Driving Practice Transformation Through Performance Measurement
Measurement Year 3 Performance Improvement

Greg Allen, NYSDOH, Office of Health Insurance Programs

DSRIP Learning Symposium
Syracuse, NY
September 21, 2016
Panel Introduction

Today’s panel will provide detailed examples of how PPS are using population health data tools and applying data analytics to change workflow within their systems of care. Further, they will discuss tracking of performance measures over time to ensure improvement.

Suffolk Care Collaborative PPS

• Kevin Bozza, MPA, FACHE, CPHQ, RHIT, Senior Director for Network Development and Performance
• Kelli Vasquez, LCSW, Senior Director for Care Management and Care Coordination

Staten Island PPS

• Joseph Conte, PhD, CPHQ, Executive Director
• Anyi Chen, Senior Director of Enterprise Data and Analytics

Albany Medical Center Hospital PPS

• Kallanna Manjunath, MD, CPE, Medical Director
Current state: DSRIP is in Demonstration Year 2 and Measurement Year 3.

- Performance is measured during a MY and affects future Pay for Performance (P4P) payments in subsequent Demonstration Years (DY).

While very early in PPS development, PPSs failed to close the gap to goal for most measures in MY1.

• MY1 targets are established by:
  o Regular Performance: using 10% improvement over baseline towards the statewide goal.
  o High Performance (HP): using 20% improvement over baseline or met/exceeded the statewide goal.

<table>
<thead>
<tr>
<th>Measure type</th>
<th>Total performance measures*</th>
<th>Total targets achieved</th>
<th>Total measures improved but not achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Performance</td>
<td>705</td>
<td>192 (27%)</td>
<td>151 (21%)</td>
</tr>
<tr>
<td>High Performance</td>
<td>225</td>
<td>40 (18%)</td>
<td>97 (43%)</td>
</tr>
</tbody>
</table>

• Potential penalties related to performance of statewide milestones would reduce the overall funding beginning in DY3.

• **No P4P funds were tied to measures in MY1. MY1 performance sets the MY2 targets.**

• MY2 (July 2015 – June 2016) official year-end results are scheduled to be finalized in January 2017, however unofficial MY2 data is available via Snapshots in the DSRIP Performance Dashboards and Salient Interactive Miner (SIM).

*Includes all measures that will be P4P at any point throughout DSRIP. Data source: DSRIP Performance Dashboards
42% of available P4P dollars are tied to performance in MY3.

- Performance results from MY3 affect $902M in net project valuation.
  - MY3 P4P payments are split between payments in DY3 (payment 2 - $502M) and DY4 (payment 1 - $400M).
- All unearned dollars tied to MY3 performance results will roll in to the High Performance Fund (HPF) in MY4.
  - Unearned dollars will be available to all PPSs who meet HP targets.

Most improved high value measures in MY1.

- DOH examined the measures tied to the highest P4P Net Project Valuation. 21 measures were identified.
  - At least two thirds of PPSs improved on 4 of the 21 high value claims based measures.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Applicable PPSs</th>
<th>PPSs improving</th>
<th>Percent Improving</th>
<th>Total P4P $ available¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention Quality Indicator # 1 (DM Short term complication)</td>
<td>10</td>
<td>8</td>
<td>80%</td>
<td>36,688,269</td>
</tr>
<tr>
<td>Children's Access to Primary Care – 12 to 19 years</td>
<td>25</td>
<td>19</td>
<td>76%</td>
<td>28,369,280</td>
</tr>
<tr>
<td>Children's Access to Primary Care – 7 to 11 years</td>
<td>25</td>
<td>17</td>
<td>68%</td>
<td>28,369,280</td>
</tr>
<tr>
<td>Prevention Quality Indicator # 13 (Angina without procedure)²</td>
<td>15</td>
<td>10</td>
<td>67%</td>
<td>36,036,554</td>
</tr>
</tbody>
</table>

¹Includes all P4P dollars available throughout the five years of DSRIP.
Source: Achievement Value Guide for PPSs: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/webinars_presentations.htm and DSRIP Performance Dashboards
²PQI13 has been retired by AHRQ and will be replaced with PQI8 for DSRIP MY2-MY5
Least improved high value measures in MY1.

- Less than one third of PPSs improved on 7 of the 21 high value claims based measures.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Applicable PPSs</th>
<th>PPSs improving</th>
<th>Percent Improving</th>
<th>Total P4P $ available*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially Preventable Emergency Room Visits</td>
<td>25</td>
<td>8</td>
<td>32%</td>
<td>113,477,119</td>
</tr>
<tr>
<td>Pediatric Quality Indicator # 14 Pediatric Asthma</td>
<td>13</td>
<td>3</td>
<td>23%</td>
<td>29,273,460</td>
</tr>
<tr>
<td>Asthma Medication Ratio (5 – 64 Years)</td>
<td>13</td>
<td>2</td>
<td>15%</td>
<td>29,273,460</td>
</tr>
<tr>
<td>Adherence to Antipsychotic Medications for People with Schizophrenia</td>
<td>25</td>
<td>3</td>
<td>12%</td>
<td>45,212,304</td>
</tr>
<tr>
<td>Children’s Access to Primary Care – 12 to 24 months</td>
<td>25</td>
<td>2</td>
<td>8%</td>
<td>28,369,280</td>
</tr>
<tr>
<td>Adult Access to Preventive or Ambulatory Care – 45 to 64 years</td>
<td>25</td>
<td>0</td>
<td>0%</td>
<td>37,825,706</td>
</tr>
<tr>
<td>Adult Access to Preventive or Ambulatory Care – 20 to 44 years</td>
<td>25</td>
<td>0</td>
<td>0%</td>
<td>37,658,658</td>
</tr>
</tbody>
</table>

