AN INTEGRATED APPROACH TO PHYSICAL AND BEHAVIORAL HEALTH: An Update

GEISINGER HEALTH PLAN

and

SERVICE ACCESS & MANAGEMENT, INC.

PRESENTATION OUTLINE

- History of Program Development
- "Care/Case Management" Model
- Data Application Functions
- Program Updates
- Program Data
- Results: Outcomes & Successes
- Constants
- Future Plans

Geisinger GHP Family

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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
- Home health and hospice services
- 2,663 licensed inpatient beds

Physician Practice Group

- Multispecialty group
- ~ 1,500 physician FTEs
- ~ 800 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

- ~555,000 members (including ~90,000 Medicare Advantage members and ~188,000+ Medicaid members)
- Diversified products
- ~56,000 contracted providers/facilities
- 45 PA counties
- Offered on public & private exchanges
- Members in 4 states

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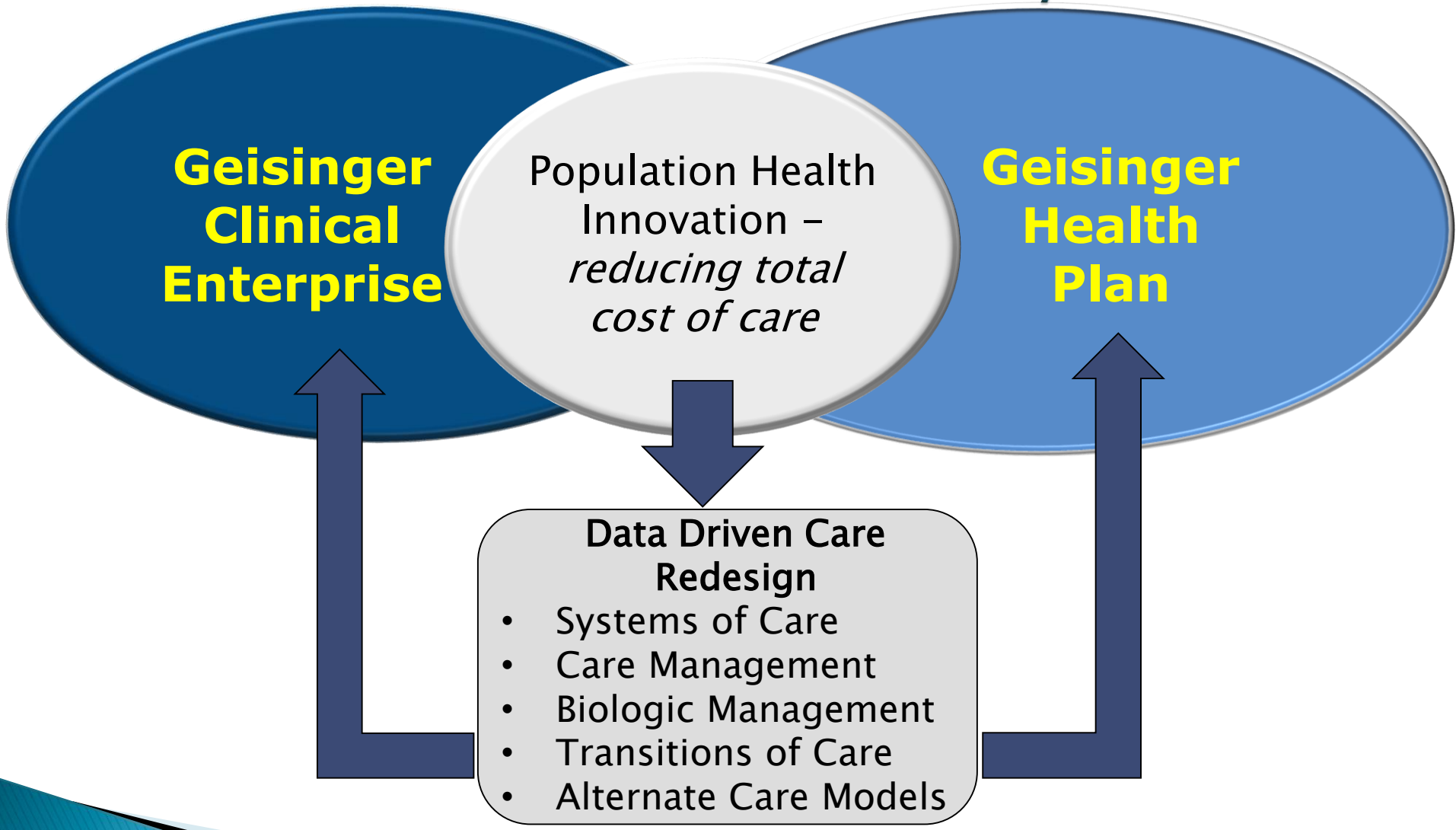
Leveraging the skills and competencies of both the Provider and Payer



