Florida Blue
Care Management Programs

Care Management Programs

Executive Summary

Care management (CM) exists to ***improve member health outcomes***. The place of delivery (POD) model provides a framework within which Medical Directors, RN Care Managers, Pharmacists, Registered Dietitian Nutritionists and Social Workers coordinate delivery of services, information, and member support with the members physician and internal and external partners to

1) *do the right things – being effective*
2) *do things right – being efficient.*

POD model care delivery empowers members to reach their health goals and gain assurance that we are "My Kind of Blue".

Care Management Program Goals

- Optimize member outcomes
- Demonstrate measurable performance
- Maximize utilization efficiency
- Maximize Net Promoter Scores (NPS)

The Care team is responding to what members say they want

1. **"Know and understand me"**
   Uses Care360 information during member discussions to deliver personal health information
2. **" Make it simple for me"**
   Identify symptoms I need to monitor; suggest tools to help me be as healthy as possible
3. **"Personalize for me"**
   Practices Motivational Interviewing (MI) to align to my goals and lifestyle
4. **"Care about me"**
   Helps solve problems and prioritize member needs using MI approach and mindset to guide, educate and deliver individualized care
5. **"Show me value"**
   Is supported by leadership commitment to simplify, enable & measure success

Care Team Strategic Imperatives

Two basic principles define the strategy:

1) Actively optimize member relationships and
2) Enable maximum use of clinical licensure

High intensity specialty Care management (e.g. Targeted, Acute, Complex, Chronic)

Appointment set-up and scheduling support (Partner Collaboration)

Automated prioritized work queue

Motivational Interviewing excellence

Program and individual M&E

Customer Experience, Branding (New name TBD), Survey Redesign Communication: Transforming Care Management

In Motion

Optimizing member relationships to effect sustained, appropriate member engagement, better health outcomes and subsequent optimal NPS.

Enabling maximum use of clinical licensure requires supplemental support for the outreach process, simplify information access and documentation, focus engagement on most critical identified populations, optimizing MI skills and establishing meaning outcomes measurement at the program and individual level. RMD /PCP / Vendors.

Care Team Strategic Imperatives

Actively optimize member relationships through:

Member Engagement

- A member centric outreach approach that promotes Self Management and enables the member to return to and/or maintain an optimum level of health.
- Introducing and reinforcing Self Management education fosters member empowerment by enhanced understanding their benefits, proactive management of their condition/disease and the value of maintained provider relationships.
- Potential realization of reduce medical costs.

Care Management Program

Identifier	Program Focus: General, Complex or Chronic Condition	Member Profile and Impactability
Condition Based	**High Acuity:** CHF COPD Diabetes CV conditions	Advanced chronic conditions as evidenced by multiple co-morbid conditions, disease complications and or recent inpatient or emergency room utilization. **Engagement Focus:** Improved self-management, reduce unnecessary or avoidable IP/ER visits, improved clinical outcomes, discussion on advanced directives on end of life options as appropriate
	Low Acuity: Asthma Diabetes CV Conditions	Newly diagnosed, lower acuity, limited disease complications **Engagement Focus:** Improved self-management, lifestyle modification, compliance with physician directed plan of care resulting in prevention or delay of disease progression and complications

Care Management Programs:

Identifier	Program Focus: General & Complex CM	Member Profile and Impactability
Event Based	**High ER Utilization**	Last 6 months, stratified by cost and visit volume of preventable type visits (NYU study criteria) **Engagement Focus:** Identify root cause of ER usage with Social Worker and or Nurse CM interventions to mitigate
	Inpatient with high risk scores: (LACE>12)	High risk for readmission **Engagement Focus:** Transition planning and intervention to minimize readmission risk
	Inpatient readmission	Current readmission (unplanned) **Engagement Focus:** Identify root cause of readmission and interventions to prevent further admissions (referrals/consults initiated to SME as needed)
	Transplants	Managed in Complex CM per NCQA guidelines **Engagement Focus:** Pre and Post Transplant care coordination and education for improved outcomes
	Recent High Cost: (i.e. Acute, Catastrophic, Rare Condition, Pharmaceuticals etc.….)	Evaluates recent month, prior 3 months and prior 12 month spend **Engagement Focus:** Screen for care coordination needs, referrals as needed, improve self-management, reduce unnecessary or avoidable ER or IP

Care Management's Delivery Team

Member is at the Center of a Team Dedicated to Delivering Optimal Care Management

Engages high and low acuity members with goal to improved member self management, identify and coordinate resolution of barriers to care with treating MD and other care partners.

