2018 Learning Collaborative Series

Access To Care: Patient Experience
March 6, 2018 10:00-12:00PM

Welcome/Introductions

- Review of Performance Outcomes Related To:
  - 2017 All PPS CG-CAHPS Summary
  - Access To Care Composite (Q6,Q8,Q10)
  - PPS Annual Targets and Value
- Panel Discussion: Patient Experience
- Group Discussion
- Wrap Up
  - Next Meeting April 3rd , 2018 10:00AM-12:00PM

CAHPS® Clinician & Group Survey (CG-CAHPS)

- CG-CAHPS
  - Assesses patients' experiences with health care providers and staff in doctor's offices.
- Survey results can be used to:
  - Improve care provided by individual providers, site of care, medical groups, or provider networks
- Survey Methodology
  - Random sample of 1500 adults, ages 18-64 for each PPS
  - Medicaid Members
  - At least one qualifying outpatient visit to one provider in the PPS network in the last six months
  - Survey administered over a twelve-week period using mixed mode (mail and telephone)
  - Up to 5 outreaches resulted in 30.72%(451 responses) response rate in 2016

CAHPS® Clinician & Group Survey (CG-CAHPS)

Getting Timely Appointments, Care, and Information

- Q6. Usually or always got appointment for urgent care as soon as you needed
- Q8. Usually or always got appointment for non-urgent care as soon as you needed
- Q10. Usually or always got answer to medical question the same day you contacted provider's office

How Well Providers Communicate with Patients

- Q11. Provider usually or always explained things in way that was easy to understand
- Q12. Provider usually or always listened carefully to you
- Q14. Provider usually or always showed respect for what you had to say
- Q15. Provider usually or always spent enough time with you

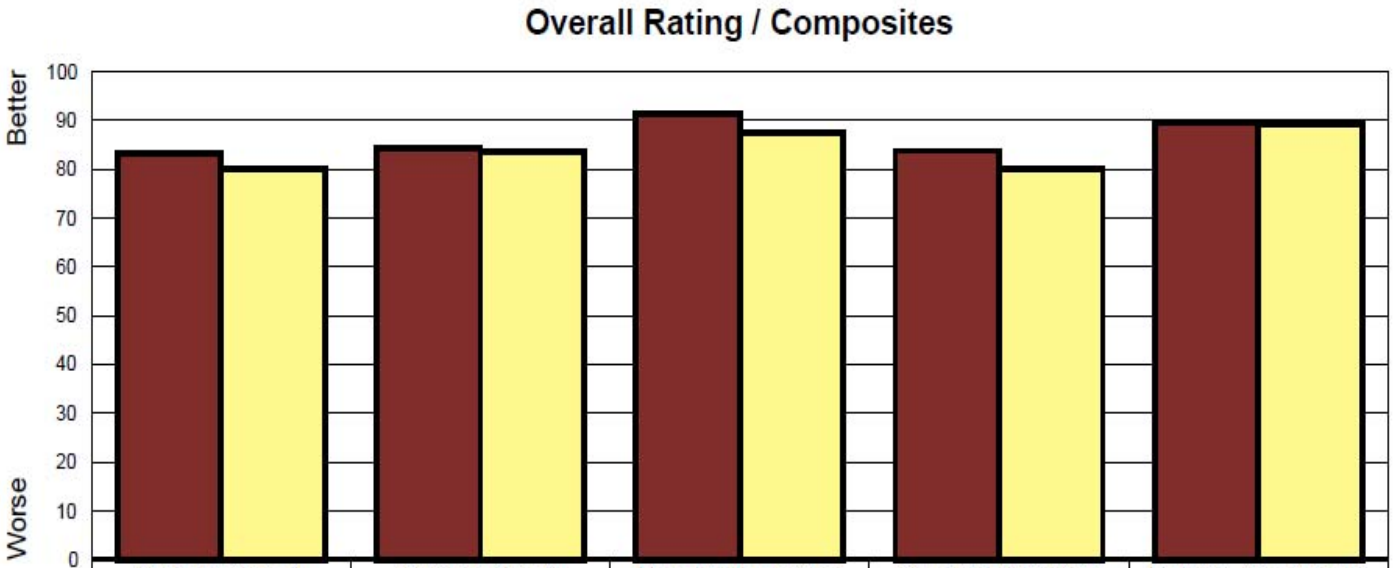
Care Coordination

- Q13. Provider usually or always knew important information about your medical history
- Q22. Someone from provider's office usually or always followed up with you to give results of blood test, x-ray, or other test
- Q24. Someone from provider's office usually or always talked about all prescription medications being taken

Helpful, Courteous, and Respectful Office Staff

- Q26. Clerks and receptionists usually or always helpful
- Q27. Clerks and receptionists usually or always courteous and respectful

CAHPS® Clinician & Group Survey (CG-CAHPS)



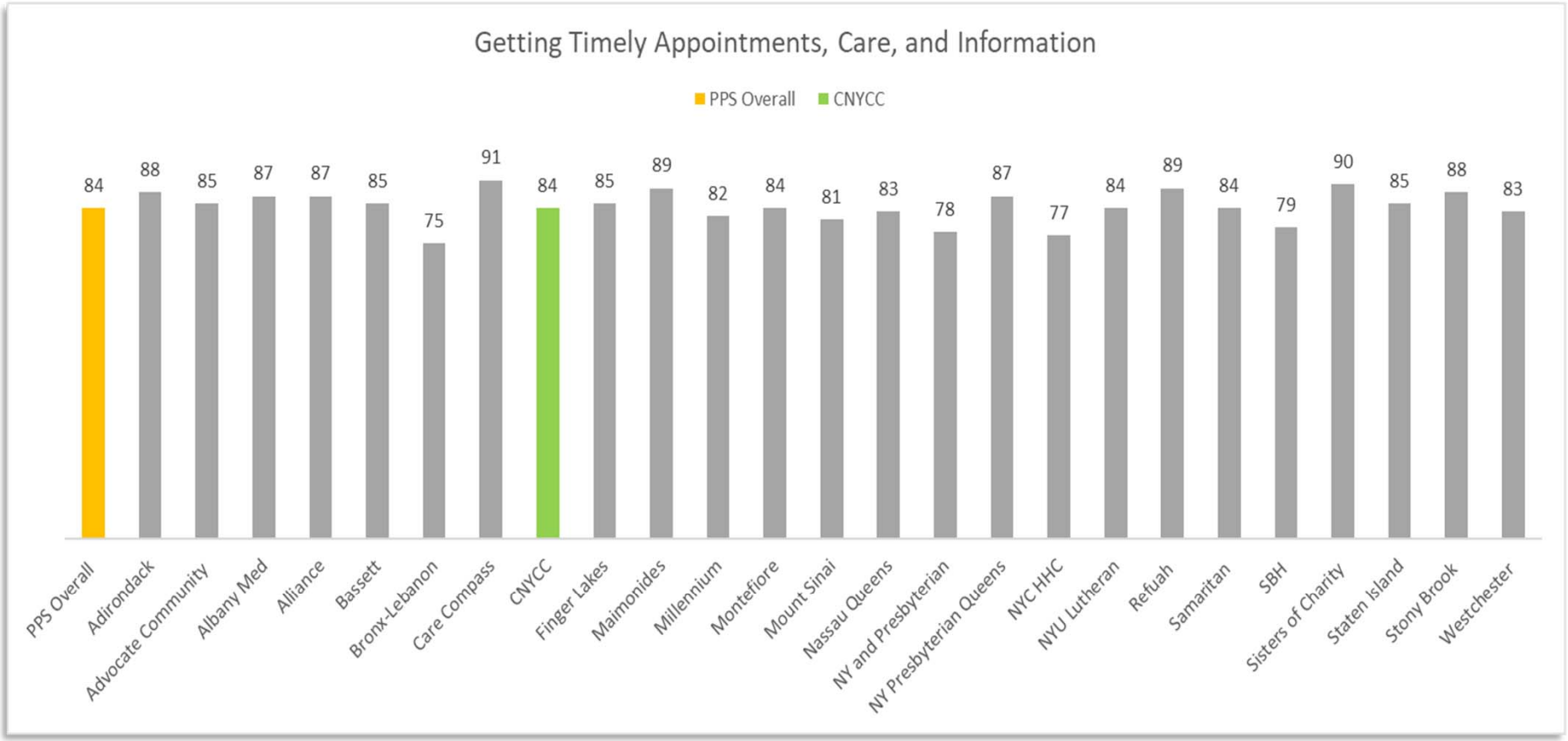
	Q25. Rating of Provider (8, 9 or 10)	Getting Timely Appointments, Care, and Information (Usually or Always)	How Well Doctors Communicate with Patients (Usually or Always)	Care Coordination (Usually or Always)	Helpful, Courteous, and Respectful Office Staff (Usually or Always)
PPS Overall	83.12%	84.28%	91.45%	83.70%	89.53%
Central New York	79.93%	83.62%	87.30%	80.14%	89.29%

