Adirondack Health Institute 2019 Summit

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New York State Department of Health

September 19, 2019

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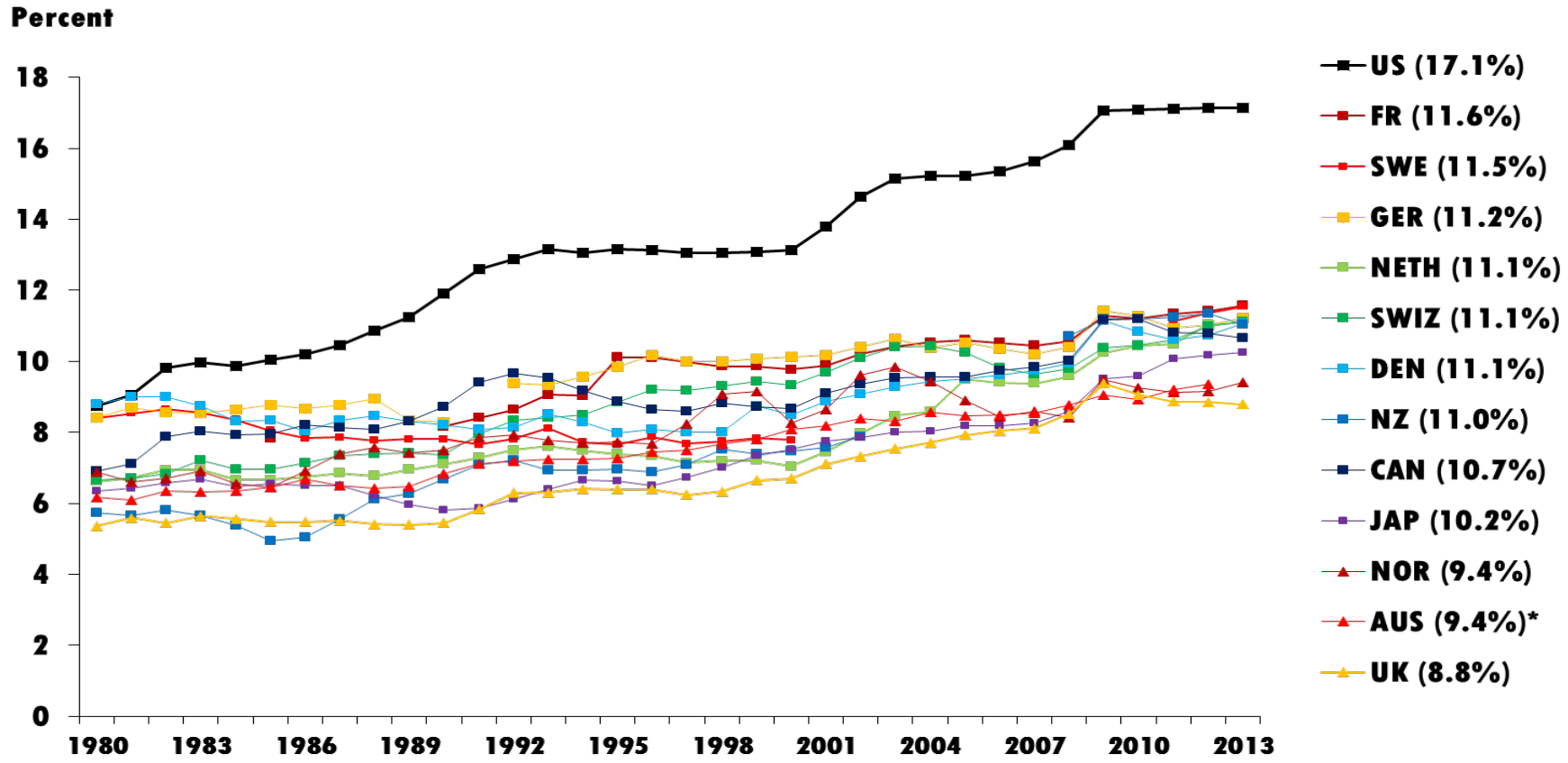
DOH Update

Another Summit

Health Care Spending in US & Other Countries

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

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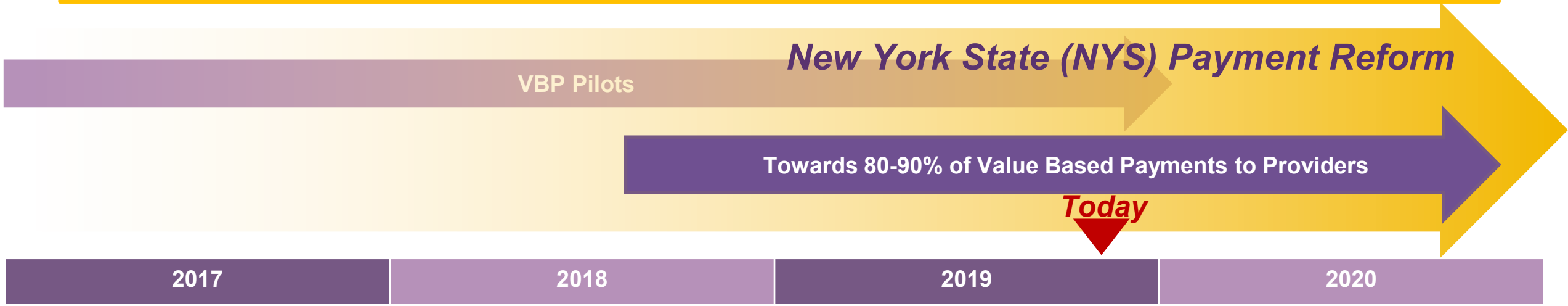
VBP Transformation: Overall Goals and Timeline

Goal: To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.



April 2017

Performing Provider Systems (PPS) requested to submit growth plan outlining path to 80-90% VBP

☑

April 2018

≥ 10% of total Managed Care Organization (MCO) expenditure in Level 1 VBP or above

☑

April 2019

≥ 50% of total MCO expenditure in Level 1 VBP or above.
≥ 15% of total payments contracted in Level 2 or higher *

April 2020

80-90% of total MCO expenditure in Level 1 VBP or above
≥ 35% of total payments contracted in Level 2 or higher *

* For goals relating to VBP level 2 and higher, calculation excludes partial capitation plans such as MLTC from this minimum target.

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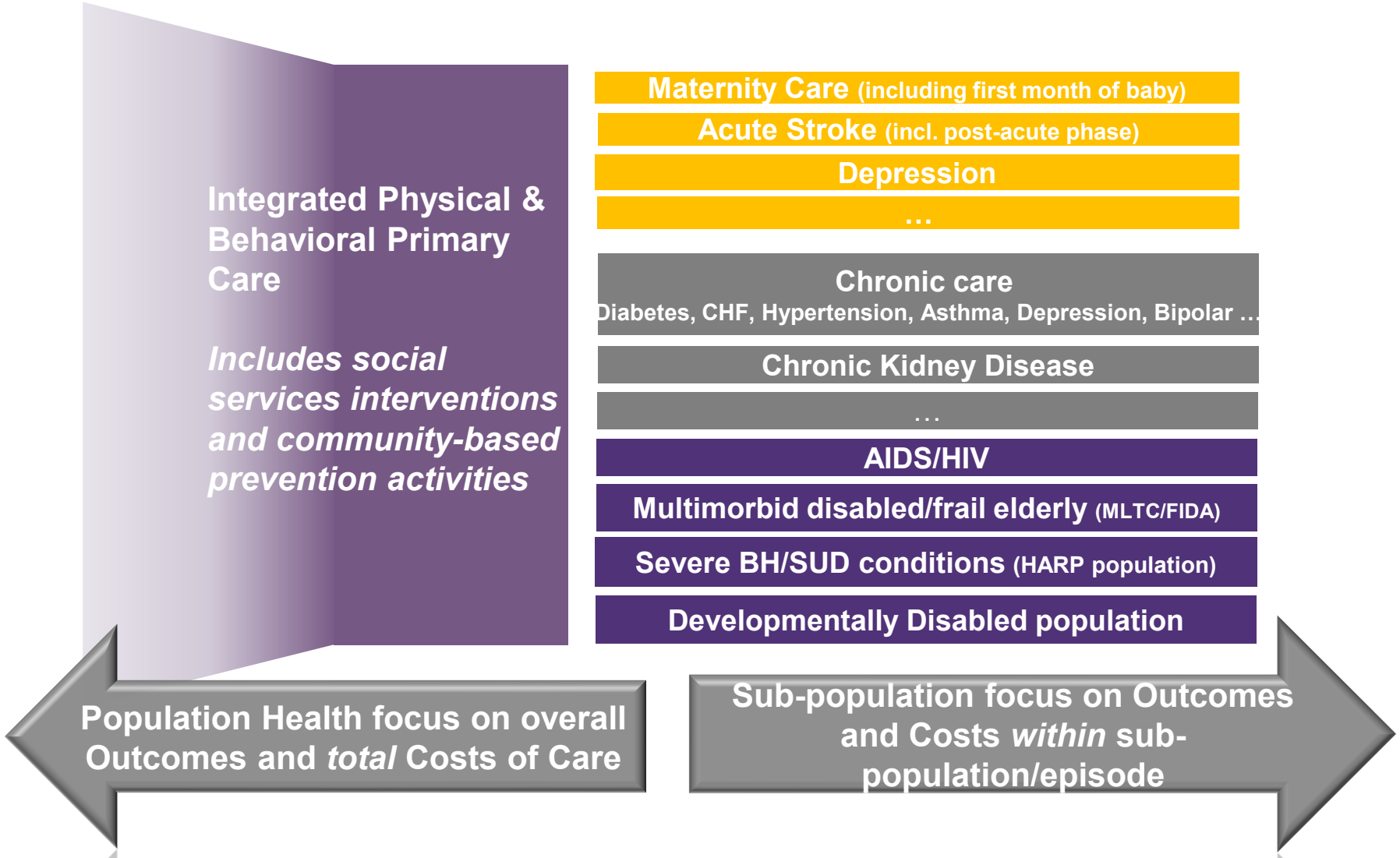
The VBP Roadmap starts from DSRIP Vision on how an Integrated Delivery System should function



