PASSPORT HEALTH PLAN

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Maternity Care Management

Complex Care Management

Chronic Respiratory

Diabetes

2018
Complex Care

Program Evaluation

Coronary Artery Disease

Catastrophic Care Management

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

Heart Failure

Transition Care Management

2018 Complex Care Program Evaluation

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2018 Complex Care Program Evaluation

Program Title: Complex Care (CC) Program Evaluation

Evaluation Period: January 1, 2018 – December 31, 2018

Program Purpose: The CC Program is a system of coordinated healthcare interventions and communications. The CC Program targets individuals with conditions for which patient self-care efforts are paramount. Adherence to evidence-based medicine combined with a team approach assist in:

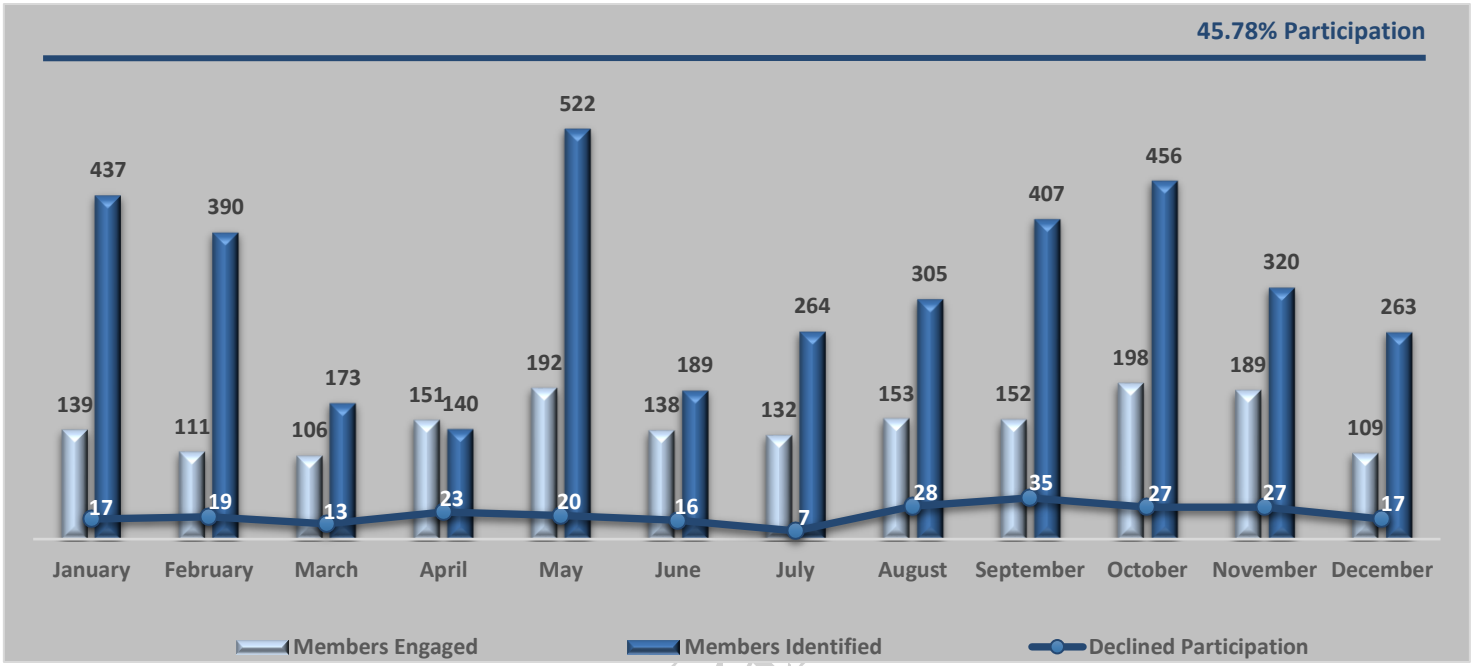
- Empowering members
- Supporting behavior modification
- Reducing incidence of complications
- Improving physical functioning
- Improving emotional well-being
- Supporting the clinician/patient relationship
- Emphasizing and reinforcing use of clinical practice guidelines

Program Goals and Objectives: The goal of the CC Program is to improve the behavioral and physical health outcomes and quality of life of patients with chronic conditions by using a multi-faceted approach to achieve the best possible therapeutic outcomes based on assessment of member needs, ongoing care monitoring, evaluation, and tailored member and clinician interventions. The CC Program can also reduce hospital length of stay and lower overall costs. Program goals include:

- Partner with members, their caregiver and their primary and specialty care clinicians to develop a plan of care or action plan by a nurse Care Advisor
- Improve medication adherence
- Facilitate appropriate communication across the entire care team
- Optimize care management and close relevant gaps in evidence-based care
- Educate patients on their condition and self-management

Annual Participation Rate

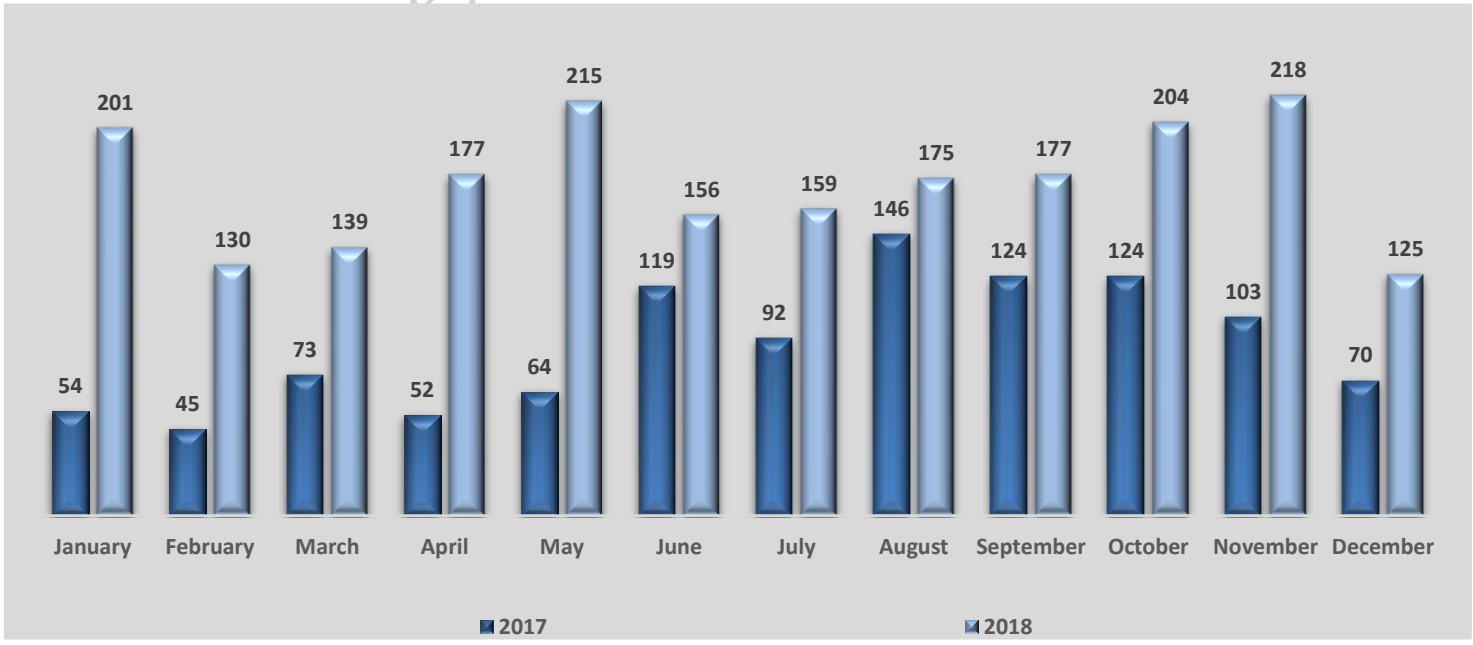
Eligible members are identified and passively enrolled in the CC Program. Members may "opt out" of the Program and elect not to receive services, by notifying a Care Advisor or the Care Connector Program, either telephonically or in writing. Participation Rates are tracked and reported annually.



