Concurrent Sessions
The Role of Primary Care in the PPS- the NOCHSI story

Tricia Clark VP/COO
Nancy Deavers VP/CNO
Our Practice

* 2013 Acquisition- 3 hospital based primary care practices and 2 Health and Human Service run primary care practices join the NOCHSI FQHC infrastructure
* 6 Primary Care sites across Oswego County with PCMH level two 2011 standards
* 6 School Based Health Centers in 4 school districts located across Oswego County
* 2 sites offering Dental Services (3 in 2017)
* Behavioral Health integration at all sites
52 Professional Staff

Family Practice Physicians-9
Nurse Practitioners-16
Physician Assistants-5
Pediatricians-2
Dentists-3

Internal Medicine Physicians-3
Nurse Practitioners-1
Behavioral Health-8
Registered Dental Hygienist-5

Contributing to 117,920 visits in 2015
Our Journey

- Engaged in 8 of the 11 DSRIP projects
- Actively pursuing PCMH level 3 - 2014 standards
- Recognized need for clear coordination of projects
- Developed team leaders for each project
- Ensured Medical and Administrative Leadership support
- Worked to integrate DSRIP and PCMH goals as much as possible
Began Journey for PCMH 2014 level 3 in 2015
Submission to NCQA expected 2017
Utilized patient population targets for care management to coincide with behavioral health, ED care transition and CVD project targets
PDSA’s for these projects supported the quality standards for PCMH
Beginning this project with Appendix B fully executed last week-Now allowing primary care involvement

Plan to focus on pediatric patients with asthma or ADHD
2.b.iii- ED Care Triage

- Interface with HealtheConnections RHIO so all ED/UC reports flow directly into our EMR-making for timely notification of a visit.
- RN Care managers communicate with all patients to review discharge instructions and coordinate followup.
- Local hospital ED navigator communicates with RNs to set up followup appointments.
2.b.iv- Care transitions to reduce 30 day readmissions

- Interface with HealtheConnections RHIO so all admission notices and discharge reports flow directly into our EMR
- RN Care managers communicate with all patients for followup
- Chose patient population for care management based on high hospital use and chronic conditions
### PILOT - Patient Goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Status</th>
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<tbody>
<tr>
<td><strong>Self-Management Goals Initiated</strong></td>
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<tr>
<td><strong>Goal Weight</strong></td>
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<tr>
<td><strong>Current Weight Status</strong></td>
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<tr>
<td><strong>Exercise Sessions</strong></td>
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<td><strong>Exercise Minutes Per Session</strong></td>
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<td><strong>Current Exercise Duration</strong></td>
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<td><strong>Smoke Less Than</strong></td>
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<td><strong>Pack Per Day</strong></td>
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<td><strong>Current Smoking Status</strong></td>
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<tr>
<td><strong>Drink Less Than</strong></td>
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<tr>
<td><strong>Alcoholic Drinks Per</strong></td>
<td></td>
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<tr>
<td><strong>Current Alcohol Status</strong></td>
<td></td>
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<tr>
<td><strong>Less Than</strong> Fast Food Meals Per Week</td>
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<tr>
<td><strong>Fast Food Status</strong></td>
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<tr>
<td><strong>Fresh Fruits</strong></td>
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<td><strong>Servings Per Week</strong></td>
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<tr>
<td><strong>Current Fresh Fruit Status</strong></td>
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<tr>
<td><strong>Monitor Blood Pressure</strong></td>
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<tr>
<td><strong>Times Per Week</strong></td>
<td></td>
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<tr>
<td><strong>Current BP Monitoring</strong></td>
<td></td>
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<tr>
<td><strong>Less Than</strong> Mixed Medication**</td>
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</tbody>
</table>

### Barriers

- Y noncompliance with Tx: noncomprehension due to complexity
- Y noncompliance with Tx: no comprehension due to anxiety
- Y noncompliance with therapy because unavailable in area
- Y noncompliance with therapy because no transportation
- Y noncompliance with therapy because of cost
- Y noncompliance with therapy due to mental disorder
- Y noncompliance with therapy because of denial of condition
- Y noncompliance with therapy due to religious beliefs
- Y noncompliance with therapy due to subcultural beliefs
- Y noncompliance with therapy for dietary reasons
- Y noncompliance with therapy due to lack of comprehension
- Y generalized noncompliance
2.d.i- Patient Activation

- Trained Facilitated Enrollers as well as RN Care Managers on the different components of PAM
- Developed documentation process for coaching
- Utilize the Flourish Program to support education and goals for patients in care management
PAM Documentation

