ALBANY MEDICAL CENTER HOSPITAL
Performing Provider System
AMCH PPS (Better Health for Northeast New York) Governance Structure
Value Based Purchasing and Funds Flow
Financial Sustainability

Surveyed partners on various financial ratios and requested financial statements [days cash on hand, debt ratio, operating margin, current ratio, debt service coverage and working capital]

Budget subcommittee set benchmarks for ratios

Analysis to define organizations that provide unique and critical services

Will provide performance improvement plan, training, and technical assistance
Value Based Purchasing

Monthly VBP Workgroups established April 2016

- Membership includes 4 MCOs, 12 partner organizations including 6 PCPs and 2 CBOs
- Co-chairs: 1 Partner Organization, 1 MCO
- Provides education/guidance to network
- VBP assessments completed in 2015 and 2016
  - Current State, future plans, educational needs, and barriers

Implementing education sessions based on new guidance – DY3

- Education session topics based on partner feedback and identified needs
- Develop VBP support implementation plan
Contracting Process

Partner Organization Agreement
- Five-year boilerplate agreement, no funding implications

Master Project Agreement & Exhibit A – Phase 1
- 04/01/15-12/31/16
- $9.7M allocated to Phase 1, 3 payment periods
- Focused on engagement activities, policies/procedures, job descriptions (patient navigators), training & assessments

Master Project Agreement & Exhibit A – Phase 2
- 01/01/17-03/31/18
- $13M allocated to Phase 2
- Focused on performance measures and outcomes
Contracting Process

2ai – Comprehensive Baseline Assessment [2015]
- $6,000 for submission by 10/16/2015
- $5,000 for late submission

2ai – Listening Sessions
- Funding varied based on request for proposal process
  - 15 sessions in Spring 2016, 11 in Fall 2016
  - $24,777.50 funded – mostly to CBOs

2di – Patient Activation Measure (PAM)
- 4/1/15-3/31/16 - $36/PAM
- 4/1/16-3/31/17 - $50/In-person PAM that includes coaching, $35/In-person PAM without coaching and $20/telephonic PAM

Law Enforcement Assisted Diversion (LEAD) Contract
- $45,000 funding – 2016
- $60,000 funding – 2017
Funds Flow by Provider Type as of 09/30/2016

- **Practitioner - PCP**: 12.26%
- **Hospital**: 0.70%
- **Clinic**: 0.85%
- **Case Management/Health Home**: 0.59%
- **Mental Health**: 1.06%
- **Substance Abuse**: 0.26%
- **Nursing Home**: 0.27%
- **Community Based Organizations**: 0.26%
- **All Other**: 6.82%
- **Uncategorized**: 0.44%
- **Additional Providers**: 0.48%
- **PPS PMO**: 76.01%
Funds Flow by Provider Type as of 12/31/2016

- Practitioner - PCP: 1.74%
- Hospital: 21.54%
- Clinic: 0.90%
- Case Management/Health Home: 1.18%
- Mental Health: 2.36%
- Substance Abuse: 0.34%
- Nursing Home: 0.27%
- Community Based Organizations: 0.39%
- All Other: 7.31%
- Uncategorized: 61.98%
- Additional Providers: 1.67%
- PPS PMO: 1.67%
Funds Flow by Provider Type as of 01/31/2017

- **56.70%**
  - Practitioner - PCP
  - Hospital
  - Clinic
  - Case Management/Health Home
  - Mental Health
  - Substance Abuse
  - Nursing Home
  - Community Based Organizations
  - All Other
  - Uncategorized
  - Additional Providers
  - PPS PMO

