Staten Island
Performing Provider System, LLC

NEW YORK STATE OF OPPORTUNITY. | Department of Health

All PPS Meeting

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Agenda

- MCO and PPS Alignment & Collaboration
- Performance Pain Points
- Population Health 2.0 Application
- Plan Performance Analysis
- Use Case illustrations
- Plan Collaboration
- Opportunities for future alignment and initiatives

Plan and PPS Natural Alignment

- Population health improvement for communities we serve
- Measured by many common indicators
- Significant funds at risk in VBP/P4P methodology
- Challenges with small practice engagement-capacity change, data management, PCMH, multiple EMRs in practice environment
- Move to Value Based care demands coordinated effort with partners
- Complimenting each others expertise and resources- Business Intelligence (BI), care coordination, engaging CBOs, physician practice alignment, etc.

Current Areas for Collaboration

- Asthma Coalition – community-wide effort with Department of School Health, physician practices, hospitals and MCOs to improve asthma outcomes in school age children
- Diabetes Management – PPS focus on improved HEDIS and patient outcomes for short and long term complications of diabetes
- Behavioral Health – community-wide effort with hospitals, behavioral health providers, physician practices, and CBOs to improve health outcomes for individuals with co-occurring mental health and substance use disorders
- Readmission reduction – ongoing efforts with nursing homes, home care agencies, and hospitals to reduce hospital transfer rates and readmissions
- Initiatives to improve access to primary and preventive care for adults and children
- Multiple MCOs have signed agreements with SI PPS to support these programs

MY2 P4P measures showing opportunity for improvement July 1, 2015- June 30, 2016

MY2 P4P measures showing opportunity for improvement
(lower performing, higher value measures impacting most PPS)

Measure Name	PPS meeting MY2 AIT	Performance Value	MY3 Trend[2]
HP Antidepressant Medication Management - Effective Acute Phase Treatment	1/25 (4%)	$22,255,453	9/25 (36%)
HP Antidepressant Medication Management - Effective Continuation Phase Treatment	1/25 (4%)	$21,993,287	9/25 (36%)
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	1/25 (4%)	$21,799,757	13/25 (52%)
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	3/25 (12%)	$21,799,757	16/25 (64%)
HP Follow-up after hospitalization for Mental Illness - within 7 days	3/25 (12%)	$22,553,222	14/25 (56%)
HP Follow-up after hospitalization for Mental Illness - within 30 days	5/25 (20%)	$22,553,222	16/25 (64%)
PQI 1 Diabetes Mellitus Short Term Complications[1]	2/10 (20%)	$39,124,734	5/10 (50%)
Medication Management for People with Asthma - 75% of Treatment Days Covered	3/13 (23%)	$14,704,317	1/13 (8%)
Total		$186,783,749	

HP: High Performance measure
1. MY2 measure results should not be compared to measure results for prior years due to the use of ICD-10 diagnosis codes.`
2. MY3 trend is based on MY3 month5 data and is the number of PPS "on-track" as shown in DSRIP dashboards

Value-Based Care Data Management Model

Key Components to Success

Identify Care Gaps

- Care Alerts to be Embedded w/i EHR

***MCO Data Exchange**

Interoperability

- Send/Received CEN (clinical event notification)
- Connected to HIE, received and share information

