Medical Management
Today’s Agenda

- Section 1: Overview of Medical Management
- Section 2: Case Management
- Section 3: Disease Management
- Section 4: Maternity
- Section 5: Management of Behavioral Health Conditions
- Section 6: Additional Services
- Section 7: Questions and Answers
Objectives

At the end of the session, the participant will:

- Identify the goals of medical management
- Differentiate between case management and disease management
- Understand the role of disease management in assisting members with chronic diseases
- Identify topics that can be discussed with coach on call sessions
- Understand the role of case managers in behavioral health
- Understand the impact of depression on chronic disease
- Identify tools available to assist members with managing their health
Medical Management Goals

I. Improving Quality of Care
II. Achieving Financial Targets
III. Satisfying Customers
IV. Creating Knowledge and Changing Behavior
V. Assisting Members with Self Management Skills
VI. Improving the Health of the Community
Snapshot of Medical Management

UTILIZATION MANAGEMENT
- Authorizes coverage of certain procedures, hospital stays
- Performs predetermination reviews
- Authorizes out-of-network and out-of-area care

CASE MANAGEMENT
- Offers care management services for medically complex cases
- Provides access to special needs services

HEALTH COACHING/DISEASE MANAGEMENT
- Provides access to disease management services for members with specific chronic diseases
Utilization Management
Utilization Management

- Review appropriateness of medical services based on medical standards
  
  - Surgeries
  - Inpatient admissions
  - Durable Medical Equipment
  - Proactive Discharge Planning
  - Transition of care from inpatient to home/SNF/Rehab/LTAC, etc.
Utilization Management Includes:

- Responsible for determining...
  - The right care in the right amount at the right time in the right place is critical to reducing health care costs and improving clinical outcomes
- Observation Status vs. Admission
- Concurrent Clinical Reviews – Acute Admissions, Transfers to Rehabilitation, Skilled Nursing & Long Term Acute Care Facilities
- Pre-Certification/Authorization Reviews
- Peer-to-Peer Appeals
- Coordination of Transition of Care for New Enrollees
- Disabled Dependent Status Determination
- Evaluation of Technology
Utilization Operations

**Predetermination List – Authorization Required**

- Abdominoplasty
- Acupuncture
- Bone Growth Stimulators
- Breast Reduction (Female Only)
- Cardiac Home Telemonitoring
- Chiropractic Services (13 years old or younger)
- Custom, Power Wheelchairs & Vehicles
- Enteral / Parenteral Nutrition
- Lymphedema Pumps
- Microprocessor Controlled Knee
- Private Duty Nursing
- Rhinoplasty / Septoplasty
- Stent, Carotid Angioplasty
- Stent, Endovascular for Abdominal Aortic Aneurysm
- Transplants: Bone Marrow, Stem Cell, Solid Organ
- Weight Reduction Surgery
- Wheelchair Accessories / Repairs, Misc.
- Wound Vacs
Onsite Care Management

• Improves care coordination processes to achieve the highest level of quality, clinical and appropriate resource utilization outcomes.

• Manages utilization of care and transitions of care through direct communication with members, caregivers, hospital staff, physicians and UPMC Health Plan medical directors.
• **Support the best outcomes for HP members by coordinating care to promote seamless transitions at all levels of care**

  • Coordinate transitions of care to home or for placement in skilled, rehabilitation, and LTAC

  • Collaborate closely with healthcare team regarding all aspects of case management for members

  • Educate members and caregivers to the prescribed treatment plan

  • Make appropriate and timely referrals to UPMC Health Plan case management, health coaching, and behavioral health programs
Case Management
Case Management

- Assist members in reaching/maintaining the optimum level of health and functioning that is possible, while taking into consideration their physical, emotional, psychosocial, economical and environmental circumstances.
Case Management

Support and assist members with:

- Complex clinical conditions
- Social and environmental barriers
- Coordination of care
- Linkage to community services
- Self management for chronic disease
Member Identification for Case Management

Various data sources are used to identify members for case management. The data sources used include the following:

- Claims or encounter data - identify members with specific diagnoses, high cost members, and utilization services
  - Healthy Frontiers
  - Healthy Collaborations
- Hospital discharge data - identify specific diagnoses, inpatient stay services and readmission patterns
- Health Information Line
- Pharmacy data
- Data collected through the UM processes - identify members through hospital admission, concurrent, and prior authorization review processes.
  - Members identified as moderate risk for readmission
- Identification of members with frequent ER visits
- Members and caregivers
- Practitioners
Conditions Appropriate for Case Management Referrals

- Newly diagnosed cancers
- Complex trauma-multiple fractures, lacerations, major organ injury
- Spinal cord injuries
- Traumatic brain injuries
- End stage diseases
- Neonates with complex needs
- Progressive neurological diseases
- Major strokes
- Multiple co-morbidities
Role of the Case Manager

- Telephonic assessment to identify medical needs & social needs, holistic management of the member
- Active collaboration and care coordination with the treating physician
- Provide information on disability or disease
- Serve as advocates to help members and their families deal with the complexities of the health care system
- Assist members in making informed decisions
- Monitor appropriate resource utilization
- Education and self-care strategies
- Identify community, regional and national health care resources and support groups that may offer additional assistance
Integrated Team Meetings

- An integrated care team is a group of Health Plan staff from various disciplines who holistically manage members with illnesses or conditions requiring a more comprehensive approach to case management. It may include case managers, disease managers, lifestyle health coaches, pharmacists, behavioral health staff, utilization management staff and medical directors.

- Goals of the meeting:
  - Improve health and clinical outcomes
  - Identify barriers to care
  - Identify most appropriate resources to meet member's needs
  - Improve adherence to treatment plan
  - Communicate and coordinate care with treating physician
Dedicated Care Managers

- End Stage Renal Disease (ESRD)
- Hemophilia
- Sickle Cell
- Wound Care
- Oncology
- Pediatrics

A network of people committed to you.

UPMC Health Plan
Where you belong.
Mobile Care Managers

• Developed to assist in finding members who might benefit from case management intervention

• Mobile team: RN, Social Worker, Outreach representatives

• Offer face to face interaction.
Disease Management/Health Coaching

• The concept of reducing health care costs and/or improving the quality of life for individuals with chronic disease conditions by preventing or minimizing the effects of a disease, usually a chronic condition.

• Also known as chronic care management, population health improvement, or health management
Chronic Diseases

- **Definition:** ongoing, generally incurable illnesses or conditions that are often preventable and frequently manageable through early detection, improved diet, exercise, and treatment
  - Examples: asthma, COPD, diabetes, hypertension, hyperlipidemia, coronary artery disease, heart failure, low back pain
Prevalence of Chronic Disease

- Chronic diseases are the most prevalent and costly illnesses affecting Americans today
- 45% of the population (about 133 million) Americans have at least one chronic disease
  - The number of people with diabetes has almost doubled between 1995-2005
    - According to the American Diabetes Association, one in three of today’s first graders will develop diabetes during their lifetime
    - Diabetes continues to be the leading cause of kidney failure, non-traumatic lower-extremity amputations, and blindness among adults, aged 20-74.
  - The number of people with asthma increased 10% between 2000 – 2005
Incidence and Economic Impact

- Cancers: 10,555,000 cases (3.7%)
- Diabetes: 13,729,000 cases (4.9%)
- Heart disease: 19,145,000 cases (6.8%)
- Hypertension: 36,761,000 cases (13%)
- Stroke: 2,425,000 cases (0.9%)
- Mental disorders: 30,338,000 cases (10.7%)
- Pulmonary conditions: 49,206,000 cases (17.4%)

The costs for treating these conditions without taking into consideration the secondary health problems they cause totaled $277 billion in 2003. The impact of lost productivity due to both absenteeism and presenteeism resulted in an economic loss of over $1 trillion. The report estimates that improvements in preventing and managing chronic disease could reduce future economic costs and burdens by 27%.
Costs of Chronic Disease

- Impact on individuals and families – financial, emotional
- Skyrocketing health care costs
  - Chronic diseases account for more than 75% of the money spend each year on health care
- 70% of all deaths (1.7 million deaths per year) attributed to chronic disease
  - Heart disease, cancer and stroke account for more than 50% of all deaths each year.
Modifiable Health Risk Behaviors and Chronic Illness

- Eliminating four risk factors (poor diet, inactivity, alcohol consumption and smoking) would prevent:
  - 80% of heart disease and stroke
  - 80% of type 2 diabetes
  - 40% of cancer

- More than one-third of all adults do not meet recommendations for aerobic physical activity based on the 2008 Physical Activity Guidelines for Americans, and 23% report no leisure-time physical activity at all in the preceding month.

