managed long-term services and supports (MLTSS) program
- Members who are pregnant
- Members in a nursing facility for any length of time including members in long-term care (LTC)
- Members receiving home and community-based services (HCBS)
- Members who have received a transplant
- Special Needs Children (SNC)
- Children and adolescents who have been hospitalized for behavioral health
- Super utilizers of health care (see High Utilizer section)

Others who may need care management requiring some further detailed evaluation include refugees, members who are justice-involved, members in need of housing or other fundamental support, or anyone else who may need special consideration or planning to optimize their access to health care. If the member does not fall into one of the required categories yet merits a more complex, more intense level of service, the member interested in this level of service may be enrolled in Complex Care Management at the discretion of the interdisciplinary care team, the clinical care team, or at the request of the member. Please see the Care Management Program Manual for more information about special populations.

Care Management Data Tools and Exchanges

CountyCare CMEs utilize shared care management systems to ensure real-time access to key member data, including ADT alerts, eligibility files, behavioral health crisis alerts, prior authorizations, and call logs from Member Services and the Nurse Call Line.

Care management and data analysis rely on the **Chronic Illness and Disability Payment System (CDPS)** and **Medicaid Rx**, which generate **Predictive Modeling scores** to identify risk levels and inform care management decisions. These systems integrate with CMIS and other CountyCare data tools to provide a comprehensive view of member needs.

Care Management System Requirements

CME Case Management Systems are designed to ensure accurate documentation, effective care coordination, and proactive follow-up. These systems include:

- Integration of Evidence-Based Assessments:
  - Incorporates validated assessments to support risk identification and care planning (see Evidence-Based Program section for details).
- Automated Documentation:
  - Automatically records staff identification, date, and time stamps for each case action or interaction.
  - Ensures accurate tracking of member interactions, provider communications, and case management activities.
- Automated Prompts and Follow-Up Reminders:
  - Generates reminders for follow-up actions based on the care management plan.
  - Includes alerts for next steps, scheduled activities, and required actions related to case management interventions.
  - Supports timely follow-up care coordination to ensure continuity of care.
- Care Plan Sharing and Provider Notifications:
  - Documents Interdisciplinary Care Team (ICT) members and care plan distribution.
  - Tracks and notifies providers if a Health Risk Screening/Assessment (HRS/A) is not completed within 60 days of enrollment.
- Oversight Access:
  - Grants read-only system access to CountyCare Health Plan's clinical and vendor oversight staff to support quality monitoring and program effectiveness.

These system capabilities help ensure that care management processes are efficient, well-documented, and responsive to members' needs, while facilitating proactive care coordination and timely interventions.

Care Management Process

Care Management is accomplished within an **Interdisciplinary Care Team** (ICT), led by the member, facilitated by CM Program staff, and including those providing services and support to the member. That team may meet in person. Most often, however, the CM Program staff serves as the central point of communication, ensuring that relevant input is collected from each team member and that the care plan reflects consideration of the information collected. All information is evaluated through the prism of the member's own goals and priorities. Illustrated by picture below, ICTs are inclusive of medical, behavioral health, social, community providers, specialty scope of potential participation subject to member's preferences for participation.

Referral pathways ensure that members with high-risk or complex needs are identified and receive appropriate care coordination. Members may be referred to Care Management through the following sources:

- Medical management programs
- Discharge planners
- Practitioners
- Members or caregivers

Referrals can be submitted through the Online Referral Form or Call Center. Information on how to request a Care Management referral can be found in:

- CountyCare website
- Member Handbook
- Provider Handbook

These multiple entry points support timely identification and engagement of members in need of care management services. For more details on eligibility and referral processes, please refer to the **Care Management Program Manual**.

Engagement may require creative and persistent research to validate contact information. Motivational interviewing may be required to interest members in a care management partnership. Please see the Care Management Program Manual for specific protocols for engaging members, and for managing members who are unable to be reached or who have chosen to opt out. Early investment in member contact, astute listening, and quick problem-solving engender trust and member willingness to stay in contact.

A Health Risk Screening (HRS) permits CM Program staff to ascertain the member's need for additional services based on member self-reported information. The screening tool is designed to be short but comprehensive, covering perceived health status, brief health history, social supports (e.g., adequate food, housing), safety, and current concerns. To reach more members, a version of the screening tool is now also offered by text. For more information about screening, please see the Care Management Program Manual.

A **Health Risk Assessment (HRA)** occurs when screening indicates that a more thorough review of a member's health status is indicated. The assessment covers a broad range of domains and is designed to uncover current health status, the health, and social services a member may need, who is (or should be) involved with their care, what other social supports are indicated, and what outcomes the member wants to obtain. The assessment is **supported by other data** from clinical treatment plans, utilization records, HEDIS care gaps, discharge summaries, 504 plans or Individual Education Plans, and reports from others providing services to the member. For more information about assessment, please see the Care Management Program Manual.

