ACO Technical Assistance: Population Management from Empanelment to Care Coordination

Presented By: Art Jones, MD and Lisa Whittemore, MSW

July 14, 2017
AGENDA

1. Introduction and Goals

2. Provider-Led Medicaid ACOs: A National Context

3. Population Health Overview (Exercise 1)

4. Care Management Structure and Staffing (Exercise 2)

5. Risk Stratification and Social Determinants of Health (Exercise 3)

6. Improving Quality Performance

7. Care Management’s Role in Behavioral Health Integration

8. Incenting Care Management Performance via Distribution of Value-based Payments

9. Wrap up
INTRODUCTION & GOALS
Four-Part Series on Value Based Payment Readiness: Overview

Overview of Readiness Roadmap: How to Succeed in New Environment
• Setting the tone for change
• Review of roadmap
• Building the pyramid: risk stratification

Elements for Success – Finances and Infrastructure:
• Negotiation strategies
• Funds flow, infrastructure investments and levels of risk
• Division of Responsibilities: MCO and ACO
• Compensation systems to align incentives

Elements for Success – Population Management:
• Empanelment/engagement
• Population Management tasks and division of responsibilities
• Care Management Staffing & ROI
• Risk stratification: who to care manage
• BH Integration

Elements for Success: ACO Risk Stratification and Coding for Improvement
• Coding in new MassHealth environment
• Approaches to risk stratification for financial and quality improvements
• Role of social determinants
Discuss aspects of population management important to consider when establishing your models for ACO

Learn from the experience of successful ACO (Medical Health Network) in establishing infrastructure for system transformation and population management

Explore Care Coordination/ Care Management structure and staffing patterns with impact on cost

Risk stratification and impact on Care Management program and decisions

Discuss integration of Behavioral Health and Primary Care

Hear model for funds flow and incentives within the ACO
PROVIDER-LED MEDICAID ACOS
A NATIONAL CONTEXT

Health Management Associates
THE ONGOING EVOLUTION OF HIGH-VALUE CHCs

- Change provider focus from simply service provision to client outcomes
- Increase the delivery of evidence-based care
- Support access to services in the most member-centric fashion
- Expand the use of non-traditional workforce team members
- Improve client safety
- Reduce waste
- Improve provider collaboration across the full continuum of care
MEDICAID ACO: STATE ACTIVITIES

CHALLENGES TO CLINICAL AND FINANCIAL INTEGRATION

- Developing trust, common purpose and accountability
- Consensus on a model of care
- Assignment of care management responsibilities
- Real time connectivity across the full continuum of care
- Value-based metrics and targets
- Reward structure commensurate to contribution in generating payer-incentivized outcomes
Many ACOs have identified one or a few focus areas for improving efficiency and reducing the total cost of care. Which of these focus areas are your top three priorities for 2017?

- Prevent. readmissions/transl. care improvement
- Management of chronic conditions
- Prevent. ED visits/inpatient admissions
- Post-acute care integration
- Mental health care integration
- End-of-life care assessment
- Pharmacy or medication adherence
- Patient engagement
- Palliative care
- Overuse of spec/./redund. imaging & diagnostics
- Surgical care standardization
- Supply chain efficiencies
- Long term care integration

n=168

Yes  No
Please indicate the priority your ACO is placing on each of the following strategies to address acute unscheduled care (e.g. emergency department (ED), urgent care).

Insight: There is greater consensus around preventing ED use with outpatient options than strategies within the ED. Measures and incentives for ED providers lack the most consensus.
Health Care’s Influence on Health Is Limited

Only 10% of health outcomes are associated with health care

90% of health outcomes are associated with factors other than health care

Health Outcomes

10% Health Care

30% Genetics

60% Behavioral, social, environmental
(individual behavioral patterns = 40%
social circumstances = 15%
environmental = 5%)

Upstream Evolution

Source: Schroeder, 2007
INTRODUCTION TO MEDICAL HOME NETWORK: INTEGRATION DRIVING TRANSFORMATION

MHN ACO Population

<table>
<thead>
<tr>
<th></th>
<th>Medicaid Members</th>
<th>ACO % of Total</th>
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</thead>
<tbody>
<tr>
<td>ACA</td>
<td>24,347</td>
<td>30%</td>
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<tr>
<td>FHP</td>
<td>55,170</td>
<td>68%</td>
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<tr>
<td>SPD</td>
<td>1,589</td>
<td>2%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>81,106</strong></td>
<td><strong>100%</strong></td>
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MHN ACO Providers

- 9 FQHCs
- 3 Hospital Systems
- 86 Medical Homes
- *486 PCPs
- 150+ Care Managers
- 1,200 Specialists
- 6 Hospitals

*Includes PAs & APNs

MHN Geography

- Cook County
- City of Chicago

MHN ACO
Partnerships for Better Health
Operated by Medical Home Network

Health Management Associates
LIFE EXPECTANCY ON CHICAGO’S WEST SIDE

Life Expectancy (Years) at Birth by Neighborhood

Medical Home Network | ©2016-17 All Rights Reserved | Proprietary & Confidential
CHICAGO HARDSHIP INDEX

Crowded Housing
Households Below Poverty
Unemployment
High School Graduation
Dependent Population
Income

Hardship Index
(Range: 1 to 98)

Hardship Index Quartile

Q1 (Lowest Hardship)
Q2
Q3
Q4 (Highest Hardship)

### COMMUNITY CENTERED HEALTH HOME APPROACH TO NORTH LAWNDALE

<table>
<thead>
<tr>
<th>Community Development Organization</th>
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<tbody>
<tr>
<td>Housing rehab and affordable new housing</td>
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<tr>
<td>Legal assistance</td>
</tr>
<tr>
<td>After-school and summer programs for youth</td>
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<tr>
<td>Pre-school</td>
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<tr>
<td>Hope House: Escaping street violence lifestyle</td>
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<tr>
<th>Job training and employment opportunities</th>
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</thead>
<tbody>
<tr>
<td>Peer counselling and centering programs</td>
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<tr>
<td>Gyms and fitness centers</td>
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<tr>
<td>Nutrition classes</td>
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<tr>
<td>Healthy food options</td>
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<tr>
<td>Police relations</td>
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<tr>
<td>Political advocacy</td>
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</tbody>
</table>
**Medical Home Network ACO Results: Impact on Cost and Outcomes**

### Total Cost of Care – State Medicaid Pilot

The difference in cost of care for MHN versus other Medicaid patients in IL is 3.5% in Year 1 and 5% in Year 2.

- **Year 1:** 3.5% lower cost (risk adjusted)
- **Year 2:** 5% lower cost (risk adjusted)

**Source:** Findings of the MHN HFS Care Coordination Pilot for the Illinois Health Connect population.

### ACA Utilization - ACO

**Inpatient Days/1000**
- **Year 1 Acute Days/1000**
  - External Network: 659
  - MHN: 568
- **Year 2 Acute Days/1000**
  - External Network: 772
  - MHN: 608

**ED Visits/1000**
- **Year 1 ED Visits/1000**
  - External Network: 907
  - MHN: 743
- **Year 2 ED Visits/1000**
  - External Network: 903
  - MHN: 750

**Year 1 Jul14–Jun15**
- External Network: 14% better outcome
- MHN: 21% better outcome

**Year 2 Jul15–Jun16**
- External Network: 18% better outcome
- MHN: 17% better outcome

**Patient Engagement - ACO**

**MHN ACO:** 86% complete

Period: July 1, 2014 – Present

### Total Cost of Care - ACO

**Contract Year 1**
- **Savings:** $17.7m
- +12.1% variance from target

**Contract Year 2 Q1**
- **Savings:** $6.6m
- +18% variance from target

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THE BUILDING BLOCKS FOR DELIVERY SYSTEM TRANSFORMATION & POPULATION MANAGEMENT

Organizational Structure
- Shared vision & culture of accountability
- Egalitarian governance
- Build trust & common purpose
- Competent leadership

Practice Transformation
- Team-based model of care implemented
- Complex care coordination capability
- Care management at the practice level
- Alternative access to primary care
- Integration of BH and LTSS into model

Workforce Development
- Develop education & training around the new model of care
- Developing new workforce for collaborative care model
- Create pipeline of allied health professionals prepared to work in underserved communities

Connectivity MHNConnect Portal
- Real-time alerts information exchange between hospitals and primary care sites
- Communication & exchange with non-acute settings
- Bridge to social service agencies

Care Management & Analytics
- Timely & actionable reporting based on integrated historical, care management & real-time data
- Advanced analytics to support population management
- Risk-stratification

Patient Engagement
- Fostering the accountable patient
- Remote home monitoring for CHF & hypertension patients
- E-consults & virtual visits

Value-Based Payment
- Pay-for-performance program that rewards process, outcomes & program implementation
- Facilitative financing to support care management at the practice level

