AETNA BETTER HEALTH®

Medicaid Advisory Committee
Care Coordination Sub-Committee

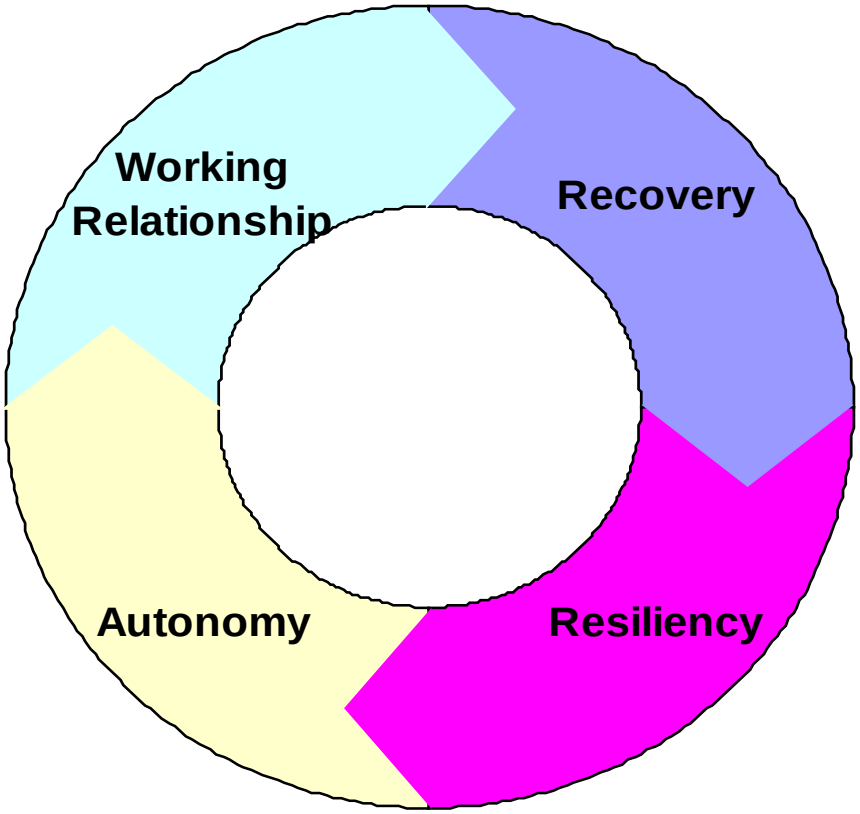
Preventing Inappropriate ED use with Care Coordination

Robert Mendonsa, CEO
William Gerardi, CMO
October 2, 2012

Agenda

- **Care Coordination Model**
- **ED Experience in Integrated Care Program (ICP)**
- **Strategy to address ED Usage**
- **Member Stories**
- **Questions**

Cycle of Care Management



Healthcare Home: Adults w BH Needs

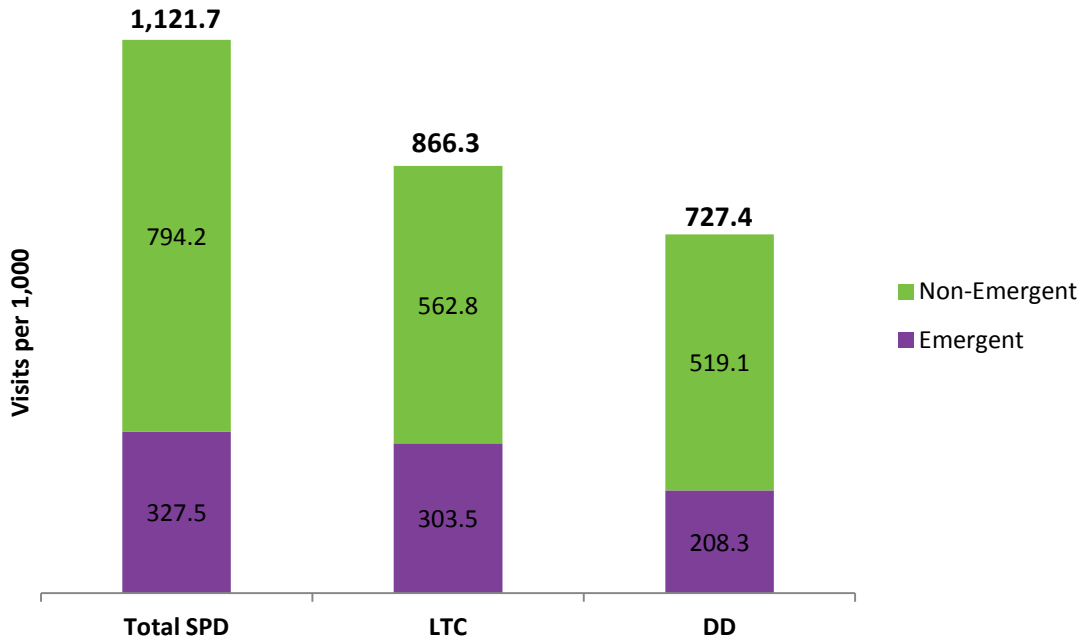
[Adapted from Four Quadrant Model: National Council for Community Behavioral Healthcare]

		BH Needs		
		High		Low
		Acute or Recurring; Non-Disabling	Disabling: SPMI*	
PH Needs	High	Integrated: PCP	Integrated: CMHC	PMP
	Low	Patient preference & PCP consensus	CMHC	PMP

* Severe and Persisting Mental Illness

ED Utilization in ICP

The majority of ED visits are Non-Emergent



Claims paid through 8/31/2012 with service dates from 8/1/2012 through 7/31/2012

The Top 10 ED Diagnoses

Common conditions that can be managed in the Outpatient setting by PCPs:

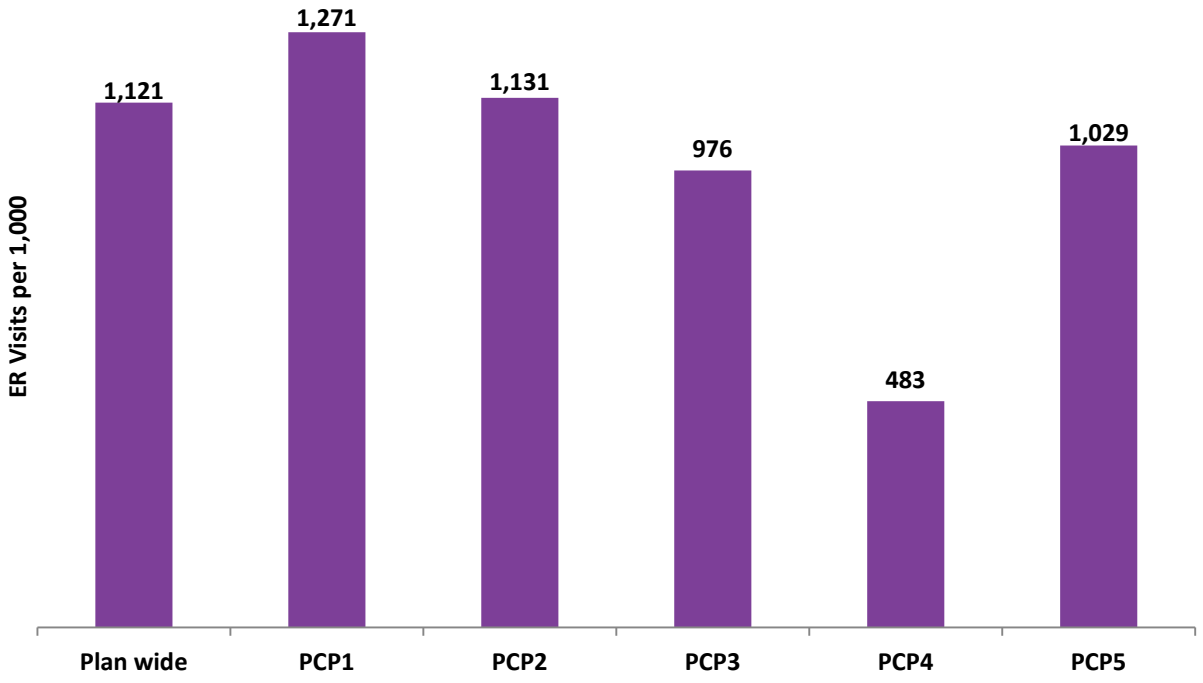
1. **Chest pain unspecified**
2. **Abdominal pain, unspecified site**
3. **Headache**
4. **Lumbago**
5. **Other chest pain**
6. **Pain in soft tissues of limb**
7. **Asthma unspecified with exacerbation**
8. **Non-dependent alcohol abuse**
9. **Unspecified backache**
10. **Urinary tract infection**

ED Usage by Members

- **134 members with 10 or more ED visits in 12 months**
- **1 member (M-50) had 84 visits in same 12 month period**
- **0.7% of members account for 15.5% of ED visits.**

Physician Profiles

Some practices better than others in managing ED usage by their patients



Claims paid through 6/30/2012 with service dates from 7/1/2012 through 6/30/2012

Strategies to Address ER Usage

- **Behavior change requires intense individual engagement**
- **Engagement is the major challenge**
- **High ED members assigned to Care Coordinators**
- **Employing multiple Behavioral Health approaches**
  - **Case Management Rounds**
  - **Inter Disciplinary Team rounds**
  - **Visits to members while hospitalized**
- **Co-locating Care Coordinator in physician offices**
- **Focus on Behavioral Health discharges and follow-up visits**
- **P4P**

Case Studies

- **Member 1**
- **Member 2**

Questions

Enterprise Care Management

Elyse Forkosh Cutler
VP, Strategic Planning and Network Development

Advocate Health Care
Inspiring medicine. Changing lives.

AdvocateCare- The Largest ACO Nationally

- **Over 500,000 covered lives**
- **Blue Cross & Medicare**
- **Major program components**
  - Enterprise care management
  - Care coordination tools
  - Care management analytics
- **Key challenge—Right level of care at the right time– all the time**

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Enterprise Care Management

Growth	**Access**
Data + Analytics	**Communication**

What Is Enterprise Care Management (ECM)?

