

# Webinar Series Session 4: How Health Plans Can Meet Competing Performance Demands of Stakeholders

# HMA - HealthEC Collaboration

## Opportunity

Workgroups comprised of subject matter experts from HMA and HealthEC met over several months in 2019 to discuss ways in which **healthcare consulting and advisory services** such as those offered by HMA and **population health management (PHM) and analytics applications** such as those offered by HealthEC could be leveraged more effectively by government agencies, healthcare providers, and payers to address critical needs in select



## Focus Areas

1. Health Equity
2. Communicable Disease Management
3. MCO Performance Management
4. **Supports to Small/Midsize Health Plans**
5. VBP Contract Supports
6. Opioids
7. HHS Service and Data Integration



## Outputs

### *Health Performance Accelerator*

Tailored consulting and advisory services that can be coupled with tailored PHM and analytics platform deployments

# Today's Speakers

**Frank Persinger**

VP Strategic Development- HealthEC



**Glenda Stepchinski, RN, BSN**

Senior Consultant- HMA



# Learning Objectives

1. Understand how to design, implement and operate performance and quality management systems
2. Learn how to develop and sustain effective care management programs
3. Identify and improve provider access and network adequacy issues
4. Understand best practices in value-based care programs and other delivery systems

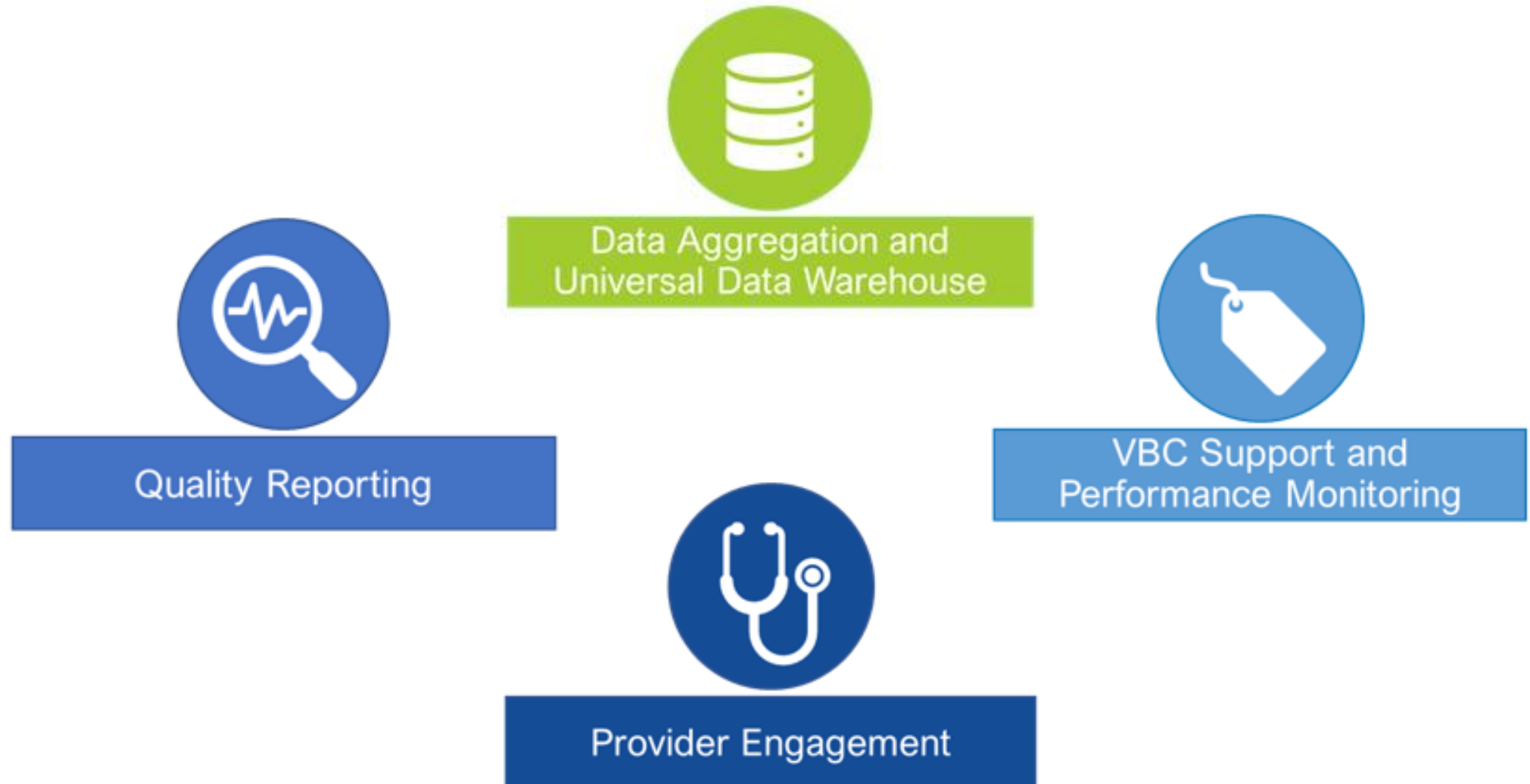
# Health Plan Challenges

- Managing multiple stakeholders – state and federal regulatory agencies, enrollees, providers, and advocacy groups
- Limited IT infrastructure and management capacity
- Limited access to timely, accurate and meaningful data
- Limited analytics capabilities
- Limited ability to synthesize data to cost-effectively manage care

