Provider Information Guide

Complex Care and Condition Care Overview

Introduction

Complex Care and Condition Care are essential components of Passport Health Plan's (Passport) Care Coordination services, which are used to support the practitioner-patient relationship and plan of care. These programs evaluate clinical, economic, and quality of life outcomes on an ongoing basis, and use evidence-based practice guidelines to emphasize the prevention of exacerbations and complications.

Complex and Condition Care target your patients with at least one of five chronic conditions: **congestive heart failure** (CHF), **chronic obstructive pulmonary disease** (COPD), **coronary artery disease** (CAD), **diabetes**, and **asthma**.

Complex and Condition Care use coordinated health care interventions and communications for populations with significant self-care needs. Evidence-based medicine and a team approach are used to:

- Empower your patients
- Support behavior modification
- Reduce incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Support the physician/patient relationship
- Emphasize and reinforce use of clinical practice guidelines

The team approach to care is supported by a multi-disciplinary roster of health professionals, including a registered nurse Care Advisor or health educator, pharmacist, dietitian, and social worker. They inform and collaborate with the patient's primary care physician to enhance care coordination.

Whether identified for Complex Care or Condition Care, your patients are offered services appropriate for their health needs through Care Coordination, a part of their Personal Approach to Health (PATH).

Program Goals

The goal of both Complex Care and Condition Care is to effectively impact the health outcome and quality of life of patients with chronic conditions. This is accomplished by using a multi-faceted approach based on assessment of patient needs, ongoing care monitoring, evaluation, and tailored patient and practitioner interventions. Complex and Condition Care can also reduce hospital length of stay and lower overall costs.

Patient Identification

Passport Health Plan systematically evaluates patient data against a set of identification and stratification criteria. For Complex and Condition Care, criteria are established to identify eligible patients, stratify them by risk, and determine an appropriate intervention level based on their known needs and status. Stratification is a dynamic process, and stratification level can change as a patient's condition changes. The following data sources are used to identify your eligible patients on a monthly basis, when available:

- Enrollment data
- Health Information Line
- Medical claims or encounters
- Pharmacy claims
- Assessment screening results
- Practitioner referrals
- Data collected through utilization (UM), condition care and care management (CM) activities
- Data collected from health management or wellness programs
- Laboratory results
- Electronic medical/health records

Based on stratification, intervention-level patient criteria are as follows:

Program	Criteria
Low Risk Condition Care	Patients with two paid claims for evaluation and management visits with primary diagnosis of asthma, diabetes, COPD, heart failure, or coronary artery disease. These patients have no significant care gaps and have their condition controlled.
Condition Care	In addition to the above criteria, patients have at least one of the following outcome-based gaps: • Patient has condition-related inpatient admission within six months • Patient has a condition-related ER visit within three months • Patient has no PCP or condition-related specialist visit within 12 months • Patient does not have a prescription(s) for a condition-related medication(s)
Complex Care	Patients most likely to incur a disease-specific adverse event. Some of the covariates include co-existing chronic conditions, prior utilization, change in utilization rates, drugs that indicate disease progression or severity, medical equipment, and gaps in care.

Patient Engagement and Support

Patients identified for Complex and Condition Care are considered to be participating unless they specifically request to receive no program services or to "opt-out." Once identified as eligible, patient engagement follows the steps outlined below.

Welcome Packet Mailed	• A staff member of Passport's Care team sends patient a welcome packet. • The welcome packet includes information about education and support provided through Care Coordination, the extended care team, the rights and obligations of Passport members, and how Care Coordination services support the patient-provider relationship.
Introductory Phone Call	• The welcome packet is followed by a phone call from a Care Coordination staff member. Over the phone, the staff member shares the advantages of Care Coordination and encourages the patient to actively participate. • Patients identified for Low Risk Condition Care will not receive a proactive phone call, but will be invited to contact the care team if he or she chooses to participate.
Physician Notification	• When a patient engages in Care Coordination, a staff member notifies the patient's primary care physician directly.

