Driving Practice Transformation Through Performance Measurement

Measurement Year 3 Performance Improvement

Greg Allen, NYSDOH, Office of Health Insurance Programs

DSRIP Learning Symposium

Syracuse, NY

September 21, 2016

Panel Introduction

Today's panel will provide detailed examples of how PPS are using population health data tools and applying data analytics to change workflow within their systems of care. Further, they will discuss tracking of performance measures over time to ensure improvement.

<u>Suffolk Care Collaborative PPS</u>
- Kevin Bozza, MPA, FACHE, CPHQ, RHIT, Senior Director for Network Development and Performance
- Kelli Vasquez, LCSW, Senior Director for Care Management and Care Coordination

<u>Staten Island PPS</u>
- Joseph Conte, PhD, CPHQ, Executive Director
- Anyi Chen, Senior Director of Enterprise Data and Analytics

<u>Albany Medical Center Hospital PPS</u>
- Kallanna Manjunath, MD, CPE, Medical Director

Current state: DSRIP is in Demonstration Year 2 and Measurement Year 3.

- Performance is measured during a MY and affects future Pay for Performance (P4P) payments in subsequent Demonstration Years (DY).
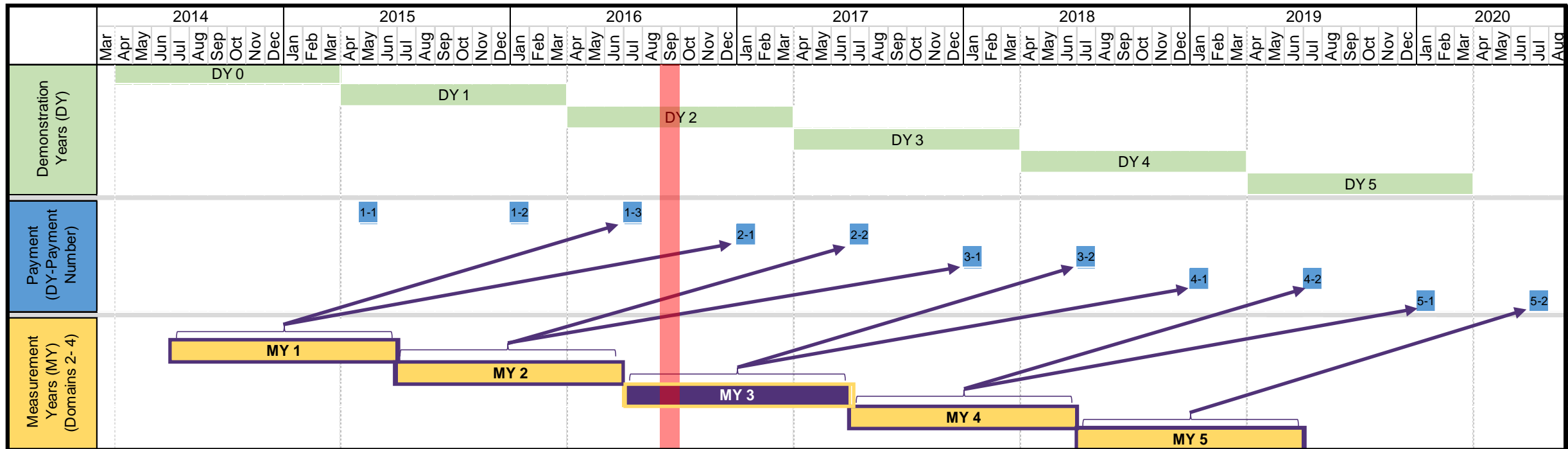
While very early in PPS development, PPSs failed to close the gap to goal for most measures in MY1.

- MY1 targets are established by:
    - o Regular Performance: using 10% improvement over baseline towards the statewide goal.
    - o High Performance (HP): using 20% improvement over baseline or met/exceeded the statewide goal.
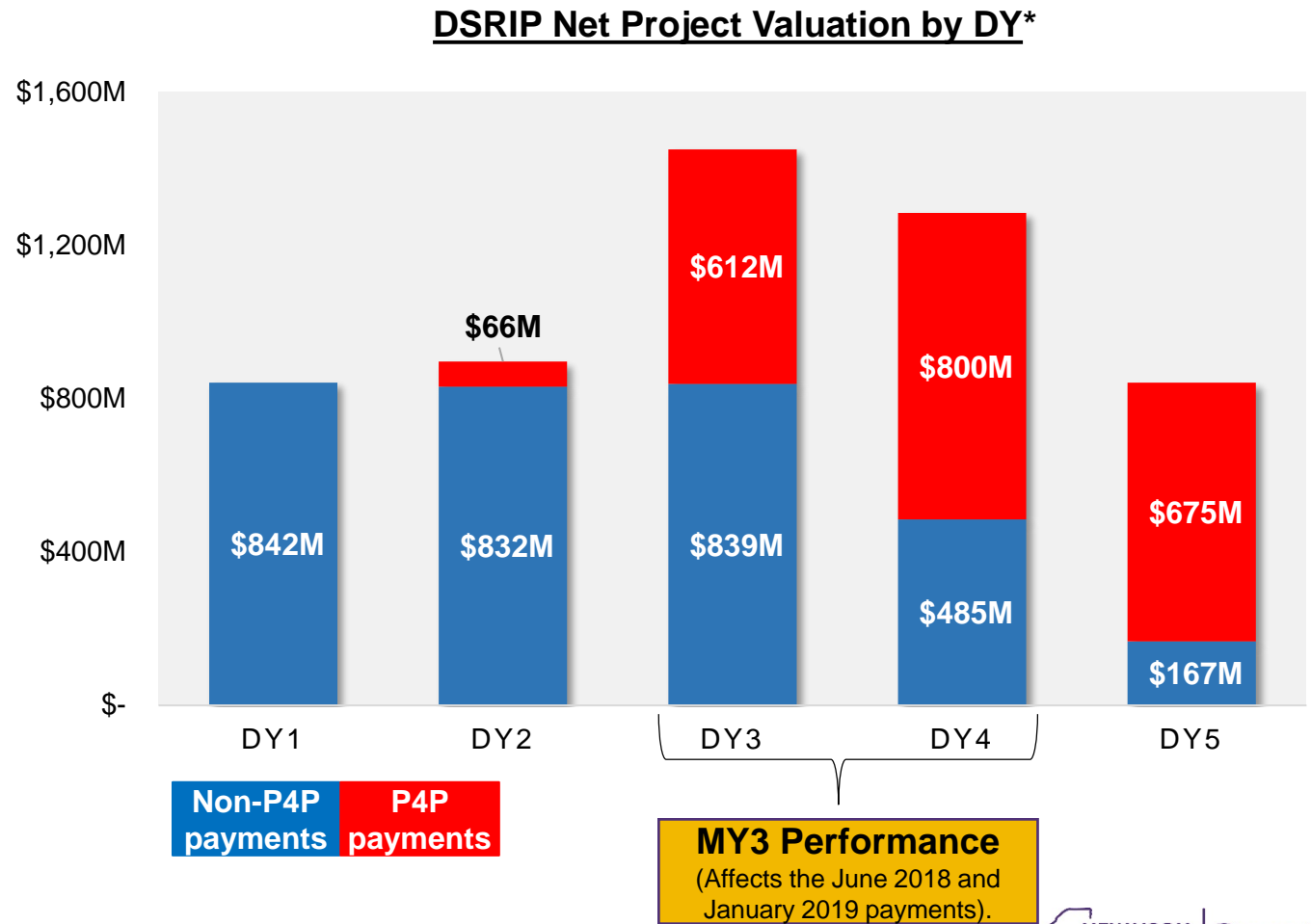
Measure type	Total performance measures*	Total targets achieved	Total measures improved but not achieved
Regular Performance	705	192 (27%)	151 (21%)
High Performance	225	40 (18%)	97 (43%)

- Potential penalties related to performance of statewide milestones would reduce the overall funding beginning in DY3.
- **No P4P funds were tied to measures in MY1. MY1 performance sets the MY2 targets.**
- MY2 (July 2015 – June 2016) official year-end results are scheduled to be finalized in January 2017, however unofficial MY2 data is available via Snapshots in the DSRIP Performance Dashboards and Salient Interactive Miner (SIM).

*Includes all measures that will be P4P at any point throughout DSRIP. Data source: DSRIP Performance Dashboards

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42% of available P4P dollars are tied to performance in MY3.

- Performance results from MY3 affect $902M in net project valuation.
  - o MY3 P4P payments are split between payments in DY3 (payment 2 - $502M) and DY4 (payment 1 - $400M).

- All unearned dollars tied to MY3 performance results will roll in to the High Performance Fund (HPF) in MY4.
  - o Unearned dollars will be available to all PPSs who meet HP targets.

DSRIP Net Project Valuation by DY*

DY1	DY2	DY3	DY4	DY5
$842M	$832M	$839M	$485M	$167M
	$66M	$612M	$800M	$675M

Legend:
- Non-P4P payments (blue)
- P4P payments (red)

MY3 Performance (Affects the June 2018 and January 2019 payments).

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Most improved high value measures in MY1.

- DOH examined the measures tied to the highest P4P Net Project Valuation. 21 measures were identified.
  - At least two thirds of PPSs improved on 4 of the 21 high value claims based measures.

Measure	Applicable PPSs	PPSs improving	Percent Improving	Total P4P $ available[1]
Prevention Quality Indicator # 1 (DM Short term complication)	10	8	80%	36,688,269
Children's Access to Primary Care – 12 to 19 years	25	19	76%	28,369,280
Children's Access to Primary Care – 7 to 11 years	25	17	68%	28,369,280
Prevention Quality Indicator # 13 (Angina without procedure)[2]	15	10	67%	36,036,554

[1]Includes all P4P dollars available throughout the five years of DSRIP.
Source: Achievement Value Guide for PPSs:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/webinars_presentations.htm and DSRIP Performance Dashboards
[2]PQI13 has been retired by AHRQ and will be replaced with PQI8 for DSRIP MY2-MY5

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Least improved high value measures in MY1.

- Less than one third of PPSs improved on 7 of the 21 high value claims based measures.

| Measure	Applicable PPSs	PPSs improving	Percent Improving	Total P4P $ available*
Potentially Preventable Emergency Room Visits	25	8	32%	113,477,119
Pediatric Quality Indicator # 14 Pediatric Asthma	13	3	23%	29,273,460
Asthma Medication Ratio (5 – 64 Years)	13	2	15%	29,273,460
Adherence to Antipsychotic Medications for People with Schizophrenia	25	3	12%	45,212,304
Children's Access to Primary Care – 12 to 24 months	25	2	8%	28,369,280
Adult Access to Preventive or Ambulatory Care – 45 to 64 years	25	0	0%	37,825,706
Adult Access to Preventive or Ambulatory Care – 20 to 44 years	25	0	0%	37,658,658

*Includes all P4P dollars available throughout the five years of DSRIP.
Source: Achievement Value Guide for PPSs: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/webinars_presentations.htm
and DSRIP Performance Dashboards

Potentially Preventable Readmissions ±

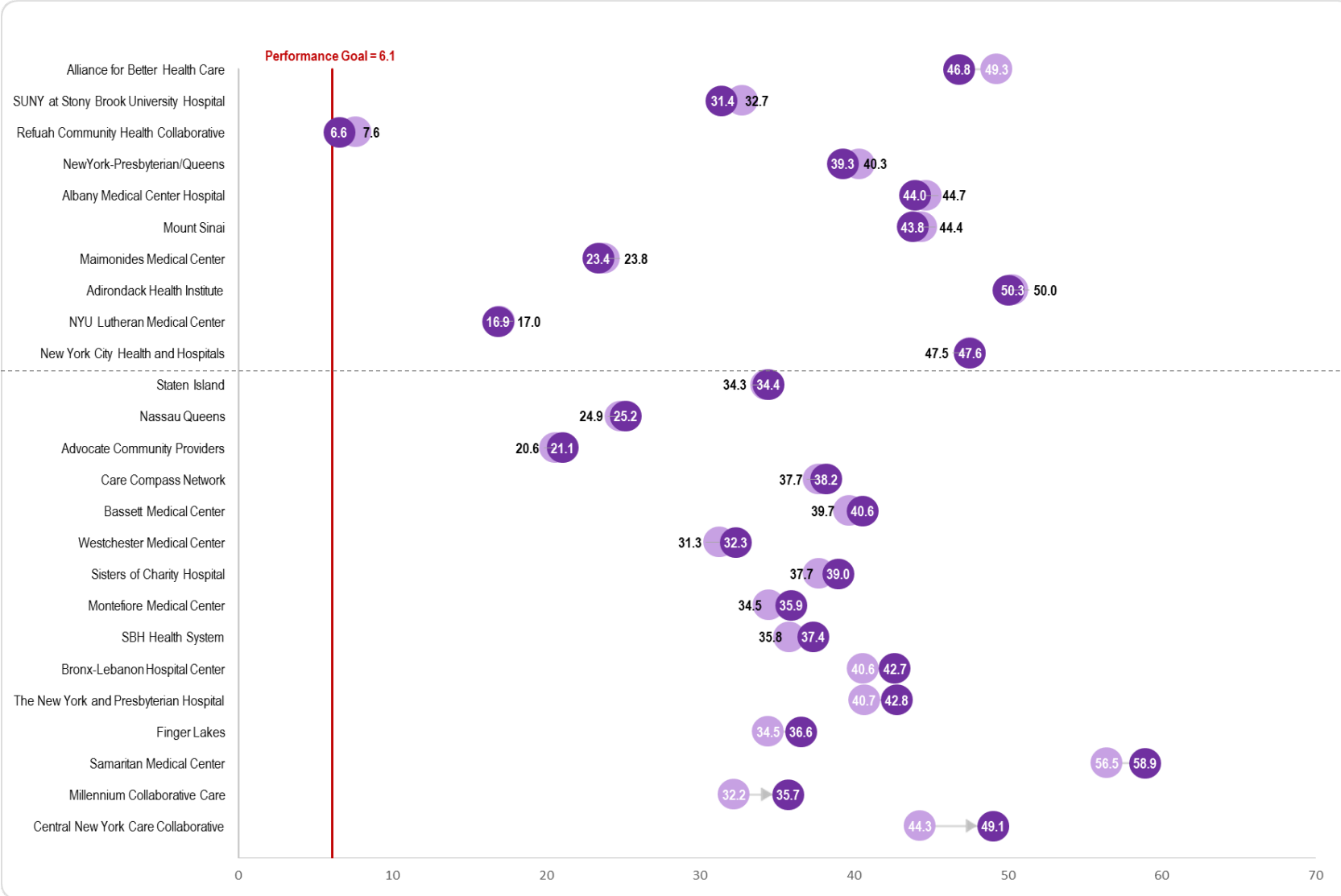## Rate of preventable hospital readmissions per 100,000 members in MY0 and MY1
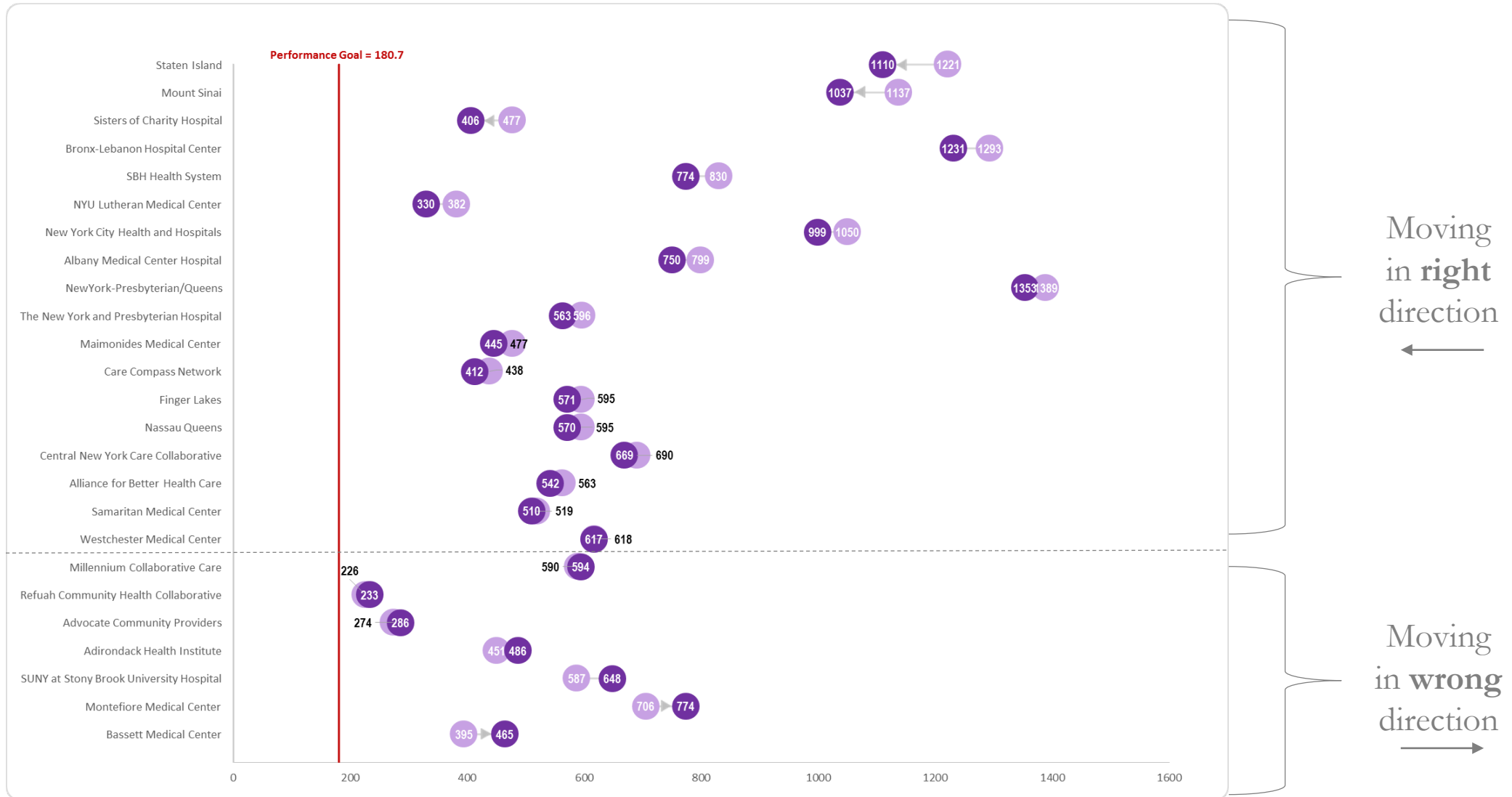
MY1 results are helpful to understand how PPSs are trending from the baseline, but they are not necessarily indicative of future performance.
Data Source : Medicaid Analytics Performance Portal (MAPP) – official MY0 and MY1 Attribution for Performance results.

