Provider Network Management & Clinical Performance Optimization In Population Health Management: Preparing For Value-Based Reimbursement

The 2017 OPEN MINDS Performance Management Institute Thursday, February 16, 2017 | 11:30am – 12:45pm

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Agenda

I. The Relationship Between Population Health Management & Value-Based Reimbursement

II. Seven Key Competencies For Provider Network Management & Clinical Performance Optimization

III. Provider Network Management & Clinical Performance Optimization In Population Health: The Chestnut Health Systems Case Study

IV. Provider Network Management & Clinical Performance Optimization In Population Health: The Gracepoint Case Study

V. Questions & Discussion
The Relationship Between Population Health Management & Value-Based Reimbursement
Value-Based Reimbursement

- P4P FFS
- PFS
- Outcomes-based funding
- Bundled/episodic/case rates
- Capitation for care coordination
- Capitation for service delivery
Population Health Management Approach

Population health management” is an approach to managing health outcomes and resource utilization of a group needed for success in value-based reimbursement arrangements.

A best-in-class PHM program brings clinical, financial and operational data together from across the enterprise and provides actionable analytics for providers to improve efficiency and patient care...²

“the health outcomes of a group of individuals, including the distribution of such outcomes within the group”¹
Four Domains in OPEN MINDS Model For Assessing Population Health Management Readiness

Financial Management & Leadership/Governance Structure
- Alignment of strategy with infrastructure & resources

Technology & Reporting Infrastructure Functionality
- Data leveraged to gain insight

Provider Network Management & Clinical Performance Optimization
- Data analyzed to drive clinical decision-making

Consumer Access, Customer Service, & Consumer Engagement
- Processes to empower consumers and create engagement
Seven Key Competencies For Provider Network Management & Clinical Performance Optimization
Seven Key Competencies Of Provider Network Management & Clinical Performance Optimization

- Provider Organization & Professional Recruiting & Credentialing
- Care Coordination & Care Management
- Consumer Screening, Care, Provider Referrals, & Case Authorizations
- Decision Support & Care Standardization
- Integration of Physical Health, Behavioral Health, & Social Services
- Clinical Performance Tracking, Assessment & Optimization
1. Provider Organization & Clinical Professional Recruiting & Credentialing

**Focus:**
Ability to recruit and management credentials of clinicians that meet the requirements of payer organizations

**Key Competencies for Success**
- Accreditation in serving consumers with complex needs
- Ability to recruit and retain qualified clinicians
- Effective workflows for managing clinician credentials
2. Consumer Screening, Provider Referrals, & Care Authorization

Focus:
Ability to identify high-risk and high-needs individuals and ensure the most effective care management plan and services

Key Competencies for Success
- Ability to identify high-utilization consumers
- Process to screen, assess and refer consumers to the appropriate level of service
3. Care Coordination & Care Management

Focus:
Ability to identify care management needs, obtain payer authorizations and refer to appropriate services

Key Competencies for Success

- Processes in place to receive care management referrals, assess needs and refer consumers for services
- Authorizations expertise
- Focus on integration, follow-up and communications
- Systems to track usage of other community providers
4. Decision Support & Care Standardization

Focus:
Ability to use data to determine and promote the most effective evidenced-based practices

<table>
<thead>
<tr>
<th>Key Competencies for Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Standardized guide to care management and treatment</td>
</tr>
<tr>
<td>▪ Implementation of data-informed planning, treatment and referral</td>
</tr>
<tr>
<td>▪ Continuity of care planning and transition between care settings</td>
</tr>
</tbody>
</table>
Focus:
Ability to ensure that chronic physical health issues are integrated into the care plan

Key Competencies for Success
- Established referral and data sharing relationships with primary care
- Established protocols for referrals and care transitions
- Focus on identifying consumer preferences when making primary care referrals
6. Clinical Performance Tracking, Assessment & Optimization

**Focus:**

Ability to track outcomes, assess how to optimize services, and implement performance improvements

**Key Competencies for Success**

- Track clinical outcomes and consumer experience by provider organization
- Assess tracking data to identify best performers and best practices
Case Study Examples of Provider Network Management & Clinical Performance Optimization