Population Health Management

- Risk Stratification
- Consider SDOH

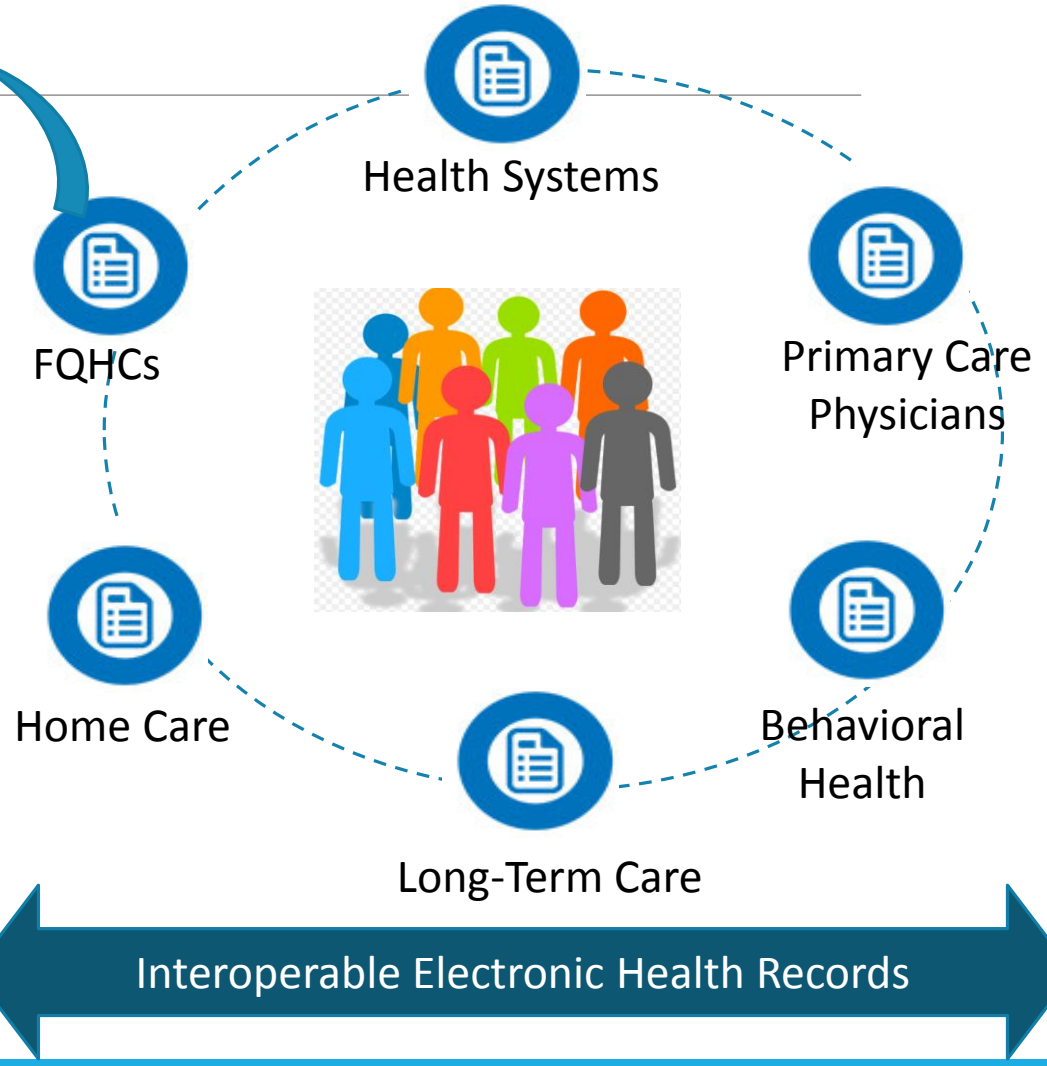
*** MCO/PPS Alignment**

Quality Metric Reporting

- Measurement Portal

*** MCO PPS Outcomes Management**

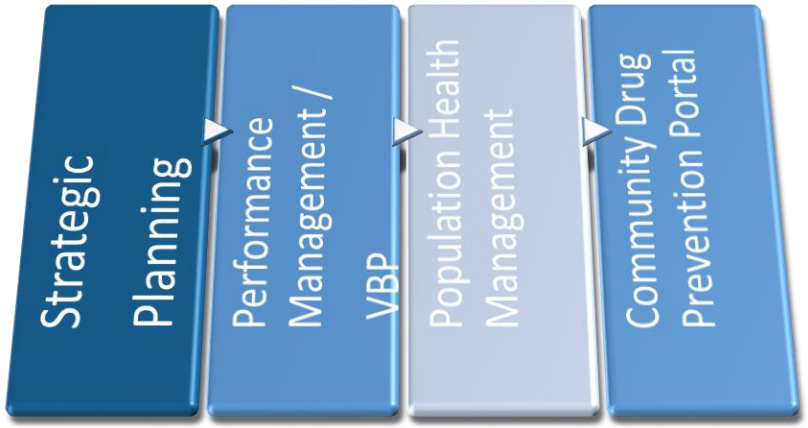
Integration Across the Continuum of Care



