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Response to Legislative Request for Information

8/20/2016

Health Choice of Utah (HCU) has written a program description, as well as written policies to support the procedures and processes (P&Ps) used to identify the needs of all members enrolled in the health plan, including those with complex conditions. The purpose of our written P&Ps is to describe our integrated case management approach which assists our enrollees to access needed resources via the support of HCU's Care Coordination and Case Management Staff.

The integrated case management (CM) program is a result of the dynamic relationship of assessment, stratification of acuity and intensity of needs, intervention with reassessment and outcomes evaluation. The HCU staff is currently comprised of:

- Nurses (LPN & RNs)
- Health Services Coordinators
- A Medical Director,
- A Social Worker Professional (LCSW),
- Pharmacy staff and
- Quality Improvement staff members.

The HCU team works together to identify the specific needs of the Medicaid population and create integrated plans of care while striving for full integration of physical health, behavioral health and social support. The case management team can also include members outside of HCU staff. Examples include the enrollee, the enrollee's primary care provider, other treating physicians, caregivers, therapists, home health providers, etc.

The following process is used to identify need for and provide timely access to the appropriate level of care. This includes primary care, specialty care and behavioral health. The process may also include transportation, dental benefits, access to DME and medications. Necessary long term services are provided, such as referrals to ameliorate physical and cognitive barriers to the effective provision of care and access to file complaints and grievances.

1. **Population Assessment** – On at least an annual basis, HCU performs a population assessment to identify the unique needs of its members. HCU assesses the following at least annually:
 - a. The characteristics and needs of its member population and relevant subpopulations.
 - b. The needs of children and adolescents
 - c. The needs of individuals with disabilities
 - d. The needs of individuals with serious and persistent mental illness through collaborative assessment and identification efforts with the prepaid mental health plans.
 - e. The need to update current complex CM processes and resources in order to address changing member needs

These assessments are completed using enrollment and claims information from electronic claims and care management data platforms. This an evaluation of the population characteristics including demographic factors such as race, ethnicity and language preference. It also includes an evaluation of the prevalence of various chronic conditions within the population.



The analysis is supported by Information Technology department, and the information is evaluated by medical, quality, behavioral health and case management staff. The evaluation includes the identification of conditions which require complex CM, the potential volume of members requiring evaluation for CM services, the resources required to evaluate identified members and the training needed to ensure that the specific population needs are addressed. Case management processes and resources are reviewed and updated to address specific population needs. Evidence-based assessment tools and care planning tools are evaluated for relevance and to ensure they address the unique needs of the population.

2. **Member Identification** – Operating within regulations set forth by the Health Information Portability and Accountability Act (HIPAA,) the HCU CM staff identifies eligible members who may benefit from case management through an analysis of all available data which may include but is not limited to; claims data, encounter data, hospital admission/discharge data, pharmacy data, data collected through the Utilization Management (UM) process (prior authorization and concurrent review data), laboratory results, Emergency Department (ED) reports, Community Health Information Exchange (cHIE) reports, data supplied by members or caregivers and data supplied by practitioners, etc. Members are also identified during initial and/or annual screening using a telephonic health risk assessment (HRA) tool. HCU’s electronic CM platform uses a risk assignment algorithm to identify and stratify members that may benefit from CM through system-based rules. It evaluates medical conditions and other considerations including behavioral health needs, utilization patterns, claims, pharmacy utilization and laboratory data. When data are available prior to enrollment to health plan, HCU will analyze the data to assign to a level of risk stratification to establish priority for outreach to new members.
3. **Access to Case Management Programs** – HCU has multiple avenues through which members may be considered for health and wellness management or case management services, including:
 - Internal conduits, including referrals from;
 1. UM processes and activities,
 2. Disease and Wellness Management,
 3. Pre-service review,
 4. Admission and concurrent review,
 5. Pharmacists and pharmacy programs including medication therapy management,
 6. Social workers,
 7. Member services,
 8. Provider services,
 9. Nurse Advice Line.
 - External sources, including referrals from:
 1. Hospital discharge planners and social workers,
 2. Members and or member’s family/caregivers/representatives,
 3. Physicians and other providers,
 4. Community based agencies such as behavioral health providers,
 5. State agency staff.