- Process for receiving care management referrals
- Process for profiling and risk-adjusted care planning
- Process to refer consumers to the most appropriate level of service
- Marketing that addresses return on investment
- Processes and tools to facilitate the communication between care teams
- Protocols for referrals and care transitions with physical health providers
- System to track hospitalizations and provide timely follow-up post discharge
The Chestnut Health Systems Case Study

Orville Mercer, MSW, Vice President, Behavioral Health, Chestnut Health Systems, and President, IBHHC LLC
PROVIDER NETWORK SOLUTIONS FOR TARGETED HIGH USER MEDICAID POPULATION

ORVILLE MERCER MSW • VICE PRESIDENT OF BEHAVIORAL HEALTH • CHESTNUT HEALTH SYSTEMS PRESIDENT • ILLINOIS BEHAVIORAL HEALTH COALITION LLC.
Illinois Medicaid
Managed Care > 2 million citizens
1. Managed Care company engaged Provider Owned Network in a project to address HIGH USERS throughout Central Illinois.

2. Evaluation of project based on evaluation of total health claims Pre referral and Post referral at 3, 6, 9 month intervals.

3. Annualized savings of approximately 1 million dollars realized on co-hort of 79 high users. If scaled 25 times (2000), savings of 26 million might be realized.

4. Currently negotiating this scale up

5. What is a “good enough” ROI? 2/1; 3/1; 4/1; ???
What is a high user?

- 2-3 inpatient episodes < 6 months
- 2 or more ED visit < 6 months
- MLR 300% - 2000% based on claims
- Chronic co-morbid conditions (3-5)
- Drug abuse/addiction
Illinois Behavioral Health Home Coalition

Partner Locations

Knox County
Bridgeway Inc.
Galesburg, Illinois

Macon County
Heritage Behavioral Health
Decatur, IL

Madison County
Chestnut Health Systems
Maryville, IL

McLean County
Chestnut Health Systems
Bloomington, IL

Peoria County
HSC
Peoria, IL

Sangamon County
Memorial Health System
Springfield, IL

Vermilion County
Crosspoint Human Services
Danville, IL
1. Six Not-For-Profit Owners

2. All providers licensed / credentialed and contracted with all M/C companies in their region

3. Providing comprehensive services directly or through agreements

4. 136 million in annual revenues into network annually
   - 40,000 clients served annually
   - 22 counties served
   - 33 hospitals in network
Network Characteristics

1. Integrated Care Activities
   - 5 major geographies with FQHC status or co-located FQHC partners
2. 4 partners with / had SAMHSA funded Primary care behavioral health integration projects
3. Best Practice Pharmacies
   - 4 Genoa pharmacies located in 4 most populated partner sites
4. FY 17 --28 Certified Group Leaders through the Stanford Chronic Disease Management Program
5. Care Management Technologies / Predictive Analytics
6. FY 18 System wide utilization of the Patient Activation Measure
Network Activities

1. TCM teams / leadership participate in ongoing Learning Community Activities
2. Fidelity to all training requirements / Baseline testing pre-post
3. Special emphasis on:
   - Motivational Interviewing --BH and Primary Care
   - Recovery Oriented Philosophy
   - Social Determinant's of Health
4. Network Wide PAM utilization
5. Care Management Technologies
   - Reviewed by project
   - Reviewed by network partner and region
Network Staff Course Training

- Behavioral Healthcare
- Breast Health and Breast Cancer
- Blood Pressure/Hypertension
- Cardiovascular Health and Heart Disease
- Cervical Health and Cervical Cancer
- Colorectal Health and Colorectal Cancer
- Health Coaching and Motivational Interviewing

- Health Literacy
- Healthy Eating Active Living
- Navigating Health Insurance
- Pre-Diabetes and Diabetes
- Prostate Health and Prostate Cancer
- Social Determinants of Health Disparities
"Local Solutions"
Community Provider Synergies

TCM TEAM
Managed Care Cohort

- All points bulletin on cohort monthly
- Residential chemical dependency
- Flex funds
- Outpatient mental health children and adults
- Outpatient chemical dependency
- IPS Employment program
- Case management Homeless shelters Hospital Liaison
- Opportunities psycho-social
- FQHC
- Psychiatry
- Specialized programs
- Crisis residential unit
- 24 hour support and supervised housing
- 24 hours crisis intervention
- PCBHIP
- Medical monitoring detox
Information Flow

CMT

M.C.

