Complex Care Management

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HUSKY HEALTH
CONNECTICUT

Connecticut Department of Social Services
Making a Difference

HUSKY Health Medical ASO Services to Support Care Management

- Care management is a system of collaborative processes which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs and promote quality, cost-effective improved health outcomes for members who have complex or specific healthcare needs
- HUSKY Health's Care Management teams provide care, coaching, and resource coordination to support and empower members to help them take control of managing their healthcare needs
- Care management focus includes high-risk, high-need members which includes those with frequent hospitalizations or emergency department (ED) visits

CHNCT Care Management Teams

- Intensive Care Management (ICM)
  - Concentrates on enhancing the health and quality of life for HUSKY Health members identified as having the greatest need in managing complex co-morbid health conditions and/or behavioral health conditions
- Emergency Department Care Management
  - Targets members while in the ED who have specific health conditions and work with hospital staff to coordinate post-discharge care and services for these members
  - Its interventions are focused on members with ED visits for the specific health conditions of asthma, diabetes, and sickle cell disease (SCD)
- Inpatient Care Management
  - Performs utilization review of inpatient admissions and supports the hospital care managers and discharge planners. Inpatient Care Management nurses coordinate and make referrals to the Connecticut Behavioral Health Partnership (CT BHP) for members with behavioral health needs while inpatient
  - Provides notice to the relevant prior authorization teams when the need for immediate services in the home becomes apparent to help ensure medically necessary services are in place at the time of discharge
- Inpatient Discharge Care Management
  - Provides intensive discharge planning for members with targeted chronic conditions or who are at risk for readmissions
  - The Inpatient Discharge Care Management staff is either embedded at hospitals with high admission volume where they meet with the member face-to-face at bedside or they coordinate telephonically with the member and hospital staff for lower volume admission hospitals
- Transitional Care Management
  - Conducts outreach calls to members post-hospital discharge to ensure that follow-up appointments and post-discharge services are in place and/or coordinate care for any newly assessed needs
  - Conducts outreach to members with targeted conditions who have gaps in care

Intensive Care Management

- Intensive Care Management (ICM) is a voluntary, person-centered program developed to support HUSKY Health members in reaching their health goals through education and access to quality healthcare
- The ICM team recognizes that members present with complex needs and barriers that place them at higher risk for poor health outcomes. The ICM program strives to minimize barriers by utilizing a culturally aware and person-centered approach that recognizes that many factors can impact a person's ability to successfully manage their health, such as:
  - Behavioral
  - Cultural
  - Environmental
  - Financial
  - Physical
  - Social Determinants of Health

ICM Model Design

- Goals of the ICM Program
  - Assist with identifying barriers and strengths
  - Encourage participation with provider treatment plans
  - Empower members to take control of their conditions
  - Promote health and wellness
  - Improve healthcare outcomes
  - Promote cost savings
- ICM Regionalized Care Teams consist of:
  - Registered Nurses, Community Health Workers, Behavioral Health Clinicians, Registered Dieticians, Administrative Care Coordinators, Pharmacists
- Member engagement is through multiple forms:
  - Face-to-Face visits with the member in the community
  - Videoconferencing between ICM and the member
  - Telephonic Outreach

Who are the ICM Complex Members?

