



**Suffolk Care**  
Collaborative

# PERFORMANCE MANAGEMENT PROGRAM

NYS DSRIP ALL-PPS MEETING

JULY 12, 2017

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Vice President, Population Health Management Services

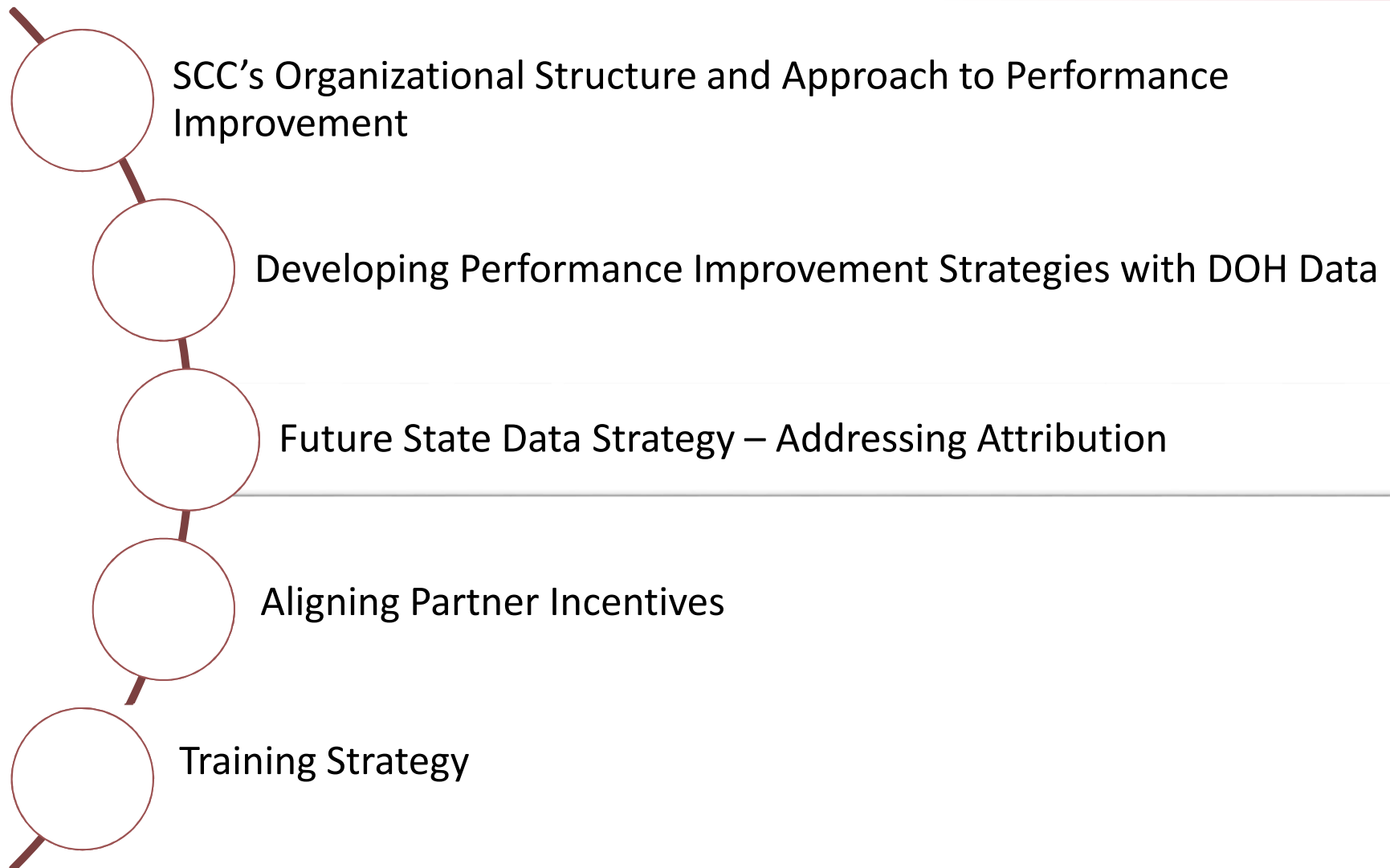
**Sam Lin, MHA, PMP**

Administrative Manager, Integrated Care Programs

**Christopher Ray, MS**

Data Analyst, Network Development and Performance







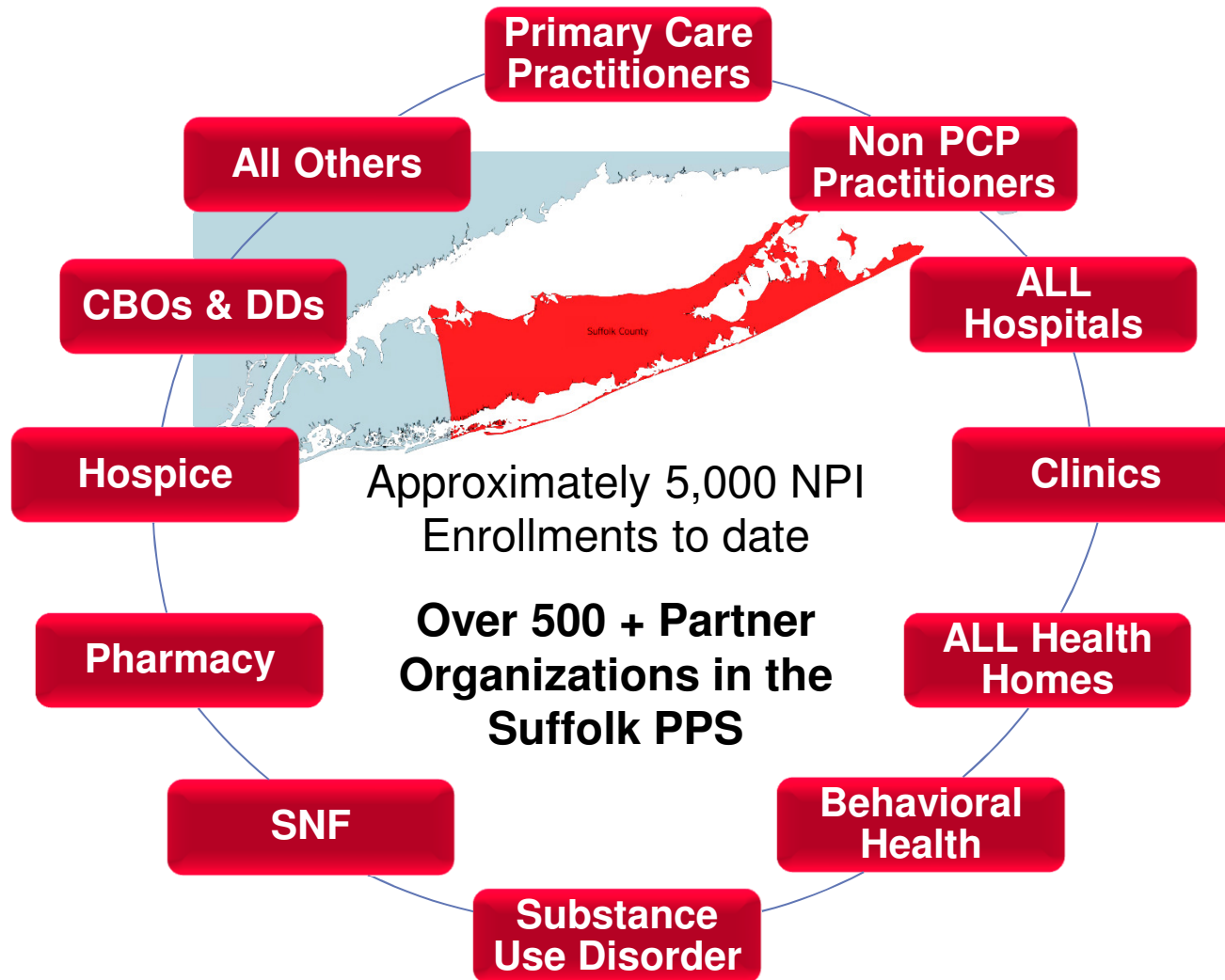
## **SCC'S ORGANIZATIONAL STRUCTURE AND APPROACH TO PERFORMANCE IMPROVEMENT**

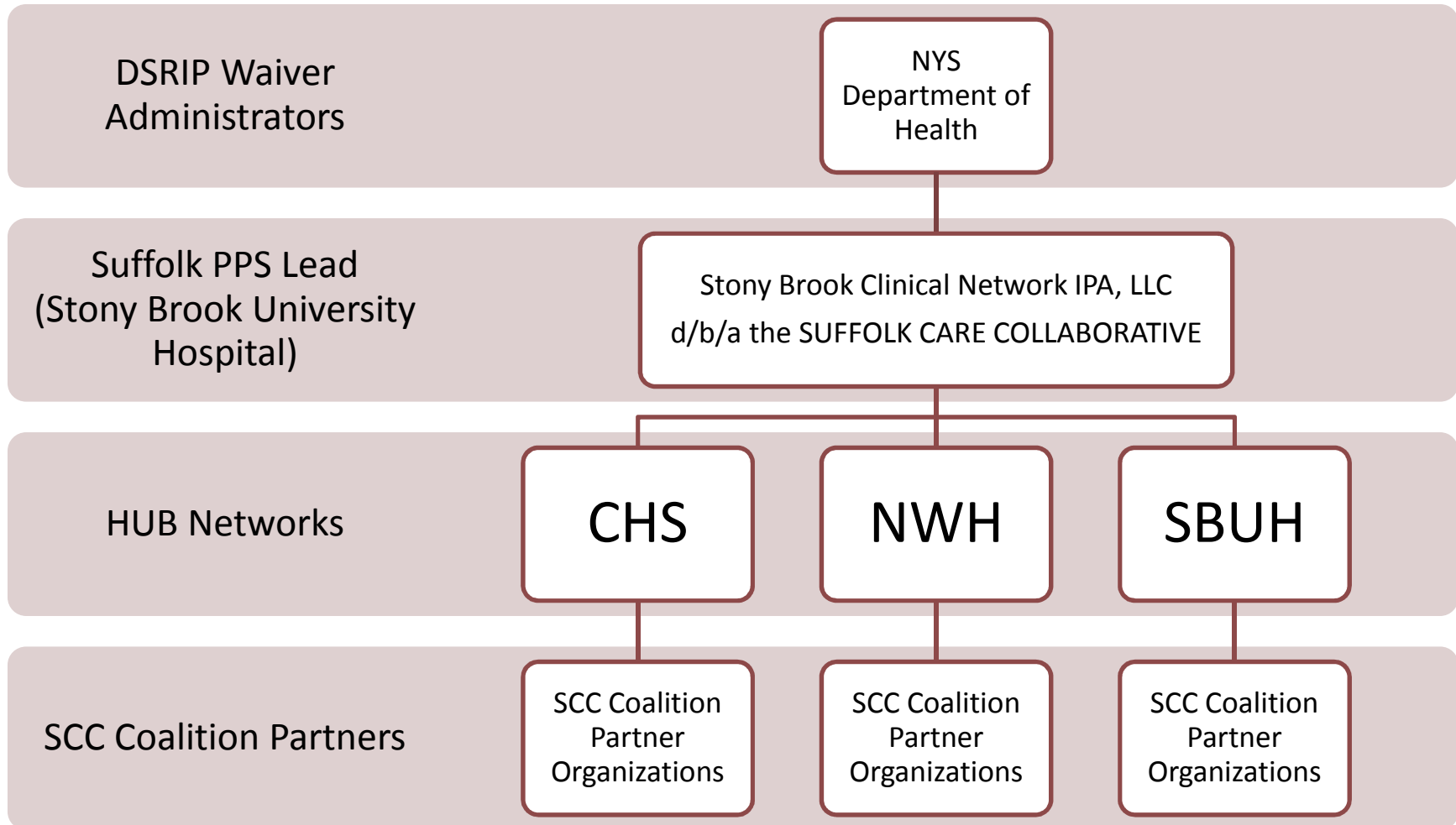
*Presented by:*

**Kevin Bozza, MPA, FACHE, CPHQ, RHIT**

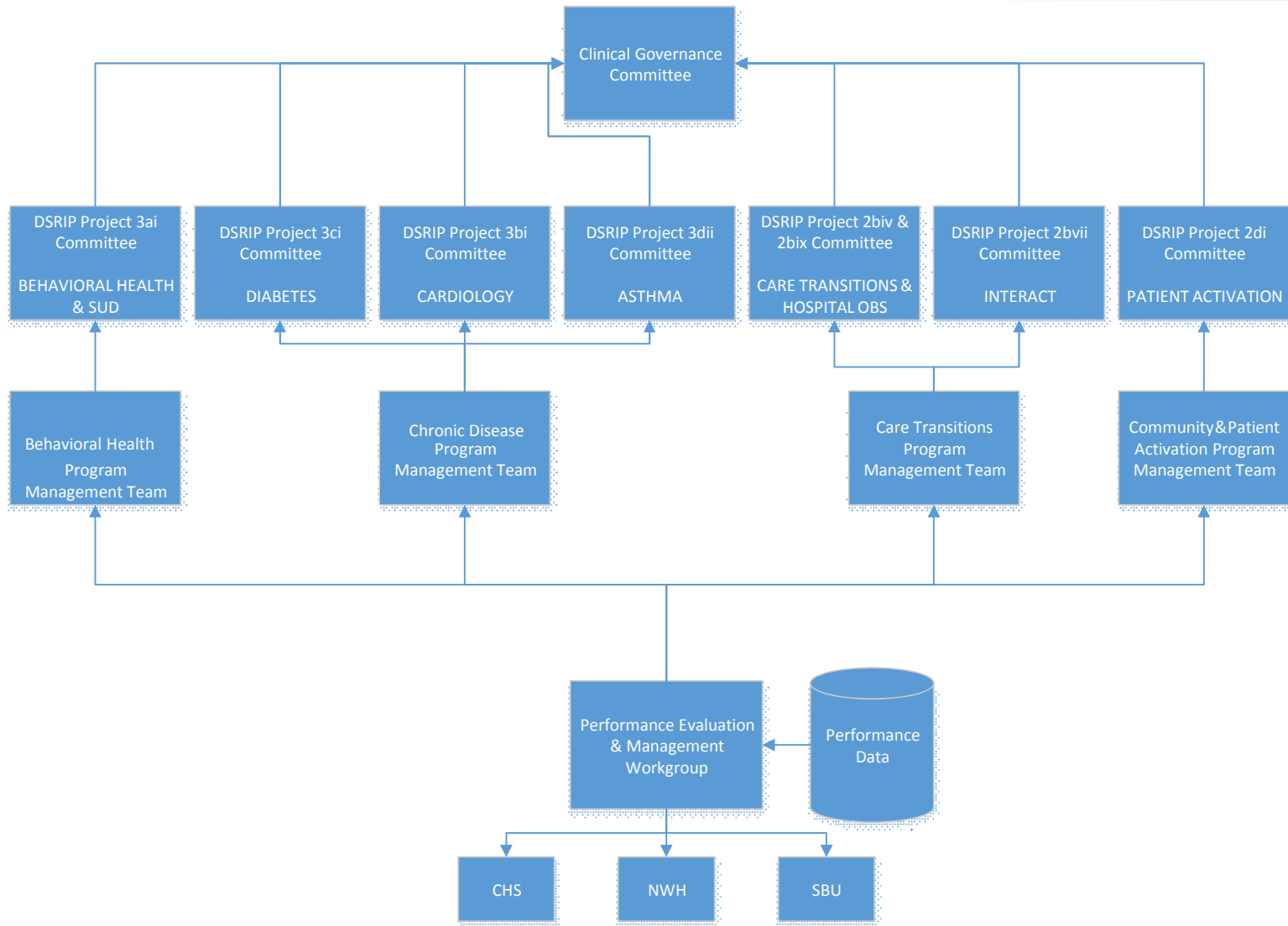
Vice President, Population Health Management Services  
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## PERFORMING PROVIDER SYSTEM COMPOSITION





- The **PMO Team** and **Network Development & Performance Team** has aligned operations into 1 Program Management Structure.
- The 11 DSRIP projects have been organized into 5 clinical improvement programs:
  - **Chronic Diseases Program**
  - **Behavioral Health Program**
  - **Care Transitions Program**
  - **Community & Patient Activation Program**
  - **Integrated Delivery System Program**
- Program Management efforts have been categorized into two main functions:
  - Program Operations/Process Improvement
  - Performance Improvement
- Programs will be managed by a “**Program Management Team**” representative of internal stakeholders with responsibility to ensure program success
- The Program Management Team is supported by one PM from the PMO and one PM from the Performance Team





QI STEPS	SCC Action Plan
<b>Prioritization</b>	<ul style="list-style-type: none"> <li>• Measures prioritized at the beginning of each Measurement Year based on dollar valuation, number of lives to close</li> <li>• Performance Workbooks created by HUB prioritizing partners for outreach (Heat Maps)</li> <li>• SCC Clinical Alert</li> </ul>
<b>Performance Drivers</b>	<ul style="list-style-type: none"> <li>• Clinical Documentation Improvement Guide created to identify the specific performance drivers to close the gap</li> </ul>
<b>Process Deficiency</b>	<ul style="list-style-type: none"> <li>• Clinical Transformation Teams across the HUBS working with partners to identify and address gaps</li> </ul>
<b>Process Improvement</b>	<ul style="list-style-type: none"> <li>• SCC PI Toolkit               <ul style="list-style-type: none"> <li>Data Collection Plan</li> <li>PDSA Cycle Template</li> <li>Corrective Action Plan</li> </ul> </li> <li>• Lean Projects</li> <li>• MAX Series</li> <li>• SCC Learning Center</li> <li>• GNYHA Ambulatory PI Training Collaborative</li> </ul>



# DEVELOPING PERFORMANCE IMPROVEMENT STRATEGIES WITH DOH DATA

*Presented by:*

**Christopher Ray, MS**

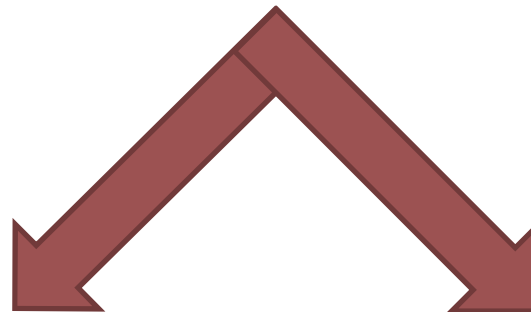
Data Analyst, Network Development & Performance

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The SCC has utilized several data sources to support performance improvement:

<b>Data Source</b>	<b>Purpose</b>
