

The PrimeWest Health County-Integrated Care Management Program

PrimeWest Health (PrimeWest) developed and utilizes a comprehensive member-centered care management process called the County-Integrated Care Management Program (CICMP). The CICMP promotes wellness and prevention by emphasizing and enabling early identification of health risks and emerging health concerns of our members. Embedded in the CICMP are county public health and social services; this facilitates the integration of medical providers with public health, social services, mental health, chemical dependency treatment providers, and community support organizations to provide a coordinated set of services specific to the member's assessed needs. The CICMP is a process model that includes a variety of steps and activities which are outlined below.

The CICMP is adapted to the specific needs of and program requirements for members enrolled in each of PrimeWest's Minnesota Health Care Programs (MHCP). The CICMP was jointly developed by PrimeWest and our owner counties' local public health and social service directors and case management supervisors. It has evolved over the years based on input from members and their health care and human services providers—and to keep pace with a changing health care environment. The CICMP now forms the foundation of all PrimeWest efforts to provide our members timely access to coordinated, cost-effective, and high quality care and services.

A. INDIVIDUALIZED HEALTH NEEDS AND RISK ASSESSMENT

PrimeWest uses multiple methods for identifying PrimeWest members who would benefit from participation in the PrimeWest CICMP.

1. Referrals

a. Member Self-Referral

Members may refer themselves to any level of care management provided through the PrimeWest CICMP. Self-referrals can be made by simply calling PrimeWest or by completing the referral form posted on the PrimeWest website.

b. Provider Referral and Provider Assessments

Providers, nurses, care coordinators, case managers, and discharge planners have firsthand knowledge of our members and information and data regarding our members' needs. Therefore, they are in an ideal position to identify members who would benefit from participation in the CICMP. Providers refer identified members to the CICMP by calling PrimeWest or sending us a secure email. This includes notifications of new pregnancies from primary care clinics and county public health and social services.

Health homes participating in PrimeWest's Accountable Rural Community Health (ARCH) program also review their health records to determine if any PrimeWest members attributed to them through ARCH have diagnoses, conditions, or symptoms that indicate the need for additional care management services. ARCH Health Homes follow the PrimeWest CICMP model—coordinating their care management efforts with county public health and social services and PrimeWest.

PrimeWest's providers are contractually required to use Minnesota Department of Human Services (DHS) approved screening tools. PrimeWest has provided links on its website to these screening tools to increase ease of access for providers. These tools include the following:

Physical/Developmental

- ASQ (Ages & Stages Developmental Screening)
- C&TC (Child and Teen Checkup Screening)
- Heart Disease and/or High Blood Pressure Screening
- DD Screen (Developmental Disabilities Screening)

Mental Health screening tools for children and adults

- Ages & Stages Questionnaire: Social Emotional (ASQ-SE) for ages 2 months-5 years
- Pediatric Symptom Checklist (PSC) for ages 6-16
- C&TC (includes both developmental and mental health components)
- Patient Health Questionnaire: Adolescents – Severity Measure for Depression (PHQ-A) for ages 11-17
- Patient Health Questionnaire: Depression – (PHQ-9) for ages 18+
- Global Appraisal of Individual Needs: Short Screener (GAIN-SS) for ages 10+

Chemical Dependency screening tools for children ages 12 and up and adults

PrimeWest's providers are contractually required to use the DHS-approved Screening, Brief Intervention, and Referral to Services (SBIRT). PrimeWest has links on our website to these screening tools to increase ease of access for providers:

- Alcohol Use Disorders Identification Test (AUDIT or AUDIT C): adult alcohol use
- Drug Abuse Screen Test (DAST-10): adult drug use
- Alcohol, Smoking and Substance Involvement Screening Test (Assist): adult poly-substance use
- CRAFFT: adolescent alcohol and drug use
- CAGE Adapted to Include Drugs (CAGE-AID): alcohol and drug use

c. Health Information/Nurse Line Referral

PrimeWest's contracted 24-hour health information/nurse line, *Ask Mayo Clinic*, sends PrimeWest reports twice a week with member call information including date of call, reason for call, and direction provided by the registered nurse who talked with the member. PrimeWest care coordinators identify members who report concerns that may indicate health conditions that could require or benefit from proper care management. They follow up with these members to invite them to take a health risk assessment (HRA), using one or more DHS-approved assessment tools that can help them determine the need for care management services.

2. Type of Health Risk Assessments Conducted

Upon enrollment, at any time during their enrollment with PrimeWest, after a significant health event, and at least annually, PrimeWest members ages 18 – 64 have the

opportunity to self-report diagnoses by completing an HRA. HRA tools utilized by PrimeWest are approved by DHS or National Committee for Quality Assurance (NCQA) and identify a member's medical, behavioral health (mental health and chemical dependency), social, and cultural needs and conditions. PrimeWest cannot require members to complete HRAs, but we provide education about the value of HRAs and encourage members to take advantage of the opportunity. If the member completes an HRA, a wellness score is calculated (0-100). Members are sent an invitation packet for the CICMP if they have a wellness score of less than 50 and/or self-report having a diagnosis or health condition that would benefit from participation in the PrimeWest CICMP. PrimeWest cannot require participation in the CICMP, but we encourage members with such wellness scores to do so. The assessment tools used by PrimeWest include, but are not limited to, those listed below.

a. TRALE

The TRALE assessment obtains information on gender, age, ethnicity, and assesses tobacco use, nutrition, physical activity, alcohol use, environmental safety, mental and social wellbeing, Current health, rating of current health, health history, health literacy, specific gender history, readiness to change, and biometric measures. Each area includes questions on stages of readiness to change, which can help in targeting risk management or disease prevention measures to those most willing to change their behavior. PrimeWest contracts with Horizon Public Health to administer the TRALE. Completed results are sent via secure network to the PrimeWest Care Coordination team for review and follow-up. TRALE results include a personal wellness report that contains the overall wellness score, a comprehensive assessment of risk in a number of categories, including the highest risk areas, and a personal goal diary. It also describes steps that can be taken to reduce risks. Comparison reports showing progress over a period of time can also be generated. The categories include:

