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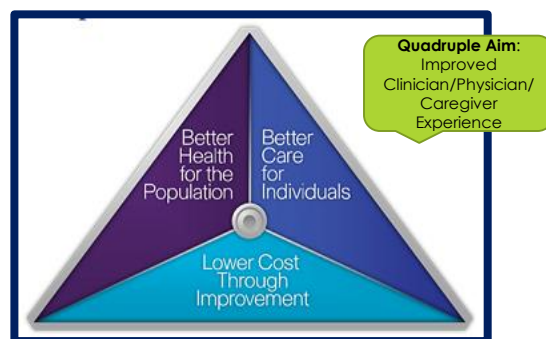
Population Health & Integrated Care

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2

What is Population Health?

- ▶ Systematic effort to **improve health outcomes in sub-populations** that share multiple clinical and social attributes
- ▶ Reflects the interdependence of **biology, behaviors, social, cultural, economic, and environmental factors that impact wellbeing**
- ▶ Compels healthcare and social service providers and the insurer to envision and **develop organized and integrated delivery systems** capable of achieving the **Triple Aim**



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3

Operationalizing Population Health

1. **Collaborating** with Partners and Payers to Initially Define Attributes of **Target Population(s)**
2. **Identify Immediate Gaps in Care** and Services and Develop Improvement Plan to Include Additional Partners/Providers
3. **Predictive Modeling:** Stratify Risks Based on Analysis of Prevalence and Historic Utilization
4. **Engage Patients** in Treatment Planning, Treatment, and Self-Management (through Provider Network)
5. **Manage Care and Benefits, Coordinate Care within Integrated Delivery System.** Continue to **Refine Risk Stratification.**
6. **Measure Outcomes and Monitor Performance** of System in Relation to Quality and Reimbursement Model

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4

Population Health

- Data Integration
- Information Exchange
- Communication & Collaboration
- Care Coordination Including Team-based Intervention
- Apply Evidence & Standards
- Partner with Service Providers
- Patient & Family Education
- Analysis & Reporting

MSHN's Strategy to Population Health

- ▶ Receive enrollee data from MDHHS including both Physical Health and Behavioral Health
- ▶ Information exchange with Hospitals
- ▶ Collaborate with MHPs, CMHSPs, SUD Providers
- ▶ Developed Risk Stratifications & Care Coordination Plans
- ▶ Educating consumers on sharing data and benefits of integrated care plans
- ▶ Develop data analytics to monitor and identify sub-populations, gaps in care and outcomes

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5

MDHHS Contract Requirements – FY2016

1. Identification of and Access to Data on Joint Members

- CC360: Reports on shared members
- Admission, Discharge, Transfer Messaging
- MiHIN: Use Cases, Active Care Relationship Services

2. Development of Joint Care Management Standards and Tools

- Submit narrative descriptions including dates, attendees, and brief meeting notes of MHP & PIHP meetings
- Developed care management tool, tracked in CC360

3. Implementation of Joint Care Management Processes

- Submit list of shared members receiving care coordination

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6

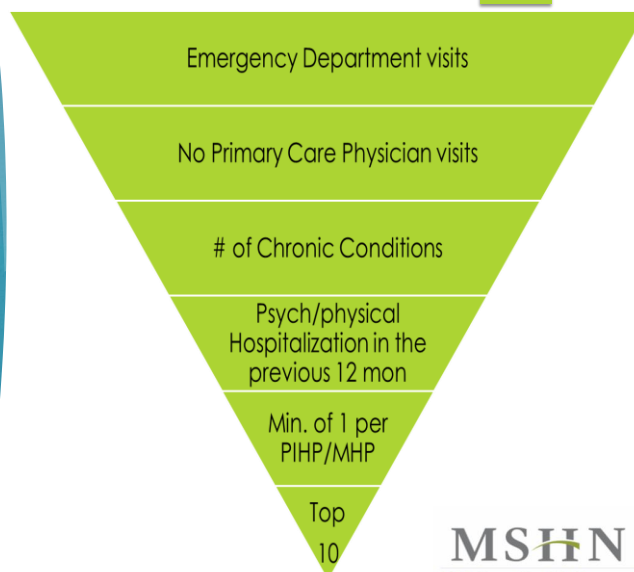
Risk Stratification Criteria

Developed through PIHP & MHPs State-Wide monthly meetings.

MSHN meets individually with each MHP monthly.

Eight (8) Medicaid Health Plans in our region.

