CARE MANAGEMENT
Value-Based Architecture

Health Ecosystem

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CNSI
www.cns-inc.com
Care Management - Health Care Ecosystem

1. Streamlined Eligibility, Simplify Enrollment
   (*stratification*)

2. Integrated Delivery & Payment Models
   (*prioritization*)

3. Analytic-Driven Action
   (*intervention*)

4. Customer Experience & Engagement
   (*evaluation*)

Medicaid – *today & tomorrow*

Final thoughts…
Medicaid Ecosystem ... State of Change

From Welfare to Health Care

- Medicaid’s delink from welfare set stage for Medicaid as platform for universal coverage
- Impact of Medicaid coverage

Value Purchasing Managed Care (MC)

- 74.22% of Medicaid customers are covered by MC
- States moving more of ABD

Complex Care Management

- 5% Medicaid population accounts for 55% expenditures
- with providers to foster care delivery change – Health Home, duals, integrated care
- HIT implications

Person-Centered Care

- Triple Aim –
- Standards & economies of scale
- Performance & outcome measures
- Mobile
- Engagement

**Triple Aim 21st Century Health Care**

- **Better healthcare**
  - Improving patients’ experience of care within the Institute of Medicine’s 6 domains of quality: Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, and Equity.

- **Better health**
  - Keeping patients well so they can do what they want to do. Increasing the overall health of populations: address behavioral risk factors; focus on preventive care.

- **Reduced costs**
  - Lowering the total cost of care while improving quality, resulting in reduced monthly expenditures for Medicare, Medicaid, and CHIP beneficiaries. Supporting new models of payment.

*SOURCE: Institute for Healthcare Improvement, History. Accessed at: [http://www.ihi.org/about/Pages/History.aspx](http://www.ihi.org/about/Pages/History.aspx)*
Medicaid – large plan (& getting larger)

Expansion

48%
Births covered by Medicaid

25%
Projected U.S. population covered by Medicaid by 2020, up from 15% in 2010

“Any program for resolving runaway health care costs that does not have a credible plan for changing the way we care for people with chronic illnesses – cannot make more than a small dent in the total problem.”*

SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012. MSIS FY 2008 data were used for MA, PA, UT, and WI, but adjusted to 2009 CMS-64.  
* Clayton Christianson, Disruptive Innovation
1. Regulatory compliance for provider and member enrollment, and claims payment timeliness to encourage provider participation access to care

2. Improved health care outcomes are a by-product of managed care and waiver programs primarily focused on managing costs.

3. Adoption and use of national standards for administrative data and business services to compare outcomes; and contribute to improved outcomes.

4. Stakeholder access to clinical data to analyze health care outcomes, and empowers member and providers to make decisions affecting outcomes.

5. National interoperability allows national agencies to access data and compare outcomes across a broad spectrum of other agencies and States.

**Should maturity = business results…**

Efficient, effective & economical administration of plan
- Transparency & Accountably
- Performance Measurement & Analytics
- Government shared services/platform
- Innovation & Optimization
- Unleash the power of data
- Triple Aim - measurable improvement in health outcomes, care delivery & cost efficiency
MITA 3.0 Care Management

“support the shift away from fee-for-service model of care”

- **Business Processes**
  1. **Case** Management - establish, manage, outreach, registry, screening & outcomes
  2. **Authorization** Determination - referral, service & treatment plan

- **Collects data**
  - *member needs, treatment plan, targeted outcomes & health status*
  1. Disease Management
  2. Catastrophic Case Management
  3. Early Periodic Screening, Diagnosis & Treatment (EPSDT)
  4. Population Management - targets members with similar characteristics to promote health education & awareness
  5. Patient Self-Directed Care Management
  6. National Health Registries
  7. Waiver Program Case Management

**What if the focus was on the “Meaningful Use” of information?**
## CMS Standards & Conditions

*Disruptive Innovation – making things simpler, more affordable, open to innovation*