Redesign Delivery to Achieve Triple Aim
**Better Health | Better Healthcare | Lower Cost**
THE BUILDING BLOCKS FOR TRANSFORMATION & POPULATION MANAGEMENT

MHN ACO’s Path

Organizational Structure
- Shared vision & culture of accountability
- Established governance
- Competent leadership

Connectivity MHNConnect Portal
- Real-time alerts information exchange between 17 hospitals and 150 primary care sites
- Bridge to social service agencies

Actionable Reporting & Analytics
- Timely & actionable reporting based on integrated historical & real-time data
- Advanced analytics to support high-risk population management
- Transparent provider-performance reporting that drives improvement

Practice Transformation
- Team-based model of care implemented
- Pertinent patient information available at point of care
- Integration of BH and LTSS into model
- Complex Care Coordination Capability

Workforce Development
- Develop education & training around the new model of care
- Create pipeline of allied health professionals prepared to work in underserved communities

Value-Based Payment
- Active pay-for-performance program that rewards reductions in utilization, improvements in quality, as well as program implementation

Patient Engagement
- Fostering the accountable patient
- Remote home monitoring for CHF & hypertension patients
- E-consults & virtual visits

Redesign Delivery to Achieve Triple Aim
- Better Health
- Better Healthcare
- Lower Cost

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MEDICAL HOME NETWORK ORGANIZATIONAL SUCCESS: TRADITIONAL COMPETITORS AS COLLABORATORS

Organizational Evolution

Regional Partnership
Informal collaboration

Not for Profit Corporation
2 Year IL Medicaid Pilot

LLC
Formed ACO to support clinical & financial integration

Funding

Comer Family Foundation Funding
State of IL Medicaid Funding
Payor Funded Contract

Goals

• Planning
• Building Trust & Common Purpose
• Model of Care Development

• Implementation
• Clinical Integration
• Test Integrated Delivery System Capabilities
• Model of Care Refinement

• Contracting Vehicle
• Financial Integration for Total Cost of Care
• Structure to Go Multi-Payer
Success is a team effort, not an individual competition.

CEO participation and emphasis is essential.

Involve the health plan in your operations meetings in a transparent fashion.

Create clear expectations for the health plan and hold them accountable for their performance (timely claims data, carved out services, etc.).

Anticipate that some participants will only deliver when faced with deadlines and significant consequences; plan accordingly.
There is no accountability if it isn’t monitored and enforced with consequences in a timely fashion.

There is a balance between perfect data reports and presenting those reports in a timely fashion.

On the ground care managers should corporately be given decision-making authority and a voice in the larger discussion.

Don’t underestimate the ability of clinicians to undermine change.

Don’t assume, test your hypothesis.
POPULATION HEALTH AN OVERVIEW
CORE COMPONENTS OF POPULATION HEALTH MANAGEMENT

- Member Data Aggregation and Analytics
- Health Risk Assessment and Stratification
- Development of Individualized Care Plans based on Risk Levels
- Member Outreach and Engagement into primary care and to support member self-management
- Care Management
- Disease Management
- Utilization Management
- Care Coordination including addressing gaps in care
- Transitions of Care
- Wellness
- Addressing Social Determinant of Health, including building community partnerships
### POPULATION HEALTH MANAGEMENT CONTINUUM

<table>
<thead>
<tr>
<th>Identify Population</th>
<th>Understand Risk Profile</th>
<th>Manage Care Process</th>
<th>Manage Population</th>
<th>Report Performance</th>
<th>Manage Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build Network</td>
<td>Claims eval</td>
<td>Structured</td>
<td>Population</td>
<td>Standardize Inputs</td>
<td>Optimize claims</td>
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<td></td>
<td>Predictive analytics</td>
<td>documentation</td>
<td>reporting and</td>
<td>Integration of</td>
<td>Incorporate</td>
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<td>Primary care</td>
<td>analysis</td>
<td>claims and</td>
<td>Enhanced</td>
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<td>infrastructure</td>
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<td>clinical</td>
<td>Payments</td>
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<td>Care coordination</td>
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<td>Outreach</td>
<td>Allocate</td>
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<td>Targeted Care</td>
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<td>mechanisms</td>
<td>enhanced</td>
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<td>Processes</td>
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<td>Client</td>
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<td>Network Profiling</td>
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<td>Model Revenues</td>
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<tr>
<td>Member Data</td>
<td>Health Risk Assessment</td>
<td>Care Management</td>
<td>Disease Management</td>
<td>Link to TCOC/</td>
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<td>Aggregation</td>
<td>&amp; Stratification</td>
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<td>Management</td>
<td>Cost and</td>
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<td>Wellness</td>
<td>Quality</td>
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<td>Individualized Care Plan</td>
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<td>Performance</td>
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<td>Development</td>
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**Health Management Associates**
• Process of determining how accountability is assigned to providers for members/patients enrolled in a value-based care program

• Attribution can form the basis for quality measurement, performance reporting, and/or payment
  • Goal is to improve the quality of care, patient experience and cost of healthcare through direct provider accountability

• Attribution implies responsibility for patient care regardless of whether that client has ever seen you

• Attribution becomes the linchpin for all population health management work; how patients/members are attributed guides engagement in different levels of PHM work
Patient Declaration or Choice
This is the “gold standard”

Claims Analysis
Important to identify what elements will be factored into the analysis

Provider Buy-In
Providers typically define “patients” as individuals who have had a visit with them in the past 2 or 3 years.

A PHM attribution methodology requires engagement of individuals who are identified as “attributed” to a provider even without a visit.

A VBC Model encourages shared accountability for engaging all individuals in the appropriate level of care.

Plans can support provider organizations to engage individuals in connecting with the appropriate level of care.

Is this individual eligible?

Is this my employee?
Population Health:

“The health outcomes of a group of individuals, including the distribution of such outcomes within the group.”

- Addresses social determinants of health, population rates
- Useful definition for policy discussions

Population Health Management:

“...a data-driven healthcare delivery model that provides individualized care plans to populations based on health risks and conditions. PHM uses data aggregation, risk stratification, and analytics to design and monitor the effectiveness of treatments and interventions tailored to individual health profiles. The PHM model requires functional integration to deliver coordinated care, clinical integration of providers, and advanced health informatics capabilities to risk stratify and manage the population for quality outcomes.”

- Addresses care needs in populations who are engaged in OR attributed to care organizations.
- Recognizes the components of population health that a health plan and its providers can address alone or in partnership with CBOs upon referral.
- “…encompasses both the population to be managed and the approach chosen to accomplish that goal.”

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In care management models, clients are stratified and cared for based on their needs, diagnoses, risk level/utilization patterns, and eligibility for programs. Engagement and outreach is continuous.
Population Health Management Goal:

+ Ensure all clients engaged in appropriate level of care
+ This could be different for clients with SMI diagnosis as psychiatric provider may act as the PCP
## VBP Payer/Provider Service Continuum: Assess ACO Participants Current State

<table>
<thead>
<tr>
<th>Provider function</th>
<th>Payer function</th>
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<tbody>
<tr>
<td>Inpatient care</td>
<td>Plan billing for consumers</td>
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<tr>
<td>Outpatient care</td>
<td>Risk-pooling</td>
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<td>Disease screening</td>
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<td>Ancillary services (e.g. lab)</td>
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<td>Telemedicine</td>
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<td>Care delivery</td>
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<tr>
<td>Provider management services</td>
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<tr>
<td>Care enhancement</td>
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<tr>
<td>Quality/informatics</td>
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<tr>
<td>Medical management</td>
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<td>Pharmacy</td>
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<td>Member acquisition/management</td>
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<td>Network management</td>
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<tr>
<td>Admin. services</td>
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</tbody>
</table>

- **Inpatient care**
  - Scheduling services
  - Care coordination
- **Outpatient care**
  - Patient billing for services rendered
  - EBM guidelines / care protocols
- **Disease screening**
  - Capacity or access management
  - Provider process & quality improvement
- **Ancillary services (e.g. lab)**
  - Procurement
- **Telemedicine**
  - ACO: financial/data management
  - Compliance management
Providers and payers have different perspectives of the activities that are included in utilization management, case management, and chronic condition management.

The highly regulated nature of the health insurance industry presently requires that payers maintain oversight of functions that they shift to providers.

The current process for function oversight is tightly managed and highly controlled which poses challenges to making it scalable across a large network.

There is a significant change management challenge in sharing accountability between payers and providers. Clear communication of the driving factors behind the strategy to shift accountability will need top-down executive reinforcement as well as bottom-up operational buy-in.

