Care Network

of East Alabama, Inc.

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- *Established in 2011 as a not-for-profit organization to promote the medical home and to address the needs of Patient 1st patients in east Alabama*

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Timeline

- December 2010 – 1st Task Force Meeting
- January 2011 – Medicaid Vendor Meeting
- August 2011 – CNEA begins case management in Chambers, Lee, Macon and Tallapoosa counties
- September 2011 – West and North networks begin case management
- May 2012 – State Plan Amendment submitted to CMS to move to Health Home Model

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Timeline

- July 2012 – CNEA expanded case management to serve Bullock, Coosa and Russell counties
- July 2012 – Gulf Coast Patient Care Network was approved
- April 2013 – State Plan Amendment was approved by CMS for time period July 1, 2012 through June 30, 2014.
- June 2014 – Contract extended through June 30, 2015

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- The goal of the network is to:
  - Improve health outcomes for Alabama Medicaid Patient 1st Population
  - Help primary care providers effectively manage patients with chronic conditions
  - Improve communication across care settings
  - Empower the patient to self-manage their conditions
  - Reduce the costs of care

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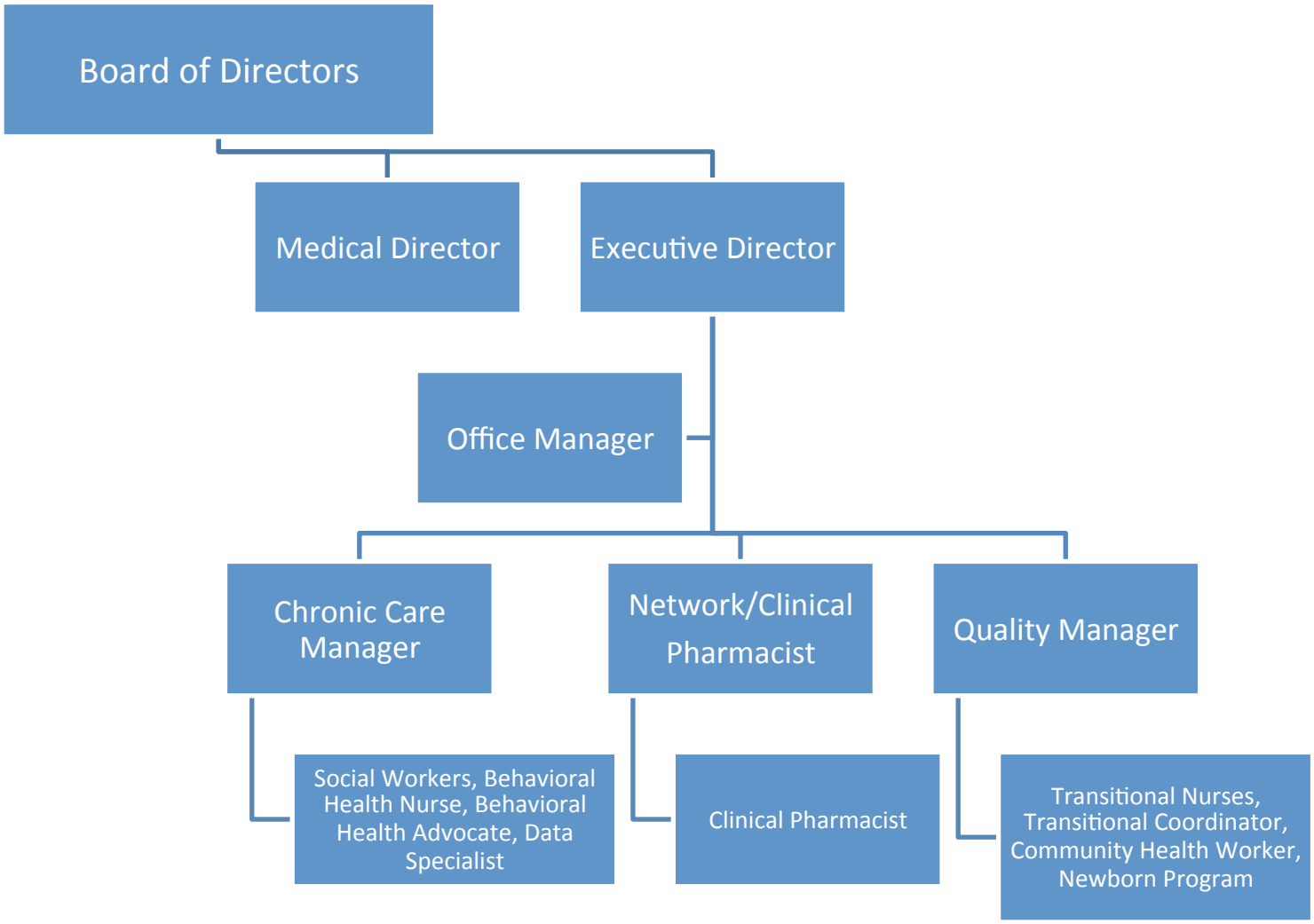

