NEW YORK STATE | Department of Health | Medicaid Redesign Team

Breakout B:

Successful Qualified Entity (QE) Partnerships

ROCHESTER RHIO
Regional Health Information Organization

FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

FLPPS & RHIO PARTNERSHIP

DSRIP LEARNING SYMPOSIUM

September 21, 2016

Denise DiNoto

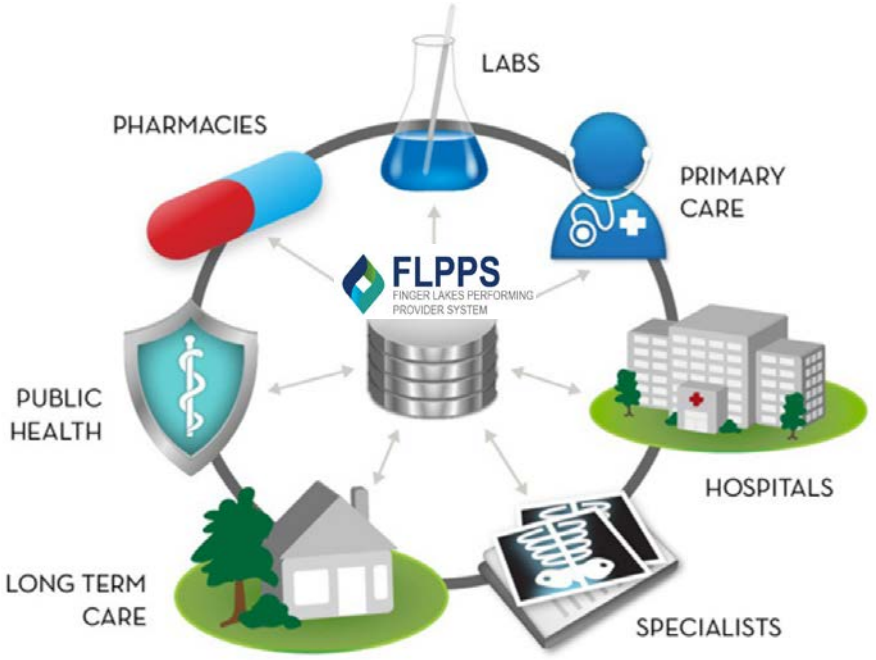
Dir. Community Services, GRRHIO

José (Joey) Rosario

Sr. Director IT & Analytics, FLPPS

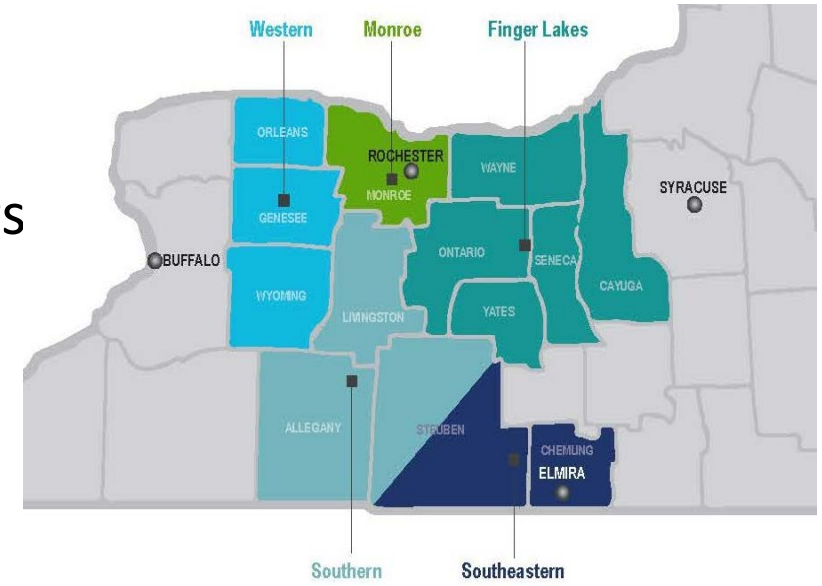
Agenda

- Pathway to a Strategic Partnership
- Partnership Roadmap
- Our Journey thus Far
- Accomplishments & Challenges