Not all providers within your ACO have the same capacity, expertise, or desire to perform these functions.
POPULATION HEALTH MANAGEMENT FRAMEWORK

Population Health Management Model

Member

- Attribution and Empanelment
- Member Engagement and Care Needs Screening
- Risk Stratification
- Comprehensive Assessment
- Coordination of Care and Services
- Person-Centered Care Planning
- Reassessment

Fundamental Approach

- Member-Centered, Culturally Competent
- Whole Person
- Integrated and Team-based
- Care Management at the point of service (CMs located in provider offices)
- Data-driven: patterns in needs, results of interventions
**Attrition and Empanelment**

- Enrollment file information and claims review
- Outreach to Members, multiple methods, perseverance
- Engage all staff roles in connecting with members not previously engaged with PCPs

**Member Engagement and Care Needs Screening**

- Timely Outreach to all Members attributed the Health Center
- Care Needs Screening within 90 days of enrollment
- Predictive modeling
- Referrals from providers, members, other plan staff

**Risk Stratification**

- Low, moderate, or high risk
- Risk level reflects physical, behavioral, functional, social and overall need for assistance
- Tailored and timely response to identified needs and predicted needs
- Stratification changes as member's needs change

**Comprehensive Assessment**

- Member interview, family/caregiver, formal/informal supports, provider involvement
- Determines need for our tailored CM programs to meet specialized member needs
- Determines intensity and frequency of follow-up
- Completed in the most appropriate setting honoring the preference of each member
Person-Centered Care Planning

- Single point of contact (Care Coordinator or Clinical Care Manager)
- Individualized and person-centered, member is decision-maker
- Establishment of Care Team based on member preferences (minimum member, PCP, CM, BH or LTSS provider)
- Documented Care Plan, available to Care Team, based on assessment and member goals and desires with action steps and ongoing communication plan
- Identification and referral of providers, services and supports (including authorization for LTSS)
- Engagement of PCP treating providers throughout

Coordination of Care and Services

- Ensure providers have authorizations and that services are delivered per the care plan
- Facilitate ongoing communication among the member's Care Team
- Coordinate with State and county agencies, public assistance programs, and other entities serving the member

Care Monitoring

- Measure progress against care plan goals
- Monitor adherence to provider treatment plan and medications
- Quickly identify and address new or changed needs

Reassessment

- Regular frequency based on risk level (no less than annually)
- Whenever the member has a new or changed condition or event
FOR EACH COMPONENT WITHIN CARE MANAGEMENT, NEED TO DEFINE:

- Vision for the future shared of care management accountability
- Your priority populations and plan interventions for those populations
- Your current capabilities, the capabilities of your ACO partner, the capabilities of your MCO partner
- What you need to do to get to the future vision
- How you are going to measure performance
- The implications for staffing at your Health Center, at the ACO, at the MCO
# EXERCISE #1: CRITICAL COMPONENTS FOR COMPREHENSIVE POPULATION MANAGEMENT

<table>
<thead>
<tr>
<th>Population</th>
<th>Current Interventions: Engaged Patients</th>
<th>Current Interventions: Non-Engaged Patients</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-Cost, High Need Patients</td>
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<tr>
<td>High SDH or Economic Barriers to Engagement</td>
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<tr>
<td>Acute Event, Episodic Need</td>
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<tr>
<td>Multiple Complex Conditions</td>
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<tr>
<td>Multiple Chronic Conditions</td>
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<tr>
<td>Unengaged in Primary Care</td>
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</table>
### EXERCISE #1: CRITICAL COMPONENTS FOR COMPREHENSIVE POPULATION MANAGEMENT, CONTINUED

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</tr>
</thead>
<tbody>
<tr>
<td>BH Condition</td>
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<tr>
<td>BH Condition Co-Morbid with Chronic Medical Condition</td>
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<tr>
<td>Substance Use Disorder</td>
<td></td>
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<tr>
<td>Chronic Pain</td>
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<tr>
<td>Unknown to the Health Center</td>
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<tr>
<td>Well Patients</td>
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CARE MANAGEMENT STRUCTURE AND STAFFING
THE BUILDING BLOCKS FOR DELIVERY SYSTEM TRANSFORMATION & POPULATION MANAGEMENT

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- Bridge to social service agencies

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- E-consults & virtual visits

Value-Based Payment
- Pay-for-performance program that rewards process, outcomes & program implementation
- Facilitative financing to support care management at the practice level

Redesign Delivery to Achieve Triple Aim
Better Health | Better Healthcare | Lower Cost

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KEY SERVICE ELEMENT: CARE MANAGEMENT

CARE MANAGEMENT

- Gaps in Care
- Social Determinants of Health
- Disease Management
- Utilization Management
- Transitions of Care

Care Coordination

Enabling: Technology and Standardization
HOW ARE ACOs DEPLOYING CARE COORDINATORS?

Which of the following services do care coordinators in your ACO provide?

- 87% of ACOs say care coordinators are very important or extremely important to the success of the ACO

Insight: Care coordinators are more likely to be used as connectors than for administrative tasks

n=174
CARE MANAGEMENT AND CARE COORDINATION – HOW ARE THEY DIFFERENT?

**Care Coordination**

- Population level management and monitoring
- More “High Tech” than “High Touch”
- Supports Care Management

**Care Management**

- Individually focused coordination and monitoring
- More “High Touch” than “High Tech”
- Supports Individual and Family
Characteristics of Successful Care Management Programs

- Frequent (monthly) in-person meetings with patient plus telephonic contact
- Occasional in-person contact with PCP; PCP had a single CM for all of his/her cases
- PCP access to all key external data
- Provided evidence-based education using motivational interviewing and behavioral-change techniques
- Strong medication management
- Timely and comprehensive transition of care including direct patient contact
CHALLENGED TO CARE COORDINATION SERVICES: MHN ACO IS ADDRESSING MISSING LINKS

- Patients expected to coordinate on their own
- Telephonic care management ineffective in engaging patients
- Lack of timely bidirectional information exchange
- Lack of a systematic, prioritized approach to care management, effective supporting tools, sharable electronic platform and ability to monitor outcomes
- Wrong care in the wrong place at the wrong time
PROCESS AND TECHNOLOGY REQUIRED TO IMPROVE CARE MANAGEMENT

- Care managers employed as part of the care team
- Complex interdisciplinary care team consultations
- Structure and staff to achieve a positive ROI
- Supplemental, electronic patient communication
- Risk stratification that expands beyond claims data
PROCESS AND TECHNOLOGY REQUIRED TO IMPROVE CARE MANAGEMENT

- Actionable real time information to inform decision making
- Care management solution to prioritize tasks & organize workflow
- Lead and lag metrics monitoring
- Outcomes-based payment incentives
- CQI & mentoring of practice-employed care managers
IMPLICATIONS FOR WORKING WITHIN AN PAYER/ACO CONTEXT

+ Payers depend on effective care management to handle financial risk; don’t expect delegation without assuming some of the latter

+ Delegate care management responsibilities based on strengths and competencies

+ Must be able to exchange data and share care plans

+ Meet NCQA and any state specific care management delegation requirements

+ Agree to clear deliverables, metrics, targets and methods for monitoring performance

+ Negotiate a value-based payment that recognizes upfront investment but is ultimately supported by savings from improved management of the full continuum of care
IMPLEMENTATION CHALLENGES TO PROVIDER LEVEL CARE MANAGEMENT

+ Imbedding the care manager as part of the care team
+ Create a common, structured approach to care management with tools, processes, staffing and sharing of care plans
+ Create a model with a positive return on investment
+ Improve on current risk stratification methodology by adding addressable barriers to treatment plan adherence to the usual claims-based diagnosis, utilization and cost factors
+ Inform care management staff with real time information placed in historical context
+ Follow task completion, lead and lag metrics aimed at improved utilization and cost across the full continuum of care
CARE MANAGEMENT: A TEAM APPROACH

- **Chief Executive Officer**- Connects care management to the mission and conveys vision to all Directors

- **Medical Director and Provider Champion**- Engage peers into process by keeping them informed about practice changes, addressing concerns and provide behavior change support. (During provider meetings, rounding and emails)

- **Care Manager Lead**- Directs care management and care coordination teams that execute the process

- **Chief Information Officer**- Creates connectivity with disparity provider entities and actionable data to inform decision-making

- **CFO**- creates a budget with a return-on-investment mentality and monitors performance from that perspective
Someone that has **natural leadership skills**, respect from their peer physicians

They may be in a formal leadership role or not – but they are seen as having a **respected opinion** by their colleagues and peers (formal or informal leader)

Understand the **integration and team approach** to all care – respecting various roles and that while typically clinicians are leading the team, the other roles are vitally important and need to be respected. They **can lead other clinicians to that approach** and ability to “let go” of some of the work that they think they are the only ones that can do.