- In 2007, less than 22% of high school students and only 24% of adults reported eating 5 or more servings of fruits and vegetables per day.

- More than 43 million American adults (approximately 1 in 5) smoke.
Modifiable Health Risk Behaviors and Chronic Illness (cont)

- In 2007, 20% of high school students in the United States were current cigarette smokers.

- About 30% of adult current drinkers report binge drinking (consuming 4 or more drinks on an occasion for women, 5 or more drinks on an occasion for men) in the past 30 days.

- Nearly 45% of high school students report consuming alcohol in the past 30 days, and over 60% of those who drink report binge drinking (consuming 5 or more drinks on an occasion) within the past 30 days.
UPMC Health Plan Disease Management Programs

- Respiratory – asthma and COPD
- Diabetes
- Cardiovascular – CAD, heart failure, hypertension and hyperlipidemia
- Low Back Pain
Disease Management Goals

- Improve health status
- Reduce ER visits and hospitalization
- Empower members to make lifestyle behavior changes
- Improve disease and symptom management
- Communicate with physicians
- Increase self-care skills
- Improve compliance with medication and health care recommendations
- Locate resources and programs
- Set SMART goals
Disease Management Programs

Referral Sources

• Healthy Frontier – utilizes claims data, biometric screening data, and health risk assessments to identify members with poor clinical outcomes or gaps in care.

• Predictive Modeling – utilizes claims data and lab data to determine risk and predict future costs and utilization.

• Utilization Management – real time referrals for members who are currently hospitalized with a chronic condition.

• MARS/ED reports – identifies members with designated diagnoses who had were seen in a UPMC emergency room or admitted to a UPMC facility.

• Physicians

• Health risk assessments and biometric screenings

• Self referrals

• My Health Advice Line
Disease Management Interventions

- All identified members receive a letter about the program annually

- All members receive a quarterly newsletter

- All members with asthma, COPD, cardiovascular disease, diabetes or low back pain receive a call within 48 hours of discharge from the hospital or an emergency room

- Members who enroll in the program and engage with a health coach receive:
  - Initial call to perform assessments of a member’s medical and behavioral health and compliance status, use of self monitoring tools and medical testing, as well as their understanding of their condition to determine areas for focused education or care coordination.
Disease Management Interventions (cont)

- Regularly scheduled telephone calls from their personal health coach to monitor their condition and identify further educational needs. Subsequent calls focus on:
  - Understanding condition
  - Self Management Skills
  - Adherence to Standards of Care
  - Physician Relationship
  - Barriers to care
  - Readiness to change

- Program welcome packet with educational materials

- Initial behavioral health assessment to screen for depression

- Identification and assistance with lifestyle risk factors, co-morbidities, or other conditions that could impact the management of their condition and clinical outcomes.
Disease Management Interventions (cont)

- Post card reminders for flu and pneumonia immunizations
- Information about online health education tools, such as Web MD and EMMI
- Care coordination with physicians, pharmacists, case managers, lifestyle health coaches or behavioral health staff if applicable
Outcome Measures

- ER visits and inpatient admissions
- % of members who saw PCP or specialist
- Program satisfaction
- Member complaints
- % of members completing gaps in care
Focus on HEDIS Measures – Closing Gaps in Care

- Asthma – appropriate medications for people with asthma
- COPD – spirometry testing and appropriate use of medications after a hospital admission
- Diabetes – dilated retinal exam, hemoglobin A1c, LDL screen, nephropathy screen
  - % of member with LDL<100
  - % of members with HgbA1c < 7.0%
- Cardiovascular disease
  - % of members with controlled hypertension
  - % of members on appropriate medications
  - % of members with an LDL screen
  - % of members with an LDL < 100
In 2011 graduation criteria were added to the programs, allowing for an additional measurement of program effectiveness. A member “graduates” from the program once the member demonstrates:

- Knowledge of condition
- Sustained self management skills and behavior and lifestyle changes (e.g. medication management, diet and nutrition plan adherence)
- Ability to adhere to treatment plan
- Functional provider-patient relationship
Knowledge of Condition
(Self Management)

- Understands the basics of diabetes management, its complications (e.g. CAD, kidney disease, nerve damage, dental disease, depression) and the impact of stress on diabetes ♦
- Knows glucose target ranges recommended by physician, knows how to use glucose monitor and understands the importance of regular testing
- Knows HbA1c and significance
- Knows current cholesterol and blood pressure levels and importance of monitoring
- Understands the importance of regular health care testing and which tests are required to monitor diabetes
- Understands importance of diet and exercise and impact on diabetes ♦
Lifestyle Management (Self Management)

- Follows prescribed dietary plan ♦
- Follows prescribed activity plan or participates at least 150 min/week of moderate-intensity aerobic physical activity
- Does not smoke or understands the impact of tobacco use on health status and has knowledge of resources available for tobacco cessation ADA Recommendations
Adherence to Treatment Plan (Self Management)

- Follows recommended blood glucose self monitoring schedule
- Up to date on A1c testing schedule: At least every 6 months

Medication Management

- Understands the action, rational and side effects of prescribed medications
- Follows prescribed medication regime

Symptom Response and Management

- Understands and has a plan for managing glucose highs and lows and including plan for managing illness/sick days ♦
- Has plan for managing wounds and foot care
Adherence to Standards of Care/Health Exams (Self Management)

Up To Date On The Following Exams:
- Annual dilated eye exam
- Annual foot exam visit
- Annual flu shot
- Annual cholesterol screening
- Annual urine screening for micro albumin
- Pneumonia Vaccine within the last 10 years
- Visits physician at least 2 times annually for diabetes management ♦
Effective Communication with Provider/Medical Home (Access to Care)

- Actively works with provider/medical home on treatment plan and shares in decision-making ♦

Effective Care Giver Support and Barrier Management

- Care give support systems are in place and barriers addressed for member to effectively manage condition ♦
Maternity Program

- Focus on healthy pregnancy and healthy delivery with a focus on:
  - Identification of members early in pregnancy
  - Focus on nutrition, exercise, smoking cessation and breastfeeding
  - Early identification of complications.
Coordinated Care

- Coordination with:
  - Health coaches for nutrition, physical activity, weight management and stress
  - EAP for assistance with child care, return to work and legal issues
  - Behavioral health for depression, alcohol and substance abuse

- Employment Support
  - Helping to identify safe, gestation-appropriate activities
  - Assisting with the identification of child care alternatives
  - Assessing for physical environmental concerns and a healthy work environment.
Maternity Program

- Stratification
  - Low Risk
    - Welcome Packet
    - Initial call, call each trimester and post-partum call
    - Referrals to EAP and health coaching when appropriate
Maternity Program

High Risk, including

- existing co-morbid medical conditions, such as diabetes, hypertension, heart, respiratory, kidney or thyroid disease
- advanced maternal age greater than 40 years of age,
- history of preterm labor/birth less than 37 weeks, pregnancy induced hypertension or gestational diabetes
- history of substance abuse, including drugs or alcohol
- current status as a smoker
- history of domestic violence
- history of behavioral health issues, including previous post partum depression
- multiple gestations
Maternity Program

High Risk Interventions

- Scheduled monthly calls and additional calls as determined by member’s particular needs to assess member’s physical and emotional status
- Care coordination with OB provider
- Referrals to behavioral health when indicated
- Referrals to EAP when indicated
- Referrals to health coach
- Referrals to community resources when indicated
Maternity Program

All enrolled members receive an educational packet with information on:

- Nutrition and pregnancy
- Fitness and pregnancy
- Smoking, alcohol and drugs in pregnancy
- How to talk to your employer about pregnancy related issues
- Depression and the blues after childbirth
- Tips on looking for a daycare or babysitter
- Breastfeeding
- Gestational Diabetes
- Caring for yourself after you have your baby
- Caring for your baby
- Additional materials as needed
Maternity Program