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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

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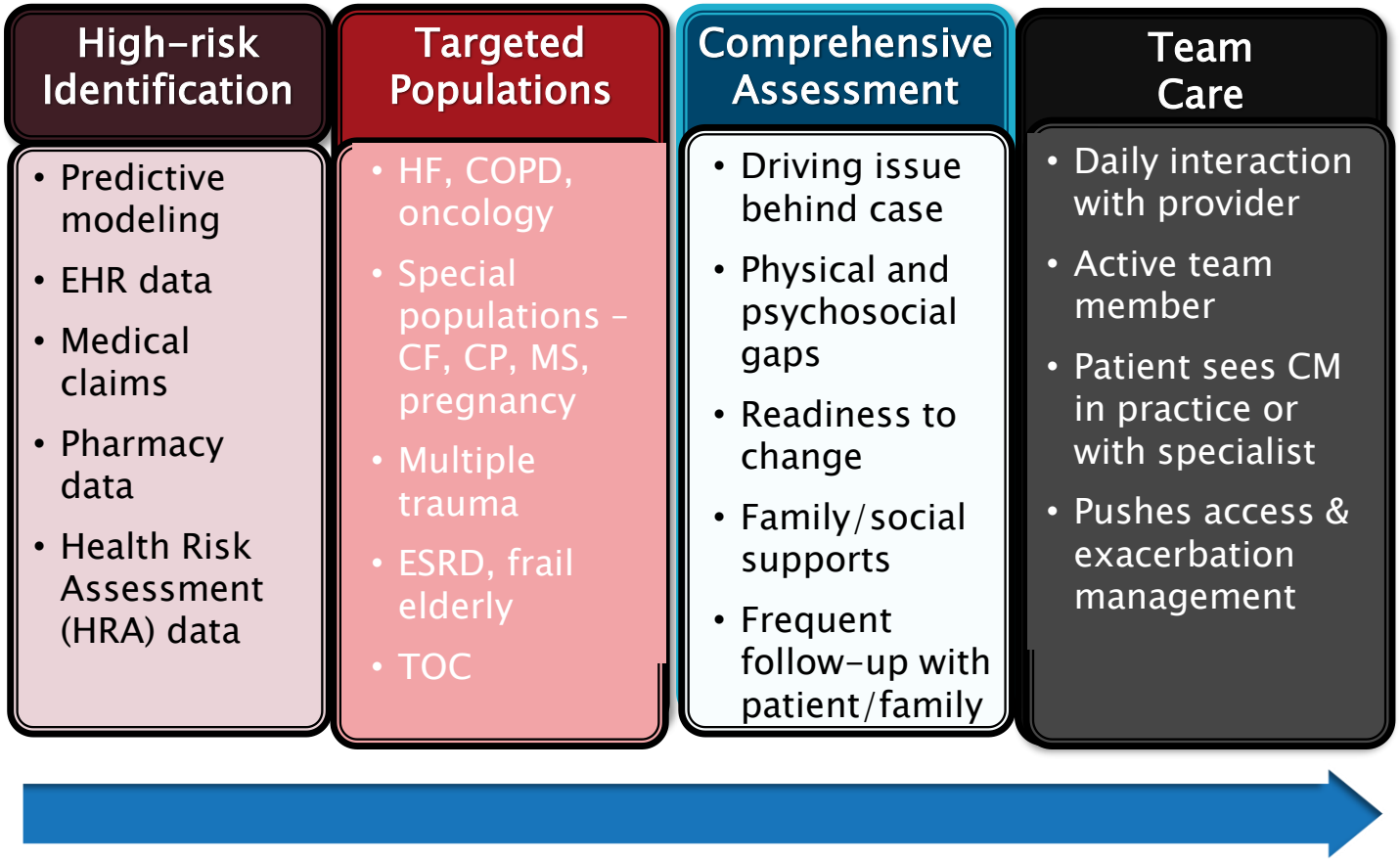
Our Approach to Advanced Case Management



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Medical Neighborhood

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Care Management Collaboration with SAM, Inc.