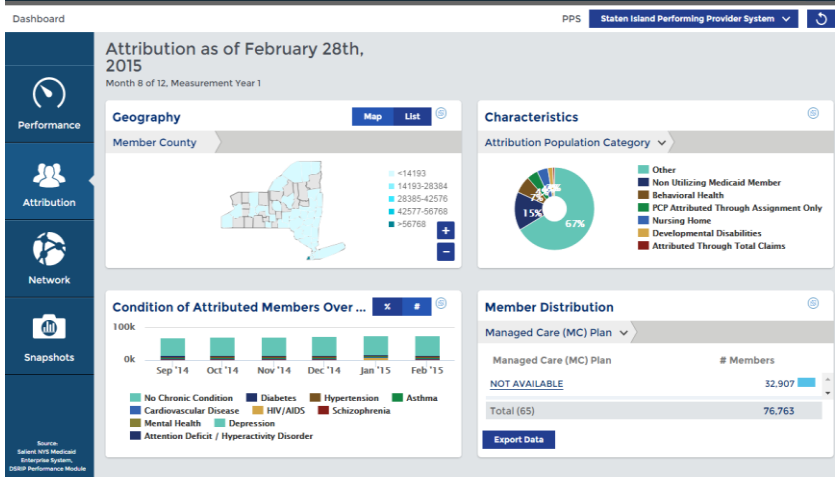
SI PPS Analytics: Tool Portfolio

Turn Data into Actionable Insights

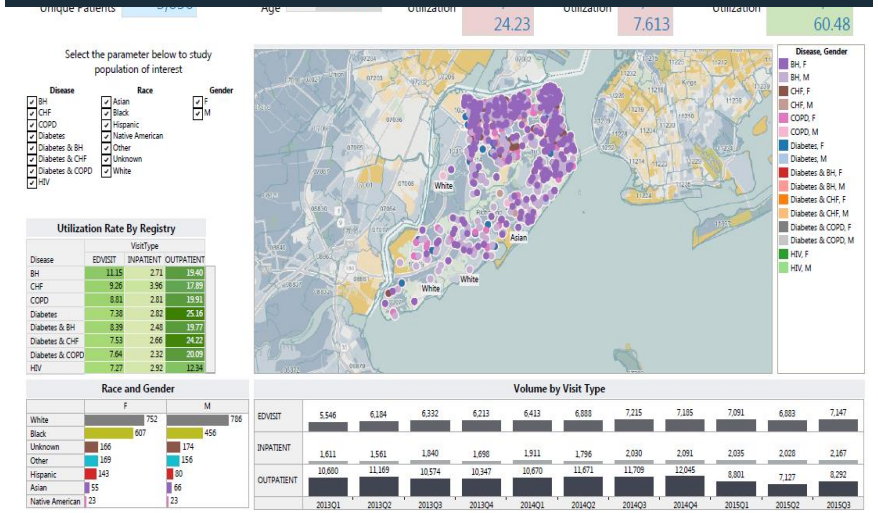
Program Areas



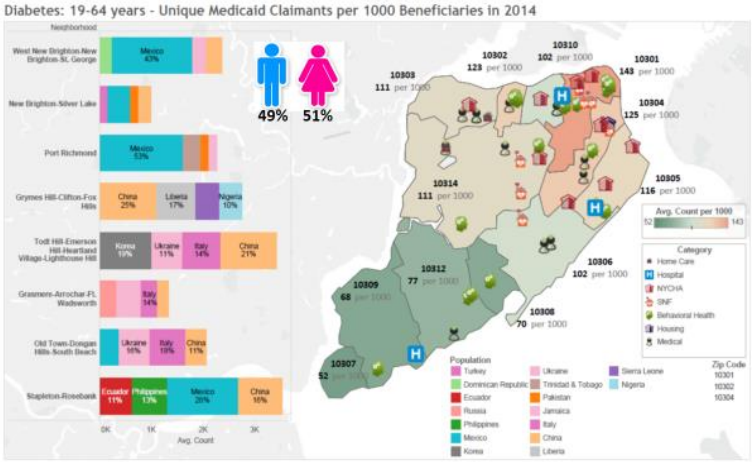
MAPP Dashboard - VBP



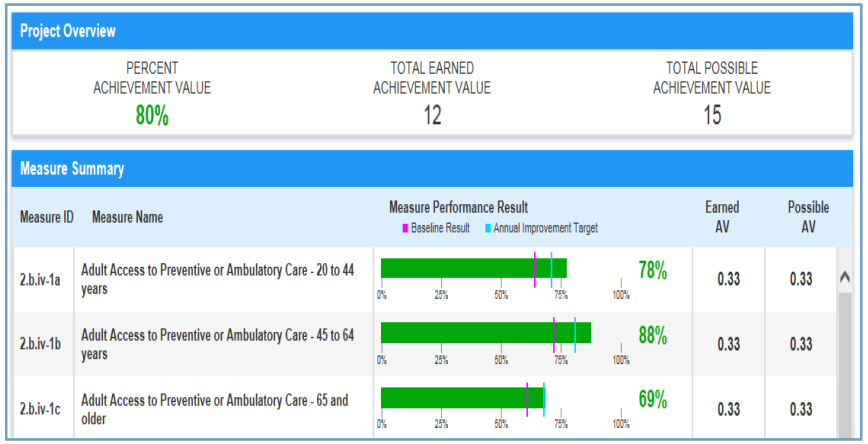
Population Health Management



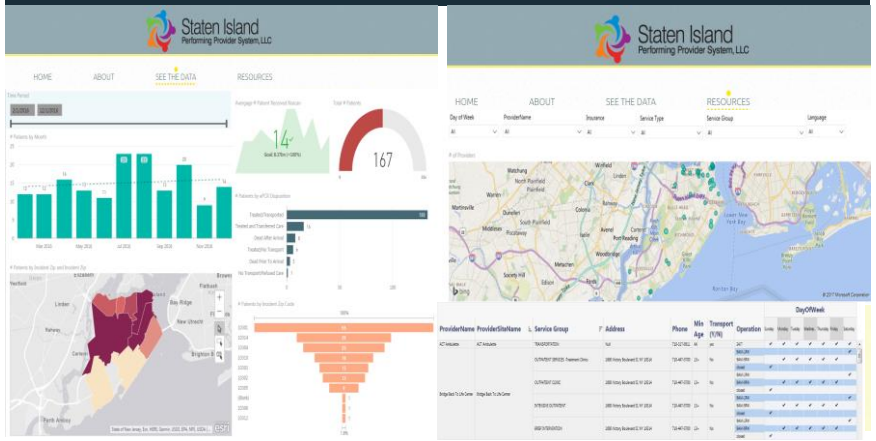
Healthcare Hotspotting



Partner P4P Dashboard



SI Drug Prevention Portal



Population Health 2.0 – Adult Diabetes

Staten Island Performing Provider System

Staten Island PPS Population Health 2.0

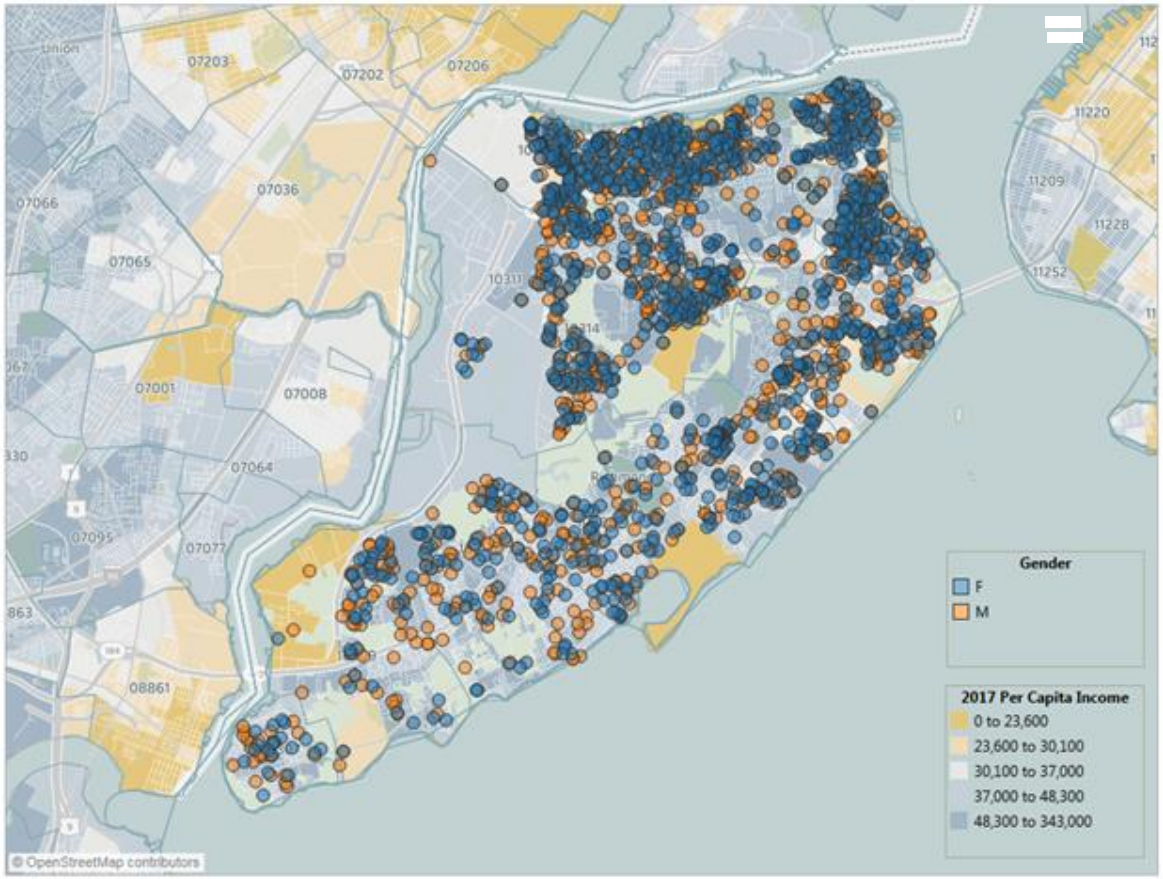
Patient 360 View | Rx Dashboard

Gender: F, M, U | Race: (All) | Age Group: (All) | Visit Date: 7/31/2014 – 7/31/2016

