High Cost Members – Top 5% Costs- Care Management Strategies
University of Utah Health Plan (UUHP) – Healthy U

I. **Introduction:**

University of Utah Health Plans (UUHP) identifies high-risk, high-cost members through multiple means including a risk stratification model. UUHP has a trigger alert system that can capture claims activity, referrals from providers accessing EPIC's electronic medical record, and Utah Health Information Network Clinical Health Information Exchange (UHIN cHIE) to help identify members that can benefit from care management. UUHP analytics program provides concurrent and prospective risk scores, including allowed costs, to help us identify potential high cost, high risk members. UUHP care managers' partner with providers, clinic care managers, hospital personnel, vendors, waiver care managers and community partners to best meet the overall needs of our members.

II. **Interventions:**

Care management teams use several methods to identify potential high risk members or any member that may need assistance in managing their health care.

- Epic Claims triggers
    i. UUHP has implemented a number of triggers utilizing our EPIC claims and referral system. The care managers will receive an alert in EPIC that a specific claim or referral has been generated on one of our Healthy U members. Trigger examples are:
        1. Epic Referrals
            a. Lab test – high risk pregnancy
        2. Epic Claims
            a. Emergency room
            b. Diagnosis specific
                i. Asthma
                ii. COPD
- Monthly Stratification Report identifies utilization and concurrent and prospective risk scores.
    i. Risk score of 4 or greater are identified as high risk and care management inclusive of a home visit is indicated.
    ii. Care plans are developed with the member, provider (PCP, specialist), other service agencies, and prepaid behavioral health plans. Community supports are identified and accountability, benchmarks and measurable goals are outlined.
- Interdisciplinary Care Team (ICT) meetings with the UUHP Chief Medical Officer and other care team members ensure we are addressing the overall healthcare needs and social determinants that may impact care or a member's ability to engage in their care.
- Team meetings with Prepaid Mental Health Plans are coordinated to address behavioral health concerns and build accountability to support the member in meeting their goals.
- The ED Collaboration Committee meets monthly to address members that frequent the ED for non-urgent care. The committee is facilitated by UUHP Care Managers and is comprised of ED care managers representing the University, Iasis, MountainStar, Intermountain Healthcare, University Neuropsychiatric Institute (UNI), 4th Street Clinic, Valley Behavioral Health, Wasatch Mental Health and Health Choice. The

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purpose of this committee is to develop practice protocols for managing members using the ED for non-urgent care.

    i. During triage, ED care managers reach out to UUHP care managers when a member comes to the ED. A UUHP care manager visits the patient, onsite, in the ED.

    ii. A UUHP social worker participates in the ED onsite visit for those members with a behavioral health diagnosis.

- Top 1% are managed by the Empower U team to assist the member in articulating Advance Care Planning wishes. The team coordinates care with the primary care provider, specialists, and the member and the member's family to assure that Advance Directives are in place and the member is able to clearly define their desires.

    i. RN care manager meets with the member and their supports in the home so that they are comfortable and can discuss options when they are not in crisis.

    ii. Assists the patient and their supports to complete an Advance Directive and Advance Care Planning.

    iii. Works closely with the treating provider and PCP to coordinate completion of paper work to make sure the life planning needs are communicated through the team.

    iv. Consultations are coordinated with the University of Utah Health Care (UUHC) Palliative Team to reach out to those members that are interested in discussing life planning needs when inpatient.

        1. UUHP RN will follow up with the patient upon discharge.

        2. There is ongoing coordination between the UUHC Palliative Team and the PCP.

III. **Care Team Model:**

UUHP care management teams are population based. Each team has key determinants that they address with the members they manage. Figures I and II outlines the interventions described above.

