Suffolk Care Collaborative

PERFORMANCE MANAGEMENT PROGRAM

NYS DSRIP ALL-PPS MEETING

JULY 12, 2017

Kevin Bozza, MPA, FACHE, CPHQ, RHIT
Vice President, Population Health Management Services

Sam Lin, MHA, PMP
Administrative Manager, Integrated Care Programs

Christopher Ray, MS
Data Analyst, Network Development and Performance

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AGENDA

- SCC's Organizational Structure and Approach to Performance Improvement
- Developing Performance Improvement Strategies with DOH Data
- Future State Data Strategy – Addressing Attribution
- Aligning Partner Incentives
- Training Strategy

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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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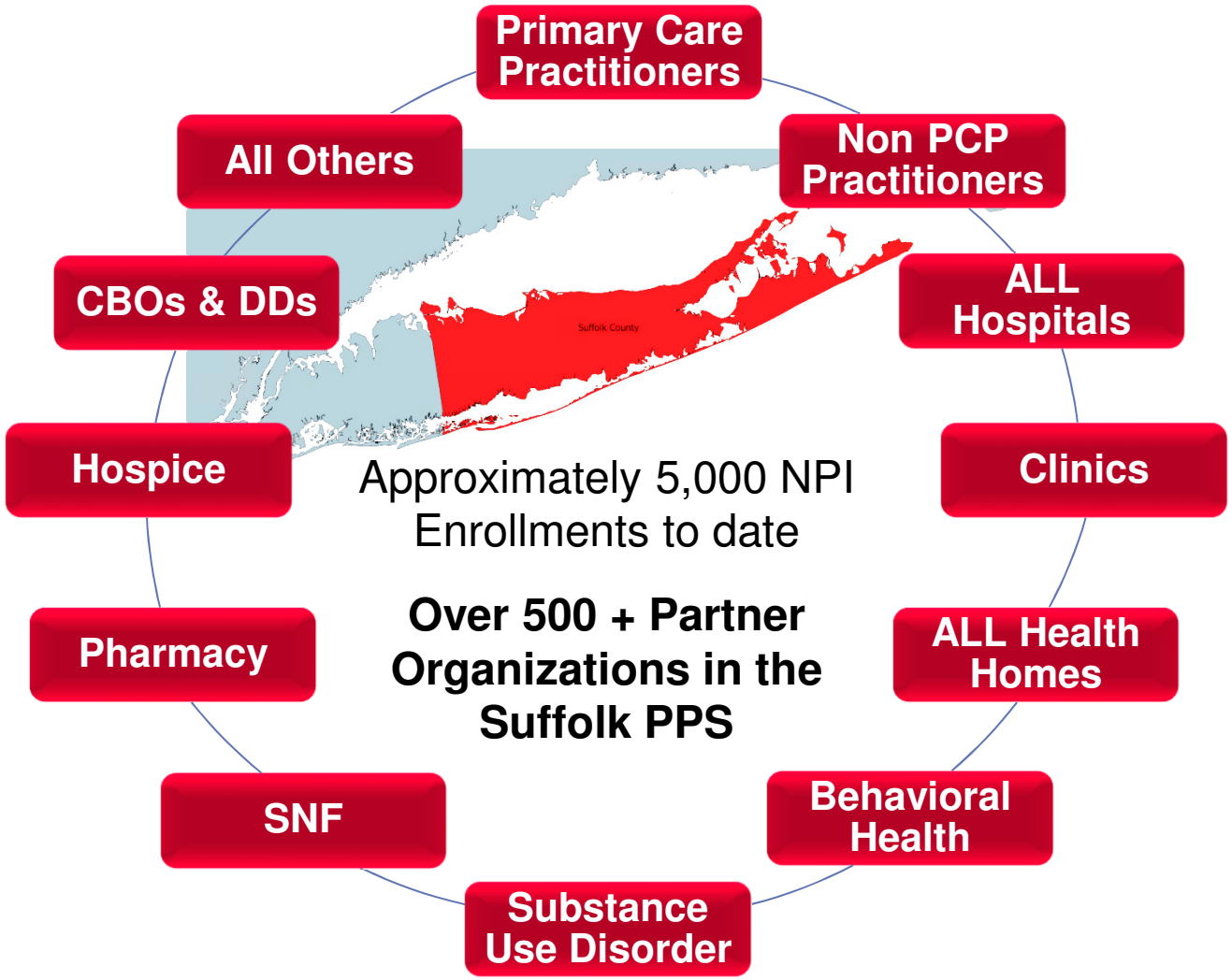
PERFORMING PROVIDER SYSTEM COMPOSITION



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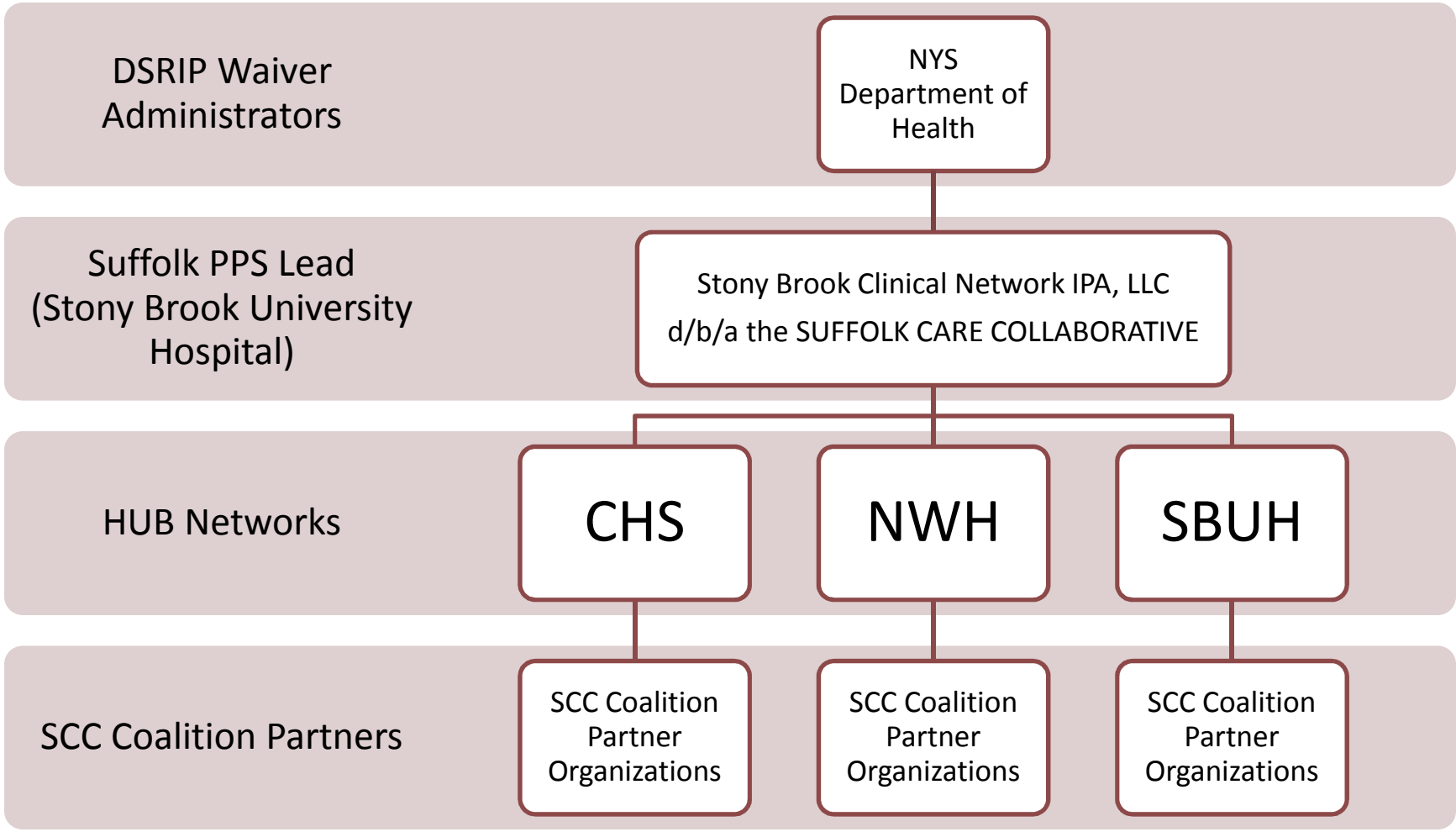
SCC (PPS) HUB MODEL TABLE OF ORGANIZATION



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SCC PROGRAM MANAGEMENT STRUCTURE

