BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director

MARTA JENSEN
Acting Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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August 29, 2016

Patricia Hansen, Ed.D.
CMCS, State Demonstrations Group (SDG)
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Nevada Comprehensive Care Waiver (NCCW), Project Number: 11W-00284/9

Dear Ms. Hansen:

Please accept the following submission requirement: "Quarterly Operational Reports", as outlined in the Special Terms and Condition (STC) 55 of the approved Nevada Comprehensive Care 1115 Research and Demonstration Waiver. Per STC 55, the state must submit progress reports in the format specified in Attachment A, 60 days following the end of each quarter. The attached report is for the period of April 1, 2016 – June 30, 2016, or Federal Q3/2016.

Should you have any questions regarding this submission please contact Gladys Cook, Program Specialist, at (775) 684-7596 or via email at gladys.cook@dhcfp.nv.gov.

We look forward to continuing to work with you and your staff.

Sincerely,

Marta Jensen
Acting Administrator

Enclosures

Cc: Elizabeth Aiello, Deputy Administrator
Gloria Macdonald, Chief, Program, Research and Development

Nevada Comprehensive Care Waiver (NCCW)
Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:

Demonstration Year: 3 (7/1/2015 – 6/30/2016)

Federal Fiscal Quarter: 3 (04/1/16 – 06/30/16)

Introduction

On June 28, 2013, the Nevada Division of Health Care Financing and Policy (DHCFP) received approval for the Nevada Comprehensive Care Waiver (NCCW), (Project Number 11W-00284/9) from the Centers for Medicare & Medicaid Services (CMS) in accordance with section 1115(a) of the Social Security Act. Approval for the NCCW is effective from July 1, 2013 through June 30, 2018.

Under the NCCW, the DHCFP has implemented mandatory care management services throughout the State for a subset of high-cost, high-need beneficiaries not served by the existing Managed Care Organizations (MCOs). This subset of beneficiaries will receive care management services from a Care Management Organization (CMO), named the Health Care Guidance Program (HCGP). This entity will support improved quality of care, which is expected to generate savings/efficiencies for the Medicaid program. Enrollment in the HCGP is mandatory for demonstration eligible Fee-For-Service (FFS) Medicaid beneficiaries with qualifying chronic health conditions. The HCGP launched on June 2, 2014.

The NCCW demonstration will assist the State in its goals and objectives as follows:

Goal 1: Provide care management to high-cost, high-need Medicaid beneficiaries who receive services on a FFS basis.

- **Objective 1.1:** Successfully enroll all Medicaid beneficiaries who qualify for the NCCW program.
- **Objective 1.2:** Stratify all enrollees into case management tiers according to assessed needs.
- **Objective 1.3:** Complete a comprehensive assessment of enrollees with complex or high risk needs.
- **Objective 1.4:** Complete a comprehensive assessment of enrollees with moderate or low risk needs.
- **Objective 1.5:** Increase utilization of primary care, ambulatory care, and outpatient services for members with chronic conditions.

Goal 2: Improve the quality of care that high-cost, high-need Nevada Medicaid beneficiaries in FFS receive through care management and financial incentives such as pay for performance (quality and outcomes).

- **Objective 2.1:** Increase use of preventive services by 10 percent. [1-1]
- **Objective 2.2:** Increase follow-up ambulatory care visit after hospitalization by 10 percent. [1-1]

[1-1] The goal for all measures to increase performance by 10 percent refers to the hybrid Quality Improvement System for Managed Care (QISMC) methodology for reducing the gap between the performance measure rate and 100 percent by 10 percent.

Objective 2.3: Increase patient compliance with anti-depressant medication treatment protocols by 10 percent. [1-1]
Objective 2.4: Increase use of best practice pharmacological treatment for persons with chronic conditions by 10 percent. [1-1]

Goal 3: Establish long-lasting reforms that sustain the improvements in the quality of health and wellness for Nevada Medicaid beneficiaries and provide care in a more cost-efficient manner.

Objective 3.1: Reduce hospital readmissions by 10 percent. [1-1]
Objective 3.2: Reduce emergency department utilization by 10 percent. [1-1]

Goal 4: Improve NCCW enrollee's satisfaction with care received.

Objective 4.1: NCCW enrollee satisfaction improves over baseline.

Enrollment Information

Demonstration Populations (in person counts)	**Enrolled in Current Quarter** (06/30/16)	**Disenrolled in Current Quarter** (06/30/16)	**Current Enrollees** (07/31/16)
Population 1: MAABD	21,711	0	21,575
Population 2: TANF/CHAP	17,091	0	16,677
Total:	38,802	0	38,252

Note: * DHCFP uses the formalized process according to CFR 42 438.56; which states there are two ways in which a disenrollment occurs. The ways in which the disenrollment may be completed are that of the State requesting the disenrollment or the beneficiary submits a request for disenrollment. It is not considered disenrollment when someone is removed from the program due to eligibility status change.

Demonstration-Qualifying Conditions (in person counts)	**Enrolled in Current Quarter** (06/30/16)	**Disenrolled in Current Quarter** (06/30/16)	**Current Enrollees** (07/31/16)
Diagnosis 1: Asthma	5,448	0	5,476
Diagnosis 2: Cerebrovascular disease, aneurysm, and epilepsy	3,374	0	3,341
Diagnosis 3: Chronic obstructive pulmonary disease, chronic bronchitis, and emphysema	3,255	0	3,259
Diagnosis 4: Diabetes mellitus	3,805	0	3,800
Diagnosis 5: End stage renal disease and chronic kidney disease	1,393	0	1,393

Note: *

Demonstration-Qualifying Conditions (in person counts)	**Enrolleed in Current Quarter** (06/30/16)	**Disenrolled in Current Quarter** (06/30/16)	**Current Enrollees** (07/31/16)
Diagnosis 6: Heart disease and coronary artery disease	2,356	0	2,375
Diagnosis 7: HIV/AIDS	341	0	337
Diagnosis 8: Mental health	22,103	0	22,154
Diagnosis 9: Musculoskeletal system	7,390	0	7,481
Diagnosis 10: Neoplasm/cancer	271	0	259
Diagnosis 11: Obesity	4,208	0	4,245
Diagnosis 12: Substance use disorder	7,234	0	7,290
Diagnosis 13: Pregnancy	2,789	0	2,564
Diagnosis 14: Complex Condition/High Utilizer	660	0	642

Note: enrollees may be counted twice due to the ability to fall under multiple diagnoses categories at the same time.

Determinations

The following chart reflects data on demonstration eligibility determinations during Q3/2016 as required under STC 26:

# of Determinations (by methodology)	Determination methodology (in person, telephonic, etc.)	Determination outcomes by determination methodology
Approximately 60,000 eligible members provided to vendor.	Per vendors automated medical claims analysis and stratification	Approximately 38,000 enrolled beneficiaries at quarter ending 06/30/16

Disenrollment's

The following chart reflects data on demonstration disenrollments during Q3/2016 as required under STC 26:

# of disenrollments (by reason)	Reason(s) for disenrollment
0	N/A

Note: DHCFP uses the formalized process according to CFR 42 438.56; which states there are two ways in which a disenrollment occurs. The ways in which the disenrollment may be completed are that of the State requesting the disenrollment or the beneficiary submits a request for disenrollment. It is not considered disenrollment when someone is removed from the program due to eligibility status change.

Non-compliance

The following chart reflects data on beneficiaries determined non-compliant during Q3/2016 as required under STC 27:

# of recipients categorized as noncompliant	0

Note: The DHCFP requested guidance regarding the definition of noncompliant. It is the current understanding of the state that it is not considered to be noncompliant when a recipient is no longer enrolled in the program due to relocation or the member is deceased.

# of demonstration-eligible beneficiaries on CMO waiting list	# added to waiting list since previous quarter	# moved from waiting list to enrollment in the CMO
0	0	0

Enrollment Fluctuations

DHCFP reports the enrollment numbers for Q3/2016 continues to steadily increase for the following months; 04/2016 enrollment numbers totaled 38,527, 05/2016 enrollment totaled 38,752, and 06/2016 enrollment numbers totaled 38,802.

Outreach/Innovative Activities

The DHCFP continued CMO outreach activities with AxisPoint Health (APH) during Q3/2016. The following chart lists the outreach activities for Q3/2016.

Date	Outreach Activity	Summary of Activity
April 19, 2016	Medical Care Advisory Committee (MCAC) meeting at the Legislative Building in Carson City NV	Dr. Thomas McCrorey and Cheri Glockner presented an update on the HCGP to MCAC board members.
April 21, 2016	Washoe County Children’s Mental Health Coalition; 2655 Enterprise Road Reno NV	An update on System of Care Grant, along with updated certified community behavioral health grant, neighborhood assessment centers and workgroup committees presented by the Health Care Guidance Program (HCGP) employee Maxfield was presented.

Date	Outreach Activity	Summary of Activity
May 23, 2016	Stakeholder Webinar Certified Community Behavioral Health Clinics; 4150 Technology Way Room 303 Carson City NV.	Erin Snell, Beacon's Mental Health Program Director was present at meeting to present on the HCGP as needed.
May 24, 2016	Nevada Children's Behavioral Health Consortium; Video Conference	This is an ongoing meeting that Erin Snell was present for; but nothing new at this time was presented to the group.
May 31, 2016	Sunrise Hospital, Las Vegas NV, Teleconference	The HCGP Staff Supervisor, Patricia Reagan set up a call and included Stephanie White and Erin Snell. A discussion with Sherry Siewers, Director of Case Management at Sunrise Hospital occurred. Behavioral Health has not had the opportunity to go to Sunrise historically but Sherry mentioned there is plenty of opportunity and need. She communicated that there is a 33 bed holding unit that is currently part of the ER and will soon also include an observation unit. On any given day, she reported that they will have 30 – 50 individuals on L2K's. The Director of the BH unit is Damali Brooks – HCGP requested a meeting with Damali. Sherry thought that was a good idea. Sherry scheduled a meeting with Stephanie White, Pat Regan and any of the HCGP CM's in the South to come to the hospital on Tuesday, June 28 from 10 – 11 am to meet and discuss the HCGP collaboration. Sherry & Damali will also both attend. The meeting is at 3186 S. Maryland Parkway. Pat & Stephanie will work together to

Date	Outreach Activity	Summary of Activity
		get our staff through the required training to have full access to the hospital. In the meantime, anyone who goes in to the hospital is asked to contact Jody Eggers, Case Management Associate. Sherry provided us with her cell phone number as well, should we ever need to reach her.
May 2, 2016	Million Hearts Task Force Discussion with Vicky Kolar; Conference Call	HCGP staff member Smith along with Dr. Thomas McCrorey provided an introduction meeting to reacquaint the HCGP with the Million Hearts and Stroke Task Force. HCGP staff member gave an overview of the program and invited Ms. Kolar to the quarterly meeting.
May 4, 2016	Chronic Disease Stakeholder Workshop; Conference Call and Health Insight, Inc. Community Room, 6830 W Oquendo Road Ste 102 Las Vegas, NV 89118	HCGP staff members Smith, McCrorey, and Regan presented at the Heart Disease and Stroke Task Force overview, self-monitoring blood pressure program intro, completing electronic referrals to education and receiving feedback utilizing the HIE, Renown Health's telehealth reimbursement model, and diabetes education stakeholder workgroup.
May 5, 2016	Access to Care Conference; teleconference	HCGP staff Dr. McCrorey and Cheri Glockner present for discussion of the following: Started >10 years ago -- Medical Discount program-- membership program-- 2000 providers, visit at a greatly discounted rate $35/ mo -- call

Date	Outreach Activity	Summary of Activity
		providers if you will miss appt. try to protect providers 4000 members fall into the income Guidelines of -300% federal poverty level-- uninsured or under insured. Also undocumented HSA program -4 hrs of financial classes. Save money and get matched grants. Help make 82 employees mostly in N. Nevada. State aging and disability Colon cancer control Dental program Health insurance program/ brokers --help them get on plans Care coordination through the brokers Nutrition program- food bank boxes. Help get people to the appointments Door to door service assistance Grant funded by Ryan white for HIV pos. Women's health connection-- access to mammogram and mg and gynecologist visit Blood and cancer program with Sierra pediatric Specialty care

Date	Outreach Activity	Summary of Activity
		Coordination with St. Mary's Meet pts that are in patients Locate PCP set up appointments for them Case coordination A lot of pts are Medicaid or self pay. Want to help decrease readmission by following doctor guidance. Pregnancy program transport etc.
May 11, 2016	Community Partners Meeting Rural Area; Conference Call	HCGP staff members Smith and Dr. McCrorey attended but did not have anything new to present at this time.
May 12, 2016	Community Partners Meeting North; 4001 S. Virginia St Reno, NV	HCGP staff members Smith and Dr. McCrorey attended but did not have anything new to present at this time.
May 31, 2016	Vicky Ives, Coordinator for community health worker association; teleconference	HCGP staff members Dr. McCrorey and Cheri Glockner present and interacted in discussions regarding the following: Possible start of CHW association Possible new regulations Possible public hearings coming up. Cheri explained the HCGP community health worker (CHW) program Considering Licensing vs

Date	Outreach Activity	Summary of Activity
		CHW certification-- may be doing licensing of an organization that has a pool of CHWs -- intent to explore for reimbursement people aren’t ready for certification yet HC Quality compliance office working on proposals. We use CHW in all programs-- "sleuth" to find people Discussion of training Vickie interested in return on investment (ROI) wanted to know what ours was but the HCGP couldn’t give that and explained that the HCGP doesn’t break out costs that way. RN Health network--training webinars, statewide meeting. Continuing education piece. Website: just getting started. Welfare dept: looking at a grant opportunity for diploma HS studies AmeriCorp: Online training for Rural NV. Health net work to get a combination of CHW/ Social work training Discussed ideas of CHW working for Fire Dept in their Community Para medicine program. Offered to have Vickie learn more about the HCGP.