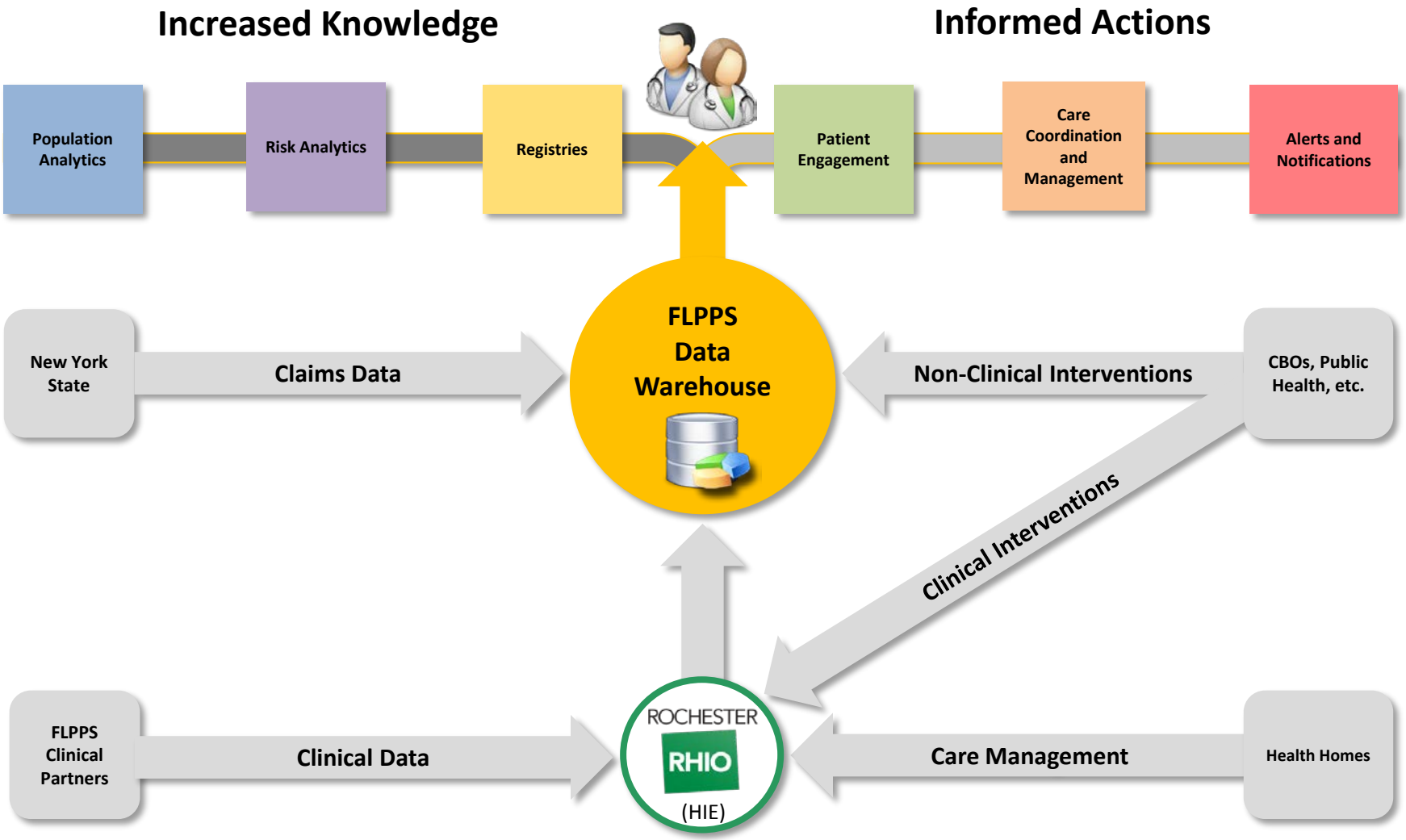


Pathway to a Strategic Partnership

- An HIE ...To Build or Not to Build?
- Requirements of DSRIP's Project 2.a.i demand that FLPPS create an Integrated Delivery System (IDS) that clinically integrates a network of:
  - 19 Hospitals
  - ~7000 Providers
  - 300,000+ Medicaid Members
  - Across 13 Counties
  - Over 8,000 sq. miles
  - 168 Contracted Entities



