

Working together for healthy members



Geisinger Health Plan's (GHP) Care Coordination Department is responsible for the development, implementation, and measurement of disease and case management programs for Health Plan members. Listed below are the current Care Coordination programs:

- Adult and Pediatric Asthma
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (HeartWise)
- Diabetes
- General Case Management
- Heart Failure (HF)
- Hypertension
- Osteoporosis Prevention and Management
- Tobacco Cessation (teen and adult)

Disease Management Program Development

The Care Coordination administrative staff conducts an analysis of the disease under consideration prior to the development of a disease management program. The following criteria are evaluated:

*Care Coordination utilizes educational materials developed internally as well as from outside agencies such as, American Diabetes Association, National Institute of Health, etc. Use of these materials does not constitute endorsement of a specific product or service by Geisinger Health Plan. Care Coordination does not advertise, market or promote specific products or services to members or practitioners when discussing a member's health condition.

- Disease prevalence.
- Disease complexity.
- Potential for reducing complications, improving quality.
- Current cost of managing the disease.
- Existence of an evidence-based clinical guideline to assist practitioners in the management of the disease.
- Value to the member and GHP if the program is implemented.

The Care Coordination team determines the need for a specific disease management program based upon the criteria listed above and submits a proposal to the Health Plan's Medical Management Administrative Committee and Quality Improvement Committee for review and approval.

Actively practicing practitioners are participating members of disease management teams and assist in the development, implementation, and monitoring of new and established disease management programs.

Practitioner Program Content

The design of all disease management programs includes: evidence-based clinical guidelines, member identification, passive or active enrollment, stratification, interventions based on stratification level, practitioner decision support and evaluation of program effectiveness.

Evidence-based clinical guidelines are a core component of all disease management programs. Board certified specialty and/or primary care practitioners are involved in the review and approval of evidenced-based guidelines.

Clinical Guidelines are reviewed every two years or when recommendations are revised by the appropriate guideline team, the GHP Guideline Committee and the GHP Quality Improvement

Committee. Identified primary and specialty care practitioners are involved in the development and review of new disease management programs. The Care Coordination Department and the accompanying teams are responsible for program content that is consistent with current clinical practice guidelines.

Evidence-based guidelines are posted online at www.thehealthplan.com, and announcements are made in the publication *Briefly* to inform practitioners of their availability. Printed copies or electronic .pdf files are available upon request for practitioners who do not have Internet access by contacting Care Coordination at (800) 883-6355, Monday through Friday from 8 a.m. to 4:30 p.m.

Identification of members who will benefit from Care Coordination's programs is accomplished through claims analysis using standard clinical specifications from criteria such as the Health Plan Employer Data & Information Set (HEDIS). Member identification is also facilitated by direct referrals from primary and specialty care practitioners, the member and/or family, and from various Health Plan departments including Utilization Management, Customer Service, Appeals, and Quality Improvement.

Passive/active enrollment

All members with a disease-specific diagnosis are identified by claims analysis and/or HEDIS criteria and mailed a disease-specific information newsletter. The members are informed of their enrollment in the program and have the opportunity to "opt out" by contacting the Care Coordination office. The members that do not opt out are considered passive enrollees.

All passive members receive disease-specific information newsletter(s) each year to increase their knowledge of disease self-management. Each

newsletter also encourages the members to become "active" enrollees in the disease management program.

A member becomes actively enrolled in the appropriate disease management program when the member contacts Care Coordination directly, is referred by a health care practitioner or a Health Plan department, or accepts an invitation extended by the Care Coordination Department (through disease-specific member newsletters or direct member invitation by letter or phone as the result of claims analysis information). The Care Coordination nurse reviews the referral information and contacts the member to either schedule an office appointment with the nurse or to arrange to routinely communicate with the member telephonically. After the member's verbal and/or written consent for participation is obtained, the member is actively enrolled in the appropriate program.

Risk stratification

The Care Coordination nurse stratifies active members based on clinical criteria according to low, moderate or high risk. For example, members enrolled in the Heart Failure program are stratified according to the American College of Cardiology (ACE) staging criteria. Members with diabetes are stratified using glycosolated hemoglobin (A1c) control and the presence of risk factors.

Interventions

The degree of intervention is based on the member's risk stratification. For example, a member classified as low risk will receive a minimum of one (1) program information newsletter each year, self-management education, a plan of care, and one or more follow-up office or phone appointments. A member with a high-risk stratification will receive these interventions in addition to more frequent office/phone visits and referrals for neces-

sary specialty or case management services.

Practitioner decision support

The Care Coordination decision support model includes evidence-based clinical guidelines (previously described), Care Coordination nursing staff; the plan of care; and the *Practitioner Quality Feedback Report*. The program is designed for actively practicing primary and/or specialty care practitioners.