- **19.88%**
  - Practitioner - PCP

- **13.10%**
  - Hospital

- **2.94%**
  - Case Management/Health Home

- **1.54%**
  - Mental Health

- **1.30%**
  - Substance Abuse

- **0.30%**
  - Nursing Home

- **0.25%**
  - Community Based Organizations

- **0.23%**
  - All Other

- **0.21%**
  - Uncategorized

- **0.31%**
  - Additional Providers

- **0.39%**
  - PPS PMO
# Funds Flow Reconciliation – through 1/31/2017

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>PIT Provider Type Allocation Through DY2Q3</th>
<th>Reclassified Provider Type Allocation Through DY2Q3</th>
<th>VAR %</th>
<th>PIT Provider Type Allocation Through 1/31/2017</th>
<th>Reclassified Provider Type Allocation Through 1/31/2017</th>
<th>VAR %</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Other</td>
<td>823,695.00</td>
<td>28,882.00</td>
<td>-96.5%</td>
<td>1,609,181.00</td>
<td>32,893.00</td>
<td>-98.0%</td>
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<tr>
<td>Case Management / Health Home</td>
<td>134,097.00</td>
<td>190,333.00</td>
<td>41.9%</td>
<td>153,037.00</td>
<td>209,673.00</td>
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<tr>
<td>Clinic</td>
<td>82,117.00</td>
<td>72,260.00</td>
<td>-12.0%</td>
<td>105,449.00</td>
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<td>Community Based Organizations</td>
<td>79,232.00</td>
<td>324,872.00</td>
<td>310.0%</td>
<td>83,366.00</td>
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<td>Hospital</td>
<td>2,408,913.00</td>
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<td>2,432,038.00</td>
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<td>Mental Health</td>
<td>350,025.50</td>
<td>343,584.50</td>
<td>-1.8%</td>
<td>373,774.50</td>
<td>367,333.50</td>
<td>-1.7%</td>
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<tr>
<td>Nursing Home</td>
<td>32,231.00</td>
<td>29,350.00</td>
<td>-8.9%</td>
<td>32,231.00</td>
<td>29,350.00</td>
<td>-8.9%</td>
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<tr>
<td>Practitioner - Primary Care Provider (PCP)</td>
<td>232,861.00</td>
<td>816,253.00</td>
<td>250.5%</td>
<td>397,549.00</td>
<td>1,760,010.00</td>
<td>342.7%</td>
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<tr>
<td>Substance Abuse</td>
<td>37,473.00</td>
<td>37,906.00</td>
<td>1.2%</td>
<td>37,473.00</td>
<td>37,906.00</td>
<td>1.2%</td>
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<tr>
<td>Uncategorized</td>
<td>71,709.00</td>
<td>-</td>
<td>-100.0%</td>
<td>74,184.00</td>
<td>-</td>
<td>-100.0%</td>
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<td><strong>Grand Total</strong></td>
<td><strong>4,252,353.50</strong></td>
<td><strong>4,252,353.50</strong></td>
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<td><strong>5,298,282.50</strong></td>
<td><strong>5,298,282.50</strong></td>
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</tr>
</tbody>
</table>

***All Other includes providers that perform home health services

***CapitalCare (PCP) classified as "all other" in PIT, Catholic Charities (CBO) classified as "all other" or "uncategorized."
Allocation of Funds 4/1/2015-09/30/2016 [Through DY2Q2]

*Hospital partner contracts represent funds flowed to both hospitals and primary care practices
**Includes project manager salaries and project related travel
Allocation of Funds 4/1/2015-12/31/2016 [Through DY2Q3]

*Hospital partner contracts represent funds flowed to both hospitals and primary care practices

**Includes project manager salaries and project related travel
CULTURAL COMPETENCY &
HEALTH LITERACY
Cultural Competency & Health Literacy Strategies

AMCH PPS Cultural Competency & Health Literacy Strategy

- Organizational focus
- Trainings
- Communications
- Patient navigators/care coordinators
- Patient Education
- Language Services
- Metrics

AMCH PPS Cultural Competency Training Strategy

- Link with DSRIP project needs:
  - Motivational Interviewing, Teach-back method, Mental Health first-aid
  - Bring Cultural Shift
  - Cross-cultural training/cultural competency 101, Social determinants of health/Bridges Program, ACEs and trauma-informed care
- Increase education about how to better care for patient subpopulation
  - including language access/limited English proficiency (LEP) population, Geriatrics, Refugees, LGBTQ, Disabled population, faith-based communities
Cultural Competency & Health Literacy Processes

• Working collaboratively with partners to develop strategies based on best practices

• Making Efforts to Measure Impacts of CCHL Activities
  • Annual Partner Survey
  • Pre- and Post-Training Assessments
  • CCHL Quality Improvement Projects In Discussion

• Seeking Continuous Partner Feedback for Effective Training
  • Intro to CCHL Webinar Training Followed by Individual Meetings with each CCHL Champion
  • Initial 2-Day Bridges Out of Poverty Training
  • Health Literacy Symposium

• Bi-monthly CCHL Committee
• Quarterly CCHL Champions
COMMUNITY RELATIONS & CBO ENGAGEMENT
Ongoing Community Relations & CBO Engagement