FLPPS Integrated Delivery System



Pathway to Strategic Partnership

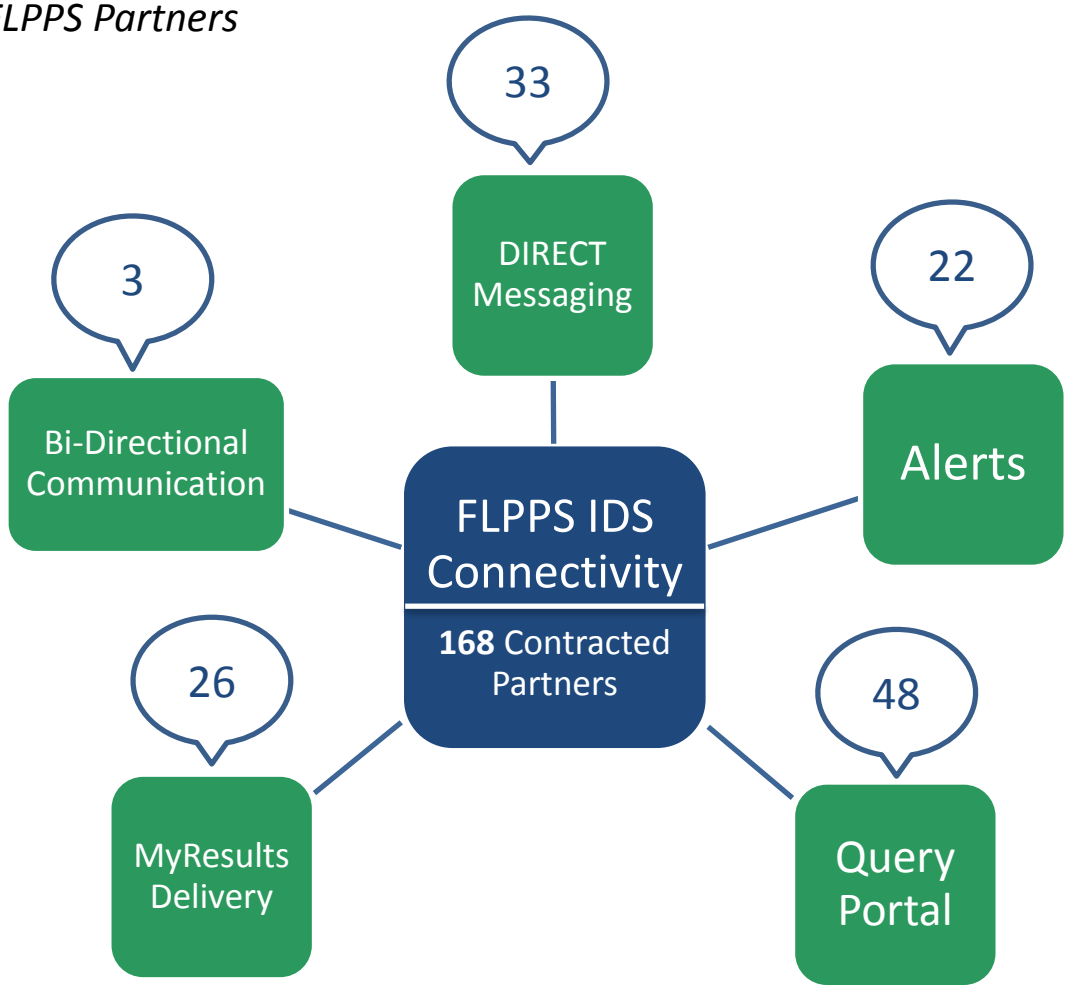
Over the last 10 years, Rochester RHIO has grown to be the region's community HIE.