Graph 1.

Member Engagement

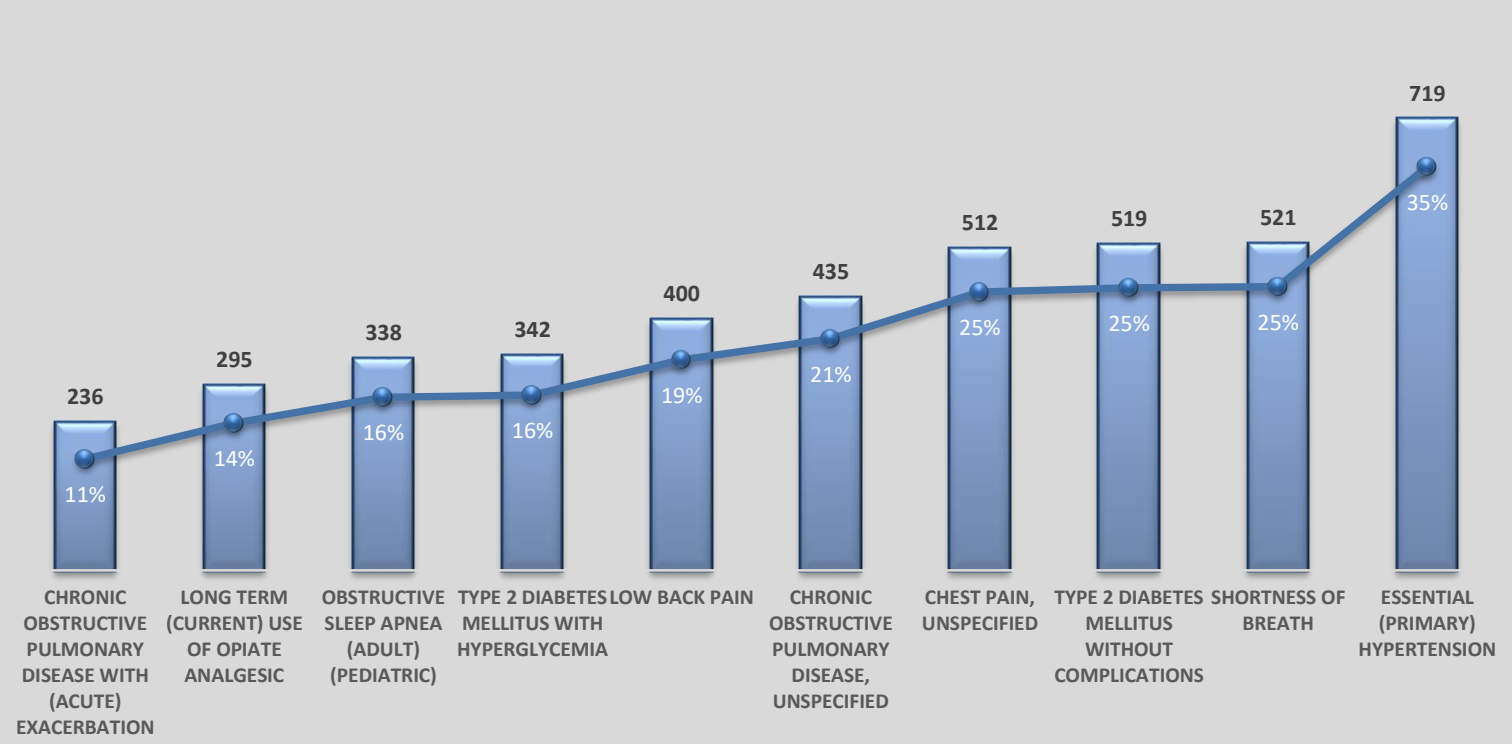
Care Advisors engaged 2,076 members in 2018. This represents a 49% increase from 2017. The program targets members with complex, multiple co-morbidities and psychosocial barriers. Care Advisors work with members to decrease readmissions and ER utilization and to increase utilization of outpatient services and compliance with treatment and care plans.



Graph 2.

