Adirondack Health Institute

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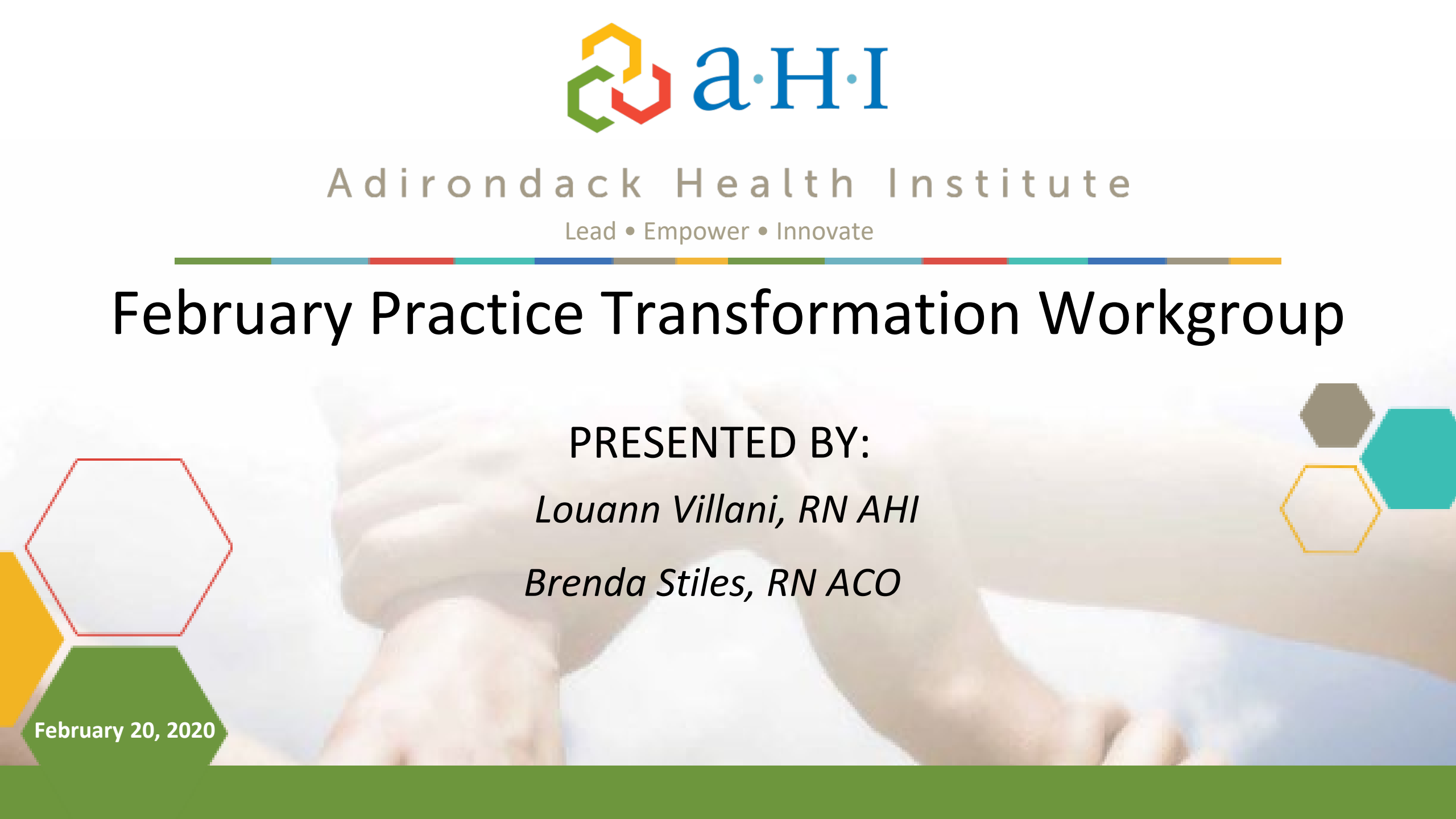
February Practice Transformation Workgroup



PRESENTED BY:

Louann Villani, RN AHI

Brenda Stiles, RN ACO

February 20, 2020

PCMH Tracking Tools

- NCQA PCMH is now on annual recognition process.
- Since April of 2018, Adirondack PPS working from SIM grant for Practice Transformation. Expert services available and fees waived to achieve NCQA Recognition for all practices.
- AHI and ACO working together to assist practices through recognition process.
- Practices in different places with ability to meet and track criteria and metrics.
- To assure all practices remain on track and to assist with successful annual renewal, tools developed.

NCQA Renewal Tracker

OVERVIEW | Practice Name: **Sample Practice** | Submission Due Date: **1/1/2021**

February-20	March-20	April-20	May-20	June-20	July-20	August-20	September-20	October-20	November-20	December-20
☐ TC 01	☐ KM 05	☐ KM 07	☐ KM 08	☐ KM 01	☐ TC 03	☐ KM 06	☐ KM 18	☐ TC 04	☐ KM 21	☐ KM 13
☐ TC 02	☐ KM 23	☐ KM 12	☐ KM 22	☐ KM 11	☐ TC 05	☐ KM 09	☐ KM 19	☐ KM 29	☐ KM 26	☐ QI 15
☐ TC 06	☐ KM 25	☐ AC 05	☐ KM 24	☐ AC 12	☐ TC 09	☐ KM 10	☐ KM 20	☐ AC 01	☐ KM 27	☐ QI 16
☐ TC 07	☐ KM 28	☐ AC 09	☐ AC 13	☐ CC 01	☐ KM 16	☐ KM 14	☐ CC 03	☐ CC 21	☐ CC 06	☐ QI 18
☐ TC 08	☐ CM 01	☐ QI 01	☐ CM 04	☐ CC 04	☐ KM 17	☐ KM 15	☐ CC 05			☐ QI 19
☐ KM 02	☐ CM 02	☐ QI 02	☐ CM 05	☐ CC 07	☐ AC 02	☐ AC 14				
☐ KM 03	☐ CM 03	☐ QI 08	☐ CM 06	☐ CC 08	☐ AC 03					
☐ KM 04	☐ CC 02	☐ QI 09	☐ CM 07	☐ CC 09	☐ AC 04					
☐ AC06	☐ CC 14	☐ QI10	☐ CM 08	☐ CC 11	☐ AC 07					
☐ AC 10	☐ CC 15	☐ QI 11	☐ CM 09	☐ CC 12	☐ AC 08					
☐ AC 11	☐ CC16	☐ QI 13	☐ CC 13		☐ CC 17					
☐ CC 10	☐ CC18	☐ QI 17	☐ CC 20		☐ QI 03					
	☐ CC19				☐ QI 12					
	☐ QI04				☐ QI 14					
	☐ QI05									
	☐ QI06									
	☐ QI07									

