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Nevada Legislature – Sub-Committee on Post-Acute Care

To whom it may concern,

Through our partnership with Prominence Health Plan we have been made aware of the fact that you are interested in learning more about our care coordination and care management programs. Specifically our programs which are designed to achieve the healthcare triple aim of improved health outcomes, improved efficiency and increased patient satisfaction for individuals being discharged from an acute care facility.

Included in this packet you will find:

- A fact sheet on our organization and all the services we currently offer to individuals and businesses in our community
- A description of our care coordination and care management programs designed to achieve the healthcare triple aim
- A detailing of the efficacy of these programs in achieving those aims

We would very much like the opportunity to discuss in person your needs, the goals you are trying to achieve and how we might be able to help you achieve those goals.

Please feel free to contact me if you have any questions,

Sherri Rice
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Access to Healthcare Network

Care Coordination and Care Management Services

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Hometown Health Plan

Access to Healthcare Network

Diabetes Care Management Proposal

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PROGRAM DESIGN AND DELIVERABLES

Population Size and Staff to Client Ratio

200 Medicare members

1 to 100 staff to client ratio

Population Stratification

This population will consist of high risk type II diabetics

High Level Program Goals

- Improve health outcomes for the target population while at the same time reducing associated healthcare costs
- We will achieve these goals by:
  - Increasing wanted/appropriate utilization
  - Decreasing unwanted/in-appropriate utilization

Sub-Goals/Deliverables

Increase Appropriate Utilization

- HEDIS Measures - Preventive Services, Diagnostic Testing and Screenings
  - We will increase the percentage of AHN clients that are receiving appropriate preventive services as compared to a defined baseline

- Establishing with and Utilizing Primary Care
  - We will increase the percentage of individuals that establish with a primary care physician and attend at least one visit each calendar year as compared to a defined baseline

- Clinical Treatment Plan Adherence
  - We will increase the percentage of individuals who are engaging with and following through on their prescribed treatment plan as compared to a defined baseline. This will include but is not limited to: primary care, specialty care, medications, home health, etc.

- Wellness Classes and Programs
  - We will increase the percentage of individuals who are engaging with health plan approved wellness programs and classes as compared to a defined baseline

Decrease In-Appropriate Utilization

- In-Appropriate ER Utilization
  - We will reduce overall ER utilization rates for the AHN population of clients as compared to a defined baseline

- Hospital Admissions
  - We will reduce overall hospital admission rates for the AHN population of clients as compared to a defined baseline

- Hospital Re-Admissions
  - In partnership with the health plans' current hospital admission vendor we will assist in reducing overall hospital re-admission rates for the AHN population of clients as compared to a defined baseline

Provide the clinical care coordination, socioeconomic case management, health coaching, education and advocacy that can assist the client in:

- Adhering to their prescribed clinical treatment plan
- Setting and following through on health related goals
- Improving their overall health and wellbeing
- By doing this we believe we will see improved health outcomes as measured by: A1C, LDL, Total Cholesterol, BP, BMI

Primary Tasks/Functions of Access to Healthcare

Relationship Building

- We will create positive working relationships with clients built upon the concepts of mutual trust and respect

Client Centered Engagement

- We will create and implement client centered systems and processes designed to allow for successful engagement with the client, the clients family and associated care givers as well as the clients team of physicians/providers

Care Coordination of Clinical Treatment Plan

- We will create systems and processes designed to increase a client's compliance with their prescribed a treatment plan
- This will include services related to:
  - Primary care, specialty care, medication and DME adherence, home health services, diabetes education, etc.
- This will include services such as: appointment reminders, insurance benefit navigation, health system navigation, socioeconomic case management, etc.

Case Management of Socioeconomic Needs

- We will perform a series of socioeconomic needs assessment with every client to determine the presence of any socioeconomic barriers that may prevent the client from following through on their prescribed treatment plan
- This can include but is not limited to: housing needs, food needs, transportation needs, utility needs, phone/communication needs, social support systems, mental health needs, etc.
- We will provide high level case management services to resolve any identified needs

Client Education and Health Coaching

- We will perform a series of health literacy/self-management assessments with every client to determine: their level of self-sufficiency in managing their disease, their level of understanding in regards to self-care protocols, disease exacerbation/warning signs, urgent/emergent care options, diet and nutrition as well as general health literacy
- We will provide the health coaching and education needed to support each client in becoming more self-sufficient in managing their disease
- Depending upon individual client need the health coaching will take the form of:
    - One on one visits with a care coordinator in various settings such as our facility or their providers office
    - Stanford chronic disease self-management classes
    - Telephonic education and support sessions

CARE COORDINATION PROGRAM BUDGET

Total Clients

200

Monthly Cost

$38,500 per month

Start Up Cost

One-time fee of $38,500

We are requesting start-up funding equaling one month's worth of operational cost to provide for staff training and the purchase of necessary equipment.

