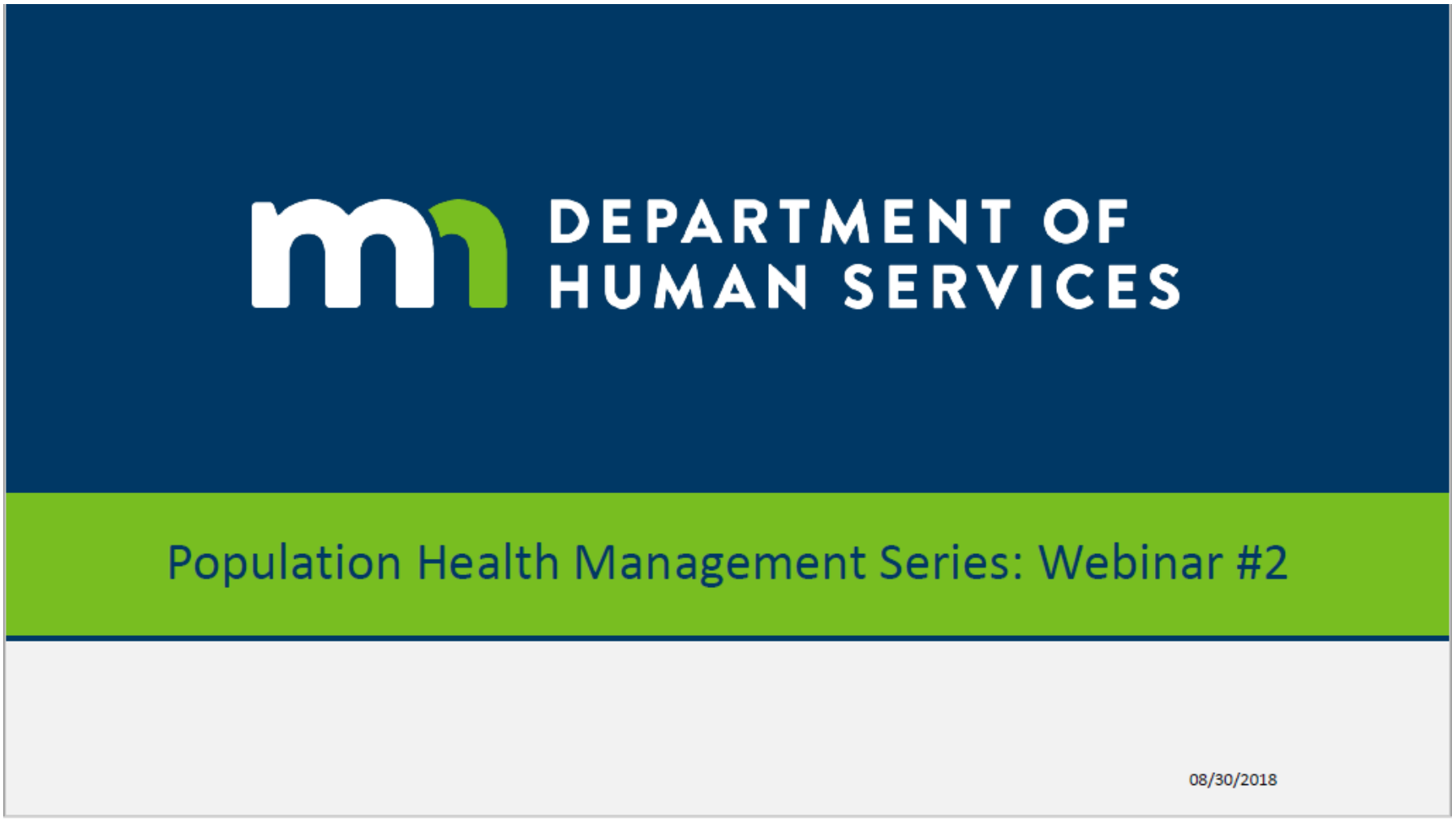
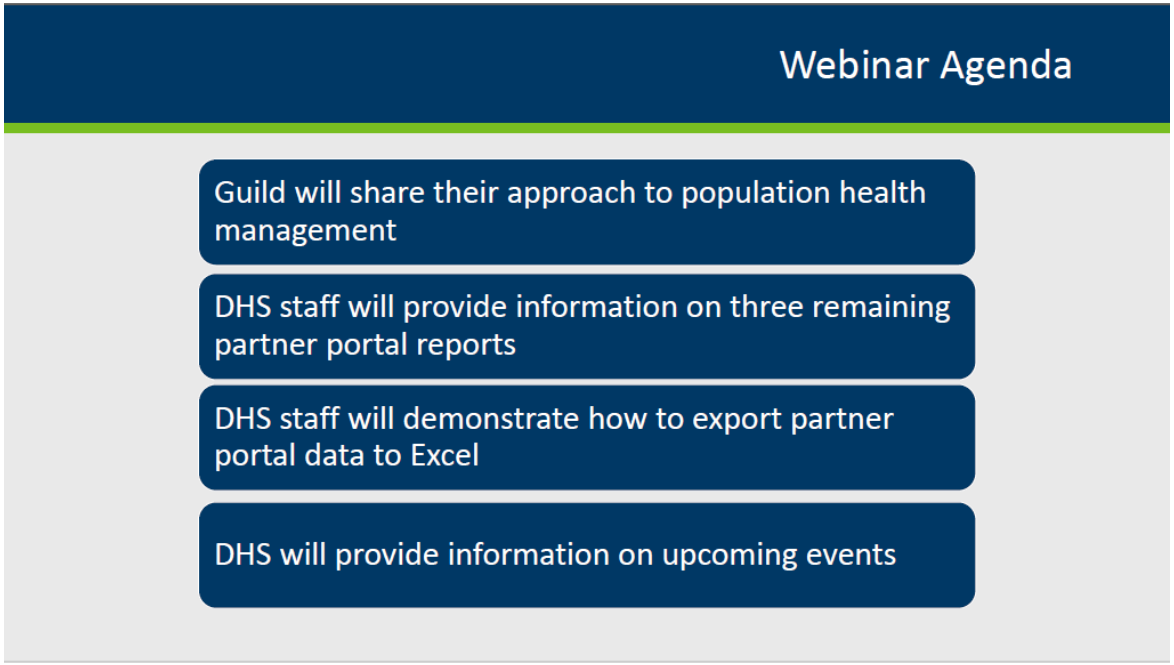
Introduction



Webinar agenda

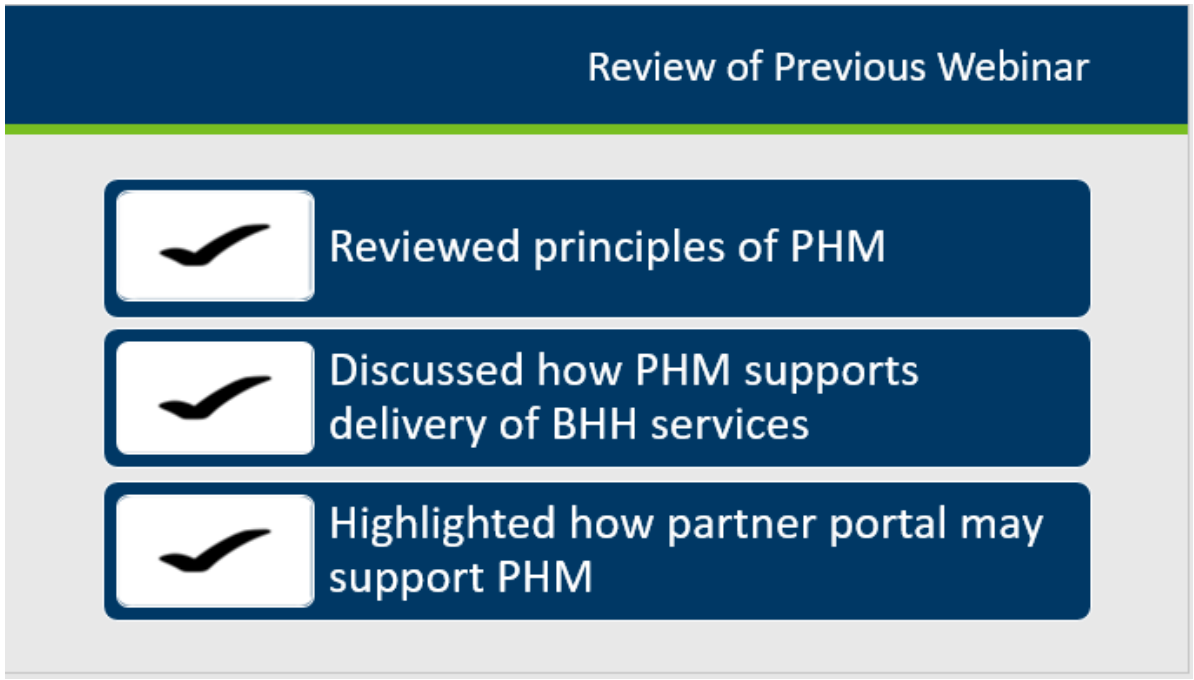


The agenda for this webinar includes the following:

Casey Langworthy from Guild Incorporated will share her organization's perspectives and approach in using data to guide the delivery of BHH services in a more effective and efficient way for the people they serve.

We will provide information on the remaining three partner portal reports that were not covered in the first webinar, including some ideas for how to use the data for population health management. We will also demonstrate how to export the partner portal data to Excel so that providers can better sort and manage the information for their own use.

Review of previous webinar



As a quick review, during the first webinar in this series:

- We reviewed the principles of population health management (PHM).
- We discussed how PHM supports the delivery of BHH services.
- We highlighted some of the components and features of the DHS Partner Portal that support population health management.

Guild Incorporated

Casey Langworth, BHH services integration specialist at Guild, Inc., will share the organization's perspectives and approach in using their data to guide the delivery of BHH services.