*Includes all P4P dollars available throughout the five years of DSRIP.
Source: Achievement Value Guide for PPSs: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/webinars_presentations.htm and DSRIP Performance Dashboards
Potentially Preventable Readmissions ±
Rate of preventable hospital readmissions per 100,000 members in MY0 and MY1

MY1 results are helpful to understand how PPSs are trending from the baseline, but they are not necessarily indicative of future performance.

Data Source: Medicaid Analytics Performance Portal (MAPP) – official MY0 and MY1 Attribution for Performance results.

A lower rate is desirable.
Potentially Preventable Emergency Room Visits

Rate of preventable ER visits per 100 members in MY0 and MY1

MY1 results are helpful to understand how PPSs are trending from the baseline, but they are not necessarily indicative of future performance.

Data Source: Medicaid Analytics Performance Portal (MAPP) – official MY0 and MY1 Attribution for Performance results.

A lower rate is desirable

Moving in right direction

Moving in wrong direction
Challenges and Opportunities

Challenges:

• Due to time requirements of processing, official performance results for claims based measures have a six month lag.

• Official data from the New York State Department of Health (DOH) is available through MY1 due to issues with data collection in the new Managed Care Encounter Intake System.
  o The DSRIP Performance Dashboards are scheduled to be loaded with more current encounter data and caught up fully by December 2016. New monthly data will be loaded as it is fixed between now and December.
  o Snapshots are current as of August 8th, 2016

Opportunity:

• Available MY1 data at the provider and patient level is likely showing durable patterns and opportunity for performance improvement.

• Further, using local data sources (Electronic Health Records (EHR), Regional Health Information Organization (RHIO) data, etc.) in conjunction with DOH data and tools can provide further insight into each PPSs population and performance.
**DOH data sources and tools**

<table>
<thead>
<tr>
<th>DOH Data Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DSRIP Performance Dashboards</strong></td>
<td>Allows users to track performance on claims-derived measures, view quarterly performance on domain 1 requirements, understand attributed populations, and analyze provider network composition. The Snapshot tool is being updated to provide timely, actionable member detail for members with Potentially Preventable Readmissions (PPR) and ED Visits (PPV). In addition, 3M is developing grouper definitions manuals, and PPS trainings will be conducted that cover the high level grouping methodology.</td>
</tr>
<tr>
<td><strong>Salient Interactive Miner (SIM) Tool</strong></td>
<td>Provides in-depth access to the State's Medicaid Claims &amp; Encounter information. PCG and Salient will be coordinating a series of resources and local facilitation sessions to introduce PPS to actionable and high value use cases for DSRIP Performance Data in SIM. The session will begin in early fall 2016.</td>
</tr>
<tr>
<td><strong>Comprehensive Provider Attribution (CPA) Report</strong></td>
<td>Provides PPS member level detail of attributed members (less those that have opted out), catalogues all Medicaid providers who provided service to a PPS’s attributed member, and displays the number of visits by provider for each attributed PPS member.</td>
</tr>
<tr>
<td><strong>Individual Provider Attribution (IPA) Report</strong></td>
<td>Shows how many attributed member counts providers drove at the individual provider level.</td>
</tr>
<tr>
<td><strong>Member Roster</strong></td>
<td>Contains the list of members attributed to the PPS for services in MY1.</td>
</tr>
<tr>
<td><strong>Claims File Extract</strong></td>
<td>Contains all claims for members attributed to the PPS for services in MY1, except for claims have been expunged from the Claim File (such as Substance Use Disorders (SUD)) and members who have chosen to opt out of having their Protected Health Information (PHI) data shared.</td>
</tr>
<tr>
<td><strong>3M PPR/PPV Detail Reports</strong></td>
<td>Describes the types of services and diagnosis that are driving utilization for both PPRs and PPVs so that action plans can be developed around those services with the greatest impact. Report will be produced without claims run so that it is as current as possible.</td>
</tr>
</tbody>
</table>
Data alone does not lead to improved performance.

- Workflow development/modification drives changes in patient outcomes.
- Incorporating DOH data sources with local data will deliver additional insight into attributed populations demographics and clinical states.
Example from Measurement Year 3 Webinar #1: ED triage no PCP workflow
Thank You!

If you have any questions, please reach out to dsrip@health.ny.gov.
Population Health Management
Applying Data Analytics & Tools to Implementation Efforts

To improve the patient experience of care (quality and patient satisfaction), improve the health of the populations we serve and reduce the per capita cost of providing healthcare services, thus achieving the Triple Aim.

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We define Population Health Management (PHM) as the aggregation of patient data across multiple health information technology resources, the analysis of that data in a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes. It is the technical field of endeavor which utilizes a variety of individual, organization and cultural interventions to help improve patient self-care, morbidity patterns and the health care use behavior of defined populations.

Goal of today’s presentation will highlight each element of our PHM strategy and share tools in place to operationalize our work.
We’ve operationalized a system to integrate data to define our populations.

