UPMC for You
Affiliate of UPMC Health Plan

Connected Care™ Program

COMMUNITY CARE
Behavioral Health Organization
Member Stratification

• Members identified from Medical & Behavioral Health claims data and stratified into 3 Intervention levels based on services utilized

• Designed to ensure members receive the right level of health plan outreach, consistent with their behavioral and physical health needs

• Re-stratification performed monthly to identify new members and those who are at high-risk

• Members will not be “moved down” to a lesser level of stratification during the project
Stratification

• Criteria for High Behavioral Health Needs:
  – Care in a state hospital or diverted from a state hospital
  – Multiple admissions or readmissions to various levels of care
  – Authorization for in-home services, diversion or acute stabilization, clozapine or methadone services, or targeted case management

• Criteria for High Physical Health Needs:
  – Three (3) or more Emergency Department visits within the past three months, or
  – Three (3) or more inpatient admissions (for any diagnosis) in the past 6 months
Member Identification: Medical Assistance
From July 1, 2009 to September 30, 2009

Total Medical Assistance Members Identified = 4,597
Connected Care™

- Initiative to improve the connection and coordination of care for those with Serious Mental Illness among health plans, PCPs, and behavioral health providers in outpatient, inpatient and ED care settings.

- Based on Patient Centered Medical Home model with integrated care team and care plan to address all medical, behavioral, social needs.

- Partnership between:
  - Center for Health Care Strategies (CHCS)
  - Department of Public Welfare (DPW)
  - UPMC for You
  - Community Care Behavioral Health
  - Allegheny County Department of Human Services
Extensive Planning Process

- Extensive analysis of federal and PA law related to privacy/confidentiality restrictions
- Feedback from a consumer advisory group
- Strong emphasis on member recovery goals
- Communication with PCPs and Behavioral Health Providers
- Data exchanges
- Staff work flow between care managers
Connected Care™ - Key Components

Integrated Care Coordination:

- All members linked to a medical home
- Identify providers seen by member
- Integrated care management team supporting providers through:
  - Holistic PH/BH care plan
  - Education and support for member self-management
  - ED and inpatient discharge coordination
  - Facilitating and tracking PH/BH visits and recommended tests or treatments
- Data infrastructure / information exchange to support care coordination
- Coordination by a lead care manager
Connected Care™ - Key Components

Coordination of care in provider offices:

11 sites have additional care coordination support in provider offices:

- 4 will have co-located physical and behavioral health services in the same office
- 7 have Practice-Based Care Managers who are UPMC for You staff working with high-volume PCP practices
Connected Care™ - Key Components

**Integrated care plan:**

- Care plan viewable by staff from both Health Plans.
- Integrated care team meetings which include input from:
  - PCP/BH providers
  - Member and/or their care givers
  - Health Plan Staff:
    - Medical directors
    - Nurses including those placed in high-volume practices
    - Social workers
    - Pharmacist
    - Network staff
Pharmacy Management and Provider Notification

• Pharmacy Adherence Initiatives

Notify PCP and/or prescribers for:
– Members on atypical antipsychotics who have a gap in filling their prescription (less than 75 days supply in the 90 day period)

– Notification if a claim for glucose screening has not been received in past 12 months for members filling antipsychotics

– Non-compliance in filling other medications that treat chronic conditions
Consumer Engagement:

- Using providers to help inform members of the program
- Letters sent to members describing the program
- Members eligible for a $25 member incentive for seeing their PCP
- Navigator / Personal Wellness Advocate:
  - Lead Care Manager
- Health Risk Assessment Tool:
  - Designed to identify behavioral, medical, social, health education needs and lifestyle risks
  - Coaching for lifestyle risks like smoking, diet, and exercise
- Encouraging substance abuse screening by PCPs
Connected Care™ - Key Components

Improved Discharge Planning:

- Essential to optimize outcomes and reduce avoidable readmissions
- Real-time hospital admission and discharge notification
- Coordinated by the Integrated Care Team
- Ensure member clearly understands what to do and everything is in place for follow-thru with the care plan
- Key Components of discharge plan:
  - Timely post-discharge follow-up appointments
  - Identify care giver support needs
  - Symptom response plans to manage care post discharge
  - Medication reconciliation
Of the 4,597 Medical Assistance members identified:

- **Enrollment:**
  - 97 members agreed to enroll and signed consents to share information
  - 94 members agreed to enroll, but do not want to share their information
  - 95 members have declined
  - 208 were unable to be reached
  - Staff are actively outreaching to an additional 1,032 members

- **Care Plans:**
  - 1,526 integrated care plans have been started

- **Inpatient and Emergency Room notices to providers** (utilization tracking as of August 2009):
  - 568 ED visits
  - 176 inpatient admissions
Preliminary Observations

- Staff are seeing the value of not working in silos. Care coordination is being integrated.

- Integrated Care Team meetings identifying valuable information related to the medical and behavioral health services the member has received, gaps in care, and their medication profile.

- Medical and behavioral health providers are seeing the value of the work of the integrated team, particularly with their challenging patients.

- Daily inpatient reports providing an opportunity for staff to visit the members that we have not been able to find while in the hospital to improve engagement and care coordination.

- Locating members is still a challenge.
Next Steps

• Continue to foster the communication and improve work flows between UPMC for You and Community Care staff.
• Further development and management of the integrated care plans.
• Use providers to help educate members on the program and engage them in the program.
• Do more provider education on the program and how it may support them in managing their members with SMI.
• Further develop the implementation plan for the Wellness Navigators.
Questions?

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