RHIO Connectivity by Service Setting

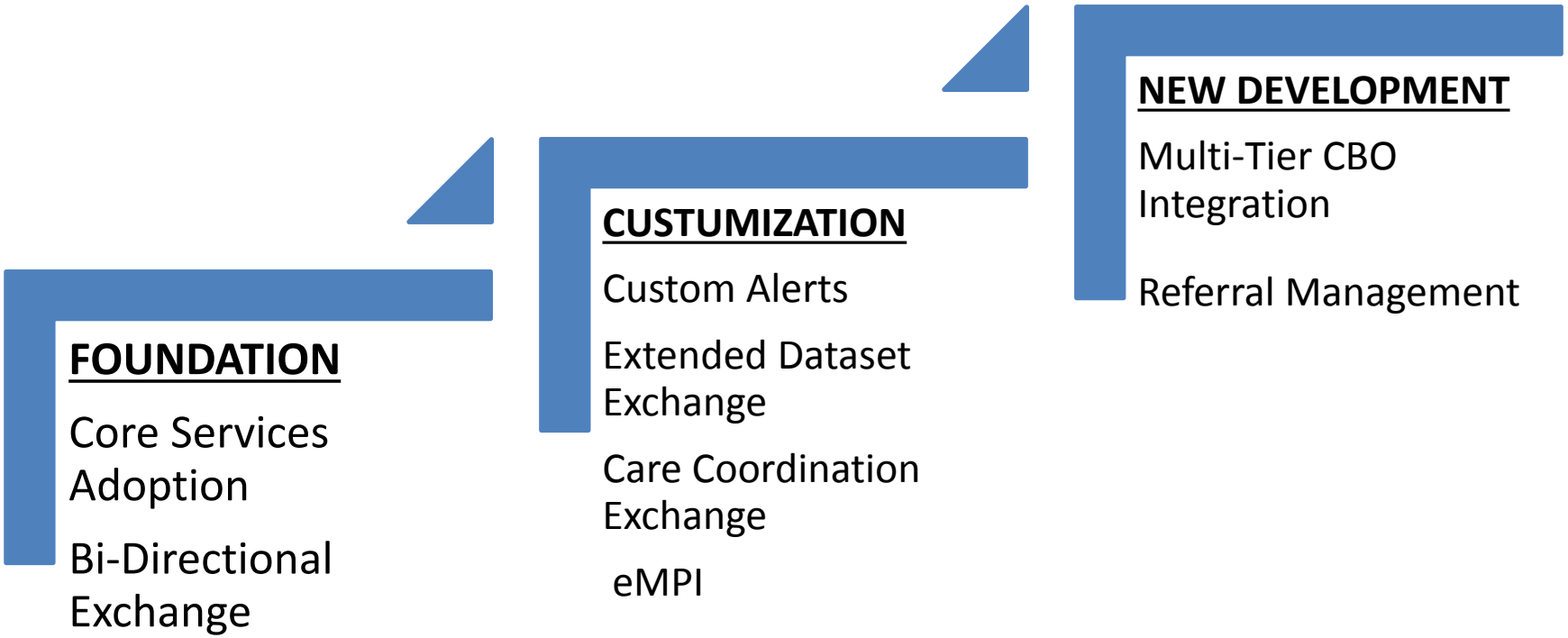
Impact to RHIO Connectivity	Health Systems	Clinical Partners	Admin/Service Coordination	CBO Partners
RHIO Begins Working w/ FLPPS	6	52	12	18
FLPPS/RHIO Partnership Announced	6	61	20	22
FLPPS Network Contracting	6	79	29	34
		52% Growth	**140%** Growth	**89%** Growth