### Care Management Implications

<table>
<thead>
<tr>
<th>Business Results</th>
<th>Better Health</th>
<th>Population Health Measures</th>
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<tbody>
<tr>
<td></td>
<td>Quality Care Experience</td>
<td>CAHPS, 21st century customer experience</td>
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<tr>
<td></td>
<td>Cost Efficiency</td>
<td>per capita costs, bend the cost curve</td>
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<table>
<thead>
<tr>
<th>Standardization</th>
<th>Clinical</th>
<th>MU 2, CQMs, CHIPRA Quality, Adult Medicaid Quality Measures, CAHPS**, Engagement</th>
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<tbody>
<tr>
<td></td>
<td>Technical</td>
<td>exchange interfaces</td>
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<tr>
<th>Interoperability</th>
<th>Health Information Exchange</th>
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<tr>
<th>Modularity</th>
<th>Service Oriented Architecture, modular, COTS-based Quality Reporting Data Architecture (QRDA)</th>
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<table>
<thead>
<tr>
<th>Maturity</th>
<th>Capability Maturity (process) Level 3 or higher (MITA 3.0, CMMI)</th>
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<tr>
<th>Reuse</th>
<th>Enterprise reuse - Enterprise Master Person Index, Provider Directory, Business (Technical) Services</th>
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<tr>
<th>Reporting</th>
<th>Transparent Actionable Accountability</th>
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<td></td>
<td>Consumer &amp; Family Engagement</td>
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* 7 of 14 requirement for Enhanced Federal Financial Participation for ALL systems.

** CAHPS = Consumer Assessment of Healthcare Providers and Systems
Care Management (CM)

**Definition**

The application of systems, science, incentives and information to **improve medical practice** and **assist consumers and their support system to become engaged in a collaborative process to manage medical/social/mental health conditions more effectively**.

**Goal**

Care management is to achieve an **optimal level of wellness** and **improve coordination of care** while providing cost effective, non-duplicative services.

Care Management Strategic Model

Policy Decisions

- Eligibility & Enrollment
  - Stratification
- Integrated Delivery & Payment
  - Prioritization
- Analytic-Driven Action
  - Intervention
- Experience & Engagement
  - Evaluation

Payment Models

Health Information Technology
CM Processes

- **Stratification**
  - Claims - analyze costs, conditions & risks
  - Medical & functional data – start with MAGI-exempt population
  - Real-time HIE – ED or hospital feeds

- **Prioritization**
  - Target “impactable” conditions & costs
  - Segment subpopulations
  - Target - evidence-based medicine (EBM) & outcomes

- **Intervention**
  - Based on Needs & Model of Improvement
  - Asses & Assign Levels of Care
  - New models of care – outreach, coordination & engagement
  - Meaningful Use – myHealthButton

- **Evaluate**
  - Experience – CAHPS & HCAHPS
  - Engagement – Patient Activation Measures

- **Payment Model**
Congress and President Obama made an explicit choice in framing the Affordable Care Act (ACA) to position Medicaid, as opposed to Medicare, as the foundation for universal coverage in this country.

- Customer Service requirements (Medicaid)
  - Real-time Eligibility - “promptly and without delay”
  - 21st Century Customer Service – online customer assistance
  - Simplify, streamline and seamless – for accessible coverage
  - (meaningfully) Reuse information
  - Keep people covered - “Stop the Drop” end the churn

Stratification
Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality

- **Super-Utilizer**
  - Individuals with complex, unaddressed health issues and a history of frequent encounters with health care providers
  - who accumulate large numbers of emergency department visits and hospital admissions which might have been prevented by relatively inexpensive early interventions and primary care

**Analysis**
1. Identify SU populations
2. Identify utilization factors
3. Assess feasibility of eliminating unnecessary utilization (targeted interventions)
4. Estimate potential cost and savings for *IMPACTABLE* populations and costs

**Analytical Capabilities**
1. Web-based Provider Portals
2. Real-Time Alerts & Data
3. Data Analysis
4. Clinical Decision Support Tools

“Most expensive people were getting terrible care”

“It pretty quickly became clear that there were hot spots of everything. There were hot spots by disease, hot spots by patient… There were hot spots by ZIP code and by neighborhood. … You could begin to take the data and tell stories with the data. And that's an incredibly powerful tool for making change.”

