Meridian Health Plan

Care Coordination Program

Meridian Health Plan

Physician Directed, Member Centered, Quality Driven

Our Mission:

To continuously improve the quality of care in a low resource environment

We are:

- ***Physician owned and directed***
- Committed to quality, innovation and member and provider satisfaction

Our Vision:

- To be the #1 health organization based on quality, innovative technology and service to our members
- To be the premier service organization in health care

Meridian Health Plan of Illinois is the **#1** Medicaid plan in Illinois and is ranked **#9** nationally according to NCQA's Medicaid Health Insurance Plan Rankings 2014–2015

PROPRIETARY & CONFIDENTIAL

Honors & Accreditation

2012 - 2014

Pinnacle Award for Best Practices **2009, 2010, 2011 & 2012**

2011 - 2014

2007, 2008, 2010, 2012 & 2013

- Meridian's Michigan Medicaid HMO received an **Excellent Accreditation** rating from NCQA
- Meridian's Illinois and Iowa Medicaid HMOs received a **Commendable Accreditation** rating from NCQA
- MeridianRx acquired **Pharmacy Benefit Management Accreditation** from URAC

Meridian Customer Service

Focused on the needs of our Members

- Single point of contact for all needs
  - Members are assigned Care Coordinator
- <u>One</u> Customer Service Number for All Members
- Single Call Resolution is the <u>*Goal*</u>
  - All calls answered in 30 seconds or less
- Convenient Resources Available Online:
  - Live Chat
  - Member Handbook
  - Member Portal

www.mhplan.com/il

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Meridian Care Coordination

Medical Director
- Provide clinical guidance to team
- Hold weekly team meetings
- Review utilization reports
- Lead Interdisciplinary Care Team member plan of care meetings

CC Licensed Team Lead
- Oversee member plan of care
- Manage acute transitions of care
- Ensure timeliness of team tasks completion/alerts
- Conduct quality audits

Care Coordinator
- Qualified staff
- Perform telephonic visits
- Conduct assessments and reassessments
- Develop and monitor individualized plans of care
- Arrange and lead ICT meetings
- Manage services and transitions of care
- Primary contact with member and family
- Arrange and authorize services

Community Care Coordinator
- Perform face-to-face assessment
- Develop individualized Service Plan
- Linkages with all health and other human support services
- Arrange personal care needs, meals and other services
- All of the above care coordinator activities

Community Health Outreach Worker (CHOW)
- Link members with community resources
- Respond to and facilitate social needs
- Conduct HRA's
- Conduct home on members unable to reach

Behavioral Health CM
- Licensed clinical staff
- Conduct BH assessment
- Ensure and monitor care coordination between BH and medical providers

Pharmacist
- Perform medication profile review
- Provide education on medication adherence

Nutritionist
- Provide nutritional guidance to members and caregivers

Medical Director
Community Care Coordination Nurse Team Lead
Community Care Coordinator
Community Care Coordinator
Community Care Coordinator
Community Care Coordinator
Consultant Behavioral Health
Consultant Pharmacy
Consultant Nutrition
Community Health Outreach Worker (CHOW)