Asthma	BH	CVD	Diabetes	HIV	Hypertension	Other Chron Cond
NO, YES	NO, YES	NO, YES	NO, YES	NO, YES	NO, YES	NO, YES

Total Visits	390,166	Inpatient Visit	6,150	Average Age	55.4
Unique Patients	3,119	Unique Patients	513		

Outpatient Visits	93,638
Unique Patients	2,165



Race and Gender

	F	M
Asian	182	160
Black	361	241
Hispanic	100	47
Native American	34	20
Other	151	127
Unknown	153	145
White	670	728

Quarterly Visits by Type

Visit Type	2014		2015				2016		
ER VISIT	651	2	946	1,030	751	914	413	580	162
INPATIENT	61	98	196	773	1,145	1,225	1,060	1,078	514
OUTPATIENT	6,256	9,150	10,155	13,140	13,579	13,709	12,677	12,044	2,928
PHARMACY	15,771	24,076	29,137	33,210	35,382	37,577	35,241	34,315	10,532
PRIMARY CARE	2,159	3,741	4,119	5,092	4,242	3,865	2,786	2,264	650

Strengthening the Health & Wellness Infrastructure

Establishing and sustaining resources & partnerships to improve access and care

Improving Behavioral Health Linkages and Pursuing PCMH

24/7 Peer Support Network

- Growing capacity
- Staffing in clinical & criminal justice sites
- Training/Certification with PPS funds
- Long-term training program

24/7 SI Connect Call Center

- Appointments
- Transportation

Expansion of Treatment Provider Availability

24/7 Crisis Stabilization & Respite Centers

24/7 Resource & Recovery Centers

Resource Guide

Provider Directory Search App

ED Warm Handoff Pilot

Reduce avoidable SUD-related ED visits

- Peer support, level of care assessment
- Expediting linkages to treatment providers

BH Specialists in ED

Peer Counselors in ED

SI Connect 24/7 call center

Provider Directory

SUD Treatment Providers

24/7 Crisis Stabilization Centers

Fund practice pursuit of PCMH certification. Actively promote PCMH standards including care management, care coordination, chronic disease management and population health through partner training and clinical projects. Provide $200,000 bonus payment for achievement of certification.

Providing Integrative Care

Collaborative Care Pilot

Technical assistance for primary care practices to integrate behavioral health

Behavioral Health Detailing

Providing all Staten Island PCPs with BH resources on Opioid Use Disorder, MAT, etc.

Reducing Stigma

Social Media Campaigns & Trainings

Feeling Blue

Awareness on MH issues during holidays

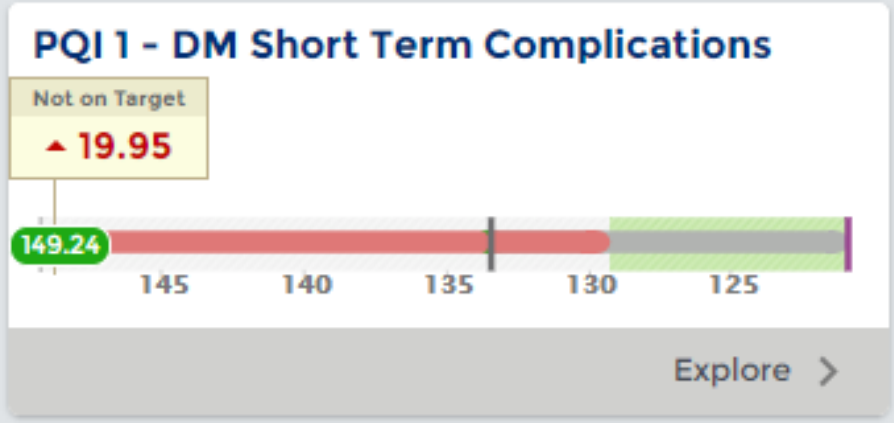
New Year's BH Wellness Resolution

Trainings for providers and front line staff

***Watch Your Words* Campaign**

Prevention Quality Indicator Analysis

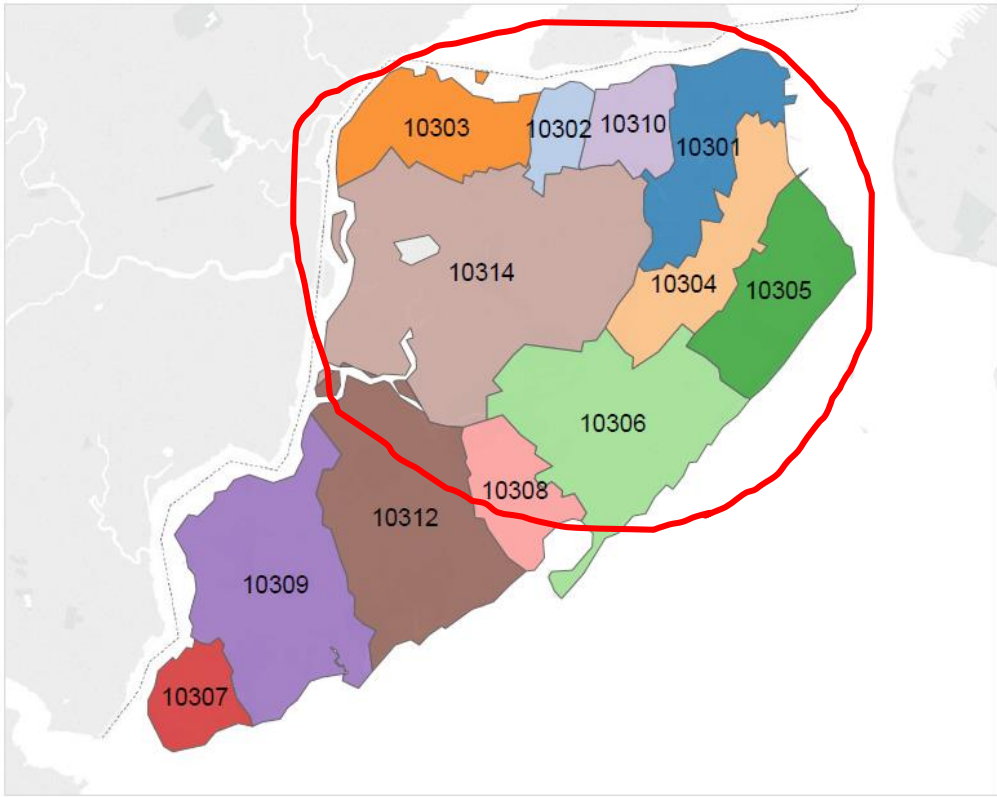
MY3 Performance



Data Observations:

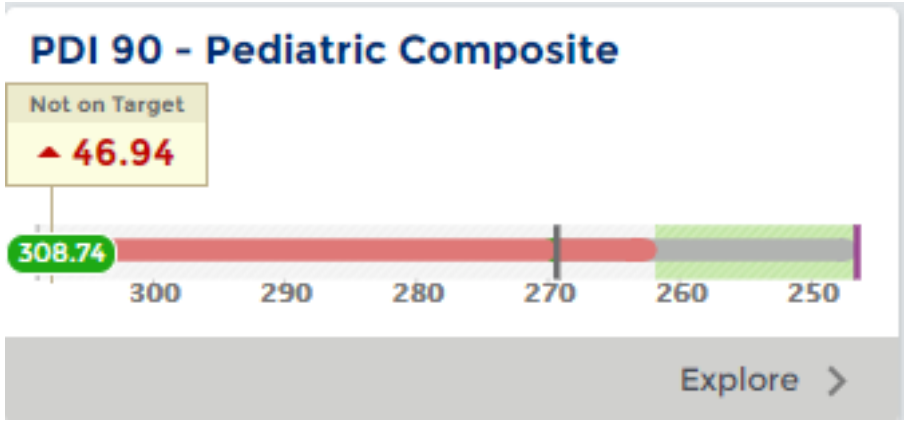
- Patients failing this measure also failing access to primary and preventive care measures
- 88% have a record in PSYCKES
- 7 patients with 2+ chronic conditions
- Only 5 enrolled in Health Home

Zip Codes with Highest Prevalence



Pediatric Overall Composite Analysis

MY3 Performance



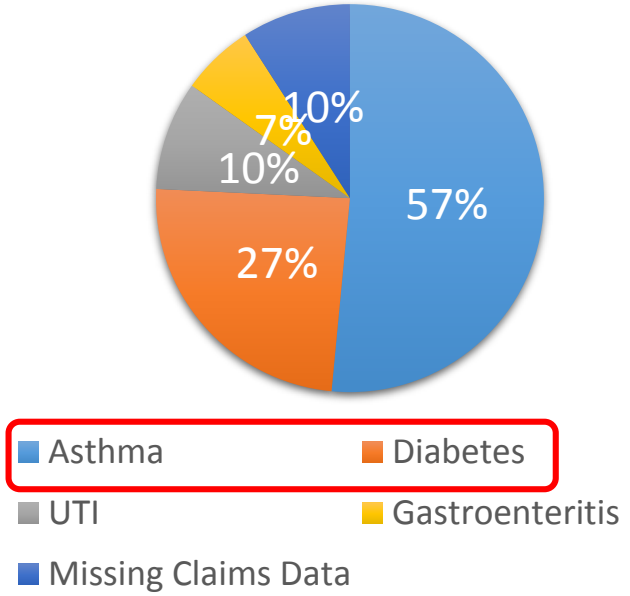
Data Observations:

- Patients located primarily on the North Shore
- 97% have a record in PSYCKES
- 5 patients with 2+ chronic conditions
- Only 1 patient enrolled in Health Home

Frequency of Primary Diagnosis

Hospital discharges with diagnoses of asthma and diabetes have the highest frequency in this measure.