Evaluation

I. Top 10 Comorbid Diagnoses



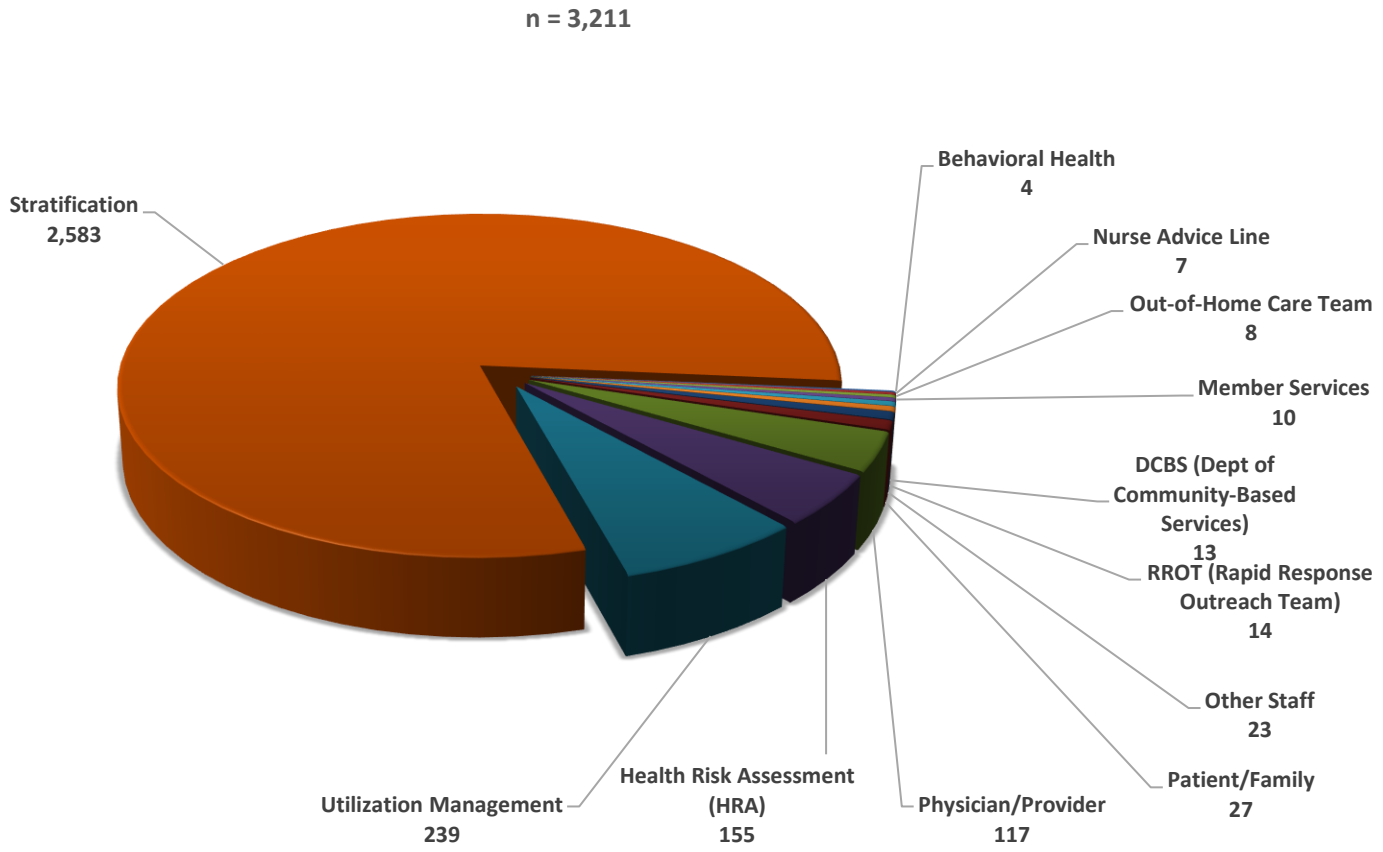
Graph 3.

Passport Health Plan (Passport) annually evaluates the comorbid diagnosis of members who enroll in the CC Program to ensure appropriate staff, materials, and resources are allocated to assist members in improving their health and quality of life.

Findings:
Graph 3 represents a total sample size of 1,719 members, many of whom had comorbid diagnoses (average number of three diagnoses per member) and may have had a different primary diagnosis on a later claim (accounting for the overlap in percentages).

Care Advisors, Health Educators, and Behavioral Health (BH) Case Managers collaborate during regular integrated meetings and via ongoing contact with one another to ensure the needs of these vulnerable members are being met. Care Advisors maintain regular communication with the Passport Foster Care and Guardianship Specialists and/or Manager of Specialty Populations to consult as well. The Care Advisor assigned to the member as well as the Foster Care Specialist participate in team conference calls led by the Children's Review Program (CRP) when a foster care member's needs or presenting issues are impacting CRP's ability to locate appropriate placement for the child.

II. Referral Sources



Graph 4.

Passport proactively identifies members for CC through multiple resource avenues.

Findings:

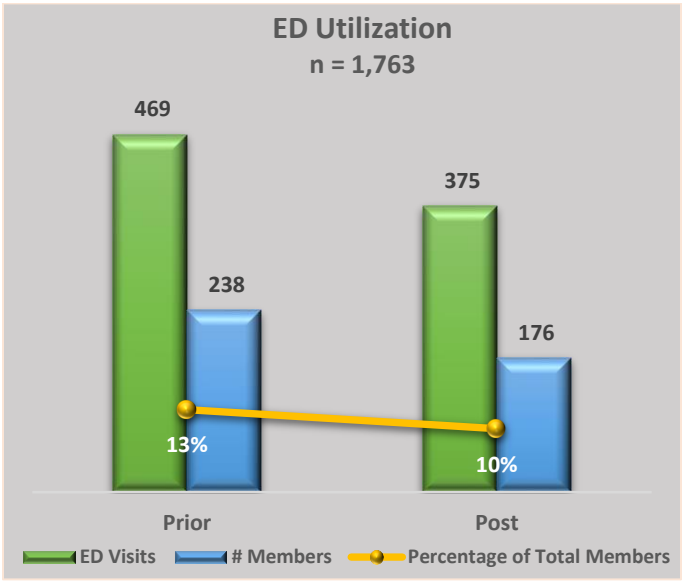
Graph 4 represents referrals by source. The top three sources were:

1) Stratification
2) Utilization Management (UM)
3) Health Risk Assessment (HRA)

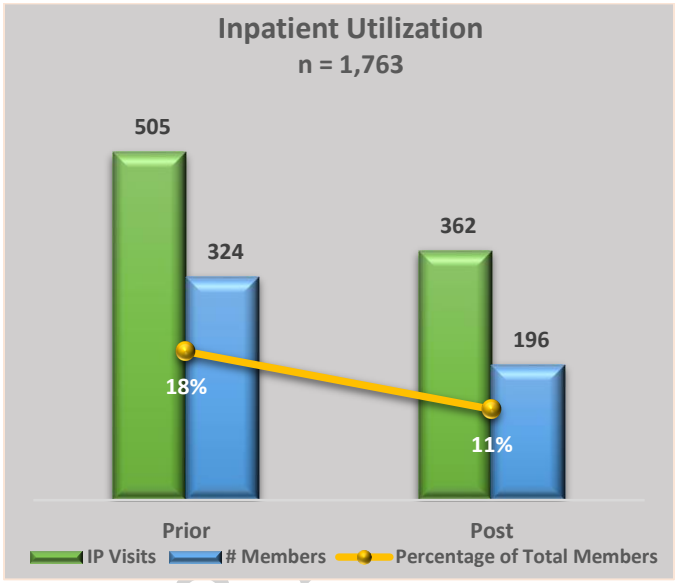
Multiple avenues are used to proactively identify members for CC. Education and information are distributed via the Member and Provider Handbooks, Member Newsletter, New Member Packets, and Member and Provider Program brochures. Provider Request for Care Management Forms are available as well on the Passport website. Education is provided through internal department meetings and internal referrals between CC and BH is encouraged. A daily report is obtained from the 24-Hour Nurse Advice Line of identified members.

