MEDICAL HOME NETWORK

Building Partnerships for Better Health

Delivery System Transformation:

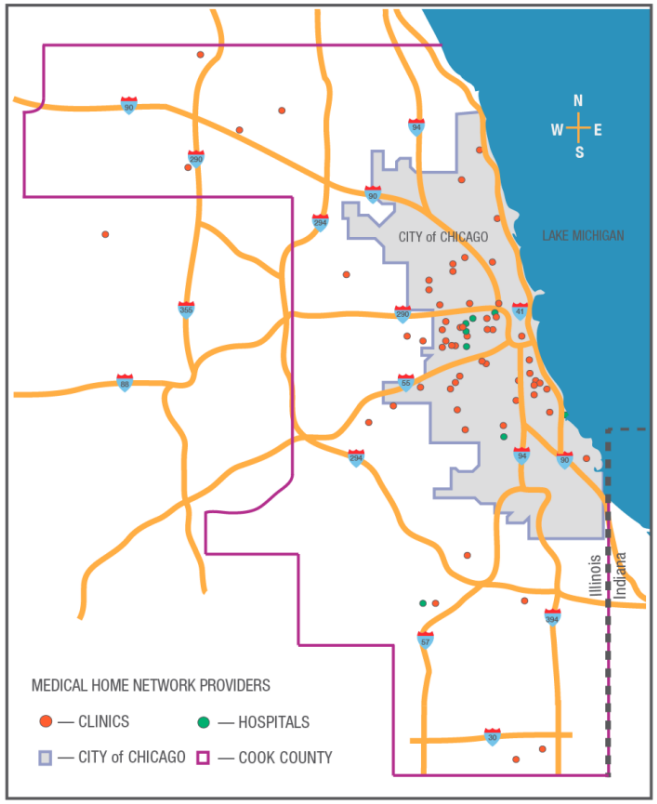
From Patient Engagement to Payment Reform

March 25, 2014

The Medical Home Network (MHN) is a 4-year-old formal provider collaborative working to improve the health of Medicaid recipients in underserved Chicagoland areas by *enhancing* **care coordination** and **quality**, *improving* **access** and *reducing* fragmentation and cost, all while *reinforcing* the Medical Home.

MHN: *Who We Are & Who We Serve*

Provider Participants



Members

- **170,000* Medicaid** beneficiaries, 73% of whom live on Chicago's South Side (Southwest, Southeast or Far South)
- Approx. 90% TANF and 10% AABD and Adult Waiver
- 9.4% of the State's PCCM Medicaid population and 11% of PCCM Medicaid costs
- In the MHN target area, approx. **25%** are covered by managed Medicaid

Participants

MEDICAL HOMES	SITES
Access Community Health Network	49
Alivio Medical Center	6
Chicago Family Health Center	5
CCHHS Ambulatory Care Network	16
Centro de Salud Esperanza	1
Friend Family Health Center	5
Holy Cross Clinic	1
La Rabida Children's Hospital	1
Lawndale Christian Health Center	4
Rush University Medical Center	4
Saint Anthony Hospital	5
Sinai Medical Group	10

COUNTY & PRIVATE HOSPITAL	SITES
Cook County Health & Hospitals System	3
Holy Cross Hospital	1
La Rabida Children's Hospital	1
Mt. Sinai Medical Center	3
Rush University Medical Center	3
Saint Anthony Hospital	1

Total Medical Homes:	107
Total County & Private Hospitals:	12
Total PCPs:	~550

STATE GOVERNMENT

Illinois Medicaid
(Department of Healthcare & Family Services)

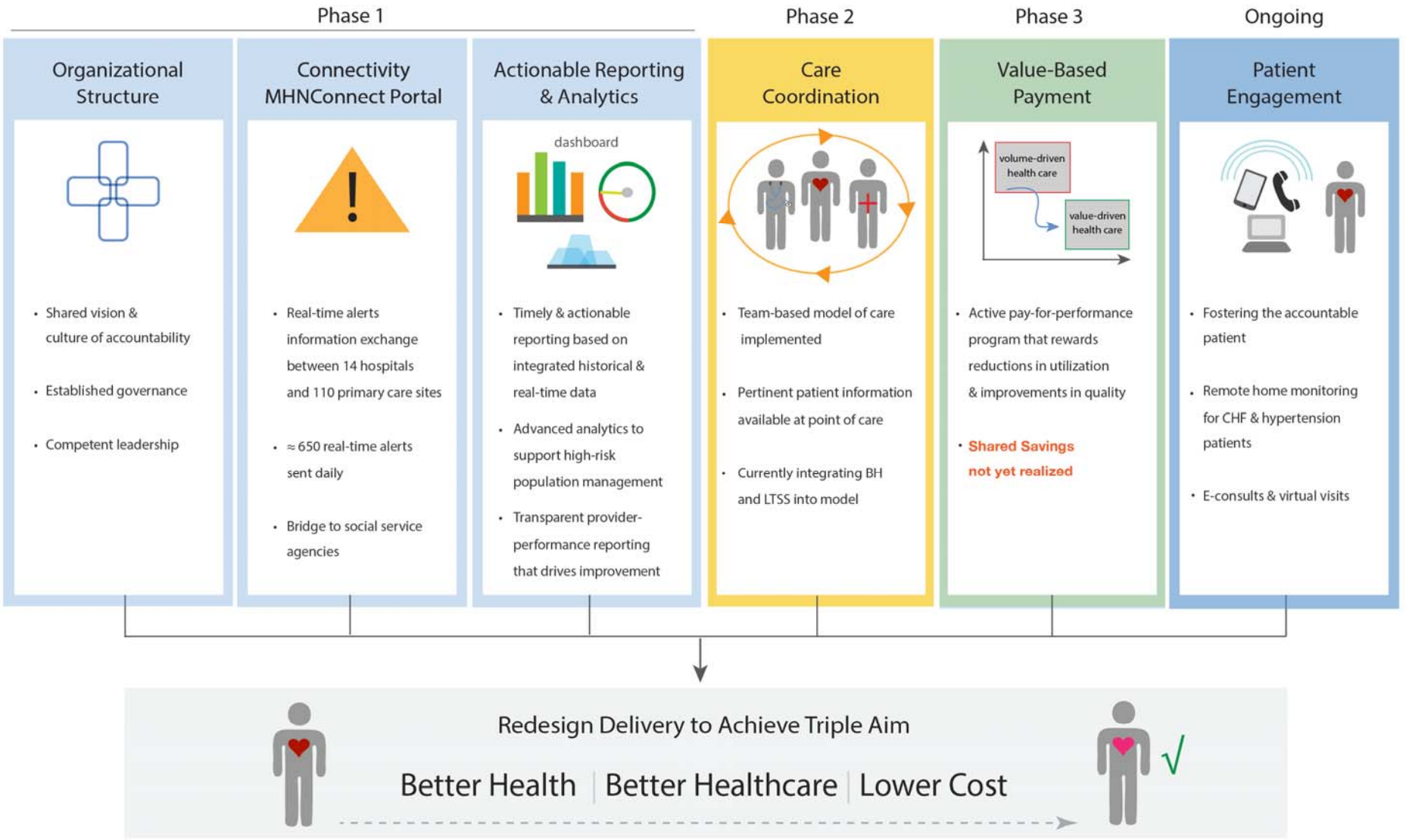
MHN: *Goals*

- ***Transition*** the Safety Net to accountability for the cost and quality of a population's health
- ***Enhance*** specialty and primary care access to meet the needs of current and future members
- ***Improve*** health status by facilitating care coordination across the continuum and reinforcing Medical Homes
- ***Reduce*** the gross cost of care for our members by 2 to 4%
- ***Improve*** patient experience and enhance patient accountability and engagement