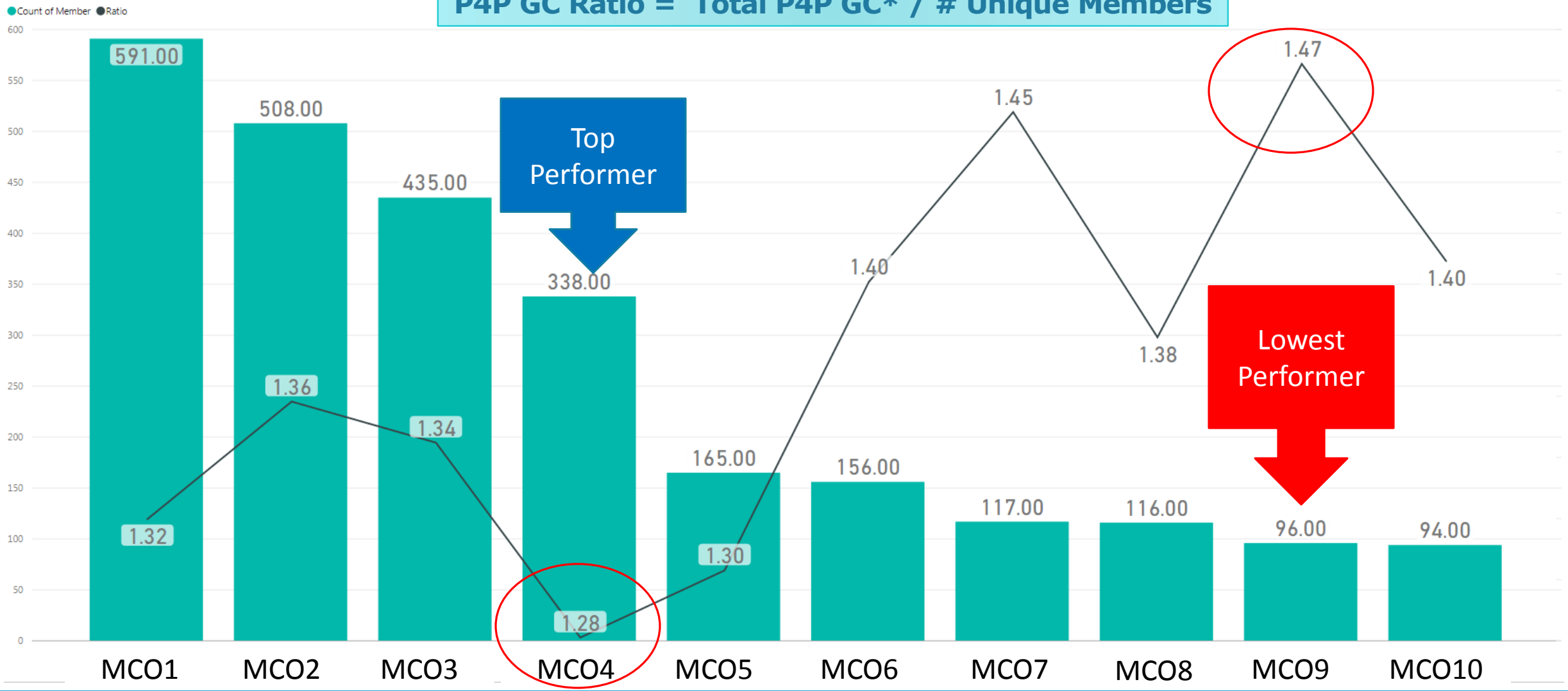
Source: DOH Claims Data



MCOs Performance Analysis

Key Indicator: P4P Gaps in Care (GC) Ratio

P4P GC Ratio = Total P4P GC* / # Unique Members

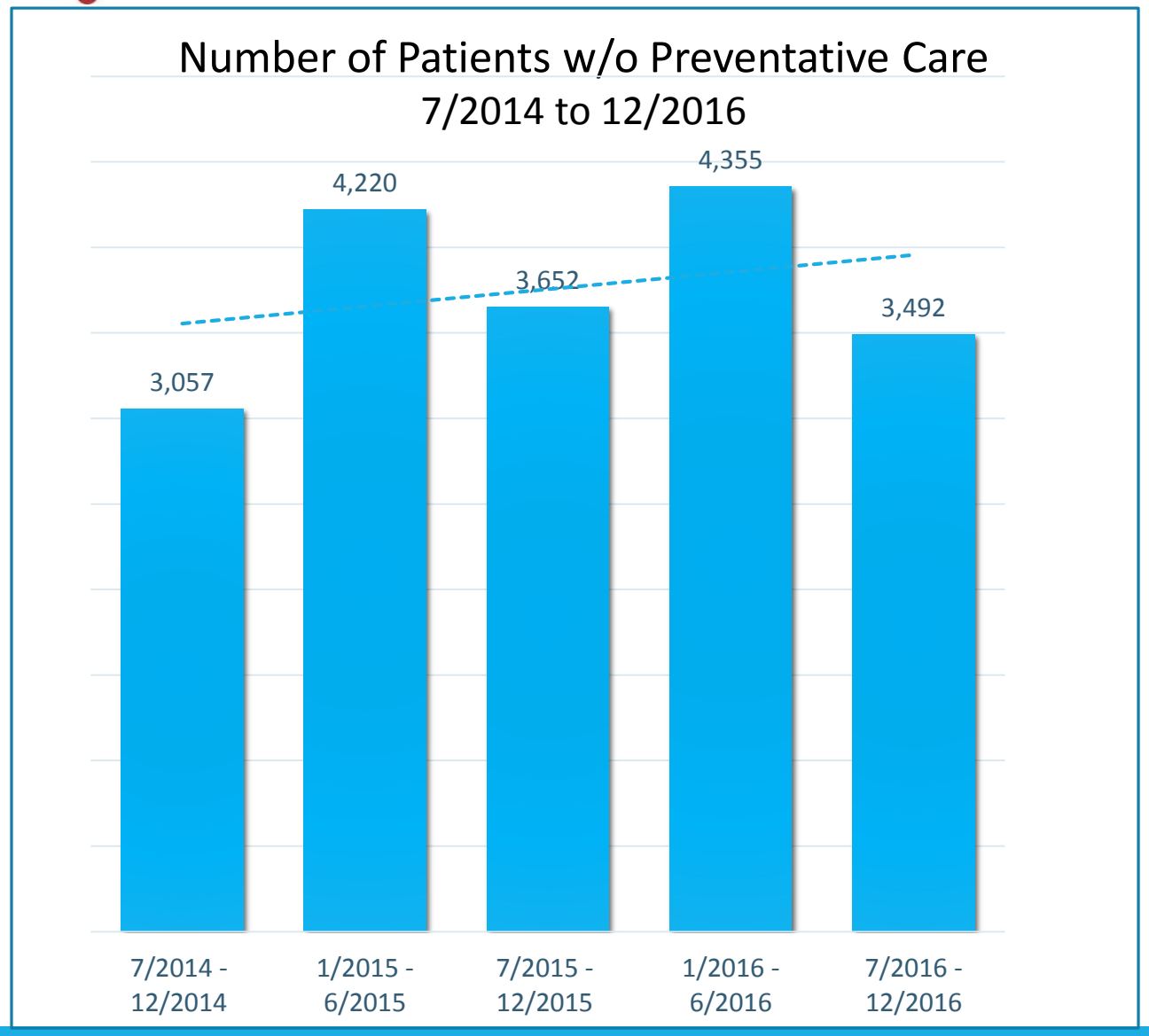


MCOs Performance Analysis

By P4P Measures

MCOs (Ranked by Member Volume)	Total members	Unique members with GC	% Total	P4P Measures							
				Adult Preventative Care	Child Access - Primary Care	CV Monitoring (CV & Schizophrenia)	Diabetes Monitoring (DM & Schizophrenia)	Diabetes Screening (Antipsychotic Medication)	PPR	PPV	PPV(BH)
MCO 1	20,128	4,715	23%	1,274	281	0	6	13	141	3,207	466
MCO 2	11,062	3,037	27%	786	158	1	3	10	88	2,143	385
MCO 3	6,603	2,675	41%	551	117	1	7	6	90	2,111	385
MCO 4	4,371	1,199	27%	400	68	0	1	0	18	773	129
MCO 5	3,415	793	23%	391	80	0	2	2	34	294	82
MCO 6	1,678	552	33%	180	43	0	2	3	8	350	57
Subtotal	47,257	12,971	27%	3,582	747	2	21	34	379	8,878	1,504