The Care Coordination nursing staff is key to providing collaborative “real time” decision support to primary or specialty care practitioners. The nurses follow internally developed Intervention Pathways that complement the clinical guideline. The Intervention Pathways provide a framework for self-management education, the recommended laboratory/diagnostic studies and targeted clinical goals.

The plan of care includes information regarding the patient’s self-management of their condition, barriers, special considerations or exceptions, review of medical test results, management of comorbidities, collaborative goal-setting and problem-solving, medication review, plans for follow-up and preventive health monitoring. The plan of care is reviewed and discussed by the primary and/or specialty care practitioner and Care Coordination nurse in person, by phone, or through an electronic medical record messaging process.

Additional decision support information is mailed to participating practitioners annually from the Care Coordination administrative staff in the form of a letter accompanied by the *Practitioner Quality Feedback Report*.

The involvement of the practitioner is integral in the design of program content for all Care Coordination programs. Practitioner participation ensures program content is appropriate for the actively practicing primary care practitioner. All primary

care practitioners are surveyed annually in order to elicit feedback regarding the program(s).

Evaluation of program effectiveness

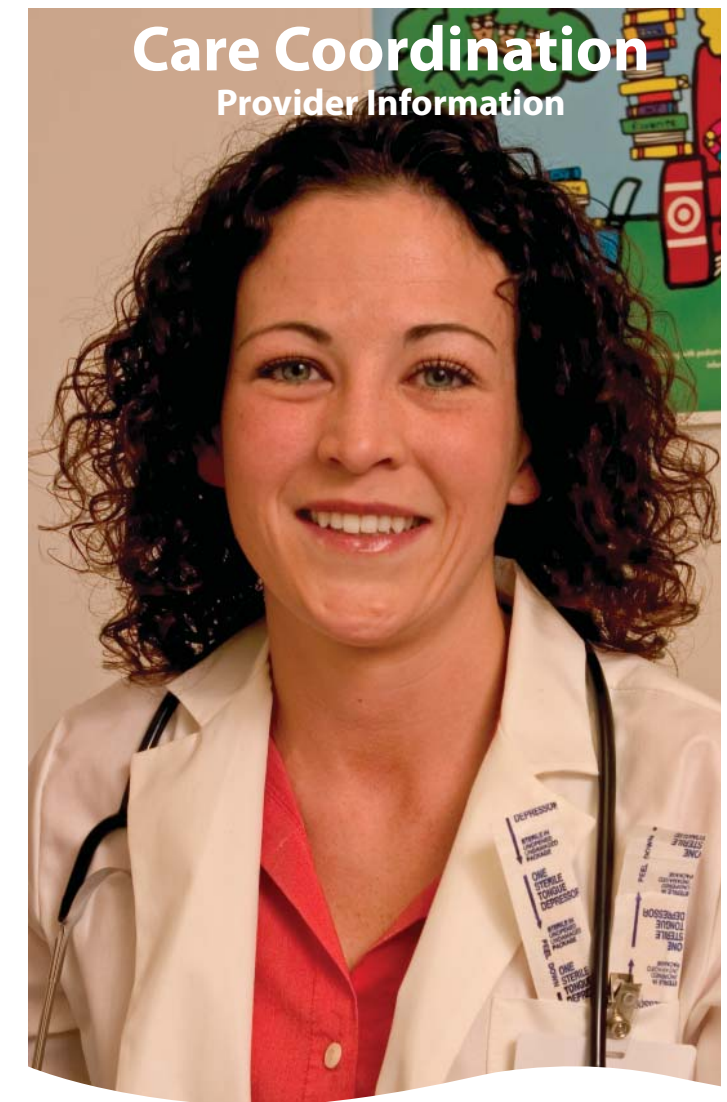
Program effectiveness is measured by conducting a pre-and post-analysis of pertinent clinical measures, annual member/practitioner program satisfaction surveys and pre- and post-comparisons of services utilized by members in the programs.

Practitioners’ Rights

Practitioners who care for Geisinger Health Plan members have the right to:

- Obtain information regarding Care Coordination programs and services in conjunction with Geisinger Health Plan as outlined in this brochure.
- Obtain information regarding the qualifications of the Care Coordination staff.
- Obtain information regarding how the Care Coordination staff facilitates interventions via treatment plans for individual members.
- Know how to contact the Care Coordination nurse responsible for managing and communicating with their patients.
- Request the support of the Care Coordination nursing staff to make decisions interactively with members regarding their health care.
- Receive courteous and respectful treatment from Care Coordination staff at all times.
- File a complaint when dissatisfied with any component of the Care Coordination programs by contacting the Care Coordination Department at (800) 883-6355.

Care Coordination Provider Information



To learn more about Care Coordination programs, or to refer a member, please call (800) 883-6355 or see the Care Coordination Web site at thehealthplan.com. Care Coordination hours of operation are Monday through Friday from 8 a.m. to 4:30 p.m.



thehealthplan.com