Question	CNYCC 2016 Score	CNYCC 2015 Score	Point Change	Composite/ Question Group
Q2. Provider is usual source of care	74.8%	74.2%	+ 0.6	Access to Primary Care
Q8. Usually or always got appointment for non-urgent care as soon as you needed	88.9%	88.5%	+ 0.4	Getting Timely Appt, Care, and Info
Q19. Provider usually or always asked you to describe how you would follow instructions for caring for illness or health condition	76.0%	75.7%	+ 0.3	Health Literacy
Q14. Provider usually or always showed respect for what you had to say	90.4%	91.3%	- 0.9	Provider Communication
Q10. Usually or always got answer to medical question the same day you contacted provider's office	80.7%	81.9%	- 1.2	Getting Timely Appt, Care, and Info
Q12. Provider usually or always listened carefully to you	87.3%	89.2%	- 1.9	Provider Communication
Q27. Clerks and receptionists usually or always courteous and respectful	92.0%	94.7%	- 2.7	Helpful, Courteous, and Respectful Office Staff
Q20. Provider usually or always explained what to do if illness or health condition got worse or came back	83.3%	86.2%	- 2.8	Health Literacy
Q3. Length of provider relationship is at least 1 year or longer	70.1%	73.0%	- 2.9	Access to Primary Care
Q6. Usually or always got appointment for urgent care as soon as you needed	81.3%	84.3%	- 3.0	Getting Timely Appt, Care, and Info
Q11. Provider usually or always explained things in way that was easy to understand	87.9%	91.1%	- 3.2	Provider Communication
Q13. Provider usually or always knew important information about your medical history	84.3%	87.6%	- 3.3	Care Coordination
Q25. Rating of Provider (8, 9 or 10)	79.9%	83.3%	- 3.3	Ratings
Q22. Someone from provider's office usually or always followed up with you to give results of blood test, x-ray, or other test	81.0%	84.4%	- 3.5	Care Coordination
Q26. Clerks and receptionists usually or always helpful	86.5%	90.6%	- 4.1	Helpful, Courteous, and Respectful Office Staff
Q15. Provider usually or always spent enough time with you	83.7%	89.3%	- 5.7 ▼	Provider Communication
Q24. Someone from provider's office usually or always talked about all prescription medications being taken	75.2%	82.9%	- 7.7 ▼	Care Coordination

