

Integrated Healthcare Management (IHM) Overview

MCO Case Management Presentations
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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

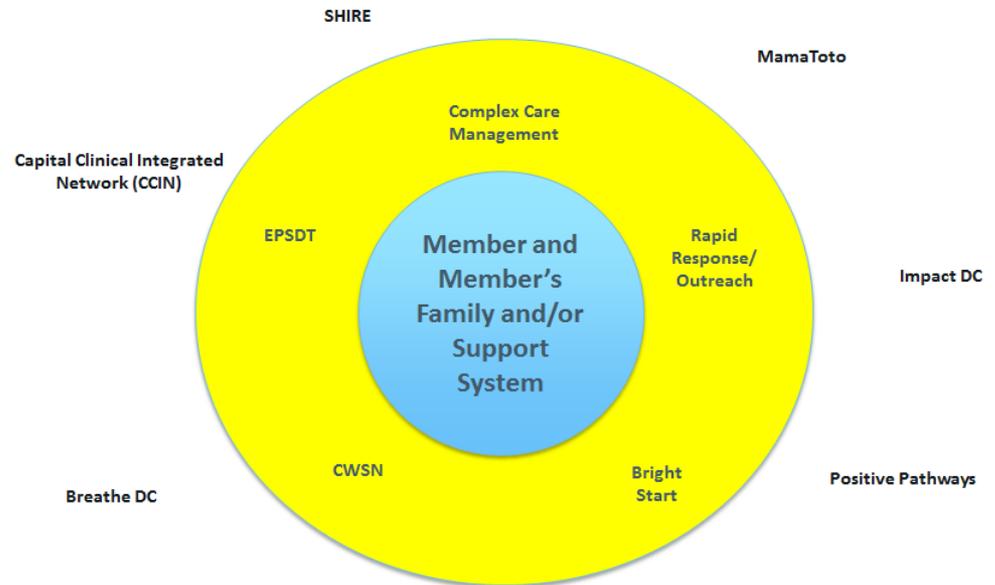
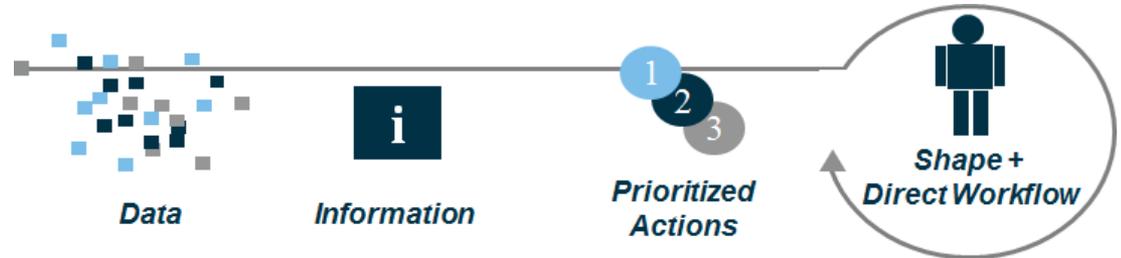
- Ensure every member interaction is leveraged to capture and evaluate physical, behavioral health and environmental challenges
- Re-think care management to be a model of member engagement