MHN: *Process*

- Formalized **collaboration** between traditional competitors
- Received **Medicaid pilot designation** to test innovative payment and delivery reforms on behalf of HFS, allowing receipt of statewide claims and Rx data
- **Launched innovative connectivity** between providers to exchange real-time hospital activity
- Agreed upon a **shared savings reimbursement model** under review by HFS and CMS
- Designed a **model of care** to foster clinical collaboration and reinforce Medical Homes

The Building Blocks for *Delivery System Transformation & Population Management*



Connectivity

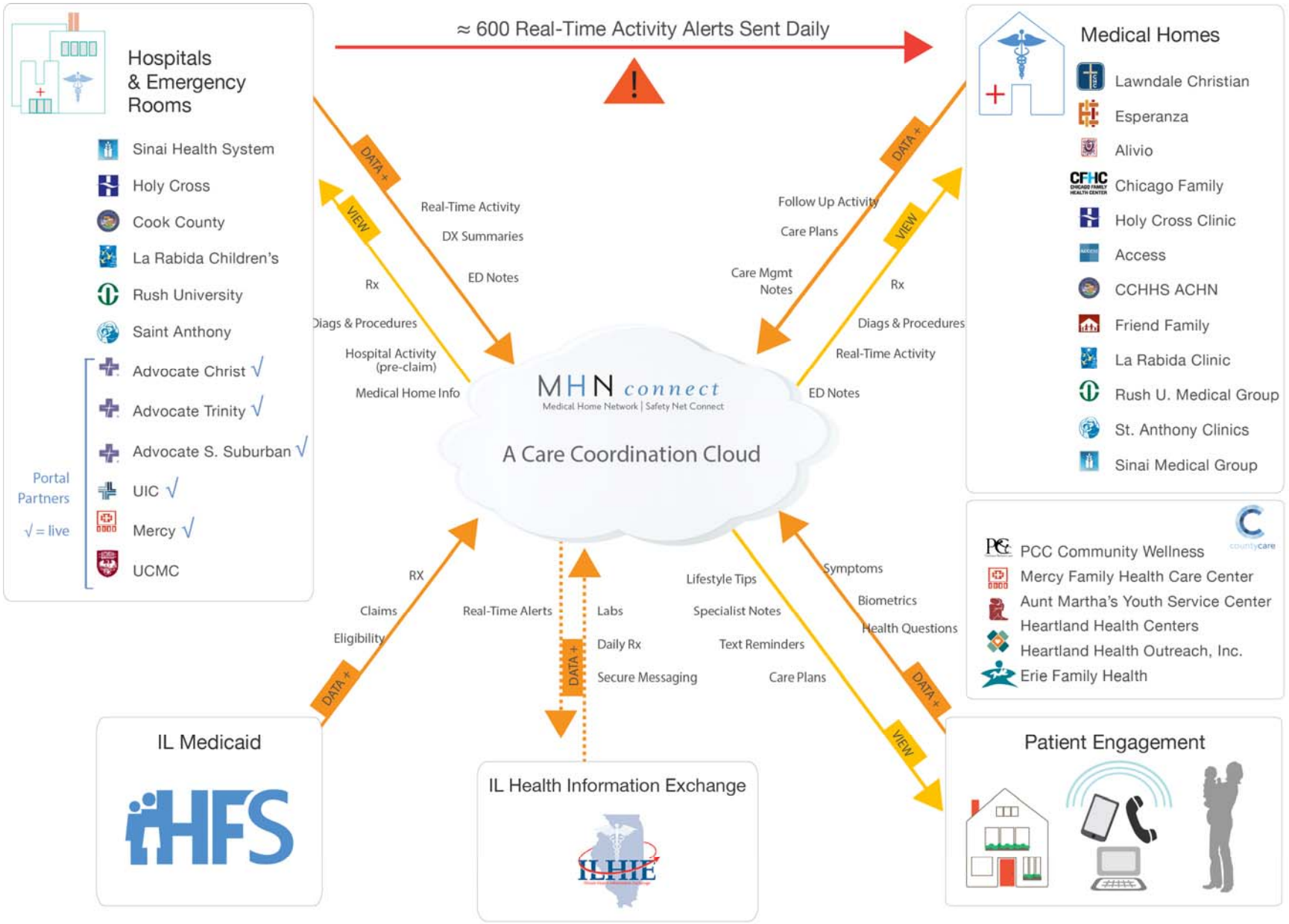
Coordinating Care through Virtual Integration

MHNconnect

Medical Home Network | Safety Net Connect

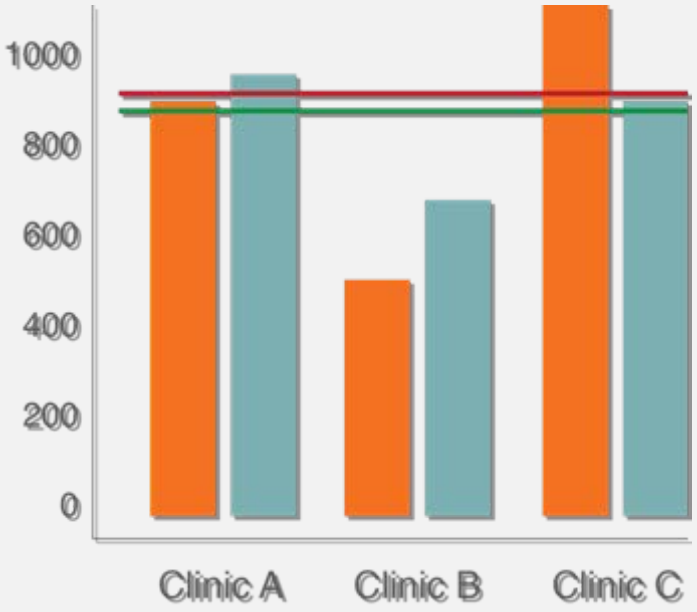
- **Employing web-based technology** currently used in Orange County, CA to manage the large uninsured population in a county without a public hospital
- Real-time, network-wide **connectivity**
- Tracks patient activity through the "community" with **real-time** notifications of hospital and ED activity to the Medical Home
- Allows for **bilateral communication** between disparate providers
- Provide **pertinent patient history** at point of care
- Pliant **platform** for additional **data sources** and **functionalities**