- 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

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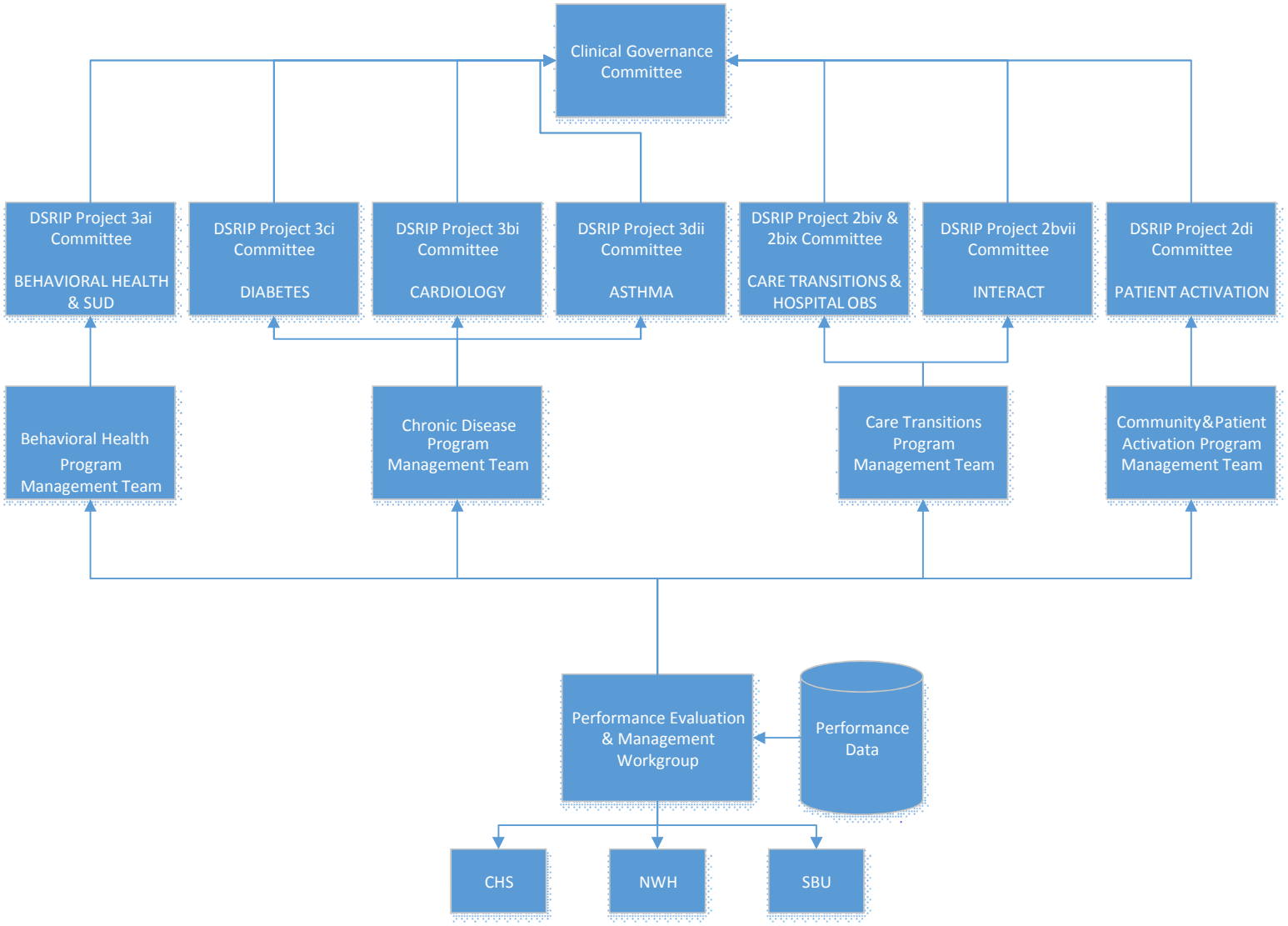
PERFORMANCE IMPROVEMENT REPORTING



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QUALITY IMPROVEMENT STEPS

QI STEPS	SCC Action Plan
Prioritization	• Measures prioritized at the beginning of each Measurement Year based on dollar valuation, number of lives to close • Performance Workbooks created by HUB prioritizing partners for outreach (Heat Maps) • SCC Clinical Alert
Performance Drivers	• Clinical Documentation Improvement Guide created to identify the specific performance drivers to close the gap
Process Deficiency	• Clinical Transformation Teams across the HUBS working with partners to identify and address gaps
Process Improvement	• SCC PI Toolkit Data Collection Plan PDSA Cycle Template Corrective Action Plan • Lean Projects • MAX Series • SCC Learning Center • GNYHA Ambulatory PI Training Collaborative

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DEVELOPING PERFORMANCE IMPROVEMENT STRATEGIES WITH DOH DATA

Presented by:

Christopher Ray, MS

Data Analyst, Network Development & Performance

Suffolk Care Collaborative

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

Data Source	Purpose
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

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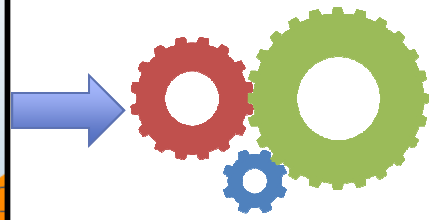
TELLING THE STORY OF PERFORMANCE

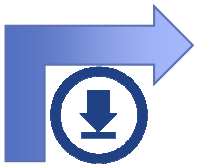
Using the DOH's performance data and combining it with SCC's Provider Network information, SCC was able to create interactive workbooks to tell the story.



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 (+)	50.08	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) is a *great* resource!



Comp ~ ME 6/2016
Context:
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

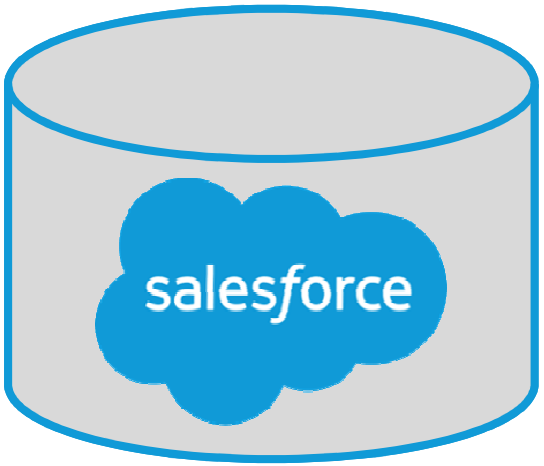
Comp ~ ME 6/2016
Total Measure Goal: 2
Dataset: NY Medicaid DV6 - DOH
User: CRAY
Cube: Tracking_Measures
Path: PPS Name:SUNY at Stony Brook University Hospital
By: Measure Goal \ Measure \ Current MC PCP Provider
Filters: Measure:G[PPS]_Dashboard Measures
Sort: Name:ASC

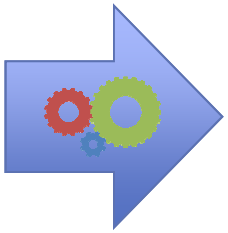
Measure Goal	Measure	Current MC PCP Provider	Line Monthly Member Measure Numerator	Line Monthly Member Measure Denominator	Monthly Member Measure Result
DOWN			65,533	956,719	5,313.84
DOWN	PDI 14 - Pediatric Asthma		147	70,754	207.76
DOWN	PDI 14 - Pediatric Asthma	Provider 1	0	1	0.00
DOWN	PDI 14 - Pediatric 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

