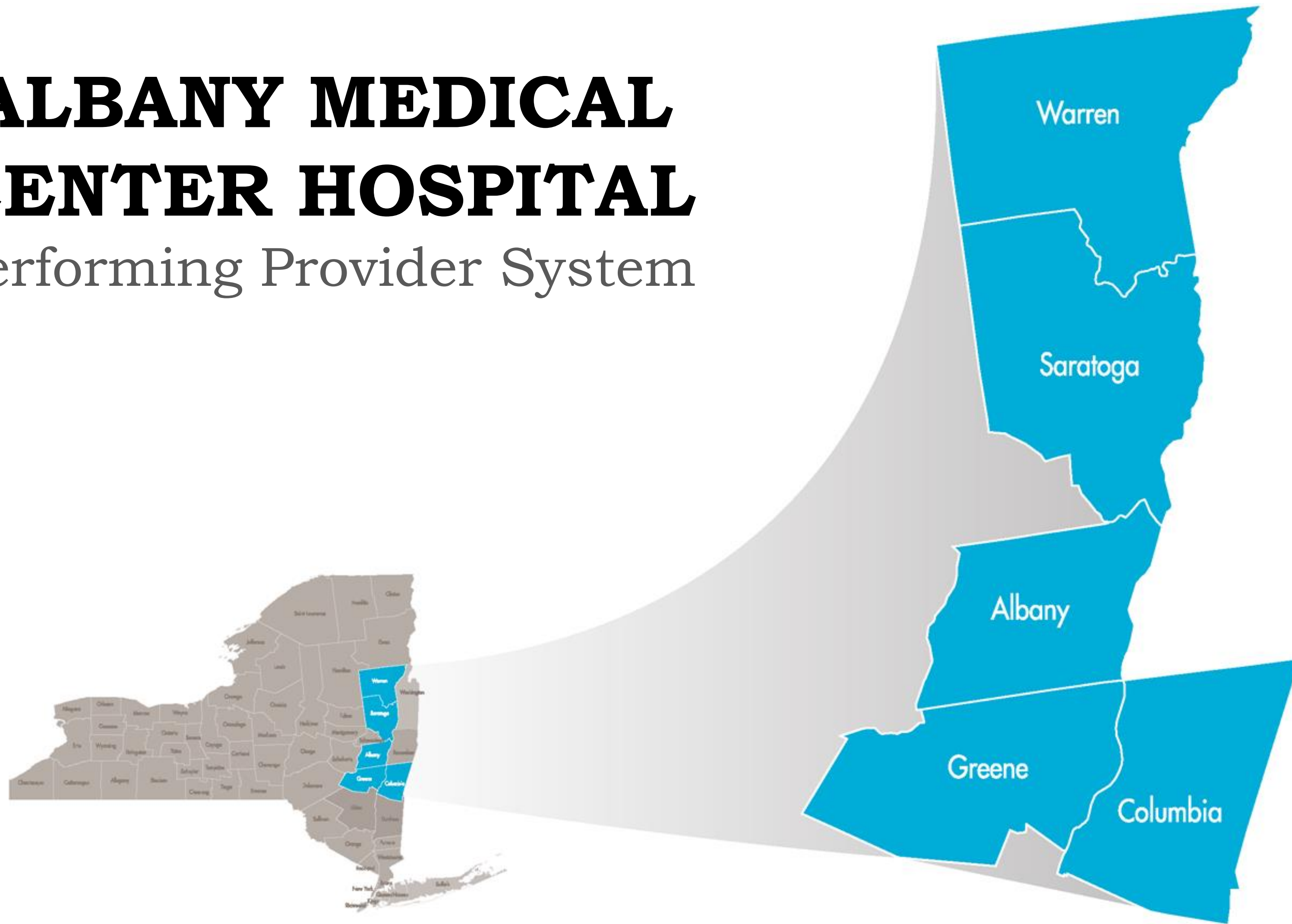
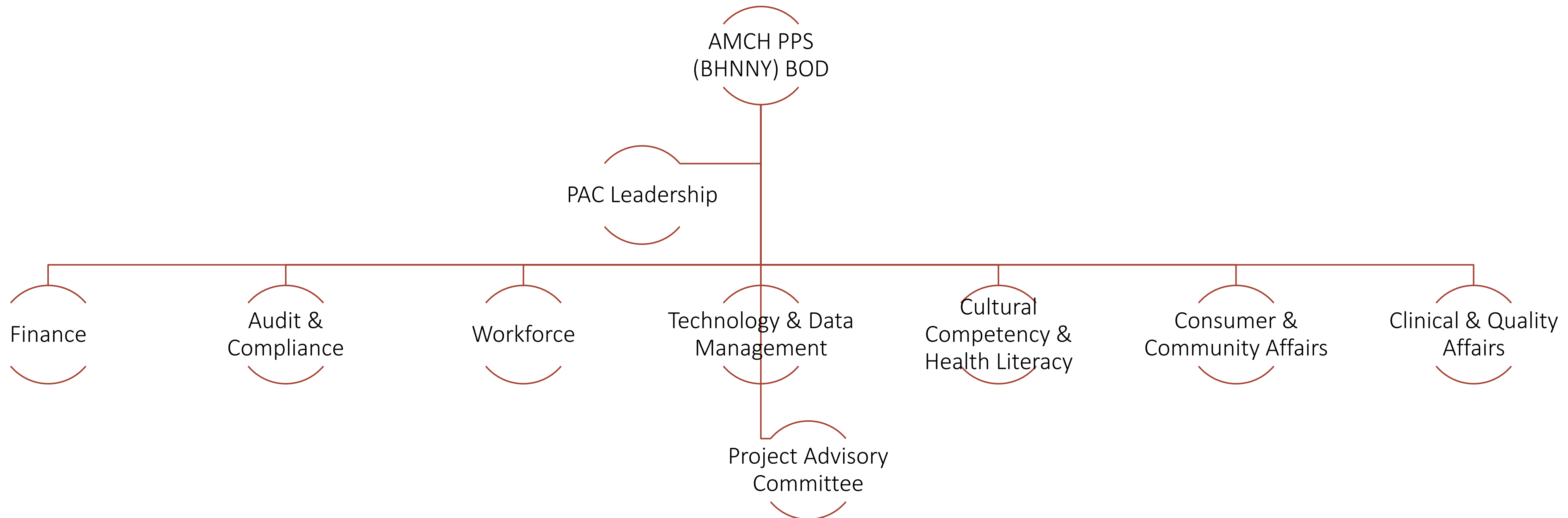
ALBANY MEDICAL CENTER HOSPITAL

Performing Provider System



Louis Filhour, PhD, CEO; Christine McIntyre, MPH, COO; Kallanna Manjunath, MD, FAAP, CPE, CMO; Lauren Ayers, MBA, CFO
Wilma Alvarado-Little, MA MSW

AMCH PPS (Better Health for Northeast New York) Governance Structure



Value Based Purchasing and Funds Flow

Financial Sustainability

Surveyed partners on various financial ratios and requested financial statements
[days cash on hand, debt ratio, operating margin, current ratio, debt service coverage and working capital]