DSRIP Waiver Renewal – Key Themes

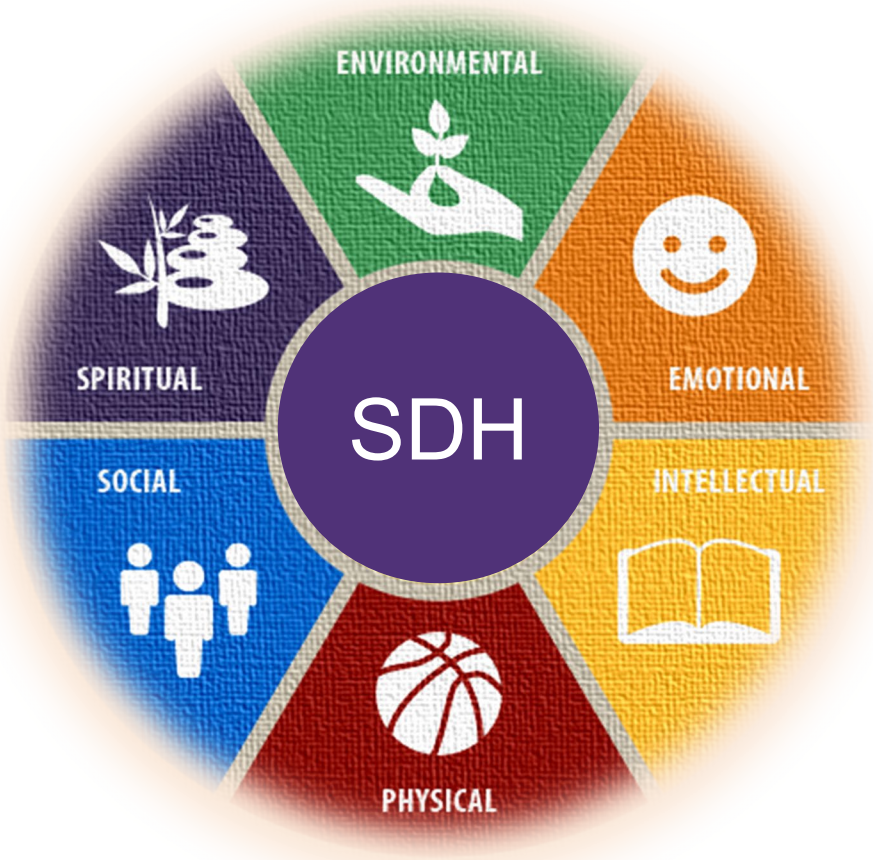
- Build on DSRIP Promising Practices
- More time for VBP models to Mature to Support Promising Practices
  - MCO/Provider/CBO collaborative teams
- Flexibility on PPS Structure and Governance
- Focus Areas
  - Opiates
  - Children
  - Criminal Justice
- Alignment of Performance with Other Initiatives

Addressing Social Determinants of Health

Social determinants of health *are defined as the* ***conditions in which people are born, grow, live, work and age****. These circumstances are* ***shaped by*** *the* ***distribution of money, power and resources at global, national and local levels****.*

Experts estimate that ***medical care accounts for only 10% of overall health****, with social, environmental, and behavioral factors accounting for the rest.* ***Lack of*** *upstream* ***investment in social determinants of health*** *probably* ***contributes to exorbitant*** *downstream* ***spending on medical care*** *in the US.*

– The New England Journal of Medicine (NEJM)



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Challenges

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Ongoing Challenges in the 7-County Rural Health Network Region*

- The percentage of adults who smoke (24.2%) far exceeds the statewide rate of 14.5%;
- Emergency Department (ED)visits per 10,000 population are higher than the overall upstate New York rate (4,866 versus 3,866);
- A higher proportion of the region is living with a disability (25.6%) - higher than (22.9%);
- The rate of adult obesity (35.2%) far exceeds the NYS rate of 25.5%;
- Rate of obesity in elementary school children (18.3%) is higher than Upstate NY (16.0%).

* Clinton, Essex, Franklin, Hamilton, Fulton, Warren and Washington

Data from the 2019-2021 Community Health Assessment Executive Summary, Reflecting Data Through 2017

In 2017, the Long Island region had the most primary care physicians per capita with 96.2 per 100,000, while the **North Country (61.0 per 100,000) had the least.**

The New York City region had the most psychiatrists per capita (41.9 per 100,000) in 2017, while the **North Country (11.3 per 100,000) region had the least.**

- The Long Island region had the highest number of health care jobs per capita in 2016 with 6,186 jobs per 100,000 total population, followed by New York City with 5,980 per 100,000.

- **The North Country had the lowest number of health care jobs per 100,000 total population (4,446).**

What are you doing?

Well Fed Essex County

WHO?	
• ADK Action, • Adirondack Community Action Program • Cornell Cooperative Extension • Essex County Office for the Aging • University of Vermont Health Network at Elizabethtown Community Hospital	• Hudson Headwaters Health Network, • Hub on the Hill (local processors of farm goods), and • private pharmacies • local retailers • farmers and • artisans.

WHAT?

"Farmacy" project

- **Wholesome Rx Healthy Pantry Conversion project**
- **Better Choice Retailer project –smaller retailers increase their availability of wholesome and local foods.**
- **WIC & SNAP: increase the number of WIC vendors in the County, recruit eligible families and increase senior participation in SNAP.**

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Transportation System Solutions

A transportation voucher system to help individuals who need to get to destinations that support their health and wellness.

- The Baywood Center (820 River Street)
- Warren-Washington Association for Mental Health
- Tri-County United Way
- Greater Glens Falls Transit

Clinical Pharmacy Services and Education

Pharmacists provide medication reconciliation for high-risk patients transitioning from a hospital to a home care setting or skilled nursing facility.

- Hudson Headwaters Health Network
- Fort Hudson Health System
- HCR Home Care
- Glens Falls Hospital

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Community Health and Wellness Program

Empowering mentally-ill and chemically-addicted individuals to take control of their physical, social, and emotional health.

- The Baywood Center (820 River Street)
- Alliance for Positive Health
- Family YMCA of the Glens Falls Region

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For VBP Success:

Yesterday's Performance Payments fuel Tomorrow's Shared Savings

INNOVATE: Think patient needs over billable services

Partner across the Care Delivery Spectrum

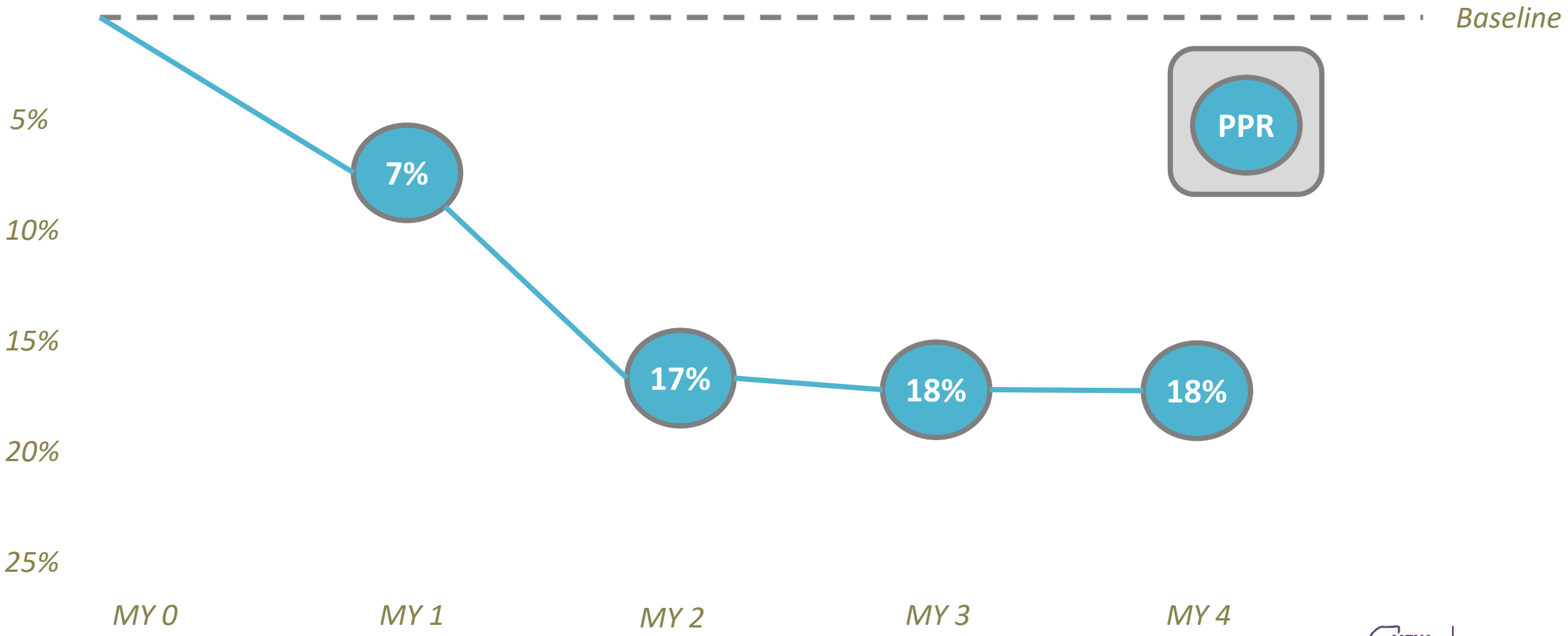
Build from DSRIP Infrastructure

Do what you do best: Provide the highest quality care for those who need it most, each and every day

So how are you doing?

Towards 25% Reduction in Avoidable Hospital Use –

Potentially Preventable Readmissions (PPR)



All figures represent DSRIP attributed population

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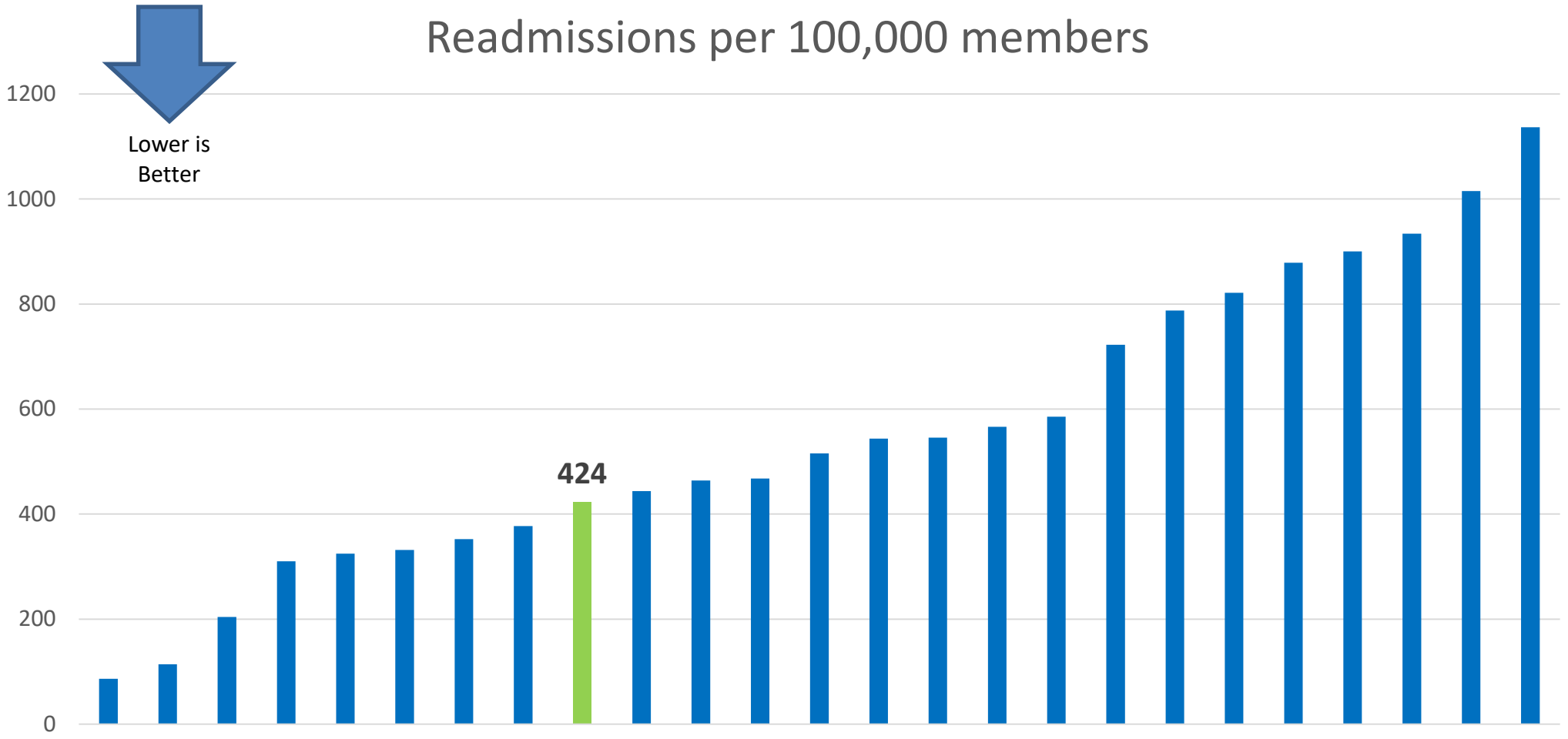
Readmissions

- The AHI PPS has reduced readmissions by 5.96% since Measurement Year 0.

- At the end of MY4, the AHI PPS had the 9th lowest readmission rate in the state.

Readmissions by PPS – MY4 Metrics



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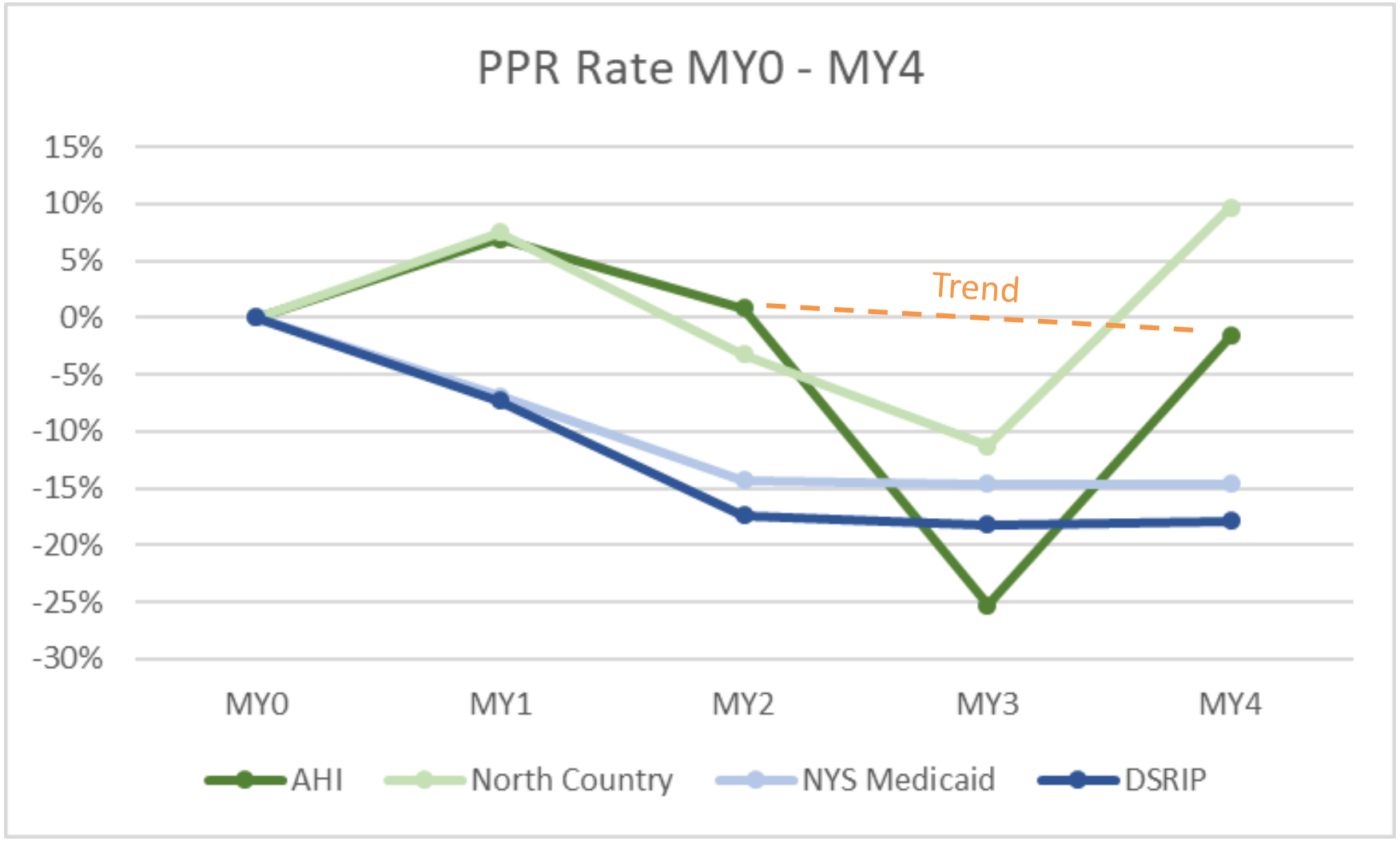

