

Highlighting some of the great work Titanium Healthcare Lead Care Managers, Care Coordinators, and Housing Navigators achieved in October 2023 for the California Enhanced Care Management Program, Community Supports Program, and Washington Health Homes.

“A New Beginning”

LCM/CC/HN/RES/Nurse: Antone

Conditions: Paraplegic (T12 incomplete, 2016 gunshot wound), ADHD, COPD, Traumatic Brain Injury.

Situation: My member is a 41-year-old African American man who became paraplegic after a life-changing gun violence incident. In 2021, he was evicted from his home while in the hospital for two weeks and despite appealing the eviction, he became homeless. In June 2023, he was connected with me through the ECM Program. He was still homeless and living in a recuperative care facility in Palmdale, CA. He also had a PCP, but was not actively seeing him or anyone else besides his home care worker for his healthcare needs. I contacted the social worker at the recuperative care facility and learned that Adolphus' last day there would be in mid-September 2023, then searching for several housing organizations to assist.

Outcome: On move-out day, I received a call from Vision For You housing organization who informed me that they could accept my member with a same-day move-in for \$800/month, along with other roommates. My member accepted the agreement and confirmed that he would be on his way, but never showed up. I eventually reconnected with him this October and learned that he had found another home in Palmdale, CA for \$200/month less than what Vision For You had offered. My member was able to find affordable housing after two years of homelessness, and his next goal is to connect with a medical team that he trusts.

Health Plan: LA Care, CA

“Optical Illusions”

LCM/CC/HN/RES/Nurse: Kevin

Conditions: Asthma, Autism, Stigmatism, Global Delay.

Situation: During a recent birthday party, my 7-year-old member sustained an injury on her head while playing with other children. After the incident, her eyes were displaying uncontrolled eye movements. Her mother took her to her pediatrician who had concerns that nystagmus was presenting. The pediatrician recommended a visit to the neurologist, but while at the hospital it was not advised for her to have a CT scan due to her age so her pediatrician recommended seeing an ophthalmologist instead. At the appointment for the eye exam however, she was not able to verbalize her answers and became frustrated. Her mother requested my assistance at locating an optometrist that could be better equipped at servicing children with Autism so I utilized LA Care's online provider tool to locate providers near her residence.

Outcome: After a few calls, I came across an office that confirmed that one of the providers had experience working with children on the spectrum so I scheduled an appointment for the following day after the office was contacted. The mother informed me that day after that the appointment was a success and that her daughter did not have difficulty with the exam as the provider was patient, kind, and caring. More importantly however, it was concluded that Leilani did not have Nystagmus. Her mother informed me that she was so satisfied with the care received at the new Optometrist, that she will be taking all of her siblings to the same location.

Health Plan: LA Care, CA

“Financial Fix”

LCM/CC/HN/RES/Nurse: Denise

Conditions: Diabetes, Hypertension, Kidney Disease.

Situation: My 68-year-old member was facing financial difficulties and she informed me she was behind rent and owed her current landlord over \$10,000 and was not sure how she would be able to pay it back. She was actively looking for resources and reached out to The People’s Project which were able to assist her with rental assistance. She was informed they would cover part of her past due rent and is currently in the process of receiving rent relief. She was also looking for food resources and TAP resources as she mentioned the bus is her primary mode of transportation.

Outcome: I was able to provide her with The Commodity Supplemental Food Program resource and assisted her with applying during an in-person visit. I also helped her apply for TAP LIFE Program for her transportation as she had mentioned she was not sure she was enrolled in the program anymore. I will continue to provide resources and support to her and will follow up on the outcomes of the applications submitted.

Health Plan: LA Care, CA

“A Veteran’s Victory”

LCM/CC/HN/RES/Nurse Name: Ana

Conditions: CHF, COPD, Diabetes, Hypertension, Major depressive disorder

Situation: My 55-year-old member is currently homeless living in his RV. I’ve been assisting him to find housing, as his income is not enough to rent any housing.

Outcome: I assisted him to find SSVF which is a local veterans services that assists in finding housing. He recently informed me that he was able to receive his VASH(Veterans Affairs Supportive Housing) voucher after years of trying to receive rental aid.

