WORKING TOGETHER
FOR BETTER HEALTH
<table>
<thead>
<tr>
<th>TIME</th>
<th>SESSION</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>8:00AM - 8:45AM</td>
<td>Registration</td>
<td>Breakfast Served</td>
</tr>
<tr>
<td>8:45AM-9:00AM</td>
<td>Welcome &amp; Introductions</td>
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</tbody>
</table>
| 9:00AM-9:45AM    | Keynote Address                      | Jason Helgerson  
Finger Lakes Ballroom  
Medicaid Director at State of New York DOH  
Jason will provide an overview of the NY State DSRIP Program and the transition to Value Based Payment care delivery |
| 9:45AM-10:45AM   | Transitions in Care                  | Thomas Graf, MD  
Finger Lakes Ballroom  
National Director of Population Health Management, Chartis Group  
Dr. Graf will give an overview of organizations that have successfully transitioned to VBP Care delivery models |
| 10:45AM-11:00AM  | Break                                |                                                                                                                                           |
| 11:00AM- 12:00PM | Community Based Partnerships         | Rebecca Bostwick  
Finger Lakes Ballroom  
Program Director, Lerner Center for Public Health Promotion  
Discussion on the importance of building community relationships to help support the healthcare needs of a diverse population |
|                  | Panel Discussion                     | Paula Cerio, Salvation Army  
Constance Gregory, Healthy Neighbors Partnership  
Gale Grunert, Lewis County  
Sharon Owens, Syracuse Model Neighborhood Facility, Inc.  
Moderated Q & A session to discuss the impact of building community-level engagement opportunities to address healthcare needs |
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<tr>
<th>TIME</th>
<th>SESSION</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>12:00PM-1:00PM</td>
<td>Lunch</td>
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<tr>
<td>1:00PM-2:00PM</td>
<td>Managed Care Perspective</td>
<td>An overview of VBP model development from the perspective of a Managed Care Organization</td>
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<tr>
<td>Finger Lakes Ballroom</td>
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<tr>
<td>2:15PM-3:00PM</td>
<td>Concurrent Breakout Sessions</td>
<td>Discussion on DSRIP Project Implementation in a Primary Care setting</td>
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<tr>
<td>Hemlock Room</td>
<td>Role of Primary Care in the PPS</td>
<td>Discussion on DSRIP Project Implementation in a Primary Care setting</td>
</tr>
<tr>
<td>Northern Oswego County Health Services, Inc. (NOCHSI)</td>
<td>Tricia Peter-Clark &amp; Nancy Deavers</td>
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<tr>
<td>Finger Lakes Ballroom</td>
<td>Screening, Brief Intervention, and Referral to Treatment (SBIRT)</td>
<td>Overview of an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs</td>
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<tr>
<td>Danielle Olsen &amp; Gerry King, OASAS</td>
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<tr>
<td>Conesus Room</td>
<td>CNYCC Population Health Management Integration</td>
<td>An overview of CNYCC’s planning for PHM System Integration</td>
</tr>
<tr>
<td>Joseph Reilly, CNYCC</td>
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<tr>
<td>Canandaigua Room</td>
<td>Care Coordination Delivery Model</td>
<td>Outline on the benefits of Care Coordination (Care Management) in the care delivery model</td>
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<tr>
<td>Brian McKee, Liberty Resources</td>
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<tr>
<td>3:15PM-3:45PM</td>
<td>Closing Remarks</td>
<td>Closing remarks by CNYCC’s Executive Director that highlights the future outlook of the PPS</td>
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<tr>
<td>Finger Lakes Ballroom</td>
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<tr>
<td>4:00PM</td>
<td>Networking Reception (Cash Bar)</td>
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<td>Cavalier Room</td>
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DSRIP & Value Based Payment: A True Opportunity to Transfer Health Care Delivery

Central New York Care Collaborative Annual Meeting
November 1, 2016

Jason Helgerson, Medicaid Director
Office of Health Insurance Programs
NYS Department of Health
Overview

• Background on MRT
• Where Are We Now?
• Moving Forward – Role of Providers Within the PPS
• Closing Thoughts
New York State Medicaid Transformation Since 2011

2011: Governor Cuomo created the Medicaid Redesign Team (MRT) which developed a series of recommendations to lower immediate spending and propose future reforms

2014: As part of the MRT plan NYS obtained a 1115 Waiver which would reinvest MRT generated federal savings back into redesigning New York’s health care delivery system known as DSRIP

2015: As part of DSRIP, NYS undertakes an ambitious payment reform plan working towards 80% value based payments by the end of the waiver period
NYS Statewide Total Medicaid Spending per Recipient (CY2003-2015)

Source: NYS DOH OHIP DataMart (based on claims paid through June 2016)
Where Are We Now?
An Important Turning Point

Performing Provider Systems (PPS) have transitioned from planning to implementing projects.

We are here

DY0 | DY1 | DY2 | DY3 | DY4 | DY5

Q1|Q2|Q3|Q4 | Q1|Q2|Q3|Q4 | Q1|Q2|Q3|Q4 | Q1|Q2|Q3|Q4 | Q1|Q2|Q3|Q4

- Submission/Approval of Project Plan
- Focus on Infrastructure Development
- Focus on System/Clinical Development
- Focus on Project Outcomes/Sustainability

- PPS Project Plan valuation
- PPS first DSRIP payment
- PPS submission and approval of Implementation Plan
- PPS submission of first quarterly report
- Payment tied to Domains 2 & 3 is predominately P4P.
- Based on MY4 data and MY5 data for the DY 5 Q4.

- Measurement Year (MY) 2 begins. Data collection for Domain 3 P4P measures begins.
- MY 3 begins. Data collection for Domain 2 P4P measures begins.
- First payment made for outcomes tied to Domain 3 P4P measures. Based on MY2 data and Demonstration Year (DY) 2 Q2 report
- First payment made for outcomes tied to Domain 2 P4P measures. Based on MY3 data and Quarterly Report and DY3 Q2 report.

