



# Operational Support and Performance Resources

*Moderator: **Chip Barnes, NYSTEC***

*Panelists:*

***Susan Lepler, Salient HHS***

***Marc Berg, KPMG***

***Mary-Sara Jones, IBM***

***Matt Sorrentino, Public Consulting Group***

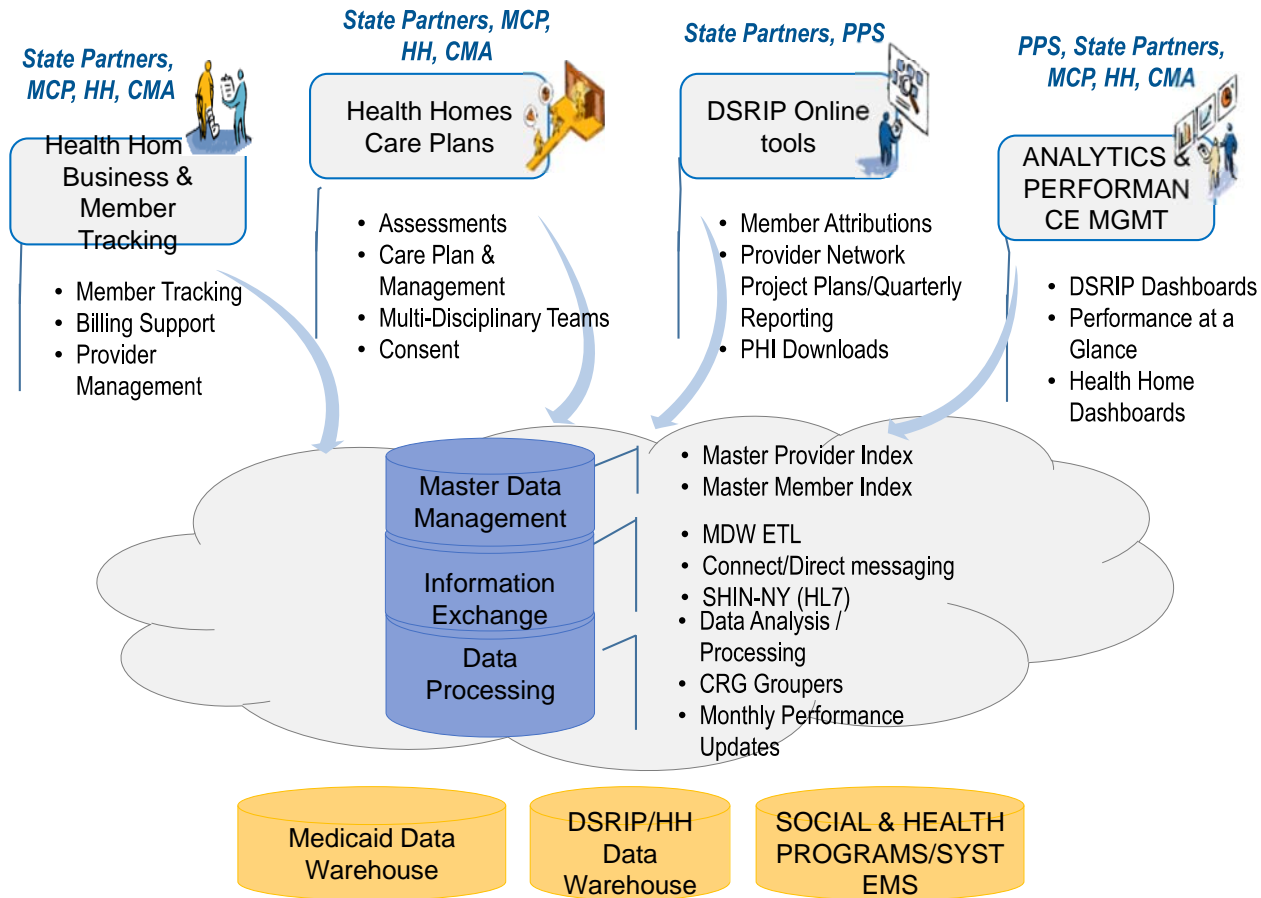
***Todd Ellis, KPMG***

# Agenda

<Objective>: To provide an overview of MAPP and its various functional components.

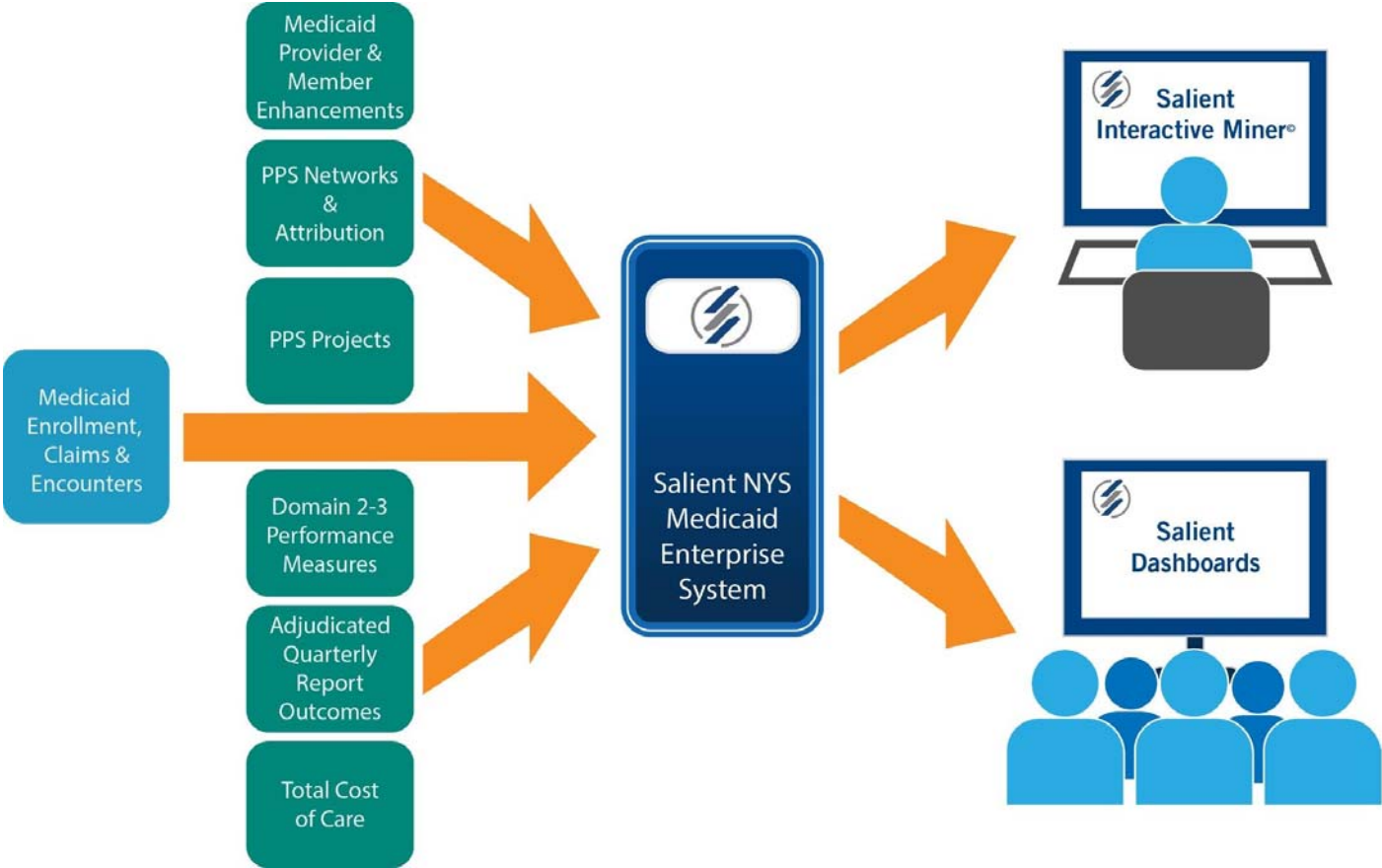
Topic	Who
■ MAPP High Level Overview	Chip Barnes: NYSTEC
■ DSRIP Performance Dashboards	Susan Lepler: Salient
■ Value Based Payment Support	Marc Berg: KPMG
■ Health Homes Care Management	Mary Sara Jones: IBM
■ MAPP Implementation Plan	Matt Sorrentino: PCG
■ IT TOM Update	Todd Ellis: KPMG
■ Q&A	All