- Overall wellness score
- Healthy habits
- Things to work on
- Overall wellness including current, high risk, or borderline status
- Weight
- Exercise
- Nutrition
- Stress
- Smoking
- Cancer
- Cholesterol
- Blood pressure
- Alcohol
- Heart health
- Gender-specific health
- Disease prevention (e.g., vision test, pap smears, mammograms, prostate, rectal exams, colonoscopies, etc.)
- Back care
- Weight management
- Sleep
- Physical fitness
- Personal goal diary

b. Alere Health Assessment

The Alere Health Assessment is compliant with NCQA Wellness and Health Promotion standards and has the unique ability to combine science, technology, and personal interaction to help people recognize and modify unhealthy behaviors. Avoiding unhealthy behaviors may help members avoid chronic illness and live

longer, more vital lives. The Alere Health Assessment and questionnaire is available online for PrimeWest members to complete at their convenience or can be conducted by telephone if so requested by the member. The Alere Health Assessment includes the following components:

- Blood pressure, cholesterol, and glucose
- HbA1c testing for diabetes risk
- Bone density screening
- Vision and glaucoma screening
- Hearing screening
- Skin cancer risk assessment
- Stress, anxiety, and depression
- Weight management
- Fitness and strength testing
- Back and core testing
- Posture and flexibility assessment
- Clinical measure
- Health history
- Medical care
- Self-care
- Alcohol use
- Nutrition
- Tobacco use

c. Long-Term Care Consultation (LTCC)

The LTCC is a comprehensive assessment to determine a member's needs, including for Home and Community-Based waiver services, and to determine their need for complex case management. PrimeWest care coordinators and county case managers (CCMs) apply this assessment tool.

d. Mental Health-Specific Assessments

Patient Health Questionnaire (PHQ-9)

The PHQ-9 is a concise, self-administered screening and diagnostic tool for depression. The tool has been field-tested, is quick and user-friendly, improves the recognition rate of depression, and facilitates diagnosis and treatment. PrimeWest care coordinators, primary care providers, and mental health providers use this screening tool.

Psychosocial Assessment

This is an evaluation of a patient's mental, physical, and emotional health. It takes into account not only the physical health of the patient, but also the patient's perception of self and his/her ability to function in the community. These components are included in the LTCC and conducted by CCMs and/or PrimeWest care coordinators for the complex case management program. In addition, any member who scores less than 50 on the TRALE would have this additional assessment conducted.

e. Chemical Dependency Assessments

Chemical Dependency - Rule 25

Following the SBIRT screening tool process described above, members identified with a positive alcohol and drug screen or in need of a chemical health assessment due to self-referral, provider referral, or as a result of a legal issue, are referred to their county or tribal social services agency for a Rule 25 assessment. The member is directed to contact the county or tribal intake worker via phone or in person to start the process and request the initial appointment with a qualified Rule 25 assessor. Per MN Rules part 9530.6615, an assessment interview must take place within 20 days of the appointment request. The Rule

25 assessment process takes two to four hours to complete. The assessment evaluates the member's acute intoxication/withdrawal potential, biomedical conditions and complications, mental status, readiness for change, relapse potential, and recovery environment as established by the American Society of Addictive Medicine (ASAM). The Rule 25 assessor also evaluates any immediate needs or concerns at the time of the assessment and makes the appropriate referrals. The Rule 25 assessor completes the Rule 25 assessment, obtains supporting information from two other credible sources such as primary provider or family member(s), and then determines the level of care needed.

Assessors are required to provide members with treatment recommendations within 10 days of the assessment. Members have the right to a second option if they do not agree with the recommendations provided in the initial assessment. Once members agree with the recommendations, they can choose the provider from which they prefer to receive services.

f. Diagnostic Assessment, Functional Assessment, or Civil Commitment

Mental Health Targeted Case Management (MH-TCM), MH-TCM services are part of the PrimeWest CICMP and are provided to children who meet the criteria in MN Stat. sec. 245.4871 for Severe Emotional Disturbance (SED) and adults who meet the criteria in MN Stat. sec. 245.462 for Serious and Persistent Mental Illness (SPMI).

When a member is identified by PrimeWest as potentially needing a diagnostic assessment (DA) or, if we are notified of the identified need by a provider, we will automatically assign a PrimeWest behavioral health care coordinator. The behavioral health care coordinator will contact the member/parent/guardian to determine if they need assistance in finding a provider and/or scheduling the diagnostic assessment and or arranging transportation if needed. No prior authorization is required for this service.

A DA that indicates the member has either SED or SPMI is one of the ways the member is identified and accesses county MH-TCM services and the PrimeWest CICMP. If it is not stated clearly in the DA, the functional assessment is reviewed to determine the level of impairment that would make the member eligible based on statutory criteria. In the case of Civil Commitment, PrimeWest identifies members as being eligible for MH-TCM services and the CICMP upon receipt of notification that the member has started the commitment process. The PrimeWest Behavioral Health care coordinator contacts the appropriate county social services department and refers this member for MH-TCM services.

3. REVIEWS AND ANALYSIS

a. Precertification, Admission, and Readmission Reviews

PrimeWest Utilization Management and Care Coordination team members regularly review Service Authorization; precertification; and hospital admission, readmission, and discharge data to identify members requesting services and treatment that may indicate unmanaged chronic or complex health conditions that are appropriate for care management services through the CICMP.

b. Utilization Data Analysis

PrimeWest Utilization Management team members regularly analyze encounter data from PrimeWest member claims to identify members who may benefit from PrimeWest CICMP services. PrimeWest looks for types of services provided, frequency of services, diagnoses, conditions, or symptoms including, but not limited to, the following:

Monthly

- High dollar claims
- One or more chronic illness diagnoses
- Personal Care Assistance (PCA) services for Level I behaviors (Level I behavior is behavior that requires the immediate response of another person; has occurred in the last 12 months with supporting documentation from professionals such as doctors, nurses, teachers, therapists, etc.; and involves at least one of the following: physical aggression towards self, physical aggression towards others, or destruction of property)
- Frequent emergency room (ER) utilization
- Hospital readmissions within 15 days
- Head trauma or spinal cord injury
- High pharmacy utilization
- Controlled substance use (members receiving controlled substances from multiple providers and multiple pharmacies)
- Use of any of the following types of medication
 - Diabetes medications including insulin and oral hypoglycemics
 - Antidepressant medications
 - Respiratory medications
 - Heart disease medications

Quarterly

- Retrospective Drug Utilization Review (rDUR) quarterly report (identifies members taking high-risk medications and members with adherence issues)

PrimeWest also utilizes software programs that apply clinical algorithms designed to detect treatment failure, complications and co-morbidities, noncompliance, and exacerbation of illness to determine which member may require health care and who may benefit most from CICMP services. Then, based on a member's condition and/or risk factors, the program automates referrals and interventions and continues to monitor the member. These software programs particularly focus on identifying members with chronic disease, treating members with chronic disease, and determining the effectiveness of treatment and care management provided to the member based on the member's health care utilization history. The programs automatically generate a monthly report identifying members who fall within the clinical algorithms.

CareAnalyzer ®

This unique analytic program combines elements of care opportunities, risk, and provider efficiency to provide a more complete member assessment. This software allows PrimeWest to do the following:

- Improve quality of care by identifying manageable gaps in care based on nationally recognized practice guidelines
- Avoid future medical costs by identifying high-risk patients for proactive, targeted intervention
- Engage providers to support more effective patient care
- Use predictive models to supply care managers with actionable data that more effectively target high-risk members who may benefit from early intervention and improved coordination of care
- Give care managers the ability to select the most appropriate intervention: consumer-oriented education/outreach programs, disease management programs, or a more comprehensive case management approach to care

CareConnect™

Integrated care management encompasses medical management, decision support, analytics, and health and wellness and communications applications into a coordinated care delivery model. It allows PrimeWest to do the following:

- Create and maintain program-specific HRAs and care plans for members in care management
- Maintain a complete history of all member activity in care management programs, including all outreach and educational materials
- Store historical clinical data such as lab results and prescribed and over-the-counter drugs
- Automate problems, goals, and tasks based on responses to assessments configured by the care plan
- Manage daily activities and share tasks and goals with other care team members
- Integrate with commercially available clinical guidelines and educational content
- Provide real-time integration with claims administration systems for accurate, timely eligibility and benefit information
- Support real-time integration with Utilization Management (authorizations and referrals)
- Remove synchronization problems and the need for multiple system logins for nurses to gather required information

B. Individualized Health Needs Triage

The PrimeWest Care Coordination team determines whether the member could benefit from care management based on the results of the assessments and reviews. If care management is not indicated, the member is assigned to the Wellness Pathway and is assigned a PrimeWest care coordinator or specialist who can assist the member with maintaining good health. If care management is indicated, a PrimeWest care coordinator manager with expertise in the areas of the member's identified health needs is assigned triage lead.

1. Stratification

The PrimeWest care coordinator and county case management assessor, with input from the member's primary care provider, determine the indicated type and intensity of care management based on the results of the needs assessment, health records review, and utilization review. In the ARCH program, the member's ARCH Health Home primary care provider and care coordinator determine type and intensity with input from the PrimeWest care coordinator and county case management assessor. Type refers to the care management pathway most appropriate for

managing the member's identified health needs, and intensity refers to the level of care management the member might require ranging from basic care system navigation assistance to complete care planning and care coordination services. Care management pathways include:

- Wellness
- Acute care
- Complex care
- Chronic disease (including co-morbid physical chronic conditions)
- Mental health
- Mental Health-Targeted Case Management
- Chemical dependency (CD)
- Co-occurring chronic medical and mental health
- Behavioral health dual diagnosis (mental health and substance abuse)
- Prenatal

2. Care Management Pathways

Note: If a PrimeWest member is an attributed member of an ARCH Health Home, the ARCH Health Home care coordinator performs the functions of the PrimeWest care coordinator described in the various pathways below. The PrimeWest care coordinator assumes a support role, providing the ARCH care coordinator and Interdisciplinary Care Team (ICT) provider access and coordination support, topical technical guidance as requested, and care and utilization data analytics support particularly focused on member utilization of services not provided by the ARCH Health Home.

a. Wellness Pathway

Our Wellness Pathway includes our new Member Action Program (MAP) which is designed to motivate and incent members to manage their health and seek preventive services in a timely manner. The Wellness Pathway is designed for members whose HRA results do not indicate any health needs requiring care management. These members are contacted by a PrimeWest care coordinator or care navigator to congratulate them on their results and ask if the member would like any assistance from PrimeWest in managing their good health. Based on the member's response, PrimeWest provides wellness services navigation support and/or wellness support education and materials, and the member is assigned a PrimeWest care coordinator or care navigator as the member's wellness management lead. We will also provide the member information about accessing the online Alere program for supporting wellness. Finally, PrimeWest will call and/or mail the member preventive care visit reminders based on Health Effectiveness Data and Information Set (HEDIS) standards and timelines to help ensure he/she gets needed preventive tests and care in a timely manner. PrimeWest will then continue to monitor the member's health care utilization patterns from our claims data for any indications that the member's health is diminishing. Members are also encouraged to complete an HRA at least annually and following any significant health event such as an inpatient hospital admission.

b. Acute Care Management Pathway

This pathway is for members who experience inpatient hospitalization(s). Members in this pathway are triaged by levels.

Level 1: Members in this level are those being hospitalized for an acute illness or injury who haven't had previous hospitalizations for the same diagnosis. The member is assigned a PrimeWest care coordinator with expertise in the area of the member's hospitalization diagnosis as care management lead. The care coordinator assists the member and the hospital discharge planner in arranging post-discharge services and ensuring member compliance with follow-up care recommendations. The care coordinator calls the member one week after discharge to ensure that: 1) the member's needs are being met, 2) he/she is following through on post-discharge care recommendations, and 3) his/her condition is stable. The care coordinator then determines the type and frequency of follow-up thereafter based on the hospitalization diagnosis, the member's primary care provider's recommendations, and the desires of the member.