* P4P = pay for performance

Source: Based on Independent Assessor Project Approval and Oversight Panel Presentation. Nov 9 – 10, 2015. NYS DSRIP Website
Measurement Year 3 (MY3) results = $902M in net project valuation

- MY3 P4P payments are split between payments in Demonstration Year 3 (DY3) (payment 2 - $502M) and DY4 (payment 1 - $400M).
- This represents 42% of all P4P dollars available through the five years of DSRIP.
We are Making Progress!

The North Country Initiative PPS used DSRIP funds to recruit 23 health care professionals including a dentist to serve a very rural community where they haven’t had a dentist in over 5 years.

Ellenville, a critical access hospital Emergency Department (ED), is seeing impressive reductions in opioid seeking utilization (-73%) and a reduction in ED visits (-34%) among their selected cohort as a result of Medicaid Accelerated eXchange (MAX) participation and DSRIP interventions.

Catholic Health System is using claims data to set ED frequency thresholds and then design workflows around high frequency ED patients that are low to non Utilizers of their plan assigned Primary Care Physician (PCP).

Staten Island PPS developed a new Community Health Worker training program in partnership with 1199 TEF and the College of Staten Island. The program lasts 26 weeks and results in college credits and a Community Health Worker certification.
Major Accomplishments

- Development of Robust Governance and Partner Network Infrastructure
  - Board of Directors
  - Committees
  - Partner Contracting

- Extensive Partner Engagement Efforts
  - Regional Project Advisory Committee(s)
  - Learning Collaboratives
  - Community Engagement (Human Services Leadership Council; Housing & Homeless Coalition of Syracuse & Onondaga County etc.)

- Comprehensive Population Health Management System Platform:
  - Integrated infrastructure to support, People (CNYCC Partner Organizations); Process (Project Implementation); and Technology (Integrated PHM Platform)
  - Focus on impact of Value Based Payment (VBP) approach to PHM Strategy including: Economies of Scale; Care Coordination; and Reporting/Analytics
  - Exploring regional collaboration with other payees & VBP initiatives
DSRIP Year 2: How are PPS performing so far?

PPSs have earned 99.4% of all available funds to date!

$1.2B Total!

There is more work to do!
Moving Forward --
Role of Providers Within the PPS
What You Are Doing Is Beautiful!
Proceed With Fact-Based Optimism
What is Fact-based Optimism?

We live in exciting times and DSRIP is a tremendous opportunity to transform the health care system in NYS.

Optimism is essential for such demanding work and to solve the great challenges ahead.

No time for Pollyanna – fully understand current conditions and focus on the possible.
What is Fact-based Optimism? Cont.

Pessimism = Self-fulfilling Prophecy

Stakeholders can’t be told that this is too hard or dwell entirely on problems

Work to create a “culture of possibility” in which DSRIP goals are seen as achievable and celebrate success.

Building such a culture requires – effective communication and inclusive decision-making
Participate in Value Based Payment
Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to allow providers to increase their margins by realizing value.

Current State
Increasing the value of care delivered more often than not threatens providers’ margins.

Future State
When VBP is done well, providers’ margins go up when the value of care delivered increases.

Goal – Pay for Value not Volume
How DSRIP and VBP Work Together

Old world:
- FFS
- Individual provider was anchor for financing and quality measurement
- Volume over Value

New world:
- VBP arrangements
- Integrated care services for patients are anchor for financing and quality measurement
- Value over Volume

DSRIP: Restructuring effort to prepare for future success in changing environment
Today: >25% of Medicaid Spend is in VBP Level 1 or Higher

Per Survey, VBP Baseline of Levels 1 - 3 for CY 2014: 25.5%*

- **Total Spending**: $22,741 M
- **FFS**: $14,372 M (63.2%)
- **VBP Level 0**: $2,576 M (11.3%)
  - Quality: $2,036 M (9%)
  - No Quality: $539 M (2.4%)
- **VBP Level 1**: $567.5 M (2.5%)
- **VBP Level 2**: $3,172 M (14%)
- **VBP Level 3**: $2,062 M (9.1%)

*Includes Mainstream, MLTC, MAP, and HIV SNP plans.
VBP Goals

By April 2020, 80-90%* of Medicaid Managed Care Spend (Plan to Provider Payments) Will Be in VBP Level 1 and Higher

*Minimum of 80%; includes MLTC and (depending on move to Managed Care) I/DD
VBP Implementation Efforts

The State is providing additional financial incentives and support for early adoption of Value Based Payment as well as for execution of higher-risk contracts through:

**VBP Pilot Program**
- The goal of the Pilots is to help the State and its participating organizations learn how VBP transformation will work in practice as well as to incentivize early adoption of VBP. This is a voluntary 2-year program. DOH reserves the right to restrict enrollment to those pilots that it deems to be most relevant.

**Ongoing Subcommittees**
- As VBP is implemented, the State will continue to explore the need for the development of new subcommittees, like a Subcommittee on Children’s Health, and reconvene existing groups as needed.

**VBP Innovator Program**
- The goal of the Innovator Program is to recognize providers that contract high risk Level 2 or Level 3 total cost of care for general and subpopulation arrangements by allowing up to 95% premium pass through.
VBP Transformation: Overall Goals and Timeline

To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

Clinical Advisory Groups

Bootcamps

Follow up Workgroups

VBP Pilots

NYS Payment Reform

2016

2017

2018

2019

2020

DSRIP Goals

DY2 – April 2017

PPS requested to submit growth plan outlining path to 90% VBP

DY3 – April 2018

> 10% of total MCO expenditure in Level 1 VBP or above

DY4 – April 2019

> 50% of total MCO expenditure in Level 1 VBP or above.

