



Santa Barbara Regional Health Authority Request for Information -- Specialized Case Management

Section I: Overview of SBRHA

The Santa Barbara Regional Health Authority (SBRHA) administers five health coverage programs serving over 55,000 residents of Santa Barbara and San Luis Obispo counties in California. For over twenty years, SBRHA has been providing access to quality health care for those who cannot afford private insurance.

SBRHA's primary program is **Santa Barbara Health Initiative**, the oldest Medicaid (Medi-Cal in California) managed care plan of its kind in the country. The over 55,000 members, who live in Santa Barbara County, are automatically inscribed and receive full health care services through a large provider network. This program has been recognized as a model for reform by many healthcare policy experts.

The **Healthy Families** program, in Santa Barbara and San Luis Obispo counties, provides low-cost health insurance for children under 19 years of age who do not have insurance and are not eligible for no-cost Medi-Cal. This program is funded by state and federal monies in addition to subscriber contributions. The new **Healthy Kids** program provides coverage for children under 19 who are not offered or can't afford employer sponsored health coverage and who are not eligible for state funded programs. This low-cost, comprehensive program, also in both counties, is funded by grants, donations, and premiums.

SBRHA is the exclusive state contractor for the Access for Infants and Mothers (AIM) program, known locally as **Prenatal Plus 2**. This program, designed for those who may not have affordable health insurance and do not qualify for Medi-Cal, provides full health care services to pregnant women through delivery. This program is paid for through State tobacco taxes and member contributions.

IHSS Healthcare provides health coverage for caregiver employees of Santa Barbara County's In-Home Supportive Services (IHSS) program. Federal, state, and county funds plus member contributions pay for this coverage.

To learn more, please visit www.sbrha.org.

GOALS AND OBJECTIVES OF SBRHA

The goals of SBRHA in all its programs are to:

- ensure access to quality care;
- maintain and increase physician participation;
- expedite payments to providers;
- increase SBHI provider reimbursement through fair incentive programs based on utilization management and quality of care criteria;
- improve the conditions fostering continuity of care;
- reduce unnecessary paperwork;
- establish more responsive program management through local administration of the program; and
- contain program medical expenditures.

SBRHA maintains a Quality Assessment and Improvement Program (QAIP) to continuously improve the quality of care and services provided by SBRHA's contracted provider network. Through the QAIP, SBRHA continues to

refine its methods for assuring access to care for its members and subscribers, to keep pace with current trends in the managed care sector, to develop programs for improvement in disease management, to focus on quality studies and measures, to assure provider qualifications meet participation standards through a credentialing program, and to emphasize SBHI physician incentive rewards that are based on quality measures as opposed to simple reduction of utilization. In June 2000, SBRHA was awarded a Knox-Keene Health Care Service Plan license by the State Department of Managed Health Care for its Healthy Families Program, and in the future, plans to obtain National Committee on Quality Assurance (NCQA) accreditation.

Section II: Scope of Work

A. PROJECT OVERVIEW

1. The Santa Barbara Regional Health Authority (SBRHA) is interested in locating and learning more about the capabilities of vendors that are able to conduct full scope Specialized Case Management (CM) programs for chronic diseases and co-morbidities, such as heart disease, hypertension, coronary artery disease, diabetes, chronic obstructive pulmonary disease, and other conditions that are clinically complex to manage. SBRHA desires to accomplish the following basic objectives:
 - a. Improve quality of care for members with complex chronic disease and co-morbidities;
 - b. Recruit and measure participation rates for eligible members;
 - c. Promote practitioners' use of nationally-recognized clinical practice guidelines;
 - d. Ensure that the members' health care practitioners are involved in SBRHA's CM program;
 - e. Provide feedback to members' Primary Care Providers on the clinical progress of individual members;
 - f. Receive and utilize feedback from practitioners and members regarding the CM program for quality improvement purposes;
 - g. Support members' self-management with evidence-based information, scheduled reminders, clinical consultations, appropriate referrals, feedback on self management, and fulfillment of treatment goals;
 - h. Measure program outcomes utilizing the following:
 - i. Clinical outcomes
 - ii. Utilization of health care services, including medical, hospital and pharmacy services
 - iii. Member and provider satisfaction
 - iv. Member surveys of quality of life/functional status
 - v. Cost of health care services

