Comprehensive Care Coordination for Public Sector Populations

– Medical, Behavioral, and Social & Community Provider Systems –

Individuals with multiple chronic physical and behavioral conditions in public sector populations frequently have poor health outcomes and are the most costly to serve; 3%-5% of the population is known to drive 40%-60% of the health care spend. Fully integrated care coordination requires a broad spectrum of clinical services data and provider input that spans both medical staff and community based social systems. Because medical care coordination systems are not well designed for this comprehensive range of provider inputs, they struggle to meet the challenges of interdisciplinary care team members and integrated care solutions for these populations. An integrated systems of care approach encompasses integrated medical and behavioral care, and also coordinated services across social systems including: housing; educational and vocational services; income supports; and other rehabilitation and social services, among others.

Medical management systems used by most health plans and medical service organizations to serve public sector populations are poorly designed to support care coordination for fully integrated care including behavioral health conditions. Historically, these systems were designed to provide information and resources to support utilization review and cost containment. As these systems have evolved to provide care coordination they have focused on information and input provided by interdisciplinary care team members who are almost exclusively health plan or medical system providers.

Effective coordination and management systems for integrated care must support a comprehensive range of integrated care team members. This includes not only information and data from health care providers, but also input and use from social service providers that support community tenure and engagement and activation for improved health outcomes. New reimbursement strategies that promote population health outcomes require expanded care coordination tools, resources, and teams.

The data that is included in most care plans is too often generated by a limited number of care coordinators at a health plan or clinical systems provider level, and at best is available as view-only to others. This limits the utility of the care plan as a tool for the integrated care team responsible for the coordination of services. As shown below, an effective care plan should support interoperability that fosters the coordination of services that can be used by multiple providers across the full systems of care.

New population health contracting arrangements link the full range of the determinants of health outcomes, including both medical and social service influences. As a part of these new requirements, health systems are acquiring increased responsibility for housing, rehabilitation services, and ongoing supports as part of health outcome determinations. Health outcome improvements are driven by this comprehensive scope of determinants and require new models of interdisciplinary care teams that span the medical and social systems of care. A single care plan that is managed by a health plan or provider is no longer an acceptable vehicle to support the multiple members of the comprehensive care team. Fully integrated care requires new models of care coordination that are not well supported by existing health plan and provider IT systems.

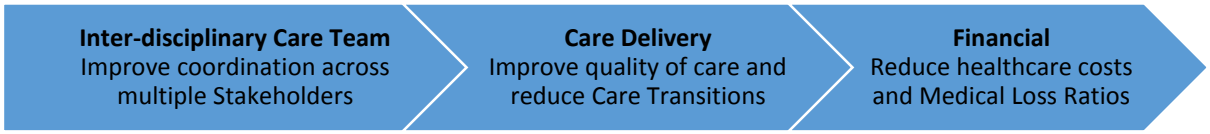
InfoMC Solutions Support Improved Quality and Collaboration

InfoMC's Coordinated Care Solution offers a suite of workflow, data exchange, and analytics products for complex or chronic care coordination to health plans, managed care organizations, health systems, and public health agencies (state, county and community health centers). InfoMC's solution helps our customers to:

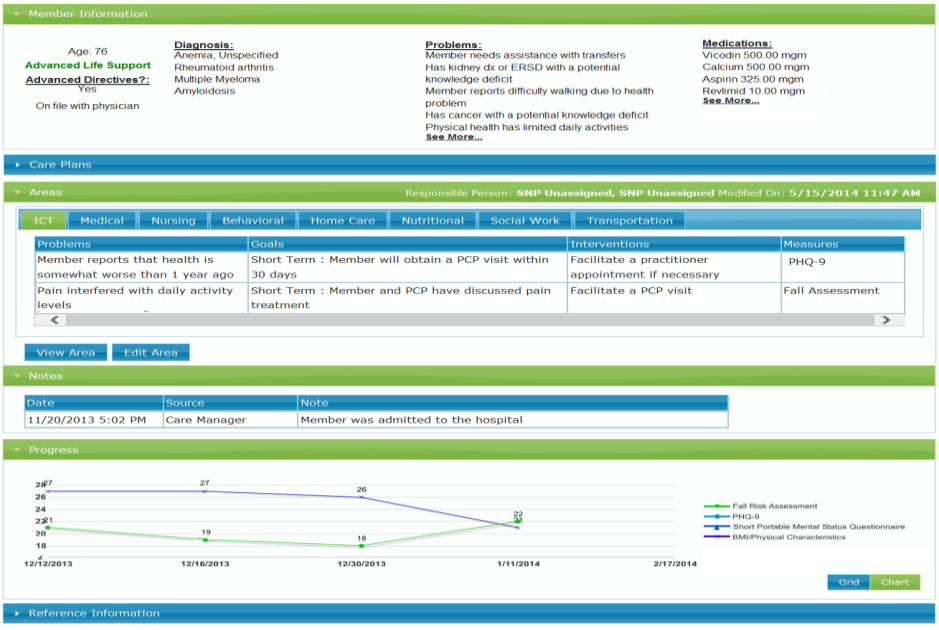
ENGAGE	Manage and coordinate the care process for members with complex chronic conditions across multiple stakeholders;
EXCHANGE	Connect payers, providers, and other stakeholders with the exchange of information to enable better decision making; and
ANALYZE	Use business intelligence and analytics to proactively identify individuals and populations to support meaningful interventions.