The programmability of the system allows the SCC to leverage data to create insightful “programs” to best manage a population or condition using real time actionable data.

Once the data has been processed and intelligence applied, it is presented to end-users in the form of solutions specific to their roles, such as registries, scorecards, care management, analytics, patient engagement, and more.

The SCC has over 25 contracted partners engaged in **Technical-onboarding**, a term used to describe a set of tasks to complete data integration into our PHM platform.
HealtheRegistries is a comprehensive disease and wellness registry solution, which leverages clinical and financial data across the continuum of care to qualify, attribute, measure and monitor members.

- Automatically identifies a population for registries and appropriate measures
- Provides visibility to the quality measures, identify care gaps for the provider’s population and performance
- Risk stratification to prioritize interventions
- Advanced patient outreach capabilities
- Provides dashboards with drill-down capabilities

The SCC has designed a set of Registries and Measures are deployed. Will be offering this tool to all contracted partners and organizations in the “SBUH HUB” permissioning will begin in Fall 2016.
Practice-level registry functionality to address gaps in care and management of chronic conditions!

Each registry has a set of measures:

<table>
<thead>
<tr>
<th>REGISTRY</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>Blood Pressure Measurement</td>
</tr>
<tr>
<td></td>
<td>High Blood Pressure Plan of Care</td>
</tr>
<tr>
<td></td>
<td>Lipid Panel</td>
</tr>
<tr>
<td></td>
<td>Influenza Vaccination - Full Season</td>
</tr>
<tr>
<td></td>
<td>Tobacco Use Screening and Cessation</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Control</td>
</tr>
<tr>
<td>Pediatric Asthma</td>
<td>Asthma Action Plan</td>
</tr>
<tr>
<td></td>
<td>Medication Management</td>
</tr>
<tr>
<td></td>
<td>Influenza Vaccination - Full Season</td>
</tr>
<tr>
<td></td>
<td>Hospital Visit/Admission</td>
</tr>
<tr>
<td>Asthma</td>
<td>Action Plan Complete</td>
</tr>
<tr>
<td></td>
<td>Medication Management</td>
</tr>
<tr>
<td></td>
<td>Influenza Vaccination - Full Season</td>
</tr>
<tr>
<td></td>
<td>Pneumonia Vaccination</td>
</tr>
<tr>
<td></td>
<td>Tobacco Use Screening and Cessation</td>
</tr>
<tr>
<td>Depression</td>
<td>Alcohol Use Screening</td>
</tr>
<tr>
<td></td>
<td>Illicit Drug Use Screening</td>
</tr>
<tr>
<td></td>
<td>Medication During Acute Phase</td>
</tr>
<tr>
<td></td>
<td>Medication During Continuous Phase</td>
</tr>
</tbody>
</table>

**Registries**

**Chronic Disease Registries**
- 7 Complete
  - Hypertension
  - IVD/CAD
  - Diabetes
  - Depression
  - Schizophrenia
  - Asthma
  - Pediatric Asthma

**Wellness Registries**
- 3 Complete
  - Pediatric Wellness
  - Adult Wellness
  - Senior Wellness
Users will be able to view the overall performance of meeting registry measures by physician practice level.

Registries and measures align with DOH reporting requirements, allowing users to identify registries that need the most improvement.

These registries and measures will also be used in planned pay for performance models.
Our Vision:
To build a patient-centered, coordinated, integrated delivery system. The PPS sponsored CMO will serve those patients currently not aligned to an existing CMO.

Current Staffing Model:
10 RN Care Managers
8 Social Workers
5 Community Health Associates

Nov. 2015 - Today
Embedded in 4 PCP Practices
Providing TOC services to 1 hospital

6 Month Look Out
Support 40 PCP Practice Sites with Embedded/Community Resources
Provide TOC services to 5 hospitals

Our Goal: Enhance patients' self-care abilities, improve access to community-based resources, break down care silos and reduce avoidable hospital admissions and emergency room visits through Population Health Management.
**Referral and Screening**
- Referral sent to CM after eligibility verified
- Document Referral Note
- Set Reminder/Task for Screening

**Outreach**
- CM validates diagnosis by reviewing:
  - HealtheCare
  - Patient Summary
  - HealtheRecord
  - IView
- CM screens patient according to SCC timeframe
  - Inpatient/Non-Admission Urgent: 1-2 business days from referral date
  - Non-Admission Non-urgent: 5 business days from referral date

**Enrollment**
- CM make initial outreach attempt to contact patient for enrollment:
  - Inpatient/ED/Non-Admission (HIGH): 1-2 business days of referral
  - All other referrals: 10 business days from referral date

**Workflows**
- Enrollment Workflow
  - Complete comprehensive assessment
  - Must be completed within 10 days of enrollment
  - Utilize HealtheRegistries data with patient and provider
  - Review case record including HealtheCare, HealtheRecord, and Practice EMR data.
  - Utilize HealtheRegistries information to identify patient Gaps in Care.
  - Complete additional documentation required within 10 days of initial assessment (HealtheCare):
    - Medications (Medication Reconciliation)
    - Allergies
    - Immunizations
  - Change "Case Status" to "Pending Enrollment"

- Outreach Attempt #1
  - If successful, proceed with enrollment workflow
  - Update Case Status to "Enrolled"