Date	Outreach Activity	Summary of Activity
June 14, 2016	Northern Nevada Behavioral Health Coalition; 18600 Wedge Parkway BLDG A Reno NV 89511	Erin Snell present to clarify and engage in discussion as needed regarding the HCGP. There was nothing new to present at this time.
June 28, 2016	Sunrise Hospital Las Vegas, NV	HCGP staff Maxfield, Holmes, and Regan present to work with staff on the following: Continuing to work on secure email between Sunrise Hospital and the HCGP. For the resolution for emails issue relies with Sunrise corporate staff. Sunrise staff Tyler Owens suggested a contact for Dr. McCrorey to get in touch with. -Informed Sunrise that new non emergency transportation vendor for the state, MTM, are now accepting reservations. -Informed that St. Rose is cutting all Pediatric surgical services as of 7/1/16. Sunrise, UMC and Summerlin are the only LV hospital doing Pediatric surgery as of that date. -Continuing to work on getting Medi-Tech access for the HCGP staff. Once HCGP staff have their badges they can start seeing HCGP eligible members at the hospital.

Note: for every provider outreach, team provides tools for immediate services such as; Real Time Referrals (RTR) forms, contact phone numbers to the 24/7 Nurse Advise Line, Enrollee Assessment, Provider Manuals and Access to the Provider Portal.

Operational Developments/Issues

The DHCFP held its Quarterly Health Care Guidance Meeting on April 26, 2016. At the meeting, AxisPoint Health (APH) presented the following:

- Program Updates, presented by Cheri Glocker, HCGP's Executive Director
    - HCGP continues to work with the community paramedicine launch. Cheri and Dr. McCrorey have attended to two hearings and made a suggestion at the hearings and it was taken into account for the community paramedicine.
    - APH is pleased and honored to have been asked to work on the group home initiative which they refer to as the vulnerable population. HCGP compliments Beacon for their efforts in finding the 1,869 members.
    - Cheri, Dr. McCrorey and staff did a rural trek and met with providers, hospitals, and case managers.
    - HCGP is getting closer to launching their standalone website. Website is being created for the general public to get more information about the program.
- Dr. Tim Moore, APH's Chief Medical Officer presented on Program Development and Rural Initiatives.
    - Dr. Tim Moore spoke about the five areas they have identified and are working on; first pillar of this is using the data better than they have before and being able to look through data sets to identify who they should focus on. They're working on revamping the whole way that they'll be identifying and focused on people in the future.
    - Secondly, they need to make sure that the people that they identify for intervention are getting the right interventions.
    - Third area is to make sure that people are going to see the person that they connect with the best that will lead to the best outcome.
    - Fourth area, that's really important, is figuring out that people have different ways that they want to connect with them that is through social networks, mobile technology, etc. They are looking at all those different modalities to deliver their services.
    - Fifth area is the data analysis side in which APH is working on improving their abilities and processes. He went on to speak about having a primary care team composed of health workers, social workers, nurse generalists, behavioral science and substance abuse because those are the issues that they are dealing with. They also want to have a specialty group that can serve as support to the primary care team that would include specialized nurses for diabetes, cardiac or neonatology problems, pharmacists, and behavioral health specialists just to name a few for example. They're undergoing a lot of these changes right now and they'll start putting the changes into their platform so that they can execute it by the first part of next year.
- Quality Module #2, Goal #1 (1.1-1.5) and Module 3, Goal #2 (2.1-2.4)
    - HCGP provided an update on Executive Summary enrollment using April 2016 data. Presented on enrollment vs. the minimum and maximum for the waiver and are pleased to report that they are above the minimum and have been above the minimum for the past couple of months.
    - APH re-presented on Quality Module #2 Goal #1 (1.1-1.5) by going over the power points slides from the January 2016 Quarterly meeting to provide the metrics and charts in exactly the way the DHCFP requested.
- The states new non emergency transportation vendor, Medical Transportation Management (MTM) staff presented power point presentation about MTM's history and footprint.

- Health Services Advisory Group, Inc. (HSAG) the states External Quality Review Organization (EQRO) started activities for the upcoming APH, Performance Measures Validation Audit (PMV). The onsite PMV audit is scheduled to take place in September 22 or 23, 2016.
- DHCFP staff attended to the HCGP Provider Advisory Board (PAB) meeting on August 28, 2016. The PAB meeting comprised of six providers and state staff. The composition of the board reflects a cross section of health care providers in Nevada including representatives from rural and urban locations, primary care and behavioral health specialties, acute care facilities and outpatient clinics, and public and private health care systems. The advisory board consists of a minimum of four and maximum of ten members. The purpose of the PAB to advise the Nevada Medicaid Health Care Guidance Program (HCGP) on matters that support the Care Management Organization (CMO) in achieving its goals. Board members discuss program progress; outcomes and ways to improve the program; a vehicle for the CMO to hear provider's opinions and recommendations about the program; a way for the CMO to gain awareness of preferred methods for outreach and communication.

Care Management Contracting

- Within FFY16 Q3/2016, the DHCFP continues to work with CMS on obtaining approval for Amendment #4 Attachment AA. The purpose of Amendment #4 is to update the contract language to match the STC's Attachment B. The DHCFP followed CMS guidance to revise the "Reconciliation Methodology "in Attachment B of the STC's. In addition, the DHCFP amended the following:
    - ICD-9 language to remove the numerical version to avoid additional amendments due to a change in ICD codes.
    - The Nevada Data Extra Table was updated to match the program launch date of June 2014.
    - Removal of procedure codes under "Additional condition inclusion criteria are as follows" to match the STC's.
- On July18, 2016, the DHCFP received approval from CMS on Amendment #4 Attachment AA.
- The DHCFP plans on working with CMS, CMO Vendor and DHCFP internal staff on Amendment #5. The purpose of this amendment is to extend the CMO contract term an additional two years ending November 30, 2018 and make minor language updates to Attachment AA.

Policy Developments/Issues

On March 6, 2014, the addition of the new Medicaid-eligible Modified Adjusted Gross Income (MAGI) individuals to the CMO-eligible population was discussed with CMS due to the implementation of health care reform. On March 12, 2014, per CMS guidance, the DHCFP submitted a technical correction to the STCs to address this new Medicaid population and align the eligibility charts (STC 17) with the revised medical assistance AID categories. As of today we have not received any additional feedback and/or final approval from CMS regarding MAGI.

Financial/Budget Neutrality Development/Issues

There are no financial developments/issues/problems with accounting or budget neutrality to report for this quarter (Q3/2016).

Member Month Reporting

Demonstration Populations	Month 1 (April 2016)	Month 2 (May 2016)	Month 3 (June 2016)	Total Ending (July 2016)
Population 1: MAABD	21,784	21,937	21,711	21,575
Population 2: TANF/CHAP	16,743	16,815	17,091	16,677
Total:	38,527	38,752	38,802	38,252

Consumer Issues

There are no consumer issues to report for this quarter (Q3/2016).

Quality Assurance/Monitoring Activity

Per STCs 26 & 27, the State is required to report on demonstration eligibility determinations, the number deemed non-compliant and "on demand for noncompliance." For this quarter (Q3/2016), please see table on page 3 for "noncompliance".

The DHCFP reports zero (0) number for those deemed non-compliant and "on demand for noncompliance". The DHCFP sent CMS an e-mail on August 19, 2015 for guidance on the definition of noncompliance to assure reporting is done adequately. The program has been operating for one (1) and half year and has a zero count. The DHCFP is awaiting the response from CMS to ensure that this measure is being accurately reported.

Demonstration Evaluation

The DHCFP draft Evaluation Design Plan for the NCCW was submitted to CMS on October 14, 2013. On February 2, 2014, DHCFP received feedback from CMS. The DHCFP re-submitted the Evaluation Design Plan for the NCCW to CMS on March 5, 2014, incorporating CMS feedback. On February 24, 2015, the DHCFP received feedback from CMS. The DHCFP submitted revisions to CMS on July 28, 2015. As of today we have not received additional feedback from CMS regarding and/or final approval from CMS regarding the Evaluation Design Plan.

Enclosures/Attachments

- FFY16 QTR 3 Cover Letter
- HCGP Quarterly Minute Meeting 04-26-16
- HCGP Quarterly Meeting Sign In Sheet 04-26-16
- NEV_AxisPoint Health _PY2_Q3 _2016 04_26 Presentation Final.
- Medical Transportation Management (MTM) Presentation

- HCGP Update and Overview for the Provider Advisory Board (PAB) Meeting
- Nevada Health Care Guidance Program PAB Minutes April 2016
- Roseman Intro – Healthcare.pptx for PAB Meeting April 2016

State Contact(s)

DHCFP Business Lines staff

Name	Title	Phone #	Fax #	Address
Elizabeth (Betsy)Aiello	Deputy Administrator	775-684-3679	775-684-3774	1100 E. William St. Carson City, NV 89701
Gladys Cook, CMO Project- Quality Lead Monitor	Social Services Program Specialist III	775-684-7596	775-684-3643	1100 E. William St. Carson City, NV 89701
Gloria Macdonald, Program Research and Development Unit	Chief	775-687-8407	775-684-8724	1100 E. William St. Carson City, NV 89701
Rachel Marchetti CMO Liaison	Social Services Program Specialist II	775-684-3617	775-684-3643	1100 E. William St. Carson City, NV 89701
John Kucera Operational Analytics and Data Quality	Management Analyst III	775-684-3631	775-684-3643	1100 E. William St. Carson City, NV 89701
Lisa Koehler Contract Manager	Management Analyst III	775-684-3708	775-684-3643	1100 E. William St. Carson City, NV 89701

Date Submitted to CMS

August 30, 2016

Health Care Guidance Program

An Update on Nevada Medicaid's Care Management Organization

THE NEW MANAGERS OF CARE

Agenda

- Overview of the Program
- Results so far---
- Presentation on the Provider Shortage and Roseman University
- Discussion of Current issues in Nevada Medicaid Provider Community and the HCGP
- Future Meeting Location and Date.

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What is the Health Care Guidance Program?

Health Care Guidance Program
Coordinating with you for better care!

- A Mandatory program provided to a subset of Nevada Medicaid's sickest and/or highest cost, Fee-for-Service beneficiaries
- Originally implemented as the *"Care Management Organization"*
- Rebranded as the **Health Care Guidance Program (HCGP)** to avoid confusion between *CMO* and *MCO*
- Mutually Exclusive from Medicaid's Managed Care Organizations (MCO's)
  - (Amerigroup *and* Health Plan of Nevada)
  - A Federally Supervised Research and Demonstration Project only for Nevada Medicaid Fee For Service

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Business Changes

- McKesson Connected Care and Analytics was selected as the Vendor for the HCGP

- McKesson divested this business line in 2015

- ***AxisPoint Health*** *(APH)* purchased the Care Management business
  - Same basic structure, capabilities, personnel
  - Email communication with HCGP staff will show an “axispointhealth” email address

- Care Management was 1% of McKesson’s world wide business, APH has 100% of focus on data-driven, quality Care Management services

- *Nevada’s Health Care Guidance Program* is an important part of AxisPoint Health.

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HCGP staff

Executive Director, Cheri Glockner

Medical Director, Dr. Thomas McCrorey

(Ms. Glockner and Dr. McCrorey are based in Carson City with frequent visits to Las Vegas and other Nevada locations)

38 nurses, social workers, community health workers and peer specialists are dispersed throughout Nevada. Largest presence in Clark County.

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Services Provided:

- Disease Management
- Complex Care Management
- Nurse Advice Line
- Provider Quality Metrics
- Staff available telephonically or face-to-face

NOTE: The HCGP is NOT an Insurance company. HCGP members have the same billing and pre-authorization rules as other Medicaid Fee-for-Service beneficiaries

- Population Profiling
- Drug use Monitoring System
- Robust Behavioral Health Care Management Component (Beacon Health Options)
- Physician Portal for real time information on your HCGP Members and how the program works

Case Study of Disease Management

- 44 yo legally blind female, mild obesity and dyslipidemia
- Immigrant-Isolated socially and unfamiliar with resources
- Support provided:
  - education on the importance of taking prescribed medications for high cholesterol; encouraged exercise with education and benefits of having an exercise buddy; provided food resources in her area; encouraged member to pursue her GED in the blindness rehab program; ongoing coaching calls with social work intervention as needed.

  - established with pcp in her area, began taking her meds for dyslipidemia; began exercising regularly with a friend and lost 10 pounds so she no longer has to take her meds for dyslipidemia; no longer has shortness of breath; attained her GED; was able to get a part time job running Keno; moved into low income housing

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Disease Management

- Chronic disease management of common chronic conditions
- All members of HCGP have a qualifying condition
- Disease management is for applicable diseases found on the Initial Assessment Survey
- Many conditions are supported by identifying

  "Gaps in Care"
- Information fed into the care plan from a variety of sources, Claims, Patient, and discussion with the care providers.
- Standard National Guidelines are used to advise the member
  - Example: Asthma patients have an action plan
  - Example: Diabetes mellitus: patients 55 years and older who have a current prescription for angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blocker (ARB) medication.

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VITAL (EMR) Care Management Platform

My Work | User Management | Search | New

Member ID:
Alternate ID:
Phone:

DOB: (61)
Gender: M
PCP: THE ELKO CLINIC
CM: .ori

Coverages: P: 0 C: 1 F: 0
Policy Holder: Not Available ( )
Plan / Product (C): State of Nevada Medi / VITAL-MHP
Benefit Group: IN9

Program: Mental Health Program
Claims Risk: HIGH
User Risk: HIGH

Main | Case - 2

Manage | Care Plan | Stratify | Tx / CM Plan | Assessments

edit | request | reminder | note

Member Care Plan

Add Barrier: Barrier Description | Save

Priority 1					
Has a medical home	In Progress since Mar 2, 2016	Source	Member	Type	Select...
Has received counseling on falls prevention	Not Started	Source	Member	Type	Select...
Outpatient services and medical equipment have been coordinated	In Progress since Apr 15, 2016	Source	Member	Type	Long Term
Priority 2					
Has a behavioral health home	In Progress since Mar 2, 2016	Source	Member	Type	Long Term
Hearing impairment needs have been addressed	Not Started	Source	Member	Type	Select...
Visual impairment needs have been addressed	In Progress since Jan 6, 2016	Source	Member	Type	Short Term
Priority 3					
Has received counseling on current tobacco use	Not Started	Source	Member	Type	Select...

