Building a Foundation for Value-Based Care

Suffolk Care Collaborative
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WHAT IS DSRIP?

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

- Sponsored by CMS
- Five-year population-based health management program; year one began in April 2015
- $6.4b in total available to NYS through DSRIP. $300m for Suffolk
- Funding must be earned by meeting performance and outcomes measures (*State wide performance matters*)
- Information technology (interconnectivity), enhanced Care Management and expanded access to Primary Care are critical to the success of the program
- Key theme is collaboration! Communities of eligible providers are required to work together to develop DSRIP Project Plans

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GOALS…

- Transform health care delivery throughout NYS improving the way care is delivered to Medicaid and uninsured patients
- Preserve and transform the State's fragile healthcare safety net system
- Create new provider type called Performing Provider Systems (PPSs). 25 PPSs Statewide. Stony Brook is the Lead for Suffolk County
- Reduce avoidable hospitalizations and ED visits by 25% *(PQI's, PPR's, etc)*
- Demonstrate improved clinical outcomes *(HEDIS, AHRQ, etc.)*
- Reduce the overall cost of care by focusing on prevention, integration and primary care
- Convert 90% of Payments for Medicaid Beneficiaries to Value Based Payments

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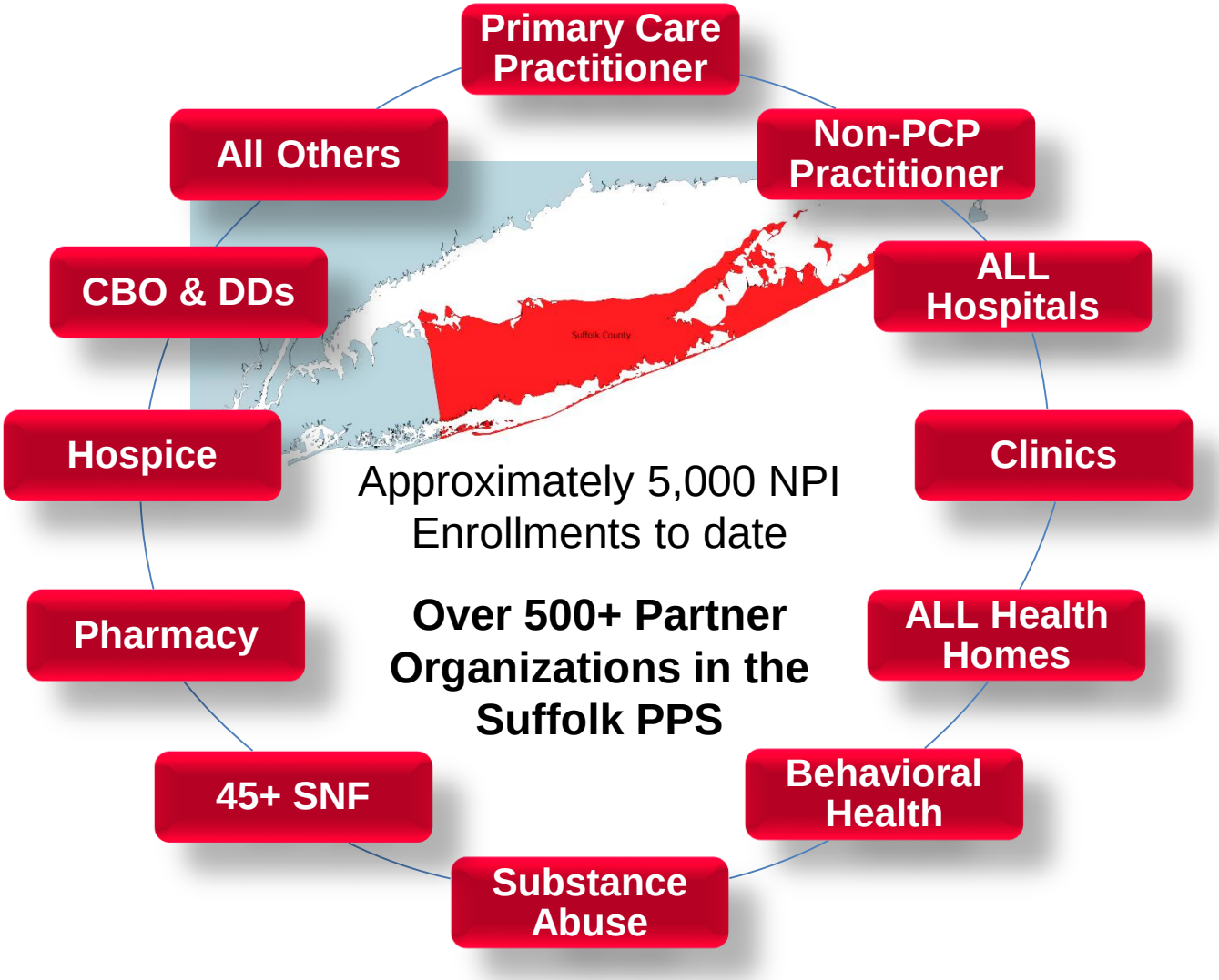
PERFORMING PROVIDER SYSTEM COMPOSITION