**Committed to the work** and most ideal would be that they are **given some time to truly lead the work** and be the “champion” – attending meetings, helping to aid in implementation, education to clinicians and other team members
Before Implementation

- This is going to slow me down
- I don’t have time to address one more problem
- This is going to be an anchor
- I already do a good job of treating mental illness

After Implementation

- This takes a load off my plate
- This speeds me up
- I always want to practice like this
- I am giving better care to my patients
- This gives me time to finish my note
## CARE MANAGEMENT: AN INTEGRATED TEAM APPROACH

### Care Manager Role
- Comprehensive risk assessment
- Goal setting
- Medication reconciliation
- Disease management education
- Transitions of care
- Behavioral health referral
- Specialist referral coordination
- Care team communication and supervision

### Care Coordinator Role
- Screening health risk assessment
- Low-intensity social needs referrals
- Assist with coordination needs (appointments, housing, food resources, and transportation)
- Closing gaps in care
- Disease management education as delegated
- Coach patient how to effectively communicate with PCP and care team
MHN ACO – TECHNOLOGY-ENABLED RISK STRATIFICATION DRIVES PRIORITIZED, STRUCTURED WORKFLOWS

Identify & Stratify

Engage & Connect Moderate & High Risk

Plan & Support

Follow Up & Reassess Risk

Transition to Low-Risk Reevaluation in Response to Triggers

Health Risk Assessment (HRA)

Comprehensive Risk Assessment (CRA)

Medication Reconciliation

Care Plan

Reassessment

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Patients who do not require care management, but may have needs for community referrals & education

Barriers addressed in real time by the Care Coordinator/CHW completing the HRA

Action Plan documented in EMR and MHNConnect
MEDICAL HOME NETWORK APPROACH: CARE MANAGEMENT

Complex Care Management

- Care Coordination

- Enrollment
  - Low
    - Social Factors Plan
    - Yearly
    - Reassessment as needed
  - Med
    - CRA
    - Med Rec
    - CP
    - 90 days
  - High
    - CRA
    - Med Rec
    - Reassessment as needed
    - CP
    - 30 days

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PRACTICE-LEVEL VS. CENTRALIZED CARE MANAGEMENT

**Practice-level Care Management**
- Builds on established patient relationships
- Requires structure and oversight
- Drives shared incentives and alignment

**Centralized Care Management**
- Challenged engaging patients
- Challenged engaging PCPs
- Limited access to EMR data

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CONNECTIVITY, COMMUNICATION & COLLABORATION ACROSS THE CONTINUUM
Health Risk Assessment

High-level responses drive more detailed assessments (e.g., PHQ-2 to PHQ-9)

Comprehensive Risk Assessment

Goals created based on assessment results

Patient Care Plan

Integrates care plan tasks across patient care team (e.g., BH and PCP)
STRUCTURED AND INFORMED CARE MANAGEMENT
Organizes & Prioritizes Care Management Tasks to Optimize Resource Allocation

Organize Real-Time Tasks

Risk Drives Care Gaps and Follow up Tasks

Scheduled Patient Tasks
**CARE PLAN**

**Developed/Updated:** [Date], **Reviewed w Patient:** [Pt Signature]

<table>
<thead>
<tr>
<th>Care team member</th>
<th>Name of provider</th>
<th>Best number to reach care team member</th>
<th>Contact frequency plan</th>
<th>Last known contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse CM</td>
<td>Pam Jacobs, RN</td>
<td>XXX-XXX-XXXX</td>
<td>Monthly</td>
<td>11/12/13</td>
</tr>
<tr>
<td>PCP</td>
<td>Dr. Greg Smith</td>
<td>XXX-XXX-XXXX</td>
<td>Q 3 mo</td>
<td>11/12/13</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Afgpdfjj</td>
<td>YYYY-YYYY-YYYY</td>
<td>As needed</td>
<td>8/10/12</td>
</tr>
<tr>
<td>Dental</td>
<td>dfsg</td>
<td>ZZZ-ZZZ-ZZZZ</td>
<td>Q 6 mo</td>
<td>5/28/13</td>
</tr>
<tr>
<td>Social Work</td>
<td>SA’FehFA</td>
<td>222-222-2222</td>
<td>As needed</td>
<td>11/12/13</td>
</tr>
<tr>
<td>Psychologist</td>
<td>Sd[go]</td>
<td>333-333-3333</td>
<td>Weekly</td>
<td>11/12/13</td>
</tr>
</tbody>
</table>

**Conditions**

<table>
<thead>
<tr>
<th>Diabetes (DM Type II)</th>
<th>Control</th>
<th>Action plan updated</th>
<th>Active SM Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>So-so (3 of 5)</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>[Med adherence]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asthma</th>
<th>Very good (5 of 5)</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Poor (1 of 5) [Unresponsive to meds]</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

**Referral for:**

<table>
<thead>
<tr>
<th>Psychiatrist</th>
<th>Non-response to anti-depressive med</th>
<th>Pending</th>
<th>None</th>
<th>NA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFT</td>
<td>Rule out restrictive component</td>
<td>Complete</td>
<td>1/22/13</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Social Svc</td>
<td>XXX</td>
<td>Pending</td>
<td>1/29/13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Factors Affecting Healthcare**

| Literacy, Depression |

**Hospital / ER utilization**

| 12/2/12 (ER, Hypoglycemia) |
| 2/4/12 (ER, Pharyngitis) |

**Medications (last reconciled 11/12/2013)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Use Qtr/Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin glargine</td>
<td>60%/80%</td>
</tr>
<tr>
<td>Insulin Regular</td>
<td>30%/60%</td>
</tr>
<tr>
<td>Advair Diskus</td>
<td>50%/75%</td>
</tr>
<tr>
<td>Albuterol inhaler</td>
<td>47%/22%</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>60%/60%</td>
</tr>
</tbody>
</table>

**Transportation notes**

| 8 bus passes monthly |

---

**Contact phone numbers**

| XXX-XXX-XXXX (Primary) |
| XXX-XXX-XXXX (Home) |
| YYYY-YYYY-YYYY (Cell) |
| ZZZ-ZZZ-ZZZZ (Emergency) |
ENHANCING CARE MANAGEMENT WITH INTEGRATED MULTI-MODALITY PATIENT COMMUNICATION

- **Patient-Caregiver** 1-on-1 communications
- **Care Team** communications can include family, others
- **Outreach Campaigns** templates, lists, track results
- **Educate Patients** deliver text, images, video
- **Assess Patients** to identify risk, track outcomes
- **Biometric data** capture and report measures
- **Multiple modes** web, mobile, text, IVR, and live video
- **Integrated** with provider and patient workflows
CARE MANAGEMENT REPORTING

Targeted reporting to improve Care Manager resource allocation and efficiency
### SAMPLE CARE MANAGEMENT DASHBOARD

**MHN ACO: Current Members - Current Risk Level**

<table>
<thead>
<tr>
<th>Monthly</th>
<th>Completes</th>
<th>ACO Average</th>
<th>Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Count</td>
<td>14001-15000</td>
<td>70%</td>
<td>14001-15000</td>
</tr>
<tr>
<td>GSA Count</td>
<td>14001-15000</td>
<td>70%</td>
<td>14001-15000</td>
</tr>
<tr>
<td>Care Plan Count</td>
<td>14001-15000</td>
<td>70%</td>
<td>14001-15000</td>
</tr>
</tbody>
</table>

**Weekly Completion**

<table>
<thead>
<tr>
<th>What we are measuring</th>
<th>Completes</th>
<th>ACO Average</th>
<th>Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>BI Monthly</td>
<td>70%</td>
<td>14001-15000</td>
<td>70%</td>
</tr>
<tr>
<td>GSA Monthly</td>
<td>70%</td>
<td>14001-15000</td>
<td>70%</td>
</tr>
<tr>
<td>Care Plan Monthly</td>
<td>70%</td>
<td>14001-15000</td>
<td>70%</td>
</tr>
</tbody>
</table>

**Members Excluded from Care Management**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Patients</td>
<td>50%</td>
</tr>
<tr>
<td>Opt Outs</td>
<td>70%</td>
</tr>
<tr>
<td>La Raya</td>
<td>70%</td>
</tr>
<tr>
<td>Total</td>
<td>70%</td>
</tr>
</tbody>
</table>

**Reduce Inappropriate Readmission Rates**

<table>
<thead>
<tr>
<th>What we are measuring</th>
<th>Number of Discharge</th>
<th>Patient Readmitted with 7 Days</th>
<th>Pro-Bi Needed Appointments</th>
<th>Pro-Bi Appointments</th>
<th>Appointments Scheduled</th>
<th>Appointments Completed within 7 Days</th>
<th>Goal</th>
<th>Ranking</th>
<th>Discharge Period Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>BI Monthly</td>
<td>70%</td>
<td>14001-15000</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GSA Monthly</td>
<td>70%</td>
<td>14001-15000</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Plan Monthly</td>
<td>70%</td>
<td>14001-15000</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Care Management Process**