# Medicaid Analytics Performance Portal



# DSRIP Performance Dashboards

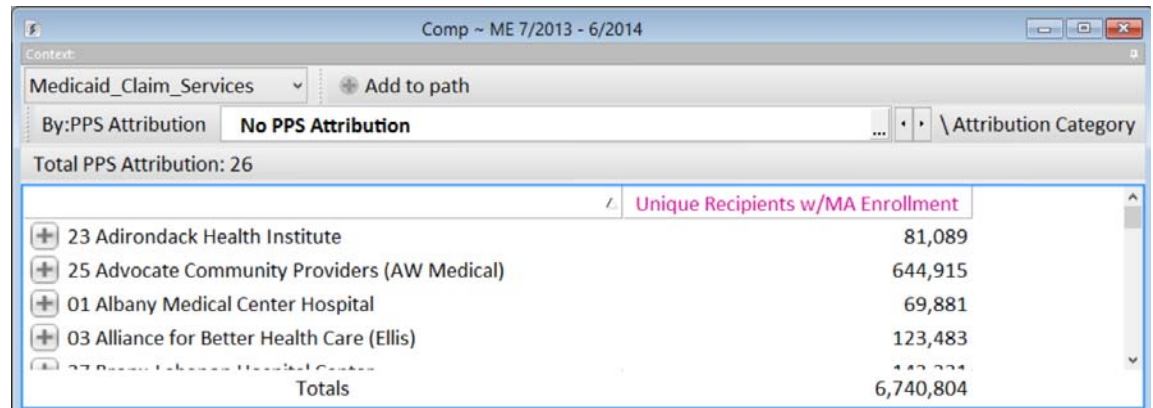
# NYS's Salient Medicaid Enterprise System



# Salient Interactive Miner (SIM) Interface

What is SIM?

- Visual data discovery
- Ad hoc analysis
- Point and click environment
- Sub-second response times



The screenshot shows a web application window titled "Comp ~ ME 7/2013 - 6/2014". The interface includes a "Context" dropdown menu set to "Medicaid\_Claim\_Services", an "Add to path" button, and a filter section with "By: PPS Attribution" and "No PPS Attribution" options. Below the filter, it displays "Total PPS Attribution: 26". The main data area is a table with a column header "Unique Recipients w/MA Enrollment". The table lists several providers and their corresponding recipient counts.

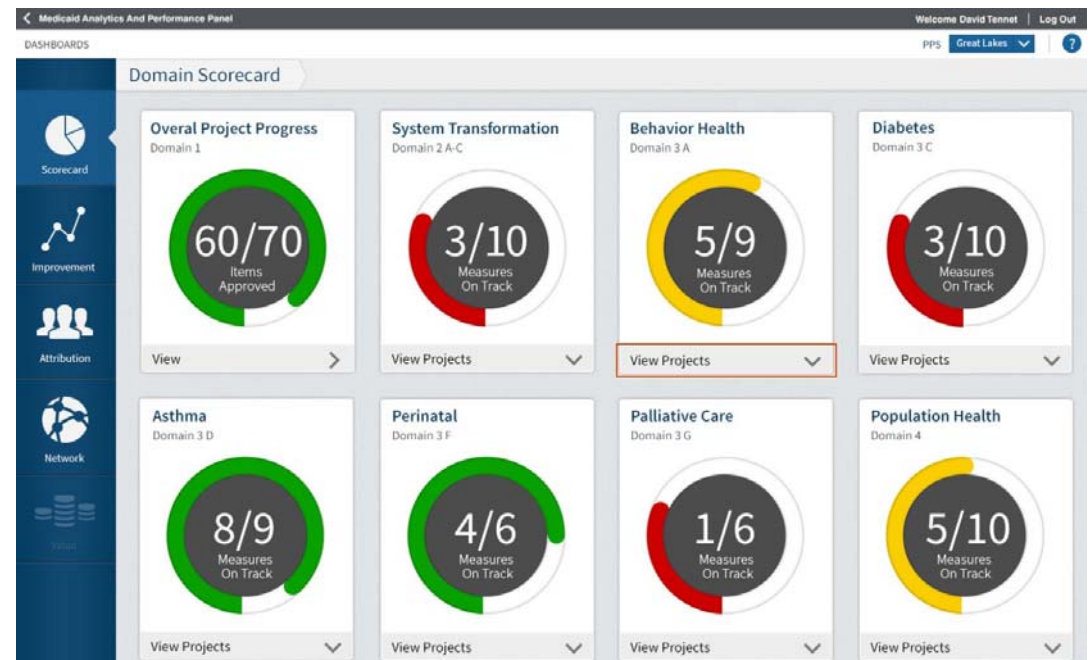
	Unique Recipients w/MA Enrollment
+ 23 Adirondack Health Institute	81,089
+ 25 Advocate Community Providers (AW Medical)	644,915
+ 01 Albany Medical Center Hospital	69,881
+ 03 Alliance for Better Health Care (Ellis)	123,483
+ 07 Albany Medical Center Hospital	143,334
Totals	6,740,804

SIM and DSRIP

- Key component of DOH's strategy for data access to DSRIP community
- 132 SIM analysts across all 25 PPS
- Assessing needs for additional users and training with DOH and KPMG

# Salient's DSRIP Performance Dashboards

- Highly directive, interpretive, consumable views
- Provide insight and actionable information to help PPS manage performance