HRAs are utilized as a means of risk screening for the member. An attempt is made to obtain an HRA for all members.

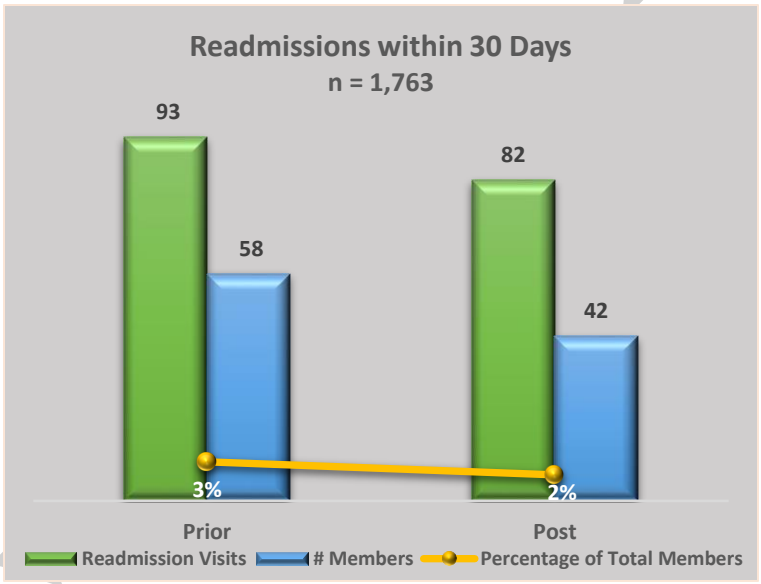
III. Emergency Department and Inpatient Utilization



Graph 5.



Graph 6.



Graph 7.

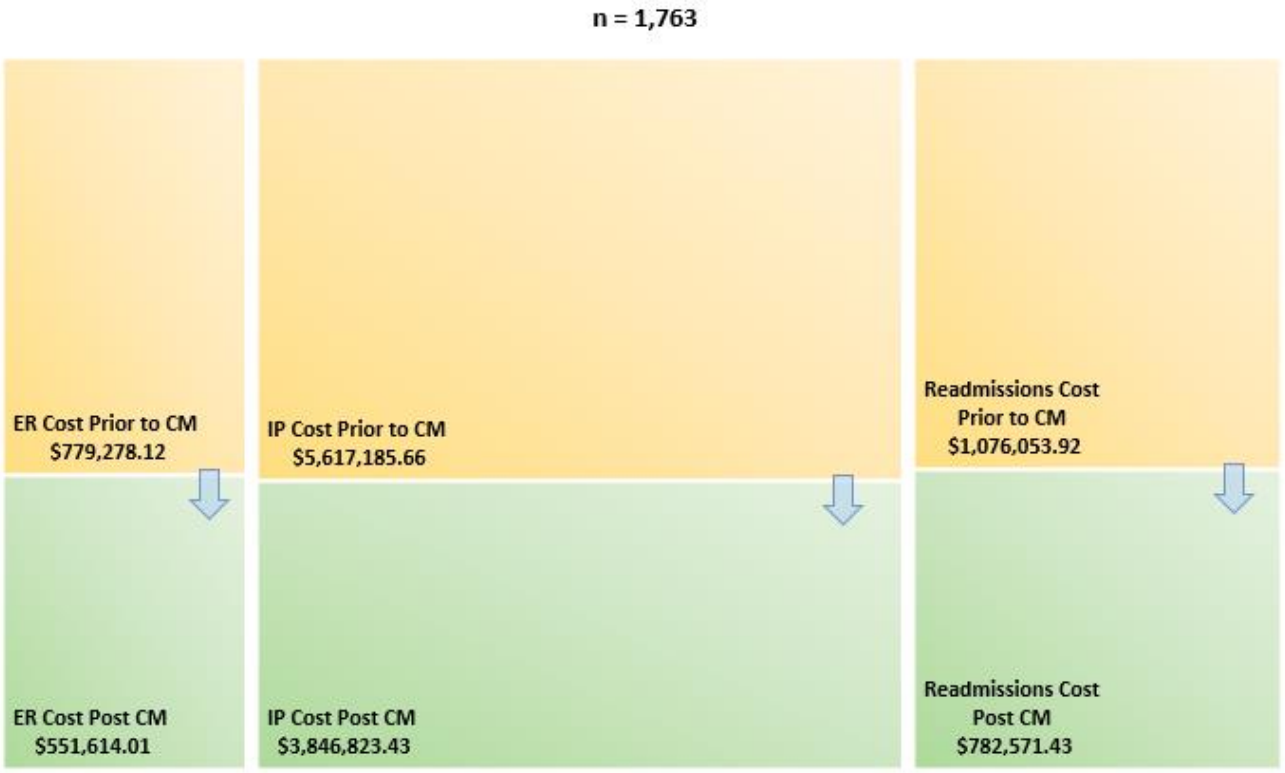
Passport aims to reduce the rate of Emergency Department (ED) utilization, Inpatient Admission, and 30-day Readmissions.

Findings:
Graphs 5, 6, and 7 represents a sample of members in CC and is a comparison of ED/Inpatient utilization six months prior to and after engagement.

After CC involvement during 2018, the data demonstrates:

- A decrease in the numbers of ***members*** accessing the ED (-26.1%), utilizing Inpatient (-39.5%) and being readmitted (-27.6%).
- A decrease in the number of ***visits*** to the ED (-20.0%), a decrease in readmissions (-11.8%), and inpatient utilization (-28.3%).

IV. Cost Trends for Complex Care



Graph 8.