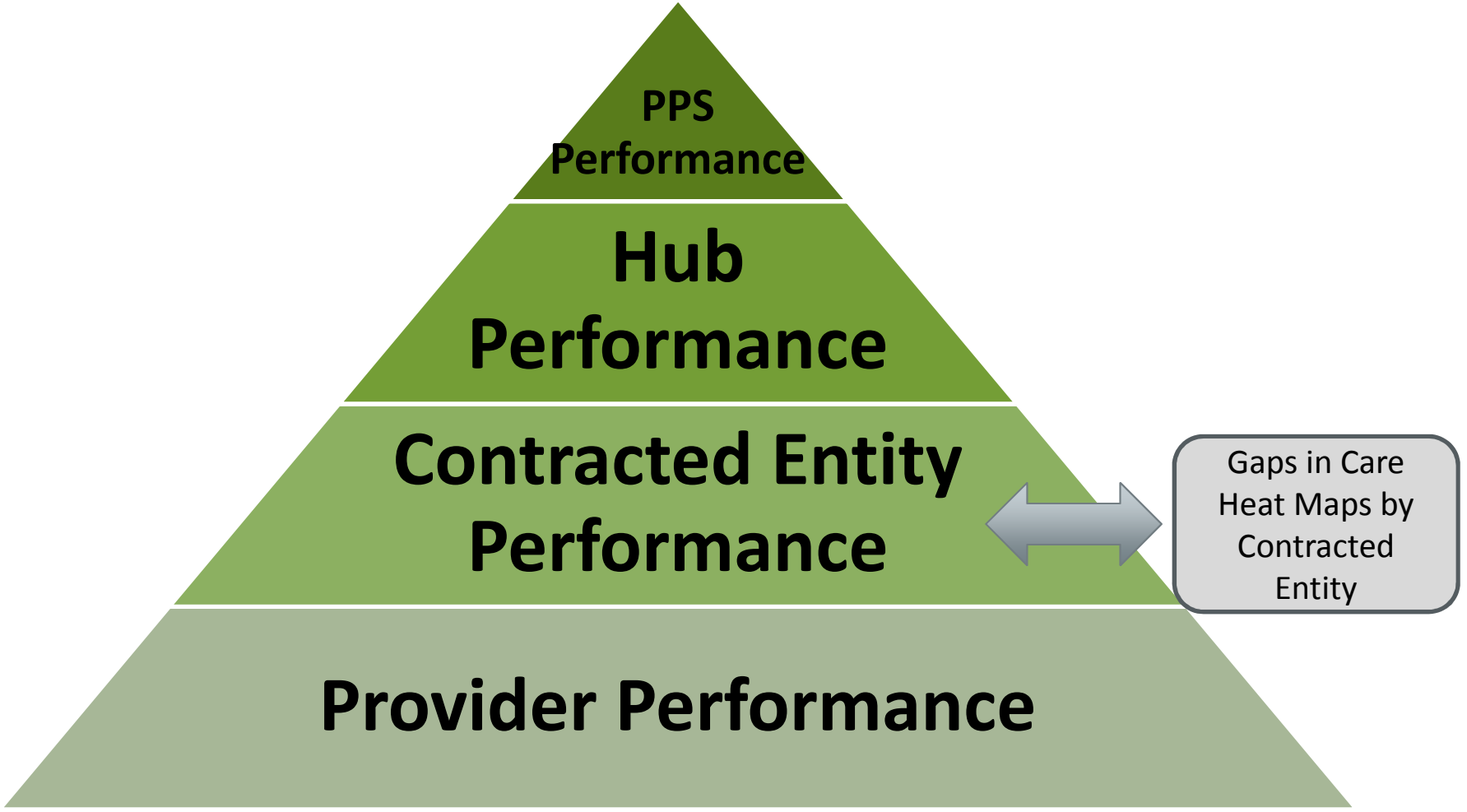




Comp ~ ME 6/2016
Total Measure Goal: 2
Dataset: NY Medicaid DV6 - DOH
User: CRAY
Cube: Tracking_Measures
Path: PPS Name:SUNY at Stony Brook University Hospital
By: Measure Goal \ Measure \ Current MC PCP Provider
Filters: Measure:G[PPS]_Dashboard Measures
Sort: Name:ASC

Measure Goa	Measure	Current MC PCP Prov der	L ne Month y Member Measure Numerator	L ne Month y Member Measure Denom nator	Month y Member Measure Resu t
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

Develop Different "Views" of Data



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TELLING THE STORY OF PERFORMANCE DATA VISUALIZATION

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 (+)	50.08	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						

PPS Performance

Contract Status: Contracted | Not Targeted | Targeted

Measure	SBU						
	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			
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	
Antidepressant Medication Mgmt (Cont) (+)	147	356	41.29	40.75		41.05	
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	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
Total*	**1280**	**410**	**340**	**270**

*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

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Contract Status

- Contracted
- Not Targeted
- Targeted

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

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Contract Status
- Contracted
- Not Targeted
- Targeted

Hub Performance

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		

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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
Total*	**1280**	**410**	**340**	**270**

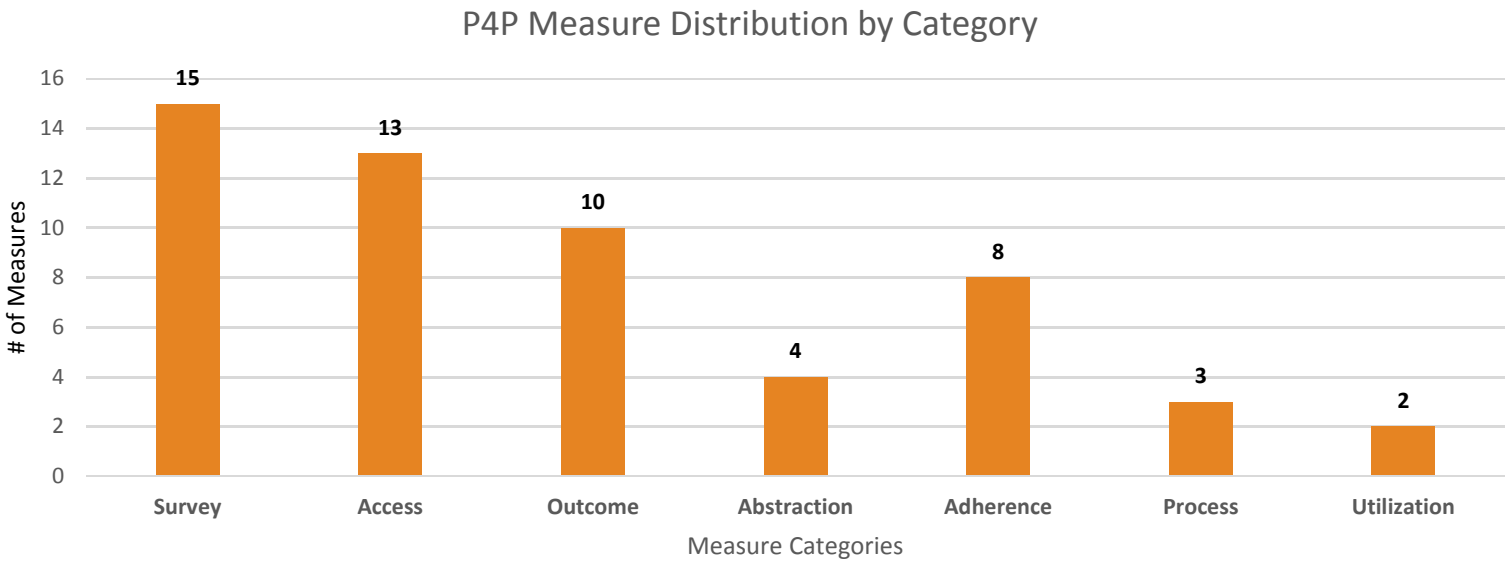
*Contracted entities are in descending order by # of outliers

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
- MY2 Target has been met
- On track to meeting measure at the end of MY2
- Will not meet MY2 target at the current rate

Links: Action Plan File | Graphs | Zip Code Analysis

Measure Type: Abstraction | Access | Adherence | Outcome

Current Measure Type Grand Total: $125,385,177 (79% of total)

P4P/P4R: P4P | P4R

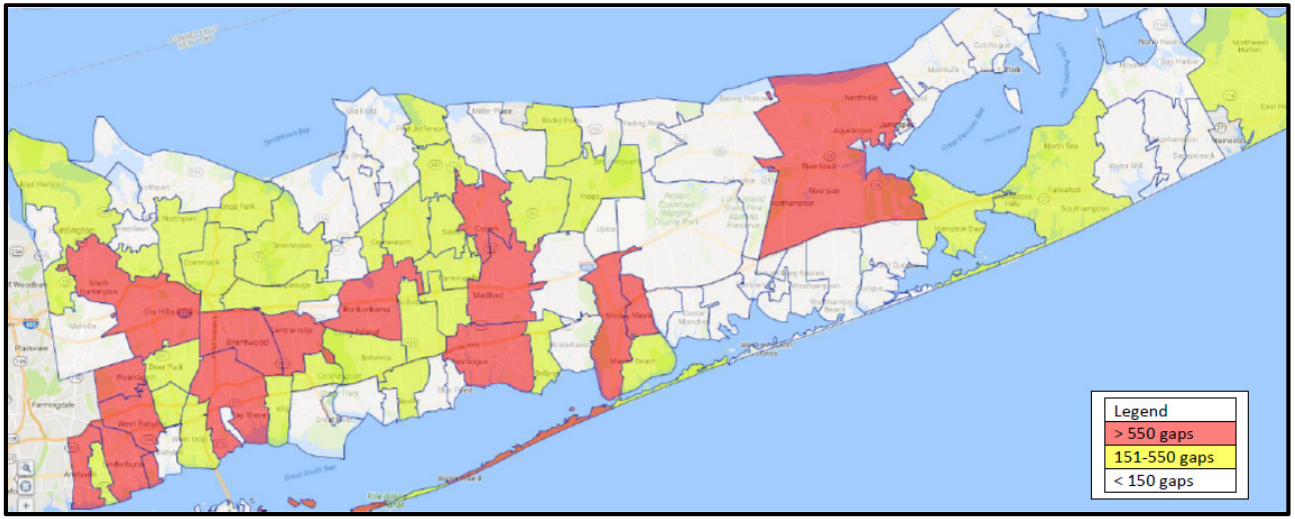
Met/Not Met: Met | Not Met | On Track | (blank)

*Actual values may increase depending on other PPS' performance

SCC Measurement Year 2 Performance Data Period: May 1, 2015 - April 30, 2016											Measure Valuation (DSRIP Total)				
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	HPF*	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

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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

Is the metric **out** of Variance for 2 consecutive quarters?