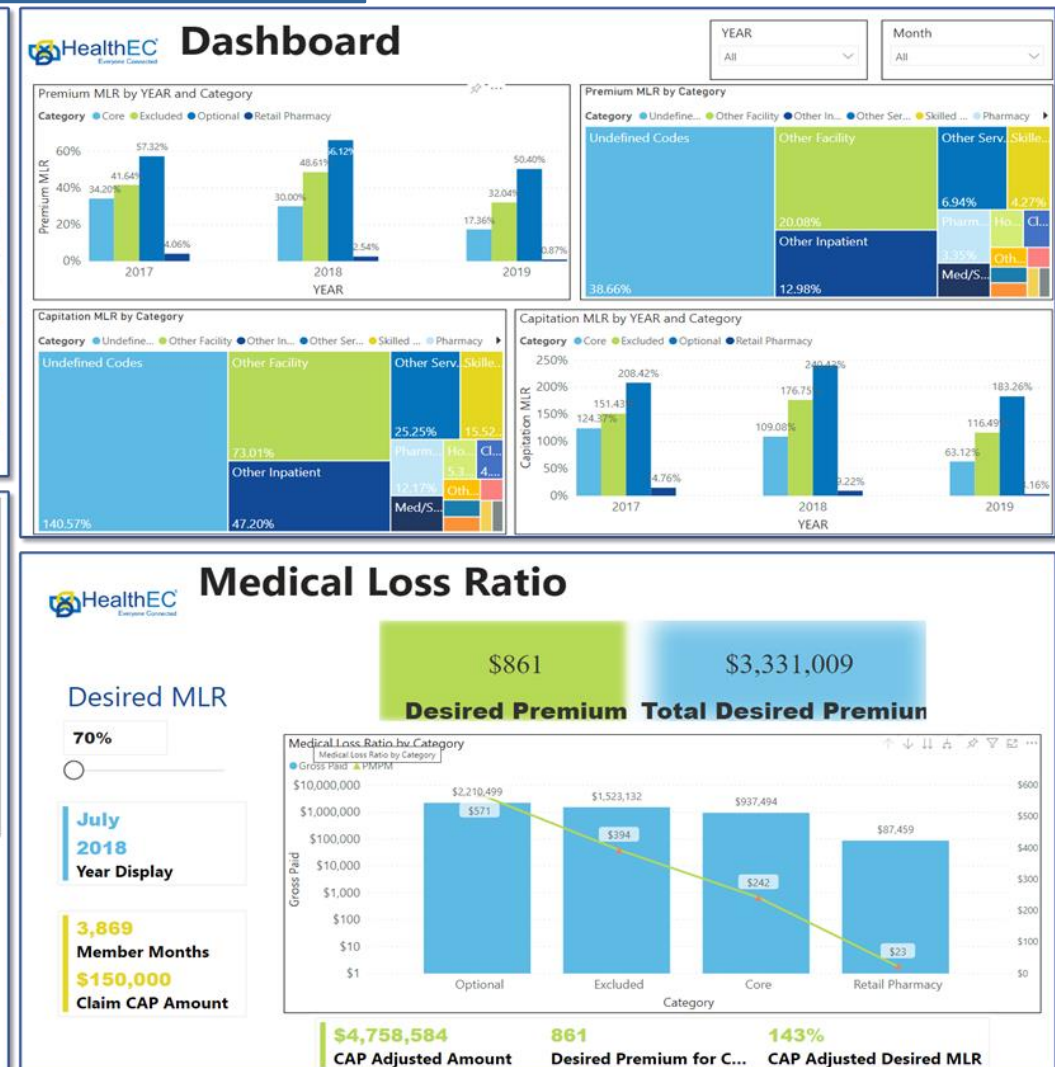
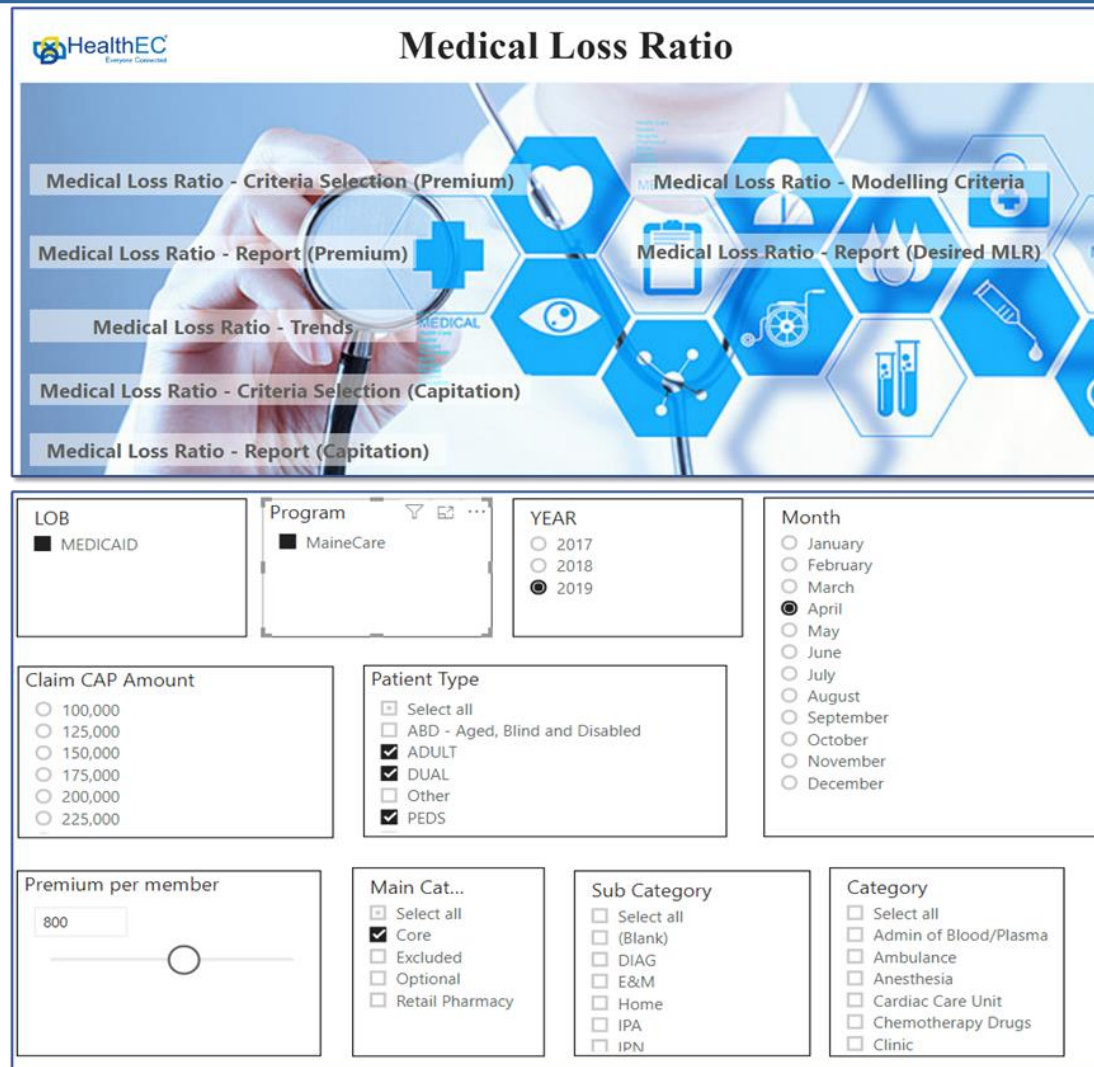
# Services Addressing Challenges

- Support design, implementation and operation of performance/quality management systems
- Develop and support implementation of quality improvement initiatives
- Support care management teams in process redesign and improvements
- Perform rapid-cycle interventions aimed at addressing performance and quality challenges
- Analyze provider access and network adequacy issues
- Develop and implement value-based care programs and/or other service delivery innovations or initiatives