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Our vision to become a highly effective, accountable, integrated, patient-centric delivery system has positioned us well to make an important contribution to the DSRIP program.

Some of the many goals will include the capacity to enhance patients' self-care abilities, improve access to community-based resources, break down care silos and reduce avoidable hospital admissions and emergency room visits.

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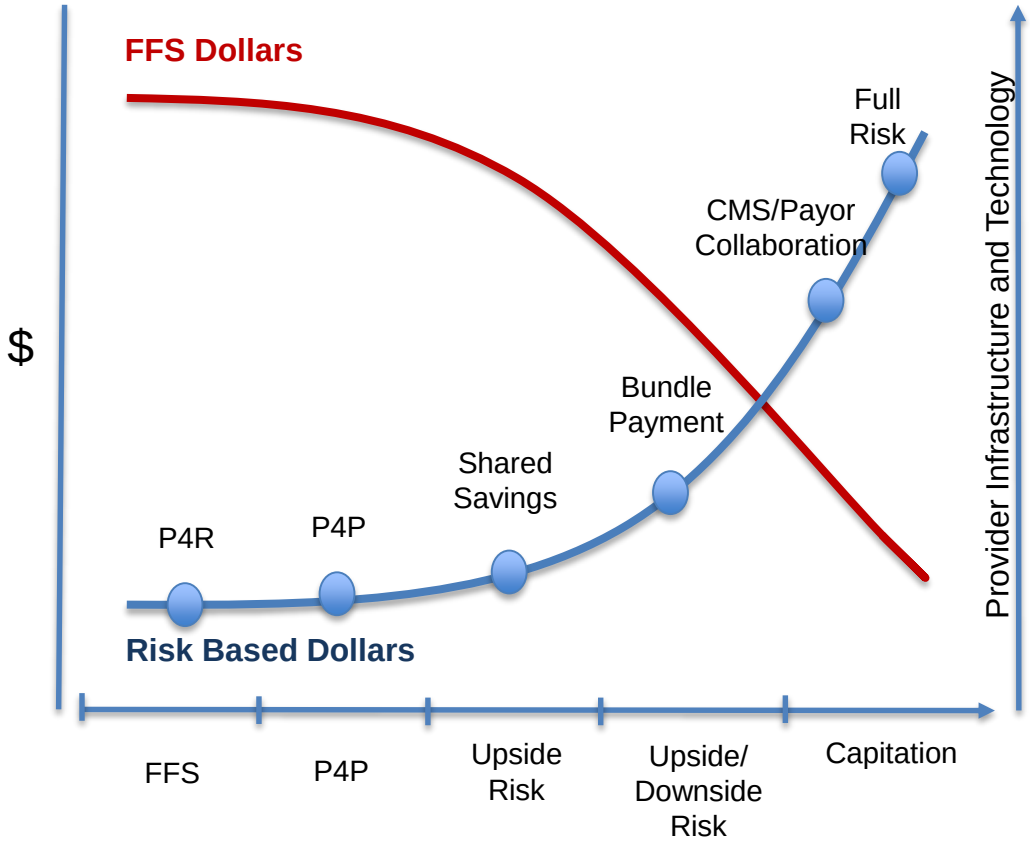
INFLECTION POINT IN VALUE BASED CARE



- VBP rewards providers for achieving quality and cost targets
- Shifting gears towards VBP involves a different set of processes and resources than those used under FFS
- Providers must also be prepared to invest in infrastructure and resources
- Danger lies in “sitting pat” (ie MACRA)
- As VBP models gain a stronger foothold in our market, how do we manage the financial risk while delivering safe, high quality and effective care
- What are the investments that need to be made?