± A lower rate is desirable

Potentially Preventable Emergency Room Visits ±
Rate of preventable ER visits per 100 members in MY0 and MY1

Performance Goal = 6.1

	MY0	MY1
Alliance for Better Health Care	46.8	49.3
SUNY at Stony Brook University Hospital	31.4	32.7
Refuah Community Health Collaborative	6.6	7.6
NewYork-Presbyterian/Queens	39.3	40.3
Albany Medical Center Hospital	44.0	44.7
Mount Sinai	43.8	44.4
Maimonides Medical Center	23.4	23.8
Adirondack Health Institute	50.3	50.0
NYU Lutheran Medical Center	16.9	17.0
New York City Health and Hospitals	47.5	47.6
Staten Island	34.3	34.4
Nassau Queens	24.9	25.2
Advocate Community Providers	20.6	21.1
Care Compass Network	37.7	38.2
Bassett Medical Center	39.7	40.6
Westchester Medical Center	31.3	32.3
Sisters of Charity Hospital	37.7	39.0
Montefiore Medical Center	34.5	35.9
SBH Health System	35.8	37.4
Bronx-Lebanon Hospital Center	40.6	42.7
The New York and Presbyterian Hospital	40.7	42.8
Finger Lakes	34.5	36.6
Samaritan Medical Center	56.5	58.9
Millennium Collaborative Care	32.2	35.7
Central New York Care Collaborative	44.3	49.1

Moving in **right** direction

Moving in **wrong** direction

MY1 results are helpful to understand how PPSs are trending from the baseline, but they are not necessarily indicative of future performance.
Data Source: Medicaid Analytics Performance Portal (MAPP) – official MY0 and MY1 Attribution for Performance results.

± A lower rate is desirable

Challenges and Opportunities

Challenges:

- Due to time requirements of processing, official performance results for claims based measures have a six month lag.

- Official data from the New York State Department of Health (DOH) is available through MY1 due to issues with data collection in the new Managed Care Encounter Intake System.
  - o The DSRIP Performance Dashboards are scheduled to be loaded with more current encounter data and caught up fully by December 2016. New monthly data will be loaded as it is fixed between now and December.
  - o Snapshots are current as of August 8th, 2016

Opportunity:

- Available MY1 data at the provider and patient level is likely showing durable patterns and opportunity for performance improvement.

- Further, using local data sources (Electronic Health Records (EHR), Regional Health Information Organization (RHIO) data, etc.) in conjunction with DOH data and tools can provide further insight into each PPSs population and performance.

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DOH data sources and tools

DOH Data Source	Description
DSRIP Performance Dashboards	Allows users to track performance on claims-derived measures, view quarterly performance on domain 1 requirements, understand attributed populations, and analyze provider network composition. The Snapshot tool is being updated to provide timely, actionable member detail for members with Potentially Preventable Readmissions (PPR) and ED Visits (PPV). In addition, 3M is developing grouper definitions manuals, and PPS trainings will be conducted that cover the high level grouping methodology.
Salient Interactive Miner (SIM) Tool	Provides in-depth access to the State's Medicaid Claims & Encounter information. PCG and Salient will be coordinating a series of resources and local facilitation sessions to introduce PPS to actionable and high value use cases for DSRIP Performance Data in SIM. The session will begin in early fall 2016.
Comprehensive Provider Attribution (CPA) Report	Provides PPS member level detail of attributed members (less those that have opted out), catalogues all Medicaid providers who provided service to a PPS's attributed member, and displays the number of visits by provider for each attributed PPS member.
Individual Provider Attribution (IPA) Report	Shows how many attributed member counts providers drove at the individual provider level.
Member Roster	Contains the list of members attributed to the PPS for services in MY1.
Claims File Extract	Contains all claims for members attributed to the PPS for services in MY1, except for claims have been expunged from the Claim File (such as Substance Use Disorders (SUD)) and members who have chosen to opt out of having their Protected Health Information (PHI) data shared.
3M PPR/PPV Detail Reports	Describes the types of services and diagnosis that are driving utilization for both PPRs and PPVs so that action plans can be developed around those services with the greatest impact. Report will be produced without claims run so that it is as current as possible.

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Data alone does not lead to improved performance.

- Workflow development/modification drives changes in patient outcomes.
- Incorporating DOH data sources with local data will deliver additional insight into attributed populations demographics and clinical states.
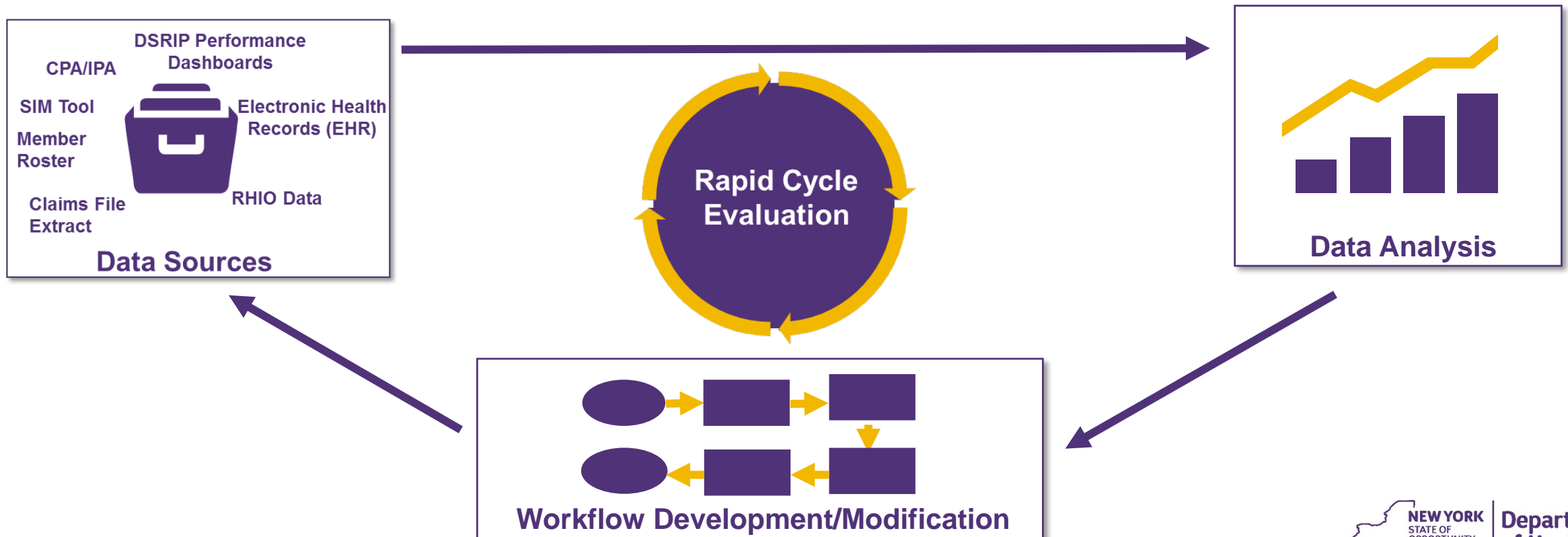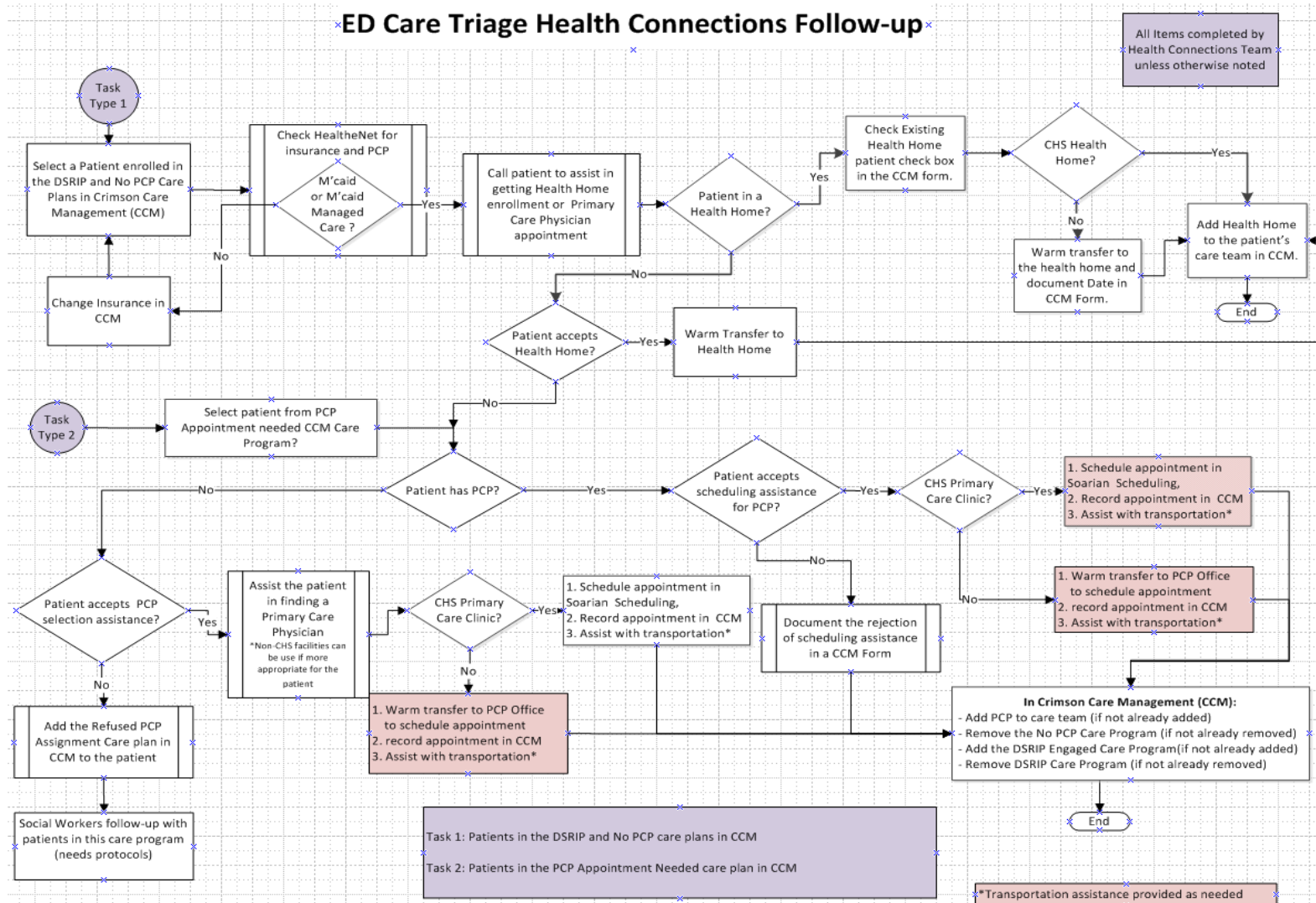
Measurement Year 3 Webinar #1

September 8, 2016

Example from Measurement Year 3 Webinar #1: ED triage no PCP workflow

Thank You!

**If you have any questions, please reach out to dsrip@health.ny.gov.**

Population Health Management
Applying Data Analytics & Tools to Implementation Efforts

To improve the patient experience of care (quality and patient satisfaction), improve the health of the populations we serve and reduce the per capita cost of providing healthcare services, thus achieving the Triple Aim.