Guild's approach: Getting Started

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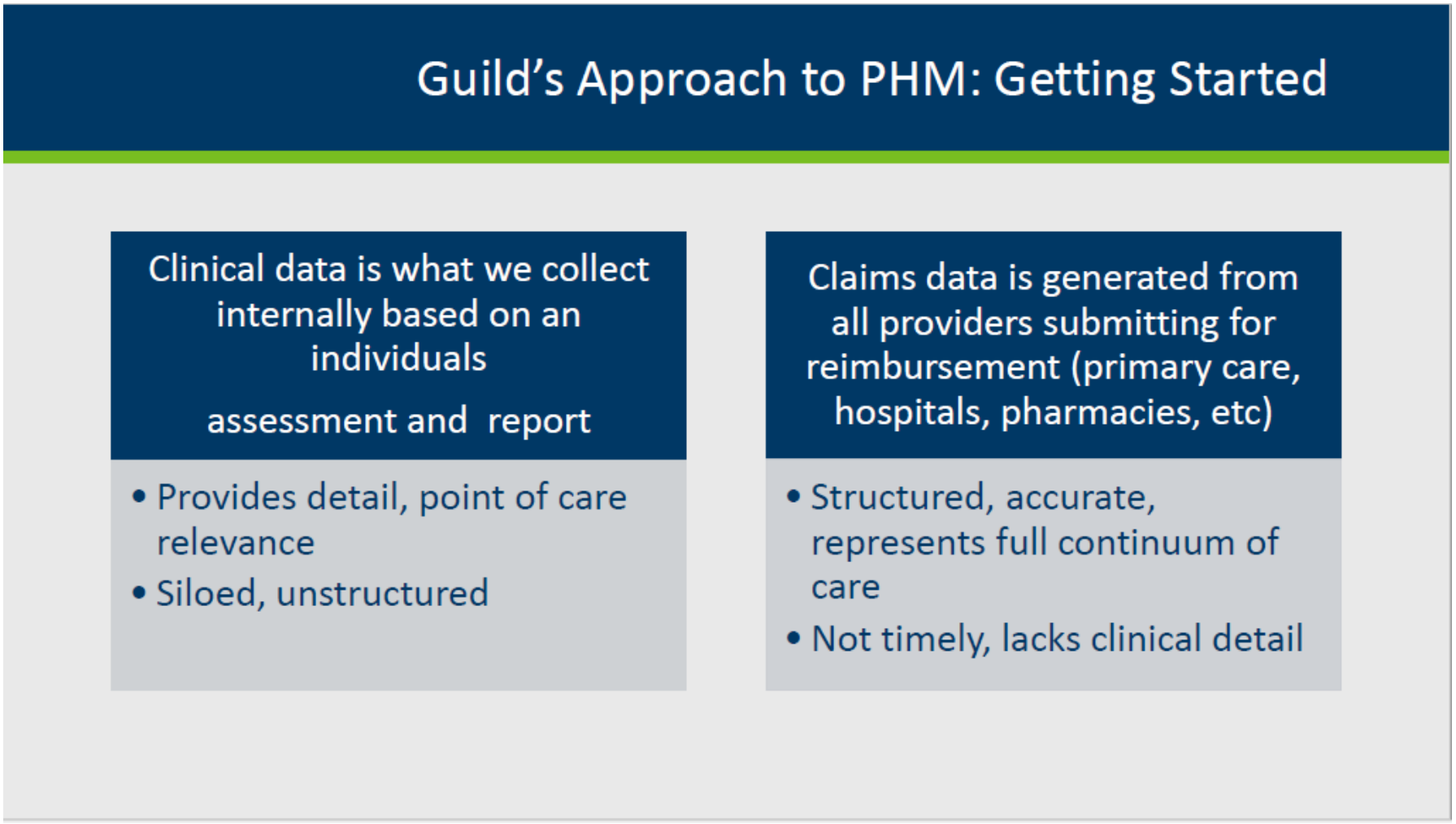
Guild's Approach: Getting started



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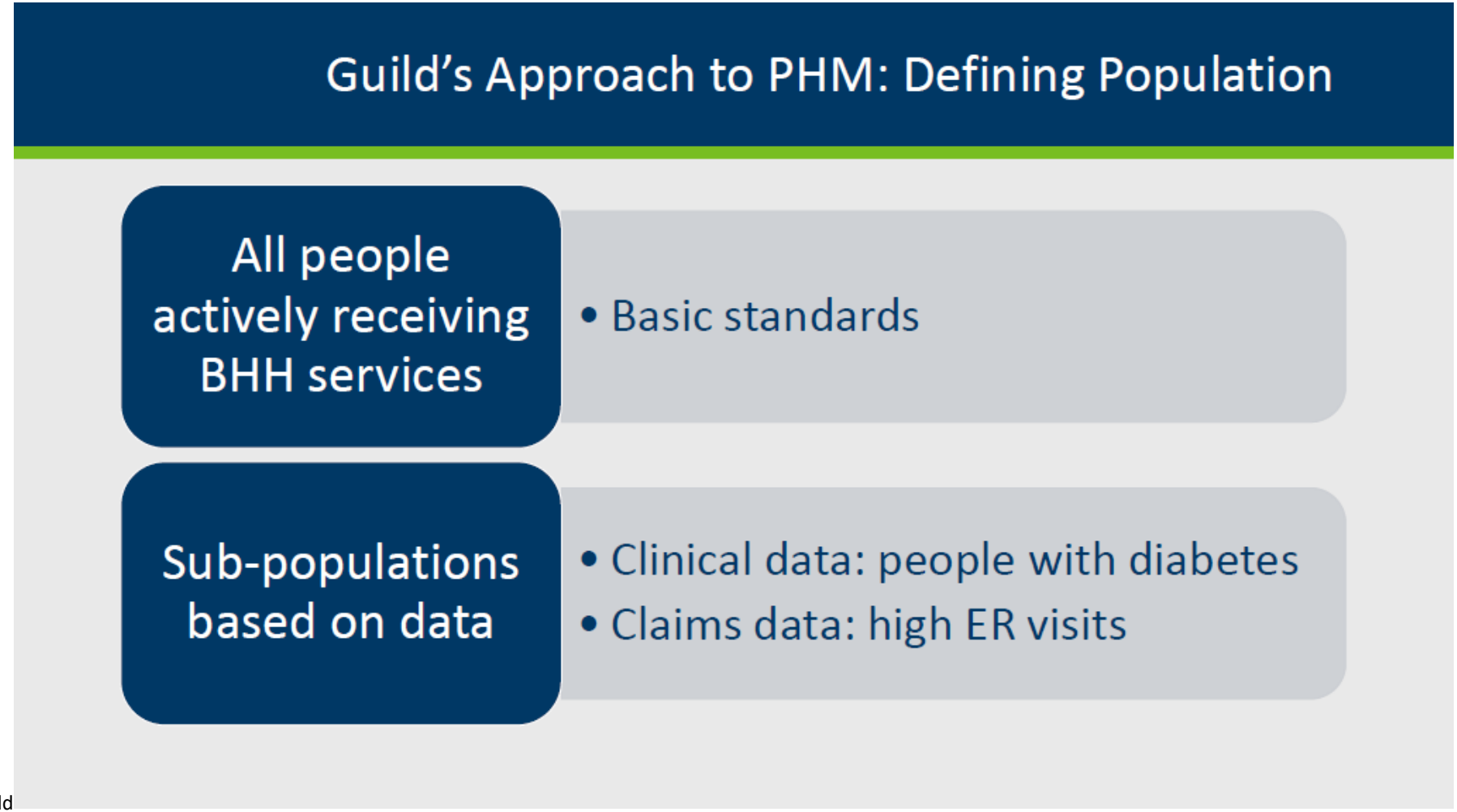
Guild's approach: defining population



Gild

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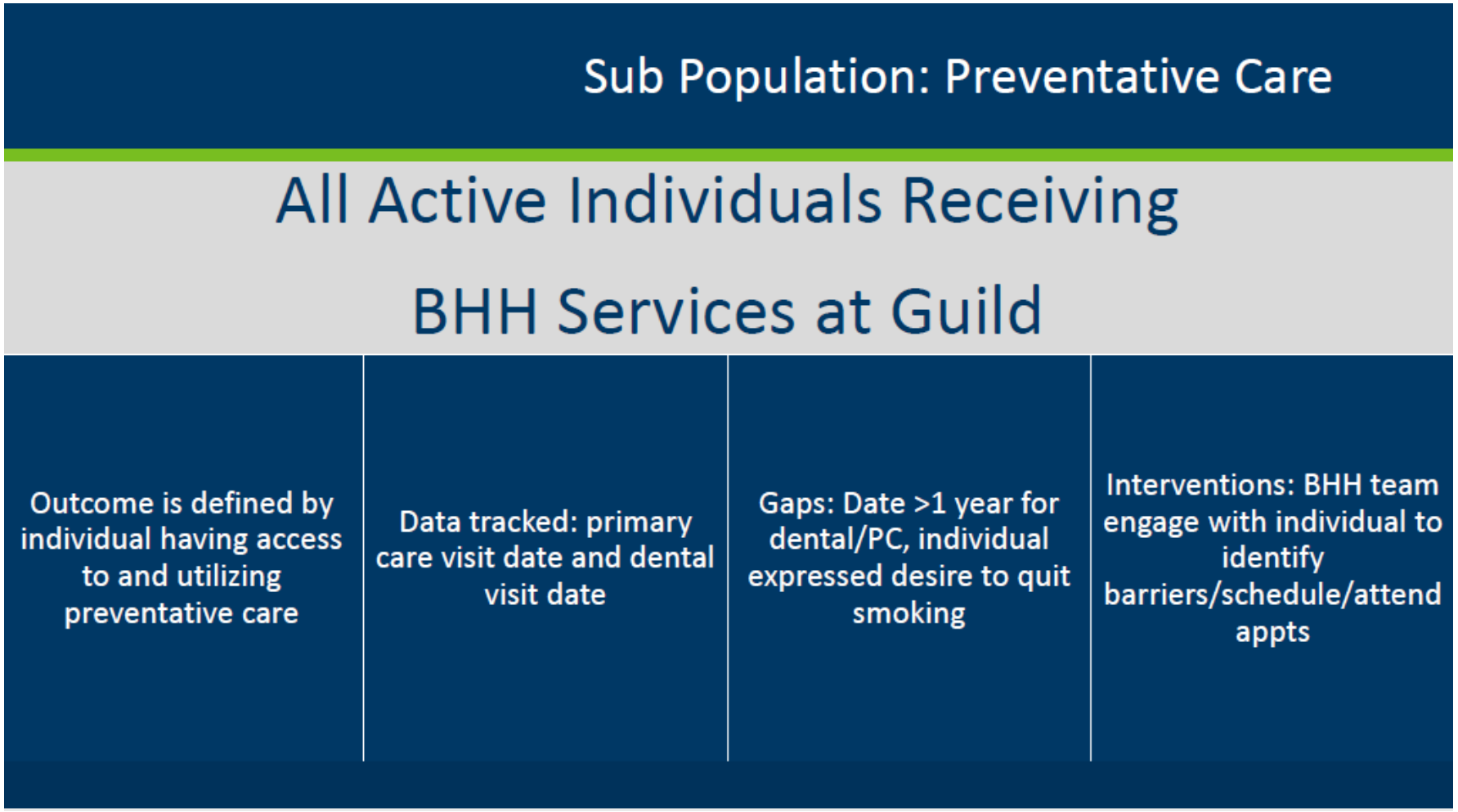
Sub population: preventative care