Coaching Encounter for

- [ ] Y Date of onset (For Acute Visits)
- [ ] Y Primary Physician (For Acute Visits)

*Primary Care Provider - IF WE ARE PCP ON INSURANCE BUT PT NOT LINKED WITH SPECIFIC PCP SELECT "NOCHSI" - IF OUTSIDE PROVIDER PLEASE ANNOTATE NAME OF PROVIDER

Coaching Encounter for

- [ ] Y Coaching encounter for: ASTHMA
- [ ] Y Coaching Encounter for: CORONARY ARTERY DISE...
- [ ] Y Coaching Encounter for: CONGESTIVE HEART FAIL...
- [ ] Y visit for: Initial medical exam
- [ ] Y visit for: unspecified drug dependence
Developed a multidisciplinary team and work plan for project

Began PDSA for integration with our Mexico Health Center in July 2016

By September 2016—all 6 primary care sites had integrated behavioral health services on site—1 day a week

Renovated existing space in our Pulaski HC to offer on site behavioral health services every day—Opening December 2016
Integration of screenings into the health record

- Completed PDSA’s on Depression Screening and SBIRT
- Integrated workflow for both documentation processes into the EMR
- Both topics were added to our Health Reminder Systems within the EMR as triggers for annual reviews
PHQ2-9 built into the EMR

PHQ2 (13 and older) SCORING: 2 NO = Negative, 1 YES / 1 NO = Mild to Mod, 2 YES = Clinically Significant

- Y N loss of interest in activities
- Y N feelings of hopelessness, down or depressed

Preventive Med Standardized Depression Screening: Negative For Symptoms
Preventive Med Standardized Depression Screening: Mild To Moderate Symptoms
Preventive Med Standard Depression Screening: Clinically Significant Symptoms

*If symptoms are Mild/Moderate or Clinically Significant, COMPLETE PHQ9*

PHQ9 score
SBIRT integration to the EMR

SBIRT

- Drug/Alcohol Abuse Structured Screening & Brief Intervention: Prescreening Completed - No Further Screening Indicated
- Drug/Alcohol Abuse Structured Screening & Brief Intervention: Prescreening Completed - Further Screening Indicated
- AUDIT alcohol use disorders identification test (0-40)
- Drug abuse screening test (1-20)
- Pediatric screening: CRAFFT
- Drug/Alcohol Abuse Structured Screening & Brief Intervention 15-30 Minutes
- Drug/Alcohol Abuse Structured Screening & Brief Intervention Over 30 Minutes
3.b.i- Evidence Based Strategies for CVD

- Active member of NYSDOH and HealtheConnections IMPACT team
- Aligned goals for both projects for best success
- Developed Hypertension Self Management plans for patients to choose goals to improve their outcomes
- Developed Home BP monitoring program with loaner equipment for patient use
Documentation process for Self Management goals
Flowsheets for patient and internal progress monitoring

<table>
<thead>
<tr>
<th>Self Management Goals (Sha)</th>
<th>03/26/13 07:24pm</th>
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<tbody>
<tr>
<td></td>
<td>Systolic BP-Sitting</td>
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<td>Diastolic BP-Sitting</td>
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<td>Systolic BP-Sitting R 120</td>
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<td>Diastolic BP-Sitting R 85</td>
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<td>Systolic BP-Sitting L</td>
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<td>Diastolic BP-Sitting L</td>
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<td><strong>Smoking Status</strong></td>
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<td>Patient Goals - Smoke Less...</td>
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<td>Patient Goals - Current Sm...</td>
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<td><strong>Alcohol</strong></td>
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<td>Patient Goals - Drink Less T...</td>
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<td>Patient Goals - Current Alc...</td>
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<td><strong>Weight</strong></td>
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<td></td>
<td>Patient Goals - Goal Weight</td>
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<td></td>
<td>Weight 220</td>
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<tr>
<td><strong>Exercise</strong></td>
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<td>Patient Goals - Exercise Ses...</td>
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<td></td>
<td>Patient Goals - Current Exer...</td>
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<td></td>
<td>Patient Goals - Exercise...</td>
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Patient Access

- Re-evaluated existing professional staff and their long term practice plans
- Reallocated resources across the system to pair seasoned staff with new providers
- Expanded capacity across the system
Key Tips for Success

* Leadership support
* Communication
* Evaluate new initiatives and Integrate projects as much as possible
* Develop action plans and timelines
* Ensure to involve key players from every department
Start with a small test group!