Use Case 1 – Access to Preventative Care (20-44)

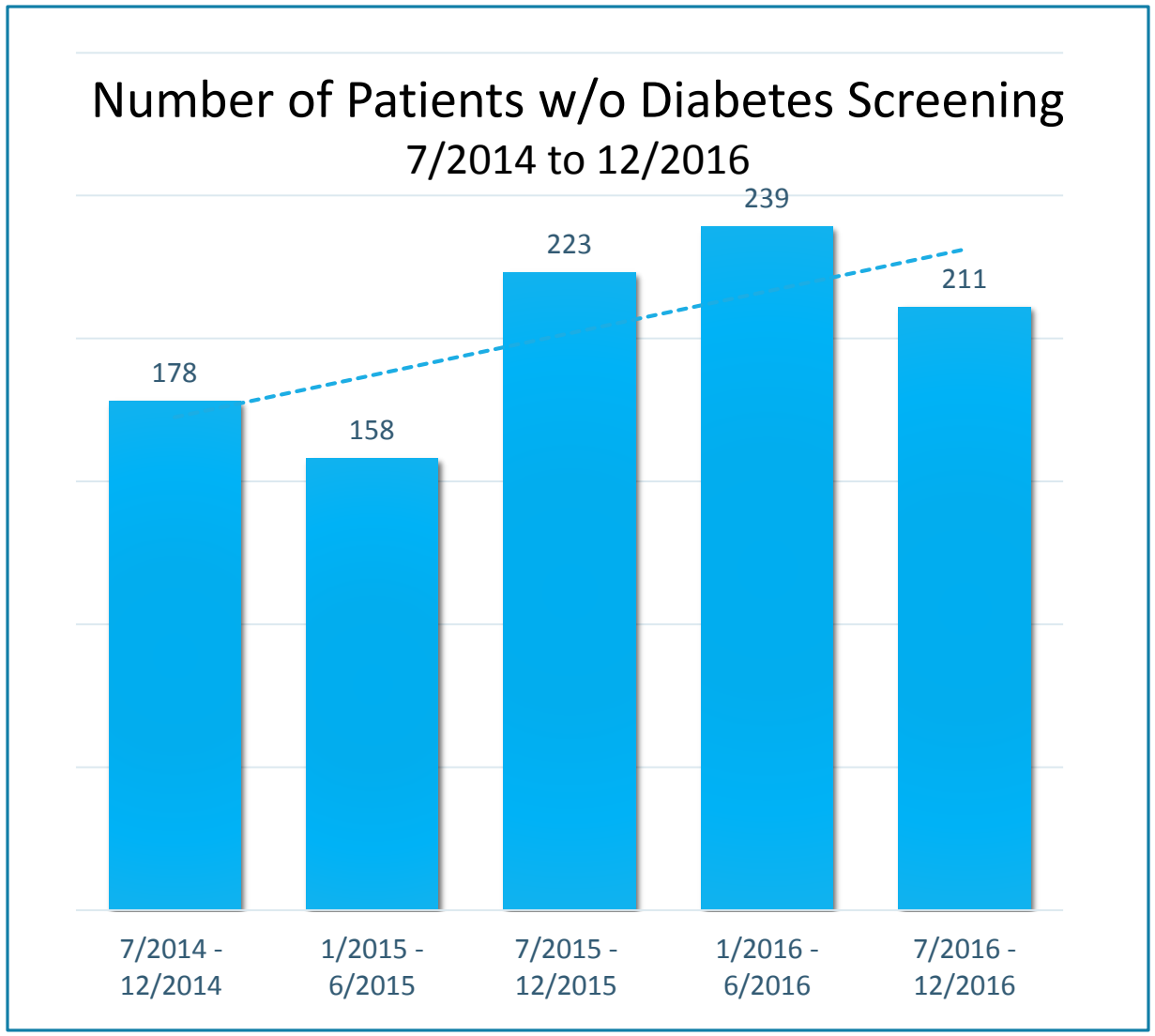


Top 15 PCPs with Gaps in Care Cases

PCP	Number of Patients w/o Preventative Care
PCP 1	80
PCP 2	58
PCP 3	58
PCP 4	56
PCP 5	54
PCP 6	52
PCP 7	49
PCP 8	49
PCP 9	44
PCP 10	43
PCP 11	42
PCP 12	41
PCP 13	41
PCP 14	39
PCP 15	38

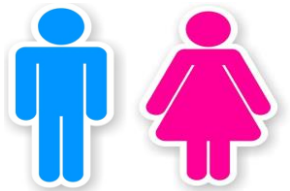
Data Source: Salient Interactive Miner and MAPP Performance Portal

Use Case 2 – Diabetes Screening for People with Schizophrenia



Patient Demographics

- % Patients with MC PCP: 59.5%
- Male average Age 45.2
- Female average Age: 41.0



MCO	Total Patients	Male: N (%)	Average Age
MCO 1	62	30 (48.4)	41.3
MCO 2	33	21 (63.6)	42.7
MCO 3	29	19 (65.5)	41.0
MCO 4	28	15 (53.6)	41.6
MCO 5	25	16 (64.0)	45.5
MCO 6	14	5 (35.7)	47.6
MCO 7	3	1 (33.3)	38.0
MCO 8	3	3 (100)	48.3
MCO 9	2	1 (50.0)	61.9
MCO 10	1	1 (100)	61.4
Grand Total	200	112 (56.0)	42.9

Data Source: Salient Interactive Miner and MAPP Performance Portal

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Non-Access Member Letter Campaign:

A Collaboration with the Staten Island Performing Provider System (PPS)

Can an MCO letter campaign increase meaningful PCP access for Medicaid members?