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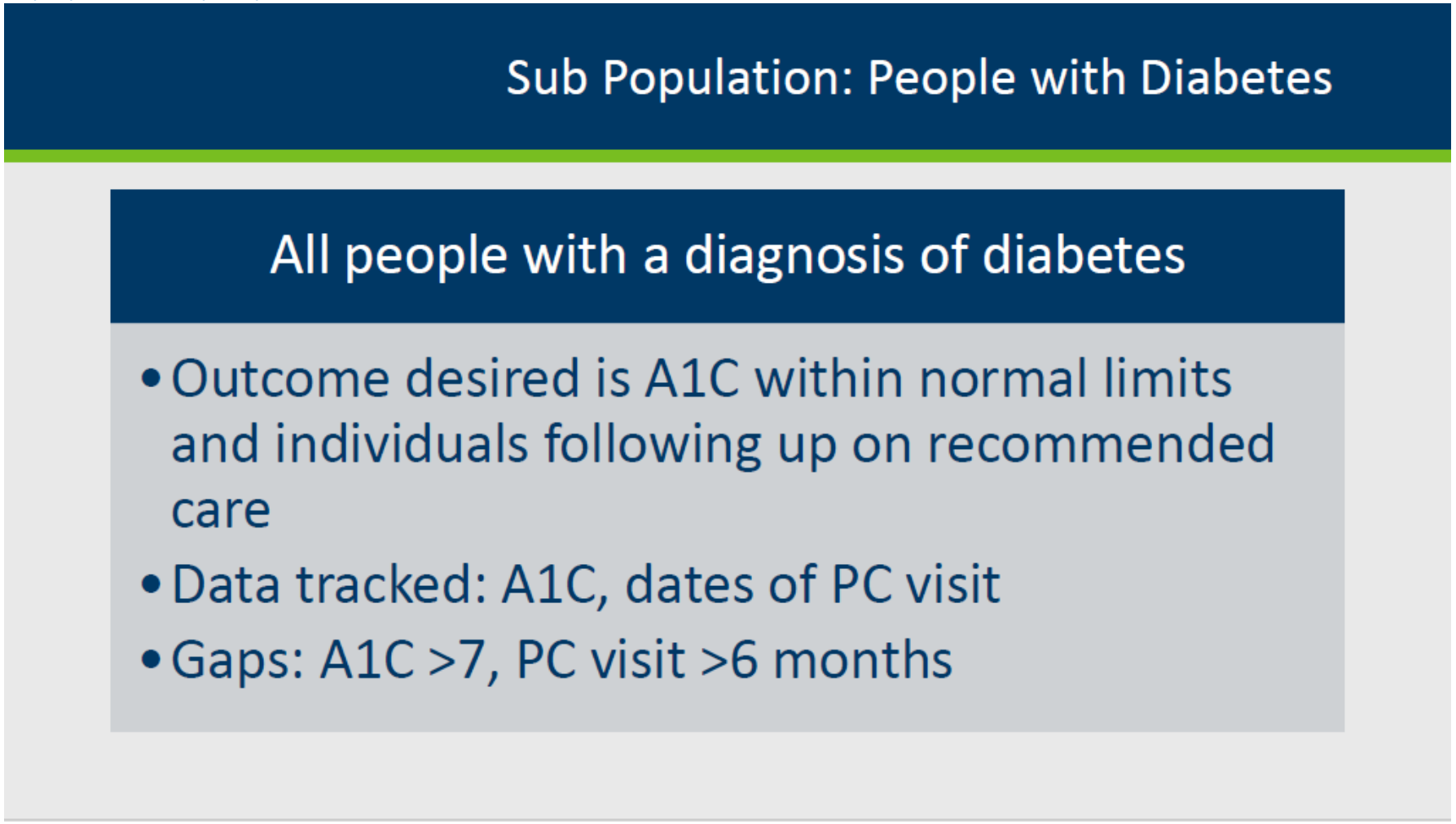
Sub population: people with diabetes



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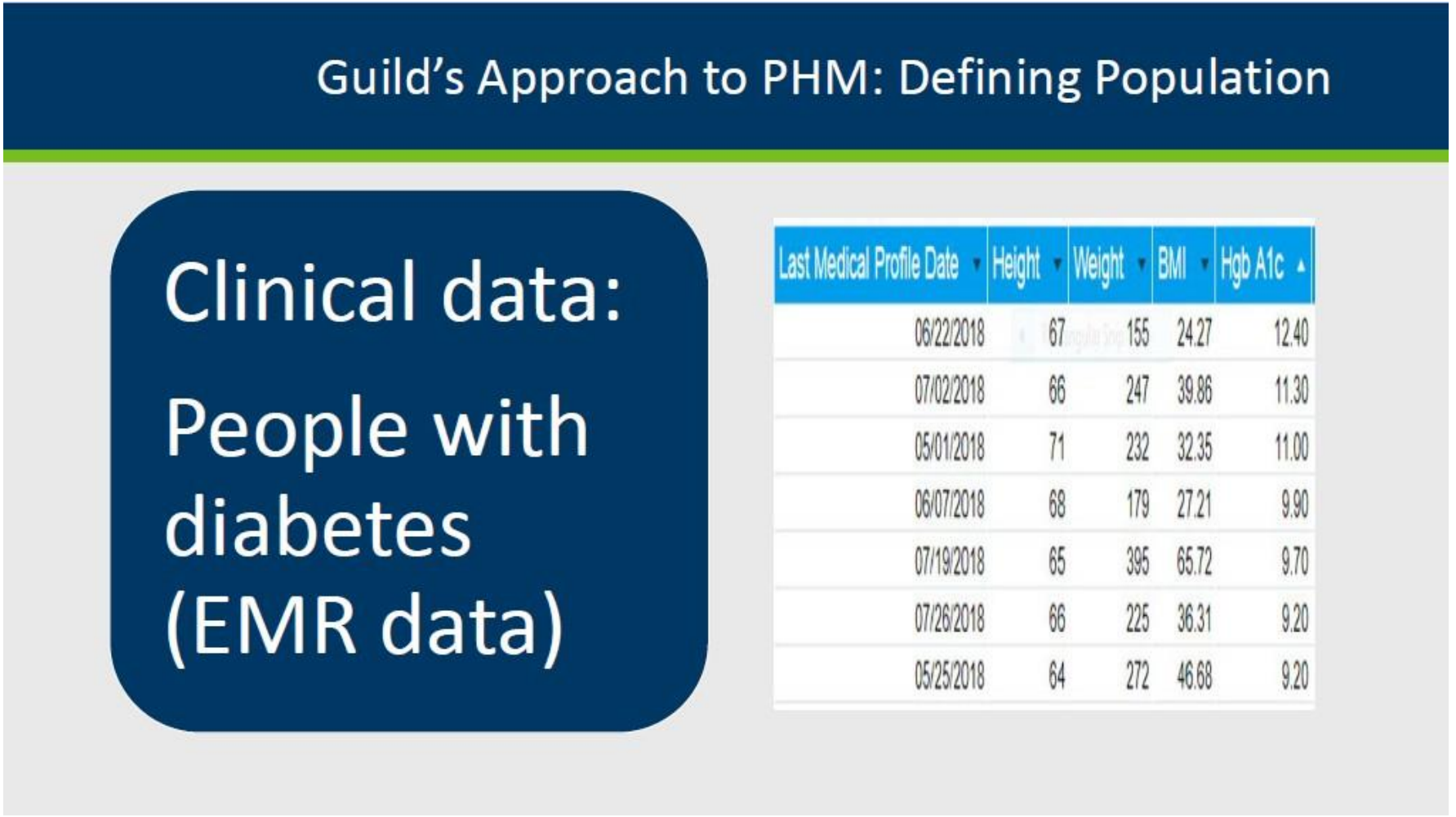
Guild's approach: defining population



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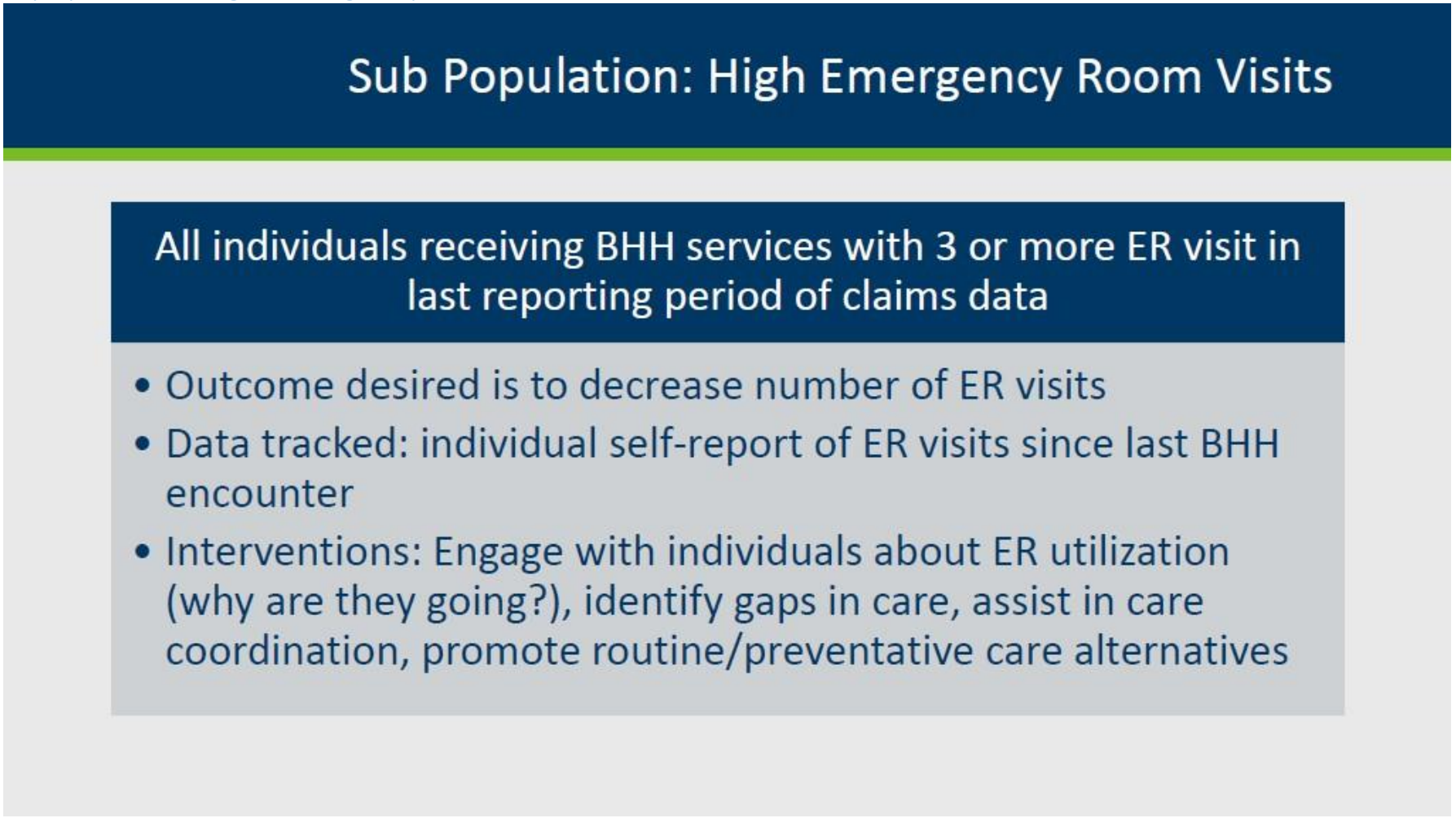
Sub population: high emergency room visits



