Data-Driven Health Outcomes: A Framework for Sustainable Success

Jonas Varnum
Population Health Management
Senior Director, Health Catalyst
The Challenge: Rising Health Spend....

Healthcare spending growth outpaces the growth of the U.S. economy

and healthcare prices grow faster than prices in the general economy
...Has Led To

The Wave of Clinical Integration
Are ACOs Successful?

Current Government Analysis

Pathways To Success: A New Start For Medicare's Accountable Care Organizations

Seema Verma

Exhibit 1: All Upside-Only ACOs

<table>
<thead>
<tr>
<th>MSSP Track</th>
<th>Number of participants</th>
<th>Total spending ($B)</th>
<th>Total benchmark amount ($B)</th>
<th>Shared savings payments ($B)</th>
<th>Shared losses recouped ($B)</th>
<th>Net impact ($B)</th>
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</thead>
<tbody>
<tr>
<td>Track 1</td>
<td>410</td>
<td>$76.177</td>
<td>$76.718</td>
<td>$0.590</td>
<td>$0</td>
<td>$0.049</td>
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</table>

Source: CMS analysis. Data for performance year 2016. A negative net impact means program savings; a positive net impact means program costs.

Exhibit 4: Two-Sided ACOs

<table>
<thead>
<tr>
<th>MSSP Track</th>
<th>Number of participants</th>
<th>Total spending ($B)</th>
<th>Total benchmark amount ($B)</th>
<th>Shared savings payments ($B)</th>
<th>Shared losses recouped ($B)</th>
<th>Net impact ($B)</th>
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</thead>
<tbody>
<tr>
<td>Track 2 &amp; 3</td>
<td>22</td>
<td>$4.548</td>
<td>$4.659</td>
<td>$0.088</td>
<td>-$0.009</td>
<td>-$0.033</td>
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</table>

Advocacy and External Analysis

SPECIAL ARTICLE

Medicare Spending after 3 Years of the Medicare Shared Savings Program

J. Michael McWilliams, M.D., Ph.D., Laura A. Hotfeld, Ph.D., Bruce E. Landers, M.D., M.B.A., Pasha Hamed, M.A., and Michael E. Chernew, Ph.D.

Estimates of Savings by Medicare Shared Savings Program Accountable Care Organizations


2013-2015: -$358 Million in Net Shared Savings Payments (CMS saved money)

2013-2015: -$541.7 in net Shared Savings Payments (CMS saved money)
Capabilities to Scale Outcomes Improvement

Leadership, Culture and Governance
Where do we focus?

What should we be doing?
Best Practice

How do we transform?
Adoption

How are we doing?
Analytics

Clinical Outcomes
Cost Outcomes
Experience Outcomes

Outcomes Improvement

How are we compensated?
Financial Alignment
Population Health Management
A Framework for Transformation

1. Data Transformation
   PHM leadership lays groundwork for a high-functioning analytic platform
   **KEY ACTIVITIES**
   1. Prioritize data sources, starting with claims data
   2. Educate stakeholders on the available data
   3. Define supporting logic—like attribution
   4. Invest in staffing

2. Analytic Transformation
   Analytics leadership builds a structure to identify and evaluate opportunities
   **KEY ACTIVITIES**
   1. Ensure baseline understanding of current requirements, goals
   2. Interview stakeholders for context
   3. Assess available data to identify quick wins, long-term focus areas
   4. Synthesize and prioritize opportunities
   5. Plan for ongoing evaluation, analysis

3a. Financial Transformation
   Financial leadership balances risks and helps set a sustainable course forward
   **KEY ACTIVITIES**
   1. Align PHM with financial plans
   2. Look to benchmarks to set expectations
   3. Ensure you’re paid for value you provide
   4. Pace utilization efforts carefully
   5. Increase ability to understand true cost of care

