Population Health & Integrated Care Update

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MSHN

Mid-State Health Network

Agenda Overview

- Population Health Activities – Joint Metrics with Medicaid Health Plans
- Data Analytics Updates
- Value Based Purchasing Pilots Updates
- Future Initiatives & FY20 Requirements
- SUD Provider Role in Follow-Up After Emergency Room Visit for Alcohol or Other Drugs

Population Health Activities

FY19 PIHP/MHP Joint Metrics

- Implementation of Joint Care Management Process
- Follow-Up After Hospitalization for Mental Illness
- Plan All-Cause Acute 30-Day Readmission
- Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug Dependence

Measurement Period: 07/01/18 – 06/30/19

Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug Dependence

The percentage of emergency department (ED) visits for individuals age 13 and older with a principle diagnosis of alcohol or other drug (AOD) abuse or dependence, who also had a follow up visit for AOD within 30 days of the ED visit.

ELIGIBLE POPULATION	
Age	Age 13 and older as of date of the ED visit.
Continuous Enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable Gap	None.
Anchor Date	None.
Event/Diagnosis	An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) during the 12-month measurement period.
Exclusions	Exclude ED visits followed by an admission to an acute or non-acute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population. **Note:** The denominator for this measure is based on ED visits, not individuals. If the member had more than one ED visit during the measurement period, only one visit per 31-day period will be included.
Numerator	A follow-up visit with any practitioner with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

Informational Only for FY19

Data Validation with MDHHS

Code Set	MI Specific SUD Service Codes:
All H0006s	Substance Use Disorder Case Management.
All H0010s	Substance Use Disorder: Sub-Acute Withdrawal Management (Sub-Acute Detoxification); medically monitored residential detox.
All H0012s	Substance Use Disorder: Sub-Acute Withdrawal Management (Sub-Acute Detoxification); residential addiction program outpatient.
H00118 – Except H0018 PO	Substance Use Disorder: Residential Services.
All H0019s	Substance Use Disorder: Residential Services.
All H0038s – Except when reported with NO modifier	Substance Use Disorder: Recover Coach (Peer Services).
All H0049s	Alcohol and/or drug screening.
All H0050s	Substance Use Disorder: Outpatient Care.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Baseline Performance- 2017

CY17 PIHP Region	NUM	DEN	RATE
REGION 1	232	599	38.73%
REGION 2	231	695	33.24%
REGION 3	545	2,172	25.09%
REGION 4	421	1,490	28.26%
REGION 5	304	2,441	12.45%
REGION 6	265	1,124	23.58%
REGION 7	871	4,608	18.90%
REGION 8	288	1,356	21.24%
REGION 9	327	1,038	31.50%
REGION 10	357	1,521	23.47%
All 10 Regions Combined	3,841	17,044	22.54%

FUA Improvement in FY2018

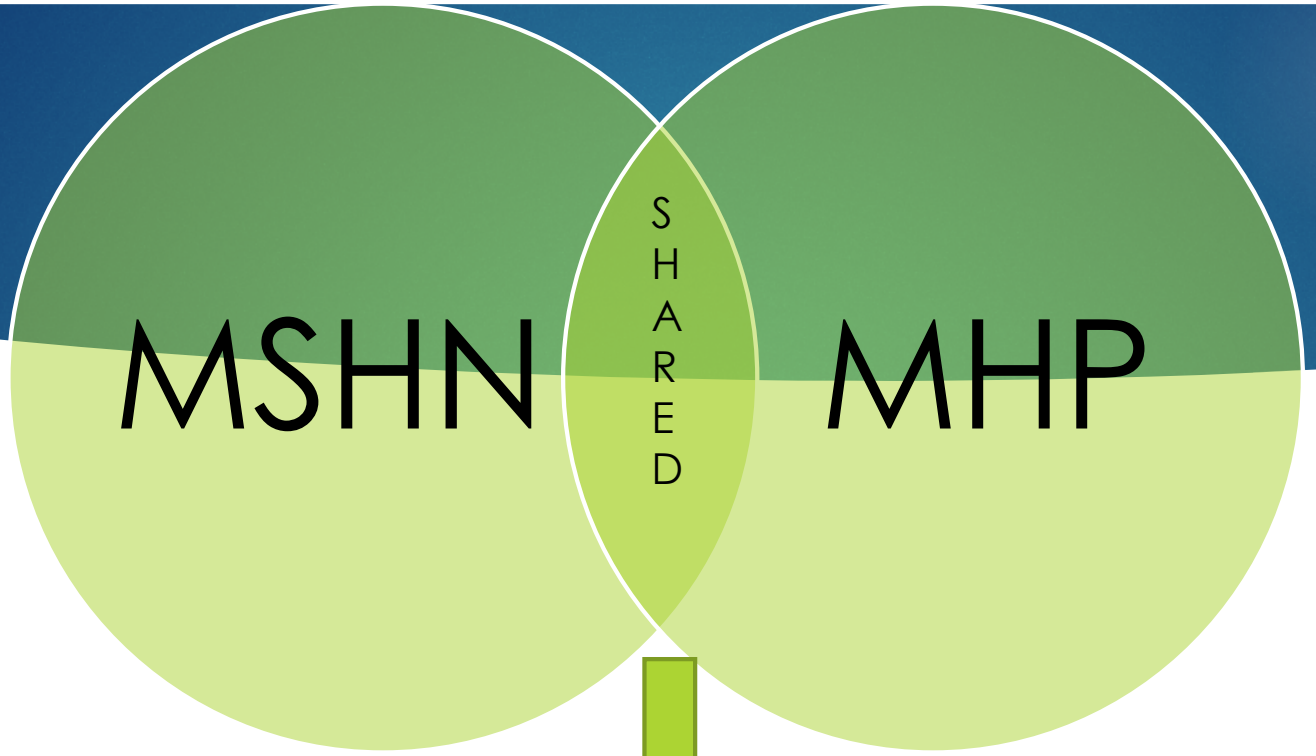
	Period Ending: 12/31/2017	Period Ending: 3/31/2018	Period Ending: 6/30/2018	Period Ending: 9/30/2018
Michigan Medicaid Total	22.75%	23.6%	24.52%	26.51%
MSHN Region	12.77%	17.34%	21.18%	26.52%