IDS Connectivity Readiness

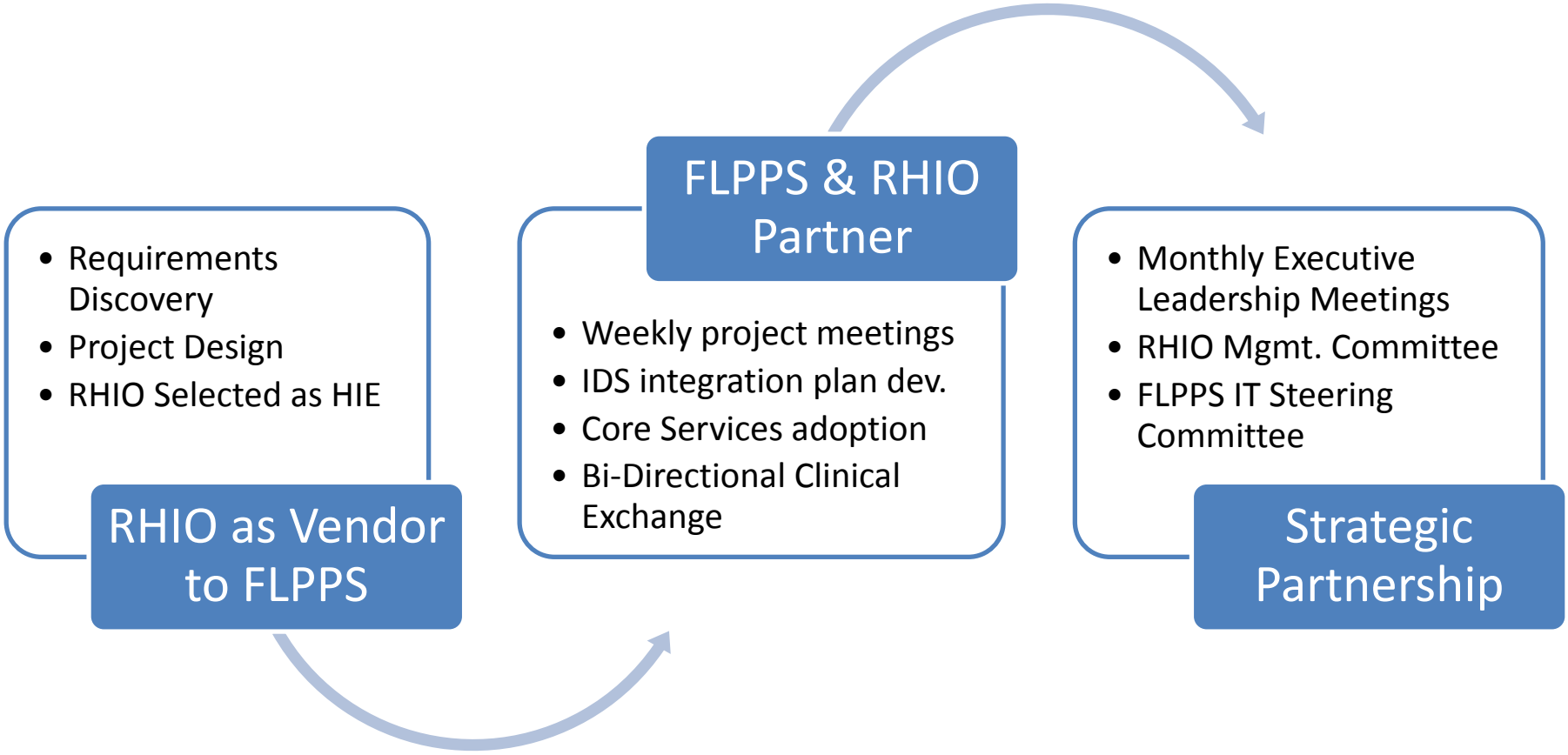
Subscribing FLPPS Partners



Partnership Roadmap



Our Journey Thus Far …



Working Through It … Together

Challenges

- Majority of RHIO participants are only consumers of data
- Patient Consent for Data Sharing
- Integration of CBO & Social Determinants