Budget subcommittee set benchmarks for ratios

Analysis to define organizations that provide unique and critical services

Will provide performance improvement plan, training, and technical assistance

Value Based Purchasing

Monthly VBP Workgroups established April 2016

Membership includes 4 MCOs, 12 partner organizations including 6 PCPs and 2 CBOs

Co-chairs: 1 Partner Organization, 1 MCO

Provides education/guidance to network

VBP assessments completed in 2015 and 2016

- Current State, future plans, educational needs, and barriers

Implementing education sessions based on new guidance – **DY3**

Education session topics based on partner feedback and identified needs

Develop VBP support implementation plan

Contracting Process

Partner Organization Agreement

- Five-year boilerplate agreement, no funding implications

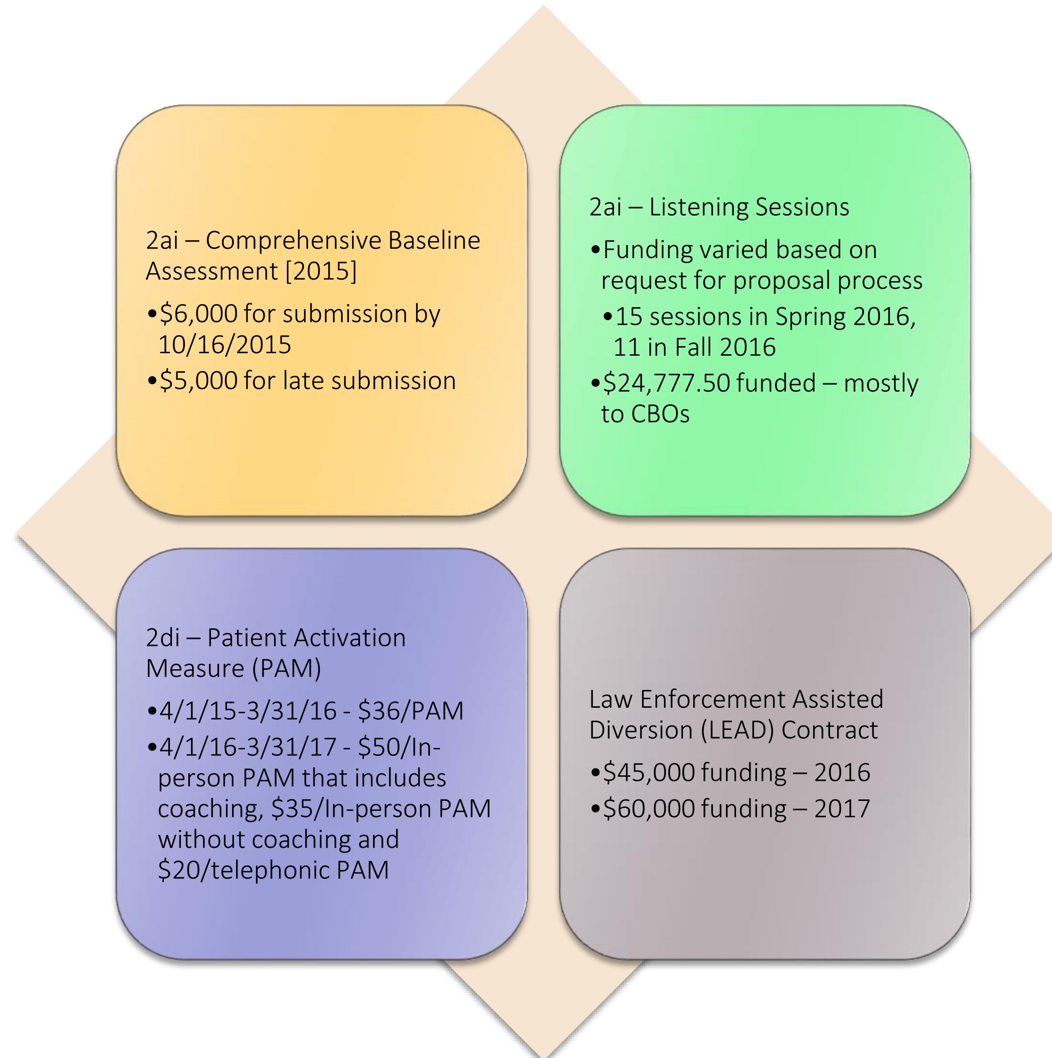
Master Project Agreement & Exhibit A – Phase 1

- 04/01/15-12/31/16
- $9.7M allocated to Phase 1, 3 payment periods
- Focused on engagement activities, policies/procedures, job descriptions (patient navigators), training & assessments

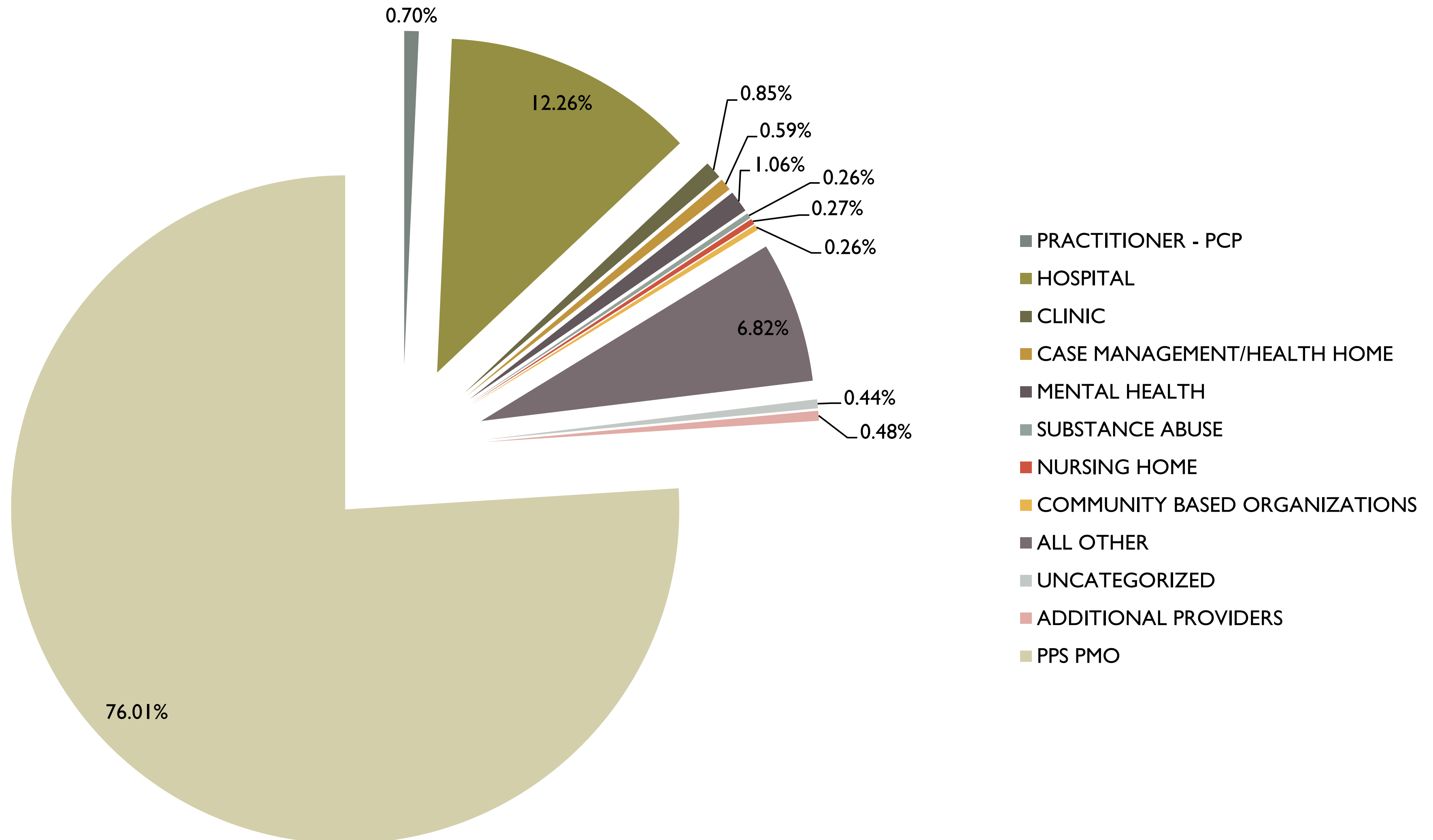
Master Project Agreement & Exhibit A – Phase 2

- 01/01/17-03/31/18
- $13M allocated to Phase 2
- Focused on performance measures and outcomes