3b. Care Transformation
   Clinical leadership identifies and implements appropriate changes in care delivery
   **KEY ACTIVITIES**
   1. Streamline your approach to quality measures
   2. Optimize care management
   3. Shore up primary care infrastructure
   4. Seek opportunities for inpatient transformation
   5. Ensure appropriate site of care
   6. Develop patient engagement strategy

**SUCCESS**
- **Near term**
  - Meet contractual requirements in FFV contracts
  - Remain successful in FFS business
- **Long term**
  - Better quality of care
  - Lower costs
  - Stronger organization
  - Healthier community

Transformative activities and investments that grow your ability to deliver the highest quality, most cost-effective, and most care for patients across the continuum
PHM Data Decision Transformation

Spreadsheet Silos

- Silos or pockets of analysis
- Conflicting spreadsheet reports and interpretations of data
- Battles over data ownership
- Most time spent on hunting for and gathering data
- Focus is on is the data “right”

Align PHM data selection process with strategic direction, available data and data source opportunities, clinical improvement lines, and PHM goals.

1. Use data from various data sources to determine opportunities across continuum.
2. When appropriate, align data with qualitative review.
An Approach to PHM Intervention Identification

1. Start with a charter. Clarify scope and responsibilities per team member

<table>
<thead>
<tr>
<th>Charter Topic</th>
<th>Specifics</th>
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</table>
| Team Purpose: | 1. Identify opportunities to reduce total cost of care in various contracts  
2. Develop and oversee methodology, definitions, and data standards to guide opportunity identification  
3. Document and measure quality and financial interventions |
2. Reduce CIN / ACO regulatory burden by tactically measuring and improving key metric areas. |
| Decision Rights (RACI Model): | 1. Health Catalyst and the Client identify members of the project team and their roles |

2. Develop cadence of intervention identification at various depths of intelligence

- Level 1 Depth
  - Starter set review w/ minimal client discussion

- Level 2 Depth
  - Directional strategic guidance

- Level 3 Depth
  - PHM longitudinal measurement

- Population-specific and/or Provider Group-specific review of key performance indicators

- Combine quantitative data with qualitative client and stakeholder context to directionally determine best opportunities and interventions

- Measure and track interventions across connected data sets (e.g. clinical, claims, and cost-related) to project and determine initiative success
Data Visibility Improves Payment, Quality

**STARTING Stats**

- **Academic medical center** engaged in value-based arrangements
- **Participant in DSRIP** (Delivery System Reform Incentive), an alternative payment model based on clinical outcomes for Medicaid and low-income uninsured patients
- **Needed** more timely, actionable data to guide their population health improvement efforts. *Which strategies are—and are not—working to improve our DSRIP performance?*

**SUCCESS in Population Health**

With new insight into opportunities for improvement and more effective prioritization of resources, UTMB achieved:

- **$2.1 million additional pay-for-performance dollars**, achieved after implementation of analytics application
- **Improvement in 23 of 32 performance measures**—nearly 72 percent
  - **Chronic diabetes care performance**, including 39.2% increase in completion/documentation of annual foot exam
  - **Chronic heart disease care performance**, including 18.6% improvement in hypertension screening, followup in completion/documentation of annual foot exam
  - **Immunizations and screening performance**, including 34.7% increase in the number of adults with up-to-date immunizations
Using PSYCKES to Demonstrate Value

Volume to Value: A Path Towards Data-Driven Outcomes

Erica Van De Wal-Ward
Medical Informatics Project Director
PSYCKES Team
September 26, 2019
What is PSYCKES?

