**AAAHC - CM/DM Information for Website**

Simply Healthcare Plans (SHP) offers Case and Disease Management programs at no cost. We have special programs that can help meet our members' needs. Members enrolled in these programs receive telephonic calls for assessment, care planning, focused interventions to address identified problems, education, coordination of care, transition of care, and monitoring. Frequency and intensity is based on risk level.

The following are a list of programs available:

- **Asthma**

  SHP Asthma Disease Management program is designed to improve overall health status of members with Asthma while promoting education about disease process, co-morbidities, associated symptoms/complications, and ways to increase disease self-management, as well as compliance with recommended clinical practice guidelines with focus on decreasing utilization of hospitalizations and emergency room visits.

- **Behavioral Health**

  SHP believes in the importance of early identification, assessment and management of those members with behavioral health concerns. In order to achieve this goal, behavioral health case managers will collaborate with other case/disease managers and members' interdisciplinary care team to assist members with coordination of both medical and behavioral services.

- **Complex Needs (Multiple Conditions)**

  The focus of this initiative is members with one or more chronic or complex medical or behavioral health conditions who have high hospital, emergency room, or pharmacy driven costs. These members are assigned a nurse case manager whose goal is to improve the quality of care through appropriate and timely provision of care and coordination while reducing controllable expenses within a four-month period.

- **Congestive Heart Failure**

  This program targets members identified with having Heart Failure. The primary goal of the program is to improve the overall health status of members with promotion of education about disease process, co-morbidities, associated symptoms and/or complications, and ways to increase disease self-management, compliance with recommended clinical practice guidelines with focus on decreasing utilization of hospitalizations and emergency room visits, as well as encourage participation in smoking cessation programs.

- **Diabetes**

  Diabetes Disease Management Program's objective is to improve overall health status of members with Diabetes while promoting education about disease process, co-morbidities, associated symptoms/complications, and ways to increase disease self-management, as well as compliance with recommended clinical practice guidelines with focus on decreasing utilization of hospitalizations and emergency room visits.
- **General Case Management/Care Coordination**

  SHP Case management team has put together a team to assist with coordination of medical services for members who have been identified through different sources, such as discharge reports, departmental referrals, member self-referrals, etc. Coordination of services, includes, but is not limited to transition of care between settings, ancillary providers such as behavioral health (PsychCare), dental, transportation and other health related issues**.**
- **High Blood Pressure**

  Hypertension (HTN) Disease Management program's main goal is to improve overall health status of members with high blood pressure while promoting education about disease process, co-morbidities, associated symptoms/complications, and ways to increase disease self-management, as well as compliance with recommended clinical practice guidelines with focus on decreasing utilization of hospitalizations and emergency room visits.
- **HIV/AIDS**

  This is a specialized program for members with HIV and/or AIDS. The care management process involves coordination of social, medical and behavioral health services through the plan's provider network, non-contracted providers, as well as state and community-based agencies such as Ryan White and Project AIDS Care (PAC) Waiver. Members are assessed for severity of illness, co-morbid conditions, medications, compliance, utilization patterns, available support services, and socioeconomic factors. Results of these assessments guide the development of the individualized plan of care and its corresponding interventions designed to improve compliance, prevent acute events and improve health outcomes.
- **Maternity/Obstetrical (OB)**

  The program focuses on and is offered to members identified as being pregnant. Participation is voluntary; however, members are encouraged to join. The program goals are: early identification of pregnancy for potential risk complications with appropriate referral and intervention, promotion of prenatal care and improvement of healthy delivery and post natal outcomes. Education is focused on healthy pregnancy, infant health, and postpartum care, which address health monitoring, risks, co-

morbidities, lifestyle issues. Program and individualized plans of care are based on the clinical practice guidelines from the American College of Obstetricians and Gynecologists (ACOG).

- **Oncology (Cancer)**

  Oncology disease management program receive telephonic assessment, care planning, focused interventions to address identified problems, education, coordination of care, transition of care, and monitoring. The Primary goal of the oncology program is to improve the health status of members with cancer (active treatment or one-year post treatment). The program focuses of educating members on the Oncology disease process, co-morbidities, associated symptoms/complications, and ways to increase their disease self-management, and reinforce compliance with recommended clinical practice guidelines based on the American Cancer Society.

- **Pediatric General**

  This program provides the same interventions as General Case Management/Care Coordination, but focuses on members under the age of 21. Coordination of services, includes, but is not limited to transition of care between settings, ancillary providers such as behavioral health (PsychCare), dental, transportation and other health related issues**.**

- **Pediatric Complex**

  Members eligible for this program are 21 years and under who are currently receiving Pediatric Duty Nursing (PDN), going to Prescribed Pediatric Extended Care (PPEC) or residing in Skilled Nursing Facility (SNF). This program is designed to meet the needs and preferences of members and family regarding health services. CM's collaborate with providers and community-based resources to facilitate the appropriate delivery of health and social services.

- **Smoking Cessation**

  Smoking Cessation Healthy Behaviors Program is a rewards initiative offered by the Plan in which members are educated about the importance of stopping smoking, encouraged to develop and maintain healthy lifestyle behaviors with the assistance of and coordination through community-based resources for smoking cessation processes.

- **Weight Management**

  The Weight Management Healthy Behaviors Program is another rewards initiative offered by the Plan for members who have been identified with a Body Mass Index (BMI) greater than 30 to achieve their weight loss goals. Care Managers educate members about the importance of weight management, encourage them to develop and maintain healthy lifestyle behaviors with the assistance of and coordination through community-based resources and services provided by the Plan.

These programs can help members meet their health goals. If members participate, a Case Manager will be assigned to them. A Case Manager will assess the member's needs and work with the member and his/her doctor in making a plan to improve health outcomes. The member can reach out to a Case Manager in the event that he/she has been discharged from the hospital, to help meet the member's post discharge needs.

If a member is interested or wants to learn more, please call our SHP and Better Health Case and Disease Management Department **toll free** at:

1. Case and Disease Management line for Simply and Better Health at 1 (855)893-5170 Monday to Friday from 8:00 AM to 5:00 PM
2. CHA Care Management Team at (855)459-1566

Members do not need to call if they do not wish to participate. They can also change their mind at any time.

**Providers:** If you would like to refer a member for case or disease management, please complete the referral form below and fax to: 877-577-0117

SHP BH CHA Case Dis Mgt Referral Form.doc