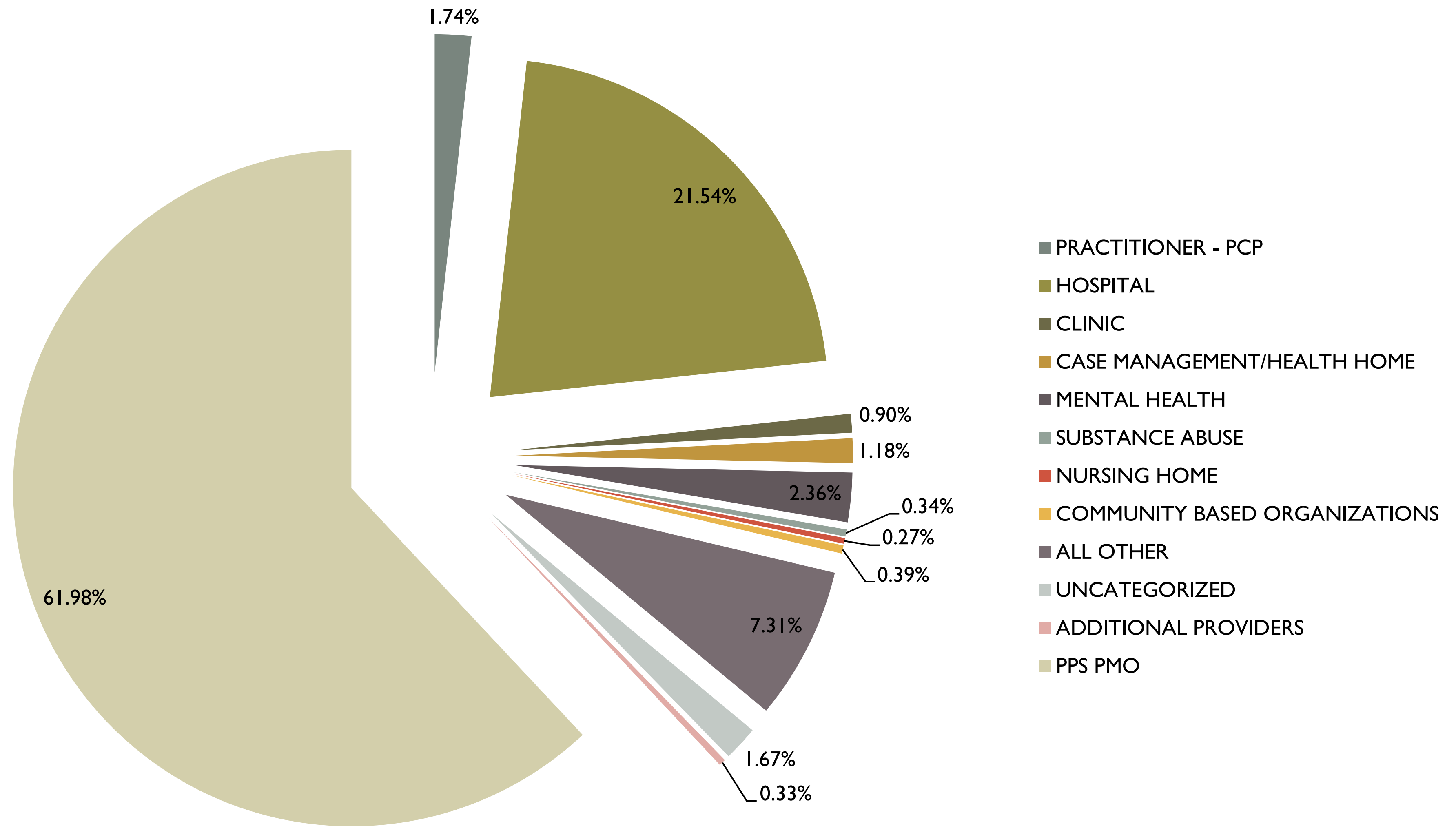
Contracting Process



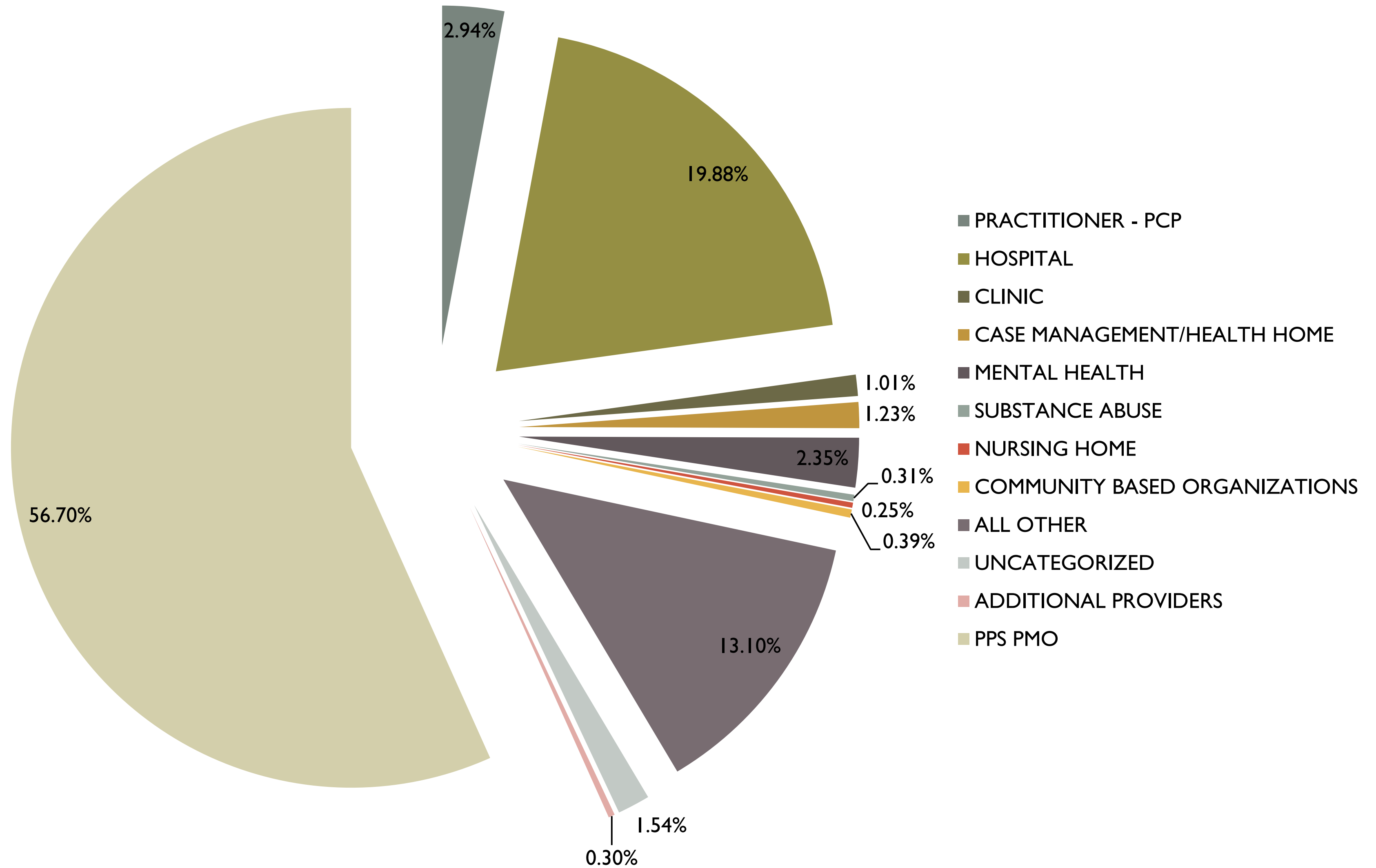
Funds Flow by Provider Type as of 09/30/2016



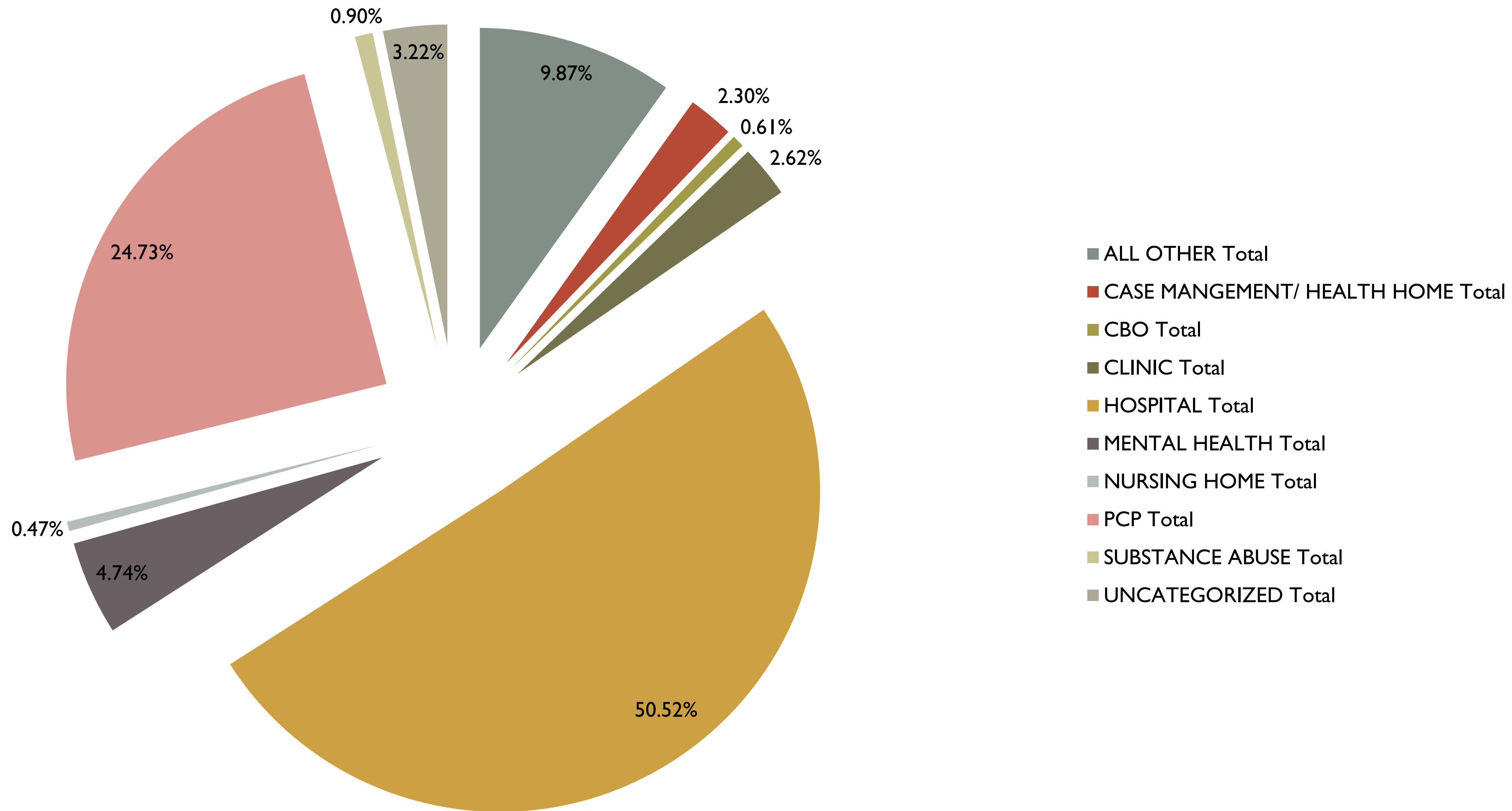
Funds Flow by Provider Type as of 12/31/2016