Case Management program and contact information is also distributed to members and providers via HCU newsletters and is available on the HCU Website. Referrals to case management can be made by telephone, fax or can be directly referred by associates utilizing forms available in the electronic case management platform.

Members identified through various channels are contacted by an HCU representative to further assess their unique needs and verify the appropriate level of CM. This process also includes assigning the acuity level for the member based on completing assessments and applying clinical protocols.



When the members' needs appear to warrant post-acute care, out of home placement, hospice, psychiatric or rehab unit, long-term care facility, home based community setting, HCU staff will coordinate transition of care plans as appropriate.

Members identified as being eligible for waiver programs will receive assistance from the staff to coordinate full range of care services including waiver service planning, connection to local community resources and services. The HCU staff will work with the member to coordinate referrals for other non-covered services, such as supportive housing and other social services to maximize opportunities for independence in the community.

If HCU staff is unclear as to the member's functional, behavioral, or substance abuse status, the member will be presented at the IDT (Interdisciplinary [Care] Team) meeting for determination of risk level and intervention.

HCU staff are trained to ensure regulatory requirements are taken into account, where applicable, when applying risk level criteria. The following list is HCU's current Risk Level Criteria (each level builds on the preceding level);

- **Level I – Disease and Wellness management**
 1. Identification of members with diabetes, hypertension, asthma etc.
 2. Outreach calls to members who have "gaps" in care per claims data to support the scheduling appointments (Hemoglobin A1c, colonoscopy, mammogram, cervical screening, etc.)
 3. Routine maternity calls to non-high risk members
 4. Simple medication management
 5. Ongoing education and support based on the patient's individual needs
- **Level II – Care Management/Care Coordination**
 1. Chronic conditions requiring on going intervention
 2. Reduce the burden of disease processes
 3. Long Term Behavioral Health needs
 4. Maternity High Risk
 5. Medication management
- **Level III – Complex Case Management**
 1. Experience a critical event or diagnosis requiring extensive use of resources
 2. Five or more co-morbid conditions
 3. Annual high cost claims expenditures
 4. Medication management and adherence
- **Level IV - High-risk chronic illness and Imminent Risk**
 1. Inability to self-manage
 2. Risk of institutionalization
 3. Hospice
 4. Five or more admits in Six months related to chronic illnesses
 5. Medication management and adherence

Examples of Interdisciplinary Intervention and Management;

Concurrent review rounds are held twice a week. This has become the closest means to obtaining *real time* referrals to CM, and the leading referral source for Complex Case Management

A monthly list of educational letters for "*new onset diabetes*" are sent every-other-month (5 letters.)



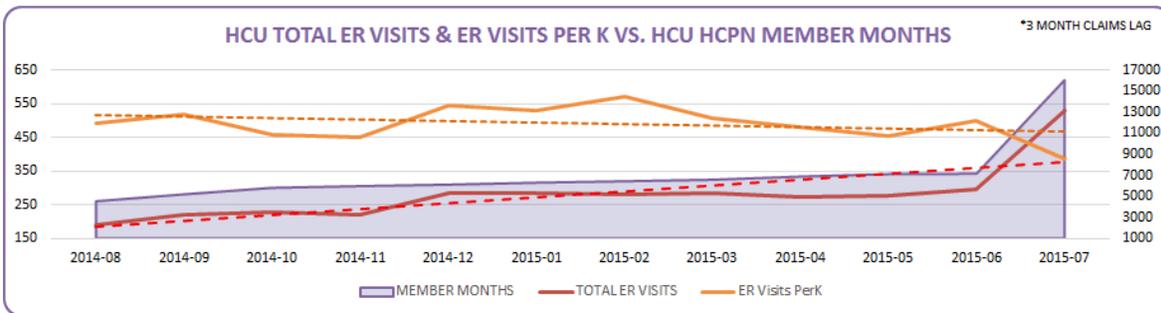
Behavioral Health (BH) CM is working closely with the State to better define and develop HCU's restriction program.