Outcomes:

- Birth outcomes, including preterm deliveries, low birth weight
- Number of high risk referrals
- Number of referrals for EAP, behavioral health and lifestyle coaching
- Rate of mothers choosing breast feeding
- Percentage of mothers returning to work after delivery
- Rate of post partum depression
Success Stories

- Case Management
- Disease Management
- Maternity
Management of Behavioral Health Conditions
Case Manager/Health Coach Role

- Initial clinical assessments including use of PHQ-9, AUDIT, etc.
- Develop and maintain rapport with member
- Education (managing symptoms and treatment expectations)
- Monitor progress via standardized and customized clinical assessments or screening tools
- Identify and resolve problems such as assisting with community resources, removing barriers to care, development of natural supports
- Encourage use and development of self management plans
- Encourage adherence to HEDIS/national quality of care guidelines
- Assistance with accessing treatment providers, including securing appointments for members when needed
- Coordination of care with PCP and other providers
Behavioral Health Program Referral Sources

- Referrals from claims such as for members newly started on an antidepressant or stimulant medication
- Referrals from members with gaps in care such as a lapse in refilling their antidepressant medication
- Referrals from utilization management (e.g. inpatient and ER visits)
- My Health Advice Line referrals
- Referrals from physicians, including the PCP Liaison program
- Referrals from Health Risk Assessment screenings
- Referrals from lifestyle and physical health coaches and other Health Plan clinical staff
- Referrals from EAP or Short Term disability to assist members in getting back to work
- Referrals from members or from their family
Workplace Costs - Depression

- Workplace Costs of Over $34 Billion per Year in Direct and Indirect Costs
- Major depression is associated with more annual sick days and higher rates of short-term disability than other chronic diseases.
- People suffering from depression have high rates of absenteeism (in some cases, three times more sick days than non-depressed workers) and are less productive at work.
- In a study comparing depression treatment costs to lost productivity costs, 45 to 98 percent of treatment costs were offset by increased productivity.
- Source: National Alliance for Mental Illness
Challenges to Depression Treatment

- Under diagnosis of depression, patient adherence to treatments, financial issues, physician-patient communication
- 30%-70% of depression is missed
- About 50% of patients stop medication within the first 3 months
- “Pandora’s Box”
- PCPs are the sole contacts for more than 50% of patients with mental illness and are the de facto system of treatment for mental health.
- Primary care physicians frequently use medication only to treat depression
- Antidepressants used at lower intensity in primary care
- Only 50% of those referred to specialty mental health practitioners complete more than one visit
- Difficulty accessing specialty care/consultation when needed
- Stigma
Depression in Diabetes

- Increased non-adherence
- Increased A1C
- Increased retinopathy, neuropathy, nephropathy
- Increased micro vascular changes
Depression in Cardiac Disease

- Increased risk of hypertension, CVA, CAD
- Risk of death after MI
- Variable heart rhythms
- Elevated insulin and cholesterol levels
Depression in Asthma

- Increased non-adherence
- Poor health outcome
- Decreased self care and daily routines
Depression Program

- Outreach to members newly started on antidepressant medications with special attention to those treated by non-BH providers
- Outreach to members with gaps in refilling their antidepressant
- Ongoing telephonic contacts by licensed BH clinician for members who enroll in Depression Case Management program
- Depression Self Management Plans
- Depression Welcome Kit (informational guide/workbook)
- PCP Liaison
- Physician Notification Letter and Provider Referral Outcome Report
- Ongoing PHQ-9 and other clinical assessments
- Referral to and consultation with medical case managers and lifestyle coaches when indicated
HEDIS Antidepressant Medication Measure

- Effective Acute Phase (medication adherence for 12 weeks)
- Effective Continuation Phase (medication adherence for 6 months)
Attention Deficit Hyperactivity Disorder (ADHD) Program