Health Plan: Central California Alliance for Health, CA

“Unbelievable Progress”

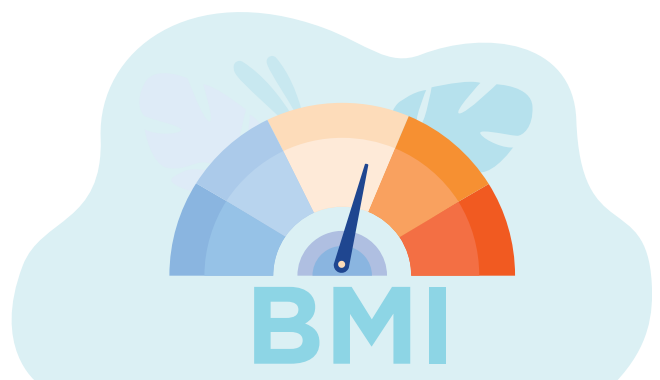
LCM/CC/HN/RES/Nurse: Giovani

Conditions: Asthma, Type II Diabetes, Hypertension, Arthritis, High Cholesterol, Anxiety, Depression.

Situation: My 54-year-old member deals with a variety of conditions, but has been feeling the effects of diabetes and arthritis in her knees most significantly due to her having a high BMI. She has been addressing knee pain through her pain management specialist who advised her that she needed to lower her BMI. Since August of this year she has dropped 50 pounds in approximately 2 1/2 months which has helped take some of the pressure off her knees. She has also been able to lower her A1C score to about a 6.2 which means her diabetes is slowly becoming more and more stable. She is a very diligent person who has been able to take control of her health and I’m so happy for her.

Outcome: I’ve been able to provide the member with education regarding weight loss, dieting, and handling her diabetes. As she continues her weight loss journey, she is going to further address her knees by obtaining 3 injections on the nerves surrounding them. I am extremely excited to be following her weight loss journey and will continue to provide her with any assistance that she needs.

Health Plan: LA Care, CA



“Scheduling: Struggle to Success”

LCM/CC/HN/RES/Nurse: Gabby

Conditions: Hypertension, Chronic Pain, Chronic Liver Disease, Ankle/ Leg Swelling, Heart Problems, High Cholesterol, Hearing Issues, Vision Issues, History of Gallstones.

Situation: Member is a 62-year-old female in the Lancaster area with a history of gallstones. She reported having a “turning feeling” in her stomach in the past and was diagnosed with gallstones after a colonoscopy, so she wanted to complete the procedure again in case she had more. She had been trying to schedule her colonoscopy and endoscopy for a couple months, but the office did not answer or return her calls so she asked for assistance in contacting the office. I was also having issues contacting the scheduling department of the gastroenterologist office, but was able to reach a different department within the office and they connected me to the scheduling department.

Outcome: I was able to schedule her on her preferred day and time, so she can make sure she has transportation to and from the procedure—her procedures are scheduled for early November.

Health Plan: Anthem, CA

“New Providers Provided”

LCM/CC/HN/RES/Nurse Name: Charlotte

Conditions: Asthma, Glaucoma, Arthritis, Anxiety, Gastric Problems

Situation: My 63-year-old member was in need of a lot of new providers due to problems with old practices not giving her the care needed for her conditions.

Outcome: We were able to work together to get a dentist, physical therapist, orthotics provider, and corneal specialist assigned to her. We are now working together to ensure she is able to attend all appointments, get acquainted with new providers, and prevent any problems in the future.

Health Plan: Anthem, CA

“Gaining Clarity”

LCM/CC/HN/RES/Nurse Name: Rebecca

Conditions: Hypertension, Asthma, Coronary Artery Disease, Thyroid Issues, High Cholesterol, Major Depression Disorder, Anxiety, Bipolar Disorder

Situation: My 59-year-old member was recently admitted to hospital—I spoke to her after and she told me she wasn’t sure of her diagnosis. She had a bad UTI and was not acting like herself and then was admitted to hospital, thinking there was something going on with her heart. I asked her if she was told if she had Sepsis, and she said she heard the doctor mention that word.

Once she was discharged, there were multiple specialists she was referred to, but she didn’t understand the referrals, and felt overwhelmed with so many appointments she needed to make.

Outcome: I was able to communicate with staff at her PCP office, got information on all of the needed referrals, and have been able to make appointments for her. Since she has a lot of personal family issues going on, she mentioned she is thankful she can rely on me for making her appointments and sending reminders.

Health Plan: LA Care, CA

“Help for dizzy member”

LCM/CC/HN/RES/Nurse Name: Mayra

Conditions: Asthma, substance use disorder, Hypertension, Major Depression Disorder, Panic attacks, Anxiety, prediabetic, Herpes, Arthritis, Scleroderma, Dysphagia.

Situation: Member is a 61-year-old Spanish speaking female. She was seen at the emergency room for severe headaches and dizziness member was told to follow up with her PCP. She called them and was told only in-person visits, no phone calls even though she told them she was dizzy and didn’t feel like going in-person.

