Whole Person Care Model

Rhode Island

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Optum Care Management in RI

Whole Person Care (WPC) product:

- High-Risk Medical and BH Case Management
- High-Risk Transitions of Care
- PDN Case Management

RI LOB:

- Medicaid TANF
- Medicaid Expansion
- ABD/SSI
- DSNP

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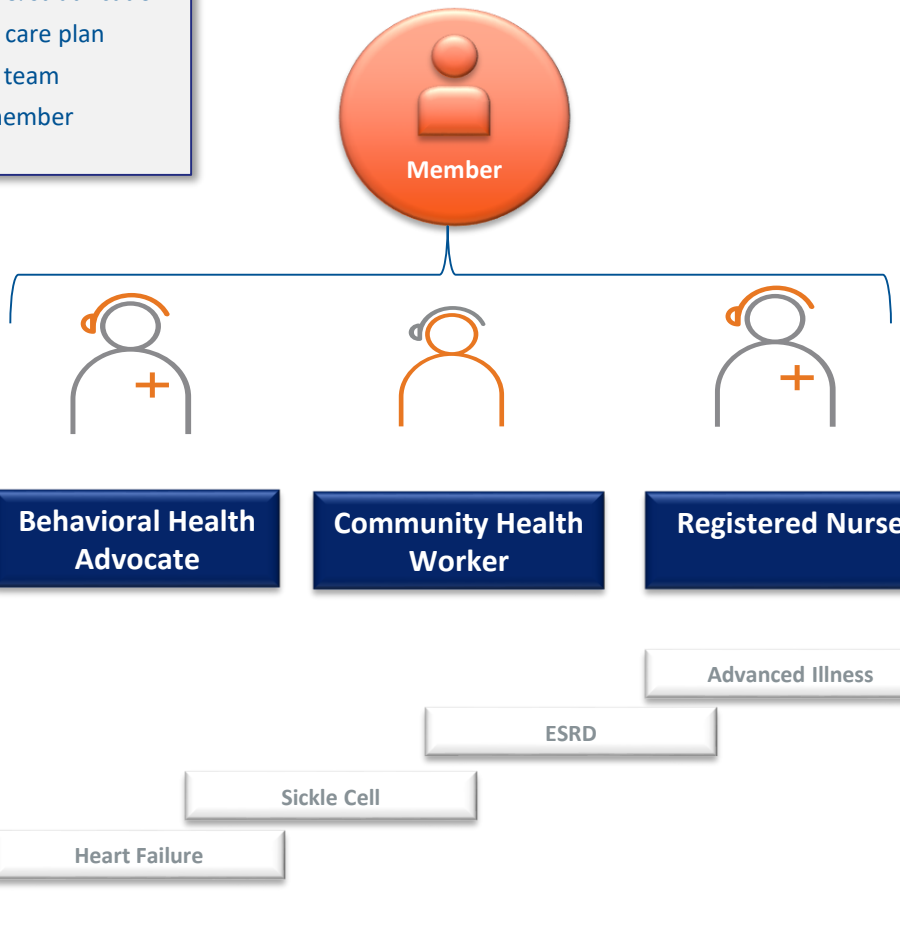
What is Whole Person Care?

- **1. Member-centric care model**
  - Integrated care coordination team (medical, behavioral, social, specialty)
  - Single point of contact to coordinate overall care
  - Incorporation of specialists
- **2. Single technology platform for Behavioral Health and Medical Case Management (Altruista CommunityCare)**
- **3. Expanded Identification Stratification into Emerging Risk population**
  - Identifies the **impactable** members **predicted** to likely be in the top 15% of costs unless an intervention is made
- **4. Supports all Optum-managed populations and stratifications under a single leadership and oversight structure including:**
  - *Persistent Super Utilizers* - Highest cost members and/or individuals with chronic and/or complex illnesses
  - *Emerging Risk* – expanded, newly managed population
  - *Transition Case Management* – Medical and Behavioral health
  - *Direct Referrals* – currently managed
  - *Maternity/Healthy First Steps*
- **5. Standardized solution across states, provides:**
  - Scalability, Consistency, and Improved Quality

Whole Person Care Clinical Design

Components of the Whole Person Care Model

- Primary point of contact
- Evidence-based identification & stratification
- Comprehensive assessment & care plan
- Locally based interdisciplinary team
- Telephonic and face-to-face member engagement



Targeted Outcome:

- Lower Impatient Admits
- Lower ER visits
- Increases Physician visits

Process Metrics:

- Qualified, Enrolled rates
- Core assessment
- Average Enrollment
- MD Follow up

WPC Team & Staffing

Over 90% of the WPC care team members reside in the local C&S markets. Care team consists of primarily RNs, BHAs and Community Health Workers.