- Secure, HIPAA-compliant online application that shares information from Medicaid billing data and other state administrative databases
- Provides reports and tools to support quality improvement, population health management, clinical decision making, and care coordination
- Captures Medicaid enrollees in the behavioral health population (psychiatric or substance use service/diagnosis or psychotropic medication billed to Medicaid)
- Contains information across all treatment settings, such as Managed Care plan, HARP status, medications, medical and behavioral health outpatient and inpatient services, ER, care coordination, residential, labs, and more!
PSYCKES Quality Flags & Alerts

- Over 60 quality indicators summarized, with flags for individual patients needing review, such as:
  - No diabetes monitoring for individuals with diabetes and schizophrenia
  - Low medication adherence for individuals with schizophrenia
  - Antidepressant trial of < 12 weeks for individuals with depression
  - High utilization of inpatient/emergency room, hospital readmission

- PSYCKES Alerts & Incidents include:
  - Suicide Attempt
  - Suicidal Ideation
  - Self Harm/Self Poisoning
  - Opioid Overdose past year, past 3 years
  - Overdose Risk – Opioid & Benzodiazepine co-prescribing past year
  - Positive suicide screen (C-SSRS), depression screen (PHQ-9)
Using PSYCKES for a Value Proposition
Using PSYCKES to Demonstrate Value

▪ My QI Report and Statewide Report
  – Show how your agency is successful at addressing a quality concern, such as high hospital utilization
  – Compare your agency’s prevalence rate on quality measures to region and state rates
  – Filter quality indicator reports by setting, MC Plan, etc.

▪ Recipient Search
  – Show high volume of clients your agency serves with a specific condition, such as diabetes
  – Opportunity and expertise with a population of interest
<table>
<thead>
<tr>
<th>Indicator Set</th>
<th>Population</th>
<th>Eligible Population</th>
<th># with QI Flag</th>
<th>Regional %</th>
<th>Statewide %</th>
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<tbody>
<tr>
<td>BH QARR - DOH Performance Tracking Measure - as of 10/01/2018</td>
<td>All</td>
<td>2,558</td>
<td>1,369</td>
<td>53.52</td>
<td>63.38</td>
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<tr>
<td>BH QARR - Improvement Measure</td>
<td>All</td>
<td>2,371</td>
<td>965</td>
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<td>General Medical Health</td>
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<td>10,959</td>
<td>2,158</td>
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<td>High Utilization - Inpt/ER</td>
<td>All</td>
<td>11,025</td>
<td>2,228</td>
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<td>Polypharmacy</td>
<td>All</td>
<td>3,129</td>
<td>523</td>
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<td>Preventable Hospitalization</td>
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<td>Readmission Post-Discharge from any Hospital</td>
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<td>1,851</td>
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<td>Treatment Engagement</td>
<td>(0-64) yrs</td>
<td>1,586</td>
<td>499</td>
<td>31.46</td>
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### MAIN STREET MENTAL HEALTH CENTER

**Quality Indicator Overview As Of 04/01/2019**

#### Indicator Set

<table>
<thead>
<tr>
<th>Indicator Set</th>
<th>Population</th>
<th>Eligible Population</th>
<th># with QI Flag</th>
<th>%</th>
<th>Regional %</th>
<th>Statewide %</th>
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<td>126</td>
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<td>15.22</td>
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<td>229</td>
<td>70.46</td>
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<td>279</td>
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<td>All</td>
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<td>34</td>
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<td>Substance Use Disorders - as of 10/01/2018</td>
<td>Adol &amp; Adult (13+)</td>
<td>130</td>
<td>99</td>
<td>76.15</td>
<td>63.97</td>
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<td>Treatment Engagement</td>
<td>(0-64) yrs</td>
<td>241</td>
<td>80</td>
<td>33.2</td>
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### Provider Search

**Main Street Mental Health Center**

**Quality Indicator Overview As Of 04/01/2019**

**Region:** All  
**County:** All  
**Site:** All  
**Program Type:** All  
**Age:** All  
**MC Product Line:** All  
**Managed Care:** All  
**DSRIP PPS:** All