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LEVERAGING DSRIP AS A CATALYST

DSRIP has created capabilities for Medicaid, most of which can be leveraged across multiple lines of business.

Population Health Management Service Org *(Foundation)*

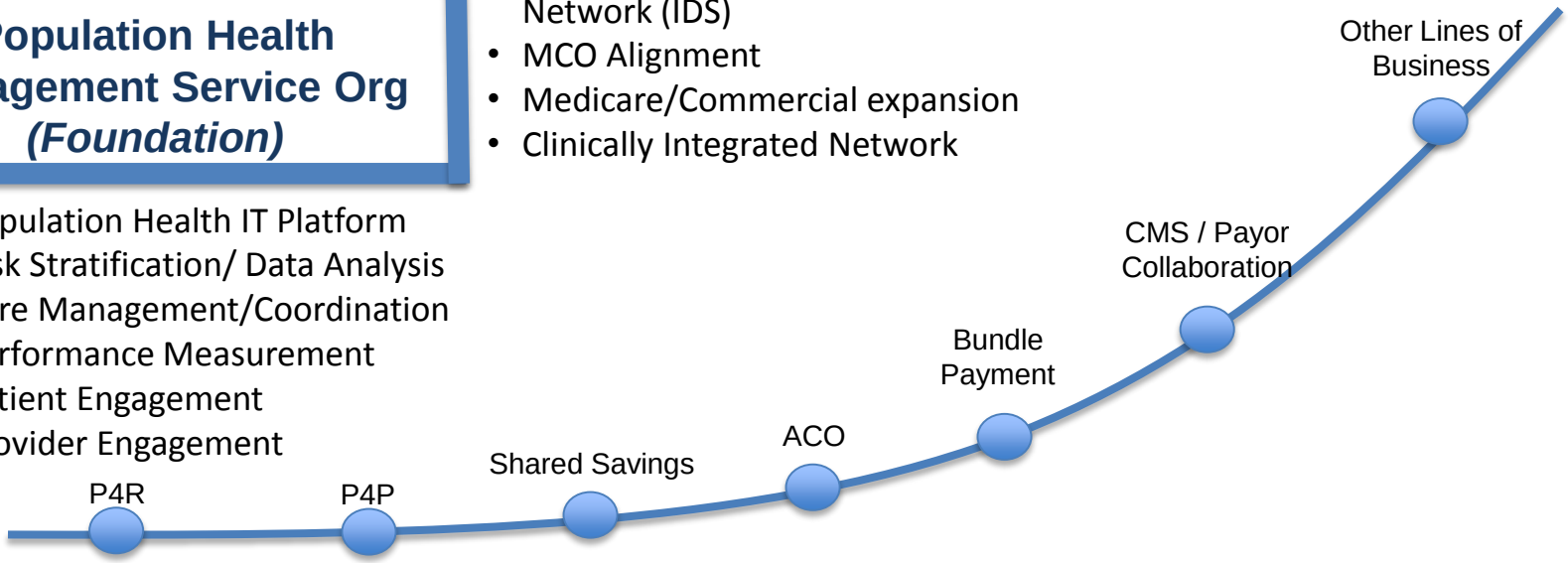
- Population Health IT Platform
- Risk Stratification/ Data Analysis
- Care Management/Coordination
- Performance Measurement
- Patient Engagement
- Provider Engagement

Clinical and Financial Model (re)Design

- Aligned, High Performing Network (IDS)
- MCO Alignment
- Medicare/Commercial expansion
- Clinically Integrated Network