Better

Worse

▲▼ **Statistically significantly higher/lower than 2015 score.**


Getting Timely Appointments, Care, and Information
PPS Overall
CNYCC
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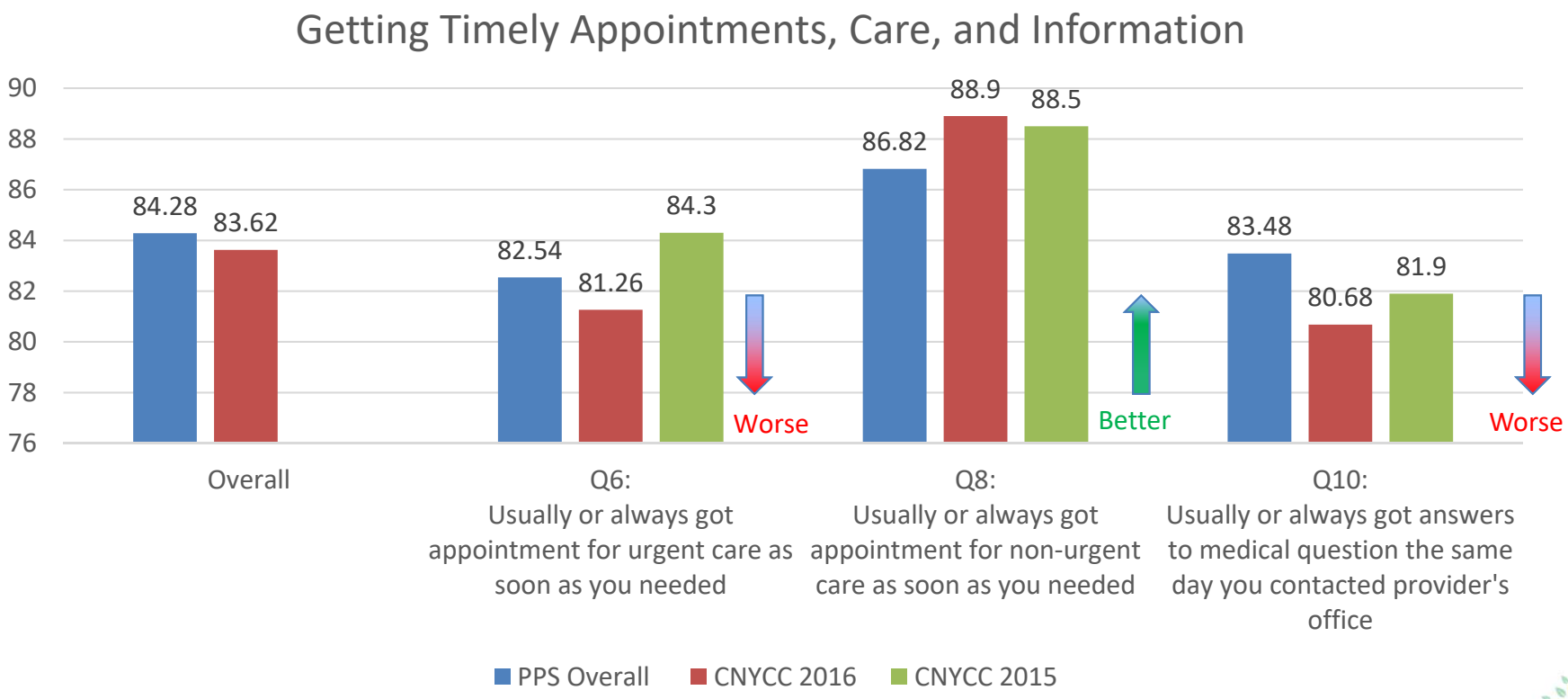
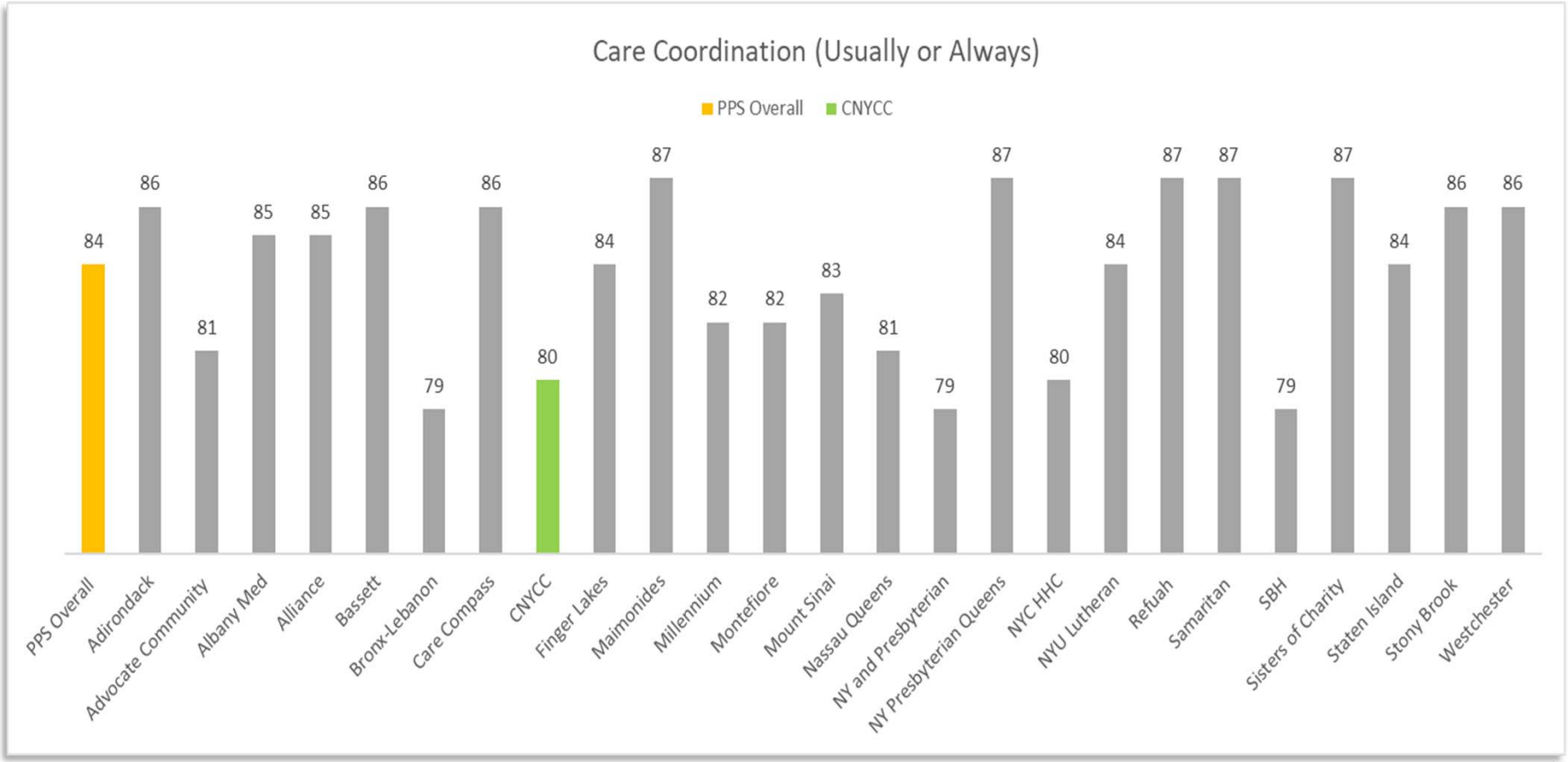
PPS Overall
Adirondack
Advocate Community
Albany Med
Alliance
Bassett
Bronx-Lebanon
Care Compass
CNYCC
Finger Lakes
Maimonides
Millennium
Montefiore
Mount Sinai
Nassau Queens
NY and Presbyterian
NY Presbyterian Queens
NYC HHC
NYU Lutheran
Refuah
Samaritan
SBH
Sisters of Charity
Staten Island
Stony Brook
Westchester