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- *We define Population Health Management (PHM) as the aggregation of patient data across multiple health information technology resources, the analysis of that data in a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes. It is the technical field of endeavor which utilizes a variety of individual, organization and cultural interventions to help improve patient self-care, morbidity patterns and the health care use behavior of defined populations.*

- **Goal of today's presentation will highlight each element of our PHM strategy and share tools in place to operationalize our work.**
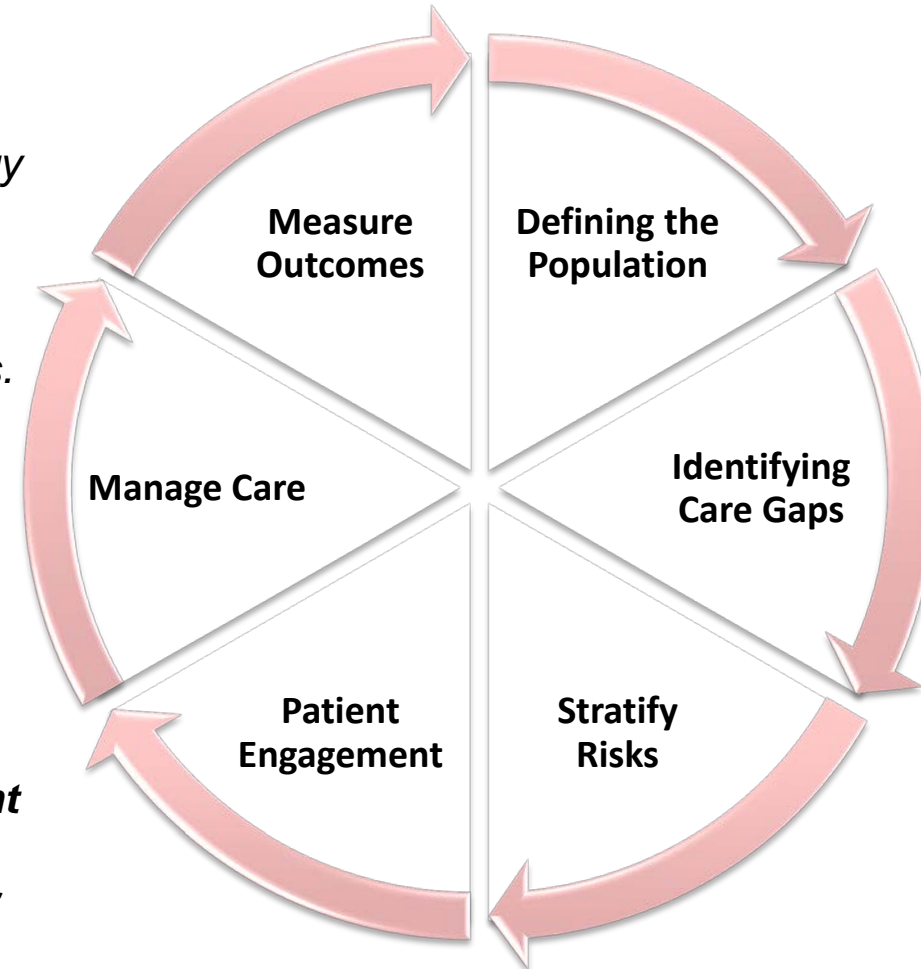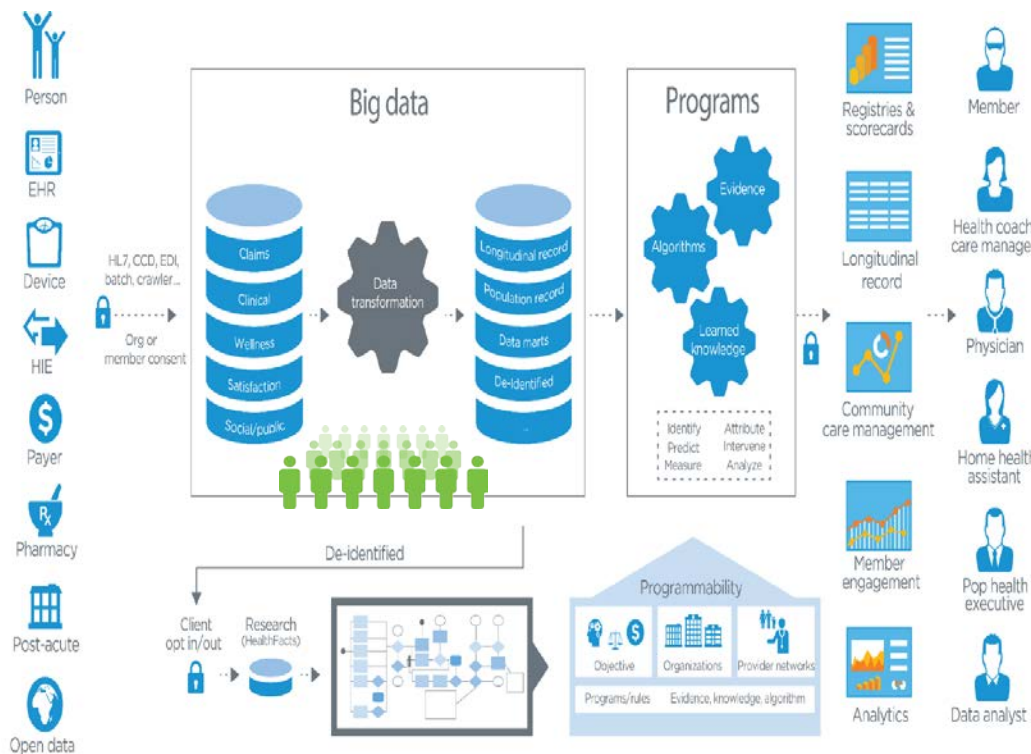
Measure Outcomes

Defining the Population

Identifying Care Gaps

Manage Care

Patient Engagement

Stratify Risks

Suffolk Care Collaborative

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

The SCC has over 25 contracted partners engaged in *Technical-onboarding*, a term used to describe a set of tasks to complete data integration into out PHM platform
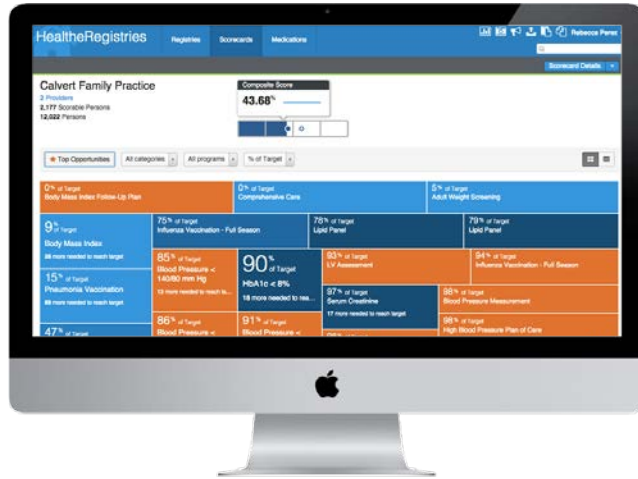
- We've operationalized a system to integrate data to define our populations

- The programmability of the system allows the SCC to leverage data to create insightful "programs" to best manage a population or condition using real time actionable data.

- Once the data has been processed and intelligence applied, it is presented to end-users in the form of solutions specific to their roles, such as registries, scorecards, care management, analytics, patient engagement, and more.

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Collaborative

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

The SCC has designed a set of Registries and Measures are deployed.
Will be offering this tool to all contracted partners and organizations in the "SBUH HUB" permissionning will begin in Fall 2016.

- HealtheRegistries is a comprehensive disease and wellness registry solution, which leverages clinical and financial data across the continuum of care to qualify, attribute, measure and monitor members.
  - Automatically identifies a population for registries and appropriate measures
  - Provides visibility to the quality measures, identify care gaps for the provider's population and performance
  - Risk stratification to prioritize interventions
  - Advanced patient outreach capabilities
  - Provides dashboards with drill-down capabilities

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Practice-level registry functionality to address gaps in care and management of chronic conditions!
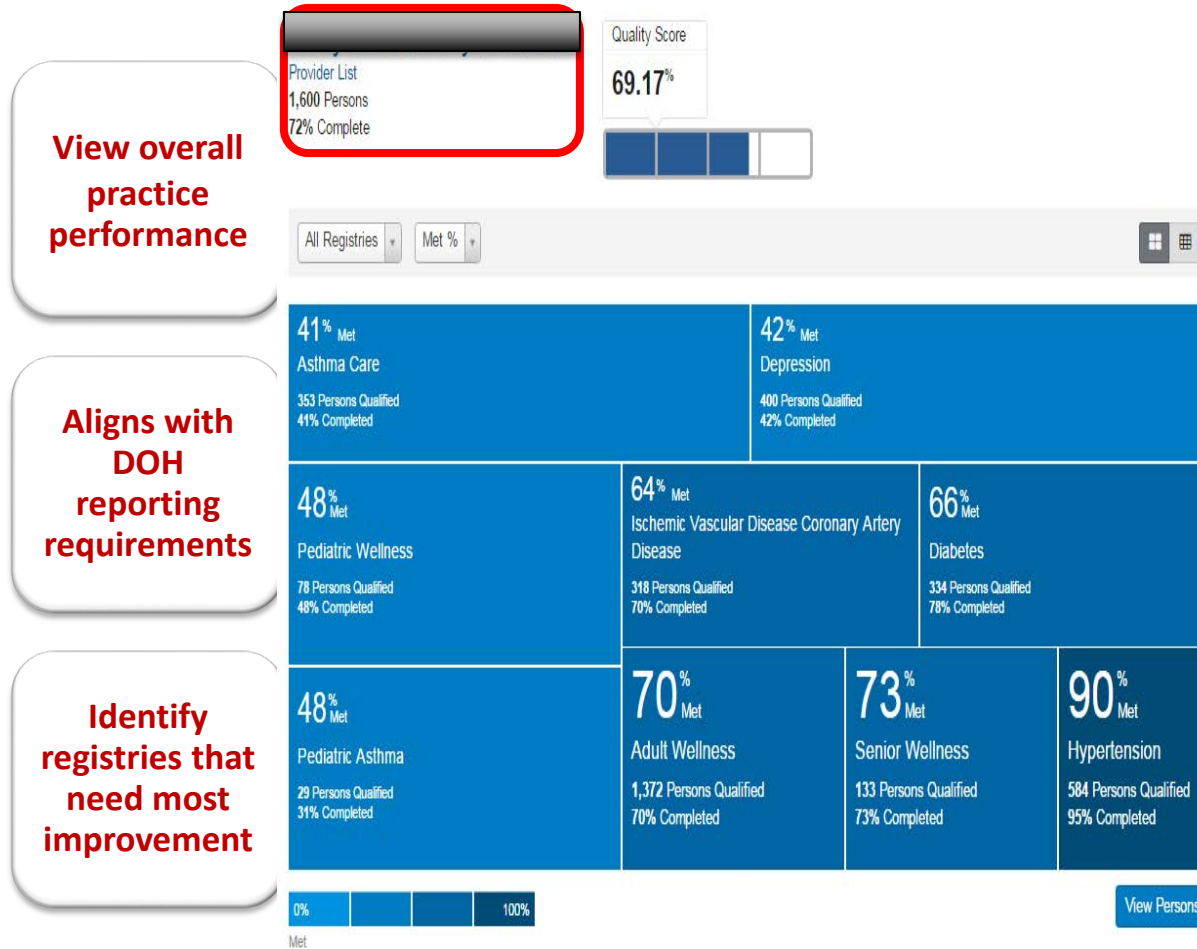
Each registry has a set of measures:

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

Chronic Disease Registries

7 Complete

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

Wellness Registries

3 Complete

- **Pediatric Wellness**
- **Adult Wellness**
- **Senior Wellness**

View overall practice performance

Aligns with DOH reporting requirements

Identify registries that need most improvement

Users will be able to view the overall performance of meeting registry measures by physician **practice level**.

Registries and measures align with DOH reporting requirements, allowing users to identify registries that need the most improvement.

These registries and measures will also be used in planned pay for performance models.

Nov. 2015 - Today

6 Month Look Out

Embedded in 4 PCP Practices

Support 40 PCP Practice Sites with Embedded/ Community Resources

Providing TOC services to 1 hospital

Provide TOC services to 5 hospitals

Our Vision:
To build a patient-centered, coordinated, integrated delivery system.
The PPS sponsored CMO will serve those patients currently not aligned to an existing CMO.

Current Staffing Model:
10 RN Care Managers
8 Social Workers
5 Community Health Associates

Our Goal: Enhance patients' self-care abilities, improve access to community-based resources, break down care silos and reduce avoidable hospital admissions and emergency room visits through Population Health Management.

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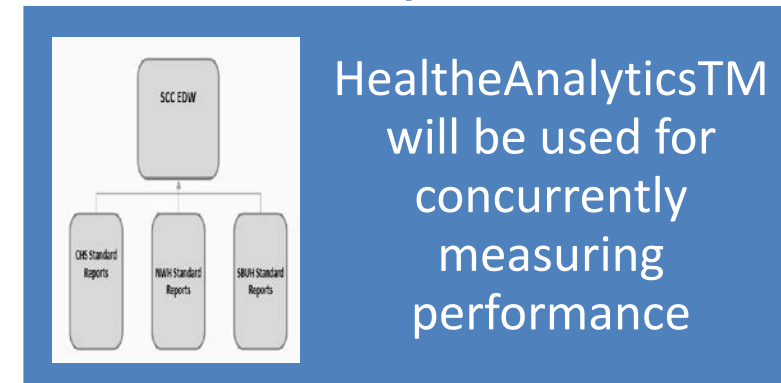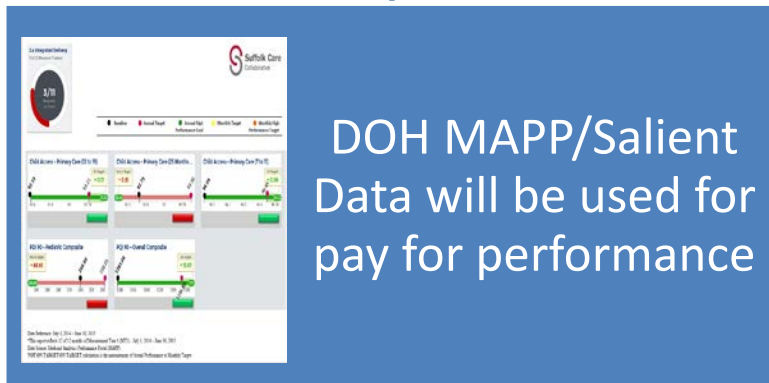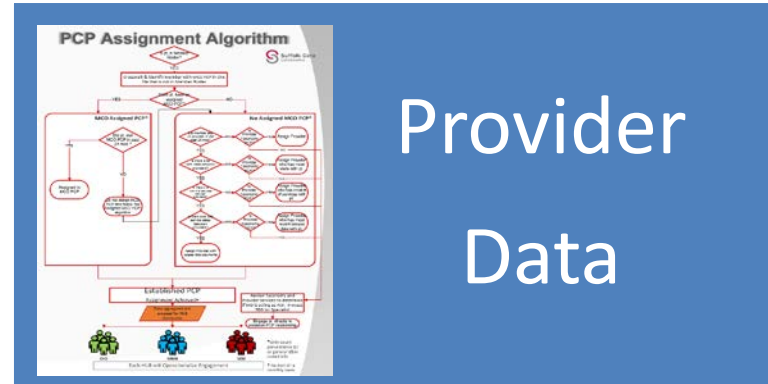| Defining the Population | Identifying Care Gaps | Stratify Risks | Patient Engagement | Manage Care | Measure Outcomes |

Performance Measurement Data Strategy

Finalizing Business Rules to Pay Providers for Performance

Testing PCP Soft Attribution Algorithm to identify the Established Physician

Provider Data

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

HealtheAnalyticsTM will be used for concurrently measuring performance

Suffolk Care Collaborative

PCP HealtheAnalytics Scorecard

SCC Performance Scorecard

Training Strategy

- Developed Extensive Workforce Training Strategy
- Facilitate Partner Onboarding Program Addressing Performance Requirements
- Developed Learning Center and Clinical Guideline Summaries to Educate Partners
- Created Core Curricula Guidelines for all participating provider practices.