Member Centric



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

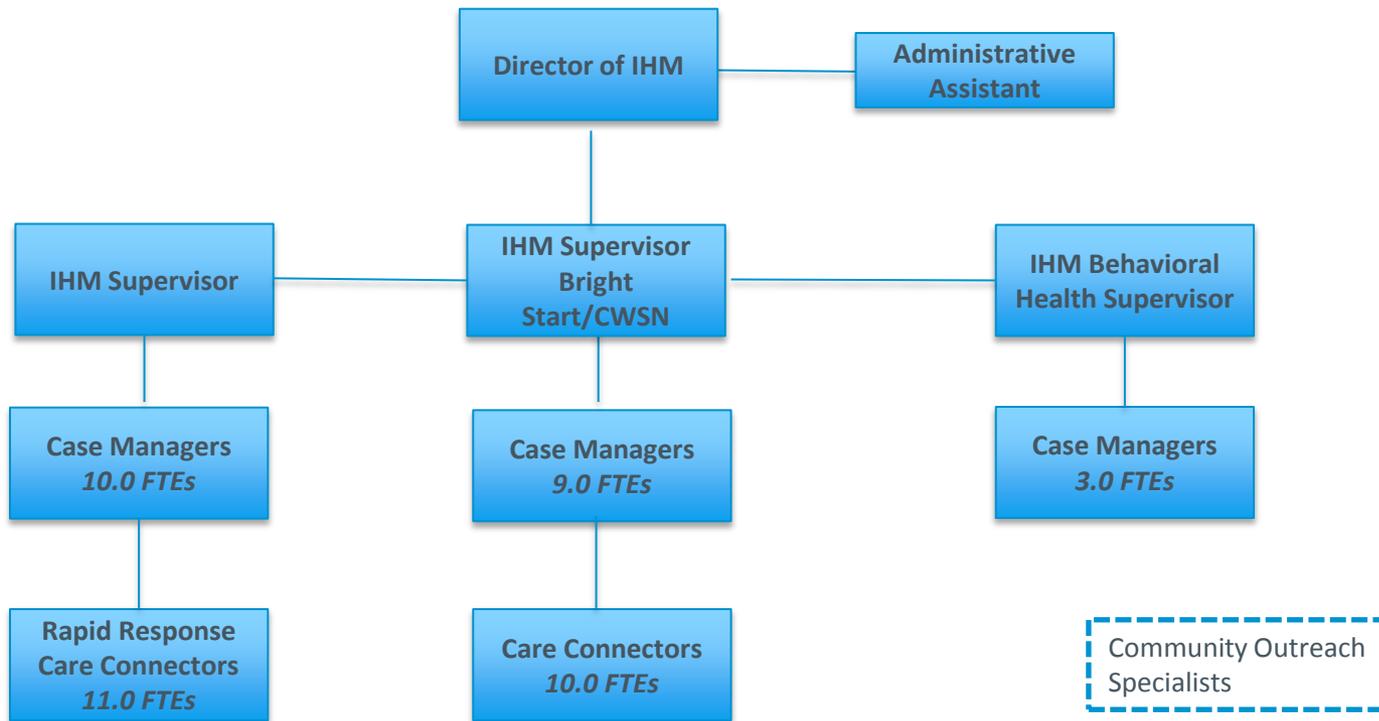
Non-clinical

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



Roles

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

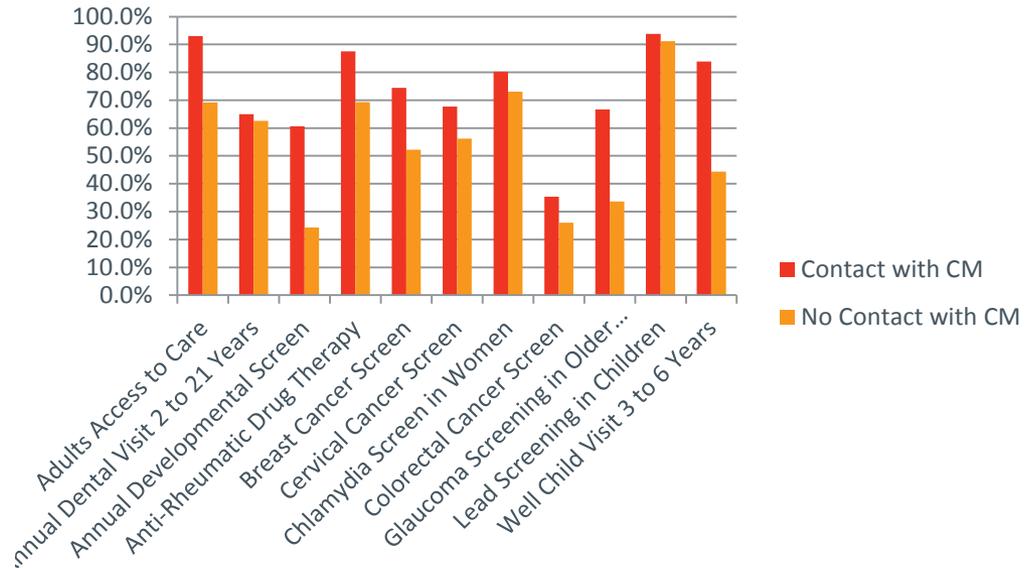
- DC Healthy Homes Program, program aimed at identifying and ending environmental health and safety threats and hazards in the homes of families throughout the District
- COS team will be trained and deployed to conduct environmental assessments

CM Activity Reporting: Current State

	January	February	March	April	May
Total Number of Persons in Case Management *	1,485	1,542	1,430	1,461	1,613
Staffing					
Number of Case Managers	25	25	25	25	25
Number of Social Workers	3	3	3	3	3
Number of Care Coordinators (non-clinical)	16	16	16	16	16
Number of RNs	22	22	22	22	22
Referrals					
Referrals to Early Intervention/Special Needs CM	20	26	41	27	38
Referrals to Diabetes CM	35	23	71	76	64
Referrals to Asthma CM	78	67	67	49	88
Barriers to Engagement					
1. Contacted members are not interested in participating in the program					
2. Contacted members express confidence in self-management of their condition					
3. Inaccurate member contact information					
Mitigation Strategies (strategies to increase member participation in case management)					
1. Project to improve accuracy of member data - Lexis Nexis					
2. Additional clinical data mining					
3. Improving communication messages to support health literacy					
4. Plan to utilize text messages for outreach					
5. Leveraging outreach team to connect members with a case manager					
* Total Number of Persons in Care Management reflects only those members with a complete assessment and open case during that month					

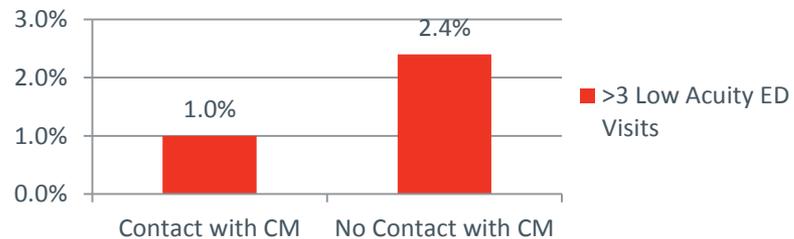
2014 Outcomes

2014 Preventative Measures



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



Question and Answer

