Integrated Healthcare Management (IHM) Overview

MCO Case Management Presentations
MCAC on June 24, 2015

Karen Dale, Market President
Member Engagement and Empowerment

• Establish frequent contact with member in addition to care management which may include text messages, tablet and a member portal
• Go to where the member is and build a reliable, trusted relationship as a partner to achieve wellness
• Utilize CLAS standards
• Ensure robust array of resources are available to meet psychosocial needs

Value added Provider and Community Partnerships

• Leverage the strengths of community partners
• Engage academic partners for rigorous research and evaluation

Informatics Excellence

• Utilize as much real-time data as possible
• Appropriately target members based on clinical and social determinant data

True Integrated Care Management

• Ensure every member interaction is leveraged to capture and evaluate physical, behavioral health and environmental challenges
• Re-think care management to be a model of member engagement
Integrated Healthcare Management (IHM)

- Patient-centered approach which addresses the patient’s preferences, concerns, lifestyle, culture, beliefs and readiness
  - multiple referral points
  - team-oriented approach

- The Program is Flexible and Adaptable to recognize the unique needs of well, chronic and acute populations
  - all members are eligible for support
  - interventions are designed to address member’s unique needs to deliver the right services, at the right time, for the right cost
  - Interventions may include contact by telephone or in-person, education materials (mail, video), referral to community-based support, text messages

- Tracking – assessments and results, member engaged, member refused, return mail, COS team contacts
## Stratification Approach

### Non-clinical
- Ward
- Homeless
- History of complaints
- Attendance at community events
- Receipt of incentives
- Household composition
- Enrollment history (continuous or not)
- “hot spots” for example for ambulance utilization
- Medical home utilization versus numerous providers

### Clinical
- **High Utilizing Patient Profile**
  - DxCG Score
- Pharmacy – new starts, inconsistent medication adherence, multiple prescribers, high utilization of narcotics.
- Sub-group level – chronic conditions (newly diagnosed versus diagnosed and stable).
- Gaps in care – e.g. member with a positive lab result for HIV and then no claims.
- ER and ambulance utilization
- Future – real time data to support case management efforts through enhancements to CRISP, sharing clinically relevant data from provider EMR. Less dependency on claims, to have information to support a timely intervention with a member e.g. short member health questionnaires.
IHM Organizational Chart

Case managers – complete assessments, develop treatment plans, provide disease management education
Non-clinical staff – screen, assist with coordinating care, resource
Community Outreach Specialists – screen, outreach in-person or telephonic, resource

CLAS - The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse members.
Asthma Focus - Pediatric

IMPACT Program
- Improve management of pediatric asthma, reduce unnecessary ED visits.
- Program components include: Shared savings with provider, in-person intensive work with the child and family, ED diversion, 80 referrals per quarter to program

Breathe DC
- Conducts home assessments for families referred by IMPACT
- Provide what is needed e.g. air filter, de-humidifier to improve the environment
- PerformRx Health Tablet to deliver targeted educational interventions several tools to measure and improve adherence and improve general and health literacy

Children’s Law Center
- Many legal problems are health problems
- Legal professionals TRAIN healthcare to recognize health harming needs
- Healthcare team members IDENTIFY patients’ health harming legal needs by implementing screening procedures

DC Department of the Environment
- DC Healthy Homes Program, program aimed at identifying and ending environmental health and safety threats and hazards in the homes of families throughout the District
- COS team will be trained and deployed to conduct environmental assessments
## CM Activity Reporting: Current State

<table>
<thead>
<tr>
<th></th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
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</thead>
<tbody>
<tr>
<td><strong>Total Number of Persons in Case Management</strong> *</td>
<td>1,485</td>
<td>1,542</td>
<td>1,430</td>
<td>1,461</td>
<td>1,613</td>
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<tr>
<td><strong>Staffing</strong></td>
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<tr>
<td>Number of Case Managers</td>
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<tr>
<td>Number of Social Workers</td>
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<tr>
<td>Number of Care Coordinators (non-clinical)</td>
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<td>Number of RNs</td>
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<td><strong>Referrals</strong></td>
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<td>Referrals to Early Intervention/Special Needs CM</td>
<td>20</td>
<td>26</td>
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<td>Referrals to Diabetes CM</td>
<td>35</td>
<td>23</td>
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<td>Referrals to Asthma CM</td>
<td>78</td>
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<td><strong>Barriers to Engagement</strong></td>
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<td>1. Contacted members are not interested in participating in the program</td>
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<td>2. Contacted members express confidence in self-management of their condition</td>
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<td>3. Inaccurate member contact information</td>
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<td><strong>Mitigation Strategies</strong> (strategies to increase member participation in case management)</td>
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<td>1. Project to improve accuracy of member data - Lexis Nexis</td>
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<td>2. Additional clinical data mining</td>
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<td>3. Improving communication messages to support health literacy</td>
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<td>4. Plan to utilize text messages for outreach</td>
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<td>5. Leveraging outreach team to connect members with a case manager</td>
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* Total Number of Persons in Care Management reflects only those members with a complete assessment and open case during that month.
2014 Outcomes

Focus shifts to measuring program impact/effectiveness using established outcome measures and comparing CM engaged members with those members not engaged in the CM program.

>3 Low Acuity ED Visits

- 1.0% Contact with CM
- 2.4% No Contact with CM

2014 Preventative Measures

- Contact with CM
- No Contact with CM