Passport Advantage
Provider Manual
Section 10.0
Care Management

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PASSPORT ADVANTAGE (HMO SNP)

10.0 Care Management

Passport Advantage is a Dual Special Needs Plan (DSNP) for members eligible for both Medicare and full Medicaid benefits. During analysis of the eligible population, Passport Advantage noted the average age was 56.7 years of age, members are disabled versus aged, and it includes a larger female population.

Members are identified for inclusion in Care Management:

- Completion of the initial Health Risk Assessment (HRA)
- Completion of the annual HRA
- Medical and pharmacy claims
- Internal plan staff referrals
- Provider referrals
- Member and/or caregiver referrals
- Medical Record Review (MRR)
- Hierarchical Condition Category (HCC) that are submitted by providers
- State-of the art stratification tool embedded in the electronic care management system
- Transition of care process

Passport Advantage's Care Management is targeted at the most vulnerable members such as those with multiple hospitalizations, readmissions within 30 days of inpatient discharge, long-term skilled nursing facility (SNF) residents, poly and/or high risk pharmacy utilization, end of life or advanced illness, and/or members with serious mental illness (SMI).

Care Management's aim is to promote care coordination of both the physical and behavioral health needs of our members. Passport Advantage utilizes the talents and knowledge of our associates (professional and non-professional), as well as those of our providers within the community to provide an interdisciplinary team approach for our members in order to deliver the highest quality of healthcare.

10.1 Model of Care (population; ICT; ICP)

Vulnerable members will be identified during completion of initial and annual HRAs, medical and pharmacy claims, care management referrals, practitioner referrals including the member's PCP, member and/or caregiver referral, HCC/MRR results, etc. Member identification is supported by a state-of-the-art stratification tool embedded in the electronic care management system. Members are stratified with follow-up interventions based on their acuity level of low/moderate/high. Stratification is based on a number of factors, such as predictive models, clinical practice guidelines, co-morbidities, gaps in care, polypharmacy and/or non-adherence, and/or uncoordinated care, etc. The stratification tool allows Passport Advantage the ability to continually assess and identify emerging vulnerable populations and to design services to address their specific needs.

An Individualized Care Plan (ICP) is generated for each member using the best available information at the time of completion. Information sources include, but are not limited to: Health Risk Assessment Tool (HRAT), pharmacy and medical claims, member and/or caregiver interactions and preferences, etc. The ICP addresses the following essential components:

ICP Components	Description
Medical History	Assessment of medical, psychosocial and cognitive needs; frailty
Member Preferences	Language and cultural preferences for health care and communication (mail, phone); Caregiver status; Articulated stressors
Advance Medical Directive	Articulated member wishes and status of documentation
Member's personal high level self-	Articulated goals provided by member and/or caregiver
Identified problem list and potential barriers	Articulated by member and/or caregiver and augmented by care management staff
Short and long term goals and interventions by priority and timeframes for reevaluation	Identification of member and care management system generated goals based on health status, medical/behavioral health history, care gaps and social needs as determined by systemic triggers, care manager and Intensive Care Team (ICT). Unmet goals are triggered as interventions and/or alerts to the care management team
Stratification Level	Determined based on available information, such as HRAT, additional assessments, pharmacy and medical claims, MMR and HCC results, care management interaction
Notes	Open text notes gathered by the care management team through engagement with the member and/or ICT
Alerts	System triggered care management team outreach or interventions based on unmet goals, gaps in care, and/or revised member health status

Member stratification and subsequent care plan updates are ongoing as changes in a member's health status and/or care needs are detected. If specific goals are not met within the targeted timeframe, the care management team outreaches to the member. Through a process of discovery and addressing barriers, the care management team works with the member and/or caregiver, the PCP and/or broader ICT to determine appropriate alternative actions, revise and/or modify goals or methods utilized to achieve results. Updates are made to the member's ICP and redistributed. Data from the Health Risk Assessment Tool, including member preferences, is integrated with other available member information, such as demographics, MMR/enrollment system, pharmacy and medical claims to form the comprehensive assessment used to develop the ICP. Care plan interventions include services and benefits covered under Medicare and Medicaid, as well as relevant community resources, such as food pantries, utility assistance, support groups, etc. Plan of care topics, barriers, goals and interventions are designed by a care manager who is either a nurse or social worker.

The care plan is reviewed by other members of the care management team that comprise the Interdisciplinary Care Team (ICT). The internal ICT includes a dedicated care manager (LPN or RN), consulting physicians (medical and behavioral), an RN supervisor, and a behavioral health ICT member (Psychologist, LSW, LCSW), if not already represented by others in the ICT with a behavioral health specialty. The ICT also includes a pharmacist who is responsible for addressing medication reconciliation, adherence and patient education goals.

