# Nassau – Queens Performing Provider System (PPS)

## PAC Meeting
## June 16, 2015

Nassau Queens
Performing Provider System
*An Alliance for a Healthy Community*

2201 Hempstead Turnpike East Meadow, NY 11554 516.486.NUMC www.nassauqueenspps.org

# Today's Meeting

1. Introduction & Meeting Goals/Agenda
2. PMO Update
3. Communication Strategy
    a. Newsletter
    b. Website
    c. Upcoming Calendar of Events
4. Award Letter Update
5. Implementation Plan Review
6. Project Workgroups Updates
7. Additional Updates
    a. Patient Centered Medical Home
    b. Information Technology Assessment
    c. Community-based Organization Collaboration
8. Concluding Remarks

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# PMO Update

# Communications Update

# Communications Strategy Update

- Broad-based strategy to communicate with all stakeholders through in-person, telephonic, web-based and other media with attention to:
  - Full participation across health systems and all stakeholders
  - DOH Deliverables
  - Right info, right time, right place
- Newsletter:  Coming Soon!!!
  - Plans to publish regularly
  - Updates, upcoming events, information for stakeholders
- Website
  - www.nassauqueenspps.org

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# Upcoming Calendar of Events: June Meetings

| Date | Time | Topic |
|---|---|---|
| June 17 | 10:30am-3:00pm | All-PPS Webinar hosted by the State |
| June 22 | 11:30am-1:00pm | GNYHA Call to discuss Project 11 for DSRIP |
| June 23 | 8:00-9:30am | NQP INTERACT Project Workgroup |
| June 24 | Noon–1:30 pm | CBO Strategy Workgroup |
| June 24 | 3:00-4:30pm | NQP Care Transitions Project Workgroup |

# Upcoming Calendar of Events: July Meetings

| Date | Time | Topic |
|---|---|---|
| July 6 | 4:00-5:00pm | NQP Co-Location of Primary Care in ED Project Workgroup |
| July 7 | 8:30-9:30am | NQP Integrated Behavioral Health Services Project Workgroup |
| July 7 | 11:00am-12:00pm | NQP Treatment of Ambulatory Conditions Project Workgroup |
| July 8 | 3:00-4:00pm | NQP Care Transitions Project Workgroup |
| July 8&9 | 9:00am-4:00pm | KPMG Salient Medicaid Enterprise System Training |
| July 9 | 2:30-3:30pm | NQP INTERACT Project Workgroup |
| July 20 | 1:30-3:00pm | NQP Ambulatory Conditions Project Workgroup |
| July 20 | 4:00-5:30pm | NQP Co-Location of Primary Care in ED Project Workgroup |
| July 21 | 8:30-10:00am | NQP Integrated Behavioral Health Services Project Workgroup |
| July 22 | 3:00-4:30pm | NQP Care Transitions Project Workgroup |
| July 23 | 2:30-4:00pm | NQP INTERACT Project Workgroup |

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# Award Letter

# Award Letter

- Approval to reinvest $8 billion in federal savings generated by the approval of a Medicaid 1115 waiver amendment to reinvest money through DSRIP.
- NQP Award for the five-year period:
  - Net Project Valuation: $447,293,833
  - Net High Performance Fund: $ 8,255,318
  - Additional High Performance Fund: $ 19,740,118
- All funds contingent on NQP's ability to meet DOH deliverables and performance measurement targets.

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# Implementation Plan

# Implementation Plan: Key Facts

- Originally due on April 1, 2015; submitted on June 1, 2015 with a more complete Implementation Plan due on July 31, 2015.
- Focused on *work streams* rather than Projects.
- The Implementation Plan represents the PPS's commitment to NYSDOH for both the '11 projects' and the associated organizational processes.

<u>Organizational Processes:</u>

Workforce*
Governance*
Financial Sustainability*
Cultural Competency / Health Literacy*
Practitioner Engagement
Budget / Funds Flow
IT
Population Health
Clinical Integration
Performance Reporting

**Achievement values are associated with this work stream.*

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# Implementation Plan Structure

