Managed Care
Community of Practice
Preparing the I/DD Field for Managed Care

Data - Information – Insight

From Collecting to Using Data to Improve Services & Supports

April 9, 2019, 2:00 – 3:00 PM

M. Renee' Bostick
Vorys Health Care Advisors

NEW YORK ALLIANCE FOR INCLUSION & INNOVATION

The Managed Care Community of Practice is a project of the New York Alliance for Inclusion & Innovation in partnership with the following organizations

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NYU SILVER SCHOOL OF SOCIAL WORK

NMR Negri Management Resources, LLC
Creating a Partnership for Client Success

VORYS Health Care Advisors

Today's Presenters

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New York Alliance for Inclusion & Innovation

(NY Alliance)

- NY's associations of non-profit providers advancing the interest of provider organizations & people with disabilities
- Merger of New York State Association of Community & Residential Services (NYSACRA) & New York State Rehabilitation Association (NYSRA)

NYSACRA STRONGER TOGETHER NYSRA

- More than 175 provider organizations across the state throughout NYS from largest, multi-service agencies to smallest, specialty I/DD service providers

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Preparing the I/DD Field for Managed Care

Managed Care Community of Practice

a project of the New York Alliance for Inclusion & Innovation (NY Alliance)

MC Community Practice Website

mc-cop.com

Training & technical assistance for ***ALL*** I/DD providers transitioning to managed care made possible through 2018-19 NYS Budget funding

Email: mccop.info@nyu.edu

Data – Information – Insight

First in a Learning Series of the "Culture of Data"

Managed Care Community of Practice

- New York Alliance for Inclusion & Innovation project for ***ALL*** providers of I/DD services transitioning to managed care

Value-based purchasing (VBP) requires **data analysis capabilities**

- To drive decision-making, improve performance & manage fiscal & care risk

Data Governance, Health Information & Technology (HIT) capabilities are essential to transform LTSS

- from pay for volume (fee for service) to payment for value,
- from collecting data to transforming it into information & knowledge, &
- from providing services to delivering value.

Developing a **Data Strategy** enables providers to clarify

- where you are on the technology adoption curve,
- what are your needs & what can you afford in the future, &
- options (build, share & buy) to meet your future needs

GOALS

1. To understand the importance of **data collection, analysis & use** in VBP
2. To learn about types of **data & data analytic processes** for performance improvement &
3. To review **options to share or partner** data capabilities to build on agency strengths

Value-based purchasing (VBP) requires **data analysis capabilities**

- drive decision-making,
- improve performance &
- manage fiscal & care risk

Value-Based Purchasing (VBP)

- NYS DSRIP program aims to **restructure** healthcare delivery system by:
  - reducing avoidable hospital use by 25% &
  - improving the financial sustainability of NYS's safety system
- By 2020, **80 – 90% of all payments** made from Managed Care Organizations (MCOs) to providers will be in **VBP arrangements** to
  - convert VBP arrangements into a sustainable system that incentivizes value over volume
  - advance the mutli-year VBP Roadmap, approved by CMS - detailing VBP options & levels for MCOs & providers to implement to accomplish quality measures
- NYS VBP Roadmap - two types of VBP arrangements:
  1. Population–based VBP arrangements
  2. Episode–based VBP arrangements

OPWDD Vision for Managed Care Transion

Managed Care, *based on specialized I/DD services* –

- better supports the needs of the population as it ages,
- ensures better access to cross-system care, &
- promotes VBP strategies to drive continued improvement I/DD services

Goals –

1. To better integrate services,
2. To promote improved use of resources to meet growing & changing needs,
3. To promote VBP strategies to drive continued improvement in I/DD services &
4. To improve system flexibility & become truly person-centered

NYS Timeline
I/DD Evolution of Services & Supports

NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities	2016	2017	2018	2019	2020	2021
FIDA-IDD national demo project operated in downstate						
I/DD & targeted HCBS populations to CCO care management						
Early Adopters of mainstream Managed Care						
Voluntary Managed Care Enrollment						
Mandatory Managed Care						

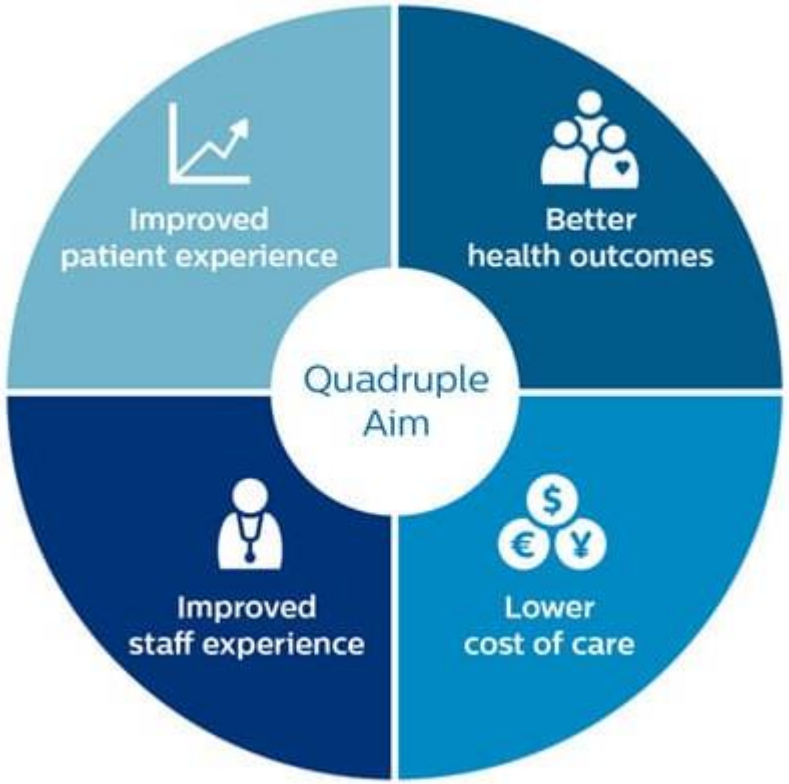
Learning Period

CCO/HH Requirements

Data, Information & Insight-Driven Change

1. Person-Centered Comprehensive **ASSESSMENT**
2. Integrated CQL Personal **OUTCOME** Measures (POMs)
3. Integrated Health & **SAFETY** Supports, Individual Protective Oversight Plan
4. OPWDD Integration – Care Coordination **DATA DICTIONARY** Compliance
5. *Electronic* **LIFE PLAN**
6. *Electronic* **CARE COORDINATION SYSTEM** – Circle of Supports Communication
7. I/DD **HH REQUIREMENTS**
8. **DATA EXCHANGE** through Regional Health Information Organization (RHIO)

Vision of Change



Quadruple Aim

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD[1]

ABSTRACT

Direct Support Professionals are essential to -

- Enable people with I/DD realize their Life Plan goals
- Ensure safety & prevent injury of people with I/DD
- Reduce stress, worry & burden of families
- Embody NYS "safety net" services
- Reduce health care provider "burn-out" which
  - lowers satisfaction measures,
  - reduces health outcomes &
  - increased overall costs

Refocus on VALUE of Change

Person-centered perspective

Staff Action Plan

Res. Hab | Day Hab | Employment | Respite | Physical Health | Mental Health | Substance Use | Other Supports

HITS

Care Coordination Organization/Health Home (CCO/HH)

CCO Administrative Services, Network Management, HIT Support/Data, Exchange

HH

Comprehensive Care Mgt	Care Coordination & Health Promotion	Transitional Care	Individual & Family Support	Community & Social Service Referral	HIT for Life Plan & Service Linkage

CCO Care Manager

COMPREHENSIVE ASSESSMENT
CAS & IAM

LIFE PLAN
AUTHORIZES Services & Supports

Specialized I/DD MCO | **Mainstream MCO**

N Y S D O H & O P W D D
DDRO Front Door- *Eligibility & Enrollment*

DATA **INFORMATION** **KNOWLEDGE**

NYS OPWDD VBP

Quality strategy - to ***reform*** how care is ***delivered & purchased by -***

- **Rewarding** health care & service providers through **incentive payments for quality** (not quantity) of care to help people
  1. **improve their health,**
  2. **reduce the incidence & effects of chronic disease &**
  3. **live healthier lives in an evidence-based way**

What will be the basis of incentive payments?

