Basic Population Health Management: Program Description

This program ensures that all members and those with emerging risk of disease, disease exacerbation, and/or newly diagnosed chronic illness are well-connected to their primary care providers or specialists who may be acting as primary care providers. Members deemed appropriate for this program will be assessed to identify their primary care coordination needs. Based on the assessed needs of members, Care Coordination staff will assist members in gaining access to the necessary resources to help overcome barriers and support lifestyle management.

Typical interventions provided include but are not limited to:

- Navigation and coordination of services (i.e. appointments, durable medical equipment [DME], transportation, medical supplies, etc.)
- Collaboration with county/community agencies
- Ensuring members have ongoing sources of care that are appropriate and timely to meet the members' needs
- Linkages to other public benefit programs (i.e. CalWorks, CalFresh, Women, Infants and Children [WIC], Supplemental Nutrition Program, Early Intervention Services, Supplemental Security Income [SSI], etc.)
- Emotional support and active listening
- Reinforcement of health maintenance screening and care
- Closed-loop referrals to physical health, mental health, oral health, and/or community resources
- Referrals to disease prevention/management programs, population health interventions, or healthy living classes
- Referrals to community support groups
- Review of health education materials