- Outreach Attempt #2
  - Document "Enrollment Outreach #2 - Unsuccessful" in Communication Events
  - Set Reminder for "Enrollment Outreach #3" in 5-7 days

- Outreach Attempt #3
  - Await response
  - If no response, proceed with case closure workflow

- Enrollment Letter
  - Document discussion in HealtheCare as "New CM Note"
  - Develop Patient Centered Care Plan in HealtheCare to include barriers to achieving improved outcomes and plans to mitigate barriers and decrease gaps in care
  - Set Reminder/Task to follow up based on Risk/Need:
    - High
    - Med
    - Low

- Close case
  - Select closure reason: "Declined"

---

**Enrollment Workflow**

**Defining the Population**

**Identifying Care Gaps**

**Stratify Risks**

**Patient Engagement**

**Manage Care**

**Measure Outcomes**
Utilizing Care Management to Close Gaps in Care

- Review case record including HealtheCare, HealtheRecord, and Practice EMR data.
- Utilize HealtheRegistries information to identify patient Gaps in Care.

- Complete comprehensive assessment
- Must be completed within 10 days of enrollment
- Address HealtheRegistries data with patient and provider

- Document discussion in HealtheCare as “New CM Note”
- Develop Patient Centered Care Plan in HealtheCare to include barriers to achieving improved outcomes and plans to mitigate barriers and decrease gaps in care.
Care Management Tool receives direct data flow of HealtheRegistries data.
Finalizing Business Rules to Pay Providers for Performance

Testing PCP Soft Attribution Algorithm to identify the Established Physician

DOH MAPP/Salient Data will be used for pay for performance

HealtheAnalyticsTM will be used for concurrently measuring performance
PCP HealtheAnalytics Scorecard

SCC Performance Scorecard

Training Strategy

- Developed Extensive Workforce Training Strategy
- Facilitate Partner Onboarding Program Addressing Performance Requirements
- Developed Learning Center and Clinical Guideline Summaries to Educate Partners
- Created Core Curricula Guidelines for all participating provider practices.
“In variance” refers to when a partner falls below the agreed-upon standard for one or more metrics.
MOVE FROM PAY FOR REPORTING TO PAY FOR PERFORMANCE

5-year Performance-based Funds Flow Model for Participating Providers & Organizations is Operational and included in all SCC Participation Agreements

 Funds flow distribution example: Primary care providers

<table>
<thead>
<tr>
<th>Performance Factor</th>
<th>Description</th>
</tr>
</thead>
</table>
| Engagement Payment | Complete SCC On-boarding documentation as outlined in the SCC Contracting Plan
| | Agreement to ongoing: Good citizenship, Timely and complete quarterly Domain 1 patient engagement reporting, Data sharing, Participation in Population-wide-prevention programs (D4), Updates towards successful completion of the Domain 1 Process Measures & Participation in Project 2ai Integrated Delivery System program & SCC Care Coordination program. |
| Technical On-boarding | 1. Complete Technical On-boarding, i.e. technical data integration and system interoperability between the Partner’s source system and the HUB data-warehouse, which will then feed the Suffolk PPS Population Health Platform. |
| | 2. EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements |
| Clinical Improvement Programs | Meet requirements of Primary & Behavioral Health Integrated Care Program |
| | Meet requirements of Cardiovascular Health Wellness & Self-Management Program |
| | Meet requirements of Diabetes Wellness & Self-Management Program |
| | Meet requirements of Promoting Asthma Self-Management Program |
| PCMH Certification | Receipt of NCQA 2014 Level 3 PCMH Certification |
| Performance Measurement | Adhere to the Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided. |
Staten Island PPS
Population Health Management – Applying Data Analytics to Implementation Efforts

LEARNING SYMPOSIUM
Objectives for Success
The Move from P4R to P4P

- Getting timely, actionable data into the hands of the clinicians at the point of service
- Disseminating patient level performance reports to partners at provider/practice level
- Using population health registries across projects/conditions to identify “defects”
- Focus Programs on High Demand Populations that Cut across multiple domains
- Supporting innovative strategies like Telemedicine Pilot, EMS Alternative Care Program, Withdrawal Call Center, Targeted Population Health programs
- Utilizing DOH claims data to supplement and validate internally generated measures
- Gathering data from other relevant sources, EMS, School Health, NYC planning data, Housing, social determinant domains, etc.
- Redesigning systems to eliminate waste and redundancy while meeting patient demand and training requirements
Rapid Cycle Performance Evaluation to Partners
End-to-End Data Management Life Cycle

**Data Collection**
- Actively Engaged (AE) Registry
- Patient Activation (PAM) project

**Measure Changes**
- Develop control charts to track changes
- Meet w/ partners to discuss areas of improvements and sustainable progress

**Define Measures**
- 30-day ED & 30-day Inpatient visits
- Establish baseline using DY1 results

**Analyze Data**
- Calculate partner level utilization performance
- Identify gaps in care

**Performance Reporting**
- Partner receives monthly performance reports and patient level details for further drill down

**DSRIP Goal 25% Reduction in Preventable ED/Readmission**

![DY1 (Baseline): 30-day Inpatient Utilization Rate - PPS Level](chart1)

![DY1 (Baseline): 30-day ED Utilization Rate – PPS Level](chart2)
Business Intelligence Infrastructure and Data Flow