FUA Data Validation Findings

- Diagnosis code errors in Carenet; Corrected in REMI which increased performance on measure in 2018
- Additional codes are not included as follow-up service: T1012, H0005, H0004, H0020
- Most frequent diagnoses during ED visit were F11.20 and F10.20
- Significant disparity in rates of follow-up between Caucasian (27.87%) and African American (13.62%) individuals in 2017

Care Coordination with Health Plans

Health Plan	Counties Covered
Aetna-	Jackson, Hillsdale
Blue Cross Complete-	Jackson, Hillsdale, Clinton, Eaton, Ingham, Shiawassee, Tuscola, Huron, Osceola, Mecosta, Newaygo, Ionia, Montcalm
Meridian-	Jackson, Hillsdale, Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
McLaren-	Jackson, Hillsdale, Clinton, Eaton, Ingham, Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
Molina-	Jackson, Hillsdale, Clinton, Eaton, Ingham, Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
Priority Health-	Osceola, Mecosta, Newaygo, Ionia, Montcalm
United Healthcare-	Jackson, Hillsdale, Clinton, Eaton, Ingham, Shiawassee, Tuscola, Huron, Gratiot, Saginaw, Isabella, Midland, Bay, Clare, Gladwin, Arenac, Osceola, Mecosta, Newaygo, Ionia, Montcalm
HAP Midwest-	Shiawassee, Tuscola, Huron



Risk Stratification Criterion for Shared High-Risk Consumers:

1. Number of Emergency Department Visits (Physical or Psychiatric)
2. Absence of Primary Care claim in past 12 months
3. Number of chronic conditions
4. Number of inpatient hospitalizations in past 12 months (Physical or Psychiatric)

Care Coordination with Health Plans

Monthly Meetings with MHPs

- MSHN care management staff participate in monthly meetings with each of the 8 MHPs in the MSHN region on an ongoing basis
- Identification of shared high-risk consumers using risk stratification criteria developed by State PIHP/MHP work group
  - Care Connect 360 risk stratification

Outcomes of Care Coordination Efforts

- **ER Visit Reduction for individuals with Care Coordination Plan:**
  After 3 Months: 70% (57/81)
  After 6 Months: 68% (41/60)
  After 9 Months: 72% (23/32)
  After 12 Months: 53% (8/15)
  (Each of the above is all individual plans when they have reached that level)
  Overall; each individual at current month in Care Coordination Plan (3, 6, 9, 12) status: 79% (64/81)
- **IP Admission Reduction for individuals with Care Coordination Plan:**
  After 3 Months: 75% (61/81)
  After 6 Months: 67% (40/60)
  After 9 Months: 72% (23/32)
  After 12 Months: 53% (8/15)
  (Each of the above is all individual plans when they have reached that level)
  Overall; each individual at current month in Care Coordination Plan (3, 6, 9, 12) status: 69% (56/81)

Total overall reduction in ED utilization of 79%

Outcomes of Care Coordination Efforts

- **Development of Joint Clinical Protocols**
  - **Coordinated efforts between MSHN, Health Plans, and CMHSPs to address high-risk health needs among individuals with serious mental illness**

    1. **Annual Diabetes Screening for individuals who are prescribed antipsychotic medications for a diagnosis of Bipolar Disorder or Schizophrenia**

    2. **Education and appropriate follow-up care for individuals who are newly diagnosed with COPD**

Performance Bonus – FY18 Protocols

MICHIGAN PIHP/MHP STATEWIDE COLLABORATION WORKGROUP

PROTOCOL FOR DIABETES SCREENING FOR INDIVIDUALS WITH SCHIZOPHRENIA AND BIPOLAR DISORDER USING ANTI-PSYCHOTIC MEDICATIONS WHO ARE MUTUALLY SERVED

Purpose: To improve the health and quality of life for individuals 18-64 years old with Schizophrenia or Bipolar Disorder who are using antipsychotic medications (SSD) by ensuring diabetes screening.