Trend Analysis: 2016 vs. 2015




Care Coordination (Usually or Always)
PPS Overall
CNYCC
84
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PPS Overall
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Bassett
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Care Compass
CNYCC
Finger Lakes
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Montefiore
Mount Sinai
Nassau Queens
NY and Presbyterian
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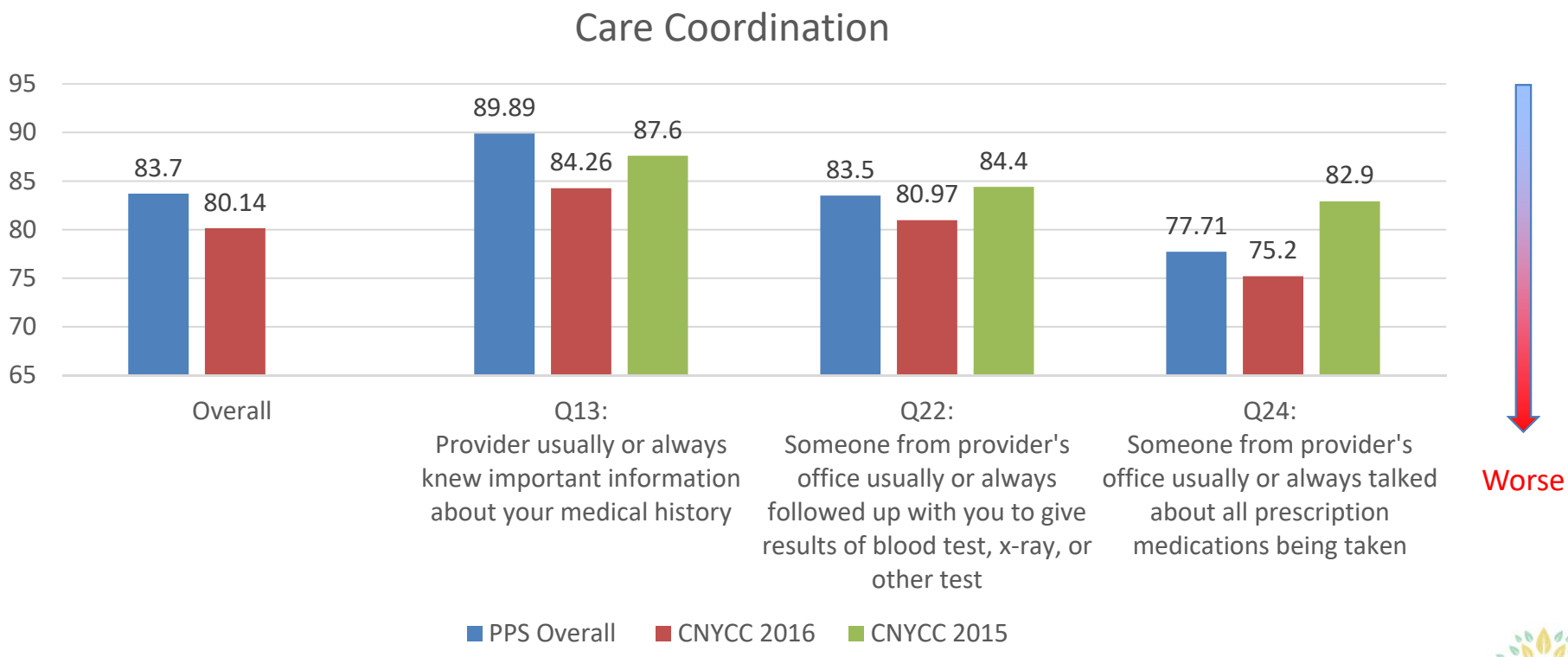

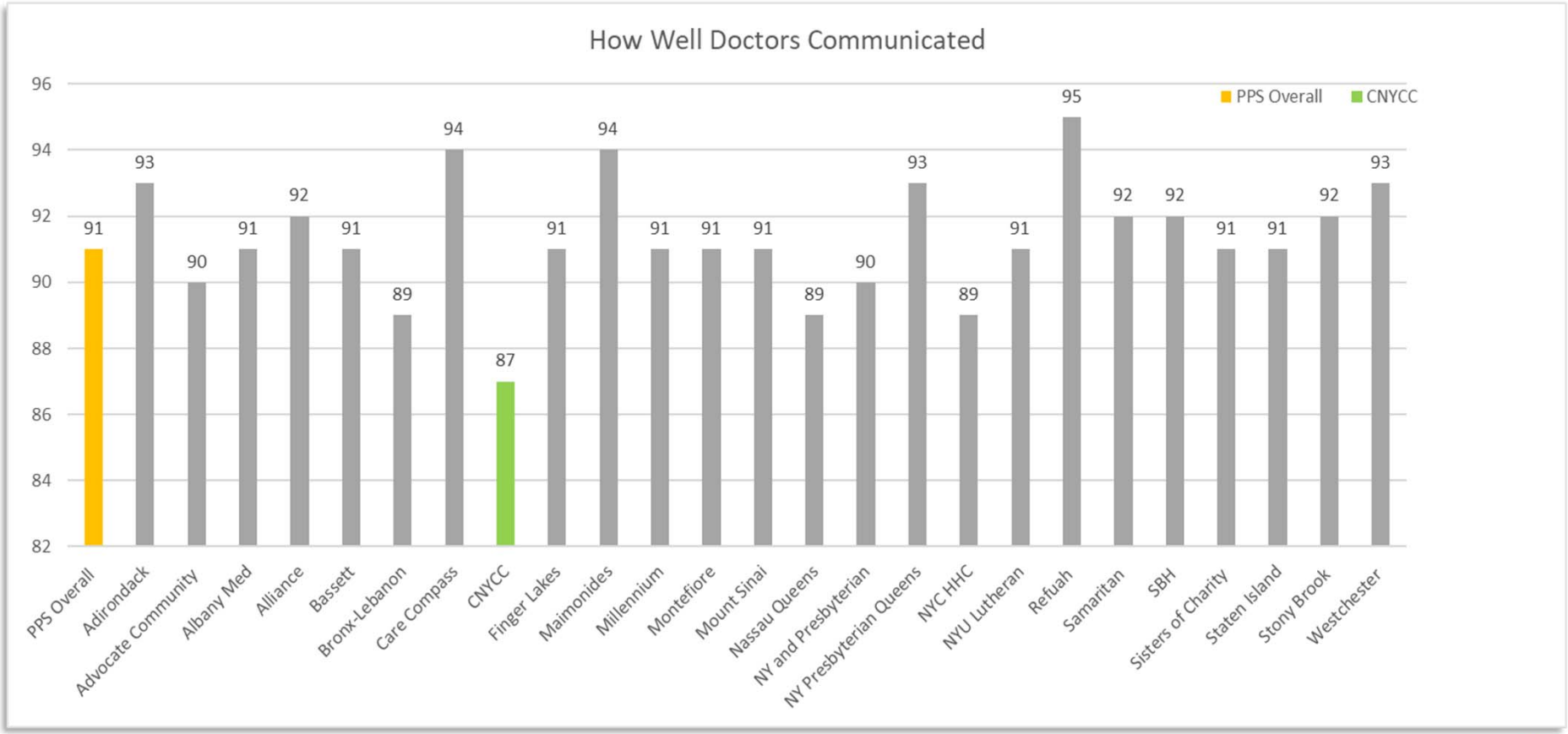
How Well Doctors Communicated
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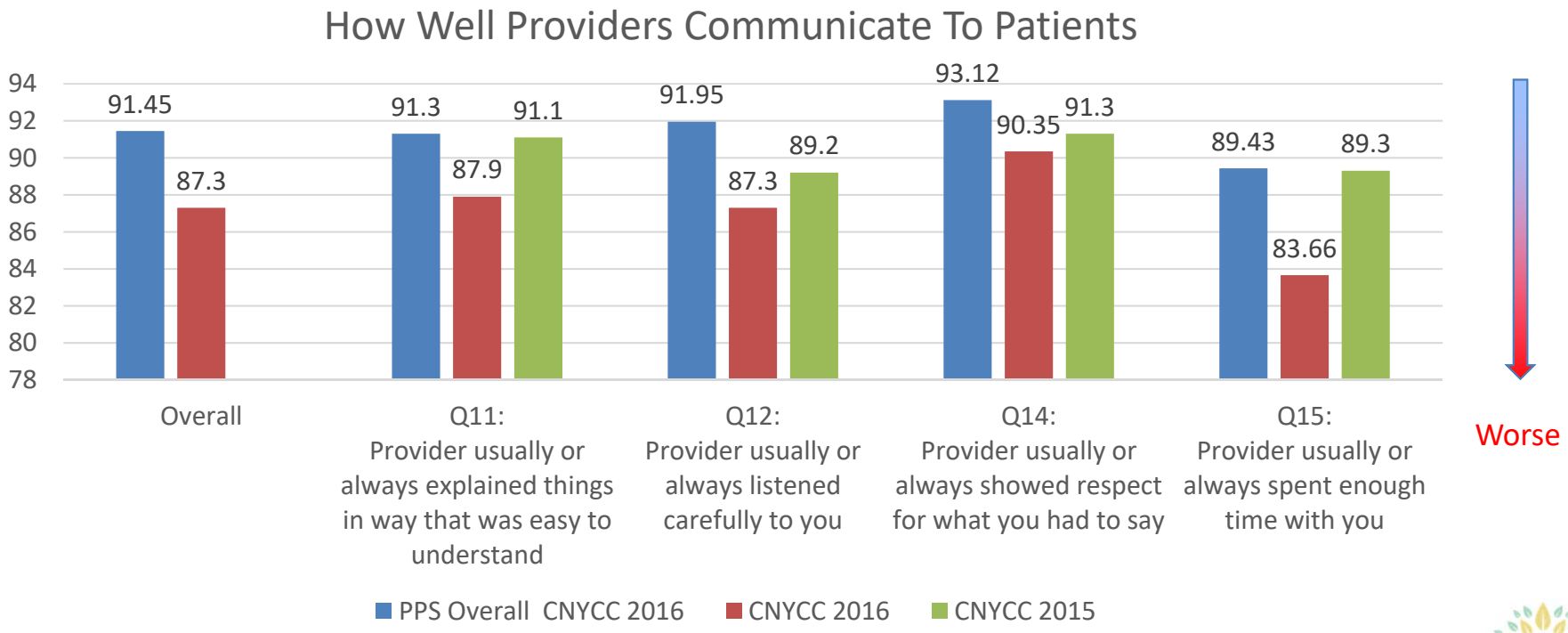