MHNConnect: *IT Infrastructure for Care Coordination Across the Continuum*



Analytics

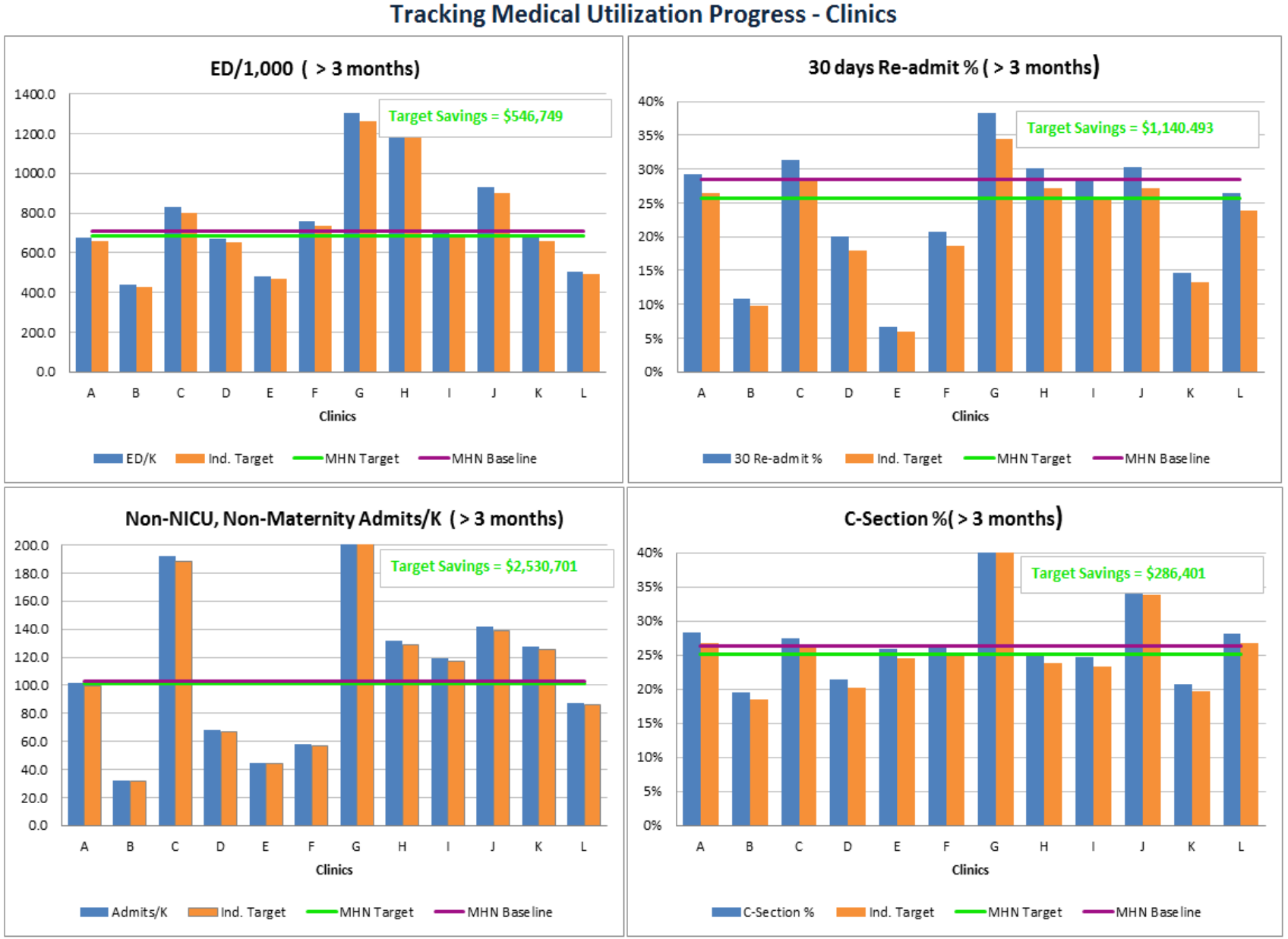
MHN: Enabling a Population Health Approach & Targeted Interventions



Reporting and analytics capabilities allow for management of health at the population, entity, physician and patient levels.

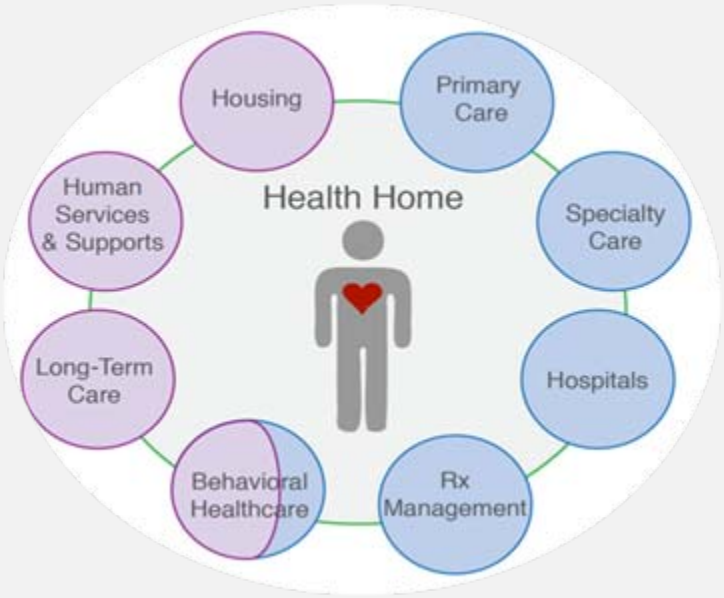
- **Combines** real-time activity (ED/INP admits & D/C) with historical DHFS claims and Rx data
- **Integrates** disparate data sources and securely warehouses data
- **Supports** quality measurement and improvement
- **Identifies** subpopulations for targeted clinical intervention
- Provider-**performance** report cards

