Effectively Moving Care Management to the Primary Care Practice Site with the Right Technology to Support it

Art Jones, M.D.

Chief Medical Officer, MHN ACO

9.23.17

MHN ACO

Partnerships for Better Health

Operated by Medical Home Network

MHN ACO – Integration Driving Transformation

MHN ACO Population

	Medicaid Members	ACO % of Total
ACA	24,347	30%
FHP	55,170	68%
SPD	1,589	2%
Total	81,106	100%

MHN ACO Providers

9 FQHCs
3 Hospital Systems

86 Medical Homes
375 PCPs
150 Care Managers
1,200 Specialists
5 Hospitals

MHN Geography

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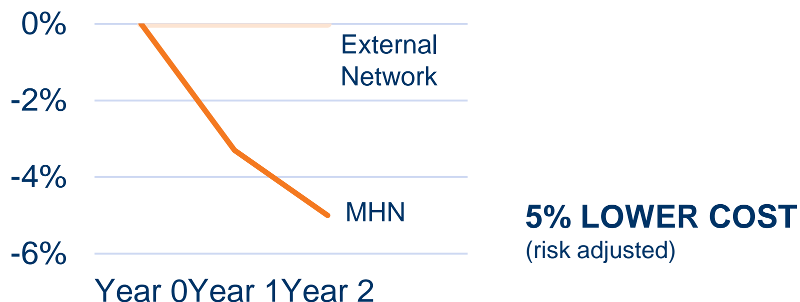
MHN Impact on Cost, Outcomes and Engagement

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



5% LOWER COST
(risk adjusted)

Difference is MHN risk adjusted cohort vs Non-MHN risk adjusted cohort percent change in cost of care
Source: Findings of the MHN HFS Care Coordination Pilot for the Illinois Health Connect population

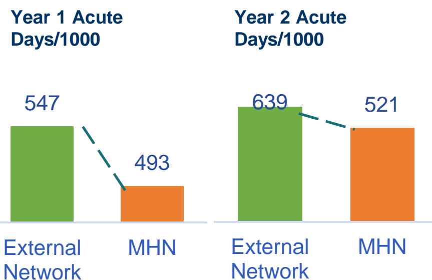
Patient Engagement - ACO

**MHN ACO:
89% HEALTH RISK ASSESSMENT COMPLETION**

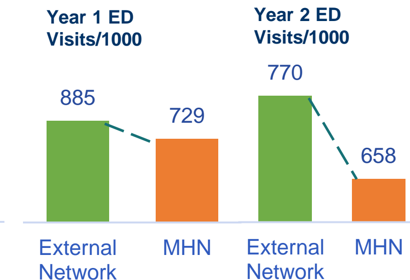
Period: July 1, 2014 – Present

ACA Utilization - ACO

Inpatient Days/1000



YEAR 1 Jul14–Jun15
10% BETTER OUTCOME



YEAR 2 Jul15– Mar16
18% BETTER OUTCOME

ED Visits/1000

Year 1 ED Visits/1000
885
729
External Network
MHN

YEAR 1 Jul14–Jun15
18% BETTER OUTCOME

Year 2 ED Visits/1000
770
658
External Network
MHN

YEAR 2 Jul15–Mar16
15% BETTER OUTCOME

Total Cost of Care - ACO

Contract Year 1	Contract Year 2 Q1	Contract Year 2 Q2
$17.7m	**$6.6m**	**$4.2m**
SAVINGS	**SAVINGS**	**SAVINGS**
+12.1% variance from target	**+18% variance from target**	**+12.5% variance from target**

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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

dashboard

- 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

volume-driven health care

value-driven health care

- 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

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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 Process Standardization

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6 Medicare Demonstrations

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 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

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Implementation Challenges to Provider-level Care Management

- Embedding the care manager as part of the care team
- Creating a common, structured approach to care management with tools, processes, staffing and sharing of care plans
- Creating a model with a positive return on investment
- Improving on current risk stratification methodology by adding addressable barriers to treatment plan adherence to the usual claims-based diagnosis, utilization and cost factors
- Informing care management staff with real time information placed in historical context
- Following task completion, lead and lag metrics aimed at improved utilization and cost across the full continuum of care

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Implications for Working Within a Payor/ACO Context

- Payors rely 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 & competencies
- Must be able to exchange data and share care plans
- Meet NCQA & any state-specific care management delegation requirements
- Agree to clear deliverables, metrics, targets & performance monitoring methods
- Negotiate a value-based payment that recognizes upfront investment but is ultimately supported by savings from improved management of the full continuum of care