Salient Interactive Miner	DOH Performance Data
Salesforce	SCC Provider Network
DOH MAPP Provider Network	SCC Provider Network
GNYHA PPS Strategic Planning Model	Financial details and forecasting for DSRIP metrics

# The SCC's Performance Management Team has two main focuses:



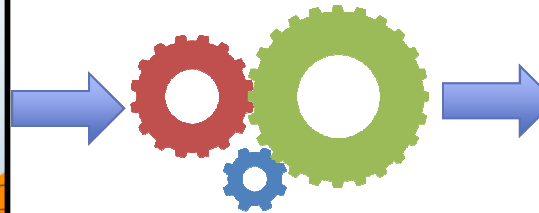
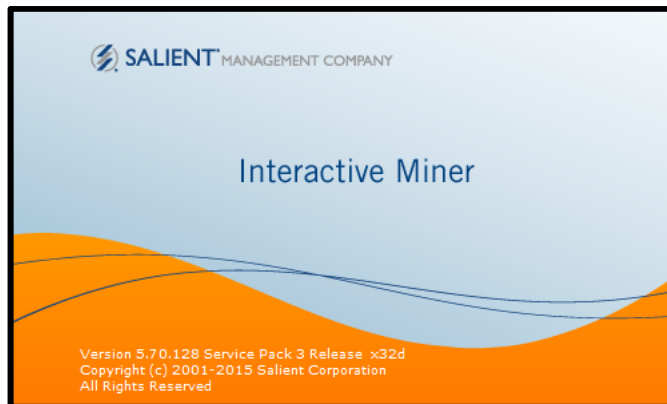
Performance  
Improvement Monitoring



Measure Prioritization



Using the DOH's performance data and combining it with SCC's Provider Network information, SCC was able to create interactive workbooks to tell the story.

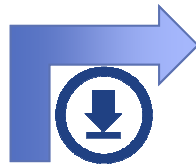


Measure	In-Network					
	Result	Annual Target	# Lives to Goal	HP Target	HP # Lives to Goal	Proportion of At-Risk Population
Adult Access Preventive (20 - 44) (+)	82.97	79.11				59.9%
Adult Access Preventive (45 - 64) (+)	88.80	86.02				68.5%
Adult Access Preventive (65 and Older) (+)	91.17	88.23				70.2%
Antidepressant Medication Mgmt (Acute) (+)	54.20	55.06	10	55.61	17	57.2%
Antidepressant Medication Mgmt (Cont) (+)	40.19	40.75	7	41.05	10	57.2%
Antipsychotic Medication Adherence (+)	64.72	64.76	1			44.1%
Asthma Medication Ratio (5 - 64 Years) (+)	64.30	62.18				77.4%
Child Access - Primary Care (12 to 19) (+)	96.79	93.93				74.8%
Child Access - Primary Care (12 to 24 Months) (+)	97.33	96.33				79.9%
Child Access - Primary Care (25 Months to 6) (+)	94.82	93.08				82.4%
Child Access - Primary Care (7 to 11) (+)	98.40	96.87				82.3%
Child ADHD Medication F/U (Continuation) (+)	54.79	60.77	5			70.2%
Child ADHD Medication F/U (Initiation) (+)	50.00	53.14	10			71.4%
CV Monitoring (CV & Schizophrenia) (+)	68.18	71.37	1	73.68	2	42.3%
Diabetes Monitoring (DM & Schizophrenia) (+)	59.85	70.05	14	72.24	17	44.4%
Diabetes Screening (Antipsychotic Medication) (+)	76.41	77.29	9			48.7%
Engagement of Alcohol/Drug Treatment (+)	29.18	28.28				55.3%
Follow Up after MH Inpatient (30 Days) (+)	62.72	60.43		63.52	7	48.6%
Follow Up after MH Inpatient (7 Days) (+)	48.25	44.36		47.68		48.6%
PQI 8 - Heart Failure Admission Rate (-)*	158.10		-			51.8%
Initiation of Alcohol/Drug Treatment (+)	90.08	52.95	85			55.3%
Medication Mgmt for Asthma (50%) (+)	48.56	54.34	65			77.4%
Medication Mgmt for Asthma (75%) (+)	23.96	28.49	51			77.4%
PDI 14 - Pediatric Asthma (-)	245.81	218.38	14			71.9%
PDI 90 - Pediatric Composite (-)	237.93	278.62				71.7%
Potentially Avoidable Readmissions (-)	439.05	601.12		554.40		59.1%
Potentially Preventable ED Visits (-)	27.92	28.87		26.34	1868	58.7%
Potentially Preventable ED Visits (BH) (-)	89.16	99.27		92.16		54.3%
PQI 1 - DM Short Term Complications (-)	99.85	85.31	9			51.8%
PQI 15 - Asthma Younger Adults (-)	82.69	95.53				48.8%
PQI 7 - Hypertension (-)	71.56	99.94				51.8%

Data Period: July 1, 2015 - June 30, 2016

# Salient Export

- Data is exported from the Salient Interactive Miner (SIM) tool when each quarter of DOH performance data is released
- Data is organized “By” Measure and MC PCP\*
- Exported to Excel
- Salient Help Team ([hhssupport@salient.com](mailto:hhssupport@salient.com)) is a *great* resource!