**Data Collection**
- Define Measures
- Analyze Data
- Performance Reporting
- Measure Changes

**Data Flow**
- Data Validation
- Data Cleaning
- Data Transformation
- Data Aggregation
- Data Loading

ETL: Extract, Transform, Load

**BI Results**
- Data Analysis (High Risk Patients / Super Utilizers)
- Data Mining
- Data Visualization
- Reports
- Dashboards
- Care Alerts

*Data Sources*
- Partner EHRs
- DOH Claims / MAPP / Salient
- Public Datasets
- Patient Registries (AE, PAM)
- EMS Dataset

*Selected Data Sources*

SI PPS Data Warehouse

Datamarts
Use Case 1 - The Impact of Top 500 High Risk Patients (HRP)

Staten Island PPS Risk profile algorithm identified top 500 High Risk Super Utilizer (HRSUs) from 63,605 Staten Island PPS Medicaid Enrollees

<1% of Staten Island PPS Medicaid Enrollees are defined as High Risk Patients (HRP)

That population drives 20% of preventable ED Visits (PPV) of Staten Island PPS Medicaid enrollees

100% HRP had one or more Chronic conditions

Asthma, Hypertension, CVD 31%
Diabetes 12%
Schizophrenia 7%
Other Mental Health 2%
Depression 1%
Other 47%

... and 20% of preventable readmissions

Avg. PPV /HRP: 8.29
Min PPV /HRP: 4 Max PPV /HRP: 140

Avg. PPR/HRP: 1.54
Min PPR /HRP: 1 Max PPR /HRP: 6

<1% of Staten Island PPS Medicaid Enrollees are defined as High Risk Patients (HRP)

That population drives 20% of preventable ED Visits (PPV) of Staten Island PPS Medicaid enrollees

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Avg. PPR/HRP: 1.54
Min PPR /HRP: 1 Max PPR /HRP: 6

Cross-project involvement of Top 500 High Risk Patients (HRP)

100% 2.a: Integrated Delivery (2.a.iii)

2.b: Care Coordination (2.b.iv, 2.b.vii, 2.b.viii)

40% 3.a: Behavioral Health (3.a.i, 3.a.iv)

18% EMS Super Utilizer Project

16% is also a MAX Super Utilizer

22% Took PAM survey as of 09-09-2016

Data Collection Define Measures Analyze Data Performance Reporting Measure Changes
Weekly Monitor of Top 500 High Risk Patients (HRP)

### SI-PPS | P4P Selected Measures
Partner Name: TBD

**Members**
- [X] Members
- [X] Members without MC Plan
- [X] Members without Current MC PCP
- [X] Members without Current Enrolled Health Home

Members that are non-compliant for selected P4P Measures

<table>
<thead>
<tr>
<th>About this Patient</th>
<th>Priority P4P Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Information</strong></td>
<td><strong>Medical</strong></td>
</tr>
<tr>
<td>CIN</td>
<td>Member Name</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |

Data Collection  Define Measures  Analyze Data  Performance Reporting  Measure Changes
Utilization Report:
PPS Partner Registry Utilization Summary Report card

Project:
All Actively Engaged projects that a SI PPS partner participated

Data Source:
Actively Engaged Member roster from participating partners / SI PPS EDW / DOH Claims

PPS Partner Registry Utilization Summary Dashboard
All Actively Engaged (AE) Projects
Data Period: DY1 (April 2015 - March 2016)

30-Day Inpatient Utilization Rate
- 3.CJ: 6.9%
- 3.A.IV: 10.3%
- 3.A.I: 4.7%
- 2.B.IV: 9.4%

30-Day ED Utilization Rate
- 3.CJ: 13.0%
- 3.A.IV: 14.5%
- 3.A.I: 16.1%
- 2.B.IV: 27.5%

Summary Statistics: 30-Day Inpatient Utilization

Summary Statistics: 30-Day ED Utilization

Privileged and Confidential
Prepared in accordance with the Public Health Law Section 2805 through and Education Law Section 6527

Data Source:
All registry and RUMC 8/3/14 data feed / DOH Claims

Data Collection  Define Measures  Analyze Data  Performance Reporting  Measure Changes
Use Case: Diabetes Management

30-day ED Utilization Log

Project: 3c.i. - Actively Engaged Patient Registry

Number of 30-day ED Visits

Participating Partner: FQHC A

<table>
<thead>
<tr>
<th>Partner</th>
<th>MedicaidID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Actively Engaged Date</th>
<th>RUMC ED Admit Date</th>
<th>SI CARES Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Partners</td>
<td>XXXXXXXX</td>
<td>Paitthname1</td>
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<tr>
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<td>3 Partners</td>
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<td>Paitthname3</td>
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<td>03/18/16</td>
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<td>Paitthname9</td>
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<td>02/19/16</td>
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<td>Paitthname12</td>
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<td>02/19/16</td>
<td>NA</td>
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<td>Paitthname14</td>
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<td>02/19/16</td>
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<td>15 Partners</td>
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<td>Paitthname15</td>
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<td>02/19/16</td>
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<td>Paitthname16</td>
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<td>NA</td>
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<tr>
<td>17 Partners</td>
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<td>Paitthname17</td>
<td>7/3/2016</td>
<td>02/19/16</td>
<td>NA</td>
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<tr>
<td>18 Partners</td>
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<td>Paitthname18</td>
<td>7/3/2016</td>
<td>02/19/16</td>
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<tr>
<td>19 Partners</td>
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<td>Paitthname19</td>
<td>7/3/2016</td>
<td>02/19/16</td>
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<td>20 Partners</td>
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<td>Paitthname20</td>
<td>Paitthname20</td>
<td>7/3/2016</td>
<td>02/19/16</td>
<td>NA</td>
</tr>
<tr>
<td>21 Partners</td>
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<td>02/19/16</td>
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<td>22 Partners</td>
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<td>Paitthname22</td>
<td>7/3/2016</td>
<td>02/19/16</td>
<td>NA</td>
</tr>
</tbody>
</table>

