PrimeWest Health

A “county-based purchasing” managed care organization (MCO) serving 37,000 public insurance program participants (Members) in 13 rural Minnesota counties since 2003.

- MCO
  - Risk-based health plan
  - Pay for and manage covered services, care and health of Members
- Public Insurance Programs
  - Medicaid, dual eligible Medicare Advantage (low-income seniors and disabilities populations), State Basic Health Plan, Elderly Waiver
  - All high risk populations – multiple social determinants present

PrimeWest Health

PrimeWest is much like where you are heading with accountable care, value-based reimbursement and achieving Triple Aim

- Rural – and all the complexities associated with rural delivery
- High proportion of high risk patients (Medicaid, Medicare)
- Responsible for total cost of care (TCOC) for a set patient population - Upside and downside financial risk
- Achieving quality of care and population health benchmarks
- Infrastructure to proactively address patient's health care and wellness management needs across the health care, wellness and human services continuum.
  - **Care management and care coordination**

Motivation for Care Coordination

Your organization's motivation (reasons) for care coordination determines your target population(s) which then shapes the focus, scale and intensity of your care coordination model(s)

PrimeWest's motivation

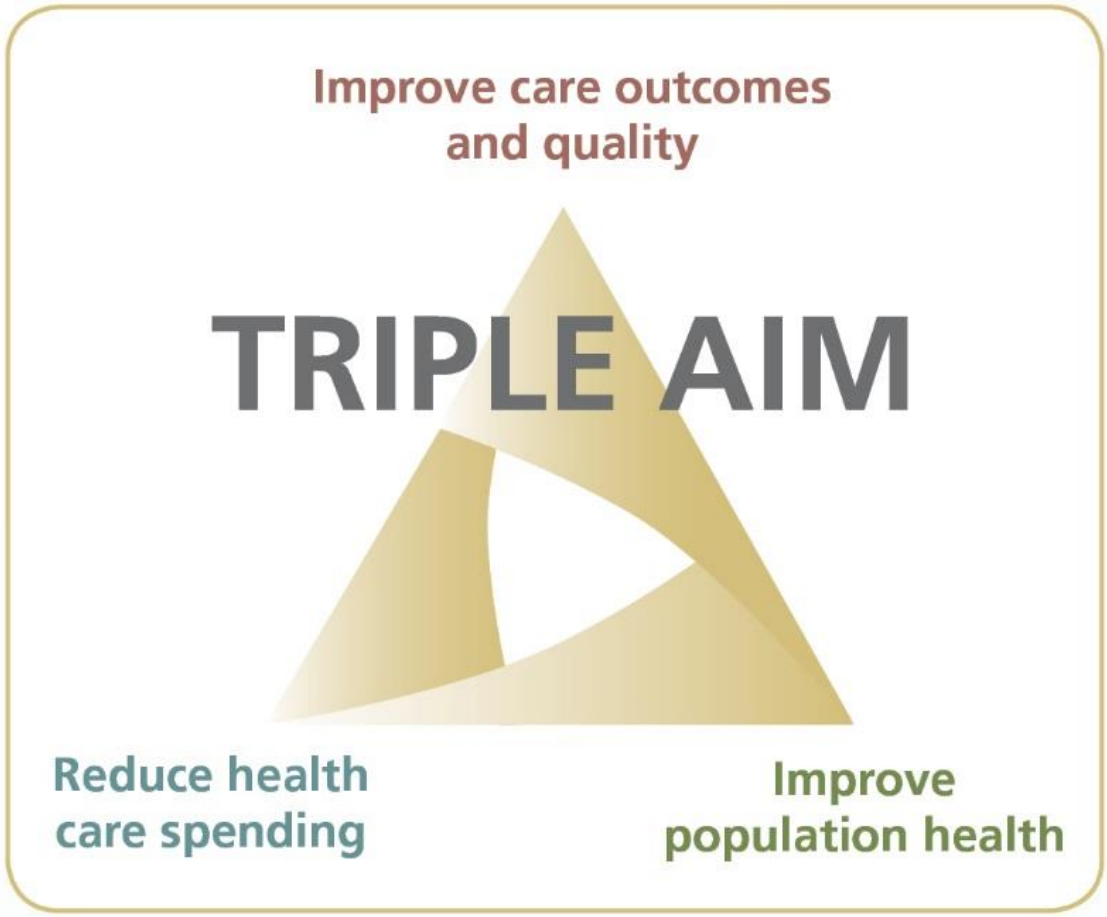
- The right thing to do
- Community-based integrated service delivery mission
- Total cost of care (TCOC) risk-based contracts with CMS and the State for all our members
  - High risk populations served
- CMS, State and NCQA quality requirements and performance-based incentives

What are your reasons for care coordination?

