

Healthcare Innovation Collaboration

Marshall Health / Aetna

October 27 2016



MarshallHealth

Agenda

- Overview of Population Served
- Challenges
- How we are working together
- Patient Examples and Interventions (focus on utilization of services)
- Next Steps



Population Overview

- Total Lives
 - TANF (~5000)
 - Expansion (~1350)
- High Risk Patient Attributes
 - Mental Health – 63%
 - Mental Health and Chronic Care Condition – 61%
 - Substance Abuse – 26%
 - Multiple Chronic Conditions (2 or more) – 90%



Challenge

- Patient Challenges
 - Relatively high amount of socioeconomic issues compared to other populations in our medical home model
 - Rate of Mental Health Issues
 - Difficulties with Patient (and Parent) engagement
 - Transient Patient Population



Provider Challenges

- Data Quality
 - Patient Attribution – Are these patients really ours? Where are they receiving primary care currently if not from us?
 - Quality Measure reporting - How we efficiently report and gather quality data for measure submission? How do we make sure it is both accurate and easy?
 - Secondary coverage – how do we report for this population?



Plan Challenges

- Information
 - Lack of ACA Expansion Population Utilization Data
 - Timeliness of Claims Information (Claims Lag)
 - Patient Attribution: Panel monitored, claims analyzed, members outreached, and panel corrected
 - Multiple Hospitals and Providers used
 - Medical Records from non-Marshall providers
 - Multiple Prescribers



Collaboration between Marshall Health and Aetna

- Well Child Visit Initiatives
- Transition Care Management and High Risk OB Management (Onsite Aetna OB/NAS Case Manager)
- NAS program and Lily's Place referrals
- Cost and Utilization Review Committee
(Scheduled Medical Director Collaborative Calls)



Benefits of Marshall Health and Aetna Collaboration

- Increased Communication
 - “We” not “Us vs. Them”
 - Identify care needs
 - Collaborative patient/member care plan development
 - Provide assistance in testing or treatment approvals
 - Identify problems real time from practitioners (referrals)
- Decrease Readmissions thru Chronic Disease Management
- Decrease ER utilization
- Improve medication utilization