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

The PI toolkit includes:

Action planning Template

PDSA Cycle Template

Data Collection Plan
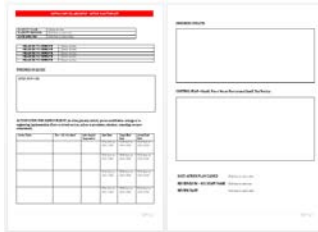
Trigger: Partner is in variance for 2 consecutive quarters

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

NO
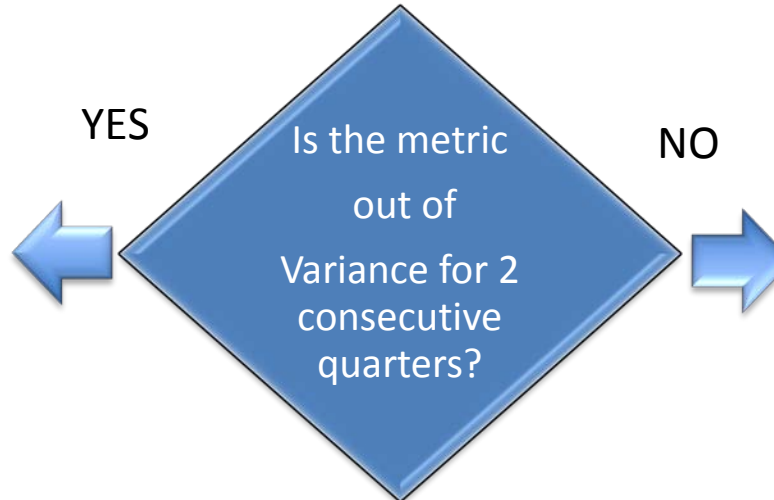
Action Plan Closed and Completed

Clinical Committee determines next steps

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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.

Staten Island PPS
Population Health Management – Applying Data Analytics to Implementation Efforts

LEARNING SYMPOSIUM
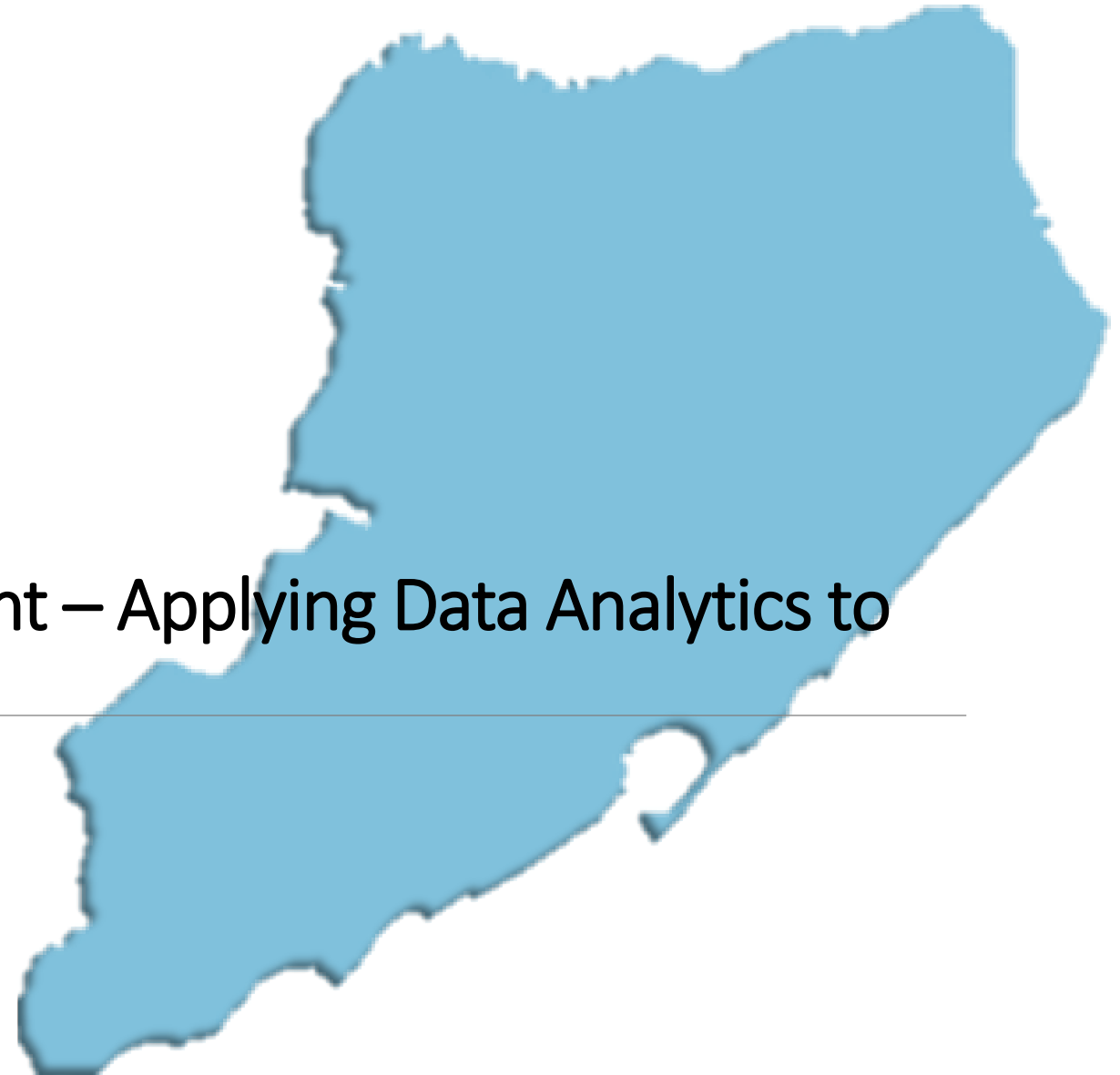
Objectives for Success
The Move from P4R to P4P

- Getting timely, actionable data into the hands of the clinicians at the point of service

- Disseminating patient level performance reports to partners at provider/practice level

- Using population health registries across projects/conditions to identify "defects"

- Focus Programs on High Demand Populations that Cut across multiple domains

- Supporting innovative strategies like Telemedicine Pilot, EMS Alternative Care Program, Withdrawal Call Center, Targeted Population Health programs

- Utilizing DOH claims data to supplement and validate internally generated measures

- Gathering data from other relevant sources, EMS, School Health, NYC planning data, Housing, social determinant domains, etc.

- Redesigning systems to eliminate waste and redundancy while meeting patient demand and training requirements

Rapid Cycle Performance Evaluation to Partners
End-to-End Data Management Life Cycle

Data Collection
- Actively Engaged (AE) Registry
- Patient Activation (PAM) project

Define Measures
- 30-day ED & 30-day Inpatient visits
- Establish baseline using DY1 results

Analyze Data
- Calculate partner level utilization performance
- Identify gaps in care

Performance Reporting
- Partner receives monthly performance reports and patient level details for further drill down

Measure Changes
- Develop control charts to track changes
- Meet w/ partners to discuss areas of improvements and sustainable progress

DY1 (Baseline) : 30-day ED Utilization Rate – PPS Level

Category	Rate
2.D.I (PAM)	10.2%
2A.III	14.0%
2.B.IV	22.3%
2.B.VII	6.4%
2.B.VIII	4.1%
3.C.I.	6.4%
3.G.II	1.3%
3.A.IV	14.4%
3.A.I	7.4%
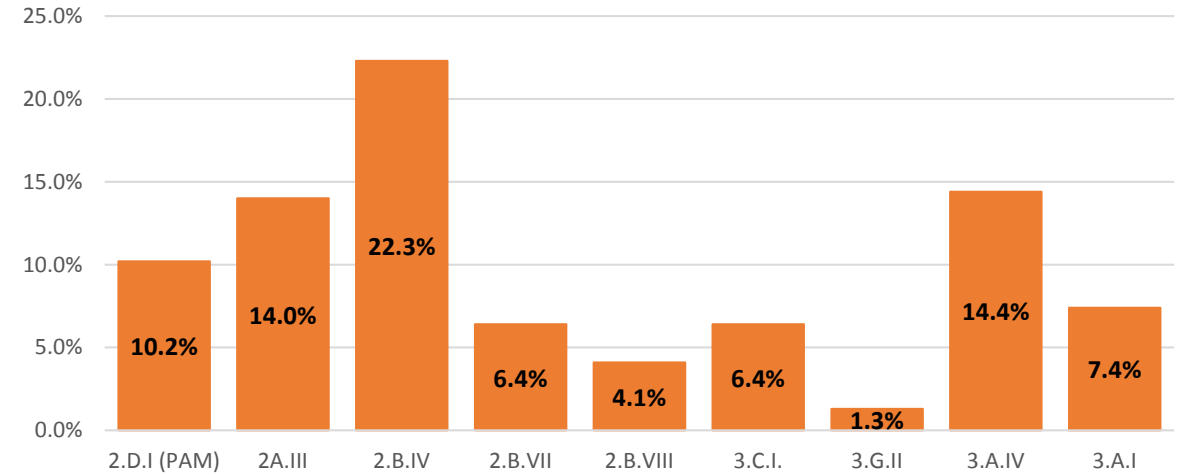
DY1 (Baseline): 30-day Inpatient Utilization Rate - PPS Level

Category	Rate
2.D.I (PAM)	5.0%
2A.III	4.3%
2.B.IV	12.0%
2.B.VII	7.6%
2.B.VIII	9.1%
3.C.I.	2.6%
3.G.II	1.8%
3.A.IV	7.3%
3.A.I	2.7%
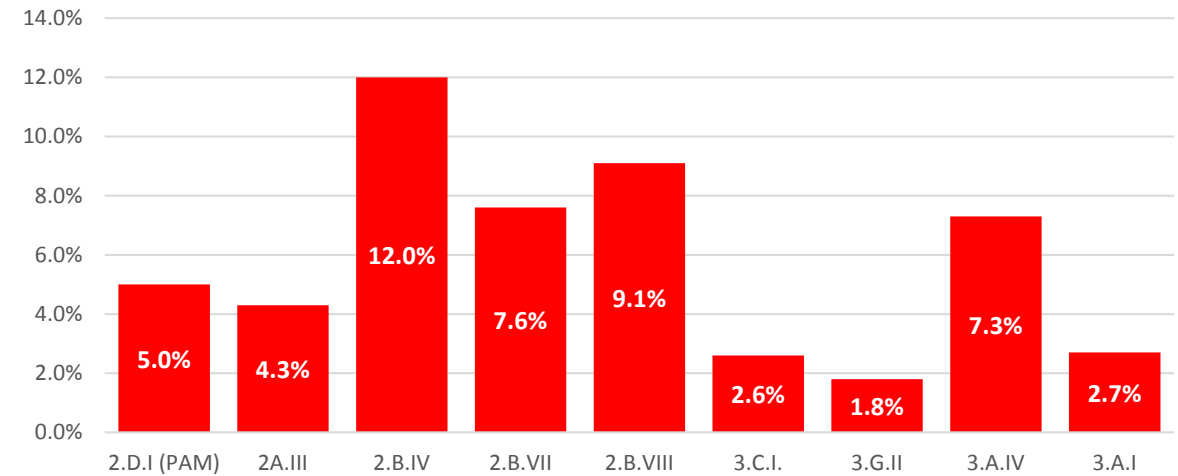
Business Intelligence Infrastructure and Data Flow

Data Flow

*Data Sources

*Selected Data Sources

BI Results

Data Sources

- Partner EHRs
- DOH Claims / MAPP / Salient
- Public Datasets
- Patient Registries (AE, PAM)
- EMS Dataset

ETL Process

- Data Validation
- Data Cleaning
- Data Transformation
- Data Aggregation
- Data Loading

ETL: Extract, Transform, Load

SI PPS Data Warehouse

Datamarts

BI Results

- Data Analysis (High Risk Patients / Super Utilizers)
- Data Mining

  5.0% 4.3%
  2.DJ (PAM) 2A. III

- Data Visualization
- Reports
- Dashboards
- Care Alerts
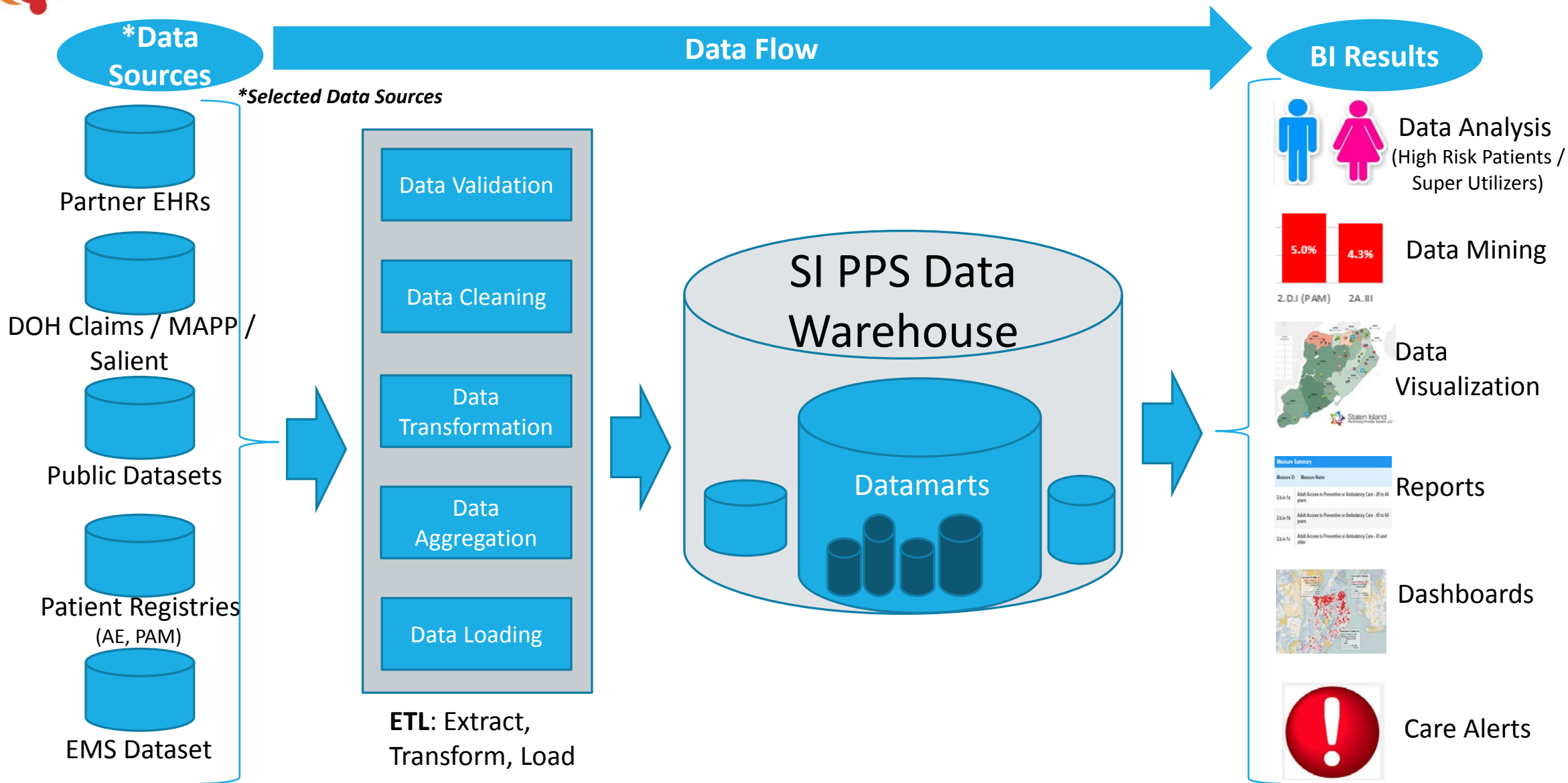
Staten Island PPS Risk profile algorithm identified top 500 High Risk Super Utilizer (HRSUs) from 63,605 Staten Island PPS Medicaid Enrollees