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Care Management Care Plan Detail

MCKESSON VITAL Platform

McCrorey, Thomas | Help | Web Links | Logout

My Work | User Management | Search | New

Member ID:
Alternate ID:
Phone:

DOB: (61)
Gender: M
PCP: THE ELKO CLINIC
CM:

Coverages: P: 0 C: 1 F: 0
Policy Holder: Not Available (
Plan / Product (C): State of Nevada Medi / VITAL-MHP
Benefit Group: IN9

Program: Mental Health Program
Claims Risk: HIGH
User Risk: HIGH

Main | Case - 2

Manage | Care Plan | Stratify | Tx / CM Plan | Assessments

Member Care Plan

Add Barrier: Barrier Description | Save

Notes

hyperlink to education materials

INTERVENTIONS	
	Discuss asthma
	Discuss coping skills
	Encourage discussion with provider
	Facilitate skill building
	If COPD, discuss COPD and asthma
	If member has written action plan, review
	Provide resource information
	Set a reminder from this intervention

INSTRUCTIONS	Deliver education component(s)
EDUCATION MATERIALS	Understanding Asthma
NOTE	
STATUS	Not Started
SAVINGS	0
VARIANCE REASON	

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Complex Case Management case study

- 49 y/o male s/p stroke in 2014. severe dysarthria. Also, bipolar d/o, alcoholism, depression
- Initial assessment showed adequate medical care and med compliance
- Pt contacted CM 2 months later –sounded distressed.
- Face to face visit --shows a Rep. Payer neighbor appointed—
  - Member worried about getting cheated/ stolen from, also neighbor was "crazy"
  - CM found out Payer was a convicted felon and mentally ill and assessed that member still has mental capacity
  - assisted member getting neighbor off status at Social Security office and Bank
- Contacted APS, Police, Social Security office
- Helped set up online automatic bill pay,
- Set up weekly PCP visits, agreement to seek counseling for behavioral health issues– Arranged Psychiatry consult. On psych meds now.
- Pt working closely with daughter now. Getting set up with Speech and Occ. Tx.— working on alcoholism.

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Complex Care Management

- Smallest number of Members
- Most discussed and publicized portion of the program
- Patients identified by computer algorithm for complexity of conditions and cost of claims,
- Also referred by providers and facilities—"Real Time Referrals"
- Many of the cases are managed by RNs with Certification in Care Management
- Social Workers integrated with the program

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McKESSON VITAL Platform

McCrorey, Thomas | Help | Web Links | Logout

My Work | User Management | Search | New

ember ID: 5	DOB:	Coverages: P: 0 C: 1 F: 0	Program: Mental Health Program
ternate ID: 6	Gender: M	Policy Holder: Not Available (	Claims Risk: HIGH
hone: (	PCP:	Plan / Product (C): State of Nevada Medi / VITAL-MHP	User Risk: HIGH
	CM:	Benefit Group: IN9	

Main | Case - 2

Manage | Care Plan | Stratify | Tx / CM Plan | Assessments

Member Care Plan

Add Barrier: Barrier Description — Save

Source — Sensitive — Status: Not Met

Notes

INTERVENTIONS
- Assist with transition of care
- Confirm care arrangements in place
- Contact medical home
- Explore level of assistance needed
- Explore level of care needed

Set a reminder from this intervention

INSTRUCTIONS
Confirm that medical home will make arrangements
-Home care evaluation including caregiver training and education
-Preadmission screening evaluation for a skilled facility, rehab or subacute admission
-Arrangements for inpatient admission to an acute care facility
-Preadmission screening for nursing home or alternative program (PACE or social managed care) if available
Discuss level of care needed
Obtain permission

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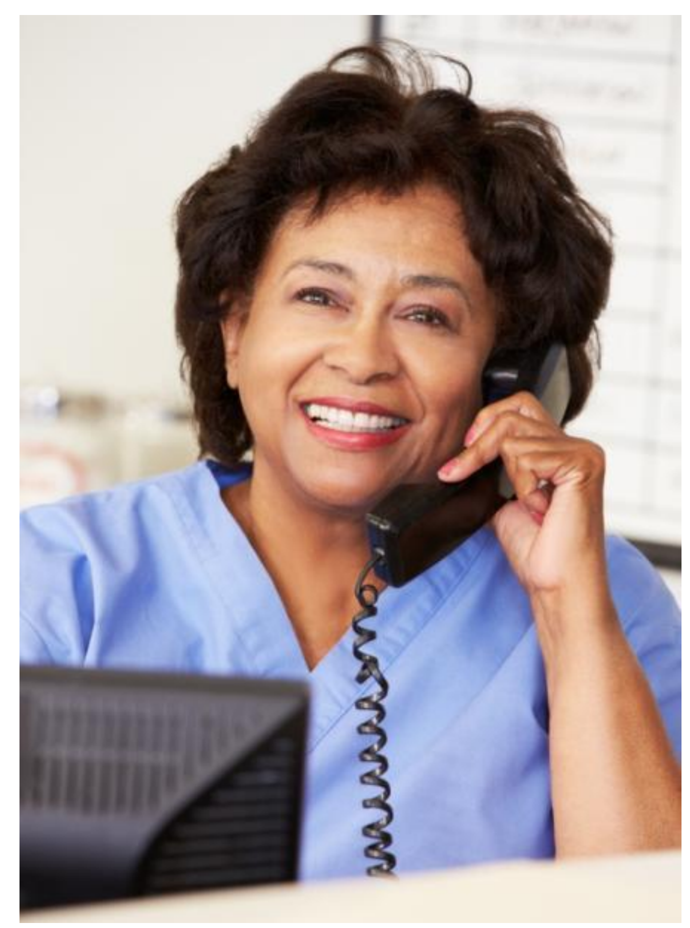
Nurse Advice Line

- Branded internally as “GuidePoint”
- Used for many health plans and the US military –considered the national leader in NAL
- Nurses follow peer-reviewed algorithm
- HCGP members chart is available to the Nurse at time of call
  - “not a cold call”



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Population Profiling

Prevalence of Conditions

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Population Profiling

Total Costs by Condition

$30,000,000.00
$25,000,000.00
$20,000,000.00
$15,000,000.00
$10,000,000.00
$5,000,000.00
$0.00

Emotional disorders
Depression
Schizophrenia
Liver Disease
Bipolar (Manic Depressive)
Diabetes
Cancer
Developmental Disabilities
ADD
Back Pain
Anxiety
HIV/AIDS
Seizure Disorder
Asthma
Kidney disease
(COPD)
Hypertension
Multiple Sclerosis
Nonorganic Psychoses
Substance Abuse total

Total

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Pharmaceutical Monitoring System

- *Clinical Care Alerts (Beacon Health Options)*
- Monitoring of all pharmacy claims for all members
- Select High Value Alerts are generated and mailed to all associated physicians and pharmacies.
- Not every alert is selected to avoid information overload.
- One problem is providers don't update their address and the letters are sent to their old practice before they moved to Nevada.

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Behavioral Health Management

- Subcontracted to a specialty team from *Beacon Health Options*
- Follow same criteria and software resources as the APH team
- Special focus on Mental Health and Substance Abuse
- Psychiatrist Medical Director --Dr. Ryan Ley
- Co-manage many patients, (Many patients have physical *and* mental health issues)
- Work with NNAMHS, SNAMHS, Mojave etc

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Physician Portal

Home Page

https://www.nvguidance.vitalplatform.com/providerportal/nev/home

Health Care Guidance Program
Coordinating with you for better care!

my account | logo

My Messag

Home | Program Information | Patient Information | Patient List | Resources | Sample Program Materials | Contact Us

Program Overview

Welcome to the Health Care Guidance Program Provider Portal.

Nevada Medicaid has launched an innovative new health care delivery model-a **Care Management Organization (CMO)**, that is designed to serve the highest risk, under-served Medicaid beneficiaries.

The Nevada Medicaid CMO program name is the **Health Care Guidance Program (HCGP)** and is a comprehensive health management service for your highest-risk Fee-for-Service patients.

The program focuses on both medical and behavioral health needs:

- Chronic care management
- Care coordination
- Emergency Room redirection and management

As an integrated extension of your care team, we support you by helping your patients:

- Receive the appropriate level of care
- Develop, manage and maintain a care plan
- Improve their overall condition(s)

A Provider Portal Guide is available for better understanding how to navigate the site, accessing valuable patient information.

Provider Portal Guide

All information on this site is intended for your general knowledge only. Use of this online service signifies your agreement to the disclaimer and the terms and conditions, which you should read or have read before going further.

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Provider Quality Metrics

B	C	D	E	F	G	H	I	J	K
NPI	Provider	Use of Appropriate Medications for Members with Asthma[1]	Use of Appropriate Meds for Members with Asthma-Denominator	Influenza Immunization[2]	Influenza Immunization-Denominator	Emergency Department[3]	Emergency Department-Denominator	Ambulatory Utilization[4]	Ambulator Utilization-Denominat
[illegible]	[illegible]	44.4%	18	5.6%	18	94.4%	18	100.0%	18
[illegible]	[illegible]	50.0%	6	0.0%	6	66.7%	6	100.0%	6
[illegible]	[illegible]	50.0%	2	50.0%	2	50.0%	2	100.0%	2
[illegible]	[illegible]	42.9%	14	14.3%	14	92.9%	14	100.0%	14
[illegible]	[illegible]	58.8%	17	5.9%	17	82.4%	17	100.0%	17
[illegible]	[illegible]	50.0%	2	0.0%	2	100.0%	2	100.0%	2
[illegible]	[illegible]	0.0%	1	0.0%	1	100.0%	1	100.0%	1
[illegible]	[illegible]	0.0%	1	0.0%	1	100.0%	1	100.0%	1
[illegible]	[illegible]	25.0%	4	0.0%	4	75.0%	4	100.0%	4
[illegible]	[illegible]	100.0%	3	0.0%	3	66.7%	3	100.0%	3
[illegible]	[illegible]	54.6%	11	9.1%	11	100.0%	11	100.0%	11
[illegible]	[illegible]	50.0%	4	0.0%	4	100.0%	4	100.0%	4
[illegible]	[illegible]	0.0%	2	0.0%	2	100.0%	2	100.0%	2
[illegible]	[illegible]	100.0%	1	0.0%	1	0.0%	1	100.0%	1
[illegible]	[illegible]	50.0%	2	0.0%	2	100.0%	2	50.0%	2
[illegible]	[illegible]	0.0%	3	0.0%	3	100.0%	3	100.0%	3

Loved, Protected

Immunized!

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How we measure success

- Initial Assessments rate
  - Face to Face
  - Telephonic
- Follow up contacts/"coaching calls"
- Interface with provider and others in the Care Network
- Provider Outreach
- Real Time Referral Responsiveness
- Cost Neutrality/Savings
- Clinical Quality Metrics (HEDIS Measures)

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Interim Results from Operational Claims Data

Outcomes and Results for Today:

- **"Pharmacy Alerts and Their Impact on Prescriber Behavior for a Subset of Nevada's Fee-for-Service Population"**

- **"Operational Utilization Metrics - June 2014 to November 2015: Total Overall Costs, Emergency Department, Inpatient Admission, Medication Expenditures"**

- **HCGP Effect on Immunization Rates**

NOTE: Results presented today have been internally vetted by APH research professionals. Be advised that no 3rd party validation has been deployed. However, we are confident in the rules and data extraction methods were applied.

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Pharmacy Clinical Care Alerts—
A program of Beacon Health Options

- CCAs are designed to target pharmacy "gaps in care"
    - Identified by pharmacy claims data
    - Letters are sent to every Pharmacy and Prescriber identified for that patient

- CCA alerts began in March 2015. However, the "look back period" was longer at the start of the program, so initial alerts are artificially elevated.
    - Therefore Month 3 (May 2015) is considered the Baseline Month

- Alert rates lower than the baseline month especially after Month 6 and 7 (September and October of 2015) are considered improved prescribing practices

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Pharmacy Clinical Care Alerts (CCA)

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CCA Early Discontinuation Alerts

early discontinuation per thousand enrollees

60
50
40
30
20
10
0

May
June
July
August
September
October
November
December
January
February

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CCA Polypharmacy Alerts

polypharmacy per thousand enrollees

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CCA Pediatric Alerts

pediatric age limits per thousand enrollees

Month	Value
May	~0.51
June	~0.06
July	~0.17
August	~0.14
September	~0.08
October	~0.16
November	~0.05
December	~0.11
January	~0.03
February	~0.19

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CCA Drug-Drug Interactions Alerts

drug-drug interactions per thousand enrollees

1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0

May June July August September October November December January

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CCA Overuse Alerts

overuse per thousand enrollees

0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0

May June July August September October November December January February

overuse per thousand enrollees

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CCA Summary

- In every category the alerts have decreased as a percent of the population
- This is at least partly due to better prescribing practices In the alert category
- This effect is likely transferred to patients with other payment sources

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Break Time?

