Name:	**Care Coordination and Case Management Policy**
Date of Origin:	**12/15/2013**
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Scheduled Review Date:	**8/16/2024**

I. CARE COORDINATION POLICY:

Capitol Dental Care (CDC) is committed to providing care coordination to its members by working with providers across the full spectrum of health care services, including medical, behavioral, hospital, institutional facilities, or alternative care settings.

CDC's delivery of care model seeks to integrate care among its medical and behavioral providers when necessary, providing resources to members when it appears that the member would benefit from additional services beyond oral health care. When it is determined that the Member may benefit from other services, a referral will be made within 10 (ten) business days.

The goal of care coordination is to ensure that the patient is treated in a holistic manner, so that the provider identifies other medical or behavioral needs that may be apparent during the dental encounter.

II. CARE COORDINATION PROCEDURES

General Coordination of Member Care

CDC care coordination specialists are responsible for the care coordination and monitoring of a member's dental care needs. The representatives ensure that the member has access to dental care in an appropriate setting through the process outlined in CDC's Referral Policy and Procedures, and in a manner consistent with OHP guidelines and HIPAA requirements.

CDC's care coordination efforts include access to a comprehensive directory of network consultants, referral providers, staff affiliated clinic dentists, community panel providers and alternative care settings necessary for the delivery of OHP covered services to CDC members. In the event that CDC's network does not offer providers that can meet the needs of CDC members it will refer its members to a qualified non-participating provider.

Examples of care coordination include but are not necessarily limited, to:

- A dental hygienist notifying a medical provider when discussions with the member/patient indicate he or she is symptomatic of diabetes.
- A dentist's discussion and/or discussion plus hand-off of the patient/member to a tobacco cessation counselor.
- A referral to an oral surgeon when an oral health exam identifies possible disease of the mouth, including cancerous lesions.
- A case manager ensuring that the primary care dentist is apprised of the outcome of his or

her patient's hospital surgery so that the dentist can support the patient's recovery.

Care coordination can exist as a single referral or may be more expansive in scope, especially in circumstances where the member has been identified and/or assessed as having "special healthcare needs."

Case management can occur with other managed care entities (MCEs), e.g., CCOs or DCOs, as well as with fee for service patients' other providers.

CDC provides care coordination and case management services in circumstances where members with special healthcare needs require enhanced oversight/navigation of services, which may include integration of care with other care providers beyond oral health care.

Case management services are typically reserved for those members identified or assessed as particularly fragile, institutionalized and/or suffer from serious injury or possess co-morbidities of a serious nature.

CDC often receives information from the CCOs about member's health. This information is critical to proper coordination of care. CDC will disseminate any such information to the appropriate providers in the most efficient manner to assist them in establishing treatment plans based on the most information possible. Some examples of this can include the mailing of gap lists to offices for special populations, Outreach team members scheduling appointments for members with certain needs, the sharing of care plans for members (outlined below), etc.

III. CASE MANAGEMENT AND THE CARE PLAN

When CDC determines that a member requires an enhanced level of care, CDC will assign that member to a care coordination specialist. Once assigned, a care coordination specialist will perform an initial assessment of needs with the member. From the assessment results, a care plan will be developed for the member by the care coordination specialist.

Case management services are provided in a consistent and confidential manner with a focus on ensuring that the member receives the necessary care under a Care Plan, and that the encounter between provider and member results in a positive health experience.

Definitions and Protocols for implementing Care Plans

Case management services and implementation of a Care Plan may be the result of a condition or disability more permanent or chronic in nature or the result of a short-term disability, such as an injury that follows from an accident.

Definition of Special Health Care Needs

Individuals who have high health needs, multiple chronic conditions, mental illness or Substance

Use Disorders and either 1) have functional disabilities, or 2) live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk facts such as homelessness or family problems that lead to the need for placement in foster care.)

CDC also acknowledges that members may, but not necessarily, be non-ambulatory or they may be ambulatory but have a severe developmental disability or mental impairment that manifests itself in behavior management issues that preclude provision of dental care in an office setting.

In the event CDC, through its primary care dentist (PCD) network, does not have the ability to service a disabled member, the PCD will initiate a referral. A member will be referred to an appropriate CDC referral provider, who meets the specific needs of the member. Pertinent patient health information is submitted to the facility coordinator (if applicable), for treatment based on OHP covered services. (See CDC Referral Policy.)

Definition of a Care Plan

A Care Plan is the documented tracking and monitoring of coordination of care for members that may require multiple providers or have conditions that warrant ongoing care on the part of the member.

Each Care Plan is individual to the member, but Care Plans generally require the following elements:

- Assessment of individual needs through the collection of health data, either through health records, input from contacts, member interviews and/or communications with a member's support system, including family, friends or other care providers.
- Development of an individualized plan through identification of needed services and treatment.
- Monitoring services and treatments in real time to confirm consensus among providers with the goal of identifying and correcting any gaps in treatment.
- Facilitation, implementation and coordination of providers' services to ensure seamless integration of care.
- Assessment of member satisfaction and compliance with services, providing a benefit-value snapshot to quality of life.
- Documentation of activities, services and outcomes.
- Reporting of outcomes, on-going condition of care to the legally responsible parties.

