All PPS Meeting

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Agenda

- MCO and PPS Alignment & Collaboration
- Performance Pain Points
- Population Health 2.0 Application
- Plan Performance Analysis
- Use Case illustrations
- Plan Collaboration
- Opportunities for future alignment and initiatives
Plan and PPS Natural Alignment

- Population health improvement for communities we serve
- Measured by many common indicators
- Significant funds at risk in VBP/P4P methodology
- Challenges with small practice engagement-capacity change, data management, PCMH, multiple EMRs in practice environment
- Move to Value Based care demands coordinated effort with partners
- Complimenting each others expertise and resources- Business Intelligence (BI), care coordination, engaging CBOs, physician practice alignment, etc.
Current Areas for Collaboration

- **Asthma Coalition** – community-wide effort with Department of School Health, physician practices, hospitals and MCOs to improve asthma outcomes in school age children
- **Diabetes Management** – PPS focus on improved HEDIS and patient outcomes for short and long term complications of diabetes
- **Behavioral Health** – community-wide effort with hospitals, behavioral health providers, physician practices, and CBOs to improve health outcomes for individuals with co-occurring mental health and substance use disorders
- **Readmission reduction** – ongoing efforts with nursing homes, home care agencies, and hospitals to reduce hospital transfer rates and readmissions
- **Initiatives to improve access** to primary and preventive care for adults and children
- **Multiple MCOs have signed agreements** with SI PPS to support these programs
MY2 P4P measures showing opportunity for improvement
July 1, 2015 - June 30, 2016

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>PPS meeting MY2 AIT</th>
<th>Performance Value</th>
<th>MY3 Trend²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant Medication Management - Effective Acute Phase Treatment</td>
<td>1/25 (4%)</td>
<td>$22,255,453</td>
<td>9/25 (36%)</td>
</tr>
<tr>
<td>Antidepressant Medication Management - Effective Continuation Phase Treatment</td>
<td>1/25 (4%)</td>
<td>$21,993,287</td>
<td>9/25 (36%)</td>
</tr>
<tr>
<td>Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)</td>
<td>1/25 (4%)</td>
<td>$21,799,757</td>
<td>13/25 (52%)</td>
</tr>
<tr>
<td>Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)</td>
<td>3/25 (12%)</td>
<td>$21,799,757</td>
<td>16/25 (64%)</td>
</tr>
<tr>
<td>Follow-up after hospitalization for Mental Illness - within 7 days</td>
<td>3/25 (12%)</td>
<td>$22,553,222</td>
<td>14/25 (56%)</td>
</tr>
<tr>
<td>Follow-up after hospitalization for Mental Illness - within 30 days</td>
<td>5/25 (20%)</td>
<td>$22,553,222</td>
<td>16/25 (64%)</td>
</tr>
<tr>
<td>Diabetes Mellitus Short Term Complications¹</td>
<td>2/10 (20%)</td>
<td>$39,124,734</td>
<td>5/10 (50%)</td>
</tr>
<tr>
<td>Medication Management for People with Asthma - 75% of Treatment Days Covered</td>
<td>3/13 (23%)</td>
<td>$14,704,317</td>
<td>1/13 (8%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$186,783,749</td>
<td></td>
</tr>
</tbody>
</table>

¹ High Performance measure
² MY3 trend is based on MY3 month5 data and is the number of PPS “on-track” as shown in DSRIP dashboards
Value-Based Care Data Management Model

Key Components to Success

- Identify Care Gaps
  - Care Alerts to be Embedded w/i EHR
    *MCO Data Exchange

- Interoperability
  - Send/Received CEN (clinical event notification)
  - Connected to HIE, received and share information

- Population Health Management
  - Risk Stratification
  - Consider SDOH
    * MCO/PPS Alignment

- Quality Metric Reporting
  - Measurement Portal
    * MCO PPS Outcomes Management

Integration Across the Continuum of Care

- Health Systems
- FQHCs
- Primary Care Physicians
- Home Care
- Behavioral Health
- Long-Term Care

Interoperable Electronic Health Records

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SI PPS Analytics: Tool Portfolio
Turn Data into Actionable Insights

Program Areas

- Strategic Planning
- Performance Management / VBP
- Population Health Management
- Community Drug Prevention Portal

MAPP Dashboard - VBP

Population Health Management

Healthcare Hotspotting

Partner P4P Dashboard

SI Drug Prevention Portal

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Total Visits 390,166
Unique Patients 3,119
Inpatient Visit 6,150
Unique Patients 513
Average Age 55.4
Outpatient Visits 93,638
Unique Patients 2,165