- Use PDSA’s as the mechanism for change
- It is all about the clicks! Document in structured fields for automated reporting
- Data mapping is very critical to successful and accurate data validation
- Develop strong linkages between PC and other community based organizations
That developing good processes takes time, commitment and in some cases an iron shield for those who do NOT like change....
HEALTH HOME CARE MANAGEMENT WITHIN CNYCC PPS REGION

Brian McKee, Vice President of Integrated Care Management
WHERE WE WERE IN 2013:

- 42 people receiving intensive case management in Madison County
- Serving people with mental illness and substance abuse problems
- 5 staff
- Stationed at 218 Liberty St., Oneida NY
WHERE WE ARE NOW (2016)

- 500 adults receiving Health Home Care Management (HHCM) in Madison, Cayuga, and Onondaga
- Serve people with mental illness, substance abuse and health problems (comprehensive care).
- Collaborations with health care and behavioral health providers to assist patients with completing treatment recommendations
- 4 different Health Homes
- 22 staff in 4 different offices
- Children’s begins 12/1/2016
BENEFITS OF CARE COORDINATION

- Care Coordination is key deliverable in several DSRIP Projects (2ai, 2biv, 2di, 3ai, 3biv, 3gi)
- Collaboration (relationships) with providers
- Improve efficiency/quality of patients care
- Enhance patient safety
- Increase connectivity to services to meet social and behavioral needs
- Improve patient satisfaction and engagement
- Position for value-based payment mode
BENEFITS OF CARE COORDINATION

- Lower Inpatient Admissions
- Improved Clinical Outcomes
- Reduction of ER visits and hospital readmissions (DSRIP Goal/Measurement)
- Better educated and engaged patients
- Lower Costs (especially for the complex chronically ill patients)
- Increased Staff satisfaction

“The right care, at the right time, at the right place, for the right cost”
Elements of Success

- Collaboration (relationships) with providers
- Communication (frequency, multiple points)
- “Make it work” staff and culture
- Measure once, measure again...
  - Caseloads
  - Engagement
  - Compliance
  - Utilization
  - Revenue
  - ....Results?
CHALLENGES

- Processes
- Systems: Multiple EHR’s, RHIO’s, HCS
- Compliance versus quality
- Multiple HH’s= different standards and systems
- HARP enrollment
- Growth management
  - Predicting revenue
  - Hiring
  - Caseload shifts
WHAT WE’VE LEARNED

- Care Management (quality) works best when working in partnership with another essential service (i.e. Primary Care, MH Therapy, etc.)
- Referrals from Providers with whom we already have a relationship (bottom-up) are 2x more likely to result in enrollment than referrals from someone who we don’t work as closely with (top-down) 2016- 44% and 23%, respectively
- Collaborations take time lot of effort to mature
QUESTIONS?
Screening, Brief Intervention, and Referral to Treatment (SBIRT)
CNYCC Annual Meeting
November 1, 2016
Danielle Olsen LMHC and Gerry King LMSW, MPA
Prevalence of Substance Use

• The National Survey of Drug Use and Health estimates that of the 22.6 million people who have a substance use disorder, 10-11% are treated. Of those who are untreated, 96% did not seek out treatment.

• For every one person who has a substance use disorder, six or more are at-risk or have already experienced problems as a result of their use.

Prevalence of Substance Use Continued

• Approximately 40% of the patients admitted to trauma centers have a positive BAC.

• If drug use is included, approximately 60% of patients seen in trauma centers are under the influence of alcohol or drugs when admitted.

The Research Is In:

SBIRT

Ranked in the top five cost-effective preventive services.
Research Studies

• Gentilello, Ebel, Wickizer, Salkever & Rivara (2005) demonstrate a cost savings of $89.00 for each patient screening and $330.00 for each person who was engaged in a brief intervention.

• In a study of Medicaid patients in Washington state, Estee, et al.(2008) demonstrate a cost savings of $271.00 per member-per month, for those who engaged in at least a brief intervention.
Research Studies -continued

• Solberg, Maciosek, & Edwards (2008) demonstrate a net savings of $254.00 for each person offered a screening, and a total medical care savings of $712.00 per person.

• A SAMHSA grant-funded SBIRT program in New Mexico reported a monthly savings of $97,356.67 (including social costs). This equates into an annual savings of $2,929,700.
Reduces ED Visits and Hospitalizations

– A 48-month study by Fleming et. al. in 2002, of brief physician advice in primary care found 20% fewer ED visits and 37% fewer days of hospitalization in intervention group compared to the control group.