2. SBRHA will utilize an “Opt Out” program design. Therefore, all members eligible for the CM program(s) will be automatically referred to the CM program vendor. The Vendor must be able to conduct SBRHA’s CM program for a Medi-Cal population using proven retention methods for a Medi-Cal or Medicaid population.
3. The CM program must have the following components for members:
 - a. A mechanism to assure member confidentiality;
 - b. A process for educating members about the program; including member rights and responsibilities, member eligibility for the program, use of the program, and use of SBRHA’s grievance process;
 - c. Utilization of clinical staff to monitor the member’s clinical condition in coordination with the member’s primary care practitioner and specialist providers;
 - d. Clinical interventions based on stratification of members’ disease severity and comorbidities;
 - e. Feedback to members on individual progress with treatment plans, and changes in treatment, if necessary, to optimize their health status;
 - f. Member self-management education and training that is based on stratification levels by disease severity;
 - g. Education and interventions adjusted for a member’s personal needs and literacy level. Written materials must be at a 4th-5th grade reading level for adults, at an age-appropriate level for children (if applicable), and translated to Spanish when appropriate;
 - h. Measurement of member participation rates, including members that opt out of the program, and those that drop out;
 - i. Documentation of all member communications required to demonstrate administration of the vendor’s CM program, including communications by telephone, mail, or direct contact with the member; and delivery of names to SBRHA of members who cannot be contacted;
 - j. A process for implementing a survey, pre- and post-program, regarding self-management, quality of life and/or functional status, health risk assessment, and basic disease knowledge, as appropriate for each CM program;
 - k. A process for conducting a pre- and post-program member satisfaction surveys.
4. The CM program must have the following components for SBRHA and/or practitioners, as specified below:
 - a. A process to conduct outreach, education and training to practitioners regarding the CM program;
 - b. A process for educating practitioners about use of the CM program, how SBRHA members become eligible, detailed documentation of a process describing how the vendor will coordinate interventions with practitioners, including Primary Care Providers and specialists, as applicable; member rights and responsibilities, and use of SBRHA’s provider grievance process;

- c. A process for SBRHA or a member's Primary Care Provider to refer members into the CM program;
- d. A process to inform practitioners of members' active participation within fourteen (14) days of the first member intervention;
- e. A process to measure variability in clinical practices of members' practitioners;
- f. A process to provide support to practitioners and inform them of any members that may need medical intervention;
- g. A process to provide a monthly report to members' practitioners on individual members enrolled in the program; and
- h. Provide a specific contact person for SBRHA to communicate with the CM vendor by postal mail, e-mail, or telephone;
- i. A process to demonstrate how the vendor will communicate urgent and routine feedback to practitioners about their members on the following topics:
 - i. Members' health status;
 - ii. Monitoring relevant medical test results;
 - iii. Co-morbidity management;
 - iv. Medication and treatment plan management;
 - v. Monitoring members' self-management progress and skills;
 - vi. Lifestyle and risk factor management;
 - vii. Preventive health monitoring.
- j. A process for conducting a pre- and post-program provider satisfaction surveys.

B. CLINICAL CONTENT

Potential vendors must provide the following information for SBRHA's consideration:

- a. Details about what clinical practice guidelines are promoted by the vendor for each chronic disease, or combination of chronic diseases, that the vendor is able to manage;
- b. Details about the process used to update materials for both members and practitioners to be consistent with SBRHA-approved clinical practice guidelines, including the components for self-management. An example of the required educational elements for members with Congestive Heart Failure (CHF) is as follows:

Congestive Heart Failure

- A medical description of CHF
- The symptoms of CHF
- Medication management
- Self-management and goal setting
- Complications: urgent and emergent signs and symptoms
- Important tests, screenings and vaccines
- Coordination and continuity of care with providers
- Behavioral: exercise, smoking cessation, diet, etc.
- Medical nutrition therapy
- Monitoring of co-morbidities, including hypertension, diabetes, etc.
- Community resources

C. OUTCOMES MEASUREMENT

1. Potential vendors must provide the following information for SBRHA's consideration:

The process by which the Vendor would evaluate improvement in individual member's clinical and behavioral outcomes.