- An enterprise approach to managing high risk patients along the continuum
- A structure to connect the work of our continuum based Care Managers
- Designed to:
  - Focus on patients at or approaching high risk
  - Ensure coordination and continuity
  - Facilitate the appropriate delivery of care
  - Manage transitions within and between settings/providers

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Opportunity To Impact Cost

	Person Years		Predicted Expenditures	
	Number	Percent	Mean $	Percent
Very Low Risk	54,398	30.5%	$ 784	3%
Low Risk	78,520	44.1%	$ 4,054	22%
Moderate Risk	24,906	14.0%	$ 11,517	20%
High Risk	16,056	9.0%	$ 24,054	27%
Very High Risk	4,270	2.4%	$ 91,062	27%
Total	178,149	100.0%	$ 7,987	100%

Critical Program Components

- 102 Care Managers with ~125 patients each
- Care Manager linked to PCP
  - Embedded or dedicated
- Prospective identification of complex patients
- Outbound calling to patients in between appointments
- Keen assessment and coaching skills to engage patient

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Outpatient ECM

- Meet with practices to review high risk pts.
- Focus on pts approaching high risk and those with gaps in care
- Act as liaison between PCP and specialist
- Develop patient-centric actionable interventions
- Tight coordination between ED, Inpatient and post-acute CM resources

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Reporting: Hospital Level

# of ED Visits	ED Visits Total	# of Patients
1	9001	9001
2	2882	1441
3	1038	346
4	344	86
5	180	36
6	84	14
7	77	11
>7	192	16
Summary	13,789	10,951

- **Staff conducting assessment to identify practices with access challenges**
- **Phone survey of high utilizers and/or low acuity**
- **High utilizers may be assigned to case management**

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PHYSICIAN PERFORMANCE REPORT

Attributed PPO and full-risk HMO

PHYSICIAN PERFORMANCE

PATIENT AND UTILIZATION OVERVIEW

	APR'10-MAR'11				
	PROVIDER				
	HMO	PPO	TOTAL	BENCHMARK	% VARIANCE
ENROLLMENT					
AVERAGE PATIENTS	2,371	2,501	4,872		
DEMOGRAPHIC INDEX	1.134	1.215	1.175	1.044	12.6%
RETROSPECTIVE RISK	1.39	1.47	1.43		
INPATIENT FACILITY UTILIZATION					
ADMITS/1000	84.8	64.0	74.1	71.9	3.0%
NON-MATERNITY ADMITS/1000	54.4	48.8	51.5	50.4	2.3%
SHORT STAY MEDICAL ADMITS/1000	6.7	4.8	5.7	6.3	-22.0%
CHRONIC ADMITS/1000	2.1	4.0	3.1	3.8	-19.5%
DISCRETIONARY ADMITS/1000	1.3	2.8	2.1	4.5	-53.9%
AMBULATORY ADMITS/1000	4.6	2.4	3.5	2.3	48.9%
READMISSION RATE	12.9%	11.3%	12.2%		
C-SECTION RATE	39.3%	40.6%	39.8%	38.5%	3.3%
DRG CASE-MIX ADJUSTED PAID/ADMIT	$22,284	$23,860	$23,020	$24,357	-5.5%
% IN-NETWORK DAYS	93.0%	73.3%	84.9%	59.1%	43.6%
OUTPATIENT FACILITY UTILIZATION					
ER VISITS/1000	161.9	149.2	155.4	209.1	-25.7%
NON-EMERGENT ER VISITS/1000	3.8	6.8	5.3		
CHRONIC ER VISITS/1000	5.5	5.6	5.5		
% FREQUENT ER USERS	18.8%	15.3%	17.0%		
% ER VISITS LEVEL 1&2	13.7%	14.2%	14.0%		
ER PAID/VISIT	$2,865	$3,085	$2,974	$2,789	6.6%
% OUTPATIENT SURGERY AT ASF					
PROFESSIONAL UTILIZATION					
E&M VISITS/1000	4,098.7	4,864.0	4,491.5	4,845.4	-7.3%
PREVENTIVE VISITS/1000	296.0	414.7	356.9		
HIGH COST RADIOLOGY SERVICES/1000	190.6	263.5	228.0		

*The benchmark population definition can be found in the glossary.

GLOSSARY

Admits/1,000: The number of hospital admissions for each 1000 persons covered within a given time period. This allows for comparison of the group experience to a normative or benchmark population. It is calculated as: (Admissions/Member Months)*1000*12

Ambulatory Admits/1,000: Identified by the following DRG categories: DRG Description; 040, Carpal Tunnel; 113-117, Eye Procedures; 133-136, Tonsillectomy/Adenoidectomy/Myringotomy/ Sinus & Mastoid Procs; 350-355, Hernia Repair; 338-343, Appendectomy; 414-416, Cholesystectomy; 417-419, Laparascopic Cholesystectomy; 509, Arthroscopy; 582-585, Mastectomy/ Partial Mastectomy/ Breast Proc/Breast Biopsy. It is calculated as: (Ambulatory Admissions/Member Months)*1000*12

Average Patients: Calculated using the measure Member Months divided by the number of months included in your report

Benchmark*: Represents all provider data for the client's book of business. Benchmark utilization and expense rates are age/gender adjusted to reflect the potential difference in the age/gender distribution between the individual provider and client's book of business. The age/gender adjustment factors are built using the paid claims and enrollment information over a 3 year period from the book of business.

C-Section Rate: Identifies if the delivery was by cesarean section.

Chronic Admits/1,000: Identified by the following DRG Categories: DRG Description; 190-192, COPD; 202-203, Bronchitis & Asthma; 291-293, CHF; 304-305, Hypertension; 637-639, Diabetes; 682-684, Renal Failure It is calculated as: (Chronic Admissions/Member Months)*1000*12

Chronic ER Visits/1,000: Identified as 3 Digit Primary Diagnosis including ICD-9 codes 250, Diabetes; 346, Migraine; 401. Essential Hypertension; 491, Chronic Bronchitis; 493, Asthma. It is calculated as: (Chronic ER Visits/Member Months)*1000*12

Demographic Index: Determined based on the demographic composition of the client

Discretionary Admits/1,000: Identified by the following DRG categories: DRG Description; 100, Seizures w MCC; 101, Seizures w/o MCC; 102, Headaches w MCC; 103, Headaches w/o MCC; 303, Artherosclerosis w/o MCC; 383, Uncomplicated Peptic Ulcer w MCC; 384, Uncomplicated Peptic Ulcer w/o MCC; 391, Esophagitis, Gastroent & Misc Digest Disorders w MCC; 392, Esophagitis, Gastroent & Misc Digest Disorders w/o MCC; 603, Cellulitis w/o MCC; 863, Postoperative & Post-Traumatic Infections w/o MCC; 917, Poisoning & Toxic Effects of Drugs w MCC; 918, Poisoning & Toxic Effects of Drugs w/o MCC. It is calculated as: (Discretionary Admissions/Member Months)*1000*12

DRG: Diagnosis Related Group, a classification of hospital case types into groups expected to have similar hospital resource use. The groupings are based on diagnoses, procedures, age, gender and the presence of complications or co-morbidities

DRG Case-Mix Adjusted Paid/Admit: Amount considered eligible for payment for the procedure divided by the DRG Case-Mix Index. It is calculated as: Paid Amount per Admit / 'DRG Case-Mix Index'

DRG Case-Mix Index: Index of severity of the admission based on DRG weight (average = 1.00). It is calculated as: Total DRG Weight / Services

E&M Visits/1,000: Professional office visits for Evaluation and Management identified as professional visits with a CPT Range: 99201-99499. It is calculated as: (E&M Visits/Member Months)*1000*12

ER Paid/Visit: Outpatient Facility Emergency Room Paid Amount per visit. It is calculated as: ER Paid Amount / Services

ER Visits/1,000: Outpatient Facility Emergency Room Service Count per 1,000. It is calculated as: (ER Visits/Member Months)*1000*12

High Cost Radiology Services/1,000: Services with CPT Codes for CT Scans and MRIs. It is calculated as: (High Cost Radiology Services/Member Months)*1000*12

Non-Emergent ER Visits/1,000: Identified as 3 Digit Primary Diagnosis including ICD-9 codes 461, Acute Sinusitis; 462, Acute Pharyngitis; 466, Acute Bronchitis; 473, Chronis Sinusitis; 490, Bronchitis; 780, General Symptoms; V67, Follow up Exam; V70, General Medical Exam. It is calculated as: (Non-Emergent ER Visits/Member Months)*1000*12

Non-Maternity Admits/1,000: Defined as all admissions excluding maternity DRGs, including 765-770 (Deliveries), 776-782 (Non-Deliveries), 795 (Normal Newborns not already linked to Mother). It is calculated as: (Non-Maternity Admissions/Member Months)*1000*12

Percentage (%) Frequent Users: Patients with 2 or more ER visits divided by Patients with 1 or more ER visits.

Percentage (%) Outpatient Surgery at ASF: Percent of ambulatory surgery performed at ambulatory surgical facilities.

Preventive Visits/1,000: Professional office visits that are considered precautionary and are defined for new and established patients as CPT service codes in the range of 99381-99397. It is calculated as: (Preventive Visits/Member Months)*1000*12

Readmission Rate: Readmission Rate defined as another admission within 30 days. Measure can be further refined to change the number of days for readmission, exclude Maternity, validate readmission for same or similar condition, same provider type, and exclude transfers.

Retrospective Risk: A score determined for each member based on their illness burden and healthcare costs. Retrospective risk predicts the risk for the 12 month period being assessed.

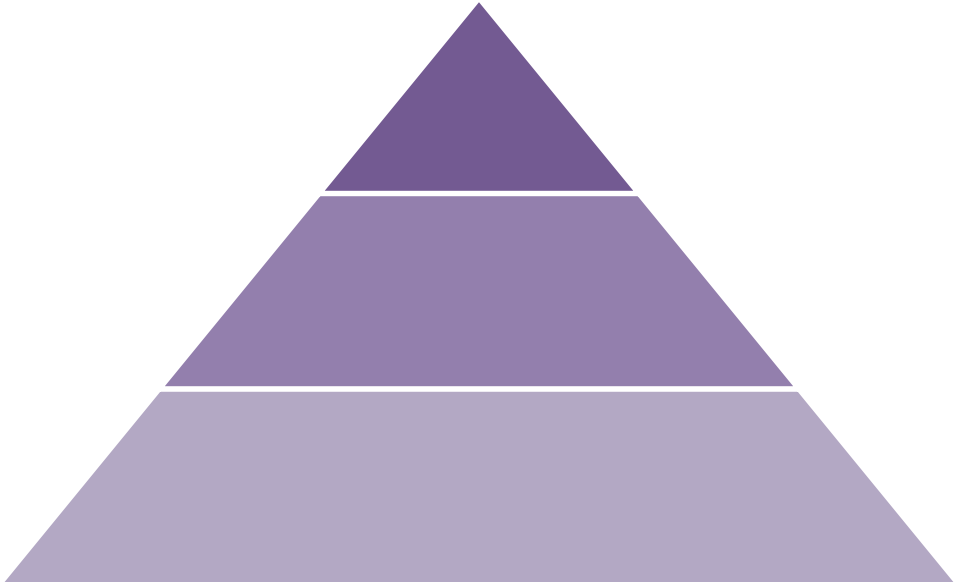
Short Stay Medical Admits/1,000: Medical admissions with a length of stay = 1

Care Coordination and PCCM Model

Margaret Kirkegaard, MD, MPH
Medical Director, Illinois Health Connect
MAC Care Coordination Subcommittee
10-2-2012

PCCM Models of Care Coordination

- Enrich Medical Home
- Shared Support Networks
- Centralized Services



Enrich Medical Home

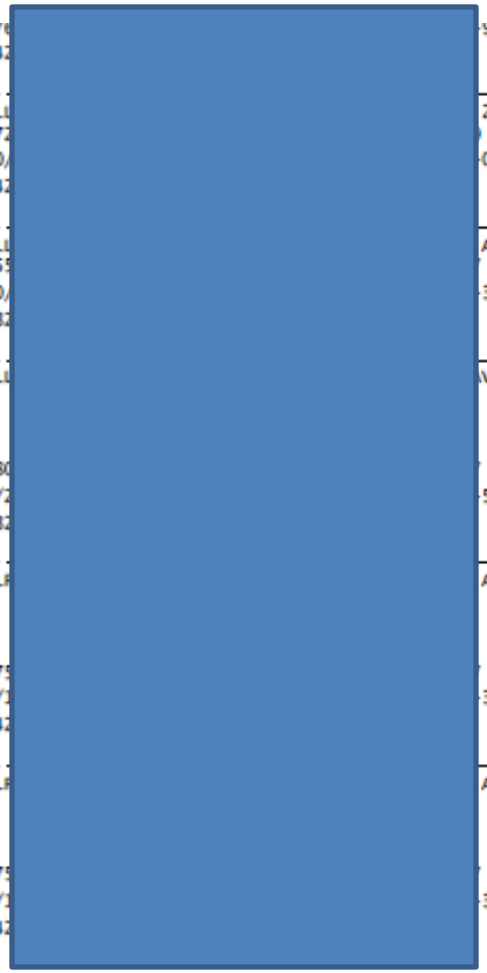
Benefits of Implementing the PCMH at www.pcpcc.net

"Although implementing the many features of a PCMH takes time, the long-term cost savings of the PCMH are impressive, as demonstrated by mature PCMH initiatives. By providing better care coordination that results in fewer unnecessary emergency room visits and inpatient hospital admissions, this report also demonstrates that PCMHs can achieve cost-savings in the short-term."