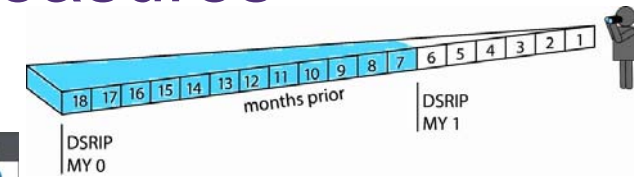


# DSRIP Performance “at a Glance”: Select Projects of Interest

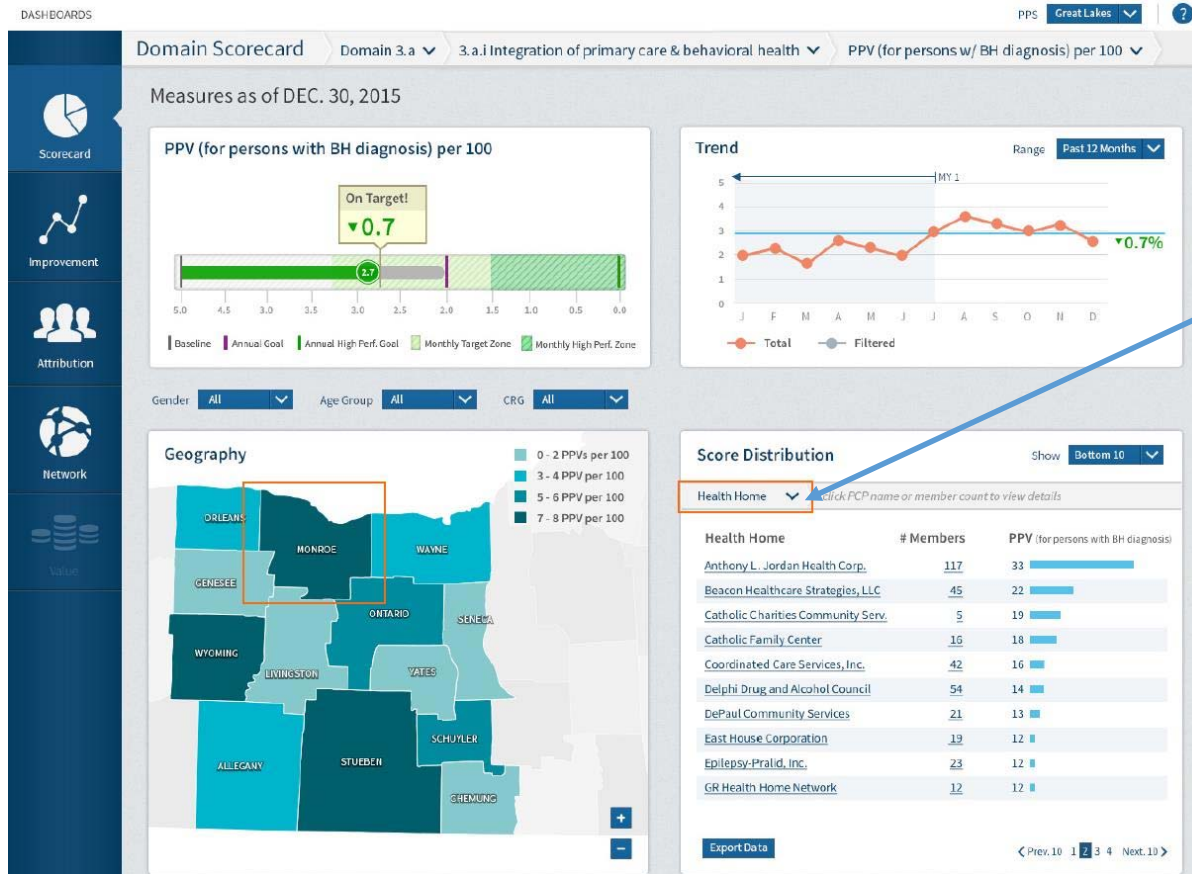




# Track Gap to Goal for Performance Measures



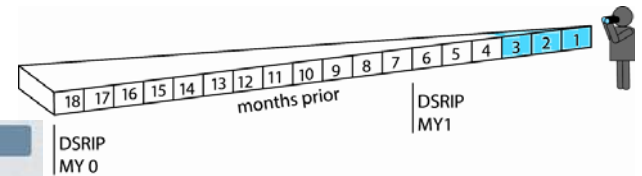
# Deeper Dive into Performance



Filter on Accountable Providers:

- PCP
- Health Home
- Care Management Agency
- MCO

# More Recent Indicators of Progress



# Get to the Member List



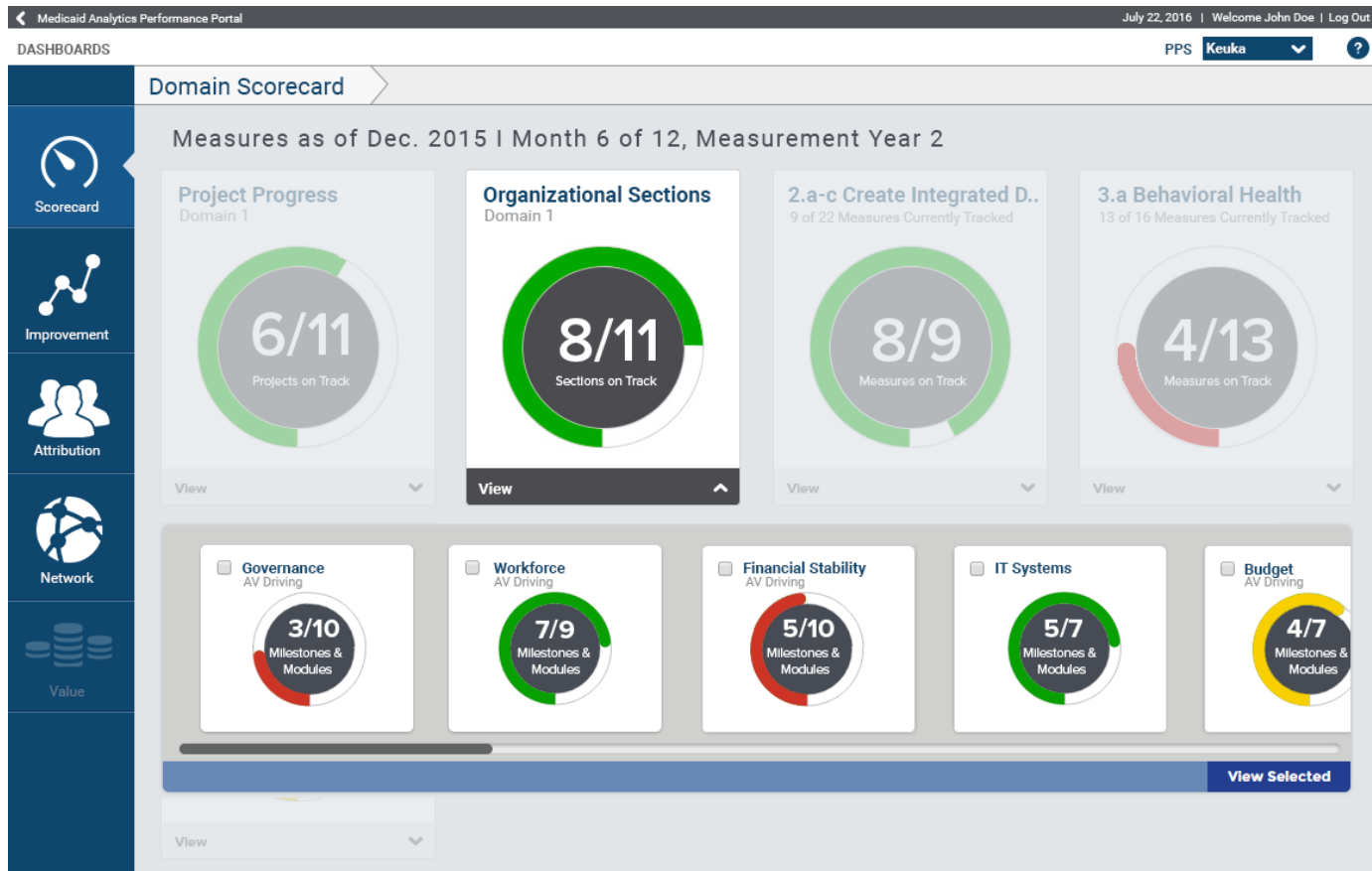
**Domain Scorecard** Domain 3.a 3.a.i PPV (for persons w/ BH diagnosis) per 100 Dr. James Wilson Export for SIM

Dr. James Wilson

Members	CIN	PPVs	Date of Birth	PCP	Health Home	Attribution Length
Vincent Taylor	FF34593A	9	29/08/1945	Dr. James Wilson	HCR	5M
Blossom Fye	GR23950A	8	27/06/1952	Dr. James Wilson	Lake Shore Behavioral Health	3M
Mollie Ko	FR50732S	2	26/11/1954	Dr. James Wilson	GBUAHN	5M
Era Bickley	RE50320A	1	03/05/1961	Dr. James Wilson	Mental Health Services of Erie County	3M
Zandra Ulmer	FR45230B	1	24/06/1971	Dr. James Wilson	Niagara Falls Memorial Medical Center	4M
Vi Stayer	DF49060F	1	01/01/1974	Dr. James Wilson	HCR	11M
Minta Barnett	DN34829S	0	13/06/1978	Dr. James Wilson	Lake Shore Behavioral Health	2M
Shantay Devillier	ER43960C	0	10/01/1981	Dr. James Wilson	GBUAHN	5M
Iris Dymond	RG59306T	0	27/03/1981	Dr. James Wilson	Mental Health Services of Erie County	5M
Aretha Mable	DH43859O	0	26/10/1989	Dr. James Wilson	Niagara Falls Memorial Medical Center	3M
Laurine Wydra	RE45682A	0	15/07/1991	Dr. James Wilson	HCR	5M

Note: This document contains fabricated data and does not include personal health information.

# Monitor Organizational Requirements



# See How Your PPS is Progressing

Medicaid Analytics Performance Portal July 22, 2016 | Welcome John Doe | Log Out

DASHBOARDS PPS Keuka ?