Funds Flow by Provider Type as of 01/31/2017



Phase I Contract – Committed Funds Flow



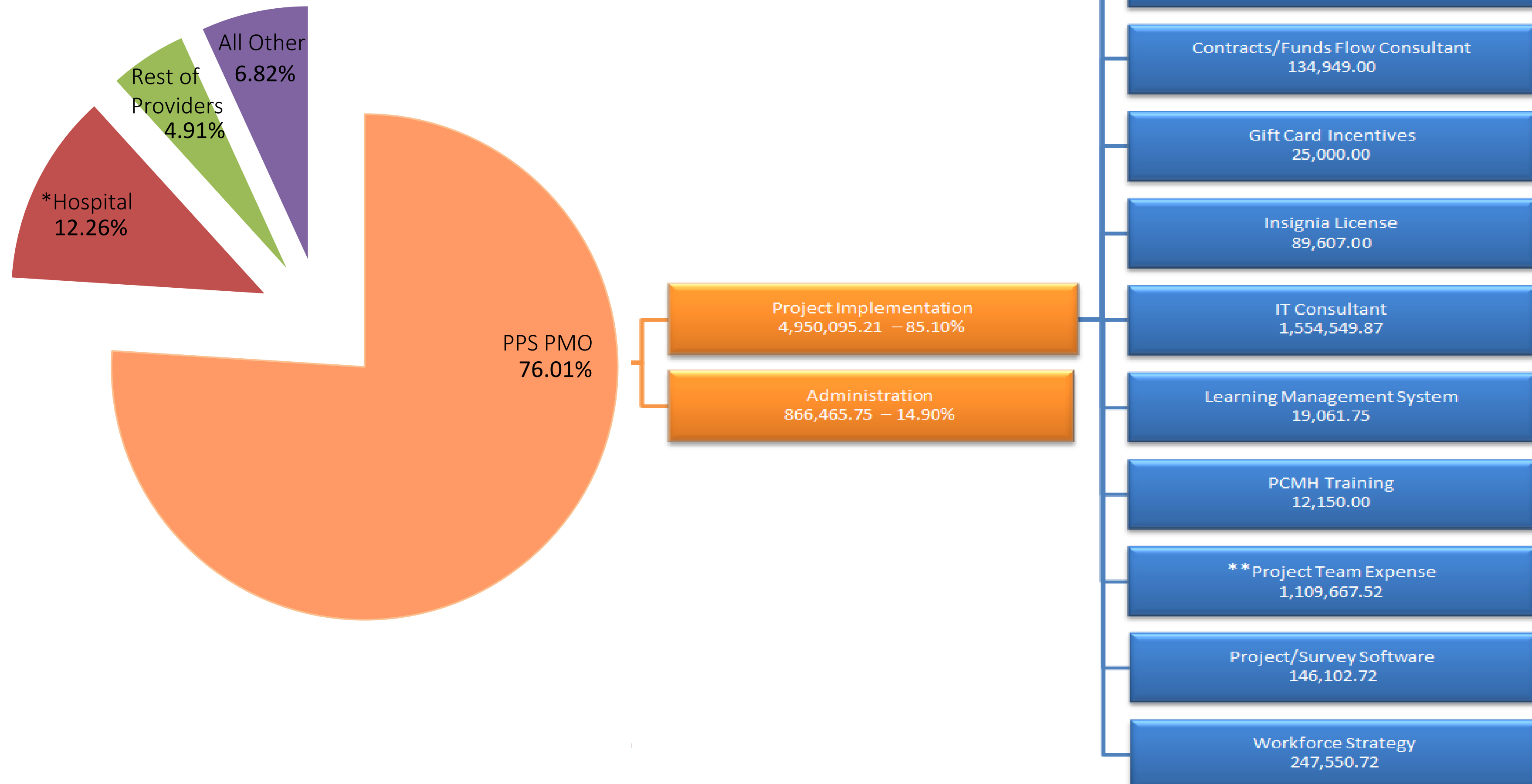
Funds Flow Reconciliation – through 1/31/2017

Provider Type	PIT Provider Type Allocation Through DY2Q3	Reclassified Provider Type Allocation Through DY2Q3	VAR %	PIT Provider Type Allocation Through 1/31/2017	Reclassified Provider Type Allocation Through 1/31/2017	VAR %
All Other	823,695.00	28,882.00	-96.5%	1,609,181.00	32,893.00	-98.0%
Case Management / Health Home	134,097.00	190,333.00	41.9%	153,037.00	209,673.00	37.0%
Clinic	82,117.00	72,260.00	-12.0%	105,449.00	95,592.00	-9.3%
Community Based Organizations	79,232.00	324,872.00	310.0%	83,366.00	333,487.00	300.0%
Hospital	2,408,913.00	2,408,913.00	0.0%	2,432,038.00	2,432,038.00	0.0%
Mental Health	350,025.50	343,584.50	-1.8%	373,774.50	367,333.50	-1.7%
Nursing Home	32,231.00	29,350.00	-8.9%	32,231.00	29,350.00	-8.9%
Practitioner - Primary Care Provider (PCP	232,861.00	816,253.00	250.5%	397,549.00	1,760,010.00	342.7%
Substance Abuse	37,473.00	37,906.00	1.2%	37,473.00	37,906.00	1.2%
Uncategorized	71,709.00	-	-100.0%	74,184.00	-	-100.0%
Grand Total	**4,252,353.50**	**4,252,353.50**		**5,298,282.50**	**5,298,282.50**	

***All Other includes providers that perform home health services

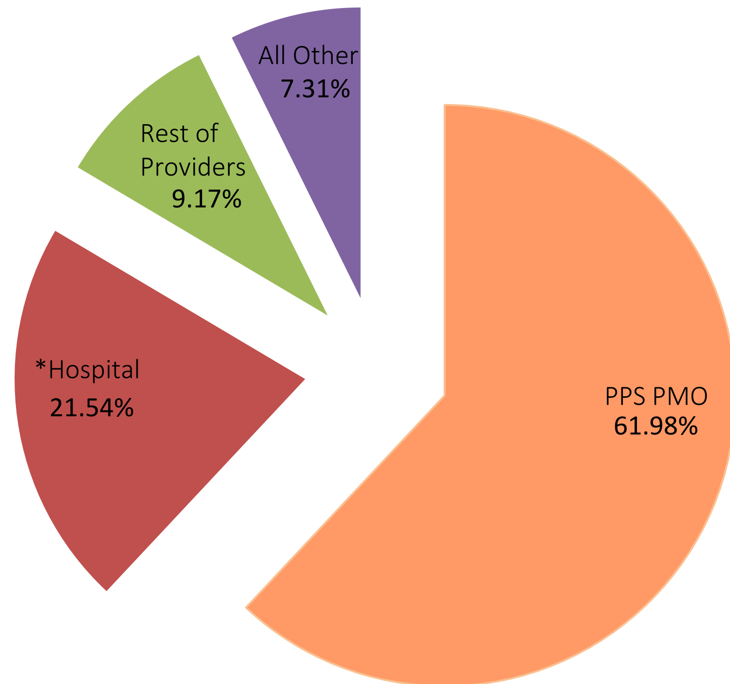
***CapitalCare (PCP) classifed as "all other" in PIT, Catholic Charities (CBO) classified as "all other" or "uncategorized."

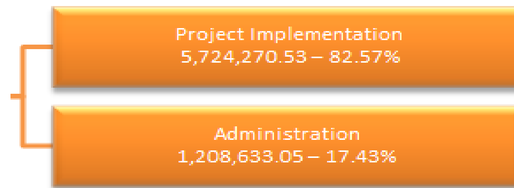
Allocation of Funds 4/1/2015-09/30/2016 [Through DY2Q2]

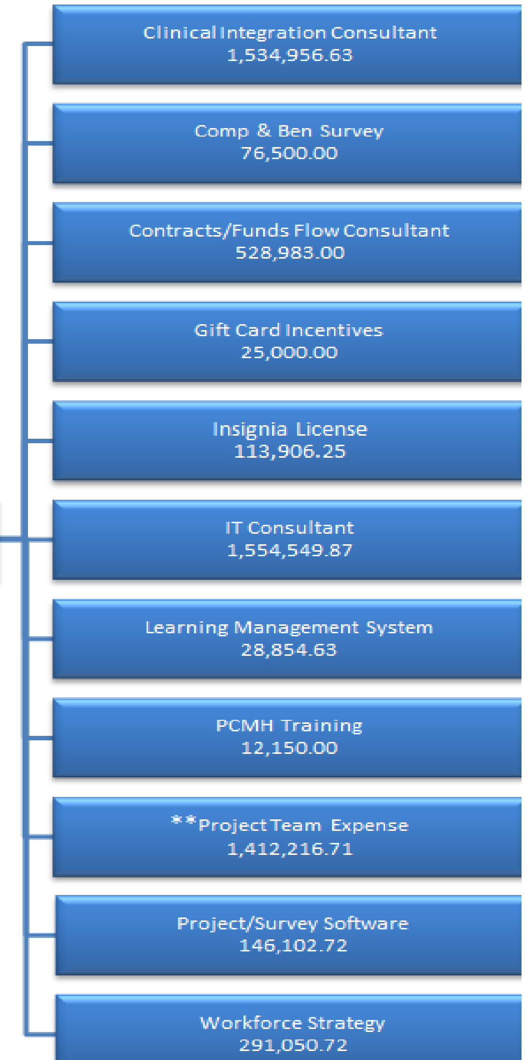


*Hospital partner contracts represent funds flowed to both hospitals and primary care practices
**Includes project manager salaries and project related travel

Allocation of Funds 4/1/2015-12/31/2016 [Through DY2Q3]







*Hospital partner contracts represent funds flowed to both hospitals and primary care practices