Eligible Population	Responsible Entity	Actions to be taken	Frequency
Individuals 18-64 with a diagnosis of Schizophrenia or Bipolar Disorder who were dispensed an antipsychotic medication who are mutually served by PIHP/MHPs	Roles	**The PIHP** role is first contact with eligible CMH-engaged individuals to ensure a diabetes screen has been completed **The MHP role** is support of the PIHP efforts to contact members for screening, provider education on requirements/need for diabetes screening in this population, and to facilitate access to medical benefits where applicable.	
	Actions and Responsibilities	**PIHP Responsibility:** 1. The PIHPs will maintain primary responsibility for initiating first contact with eligible individuals who have not had a diabetes screening. If the PIHP is having difficulty contacting or completing this protocol, they will seek assistance from the associated MHP. 2. PIHP will ensure members being seen at the CMH are being screened for diabetes or is being connected to their PCP for diabetes screening 3. PIHPs will provide general education and support to their providers on standards and screenings for this population n collaboration with their MHP partners **MHPs Responsibility:** 4. MHP will provide general member education and on request, individual member education, on being screened for diabetes when taking antipsychotic medication 5. MHPs will provide general education and support to their providers on standards and screenings for this population in collaboration with their PIHP partners 6. MHPs will provide support to members related to Medicaid benefits – (i.e. transportation for lab draws, PCP assignment. Etc...) The responsibility for follow up lies with whoever ordered the test and referrals will be made to care managers for elevated lab values…	Ongoing
	Disparities/Health Equity	**Joint Responsibilities:** In an effort to improve healthcare equity, PIHPs & MHPs will assess clients for social determinants of health and address identified factors.	Ongoing

Adopted February 22, 2018

This guideline lists core management steps. It is based on the American Diabetes Association Standards of Medical Care in Diabetes - 2016; Volume 39, Supplement 1, Pages S1-S112. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Performance Bonus – FY18 Protocols

Purpose: To ensure jointly served PIHP/MHP members with a new COPD diagnosis get appropriate follow-up care, in an attempt to avoid unnecessary use of emergency departments and hospitalization.

Eligible Population	Roles	Actions to be taken	Frequency
The percentage of members ≥ 40 years of age with a new diagnosis of COPD who received appropriate follow-up care as evidenced by the completion of spirometry testing to confirm the diagnosis (2018 HEDIS Measure SPR).	MHP	1. The MHP will send educational materials to the member and notify the PCP of the need for COPD management. 2. MHP will educate members on COPD disease process, including smoking cessation and management of the illness. 3. Barriers and unable to reach individuals will be discussed during the monthly joint care management meetings. MHPs will assess clients for social influencers and address identified factors.	Ongoing
	PIHP	1. The PIHP will support the MHPs to ensure the member has appropriate PCP follow-up visit and assist with identifying and minimizing barriers to successful follow-up care. 2. PIHP will ensure member is screened for depression and receives the appropriate follow-up care for any identified symptoms. 3. Barriers and unable to reach individuals will be discussed during the monthly joint care management meetings.	Ongoing