<1% of Staten Island PPS Medicaid Enrollees are defined as High Risk Patients (HRP)
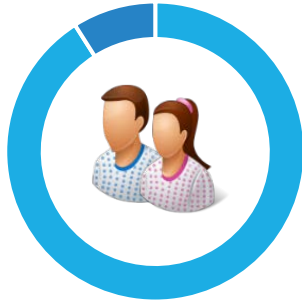
100% HRP had one or more Chronic conditions

- Asthma, Hypertension, CVD 31%
- Diabetes 12%
- Schizophrenia 7%
- Other Mental Health 2%
- Depression 1%
- Other 47%
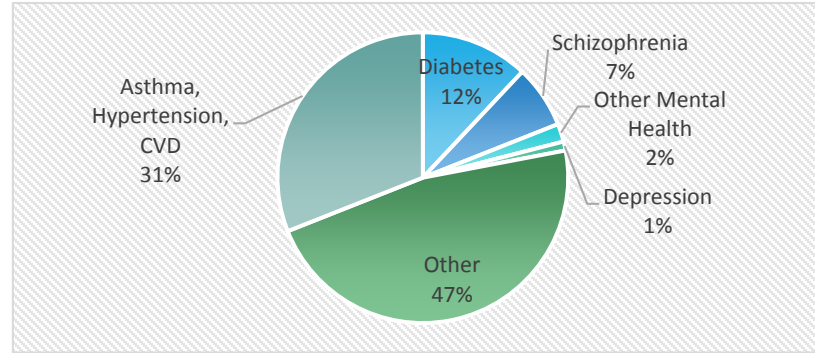
That population drives **20%** of preventable ED Visits (PPV) of Staten Island PPS Medicaid enrollees

Avg. PPV /HRP: **8.29**
Min PPV /HRP: **4**   Max PPV /HRP: **140**

… and **20%** of preventable readmissions

Avg. PPR/HRP: **1.54**
Min PPR /HRP: **1**   Max PPR /HRP: **6**

Cross-project involvement of Top 500 High Risk Patients (HRP)

100% 2.a: Integrated Delivery (2.a.iii)	**100%** 2.b: Care Coordination (2.b.iv, 2.b.vii, 2.b.viii)
40% 3.a: Behavioral Health (3.a.i, 3.a.iv)	**18%** EMS Super Utilizer Project
16% is also a MAX Super Utilizer	**22%** Took PAM survey as of 09-09-2016

Weekly Monitor of Top 500 High Risk Patients (HRP)

SI-PPS | P4P Selected Measures

Partner Name: TBD

Members	X
Members without MC Plan	X
Members without Current MC PCP	X
Members without Current Enrolled Health Home	X

Members that are non-compliant for selected P4P Measures

About this Patient — Priority P4P Measures

		Member Information							Medical											Behavioral											
	CIN	Member Name	Gender	DOB	Current Managed Care Assigned PCP	Current Health Home (HH)	Current HH Care Management Agency	Current Managed Care Plan	Potentially Avoidable Emergency Room Visits	Potentially Avoidable Readmissions	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)			Comprehensive Diabetes screening - All Three Tests (HbA1c, Dilated eye exam, and medical attention for nephropathy)						Potentially Preventable Emergency Room Visits (for persons with BH diagnosis)	Follow-up After Hospitalizations for Mental Illness - Within 7 days	Follow-up After Hospitalizations for Mental Illness Within 30 days	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	Diabetes Monitoring for People with Diabetes and Schizophrenia						Diabetes Screening for People with Schizophrenia who are Using Antipsychotic Medication	Screening for Clinical Depression and Follow-up
											HbA1C	Result	Date	HbA1C	Result	Date	Eye Exam	Date	Nephropathy				LDL-C	Result	Date	HbA1c	Result	Date	LDL-C	Result	Date		
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11																																		
12																																		
13																																		
14																																		

Staten Island Performing Provider System, LLC

Measures Calculation
30-Day Inpatient and 30-Day ED Utilization were calculated from AE submission date

30-Day ED Utilization Rate
Numerator: Number of ED Visits within 30-Day of AE Submission to SI PPS
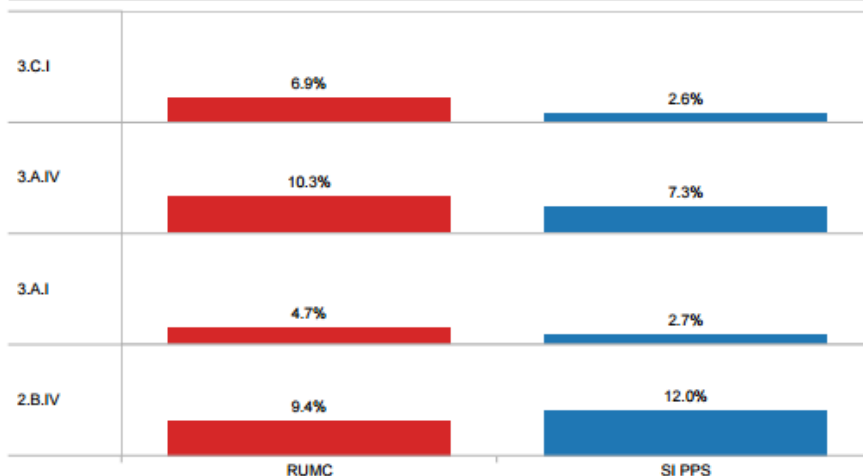**Denominator**: Number of AE Patients Submitted

30-Day Inpatient Utilization Rate
Numerator: Number of Inpatient Visits within 30-Day of AE Submission
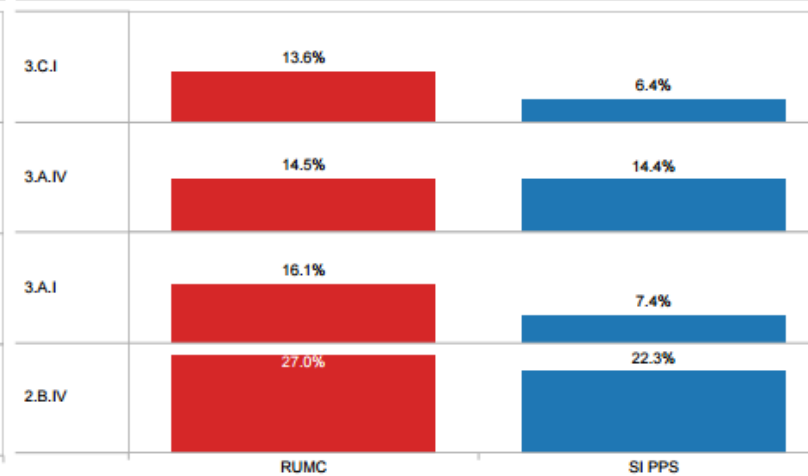**Denominator**: Number of AE Patients Submitted

SI PPS: SI PPS partners that participated in this project

Last Update: 08-10-2016

30-Day Inpatient Utilization Rate

	RUMC	SI PPS
3.C.I	6.9%	2.6%
3.A.IV	10.3%	7.3%
3.A.I	4.7%	2.7%
2.B.IV	9.4%	12.0%

30-Day ED Utilization Rate

	RUMC	SI PPS
3.C.I	13.6%	6.4%
3.A.IV	14.5%	14.4%
3.A.I	16.1%	7.4%
2.B.IV	27.0%	22.3%

Summary Statistics: 30-Day Inpatient Utilization

Org		2.B.IV	3.A.I	3.A.IV	3.C.I	Grand Total
SI PPS	30-Day IP Util. Rate	12.0%	2.7%	7.3%	2.6%	6.2%
	Total AE Patients	1,383	9,922	327	2,944	14,576
	Total Inpatient Visits	166	270	24	76	536
	Unique Patients - Inpt	137	218	19	67	441
RUMC	30-Day IP Util. Rate	9.4%	4.7%	10.3%	6.9%	7.8%
	Total AE Patients	775	850	117	376	2,118
	Total Inpatient Visits	73	40	12	26	151
	Unique Patients - Inpt	54	35	9	24	122

Summary Statistics: 30-Day ED Utilization

Org		2.B.IV	3.A.I	3.A.IV	3.C.I	Grand Total
SI PPS	30-Day ER Util. Rate	22.3%	7.4%	14.4%	6.4%	12.6%
	Total AE Patients	1,383	9,922	327	2,944	14,576
	Total ED Visits	308	737	47	188	1,280
	Unique Patient - ED	202	523	35	153	913
RUMC	30-Day ER Util. Rate	27.0%	16.1%	14.5%	13.6%	17.8%
	Total AE Patients	775	850	117	376	2,118
	Total ED Visits	209	137	17	51	414
	Unique Patient - ED	139	109	13	40	301

Privileged and Confidential
Prepared in accordance with the Public Health Law Section 2805 j through m and Education Law Section 6527

Data Source:
AE registry and RUMC & SIUH EHR data feed
DOH Claims

Utilization Report:
PPS Partner Registry Utilization Summary Report card

Project:
All Actively Engaged projects that a SI PPS partner participated

Data Source:
Actively Engaged Member roster from participating partners / SI PPS EDW / DOH Claims

Specific Partner Utilization Report
Use Case : Diabetes Management

220 # AE Members

22 # ED Visits

4 # IP Visits

Utilization Report

Project:
3c.i. Diabetes Management

Data Source:
Actively Engaged Member roster from participating partners / SI PPS EDW / DOH Claims

Qualifying:
Patients with at least one hemoglobin A1c test within the previous 12 months

30-day ED Utilization Log
Project 3c.i. - Actively Engaged Patient Registry

Number of 30-day ED Visits: 22
Number of Encounters Enrolled in SI CARES: 3

Include ONLY admissions to Hospital ER within 30 days of Actively Engaged Date to SI PPS

*Red asterisk indicates the date patient enrolled in SI CARES

	Partner Organization	MedicaidID	Last Name	First Name	Actively Engaged Date	RUMC ED Admit Date	SI CARES Date of Service*
1	Partner1	XXXXXXXX	PatLastName1	PatFirstName1	4/25/2016	05/16/16	NA
2	Partner1	XXXXXXXX	PatLastName2	PatFirstName2	3/24/2016	03/28/16	NA
3	Partner1	XXXXXXXX	PatLastName3	PatFirstName3	12/17/2015	01/14/16	NA
4	Partner1	XXXXXXXX	PatLastName4	PatFirstName4	12/17/2015	01/05/16	NA
5	Partner1	XXXXXXXX	PatLastName5	PatFirstName5	9/1/2015	09/08/16	NA
6	Partner1	XXXXXXXX	PatLastName6	PatFirstName6	7/31/2015	08/29/15	3/30/2016
7	Partner1	XXXXXXXX	PatLastName7	PatFirstName7	7/31/2015	08/25/15	NA
8	Partner1	XXXXXXXX	PatLastName8	PatFirstName8	7/31/2015	08/25/15	NA
9	Partner1	XXXXXXXX	PatLastName9	PatFirstName9	8/1/2015	08/23/15	NA
10	Partner1	XXXXXXXX	PatLastName10	PatFirstName10	7/31/2015	08/23/15	3/30/2016
11	Partner1	XXXXXXXX	PatLastName11	PatFirstName11	7/31/2015	08/21/15	NA
12	Partner1	XXXXXXXX	PatLastName12	PatFirstName12	7/31/2015	08/17/15	NA
13	Partner1	XXXXXXXX	PatLastName13	PatFirstName13	7/31/2015	08/15/15	NA
14	Partner1	XXXXXXXX	PatLastName14	PatFirstName14	7/31/2015	08/13/15	NA
15	Partner1	XXXXXXXX	PatLastName15	PatFirstName15	8/1/2015	08/12/15	NA
16	Partner1	XXXXXXXX	PatLastName16	PatFirstName16	8/1/2015	08/07/15	5/17/2016
17	Partner1	XXXXXXXX	PatLastName17	PatFirstName17	7/31/2015	08/07/15	NA
18	Partner1	XXXXXXXX	PatLastName18	PatFirstName18	7/31/2015	08/01/15	NA
19	Partner1	XXXXXXXX	PatLastName19	PatFirstName19	Apr - Jul, 2015	04/24/15	NA
20	Partner1	XXXXXXXX	PatLastName20	PatFirstName20	Apr - Jul, 2015	04/10/15	NA
21	Partner1	XXXXXXXX	PatLastName21	PatFirstName21	Apr - Jul, 2015	04/09/15	NA
22	Partner1	XXXXXXXX	PatLastName22	PatFirstName22	Apr - Jul, 2015	04/07/15	NA

30-day Inpatient Utilization Log
Project 3c.i. - Actively Engaged Patient Registry

Number of 30-day INPT Visits: 4
Number of Encounters Enrolled in SI CARES: 0

Include ONLY inpatient admissions to Hospital within 30 days of Actively Engaged Date to SI PPS

*Red asterisk indicates the date patient enrolled in SI CARES

	Partner Organization	MedicaidID	Last Name	First Name	Actively Engaged Date	RUMC INPT AdmitDT	SI CARES Date of Service*
1	Partner1	XXXXXXXX	PatLastName1	PatFirstName1	07/31/15	08/07/15	NA
2	Partner1	XXXXXXXX	PatLastName2	PatFirstName2	07/31/15	08/25/15	NA
3	Partner1	XXXXXXXX	PatLastName3	PatFirstName3	Apr - Jul, 2015	04/10/15	NA
4	Partner1	XXXXXXXX	PatLastName4	PatFirstName4	Apr - Jul, 2015	04/07/15	NA

Privileged and Confidential
Prepared in accordance with the Public Health Law Section 2805 j through m and Education Law Section 6527

Sample Report Page 2 of 2

Measures Calculation
30-Day Inpatient and 30-Day ED Utilization were calculated from AE submission date

30-Day ED Utilization Rate
Numerator: Number of ED Visits within 30-Day of AE Submission to SI PPS
Denominator: Number of AE Patients Submitted

30-Day Inpatient Utilization Rate
Numerator: Number of Inpatient Visits within 30-Day of AE Submission
Denominator: Number of AE Patients Submitted