Must meet ALL listed below
40 Core Criteria
12 NYS Criteria
25 Elective crtieria across the 6 concepts

NCQA Renewal Tracker

February-20

Core/ NYS/ Elective	AR	Concept	Can Combine with	Description	Documented Process/ Evidence	Shared/ Site-Specific	Person Responsible	Complete	Name/Location of Policy	Date Policy Updated	Name/Location of Evidence	Date Evidence Updated
Core		**TC 01**		**PCMH Transformation Leads**	☐ Detail about Clinician Lead ☐ Detail about PCMH Manager	Shared		☐				
Core		**TC 02**		**Structure and Staff Responsibilities**	☐ Staff structure overview ☐ Desciption of roles, skills & responsibilites	Shared		☐				
Core	**AR-TC 01**	**TC 06**		**Individual Patient Care Meetings/ Communication**	☐ Documented Process ☐ Evidence of Implementation	Shared-Documented Process Only		☐				
Core		**TC 07**	QI15	**Staff Involvement in Quality Improvement**	☐ Documented Process ☐ Evidence of Implementation	Shared		☐				
Elective (2)		**TC 08**		**Behavioral Health Care Manager**	☐ Identified Behavioral Healthcare Manager	Shared		☐				
Core		**KM 02**	KM03, KM04	**Comprehensive Health Assessment**	☐ Documented Process ☐ Evidence of Implementation	Shared		☐				
Core		**KM 03**	KM02, KM04	**Depression Screening**	☐ Documented Process OR ☐ Evidence of Implementation AND ☐ Report	Shared		☐				
NYS (1)		**KM 04**	KM02, KM03	**Behavioral Health Screenings**	☐ B & C Required ☐ Documented Process ☐ Evidence of Implementation	Shared		☐				
Elective (1)		**AC 06**		**Alternative Appointments**	☐ Documented Process ☐ Report	Shared-Documented Process Only		☐				
Core		**AC 10**		**Personal Clinician Selection**	☐ Documented Process	Shared		☐				
Core		**AC 11**		**Patient Visits with Clinician/Team**	☐ Report	Site-Specific		☐				
Elective (2)		**CC 10**		**Behavioral Health Integration**	☐ Documented Process ☐ Evidence of Implementation	Shared		☐				

Next Steps

We have attached the Excel spreadsheet to this meeting invite:

- Do you see your organization using this tool ?
- Do you need any assistance with set up of these tools ?

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DSRIP MY5 Update – May 2019 Data

PRESENTED BY:

Mark Adamick

Performance Improvement Specialist

February 20, 2020

AHI PPS Claims Based Measures

AHI PPS Pay for Performance Metrics Data (May 31, 2019 Data)

Measurement Year 4 (MY4) July 1, 2017 to June 30, 2018
Measurement Year 5 (MY5) July 1, 2018 to June 30, 2019