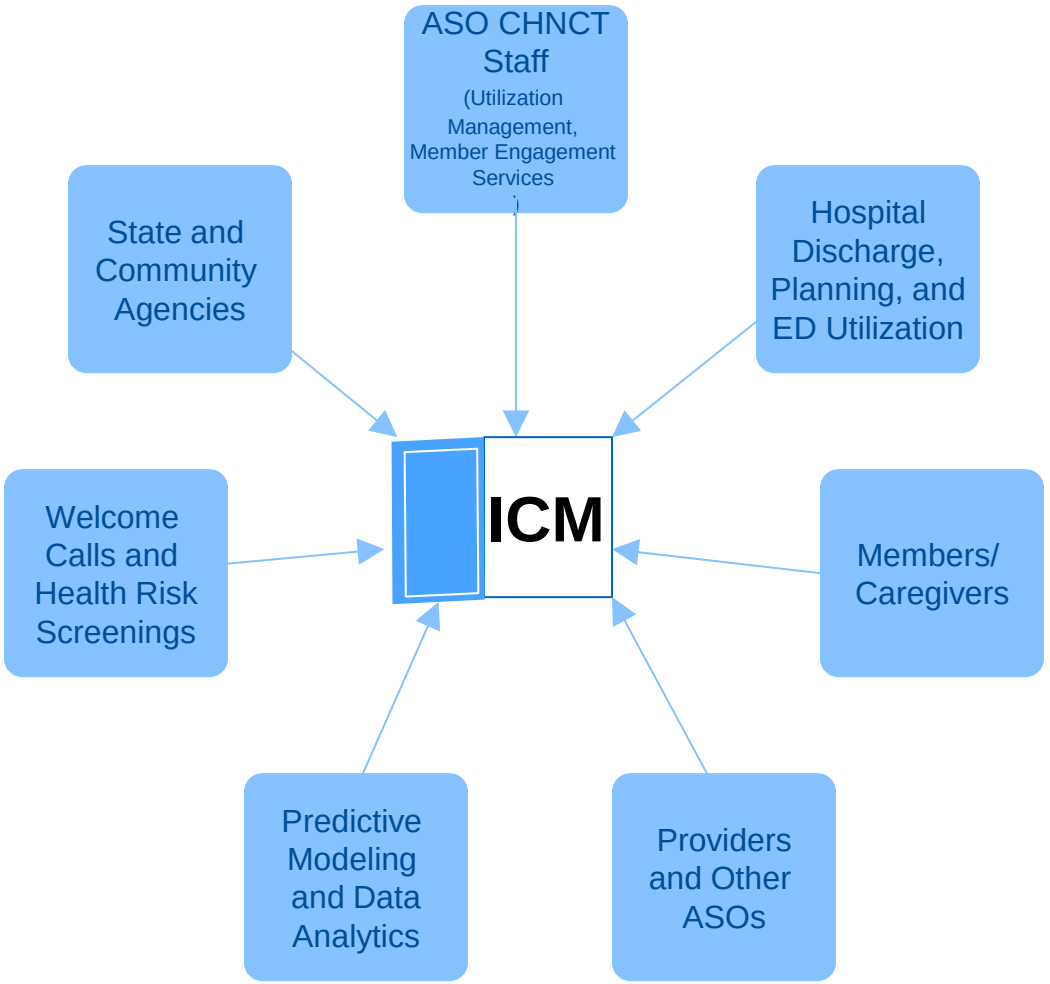
Members who are engaged in ICM are those who need help managing complex, co-morbid health conditions and/or behavioral health conditions. ICM will assist with:

- Chronic conditions, (e.g. coronary heart disease, heart failure, chronic obstructive pulmonary disease [COPD], chronic pain, gender dysphoria, children and youth with special healthcare needs, and substance abuse)
- Coexisting medical and behavioral health conditions including Serious and Persistent Mental Illness (SPMI)
- Need for Condition/Disease Care Management:
  - Asthma
  - Diabetes
  - Congestive Heart Failure (CHF)
  - COPD
  - Sickle Cell Disease
  - Perinatal, postpartum, and newborn needs

Member Identification

Referrals are received from a variety of sources, including hospital reports and staff, providers, CHNCT's Member Engagement Services, state agencies, data analytic reporting, and more

There's no wrong door!



Comprehensive Assessment & Care Plan

The components of an ICM Assessment include the following topics, which are addressed with the member/head of household:

- Adverse social determinants of health: shelter, food, and safety
- Health literacy
- Understanding conditions and diagnoses
- Understanding of self-care and participating in a care plan
- Self-care abilities (functional)
- Depression screening, domestic violence screening, and stress levels
- Medication: understanding, safety, and participation in treatment
- Provider access and engagement
- Identification of member strengths and barriers to care

Community Support Services/ Community Health Workers (CHWs)

As part of the Intensive Care Management team, CHWs assist members with addressing social determinants of health and provide coaching to promote health and wellness:

- Assist members in meeting their community resource needs including basic needs such as food, shelter, clothing
- Outreach to HUSKY Health members with gaps in care as identified by ICM
- Educate and coach member on condition-specific issues as part of the member's care plan and goals
- Assist members in overcoming barriers to meeting their health goals
- Support is given to members to schedule and attend doctor appointments