How can we best prepare?

How different are these goals than our agency's goals?

What will be the basis of the incentives?

Data

- Facts, numbers or characters that are collected, examined & used to ***help in decision-making***, or information in an electronic form that is ***stored, standardized & analyzed*** by a computer

Information

- Process of ***inspecting, cleansing, transforming & modeling*** data with the goal of ***discovering useful information, informing conclusions & supporting decision-making***

Knowledge

- Process of ***storing, protecting & analyzing*** data from ***diverse sources*** to create ***holistic views of people served, personalize treatment services & supports, improve communication & enhance health outcomes***

How can we best prepare?

CCO/HH Goals, Measures & Processes

Goals – Performance

Measures - Quality & Process

Processes -Administration

1. **Reduce utilization** associated with **avoidable / preventable inpatient stays**
2. Reduce utilization associated with **avoidable / preventable ER visits**
3. **Improve outcomes** through care coordination (health, personal & social outcomes)
4. Improve disease-related care for **chronic conditions**
5. Improve **preventive care**
6. Improve **transitional care**
7. Reduce utilization associated with **inpatient stays**

GOAL: Improve outcomes through care coordination

(health, personal & social)

CCO/HH

MEASURES	Data Source	Description
CQL POMS	% Life Plans 2+ POM measures	Life Plan (LP) must have at least 3 personal goals - 2 POM directed goals (CCO/HH records in LP POMs from CQL guideline)
Personal safeguards implementation	CCO/HH reporting	% LPs with personal safeguards goals (CCO/HH record personal safeguards in LP)
Transition to more integrated setting	Claims/ TABS	#/% of individuals in a 24-hour certified setting, who move to a more integrated setting
Employment	CCO/HH reporting	#/% of individuals' whose LP with employment choice, who are employed (compared to previous period). (CCO/HH records individual progress & verifies support to find & maintain community integrated employment)
Self-direction	Claims	#/% of the individuals who chose self-direction of employer/budget in LP & are enrolled in self- direction (compared to the previous period) (CCO/HH identify who chooses service & support self-direction)

CQL Personal Outcome Measures

Council on Quality & Leadership

Security

Community

Relationships

Choices

Goals

MY HUMAN SECURITY

1. People are safe
2. People are free from abuse and neglect
3. People have the best possible health
4. People experience continuity and security
5. People exercise rights
6. People are treated fairly
7. People are respected

MY COMMUNITY

8. People use their environments
9. People live in integrated environments
10. People interact with other members of the community
11. People participate in the life of the community

MY RELATIONSHIPS

12. People are connected to natural support networks
13. People have friends
14. People have intimate relationships
15. People decide when to share personal information
16. People perform different social roles

MY CHOICES

17. People choose where and with whom they live
18. People choose where they work
19. People choose services

MY GOALS

20. People choose personal goals
21. People realize personal goals

21 indicators of --

- presence, importance & achievement of outcomes

Involving

- choice, health, safety, social capital, relationships, rights, goals, & employment

GOAL: Improve Preventive Care
CCO/HH

Measures	Data Source	Description
Bladder & Bowel Continence	CCO/HH reporting CAS	Of the individuals with an identified bladder/bowel health risk, the number/percentage that have a Life Plan in place that includes recording of support or device needs bowel/incontinence tracking protocol, bowel/incontinence management protocol. CCO/HH will report risk based on initial screening.
Falls	CCO/HH reporting	Of the individuals with an identified risk of falls, the number/percentage who have a Life Plan that includes supervision, contact guarding, adaptive equipment, environmental modifications or other-directed support. CCO/HH will report risk based on initial screening.
Choking	CCO/HH reporting	Of the individuals with an identified risk of choking, the number/percentage who have a Life Plan with safeguard(s) including modified consistency of foods &/or liquids, avoidance of high risk foods, requires supervision, formal training/dining plan required. CCO/HH will report risk based on initial screening.

GOAL: Improve Transitional Care
CCO/HH

Measures	Data Source	Description
Supporting individuals' transition from institutional settings to community settings	Claims CAS	Of the individuals who move to a setting other than a 24- hour certified setting, the number/percentage of transitions identified in TABS/claims compared to number/percentage of care transition records transmitted to Health Care Professionals by the CCO/HH. CCO/HH must report transitions from 24-hour certified setting to community placement/setting.

How different are these goals than our agency's goals?

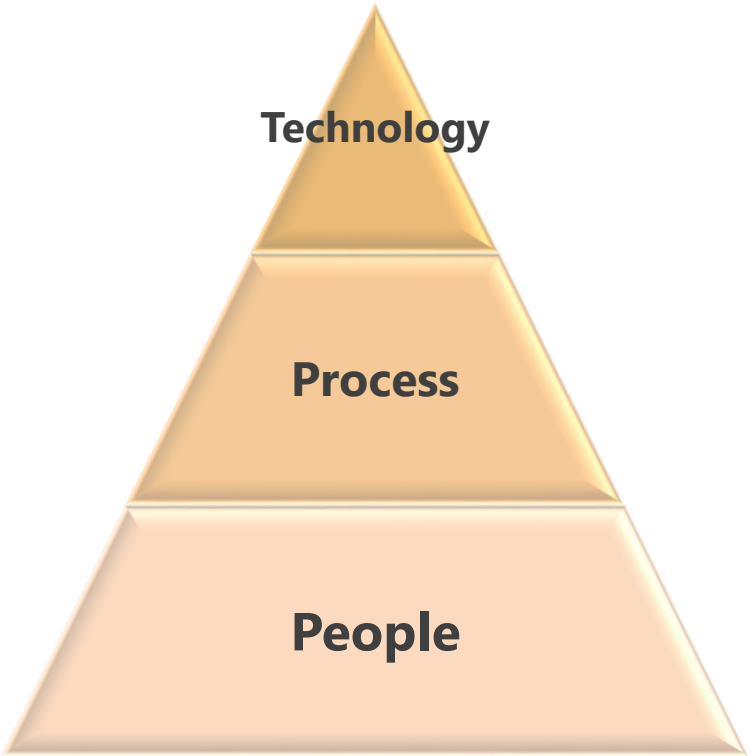
What is your current Quality Strategy?	What outcomes, health & community care?
What data do you collect?	Claims, required reporting data, other?
How is it used, organized, stored, reused?	Get paid, comply with reports…
Who has access to data?	Only the people who collect or report it
How could we improve what we are doing?	Where to start for real steps of change

Data Governance, Health Information & Technology (HIT) capabilities are essential to transform LTSS

- from pay for volume (fee for service) to payment for value,
- from collecting data to transforming it into information & knowledge, &
- from providing services to delivering value.