DY5 – April 2020

80-90% of total MCO expenditure in Level 1 VBP or above

> 35% of total payments contracted in Level 2 or higher
DSRIP → VBP → Beyond: True System Alignment

• DSRIP and VBP break down siloes within health care and build relationships to other sectors
• NYS is thinking even more broadly about the systems that serve our communities
• NYS is developing an ecosystem designed to achieve the most important outcomes to a community
• Engaging HHs are a critical part of developing this ecosystem and reaching system alignment

Source: Presentations from "Medicaid in New York: Progressing to Value-Based Payment". United Fund Hospital Website. Published July 2016.
Closing thoughts…

• We are in this together
• What you are doing is making a difference
• You CAN do it!
  ✓ What you are doing is beautiful
  ✓ Proceed with fact-based optimism
  ✓ Embrace VBP
WHAT IS HAPPENING HERE IS AWESOME!
Questions?

Additional information available at:
https://www.health.ny.gov/mrt
https://www.health.ny.gov/dsrip

Contact:
Jason.Helgerson@health.ny.gov

Follow me on Twitter!
@policywonk1

Follow MRT on Twitter!
@NewYorkMRT
Today’s Discussion

- Review the population health landscape and the imperative for improvement
- Discuss proven value-based care models and their implications for us
- Understand the role of PHM tools in creating success
- Understand how connectivity across the continuum is critical to long term success in Population Health
An Ongoing Crisis of Quality and Cost

The current healthcare industry faces an ongoing crisis of quality and cost. While some would argue that a transformation of our system is well underway, the reality is that we continue to struggle with profound challenges we have faced for years.

People are getting sicker...
Health disparities persist...
Access to care remains a challenge...
Personal medical expenses are increasing...

... and our healthcare system is ill-equipped to respond to these crisis-level challenges in its current form.
Multiple Forces Pushing Towards Structural Change

Driving increased accountability for value to providers to:

1. Curb cost growth and bend the cost curve.
2. Improve the health of individuals and groups.

Illustrative
A Need for Value

High quality and low cost should not be at odds with one another.

Source: Adapted from Regence Blue Shield; Arnie Milstein, MD - Mercer

MD Longitudinal Cost Efficiency Index (total cost per case mix-adjusted treatment episode)

MD Quality Index (outcomes or % adherence to EBM)

Lower Efficiency/Higher Cost

High Efficiency/Lower Cost

Lower Efficiency/Low Quality

High Efficiency/High Quality

Lower %ile

50th %ile

Higher %ile

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The Structural Change is Accelerating

Consolidation of Healthcare Systems

We are witnessing significant growth both in traditional merger and acquisition activity and in the development of ACOs and integrated network partnerships.

Mega-mergers of Commercial Giants

Notable health plan acquisitions have appropriately raised questions as to what the future of the industry may look like.

Regional Consortiums to Deliver Value

Single and multi-region collaborative entities have increased in recent years as an alternative to full asset mergers.

Consumerism Arrives in the Healthcare Industry

Consumers are becoming more directly responsible for healthcare costs and payments.

Greater individual responsibility for the cost of care has resulted in more engagement in healthcare decisions, moving patients towards more consumer-like behaviors.
**Commercial Payors are Bringing Significant Scale to ACO Adoption**

The ACO model has seen tremendous growth, currently covering approximately 9% of the population. Well over half of ACOs participate in Medicare, but commercial ACOs are larger, accounting for 61% of covered lives.

Source: (L) Muhlestein, David and Mark McClellan, “Accountable Care Organizations In 2016: Private And Public-Sector Growth And Dispersion,” Health Affairs Blog. April 21, 2016; past reports by Muhlestein et al. (R) Chartis estimate based on Muhlestein et al plus CMS data. Note that while 54% of ACOs are estimated to participate in a Medicare program, they may also have commercial ACO programs.
But Does It Work?

NYUPN Clinically Integrated Network and UnitedHealthcare Collaborate to Enhance Care Quality, Launch Largest Shared Savings Initiative in Region to Reduce Costs

- 70,000 UnitedHealthcare employer-sponsored health plan participants in New York to have access to improved care coordination and enhanced health services
- Physician-led approach designed to reduce cost, improve quality outcomes and increase patient satisfaction through performance incentives and analytical tools

ACOs fail to create value?

Although it's still early, the first-year results of the Medicare Shared Savings Program indicate that few participants have the ability to significantly bend the cost curve...

...and participation in the Pioneer ACO program has dwindled as several organizations found the risks of participation outweighed the benefits.

Medicare is Testing and Spreading a Range of Payment Models

Medicare is exploring a range of value-based purchasing options as well as alternative payment models – and in effect setting a stage for commercial payors and Medicaid to follow suit.

<table>
<thead>
<tr>
<th>Increasing Degree of Risk/Reward</th>
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<tbody>
<tr>
<td><strong>Payment Model</strong></td>
</tr>
<tr>
<td><strong>Note:</strong> fixed payments may be added to any model (e.g., pmpm care mgmt. fee)</td>
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</table>

**CMS Mandatory Examples:**
- Merit-based Incentive Payment System (MIPS); Readmissions Reduction Program
- Comprehensive Joint Replacement (CJR)

**CMS Voluntary Examples:**
- Comprehensive Primary Care Initiative (CPCI)
- Oncology Care Model; Bundled Payments for Care Improvement (BPCI)
- Medicare Shared Savings Program (MSSP) Track 1
- NextGen ACO
- MSSP Track 2/3

Medicare Advantage and Managed Medicaid (Select States)
MACRA Brings Additional Focus on Physician Performance

Spotlight on:

MACRA

Physicians will fall into two MACRA Tracks*

MACRA Track 1: Merit-Based Incentive Program (MIPS)

Qualifying Advanced APMs will be "models with more than nominal financial risk"

75% of attributed Medicare patients must be in such a payment model by 2023

Track 1 of the Medicare Shared Savings Program will not qualify; Tracks 2 and 3, with downside risk, may qualify

An estimated 760k+ clinicians will be on this track

An estimated 30k-90k clinicians will qualify for this track

MACRA Track 2: Advanced Alternative Payment Model (APM)

Physicians will be subject to bonuses or penalties based on performance

Physicians will be subject to bonuses or penalties based on performance

MACRA Track 1: Merit-Based Incentive Program (MIPS) Measures

- Quality (replaces PQRS)
- Advancing Care Information (replaces Meaningful Use)
- Resource Use (replaces "cost" within the existing Value Modifier Program)
- Clinical Practice Improvement Activities (new)

Through its budget-neutral design, MIPS bonuses for high-performers...