Metrics on Partner Dashboards

	Achieved Values with MAPP Data**	Target Direction	31-May-2019 Population (Denominator)	Occurrence (Numerator)	Actual Value	MY5 Target	Statewide Goal	MY5 Status	Additional Patients Needed to Reach MY5Target*	MY5 P4P	MY5 Current Revenue Projection	High Performance Target MY5	High Performance Status	Additional Patients Needed to Reach High Performance MY5 Target*	Additional High Performance Program Eligible
1	Potentially Preventable ED Visit Rate (PPV)	Lower is better	78,465	33,282	42.42%	40.89%	6.1%	Not Passing	1,201	$ 581,437	$ -	37.07%	Not Passing	4198	Yes
2	PPV rate for patients w/ Behavioral Health Dx	Lower is better	8,555	7,529	88.01%	90.21%	35.3%	Passing	-188	$ 309,763	$ 309,763	84.58%	Not Passing	293	Yes
3	Potentially Preventable Readmission (PPR) Rate	Lower is better	79,910	302	378	399	181	Passing	-17	$ 581,437	$ 581,437	375	Not Passing	2	Yes
4	PDI 90 Rate (Avoidable Admissions - Pediatrics)	Lower is better	19,014	5	26	47	41	Passing	-4	$ 581,437	$ 581,437				
5	PQI 90 rate (Avoidable Admissions - Adults)	Lower is better	48,690	398	817	913	245	Passing	-46	$ 581,437	$ 581,437				
6	% BH discharge w/ timely follow up - 7 days	Higher is better	713	445	62.41%	55.80%	78.3%	Passing	-47	$ 154,882	$ 154,882	58.31%	Passing	-29	Yes
7	% BH discharge w/ timely follow up - 30 days	Higher is better	713	556	77.98%	72.07%	93.4%	Passing	-42	$ 154,882	$ 154,882	74.44%	Passing	-25	Yes
8	% w antidepressant med mgmt - acute	Higher is better	1,877	1,059	56.42%	54.44%	60.0%	Passing	-37	$ 154,882	$ 154,882	55.06%	Passing	-26	Yes
9	% w antidepressant med mgmt - continuation	Higher is better	1,877	752	40.06%	38.97%	43.5%	Passing	-20	$ 154,882	$ 154,882	39.47%	Passing	-11	Yes
10	% diabetic schizophrenics w/ diabetes monitoring	Higher is better	68	52	76.47%	87.37%	89.8%	Not Passing	8	$ 309,763	$ -	87.64%	Not Passing	8	Yes
11	% antipsychotic med users with diabetes screening	Higher is better	1,080	867	80.28%	79.46%	89.0%	Passing	-9	$ 309,763	$ 309,763				
12	% schizophrenics with antipsychotic Med adherence	Higher is better	299	219	73.24%	70.37%	76.5%	Passing	-9	$ 309,763	$ 309,763				
13	% on ADHD meds with timely follow-up - initial (30 Days)	Higher is better	496	258	52.02%	53.00%	72.3%	Not Passing	5	$ 154,882	$ -				
14	% on ADHD meds with timely follow-up - continuation (9 Months	Higher is better	186	108	58.06%	57.92%	78.7%	Passing	0	$ 154,882	$ 154,882				
15	% with primary care visit, 12 to 24 months	Higher is better	1,429	1,394	97.55%	97.72%	100.0%	Not Passing	2	$ 145,359	$ -				
16	% with primary care visit, 25 months to 6	Higher is better	6,152	5,734	93.21%	94.27%	98.4%	Not Passing	66	$ 145,359	$ -				
17	% with primary care visit, 7 to 11	Higher is better	5,552	5,382	96.94%	97.21%	100.0%	Not Passing	15	$ 145,359	$ -				
18	% with primary care visit, 12-19	Higher is better	7,524	7,214	95.88%	95.75%	98.8%	Passing	-10	$ 145,359	$ 145,359				
19	% with primary care visit, 20-44	Higher is better	19,124	15,941	83.36%	83.18%	91.1%	Passing	-34	$ 193,812	$ 193,812				
20	% with primary care visit, 45-64	Higher is better	10,305	9,171	89.00%	89.01%	94.4%	Not Passing	1	$ 193,812	$ -				
21	% with primary care visit, 65+	Higher is better	61	41	67.21%	75.44%	94.4%	Not Passing	6	$ 193,812	$ -				
22	% with timely initiative of substance abuse treatment	Higher is better	2,627	1,095	41.68%	48.56%	57.1%	Not Passing	181	$ 154,882	$ -				
23	% engaged in substance abuse treatment	Higher is better	2,627	493	18.77%	23.76%	28.3%	Not Passing	131	$ 154,882	$ -				
	Subtotal									$ 5,966,729	$ 3,787,181				

Primary Care Visits

	Actual Value	90th Percentile
% with primary care visit, 12 to 24 months	97.55%	100.0%
% with primary care visit, 25 months to 6	93.21%	98.4%
% with primary care visit, 7 to 11	96.94%	100.0%
% with primary care visit, 12-19	95.88%	98.8%
% with primary care visit, 20-44	83.36%	91.1%
% with primary care visit, 45-64	89.00%	94.4%
% with primary care visit, 65+	67.21%	94.4%