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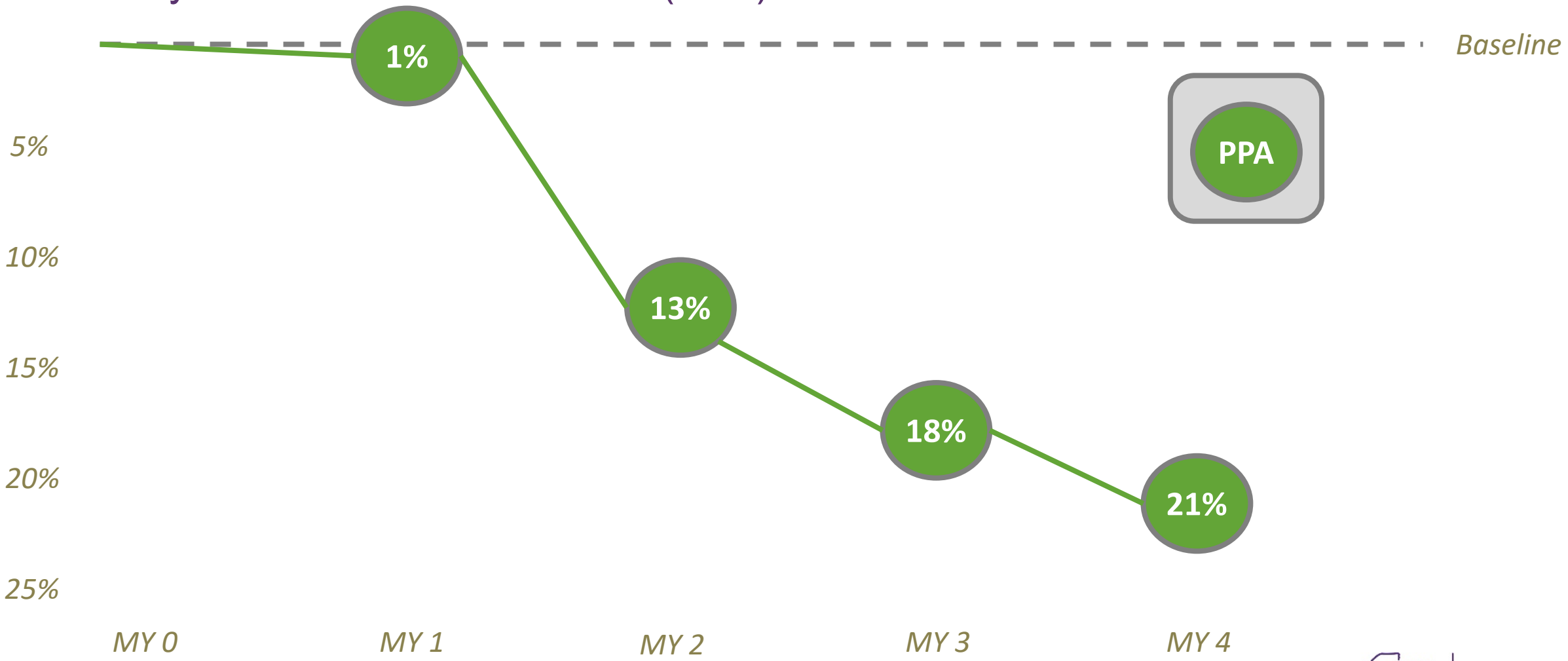
Towards 25% Reduction in Avoidable Hospital Use –

Potentially Preventable Admissions (PPA)



All figures represent DSRIP attributed population

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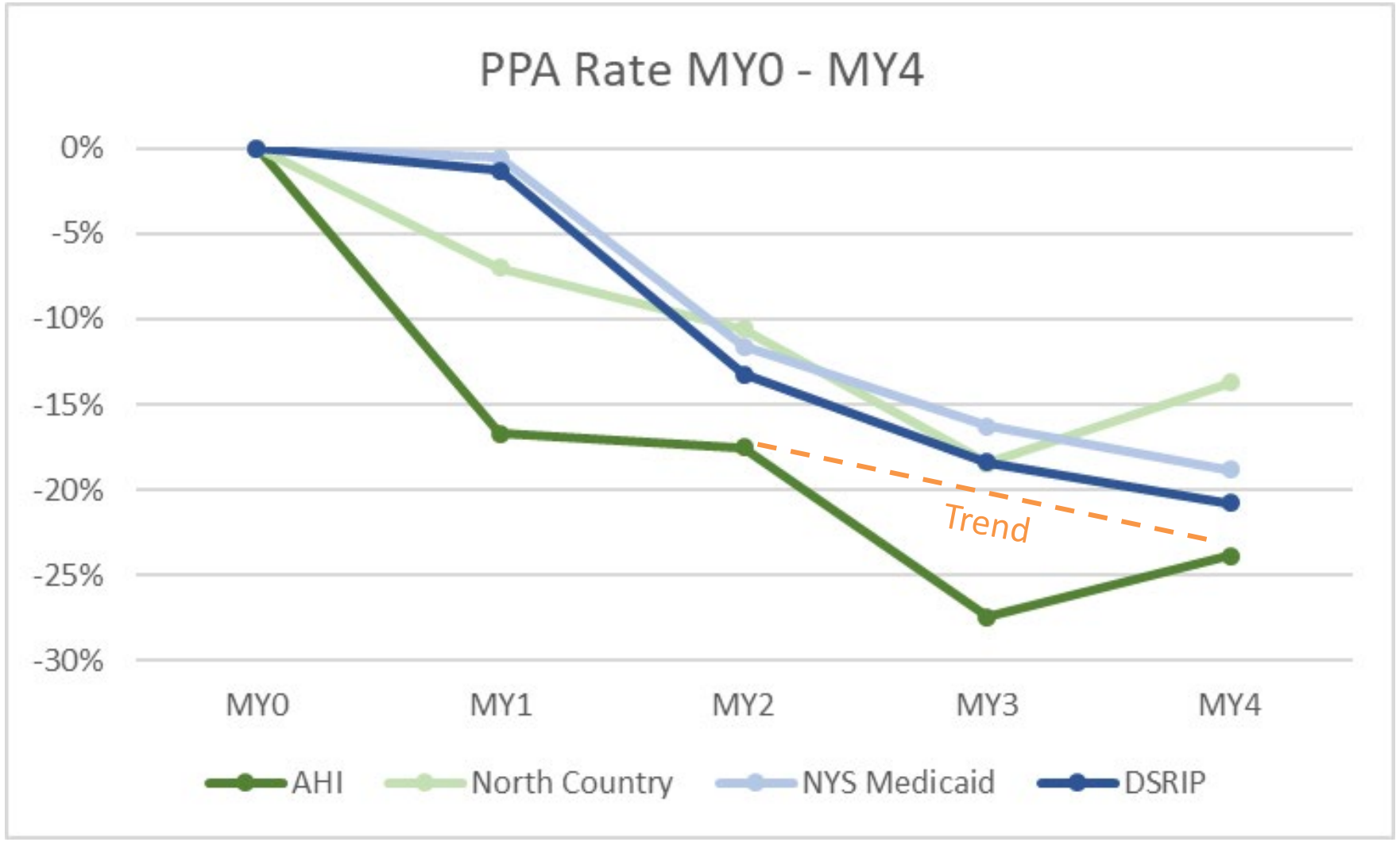

