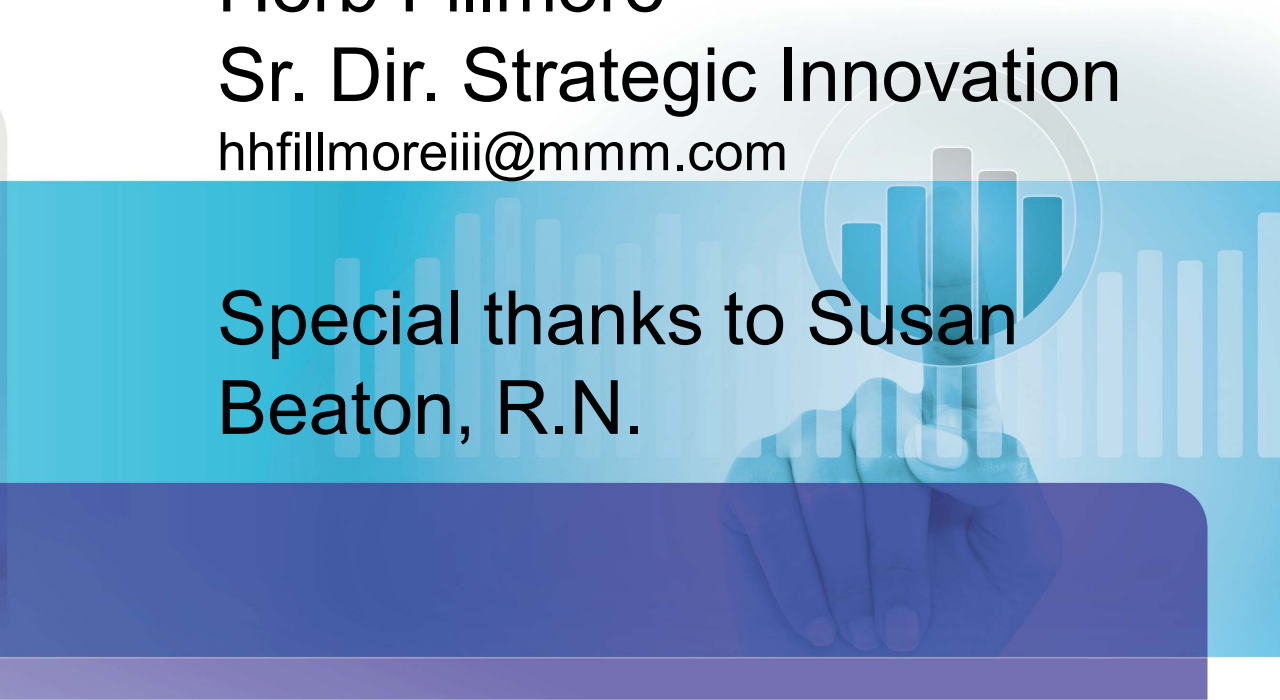


Technology Driving Contemporary Care Management: Moving beyond event-based and catastrophic care management.



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Special thanks to Susan
Beaton, R.N.



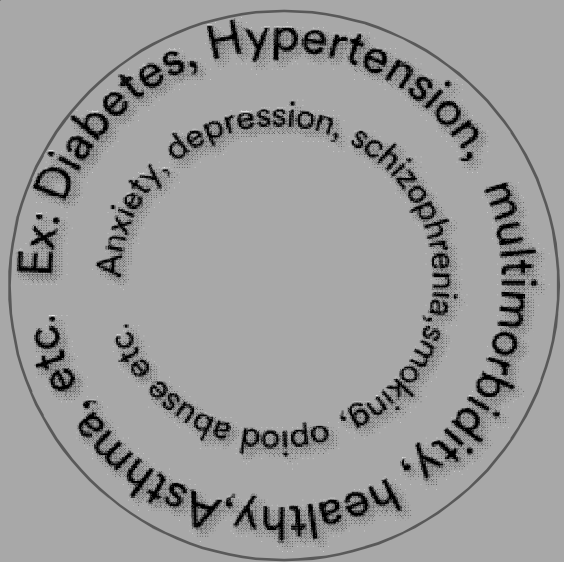
Introduction

In a world of population health and value based care,
care management initiatives must:

- Change systems of care to better support access to and delivery of high quality care
- Coordinate individual care for persons living with manageable chronic diseases
- Manage high impact catastrophic diseases
- Anticipate the evolution of individuals into high need states and change those trajectories

Why Use Predictive Models for Care Management?