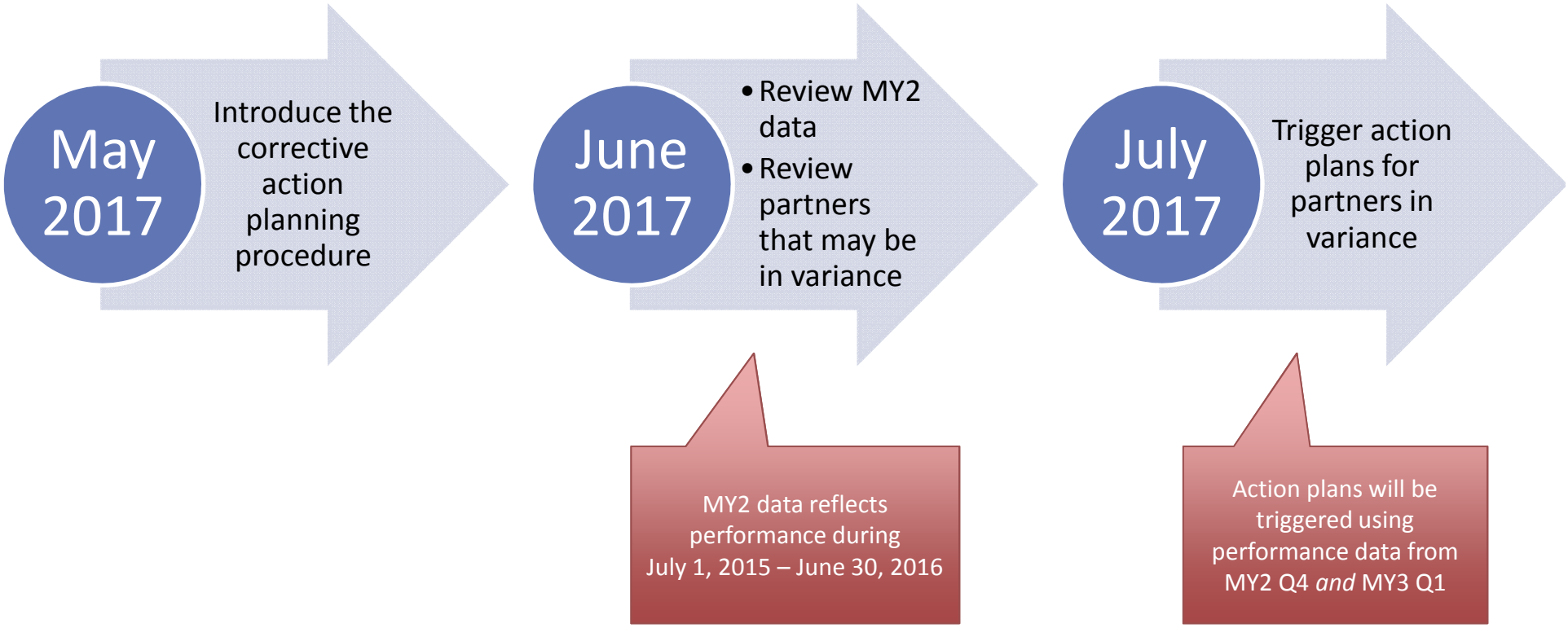
YES

Action Plan Closed and Completed

NO

Clinical Committee determines next steps

Corrective Action Planning Process Timeline



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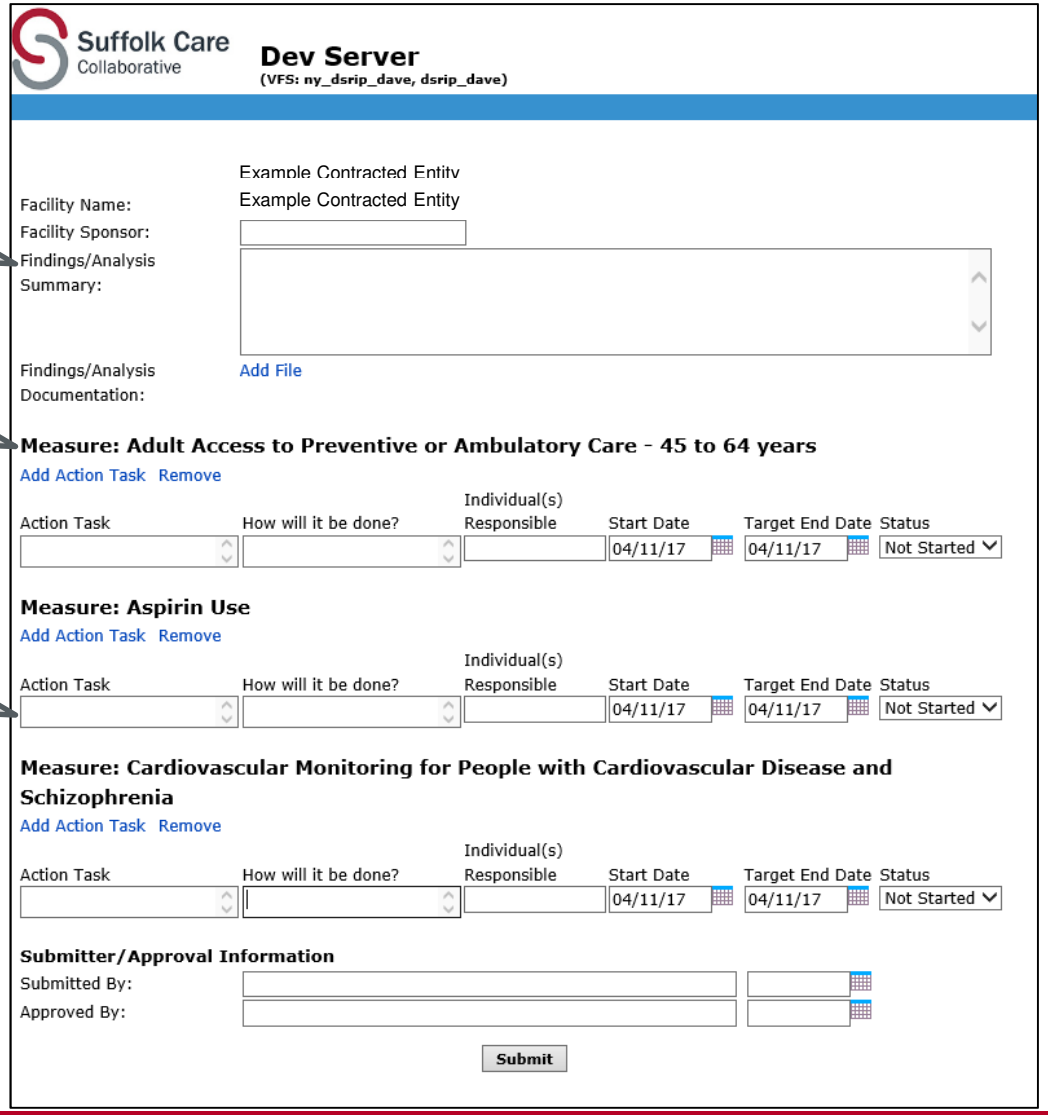
CORRECTIVE ACTION PLAN EXAMPLE

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



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SCC FUTURE STATE DATA STRATEGY – ADDRESSING ATTRIBUTION

Presented by:

Sam Lin, MHA, PMP

Administrative Manager, Project Management Office

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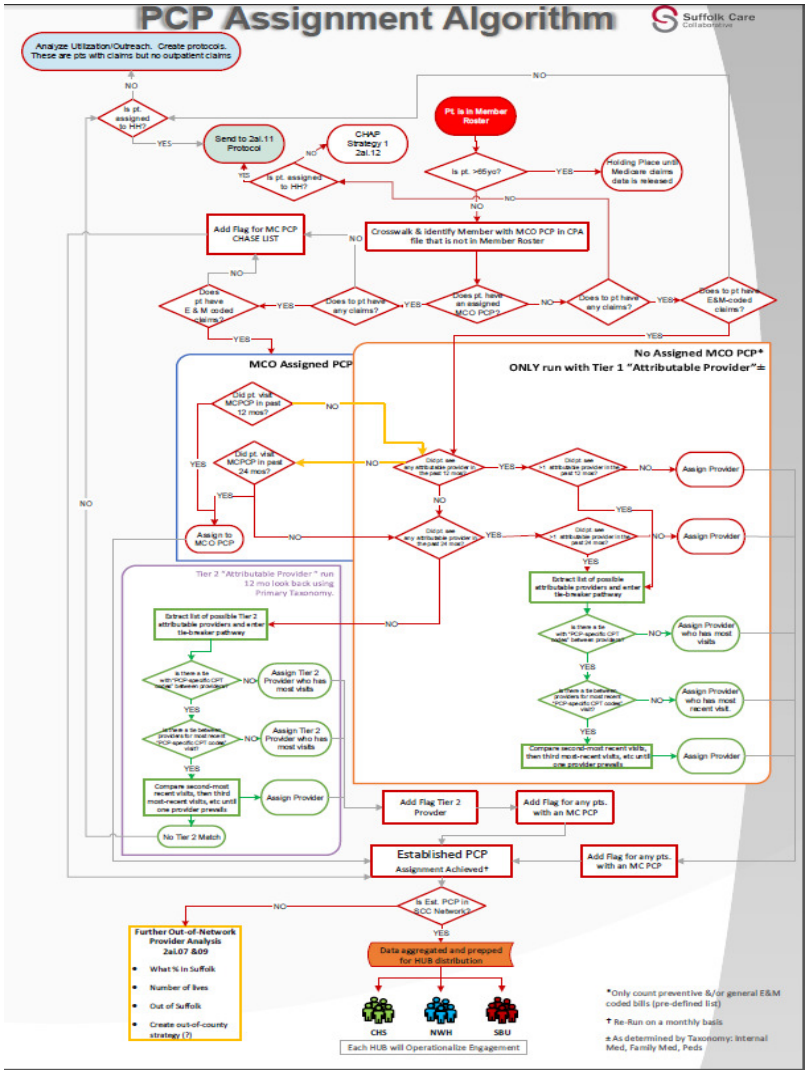
PCP ATTRIBUTION



- **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

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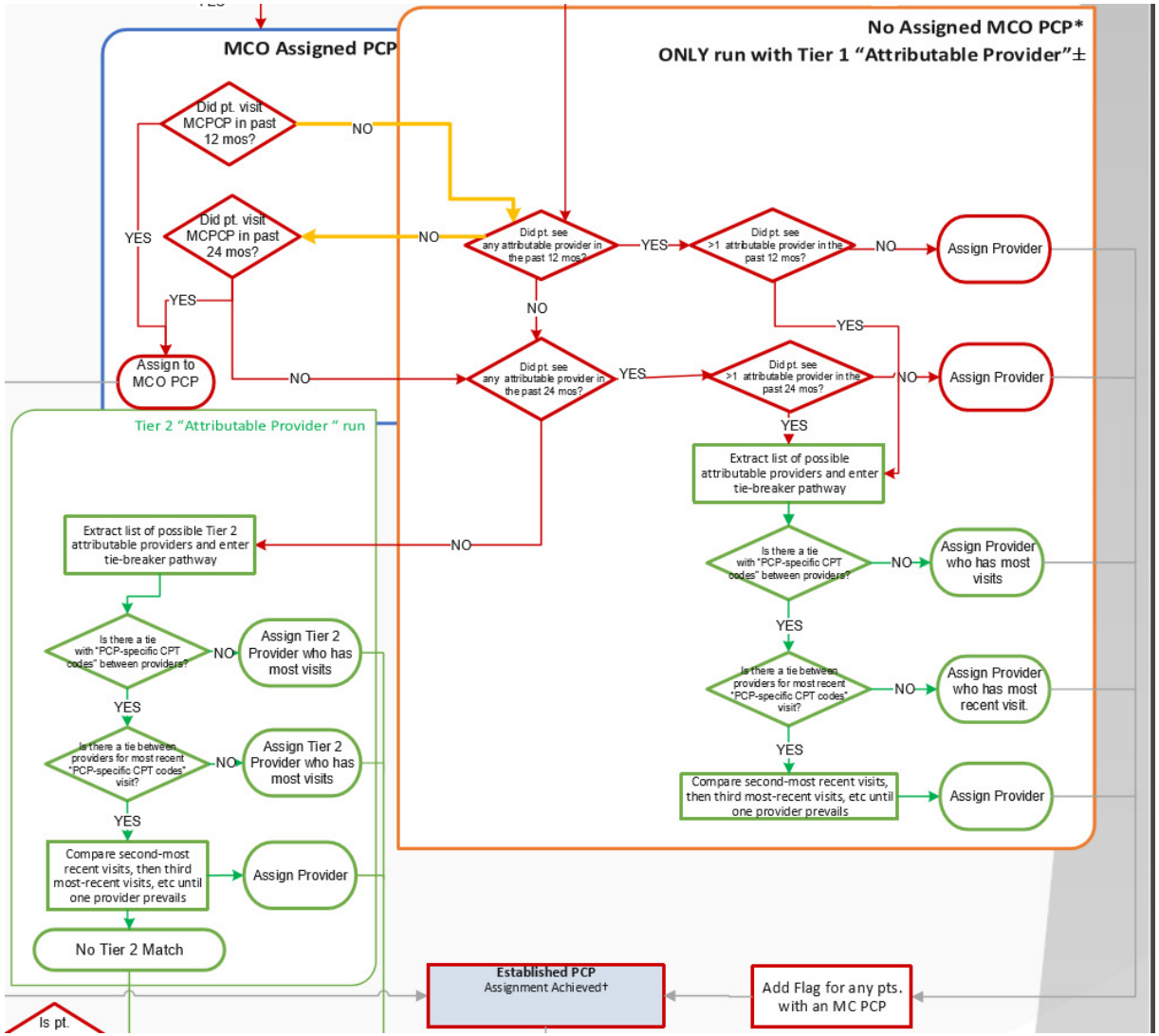
LOYALTY BASED ATTRIBUTION

- 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



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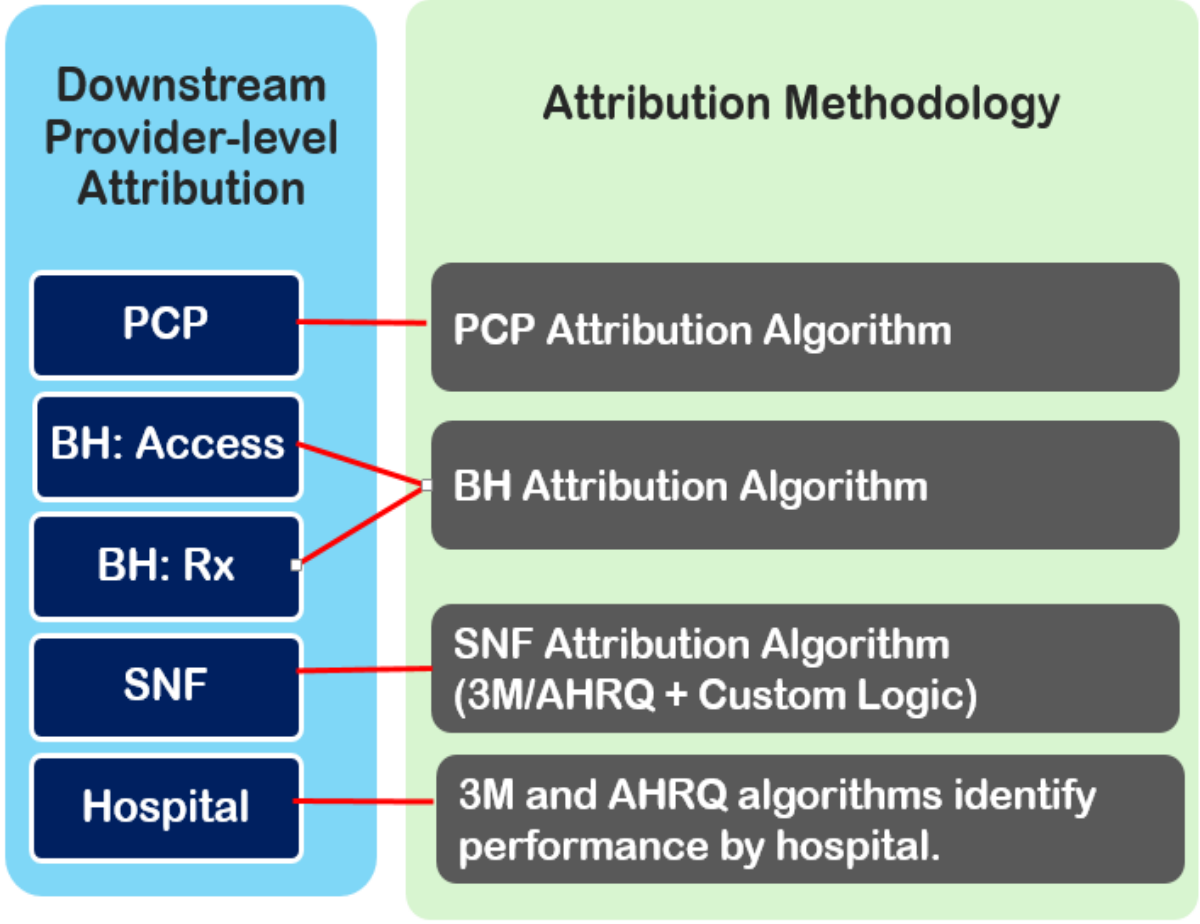
ATTRIBUTION ALGORITHMS