1. Aetna
2. Blue Cross Complete
3. HAP
4. McLaren
5. Meridian
6. Molina
7. Priority
8. United

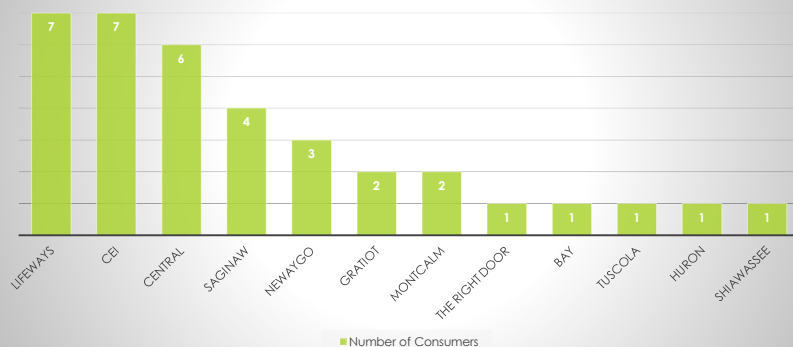


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7

MDHHS Contract Requirements – FY2016

Number of Care Coordination Consumers by CMHSP



Total Joint Care Plans: 49
Current Joint Care Plans: 36
Closed Care Plans: 13

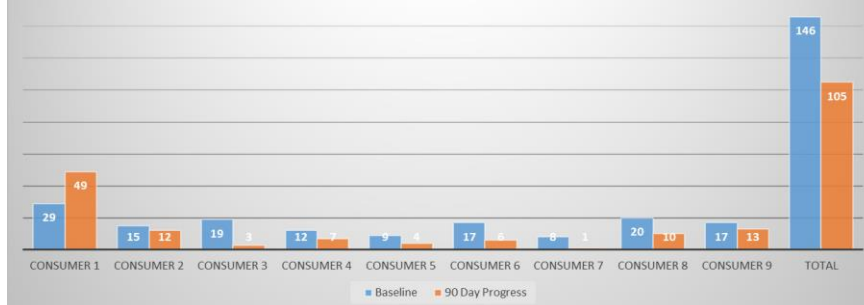
- Moved out of Region (2)
- Ineligible for Benefits (2)
- Unable to Engage Member (5)
- Member Refused (1)
- Completed (3)

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FY16 Initial Outcomes of Care Coordination Efforts

ED Utilization: Baseline and Following 90 Days of Care Coordination



ED utilization decreased in every case but one

Total overall reduction in ED utilization of 28%

9

MDHHS Contract Requirements – FY2017

1. Implementation of Joint Care Management Processes

- Quarterly, each MHP and PIHP will demonstrate that joint care plans exist for members with appropriate severity/risk that have been identified as receiving services from both entities.
- Submit a narrative description including dates, attendees, and examples of the diagnoses of members discussed to document attendance at monthly care management meetings.

DHHS selects samples for MSHN to provide evidence of care plans

2. Follow-up After Hospitalization for Mental Illness (FUH)

- The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner. (within 7/30 days) – Aligns with HEDIS measure – (NCQA standard)

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10

Follow-Up After Hospitalization for Mental Illness

Measured against an **adult minimum** standard of **58%** and a **child minimum** standard of **70%**

Baseline data were pulled from the Medicaid Data Warehouse and reflect **calendar year 2015** data

- MSHN Total – 77.23%
- MSHN Adult – 74.53%
- MSHN Child – 84.53%

MSHN utilizes our data analytics software to monitor and track this measure regionally as well as by CMHSP. Metric developed in ICDP as part of the initial key performance indicators. CMHSPs have access to and can view their CMH specific information.

Measurement period will be July 1, 2016-June 30, 2017

Expectation that performance improvement is a multi-year (3 year) activity.

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11

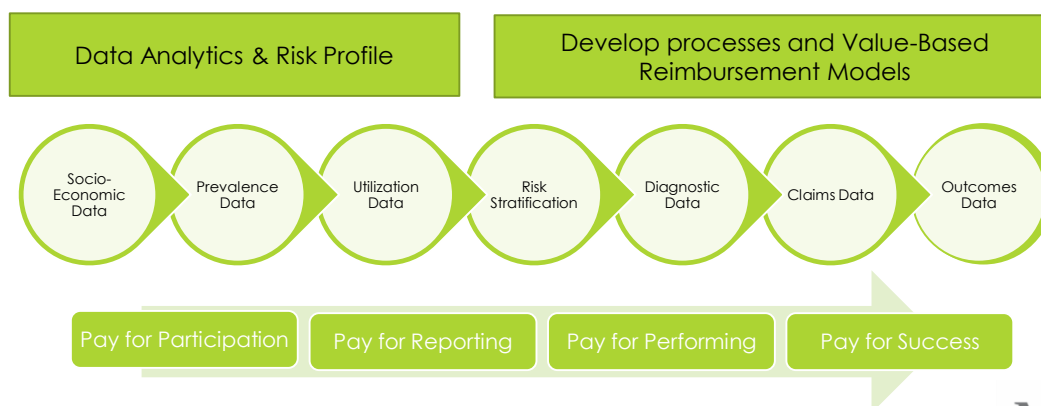
Integrated Care Coordination

- ▶ Developed and posted for internal Director of Care Management
- ▶ Developed a contract with SWMBH
 - ▶ PIHP requirement
 - ▶ Available RN capacity
 - ▶ Efficiencies
 - ▶ Meeting participation
 - ▶ Standardization in care plan management
- ▶ Continued involvement and oversight
 - ▶ Utilization Specialist communication with CMHSPs, review of care plans
 - ▶ Deputy Director receipt of monthly reporting, monitoring of progress and MDHHS reporting requirements

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Value Based Purchasing Pilots



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13

Managed Care Information Systems (MCIS) Population Health

- ▶ Consent management – sharing & exchange of health information
- ▶ Patient Engagement – Patient portals to access records
- ▶ Value Based Models - Ability to process different payment methods based on outcomes
- ▶ Health Information Exchange – Providers, Hospitals, Social Service Agencies, Schools, etc.
- ▶ Authorization & Outlier reviews – Risk management related to authorizations/liabilities (IBNR)
- ▶ NCQA Measures: Utilization Management, Provider Network Monitoring, Clinical Outcomes, etc.

14

Questions



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