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HCGP Utilization Metrics –June 2014 to November 2015– 18 months of Data

- Population financial metrics commonly used by payers

- Both arms of the study are continuously eligible members therefore not influenced by population churn

- Generated using *unreconciled* Medicaid Claims data
  - Likely the last few data points will see an increase
  - Comparison between the 2 populations is legitimate as both should see an increase

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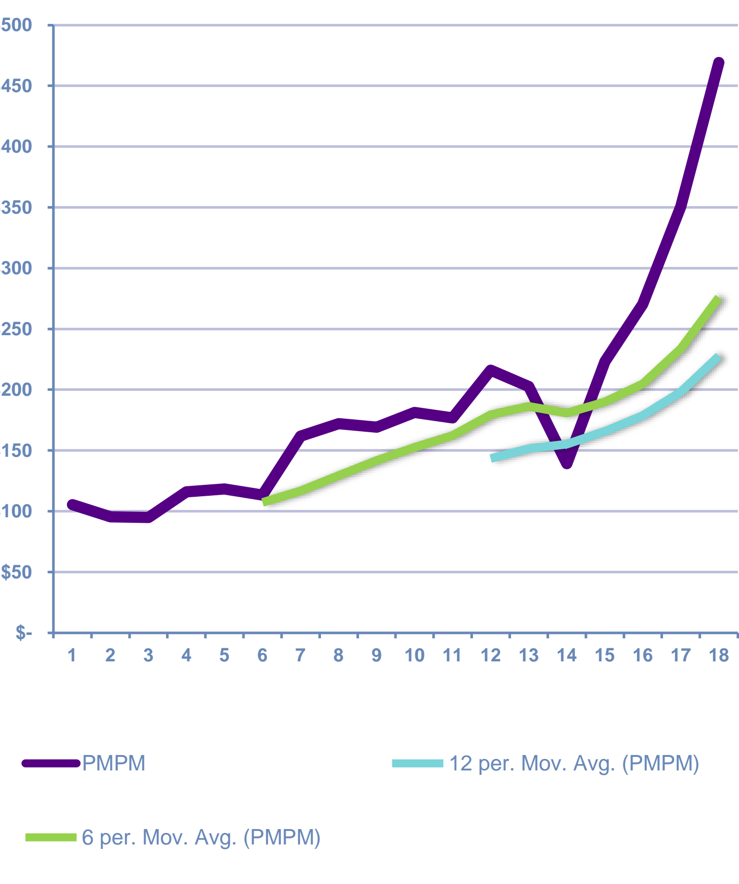
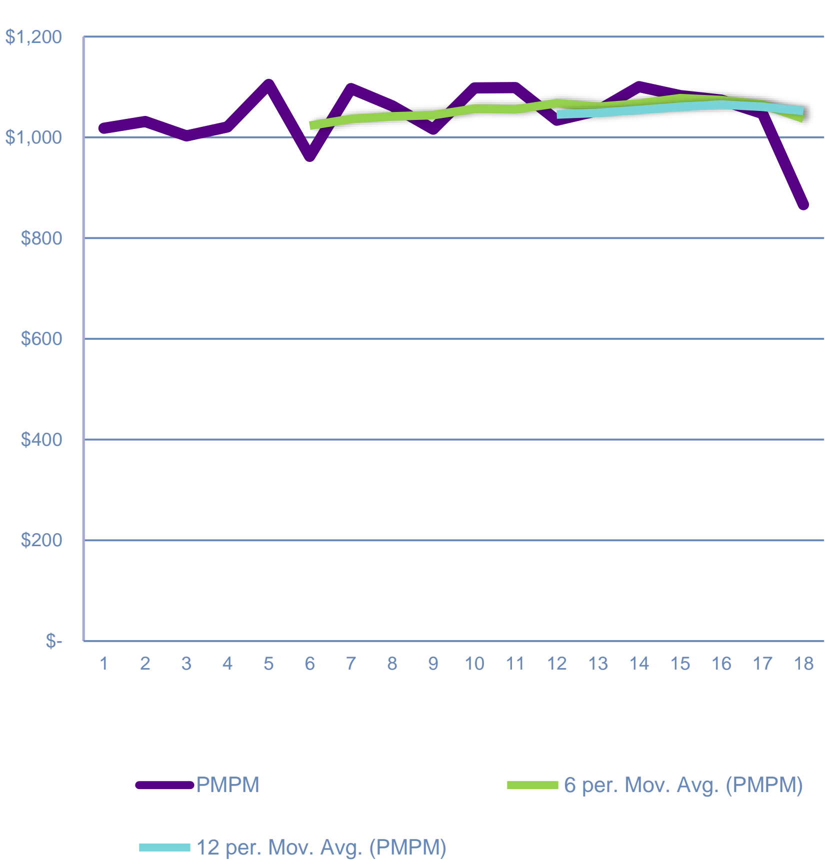
Utilization Metrics Per Member Per Month Costs



HCGP - PMPM



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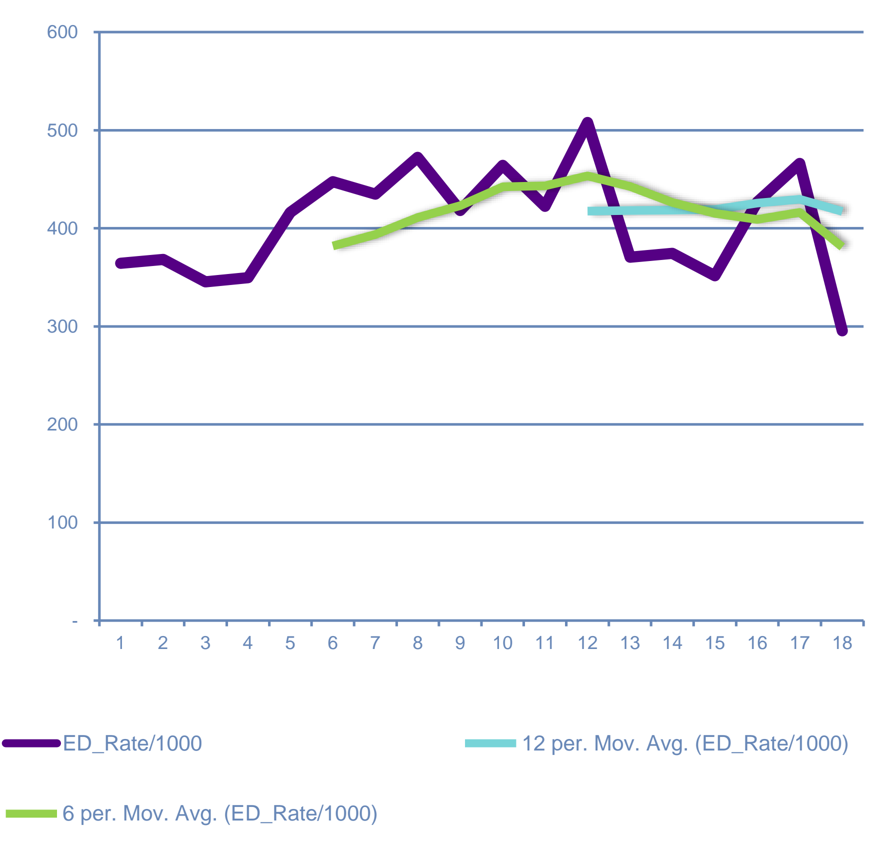
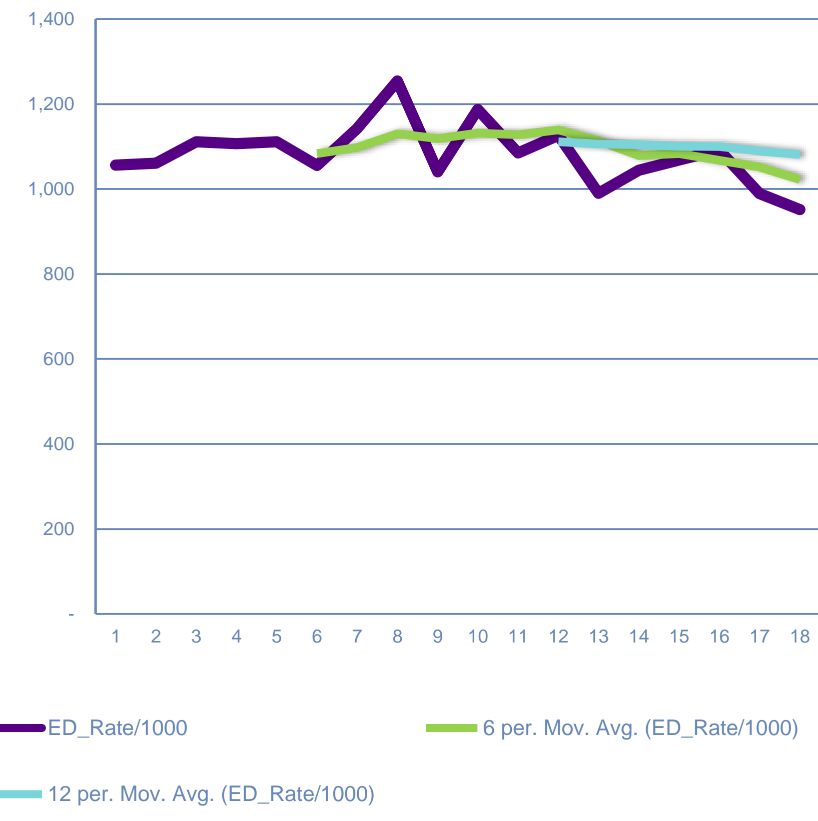
Utilization Metrics Emergency Visits





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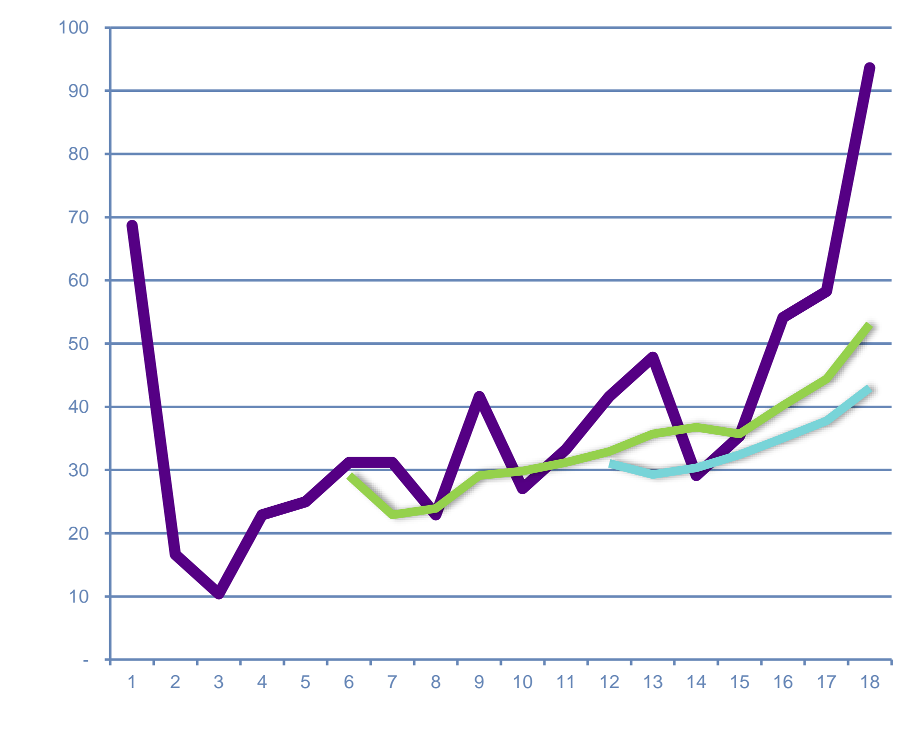
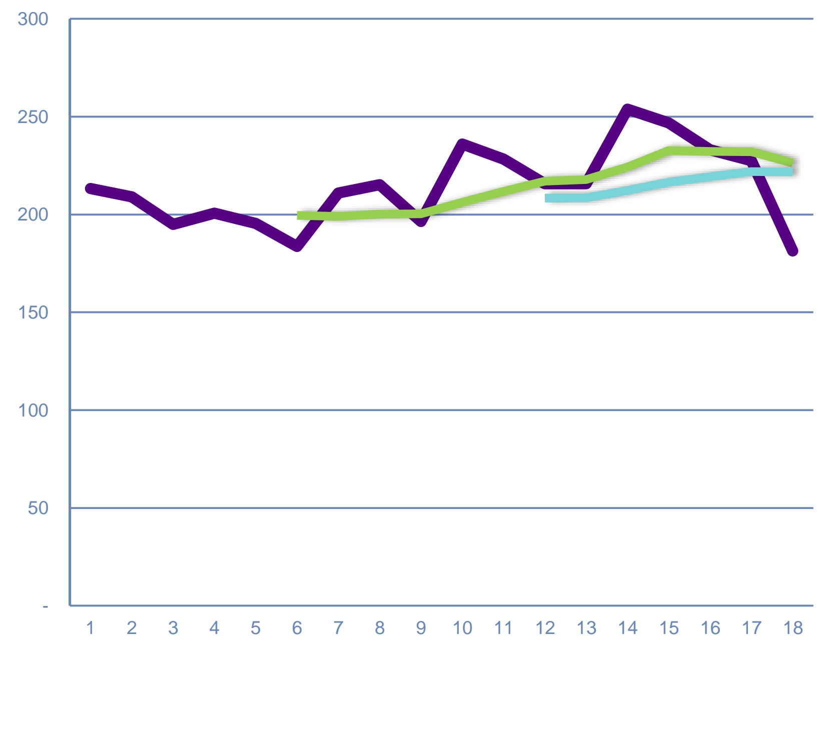
Utilization Metrics –Inpatient Admissions





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Utilization Metrics –Drug Expenses

Trend Population - RX PMPM

$140
$120
$100
$80
$60
$40
$20
$-
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

RX PMPM — 12 per. Mov. Avg. (RX PMPM) — 6 per. Mov. Avg. (RX PMPI

HCGP - RX PMPM

$450
$400
$350
$300
$250
$200
$150
$100
$50
$-
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

RX PMPM — 6 per. Mov. Avg. (RX PMPM) — 12 per. Mov. Avg. (RX PMPM)

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HCGP Utilization Metrics

- 3 out 4 operational metrics show better performance by the HCGP vs the Trend Population
- Pharmacy utilization is flat and may be partly due to the CCA program
- ED utilization is flat in both cohorts
  - Acceptable performance but further improvement will be sought.

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Influenza Immunization Compliance

- Promoting Immunizations is an important part of public and population health and a goal of the Health Care Guidance Program
- A comparison was made between HCGP members who had an active care plan, and those who did not
- Influenza immunization of the entire HCGP population was evaluated using Claims Data and the State Immunization data base (WebIZ)
- The numbers shown are lower than reality because both databases are incomplete, but comparison between the groups is valid
- High risk members of the program were encouraged to immunize (by IVR and mailings) even if there was no active care plan

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Influenza Immunization Compliance

Influenza Immunization Compliance
2014 - 2015

	Immunized w/ Care Plan	Immunized, No Care Plan
2014	25%	11%
2015	28%	11%

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The HCGP is there to support **you**, the Medicaid provider

We partner with:

- **The Medicaid Member**
- **The Primary Care Provider**
- **The State of Nevada**
- **The Specialty and Inpatient Care Provider**

Our **Greatest Challenge - Locating Members!**

- ***You can assist us by confirming the Member's contact information***

Common Problems for HCGP Members:

- **Social Structure Instability**
  - ***Shelter and Food Insecurity***
- **Transportation Problems**
- **Access to Specialty Care**

WE ARE HERE TO HELP!

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The future:

- Improved Risk Stratification and targeting of Member Conditions
- Promote Telemedicine
- Cooperate with Community Paramedicine
- Ongoing cooperation with Patient Centered Medical Homes.
- Longer term: real time monitoring

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Thank You!