Level 2: Members in this level are those who are hospitalized at least twice within 30 days, regardless of the readmission diagnosis. The member is assigned a PrimeWest care coordinator with expertise in the area of the member's hospitalization diagnosis. The care coordinator assists the member and the hospital discharge planner in arranging post-discharge services and ensuring member compliance with follow-up care recommendations. The care coordinator calls the member one week after discharge to ensure that: 1) the member's needs are being met, 2) he/she is following through on post-discharge care recommendations, and 3) his/her condition is stable. If the member is doing well post-discharge, the care coordinator will follow the member for 3 months post-discharge. This includes twice-monthly phone calls in the first month post-discharge and then monthly phone calls in months 2-3. The member may request more frequent contact or request an extended time frame for the contact. If the member is struggling post-discharge, the member is referred to the Complex Care Management Pathway.

Level 3: Members in this level are those who are hospitalized at least three times within the last month and/or have two readmissions within 30 days in the last 12 months. Members in this level are immediately referred to the Complex Care Pathway.

c. Complex Care Management Pathway

This pathway is for PrimeWest members whose conditions and/or related diseases have deteriorated to the point where they are at risk for hospitalization. These members are assigned a county complex care case manager and PrimeWest Disease Management Care Coordinator (DMCC) and follow the Individualized Care Plan (ICP) process to prevent the member's condition from deteriorating further. This Complex Care Management Pathway extends to Levels 2 and 3 Acute Care Pathway members whose conditions, if not managed, risk further hospitalization.

d. Chronic Disease Management Pathway

The pathway is for members with one or more diagnosed physical chronic diseases. The members are assigned a PrimeWest DMCC as care management lead. These members also complete a disease specific questionnaire and the HRA. The DMCC reviews the results for clinically significant signs and symptoms as identified by evidence-based guidelines and notifies the member's primary care provider of the results. Based on the results, the member follows one of two intensity care management pathways:

Level 1: Members in this level have one or more chronic diseases that are being well-managed by the member and his/her providers. Members are assigned a PrimeWest DMCC as care management lead. The DMCC provides members and their providers with monitoring, care navigation, and coordination support. This includes the following through regular contact with the member:

- Monitoring and ensuring Medication Therapy Management (MTM) adherence
- Monitoring and ensuring adherence to evidence-based disease management and treatment plans
- Monitoring member's provider(s) adherence to evidence-based chronic disease management guidelines
- Providing reminders to members of provider visits, tests, and immunizations
- Assisting members with accessing specialty providers, support groups, county case management, social services, and public health, when indicated
- Sending members educational materials regarding disease management self-care
- Facilitating any transition of care episodes related to the chronic condition
- Monitoring for signs or symptoms of deteriorating health and reporting these to the member's primary care provider

Level 2: Members in this level are those whose chronic conditions are not well-managed, whose chronic disease signs or symptoms are not under control, and/or whose condition has resulted in one or more hospitalizations to stabilize. Members in this level are assigned a CCM and PrimeWest DMCC and follow the ICP process, following evidence-based management guidelines established for managing the member's specific chronic disease(s).

e. Mental Health Pathway

Members diagnosed with a mental illness are identified through PrimeWest health care utilization data reviews and provider referrals. The following criteria apply to this pathway:

For children under age 18:

- Emotional Disturbance (ED): Emotional disturbance means an organic disorder of the brain, or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that does both of the following:
 - Has an ICD-9-CM or corresponding DSMIV-TR/DSM 5 diagnosis between 290.0-302.99 or 306.0-316.0
 - Seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation
- Severe Emotional Disturbance (SED): An emotional disturbance is present, along with one of the following criteria:
 - Child has been admitted to inpatient treatment/residential treatment within the last three years, or is at risk of being admitted
 - Child is receiving inpatient treatment or residential treatment of an emotional disturbance
 - As determined by a mental health professional, the child has one of the following:
 - Psychosis or clinical depression
 - Risk of harming self or others as a result of being a victim of physical or sexual abuse or psychic trauma

- Psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the past year
- As determined by a mental health professional, the child experiences significantly impaired home, school, or community functioning lasting one year or at risk of lasting one year, as a result of emotional disturbance

For adults ages 18 and up:

- Serious Mental Illness (SMI): Currently or at any time during the past year has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet criteria specified within the ICD 9 code ranges 290.0-302.9 or 306.0-316 in the DSMVI-TR/DSM 5 with the exceptions of V codes, substance use disorders, and developmental disorders, unless they co-occur with another diagnosable SMI and one of the following applies:
 - Has at least a) moderate impairment in at least four, b) severe impairment in two, or c) extreme impairment in one of the following areas: 1) Feeling, mood, and affect, 2) Thinking, 3) Family, 4) Interpersonal, 5) Role performance, 6) Socio-legal, 7) Self-care/basic needs
 - Has a duration of illness of at least one year and a) at least moderate impairment in two, or b) severe impairment in one of the areas listed in the bullet above
- Serious and Persistent Mental Illness (SPMI)
 - Member had two or more episodes of inpatient care for mental illness with the past 24 months
 - Member had continuous psychiatric hospitalization or residential treatment exceeding six months duration within the preceding 12 months
 - Member has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder; evidences a significant impairment in functioning; and has a written opinion from a mental health professional stating he/she is likely to have future episodes requiring inpatient or residential treatment unless community support program services are provided
 - Member has, in the last three years, been committed by a court as a mentally ill person, or the adult's commitment as a mentally ill person has been stayed or continued
 - Member was eligible as a child with severe emotional disturbance, and the recipient has a written opinion from a mental health professional in the last three years stating that he/she is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in the above criteria, unless ongoing case management or community support services are provided
 - Member has been treated by a crisis team two or more times within the preceding 24 months

Level 1: Members in this level are those who have a mental illness but who do not require continuous mental health services or psychiatric medications through their primary care provider. These members are assigned a PrimeWest Behavioral Health Care Coordinator (BHCC) as their care management lead. The BHCC provides care navigation assistance for accessing preventive care, seeking an annual psychiatric visit, and/or additional services if identified as a need through the HRA. The BHCC follows the member with monthly phone

calls for 3 months and then follows up 3 months later unless the member requests additional follow-up.