Interventions by Risk Level

Depending on stratification, patients will receive support from the extended care team in the following ways:

Program Interventions	Low Risk Condition Care	Condition Care	Complex Care
Reminder letter about making appointment to see physician for routine care and generic preventive health prompts (immunizations up-to-date, screenings, etc.)	✓	✓	✓
Notification to the patient of care gaps	✓	✓	✓
Notification to the primary care provider of patient care gaps	✓	✓	✓
Access to telephonic self-management support resources	✓	✓	✓
Completion of an assessment within 30 days of the patient agreeing to participate in the program		✓	✓
Mailing of education materials to the patient after successful outreach, unless patient declines		✓	✓
Self-management support, health education and coaching to improve patient's knowledge and self-management skills		✓	✓

Program Interventions	Low Risk Condition Care	Condition Care	Complex Care
Outreach will occur at least every three weeks unless otherwise requested by the patient or physician		✓	
Outreach will occur at least every two weeks unless otherwise requested by the patient or physician			✓

Interventions by Condition
Program content is tailored to each disease, providing education and support for each risk level. Using outreach and educational materials, your patients are encouraged to:

1. Be accountable for their chronic condition(s)
2. Adhere to their physician's recommendations for preventive care and treatment
3. Embrace educational opportunities for informed decision-making when accessing the healthcare system

Member-Centric Interventions
Throughout your patients' engagement in the program, care team members will consider individual needs to tailor targeted interventions. Care team members will take into account:

- Comorbidities and other health conditions, including behavioral health
- Depression screenings
- Health behaviors, including things like diet and tobacco use
- Psychosocial issues, such as lack of social support, that may influence patient adherence
- Caregiver support, or lack thereof
- Other factors, including physical limitations, need for adaptive devices, barriers to meeting care needs and treatment requirements, visual or hearing impairment, and language or cultural needs

As needed, care team members will develop individually tailored interventions to address:

- Condition monitoring, including self-monitoring (e.g., foot and skin care for diabetics) and reminders about tests the patient should perform themselves or complete through their practitioner
- Adherence to treatment plans (including medication adherence) and tracking mechanisms
- Communication with practitioners about patient's health conditions, self-management and condition-monitoring activities, and progress towards goals
- Additional resources external to the organization, as appropriate (e.g., community programs, American Diabetes Association)

Disease Management

Passport is committed to supporting you and your patients who have chronic conditions. We offer five disease management programs that support the patient using condition-specific education and self-management tools. Programs are available for patients living with heart failure, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, and asthma. If you have a patient who may benefit from participating in a program, please call 855-859-1734 for enrollment information.

Clinical Practice Guidelines
Care Coordination's disease management program education and self-management materials for each condition are based on nationally recognized, evidence-based guidelines, which may be accessed on the following websites:

Condition	Clinical Guideline
Heart Failure	http://circ.ahajournals.org/content/128/16/e240
COPD	http://goldcopd.org/gold-2017-global-strategy-diagnosis-management-prevention-copd/
Guideline on Lifestyle Management to Reduce Cardiovascular Risk	http://circ.ahajournals.org/content/129/25_suppl_2/S76.full
Adult Diabetes	https://professional.diabetes.org/content/clinical-practice-recommendations
Asthma	http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm

Coordinating Interventions with the Patient's Primary Care Practitioner
Care Coordination works with patients' practitioners to coordinate care as needed. For services requiring physician oversight or orders (e.g., DME, medications, physical therapy, emergent/urgent medical concerns, changes to care plan), Care Advisors contact practitioners via phone, client EMR, or in person (for example, if a nurse is embedded in the practice). Care Advisors then follow up with the patient to ensure care coordination efforts have been successful and, if not, the Care Advisor informs the patient's practitioner.

Practitioner Feedback

Passport provides semi-annual reports to practitioners alerting them to care opportunities for their patients who have one of the identified chronic conditions. The focus of the report is to notify practitioners of their patients who may have care gaps related to their chronic condition. These may include missed services, recommended tests, medications, or other care gaps based on clinical practice guidelines.

On an as-needed, individual basis, the Care Advisor or Health Educator will alert the practitioner to time-sensitive care opportunities, such as an asthma patient increasing his or her use of a rescue inhaler or a heart failure patient reporting weight gain.

For questions, or to provide feedback about Complex or Condition Care, or to request a hard copy of our disease management materials please call or write us at:

877-903-0082, Monday to Friday, 9 a.m. to 5 p.m. EST
TTY users: 800-691-5566

Passport Health Plan
Attn: Care Coordination
5100 Commerce Crossings Dr.
Louisville, KY 40229

Practitioner Rights

All practitioners with patients eligible for or enrolled in Complex or Condition Care have a right to:

- Have information about Passport, its staff, and its staff's qualifications, and any contractual relationships
- Decline to participate in or work with Passport's programs and services for their patients, if contractually allowable
- Be informed how Passport coordinates interventions with treatment plans for individual patients
- Know how to contact the person responsible for communicating with patients
- Be supported by Passport when interacting with patients to make decisions about their health care
- Receive courteous and respectful treatment from Passport's staff
- Communicate complaints to Passport