Measure to Provider Type Mapping

Metric	PCP	BH - Rx	BH - Access	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				

Measures are driven by various provider types



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BEHAVIORAL HEALTH PROVIDER ATTRIBUTION

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

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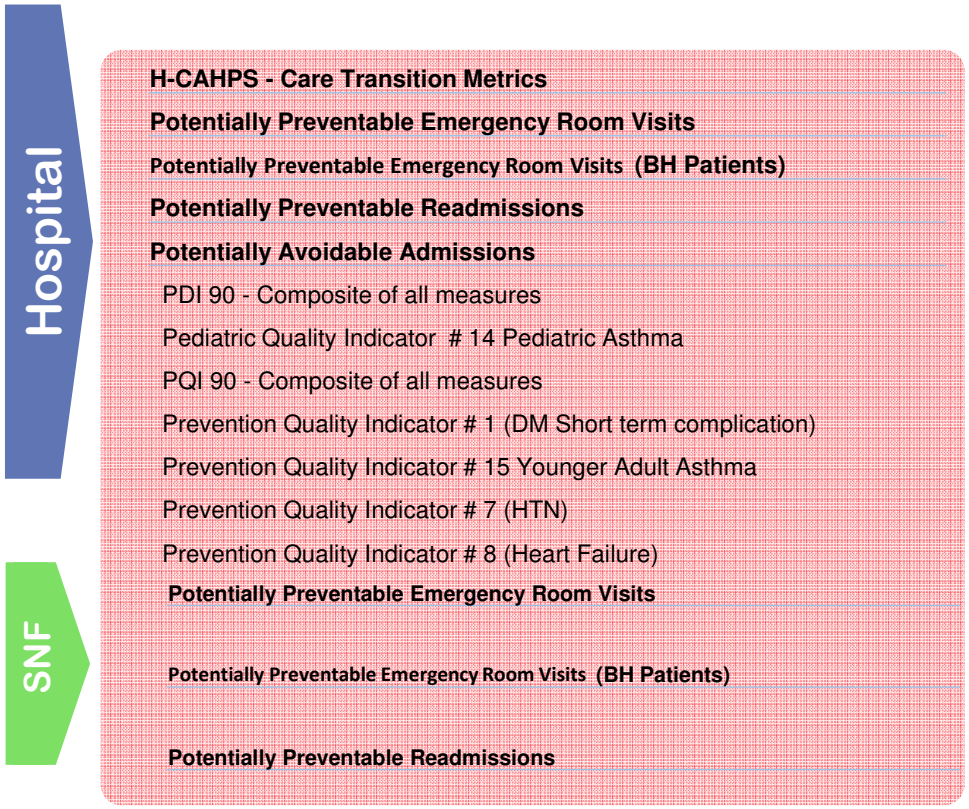
HOSPITAL & SNF ATTRIBUTION

- **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



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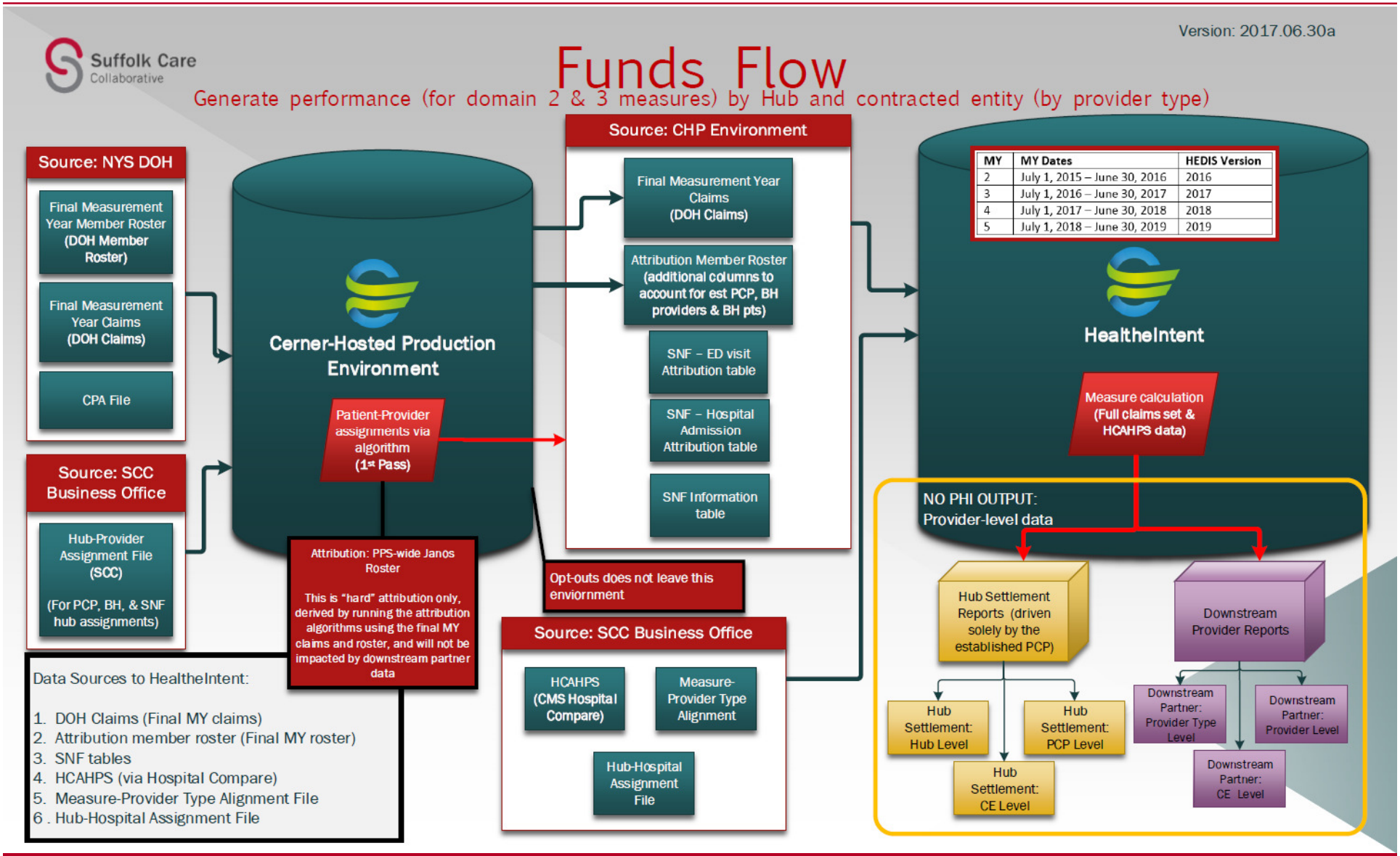
DOH DATA USE CASE – FUNDS FLOW



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PROVIDER DASHBOARD

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

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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ALIGNING PARTNER INCENTIVES

Presented by:

Kevin Bozza, MPA, FACHE, CPHQ, RHIT

Vice President, Population Health Management Services

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PERFORMANCE INCENTIVE PAYMENTS

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

Performance Factor	Description
Engagement Payment	Complete SCC On-boarding documentation as outlined in the SCC Contracting Plan Agreement 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	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. 2. EHR meets connectivity to RHIO's HIE and SHIN-NY requirements
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.