Clinical

Registered Nurse (RN) Field and Telephonic Clinical Consultant for all medical clinical issues referred by the whole person care team. Primary case owner on medically intensive cases charged with developing a member centric, clinical plan of care.

Behavioral Health Advocate (BHA) Licensed and masters prepared Clinical Consultant for all behavioral clinical issues referred by the whole person care team. Primary case owner on behavioral intensive cases charged with developing a member centric, clinical plan of care.

Medical Director Physician support on case consult and case rounds

Pharmacist Review and assessment of history, safety and cost effectiveness. Case rounds participation and case consult support

Non-Clinical

Field Community Health Worker (FCHW) locally based non clinical care coordinator tasked to help members navigate the health system and gain access and coordinate the services required by the clinical plan of care agreed upon with their care provider

Virtual Community Health Worker (VCHW) Virtual (telephonic) non clinical care coordinator tasked to help members navigate the health system and gain access to the services required by the clinical plan of care agreed upon with their care provider

Whole Person Care Clinical Design Evolution

2018 Enhancements & Remediation – National Initiatives Delivered in RI

- Focused on deeper, more meaningful engagement with fewer complex members
  - Increased % of field time for locally based staff
  - Increased % of provider outreaches for staff
  - Increased case durations of members managed
- Increased focus on direct, real time referrals via clinical continuum and hotspotting tool
- Local health plan empowerment, CMO influencing how Whole Person Care staff identify, engage and interact with members in their market
- Increased focus on successful Transition Care Management:
  - CHWs dedicated to facilities for on-site medical discharge planning of all admitted members, in addition to on-site engagement of enrolled members state-wide
  - TCM Members managed until the care plan is completed and gaps closed (versus after 30 days)
- Strengthened the skillset of local care teams through more frequent, in-depth training (e.g. trauma informed care)
- 8/2019-Childrens PDN Case Management Implemented

Whole Person Care Criteria:

PSU and Emerging Risk Specialty

Members will be identified through two algorithms: PSU and Emerging Risk

Persistent Super Utilizer

- Medicaid & DSNP Persistent Super Utilizer (PSU) with one or more diagnosis: Sickle Cell, Advanced Illness, Heart Failure and/or End Stage Renal Disease and are in the top 5% in the current 12 months of spend who are likely to continue in the top 5% in the next 12 months
- For majority of members (85%), first point of contact will be CHW, with support of BH and RNs
- Critical Risk Persistent Super Utilizer members (15%) will be managed by a cross-trained RN
- Case Duration: ~7 months

Emerging Risk Member

- **Medicaid and DSNP Emerging Risk Specialty (ER Specialty):** – members with impactable opportunities who are likely to be in the top 15% of healthcare costs in the next 12 months and have Heart Failure, Advanced Illness, Sickle Cell Disease or End Stage Renal Disease.
- For majority of members (~85%), first point of contact will be CHW, with support of BH and RNs
- Critical Risk Emerging Risk (~15%) will be managed by a cross-trained RN
- Case Duration: ~ 3 - 7 months

Hierarchy of WPC Resource Assignment

In 2018, members referred into the program through local health plans became a higher priority.