- Dr. Jeffrey Brennan

SOURCE: http://www.pbs.org/wgbh/pages/frontline/doctor-hotspot
Medicaid Eligibility – Opportunity with New Eligibles
“promptly and without undue delay”

**MAGI Determination**

*45 days*

1. **Parents** of dependent children and caretaker relatives
2. **Pregnant women**, including 60 days postpartum
3. **Children** under age 19
4. **Adults** \( \leq 138\% \) FPL
5. **State Option - Individuals** \( > 138\% \) FPL

**MAGI-Exempt Determination**

*90 days*

1. Not determined by income by Medicaid agency (SSI recipient)
2. Age 65 and older
3. Have blindness or disability
4. Based on institutional or HCBS need
5. Medicare cost-sharing assistance
6. Medically needy
Exchange & eFusion of Claims & Clinical Data

eFusion Capabilities

- **Summarizes** - clinical/administration data with user-friendly navigation & accessible through mobile devices
- **Analytics** – multi-dimensional, cube analysis of detailed & aggregated data; range of reporting capabilities

- **CCD Parsing Engine** - Open source tools, Extensible C-CCD
- **Web Service Framework** – ESB integration; validate/CCD
- **CONNECT** – nation-wide standard; Master Patient Index

- **Clinical** - CCD, extensible, additional XML-storage

<table>
<thead>
<tr>
<th>Alerts/Allergies</th>
<th>Medications</th>
<th>Immunizations</th>
<th>Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social History</td>
<td>Vital Signs</td>
<td>Procedures</td>
<td>Encounters</td>
</tr>
</tbody>
</table>

- **Administrative** – assimilates MMIS data (Service Dates, Admission/Discharge Procedures/Dx, Health Plan, TPL)
- **Analytics** – multiple dimensions; Clinical/Administrative data
- **Terminology/Auditing/Security** – HL7 coding; auditing traceability

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eFusion (eRM) Solution Stack

- **Visualize & analyze data**
- **Standards - CCD & CONNECT**
- **Performance – accelerate disability determination**
- **Stratify – CCD elements**
Electronic Care Summary Standard
Consolidated - Care Document Architecture (CCDA)

- ONC Standards Certification Rule § 170.205(a)(3), & CMS Meaningful Use Stage 2 Final Rule
- Implementation guide for HL7 Clinical Document Architecture (CDA) of reusable document templates
  1. Continuity of Care Document
  2. Consultation Note
  3. Diagnostic Imaging Report
  4. Discharge Summary
  5. History & Physical
  6. Operative Note
  7. Procedure Note
  8. Progress Note
  9. Unstructured Document
Data Analysis & Management
Example - Hot Spotting Inpatient & ED Data

Inpatient & ED Use by Member Zip

Frequency of Inpatient & ED Use

Cost of ED Visits by Principal Diagnoses
- Injury and poisoning
- Symptoms; signs; and ill-defined conditions
- Diseases of the circulatory system

Cost of IP Stays by Principal Diagnoses
- Diseases of the circulatory system
- Diseases of the musculoskeletal system
- Complications of pregnancy; childbirth
- Injury and poisoning
- Diseases of the digestive system
- Neoplasms
- Infectious and parasitic diseases
ACA Fundamental shift - from payment for Volume to Payment for Value

- Medicaid Managed Care - has managed care fixed Medicaid
  - 74.2% of Medicaid recipients are covered by managed care (2011)
  - Lack of useful data - OIG found MSIS of “limited usefulness” because of lack of data
  - Costs continue to rise
  - Care delivery & outcomes – not substantially improved

- Funding Innovation - IMPACTABLE conditions & costs
  - Super-Utilizer Alternative
  - CMMI – test integrated care delivery models

If you still don’t think things are changing...
Super Utilizer Program Payment

1. **Medicaid Case Management Payment**
   - Per-member-per-month (PMPM) Primary Care Case Management (PCCM) for care coordination (North Carolina and Vermont)

2. **Multi-Payer Case Management Payment**
   - PMPM from payer for Community Teams work with Medicaid Health Homes, Advanced Primary Care Practices, and FQHCs (Maine)