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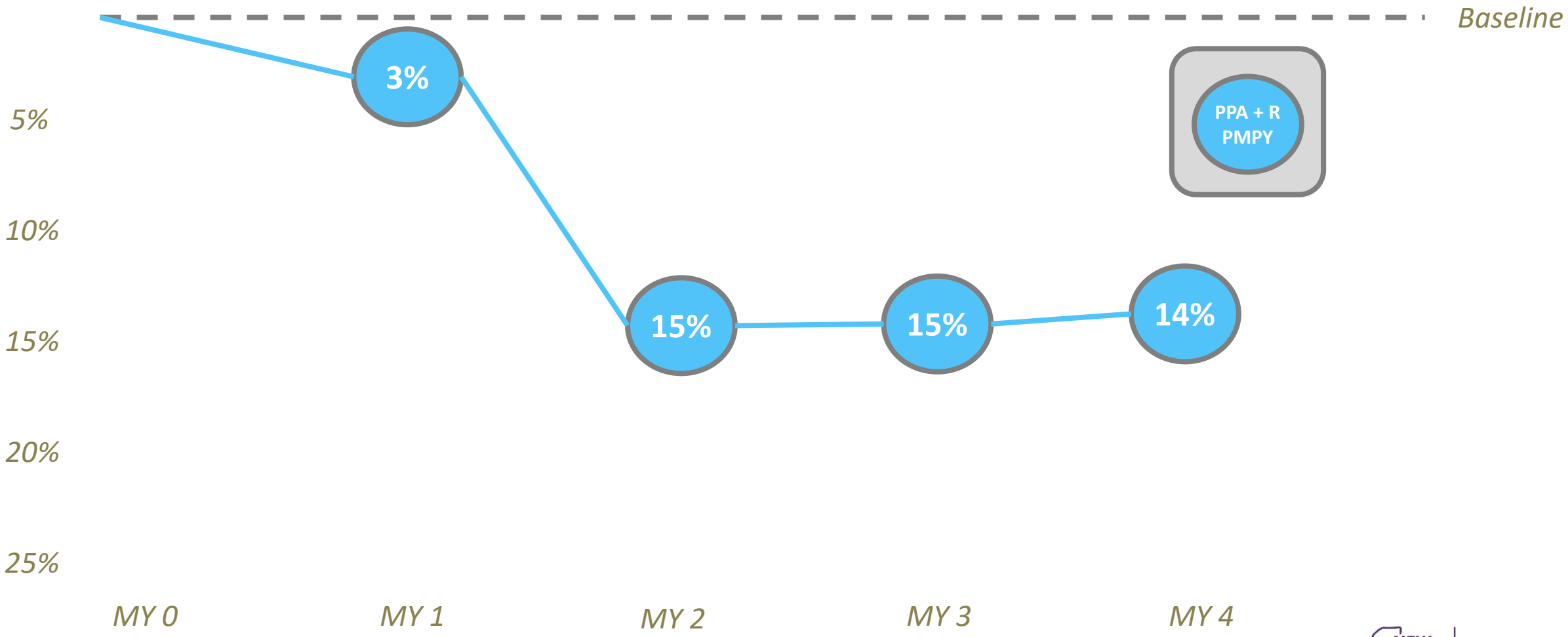
Towards 25% Reduction in Avoidable Hospital Use -

PPA + PPR Per Member Per Year (PMPY) Spending



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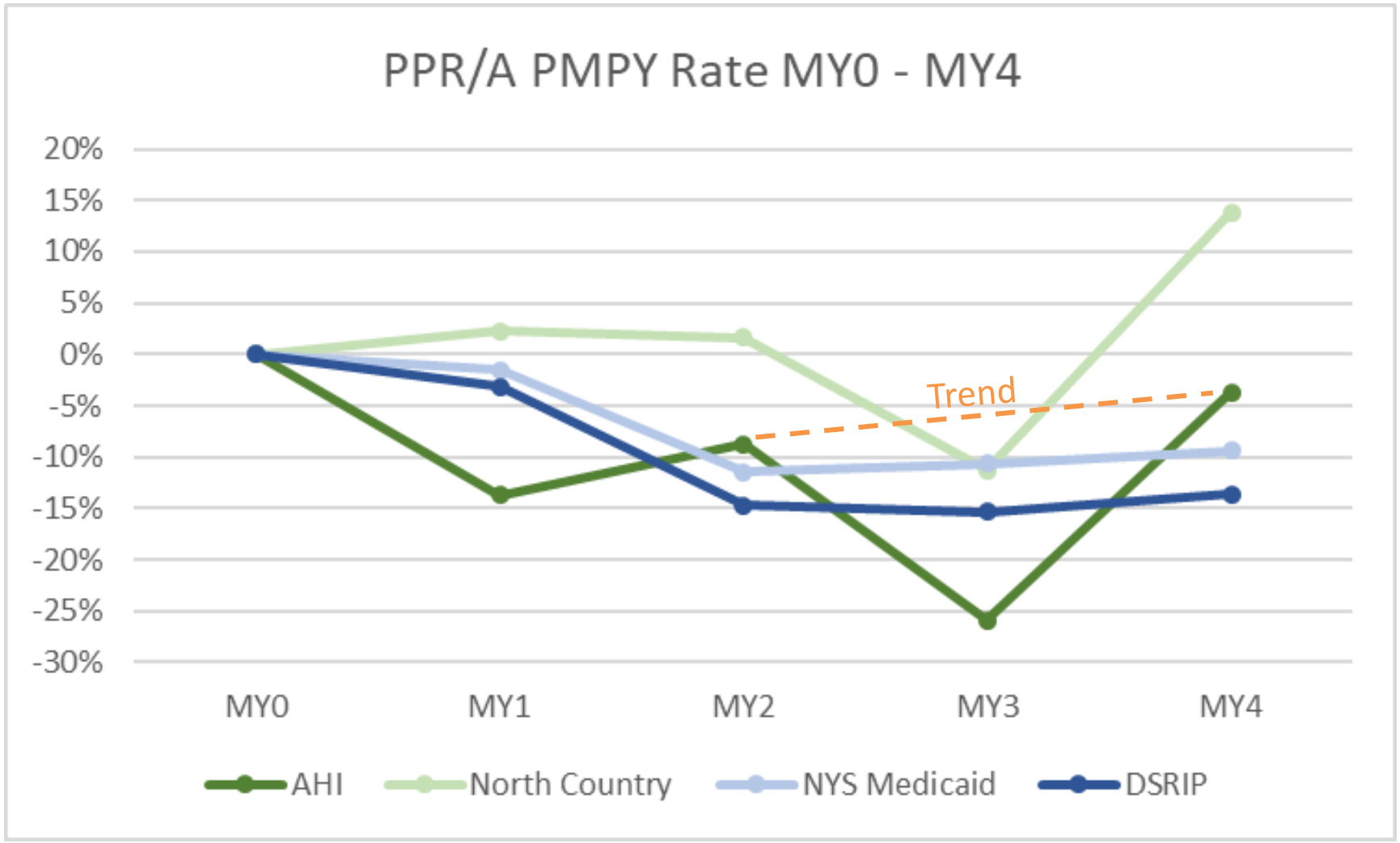
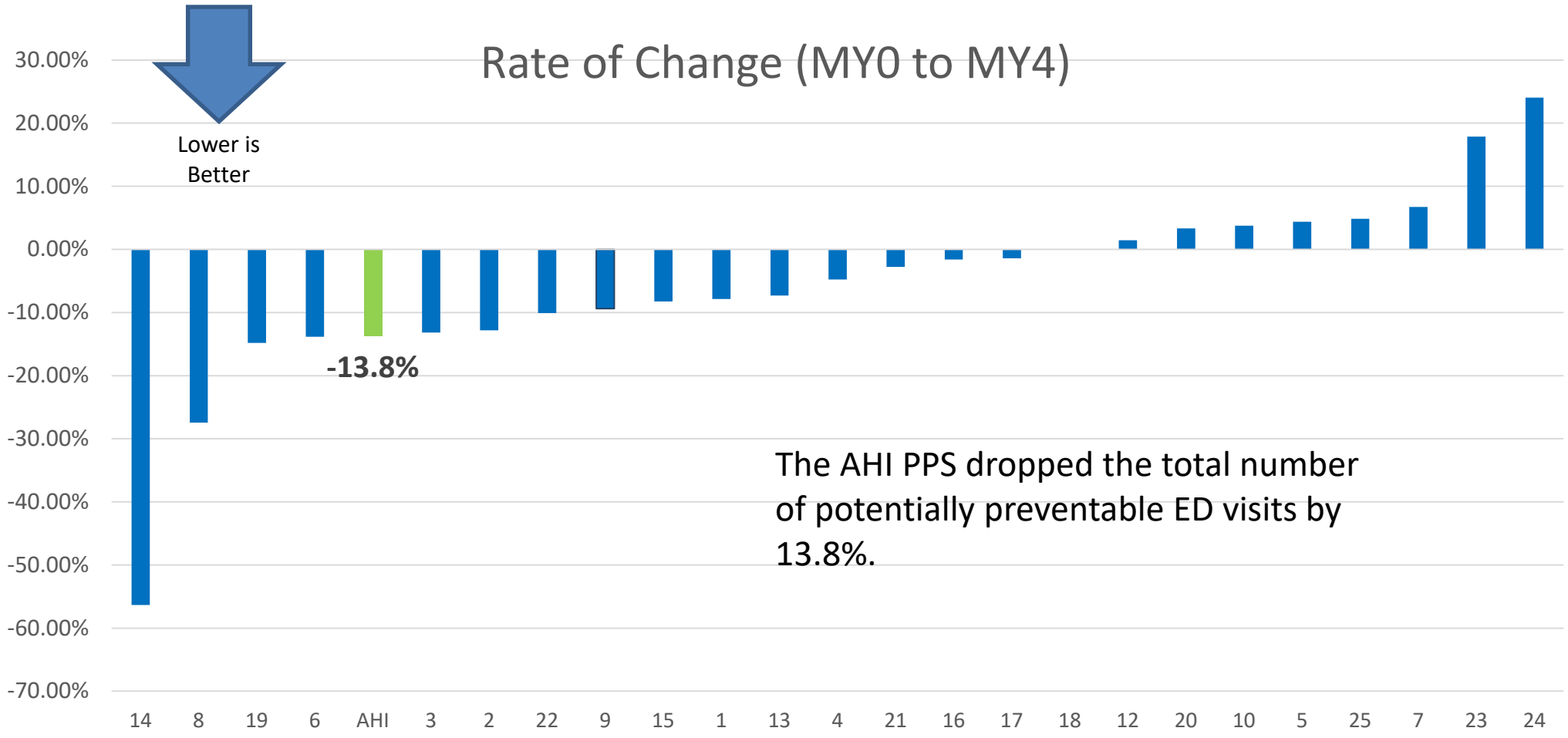