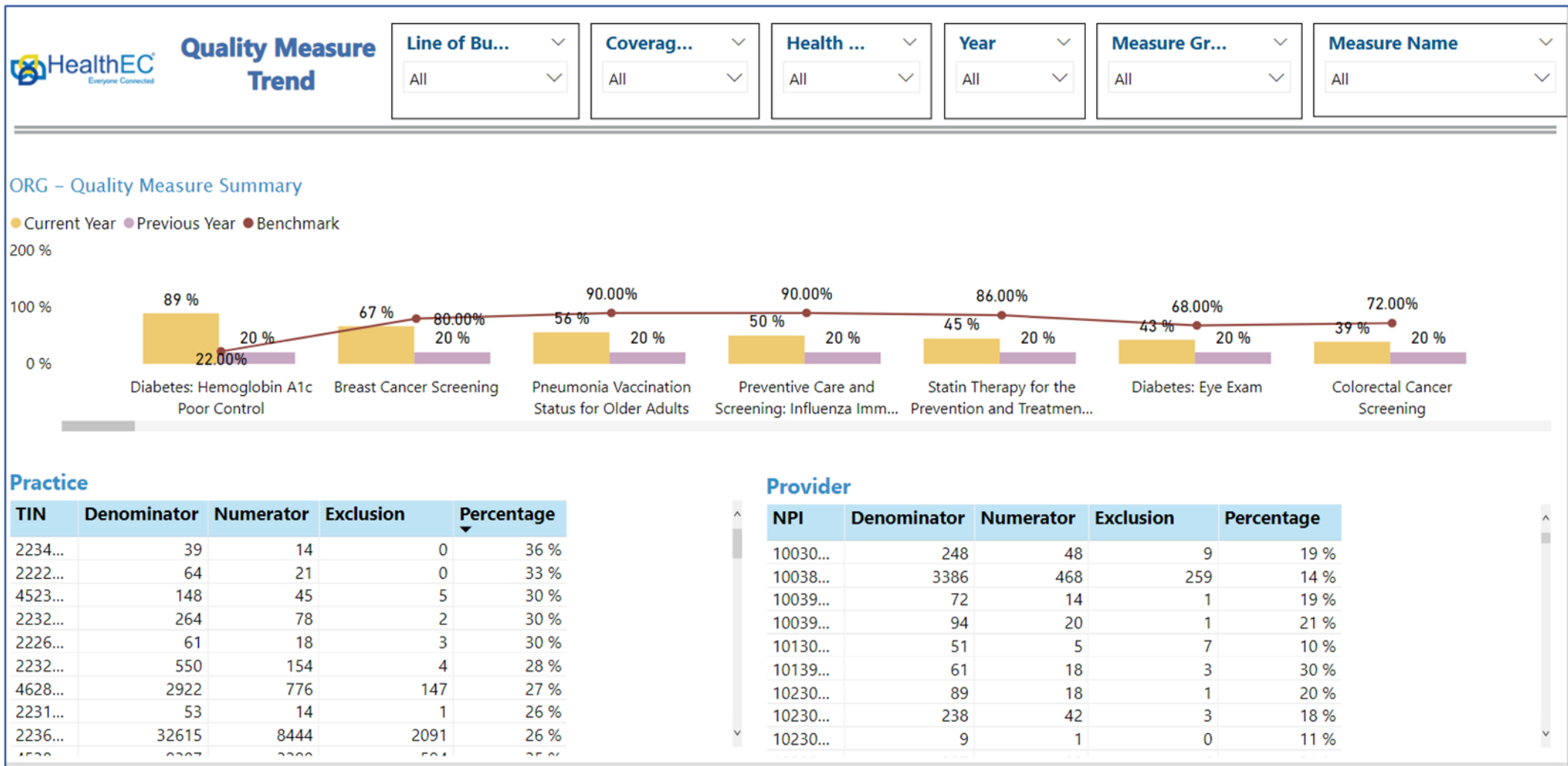
# Health Performance Accelerator



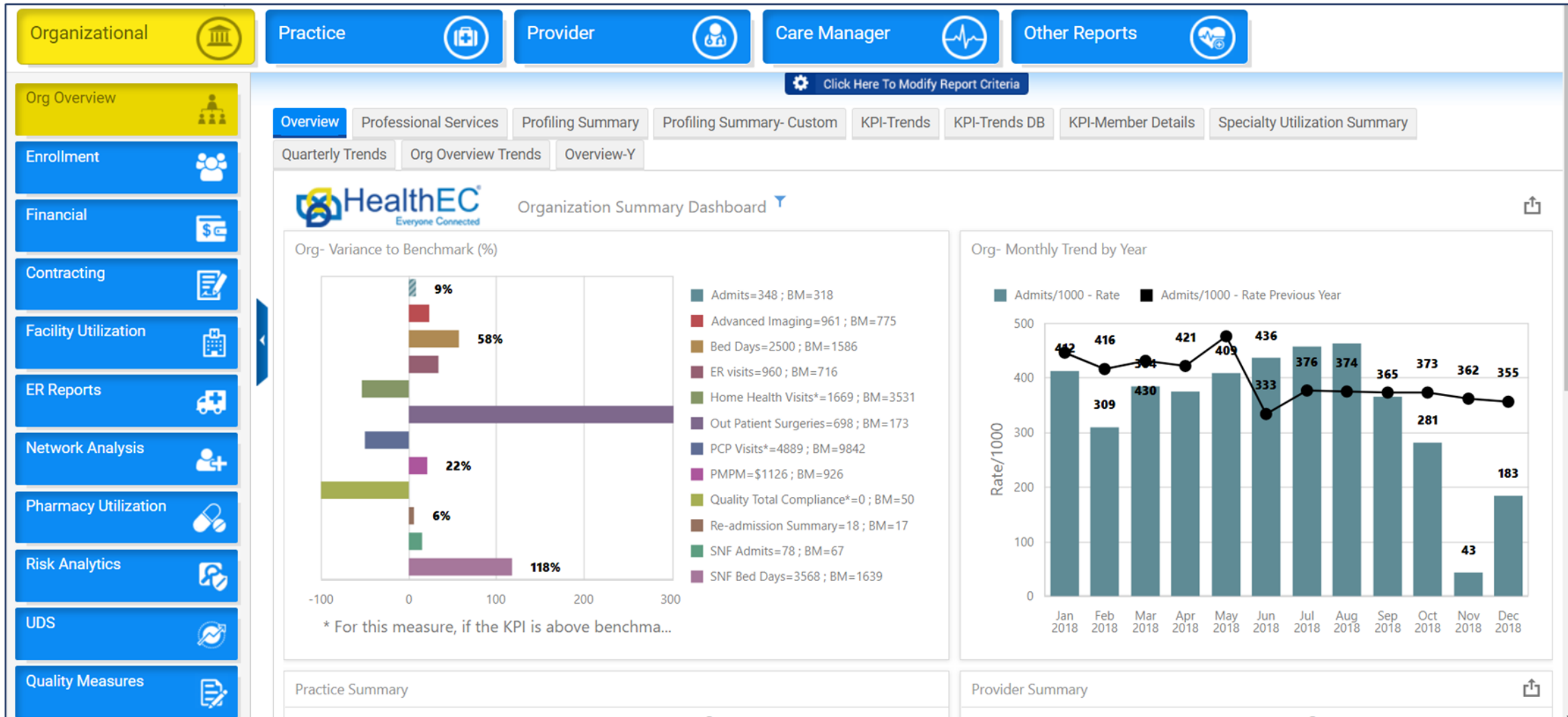
# Performance and Quality Systems



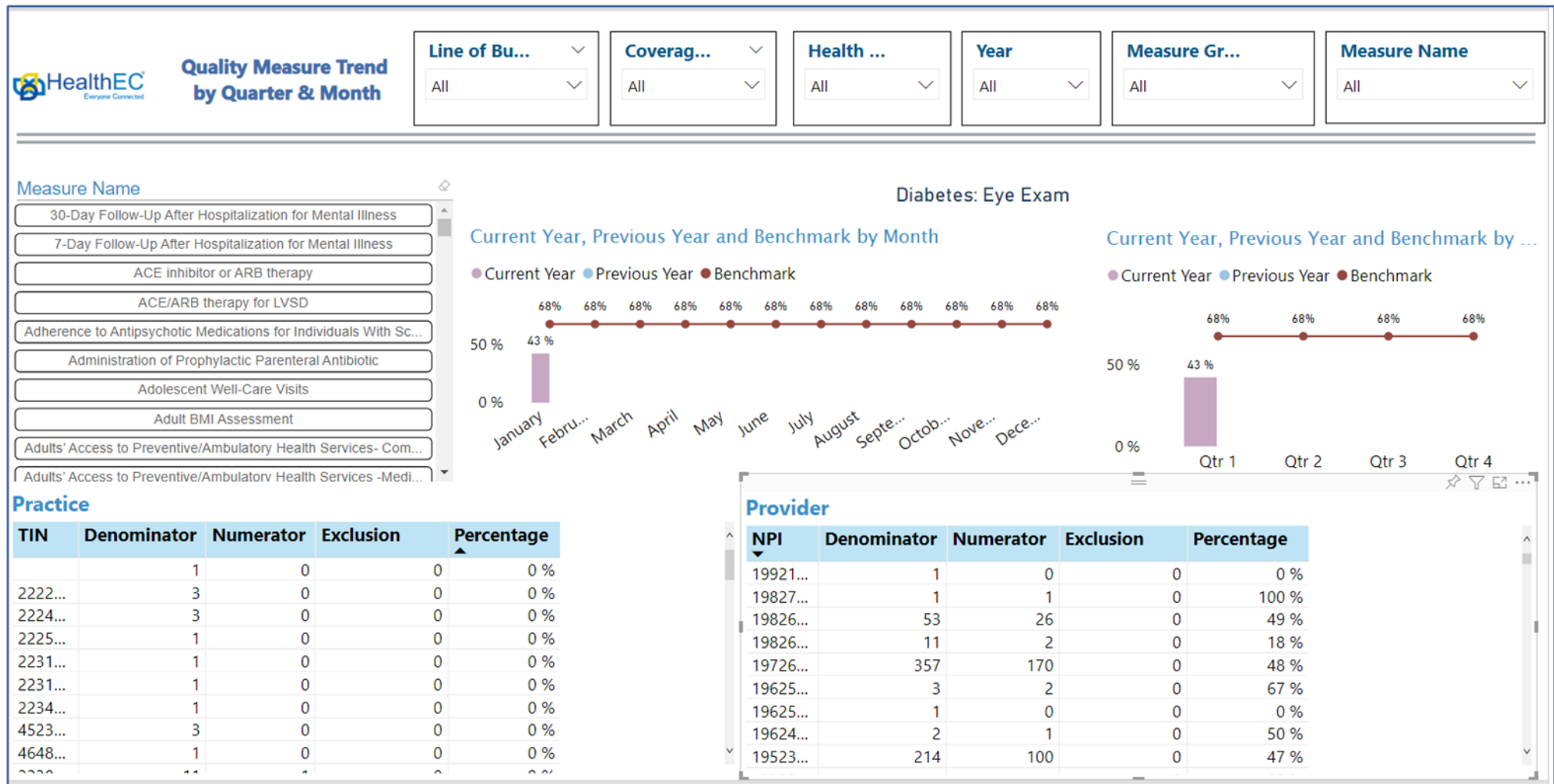