Figure I

Multiple Ways We Identify Potential High Cost/High Risk Members
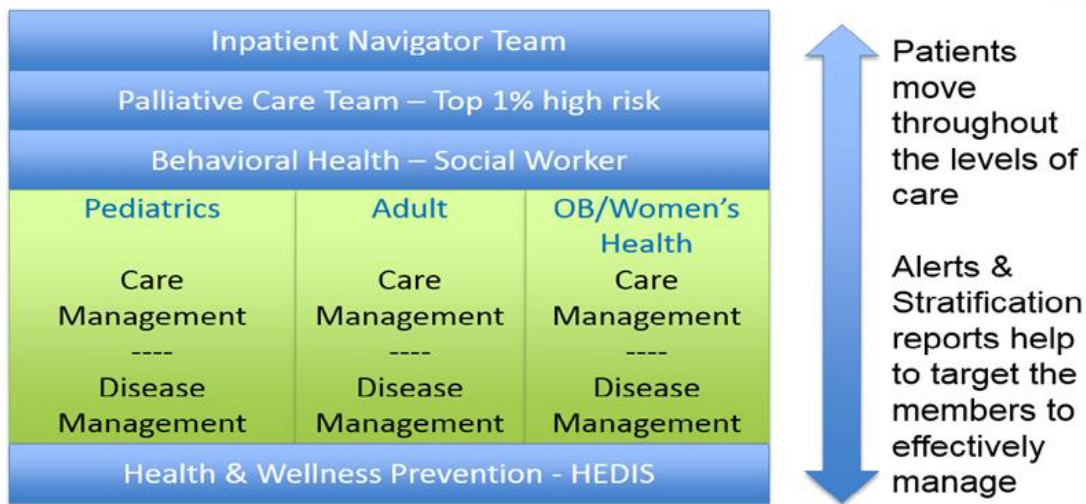
- Epic triggers and alerts from claims and referrals:
  - > High risk pregnancy Epic referral
  - > Emergency Department claim
  - > Inpatient claim
  - > Diagnosis alerts, e.g., asthma, diabetes
- cHIE alerts for ED visits
- Health Risk Assessment (HRA) for Healthy U and Healthy Advantage Plus members
- Inpatient census from all hospitals
- Stratification Report
- Crimson Population Risk Management (CPRM) analytics software

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Figure II

UUHP Care Team Design

Inpatient Navigator Team		
Palliative Care Team – Top 1% high risk		
Behavioral Health – Social Worker		
Pediatrics	**Adult**	**OB/Women's Health**
Care Management ---- Disease Management	Care Management ---- Disease Management	Care Management ---- Disease Management
Health & Wellness Prevention - HEDIS		

Patients move throughout the levels of care

Alerts & Stratification reports help to target the members to effectively manage

UUHP has designed a stratification report that is provided monthly for the care teams to identify members that are in greater need of care management. Refer to Figure III.

Figure III

Risk Area	Criteria		Points
ER Visits (within rolling year)		3-5	1
		6-9	2
		10 and up	3
Inpatient Stays (within rolling year)		2	1
CCHG Group Severe	example: Major Psychoses, Severe Heart Failure		2
CCHG Group Moderate	example: Severe Dementia, Active Cancer, Renal failure		1
CCHG Group Low	Healthy Individuals but with a concurrent risk score of 10 or higher		1
Risk Scores	Growth in risk score 10-15% (exclude when prospective risk score is less than 1) or a concurrent risk score of 0 with a prospective score higher than 1		1
mental health	Presence of one of mental health diagnoses on a claim from the past year		1

Total points = Stratification Score

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The frequency of contact with members receiving care and/or disease management services is based on acuity of their needs, risk score, and intensity of care management support required. The following Figure IV outlines how we manage care and disease management needs.