PPR/A PMPY Rate MY0 - MY4
20%
15%
10%
5%
0%
-5%
-10%
-15%
-20%
-25%
-30%
MY0
MY1
MY2
MY3
MY4
Trend
AHI
North Country
NYS Medicaid
DSRIP

Potentially Preventable ED Visits

- The AHI PPS has reduced potentially preventable ED visits by 13.8% since Measurement Year 0.

- At the end of MY4, the AHI PPS had the 5th largest drop in ED visits in the state.

Rate of Change in ED Visits by PPS Since Measurement Year 0



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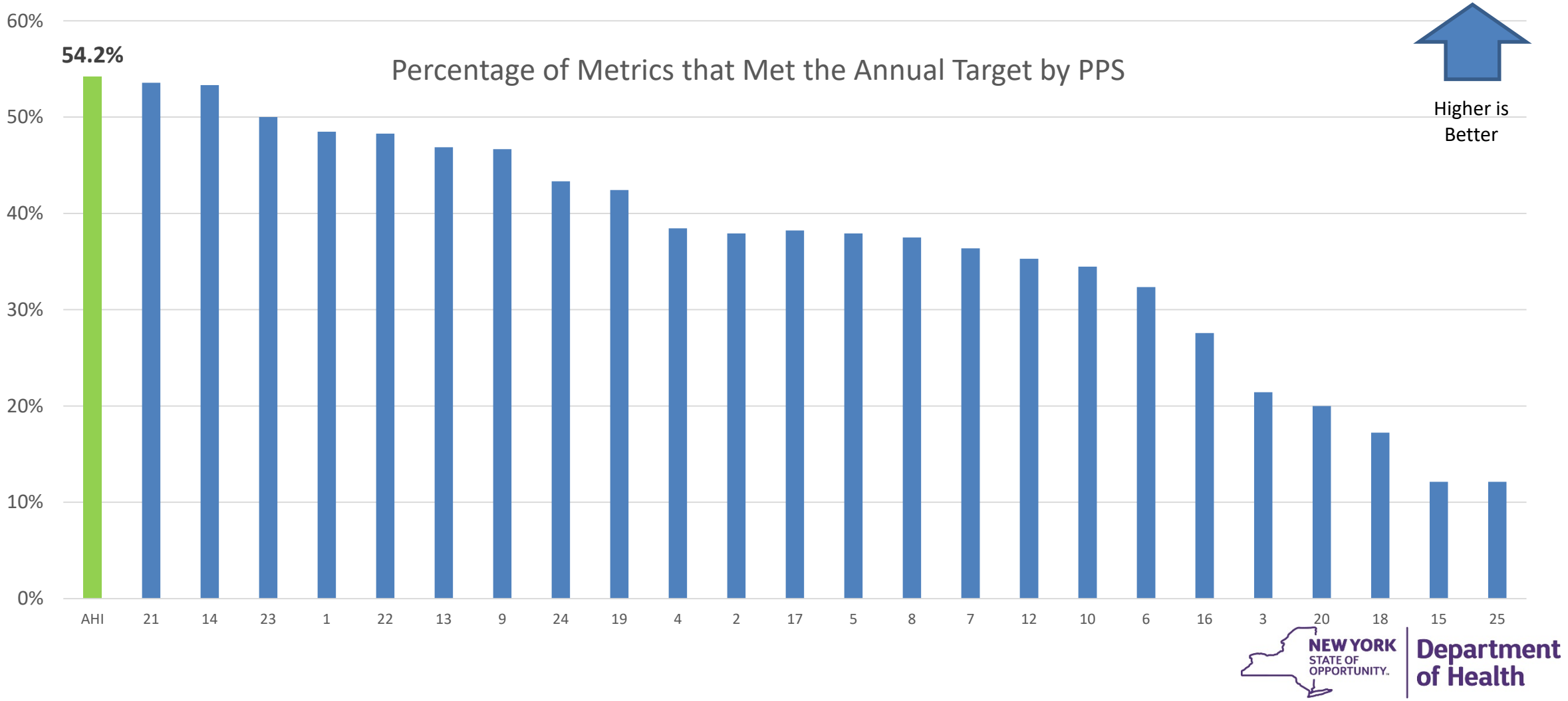
AHI as a Leader

- We passed 13 out of 24 total claims-based metrics in MY4
- This was a passing rate of 54.2%
- This passing rate was the highest in the state

Claims-Based Measures Passing Rate by PPS – MY4



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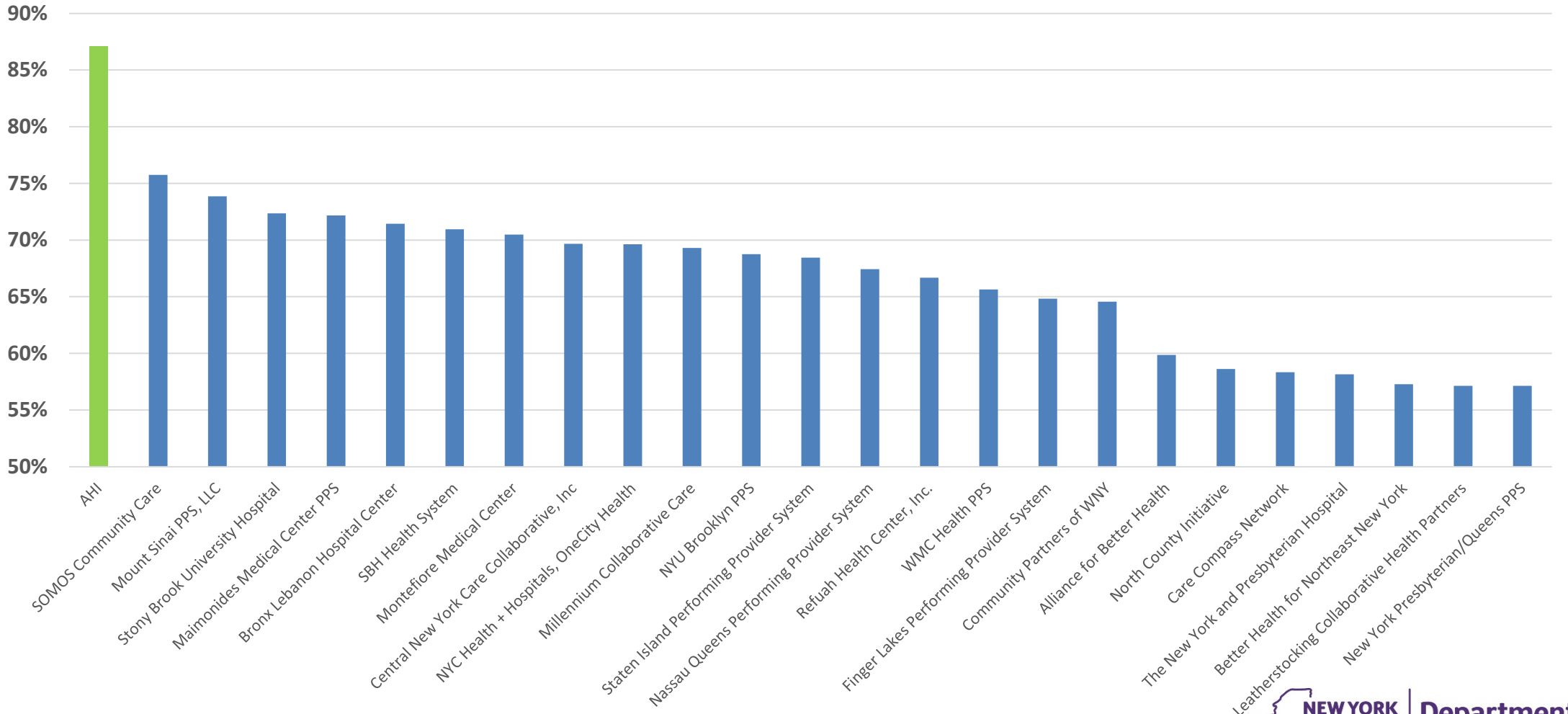
Diabetic Schizophrenic Metric by PPS – MY4

Higher is Better



Transforming Care Statewide for High Risk Members

Promising Practices Drive Exceptional Performance

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It's Only a Medical Home If the Patient Says So

New Horizons of Healthcare Delivery

Whole-Person Care

What is whole-person care?

