Point32Health Medicare Advantage Care Management Programs

Programs	Description	Member Identification	Duration & Modality	Types of Providers
Complex Management	Utilizes the latest clinical guidelines, assessment tools including program and disease specific assessments, and educational material to manage members with multiple chronic conditions, co-morbidities, and co-existing functional impairments.	Targets top 3-4% of members at the highest risk for readmission. These frail members often suffer from chronic and/or multiple co-morbid conditions, as well as psychosocial issues. Care Manager referral, Member/Caregiver referral, Provider referral, Analytics	3 to 9 months Face-to-face or telephonic care management at minimum bi-weekly	RN Care Manager Primary Care Provider Internal specialist resources: Social Worker, Serious Illness/Palliative Care, Dementia Care, Behavioral Health, Serious Persistent Mental Illness (SPMI), Pharmacy, if needed
Rising Risk Chronic Illness Management	Utilizes the latest clinical guidelines, assessment tools including program and disease specific assessments, educational materials, motivational interviewing, and self-management support strategies to educate, counsel, and empower members and their caregivers to play a more central role in managing health.	Targets the next 4-10% of members with a geriatric condition and/or specific chronic illness that places them at higher risk for admission, including heart failure, chronic obstructive lung disease, and Type 2 diabetes. Care Manager referral, Member/Caregiver referral, Provider referral, Analytics	1 to 6 months Telephonic care management at minimum monthly	RN Care Manager Primary Care Provider Internal specialist resources, if needed External disease-specific vendors
Transitional Care Management	Following discharge from an inpatient setting, a Care Manager conducts a transition of care assessment to identify member-specific needs, treatment plan issues related to discharge instructions, medication changes, and follow-up care, helps coordinate the necessary care to prevent re-hospitalization, and collaborates with the member/family and providers on a plan of care to address needs.	Targets members in the top 20% of the population at risk who need their transition managed. These members have had a hospitalization or admission to a skilled nursing facility (SNF), putting them at greater risk for readmission due to the disruptions caused by the hospitalization.	7- 45 days Telephonic care management weekly	RN Care Manager Internal specialist resources, if needed

Point32Health Medicare Advantage Care Management Programs

Programs	Description	Member Identification	Duration & Modality	Types of Providers
Emergency Department(ED) Transitions	The ED program focuses on members who may have been able to seek care in an alternative setting as well as members who utilize ED frequently. Interventions include education related to early signs and symptoms of decline, appropriate alternatives to ED, and assessing and identifying member-specific needs for more intensive care management and community supports/services.	Targets members in the top 20% of the population at risk who need their ED transition managed. Members are identified by daily Admission Discharge Transfer (ADT) notifications and referred to care management.	Up to 7 days Telephonic care management	RN Care Manager Community Health Worker (Q1 2022) Internal specialist resources, if needed
Wellness-Supportive Care	Focuses on members not currently engaged in a CM program but have been identified as needing assistance with care coordination, potentially require more intensive services (unrelated to a recent ED or hospitalization) or may benefit from outreach to address gaps in care related to quality measures or other health promotion outreach campaigns.	Primary care provider referral Member Services referral Health Risk Assessment survey Star Measure Population Health Analytics	7- 45 days Telephonic care management	RN Care Manager Community Health Worker Internal specialist resources, if needed
Landmark Health	A healthcare organization we have partnered with to provide in-home care of complex, chronic patients. Services include but are not limited to providing 24/7 In-Home concierge level care for those who need it the most, and in-home diagnostics and interventions to stabilize and treat in place.	Members are identified via Landmark's proprietary algorithm which uses a point system for select chronic and complex conditions. Landmark MA geographic coverage includes all MA counties, excluding Barnstable Landmark NH geographic coverage includes Merrimack, Hillsborough, and Cheshire	Longitudinal Care Telephonic care management In-home scheduled and urgent care visits	Geriatricians, Advanced Practice RNs RN Care Manager Community Health Worker Social Worker Palliative Care Specialists Behavioral Health Pharmacy

Point32Health Medicare Advantage Care Management Programs

Programs	Description	Member Identification	Duration & Modality	Types of Providers
Behavioral Health (BH) **Severe and Persistent Mental Illness (SPMI)**	The BH program integrates behavioral and medical care management, providing holistic care that addresses BH and physical health, including BH transitions management. The SPMI program is currently available for the TMP population only and focuses on supporting members with SPMI with strategies for long-term self-management.	Primary care provider referral Member Services referral Internal CM referral	7- 45 days Telephonic care management	BH Care Manager Social Worker Community Health Worker BH APRN Optum BH for NH Stride only
Social Care	Social care team conducts psychosocial assessments to identify needs and risks, address psychosocial determinants of health, provide information about available resources, and participate in proactive and comprehensive care planning.	Primary care provider referral Member Services referral Internal CM referral	7- 45 days Telephonic care management	Social Workers Community Health Worker
Dementia Care	In partnership with the Alzheimer's Association (MA/NH chapter), Dementia Care Consultants provide a special program for members with Alzheimer's or other memory impairments and their caregivers with education about their cognitive impairment, information about community resources and support groups, and care planning assistance.	Primary care provider referral Member Services referral Internal CM referral	7- 45 days Telephonic care management	Dementia Care Consultants Internal specialist resources, if needed
Clinical Pharmacy	Clinical Pharmacy team provides consultation to members regarding their medication and pharmacy needs, including information related to medication cost resources, to improve awareness of their treatment plans, monitor treatment response, and improve their understanding and compliance with their medication regimen.	Primary care provider referral Member Services referral Internal CM referral	7- 45 days Telephonic care management	Clinical Pharmacists Pharmacy Technicians