Figure IV
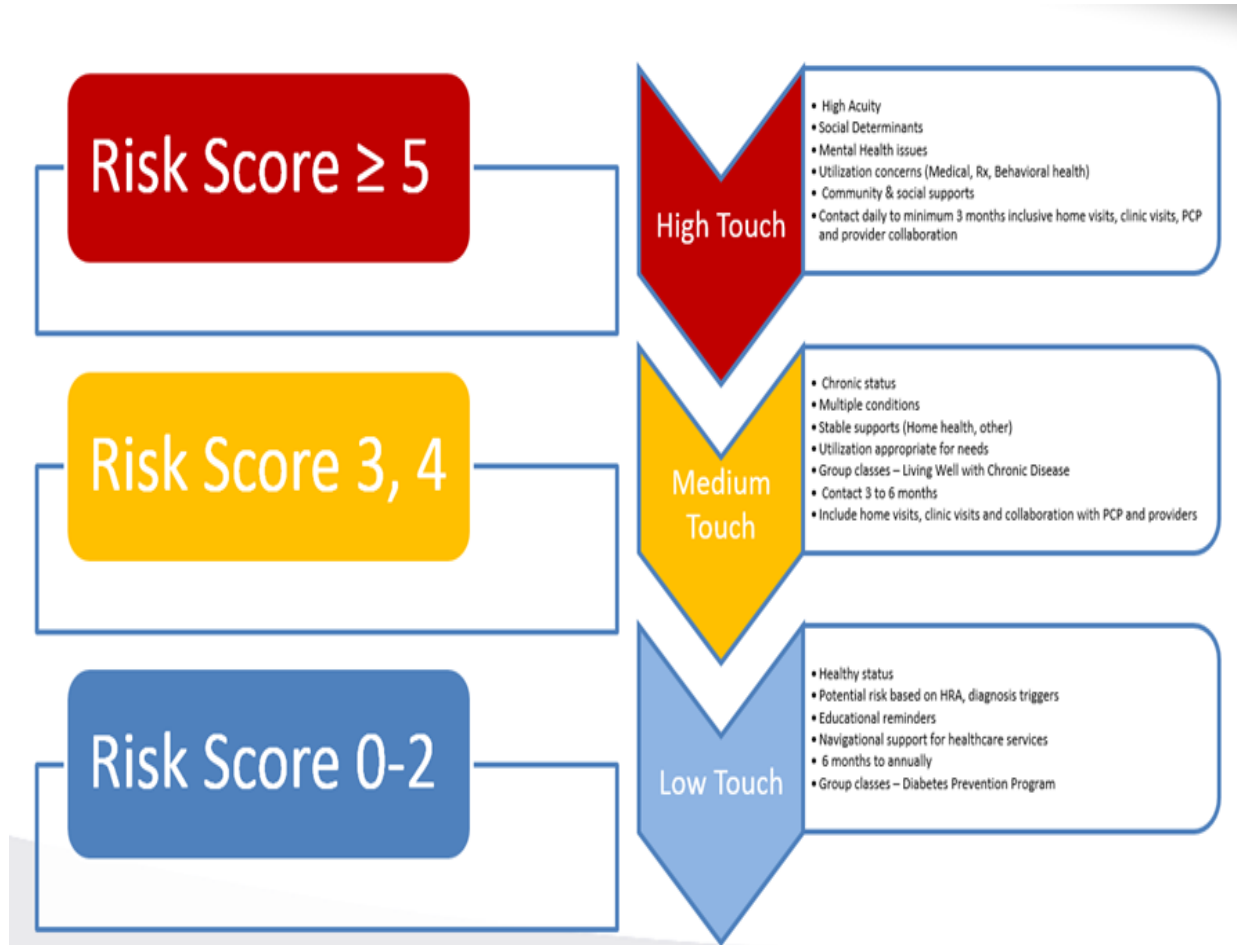
IV. **Top 5% High Cost Members with Chronic Condition Hierarchal Groupings:**

UUHP looked at the last two years, from April 2014 to March 2016, to identify the top 5% of the Healthy U high cost members. Table 1 shows the total count for the two years of Healthy U high cost members. UUHP care management also looked at those members that have been care managed consecutively over the two year period. The total count of the top 5% was then broken down to the Chronic Condition Hierarchal Groupings (CCHG) that were care managed by the various care management teams. Adult and the Pediatric teams coordinate disease and care management **(CM)** services for the members. The Inpatient Transitions Team coordinates with hospital case managers and assists with discharge needs. There is a follow-up discharge call completed by the Transitions Team within 72 hours post-discharge to complete a discharge questionnaire and make sure the member is comfortable in their home and there are arrangements for their follow up