Health Care
Guidance Program
Coordinating with you for better care!

AXISPOINT
HEALTH
Formerly a McKesson Company

Quarterly Meeting
April 26, 2016

THE NEW MANAGERS OF CARE

Today's Agenda

9:00 – 9:20	
I. Welcome and Introductions	Gladys Cook, SSPS3
9:20 – 9:30	
II. Approval of Minutes	Gladys Cook, SSPS3
9:30 – 10:10	
II. Program Updates	
Executive Director Comments	Cheri Glockner, HCGP Executive Director, APH
Program Development and Rural Initiatives	Dr. Tim Moore, CMO, APH
10:10 – 10:25 BREAK	
10:25 – 11:10	
IV. Quality	
Quality Module #2 and #3, Goal #1 (1.1 – 1.5)	Michelle Searing, CPM, APH
Proxy Measures as presented on March 22	Dr. Tom McCrorey, HCGP Medical Director, APH
11:10 – 11:45	
V. New Transportation Vendor	Rochelle van der Poel, MA 2
Medical Transportation Management (MTM)	
11:45 – noon	
VI. Contact Compliance Report	John Kucera, MA3, DHCFP

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III. HCGP Program Update

- Executive Director Comments
- Program Development and Rural Initiatives

III. Program Updates

Executive Director Comments

- Collaboration with county EMS to support July 1 launch of Community Paramedicine
- Support Department of Health and Human Services in identifying and engaging "group home" and/or vulnerable population
- Support DHCFP Behavioral Health unit with Emergency Department initiative
- Designed, produced and delivered preliminary results and outcomes: developed four "White Papers" – Utilization, Care Alerts, Immunization and Oncology
- Organized and produced Quality Assurance Report
- Leadership rural "road trip" – Winnemucca, Battle Mountain, Elko, Ely, Austin, Eureka
- Developed stand-alone HCGP Website

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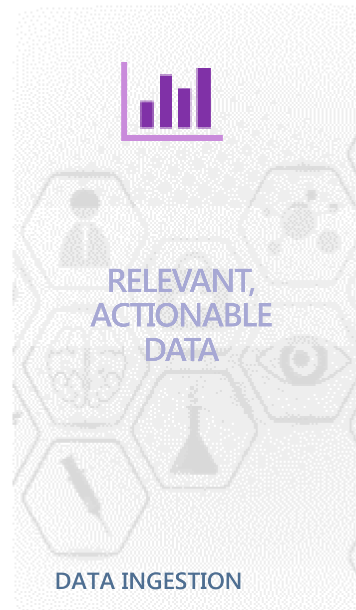
III. Program Updates

Program Development



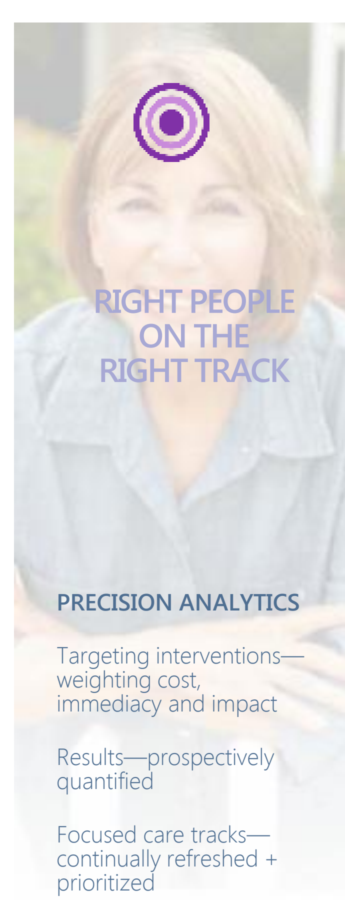
RELEVANT, ACTIONABLE DATA

DATA INGESTION

Big data made relevant

Actionable and impactful

Driving understanding of the whole person - 360



RIGHT PEOPLE ON THE RIGHT TRACK

PRECISION ANALYTICS

Targeting interventions—weighting cost, immediacy and impact

Results—prospectively quantified

Focused care tracks—continually refreshed + prioritized

SPECIALIZED TEAM WHERE & WHEN NEEDED

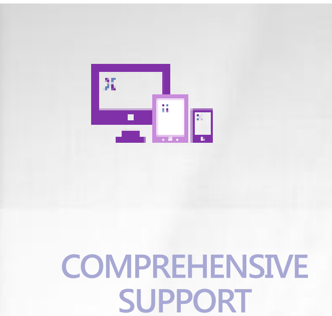
FULL SPECTRUM ENGAGEMENT

Care team composition tailored to the person through best fit algorithms

Care circle active as advocate/sentinel

Social + behavioral health upfront

365 accurately guided success—boots on the ground to the cloud



COMPREHENSIVE SUPPORT ANYWHERE, ANYTIME

DIGITAL HEALTH CENTER

Dual experience tailored to the person + care circle

Social, interactive supportive experience

Connected wireless biomonitoring

"In the moment" reminders, encouragement, and recognitions

PROVEN, QUANTIFIED RESULTS

PREDICT, ASSESS, IMPROVE

KPIs—transparent + actionable

Engagement

Outcomes

ROI

Satisfaction

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III. Program Updates

Program Development

Health Coach
Social Worker
Nurse Generalist
Behavioral Health
Substance Abuse

Nurse Specialist
Pharmacist
Behavioral Health Specialist

The Right Team In the Right Place

Person + care circle with their medical team at the center

Full spectrum of support addressing physical, behavioral, social + spiritual needs

Specialized "finders" to track down contact information

Boots on the ground to the cloud across all care settings

Omni-channel communication

Driving productive engagement

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IV. Quality

- Executive Summary
- Module 2, Goal #1 (1.1-1.5)
- Module 3, Goal #2 (2.1-2.4)

IV. Quality:

AXISPOINT HEALTH

Executive Summary – April 2016 (Rolling 12 mo)

HCGP Monthly Enrollment

Maximum = 41,500

Minimum = 37,000

Mar-15 Apr-15 May-15 Jun-15

Case Manager-to-Enrollee Ratio

Risk Level	# Enrolled	# Care Mngrs	Contract Ratio	Actual Ratio	Notes:
Complex (RL4)	324	5	1:75	65	Fully Staffed
High (RL3)	2299	29	1:186	215	2,299 / 186 = 12 FTE 3,927 / 244 = 16 FTE 28 Req FTE vs 29 Current FTE HCGP has x4 Open Req's
Moderate (RL2)	3927		1:244		
Low (RL1)	30340	A Care Manager is assigned upon escalation to a higher risk level			

Glossary:

Enrollment: all members meeting both the Milliman and APH inclusion criteria.

Actively engaged member: a member who has an active Care Plan.

Engagement rate: the percentage of members enrolled at that risk level which
have an active care plan.

Engagement rate calculation: Members with an active Care Plan/ total members enrolled

Contact Target Calculations:

Formula: ((RL Enrollment x % by RL)(RL Frequency))

	Face-to-Face	Telephonic
RL4	25% / 4 weeks	60% / 4 weeks
RL3	20% / 6 weeks	50% / 6 weeks
RL2	15% / 8 weeks	35% / 8 weeks
RL1	No Requirement	25% / 6 months

Active Care Plan Trend - by Risk Level
% of enrolled

RL4
RL3
RL2
RL1

Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16

Mar-15 Apr-15 May-15 Jun-15

HCGP Monthly Enrollment Total and by
HCGP Monthly Enrollment Total and by

Total cumm. unique members in monthly files
|
Total eligible in current monthly file
|
Total Identified using Milliman Criteria
|
Total program enrollees following APH Impactability/ Risk Analysis

Monthly Identification & Stratification

Total Cumm. Members
Total_ elig_ members
Total_ identified
Total Enrolled

Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16

- Source: Business Insight

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IV. Quality:

Quality Module #2, Goal #1 (1.1 – 1.5)
Presented in Jan-2016

- Objective 1.1: Successfully enroll all Medicaid beneficiaries who qualify for the NCCW program.
- Objective 1.2: Stratify all enrollees into case management tier according to assessed needs.
- Objective 1.3: Complete a comprehensive assessment of enrollees with complex or high risk needs.
- Objective 1.4: Complete a comprehensive assessment of enrollees with moderate or low risk needs.
- Objective 1.5 Increase utilization of primary ambulatory, and outpatient care for enrollees with chronic conditions

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IV. Quality:

Objective 1.1 Successfully enroll all Medicaid beneficiaries who qualify for the NCCW program.

HCGP Enrollees

39,000
38,000
37,000
36,000
35,000
34,000
33,000
32,000
31,000

Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15

Existing New

Source: Business Insight

IV. Quality:

Objective 1.2 Stratify all enrollees into case management tier according to assessed needs.

Enrolled vs. Active Case Management
All Risk levels

45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-

Enrolled, Active CM — Dec-14, Jan-15, Feb-15, Mar-15, Apr-15, May-15, Jun-15, Jul-15, Aug-15, Sep-15, Oct-15, Nov-15

1-Low | 2-Moderate | 3-High | 4-Complex

Source: Business Insight

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IV. Quality:

Objective 1.2 Stratify all enrollees into case management tier according to assessed needs.

Enrolled vs. Active Case Management: Risk levels 2, 3, and 4 Only

Per the RFP 3.1.6-2 A Care Manager is not assigned to Low RL1 member until they are escalated to a higher risk level

0, 1000, 2000, 3000, 4000, 5000, 6000, 7000, 8000

Enrolled, Active CM: December, January, February, March, April, May, June, July, August, September, October, November

2-Moderate, 3-High, 4-Complex

Source: Business Insight

THE NEW MANAGERS OF CARE

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IV. Quality:

Objective 1.3 & 1.4 Complete a comprehensive assessment of enrollees at each Risk Level

Persons Enrolled and Served in the HCGP

Categories	Number of Persons Ever Enrolled	Number of Persons Ever CM Assessed	Percent of Total Enrolled Who were CM Assessed	Avg # of Days Between Case Open and CM Assessment	Avg # of Days Between Enrollment and CM Assessment
Complex (4)	744	363	49%	32.0	157.9
High (3)	7832	2134	27%	28.3	157.8
Moderate (2)	4731	2153	46%	22.4	161.5
Low (1)	55739	2223	4%	13.2	136.2
All RL	69,046	6,873	10%	24.0	153.3
RL 2-4	13,307	4,650	35%	27.6	159.0

Source: Business Insight

- # of Days Enrollment-to-Assessment calculations are unreliable:
  - Changes in eligibility create eligibility spans
  - Eligibility spans create new ‘start dates’
  - When calculating “# of days” metrics, new start dates create negative values because the assessment date occurs before the enrollment date
  - Negative values artificially decrease our “# of days” metric
  - The only way to avoid negative values is to always reference the original enrollment date
  - Using the original enrollment date then causes the opposite challenge, artificially increasing our “# of days” metric

- # of days Case-to-Assessment is the Industry/NCQA Standard for Complex Case Management

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IV. Quality:

Objective 1.5 Utilization of Primary and Outpatient Care

- Real time referrals
  - Paramedicine partnerships
  - Ongoing rural outreach

- **Utilization** - Continuous tracking of 11 industry standard metrics around utilization. Examples include;

Metric	Program Goal	Projected	Comment
ED Visit Rate	Decrease	Decrease	- Access challenges across Nevada remain unchanged.
Ambulatory Rate	Increase	No Change	- Ambulatory and Office visits may remain unchanged.
Office Visits	Increase	No Change	- Increases need for member education and self-care.
RX Script Rate	Increase	Increase	- Self-care leads to higher RX costs due to increase in RX script compliance.

- **Source: Operational Data Set**

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AXISPOINT HEALTH

IV. Quality:

Goal 2: Improve the quality of care that high-cost, high-need Nevada Medicaid beneficiaries in FFS receive through care management and financial incentives such as pay for performance (quality and outcomes).

Objective 2.1:	Increase use of preventive services by 10%
Objective 2.2:	Increase follow-up ambulatory care visit after hospitalization by 10%
Objective 2.3:	Increase patient compliance with anti-depressant medication treatment protocols by 10%
Objective 2.4:	Increase use of best practice pharmacological treatment for persons with chronic conditions by 10%

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AXISPOINT HEALTH

IV. Quality:

Objective 2.1 Increase use of preventive services by 10%

Primary Care	Preventive Screening Measure	April-2015	April-2016
Well-Child Visits (NP/12m-19y/CAP)	Received one or more PCP visit	81%	93%
Prenatal Visits (NP/FPC.5)	Received over 80% of expected visits	1%	4%
PCP or OB/GYN (NP/12-21y/AWC)	Woman has had at least one PCP visit	23%	30%

Cancer Screening	Preventive Screening Measure	April-2015	April-2016
Breast (NP, BCS)	Received screening mammography	41%	38%
Cervical (NP, CCS)	Received Pap smear	30%	34%
Colorectal (NP, COL)	Received sigmo- or colono- scopy, stool test	15%	22%

Chronic Condi Mgmt	Clinical Measure	April-2015	April-2016
Diabetes (P/CDC.1)	HgA1C	57%	59%
Diabetes (P/CDC.4)	Eye Exam	82%	92%
Diabetes (P/CDC.2)	LDL-C	53%	57%
Diabetes (P/CDC.3)	Neuropathy	65%	70%
CAD (P/CAD 2)	LDL-C	60%	54%

APR-2015 Reporting using Modified HEDIS calculations / APR-2016 Standard HEDIS Calculations PRELIMINARY RESULTS

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IV. Quality:

Objective 2.2 Increase follow-up ambulatory care visit after hospitalization by 10%

Condition	Age Group	Measure	April-2015 *Modified HEDIS*	April-2016
Asthma (P/ASM 4)	All	Follow-up within 7 days	23%	29%
Coronary Artery Disease (P/CAD 3)	All	Follow-up within 7 days	33%	33%
Congestive Obstructive Pulmonary Disease (P/SPR 3)	All	Follow-up within 7 days	29%	26%
Heart Failure (P/HF4)	All	Follow-up within 7 days	30%	29%
Mental Health (P/MH4.2)	6+	Follow-up within 7 days	NEED DATA	22%
Mental Health (P/MH4.1)	6+	Follow-up within 30 days	NEED DATA	33%

APR-2015 Reporting using Modified HEDIS calculations / APR-2016 Standard HEDIS Calculations PRELIMINARY RESULTS

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IV. Quality:

Objective 2.3 Increase patient compliance with anti-depressant medication treatment protocols by 10%

Condition	Age Group	Measure	April-2015	April-2016
Bipolar I (P/MH.1)	All	Mood Stabilizer at least 80% of time	NEED DATA	22%
Major Depression (P/MH.2)	All	Antidepressant for at least 84 days	NEED DATA	11%

APR-2015 Reporting using Modified HEDIS calculations / APR-2016 Standard HEDIS Calculations PRELIMINARY RESULTS

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IV. Quality:

Objective 2.4 Increase use of best practice pharmacological treatment for persons with chronic conditions by 10%

Condition	Age Group	Measure	April-2015 *Modified HEDIS*	April-2016
Ischemic Stroke or TIA (NP/NEUR)	18+	Antithrombotic Therapy	NEED DATA	12%
Rheumatoid Arthritis (NP/RA)	18+	DMARD	61%	65%
Persistent Asthma (P/ASM1)	5-64	Prescribed?	75%	73%
Coronary Artery Disease (P/CAD 1)	All	Lipid Lowering Agent	54%	63%
Acute Myocardial Infarction (P/HF1)	18+	Beta-Blocker	41%	49%
Heart Failure (P/HF3)	18+	ACEIs or ARBs with monitoring test	100%	71%
Osteoporosis (NP/OST)	67+	Prescribed?	NEED DATA	12%
Hypertension (P/HPTN1)	All	Multi-drug therapy including a thiazide diuretic	NEED DATA	40%
Schizophrenia (P/MH3.1)	6+	Antipsychotic (6 months)	NEED DATA	54%
Schizophrenia (P/MH3.2)	6+	Antipsychotic (12 months)	NEED DATA	14%

APR-2015 Reporting using Modified HEDIS calculations / APR-2016 Standard HEDIS Calculations PRELIMINARY RESULTS

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IV. Quality:

Progress made since Aprill-2015

- Jan-2016, HCGP obtained access to WebIZ immunization data!