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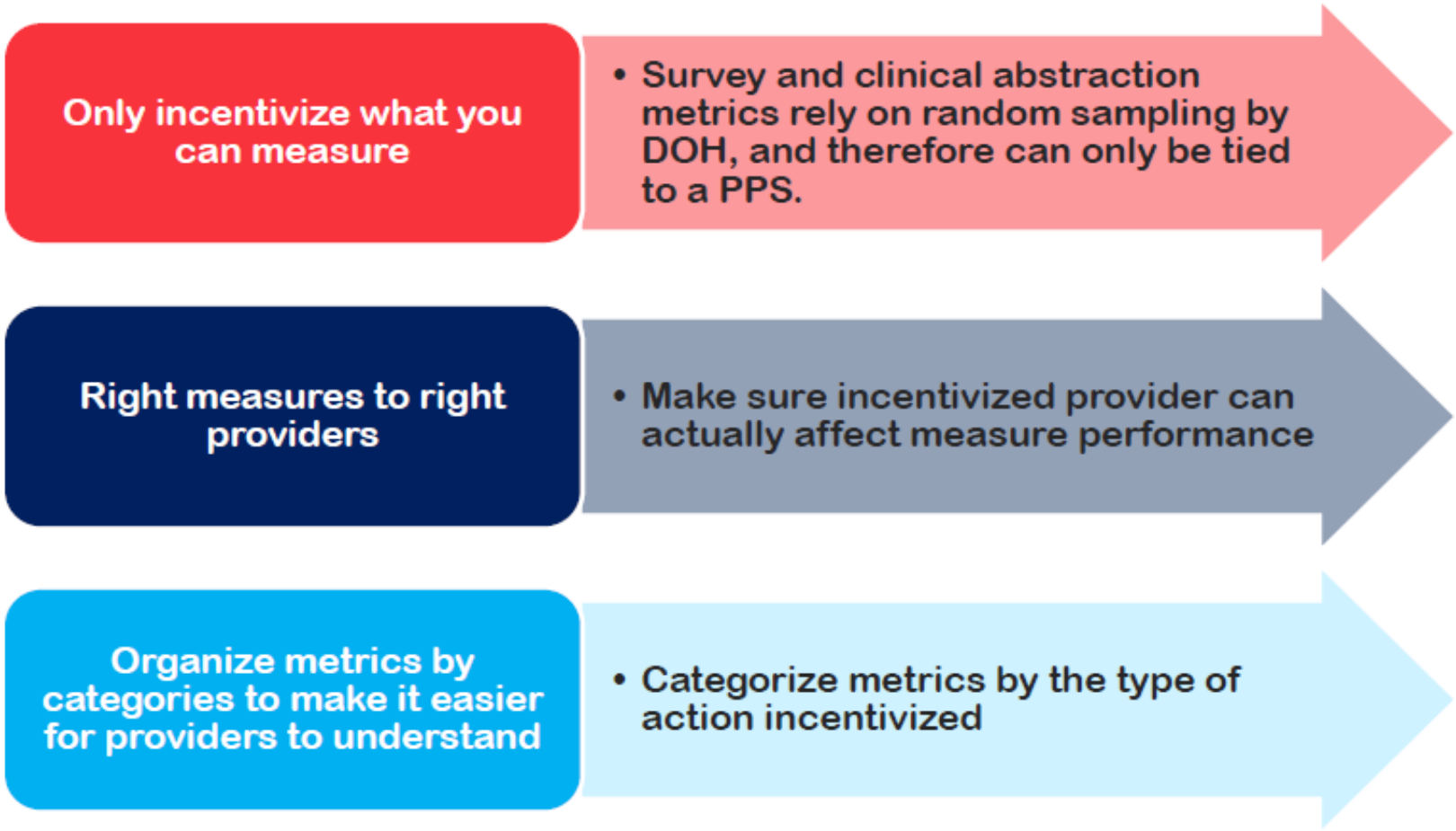
P4P GUIDING PRINCIPLES



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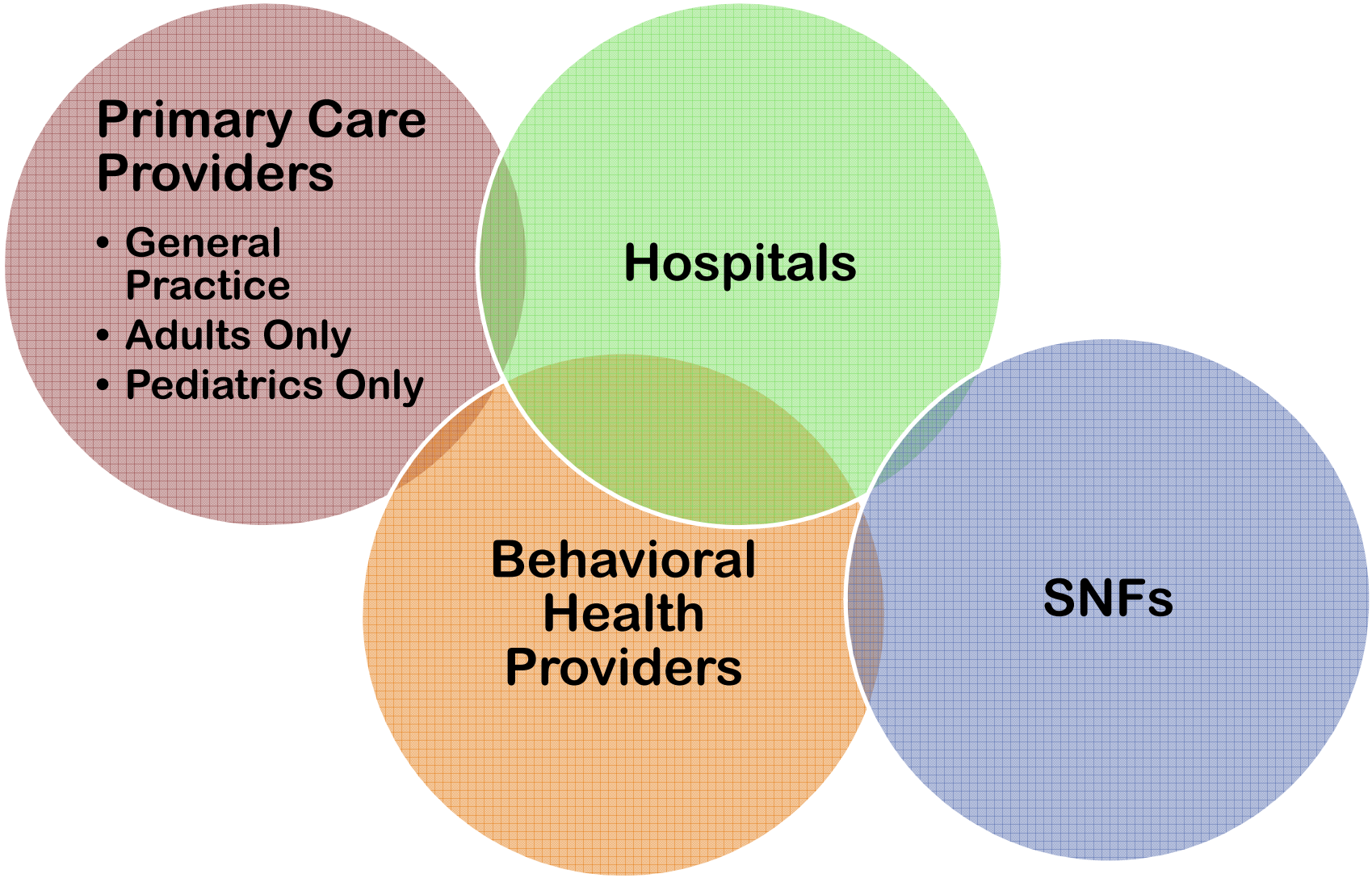
MAPPING MEASURES TO PROVIDER TYPES



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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	-	-	-