– In a 24 month study by Paltzer, et. al in 2016, of a sample of 7367 Medicaid patients receiving healthcare services from 33 clinics in Wisconsin those who screened positive and received a brief intervention changed their utilization over the 24-month follow-up period by
  • −0.036 inpatient days per member per month (PMPM) (p < 0.05),
  • −0.001 inpatient admissions PMPM (non-significant),
  • −0.004 emergency department days PMPM (non-significant) and
  • 0.143 outpatient days (PMPM) (p < 0.001).
### Survey on Adult Patient Attitudes

<table>
<thead>
<tr>
<th>Agree/Strongly Agree</th>
<th></th>
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<tbody>
<tr>
<td>“If my doctor asked me how much I drink, I would give an honest answer.”</td>
<td>99%</td>
</tr>
<tr>
<td>“If my drinking is affecting my health, my doctor should advise me to cut down on alcohol.”</td>
<td>96%</td>
</tr>
<tr>
<td>“As part of my medical care, my doctor should feel free to ask me how much alcohol I drink.”</td>
<td>93%</td>
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<table>
<thead>
<tr>
<th>Disagree/Strongly Disagree</th>
<th></th>
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<tbody>
<tr>
<td>“I would be annoyed if my doctor asked me how much alcohol I drink.”</td>
<td>86%</td>
</tr>
<tr>
<td>“I would be embarrassed if my doctor asked me how much alcohol I drink.”</td>
<td>78%</td>
</tr>
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</table>
Substance Use Is

A Public Health Problem
Historically

- Substance Use Services have focused on two areas:
  - Prevention – Precluding or delaying the onset of substance use.
  - Treatment – Providing time, cost, and labor intensive care to patients who are acutely or chronically ill with a substance use disorder.
Substance Use Disorder

Traditional Treatment
Abstinence

No Problem

Primary Prevention
No Intervention
Drink Responsibly
The Current Model
A Continuum of Substance Use

Abstinence | Responsible Use | Addiction
An Outdated Model

- This model (paradigm) of substance use:
  - Fails to recognize a full continuum of substance use behavior.
  - Fails to recognize a full continuum of substance use problems.
  - Fails to provide a full continuum of substance use interventions.
The current model identifies a substance use problem as...

Addiction
The SBIRT model identifies a substance use problem as... **Excessive Use**
Excessive Use is Correlated to

- Trauma and retraumatization.
- Causation or exacerbation of health conditions.
- Exacerbation of mental health conditions.
- Alcohol poisoning.
- DWI/Impaired Driving.
- Domestic and other forms of violence.
- Transmission of sexually transmitted diseases.
- Unintended pregnancies.
- Substance Use Disorders.
Depression. Anxiety. Aggression.

Cancer of the throat and mouth

Frequent colds and infections, increased risk of pneumonia

Liver damage

Erectile dysfunction, birth defects, developmentally delayed or low birth weight babies.

Painful nerves. Numb, tingling toes.


Premature aging.


Impaired sensation leading to falls.

Inflammation of the pancreas.

Failure to fulfill obligations at work, school, or home. Car accidents. Legal problems.
The SBIRT Model – A Continuum of Substance Use

- Abstinence
- Experimental Use
- Social Use
- Binge Use
- Abuse
- Substance Use Disorder
The Costs of Substance Use

The bulk of the societal, personal, and health care related costs is not a result of substance use disorders but of excessive substance use. Until such time as we acknowledge this fact, and address it appropriately, we are unlikely to make significant progress towards a solution.
If we could provide a 100% cure to every individual with a substance use disorder in the US, we wouldn’t be close to solving most of the substance related problems in our country.
The SBIRT Model
A Continuum of Interventions

• Prevention – Precluding or delaying the onset of substance use.

• Intervention – Providing time, cost, and labor sensitive care to patients who are at risk for psycho-social or healthcare problems related to their substance use choices.

• Treatment – Providing time, cost, and labor intensive care to patients who are acutely or chronically ill with a substance use disorder.
Primary Goal

The primary goal of SBIRT is to identify those who are at moderate or high risk for psycho-social or health care problems related to their substance use choices.

The primary goal of SBIRT is not to identify those who have a substance use disorder and need further assessment.
NIAAA Definitions

• Low Risk:
  - Healthy Men < 65
    ≤ 4 drinks per day → AND NOT MORE THAN 14 drinks per week
  - Healthy Women & Men ≥ 65
    ≤ 3 drinks per day → AND NOT MORE THAN 7 drinks per week

• Hazardous:
  Pattern that increases risk for adverse consequences.