- NYSDOH has dictated the “Milestones”, in some cases with timing, for all PPS’s to achieve
- Under each Milestone, the PPS constructs it’s detailed plan. See example:

| | |
|---|---|
| Milestone: Finalize PPS finance structure, including reporting structure | DY1, Q3 |
| 1. NQP will review the PPS Governance Structure and determine which relevant functions, related to financial reporting and sustainability, require additional attention and detail. | DY1, Q2 |
| 2. NQP will identify all necessary roles and responsibilities to manage the financial sustainability functions for the PPS. | DY1, Q2 |
| 3. NQP will develop a charter for the PPS Finance function and establish a schedule for Finance Committee meetings. | DY1, Q2 |
| 3. NQP will develop an organizational structure to house all financial functions for the PPS. The structure must include, but is not limited to, leadership from each NQP hub. It will include a defined reporting structure to the Executive Committee. | DY1, Q2 |
| 4. NQP will provide to the Executive Committee a signed off PPS finance structure and charter document. | DY1, Q2 |

- For each quarterly reporting period, the PPS will report on the current and planned actions; as well as sustainability efforts for past milestones achieved.

# Reporting Due Dates

| Organizational Level | Patient Engagement Scale & Speed | Detailed Plans Milestones / Domain 1 | Progress Reporting | Other Inputs |
|---|---|---|---|---|
| Work stream (Workforce, governance, budget / funds flow, etc.) | n/a | Done | Due July 31 | n/a |
| Workforce budget/impact | n/a | n/a | Due October 31 | Due October 31 |
| Project Level (2.a.i., 2.d.i., 3.a.i, etc.) | Done | Due July 31 | Due July 31 (as applicable) | n/a |
| Project Partners Named | n/a | n/a | n/a | Due October 31 |

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# DSRIP Project Evaluation

Key Point: Four of the 10 organizational work streams are evaluated for Achievement Value (AV) each quarter.

AV = 0 or 1 is applied across all projects, and account for 4 of the maximum 7 AV's allotted for each quarter.

| | AV Category | 2.a.ii | | 2.b.ii | | 3.a.i | | 3.c.i | | 4.a.ii | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY1 Q2 | DY2 Q4 | DY1 Q2 | DY2 Q4 | DY1 Q2 | DY2 Q4 | DY1 Q2 | DY2 Q4 | DY1 Q2 | DY2 Q4 |
| Organizational | Governance | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | Workforce | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | Cultural Competency / Health Literacy | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | Financial Sustainability | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Project | Quarterly Progress Reports/Project Budget/Flow of Funds | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | Patient Engagement Speed | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | N/A | N/A |
| | Project Implementation Speed | N/A | 1 | N/A | 1 | N/A | 1 | N/A | 1 | N/A | N/A |
| | **Total Possible AVs** | 6 | 7 | 6 | 7 | 6 | 7 | 6 | 7 | 5 | 5 |