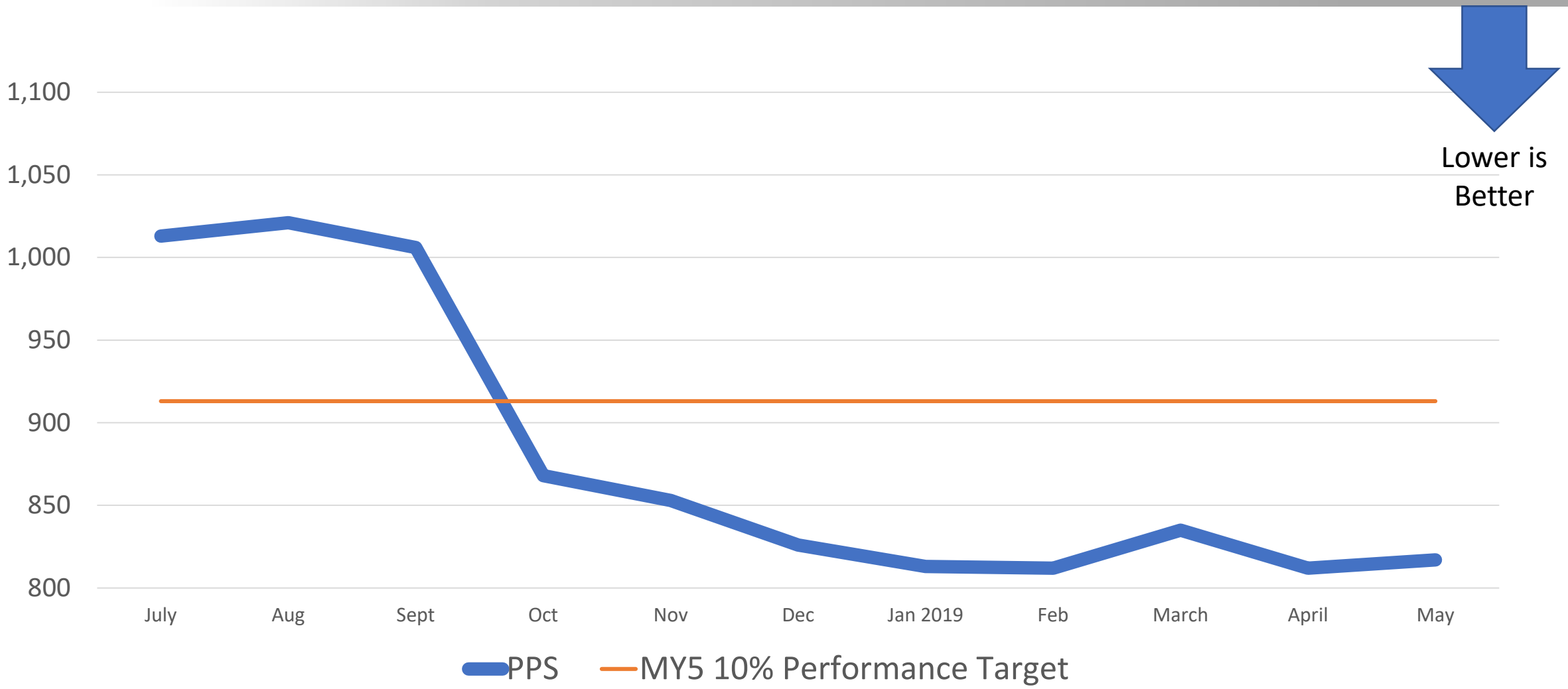
ADHD Medication Management

Initiation Phase

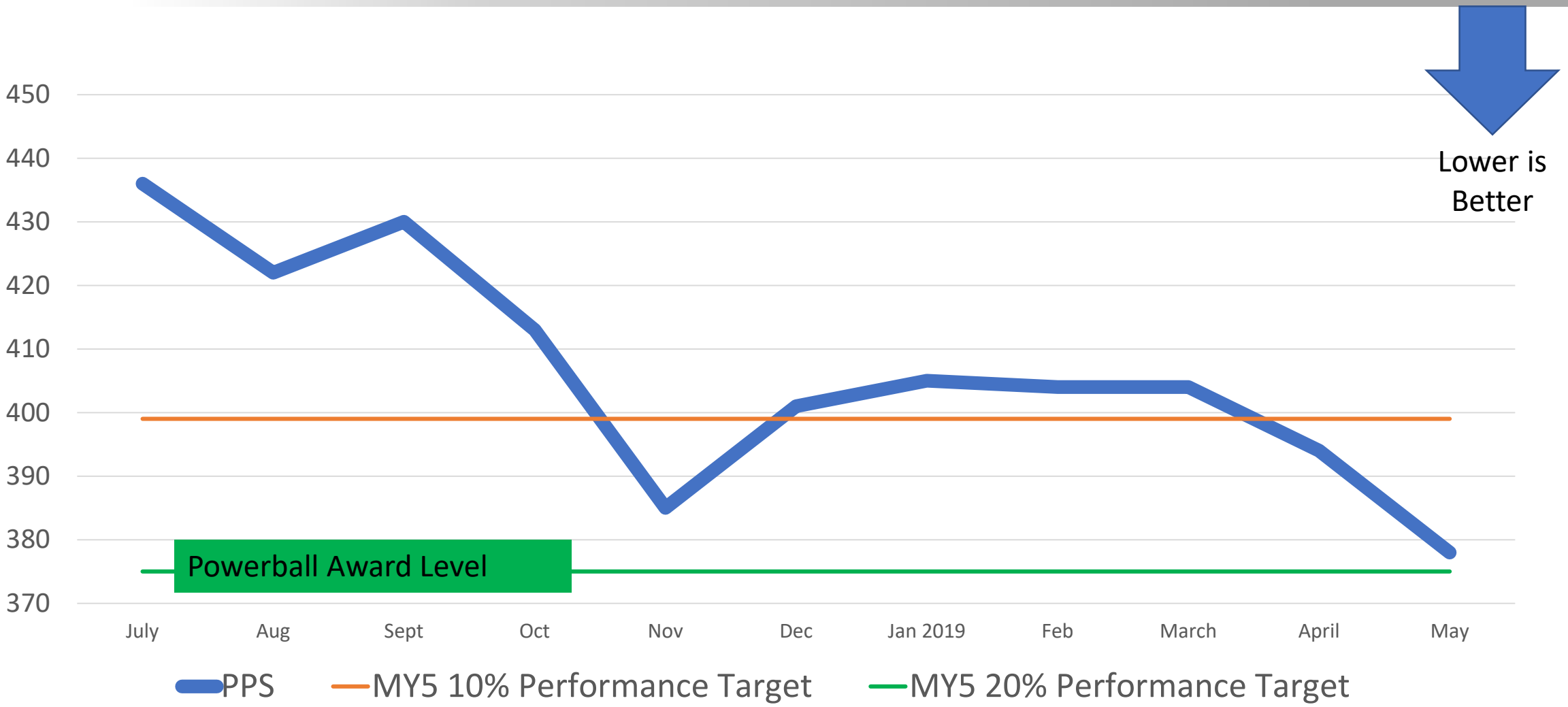
According to the HEDIS quality metric guidelines, each patient should receive one primary care visit in the first 30 days from filling their new ADHD prescription.

Currently, we are only seeing 52% of our patients in 30 days.

