An Integrated Approach to Physical and Behavioral Health

Geisinger Health Plan
and
Service Access & Management, Inc.

Overview

- History of the Development of the Community Based Care Management (CBCM) Program
- "Care/Case Management" Model
- Data Application
  - Member (Electronic) Record
  - Record of Service Delivery
  - Data Management
- Data Analysis/Outcomes
- Next Steps

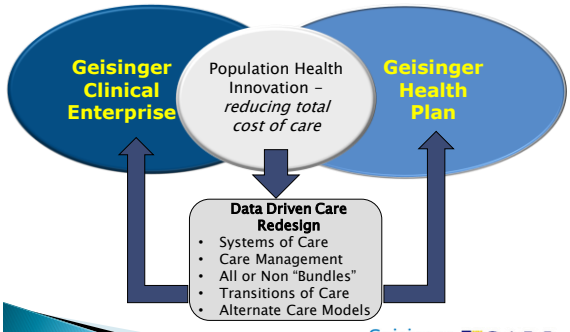
Geisinger Health System: *An Integrated Health Service Organization*

Provider Facilities
- 8 Hospital/Acute Care Campuses
- Marworth Alcohol & Chemical Dependency Treatment Center
- 8 outpatient surgery centers
- 2 Nursing Homes
- Home health and hospice services
- 2,663 licensed inpatient beds

Physician Practice Group
- ~ 1,800 physician FTEs
- Multispecialty group
- ~ 900 advanced practitioners
- ~ 215 primary & specialty clinic sites (41 community practice sites)
- ~ 3.4 million outpatient visits
- ~ 520 resident & fellow FTEs
- ~ 365 medical students

Managed Care Companies
- ~540,000 members (including ~88,000 Medicare Advantage members and ~176,000 Medicaid members)
- Diversified products
- ~56,000 contracted providers/facilities
- 45 PA counties
- Offered on public & private exchanges
- Members in 4 states

The Geisinger Advantage



Geisinger's ProvenHealth Navigator Managing and Improving the Health of Populations

Managing and improving the health of populations

Patient-Centered Primary Care	• PCP-led team-delivered care, with all members functioning at "top of skill set / license" • Enhanced access; services guided by patient needs and preferences • Enhanced member and family education & engagement
Population Health Care Management	• Population identification, segmentation and risk stratification • Chronic disease and preventive care optimized with EHR, clinical decision support • Care manager as core member within care team • Automated interventions triggered by gaps in care (EMR as team member)
Medical Neighborhood	• 360°care systems – SNF, ED, hospitals, home health, pharmacy, etc. • Physician profiling, selective specialty/facility referral • Transitions of care & community services integration
Performance Management	• Patient and clinician satisfaction • Cost of care, utilization, efficiency • Quality metrics, addressing variations in clinical care
Value-Based Reimbursement	• Bridging the journey between FFS and pay for value • Embracing payment models that support population accountability – results share, upside risk, global budgets, etc. • Payments distributed on measured quality performance

Our Approach to Advanced Case Management

High-risk Identification	Targeted Populations	Comprehensive Assessment	Team Care
• Predictive modeling • EHR data • Medical claims • Pharmacy data • Health Risk Assessment (HRA) data	• HF, COPD, oncology • Special populations – CF, CP, MS, pregnancy • Multiple trauma • ESRD, frail elderly • TOC	• Driving issue behind case • Physical and psychosocial gaps • Readiness to change • Family/social supports • Frequent follow-up with patient/family	• Daily interaction with provider • Active team member • Patient sees CM in practice or with specialist • Pushes access & exacerbation management

Medical Neighborhood

Care Management Collaboration with SAM, Inc.

Referral	Collaborate	Plan	Educate
• Length of Stay >5 • Readmission • Non emergent ED utilization • Pediatric Dental Care Gaps • GHP Care Management referral	• Patient • Physician • Family/Care-giver • Home Health • SNF • Pharmacy • Behavioral Health Provider • OP/IP CM	• SAM CHA and GHP Care Management review plan of care • Assess available Healthcare & Community Resources	• Reinforce plan (IP D/C plan, OP CM Plan, etc.) • Discuss questions or concerns with patient and family • Teach how to access resources

History: *Initiation of CBCM Program*

- Funding
- Selection of Service Access & Management, Inc. (SAM) as GHP's Partner in Developing the CBCM Program

History: *SAM*

- **SERVICES: Mobile Case Management**
  - Mental Health (MH) Case Management (CM)
  - Intellectual Developmental Disabilities (IDD) Supports Coordination (SC)
  - Early Intervention (EI) Service Coordination (SC)
  - Office of Long Term Living (OLTL) Supports Coordination
  - CBCM
  - Also: Certified Peer Support Specialist, Joint Planning Team, Housing Assistance, and Truancy Remediation Services
- **LOCATIONS**
  - Case Management Services: Forty-eight (48) Counties in PA
  - IDD SC in NJ