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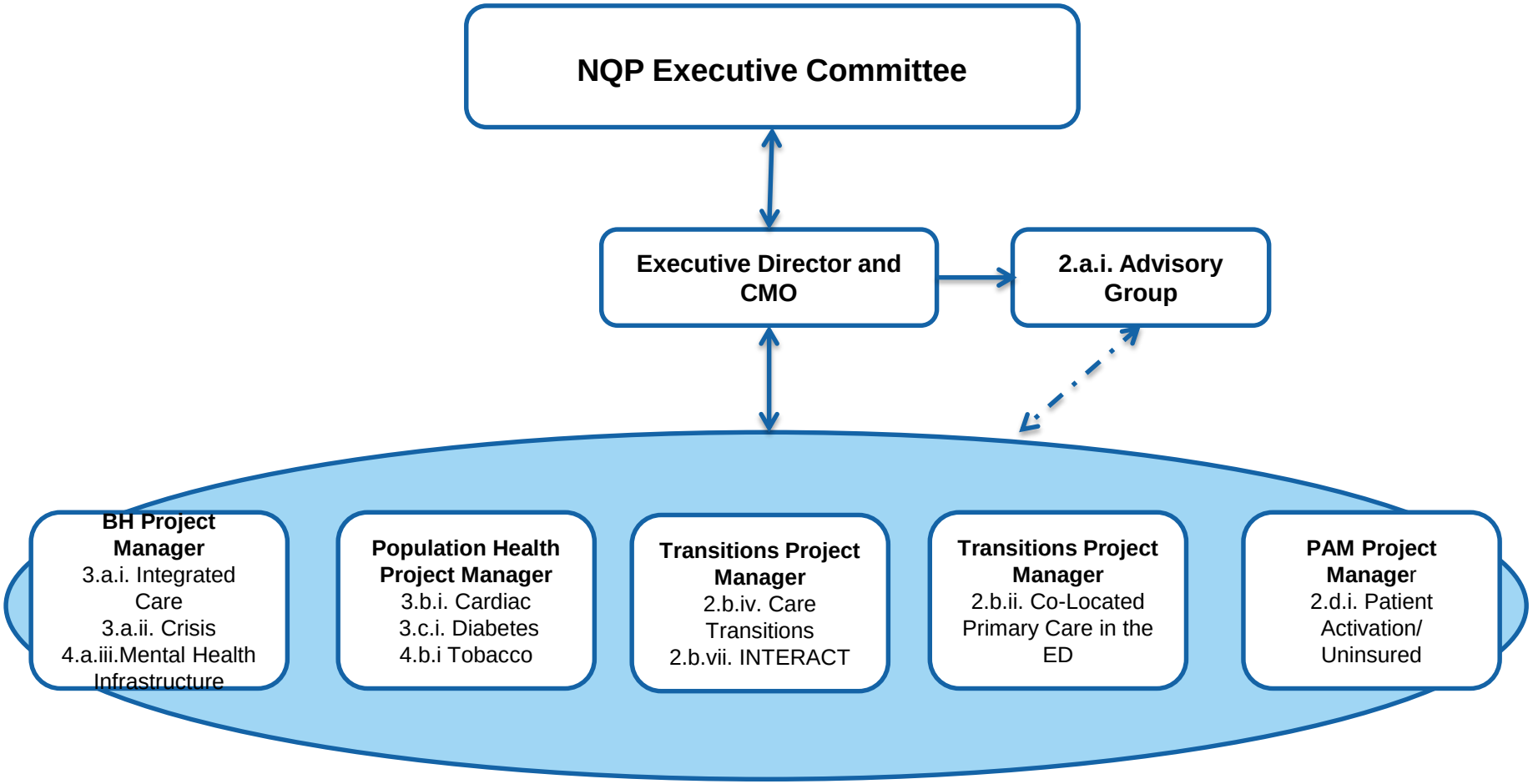
# Project Workgroup Updates

| Project | Speaker |
|---|---|
| Integrated Delivery System | Kris Smith, MD |
| Co-Located Primary Care in ED | Laurie Ward, MD |
| Care Transitions | Zenobia Brown, MD |
| INTERACT | Lawrence Diamond, MD |
| Patient Activation and Engagement | Michael Gatto |
| Behavioral Health Services Integration | Meryl Price |
| Behavioral Health Crisis Stabilization | James Dolan, DSW |
| Cardiovascular Disease Management | Amgad Makaryus, MD |
| Diabetes Management | Natalie Schwartz, MD |
| Substance Abuse & MEB | Meryl Price |
| Tobacco Cessation | Pat Folan, DNP |