An Integrated Coordinated Care Strategy

InfoMC's Coordinated Care Solution promotes a collaborative and integrated approach for assessment, care planning, facilitation of services, care monitoring, and risk management of chronic and/or complex physical and behavioral health conditions and populations. InfoMC's Coordinated Care Solution provides the tools for Providers and Practitioners across Agencies to collaborate and coordinate care. This includes the necessary services and community based resources to meet the comprehensive medical, behavioral health and social services needs of members and their caregivers, while promoting clinically-driven quality care and cost-effective outcomes. The InfoMC Coordinated Care Solution focuses on member-centered and provider-integrated care coordination – combining integrated care plans with an Interdisciplinary Care Team (ICT) approach to support optimal coordination of care and services with the use of least restrictive and cost effective care alternatives. A provider-integrated and collaborative approach to care delivery improves coordination of necessary services across the care continuum; improves quality of care, including fewer care transitions; and reduces overall healthcare costs and Medical Loss Ratios.



At the center of **InfoMC's Coordinated Care Solution** is the Care Plan and the Interdisciplinary Care Team (ICT). The ICT may be comprised of Case Managers, Social Services Coordinators, Providers and Practitioners across Agencies, as well as Caregivers and members. The Care Plan provides the care team with the necessary tools to individually and collaboratively identify the member's problems, interventions, goals, barriers and measures to develop a member-centric plan of care. InfoMC's Care Plan module captures the member's medical, behavioral health, pharmacy and social service and community resources – past, current and prospective – and tracks the member's accompanying problems, interventions, goals and outcomes.



Key features of the Care Plan module include:

- Auto-generated Care Plans
- Condition and member-centric care plan content
- Integration with HRAs, Biometrics screenings and other assessments
- Medical, behavioral health and pharmacy data capture
- Rules-driven workflows and decision making
- Automated task generation, alerts, reminders and notifications
- CMS and NCQA supported workflows

InfoMC Care Team Portal

The **Care Team Portal** is InfoMC's stakeholder portal designed to ensure optimal care coordination via real-time shared care planning. Interdisciplinary Care Team (ICT) members can access the Care Team Portal via mobile devices for the most up-to-date care planning information, including ICT messages, reminders and alerts. Incedo Coordinated Care workflows and rules engine will guide ICT members through standardized processes to promote consistent and real-time coordination of care and care management. Using the **Care Team Portal**, ICT members can add and update the member's problems, interventions, and goals; monitor barriers and progress; initiate referrals and request services; send messages and reminders; and track measures and outcomes – during or immediately following the provision of services or other interactions with the member. The **Care Team Portal** also allows members and caregivers to view the Care Plan, complete assessments and communicate with the ICT team.

InfoMC InSpotlight

InfoMC recognizes the importance of taking large aggregate health information data sets and translating them into actionable information that supports guidance for health outcomes improvement. This approach is based on the recognition that there are several key drivers of high health care costs and low health outcomes. Behavioral health conditions and their influence on health outcome are frequently not well understood, and must be a cornerstone of any population health outcomes strategy.