Level 2: Members in this level are identified as having SMI (for adults), or an ED (for children). These members are assigned a BHCC as care management lead. The BHCC level of care management services are needed to address the member’s needs from care navigation to the full scope of care management services. The BHCC follows the member through his/her treatment progress monthly for 3 months and quarterly thereafter. If the member’s mental health condition diminishes, the member is assigned a CCM and follows the ICP process. If the condition abates, the CCM refers the member back to the Level 1 pathway, and the BHCC follows up with the member at least once a month for the first 3 months and quarterly for the next 2 quarters after or longer if requested by the member.

Level 3: Adult members in this level are identified as having an SPMI; child members in this level are identified as having an SED (for children). These members will automatically be referred for MH-TCM Pathway.

f. Mental Health Targeted Case Management (MH-TCM) Pathway

This pathway is for members with SPMI and SED. This pathway follows State requirements for MH-TCM and involves the full scope of care managed services described in the Care Management Process section. The county adult MH-TCM case manager is care management lead and is supported by a PrimeWest BHCC who provides technical support, provider network service access coordination, and member service utilization notification and reporting. The table below includes the list of responsibilities of the Adult Mental Health Targeted Case Manager and the PrimeWest BHCC.

Mental Health Targeted Case Management Responsibility Grid and Process	
Adult Mental Health Targeted Case Manager (case manager)	PrimeWest Behavioral Health Care Coordinator (BHCC)
When county social services identifies a member who may be eligible for MH-TCM, they send the member notice of potential eligibility within five days of referral	When PrimeWest identifies that a member is eligible for MH-TCM services but does not currently receive them, the care coordinator sends a letter notifying the member/parent/guardian of his/her eligibility. The letter includes contact information for the member's county social services agency.
Case manager will contact PrimeWest if the member accepts MH-TCM	BHCC contacts the county to ask it to assign a case manager and offer the member MH-TCM
Case manager completes the MH-TCM Service Authorization form and sends this form to PrimeWest Utilization Management with the current diagnostic assessment or documentation that the member meets other eligibility criteria	Care coordinator processes Service Authorization form for MH-TCM services. Service Authorization is for three years from the date of the diagnostic assessment. The BHCC then notifies the case manager of Service Authorization approval or denial.

Mental Health Targeted Case Management Responsibility Grid and Process	
<p>Adult Mental Health Targeted Case Manager (case manager) Case manager contacts the member within 15 days of eligibility determination, either by phone or in writing</p>	<p>PrimeWest Behavioral Health Care Coordinator (BHCC) BHCC notifies the case manager either by email or phone of hospitalizations or admissions to any facility, and coordinates with the case manager for discharge planning</p>
<p>Case manager completes a written functional assessment and develops, together with the member, an individual community support plan (ICSP) based on the client's diagnostic assessment and needs within 30 days after the first meeting</p>	<p>BHCC collaborates with the case manager to ensure that all mental health needs are met and helps the case manager access services, supports, benefit set, and formulary exceptions, as well as answer other questions about processes or member needs</p>
<p>Case manager reviews and updates the member's ICSP according to his/her needs at least every 180 calendar days after the development of the first plan and at the same time reviews the member's functional assessment as specified in MN Rules part 9520.0919, subp. 2</p>	<p>BHCC collaborates with the case manager regarding any placement and participates on the Intensive Review Team meetings at the county either in person or by phone</p>
<p>Case manager monitors the member's progress toward achieving the outcomes specified in the ICSP and reports progress toward these outcomes to the member and other members, if any, of the case management team at the time of the member's ICSP review</p>	<p>BHCC processes the MH-TCM <i>Notice of Action</i> form and sends a <i>Denial, Termination, or Reduction of Services (DTR) Notice</i> to the member if the reason for closure meets the requirements of a DTR</p>
<p>Case manager involves the member and the member's family, physician, mental health providers, other service providers, and other interested persons in developing and implementing the ICSP to the extent possible and with the member's consent</p>	<p>BHCC conducts annual MH-TCM audit in conjunction with the Behavioral Health Manager following established NCQA file review protocols</p>
<p>Case manager arranges for a standardized assessment, by a physician of the member's choice, for the side effects related to the administration of the member's psychotropic medication, if applicable</p>	<p>BHCC coordinates and/or conducts needed and requested trainings for case managers</p>
<p>Case manager attempts to meet with the member at least once every 30 calendar days or at least once within a longer interval of between 30 and 90 calendar days as specified in the member's ICSP</p>	

Mental Health Targeted Case Management Responsibility Grid and Process	
Adult Mental Health Targeted Case Manager (case manager)	PrimeWest Behavioral Health Care Coordinator (BHCC)
Case manager is available to meet with the member at his/her request more frequently than specified above	
Case manager actively participates in discharge planning for the member and, to the extent possible, coordinates services necessary to help with the member's smooth transition to the community if he/she is in a residential treatment facility, regional treatment center, correctional facility, or any other residential placement, or an inpatient acute psychiatric care unit	
Case manager informs the member of his/her right to Appeal as specified in MN Stat. sec, 245.477, if the mental health services needed by the member are denied, suspended, reduced, terminated, or not acted upon with reasonable promptness, or are claimed to have been incorrectly provided	
Case manager completes a MH-TCM <i>Notice of Action</i> form when services are being ended and sends it to the PrimeWest BHCC	

g. Chemical Dependency Pathway

Members in this pathway are those for whom PrimeWest has received a Client Placement Authorization (CPA) form from a Rule 25 assessor indicating the level of treatment recommended and provider selected by the member for chemical dependency treatment. The PrimeWest Chemical Dependency Care Coordinator (CDCC) reviews the results of the Rule 25 assessment and authorizes treatment based on the recommendation provided by the Rule 25 assessor and includes the severity ratings listed for the ASAM six dimensions. The CDCC then communicates via phone or secure email with the Rule 25 assessor and selected chemical dependency treatment provider to arrange the start date of treatment, assist the member with any identified transportation needs, make referrals required for physician or pharmacy use while in treatment, and conduct follow-up post-discharge. All of the information gathered from the CPA document forms the basis of the member's ICP. Members who have CD issues follow one of three levels of care management.