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- 57 physicians currently enrolled representing 34 practices
- 27 Employees / 25 FTE's
- Serve ≈ 37,000 Medicaid Patient 1st patients in seven counties: Bullock, Chambers, Coosa, Lee, Macon, Russell and Tallapoosa
  - 81% of patients are pediatric

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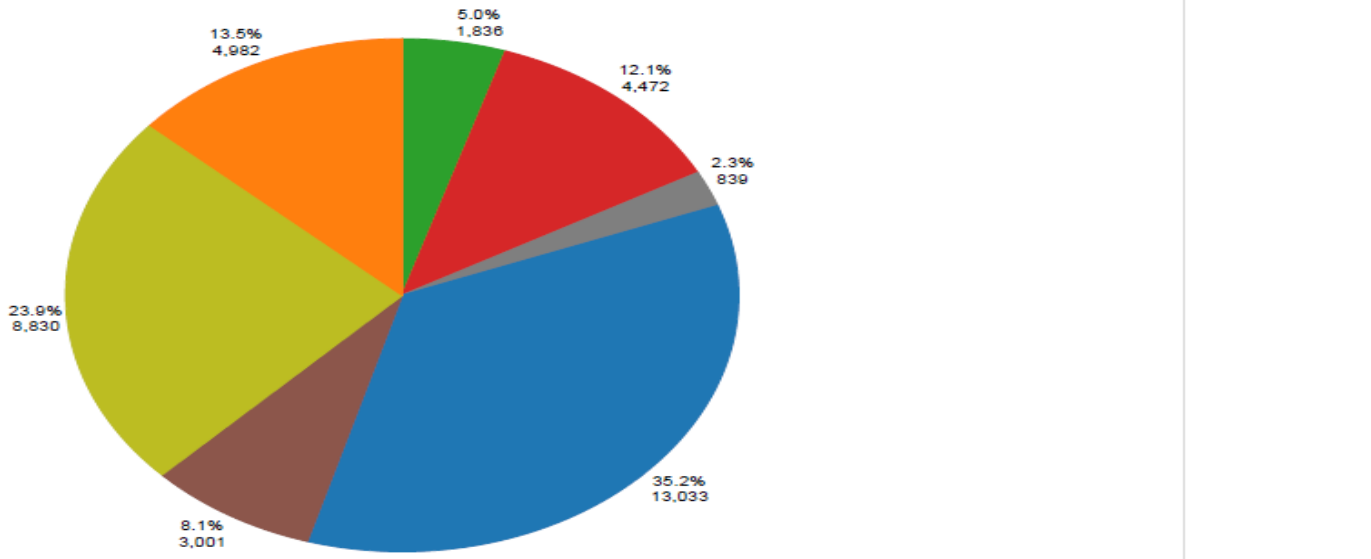
Total Patients by County



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- Patients are considered Health Home if they have been diagnosed with one of the following conditions:
  - Asthma
  - Cancer
  - COPD
  - Diabetes
  - Heart Disease
  - HIV
  - Mental Health condition
  - Sickle Cell
  - Substance Abuse Disorder
  - Transplants

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Health Home Population

- Approximately 15,700 patients are Health Home Patients
- 68% Health Home patients are Pediatric
- 32% Health Home patients are Adult