- Why? Aligned concern: PCPs on Staten Island, PPS, Healthfirst
- Method: Identified adult HF members who are Staten Island residents, Medicaid LOB with no record of a 2016-2017 PCP visit
- Mailing encouraged visit to the PCP or a call for member services assistance
- Date of Mailing:
  - 5/15/17 English
  - 5/22/17 Spanish
  - # Adult Members Outreached = 2818


healthfirst
Health Insurance for New Yorkers

«Date»

«Member First» «Member Last»
«Member Address1»
«Member Address2»
«Member City», «Member State» «Member Zip»

Dear «Member First»:

Healthfirst is committed to helping you stay healthy. That's why we want to remind you that your Medicaid plan includes a no-cost annual checkup with your Primary Care Provider (PCP). Your PCP is the main doctor responsible for your healthcare. We encourage you to visit your PCP at least once a year—even if you're feeling well—to get an overall snapshot of your health. We'll even provide transportation to and from your appointment (see reverse side for details).

During your visit, your PCP will:

- Review your lifestyle habits and family medical history
- Check vital signs such as blood pressure, heart rate, and temperature
- Examine your heart, lungs, abdomen, head, and neck
- Recommend health screenings based on your age

Call your Primary Care Provider today to make an appointment.

We look forward to helping you get the most out of your Medicaid plan. Thank you for choosing Healthfirst.

Sincerely,

Susan J. Beane, M.D.
Vice President and Medical Director

Make an Appointment with your PCP Today

Dr. «Provider First Name» «Provider Last Name»
«Provider Phone»

Need help? Call us at 1-855-246-4365
(TTY: 1-888-542-3821)
Monday to Friday, 8am–6pm

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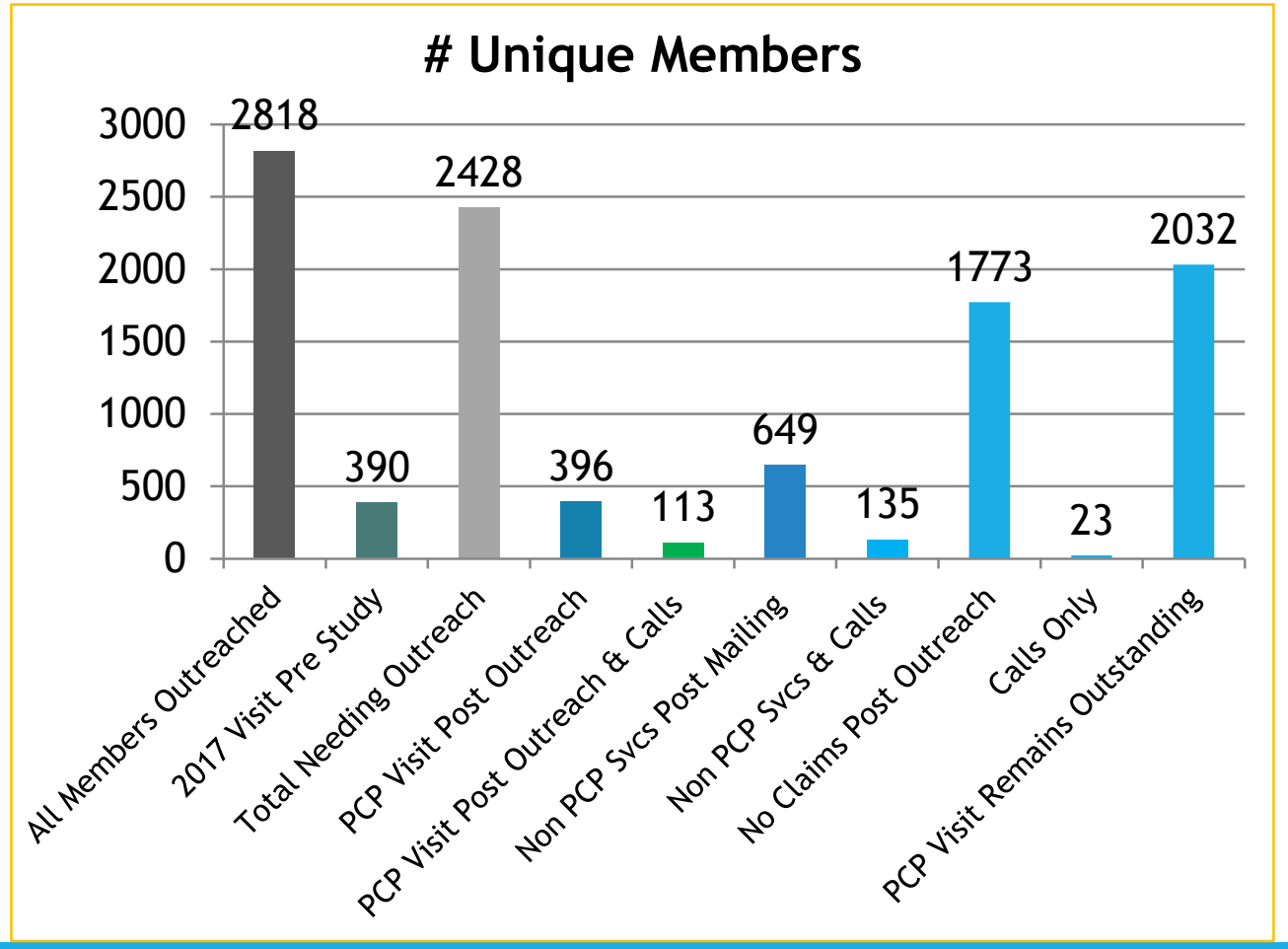
Staten Island PPS Preliminary Findings

- 13.8% of all members outreached had visit prior to study Of the 2428 remaining members for outreach
  - 16.3% had a PCP visit post mailing
    - 113 of these also called Member Services
  - 26.7% of members had a non-PCP Services visit only
  - 12.3% of all members outreached called Member Services



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Empire BlueCross BlueShield - HealthPlus Staten Island PPS Initiatives

- Diabetes Self Management
- Community Health Worker Support
- Wellness Outreach
- Practitioner prescribing alerts
- Pediatric at-risk care coordination

Areas for Future Collaboration

- Practice level campaigns focusing on performance gaps and prescribing patterns
- Use of diversion strategies for ultra high risk individuals
- Hot spotting efforts to bring specific resources to turn around community risk
- Promote practice innovation that enables integrative, whole person care
- Promotion of Wellness and Prevention through incentives
- Remote monitoring and home services for high risk and fragile clients
- Data sharing initiatives
- Explore Accountable Care delivery model

Thank you!

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