Care Coordination Program Goal

To achieve Triple Aim through coordinating members' timely access to and delivery of care and services by providers across the health and human services continuum.

Outcome Expectations



Care Coordination Models

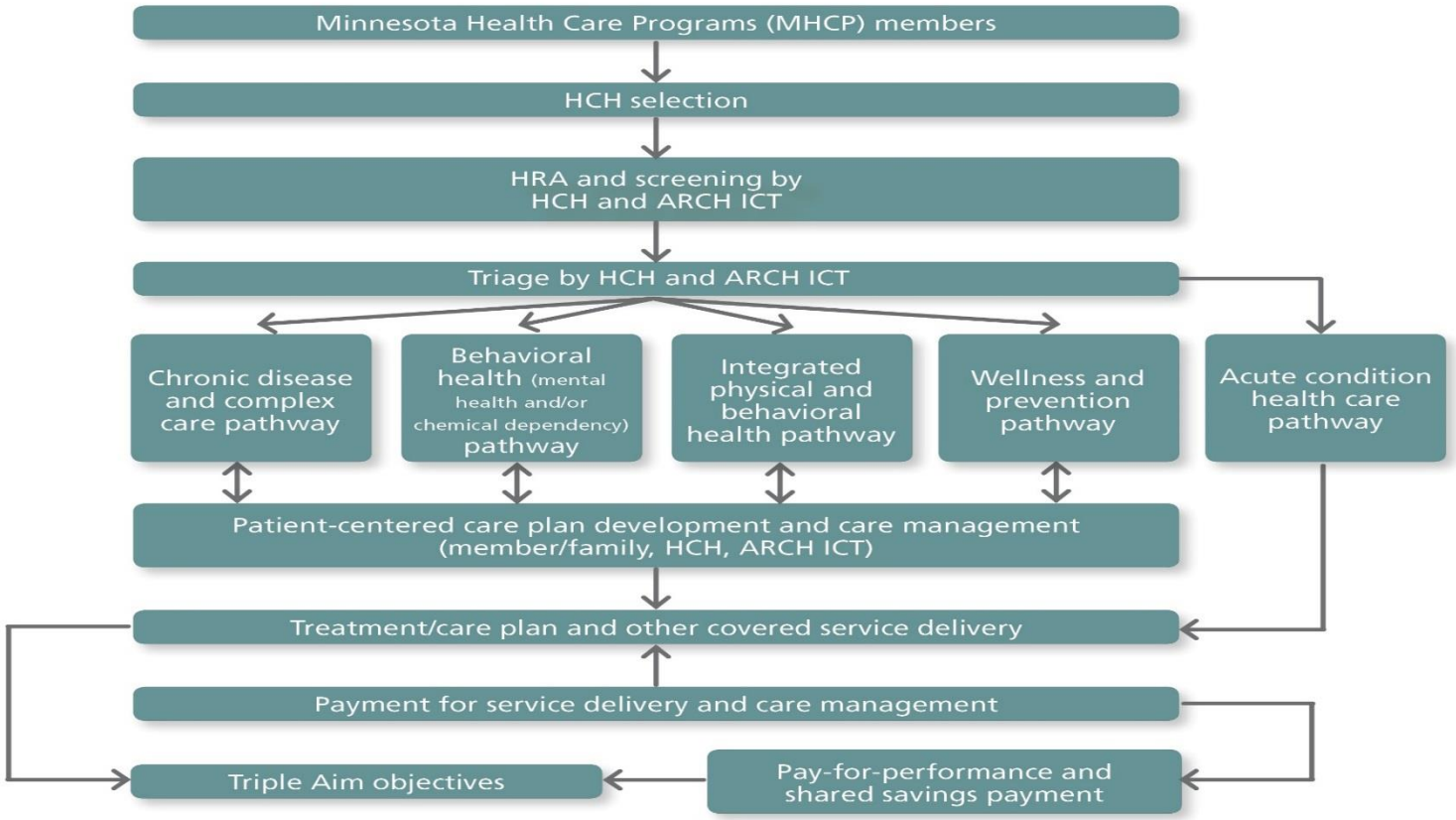
PrimeWest uses two care management platforms:

1. Health plan-based (PrimeWest)
2. Provider-Based (ARCH model)

Within each platform there are five core care coordination or management models

Only difference is who leads effort

Accountable Rural Community Health (ARCH) Process Overview



LEGEND

HCH = Health Care Home
HRA = Health Risk Assessment
ARCH ICT = ARCH Interdisciplinary Care Team

Care Coordination Models

Inside PrimeWest's Care Coordination Pathways

- Wellness
- Acute Care Management
- Complex Care Management
- Chronic Disease Management (and co-morbid variants)
- Mental Health
- Mental Health Targeted Case Management
- Chemical Dependency
- Co-occurring Chronic Medical and Mental Health Care Management
- Behavioral Health Dual Diagnosis (mental health and CD)
- Prenatal Care Management

Care Coordination Modeling

An effective care coordination model follows a standardized, logical workflow that is applied to ALL patients

However, the scope and intensity of a person-centered care coordination model must be adaptable based on patient's assessed needs and care pathway.

Care Coordination Work Flow

1. Individualized needs assessment
2. Triage
   - Prioritizing and stratifying based on assessed needs
3. Care management pathways assignment
   - Preferably patient's primary care provider determination based on assessed need
4. Person-centered Care planning
   - Patient participation-based
   - Interdisciplinary Care Team (ICT)
   - Individualized Care Plan

Care Coordination Work Flow

5. Coordinating individual patient care
   - Monitoring individual care/Tx plan compliance
   - Managing negative individual behaviors with appropriate intervention
6. Coordinating population care across continuum
   - Monitoring patient population health care utilization
   - Intervening on an individual patient basis as needed.
7. Evaluation – Individual and population

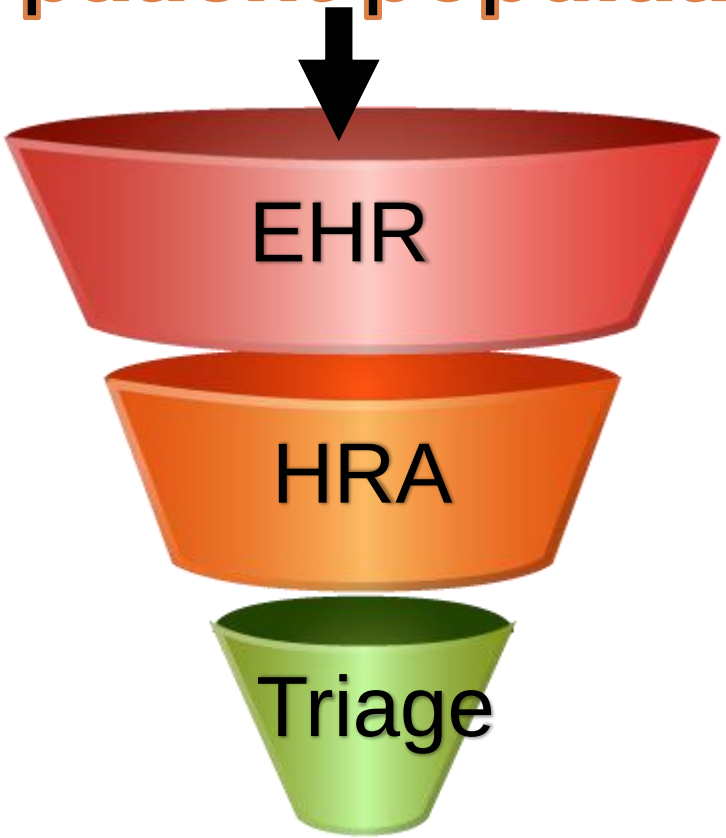
PrimeWest Health

Presentation #3

A greater Minnesota health plan

Identifying Target Population
(for Care Coordination)

Total patient population



Care Coordination Population

Assessing Need

PrimeWest uses multiple methods for identifying members appropriate for care management and care coordination:

- Referrals
  - Member self-referral
  - Provider Referral and Provider Assessments
  - Health information/nurse line referral
- Claims or encounter data (our own payer data*)
- Pharmacy data
- Utilization management data such as hospital discharge data, service authorizations (our own payer data*)
- Data supplied by health care providers