Comp ~ ME 6/2016

Tracking\_Measures

PPS Name: SUNY at Stony Brook University Hospital >

By: Measure Goal DOWN | Measure \ Current MC PCP Provider

Sort: Name:ASC

Filters: Measure:G[PPS]\_Dashboard Measures

Total Measure Goal: 2

	Line Monthly Member Measure	Line Monthly Member Measure Denominator	Monthly Member Measure Result
DOWN	65,533	956,719	5,313.84
+ PDI 14 - Pediatric Asthma	147	70,754	207.76
+ PDI 90 - Pediatric Composite	113	50,437	224.04
+ PQI 1 - DM Short Term Complications	118	116,008	101.72
+ PQI 15 - Asthma Younger Adults	47	66,869	70.29
+ PQI 7 - Hypertension	69	116,008	59.48
+ PQI 8 - Heart Failure Admission Rate	177	116,008	152.58
+ Potentially Avoidable Readmissions	1,040	205,895	505.11
+ Potentially Preventable ED Visits	51,764	201,850	25.64
+ Potentially Preventable ED Visits (BH)	12,058	12,890	93.55
UP	113,413	140,711	80.60
+ Adult Access Preventive (20 - 44)	28,853	36,548	78.95
+ Adult Access Preventive (45 - 64)	18,435	21,266	86.69
+ Adult Access Preventive (65 and Older)	1,666	1,871	89.04

Comp ~ ME 6/2016

Total Measure Goal: 2

Dataset: NY Medicaid DV6 - DOH

User: CRAY

Cube: Tracking\_Measures

Path: PPS Name: SUNY at Stony Brook University Hospital

By: Measure Goal \ Measure \ Current MC PCP Provider

Filters: Measure:G[PPS]\_Dashboard Measures

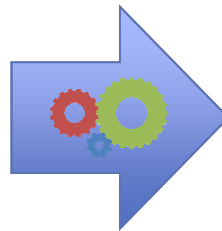
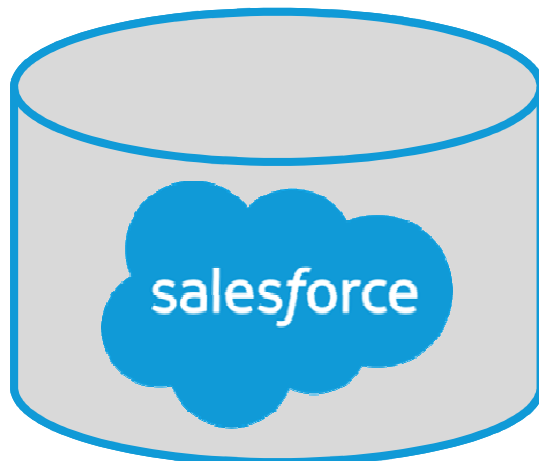
Sort: Name:ASC

Measure Goal	Measure	Current MC PCP Provider	Line Monthly Member Measure Numerator	Line Monthly Member Measure Denominator	Monthly Member Measure Result
DOWN			65,533	956,719	5,313.84
DOWN	PDI 14 - Pediatric Asthma		147	70,754	207.76
DOWN	PDI 14 - Pediatric Asthma	Provider 1	0	1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 2	0	1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 3	2	97	2,061.86
DOWN	PDI 14 - Pediatric Asthma	Provider 4	0	2	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 5	0	5	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 6	0	3	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 7	0	1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 8	0	4	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 9	0	2	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 10	0	3	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 11	0	1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 12	0	2	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 13	0	1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 14	0	1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 15	0	16	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 16	0	47	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 17	2	26	7,692.31
DOWN	PDI 14 - Pediatric Asthma	Provider 18	0	2	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 19	0	687	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 20	0	1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 21	0	58	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 22	0	1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 23	0	2	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 24	0	1	0.00

\*DOH Data MC PCP-centric. The PPS is unable to align ~ 43% of the at-risk population to a provider as of the June 2016 attribution.

# Incorporate Provider Network

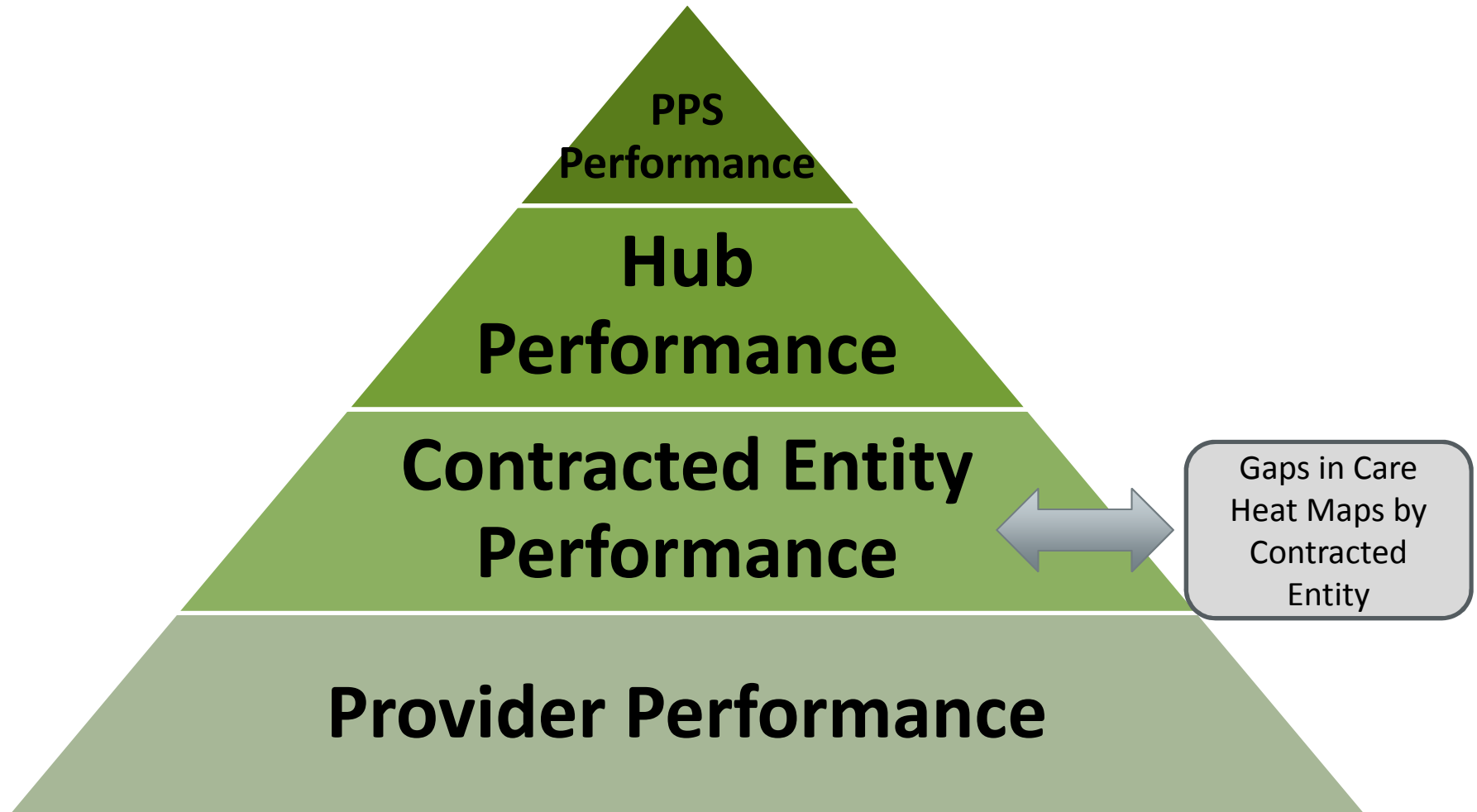
- Salient data (MC PCPs) are cross-walked with the SCC's internal provider network information (housed in Salesforce), as well as the DOH's MAPP provider network to categorize MC PCP's based on:
  - Hub
  - Contract Status
  - Attestation Status
  - Contracted Entity



Comp ~ ME 6/2016  
Total Measure Goal: 2  
Dataset: NY Medicaid DV6 - DOH  
User: CRAY  
Cube: Tracking\_Measures  
Path: PPS Name: SUNY at Stony Brook University Hospital  
By: Measure Goal \ Measure \ Current MC PCP Provider  
Filters: Measure: Q[PPS]\_Dashboard Measures  
Sort: Name: ASC

Measure Goal	Measure	Current MC PCP Provider	Line	Month y Member Measure Numerator	Line	Month y Member Measure Denominator	Month y Member Measure Result
DOWN	PDI 14 - Pediatric Asthma			65,533		956,719	5,313.84
DOWN	PDI 14 - Pediatric Asthma	Provider 1		147		70,754	207.76
DOWN	PDI 14 - Pediatric Asthma	Provider 2		0		1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 3		0		1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 4		2		97	2,061.86
DOWN	PDI 14 - Pediatric Asthma	Provider 5		0		2	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 5		0		5	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 6		0		3	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 7		0		1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 8		0		4	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 9		0		2	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 10		0		3	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 11		0		1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 12		0		2	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 13		0		1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 14		0		1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 15		0		16	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 16		0		47	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 17		2		26	7,692.31
DOWN	PDI 14 - Pediatric Asthma	Provider 18		0		2	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 19		0		687	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 20		0		1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 21		0		58	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 22		0		1	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 23		0		2	0.00
DOWN	PDI 14 - Pediatric Asthma	Provider 24		0		1	0.00

## Develop Different “Views” of Data





Measure	In-Network				Proportion of At-Risk Population	
	Result	Annual Target	# Lives to Goal	HP # Lives to Goal		
Adult Access Preventive (20 - 44) (+)	82.97	79.11			59.9%	
Adult Access Preventive (45 - 64) (+)	88.80	86.02			68.5%	
Adult Access Preventive (65 and Older) (+)	91.17	88.23			70.2%	
Antidepressant Medication Mgmt (Acute) (+)	54.29	55.06	10	55.61	17	57.2%
Antidepressant Medication Mgmt (Cont) (+)	40.19	40.75	7	41.05	10	57.2%
Antipsychotic Medication Adherence (+)	64.72	64.76	1			44.1%
Asthma Medication Ratio (5 - 64 Years) (+)	64.30	62.18				77.4%
Child Access - Primary Care (12 to 19) (+)	96.79	93.93				74.8%
Child Access - Primary Care (12 to 24 Months) (+)	97.33	96.33				79.9%
Child Access - Primary Care (25 Months to 6) (+)	94.82	93.08				82.4%
Child Access - Primary Care (7 to 11) (+)	98.40	96.87				82.3%
Child ADHD Medication F/U (Continuation) (+)	54.70	60.77	5			70.2%
Child ADHD Medication F/U (Initiation) (+)	50.00	53.14	10			71.4%
CV Monitoring (CV & Schizophrenia) (+)	68.18	71.37	1	73.68	2	42.3%
Diabetes Monitoring (DM & Schizophrenia) (+)	59.85	70.05	14	72.24	17	44.4%
Diabetes Screening (Antipsychotic Medication) (+)	76.42	77.29	9			48.7%
Engagement of Alcohol/Drug Treatment (+)	29.18	28.28				55.3%
Follow Up after MH Inpatient (30 Days) (+)	62.72	60.43		63.52	7	48.6%
Follow Up after MH Inpatient (7 Days) (+)	48.25	44.36		47.68		48.6%
PQI 8 - Heart Failure Admission Rate (-)*	158.10					51.8%
Initiation of Alcohol/Drug Treatment (+)	90.08	52.95	85			55.3%
Medication Mgmt for Asthma (50%) (+)	48.56	54.34	65			77.4%
Medication Mgmt for Asthma (75%) (+)	23.96	28.49	51			77.4%
PDI 14 - Pediatric Asthma (-)	245.81	218.38	14			71.9%
PDI 50 - Pediatric Composite (-)	237.93	278.62				71.7%
Potentially Avoidable Readmissions (-)	439.05	601.12		554.40		59.1%
Potentially Preventable ED Visits (-)	27.92	28.87		26.34	1868	58.7%
Potentially Preventable ED Visits (BH) (-)	89.16	99.27		92.16		94.3%
PQI 1 - DM Short Term Complications (-)	59.88	85.31	9			51.8%
PQI 15 - Asthma Younger Adults (-)	82.59	95.53				48.8%
PQI 7 - Hypertension (-)	71.56	99.94				51.8%

PPS Performance

Contract Status:

Measure	SBU				HP Gap to Goal # Lives	HP Target	HP Gap to Goal # Lives
	Numerator	Denominator	Result	MY2 Target			
Adult Access Preventive (20 - 44) (+)	5,008	6,220	80.51	79.11			
Adult Access Preventive (45 - 64) (+)	3,619	4,123	87.78	86.02			
Adult Access Preventive (65 and Older) (+)	288	318	90.57	88.23			
Antidepressant Medication Mgmt (Acute) (+)	201	356	56.46	55.06		55.61	17
Antidepressant Medication Mgmt (Cont) (+)	147	356	41.29	40.75		41.05	10
Antipsychotic Medication Adherence (+)	134	193	69.43	64.76			
Asthma Medication Ratio (5 - 64 Years) (+)	286	443	64.56	62.18			
Child Access - Primary Care (12 to 19) (+)	3,224	3,351	96.21	93.93			
Child Access - Primary Care (12 to 24 Months) (+)	1,947	2,005	97.11	96.33			
Child Access - Primary Care (25 Months to 6) (+)	3,166	3,393	93.31	93.08			
Child Access - Primary Care (7 to 11) (+)	3,243	3,307	98.06	96.87			
Child ADHD Medication F/U (Continuation) (+)	16	32	50.00	60.77	4		
Child ADHD Medication F/U (Initiation) (+)	62	114	54.39	53.14			
CV Monitoring (CV & Schizophrenia) (+)	5	8	62.50	71.37	1	73.68	1
Diabetes Monitoring (DM & Schizophrenia) (+)	30	52	57.69	70.05	7	72.24	8
Diabetes Screening (Antipsychotic Medication) (+)	241	316	76.27	77.29	4		
Engagement of Alcohol/Drug Treatment (+)	284	944	30.08	28.28			
Follow Up after MH Inpatient (30 Days) (+)	171	285	60.00	60.43	2	63.52	11
Follow Up after MH Inpatient (7 Days) (+)	133	285	46.67	44.36		47.68	3
PQI 8 - Heart Failure Admission Rate (-)*	37	17,551	210.81				
Initiation of Alcohol/Drug Treatment (+)	482	944	51.06	52.95	18		
Medication Mgmt for Asthma (50%) (+)	182	368	49.46	54.34	18		