Level 1: Members who meet this level are those who are entering treatment for the first time. These members are assigned a CDCC as their care management lead. The CDCC, in collaboration with the county or American Indian Tribe Rule 25 assessor, follows members during their treatment to ensure their treatment needs are met. The CDCC obtains the

discharge summary and works with the member to set up the services and supports that are recommended in the discharge summary. Aftercare follow-up occurs for 6 months post-discharge and includes a monthly phone call from the CDCC, or more often if the member requests.

Level 2: Members who meet this level are those who are experiencing a relapse after treatment. These members are assigned a CDCC as care management lead. The CDCC, in collaboration with the county or American Indian Tribe Rule 25 assessor, follows the member during his/her second round of treatment and ensures that his/her treatment needs are met. The CDCC and Rule 25 assessor discuss the member's progress during treatment. If the member is doing well in treatment, the CDCC follows the member post-discharge for 9-12 months. This includes weekly phone calls during the first month post-discharge, twice-monthly phone calls in months 2-6, and monthly phone calls in the last 3-6 months. More follow-up contact is provided if desired by the member. If the member is struggling with treatment, a referral to the county for complex case management is made. The member's county complex case manager then leads care management and follows the member for 6 months post-treatment with face-to-face visits conducted a minimum of one time per month. If the member and CCM agree that the face-to-face level of service is no longer needed, the CDCC follows the member for an additional 6 months after the CCM has transferred care management to the CDCC.

Level 3: Members who meet this level are those experiencing their second or more relapse after treatment. These members are assigned a county complex case manager as their care management lead. The case manager, in collaboration with the county or American Indian Tribe Rule 25 assessor if the case manager is different than the Rule 25 assessor, follows the member during the treatment and ensures that his/her treatment needs are met. The CDCC, CCM, and Rule 25 assessor discuss the members' progress during treatment. The CCM follows the member post-discharge for 18 months. This includes weekly phone calls during the first 2 months post-discharge, twice-monthly phone calls in months 3-9, and monthly phone calls in months 10-18. More contact is provided if desired by the member. At the end of the 18 months, the member is referred to the CDCC and receives follow-up at a frequency level determined by the member's ICT.

h. Co-occurring Chronic Medical and Mental Health Care Management Pathway

This pathway is designed for members who struggle with physical chronic disease and mental illness and need assistance based on the severity of the co-existing conditions. In addition to receiving the appropriate level of services identified below, members in this pathway are referred to the PrimeWest Behavioral Health Integrated Care Program if offered by a nearby medical clinic.

Level 1: Members who meet this level have a chronic physical disease and a mental illness, and have experienced one hospitalization for one or both of the conditions, or are identified on the monthly high utilizer list. The member is assigned a PrimeWest Behavioral Health Care Coordinator (BHCC) as care management lead. The BHCC assists the member and the hospital discharge planner in arranging recommended post-discharge services and ensuring follow-up care services/treatment adherence. The BHCC calls the member one week after

discharge to ensure that the member's needs are being met and that his/her conditions are stabilized. If the member makes a request, or the BHCC determines it is clinically appropriate, the BHCC follows the member for 3 months post-discharge with a phone call at least one time per month. If the member's condition(s) worsen, the member moves to Level 2 care management.

Level 2: Members in this level have at least two chronic disease conditions and a mental illness or one chronic disease and a Serious Mental Illness (SMI), and they have experienced on hospitalization for any one of the conditions or are identified on the monthly high utilizer list in more than one area. The member is assigned a PrimeWest Behavioral Health Care Coordinator (BHCC) as care management lead. The BHCC assists both the member and the hospital discharge planner, and will assist them in setting up the recommended post-discharge services and follow-up recommendations. The BHCC calls the member one week after discharge to ensure that the member's needs are being met and that his/her conditions are stabilized. If the member is doing well post-discharge, the BHCC will follow the member post-discharge for 3 months. This includes twice-weekly phone calls during the first month post-discharge and monthly phone calls for the last 2 months. If the member requests more frequent contact or an extended time frame for contact, this will be provided by the BHCC. If the member is struggling post-discharge, a referral to the county for complex case management. The member is assigned a county complex care case manager and follows the ICP process. The county complex care case manager follows the member for 3 months post-treatment with face-to-face visits conducted a minimum of one time per month. If the member and CCM agree that the face-to-face level of service is no longer needed, the BHCC will follow the member for an additional 3 months after the CCM has transferred care management to the BHCC.

Level 3: Members who meet this level are identified as having at least three chronic physical conditions and a mental illness/SMI or have one chronic physical condition and have a Serious Persistent Mental Illness (SPMI), and have experienced a hospitalization for any one of the conditions or been identified on the monthly high utilizer report. For members who meet the criteria for three chronic physical conditions and a mental illness/SMI, the member is assigned a CCM and follows the ICP process. The CCM follows the member post-discharge for 18 months. This includes weekly phone calls in the first 2 months post-discharge, twice-monthly phone calls in months 3-9, and monthly phone calls in months 10-18. If the member would like more contact, it will be provided. At the end of the 18 months, the member will be assigned a CDCC or BHCC and followed up at a frequency level determined by the ICT. If the member meets SPMI criteria, he/she will be referred to the county for MH-TCM services, and will follow the program as described above.

i. Behavioral Health Dual Diagnosis Pathway

This pathway is designed for members who struggle with CD and mental illness. These members follow a collaborative care management pathway with the PrimeWest CDCC and BHCC as care management co-leads. Members follow one of three levels of care management.