Key Support for Post-Discharge Coordination of Care

- Share information with provider related to participation with medications and treatments
- Ensure patients are following the home care plan
- Help identify and access resources within the community
- Collaborate with hospital and community providers to develop discharge plan
- Assist in the early identification of healthcare and behavioral health needs
- Ensure post-discharge appointments are scheduled

Emergency Department Care Management

- CHNCT collaborates with the Connecticut Hospital Association (CHA) for receipt of daily “real time” Admission, Discharge, and Transfer (ADT) transactions from Connecticut hospitals in order to identify HUSKY Health members for ED care management while the member is still in the ED
- Utilizing the ADT data, CHNCT creates reports used by the care teams for member outreach based on: frequency of member ED utilization, health conditions, age, and attribution to a primary care provider (PCP)
- ED care management collaborates with hospital ED staff to assess and determine underlying causes of the member’s frequent visits. Assessment is done to identify:
  - Medical, functional, social, and emotional needs that increase the member’s risk for continued use of the ED
  - A need for education on self-management for a member’s chronic condition
  - Psychosocial issues and/or issues with access to care/services

ED Care Management and ICM Collaboration

- ED care management collaborates with hospital ED staff and CHNCT ICM staff for members with frequent ED visits by:
  - Referring members to ICM programs to coordinate medical and behavioral health services and address longer term needs
  - Deploying ICM to the ED to engage with the member while in the hospital, or if member is not amenable to onsite engagement, ICM contact is initiated within 24-48 hours of discharge to the community
  - Scheduling an ED post-discharge follow-up appointment or connect the patient to a PCP
- Members who are identified with a first-time ED visit or who do not have a PCP are outreached via phone within 24 hours of ED discharge. Education is provided on:
  - The importance of having a PCP
  - Selecting a PCP, offering to assist with finding a PCP
  - The availability of alternatives for using the ED, such as the Nurse Helpline and urgent care providers

ED Utilization Outcomes

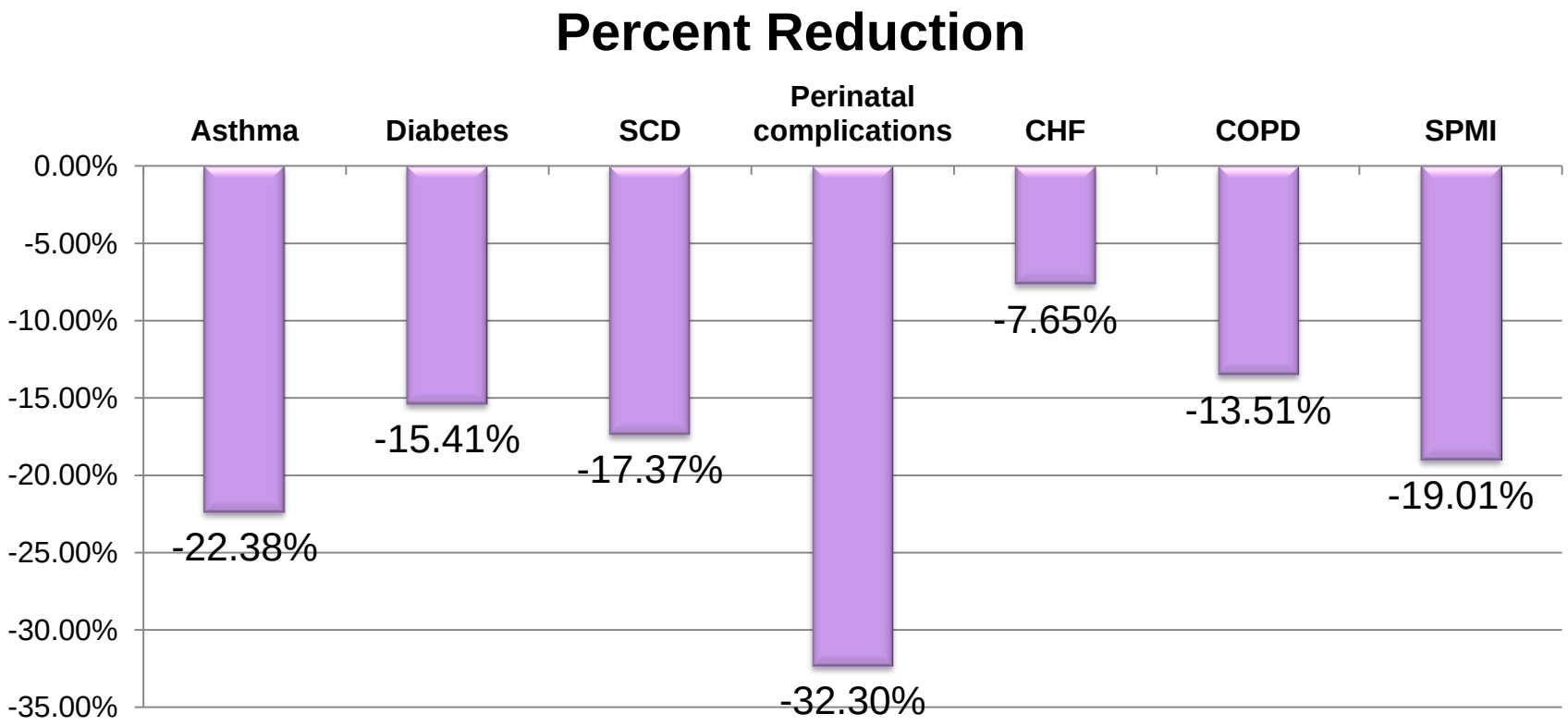
- ED utilization decreased by 25.18% for those members engaged in the ICM program in calendar year (CY) 2017. The table below displays the overall ED utilization results for members six months prior to and six months post-ICM engagement in CY 2017