Hub Performance

Contracted Entity Performance

Provider Performance

Gaps in Care Heat Maps

Measures	Entity 1	Entity 2	Entity 3	Entity 4
Adult Access Preventive (20 - 44)	522	146	0	83
Adult Access Preventive (45 - 64)	0	84	0	33
Adult Access Preventive (65 and Older)	0	9	0	3
Antidepressant Medication Mgmt (Acute)	73	0	0	11
Antidepressant Medication Mgmt (Cont)	101	0	0	0
Antipsychotic Medication Adherence	39	0	0	0
Asthma Medication Ratio (5 - 64 Years)	52	0	0	20
Child Access - Primary Care (12 to 19)	56	13	0	0
Child Access - Primary Care (12 to 24 Months)	12	3	0	16
Child Access - Primary Care (25 Months to 6)	47	0	83	32
Child Access - Primary Care (7 to 11)	27	4	0	14
Child ADHD Medication F/U (Continuation)	0	4	5	4
Child ADHD Medication F/U (Initiation)	7	4	16	9
CV Monitoring (CV & Schizophrenia)	2	0	6	0
Diabetes Monitoring (DM & Schizophrenia)	0	0	6	0
Diabetes Screening (Antipsychotic Medication)	37	12	6	4
Engagement of Alcohol/Drug Treatment	0	76	40	0
Follow Up after MH Inpatient (30 Days)	57	0	9	0
Follow Up after MH Inpatient (7 Days)	0	0	0	0
Initiation of Alcohol/Drug Treatment	195	59	28	0
Medication Mgmt for Asthma (50%)	53	0	60	17
Medication Mgmt for Asthma (75%)	0	0	87	25
<b>Total*</b>	<b>1280</b>	<b>410</b>	<b>340</b>	<b>270</b>

\*Contracted entities are in descending order by # of outliers

**Legend**

- Blanks = no eligible population
- 0 = no gaps
- Gaps in care
- Gap to goal: the number of additional numerator lives needed to achieve the

Heat maps contain both "Gap to Goal" and "Gap to Max"

**Gap to Goal** the number of additional numerator "lives" needed to achieve the annual target

**Gap to Max** the total number of recipients not meeting the measure's criteria

## PPS Performance

Measure	In-Network						No MC PCP?					Provider Not Attested, Patient in PPS					All PPS (Total)				
	Result	Annual Target	# Lives to Goal	HP Target	HP # Lives to Goal	Proportion of At-Risk Population	Result	Annual Target	# Lives to Goal	HP Target	HP # Lives to Goal	Proportion of At-Risk Population	Result	Annual Target	# Lives to Goal	HP Target	HP # Lives to Goal	Proportion of At-Risk Population	Result	Target	
Adult Access Preventive (20 - 44) (+)	82.97	79.11				59.9%	-	79.11				30.3%	80.31	79.11					9.8%	78.95	79.11
Adult Access Preventive (45 - 64) (+)	88.80	86.02				68.5%	80.46	86.02	264			22.3%	86.08	86.02					9.3%	86.69	86.02
Adult Access Preventive (65 and Older) (+)	91.17	88.23				70.2%	82.73	88.23	20			19.2%	86.36	88.23	4				10.6%	89.04	88.23
Antidepressant Medication Mgmt (Acute) (+)	54.20	55.06	10	55.61	17	57.2%	52.74	55.06	15	55.61	18	31.1%	57.26	55.06		55.61			11.7%	54.11	55.06
Antidepressant Medication Mgmt (Cont) (+)	40.19	40.75	7	41.05	10	57.2%	38.39	40.75	15	41.05	17	31.1%	42.31	40.75		41.05			11.7%	39.88	40.75
Antipsychotic Medication Adherence (+)	64.72	64.76	1			44.1%	74.38	64.76				44.2%	59.52	64.76	7				11.6%	68.39	64.76
Asthma Medication Ratio (5 - 64 Years) (+)	64.30	62.18				77.4%	72.22	62.18				17.0%	56.86	62.18	6				5.7%	65.22	62.18
Child Access - Primary Care (12 to 19) (+)	96.79	93.93				74.8%	84.30	93.93	346			20.9%	91.94	93.93	15				4.3%	93.97	93.93
Child Access - Primary Care (12 to 24 Months) (+)	97.33	96.33				79.9%	87.76	96.33	124			17.2%	90.25	96.33	15				2.8%	95.48	96.33
Child Access - Primary Care (25 Months to 6) (+)	94.82	93.08				82.4%	82.90	93.08	218			14.7%	88.39	93.08	20				2.9%	92.88	93.08
Child Access - Primary Care (7 to 11) (+)	98.40	96.87				82.3%	88.26	96.87	184			14.6%	94.62	96.87	11				3.1%	96.80	96.87
Child ADHD Medication F/U (Continuation) (+)	54.79	60.77	5			70.2%	52.00	60.77	3			24.0%	50.00	60.77	1				5.8%	53.85	60.77
Child ADHD Medication F/U (Initiation) (+)	50.00	53.14	10			71.4%	49.52	53.14	4			23.9%	66.67	53.14					4.8%	50.68	53.14
CV Monitoring (CV & Schizophrenia) (+)	68.18	71.37	1	73.68	2	42.3%	64.29	71.37	2	73.68	3	53.8%	50.00	71.37	1	73.68	1		3.8%	65.38	71.37
Diabetes Monitoring (DM & Schizophrenia) (+)	59.85	70.05	14	72.24	17	44.4%	63.64	70.05	10	72.24	13	48.1%	77.27	70.05		72.24			7.4%	62.96	70.05
Diabetes Screening (Antipsychotic Medication) (+)	76.41	77.29	9			48.7%	76.86	77.29	4			37.6%	77.04	77.29	1				13.8%	76.66	77.29
Engagement of Alcohol/Drug Treatment (+)	29.18	28.28				55.3%	29.79	28.28				31.6%	32.72	28.28					13.2%	29.84	28.28
Follow Up after MH Inpatient (30 Days) (+)	62.72	60.43		63.52	7	48.6%	50.33	60.43	61	63.52	80	36.3%	59.84	60.43	2	63.52	10		15.1%	57.78	60.43

## Hub Performance

**Contract Status**

Contracted

Not Targeted

Targeted

Measure	Hub							Hub						
	Numerator	Denominator	Result	MY2 Target	Gap to Goal # Lives	HP Target	HP Gap to Goal # Lives	Numerator	Denominator	Result	MY2 Target	Gap to Goal # Lives	HP Target	HP Gap to Goal # Lives
Adult Access Preventive (20 - 44) (+)	5,008	6,220	80.51	79.11				7,579	9,014	84.08	79.11			
Adult Access Preventive (45 - 64) (+)	3,619	4,123	87.78	86.02				5,315	5,945	89.40	86.02			
Adult Access Preventive (65 and Older) (+)	288	318	90.57	88.23				571	624	91.51	88.23			
Antidepressant Medication Mgmt (Acute) (+)	201	356	56.46	55.06		55.61		238	440	54.09	55.06	5	55.61	7
Antidepressant Medication Mgmt (Cont) (+)	147	356	41.29	40.75		41.05		178	440	40.45	40.75	2	41.05	3
Antipsychotic Medication Adherence (+)	134	193	69.43	64.76				113	170	66.47	64.76			
Asthma Medication Ratio (5 - 64 Years) (+)	286	443	64.56	62.18				329	522	63.03	62.18			
Child Access - Primary Care (12 to 19) (+)	3,224	3,351	96.21	93.93				4,231	4,387	96.44	93.93			
Child Access - Primary Care (12 to 24 Months) (+)	1,947	2,005	97.11	96.33				1,734	1,788	96.98	96.33			
Child Access - Primary Care (25 Months to 6) (+)	3,166	3,393	93.31	93.08				3,144	3,334	94.30	93.08			
Child Access - Primary Care (7 to 11) (+)	3,243	3,307	98.06	96.87				3,397	3,452	98.41	96.87			
Child ADHD Medication F/U (Continuation) (+)	16	32	50.00	60.77	4			9	19	47.37	60.77	3		

## Gap to Max Heat Map

Measures	Entity 1	Entity 2	Entity 3	Entity 4
● Adult Access Preventive (20 - 44)	522		146	0 83
● Adult Access Preventive (45 - 64)	0		84	0 33
● Adult Access Preventive (65 and Older)	0		9	0 2
● Antidepressant Medication Mgmt (Acute)	73		0	0 11
● Antidepressant Medication Mgmt (Cont)	101		0	0 0
● Antipsychotic Medication Adherence	39		0	0 0
● Asthma Medication Ratio (5 - 64 Years)	52		0	0 20
● Child Access - Primary Care (12 to 19)	56		13	0 0
● Child Access - Primary Care (12 to 24 Months)	12		3	0 16
● Child Access - Primary Care (25 Months to 6)	47		0	83 32
● Child Access - Primary Care (7 to 11)	27		4	0 14
● Child ADHD Medication F/U (Continuation)	0			5 4
● Child ADHD Medication F/U (Initiation)	7		4	16 9
● CV Monitoring (CV & Schizophrenia)	2		0	0
● Diabetes Monitoring (DM & Schizophrenia)	0		0	6 0
● Diabetes Screening (Antipsychotic Medication)	37		12	6 4
● Engagement of Alcohol/Drug Treatment	0		76	40 0
● Follow Up after MH Inpatient (30 Days)	57		0	9 0
● Follow Up after MH Inpatient (7 Days)	0		0	0 0
● Initiation of Alcohol/Drug Treatment	195		59	28 0
● Medication Mgmt for Asthma (50%)	53		0	60 17
● Medication Mgmt for Asthma (75%)	0		0	87 25
<b>Total*</b>	<b>1280</b>		<b>410</b>	<b>340 270</b>

\*Contracted entities are in descending order by  
# of outliers

### Legend

Blanks = no eligible population

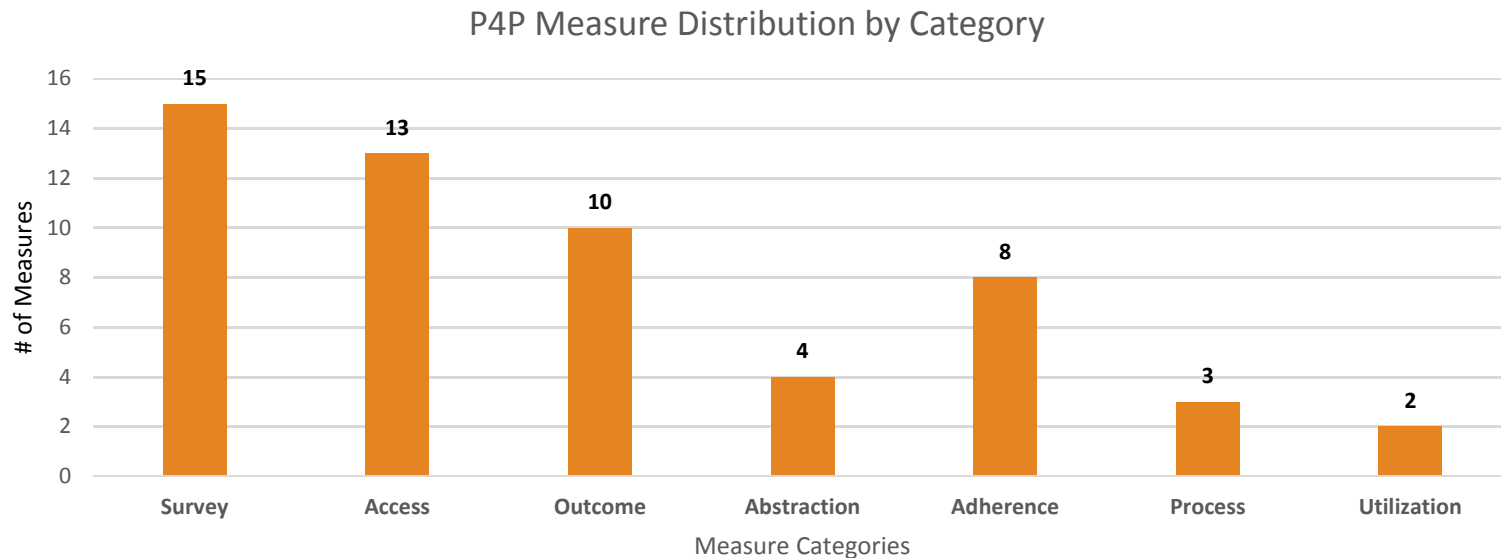
0 = no gaps

Gaps in care

**Gap to max:** the total number of gaps in care for  
a given measure

## Managing P4P Measures

- >50 P4P DSRIP measures (too many for *all* providers to focus on ***all at once***)
- SCC has utilized the GNYHA PPS Strategic Planning model to look at metric valuation *by DSRIP payment*
- Measures flip to P4P at different times (or not at all)
- Some measures have very low denominators (small gaps)