**Includes project manager salaries and project related travel

CULTURAL COMPETENCY &
HEALTH LITERACY

Cultural Competency & Health Literacy Strategies

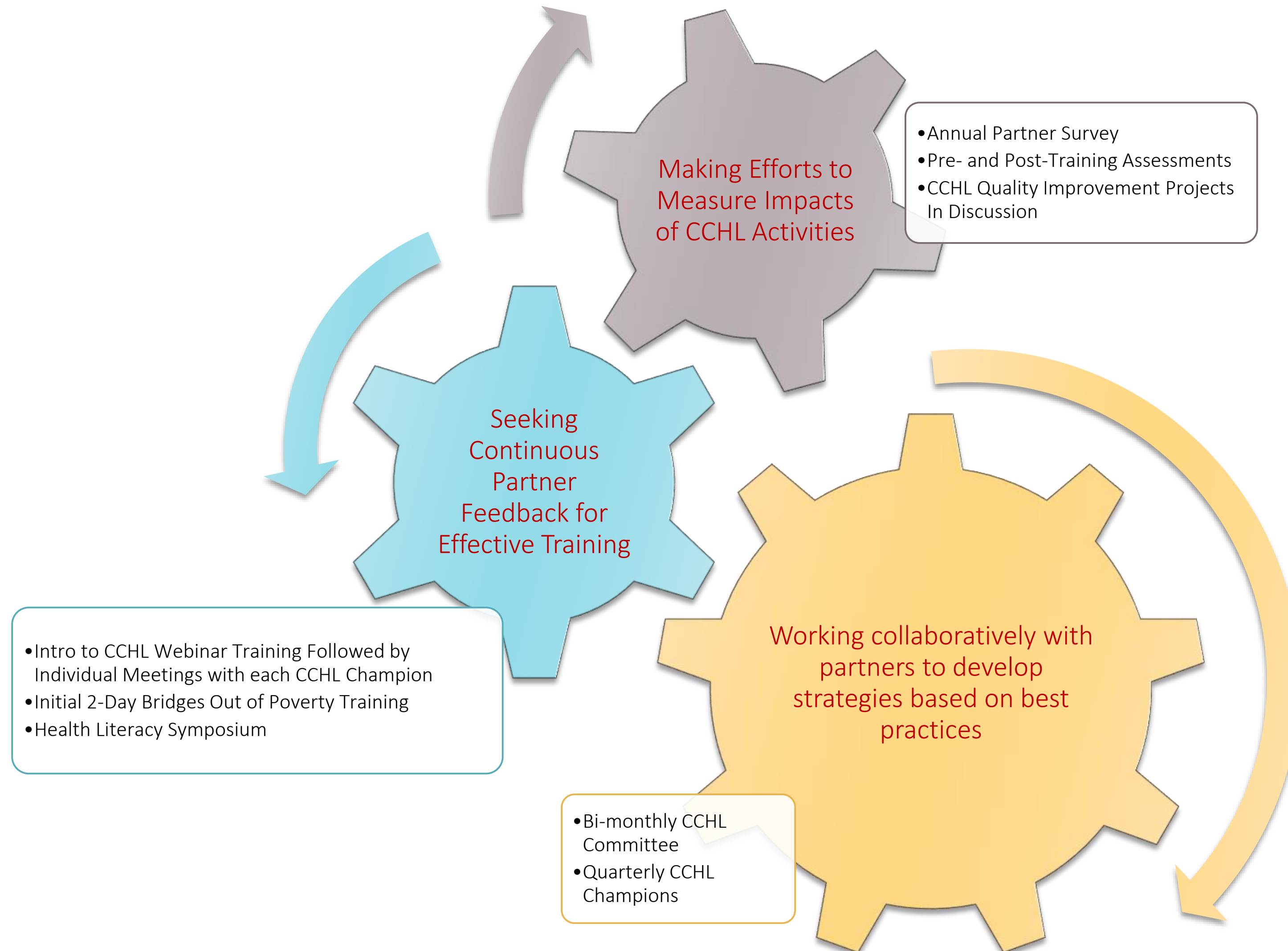
AMCH PPS Cultural Competency & Health Literacy Strategy

- Organizational focus
- Trainings
- Communications
- Patient navigators/care coordinators
- Patient Education
- Language Services
- Metrics

AMCH PPS Cultural Competency Training Strategy

- Link with DSRIP project needs:
  - Motivational Interviewing, Teach-back method, Mental Health first-aid
- Bring Cultural Shift
  - Cross-cultural training/cultural competency 101, Social determinants of health/Bridges Program, ACEs and trauma-informed care
- Increase education about how to better care for patient subpopulation
  - including language access/limited English proficiency (LEP) population, Geriatrics, Refugees, LGBTQ, Disabled population, faith-based communities

Cultural Competency & Health Literacy Processes



COMMUNITY RELATIONS &
CBO ENGAGEMENT

Ongoing Community Relations & CBO Engagement

Face to Face meetings with CBOS [Where does my CBO fit?]

PAM Plus-Amida Care; LEAN Training

Strengthening communication through newsletter and dashboards

Great American Smoke Out Innovative Collaboration

*Public Forums and collaboration with AFBH & AHI]

Consumer Listening Sessions

Participation in community events [CBO networking; Voice Your Vision, YMCA & Albany County DOH]

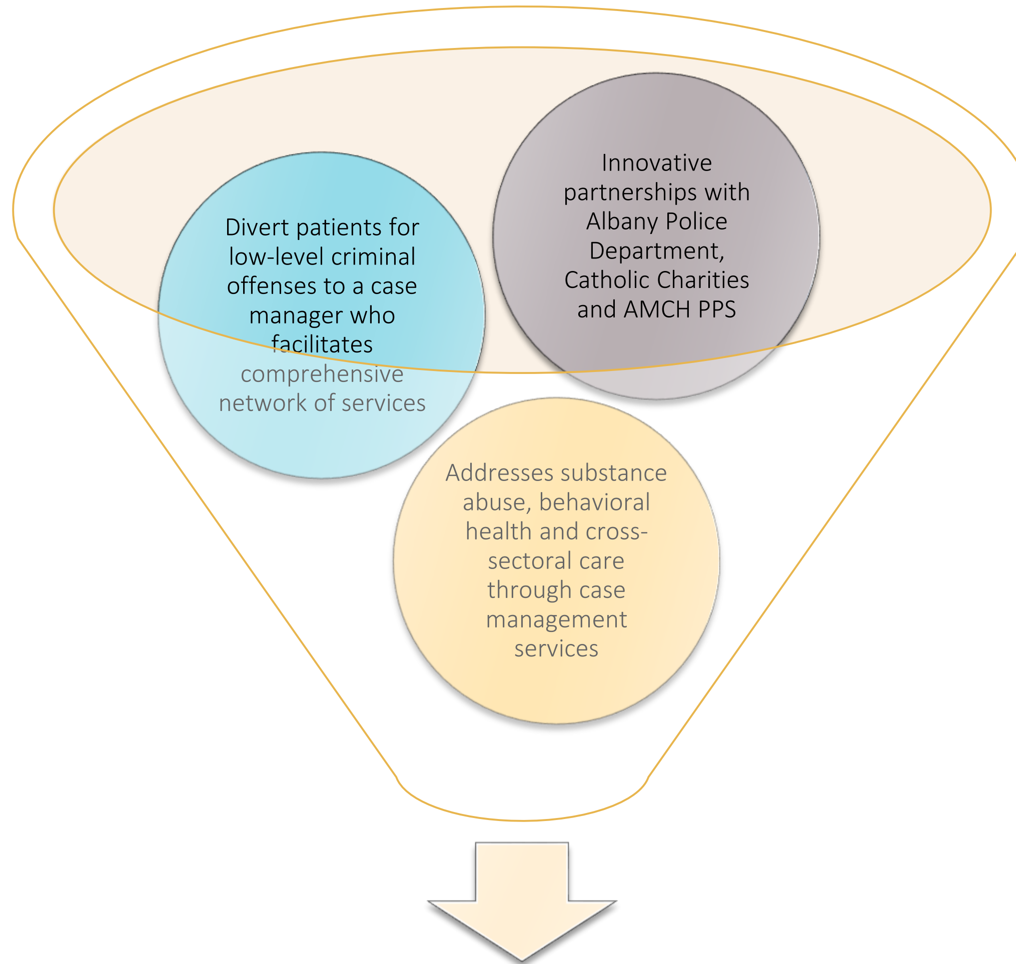
Consumer and Community Affairs

Identify community and gaps in services for the DSRIP initiative; and Maintain and foster collaborative relationships/partnerships with CBOs

Community Relations & CBO Engagement

Alcohol and Substance Abuse Prevention Council of Saratoga County	Hudson Mohawk Area Health Education Center
Black Nurses Coalition, Inc.	In Our Own Voices, Inc.
BOCES CAPIT	Independent Living Center of the Hudson Valley, Inc.
Capital District YMCA	Interfaith Partnership for the Homeless
Capital Region BOCES	Mental Health Association of NYS
Catholic Charities of Columbia and Greene Counties	Mental Health Empowerment Project, Inc.
Catholic Charities Senior and Caregiver Support Services	NY START
Catskill Hudson Area Health Education Center	Shelters of Saratoga
Community Caregivers	St. Paul's Center, Inc.
Compeer, Inc.	The Alternative Living Group, Inc.
Consumer Directed Choices, Inc.	The Next Step, Inc.
DePaul Housing Management	The Quality and Technical Assistance Center of NY
Greene County Rural Health Network	Troy Crossings, LLC DBA The Pines at Heartwood
Healthy Capital District Initiative	Wildwood Programs, Inc.
Hope House, Inc.	