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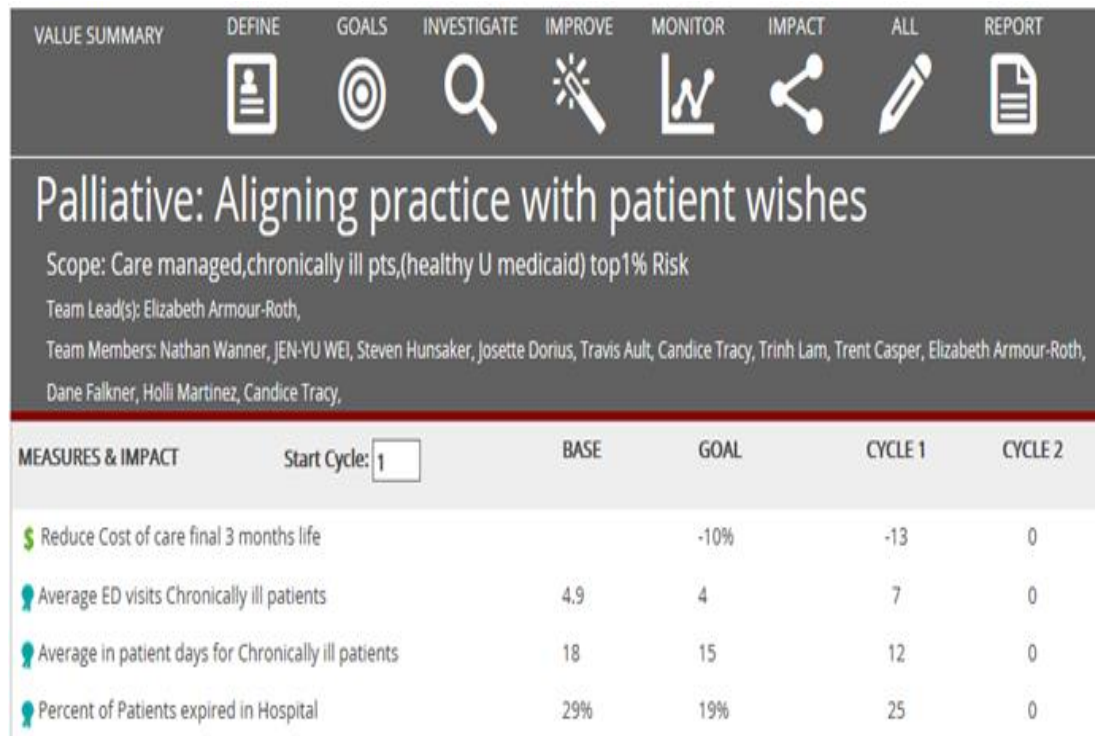## University of Utah Health Plan (UUHP) – Healthy U

appointment. Medication reconciliation is completed and, if there are concerns, the nurse will reach out to our pharmacy team to assist with medication education and management.

Table 1.

	Apr 2014-Mar 15	Apr 2015 - Mar 16	CM for 2 Years Continuous
Total 5% High Risk	2,822	3,741	1,693
5 % with CCHG CM	2,068	2,546	1,350

The Empower U Team/Advance Life Planning is aligned with Palliative Team at University of Utah Hospital and Huntsman Cancer Institute. UUHP participates in a value summary project "Palliative: Aligning practice with Patient Wishes". The scope is focused on the chronically ill Healthy U top 1% risk. In Figure V is a report of the outcomes monitored for the value summary.

Figure V

Palliative: Aligning practice with patient wishes

Scope: Care managed,chronically ill pts,(healthy U medicaid) top1% Risk

Team Lead(s): Elizabeth Armour-Roth,

Team Members: Nathan Wanner, JEN-YU WEI, Steven Hunsaker, Josette Dorius, Travis Ault, Candice Tracy, Trinh Lam, Trent Casper, Elizabeth Armour-Roth, Dane Falkner, Holli Martinez, Candice Tracy,

| MEASURES & IMPACT	Start Cycle: 1	BASE	GOAL	CYCLE 1	CYCLE 2
$ Reduce Cost of care final 3 months life			-10%	-13	0
Average ED visits Chronically ill patients		4.9	4	7	0
Average in patient days for Chronically ill patients		18	15	12	0
Percent of Patients expired in Hospital		29%	19%	25	0

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Further breakdown of the Chronic Condition Hierarchal Groupings is-shown in Figure VI.

