Care Coordination Institute
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Condition Management Program

The Care Coordination Institute's Condition Management Program ("CM" or the "Program") is a proactive, multidisciplinary, systematic approach of coordinating healthcare utilizing targeted evidence-based interventions and communications for defined patient populations with conditions where self-management efforts can be implemented. The Program is designed to empower patients, working with their health care provider(s), to manage their condition, prevent exacerbations and complications, with the goal of slowing the progression of the condition, minimizing its effects, and improving quality of life for patients. This document describes the process for identifying patients who can benefit from the program and developing the individualized plan of care based on needs and risk level. In addition to this program description, CCI has condition-specific program content descriptions for each condition management program.

The Condition Management Program identifies patients who can benefit from CM and determines the best plan of care for each patient based on their individualized health needs utilizing targeted, evidenced-based interventions and communications.

The goal of the Condition Management Program is to identify and support patients, caregivers, and their health care provider(s) to manage their condition(s) by providing tools and resources to empower patient's participation in their plan of care to improve their health and quality of life.

The objectives of the Condition Management Program are to:

a. Promote consistency in long-term management approaches and optimize treatment for patients with targeted conditions
b. Achieve optimal levels of wellness in these targeted patients
c. Improve the patient's basic understanding of his/her condition process
d. Increase provider awareness and participation with recommended treatment modalities
e. Monitor patient's condition, including consideration of other health conditions and addressing lifestyle issues
f. Provide early complex care management or health care provider intervention when specific patient indicators exceed the established threshold
g. Attain increased compliance with treatment regimen
h. Reduce emergency room utilization and frequency of inpatient admissions
i. Reduce and delay late-stage condition manifestations

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The Care Coordination Institute offers CM programs for all eligible patients who are identified with one or more of the following conditions: diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, hypertension, and hyperlipidemia.

All patients with a confirmed diagnosis for the targeted condition who meet the eligibility criteria are automatically eligible for enrollment in the program. Welcome packets are mailed to the patient describing how they became eligible for participation, what services are available, and how to access the services offered.

A. Criteria for identifying patients who are eligible for the program

To be eligible for CM services, a patient must meet the following four criteria:

a. Be a covered member (patient) under a contracted payer population.

b. Have a normalized MARA total prospective risk score appropriate for CM. A predictive risk model, Milliman Advanced Risk Adjusters (MARA) prospective model, uses the most recent 12 months of claims data to predict risk for the upcoming 12 months of utilization and cost.

c. Must have at least one of the six conditions: diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, hypertension, or hyperlipidemia.

d. Patients who are not already receiving care coordination services (data source: care coordination platform (CCP)).

B. Evaluating patient risk level and Interventions

a. The CM Program stratifies patients into low, moderate, or high-risk categories based on the number of conditions, stage of specific conditions, clinical data, barriers, psychosocial and health behaviors. The risk stratification tool accounts for comorbidities and severity of risk factors and assigns a point value that determines a patient's risk level and determine whether an intervention is necessary.

b. The number, frequency and type of interventions are based on the patient's identified condition, their response to the health assessment, and risk

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stratification scoring table. Interventions are automatically assigned based on patient responses to the health assessment completed in the CCP.

c. The stratification scoring tool is utilized to ensure risk stratification levels are applied uniformly to patients with similar profiles and needs. Annually patient stratification tools are randomly selected and audited for uniformity.

C. Medical and behavioral health comorbidities and other health conditions

a. Medical comorbidities are assessed utilizing patient responses to the cardiovascular, respiratory, and endocrine topics embedded in the health assessment. Based on patient responses appropriate interventions are assigned to the plan of care.

b. Behavioral comorbidities are assessed utilizing patient responses to the patient activation tool. This tool provides a baseline measure of patient's readiness to make behavior change. Care plans are individualized to patients' stage of readiness.

c. A depression screening tool is used to assess depression. If the patient's screening is positive, the Health Coach verifies whether the patient sees a mental health provider, takes medications if prescribed, participates in support activities, attends counseling or other behavioral health management interventions.

d. Health behaviors are addressed within the assessment. Motivational interviewing is utilized to address goals and interventions in the plan of care to reduce unhealthy behaviors. If the patient may benefit from weight management programs, smoking cessation programs, employee assistance program, diabetes support groups, community-based resources, wellness programs and higher level of care the health coach would initiate the referral process.

e. Social issues such as religion/spirituality, cultural/religious needs, and language barriers identified during the assessment are taken into consideration in the delivery of the care plan. A patient's beliefs, concerns, and perceived barriers, i.e., access to treatment, transportation and financial barriers are taken into consideration for the condition and treatment requirements.

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D. Consumer Input

To maximize CM Program effectiveness, program surveys are mailed to each program participant that graduates, dis-enrolls or is discharged from the program. The survey gauges program effectiveness and satisfaction with members of the care team. The survey helps to provide ongoing development of program content for patients. In addition, consumer groups can request program specific changes for their population.

E. Patient Support

Caregiver support is assessed in the health assessment. If caregiver support is needed, then results of the assessment are communicated to the health care provider to help coordinate care. Based on the caregiver assessment, the Health Coach provides activities (e.g., referral for transportation, home health services) depending on the level of support needed.

About the CCI

The Care Coordination Institute (CCI), an independent entity of Prisma Health, enables integrated delivery systems and provider networks (CINs/ACOs) to be successful in implementing true population health. Using a patient-centric, provider-led approach to care transformation, the CCI supports providers and care teams with their efforts to:

- Improve patient outcomes and patient experience;
- Drive clinical integration and care coordination;
- Reduce the total costs of care.