Enrich Medical Home

- Population data: IHC Panel Rosters, Profiles, Bonus Data; Claims History
- Personnel: Your Healthcare Plus embedded Care Coordinators
- Resources: CMF, bonus payments
- Technical skills: OK practice facilitation, IHC academic detailing with 350 visits per week by field reps and QA nurses

IHC Panel Rosters Flag Frequent ED Users



9945

Last PCP Visit: 10/26/2011 Claim

2 5/11/2010

PAP Test: Due 4/6/2005 Claim

0513

Last PCP Visit: 8/25/2011 Claim

AVE APT 2B 4/22/2010

Frequent ED User

Test: 9/14/2011 Claim

3445

Mammogram: Due

Last PCP Visit: 2/24/2012 Claim

VE FL 2 6/23/2012

Well Child Visit:
Screenings -
Developmental:
Vision:
Lead:

PAP Test: Due

5527

Last PCP Visit: No Claims

AVE APT 1F 9/26/2007

Well Child Visit: 1/27/2012 Claim
Screenings -
Developmental:
Vision: 3/21/2012 Claim
Lead: 8/13/2009 Claim

3125

Last PCP Visit: 6/27/2011 Claim

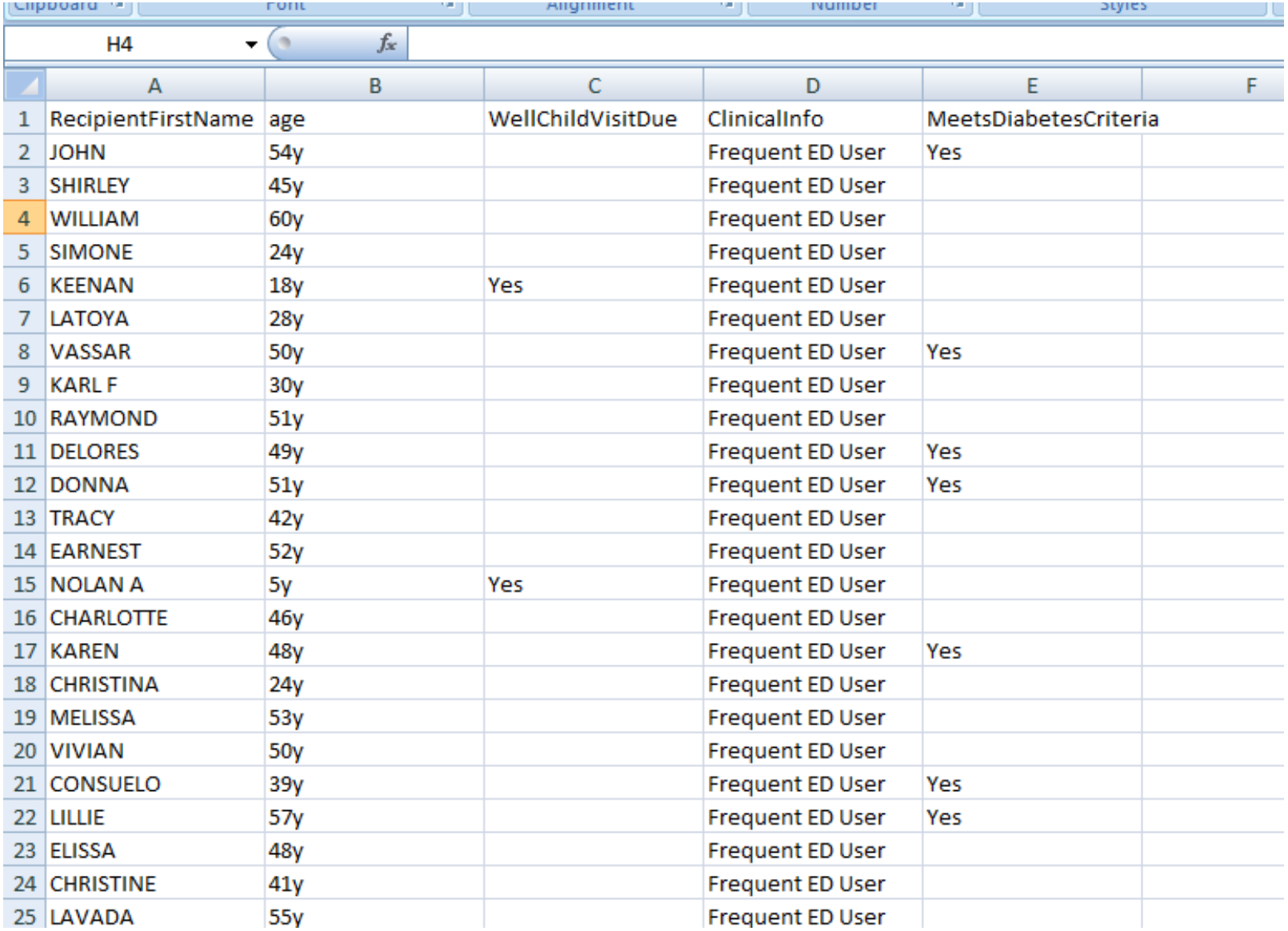
AVE APT 1F 9/26/2007

Well Child Visit: 1/27/2012 Claim
Screenings -
Developmental:
Vision: Due 11/10/2010 Claim
Lead: 8/13/2009 Claim

3125

Last PCP Visit: 8/17/2011 Claim

Sorted CSV Roster



H4

	A	B	C	D	E	F
1	RecipientFirstName	age	WellChildVisitDue	ClinicalInfo	MeetsDiabetesCriteria	
2	JOHN	54y		Frequent ED User	Yes	
3	SHIRLEY	45y		Frequent ED User		
4	WILLIAM	60y		Frequent ED User		
5	SIMONE	24y		Frequent ED User		
6	KEENAN	18y	Yes	Frequent ED User		
7	LATOYA	28y		Frequent ED User		
8	VASSAR	50y		Frequent ED User	Yes	
9	KARL F	30y		Frequent ED User		
10	RAYMOND	51y		Frequent ED User		
11	DELORES	49y		Frequent ED User	Yes	
12	DONNA	51y		Frequent ED User	Yes	
13	TRACY	42y		Frequent ED User		
14	EARNEST	52y		Frequent ED User		
15	NOLAN A	5y	Yes	Frequent ED User		
16	CHARLOTTE	46y		Frequent ED User		
17	KAREN	48y		Frequent ED User	Yes	
18	CHRISTINA	24y		Frequent ED User		
19	MELISSA	53y		Frequent ED User		
20	VIVIAN	50y		Frequent ED User		
21	CONSUELO	39y		Frequent ED User	Yes	
22	LILLIE	57y		Frequent ED User	Yes	
23	ELISSA	48y		Frequent ED User		
24	CHRISTINE	41y		Frequent ED User		
25	LAVADA	55y		Frequent ED User		

Provider Profile Example

Illinois Health Connect
Provider Profile
Report Created Fall 2012
for dates of service from 04/01/2011 through 03/31/2012

PCP: 

Total # of Enrollees Served: 10,815

Quality of Care Indicators

Indicator		# Eligible Enrollees	# Eligible Events	Current Rate	Prior Rate	IHC State Rate (2011)	Comparison to All IHC PCPs	Bonus Payment Benchmarks
1a.	Immunization status for 2 year olds - Combination 2	344	221	64%	59%	63%		NA
1b.	Immunization status for 2 year olds - Combination 3	344	145	42%	37%	58%		71%
2a.	Lead toxicity testing: At least one by age 2	344	252	73%	73%	71%		72%
2b.	Lead toxicity testing: At least two by age 2	344	55	16%	17%	18%		NA
3a.	Developmental screening by age 12 months	363	255	70%	62%	63%		80%
3b.	Developmental screening between age 12 and 24 months	344	142	41%	46%	52%		70%
3c.	Developmental screening between age 24 and 36 months	392	70	18%	16%	39%		65%
4a.	Appropriate asthma medications for patients age 5 to 11 years	57	53	93%	87%	91%		92%
4b.	Appropriate asthma medications for patients age 12 to 50 years	139	108	78%	78%	84%		86%
5.	Diabetic HbA1c testing for patients age 18 to 75 years	349	262	75%	75%	69%		82%
6a.	Zero well baby visits in the first 15 months of life	358	32	9%	9%	5%		NA
6g.	Six well baby visits in the first 15 months of life	358	149	42%	46%	59%		NA
7.	Well child visit in the 3rd, 4th, 5th and 6th years of life	1,473	984	67%	54%	63%		NA

NA Not Available / Not Applicable
H PCP performance on this indicator is in the top 10 percentile of all IHC PCPs
L PCP performance on this indicator is in the bottom 10 percentile of all IHC PCPs

Illinois Health Connect
Provider Profile
Report Created Fall 2012
for dates of service from 04/01/2011 through 03/31/2012

PCP: [redacted]

Total # of Enrollees Served: 10,815

Quality of Care Indicators, continued

Indicator		# Eligible Enrollees	# Eligible Events	Current Rate	Prior Rate	IHC State Rate (2011)	Comparison to All IHC PCPs	Bonus Payment Benchmarks
8a.	Vision screening in the 3rd year of life	427	70	16%	14%	16%		NA
8b.	Vision screening in the 4th year of life	317	64	20%	23%	30%		NA
9.	Cervical cancer screening for women age 21 to 64 years	3,233	2,031	63%	59%	25%		NA
10.	Adolescent well-care visits for patients age 12 to 21 years	2,460	624	25%	23%	57%		NA
11c.	Breast cancer screening for women age 40 to 69 years old	822	213	26%	26%	42%		52%
17a.	Ambulatory care visit for adults age 20 to 44 years	3,603	2,811	78%	75%	72%		NA
17b.	Ambulatory care visit for adults age 45 to 64 years	934	746	80%	76%	77%		NA
17c.	Ambulatory care visit for adults age 65 years and older	59	47	80%	83%	69%		NA
18a.	ED visits per 1000 member months for patients up to age 20 years	69,492	3,981	57	51	46		NA
18b.	ED visits per 1000 member months for patients age 21 years and older	47,616	6,289	132	116	88		NA

NA Not Available / Not Applicable
H PCP performance on this indicator is in the top 10 percentile of all IHC PCPs
L PCP performance on this indicator is in the bottom 10 percentile of all IHC PCPs

IHC Claims History Screen Shot

Patient Claim History

Due to Illinois confidentiality laws, this Claims History Report does not contain claims information related to HIV/AIDS care. This Claims History Report only reflects claims received by HFS so services paid by other payers are not included. This report is intended to augment, not replace, a patient's complete clinical history.

