PASSPORT HEALTH PLAN

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Mommy Steps

Complex Case Management

Diabetes Management

Healthy Heart Program

2017
Embedded/Rapid Response
Care Management
Program Description

Obesity Management

Chronic Respiratory Management

Congestive Heart Failure Management

Our mission is to improve the health and quality of life of our members

EPSDT Program

Rapid Response Outreach Team

Embedded/Rapid Response Care Management Program Description

I. Purpose

The purpose of the Embedded/Rapid Response (ECM/RR) Care Management Program is to:

- Improve the health status and quality of life of members with medical conditions and barriers to care, while decreasing unnecessary hospitalizations and emergency room (ER) visits. This is achieved by improving member self-management skills and by increasing member and clinician adherence with evidence-based clinical practice guidelines.
- Proactively provide coordination of care and services to members who have experienced a critical event or diagnosis requiring the extensive use of resources and who need assistance navigating the health care system.
- Triage and process referrals to our Care Coordination Programs where applicable.

II. Mission and Values

The ECM/RR Care Management Program's vision is to coordinate the closure of healthcare gaps; identify and address barriers to care; engage in face-to-face contact for education and advocacy, creating a positive overall experience for our members.

It is also designed to support Passport Health Plan's (Passport) values and the guiding principles of care management, which include the following:

- Integrity: The virtue that requires our adherence to moral and ethical principles, and soundness of moral character.
- Collaboration: The principal that directs us to recognize the inherent worth of each associate and to mine individual talent, skills and competencies to create value for our members, clinicians, and the Commonwealth of Kentucky.
- Community: The commitment to an environment that focuses on serving our community of associates, members, clinicians and citizens that values understanding, acceptance, and respect of individuals and their multicultural richness.
- Stewardship: The wise and responsible use of all resources; human, financial, and material, for the greater good.

III. Program Goals

- Reduce unnecessary Emergency Department (ED) Visits by 80% or greater.
- Reduce ED, Inpatient (IP) Admission, and 30-Day Readmission Reduction by 20% or greater.
- Achieve a rate of 90% or higher in member satisfaction with ECM/RR services.
- Meet or exceed a rate of 75% or above in member's perception of improved overall health status and quality of life.

IV. Program Objectives

- Provide for the collaborative process in assessing, planning, implementing, coordinating, monitoring and evaluating the options and services needed to meet the members' health and human service needs.
- To increase the number of members who either improved or reached their optimal level of health at the time of discharge from case management.
- Decrease unnecessary hospitalizations and ER visits.
- Improve member self-management skills and self-advocacy.
- Provide coordination of care and services to members who have experienced a critical event or diagnosis needing the extensive use of resources and who need assistance navigating the health care system.
- To annually evaluate the primary diagnosis of members who trigger and enroll in ECM/RR services to assure Passport has the appropriate staff, materials, and resources to assist members in improving their health and quality of life.
- To annually assess the characteristics of Passport's populations and evaluate available resources to meet the needs of these members.

V. Scope

Passport's ECM/RR Programs have adopted the Commission for Case Management Certification (CCMC) definition of Case Management: "Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes."[1]

Embedded Care Managers (in high volume clinician offices) engages members into care coordination activities to reduce care gaps, evaluate for and work to eliminate barriers to care, promote the most cost effective healthcare delivery by coordinating with all care clinicians, work to reduce inappropriate utilization of the ER, and partner in the member's treatment plan to promote improved compliance.

[1] http://ccmcertification.org/about-us/about-case-management/definition-and-philosophy-case-management

RR Care Managers addresses the urgent needs of our members. An urgent need could cause the member to seek medical intervention through emergency or hospital level of care. The RR Care Manager monitors services provided for quality, quantity, and effectiveness, to evaluate the need for revision, and for evaluation of member and family or caregiver cooperation. The RR Care Manager evaluates members for appropriate placement in case management.

Department of Health (DOH) School Board Manager identifies, assesses, plans, coordinates and implements appropriate cost-effective health care services for individuals identified with special health care needs and medically fragile children. The DOH School Board Manager works onsite at health departments and schools throughout the state in order to monitor the continuity and coordination of care and prevention of duplication for these children as part of the continuous quality improvement program.