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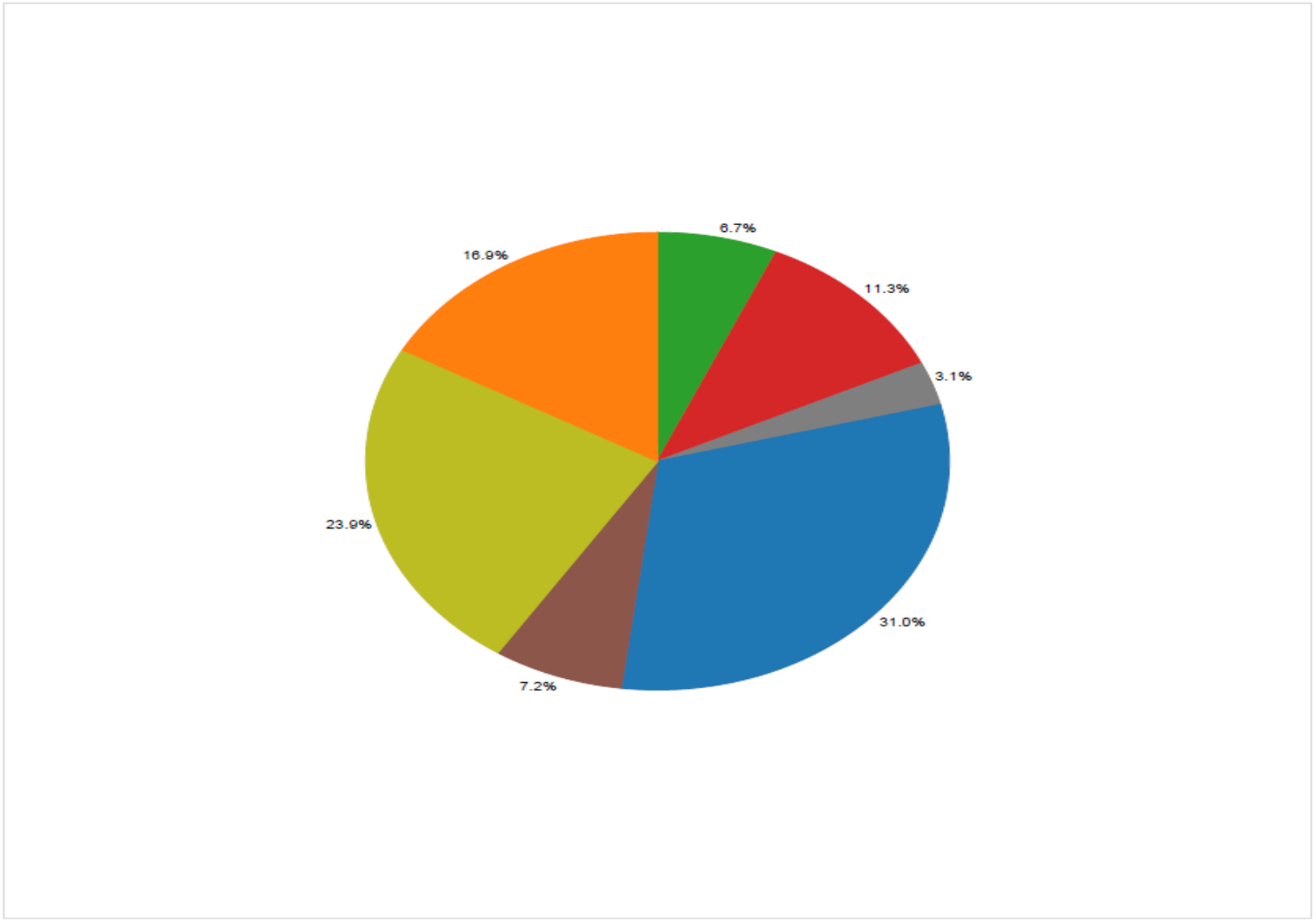
Health Home Patients by County



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Medical Management Meetings

- Meet Quarterly with Providers to discuss initiatives
  - Asthma
  - Diabetes
  - Flu Vaccine
  - Immunizations
  - Pediatric Hypertension

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- Medicaid provides the networks access to data to identify high risk and high cost patients
  - Stubblefield report
  - Network Metrics
  - Inpatient/ED monthly reports
  - High Cost Pharmacy reports

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CNEA Services

- Transitional Care
- Care Management
- Behavioral Health Care Management
- Pharmacy Support
- Nutrition Education

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Transitional Care Services

- The network currently partners with six hospitals in our network area to transition patients from the hospital to home and then to their primary medical home.
- Transitional Care Coordinator visits patients in East Alabama Medical Center daily and communicates with staff at other hospitals regarding discharge instructions and patient needs.
- The transitional care nurses visit patients during their hospital stay, when possible, and then conduct an in-home visit within five days of discharge.
- Transitional care nurses follow patients for 30 days post-discharge. At end of 30 days patient file is closed or if additional services are identified, patient is referred to social worker case manager.
- Primary purpose of the home visit is medication reconciliation and to make sure the patient has a scheduled follow-up appointment with their primary care provider.