# NQP Implementation Structure Including 2.a.i. IDS

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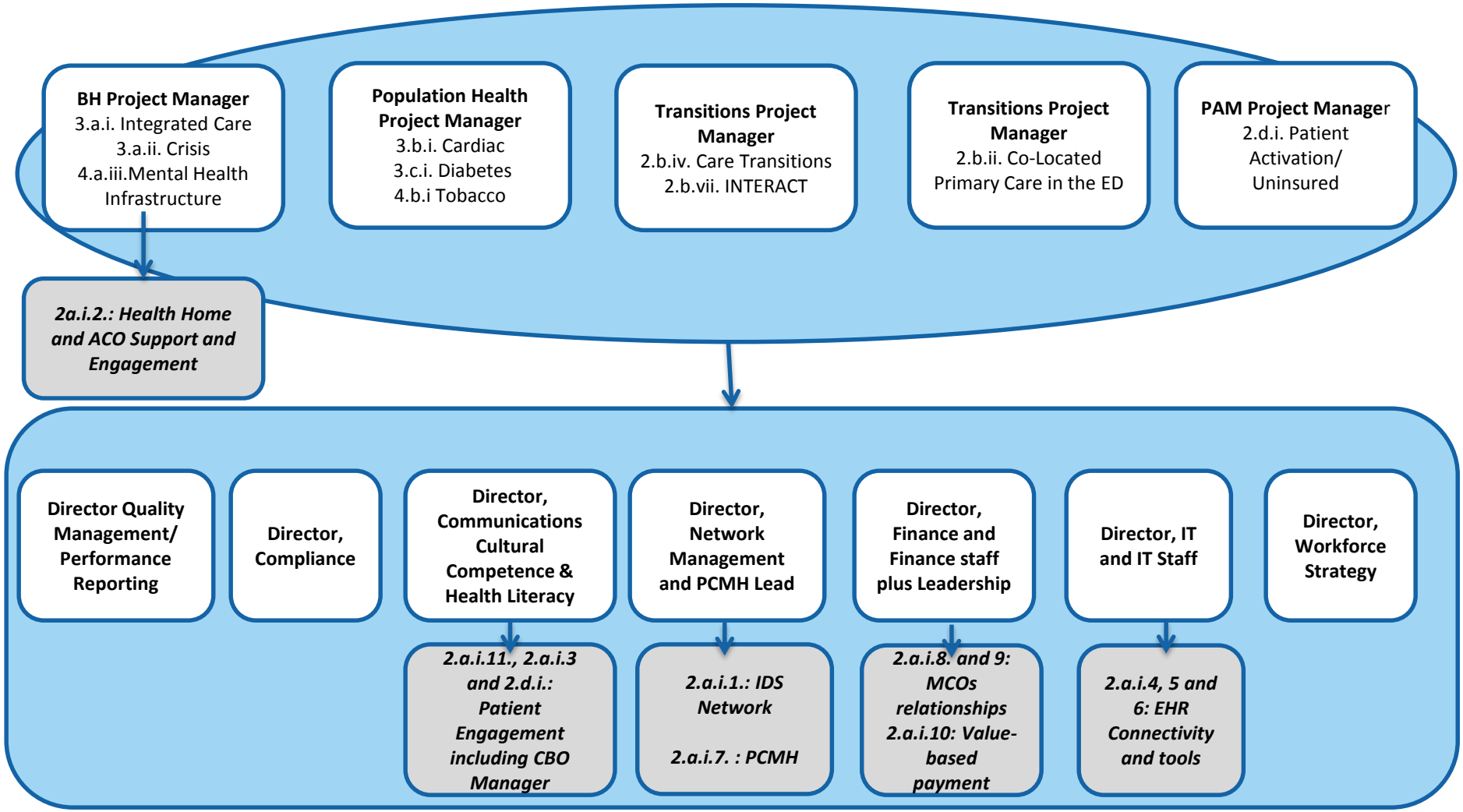
# Project Update: Integrated Delivery System (IDS)/Project Structure

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# Integrated Delivery System: Advisory Role

- Engage stakeholders including CBOs.
- Maximize stakeholder input from 2.a.i. participants.
- Contribute to the design of deliverables under 2.a.i..
- Assist in managing information flow regarding infrastructure development to stakeholders.
- Review and provide input/advice on project plans and work streams.

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# Integrated Delivery System: Activities

- Meet at least monthly to advise on:
  - 2.a.i.-related project plans and work streams.
  - Review data regarding 2.a.i. related deliverables.
  - Obtain input on additional stakeholder issues.
  - Discuss infrastructure issues.