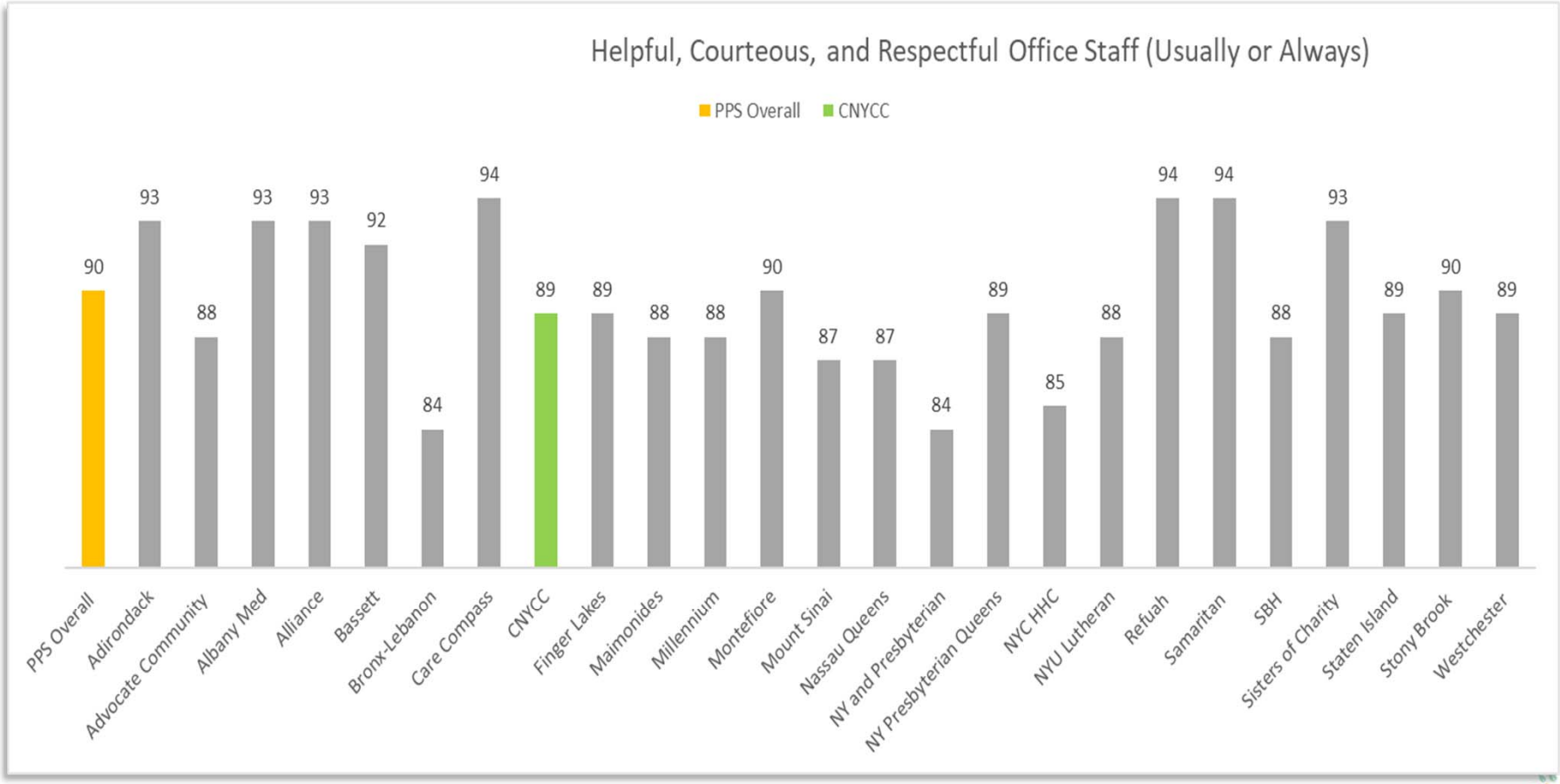
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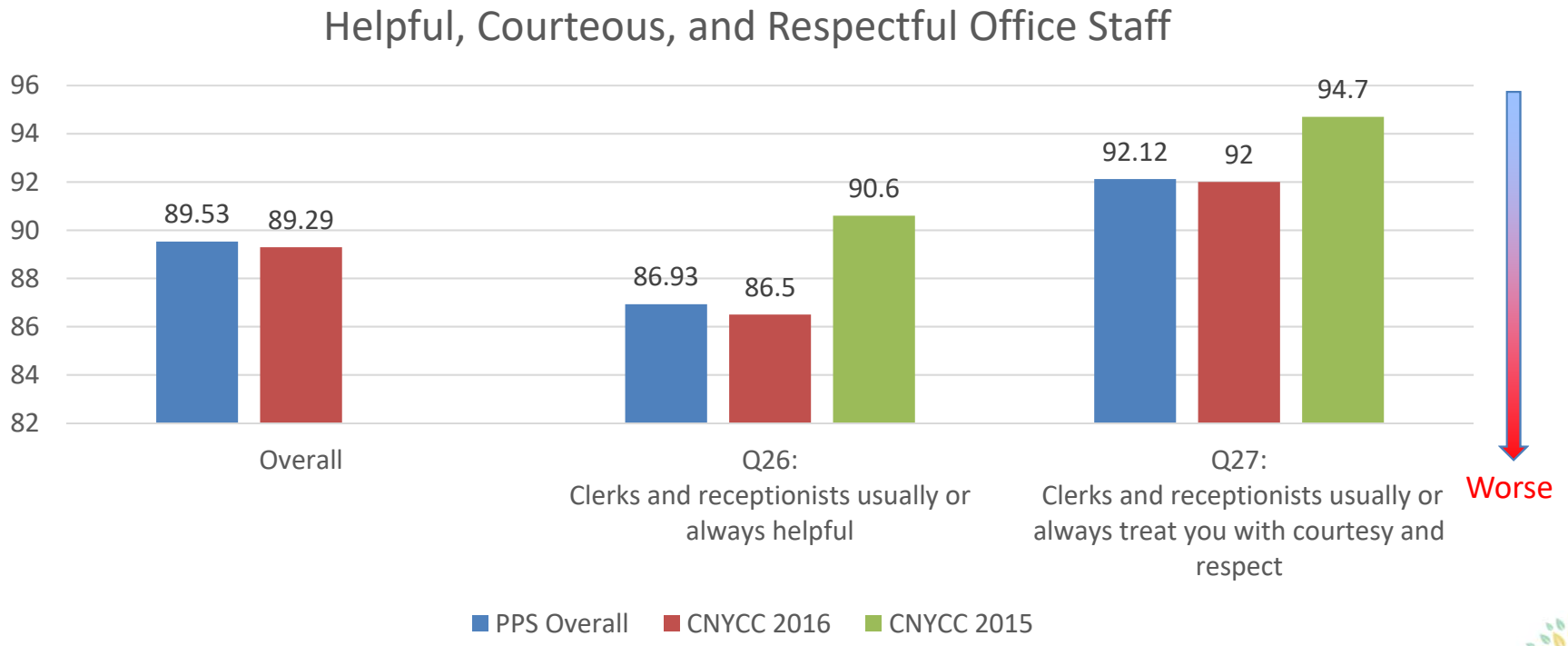
Trend Analysis: 2016 vs. 2015