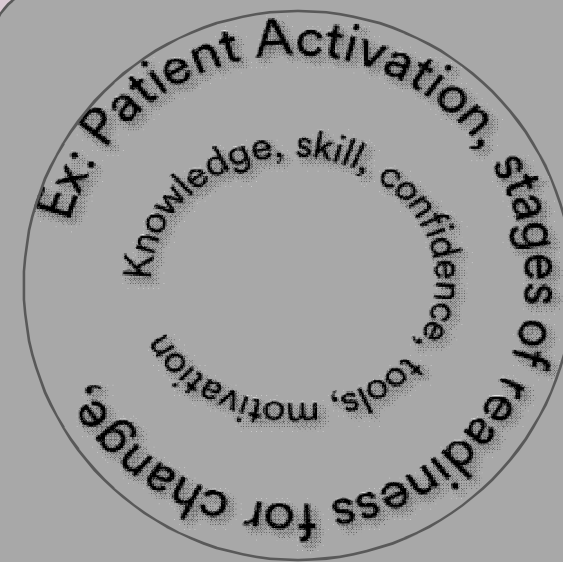
- Not everyone with a chronic disease needs care management.
- A small percentage of persons can drive “outsized” costs in a year... often because of events which will not be repeated.
- We need to focus care management resources on narrow subsets of patients who will most benefit from longer term care management
- Good predictive models can not only pinpoint who will have recurring needs but *why*, giving care managers “*a place to start.*”



