Longitudinal Care Management

September 2016
ALL PATIENTS & MEMBERS

Risk Score

Assignment of Longitudinal CM Referral sources

Longitudinal CM

SelectHealth CM

Medical Group CM

Episodic CM

Screening: Need CM?

Clinical Assessment tools

Program Services

Integrated Care Management Model, 2016

LONGITUDINAL CM

Longitudinal Intermountain & Community-based Interventions

Episodic Intermountain & Community-based Interventions

Prevention Services: PPC, Health Answers, LiVe Well

Community Partners & Resources

* Patients will move between episodic and longitudinal as needed
Risk Stratification, Screening, Assessment for Longitudinal Care Management

• All Intermountain patients stratified by risk:

<table>
<thead>
<tr>
<th>Quality</th>
<th>Utilization</th>
<th>Cost</th>
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</thead>
<tbody>
<tr>
<td># Charlson Chronic Conditions</td>
<td># Ambulatory Sensitive Encounters</td>
<td>Hospital and Clinic Allowed Amounts</td>
</tr>
<tr>
<td>% Adherence to Evidence-Based Quality Measures</td>
<td># Inpatient and Outpatient Hospital Encounters</td>
<td>Total Allowed Amounts for Non-Hospital/Clinic SelectHealth Claims</td>
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<tr>
<td>Indigo Expected Benefit Score</td>
<td># Emergency Department Encounters</td>
<td>Optum Pharmacy Risk Grouper (PRG) Score</td>
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• Screening of Top 1% for Longitudinal Care Management
  • Medical Group PCP by Medical Group Care Manager
  • SelectHealth insurance by SelectHealth Care Manager
  • (Affiliated PCP without SelectHealth receive Episodic Care Management)

• Assessment of patients that “Screen In”
• Care Plan for those that accept Care Management
## Care Manager Screening, Assessment, Plan of Care

<table>
<thead>
<tr>
<th></th>
<th>IMG PCP</th>
<th>Affiliated PCP</th>
<th>No PCP</th>
<th>Total</th>
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<tbody>
<tr>
<td>SelectHealth*</td>
<td>100,000</td>
<td>100,000</td>
<td>230,000</td>
<td>430,000</td>
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<tr>
<td>Other Payers</td>
<td>150,000</td>
<td>140,000</td>
<td>190,000</td>
<td>480,000</td>
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<tr>
<td>Total</td>
<td>250,000</td>
<td>240,000</td>
<td>420,000</td>
<td>910,000</td>
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*Model specific to post-NCQA certification by Medical Group, for purposes of SelectHealth accreditation

**SelectHealth attribution calculation is based on adult members (>18) on for members on Utah plans, calculated on 1/15/2015
Integrated Care Management Structure

**Episodic Care Management Services**

*Provided to patients who have a need for Care Management for a particular “episode” of care that has a foreseeable “endpoint”.*

**Examples:**

- Inpatient stay
- Post-acute care
- High risk pregnancy
- New cancer diagnosis
- Unstable episode for highly complex patients or patients with unusually high utilization of healthcare services
- Need for navigation assistance to access healthcare
Episodic Care Management Programs

- Inpatient Care Management
- Health Answers
- Community Care Management (CCM)
- Complex Care Clinic (CCC)
- Integrated Community Care Management (ICC)
- Specialty Programs – Maternal Fetal Medicine, Neuro-Oncology, Transplant Services, Endocrinology Services, Congestive Heart Failure Programs
- Community Partnerships – Nurse Family Partnership, Community Health Workers, United Way 211, Community Paramedic Program
Integrated Care Management Structure

**Longitudinal Care Management Services**

*Provided to patients who are determined to be high risk or high complexity using a variety of scoring, screening and assessment tools and for whom an “endpoint” isn’t clear.*

**Examples of Factors contributing to high risk or high complexity:**

- Multiple Chronic Illnesses
- High healthcare costs
- High utilization of healthcare services
- Behavioral Health and/or Substance Abuse diagnoses
- Lack of social and other necessary support
- Catastrophic event or diagnosis
Longitudinal Care Management Programs

- Personalized Primary Care Clinic Care Management
- SelectHealth Care Management
## Longitudinal Care Management - PPC

<table>
<thead>
<tr>
<th>Locations</th>
<th>79</th>
</tr>
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</table>
| Staff     | 62.5 RN  
            | 63.3 Heath Advocate/Car Guide |
| Patients Served | Anticipate at least 4500 in 2017 |

| Risk Screening Methods | Proprietary Risk Scoring Tool  
Care Management Screening Tool  
List of ED visits and IP stays  
Provider referrals  
Lists of Chronic Disease Patients |
|------------------------|-------------------------------|

| Services Provided | • Telephone and In-person clinic visits to provide:  
• Risk Screening and Assessment  
• Individualized Care Plan  
• Identification of Barriers and Resources  
• Care Coordination and Facilitation  
• Health Education for Self Management  
• Referral to Community Resources |
|-------------------|---------------------------------|

| Measures of success | • Team Based Care (TBC) (including Care Management) reduced delivery system payments by $115pmpy  
• TBC reduce ED visits by 30%  
• TBC reduced IP admits by 14%  
• TBC improved Depression Screen Score, Adherence to DM bundle, and HTN control  
• Note – PMPY investment $22.19 w/o overhead |
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<tr>
<td>Locations</td>
<td>1</td>
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</table>
| Staff     | Approximately 46 CM/DM RN’s  
Approximately 130 total including UR, Benefits Mgmt., admin. |
| Patients Served | UM provided to all members using services 
Approx. 26,000 Screened/Evaluated 
Approx. 3700 enrolled in CM/DM |
| Risk Screening Methods | Proprietary Risk Scoring Tool  
Care Management Screening Tool  
Trigger List (90+ items)  
Referrals from Providers  
Utilization and Cost Reports  
Specific Chronic Disease Diagnoses  
Health Risk Assessments  
High Risk Managed Medicaid and Dual Eligible populations |
| Services Provided | • Telephone visits to provide:  
• Risk Screening and Assessment  
• Individualized Care Plan  
• Identification of Barriers and Resources  
• Care Coordination and Facilitation  
• Health Education for Self Management  
• Referral to Community Resources  
• Utilization Management  
• Disease Management |
| Measures of success | Studies of Sample Care Managed Populations show:  
• ED visits decreased for Asthma patients  
• IP admits decreased for Heart Failure patients  
• Hgb A1C decreased for Diabetic patients  
• ED visits decreased for High Risk Managed Medicaid Patients |
What’s Next?

1. Create Dashboard for Longitudinal Care Management to demonstrate “Did it make a difference?”

2. Standardize and Optimize Care Management documentation in EMR to support Shared Plan of Care and all regulatory and quality auditing requirements.

3. Expand target populations to include more high risk patients:
   - SelectHealth Medicare Advantage
   - SelectHealth Medicaid
   - New Risk Contract populations
   - SelectHealth individual plans sold through the exchange

4. Continuously evaluate the effectiveness of our Risk Scoring Tool and our work processes to improve our impact