# Performance and Quality Systems



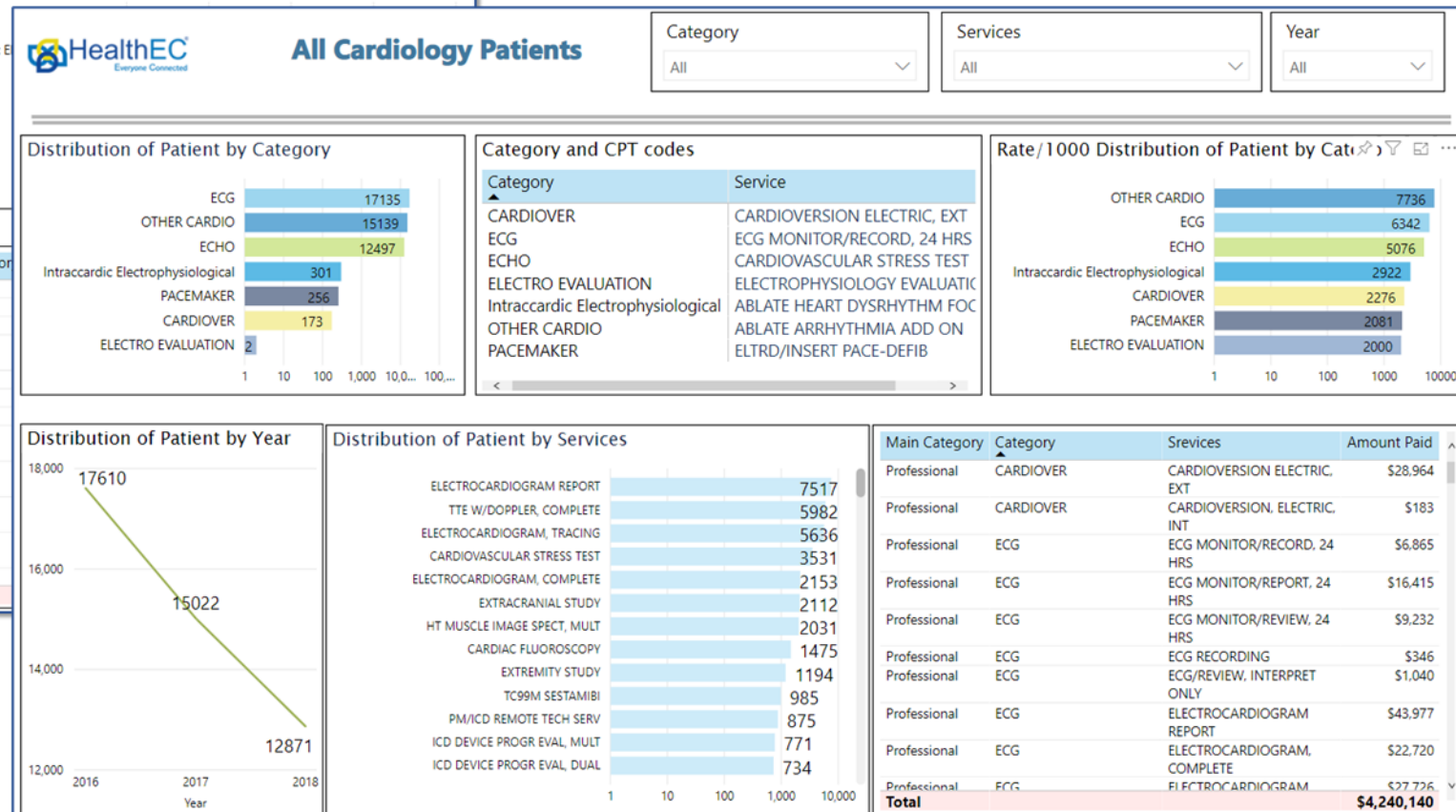
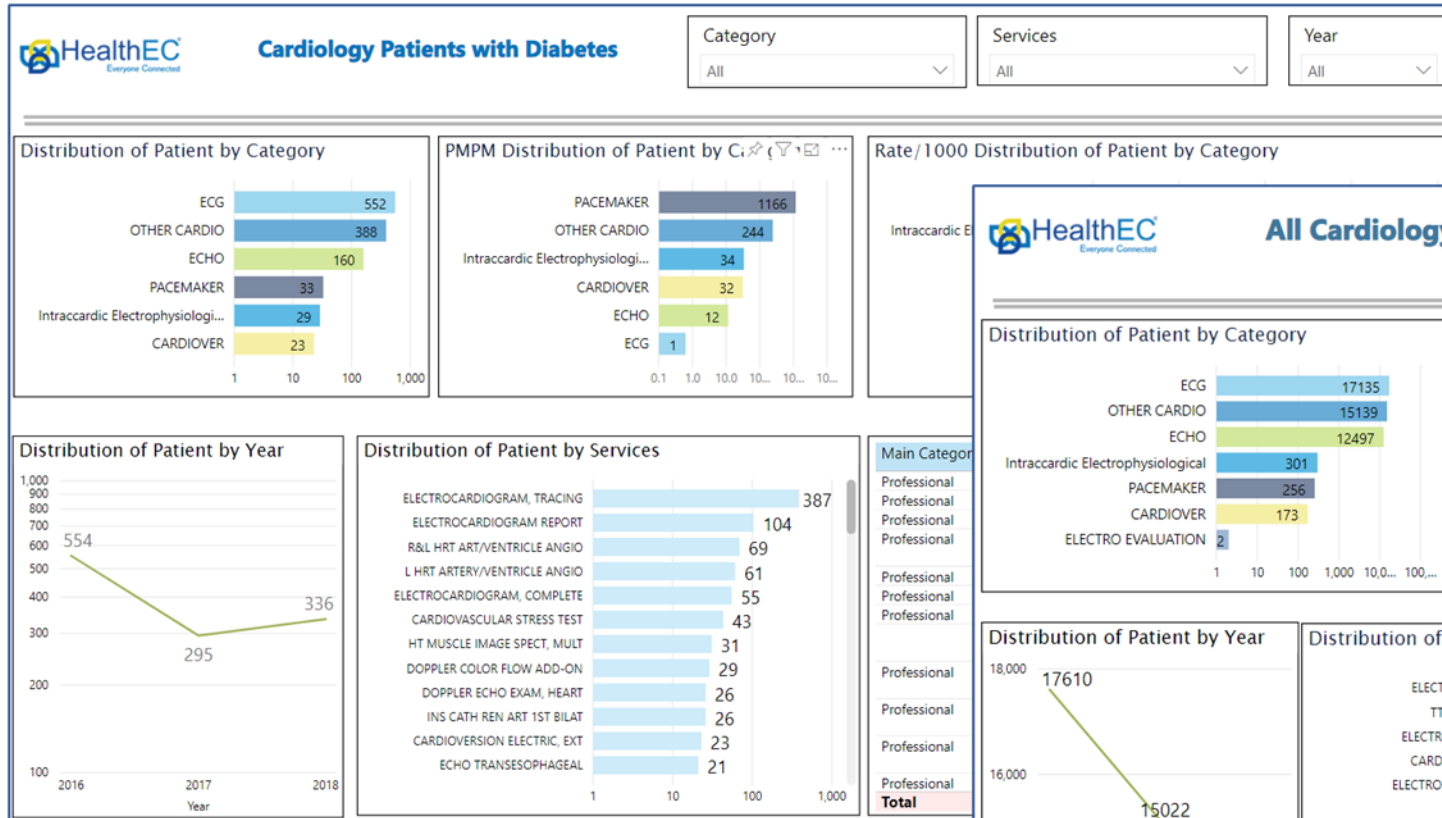
# Support of Quality Initiatives