The Whole Person Care Team in each C&S market manages a mixed cohort of members. Prioritization of members is as follows:

1. **Contract required work: PDN**
2. **Hotspot members:** 30-50 members in each market determined to be highest need and assigned to designated Hotspot team members in partnership with the CMO
3. **Direct Local market referrals:** individual referrals determined by the local medical director to need assignment.
   - Examples include clinical continuum referrals, members identified by the CMO using the Hotspotting tool
4. **Non PSU TCM:** our goal is to assign 100% of non PSU TCM members prior to assigning any new PSU members
5. **PSU:** PSU members will be assigned following 100% of non PSU TCM
6. **Emerging Risk-** emerging risk will only be assigned following outreach to PSU members, unless contractually required

Key WPC interventions

Creating deeper, more meaningful engagements with members

- On average, WPC care team members reach out to members ~3/month and reach out to providers 2/month.
- On average, a care team member will engage 100 unique members annually

Interventions may include, but are not limited to:

- Complete *Access to Care* to identify members' needs; address barriers to care; identify depression, anxiety or substance abuse; and connect member to social services
- Complete *Health Action Plan* to drive gap closure
- Connect member to providers and specialists, help arrange appointments and ensure follow up occurred
- Assess barriers in medication adherence
- Complete behavioral and/or substance abuse assessments (as needed)
- Rx Consult (as needed)
- Participate in weekly interdisciplinary rounds (as needed)
- Coach on gaps in care

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WPC Identification & Stratification

In 2018, WPC referral sources were enhanced to include Hotspotting. Additionally, the PSU algorithm was bifurcated to identify members with high RX spend from those without high RX.

COHORT	IDENTIFICATION CRITERIA
Hotspotting Tool / Clinical Continuum / Local market Referrals	• Direct referrals into Whole Person Care come from a variety of inputs, including: Health Plan CMO, Hotspotting Tool, HRA, Provider, and UM. The hotspotting tool allows Chief Medical Officers to use data to reallocate care team resources to a small subset of high-needs, high-cost patients. Tool helps discovers the outliers and realign resources and interventions based on the members' needs
High Risk at Readmission (Non PSU TCM)	• Members are identified through readmission Predictive Model or Risk Scoring Tool. • RPM: is a proprietary predictive model built by UHC. The resulting score estimates the probability that, for a given admission, a member will be readmitted within 30 days of discharge. The model takes into account the member's age and sex, several elements from the current admission (admitting diagnosis, length of stay and whether the admission itself was a readmission) as well as elements from the member's claims history (previous admissions, previous diagnoses, visits to specialists, home health and DME use, prescription use, etc.) • Risk Scoring Tool: Proprietary predictive model that is used by the UHC inpatient case management team. Tool is comprised of 8 questions, each worth a certain # of points.
Persistent Super Utilizer Algorithm	• Identifies individuals for referral to the WPC model who have a 78% likelihood of repeated identification in the top five percent of spend and utilization in the previous year and prospectively in the next 12 months. • UHC proprietary algorithm is based on a member's demographics, product characteristics, chronic morbidity and comorbidity, medical and pharmacy expense, utilization and trends, as well as inputs from other proprietary UHC algorithms
Emerging Risk Algorithm	• Algorithm includes two approaches: a cost an utilization predictive model and a clinical algorithm. Identifies Individuals who remain in the top 15% of health plan cost from year to year. • The foundation of the model is similar to the PSU model; however, the Emerging Risk algorithm includes an expanded focus on pharmacy, behavioral health, and chemical dependency, as well as a new focus on social determinants (e.g.., problems with living situation, isolation, issues affording food, etc. • Additionally, algorithm uses 300 clinical rules to identify members with gaps in care, condition-specific triggering events, quality measures, high utilization and risk markers. These rules apply to medical, pharmacy and behavior health claims and authorizations to help identify members that are appropriate for intervention.
Behavioral Health Intensive	Members are identified through Readmission Predictive Model, and must have had BH discharge and a RPM score >.105 and/or identified as intensive ID
Behavioral Health Standard	Members are identified through Readmission Predictive Model, and must have had BH discharge and a RPM score ≤.105 and/or identified as standard.

Care Management

Referalls to the Whole Person Care Team

- **Referrals to the Whole Person Care Team**
- **The team is staffed based on PSU, Emerging Risk, Transitions of care and escalated referrals.**
- Emails can be sent to CareManagement_RI@UHC.com and are checked regularly and routed to the care managers from there.
- Calls can also be made to the Care Management Line- 1-800-672-2156.

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