- Outreach to parents of members newly started on ADHD medication
  - Education regarding symptoms, treatment options, behavior management issues
  - Assistance with behavioral health referrals or securing appointments for members
- Ongoing telephonic contacts by licensed BH clinician for members who enroll in the ADHD Case Management program
- ADHD Welcome Kit (educational information/workbook)
- Physician coordination as indicated
- Ongoing clinical assessments
- Referral to and consultation with medical case managers and lifestyle coaches when indicated
HEDIS Follow-up Care for Children Prescribed ADHD Medication

- Children who received an initial prescription for ADHD medication and:
  - Received at least one follow-up visit with a prescriber within 30 days of initiation of medication
  - Remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two visits between four weeks and 9 months
Follow-Up After Inpatient Behavioral Health Treatment

- Letters to all members after inpatient discharge to provide education and phone contact for their personal health coach
- Licensed behavioral health clinician outreaches all members discharged from inpatient behavioral health treatment within 48 hours of discharge
- Appointment reminders
- Contact provider of follow-up treatment to ensure member engages in treatment after inpatient care
- All members receive telephonic outreach for 30-60 days post discharge to ensure needs met, medications refilled, etc.
- Letter sent to all members that can’t be reached telephonically
HEDIS Follow-up After Hospitalization for Mental Illness

- Patients discharged from an inpatient mental health admission and receive:
  - One follow-up encounter with a mental health provider within 7 days after discharge.
  - One follow-up encounter with a mental health provider within 30 days after discharge.
Anxiety Disorders Program

- Outreach to members with anxiety diagnoses or potential anxiety disorders are outreached
  - Members with confirmed anxiety diagnosis referred by other departments, ER visits, etc
  - Members who indicate problems dealing with stress when completing HRA
  - Members who go to ER for other issues that could indicate an untreated or poorly managed anxiety disorder such as repeated attempts to obtain anti-anxiety meds or for palpitations/chest pains etc
Anxiety Program Interventions

- Telephonic outreach to offer anxiety program
  - Education regarding symptoms, treatment options, behavior management issues
  - Development of self-management plan
  - Assistance with behavioral health referrals or securing appointments for members
- Ongoing telephonic contacts by licensed BH clinician for members who enroll in the ADHD Case Management program
- Anxiety Welcome Kit (educational information/workbook)
- Physician coordination as indicated
- Ongoing clinical assessments and screenings such as the GAD-7
- Referral to and consultation with medical case managers and lifestyle coaches when indicated
Substance Abuse Program

- Case Management offered to all members discharged from inpatient substance abuse treatment (i.e. inpatient detox, rehab) – followed for at least 60 days
- Outreach to members who screen positive on the CAGE alcohol screening tool in the Health Risk Assessment and who indicate a desire to change their alcohol or drug use within the next 30 days
  - Case Manager completes a thorough substance use assessment with member
  - Case Manager offers assistance with referrals or setting up appointments with substance abuse treatment providers
  - Case Manager provides education regarding substance abuse symptoms, risk factors, treatment options, etc.
  - Case Manager refers members to community resources (e.g. Alcoholics Anonymous, Narcotics Anonymous, AlAnon, etc.)
General Behavioral Health Case Management

- **Triage** - Member Services warm transfers all calls in which member says they want to be seen right away or think they need to be hospitalized or other calls that need clinical contact
  - Divert potential unnecessary hospital admission
  - Assist member in getting the right care as timely as possible
  - Clinician obtains appointment for member within 24 hours for all urgent needs

- **Medication Compliance** - Case Managers outreach members who have not refilled their maintenance medications to determine reason for the gap in care and attempt to alleviate barriers

- **General behavioral health** - referrals from medical case managers, lifestyle coaches, clinical account management, utilization management, members, providers, member’s family, health risk assessment, 24 hour advice line

- **ER Referrals** - Members seen in the ER for behavioral conditions are outreached
Additional Services
# Five Core Wellness Lifestyle Programs

**UPMC MyHealth Lifestyle Programs**

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<th>Program Title</th>
<th>Topic</th>
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<td>Tobacco Cessation</td>
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<tr>
<td>Weigh to Wellness</td>
<td>Weight Management</td>
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<tr>
<td>Step Up to Wellness</td>
<td>Physical Activity</td>
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<tr>
<td>Eating Well</td>
<td>Nutrition</td>
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<tr>
<td>Less Stress</td>
<td>Stress Management</td>
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Comprehensive Programs