SI PPS: SI PPS partners that participated in this project

Outcomes Report : Follow –up after Mental Health Inpatient Discharge

Current Progress - Improving Care Outcomes

2.A.III : HH at Risk

	DY1	DY2Q1
30-Day ER Util. Rate	14.00%	6.30%
Total AE Patients	607	1,064

3.C.I : Diabetes Management

	DY1	DY2Q1
30-Day ER Util. Rate	6.40%	3.70%
Total AE Patients	2,944	3,443

3.A.I

	DY1	DY2Q1
30-Day ER Util. Rate	7.40%	5.00%
Total AE Patients	9,922	6,851

3.A.IV

	DY1	DY2Q1
30-Day ER Util. Rate	14.40%	9.70%
Total AE Patients	327	269
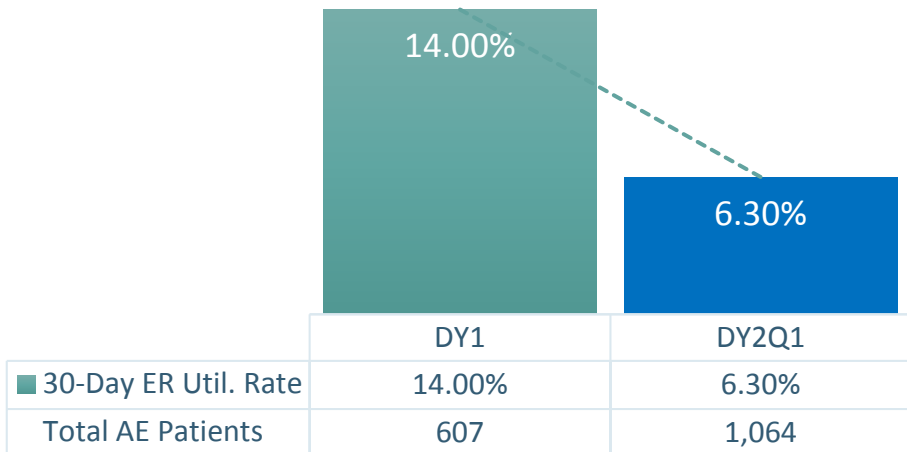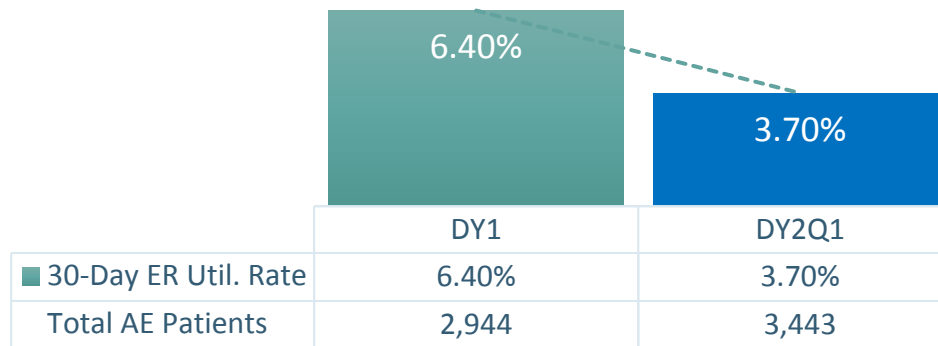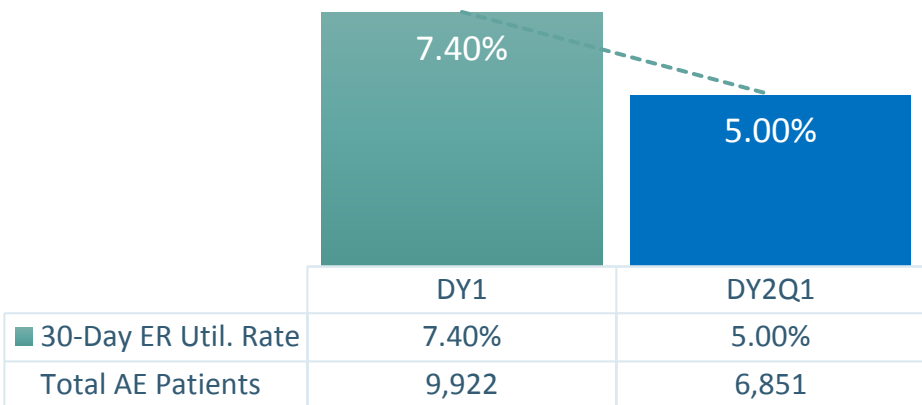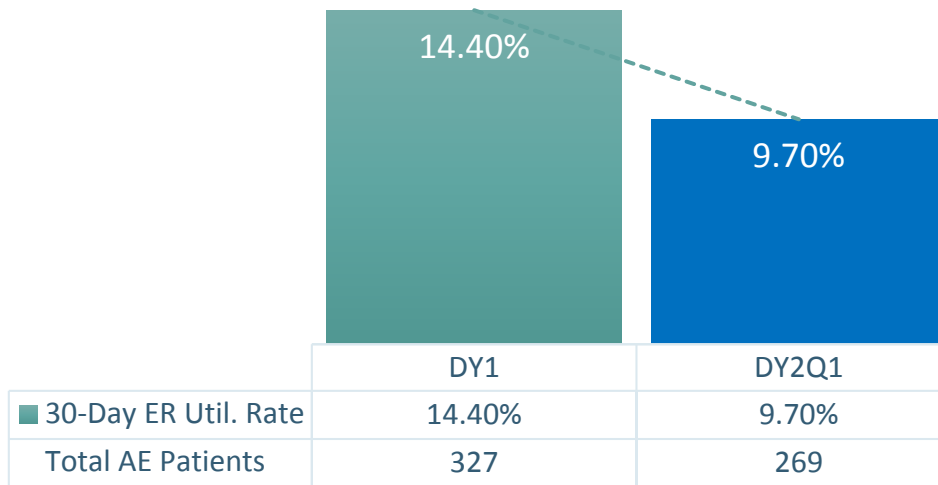
Key Findings:
Significant improvement in 30-day ER Utilization Rate *(DY1 vs. DY2Q1)*

- 2.A.III: **55%** improvement, decreased from 14% to 6.3%.
- 3.C.I: **42%** improvement, decreased from 6.4% to 3.7%.
- 3.A.I: **32%** improvement, decreased from 7.4% to 5.0%.
- 3.A.IV: **33%** improvement, decreased from 14.4% to 9.7%.

Behavioral Health Integrated Care Workflow
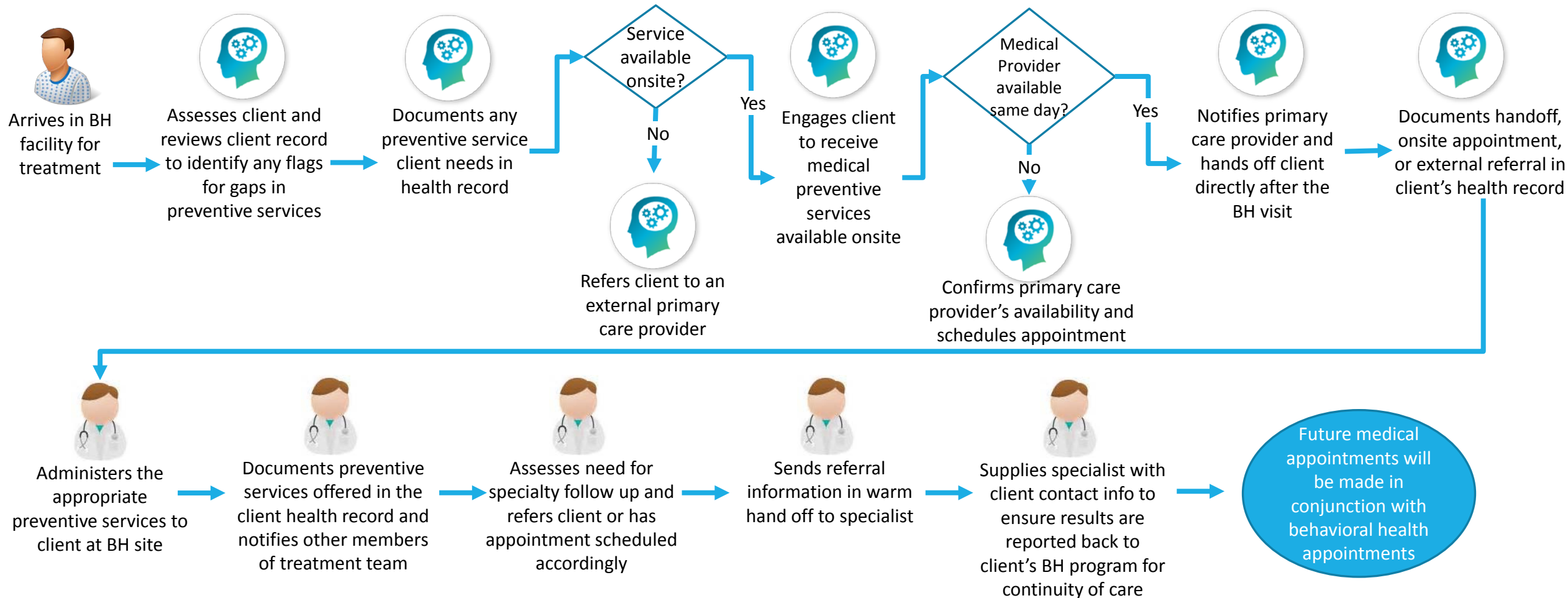
Client   **Behavioral Health Provider**   **Primary Care Provider**

Arrives in BH facility for treatment

Assesses client and reviews client record to identify any flags for gaps in preventive services

Documents any preventive service client needs in health record

Service available onsite?

No → Refers client to an external primary care provider

Yes → Engages client to receive medical preventive services available onsite

Medical Provider available same day?

Yes → Notifies primary care provider and hands off client directly after the BH visit

No → Confirms primary care provider's availability and schedules appointment

Documents handoff, onsite appointment, or external referral in client's health record

Administers the appropriate preventive services to client at BH site

Documents preventive services offered in the client health record and notifies other members of treatment team

Assesses need for specialty follow up and refers client or has appointment scheduled accordingly

Sends referral information in warm hand off to specialist

Supplies specialist with client contact info to ensure results are reported back to client's BH program for continuity of care

Future medical appointments will be made in conjunction with behavioral health appointments

Staten Island PPS Population Patient Registry 1.0

1 Key Statistics

Total Visits	139,488	Average Age	F	42.74751	ED Visits	49,308	Inpatient Visit	12,356	Outpatient Visits	77,824
Unique Patients	2,609		M	42.80918	Unique Patients	2,544	Unique Patients	2,150	Unique Patients	1,695

Tool:
Population-based Patient Registry Ver. 1.0

Use Case:
Diabetes w/chronic Comorbid Conditions

Disease
- [ ] (All)
- [ ] Asthma
- [ ] BH
- [ ] CHF
- [ ] COPD
- [ ] Diabetes
- [x] Diabetes & BH
- [x] Diabetes & CHF
- [x] Diabetes & COPD
- [ ] HIV
- [ ] NULL

Race
- [ ] (All)
- [x] Asian
- [x] Black
- [x] Hispanic
- [x] Native American
- [ ] NULL
- [x] Other
- [ ] Unknown
- [x] White

Age_Group
- [ ] (All)
- [ ] 0-18
- [ ] 19-64
- [ ] 65+

Gender
- [x] (All)
- [x] F
- [x] M

Year
- [ ] (All)
- [ ] 2012
- [x] 2013
- [x] 2014
- [x] 2015
- [ ] 2016

Utilization Rate (Per 100 Patient) By Disease Area

	VisitType		
Disease	EDVISIT	INPATIENT	OUTPATIENT
Diabetes & BH	214.0	123.9	329.2
Diabetes & CHF	190.5	125.1	388.2
Diabetes & COPD	185.2	125.1	341.4

2 Utilization by Population

Use Case #2: Male, 21
Super Utilizeer: YES
Utilization: 26 (8ED,2IP)
Disease: **Diabetes & BH**
Gender: **M**
Race: **Black**
Address Lattitude: **40.6392**
Address Longitude: **-74.1218**

Use Case#1: Female, 61
Super Utilizeer: YES
Utilization: 12 (7ED,3IP)
Disease: **Diabetes & BH**
Gender: **F**
Race: **White**
Address Lattitude: **40.6343**
Address Longitude: **-74.1005**

Use Case #3: Male, 46
Super Utilizeer: NO
Utilization: 26 (2ED,2IP)
Disease: **Diabetes & CHF**
Gender: **M**
Race: **White**
Address Lattitude: **40.5758**
Address Longitude: **-74.1235**

Disease, Gender
- Diabetes & BH, F
- Diabetes & BH, M
- Diabetes & CHF, F
- Diabetes & CHF, M
- Diabetes & COPD, F
- Diabetes & COPD, M

Population:
Attributed Members with at least one of the chronic comorbid conditions : Diabetes, BH, COPD and CHF

Race and Gender

	F		M	
White		528		597
Black		532	403	
Other	105		117	
Hispanic	142		74	
Asian	35		42	
Native American	14		20	

3 Patient Demographics
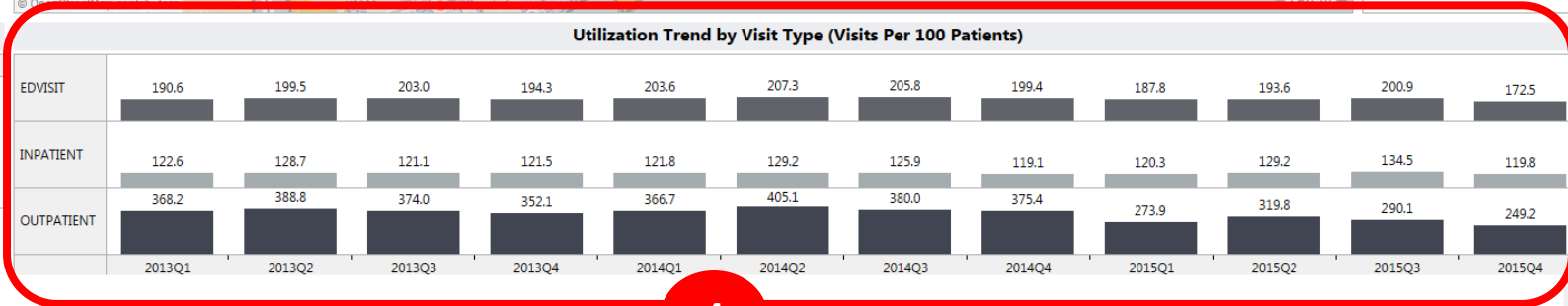
4 Hospital Utilization Trend

Utilization Trend by Visit Type (Visits Per 100 Patients)

	2013Q1	2013Q2	2013Q3	2013Q4	2014Q1	2014Q2	2014Q3	2014Q4	2015Q1	2015Q2	2015Q3	2015Q4
EDVISIT	190.6	199.5	203.0	194.3	203.6	207.3	205.8	199.4	187.8	193.6	200.9	172.5
INPATIENT	122.6	128.7	121.1	121.5	121.8	129.2	125.9	119.1	120.3	129.2	134.5	119.8
OUTPATIENT	368.2	388.8	374.0	352.1	366.7	405.1	380.0	375.4	273.9	319.8	290.1	249.2

Next Steps

- Timely transfer of data into business intelligence is strategic imperative
  - Continue our efforts integrating Medicaid claims and clinical datasets from local RHIO, partner EHRs and other data sources

- Expanding current MAPP capability with new data fields
  - Date of Service
  - Service Provider Name/NPI
  - Charges versus actual paid claims

- Data Exchange with MCO organizations
  - Under / Non Utilizers
  - Super Utilizers
  - Hi Need Care Roster