... will come at the expense of MIPS penalties for under-performers.

• CMS estimates that 87% of solo practices will be penalized in 2019 while 81% of large practices (100 or more physicians) will receive a bonus
Defining Population Health Management

We define population health management as the following:

The advancement of the health of a defined or specific population through coordinated programs and activities that address medical and/or social determinants of health and are supported by an aligned payment model that rewards improvement of the population’s health and the delivery of high-value care.
Healthcare is a Clinical Activity

Whether improving performance for a narrow population, a site of service or an entire community, the most successful organizations will advance core competencies across their system of care.

- Organizing population cohorts to deliver purposeful care to meet care needs and preferences.
- Determining optimal clinical interventions, utilizing evidence-based medicine and leading practices, to deliver highly reliable care.
- Engaging with individuals in their health, providing timely and convenient access to services and information, and helping patients navigate to the right modality.
- Harnessing the power of data, analytics, and technology to drive care transformation solutions and improve clinical care delivery.
- Embedding disciplined care planning and patient progression to ensure a seamless care process for each individual across space and time.
- Developing & deploying leading practice care models – people, tools, and processes – to address the clinical needs of specific patient populations.
Transforming Care to Improve Performance

The only way for healthcare providers to truly impact cost and quality performance is to transform clinical care delivery.

**Cost**

% of Total Cost of Care related to clinical care delivery based on Medicare Cost Report data for the Truven Top 100 Hospitals

- **68% Clinical**

**Experience**

% of HCAHPS questions impacted by clinical care delivery

- **82% Clinical**

**Health Outcomes**

% of The Joint Commission’s Top Performance on Key Quality Measures impacted by clinical care delivery

- **100% Clinical**
The Triple Aim is critical but may be impossible to achieve if professional experience is not incorporated into the equation.
What Does This Look Like Once Achieved? (at least partially)

"Work implies not only that somebody is supposed to do the job, but also accountability, a deadline and, finally, the measurement of results—that is, feedback from results on the work and on the planning process itself."

Peter Drucker

November 19, 1909 - November 11, 2005
Creating Care Systems at Geisinger

The Geisinger transformation experience included focused change across multiple dimensions.

Comprehensive disease management driven by all-or-none measures

Redesign mantra:
- Streamline
- Team delegation, including IT
- Evolution of the innovation to standard practice
- Engage patients and families

Targeted, active clinical decision making

Proactive outreach

Engaged patients

Compensation
Achieving Results: Better Care

If done well, the results can be spectacular.

**IMPACT ON QUALITY**

**Diabetes Mellitus (DM) ProvenCare Bundle**

*Reduction in the risk of MI, stroke and retinopathy in a 3-year period*

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Hazard Ratio</th>
<th>Number of Patients Needed to Treat to Prevent 1 Event over 3 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial Infarction</td>
<td>0.77</td>
<td>82</td>
</tr>
<tr>
<td>Stroke</td>
<td>0.79</td>
<td>178</td>
</tr>
<tr>
<td>Retinopathy</td>
<td>0.81</td>
<td>151</td>
</tr>
</tbody>
</table>

Source: Bloom, Graf et al. "Primary Care Diabetes Bundle Management: 3-Year Outcomes for Microvascular and Macrovascular Events." *Am J Manag Care*. 2014;20(6):e175-e182. Note: 95% CI for MI: Hazard Ratio: 0.65-0.90, NNT: 37-133; Stroke: Hazard Ratio: 0.65-0.97, NNT: 57-681; Retinopathy: Hazard Ratio: 0.68-0.97, NNT: 47-510)
Achieving Results: Better Care at Lower Cost

The experience reinforced the fact that better quality and lower cost are mutually attainable – and often may be directly related.

**IMPACT ON COST**

**Diabetes Mellitus (DM) ProvenCare Bundle**

*Reduction in Total Medical Spend*

- Year one: Higher outpatient and professional costs
- Subsequent years: Reductions in total spend driven by lower inpatient costs

<table>
<thead>
<tr>
<th>Expected</th>
<th>Observed</th>
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<tr>
<td>$677</td>
<td>$630</td>
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</table>

- $47
- 6.9%

Change in Total Medical Spend (Expected vs. Observed)

Source: Maeng, Yan, Graf, Steele. "Value of Primary Care Diabetes Management: Impacts on Long-Term Cost of Care." Note: analysis based on claims data covering period 1/1/2005 to 12/31/2013, with construction of a 1-to-1 propensity score matching method to construct comparison group of individuals that received care from PCP practices that had not adopted the DM Bundle.
Achieving Results: 
Widespread Impact of Change

Geisinger achieved similarly positive results across multiple areas that implemented focused transformation efforts through the ProvenHealth Navigator (PHN) system.

