



PRIORITY HEALTH

HEALTH MANAGEMENT SERVICES

Priority Health's intent is to help people experience healthier lives via a comprehensive preventive and therapeutic health care delivery system which promotes the coordination of effective health care and service and is committed to a mutually respectful relationship with members. To that end, Priority Health provides case management and disease management services.

Case Management (CM) is a process designed to manage members who are at risk for a high-cost, episodic, acute event, have a condition that could lead to an increased utilization of services, or have a catastrophic outcome. Case Management's goal is to identify specific member needs, develop a plan of care that utilizes health care resources and leads to optimum member outcomes in a cost-effective manner. All members who enter the health care system with a "health need" will be screened for CM services. The case manager decides which patients need active intervention. Utilization Management (UM) is the joined processes of utilization review and case management. Through UM, a red flag system identifies selected patients for referral to case management services by applying predetermined selection criteria. The UM nurse reviews in-patient admissions and separates out those people who are likely to generate a need for case management services based on clinical and cost criteria.

Disease Management is an integrated, systematic approach to delivering care to populations of members with chronic illness. Working collaboratively with the Primary Care Provider, members are provided access to state of the art care, information and physician support. Priority Health is focused on six conditions of high-risk, high cost and high volume: asthma, diabetes, cardiovascular, tobacco cessation, extreme obesity with co-morbidities, and pregnancy/high-risk pregnancy (Healthy Expectations). Our goal is to support our physicians' practice of moving patients toward optimum health by identifying and stratifying members into risk levels for interventions. Priority Health Registries are the tool used in this process.

Once members have been stratified, Priority Health's Nurse Health Advisors (NHAs), who are Registered Nurses, use the established processes to assist physicians in educating and motivating patients who are at risk. The NHAs collect information, assess the patient's immediate needs, and provide on-the-spot health information via telephonic contact, followed by educational material mailings and direct communication with the physician.

Healthy Expectations is Priority Health's maternity support program. Members are identified through precertification, which is strongly advocated for the first trimester. Precertified members are mailed an introductory prenatal packet, which includes educational materials, a designer bib with an immunization message, and 50% off prenatal class coupons. If the member is high risk, she receives ongoing telephone followup from a RN Health Advisor who offers personal support and customized educational materials, and answers questions. The physician/specialist is involved throughout the process. Upon delivery, home visits are provided according to Healthy Expectations criteria.

Case Management Process

CASE FINDING:

**Identify Member
by Health Need**

Assign Risk Level

- Low Risk
- Moderate Risk
- High Risk

Assign Care Level

for intervention based on risk

Enter Patient into Process

at appropriate care level

Stable Care Level (Low Risk) Interventions

- Phone call as needed
- PCP/Specialist interaction throughout
- Customized educational mailings as needed
- Home Care and DME referral management as needed
- Personalized postcard to member with Case Manager phone number
- Promotion of flu and pneumovax vaccines
- Handoff to specialty case manager when appropriate

Intermediate Care Level (Moderate Risk) Interventions

- RN phone contact with member as needed
- PCP Specialist interaction throughout
- Customized educational mailings as needed
- Home Care and DME referral management as needed
- Personalized postcard to member with Case Manager phone number
- Promotion of flu and pneumovax vaccines
- Handoff to specialty case manager when appropriate

Complex Care Level (High Risk) Interventions

- RN phone contact with member as needed
- RN phone contact with family members as needed
- PCP/Specialist interaction throughout
- Customized educational mailings as needed
- Home Care and DME referral management as needed
- Home visits as needed or requested
- Personalized postcard to member with Case Manager phone number
- Promotion of flu and pneumovax vaccines
- Handoffs to specialty case manager when appropriate

Close Case

when appropriate

Disease Management Process

CASE FINDING:

**Identify Member
by Diagnosis Using Registries**
(Asthma, Diabetes, Cardiovascular,
Tobacco Cessation, Extreme Obesity with
Co-morbidities)

Assign Risk Level

- At Risk
- Moderate Risk
- High Risk

Assign Intensity Level
for intervention based on risk

Enter Patient
into disease-specific process at
Intensity level I, II or III

Intensity I (At Risk)

- Personalized Letter(s)
- Disease-specific Educational Mailings
- HealthFit discounts
- Disease Management 800#
- Access to RN Counseling
- Wellness classes

Intensity II (Moderate)

- Personalized Letter(s)
- Disease-specific Educational Mailings
- HealthFit discounts
- Disease Management 800#
- Assessment Tool
- Community Resource Referral
- Wellness Classes
- RN telephone counseling every 3 to 6 months to evaluate, educate and encourage.
- PCP interaction throughout.

Intensity III (High Risk)

- Personalized Letter(s)
- Disease-specific Educational Mailings
- HealthFit discounts
- Disease Management 800#
- Assessment Tool
- Community Resource Referral
- Wellness Classes
- RN telephone monitoring & coordination monthly
- PCP interaction throughout.
- Third-party referral (such as home care) as appropriate.

Maintenance

Member remains in process
for yearly Monitoring.

Healthy Expectations OB High & Low Risk Management Process

