Health Net's Case Management

Health Net offers integrated care management to eligible members. The goal of integrated care management is to address the holistic needs of each member through their individual continuum of health care. Integrated Care Management is comprised of two components, complex care management and care coordination. Complex care management focuses on members identified as having multiple co-morbidities, being at high risk for hospitalizations or poor outcomes, or in need of extensive use of resources related to catastrophic illness or injury, (e.g. transplants, HIV/AIDS, cancer, serious motor vehicle accidents) and high risk pregnancy. The program utilizes a member-focused, goal-directed, evidence-based approach to develop, implement and monitor a care plan. Trained nurse care managers and licensed clinical social workers, in collaboration with a multidisciplinary team, provide coordination, education and support to the member in achieving optimal health, enhancing quality of life and accessing appropriate services and resources. Care coordination is designed to assist members with primarily psychosocial issues such as housing, financial, lack of family or social support etc., with need for referrals to community resources or assistance with accessing health care services.

Providers may refer members to case management by:

- Calling 866-801-6294
- Faxing a completed referral form to 866-581-0540
- Emailing the completed referral form to CASHP.ACM.CMA@healthnet.com

Members may self-refer to the program by calling the Member Services telephone number 800-675-6110, the number can be found on the back of their identification (ID) card.

- Over 2000 members managed in 2017 (as of 8/31/17)
- Early outcome data demonstrates:
  - Reduction in ED utilization
  - Reduction in admissions and readmissions
  - Increased member engagement with their providers
  - Increased member self-management skills

Disease Management – *Be in Charge!* Program

- Disease Management – *Be in Charge!* Program is for Health Net members who have asthma, diabetes, and heart failure.
- The goal of the Disease Management - *Be in Charge!* Program is to improve member knowledge and self-management of these diseases leading to improved quality of life, better functional status and decreased absenteeism.
- Health Net mails educational materials, action plans and information about the program to the members. Members will be empowered to manage their disease as a result of being enrolled in the program.

- Providers should contact the Health Net Health Education Department at 1-800-804-6074 to refer Health Net members who have asthma, diabetes or heart failure, and who are not currently enrolled in the Disease Management – *Be in Charge!* Program. Members may also self-refer into the program or opt out of the program at any time by contacting the Health Net Health Education Department at 1-800-804-6074. Health Net Member Services can also be contacted at 1-800-675-6110, which is the phone number on the back of the identification (ID) card, in order to be transferred to the Disease Management – *Be in Charge!* Program.
- Currently there are approximately 1500 members enrolled in the Disease Management – *Be in Charge!* Program.
- Early outcome data demonstrates:
    - Exceeding the clinical goals for self-reported clinical metrics of:
        - Receiving influenza vaccinations
        - Urine kidney function test for diabetes
        - Daily acetylsalicylic acid (ASA)/antiplatelet medication use
        - Controller medication use for asthma