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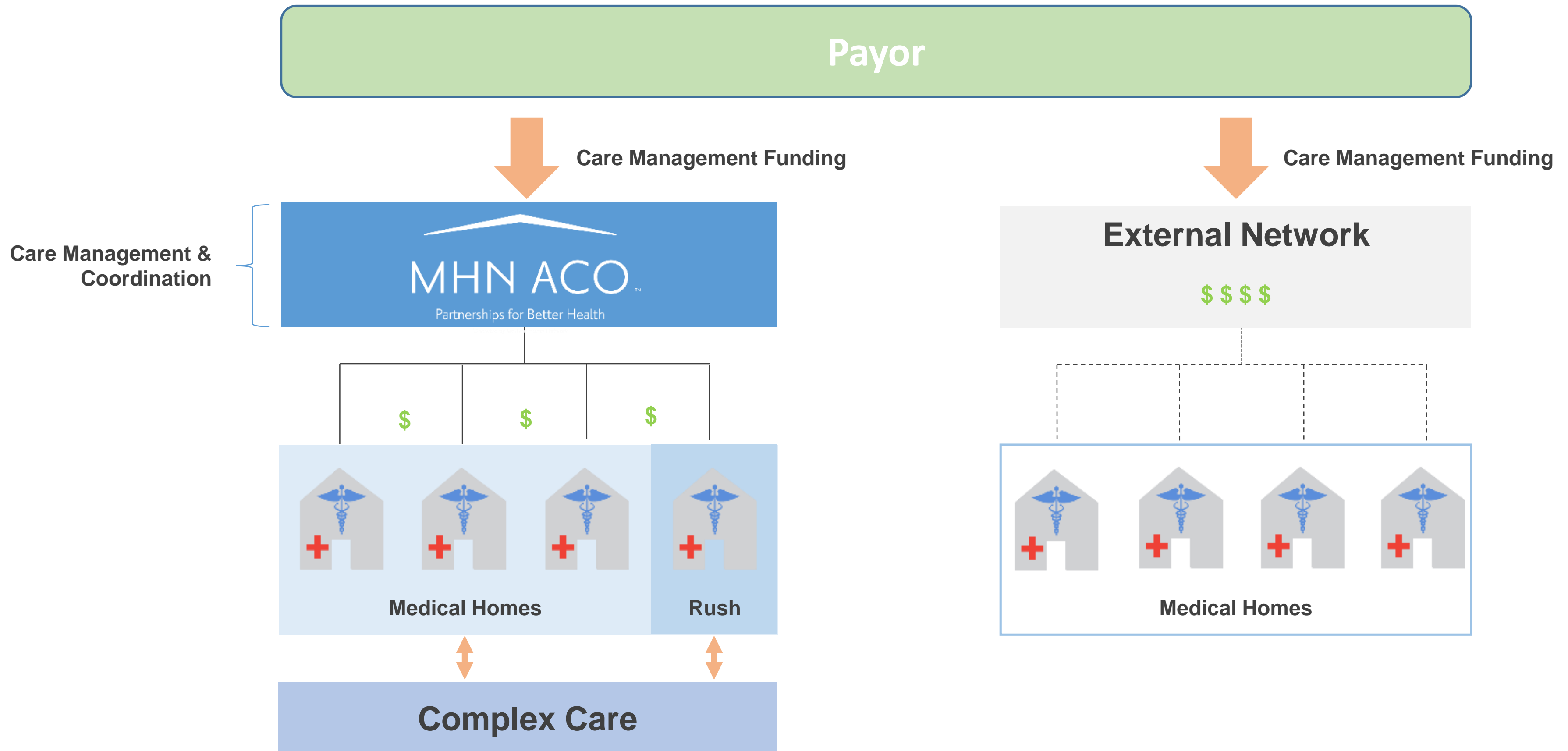
Practice-Level vs. Centralized Care Management