MHN Analytics: *Medical Utilization by Clinic*



Model of Care

MHN: A Transformational Model of Care

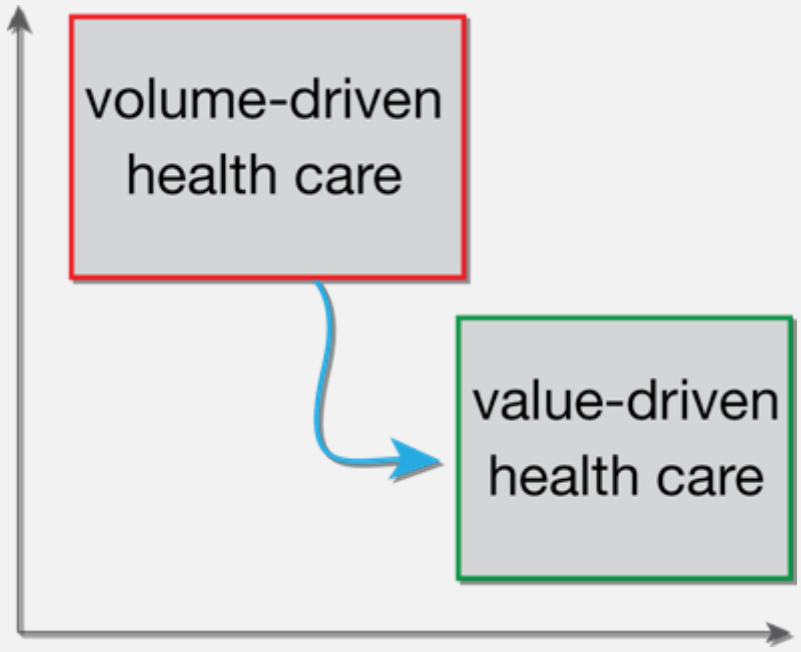


- **Real-time** alerts and **enhanced communication** during **transitions** of care
  - **Data analytics** translated into actionable, impactful interventions
  - A **team** approach to care that incorporates new workforce members trained to use data to coordinate care
  - **Interventions** for high-risk populations to reduce avoidable hospitalizations
- Evidenced-based referrals and e-consults to **maximize** specialty access
- **Integrated approach** to behavioral health
- Provider champions to engage participants and spread **best practice**

Payment

Payment That Drives Change Through Provider Engagement

MHN has designed a payment strategy to reward performance and transition providers from volume to value

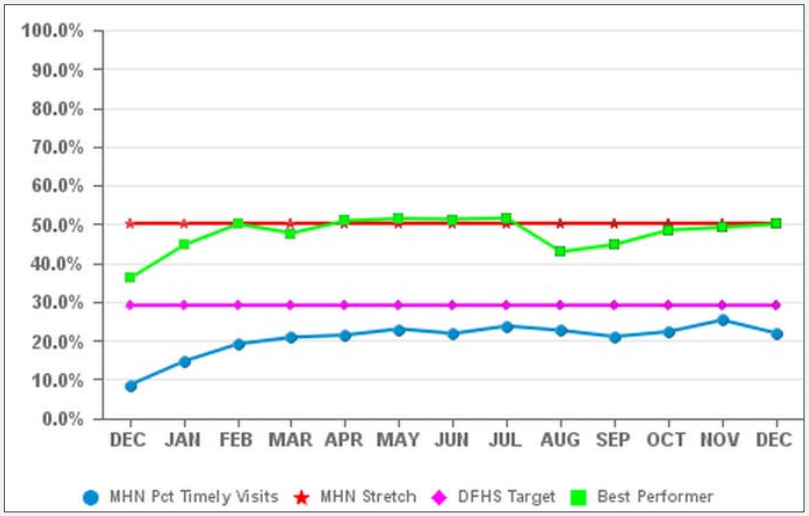


This strategy is designed to:

- **Build accountability** for the Medicaid population's healthcare
- **Include** all parties responsible for cost and quality
- **Facilitate** and **reward** care coordination activities
- **Generate savings** based on real reductions in waste and improvements in health
- **Promote delivery re-design and infrastructure development to achieve the triple-aim**

P4P Case Study

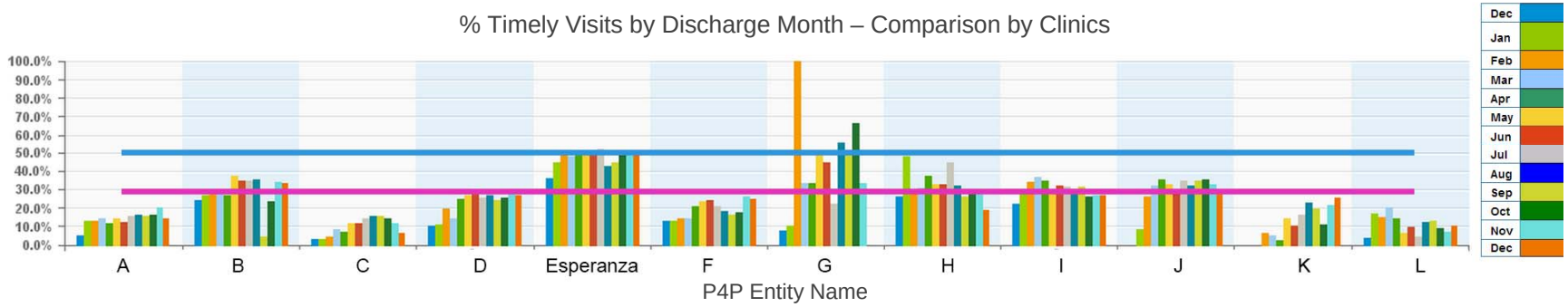
7 Day Medical Home Follow-up Appointment Post IP Discharge or ED Visit



Driving care coordination at the practice level:

- **Choice of process measure** that is supported by a sustainable business case
- **Actionable data** facilitates successful attainment
- Use of a new **cost effective work force**
- **Up front funding required** to initiate the process
- Transition to for long term process support **outcomes-based payment**