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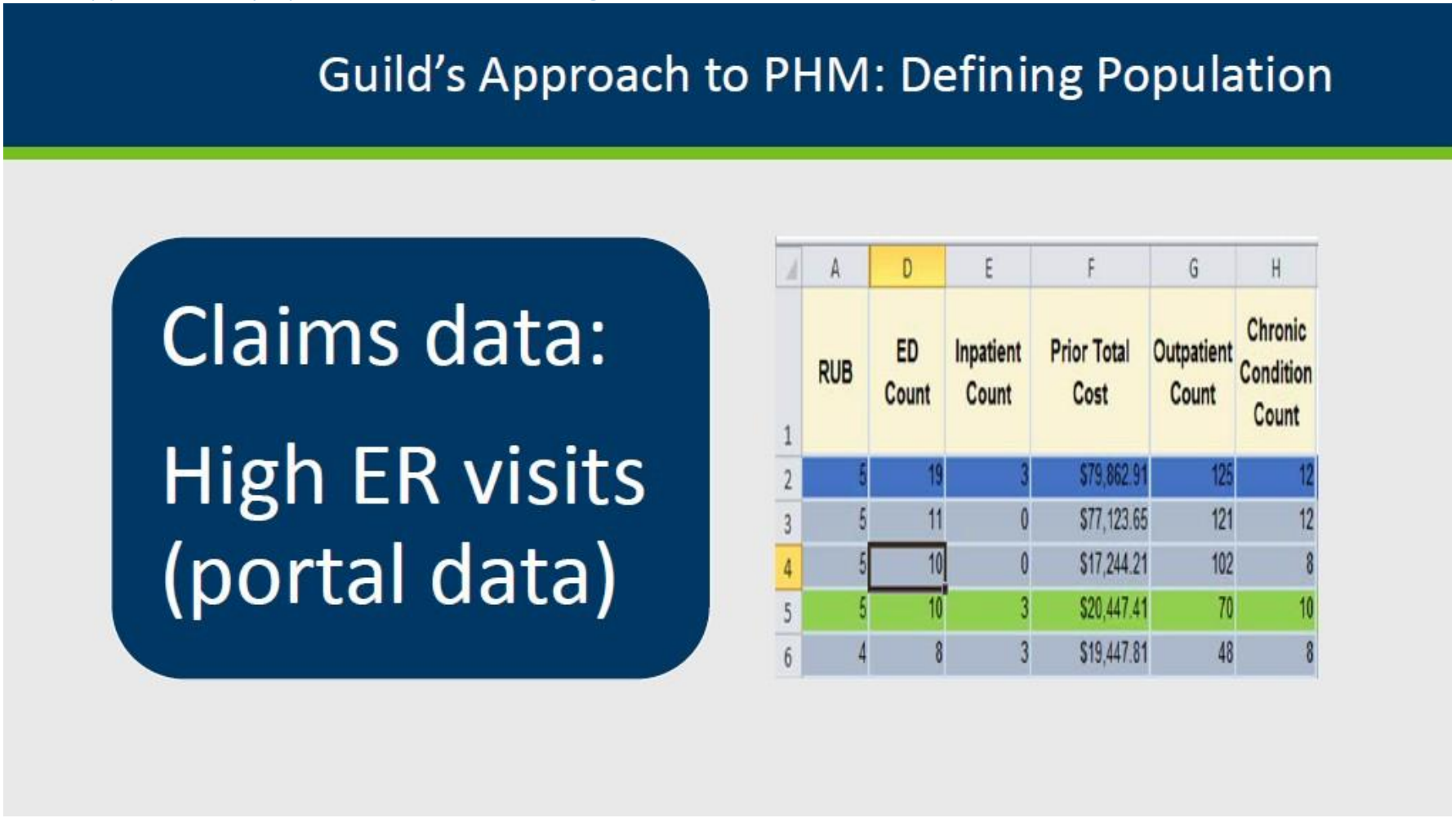
Guild's approach to population health management



	A	D	E	F	G	H
1	RUB	ED Count	Inpatient Count	Prior Total Cost	Outpatient Count	Chronic Condition Count
2	5	19	3	$79,862.91	125	12
3	5	11	0	$77,123.65	121	12
4	5	10	0	$17,244.21	102	8
5	5	10	3	$20,447.41	70	10
6	4	8	3	$19,447.81	48	8

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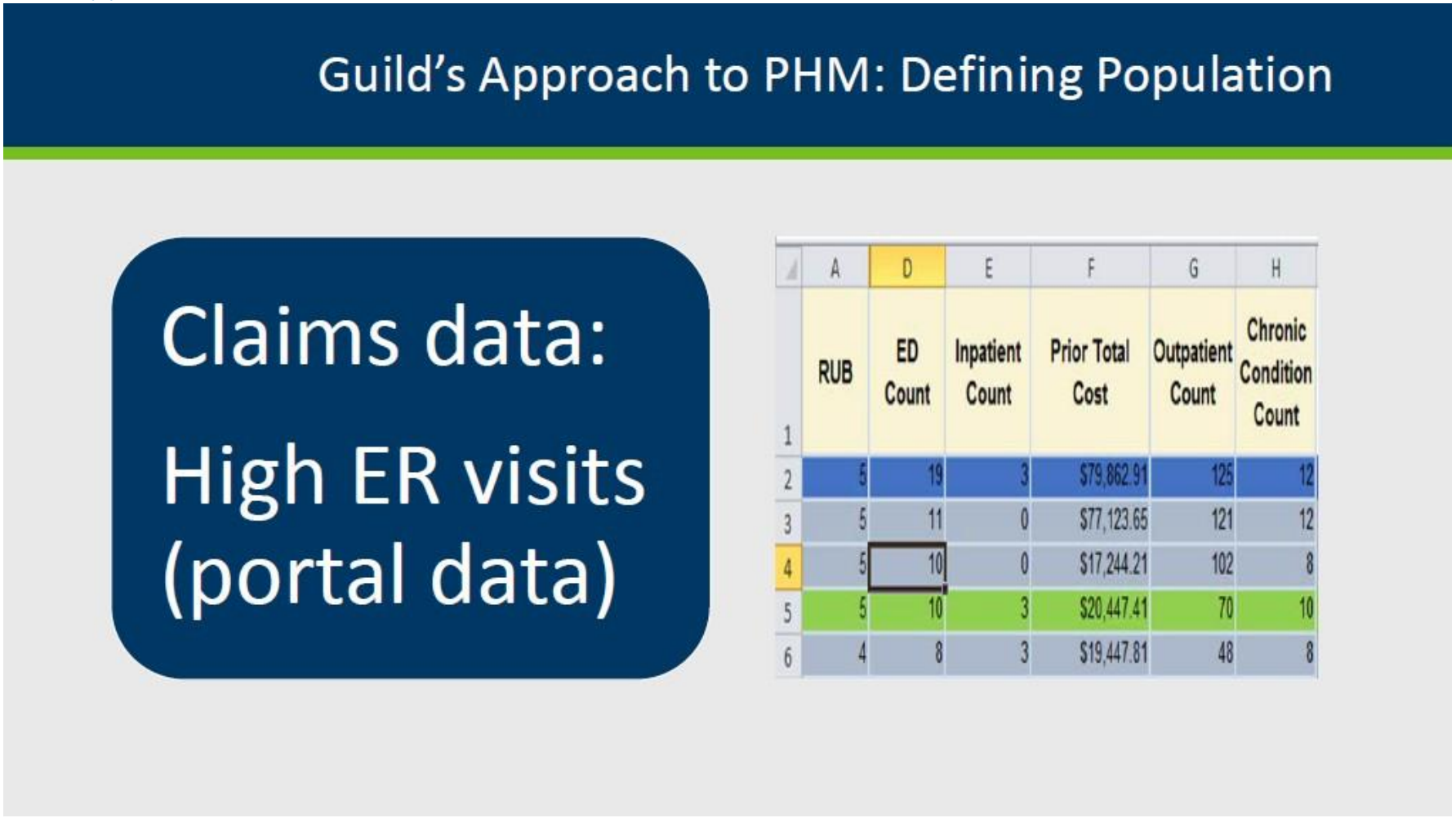
Guild's approach: claim data



	A	D	E	F	G	H
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5	5	10	3	$20,447.41	70	10
6	4	8	3	$19,447.81	48	8

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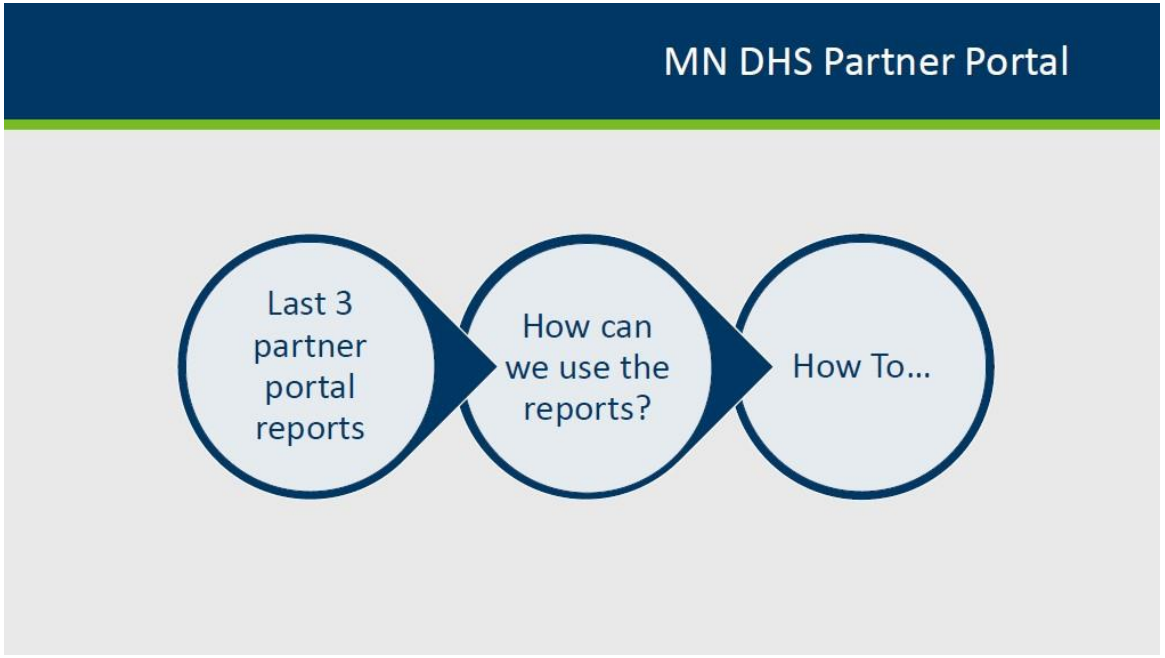
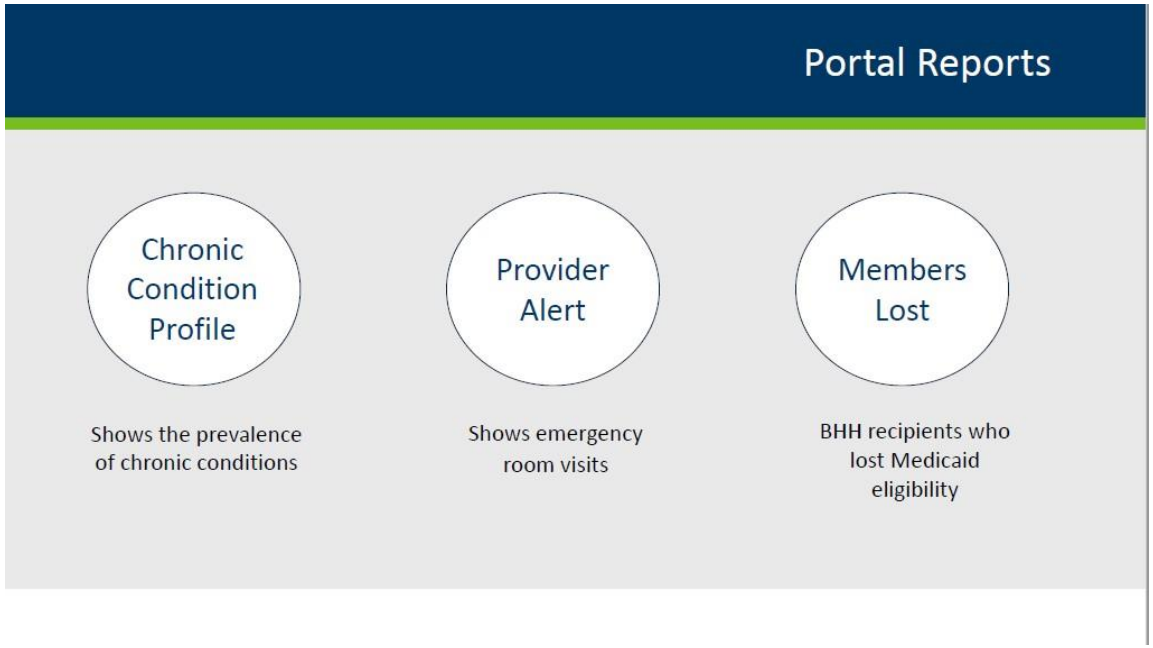
Minnesota Partner Portal