Figure VI
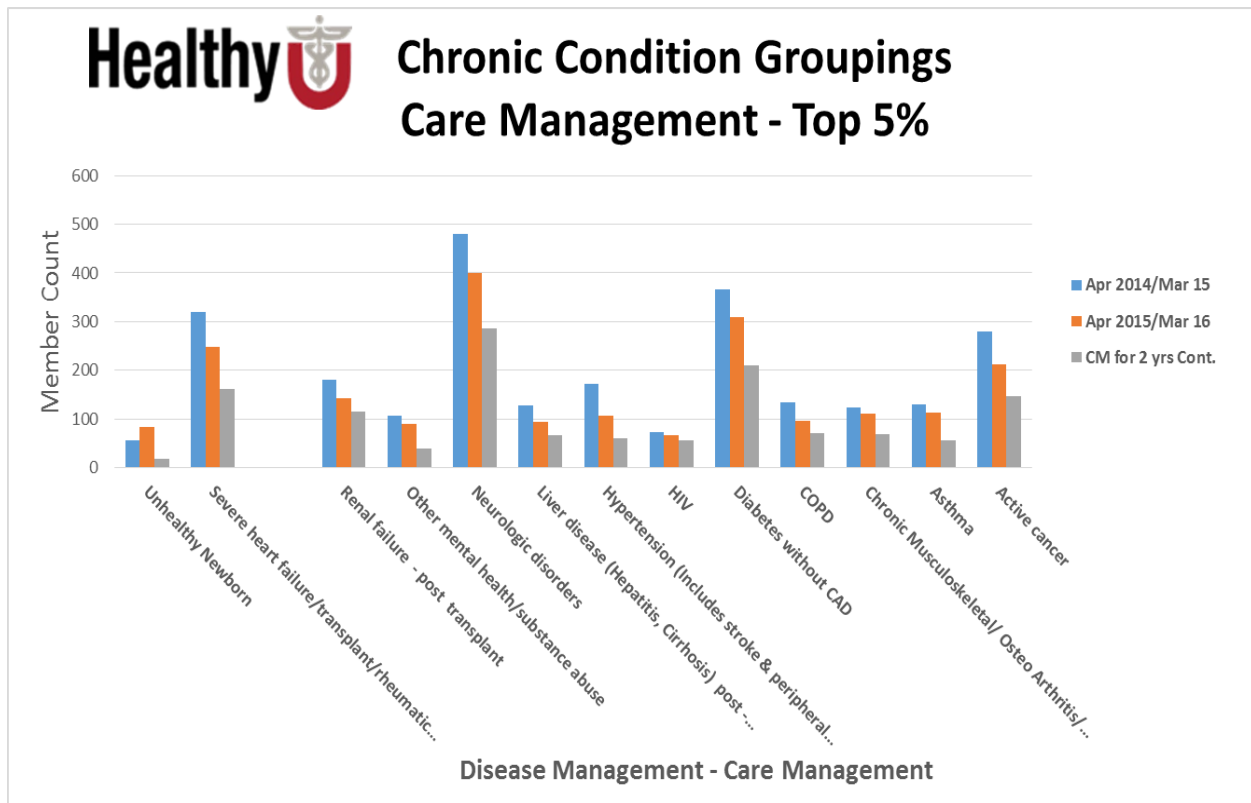
Unhealthy newborns are managed by the U Baby – Maternal/Newborn team. The infant is transitioned to the Pediatric team if there are ongoing needs.

Severe heart failure, renal failure, liver disease, hypertension, chronic musculoskeletal conditions are managed by the Adult Team. Ongoing education and care treatment goals are set by engaging the member and provider. Home visits may be warranted on the top 5% of members to address potential barriers to care and to assess social determinants of care.

Diabetes, COPD, asthma or active cancer are managed by the Adult and Pediatric teams based on age

Members with mental health or substance use conditions are managed by our Behavioral Health Team. The Behavioral Health Team takes the lead and collaborates with the other team members to assure all needs are effectively addressed for the member.

Our Pharmacy Team is actively engaged with the care management teams to assist with pharmacy utilization, medication compliance, member education, and potential adverse reactions associated with polypharmacy.

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The UUHP Chief Medical Officer is actively engaged in care management activities as well as monitoring utilization, care planning, and outreach to providers serving our members.

Figure VII shows members with chronic conditions being care managed by UUHP in collaboration with providers, clinic staff, vendors and other community supports.

