Payer Collaborations:
Enhancing care coordination and mental health access for Medicaid populations using HIE data and virtual technology

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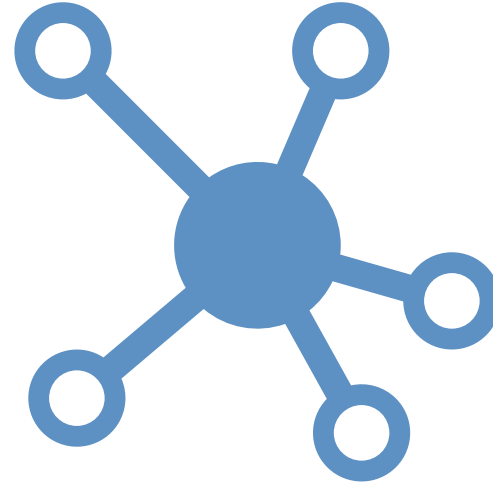Philip Beckett, Ph.D HASA
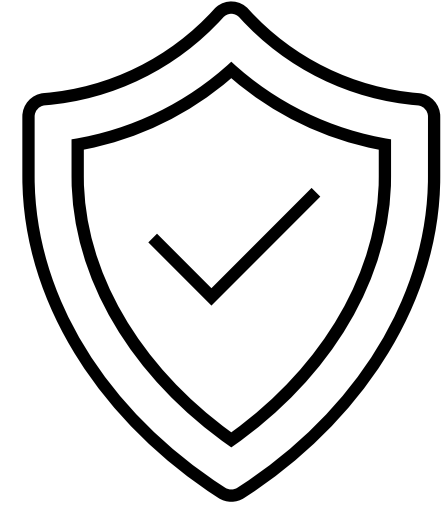
Collaboration Partners

Session Key Takeaways

1

Show that collaboration between a Health Plan, key providers, HIEs, and how innovation can make the delivery of behavioral health more successful and improve the health of Members.

2

Identify how telehealth and HIE can integrate technologically to improve patient-provider connectivity and patient satisfaction.

3

Recognize health plan innovation and partner engagement as integral to the successful advancement of efficient healthcare delivery

Collaboration Opportunities

1 | Extend Behavioral Health Access to a Foster Care Center of Excellence

2 | Improve care coordination and Patient Engagement (Real-Time ADT/CCD delivery) with collaborating health information exchanges and a digital health engagement vendor.

✓ *Advancing Care Delivery, Transformation, and Value*

✓ *Next-Generation Consumer Experience and Engagement*

✓ *Technology, Tools, and Business Insights*

Foster Care Obstacles

- **Population**

  - 45,000 Foster Care members

- **Obstacles**

  - Fragmented care due to frequent placement changes

    - Up to 1,300 Placement changes a month

  - Extreme lead times: Estimated 9 Months out for BH providers

- **The role of trauma and trauma informed care**

  - Trauma as part of abuse/neglect

  - Trauma within the system

Foster Care Center of Excellence Project

- **Foster Care Center of Excellence Providers**

  - Groups that have demonstrated that they can provide integrated care delivery to support Foster Care Members

  - We chose them to support the Patient Centered Medical Home

- **Importance of Clinical Collaboration Partners**

  - Collaboration between BH and PH providers to promote continuity of care

  - Share clinical data to support care through placement changes

Behavioral Health Workflow

- o **Referral**
- o **Scheduling**
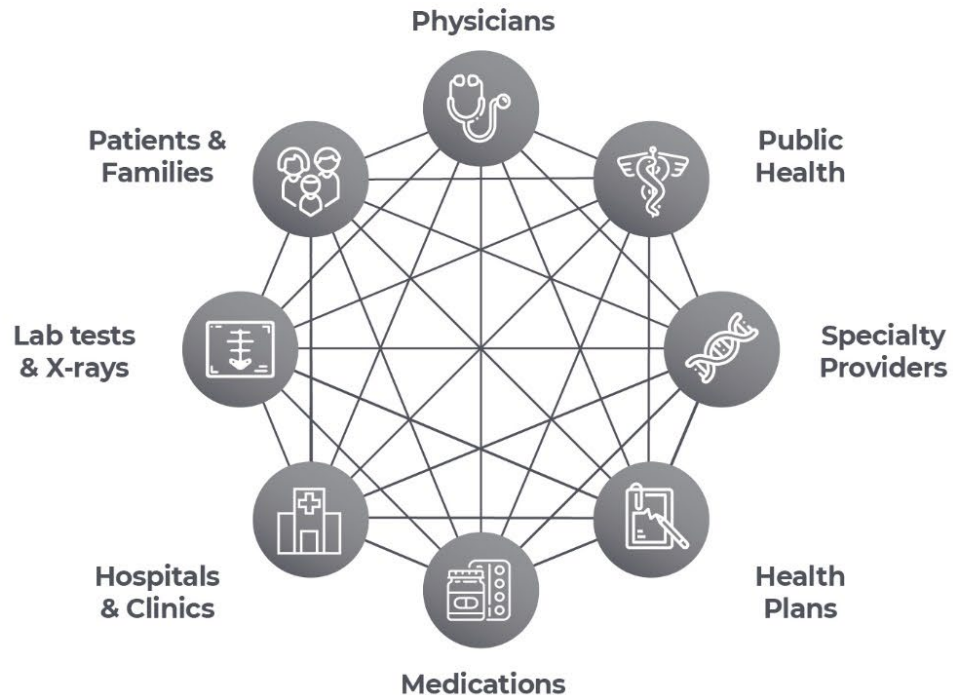- o **Telehealth visits**
- o **Reports**