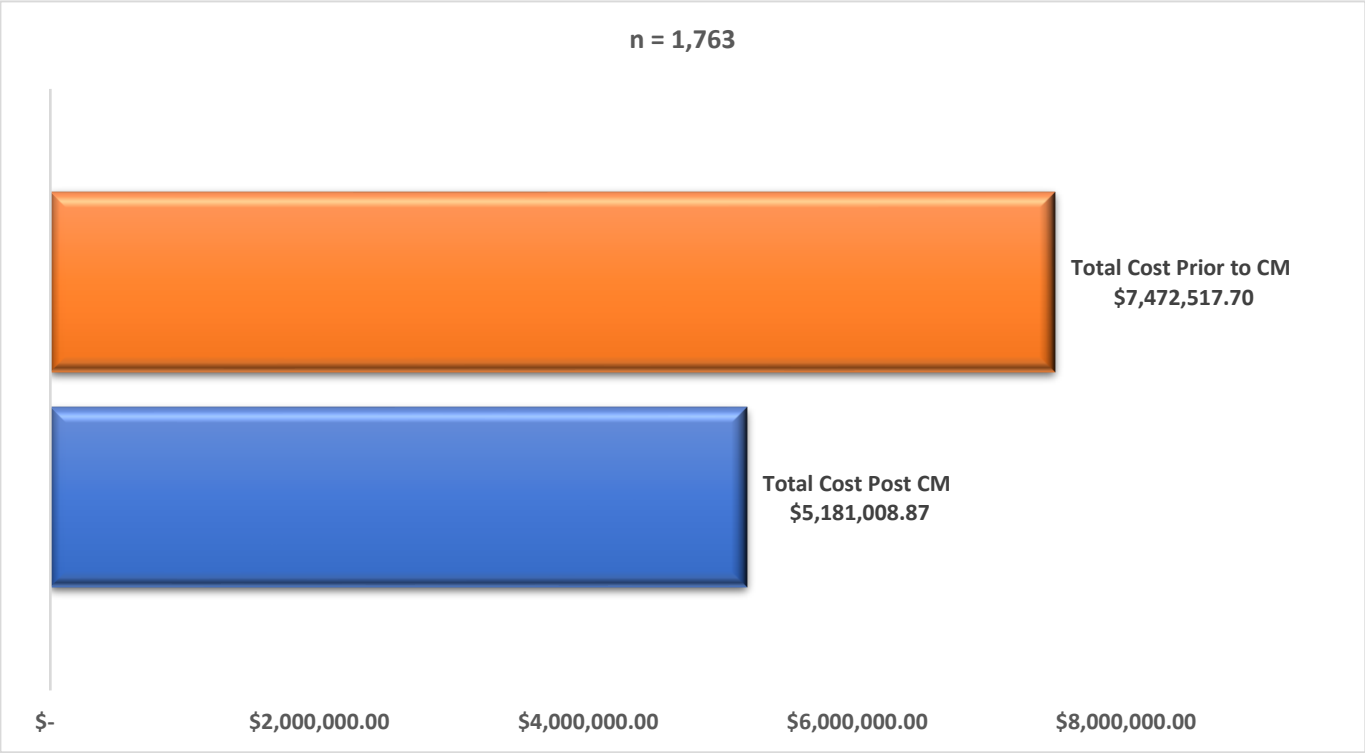
Passport aims to reduce cost related to ED utilization, Inpatient Admission, and 30-day Readmissions.

Findings:
Graphs 8 represents a sample of members in CC analyzing utilization six months prior comparative to after engagement.

After CC involvement during 2018, the data demonstrates:

- A decrease of $227,664.11 in ED cost.
- A decrease of $1,770,362.23 in inpatient cost.
- A decrease of $293,482.49 in readmission cost.

V. Overall Impact for Identified Sample of Complex Care

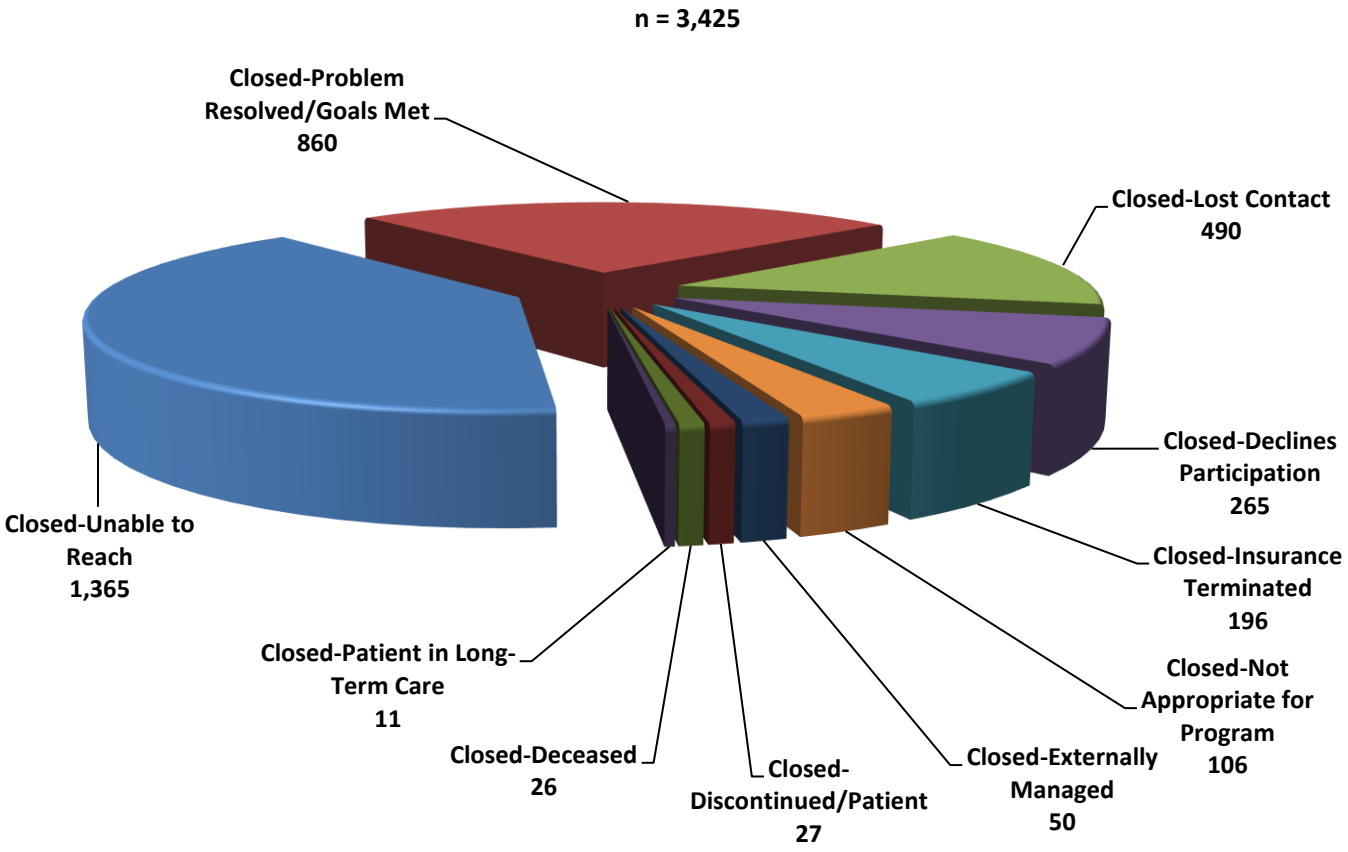


Graph 9.