Impact on claims

IBHHC

Clinical Intervention
Using Data to Solve Real Problems — CMT Analytics

Let’s solve this problem by using the big data none of us have the slightest idea what to do with.
Tipping Point

Problem
Co-morbid & Complex Disease States

Solution
Data Enabled - Targeted Case Management

- More Complete Problem List
- Identification of Providers and Key Stakeholders
- Lacking complete picture of problems or treatment
- Care decisions made by patient’s in isolation
- Clearer understanding of barriers to remove to meet patient goals
CMT: How Analytics Works

- A web-based data analytics solution supporting population health
- Works in the background to aggregate, analyze and interpret data
- Supports evidence-based management of complex populations
- Enhances clinical and financial risk analysis
CMT’s Population Health Cycle

Data

Targeted evidence-based interventions for patients and care team

Improved Outcomes

Meeting the Triple Aim of
Improved Care, Improved Health and Lowered Costs
IBHHC Cohort Population

- N = 79
- Mood Disorders = 68
- Alcohol and Drug Abuse Disorders = 56
- Psychotic Disorders = 43
- Medical comorbidities – Ambulatory Care Sensitive Conditions (ACS):
  - 1 member has 13; 2 have 8; 1 has 7; 2 have 6; 4 have 5; 6 have 3; and the rest have 2 or less.
  - 33 individuals have hypertension
  - 20 have asthma
  - 16 have metabolic disorder, lipid.
  - 46 (58%) have an Ambulatory Care Sensitive Condition (ACS)
Hospitalization and ED Trends

<table>
<thead>
<tr>
<th>Year / Month</th>
<th>ED Visits - Behavioral</th>
<th>ED Visits - Non-Behavioral</th>
<th>Hospitalizations - Behavioral</th>
<th>Hospitalizations - Non-Behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/04</td>
<td>15</td>
<td>21</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>2015/05</td>
<td>21</td>
<td>24</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>2015/06</td>
<td>19</td>
<td>13</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>2015/07</td>
<td>28</td>
<td>40</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>2015/08</td>
<td>29</td>
<td>30</td>
<td>23</td>
<td>4</td>
</tr>
<tr>
<td>2015/09</td>
<td>40</td>
<td>29</td>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>2015/10</td>
<td>35</td>
<td>36</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>2015/11</td>
<td>27</td>
<td>33</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>2015/12</td>
<td>30</td>
<td>27</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>2016/01</td>
<td>31</td>
<td>31</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>2016/02</td>
<td>23</td>
<td>25</td>
<td>16</td>
<td>4</td>
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<td>2016/03</td>
<td>23</td>
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<td>3</td>
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<td>2016/04</td>
<td>13</td>
<td>38</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>2016/05</td>
<td>21</td>
<td>30</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>2016/06</td>
<td>12</td>
<td>16</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

% Change from Jan in April (last month of complete medical data) -58% 23% -55% 167%
# ADMITS, BED DAYS, ED VISITS AND PMPM% CHANGE

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>IP ADMITS / 1000 (AUTH)</th>
<th>BED DAYS / 1000 (AUTH)</th>
<th>ED VISITS / 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE</td>
<td>4,531</td>
<td>18,301</td>
<td>12,106</td>
</tr>
<tr>
<td>POST</td>
<td>1,942</td>
<td>7,288</td>
<td>8,385</td>
</tr>
<tr>
<td>DIFFERENCE</td>
<td>2,589</td>
<td>11,013</td>
<td>3,721</td>
</tr>
<tr>
<td>% DIFFERENCE</td>
<td>57%</td>
<td>60%</td>
<td>31%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>MED PMPM</th>
<th>RX PMPM</th>
<th>TOTAL PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE</td>
<td>$2,375</td>
<td>$324</td>
<td>$2,699</td>
</tr>
<tr>
<td>POST</td>
<td>$1,217</td>
<td>$411</td>
<td>$1,629</td>
</tr>
<tr>
<td>DIFFERENCE</td>
<td>1,158</td>
<td>-87</td>
<td>1,070</td>
</tr>
<tr>
<td>% DIFFERENCE</td>
<td>49%</td>
<td>-27%</td>
<td>40%</td>
</tr>
</tbody>
</table>