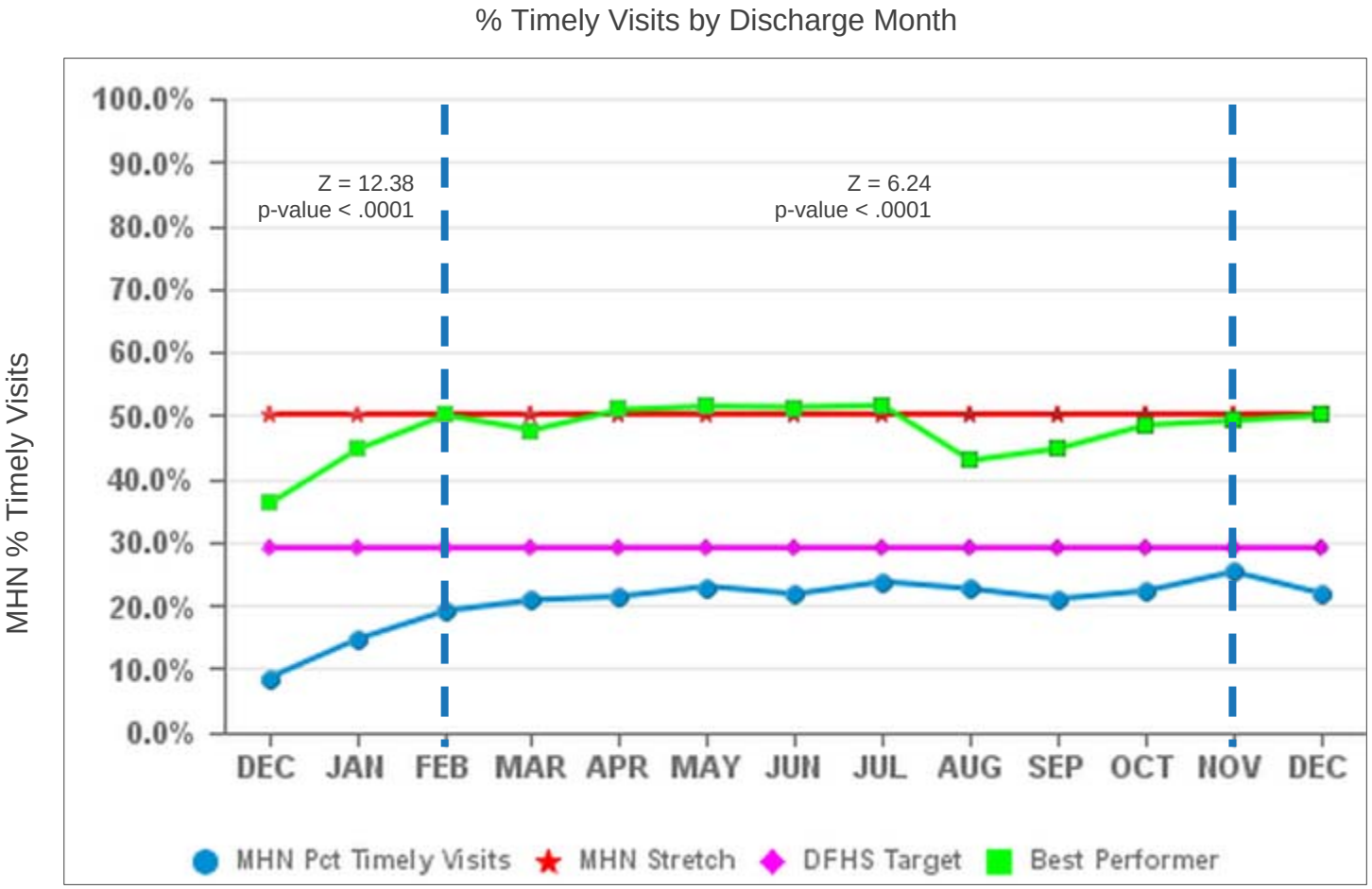
MHN P4P: *7 Day Appointment Follow-Up*



MHN Discharge follow-up activity & PCP follow-up activity

Discharge Event Type	Performance Quarter	1	1	1	2	2	2	3	3	3	4	4	4
	Performance Month	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV
ER	Nbr Discharges	2,659	2,375	2,486	3,039	2,913	3,480	3,464	3,286	3,175	3,283	3,282	2,931
	% Timely PCP Visits	8.2%	13.1%	17.2%	18.2%	19.5%	21.6%	19.5%	21.5%	20.6%	19.5%	20.7%	22.9%
	P4P $ Payment	$4,340	$6,240	$8,560	$11,060	$11,340	$15,020	$13,540	$14,100	$13,080	$12,800	$13,580	$13,420
	P4P Funded at 50%	$26,590	$23,750	$24,860	$30,390	$29,130	$34,800	$34,640	$32,860	$31,750	$32,830	$32,820	$29,310
Inpatient	Nbr Discharges	714	753	607	648	599	799	842	812	802	756	750	731
	% Timely PCP Visits	9.8%	18.6%	22.6%	25.3%	24.0%	25.8%	26.7%	28.1%	26.9%	21.7%	24.1%	29.1%
	P4P $ Payment	$1,400	$2,800	$2,740	$3,280	$2,880	$4,120	$4,500	$4,560	$4,320	$3,280	$3,620	$4,260
	P4P Funded at 50%	$7,140	$7,530	$6,070	$6,480	$5,990	$7,990	$8,420	$8,120	$8,020	$7,560	$7,500	$7,310
Maternity	Nbr Discharges	23	25	76	106	95	73	101	135	104	102	99	122
	% Timely PCP Visits	21.7%	40.0%	53.9%	70.8%	71.6%	97.3%	69.3%	52.6%	50.0%	63.7%	60.6%	59.0%
	P4P $ Payment	$100	$200	$800	$1,460	$1,240	$960	$1,200	$1,420	$1,040	$1,300	$1,200	$1,440
	P4P Funded at 50%	$230	$250	$760	$1,060	$950	$730	$1,010	$1,350	$1,040	$1,020	$990	$1,220
Total Nbr Discharges		**3,396**	**3,153**	**3,170**	**3,795**	**3,613**	**4,375**	**4,417**	**4,233**	**4,081**	**4,141**	**4,131**	**3,784**
Total Pct Timely PCP Visits		**8.6%**	**14.7%**	**19.1%**	**20.8%**	**21.4%**	**23.0%**	**21.8%**	**23.7%**	**22.6%**	**21.0%**	**22.3%**	**25.3%**
Potential P4P $ Payments		**$5,840**	**$9,240**	**$12,100**	**$15,800**	**$15,460**	**$20,100**	**$19,240**	**$20,080**	**$18,440**	**$17,380**	**$18,400**	**$19,120**
Potential P4P $ Funded at 50% Timely		**$33,960**	**$31,530**	**$31,700**	**$37,950**	**$36,130**	**$43,750**	**$44,170**	**$42,330**	**$40,810**	**$41,410**	**$41,310**	**$37,840**

MHN P4P: *MHN Network 7 Day Appointment Follow-Up Performance*



Esperanza Case Study: *Driving Improved Outcomes*

Innovations

- **Face-to-face care management** in ED ***prompted by real-time MHN alerts***
- **New patient outreach** guided by the ***MHNConnect New Patient List***
- **Frequent ED user outreach** using the ***MHNConnect ED Frequent Flyer Report***

Goals

- Working to ***improve*** **health**, ***lower*** **costs** & ***engage*** **patients**
- *Reducing* inappropriate **ED utilization** and **re-hospitalizations**

Results

- *Managing* ***81%*** of **transitions of care**
- **50% 7 day follow-up rate** ***from a baseline of 32% pre-pay-for-performance***
- **27%** ***of members with a 7 day follow-up had*** **1 or more chronic condition,** ***most commonly asthma***

IP Utilization Comparative Analysis Case Study: *P4P vs. Shared Savings*

Period: 12/01/2011 - 03/31/2012 (Prior Year (4 months) - Pre Intervention)
Period: 12/01/2012 - 03/31/2013 (4 months -Q1 Performance Period)

Clinic 1_MHN

Days/1000

	Pre # of Days	Pre Member months	Per K Calc	Post # of Days	Post Member Months	Per K Calc	% Change
Clinic_1 Total	2,136	28,026	915	1597	26,583	721	
Less Clinic_1 Waiver	82	142	6,920	4	66	800	
Less LCHC AABD	628	2,562	2,941	652	2,663	2,937	
Comparative Clinic_1	**1,426**	**25,322**	676	941	23,854	473	
Recalculated Days/1,000	**676**			**473**			*-30%*