Law Enforcement Assisted Diversion (LEAD)

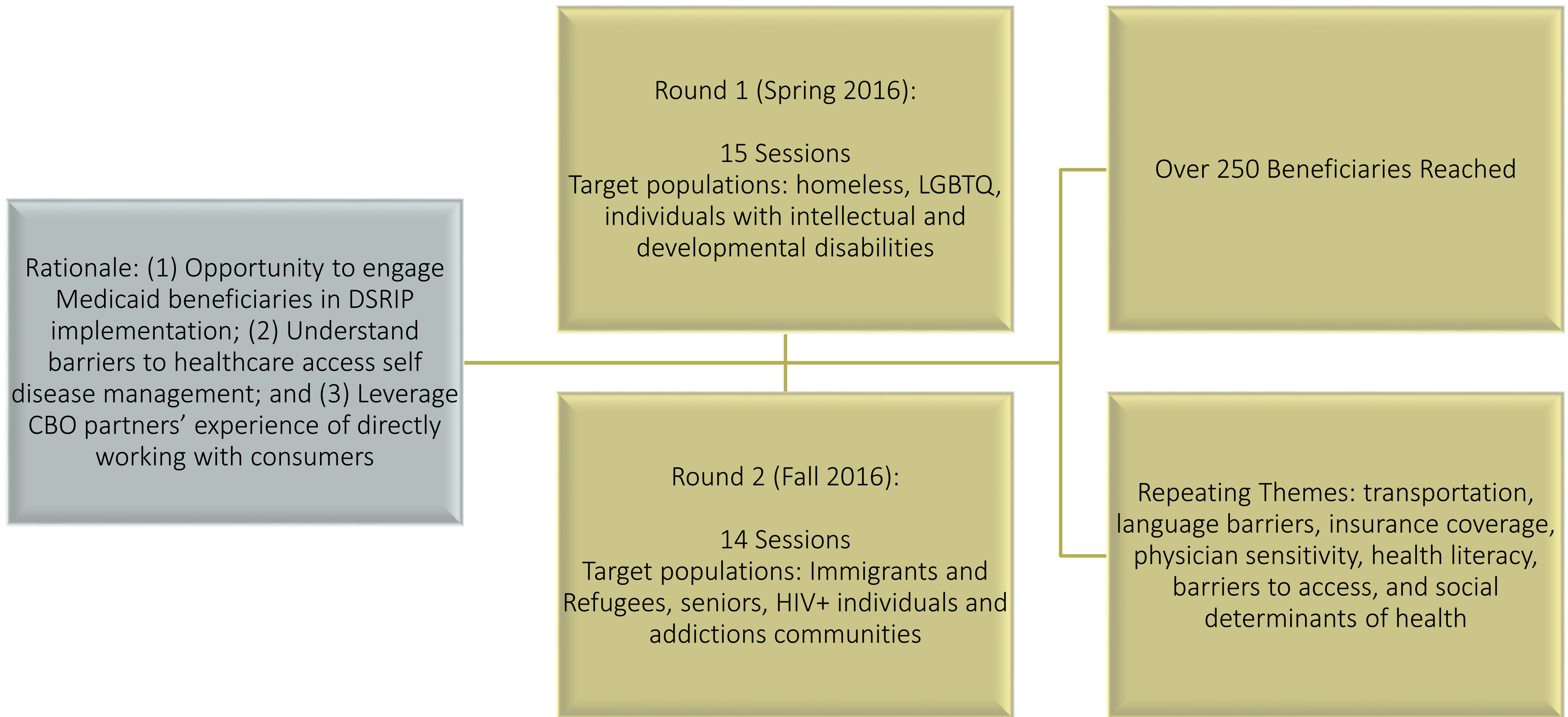


Reduce recidivism and unnecessary Emergency Department visits

DSRIP 360 Survey

CONSUMER LISTENING SESSIONS

Consumer Listening Sessions



Immigrant and Refugee Consumer Listening Sessions

သင်သည် မြန်မာနိုင်ငံမှလာပါသလား။

သင်သည် (အော်လဘာနီ) Albany မြို့ တွင်နေထိုင်ပါသလား။

သင့်ကျန်းမာရေးအကူအညီပေးမှု (Medicaid) ရရှိပါသလား။

(သို့) ကျန်းမာရေးအာမခံ (Insurance) မရှိခြင်း။

ကျွန်ုပ်တို့ သည် သင်၏ကျန်းမာရေးပြုစု စောင့်ရှောက်မှုအား တိုးတက်လာစေရန် ကြိုးပမ်းဆောင်ရွက်နေပါသည်။

ကျွန်ုပ်တို့ နှင့်တွေ့ ဆုံရန် သင့်အားဖိတ်ကြားအပ်ပါသည်

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အချိန် - ညနေ ၄း၀၀ - ၆း၀၀

Lutheran Church of the Holy Spirit

57 Hurlbut St., Albany NY

မေးခွန်းများရှိပါက

Questions? Call or text Betsy Campisi: 518-596-4984
or email Wilma Alvarado-Little:
interpreter@walvarado-little.net

Burma listening session flyer_Burmese

Population Represented

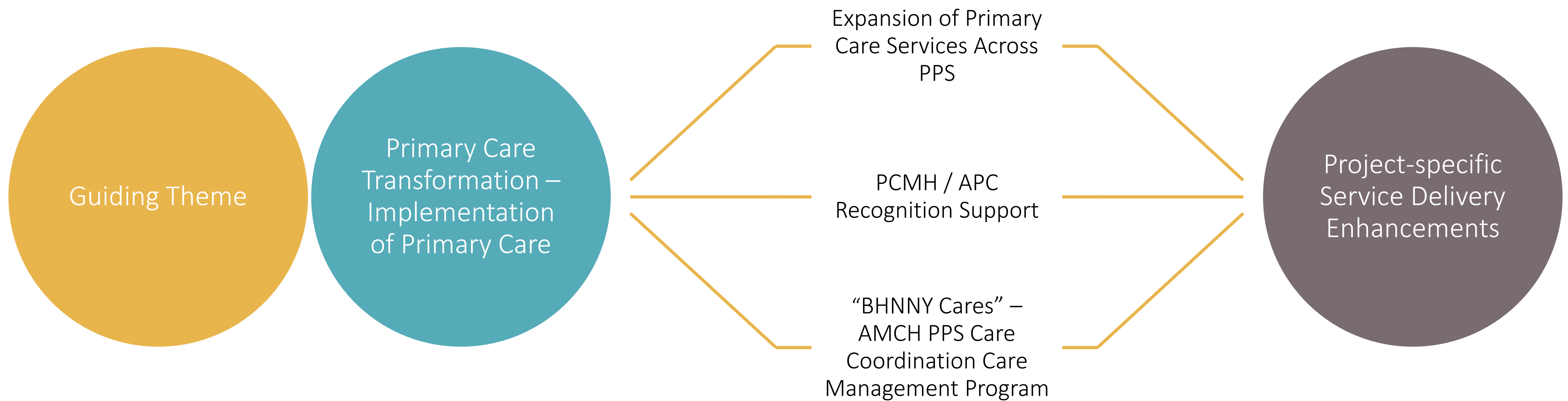
- Session 1: Triqui Community from Oaxaca, Mexico
  [Partnered with Triquis Sin Froneras]
- Session 2: Chin, Burmese and Karen
  [Partnered with Lutheran Church of the Holy Spirit]
- Session 3: Syrian, Afghan and Iraqi
  [Partnered with RISSE]

Main Themes and PPS's Next Steps

- Transportation - Identify CBOs with transportation services to expand their current capacity
- Language Barriers - Enhance existing language access services and consider adoption of centralized service for all community-based partners
- Cultural differences in navigating the system - Collaborate with partners to address social determinants of health