For the rest of this webinar we will discuss the last three reports in the partner portal, some ways these reports can be used and how to export reports to an excel document.

Chronic condition profile, provider and members lost reports



The three reports we will cover in this webinar are the chronic condition profile report, the provider alert report and the members lost report.

The chronic condition profile shows the prevalence of chronic conditions for individuals receiving BHH services at your organization.

The provider alert report shows emergency room visits by month and year, the number of hospital admissions, readmissions and the probability of a future inpatient stay.

The members lost report shows individuals that were included in the previous months partner portal reports but who have now been removed in the current month and the reason for their removal.

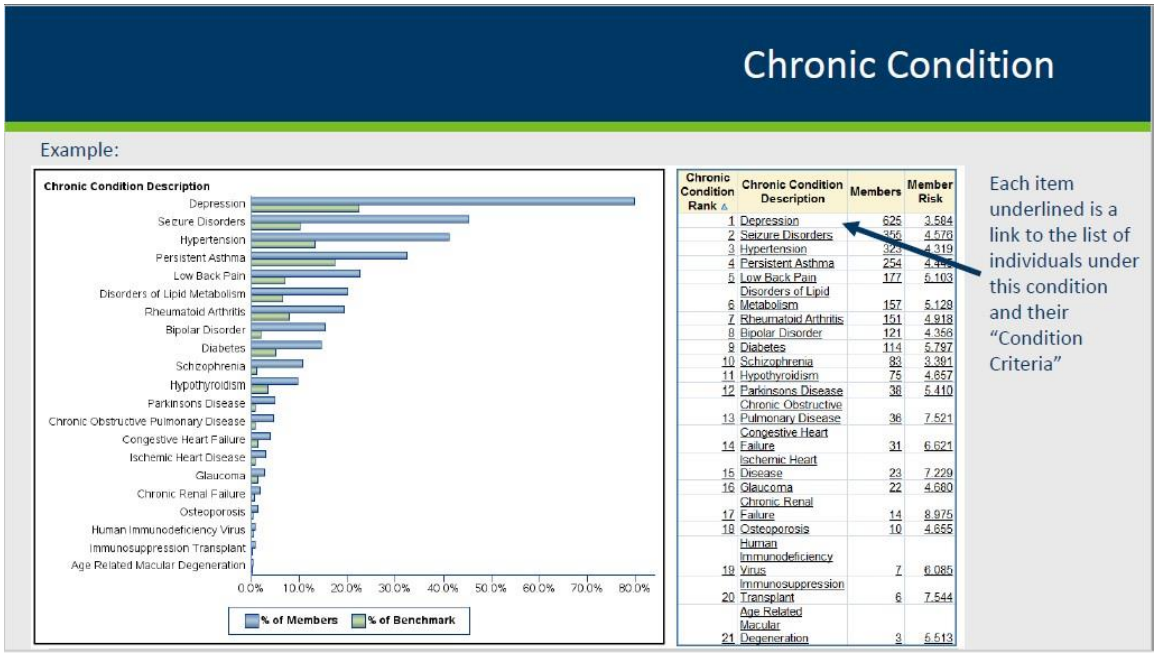
Things to remember

Some things to keep in mind about the partner portal:

- Information in the reports is not real-time. Reports are updated at the end of every month.
- Information is ONLY pulled from claim and enrollment data; it is limited to those two sources. For example, information submitted to the MentalHealth Information System (MHIS) is not included.
- The reports should not be used as a complete list of your BHH services population because BHH services providers can only see data on individuals once a claim is billed and paid.
- While in the portal, the reports can be used to look at your BHH services population as a whole. They do not work well for comparing an individual's progress month-to-month since you can only run and see a report by a single month at a time and cannot run them by a single individual. However, by exporting the reports to excel, the reports can be managed so one could pull an individual's data to a separate spreadsheet or a single row in a portal report can be copied and pasted to an excel document.

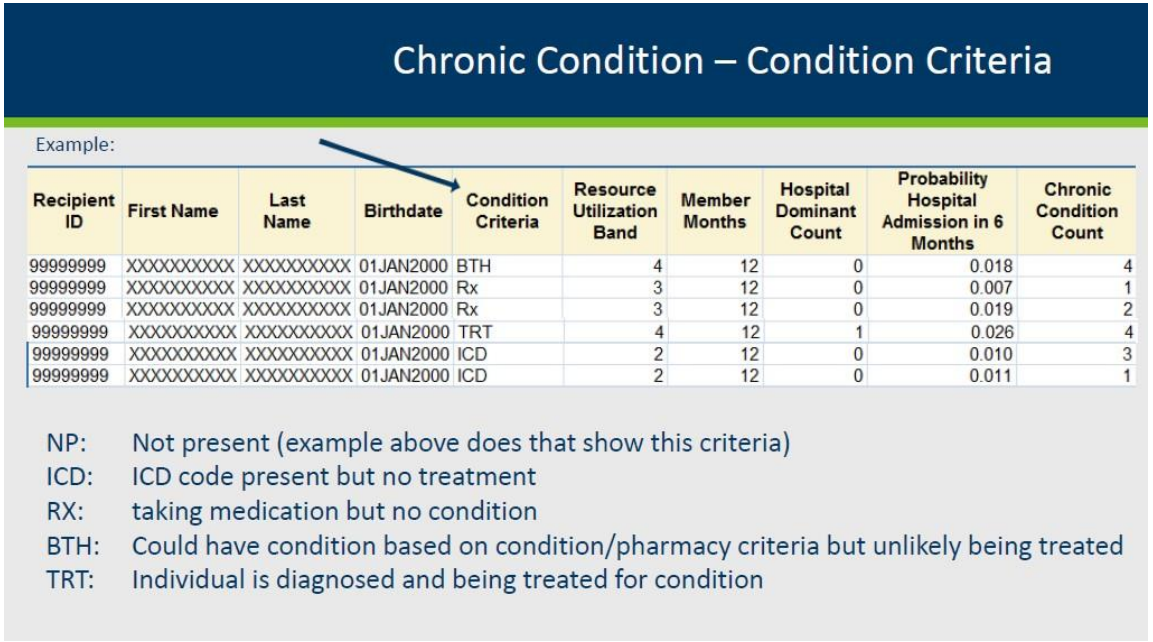
Despite these limitations, the data can be used for population health management. We cover specific examples in the slides to come.

Chronic Condition



The chronic condition report graph on the left shows the percentage of people a provider is serving within BHH services who show some indication of that chronic condition. This percentage is compared with the overall percentage of people in Minnesota enrolled in one or more Minnesota Health Care Programs (MHCP) with the same chronic condition.

Condition criteria



Chronic Condition – Condition Criteria

Example:

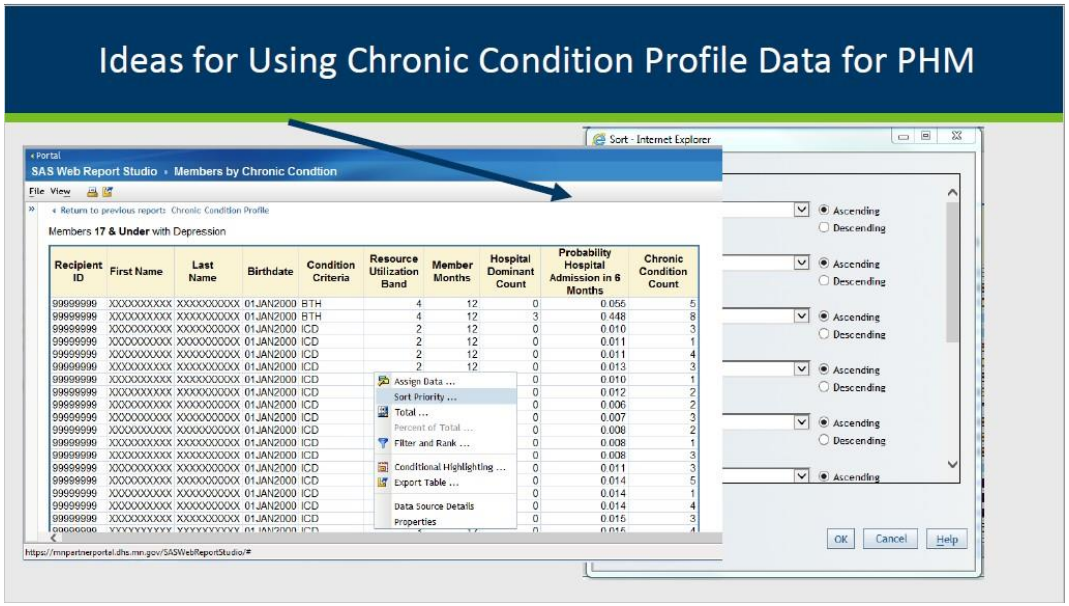
Recipient ID	First Name	Last Name	Birthdate	Condition Criteria	Resource Utilization Band	Member Months	Hospital Dominant Count	Probability Hospital Admission in 6 Months	Chronic Condition Count
99999999	XXXXXXXXXX	XXXXXXXXXX	01JAN2000	BTH	4	12	0	0.018	4
99999999	XXXXXXXXXX	XXXXXXXXXX	01JAN2000	Rx	3	12	0	0.007	1
99999999	XXXXXXXXXX	XXXXXXXXXX	01JAN2000	Rx	3	12	0	0.019	2
99999999	XXXXXXXXXX	XXXXXXXXXX	01JAN2000	TRT	4	12	1	0.026	4
99999999	XXXXXXXXXX	XXXXXXXXXX	01JAN2000	ICD	2	12	0	0.010	3
99999999	XXXXXXXXXX	XXXXXXXXXX	01JAN2000	ICD	2	12	0	0.011	1