Reporting Year	Total Number of ICM-engaged Members	Number of ED Visits 6 Months Prior to ICM Engagement	Number of ED Visits 6 Months Post-ICM Engagement	% Change
2017	6,818	9,610	7,190	-25.18%

Source: CHNCT 2017 Quality Management (QM) Evaluation

ED Visit Reduction

Members with specific conditions showed the following reduction in their ED utilization six months post-ICM engagement:



Source: CHNCT 2017 QM Evaluation

ED Utilization Overall Outcomes

- In CY 2017, CHNCT achieved a 6.29% reduction in the overall 2017 HEDIS® Ambulatory Care ED visit rate compared to CY 2016 as shown in the following table:

Ambulatory Care-Emergency Department Visits Total - Medicaid-Proc Per 1,000 MM	CY 2016 Rate	CY 2017 Rate	% Change
Statewide Rate	68.71%	64.39%	-6.29%

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.
Source: CHNCT 2017 QM Evaluation

ED Utilization Overall Outcomes (cont.)

- The number of total medical ED visits incurred by members with 10 or more visits decreased by 11.57% (50,111 in CY 2016 to 44,313 in CY 2017). The reduction was across all HUSKY Health programs as shown in the following table:

	Unique Members			Total Medical ED Visits	% Change	
All Programs	CY 2016	CY 2017	% Change	CY 2016	CY 2017	% Change
	4,040	3,593	-11.06%	50,111	44,313	-11.57%