6 Month Data: 53% increase in rx PMPM • 51% decrease in IP admits • 58% decrease in bed days • 25% decrease in ED visits • 30% decrease in total PMPM
Integrated Pharmacies at Community Mental Health Centers: Medication Adherence and Outcomes

W. Alix Wright, ANP; Jack M. Germin, MD; Melkisa Osterlenski, PharmD; Mark J. Patterson, BPharm; and Carla Clayton, PhD

ABSTRACT

Patients receiving psychiatric services of community mental health centers (CMHCs) may experience challenges in adhering to prescribed medications. To evaluate medication adherence and outcomes, the impact of community pharmacy services on patients of CMHCs was examined. Patients were identified through the Community Behavioral Health Services (CBHS) program and linked with their primary care pharmacist. Medication adherence was measured using the Micromedex system, which tracks patients’ medication usage and frequency. The study identified significant differences in medication adherence rates between patients who used community pharmacy services and those who did not. These findings suggest that community pharmacy services may play a crucial role in improving adherence and outcomes for patients receiving care at CMHCs. Further research is needed to explore the potential mechanisms through which community pharmacy services affect medication adherence and outcomes.
Genoa Pharmacy and Medication Report

Below is an overview of the organizational analytics (pharmacy business and medication adherence) utilizing medication possession ratio (MPR), gap in therapy and proportion days covered (PDC).

To see a more detailed view, please visit http://apps.genoa-qpf.com/

The adherence data provided in this report is intended to be used as a tool to help identify individuals that might benefit from further review.

Studies suggest a correlation between a consumer’s adherence to their treatment plan and rate/score for re-hospitalization. Pharmacy data is not perfect and therefore, this should be used merely as a tool.

Report for month ending: November 30, 2016

Monthly Snapshot

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Date</th>
<th>Total Rx</th>
<th>Avg Rx Per Consumer</th>
<th>Total Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Granite City - IL - 00103</td>
<td>Sep 2016</td>
<td>3,550</td>
<td>4.9</td>
<td>727</td>
</tr>
<tr>
<td>Granite City - IL - 00103</td>
<td>Oct 2016</td>
<td>3,605</td>
<td>5.0</td>
<td>719</td>
</tr>
<tr>
<td>Granite City - IL - 00103</td>
<td>Nov 2016</td>
<td>3,949</td>
<td>5.1</td>
<td>769</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Date</th>
<th>Total Rx</th>
<th>Avg Rx Per Consumer</th>
<th>Total Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Granite City - IL - 00103</td>
<td>Sep 2016</td>
<td>727</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Granite City - IL - 00103</td>
<td>Oct 2016</td>
<td>719</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Granite City - IL - 00103</td>
<td>Nov 2016</td>
<td>769</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adherence: Medication Possession Ratio (MPR) - Atypical Antipsychotics

<table>
<thead>
<tr>
<th></th>
<th>08/01/2015 to 07/31/2016</th>
<th>09/01/2015 to 08/30/2016</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Pharmacy</td>
<td>0.89</td>
<td>0.89</td>
<td>0.00</td>
</tr>
<tr>
<td>All Genoa</td>
<td>0.92</td>
<td>0.92</td>
<td>0.00</td>
</tr>
<tr>
<td>Best Pharmacy</td>
<td>1.00</td>
<td>0.99</td>
<td>-0.01</td>
</tr>
</tbody>
</table>

U.S. National Average: 0.5
Top 5 Co-Morbid Diagnosed ACSC Population

Volume (per 1000 patients)

Top 5 Co-Morbid Diagnosis

- Hypertension, Essential
- Asthma
- Diabetes Mellitus
- Urethral/Urinary Tract Disorder, Other
- Heart Failure
Top 5 Care Gaps with the Highest ED Utilization

- Diabetes - No ACE inhibitor or ARB
- Diabetes - Absence of a Statin
- Cardiovascular - History of Cardiovascular Disease, No Evidence of Statin
- Cardiovascular - History of Cardiovascular Disease, No Evidence of Beta-blocker
- Diabetes - No Beta Blockers

