February 11, 2013

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I. Introduction

Background

Mental illnesses are common in the United States. The National Institute of Mental Health (NIMH) estimates that 26 to 30% of Americans ages 18 and older suffer from a mental or substance use disorder during the course of a year. The main impacts of these illnesses are typically reported to be concentrated in about 5 to 7% of adults who have a serious mental illness (SMI; Kessler et al., 2001). Each year over 33 million Americans use health care services for their mental problems and illnesses and/or their use of alcohol and/or their inappropriate use of prescription drugs or illegal drugs and in 2003 approximately 13% of this population received mental health treatment in an inpatient or outpatient setting (Institute of Medicine [IOM], 2006). Millions more reported that they needed treatment for mental health or substance use conditions but did not receive it. In 2003, it was estimated that only 41% of those aged 18-54 who met specific definitions of SMI and did not received any treatment (Kessler et al., 2005).

Based on data from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2004):

- Approximately 2.4 million Americans (1.1% of the total population) have a diagnosis of schizophrenia, one of the most serious mental disorders.
- Each year approximately 6 million Americans are diagnosed with bipolar disorder, around 3% of the total population.
- Approximately 3 million Americans are at risk of suffering from panic disorder.
- More than 90% of individuals who commit suicide have a diagnosis of one or more SMIs.

Individuals with SMI, on average, have a life span that is 25 years less compared to the general population, and 60% of premature deaths in persons with schizophrenia are due to cardiovascular, pulmonary and infectious diseases (Parks et al., 2006). Among persons with SMI, the primary natural causes of death include cardiovascular disease, diabetes (including kidney failure), respiratory disease (COPD/pneumonia, influenza), and infectious disease (HIV/AIDS). Other modifiable risk factors that place people with SMI at higher risk of morbidity and mortality include: smoking, alcohol consumption, poor nutrition/obesity, lack of exercise, "unsafe" sexual behavior, IV drug use, and residing in group care facilities and homeless shelters. Additionally, individuals with SMI are vulnerable due to negative health outcomes because of their higher than normal rates of homelessness, victimization/trauma, unemployment, poverty, incarceration, and social isolation,

Symptoms associated with SMI frequently cause fear of accessing health care and difficulty in following medical recommendations. SMI symptoms may mask medical/somatic illnesses. Psychotropic medications can mask medical illness and cause metabolic syndromes and polypharmacy issues. Additionally, the lack of access to appropriate health care and the lack of coordination between mental health and general health care providers contribute to poor health outcomes. Furthermore, psychotropic medications are associated with weight gain (overweight/obesity), insulin resistance, diabetes/hyperglycemia, and dyslipidemia (Part et al., 2006).

Individuals with SMI have problems in accessing health care related to their own characteristics as an enrollee, to provider related factors, and other system factors (Druss et al., 2001). Enrollee characteristics that create difficulties include but are not limited to a lack of motivation, fearfulness, and social instability. Provider factors that create impediments include

but are not limited to competing service demands and stigma associated with treating mental illness/substance abuse. System factors that create roadblocks include but are not limited to care fragmentation and a lack of care coordination. Individuals suffering from SMI are susceptible to overuse, underuse, and misuse of health care services (Druss and von Esenwein, 2006). An example of overuse is high use of somatic emergency services. Underuse includes fewer routine preventive services, lower rates of cardiovascular procedures, and lower quality diabetes care. An example of misuse may occur during a medical hospitalization in which individuals with schizophrenia have been shown to be twice as likely to develop infections due to medical care postoperative deep venous thrombosis and postoperative sepsis.

From 1993-2003, mental health and substance abuse expenditures grew from $70 billion to $121 billion (Mark et al., 2007). However, the proportion of all health care spending attributed to mental health and substance abuse actually declined, from 8% of total health care spending in 1993 to 7.5% in 2003. Public payers accounted for a greater proportion of expenditures than public payers did for all healthcare expenditures. The largest proportion of mental health and substance abuse health care costs occurred in hospital-based services, including inpatient, outpatient, and residential care provided by hospitals (27%). Physicians and other professional services accounted for twenty-two percent (22%) of healthcare expenses for this population while prescription medicine accounted for nineteen percent (19%). Medicaid has increased to now be the largest payer of mental health care, with prescription medicines as the fastest-growing expense component. Private insurance payment for substance abuse treatment has actually decreased in real dollars increasing the public share of substance abuse treatment spending (Mark, 2005).

Serious Mental Illnesses and Substance Abuse

Approximately, 50% of individuals with SMI develop a substance use disorder (SUD) at some point during their lives with half of this group exhibiting current substance abuse or dependence (Regier et al. 1990). "Dual diagnosis" commonly refers to the combination of SMI and SUD, and this type of co-morbidity is the rule rather than the exception (Abou-Saleh, 2004). Primary predictive factors for dual diagnosis include male gender, younger age at diagnosis, lower educational level/attainment, and single (or divorced) marital status.

Alcohol and drug abuse adversely influences affective stability, cognition, and behavior among persons with mental illness. The co-morbidity of these two conditions complicates clinical management and is associated with poorer outcomes than either SMI or SUD alone due to low rates of identification and poor coordination of care (New Freedom Commission on Mental Health, 2003). Dual diagnosis is associated with increased risk of violence, suicide, and adverse clinical and adverse social outcomes (Abou-Saleh, 2000).

The clinical characteristics for individuals with dual diagnosis are summarized below (Buckley, 2011; RachBeisel et al. 1999; Hegner, 1998; Regier et al., 1990).

- The ***median*** age for the development of mental illness is approximately 11 years of age, while the substance abuse diagnosis typically follows 5 to 10 years later.
- SMI and SUD co-occur at high rates; up to 15% of persons with a mental disorder and 42% with a SUD are prone to have the other condition.
    - *Schizophrenia*: Approximately 47% of individuals with schizophrenia have had a SUD over their lifetime, 34% have had an alcohol use disorder and 28% have a disorder with other drugs. Cannabis and cocaine are the most frequent drugs of choice.

- *Mood disorders*: Individuals with mood disorders have a lifetime SUD rate of approximately 32%. The co-morbidity in bipolar disorder is twice that of major depression (56% vs. 27%). Despite its lesser severity, dysthymia also has a high rate of SUD (31%). Alcohol is the most common substance of abuse/dependence across the mood disorders.
- *Anxiety disorders*: Approximately 15% of individuals with an anxiety disorder have a co-occuring SUD. SUD is highest in generalized anxiety disorder (21%). While SUD co-occurs with post-traumatic stress disorder at a frequency of eighteen percent (PTSD, 18%) while seventeen percent (17%) of individuals with a social phobia have a co-occurring SUD.

- Individuals with dual diagnosis are more likely to be non-adherent to treatment and are at higher risk for admission to a psychiatric facility.
- Individuals with SMI or SUD should be assessed for the presence of a co morbid disorder through routine screening with a validated, age appropriate tool.
- Individuals with dual diagnosis are at higher risk of suicide than those with either SMI or SUD alone and should be explicitly assessed and monitored.

Healthcare needs of adults with Serious Mental Illness

Compared to people without mental disorders, adults with SMI have higher rates of chronic conditions, including hypertension, COPD, HIV/AIDS, and diabetes, as well as a higher frequency of multiple chronic conditions and functional impairments. Because general medical conditions may be missed, the true prevalence rates are likely to be higher than reported (Druss and Rosenbeck, 1997). Nowhere is this more prominent than when examining Medicaid

beneficiaries. A small subset of the program's beneficiaries, roughly 5%, account for approximately 60% of total program expenditures with mental illness and substance abuse endemic among these high cost beneficiaries (Hamblin and Somers, 2011). Psychiatric illnesses are connected with chronic illnesses for these beneficiaries; 40% of high cost Medicaid beneficiaries have a SMI and a diagnosis of cardiovascular disease, 40% have a SMI and a diagnosis of central nervous system disorder, and 29% have a SMI and a diagnosis of pulmonary disorder (Kronick et al., 2009).

The addition of an SMI with chronic physical conditions and a drug and/or alcohol disorder for Medicaid beneficiaries results in 2 to 3 fold higher health care costs (Boyd et al., 2010). For example, spending for beneficiaries with diabetes and *no* SMI and drug and alcohol disorder averages just under $10,000 per year, whereas spending for beneficiaries with diabetes, an SMI and drug and alcohol disorder tops $35,000 annually. Spending for beneficiaries with CAD and no SMI and no drug and alcohol disorder averages just under $9,000 per year, and spending for beneficiaries with CAD, an SMI and drug and alcohol disorder is over $24,000 annually.

Despite the high burden in terms of human and financial costs, the majority of individuals with SMI are in fragmented systems of care. Behavioral health services are usually provided separately from physical health care, with little or no coordination between the two delivery systems. As a result, enrollees typically receive care from a confusing array of disparate providers that are frequently unaware of the individual patents' overall needs as well as the treatments and prescriptions they are receiving from other providers. Evidence suggests that people with SMI have difficulties obtaining general health care, their overall quality care is

poorer compared to less impaired people, and older adults with SMI and substance abuse appear to be at even higher risk for substandard quality of care (Horvitz-Lennon, et al., (2009).

These deficiencies are coupled with low rates of adoption of evidence-based practice and high rates of adoption of non-evidence-based practices plague the care of people with SMI (IOM, 2006). The IOM (2006) found that only 27% of studies assessing the quality of care for persons with SMI reported adequate rates of adherence to established clinical practice guidelines. Poor care has serious consequences for people seeking treatment for SMI, leading to serious medication errors and increased mortality risk (Grasso et al., 2003).

In the past two decades, psychosocial and clinical programs in schizophrenia have greatly expanded and improved enrollees' odds of leading fuller lives (Horvitz-Lennon, 2009). However, the underuse of evidence-based practices has kept scores of these enrollees from receiving potentially beneficial interventions. Supported employment, family psycho-education, and other evidence-based psychosocial practices used to treat schizophrenia have shown great promise but are more likely than pharmacological evidence-based practices to diffuse slowly, and they are used less frequently. Additionally, the evidence suggests that psychosocial practices are being used less frequently compared to past practice. The IOM (2006) concluded that research is increasingly demonstrating that care for SMI and substance abuse is both effective (it works) and can be cost-effective (it is a good value).

Care Management Recommendations

In its landmark publication on quality of care, the IOM (2001) described the US health care system as "a highly fragmented delivery system that lacks even rudimentary clinical informational capabilities" and highlighted the poor outcomes that result from lack of

coordination. Its publication on quality of care for individuals with SMI and/or substance use conditions suggests that progress toward optimal quality of care is still lacking and has been slow and uneven (IOM, 2006). The IOM report strongly suggests that "care as usual" is not meeting the health care needs of this population, and achieving greater clinical integration between service providers is central to improving quality of care for individuals with mental and substance abuse disorders.

Recommendations to improve the quality of care for persons with SMI and substance abuse disorders outlined by the IOM (2006) and the New Freedom Commission on Mental Health (Unutzer et al., 2006) are briefly summarized below (Horvitz-Lennon, 2006).

- Reorganization of mental health service delivery. The goal of reorganization is for mental health care providers and practices to assume responsibility for all of the health care needs of their enrollees with SMI and focus on best practice interventions, including clinical integration, case management and self-management skills.
- Promotion of enrollee-sanctioned communication and collaboration among providers. Mental health care providers and practices need improved information exchange through the use of integrated clinical information systems.
- Preparation of the health care workforce to provide coordinated care. Health care professionals need the education and skills necessary to deliver care through interdisciplinary teamwork.
- Develop policies and practices that offer incentives for integrated care. Traditional indemnity plans need to be restructured to reimburse collaborative work to provide incentives for clinically integrated care.

These recommendations have spurred some states to implement programs that provide "high touch" care management programs for targeted groups of Medicaid beneficiaries. Best practices suggest the following core elements should be considered in the design of comprehensive care coordination programs (Hamblin and Somers, 2011):

- Stratification and triage by risk/need.
- Clinical integration of services.
- Designated "care home" and personalized care plan.
- Consumer engagement strategies.
- Information exchange among all stakeholders.
- Performance measurement and accountability.
- Financial incentives aligned with quality care.

Despite the growing consensus that improved integration of behavioral and physical health care for persons with SMI will produce improved quality care with lower costs, evidence on how best to achieve this increase in quality and decrease in expenses is lacking. An initiative by the Center for Health Care Strategies (CHCS), the Rethinking Care Program, was created to find ways to improve the quality and lower the costs of care for high-need, high-cost Medicaid beneficiaries. Early findings from the Pennsylvania project provides insight for Medicaid stakeholders who seek to integrate care for high-cost Medicaid beneficiaries with SMI and physical health conditions (Kim et al., 2012). These findings suggest the following.

- State leadership is essential to a successful program, especially in encouraging behavioral health and medical divisions to work together.
- Information exchange among partners and providers is essential, and constraints and privacy issues must be addressed up front. Specific guidelines must be developed and

implemented for sharing drug, alcohol, mental health and/or HIV information between different entities and providers.

- Nurses were critical to multidisciplinary care teams in integrating care for individuals with SMI. They are well-suited to serve as a clinical bridge between physical and behavioral health providers.
- Enrolling individuals with SMI in coordinated care programs calls for creative engagement strategies. Participation rates are higher when providers who already have existing relationships with these individuals are active in recruitment and enrollment activities.
- Provider relationships were critical for supporting integrated care, and took time and resources to build. Collaborative relationships between team members and providers do not form overnight.
- Integrated health profiles are necessary to support integrated care management and care coordination. The health profile serves as a single source of integrated physical and behavioral health information shared across providers.