Assess/manage risks that could lead to readmission within 30 days of discharge; triage of incoming referrals for care needs and or referral to other programs and or care partners.

Provides clinical leadership and consultation to the POD team. Develops and implements regionally based medical management strategies. Collaborates with regional providers to improve population clinical and financial outcomes.

Performs interventions to support the member in the community, addressing social determinants of health to assist in removing barriers to care.

Leads and guides multidisciplinary team. Accountable for the outcomes related to clinical programs and member satisfaction.

Reviews medication management and suggests drug regime improvements and/or lower cost options. Consults with members and providers.

Performs nutritional diagnostic, therapy, and counseling services that support members to set priorities, establish goals, and create individualized action plans.

Care Management's Delivery Team

Our Care Team consists of registered nurses, pharmacists, social workers, dietitians and physicians.

Population Care Managers (PCM):

- Responsible for leading and guiding a multidisciplinary team to achieve quality outcome measures for a specific geographic area
- Gather, support and develop resources needed in order to direct staff to execute strategic and operational objectives.
- Guide the direction of work within the multidisciplinary team and remove barriers for staff so they can perform their work efficiently and timely.
- Track and report performance, trends, potential opportunities for process improvements that will impact the overall quality of care, total cost of care and optimize the full capabilities of the team in supporting our members

Transition Nurses:

- Serve as an advocate for members admitted to facilities and assist them in transitioning through the continuum, educate regarding benefits, conditions/illnesses, self management strategies and treatment plan understanding
- Short term Case Management (up to 30 days) with the purpose to assess member's comprehensive care and discharge needs to assure a smooth transition of care across the continuum to help prevent future unnecessary readmissions
- Determine member's long term care needs and initiate appropriate Program referrals and indicate any additional needs and services that require ongoing Care Coordination of services.

Care Management's Delivery Team

Care/Case Managers/RNs: RN Care Managers call members that have been triggered through an analytic report based on actual or potential high risk or high cost.

- ✓ new diagnosis such as diabetes
- ✓ an ER visit such as an asthma attack
- ✓ hospital inpatient such as for COPD/ pneumonia
- ✓ member has several conditions that require attention

- Manage Referrals: Member-self, MD, IP Setting, Family/SO/Caregiver
- Conduct Telephonic Assessment: knowledge of benefits, health condition, self-management plan, barriers to care, providers and/or services
- Develop Member Driven Care Plan: to address problems, apply interventions and achieve goals
- Provide Education: benefits, health condition, self management strategies
- Initiate consults to other SME/disciplines as needed
- Once a member is successfully on track and has a good understanding of how to manage their condition along with the medication, medical equipment, and specialists to help them, together we decide if they are comfortable to manage on their own now that their goals have been met.
- Members can always reach back out to their nurse care manager should concerns arise in the future.

Care Management's Delivery Team

LCSWs / Community SWs: Social Workers receive referrals from analytic reports, MD, IP setting, self referral, family members or Nurse Care Managers to assist members with a multitude of barriers. Common barriers and or Community Resources.

Common SW consults triggers include:

- ✓ Medication co-payment assistance
- ✓ Co-payment assistance based on diagnosis
- ✓ Support Group information
- ✓ In-Home Services (paid caregiver, meals on wheels, respite care, etc.)
- ✓ Transportation, community resources only including county provided bus line, ex SCAT
- ✓ Community Resources such as Food (EBT)
- ✓ Housing Assistance
- ✓ Utility Assistance
- ✓ Advance Directives
- ✓ Assisted Living Placement , general information only
- ✓ Medicaid: direct member to Medicaid website and customer service . (SW can verify Medicaid)

Care Management's Delivery Team

Registered Pharmacists: Pharmacist receives referrals from the Care Management team – nurses, social worker, registered dietitian etc...