Top 5 Care Gaps with Highest ED Visits
# Hospital and ED Utilization Comparison

<table>
<thead>
<tr>
<th>Agency</th>
<th>Total Population</th>
<th>Hospital Admits (per 1000 patients)</th>
<th>% Hospital Admits that are a 30-Day Re-Admit</th>
<th>Average Hospital LOS (per 1000 patients)</th>
<th>ED Visits (per 1000 patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency 1</td>
<td>1,418,518</td>
<td>119</td>
<td>20.51%</td>
<td>14</td>
<td>620</td>
</tr>
<tr>
<td>Agency 2</td>
<td>168,713</td>
<td>109</td>
<td>18.58%</td>
<td>13</td>
<td>537</td>
</tr>
<tr>
<td>Agency 3</td>
<td>282,520</td>
<td>111</td>
<td>21.33%</td>
<td>13</td>
<td>609</td>
</tr>
<tr>
<td>Agency 4</td>
<td>110,975</td>
<td>106</td>
<td>23.96%</td>
<td>14</td>
<td>541</td>
</tr>
<tr>
<td>Agency 5</td>
<td>158,225</td>
<td>161</td>
<td>24.01%</td>
<td>11</td>
<td>749</td>
</tr>
<tr>
<td>Agency 6</td>
<td>198,476</td>
<td>108</td>
<td>18.64%</td>
<td>14</td>
<td>651</td>
</tr>
<tr>
<td>Agency 7</td>
<td>136,409</td>
<td>136</td>
<td>21.71%</td>
<td>13</td>
<td>712</td>
</tr>
<tr>
<td>Agency 8</td>
<td>218,742</td>
<td>121</td>
<td>18.64%</td>
<td>18</td>
<td>575</td>
</tr>
<tr>
<td>Agency 9</td>
<td>144,458</td>
<td>111</td>
<td>17.23%</td>
<td>13</td>
<td>474</td>
</tr>
</tbody>
</table>
Client Success Stories

**Female**
Treatment includes personality disorder, depression, substance abuse (crack and alcohol), and metabolic syndrome. She has a long history of criminal involvement and homelessness. Hospitalizations have dramatically decreased and he has started engaging with treatment and attends appointments with her prescriber. She is now completing a 28 day inpatient residential substance abuse treatment program and will be linked with a transitional living facility upon completion.

**Male**
He received several criminal charges stemming from chronic poly-substance dependence. He is now beginning to engage with staff and has developed a plan for completing goals including obtaining his GED, remaining sober, and following through with mental health treatment.

**Female**
Treatment includes schizoaffective disorder and intellectual disabilities. Previously lived in a financially exploitive and abusive environment and was transitioned into a group home. She is now happy and has not required hospitalization.
Client Success Stories

Female
Treatment includes opiate dependence, anxiety, and diabetes. Using data from CMT we were able to understand the severity of this client’s substance abuse (opiates) as well as physical health conditions (diabetes). After losing custody of her children she has started engaging with us and is now attending appointments and will begin parenting classes.

Male
Treatment includes conduct disturbance, depressive disorder, psychosis, and PTSD. He had a history of about 2 hospital stays per month from 6/2015 until we began working with him near the end of January and has struggled with chronic homelessness. Hospital stays have decreased to one per month for inpatient stays. In addition, he is now following through with substance abuse treatment and has continued to participate in an inpatient residential substance abuse treatment program for the past three months.
“There has to be an easier way for me to get my wings.”

Clarence Oddboddy
Angel 2nd Class
“It’s a Wonderful Life”
The Gracepoint Case Study

Maurice Lelii, LMHC, NCC, Director, Outpatient Services, Gracepoint
Provider Role In Value-Based Delivery

Maurice Lelii LMHC
Director of Outpatient /Managed Care

February 16, 2017
Gracepoint Overview

Gracepoint, formerly Mental Health Care Inc., is a private, non-profit behavioral healthcare organization founded in 1949 by the Tampa Junior League.

Gracepoint provided services to more than 21,000 individuals (2016) in Hillsborough County, and employs 600 staff members.