Clinical Transformation Team

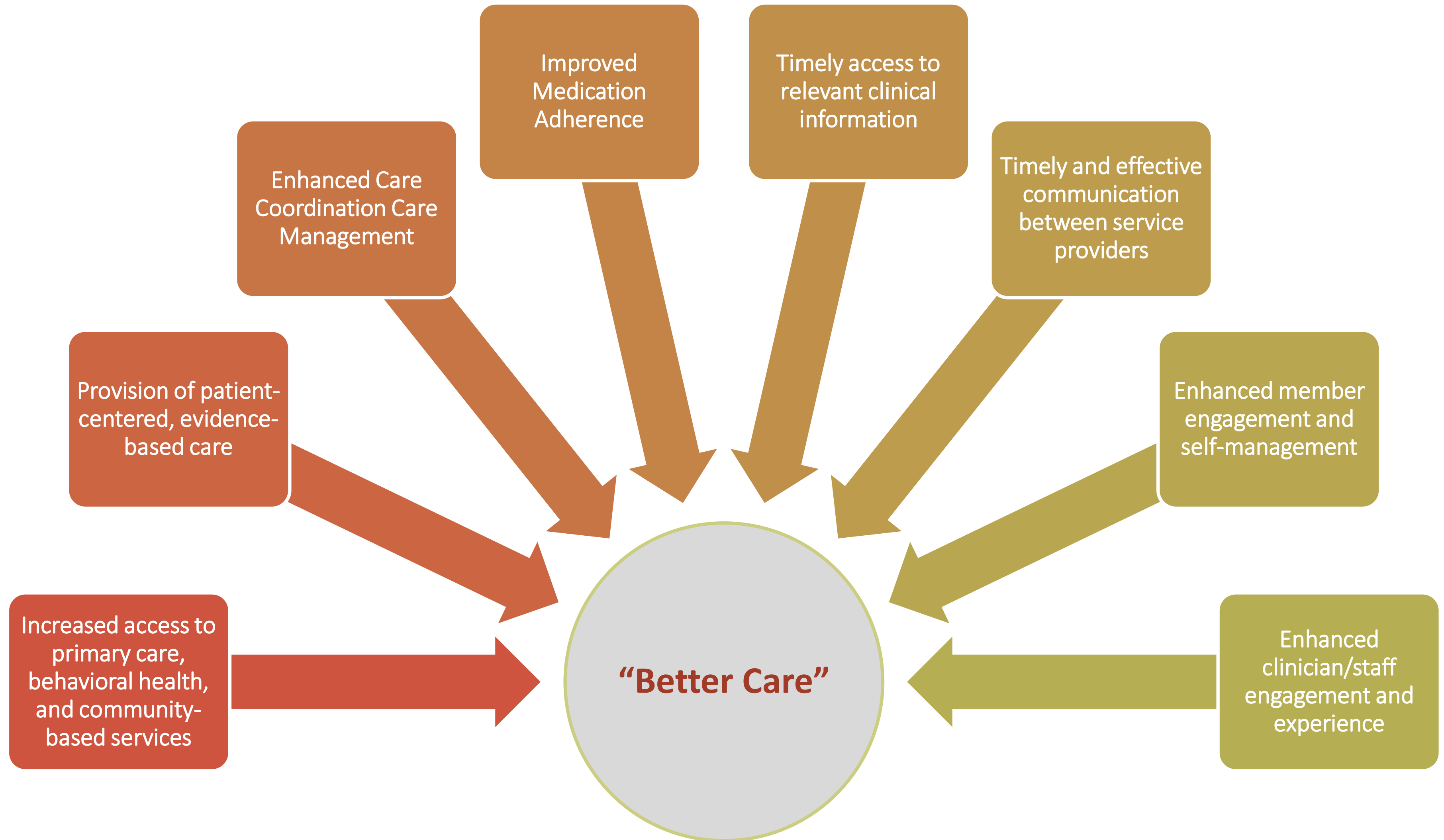
Primary Care Plan & Project Updates



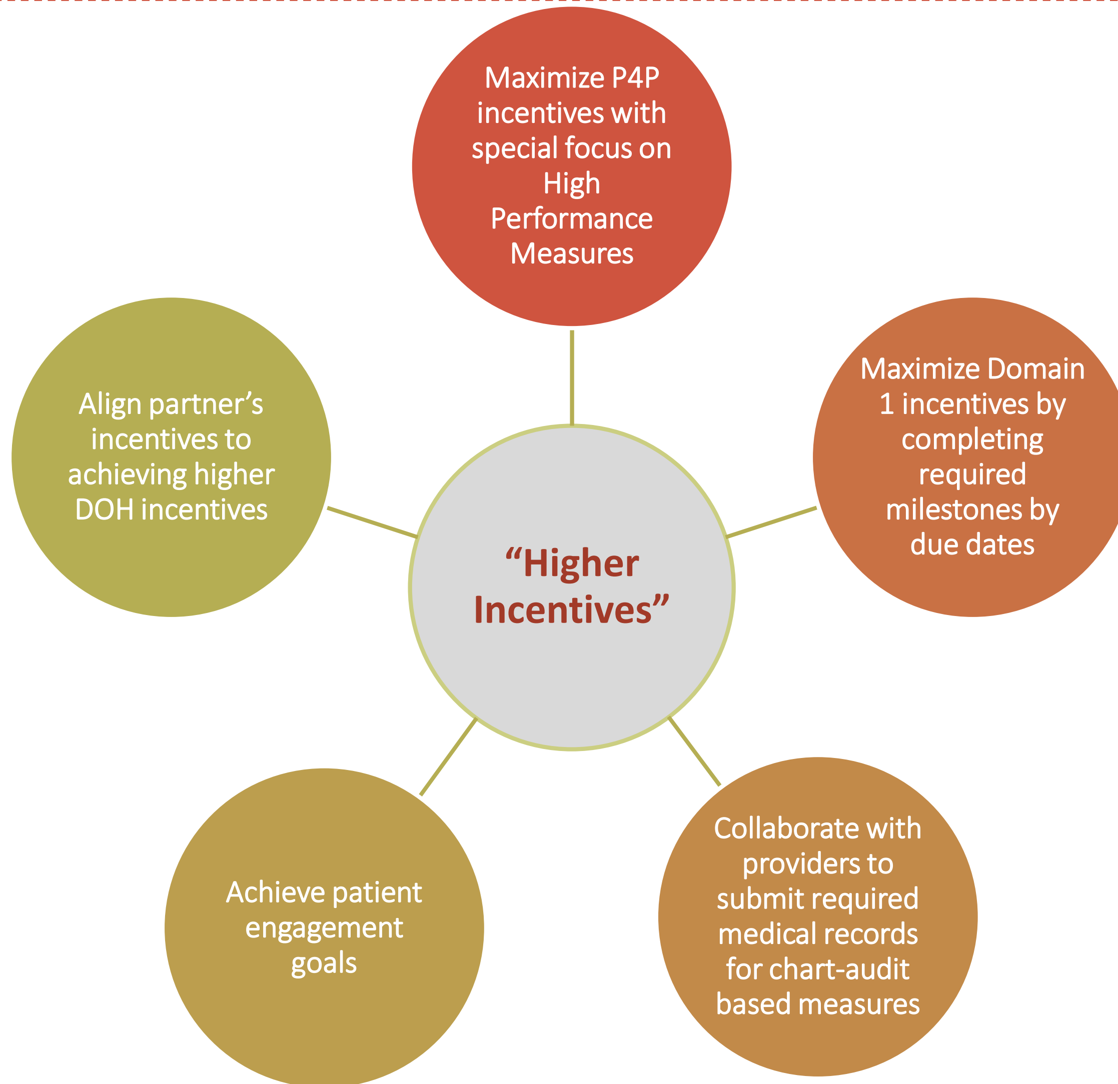
AMCH PMO – "GUIDING THEME"

"Better Care, Higher Incentives"

Guiding Theme – “Better Care”



Guiding Theme – “Higher Incentives”



PRIMARY CARE TRANSFORMATION

Implementation of Primary Care Plan

Primary Care Transformation – Primary Care Expansion

- Applied for the NYS ***Statewide Health Care Facility Transformation Program*** grant to support development of primary care centers in two 'hot spot' areas – ***awaiting award announcement***

Albany Medical Center

- Hired two PCPs in 2016 and will be adding two part-time providers in summer 2017

Albany Family Medicine [CCP]

- Increased PCP FTEs from 1.5 to 2.9 in 2016 & in the process of hiring a patient educator
- Access has improved considerably in the last year

Center for Disability Services

- Expanding the care team to include LCSW and clinical pharmacist
- In 2016, hired two providers to support two practices with high Medicaid populations

CapitalCare Medical Group

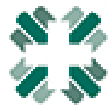
- Ongoing provider recruitment to support expanding needs
- Recently selected for CPC+ at all primary care sites requiring hiring case managers to support primary care providers

Saratoga Hospital Physician Group

Primary Care Transformation – Primary Care Expansion

- **Greene County** - Recruited one Family Medicine physician to work at their site in Jefferson Heights, and searching for another primary care physician to work at their second site.
- **Columbia County** – Just hired an internist to work 2 days a week at the Hudson location, and a Nurse Practitioner to work at their Valatie office.

Columbia Memorial Hospital



- Early morning walk-in clinic

Harmony Mills Pediatrics

- Recruiting another PCP to expand access

Koinonia Primary Care

Primary Care Transformation – Practice Transformation Support

PCMH / APC Recognition Support: - HANYS Patient-Centered Medical Home Advisory Services have been selected to assist up to 85 primary care sites to achieve/sustain PCMH/APC recognition by March 2018.

Key areas:

- Readiness Assessment and Gap Analysis
- Prioritization Strategy
- Customized Implementation plan to support transformation through NCQA PCMH or NYS APC standards
- Train PMO team to assure sustainability of transformation initiatives

Primary Care Transformation – Financial Support

- Adoption of Adirondack Health Institute PPS's model for providing financial incentives to support safety-net practices with their provider recruitment & retention efforts.