NP: Not present (example above does that show this criteria)
ICD: ICD code present but no treatment
RX: taking medication but no condition
BTH: Could have condition based on condition/pharmacy criteria but unlikely being treated
TRT: Individual is diagnosed and being treated for condition

Here is an example of that list after clicking on any part of the underlined row. The column titled “condition criteria” defines why this individual is under this condition. The possible reasons an individual might be under this condition include:

- **NP**: They meet all the criteria but chronic condition is not present,
- **ICD**: The ICD code for that condition is present for this individual but they aren’t being treated for it,
- **Rx**: The individual is taking a medication that can treat that condition but they do not have that condition diagnosed,
- **BTH**: Individual met condition and pharmacy criteria but it is unlikely the individual is being treated for the condition OR
- **TRT**: The individual is diagnosed and is being treated for the condition.

Using chronic condition profile data

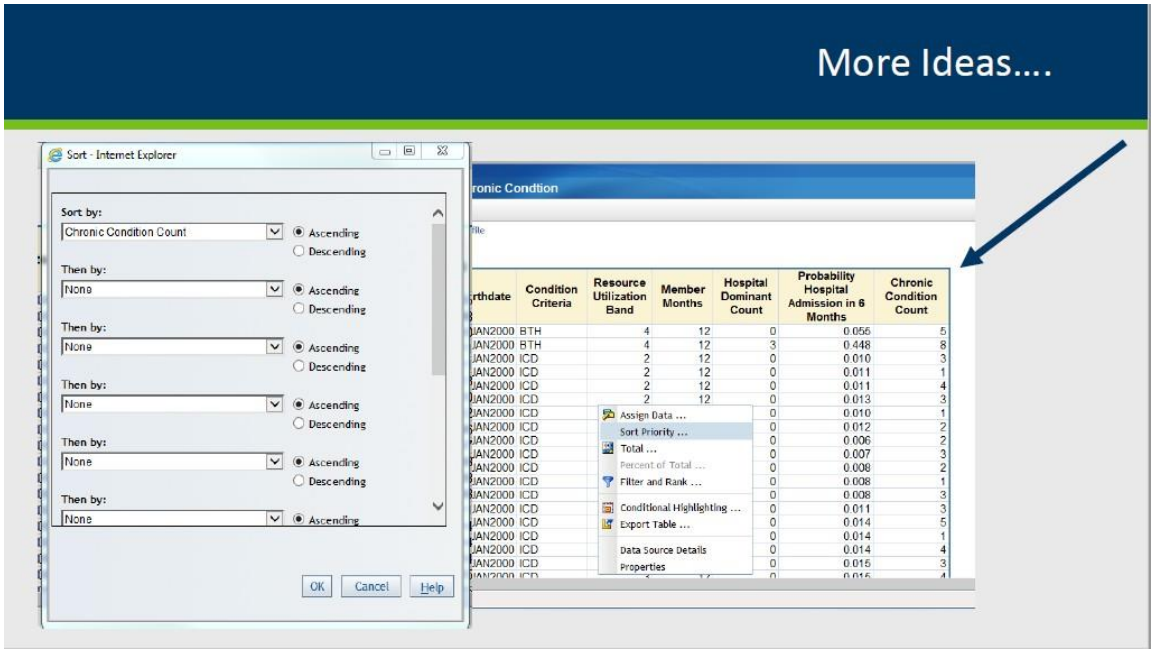


The chronic conditions profile report could be used to track individuals with certain condition criteria codes. A provider could decide as a team to track individuals under the depression list that have the condition criteria “BTH” which – as a reminder from the previous screen – means the condition was identified by the individual’s diagnosis and pharmacy criteria but likely that person is NOT being treated for the condition.

A provider may decide to track the people with these codes and assign specific interventions to them to make sure they start getting regular treatment for their chronic condition.

So a way to track these people may be to create a sub-registry where you track everyone with a BTH condition criteria and then use the registry to also “close the loop” on referrals for getting them connected to treatment for their chronic conditions.

Chronic condition report more ideas

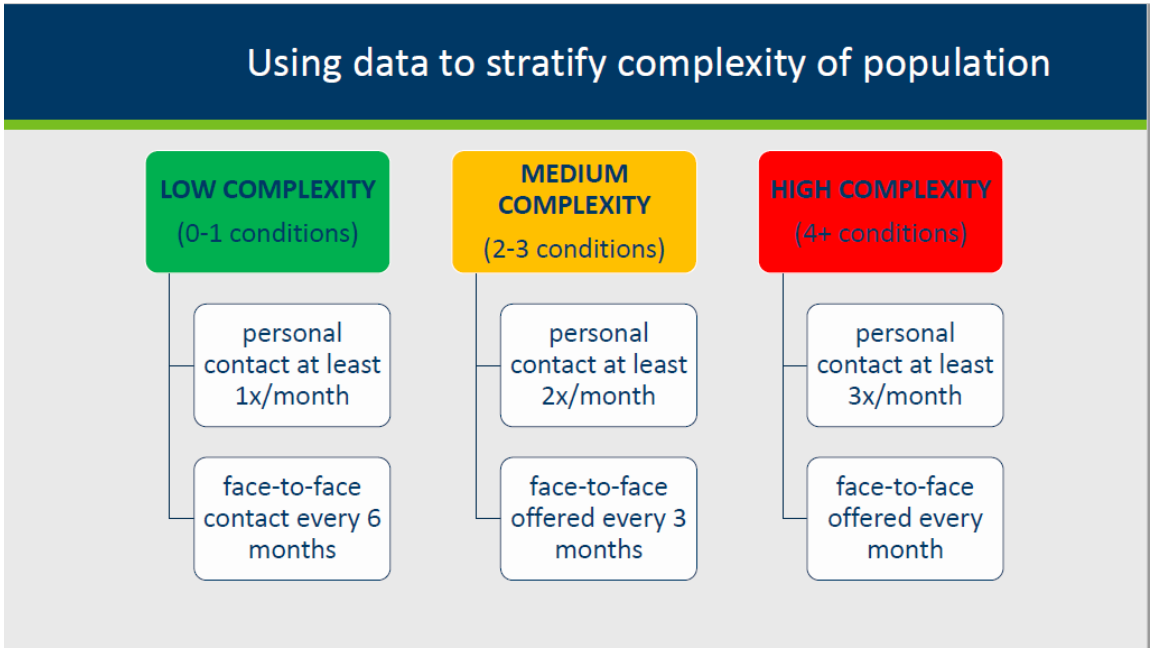


Another example of how to use the chronic condition report is to stratify the complexity of your population based off of that data. So you might choose three different complexity levels:

- 0-1 chronic conditions range means low complexity
- 2-3 chronic condition range means medium complexity
- 4+ range means high complexity

You could then develop standard follow-up protocols for each complexity level that all team members would need to follow.

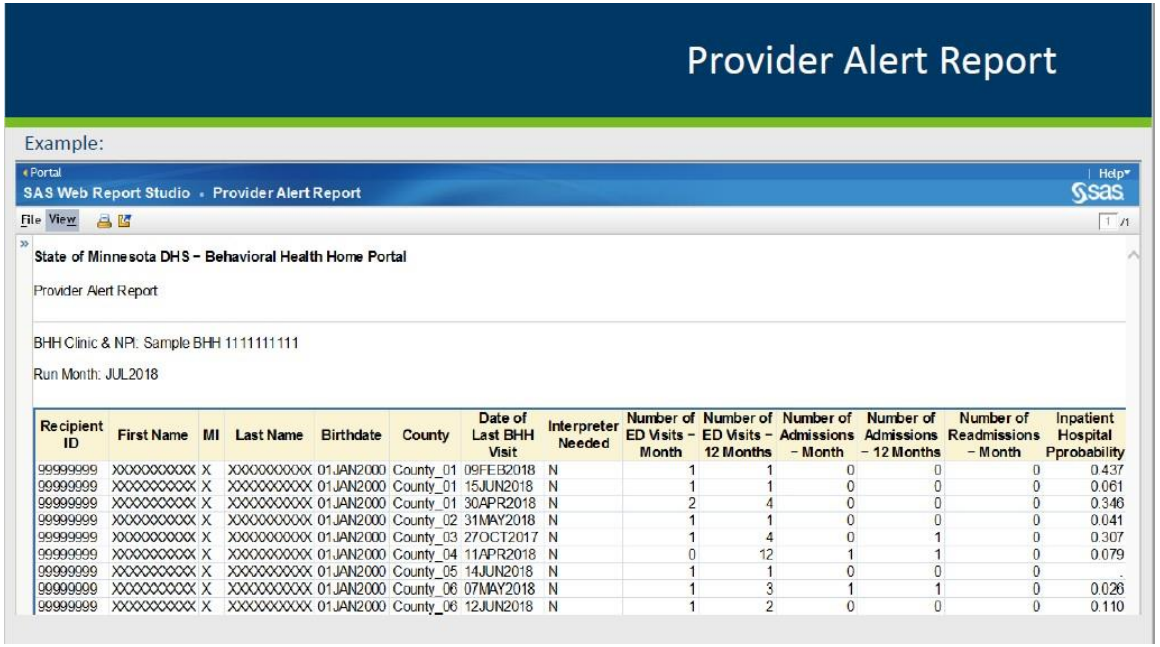
Using data to stratify complexity of population



An example of standard follow-up protocols could be:

- For the low-complexity range, a BHH team could continue the standard follow-up requirements set forth by DHS, having a personal contact with the person or identified support at least once per month.
- For medium-complexity a BHH team could decide they want to follow-up with these people two times per month, with a face-to-face contact offered every three months.
- And then for high-complexity, a BHH team might decide they want to follow up with this group, at minimum, with a personal contact three times per month, offering a face-to-face as one of those contacts every single month.