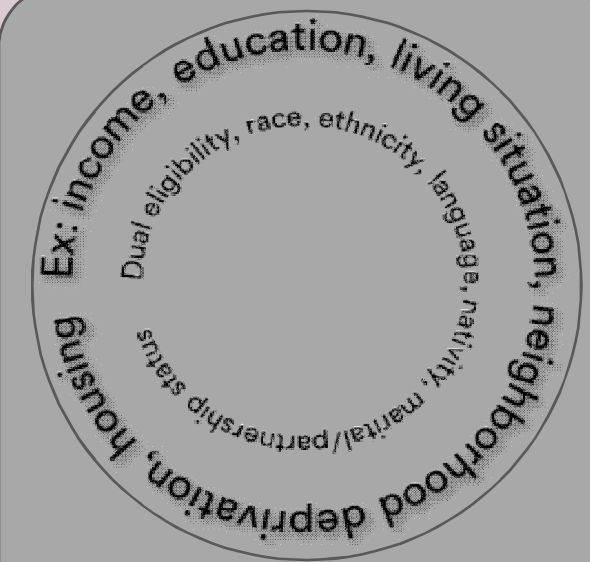
Physical/Behavioral DX



Functional Status



Readiness and ability to change/manage

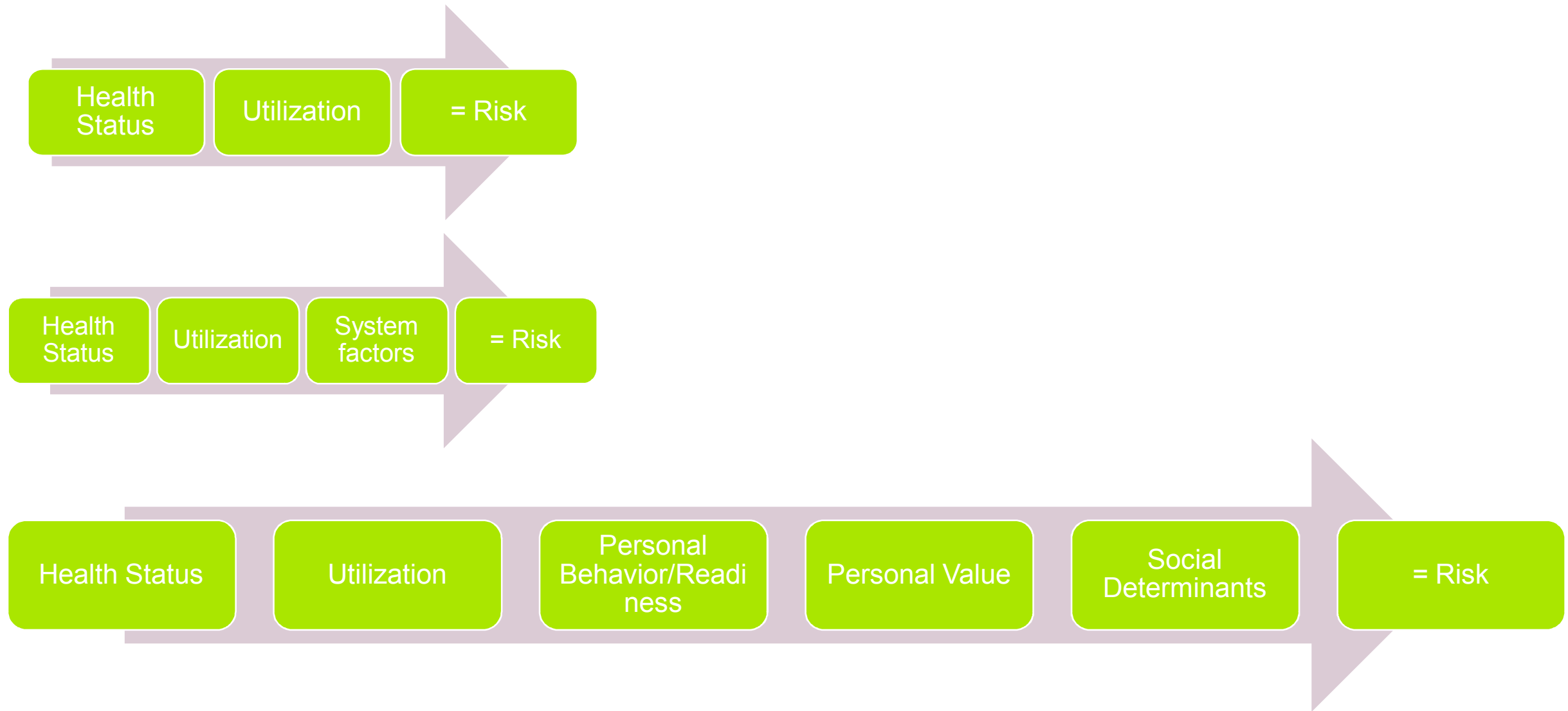


Physical and Social environment (i.e., SDOH)

Multiple Determinants of Health

Herb Fillmore, 3M HIS 2017

Model evolutions



New Perspectives for Care Management: The Persistent High Needs Model

Who are persons with Persistent High Needs?

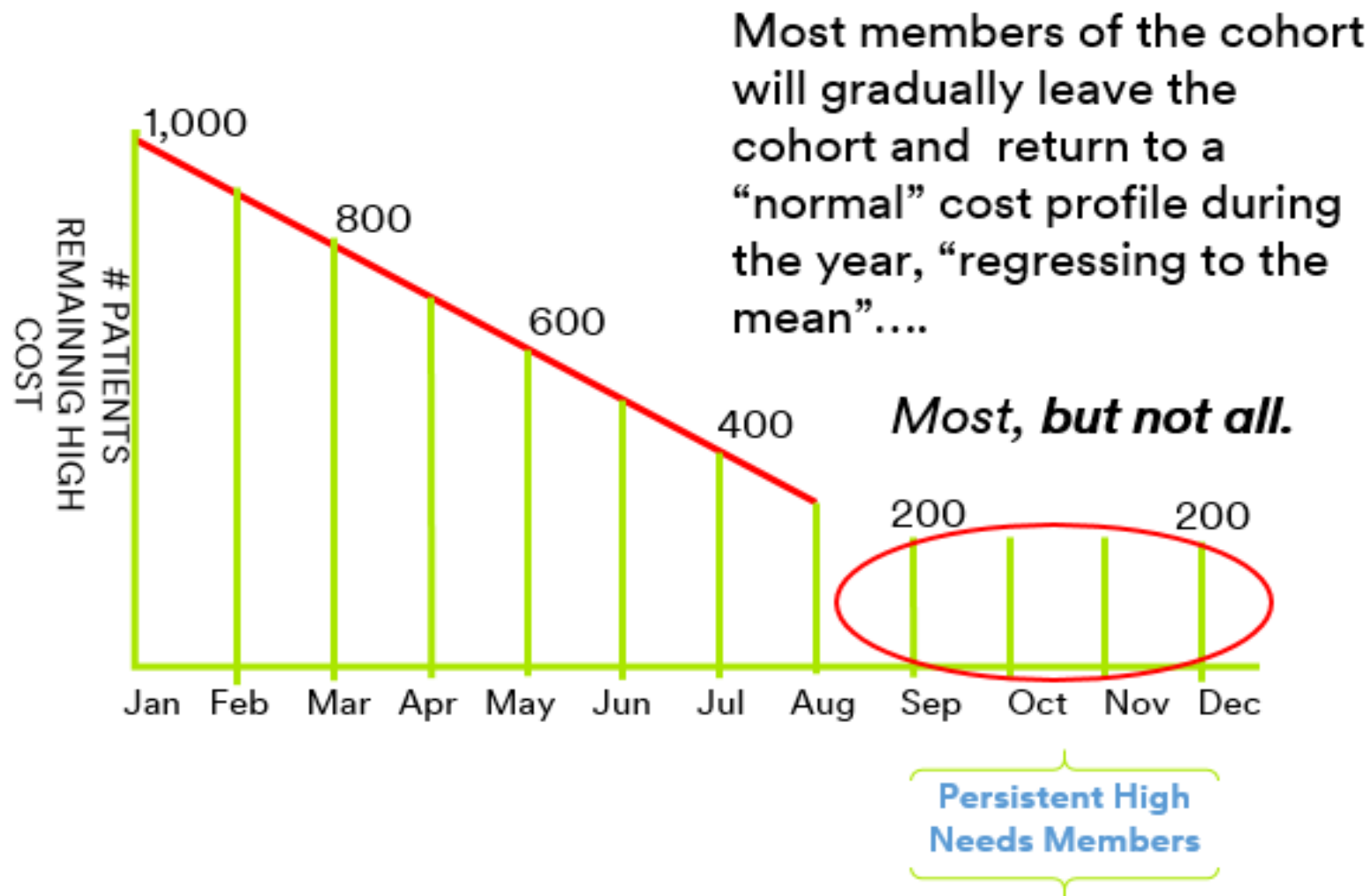
People who exhibit a history of high resource utilization, who are likely to utilize a high amount of resources in the future, and are susceptible to moderate intensity care management.