Building / Improving Capabilities

CHANGE MANAGEMENT - discipline that guides <u>how</u> we prepare, equip & support individuals to successfully adopt change in order to drive organizational success & outcomes



"Golden Triangle"

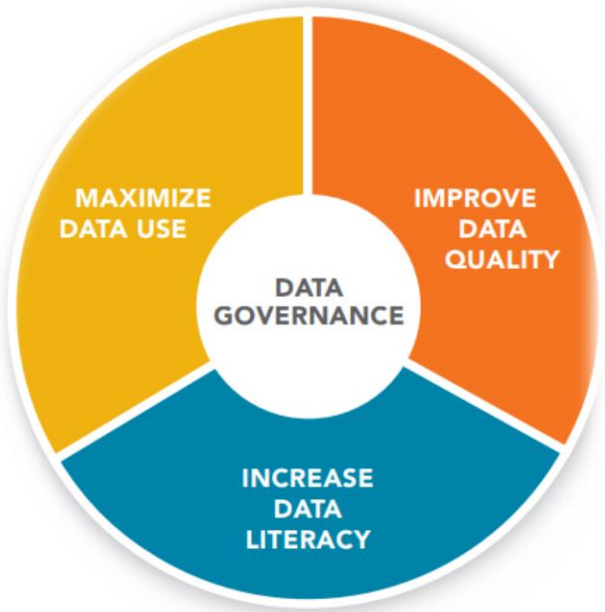
- **PEOPLE** – (KEY)
  - how people experience change & what they need to change successfully,
  - how to demonstrate & coach people to new behaviors, & what makes changes "stick"
- **PROCESS**
  - how to connect goals to roles, structures, processes, projects & leadership competencies;
  - how to close the gap between our current processes & future processes
- **TECHNOLOGY –** not all about IT
  - what are repeated / routine processes we can automate
  - how can we use analytics to improve our outcomes

Data Governance

"You can't make good decisions with bad data."

- Problem is good data is hard to come by &
- Available data **doubles every 18 months**, according to Moore's law

Data Governance



Need a systematic way to manage data… or we will drown

Data Driven Culture

From		To
Technology-centric	**Vision**	Information-centric
Out of IT	**Strategy**	Into the business
Collection	**Infrastructure**	Collection *and* connection
Truth	**Governance**	Trust
Monolithic	**Organization**	Distributed
Technology-savvy	**Roles**	Data literacy
Efficiency and cost	**Metrics**	Diverse business benefits (including monetization)

Data Governance (DG)

❶ Lay the Foundation

- identify & prioritize problems to solve,
- what do you need to achieve &
- how to establish leadership support

❷ Assemble the Team

- Executive sponsor
- Key stakeholders
- Needed resources

❸ Governance in Motion

- Develop a data governance plan
- Provide training & communication
- DG Policies & Procedures

❶ Lay the Foundation

(and think ahead)

Establish CLEAR Value Proposition

1. Define the Problem - what is the problem/issue you are trying to solve?
   - It needs to relate to clients
2. Outcome – what do you need to achieve?
   - How are you trying to improve services & support
3. Executive Sponsor – broker leadership support

"*Triple Aim* of Data Governance"

- improving data quality,
- increasing data literacy
- maximizing access to data

2 Assemble the Team

- **Start - choose a specific measure & focus on building trust in the data by collecting & reviewing data inputs & outputs**
  - Starting small, focus on manageable issue, refine your process & quickly demonstrate value
- **Executive sponsor or champion with leadership support from a clinical or operational area**
  - MISTAKE - to assume that data governance & management an IT responsibility
- **Get 1 – 2 end users excited by about data that they can trust – they are the future data stewards**
- **Avoid referring to data governance as a "project,"**
  - Announce the next initiative to communicate the work continues
- **Develop policies & procedures as needed, as communication tools (rather than rules)**
  - MISTAKE – to confuse governance with restriction, it's just the opposite!

❷ Assemble the Team

- **Baseline your health care analytic capabilities & assess progress using an Analytics Capability Assessment**

1. PEOPLE												
Capability Levels	Reactive			Responsive			Proactive			Predictive		
Senior Leader Sponsorship: Senior Leader Sponsorship assesses the degree to which leaders in the organization sponsor healthcare analytics efforts, advocate for a structured approach to analytics and allocate resources to it.												
1A. To what extent are senior leaders involved with and supportive of data efforts, issues and analytics in your organization?	Managers typically firefight data issues as they arise; senior leaders are rarely involved in the detail of such issues.			Managers/Directors are responsible for departmental data issues and resolving problems as they relate to operations.			Senior leaders have responsibility for ensuring that data is available for driving decisions and allocate resources to ensure its quality, availability and timeliness.			Senior leaders sponsor efforts throughout the organization to ensure healthy data and analytics efforts, and ensure that departmental efforts are balanced and aligned to maximize the use of data as a strategic asset.		
SCORE	0	1	2	3	4	5	6	7	8	9	10	11
Data Stewardship: The role of the "data steward" may be formally defined or informally recognized and is typically the "go to" person within a department or site for all the queries/issues and usability of the data. Data stewards ensure the data is complete, accurate, and timely and that it is useful to the department or site in measuring performance and making improvement.												

SOURCE: https://www.careinnovations.org/wp-content/uploads/2016/07/CCI_Analytics_Capability_Assessment-201711-2.pdf

Analytics Capability Assessment

Questions about your Agency

- People - 4,
- Process - 6
- Technology - 3

Reactive	Responsive	Proactive	Predictive
No evidence or very limited evidence of capability, decentralized efforts to get data, access to information for the first time, situational reporting.	Some departmental evidence but not integrated or aligned, initial data marts, standardized reporting through IT, improved data capture at department level, some historical trending and analysis.	Evidence of an emerging integrated approach, clinical and business process improvements based on analytics, analytics driving change and strategy, culture change, integration of measure across domains (clinical, financial, operations, patient experience).	Fully integrated and aligned organizationally, leading edge tools and skills, data services provide robust support across the health center, automated analytic results are fed back into predictive models for value-driven health care.

Analytics Capability Assessment

People

- Senior Leadership
- Data Stewardship
- Clinical & Business Analysts
- Data-driven culture

Process

- Data Strategy
- Data Governance
- Performance Measurement
- Data Quality
- Analysis of Data
- Acting on Results

Technology

- IT Tools & Supports for Analytics
- Integration
- Self-Service Analytics

Building DG Understanding

Exercise – have each member of our DG committee score the Analytics Capability Assessment & compare results