Figure VII
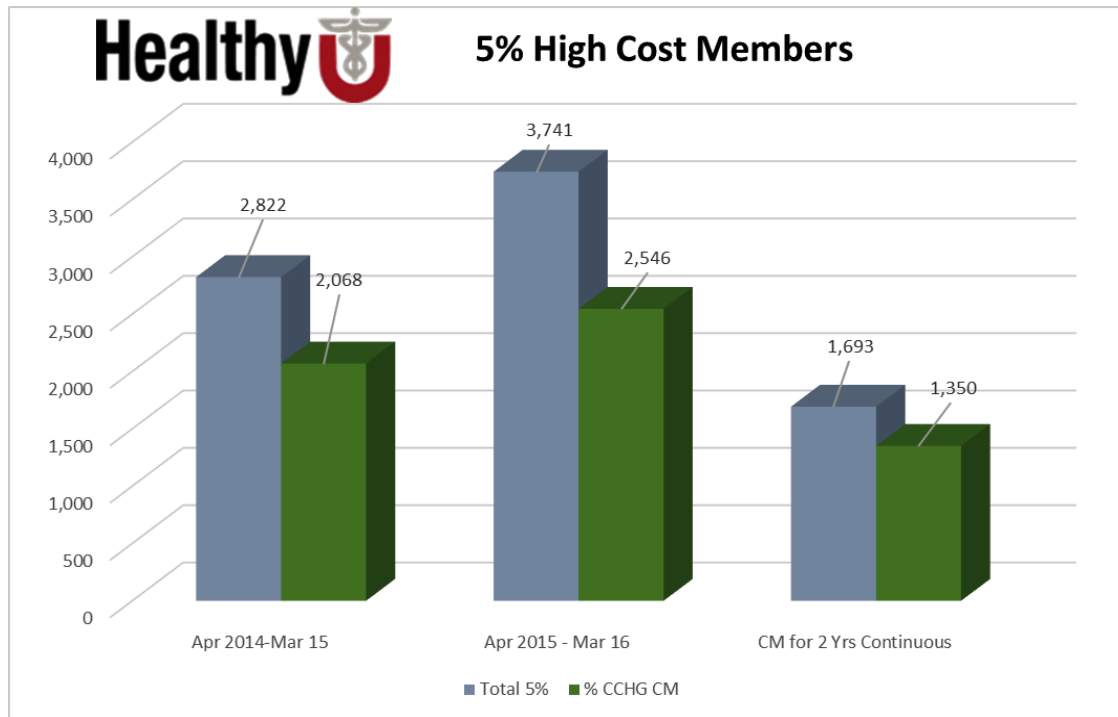
V. **Results:**

1,693 members have been managed continuously from April 2014 through March 2016.

	Total Members Continuous 2 Years	Risk Score Variance	Average Savings	Total Savings
Top 5%	1,693	0.898 per member improvement	$711.46 per member savings	**$493,753,24**

Each team monitors its key determinants and monitors impact related to the Triple Aim®. Sample slides are represented to demonstrate the impact each team is able to make in managing the Healthy U population. UUHP does not only focus on the top 5% but will utilize the opportunity to support our members as needs arise across the continuum of healthcare needs and services.

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Pediatric Team in Partnership with Green and Healthy Homes
Minimize asthma triggers in the home with home remediation and member education.