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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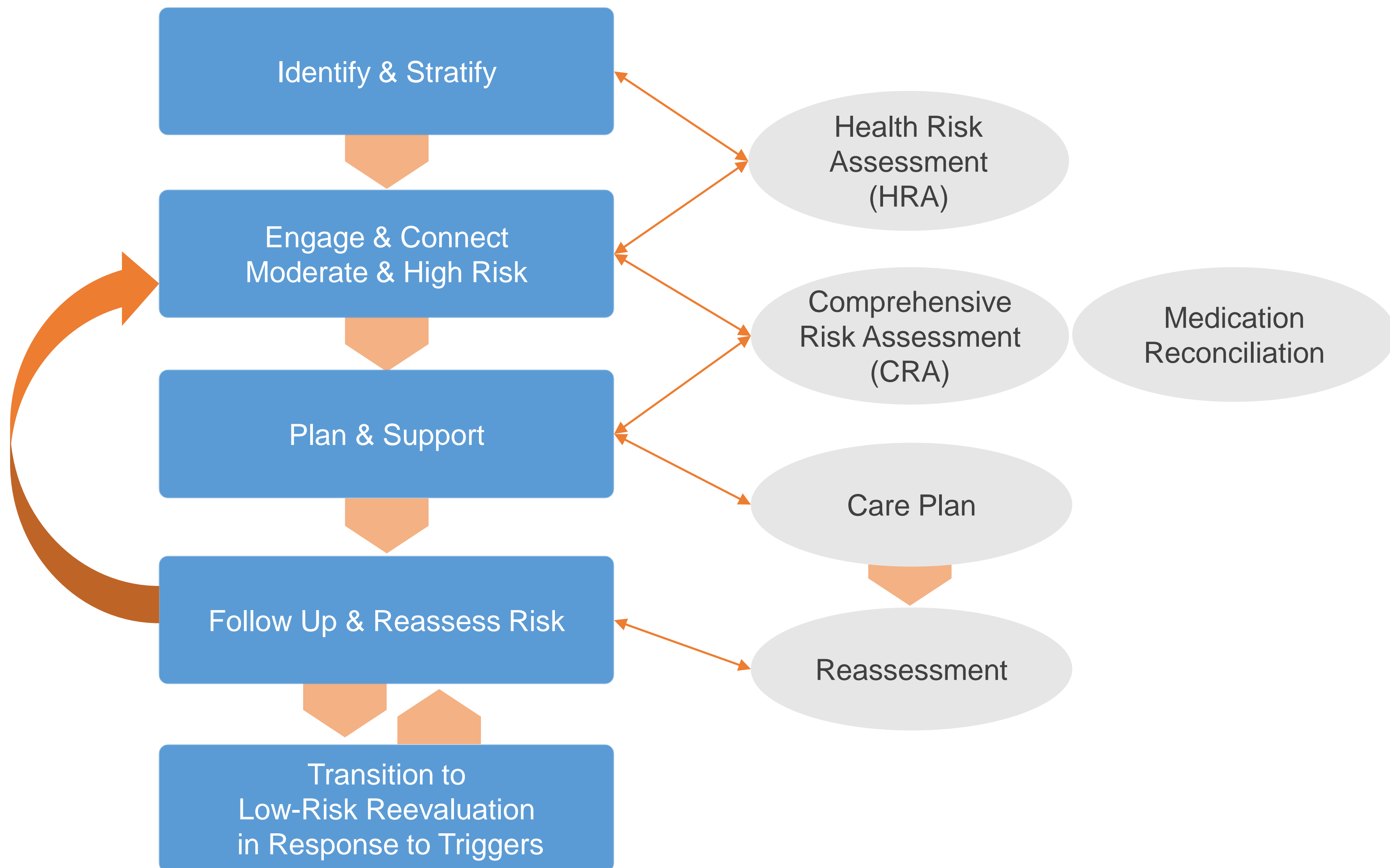
MHN ACO – Technology-Enabled Risk Stratification Drives Prioritized, Structured Workflows



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Structure the Care Management Process with the Right Care Management Platform

Technology connects risk assessment to care planning

Health Risk Assessment

HEALTH RISK ASSESSMENT

1. Access to Medical Care & Transportation | 2. General Health & Healthcare History | 3. Mental Health & Substance Abuse History | 4. Social Support & Needs

1.What language do you prefer to speak? *
- English
- Spanish

Other

2.How do you prefer to be contacted? *
- Home phone
- Cell phone
- E-mail
- Text
- Mail
- In person

3.When did you last see your Primary Care Provider (PCP)? Within last: *
- 3 months
- 6 months
- 9 months
- Year
- Over a Year
- No Answer Provided

4.Do you need help making appointments with your PCP or other doctors? *
- Yes
- No
- No Answer Provided

5.Does lack of transportation keep you from making it to your appointments or getting your medication? *
- Yes

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

Patient Care Plan

CAREPLAN

Careplan Title*: Diabetes Assessment Form generated - careplan

Owner Type: Care Manager

Owner: Sana Syal

CONDITIONS | NEEDS | GOALS | BARRIER | CLINICAL MEASURES | INTERVENTIONS | APPROVERS

Add Goal

Search:

Goal Type	Goal	Priority	Due Date	Owner (Team Role)	Action
SHORTTERMGOAL	Increase knowledge of disease process	HIGH	01-04-2017	Sana Syal (CARECOORDINATOR)	
SHORTTERMGOAL	Monitor and supervise to avoid clinical complications	HIGH	01-04-2017	Sana Syal (CARECOORDINATOR)	
SHORTTERMGOAL	Decrease readmission	HIGH	01-04-2017	Sana Syal (CARECOORDINATOR)	
SHORTTERMGOAL	Decrease ER visits	HIGH	01-04-2017	Sana Syal (CARECOORDINATOR)	
SHORTTERMGOAL	Reduce diabetes symptoms	HIGH	01-04-2017	Sana Syal (CARECOORDINATOR)	