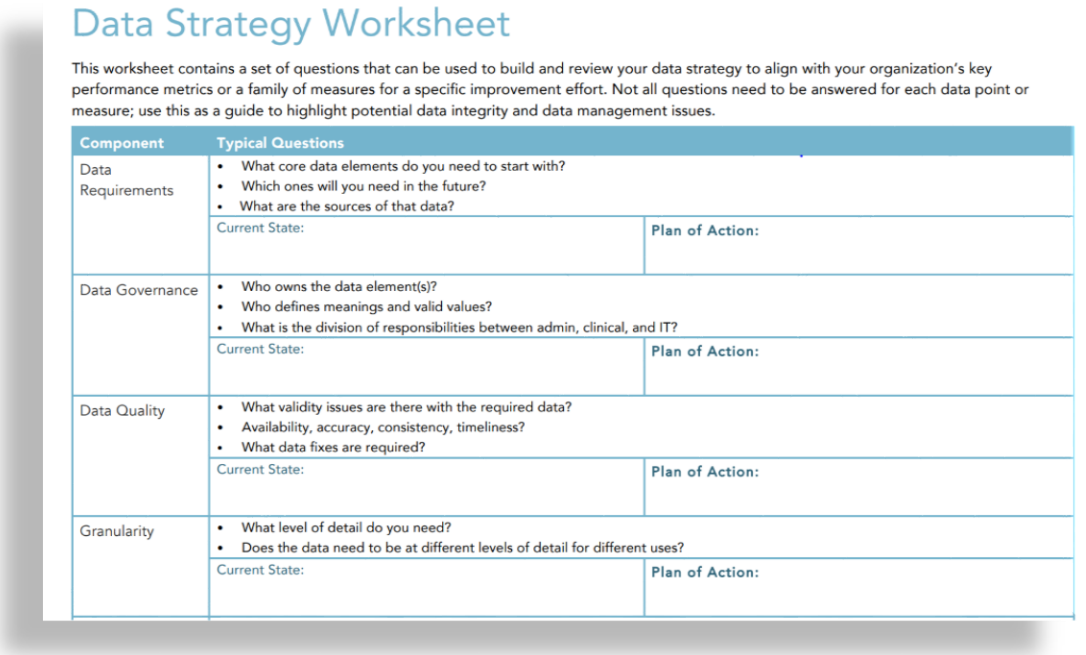
- **Review aggregated scores and discuss**
  - Identify your high scores & how to leverage these strengths
  - Discuss scores that were low or had wide variability
- **Gain consensus on a final score for each factor**
  - With brief comment on each on rationale for score
- **Identify what factors have the greatest potential impact**
  - Use these factors to guide analytic capability development efforts by your DG committee

3 Governance in Motion

- **Usually a DG team starts as some other kind of group**
  - EHR Implementation or Enhancement Committee
  - Quality Improvement Committee
- **Purpose to**
  - increase data quality,
  - improve data literacy &
  - ensure the organization maximizes the value of the data collected
- **Includes staff representatives for groups that use IT systems**
- **Identify Data Stewards**
  - People responsible for processes & activities to ensure that usable data & information is available throughout the organization

Tools & Templates

- **Usually staff are have their own favorite data tool or template**
- **DG can collect & review these as well as other online tools**
- **Worksheet** (set of standard questions)
  - To build & review your data strategy
  - To align with your organization's key performance metrics or a group of measures for a specific improvement effort
  - Not all questions may need to be answered for each data point or measure
  - Guide - to highlight potential data integrity & data management issues



Data Strategy Worksheet

This worksheet contains a set of questions that can be used to build and review your data strategy to align with your organization's key performance metrics or a family of measures for a specific improvement effort. Not all questions need to be answered for each data point or measure; use this as a guide to highlight potential data integrity and data management issues.

Component	Typical Questions	
Data Requirements	• What core data elements do you need to start with? • Which ones will you need in the future? • What are the sources of that data?	
	Current State:	**Plan of Action:**
Data Governance	• Who owns the data element(s)? • Who defines meanings and valid values? • What is the division of responsibilities between admin, clinical, and IT?	
	Current State:	**Plan of Action:**
Data Quality	• What validity issues are there with the required data? • Availability, accuracy, consistency, timeliness? • What data fixes are required?	
	Current State:	**Plan of Action:**
Granularity	• What level of detail do you need? • Does the data need to be at different levels of detail for different uses?	
	Current State:	**Plan of Action:**

SOURCE: https://www.careinnovations.org/wp-content/uploads/2016/07/Data-Strategy-Worksheet-07-20-16-rev.pdf

Incrementally Building a Data Strategy

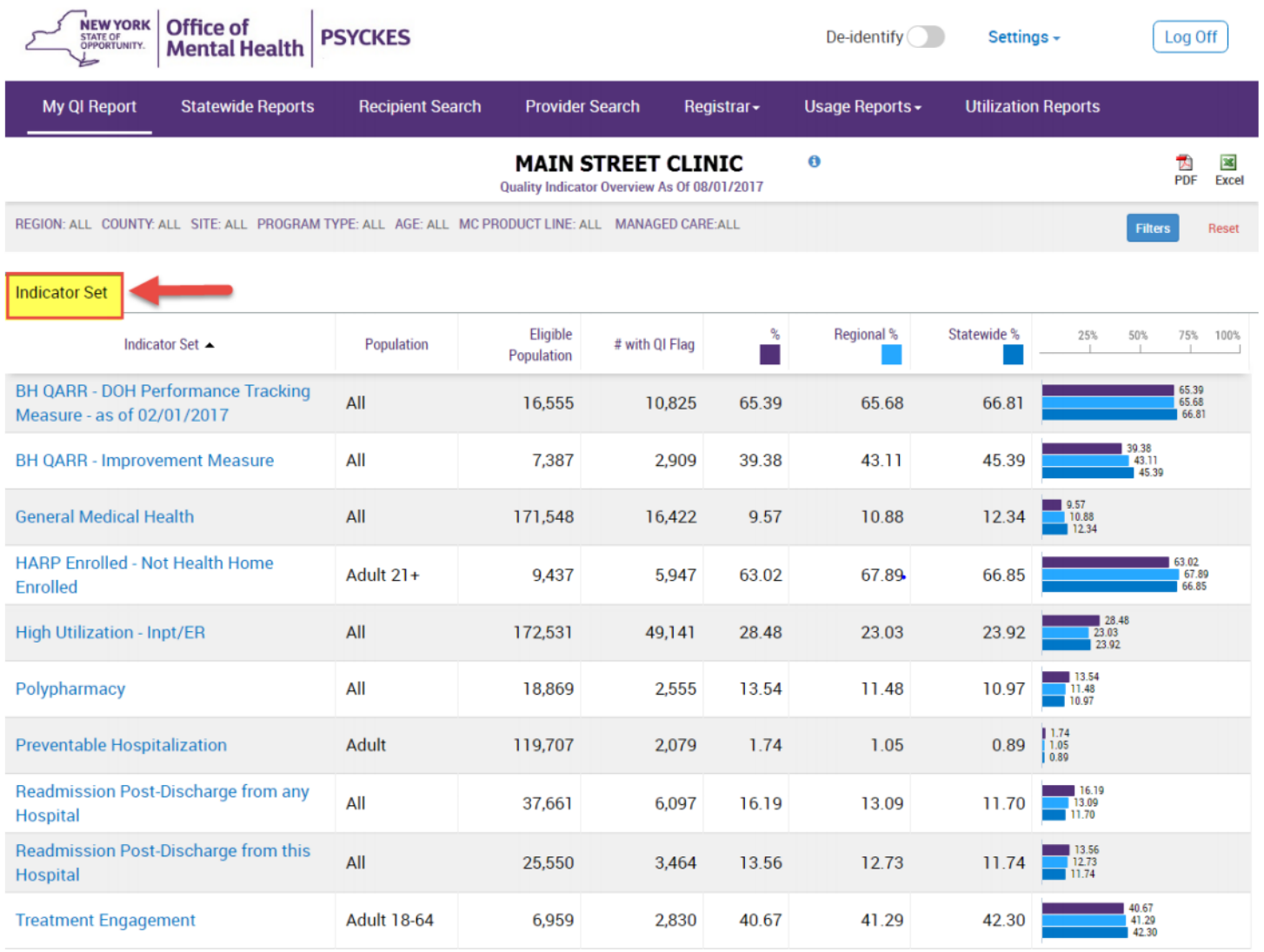
Data Strategy - clarifies the primary purpose of your **data** & guides your agency in the strategic use & management of data to achieve your goals