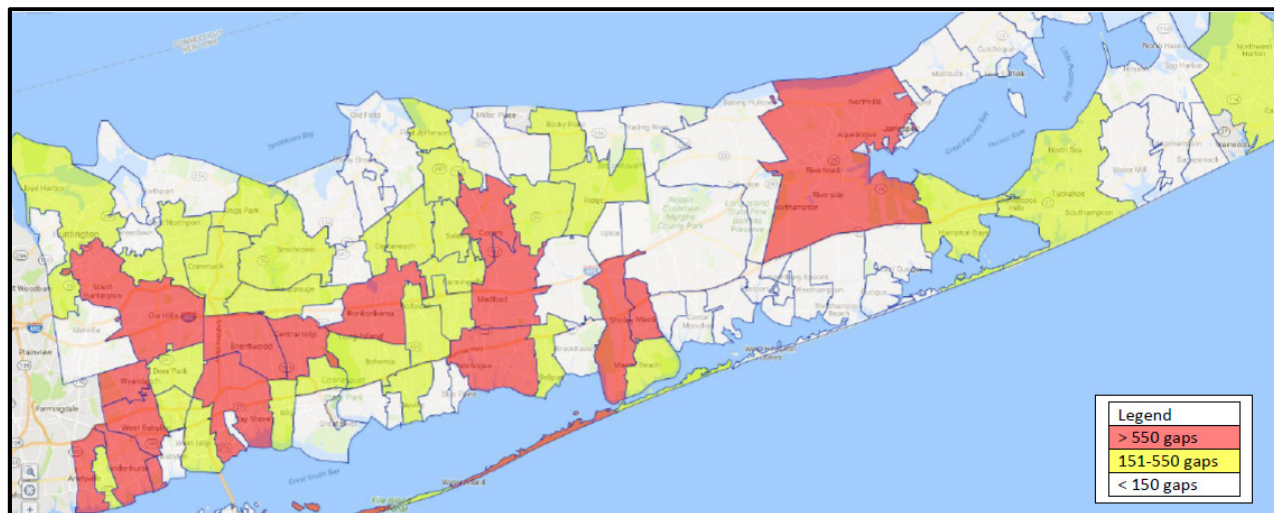
# Managing P4P Measures

- All P4P measures were looked at individually with a few factors in mind:
  - When the measure flips to P4P (in which DSRIP payment, based on which Measurement Year data)
  - Total dollars at risk in total for each measure
  - Total dollars at risk in each payment
  - Whether the measure is an EPP, high performance, or additional high performance measure
  - Whether the PPS has achieved the measure in the most recent MY
  - How many lives are needed to close the gap if not achieving

Legend		Links		Measure Type		Current Measure Type Grand Total		P4P/P4R		Met/Not Met		*Actual values may increase depending on other PPS' performance			
	MY2 Target has been met	<a href="#">Action Plan File</a>		Abstraction	Access	\$125,385,177		P4P	Met	Not Met					
	On track to meeting measure at the end of MY2	<a href="#">Graphs</a>		Adherence	Outcome	79% of total		P4R	On Track	(blank)					
	Will not meet MY2 target at the current rate	<a href="#">Zip Code Analysis</a>													
SCC Measurement Year 2 Performance												Measure Valuation (DSRIP Total)			
Data Period: May 1, 2015 - April 30, 2016															
Measure	Measure Type	Numerator	Denominator	MAPP Reporting Period (*MY2 Performance)	SCC MY2 Target	Monthly Target	# Lives to Close Annual Gap	High Performance Target MY2	# Lives to Close HP Gap	Flips to P4P in Payment	Net Project Valuation	EPP	HPP*	AHPP*	Measure Total
Children's Access to Primary Care - 12 to 19 years	Access	15,912	16,941	93.93%	93.93%	93.84%				DY3 Pmt 2	\$1.00	\$8.00			\$8.50
Comprehensive Diabetes screening - All Three Tests (HbA1c, dilated eye exam, nephropathy monitor)	Abstraction									DY4 Pmt 1	\$1.00	\$8.00			\$8.50
Aspirin Use	Survey									DY4 Pmt 1	\$0.50				\$0.50
Follow-up care for Children Prescribed ADHD Medications - Continuation Phase	Access	53	101	52.48%	60.77%	60.43%	9			DY4 Pmt 1	\$0.70	\$8.00			\$8.00
Follow-up care for Children Prescribed ADHD Medications - Initiation Phase	Access	224	450	49.78%	53.14%	52.78%	16			DY4 Pmt 1	\$0.70	\$8.00			\$8.00

## Geographic Gap Analysis

- In the beginning of each measurement year, through use of the SIM, the SCC has also incorporated geographic analyses into the measure prioritization exercise
- For each measure, the total number of gaps in care are stratified across zip codes in the PPS
- This information is then cross-walked with Salesforce to identify where the SCC has contracted partners in areas of need across Suffolk County



*3ai Measures Gaps in Care*

## SCC CORRECTIVE ACTION PLANNING TRIGGERS

*“In variance” refers to when a partner falls below the agreed-upon standard for one or more metrics*

**The SCC PI toolkit includes:**  
**Action planning Template**  
**PDSA Cycle Template**  
**Data Collection Plan**



**Trigger:** Partner is in variance for 2 consecutive quarters



**Corrective Action Plan**



- Action plans may include:
- Process Redesign
  - Further Trending
  - Implementation of new service or procedure
  - Education
  - Counseling
  - Focused Audit

YES

Is the metric  
out of  
Variance for 2  
consecutive  
quarters?

NO

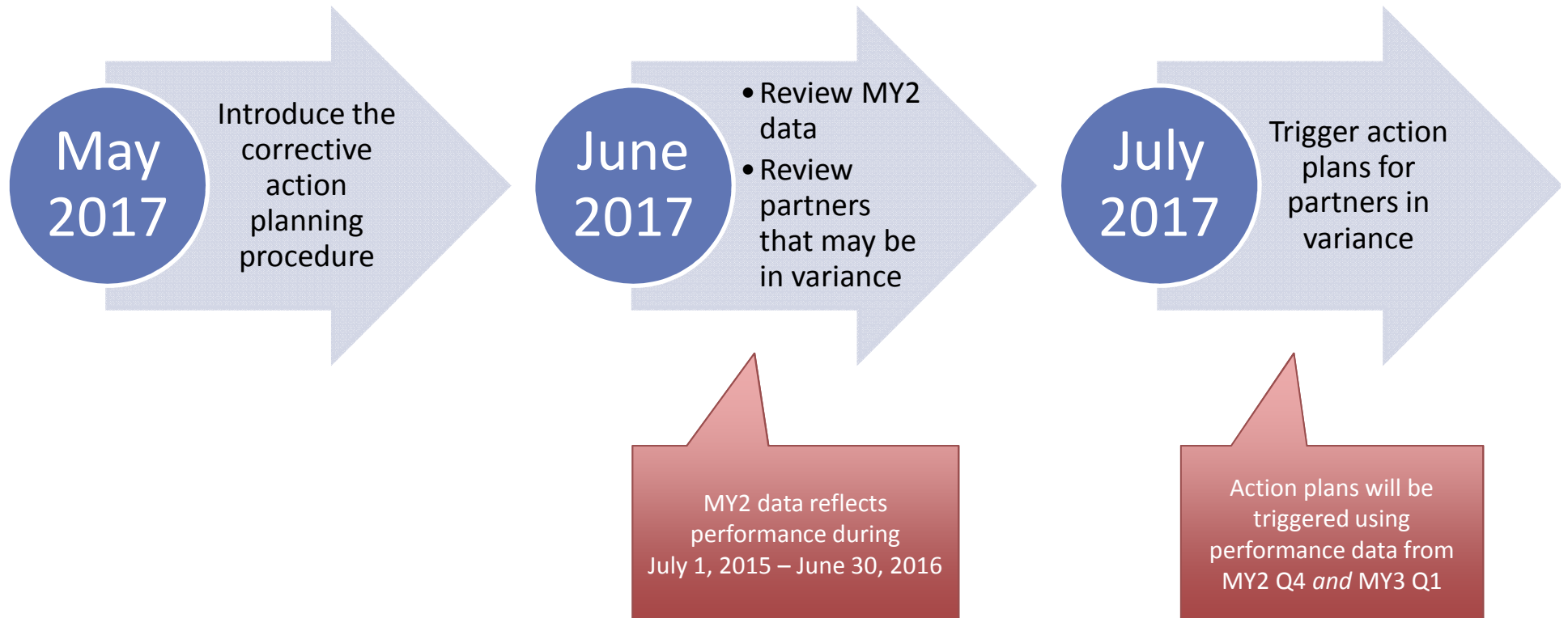
**Action Plan  
Closed and  
Completed**

**Clinical  
Committee  
determines  
next steps**






# Corrective Action Planning Process Timeline



Partners are able to upload the gap analysis they've performed, which informs how they've arrived at the action steps below

Each measure not achieving the PPS-wide target for two consecutive quarters is included

Partners are expected to fill in at least one action task for each measure in variance, detailing the ways in which they intend to improve performance



**Suffolk Care**  
Collaborative

**Dev Server**  
(VFS: ny\_dsrip\_dave, dsrip\_dave)

---

Facility Name: Example Contracted Entity

Facility Sponsor:

Findings/Analysis Summary:

Findings/Analysis Documentation: [Add File](#)

**Measure: Adult Access to Preventive or Ambulatory Care - 45 to 64 years**

[Add Action Task](#) [Remove](#)

Action Task	How will it be done?	Individual(s) Responsible	Start Date	Target End Date	Status
<input type="text"/>	<input type="text"/>	<input type="text"/>	04/11/17 <input type="text"/>	04/11/17 <input type="text"/>	Not Started <input type="text"/>

**Measure: Aspirin Use**

[Add Action Task](#) [Remove](#)

Action Task	How will it be done?	Individual(s) Responsible	Start Date	Target End Date	Status
<input type="text"/>	<input type="text"/>	<input type="text"/>	04/11/17 <input type="text"/>	04/11/17 <input type="text"/>	Not Started <input type="text"/>

**Measure: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia**

[Add Action Task](#) [Remove](#)

Action Task	How will it be done?	Individual(s) Responsible	Start Date	Target End Date	Status
<input type="text"/>	<input type="text"/>	<input type="text"/>	04/11/17 <input type="text"/>	04/11/17 <input type="text"/>	Not Started <input type="text"/>

**Submitter/Approval Information**

Submitted By:

Approved By:



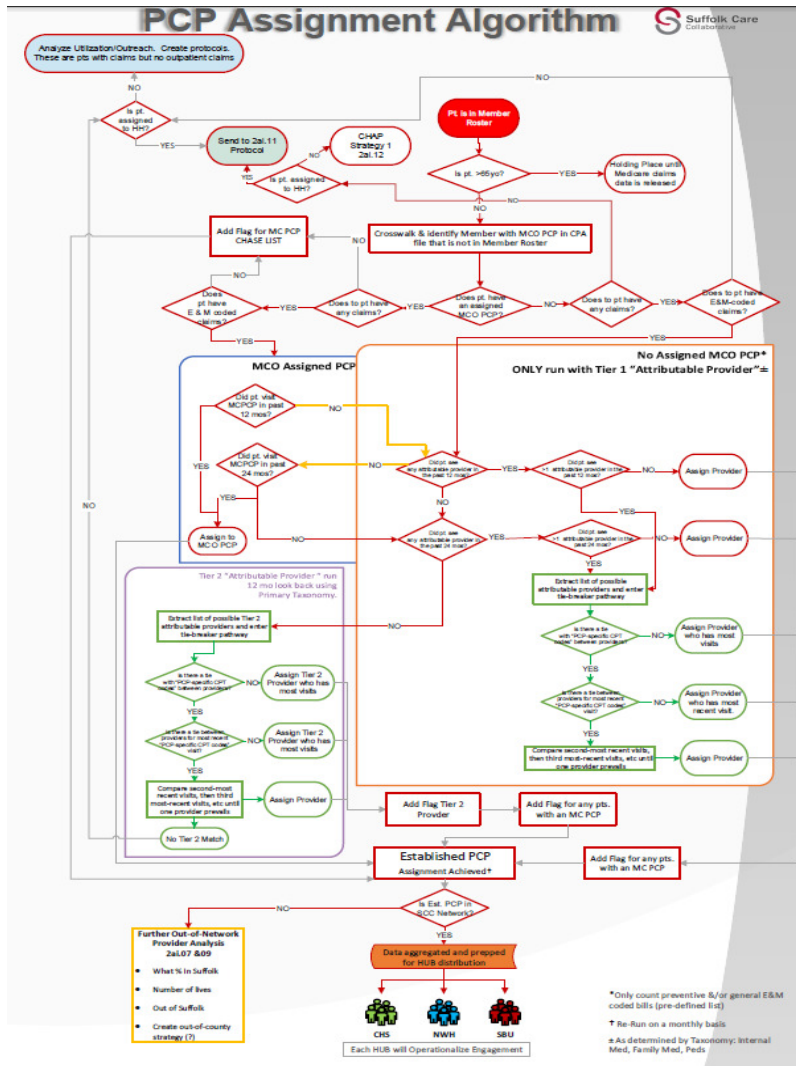
# SCC FUTURE STATE DATA STRATEGY – ADDRESSING ATTRIBUTION

*Presented by:*

**Sam Lin, MHA, PMP**

Administrative Manager, Project Management Office

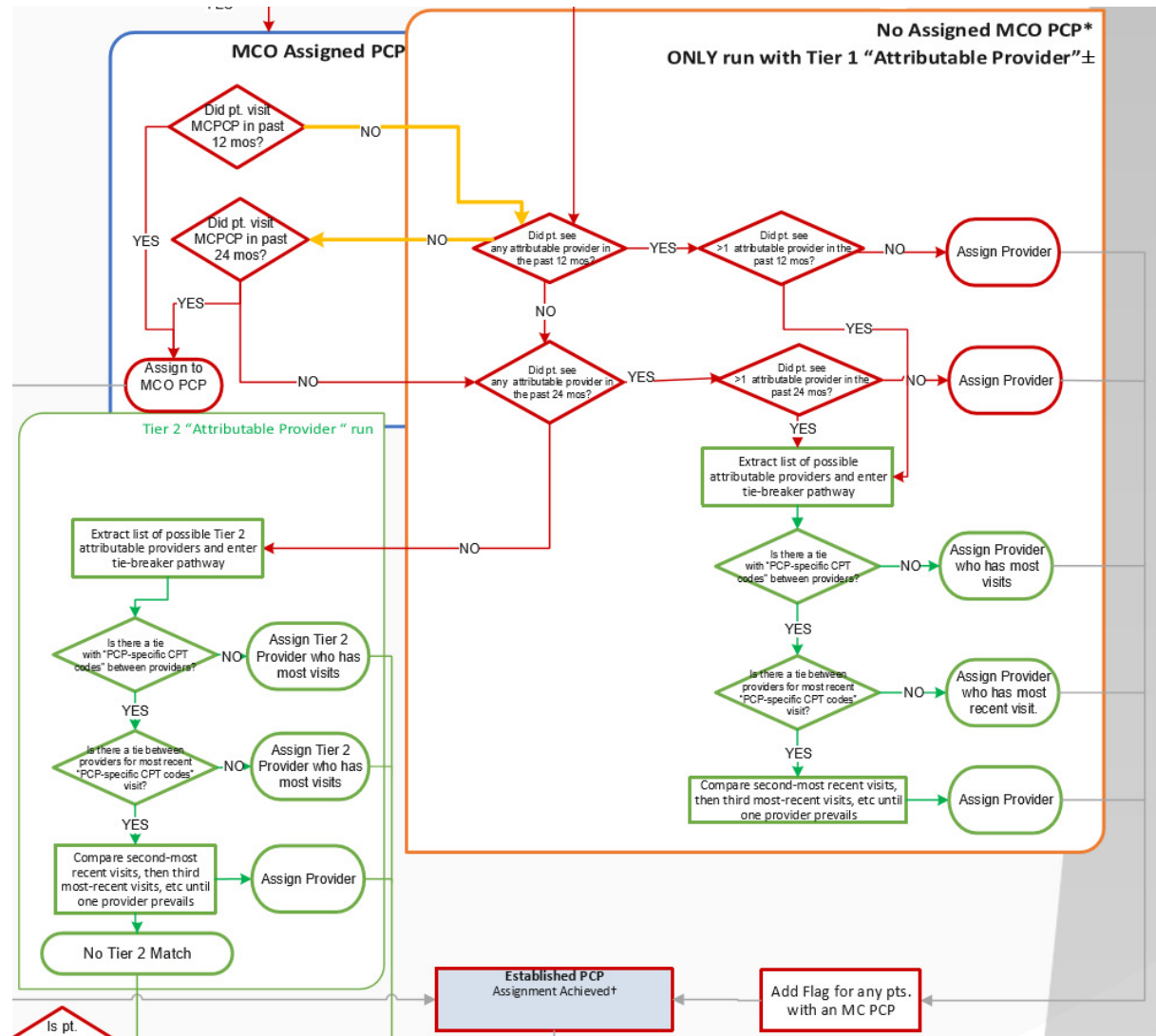
Suffolk Care Collaborative



- **Goal**
  - Create a Pay for Performance model and Performance Improvement strategies
- **Initial Analysis of Member Roster: May 2016**
  - 54% of attributed population do not have an assigned MCO PCP
- **Observed Challenges:**
  - Attributing performance at a provider level when a Medicaid member is not assigned to an MCO PCP (54%)
  - Accuracy of performance attribution to MCO assigned PCP

# LOYALTY BASED ATTRIBUTION

- How do we define a “primary care visit”?
- Three possible loyalty algorithms to an established PCP
  - MC assigned PCP
  - SCC defined PCP
  - Specialist acting as PCP



Measure to Provider Type Mapping

Measure	PCP	BH - Rx	BH - Access	Hospital	SNF
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis)	X				X
Potentially Preventable Emergency Department Visits	X				X
Potentially Preventable Readmissions	X				X
Adherence to Antipsychotic Medications for People with Schizophrenia	X	X			
Antidepressant Medication Management - Effective Acute Phase Treatment	X	X			
Antidepressant Medication Management - Effective Continuation Phase Treatment	X	X			
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	X	X			
Diabetes Monitoring for People with Diabetes and Schizophrenia	X	X			
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	X	X			
Follow-up care for Children Prescribed ADHD Medications - Continuation Phase	X	X			
Follow-up care for Children Prescribed ADHD Medications - Initiation Phase	X	X			
PPI 90 - Composite of all measures	X			X	
Pediatric Quality Indicator # 14 Pediatric Asthma	X			X	
PQI 90 - Composite of all measures	X			X	
Prevention Quality Indicator # 1 (DM Short term complication)	X			X	
Prevention Quality Indicator # 15 Younger Adult Asthma	X			X	
Prevention Quality Indicator # 7 (HFN)	X			X	
Prevention Quality Indicator # 8 (Heart Failure)	X			X	
Follow-up after hospitalization for Mental Illness - within 30 days			X	X	
Follow-up after hospitalization for Mental Illness - within 7 days			X	X	
HCAHPS - Care Transition Metrics (Q23, 24, and 25)			X	X	
Adult Access to Preventive or Ambulatory Care - 20 to 44 years	X				
Adult Access to Preventive or Ambulatory Care - 45 to 64 years	X				
Adult Access to Preventive or Ambulatory Care - 65 and older	X				
Asthma Medication Ratio (5 - 64 Years)	X				
Children's Access to Primary Care - 12 to 18 years	X				
Children's Access to Primary Care - 12 to 24 Months	X				
Children's Access to Primary Care - 25 months to 5 years	X				
Children's Access to Primary Care - 7 to 11 years	X				
Medication Management for People with Asthma (5 - 64 Years) - 50% of Treatment Days Covered	X				
Medication Management for People with Asthma (5 - 64 Years) - 75% of Treatment Days Covered	X				

Measures are driven by various provider types

## Downstream Provider-level Attribution

PCP

BH: Access

BH: Rx

SNF

Hospital

## Attribution Methodology

PCP Attribution Algorithm

BH Attribution Algorithm

SNF Attribution Algorithm  
(3M/AHRQ + Custom Logic)

3M and AHRQ algorithms identify performance by hospital.

### Business Rules

- **Population:** Algorithm to be run on full SCC population.
- **Attribution:** Two different attribution approaches for
  - Access Metrics
  - Rx Metrics
    - Only a prescriber can be attributed for Rx Metrics
- **Applicability:** Applies to all BH metrics except Alcohol/Substance Abuse
  - “Initiation/Engagement in Treatment for Alcohol/Substance Abuse” to be moved to PPS-level because member-level data suppressed by DOH

- **Key Issue**

- DOH metric definition **not compatible with provider-level performance** evaluation for highlighted metrics
  - DOH denominator is total population, but Hospitals and SNFs don't have attributable populations

- **SCC Approach**

- Use Hospital- and SNF-friendly denominators
  - e.g. Discharges or Resident Days
- Recast DOH Target in terms of these new denominators

Hospital

SNF

### H-CAHPS - Care Transition Metrics

#### Potentially Preventable Emergency Room Visits

#### Potentially Preventable Emergency Room Visits (BH Patients)

#### Potentially Preventable Readmissions

#### Potentially Avoidable Admissions

PDI 90 - Composite of all measures

Pediatric Quality Indicator # 14 Pediatric Asthma

PQI 90 - Composite of all measures

Prevention Quality Indicator # 1 (DM Short term complication)

Prevention Quality Indicator # 15 Younger Adult Asthma

Prevention Quality Indicator # 7 (HTN)

Prevention Quality Indicator # 8 (Heart Failure)