---

**Indicator Set:** High Utilization - Inpt/ER  
**Indicator:** 2+ Inpatient / 2+ ER - Summary

<table>
<thead>
<tr>
<th>Managed Care Name</th>
<th>Total Agency MCO Census</th>
<th>Eligible Population for QI Flag</th>
<th># with QI Flag</th>
<th>%</th>
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<td>Healthfirst PHSP, Inc.</td>
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<td>Fidelis Care New York</td>
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<td>MetroPlus Health Plan</td>
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<td>838</td>
<td>218</td>
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<td>UnitedHealthcare Community Plan</td>
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<td>Affinity Health Plan</td>
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<td>537</td>
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<td>WellCare of New York</td>
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<td>VNSNY Choice Select Health</td>
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<td>Amida Care</td>
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<td>11</td>
<td>3</td>
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<td>CDPHP</td>
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<td>2</td>
<td>1</td>
<td>50</td>
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1,147 Recipients Found

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<th>Name</th>
<th>Medicaid ID</th>
<th>DOB</th>
<th>Gender</th>
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<td>TUFOUqz0</td>
<td>WbAmOAOq2</td>
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<td>R6 LQ NTQ</td>
<td>2+ ER-Medical, 2+ Inpt-Medical, 4+ Inpt/ER-Med, No MAT Utilization - OUD, No OUD MAT Initiation - 30d, Readmit 30d - Medical to Medical</td>
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<tr>
<td>TUVSTEbORQ</td>
<td></td>
<td></td>
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<td>SFVOREnFWQ</td>
<td>WVApMTaoNFY</td>
<td>MTAIMTUMTatM6</td>
<td>R6 LQ NDy</td>
<td>2+ Inpt-BH, 2+ Inpt-MH, Adher-AP, BH QARR - DOH, POP Cloz Candidate, POP High User</td>
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<td>R6 LQ ND6</td>
<td>2+ ER-Medical</td>
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<td>MDEIMTUMtM6</td>
<td>TQ LQ Mp2</td>
<td>BH QARR - DOH, No SUD Tx Engage</td>
</tr>
<tr>
<td>UabWIVbSbIUfoVUVM</td>
<td></td>
<td></td>
<td></td>
<td>HIP (EmblemHealth)</td>
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<tr>
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<td>MTEIMDalMTasNm</td>
<td>TQ LQ NTE</td>
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<td>2+ ER BH, 2+ ER MH, 2AP, 4PP(A), BH QARR - DOH, No Gluc/HbA1c &amp; LDL-C - AP, No HbA1c &amp; LDL-C (DM &amp; Schiz), No LDL-C - AP</td>
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<td>TQ LQ NTa</td>
<td>Amerigroup New York</td>
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Using PSYCKES for Clinical Decision Making & Care Coordination
Clinical Summary

SMITH, JOHN
Clinical Summary as of 9/9/2019

DOB: MTIMMT1MTauCQ (M9a Yrs)
Address: MAn VUnTVETEV QVZF QVBU OCqoLA VqFMREVOLa Tbe MTrOYD

Medical ID: Qb2sMTYCOUI
Managed Care Plan: Affinity Health Plan (HARP)

Medicare: No
HARP Status: Eligible Pending Enrollment (H9)

Managed PPS: Westchester Medical Center PPS

Current Care Coordination
Health Home (Enrolled) - HUDSON VALLEY CARE COALITION INC - Status: Active, (Begin Date: 01-DEC-18)
Care Management (Enrolled): OCCUPATIONS INC MH MR

Alerts & Incidents - all available
1 - Suicidal Ideation (1 Inpatient, 2 ER, 1 Other)
2 - Intentional Overdose - Opioid (2 ER)

Most Recent
- 8/13/2018 BON SECOURS COMMUNITY HOSPITAL (Clinic - MH Specialty)
- 8/12/2018 ST LUKES CORNWALL (ER - MH)

Note: Higher # count totals for Inpatient, ER, and Other settings may represent multiple services in same day

Active Quality Flags - as of monthly QI report 6/1/2019
BH QARR - DOH Performance Tracking Measure - as of 12/01/2018
No Engagement of Alcohol/Drug Treatment