Care Coordination and Patient Engagement through Clinical Data Exchange

Real-time ADT Hospital Notifications and Discharge Summaries (CCD) with collaborating Health Information Exchanges and a digital health engagement vendor.
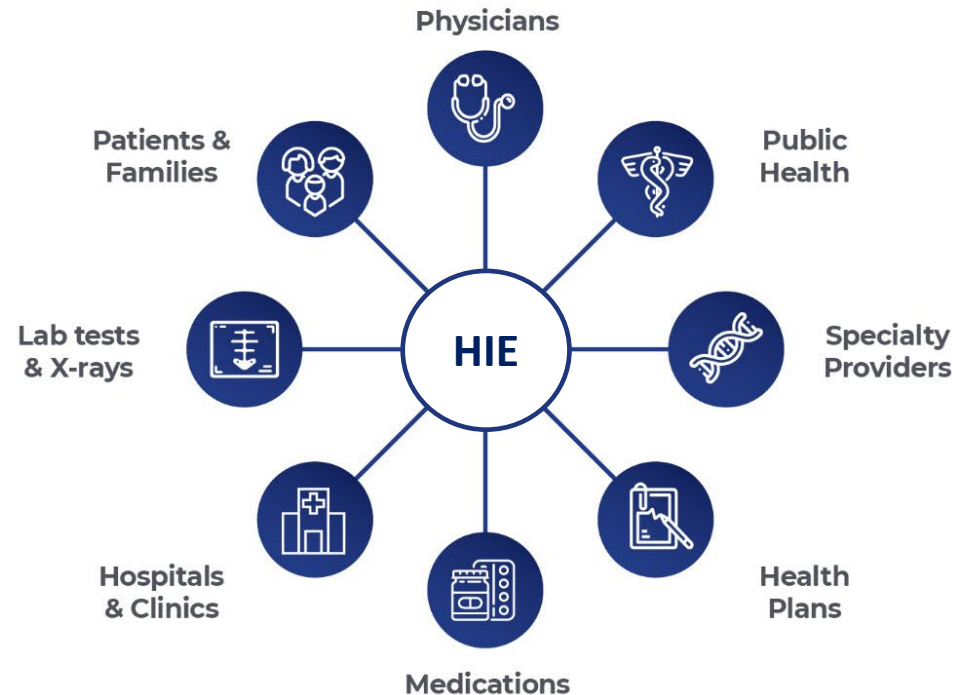
Health Information Exchanges Creates Efficiency

BEFORE:
Duplication of effort, Waste and expense

Physicians
Public Health
Specialty Providers
Health Plans
Medications
Hospitals & Clinics
Lab tests & X-rays
Patients & Families

NOW:
Connect once to access shared services

HIE

Physicians
Public Health
Specialty Providers
Health Plans
Medications
Hospitals & Clinics
Lab tests & X-rays
Patients & Families

