Premier Health Group

Provider Information Guide

Complex and Condition Care Overview

This document is sent to all providers affiliated with Premier Health Group to inform providers of the goals of care programs, how patients are identified and engaged, provider feedback processes and provider rights for Care Advising services.

Introduction

Premier Health Group's mission is to improve the health of the community, one patient at a time. The Introduction Complex Care and Condition Care are essential components of PHG's Care Advising services. Complex Care and Condition Care support your relationship with your patients, as well as how you choose the right care. These programs emphasize the prevention of exacerbations and complications through evidence-based practice guidelines, and by evaluating clinical, humanistic and economic outcomes on an ongoing basis. Complex and Condition Care target patients with at least one of five chronic conditions: **congestive heart failure** (CHF), **chronic obstructive pulmonary disease** (COPD), **coronary artery disease** (CAD), **diabetes**, and **asthma**.

Complex and Condition Care use coordinated health care interventions and communications for your patients with significant self-care needs. Evidence-based medicine and a team approach are used to:

- Empower your patients
- Support behavior modification
- Reduce incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Support your relationship with your patients
- Emphasize and reinforce use of clinical practice guidelines

The team approach to care includes a multi-disciplinary team, which consists of a registered nurse Care Advisor or health coach, pharmacist, dietitian, and social worker, who work together to coordinate care for the patient and inform and collaborate with the you as the primary care physician.

Patients are never informed that they are selected for, or enrolled in, "Condition Care" or "Complex Care," instead that they are offered services appropriate for their health needs through Care Advising, a part of their Personal Approach To Health (PATH).

Program Goals

The goal of Complex Care and Condition Care is to effectively impact the health outcome and quality of life of patients with chronic conditions. This is accomplished by using a multi-faceted approach based on assessment of patient needs, ongoing care monitoring, evaluation,

and tailored patient and practitioner interventions. Complex and Condition Care can also reduce hospital length of stay and lower overall costs.

Patient Identification

Premier Health Group systematically evaluates patient data against a set of identification and stratification criteria. For Complex and Condition Care, criteria are established to identify eligible patients, stratify them by risk, and determine the appropriate intervention level. The following data sources are used to identify patients on a monthly basis, when available:

- Enrollment data
- Health Information Line
- Medical claims or encounters
- Pharmacy claims
- Assessment screening results
- Practitioner referrals
- Data collected through utilization (UM), condition care and care management (CM) activities
- Data collected from health management or wellness programs
- Laboratory results
- Electronic medical/health records

Once identified, patients are stratified to determine the appropriate intervention level based on their identified need and status. Stratification is a dynamic process, and stratification level can change as a patient's condition changes. Patient criteria are as follows:

Program	Criteria
Low Risk Condition Care	Patients with two paid claims for evaluation and management visits with primary diagnosis of asthma, diabetes, COPD, heart failure or coronary artery disease. These patients have no significant care gaps and have their condition controlled.
Condition Care	In addition to the above criteria, patients have at least one of the following outcome-based gaps: • Patient has condition related inpatient admission within six months • Patient has a condition related ER visit within three months • Patient has no PCP or condition related specialist visit within 12 months • Patient does not have a prescription(s) for a condition-related medications
Complex Care	Patients most likely to incur a disease-specific adverse event. Some of the covariates include co-existing chronic conditions, prior utilization, change in utilization rates, drugs that indicate disease progression or severity, medical equipment, and gaps in care.

Patient Engagement and Support

Patients identified for Complex and Condition Care are considered to be participating unless they specifically request to receive no program services or to "opt-out." Once identified as eligible, patient engagement follows the steps outlined below:

Welcome Packet Mailed	• A staff member of Premier Health Group's care team sends patient a welcome packet. • The welcome packet includes information about education and support provided through Care Advising, the extended care team, required legal and regulatory information and explains how these services support the patient-provider relationship.
Introductory Phone Call	• The welcome packet is followed by a phone call from a Care Advising staff member. Over the phone, the staff member shares the advantages of Care Advising and encourages the patient to participate. • Patients identified for Low Risk Condition Care will not receive a proactive phone call, but will be invited to contact the care team if he or she chooses to participate.
Physician Notification	• A staff member notifies the patient's primary care physician directly when the patient engages in Care Advising

Interventions by Risk Level

Depending on stratification, patients will receive support from the extended care team in the following ways:

Program Interventions	Low Risk Condition Care	Condition Care	Complex Care
Letter reminding about making appointment to see physician for routine care, generic preventive health prompts (immunizations up-to-date, screenings, etc.)	✓	✓	✓
Notification to the patient of care gaps	✓	✓	✓
Notification to the primary care provider of patient care gaps	✓	✓	✓
Access to telephonic self-management support resources	✓	✓	✓
Completion of an assessment within 30 days of the patient agreeing to participate in the program		✓	✓
Mailing of education materials to the patient after successful outreach, unless patient declines		✓	✓