*Public Forums and collaboration with AFBH & AHI*

*Great American Smoke Out - Innovative Collaboration*

*Strengthening communication through newsletter and dashboards*

*Forums and collaboration with AFBH & AHI [Where does my CBO fit?]*

*Face to Face meetings with CBOS [Where does my CBO fit?]*

*Strengthening communication through newsletter and dashboards*

*Public Forums and collaboration with AFBH & AHI [Where does my CBO fit?]*

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*Strengthening communication through newsletter and dashboards*
## Community Relations & CBO Engagement

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<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Substance Abuse Prevention Council of Saratoga County</td>
<td>Hudson Mohawk Area Health Education Center</td>
</tr>
<tr>
<td>Black Nurses Coalition, Inc.</td>
<td>In Our Own Voices, Inc.</td>
</tr>
<tr>
<td>BOCES CAPIT</td>
<td>Independent Living Center of the Hudson Valley, Inc.</td>
</tr>
<tr>
<td>Capital District YMCA</td>
<td>Interfaith Partnership for the Homeless</td>
</tr>
<tr>
<td>Capital Region BOCES</td>
<td>Mental Health Association of NYS</td>
</tr>
<tr>
<td>Catholic Charities of Columbia and Greene Counties</td>
<td>Mental Health Empowerment Project, Inc.</td>
</tr>
<tr>
<td>Catholic Charities Senior and Caregiver Support Services</td>
<td>NY START</td>
</tr>
<tr>
<td>Catskill Hudson Area Health Education Center</td>
<td>Shelters of Saratoga</td>
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<tr>
<td>Community Caregivers</td>
<td>St. Paul’s Center, Inc.</td>
</tr>
<tr>
<td>Compeer, Inc.</td>
<td>The Alternative Living Group, Inc.</td>
</tr>
<tr>
<td>Consumer Directed Choices, Inc.</td>
<td>The Next Step, Inc.</td>
</tr>
<tr>
<td>DePaul Housing Management</td>
<td>The Quality and Technical Assistance Center of NY</td>
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<td>Greene County Rural Health Network</td>
<td>Troy Crossings, LLC DBA The Pines at Heartwood</td>
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<tr>
<td>Healthy Capital District Initiative</td>
<td>Wildwood Programs, Inc.</td>
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<tr>
<td>Hope House, Inc.</td>
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</table>
Law Enforcement Assisted Diversion (LEAD)

Reduce recidivism and unnecessary Emergency Department visits
DSRIP 360 Survey

168 surveys from 14 organizations
74% high response rate

81% of all respondents’ answers were either “strongly agree” or “agree”
CONSUMER LISTENING SESSIONS
Consumer Listening Sessions

Rationale: (1) Opportunity to engage Medicaid beneficiaries in DSRIP implementation; (2) Understand barriers to healthcare access self disease management; and (3) Leverage CBO partners' experience of directly working with consumers

Round 1 (Spring 2016):
15 Sessions
Target populations: homeless, LGBTQ, individuals with intellectual and developmental disabilities

Round 2 (Fall 2016):
14 Sessions
Target populations: Immigrants and Refugees, seniors, HIV+ individuals and addictions communities

Over 250 Beneficiaries Reached

Repeating Themes: transportation, language barriers, insurance coverage, physician sensitivity, health literacy, barriers to access, and social determinants of health
Immigrant and Refugee Consumer Listening Sessions

Population Represented
- Session 1: Triqui Community from Oaxaca, Mexico [Partnered with Triquis Sin Froneras]
- Session 2: Chin, Burmese and Karen [Partnered with Lutheran Church of the Holy Spirit]
- Session 3: Syrian, Afghan and Iraqi [Partnered with RISSE]

Main Themes and PPS’s Next Steps
- Transportation - Identify CBOs with transportation services to expand their current capacity
- Language Barriers - Enhance existing language access services and consider adoption of centralized service for all community-based partners
- Cultural differences in navigating the system - Collaborate with partners to address social determinants of health
PRIMARY CARE PLAN & PROJECT UPDATES

Clinical Transformation Team
Primary Care Plan & Project Updates

Guiding Theme

Primary Care Transformation – Implementation of Primary Care

- Expansion of Primary Care Services Across PPS
- PCMH / APC Recognition Support
- “BHNNY Cares” – AMCH PPS Care Coordination Care Management Program

Project-specific Service Delivery Enhancements
AMCH PMO – “GUIDING THEME”

“Better Care, Higher Incentives”
Guiding Theme – “Better Care”