Data Analytics Update

Primary Drug at SUD Admission

Admission Month: 10/1/2014 – 3/1/2019

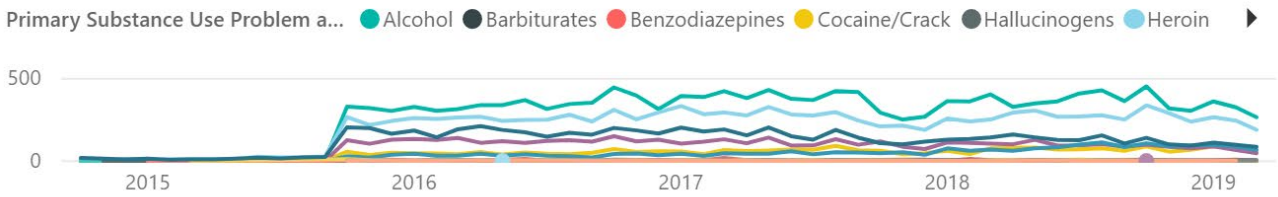
Age at Admission: All

County of Residence at Admission: All

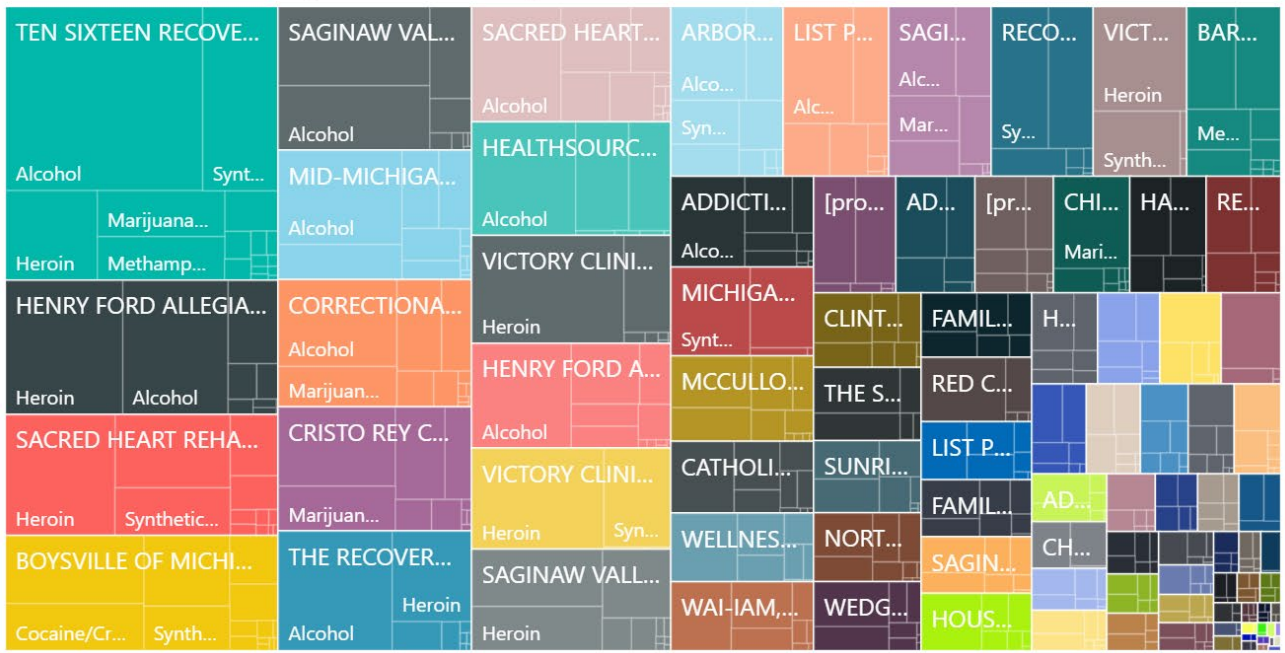
Type of Treatment Setting: All

Count of SUD Admissions by Admission Month

Count of SUD Admissions by Admission Month and Primary Substance Use Problem at Admission



% of Total SUD Admissions by Provider and Primary Substance at Admission



99.86%

% of Admissions with Primary Substance Use Problem

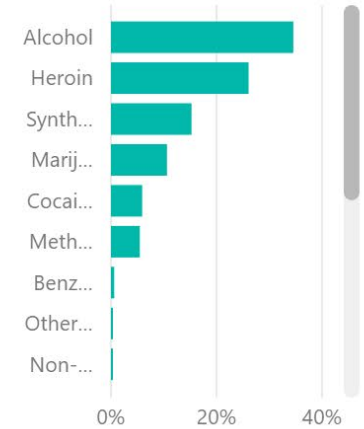
61.50%

% of Admissions with Secondary Substance Use Proble...

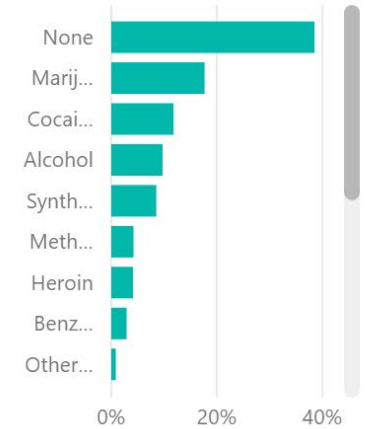
27.62%

% of Admissions with Tertiary Substance Use Problem

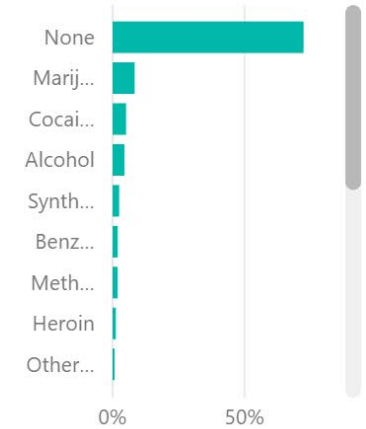
By Primary Substance Use Probl...



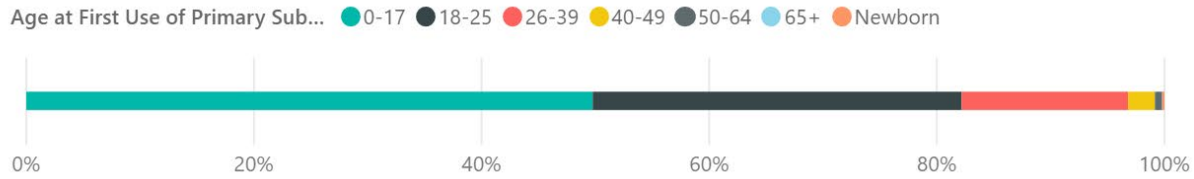
By Secondary Substance Use Pro...



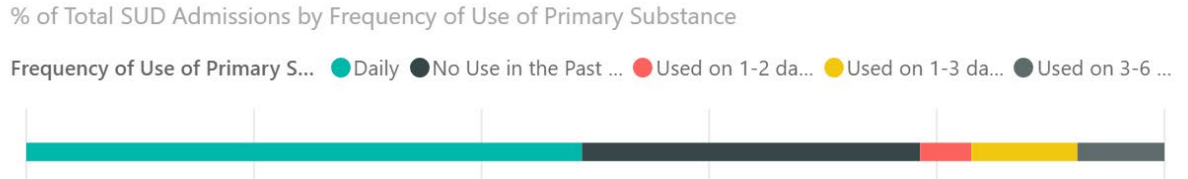
By Tertiary Substance Use Proble...