- Move EDW into the cloud environment

- Putting information into the hands of the practitioner and practice is critical
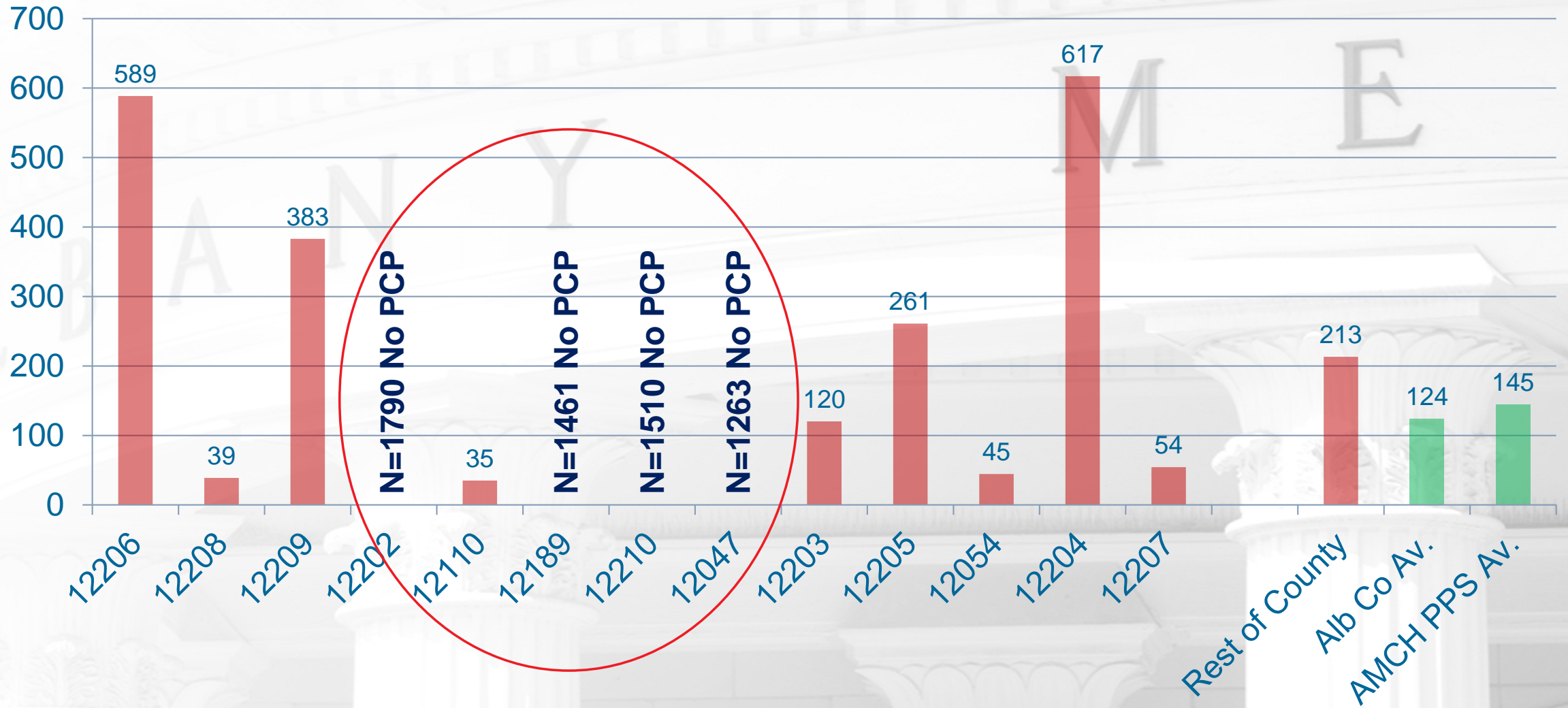 - Build care alerts into partner EHRs for at risk populations

AMCH PPS: Applying Data Analytics to Implementation Efforts

- Approach – "Maximize Available Resources"

- Utilization of <u>MAPP Data</u>:
  - Identification of PCP shortage areas by ZIP Code
  - Improve performance measures
  - Utilization of Snapshot feature to Identify patients in need of a service
  - Identify at-risk individuals for care management
  - Increase MC PCP assignment rates
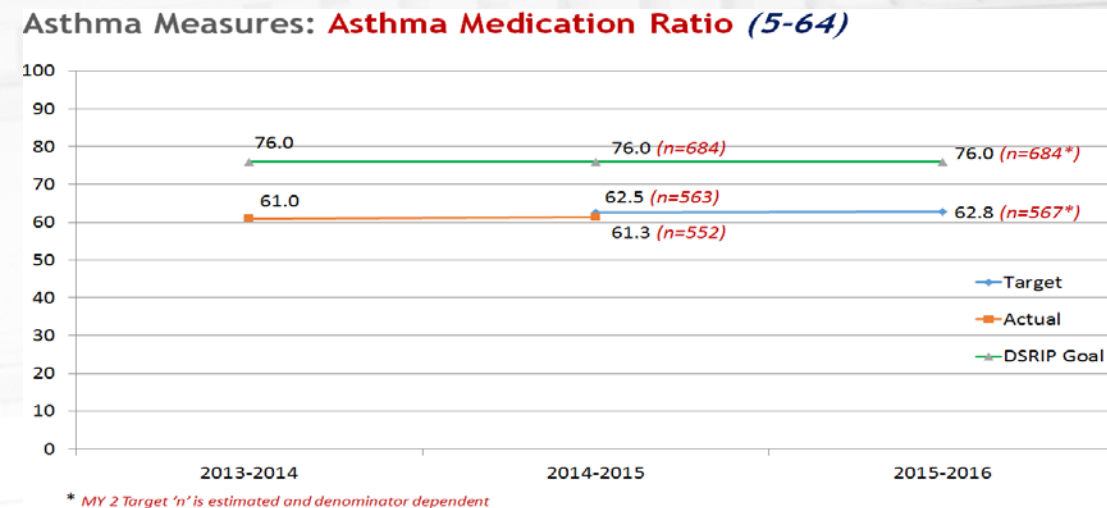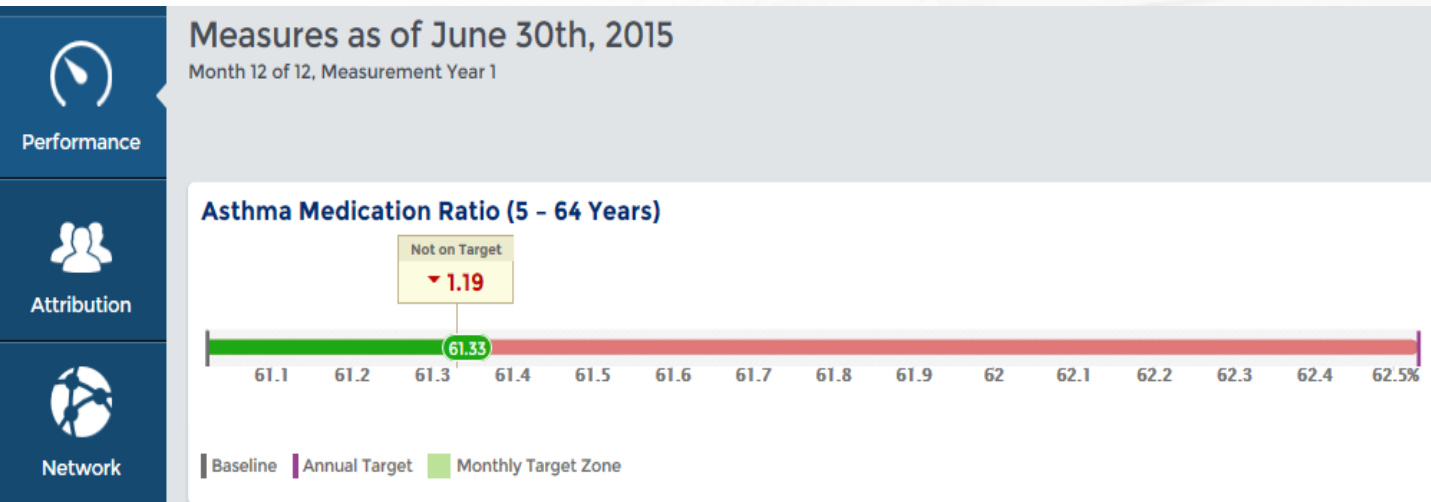 - PCP level analysis to prioritize intervention efforts

- Future plans

AMCH PPS: Albany County - PCP per Attributed Patients

Attribution by Zip Code

PCP Distribution

AMCH PPS: Albany County - Individuals per PCP by Zip Code

AMCH PPS: Performance Improvement Activities

Measures as of June 30th, 2015
Month 12 of 12, Measurement Year 1

Asthma Medication Ratio (5 – 64 Years)

Not on Target ▼ 1.19

Baseline | Annual Target | Monthly Target Zone

Asthma Measures: Asthma Medication Ratio (5-64)

Asthma Medication Measures – Interventions to Improve Adherence

- Train practitioners and care management staff on Motivational interviewing, Teach back method and other self-management support techniques.

- Collaborate with pharmacy team on self-management support

- 2-4 week post-visit phone call to perform Asthma Control Test over the phone

- Implement reminder systems/ gap list management across the continuum.

- Establish a default quantity of 90 days for asthma controller medications

AMCH PPS

- Data Analytics – Asthma Controller Prescription Report (Partner EMR, Live Report)

Asthma Controller Prescription Instances in DEPT

MRN	Patient Name	Age	Medication	Prescribed On	Medication Action	Quantity	Dosage	Refills	Notes
#######	NAME, PATIENT	22.4	Montelukast Sodium 10 MG Oral Tablet	1/1/1900	Send To Retail	30	0	5	TAKE 1 TABLET DAILY.
#######	NAME, PATIENT	22.4	PredniSONE 20 MG Oral Tablet	1/1/1900	Send To Retail	10	0	0	1 tablet BID
#######	NAME, PATIENT	22.0	PrednisoLONE 15 MG/5ML Oral Syrup	1/1/1900	Record	100	2	0	TAKE 2 TSP Twice daily
#######	NAME, PATIENT	22.0	Montelukast Sodium 10 MG Oral Tablet	1/1/1900	Send To Retail	90	0	3	TAKE 1 TABLET BY MOUTH DAILY
#######	NAME, PATIENT	22.0	PrednisoLONE 15 MG/5ML Oral Syrup	1/1/1900	Record	100	2	0	TAKE 2 TSP Twice daily
#######	NAME, PATIENT	21.2	Flovent HFA 44 MCG/ACT Inhalation Aerosol	1/1/1900	Send To Retail	1		3	INHALE 2 PUFFS TWICE DAILY.
#######	NAME, PATIENT	20.7	Pulmicort Flexhaler 90 MCG/ACT Inhalation Aerosol Powder Breath Activated	1/1/1900	Record	1	0	5	INHALE 1 PUFF TWICE DAILY. RINSE MOUTH AFTER USE.
#######	NAME, PATIENT	20.7	Pulmicort Flexhaler 90 MCG/ACT Inhalation Aerosol Powder Breath Activated	1/1/1900	Record	1	0	5	INHALE 1 PUFF TWICE DAILY. RINSE MOUTH AFTER USE.
#######	NAME, PATIENT	20.6	PrednisoLONE 15 MG/5ML Oral Solution	1/1/1900	Record	85	60	0	TAKE 60 MG 1 time daily
#######	NAME, PATIENT	20.1	Flovent HFA 44 MCG/ACT Inhalation Aerosol	1/1/1900	Send To Retail	1	2	1	INHALE 2 PUFFS 2 times daily rinse mouth after use
#######	NAME, PATIENT	19.4	Montelukast Sodium 10 MG Oral Tablet	1/1/1900	Send To Retail	30	0	5	TAKE 1 TABLET DAILY.
#######	NAME, PATIENT	19.1	Pulmicort Flexhaler 180 MCG/ACT Inhalation Aerosol Powder Breath Activated	1/1/1900	Record	1	0	2	INHALE 2 PUFF ONCE DAILY. RINSE MOUTH AFTER USE.

KNOWN FOR OUR EXPERTISE.
CHOSEN FOR OUR CARE.

Dashboard | MC HIOS Name [All ▼] | MC Product Line [All ▼] | PPS [Albany Medical Center Hospital ▼]

‹ Back › Snapshots › FUMH-Hosp ▼

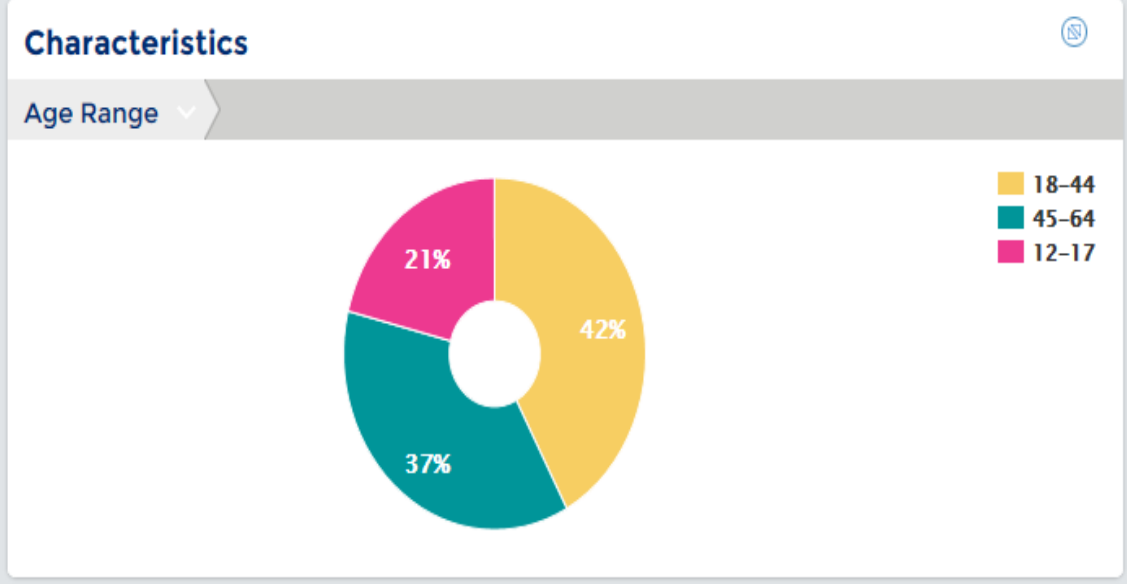**Performance**

Attribution

Network

Snapshots

Snapshots are intended to provide information generated from the most recent paid claims data available. However, some services that transpired during the timeframe will not be represented in these views because of delays in claim submission and processing. Therefore, these data should be considered incomplete, and are in no way predictive of ...