Start Date

We are proposing a program start date of two months from the date the contract is finalized.

access to HEALTHCARE NETWORK

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AHN History and Program Fact Sheet

A Trusted Nevada Non-Profit Organization

Since 2006 AHN has been excelling at creating services and programs designed to help individuals, families, businesses and government organizations manage healthcare effectively, efficiently and affordably. We fulfill our mission by serving over 20,000 Nevadans annually with the following programs:

The AHN Medical Discount Program

Not everyone will qualify for health insurance through the Affordable Care Act, which is why AHN offers a Medical Discount Program (MDP). With membership in the MDP, members get discounted medical services through our network of 2,000+ local Nevada providers. The AHN Medical Discount Program follows a Shared Responsibility Model where members pay a small, income-based membership fee for access to the discounted provider network and AHN Personal Healthcare Coordination services. Participating healthcare providers receive a timely, yet reduced, payment. Being part of a Shared Responsibility Model means that everyone gives a little, and everyone benefits.

The AHN Health Insurance Program

Offers Nevadans FREE one-on-one health insurance enrollment services with Licensed Health Insurance Brokers. Members enrolled by AHN then receive free Personal Healthcare Coordination for the duration of their insurance coverage, which means they have a partner in effectively managing all facets of using their health insurance plan and navigating the healthcare system.

Medicare Counseling Program (SHIP)

Our team of Medicare experts travels throughout Northern Nevada educating and counseling seniors about their Medicare plan options. From traditional Medicare to the various advantage plans we can help someone enroll into the option that best suits their needs.

Aging and Disability Resource Centers

Anyone who is over the age of 60 or has a disabling condition can obtain high level/high touch case management through our network of Aging and Disability Resource Centers throughout Northern Nevada. Our team of highly trained case managers can assist things like: Medicaid applications, home modifications, legal issues, etc.

Women's Health Connection

Through the Women's Health Connection program any woman who is either uninsured or underinsured can get financial assistance in obtaining potentially life-saving breast and cervical cancer screenings. If someone is unfortunately diagnosed with cancer we can also help them obtain the care they need and care coordinate them though the process.

Care Management Programs

We offer a range of programs designed to achieve the triple aim of healthcare (improved outcomes, increased cost effectiveness, enhanced patient satisfaction) with a focus on socioeconomically needy and clinically high risk patients. Our models have proven to be effective in reducing unnecessary/unwanted utilization such as: in-patient admissions/re-admissions and inappropriate ER visits, increasing appropriate utilization: such as primary and specialty care, while at the same time improving health outcomes.

Non Emergent Medical Transportation

Offers low- to moderate-income individuals and families with rides to doctors' appointments, to pick up prescriptions, obtain food from a grocery store and generally take care of business associated with maintaining a healthy lifestyle.

AHN Care Management Programs - Overview

Program Philosophy and Design

We believe that the success of our care management programs in achieving the healthcare triple aim of improved health outcomes, increased cost efficiency and enhanced patient satisfaction stems from several simple concepts.

Relationships

We believe that achieving positive results in any care management program must start with creating client relationships built upon a foundation of mutual trust and respect. Creating these types of positive relationships is our number one focus as we understand that without them our clients will simply not engage with us to the level we need to be successful.

Client Centered Engagement

We design our programs to be truly client centered. It's not just a catch phrase for us. It's embedded in everything we do. We understand that for someone to make long term positive change they must be invested and committed to the process and the only way for that to happen is if they are making their own decisions and finding their own motivation. We simply help guide them down the path.

Case Management of the Socioeconomic Determinants of Health

The fundamentals of our care management programs are built around the understanding that to help someone become and stay healthy and achieve the healthcare triple aim you must address the socioeconomic determinants of health. A best practice clinical treatment plan cannot accomplish its goal if the patient cannot afford their medications, has a lack of stable housing, goes without access to healthy foods, lacks the transportation needed to see their physicians, or has a treatable mental illness that gets in the way, etc. That is why every one of our clients is provided with high touch case management services with one of our highly trained social workers who will identify any existing socioeconomic needs and work with community organizations to address those needs. We have even built our own internal database of community resources to help us more easily and quickly get our clients access to the services they need when they need them.

Care Coordination of the Clinical Treatment Plan

In addition to socioeconomic case management we also provide our clients with care coordination services designed to identify any logistical and/or systemic barriers that may prevent someone from following through on their clinical treatment plan. Our clinical care coordination consists of: navigation of insurance benefits, assisting with referrals/authorizations, financial planning, financial assistance when necessary, navigation of the healthcare system, assistance with finding needed providers, assistance with making appointments, appointment reminders, locating transportation services, etc.

Client Education

We understand that even if the client has adequate resources and motivation it will be difficult for them to be successful, especially in the long term, without the education they need to manage their disease and navigate the healthcare system. Every one of our care coordinators are trained in the Stanford Chronic Disease Self-Management program and use the tools/teaching methods therein to educate our clients on topics such as: self-care protocols, exacerbation warning signs, emergent/urgent care options, proper nutrition, general health and healthcare literacy, etc.