% of Total SUD Admissions by Age at First Use of Primary Substance



% of Total SUD Admissions by Frequency of Use of Primary Substance



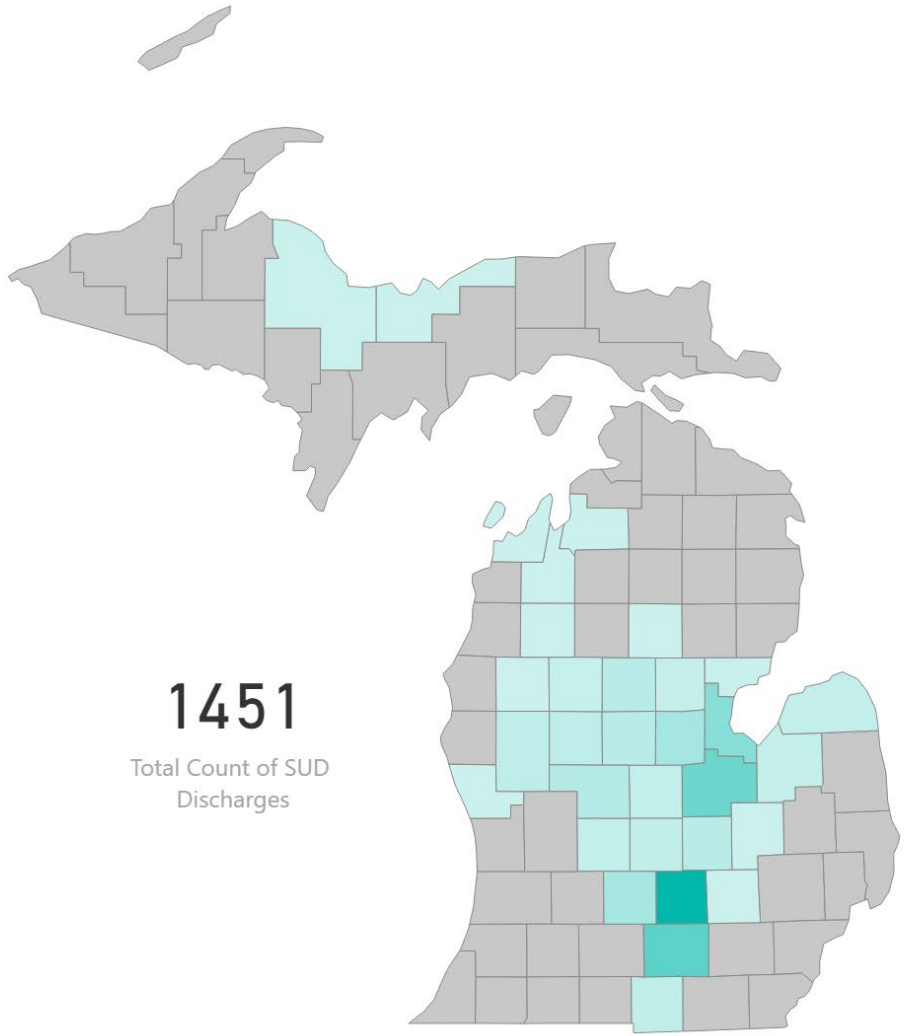
SUD Detox Recidivism

Discharge Month

10/1/2017 9/30/2018

Count of SUD Detox Discharges by Discharge Month

Count of SUD Detox Discharges by County of Residence at Detox Discharge



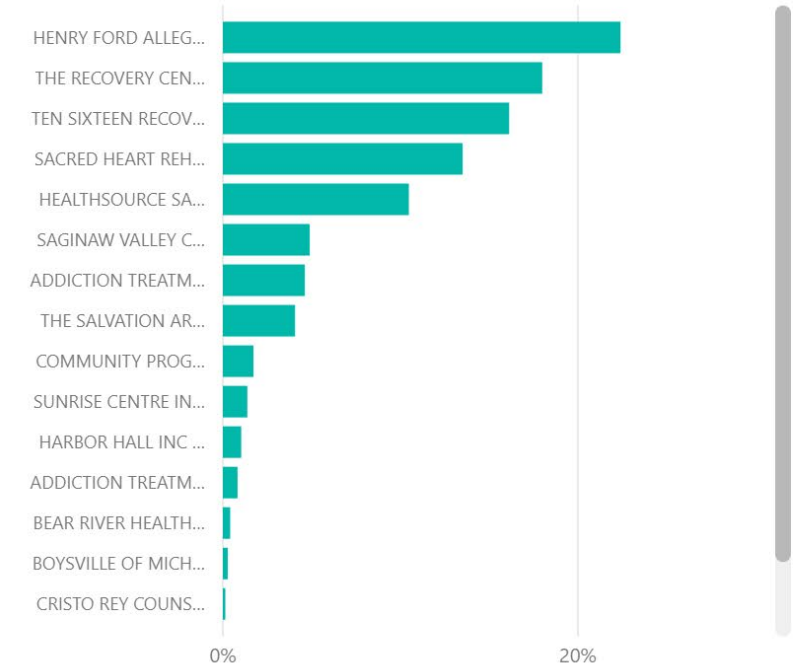
8.27%
% Recidivism within 30 Days

6.55%
% Recidivism within 30-60 Days

5.31%
% Recidivism within 60-90 Days

1451
Total Count of SUD Discharges

% of Total SUD Discharges by Provider



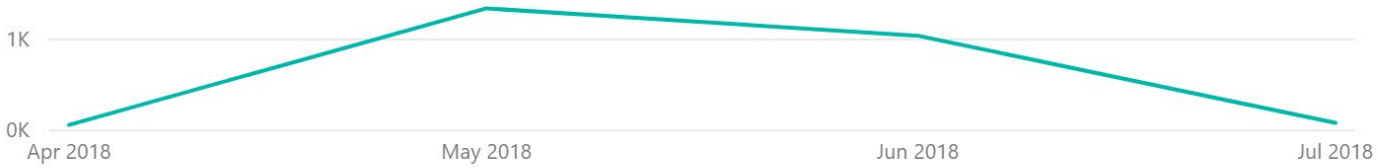
% of Total SUD Discharges by Discharge Reason