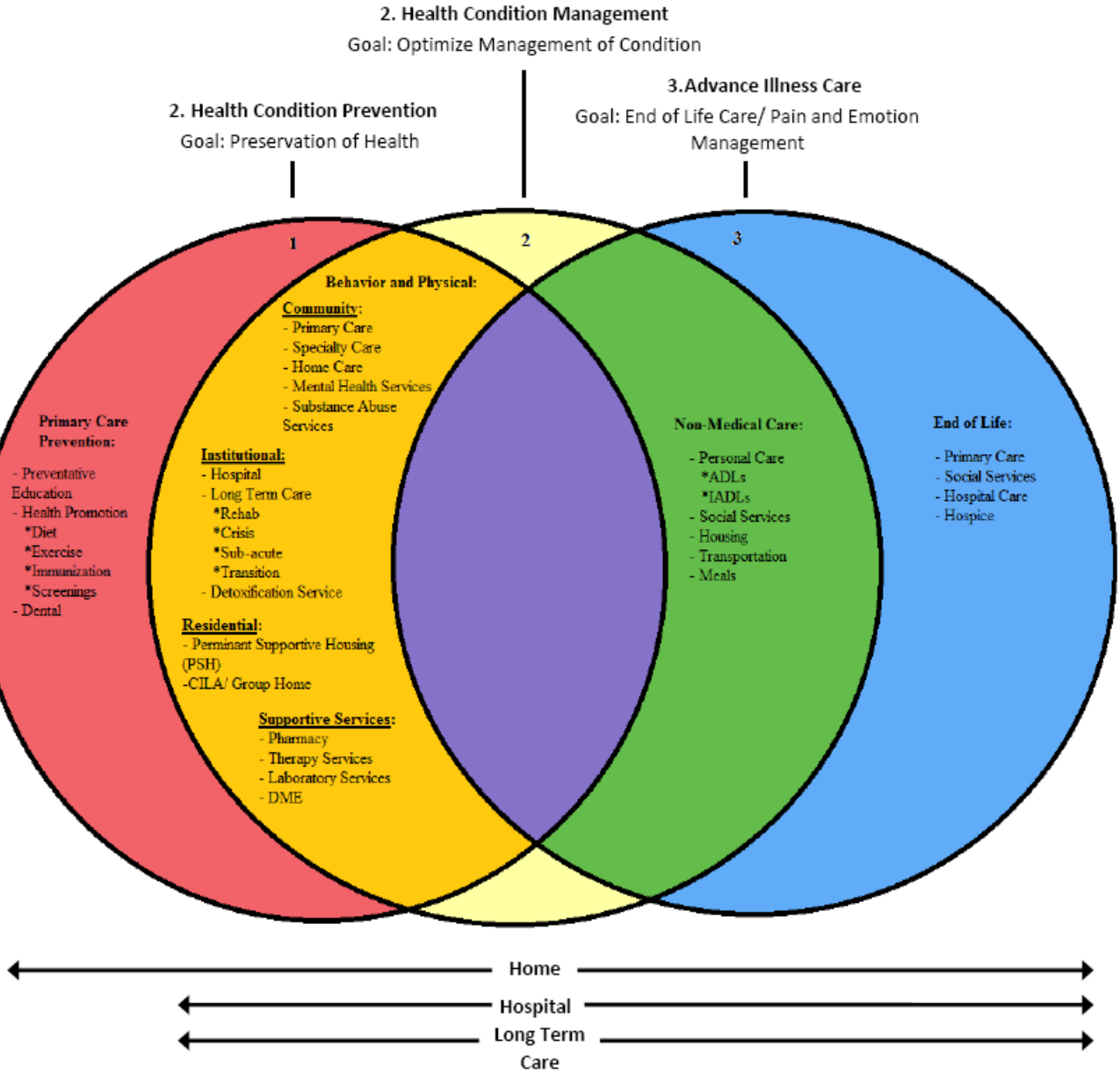
Be Well's Comprehensive Care Management and Continuum of Care

Be Well's continuum of care spans the community setting, primary care, tertiary care and long-term care. The following diagram provides a framework to examine how Be Well views the continuum of care. Circle one represents services related to prevention and preservation of health. Circle two represents services to optimize the management of health conditions. Circle three represents services related to advance illness care. Where the circles overlap, this

represents situations where an enrollee would receive services from two or three of the service categories.

Be Well plans to target enrollees that reflect Circle 2, targeting enrollees that need health condition management. However, when appropriate, a Be Well enrollee would be receiving services represented by multiple circles.

Be Well's Continuum of Care



The circles represent categories of services related to the health status of the enrollees and service providers appropriate for the enrollee's health status. Be Well will coordinate services from its network providers that may involve services from multiple circles and in multiple locations. Be Well's care management will manage the transitions of care that occurs from one circle to another or from preservation of health to health condition management to advance illness care.

Circle 1 represents a healthy person who may only need health promotion activities and/or education. Circle 2 represents individuals with health conditions that need to be managed. All of Be Well's enrollees will have a serious mental illness and/or moderate to severe developmental disability. Therefore, Be Well's enrollees' service and care needs are represented by Circle 2 and areas of overlap with Circle 1 and Circle 2. The enrollee may transition between locations of care and provider involvement as their health condition progresses requiring care from a Be Well specialty care provider and/or care from a hospital or intermediate care facility. Be Well's care managers will work with these enrollees to facilitate an understanding of their new health condition while teaching and coaching the enrollee on necessary self-management skills for the condition. Be Well's care managers will follow enrollees through transitions of care. These transitions may include but not be limited to home to hospital, hospital to home, long term care facilty to hospital, and/or hospital to long term care facility.

Be Well's care managers will ensure medication reconciliation and communication between necessary network providers and enrollees as transitions occur. Furthermore, care managers will assist these Be Well enrollees to obtain needed medical equipment or supplies. They will refer and coordinate services for the enrollee from both formal and informal

community based providers, including assistance in identifying and addressing unmet basic and social needs. Care managers will proactively monitor Be Well enrollees so any unexpected changes in health status can be identified early and managed effectively and efficiently. Be Well enrollees who receive this level of care may reside in a long-term care facility, residential treatment facility, or in the community.

Level 3 represents advanced and palliative care. Be Well enrollees at this level of care are at the end of their lives and the focus of care is symptom management and comfort. These enrollees may receive this care in the community and in a long term care facility or hospital setting. Care managers will assist Be Well's enrollees at this level in identifying their goals and needs for their end of life care and will arrange psychosocial, physical or behavioral care as needed.

II. Be Well Partners in Health

Care Coordination Entity

MADO Healthcare LLC, Bethany Homes and Methodist Hospital, Norwegian American Hospital, and Neumann Family Services formed a limited liability corporation, Be Well Partners in Health. In 2010, these four corporations began collaborating to improve services for adults with SMI by creating and coordinating an array of treatment services and supports so that adults with SMI could live successfully in the least restrictive environment and effectively self-manage their mental illness and other health conditions. When the State of Illinois Department of Health and Family Services announced the Innovation Project, this partnership focused on understanding and developing a care coordination entity to respond to the State's solicitation. Be Well desires to join with the State of Illinois in an effort to improve health care outcomes and

increase cost efficiency of health care for Medicaid recipients with SMI and co-occurring chronic health conditions, including substance abuse. Be Well recognizes that SMI, with its resulting residual deficits along with the ebb and flow of acute symptoms throughout the course of the illness, compromises an individual's ability to care for their mental illness and their other health conditions. Be Well believes that providing care management will help these individuals improve compliance with prescribed treatment protocols and medication regimens thereby increasing the cost efficiency of the use of Medicaid funds.

These organizations gained experience working with each other and demonstrated a commitment to individuals with SMI. Examples of this dedication and cooperative efforts are as follows.

- Methodist Hospital initiated and operates an Intensive Outpatient Program at MADO's Sacred Heart which is an intermediate care facility for adults with SMI. This cooperative program between MADO Management and Methodist Hospital focuses on teaching Sacred Heart Residents to improve self-management and coping skills related to their mental illness and other co-occurring disorders so they may successfully live in the community or the least restrictive environment possible.
- MADO Management constructed 8, 2 bedroom apartments at Sacred Heart Home to form a transition program to facilitate successful transitions from the institution into the community. These apartments simulate independent community living with a treatment/rehabilitative environment that focuses on learning and practicing skills that foster successful independent living as well as improved self-management of health conditions.

- Methodist Hospital is piloting an effort aimed at shortening the length of hospital stays for psychiatric conditions and preventing inappropriate psychiatric hospital admissions by developing new psychiatric admission and management protocols within their emergency room and psychiatric units.
- MADO Management and Neumann Family Services have jointly developed a pilot community transition program for MADO Management residents in their SMI intermediate care facilities to transition into a CILA community placement with Neumann.
- MADO Management, with assistance from all the partners, developed and operates a crises/triage unit at one of its facilities. This unit provides crises services for individuals experiencing increasing acute symptoms of their illness(es) to prevent hospital admissions for mental illness by providing supportive treatment services that assist the individual in managing their mental illness. This program has developed in-depth assessment protocols that exceed regulatory requirements. These assessment protocols provide a foundation for an in-depth treatment plan. Since implementation, data suggest that many psychiatric hospital admissions have been prevented. In the first 60 days of operation psychiatric hospitalizations were reduced by 45% at MADO Management's intermediate care home, Sacred Heart.
- All partners invested in consultative services to assist in developing a response to the State of Illinois' Department of Health and Family Services' solicitation for care management targeting adults with SMI.

In the Letter of Intent (LOI) Be Well's partners had signed documents attesting to their intent to form a limited LLC, Be Well Partners in Health. Be Well is an officially registered LLC with

the State of Illinois. On May 7, 2012, the Illinois Secretary of State issued official recognition of the creation of Be Well (file number of 0392-598-6). All partners have signed the Operating Agreement of Be Well Partners in Health, LLC. This operating agreement provides the guidelines for overall governance and operation. These are similar to By-Laws of a not-for-profit corporation. Be Well has obtained an NPI number, a Dunn's number and a State of Illinois DNR registration number.

Be Well's Core Members

MADO Management, an affiliate of MADO Healthcare LLC, is a private for profit corporation operating a system of 5 distinct facilities in Chicago that provide a range of services including short and long term rehabilitation, skilled nursing care and intermediate care. Four of the 5 facilities specialize in services to adults with SMI. MADO Management facilities provide residents with a full array of medical, rehabilitative and social services. Based on a 51 year tradition of offering exceptional care, MADO Management strives to deliver a spectrum of enrollee-centered comprehensive care by providing individualized treatment and care through a process of comprehensive assessments and multi-disciplinary treatment planning and service provision. MADO Management works in partnership with its residents, the residents' families, hospitals, social service organizations, community mental health centers and communities to accomplish its mission of helping each individual in its care to achieve the highest level of recovery while living in the most independent setting possible. MADO Management operates the following homes:

- St. Agnes Healthcare Center, a skilled care nursing facility specializing in short term rehabilitation and long term care.

- St. Martha Manor, an intermediate and skilled care nursing facility specializing in the treatment and long term care of individuals with mental illness.
- Margaret Manor North an intermediate care facility specializing in the treatment of individuals with mental illness.
- Margaret Manor Central, an intermediate care facility specializing in the treatment of individuals with mental illness.
- Sacred Heart Home, an intermediate care facility specializing in treatment of individuals with mental illness.

Neumann Family Services is a comprehensive not- for- profit community based organization serving over 500 individuals with intellectual challenges and/or mental illness. Many of these individuals have co-occurring mental illness and intellectual disabilities. Neumann Family Services' mission is to integrate enrollees with disabilities and other life issues into the community and enrich their quality of life with choice and independence. Neumann operates 31 Community Integrated Living Arrangements (CILAs) throughout the City of Chicago. Neumann's provides an array of specialized Developmental Day Training (DT) Programs including but not limited to programming for people with autism, seniors, people with a severe or profound intellectual disabilities and those with a co-occurring developmental disability and mental illness. Neumann offers psychosocial rehabilitation programs for adults with mental illness. In addition to these day services Neumann when appropriate provides individual and group therapy/counseling, psychiatric evaluations/consultations, psychological evaluations, medication monitoring groups, and behavior management and intervention services.

Neumann operates a Medical Clinic which offers routine physicals, primary care medical services, dental examinations, podiatry services, comprehensive eye and vision examinations,

nursing services, and referral and linkage to medical specialties. Neumann provides case management services that are dedicated to helping individuals maintain independence in the community by addressing their physical, financial, educational, recreational, environmental and mental health needs.

Norwegian American Hospital, established in 1894, has provided high quality charitable health care for the residents of the near northwest side of Chicago for over 115 years. Norwegian's mission is to provide high quality and compassionate health care services by partnering with patients, their families, our employees, physicians and the communities that Norwegian serves. Norwegian American Hospital is a 200-bed, acute care facility, offering a variety of health care programs and services including: inpatient and same-day surgery, outpatient pharmacy, radiology department, All Kids health care program, cardiology department, corporate health program, intensive care unit, telemetry unit, pediatrics unit, emergency department, physician specialty center, and a comprehensive array of women's health care with an incorporated midwife program.