Source: CHNCT Claims Data Warehouse

Hospital Inpatient Utilization Outcomes

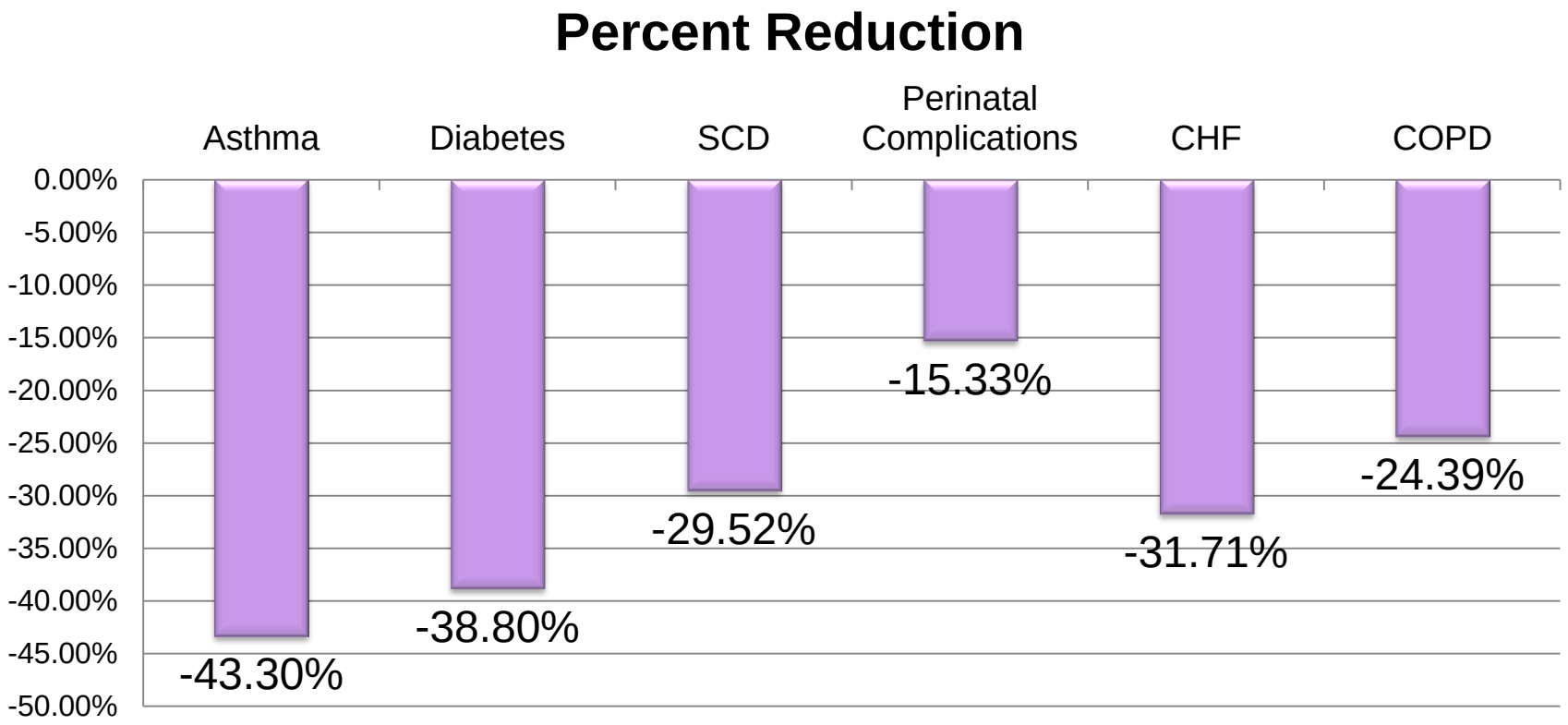
- Overall hospital inpatient utilization decreased by 44.07% for those members engaged in the ICM program in CY 2017. The table below displays the overall hospital inpatient utilization results for members six months prior to and six months post-ICM engagement in CY 2017

Reporting Year	Total Number of Members Newly Engaged in CY 2017	Number of Inpatient Admissions 6 Months Prior to ICM Engagement	Number of Inpatient Admissions 6 Months Post-ICM Engagement	% Change
2017	6,818	2,471	1,382	-44.07%

Source: CHNCT 2017 QM Evaluation

Hospital Admission Outcomes

Members engaged in ICM with specific conditions showed the following results six months post-ICM engagement:



Source: CHNCT 2017 QM Evaluation

Inpatient Discharge Care Management Outcomes

- Reduced readmissions by 45.87% for those members receiving CHNCT's Inpatient Discharge Care Management services
- In CY 2017, 85.72% of the 4,932 members managed by Inpatient Discharge Care Management had a follow-up visit scheduled prior to discharge which, is an increase of 20.24% from CY 2016

Source: 2017 CHNCT QM Evaluation

Diabetes Outcomes

CHNCT reviewed lab test results data for 405 ICM-engaged members who had HbA1c screenings prior to and following ICM engagement in CY 2017.

CHNCT's analysis showed that after ICM engagement:

- 260 (or 64.20%) of the 405 members demonstrated improvement in their HbA1c level
- Prior to ICM engagement, 151 of the 405 members had HbA1c levels ≥9.0% (poor control). After ICM engagement, 73 (or 48.34%) of the 151 members were brought under control (<9%)
- Prior to ICM engagement, 200 of the 405 members had HbA1c levels ≥8.0%. After ICM engagement, 63 (or 31.50%) of the 200 members had improvement in their levels with rates <8.0%

Source: HEDIS® and Data Warehouse available clinical lab values

Diabetes Outcomes (cont.)