Level 1: Members in this level are those who are entering dual diagnosis treatment for the first time. These members are assigned both a CDCC and BHCC for coordination of both the CD treatment and their mental health treatment. The CDCC and BHCC, in collaboration with the county or American Indian Tribe Rule 25 assessor, follow the member during his/her treatment to ensure his/her treatment needs are met. The CDCC obtains the discharge summary from the dual diagnosis treatment center and works with the BHCC, the member's ICT, and the member to implement the member's care plan, including arranging and coordinating services and supports recommended in the discharge summary for both CD and mental health follow-up. Aftercare follow-up occurs for 6 months post-discharge. This includes monthly phone calls from the CDCC or the BHCC. More frequent contact is provided if needed or requested by the member.

Level 2: Members who meet this level are those who are experiencing a relapse after dual diagnosis treatment in either their CD treatment or their mental health treatment (this includes members with SMI). Relapse for CD means the resumption of use of their substance of choice or another substance, relapse for mental health is when members fail to follow their psychiatric medication therapy and/or their outpatient services care plan. Depending on the nature of which illness is primary, members will be assigned a CDCC or the BHCC as their care management lead. The CDCC/BHCC follows the member during his/her second round of treatment and, in collaboration with the county or American Indian Tribe Rule 25 assessor and the member's mental health provider, ensures that his/her treatment needs are met. The CDCC/BHCC and Rule 25 assessor and mental health provider discuss the member's progress during treatment. If the member is doing well in his/her treatment protocol, the CDCC/BHCC follows the member post-discharge for 9-12 months. This includes weekly phone calls during the first month post-discharge, twice-monthly phone calls in months 2-3, and monthly phone calls in the last 3-6 months. More frequent contact is provided if requested by the member. If the member is struggling with treatment, the member is referred to the county for complex case management. The county complex care case manager follows the member for 6 months post-treatment with face-to-face visits conducted a minimum of one time per month. If the member and case manager agree that this level of contact is no longer needed, the PrimeWest CDCC or BHCC follows the member for an additional 6 months.

Level 3: Members who meet this level are those who are experiencing their second or more relapse after dual diagnosis treatment and have an SMI or SPMI. Members who are SMI members in this level follow the ICP process and are assigned a county complex care case manager and both a PrimeWest BHCC and CDCC. The county complex care case manager, in collaboration with the county or American Indian Tribe Rule 25 assessor (if the case manager is different than the Rule 25 assessor) and mental health provider, follows the member during the treatment and ensures his/her treatment needs are met. The CDCC, BHCC, CCM, Rule 25 assessor, and mental health provider discuss the member's progress during treatment. Post-discharge care planning is conducted with the member by the case manager, BHCC, and/or CDCC and primary outpatient CD and mental health provider. The case manager follows the member post-discharge for 18 months. This includes weekly phone calls in the first 2 months post-discharge, twice-monthly phone calls in months 3-9, and monthly phone calls in months 10-18. More contact is provided if needed or requested by the

member. At the end of the 18 months, the PrimeWest BHCC or CDCC follow the member at a frequency level determined by the member's ICT. If the member meets SPMI criteria at any time during the process, the member moves to the MH-TCM pathway.

In addition to the above, members in this pathway are also referred to the PrimeWest Behavioral Health Integrated Care Program if offered by a nearby medical clinic.

j. Prenatal Care Management Pathway

Members in this pathway are identified as pregnant through self-reporting, enrollment rate cell assignment, the Minnesota Pregnancy Assessment Form, PrimeWest claims data, or provider referrals. The PrimeWest Women and Children Care Coordinator (WCCC) immediately notifies the member's county public health department of the pregnancy, and public health offers prenatal and parenting services such as the Nurse Family Partnership Program, lactation services, and prenatal classes. The WCCC provides the member care navigation assistance for scheduling prenatal care visits as needed or requested by the member and monitors the member's prenatal and health care utilization. PrimeWest's prenatal care management pathway also includes our Bright Start program. Bright Start is a collaborative effort involving PrimeWest, primary care providers, county public health nurses, and our members who are expecting.

C. Person-Centered Care Management

PrimeWest's individualized care management activity and processes are based on the member's assessed needs, preferences, and priorities. The needs assessment, member choice, and triage process point the direction to the care management pathway most appropriate for the member, and stratification helps define what level of care management services are needed to best help our member address his/her needs. Care management services include the following activities and services:

1. Care Navigation

Care Navigation is provided to all members who just need some assistance to access health care services and/or manage their health needs or the needs of their PrimeWest child members. Typically, these are members in Level 1 of all Care Management Pathways. PrimeWest Care Navigation personally assists our members with finding providers and setting appointments and appointment reminders; scheduling preventive care services; and understanding their MHCP-covered services, their member rights and responsibilities, and various PrimeWest member-related policies. Each member is assigned a PrimeWest Care Navigator with whom the member can develop a lasting and trusting rapport and rely on by name to respond promptly to his/her questions and concerns.

- a. Dental Care Navigation – Many MHCP participants across Minnesota experience great difficulty in accessing dental care in a timely manner due to the limited number of dental providers who will accept MHCP patients. This is particularly the case in rural Minnesota, including the 13 rural counties served by PrimeWest. While PrimeWest's dental provider network is now quite large, many of our members are not taking advantage of this access or seeking needed preventive and restorative dental care in a timely manner. Therefore, PrimeWest developed a care navigation service specific to dental care. The PrimeWest

Dental Coordinator and Member Care Navigators reach out and assist members in finding a dental provider, establishing a dental care home, and making and keeping dental appointments. PrimeWest also provides our members with education and materials on the importance of oral health including seeking dental care in a timely manner.

2. Care Coordination

The goal of care coordination is to ensure a member receives timely and appropriate care from multiple providers delivering care services for his/her assessed needs. Care coordination safeguards against gaps in services and confusing or conflicting duplication of services. Care coordination is for members whose health care and/or psychosocial needs require a more involved level of support and assistance than care navigation. PrimeWest's care coordinators are highly qualified and knowledgeable health and human services professionals. The care coordinator is the member's care management lead for Levels 1 and 2 in most Care Management Pathways. The care coordinator helps the member identify needed service providers, make and keep appointments, make health care transportation arrangements, adhere to medical and behavioral health treatment plans, and follow medication therapies. The care coordinator also monitors the member's care utilization patterns for indications of diminished health or breakdowns in timely coordinated care delivery. If such breakdowns occur, the care coordinator works with the member's providers to address the problem(s). Care coordination is offered to the member regardless of whether the member has completed an ICP through the PrimeWest CICMP.