Specific Populations Served
- Adults, Adolescent, and Children with mental health and substance abuse issues
- Adults with Severe Persistent Mental Illness
- Adults in the criminal justice system
- Children with behavioral health/special education needs
- Children in child welfare
- Adult Homeless services
- Elderly and Supportive housing programs

# Gracepoint Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Intake – “No Wrong Door” Baker &amp; Marchman Act Receiving Facility</td>
<td>Community Action Team (CAT)</td>
</tr>
<tr>
<td>Adult Crisis Stabilization Unit - 60 bed</td>
<td>Mobile Crisis Response Team</td>
</tr>
<tr>
<td>Children’s Crisis Stabilization Unit - 28 bed</td>
<td>Homeless Services</td>
</tr>
<tr>
<td>Forensic Treatment Program - 30 bed</td>
<td>**High Utilizer Project</td>
</tr>
<tr>
<td>Outpatient Program</td>
<td>**Telehealth</td>
</tr>
<tr>
<td>Psychotherapy/Medication Management Clinics</td>
<td>**Onsite Pharmacy</td>
</tr>
<tr>
<td>Intensive Case Management</td>
<td>**Integrated Primary Care (Tampa Family Health - FQHC)</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation Program</td>
<td></td>
</tr>
</tbody>
</table>

** Value-Added Services

# Gracepoint Value-Added Services

<table>
<thead>
<tr>
<th>Health Home¹</th>
<th>Telehealth¹</th>
<th>Onsite Pharmacy²</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Onsite integrated medical primary care services</td>
<td>• Currently used in our Central Intake, CSU, Outpatient medication and case management program</td>
<td>• Joint venture with Genoa Healthcare</td>
</tr>
<tr>
<td>• Joint venture with Tampa Family Health (FQHC)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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High Utilizer Care Coordination

October 2015, initiated High Utilizer Project

Goals:

• Reduce re-admissions to CSU and Hospital ER
• Determine the root cause for admissions
• Provide comprehensive coordination of care
High Utilizer Care Coordination

October 2015, initiated High Utilizer Project

Program Components:

- Established a care coordination specialty team with a representative from every Gracepoint program
- Established an internal IT 24/7 alert system
- Streamlined access for referral and admission to all Gracepoint programs via EHR referral system
- Weekly care coordination case review meetings
High Utilizer Care Coordination

- High Utilizer = (3) CSU admissions within 90 days
- 92 Adult High Utilizers were identified from January 2015-June 2016

Results:
- 75% (69) identified have ≤ 1 readmission to Gracepoint.
- 25% (23) identified continue to be readmitted > 1 to Gracepoint.
High Utilizer Care Coordination

Funding Data

• 58% (53/92) of all adult high utilizers are insured.
• 77% (41/53) of insured have $\leq$ 1 readmission.

• 42% (39/92) of all adult high utilizers are DCF funded.
• 72% (28/39) of DCF funded have $< 1$ readmission.
Value-Based Contracting: Health Plan

You are as good as your network!

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full continuum of services</td>
<td>Intensive Case Management</td>
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HEDIS=Health Effectiveness Data Information Set
**Value-Based Contracting: Provider**

You are as good as your partnerships!

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HEDIS=Health Effectiveness Data Information Set

[gracepoint](#)
# Model Comparison

<table>
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<tr>
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<th>Capitation</th>
<th>Value Based</th>
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<td>• Greater Administrative Costs</td>
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<td>• Incentive /Gain Share Program to Drive Provider Performance</td>
</tr>
<tr>
<td></td>
<td>• Lower Cost Controls</td>
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1. Gracepoint internal data.
Gracepoint Capitation Model

- One of the five founding members of Florida Health Partners – contract entity with Florida’s Agency for Health Care Administration
- Area 6 Medicaid waiver program 1992-2014
- Partnership between regional providers and ValueOptions
- Capitation based on covered lives, provider’s revenue based on 90% encounter MLR, shared risk with Area 6 partners
- Reporting requirement: service encounters, quality audits

MLR=Medical loss ratio, UM=Utilization management
1. Gracepoint internal data.
Questions & Discussion
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Mental Health Services  ▪  Chronic Care Management  ▪  Disability Supports & Long-Term Care  
Addiction Treatment  ▪  Social Services  ▪  Intellectual & Developmental Disability Supports  
Child & Family Services  ▪  Juvenile Justice  ▪  Adult Corrections Health Care