- 2017 ICM-engaged members with diabetes HbA1c screening rate as compared to 2017 HEDIS® data

# ICM-engaged members in HEDIS® CY 2017 Denominator	# ICM-engaged members with HbA1c Test	ICM Cohort HbA1c Test Rate	2017 HEDIS® Statewide Admin HbA1c Test Rate	2017 HEDIS® Nationwide HbA1c Test Rate
1,155	1,028	89.00%	84.62%	91.16%

Source: CHNCT 2017 QM Evaluation

Asthma Outcomes

CHNCT showed a decrease in ED usage by ICM-engaged members with asthma who had utilized the ED over six times within a six month period with asthma-related issues

- Six months prior to ICM engagement, 226 of the 2,053 engaged members had six or more asthma ED visits
- Six months post-ICM engagement, the total number decreased to 87 members who utilized the ED six or more times. This represents a **61.50%** reduction

Source: Claims Data Warehouse

Asthma Outcomes (cont.)

- ICM-engaged members with persistent asthma who remained on the asthma controller for at least 75% of their treatment:

# ICM-engaged members in HEDIS® CY 2017 denominator	ICM-engaged members in the denominator who remained on the asthma controller for at least 75% of their treatment	2017 HEDIS® statewide admin rate of patients who remained on the asthma controller for at least 75% of their treatment
325	53.54%	47.30%

Source: CHNCT 2017 QM Evaluation

Sickle Cell Disease (SCD) ICM Outcomes

ED Care Management Outcomes:

- In CY 2017, CHNCT expanded referrals to two physician consultants located at Connecticut sickle cell clinics. Referrals were made for members with SCD who also had high ED utilization so that consultants could connect with hospitals while members were in the ED to coordinate post-ED discharge services
- Utilizing the ADT data, CHNCT configured alerts in its care management software to allow CHNCT staff to refer cases in real time to the SCD physician consultants who would then reach out to the ED physician for care collaboration and coordination, including scheduling follow-up care

In 2017, CHNCT targeted 19 members for referrals to the SCD physician consultants

Pre-referral ED visits	Post-referral ED visits	ED reduction after referral
361	300	16.90%

Source: 2017 CHNCT QM Evaluation

Sickle Cell Disease
ICM Outcomes (cont.)

- In 2017, 71 members with sickle cell disease were engaged in ICM:

ED Visits 6 Months Pre-ICM	ED Visits 6 Months Post-ICM	% Change in ED Visits
668	552	-17.37%