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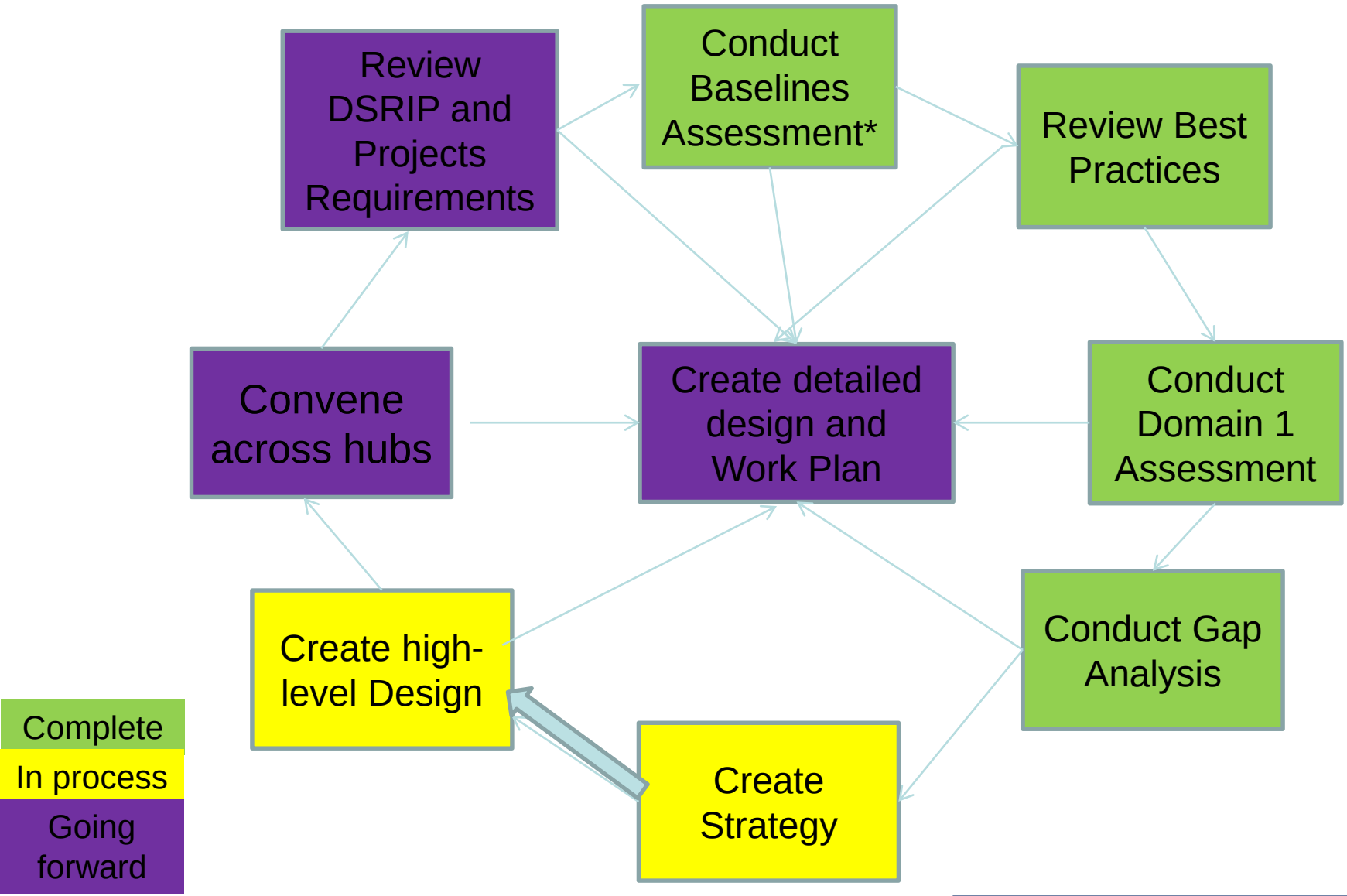
# DSRIP Project Development Process




* Includes: Surveys, Baseline Data (when available), Flowcharts, Discussion, Domain 1 Assessments and Other Data.

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# Project Update: Gap Analysis

| | 2.a.i. | Integrated Behavioral Health | Ambulatory Conditions | Care Transitions | Co-Located PCMH in the ED | Patient Activation |
|---|---|---|---|---|---|---|
| Process Flows | N/A | ✓ | ✓ | ✓ | ✓ | In process |
| Domain 1 Assessments/ Surveys | PCMH Survey IT Assessment | ✓ | ✓ | ✓ | ✓ | ✓ |
| Baseline Data | N/A | Analysis In Process | | | | |
| Discussion | N/A | ✓ | ✓ | ✓ | ✓ | In process |
| Gap Analysis | In process | ✓ | ✓ | ✓ | ✓ | In process |

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# Co-Location of PC in ED: Key Gap Analysis Findings

- EDs have varying workflows, but all have some service and protocol for non-emergent conditions (e.g. “Fast Track”).
- The hubs all have concerns regarding differential treatment of Medicaid patients.
- Concern over EMTALA requirements.
- Build-out requirements and costs with uncertainties around Capital Grant funding.
- EDs at each hub will need to expand relationships with CBOs in order for this approach to succeed.

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# Co-Location of PC in ED: Key Challenges

- More than any other project, co-location requires a disruption of current workflows and infrastructure building.
- Speed and Scale goals for this project are at odds with the other projects to reduce overall ED use.
- Work flow challenges with respect to EMTALA and project requirements.
- Developing strategies to maximize Speed and Scale for this and other projects will present challenges in design as well.