Hospital Re-admission Reduction Program

We currently operate a hospital re-admission reduction program in partnership with Saint Mary's Regional Medical Center, designed to reduce the 30 day re-admission rates of high risk in-patient clients with a focus on three diagnoses, congestive health failure (CHF), chronic obstructive pulmonary disorder (COPD), and Acute Myocardial Infarction (AMI). Since January of 2015 we have served 578 socioeconomically and clinically high risk clients with an engagement rate of 78%.

Client Demographics

In general, the clients we served in the hospital re-admission reduction program are socioeconomically disadvantaged and lack the resources and tools they need to be successful following a hospital discharge.

Socioeconomic Information

- 5% of our clients where either homeless or in an unstable housing situation
- 4% of our clients have some form of a severe mental illness
- 9% of our clients suffer from substance abuse
- 97% of our clients live below 200% of the federal poverty level
- 58% of our clients live at or below 165% of the federal poverty level

Payer Source

- 57% are on Medicare
- 25% are on Medicaid
- 12% are on private insurance
- 6% are uninsured

Risk for Re-Admission

- 54% of our clients were deemed to be a high risk for re-admission
- 21% of our clients were deemed to be a medium risk for re-admission
- 25% of our clients were deemed to be a low risk for re-admission

Program Outcomes

Over the course of the program we have achieved a reduction in the overall hospital 30 day re-admission rates as follows.

CHF – we reduced the overall hospital re-admission rate for CHF patients by 15.94%
COPD – we reduced the overall hospital re-admission rate for COPD patients by 25.46%
AMI – we reduced the overall hospital re-admission rate for AMI patients by 26.87%

This information was gathered through the hospital's EMR system and verified by the hospital's team on quality management.

OB Care Coordination Program

We currently operate an OB care coordination program in partnership with Saint Mary's Regional Medical Center designed to serve Medicaid and self-pay OB patients with the goal of improving their compliance in relation to their pre-natal and post-partum treatment plan. We believe that if we can increase their compliance to a prescribed treatment plan we will see improved health outcomes for both mother and baby and a reduction in associated hospitalization and complications. Since January of 2015 we have served 168 Medicaid and self-pay OB patients of the Saint Mary's Women's Health Center.

Client Demographics

Socioeconomic Information

- 6% of our clients where either homeless or in an unstable housing situation
- 2% of our clients have some form of a severe mental illness
- 1% of our clients suffer from substance abuse
- 100% of our clients live below 165% of the federal poverty level ($1,618 per month for an individual)

Payer Source

- 73% are on Medicaid
- 27% are uninsured/self-pay

Program Outcomes

Treatment Plan Compliance

- AHN clients had a compliance rate of 98% in regards to their pre-natal treatment plan – meaning that AHN clients attended 98% of all prescribed pre-natal visits
- AHN clients had a compliance rate of 96% in regards to their post-partum treatment plan – meaning that AHN clients attended 96% of all post-partum visits
- AHN clients had a compliance rate of 100% in regards to their post discharge pediatric treatment plan – meaning that 100% of children born in the program saw a pediatrician within 2 weeks of discharge

C-Section Rates

- AHN clients had a total c-section rate of 23% as compared to a national average of 32% according to the CDC

Pre-Term Delivery Rates

- AHN clients have a pre-term delivery rate of 6% as compared to a national average of 11.4% according to the CDC

Birth Weight

- AHN clients have a low birth weight rate of 5.6% as compared to a national average of 8% according to the CDC

This information was gathered from the hospital and medical group EMR systems.

Diabetes Management Program

For the past three years we have operated a diabetes care management program in partnership with the FQHC Community Health Alliance (CHA) designed to serve high risk uninsured type II diabetics with the goal improving their health outcomes as evidenced by the following health indicators: A1C, LDL, Total Cholesterol, Blood Pressure and BMI. Specifically we were tasked with having 80% of our clients show an improvement with at least two health indicators over the life of the program. Since April of 2013 we have served 185 high risk uninsured type II diabetics.

Client Demographics

Income

- 98% of our clients live at or below 150% of the federal poverty level

Average Length of Participation

- 1.2 years

Program Outcomes

Utilization

- AHN clients had a 99% compliance rate in regards to their primary care and specialty care treatment plan – meaning that they attended 99% of their prescribed primary care and specialty care visits
- There were a total of 5 ER visits over the life of the program
- There was 1 hospital admission over the life of the program

Health Indicators

- 82% of all members showed an improvement with at least two health indicators
- 62% of all members showed an improvement with at least three health indicators

Co-Hort Comparison

In partnership with CHA we were able to complete a study comparing the outcomes of AHN clients vs a co-hort of CHA patients that were referred to the program but did not participate. As you can see AHN clients did much better than the co-hort group.

Program Group

Health Indicator	Average Percent Change
Systolic BP	-2.5%
Diastolic BP	-1.5%
BMI	-2.5%
Total Cholesterol	-9.0%
LDL	-15.5%
A1C	-8.9%

Co-Hort Group

Health Indicator	Average Percent Change
Systolic BP	9.5%
Diastolic BP	14.5%
BMI	-2.3%
Total Cholesterol	0.2%
LDL	1.9%
A1C	6.4%

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