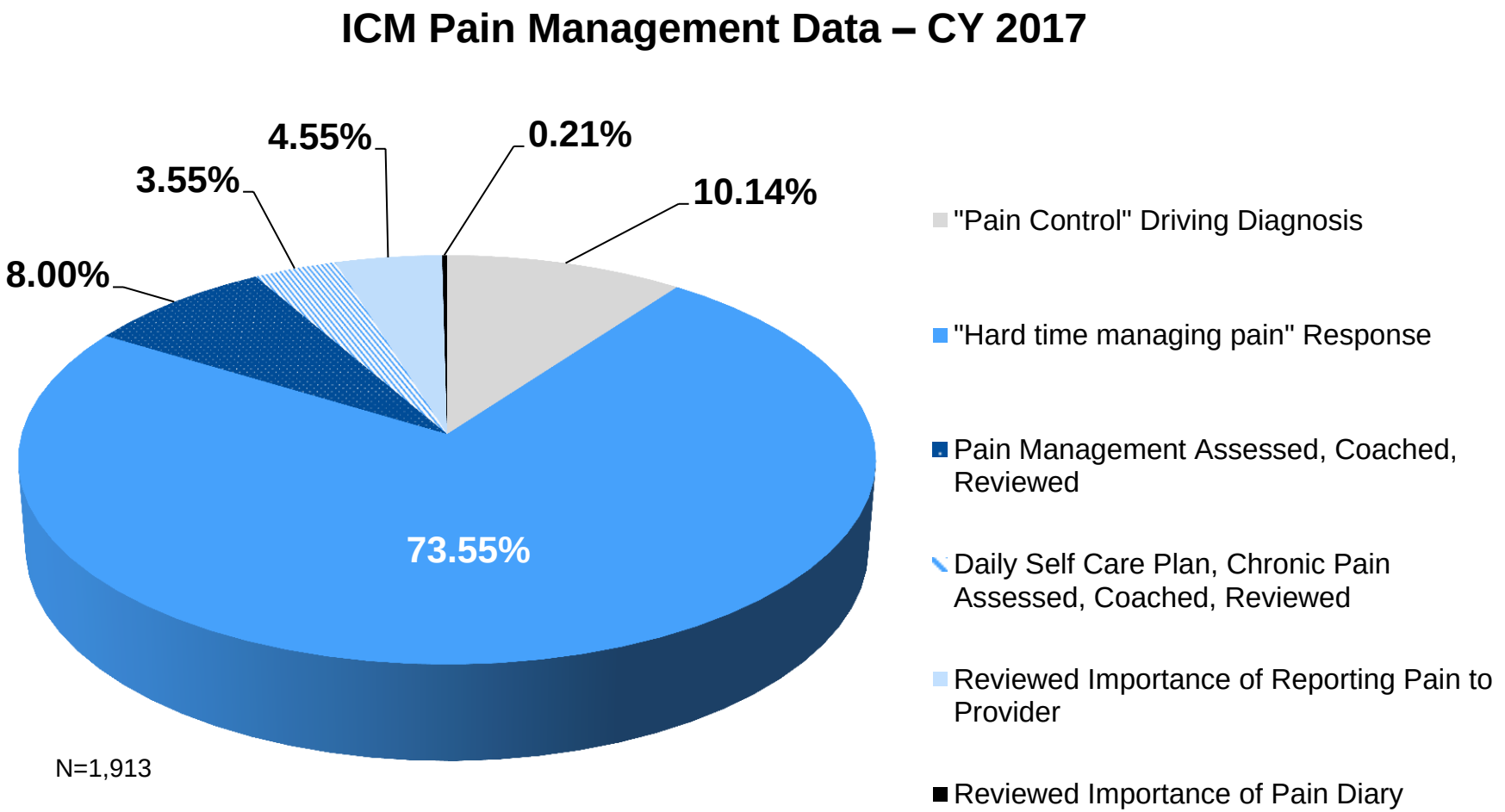
Source: 2017 CHNCT QM Evaluation

ICM Pain Management

The HUSKY Health ICM program assists providers with coordinating care for patients with chronic pain by:

- Assessing the patient's health status, barriers, and strengths
- Developing a patient-centered care plan
- Identifying gaps in care, coordinating with specialists, and coordinating with the CT BHP
- Conducting patient visits
- Coordinating transportation
- Providing appointment reminders

ICM Pain Management (cont.)



PCMH+ Coordination

- The PCMH+ participating entities provide enhanced care coordination activities to PCMH+ HUSKY Health members attributed to their practices. ICM collaborates with provider entities participating in the PCMH+ program for care coordination needs of members attributed to those providers
- Members receiving care within a PCMH+ practice, with identified care coordination needs, are referred to the care coordinator(s) within the practice. Members who opt out of PCMH+ care coordination services remain eligible for services through CHNCT's ICM program
- Members who ICM will continue to follow regardless of PCMH+ assignment include members:
  - Who are part of the perinatal program
  - Diagnosed with SCD
  - On a transplant waitlist
  - Who are receiving hepatitis C medication treatment
  - On beta blocker medications post myocardial infarction
  - Diagnosed with gender dysphoria
  - Diagnosed with inflammatory bowel disease

Key Care Management Outcomes

- The ICM program continued to show success in improving outcomes and reducing costs in CY 2017
- The table below displays the total cost of care for members newly engaged in ICM in CY 2017 and a cost reduction of $11,986,480 post-ICM engagement

Cost of Care Six Months Prior to ICM Engagement	Cost of Care Six Months Post-ICM Engagement	Cost of Care Reduction Post-ICM Engagement
$ 99,059,142	$ 87,072,662	$ 11,986,480

Source: CHNCT 2017 QM Evaluation

Care Management Interventions and Plans for Continued Development

- ICM intensified collaboration with the area SCD clinics and expanded its SCD specialty program
- ICM launched an Inflammatory Bowel Disease (IBD) specialty program for members with Crohn's or ulcerative colitis
- CHWs perform home/environmental screening for asthma triggers during face-to-face home visits
- Ongoing collaboration with the March of Dimes to address reduction of cesarean section rates, and a focus on health equity and poor maternal health outcomes for Black non-Hispanic and Hispanic women
- Interventions to address obesity-related risk factors and diabetes prevention
- Interventions to address hypertension-related risk factors

Questions/Comments