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

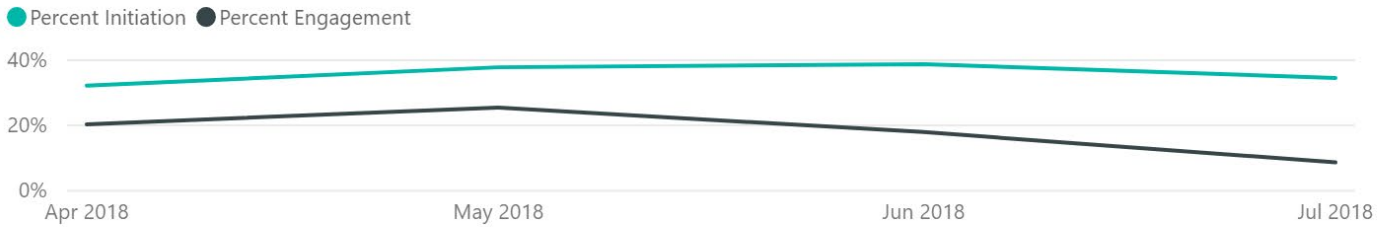
Month of AOD Treatment Episode Start

10/1/2017 9/30/2018

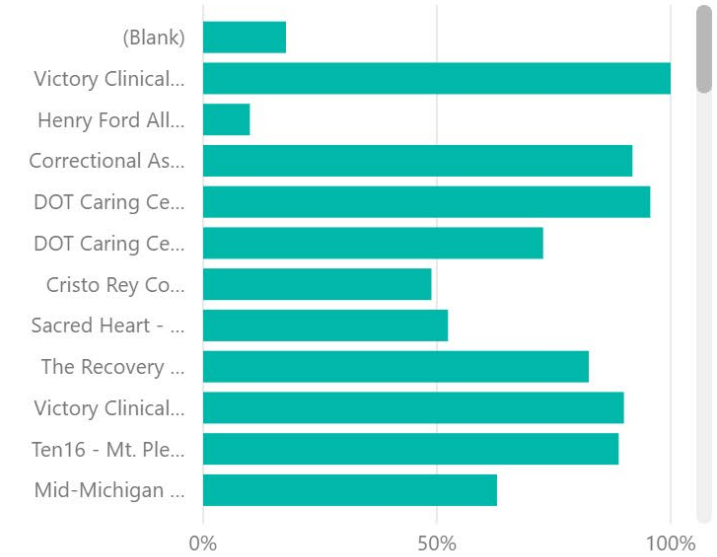
Count of New AOD Treatment Episodes by Month of AOD Treatment Episode Start



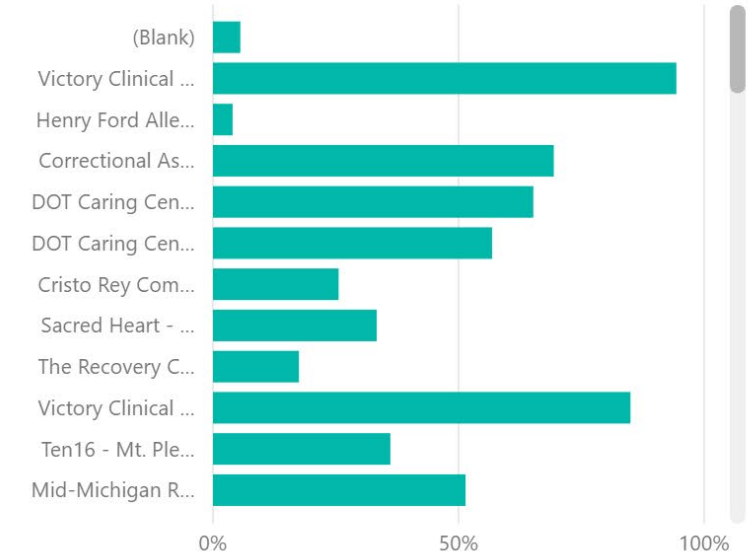
Percent Initiation and Percent Engagement by Month of AOD Treatment Episode Start