ProvenHealth Navigator System Observed vs. Expected Cost by Length of Exposure, with Prescription Interaction

<table>
<thead>
<tr>
<th>Length of Exposure</th>
<th>Expected Medical Cost</th>
<th>Observed Medical Cost</th>
<th>Percent Difference</th>
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<tbody>
<tr>
<td>1-6 months</td>
<td>$839</td>
<td>$800</td>
<td>-4.6%</td>
</tr>
<tr>
<td>7-12 months</td>
<td>$890</td>
<td>$850</td>
<td>-4.5%</td>
</tr>
<tr>
<td>13-24 months*</td>
<td>$974</td>
<td>$904</td>
<td>-7.1%*</td>
</tr>
<tr>
<td>&gt;24 months*</td>
<td>$1,072</td>
<td>$955</td>
<td>-10.8%*</td>
</tr>
<tr>
<td>Overall*</td>
<td>$949</td>
<td>$881</td>
<td>-7.1%*</td>
</tr>
</tbody>
</table>

*Statistically significant at p<0.01
Source: Geisinger Health System; Note: reflects analysis of PHN effect with prescription interaction. Analysis completed assuming PHN effect is independent of drug coverage found statistically significant results at p<0.05 for >24 months and overall results.
Care Design Principles

**HealthPartners** uses the following design principles to ensure our care achieves **Triple Aim** results.

### Four Care Design Principles

1. **Reliability**
   - Reliable processes to systematically deliver the best care

2. **Customization**
   - Care is customized to individual needs and values

3. **Access**
   - Easy, convenient and affordable access to care and information

4. **Coordination**
   - Coordinated care across sites, specialties, conditions and time
HealthPartners Redesign Principles in Action

Reliability Care Model Process Visit Cycle

Before The Visit
- Visit Scheduling
- Pre-visit Planning

During the Visit
- Check-in
- Visit

After the Visit
- Follow-up

Between Visits
- Between Visits

Determined for each workflow:
- **WHAT** – must be done – the task
- **WHERE** – where will the task be done
- **WHO** – appropriate role to complete the task
- **HOW** – tools needed to support the task
- **WHEN** – what part of the visit
HealthPartners Outcomes

System Clinical Results
Improvement from 1st Qtr. 2005 to 3rd Qtr. 2007

- Mammography Screening (N=14485)
- C&TC Preventive Visit Rate (N=4888)
- Diabetes – Optimal Measure (N=7583)
- Pediatric Immunizations (N=1597)
- Depression – PHQ-9 use (N=639)
- Body Mass Index (N=51550)
- Lead Screening - PCV (N= )

- 1st qtr, 2005
- 3rd Qtr 2007
HealthPartners Outcomes

Chronic Care: Diabetes Avoided Complications

- AMI/1000
- Amputations /1000
- New Cases of Retinopathy/1000

<table>
<thead>
<tr>
<th>Year</th>
<th>AMI/1000</th>
<th>Amputations /1000</th>
<th>New Cases of Retinopathy/1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>60</td>
<td></td>
<td></td>
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<td>2010</td>
<td>41</td>
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</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>AMI/1000</th>
<th>Amputations /1000</th>
<th>New Cases of Retinopathy/1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>18</td>
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<td></td>
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<tr>
<td>2002</td>
<td>10</td>
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<td>2003</td>
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<td>2004</td>
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<td>2006</td>
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<td>2007</td>
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<tr>
<td>2008</td>
<td>8</td>
<td></td>
<td></td>
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<tr>
<td>2009</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>6</td>
<td></td>
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</tbody>
</table>
HealthPartners Outcomes

Reduce readmissions through collaboration of our hospital, clinics, care management and pharmacy services:

- Identify high risk patients
- Create care plans and implement health coaching
- Participate in medication “boot camp”
- Schedule orders for follow-up clinic appointment
- Coordinate care with home care and other resources
- Simplify patient discharge instructions
- Engage patients in “teach back” methods
- Call patients post discharge
HealthPartners Outcomes

AMGA Physician Satisfaction Survey 2005

Preauthorization
Computers
Colleagues
Resources
Compensation
Adm/Patient
Time Working
Staff
Quality
Leadership

2005

Low
AMGA Correlation with Overall Satisfaction
High
The Path Forward

Requires the accelerated advancement in 4 critical areas:

1. **Information and Technology Tools**

2. **Physician Leadership**

3. **Clinical Re-design**

4. **Informed Consumerism and Synergistic Continuum Integration**
Data Transformed by Advanced Analytics into Actionable Information is the Substrate of Reliable Delivery of Measurably Better Care

- Actuarial informatics allow you to fully understand your population and its individuals and their health related needs and divide them into clinically meaningful different groups.
- Operational informatics allow you to easily provide optimized care to each individual and thereby, the overall population.
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)

- Population Identification
- Care Management

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
- Readmission/ED utilization risk

Financial Risk
- Pro/retrospective utilization
- Pro/retrospective cost

Patient Engagement
- Outreach management
- Care team coordination
- Social, clinical, behavioral risk assessments

Care Coordination
- Utilization alerts
- Collaborative care planning
- Facilitating transitions of care (warm handoffs)
- Care team coordination
- Program/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
Understand Populations Across Multiple Dimensions

Leading providers understand their populations along multiple dimensions – and use different definitions to direct various activities and priorities.

<table>
<thead>
<tr>
<th>Disease Condition / Health Status</th>
<th>Utilization Patterns</th>
<th>Risk Factors</th>
<th>Geography</th>
<th>Socio-Economic Status</th>
<th>Social Needs</th>
<th>Preferences and Attitudes</th>
</tr>
</thead>
</table>

**Example Definitions**

- All patients the system touched in the last three years
- All lives in a particular geography

- Individuals admitted more than once in the past 12 months
- Individuals with Heart Failure
- Medicare beneficiaries attributed to ACO via primary care
- Individuals with multiple chronic conditions

- Patients with Heart Failure at risk for treatment non-adherence
- Individuals from a specific geography with multiple chronic conditions and social needs, e.g., transportation
- Individuals with COPD who actively seek services and information online
Future Model: Care Management

Provider Leadership/ Care Team Management

Criteria-based Segmentation

Populations of Interest

Care Management: individualized comprehensive care plan or action plan aligned with resources

Care Plan P1: Med mgmt., Nutrition
Care Plan P2: Med mgmt., exercise therapy
Care Plan P3: Med mgmt., transportation
Care Plan P4: Coordination, coaching

Total Population

Next Population "Population of Intervention"

Information, Technology and Tools
(EMR, registries, automatic notifications, etc.)