Outcome: I called her PCP and spoke to the medical assistant and she was able to speak to members primary care to get an okay to schedule her for a phone appointment that same day. Member was thankful!

Health Plan: Health Net, CA

“3rd Time’s a Charm”

LCM/CC/HN/RES/Nurse Name: Eric

Conditions: Hypertension, Epigastric Pain

Situation: My 30-year-old member is homeless, living in an RV. He was transferred from a different ECM provider to Titanium in August, and first contact was made in September. Attempts to contact him were unsuccessful thereafter as he did not have a permanent address, only a location where he was last reported to be. As I was not getting any callbacks from him, I went in-person to that exact location. Once there, I searched the entire premises trying to find an RV that matched the description but was not successful. I went a second time and was not able to find him. It wasn’t until the third, where we successfully met face-to-face. During the encounter, I made sure to ask for the locations he stations their RV for future follow-ups.

Outcome: He consented to submission of a Community Supports Referral Housing Navigation and we agreed to meet the following week at one of the 2 locations he frequents to conduct a HRA and begin developing the Care Plan.

Health Plan: Molina, CA

“Hope Renewed”

LCM/CC/HN/RES/Nurse Name: Karina

Conditions: Osteoporosis, Chronic Back Pain, Diabetes, High Cholesterol, Hypertension, Vision Loss

Situation: My member is a 53-year-old Hispanic male who lives at home with his wife and two adult children. He called me and stated he received a package in the mail but did not know what it was so I asked him to send me a photo of the documents he received—it was his Medi-Cal renewal paperwork and it needed to be filled out and turned in before 11/13/23. He stated he did not know how to fill it out so I offered to meet the member in-person to assist him in filling out the paperwork.

Outcome: We met at the Winchell’s Donut house near his home and filled out the renewal application. During the in-person meeting the member stated he also wanted to apply for CALFRESH so we also completed that online application. He successfully mailed out his completed Medi-Cal renewal application and submitted a CalFresh application online on 10/19/23.

Health Plan: LA Care, CA

“Much needed follow-up”

LCM/CC/HN/RES/Nurse Name: Laura

Conditions: Asthma, Diabetes, Chronic pain, Chronic Kidney Disease, Hypertension

Situation: My 48-year-old member recently underwent cardiac triple bypass surgery. During October, I communicated with him frequently to obtain updates from surgery and recovery. He was released from the hospital with no after visit summary and no follow-up appointments. Once he was released from the hospital he called me immediately, nervous because he did not know how to proceed.

Outcome: I was able to schedule a follow-up appointment the next day with his primary care physician. I offered to accompany him to his follow-up appointment. During the appointment his primary care physician was able to request referrals to the member’s cardiologist, nephrologist, physical therapy and surgeon. He was also able to request referrals for home health and blood test strips. After the appointment, he felt relief and thanked me for helping him find his next steps. He is now in contact with all his specialists, and I’ll continue to monitor his recovery.

Health Plan: LA Care, CA

“MRI Approved”

LCM/CC/HN/RES/Nurse Name: Joan

Conditions: HIV Risk, Hypertensive with Heart Failure, GERD, PTSD

Situation: In 2019 my 62-year-old member had a car accident that injured her spine, hip, and leg. Since then, her legs have shown nerve damage that seems to be progressing and now she has very little feeling in one leg, with the other now “burning.” The provider ordered an MRI of the area, but the prior authorization for it was denied.

Outcome: I communicated with the doctor’s office and member’s insurance to figure out why the prior authorization was denied and what information was necessary in order for it to be approved. I walked her through the process and summarized with the member a rough timeline of her treatment since 2019 to provide to her doctor and put in the appeal and within a week the MRI was approved and scheduled.

Health Plan: Coordinated Care Health, WA

“Good Luck Charm”

LCM/CC/HN/RES/Nurse Name: Samantha

Situation: My 37-year-old member has been struggling with making ends meet, expressing that she was being evicted from her home. I had previously helped her get assistance from a program that helps people with furniture and appliances for their home. She told me that the landlord had given her 30 days to move out with her daughter, so I worked double time to try and find some resources to help her with paying her past due rent and keeping her in her home. That's when I found a program called Hopics and asked her if she'd like me to submit an application on her behalf, to which she agreed. We submitted an application and continued to look and apply for many different programs. A week later we heard back from Hopics and she was approved!