- Non emergent ED utilization
- GHP Care Management referral
- Pediatric Asthma – Medication Non Adherence
- Social Determinants of Health

- Patient
- Physician
- Family/
- Caregiver
- 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

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HISTORY:
INITIATION OF CBCM PROGRAM

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

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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 Advancing School Attendance Program
- **LOCATIONS**
  - Case Management Services: Forty-eight (48) Counties in PA
  - IDD SC in Six (6) Counties in NJ

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HISTORY: *POPULATIONS SERVED*

- Non-Emergent ER Visits
- Length of Stay (>5 Days)
- Hospital Re-Admission
- Pediatric Dental Care
- GHP Care Management Referral

HISTORY: *CURRENT STATUS*

SCOPE OF PROGRAM

- **Total GHP Family (Medicaid) Membership:**
  188,000+
- **Outreach Attempted by the CBCM Program:**
  Nearly 12,000 Members
- **Successful Attempted Contacts:**
  Nearly 5,000 Members "Touched"
- **Counties:** 22
- **Staff:**
  - Director
  - Supervisor
  - 15 Community Health Assistants (CHA's)

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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

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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;
  - Improving integration efforts between physical and behavioral health care, specifically for those with identified mental health issues or other issues as identified by GHP Case Managers.

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CARE/CASE MANAGEMENT MODEL

- **Health Plan Members** are referred from GHP to SAM
- **Outcomes** are Related to Member Classification
  - Non-Emergent Emergency Room Visits: Non-Emergent Discussion
  - Asthma: Education and Medication Adherence
  - Elevated Blood Lead Levels: Environmental Assessment, Education, and Referral
  - GHP Case Manager Referral: Education

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CARE/CASE MANAGEMENT MODEL

- **FUNDAMENTAL PROGRAM PROCESS**
  - Outreach and Engagement
  - Information and Referral

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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

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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

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DATA ELEMENTS and ANALYSIS

- **PROCESS TARGETS**
  - Completing Required Attempts to Contact Members, Family Members, and Other Professionals
    - Amount, Type, Success/Failure

DATA ELEMENTS and 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
  - **Interventions**
    - Also identifies Issues (Member and System)
  - **Outcomes:** Accessing Healthcare (per Reason for Referral/Member Classification)

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DATA ANALYSIS

- **LONG-TERM CONSIDERATIONS**
  - Outcomes related to Outreach/Accessibility of Services
  - Reductions in Non-Emergency Room Visits
    - Reductions in related Costs
  - Outcomes in terms of Health Status relative to:
    - Adherence to Medication
    - Referrals to Behavioral Health, Drug & Alcohol, and Other Community Resources
    - Other Issues Identified by GHP

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PROGRAM UPDATES

- **POPULATIONS SERVED & INTENDED OUTCOMES**
  - Non-Emergent Emergency Room (ER) Visits:
    - Non-Emergent Discussion
  - Asthma:
    - Education and Medication Adherence
  - Elevated Blood Lead Levels:
    - Environmental Assessment, Education, and Referral
  - GHP Case Manager Referral:
    - Education

PROGRAM UPDATES

- **NUMBER of REFERRALS by POPULATION (Average per Month over the Last Year)**
  - Non-Emergent ER Visits: 1,269
  - Asthma: 197
  - Elevated Blood Lead Levels: 10 (total)
  - GHP Case Manager Referrals: 55

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PROGRAM UPDATES

- **STAFFING**
  - **Geisinger Health Plan**
    - RN Case/Health Managers
    - Behavioral Health Case Management
    - Respiratory Therapists
    - Community Health Assistants (CHA's)
    - Dietician
  - **SAM**
    - Director
    - Community Wellness Service Support Program Supervisor
    - 15 Community Health Assistants (CHA's)

PROGRAM UPDATES

- **FUNDING**
  - Pennsylvania Department of Human Services (DHS)
  - Funding based on a Per Member Per Month
    - Funding must be utilized to hire staff with the goal of increasing face to face interactions with members while improve health outcomes

PROGRAM UPDATES

- GEISINGER'S DATA MANAGEMENT
  - Operations Reporting Requirement Quarterly
    - Importance of flexibility:
      - Reporting requirements shifting
      - Populations managed changing
  - Referrals:
    - Claims
      - Medical
      - Pharmacy
    - Utilization
    - Authorization
    - EMR

PROGRAM UPDATES

- **CCAMIS**
  - Automation of Referrals
  - Self-Assignment of Referrals
  - History of Referrals
  - Tracking of Outreach/Engagement Activities
  - Tracking of Case Closures and Outcomes
  - Generation of Reports

PROGRAM DATA

- **ENGAGEMENT: Mobility as Facilitating Engagement, Assessment, and Intervention**
  - "Successful" Face-to-Face Contacts in Community
  - "Unsuccessful" Contacts also result in "Successful" Contacts
  - Follow-up Contacts Initiated by Members for New Concerns

PROGRAM DATA

- **SATISFACTION SURVEY**
  - 100% strongly agreed or agreed that they were happy with the services provided by the Community Health Assistant
  - 96% agreed that the Community Health Assistant explained the purpose of the program and how they could help
  - 96% strongly agreed or agreed that the Community Health Assistant listened and helped the member or their family work through their problems
  - 100% strongly agreed or agreed they would recommend the program to a friend for family