Below is an example of the pre- and post-intervention outcomes for measurement in a diabetes CM program:

Diabetes

- A1c testing
- A1c levels (goal <7%)
- LDL cholesterol testing
- LDL cholesterol levels (goal of <100 mg/dL)
- HDL cholesterol testing
- HDL cholesterol levels (goal of >40 mg/dL for men and >50 mg/dL for women)
- Triglyceride testing
- Triglyceride levels (goal of <150 mg/dL)
- Percentage of members who had retinal eye exams
- Nephropathy screening and treatment
- Blood pressure (goal of <130/80)
- Percentage of members who had foot exams
- ACE inhibitor utilization
- Aspirin therapy when indicated
- Self-monitoring of blood glucose
- Blood sugar levels
- Medication compliance
- Medical nutrition therapy
- Weight
- Physical activity level
- Smoking status
- Immunization status

2. The process and outcomes for evaluation of the overall success of the program, including data collection, evaluation methods, and a description of the resources available to perform the evaluation; including a description of methods used to evaluate utilization, overall compliance with clinical guidelines, and change in health status for subpopulations stratified by severity of disease.
3. The process by which the vendor would evaluate improvement in Member, Primary Care Provider and specialist satisfaction with the quality of the program, including satisfaction with the CM program's staff.
4. The process by which the vendor would evaluate improvement in members' ability to self-manage and comply with prescribed treatment plans.

D. DATA COLLECTION, COORDINATION OF INFORMATION AND REPORTING

1. Potential vendors must demonstrate their ability to provide the following information to SBRHA:
 - a. A bi-weekly report of Primary Care Provider outreach activities Planned and completed during the first sixty (60) days of CM program implementation;
 - b. Ability to present to SBRHA, on a monthly basis, a quantitative summary of program achievements and status, specific to disease state, including but not limited to:
 - i. Monthly reports of Primary Care Provider and specialist outreach activity;
 - ii. Monthly reports of completed and planned member and provider interventions,
 - iii. Quarterly reports of member-level data to demonstrate outcome trends, data completeness, and appropriate clinical follow-up
 - c. Ability to provide SBRHA with quarterly outcomes reports;
 - d. Submission of examples of currently developed data reports and the process for implementation of custom reports; and
 - e. Identification of areas where opportunities for improvement exist.

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Section III: Questionnaire

SBRHA requests that all organizations responding to this RFI provide concise responses to the questions presented below:

	Question	Answer
1.	Please briefly state your understanding of this project. Identify any issues or challenges that your organization might face in undertaking this effort.	
2.	Please briefly explain how you would approach this project, including potential strategies that you would employ to help SBRHA develop a specialized case management program.	
3.	Please provide a brief description of your experience in developing and implementing specialized case management programs for Medicaid / Medicare populations.	
4.	Please briefly describe your experience in enrolling and retaining special needs individuals, such as the aged and disabled, into specialized case management programs.	
5.	Please briefly describe how you will staff this project. What skill sets do you predict will be necessary to accomplish the work? Is your staff local?	
6.	What are the credentials and expertise of your staff?	
7.	Please describe the cultural and linguistic capabilities of your staff, particularly as it pertains to Santa Barbara County's threshold languages (English and Spanish).	
8.	Please describe your ability to handle calls and inquiries related to enrollment and specialized case management questions for a special needs population.	

9.	Please describe how you will submit enrollment information to SBRHA and in what format (hard or soft copy, both)? What information will you collect from enrollees and how?	
10.	Do you subcontract with other parties and, if yes, what percentage would be subcontracted? Are your subcontractors local?	
11.	What do you believe is needed to ensure a successful working relationship with SBRHA?	
12.	Describe the problem-solving process you would use in resolving differences in approach, strategy and/or operational differences?	
13.	Please provide two (2) references from previous engagements that highlight your qualifications to enroll the Medi-Cal/Medicaid population and implement specialized case management programs. References must include the name, title, address and telephone number of the person(s) at the client organization who is most knowledgeable about the work performed.	

Thank you for your assistance in completing this questionnaire.

SUBMITTAL INSTRUCTIONS

To submit a response to this RFI, please complete the questionnaire in Section III of this RFI along with an overview of your company and the services that may be applicable to the prospective project of the Santa Barbara Regional Health Authority. Information submitted may include marketing materials; however, documentation of prior performance is encouraged, including independent evaluations of clinical outcomes, cost savings, provider and member satisfaction ratings, and a list of contracting managed care organizations.

Submit all materials to:

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