Service Date	Claim Date	Provider Name	Diagnosis Code Description	Procedure Code Description	Claim Type
06/17/2011					
	06/29/2011	[redacted] UKWU	25000 DIABETES W/O MENTION COMPLIC,TYPI/UNSPEC,NOT STATED UNCONTR	99213 OFFICE/OTHER OUTPT VISIT,ESTABLISHED PT,EXPANDED FOCUS	
06/06/2011					
	07/28/2011	[redacted]	25000 DIABETES W/O MENTION COMPLIC,TYPI/UNSPEC,NOT STATED UNCONTR	82043 ALBUMIN; URINE, MICROALBUMIN, QUANTITIATIVE	
			25000 DIABETES W/O MENTION COMPLIC,TYPI/UNSPEC,NOT STATED UNCONTR	83036 HEMOGLOBIN; GLYCOSYLATED	
			25000 DIABETES W/O MENTION COMPLIC,TYPI/UNSPEC,NOT STATED UNCONTR	80053 COMPREHENSIVE METABOLIC PANEL	
			25000 DIABETES W/O MENTION COMPLIC,TYPI/UNSPEC,NOT STATED UNCONTR	80061 LIPID PANEL	
	08/23/2011		25000 DIABETES W/O MENTION COMPLIC,TYPI/UNSPEC,NOT STATED UNCONTR	36415 VENIPUNCTURE COLLECT SPECIMEN	
			25000 DIABETES W/O MENTION COMPLIC,TYPI/UNSPEC,NOT STATED UNCONTR	80061 LIPID PANEL	
			25000 DIABETES W/O MENTION COMPLIC,TYPI/UNSPEC,NOT STATED UNCONTR	80053 COMPREHENSIVE METABOLIC PANEL	
		FOUNDATION	25000 DIABETES W/O MENTION COMPLIC,TYPI/UNSPEC,NOT STATED UNCONTR	83036 HEMOGLOBIN; GLYCOSYLATED	

Date Printed: 9/25/2012 J[redacted] DOB: [redacted] Page 7 of 13

Claims History Example

Patient Claim History

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Service Date	Claim Date	Provider Name	Diagnosis Code Description	Procedure Code Description	Claim Type
		[redacted]R	78650 CHEST PAIN NOS	87591 INF AGENT DETECT,NUCLC ACID;NEISSERIA GONORHOEAE,AMP PROBE	
	12/02/2011		78651 PRECORDIAL PAIN	93010 ELECTROCARDIOGRAM REPORT	
	11/30/2011	[redacted]AL	78650 CHEST PAIN NOS	3995 HEMODIALYSIS	Inpatient
	03/02/2012		78650 CHEST PAIN NOS	99223 E/M INT HOSP VISIT PER DAY	
11/03/2011					
	12/16/2011		5856 END STAGE RENAL DISEASE	85025 BLOOD COUNT; COMPLETE CBC, HGB HCT RBC WBC PLT,AUTO DIFF WBC	
			5856 END STAGE RENAL DISEASE	83540 ASSAY SERUM IRON	
			5856 END STAGE RENAL DISEASE	80053 COMPREHENSIVE METABOLIC PANEL	
			5856 END STAGE RENAL DISEASE	84466 TRANSFERRIN	
	04/23/2012	[redacted]HOSPITAL	5856 END STAGE RENAL DISEASE	83540 ASSAY SERUM IRON	
		[redacted]HOSPITAL	5856 END STAGE RENAL DISEASE	80053 COMPREHENSIVE METABOLIC PANEL	
		[redacted]HOSPITAL	5856 END STAGE RENAL DISEASE	84466 TRANSFERRIN	
		[redacted]HOSPITAL	5856 END STAGE RENAL DISEASE	84100 ASSAY BLOOD PHOSPHORUS	
		[redacted]HOSPITAL	5856 END STAGE RENAL DISEASE	85045 HEMATOLOGY RETICULOCYTE COUNT	
		[redacted]HOSPITAL	5856 END STAGE RENAL DISEASE	85025 BLOOD COUNT; COMPLETE CBC, HGB HCT RBC WBC PLT,AUTO DIFF WBC	
11/02/2011					
	11/18/2011		36501 OPEN ANGLE W/BORDERLINE FIND, LOW RISK	99213 OFFICE/OTHER OUTPT VISIT,ESTABLISHED PT,EXPANDED FOCUS	
11/01/2011					
	12/28/2011	S AND P CARE TRANSPORTATION		A0120 SERVICE CAR, BASE RATE	

Shared Support Networks (Medical Neighborhood)

- Model most fully developed by NC
  - http://www.illinoishealthconnect.com/files/downloads/Denise_Levis_Hewson_IHC_Quality_Conference_Presentation_June_2012_on_CCNC_Transitions.pdf
- Also recently implemented by OK and AL
  - Toolkit: http://commonwealth.communitycarenc.org/
- AL report during NASHP webinar: decreased cost by 7.1% and ED visits by 17%
  - http://nashp.org/webinar/building-medical-home-neighborhoods-through-community-based-teams
- IHC working on Hospital-PCP-Client communication pilot

Centralized Care Coordination

- Model used by Your Healthcare Plus

  2006-2011
- IHC Call Center 50-80K inbound calls per month, 120-160K outbound calls
  - 46K EPSDT call reminders (live call)
  - 10K calls assistance with access to specialty care
  - ED coaching pilot; 35% reduction in ED use in PA; opportunity to outreach to frequent ED patients but also query about inappropriate ED use

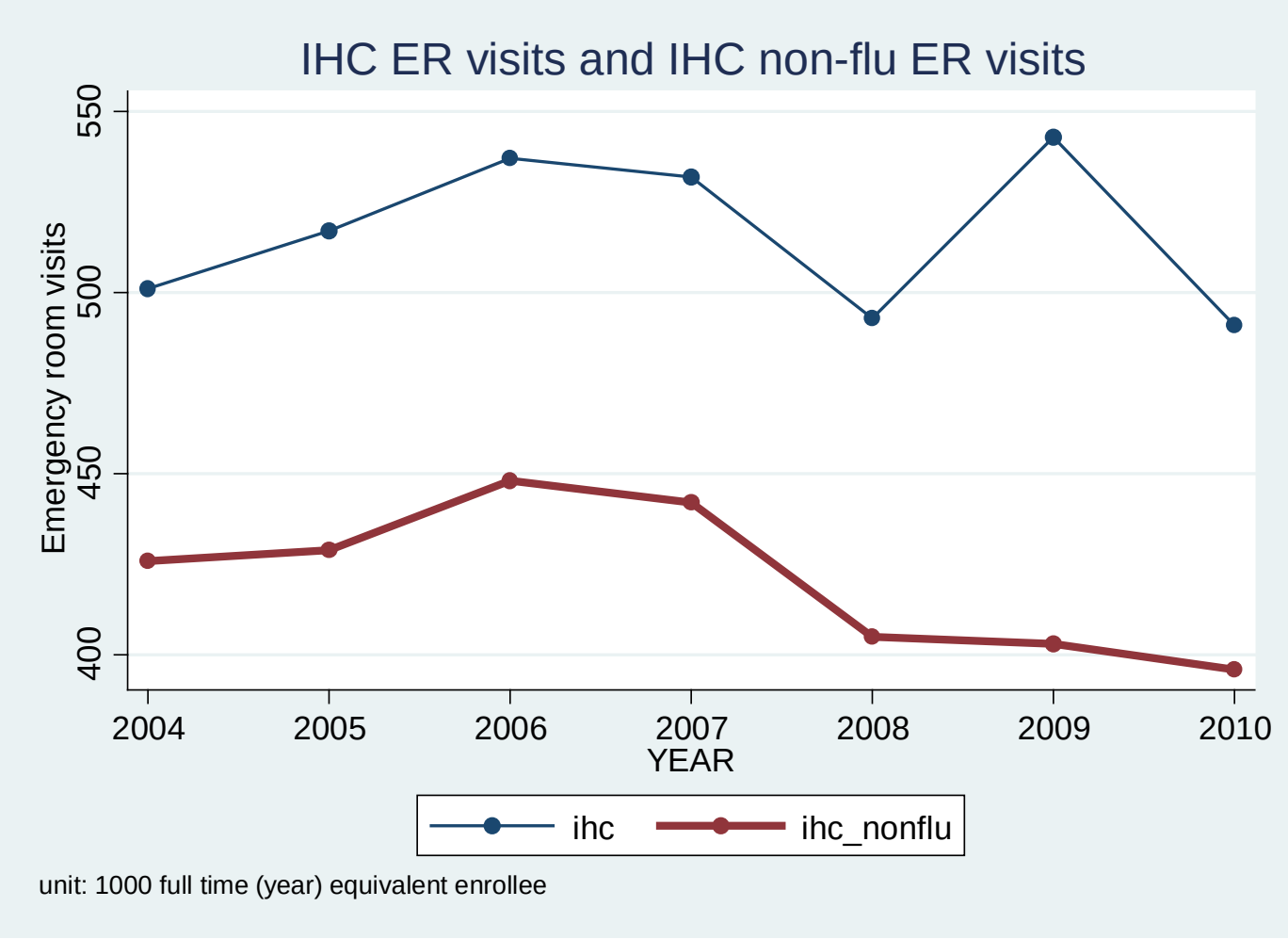
Pt Education about ED Use Necessary

- Client survey results:
- 759/797 (95%) know name of PCP
- 365/797 (46%) had used ED in past year
- 204 pts indicated that they had not contacted their PCP for advice first
- 127/204 (62%) indicated that “it was too much of an emergency” to contact PCP first
- Understanding when to go to ED appears to be most significant factor in ED use

After Hours Nurse Consultation Line

- In rare circumstances when patient cannot reach PCP after hours, IHC provides an after hours nurse consultation line.
- Available 7 pm to 7 am weekdays and 24/7 on weekends.
- Call 1-877-912-1999
- If patient is directed to ED by nurse, letter is sent informing PCP of this.

IHC Outcomes: Robert Graham Center Study



IHC Outcomes

- 95% of PCPs feel that IHC is beneficial to clients
- Over 90% of clients are satisfied with IHC and PCP
- Cost savings $531 million based on Robert Graham Study comparing actual costs to 3% per year projected increase
- 4% decrease in ED visits, 11% reduction in hospitalizations (HFS estimates)
- Improved clinical results:
  - Mammogram 2008: 42% to 2011: 48%
  - 1yr old Ob Dev screening 2008: 42% 2011: 73%

MEDICAL HOME NETWORK

Building Partnerships for Better Health

HFS/MAC Care Coordination Meeting

October 2, 2012

MHN

The Medical Home Network (MHN) is a 4-year-old formal provider collaborative working to improve the health of Medicaid recipients in Chicago 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

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
- 9.4% of the State's PCCM Medicaid population and 11% of PCCM Medicaid costs
- In the MHN target area, **20.4%** are covered by managed Medicaid**

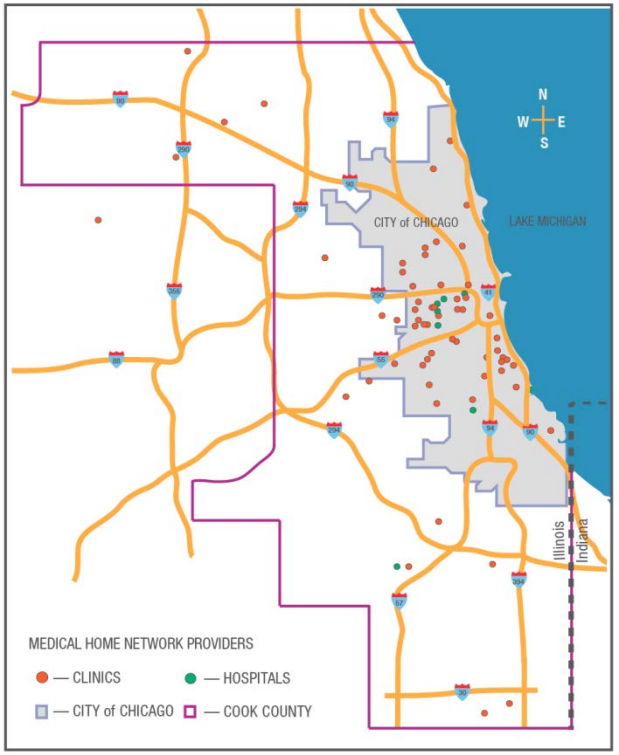
* 12/31/11 DHFS Eligibility file, ** 12/31/09 DHFS Eligibility File

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	12

COUNTY AND PRIVATE HOSPITALS	SITES
Cook County Health & Hospitals System	3
Holy Cross Hospital	1
La Rabida Children's Hospital	1
Sinai Health System	3
Rush University Medical Center	3
Saint Anthony Hospital	1
Total Medical Homes:	**109**
Total County and Private Hospital Sites:	**12**
Total PCPs:	**~550**

Provider Participants



STATE GOVT

Illinois Medicaid (Department of Healthcare and Family Services)