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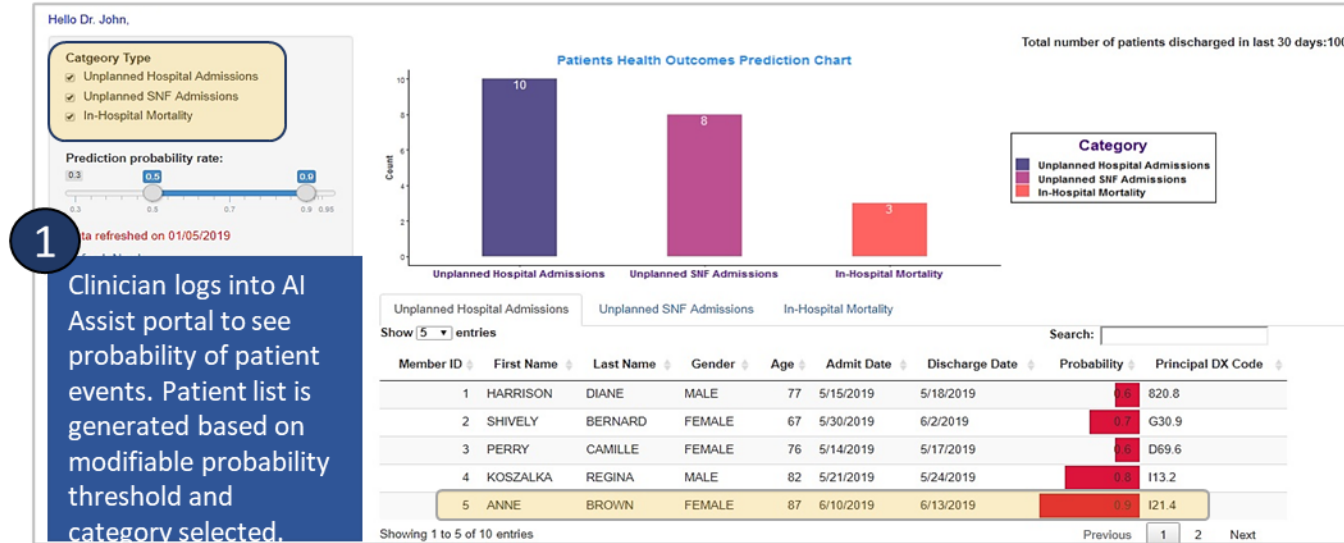


# Support of Care Management Initiatives



# Support of Care Management Initiatives

Model output in comprehensible format, including potential process to capture risk factors as care tasks for appropriate resource assignment and follow-up.



1 Clinician logs into AI Assist portal to see probability of patient events. Patient list is generated based on modifiable probability threshold and category selected.

2

5 ANNE BROWN FEMALE 87

Showing 1 to 5 of 10 entries

### Patient Details

Non-Modifiable Risk Factors Modifiable Risk Factors

First Name ANNE

Last Name BROWN

Gender FEMALE

Age 87

RACE Hispanic

Family History CHF, Smoking, Diabetes, Hypertension

Open Care Plan Add to Care Task

### Patient Details

Non-Modifiable Risk Factors Modifiable Risk Factors

Disease Burden

Diagnosis

- 1 Congestive Heart Failure
- 2 Diabetes Mellitus Type II
- 3 Mood disorder, depressed
- 4 Hypertension
- 5 Psychotic & schizophrenic disorders

Charlson Comorbidity Score 10

Recent Procedures Coronary Artery Bypass Graft

Medications

- 1 Polypharmacy
- 2 > 15 prescription medications
- 3 Proportion of days covered - 0.5

Open Care Plan Add to Care Task

Utilization

Readmissions 8

Inpatient admissions 4

ALOS 25

Total cost of care \$175,231

Functional Status

Low ADL and IADL

High Fall Risk

Social Determinants

Substandard Housing

No Social Support

Low Income

3 From AI Assist, a care plan is auto-generated with problems, goals, barriers, and interventions; resources are assigned. The clinician can generate care tasks for proactive care coordination and prioritized interventions in HealthEC's CareConnect application.