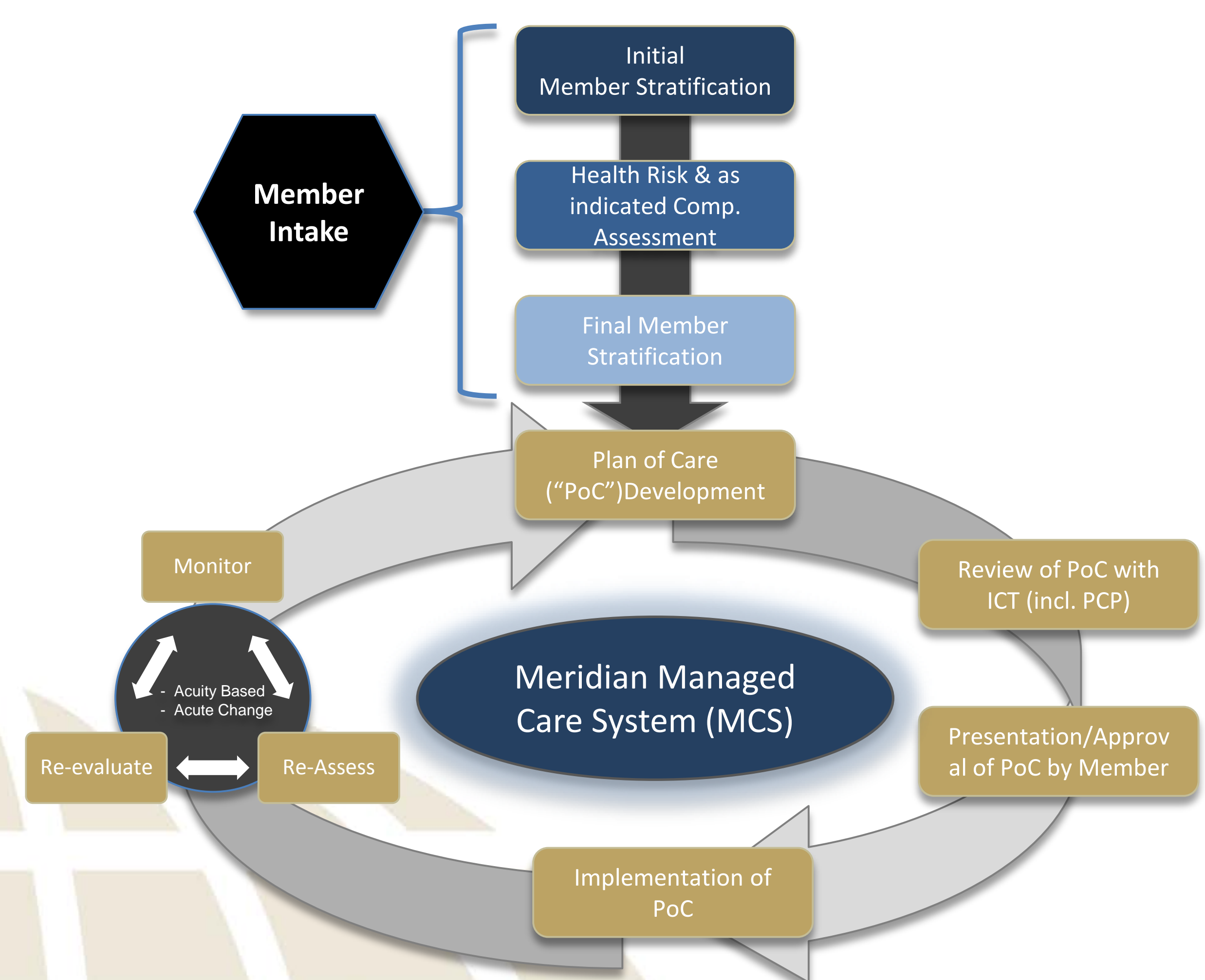
Medical Director
Care Coordination Nurse Team Lead
Care Coordinator
Care Coordinator
Care Coordinator
Care Coordinator
Consultant Behavioral Health
Consultant Pharmacy
Consultant Nutrition
Community Health Outreach Worker (CHOW)

Care Coordination Programs/Populations Served

- Medical – high risk, chronically ill
- Maternity – all pregnant members, high risk OB
- Behavioral Health – SPMI with functional deficits, high risk
- Weight Management – BMI > 30, telephonic support and structured weight loss program
- High ED – high utilizers seeking PCP treatable care in ED
- Hospital – concurrent monitoring of high-risk acute admissions
- Transitional – hospital care to skilled nursing, custodial care or back to home
- Special Needs – children with physical disability, foster care
- Medicare – frail and elderly, dual eligible
- Community - nursing home eligible waiver population
- Complex Case Management – multiple chronic conditions and catastrophic illnesses

Meridian Care Coordination Overview

Care Management Process



Member Stratification

- Predictive Models
- Claims Data
- Long Term Support Service Use
- Disease Management
- Historical Plans of Care
- Open Authorizations
- Health Risk Assessments
- Comprehensive Assessments
- Physician Referrals
- Member Self Referrals

Stratification Levels

- Four levels
- Highest level enrolled in Complex Case Management

Monitoring

- Stratification
- Acuity
- Acute Change
- Hospital Admission
- ER visit

Stratification

Through the use of a predictive modeling tool and HRA, Meridian proactively identifies high-risk members. This tool analyzes pharmacy expenses, diagnoses and demographics to categorize members into one of four levels of care.

- **Level 1:** Members are healthy, well and require occasional assistance or episodic management (low-risk and low-cost). Many TANFs fall into this category
- **Level 2:** Members with a chronic illness able to self-manage (generally low-risk and low-cost, depending on conditions)
- **Level 3:** Members with chronic diseases or behavioral conditions (high-risk and high-cost). ABADs generally fall into this category
- **Level 4:** Members with special healthcare needs who have or are at high risk for chronic physical, developmental, behavioral, neurological or emotional conditions (highest-risk and highest-cost)

Healthy members, usually stratified at Level 1 or Level 2 receive regularly scheduled outreach calls and written reminders of available preventive health services.

Members in Level 3 and Level 4 are placed in Meridian's Care Coordination program.