All newly identified pregnant members are now receiving the *Total OB Care* educational packets, along with our local high risk OB RN's contact information

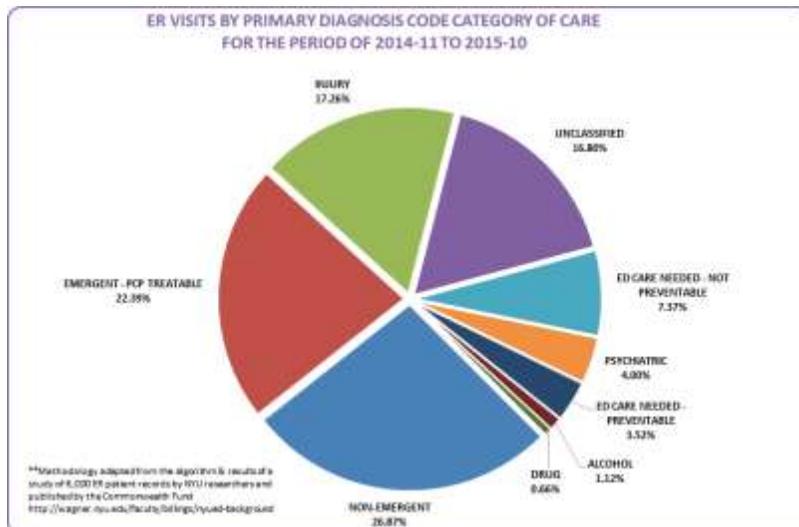
The staff is working directly with providers to assist our members to be proactive through a claims gaps-in-care report, ensuring that the enrollees get scheduled for timely routine services, such as; checkups, lab draws (A1C etc.), blood pressure monitoring, mammograms, colonoscopy, cervical cancer screening etc.

One of our highest ED utilizers had 54 visits in 2014 and 55 visits in 2015 – a consistent average of 5 ED visits per month. This member was continually among the top 5 high utilizers. Through the efforts of Medical and Behavioral Health Case Management, follow-up showed that the member has had just 4 ED visits documented from February 1st – May 1st 2016, an average of 1.3 per month, representing a decrease of **74%**. This resulted from twice-a-week CM interdisciplinary team meetings, outreach, home visitation, assigning a PCP that visits members in their home, BH and medical Complex CM enrollment, education etc.

In addition to individual successes, the population has experienced a decline in overall ED utilization.

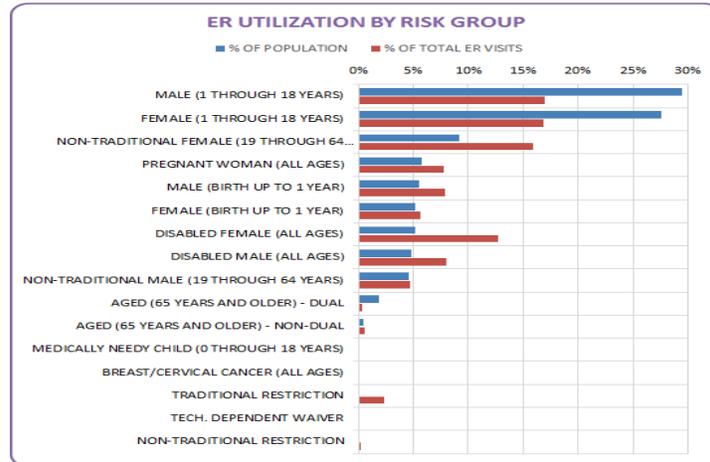


Emergency Department use is tracked by diagnosis in order to evaluate conditions that may indicate an avoidable ED visit. Interventional education can be tailored to messages that address the reasons members use the ED.





It can also address the groups whose populations are most likely to use the ED.



Optimal case management relies on both a careful analysis of the population as a whole as well as attention to the unique needs of the individual. Attention to both relies on quality, timely data and prompt action. Our goal with continual quality improvement is to improve communication among the internal and external components of the health care team and with the individual patient. We are confident that this will result in an optimal level of care for the neediest patients at the right time.