Provider Sponsored Health Plan

- Patient Enrollment
- Utilization Management
- Claims Payment



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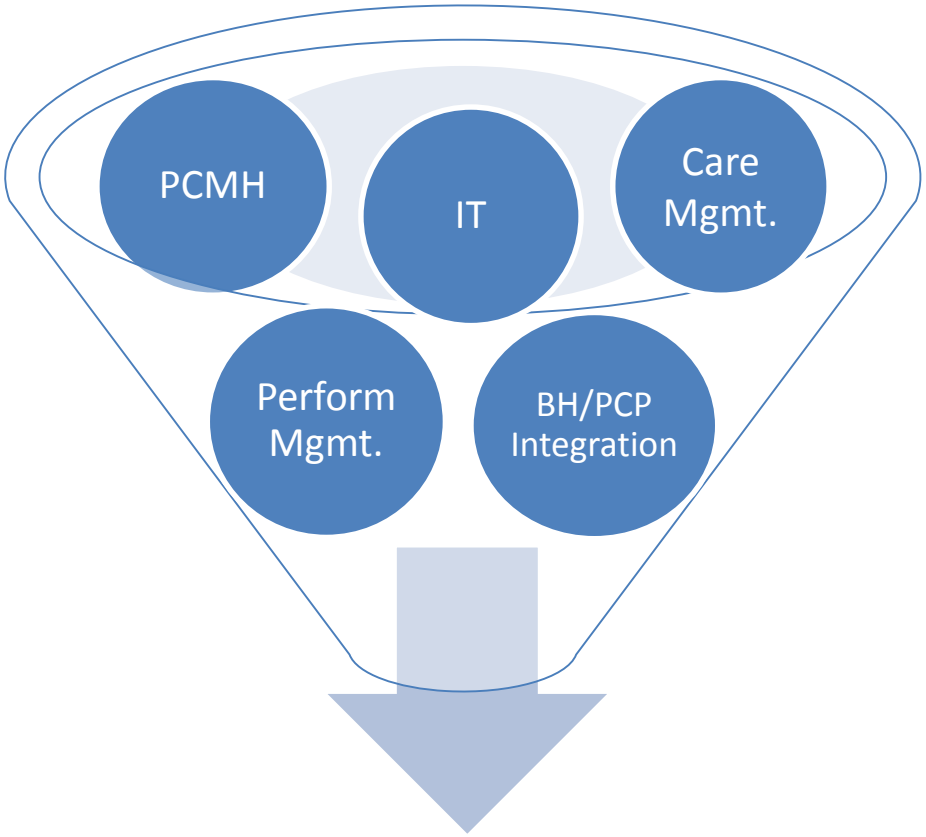
UNDERSTANDING VALUE



SUPPORTING THE TRANSITION FROM FFS TO VALUE

- We believe that a Primary Care driven, patient centered model is the core of a successful VBP Model
- More than just changing provider contracts and compensation. Real change must occur
- Requires a proactive clinical focus, in which patients at high/rising risk for disease progression are identified for early intervention
- Requires ongoing patient engagement and education
- Coordination with CBO's to address Social Determinants is a must
- Population Health Management Infrastructure

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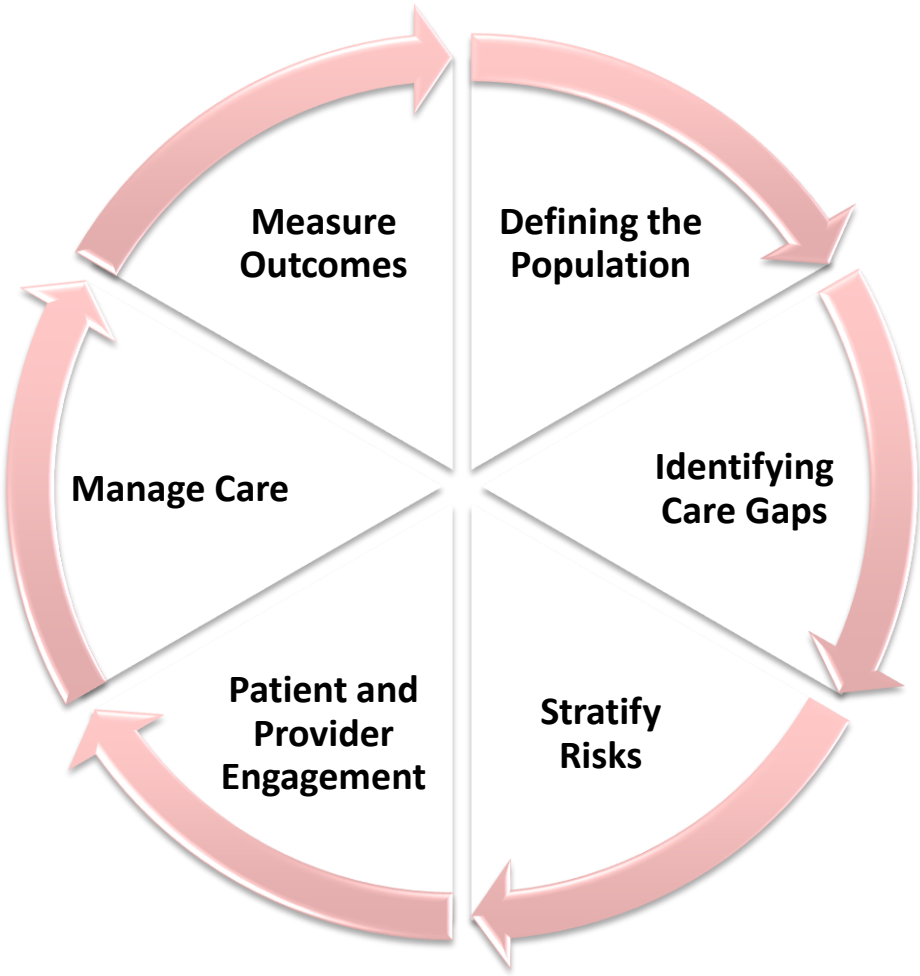
"HOW DO YOU AFFECT CHANGE"
POPULATION HEALTH MANAGEMENT STRATEGY