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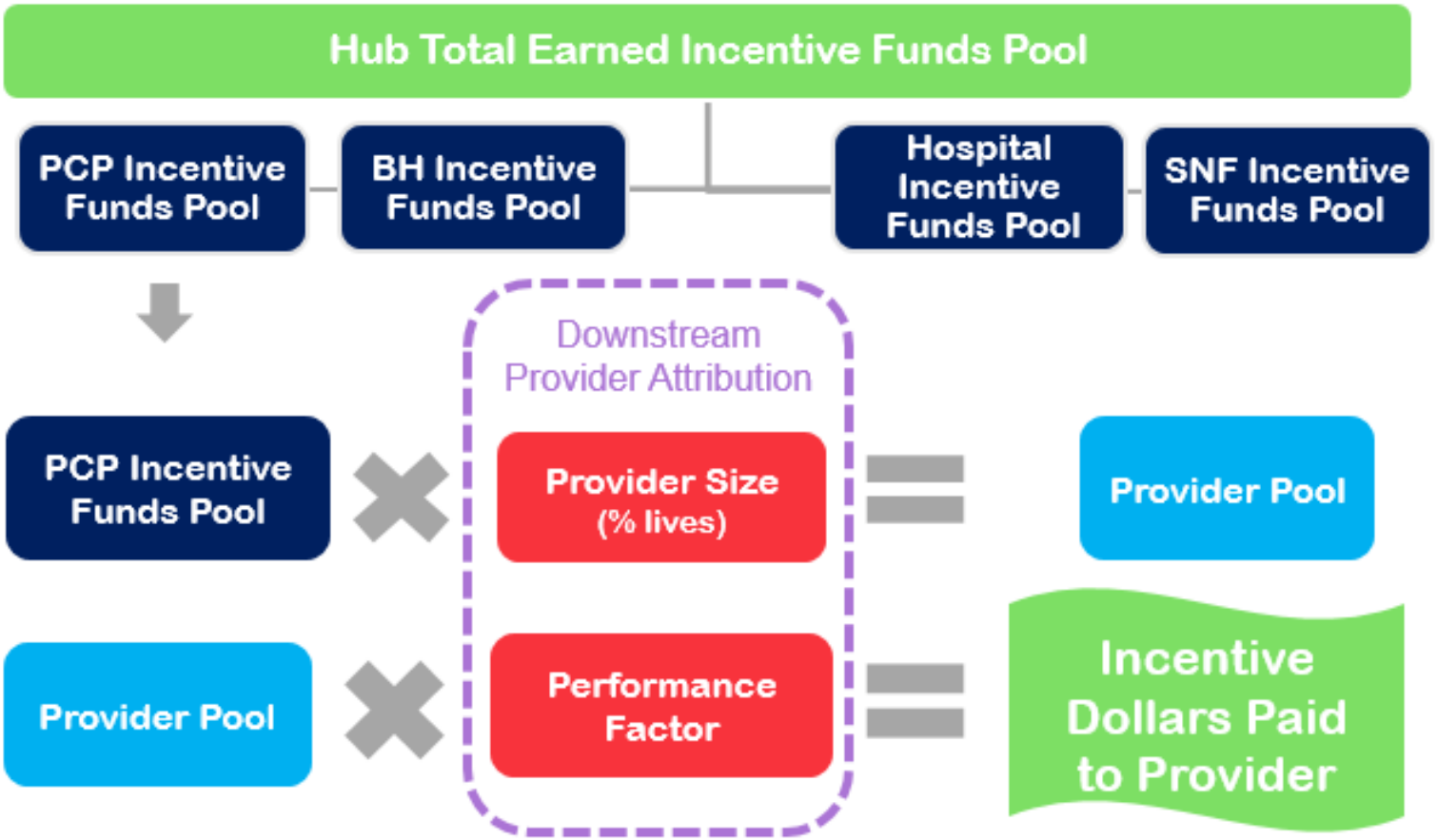
DETERMINING INCENTIVE POOL PAYMENT



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.

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DERIVING METRIC POINT VALUES: BUSINESS RULES

Metric Name	DY2 Payment 2 Dollar Value	DY2 Payment 2 Point Value
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
Total	**$250**	**100 pts**

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CALCULATING PERFORMANCE INCENTIVE PAYMENTS

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%)

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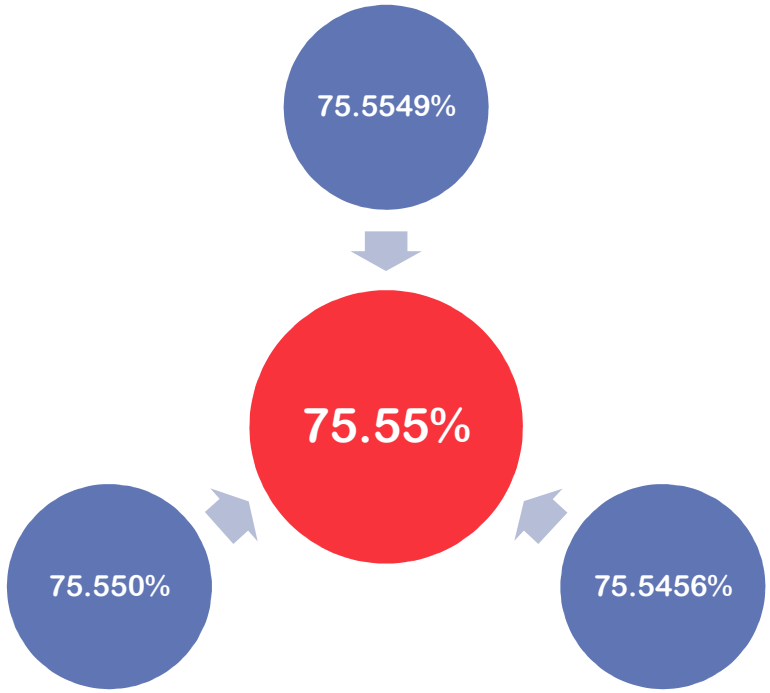
PERFORMANCE PRECISION: BUSINESS RULES

- 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")



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TRAINING STRATEGY

Presented by:
Kevin Bozza, MPA, FACHE, CPHQ, RHIT
Vice President, Population Health Management Services
Suffolk Care Collaborative

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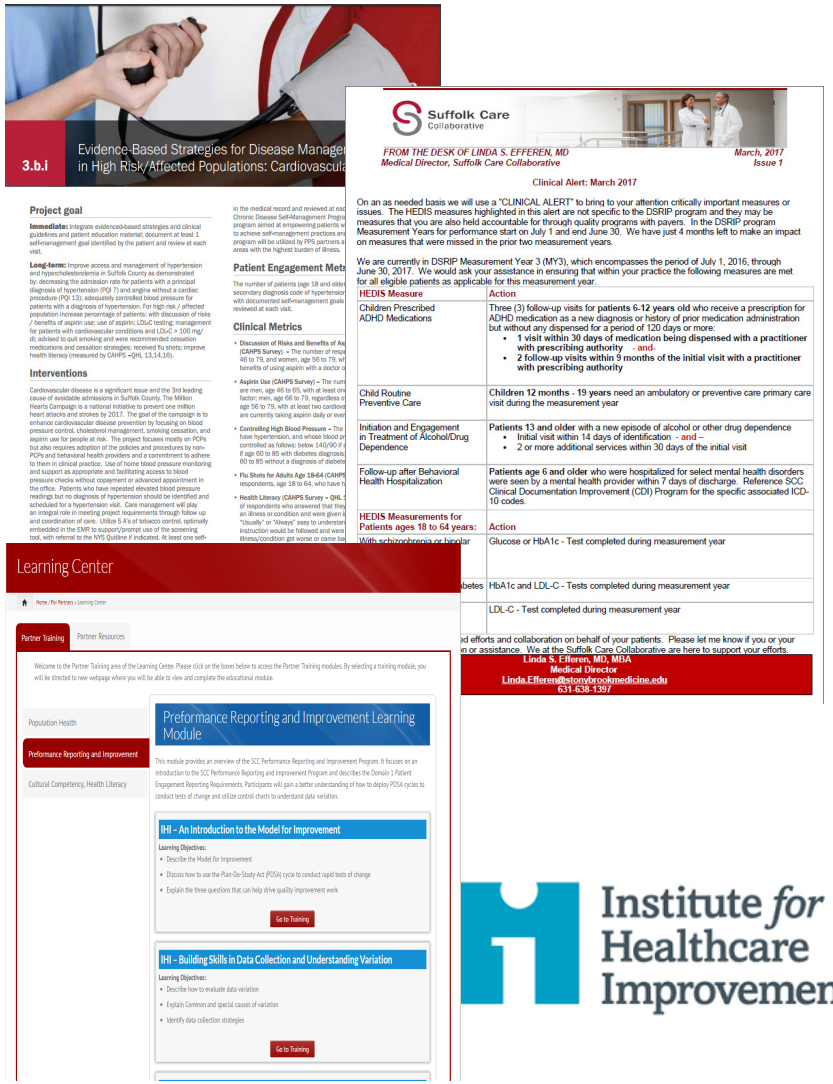
TRAINING STRATEGY & PLAN



- 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

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CLINICAL DOCUMENTATION IMPROVEMENT GUIDE

Clinical Documentation Improvement Program

2017

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