Race and Gender

Quarterly Visits by Type

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Strengthening the Health & Wellness Infrastructure

Establishing and sustaining resources & partnerships to improve access and care

### Improving Behavioral Health Linkages and Pursuing PCMH

**24/7 Peer Support Network**
- Growing capacity
- Staffing in clinical & criminal justice sites
- Training/Certification with PPS funds
- Long-term training program

**24/7 SI Connect Call Center**
- Appointments
- Transportation

**24/7 Crisis Stabilization & Respite Centers**

**24/7 Resource & Recovery Centers**

**Expansion of Treatment Provider Availability**

**ED Warm Handoff Pilot**
Reduce avoidable SUD-related ED visits
- Peer support, level of care assessment
- Expediting linkages to treatment providers

Fund practice pursuit of PCMH certification. Actively promote PCMH standards including care management, care coordination, chronic disease management and population health through partner training and clinical projects. Provide $200,000 bonus payment for achievement of certification.

**Providing Integrative Care**

**Collaborative Care Pilot**
Technical assistance for primary care practices to integrate behavioral health

**Behavioral Health Detailing**
Providing all Staten Island PCPs with BH resources on Opioid Use Disorder, MAT, etc.

**Reducing Stigma**

**Social Media Campaigns & Trainings**
- **Feeling Blue**
  - Awareness on MH issues during holidays
- **New Year’s BH Wellness Resolution**
- **Watch Your Words Campaign**

**Resource Guide**

**Provider Directory Search App**

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Prevention Quality Indicator Analysis

MY3 Performance

Data Observations:
❖ Patients failing this measure also failing access to primary and preventive care measures
❖ 88% have a record in PSYCKES
❖ 7 patients with 2+ chronic conditions
❖ Only 5 enrolled in Health Home

Zip Codes with Highest Prevalence
Pediatric Overall Composite Analysis

**MY3 Performance**

**Frequency of Primary Diagnosis**

Hospital discharges with diagnoses of asthma and diabetes have the highest frequency in this measure.

Data Observations:
- Patients located primarily on the North Shore
- 97% have a record in PSYCKES
- 5 patients with 2+ chronic conditions
- Only 1 patient enrolled in Health Home

Source: DOH Claims Data

- Asthma: 57%
- Diabetes: 27%
- UTI: 10%
- Gastroenteritis: 10%
- Missing Claims Data: 10%
MCOs Performance Analysis

Key Indicator: P4P Gaps in Care (GC) Ratio

P4P GC Ratio = Total P4P GC*/ # Unique Members

Data Source: MAPP Performance Portal (06/2015 to 05/2016)

*focus on 11 BH P4P
## MCOs Performance Analysis
### By P4P Measures

<table>
<thead>
<tr>
<th>MCOs (Ranked by Member Volume)</th>
<th>Total members</th>
<th>Unique members with GC</th>
<th>% Total</th>
<th>P4P Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adult Preventive Care</td>
</tr>
<tr>
<td>MCO 1</td>
<td>20,128</td>
<td>4,715</td>
<td>23%</td>
<td>1,274</td>
</tr>
<tr>
<td>MCO 2</td>
<td>11,062</td>
<td>3,037</td>
<td>27%</td>
<td>786</td>
</tr>
<tr>
<td>MCO 3</td>
<td>6,603</td>
<td>2,675</td>
<td>41%</td>
<td>551</td>
</tr>
<tr>
<td>MCO 4</td>
<td>4,371</td>
<td>1,199</td>
<td>27%</td>
<td>400</td>
</tr>
<tr>
<td>MCO 5</td>
<td>3,415</td>
<td>793</td>
<td>23%</td>
<td>391</td>
</tr>
<tr>
<td>MCO 6</td>
<td>1,678</td>
<td>552</td>
<td>33%</td>
<td>180</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>47,257</strong></td>
<td><strong>12,971</strong></td>
<td><strong>27%</strong></td>
<td><strong>3,582</strong></td>
</tr>
</tbody>
</table>

**Data Source:** MAPP Performance Portal

**Data Period:** 12/2015 to 11/2016

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Use Case 1 – Access to Preventative Care (20-44)