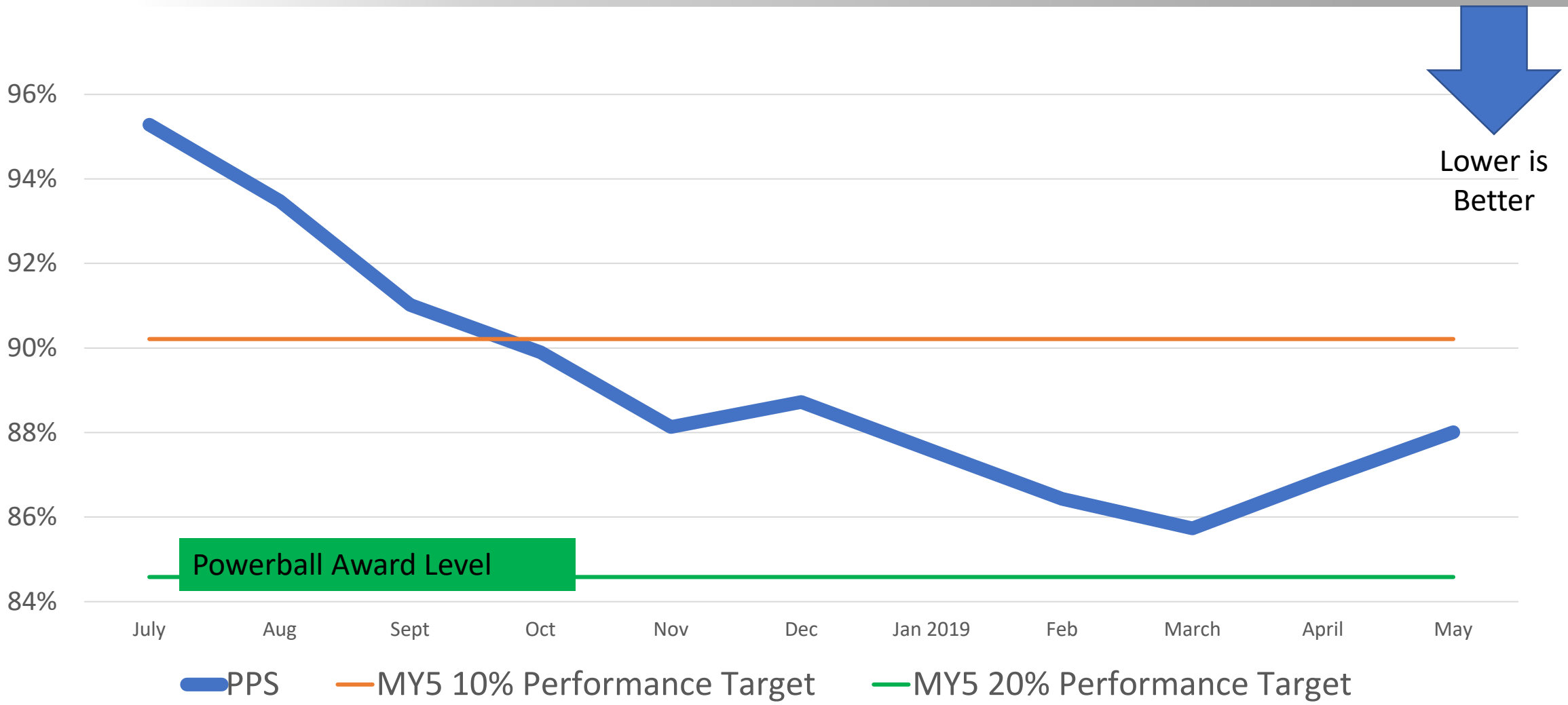
Avoidable Admissions – Adults – May 2019



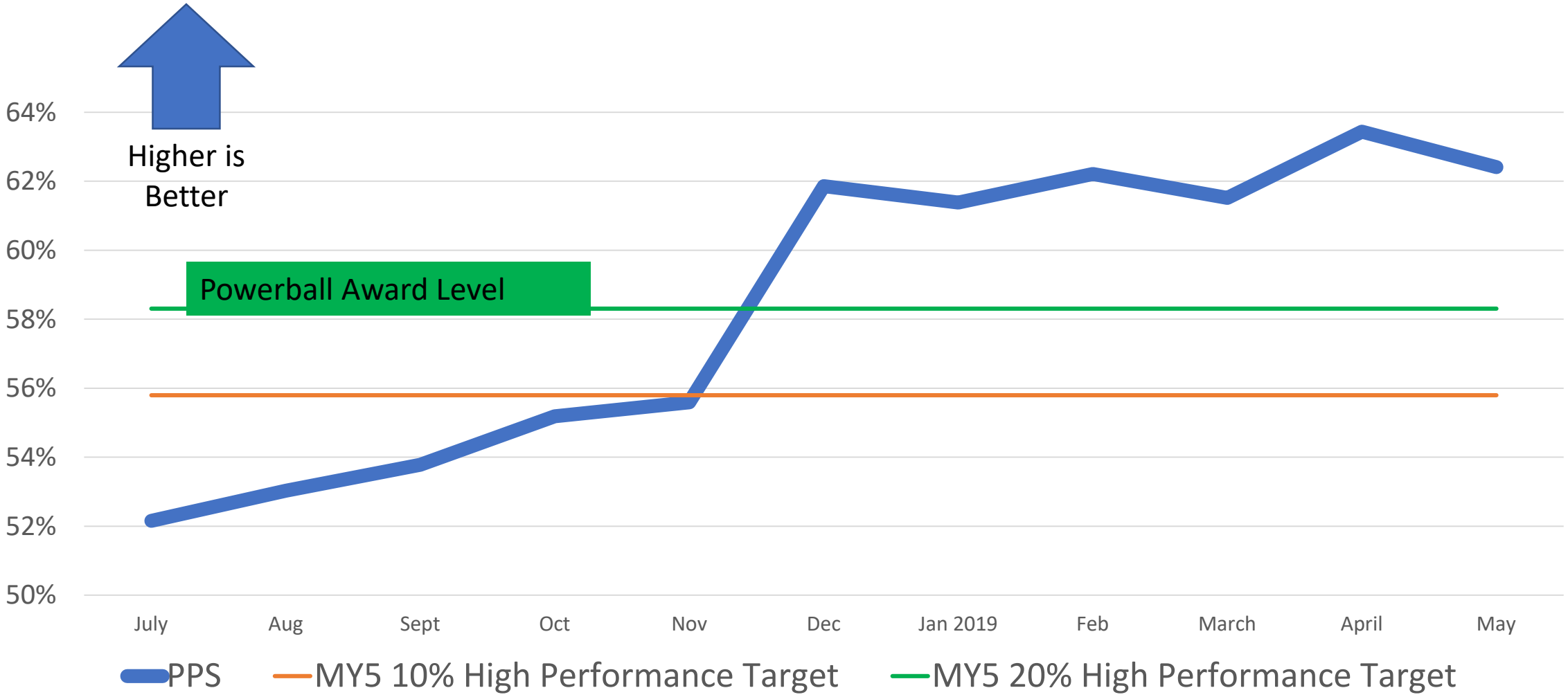
Potentially Preventable Readmissions – May 2019