3. **Per-Episode of Care Payment (EOC)**
   - Each covered individual to cover all program costs with risk adjustment (Spectrum Health)

4. **PMPM to Managed Care Organization (MCO)**
   - Risk-based PMPM for each enrollee (Hennepin Health)

5. **Shared Savings for Total Cost of Care**
   - Partial risk-sharing agreement between Medicaid and care team organization (Minnesota’s Integrated Care Model)
<table>
<thead>
<tr>
<th>Domains (7)</th>
<th>Initiatives (41)</th>
</tr>
</thead>
</table>
| **Accountable Care**              | 1. ACO: General Information  
2. Advance Payment ACO Model  
3. Comprehensive ESRD Care Initiative  
4. Medicare Health Care Quality Demo  
5. Nursing Home Value-Based Purchasing |
| **Bundled Payments for Care Improvement** | 6. Physician Group Practice Transition Demo  
7. Pioneer ACO Model  
8. Program for All-Inclusive Care for the Elderly  
9. Rural Community Hospital Demo |
| **Primary Care Transformation**   | 1. Retrospective Acute Care Hospital Stay  
2. Retrospective Acute & Post Acute Care Episode  
3. Retrospective Post Acute Care Only  
4. Prospective Acute Care Hospital Stay Only |
| **Speed Adoption of Best Practices** | 5. Bundled Payment: General  
6. Medicare Acute Care Episode Demo  
7. Medicare Hospital Gain sharing Demo  
8. Physician Hospital Collaboration Demo |
| **Accelerate Payment & Service Delivery Models** | 1. Comprehensive Primary Care Initiative  
2. FQHC Advance Primary Care Practice Demo  
3. Frontier Extended Stay Clinic Demo  
4. Graduate Nurse Education Demo |
| **Medicare & Medicaid Initiatives** | 5. Independence at Home Demo  
6. Medicare Coordinated Care Demo  
7. Multi-Payer Advanced Primary Care Practice |
| **Medicaid & CHIP Initiatives**    | 1. Community-based Care Transition  
2. Innovation Advisors Program  
3. Medicare Imaging Demo |
|                                   | 4. Million Hearts  
5. Partnership for Patients |
|                                   | 1. HC Innovation Awards-$275M to States  
2. State Model Awards: General  
|                                   | 4. SIM: Model Pre-Test Awards  
5. SIM: Model Testing Awards |
|                                   | 1. Financial Alignment for Medicare – Medicaid Enrollees |
|                                   | 2. Reduce Avoidable Hospitalization among Nursing Facilities |
|                                   | 1. Medicaid Emergency Psychiatric Demo  
2. Prevention of Chronic Disease Incentives  
3. Strong Start Mothers & Newborns (SS) General |
|                                   | 4. SS Mothers & Newborns Reduce Early Delivery  
5. SS Mothers & Newborns Enhance Prenatal Care |
From Volume to Value – requires Rules Engine

- **Rule Composer**: user interface to create, edit, & import/export rules to repository
- **Rule Repository**: centralized store for all defined rules, & stores rules for multiple applications
- **Rule Configurator**: defines & creates variables, constants & methods
- **Rule Processor**: Enterprise Java Bean® (EJB) runtime evaluator / executor for defined rules in repository

Flexible, user-friendly, extensible
Plain English to define & describe rules
3. Analytic-Driven Action

(intervention)

- USING information to redesign Care Delivery
  - Begin with the needs of the individuals
  - Focus on Flow – of Care & Information
  - Establish Levels of Care - Evidence-Based Medicine (EBM)
  - Manage Actionable Information to improve care
  - Aggregated Quality Management

“Effective population health management requires fundamental change in care delivery”
# Requires Clinical Health Information Exchange