In 2006 Norwegian opened a behavioral health care unit for both adults and seniors. Recently, Norwegian initiated partial hospitalization services (an Intensive Outpatient Program) for the mentally ill. Additionally, Norwegian American Hospital provides 24/7 detoxification services for patients who are dependent on opiates and/or alcohol. Patients receive assistance with multiple issues related to their addiction and overall well-being. Norwegian additionally operates several community clinics and an outpatient physician specialty center. Norwegian American Hospital is recognized as a safety net hospital.

Bethany- Methodist Hospital, established in 1925, has a not-for-profit mission based on the story of the Good Samaritan. Methodist Hospital focuses on an all faith tradition providing

attentive and compassionate care that nurtures the body, mind and spirit. Bethany Methodist is deeply committed to caring for vulnerable populations including seniors and chronically mentally ill adults. Methodist Hospital offers 240 licensed beds, an Intensive Outpatient Program for the SMI population on site and at Sacred Heart Home, and a twenty-four hour mobile crisis clinic for both seniors and SMI clients. Methodist has physician specialists available including internists, cardiologists, neurologists, ophthalmologists, pulmonary specialists, orthopedic specialists, and dentists. Methodist also operates a comprehensive community based medical clinic, home health care services, rehabilitative services, and is recognized as a safety net hospital.

Be Well's Goals

Be Well recognizes that research demonstrates that 5 to 7% of Medicaid beneficiaries use from 60 to 70% of the program's expenditures. This group of Medicaid beneficiaries has chronic physical health problems plus a variety of socioeconomic barriers that impede access to medical, psychiatric and substance abuse treatment and care. Individuals in this group who have a serious mental illness have Medicaid expenses that are 60 to 75% higher than individuals with chronic health problems and no mental illness. Be Well understands and recognizes that more often than not there are multiple chronic health problems associated with serious and persistent mental illness. Forty % (40.55) have a mental illness and a cardiovascular health condition; 39% have a central nervous system disorder co-occurring with the mental illness; 29% have a mental illness and a pulmonary disorder (Hamblin and Somers, 2011). Additionally, the National Co-morbidity Study R (2005) demonstrated that the majority of individuals with persistent and SMI

have one or two additional mental disorders and a high frequency of a co-morbid substance abuse disorder.

Be Well's major goal is to improve health care outcomes and to improve the cost efficiency of health care for Medicaid recipients with SMI and co-occurring chronic health conditions and/or substance abuse. Be Well will develop a Care Coordination Entity that will implement a holistic integrated approach to managing care for enrollees across all aspects of medical and psychiatric care with the primary care physician and/or medical home central to the process. Be Well will create a broad network of service providers that will function similar to a preferred provider network. Be Well, working with a multi-disciplinary team from the network of providers, will develop a personalized care plan for each enrollee. Be Well will assist its enrollees with any existing socioeconomic barriers that impede access to care and impedes the meeting of an enrollee's basic needs. Be Well has an additional goal of developing the capabilities to implement a full-risk capitation over the first 3 years of operation.

Be Well's Governance Structure

Be Well is a LLC consisting of four equal partners. Each partner has 2 representatives on the 8 person Board of Directors. The Operating Agreement is the legal document similar to a corporation's by-laws that delineates major aspects of governance. Be Well intends to have an executive director/chief operating officer, a chief financial officer, a medical director, and care management teams. Care management will be lead by a master's level nurse. Be Well's partners have vast experience in complying with financial and other requirements of State and Federal contracts, and experience at complying with local, State and/or Federal rules and regulations. All partners have experience with following Medicaid rules and regulations.

Each network service provider will sign an agreement with Be Well that delineates the provider's responsibilities as well as Be Well's responsibilities. Be Well invested in the development of a Memorandum of Understanding that defines these roles and responsibilities. Additionally, each network provider has or will sign the HIPPA Exchange of Information agreement.

III. Providers

Be Well's Network of Providers

Based on the data analysis Be Well has recruited PCPs, hospitals, long term care providers, mental health providers, substance abuse providers, specialty providers, and other providers of medical or supportive services. These were chosen based on their capacity to serve enrollees, the target population's pattern of health conditions plus pattern of use of hospitals and emergency rooms in the target population. All providers have multilingual capacity and ongoing training in understanding the delivery of services in multicultural environments.

IV. Outreach and Marketing

Outreach and Marketing

Be Well Partners has developed a strong, enrollee-centered marketing plan for our targeted population. Through a series of several focus groups in various settings (community mental health centers, hospitals, and long-term care units) participants identified several key healthcare preferences. The themes of these preferences include: feeling connected and supported, having a PCP who respects and listens to his/her patients, receiving follow-up education to maintain health, and finding answers to questions. With input from these focus groups Be Well set forth marketing materials and a plan.

The logo for Be Well represents both the connection to care management and the transformation of change. The banded handshake represents the bond between an enrollee with a Partner in Health or care manager, signifying the partnership of the coordinated relationship(s). The open circle represents the transformation of change as one finds healing, wellness, and recovery. Constantly moving, the circle represents both the completeness of care management was well as the process of positive changes. The logo will be on the brochure and other key material.

The brochure is a key piece of the marketing and outreach plan to our targeted population, adults with severe mental illness and medical co-morbidities. Extrapolating themes from the focus groups, the Be Well team created a document that pinpoints key areas of communication: being connected, being treated, being empowered, being healthy and being well. Sample introductory text for the brochure includes the following:

There is a friendly wish that is often used as we embark on a new journey – "*Be Well*"

- At *Be Well Partners in Health,* our wish for you is to "Be well" on your path, your journey to wellness.
- At *Be Well Partners in Health,* we work with you to design your own path to wellness and connect you to your personal Partner in Health. Your Partner in Health will help you get the treatment you need for healing, the tools you need to be empowered and the support you need to be healthy.
- By enrolling with *Be Well Partners in Health,* you will have access to care 24 hours a day/7 days a week. You will be treated and supported by knowledgeable doctors and professionals whose focus will be on you and your path to wellness
- At *Be Well Partners in Health,* our ultimate wish is for you to "BE WELL"

The brochure and any marketing and outreach materials, including any video or digital display and software, will be translated into Spanish and Polish (the top two languages used in addition to English in our geographic areas). Additionally, a highly visual, modified version for enrollees with cognitive/intellectual disabilities and challenges will be developed. The written materials have been vetted by several focus groups in various settings: community mental health facilities, hospitals, and long-term care units. Translated materials will be vetted by educators of specific languages, including disability specialists for modified materials.

Initial outreach will be conducted in the natural settings of the Be Well enrollee and provider agencies. Using various modes of communication (including language and sign language interpreters when needed) Be Well staff will conduct face to face meetings with individuals and groups of potential enrollees. Using marketing materials and digital display devices/tablets, staff will engage in conversation with enrollees about Be Well and Care Management. Video and/or interactive software will also be developed for use on a touch screen tablet designed to engage potential enrollees. This presentation will highlight the key themes identified by prior focus groups as well as provide an educational base for care management and its benefits. Links to HFS Enrollee brokers will be immediately displayed for easy access.

Both Be Well staff and Be Well Network staff (i.e. provider case workers) will be trained on the engagement and processes for enrolling and linking to HFS Enrollee Brokers. It is anticipated that 1500 to 5000 enrollees will be engaged through the Be Well Network. Outreach to enrollees in PCP offices will initially take place as described above. As potential enrollees enter any possible portal (ER contact, hospital admissions, and intake departments of provider agencies) Be Well Network staff will be contacted and will make personal connections with

potential enrollees. Potential enrollees will be given copies of materials during face-to-face contact with Be Well Staff or Be Well Network staff.

V. Enrollment

Be Well will enroll 5,353 beneficiaries during the 36 month project. Enrollment projections are based on two primary factors: risk category (high vs. low/moderate) and living location (residential vs. non-residential). The projected enrollment figures are shown in the table below.

Living Location	**High Risk**	**Low/Moderate Risk**
Residential	481	78
Non-Residential	2,831	1,963
Total	3,312	2,041

As the chart indicates, 62% (3,312/5,353) of the total enrolled beneficiaries are Low Risk and 38% (2,041/5,353) are High Risk. We have made several assumptions in these enrollment projections.

- Be Well will begin active enrollment will begin in the 4th month of program operation.
- Initial enrollment will be targeted toward residential and non-residential high risk beneficiaries. We assume a 50% enrollment rate of high risk residential beneficiaries and a 20% enrollment rate of high risk non-residential beneficiaries. The major focus of Year 1 will be to enroll a majority of the high risk residential beneficiaries (77% of the total high risk residential enrollment).

- Be Well assumes a modest enrollment rate of low and moderate risk beneficiaries; a 10% enrollment rate of residential beneficiaries and a 5% enrollment rate of non-residential beneficiaries.
- Enrollment will be continuous for all 36 months of the program.
- Enrollment and disenrollment in Be Well: Partners in Health is strictly voluntary. We will replace all beneficiaries who disenroll at any time during the 36 months of operation.

The table below displays the total enrolled beneficiaries by risk category, living location, and program year.

Living Location	**High Risk**	**Low/Moderate Risk**
Year 1		
Residential	369	60
Non-Residential	1,161	684
Year 2		
Residential	465	72
Non-Residential	2,085	1,332
Year 3		
Residential	489	84
Non-Residential	2,829	1,956

The table on the next page displays our enrollment projections on a continuous basis for the entire 36 months.

Year 1	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Residential												
HR	0	0	0	41	82	123	164	205	246	287	328	369
LM	0	0	0	6	12	24	30	36	42	48	54	60
Community												
HR	0	0	0	129	258	387	516	645	774	903	1,032	1,161
LM	0	0	0	76	152	228	304	380	456	532	608	684
Total	0	0	0	252	504	762	1,014	1,266	1,518	1,770	2,022	2,274

Year 2	M13	M14	M15	M16	M17	M18	M19	M20	M21	M22	M23	M24
Residential												
HR	377	385	393	401	409	417	425	433	441	449	457	465
LM	61	62	63	64	65	66	67	68	69	70	71	72
Community												
HR	1,238	1,315	1,392	1,469	1,546	1,623	1,700	1,777	1,854	1,931	2,008	2,085
LM	738	792	846	900	954	1,008	1,062	1,116	1,170	1,224	1,278	1,332
Total	2,414	2,554	2,694	2,834	2,974	3,114	3,254	3,394	3,534	3,674	3,814	3,954

Year 3	M25	M26	M27	M28	M29	M30	M31	M32	M33	M34	M35	M36
Residential												
HR	467	469	471	473	475	477	479	481	483	485	487	489
LM	73	74	75	76	77	78	79	80	81	82	83	84
Community												
HR	2,147	2,209	2,271	2,333	2,395	2,457	2,519	2,581	2,643	2,705	2,767	2,829
LM	1,384	1,436	1,488	1,540	1,592	1,644	1,696	1,748	1,800	1,852	1,904	1,956
Total	4,071	4,188	4,305	4,422	4,539	4,656	4,773	4,890	5,007	5,124	5,241	5,358

VI. Population

Intended Population

The intended population will include adults 18 years of age and older who have a SMI diagnosis as defined by section 1.7.43 of the Care Coordination Innovations Project. After an individual is enrolled in Be Well they will be administered a risk screen. The results of the risk screen will determine if they are placed in the high risk or low-moderate risk group. This designation can change based on changes in the individual's health status. The individuals stratified to high risk will have the following characteristics.

- Have ***one*** or more of the following chronic health (tracer) conditions: chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD; acute myocardial infarction or ischemic heart disease), diabetes, substance abuse (drugs or alcohol), *AND*
- Have had ***one*** or more hospital admissions in the previous 12 months before enrollment.

Population Description

Based on 2010 claims data supplied by HFS, we examined the Medicaid SMI population for the City of Chicago who met the age and SMI criteria for the selected zip codes that are included in the catchment area (approximately 70% of all Chicago zip codes). We identified approximately 28,000 individuals who met the age and SMI criteria. Their demographic, health status, health utilization, and cost information includes:

- 56% are between the ages of 45 and 64, and 17% are 65 years or older;
- 55% are female;
- 42% are Afro-American;

- 29% live in a residential facility;
- 30% are covered by both Medicaid and Medicare (dual eligibles);
- 43% have a SMI diagnosis of schizophrenia or related disorder;
- 15% have a co-morbid substance abuse diagnosis;
- 28% have diagnosis of CFH, 30% have CAD, 60% have COPD, 30% diabetes;
- 46% had at least one ER visit in 2010;
- 40% had at least one hospital admission in 2010, and approximately 60% of all hospital admissions were for mental health or substance abuse reasons; and
- The average cost per beneficiary was approximately $22,000 in 2010 dollars.

However, using the enrollment criteria identified above we see a very different picture of the 28,000 Medicaid beneficiaries. Using the age, SMI, and hospitalization criteria three distinct groups emerge: (1) beneficiaries 18+ years of age, 1 or more SMIs and 1 or more tracer conditions, and 1 or more hospitalizations in 2010 (Group 1); (2) beneficiaries 18+ years of age, 1 or more SMIs and 1 or more tracer conditions, and NO hospitalizations in 2010 (Group 2); and (3) beneficiaries 18+ years of age, 1 or more SMIs, and NO tracer conditions (Group 3). Beneficiaries from Group 1 would comprise the high risk group and beneficiaries from Groups 2 and 3 would comprise the low/moderate risk group. Their demographic, health status, health service utilization, and total costs of care are displayed in the table below.