Integrates care plan tasks across patient care team (e.g., BH and PCP)

Comprehensive Risk Assessment

ASSESSMENT : COMPREHENSIVE RISK ASSESSMENT

1. HRA Overview | 2. General Health & Healthcare History | 3. Mental Health & Substance Abuse Screening

1.Have you stayed overnight in the hospital in the past year? *
- Yes
- No

2.Have you been to the Emergency Room in the past year? *
- Yes
- No

3.Do you know your Primary Care Provider's name? *
- Yes
- No

PCP Name:

4.Do you know how to contact your Primary Care Provider if needed? *
- Yes
- No

5.Have you missed any appointments with your Primary Care Provider in the past 6 months? *
- Yes
- No

6.If yes, what has made it difficult for you to attend your PCP appointment? *

7.Are you up to date on your vaccines and preventive services? *
- Yes
- No
- Unsure

8.Do you have any problems with chronic pain? *
- Yes
- No

Goals created based on assessment results

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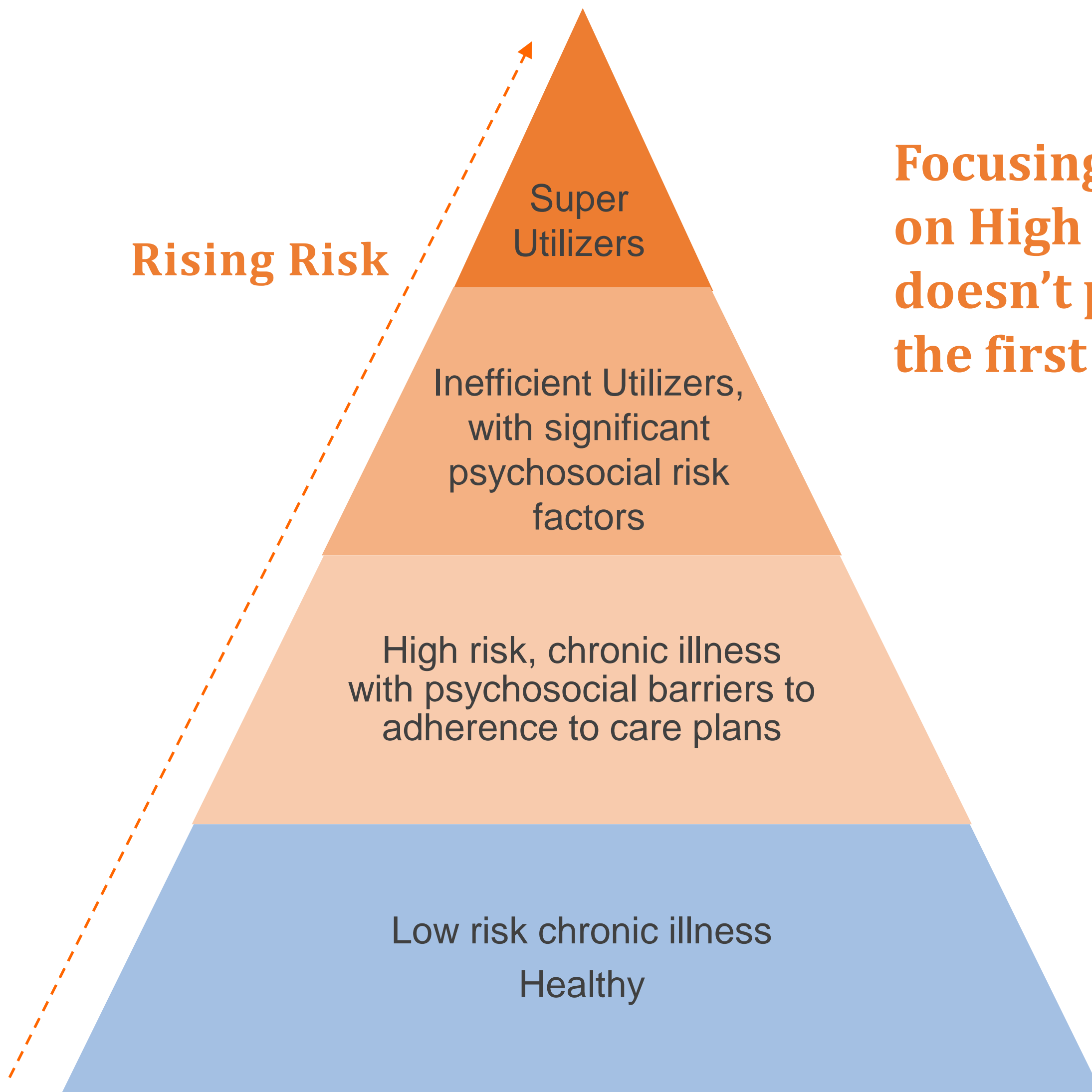
Identify Rising Risk Through Addressable Medical, Behavioral & Social Factors to Drive Cost Savings