# Care Transitions: Key Gap Analysis Findings

- Each hospital system has varying programs and processes targeted to avoiding readmissions by payor source.
- There is varied adherence to essential interventions for transitions of care:
  - Interventions with highest adherence: medications management, transition planning, and patient/family education.
  - Interventions with lowest adherence: follow-up care, healthcare provider engagement, and shared accountability across providers and organizations.
- Once the patient has left the hospital, capabilities to track and address refusals or missed connections to home care, medical care and social services for follow-up are not routinely available and frequently lack IT infrastructure.

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# Care Transitions: Key Challenges

- Developing centralized PPS resources while respecting and promoting local care delivery systems.
- Implementing new care protocols across the hubs with adequate training and ongoing measurement of adoption of protocols.
- Developing IT capabilities to track Medicaid patients through discharge and readmission to sites across the PPS poses a technical challenge.
- Developing IT capabilities to track ED use for patients in transition in real-time and, to respond to such opportunities.
- Developing IT and infrastructure capabilities to insure communications along the health care spectrum from admission to primary, behavioral, specialty care as well as non-medical care and follow-up.

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# INTERACT: Key Gap Analysis Findings

- Need for a culture of quality across all levels of the facility.
- Many facilities use INTERACT-like strategies – but not INTERACT per se.
- The level and type of medical capabilities in NQP SNFs is highly variable.
- Most SNFs find integrating specific INTERACT tools with their own established protocols just as helpful.
- Families often drive decisions to seek acute care.

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# INTERACT: Key Challenges

- "Selling" INTERACT to SNFs.
- Workflow re-design.
- Time associated with completing INTERACT forms.
- Training costs and time required by staff to train.
- Family trust in the SNF (vs. the acute care setting)
- Need for cultural change across SNFs, caregivers and families.
- Inter-connectivity with hospital and ED
- Technical assistance with EMRs (Many SNFs have one but it is not robust.)

# Patient Activation Measurement (PAM)

- Patient activation is a major issue for the State including issues related to cultural and linguistic appropriateness.
- The uninsured, low utilizers and non-utilizers can benefit from greater access to care.
- This project requires a somewhat different approach relative to other NQP DSRIP projects.

# PAM Key Challenges

- Finding individuals who do not utilize services is a major challenge.
- NQP must maximize the value of PAM to ensure true improvement in access and outcomes.
- Hospital systems must forge new relationships with Community-based organizations to reach the uninsured, low-utilizers and non-utilizers.
- Efforts to reach the uninsured as well as low/non-utilizers will require significant hot-spotting efforts.
- IT infrastructure will be necessary to create a PAM process that contributes meaningfully to care delivery efforts.

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# BH Integration: Key Gap Analysis Findings

- Space to see patients in both the primary care and BH settings.
- Cultural differences between PCPs and Behavioral Health Providers.
- Lack of an integrated care management approach.
- Lack of current use of evidence-based standards.
- Need to select and leverage appropriate screening tools for both chronic disease and for behavioral health conditions.
- Gaps in technology to share information across providers and settings.
- There are ample best practices to follow regarding integrated care.

# BH Integration: Key Challenges

- "Cultural divide" between PCPs and BHPs
- Significant re-design of work flows, physical space and orientation to care delivery  is needed.
- Reimbursement challenges, especially for primary care.
- Importance of CBO engagement, involvement and investment.
- Space constraints in both the primary care and the behavioral health settings and costs associated with building.
- IT challenges associated with connectivity, care management program design and inter-operable records.
- Overall challenges serving individuals with SMI.

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# BH Crisis: Key Gap Analysis Findings

- Crisis services are fragmented and inaccessible.
- The existing system is not proactive.
- Currently, there is no outreach or intensive crisis service available.
- There are limited linkages between Crisis and Health Homes.
- Consistent crisis treatment protocols are not generally used.
- Observation space for individuals in crisis is very limited.
- There is limited availability of mobile crisis teams.
- There are no central triage agreements in place with psychiatrists, mental health, behavioral health and substance abuse providers.

# BH Crisis: Key Challenges

- The ability to weave together different systems across such a wide geography will be difficult.
- DSRIP requirements fundamentally differ from the manner in which the PPS's systems are currently configured.
- Wide variety of systems to coordinate – going in and coming out of crisis systems.

# Cardiovascular Disease: Key Gap Analysis Findings

- Use of guidelines is variable, especially in primary care.
- There are no standardized treatment protocols across the practices. Often individual practitioners are using their own expertise.
- Blood pressure checks are not available on walk-in basis.
- The lack of preferred drug lists is problematic.
- Documenting patient-driven self-management goals in the medical record varies across practices.
- Utilizing methods like hot spotting to target care is variable.
- Difficult to track patients for pre-hypertension due to limitations with EHR.
- There is variability in MCO relationships.

