EHS Sacramento Care Coordination Guide

RESOURCES	CONTACT	INSTRUCTIONS
WWW.EHSMD.COM	WWW.EHSMD.COM	
MEMBER SERVICES – CUSTOMER CARE DEPT	EHS TOLL FREE PHONE LINE: 888-475-1997 SYNERMED, INC. EHS MEDICAL GROUP 1600 CORPORATE CENTER DRIVE MONTEREY PARK, CA 91754	Members receive assistance through Customer Care for any range of issues: help with authorizations or PCP assignment or locating other services.
EHS 24-NURSE HELP LINE NURSE (24 HOUR)	866-293-0134	EHS members can contact the Nurse Help Line for assistance with health care questions and/or guidance on going to ER vs. Urgent Care vs. PCP.
URGENT CARE CLINICS		Urgent Care list and posters available at all EHS PCP offices and on our website and through the Nurse Help Line.
BEHAVIORAL HEALTH	HEALTH PLAN BENEFIT	EHS / PCPs are responsible for managing mild-moderate mental health care, including medication management (depression, anxiety, etc.) and for assisting members with other resources and benefits through their health plan benefits or County Mental Health for ongoing treatment and/or counseling.
SUBSTANCE USE DISORDERS		EHS / PCPs are responsible for identifying patient needs and providing member with available resources through County Alcohol & Drug Treatment Services when appropriate. Members may/can contact their health plan for information on mental health providers and benefits.

RESOURCES	CONTACT	INSTRUCTIONS
TRANSPORTATION SERVICES	HEALTH PLAN BENEFIT	EHS and/or PCPs are responsible for identifying patient need for transportation and referring them to their health plan for assistance.
LINGUISTIC SERVICES	HEALTH PLAN BENEFIT	EHS and PCPs are responsible for identifying patient need for linguistic services and referring them to their health plan as applicable.

CASE MANAGEMENT			
CARE MANAGEMENT BY HEALTH PLAN	PLAN NAME FOR CARE MANAGEMENT	RESPONSIBLE PARTY – HEALTH PLAN, PCP, CLINIC OR IPA (SPECIFY)	CONTACT INFORMATION INSTRUCTION
MOLINA	BASIC CASE MANAGEMENT	EHS	CARE COORDINATION PEDS: (213) 406-2769 CARE COORDINATION ADULTS (MEDI-CAL): (213) 406-2770 CARE COORDINATION SENIORS (MEDICARE, MEDI-MEDI/SNP, CMC): (213) 406-2771
HEALTH NET	BASIC CASE MANAGEMENT	EHS	
ANTHEM	BASIC CASE MANAGEMENT	EHS	
TRANSITIONS OF CARE			
INPATIENT/ DISCHARGE PLANNING			
HOSPITALS	PLAN NAME	CONTACT	INSTRUCTION
ALL SACRAMENTO AREA HOSPITALS	**HEALTH NET**	**EHS MEDICAL GROUP**	INPATIENT / CONCURRENT REVIEW/ DISCHARGE PLANNING: TEL# 213-406-2847 / FAX# 213-572-3854
	ANTHEM	**CONTACT ANTHEM DISCHARGE PLANNING**	**NA**
	MOLINA	**CONTACT MOLINA DISCHARGE PLANNING**	**NA**

EHS Care Coordination

1. Basic Case Management

- PCP remains the primary Case Manager
- EHS Care Coordination team consists of Clinical (LVNs and RNs) and Non-Clinical staff
  - Initiated by health care provider, Member, health plan and/or referral authorization review
    - Call, email, or Synermed CONNECT portal
- Basic case management services may include:
  - Clinical information from the provider, such as history & physical and progress notes
  - Obtaining copy of completed Health Risk Assessment (HRA) from the Plan
  - Creation of an Individual Care Plan (ICP)
  - Direct communication with member and member's family
  - Health education, including lifestyle changes when appropriate
  - Education about health plan coverage and benefits, transportation, and other resources
  - Urgent Care facilities close to member
  - Address immediate needs of the member
  - Medication Reconciliation if needed
  - Assess for any functional limitations and coordinate any DME needs with PCP
  - Assess for any social or behavioral health needs and initiate referral to Social Worker for screening
  - Assist member in coordinating care with PCP and other Specialists or providers
  - Coordination of services outside the health plan such as referral to appropriate community social services or Drug Medi-Cal services.
  - Refer identified or potential high risk members to Health Plan for Complex Case Management Program

2. Transition of Care

- Discharge Planning
  - PCP is notified of admission by EHS via faxed copy of hospital facesheet
  - PCP Transition of Care Notification by EHS through Provider Portal with information of admission and discharge date
  - Care Transitions Team consists of Clinical (LVNs and RNs) and Non-Clinical staff
    - Members who scored HIGH on RST (Risk Stratification Tool) is contacted within 24 to 72 hrs. post discharge
    - Focus is on ensuring PCP or any Specialty follow up visits to avoid readmission
    - Medication Reconciliation if needed
    - Discharge orders are addressed such as DME or Home Health visits
    - Any immediate needs such as issues with transportation, assistance at home/caregiver

- ER Visits and follow up

  Identified through standard utilization reports, Sac Covered Navigator partners, and more recently direct reporting from Kaiser
  - Data is shared with PCPs for immediate follow up and appointment scheduling
  - High utilizers are referred to case management for intervention and assistance

3. Obstacles/Challenges:

- GMC health care model
- Shortage of PCPs and Specialists
- Access to certain specialty providers
  - Either don't exist in Sacramento
  - Exist but won't take Medi-Cal at all
  - Exist and may or may not take Medi-Cal via LOA
  - Exist and will take case on LOA but at an unacceptable price
  - Exist and are in-network but long wait for appointment (2 months or more)
  - Referring out of county to bay area or Fresno is time consuming, expensive, and creates other challenges around transportation and follow up care
- DOFR confusion
  - Who's responsible for what?
- Members who transfer from other groups with COC issues
- Non-compliant members (frequent ER use, no-shows, etc)
- Lack of alignment between IPA, Health Plan, Hospital for common efforts like ED diversion

4. Opportunities / Other Models

- DC3
- PHII