Transitions Team
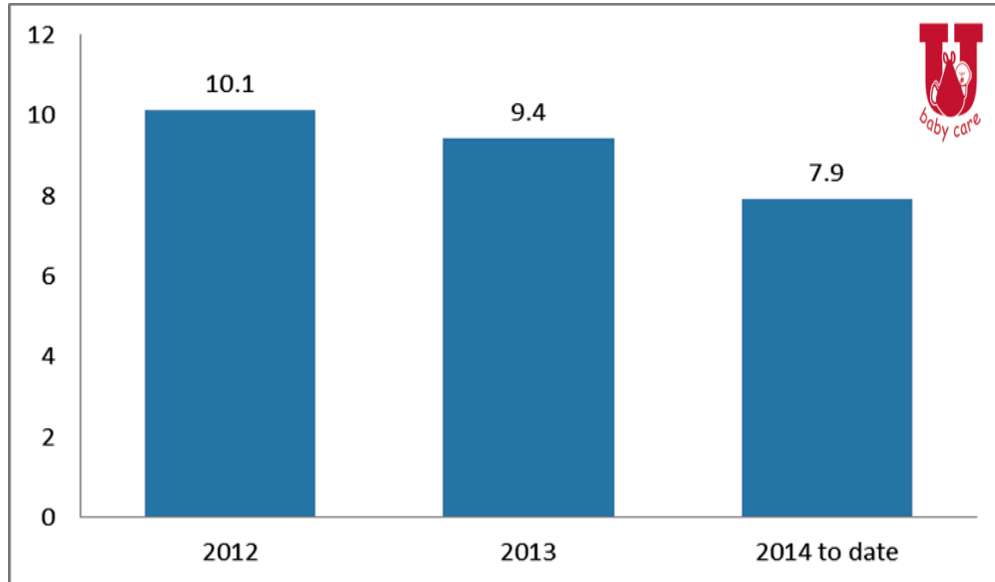Readmission rate reduction
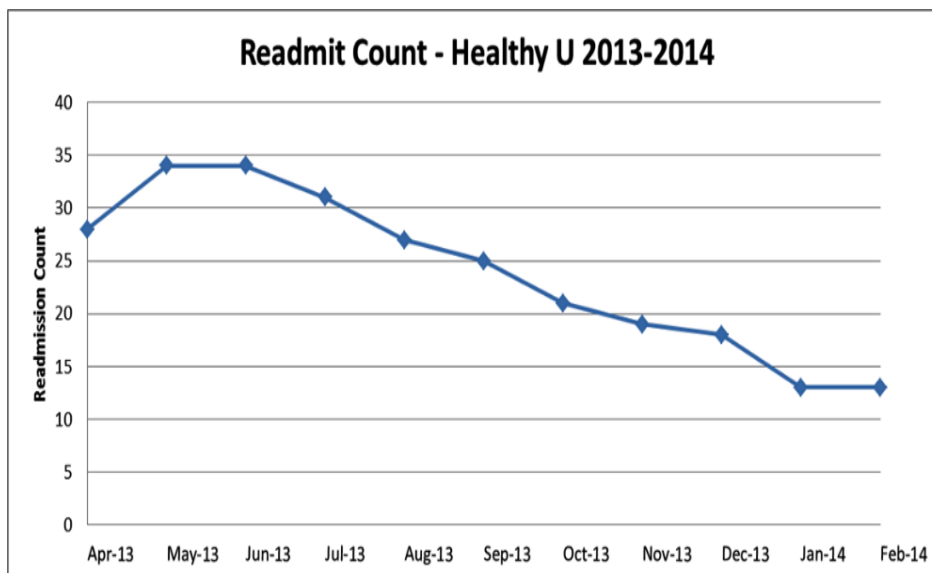
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U Baby/Maternal Newborn Team

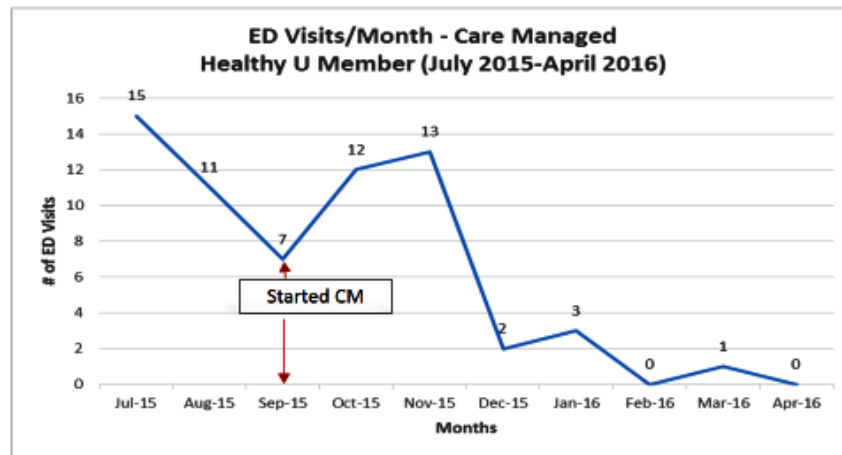Monitors high risk pregnancies to lower the preterm birth rate

Behavioral Health Team/Emergency Room Utilization Team

Appropriate ED Use and Aligning Members with a Primary Care Provider

Targeted goals for Member:
1) Reduce dependency on ED Visits
2) Coordinate care with PCP

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VI.   **Future Goals:**

UUHP continues to operate under a model of continuous improvement. No program is stagnant, as there are always opportunities to learn and improve processes with outcome monitoring.

UUHP is working on shifting our population health perspective from acute care to wellness. We are expanding in the areas of disease management and building on our community partnerships.

UUHP has developed partnerships with the various colleges at the University of Utah. Our care managers work closely with the Connect 2 Health program, the Colleges of Nursing, Pharmacy, and Social Work and with departments within the School of Medicine.

Thank you for the opportunity to provide information on the care management of our top 5% high risk members. If there are further questions or interests please contact:

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