• Harmful:
  Negative consequences have already occurred.


Let’s Review

• SBIRT is a systems change initiative requiring us to re-conceptualize, re-define, and re-design our approach to substance use problems and services.
• SBIRT uses a public health approach.
• The current model defines the problem in terms of addiction.
• The SBIRT model defines the problem as excessive use.
• SBIRT recognizes a continuum of substance use behavior, a continuum of substance use problems, and a continuum of substance use interventions.
Two Levels of Screening

1. Universal:
   Pre-screen provided to all adult and adolescent patients.
   • Serves to educate and affirm patients who are at low or no-risk.
   • Can (should) be done at intake or triage.
   • Positive pre-screen = proceed with full screen.
Two Levels of Screening - continued

2. Full Screen:
   Provided to specific patients:
   • Scored positive on the pre-screen,
   • Alcohol on breath,
   • Positive Blood Alcohol Concentration (BAC),
   • Suspected alcohol/drug related health problems.
Screening Does Provide

• Education and positive feedback for low/no risk users.
• Immediate identification of level of risk.
• A context for a discussion of substance use.
• Information on the level of involvement in substance use.
• Insight into areas where substance use may be problematic.
• Identification of patients who are most likely to benefit from brief intervention.
• Identification of patients who are most likely in need of referral for further assessment.
Four Types of Intervention

1. Feedback only.
2. Brief Intervention.
3. Extended Brief Intervention or Brief Treatment.
4. Referral for further assessment.

Validated Screening Tools

- AUDIT: Alcohol Use Disorder Identification Test
- DAST: Drug Abuse Screening Test
- CRAFFT: Adolescent Screen (Car, Relax, Alone, Forget, Family or Friends, Trouble)
- NIAAA Alcohol Screening for Youth Ages 9–18
- S2BI: Screening to Brief Intervention Tool
- ASSIST: Alcohol, Smoking, and Substance Abuse Involvement Screening Test
- T-ACE
- TWEAK
- NIAAAA and NIDA single question pre-screens
What is Brief Intervention (BI)?

A Brief Intervention is a time limited, individual counseling session.
What are the Goals of a BI?

• The general goal of a BI is to:
  • **Educate** patients on safe levels of substance use.
  • **Increase** patients’ **awareness** of the consequences of substance use.
  • **Motivate** patients towards **changing** substance use behavior.
  • **Assist** patients in making **choices** that reduce their risk of substance use problems.
What are the Goals of a BI? - continued

The goals of a BI are fluid and are dependent on a variety of factors including:

- The patient’s screening score.
- The patient’s readiness to change.
- The patient’s specific needs.
What is Your Role?

• **Provide** feedback about the screening results.

• **Offer** information on low-risk substance use, the link between substance use and other lifestyle or healthcare related problems.

• **Understand** the patient’s viewpoints regarding their substance use.
What is Your Role?- continued

- **Explore** options for change.
- **Assist** the patients in making new decisions regarding their substance use.
- **Support** the patients in making changes in their substance use behavior.
- **Give** advice if requested or if you ask permission to offer advice.
Brief Negotiated Interview (BNI)

1. Build Rapport
2. Pros and Cons
3. Information and Feedback
4. Readiness Ruler
5. Action Plan

Referral to Treatment

• Any provider proposing to implement SBIRT must have at least one current referral agreement with an accessible OASAS-certified treatment provider to meet the needs of individuals who require such referrals

• Suggestion - Develop a relationship with 1 or 2 SUD providers that can accept referrals and let them make LOC determinations
Barriers to Implementation

- Time constraints
- Belief that patients do not tell the truth
- Uncertain treatment is effective
- Uncomfortable talking about AOD use
- Do not feel competent what to do if patient screens positive
- Did not have sufficient information about referral options
- Do not want to frighten or anger patient
- Challenges with reimbursement
Models for Implementation

Question is who will deliver BI?

• Generally 2 models
• Implement with existing staff and workflow – Whomever does assessment and provides services, delivers BI
• Patient with + screen is identified and warm handoff to Health Coach/other staff member to deliver BI
Future for SBIRT and Collaborative Care and ??

