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Affordable Care Act/Coordinated Care Initiative
Glossary

Excerpted from the Coordinated Care Initiative Draft Assessment and Care Coordination Standards January 22, 2013 http://www.calduals.org/2013/02/20/cc_standards/

Care Coordination: Services which are included in Care Management, Basic and Complex Case Management, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.

Care Management: A collaborative process to manage the medical, social, behavioral and mental health conditions of health plan Members, using evidence-based and integrated clinical care. The goals of care management are for health plans to achieve an optimal level of wellness for members, improving care coordination, and resource management/cost containment.

Behavioral Health Home: A model where consumers of mental health and substance use treatment services receive primary care, prevention, and wellness activities in behavioral health settings.

Care Coordinator: A clinician or other trained individual employed or contracted by the Primary Care Provider or the Participating Plan who is accountable for providing care coordination services, which include assuring appropriate referrals and timely two-way transmission of useful patient information; obtaining reliable and timely information about services other than those provided by the primary care provider; participating in the initial assessment; and supporting safe transitions in care for enrollees moving between settings. The Care Coordinator serves on one or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each enrollee on whose ICT he or she serves.

Health Insurance Exchange (HIE): Administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. In 2014 and beyond most Americans who work for small businesses or obtain their coverage in the individual health insurance market will do so through health insurance exchanges. *Covered California* is the federally approved California health insurance exchange which will begin to enroll individuals October 2013.

Health Navigator: Assist with primary health insurance and service delivery access. In some cases these will be new roles for local public agency eligibility departments. In CA, within the Coordinated Care Initiative some health plans have identified health care navigators who will be responsible for helping navigate dual-eligible members throughout the care continuum, including medical, behavioral health, long-term services and supports (LTSS) and Home and Community-Based Services (HCBS).

Individualized Care Plan - The plan of care developed by an enrollee and an enrollee's Interdisciplinary Care Team or health plan**.**

Interdisciplinary Care Team (ICT): A team of primary care provider and Care Coordinator, and other providers at the discretion of the enrollee that work with the enrollee to develop, implement, and maintain the Individualized Care Plan.

Long Term Services and Supports (LTSS): A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Medi-Cal covered LTSS includes all of the following: In-Home Supportive Services (IHSS); Community-Based Adult Services (CBAS)**;** Multipurpose Senior Services Program (MSSP) services**;** and skilled nursing facility services and subacute care services

Medical Home: A place where a Member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home will include at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support care management, coordination of care, enhanced communication, access and quality measurement services.

Person-Centered Planning: A highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered planning is an integral part of Case Management and Discharge Planning.

Primary Care Physician/Provider (PCP): A physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, obstetrician/gynecologist (OB/GYN) or geriatrician. A PCP may also be a nurse practitioner, physician's assistant, specialist or clinic.

Reassessment (Comprehensive): A detailed assessment of health plan Members at specified intervals and/or after a change in health status.

Self-Directed Care: Includes the ability for Members to:

- Decide whether, how and what long-term services and supports to receive to maintain independence and quality of life, as authorized by a physician or other appropriate medical professional, if the participant is an IHSS recipient, and within state rules.
- Select their health care providers in the health plan network (or as allowed for by continuity of care provisions) and control care planning and coordination with their health care providers.
- Have access to services that are culturally, linguistically, and operationally sensitive to meet their needs, and that improve their health outcomes, enhance independence, and promote living in home and community settings.