Top 15 PCPs with Gaps in Care Cases

<table>
<thead>
<tr>
<th>PCP</th>
<th>Number of Patients w/o Preventative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP 1</td>
<td>80</td>
</tr>
<tr>
<td>PCP 2</td>
<td>58</td>
</tr>
<tr>
<td>PCP 3</td>
<td>58</td>
</tr>
<tr>
<td>PCP 4</td>
<td>56</td>
</tr>
<tr>
<td>PCP 5</td>
<td>54</td>
</tr>
<tr>
<td>PCP 6</td>
<td>52</td>
</tr>
<tr>
<td>PCP 7</td>
<td>49</td>
</tr>
<tr>
<td>PCP 8</td>
<td>49</td>
</tr>
<tr>
<td>PCP 9</td>
<td>44</td>
</tr>
<tr>
<td>PCP 10</td>
<td>43</td>
</tr>
<tr>
<td>PCP 11</td>
<td>42</td>
</tr>
<tr>
<td>PCP 12</td>
<td>41</td>
</tr>
<tr>
<td>PCP 13</td>
<td>41</td>
</tr>
<tr>
<td>PCP 14</td>
<td>39</td>
</tr>
<tr>
<td>PCP 15</td>
<td>38</td>
</tr>
</tbody>
</table>

Number of Patients w/o Preventative Care
7/2014 to 12/2016

Data Source: Salient Interactive Miner and MAPP Performance Portal

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Use Case 2 – Diabetes Screening for People with Schizophrenia

Patient Demographics
- % Patients with MC PCP: 59.5%
- Male average Age 45.2
- Female average Age: 41.0

Number of Patients w/o Diabetes Screening
7/2014 to 12/2016

<table>
<thead>
<tr>
<th>MCO</th>
<th>Total Patients</th>
<th>Male: N (%)</th>
<th>Average Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO 1</td>
<td>62</td>
<td>30 (48.4)</td>
<td>41.3</td>
</tr>
<tr>
<td>MCO 2</td>
<td>33</td>
<td>21 (63.6)</td>
<td>42.7</td>
</tr>
<tr>
<td>MCO 3</td>
<td>29</td>
<td>19 (65.5)</td>
<td>41.0</td>
</tr>
<tr>
<td>MCO 4</td>
<td>28</td>
<td>15 (53.6)</td>
<td>41.6</td>
</tr>
<tr>
<td>MCO 5</td>
<td>25</td>
<td>16 (64.0)</td>
<td>45.5</td>
</tr>
<tr>
<td>MCO 6</td>
<td>14</td>
<td>5 (35.7)</td>
<td>47.6</td>
</tr>
<tr>
<td>MCO 7</td>
<td>3</td>
<td>1 (33.3)</td>
<td>38.0</td>
</tr>
<tr>
<td>MCO 8</td>
<td>3</td>
<td>3 (100)</td>
<td>48.3</td>
</tr>
<tr>
<td>MCO 9</td>
<td>2</td>
<td>1 (50.0)</td>
<td>61.9</td>
</tr>
<tr>
<td>MCO 10</td>
<td>1</td>
<td>1 (100)</td>
<td>61.4</td>
</tr>
<tr>
<td>Grand Total</td>
<td>200</td>
<td>112 (56.0)</td>
<td>42.9</td>
</tr>
</tbody>
</table>
Non-Access Member Letter Campaign:

A Collaboration with the Staten Island Performing Provider System (PPS)
Can an MCO letter campaign increase meaningful PCP access for Medicaid members?

- **Why?** Aligned concern: PCPs on Staten Island, PPS, Healthfirst

- **Method:** Identified adult HF members who are Staten Island residents, Medicaid LOB with no record of a 2016-2017 PCP visit

- **Mailing encouraged visit to the PCP or a call for member services assistance

- **Date of Mailing:**
  - 5/15/17 English
  - 5/22/17 Spanish
  - # Adult Members Outreached = 2818
13.8% of all members outreached had visit prior to study. Of the 2428 remaining members for outreach:

- 16.3% had a PCP visit post mailing
- 113 of these also called Member Services
- 26.7% of members had a non-PCP Services visit only
- 12.3% of all members outreached called Member Services
Empire BlueCross BlueShield - HealthPlus Staten Island PPS Initiatives

- Diabetes Self Management
- Community Health Worker Support
- Wellness Outreach
- Practitioner prescribing alerts
- Pediatric at-risk care coordination
Areas for Future Collaboration

- Practice level campaigns focusing on performance gaps and prescribing patterns
- Use of diversion strategies for ultra high risk individuals
- Hot spotting efforts to bring specific resources to turn around community risk
- Promote practice innovation that enables integrative, whole person care
- Promotion of Wellness and Prevention through incentives
- Remote monitoring and home services for high risk and fragile clients
- Data sharing initiatives
- Explore Accountable Care delivery model
Thank you!

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