Program Interventions	Low Risk Condition Care	Condition Care	Complex Care
Self-management support and health education and coaching to improve knowledge and self-management skills		✓	✓
Outreach will occur at least every three weeks unless otherwise requested by the patient or physician		✓	
Outreach will occur at least every two weeks unless otherwise requested by the patient or physician			✓

Interventions by Condition
Program content is tailored to each patient, providing education and support for each risk level. Using outreach and educational materials, patients are encouraged to:

1. Be accountable for their chronic condition(s)
2. Adhere to their physician's recommendations for preventive care and treatment
3. Embrace educational opportunities for informed decision-making when accessing the healthcare system.

Member-Centric Interventions
Throughout patients' engagement in the program, care team members will take into account individual needs to tailor targeted interventions. Care team members will take into account:

- Comorbidities and other health conditions, including behavioral health
- Depression screenings
- Health behaviors, including things like diet and tobacco use
- Psycho-social issues, such as lack of social support, that may influence patient adherence
- Caregiver support, or lack thereof
- Other factors, including physician limitation, need for adaptive devices, barriers to meeting care needs and treatment requirements, visual or hearing impairment, and language or cultural needs

As needed, care team members will develop individually-tailored interventions to address:

- Condition monitoring, including self-monitoring (e.g., foot and skin care for diabetics) and reminders about tests the patient should perform themselves or complete through their practitioner
- Adherence to treatment plans (including medication adherence) and tracking mechanisms
- Communication with practitioners about patient's health conditions, self-management and condition monitoring activities, and progress towards goals
- Additional resources external to the organization, as appropriate (e.g., community programs, American Diabetes Association)

Disease Management Program Content

Premier Health is committed to supporting you and your patients who have chronic conditions. We offer five disease management programs which support the patient with education on their condition and with self-management tools. Programs are available for diabetes, heart failure, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and asthma. If you have a patient who could benefit from a program, please call (855) 859-1734 for enrollment information.

Clinical Practice Guidelines

Care Advising's disease management program education and self-management materials are based on nationally recognized, evidence-based guidelines for the conditions. You can access the guidelines on the following websites:

Condition	Clinical Guideline
Heart Failure	http://circ.ahajournals.org/content/128/16/e240
Guideline on Lifestyle Management to Reduce Cardiovascular Risk	http://circ.ahajournals.org/content/129/25_suppl_2/S76.full
Adult Diabetes	http://care.diabetesjournals.org/content/37/Supplement_1/S5.full
Asthma	http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm
COPD	http://goldcopd.org/global-strategy-diagnosis-management-prevention-copd-2016/

Coordinating Interventions with the Patient's Primary Care Practitioner

Care Advising works with patients' practitioners to coordinate care as needed. For services requiring physician oversight or orders (e.g., DME, medications, physical therapy, emergent/urgent medical concerns, changes to care plan), Care Advisors contact practitioners via phone, client EMR, or in person (for example, if a nurse is embedded in the practice). Care Advisors then follow up with the patient to ensure the care coordination efforts have been successful and, if not, the Care Advisor informs the patient's practitioner.

Practitioner Feedback

Premier Health Group provides semiannual reports to practitioners alerting them to care opportunities for their patients with one of the identified chronic conditions. The focus of the report is to support you in closing your patients' care gaps related to their chronic condition. These may include missed services, recommended tests, medications, or other care gaps based on clinical practice guidelines.

On an as needed, individual basis, the Care Advisors or Health coach will alert you to time-sensitive care opportunities, such as an asthma patient increasing his or her use of a rescue inhaler or a heart failure patient reporting weight gain.

For questions, feedback or complaints about Complex or Condition Care, or to request a hard copy of our disease management materials please call or write us at:

(855) 859-1734, Monday - Friday, 9 a.m. to 5 p.m. EST
TTY users: 855-250-5604

Premier Health Group
Attn: Care Advising
800 N Glebe Road
Suite 500
Arlington, VA 22203

Practitioner Rights

All practitioners with patients eligible for or enrolled in Complex or Condition Care have a right to:

- Have information about the organization administering the clinical programs, its staff and its staff's qualifications, and any contractual relationships
- Decline to participate in or work with the administering organization's programs and services for their patients, if contractually allowable
- Be informed how the administering organization coordinates interventions with treatment plans for individual patients
- Know how to contact the person responsible for managing and communicating with patients
- Be supported by the administering organization when interacting with patients to make decisions about their health care
- Receive courteous and respectful treatment from the administering organization's staff
- Communicate complaints to the administering organization