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

*Denver Health Health Affairs, 34, no.8 (2015):1312-1319

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Enhanced Risk Stratification is Key to Care Management Efficiency & Improved Outcomes

MHN ACO Medicaid/ACA Experience

HRA Risk Profile	Count	% Members with No Claims	ER Visits /1000	Inpatient Admits /1000	Medical & Rx Cost	Relative Cost
Low by Utilization without any Impactable Risk Factors			---	---	---	---
Low by Impactable Risk Factors			↑	↑	↑	↑
Medium by Impactable Risk Factors			↑	↑↑	↑↑	↑↑
High by Utilization +/- Impactable Risk Factors			↑↑↑↑	↑↑↑↑	↑↑↑↑	↑↑↑↑
High by Impactable Risk Factors			↑↑↑↑	↑↑	↑↑↑	↑↑↑
Total	**5,798**					

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***

Source: MHNConnect & CountyCare Claims Data

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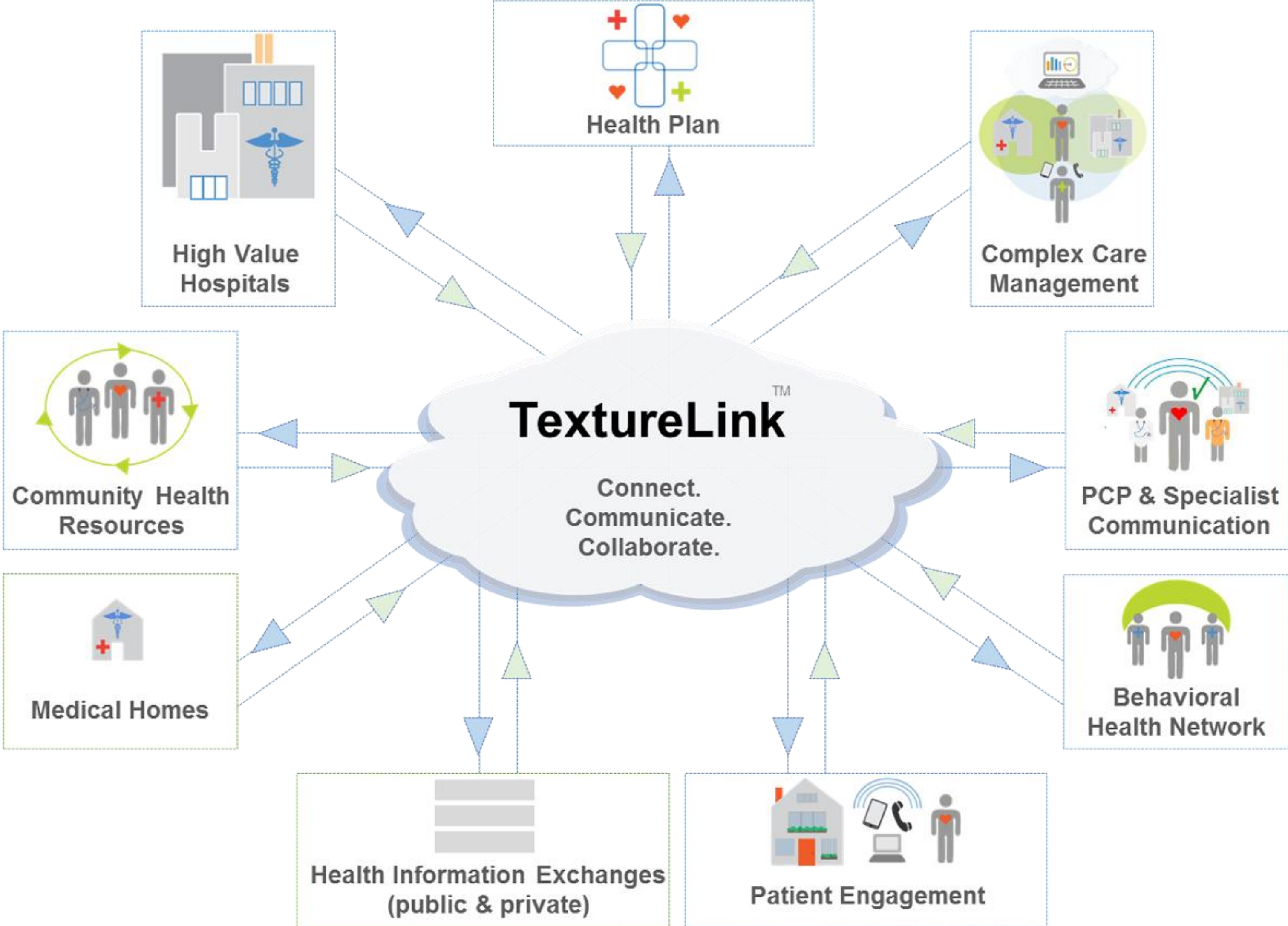
Integrated Care Management Technology Drives Scale, Structure & Efficiency Across the Continuum



