

Case Management & Health Management Provider Information



Working together for healthy members

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

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

Case Management/Disease Management Program Development

Case Management conducts an analysis of the disease under consideration prior to the development of a case management/disease management program. The following criteria are evaluated:

- 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.

Case Management leadership determines the need for a specific case management/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 case management/disease management teams and assist in the development, implementation, and monitoring of new and established case management/disease management programs.

Practitioner Program Content

The design of all case management/disease management programs includes but is not limited to: 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 case management/disease management programs. The Case Management 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 the Case Management Department at (570) 271-8763 or toll free (800) 883-6355, Monday through Friday from 8 a.m. to 4:30 p.m.

Identification of members who will benefit from Case Management/Disease Management programs is accomplished through claims analysis using standard clinical specifications from criteria such as the Healthcare Effectiveness 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 Medical 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 Case Management office. The members that do not opt out may be 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 case management/disease management programs.

A member becomes actively enrolled in the appropriate case management/disease management program when the member contacts Case Management directly, is referred by a health care practitioner or a Health Plan department or accepts an invitation extended by the Case Management Department (through disease-specific member

newsletters or direct member invitation by letter or phone as the result of claims analysis information). The Case Manager/Health Manager (CM/HM) 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 Case Manager/Health Manager 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 necessary specialty or case management services.

Practitioner decision support

(How the Health Plan works with your patients in the program)

The Case Management/Disease Management decision support model includes evidence-based clinical guidelines (previously described), nurse Case Managers/Health Managers; and the plan of care. The program is designed for actively practicing primary and/or specialty care practitioners.

The Case Manager/Health Manager is key to providing collaborative "real time" decision support to primary or specialty care practitioners. The CM/HM follows internally developed Care Paths (Algorithms) that complement the clinical guidelines. The Care Paths (Algorithms) 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 co-morbidities, 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 Case Manager/Health Manager in person, by phone, or through an electronic medical record messaging process.

The involvement of the practitioner is integral in the design of program content for all Case Management/Disease Management 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.

Practitioner Rights

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

- Obtain information regarding Case Management/Disease Management programs and services in conjunction with Geisinger Health Plan as outlined in this brochure.
- Obtain information regarding the qualifications of the Case Management staff.
- Obtain information regarding how the Case Management staff facilitates interventions via treatment plans for individual members.
- Know how to contact the Case Manager/Health Manager responsible for managing and communicating with their patients.
- Request the support of the Case Manager/Health Manager to make decisions interactively with members regarding their health care.
- Receive courteous and respectful treatment from Case Management staff at all times.
- File a complaint when dissatisfied with any component of the Case Management/Disease Management programs by contacting the Case Management Department at (570) 271-8763 or toll free at (800) 883-6355, or the Customer Service Department at the number listed in your insurance card.

How to use Case Management/Disease Management services

To learn how to use Case Management/Disease Management services, or to refer a member, please call (570) 271-8763, toll free (800) 883-6355, or visit the Case Management Web site at www.thehealthplan.com. Case Management hours of operation are Monday through Friday from 8 a.m. to 4:30 p.m.

*The Health Plan 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 the Health Plan. The Health Plan does not advertise, market or promote specific products or services to members or practitioners when discussing a member's health condition.

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