• Integrate SBIRT with Collaborative Care (depression)
• Easier to add SBIRT to CC, than other way around
• Collaborative Care Manager conduct BIs and provide intervention for depression
• Models exist that
  – Combine both SBIRT and CC e.g. Wisconsin SBIRT
  – Add in physical problems e.g. diabetes and cardiovascular disease e.g. Care of Mental, Physical and Substance Use Syndromes (COMPASS)
Thank you for your time and attention!
Population Health Management Approach & Implementation Overview
Central New York Care Collaborative (CNYCC) Annual Meeting
Population Health Management
Approach
CNYCC PHM Approach: Planning

The Work We Have Collectively Done To-Date Has Laid the Foundation for Our PHM Planning Efforts

**IT Assessments**
- IT Systems, Processes and Resources
- High Level PHM Capabilities

**Data Dictionary**
- Availability of information to build DSRIP performance measures

**Benefits Realization**
- Barriers to PHM program development
- Expected impact of PHM infrastructure

**VBP and PHM Assessments**
- Detailed Clinical, Operational and Technical Readiness
- Application of PPS toolsets specific to each partner

PHM Planning Inputs

The Work We Have Collectively Done To-Date Has Laid the Foundation for Our PHM Planning Efforts
CNYCC PHM Approach: Overview

To Achieve the Overarching Goals of DSRIP CNYCC Must Focus on Population Health Management (PHM)

- People: CNYCC Partner Project Participants and Workforce
- Process: CNYCC Project Development and Integrated Delivery Network (IDN) Formation
- Technology: CNYCC Integrated PHM Platform

Population Health Management Components
### CNYCC PHM Approach: Process

Success in DSRIP and other Value Based Payment (VBP) Programs Requires a Transition from Conventional Medical Care to Population Health Management

<table>
<thead>
<tr>
<th>Conventional Medical Care</th>
<th>Population Health Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of responsibility based primarily on treatment episodes</td>
<td>Scope of responsibility based on defined population of assigned or attributed patients over time</td>
</tr>
<tr>
<td>Reactive: Address illness of presenting patient</td>
<td>Proactive: Care processes also emphasize outreach based on needs, including primary and secondary prevention</td>
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<tr>
<td>Care delivered primarily by individual professional contributors</td>
<td>Care delivered by multi-disciplinary teams, including patient and informal caregivers</td>
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<tr>
<td>Provider advocates for individual patients, without regard to economic outcomes to third parties</td>
<td>Provider balances between duty to individual patients and stewardship for population resources</td>
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<tr>
<td>Health information management is focused on professional communications, medical-legal documentation, and reimbursement</td>
<td>Health information management also prioritizes support for care process enablement, learning for improvement and innovation, and accountability</td>
</tr>
<tr>
<td>Volume driven reimbursement primarily based on fee-for-service</td>
<td>Value driven reimbursement based at least partly on acceptance of responsibility and risk and delivery of value</td>
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## CNYCC Approach: Process

To Create an Integrated Delivery Network (IDN) that Can Succeed in VBP, CNYCC Must Enable a Set of Core Functional Requirements

<table>
<thead>
<tr>
<th>VBP Functional Requirements</th>
<th>Population Health Management Impact</th>
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<tbody>
<tr>
<td><strong>Performance Management</strong></td>
<td>• Timely measurement and monitoring of metrics associated with quality initiatives</td>
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<td></td>
<td>• Actionable insights: Longitudinal clinical record, care management capabilities and patient engagement capabilities allow care team members to take action on patients who are not achieving quality goals</td>
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<tr>
<td><strong>Quality Improvement</strong></td>
<td>• Monitoring patient and provider/partner adherence to quality improvement protocols</td>
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<td>• Supports analysis of causative factors influencing quality outcomes</td>
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<td><strong>Data Analytics</strong></td>
<td>• Access to centralized risk assessment and scoring capabilities across a partner network allow for standardization of protocols to address high risk patient cohorts</td>
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<td>• Simultaneous analysis of clinical and utilization data allows for enhanced patient targeting, more effective use of resources to mitigate potentially high cost/adverse outcomes</td>
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<td>• Facilitation of Rapid Cycle Evaluation (RCE) process to gain insight into the effectiveness of particular interventions, or programming efforts</td>
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<tr>
<td><strong>Care Management and Care Coordination Programs</strong></td>
<td>• Access to a shared longitudinal patient care record and care plan enhances patient transition and collaborative care delivery</td>
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<tr>
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<td>• Patient engagement tools assist with outreach and enrollment activities</td>
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<td>• Care management/coordination strategy and program design can be informed and prioritized based on the supporting analytics that identify high risk patient cohorts</td>
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<td>• Supporting the administration of standard assessment criteria, toolsets and processes to ensure consistent measurement and mitigation of a patient’s level of risk</td>
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CNYCC Approach: Technology

An Integrated PHM Infrastructure is the Corner Stone of the IT Infrastructure Required to Develop and Support an Integrated Delivery Network (IDN)
Integrated PHM Infrastructure: Development

**Partner Infrastructure Development**
- The ability to capture and share data locally, by each partner, governs the information that is available to support the coordination and integration of care across the continuum as well as the analytics that can be applied to drive shared insights.