Measurement Year 4: Measures and Value

Measure	Numerator Description	Denominator Description	MY4 Performance Goal	Value ($)
Getting Timely Appointments, Care and information (Q6, 8, 10, and 12)	Number responses "Usually" or "Always" got apt for urgent care or routine care as soon as needed, and got answers the same day if called during the day	Number answered they called for appointments or called for information	92.5 %	$1,128,886.13
CAHPS Measures - Care Coordination with provider up-to-date about care received from other providers	Number responses "Usually" or "Always" that provider seemed to know important history, follow-up to give results from tests, and talked about all prescription medicines	All Responses	91.9 %	$1,128,886.13
			Total Valuation	$2,257,772.26

PPS Strategies For Improvement: Project Work

PPS Strategies For Improvement: Performance Activities

- PA 41: Have a primary care provider (PCP, NP, or PA) available onsite providing primary care services a minimum of eight (8) hours per week by December 31, 2017.

- PA 54: Implement a process to:
  - 1. Make referrals to the appropriate Community Based Organization(s) (CBO) and ensure that the receiving CBO is notified of the referral
  - 2. Follow up with referred patient within 5 business days if referral status indicates that service has not been provided or scheduled

- PA 57: Demonstrate that practice has extended operating hours for primary care services to include evening and/or weekend coverage. If current hours already have both evening and weekend coverage, develop an operational plan to optimize the distribution of appointment slots to reduce third next available appointment and/or increase the ability to accept more patient volumes.

- PA 79: Have a primary care provider (PCP, NP or PA) available onsite providing primary care services a minimum of sixteen (16) hours per week by March 31, 2018.

PPS Strategies For Improvement: Performance Activities

- PA 89: Demonstrate that capacity to accept new patients for primary care services has increased and access for existing patients has improved by hiring an additional MD, DO, NP, or PA or increasing part time MD, DO, NP, or PA hours. Additional hire or increased hours must result in an overall maintenance or increase in the percentage of providers that accept Medicaid patients and/or Medicaid Managed Care members.

- PA 101: For patients prescribed antipsychotic, antidepressant, and/or statin therapy (for patients with ischemic heart disease) medication:
  - 1. Track patients to ensure that patient fills prescription and is taking medication properly
  - 2. Reach out to those that are overdue for prescription refill to ensure medication adherence

- PA 130: Establish a care coordination team that provides ongoing services to patients identified as high risk for cardiovascular disease and co-occurring mental health or substance use disorders. Care coordination team must:
  - 1. Include at least one behavioral health (BH) provider and an ambulatory primary or cardiac specialty care provider
  - 2. Be developed by using existing staff, hiring additional staff, or establishing formal bi-directional agreement(s)

- PA 131: Implement intake process for new patients referred by PAM®/CFA coaches that includes patients' PAM level and score and ensures initial appointments are scheduled within 60 days of referral. Train at least 75% of intake staff on this process.

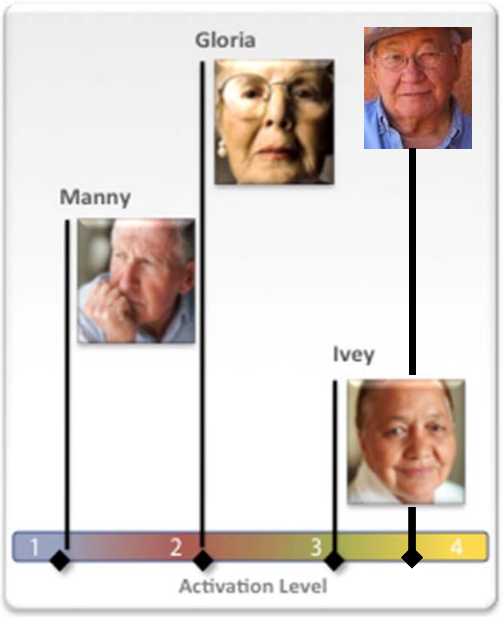
PPS Strategies For Improvement: Patient Activation

- Patient Activation Measure (PAM®)
  - 10 question survey
  - Activation Levels:
    - Level 1: Disengaged and Overwhelmed
    - Level 2: Becoming aware, but still struggling
    - Level 3: Taking action
    - Level 4: Maintaining behavior and pushing further
  - Utilizing an individual's activation level helps to set realistic and attainable goals/action steps
  - The individual's identification of their perceived barriers to making progress is very important for the practitioner
  - Research shows when people start feeling more capable and more in charge of their health, they are more likely to change/adjust behaviors!