Domain Scorecard > Organizational Sections > Governance

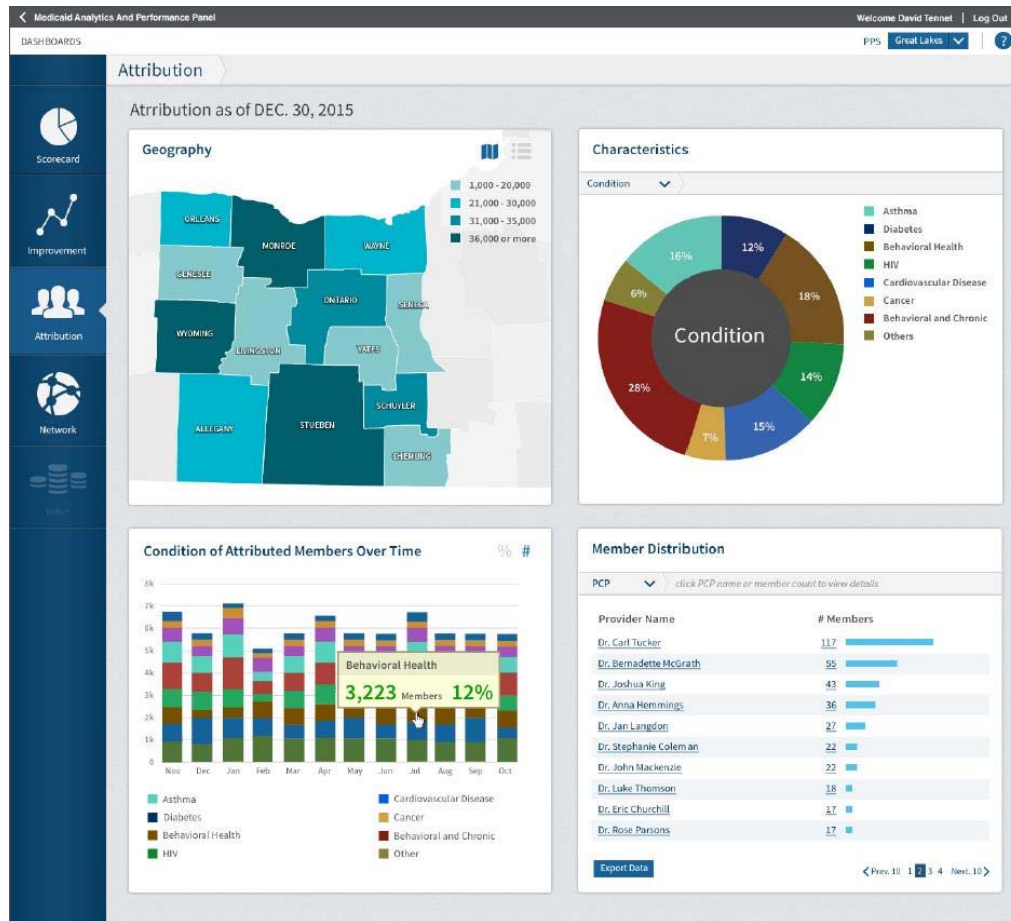
Measures as of Dec. 2015 | Month 6 of 12, Measurement Year 2

● Pass and Ongoing | 
 ✔ Pass and Complete | 
 ▲ Pass (with Exception) and Ongoing | 
 ▲✔ Pass (with Exception) and Complete | 
 ■ Fail

### Governance

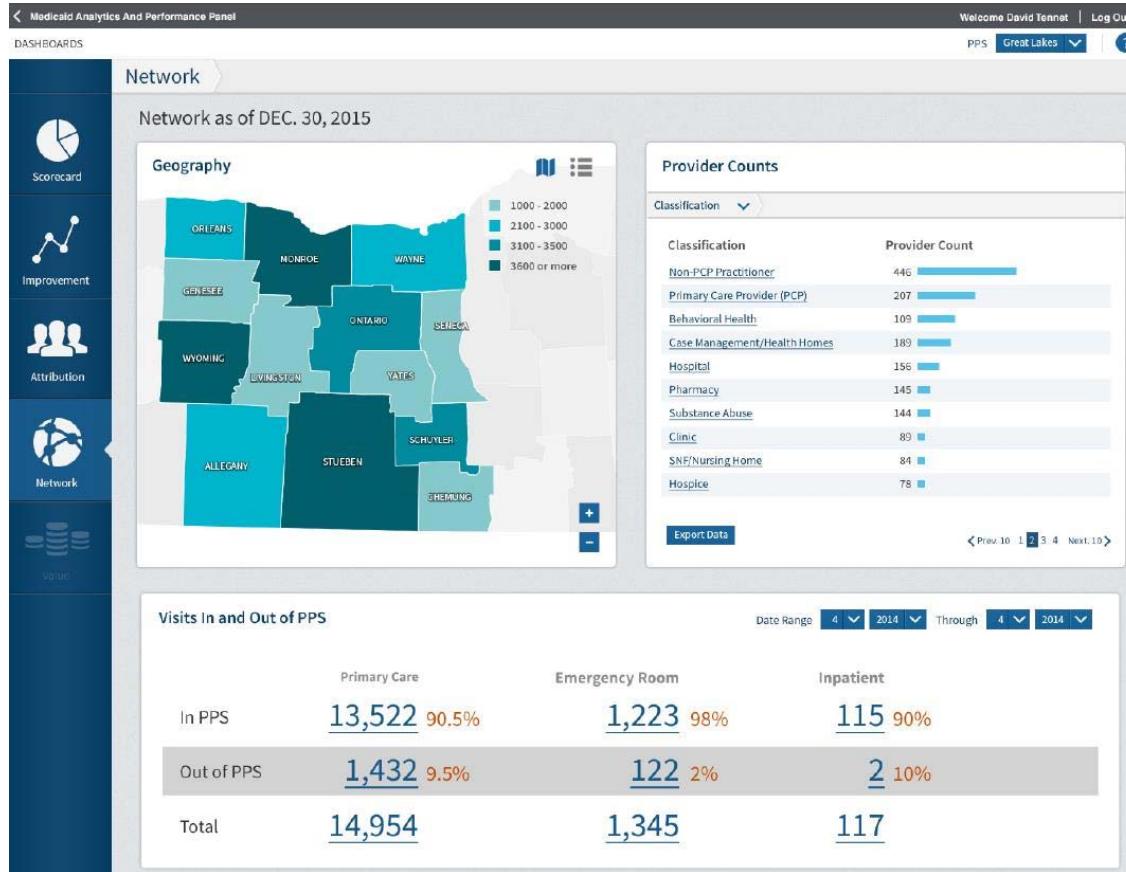
Milestones & Modules	AV	Q1DY1	Q2DY1	Q3DY1	Q4DY1
Finalize governance structure and sub-committee structure	✔	■	▲	▲✔	▲✔
Establish a clinical governance structure, including clinical quality committees for each DISRIP project	✔	■	■	▲	▲✔
Finalize bylaws and policies or Committee Guidelines where applicable	✔	■	■	▲	▲✔
Establish governance structure reporting and monitoring process	✔	■	■	■	■
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)		■	▲	●	✔
Finalize partnership agreements or contacts with CBO's		▲	▲	▲	▲✔
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)		■	■	▲	✔
Finalize workforce communication & engagement plan		■	■	▲	▲✔