- **Start with your own data**
  - What can you learn & improve
- **Look for other easily accessible valid data sources to inform your data strategy**
  1. PSYCKES
  2. DOH Medicaid Data Dashboard
  3. CQL

Psychiatric Services & Clinical Knowledge Enhancement System (PSYCKES)

- PSYCKES - web portfolio of tools designed to support quality improvement & clinical decision-making for people covered by NYS Medicaid
- Provides access to a portfolio of quality indicator reports
  - state, region, county, agency, site, program & client level updated weekly or monthly
  - to review performance, identify individuals who could benefit from clinical review, and inform treatment planning
- NYS OMH PSYCHES uses administrative data from the NYS Medicaid claims database to generate quality indicators and summarize treatment histories
  - States are required by CMS to monitor the quality of their Medicaid programs

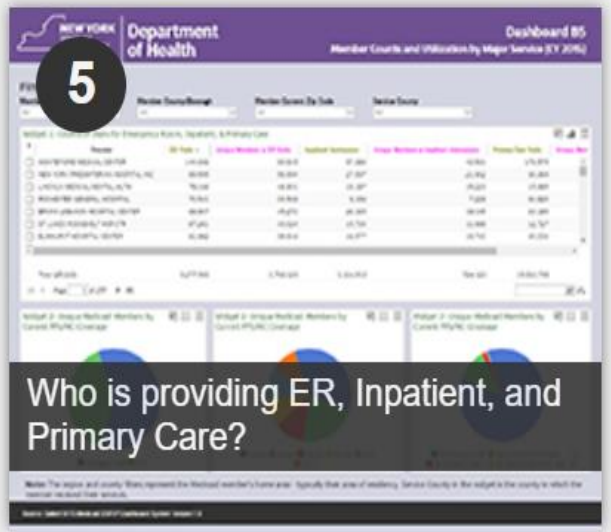
PSYCKES-Medicaid QI Report

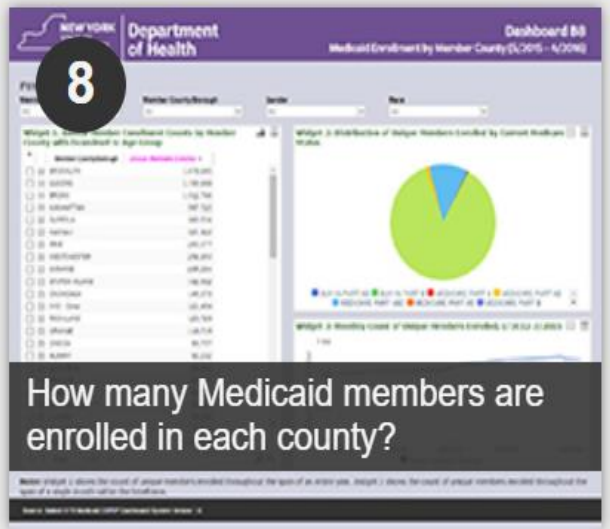


PSYCHES Information

- **Health Claims** - Medicaid claims Medicaid claims - BH Services & psychotropic medication, illnesses or injuries, outpatient services, hospital services, medications, dental & vision appointments, & labs or x-rays
- **NYS Operated Psychiatric Center (PC) services** - service type, provider (name of state PC), admission date, discharge date/last date billed, & most recent primary diagnosis for the state PC visit(s)
- **DOH Health Home & Care Management** - provider name, start date, end date, & contact name & phone
- **Child & Adult Integrated Reporting System (CAIRS)** - Assertive Community Treatment (ACT) services, provider name, start date & main contact name & phone number
- **Assisted Outpatient Treatment (AOT) order & Treatment (TACT)** - AOT provider name, enrollment date & main contact name & phone number
- **NYS Incident Management and Reporting System (NIMRS)** - critical incidents in real-time, including consumers who have had a suicide attempt (incident date, name of the provider & program reporting the incident,& severity/harm resulting of attempt

NYS DOH Medicaid Dashboard





CQL Building the Framework for IDD Quality Measures

Identify Outcomes	Produce Culture Change	Need to Invest in Quality
• Quality measures • Methods to assess	• Quality of service & support • VBP services built around the individual	• Funding lags behind commitment to person-centered care • Focus on shared savings
• Dignity • Respect • Potential	• HCBS regs • Person-centered	• Need to focus on business processes & provider skills

SOURCE: CQL Webinars Utilizing Personal Outcomes to Improve Person-Centered Planning & Supports; Social Determinants of Health

Developing a **Data Strategy** enables providers to clarify

- where you are on the technology adoption curve,
- what are your needs & what can you afford in the future, &
- options (build, share & buy) to meet your future needs

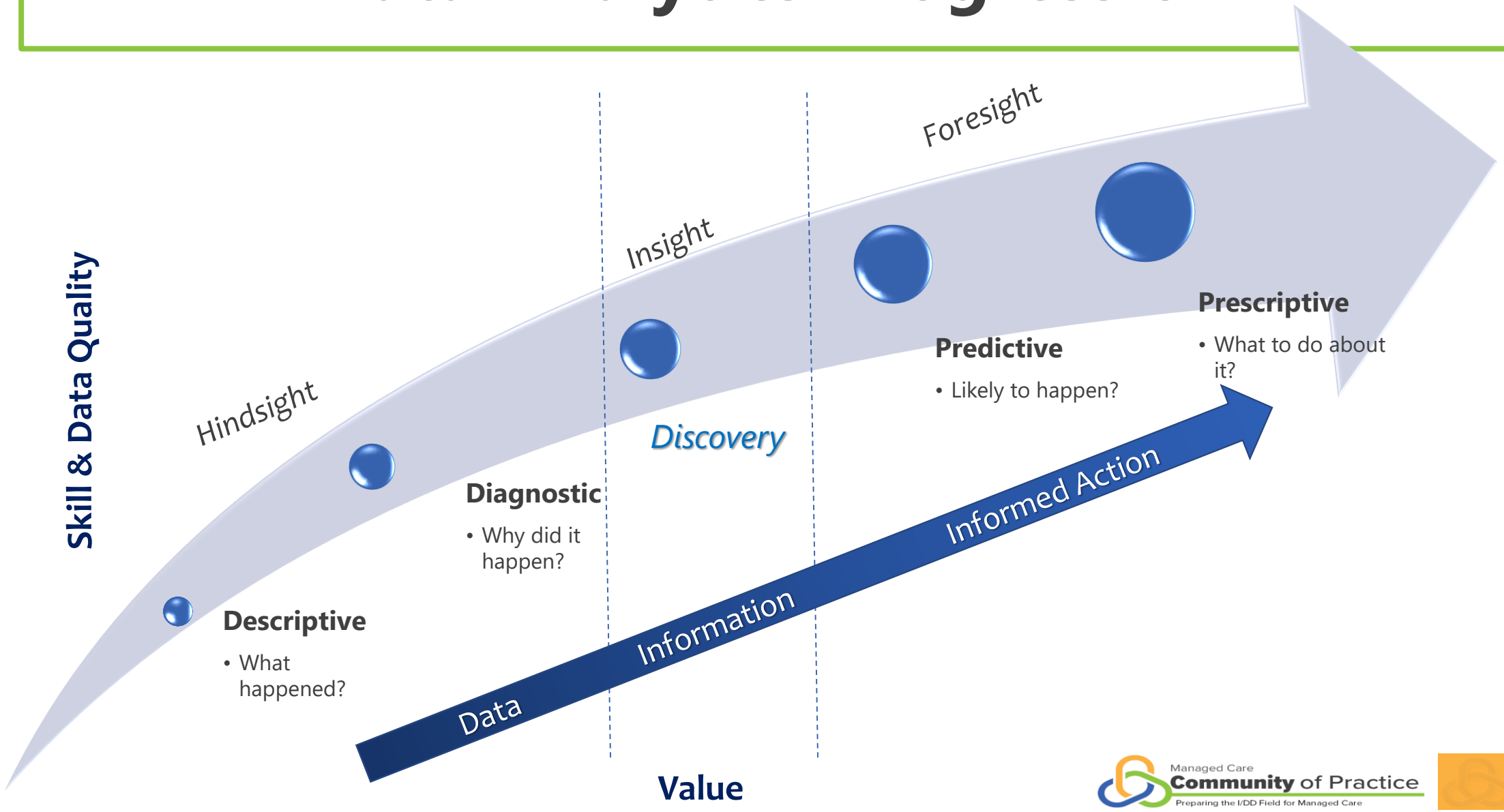
Good Data for the "Soul Purpose"