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Care Management Dashboards Structure Disparate Data into Actions

Logs Care Gaps, Plans, & Patient Engagement Activities

Patient View – Care Gaps and Care Plan

Assessments Drive Care Gaps and Care Plans, Viewable by Patient and Care Team

CAREPLANS

Care Plan	Owner	Approved Date
sample	Ahs sample Carecoordinator	
Diabetes Assessment Form generated - careplan	Sana Syal	12-05-2016
Diabetes Careplan - Low Risk	Ahs sample Carecoordinator	11-21-2016
Diabetes Careplan - Low Risk	Ahs sample Carecoordinator	11-10-2016

CAREGAPS

Gap		Due Date	Last Test Date
Cervical Cancer Screening	R	06-13-2015	
Weight (lb)	R	06-13-2015	
Pulse	R	06-13-2015	
BMI Follow-up Plan Documented	R	06-13-2015	
Tobacco Use/Exposure Assessment	R	06-13-2015	
Body Mass Index	R	06-13-2015	
BP Systolic	R	06-13-2015	
Triglycerides	R	06-13-2015	

← 1 2 3 4 →

O Open C Closed

Patient Engagement View

texture HEALTH — SALLY LAW — Ahs sample Carecoordinator — Timezone: EDT - America/New_York — 124

SALLY LAW

ID:	TGS7423811RB
Healthplan ID:	8651388PH8
Status:	
Phone:	6302295461
Mobile:	6302295461 Notify
Gender:	F
DOB:	08-23-1985
Email:	sally.law@vcareconnect.com
Address:	8751 NORTH NASHVILLE ROAD,, WILKINSON-46186, IN
PCP/Medical Home:	PCP Referral
	SARAH,CURRY

CARE PROFILE | SPEND & UTILIZATION | VITALS

ASSESSMENTS LAST 6 MONTHS

Assessment	Filled By	Filled Date
Diabetes Assessment Form	Admin AHS	12-05-2016
Health Risk Assessment	Admin AHS	12-02-2016
Health Risk Assessment	Admin AHS	11-07-2016
Health Risk Assessment	Admin AHS	10-27-2016
Care Transitional Measure	Ahs sample Carecoordinator	09-30-2016

← 1 2 →

CARE OUTREACH LOG - 1 MONTH

Contact Date	Status	Campaign Name	By
12-02-2016 11:23 am	HUNGUP	Blood-Sugar-English	Admin AHS
12-01-2016 12:47 pm	HUNGUP	Blood-Sugar-English	Ahs sample Carecoordinator
11-30-2016 03:09 pm	SUCCESS	LDL Screening	Admin AHS
11-30-2016 03:08 pm	HUNGUP	Blood-Sugar-Spanish	Admin AHS
11-18-2016 06:34 pm	HUNGUP	Blood-Sugar-Spanish	Admin AHS

← 1 2 3 →

Record of Patient Engagement Attempts and Results

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Care Coordinator Work Space Organizes & Prioritizes Care Management Tasks to Optimize Resource Allocation

Organize Real-Time Tasks

New Patient Welcome Calls

ACTIVE CARE DASHBOARD

Inpatient		ER		Maternity		New Patients
1 Admits	5 Discharged	0 Admits	0 Discharged	0 Admits	0 Discharged	73 Need Onboarding

10 records per page Search:

Click to Call

Name (Phone)	Plan	DOB/Gender	Hospital	Admit	Discharge	Discharged To	Appt Date	Status	Risk	Medical Home	PHQ-9	CTM-3	F/U
COURTNEY,BEARS - 8906048 713 call	NO PLAN	10-11-1944 / F	PrimeCare,Fullerton	07-13-2016	07-13-2016			Patient Call/Need followup	Start	FFHC,East 55th	Start	Start	+
JILL,ST PAUL - 3173622596 call	Needs Plan	12-22-1932 / F	CCHHS ACHN,Fantus	07-04-2016	07-05-2016		11-29-2016 10:49 am status::REQUESTED	Face to Face Contact/Completed	Start	CCHHS ACHN,Prieto	Edit	✔ Score:6	+