30-day Inpatient Utilization Log

Project: 3c.i. - Actively Engaged Patient Registry

Number of 30-day INPT Visits

<table>
<thead>
<tr>
<th>Partner</th>
<th>MedicaidID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Actively Engaged Date</th>
<th>RUMC INPT Admit Date</th>
<th>SI CARES Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Partners</td>
<td>XXXXXXXX</td>
<td>Paitthname1</td>
<td>Paitthname1</td>
<td>03/15/2016</td>
<td>03/20/15</td>
<td>NA</td>
</tr>
<tr>
<td>2 Partners</td>
<td>XXXXXXXX</td>
<td>Paitthname2</td>
<td>Paitthname2</td>
<td>03/15/2016</td>
<td>03/20/15</td>
<td>NA</td>
</tr>
<tr>
<td>3 Partners</td>
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<td>Paitthname3</td>
<td>Paitthname3</td>
<td>03/15/2016</td>
<td>03/20/15</td>
<td>NA</td>
</tr>
<tr>
<td>4 Partners</td>
<td>XXXXXXXX</td>
<td>Paitthname4</td>
<td>Paitthname4</td>
<td>03/15/2016</td>
<td>03/20/15</td>
<td>NA</td>
</tr>
</tbody>
</table>

30-Day ED Utilization Rate

Numerator: Number of ED Visits within 30-Day of AE Submission to SI PPS
Denominator: Number of AE Patients Submitted

30-Day Inpatient Utilization Rate

Numerator: Number of Inpatient Visits within 30-Day of AE Submission
Denominator: Number of AE Patients Submitted

Sample Report Page 2 of 2

Privileged and Confidential

Prepared in accordance with the Public Health Law Section 2805j through m and Education Law Section 6527
Value of MAPP Data

Outcomes Report: Follow-up after Mental Health Inpatient Discharge

**FOLLOW-UP AFTER HOSPITALIZATION DATA AS OF JUNE 31**, 2016

<table>
<thead>
<tr>
<th>SIPPS STATISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Members who may not have had a follow-up after a mental health inpatient discharge</td>
</tr>
<tr>
<td>22 No Current Enrolled Health Home</td>
</tr>
<tr>
<td>8 No MC Plan</td>
</tr>
<tr>
<td>11 No Current MC PCP</td>
</tr>
</tbody>
</table>

**SIPPS STATISTICS**

| Members: Qualifying members who did not have an outpatient Mental Health visit within one month after discharge |
| Qualifying: All attributed members with a Mental Health Inpatient discharge in the month that was 2 months prior to current month |
| 9 Members who may not have had a follow-up after a mental health inpatient discharge |
| 5 No Current Enrolled Health Home |
| 2 No MC Plan |
| 3 No Current MC PCP |

**Sample Report**

Data Collection  Define Measures  Analyze Data  Performance Reporting  Measure Changes
Current Progress - Improving Care Outcomes

Data Collection
- Define Measures
- Analyze Data
- Performance Reporting
- Measure Changes

Key Findings:
Significant improvement in 30-day ER Utilization Rate (DY1 vs. DY2Q1)

- **2.A.III:** HH at Risk
  - **DY1:** 14.00%
  - **DY2Q1:** 6.30%
  - Improvement: 55%, decreased from 14% to 6.3%.

- **3.C.I:** Diabetes Management
  - **DY1:** 6.40%
  - **DY2Q1:** 3.70%
  - Improvement: 42%, decreased from 6.4% to 3.7%.

- **3.A.I:**
  - **DY1:** 7.40%
  - **DY2Q1:** 5.00%
  - Improvement: 32%, decreased from 7.4% to 5.0%.

- **3.A.IV:**
  - **DY1:** 14.40%
  - **DY2Q1:** 9.70%
  - Improvement: 33%, decreased from 14.4% to 9.7%.
Behavioral Health Integrated Care Workflow

Arrives in BH facility for treatment

Assesses client and reviews client record to identify any flags for gaps in preventive services

Documents any preventive service client needs in health record

Service available onsite?

No

Documents any preventive service client needs in health record

Engages client to receive medical preventive services available onsite

Medical Provider available same day?

No

Refers client to an external primary care provider

Confirms primary care provider’s availability and schedules appointment

Medical Provider available same day?