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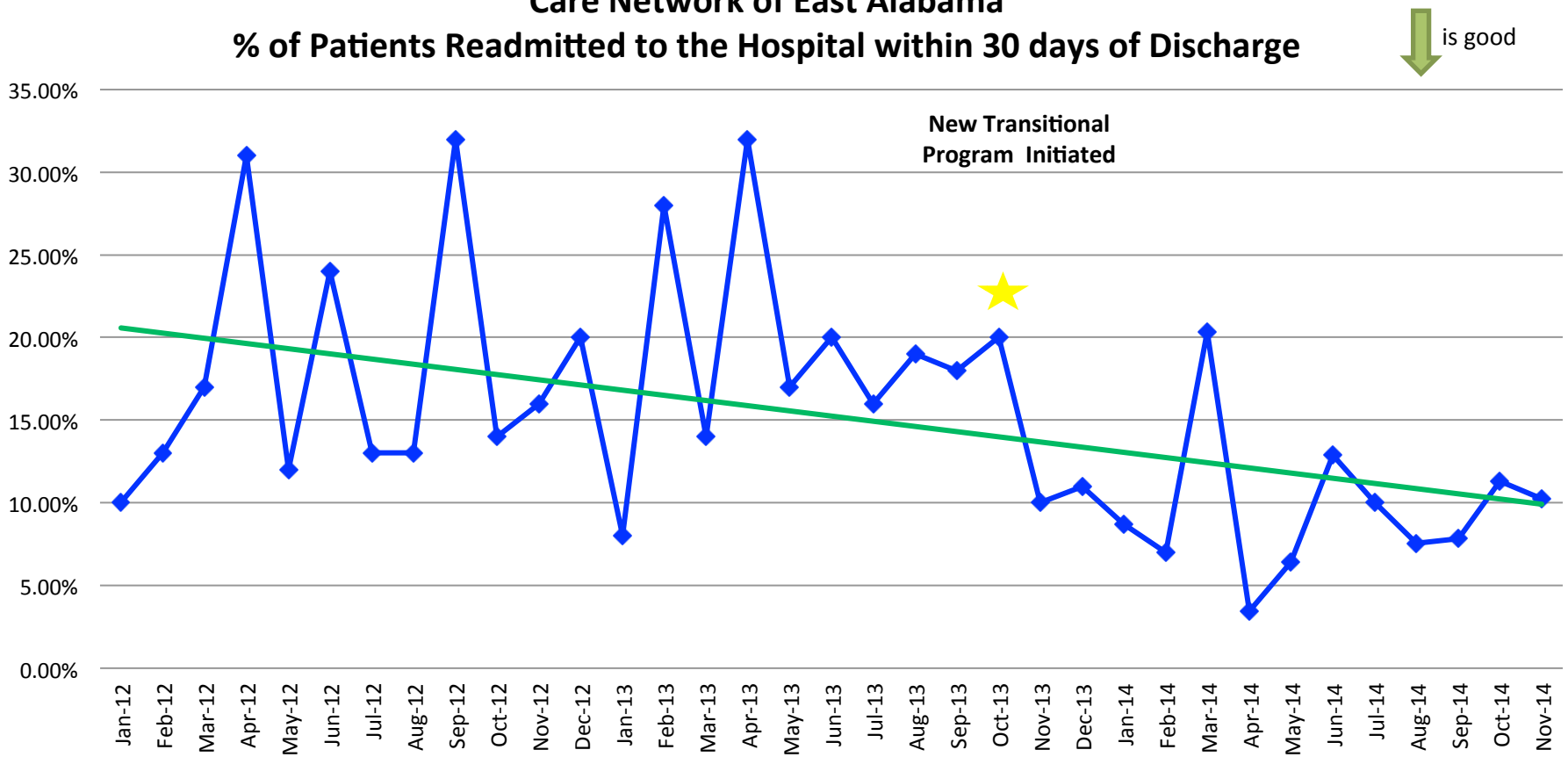
% of Patients Readmitted to the Hospital within 30 days of Discharge