Meridian Health Plan

** All pregnant members are stratified according to prenatal assessment.*

Meridian Care Coordination Outcomes

After enrollment:

	After 3 Months		After 6 Months	
Measure	Count Change	Spend Change	Count Change	Spend Change
Inpatient Admissions	↓ 26.95%	↓ 22.85%	↓ 37.13%	↓ 36.49%
ED/UC	↑ 7.33%	↓ 8.66%	↓ 1.23%	↓ 14.24%
Outpatient Visits	↓ 10.39%	↓ 28.79%	↓ 18.99%	↓ 28.36%
Professional Visits	↓ 3.56%	↓ 11.15%	↓ 9.97%	↓ 11.32%
Prescriptions	↑ 2.18%	↓ 1.71%	↓ 1.41%	↓ 7.39%

Proven Effective

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Person-Centered Plan of Care

MEMBER INFORMATION			
Member Name: John Doe		**Medicaid ID#:** 333333333	
Address: 222 Mayberry Lane Chicago, IL 60606		**Gender**: Male	
Phone: (555) 555-5555		**Date of Birth**: 01/01/1960	**Age**: 54
PCP Name: George Smith		**PCP Phone**: (777) 777-7777	
Waiver: Yes	Type: Disabilities	**Risk Stratification**: Moderate	
Date of ICT Meeting: 02/14/2015		**Date of Last POC Review**: 11/03/2014	

PROBLEM: Member does not take all medications according to his/her provider's instruction				**Start Date:** 11/12/2014
Priority 1	**Short Term Goal:** Member will understand the importance of and follow the directed medication plan.		**Long Term Goal:** Member will be able to tell physician the name(s) of the medication(s) being taken and why he/she is taking medication(s).	
	Goal Start Date	**Timeframe for Completion**	**Status**	**Goal End Date**
	11/12/20	45 Days	Not Met	
Comments: 11/25/2014 Member will contact PCP to obtain appropriate medications. Care Coordinator assisted member with setting up appointment with PCP for 12/1/2014.				

PROBLEM: Member does not have consistent housing				**Start Date:** 11/12/2014
Priority 2	**Short Term Goal:** Member will identify the resources needed to gain safe and stable housing.		**Long Term Goal:** By making the identified necessary changes, member will secure and maintain stable housing.	
	Goal Start Date	**Timeframe for Completion**	**Status**	**Goal End Date**
	11/12/2014	180 Days	Not Met	
	Comments: Community Health Outreach Worker will assist member with locating and applying for appropriate housing in desired areas.			
	Short Term Goal:		**Long Term Goal:**	
	Goal Start Date	**Timeframe for Completion**	**Status**	**Goal End Date**
	Comments:			

STRENGTHS:	
1	Motivated to change
2	Knowledgeable of his/her conditions
3	Maintains positive attitude
4	Effective communication skills
5	Seeks additional help or supports when needed

GOALS IDENTIFIED BUT DECLINED				
	Problem	**Short Term Goal**	**Long Term Goal**	**Decline Date**
1	Member is addicted to tobacco products	Member will accept a referral to the smoking cessation program	Member will identify lifestyle changes to improve overall health	11/14/2014
2				
3				
4				
5				

SERVICE PLAN SUMMARY										
Function	**Service Type**	**Provider**	**Self-Directed**	**Provider Doc. Req.**	**Auth From**	**Auth To**	**Rate**	**Days per Month**	**Hours per Day**	**Projected Monthly Cost**
Grooming	Personal Assistant	DRS			06/01/2014	01/01/2015	11.56	31	.25	89.59
Details:										
Function	**Service Type**	**Provider**	**Self-Directed**	**Provider Doc. Req.**	**Auth From**	**Auth To**	**Rate**	**Days per Month**	**Hours per Day**	**Projected Monthly Cost**
Laundry	Personal Assistant	DRS			06/01/2014	01/01/2015	11.56	15	1	173.40
Details:										

Total Projected Monthly Costs	
Total Projected Annual Costs	

Back-Up Plans:		
	Helper 1	**Helper 2**
*Name	Joshua Thomas	Alexandra Jenkins
*Phone Number	(888) 123 4567	(777) 987 6543
*Relationship to person	Friend	Niece
*Lives with person	No	Yes
*Areas of informal help during last 3 days: Non-personal care (IADL)	Assist with stairs	Preparing meals
*Areas of informal help during last 3 days: Personal care (ADL)	Grooming	Bathing

EMERGENCY CONTACTS						
Type	**Name**	**Phone**	**Address**	**City**	**State**	**Zip Code**
	Joshua Thomas	(888) 123 4567	818 Hiller Drive	Chicago	IL	60606
	Alexandra Jenkins	(777) 987 6543	313 Detroit Blvd	Chicago	IL	60606
	Taylor Green	(666) 369 2587	616 Fort St	Chicago	IL	60606

Additional Comments:

By signing below, I agree with the following statements:

- I agree with the goals listed above and was offered options and choices in developing my plan of care
- I was offered the choice between receiving waiver services in my home and community and receiving services in an institutional care setting
- I was offered choices of services and providers to meet my needs
- My Care Coordinator told me how to report abuse, neglect, and exploitation, and whom to report it to
- I received information and was offered options and choices regarding self-direction of my plan of care
- I received informational brochures regarding my waiver services as provided by the applicable state agency

Member Signature	Date
Legal Guardian Signature (if applicable)	Date
Care Coordinator Signature	Date

Questions?