Summary:
Graphs 9 represents overall impact for the identified sample of members in CC analyzing utilization six months prior comparative to after engagement.

After CC involvement during 2018, the data demonstrates a potential cost savings of $2,291,508.83. This is not representative of the entire program, but instead of only the sample for analysis. This represents what is a potentially significant higher amount for the entire program year.

VI. Discharge Status



Graph 10.

Passport aims to reduce the inability to sustain engagement for CC members by identifying barriers and trends.

Findings:

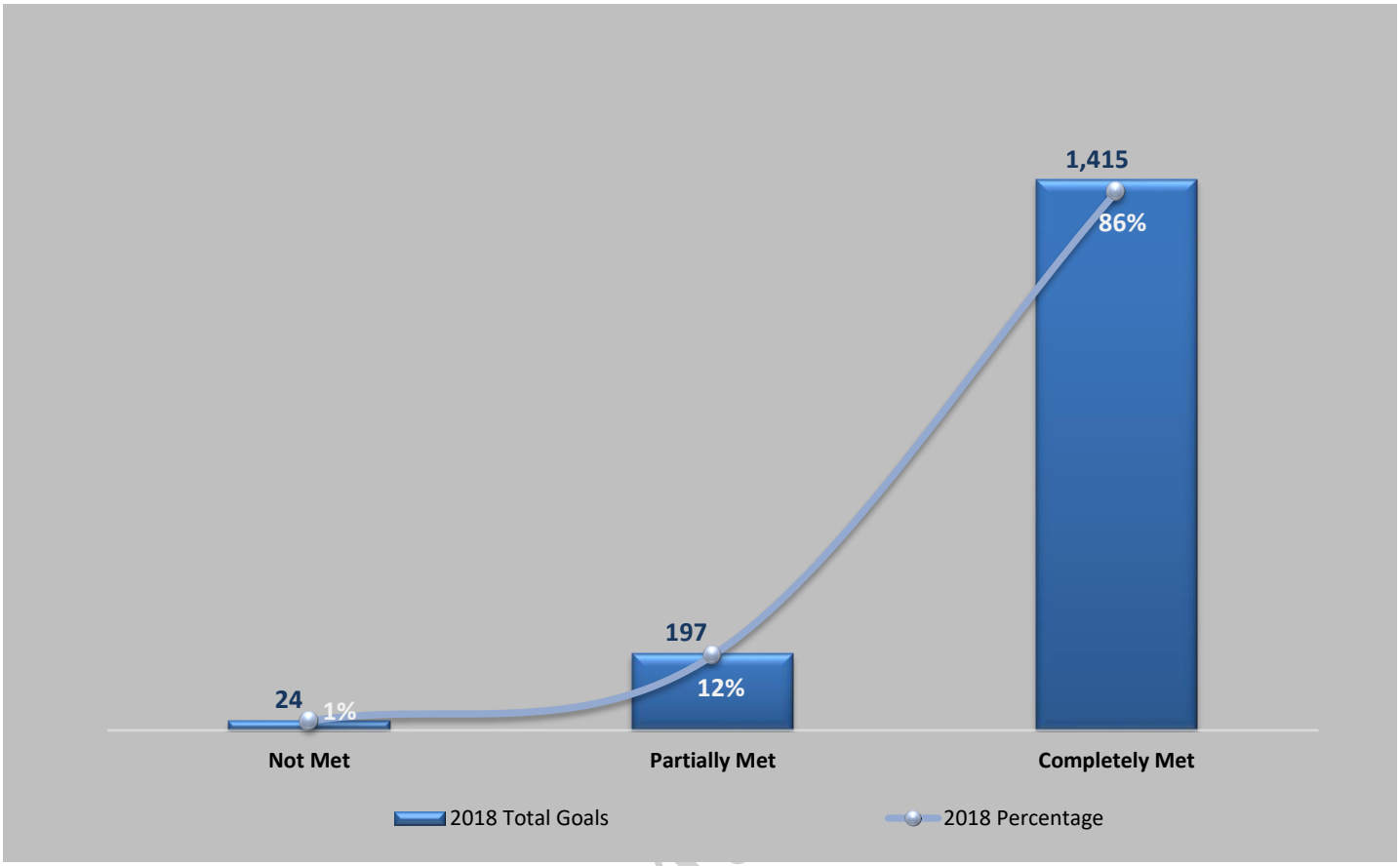
Graph 10 represents reasons for member's discharge from CC during 2018. The top three reasons were:

1) Closed – Unable to Reach
2) Problem Resolved/Goals Met
3) Closed – Lost Contact

There were 1,365 (40%) members discharged due to Care Advisor being unable to reach the member; 860 (25%) members were discharged/closed due to problems resolved/goals met; and 490 (14%) members closed due to lost contact.

Discharge reasons remain consistent with 2017.

VII. Care Plan Goals



Graph 11.