# Cardiovascular Disease: Key Challenges

- Aligning all providers, understanding the may be originating from different schools of training, to adopt the same approach to care management.
- Implementing critical tracking requirements in EHRs, recognizing there are varying levels of robustness.
- No Hub has adopted strategies from the Million Hearts Campaign.
- Concern among some practitioners as to the usefulness of home blood pressure monitoring due to operational error.

# Diabetes: Key Gap Analysis Findings

- Use of guidelines is variable, especially in primary care.
- There are no standardized treatment protocols across the practices. Often individual practitioners are using their own expertise.
- Blood pressure checks are not available on walk-in basis.
- Lack of preferred drug list is problematic.
- Challenge to achieve adoptability across practices.
- Difficult to track patients for pre-hypertension due to limitations with EHR.

# Diabetes: Key Challenges

- Engaging CBOs to assist in dissemination of materials and tools to enhance self-care strategies.
- Aligning all providers to adopt and rigorously follow protocols.
- Implementing critical tracking requirements in EHRs, recognizing there are varying levels of robustness.
- Increasing health literacy, cultural and linguistic competence will be critical to enhancing self-care and ultimately, outcomes.

# Substance Abuse: Update

- This project focuses on strengthening mental health and substance abuse infrastructure across systems. In particular, the goal of this project is to enhance the mental, emotional, and behavioral (MEB) health in communities.
- Plans for this project are in process following significant progress on other PPS behavioral health projects (3.a.i. & 3.a.ii.).

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# Tobacco Cessation: Key Gap Analysis Findings

- Smoking Cessation initiatives and best practices in Nassau County and in New York City (Queens) have been ongoing for years.
- There are remaining pockets, or “hot spots” that need more penetration of these initiatives, i.e.: smoke free locations in the Rockaways.
- Some of the clinical aspects of 4.a.i overlap with 3.b.i, 3.c.i. and 4.a.iii. (Cardiovascular) such as “the 5As.”

# Tobacco Cessation: Key Challenges

- Managed Care Organizations' mandated coverage for tobacco cessation products and counseling are not consistently followed.
- While there is widespread adoption of EHR screening and following the US Public Health Services Guidelines for Treating Tobacco Use, there is variability in implementation.
- Challenges include:
  - Low motivation in this population;
  - Low motivation among some staff to counsel;
  - Reluctance of some prescribers to prescribe cessation medications;
  - Attitudes and beliefs related to the "benefits" of continued smoking in the population.

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# Additional Updates

# Patient-Centered Medical Home

- PCMH is a core DSRIP requirement spanning multiple NQP projects.
- Work to date includes:
  - Assembly of a primary care provider data base;
  - Plans to initiate DSRIP project education for PCPs;
  - Plans to initiate PCMH education for providers with less familiarity with this process; and,
  - Strategy to incent providers to participate in PCMH recognition process.
- PCMH baseline survey across the primary care network will be issued (electronically) shortly.

# Information Technology Assessment

- DSRIP requires the PPS to perform an assessment of IT resources and, to develop a gap analysis to achieve DSRIP requirements.
- Currently exploring with vendors the optimal way to execute this work.
  - What does each health systems' IT infrastructure look like today?
  - What additional IT infrastructure is required to meet all DSRIP requirements?
  - How will the three health systems and partners achieve interoperability for the purpose of care management and reporting to achieve DSRIP goals and metrics?
- Selection of IT Assessment vendor is pending further review.

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# Importance of CBOs to NQP

- Community-based Organizations (CBOs) have significant expertise in working with the target population (uninsured, Medicaid patients).
- Patient Activation Measures (PAMs) offers an opportunity to connect these individuals with services.
- Seven of the 11 projects chosen by NQP to pursue have specific requirements that relate to CBOs.
  - Trust among patients and families
  - Cultural and linguistic expertise
  - Knowledge of, and access to, community-based resources
  - Ability to relate to patients and families
  - Hands-on experience with the population
  - Ability to create a “bridge” to the medical and behavioral health systems.
  - Ability to assist patients in navigating the health care system.

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# Closing Remarks

- Questions???
- Thank you for participating!
- See you at the next PAC meeting…September 17, 2015

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