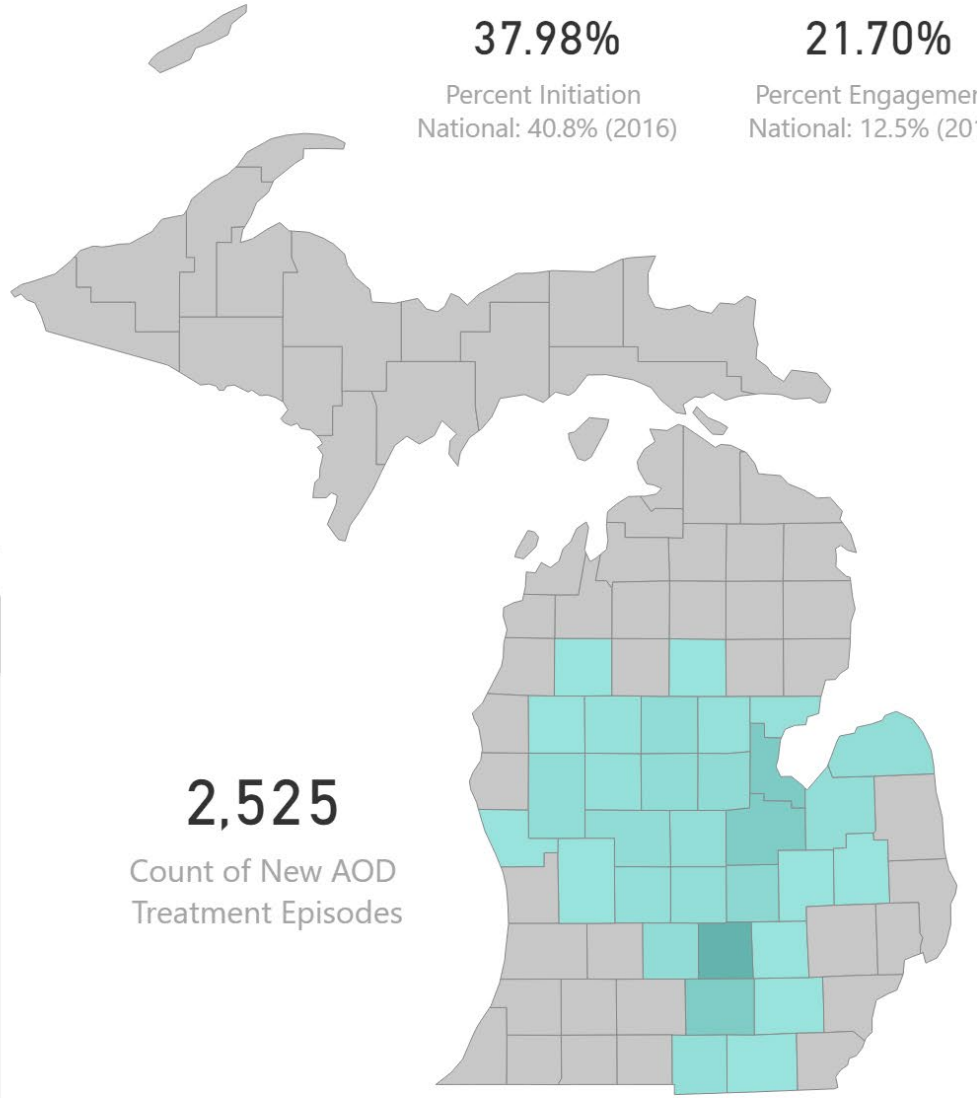
% Initiation by Provider of New AOD Treatment Episode Encounter



% Engagement by Provider of New AOD Treatment Episode Encounter



Count of New AOD Treatment Episodes by Current County of Residence



37.98%

Percent Initiation
National: 40.8% (2016)

21.70%

Percent Engagement
National: 12.5% (2016)

2,525

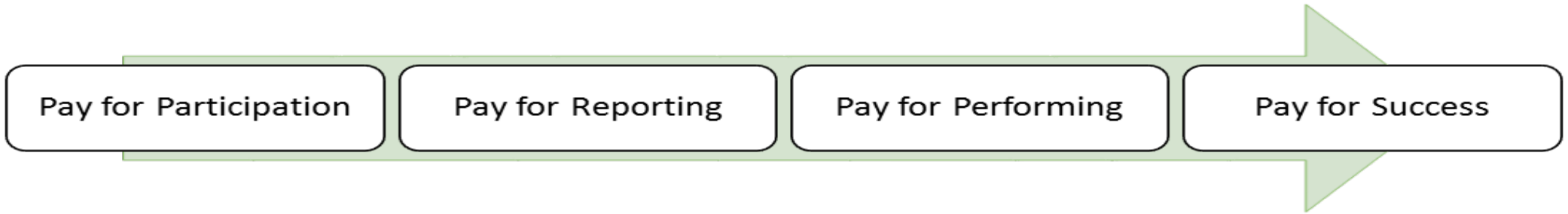
Count of New AOD Treatment Episodes

Value Based Purchasing Pilot Program

Overview

MSHN Pilot with Holy Cross and Cristo Rey:

- Improved clinical outcomes for at-risk populations
- Expanded care coordination between providers at all levels
- Consistent engagement in an SUD treatment and recovery relationship
- Engagement with primary care
- Reduction in unnecessary emergency department use
- Increase in the use of evidence-based trauma-informed care practices



Participation Phase (FY17)

- MSHN provided consumer level data
- Providers reviewed charts & identify trends, characteristics
- Providers evaluate process – admission, discharge, aftercare
- Obtain SUD provider access to data in CareConnect360
- Discuss initiative based on data
  - Revise consents to include PCP
  - Identify a PCP & referral if needed
  - Refer to PCP if not seen in 12m
  - Train / Educate staff on new process
  - Discuss ER use and process to see PCP, Provider
- Coordination with CMHSP
  - Consent and referrals

Reporting Phase (FY18-FY19)