<table>
<thead>
<tr>
<th>Care Management Process</th>
<th>MHN ACO</th>
<th>MHN ACO</th>
<th>Data Period Reported (if any))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total MHN ACO</td>
<td>70%</td>
<td>14001-15000</td>
<td>70%</td>
</tr>
<tr>
<td>All Products Combined</td>
<td>70%</td>
<td>14001-15000</td>
<td>70%</td>
</tr>
<tr>
<td>High Income</td>
<td>70%</td>
<td>14001-15000</td>
<td>70%</td>
</tr>
<tr>
<td>Medically needy</td>
<td>50%</td>
<td>14001-15000</td>
<td>50%</td>
</tr>
<tr>
<td>ACA Members</td>
<td>75%</td>
<td>14001-15000</td>
<td>75%</td>
</tr>
<tr>
<td>High Income</td>
<td>75%</td>
<td>14001-15000</td>
<td>75%</td>
</tr>
<tr>
<td>Medically needy</td>
<td>50%</td>
<td>14001-15000</td>
<td>50%</td>
</tr>
<tr>
<td>TIP Members</td>
<td>75%</td>
<td>14001-15000</td>
<td>75%</td>
</tr>
<tr>
<td>High Income</td>
<td>75%</td>
<td>14001-15000</td>
<td>75%</td>
</tr>
<tr>
<td>Medically needy</td>
<td>50%</td>
<td>14001-15000</td>
<td>50%</td>
</tr>
<tr>
<td>IOP Members</td>
<td>75%</td>
<td>14001-15000</td>
<td>75%</td>
</tr>
<tr>
<td>High Income</td>
<td>75%</td>
<td>14001-15000</td>
<td>75%</td>
</tr>
<tr>
<td>Medically needy</td>
<td>50%</td>
<td>14001-15000</td>
<td>50%</td>
</tr>
</tbody>
</table>

Dashboard provided courtesy of Medical Home Network – not for duplication.
EXERCISE 2
CREATING A CARE TEAM WITH A POSITIVE ROI
RISK STRATIFICATION INCLUSIVE OF SOCIAL DETERMINANTS OF HEALTH
Identifying Rising Risk Through Addressable Medical, Behavioral and Social Factors

- **Rising Risk**
  - Super Utilizers
  - Inefficient Utilizers, with significant psychosocial risk factors
  - High risk, chronic illness with psychosocial barriers to adherence to care plans
  - Low risk chronic illness
  - Healthy

Focusing exclusively on High Cost Utilizers doesn’t prevent them in the first place*

*Denver Health Health Affairs, 34, no.8 (2015):1312-1319
MHN judges effective care management by its ability to lower patient risk

### Medical Complexity
- **High Risk**
  - Frequent ED Use
  - Avoidable Hospitalization
  - Chronic PQI (potentially avoidable hospitalization)
  - Gaps in Care
- **Low Risk**

### Behavioral Health Complexity
- **High Risk**
  - Hospitalization or ED Use for SMI or SA
  - High PHQ9
  - Untreated SA
- **Low Risk**

### Social Complexity
- **High Risk**
  - Barriers to therapeutic compliance
- **Low Risk**
Topics Covered:

- Responses stratify patients into 3 risk categories
- 20 questions take 5-7 minutes to complete
- Addresses:
  - Hospitalization/Emergency Department usage
  - Barriers to care (transportation, $$ for meds)
  - Health risk factors: BMI, smoking, ETOH/drugs
  - Social Determinates of health: Housing/food/clothing
  - Depression
- Adult & Pediatric HRA
Engage the whole care team; train registration, operators, MAs, nurses on appropriate workflow to complete HRA on all ACO patients;

Use enrollment staff by completing HRAs on all patients when they apply for Medicaid;

Update financial class for all ACO patients in EHR/PM system on a monthly basis and flag patients that are due for HRA;

Check all available systems to find correct phone number (practice EMR, hospital EMR/portal, health plan portal). Missing and incorrect telephone numbers are an issue and need to be validated each and every time there is an encounter with the patient;
MEMBER OUTREACH AND ENGAGEMENT: LESSONS LEARNED

+ Develop and follow a HRA Script
  • When you reach the patient, identify yourself as being an assistant to Dr. (PCP) or as working for the health center
  • Engage in a conversation at first and then bring up completion of the HRA, its purpose and the confidentiality of the information
  • Prepare them that it will only take 5 minutes to complete;

+ Adjust staff schedules to do HRA calls during evenings and on Saturdays; run HRA reports to identify the best times and days for successful HRA completion for your sites;

+ Use real time ADT feeds to contact members while they are in the ER/Inpatient to do HRA over the phone
MEMBER OUTREACH AND ENGAGEMENT: LESSONS LEARNED

- Track staff HRA completion performance and set weekly goals; reward highest performer; overtime can be awarded to the most productive individuals; provide feedback; celebrate successes;
- Create friendly competitions within the ACO;
- Have HRA drives;
- Persistence is key; multiple attempts (at least three on different dates and times) even for disconnected numbers; minutes may have run out on patient phones and they may be renewed for the month;
- Mailing out HRAs and home visits had very low ROI.
Q-CM – Complex Medically

Q-C² – Complex Medically and Psychosocially

Team Enhanced Care, RN Coordinated:
Complex medically, Straightforward socially

High Intensity Team Enhanced Care
(One designated patient point person):
Complex medically, Complex socially

Usual Care:
Straightforward medically, Straightforward socially

Team Enhanced Care, Social Work Coordinated
Straightforward medically, Complex socially

Q-SF – Straightforward

Q-CS – Complex Socially
## ENHANCED RISK STRATIFICATION: KEY TO CARE MANAGEMENT EFFICIENCY & IMPROVED OUTCOMES

### MHN ACO Medicaid Expansion Population Experience

<table>
<thead>
<tr>
<th>HRA Risk Profile</th>
<th>Count</th>
<th>% Members with No Claims</th>
<th>ER Visits /1000</th>
<th>Inpatient Admits /1000</th>
<th>Medical &amp; Rx Cost</th>
<th>Relative Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low by Utilization without any Impactable Risk Factors</td>
<td></td>
<td></td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Low by Impactable Risk Factors</td>
<td></td>
<td></td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Medium by Impactable Risk Factors</td>
<td></td>
<td></td>
<td>↑</td>
<td>↑↑</td>
<td>↑↑</td>
<td>↑↑</td>
</tr>
<tr>
<td>High by Utilization +/- Impactable Risk Factors</td>
<td></td>
<td></td>
<td>↑↑↑↑</td>
<td>↑↑↑↑</td>
<td>↑↑↑↑</td>
<td>↑↑↑↑</td>
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<tr>
<td>High by Impactable Risk Factors</td>
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<tr>
<td>Total</td>
<td>5,798</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Source: MHNConnect & CountyCare Claims Data

### PROSPECTIVE ANALYSIS FINDINGS

1. MHN ACO’s risk stratification algorithm **accurately correlates with subsequent cost of care**
2. **Presence of impactable risk factors** even in the absence of historical high inpatient or emergency room utilization predicts **increased hospital utilization and total cost of care**
EXERCISE 3
RISK STRATIFICATION ALGORITHMS
# TANF Adult Population

Claims incurred January – June 2016

<table>
<thead>
<tr>
<th>Social Factors</th>
<th>Social Factors &gt;=4</th>
<th>Social Factors &lt;4</th>
<th>No HRA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDPS &gt;=3.5</td>
<td>0.14%</td>
<td>1.29%</td>
<td>0.24%</td>
<td>1.67%</td>
</tr>
<tr>
<td>Average PMPM</td>
<td>$1,062</td>
<td>$1,855</td>
<td>$1,241</td>
<td>$1,700</td>
</tr>
<tr>
<td>3.0&lt;=CDPS&lt;3.5</td>
<td>0.13%</td>
<td>0.60%</td>
<td>0.08%</td>
<td>0.81%</td>
</tr>
<tr>
<td>Average PMPM</td>
<td>$641</td>
<td>$438</td>
<td>$822</td>
<td>$509</td>
</tr>
<tr>
<td>2.5&lt;=CDPS&lt;3.0</td>
<td>0.12%</td>
<td>0.93%</td>
<td>0.20%</td>
<td>1.25%</td>
</tr>
<tr>
<td>Average PMPM</td>
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<td>$528</td>
<td>$704</td>
<td>$563</td>
</tr>
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Total population = 15,847

- Combines number of social factors reported from HRA and CDPS scores for a hybrid risk stratification method.
- CDPS score breakouts too granular to use, but confirms 3.5+ threshold for high risk.
### FHP Adult Population: Recommendations for Future Risk Stratification

Claims incurred January – June 2016

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**Total population =** 15,847

- Combines self-reported utilization from HRA and CDPS scores for a hybrid risk stratification method

---

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PROCESS FOR IMPROVING QUALITY PERFORMANCE
Why a RIE?