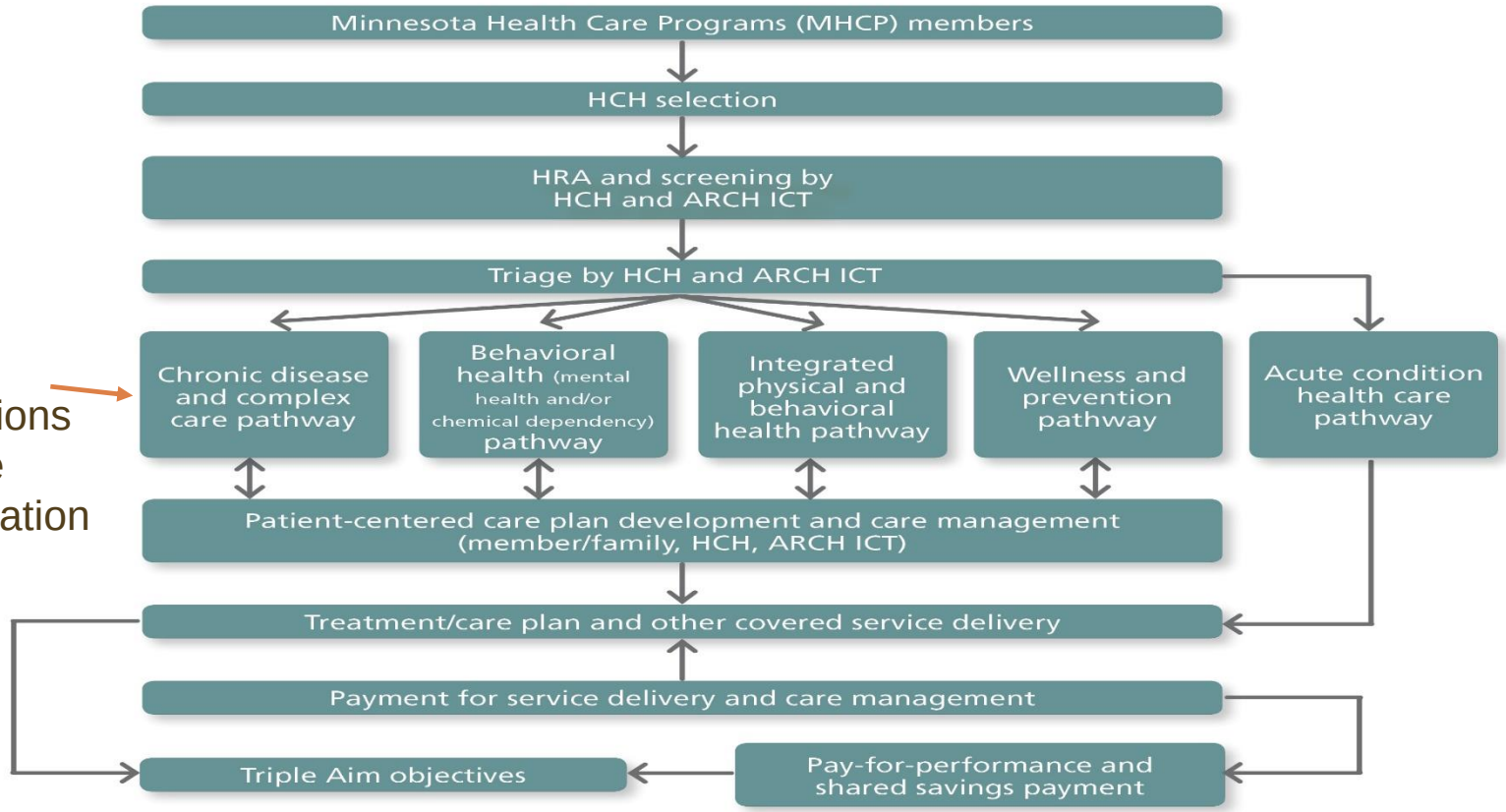
Assessing Need

Needs Assessment tools used by PrimeWest

- Health Risk Assessments
- PraPlus
- Long-Term Care Consultation (LTCC) and MnCHOICES
- Developmental Disability (DD) Screen
- Skilled Nursing Facility Comprehensive Assessment
- TRALE
- ALERE Health Risk Assessment
- Complex Case Management Assessment
- Mental Health Specific Assessments
- Chemical Dependency Assessments
- Diagnostic Assessment, Functional Assessment
- Civil Commitment information

