

## Valley Health Plan Condition and Complex Case Management Programs

*A brief overview of what this Care Management Organization is and how it partners with providers to improve patient health.*

### What is the Valley Health Plan Care Management Program?

The Valley Health Plan Care Management Program partners with local providers by offering additional support to patients who live with chronic medical conditions. The care management program is designed to help these patients improve and better manage their health. The Valley Health Plan Care Management Program launched on June 16, 2014.

### Program Goals

- Coach patients to better understand their condition, adhere to treatment plans and encourage lifestyle modifications.
- Help providers coordinate care for their qualifying highest risk, chronically ill patients.
- Help improve the quality of health care that Valley Health Plan beneficiaries receive with these care management services.
- Offer program beneficiaries with one-on-one care management services to promote patient self-management skills.
- Work to improve health outcomes by sharing relevant evidence-based practice guideline information with providers.

### Benefits to Providers

- Additional, no-cost program resources
- Direct collaboration with program resources on patient care plans
- Additional support for your highest risk, neediest patients
- Help decreasing appointment no-shows
- Targeted outreach for proper medication adherence
- After hours clinical support for patients
- Improved patient self-management skills and health outcomes

### Beneficiary Participation

- The Care Management Program is a free, enhanced medical benefit; beneficiaries will continue to receive medical services through their Valley Health Plan coverage.
- The Care Management Program is a voluntary program.
- Eligible Valley Health Plan patients are those with one or more of the demonstrated-qualifying chronic conditions:
  - Asthma
  - Bipolar Disorder
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Coronary Artery Disease (CAD)
  - Depression
  - Diabetes
  - Heart Failure
  - Schizophrenia

“When a patient and their caregivers understand how to better manage chronic diseases on a daily basis, the patients often need fewer extended hospital stays, ED visits, or other costly medical interventions,” says Timothy Moore, MD, Chief Medical Officer, AxisPoint Health. “We work closely with local providers to break down barriers to care and help improve the health outcomes of their patients.”

### **Participant Identification and Assessment**

- Eligible patients are identified and stratified by chronic condition risk levels using historical claims data.
- Predictive modeling tools will be used to assess nearly 120,000 potentially eligible beneficiaries and identify their risk level and presence of one or more of the qualifying conditions.
- Providers are also able to make real-time referrals of eligible patients into the program by contacting the Valley Health Plan Care Management Program.

### **Program Delivery**

- Patients receive targeted one-on-one support from their care team that may include:
  - Telephonic coaching for patients and caregivers on their conditions and treatment plans
  - Scheduled calls and easy to understand written materials for patients
  - Identification of both medical and non-medical barriers that impact patient health
  - Access to 24/7 nurse advice services for all eligible patients
  - Access to community resources and health education materials
  - Help coordinating follow-up appointments and services
  - Support for care transitions between settings of care and providers
  - Targeted campaigns delivered through SMS text and/or email on health reminders such as flu shots and breast cancer screenings.

### **Contact Us**

For questions about the Valley Health Plan Care Management Program or to request copies of the clinical guidelines summaries, please call 1.855.624.5223 (toll-free).

The Care Management Program hours are Monday through Friday, 8 a.m. to 8 p.m. (PST).