Accomplishments

- Consent Model
- Customized Alerts
- Project Dashboard

Steve Maggio, Bronx Health Access
and Keela Rose Shatzkin, Bronx RHIO

Agenda

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Connecting for Better Health

- Lifecycle of Partnership
- Overview of RHIO's Core Technology
- Overview of Care Coordination Clearinghouse Initiative
- Lessons Learned and Challenges

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Lifecycle of Partnership

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- **Initial question for PPS**: Invest in BxRHIO or procure technology?
  - RFI and demo day for interface engines and analytics platforms
    - Vendor's sales pitches vs. RHIO experience
      - Implementation vs. Ongoing operations
      - Cost and operational challenges (staffing, policies)
    - Data aggregation vs. Added functionality
  - Relationships within the PPS
  - State's guidance on RHIOs

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Lifecycle of Partnership

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- **Decision**: Invest in BxRHIO
  - BxRHIO shifts into role of vendor:
    - Included in all PPS IT Committee and Clinical Committee meetings
    - Monthly/Quarterly reports
  - Negotiated contract provisions:
    - Funding tied to onboarding of partners
    - Milestone based budget for Analytics

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BRONX RHIO TECHNOLOGY OVERVIEW

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Bronx RHIO History

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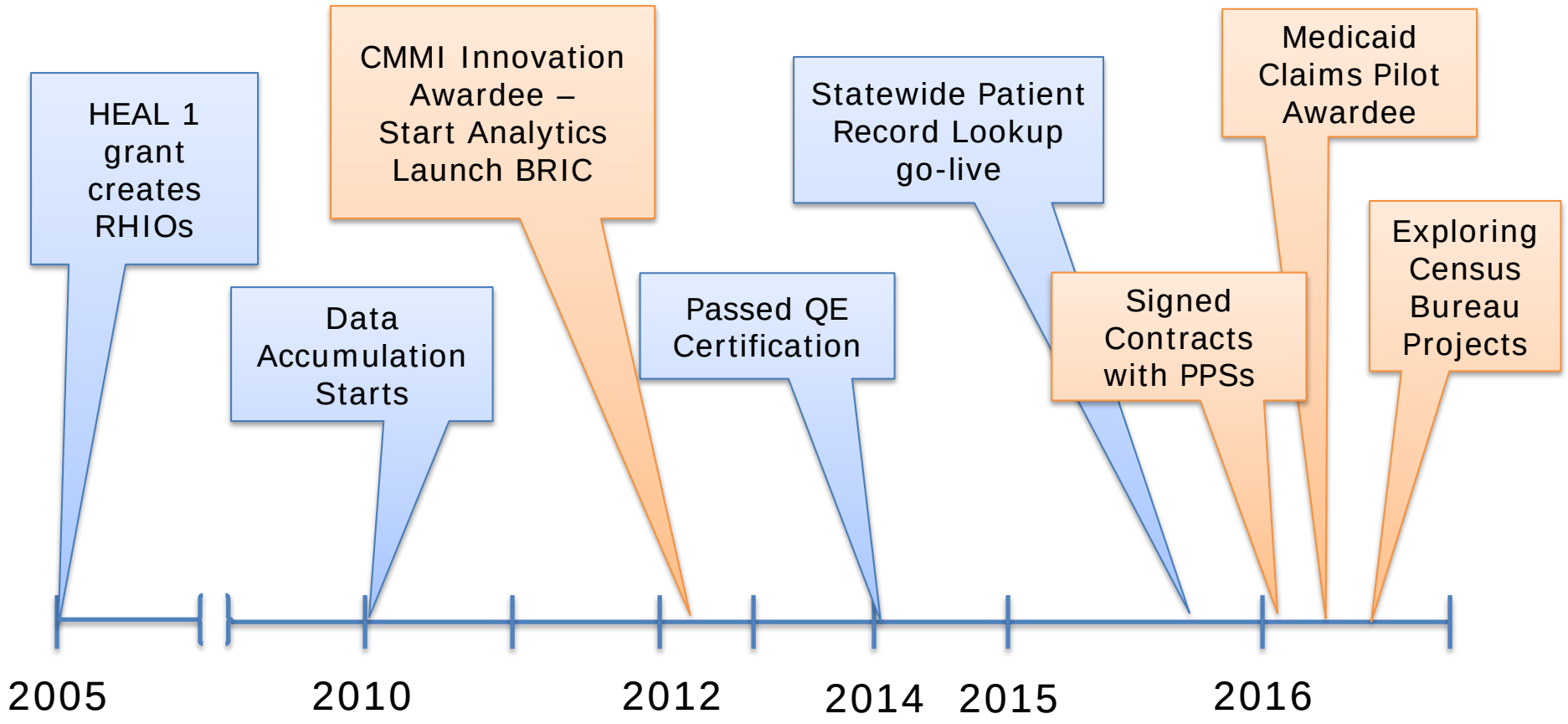