Addressing patient activation starts with measurement

The ability to measure activation is important:

- To know who needs more support
- To tailor the support and information patients need to achieve their potential
- To measure performance and to have a marker for quality care

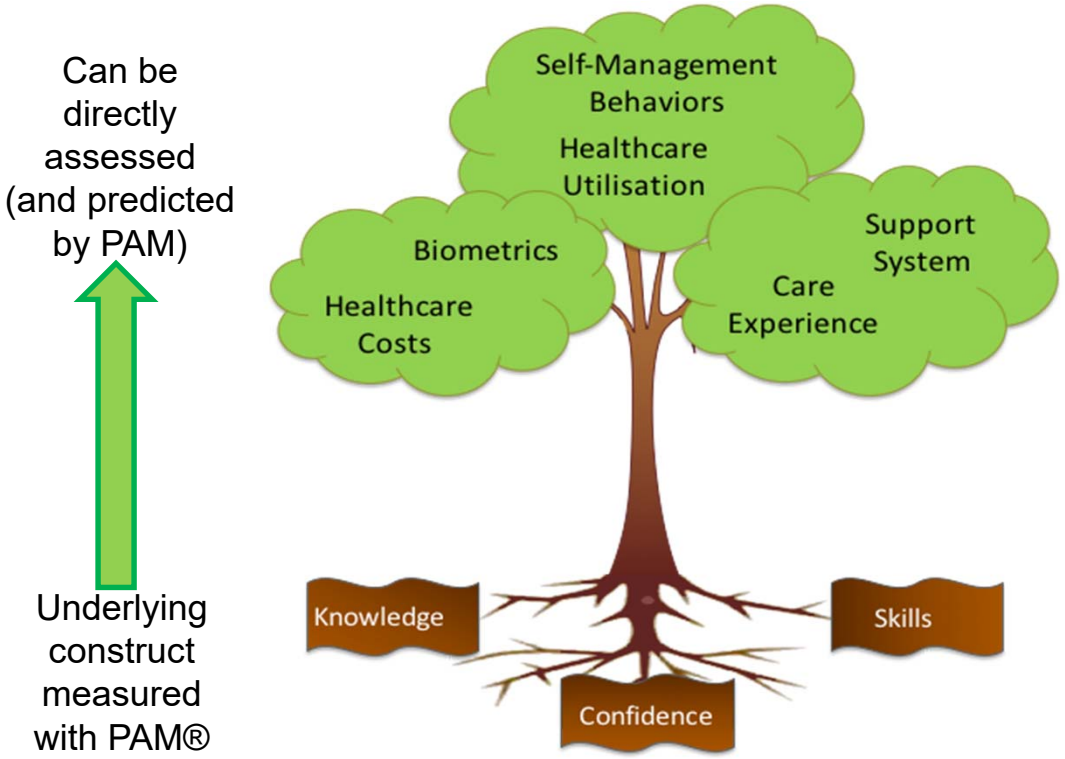


Patient Activation:

Possessing the knowledge, skills and confidence to actively engage in your health and change behaviors where needed to achieve better health outcomes

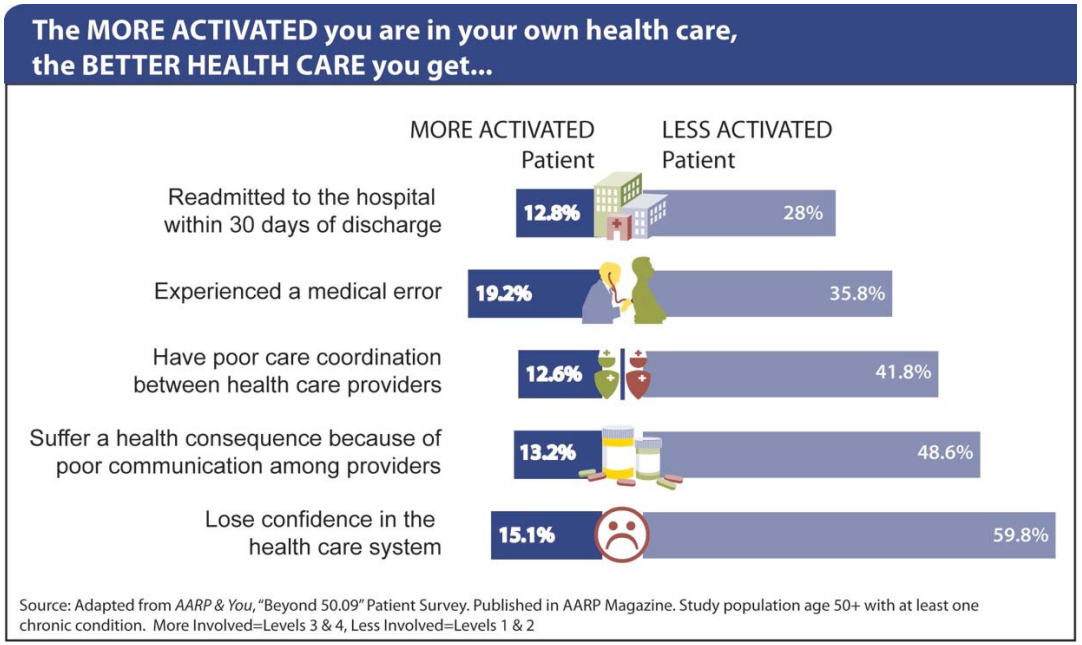
PAM assesses the underlying competencies essential to successful self-management

Can be directly assessed (and predicted by PAM)



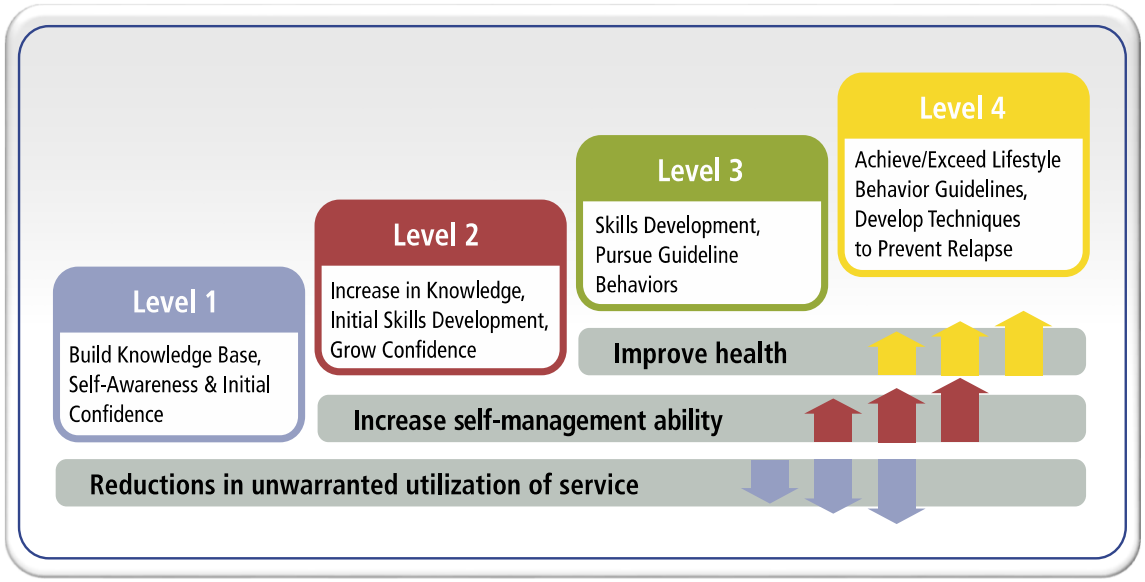
Underlying construct measured with PAM®

Low Activation Signals
Problems & Opportunities



One size support does not fit all

More clinically significant skills are developed once a base of knowledge and confidence is established