Admit/1000

	Pre # of Admits	Pre Member months	Per K Calc	Post # of Admits	Post Member Months	Per K Calc	% Change
Clinic_1 Total	465	28,026	199	399	26,583	180	
Less Clinic_1 Waiver	13	142	1,098	1	66	200	
Less Clinic_1 AABD	136	2,562	638	125	2,663	561	
Comparative Clinic_1	**315**	**25,322**	149	274	23,854	138	
Recalculated Admits/1,000	**149**			**138**			*-8%*

Z-Test

Z-Value	**8.81**
P-Value	**< .0001**

*Comparing pre inpt. Admits/1000 between MHN and Managed Medicaid Plan

Z-Value	**23.19**
P-Value	**< .0001**

*Comparing pre inpt. Days/1000 between MHN and Managed Medicaid Plan

Managed Medicaid Plan Shared Savings

Days/1000

	Pre # of Days	Pre Member months	Post # of Days	Post Member Months	% Change
Clinic_1 Total	N/A	N/A	N/A	N/A	
Less Clinic_1 Waiver	N/A	N/A	N/A	N/A	
Less Clinic_1 AABD	N/A	N/A	N/A	N/A	
Comparative Clinic_1	**487**	**35,640**	650	38,330	
Days/1,000	**164**		**203**		*24%*

Admit/1000

	Pre # of Admits	Pre Member months	Post Utilization	Post Member Months	% Change
Clinic_1 Total	N/A	N/A	N/A	N/A	
Less Clinic_1 Waiver	N/A	N/A	N/A	N/A	
Less Clinic_1 AABD	N/A	N/A	N/A	N/A	
Comparative Clinic_1	**105**	**35640**	222	38330	
Admits/1,000	**35**		**70**		*97%*