# Insight into your Attributed Population





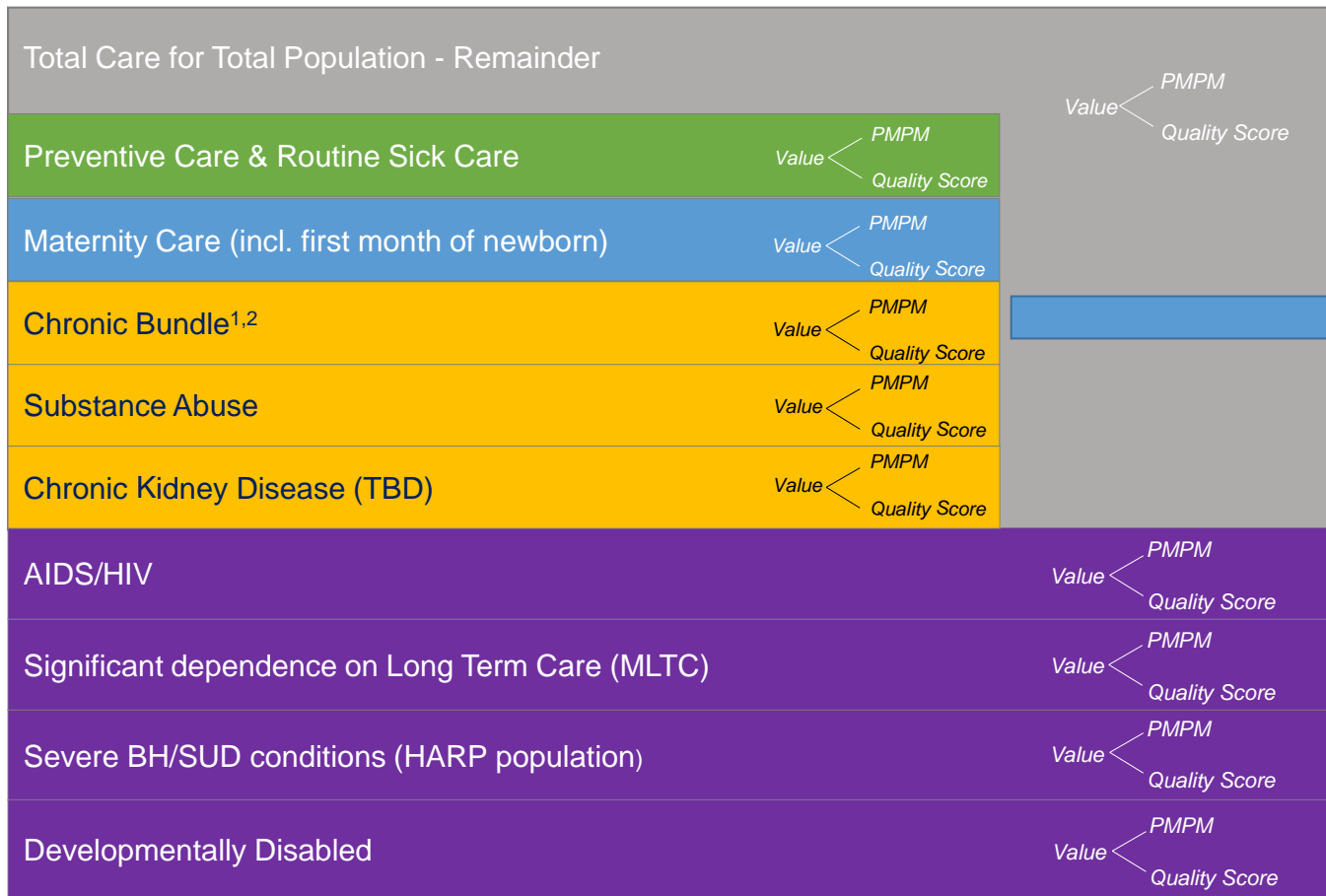
# Understand your Network Composition & Utilization





# Value Based Payment Support

# Value Based Payment support



**Chronic Bundle consists of the following individual bundles:**

Bundle
Diabetes
COPD
Asthma
Hypertension
Coronary Artery Disease
HF
Arrhythmia / Heart Block
Chronic Depression
Bipolar Disorder
Gastro-Esophageal Reflux Disease
Osteoarthritis
LBP

# Value Based Payment support

Total Care for Total Population	<i>Value</i> <ul style="list-style-type: none"> <li><i>PMPM</i></li> <li><i>Quality Score</i></li> </ul>
Significant dependence on Long Term Care (MLTC)	<i>Value</i> <ul style="list-style-type: none"> <li><i>PMPM</i></li> <li><i>Quality Score</i></li> </ul>
Severe BH/SUD conditions (HARP population)	<i>Value</i> <ul style="list-style-type: none"> <li><i>PMPM</i></li> <li><i>Quality Score</i></li> </ul>
Developmentally Disabled	<i>Value</i> <ul style="list-style-type: none"> <li><i>PMPM</i></li> <li><i>Quality Score</i></li> </ul>

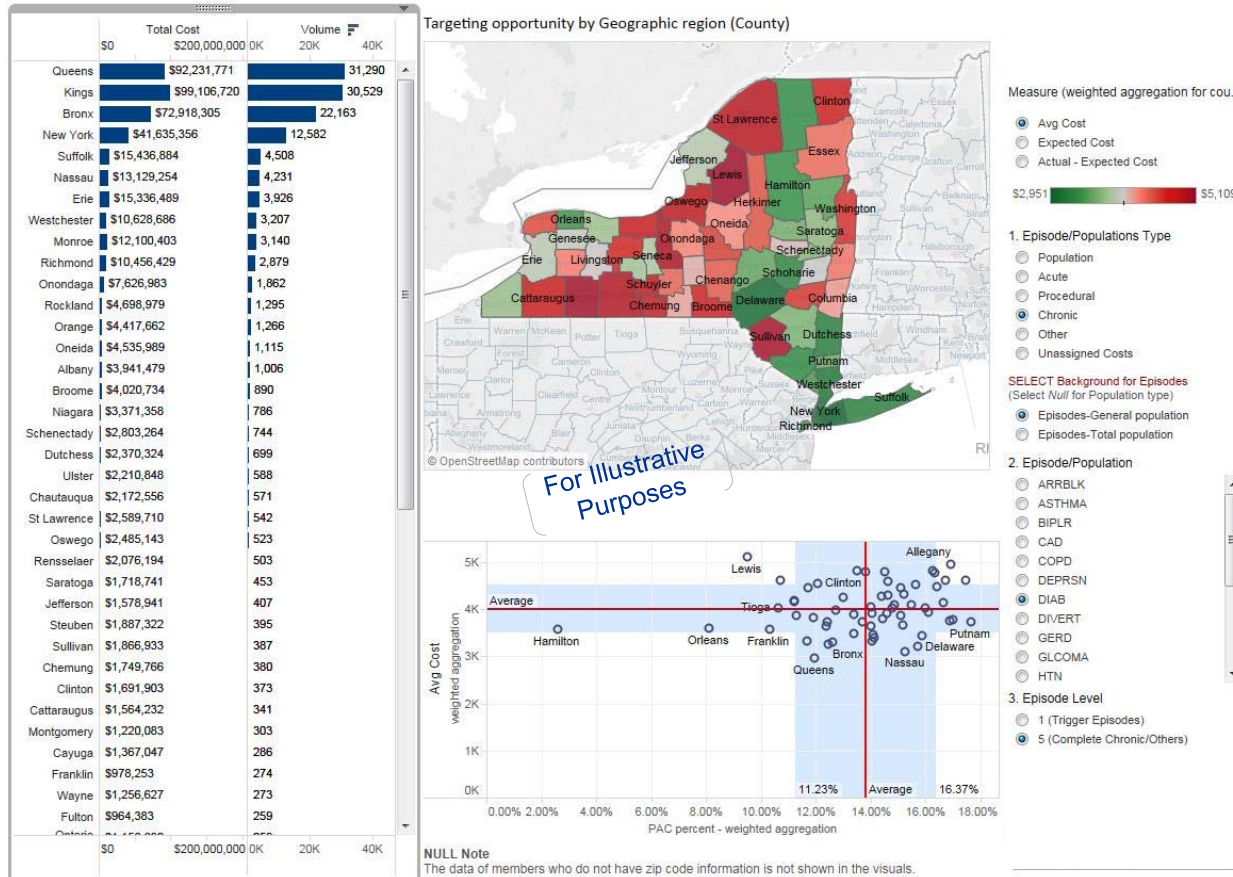
1. Estimate based on combination of HC13 grouper and Dx codes
2. For a specific chronic condition, every 'episode' is one individual with the condition (equivalent to counting beneficiaries in a population)
3. This groups all preventive care activities and routine sick care activities in one bundle. Episode cost = total cost of this care per beneficiary (excl. non-utilizers of preventive nor routine sick care)
4. Xcheck with HC13 whether this description is correct. Only includes cancer of the breast, colon, rectum, lung and prostate.