**PPS Infrastructure Development**
- The ability to harmonize data from across the continuum and turn that data into actionable, shared insights will drive PPS operations, inform project development and foster accountability and performance monitoring.
## Integrated PHM Infrastructure: Components

### 1. Collect
Aggregate Data

### 2. Define
Population Identification

### 3. Assess
Health Assessment

### 4. Stratify
Risk Stratification

### 5. Engage
Enrollment / Engagement Strategies

### 6. Manage
Management / Interventions

### Data Management
(Extraction, Movement, Aggregation, Harmonization, Security)

<table>
<thead>
<tr>
<th>Attribution Management</th>
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<tbody>
<tr>
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<td>• Social, clinical, behavioral risk assessments</td>
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### Reporting & Analytics
(Quality Improvement, Performance Management, Business Intelligence)

Correlation vs. Causation | Program Effectiveness (ROI) | Evaluation of Clinical, Financial and Social Indicators | PHM Programming Design
Integrated PHM Infrastructure: Broader Regional Benefits

Infrastructure Developed by the PPS Can Support Additional Regional PHM and VBP Activities

**Economies of Scale**
- Single Technical Integration
  - Shared Costs for Overlapping Network Providers
  - Minimizes Burden for Training and Adoption

**Care Coordination**
- Single Platform for All Collaborative Patient Care Delivery
  - Tracking Patient Care Outside of Geopolitical Boundaries
    - Establishment of Common Processes Across Payer Populations

**Reporting & Analytics**
- Establishment of Common Risk, Quality and Outcome Criteria Across Payer Populations
- Robust Population Level Reporting to Support Regional Initiatives and PHM Programming/Interventions
Population Health Management
Implementation Overview
PHM Implementation Phases: Data Source Integration Strategy

**Strategy Components**
- Cohorting of Vendor EMR Integration by Vendor Type and Integration Capabilities
- Perform Partner Integration Readiness Assessments
- Define Partner Integration Phases Based on Outcomes of Integration Capabilities, Prioritization and Readiness Processes

**Data Source Prioritization Factors**
- Previous EMR Integration History with PHM Vendor
- Partner resource bandwidth
- Relative Medicaid Population
- Vendor Readiness Requirements
  - Technical
  - Operational
- Willingness to adopt platform
PHM Implementation Phases: Data Source Integration Steps

* This phase of integration will require CNYCC to engage directly with partner’s operational, clinical and technical staff to complete PHM integration requirements.
System Design Plan (User Interface Development)

- Pre-Implementation Planning
- Partner VBP and PHM Readiness Assessments
- Inventory Use Cases per DSRIP and PHM Programming Requirements
- Inventory User Types
- Define Required Functionality by User Type to Satisfy Use Cases
- Create Tiered PHM Roadmap Based on Partner Readiness Cohorts Identified Through VBP and PHM Readiness Assessment and Use Case Requirements
PHM Implementation Phases: User Interface Development

Initial PHM Use Case UI Build

Initial Care Coordination and Management UI Build

Workflow Demonstration Sessions—Internal and Partners*

Develop Internal and Partner feedback into the system

*Perform Quality Assurance Testing on UI

Care Management Module UI Development Factors
- Analysis of care management workflows
- Project defined workflows
- Transitional care workflows

Data and Analytics Module UI Development Factors
- State Defined Measures and Metrics
- Local and Regional Measures
- Dashboards for performance measures
- Patient Registries

*This phase of development will require CNYCC to engage directly with partner’s operational, clinical and technical staff to complete PHM project requirements.
PHM Implementation Phases: Application Roll Out

Develop Training Materials and Train CNYCC Training Staff

Develop Support Strategy

End User Training Sessions – Internal and Partners*

Implement Support Strategy

Implement End Support Strategy and Roll out application to end users*

Care Management Module Roll Out Factors
- Completion and validation of required workflows/use cases
- Role based

Data and Analytics Module Roll Out Factors
- Timing/Functions Based on Data Sets
  - Claims
  - Clinical