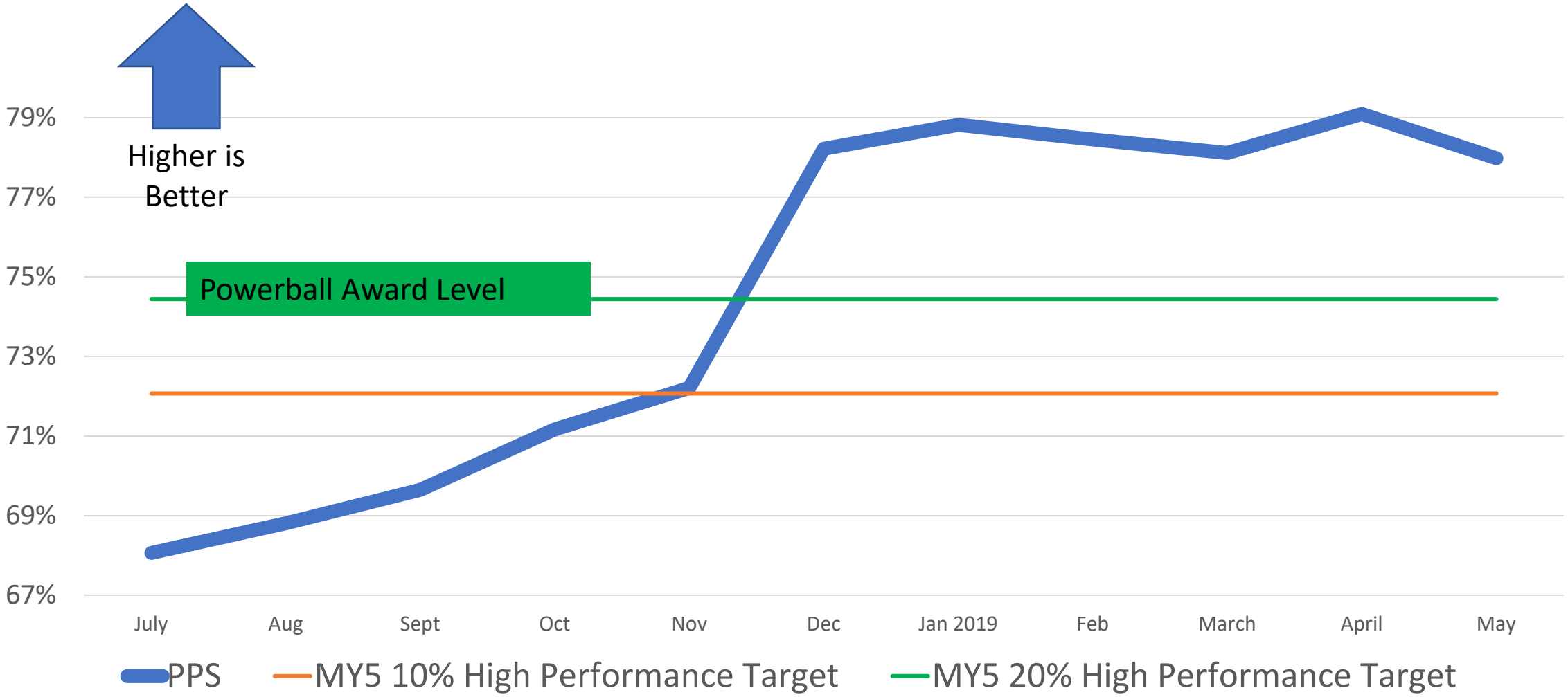
Potentially Preventable ED Visits (Behavioral Health Patients)



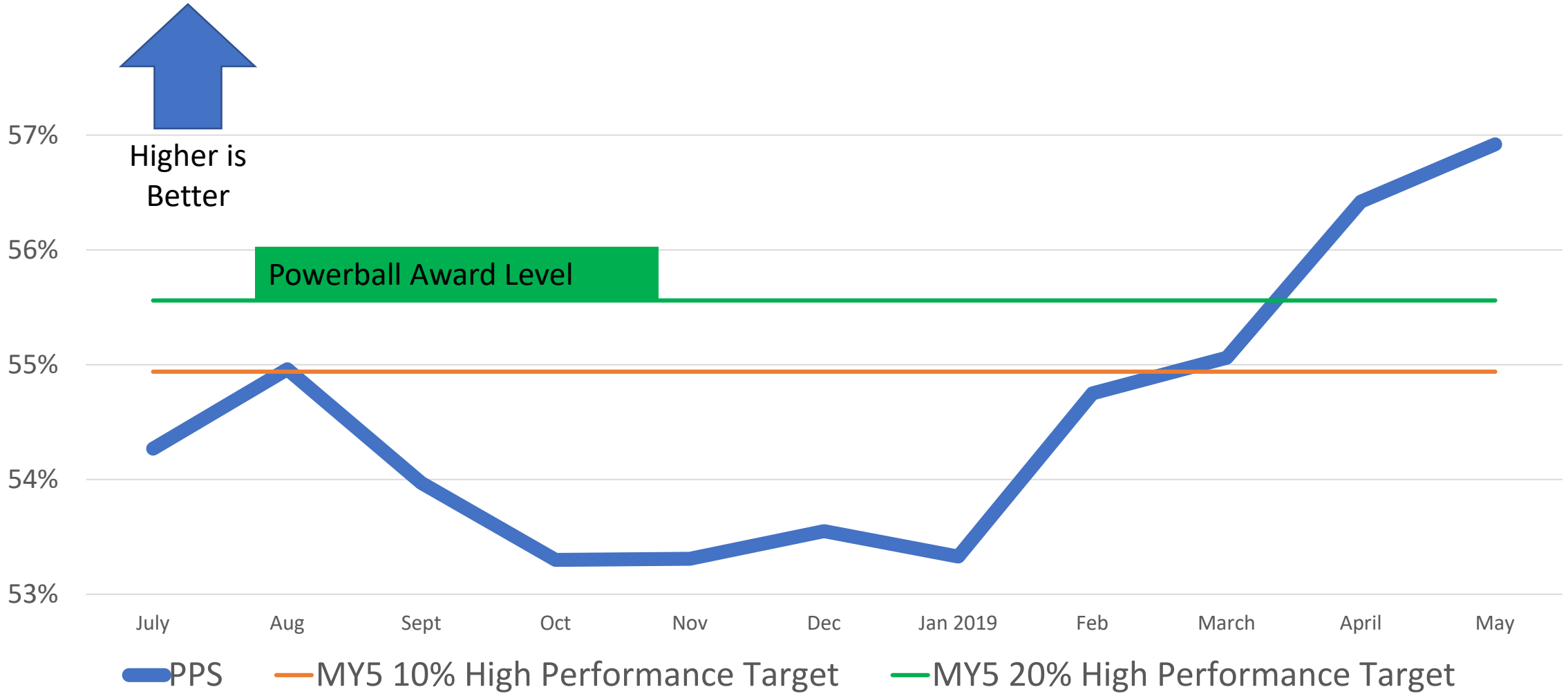
7 Day Follow Up – Mental Health Discharge - 2019