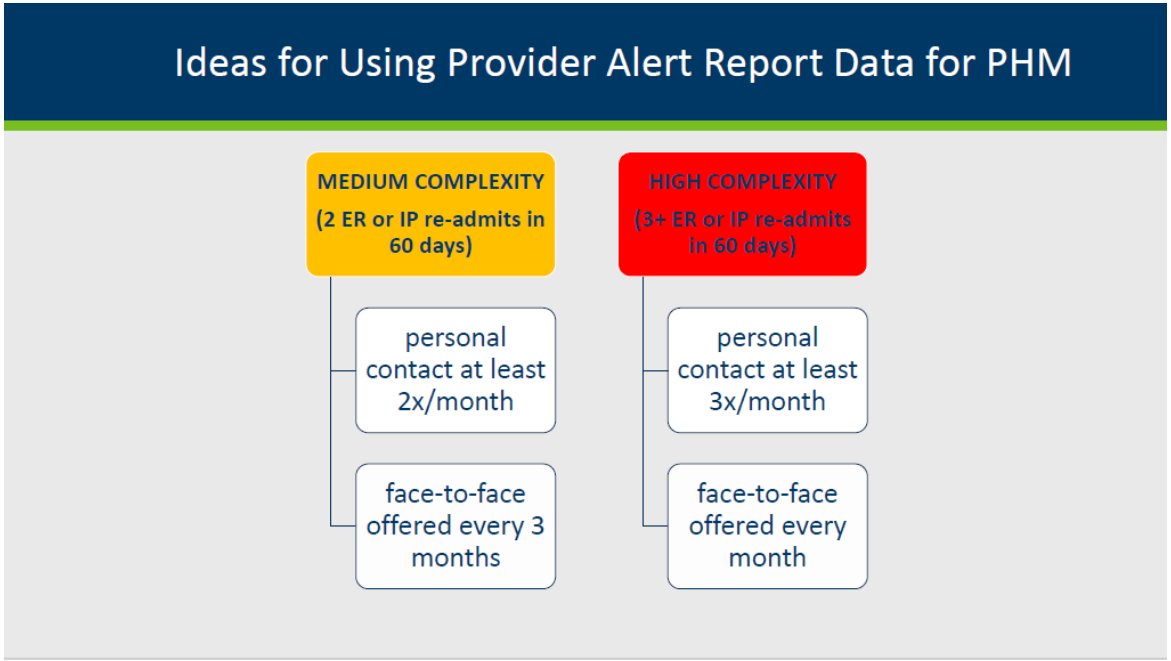
Provider alert report



Recipient ID	First Name	MI	Last Name	Birthdate	County	Date of Last BHH Visit	Interpreter Needed	Number of ED Visits – Month	Number of ED Visits – 12 Months	Number of Admissions – Month	Number of Admissions – 12 Months	Number of Readmissions – Month	Inpatient Hospital Pprobability
99999999	XXXXXXXXX	X	XXXXXXXXX	01JAN2000	County_01	09FEB2018	N	1	1	0	0	0	0.437
99999999	XXXXXXXXX	X	XXXXXXXXX	01JAN2000	County_01	15JUN2018	N	1	1	0	0	0	0.061
99999999	XXXXXXXXX	X	XXXXXXXXX	01JAN2000	County_01	30APR2018	N	2	4	0	0	0	0.346
99999999	XXXXXXXXX	X	XXXXXXXXX	01JAN2000	County_02	31MAY2018	N	1	1	0	0	0	0.041
99999999	XXXXXXXXX	X	XXXXXXXXX	01JAN2000	County_03	27OCT2017	N	1	4	0	1	0	0.307
99999999	XXXXXXXXX	X	XXXXXXXXX	01JAN2000	County_04	11APR2018	N	0	12	1	1	0	0.079
99999999	XXXXXXXXX	X	XXXXXXXXX	01JAN2000	County_05	14JUN2018	N	1	1	0	0	0	.
99999999	XXXXXXXXX	X	XXXXXXXXX	01JAN2000	County_06	07MAY2018	N	1	3	1	1	0	0.026
99999999	XXXXXXXXX	X	XXXXXXXXX	01JAN2000	County_06	12JUN2018	N	1	2	0	0	0	0.110

The provider alert report shows the emergency department visits for a providers BHH population in the last month and year, the number of readmissions in the last month and year and the probability of an inpatient admission.

Provider alert report

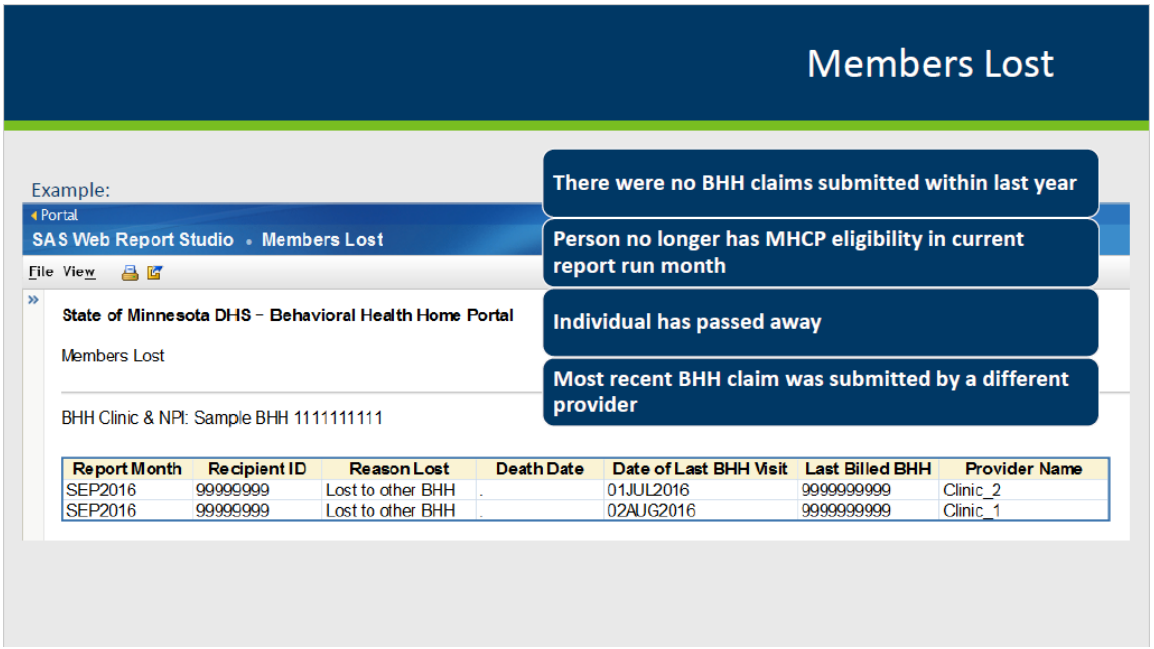


The same kind of stratification process outlined for the chronic condition profile report could be done using the ER visit and hospital admission data from the provider alert report.

People could be placed at different complexity levels with associated follow-up protocols and interventions based on a chosen number of ED visits or hospital readmissions within a certain timeframe. For example, an integration specialist could send out a report of the provider alert data once a month to the entire BHH team. Team members could decide, as a stratification protocol, that anyone with two ER or inpatient re-admits in the previous 60 days would be automatically changed to medium complexity. And maybe anyone with three or more ER or inpatient re-admits in the last 60 days will be automatically changed to high complexity. Then follow up with protocols and associated interventions in place for each complexity level.

This data could continue to be used to keep track of ER visits and inpatient readmissions, to see if people's visits and readmissions are going down because of the protocols and interventions in place. If they aren't going down, it may be worth trying new follow-up protocols or trying new population-based interventions.

Members Lost report

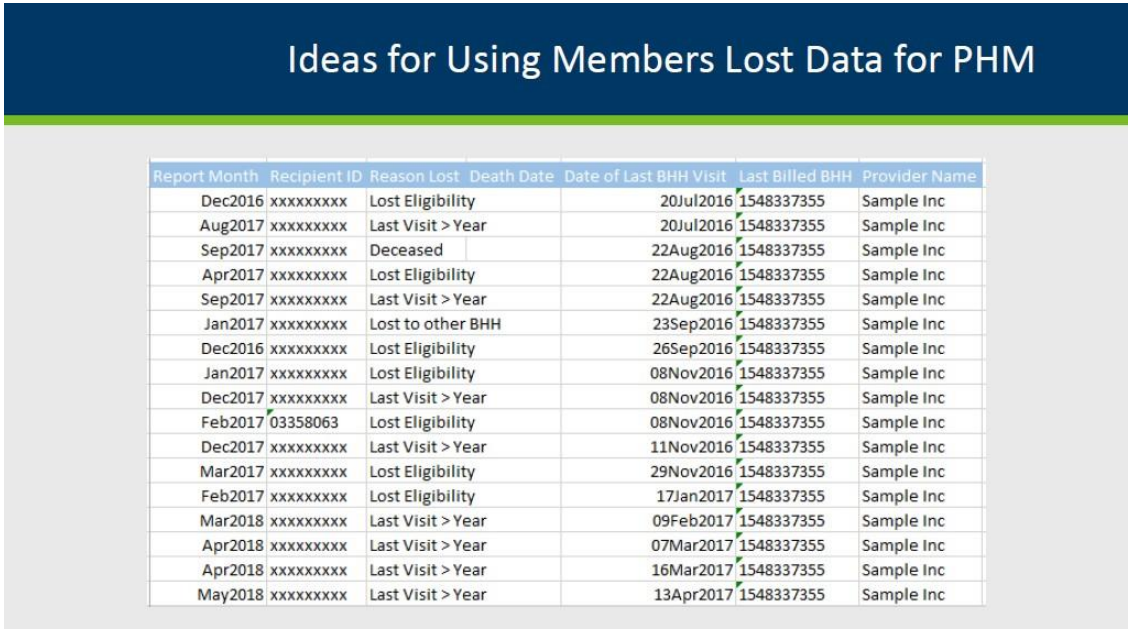


Members Lost report shows the BHH individuals who have been removed from BHH services in the current month for any of the following reasons:

- There were no BHH services claims submitted within the last year.
- The individual no longer has MHCP eligibility in the current report run month
- The individual has passed away
- The most recent BHH services claim was submitted by a different provider

If a BHH provider tries to run this report and their agency isn't listed, this means that your agency hasn't had an occurrences of members lost in the last monthly cycle.