BH QARR - Improvement Measure
Adherence - Antipsychotic (Schiz)

High Utilization - Inpt/ER
2+ ER - BH: 2+ ER - MH: 2+ ER - Medical: 2+ Inpatient - Medical

Medications Past Year
Divalproex Sodium (Divalproex Sodium Er) - Mood Stabilizer
Buspirone Hcl - Anxiolytic/Anxiolytic
Risperidone - Antipsychotic

Outpatient Providers Past Year - Last Service Date & Type
CORNERSTONE FAMILY
HEALTHCARE
6/29/2019 Clinic - Medical Specialty
ACCESS SUPPORTS FOR LIVING INC
5/30/2019 Clinic - MH Specialty
CRYSTAL RUN HEALTHCARE PHYSICIANS
4/29/2019 Multi-Type Group - Neurology

Diagnoses Past Year

Medical (26)
5 Most Recent: Conjunctivitis • Persons encountering health services in other circumstances • Encounter for general examination without

Last Pick Up
8/21/2019 Dose: 500 MG, 2/day • Quantity: 60
8/21/2019 Dose: 5 MG, 2/day • Quantity: 60
8/21/2019 Dose: 0.5 MG, 1/day • Quantity: 30

ER Visits • # Facilities • Last Facility Visit
2 Mental Health 1 ST LUKES CORNWALL on 8/12/2018
2 Substance Use 2 BON SECOURS COMM HOSP on 8/21/2018
25 Medical 4 GOOD SAMARITAN HSP SUFFERN on 10/5/2018

All Hospital Utilization - 5 Years
Access to PSYCKES
What Organizations are Eligible for PSYCKES?

Eligible for PSYCKES access now:

- Behavioral Health agencies with one or more OMH or OASAS licensed programs
- HCBS Programs
- DOH Health Homes and Care Management Agencies
- DOH Hospitals
- Federally Qualified Health Centers
- Local Government Units
- Medicaid Managed Care Plans

Will be eligible after future expansions:

- Freestanding Medical Clinics (e.g., Primary Care)
- Agencies licensed by OPWDD
How to Get Access to PSYCKES

When Your Agency Already Has Access

- PSYCKES access for individual staff is managed by your agency’s Security Manager(s)
- Security Managers are appointed by your CEO/ED
- Security Manager uses Security Management System (SMS) to grant PSYCKES access to staff and revoke access if staff leave
- Contact PSYCKES-Help@omh.ny.gov to find out your agency’s security manager
How to Get Access to PSYCKES
When Your Agency Does Not Have Access

- Complete and return documentation to obtain agency access to PSYCKES
  - PSYCKES Access Online Contact Form (Survey Monkey)
  - CEO/ED signs PSYCKES Confidentiality Agreement (PDF)

- CEO/ED signs electronic CNDA and designates Security Manager(s)

- Security Manager uses SMS to grant PSYCKES access to staff and revoke access if staff leave
PSYCKES for Non-Clinical HCBS Agencies

Two types of PSYCKES access for HCBS:

- **Full PSYCKES provider-level access** is available for CPST, Intensive Crisis Respite, and any HCBS programs that are part of an organization that is eligible for full PSYCKES access.

- **Partial Care Coordination only PSYCKES access** is available for HCBS organizations where the only programs are: Educational Support, Family Support and Training, Habilitation, Supported/Transitional Employment, Peer Support, Psychosocial Rehab, or Short-Term Respite.
PSYCKES Training & Technical Support
PSYCKES Training

- PSYCKES website: www.psyckes.org
- Webinars
  - Live: Register in “Calendar” section of website
  - Recorded: Posted in “Recorded Webinars” of website
    • Using PSYCKES for Clinicians
    • Enable Access to Client-Level Data in PSYCKES
    • Using PSYCKES Recipient Search
    • Using PSYCKES Quality Indicator Reports
    • PSYCKES Mobile App for iPhones & iPads
- User Guides
  - Available in “About PSYCKES” section of website
PSYCKES Technical Support

