luminare health℠

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Luminare Health Case Management Overview

Individual case management is a voluntary program used to help your employees and their family members enrolled under your Plan to deal with chronic, terminal or catastrophic illness or injuries.

An experienced Luminare Health case manager serves as a liaison between a participant, his/her physician and/or healthcare providers and Luminare Health. This allows for better coordination and monitoring of all of the participant's healthcare needs while keeping everyone who is involved, mindful of the specific requirements, covered benefits, member cost sharing and exclusions associated with your health benefits Plan.

The case manager's involvement includes the acute phase of the illness as well as recovery. This approach provides support along with an additional resource to assist individuals having complex and/or long-term healthcare needs.

The Luminare Health case management program is designed to identify potentially large patient cases that benefit from early identification to affect quality, cost-effective outcomes. They use a collaborative process for assessing, planning, implementing, coordinating, monitoring, evaluating and implementing options and services targeted toward meeting each individual's health needs. Nurse case managers are adept at managing available resources and communicating clearly.

As part of the core case management services, Luminare Health has specially trained, dedicated transplant case managers. If a potential transplant case is identified, Luminare Health offers the patient large case management services. Upon acceptance, a Luminare Health nurse conducts a thorough assessment, which includes collection all available clinical information. Each recommended transplant is forwarded to a physician advisor for peer review in order to confirm that the transplant is medically necessary, appropriate and considered the standard of care versus experimental or investigational. All available documentation, including the results of the transplant evaluation, the transplant protocol and the patient's signed consent form are included in the peer review. If a transplant can be certified as medically necessary and appropriate during peer review, a network Centers of Excellence transplant facility is notified of the certification and referred to a transplant nurse case manager. The case manager monitors the individual's medical progress throughout the transplantation process, from pre- transplantation through post-transplantation.

Case Management Process

Once a patient has been identified as a candidate for case management, a nurse case manager assesses information provided from the referral source and screens it against several criteria for acceptance. Criteria for acceptance into case management include:

- The plan of care must be deemed medically necessary.
- The patient/caregiver must be willing and able to participate in the plan of care.
- There must be documentation of a safe environment in order to provide alternate site care.
- The patient must have an understanding of, and consent to, the treatment plan.
- The plan of care must be cost effective and attempt to improve the quality of life and medical outcomes of the patient being managed.

- The patient/caregiver must have the ability to be educated about the disease process and the plan of care, in an attempt to prevent future exacerbation of chronic illness.
- There is a high probability that value to the payer can be demonstrated through case management interventions.

Once a candidate meets established criteria, a nurse case manager contacts the individual to explain the program and to determine if the individual is willing to participate. Based on client preference, if a candidate cannot be reached via telephone after three attempts, he/she can be mailed an "unable to reach" letter along with detailed contact information.

Specific diagnoses that require mandatory referral for case management assessment and those situations with key indicators of potential catastrophic impact needing assessment for case management are outlined in our HealthCare Management Policy Guidelines for Identifying Potential Case Management Cases. A nurse case manager always assesses direct referrals that have been received from a client, provider, member, utilization review nurse, or other clinician.

While this program is voluntary, Luminare Health experiences high levels of success getting candidates that have been screened for case management to enroll in our program. If a candidate should refuse to participate, Luminare Health discontinues attempts to enroll him/her into the program.

Case Management – Prioritization
Specific diagnoses that require mandatory referral for case management assessment and those situations with key indicators of potential catastrophic impact needing assessment for case management are outlined in our HealthCare Management Policy Guidelines for Identifying Potential Case Management Cases. A nurse case manager always assesses direct referrals that have been received from a client, provider, member, utilization review nurse, or other clinician. Based on the clinical assessment, a severity level is assigned by frequency of case management interventions.

- LEVEL ONE: minimal contact once per week
- LEVEL TWO: minimal contact every 2 to 4 weeks
- LEVEL THREE: minimal contact every four weeks

Urgent assessment and management is performed as indicated by the patient's clinical picture and specific needs at the time of referral.

Process for Identifying Cases by Network Tier
Luminare Health is able to identify cases by network tier and develop a process for sharing that information based on your needs. Conceptually there are no differences in Luminare Health's approach to case management for out-of-network and network care. However, nurse case managers attempt to steer patients enrolled in case management to network providers.

Case Management Termination
In general, when it is determined that continued impact can no longer be achieved and the patient/family no longer has needs that the nurse case manager can address, then the case is closed.

When a member reaches a terminal stage of an illness, Luminare Health works with the member to enter into hospice as it is believed this service is best equipped to handle end of life issues for both the member and his/her family.

Otherwise, case management termination criteria include, but are not limited to the following:

- Voluntarily withdrawal by the patient from the program.
- Procedure/treatment is determined to be not medically necessary.
- Patient care is determined to be custodial.
- Plan of care is not cost effective, not an appropriate utilization of resources and not expected to improve the patient's quality of life or medical outcomes.
- Procedure or treatment is not approved by the Federal Drug Administration (FDA).
- Death of the patient.

Luminare Health Healthcare Management Results
Luminare Health's healthcare management program results are closely aligned with benchmark data for the PPO marketplace. The table below provides a comparison of benchmark results between Luminare Health and the benchmark in the categories of medical/surgical and mental health/substance abuse for Admits per 1000, Days per 1,000 and Length of Stay:

	Luminare Health			Moderate Benchmark		
	Annual Admits/1000*	Annual Days/1000*	Length of Stay (LOS)*	Annual Admits/1000	Annual Days/1000	Length of Stay (LOS)
Medical/Surgical	30.26	151.84	5.02	31.07	142.76	4.59
Mental Health/ Substance Abuse	1.10	17.84	16.22	3.86	31.06	7.08
Total	31.36	169.68	5.41	34.93	173.82	4.98