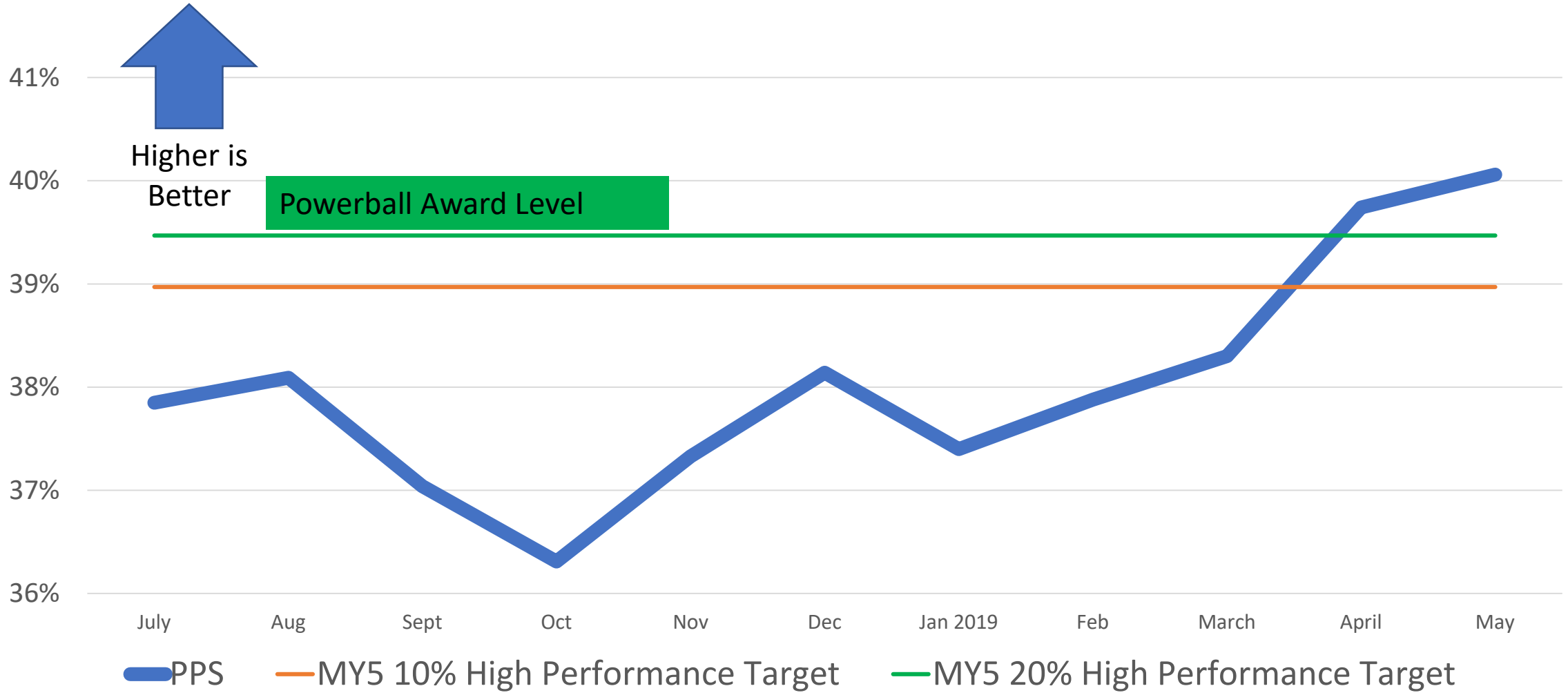
30 Day Follow Up – Mental Health Discharge - 2019



Antidepressant Medication Management (3 Months)



Antidepressant Medication Management (6 Months)



Mark Adamick

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Feedback Survey Results

- 9 Practices responded

Does this work group meet your needs?

6 Yes
2 Most of the time
1 No

Does the current meeting schedule work for your calendar?

6 Yes
1 Later ~ 0830
1 Alternate with afternoon
1 Tuesday better

What areas of PCMH Criteria do you struggle most?

ANSWER CHOICES	RESPONSES	
Practice Organization	30.00%	3
Team Communication	30.00%	3
Medical Home Responsibilities	30.00%	3
Collecting Patient Information	20.00%	2
Patient Diversity	10.00%	1
Addressing Patient Needs	20.00%	2
Medication Management	10.00%	1
Evidence-Based Care	20.00%	2
Connecting with Community Resources	20.00%	2
Additional Patient Collaboration	10.00%	1
Patient Access to the Practice	20.00%	2
Empanelment and Access to the Medical Record	0.00%	0
Identifying Care-Managed Patients	10.00%	1
Care Plan Development	40.00%	4
Diagnostic Test Tracking and Follow-Up	10.00%	1
Referrals to Specialists	30.00%	3
Coordinating Care with Health Care Facilities	20.00%	2
Measuring Performance	10.00%	1
Setting Goals and Acting to Improve	10.00%	1
Reporting Performance	20.00%	2
Total Respondents: 10		

Survey Results - Quality Improvement

Do you have a 2020 quality improvement plan?