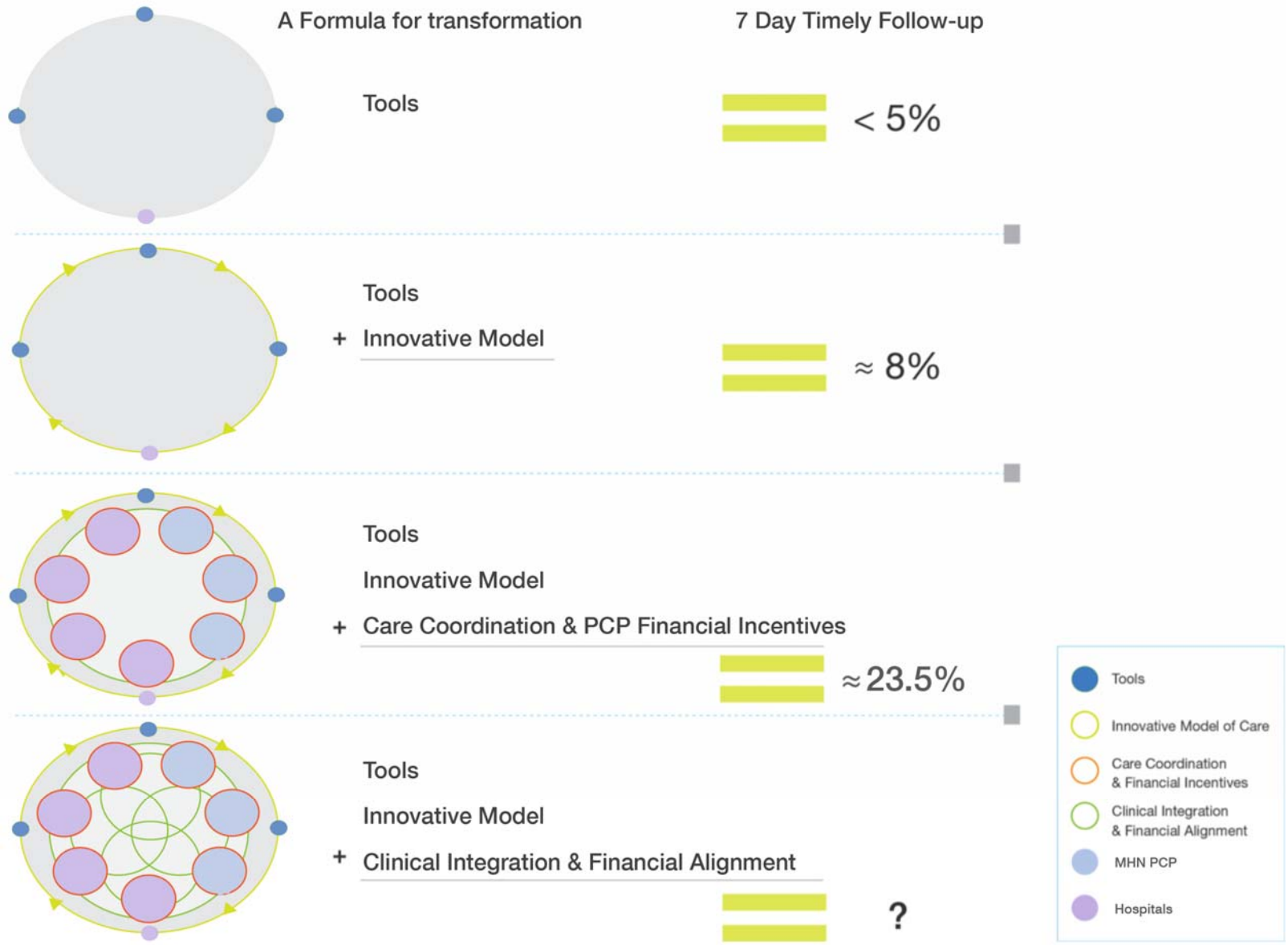
Z-Value	**12.76**
P-Value	**< .0001**

*comparing post inpt. days/1000 between MHN and Managed Medicaid Plan

Z-Value	**5.00**
P-Value	**< .0001**

*comparing post inpt. Admits/1000 between MHN and Managed Medicaid Plan

Phases of System Transformation: *A Case Study*



MHN Preliminary P4P Results: *First 4 Months Results*

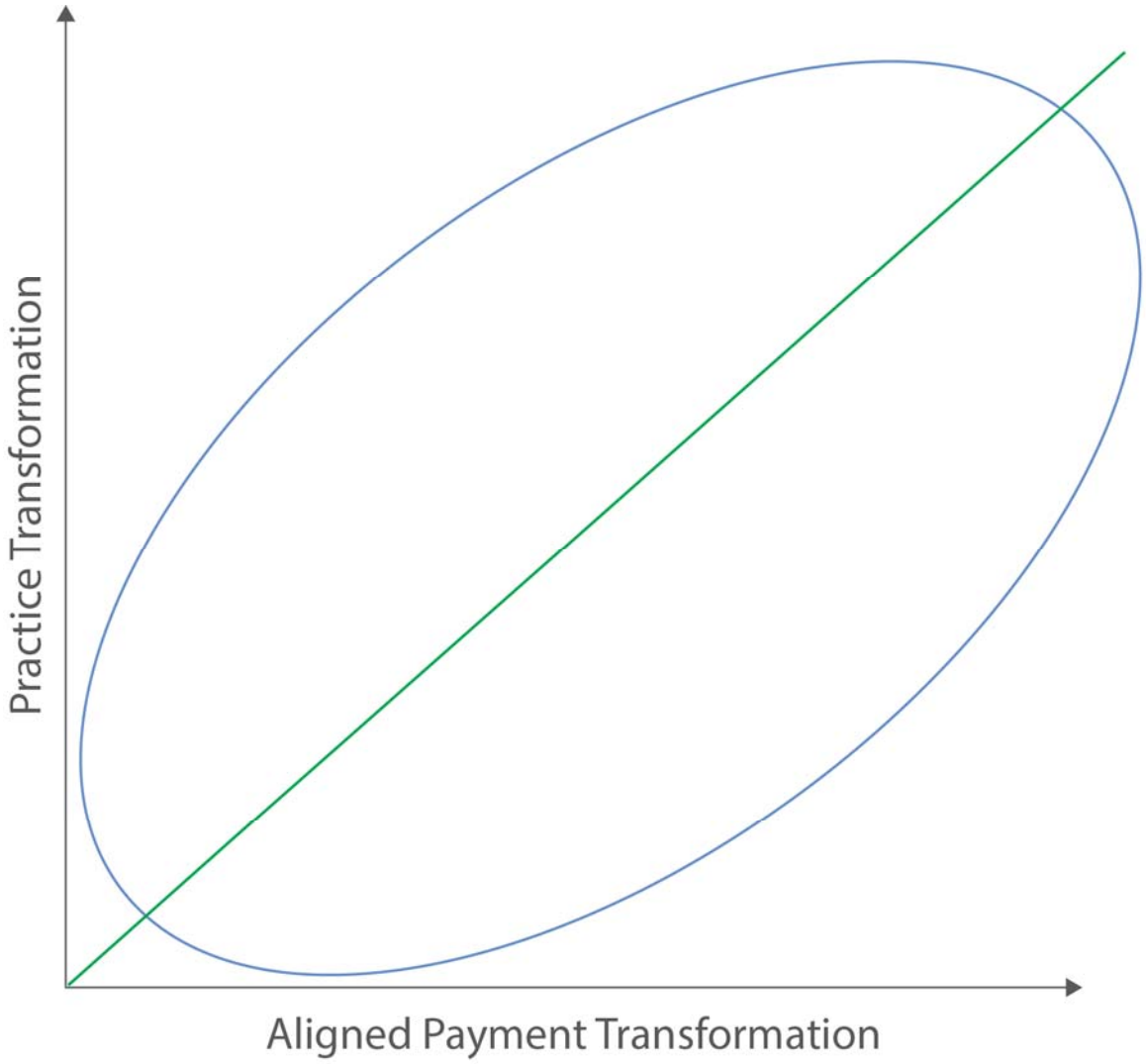
MEDICAL HOME NETWORK
Building Partnerships for Better Health

MHN Clinic Summary By Measures
Period: 12/01/2011 - 03/31/2012 (Prior Year - Pre Intervention)
Period: 12/01/2012 - 03/31/2013 (Performance Period)

	Measures	Clinic A	Clinic B	Clinic C	Clinic D	Clinic E	Clinic F	Clinic G	Clinic H	Clinic I	Clinic J	Clinic K	Clinic L	All MHN Clinics
	1. Inpatient Days/K													
PRE	Inpatient Days per 1,000 per Year	774.2	515.1	1,436.2	755.0	390.2	605.2	6,676.6	937.4	914.6	946.4	1,132.0	1,244.3	840.8
POST	Inpatient Days per 1,000 per Year	792.4	421.9	1,445.6	737.5	475.2	536.1	1,351.6	647.9	721.1	967.6	1,186.5	1,049.9	806.3
	RESULTS	🔴	🟢	🔴	🟢	🔴	🟢	🟢	🟢	🟢	🔴	🔴	🟢	🟢
	% Change	2.4%	-18.1%	0.7%	-2.3%	21.8%	-11.4%	-79.8%	-30.9%	-21.2%	2.2%	4.8%	-15.6%	-4.1%
	2. Non-Maternity Inpatient Days/K													
PRE	Non-Maternity Inpatient Days per 1,000/Year	649.6	321.2	1,252.2	585.3	262.6	507.3	6,676.6	931.2	682.7	866.1	1,023.3	1,122.6	706.8
POST	Non-Maternity Inpatient Days per 1,000/Year	671.0	206.5	1,296.8	510.8	340.6	420.4	1,276.7	641.4	533.7	880.1	1,092.3	902.8	670.4
	RESULTS	🔴	🟢	🔴	🟢	🔴	🟢	🟢	🟢	🟢	🔴	🔴	🟢	🟢
	% Change	3.3%	-35.7%	3.6%	-12.7%	29.7%	-17.1%	-80.9%	-31.1%	-21.8%	1.6%	6.7%	-19.6%	-5.2%
	3. Admits/K													
PRE	Inpatient Admits per 1,000 per Year	162.9	140.5	275.2	158.8	115.7	120.7	1,000.4	166.0	198.9	178.5	220.4	243.5	172.5
POST	Inpatient Admits per 1,000 per Year	160.8	150.0	253.6	177.5	135.5	120.6	335.8	154.7	180.2	182.4	184.2	211.2	168.2
	RESULTS	🟢	🔴	🟢	🔴	🔴	😐	🟢	🟢	🟢	🔴	🟢	🟢	🟢
	% Change	-1.3%	6.7%	-7.8%	11.8%	17.2%	0.0%	-66.4%	-6.8%	-9.4%	2.2%	-16.4%	-13.2%	-2.5%
	4. Non-Maternity Admits/K													
PRE	Non-Maternity Inpatient Admits per 1,000 /Year	113.69	52.6	208.2	88.1	54.0	84.0	1,000.4	162.9	114.9	153.1	181.7	189.8	120.3
POST	Non-Maternity Inpatient Admits per 1,000 /Year	113.75	47.7	198.5	90.3	76.0	77.6	310.8	152.5	100.7	155.2	156.6	146.1	115.1
	RESULTS	🔴	🟢	🟢	🔴	🔴	🟢	🟢	🟢	🟢	🔴	🟢	🟢	🟢
	% Change	0.1%	-9.3%	-4.6%	2.5%	40.7%	-7.6%	-68.9%	-6.4%	-12.4%	1.4%	-13.8%	-23.0%	-4.3%
	5. ER (APL)/K													
PRE	No. of ER Cases Per 1,000 Per Year	579.7	468.2	746.5	677.3	492.8	738.7	1,230.3	1,251.9	588.7	825.8	592.8	567.5	657.3
POST	No. of ER Cases Per 1,000 Per Year	655.4	497.6	844.2	705.9	537.2	774.7	1,261.8	1,342.4	622.5	886.3	752.8	579.4	718.5
	RESULTS	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴	🔴
	% Change	13.1%	6.3%	13.1%	4.2%	9.0%	4.9%	2.6%	7.2%	5.7%	7.3%	27.0%	2.1%	9.3%
	6. % Timely Follow-up Visits from MHN Participating Hospitals													
PRE	*% IP or ER Discharges with PCP Visit*	24.0%	22.5%	13.2%	14.3%	30.3%	10.7%	10.0%	8.1%	29.1%	24.4%	18.4%	18.7%	21.3%
POST	*% IP or ER Discharges with PCP Visit*	19.8%	34.7%	15.9%	12.2%	43.0%	21.0%	19.4%	32.0%	31.0%	23.8%	16.2%	16.8%	23.0%
	RESULTS	🔴	🟢	🟢	🔴	🟢	🟢	🟢	🟢	🟢	🔴	🔴	🔴	🟢
	% Change	-17.4%	53.9%	20.0%	-14.6%	41.8%	95.8%	94.3%	296.8%	6.6%	-2.2%	-12.3%	-10.1%	7.9%
	7. Non-Maternity Re-admit Rate by MHN members at all Hospitals													
PRE	7-day Window *Percentage of Admissions with a Readmission within 7 Days*	18.9%	8.2%	26.3%	14.6%	6.0%	15.4%	47.5%	6.7%	19.0%	12.6%	31.6%	17.0%	19.0%
	30-day Window *Percentage of Admissions with a Readmission within 30 Days*	34.1%	13.8%	41.4%	27.7%	16.0%	25.1%	67.2%	16.2%	32.8%	29.6%	41.0%	33.0%	32.9%
POST	7-day Window *Percentage of Admissions with a Readmission within 7 Days*	11.1%	7.2%	17.8%	11.5%	5.9%	12.7%	7.4%	7.8%	13.8%	13.7%	16.0%	15.7%	13.0%
	30-day Window *Percentage of Admissions with a Readmission within 30 Days*	24.5%	13.4%	35.5%	21.3%	13.9%	24.3%	15.0%	28.8%	24.9%	31.6%	32.2%	35.6%	27.3%
	7 Day Re-admit Results	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🟢	🟢	🟢
	% Change	-41.5%	-12.1%	-32.0%	-21.2%	-2.0%	-17.8%	-84.4%	17.1%	-27.6%	9.0%	-49.3%	-7.4%	-31.6%
	30 Day Re-admit Results	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🟢	🔴	🟢
	% Change	-28.3%	-3.0%	-14.2%	-23.2%	-13.1%	-3.0%	-77.6%	77.9%	-24.1%	6.6%	-21.3%	7.7%	-17.0%