## Meaningful Use Stage 2

<table>
<thead>
<tr>
<th>Provider Interoperability</th>
<th>Patient Access</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. e-Prescribing</strong> - ambulatory &amp; inpatient discharge</td>
<td><strong>1. Reminders</strong> - preventive &amp; follow-up care</td>
</tr>
<tr>
<td><strong>2. Transition of Care</strong> - summary exchange</td>
<td><strong>2. Educational Resources</strong> - identified &amp; provided</td>
</tr>
<tr>
<td>• Create &amp; transmit <em>from</em> EHR</td>
<td><strong>3. Online Personal Health Information</strong> – portal, &amp;/or PHR</td>
</tr>
<tr>
<td>• Receive &amp; incorporate <em>into</em> EHR</td>
<td><strong>4. Visit Summary</strong></td>
</tr>
<tr>
<td><strong>3. Lab Tests &amp; Results</strong> - inpatient to ambulatory</td>
<td><strong>5. Secure Messages</strong> – consumer to provider</td>
</tr>
<tr>
<td><strong>4. Public Health Reporting</strong> – transmission to:</td>
<td><strong>6. View, Download and Transmit</strong> – consumer to 3rd Party</td>
</tr>
<tr>
<td>• Immunization Registries</td>
<td></td>
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<tr>
<td>• Syndromic Surveillance</td>
<td></td>
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<tr>
<td>• Lab Results</td>
<td></td>
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<tr>
<td>• Cancer Registries</td>
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<tr>
<td><strong>5. View, Download &amp; Transmit</strong> - Patient VDT health data to 3rd Party</td>
<td></td>
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<tr>
<td><strong>6. Patient Data Summary</strong> - create export summary for portability</td>
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CM Flow

Data
- Claims
- HIE

Triage
- Assessment
- Assignment

Target
- 2+ hospitalizations < 6 months

Criteria:
- Chronic conditions
- Multiple admissions
- Assign to pathway

High Risk
- Medically & socially complex
- 6-12 mo. engagement

Care Coordination
- Quality improvement
- Patient engagement
- Care coordination

Interm. Risk
- Medically complex
- 30-90 day engagement

Care Transitions

Adapted from: www.camdenhealth.org
# CM Levels of Care

<table>
<thead>
<tr>
<th>LEVEL OF CARE 1</th>
<th>LEVEL OF CARE 2</th>
<th>LEVEL OF CARE 3</th>
<th>LEVEL OF CARE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of Contact:</strong></td>
<td><strong>Frequency of Contact:</strong></td>
<td><strong>Frequency of Contact:</strong></td>
<td><strong>Frequency of Contact:</strong></td>
</tr>
<tr>
<td>□ Weekly Home Visits</td>
<td>□ Bi-weekly Home Visits</td>
<td>□ Monthly Home Visits</td>
<td>□ Monthly phone calls / health coaching as needed</td>
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<tr>
<td>□ Interim Phone Calls</td>
<td>□ Interim Phone Calls</td>
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<thead>
<tr>
<th>Care Management/Coordination Activity:</th>
<th>Care Management/Coordination Activity:</th>
<th>Care Management/Coordination Activity:</th>
<th>Coaching Activity:</th>
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<tbody>
<tr>
<td><strong>Clinical</strong></td>
<td><strong>Clinical</strong></td>
<td><strong>Clinical</strong></td>
<td><strong>Logistics</strong></td>
</tr>
<tr>
<td>□ Comprehensive Health Assessment</td>
<td>□ PCP/Specialty Coordination</td>
<td>□ Determine Goals for Health Coaches</td>
<td>□ Disease management</td>
</tr>
<tr>
<td>□ PCP follow up</td>
<td>□ Clinical Reinforcement</td>
<td>□ Follow up on outstanding medical needs</td>
<td>□ Provider communication</td>
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<tr>
<td>□ Med. Rec.</td>
<td>□ Chronic Disease Management</td>
<td></td>
<td>□ Social skills</td>
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<tr>
<td>□ Disease Management Education</td>
<td>□ Medication Management</td>
<td></td>
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<tr>
<td>□ Other provider coordination</td>
<td>□ Patient Education &amp; Advocacy</td>
<td></td>
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<tr>
<td>□ Medical Goal Setting</td>
<td>□ Relationship Building</td>
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<tr>
<td>□ Relationship Building</td>
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<tr>
<td><strong>Social</strong></td>
<td><strong>Social</strong></td>
<td><strong>Social</strong></td>
<td><strong>Graduation / hand-off to PCP</strong></td>
</tr>
<tr>
<td>□ Social History</td>
<td>□ Follow up on Applications</td>
<td>□ Determine Goals for Health Coaches</td>
<td></td>
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<tr>
<td>□ Psycho/Social Assessment</td>
<td>□ Follow up on referrals</td>
<td>□ Follow up on outstanding social / coordination needs</td>
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<tr>
<td>□ Home Care Coordination</td>
<td>□ Patient support and empowerment</td>
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<td>□ Behavioral Health</td>
<td>□ Relationship Building</td>
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<td>□ Entitlements / Benefits</td>
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<td>□ Nutrition Referral</td>
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<td>□ IDs</td>
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<td>□ Emergency Shelter</td>
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<tr>
<td>□ Goal Setting</td>
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<td>□ Prescription Assistance</td>
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<tr>
<td>□ Relationship Building</td>
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**Hand-off to health coaches**