Implementation of the Care Plan

Once developed, implementation of the Care Plan shall be the responsibility of the case manager. It shall be the responsibility of CDC to support the case manager so that all staff (clinical, administrative and management) are available to the case manager to address any concerns or issue that may arise out of the Care Plan.

The care plan will be communicated to the member's provider. The purpose of this is to integrate information with CDC and the provider office. Additionally, CDC desires to maintain an open channel of communication with the provider regarding the member's care and any needs that might extend beyond the dental context. While CDC providers have always felt comfortable in calling to discuss a specific member's needs—the care coordination specialist should include any such communications in the member's care coordination file.

IV. CASE MANAGEMENT INTEGRATION WITH ENDS

CDC and Exceptional Dental Needs Services (ENDS) have entered into a partnership that supports members with "special healthcare needs" by ensuring that they have access to specially trained providers.

Not all special needs members are served by ENDS; however, many are as a result of ENDS' network of specialists. CDC has contracts with other providers to achieve treatment in the hospital and/or alternate settings in the event that ENDS cannot deliver the care. The same Referral Policy applies when referring to non-ENDS providers.

The goal of the ENDS program is to provide members with "special health care needs" access to comprehensive dental services, which may include annual oral health assessment, and treatments, as needed, by dentists, dental hygienists, and dental specialists.

Services are for patients who are non-ambulatory or have severe developmental disability or a mental impairment. Typically, these are members whose physical, social or environmental limitations demonstrate that they cannot be seen in a dental office or via mobile dental services.

The case manager shall work closely with the ENDS Administrator to ensure that the referral to an ENDS provider is appropriate, timely and that services/treatments needed are delivered to the member. These elements shall be documented in the Care Plan.

In addition, the case manager shall regularly review all quarterly reporting from ENDS to CDC, to ensure that those members participating in a Care Plan are appropriately, internally monitored by ENDS. CDC's case manager shall defer to ENDS with respect to clinical decisions, but shall provide any administrative support, as necessary.

V. ENDS CARE COORDINATION OF SPECIAL NEEDS MEMBERS: Protocols

In cases where a member may qualify as a "special needs" member, a CDC Member Services representative will, upon request from patient's PCD, a facility coordinator or a member or member's legal guardian, initiate a series of screening questions to determine ENDS' program eligibility and identify the members immediate dental care needs. (See CDC's Referral Policy).

If a member qualifies for ENDS a completed screening form and referral request together with

any applicable documentation will be delivered to the ENDS Administrator. ENDS will contact the OHP member's facility to arrange mobile dental services for the member. ENDS will forward the member's referral and pertinent patient health information for proper diagnosis and treatment by the mobile and/or hospital dentistry provider.

ENDS coordinates with multiple providers that provide services. Mobile dental equipment is used to provide exams and basic dental care at bed side. ENDS coordinates with contracted providers to ensure adequate equipment provisions are made based on the treatment needs of the member. ENDS protocols, include:

- Provider maintains a comprehensive problem list within the member's record.
- Provider maintains a comprehensive medication list, which includes all prescription medications the member is taking and their medications, including allergies.
- Provider coordinates care within 24 hours for any member with an emergent problem.
- Provider care includes access to telephone advice for member questions during regular business hours and after -hours.
- Provider offers preventive services and oral care education material for patient care coordinator.
- Provider ensures specific written communication including initial diagnosis and procedures are available to CDC's case manager and to the member's PCD to ensure follow-up care.

Complex treatment of a "special needs" member is provided at clinics or in a hospital setting. ENDS coordinates with contracted provider and member's facility coordinator for follow-up and continuity of care based on member's needs and OHP coverage.

Where CDC's case manager has an active Care Plan in place for a member, ENDS and CDC will contact the facility coordinator 30-40 days in advance for reminder of re-call care for the CDC member.

Compliance and Monitoring

The CDC case manager and the Director of Member Services communicates with referral providers and/or facility patient care coordinators, medical providers, coordinated care organization staff, ENDS care coordinators or others, as needed, to establish, monitor and improve coordination methods and procedures consistent with OHP and CDC policies and procedures, and to ensure provider compliance.

Provider compliance is assessed through regular review of the referral process, chart audits, complaints, and feedback from those routinely engaged with CDC in the care coordination process.

CDC's Quality Improvement Committee (QIC) reviews and discusses coordination and continuity issues, case management and Care Plan content, suggesting areas for improvement,

revisions to the coordination process, alternative care settings to consider for improving dental health outcomes.

In addition, where special needs providers fall below professional standards, the QI Committee may initiate corrective action against those providers to ensure on-going quality care. The corrective action process is more fully addressed in the Special Needs Policy and Corrective Action Policy.

VI. Affected Departments:

All CDC Providers and Administrative staff.

VI. Revision Activity

Modification Date	Change or Revision and Rationale	Effective Date of Policy Change
01/05/2021	Annual Review	01/05/2021
08/18/2021	Review	08/18/2021
8/16/2023	Reviewed	8/16/2023

VII. References:

CDC Referral Policy and Procedures
Special Needs Policy
Corrective Action Plan Policy
Provider Handbook
QI Committee Policy