MHN: Building Blocks For Transformation

Connectivity
MHNConnect Portal

- Virtually connects disparate providers
- Facilitate communication & follow-up to manage critical transitions of care
- **Real-time alerts** to Medical Home of patients' inpatient & emergency department activity

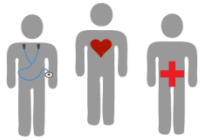
+

Reporting & Analytics

- Timely & actionable reporting based on historical & real-time data
- Advanced analytics to support high-risk populations management
- Provider-performance reporting

+

Care Coordination



- View pertinent patient information at point of care
- Support a team-based model of care
- Reinforce the centrality of the Medical Home
- Facilitate proactive management of care & cost for a population

+

Patient Engagement

- Foster accountable patients
- Leverage technology to reach the patient via multiple channels
- Enable self-management through education

=

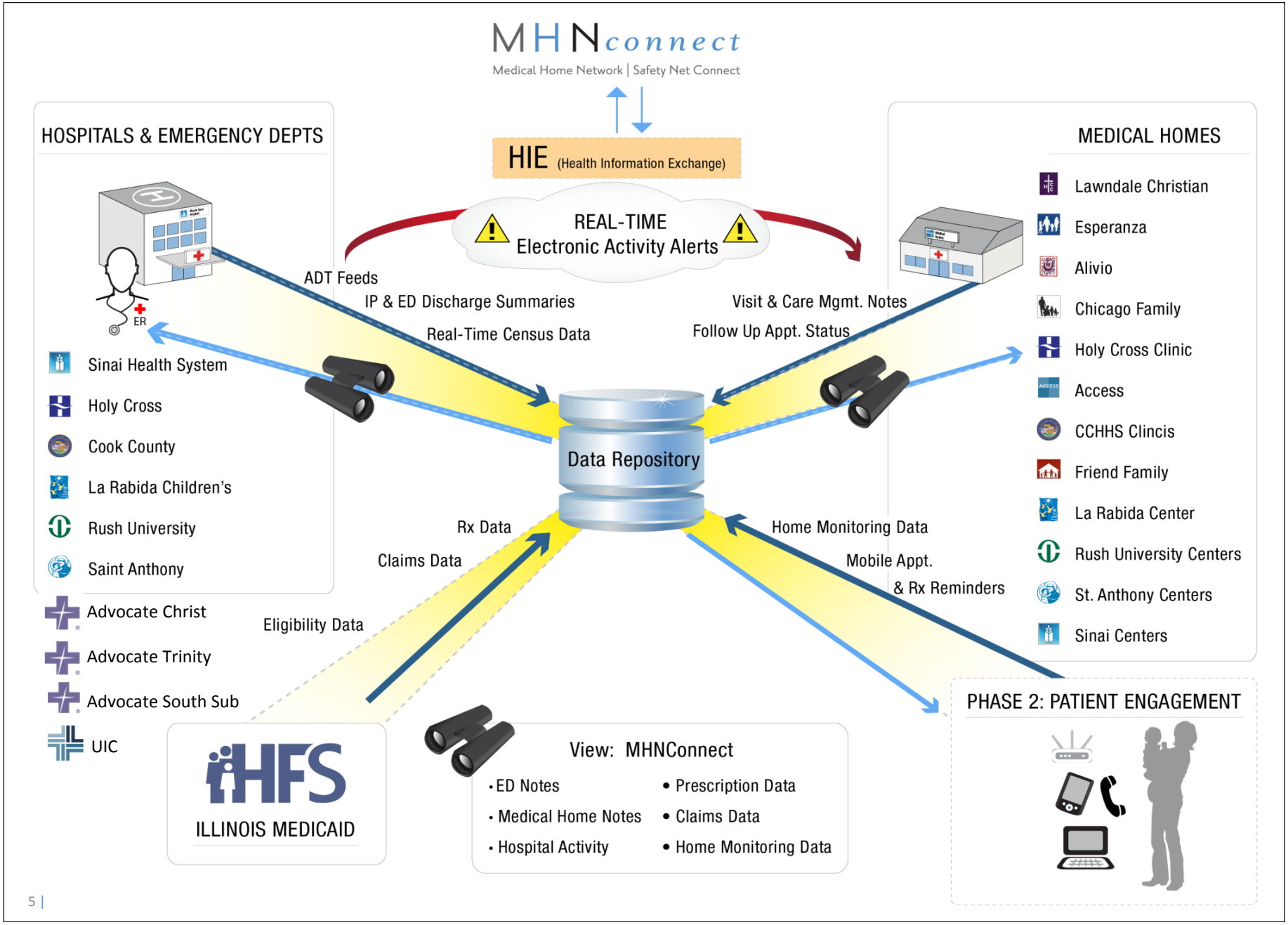
Redesign Delivery to Achieve Three-Part Aim