# Value Based Payment support



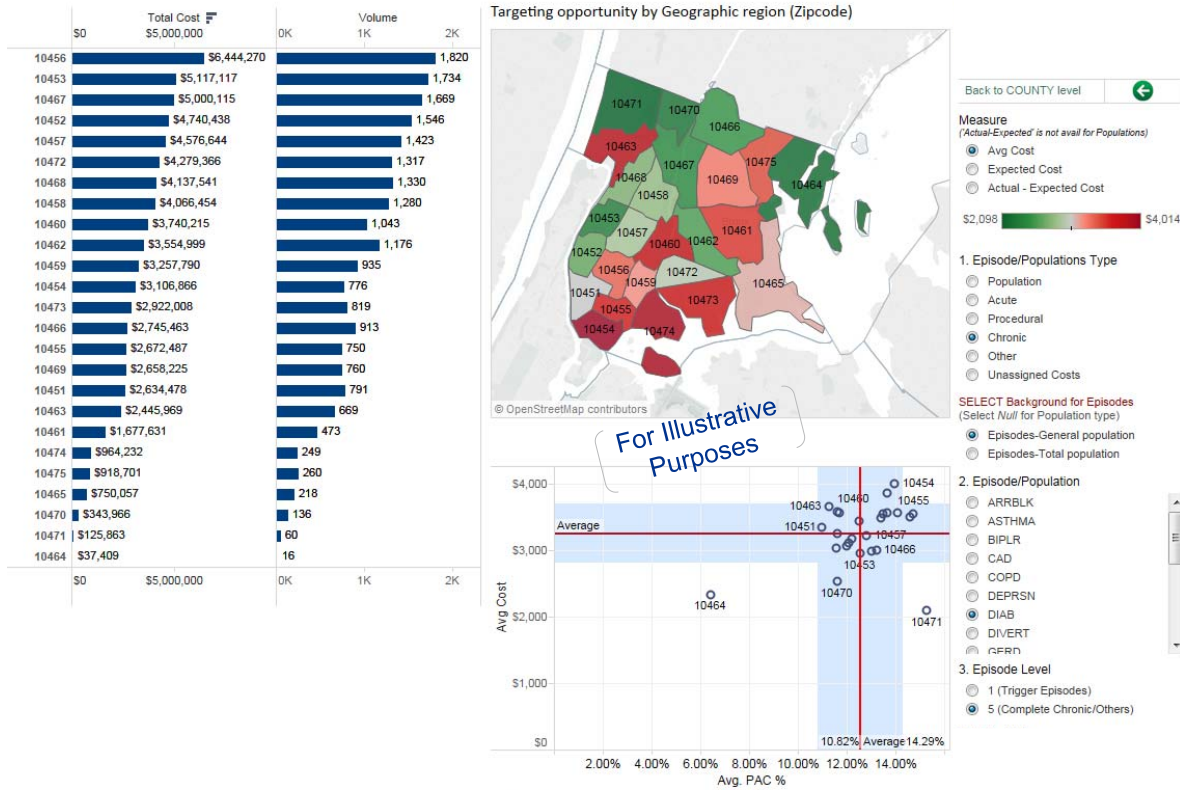
- Dashboard per PPS and per VBP Contractor (ACO/IPA/individual provider)
- Dashboard per MCO

# Value Based Payment support



- Provides insight of **Average Member Costs and Quality Scores** by geography, sub-populations and episode types with additional drill down views to zip code level and provider.
- Enabling rapid measurement of disparities and variation in spend across the state.

# Value Based Payment support



For Illustrative Purposes

**NULL Note**  
The data of members who do not have zip code information is not shown in the visuals.

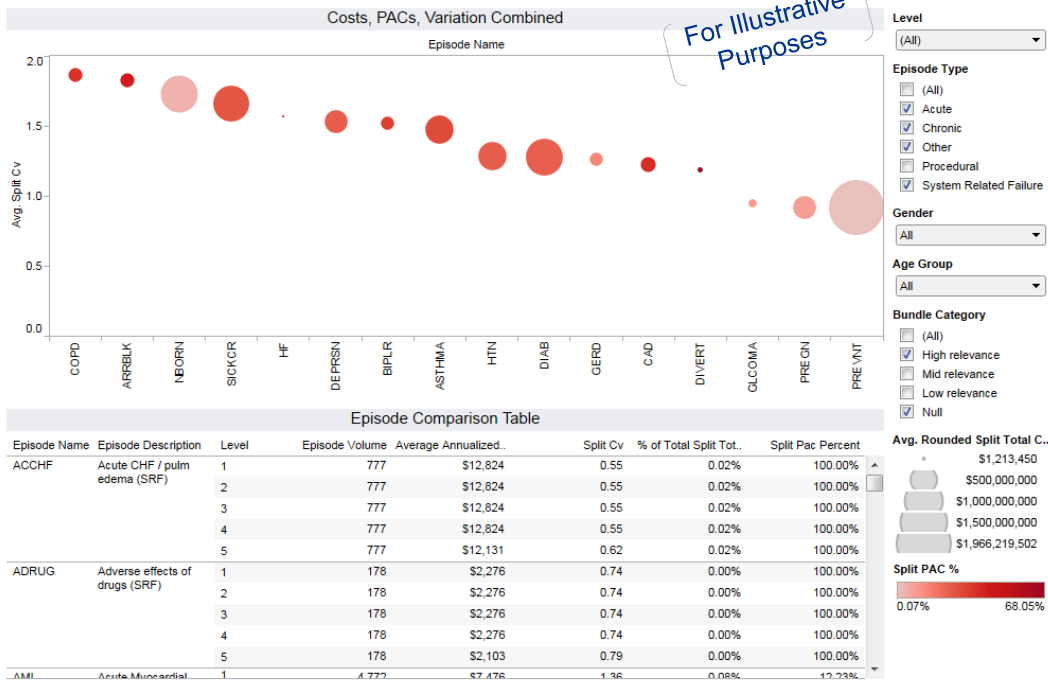
# Where are the opportunities for improvement (across NYS, PPS Region, provider)?

## Targeting Episode Opportunity

Focus on episodes with high proportion of costs, high cost variability and high PAC percent. ONLY costs bundled by episodes are shown in this tab.

The bubble plot below presents information for episodes at the level at which they are complete. The Episode Comparison Table shows relevant information for all episodes at all levels. Note: Only episodes with a frequency of greater than 50 will yield a reliable average cost and the CV may be distorted for episodes with fewer than 200 episodes.

Interaction: Click on a bubble in the top chart to see the detail for all levels for that episode in the table below.



- Finding opportunities for improvement and savings by looking at:
  - variation in episode costs
  - total volume
  - % of costs that are Potentially Avoidable Complications (PACs).