PROGRAM DATA

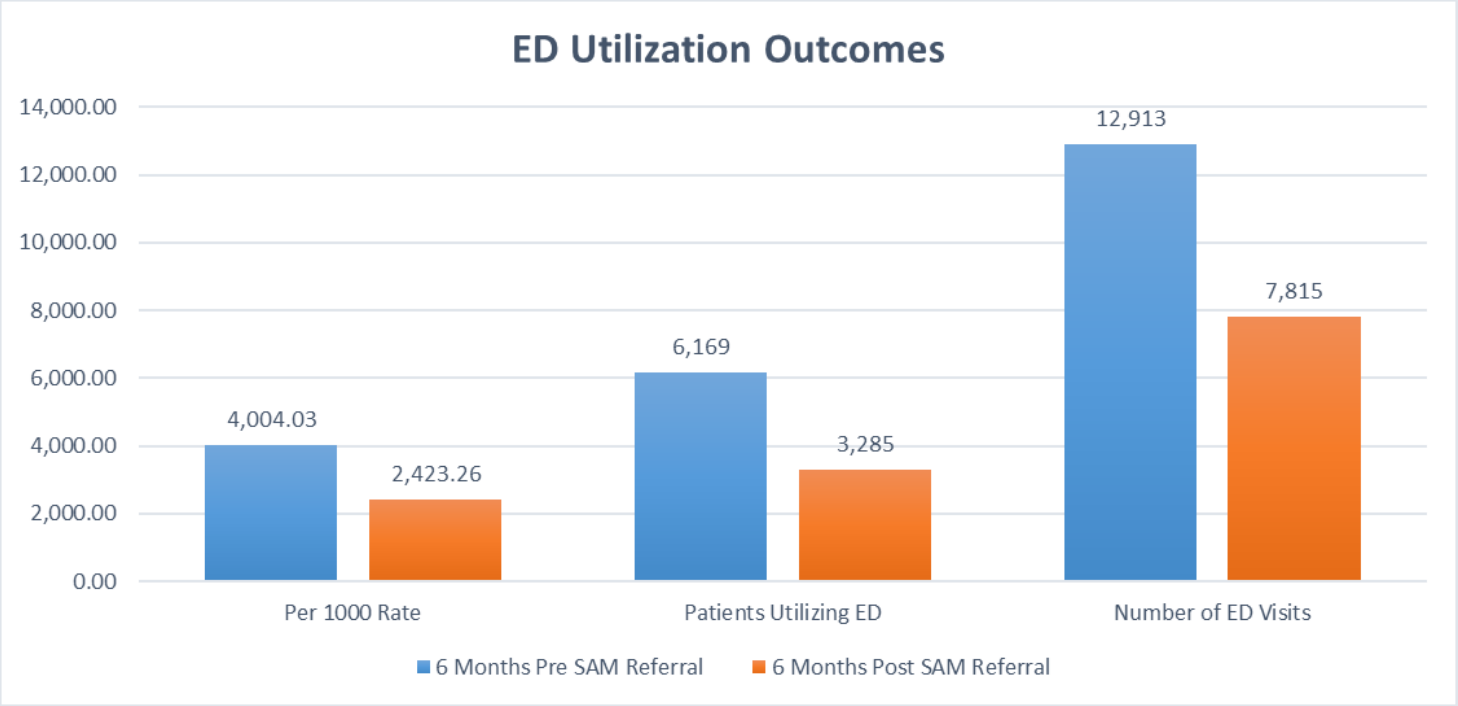
- **BARRIERS**
  - **Individual**
    - Relocations
    - Refused to Participate
  - **System**
    - Incorrect Addresses
    - PCP Offices Declining New Patients
    - Transportation

RESULTS: Outcomes & Successes

- **INCREASES/IMPROVEMENTS in SERVICES**
  - Supports for Transportation
  - Mobile Education and Monitoring
  - Adherence to Medication for Asthma

- **ANECDOTES**

RESULTS: Outcomes & Successes



- Change in ED visits per 1000: Decreased by 39%
- Total number of members utilizing ED: Decreased by 46%
- Total number of ED visits: Decreased by 46%

***Data is reporting overall outcomes since program inception through August 2017.

CONSTANTS

- **FUNDAMENTAL MISSION and CASE MANAGEMENT FUNCTIONS**
  - Independence
  - Improving Overall Health and Wellness
  - Connecting Individuals with Community Resources
- **LOOKING for OPPORTUNITIES for CASE MANAGEMENT**

FUTURE PLANS

- Creating Viable Fee-for-Service and/or Performance-Based Model(s)
- Continuing to Develop Effectiveness Measures
- CCAMIS
  - Off-line Capability
  - Improved Data Collection, Management, and Reporting