Hosted on May 18th, 2017 12:00pm – 4:30pm

• Goals
  • Analyze current HEDIS performance
  • Review all eight HEDIS P4P measures and identify best practices/recommendations
  • Identify next steps as an ACO and at an organization level to improve HEDIS performance

• Priority
  • Member-PCP bonding
  • P4P dollars
  • Default assignment of members
**EXAMPLE: RAPID IMPROVEMENT EVENT**

### CDC- A1c

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**CDC- Nephropathy**
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### RAPID IMPROVEMENT EVENT: EVENT NOTES

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| **CDC – Eye Exam** | • Provider sends referral but does not follow up  
• Lengthy referral process (auth issues, missed appt, no consult note, unable to reach patient)  
• Authorization issues – website says authorized but opth still wants proof  
• Provider did not refer for eye exam  
• Provider identification of gaps not easy  
• New patients with no diagnosis of CM present in chart  
• Patients do not associate eyes with diabetes (don’t understand necessity of eye exam)  
• Lack of resources to manage patients timely | • No retinal camera – have to refer out  
• Authorizations delay process  
• Complex patients, too many specialty referrals to go to  
• Unsure how to bill for service  
• Lack of education  
• Do not get report back from specialist  
• Don’t know exam was done  
• Access difficulty to specialists  
• Release of information required to get info from specialist  
• Camera breaks | • Do eye exam in house/telemedicine (5 votes)  
• **Cameras in clinic** (12 votes)  
• Follow-up process to obtain referrals (care managers/care coordinators) (1 vote)  
• Close referral loop  
• Change standard to every 2 years  
• **Care coordination navigators to obtain results** (8 votes)  
• Automate referral back once result is completed “hospital connect” (2 votes)  
• Information exchange agreement (2 votes)  
• Diabetes health care event (multiple services/one stop shop) (3 votes)  
• Incentive program (1 vote)  
• Education that release not needed | Patients included in measure who don’t have diabetes |

| **CDC- Nephropathy** | • Tested, billed but not reflected as met  
• Patient does not have diabetes  
• Did not come back for lab testing  
• Provider sent referral but patient has not followed up  
• Failure of patients showing up for visit  
• Resolved diabetes  
• No provider reminder | • Hospital or external billing  
• Patient not compliant  
• Provider reminder not built into system | **Care coordinator follow-up** (6 votes)  
• **Broad outreach calls**  
• **Use population health to identify care gap** (8 votes)  
• Add health alerts in medical record  
• Follow-up call if missed (5 votes)  
• Chronic no show refer to BH (1 vote) | Patients included in the measure who don’t have diabetes, patient tested and billed to CountyCare but not reflected in Vision data? Can we get a process of how to submit proof to CountyCare? |
<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>Issues</th>
<th>Root Causes</th>
<th>Solutions</th>
<th>CountyCare Questions/Issues</th>
</tr>
</thead>
</table>
| CCS – cervical cancer screening | • PCP not doing paps  
• Male patient in denominator  
• Patient had different insurance/no insurance on date of service  
• Patient had an order but test wasn’t completed  
• Providers not educating patients  
• Lack of history on pap documentation in chart  
• Patient non-compliant  
• Lack of preventive out-reach  
• Lack of data and tools  
• Clinical practice guidelines say if normal, paps can be completed every 5 years instead of 3  
• No wellness visits | • PCPs not conducting paps, not collecting history (not enough time during visit)  
• Clinical guidelines don’t align with HEDIS | • Outreach using patient reports (9 votes)  
• Transparent provider dashboard (5 votes)  
• Individual provider improvement plans (1)  
• Provider incentivization  
• Provide preventive health education to patients (based on gaps of care) (2 votes)  
• Texting apps, based on age and sex e.g. Text for Baby (8 votes) | Males in denominator |
| FUH- follow-up after hospitalization for mental illness | • Non-compliant patients  
• No discharge documentation  
• Not proper authorization on file to get records  
• Disconnect between the psych providers and PCP  
• Unable to retrieve outside psych records  
• Lack of discharge planning – no follow up appt scheduled  
• Lack of information about patients  
• f/u happened but was too late | • Not all hospitals are in portal, unable to be aware of discharge  
• No access to patient information, hard to get records  
• Release of information needs to be signed  
• Unaware patient was hospitalized  
• Cant reach patient  
• Cant tell in MHNConnect if BH admission | • BH network to address social determinants  
• Joint case conferences (2 votes)  
• Variety of type of appointments  
• Complete care plans together with BH And medical  
• Rush send BH auths to clinics (7 votes)  
• Schedule for PCP f/u and do warm hand-off to BH (prevents stigma issues) (9 votes)  
• Add hospitals to portal (7 votes)  
• TOC type intervention (3 votes)  
• Plan for complex patients (2 votes) |
• Quality Operations Meeting
  • July 14th 9:00-11:00
  • Operations lead(s) must be identified to join
  • Define responsibility by role for potential implementation and
daily workflow responsibility (ie. PCP, MA, Care Coordinator,
Operations Lead, etc)
  • Establish Priorities for implementation
• Ask each medical home to evaluate
feasibility/applicability of selected recommendations
  • Each medical home will evaluate with CMO, Operations Lead,
and Quality Lead
  • Develop implementation plan
• Determine where additional resources are needed and
the associated costs for implementation (i.e. retinal
cameras)
• Subcommittee compiles overall implementation plans,
schedule, and monitoring process
CARE MANAGEMENT’S ROLE IN BEHAVIORAL HEALTH INTEGRATION
COLLABORATIVE CARE MODEL: WHY DEPRESSION?

Physical Health Condition + Behavioral Health Condition =

- 2-3 fold increase in cost
- 30 day readmissions
- Frequent ED visits
- Worse Outcomes
- Early mortality

Melek S et al APA 2013 [www.psych.org](http://www.psych.org)
• Issues with depression and substance abuse can be pre-empted, rather than progressing to diagnosis

• Goal is to detect early and apply early interventions to prevent from getting more severe
# Ongoing Initiatives: MHN ACO’s Emphasis on Behavior and Social Factors

<table>
<thead>
<tr>
<th>Medical Home</th>
<th>Sample Size</th>
<th>% No PHQ9</th>
<th>% PHQ9 &lt; 10</th>
<th>% PHQ9 with 10 or higher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice #1</td>
<td>50</td>
<td>38%</td>
<td>28%</td>
<td>34%</td>
</tr>
<tr>
<td>Practice #2</td>
<td>50</td>
<td>50%</td>
<td>24%</td>
<td>26%</td>
</tr>
<tr>
<td>Practice #3</td>
<td>50</td>
<td>12%</td>
<td>48%</td>
<td>40%</td>
</tr>
<tr>
<td>Practice #4</td>
<td>50</td>
<td>56%</td>
<td>6%</td>
<td>38%</td>
</tr>
<tr>
<td>Practice #5</td>
<td>50</td>
<td>78%</td>
<td>18%</td>
<td>4%</td>
</tr>
<tr>
<td>Practice #6</td>
<td>50</td>
<td>34%</td>
<td>44%</td>
<td>22%</td>
</tr>
<tr>
<td>Practice #7</td>
<td>50</td>
<td>96%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Practice #8</td>
<td>50</td>
<td>68%</td>
<td>6%</td>
<td>26%</td>
</tr>
<tr>
<td>Practice #9</td>
<td>219</td>
<td>37%</td>
<td>15%</td>
<td>48%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>619</strong></td>
<td><strong>48%</strong></td>
<td><strong>19%</strong></td>
<td><strong>33%</strong></td>
</tr>
</tbody>
</table>

63% of those with a positive screen on the PHQ2 questions scored 10 or higher on a subsequent PHQ9
Collaborative Care is a specific type of integrated care that operationalizes the principles of the Wagner Chronic Care Model to improve access to evidence based mental health treatments for primary care patients.