19
Members who may not have had a follow up after a mental health inpatient discharge

Members: Qualifying members who did not have an outpatient Mental Health visit within one month after discharge

Qualifying: All attributed members with a Mental Health Inpatient discharge in the month that was 2 months prior to current month

Characteristics

Age Range ▼

- 18–44
- 45–64
- 12–17

42% (18–44)
37% (45–64)
21% (12–17)

Geography

[Map] [List]

Member County ▼

Member...	# Members
ALBANY	9
SARATOGA	3
COLUMBIA	2
GREENE	1
ONEIDA	1
ORANGE	1

Member Distribution

Current MC HIOS Name ▼

| Current MC HIOS Name	# Members	# Qualifying
NO CURRENT MC HIOS NAME	10	24
94788 Capital District Physicians' Health Plan, Inc.	5	18
Total (5)	19	53

Export Data
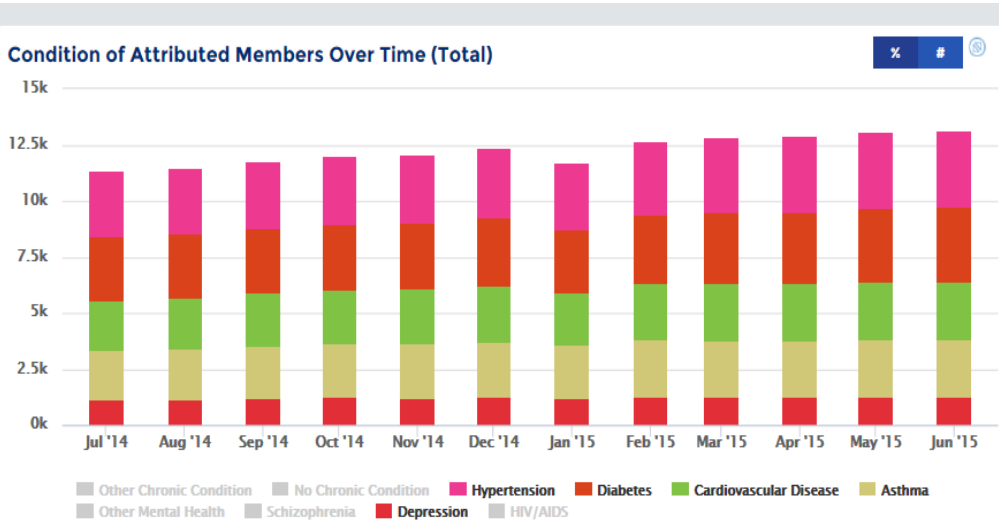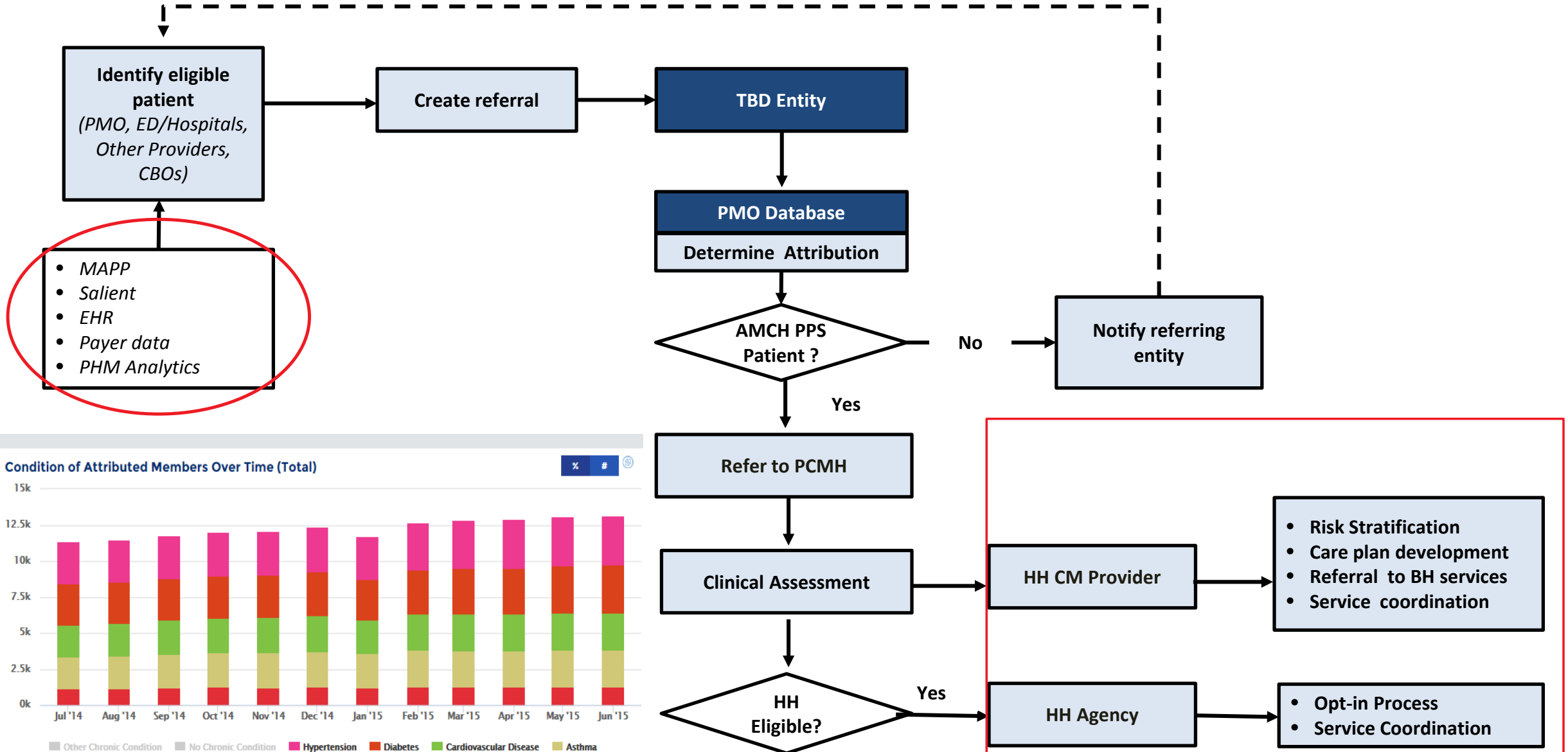
Discharge Planning and Transitions of Care

Medical input and hand over together with clear care team coordination with the receiving services is key for patients requiring BH care

Section Process: Discharge planning and transition of care to BH out patient services
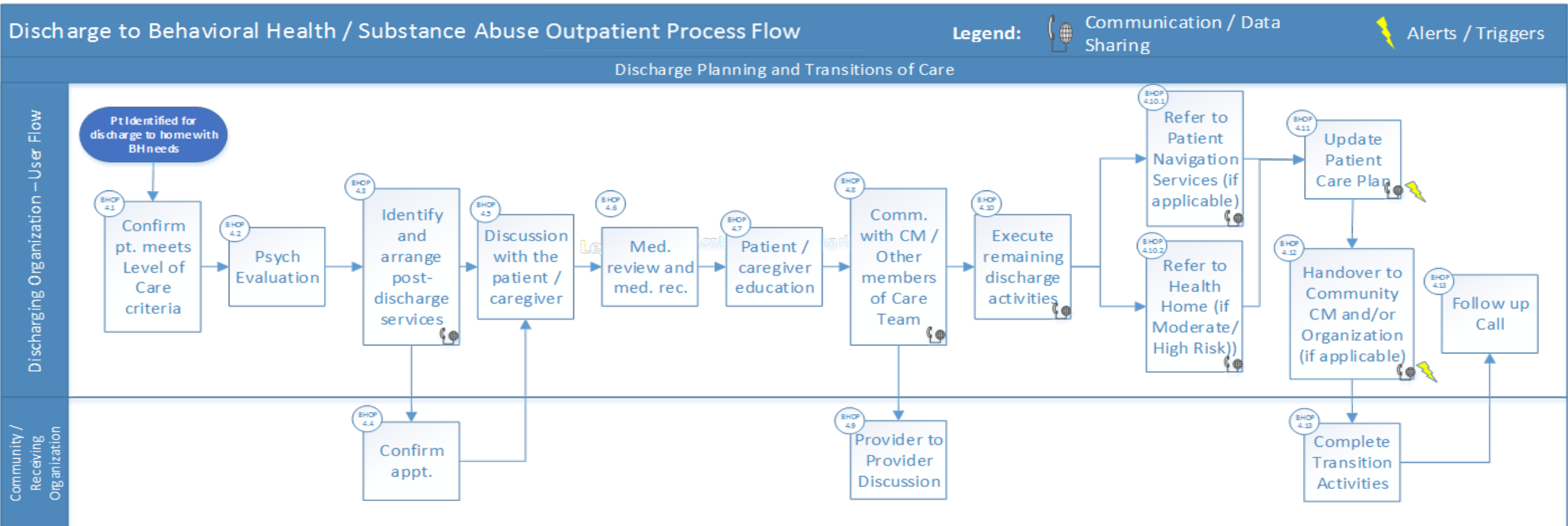
* Please refer to AMCH DSRIP Process Flow w Tech.vsd for further detail
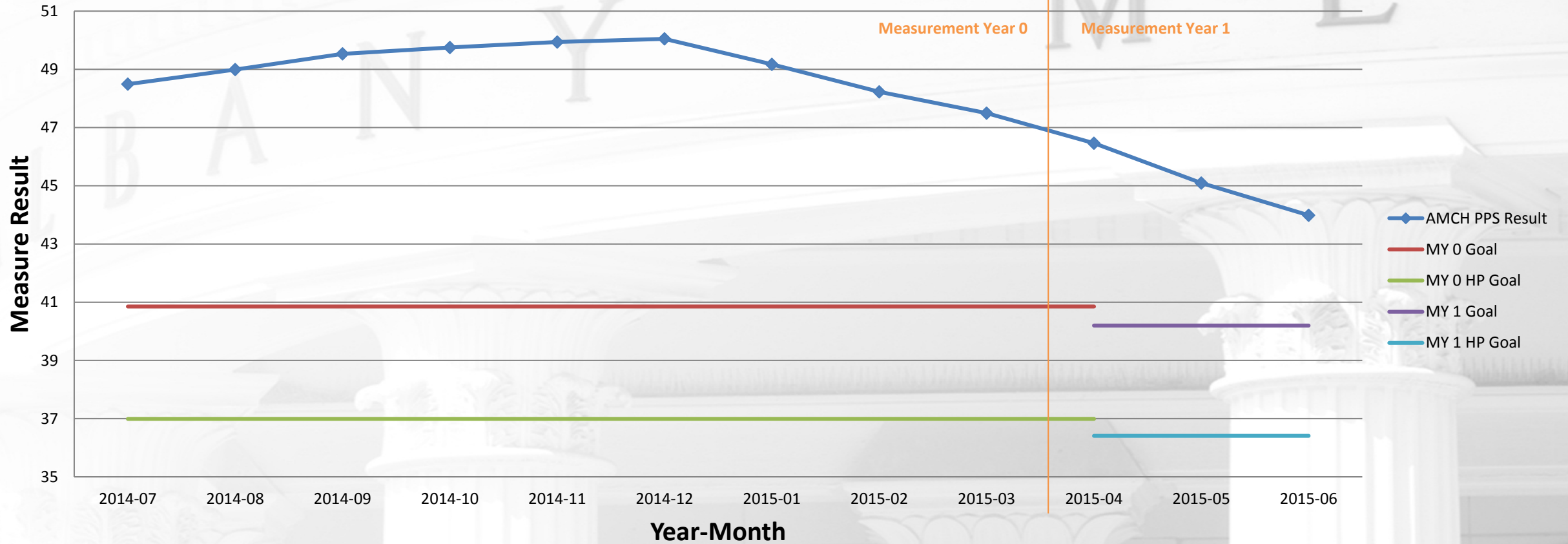
AMCH PPS

- Data Analytics – ED Utilization by County (Salient UXT, Live Report)

Potentially Avoidable ED Visits - AMCH PPS

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OUR EXPERTISE.
CHOSEN FOR
OUR CARE.

AMCH PPS

- Data Analytics – Hypertension Monitoring (Partner EMR, Live Report)

Reporting Week	PCP per Allscripts	MRN	Patient Name	Date of Birth	Qualifying BP	Repeated	Age Upon Qual. BP	6 Month Blood Pressure Trend (Last BP Reading Each Week In Which Reading Exists) Green = Normal, Yellow = Stage 1, Orange = Stage 2, Red = Hypertensive Crisis										Dept. of Last High Risk BP Measurement	Last High Risk BP Measured while seeing	Referring Provider for Visit	Active Approved ICD9 Code
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	156/92 (Repeated) on 07-27 14:36	Y	36	Systolic Trend: 136 138 142 130 106 134 128 156 / Diastolic Trend: 86 84 80 82 82 70 90 92										DEPT	LAST-SEEN, PROVIDER	REFERRING, PROVIDER	401.9
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	144/77 (Repeated) on 07-26 15:07	Y	36	Systolic Trend: 178 172 163 144 / Diastolic Trend: 101 91 97 77										DEPT	LAST-SEEN, PROVIDER		401.9
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	151/72 (Repeated) on 07-27 13:35	Y	36	Systolic Trend: 151 / Diastolic Trend: 72										DEPT	LAST-SEEN, PROVIDER		
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	132/100 on 07-26 12:19		36	Systolic Trend: 138 144 132 / Diastolic Trend: 82 90 100										DEPT	LAST-SEEN, PROVIDER		401.9
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	150/90 (Repeated) on 07-26 10:00	Y	36	Systolic Trend: 150 / Diastolic Trend: 90										DEPT	LAST-SEEN, PROVIDER	REFERRING, PROVIDER	
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	148/98 (Repeated) on 07-27 09:25	Y	36	Systolic Trend: 120 124 138 136 148 / Diastolic Trend: 86 84 86 82 98										DEPT	LAST-SEEN, PROVIDER		
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	154/72 (Repeated) on 07-27 11:18	Y	36	Systolic Trend: 154 / Diastolic Trend: 72										DEPT	LAST-SEEN, PROVIDER	REFERRING, PROVIDER	
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	145/55 (Repeated) on 07-27 13:17	Y	36	Systolic Trend: 108 102 / Diastolic Trend: 64 64										DEPT	LAST-SEEN, PROVIDER		
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	188/84 (Repeated) on 07-26 13:10	Y	36	Systolic Trend: 126 124 188 / Diastolic Trend: 64 74 84										DEPT	LAST-SEEN, PROVIDER	REFERRING, PROVIDER	401.1
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	142/108 (Repeated) on 07-27 09:59	Y	36	Systolic Trend: 142 / Diastolic Trend: 108										DEPT	LAST-SEEN, PROVIDER		
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	142/82 (Repeated) on 07-27 08:37	Y	36	Systolic Trend: 144 142 / Diastolic Trend: 90 82										DEPT	LAST-SEEN, PROVIDER		
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	140/82 (Repeated) on 07-26 10:02	Y	36	Systolic Trend: 140 / Diastolic Trend: 82										DEPT	LAST-SEEN, PROVIDER		401.9
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	140/80 (Repeated) on 07-27 10:30	Y	36	Systolic Trend: 132 124 138 118 124 130 140 / Diastolic Trend: 78 62 78 70 72 86 80										DEPT	LAST-SEEN, PROVIDER		
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	142/82 (Repeated) on 07-27 13:22	Y	36	Systolic Trend: 142 / Diastolic Trend: 82										DEPT	LAST-SEEN, PROVIDER		
####-##	LAST MD, FIRST / LAST MD, FIRST	######## / ######### DOE, JANE		1/1/1980	162/95 on 07-25 13:33		36	Systolic Trend: 110 136 121 162 / Diastolic Trend: 70 70 59 95										DEPT	LAST-SEEN, PROVIDER		401.9

KNOWN FOR OUR EXPERTISE. CHOSEN FOR OUR CARE.

AMCH PPS: Applying Data Analytics to Implementation Efforts

- Future plans
  - Collaborate with QE for population health analytics
  - Explore funding opportunities for a low-cost PHM system solution
  - Analysis of SIM claims data for risk stratification

Q&A