Digital Health & Advanced Transition of Care
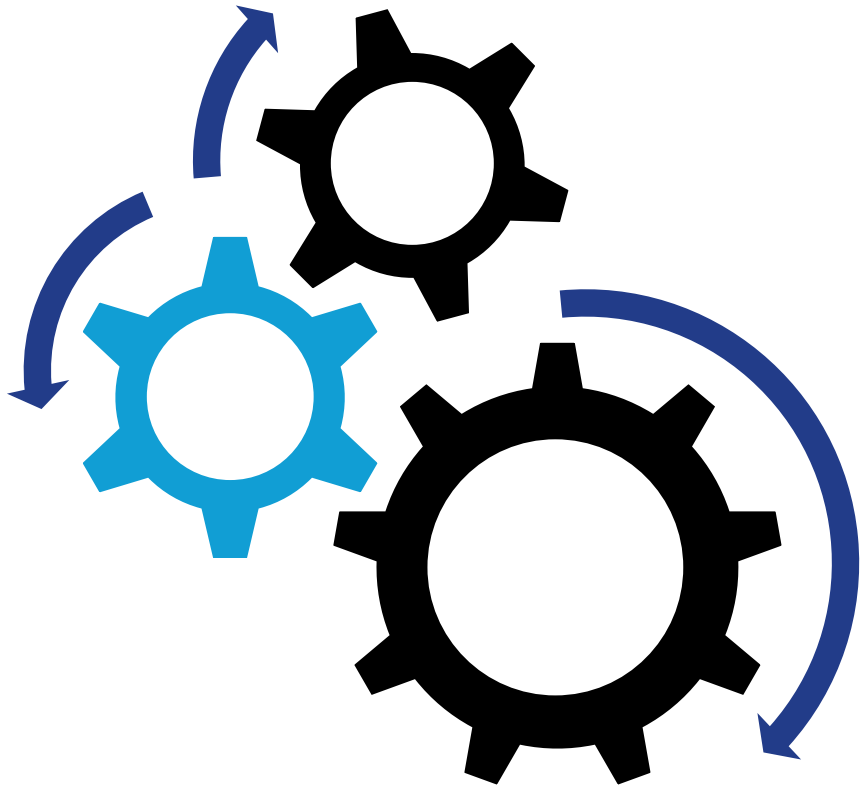
Active Care Relationship Services (ACRS) ™

Accurately routes information to alert providers in active care relationships with patients (e.g,. Admission, Discharge, Transfer Notifications, medication reconciliation, etc.)

Admission, Discharge, & Transfer Notifications (ADTs)

sending notifications on the status of patients' care transitions to every care team member interested in that patient.

Medication Reconciliation - CCDA

Share patient medication information at multiple points of care, including pharmacies, physician offices, hospitals, and transitional facilities such as outpatient tertiary and skilled nursing facilities.

Digital Health HIE Integration Overview

Hospital / Sending Facilities

Receiving Organizations

ADT/CCD

HIE

CareConvene

1. **VPN Tunnel to CareConvene**
2. **Attach Receiving Organization OID to Sending Facility ADT Message**

MiHIN
MICHIGAN HEALTH INFORMATION NETWORK
SHARED SERVICES

Ideal State for Care Coordination

Hospital Admit/Discharge Event	Step 1 Receive Discharge Notification	Step 2 Filter Population for ADTs	Step 3 48 Hour Outreach Engagement	Step 4 7 Day Med Rec Virtual Visit	TRC STARS Compliance

7 Day Timeline

Step 1

- Integration to real-time ADTs source

Step 2

- Custom population filtering
  (Example: Risk score by condition)
- Configure real-time SMS Alert notifications
- Discharge Summary (CCDA) Delivery

Step 3

- Instant Post Discharge Interactions via Text/Email Delivered Assessments
- Patient Phone Communication

Step 4

- Initiate One click virtual visit (Text-a-Visit)
- Upload Discharge (Discharge Meds, Discharge Note etc)

7 DAY TRANSITION OF CARE RESULTS

Provider Cohort 1: Results

Employed Primary Care Practices
25 Practices - 67 Physicians

20%

Improvement

20% performance rate increase
(7 Day TOC from 65% to 85% 4 weeks post training)

Approximately **95th** Percentile in HEDIS TRC Measure

Provider Cohort 2: Results

Independent Primary Care Practices
85 Practices - 311 Physicians

34%

Improvement

34% performance rate increase
(7 Day TOC from 35% to 69% 4 weeks post training)

Approximately **80th** Percentile in HEDIS TRC Measure

Superior Health Plan Care Coordination

Use Case

Discharge Planning Outreach, Post Discharge Follow-up and Member Education and PCP Selection

Filter / Search Capabilities
- County Location
- Health Plan Products

24 hour follow up post discharge
- Look up members daily for ADT
- Not reliant on timing of claims
- Alerted via real-time text notification

Future Collaboration Opportunities

Improve Patient Engagement

Opportunity:
Optimize care coordination workflows and enable patient engagement using the following tools:

- ✓ Structured care coordinator education
- ✓ Easy-to-use, intuitive technology to identify patient transitions in real-time
- ✓ 24/48-hour outreach assessment
- ✓ Virtual visits with discharge summary upload tools
- ✓ Increase consumer access to HIE records through the consumer access application

Thank you!