Condition	Age Group	Measure	April-2015 *Modified HEDIS*	April-2016
Preventative: Childhood Immunization Status	2 Years	DTaP vaccines	NEED DATA	**52.0%**
		IPV vaccines	NEED DATA	**64.9%**
		MMR vaccine	NEED DATA	**64.7%**
		HiB vaccines	NEED DATA	**63.9%**
		HepB vaccines	NEED DATA	**65.5%**
		VZV (varicella) vaccine	NEED DATA	**65.3%**
		PCV vaccines	NEED DATA	**52.4%**
		HepA vaccine	NEED DATA	**65.2%**
		RV vaccines	NEED DATA	**53.7%**
		Annual Influenza vaccines	NEED DATA	**33.3%**

APR-2015 Reporting using Modified HEDIS calculations / APR-2016 Standard HEDIS Calculations PRELIMINARY RESULTS

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IV. Quality:

Proxy Measures as Presented on March 22nd

- Pharmacy Alerts and Their Impact on Prescriber Behavior for a Subset of Nevada's Fee-for-Service Population
- Influenza Immunization Compliance, 2014 and 2015: Members Enrolled with an Active Care Plan vs. Members Enrolled, No Active Care
- Care Management's Influence on Inpatient and Emergency Department Utilization for Engaged Oncology Patients
- Operational Utilization Metrics - June 2014 to November 2015: Total Overall Costs, Emergency Department, Inpatient Admission, Medication Expenditures

NOTE: Results presented today have been internally vetted by APH research professionals. Be advised that no 3rd party validation has been deployed. However, we are confident in the rules and data extraction methods were applied.

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IV. Quality:

Pharmacy Clinical Care Alerts (CCA)

- CCAs are designed to target pharmacy "gaps in care"
  - Identified by pharmacy claims data
  - Letters are sent to every pharmacy and prescriber identified for individual HCGP member
- CCA alerts began in March 2015. However, the "look back period" was longer at the start of the program; initial alerts are artificially elevated.
  - Month three (May 2015) is considered the Baseline Month
- Alert rates lower than the baseline month especially after Month six and seven (September and October of 2015) are considered improved prescribing practices

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IV. Quality:

Pharmacy Clinical Care Alerts (CCA)

Total alerts per thousand enrollees

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IV. Quality:
CCA Early Discontinuation Alerts

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IV. Quality:
CCA Polypharmacy Alerts

polypharmacy per thousand enrollees

4
3.5
3
2.5
2
1.5
1
0.5
0

May | June | July | August | September | October | November | December | January | February

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IV. Quality:

CCA Pediatric Alerts

pediatric age limits per thousand enrollees

0.6
0.5
0.4
0.3
0.2
0.1
0

May June July August September October November December January February

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IV. Quality:
CCA Drug-drug Interactions Alerts

drug-drug interactions per thousand enrollees

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IV. Quality:
CCA Overuse Alerts

overuse per thousand enrollees

0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0

May June July August September October November December January February

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IV. Quality:

CCA Summary

- In every category the alerts have decreased as a percent of the population
- This is at least partly due to better prescribing practices in the alert category
- This effect is likely transferred to patients with other payment sources

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IV. Quality:

HCGP Utilization Metrics –June 2014 to November 2015– 18 months of Data

- Population financial metrics commonly used by payers
- Both arms of the study are continuously eligible members therefore not influenced by population churn
- Generated using *unreconciled* Medicaid claims data
  - Likely the last few data points will see an increase
  - Comparison between the two populations is legitimate as both should see an increase

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IV. Quality:

Utilization Metrics – Per Member Per Month

Trend Population - PMPM

$500
$450
$400
$350
$300
$250
$200
$150
$100
$50
$-

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

PMPM
12 per. Mov. Avg. (PMPM)
6 per. Mov. Avg. (PMPM)

HCGP - PMPM

$1,200
$1,000
$800
$600
$400
$200
$-

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

PMPM
6 per. Mov. Avg. (PMPM)
12 per. Mov. Avg. (PMPM)

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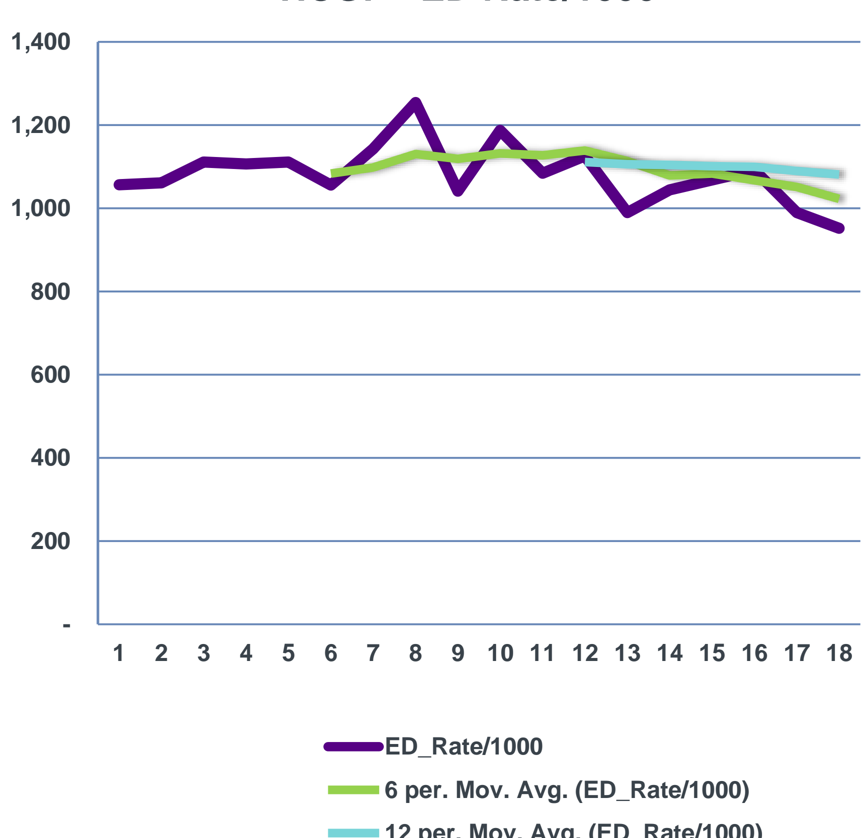
IV. Quality:

HCGP Utilization Metrics –Emergency Visits



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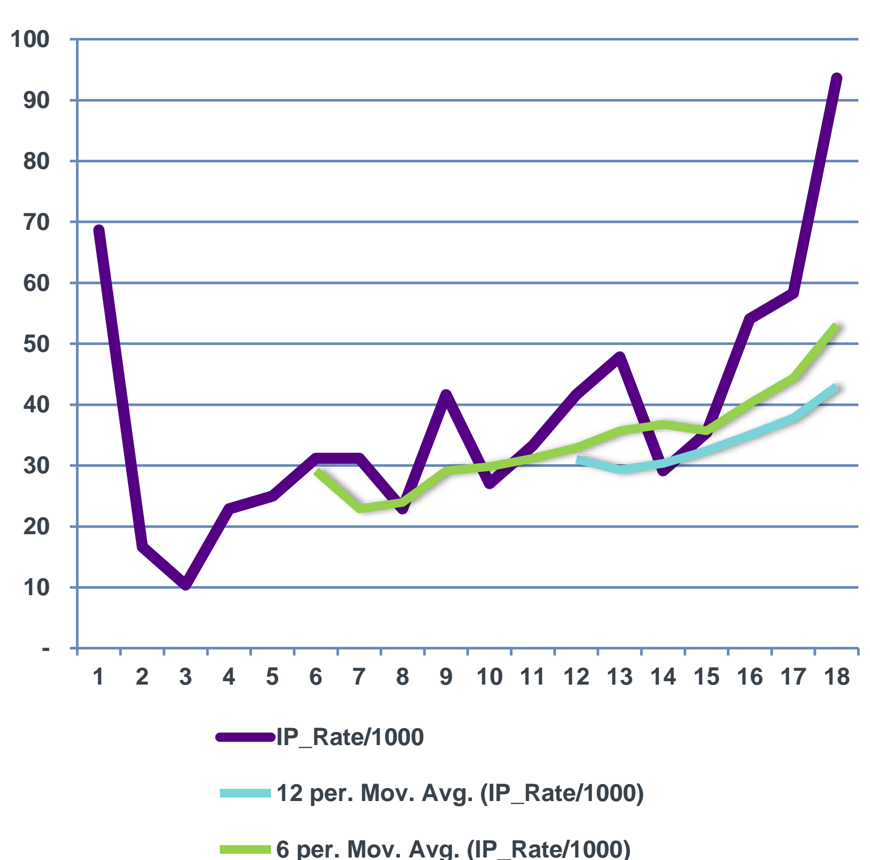
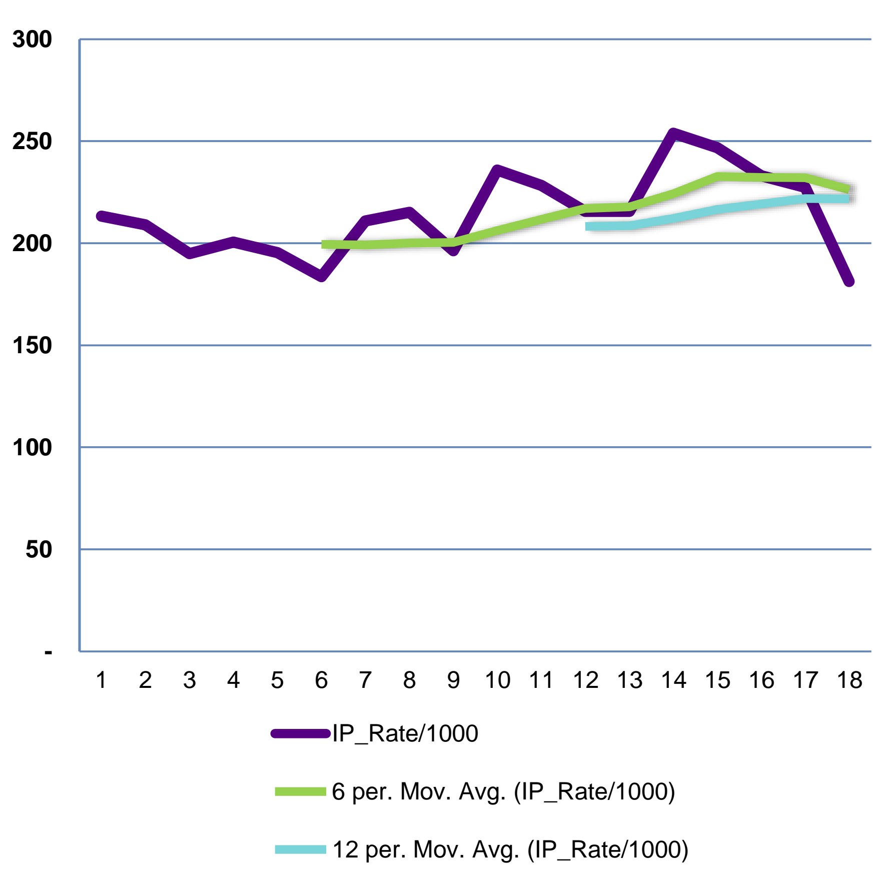
IV. Quality:

HCGP Utilization Metrics – Inpatient Admissions





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IV. Quality:

HCGP Utilization Metrics – Drug Expenses

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IV. Quality:

HCGP Utilization Metrics Summary

- Three out five operational metrics show better performance by the HCGP vs the trend population

- Pharmacy utilization is flat and may be partly due to the CCA program

- ED utilization is flat in both cohorts; acceptable performance but further improvement will be sought.