Characteristics	**Gp 1 (High Risk)**	**Gp 2 (Low/Mod Risk)**	**Gp 3 (Low/Mod Risk)**
N Beneficiaries	10,678	10,234	7,281
% Total Beneficiaries	**38%**	**36%**	**26%**
Demographics			
Age Groups:			
45-64 years	50%	50%	44%
65+ years	22%	19%	10%
Female	50%	61%	54%
Race:			
Afro-American	47%	39%	41%
Caucasian	35%	39%	35%
Hispanic	16%	22%	21%
Dual Eligibles (Medicaid & Medicare coverage)	47%	42%	39%
Living in Residential Facility	46%	24%	18%
Health Service Utilization			
ER Visits	74%	42%	23%
Average ER Visits	4.3	2.2	1.6
Hospitalizations	100%	-	8%
Mental Health Admissions	33%	-	64%
Substance Abuse Admissions	24%	-	-
Medical/Surgical/Other Admissions	43%	-	36%
Cost of Care			
ER Cost	$5,496,081	$1,431,049	$372,391
Hospital	$141,060,108	-	$3,030,486
Total Cost	$373,434,830	$160,173,277	$87,208,627
Total % Cost All Groups	**60%**	**26%**	**14%**

Average Total Cost per Beneficiary	$34,972	$15,651	$11,978
Health Conditions			
Schizophrenia and Related Disorders	54%	35%	41%
Bipolar Disorder/Psychotic/Autistic	17%	18%	17%
Bipolar Disorder/Manic Depression/PTSD	26%	47%	40%
Alcohol/Substance Abuse	56%	26%	-
CAD	32%	18%	-
CHF	21%	7%	-
COPD/Pneumonia/Emphysema/Pulmonary Disorders	69%	61%	-
Diabetes (Type 1 and 2)	38%	34%	-
Developmental Disability	3%	1%	3%
HIV/Aids/Infectious Disease	18%	16%	7%

The chart indicates that the high risk group (Group 1) accounts for 38% of all beneficiaries and 60% of total expenditures. The high risk group has total costs that are over 2 times higher than Group 2 and 3 times higher than Group 3, primarily due to residential costs and 92% of hospitalizations. As the data also highlight, approximately 60% of hospital admissions are for mental health or substance abuse reasons. Additionally, over 40% of the beneficiaries are dual eligibles and their total hospital costs are probably under stated by 40 to 50% because these costs are not captured in the HFS state Medicaid claims data.

An analysis of the targeted high risk group by living location highlights the differences even further. The table below displays their demographic, health status, health service utilization, and total costs of care.

Characteristics	**Residential Living**	**Non-Residential Living**
N Beneficiaries	4,877	5,801
% Total Beneficiaries	46%	54%
Demographics		
Age Groups:		
45-64 years	49%	51%
65+ years	34%	29%
Female	41%	57%
Race:		
Afro-American	46%	49%
Caucasian	42%	30%
Hispanic	9%	23%
Dual Eligibles (Medicaid & Medicare coverage)	57%	38%
Health Service Utilization		
ER Visits	67%	81%
Average ER Visits	4.0	4.5
Average Hospitalizations	3.1	3.5
Mental Health Admissions	41%	28%
Substance Abuse Admissions	4%	38%
Medical/Surgical/Other Admissions	55%	34%
Cost of Care		
ER Cost	$1,965,233	$3,530,848
Hospital	$68,516,251	$72,543,858
Total Cost	$232,879,241	$140,555,587
Total % Cost All Groups	62%	38%
Average Total Cost per Beneficiary	$47,751	$24,230

Health Conditions		
Schizophrenia and Related Disorders	67%	43%
Bipolar Disorder/Psychotic/Autistic	14%	20%
Bipolar Disorder/Manic Depression/PTSD	18%	36%
Alcohol/Substance Abuse	46%	64%
CAD	28%	16%
CHF	30%	28%
COPD/Pneumonia/Emphysema/Pulmonary Disorders	62%	65%
Characteristics	**Residential Living**	**Non-Residential Living**
Diabetes (Type 1 and 2)	47%	32%
Developmental Disability	3%	3%
HIV/Aids/Infectious Disease	18%	33%

Residential beneficiaries account for 46% of the total high risk population and 62% of the total costs. In addition, 57% of the residential beneficiaries are dual eligible compared to 38% of the non-residential beneficiaries, and 34% of the residential beneficiaries are covered by Medicare primary compared to 29% of non-residential beneficiaries.

Chronic Health Condition Codes

Chronic (tracer) health conditions will be defined by the CMS Chronic Condition Data Warehouse (CCW) ICD-9, CPT 4, and HCPCS Codes (www.resdac.umn.edu/CCW/data_available.asp) and are listed in the following table.

Chronic Condition	**ICD-9/CPT 4/HCPCS Codes**
Acute Myocardial Infarction (CAD)	410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91)
Ischemic Heart Disease (CAD)	410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.82, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.10, 414.11, 414.12, 414.19, 414.2, 414.3, 414.8, 414.9, Proc 00.66, 36.01, 36.02, 36.03, 36.04, 36.05, 36.06, 36.07, 36.09, 36.10, 36.11, 36.12, 36.13, 36.14, 36.15, 36.16, 36.17, 36.19, 36.2, 36.31, 36.32, HCPCS 33510, 33511, 33512, 33513, 33514, 33515, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33533, 33536, 33542, 33545, 33548, 92975, 92977, 92980, 92982, 92995, 33140, 33141
Congestive Heart Failure (CHF)	398.91, 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 404.03, 404.13, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Chronic Obstructive Pulmonary Disease (COPD)	491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 494.0, 494.1, 496
Diabetes	249.00, 249.01, 249.10, 249.11, 249.20, 249.21, 249.30, 249.31, 249.40, 249.41, 249.50, 249.51, 249.60, 249.61, 249.70, 249.71, 249.80, 249.81, 249.90, 249.91, 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.31, 250.33,250.40, 250.41, 250.42,250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 366.41
Alcohol Dependence	303.0, 303.00, 303.01, 303.02, 303.03, 303.9, 303.90, 303.91, 303.92, 303.93
Drug Dependence	304.00-304.03, 304.10-304.13, 304.20-304.23, 304.30-304.33, 304.40-304.43, 304.50-304.53, 304.60-304.63, 304.70-304.73, 304.80-304.83, 304.90-304.90, 305.00-305.03, 305.20-305.23, 305.30-305.33, 305.40-305.43, 305.50-305.53, 305.60-305.63, 305.70-305.73, 305.80-305.83, 305.90-305.93

VII. Comprehensive Care Management

Care Management Core Components

CCM is designed to assist enrollees and families to self-manage their health conditions and related psychosocial problems more effectively; coordinate care among multiple health and community providers; bridge gaps in care; and ensure that enrollees receive the appropriate level of care. Care management is provided by a nurse in collaboration with the enrollee/family, their primary care provider (PCP)/ psychiatrist, and other health and community providers involved in their care (Schraeder & Shelton, 2012). Be Well's model of comprehensive care management (CCM) is intended to impact: self-management skills and abilities, preventative health practices, quality of care, avoidable hospitalizations and re-hospitalizations, provider and enrollee satisfaction, mortality and total cost of care. The Be Well CCM is based on evidence based practices (Schraeder & Shelton, 2012). The core CCM components include risk stratification, provider/enrollee/CM teams, evidence based guidelines, standardized care management processes/ activities, education and training, web based information system, and evaluation (see section IX). It is a collaborative, enrollee centered, team approach to delivering high quality, coordinated cost effective care.

Risk Stratification

At the enrollee/population level Be Well's risk stratification will be accomplished through a questionnaire and algorithm which identifies the characteristics that has been shown to result in poor outcomes and/or high utilization. Be Well has identified the following characteristics of their high risk enrollees based on the evidence (Parks *et al*. 2006) and their population utilization.

- SMI with co-occurring Coronary Artery Disease and/or Congestive Heart Failure and/or Chronic Obstructive Pulmonary Disease and/or Diabetes and/or Alcohol/Substance abuse.
- And at least one hospitalization in the past 12 months.

In order to determine the risk status at the time of enrollment, a brief risk screening form will be included in the initial assessment process. The form will also be in the HIT system for Be Well. At the time of the risk screen the enrollees will identify their PCP, the enrollee will be assigned to a care management team (health home) based upon their identified PCP. Be Well's nurse care managers are aligned with the PCPs and the ratio may be one care manager to four to five or more PCPs. Care management will be provided to enrollees who reside in one of the contracted Be Well facilities (residential) as well as those who live in the community (community). Enrollees who live in a facility will work with the care manager that is assigned to that facility.

Both Be Well's residential and community CCM programs will enroll enrollees into high and moderate/low groups. Caseload sizes will differ between the groups as well frequency and type of contacts. Every enrollee will receive an initial face-to-face comprehensive assessment and development of an individualized plan of care. All enrollees' assessment and plan of care will be reviewed and updated at least annually and with any change in the enrollees' status (i.e. ED visit or hospitalization). At the time of reassessment a decision will be made to have the enrollee remain in the CCM group they are in or transfer to a different level of CCM. Initial level of CCM will be determined by the risk stratification algorithm.

Residential care management	Community care management
<u>High risk</u> Frequency of contact • Initial and annual face-to-face comprehensive assessment • Additional face-to-face visits as needed based upon plan of care or with change in enrollee status • Weekly monitoring after any hospitalization or ED visit or change in status (i.e. decompensation or new diagnosis) • Weekly open clinic for the enrollees to be seen as needed	<u>High risk</u> Case load size: 110 enrollees Frequency of contact • Initial and annual face-to-face comprehensive assessment • Monthly face-to-face visit • Additional home or office visits as planned in per plan of care or with change in enrollee status • Phone call contacts weekly or as planned into plan of care • Home visits within 24-48 hours post-transition from long-term or acute care.
<u>Moderate/low risk</u> Frequency of contact • Initial and annual comprehensive assessment • Bi-Monthly evaluation for least restrictive living environment • Additional face-to-face visits will be as planned into plan of care or with any change in enrollee status. • Weekly open clinic for the enrollees to be seen as needed	<u>Moderate/low risk</u> Caseload size: 500 enrollees Frequency of contact • Initial and annual comprehensive assessment • Quarterly contacts either face-to-face or by phone • Additional phone calls and/or face-to-face visits will be as planned into plan of care and with any change in status. • Changes in enrollee status will prompt a re-evaluation of risk status.

The care manager on the team the enrollee is assigned to will contact the enrollee and schedule the initial assessment visit within that first week following enrollment.

Teams

CCM teams are multi disciplinary and the core team is comprised of the enrollee/family, primary care provider/psychiatrist, nurse care manager/care manager navigator. The team communicates electronically and by telephone, through formal informal meetings and written summaries/plans. Team processes include developing relationships, team building, joint decision making and mutual support. At the center of the CCM team is the enrollee and the enrollee's primary support person(s). Be Well recognizes that not all support persons will be family members. "Support person(s)" will be defined by the enrollee. All efforts will be made by the nurse care manager to include the enrollee's primary support person(s) in all steps of the care process. Be Well also recognizes the importance of cultural sensitivity and cultural diversity and the enrollee's cultural needs and practices will be assessed and integrated into the enrollee's plan of care.

Be Well will have separate and distinct care management teams that work with the institutionalized persons or the community dwelling persons. The care management services for the institutionalized person will be lead by an advanced practice nurse (APN). Be Well's APNs will collaborate with the psychiatrist and other facility staff to provide management of chronic conditions to prevent exacerbations and manage acute illnesses. Enrollee centered care plans will be developed with the enrollee and interventions will be based upon evidence based guidelines and standards of practice. Previous programs of this nature have reduced hospital admission rates by 47% and emergency room visits by 49% (Kane, Flood, Bershadsky, & Keckhafer, 2004). Other activities of Be Well's APNs include: enhancing communication by providing standard and accurate information to all providers engaged in the enrollee's care; enrollee education/coaching to increase self-care skills and abilities; timely follow-up with

enrollee/family/nursing facility within 48 hours of discharge from an acute care setting; and procurement and timely delivery of durable medical equipment and supplies.

The Be Well APNs will also coordinate care for those enrollees transitioning between a long term care facility and hospital. The goal of the APN will be to reduce the frequency of avoidable hospital admissions and readmissions, engage the enrollee and family in the transition process, improve the enrollee's health outcomes, improve the process of transitioning between the hospital and long term care facility by bridging the gaps in care usually associated with transitioning by improving communication and providing information to both entities such as updated medication lists. The APN will retain accountability and responsibility for the enrollee as the transition is occurring until the acute care provider assumes responsibility. Information provided to providers during transitions will include the following:

- Primary diagnoses and major health problems
- Care plan that includes enrollee's preferences and goals, diagnosis and treatment plan, and description of involvement of any community services
- Enrollee's goals of care, and advance directives
- Emergency plan and contact information: name and phone number
- Reconciled medication list
- Identification of, and contact information of transferring facility/providers
- Enrollee's cognitive and functional status
- Test results/pending results and planned interventions
- Follow-up appointment schedule
- Formal and informal care giver status and contact information
- Designated community based care provider, long-term services and social supports as appropriate

Failure to monitor medications during transitions has been shown to result in adverse drug events and results in readmission for many persons (Leape, et al,. 1995; Gurwitz, et. al., 2005). Be Well APNs will be responsible for providing medication reconciliation, monitoring, education, and assessing for therapeutic and adverse drug reactions.