Without good data, patient-centeredness is just a buzzword.

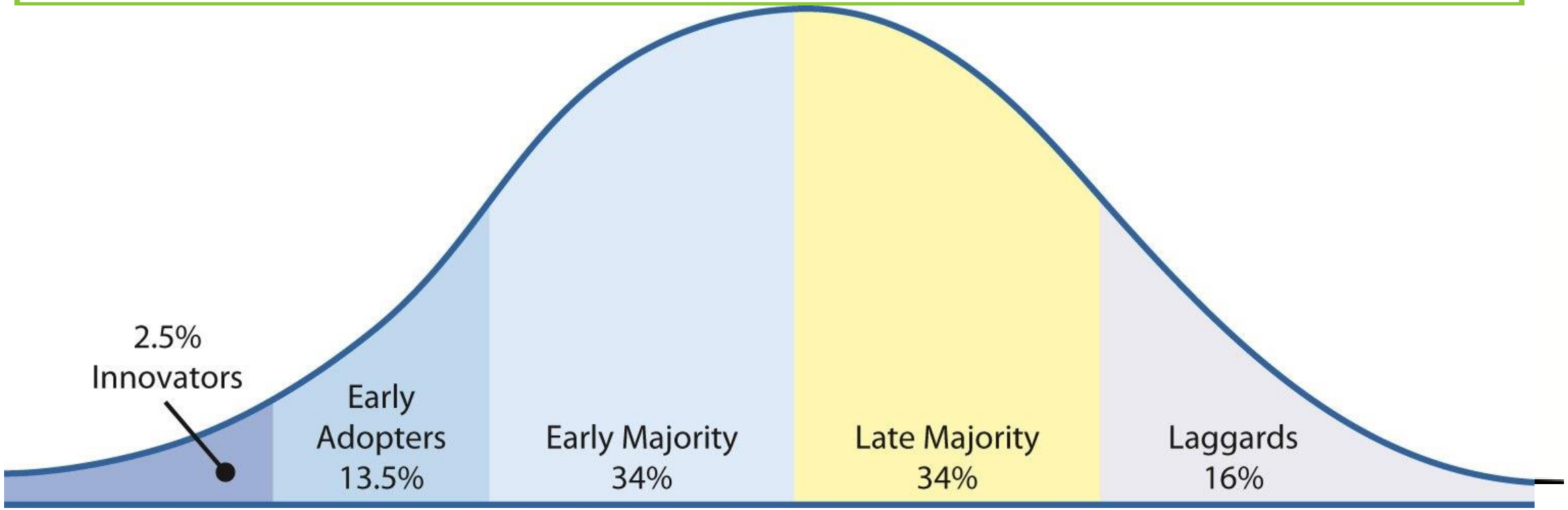
And without a patient-centric focus & proper organization, data can be rather useless.

SOURCE: 5 steps toward a learning health system

Data Analytics Progression



Technology Adoption Curve



Innovators
(2.5%) are risk takers who have the resources and desire to try new things, even if they fail

Early Adopters
(13.5%) are selective about which technologies they start using. They are considered the "one to check in with" for new information and reduce others' uncertainty about a new technology by adopting it.

Early Majority
(34%) take their time before adopting a new idea. They are willing to embrace a new technology as long as they understand how it fits with their lives.

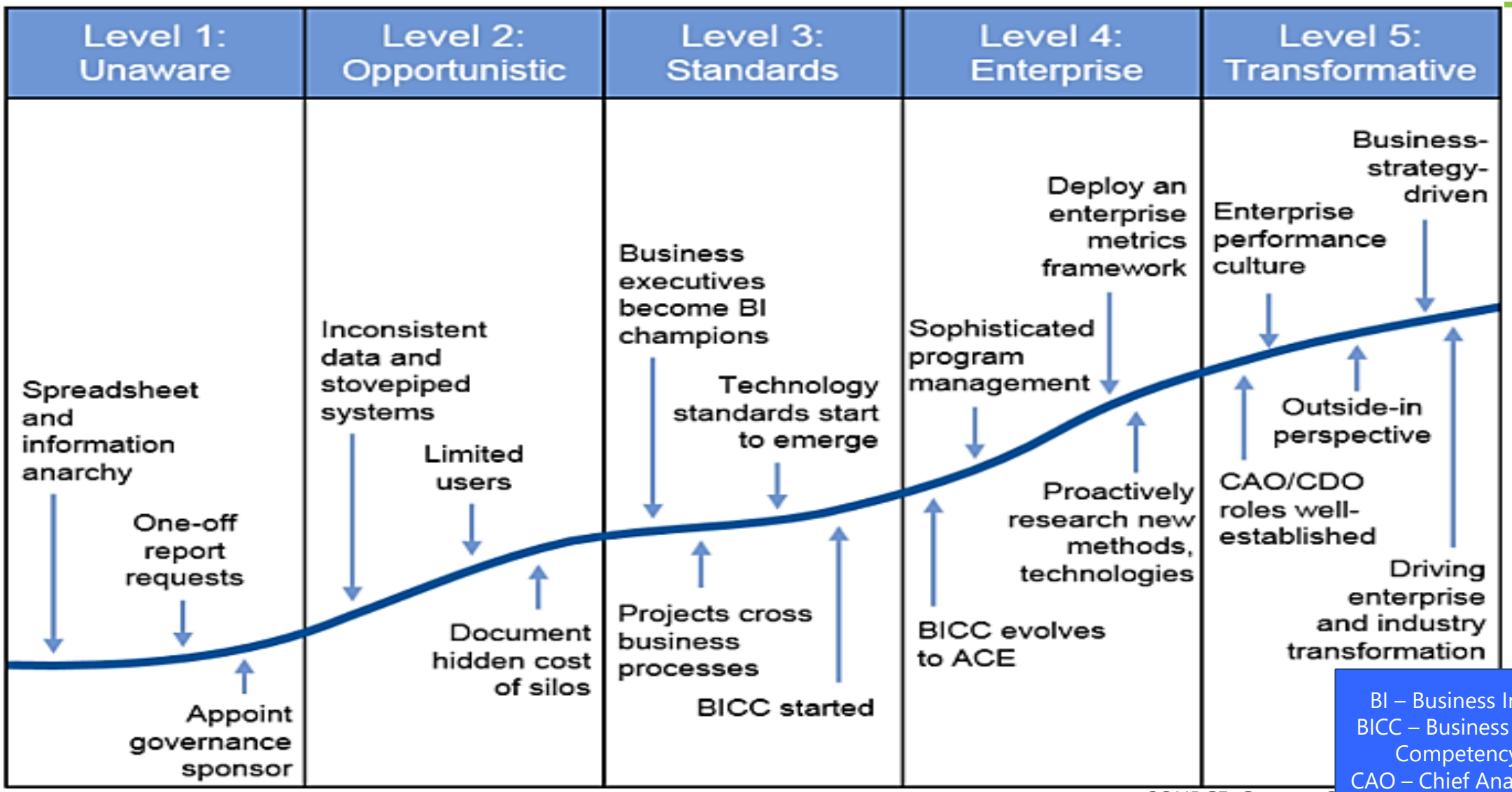
Late Majority
(34%) adopt in reaction to peer pressure, emerging norms, or economic necessity. Most of the uncertainty around an idea must be resolved before they adopt.