Key: Analytics

Health Information Exchange

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Overview of BxRHIO Technology: Where we are today

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- Traditional HIE:
  - Provider Portal
  - Alerts/Subscriptions
  - Partner data integrations
  - Statewide Patient Record Look-up (sPRL)

- Analytics
  - Dashboards
  - Actively Engaged Counting
  - Reporting from BxRHIO data (patient utilization)
  - Routing eligible patients to programs

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Overview of BxRHIO Technology: Future PPS Support

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- Additional dashboards
  - Intersection of Clinical and Claims for Reporting
- Expanded access to Care Plans
  - Health Homes in the PPS
  - Additional Partners in the PPS
- Expanded Clinical Dataset
  - PHQ-2/9, Spirometry, Peak Flow, Self Management Goals
- Integration of non-clinical data
  - Social determinants, 270/271, MCO Members' Gaps in Care, Recertification Dates etc.

Question: How can we leverage these tools to drive clinical outcomes?

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CARE COORDINATION CLEARINGHOUSE: PHASE 1

Operationalize Available Technology
&
Inject Information into Clinician's Workflow

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What is the Care Coordination Clearinghouse?

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- Use all existing data and add technology to support:
  - Linking Patients to Care Coordinators
  - Alerting PCP's of Specific Events
  - Injecting the MCO Gaps in Care (i.e. HEDIS Measures) into the PCP and Care Coordinators Workflow
  - Accountability Reporting
  - Submitting Historical Clinical Utilization Data to MCOs (pseudo claims)

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Care Coordination Clearinghouse Step 1

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Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

Bronx RHIO | **BHA PPS** | **MCO PCP** | **Health Home / CMA**

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Care Coordination Clearinghouse Step 1

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Connecting for Better Health

Patient Presents

Risk Stratification & Program Eligibility

Data elements:
- HHTS Eligibility & Enrollment Data
- Clinical Diagnosis and Conditions

Connect Patient to Care Coordination

Analysis:
- Does clinical data indicate eligibility for HH or HH@R?
- Does HHTS data indicate the patient is engaged?
- If NOT, automate bottom-up referral to Care Coordination

Integration with Care Management Platforms

HHTS = Health Home Tracking System
HH = Health Home
HH@R = Health Home at Risk

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Care Coordination Clearinghouse Step 2

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BronxRHIO
Connecting for Better Health

Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

Alert to HH

Alert to MCO PCP

Disseminate to CMAs & CMs

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Care Coordination Clearinghouse Step 2

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Connecting for Better Health

Patient Presents

Risk Stratification & Program Eligibility

Analysis:
- Is MCO PCP known to PPS?
- Is Health Home known to PPS?