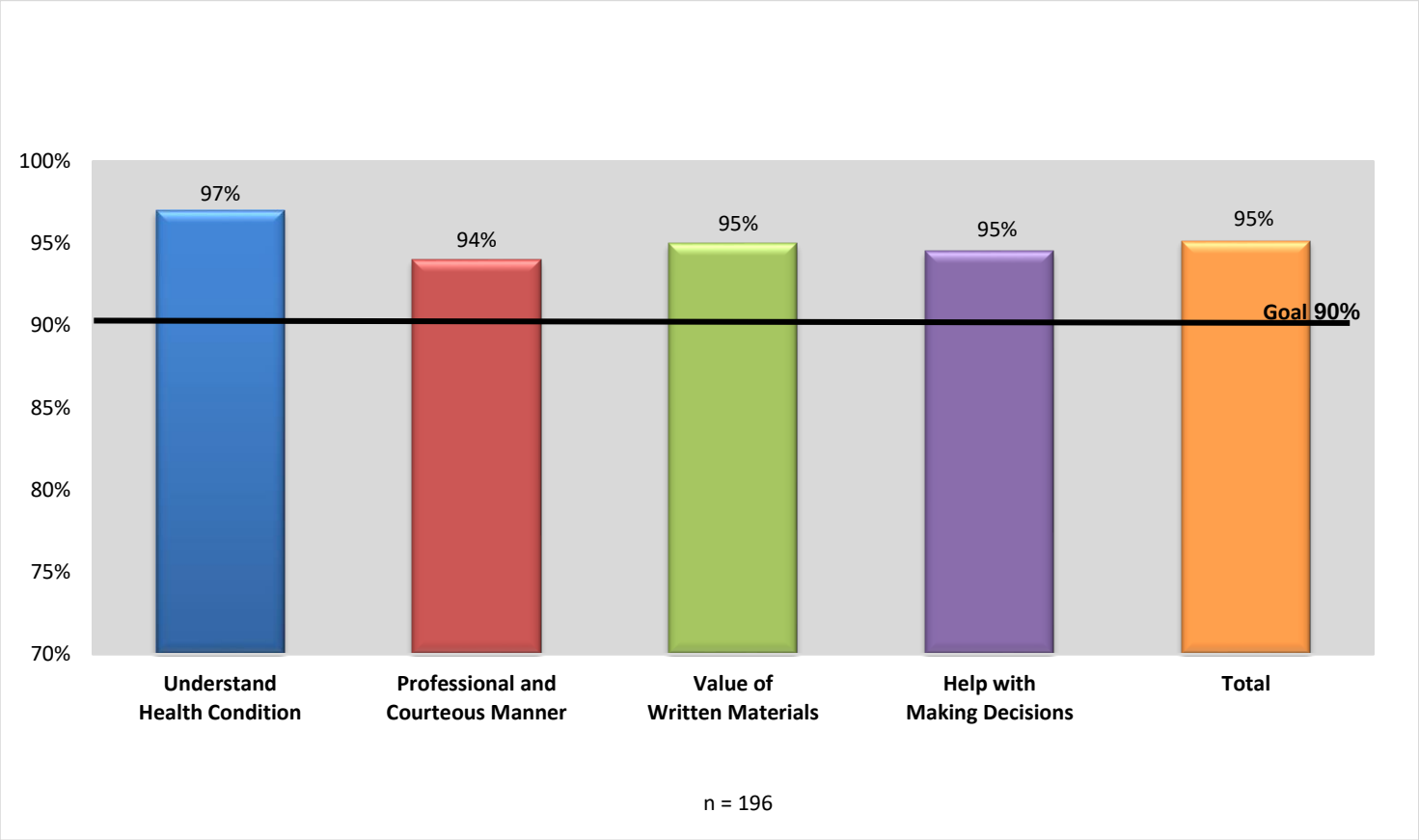
Passport aims to meet or exceed a rate of 90% of care plan goals partially or completely met for members enrolled in CC.

Findings:
Graph 11 represents the status of care plan goals for members enrolled in the CC Program.

In 2018, 1,612 care plan goals were "completed/partially completed." There was a total of 24 goals that were not met.

There was a goal completion rate of 98.53% for 2018; which remains consistent from 2017 (98.35%). The goal to meet or exceed the target of 90% of care plan goals partially or completely met for members enrolled in CC was exceeded.

VIII. Satisfaction Results for Services Received



Graph 12.

Passport aims to achieve or exceed a score of 90% or above in all areas of member satisfaction for CC.

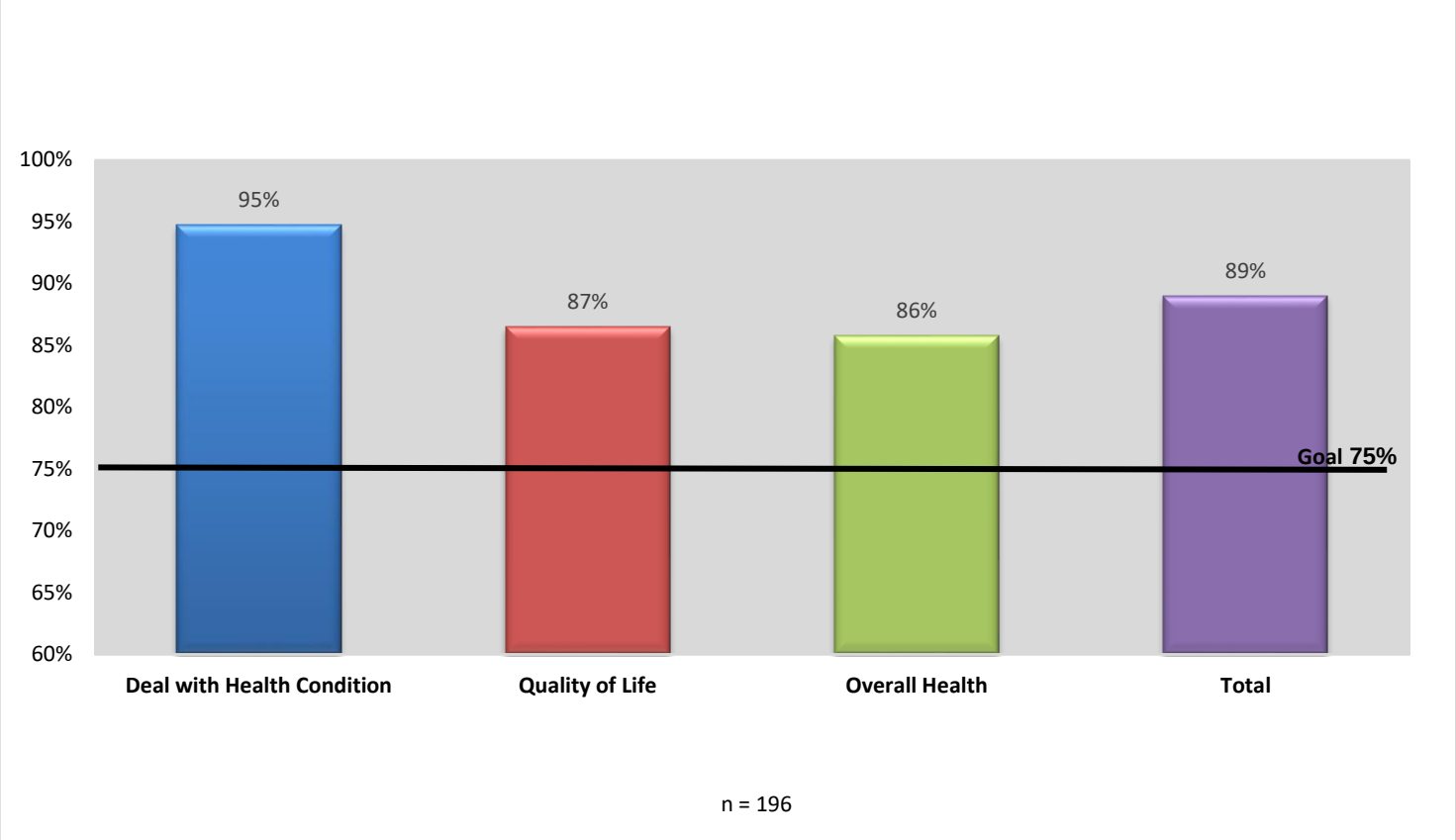
Findings:

Graph 12 represents the members' satisfaction regarding services received. The areas surveyed include:

1) Understand Health Condition
2) Professional and Courteous Manner
3) Value of Written Materials
4) Help with Making Decisions

The goal was to achieve 90% satisfaction for each area. For 2018, 718 telephonic member surveys were conducted, of which 196 were returned (23% response rate). Of the members who responded to the survey, 97% reported they could understand their health condition better, 94% reported the Care Advisor had a professional and courteous manner, and 95% reported the written materials they received had value and help with making decisions regarding their health. The target was exceeded in all areas.

IX. Satisfaction Results for Improvement of Health and Quality of Life



Graph 13.

Passport aims to maintain or exceed the goal of 75% or above in member's perception of improved overall health status and quality of life.

Findings:

Graph 13 represents the members' satisfaction regarding improvement in health or quality of life. The areas surveyed include:

1) Deal with Health Condition
2) Quality of Life
3) Overall Health

The goal was to achieve 75% satisfaction/agreement for each topic. Of the 196 members who responded to the survey, 95% reported they could deal with their health condition; 87% reported improvement in quality of life, and 86% reported improvement in overall health. The target was exceeded in all areas.

During 2018, there were no complaints received regarding the CC Program or the Complex Care Advisors.

Barriers and Opportunities

Barrier:
Inability to locate member for initial assessment or ongoing contact.

Opportunity:
- Collaborate with providers to encourage member participation and locate additional demographics.

- Attempt to obtain working phone numbers through unable to reach letter, providers, pharmacies, Spokeo, and TracFone. (Use Program Coordinators to assist with this when needed.)

Barrier:
Member unwilling to comply with treatment plan and its completion.

Opportunity:
- Member education regarding the benefits of CC through individualized contact with the member.

- Care Advisors and Population Health managers collaborate with providers to encourage member participation.

Barrier:
Limited member response to the CC survey.

Opportunity:
- Encourage member response to survey at the time of discharge.

- Implemented telephonic Member Satisfaction Survey. Questions include how the program helped the member understand their health condition, if the Care Advisor was professional and polite, if the program materials were helpful, if the Care Advisor gave information that helped the member make decisions about their care, if the Care Advisor helped the member deal with their health condition, and if their overall health and quality of life had improved since working with the Care Advisor.

Completed Activities for 2018:

Provider Education:

- Encouraged provider involvement with CC.

Member Education:

- Educated members/caregivers regarding CC benefits and services through telephonic outreach, Passport's website, and member educational material.

- CC identified and enrolled medically complex foster care members, and members identified as individuals with special health care needs.

Screening Activities:

- Administered the Patient Health Questionnaire (PHQ) 2 and the Pediatric Symptom Checklist-17 (PSC-17) a BH screening used with member's ages 4 to 17. There were 1,365 adult members screened and 36% of those members had a positive result, leading to the PHQ-9 being administered. Of those members, 430 were referred for BH services. There were no pediatric members screened using the PSC-17 screening tool during 2018.

- The Member Satisfaction Survey is administered telephonically to members enrolled in the CC Program. Surveys were reviewed as received and outreach was conducted to those members who indicated "fair" or "poor" responses on their survey (if the member completes contact information section of the survey tool). Passport monitored surveys for trends, and none were identified. Managers provided feedback to individual staff when appropriate. No areas were identified that needed improvement.

Identification Activities:

- CC engaged with 2,076 members in 2018.

- Care Advisors exhausted all measures to establish and maintain contact with members including calling provider offices, utilizing the Medical Management System to locate current address and phone numbers, checking Spokeo for other contacts, and mailing unable to reach letters with contact information included.

- Collaborated with other departments such as UM, Member Services, and Provider Relations to identify members who could potentially benefit from CC services.

- Continued to improve integration and collaboration with BH to improve overall coordination of care for members with co-existing medical and BH diagnoses/conditions.

Planned Activities for 2019:

<u>Continued Interventions</u>:

- Encourage provider involvement with CC.

- Increase provider/practice engagement, targeting select practices to implement care conferences where CC needs of patient roster will be discussed.

- Educate members/caregivers through:
  - Telephonic outreach
  - Member newsletters
  - On-hold SoundCare messages
  - Passport's website
  - Member educational materials

- Continue to monitor member care gaps and work with member and clinician to increase preventative health screenings.

- Evaluate alternate methods of communication with members for health messaging.

- Administer the PHQ-2, PHQ-9 (for adults) and PSC-17 (for children ages 4-17) to prescreen and screen for depression in members and referred members to the BH team as needed.

- Review surveys as received and conduct outreach to those members who indicate "fair" or "poor" responses on their survey (if the member completes contact information section of the survey tool).

- Monitor for trends, provide feedback both positive and negative to individual staff and address any identified areas that need improvement.

- Collaborate with other departments such as UM, Member Services, and Provider Relations to identify members who could potentially benefit from CC services.

- Continue to improve collaboration with BH to improve overall coordination of care for members with co-existing medical and BH diagnoses. To include behavioral health/substance abuse facilities.

- Revise member and provider correspondence (*i.e.,* letters, materials, etc.) to improve member and clinician education regarding CC services.

- Utilize care conferences with select practices to solicit feedback from provider/practices on needed provider education materials, webinars, etc.

Overall the CC Program noted improvements in 2018, particularly in the number of members engaged in the program during the year. Based upon the 2018 evaluation, Passport continued to adapt and evolve in working toward the overall goal of improving the health and quality of life for our members with complex conditions.