Laggards
(16%) are traditional and make decisions based on past experience. They are often economically unable to take risks on new ideas.

SOURCE: Everett Rogers, ***Diffusion of Innovation***

Technology Enabled Transformation

"You have to learn to walk before you run"

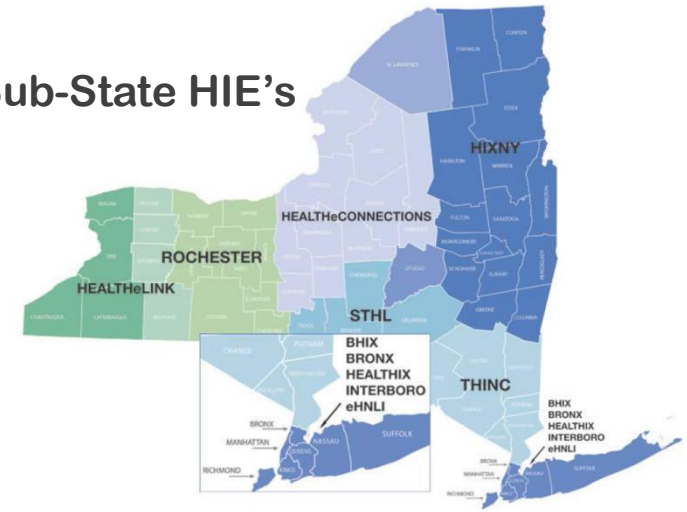


BI – Business Intelligence
BICC – Business Intelligence Competency Center
CAO – Chief Analytics Officer

SOURCE: Gartner, C

NY Health Information Exchange

Sub-State HIE's



Connected to Exchange Health Information

97% of FQHCs

92% of Hospitals

84% of Home Care Agencies

79% of Public Health Departments

49% of Long Term Care Facilities

24% of Clinical Practices

Care Coordination

Applications to manage transitions of care

Analytics

Analytics across multiple sources of clinical & administrative data

Physician Alerts

Real-time messaging at the point of care

Patient Engagement

Tools that allow patients to make better health care decisions and track their own health

A balance of local autonomy & statewide accountability to meet consensus driven expectations base on minimum technical & policy requirements for interoperability

Learning from Colleagues

Large provider of IDD LTSS & residential services with long & stellar history

Commitment to - *Data-driven Culture*

- **QI Committee – root cause analysis on choking incidents**
  - Collected, analyzed data, conducted on-site reviews & interviews, gather additional data – seeking common element
  - Exhaustive research & analysis → identified that a certain type of pork & way it was cooked was the root cause
- **Specific efforts to not only identify, publicize & change practices, but to reward & *recognize the work of the committee***

Learning from Colleagues

Large provider of range of comprehensive services for adults, seniors & children with a range of conditions, including IDD

- **Senior staff – convened comprehensive team to begin a thorough examination of incident report from across their system**
  - No data strategy, little consistent report, challenges with small issues escalating to Justice Center investigations
  - No chronic disease management programs – begin reviewing all ER visits each week
- **Began a pilot Population Health Model – RN TeleHealth Triage Model**
  - Decrease caseloads – redesigned RN goals for care management
  - Begin visual data modeling – across system
  - **Decreased ER utilization by 50%**
  - Identified key conditions that require
    - **Specialist care – Cardiology, Neurology & Psychiatry**
    - **Fall prevention training** -

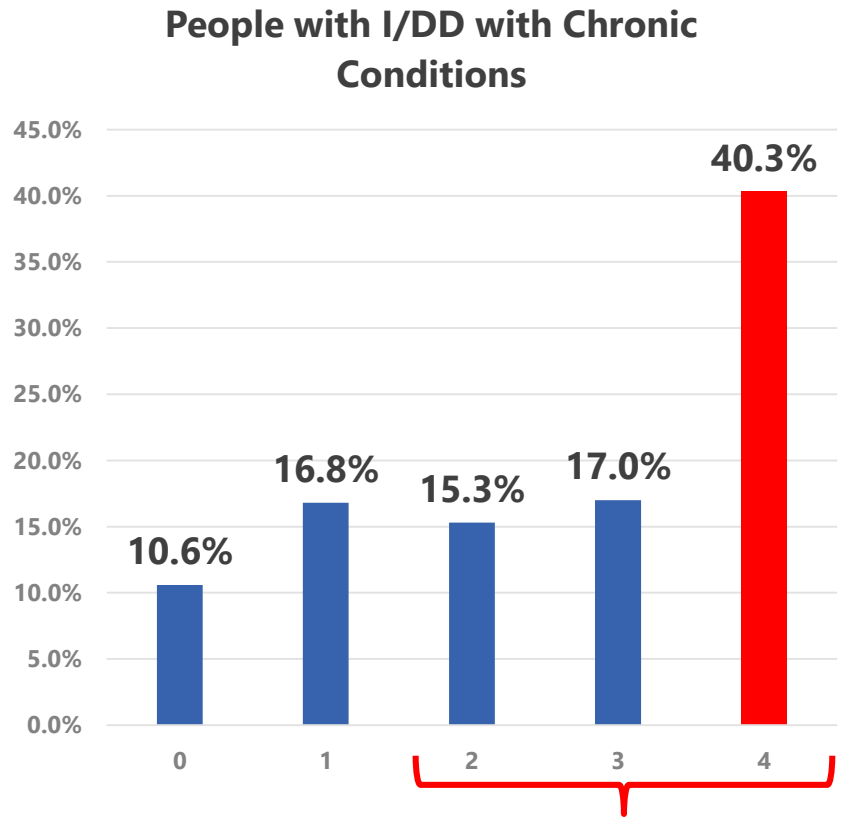
Improve Health of Population

Population Health

- Health outcomes of people with I/DD, & outcome distribution within the population – focuses on
  - significant health concerns &
  - addressing problems driving poor health conditions in the population