**Graduation / hand-off to PCP**

CM Capabilities

eFRM Capabilities
Facilitating “Transitions of Care” (TOC)

- **Care transitions** - enabled by an unambiguously-defined core set of high-quality clinical data
  - electronic exchange of core clinical information with providers & patients
  - in human readable format
  - support quality of care
    - Meaningful Use
    - IOM care improvement
Key Information Exchange

Discharge Summary
- Medications List
- Existence of Advanced Directives
- Consultation(s)
- Immunization History
- Assessment(s) & Plan(s)
- Allergies and Intolerances
- Recommendations
- Problems List
- Medical Equipment
- Demographics

1. Discharge Summary
2. Discharge Instructions
3. Consultation Summary
4. Consultation Request

Data Elements from EHR

Data Elements accepted into RI

RI processes Data Elements per CIM

RI creates ToC Document per Document Rqmts

ToC Document available for use by Application

4. Customer Experience & Engagement
(clinical quality & performance measurement)

Ensure person- & family-centered care
- National Quality Strategy

1. Improve patient, family, and caregiver experience of care
2. ...for shared decision-making process—develop culturally sensitive and understandable care plans
3. ... to navigate, coordinate, and manage their care appropriately and effectively

Engaging people as full partners in care
- Person centered care - needs of individual & family needs
- Productive relationships
- Shared decision making
- Balancing clinical guidelines & people’s preferences &
- Projected savings $9 billion over 10 years

50% of U.S. adults already own smartphones
134% increase in health information searches via mobile devices.

*Pew Research
*Nielsen

Individuals & families are the common thread throughout health care experience

SOURCE: Commonwealth Fund research
Who really (controls) decides what drives outcomes?
### Patient (Activation) Engagement

- **The MORE INVOLVED you are in your own health care, the BETTER HEALTH CARE you get**

<table>
<thead>
<tr>
<th>MORE INVOLVED Patients</th>
<th>LESS INVOLVED Patients</th>
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<tbody>
<tr>
<td>Readmitted to the hospital within 30 days of discharge&lt;br&gt;12.8%</td>
<td>28%</td>
</tr>
<tr>
<td>Experienced a medical error&lt;br&gt;19.2%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Have poor care coordination among health care providers&lt;br&gt;12.6%</td>
<td>41.8%</td>
</tr>
<tr>
<td>Suffer a health consequence because of poor communication among providers&lt;br&gt;13.2%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Lose confidence in the health care system&lt;br&gt;15.1%</td>
<td>59.8%</td>
</tr>
</tbody>
</table>

- “Patients who play an active role in managing their health
  - experience significantly fewer complications &
  - have more faith in the health care system”

- “Patients who have more knowledge, skill, and confidence in managing their health, and who are more adept at navigating and using the health care system, appear to **incur lower costs**,”

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AARP & You, “Your Key to Better Care,” 50.09 Patient Survey, Quality of Health Care
http://pubs.aarp.org/aarpthemag/20090708?pg=120#pg120
http://www.commonwealthfund.org/~/media/Files/Publications/In%20the%20Literature/2013/Feb/1669_Hibbard_patients_lower_activation_HA_02_2013_ITL.pdf
Measure Taxonomy

Patient Satisfaction

1. How satisfied are you with the ease of making appointments?
2. How caring is your doctor?
Source: Patient Satisfaction Survey, American Academy of Family Physicians, 1996

Patient Experience

1. How often did you get an appointment as soon as you thought you needed?
2. When the doctor ordered a test or x-ray, how often did the office follow up to give you results?
Source: CAHPS® Clinician & Group Survey –Adult Primary Care Questionnaire, Version 1.0.