- Increased access to primary care, behavioral health, and community-based services
- Provision of patient-centered, evidence-based care
- Enhanced Care Coordination Care Management
- Improved Medication Adherence
- Timely access to relevant clinical information
- Enhanced member engagement and self-management
- Enhanced clinician/staff engagement and experience
- Timely and effective communication between service providers
- Improved Medication Adherence
- Enhanced Care Coordination Care Management
- Timely access to relevant clinical information
- Enhanced member engagement and self-management
- Enhanced clinician/staff engagement and experience
- Timely and effective communication between service providers
- “Better Care”
Guiding Theme – “Higher Incentives”

- Maximize P4P incentives with special focus on High Performance Measures
- Maximize Domain 1 incentives by completing required milestones by due dates
- Collaborate with providers to submit required medical records for chart-audit based measures
- Achieve patient engagement goals
- Align partner’s incentives to achieving higher DOH incentives
PRIMARY CARE TRANSFORMATION

Implementation of Primary Care Plan
Primary Care Transformation – Primary Care Expansion

Albany Medical Center
- Applied for the NYS Statewide Health Care Facility Transformation Program grant to support development of primary care centers in two ‘hot spot’ areas – awaiting award announcement

Albany Family Medicine [CCP]
- Hired two PCPs in 2016 and will be adding two part-time providers in summer 2017

Center for Disability Services
- Increased PCP FTEs from 1.5 to 2.9 in 2016 & in the process of hiring a patient educator
- Access has improved considerably in the last year

CapitalCare Medical Group
- Expanding the care team to include LCSW and clinical pharmacist
- In 2016, hired two providers to support two practices with high Medicaid populations

Saratoga Hospital Physician Group
- Ongoing provider recruitment to support expanding needs
- Recently selected for CPC+ at all primary care sites requiring hiring case managers to support primary care providers
Primary Care Transformation – Primary Care Expansion

- **Greene County** – Recruited one Family Medicine physician to work at their site in Jefferson Heights, and searching for another primary care physician to work at their second site.

- **Columbia County** – Just hired an internist to work 2 days a week at the Hudson location, and a Nurse Practitioner to work at their Valatie office.

- **Columbia Memorial Hospital**

- **Harmony Mills Pediatrics**

- **Koinonia Primary Care**

  - Early morning walk-in clinic

  - Recruiting another PCP to expand access
Primary Care Transformation – Practice Transformation Support

PCMH / APC Recognition Support: - HANYS Patient-Centered Medical Home Advisory Services have been selected to assist up to 85 primary care sites to achieve/sustain PCMH/APC recognition by March 2018.

Key areas:

- Readiness Assessment and Gap Analysis
- Prioritization Strategy
- Customized Implementation plan to support transformation through NCQA PCMH or NYS APC standards
- Train PMO team to assure sustainability of transformation initiatives
Primary Care Transformation – Financial Support

- Adoption of Adirondack Health Institute PPS’s model for providing financial incentives to support safety-net practices with their provider recruitment & retention efforts.

- Align incentives for primary care practitioners to enhance AMCH PPS’s ability to meet P4P measure targets.  
  - Phase II funds flow model to support process improvement initiatives – *Increase screening rates for depression, asthma medication prescription rates, etc.*

- Incentives to support the sustainability of core PCMH/APC functions.  
  - Phase II funds flow model to support sustainability of critical PCMH functions – *open access, team huddles, proactive outreach, care coordination, etc.*

- Incentives and other appropriate support for partnering organizations with their efforts to integrate primary care and behavioral health services.
Primary Care Transformation: “BHNYY Cares” (Care Coordination Care Management Program)

Goals & Objectives:

- Link attributed members to appropriate care coordination and care management resources.
- Enhance engagement of high-risk members in complex care management program.
- Proactively identify members for eligible for NYSDOH Health Home services and refer them to a Health Home entity.
- Facilitate access to primary and preventive care services, including community-based behavioral health services.
- Collaborate with community-based organizations to address relevant Social Determinants of Health (SDH).
- Improve members’ experience of care.
"BHNYY Cares" CCCM Program – Model

Facilitators
- Proactive clinical teams
- Member engagement
- Culturally relevant services to SDHs
- EBM guidelines
- Effective Communication

Facilitators
- Effective IDS
- Workforce
- PHM System
- Reimbursement
- MCO support
- Hixny connectivity

Keys:
PCMH – Current and Eligible Patient Centered Medical Homes
Central CCCM – AMCH PPS Central CCCM Program supported by CDPHP
Community CCCM – HH CMAs and other partners providing Patient Navigation / CHW services to address selected SDH
IDS – Integrated Delivery System
PHM- Population Health Management
MCO – Managed Care Organization
SDH – Social Determinants of Health
EBM – Evidence-based Medicine