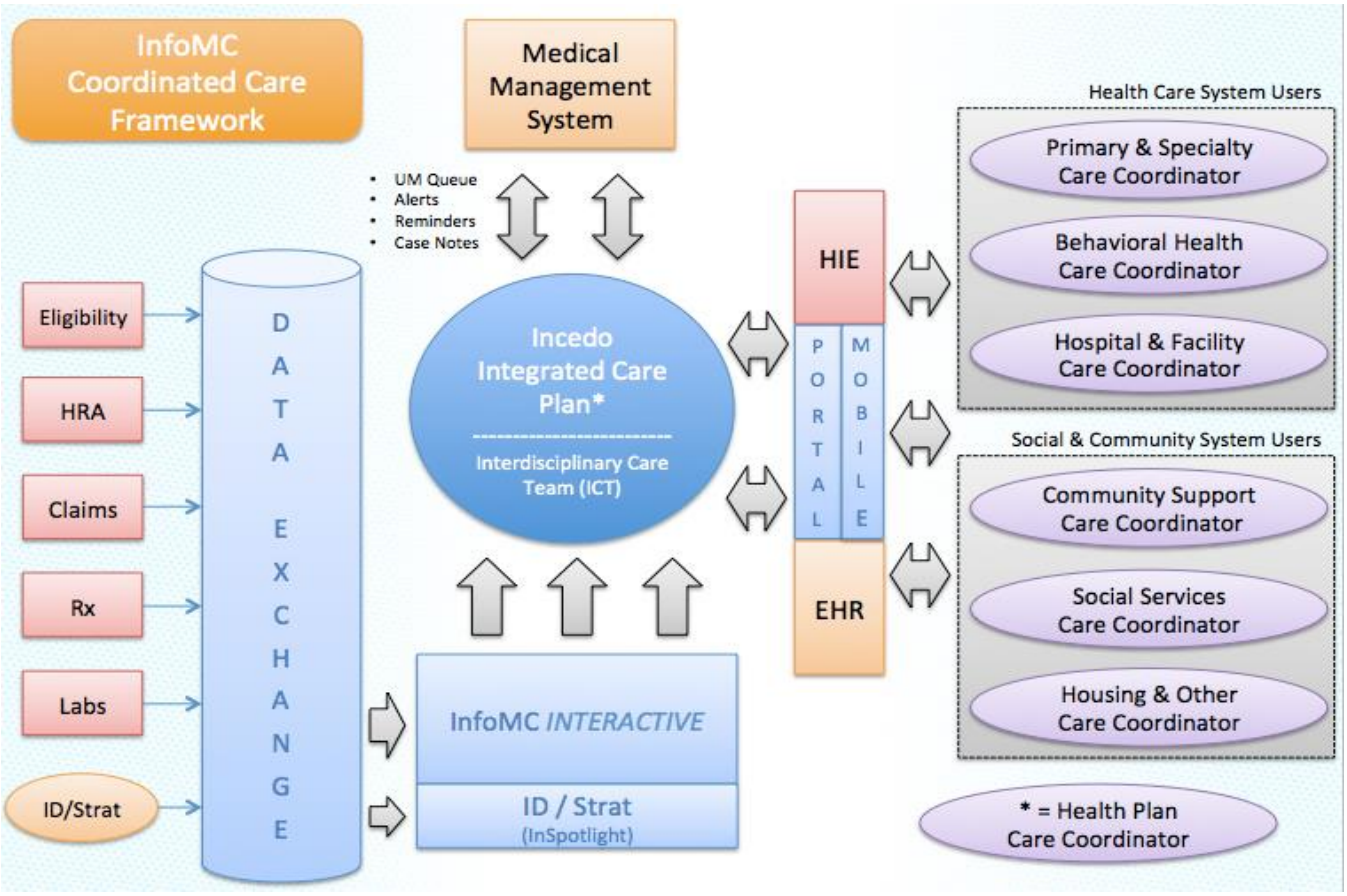
InSpotlight tools provide resources for the use of broad population health data and filtering key factors of chronic health and behavioral health conditions into care management strategies. Aggregated identification and stratification reports are presented via dashboard supports and care coordination workflows. Three methodologies are used for the identification of at risk patients and the prioritization of care coordination service needs. These include InSpotlight tools for:

- Selective high dollar claims analytics;
- Prioritized service utilization methodologies; and
- Health risk assessment stratification systems.

Many health systems are overburdened with health services data that is not useful, and generally ineffective for the improvement of care outcomes. These systems also fail to integrate physical and behavioral health data, and unable support care coordination for individuals with co-morbid conditions. **InSpotlight** utilizes evidence-based indicators to translate selective health care data into actionable care coordination workflows. This is accomplished through selective high dollar claims analytics; prioritized service utilization methodologies; and Health Risk Assessment stratification systems.

Comprehensive Strategies for Improved Care Coordination and Outcomes

InfoMC recognizes that in order to provide effective and quality care for individuals and populations with complex or chronic behavioral and/or physical health conditions, a range of solutions are necessary. A provider-integrated and information driven care coordination strategy promotes member-centered care that is well coordinated across providers, payers, members, caregivers and other stakeholders who are able to engage and activate identified individuals. It also promotes the management of care and population health outcomes by providers and payers who provide the support and resources to assure appropriate care and services are provided with quality and cost efficient outcomes. A quality driven approach is built with timely, actionable, and practical information sharing. **InfoMc's Coordinated Care Framework, with its integrated system approach, bridges the information sharing gaps between payers, providers and other stakeholders as described below.**


InfoMC Coordinated Care Framework
Medical Management System
UM Queue
Alerts
Reminders
Case Notes
Eligibility
HRA
Claims
Rx
Labs
ID/Strat
DATA EXCHANGE
Incedo Integrated Care Plan*
Interdisciplinary Care Team (ICT)
InfoMC INTERACTIVE
ID / Strat
(InSpotlight)
HIE
PORTAL
MOBILE
EHR
Health Care System Users
Primary & Specialty Care Coordinator
Behavioral Health Care Coordinator
Hospital & Facility Care Coordinator
Social & Community System Users
Community Support Care Coordinator
Social Services Care Coordinator
Housing & Other Care Coordinator
* = Health Plan Care Coordinator