Predicting Persistent and Emerging High Need Members

Consider a cohort of 1,000 patients who were very high cost last year.

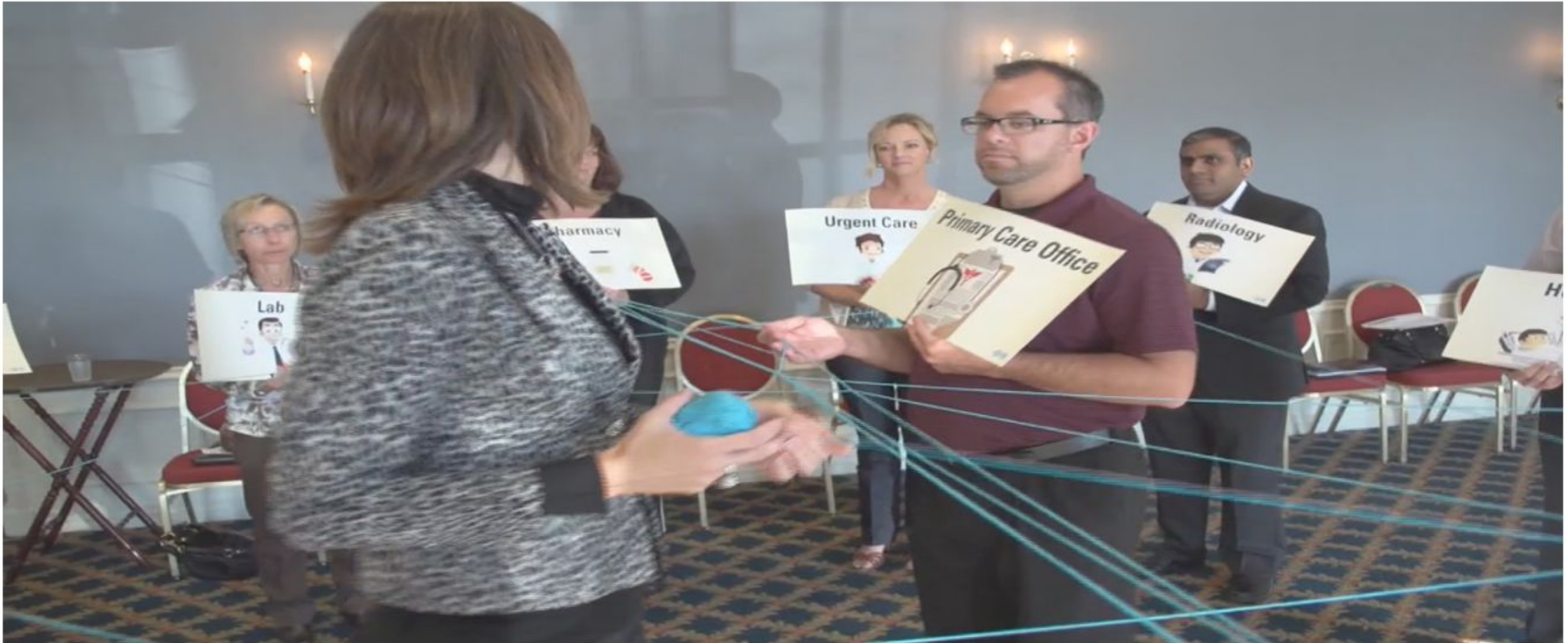
Starting in January, we examine their average prior twelve month costs each successive month for a year.