#### Potentially Preventable Emergency Room Visits

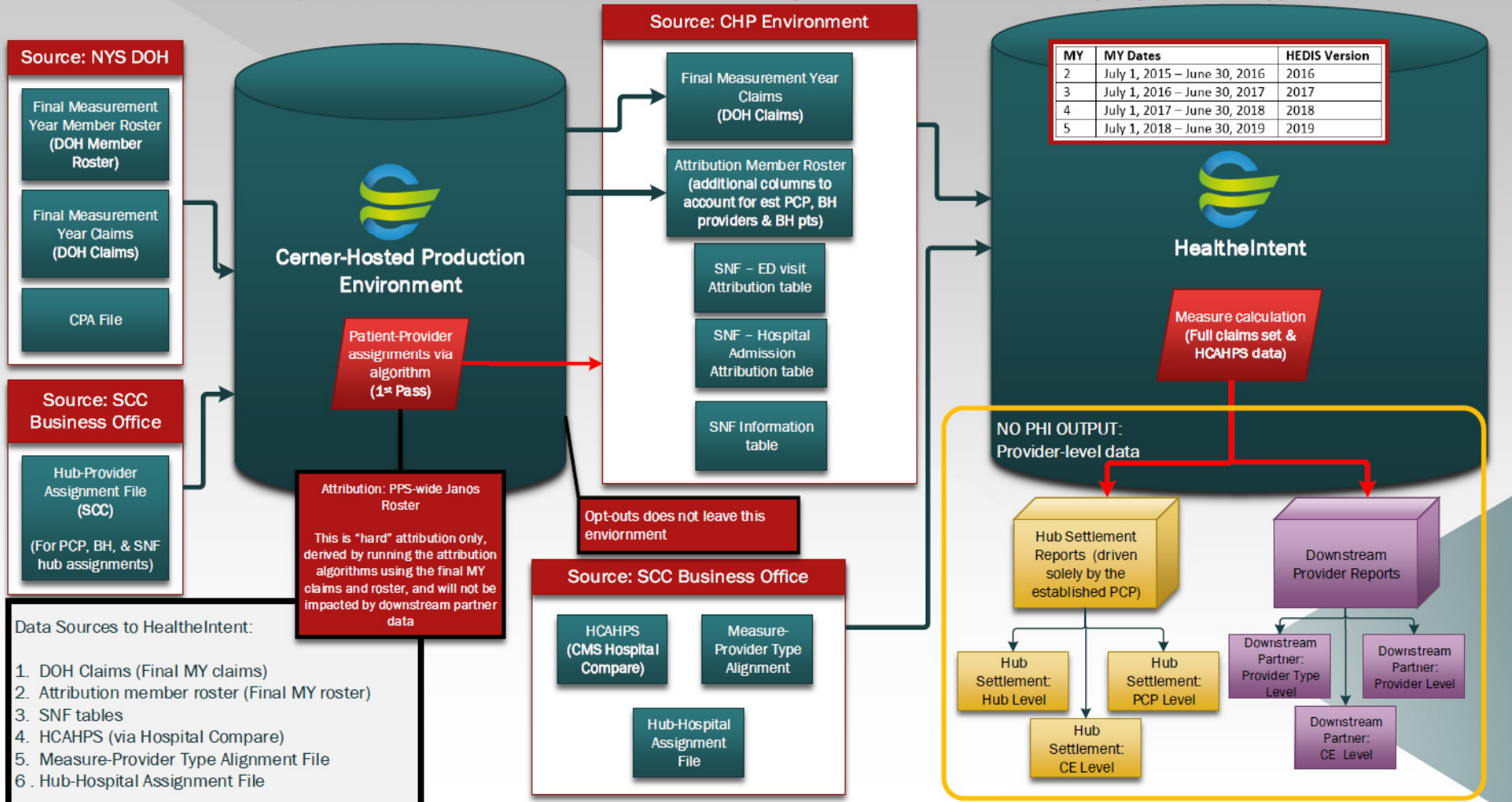
#### Potentially Preventable Emergency Room Visits (BH Patients)

#### Potentially Preventable Readmissions



## Funds Flow

Generate performance (for domain 2 & 3 measures) by Hub and contracted entity (by provider type)



MY	MY Dates	HEDIS Version
2	July 1, 2015 – June 30, 2016	2016
3	July 1, 2016 – June 30, 2017	2017
4	July 1, 2017 – June 30, 2018	2018
5	July 1, 2018 – June 30, 2019	2019

- Leveraging *HealthEDW* 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
- Will be used by the Provider Relationship Manager to engage providers on performance on critical DSRIP P4P measures





## **ALIGNING PARTNER INCENTIVES**

*Presented by:*

**Kevin Bozza, MPA, FACHE, CPHQ, RHIT**

Vice President, Population Health Management Services  
Suffolk Care Collaborative

**5-year Performance-based Funds Flow Model for Participating Providers & Organizations is Operational and included in all SCC Participation Agreements**

**Funds flow distribution example: Primary care providers**

<b>Performance Factor</b>	<b>Description</b>
Engagement Payment	Complete SCC On-boarding documentation as outlined in the <u>SCC Contracting Plan Agreement</u> to ongoing: Good citizenship, Timely and complete quarterly Domain 1 patient engagement reporting , Data sharing, Participation in Population-wide-prevention programs (D4), Updates towards successful completion of the Domain 1 Process Measures & Participation in Project 2ai Integrated Delivery System program & SCC Care Coordination program.
Technical On-boarding	<ol style="list-style-type: none"> <li>1. Complete Technical On-boarding, i.e. technical data integration and system interoperability between the Partner's source system and the HUB data-warehouse, which will then feed the Suffolk PPS Population Health Platform.</li> <li>2. EHR meets connectivity to RHIO's HIE and SHIN-NY requirements</li> </ol>
Clinical Improvement Programs	Meet requirements of Primary & Behavioral Health Integrated Care Program
	Meet requirements of Cardiovascular Health Wellness & Self-Management Program
	Meet requirements of Diabetes Wellness & Self-Management Program
	Meet requirements of Promoting Asthma Self-Management Program
PCMH Certification	Receipt of NCQA 2014 Level 3 PCMH Certification
Performance Measurement	Adhere to the Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided.

**Only incentivize what you can measure**

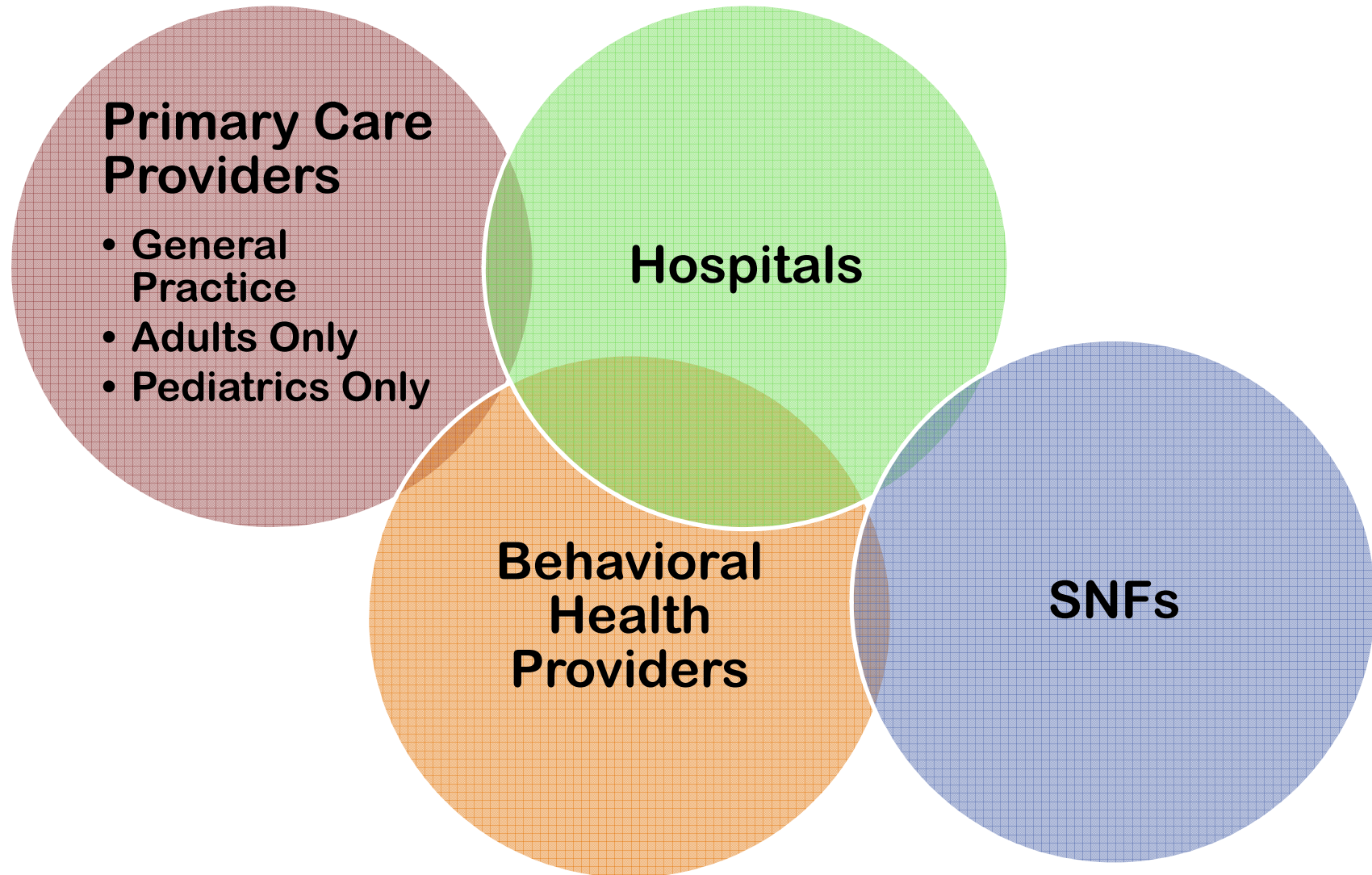
- Survey and clinical abstraction metrics rely on random sampling by DOH, and therefore can only be tied to a PPS.

**Right measures to right providers**

- Make sure incentivized provider can actually affect measure performance

**Organize metrics by categories to make it easier for providers to understand**

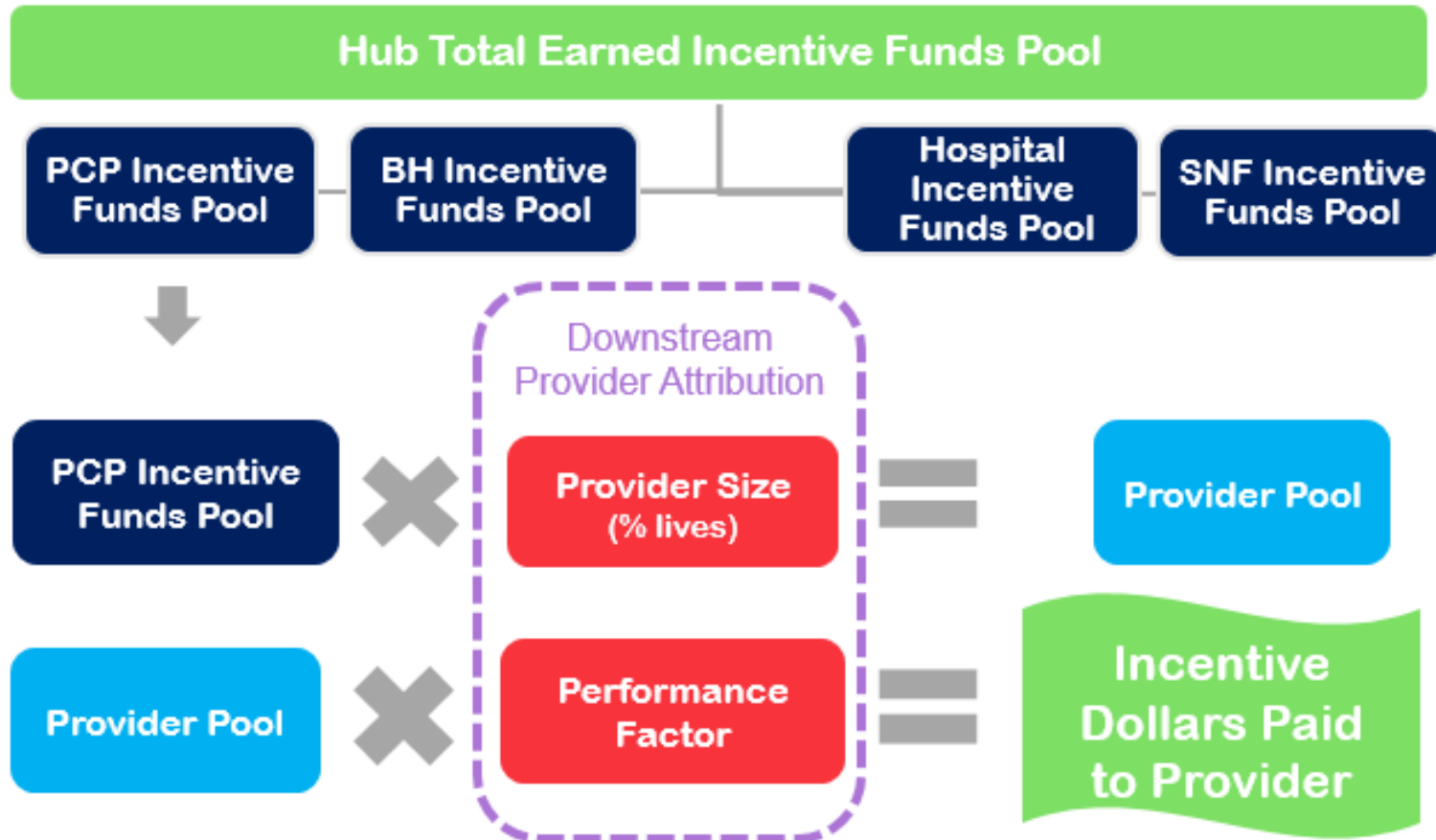
- Categorize metrics by the type of action incentivized