VI. Population Identification

Members are identified for the ECM/RR Programs through the following sources:

- Referrals from:
  - Member or caregivers
  - Clinicians and practitioners
  - Internal Passport departments such as Members Services or Condition Management
  - Hospital discharge planners and Passport on-site care managers.
  - Community agencies
- Nurse 24/7 triage line encounter forms.
- Daily hospital census report, which includes information regarding discharges.
- Health Risk Assessment Forms (HRA). These are health risk assessments which are mailed to all new health plan members and are completed and returned by the member or may be completed telephonically by a Care Connector outreach representative.
- Scripted screening completed by the Care Connector outreach representative.
- Members with identified behavioral health needs as follows:
  - Member has a prior history of acute psychiatric or substance use disorder. Admissions authorized by the Behavioral Health (BH) Program; with a re-admission within a 60-day period.
  - First inpatient hospitalization following lethal suicide attempt, or treatment for first psychotic episode.
  - Member has combination of severe, persistent psychiatric clinical symptoms, and lack of family, or social support along with an inadequate outpatient treatment relationship which places the member at risk of requiring acute behavioral health services.
  - Presence of a co-morbid medical condition that when combined with psychiatric and/or substance use disorder could result in exacerbation of fragile medical status.
  - Adolescent or adult that is currently pregnant, or within a 90-day postpartum period that is actively using substances, or requires acute BH treatment services.

- A child living with significant family dysfunction and continued instability following discharge from inpatient or intensive outpatient family services that requires support to link family, clinician and state agencies which places the member at risk of requiring acute behavioral health services.
- Multiple family members that are receiving acute behavioral health and/or substance use treatment services at the same time.

In addition to the above methods of member identification, Passport at least annually, assesses the characteristics of its entire enrolled population to determine its relevant needs in order to update processes, resources, and special programs as needed.

Multidisciplinary team meetings occur every two weeks between Passport and BH Program staff to discuss cases to evaluate and optimize resource assistance and availability. The team collaborates to identify issues and to discuss options to meet team/member goals, and utilize resources to achieve optimal results for members and their families.

VII. Integrating Member Information

Passport utilizes Identifi, an integrated medical management technology platform, in order to allow all Passport staff access to member information. In Identifi, all users are able to view information that is specific to the member such as demographics, eligibility, member's clinician, spoken language, and preferences on receiving educational materials or phone contact. Users also have the ability to enter additional addresses or phone numbers, which the member may give as an alternative way to reach him/her that is not associated with the state file download that populates the basic demographic fields in Identifi. The Patient View may be utilized to denote a caregiver name and phone number, as needed.

Passport's ECM/RR Care Managers use algorithms integrated into Identifi to conduct assessments and case manage members. These tools are utilized to guide the ECM/RR Care Managers to direct members to the appropriate preventive services for the member's age and sex as well as the expected treatment for specific medical conditions. The basic Adult and Pediatric Assessments or Maternity Assessment are algorithmic, based on evidence-based clinical practice guidelines, and drive the ECM/RR Care Manager to specific interventions based on member responses to specific questions. All interactions, or attempted interactions, with a member or on a member's behalf, are documented in the case management notes. All case management notes are automatically stamped with the time, date, and the ECM/RR Care Manager's identifier code.

In addition, Identifi users can perform the following activities:

- Edit demographic information and preferences, as needed.
- Upload documents related to the member and/or the member's care that need to be visible to all users in order to facilitate seamless care coordination.
- View all the documentation that has been entered as it relates to the member.
- View any correspondence that the member has sent to Passport, or that Passport has sent to the member.
- View the member's established care coordination assessment and plan of care.

- View claims, both pharmacy and medical, related to the member.
- View results of labs/screenings, as available.
- View a clinical summary/history of the last six months of the member including tests and services, medical conditions, medications, ER visits, IP admissions, office visits, etc.
- View historical data or "closed" cases.