7 Yes
2 No

Reduce inpt visits,
Increase F/u after D/C,
Depression Screening,
Maximum benefit of Hedis measures,
Mgmt & Care of BH pt.
Diabetes Care
Preventive Care: breast CA, Colorectal CA Screening, lead testing, ADHD med monitoring (cont)
Patient panel review re: pop health, access and reducing barriers.

Survey Results – VBP Feedback

Do you feel you would benefit from value-based payment and contracting training sessions?

5 Yes

2 Depends on topic

1 Maybe

1 No

Is your organization engaged in value-based contracting?

6 Yes (1 Upside Risk, 1 Up and Downside Risk, 2 ACO: not sure details, risk to start in 2021)

3 No

Discussion – Future Workgroup Structure and Process

Goal: Optimize time and increase transferable knowledge to continue practice transformation.

- ❑ Reduce to half hour presentation.
- ❑ Allow half hour for “open forum” for PCMH specific questions.
- ❑ Develop FAQ’s based on questions and discussions.
- ❑ Other Suggestions ?

Communications and Save the Dates

- VBP programs
- NC PHIP Stakeholder Meeting
- Patient Experience Webinar Series
- LGBTQ+ Resources

Upcoming Event

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Preparing for Success in a Value-Based Care Environment

A Webinar Learning Series for Community-Based Organizations

In collaboration with the AHI Performing Provider System (AHI PPS) and North Country Population Health Improvement Program (NC PHIP), this webinar learning series is tailored for community-based organizations in Clinton, Essex, Franklin, Fulton, Hamilton, Saratoga, St. Lawrence, Warren, and Washington counties. Other regional community providers are also invited to participate.

The Move to Value-Based Payment Fundamentals

Thursday, February 20, 2020, 10:00 a.m.—12:00 p.m.

This webinar will explore the overarching concepts of the move to value-based payment, including:

- Reviewing the health care delivery system and how this change is rolling out across the state and nation, and what it means for you;
- Looking at New York State-specific updates, including the results of the five-year Delivery System Reform Incentive Payment (DSRIP) Program, and trends happening across the state;
- Reviewing examples of new, value-based arrangements that will be shared to show you what's possible in this new, value-based world.

Presenters: Jason Helgerson, former NY Medicaid Director, Kalin Scott, and Juliette Price, Helgerson Solutions Group.

Content: 90 minutes of lecture; 30 minutes for questions and answers.

Helgerson

Registration: https://zoom.us/webinar/register/WN_ZppjeyEbS7CmzPsm-ySMxQ.

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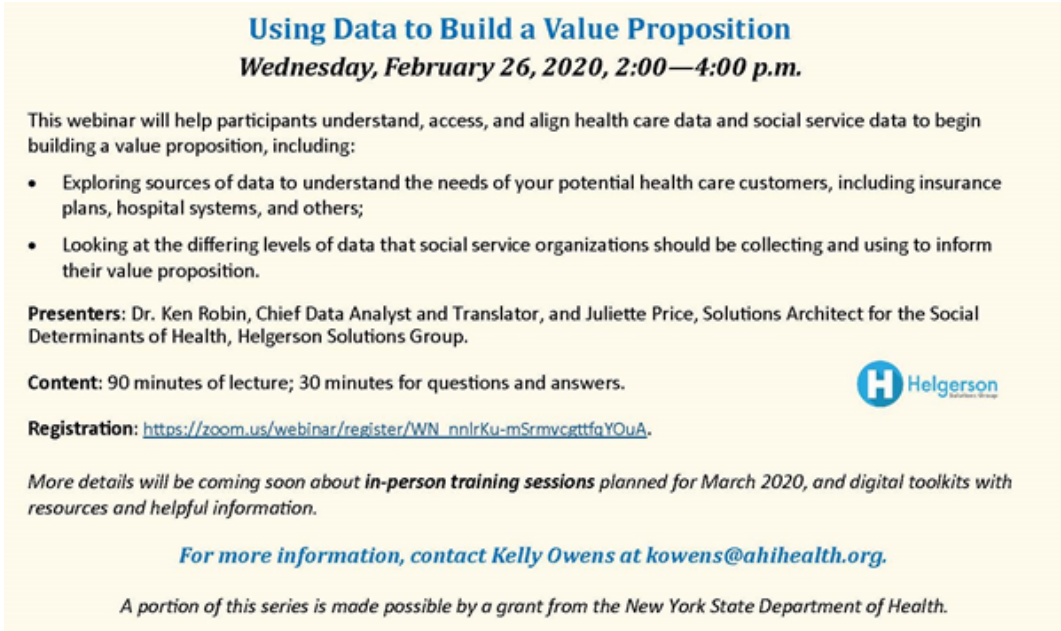

Using Data to Build a Value Proposition

Wednesday, February 26, 2020, 2:00—4:00 p.m.

This webinar will help participants understand, access, and align health care data and social service data to begin building a value proposition, including:

- Exploring sources of data to understand the needs of your potential health care customers, including insurance plans, hospital systems, and others;
- Looking at the differing levels of data that social service organizations should be collecting and using to inform their value proposition.

Presenters: Dr. Ken Robin, Chief Data Analyst and Translator, and Juliette Price, Solutions Architect for the Social Determinants of Health, Helgerson Solutions Group.

Content: 90 minutes of lecture; 30 minutes for questions and answers.

Helgerson

Registration: https://zoom.us/webinar/register/WN_nnlrKu-mSrmvcgttfqYOuA.

*More details will be coming soon about **in-person training sessions** planned for March 2020, and digital toolkits with resources and helpful information.*

For more information, contact Kelly Owens at kowens@ahihealth.org.

A portion of this series is made possible by a grant from the New York State Department of Health.

https://zoom.us/webinar/register/WN_nnlrKu-mSrmvcgttfqYOuA

Upcoming Event

LGBTQ+ Resources

https://ahihealth.org/resources-for-supporting-lgbtq/

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