Subcommittee to Conduct a Study of Post-acute Care

February 17, 2016

HEALTH PLAN OF NEVADA
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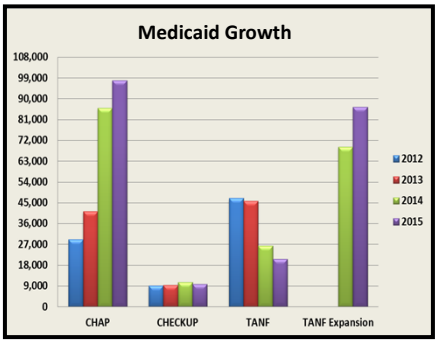
Overview

- Examples of Medical Management Quality Programs & Program Metrics
  - The Access Center / The Telephone Advice Nurse (TAN)
  - Complex Case Management (CCM)
  - Care for Me Program (CFMP)
  - Willing Hands Program
- Success Stories

Membership

There has been significant growth, especially in Medicaid membership since 2012.



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Access Center / The Telephone Advice Nurse (TAN)

- **24-hour-a-day Clinical Access Center** that continues transitions of care after traditional business hours, weekends and holidays so **the member gets the best possible care and services at all times.**
- **Triaging** to the appropriate care setting and making certain that the care setting is in-line with the level of severity.
- **Eliminating waste and redundancy** by identifying members with chronic conditions at the point of contact and ensuring that they receive the right care at the right time.
- **Collaborating with our Southwest Medical Associates (SMA) / Optum partners** to evaluate best practices and adopting methods that improve the quality and experience of care

Calls Per Month

~**10,000** Inbound Calls
~**7,100** Outbound Calls

Total based on December 2014 – November 2015 data.

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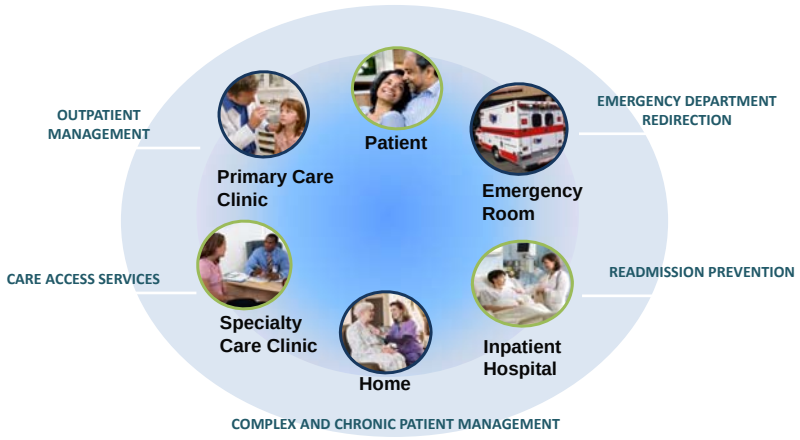
The Access Center in Health Management



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Complex Case Management (CCM)

Complex Case Management (CCM) is the coordination of care and services provided to members who have **experienced a critical event or diagnosis** that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Goals Include:

- **Coordinate services** with other organizations and to appropriate community resources and social service programs
- **Help members regain optimum health or improved functional capability,** in the right setting and in a cost effective manner
- **Assess and determine the member's condition,** including not only specific diagnosis or health condition, but also the complexities of co-morbidities including behavioral health related issues such as the lack of social or family support

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Care for Me Program (CFMP)

The Care For Me Program (CFMP) provides high-touch case management services and care coordination with a **single point of contact for hospital discharges and outpatient members** in all clinics. The case manager works in collaboration with members, providers and key stakeholders in coordinating healthcare services and referrals. This program focuses on the Health Plan's complete member population.

The impact of the CFMP includes the following:

- **Decrease admissions** and readmissions for all lines of business
- **Increase customer satisfaction** to support STAR Ratings
- **Increase engagement** with PCP's and members
- **Encourage** self-management of care

CFMP serves as a single point of contact for complex patients

Care for Me Program Metrics (2015 calendar year)

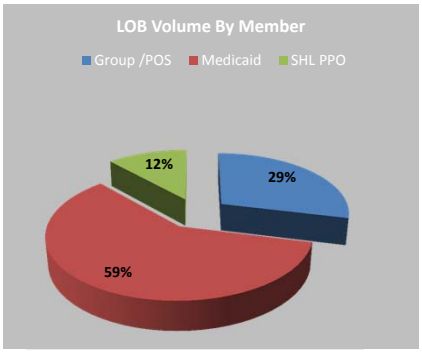
Member Statistics	1st Quarter 2015	2nd Quarter 2015	3rd Quarter 2015	4th Quarter 2015	TOTAL
Total members admitted to CFMP	321	438	318	424	**1,501**
Total members unable to contact (*in addition to total members admitted)*	154	120	122	138	**534**
# of Referrals *Per Day* to CFMP	6	10	10	14	
Participation Time in Program	30-day	30-day	30-day	30-day	

Care for Me Program Metrics (through 3rd Quarter 2015)

1st Quarter	Difference (Before CFMP and After)
ER Visits	-47%
Readmits	-72%
SNF Utilization	-66%

2nd Quarter	Difference (Before CFMP and After)
ER Visits	-40%
Readmits	-68%
SNF Utilization	-45%

3rd Quarter	Difference (Before CFMP and After)
ER Visits	-34%
Readmits	-69%
SNF Utilization	-13%



Willing Hands Transitional Housing

Willing Hands quality program includes the following goals:

- **Support and complete** the homeless members post-discharge care prior to them returning to the street.
- **Decrease** admissions and readmissions
- **Decrease** ER Utilization
- **Secure permanent housing** when applicable

Willing Hands Transitional Housing

Admission Criteria

- Independent for Active Daily Living (ADL's)
- Ability to take own medications
- No violent past
- No sex offenses

Benefits

- Basic skills training
- Short and long-term goal development
- Housing manager onsite – 24/7
- 3-meals/day and snacks
- Home Health, Social Worker, Case Manager and other stakeholders to meet member at the facility
- 11-beds available

Willing Hands Metrics (2015)

2015 Patient Count *(Start Date: April 2015)*	Readmits (within 30-days)	Difference
68	16	-76%

Patients Accepted to the Healthy Living Program *(Start Date: July 2015)*	
2015	19 HPN SmartChoice Members

Success Stories: Health Plan Programs and Community Collaborating Together

A member had seven admissions from 2014-2015, mostly for diabetic ketoacidosis (DKA). She was referred to the CFMP. After talking to the member, the CFMP Case Manager learned she was living in a shelter with her daughter.

The member was accepted to Willing Hands, while a family member was contacted and provided a home for the daughter during the member's stay.

While at Willing Hands, the member was connected with various services. Member was accepted to Healthy Living and admitted to Veteran's Village. She is able to plan her meals and snacks to include proteins and complex carbohydrates. She checks her blood sugar, still struggles with diabetes management, but has gained a great deal of knowledge about diabetes.

The Healthy Living Program was able to give her a home and a chance to be with her daughter in a safe environment.

Before transitioning to Willing Hands, one client had been in and out of the hospital due to heart failure. During his stay, his blood levels were continuously monitored and with staff support he was able to keep all his appointments. A social worker assisted him in obtaining his social security.

The patient has since moved into his own place and is currently keeping up with all his follow-up treatments and appointments.

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Thank You

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