Workbook | Toolkit | Trackers | Inserts
Modalities to Match Members’ Needs

- Telephonic Coaching Program (*Wellness Members*)
- Self-Study Program (*Wellness Members*)
- On-site Group (*limited offering*)
- Tele-group (*limited offering*)
- Online Program (*All members*)
- Coach on Call (*All members*)
Online Programs

• All programs available online www.upmchealthplan.com

• 10 weeks, 7 phases per week

• Programs:
  – Weight Management
  – Tobacco Cessation
  – Nutrition
  – Physical Activity
  – Stress
  – Mood
Coach on Call

What is Coach on Call?

- Single intervention with a health coach
- Information about a lifestyle behavior change
- Goal setting and problem-solving
- Support and accountability
- Follow up as needed

Topics

- Weight Management
- Tobacco Cessation
- Stress Management
- Nutrition
- Physical Activity
Clinical Account Management

Primary responsibilities include:

• Serve as liaison between Medical Management and account managers
• Clinically interpret high cost utilization reports for large and key accounts
• Project future health care cost by employer group
• Recommend saving opportunities for their assigned employer groups
• Make real-time referrals to both case and health management programs
Prevention and Wellness Tools

Provide health improvement tools to reach personal health goals

- Web-based tools, powered by WebMD, a national leader in e-health

- Health risk assessment

- Interactive tools - emmi

- On line assessments

- Help to understand and manage health issues and physician visits
WebMD® Resources

• Comprehensive member portal powered by WebMD®
• One of the most respected names in health information
• Provides a variety of important health facts, advice, and tools to keep members healthy

• UPMC Health Plan site complete with:
  – MyHealth Questionnaire
  – Physical Activity Program
  – Nutrition Program
  – Lifestyle (Condition) Centers and Symptom Checkers
  – Drug Compare
**MyHealth Record**

- Personal Health Record (PHR) designed to empower members to take an active role in managing their health care

- Encourages members to conveniently view and manage their health-related information online

- Easily accessible through *MyHealth OnLine*

- Securely maintained online tool held to the same security standards as the banking and finance industries

- Only members have the ability to retrieve and edit their records
Technology Supports Care

- Interactive, information based web program that the member can access from the privacy of home

- Used by Care Managers in the following programs: Asthma, Hypertension, Diabetes, Coronary Artery Disease (CAD), COPD, Heart failure, Maternity, Low Back Pain

- Goal: Increase patient adherence to guidelines

- emmi talks to the member through their specific condition, allowing them to start and stop at their own speed

- Programs for pre-surgical reviews - total hip replacement, gastric bypass, CABG, hysterectomy, back surgery
Home Telemonitoring

Criteria for selection include:

• a primary diagnosis of congestive heart failure
• a history of questionable compliance
• or a history of repeated hospitalizations or emergency department visits

The members selected must be willing and physically able to use the technology, have the ability to read and hear prompts, and be able to hold telephone conversations. The physician must also give permission for use of the technology.
Practice-Based Care Management

- Improve members’ knowledge about their disease or condition, treatment plan, access to health care benefits and other community resources

- Demonstrate improvement in related quality measures

- Reduce practice’s overall rates of admission, emergency department visits and readmissions

- Improve members’ health status

- Mitigate risks from non-compliance and lack of education
MyHealth Advice Line

To ensure UPMC Health Plan stays a leader in the field by continuing our efforts at providing excellent customer service by:

- Extending our availability 24/7 for health advice
- Providing “High Touch” contact with every member, every time
- Utilizing a highly professional and trained staff
- Follow-up reporting daily
- Warm transfers of members to appropriate staff/departments during normal business hours.

Available 24/7
1-866-918-1591
Assist America

- Provides global emergency services
- Medical consultations, evaluations & referrals
- Hospital admissions
- Emergency Medical Evacuation
- Critical Care Monitoring
- Medical Repatriation
- Prescription Assistance
- Transportation for Minor Children
Wrap Up

- Questions and answers