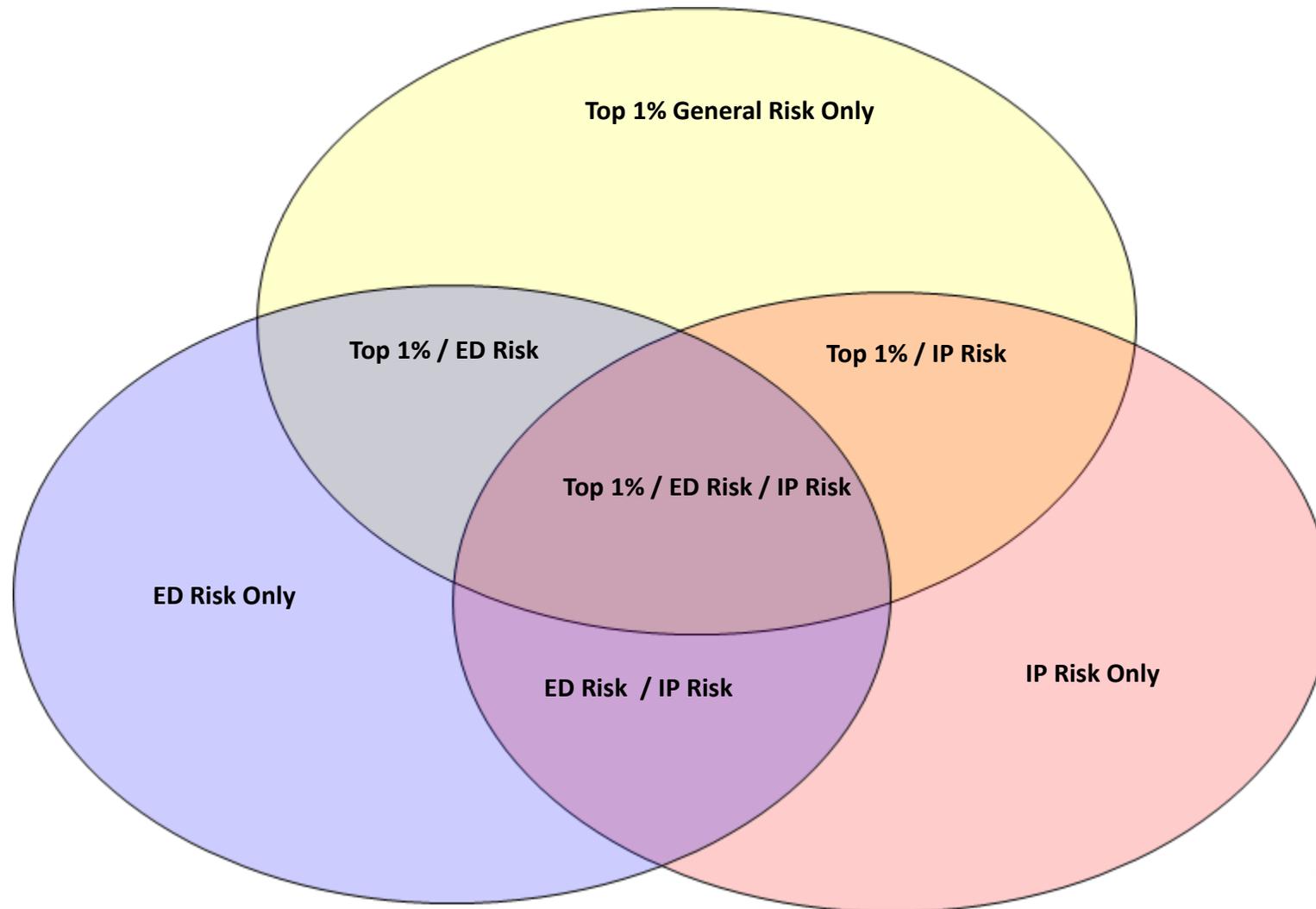


Benefits of Marshall Health and Aetna Collaboration

- Reports
 - Trends (Utilization and Cost)
 - Inpatient/Outpatient Utilization (Physical/Behavioral)
 - ER utilization (3+ visits/6 months, ER visit breakdown)
 - Prescriptions and Prescribers
 - Gaps in Care
 - HEDIS Quality Tracking and Scoring
 - Electronic data transfer from Marshall (alternative claims data verification methods for HEDIS/Gaps in Care)
 - Improved Risk Assessment Process (CORE)



CORE Diagram



CORE Report Example

Member Name	Verified PCP	Location of PCP	Marshall Health Follow-Up	Stratified Risk Model Score	Stratified Risk Model Rank	Stratified Risk Percentile	Top 1%	Inpatient Admission Risk Score	Inpatient Admission Risk Grp	ED Visit Risk Score	ED Visit Risk Grp	CORE Group	New to CORE Group 4	Likelihood of Surviving less than 12 months (Mbrs age 18+)
TANF - Adult Patient 1	Vanhorn, Lee (Resident - FM)	Family Medicine - Marshall Health	46-year-old male – Stratified Risk Model Score 11.372 – Dx Diabetes Mellitus and Anxiety. Patient appears to be homeless with multiple ED visits to various facilities, however 34 specialist visits were documented per Coventry Care (services were not provided by Marshall Health) – c/o of head lice and scabies. Patient will be reviewed by MSW to determine status and will begin to obtain available resources to assist with social status. Further audit performed by Coventry Care to locate where the patient is seeking care for addition specialty appointment and ED utilization	11.372	88	1%	Y	66.2%	Medium	42.2%	Low	5	No	0.1%
TANF - Pediatric Patient 1	Dunlap, Brian	Pediatrics - Marshall Health	5-year-old male – Stratified Risk Model Score - 0.944. Dx Mild Persistent Asthma with speech delays (Referral to speech pathologist). Patient has 12 ED visits with 7 sick visits with in a year. Appears to have over lapping therapies – Patient has been referred to SW to evaluate transportation, ED utilization and education.	-0.944	123,361	100%	N	60.0%	Medium	64.2%	Medium	7	No	0.0%
TANF - Pediatric Patient 2	Wipple, Mark	Pediatrics - Marshall Health	14 year old male with ADHD, Autistic disorder and growth hormone deficiency. The patient had previously been seen at Pretera but after multiple cancelations on the part of Pretera the patient did not have the proper medication. The patient was seen by Dr Wipple on 9/29/2016 and Dr Lewis on 9/30/2016. Currently followed by Marshall Health.	12.291	59	1%	Y	0.9%	Low	21.0%	Low	1	No	0.0%



TANF–Pediatric Patient 1

- 5 year old male with persistent asthma, speech delays
- Patient has 12 ED visits along with 7 sick visits within a year
- Appeared to have over lapping therapies
- Patient referred to speech pathologist
- Social Worker consult concerning knowledge deficit of transportation issues and high ED utilization
- Marshall Health NOW Care and transportation issues resolved



TANF-Pediatric Patient 2

- 14 year old male with Attention Deficit Hyperactivity Disorder (ADHD), Autistic Disorder and Growth Hormone Deficiency
- Patient evaluated by Social Services at Marshall Health
- Patient's family with knowledge deficit concerning growth hormone and ADHD medication
- Collaboration of care began with Aetna, school nurse, social services, primary care physician, pediatric endocrinologist, and mental health specialist



TANF-Pediatric Patient 3

- 12 year old male with poorly controlled Type 1 Diabetes and Obesity
- Patient had presented to the ED with a seizure; mother stated blood sugar prior to going to bed was 500 mg/dl
- Knowledge deficit revealed concerning insulin pump and diet
- Patient referred to Social Services, Clinical Pharmacist and Diabetic Educator



TANF - Adult Patient 1

- 46 year old female with Hypothyroidism, Type 2 Diabetes and Anxiety
- Patient documented within Coventry Care 34 specialist visits which were outside of Marshall Health
- Patient referred to the Clinical Pharmacist and Social Service for evaluation
- Case Management began with collaboration with Aetna



Next Steps

- Incorporating quality metrics required by the state
- Adapting to changes in state (e.g. opioid protocols)
- Coordinating efforts between insurance plan case management and provider care coordination team