Better Health

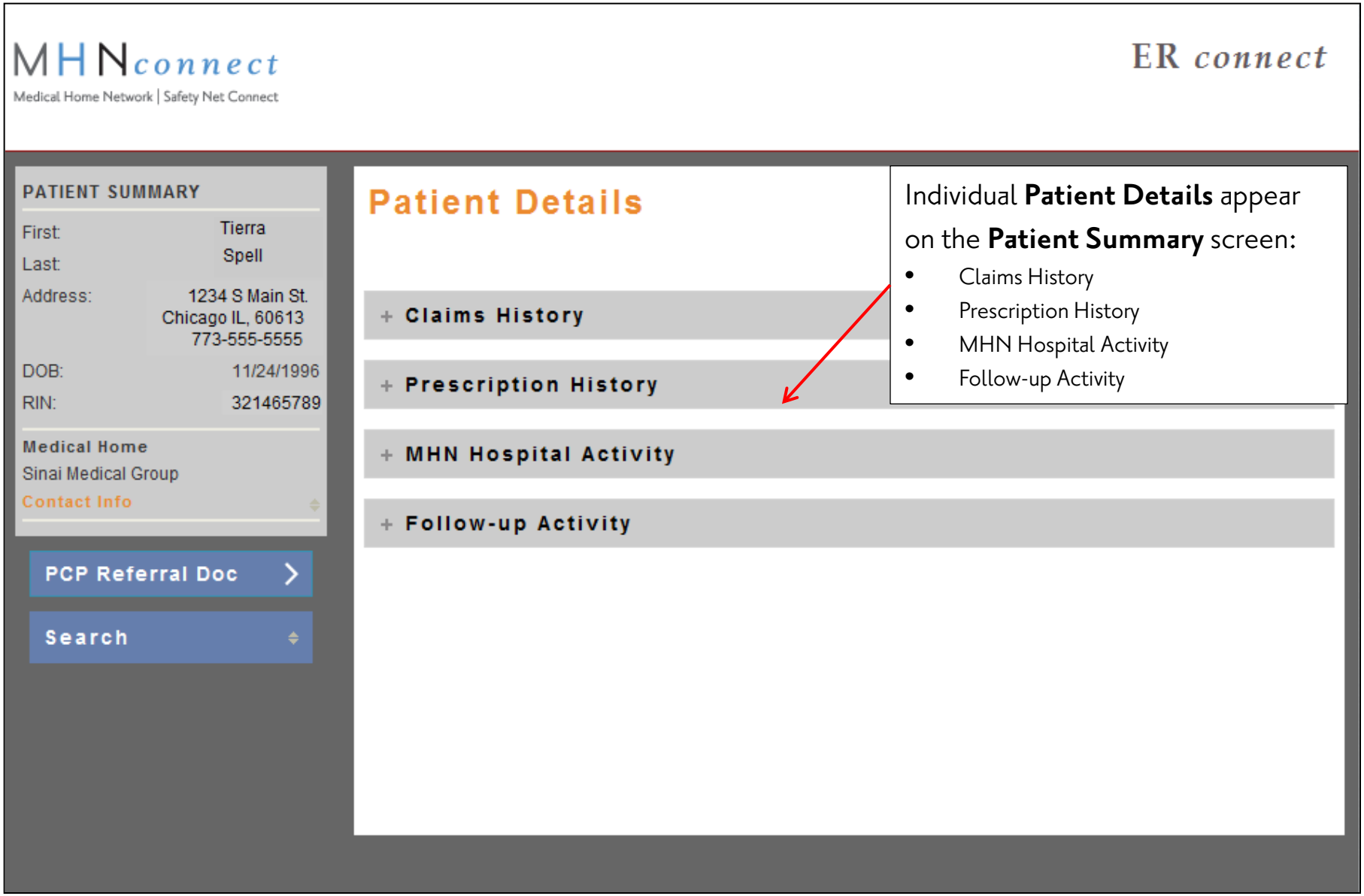
Better Healthcare

Lower Cost

MHNConnect: Flow of Information



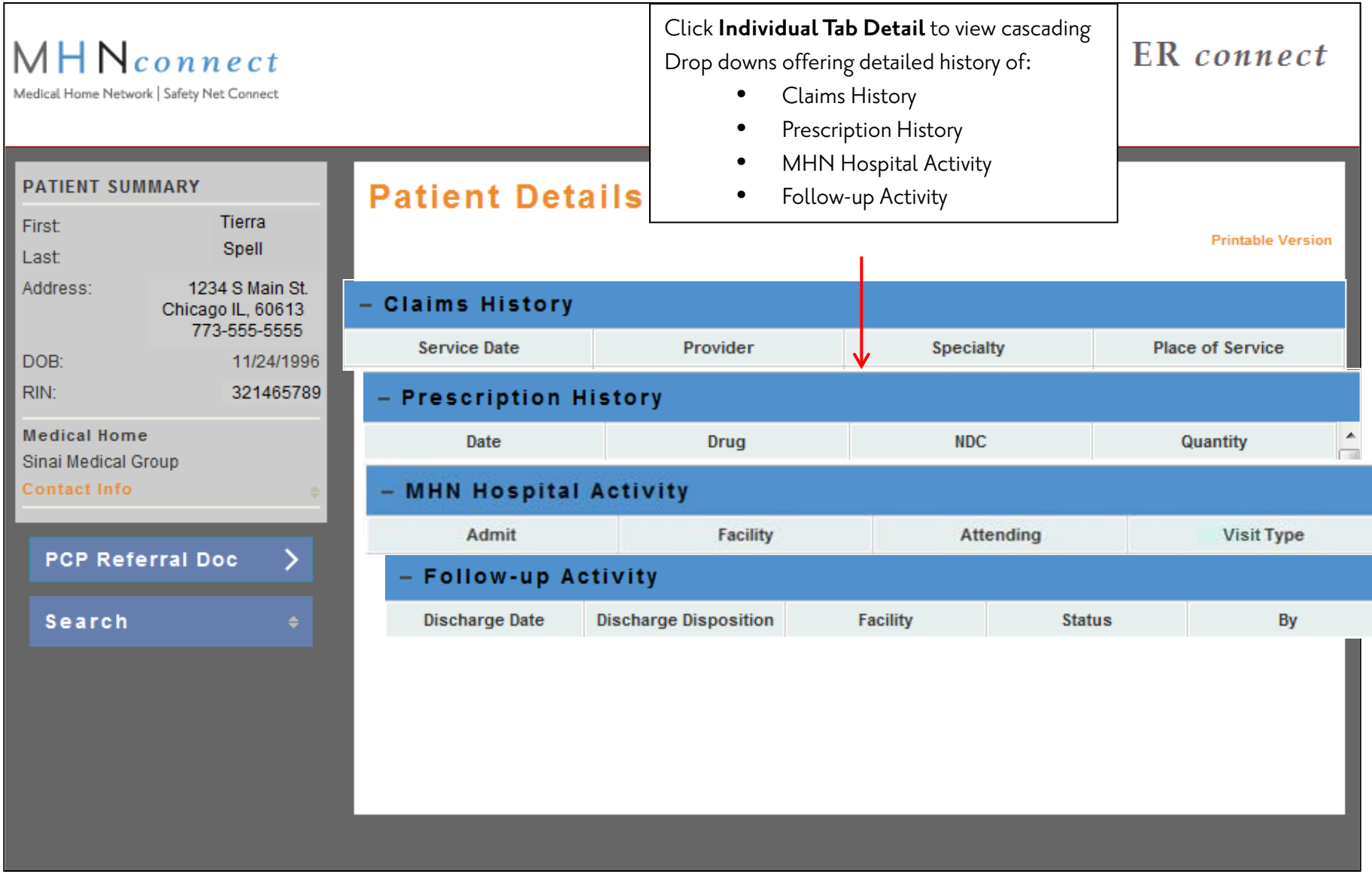
ER Connect: Patient Summary & Detail



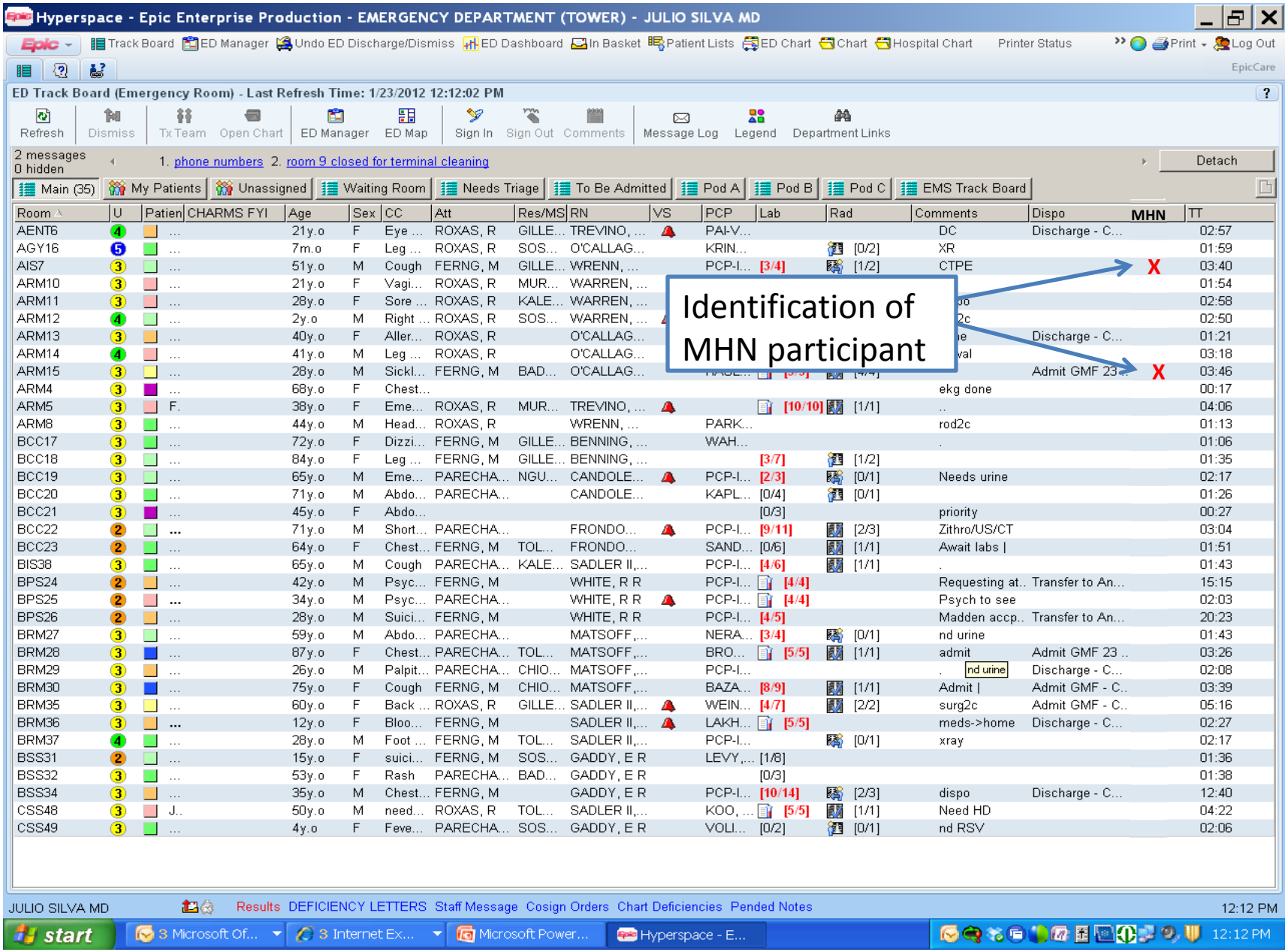
ER Connect: Claims History, Rx History, MHN Hospital Activity, & Follow-up Activity

Click **Individual Tab Detail** to view cascading Drop downs offering detailed history of:

- Claims History
- Prescription History
- MHN Hospital Activity
- Follow-up Activity



ER Connect: EMR & ED Tracking Board Integration



Room	U	Patien	CHARMS FYI	Age	Sex	CC	Att	Res/MS	RN	VS	PCP	Lab	Rad	Comments	Dispo	MHN	TT
AENT6	4		...	21y.o	F	Eye ...	ROXAS, R	GILLE...	TREVINO, ...		PAI-V...			DC	Discharge - C...		02:57
AGY16	5		...	7m.o	F	Leg ...	ROXAS, R	SOS...	O'CALLAG...		KRIN...		[0/2]	XR			01:59
AIS7	3		...	51y.o	M	Cough	FERNG, M	GILLE...	WRENN, ...		PCP-I...	[3/4]	[1/2]	CTPE		X	03:40
ARM10	3		...	21y.o	F	Vagi...	ROXAS, R	MUR...	WARREN, ...								01:54
ARM11	3		...	28y.o	F	Sore ...	ROXAS, R	KALE...	WARREN, ...								02:58
ARM12	4		...	2y.o	M	Right ...	ROXAS, R	SOS...	WARREN, ...								02:50
ARM13	3		...	40y.o	F	Aller...	ROXAS, R		O'CALLAG...						Discharge - C...		01:21
ARM14	4		...	41y.o	M	Leg ...	ROXAS, R		O'CALLAG...								03:18
ARM15	3		...	28y.o	M	Sickl...	FERNG, M	BAD...	O'CALLAG...						Admit GMF 23...	X	03:46
ARM4	3		...	68y.o	F	Chest...								ekg done			00:17
ARM5	3		F.	38y.o	F	Eme...	ROXAS, R	MUR...	TREVINO, ...			[10/10]	[1/1]	..			04:06
ARM8	3		...	44y.o	M	Head...	ROXAS, R		WRENN, ...		PARK...			rod2c			01:13
BCC17	3		...	72y.o	F	Dizzi...	FERNG, M	GILLE...	BENNING, ...		WAH...			.			01:06
BCC18	3		...	84y.o	F	Leg ...	FERNG, M	GILLE...	BENNING, ...			[3/7]	[1/2]				01:35
BCC19	3		...	65y.o	M	Eme...	PARECHA...	NGU...	CANDOLE...		PCP-I...	[2/3]	[0/1]	Needs urine			02:17
BCC20	3		...	71y.o	M	Abdo...	PARECHA...		CANDOLE...		KAPL...	[0/4]	[0/1]				01:26
BCC21	3		...	45y.o	F	Abdo...						[0/3]		priority			00:27
BCC22	2		...	71y.o	M	Short...	PARECHA...		FRONDO...		PCP-I...	[9/11]	[2/3]	Zithro/US/CT			03:04
BCC23	2		...	64y.o	F	Chest...	FERNG, M	TOL...	FRONDO...		SAND...	[0/6]	[1/1]	Await labs |			01:51
BIS38	3		...	65y.o	M	Cough	PARECHA...	KALE...	SADLER II,...		PCP-I...	[4/6]	[1/1]	.			01:43
BPS24	2		...	42y.o	M	Psyc...	FERNG, M		WHITE, R R		PCP-I...	[4/4]		Requesting at...	Transfer to An...		15:15
BPS25	2		...	34y.o	M	Psyc...	PARECHA...		WHITE, R R		PCP-I...	[4/4]		Psych to see			02:03
BPS26	2		...	28y.o	M	Suici...	FERNG, M		WHITE, R R		PCP-I...	[4/5]		Madden accp...	Transfer to An...		20:23
BRM27	3		...	59y.o	M	Abdo...	PARECHA...		MATSOFF,...		NERA...	[3/4]	[0/1]	nd urine			01:43
BRM28	3		...	87y.o	F	Chest...	PARECHA...	TOL...	MATSOFF,...		BRO...	[5/5]	[1/1]	admit	Admit GMF 23 ..		03:26
BRM29	3		...	26y.o	M	Palpit...	PARECHA...	CHIO...	MATSOFF,...		PCP-I...			. nd urine	Discharge - C...		02:08
BRM30	3		...	75y.o	F	Cough	FERNG, M	CHIO...	MATSOFF,...		BAZA...	[8/9]	[1/1]	Admit |	Admit GMF - C..		03:39
BRM35	3		...	60y.o	F	Back ...	ROXAS, R	GILLE...	SADLER II,...		WEIN...	[4/7]	[2/2]	surg2c	Admit GMF - C..		05:16
BRM36	3		...	12y.o	F	Bloo...	FERNG, M		SADLER II,...		LAKH...	[5/5]		meds->home	Discharge - C...		02:27
BRM37	4		...	28y.o	M	Foot ...	FERNG, M	TOL...	SADLER II,...		PCP-I...		[0/1]	xray			02:17
BSS31	2		...	15y.o	F	suici...	FERNG, M	SOS...	GADDY, E R		LEVY,...	[1/8]					01:36
BSS32	3		...	53y.o	F	Rash	PARECHA...	BAD...	GADDY, E R			[0/3]					01:38
BSS34	3		...	35y.o	M	Chest...	FERNG, M		GADDY, E R		PCP-I...	[10/14]	[2/3]	dispo	Discharge - C...		12:40
CSS48	3		J..	50y.o	M	need...	ROXAS, R	TOL...	SADLER II,...		KOO, ...	[5/5]	[1/1]	Need HD			04:22
CSS49	3		...	4y.o	F	Feve...	PARECHA...	SOS...	GADDY, E R		VOLI...	[0/2]	[0/1]	nd RSV			02:06

ER Connect: ED Referral to Medical Home Print Out

Printable Referral forms will be generated at the Patient's discharge from the ED.

Each referral form will include:

- clinic contact information & operating hours
- a map detailing public transportation options
- an image of the clinic façade.

MHNConnect Medical Home Referral

Please contact your physicians office listed below to schedule a follow-up appointment. This is your Illinois Health Connect assigned medical home where you can go to see your Primary Care Provider (PCP).

Por favor, comuniquese con la oficina de su medico para programar una cita de seguimiento. Este es el Illinois Health Connect hogar medico asignado donde usted puede ir a ver a su Medico de Cabecera (PCP).

Print

Referral By

Doctor:	Jones, Bob
Referral Date:	09/06/11
Tracking Number:	20110906909871

Referral From

Facility:	Holy Cross Hospital
Address:	2701 W 68th Street Chicago, IL 60629
Phone:	773.884.4010

Referral For

First:	TIERRA
Last:	SPELL

Referral To

Name:	Lawndale Christian Health Center
Address:	3860 W. Ogden Avenue Chicago, IL 60623

For Quality Management and Continuing Patient Care purposes, this authorization will be tracked and monitored to insure the delivery of necessary health services to you, the Patient.