- **PSYCKES Help**
  - Support using PSYCKES and questions about data
  - 9:00AM – 5:00PM, Monday – Friday
  - PSYCKES-help@omh.ny.gov

- **ITS Help Desk**
  - Token, login, and SMS support
  - Provider Partner ITS Helpdesk:
    - healthhelp@its.ny.gov; 1-800-435-7697
  - OMH Employee ITS Helpdesk:
    - fixit@its.ny.gov; 1-844-891-1786
Building Healthier Communities Together

We connect health and social care.
Unite Us

Outcome-focused software addressing the social determinants of health.

We're interconnecting healthcare and social services into one accountable, coordinated ecosystem – empowering health systems and communities to work together seamlessly to impact every person’s health and social needs.
Continue to focus on what you do best.

Community partners address your patients' needs without intervention.
Patients seek clinical care for social needs.

Providers go blind once patients are discharged.

Old System
Payment Models

**Fee-for-Service**
- Provides health care services to beneficiary
- CMS/State Medicaid Agency reimburses provider for services, based on claims (with set fee schedule)

**Managed Care**
- Depending on contract, MCO either pays provider through capitation rate or fee for service
- CMS/State Medicaid Agency pays MCO fixed monthly capitation payment based on number of beneficiaries enrolled
- Provides health care services to beneficiary
Even with MCOs, **many providers are still paid fee-for-service.** Value-based payment models create incentives to address social needs that can affect patient health and healthcare costs:

- Under fee-for-service, providers have no incentive to address SDoH because their costs fall onto payers
- Payers have incentive to reduce costs, but have limited patient interaction/information
- Value-based payment models allow for benefits and costs to be borne to the same entity
Linking Data to Value

Report on outcomes, services delivered, and population needs in real time.

Patient-Level Coordination and Tracking

Track patient-level service episode data, including service types requested, patient access points, service delivery history, and outcome breakdowns.

Network-Level Transparency and Accountability

Track patient demographics, community-wide resource needs and gaps, and network performance.
Network Examples
We tracked the financial impact of one network.

Coordinating service delivery across New York City

One of our networks consists of several food and nutrition service providers that served over 450 unique patients in under six months. In that timeframe, they were already able to demonstrate:

$320k estimated annualized Medicaid savings
### Bridge to Self-sufficiency*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>Dependents Needs</td>
<td>Health &amp; BH</td>
<td>Social Networks</td>
<td>Debts</td>
</tr>
<tr>
<td>- No housing instability, financial struggle, or mental illness</td>
<td>- No mental illness, dependency, or substance abuse</td>
<td>- No health issues</td>
<td>- No social isolation</td>
<td>- No debt problems</td>
</tr>
</tbody>
</table>

*Adapted with permission from EMPath’s Bridge to Self-Sufficiency®. ©2016 Economic Mobility Pathways. All other rights reserved

Partners: Action for a Better Community, Catholic Family Center, The Community Place of Greater Rochester, The City of Rochester Office of Innovation & Strategic Initiatives, and Notre Dame Lab for Economic Opportunities

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**DIAGRAM**

- **Mentor / Navigator**
  - Personal Goals & Action Plan
  - Comparison Group (154 total)
- **Participant**
  - (160 total)
  - Job Prep Counselor
    - e.g., soft-skills, training, resume prep., job interviewing
  - Job Developer
    - JOBS
    - GED
    - JOBS

**360 COLLABORATIVE NETWORK**

- Housing
- Social Networks
- Education
- Savings/Debt
- Health & BH
- Dependent Needs