Yes

Notifies primary care provider and hands off client directly after the BH visit

Yes

Documents handoff, onsite appointment, or external referral in client’s health record

Administers the appropriate preventive services to client at BH site

Documents preventive services offered in the client health record and notifies other members of treatment team

Assesses need for specialty follow up and refers client or has appointment scheduled accordingly

Sends referral information in warm hand off to specialist

Supplies specialist with client contact info to ensure results are reported back to client’s BH program for continuity of care

Future medical appointments will be made in conjunction with behavioral health appointments

Note: Medical Provider access to client behavioral health record is strongly recommended for collaborative care
Use Case: Diabetes w/chronic Comorbid Conditions

Population: Attributed Members with at least one of the chronic comorbid conditions: Diabetes, BH, COPD and CHF

Key Statistics

Utilization by Population

Patient Demographics

Hospital Utilization Trend
Next Steps

- Timely transfer of data into business intelligence is strategic imperative
  - Continue our efforts integrating Medicaid claims and clinical datasets from local RHIO, partner EHRs and other data sources

- Expanding current MAPP capability with new data fields
  - Date of Service
  - Service Provider Name/NPI
  - Charges versus actual paid claims

- Data Exchange with MCO organizations
  - Under / Non Utilizers
  - Super Utilizers
  - Hi Need Care Roster

- Move EDW into the cloud environment

- Putting information into the hands of the practitioner and practice is critical
  - Build care alerts into partner EHRs for at risk populations
AMCH PPS: Applying Data Analytics to Implementation Efforts

- Approach - “Maximize Available Resources”
- Utilization of MAPP Data:
  - Identification of PCP shortage areas by ZIP Code
  - Improve performance measures
  - Utilization of Snapshot feature to identify patients in need of a service
  - Identify at-risk individuals for care management
  - Increase MC PCP assignment rates
  - PCP level analysis to prioritize intervention efforts
- Future plans
AMCH PPS: Albany County - PCP per Attributed Patients

Attribution by Zip Code

PCP Distribution
AMCH PPS: Albany County - Individuals per PCP by Zip Code

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Individuals per PCP</th>
<th>N=1790 No PCP</th>
<th>N=1461 No PCP</th>
<th>N=1510 No PCP</th>
<th>N=1263 No PCP</th>
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<tbody>
<tr>
<td>12206</td>
<td>589</td>
<td></td>
<td></td>
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</tr>
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<td>12208</td>
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<td>12207</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Rest of County</td>
<td>213</td>
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<td></td>
<td>Alb Co Av.</td>
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<tr>
<td></td>
<td>AMCH PPS Av.</td>
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</tr>
</tbody>
</table>

Total: N=1790 No PCP, N=1461 No PCP, N=1510 No PCP, N=1263 No PCP
Asthma Medication Measures – Interventions to Improve Adherence

- Train practitioners and care management staff on Motivational interviewing, Teach back method and other self-management support techniques.
- Collaborate with pharmacy team on self-management support
- 2-4 week post-visit phone call to perform Asthma Control Test over the phone
- Implement reminder systems/ gap list management across the continuum.
- Establish a default quantity of 90 days for asthma controller medications
### Asthma Controller Prescription Instances in DEPT

<table>
<thead>
<tr>
<th>MRN</th>
<th>Patient Name</th>
<th>Age</th>
<th>Medication</th>
<th>Prescribed On</th>
<th>Medication Action</th>
<th>Quantity</th>
<th>Dosage</th>
<th>Refills</th>
<th>Notes</th>
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<tbody>
<tr>
<td>22.4</td>
<td>NAME, PATIENT</td>
<td>22.4</td>
<td>Montelukast Sodium 10 MG Oral Tablet</td>
<td>1/1/1900</td>
<td>Send To Retail</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>5 TAKE 1 TABLET DAILY.</td>
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<td>Prednisolone 30 MG Oral Tablet</td>
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<td>0</td>
<td>0</td>
<td>0 1 tablet BID</td>
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<td>22.0</td>
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<td>22.0</td>
<td>Prednisolone 15 MG/5ML Oral Syrup</td>
<td>1/1/1900</td>
<td>Record</td>
<td>100</td>
<td>2</td>
<td>0</td>
<td>0 TAKE 2 TSP Twice daily</td>
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<tr>
<td>22.0</td>
<td>NAME, PATIENT</td>
<td>22.0</td>
<td>Montelukast Sodium 10 MG Oral Tablet</td>
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<td>90</td>
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<td>0</td>
<td>3 TAKE 1 TABLET BY MOUTH DAILY</td>
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<tr>
<td>22.0</td>
<td>NAME, PATIENT</td>
<td>22.0</td>
<td>Prednisolone 15 MG/5ML Oral Syrup</td>
<td>1/1/1900</td>
<td>Record</td>
<td>100</td>
<td>2</td>
<td>0</td>
<td>0 TAKE 2 TSP Twice daily</td>
</tr>
<tr>
<td>21.2</td>
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<td>Flovent HFA 44 MCG/ACT Inhalation Aerosol</td>
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<td>0</td>
<td>3</td>
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<tr>
<td>20.7</td>
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<td>20.7</td>
<td>Pulmicort Flexhaler 90 MCG/ACT Inhalation Aerosol Powder Breath Activated</td>
<td>1/1/1900</td>
<td>Record</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>5 INHALE 1 PUFF TWICE DAILY. RINSE MOUTH AFTER USE.</td>
</tr>
<tr>
<td>20.7</td>
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<td>20.7</td>
<td>Pulmicort Flexhaler 90 MCG/ACT Inhalation Aerosol Powder Breath Activated</td>
<td>1/1/1900</td>
<td>Record</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>5 INHALE 1 PUFF TWICE DAILY. RINSE MOUTH AFTER USE.</td>
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<td>20.6</td>
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<td>60</td>
<td>0</td>
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<td>Flovent HFA 44 MCG/ACT Inhalation Aerosol</td>
<td>1/1/1900</td>
<td>Send To Retail</td>
<td>1</td>
<td>2</td>
<td>1*</td>
<td>1 INHALE 2 PUFS 2 times daily rinse mouth after use</td>
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<tr>
<td>19.4</td>
<td>NAME, PATIENT</td>
<td>19.4</td>
<td>Montelukast Sodium 10 MG Oral Tablet</td>
<td>1/1/1900</td>
<td>Send To Retail</td>
<td>30</td>
<td>0</td>
<td>5</td>
<td>5 TAKE 1 TABLET DAILY.</td>
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<tr>
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<td>NAME, PATIENT</td>
<td>19.1</td>
<td>Pulmicort Flexhaler 180 MCG/ACT Inhalation Aerosol Powder Breath Activated</td>
<td>1/1/1900</td>
<td>Record</td>
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<td>0</td>
<td>2*</td>
<td>2 INHALE 2 PUFS ONCE DAILY. RINSE MOUTH AFTER USE.</td>
</tr>
</tbody>
</table>
Snapsots are intended to provide information generated from the most recent paid claims data available. However, some services that transpired during the timeframe will not be represented in these views because of delays in claim submission and processing. Therefore, these data should be considered incomplete, and are in no way predictive of...