Pharmacist activities include:

- ✓ Comprehensive Medication Review
- ✓ Answers specific questions
- ✓ Identifies and addresses medication related problems such as:
  - Duplication of therapy
  - Adherence issues
  - Side effects
  - Untreated diseases/conditions
- ✓ Educates/trains on appropriate use of medications
- ✓ Provides cost savings opportunities
- ✓ Collaborates with nurses, physicians, & pharmacists
- ✓ Available for follow up as needed

Care Management's Delivery Team

Registered Dietitian Nutritionists: Newest discipline added to the team

- Performs nutritional assessment, therapy and counseling services that support members to set priorities, establish goals and create individualized action plans.
- Contributes to the design of educational materials related to nutrition health

Common consult triggers include:

- ✓ Diabetes/Renal
- ✓ Cardiovascular Disease
- ✓ Gastrointestinal Disorders
- ✓ Complex Case Management
- ✓ Cancer
- ✓ Hepatic and Biliary Disorders
- ✓ Malnutrition
- ✓ Bariatric Surgery (pre and post)
- ✓ Non-healing wounds
- ✓ Others as needed

Care Management's Delivery Team

Regional Medical Directors

- ✓ Provide clinical leadership to the Care Management team.
- ✓ Develop and implement regionally based medical management strategies.
- ✓ Collaborate with Care Management design team in the development and implementation of Care Programs and protocols.

Engagement Specialists/ Schedulers:

- ✓ Non-clinical staff that conducts outreach calls to members to increase efficiency and effectiveness of the Care Team.
- ✓ Focusing on "selling" the benefits to the member of Care Management and book the appointment

Care Management's Delivery Team Partners

Our Care Team collaborates with Care Partners

Pop Health: Improve member health outcomes by providing access to health screenings and other medical services.

- **CareSight**: Help members in poor health get the care they need from the convenience of their home and provide the assigned PCP

- **CareSight Transition of Care (TOC)**: PopHealth will help members during the first 30 days they are home after a hospital or skilled nursing facility stay to help them transition back to taking care of their health at home.

New Directions: Manages Behavioral Health/Substance Abuse Services for Florida Blue

Health Dialog: 24/7 Nurse Line and Chronic Condition Management Program (ASO Groups)

Care Centrix: Home Health services and DME provider

Care Management

Measures of Success

Improved Health Outcomes
Member Satisfaction (NPS and Satisfaction)
Medical and Member Cost Savings
NCQA Accreditation

https://www.floridablue.com/why-florida-blue

Additional Program Offerings:

Our Care Team introduces members to Health and Wellness Programs

Web Based - Retail Centers - Provider Partners – Telephonic
Call-Click-Visit

Online Wellness Programs:

- **Web/mobile based**
- **Personal Health Itinerary**

Lifestyle Programs:

- **Stress**
- **Nutrition**
- **Exercise**
- **Family**

Health Coaching:

- **Next Steps Program**
- **Healthy Additions**

Incentive Programs (as appropriate)

- **Eligibility Reminder**
- **Points & Activity Tracking**

How Can You Help?

Provide member with Florida Blue Care Management contact Information:

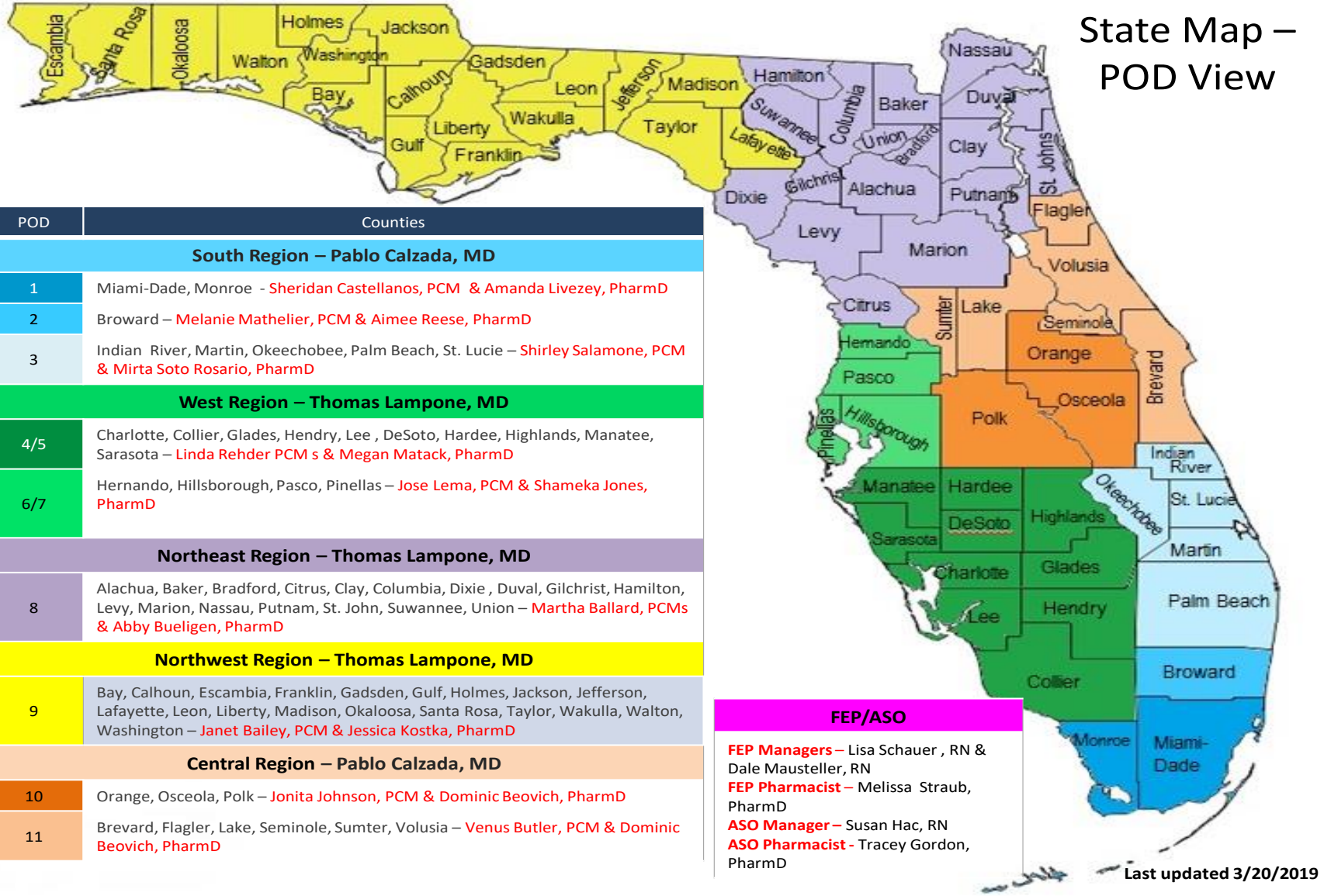
- Call: 1(800) 955-5692 and select option 3
  (Care Management)

- Send email to: www.CareMemberOutreach@bcbsfl.com

To expedite assigning the case to a member of our team please include the following:

- member's name
- Member's ID #
- member's date of birth
- Member's contact information if available

State Map – POD View



POD	Counties
South Region – Pablo Calzada, MD	
1	Miami-Dade, Monroe - Sheridan Castellanos, PCM & Amanda Livezey, PharmD
2	Broward – Melanie Mathelier, PCM & Aimee Reese, PharmD
3	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie – Shirley Salamone, PCM & Mirta Soto Rosario, PharmD
West Region – Thomas Lampone, MD	
4/5	Charlotte, Collier, Glades, Hendry, Lee , DeSoto, Hardee, Highlands, Manatee, Sarasota – Linda Rehder PCM s & Megan Matack, PharmD
6/7	Hernando, Hillsborough, Pasco, Pinellas – Jose Lema, PCM & Shameka Jones, PharmD
Northeast Region – Thomas Lampone, MD	
8	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie , Duval, Gilchrist, Hamilton, Levy, Marion, Nassau, Putnam, St. John, Suwannee, Union – Martha Ballard, PCMs & Abby Bueligen, PharmD
Northwest Region – Thomas Lampone, MD	
9	Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Lafayette, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington – Janet Bailey, PCM & Jessica Kostka, PharmD
Central Region – Pablo Calzada, MD	
10	Orange, Osceola, Polk – Jonita Johnson, PCM & Dominic Beovich, PharmD
11	Brevard, Flagler, Lake, Seminole, Sumter, Volusia – Venus Butler, PCM & Dominic Beovich, PharmD

FEP/ASO

FEP Managers – Lisa Schauer , RN & Dale Mausteller, RN
FEP Pharmacist – Melissa Straub, PharmD
ASO Manager – Susan Hac, RN
ASO Pharmacist - Tracey Gordon, PharmD

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