**Core Principles of Effective Collaborative Care are:**

- Team-driven collaboration and Patient-centered
- Evidence-based and practice-tested
- Measurement-guided treatment to target
- Population-focused
- Accountable care

http://aims.uw.edu
COLLABORATIVE CARE: USING E-CONSULTS

Collaborative Team Approach

- PCP
- Patient
- BHCC/Care Manager
- Consulting Psychiatric Provider
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

New Roles

Core Program

Additional Clinic Resources

Outside Resources

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**Collaborative Care Model Dashboard DRAFT**

**What we are measuring…..**

<table>
<thead>
<tr>
<th>Medical Home</th>
<th>Allocated FTE</th>
<th>Current Month of Program Rollout</th>
<th>Current Caseload Actual</th>
<th>Current Month caseload goal</th>
<th>3 Month Caseload Goal: 50%</th>
<th>6 Month Caseload Goal: 100%</th>
<th>#/% Patients with 50% Reduction in PHQ-9</th>
<th>Reduction Goal *national standard is 40%</th>
<th>#/% Patients in remission (PHQ-9 &lt;5 PHQ9)</th>
<th>Remission Goal *National standard is 20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice #1</td>
<td>1.15</td>
<td>6</td>
<td>71</td>
<td>92</td>
<td>46</td>
<td>92</td>
<td>3 (4%)</td>
<td>40.0%</td>
<td>0 (0%)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Practice #2</td>
<td>2.32</td>
<td>6</td>
<td>71</td>
<td>186</td>
<td>93</td>
<td>186</td>
<td>27 (27%)</td>
<td>40.0%</td>
<td>2 (2%)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Practice #3</td>
<td>0.51</td>
<td>5</td>
<td>28</td>
<td>34</td>
<td>20</td>
<td>41</td>
<td>13 (39%)</td>
<td>40.0%</td>
<td>3 (9%)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Practice #4</td>
<td>1.43</td>
<td>5</td>
<td>82</td>
<td>95</td>
<td>57</td>
<td>114</td>
<td>12 (10%)</td>
<td>40.0%</td>
<td>4 (3%)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Practice #5</td>
<td>0.52</td>
<td>5</td>
<td>28</td>
<td>35</td>
<td>21</td>
<td>42</td>
<td>7 (21%)</td>
<td>40.0%</td>
<td>0 (0%)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Practice #6</td>
<td>2.71</td>
<td>4</td>
<td>82</td>
<td>145</td>
<td>108</td>
<td>217</td>
<td>19 (20%)</td>
<td>40.0%</td>
<td>2 (2%)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Practice #7</td>
<td>2.97</td>
<td>4</td>
<td>93</td>
<td>159</td>
<td>119</td>
<td>238</td>
<td>27 (19%)</td>
<td>40.0%</td>
<td>15 (11%)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Practice #8</td>
<td>2.39</td>
<td>3</td>
<td>81</td>
<td>95</td>
<td>96</td>
<td>191</td>
<td>8 (9%)</td>
<td>40.0%</td>
<td>2 (2%)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Practice #9</td>
<td>2.6</td>
<td>3</td>
<td>95</td>
<td>104</td>
<td>104</td>
<td>208</td>
<td>5 (5%)</td>
<td>40.0%</td>
<td>0 (0%)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Practice #10</td>
<td>0.6</td>
<td>3</td>
<td>15</td>
<td>24</td>
<td>24</td>
<td>48</td>
<td>3 (15%)</td>
<td>40.0%</td>
<td>0 (0%)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Practice #11</td>
<td>1.43</td>
<td>3</td>
<td>26</td>
<td>57</td>
<td>57</td>
<td>114</td>
<td>4 (11%)</td>
<td>40.0%</td>
<td>0 (0%)</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

**All ACO**

| 18.63        | 672           | 1026                        | 745                      | 1,490                       | 128 (15%)                   | 40%                            | 28 (3%)                          | 20.0%                            |

* Full Active caseload = 80 patients

*Site with Allocated FTE<1 are reimbursed for a full FTE

*As of April 2017, remission is counted on dashboard as those having 2 consecutive PHQ9 scores of <

*Note: current caseload active includes active pts. only (i.e. those in remission are excluded from current active caseload counts)
COLLABORATIVE CARE REGISTRY DATA: TYPES OF REFERRALS FOR CoCM PATIENTS (N = 665)

- BH Referral: 23%
- PCP Referral: 7%
- Elevated PHQ-9: 1%
- TOC/Hospitalization: 1%
- Ongoing Care Mgmt: 13%
- Positive HRA/CRA: 38%
- Unspecified: 1%
- Other: 16%

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COLLABORATIVE CARE REGISTRY DATA: STATUS OF THE DIAGNOSIS (N = 665)

- Existing Dx = 493
- New Dx = 171
- Unspecified

26% 74%
DISTRIBUTION OF PHQ-9 SCORES: HIGH PREVALENCE OF DEPRESSION

Initial PHQ-9 Scores By Category (N=665)

<table>
<thead>
<tr>
<th>Initial PHQ-9 Scores</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>22</td>
</tr>
<tr>
<td>10-14</td>
<td>274</td>
</tr>
<tr>
<td>15-19</td>
<td>225</td>
</tr>
<tr>
<td>20-27</td>
<td>134</td>
</tr>
<tr>
<td>Unspecified</td>
<td>10</td>
</tr>
</tbody>
</table>

Number of Patients
INCENTING CARE MANAGEMENT PERFORMANCE VIA DISTRIBUTION OF VALUE-BASED PAYMENTS
BUILDING BLOCKS FOR DELIVERY SYSTEM TRANSFORMATION AND POPULATION MANAGEMENT

Organizational Structure
- Shared vision & culture of accountability
- Egisitarian governance
- Build trust & common purpose
- Competent leadership

Practice Transformation
- Team-based model of care implemented
- Complex care coordination capability
- Care management at the practice level
- Alternative access to primary care
- Integration of BH and LTSS into model

Workforce Development
- Develop education & training around the new model of care
- Developing new workforce for collaborative care model
- Create pipeline of allied health professionals prepared to work in underserved communities

Connectivity MHNConnect Portal
- Real-time alerts information exchange between hospitals and primary care sites
- Communication & exchange with non-acute settings
- Bridge to social service agencies

Care Management & Analytics
- Timely & actionable reporting based on integrated historical, care management & real-time data
- Advanced analytics to support population management
- Risk-stratification

Patient Engagement
- Fostering the accountable patient
- Remote home monitoring for CHF & hypertension patients
- E-consults & virtual visits

Value-Based Payment
- Pay-for-performance program that rewards process, outcomes & program implementation
- Facilitative financing to support care management at the practice level

Redesign Delivery to Achieve Triple Aim
Better Health | Better Healthcare | Lower Cost

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MEDICAL HOME NETWORK VALUE BASED CONTRACTING CONSTRUCT

MHN ACO Contract
ACA, FHP, ICP

Health Plan

Direct Provider Contracts
All Products

Migrating to Shared Risk

Shared Savings Distribution

Assured Infrastructure Funding
Monthly PMPM

Earned Savings Funding
Quarterly

Expense Offset

Complex Care Management
Care Management Capitation

At Risk P4P

Annual Settlement

Medical Homes/Primary Care Practice Sites

Hospitals & Specialists

Clinical Investment Fund
Reserves

Direct Contract

Provider Payment
(FFS or Cap)
**EARNED SHARED SAVINGS FUNDING: Enabling Collaborative Delivery Redesign**

**Medical Homes/PCP Sites**  
50% of Pool Funding  
**Measures**  
- ▼ 30 Day All Cause Readmissions *  
- % 7 Day PCP Visit -IP Discharge  
- % 7 Day PCP Follow-Up -ER Admissions  
- % CTM3 Compliance Survey Completion  
- % New Patient Visits within 90 Days  
- % Care Plans with timely updates  
- % PHQ-2 positives with a completed PHQ-9  
- ▼ ED Utilization per 1000 (FHP only) *

**Specialists & Hospitals**  
50% of Pool Funding  
**Measures**  
- ▼ 7 Day All Cause Readmissions *  
- % Repeat ED visits w/in 30 days *  
- CTM3 Score (Value)  
- ≥95% System Uptime for HL7/ADT in MHNConnect Portal  
- % Reduction of 24 Hour Admits *  
- % Specialist Visits at ACO Hospital Providers

**Earned Savings Distribution**

- **Surplus**  
  - % MHN ACO X%  
  - Surplus Distribution: 60%  

- **Risk Reserves**  
  - 25%  

- **Clinical Initiatives Investment**  
  - 15%  

- **Deficit**  
  - $0 Payout  

- **Surplus Distribution**  
  - 60%  

**Supports:**  
- Practice Transformation  
- Collaborative Care Model

**Medical Cost of Care MLR < Contract MLR**
1) Hospital discharges patient and provides instruction on health management and medication.

2) Clinic schedules a timely follow up appointment post-ED or IP hospital visit.

3) Clinic completes CTM-3 to identify and address patient questions about their follow up care.

4) MHNConnect captures CTM-3 score, allowing us to evaluate hospital care transition practices.