Definition and Approach

We define Population Health Management (PHM) as the aggregation of patient data across multiple platforms, the analysis of that data and the actions taken through which care providers can improve both clinical and financial outcomes.

It is the technical field of endeavor which utilizes a variety of individual, organization and cultural interventions to help improve patient self-care, morbidity patterns and the health care use behavior of defined populations.



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Defining the Population → Identifying Care Gaps → Stratify Risks → Engagement → Manage Care → Measure Outcomes

We've operationalized a system to integrate data to define our populations

Aggregate and normalize

Create and apply intelligence

Act and measure

Over 50 contracted partners engaged in *technical onboarding*, a term used to describe a set of tasks to complete data integration into our PHM platform

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Defining the Population → Identifying Care Gaps → Stratify Risks → Engagement → Manage Care → Measure Outcomes

Practice-level registry functionality to address gaps in care and management of chronic conditions!

Each registry has a set of measures:

REGISTRY	MEASURE
Hypertension	Blood Pressure Measurement
	High Blood Pressure Plan of Care
	Lipid Panel
	Influenza Vaccination - Full Season
	Tobacco Use Screening and Cessation
	Blood Pressure Control
Pediatric Asthma	Asthma Action Plan
	Medication Management
	Influenza Vaccination - Full Season
	Hospital Visit/Admission
Asthma	Action Plan Complete
	Medication Management
	Influenza Vaccination - Full Season
	Pneumonia Vaccination
	Tobacco Use Screening and Cessation
Depression	Alcohol Use Screening
	Illicit Drug Use Screening
	Medication During Acute Phase
	Medication During Continuous Phase

Chronic Disease Registries

6 Complete

- Hypertension
- IVD/CAD
- Diabetes
- Depression
- Asthma
- Pediatric Asthma

Wellness Registries

3 Complete

- Pediatric Wellness
- Adult Wellness
- Senior Wellness

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Defining the Population → Identifying Care Gaps → Stratify Risks → **Engagement** → **Manage Care** → Measure Outcomes

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RN Care Managers

- High risk medical conditions
- New diagnosis
- Education on disease and medications
- Medication reconciliation
- Wound concerns
- IV antibiotics and high risk medication review
- Coordination of care with the PCP
- Advanced care planning
- Transitions of Care

Social Workers/ Mental Health Counselors

- Behavioral health diagnosis
- Co-morbid behavioral health diagnosis
- Suicidality
- Substance use disorders
- Abuse, neglect concerns
- Family dynamic impeding care
- Advanced care planning
- Financial concerns
- Brief supportive counseling
- Cognitive concerns leading to inability to care for oneself
- Transitions of care (behavioral health)

Community Health Associates

- Resource optimization
- Functional limitations requiring intervention
- Home safety evaluations
- Medication reviews
- Advanced care planning
- Financial concerns
- Transitions of care (low risk)

Embedded and Remote Care Management

Transitions of Care

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Care Management To Addresses Barriers Associated With The Social Determinants Of Health

Patient identification, selection, and engagement → Assessment and opportunity identification → Development and implementation of the care management plan of care → Monitoring and evaluating the care management plan of care → Closure of professional care management services