“Whole-person care can be **defined** as the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.”

~California’s 1115 Waiver: An Opportunity to Move from Coverage to Whole-Person Care

Integrating and Collaborating Medical Care Around the Patient

WHY WE Should PARTICIPATE

We all think that we are the best at what we do (in our own little silos)

We then get the data about ourselves ..

Then we say the data is corrupt

Then we generate our own data

The system must be flawed

Then there is reality

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We may be great at *any* given time but not at *every* given time.

90% x 90% x 90% x 90% x 90% x 90% x 90% x 90% x 90% =38.7%

Rule of 90%

New Horizons of Healthcare Delivery

Patient Centered

Value

Innovative

Transparent

Integrated

Sustainable

Accountable

Collaborative

Quality

Accessible

NCIP seeks to establish a comprehensive patient-centered care delivery model supported by a multi-payer global budget

The NCIP is a unique partnership of providers and community members working together to improve the health of residents of the North Country by assuring access to needed care for those who are sick and promoting health for those who are well.

Why?

To further align providers across the North Country and build on decade's of progress to assure high quality, affordable care.

NCIP Steering Committee Membership

NCIP Steering Committee

- Karen Ashline: AVP, Adirondacks ACO
- John Brumstead: President and CEO, The University of Vermont Health Network
- Eric Burton: CEO, Adirondack Health Institute
- James Button: Executive Director, Northwinds ACO
- Sylvia Getman: CEO Adirondack Health
- Karen Lee: CEO Adirondacks ACO
- Robert Ross: CEO and President, St Josephs Addiction Treatment and Recovery Centers
- John Rugge: Hudson Headwaters Health Network
- Diana Scalise: SVP High Value Care, University of Vermont Health Network
- Dianne Shugrue: CEO Glens Falls Hospital
- D. Tucker Slingerland: CEO Hudson Headwaters Health Network

Adirondacks ACO
Better Community Care Through Collaboration

Adirondack Health
Leading care for a healthy community.

a·H·I
Adirondack Health Institute

St Joseph's
Addiction Treatment & Recovery Centers

Glens Falls Hospital

Hudson Headwaters Health Network

The University of Vermont Health Network

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North Country Innovation Pilot

Care that:

- Considers the whole person;
- Is aligned, integrated, and coordinated;
- Includes treating the sick and supporting the well.

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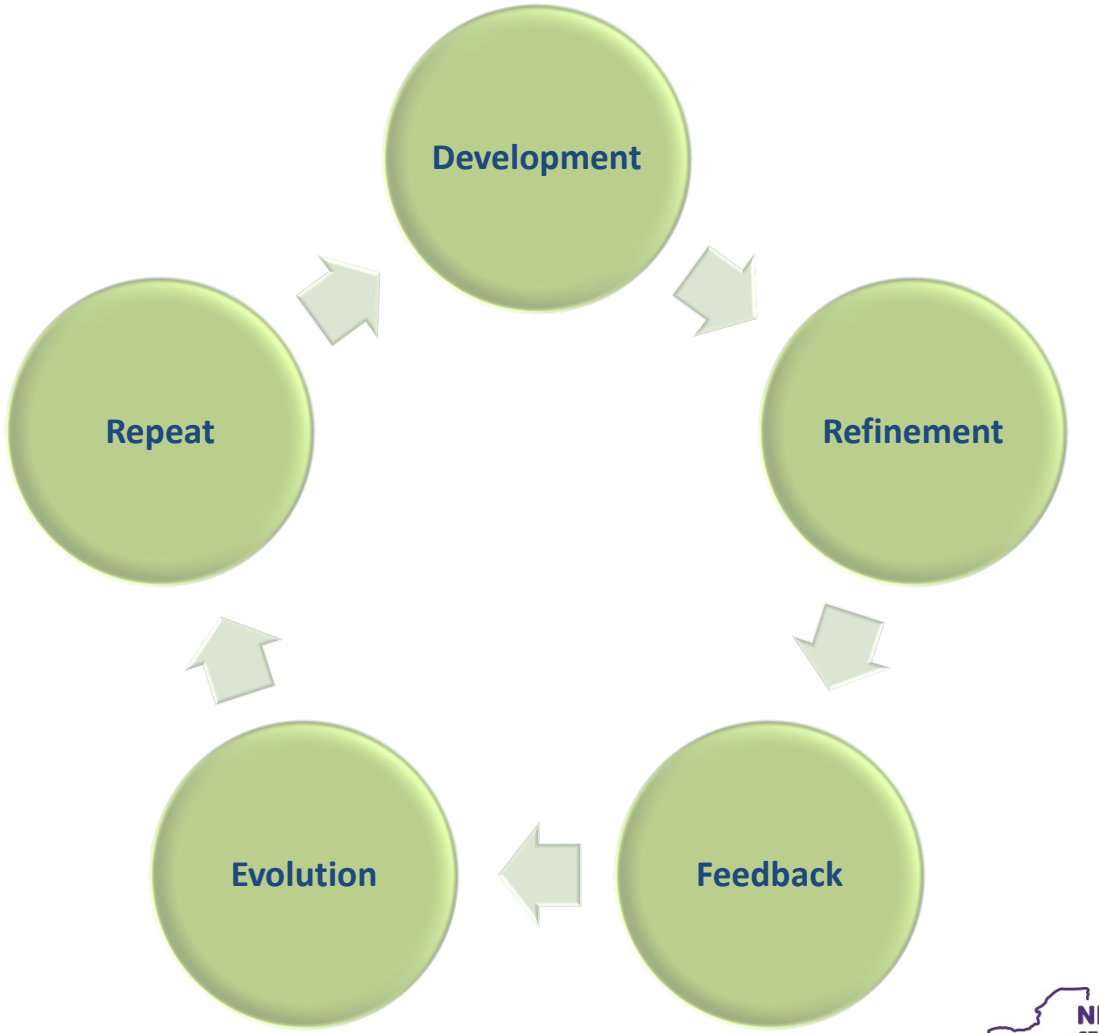
North Country Innovation Pilot: Who?

Who?

- People living at or near the poverty level.
- People with substance abuse issues.
- People with disabilities.
- Women of reproductive age.
- People who are aging.
- Migrant workers.
- Farmers.
- People struggling with the cost of care.
- All of us.

NCIP Timeline: 2019-2026



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Goals of Value Based Payment Model(s)