The CCM team for enrollees who reside in the community will be composed of the enrollee/family, primary care provider and/or psychiatrist, primary care manager (PCM), transitional care manager (TCM) as needed and a care manager navigator (CMN). The role of the enrollee/family is to provide accurate information concerning their health status along with new needs or problems and alerting the team to changes in their health status or life situation. Once a plan of care has been developed they will be responsible for completing self-management activities and adhering to recommended care protocols.

The PCP/psychiatrist role revolves around diagnosing and evaluating the enrollee, performing specified procedures, and coordinating care with specialty providers. The PCP/ psychiatrist will interpret tests results and assist the enrollee/family in understanding the information regarding their health status and recommendations for care. They will also reinforce recommendations made by other team members.

The Be Well PCM will complete the assessment and care plans for the enrollee in an office (health home) or home setting depending on need. In order to build these plans the PCM will integrate data from a variety of sources including, but not limited to: medical records, face-to-face visits, PCP/ psychiatrist reports, family/ enrollee reports, office staff comments, and health and community provider reports. The PCM will also follow the enrollee longitudinally, across time, and across the care continuum.

The Be Well TCM will coordinate care, facilitate communication, and provide care to enrollees during an inpatient encounter and during transitions back to community living. The TCM will engage the enrollee/family during the hospitalization/ED admissions and continue management and support during the four weeks following discharge from the hospital/ED. The TCM will re-assess enrollees in the hospital and at home in order to revise the plan of care to

better meet the enrollee's needs. They will also coordinate post-acute care along with health and community services. The TCM will meet with the enrollee/circle of support upon admission into the hospital or other inpatient setting, within the first 24-48 hours, and collaborate with inpatient staff and participate in the discharge planning process. When the enrollee is transitioned to home the TCM will make a home visit to the person within the first 24-48 hours. During the home visit all of the enrollee's discharge instructions will be reviewed with the enrollee and the enrollee will be provided education, management of services, and medication reconciliation. In addition the TCM will ensure that all follow-up appointments have been scheduled and all needed home support services have been arranged for. The TCM will evaluate the support services to ensure the service meets the needs of the enrollee. The TCM will follow the enrollee at home for the initial four weeks prior to transferring the enrollee's care back to the PCM.

If the enrollee is transferred from the hospital or ED to an intermediate or long-term care facility the transitional nurse care manager will collaborate with the Be Well APN providing care management to the institutionalized persons and transfer care to that APN.

The CMN will work collaboratively with the enrollee/family and CCM team. A study conducted by Anderson & Larke (2009) found that a CMN working with primary care and community-based mental health persons resulted in improved communication between patients, providers and community service agencies, and enhanced support and service linkage with community services. In Be Well's CCM the PCM conducts a comprehensive assessment of the enrollee to identify needs including gaps in care. The CMN will work with the PCM and enrollee to develop plan to fill these gaps. The CMN will provide up-to-date information to the enrollee/family on formal and informal resources that are available. The CMN will make and coordinate referrals to community and support services for services such as housing, meals,

support groups, peer groups and counseling. The CMN will also follow-up with enrollees to determine if the services provided were successful or unsuccessful at meeting the enrollee's needs.

For example if Mary is admitted to the hospital for an episode of CHF the Be Well TCM will meet with Mary in the first 24-48 hours of admission. The Be Well PCM that has been working with Mary in the community will contact the Be Well TCM to provide information to the TCM as needed including a home medications list and information about the home environment. If the PCM anticipates that Mary will need additional home support services after discharge back to home this information is also passed from the PCM to the TCM. The Be Well TCM will meet with Mary periodically during her hospital stay and work with the discharge planning team to prepare for Mary's discharge. When Mary is discharged back to home the Be Well TCM will visit Mary within the first 24-48 hours after discharge and at least weekly for the next four weeks. The TCM will ensure that Mary's medication list is reconciled and reported to the PCP and that Mary has follow-up appointments set and makes those appointments. If Mary needs additional community services such as transportation to the appointments then the Be Well TCM will work with Mary's Be Well CMN to arrange the transportation. After the initial four weeks post-discharge Mary's care management will be transferred from the Be Well TCM back to Mary's PCM she had been working with previously (the one that is aligned with Mary's PCP). If Mary is discharged to a long-term care facility then the Be Well TCM will contact the Be Well Facilities APN to provide information on Mary's stay and an accurate medication list.

Roles of Team Members

Care Management Components	Primary Care Provider/ Psychiatrist	Enrollee	Advanced Practice Nurse (APN)	RN Primary Care Manager (PCM)	RN Transitional Care Manager (TCM)	Care Management Navigator (CMN)
Assessment	• Diagnose and evaluate enrollee and perform specified procedures. • Interpret test results with the enrollee/family. • Assist enrollees in synthesizing information regarding health status and recommendations for care.	• Provide accurate information to the care manager, primary care provider, and other health/community providers. • Alert the team to changes in their life situation or health status. • Prioritize health problems with team.	• Diagnose and evaluate enrollee in the institutionalized setting • Interpret test results with the enrollee/family. • Assist enrollees in synthesizing information regarding health status and recommendations for care. • Complete assessments and care plans in the long-term care facility and/or acute care setting.	• Complete assessments and care plans in the home or office, depending on enrollee need. • Integrate objective and subjective data from medical records, face-to-face visits, primary care provider reports, office staff comments, family and enrollee reports, and health and community provider reports to build the initial assessment and longitudinal, comprehensive care plan.	• Complete/Update assessments and care plans in the hospital or ED setting • Complete/update assessments and care plans in the home after acute care visit incorporating transitional care • Integrate information from hospital or ED stay, face-to-face visits, provider reports, diagnostic and lab testing, staff comments to build assessment and care plan	• Obtain information from the enrollee for evaluation by the care manager, i.e. blood pressure or blood glucose results
Guideline/ Protocol	• Utilize evidence based guidelines/protocols to guide practice.	• Follow guideline/protocol recommendations from team.	• Utilize evidence based guidelines/protocols to guide practice.	• Utilize evidence based guidelines/protocols to guide practice.	• Utilize evidence based guidelines/protocols to guide practice	• Follow guideline/protocol recommendations
Care planning	• Develop medical plan of care interventions with input from the health care team.	• Identify goals and assist team in personalizing and prioritizing plan recommendations.	• Develop plan of care interventions with input from the enrollee/family and health care team.	• Develop plan of care with enrollee, family, and team.	• Develop plan of care with enrollee, family, and team. • Incorporate transition care with	• Contribute information from enrollee/provider interactions to be included into the

					goal to return care management to longitudinal care manager	plan of care
Implementation	• Reinforce recommendations from guidelines/protocols. • Reinforce recommendations for care manager/service provider.	• Responsible for follow-through on agreed upon action in order to manage plan of care.	• Reinforce recommendations from guidelines/protocols. • Support enrollee/family in implementing plan of care by assisting with identification of barriers to implementation and problem solving.	• Support enrollee/family in implementing plan of care by assisting with identification of barriers to implementation and problem solving.	• Support enrollee/family implementing plan of care by assisting with identification of barriers to implementation and problem solving • Responsible for follow-through post acute care visit to manage plan of care	• Support enrollee/ family in implementing plan of care
Teach/ Coach	• Provide basis for prescribed treatments and recommendations/ introductory teaching. • Determine type of health promotion activities needed	• Responsible for personal health and make appropriate lifestyle changes. • Complete self-management activities and adhere to recommended care protocols.	• Teach/coach enrollee/family about acute and chronic disease processes, medications and evidence based self-management strategies. • Reinforce positive steps when implementing self-management strategies. • Determine type of health promotion activities needed	• Teach/coach enrollee/family about disease processes, medications and evidence based self-management strategies. • Reinforce positive steps when implementing self-management strategies. • Reinforce reason and need for health promotion activities	• Teach/coach enrollee/family about acute disease processes, medications and evidence based self-management strategies. • Reinforce positive steps when implementing self-management strategies.	• Teach/coach enrollee/family about community and health care resources, i.e. pharmaceutical assistance
Medication	• Review and	• Take medications	• Review and	• Complete	• Complete	• Report any

management	prescribe appropriate medications	as prescribed • Report any suspected complications from medications: not effective, side effects, adverse events	prescribe appropriate medications • Complete medication reconciliation • Provide accurate information to providers during transitions in care	medication reconciliation • Provide accurate information to providers during transitions in care	medication reconciliation • Provide accurate information to providers during transitions in care	suspected barriers or issues to enrollees taking medications as prescribed
Referral	• Refer as appropriate to health providers.	• Utilize correct level of service with assistance from team.	• Refer as appropriate to health providers. • Refer to appropriate disease specific organizations, self-help groups, and other community services.	• Refer to appropriate disease specific organizations, self-help groups, and other community services.	• Refer to appropriate disease specific organizations, self-help groups, and other community services.	• Obtain information from community resources/groups for use of care managers
Coordinate	• Coordinate care (primary through tertiary) in a variety of settings.	• Alert team to use of health/community services, any recommendations, or issues encountered.	• Coordinate care to enrollees who reside in long-term care facilities and across the continuum of care as needed	• Coordinate longitudinal health and community services.	• Coordinate post-acute care health and community services to facility safe return to home environment	• Follow-up on health and community service referrals • Provide information to enrollee/family on available formal and informal resources
Monitor and Evaluate	• Evaluate health status and follow through on plan of care.	• Alert team to difficulties following the plan of care and change in health status or new	• Evaluate health status and follow through on plan of care. • Proactively monitor enrollees	• Proactively monitor enrollees on a regular basis. • Evaluate and document enrollee progress	• Monitor and evaluate enrollees during acute care episodes • Evaluate and document enrollee	• Proactively monitor enrollee on a regular basis

		needs/problems.	on a regular basis. • Evaluate and document enrollee progress • Re-assess enrollees and adjust plan of care at each contact, (comprehensively every 12 months) • Assess and plan for transition to lesser restrictive environment	• Re-assess enrollees at each contact, (comprehensively every 12 months), and revise the plan of care. • Adjust plan of care based on change in status, information from team members and enrollee preferences.	progress • Re-assess enrollees daily while in hospital and 3-7 times weekly following hospital and emergency department admits, and revise plan of care.	
Communication	• Communicate effectively with team members using multiple formats.	• Communicate effectively with team members.	• Communicate effectively with team members using multiple formats. • Provide detailed written information to receiving facility providers if enrollee experiences a transition in car	• Maintain an enrollee panel over time. • Serve as a conduit for continual communication among care team members using multiple formats	• Communicate/serve as a conduit for communication between multiple formal and informal providers in the post-acute period	• Facilitate communication between enrollee/family and providers
Advocacy	• Advocate for the value of the care manager's contribution to the team. • Advocate for enrollee services.	• Express viewpoint concerning needs, problems, and services.	• Communicate effectively with team members using multiple formats.	• Advocate for the enrollee/family needs and services.	• Advocate for the enrollee/family needs and services.	• Advocate for enrollee/family needs and services

Evidence-Based Guidelines/Protocols

Be Well's CCM will be based on guidelines and protocols. Care guidelines and protocols are evidenced-based and systematically developed statements and processes to assist the CCM team and enrollee in making decisions about appropriate health care and self-management activities for specific clinical circumstances. The care guidelines and protocols are developed from current national guidelines and the most current evidence based care recommendations and address medical, nursing, self-management, and community based care components. Be Well will develop evidence-based guidelines and protocols to be shared with each partner. A Clinical Advisory Group will be formed with representatives from each partner who will oversee the development of guidelines/protocols. The Clinical Advisory Group will include practicing specialists in the areas of physical and mental health, substance abuse, and nursing. The Clinical Advisory Group will review and update the guidelines each year based upon the most recent published evidence. Included in the guidelines will be information on diagnosis and management of the chronic physical or mental condition, substance abuse management, medication management and monitoring, nursing care management protocols, and teaching and coaching protocols on physical health, behavioral health, substance use, and health promotion activities. Provider and care management protocols will be developed for each of the targeted conditions, symptoms and behaviors.

Standardized Care Management Processes/Activities

The Be Well care management processes have been delineated from successful programs that have reduced hospital admissions and total cost of Care (Schraeder, 2011). The care management process includes engaging the population, a comprehensive assessment, care planning, teaching/coaching enrollee and family self-management skills, medication

management, provider coordination, health promotion activities, proactive monitoring and evaluation, facilitation of communication, evaluation of effectiveness of plan and ongoing guidance and support for self-management, and transitional care. Enrollees are encouraged to assume an active role in the management of their health conditions. It has been shown that collaborative partnerships can increase the efficiency and effectiveness of health care services, enhance accessibility of care, maintain and improve quality of care, decrease costs, and improve enrollee and provider satisfaction (Bodenheimer *et al*. 2002a, 2002b). See *Care Management Activities* section for details.

Education and Training

PCP education will be presented in various modes of communication and will be coordinated by the Clinical Advisory Committee. All providers and their staff will receive an overview of the CCM project at their clinical location. All providers will have access to the web-based training modules on CCM and the Person Care Guidelines and Protocols. Shortened versions of the Care Guidelines and Protocols will be provided to providers in the form of tri-fold pocket cards. After the CCM has become operational, specialist physicians will visit each clinic location every six months for in-depth, case study presentations (academic detailing) on the medical management of persons with complex health conditions.