Risk Drives Care Gaps and Follow up Tasks

Ahs sample Carecoordinator 124

Timezone: EDT - America/New_York

OVERALL CARE PROGRESS

OVERALL | ASTHMA | CHF | COPD | COMPLEXCASE | CAD | DIABETES | HYPERTENSION

Level	Count	Summary
Level 1	20	Patients with over due CareGaps:7 Patients with BP>140/90:2
Level 2	5	Patients with over due CareGaps:5 Patients with BP>140/90:0
Level 3	3	Patients with over due CareGaps:3 Patients with BP>140/90:2
Level 4	27	Patients with over due CareGaps:17 Patients with BP>140/90:2

Risk Stratified Care Gaps Updates in Real-Time

TASK

Interventions | Goals | Careplan Approvals | Appointments

Intervention Desc.	Due Date	Status	Action
ANGELA COPPER View All			
Provide Asthma chronic care education and assess compliance	12-04-2015	OPEN	
Send educational material to patient	12-04-2015	OPEN	
Notify PCP, Send educational materials to patent	12-04-2015	OPEN	
Administer Ask-12 Survey	12-04-2015	OPEN	
CLOE CARTER View All			
Provide Asthma chronic care education and assess compliance	02-12-2016	OPEN	
Provide Asthma chronic care education and assess compliance	02-12-2016	OPEN	
Send educational material to patient	02-12-2016	OPEN	
Notify PCP, Send educational materials to patent	02-12-2016	OPEN	
Administer Ask-12 Survey	02-12-2016	OPEN	
Develop self-management plan or plan of care	02-12-2016	INPROGRESS	

Scheduled Patient Tasks

1 2 3 4 5 →

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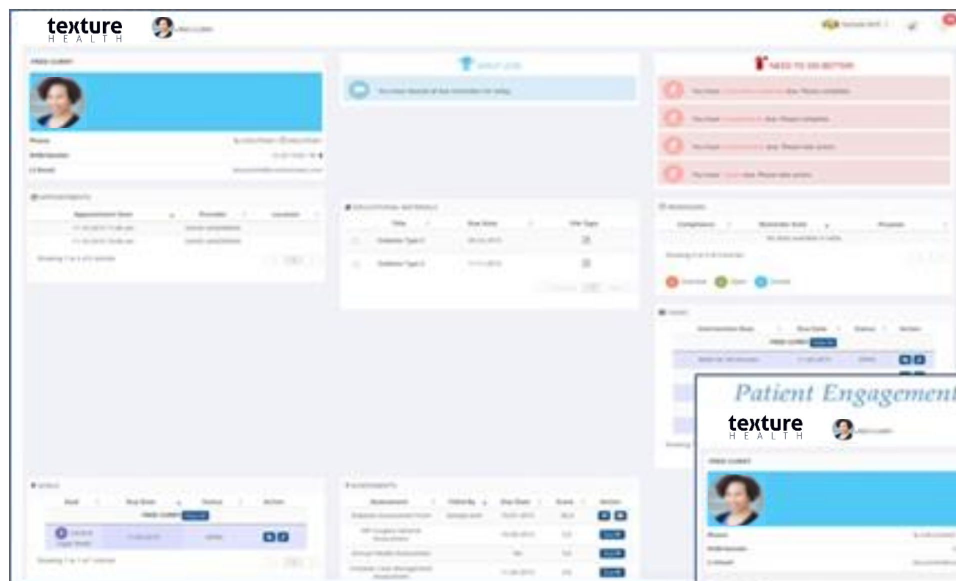
Integrated Patient Engagement allows Care Management Process to Trigger Outreach



- **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

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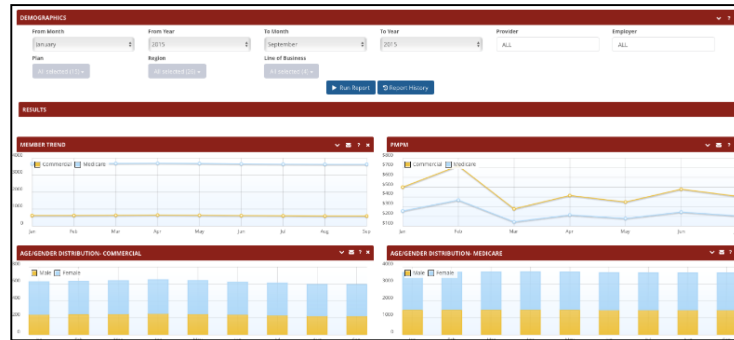
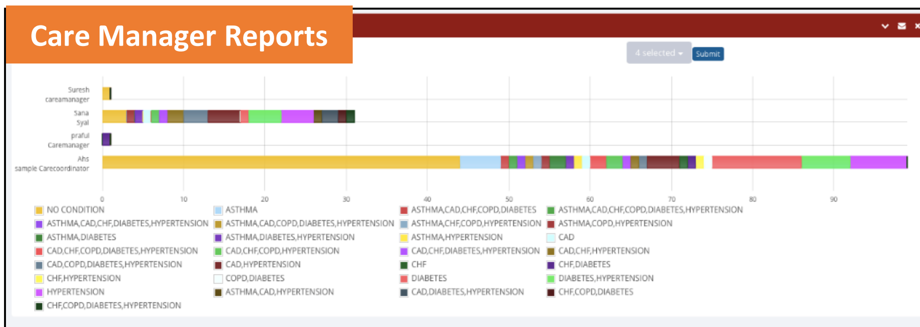
Targeted Reporting to Improve Performance, Resource Allocation & Efficiency