Current State

Scope of Program

- **Total GHP Family (Medicaid) Membership:**
  - 176,000+
- **Outreach Attempted by the CBCM Program:**
  - Nearly 12,000 Members
- **Successful Attempted Contacts:**
  Nearly 5,000 Members "Touched"
- **Counties:**
  - 22
- **Staff:**
  - Director
  - Supervisor
  - 21 Community Health Assistants (CHA's)

Care/Case Management Model: *Mission*

- To improve population management in terms of members'/caregivers' independence/self-sufficiency, community integration, and general well-being by extending health management resources and services to at-risk members

Care/Case Management Model: *Mission*

- To implement a holistic and community-based approach to care management, which focuses on accessing health care to meet physical health needs and to promote physical health and general well-being in terms of:
  - Reducing preventable admissions, readmissions, and non-emergent emergency room visits;
  - Enhancing outreach efforts for preventative pediatric dental visit compliance; and
  - Improving integration efforts between physical and behavioral health care, specifically for those with identified mental health issues, high risk pregnancy or other issues as identified by GHP Case Managers

Care/Case Management Model

- **Health Plan Members** are referred from GHP to SAM
- **Outcomes** are Related to Member Classification
  - Pediatric Dental Care Gap: Pediatric Dental Visit
  - Re-Admission/Post-Acute Discharge: Re-Admission/Post-Acute Care Discharge Education, Medication Reconciliation, and Appointment
  - Non-Emergent Emergency Room Visits: Non-Emergent Discussion
  - Length of Stay (>5 Days): Education, Medication Reconciliation, and Appointment
  - Case Manager Referral: Education
  - High Risk Pregnancy: Education

Care/Case Management Model

- **Fundamental Program Process**
  - Outreach and Engagement
  - Information and Referral

Fundamental Program Process

- **Implementation of Case Management Functions**
  - Indicators for Implementation
    - Referral from a GHP Case Manager
    - Multiple Referrals for the same Member
    - Multiple Contacts for the same Member (by a CHA)
    - Identification of an Issue which Creates a Barrier to Achievement of a Standard (classification-based) Outcome
      - Goals/Objectives which must be completed in order to accomplish the standard outcome

Fundamental Program Process

- **Holistic Assessment of Needs and Resources:**
  - Biopsychosocial Domains as related to Physical Health
  - Barriers, Influences, or Issues which Impact Accessing of Healthcare
  - Strengths/Skills/Resources, Needs, and Preferences/Desired Changes relative to Physical Health and related Services
- **Planning:** Goals and Objectives
- **Intervention:** Facilitating Engagement in Healthcare and other Necessary/Related Services

Fundamental Program Process

- **Other Critical Elements:** Congruence with NACM Practice Guidelines
  - Mobility
  - Frequency of Contact – Determined by Need and Goals/Objectives
  - Implementation of a Service Plan
  - Collaboration with other Providers/Stakeholders
  - Monitoring
  - Advocacy
  - Utilization of Natural Supports/Community Resources

Care Coordination and Management Information System (CCAMIS)

- **Functions of Data Application**
  - Member (Electronic) Record
  - Record of Service Delivery
  - Guide to Program Process
  - Data Gathering and Reporting
    - Data Entry as a "Live" Function, resulting in…
    - The Ability to Aggregate Data for the Purposes of…
    - Program Management and…
    - Reporting to GHP

Data Analysis

- **Process Targets**
  - Completing Required Attempts to Contact Members
    - Amount, Type, Success/Failure

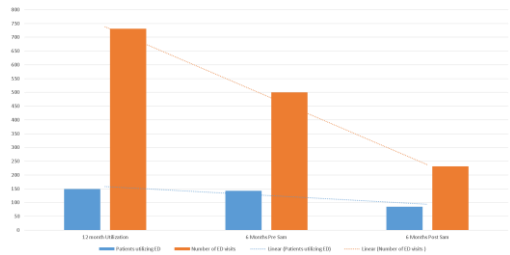
Data Analysis

- **Relationships between Fundamental Program Elements**
  - **Reason for Referral:** per GHP Membership Classification
  - **Parameters of Contact**
    - Location/Type of Contact, Person, Amount/Duration of Service
  - **Issues/Barriers Identified**
    - Member Issues
    - Systems Issues
  - **Interventions**
  - **Outcomes:** Accessing Healthcare (per Reason for Referral/Member Classification)

Data Analysis

- **Long-Term Considerations**
  - Outcomes related to outreach/accessibility of services
  - Reductions in preventable admissions, re-admissions, and non-emergency room visits
    - Reductions in related costs
  - Outcomes in terms of health status relative to mental health, high risk pregnancy, or other issues identified by GHP

ED Utilization Outcomes: Initial 3 Months



- Total number of members utilizing ED: Decreased by 40%
- Total number of ED visits: Decreased by 53%

Next Steps

- Oversight
- Expansion
- Data Analysis