Outcome: They paid her past due rent and 2 months ahead to give her some time to figure out her next steps. When I called her with the news she was beyond happy. That week was a good week. She was also given her hours back and got a dollar raise at work. She said that I was her good luck charm. I assured her I was not but that things are finally turning around for her and her daughter. I told her to stay on top of the forms the Hopics program requests from her so she can continue in the program should she need help in the future.

Health Plan: Healthnet, CA

“Family Journey”

LCM/CC/HN/RES/Nurse Name: Cristina

Conditions: Failure to thrive, Microcephaly
Developmental Delay, Spasticity in all four limbs

Situation: Member is a 6-year-old that has moved 2 times with his family in the last 2 months. Mom, dad, brother, and my member were all staying in one room, but were told by the person they were staying with that they needed to get their own place. The family is undocumented. The father is the breadwinner who works in the fields.

Outcome: I referred them to the CS housing program which they were approved and are working with our housing navigator Elizabeth. The mother was very appreciative of all the resources I have found. They also have a food bank coming to their home 2 times a month with food for them.

Health Plan: Central California Alliance for Health, CA

“A Healing Conversation”

LCM/CC/HN/RES Name: Karl

Conditions: PTSD, Major Depressive Disorder

Situation: When I first met my 62-year-old member, she had been struggling for years with serious issues like PTSD and MDD. In our first in-person meeting I told her I studied psychology in college, which fascinated her. I met the member at a Starbucks near her home and we talked for an hour and a half while I did my best to answer all of her questions about psychology.

Outcome: By the time our conversation came to a close, she agreed to give mental health counseling a try, in spite of her issues trusting clinicians. She agreed to allow me to connect her with a therapist, after a few months of work, she reported feeling a reduction in her symptoms and having the energy to do things she could not do before such as working with her NAMI mental health support groups, getting back to working on her art and seeing her friends again.

Health Plan: Amerigroup, CA

“Taking Back Control”

LCM/CC/HN/RES/Nurse Name: Jessica

Situation: My 33-year-old member informed that his poor health management was due to a lack of education and expressed a desire to improve. He has behavioral issues; he feels anxious and sometimes depressive. He also felt that his health was out of control, having had pancreatitis attacks in the past.

Outcome: He has started eating healthier and doing more physical exercise due to his diabetes. He has significantly decreased his alcohol consumption and stopped using other substances that harm his health. The member recently had a physical exam with his primary care provider, including blood work and other tests. He has referrals for Dermatology, X-rays, Optometrist, and Dental. He expressed gratitude to me for the assistance in helping him get his health back.

Health Plan: Community Health Group, CA

“All Smiles”

LCM/CC/HN/RES/Nurse Name: Rosalba

Conditions: Arthritis, Chronic Pain, Ankle and Leg Swelling, Skin Cancer, Congestive heart failure, Circulation Problems, type II diabetes, Heart Problems, High Cholesterol, Urinary Problems, Substance Use Disorder, Hypertension

Situation: My member is a 62-year-old homeless man. He contacted me on 10/20 asking for assistance in getting a document from his dentist’s office to his PCP to get filled out for a clearance to get teeth pulled. He was very upset with his PCP office because the dentist office had faxed the form to them 3 times and PCP claimed they never received it so I went back and forth with the PCP Watsonville Health Center and Dientes dental office, asking Dientes to forward the document to me as well. I forwarded the document to LCM Suzanne who printed it and while doing her in-person, dropped off the document at Watsonville Health Center. The receptionist informed LCM Suzanne it would take up to one week for it to get filled out.

Outcome: I informed my member of this and he thanked me and LCM Suzanne for our work. He called me on 10/24 and informed her that the PCP had filled out the paper and had been faxed over to Dientes. Member has his cleaning today, 10/25, at 1:30PM and will proceed to getting his dental surgery scheduled.

Health Plan: *Central California Alliance for Health, CA*

“Taking Charge”

LCM/CC/HN/RES/Nurse Name: Maria

Conditions: Diabetes, arthritis, Fatty Liver, High Cholesterol, High Blood Pressure, vision loss

Situation: My member is a 62-year-old Hispanic, Spanish-speaking female who enrolled in Titanium in 2021. During this time the member was not engaged with her care and was not able to advocate on behalf of herself.

Outcome: With my support, she learned how to ask for referrals from her PCP. She began to comply and follow her doctor’s recommendations. The member’s A1c at one point reached 9.6 and today it’s 5.6. Furthermore, she’s able to schedule her own transportation and follow-up appointments. The member has been submitted for graduation and the Clinical Care Team has approved the request for graduation.

Health Plan: *LA Care, CA*



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