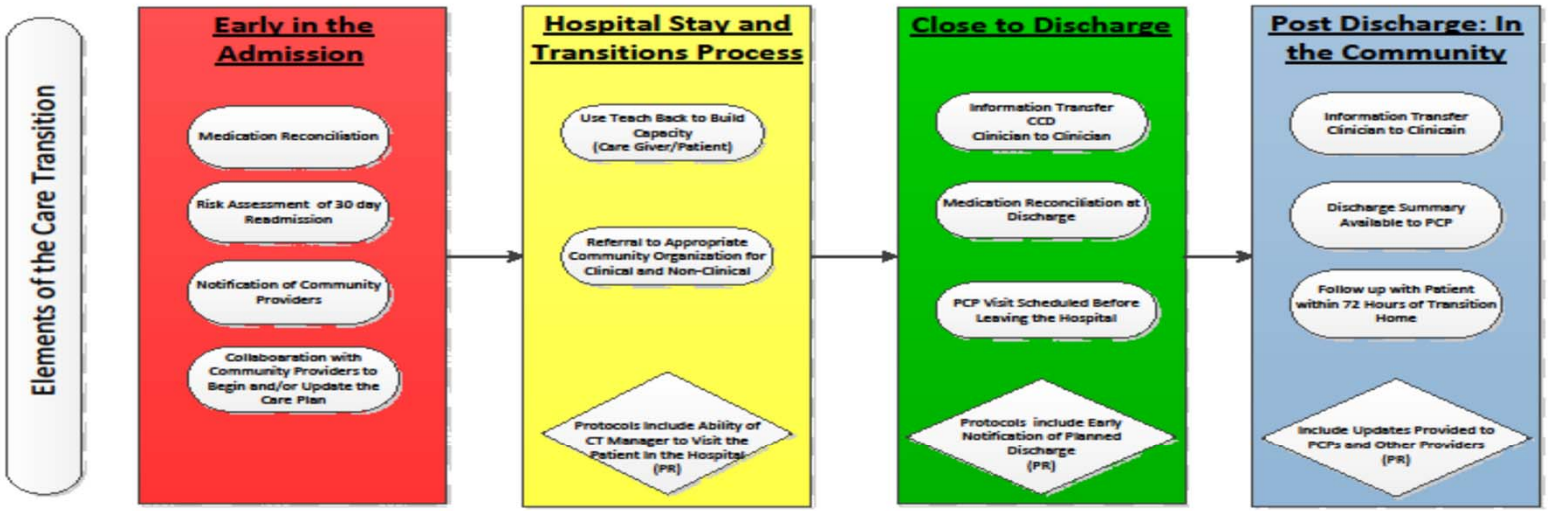
PPS Strategies For Improvement: Project Work

- Care Transitions Standardized Protocol addressing patients at High Risk of Readmission

- Communications Workflow for Care Transitions (Care Planning)
  - Hospital to Lead Health Home
  - Hospital to Care Management Organization
  - Hospital to Community Support Services Agencies
  - Care Management Organization/Support Services/Lead Health Home to Hospital

- Care Transitions Coalitions (7 Coalitions within the 6 Counties)
  - Work of each county varies
  - Examples of work addressed: Standardized Patient Transfers to SNF; Involvement of EMS services to assist with Social Determinants of Health; Nutrition sub-committee; eMOLST integration; Health Home/Care Management/Hospital communication loops; Patient Education; Medication Reconciliation; Peer Specialist integration; Palliative Care Integration

Standardized Protocol for a Care Transitions Intervention Model (PR)
Ensuring an Established 30 Day Transition of Care Period (PR)



PPS Strategies For Improvement: Review of Patient-Centered Medical Home Alignment (PCMH 2017)

- PCMH Alignment (QI 4): Monitoring Patient Experience
  - Access to Care- Should include: Routine, Urgent and after-hours care; receiving timely advice by telephone
  - Communication- Feeling respected and listened to and able to get questions answered
  - Coordination of Care- Provider is informed on referrals; test results; medication changes
  - Practice receives extra credit for using standardized tool with external benchmarking (QI 6)

- PCMH Alignment (AC 01-04; 09) - Access to Care- Practice considers the needs and preferences of the patient population when establishing and updating standards for access (including understanding access equity for those with health disparities); monitors timeliness of response for receiving clinical advice and strives for same day service.

- PCMH Alignment (CC)-Care Coordination – Practice tracks tests and notifies patients of the results; tracks referrals; manages care transitions

Note: APC has similar requirements which will be integrated into NYS PCMH

PPS Strategies For Improvement: Practice Transformation

- Transformation activities on-going
  - NYS PCMH Launching this spring – CNYCC Webinar planned for March 23rd
  - New CNYCC PCMH cohort to begin in April
  - Performance Activities and CNYCC organizational goals align with improving capacity
  - Learning Collaborative to focus on performance outcomes and review of best practices.
  - Training to improve patient engagement-PAM; Motivational Interviewing

PPS Strategies For Improvement: Cardiovascular Disease Management (3bi)

- Focus on Cardiovascular Disease Management and Performance Improvement in Learning Collaborative, Project Implementation Collaborative, Care Transitions/RPAC
- Offer trainings: Self-Management, Warm Handoffs, Care Plan Development, Care Coordination, Population Health Management,
- Develop strategies to improve access for priority populations-develop strategies for patients with health disparities
- Focus strategies on medication adherence, communication and patient safety
- Focus on Chronic Care Management strategies to improve skills in self-management support partnerships with community organizations, improved chronic care management across the care continuum.

Community Engagement Forums

- Panelist:
  - Jessica Soule, Cayuga Community Health Network
  - Sherry Buglione, Oneida Healthcare
  - Eliesa Ansarino, CNYHHN
  - Allison Douglas, The Salvation Army

Group Discussion

- Does your organization currently measure patient experience?
  - If so, how? (i.e. patient experience surveys; focus groups; patient interviews; other?)
  - If using a patient satisfaction survey, do you use the CG-CAHPS tool or ask the same questions as we have discussed today?
  - Are you using a vendor to collect and/or analyze this data? If so, what vendors do you use?
    - Is there an isolated analysis for Medicaid patients?
- What quality improvement initiatives have you undertaken to improve access, communication and care coordination?
- What are you thoughts on how the patient experience can be improved?

Learning Collaborative 2018

- Series 1: Access To Care Access
  - To Care: Patient Experience (March)
  - Access To Care: Data Analysis and Strategy (April)
  - Access To Care: Action Planning (May)
- Series 2: CBOs: Positioning For VBP (June, July)
- Series 3: Cardiovascular: Monitoring & Treatment (Aug, September, October)
- Series 4: Behavioral Health (November, December)