A person-centered **care plan** results from integration of the information gathered through the assessment process as well information about new services which may be required. Effective care plans are comprehensive in scope but reflect digested information, focusing attention on matters that reflect member priority, clinical urgency or are foundational to later success. For example, a person without housing or food will likely focus on those two necessities before being able to address medical appointments or treatment adherence. Members are most successful when they can focus on a small number of goals, with action steps that have been broken down into easily achievable steps. For more information about the care plan, please see the Care Management Program Manual.

Care Management **contact, review and documentation expectations** vary by level of intensity and specific program. Care plans are reviewed and updated; goals are evaluated; and action steps are modified as needed. Unanticipated events – such as a hospitalization – require revision of the assessment and care plan to reflect new priorities. For more information, please see the Care Management Program Manual.

Short, frequent, goal-focused member contacts typically facilitate the most successful member care management partnerships. For more information about the conduct of care management relationships, please see the Care Management Program Manual.

Types of Care Management Staff

Care Managers

Care Managers work with the more complex cases and are typically masters-prepared and/or licensed nurses, social workers, hold specialized education with extended work experience, or are behavioral health professionals. They may provide oversight to care coordinators and community health workers and are the consultants of choice for care coordination challenges because of their preparation and breadth of experience.

Care Coordinators

Care Coordinators provide the backbone of CM Program work with members: finding and engaging members, gathering information, screening, assessing, and developing care plans for members at lower risk. Coordinators remind members of appointments, find needed resources, and accompany members to appointments as needed. Many Care Coordinators develop specialty knowledge through working in a subset of the healthcare system and excel at forming effective relationships with members. Care Coordinators are typically bachelor's prepared and may not be licensed. For specific training and experience requirements, please see the Care Management Program Manual.

Community Resource Navigators Community Resource Navigators focus on finding and engaging members. They typically excel at connecting with members because they know their communities and operate comfortably in local cultural contexts. They may maintain contact, and support care plans by reminding of appointments, arranging for transportation, or completing other tasks that enable members to adhere to their plan. Social determinant of health for low acuity and non-complex members.

Risk Level

The screening tool used by CM Program staff to assess risk yields a finding of High, Moderate or Low, enabling CountyCare to adjust services more easily to meet member needs. Typically, those with high risk are managed through Care Management or Complex Care Management, those with moderate risk are managed through Care Coordination, and those with low risk usually do not require CMP support.

High Risk

High Risk members – which includes high risk and that either require intensive services or complex care management. This population may require the organization of multiple providers and services and may have frequent changes to the treatment plan or care plan and require extensive member/caregiver support and teaching. They may be children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have not progressed with their recommended treatment or services or with less intensive care coordination; or those who are frail, elderly, disabled, or at the end of life.

The immediate goals for the CM Program are to decrease the risk of poor outcomes, ease suffering and promote a better quality of life by stabilizing members with appropriate services and supports. Longer term outcomes include more appropriate use of health care services and some growth in the members' ability to better manage their condition.

Complex Care management is a subset of high-risk members – who have both intense needs, agree to care planning and are willing to engage in a CM Program partnership These relationships require skilled discernment of where to focus, the ability to foresee and forestall challenges, and significant member engagement, as evidenced by their participation in the Complex Care Management process and collegial development of a care plan.

- Major trauma, organ transplant or failure, multiple chronic condition.
- Repeat utilization of services such as acute inpatient admissions, misuse of emergency room or catastrophic events.
- Poly-pharmacy utilization, specialized needs or high cost pharmaceuticals.
- Cancer diagnosis requiring multiple treatment modalities with complex care coordination across multiple disciplines
- Unstable physical or behavioral health conditions or member choice.

Exclusions include: All participants in the (M)LTDD program, Custodial Longer Term Care and Home and Community Based Services members.

Moderate Risk

Moderate-risk members may require episodic involvement of care coordinators and/or ongoing involvement of a care coordinator to maintain established services. Moderate-risk members may be experiencing a significant change in health status, managing a chronic health condition requiring multiple treatment modalities or require assistance to manage health care services. The goals for care management of moderate-risk members are to prevent escalation of health conditions to high risk, increase member self-management skills and promote appropriate health care utilization aligned with evidence-based guidelines.

Low Risk

Members with low risk do not typically engage in the CM Program unless an episodic need arises. CountyCare promotes member self-management skills, rewards participation in preventive and screening services, and distributes health education materials using population-level strategies. Please see the Population Health Program Description for more information about these strategies.