- Income/Poverty
- Financial Instability/Sustainability
- Access to Food
- Access to Clothing
- Safe and Affordable Housing
- Availability of Resources
- Community Safety
- Safe, Reliable, Affordable Transportation
- Education
- Cultural Needs
- Lack of Child Care
- Lack of Elder Care
- Coordination/Support
- Family Dynamics
- Chronic Disease
- Justice System Interaction
- Lack of Physical Activity
- Access and Affordability of Medications
- Relationship with Medical Providers
- Religious/Spiritual Needs
- Health Literacy
- Employment/Vocational Needs
- Access to Care
- Palliative Care Needs
- Language Barriers
- Social Isolation
- Behavioral Health Diagnosis with Treatment
- Behavioral Health Diagnosis without Treatment
- Undiagnosed Behavioral Health
- Tobacco Use
- Substance Use/Abuse
- Affordability of Utilities
- Development/Acquired Disabilities

Addressing Social Determinants of Health

The SCC CMO has interacted with over **2,000 patients** to date and has made approximately **1,500 referrals** to Community Based Organizations, representing **over 100 different organizations**.

The **areas of need** we have found most prevalent:

- Housing
- Food Instability
- Transportation
- Legal Services & Immigration Needs
- Clothing & Other Supply Needs
- Home Modifications & Renovations
- Financial Instability
- Healthy Activity Needs

The CMO has engaged **CBO Partners** to conduct in-services and trainings with the Care Management staff.

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COMMUNITY HEALTH ACTIVATION PROGRAM AND COMMUNITY BASED ORGANIZATION PARTNERSHIPS

CBOs Lead Program Operations of CHAP

Four CBO partners have been engaged to date, since the initiation of CHAP in 2015, and continue to provide survey, coaching and navigation services for the CHAP program

HRHCare Hudson River Community Health

Association for Mental Health and Wellness — To Advocate. To Educate. To Empower. Together.

Helping People. Changing Lives. Community Action Partnership — America's Poverty Fighting Network

Planned Parenthood® Care. No matter what.

Program Highlights:

- ~32,000 Surveys completed & individuals engaged since initiation of program
- Over 350 CHW's trained in PAM, Coaching for Activation and CC/HL
- Address gaps and track referrals to primary care, social services, MCO's, etc.
- Resurveyed 32% and 21% moved PAM levels in a positive direction
- Creating focused list of Non-Utilizers (NU) and Low-Utilizers (LU)

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PROMOTING CHRONIC DISEASE SELF MANAGEMENT PROGRAMS

CMO staff drive referrals…

Asthma Home Environmental Trigger Assessment Program

- Provides home assessments as well as support, training and education for patients and families on, self-monitoring, medication use, and medical follow-up to reduce avoidable emergency department and hospital visits

Stanford Chronic Disease Self Management Program - Cardiovascular and Diabetes Wellness

- FREE CDSMP or DSMP workshop series are offered at no cost to participants. The workshops consist of small groups who meet once per week for 6 weeks, 2 ½ hours per session at convenient locations.
- Topics covered include:
    - Techniques to deal with symptoms
    - Appropriate exercise for maintaining and improving strength, flexibility, and endurance
    - Healthy eating and nutrition
    - Appropriate use of medications
    - Communicating effectively with family, friends, and health professionals
    - Decision making
    - How to evaluate new treatments

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NEW MODELS OF HEALTH CARE DELIVERY
INTEGRATING PRIMARY CARE & BEHAVIORAL HEALTH SERVICES

The "burning platform"

- Approximately **23%** of our PPS Medicaid members are defined as behavioral health recipients.
- Behavioral health recipients cost, on average, **4.65 times more** per recipient and represent **58%** of total Medicaid spending
- Behavioral health recipients drive **48% of all ED visits**
- Behavioral health recipients represent **58%** of admissions to hospital and on average have a **1.65X** longer length of stay in hospital than non-behavioral health recipients
- ***32%* of all Primary Care visits are attributed to behavioral health recipients**

How we're making a change?