1 Polypharmacy

2 > 15 prescription medications

3 Proportion of days covered - 0.5

Open Care Plan Add to Care Task

Current Medication List (Last Updated by NAGELLA L ... on 08/01/2019)

☐ No Known Medications ☐ Medication List Reviewed With Patient

Medication Name	Dose	Route	Frequency	Prescriber	Status	Source
0.6 ML NEULASTA 10 MG/ML	1	PO	Once a day	RANA NILESH	Active	NAGELLA L, DR. CHANDAN
0.15 ML ADRENALIN 1 MG/ML	2		Once a day	Pomeroy Jon	Active	NAGELLA L, DR. CHANDAN
PREDNISONE 10 MG				PATEL RAKESH	Active	Claims

Depression Screening Tool (PHQ-9)

Completed On 08/20/2018 12:15:42 PHQ-9 Score 1

Proposed Treatment Action None Suicidal Ideation NO

Problems, Goals, Barriers and Interventions

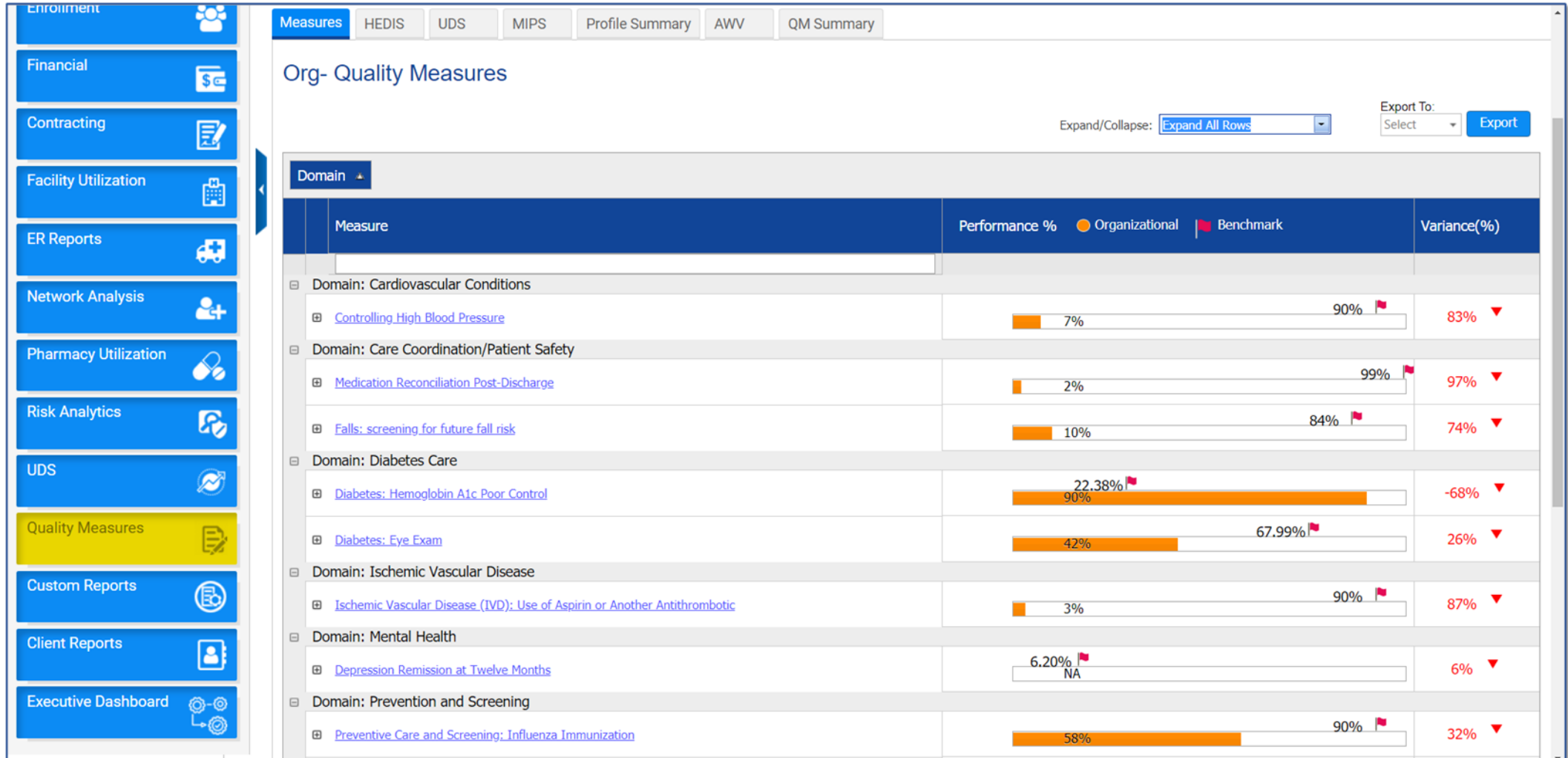
Status	Nursing Diagnosis/Problems	Goals	Barriers	Interventions	Scheduled Interventions	Goal Due	Notes	Last Updated On	Created By	Created On
Active	Patient needs follow up appointment				12/22/2019			12/20/2019 00:00:02	Admin HealthEC	12/20/2019 00:00:02
Active	Patient discharged from hospital				12/20/2019			12/20/2019 00:00:02	Admin HealthEC	12/20/2019 00:00:02
Active	Patient admitted to hospital				12/19/2019			12/19/2019 00:00:05	Admin HealthEC	12/19/2019 00:00:05

4 Care tasks based on risk factors can now be tracked, engaging both clinicians and patients in the care management process.

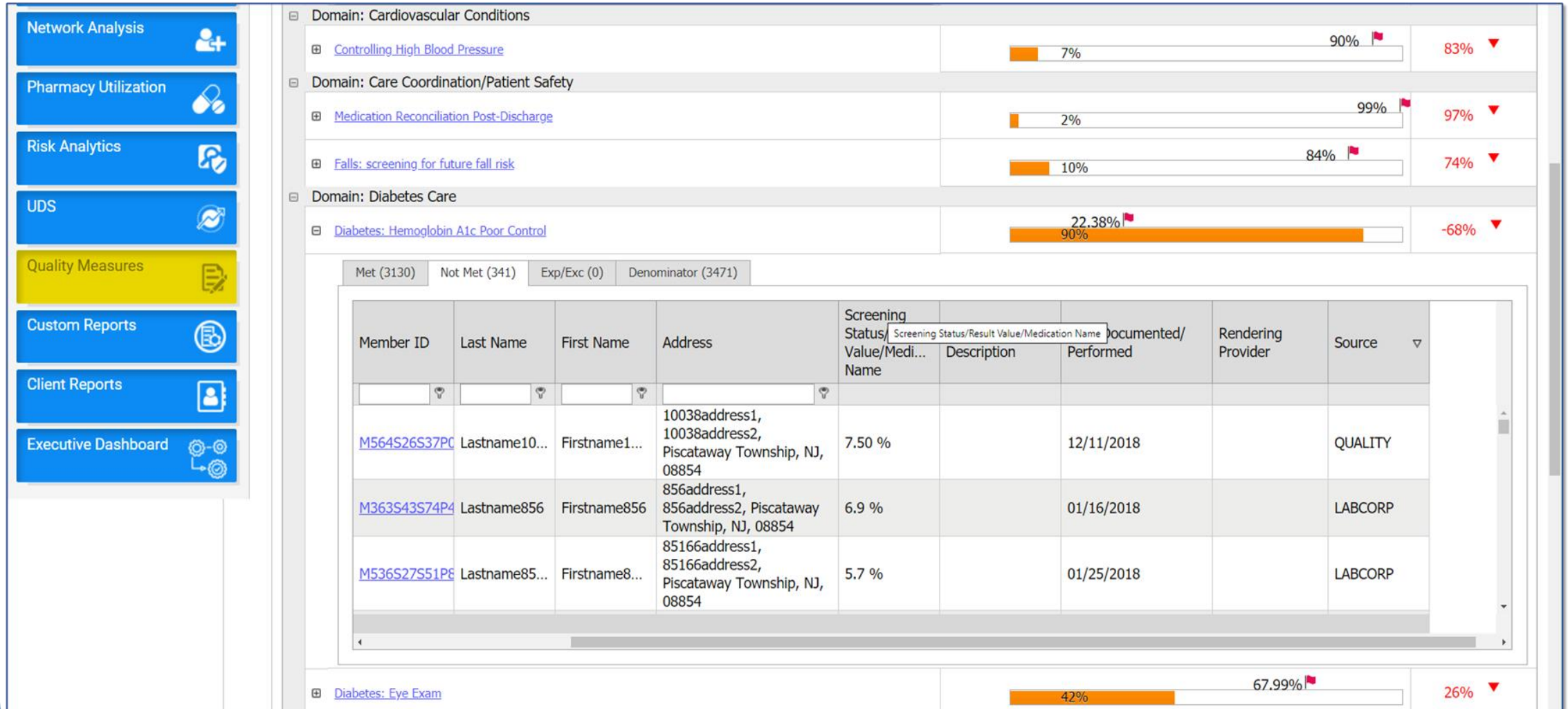
Problems, Goals, Barriers and Interventions - View/Edit All