CARE MANAGER PRODUCTIVITY (LAST 120 DAYS)

7 days | 30 days | 90 days | YTD

10 records per page Search:

Care Manager Name	Outreach Count	Assessments Count	Careplan Count	Contact Count
Ahs sampleCarecoordinator	48	6	9	2
ahscmanager11ahscmanager11	0	0	0	0
DivyVarshney	0	0	0	0
RegCM2	44	1	21	0
samsamy	0	0	0	0
SanaSyal	3	3	5	0

Showing 1 to 6 of 6 entries ← Previous 1 Next →

CARE MANAGER PRODUCTIVITY DETAIL FOR AHS SAMPLE CARECOORDINATOR FOR ACTIVITY CAREPLANADD;CAREPLANMOD

10 records per page Search:

Activity Date	Member Id	Details
09-07-2016 09:21 am	TGS058417RB	553::
09-07-2016 09:23 am	TGS058417RB	553::
09-09-2016 10:35 am	TS079120000	554::
10-28-2016 12:10 pm	TGS09306217RB	560::
10-28-2016 12:11 pm	TGS09306217RB	560::

Self-Query Reports

Search:

NDC	Drug Name	Total cost	# of Member(s)
68727010001	Sodium Oxybate 500 MG/ML Oral Solution [Xyrem]	$111,043.35	3
13533080071	Immunoglobulin G, Human 100 MG/ML Injectable Solution [Gamunex]	$106,115.67	1
00088221905	3 ML Insulin Glargine 100 UNT/ML Prefilled Syringe [Lantus]	$92,584.96	105
00597007541	tiotropium 0.018 MG/ACTUAT Inhalant Powder [Spiriva]	$87,612.09	116
59572041000	lenalidomide 10 MG Oral Capsule [Revlimid]	$63,937.19	1
00173069600	60 ACTUAT Fluticasone propionate 0.25 MG/ACTUAT / salmeterol 0.05 MG/ACTUAT Dry Powder Inhaler [Advair]	$63,888.28	102
00169633910	3 ML Insulin, Aspart, Human 100 UNT/ML Prefilled Syringe [NovoLog]	$62,320.20	83
00088222033	Insulin Glargine 100 UNT/ML Injectable Solution [Lantus]	$59,802.83	66
00169643810	3 ML insulin detemir 100 UNT/ML Prefilled Syringe [Levemir]	$51,615.78	48
00078040134	imatinib 100 MG Oral Tablet [Gleevec]	$51,504.45	2

Showing 1 to 10 of 50 entries ← Previous 1 2 3 4 5 Next →

COST & UTILIZATION - HIGH COST

From Month: March | From Year: 2015 | To Month: August | To Year: 2015 | Provider: ALL | Employer: ALL

Plan: All selected (15) | Region: All selected (26) | Line of Business: All selected (4)

Run Report | Report History

RESULTS

HIGH COST MEMBER (OVER 75K)

10 records per page Search:

Member ID	Age\Gender	Line of Business	Total	ER visits	Admits
TS060840000	78\M	Medicare	$294,758.80	0	2
TS020490000	72\M	Medicare	$175,854.63	6	23
TS002080000	55\M	Medicare	$169,770.71	3	30
TS070811000	72\F	Medicare	$147,402.13	0	7
TS042001000	50\F	Medicare	$127,643.91	3	9
TS041380000	80\M	Medicare	$124,293.63	0	1
TS085521000	63\F	Medicare	$121,611.22	0	0
TS074170000	59\F	Medicare	$106,419.66	0	0

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In Summary – Successful Care Management in Primary Care Setting Requires

Innovative patient-centered, team-based model of care

Virtual connectivity across provider settings

Robust Care Management and Patient Engagement platform with integrated analytics

Value-based financing and shared incentives

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Thank You

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