The member's PCP is part of their ICT. The ICP is forwarded to the PCP for input and/or confirmation of the member's plan of care. The ICP is useful during office visits, so that the PCP can support the member's goals and preferences.

The care manager discusses goals with the member and whenever possible, integrates the member's preferences and personal goals as a basis for the ICP. If the care manager is unable to contact the member, a care plan is created based on known information. The ICP is shared with the PCP, so that Passport Advantage can be shared with the member during the next office visit. The PCP can help reinforce the importance of the member's engagement in the care management process and encourage them to contact their care manager.

Individual care plans initially are developed and shared following a member's enrollment into Passport Advantage, as part of the HRAT process. The care plan is again updated at the time of HRAT re-assessment, which must be completed within a year. Care plans are also updated when a member experiences a significant change in health care needs/status, and/or a transition of care occurs. Changes to the ICP are reviewed by the ICT.

Sample PCP Letter

HomeTown Doctors
123 Central Ave.
Any City, US 12345

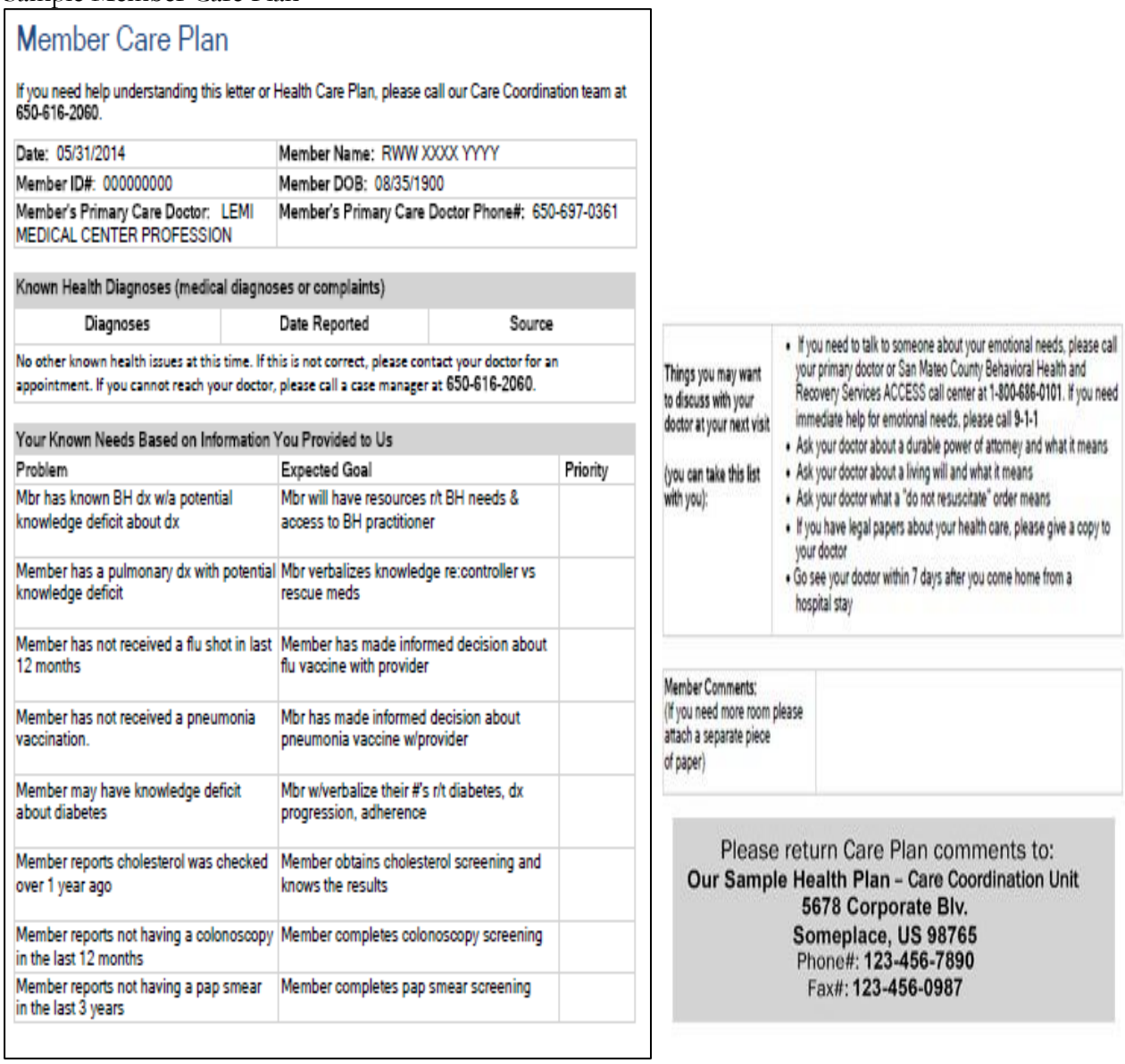
Dear HomeTown Doctors:

Your patient, Sample Member , is a member of Our Sample Health Plan's Model of Care Program, a plan for people with complex medical and social needs. In order to improve the care and coordination of medical services, we prepare a care plan for each member. We hope that these plans will help patients keep track of their own medical issues, improve communications with their doctors, and ultimately improve the quality of their health care.