Criteria-based Segmentation

Populations of Interest

Care Management: individualized comprehensive care plan or action plan aligned with resources

Care Plan P1: Med mgmt., Nutrition
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Care Plan P4: Coordination, coaching

Next Population "Population of Intervention"

Information, Technology and Tools
(EMR, registries, automatic notifications, etc.)
Physician Leadership Drives These Efforts

Better Quality Driving Lower Cost

Unique Professional and Patient Experience

Physician Leadership
Your first role...is the personal one,...It is the relationship with people, the development of mutual confidence, the identification of people, the creation of a community. This is something only you can do. It cannot be measured or easily defined. But it is not only a key function. It is one only you can perform.
Core Elements of Advanced Primary Care

- Physician directed, team delivered care
- Expanded office teams
  - Embedded care management
  - Active electronics
  - Engaged patients/families
- Proactive care connectivity
- Medical neighborhood connections

- Team focused data
  - Quality
  - Utilization
- Focused Improvement
- Active change leadership
  - Physician
  - Administrative
- Programmed innovation
  - Creation
  - Refinement
  - Dissemination

- Granular, actionable metrics
  - Quality prevention
  - Quality chronicDs
  - Utilization
- Supportive revenue stream

- Active proximal leadership
  - Physician
  - Administrative
- Operational informatics optimization
  - Physician directed
  - Flow enhancing
  - Ease of use
- Programmed innovation
  - Creation
  - Refinement
  - Dissemination
Care Bundles Illustrates the need for connectivity across the continuum

Anatomy of a Bundle

**Professional**

- Inpatient Professional
- Outpatient Professional

**Technical**

- Index Hospitalization
- SNF

**Key**

- Blue: Claims for typical care and services
- Red: Claims with potentially avoidable complications
- Yellow: Either typical or PACs

**30 day look-back**

**Trigger Event**

**180 day look-forward**

**Example**

**PROMETHEUS ECR for Knee Replacement**

<table>
<thead>
<tr>
<th>Example</th>
<th>PROMETHEUS ECR for Knee Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trigger codes</strong></td>
<td>ICD-9 procedure code for knee arthroplasty or ICD-9 diagnosis codes (specified) as primary diagnosis</td>
</tr>
<tr>
<td><strong>Patient exclusions</strong></td>
<td>In-hospital death; discharge status left against medical advice; index stay for double knee replacement.</td>
</tr>
<tr>
<td><strong>PAC</strong></td>
<td>Readmission; adverse effects of drugs; overdose; complications of implanted device; complications of surgical procedure; revision procedures; vascular catheter associated infection; septicemia; perioperative hematoma; hemorrhage; stroke; coma; syncope; delirium; AMI; shock; cardiac arrest; air embolism; pneumonia; respiratory failure; lung complications; urinary tract infections.</td>
</tr>
</tbody>
</table>
For Medicare patients, post acute care presents an important opportunity for savings.
True Community Integration

Requires not just aggregation, or functional connectivity, but full synergistic integration of cross continuum services.

- Many systems are approaching healthcare reform via merely aggregating targeted services to expand their footprint in the continuum in an opportunistic fashion.
- Others are working to improve the functional connectivity amongst the elements they have connect with.
- Optimal care of the community requires a far more effective and proactive orientation, synergistic integration. This approach optimizes not just the function, but also the use of all continuum elements and has a disciplined approach to both ongoing management of current processes, iteration of minor improvements, and revolutionary innovation of the model.
- This synergistic integration is grounded in the needs and issues of the community, and is designed to improve Population Health.
“Informed” Consumerism tied to synergistic integration as a Durable Strategic Differentiator

Customer service alone is not enough:

- Deep understanding of the community and its needs, family and its needs and the individual and needs
- New era of competition based on real differences in performance created by convergence of accountability and consensus
  - Feb. 16 — Seventy percent of commercial payer enrollees—including those covered by UnitedHealth Group, Aetna, Anthem, Cigna, Health Care Service Corp., Humana, Kaiser Permanente and the Blue Cross Blue Shield Association—as well as Medicare patients will be covered by new quality measures announced Feb. 16 by the CMS and America’s Health Insurance Plans (AHIP).

- “Informed consumerism” is the complete transparency of quality, cost, and performance information.
- Linking this to a synergistic integration with your community yields exceptional results
The Camden Coalition of Healthcare Providers has announced plans to establish a national center to improve care for high-need patients who experience poor outcomes despite extreme patterns of hospitalizations or emergency care. Inefficient and ineffective care of these patients has been identified as a driver of unnecessary health care spending in the United States. AARP, The Atlantic Philanthropies, and the Robert Wood Johnson Foundation are collectively providing $8.7 million to fund the center.

The Camden Coalition has been a leader in identifying these patients and working to improve their care through coordinated, data-driven, and patient-centered approaches—including addressing needs that have traditionally been considered “non-medical,” such as addiction, housing, transportation, hunger, mental health, and emotional and educational support. The national center will bring together practitioners working with these patients around the country and serve as a hub to unite and advance the nascent field.
ProvenWellness Neighborhood (PWN) is a free program that helps individuals who are uninsured or underinsured achieve better health and wellness close to home. Staff members identify needs and coordinate resources for individuals and families that include patient advocacy, transportation, prevention coaching, healthy lifestyle education and direct care/monitoring of chronic diseases. PWN operates in five northeastern Pennsylvania counties (Lackawanna, Wayne, Susquehanna, Wyoming and Pike.

Our team includes doctors, nurses, licensed social workers, physical therapists, and nutritionists who work with adults. Our services are free of charge.