- Quarterly progress reports to MSHN regarding progress toward implementation of clinical processes at SUD provider level to support identified goals and objectives
- Continued staff training and development at provider level related to trauma-informed screening tools (ACES) and evidence-based interventions
- SUD provider staff utilizing CC360 to better inform care coordination with physical health and behavioral health providers
- Development of performance metrics to be used during Pay for Performing stage of pilot

Performing Phase (FY19-FY20)

- Beginning FY19 Q4 (7/01/2019), SUD VBP providers will implement the use of HCPCS code H0050:HV Brief Intervention/Care Coordination to track all services related to the MSHN SUD Value-Based Purchasing (VBP) pilot:
  - Connecting individuals to primary care providers
  - Coordination with Medicaid health plans on behalf of an individual
  - Coordination activities with primary care providers and other healthcare providers
  - Coordination with community mental health providers
  - Consultation with nursing staff regarding client medical needs, etc.

Performing Phase (FY19-FY20)

- Achievement of Performance Metrics will provide SUD VBP Providers the opportunity to earn performance bonuses during FY20
- Examples of Performance Metrics:
  - 80% of consumers open to the agency will have seen a PCP within the last 12 months
  - ED use will decrease by at least 10% for consumers involved in treatment with the provider each quarter
  - 90% of consumers who screen positive for trauma at admission will have a trauma-related goal on their tx plan

Future Initiatives & FY19 Requirements

- Predictive Modeling - ICDP
- Expand Dashboard product availability: CMHSP & SUD Provider Network
- Expand cc360 Access: SUD Provider Network
- FY20 Shared Metrics with MHPs
- Increase care coordination & collaboration – Primary Care & Behavioral Health, including SUD
  - SUD ER: Coordination with Hospitals
  - Physician Letters

FY20 Proposed Shared Metrics with MHPs

1. **Implementation of Joint Care Management Processes**: MSHN continues to meet monthly with the MHPs to develop care plans for those identified in the joint risk stratification.
2. **Follow-Up After Hospitalization for Mental Illness within 30 Days**: MSHN has been monitoring this measure for a few years and continues to demonstrate high performance.
3. **Plan All-Cause Readmission (PRC):** MSHN identified this measure as a priority in 2016 and began initiatives for performance improvement. In FY20, MDHHS is including this measure only as a review and validation of data. MSHN will work with MDHHS to identify any discrepancies.
4. **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence:** This measure is also informational for FY19. Validation of this measure will continue throughout FY20

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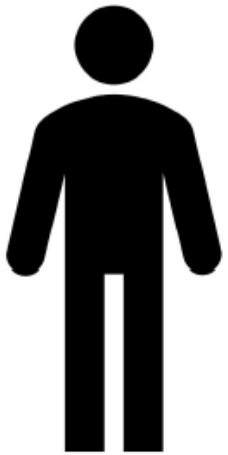
"No Wrong Door" Access for Substance Use Services

MSHN's goal for regional access to SUD services is not a single point of entry system; rather a "no wrong door" approach that eliminates barriers by allowing individuals to access treatment through multiple points of entry



Community Mental Health Service Provider

- Screening and referral for substance use services available 24/7/365 through the local community mental health access center for the county in which the individual lives (directory attached)

Substance Use Disorder Service Provider

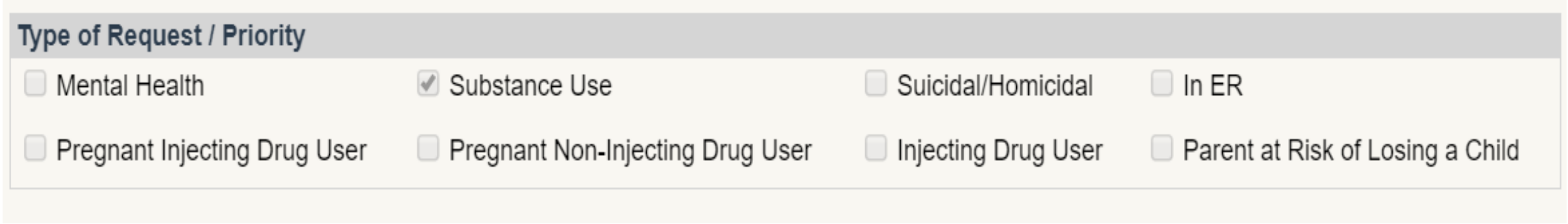
- Individuals can call the substance use treatment provider of their choice directly for screening, scheduling, and/or referral
- Complete directory of MSHN providers available at www.midstatehealthnetwork.org
- No referral or "prior auth" from MSHN necessary

Mid-State Health Network

- Available Mon-Fri, 8am-5pm; Individuals may call if they have questions about benefits or services, however they are <u>not required</u> to call MSHN to access services
- MSHN Utilization Management Department: 1-844-405-3095

SUD Provider Role in FUA

- During initial phone call/contact, ask about referral from emergency department
- Record in REMI on BRIEF SCREEN



SUD Provider Role in FUA

- Perform outreach to individuals referred from ER to confirm that follow up appointment was kept
- Work with local Emergency Rooms to ensure smooth referral processes are in place
- Use Motivational Interviewing and stage-matched interventions
  - ie: if not formal tx, will an individual meet with a recovery coach?
- Submit all encounters for follow up service in REMI

Questions

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