Nurse Care Managers will complete an education and training program prior to becoming active care manager with a case load of enrollees. This program will include both one-one education with experienced care managers and class room education from nurses and other professionals with expertise in the individual areas. The curriculum will include completion of modules on enrollee engagement, comprehensive assessment, cultural care, care planning,

teaching self-management skills including stages of change and self-efficacy, longitudinal and transitional care management, communication with physicians and other health-care providers, development of collaborative working relationships, medication management, chronic conditions and chronic condition management, behavioral management, substance use evaluation and management, electronic health records, and insurance benefits.

Community Care Navigators will undergo similar education and training prior to active engagement with enrollees. Their curriculum will include completion of modules on enrollee engagement, monitoring and reporting of enrollee conditions, identifying and communicating with community providers, and identification of barriers to care and evaluation of self-management activities. Modules will include assessing current level of knowledge, education on the model topic and evaluation using competency based evaluations. After completion of the modules, nurse care managers and care manager navigators will take part in competency based evaluations including cultural competency. Each year nurses knowledge and skill levels will be assessed through competency evaluations as needed new educational modules will be developed to address any areas of need.

Web-Based Information System

Be Well's Web-Based Information System is a secure, clinical information system that supports the ability to coordinate care across time, settings and providers. Be Well's system combines enrollee socio-demographic and clinical information and produces clinical and administrative reports. The information system will also contain the necessary forms and information for each enrollee in Be Well. The forms that the system will contain are: demographics, strengths/ goals, diagnosis list, utilization, medication list, laboratory information, physical/behavioral health, social relationships, mood, anxiety, substance use, functional,

medical equipment, fall risk, home safety, preventative care, self-management, provider log. In addition, the system will house CCM procedure manuals, clinical protocols/guidelines and enrollee/family self-management guides. The system will also include a Clinical Alert System which will provide an e-mail notification to the CCM team regarding pre-registration, inpatient admission and discharge, ED visits, specialist visits, and other hospital services or outpatient procedures. This system established procedures for timely and effective transitional care planning and provider follow-up before and during hospitalization, and upon hospital discharge to extended care, home care, or ambulatory and community based care.

Care Management Activities

Be Well's CCM is based on the Chronic Care Model (CCM) framework: pertinent medical, behavioral, psychological, and social determinants of health are assessed and a care plan, with evidence-based interventions, is developed, implemented, monitored and evaluated on a longitudinal basis. The specific activities of CCM include: (1) engaging enrollee, (2) completing a comprehensive assessment and reassessment at specific intervals that assesses the risks, needs, and strengths of each enrollee, including knowledge of their health conditions, current level of self management activities, and their own goals of care; (3) developing, implementing, and revising an individualized plan of care based upon evidence based guidelines and protocols which reflects cultural differences and needs; (4) teaching and coaching enrollees and their families about their health conditions and medications, including self-management activities and how to anticipate and plan for their needs based upon their prior responses to their health conditions and contact with the health care system; (5) managing and reconciling medications and referral to pharmaceutical consult services; (6) coordinating and managing services between health/ community care settings and across the continuum of care: (7) ensuring

that enrollees are current on recommended health promotion activities; (8) monitoring proactively to identify changes in their health status or related psychosocial needs; (9) facilitating communication among providers and with enrollee/family; (10) evaluating the effectiveness of the plan of care, and teaching enrollees to evaluate self- management activities; and (11) managing care transitions.

Engaging Enrollees

At Be Well enrollee engagement will start at the initial outreach contact. A study completed by Staudt, Loato, & Hickman (2012) found that participants who had positive initial contacts were more likely to return or more likely to actively participate in subsequent encounters. The authors define engagement as creating a safe environment for the person to share information in and the development of a connection so the person will want to return. Barriers that the person experienced were identified as well. These barriers included: lack of commitment, lack of understanding, lack of trust and environmental constraints or a chaotic environment. Be Well will address these beginning at the initial contact and ongoing by creating a quiet, secure location and providing information through various modes of communication to the potential enrollee with emphasis on how Be Well's CCM can benefit them. After the outreach/enrollment encounter Be Well's CCM team will continue to provide education and support to the enrollee that will increase their knowledge of their specific conditions and how those conditions are managed. The enrollee's assigned care manager will assist them in identifying their individual barriers and collaboratively develop an individualized plan of care that will address these areas.

Comprehensive Assessment/Reassessment

The enrollee/family participates in an initial face-to-face assessment visit with Be Well's nurse care manager. The comprehensive assessment assesses the enrollee's health history and medications; their social, cognitive, physical, mental and behavioral domains; their health and well-being through assessing nutrition, pain, and sleep habits; their safety through the functional and environmental domains; substance use patterns; and their previous service utilization pattern. Enrollees identify their strengths and goals and an evaluation of their current knowledge level, health literacy, self-management skills and ability, and community-based formal and informal care-giving services and needs is completed. Upon completion of the assessment Be Well's nurse care manager, in collaboration with the enrollee's primary care provider/ psychiatrist, evaluates the enrollee's current status and how it aligns with evidence-based guidelines/protocols.

The enrollee/family participates in re-assessments at intervals dictated by the applicable protocol(s), agreed upon plan of care, existing needs, and newly identified problems. Depending on the plan of care, re-assessments may take place via telephone, in the health home, or in the home. All monitoring and/or reassessment contacts include reviews of clinical status, protocol adherence, service needs, available community resources, and the enrollee's self-management skills and progress toward goals.

Care Planning

Assessment data is compiled and used to formulate the development of an individualized plan of care using the evidence based practice guidelines and protocols that Be Well's Advisory Group developed. This plan would be an ongoing framework to guide integrating care. This plan will map out the physical, behavioral, and psychosocial needs, the primary care provider, the health home, the specialty providers and any community service provider appropriate for the

enrollee. The enrollee identifies preferences in current care activities and goals of care/treatment to achieve the best possible outcomes. The PCP, psychiatrist, or APN incorporates disease specific information related to clinical protocols to maximize management. The PCM or TCM identifies interventions and resources to improve the enrollee/family ability to effectively manage their care. The CMN identifies involved community providers and current services in place and those that may be needed. These recommendations for care are collaboratively agreed upon by the enrollee/family and the CCM team. The interventions address the enrollee's health literacy level, promote self-management and self-efficacy, and educate toward wellness, health promotion and prevention of complications. The nurse care manager documents the care and treatment plan in electronic format to facilitate communication across care settings and ease revision of care plans. The care plan is shared with the enrollee in a care plan letter that will specify and reinforce agreed upon interventions and established goals. The care plan is maintained and is accessible by all members of an interdisciplinary team and the enrollee.

When the enrollee has an ED visit or unplanned hospital admission Be Well's TCM proactively identifies discharge and social service needs and updates the plan of care as needed. The TCM works with hospital and other facility and community providers in concurrent review processes as indicated. They review hospital admission information and visit the enrollee/family during their stay. They monitor and reassess enrollees for four weeks post hospitalization, updating the plan of care as needed, and then transition the care of the enrollee back to Be Well's PCM.

Self Management (Teaching/Coaching)

Self management (SM) support has been shown to improve health related behaviors (Schraeder et al. 2011b) by assisting chronically ill enrollees to become actively involved in their

treatment. In order for SM to be successful, the enrollee needs to become informed about their illness, be able to make informed decisions about their care, and become self-motivated. Initially, when establishing an agenda for what needs to occur during encounters, the care management team will use the ask, tell, ask sequence in ensuring the information given to the enrollee is not too much or too little, assess the enrollee's readiness to change with motivational interviewing focusing on behaviors, and goal-setting. The enrollee's health literacy will be assessed using already available tools. Health literacy is the enrollee's ability to understand, interpret and appropriately respond to or act upon health related information such as blood glucose levels, weights or symptoms of their illness that may be signaling an exacerbation or decompensation. Goal setting will focus on concrete, short-term goals with specific action plans to obtain the goal.

Various tools will be used to improve enrollees' ability to self-manage. Personal Health Records (PHR) will be available for enrollees to track their own health appointments, provide a list of their medications, and record key findings from testing. Care protocols will be individualized to meet the enrollee's learning needs and expectations. Self-management protocols focus on enhancing enrollees' ability to understand and participate in managing their chronic conditions and care. In addition to providing the best educational materials available, including audio and video recordings and web links to educational resources, the PCM/CMN will make enrollees aware of opportunities to participate in self-care groups, such as smoking cessation, nutrition, weight management, diabetes management, exercise, fall prevention, and health maintenance programs.

Be Well's guidelines/protocols will contain information on enrollee self-management activities. For example an enrollee with diabetes will need to monitor their blood sugar, identify results that are outside of the normal range and implement a plan to address those results. In Be

Well's CCM the nurse care manager will have protocols that will identify what the normal range of results are; when it is okay for the results to be outside of the normal range; what self-management activities the enrollee needs to perform; and what the options for management are. The guidelines will also contain enrollee handouts that assist the care manager in educating and coaching the enrollee in self-management activities and problem solving.

Medication Management

Medication management is an integral part of care management. Enrollees with multiple chronic conditions are typically prescribed complex medication regimens. The use of multiple medications, changes associated with aging and changes as a result of chronic conditions places enrollees at risk for adverse medication reactions and interactions, falls and other unwanted consequences. Be Well care managers will have the ability to perform a comprehensive medication assessment, communicate with primary care providers and other providers any barriers to adherence, changes in enrollee's ability to self-medicate, indications the medication(s) are not effective, or the enrollee is experiencing unwanted effects. The enrollee's medication knowledge will be assessed using the Medication Knowledge Assessment (ASA and ASCP Foundation 2006). Medication management will be assessed at each encounter and medication reconciliation will occur. Barriers to adherence will be identified and resolved.

Be Well care managers will then address any issues with the enrollee in the enrollee's plan of care. Included will be interventions on enrollee education, medication review with the primary care provider, medication review by a pharmacist, and interventions that enhance the enrollee's ability to self medicate. The goals of medication management are: to improve enrollee outcome and chronic condition management; avoid adverse medication reactions; reduce the incidence of polypharmacy and streamline the medication regimen; improve enrollee's ability at

self-management and self-medication and enhance communication between providers by keeping an updated and complete medication record both in the enrollee's home and in the Be Well's care management web-based information system.

Teaching content includes mechanism of action, expected therapeutic benefits, possible side effects or adverse reactions, what to do if a dose is missed or not taken, what type or self-management activity is needed to monitor the effects of the medication, and who to contact with questions or results outside of their targets. Enrollees and families will be assisted in developing a medication management system that ensures adherence to the regimen. Communication between enrollees/families, their primary care provider /specialist(s), and pharmacy will be supported to help ensure the enrollee has timely refills of medications, therapeutic benefits are being achieved, and side effects are addressed. This support will empower the enrollee and family to identify and communicate problems or barriers to treatment adherence with providers.

Coordination/Management

Be Well CCM coordination/management activities include referral, advocacy, planning and arranging services. The CMN will be instrumental in determining the location of available community resources, making and following up on referrals and educating enrollees/families on how to access services and what services they should expect to receive. The CMN will work with the enrollee/ family to coordinate health services, recommended actions made by providers of these services and reconciliation of medications.

If one of Be Well's enrollees is newly diagnoses with a chronic condition the CMN can provide information to the enrollee/family on available community resources to support the management of the new condition. If the PCP recommends professional services such a therapy

or dietary then the CMN will work with the enrollee and identify any barriers to participation in the service and develop a plan to address the barriers.

Health Promotion

Health promotion activities will be included in Be Well's guidelines/protocols. Health promotion activities will also be included in the enrollee's plan of care. Be Well's nurse care manager will educate and coach the enrollee on the importance of and types of health promotion activities that are needed to support, maintain and improve the enrollee's health status. Primary care providers, APNs and nurse care managers will encourage and facilitate health promotion activities such as exercise, nutrition, and other lifestyle patterns as part of the comprehensive initial assessment and care plan. Recommendations will be provided on preventive practices such as mammograms, prostate exams, routine physicals, and immunizations. The comprehensive assessment will include a thorough review of the enrollee's health promotion status and activities. A nursing protocol will be developed that will allow Be Wells nurse care managers to arrange for needed education, immunizations, and other health promotion activities that will address an identified enrollee's needs.

At Be Well all enrollees are informed of and engaged in health promotion activities. Successful plans of care reveal that enrollees are up-to-date in immunizations and screenings, and they are performing needed health maintenance activities to the best of their abilities. Health promotion activities will be included in Be Well's guidelines and protocols. For example the guideline for COPD will include a nurse care manager protocol for fluogen and pneumovax immunizations. Guidelines on schizophrenia will include protocols for monitoring for and prevention of metabolic syndrome (diet and exercise) if the enrollee is on antipsychotic medications that are known to cause this condition.

Monitoring & Evaluation

Monitoring is a complex intervention because it can impact several interrelated areas. For example, monitoring may result in improvement in health status following implementation of the plan of care, better selection of treatments based on enrollee response, better titration of care, identification of enrollees'/families learning needs, and improved and timely performance of self-management activities.