All of this data allows everyone interacting with the member to have the most current and available data in order to make every member contact count to its fullest potential and improve coordination of care by all users having the same information.

VIII. Member Participation and Opting Out of the Program

Participation in ECM/RR Care Management Program is voluntary and the member has the right to decline participation. If the member initially accepts ECM/RR services he/she may choose to "opt out" at any time. If members wish to access the services in the future they can call or write. Members are also advised that they may request verbally or in writing to discontinue case management services at any time. Members are educated on case management services and advised at the time of the initial ECM/RR Care Manager's contact that participation is voluntary.

IX. Member Contact

Contacts with those members who agree to participate in ECM/RR Care Management Program may be by phone, mail, or face-to-face based upon their individually identified level of need. Members receive information about case management and how to contact the Care Coordination Department via the member handbook, articles in member newsletters, informational handout, and through the Passport member website (www.passporthealthplan.com).

X. Clinician Notification and Involvement

Participating clinicians with Passport are notified of the ECM/RR Care Management Program by the following:

- Welcome packet to new participating clinicians with information regarding how the ECM/RR Care Managers work with members and instructions on how to access the Program.
- The Passport Provider Manual
- The Passport Provider Website @ www.passporthealthplan.com
- Quick Reference Guide
- Provider Orientation Kit
- eNews

Evidence-based clinical practice guidelines are distributed to all participating clinicians as part of the Provider Manual and are available on the Passport website. Guidelines are reviewed, updated, and posted on the Passport website www.passporthealthplan.com at least every two years, and anytime new scientific evidence or national standards are published.

XI. Member Satisfaction with ECM/RR Programs

Passport's ECM/RR Care Management Program have Member Satisfaction Survey Postcard (*Appendix A*) that is mailed out to members regarding the ECM/RR Care Management Program directing them to the Passport website to complete the survey. Members have the option to call the Care Connectors and have a hard copy of the satisfaction survey (*Appendix B)* mailed to them to complete. Results measure the frequency of contact and satisfaction with the ECM/RR Care Manager, the member's perceived improvement of overall quality of life, and the member's perceived improvement in their overall health status.

The survey results are tracked and analyzed to identify opportunities to improve satisfaction with the ECM/RR Care Management Program. Results are reported quarterly by the Manager of Care Coordination or his/her designee, with the goal of 90% or above in member satisfaction with all areas of ECM/RR services and 75% or above in the member's perception of improved overall health status and quality of life. Changes to the ECM/RR Care Management Program are made as needed.

The member has the option to be contacted by the Manager of Care Coordination or his/her designee, regarding inquiries about the ECM/RR Care Management Program. Two (2) attempts are made by the Manager of Care Coordination or his/her designee, to contact the member. If outreach is unsuccessful, then the Manager of Care Coordination or his/her designee, will send out the Satisfaction Survey Return Call Letter (*Appendix C*) and wait two (2) weeks for a reply. All outreach to the member are tracked for reporting purposes.

Complaints and/or inquiries regarding ECM/RR Care Management Program can be received by Member Services or through the Care Coordination Department. Complaints and inquiries through Member Services are documented in EXP, a customer-service software package that records, tracks, and reports on all member and clinician inquiries and complaints allowing for real-time on-line communication between departments.

Complaints or inquiries through the Care Coordination Department are resolved in the Care Coordination Department and then forwarded to Member Services for documentation in EXP. Additionally, all member complaints regarding ECM/RR services are forwarded to the Manager of Care Coordination or his/her designee, for follow-up.

The Manager of Care Coordination or his/her designee, conducts a quantitative and qualitative analysis of complaints and inquiries regarding ECM/RR services, annually. This analysis is used to identify patterns of member complaints and opportunities to improve satisfaction with the ECM/RR Care Management Program. Changes to the ECM/RR Care Management Program are made as needed.

XII. Annual Evaluation

The annual evaluation of the ECM/RR Care Management Program is conducted by the Manager of Care Coordination, the Director of Medical Management Care Coordination, the Director of Quality, the Chief Medical Officer, or designee.