**Participating Agencies Include:**

- American Red Cross
- CARENET
- MFHS Maternal and Family Health Services, Inc.
- Northeast Regional Cancer Institute
- United Neighborhood Centers of Northeastern Pennsylvania
- Marywood University
- Friends of the Poor
- The Edward R. Leahy Jr. Center Clinic for the Uninsured at the University of Scranton
- The Clinics at Scranton Primary Health Care Center
- University of Scranton
- Quarterly Newsletter
Every few hundred years, throughout Western history, a sharp transformation has occurred. In a matter of decades, society altogether rearranges itself: its worldview, its basic values, its social and political structures, its arts, its key institutions. Fifty years later, a new world exists, and the people born into that world cannot even imagine the world in which their grandparents lived and into which their own parents were born. Our age is such a period of transformation.
Contact Information

Dr. Thomas R Graf
National Director of Population Health

tgraf@chartis.com
The MCO Role in Value Based Payments

Central New York Care Collaborative 2016 Annual Meeting

November 1, 2016
What is Managed Care?

...intended to reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases.

www.wikipedia.com
Reform Projects: DSRIP

5 MCO related measures

2ai, Milestone 9: Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform

2biv, Milestone 2: Engage with the MCOs and HH to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed

2di, Milestone 6: Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member’s MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP.
3bi, Milestone 19: Form agreements with the Medicaid MCOs serving the affected population to coordinate services under this project

2ai, Milestone 8: Contract with Medicaid MCOs and other payers as an integrated system and establish *value-based payment* arrangements
A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well.

Many of NYS system’s problems (fragmentation, high re-admission rates) are rooted in how the State pays for services:

- Fee For Service (FFS) pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
- Current payment systems do not adequately incentivize prevention, coordination, or integration

Financial and regulatory incentives drive...

A delivery system which realizes...

Cost efficiency and quality outcomes: value
New York State has committed to reaching 80-90% value based payments (VBP) by the end of the waiver period (end of Q1 2020).

<table>
<thead>
<tr>
<th>NY DSRIP Goals and Penalties</th>
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<tr>
<td></td>
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<tr>
<td><strong>Level 1</strong></td>
</tr>
<tr>
<td><strong>Target</strong></td>
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<tr>
<td>CY 2017</td>
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<tr>
<td>CY 2018</td>
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<tr>
<td>CY 2019</td>
</tr>
</tbody>
</table>

*Penalty will be marginal difference between Goal% of Medicaid Managed Care expenditure and total expenditure on Level 1/2 or above VBP contracts*
NY DSRIP VBC Models

Total Care for the General Population (TCGP)

VBP contractor assumes responsibility for the total care of its total attributed population. The default method for attribution is MCO-assigned PCP.

Integrated Primary Care (IPC)

MCO contracts Patient Centered Medical Homes (PCMH) or Advance Primary Care (APC) arrangements and rewards the VBP contractor based on the savings and quality outcomes achieved. IPC contracts can include additional payments for practice transformation, care management, and can tie additional rewards to progression towards APC status, for example. All attributed members are included.

Bundles of Care

VBP contractor assumes responsibility for both the outcomes and the costs of the care across the continuum of the patient’s trajectory. NYS has prioritized two key bundles: Maternity Care (spanning the pregnancy, delivery and first month of the baby’s care) and the Chronic Care Bundle (including the chronic conditions with the highest prevalence in NYS).

Total Care for Special Needs Populations

For these subpopulations, a capitated model (a per member per month (PMPM) payment) is best suited. HIV/AIDS, HARP, Managed Long-Term Care, Care for the Developmentally Disabled (DD). When members are eligible for more than one subpopulation (e.g. HARP and HIV/AIDS), the MCO/SNP decides with the VBP contractor(s) which VBP subpopulation prevails.
<table>
<thead>
<tr>
<th></th>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP (only feasible after experience with Level 2; requires mature VBP contractor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Care for General Population</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings when quality scores are sufficient</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>Global capitation (with quality-based component)</td>
</tr>
<tr>
<td>Integrated Primary Care</td>
<td>FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores</td>
<td>FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when quality scores are sufficient)</td>
<td>FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>PMPM capitated payment for primary care services (with quality-based component)</td>
</tr>
<tr>
<td>Bundles</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)</td>
<td>FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>Prospective bundled payment (with quality-based component)</td>
</tr>
<tr>
<td>Total Care for Subpopulation</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on subpopulation capitation (savings available when quality scores are sufficient)</td>
<td>FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>PMPM capitated payment for Total Care for Subpopulation (with quality-based component)</td>
</tr>
</tbody>
</table>
A Value Based Payment deal cannot effectively be negotiated without sound data
determination of baseline
  * utilization
  * cost
  * quality

A Value Based Payment deal cannot effectively be monitored without robust data
determination of potential for shared savings or losses
  * utilization
  * cost
  * quality

Who are the players?  What types of data are available?  What is the capacity to send/receive data?  HIPPA/Security concerns?  What analytics are available?
To achieve success, all components of the New York State Medicaid program must understand the fundamental shift that DSRIP and VBP represent.

**PPS, Health Systems, Providers, CBO’s**

PPS no longer the contracting entity

Contracting with Health Systems

Options for individual Providers

CBO involvement
Food for thought

~ What is the Provider’s current ability to take on VBC?
  - What is the population you want to contract for?
  - consider how many members in that population and how you have built an infrastructure to drive down costs in that population
  - think about shared savings and losses; what are you ready for?
  - stop loss
  - risk corridors
  - performance against quality measures, how are you doing?
  - risk adjustment
  - care coordination and other fees

~ What are the data exchange capabilities of the entity to support VBC risk deals?
  - flat files
  - interactive tools/dashboards
  - ability to build or buy analytics
  - ability to share data
Food for thought

~ How is the CBO partnered with the provider to bring more to the table in an MCO negotiation?

~ How well do partner providers understand the CBO’s admissions/intake/program requirements? Is there an opportunity to train or be part of the provider care management team?

~ How are the CBO and the MCO Community Outreach team working together?