People with I/DD *compared to other adults have*

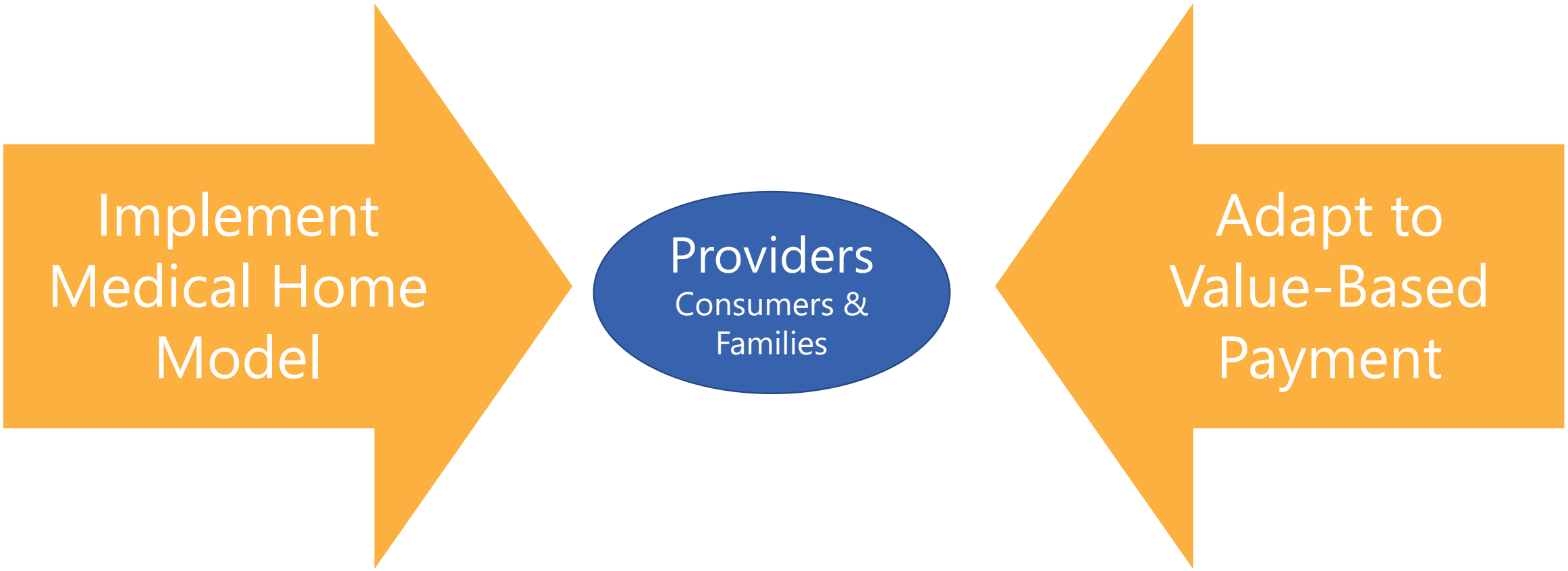
- **1.5 times higher** incidence of
  - congestive heart failure,
  - COPD,
  - diabetes &
  - psychiatric conditions
- **50% higher** frequency of ER visits
- **2 times** as likely to be hospitalized &
- **69% readmission** rate



72.6% of the population with I/DD have **2 or more chronic conditions**

NYS Convergence

NYS DOH funded project – small physician practice collaboration



Convergence of *Standards* & *Payment* Models

Person-Centered Health Home

- Improve quality of care & reduce costs of care, particularly for individuals with multiple chronic diseases,
- Reduce avoidable hospitalizations & emergency department visits
- Focus on improving
  - access to & continuity of care,
  - comprehensive & coordinated care & care management for high-risk individuals
  - quality & consumer engagement, &
  - planned care and actions to improve population health
- **Standards** - National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH)

Value-Based Payment

- VBP to reward providers for health, quality & cost outcomese
- Providers contract with MCO to manage quality, costs & care for a defined group of "attributed" individuals "
  1. **Shared savings** providers share in any savings generated compared to an expenditure benchmark
  2. **Shared risk** - providers at-risk for expenditures above the benchmark
  3. **Performance incentives**
  4. **Bundled payment**
- **Payment** - VBP contract to
  - improve performance on specific quality measures &
  - reduce utilization & cost for covered members

SOURCE: https://www1.nyc.gov/assets/doh/downloads/pdf/public/phip-report2018.pdf

Develop New & Required Skills & Capabilities

Cumulative, sequential & stepped investments

Health Information Technology

EHR - track & assess client population & proactively recall clients for follow-up or assessment

Participate in health information exchange - receive alerts such as ED visits, or hospital admissions, discharges, or transfers

Health Home

'Transform" workflows – scheduling, systematizing care management, & connect community supports

Train staff on new roles, teamwork, & new personnel

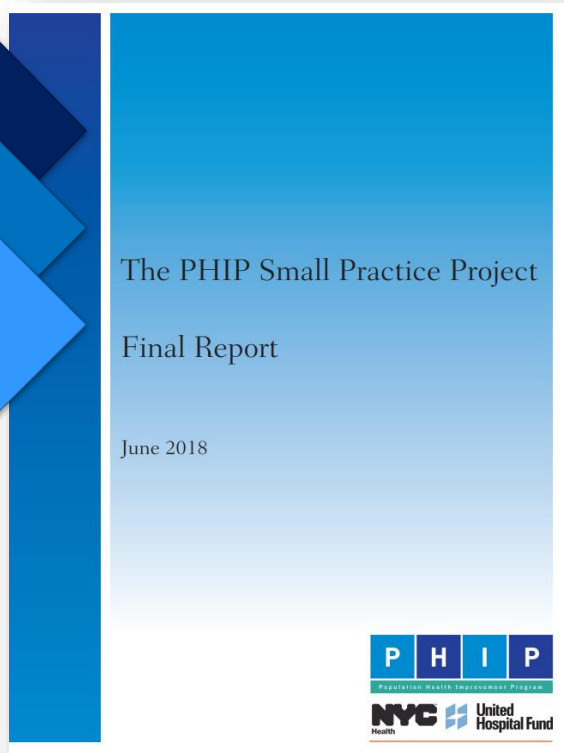
Change operations & cash-flow to achieve Health Home recognition

Value-Based Payment

Negotiate & manage payer VBP contracts to achieve measurable results

Develop data & analytic capacities to use data to improve care

New staff & contracts with outside experts



High-Priority for Shareable Services

NYC Population Health Improvement Program - viability of a *shared-services models*

Health Information Technologies	Business / Administrative Services	Data Analytics & VBP Support	Quality Improvement (QI) Staff & Services	Professionals who Interact with Clients
• EHR – purchase, optimized use, technical assistance & life cycle maintenance • Registry – for care management • Regional Health Information Organization (RHIO) – connectivity & optimized use	• Group purchasing of business supplies & services • Revenue management & improvement • Workforce development, staff training & practice management support	• Analytics - clinical & claims data for QI • Population attribution analysis for VBP • Report on quality, utilization measures & outcomes • Negotiate VBP contracts	• Shared staff to support QI • Shared QI, learning collaboratives, sharing best practices • Benchmarking quality measures, outcomes across participating providers	• Specialized professional - nutritionists, diabetes educators, BH professionals • Care Coordination & Management • Client outreach & engagement

Adapted from the NYC United Health Fund, Population Health Improvement Project, Small Project Final Report 2018


PROFITS
SALES
"What if we don't change at all ...
and something magical just happens?"

Questions

Data – Information – Insight

Managed Care CoP – *1st in series*

VBP requires **data analysis capabilities –** *learning "how"*

Data Governance & HIT capabilities – *start with own data to improve LTSS*

Data Strategy – *where you are, are going & options*