Shannon's Journey to Improved Health: The Impact of Enhanced Care Management

Shannon, a Medi-Cal patient with diabetes, is living with her friend in Los Angeles.

A lack of stable housing and transportation make it difficult for her to attend regular doctor's visits and manage her condition.

Shannon's health-related social needs suggest she would benefit from Enhanced Care Management (ECM) under Medi-Cal.

DATA EXCHANGE FRAMEWORK

STORIES OF A CONNECTED CALIFORNIA

1 Shannon Has a Medical Emergency and Receives Informed Care at the Emergency Department

- One day, Shannon experiences severe stomach pains. Her friend drives her to the Emergency Room, her fifth visit in six months.
- The ER staff run tests. Her blood work indicates high A1C levels, a result of unmanaged diabetes.
- Doctors and nurses review Shannon's medical records from her four recent ER visits.
- Shannon is treated with insulin, fluids, and electrolytes.
- Due to the frequency of her ED visits, the clinical staff designates Shannon as likely eligible* for Enhanced Care Management under Medi-Cal.

**Shannon's specific population of focus designation is, "Adult At Risk for Avoidable Hospital or Emergency Department (ED) Utilization"*

DATA EXCHANGE FRAMEWORK

2 Secure Data Sharing Enables Providers to Quickly Enroll Shannon in ECM Services to Help Avoid Future Emergencies

- The ED shares Shannon's discharge and discharge diagnoses with its QHIO. The QHIO then shares a notification of the discharge with the Managed Care Plan (MCP) serving Shannon.
- The navigator assigned to Shannon verifies that she meets the eligibility criteria for ECM services and promptly submits an ECM enrollment request, which is swiftly approved.
- The navigator contacts Shannon and obtains her consent to receive ECM services.

DATA EXCHANGE FRAMEWORK

STORIES OF A CONNECTED CALIFORNIA

3 Shannon's Care Manager Identifies and Helps Address the Root Causes of her Frequent ER Visits

- Shannon is assigned an ECM care manager, Jack, who is responsible for coordinating community support to help address her health-related social needs.
- With Shannon's consent, Jack queries the QHIO to receive information on Shannon's admission, and schedules a meeting with Shannon.
- Reviewing the Emergency Department's discharge summary that was shared with the QHIO, Jack learns that Shannon is housing insecure and has difficulty attending regular medical appointments to manage her diabetes.
- Jack refers Shannon for housing transition navigation services offered by the ECM program.

DATA EXCHANGE FRAMEWORK

STORIES OF A CONNECTED CALIFORNIA

4 Comprehensive Care Management Leads to Lasting, Improved Health Outcomes for Shannon

- With the support of her care manager, Shannon is able to secure a new apartment.
- The stability made possible by reliable housing allows Shannon to begin seeking regular care from a nearby provider, and effectively manage her diabetes.
- Shannon no longer experiences regular emergencies due to her condition, and is living a healthier, happier life.

DATA EXCHANGE FRAMEWORK