*This phase of development will require CNYCC to engage directly with partner’s operational, clinical and, technical staff to complete PHM project requirements.
*This phase of development will require CNYCC to engage directly with partner’s operational, clinical and, technical staff to complete PHM project requirements.*
## Draft PHM Platform Implementation Timeline

| Task                                      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 |
|-------------------------------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Pre-Implmentation Planning                |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| System Design Plan                        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Data Source Integration Strategy          |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| User Interface Development                |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Non EMR Integration (Claims)              |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Non EMR Integration (HIE)                 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| EMR Integration (Phase 1)                 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| EMR Integration (Phase 2)                 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| EMR Integration (Phase 3)                 |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Application Roll Out                     |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
Population Health Management:

Project Overview
This region is characterized by a very diverse EMR vendor landscape, which impedes meaningful data sharing and clinical integration—both of which are critical for managing population health. The introduction of a centralized PHM solution will provide timely access to pertinent clinical data from across the continuum of care and turn that data into actionable intelligence that, combined with a broad spectrum of and essential PHM tools, will help drive regional integration and transformation efforts.

The breadth, depth, and timeliness of available data and tools will accelerate the region’s ability to understand and respond to the current and emerging needs of our providers and the Medicaid, uninsured, and other populations they serve. This project will develop an infrastructure that enables an agile and informed approach, which will allow for success in our dynamic and rapidly evolving health care environment.

Contribution to Achieving Goals and Objectives of the DSRIP Program and VBP Readiness
This project will create a centralized system that will drive the success of the Plan. This project will implement a PHM infrastructure (Figure 1) that will enable providers and the network to make data-driven decisions about: clinical care delivery and interventions; clinical, operational, and financial performance; patient engagement; resource use and allocation; workforce; operational efficiencies; and type and level of value-based payment readiness.

Figure 1: Integrated Population Health Management Infrastructure

Data Management
(Extraction, Movement, Aggregation, Harmonization, Security)

Population Identification

- Attribution Management
  - Provider
  - Practice
  - Collaborative
  - Programs and interventions
  - Service line and project eligibility
  - Patient cohorts

- Clinical Risk
  - Chronic disease identification and progression
  - Chronic disease registries
  - Quality and preventative care best practices/gaps
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  - Pro/prospective utilization
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- Patient Engagement
  - Outreach management
  - Care team coordination
  - Social, clinical, behavioral risk assessments

Care Management

- Care Coordination
  - Utilization alerts
  - Collaborative care planning
  - Facilitating transitions of care (warm handoffs)
  - Care team coordination
  - Programs/Intervention oversight

Reporting & Analytics
(Quality Improvement, Performance Management, Business Intelligence)

- Correlation vs. Causation
- Program Effectiveness (ROI)
- Evaluation of Clinical, Financial and Social Indicators
- PHM Programming Design
Population Health Management:

As depicted on side one, an integrated PHM platform is characterized by four primary functional areas: data management, population identification, care management, reporting and analytics. In aggregate, these components will enable a PHM process that focuses on six key steps:

1. **Data Collection**: This foundational element is key to a successful PHM strategy and allows for the aggregation and harmonization of data so that the information gathered from disparate sources can be coalesced in a meaningful way that promotes true interoperability. Coded data will be mapped to standard definitions, and non-coded data, which comprises a large portion of valuable information currently available within EMRs, will be both coded and mapped to clinical equivalences. In addition, access to that data will be governed through roles- and rules-based security mechanisms that allow for the appropriate information to be available to the appropriate parties.

2. **Defining the Population**: The data that have been collected will then be used to identify populations of interest based on eligibility criteria for programs, interventions, provider relationships, or disease cohorts.

3. **Health and Needs Assessment**: The needs of the populations of interest will then be accessed to ensure that interventions and programming efforts are designed appropriately. This can be accomplished through the evaluation of gaps in care associated with a patients’ clinical risk along with patient-reported information collected through patient engagement and assessment tools.

4. **Risk Stratification**: To ensure that limited resources are appropriately utilized, a target population will be stratified to identify members who are at greatest risk for adverse outcomes. The stratification will include patient’s clinical, financial, social, and behavioral risk factors. This process requires that these data exist in a single, unified platform.

5. **Patient Engagement**: Assessment and risk stratification activities will help to identify the most vulnerable populations. The platform will provide toolsets to support engaging those patients in a meaningful and coordinated fashion and allows for a shared perspective of the patients across collaborating health care partners.

6. **Intervention Management**: To improve the outcomes of at-risk engaged populations, the platform will help us identify and implement interventions across the continuum of care that address their needs. To inform the efficacy of interventions, the platform provides access to centralized care planning capabilities and analytics. Additionally, the platform has performance management and reporting, including benchmarking partner performance, to foster accountability among partners.