- **401 PCP** and **347 BH Providers** are Participating in the SCC's PCBH Integrated Care Program

	Target Number of Practice Sites	Engagement Complete (Educated and/or Evaluated)	Integrated Care Complete
Grand Total	**144**	**144 (100%)**	**39 (27%)**

*Source: CY 2013-2014 Medicaid claims data is the data source

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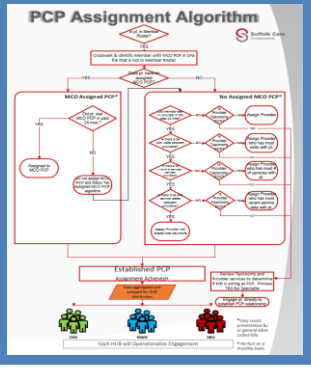
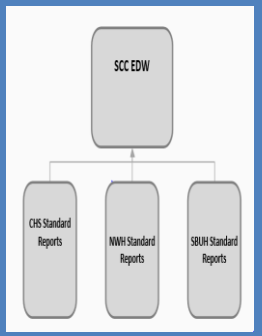
Performance Measurement Data Strategy



Provider Data

DOH MAPP/Salient Data will be used for pay for performance



HealtheAnalyticsTM will be used for concurrently measuring performance

Provider Dashboards

- Used by the Provider Relations Team to engage physicians on performance on critical DSRIP P4P measures
- Leveraging *HealtheEDW* tools to view all measures in a single dashboard
- Measures
  - 15 AHRQ
  - Prevention quality indicators
  - Pediatric quality indicators
  - 3 3M measures
  - Potentially preventable visits
  - Potentially preventable readmission
  - 33 HEDIS
  - Clinical measures
  - Access to care

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

3M Science. Applied to Life.™

NCQA Measuring quality. Improving health care.

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Measure > Practice > Provider	Numerator	Denominator	Result	Target	Gap to Goal Lives
ABU MUHAMMAD M. HAQUE M.D.P.C.					
Adult Access Preventive (45 - 64)	38	41	92.7%	86.0%	
Adult Access Preventive (65 and Older)	10	10	100.0%	88.2%	
Adult Access Preventive (20 - 44)	40	45	88.9%	79.1%	
Antipsychotic Medication Adherence	0	4	0.0%	64.8%	3
Asthma Medication Ratio (5 - 64 Years)	2	2	100.0%	62.2%	
Child Access - Primary Care (12 to 19)	1	1	100.0%	93.9%	
CV Monitoring (CV & Schizophrenia)	0	1	0.0%	71.4%	1
Diabetes Monitoring (DM & Schizophrenia)	1	2	50.0%	70.1%	1
Diabetes Screening (Antipsychotic Medication)	4	5	80.0%	77.3%	
Engagement of Alcohol/Drug Treatment	1	8	12.5%	28.3%	2
Follow Up after MH Inpatient (30 Days)	1	2	50.0%	60.4%	1
Follow Up after MH Inpatient (7 Days)	1	2	50.0%	44.4%	
Initiation of Alcohol/Drug Treatment	2	8	25.0%	53.0%	3
Medication Mgmt for Asthma (50%)	0	2	0.0%	54.3%	2
Medication Mgmt for Asthma (75%)	0	2	0.0%	28.5%	1
ADAM M. KATOF, D.O., PLLC					
Adult Access Preventive (20 - 44)	1	1	100.0%	79.1%	
Advantage Care					
Adult Access Preventive (45 - 64)	5	5	100.0%	86.0%	
Adult Access Preventive (20 - 44)	1	1	100.0%	79.1%	
Asthma Medication Ratio (5 - 64 Years)	1	1	100.0%	62.2%	
Child Access - Primary Care (12 to 19)	2	2	100.0%	93.9%	
Medication Mgmt for Asthma (50%)	0	1	0.0%	54.3%	1
Medication Mgmt for Asthma (75%)	0	1	0.0%	28.5%	1

**Data reflects: January-December, 2015

HUB Filter
- CHS
- NO MC PCP
- Not in SCC
- NWH
- SBU

Practice Location Filter
- Advantage Care
- Advantage Care 300 Bay Shore Rd - Bay Shore
- Advantage Care 640 Hawkins - Lake Ronkonko...

Measure Filter
- Adult Access Preventive (45 - 64)
- Adult Access Preventive (65 and Older)
- Adult Access Preventive (20 - 44)
- Antipsychotic Medication Adherence
- Asthma Medication Ratio (5 - 64 Years)

- **Drilldown Functionality By HUB, Practice, Provider, Measure**
- **Filter Report To Identify Targets Not Met (Highlighted in Red)**
- **Identified The Number Of Lives Needed To Close Performance Gaps**