	Nursing Diagnosis/Problems	Goals	Barriers	Interventions	Scheduled Interventions	Goal Due
	Patient needs follow up appointment				12/22/2019	
	Patient discharged from hospital				12/20/2019	
	Patient admitted to hospital				12/19/2019	
	Patient admitted to hospital				12/17/2019	
	Patient discharged from hospital				12/17/2019	
	Patient needs follow up appointment				12/19/2019	

# Care Management and Quality



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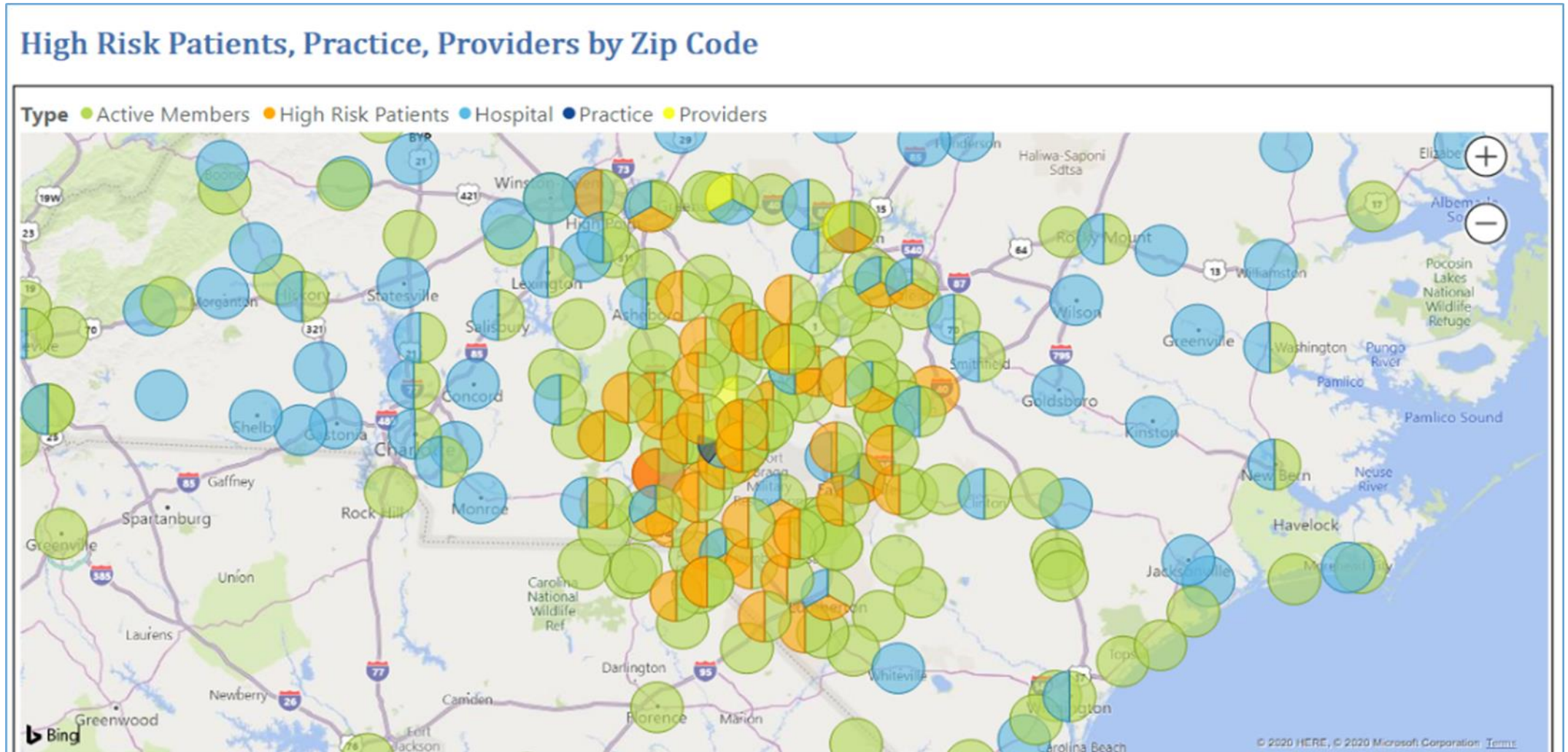
The screenshot displays the HealthEC Care Management interface. On the left is a sidebar with navigation options: Network Analysis, Pharmacy Utilization, Risk Analytics, UDS, Quality Measures (highlighted in yellow), Custom Reports, Client Reports, and Executive Dashboard. The main content area shows patient information for a female patient, including name, DOB, address, and contact details. Below this, there are filters for Non Compliant, Compliant, and Excluded status. The interface lists several preventive care measures grouped under 'Preventive Care Measures Group (PCMG)', 'Hypertension Measures Group (HTN)', and 'Chronic Care (CCM)'. Each measure includes a table with columns for Name, Last Performed, Next Due, Compliance, and a Result button. For example, 'Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan' shows a compliance status of 'Non Compliant' (red X) and a 'Result' button. Other measures like 'Colorectal Cancer Screening' and 'Statin Therapy' show 'Compliant' status (green checkmarks). On the right side of the interface, there are performance metrics showing percentages (90%, 83%, 99%, 97%, 84%, 74%, -68%) and a table with 'Source' and 'LABCORP' entries.