Accountable Rural Community Health (ARCH) Process Overview

Target Populations for Care Coordination



LEGEND

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HIT's Role in Needs Assessment

Electronic Health Records (EHR)

- Help identify target populations within your total patient population appropriate for care coordination.
  - EHR can help identify patients with:
    - Chronic disease, especially co-morbid physical conditions and chronic physical-mental health co-morbidity
    - Patterns of preventable use of health care services, particularly costly services
    - At-risk populations (i.e., lab values)
    - Good and poor therapy compliance patterns (Rx)
  - Creating electronic **Patient Registries**
  - Baseline health status data

HIT's Role in Needs Assessment

Electronic Health Risk Assessments

- Does not require clinic visit to complete
- Extensive scope of health areas covered
- Fills information gaps in EHR, particularly valuable for patients not recently seen in clinic and under-utilizers of care, including preventive
  - Easily aggregates current self-reported health status and conditions of patients
- Triages level of risk
- Recommends various evidence-based health management activities
- Repeated annually or after sentinel health events (to compare against baselines)

HIT's Role in Needs Assessment

Electronic data warehouse

- Payer data – utilization and cost
- EHR data
- Data mining and analytics
- Secure File Transfer Protocol (SFTP)
- Allow you to pull data real time

Ideally, you would like to create an all-payer database since health conditions warranting care coordination do not recognize payer source.

PrimeWest Health

Presentation #5

A greater Minnesota health plan

Person-Centered Care Plan

- Patient participation in care plan development
- Based on individual patient's assessed needs
- Accounts for medical, behavioral health, wellness and human services needs (social determinants)
- Incorporates existing care and Tx plan information
- Components
  - Goals and objectives
    - Medical, psychosocial, functional, cognitive, mental health, utilization and health metrics
  - Interventions (services and treatments)
  - Frequency and Mode (when and where)
  - Service providers names

Electronic Care Plan

- Purpose to ensure timely delivery of care plan services, member compliance, and progress
- Accessible to all integral members of the patient's care and treatment teams
  - Hosted and monitored by Care Coordination lead entity
- Achieved through secure, web-based platform
- Customizable for specific patient population types
- Helps overcome EHR interoperability
  - Allows ICT to review one another's progress notes and communication in real time
- Report generation
  - Real-time monitoring HEDIS measures, timely provision of services, member compliance with care and Tx plans, etc.

Electronic Care Plan

Currently Open Care Plan: MARY PRIMEWEST (99999001) 3 Reminder(s)

Home Details Interventions Intervention Goals Assessments Notifications Logout (Logged in as Jen Bundy)

Client | Provider/Diagnosis | Case Management | Updates | Notes | Provider Visit | Backup Plan | Service Agreement | ICT | Wellness

Client Demographics

PMI: 99999001

Name: Mary Primewest

DOB: 07/01/1954

Soc Sec:

Gender: FEMALE

Client Additional Info

County of Financial Responsibility: Douglas

Client Enrollment

PrimeWest: 01/01/2008

Type of Care Plan

Care Plan Information

Managing County: Beltrami

Phone/Address Information Source

(•) PrimeWest ( ) Non-PrimeWest

Phone Numbers

TYPE	NUMBER
OTHER	8664310802

Addresses

TYPE	ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP
DEFAULT	2209 JEFFERSON ST STE 101		ALEXANDRIA	MN	56308

Contacts

TYPE	NAME	ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP	PHONE
Financial	test						-no primary-

Interdisciplinary Care Team

- Based on member identified need and service
- Need and choice approved by the member
- PrimeWest model: minimum of member and/or caregiver, PCP/specialist, CCM/care coordinator (RN/SW)
- Concurrent review to determine progress towards stated goals
- ICT may be updated/changed based on member progress and need
- HIT's role – Electronic care plan communication between and monitoring of ICT member performance

ICT Composition

- Depending on needs and services needed:
  - Patient (Patient's family/authorized rep*)
  - Patient's primary care provider
  - Care coordinator
  - Case manager, community health worker and/or care navigator
  - Other Care and Tx Plan services providers:
    - Specialists
    - Social services
    - Home & Community-based Services (PCA, home health, etc)
    - Skilled nursing facility/long-term care facility care coordinator
    - Pharmacy
    - Behavioral health provider