Model representation adopted from “Collaborative Care Manager Model - Toolkit for Implementing the Chronic Care Model in an Academic Environment” – AHRQ 2014
PROJECT-SPECIFIC SERVICE DELIVERY ENHANCEMENTS
2ai: Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management

**Completed**
- Partner with HH and ACO
- Track actively engaged patients
- MCO contracts in place including Value Based Payments
- Re-enforce transition towards VBP
- Community Health Workers and CBOs utilized in IDS for outreach and navigation activities

**In Progress**
- Implement an IDS
- Clinically Interoperable System
- RHIO’s HIE and SHIN-NY connectivity
- NCQA 2014 Level 3 PCMH standards
- Monthly Medicaid MCO meetings
2biii ED care triage for at-risk populations

- 1 out of 4 milestones not completed.

Key service enhancements:

- Recruitment/retraining of ED Case Managers to improve care transitions and linkages with PCMHs and community-based organizations for access to care & care coordination needs.

- Establishment of linkages between Columbia Memorial Hospital’s case management and four regional Health Home Care Management Agencies (HH CMAs) to pilot a SPOA model for in-patient psychiatric & other at-risk patients.

- Adoption of national guidelines across the three EDs to limit opioid prescriptions written in EDs to 3 days.
3bi Evidence-based strategies for disease management in high risk/affected populations (adult only)

- 13 out of 20 milestones not completed.
- 10-11 milestones are on track for completion by September 2017.
- Practitioner speed & scale milestone will be a challenge.

Key service enhancements:

- Adoption of national guidelines for managing hypertension and elevated cholesterol.
- Implementation of walk-in BP screening at many participating primary care practices.
- Adoption of standardized hypertension medication management protocol utilizing Million Hearts Strategies framework.
3bi Evidence-based strategies for disease management in high risk/affected populations (adult only)

- Discussions underway with three primary care groups and Albany County Health Department to implement Self-Measured Blood Pressure Monitoring program utilizing CDC/AMA protocols

Key Service Enhancements:
Include efforts underway at participating primary care practices to:

- Assure ongoing staff competencies in obtaining BP readings accurately.

- Identify patients with hypertension and without a timely follow-up visit and conduct proactive outreach for follow-up

- Identify patients with high BP readings and without a diagnosis of hypertension for diagnosis confirmation.
3diii Implementation of evidence-based medicine guidelines for asthma management

- 3 out of 5 milestones not completed.
- Practitioner speed & scale milestone will be a challenge.
- Remaining milestones on track for completion by September, 2017

**Key service enhancements:**

- Adoption and implementation of evidence-based asthma guidelines (EPR-3) based on most current national standards.
- Standardized assessment and monitoring
- Increase controller medication prescription & adherence
- Patient education & self-management support
- Control of environmental factors and other triggers
3diii Implementation of evidence-based medicine guidelines for asthma management

**Key service enhancements:**

- Adoption & implementation of standardized pathway for managing asthma exacerbation in EDs
- Steps to identify patients with persistent asthma and not on necessary controller medications using EHR registries.
- Discussions with Columbia Memorial Hospital & Pediatric Pulmonary group at Albany Medical Center to pilot telemedicine services to increase access to specialists.
Project-Specific Service Delivery Enhancements

- Recruitment/retraining of ED Case Managers to improve care transitions
- Contract discussions with HH CMAs to support Primary Care Practices
- Establish Linkages between CMH’s CM and four regional HH CMAs
- Adoption of guidelines: screening for Depression and managing hypertension
- Provision of technical assistance for PC and BH Organizations
- Implement walk-in BP screening
- Adoption of standardized hypertension medication management protocol
- Implement Self-Measured Blood Pressure Monitoring Program
- *Efforts underway at participating Primary Care practices
- **Adopt and implement evidence-based asthma guidelines
- Identify patients w/persistent asthma not on controller medications
- Telemedicine services to increase specialist access

- Limit opioid prescriptions written in EDs to three days
- Implement walk-in BP screening
- Implementation of standardized hypertension medication management protocol
- Self-Measured Blood Pressure Monitoring Program
- *Efforts underway at participating Primary Care practices
- **Adopt and implement evidence-based asthma guidelines
- Identify patients w/persistent asthma not on controller medications

- Telemedicine services to increase specialist access

- Project-Specific Service Delivery Enhancements