3. Case Management

Case management is a highly individualized process for addressing a member's assessed needs. Case management involves planning, identifying, coordinating, monitoring, and evaluating the health care, human services, and service providers who will address the member's needs and help him/her realize his/her personal health goals. A CCM assumes the care management lead role when a PrimeWest member requires this level of support. Members can select their CCM or one is assigned to the member. The assigned CCM has expertise in the areas of the member's assessed need(s). The case manager is responsible for collaboratively developing, implementing, monitoring, and evaluating the member's care plan with the member, the member's PrimeWest care coordinator, the member's primary care provider, and member's ICP services providers. The case manager, with support from the care coordinator, ensures the member is receiving all care plan services in a timely, appropriate, and coordinated manner. The case manager maintains regular face-to-face and/or phone contact with the member to continuously assess the member's progress, health status, and overall health care patient experience.

4. Person-Centered Care Planning

The member's ICP is collaboratively developed by the member, family, and/or authorized representative, and the member's CCM, PrimeWest care coordinator, primary care provider, and other providers currently involved in his/her care.

The ICP establishes the member's prioritized personal health goals and identifies the services, including preventive care, most appropriate for addressing the member's needs that have been identified through the various health assessments conducted with the member. The ICP addresses assessed medical, mental health, chemical health, psychosocial, functional, cognitive,

and cultural needs. The ICP incorporates any existing care or treatment plan information already in place for the member (e.g., ICSP for MH-TCM) in order to integrate MHCP-covered and non-covered services in the ICP and to avoid including duplicative or conflicting services and treatment. The ICP also establishes measurable care and treatment objectives and outcomes. And, it identifies barriers to meeting these objectives and the member's personal health goals. Finally, the member chooses the providers and community organizations that will provide the ICP services. These service providers, along with the member, family, and/or authorized representative, and his/her CCM, PrimeWest care coordinator, and primary care provider comprise the member's ICT. Composition of the beneficiary's ICT is evaluated annually and when any changes in service needs or staffing are identified. Members of the ICT may include, but are not limited to, the following:

- Member or authorized representative
- Member's family
- Tribal organizations, Veterans Administration, and community organizations
- Primary care provider
- Clinic-based care coordinator
- Medical specialists
- Long-term services and supports provider(s)
- County social worker
- County public health nurse
- Nurse educator
- Rule 25 assessor
- Physical therapist
- Occupational therapist
- Speech therapist
- Mental health provider
- Chemical dependency treatment provider
- Dietitian or nutritionist
- Pharmacist
- Disease management specialist
- Pastoral specialist
- Preventive health specialist/health promotion specialist
- Other providers and/or specialties as appropriate

Once the ICP is completed, the member or authorized representative receives a copy of the ICP, and the ICP is downloaded into the PrimeWest Electronic Care Plan (ECP) program. Once the ICP is implemented, the member's CCM and PrimeWest care coordinator maintain contact with the member as indicated in the Care Management Pathway the member is following. The case manager also assists the member in making and keeping ICP service appointments, including assisting with transportation arrangements. The PrimeWest care coordinator ensures all ICP services and providers are prior authorized to prevent any administrative delays in the member receiving ICP services.

5. ICP Monitoring

The member's case manager, PrimeWest care coordinator, and ICT (including the member) evaluate the progress the member is making toward his/her ICP goals and adherence to the ICP. ICP service, care, and progress notes, along with updates, are entered by the case manager and ICT providers using the PrimeWest ECP and care management software system. The ECP enables the ICT to enter and communicate ICP information in real time. The ECP serves to virtually integrate the providers around the member's ICP and facilitates care coordination among multiple independent providers and organizations involved in the member's care. The ECP also allows the case

manager and care coordinator to evaluate the member's ICP progress in real time. The ECP is a web application that enables providers to jointly create and update care plans for their clients using only their web browser secured over Secure Sockets Layer (SSL). All data is secured in the PrimeWest network with backups occurring daily. Reports like the Wellness Checklist and (In)Formal Services (community support services identified to facilitate optimal outcomes—aimed at supporting the member and/or family) are built into the web application and can be viewed and saved as a PDF. Auditing features are provided as well. This includes client access where a report can be generated to know who created, updated, and archived the care plan and when.

The member's CCM and PrimeWest care coordinator facilitate communication with and among the entire ICT. Communication occurs through phone and secure email, through documentation in PrimeWest's ECP, and through ICT meetings. The frequency of face-to-face and/or teleconference meetings of the ICT meetings is based on member need and preference. The care coordinator also monitors and communicates the member's utilization patterns from PrimeWest claims data to ensure the member is receiving ICP services as planned and to watch for unplanned service utilization which may indicate a change in the member's health status. A significant change in the member's health status or significant unplanned health care event is reported to the appropriate members of the ICT to determine whether the member should be reassessed or the ICP modified to address the change or event. The care coordinator disseminates utilization data and reports to the member's case manager and primary care provider as well as other ICT members as necessary to assist them in their role in the ICP.

6. ICP Evaluation

Unsatisfactory progress toward achieving the member's ICP goals and ICP care and service objectives and outcomes may also trigger the need to revisit the ICP to identify and address any barriers impeding the member's progress. Any recommended changes to the ICP are discussed with the member, and, if the member agrees, the ICP is updated accordingly. The PrimeWest ICT, including the member, evaluates progress toward ICP goals and ICP care and service objectives and outcomes. If the member has not achieved his/her ICP goals by the end of the ICP term, the member's needs and risks are reassessed, and the ICP development, implementation, and monitoring process is repeated, taking into consideration any new results from the reassessment and lessons learned from the previous ICP.