Approved by ICNF Board 6/23/2020

ICNF Risk Stratification and Care Management

Definitions

Care Management - This is the term that ICNF will be using for ICNF-delegated care coordination activities.

Sunshine Case Management – Sunshine Health's Case Management program assists members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition

Sunshine Care Managers (CMs) - Sunshine Care Managers (CMs) are designated staff members that support the Sunshine Case Management program. ICNF Attributed Members who are complex will be assigned a Sunshine CM.

Introduction

Health plans use historic claims data, patterns of utilization, pharmacy data and predictive analytics to determine a risk stratification score that is used by the plan to guide case management supports and identify needed services. ICNF has the opportunity to utilize the plan's determined risk stratification for each client and consider factors the plan does not have access to, namely first-hand clinical experience with the client and a nuanced understanding of factors impacting the client's ability to manage challenges and leverage interventions in place. ICNF care management supports offered based on this shared framework can assist ICNF provider organizations in achieving performance outcomes and reducing Total Cost of Care over time.

While Sunshine Health will provide risk tiers and case management to clients categorized as *complex* (Tier 1 and some Tier 2 Sunshine Health members), ICNF provider organizations are expected to determine level of risk for each assigned client upon assignment and quarterly thereafter and provide care management supports needed to help improve health outcomes. The following criteria can be used to identify the level of care management activities needed:

ICNF Level	Sunshine Tier Level	ICNF Level Criteria	ICNF Care Management Tasks/Responsibilities
High	Complex Case Management Assigned/ No Sunshine CM assignment (Tier 1/Could be Tier 2 or 3)	• Multiple chronic health issues (e.g. substance abuse, diabetes; bi-polar episodes resulting in exacerbation of symptoms) which require considerable community interventions • 2 or more ED visits or inpatient admissions in last 4 months • Participation in BH care inconsistent, high percentage of community interventions necessary to ensure engagement • Inability to form therapeutic alliance, necessitating a high level of community interventions initiated by provider • Medication fills inconsistent in last 4 months, requiring community interventions including medication reviews and assistance with filling prescriptions • SDOH needs identified via the organization's standard assessment or other tool (e.g. Sunshine SDOH tool) requiring significant community interventions • Jail and or high level of criminal justice involvement creating barriers and challenges that will require considerable community interventions	• Weekly documentation review • Weekly F2F or phone contact with client
Medium	No Sunshine CM assignment (Tier 2/Tier 3)	• Engaged in care but has complex chronic illnesses with multiple providers involved in care • Contact with ED/inpatient in the last 12 months (if activity is concentrated within last 6 months consider high risk stratification) • Inconsistent medication adherence • Needs assistance addressing social determinants of health	• Bi-weekly documentation review • Bi-weekly F2F or phone contact with client
Low	No Sunshine CM assignment (Tier 3/Tier 4)	• Engaged in BH and medical care; chronic illnesses managed • No ED/inpatient hospitalizations in the last year • Social determinants of health effectively managed • Compliant with medications	• Monthly documentation review* • Check-in with client as clinically indicated *If client is receiving medication management only, documentation review as clinically indicated

Care Management Activities for All ICNF Assigned Clients

- Documentation review includes: review of provider client care data with particular attention paid to task alerts, alerts and new available information; review of care and treatment plans; review of medication use; review of service utilization and claims data to assess if there may be any barriers to care/treatment plan adherence and achievement of treatment goals and outcomes.
- Review and update level of risk for clients upon assignment and quarterly thereafter
- Facilitate Transitions of Care (TOC)
    - Utilize and complete a TOC checklist for all assigned clients (see TOC Recommended Workflow for possible models) Medication review at transition of care point(s)
- Check in with clients on their annual wellness visit by a PCP
    - ICNF provider organizations will ask their clients at least once per year if they have had a wellness visit, and if needed, will assist in obtaining the visit
- Communication/coordination with PCP as indicated
- Documentation of care management activities provided on behalf of an individual client at the individual client and provider level which will be aggregated at the network system of care level. Documentation may be entered directly into ICNF's population health platform, embedded in provider EHR systems that can be integrated to the ICNF designated network system; regular uploads of data; or other means yet to be determined.
- Bring forward care coordination needs related to clients during huddles with Sunshine case management team (as necessary and included in the plan of care)
- Follow Weekly Collaborative Rounds document to ensure clinical communication occurs between ICNF and Sunshine Health