Clinic Connect: Real-Time Hospital Activity E-mail Alert Sample

MHNConnect: New Hospital Activity

MHN Event Alerts mhnconnect@mhnchicago.org
Sent: Tuesday 3/13/2012 7:15 AM
To: Laura Merrick

You currently have hospital activity for the following Medical Home(s):

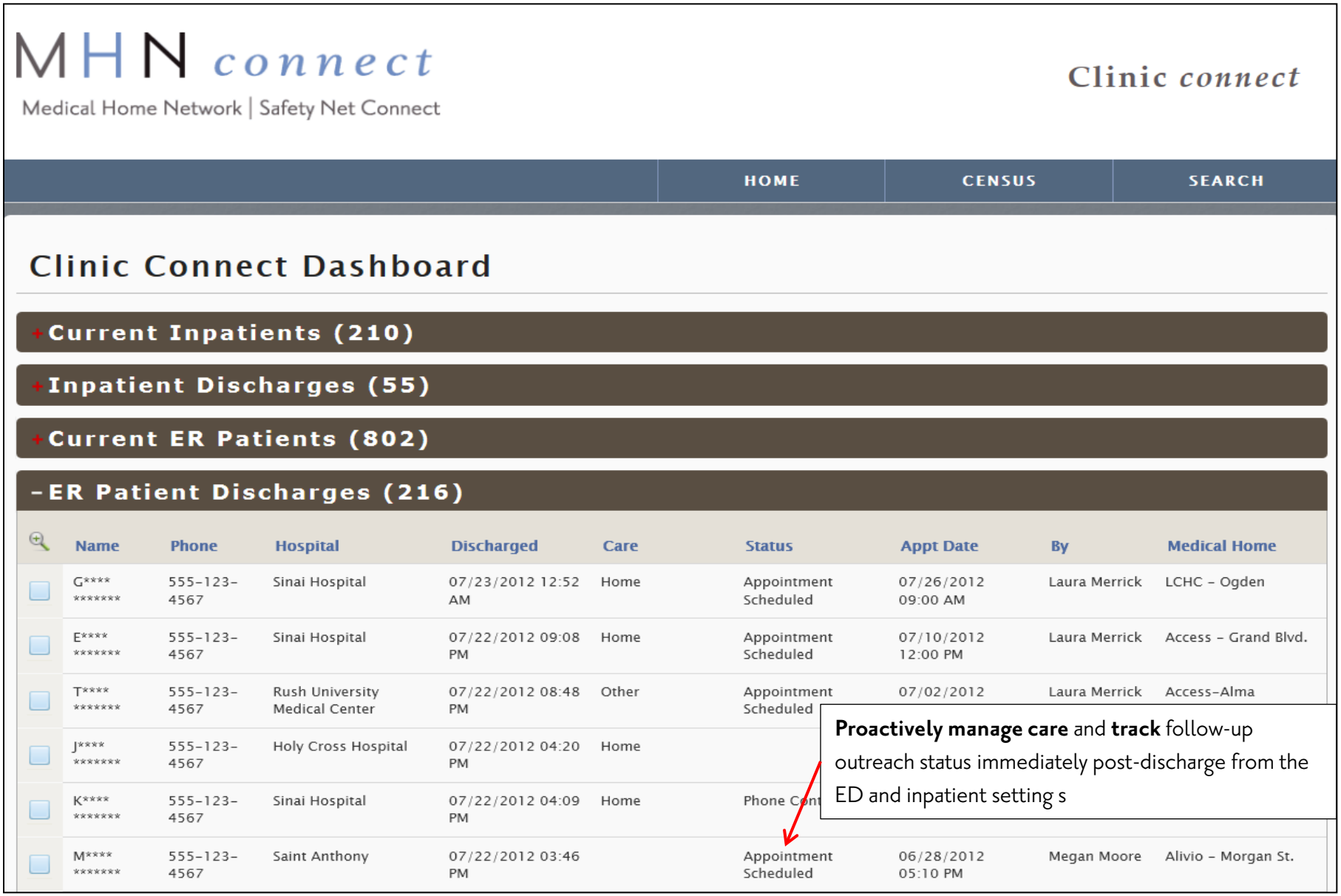
Medical Home	Current Inpatients	Current ER Patients	Inpatient Discharges	ER Patient Discharges
Lawndale Christian Health Center-Ogden			1	
Lawndale Christian Health Center-Homan		1		

Please log on to the MHNConnect Web Portal to view your patient activity at www.mhnconnect.com

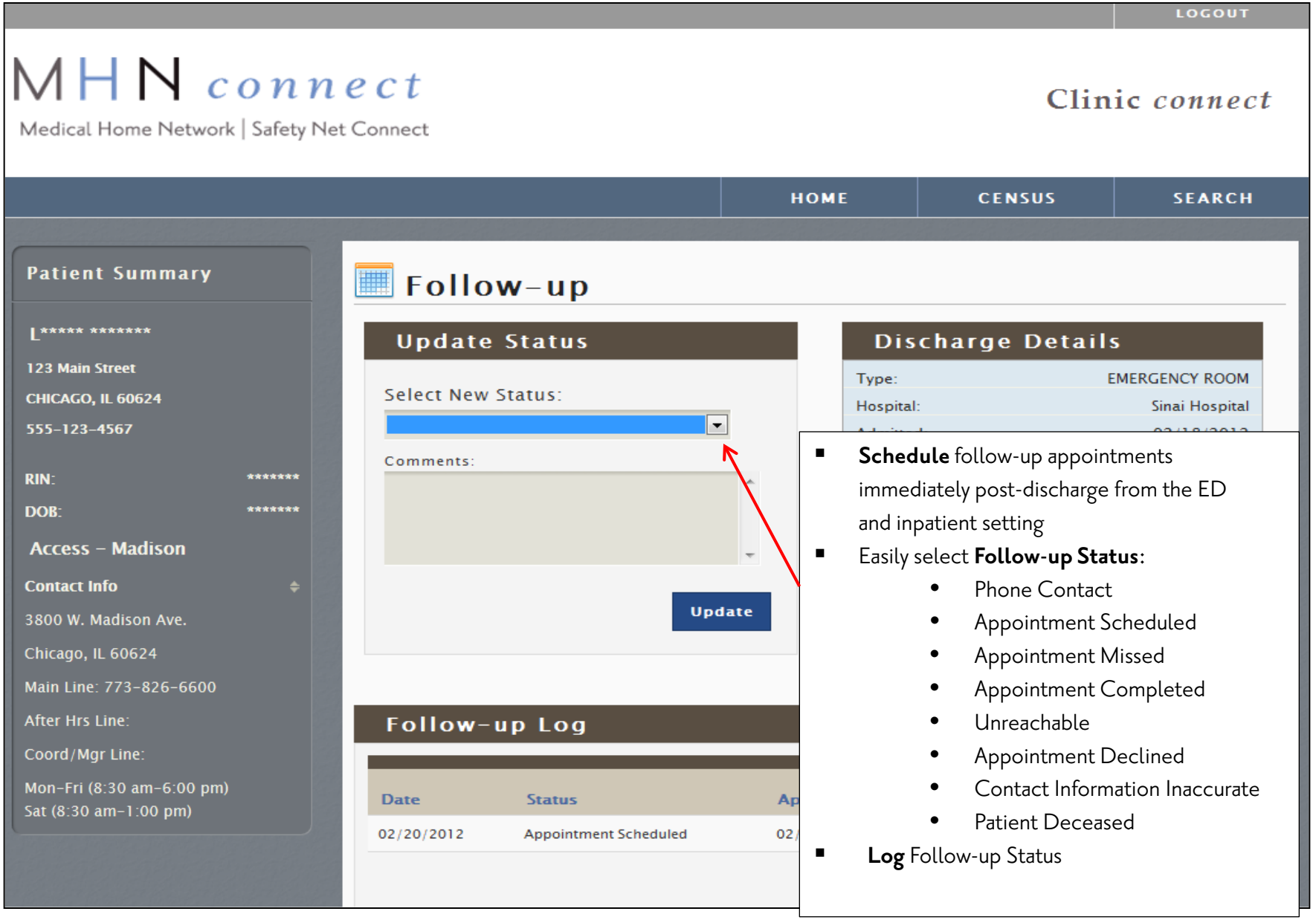
Thank you,

MHNConnect

Clinic Connect: Proactive Care Management Tracking

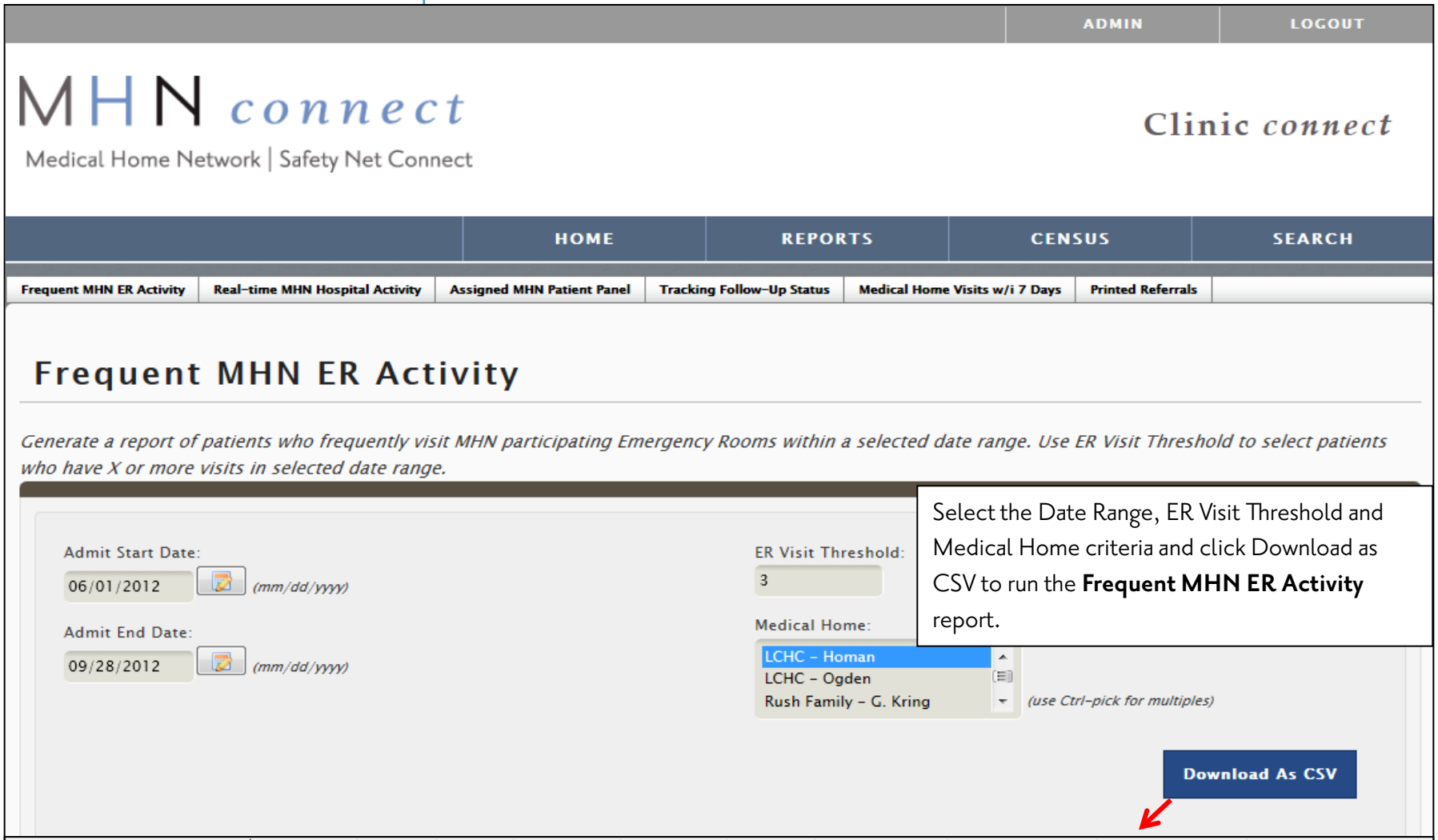


Clinic Connect: Appointment Scheduling & Patient Outreach Tools



- **Schedule** follow-up appointments immediately post-discharge from the ED and inpatient setting
- Easily select **Follow-up Status**:
  - Phone Contact
  - Appointment Scheduled
  - Appointment Missed
  - Appointment Completed
  - Unreachable
  - Appointment Declined
  - Contact Information Inaccurate
  - Patient Deceased
- **Log** Follow-up Status

Clinic Connect: Reports



Select the Date Range, ER Visit Threshold and Medical Home criteria and click Download as CSV to run the **Frequent MHN ER Activity** report.