If they remain high cost they stay in our chart.



Who are these individuals?

Knowing Our VIP Members



Composite Vignettes



"Adult female with spinal stenosis and bipolar disorder with repeated ER and physician visits for back and abdominal pain. Numerous visits are made for bipolar disorder to a general practice physician, with 1 visit to a psychiatrist. Recently the patient has sought medical services on 20 distinct days within a given month. Patient also has a history of anxiety, migraines and nausea that are frequently documented along with the pain issues. Patient has had multiple spinal fusions and drug injection therapies for pain, but no documentation of physical therapy being received. In addition 11 different imaging procedures have been done in the past year, mostly involving the abdomen. A prescription for oxycodone has been regularly refilled and frequently accompanied with anti-anxiety and anti-nausea medication. Patient has a history of drug withdrawal and tobacco dependence."



"Female, young adult with major depression and anxiety issues with frequent and regular psychiatric care. Patient is obese with numerous complaints for pain in the abdomen, ankle and neck, which has led to several different CT scans of the head/neck and abdomen. Patient has had multiple visits to the ER for a variety of reasons including pain, depression and non-emergent events such as having a cough."



"Adult male with back pain who has recently had an obesity related gastrectomy procedure. Chief complaints for the patient in addition to the back pain include malaise/fatigue, difficulty walking, and obstructive sleep apnea. Although the patient gets semi-regular psychiatric care for depression and anxiety he still occasionally ends up in the ER for depression related reasons. He also has frequent ER visits related to fatigue and head injuries."

USING DATA TO ENGAGE THE RIGHT MEMBERS

SUSTAINED ENGAGEMENT FRAMEWORK & GUIDING PRINCIPLES



SUSTAINED ENGAGEMENT WORKSHOP



NEW APPROACH AND OUTREACH: HEALTH COACH

Take The Call

Healthier Choices Are a Phone Call Away



Blue Cross and Blue Shield of Nebraska now offers a Health Coaching Program at no cost to you. Our Certified Health Coach is a Registered Nurse who is specially trained to help you lower your risk for illnesses, better manage a health condition, provide extensive support for a complex health problem and work with you individually to inspire healthy living and wellness. Your Health Coach may call to offer you guidance and support to better manage your health. Take a few minutes to talk to your coach. What you learn could make a real difference in improving your wellbeing.



REACHING OUT IN NEW WAYS:

Wellframe Platform

Three components of our cloud-based mobile platform facilitate care management and create valuable human connection to promote long-term member engagement.

Logic structure for care protocols and
data analytics engine



CARE TEAM

Real-time member insights and secure
communication via web-dashboard



MEMBER

Dynamic daily care plan
delivered to mobile device

Confidential & Proprietary | Wellframe, Inc. (2015)

Steps to action

Clinical Data Integration – Health Plan & Physician Collaboration

- **Spotlight the Cost of Care**
- **Identify patients who are in most need of engagement**
- **3M Dashboard and Predictive Modeling Data is shared with all PCMH's and ACO's participating with BCBSNE covering over 160,000 members**
- **Current Cost of Care Savings practices is \$10PM/PM**



Lessons

Lessons Learned. Recommendations & Conclusions

- 1) Define your care management capabilities**
- 2) Segment high-risk patients into actionable buckets**
- 3) Use patient engagement and patient-reported metrics to enhance and evaluate your population health efforts**



Previous Customer Experiences with High Needs Models

- Immediate adoption in the field
- Assists in triaging payer/provider care management
- Assists in assigning health coaches
- Care managers report these are new “cases” not previously identified
- Care management materials, outreach, and communication modified away from event based contacts
- RN’s reassigned to management, away from finding the needle in a haystack.
- ACOs are still “list” oriented and this list provides actionable data that is patient-centered. A perfect positive storm.
- Has become a basis for anticipating staffing needs and managing tenure on a care managers case load.
- Targeting rural clusters for intervention enhanced.

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