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IV. Quality:

HCGP Influenza Immunization Compliance

- Promoting immunizations is an important part of public and population health and a goal of the Health Care Guidance Program
- A comparison was made between HCGP members who had an active care plan, and those who did not
- Influenza immunization of the entire HCGP population was evaluated using claims data and Nevada immunization data base (WebIZ)
- The numbers shown are lower than reality because both databases are incomplete, but comparison between the groups is valid
- High risk members of the program were encouraged to immunize (by IVR and mailings) even if there was no active care plan

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IV. Quality:

HCGP Influenza Immunization Compliance

Influenza Immunization Compliance 2014 - 2015

	Immunized w/ Care Plan	Immunized, No Care Plan
2014	25%	11%
2015	28%	11%

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IV. Quality:

HCGP Influenza Immunization Compliance

- It is clear that members with an active care plan, are much more likely to have received their immunizations
- This data does not validate nor invalidate the effectiveness of the automated IVR outreach versus no IVR outreach

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IV. Quality:

Care Management Effect on Oncology Patients Inpatient and ED Use

- Study analyzed HCGP members in active cancer treatment (chemotherapy and radiotherapy)
- Measured the Inpatient and ED utilization before the study period and during.

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IV. Quality:

AXISPOINT HEALTH

Care Management Effect on Oncology Patients Inpatient and ED Use

Inpatient Admissions Rate

1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0

pre IP admits per member
post IP admits per member

Active Care Plan
No Active Plan

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IV. Quality:

AXISPOINT HEALTH

Care Management Effect on Oncology Patients Inpatient and ED Use

ED Admissions Rate

1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0

pre ED admits per member
post ED admits per member

Active Care Plan
No Active Care Plan

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IV. Quality:

Care Management Effect on Oncology Patients Inpatient and ED Use

- Cancer patients in active care management is less likely to be admitted to the hospital or the Emergency Department

- Results show that care manager interventions may:
  - Help compliance with the oncology care plan
  - Decreases anxiety about side effects
  - Advocates early intervention before a problem worsens

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III. Program Updates

Program Activities for Q4

- Continue collaboration with Community Paramedicine stakeholders
- Determine process and timing for 2-year renewal of HCGP contract
- Commence Reconciliation process
  - Determine timing with Milliman
  - Secure data requirements
- Begin discussions on Contract Amendment # 5
  - NAL/GuidePoint language revisions
  - Member Communication update
- Determine stakeholder communication opportunities for:
  - Cost Savings/Budget Neutrality
  - Program goals achievement

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Nevada Health Care Guidance Program (HCGP)
Provider Advisory Board (PAB) Quarterly Meeting
AGENDA

Teleconference: https://axispointhealth.globalmeet.com/ThomasMcCrorey
tel://1-719-234-7800,*,766666#
Date: Thursday, April 28th, 2016; 12 Noon – 3 PM Pacific Time

	Members		**AxisPoint Health**		**Beacon Health Options**		**Invited Guests**
	Dr. Tom Hunt	x	Dr. Thomas McCrorey	x	Dr. Ryan Ley		
	Dr. Lisa Durette	x	Cheri Glockner	x	Dr. Sanjay Vaswani		Betsy Aiello, NV DHCFP Deputy Administrator
			Angela Cave-Brown		Erin Snell		
x	Dr. Katherine Keeley					X	Gladys Cook, NV DHCFP
	Ms. Holly Hansen						Dr. Tim Moore, AxisPoint Health Chief Medical Officer
x	Taylor Ann Johnson, NP						
	Dr. Nicole Pavlatos						
x	Dr. Aditi Singh					X	John Kucera, NV DHCFP

X = Indicates Meeting Attendance

Agenda:

Topic	**Discussion Items/Actions**
12:00 PM: Call to order (Chair) • Welcome new members and guests • Introductions (All)	Introductions made. Special Guest Dr. Sanjay Vaswani, Western Chief Medical Officer for Beacon Health Options
12:10 PM Lunch served	
12:20 PM: • Presentation on Nevada's Provider Shortage and Roseman University New School of Medicine (Dr. Tom Hunt)	Brief discussion about the expansion from 2 to 4 medical schools and the need for increased residency slots
1:00 PM Presentation: Update on Nevada Medicaid's Care Management Organization (Dr. Thomas McCrorey) •	Intended to give a thorough understanding of the workings of the care management program to allow PAB members to best assist the program
2:20 PM: Topics of discussion (Dr. Thomas McCrorey) • Encouraging providers to practice in NV • MCO Expansion • Rural Shortages • Mental health provider shortage • Provider outreach --focus ? • Communication from me? • Activities that you would like to see and participate in.	lots of interest in the MCO expansion--thought it was a done deal. a lot of unhappiness with the HPN and Amerigroup. --encouraged to contact state Medicaid and Legislators to inform them. discussion by John Kucera --Keeley: issues with not getting on panels- and not clear GL --may want to discuss with HP at next PAB

	--interest in having regular news from the HCGP and Medicaid. Will make intermittent email "news" blasts
2:50 PM: Topics for Future Meetings (All)	• Please email Dr. Thomas McCrorey
3:00 PM: Meeting adjourned	• Next Dates TBD, Location will be Northern Nevada or Web based.

Attachments:

A: HCGP update and overview for PAB.
B: Roseman intro-healthcare.

HCGP Quarterly Meeting April 26, 2016

Location: Division of Public & Behavioral Health (DPBH)
4150 Technology Way, Suite 303 (3rd Floor)
Carson City, Nevada 89706
Phone Number: 877-336-1829 Access Code: 8793897

9:00 am – 9:20 am
I. Welcome and Introductions — Gladys Cook, SSPS 3

9:20 am – 9:30 am
II. Approval of Minutes — Gladys Cook, SSPS 3

9:30 am – 10:10 am
III. Program Updates
- Executive Director Comments — Cheri Glockner, HCGP Executive Director, APH
- Program Development and Rural Initiatives — Dr. Ron Geraty, CEO, APH

10:10 am – 10:25 am BREAK

10:25 am – 11:10 am
IV. Quality
- Quality Module #2 and #3, Goal #1 (1.1 – 1.5) — Michelle Searing, Client Program Manager, APH
- Proxy Measures as Presented on March 22 — Dr. Thomas McCrorey, HCGP Medical Director

11:10 am – 11:45 am
V. New Transportation Vendor — Rochelle van der Poel, MA 2
- Medical Transportation Management (MTM)

11:45 am – 12:00 pm
VI. Contact Compliance Report — John Kucera, MA 3, DHCFP

*DIRECTIONS: For those who will be teleconferencing for this meeting, please call at the time scheduled for your agenda item. The dial in number is 877-336-1829. Key in the Pass Code 8793897.

* Should you need assistance during your conference, please press *# for a list of menu options and *0 to obtain Specialist assistance.

Nevada's Physician Shortage And the Transformation of Medical Education in Southern Nevada

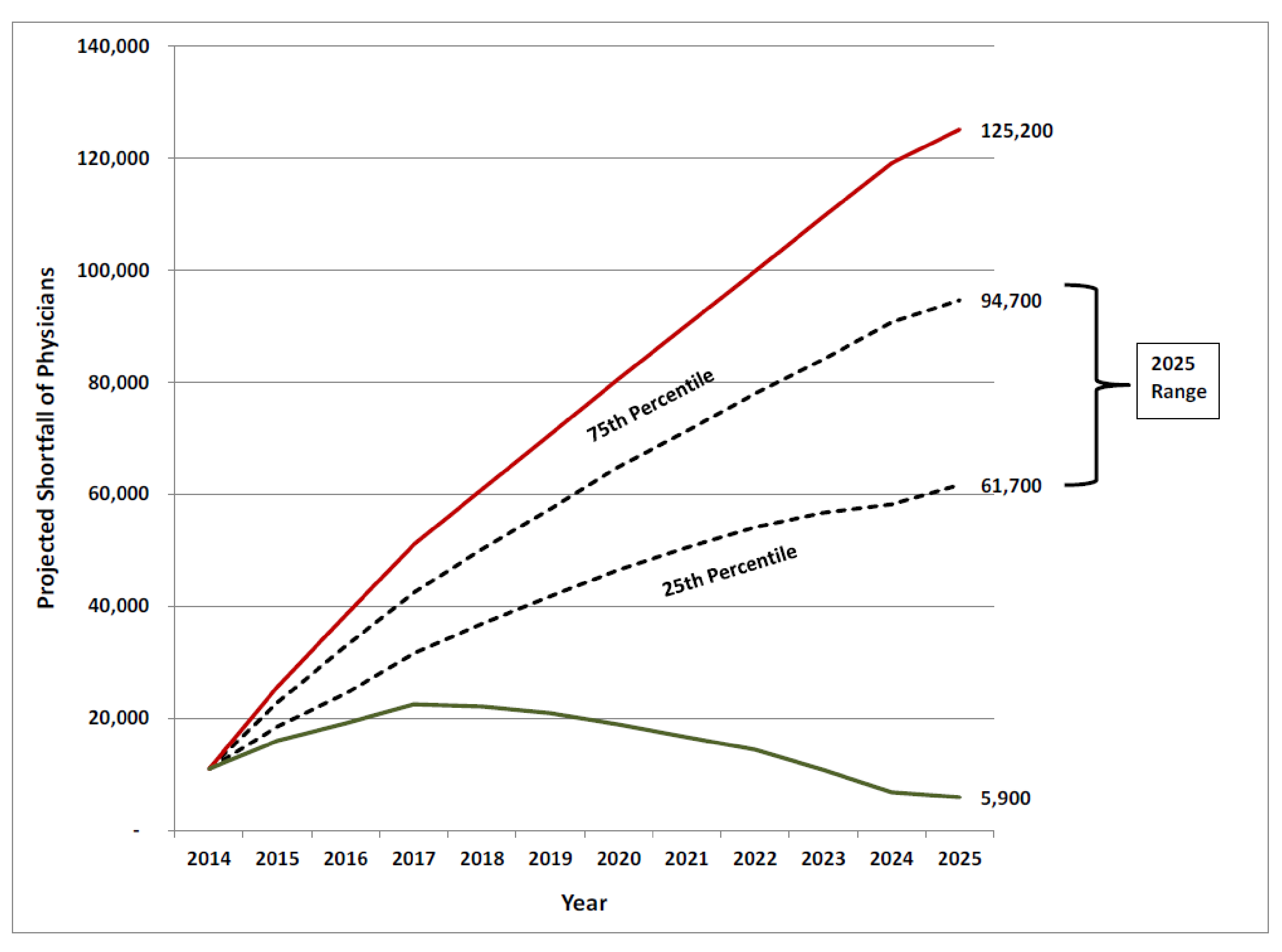
Thomas Hunt, MD

Professor and Chair, Family Medicine

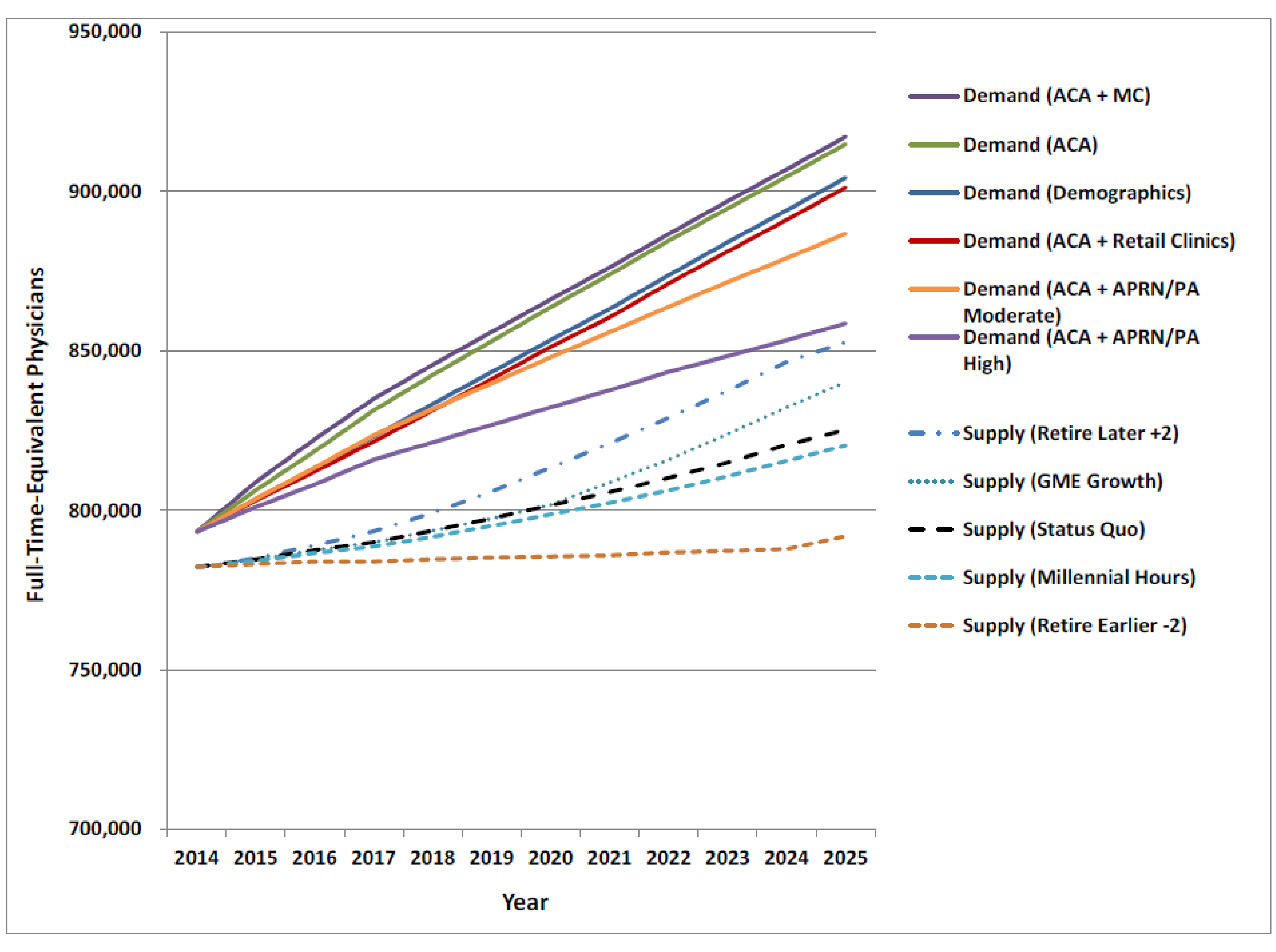
Roseman University College of Medicine

Nevada's Physician Shortage

Projected US physician shortfall



Supply and Demand



How to address

Expansion of Medical school class size

AAMC Calls for 30 Percent Increase in Medical School Enrollment-2006

Add new medical schools

- Today’s growth of new medical schools has not been seen since the late 1960s.
- No new medical schools accredited in the United States from 1986 until 2005.
- **2005-2012:** 17 new schools were accredited.
- **2012-2015:** 4 schools
- **Today:** 7 schools (2 in Nevada) are in process of accreditation

Scope of problem in Nevada

- **1980**: 1,171 physicians in Nevada
- **2012:** 6,153 physicians in Nevada
- **Nevada's physician-to-population rank among U.S. states dropped from 36th to 47th during the same time period.**

Nevada’s physician shortage by the numbers

Number needed to meet **regional** number of Family Medicine MDs per capita	285
Number needed to meet or exceed the **national** number of psychiatric MDs per capita	172
Number needed to meet or exceed the **national** number of patient care MDs per capita	2,235
Nevada has 194.3 active physicians per 100,000	US rate of 260.5 active physicians per 100,000 population

Other considerations

Other Variables	
Nevada MDs over the age of 65	25.2%
Nevada MDs trained overseas (IMG)	33.3%
Percentage of Physicians who went to Med school and residency in Nevada who practice here	79.1% (though only is 167 total physicians or 2.7% of active workforce)

What about GME?