Please modify the plan and make any revisions that you feel are medically indicated.
You are welcome to call **1-123-456-789** , Monday through Friday, 9 a.m. to 5 p.m., should you have any questions or comments.

Sincerely,

Sample Member Care Plan



Member Care Plan

If you need help understanding this letter or Health Care Plan, please call our Care Coordination team at 650-616-2060.

Date: 05/31/2014	Member Name: RWW XXXX YYYY
Member ID#: 000000000	Member DOB: 08/35/1900
Member's Primary Care Doctor: LEMI MEDICAL CENTER PROFESSION	Member's Primary Care Doctor Phone#: 650-697-0361

Known Health Diagnoses (medical diagnoses or complaints)

Diagnoses	Date Reported	Source

No other known health issues at this time. If this is not correct, please contact your doctor for an appointment. If you cannot reach your doctor, please call a case manager at 650-616-2060.

Your Known Needs Based on Information You Provided to Us

Problem	Expected Goal	Priority
Mbr has known BH dx w/a potential knowledge deficit about dx	Mbr will have resources r/t BH needs & access to BH practitioner	
Member has a pulmonary dx with potential knowledge deficit	Mbr verbalizes knowledge re:controller vs rescue meds	
Member has not received a flu shot in last 12 months	Member has made informed decision about flu vaccine with provider	
Member has not received a pneumonia vaccination.	Mbr has made informed decision about pneumonia vaccine w/provider	
Member may have knowledge deficit about diabetes	Mbr w/verbalize their #'s r/t diabetes, dx progression, adherence	
Member reports cholesterol was checked over 1 year ago	Member obtains cholesterol screening and knows the results	
Member reports not having a colonoscopy in the last 12 months	Member completes colonoscopy screening	
Member reports not having a pap smear in the last 3 years	Member completes pap smear screening	

Things you may want to discuss with your doctor at your next visit (you can take this list with you):	• If you need to talk to someone about your emotional needs, please call your primary doctor or San Mateo County Behavioral Health and Recovery Services ACCESS call center at 1-800-686-0101. If you need immediate help for emotional needs, please call 9-1-1 • Ask your doctor about a durable power of attorney and what it means • Ask your doctor about a living will and what it means • Ask your doctor what a "do not resuscitate" order means • If you have legal papers about your health care, please give a copy to your doctor • Go see your doctor within 7 days after you come home from a hospital stay

Member Comments: (If you need more room please attach a separate piece of paper)	

Please return Care Plan comments to:
Our Sample Health Plan – Care Coordination Unit
5678 Corporate Blv.
Someplace, US 98765
Phone#: **123-456-7890**
Fax#: **123-456-0987**

The ICT is a group of professionals, paraprofessionals and non-professionals who possess the knowledge, skill and expertise necessary to accurately identify the comprehensive array of the member's needs, identify appropriate services, and design specialized interventions responsive to those needs. The ICT attempts to identify relevant issues, modifies interventions based on previous response, determine subsequent goals and interventions.

Composition of the ICT varies according to the member's individual care needs, which are identified during the HRAT and ICP development process. Additionally, care managers are assigned that can best meet the needs of the member. As an example, an LCSW can be assigned to a member that has a diagnosis of severe mental illness. In addition to the member and/or caregiver and their care manager, the ICT includes internal Plan resources, such as nurses (RN, LPN), psychologist, LSW or LCSW; consulting medical directors, including psychiatrist; pharmacist; and ancillary care management team members, such as care coordinators. ICT external

participants may include contracted physicians, the PCP, specialists and ancillary providers involved in the member's treatment and community resource staff. ICT composition is determined based on the unique needs of each member and additional team participants added to address specific nuances. As an example, a member that develops cancer could benefit from having their oncologist added to the ICT and have input and review of the ICP.

Members and/or caregivers are involved in ICT activities through participation in ICT meetings and via updates from the care manager. ICT meetings are held as frequently as needed based on the member's clinical situation and care needs. Meetings are typically conducted via phone, with face-to-face meetings occurring in practitioner offices, facilities, or in the community.