Oversight and Evaluation

CountyCare oversees and evaluates CM Program activity through multiple mechanisms:

- Contractually established Key Performance Indicators (KPI) for CM Program services
- KPI Dashboard, produced monthly
- Monthly review of CMP performance with individual CMEs
- Quarterly reviews with individual CMEs
- Executive Quarterly review of all CME performance
- Performance Improvement and Corrective Action Plans
- Assessment of population subsets as defined by diagnosis, utilization, age, condition, or other metrics
- Assessment of care as measured by HEDIS
- CME-directed quarterly audits, presented to CountyCare
- An annual administrative and file audit of each CME
- Random audits as indicated
- Annual member CM Program experience survey
- Review of member complaints and critical incidents
- Members via the Enrollee Advisory Committee and the Family Leadership Council
- Provider observations, particularly gathered through the Quality Improvement Committee as well as provider relations contact

For a description of CME oversight, please see the Population Health Management Program Description. For member and provider input, please see the Quality Improvement Committee Records and Program Description.

Training

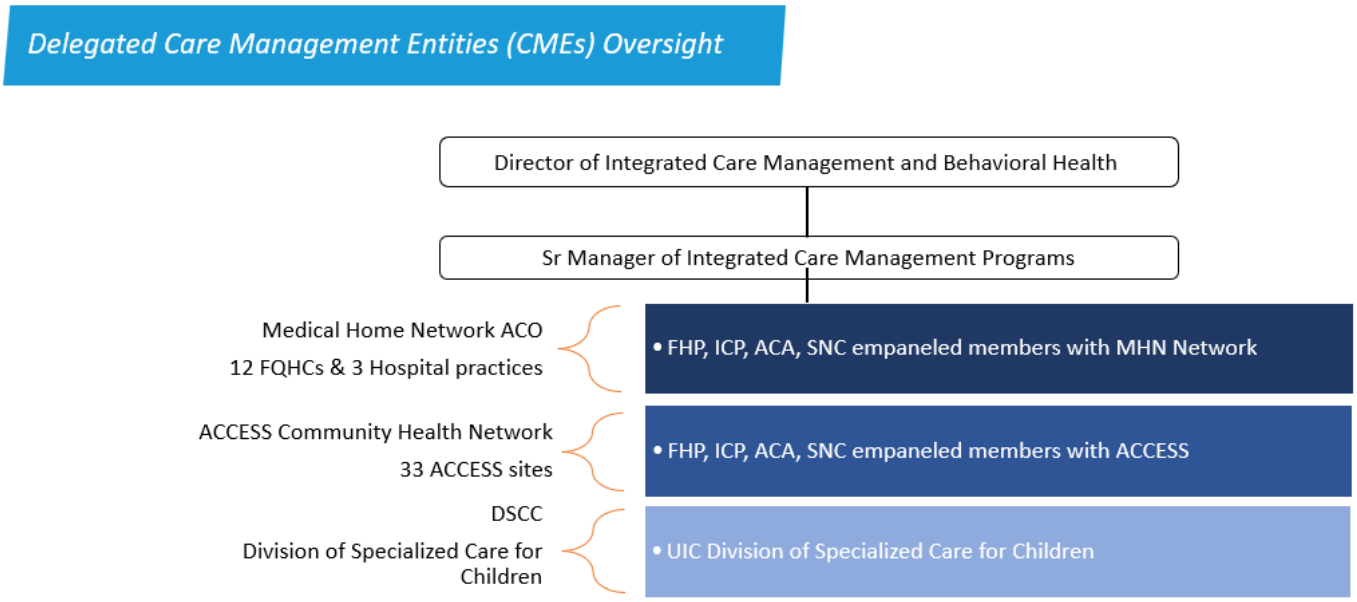
Each CME provides a structured staff orientation and training program approved by CountyCare. The program includes:

- Roles, policies, and procedures
- Care coordination documentation and skills
- Training on the applicable software platform
- An introduction to CountyCare policies, procedures, and resources
- Applicable regulatory requirements (HIPAA, FWA, health, safety, and welfare)
- Critical incidents
- Motivational interviewing
- Cultural competency
- Resources

CMEs are also required to repeat significant portions of this training annually, and to augment training with additional topics of their choice, which typically include information on specific conditions, resources, or skill enhancements. Training records are required and are routinely audited. Care Coordinators serving HCBS Waiver Members and select other special populations must meet additional training requirements. Please see the Care Management Program Manual for specific details regarding training requirements.

Appendix A

Please see the below diagram illustrating CountyCare's current CMEs and structure.



Activity/Version Control

Version	Main Author	Date
Revision	Debra Brophy	March 2025
Revision	Debra Brophy	December 2023
Revision	Debra Brophy	March 2023
Revision	Waltrich	July 2021
Revision	Carvalho/Brophy	June 2020
Original Document	Reichlin	May 2020