<table>
<thead>
<tr>
<th>Facility</th>
<th>Discharges with completed CTM3</th>
<th>Average CTM3 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>308</td>
<td>72.77</td>
</tr>
<tr>
<td>Hospital B</td>
<td>4</td>
<td>66.67</td>
</tr>
<tr>
<td>Hospital C</td>
<td>144</td>
<td>74.04</td>
</tr>
<tr>
<td>Hospital D</td>
<td>191</td>
<td>70.73</td>
</tr>
<tr>
<td>Hospital E</td>
<td>72</td>
<td>76.36</td>
</tr>
<tr>
<td>All Portal Facilities</td>
<td>866</td>
<td>73.74</td>
</tr>
</tbody>
</table>
LESSONS LEARNED FROM MHN’S SUCCESSES

- MHN built a **shared vision with all organizations** to maintain commitment
- MHN led **collaboration** that mandated the right people at the table who can check institutional identity at the door
- MHN led **cultural change and practice transformation** to yield Population health management
- MHN developed a **health IT platform** to support care management across the continuum
- MNH created **incentives** for practice redesign that insured success
- MHN worked with Providers to create **pipeline programs** that serve as **career ladders** for allied health professionals
- MHN led **payment reform** initiatives to drive delivery reform

Stakeholder Engagement

Leadership Development

Aligned Incentives

Innovative Model of Care

Data Sharing and Analytics

Shared Purpose, Governance and Decision Making

MHN Pilot: Catalyst for Regional Collaboration and Culture Change
WRAP-UP
TOPICS COVERED TODAY

• Population Management in the ACO starts with attribution, member engagement and risk stratification.
• Decisions needed about what services will be offered at the Health Center, what will be offered by MCO and/or ACO to maximize efficiency and effectiveness in meeting Member needs and contain costs.
• Care management and care coordination should be informed by wide range of data sources and facilitated by technology.
• Consistent and transparent measurement of process, impact and testing assumptions is important.
• Integrating behavioral health with primary care through Collaborative Care offers an opportunity to reduce cost and improve outcomes for sub-set of the population.
• Funds flow and accountability are important to maintain the practice transformation and incentives.
October 20, 2017

See You Then!
COORDINATING MEMBER-CENTRIC SPECIALTY CARE
Driving Impact

• Improve access to specialty care
• Increase specialty capacity
• Reduce no-show rates
• Streamline scheduling process and increase patient choice
• Strengthen the specialty network and provider relationships
• Expand scope of PCP practice
eConsult Workflow: Meeting a Patient’s Specialty Care Needs

PCP determines patient’s medical needs require specialist consultation

PCP submits an eConsult with pertinent clinical questions

An e-mail alert is sent to the specialist’s email

Specialist logs into eConsult to review & respond to PCP

Communication can continue between PCP & Specialist

PCP receives final eConsult noting specialist’s recommendations

The patient’s specialty care needs have been met
## Services Available

- **27 Adult Specialties and 12 Pediatric**

<table>
<thead>
<tr>
<th>ADULT SPECIALTIES</th>
<th>PEDIATRIC SPECIALTIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy/Immunology</td>
<td>Adolescent &amp; Young Adult Clinic</td>
</tr>
<tr>
<td>ENT</td>
<td>Allergy/Immunology</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Cardiac Thoracic Surgery</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Neurology</td>
<td>Neuro-Surgery</td>
</tr>
<tr>
<td>Sleep Disorders</td>
<td>Urology</td>
</tr>
<tr>
<td>Neurology</td>
<td>OB/GYN</td>
</tr>
<tr>
<td>Dermatology</td>
<td>OMFS: Jaw Tumor</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Infectious Disease</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>OMFS: Oral &amp; Maxillofacial Surgery</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Endocrinology</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Pulmonary</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Pulmonary</td>
</tr>
</tbody>
</table>

**eConsult**

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<table>
<thead>
<tr>
<th>Specialty</th>
<th>Appointments Scheduled Within 1 week of Specialist’s Recommended Time</th>
<th>Appointments not Scheduled within 1 week of Specialist’s Recommended Time</th>
<th>Show Rate as of 5/31</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULTS &amp; Peds - Urology</td>
<td>226</td>
<td>21</td>
<td>76%</td>
</tr>
<tr>
<td>Adults - Gastroenterology</td>
<td>165</td>
<td>42</td>
<td>78%</td>
</tr>
<tr>
<td>ADULTS &amp; Peds - Dermatology</td>
<td>67</td>
<td>7</td>
<td>78%</td>
</tr>
<tr>
<td>ADULTS - Endocrinology</td>
<td>64</td>
<td>2</td>
<td>72%</td>
</tr>
<tr>
<td>ADULTS &amp; Peds - Orthopedics</td>
<td>57</td>
<td>1</td>
<td>86%</td>
</tr>
<tr>
<td>Adults - Neurology</td>
<td>55</td>
<td>0</td>
<td>58%</td>
</tr>
<tr>
<td>ADULTS - Rheumatology</td>
<td>46</td>
<td>0</td>
<td>73%</td>
</tr>
<tr>
<td>ADULTS - General Surgery</td>
<td>39</td>
<td>5</td>
<td>78%</td>
</tr>
<tr>
<td>ADULTS - Sleep Disorders</td>
<td>37</td>
<td>2</td>
<td>80%</td>
</tr>
<tr>
<td>ADULTS - Cardiology</td>
<td>36</td>
<td>2</td>
<td>88%</td>
</tr>
<tr>
<td>Adults - ENT/ENT Head and Neck Tumor</td>
<td>40</td>
<td>1</td>
<td>77%</td>
</tr>
<tr>
<td>Adults - OB/GYN</td>
<td>28</td>
<td>3</td>
<td>78%</td>
</tr>
<tr>
<td>ADULTS - Hepatology</td>
<td>27</td>
<td>5</td>
<td>60%</td>
</tr>
<tr>
<td>ADULTS - Pulmonary</td>
<td>23</td>
<td>1</td>
<td>78%</td>
</tr>
<tr>
<td>ADULTS - Psychiatry</td>
<td>23</td>
<td>3</td>
<td>67%</td>
</tr>
<tr>
<td>ADULTS - Podiatry</td>
<td>19</td>
<td>2</td>
<td>84%</td>
</tr>
<tr>
<td>ADULTS - Nephrology</td>
<td>16</td>
<td>1</td>
<td>91%</td>
</tr>
<tr>
<td>ADULTS - Colorectal</td>
<td>15</td>
<td>0</td>
<td>80%</td>
</tr>
<tr>
<td>ADULTS - Pain Management</td>
<td>11</td>
<td>11</td>
<td>73%</td>
</tr>
<tr>
<td>Adults - Neurosurgery</td>
<td>9</td>
<td>4</td>
<td>56%</td>
</tr>
<tr>
<td>ADULTS - OMFS: Oral &amp; Maxillofacial Surgery</td>
<td>7</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Pediatrics - Gastroenterology</td>
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</tr>
<tr>
<td>Adults - Allergy/Immunology</td>
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<td>75%</td>
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<tr>
<td>Adults - Physical Medicine &amp; Rehab</td>
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<tr>
<td>Pediatrics - Hematology/Oncology</td>
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<tr>
<td>ADULTS - Cardiothoracic Surgery</td>
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<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Pediatrics - Cardiology</td>
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<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>Pediatrics - Endocrinology</td>
<td>1</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1030</strong></td>
<td><strong>114</strong></td>
<td><strong>76%</strong></td>
</tr>
</tbody>
</table>
## Program Impact

### Patient:
- Reduced wait times for specialty care
- Less travel
- Fewer days off work
- Better coordination of care - transitions of care better managed, process more transparent
- Specialist more informed at the time initial visit
- Fewer specialty visits required to devise treatment plan

### Primary Care:
- Improved access to specialty expertise
- Connected to larger system of care (reduced isolation)
- Opportunity to enhance clinical capability (eConsult “CME”)
- Reduced wait times
- Co-mgmt. of complex patients
- Transparent scheduling process - improves tracking of visits
- Shared notes - improves team communication
- Potential to reduce specialty costs

### Specialist:
- When indicated, face to face visits are more productive:
- Pre-visit testing is completed
- Avoidance of inappropriate referrals
- Increased complexity of clinic patients
- Improved communication with primary care
- Alternative source of revenue when patients no-show for face-to-face visits
EOHHS DEFINITIONS

**Clinical Care Manager** - a licensed Registered Nurse or other individual, employed by the Contractor or an Enrollee’s PCP and licensed to provide clinical care management, including intensive monitoring, follow-up, and care coordination, clinical management of high-risk Enrollees, as further specified by EOHHS.

**Care Coordinator** – a provider-based clinician or other trained individual who is employed or contracted by the Contractor or an Enrollee’s PCP. The Care Coordinator is accountable for providing care coordination activities, which include assuring appropriate referrals and timely two-way transmission of useful patient information; obtaining reliable and timely information about services other than those provided by the PCP; participating in the Enrollee’s Comprehensive Assessment, if any; and supporting safe transitions in care for Enrollees moving between settings in accordance with the Contractor’s Transitional Care Management program. The Care Coordinator may serve on one or more care teams, coordinate and facilitates meetings and other activities of those care teams.
**EOHHS DEFINITIONS**

- **Disease Management** – the Contractor’s disease or condition specific packages of ongoing services and assistance for specific disease and/or conditions. Services include specific interventions and education/outreach targeted to Enrollees with, or at risk for, these conditions.

- **Utilization Management** – a process of evaluating and determining coverage for, and appropriateness of, medical care services and Behavioral Health Services, as well as providing needed assistance to clinicians or patients, in cooperation with other parties, to ensure appropriate use of resources, which can be done on a prospective or retrospective basis, including service authorization and prior authorization.

- **Transitional Care Management** – the evaluation of an Enrollee’s medical care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one level of care to another level of care, including referral to appropriate services.