~ Does the MCO have a good understanding of the program, services, and how to refer? Are printed materials available? In a variety of languages etc?
Providers/provider networks and MCOs should invest in **effective** interventions that have a **meaningful** impact on the overall population health and the overall wellbeing of the community in which it serves.

*The nature of the intervention(s) should be negotiated between the VBP contractor and MCO, taking into account population health and preventative health needs identified by the community. Providers/provider networks and MCOs may wish to collaborate with CBOs to support, develop, and broaden their reach to more communities.*

Networks may want to consider larger partnerships and advocate for systemic improvements that might not be easily quantified on the individual member level immediately or in the short-term. Ultimately the goal should be to track the impact of interventions, not just on an individual level, but on a population level.
Leading the way

The Camden Coalition
www.camdenhealth.org
Super Utilizer Program

**Goal**: improve quality of care received, quality of life, reduce preventable ED and Inpatient care

**Composition**: Physician or advanced practice nurse, nursing, pharmacy, behavioral health, social worker and community health worker

**Structure**: intensive team-based and relationship centered care, outreach, coordination of care, community engagement, foundation of high quality shared data
THE IMPORTANCE OF BUILDING RELATIONSHIPS ACROSS THE CONTINUUM OF CARE

Rebecca Bostwick, MPA
Program Director, Lerner Center for Public Health Promotion

CNY CARE Collaborative Annual Meeting 2016
What Goes Into Your Health?

Socioeconomic Factors
- Education
- Job Status
- Family/Social Support
- Income
- Community Safety

Physical Environment

Health Behaviors
- Tobacco Use
- Diet & Exercise
- Alcohol Use
- Sexual Activity

Health Care
- Access to Care
- Quality of Care

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

The Bridgespan Group
First Curve to Second Curve of Health Care

Volume-Based First Curve
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

Value-Based Second Curve
- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encourage coordination

The Gap

Adapted from Ian Morrison 2011
First Curve to Second Curve of Population Health

But what about the bottom line?
Our Common Approach

Dimensions of Success

Results
Goal or task accomplished

Relationships
The quality of the connections between the people engaged in the work

Process
The way or spirit in which work is carried out

Source: IHI; Interaction Institute for Social Change
Network Leadership & Collective Impact Principles

**Network Leadership**
- Mission, Not Organization
- Node, Not Hub
- Humility, Not Brand
- Trust, Not Control

**Collective Impact**
- Common Agenda
- Shared Measurement
- Mutually Reinforcing Activities
- Continuous Communication
- Backbone Organization

Stanford Social Innovation Review
Informing and inspiring leaders of social change
• By their very nature, complex problems cannot be solved by any single organization or sector alone.

• Look for silver buckshot instead of the silver bullet.

• Align mission, organizational culture, and services.

• Reach outside the hospital walls, where health happens.

• Seat at the community table- and not always at the head of it.
“Culture eats strategy for lunch.”
(Attributed to Peter Drucker)

“Every system is perfectly designed to get the results it gets.”
(Don Berwick, Past President of IHI)
Central New York Care Collaborative (CNYCC)

2016 Annual Meeting

Closing Remarks
Virginia Opipare
Executive Director, CNYCC

“Working Together for Better Health”
Annual Meeting – What We’ve Learned?

- Themes of the Day
  - VBP & DSRIP – “Two Sides of the Same Coin”
  - A PHM System to Provide Data and Analytics
  - Building Community Partnerships
  - Care Coordination
Our Partnership – “We Can Do This!”

• Diverse Group of Partner Organizations
  • Partners Vary in Size, Complexity, & Provider Types
  • 1,400 Healthcare And Community-Based Service Providers
• Span Across 6 Counties (Cayuga, Lewis, Madison, Oneida, Onondaga, and Oswego)
  • 6,000 Square Miles
  • Urban Centers (Syracuse, Utica)
  • Rural Settings
• 200,000 Attribute Medicaid Lives Regionally
Challenges of Transformation
• Data for Quality Improvement and VBC
• Value Based Contracting Vehicle(s)
• Understanding Your Value Based Contracting Readiness
• Developing Partnerships
• Limited Resource Environment
Enabling Tools & Structures

- Data Analytics and Care Coordination Platform (PHM System)
- Communication Vehicles
  - CNYCC Weekly Newsletter
- CNYCC Website
  - Webinar Series
  - “Partner Spotlight Series”
- Central “Backbone” Organization and Governance Structure
- PPS Wide Outcome Measurement and Improvement
- Venues for Partner Networking & Benchmarking
  - RPAC
  - Learning Collaborative
- Participation in VBP QIP Program
Network Accomplishments

- Partner Network Development
  - 130+ Partner Organizations Currently Under Contract
- Governance
- More than 30K Actively Engaged Patients Across Projects in DSRIP Year 2
- Partner Payment Process with $6 Million Distributed
  - Board Approved Payment Policies
  - Accelerated Payment Program
  - Actively Engaged Patient Payments
Our Future Together....

• Add Value to Our Partners
• Assist Partners in Transition to Value Based Payment
• Provide & Share Data to Measure Our Success
• Implement Population Health Management System
  • Community Wide Data Analytics
  • Combined Clinical & Claims Data
  • Central Care Management Module
Our Future Together....

• Care Coordination Strategy for the Network
• Provide Quality Improvement Tools & Training to Enable the Acceleration of Change Process
  • Rapid Cycle Improvement Methods
• Serve as a Convener to Facilitate & Coordinate Meaningful Connections Across Partner Network
Making A Difference Together...

- Integrate Services
- Collaborate on Patient Care
- Focus on Quality
- Patient-Centered Approach to Care Delivery

"I didn’t realize it wasn't normal to feel so bad"
THANK YOU

Thank you to CNY Care Collaborative Partner Organizations for everything you do to transform the healthcare system and improve the quality of care for our community.

CNY CARE COLLABORATIVE