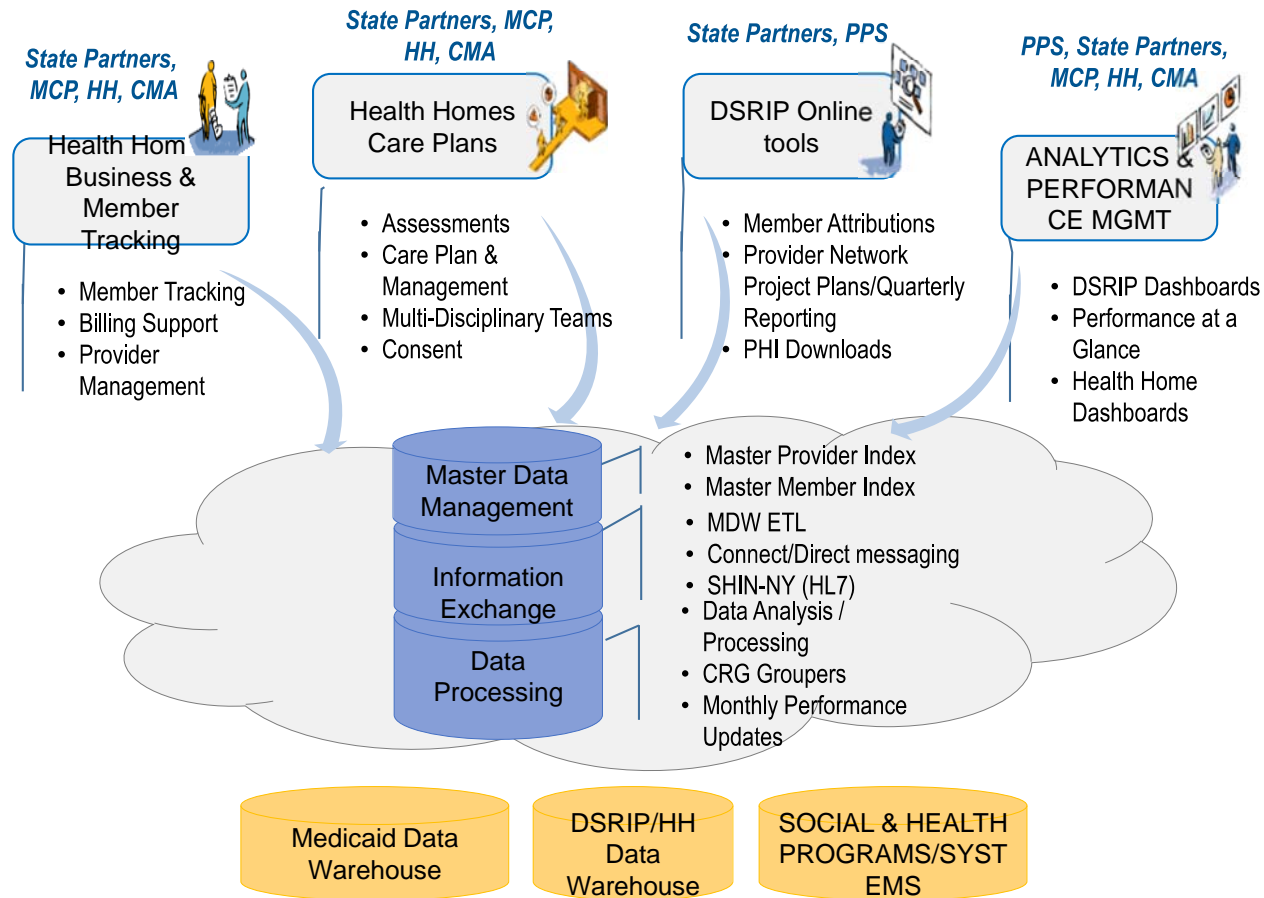
**LEGEND:**

- X-Axis: Episodes
- Y-Axis: Co-efficient of Variation
- Size of Bubble: Split Total Costs
- Color of Bubble: Split PACS %

# Health Homes Care Management




# Medicaid Analytics Performance Portal



Home Care Plans Inbox Calendar Enter a Reference Number

Vincent Taylor x

**Vincent Taylor** ACTIONS



**Vincent Taylor** 24001

1760 N Wells St, Chicago, Illinois, 60614 [Map](#)

Born 10/26/1966, Age 46

Marital Status: Divorced  
Community: Socially isolated  
Living Arrangements: Lives alone

312 785 1258 vtaylor@gmail.com

INSURANCE: Medicaid

RISK LEVEL: Risk Level Information

HEALTH BEHAVIOURS: Unhealthy Diet, Sedentary life-style

CARE PLANS: No Care Plan


EMERGENCY CONTACT: Maria Taylor 312 355 6739


PRIMARY CARE PHYSICIAN: Dr. James Wilson 312 565 7811 ext 8745


Home Notes Attachments Communications Client Contact

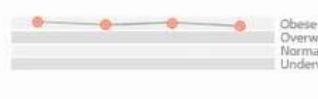
**Home**

**Clinical Summary**

Pulse 7/14/2013: 90bpm 

Blood Pressure 7/14/2013: 150/90mmHg 

Blood Glucose 7/14/2013: 133mg/dL 

BMI 7/14/2013: 33 

**Diagnosis**

Description	Date
Degenerative disc disease	5/12/2013
Diabetes Mellitus Type 2	5/20/2013

**Lab Results**

Description	Date
HbA1c, 10%	5/20/2013

**Medications**

Description	Date
Difene, 50 milligrams (mg), 1 tablet, 3 times a day	5/20/2013 -
Metformin, 500 (mg), twice a day	6/20/2013 - 9/13/2014

**Allergies**


Description	Date
Penicillin, causes hives, moderate severity	5/12/2013

Note: This document contains fabricated data and does not include personal health information.

Home Care Plans Inbox Calendar Enter a Reference Number

Vincent Taylor Vincent Taylor Care Plan

**Vincent Taylor Care Plan** ACTIONS

Vincent Taylor  46 years

**Vincent Taylor Care Plan**

Created 7/15/2013 by Susan Brown  
 Owner Susan Brown  
 Next Review 11/19/2013

Diabetes Mellitus Type 2  
 Medicaid




Start 7/15/2013 Expected End

Home Timeline Progress Reviews Notes Assessments Agreements Collaboration Attachments Admin

**Home**

**Mental Health Improvement (3)** Pe

Expected End Date: 7/18/2014 Last updated by Susan Brown 9/24/2013  
 Created By: Susan Brown 7/15/2013

-  **Individual Counselling** In Prog  
 Duration: 7/18/2013 - 7/18/2014 Last updated by Jane Smith 9/30/2013
-  **Mental Health Education Group** Ac  
 Added: 9/24/2013 - 3/24/2014
-  **Depression Support Group** In Prog  
 Duration: 10/2/2013 - 6/2/2014

**Independent Living** Pending

(3) Expected End Date: 3/2/2014 Last updated by Susan Brown 9/24/2013  
 Created By: Susan Brown 9/2/2013

**Objectives**

- New Objective
- Independent Living
- Asthma Management
- Children to Thrive
- CHF Risk Management
- Diabetes Management
- Disability Management
- Home Care and Safety Mana
- Hypertension Management
- Maintain Healthy Diet
- Mental Health Improvement
- Pain Management
- Spiritual Fulfilment

**Recommended Activities**

**All Activities**

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# MAPP Implementation Plan (IPP)