- GME-Graduate Medical Education
- Studies show that doctors stay where they train
- Nevada has a rate of only 10.1 residents and fellows per 100,000 population in ACGME-Accredited programs
- 46th among US states

What are we doing about this problem here in Southern Nevada?

3 Medical Schools in Clark county

- Roseman-Private, not for profit
- UNLV/UNSOM-Public
- Touro – existing Osteopathic school

New hospital based residencies and fellowships

- UHS
- HCA/Mountain View
- Dignity

$10 million in state funds allocated last biennium

Roseman University

Roseman University of Health Sciences

Founded 1999 in Henderson, NV

Private, not-for-profit

Nevada-based (and now Utah)

Institution of higher education focused on health professions

- Pharmacy
- Nursing
- Dentistry
- MBA
- Orthodontic Dental residency

CLASSROOM AS TEACHER

Classroom design and layout assures that every student is in close proximity to the instructor, to facilitate learning and encourage student participation.

BLOCK CURRICULUM

Students focus on one academic subject at a time, and must demonstrate competency at 90% or higher to pass.

EARLY EXPERIENTIAL LEARNING

Early exposure to clinical experiences enhances and supports learning in the classroom by providing students the opportunity to see, feel, and understand what is taught in the classroom in an actual healthcare setting.

ROSEMAN UNIVERSITY OF HEALTH SCIENCES

MASTERY LEARNING

Class time incorporates a variety of activities to encourage participation and foster student interest, including discussions, case presentations, simulations, debates, group projects, role-playing, seminars, workshops and more.

ACTIVE & COLLABORATIVE LEARNING

Class time incorporates a variety of activities to encourage participation and foster student interest, including discussions, case presentations, simulations, debates, group projects, role-playing, seminars, workshops and more.

ASSESSMENT LEARNING

Learning, assessment, feedback and re-assessment are ongoing and continuous, allowing students to gauge their learning and detect areas of misunderstanding early.

COMPETENCY-BASED EDUCATION

Students are measured on criterion-referenced test achievement, not against the performance of others.

VALUES

COLLEGE OF MEDICINE VALUES

COM**P**ETENCE
COMP**A**SSION
IN**T**EGRITY
D**I**VERSITY
RESP**E**CT
COMMU**N**ICATION
COMMUNI**T**Y
DI**S**COVERY

Roseman College of Medicine LCME accreditation targets

- Candidate status paperwork submitted 7/2015
  - Reviewed and Granted 10/2015
- Preliminary Accreditation Site Visit 2/2016
  - Decision 6/2016
- Matriculate first class 8/2017
- Graduate charter class 5/2021

The Upcoming Transformation of Medical Education in Southern Nevada is Unheralded!

College of Medicine

Thomas Hunt, MD
Professor and Chair, Department of Family Medicine
Roseman University College of Medicine

References

https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf

Packham, J., Griswold, T., Etchegoyhen, L., and Marchand, C. (2014). *Physician Workforce in Nevada – 2014 Edition*. Reno, NV: Office of Statewide Initiatives, University of Nevada School of Medicine.

Health Care Guidance Program Meeting Minutes, Face to Face **Date: 04/26/2016**

DHCFP Attendees: Gloria Macdonald, Tracy Palmer, Janice Hadlock-Burnett, Gladys Cook, Rachel Marchetti, John Kucera, Heather Lazarakis, Linda Bowman, Shawna Vollmer, Rochelle van der Poel, Lisa Koehler, Andrew Rico, Margaret Dillon, Raul Martinez

Organization Attendees: HCGP: Angela Cave Brown, Margaret Flaum, Patricia Regan, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Kris Wilson, Summer Smith, Michelle Searing, Brian Baker, Erin Snell, Dr. Ryan Ley, Mary, Stephanie White, Lorna Lizotte **HSAG:** Gretchen Thompson **MTM:** Stacey Brune

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
Welcome and Introductions **Approval of Minutes** **Program Updates**	**Welcome and Introductions** • Gladys Cook, Social Services Program Specialist III, Program Research & Development (PRD) opened the meeting **Approval of Minutes** • There were corrections made and the minutes were approved. **Program Updates** • Cheri Glockner, Health Care Guidance Program (HCGP) Executive Director, AxisPoint Health (APH) presented program updates. She called to attention a few things that they have been spending time on as a program. First of which, working with the community paramedicine launch. Cheri and Dr. McCrorey have now met with three departments and they will be meeting with Las Vegas soon. There are still some processes that need to be worked out in particular some of the referral things that will need to occur and the logistics of that. Cheri and Dr. McCrorey have been to two hearings and actually made a suggestion at the last one that was taken into account for the community paramedicine. Secondly, they're pleased and honored to have been asked to work immediately with everyone on the group home initiative which they refer to as the vulnerable population and she thanked Beacon for going out to find the 1,869 people population. Also, they worked with Betsy Aiello and Alexis Tucey on the ED workflow for the behavioral health placing. They worked with the MCOs. Cheri and Dr. McCrorey attended meetings with Alexis and they have two more coming up. Per Gloria's and Betsy's request at the last quarterly, they worked hard on producing some white papers to show outcomes and results which she planned to go over. They worked on the quality assurance report and she thinks that it'll serve as a good road map for them as they move forward. Cheri, Dr. McCrorey and team members did a rural truck and met with providers, hospitals, and case managers. They are getting closer to launching their standalone website			

Health Care Guidance Program Meeting Minutes, Face to Face 04/26/2016	Date:

DHCFP Attendees: Gloria Macdonald, Tracy Palmer, Janice Hadlock-Burnett, Gladys Cook, Rachel Marchetti, John Kucera, Heather Lazarakis, Linda Bowman, Shawna Vollmer, Rochelle van der Poel, Lisa Koehler, Andrew Rico, Margaret Dillon, Raul Martinez

Organization Attendees: HCGP: Angela Cave Brown, Margaret Flaum, Patricia Regan, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Kris Wilson, Summer Smith, Michelle Searing, Brian Baker, Erin Snell, Dr. Ryan Ley, Mary, Stephanie White, Lorna Lizotte **HSAG:** Gretchen Thompson **MTM:** Stacey Brune

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	for the HCGP. Cheri turned it over to Dr. Tim Moore so he could talk about things that APH is doing, some initiatives that they can maybe bring into the HCGP to help with engagement and some of those things. • Dr. Tim Moore, Chief Medical Officer, APH spoke about using data to figure out for specific people what interventions can drive an outcome and which people you should focus on versus which people you shouldn't focus on. He went on to identify five areas in which they are working on. The first pillar of this is using the data better than they have before and being able to look through data sets to identify who they should focus on. They're working on revamping the whole way that they'll be identifying and focused on people in the future. Secondly, they need to make sure that the people that they identify for intervention are getting the right interventions. The third area is to make sure that people are going to see the person that they connect with the best that will lead to the best outcome. The fourth area, that's really important, is figuring out that people have different ways that they want to connect with them that is through social networks, mobile technology, etc. They are looking at all those different modalities to deliver their services. The fifth area is the whole data analysis side which he admits APH has not been as good as it should have been. He went on to speak about having a primary care team composed of health workers, social workers, nurse generalists, behavioral science and substance abuse because those are the issues that they are dealing with. They also want to have a specialty group that can serve as support to the primary care team that would include specialized nurses for diabetes, cardiac or neonatology problems, pharmacists, and behavioral health specialists just to name a few for example. They're undergoing a lot of these changes right now and they'll start putting the changes into their platform so that they can execute it by the first part of next year. He concluded his presentation.			

Health Care Guidance Program Meeting Minutes, Face to Face **Date: 04/26/2016**				
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Quality	• Gloria Macdonald, Chief , PRD had a question in regards to the primary care team. She asked if the team is going to be focused on level 4? • Dr. Moore responded by saying that the primary care team will be focused on all of the levels and each group would still have a primary care manager, but it would be one that could work with them in the best way to solve their care gap that they have. He also commented that another big change that they are making on their platform is the ability to prioritize all of the people that they page with and manage on a daily basis for who's going to need that call or intervention to deliver the best result because when you are managing thousands of people most of the people on any one day don't need any intervention, but there is always a few people that they need to intervene on that day to help prevent a hospitalization. • Gretchen Thompson, MTM asked Dr. Moore how they are able to identify the members if it's not their claim, would it be through cold calling and reaching out doing an assessment of those people? • Dr. Moore responded that it would be through medical and pharmacy claims, specifically for medication the pharmacy claims will be the richest source of information because the pharmacy claims are the quickest to turn around and the most current anyway. They are also planning to take admission discharge information from hospitals. They're looking at multiple different data sources to help drive this including real time referrals from the provider networks and assessments created by the care manager. **<u>Quality</u>** • Michelle Searing, Client Program Manager, APH gave an update on quality and began her presentation by discussing the Executive Summary which included the latest data from March. She want over the first graph which showed enrollment vs. the minimum and maximum for the waiver and they were very pleased to report that they are above the minimum and			

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	have been above the minimum for the past couple of months. She went on to discuss high points of the rest of the data and then was open to questions. • Gladys Cook asked a question, in reference to the Real-time-Referrals (RTR), if they are ineligible are they put aside? Do they go back to into them? Also, on a monthly basis when they stratify the recipients do they check it and see if any of the RTRs are matches? • Michelle responded by stating that they do an immediate check and the RTRs do get put through the identification and stratification process in the next month and then they fall out or in. • John Kucera, Management Analyst III, Data Analytics added to the question by asking if that would be a way to manually put someone on the program? • Michelle responded yes and she concluded the Executive Summary by stating that she is always open to input. • Someone from HCGP asked if the reports are helpful to DHCFP? • John Kucera responded by stating yes, it is a good way to explain to Betsy Aiello, Deputy Administrator, for example. Especially, it gives her information when she has to report on the program to show how they get there. He also thought that it's a positive thing that they're being selective of people that they think they may be able to impact. • Gretchen Thompson expressed concern over the risk level 2 patients. • Michelle went on to speak about the Quality Module #2 by going over the power point slides which they re-presented from the January Quarterly meeting to provide the metrics and charts in exactly the way prescribed. Everyone went into discussion about getting more accurate data in regards to # of Days Enrollment-to-Assessment calculations. John Kucera commented that they aren't terribly picky with what they do as long as it's consistent and it makes sense. If they can pick a			

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	method that they can rely on the program and give numbers on and report in a consistent way, that's fine with them. Michelle continued to go over the power point slides. Everyone went into discussion about the measures and how they can be presented more clearly. Gretchen and Gloria provided feedback and made some suggestions in regards to making a spreadsheet that is more easily understood. Michelle agreed and concluded her presentation. • Dr. Thomas McCrorey, HCGP Medical Director, began his presentation on proxy measures. He said these are measures that they presented as a white paper. They have been presented formally to state leadership that was involved with the program. The program was designed to have formal results presented at a delayed period of time and they still do not have that completely done. All the people involved in the program want to have measures showing how effective the program is, interim measures or proxy measures, which are not the same measures as what are going to be formally used by the program per measurements. They produced four different white papers. First of which was the Pharmacy Clinical Care Alerts (CCA). Dr. McCrorey went over graphs that were provided on the power point presentation. Secondly, the Utilization Metrics which are population financial metrics commonly used by payers. Dr. McCrorey went over graphs that were provided on the power point presentation. Third, a small study targeted on the use of Influenza Immunization which is basically an adult and children vaccination program. The fourth and final is a study that looks at those people who have an active cancer treatment (chemotherapy and radiotherapy).			
Contact Compliance Report	**Contact Compliance Report** • John Kucera, Management Analyst III, Data Analytics, presented a contact compliance report in draft form. This report came from two data sources. The first is the monthly stratification report that lists all program members and their			

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	both, claims assigned risk level and their user assigned risk level if they're assessed. If it turns out that their assessed risk level is greater or less than their assigned risk level, one of the care managers would change it and that information is reflected on the stratification report. Secondly, on a monthly basis they also receive a raw list of completed members. • Dr. McCrorey commented that they all need to sit down to discuss how they can have accurate measures showing that they are doing the right thing and have a dialogue going forward to have a valuable useful metric that they both agree the methodology on.			
New Transportation Vendor	**New Transportation Vendor** • Rochelle van der Poel, Management Analyst II, Long Term Services & Support, introduced the new non emergency transportation vendor, Medical Transportation Management (MTM), who will replace LogistiCare as of July 1, 2016. • Stacy Brune, Manager, Business Implementation, presented a power point presentation about MTM's history and footprint.			

Sign-in Sheet for Health Care Guidance Program (HCGP) Quarterly Meeting April 26, 2016

NAME	ORGANIZATION	PHONE NUMBER	E-MAIL ADDRESS
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Gloria Macdonald DHCFP

Cheri Glockner HCGP

Sign-in Sheet for Health Care Guidance Program (HCGP) Quarterly Meeting
April 26, 2016

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Kris Wilson	HCGP	call in	
Rochelle Vander Poel	DHCFP	call in	
Lisa Koehler	DHCFP	call in	
Shawna Vollmer	DHCFP	call in	
Gretchen Thompson	HSAG	call in	
Stacey Brune	MTM	call in	