Name	Last Performed	Next Due	Compliance	Result
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan		Now	Non Compliant	Result
Colorectal Cancer Screening	05/22/2017	05/22/2027	Compliant	Result
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease		Now	Non Compliant	Result
Preventive Care and Screening: Influenza Immunization	10/16/2018	Now	Compliant	Result
Breast Cancer Screening	06/04/2018	09/04/2020	Compliant	Result
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	01/21/2019	01/21/2021	Compliant	Result

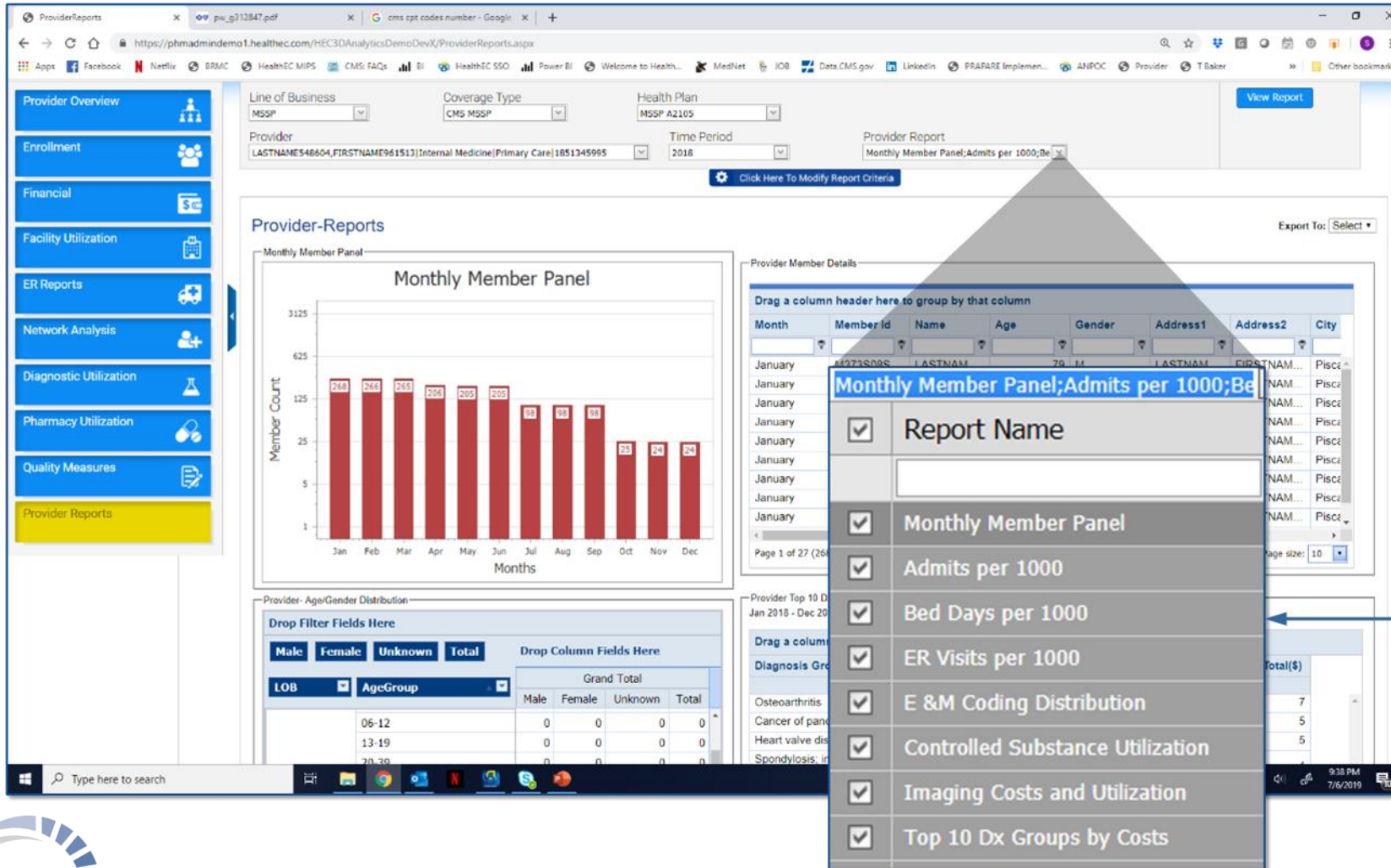
Name	Last Performed	Next Due	Compliance	Result
Controlling High Blood Pressure		Now	Non Compliant	Result

Name	Last Performed	Next Due	Compliance	Result
Wellness Visit	01/21/2019	01/21/2020	Compliant	Result
Review Care Plan	03/07/2019	Now	Compliant	Result

# Provider Access and Network Adequacy



# Value Based Initiatives




Provider reports can be:

- Automatically generated
- Emailed or mailed
- An interactive or static report
- Configured to update once a month only

End users can select report panels to view from a drop-down menu

# Value Based Initiatives

 <b>Comparative Performance by Practice/Domain</b> <div>Practice Na... All</div> <div>Measures All</div>														
Practice Name	Bread For The City		Childrens Hospital		Community Of		Family And Medical		FQHC 01		FQHC 02		FQHC 03	
Disease Condition	Star	Weight	Star	Weight	Star	Weight	Star	Weight	Star	Weight	Star	Weight	Star	Weight
<b>Cardiovascular Conditions</b>	★★★	3.0	★	1.0	★★★	3.0	★★★	3.0	★	1.0	★★★	2.5	★★	
<b>Diabetes Care</b>									★★	2.0	★★★	3.0	★★★	
<b>Prevention and Screening</b>														
Immunizations for Adolescents-Combo2									★	1.0				
Adult BMI Assessment	★★★★★	5.0	★★★★★	4.0	★	1.0	★★★★★	4.0						
Preventive Care and Screening:Depression Screening and Follow-Up for Adolescents and Adults	★	1.0	★	1.0	★	1.0	★	1.0						
<b>Utilization</b>									★★★	3.0	★★★	3.0	★★★	
<b>Risk Adjusted Utilization</b>	★★★	3.5	★★★	3.0	★★★	3.5	★★★	3.0						
<b>Access/Availability of Care</b>	★	1.0	★	1.0	★	1.0	★	1.0						
<b>Behavioral Health</b>									★	1.0	★	1.0	★	

# Health Performance Accelerator



## Data Aggregation and Universal Data Warehouse

- Aggregated claims, lab, and pharmacy data
- Creation of, or integration with, a data warehouse
- EMR clinical data extraction and integration
- Enabling of decision support at the plan level
- Monitoring of utilization and costs by major diagnostic categories (MDCs)
- Tracking of HCC scores at the practice and provider level



## VBC Support and Performance Monitoring

- Monitoring of practice and provider performance on key contract metrics
- Inpatient/ER/network utilization by disease, practice, or provider monitoring
- Tracking of performance against capitation and monitoring of expenditures against medical loss ratio (MLR) at the practice and provider level
- HEDIS and Star ratings by practice and provider
- Capitation vs. FFS by service category and provider type



## Provider Engagement

- VBC and care management tools to practices
- Real-time claims- and EMR-based gaps in care monitoring
- Expenditures against budget and previous year
- Utilization of ER- and facility-based services for nonemergent reasons tracking
- Care coordination documentation and referral management



## Quality Reporting

- Over 500 industry-certified quality measures
- Benchmarked dashboards for the state by program
- HEDIS and Star measure compliance monitoring by agency and MCO
- NQCA certification for eCQM measures by summer 2020
- Extraction of hybrid/supplement measures from EMRs
- Provider engagement on accurate coding for HCC

# Questions?



# Upcoming Webinars



**Value-Based Payment (VBP)  
Contract Supports**

**Tuesday 9/15**



**Opioids Program Supports**

**Thursday 9/17**



**Health & Human Services  
(HHS) Service and Data  
Integration**

**Tuesday 9/22**



# Appendix