# of pts readmitted w/in 30 days
# of pts seen post-hospital

% of Patients Readmitted w/in 30 Days

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Care Management

- Each Primary Medical Provider practice is assigned a social worker case manager or a nurse case manager

- Case Managers:
  - Help identify patients with high-risk and chronic conditions
  - Provide education to patients about their chronic conditions
  - Provide on-going patient support to make sure they attend physician appointments and take medications as prescribed
  - Visit patients in their home to assess for other needs
  - Assist patients in accessing resources for identified social needs

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Care Management

- Categorizes patient contact by need of contact frequency.
  - Heavy – weekly contact by case manager
  - Medium – monthly contact by case manager
  - Light – contact at least once per quarter
- Re-evaluates status every 90 days

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Behavioral Health

- Staff are embedded in the area Mental Health Centers. The goal of this program is to bridge the Mental Health consumer into Primary Care as well as assist consumers with appointment access into mental health.
- Obtains medication recommendations from Psychiatrists at Mental Health Center for our Primary Care Physicians who are managing psychotropic drugs for their patients with mental health diagnoses.
- Provides case management to Network patients with severe mental illness in addition to other Health Home diagnoses.

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Pharmacy Support

- Pharmacists complete medication reconciliations for network patients and communicates with primary medical providers.
- Pharmacist rounds on inpatients at East Alabama Medical Center to identify medication concerns before patients are discharged.
- Pharmacists are liaisons between community pharmacists, primary medical providers and the Alabama Medicaid Agency.

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Nutrition Education

- Registered Dietitian provides education in patient homes and primary care physician offices.
- Education provided on diet for the following conditions: high cholesterol, hypertension, iron deficient anemia, failure to thrive, obesity, Type 1 and Type 2 Diabetes, pancreatitis and underweight
- Group education in summer-camp format has been provided in three counties for children identified as high risk due to BMI or diagnosis

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Network Resources

- As an Agency of the East Alabama Food Bank, CNEA is able to provide food to patients in need
- The Network has budgeted resources for transportation and help arrange transportation for patients so they can attend their physician appointments
- Resources are budgeted to help patients with items to assist with medical care, but not covered by Medicaid (adult diapers, special needs bottles, socks and shoes for patients with diabetes)

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Physician Comments

- *" I will say that having Christina in house has been invaluable. She is able to do things that I used to have to do like calling people before important appointments in Birmingham to make sure they have a way to get there, but you are much more effective at doing this than I was. Her relationship with mental health has also been valuable, as it was previously difficult to know if patients were even being seen there. I have definitely had a couple of kids with chronic illnesses lately that were not getting proper care until I got her involved." Brooke L. Taylor, M.D.*
- *"The support of the Care Network staff has been invaluable in taking care of patients that are either difficult to manage or fall through the cracks. Even if it were a break-even money proposition, I think it is still useful because it helps us take better care of our patients by coordinating care, fulfilling needs we were not aware of, or preventing unnecessary emergency department utilization. I was a skeptic, but I don't think I can say enough about it. " Richard L. Glaze, M.D.*

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Patient Success Story

- 54 year old – African American Male – Diabetes and Heart Disease
- Referral reason
  - High Service Utilization
  - Non-compliant with diabetes and hypertension medication
  - DKA inpatient stays in the ICU
- Transitional Nurse/Social Worker Case Manager
  - Home visits – provided education and encouragement regarding medication compliance
  - Downloaded patient's glucometer readings at pharmacy to review glucose levels
  - Regular communication with patient
- 12 month cost January 2013 Stubblefield report
  - **$19,545.53**
- 12 month cost August 2014 Stubblefield report
  - **$3,853.58 – no inpatient or ED visits in previous 12 months**