19

Members who may not have had a follow up after a mental health inpatient discharge

Members: Qualifying members who did not have an outpatient Mental Health visit within one month after discharge

Qualifying: All attributed members with a Mental Health inpatient discharge in the month that was 2 months prior to current month

Characteristics

Age Range

- 21%: 21-44
- 42%: 45-64
- 37%: 12-17

Member Distribution

Current MC HIOS Name

<table>
<thead>
<tr>
<th>Member County</th>
<th># Members</th>
<th># Qualifying</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALBANY</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>SARATOGA</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>COLUMBIA</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>GREENE</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ONEIDA</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ORANGE</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>94788 Capital District Physicians’ Health Plan, Inc.</td>
<td>5</td>
<td>18</td>
</tr>
</tbody>
</table>

Total (5) 19 53

Source: NYS Medicaid
Discharge Planning and Transitions of Care

Medical input and hand over together with clear care team coordination with the receiving services is key for patients requiring BH care

Section Process: Discharge planning and transition of care to BH out patient services

* Please refer to AMCH DSRIP Process Flow w Tech.vsd for further detail
AMCH PPS: Health Home At-Risk Project - Process Flow

Identify eligible patient (PMO, ED/Hospitals, Other Providers, CBOs)

- MAPP
- Salient
- EHR
- Payer data
- PHM Analytics

Create referral

TBD Entity

PMO Database

Determine Attribution

AMCH PPS Patient?

Yes

Refer to PCMH

Clinical Assessment

HH Eligible?

Yes

HH CM Provider

- Risk Stratification
- Care plan development
- Referral to BH services
- Service coordination

HH Agency

- Opt-in Process
- Service Coordination

No

Notify referring entity

* HH – Health Home
AMCH PPS

- Data Analytics – ED Utilization by County (Salient UXT, Live Report)

Potentially Avoidable ED Visits - AMCH PPS

Measurement Year 0

Measurement Year 1
### AMCH PPS

- **Data Analytics – Hypertension Monitoring** (Partner EMR, Live Report)

<table>
<thead>
<tr>
<th>Reporting Date</th>
<th>PCP per EmrScript</th>
<th>RSN</th>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Qualifying BP</th>
<th>Systolic Trend</th>
<th>Diastolic Trend</th>
<th>6-Month Blood Pressure Trend (Last BP Reading Each Week in Which Reading Exists)</th>
<th>Dept. of Last High Risk BP Measurement</th>
<th>Last High Risk BP Measured value setting</th>
<th>Referring Provider for Visit</th>
<th>Active Approved ICD Code</th>
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</thead>
<tbody>
<tr>
<td>07-06-2023</td>
<td>LAST MD, FIRST</td>
<td>DOE, JANE</td>
<td>1/1/1980</td>
<td>156/92 (Repeated) on 07-27 14:36</td>
<td>Y 36</td>
<td>Systolic Trend</td>
<td>Diastolic Trend</td>
<td>136 138 142 130 106 134 128 156</td>
<td>DEPT LAST-SEEN PROVIDER</td>
<td>REFERRING PROVIDER</td>
<td>401.9</td>
<td></td>
</tr>
<tr>
<td>07-06-2023</td>
<td>LAST MD, FIRST</td>
<td>DOE, JANE</td>
<td>1/1/1980</td>
<td>144/77 (Repeated) on 07-26 15:07</td>
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<td>Diastolic Trend</td>
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<td>DEPT LAST-SEEN PROVIDER</td>
<td>REFERRING PROVIDER</td>
<td>401.9</td>
<td></td>
</tr>
<tr>
<td>07-06-2023</td>
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**Legend:**
- **Green:** Normal
- **Yellow:** Stage 1
- **Orange:** Stage 2
- **Red:** Hypertensive Crisis
AMCH PPS: Applying Data Analytics to Implementation Efforts

- Future plans
  - Collaborate with QE for population health analytics
  - Explore funding opportunities for a low-cost PHM system solution
  - Analysis of SIM claims data for risk stratification
Q&A