Coordinating Care

Patient-centered

- Arranging for appointments and services as needed
  - Care system navigation support
- Monitoring patient care and Tx plan compliance and progress
- Monitoring for sentinel health events and outlier utilization
  - Conduct updated health risk assessment (HRA)
  - Revise care plan based on update HRA results
- Regular in-person or telephonic touches with patient
  - Case managers –if patient has Medicaid or waivered services case manager, huge cost saver versus employing own case managers
- Periodic team-based case reviews with key ICT members
- Care plan and EHR management to ensure capture of critical provider notes across entire ICT.

Coordinating Care

The patient's role in care coordination

- Care coordination cannot succeed with a disengaged patient.
- Care planning should be used to educate patient on their health needs and the health care and wellness services and personal behaviors to address them
- The care plan should clearly articulate patient's responsibilities
- During each "touch" with the patient, encourage patient engagement and accountability in managing their health care and health status.
  - Be careful of enabling health care dependency, which can occur with the added provider attention and support that comes from care coordination. Understand what motivates the patient to engage.

Coordinating Care

Patient Population-based

- Continually analyzing for areas for improving health care utilization, costs and quality
- At the very least, monitor:
  - Pharmacy utilization, i.e., MTM compliance, generic drug use, etc.
  - Preventable utilization of costly health care services from Ambulatory Care Sensitive Conditions, Unmanaged complex or chronic physical and mental health conditions, over or underutilization of services, etc.
  - Trends among certain demographic, psycho-social segments of your patient populations (disparities)
  - Cost and quality (outcomes) comparisons of like referral providers by service or Dx (assessing value proposition of your referral resources)

Keep in mind: Population-based identification/patient-based intervention. You improve one patient at a time!

HIT in Coordinating Care

Patient-centered examples

- EHR
  - alerts to remind treating provider of a service needed or metric to check when patient presents at clinic – alerts usually aligned with quality measurement, e.g., evidence-based chronic disease management services standard (e.g., HbA1c, eye exam).
  - Interoperable EHR – unanticipated health care events or utilization, e.g., ER use, utilization of a specialty not in care or Tx plan, MTM compliance, lab and other test results etc.
- ECP
  - Service provided according to plans, ICT progress notes, indications of patient or provider non-compliance with care and Tx plans, etc.
- Data warehouse (payer data)
  - Outlier (unplanned) utilization of health care services possibly indicating a change in health status, health care costs and value, etc.

HIT in Coordinating Care

Population-based examples

- Electronic patient registries
  - Payer(s) patient attribution – typically applies to medical homes, ACOs
  - Categorized by health condition or diagnoses and demographic and psycho-social variables, including disparities
- EHR
  - Interoperable EHR – monitor (sample auditing) patient care quality
- Data warehouse (payer data)
  - Preventable utilization of costly health care services - ambulatory care sensitive conditions (ACSC) hospitalizations and ER use, indications for unmanaged chronic or complex conditions, etc.
  - Utilization and average per capita cost by service type
  - Quarterly comparisons against baseline data to measure progress

All of the above identify additional patients for care coordination

Evaluation/metrics of models

- Care Management Audits
  - Care Plan
    - Timeliness of care plan service delivery
    - Patient compliance with care and treatment plans
  - Transition of Care effectiveness
  - Annual Care System Review
  - Care plan goal and objective achievement
- Monitoring quality of care and care plan providers
  - HEDIS
  - Patient satisfaction surveys
  - Medical Record Review – assess quality of care provided
- Utilization Management review
  - Review of utilization patterns and cost data from payers

Best Practices

- **Best Practice Guidelines for Special Needs Members**
  - Congestive Heart Failure (CHF)
  - Dehydration
  - Fever
  - Lower Respiratory Infection
  - Mental Health Status
  - Urinary Tract Infection (UTI)
- **Standards of Practice**
  - All Case Managers
  - EW and Non-EW Case Managers
  - Clinic Case Management
  - Skilled Nursing Facility Case Management
- **Member Care Strategies**
  - Chronic Heart Failure (CHF) Care Strategy
  - Urinary Tract Infection (UTI)
  - Pneumonia Care Strategy

Member Action Plans

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Depression
- Heart Failure