Patient Activation & Engagement

“skills and confidence to equip patients to become actively engaged in their health care”
1. I am confident I can tell my health care provider concerns I have even when s/he does not ask.
2. I know the different medical treatment options available for my health condition.

“Activities individuals must take to obtain the greatest benefit from the health care services available to them” ONC Strategy ➔ ACCESS | ACTION | ATTITUDES
Source: Engagement Behavior Framework (Center for Advancing); Patient Engagement Framework (NeHC)

PATIENT PERSON-CENTEREDNESS*
care that is respectful of & responsive to individual preferences, needs & values & ensures the person’s values guide all clinical decisions

SOURCE: IOM, Crossing the Quality Chasm
Patient Experience
Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS®)

- CAHPS - assessment of consumers' health care experiences
  - Information for consumers, purchasers, health plans, providers, and policymakers
  - Standardized consumer (public domain) surveys – enables comparison results across sponsors and over time
  - Tools and resources to produce usable comparative information

- Quality of care for which consumers are the best or only source to assess
  - Consumers and patients have identified as being important
  - Communication skills of providers and ease of access to health care services
  - Used to inform decisions about care and how to improve the quality of health care
CAHPS From Compliance to Consumer Reports

How Does Your Doctor Compare?

In this special report, Consumer Reports Health evaluated 552 Minnesota physician offices to help you learn about the doctors and nurses who are key partners in managing your family’s health. These ratings are based on data collected by the physician offices on how well their patients control two of the most common and deadly chronic diseases: diabetes and cardiovascular disease, which includes heart failure and stroke, and peripheral artery disease.

We ranked practices using a variety of criteria, including patient satisfaction and physician ratings. The best performers are those that achieved the highest scores for diabetes management and cardiovascular disease care.

### Ratings of Medical Practices

<table>
<thead>
<tr>
<th>Practice</th>
<th>Address</th>
<th>Score</th>
<th>Percent of patients achieving optimal care</th>
</tr>
</thead>
<tbody>
<tr>
<td>37 clinics earned our highest score for diabetes and vascular care.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

While this is a list of the top performers, it’s important to remember that there is no substitute for regular check-ups and screenings. If you have concerns about your health, contact your doctor for guidance.

View the CG-CAHPS®

© 2013 CNSI
21st Century Customer Service Experience

- Same **customer experience** for all individuals, regardless of plan
- Customers experience a **high level of service** support & ease of use
- **Seamless coordination** between Medicaid/CHIP programs, Exchanges, plans, employers & navigators
- **Collaboration** among Federal & State agencies
- **Integration** of systems, programs & administration to prevent duplication

*Who are customers & how do they communicate?*

**Text Message Usage by Insurance Type**

- 80% of Medicaid recipients & nearly half of all Medicare beneficiaries

*How to translate these requirements into technology-support results?*
Medicaid & CHIP Business Functions

- What is the Business Result?
  - As “States develop and implement sophisticated, consumer-friendly IT infrastructure and achieve interoperability”

- Performance Indicators
  1. Individuals’ Experience
     - Eligibility and Enrollment
  2. Provider Experience
     - Enrollment and Claims Payment

Performance Indicators for Medicaid & CHIP Business Functions

SOURCE: “Federal Funding for Medicaid Eligibility Determination and Enrollment Activities” (75 FR 21950) “Eligibility Changes under the Affordable Care Act of 2010” (77 FR 17144)
Making (Performance) Reporting
Timely, Accurate, Meaningful, Useful, Transparent...& Real