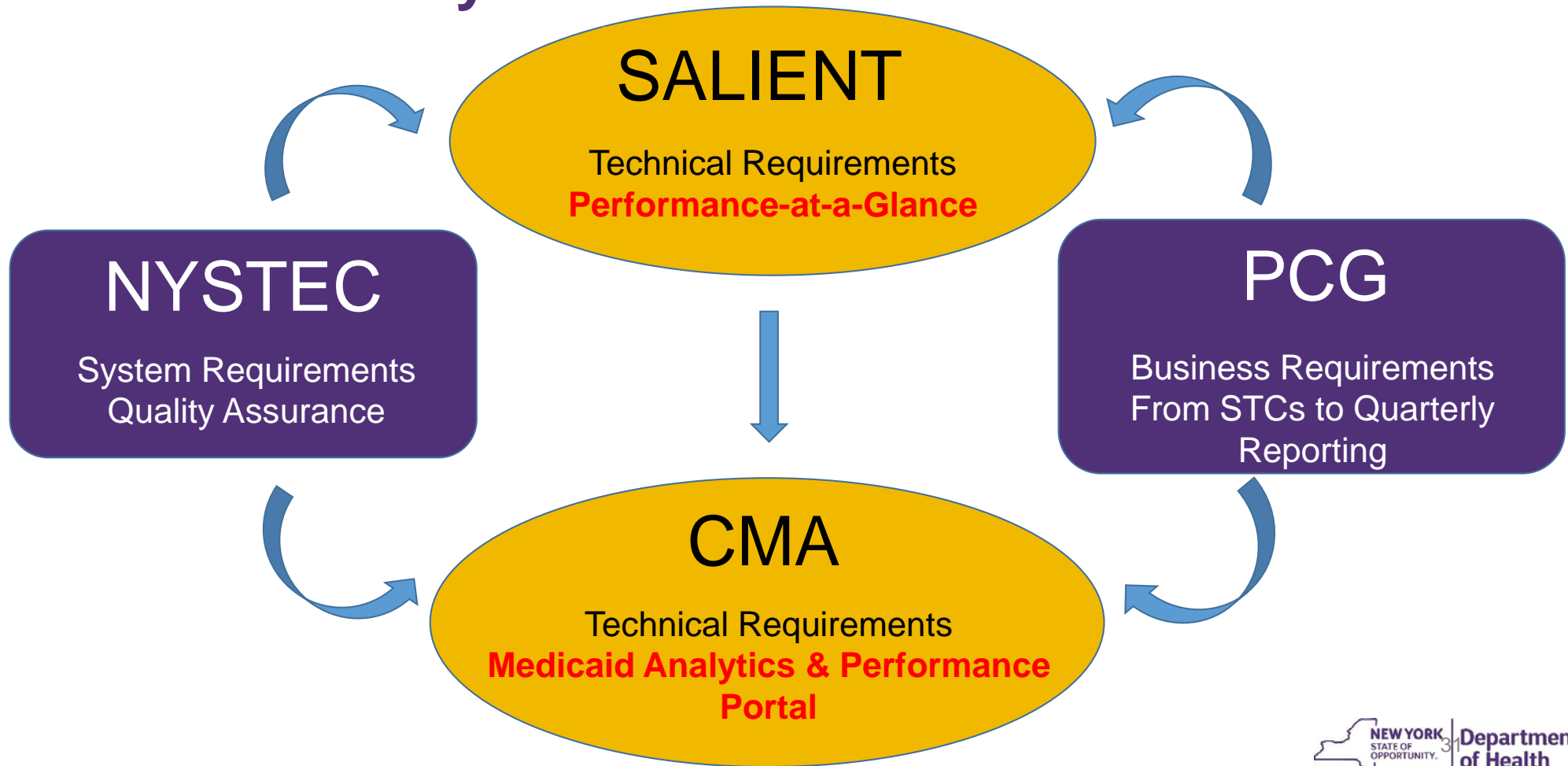
# MAPP – IPP & Performance Dashboards

- As the Independent Assessor, PCG is charged to interface with Salient and CMA in tandem with NYSTEC
- Identify business needs based on translation of the **Standard Terms and Conditions** (STCs)
  - STCs require quarterly reporting to monitor PPS performance throughout DSRIP
  - Quarterly reports will be used to evaluate the earning of Achievement Values, which translate into DSRIP payments
  - MAPP IPP is the tool built to facilitate this reporting process and will be used throughout the life of DSRIP
- Develop and design business and functional requirements for the Implementation Plan Project (IPP) reporting and Performance-at-a-Glance dashboard applications
  - Perform user acceptance testing and support quality assurance processes

# MAPP – IPP & Performance Dashboards

- CMA
  - Program, develop, and maintain the IPP application
  - Support tool from end user standpoint (technical, not content, support)
  - Resolve defects and/or performance issues with the application
- Salient
  - Program, develop, and maintain visual analytics platform for ongoing performance monitoring
  - Design and develop AV and payment scorecard for official quarterly report performance results

# Who are the Players?



# Recent Highlights & Looking Forward

## JUL 2015

- IPP DY1 Q1 reports to baseline PPS Organizational and Project planned activities submitted



## OCT 2015

- IPP DY1 Q2 reports due - begins process of PPS ongoing quarterly activity updates
- PPS to submit Organizational work plan steps for Workforce
- New functionality released to allow for PPS/IA interaction within the IPP tool



## JAN 2016

- IPP DY1 Q3 reports to include integrated functionality with Network Tool
  - Selection of providers participating by project
  - Ability to identify providers when Domain 1 Project Requirements are completed
- Workforce ongoing reporting
- Performance at a Glance Accountability View to Go-Live



# Recent Highlights & Looking Forward

- **In the Pipeline for April 2016 & Beyond**
  - IPP DY2 reports complete transition to ongoing updates
  - Performance at a Glance Scorecard View to Go-Live
  - Statewide Performance View
  - Primary Care Roadmap incorporated into MAPP
- **We want your feedback on IPP!**
  - We understand the need to constantly re-evaluate and make improvements to these applications that are meant to be efficient and effective state-wide tools throughout DSRIP
  - Please circulate any usability and/or functional systems improvements you would like to see through your Performance Facilitator

# IT Target Operating Model Project Overview

# IT Target Operating Model Project Overview:

To assist with adaptation to the new IDS environment, the DSRIP Support Team (DST) is collaborating with PPSs to define an IT Target Operating Model

## OBJECTIVE

- **Generate a holistic target operating model:** Generate patient-centric scenarios to demonstrate target state use cases that align with the goals of the 2 selected DSRIP projects **(2.a.i & 3.a.i)**
- **Identification of system requirements:** Assist PPSs to extract detailed system requirements needed to comply with DSRIP project requirements and enable an integrated delivery system

## SCOPE

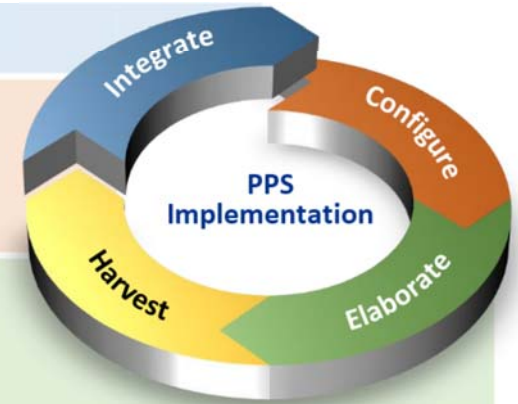
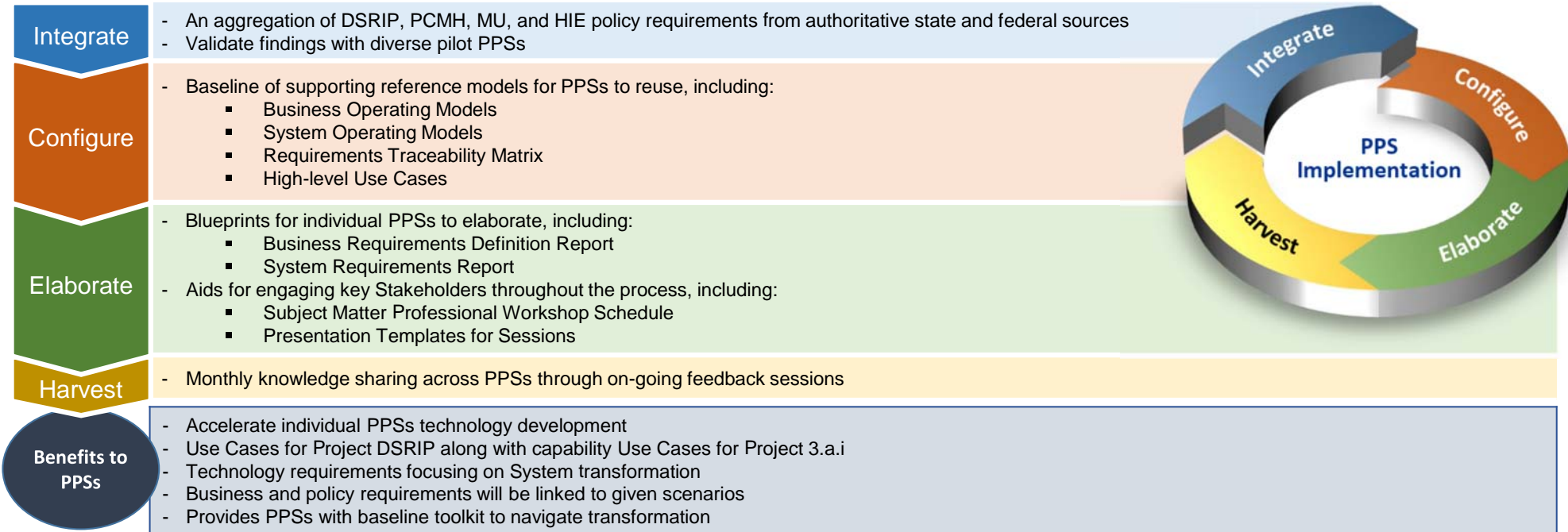
- **Focus on 2 foundational DSRIP Projects:** Projects 2.a.i and 3.a.i were specifically selected for elaboration because they provide the building blocks needed to enable the majority of additional DSRIP Projects
- **Development of comprehensive scenarios:** Leveraging a detailed capability model allows us to craft a select number of patient-centric scenarios that will provide wide-ranging coverage of required capabilities needed in an IDS target state
- **Validation with a variety of PPSs:** An agile development method will be used to incorporate feedback from multiple PPSs that were selected based on the complexity and diversity of their target state

## APPROACH

- **Conduct pilot design sessions:** A series of design workshops will be conducted with 6 pilot PPSs to review each scenario and complimentary models and requirements
- **Generate DSRIP specific IT TOM:** Each pilot PPS will be provide feedback on needed capabilities, requirements and other design elements to create an IDS target operating model
- **Share observations and findings:** Throughout the project we will share results with the DSRIP community, and upon conclusion produce deliverables that can be used by all PPSs

# IT Target Operating Model Master Toolkit for PPSs

The Enterprise Reference Architecture will help to integrate DSRIP specific polices and scenarios to provide PPSs with a DSRIP IT Target Operating Model toolkit of deliverables to accelerate PPSs path to transformation.



# Summary of the IT TOM Toolkit Components