onnect ient to Care Coordination

Alert to HH

Alert to MCO PCP

Disseminate to CMAs & CMs

Data Elements:
- HHTS Enrollment
- 270/271 Medicaid PCP
- ADT Admission/Discharge

Bronx RHIO | BHA PPS | MCO PCP | Health Home/CMA

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Care Coordination Clearinghouse Step 3

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BronxRHIO
Connecting for Better Health

Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

Alert to HH

Alert to MCO PCP

Disseminate to CMAs & CMs

Generate Patient Snapshot

Deliver to HH System

Deliver to PCP System

Deliver Patient Care

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Care Coordination Clearinghouse Step 3

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Connecting for Better Health

Patient Snapshot:

- MCO PCP
- HHTS Eligibility & Enrollment data
- Gaps in Care Data
- Last 5 PCP visits
- Last 5 BH visits
- PCP Alignment flag (to address auto-assignment issues)

Connect Patient to Care Coordination

Analysis:

- MCO Gaps in Care vs RHIO Clinical Gaps in Care to compile accurate list

CMAS & CMS

Generate Patient Snapshot

Deliver to HH System

Deliver to PCP System

Deliver Patient Care

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Care Coordination Clearinghouse Step 4

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BronxRHIO
Connecting for Better Health

Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

Alert to HH

Alert to MCO PCP

Disseminate to CMAs & CMs

Generate Patient Snapshot

Deliver to HH System

Deliver to PCP System

Pseudo Claims

Deliver Patient Care

Accountability Reporting

Performance Review and Oversight

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Care Coordination Clearinghouse Step 4

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Connecting for Better Health

Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

Pseudo Claims:
- Notification to MCO based on Clinical evidence of care delivery

Alert to HH

lert to
CO PCP

Disseminate to
CMs

Accountability Reporting:
- Information to PPS for partnership analysis
- Potentially tied to PPS funds flow

Generate
Snaps

to
tem

PCP System

Pseudo Claims

Deliver Patient Care

Accountability Reporting

Performance Review and Oversight

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Care Coordination Clearinghouse Challenges

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BronxRHIO
Connecting for Better Health

Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

On what Basis/ Consent?

Alert to HH

Alert to MCO PCP

Disseminate to CMAs & CMs

Generate Patient Snapshot

MCO Gaps in Care?

Deliver to HH System

Deliver to PCP System

Pseudo Claims

Deliver Patient Care

Performance Review and Oversight

Accountability Reporting

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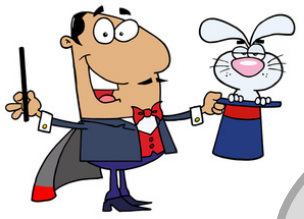
Solution Architecture



MCO

Hospital

DAA

PCP Organization

Health Home

Bronx RHIO

PPS

State MDW

- No MCO Gaps in Care

Data Access Agreement

Existing Contracts

Data Exchange enabled by DAA

Data Exchange Only

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Challenges to Success

- State support for MCOs to release data to RHIOs and PPSs
  - Priority Data: MCO Gaps in Care
  - MCOs in holding pattern until State guidance is issued

- State support for MCO participation in Data Access Agreements
  - BxRHIO cannot alert on Health Home Patients who are assigned (not yet enrolled)
  - RHIO cannot alert MCO PCP without consent

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Lessons Learned

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Connecting for Better Health

- Importance of integrating non-traditional datasets
  - Member Gaps in Care
  - 270/271 Medicaid Eligibility data
  - HHTS data
  - Social determinants data
- Narrow meeting scope for successful outcomes
- Start negotiations with Plans immediately
- Involve consent and privacy Subject Matter Experts (SMEs) from the start
  - Allocate legal expenses in your IT budgets

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THANK YOU!

Steve Maggio:
SMaggio@Bronxleb.org

Keela Rose Shatzkin:
Keela@Shatzkinsystems.com

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Q&A