Actionable Performance Measurement
MITA & ITIL –aligned measurement
CMS Performance Indicators
21st Century Customer Experience
Measure Transparency & Accountability

1. **Measureable Maturity Improvement**
   - Set standard, Measure to improve

2. **Diagnosis & Correction**
   - Identify issues, Target corrective action

3. **Track, Predict & Prepare**
   - Visualize, Organize & Manage

4. **Forecast & Self-Heal**
   - Proactively identify, alerts & suggests / corrects action

5. **Correlate & Quantify Action/Effect**
   - Correlations between multiple metrics
   - Correlation calculator – track relationships

Real-Time, Online e-Performance Management
Patient Activation Measure – Short Form

1. When all is said and done, I am the person who is responsible for managing my health condition
2. Taking an active role in my own health care is the most important factor in determining my health and ability to function
3. I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition
4. I know what each of my prescribed medications do
5. I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself
6. I am confident I can tell my health care provider concerns I have even when he or she does not ask
7. I am confident that I can follow through on medical treatments I need to do at home
8. I understand the nature and causes of my health condition(s)
9. I know the different medical treatment options available for my health condition
10. I have been able to maintain the lifestyle changes for my health that I have made
11. I know how to prevent further problems with my health condition
12. I am confident I can figure out solutions when new situations or problems arise with my health condition
13. I am confident that I can maintain lifestyle changes like diet and exercise even during times of stress

“There is wide agreement that engaging patients to be an active part of the care process is an essential element of quality of care.”
# Patient Engagement Framework

## Business Drivers

<table>
<thead>
<tr>
<th>E-Tools</th>
<th>Emerging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forms</td>
<td>Printable</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
</tbody>
</table>

## Patient Drivers

<table>
<thead>
<tr>
<th>Inform Me</th>
<th>Engage Me</th>
<th>Empower Me</th>
<th>Partner with Me</th>
<th>Support my e-Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inform &amp; Attract</td>
<td>Retain &amp; Interact</td>
<td>Partner Efficiently</td>
<td>Synergy &amp; Extend Reach</td>
<td></td>
</tr>
</tbody>
</table>

## Wellness

### Interactive Forms
- Patient-specific Ed
- Patient Access to Records

### Clinical / EHR
- Patient-specific Ed: ACO, readmission prevention
- Patient View, Download & Transmit Records (VDT)
- Patient Generated Data
- Interoperable Records

### Patient View, Download & Transmit Records (VDT)
- Patient VDT: Publish & Subscribe
- Patient Generated Data: Shared decision making, informed choice, pre-visit
- Interoperable Records: external
- Collaborative Care: LTPAC, ES, home

### Patient Specific Ed: ACO, coaching
- Patient Records: Control access, permission & distribution
- Collaborative Care Records
- e-Visits
- Community Support

### PATIENT-DEFINED PROVIDER-SUPPORTED

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http://www.nationalehealth.org/consumers

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CNSI on eHealth

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Engagement - Mobile Medicaid

first mobile app targeted for people covered by Medicaid

- **Real-time information**
  - Providers, Claims, Eligibility & Benefits
- **Reminders, Alerts & Search**
  - Reminders & educational alerts
  - Search Providers "Near Me"

**HHS integration**
- WIC (Women, Infants & Children)
- CSHCS (Children's Special Health Care Services)

**Ease of Use**
- Mobile app – downloadable from iTunes
- Cloud - business logic
  - Write once, deploy across multiple mobile platforms

"Data shows that the number of Medicaid recipients – particularly, people of color and of low-income populations – are adopting mobile technology at a rapid pace and are increasingly using mobile tools to access the Internet. This data suggests that mobile-friendly versions of patient portals could help close the online access gap for Medicaid patients.

**SOURCE:** http://www.healthmgtech.com/articles/201209/how-mobile-technology-helps-meet-mu.php

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Engagement is the Blockbuster drug of the Century

- Leonard Kish, HIT Strategist; and Farzad Mostashari, MD, ScM,
  National Coordinator for Health IT
Blue Button → myHealthButton

SAFE, EASY HEALTH ACCESS IN ONE TOUCH

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