Using the members lost report



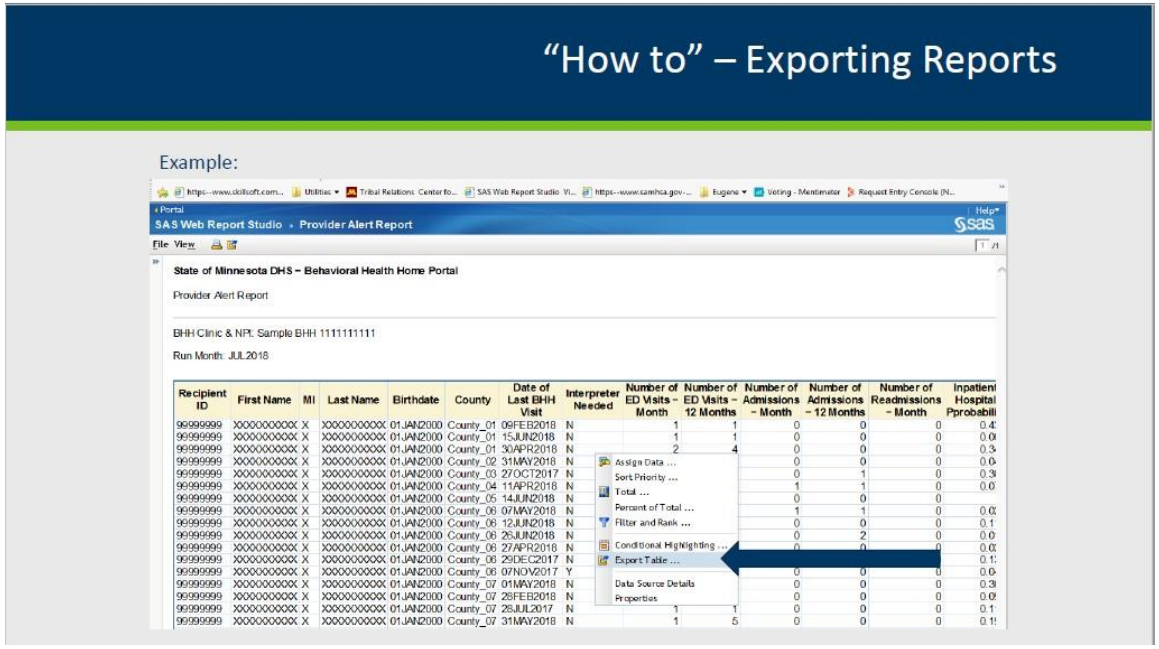
Report Month	Recipient ID	Reason Lost	Death Date	Date of Last BHH Visit	Last Billed BHH	Provider Name
Dec2016	xxxxxxxxx	Lost Eligibility		20Jul2016	1548337355	Sample Inc
Aug2017	xxxxxxxxx	Last Visit > Year		20Jul2016	1548337355	Sample Inc
Sep2017	xxxxxxxxx	Deceased		22Aug2016	1548337355	Sample Inc
Apr2017	xxxxxxxxx	Lost Eligibility		22Aug2016	1548337355	Sample Inc
Sep2017	xxxxxxxxx	Last Visit > Year		22Aug2016	1548337355	Sample Inc
Jan2017	xxxxxxxxx	Lost to other BHH		23Sep2016	1548337355	Sample Inc
Dec2016	xxxxxxxxx	Lost Eligibility		26Sep2016	1548337355	Sample Inc
Jan2017	xxxxxxxxx	Lost Eligibility		08Nov2016	1548337355	Sample Inc
Dec2017	xxxxxxxxx	Last Visit > Year		08Nov2016	1548337355	Sample Inc
Feb2017	03358063	Lost Eligibility		08Nov2016	1548337355	Sample Inc
Dec2017	xxxxxxxxx	Last Visit > Year		11Nov2016	1548337355	Sample Inc
Mar2017	xxxxxxxxx	Lost Eligibility		29Nov2016	1548337355	Sample Inc
Feb2017	xxxxxxxxx	Lost Eligibility		17Jan2017	1548337355	Sample Inc
Mar2018	xxxxxxxxx	Last Visit > Year		09Feb2017	1548337355	Sample Inc
Apr2018	xxxxxxxxx	Last Visit > Year		07Mar2017	1548337355	Sample Inc
Apr2018	xxxxxxxxx	Last Visit > Year		16Mar2017	1548337355	Sample Inc
May2018	xxxxxxxxx	Last Visit > Year		13Apr2017	1548337355	Sample Inc

This data could be used to identify individuals who lose their eligibility on a consistent basis and be prepared to offer a population-based intervention to help people complete paperwork. A BHH provider could offer quarterly educational groups to give tips on how people can, for example, keep better track of when and how to complete Medicaid paperwork.

Exporting partner portal reports to excel

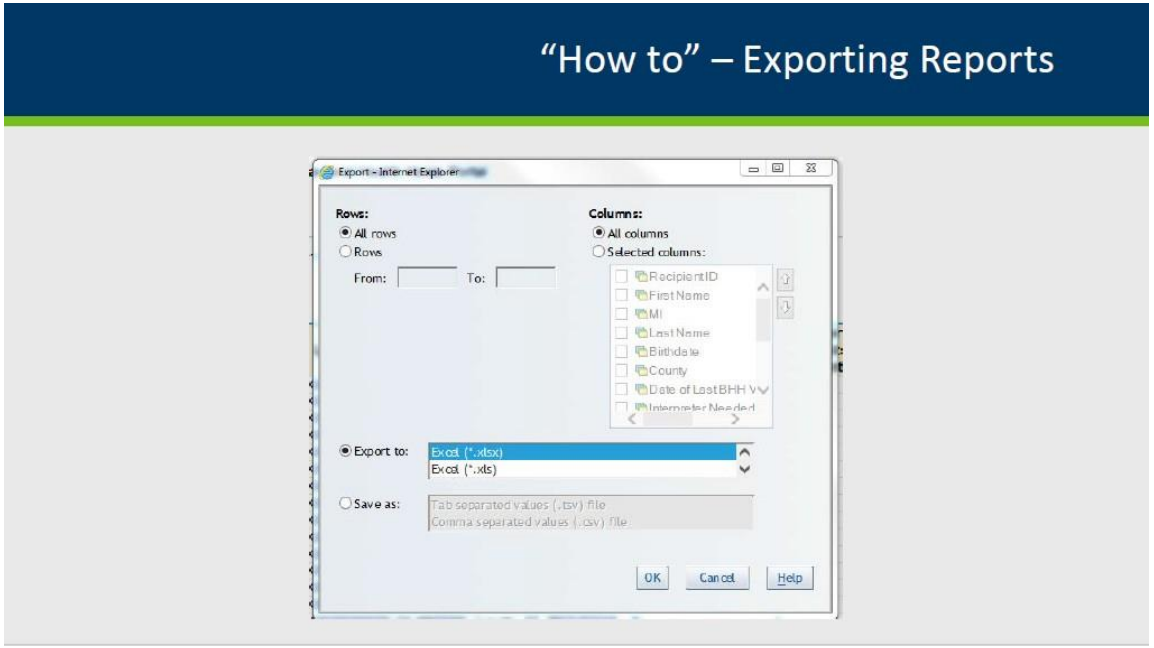
Exporting reports to excel can allow the BHH provider to manage the data to pull information on single BHH individuals or a group of individuals that share similar traits.

How to export reports



To export the report after it has run, first right-click on the report and choose "Export Table," as shown in screenshot.

Exporting reports, continued



Click "OK" to choose the default options OR choose to export specific rows or columns in the pop-up window.

To export specific rows, click the "rows" radio button in the pop-up window and enter the range of rows you wish to export.

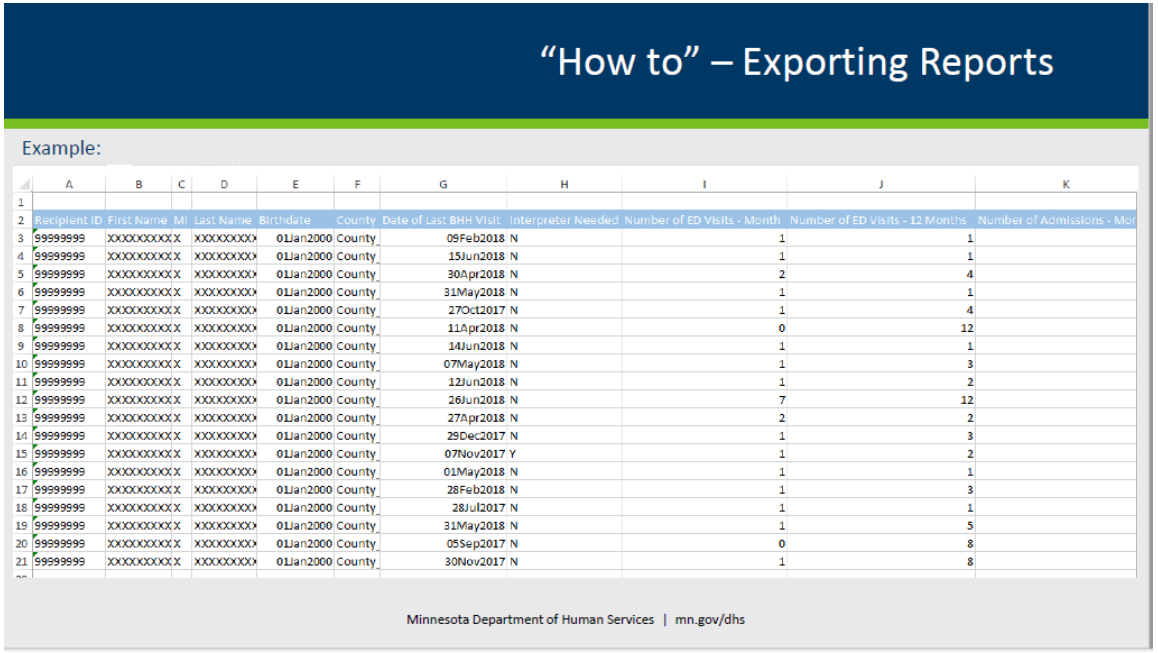
Choose specific columns to export by clicking "select columns" on the upper right corner of the pop up window. When that radio button is chosen, check the columns to export from the report. For example, use this option when running the care management report. Note, this report has 3+ pages of columns; a BHH team may only want to view a few of the columns.

After export selections have been made, click "OK."

Opening exported report

The next pop-up screen will show open, save or save as. Any option can be chosen here. If you choose "open," the report can be saved later to your desired location.

Reports in excel



Recipient ID	First Name	MI	Last Name	Birthdate	County	Date of Last BHH Visit	Interpreter Needed	Number of ED Visits - Month	Number of ED Visits - 12 Months	Number of Admissions - Mor
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	09Feb2018	N	1	1	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	15Jun2018	N	1	1	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	30Apr2018	N	2	4	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	31May2018	N	1	1	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	27Oct2017	N	1	4	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	11Apr2018	N	0	12	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	14Jun2018	N	1	1	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	07May2018	N	1	3	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	12Jun2018	N	1	2	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	26Jun2018	N	7	12	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	27Apr2018	N	2	2	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	29Dec2017	N	1	3	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	07Nov2017	Y	1	2	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	01May2018	N	1	1	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	28Feb2018	N	1	3	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	28Jul2017	N	1	1	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	31May2018	N	1	5	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	05Sep2017	N	0	8	
99999999	XXXXXXXXX	X	XXXXXXXX	01Jan2000	County	30Nov2017	N	1	8	

Once the report is exported it will look similar to this example. From here the report can edited as needed.

Thank you


DEPARTMENT OF HUMAN SERVICES
Thank you!
Questions?
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