10.2 Medication Therapy Management Program

Passport Advantage offers a medication therapy management (MTM) program through SinfoníaRx to assist members with complex health needs. Members who qualify can receive a comprehensive medication review (CMR) through a one-on-one consultation with a pharmacist or licensed pharmacy intern under the direct supervision of a pharmacist. During the CMR, the member's entire medication profile is reviewed (including prescriptions, OTCs, herbal supplements and samples) for appropriateness of therapy. The purpose and direction of each medication are reviewed with the member and documented on the Personal Medication List (PML). Disease-specific goals of therapy and medication-related problems are discussed with the member, as well as any member-specific questions. After the CMR, the member is mailed the standardized post-CMR takeaway letter which includes a Medication Action Plan detailing the conversation with the pharmacist or licensed pharmacy intern and a PML.

Members in the program also receive ongoing Targeted Medication Reviews (TMRs) on at least a quarterly basis. TMRs identify opportunities for interventions based on systematic drug utilization review including cost savings, adherence to national consensus treatment guidelines, adherence to prescribed medication regimens, and safety concerns. TMRs that identify drug therapy problems are categorized and triaged based on the severity of the alert. The member or provider is then contacted via phone, mail, or fax as appropriate for review of potential drug therapy changes.

As a special needs plan, Passport Advantage is required to provide this MTM program that includes quarterly TMRs and annual CMRs. Interventions resulting from these TMRs and CMRs can result in provider contact via fax, phone, or mail, when appropriate. Most provider outreach will occur via fax after a patient intervention. Faxes sent to providers will be related to medication adherence, cost-savings opportunities for members, altering therapy based on treatment guidelines, and other safety concerns.

10.3 Care Coordination

Care Coordination assists members in obtaining and coordinating needed medical and social services. The Case Manager, who is either a Registered Nurse or a Social Worker, contacts members and performs an assessment to identify specific needs. The Case Manager then creates a plan that works in conjunction with the medical plan and the member. The member's primary care provider receives a copy of the member's care plan along with the name and telephone number of the assigned Case Manager. Providers can contact the Case Manager with any questions or concerns.

Clinical staff manages the entire care coordination program for the SNP population which includes: Health Risk Assessment Tool (HRAT) process, development of the Individualized Care Plan (ICP), facilitation of the Interdisciplinary Care Team (ICT) process, care coordination services, care transition management and complex case management.

Providers, as well as members and other interested parties, can request care coordination. Providers can contact the Care Coordination department at (844) 602-4633.

10.4 Complex Case Management

Complex Case Management (Complex CM) is a program designed to work with a relatively small number of individuals with a complex range of acute and or unstable medical, behavioral, and/or social care issues, who utilize a disproportionate amount of resources and are stratified as being > High (Level 3) Risk level. It is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. The intensive CM services provided through this level of care are expected to be episodic and for a finite period with frequent care navigation/coordination outreaches.

A Complex Case Manager is a Registered Nurse (RN) or Licensed Clinical Social Worker (LCSW) with diverse clinical experience who perform case management activities to assist members stratified as being > High (Level 3) Risk level in meeting their identified needs.

Case management utilizes the stratification schema to design the appropriate level of outreach and follow-up. The risk stratification schema takes into account evidence of the member's ability to successfully self-manage their health status, supports available to the member, and identified barriers to care. The ICP is generated from the assessment(s) and subsequent risk stratification. Stratification occurs on an ongoing basis, as additional information is generated following enrollment, such as pharmacy and medical claims data, interaction between case management and the member, prior authorizations, etc.

Stratification Levels		
Risk Level	**Characteristics**	**Case Management**
Low (Level 1)	• 45-50% of Population • General age and gender based needs • Minimal Resource needs	• HRA, ICP, ICT, Care Coordination Assessment • Care Coordination as needed • Management of Care Transitions • Annual Follow-up

Moderate (Level 2)	• 45-50% of population • Requiring low to moderate intervention • No extensive issues • Some resource needs; • guidance on self-efficacy	All of above, plus: • Advanced Care Planning (LPN) • F/up every 60 days • Medical & cognitive behavioral interventions • Self- management techniques
High (Level 3)	• 5-8% of Population • Significant co-morbid medical & BH needs • Significant resource needs	All of above, plus: • Intensive Care Management (RN, LCSW) • Minimum outreach every 30 days • Frequent care navigation/coordination
Complex Case Management	• 1-2% of Population • Experienced a critical event • Extensive use of resources	All of above, plus: • Complex Care/Case Management(RN, LCSW) • Episodic • Minimum weekly outreach • Finite period usually 60-90 days