★ = statistically significant improvement

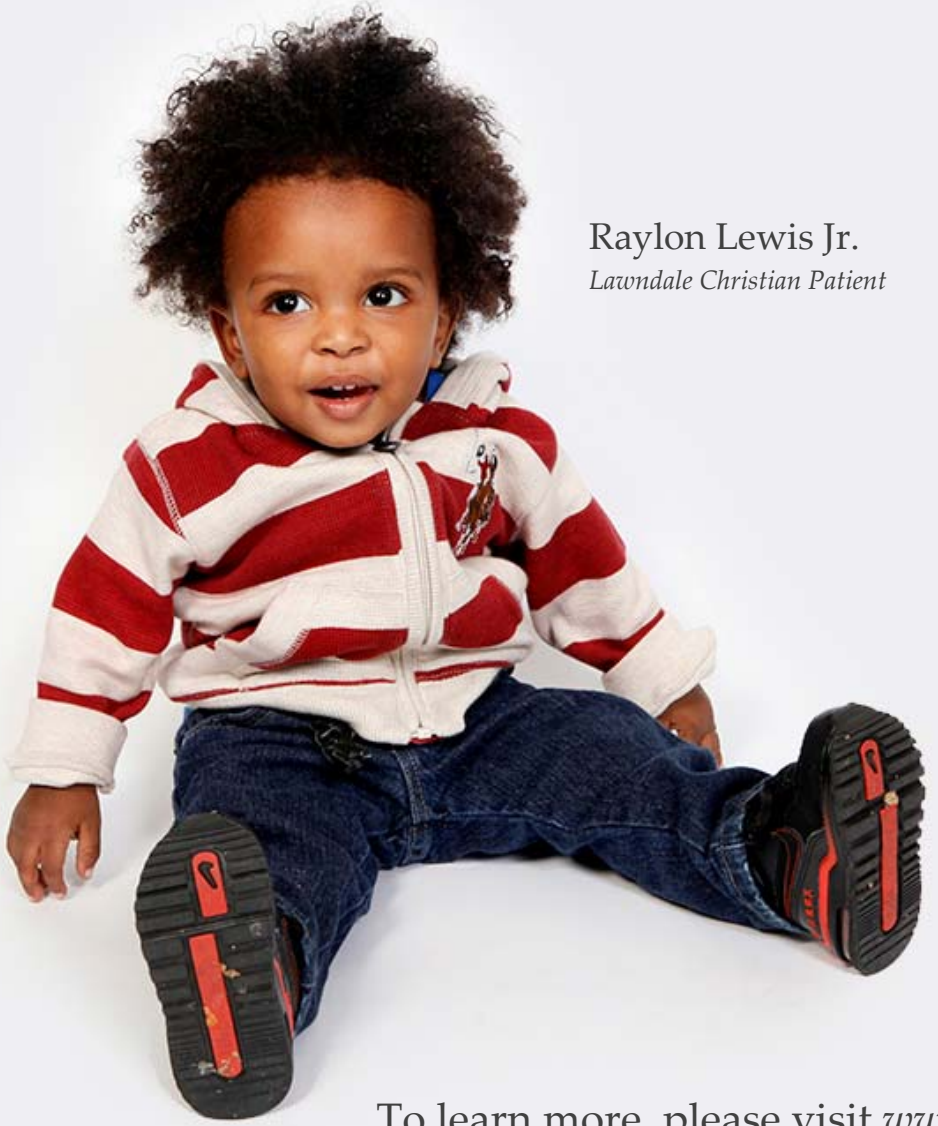
Transition to Value-Based Care



Initial *Lessons* Learned

- Need to build around a **shared vision** to maintain commitment
- **Collaboration** requires the right people at the table who can check institutional identity at the door
- Population health management requires **cultural change & practice transformation**
- Need to develop **health IT platform** to support care management across the continuum
- Practice redesign without **proper incentives** has limited impact
- Need wholesale payment reform to drive **delivery reform**

Thank you



Raylon Lewis Jr.
Lawndale Christian Patient

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