The purpose of monitoring and evaluating chronically ill enrollees is to improve care effectiveness which has the potential to reduce their overall health care costs (Cesta & Tahan 2003). The monitoring process checks the progression or deterioration of the enrollee's disease processes and determines if any complications have developed. Choosing what to monitor, how to monitor, and the frequency of monitoring are important decisions as they assist in making adaptations to the care plan. Monitoring is conducted by clinicians, enrollee/family, or both. For enrollees/families, monitoring may provide a signal for action or simply provide motivation to follow the care plan. For clinicians, monitoring provides timely proactive information on enrollees' status so that the plan of care can be adjusted as needed. For Be Well enrollees proactive monitoring will be planned into their individualized plan of care.

Proactive monitoring allows Be Well care managers to identify health and/or behavioral/self-management problems before they result in acute crises and serve as a means to reinforce and/or deliver enrollee/family education or other disease management information or counseling according to evidence-based guideline/protocol recommendations. Monitoring also encourages effective communication between enrollees and their health care providers, support for the enrollee/family in navigating the health care system, and coordination and evaluation of care provided by multiple community agencies.

Proactive monitoring will be performed by Be Well's nurse care manager and CMN. They will evaluate and document the enrollee's progress at each contact. Monitoring will be performed in the residence whether institutionalized or community based, in any acute care or short-term rehab facility, in the PCP or psychiatrists office and by telephone. Adjustments to the plan of care will be made based upon the information obtained during monitoring activities.

For example Jim was referred to a specialty provider due to joint pain. It was determined that the joint pain was due to an inflammatory arthritis and that Jim need to be on a tapered prednisone regimen for management. When the PCM meet with Jim at a pre-arranged follow-up home visit Jim's blood sugar was up over 350. Jim did not understand what had happened to make his blood sugar elevate. The PCM contacted Jim's PCP and developed a blood sugar management plan the coincided with Jim's prednisone use and arranged a visit for Jim with his PCP.

Provider Communication Across the Continuum

The Be Well care manager, along with the enrollee/family becomes the communication hub. The care manager will work with the enrollee/ family in facilitating and clarifying communication among the providers. An important role for the care manager is to work with the enrollee/ family in understanding recommendations made to them by providers and establish goals/ strategies for implementing the recommendations. It is also important for the case manager to assist the enrollee/ family in resolving conflicting recommendations made by providers. The CM can visits the enrollee in their home and will be able to relay back to the team their observations and concerns.

Jane has been into see her PCP several times for shortness of breath. The PCP has tried multiple interventions to no avail. Jane is referred to a pulmonologist for evaluation and treatment. The pulmonologist determines that Jane's respiratory system is normal and cannot

find a reason for the shortness of breath. Jane's PCM visits her in her home and evaluates the situation. When the PCM arrives at Jane's home Jane is sitting in the home will all windows and doors locked and everything in the home is covered with a thick layer of dust and cat fur. The PCM realizes that Jane's shortness of breath is due to the environment she is living in. When questioning Jane the PCM further determines that Jane is afraid to open her doors and windows to let fresh air in and now that she is short of breath her activity is limited and she has a hard time cleaning. The PCM and CMN can now work with Jane to develop a plan to address the issues that are causing the shortness of breath.

Plan Evaluation

Evaluation of the implemented plan of care is conducted on an ongoing basis and planned into the plan of care at inception. At each contact, the plan of care is evaluated and adjusted to reflect changes in the enrollee's status and ability for self-management. Identification of both successful and unsuccessful interventions is noted. Unsuccessful interventions are removed from the care plan and the care manager works with the enrollee/ family and primary care provider to determine why the interventions were unsuccessful. New interventions, including those that address any barriers to implementation, are planned, implemented, and evaluated.

At Be Well plans of care will include guideline/ protocol recommendations for management of chronic illnesses. Successful evaluations reveal that enrollees/ family are up-to-date on guidelines/ protocol recommendations. The recommended laboratory and diagnostic testing schedules that monitor the condition (i.e. Hemoglobin Alc, lipid panels, CBC, chest x-rays, electrocardiograms), are completed and current and the enrollee's medication regimes are those recommended by the guidelines/ protocols. As appropriate, the enrollee's family is involved in the plan of care and evaluation.

Managing Transitions

The period following discharge from an inpatient setting is a difficult time for enrollees. They frequently experience a change in medication and self-management needs. According to Kripalani and colleagues (2007), about 19% to 23% of those discharges experience an adverse reaction, typically related to medications. Transitional care is designed to assist enrollees in smooth transition from one location or level of care to another. It is defined as a set of activities that ensure coordination and continuity of care (Coleman *et al*. 2005). After discharge from an inpatient setting adults with multiple co-morbid conditions are frequently challenged with managing a new medication regime and a new set of self management activities. It is imperative that they develop these new skills to ensure management of conditions and prevention of re-hospitalization. Be Well care managers will be knowledgeable in medications and medication management and can assist with medication reconciliation at admission to an inpatient setting, transition from one setting to another and discharge to home. They are also knowledgeable in needed self-management strategies and can assist enrollees/ families in assimilating these into their daily routines.

Be Well care managers not only provide education on medication and self-management techniques, but they can also assist the enrollee/ family in communication strategies to bridge care, identification of needed home care assistance, and identification and management of symptoms. Be Well care managers will collaborate with physicians and other health care providers to provide optimal home assistance and support to the enrollee/ family. Enrollee and family are assisted and encouraged to identify their self-care needs and health status changes and communicate these to their PCP or psychiatrist. It is important for enrollees to be aware of signs and symptoms that signal when their condition is worsening (red flags) and what level of care

they need to seek. Be Well care manages will educate the enrollee/family in these red flags and how to respond to them.

Be Well TCMs with the enrollee/family will update the plan of care and develop a follow-up schedule that optimizes the enrollee's ability to self-manage at home. Follow-up by the Be Well TCM post transition includes, home visits, office visits and phone calls. The type and location of visit is planned into the plan of care. Initial follow-up includes at least weekly contacts and identification of where enrollees/ families can obtain information and guidance if the care manager is not available. The duration of the more intensive and proactive follow-up is dependent upon the enrollee and family and available support systems and will be no shorter than four weeks.

VIII. Information System

Be Well recognizes that electronic capabilities and health information technology are essential to support efficient and effective care management. Be Well will have functioning electronic capabilities supporting care management well within the first 12 months of being awarded a contract. Be Well will have a web-based information system. This web based system will support electronic communication among Be Well's care management staff, the primary care physicians and all other providers in its network. This will support the ability to manage care across time, settings and providers. In addition to electronic communication, Be Well's web based electronic system will be an information storehouse. This repository function will provide secure access for care managers and network providers into an enrollee's socio-demographic and clinical information including the required essential care management forms. Each enrollee will have at least their enrollment data, the delineation of all their providers, their personalized care

plan, their diagnoses, their assessment data, their current medication, their service utilization history, care management notes, a record displaying the enrollee's contacts with their providers and care managers. Additionally, Be Well's electronic web based information system will house the care management manuals, the clinical protocols and guidelines, the patient/family self-management guides and health promotion material. Detail profiles of all providers in Be Well network with the intent to make referrals and access efficient will also be present. The fourth function of Be Well's electronic system is clinical alert notification of care managers and providers. This clinical alert function will provide, an e-mail notification to the care management teams regarding hospital pre-registrations, inpatient admissions and discharges, ER visits, specialist visits and other hospital and/or outpatient services. This establishes procedures for timely and effective transitional care planning and provider follow-up before and during hospitalization and upon hospital discharge to extended care, homecare, or ambulatory and community care. This establishes procedures for the same planning and follow-up with long term care admissions and discharges.

Be Well and its collaborators represent a broad range of technology capacity, ranging from fully integrated electronic health record systems to custom systems supported substantially by manual processes. In order to bridge this disparity of systems (or technology) capabilities and provide the vehicle of coordinated communications, Be Well's core collaborators determined that it needed to implement a common database with common communication systems and processes. Be Well worked with a consultant to identify options and possibilities. This process identified two particular and complimentary web-based solutions:

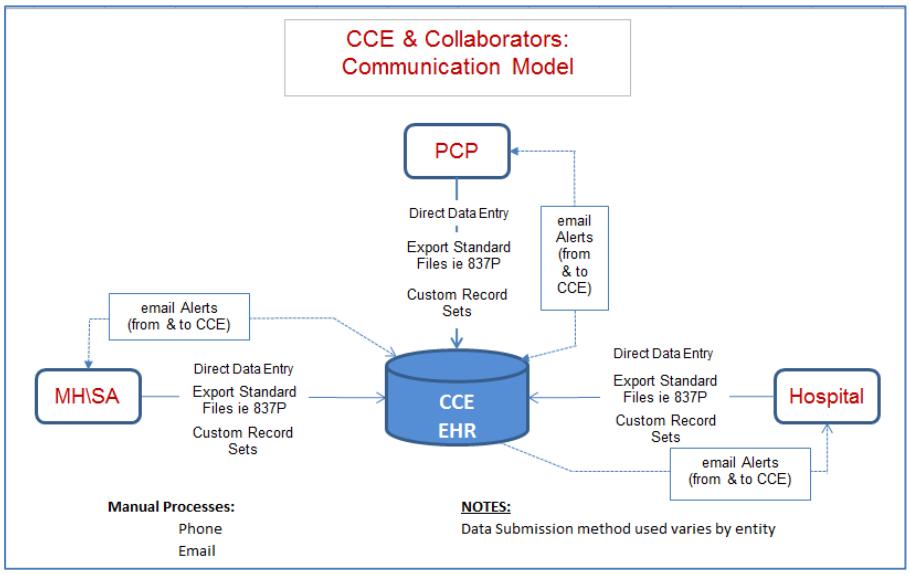
1. Electronic Health Record system ("EHR System"), and
2. Custom Information and Communication Exchange Repository ("Repository").

EHR+ System:

This browser-based application has achieved ONC-ATCB Complete EHR certification. In summary, its suite of applications includes the following:

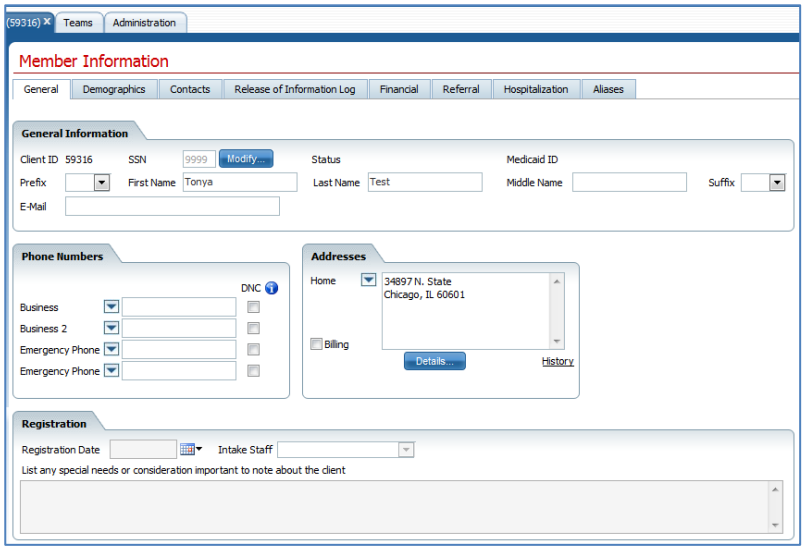
- **Electronic Health Record (EHR):** HIPAA compliant electronic health record for clinicians, supervisors, care managers, doctors and nurses
- **Practice Management (PM):** Registration, scheduling, billing, accounts receivable, scanning and administration for providers.
- **Managed Care (MCO):** Provider contracting, authorizations, claims adjudication for managed care organizations.
- **Medication (Rx):** Integrated electronic prescribing for providers.

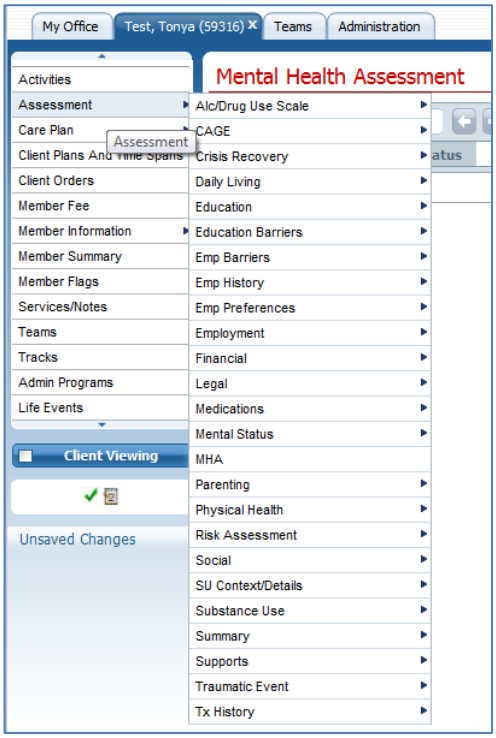
The emphasis of these applications has been on behavioral health. However, primary care functionality is being and will be integrated into this EHR system by the end of 2012. This integration meets the requirements of linking the various Be Well collaborators together. The interoperability of the EHR System is reflected in its flexibility of providing access and data entry capability through direct data entry (DDE) and\or through the importing of standard record formats (ie 837Ps) as well as custom records uploads via flat text files(ie in .csv format). Email alerts will also be generated by the System to advise Collaborators of upcoming, key milestones or events.