Objectives, activities, and outcomes are evaluated at a minimum of annually in order to:

- Determine whether the ECM/RR Care Management Program has demonstrated improvement in the health status and/or quality of life of the member.
- Evaluate the overall effectiveness of the ECM/RR Care Management Program.
- Allow for exploration of barriers and limitations of the ECM/RR Care Management Program.
- Revise areas as needed to improve effectiveness of the ECM/RR Care Management Program.

Results of this evaluation process are utilized to revise the ECM/RR Care Management Program and set the program goals for the following year. Any identified changes will be submitted to the Department of Medicaid Services (DMS) for review and approval. Passport shall have approval from DMS for any changes prior to implementation.

Final approval by the Quality Medical Management Committee:
June 14, 2016
April 18, 2017

Appendices

A. ECM/RR Member Satisfaction Survey Postcard

B. ECM/RR Member Satisfaction Survey

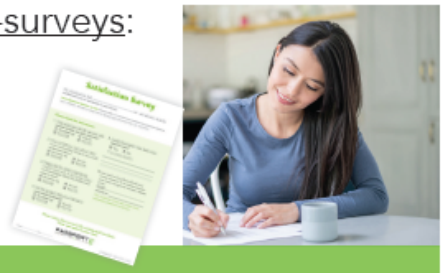
C. ECM/RR Satisfaction Survey Return Call Letter

ECM/RR Program Description
Appendix A
ECM/RR Member Satisfaction Survey Postcard

We Want to Hear from You!

Your Passport friends value you as a member and want to know how things are going for you. Please visit: passporthealthplan.com/member-health-surveys:

- Click on Survey #2
- If you'd like us to mail you a survey, please call us at **1-877-903-0082**.



Thank you for being a part of our Care Coordination Program!

PASSPORT HEALTH PLAN

EVOH63055 APP_12/29/2016

Your survey answers are a great way for you to say "thank you" to the care team who helped you and to let us know how we can do better.

PASSPORT HEALTH PLAN

5100 Commerce Crossings Drive, Ste 2
Louisville, KY 40229

CC151

Thank you!

Embedded Care Coordination Satisfaction Survey

Our records show that _____, our Embedded Care Advisor, recently worked with you or someone in your family.

Your Opinions Matter to Us! Please take a moment to answer the questions below. Your answers will tell us what we're doing right and how we can improve.

Please check the best answer.

How would you rate the following?

1. How well he or she listened to you and explained things to you:
   - ☐ Excellent (4) ☐ Fair (2)
   - ☐ Good (3) ☐ Poor (1)

2. The professional and courteous manner of your Embedded Care Advisor:
   - ☐ Excellent (4) ☐ Fair (2)
   - ☐ Good (3) ☐ Poor (1)

3. His or her overall helpfulness:
   - ☐ Excellent (4) ☐ Fair (2)
   - ☐ Good (3) ☐ Poor (1)

4. The written materials given to you (brochures, letters, newsletters):
   - ☐ Excellent (4) ☐ Fair (2)
   - ☐ Good (3) ☐ Poor (1)

Please answer the following questions:

5. Did your Embedded Care Advisor help you understand your health problems?
   ☐ Yes ☐ No

6. Did he or she give you information to help you make decisions about your care? ☐ Yes ☐ No

7. Do you want us to call you about your survey answers? If so, please provide your name and phone number: *(Please print)*
   NAME:_____
   PHONE #: _____
   This is optional. If you don't want to be contacted, please skip

8. Are there ways the program could have been more helpful to you? If so, please explain: ☐ Yes ☐ No
   If so, please explain.
   _____
   _____

Please return this survey in the postage-paid envelope.
Thank you again for your time!

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Month_____ Year_____

[Date]

[Member]
[Address]
[City, State, Zip]

Dear **Member**,

We have received your Satisfaction Survey and see that you would like to speak with someone at Passport.

I am very happy to talk with you and help answer your questions. However, I have been unable to reach you by phone. You may call me back at **1-877-903-0082**, press **0**, then press **[ext]**.

I look forward to hearing from you!

Sincerely,

[Name and Credentials]
[Title]
Passport Health Plan