Frequent MHN ER Activity	Last Name	First Name	RIN	DOB	MH Name	Visits	Admit Date	ER Hospital Name	Attending Physician	Follow Up
3 Or More Visits	AXXXX	AA	123456	3/24/1965	LCHC - Homan	3	6/18/2012	Sinai	Merrick, Laura	Unreachable
And Most Recent Visit Info	BXXXX	BB	87910	8/20/1974	LCHC - Homan	4	7/21/2012	Rush	Moore, Megan	No Follow-up
For Medical Homes: **LCHC Homan**	CXXXX	CC	111213	5/31/1981	LCHC - Homan	4	7/11/2012	CCHHS	Clark, Kathleen	Unreachable
From 06/01/2012	DXXXX	DD	141516	9/17/1969	LCHC - Homan	3	7/22/2012	Holy Cross	Green, Ann	Missed Appointment
To 09/28/2012	EXXXX	EE	171819	11/11/1979	LCHC - Homan	3	7/24/2012	Sinai	Lulias, Cheryl	Scheduled Appointment

MHN Analytics: ED/K Initiative, Intervention Reports

Medical Home Network - Emergency Room Frequent Flyer Reports (with Disease Flagging)

Future Reports: 3 months rolling - By Clinic

Member Info Blinded for Presentation

Future Reports: Active (Y/N) Flag instead of effective dates

Top 4 Frequent Flyers - Sickle Cell Diagnosis

									# ER VISITS WITH DIAGNOSIS				
Member	DOB	First Name	Last Name	MEM_EFF_DATE	MEM_TERM_DATE	# ER CURR. PCP	# ER VISITS ALL PCP	TOT ER PAID	ASTHMA	CHF	COPD	DIAB	HYPR
				2008-01-01	2011-10-30	314	314	$ 33,165	-	-	-	-	-
				2008-01-01	2011-10-30	170	170	$ 21,368	3	-	-	-	-
				2008-01-01	2011-10-30	140	140	$ 21,461	-	-	-	-	-
				2008-01-01	2011-10-31	127	127	$ 13,629	-	-	-	-	-
				2008-06-11	2010-11-30	91	91	$ 20,384	-	-	-	-	-
				2008-01-01	2011-10-30	63	63	$ 10,589	50	-	-	-	-

Medical Home Network - Emergency Room Pregnant Member

Future Reports: Previous Month (or last data dump)

Member Info Blinded for Presentation

Member	LastName	FirstName	DOS	PROV_NAME	ICD9_Descr	Future Reports Last PCP Visit
			2010-07-29	MT SINAI HOSP MED CTR CHIC	OTH MTRN CV DZ PREVIOUS PP COND	##/##/###
			2011-03-05	MT SINAI HOSP MED CTR CHIC	THREATENED ABORTION ANTEPARTUM	##/##/###
			2011-03-17	SOUTH SUBURBAN HOSPITAL	THREATENED ABORTION ANTEPARTUM	
			2011-02-10	VHS WEST SUBURBAN MEDICA	SPOTTING COMP PG ANTEPRTM COND/COMP	
			2010-05-17	ST ANTHONY HOSPITAL	UNSPEC VOMITING PREGNANCY ANTPRTM	
			2010-05-18	GOOD SAMARITAN HOSPITAL	MILD HYPEREMESIS GRAVIDARUM ANTPRTM	
			2010-10-29	UNIVERSITY OF ILLINOIS HOSP	OTH CURRENT MATERNAL CCE ANTEPARTUM	
			2010-10-30	MT SINAI HOSP MED CTR CHIC	OTH CURRENT MATERNAL CCE ANTEPARTUM	
			2010-11-10	UNIVERSITY OF ILLINOIS HOSP	SPOTTING COMP PG ANTEPRTM COND/COMP	
			2011-01-17	UNIVERSITY OF ILLINOIS HOSP	TWIN PREGNANCY ANTEPARTUM	

MHNConnect: Facilitating Care Coordination on the Ground

"I remember a mom who was relieved that we had called to offer a follow-up appointment; she told me her child had not been feeling better after being discharged from the hospital. She was afraid that an appointment would be scheduled at too late of a date if she called. She was very happy that we had contacted her as she was thinking about taking her child back to the ER. I get the sense that if we do not initialize contact with these patients some of them will not take the time to call and set up a follow-up appointment at all. The fact that we do is the reason that they do come in."

Margarita G., *Pediatric Care Team*

"A patient delivered a baby and became an inpatient. When I called her, she accepted a post-partum appointment within 4-6 weeks after delivery. The patient stated that she didn't know she needed a follow-up appointment with her doctor here at LCHC. I gave her optional dates and she took the appointment. Her husband was in the background saying 'Thank you' as well."

Carmetha G., *OB Care Team*

"MHNconnect has been very successful for both providers and patients. It allows the providers to be aware of anything occurring with the health of their patients and allows them to help patients avoid any future visits or admissions to the hospital. We have just started working in the Portal and are making great progress by contacting patients to connect with their PCP for follow-up. We have received many compliments from patients because some were unaware that they were supposed to follow-up with their PCPs. Some assumed that everything had been resolved in the hospital."

Oliva R., *Care Team*

"MHNConnect is an incredibly pro-active tool that enables us as a clinic to reach out to our patients in a way that would otherwise not be possible when they are battling sickness or trying to recover. In the three weeks I have been using MHNConnect, I have scheduled many follow-up appointments for patients who have recently been discharged from the hospital."

Genna K., *Care Team*

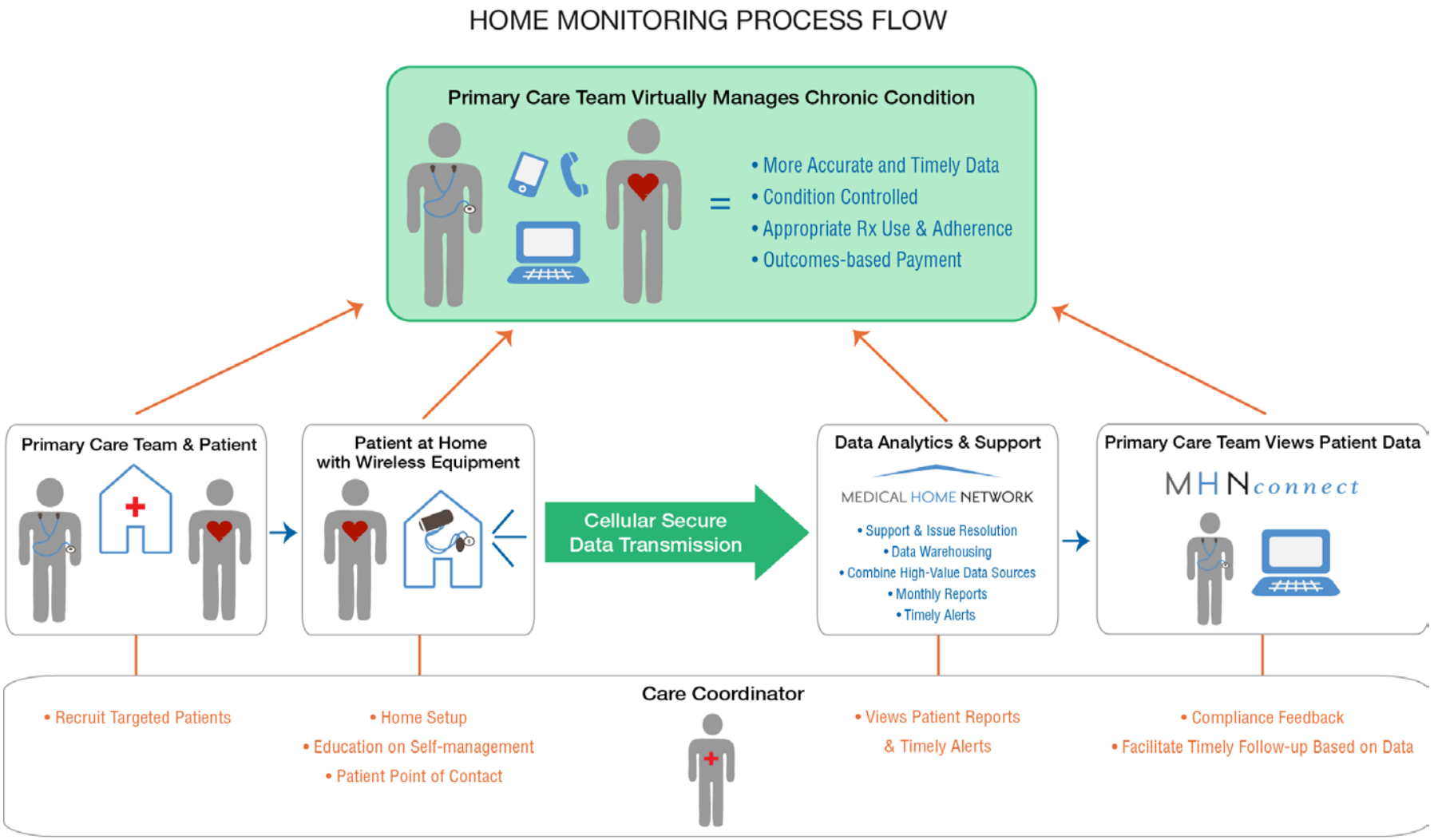
A pediatric patient assigned to Esperanza went to the ED for the stomach flu. Esperanza brought the patient in for timely follow-up based on a real-time MHNConnect alert and discovered that the child was over a year behind on required immunizations. Esperanza brought immunizations up to date and educated the family about the role of their Medical Home.

Esperanza Experience

Through the MHNConnect portal, Lawndale Christian Health Center identified an adult patient who had been to the ED 4 times since the start of the year, both for acute care and exacerbations of asthma and hypertension. Lawndale was able to bring the patient in for follow-up to address his chronic conditions and provide education about the role of the Medical Home.

Lawndale Christian Experience

Remote Home Monitoring: Engaging the Patient Through Technology



Remote Home Monitoring Reporting and Communication Protocol

Functionality	CHF		Hypertension	
	Care Team	Patient	Care Team	Patient
Daily BP/Weight Readings	Monthly Report from MHN	Monthly Call from Care Team	Monthly Report from MHN	Monthly Call from Care Team
Medication Non-Compliance	Monthly Report from MHN	Monthly Call from Care Team	Monthly Report from MHN	Monthly Call from Care Team
Home Monitoring Non-Compliance	Alert after 72 hours	Call from Care Team	Alert after 72 hours	Call from Care Team
Abnormal BP/Weight Readings	Real-time Alert	Immediate Follow-Up Call from Care Team	Real-time Alert	Immediate Follow-Up Call from Care Team
Hospital Activity at MHN Participating Hospital	Near Real-time Alert via MHNConnect	Immediate Follow-Up Call from Care Team	Near Real-time Alert via MHNConnect	Immediate Follow-Up Call from Care Team
ED Activity at MHN Participating Hospital	Near Real-time Alert via MHNConnect	Immediate Follow-Up Call from Care Team	Near Real-time Alert via MHNConnect	Immediate Follow-Up Call from Care Team