---

**UNITE US**

**PROPRIETARY & CONFIDENTIAL**
## Demographics at Intake

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Average age</td>
<td>38</td>
</tr>
<tr>
<td>Gender</td>
<td>22% M; 78% F</td>
</tr>
<tr>
<td>Marital status</td>
<td>3.8% Married</td>
</tr>
<tr>
<td>Race</td>
<td>62% Black, 9% White (non-Spanish), 29% Other (Inc. Multi race)</td>
</tr>
<tr>
<td>Avg. Household size</td>
<td>2.8</td>
</tr>
<tr>
<td>Education</td>
<td>35% &lt; HS/GED, 37% HS/GED, 13% Some college, 15% College Grad.</td>
</tr>
<tr>
<td>Employed full or part-time</td>
<td>29% (N-160)</td>
</tr>
</tbody>
</table>

## Outcomes (Active Participants)

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average employed since program enrollment increased</td>
<td>97.6%</td>
</tr>
<tr>
<td>Average earned household income since enrollment increased</td>
<td>107.8%</td>
</tr>
</tbody>
</table>

**Partners:**
- Action for a Better Community
- Catholic Family Center
- The Community Place of Greater Rochester
- The City of Rochester Office of Innovation & Strategic Initiatives
- Notre Dame Lab for Economic Opportunities
Value-Based Payment Plans in Progress
Where are we headed together?

Resource Directories

Coordinating the Community

Leveraging the Platform

Value-Driven CBO Performance and Payments

Standards of Care that Include the Community

Influence Policy

Drive Change

The Past

Phase 0

Phase 30

PROPRIETARY & CONFIDENTIAL
Thank you!

Data Quality

Tavia Rauch
Director Strategic Initiatives
What is Data Quality

Clinical Data

- Diagnosis
  - Diabetes, Schizophrenia

- Lab Test Results
  - A1C 7.4

- Vital Signs
  - Weight, Height, Blood Pressure

- Procedures
  - Mammogram, Colonoscopy

- Assessments
  - Depression Screening PHQ-9, Nicotine Dependence
## What Makes Data Interoperable

<table>
<thead>
<tr>
<th>Data Type</th>
<th>Coding Standard</th>
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</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>SNOMED, ICD-10</td>
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<tr>
<td>Lab Results</td>
<td>LOINC</td>
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<tr>
<td>Procedures</td>
<td>SNOMED, CPT</td>
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<tr>
<td>Vital Signs</td>
<td>LOINC</td>
</tr>
<tr>
<td>Assessments</td>
<td>LOINC</td>
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</tbody>
</table>

[https://www.healthit.gov/sites/default/files/commonclinicaldataset_ml_11-4-15.pdf](https://www.healthit.gov/sites/default/files/commonclinicaldataset_ml_11-4-15.pdf)
Non Standard Codes

Mammograms

Standard Codes

LOINC: 26175-0
SNOMED: 71651007
CPT: 77067

Non-standard Codes Sent to Hixny

AMAMOWASPERFORMED6172017
KDIGMDCBN
1234534
MAMMOKILZ
# Quality Measurement

## Breast Cancer Screening

<table>
<thead>
<tr>
<th>Hide</th>
<th>MRN</th>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>Gender</th>
<th>Needs Screening</th>
<th>Date</th>
<th>Facility</th>
<th>Date</th>
<th>Facility</th>
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<tbody>
<tr>
<td></td>
<td>134</td>
<td>Jane Smith</td>
<td>11/22/79</td>
<td>39</td>
<td>M</td>
<td>N</td>
<td>2/15/2019</td>
<td>Dr. Bob’s Office</td>
<td>8/2/2019</td>
<td>Quick Pics Radiology</td>
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<tr>
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<td>0002</td>
<td>Becky Jones</td>
<td>11/22/79</td>
<td>39</td>
<td>M</td>
<td>Y</td>
<td>1/16/2019</td>
<td>First Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Your Data Your Call

Decide What Data is Important
  ▪ Mission
  ▪ Measuring Quality Care
  ▪ Risk Based Contracts

Do Your Research

Work with Your Vendor to Ensure That Your Data is Coded and Interoperable
Thank You