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Patient Success Story

- 61 year old– African American Male – CHF/Hypertension
- Referral reason
    - High Service Utilization – IP and ED visits
    - 8 or more prescriptions
- Transition nurse
    - Home visits – identified that patient is illiterate and cannot read instructions on his medication
    - Patient lives alone – has friend who can help transport patient to physician appointments
    - Provided patient with pill box – CNEA staff refills pill box weekly
    - CNEA staff helps patient to schedule MD visits

- 12 month cost January 2013 Stubblefield report
    - **$10,394.58**
- 12 month cost August 2014 Stubblefield report
    - **$3,362.14 – no inpatient/ED visits in over 12 months**

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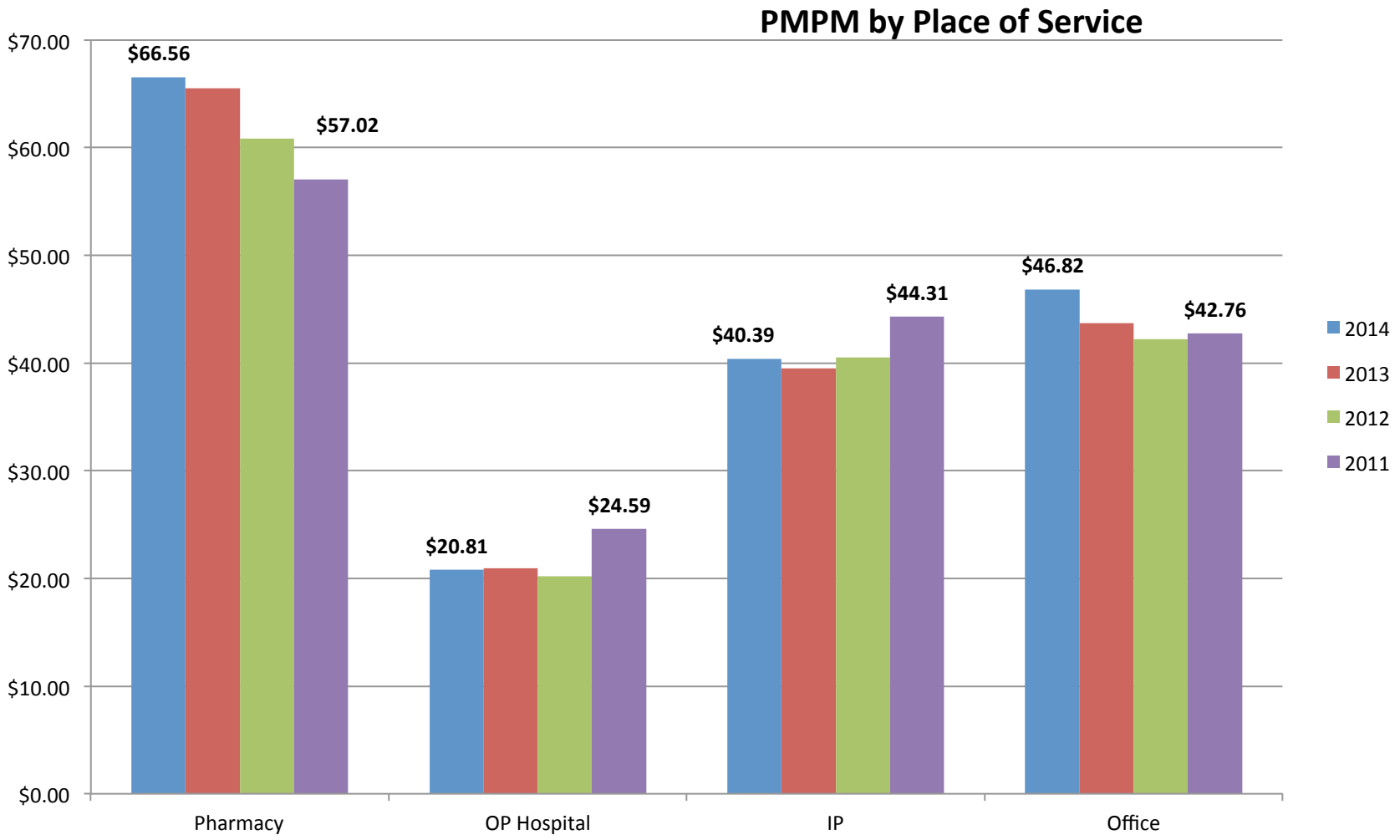

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