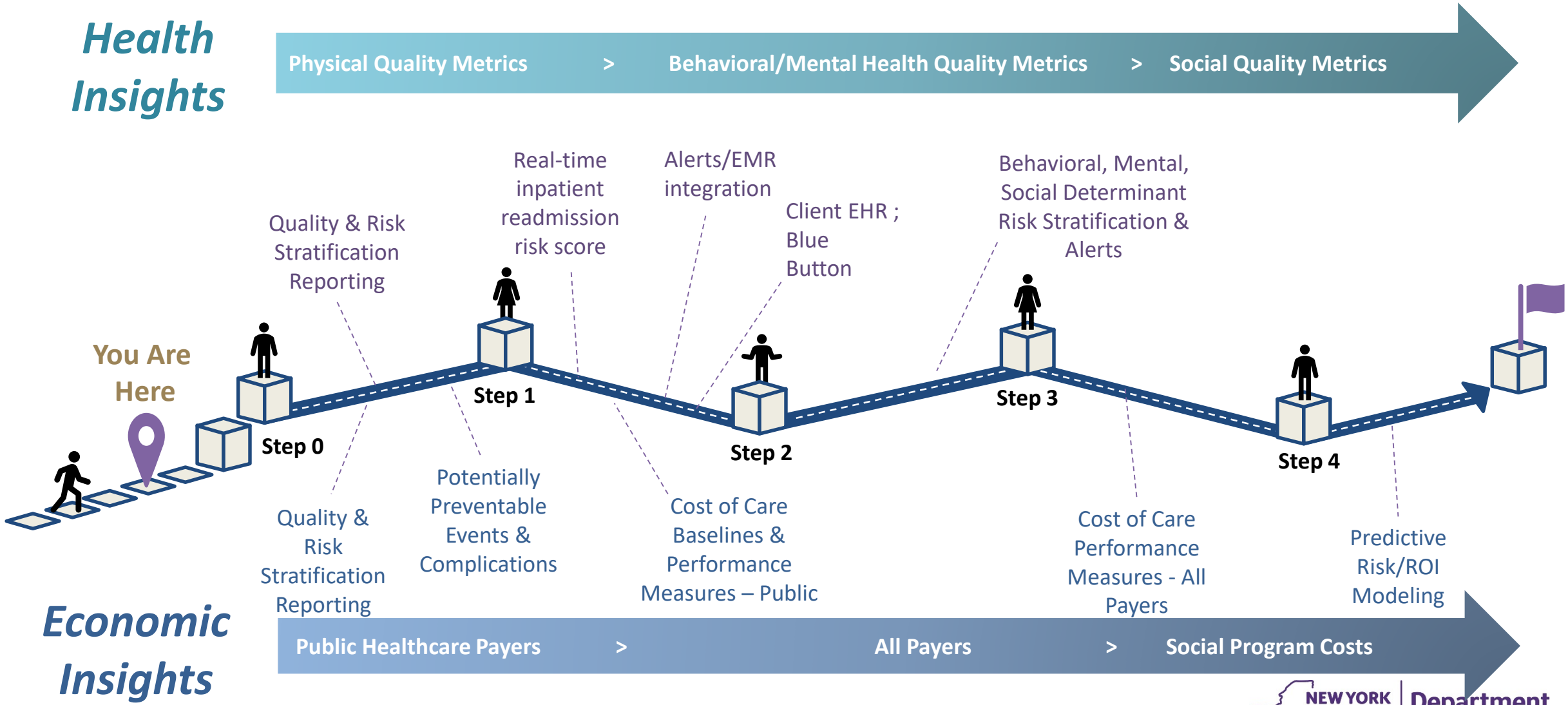
- Assure enough people participate in the model to make a difference.

- Reduce health expenditure growth in the future.
- Ensure affordability of care for all.

- Create mechanisms to fund new care models and support fragile providers.

- Support care in the right place, at the right time to meet patient needs.

NCIP - Data & Analytics Roadmap



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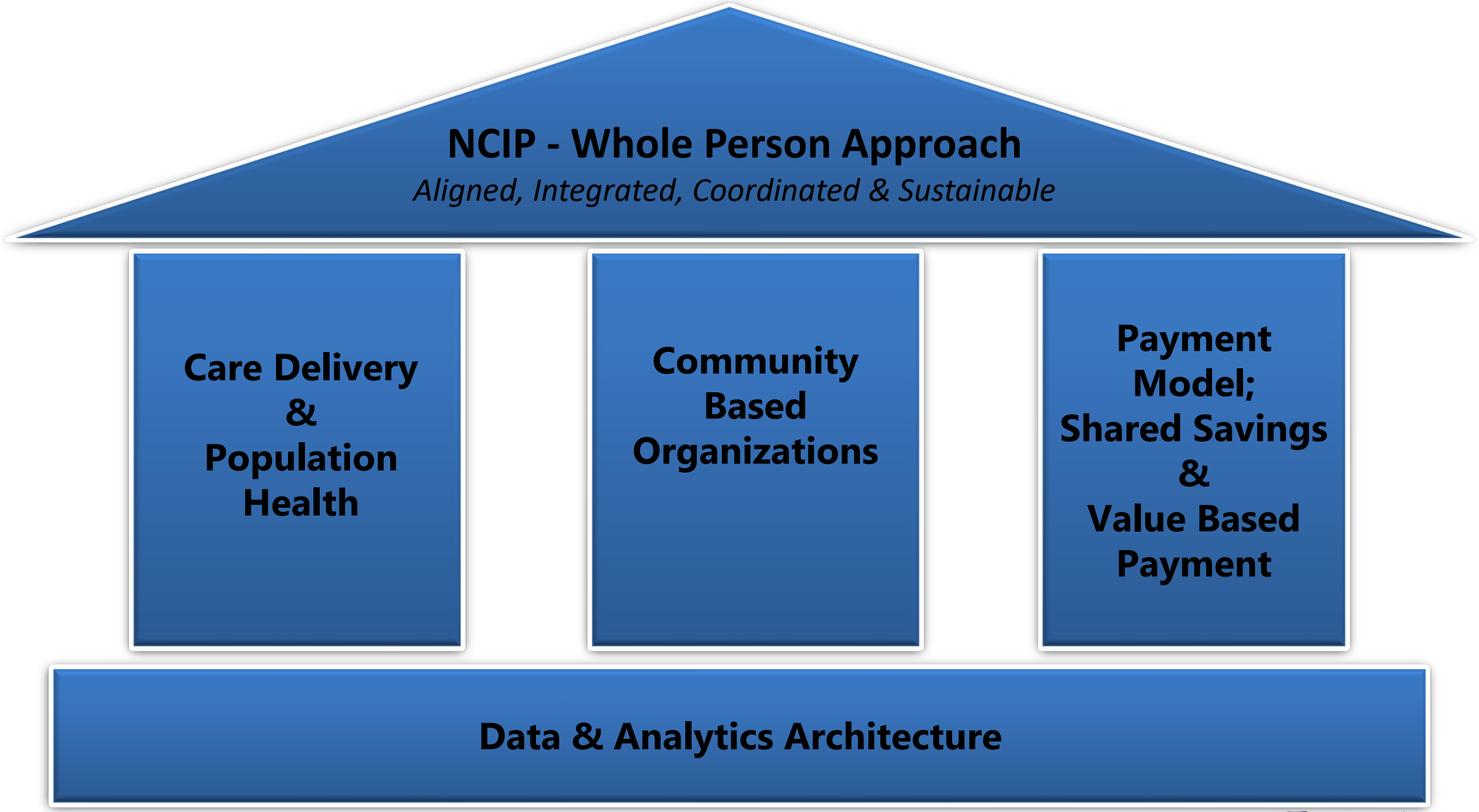
Optimizing Data Alignment, Integration & Coordination



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Trickle down benefits of the NCIP

- Strengthened our relationships and accelerated our work with a number of the other stakeholders
- Accelerated relationship with AHI – working closely together to develop Network (and provider level) quality scorecards using physical and behavioral health metrics.
- The work that NCIP steering committee has done to create shared definitions and terminology (ex. global hospital budget, behavioral health, etc.) has been exceptionally helpful. Prior to defining these terms, it seemed as though each stakeholder had a slightly different perspective on what the terms meant.
- Increased knowledge of the current pursuits and offerings of each provider at the table has led to several one-offs on potential collaborations.
- Participating in the NCIP has also helped us to avoid creating duplicative healthcare infrastructure in the region.
- Improved our communication and partnership with the State

- Enhanced collaboration efforts between AHI and ADK ACO.
- Peaked interest in ADK Wellness / UniteUS platform.
- AHI Data Team working with Northwinds to create dashboards for quality measures related to the Northwinds IPA.
- AHI and ADK ACO asked to present @ NCBHN to discuss “post-DRIP initiatives”.
- ADK ACO and Northwinds team members are presenting today!
- Improved relationships across the region between AHI and partners, showing AHI is much more than the DSRIP program.
- There has been greater focus, involvement, and communication with AHIs Health Home Program through Care Coordination sub-workgroup.

CARE COORDINATION AND WHOLE PERSON CARE

Care coordination ensures all individuals access to and utilization of health and social supports needed to realize optimal health and wellness

WHO IS INVOLVED?

Everyone..

- Primary care (HHHN)
- Long-Term/Post-Acute Care: Fort Hudson
- Acute Care: Glens Falls Hospital; Champlain Valley Physicians' Hospital
- Community-Supports: Adirondack Health Institute
- ACO

CURERENT CHALLENGES / OPPORTUNITIES

Multiple care coordination entities, using multiple platforms

Platforms include:
Adirondack Wellness Connections,
NetSmart,
Care Navigator,
HIXNY
and others…

***GOAL**: Develop a platform that ensures timely communications between multiple care coordinators, across disciplines and across sites of care to promote wellness, improve outcomes for those with chronic and preventable illness and to assist those experiencing geographic access issues.*

CC GOAL ONE: CREATE AND USE A SINGLE, CONSISTENT TOOL TO ASSESS NEED AND OFFER SERVICES, SUPPORTS AND REFERRALS

Multiple Assessment Tools Used Today:

- ADK Wellness Connections - Social determinant of health screening
- NCQA (PCMH certification)
- Hospital-specific tools
- Payer-specific tools
- Medicaid Health Home Assessments

The long-term goal

Single communication platform

Available to all clinical and social support

Common risk-assessment tool

Identify and use the most appropriate care coordinator (plan, practice, hospital or community-based) premised on patient need.

Final thoughts

Caring for our patients is more than the pills, potions, and mechanical things that we can do;

We must stand in front of them, behind them and beside them;

EPH 2014