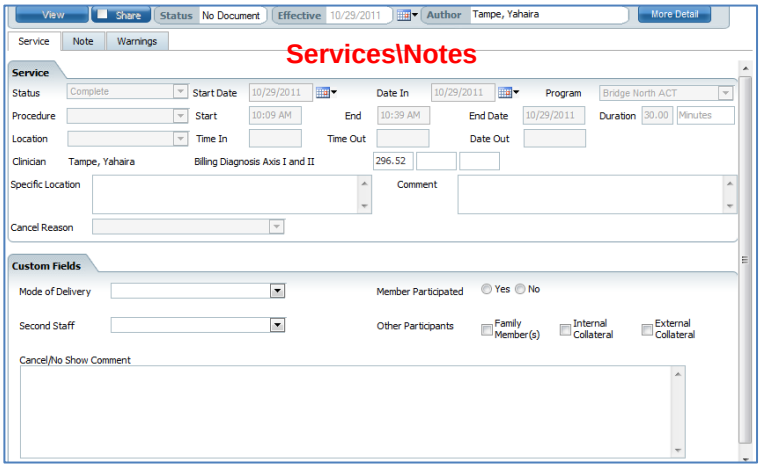


The EHR System will have the ability to collect at a minimum the following data areas:

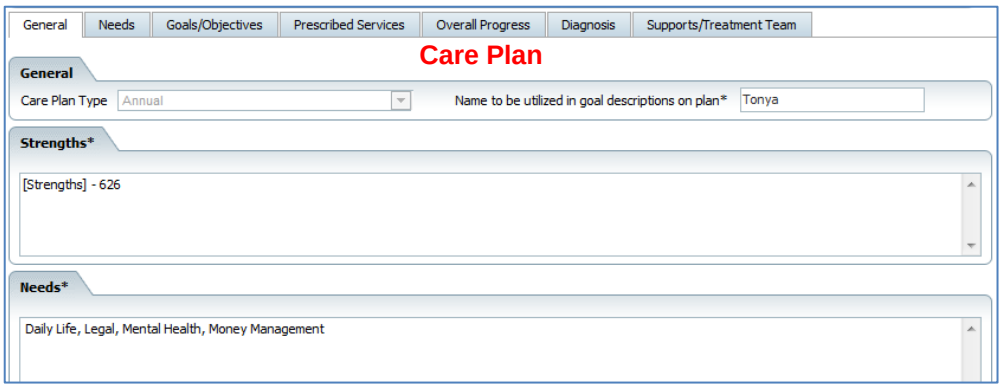
- **Enrollment\De-Enrollment**: Import of EDI270 from Illinois Client Enrollment Broker.
- **Demographics**
- **Screening, Assessments & Risk Assessments**
- **Care Plans**
- **Services/Notes**
- **Medications**
- **Critical Alerts**
- **Procedure Manuals, etc.**
- **Treatment Protocols**







Be Well's system will provide a secure, web-based system that serves as a common repository for Be Well and its collaborators to exchange appropriate documents and communication on key matters. File sharing and the exchange of communication can be set at a one to one level (Be Well to a single provider) or at a one to many (Be Well to multiple providers).



Be Well's electronic information system will comply with all HIPPA requirements and all confidentiality requirements from State law and regulations. Additionally, Be Well is designing procedures in the system that will allow the following considerations.

System:

- User ID and password-based Authentication
- Function-level security groups that feature on\off selection
- Program-level security which restricts user access based on organization, program, location etc
- Encrypts data during authentication

- Change password dialog allows user to change password if needed more frequently than required
- Application requires user to change initial password when logging in for the first time
- Requires password change every to be determined interval
- Locks user out for specified period after a pre-determined number of unsuccessful login attempts.
- Provider restrictions by patient
- Audit trail: Log user log-on\log off of system
- Providers assigned to a Security group for application access.
- Providers cannot change authorization data.

Process:

- Client release of information before setting up Authorizations
- System administrator role clearly defined in assignment of providers\clinicians to clients.
- Define levels of access for care manager supervisor, care manager, provider organization, provider individual role and so on.

Among the core collaborators, Bethany- Methodist Hospital uses Meditech and has registered for electronic health record incentive program payments. Norwegian Hospital is currently implementing Meditech and has registered for electronic health record incentive program payments. Neumann Family Services and MADO Healthcare currently do not have an electronic record system nor have they registered for electronic health record incentive program payments. Among major network providers, Access currently uses EPIC and have registered for electronic health record incentive program payments for phase I. C4 has a custom electronic record and billing system that it has used for 4 years. They are in the final stages of completing an

application for electronic health record incentive program payments. HAS current uses Health Alternative Systems and registered for electronic health record incentive program payments. All providers in Be Well's network have e-mail capability and electronic access to the Web. All providers will be able to upload and download information from their systems into Be Well's information system. All primary care physicians are associated with Bethany-Methodist Hospital and/or Norwegian American Hospital and/or Access. Therefore, all primary care physicians have the capability of using all four functions of Be Well's electronic record system. Be Well's memo of understanding signed by its network's hospitals, mental health providers and substance abuse providers demonstrates their commitment and support of Be Well's electronic record and communication system.

All care managers will use smart phones with the capability to e-mail and access Be Well's information system. A care manager will be able to upload and download information, do e-mail communication, review an enrollee's records and receive critical alerts without being in Be Well's office.

Be Well has already invested over $10,000 in the development of these functions. Be Well core collaborators are ready to make further monetary contributions to this development if awarded a contract.

IX. Evaluation

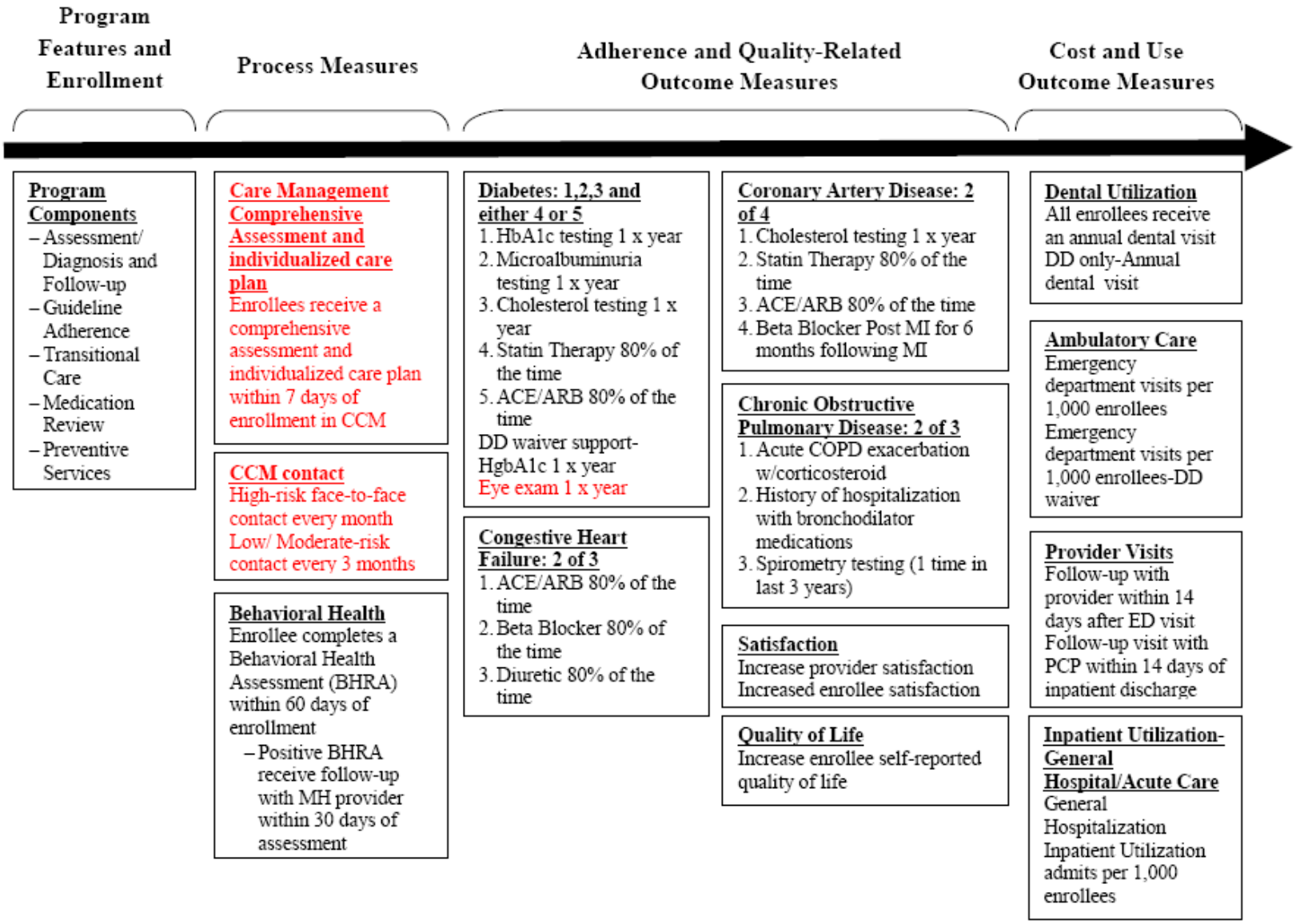
Ongoing evaluation of Be Well's CCM is an essential activity. The design of a management care evaluation, including the focus and methods used, must reflect the shared prospective of the major stakeholders – the funder or funding sources, the sponsoring health care organization, clinical team members, and enrollees. Identifying the sponsoring organization's primary goals for sponsoring the program is a critical element of the evaluation. Also, designing an evaluation strategy *a priori* is important in maximizing the potential applicability of the

program as well as the ability to provide ongoing feedback to stakeholders, especially the care management team (Mollica *et al*. 2003) during the intervention.

> "Evaluation designs typically focus on three primary areas: intervention structure and implementation, quality related care processes and healthcare utilization and cost measures. These areas are evaluated within designs that identify treatment compliance measures and behavioral adjustments that are considered accurate indicators of chronic disease outcomes. The approaches are usually standardized and titrated in terms of doses related to the amount of education, support, and monitoring of clinical markers and behavioral patterns related to specific groups of enrollees" (Dorr *et al*. 2006).

Following is a description of the Quality measures which will be evaluated in Be Well.

Be Well Quality Measures



Follow-up with MH provider 30 days after initial BH diagnosis

Alcohol/Drug Dependence
Initiation and engagement of Alcohol or other Drug (AOD) treatment following new episodes of dependence

Transitional Care:
Follow-up after hospitalization for BH
-7 Days
-30 Days
Follow-up after hospitalization for medical
-7 Days
-30 Days

Medication Reviews
Annual Monitoring
Complete a Medication Review on all enrollees taking 5 or more prescription medications with document plan for reducing medications when appropriate

Medication Reviews
Antidepressant Medication Management
- at least 84 days continuous treatment with antidepressant medication during 114 day period following Index Episode Start Date (IESD)
- at least 180 days continuous treatment with antidepressant medication during 231 day period

Schizophrenia:
percentage of enrollees who maintain medication adherence at 6 months and

Preventive Services
Colorectal Cancer Screening
Breast Cancer Screening
Cervical Cancer Screening
Adult BMI Assessment
Enrollees receive at least one influenza immunization annually
Pneumovax immunization at 65 and per COPD guidelines

Self-Management
Increased number of enrollees with CHF who self-report they weigh themselves daily
Increased number of persons with Diabetes who self-report self-monitoring of blood sugar

Inpatient Utilization-General Hospital/Acute Care
General Hospitalization
Inpatient Utilization admits per 1,000 enrollees

Mental Health Utilization
Mental Health services
Utilization per 1,000 enrollees

In-patient readmits
30 day re-admissions, MH reported separately
90 day re-admissions, MH reported separately

Long-Term Care
LTC-admits due to UTIs
LTC-admits due to bacterial pneumonia
LTC-residents that have category/stage II or greater pressure ulcers

(See Section IX – Evaluation)

Adapted from Dorr 2011

The evaluation plan will track, monitor and report all quality outcomes designated by HFS. We will report all quality indicators on a yearly basis unless otherwise specified. Also, we will track, monitor, and evaluate additional parameters, including program enrollment; process of care measures; disease specific quality of care measures; and health service utilization measures. These additional parameters are outlined in the table below.

Evaluation Parameter	**Measurement Definition**	**When Measured**	**Evaluation Approach**
Program Enrollment	Number of Beneficiaries Enrolled	Every Month	% of actual enrollment vs. projections by risk category and living situation.
Process of Care			
Care Management	Comprehensive Assessment and Care Plan	Every 12 Months	% with assessment and care plan w/in 7 days of enrollment.
Care Management Contact	Number of Face-to-Face Visits and Telephone Contacts	Every 12 Months	High Risk: number of total contacts and % of monthly face-to-face contacts. Low Risk: number of total contacts and % of beneficiaries w/ contact.
Quality of Care			
Preventive Services	Pneumovax Immunization	Every 12 Months	% 65+ years having pneumovax immunization. % having COPD having penumovax immunization per guidelines.
Self Management	Daily Weighing Blood Sugar Monitoring	Every 12 Months	% having CHF and self-report daily weighing. % having diabetes and self-report monitoring blood sugar.

Health Service Utilization			
Hospitalizations	Readmissions	Every 12 Months	% re-hospitalized within 90 days of index hospitalization (all cause). % re-hospitalized within 90 days of index MH hospitalization.

All outcomes will be reported at the program and provider level and shared with individual care teams as part of a continuous overall quality improvement process.

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