## P4P METRICS ASSIGNED BY PROVIDER TYPE

Metric	PCP	BH	Hospital	SNF
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis)	X	X	X	X
Potentially Preventable Emergency Department Visits	X	-	X	X
Potentially Preventable Readmissions	X	-	X	X
Adherence to Antipsychotic Medications for People with Schizophrenia	X	X	-	-
Antidepressant Medication Management - Effective Acute Phase Treatment	X	X	-	-
Antidepressant Medication Management - Effective Continuation Phase Treatment	X	X	-	-
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	X	X	-	-
Diabetes Monitoring for People with Diabetes and Schizophrenia	X	X	-	-
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	X	X	-	-
Follow-up care for Children Prescribed ADHD Medications - Continuation Phase	X	X	-	-
Follow-up care for Children Prescribed ADHD Medications - Initiation Phase	X	X	-	-
PDI 90 - Composite of all measures	X	-	X	-
Pediatric Quality Indicator # 14 Pediatric Asthma	X	-	X	-
PQI 90 - Composite of all measures	X	-	X	-
Prevention Quality Indicator # 1 (DM Short term complication)	X	-	X	-
Prevention Quality Indicator # 15 Younger Adult Asthma	X	-	X	-
Prevention Quality Indicator # 7 (HTN)	X	-	X	-
Prevention Quality Indicator # 8 (Heart Failure)	X	-	X	-
Follow-up after hospitalization for Mental Illness - within 30 days	-	X	X	-
Follow-up after hospitalization for Mental Illness - within 7 days	-	X	X	-
H-CAHPS - Care Transition Metrics (Q23, 24, and 25)	-	-	X	-
Adult Access to Preventive or Ambulatory Care - 20 to 44 years	X	-	-	-
Adult Access to Preventive or Ambulatory Care - 45 to 64 years	X	-	-	-
Adult Access to Preventive or Ambulatory Care - 65 and older	X	-	-	-
Asthma Medication Ratio (5 - 64 Years)	X	-	-	-
Children's Access to Primary Care - 12 to 19 years	X	-	-	-
Children's Access to Primary Care - 12 to 24 Months	X	-	-	-
Children's Access to Primary Care - 25 months to 6 years	X	-	-	-
Children's Access to Primary Care - 7 to 11 years	X	-	-	-
Medication Management for People with Asthma (5 - 64 Years) - 50% of Treatment Days Covered	X	-	-	-
Medication Management for People with Asthma (5 - 64 Years) - 75% of Treatment Days Covered	X	-	-	-

## DETERMINING INCENTIVE POOL PAYMENT





## **Business Rules**

- Each measure will be assigned a point value derived from relative dollar value of each metric within a given payment period
- Point values will be recalculated each payment period and may fluctuate based on DOH's payment schedule for each metric.



## DERIVING METRIC POINT VALUES: BUSINESS RULES

<b>Metric Name</b>	<b>DY2 Payment 2 Dollar Value</b>	<b>DY2 Payment 2 Point Value</b>
Antidepressant Medication Management - Effective Acute Phase Treatment	\$150	60 pts
Potentially Preventable Emergency Department Visits - BH	\$50	20 pts
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	\$50	20 pts
<b>Total</b>	<b>\$250</b>	<b>100 pts</b>

### PPS Performance

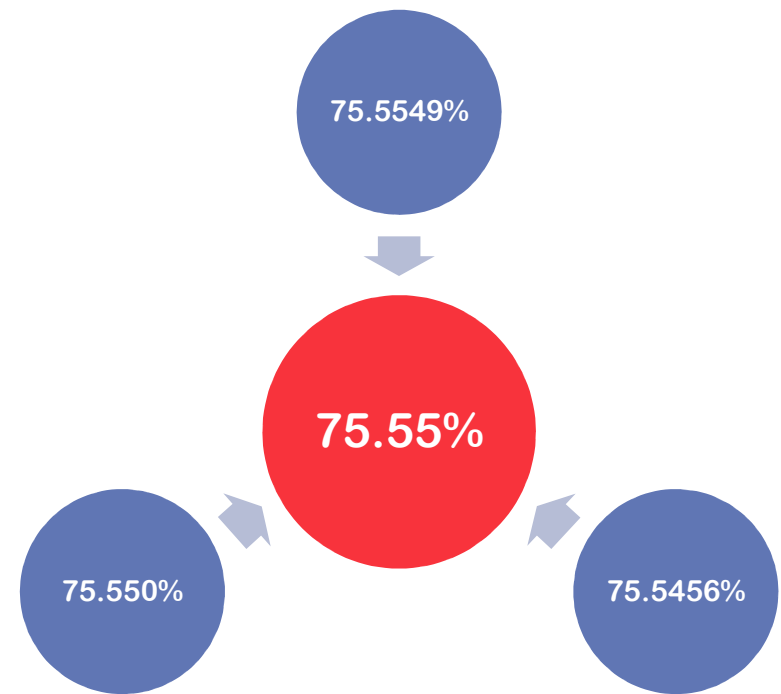
Measure	PPS Performance	PPS Target	Point Value
Children's Access to Primary Care - 12 to 19 years	95.4%	93.9%	50 pts
Adult Access to Preventive or Ambulatory Care - 20 to 44 years	80.6%	79.1%	30 pts
Adult Access to Preventive or Ambulatory Care - 45 to 64 years	87.5%	86.0%	10 pts
Adult Access to Preventive or Ambulatory Care - 65 and older	89.7%	88.2%	10 pts
			100 pts

### HUB Performance

Measure	Hub Performance	PPS Target	Points Qualified	Points Earned
Children's Access to Primary Care - 12 to 19 years	97.7%	93.9%	50 pts	50 pts
Adult Access to Preventive or Ambulatory Care - 20 to 44 years	80.6%	79.1%	0 pts	0 pts
Adult Access to Preventive or Ambulatory Care - 45 to 64 years	89.8%	86.0%	10 pts	10 pts
Adult Access to Preventive or Ambulatory Care - 65 and older	87.4%	88.2%	10 pts	0 pts
			70 pts	60 pts

**86%** of HUB's Incentive Pool Earned  
(60pts/70pts = 85.71%)

- PPS Target will be rounded to the nearest “hundredth” of a percent.
  - **Example:** If the gap-to-goal for the PPS is 75.556%, the target used will be 75.56%
- Hub performance will also be rounded to the nearest hundredth of a percent.
- Performance that is **equal to target** will be awarded (“tie goes to the runner”)



## **TRAINING STRATEGY**

*Presented by:*

**Kevin Bozza, MPA, FACHE, CPHQ, RHIT**

Vice President, Population Health Management Services  
Suffolk Care Collaborative

Suffolk County



3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations: Cardiovascular

**Project goal**  
**Immediate:** Integrate evidence-based strategies and clinical guidelines and patient education materials, document at least 1 self-management goal identified by the patient and review at each visit.  
**Long-term:** Improve access and management of hypertension and hypercholesterolemia in Suffolk County as demonstrated by decreasing the admission rate for patients with a principal diagnosis of hypertension (ICD 7) and angina without a cardiac procedure (ICD 12) adequately controlled blood pressure for patients with a diagnosis of hypertension. For high risk / affected population increase percentage of patients with education of risks / benefits of aspirin use, use of aspirin, LDL-C testing, management for patients with cardiovascular conditions and LDL-C > 100 mg/dL, advised to quit smoking and were recommended cessation medications and cessation strategies, measured by 10% improve health literacy (measured by CASPS - QH, 13.3.4.16).

**Interventions**  
 Cardiovascular disease is a significant issue and the 3rd leading cause of avoidable admissions in Suffolk County. The Million Hearts Campaign is a national initiative to prevent one million heart attacks and strokes by 2021. The goal of the campaign is to enhance cardiovascular disease prevention by focusing on blood pressure control, cholesterol management, smoking cessation, and aspirin use for people at risk. The project focuses on these areas but also requires adoption of the policies and procedures by non-PPS and behavioral health providers and a commitment to adhere to them in clinical practice. Use of home blood pressure monitoring and support as appropriate and facilitating access to blood pressure checks without co-payment or advanced appointment in the office. Patients who have uncontrolled blood pressure readings but no diagnosis of hypertension should be identified and scheduled for a hypertension visit. Care management will play an integral role in meeting project requirements through follow up and coordination of care. Utilize a set of process controls, optimally embedded in the EMR to support prompt use of the screening tool, with referral to the NHS/clinician if indicated. At least one visit

**Suffolk Care Collaborative**  
 FROM THE DESK OF LINDA S. EFFEREN, MD  
 Medical Director, Suffolk Care Collaborative  
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 Issue 1

**Clinical Alert: March 2017**

On an as needed basis we will use a "CLINICAL ALERT" to bring to your attention critically important measures or issues. The HEDIS measures highlighted in this alert are not specific to the DSRIP program and they may be measures that you are also held accountable for through quality programs with payers. In the DSRIP program Measurement Years for performance start on July 1 and end June 30. We have just 4 months left to make an impact on measures that were missed in the prior two measurement years.

We are currently in DSRIP Measurement Year 3 (MY3), which encompasses the period of July 1, 2016, through June 30, 2017. We would ask your assistance in ensuring that within your practice the following measures are met for all eligible patients as applicable for this measurement year.

HEDIS Measure	Action
Children Prescribed ADHD Medications	Three (3) follow-up visits for patients 6-12 years old who receive a prescription for ADHD medication as a new diagnosis or history of prior medication administration but without any dispensed for a period of 120 days or more. <ul style="list-style-type: none"> <li>1 visit within 30 days of medication being dispensed with a practitioner with prescribing authority - and,</li> <li>2 follow-up visits within 9 months of the initial visit with a practitioner with prescribing authority</li> </ul>
Child Routine Preventive Care	Children 12 months - 19 years need an ambulatory or preventive care primary care visit during the measurement year
Initiation and Engagement in Treatment of Alcohol/Drug Dependence	Patients 13 and older with a new episode of alcohol or other drug dependence <ul style="list-style-type: none"> <li>Initial visit within 14 days of identification - and,</li> <li>2 or more additional services within 30 days of the initial visit</li> </ul>
Follow-up after Behavioral Health Hospitalization	Patients age 6 and older who were hospitalized for selected mental health disorders were seen by a mental health provider within 7 days of discharge. Reference: SOC Clinical Documentation Improvement (C/DI) Program for the specific associated ICD-10 codes.
HEDIS Measurements for Patients ages 18 to 64 years: With a diagnosis of diabetes	<b>Action</b> Glucose or HbA1c - Test completed during measurement year HbA1c and LDL-C - Tests completed during measurement year LDL-C - Test completed during measurement year

With a diagnosis of diabetes  
 HbA1c and LDL-C - Tests completed during measurement year  
 LDL-C - Test completed during measurement year

your efforts and collaboration on behalf of your patients. Please let me know if you or your staff need assistance. We at the Suffolk Care Collaborative are here to support your efforts.

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**Learning Center**

Home / My Home / Learning Center

**Partner Training** Partner Resources

Welcome to the Partner Training area of the Learning Center. Please click on the boxes below to access the Partner Training modules. By selecting a training module, you will be directed to new webpage where you will be able to view and complete the educational module.

Population Health  
 Performance Reporting and Improvement  
 Cultural Competency Health Literacy

**Performance Reporting and Improvement Learning Module**

This module provides an overview of the SCC Performance Reporting and Improvement Program. It focuses on an introduction to the SCC Performance Reporting and Improvement Program and describe the Domain 1 Patient Engagement Reporting Requirements. Participants will gain a better understanding of how to deploy PDSA cycles to conduct tests of change and utilize control charts to understand data variation.

**IHI - An Introduction to the Model for Improvement**

**Learning Objectives:**

- Describe the Model for Improvement
- Discuss how to use the Plan-Do-Study-Act (PDSA) cycle to conduct rapid tests of change
- Explain the three questions that can help drive quality improvement work

**Go to Training**

**IHI - Building Skills in Data Collection and Understanding Variation**

**Learning Objectives:**

- Describe how to evaluate data variation
- Explain Common and special causes of variation
- Identify data collection strategies

**Go to Training**



- Facilitate Partner Onboarding Program Addressing Performance Requirements
- Clinical Alerts – highlights key metrics requiring SCC’s focus based on performance trends
- Supporting Lean Projects Across PPS
- GNYHA – Ambulatory PI Training for Front Line Staff
- Developed Learning Center that provides access to E-Learning Modules
  - IHI Improvement Model
  - Building Skills in Data Collection and Understanding Variation
  - Use of Run and Control Charts to Understand Variation

## Clinical Documentation Improvement Program 2017



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