- Align incentives for primary care practitioners to enhance AMCH PPS's ability to meet P4P measure targets.
  - Phase II funds flow model to support process improvement initiatives – *Increase screening rates for depression, asthma medication prescription rates, etc.*

- Incentives to support the sustainability of core PCMH /APC functions.
  - Phase II funds flow model to support sustainability of critical PCMH functions – *open access, team huddles, proactive outreach, care coordination, etc.*

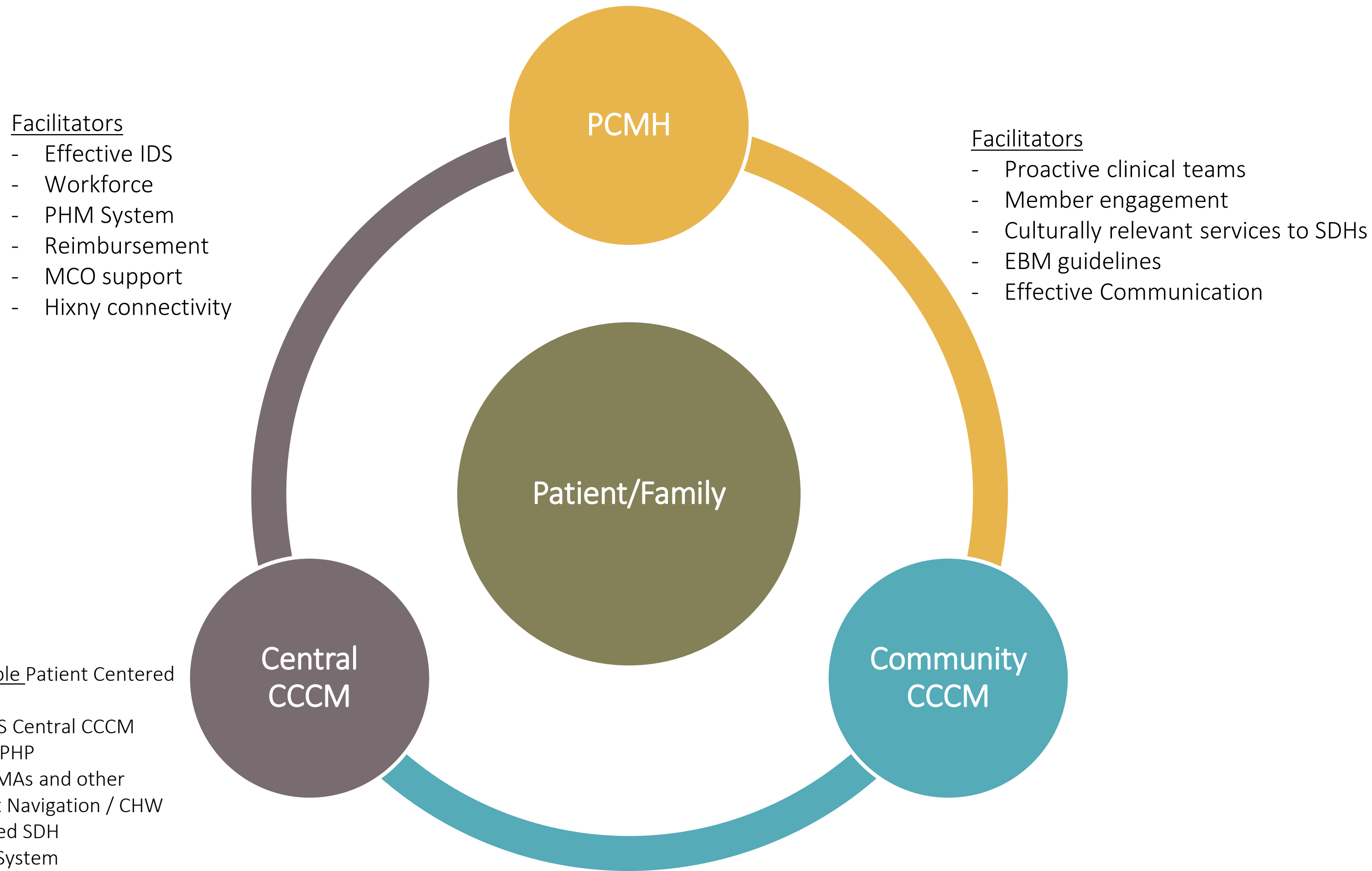
- Incentives and other appropriate support for partnering organizations with their efforts to integrate primary care and behavioral health services.

Primary Care Transformation: "BHNNY Cares" (Care Coordination Care Management Program)

Goals & Objectives:

- Link attributed members to appropriate care coordination and care management resources
- Enhance engagement of high-risk members in complex care management program.
- Proactively identify members for eligible for NYSDOH Health Home services and refer them to a Health Home entity.
- Facilitate access to primary and preventive care services, including community-based behavioral health services.
- Collaborate with community-based organizations to address relevant Social Determinants of Health (SDH).
- Improve members' experience of care.

“BHNNY Cares” CCCM Program – Model



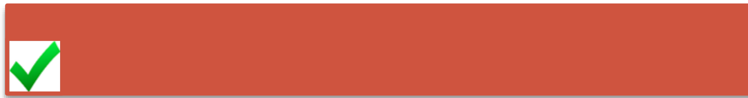
Keys:
PCMH – Current and Eligible Patient Centered Medical Homes
Central CCCM – AMCH PPS Central CCCM Program supported by CDPHP
Community CCCM – HH CMAs and other partners providing Patient Navigation / CHW services to address selected SDH
IDS – Integrated Delivery System
PHM- Population Health Management
MCO – Managed Care Organization
SDH – Social Determinants of Health
EBM – Evidence-based Medicine

Model representation adopted from “Collaborative Care Manager Model - Toolkit for Implementing the Chronic Care Model in an Academic Environment” – AHRQ 2014

PROJECT-SPECIFIC SERVICE DELIVERY ENHANCEMENTS

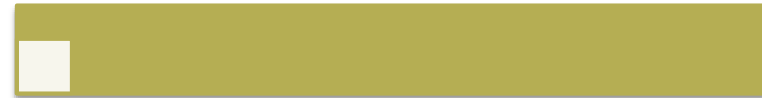
2ai: Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management

Completed



- [x] Partner with HH and ACO
- [x] Track actively engaged patients
- [x] MCO contracts in place including Value Based Payments
- [x] Re-enforce transition towards VBP
- [x] Community Health Workers and CBOs utilized in IDS for outreach and navigation activities

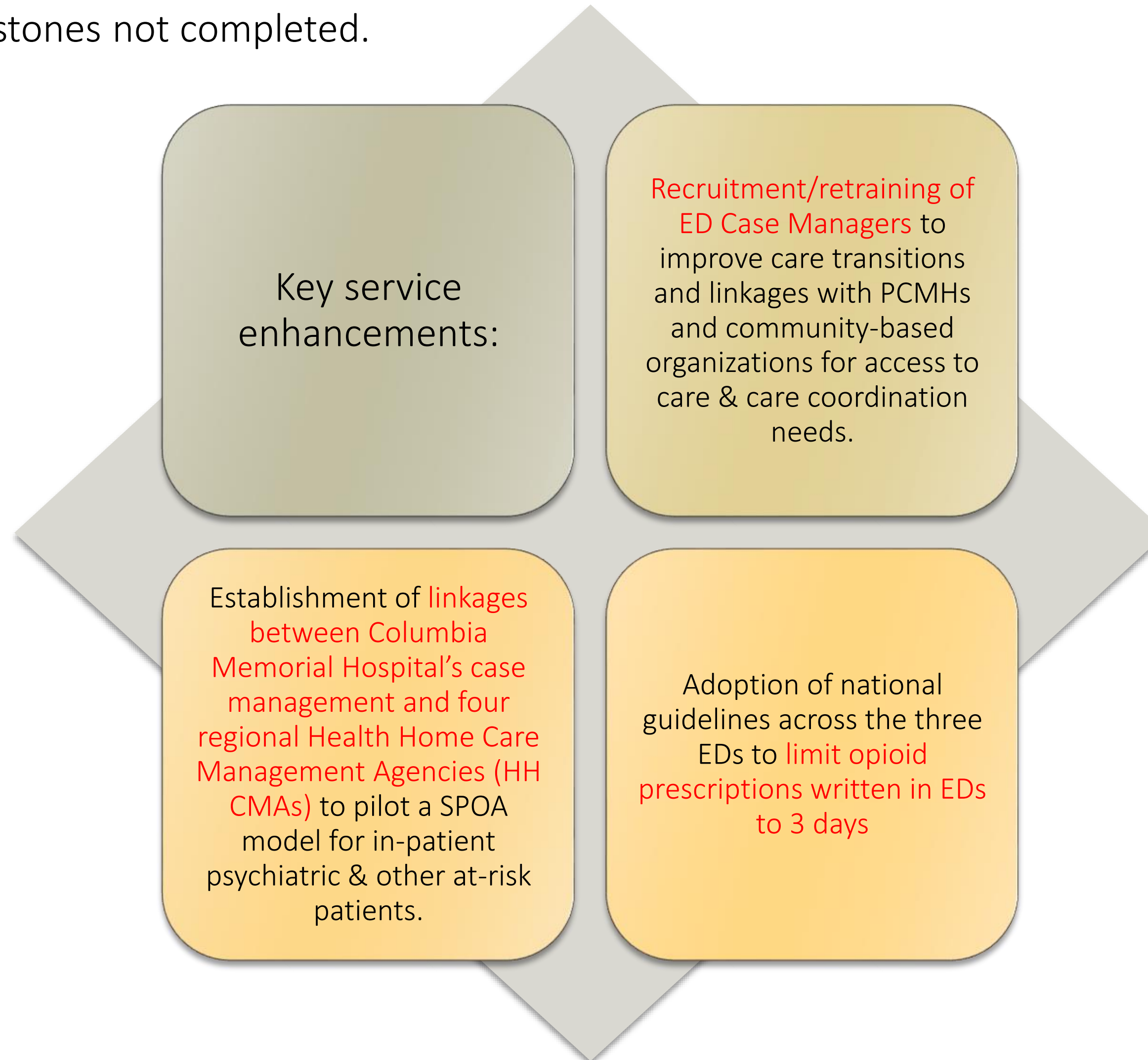
In Progress



- [ ] Implement an IDS
- [ ] Clinically Interoperable System
- [ ] RHIO's HIE and SHIN-NY connectivity
- [ ] NCQA 2014 Level 3 PCMH standards
- [ ] NCQA 2014 Level 3 PCMH standards
- [ ] Monthly Medicaid MCO meetings

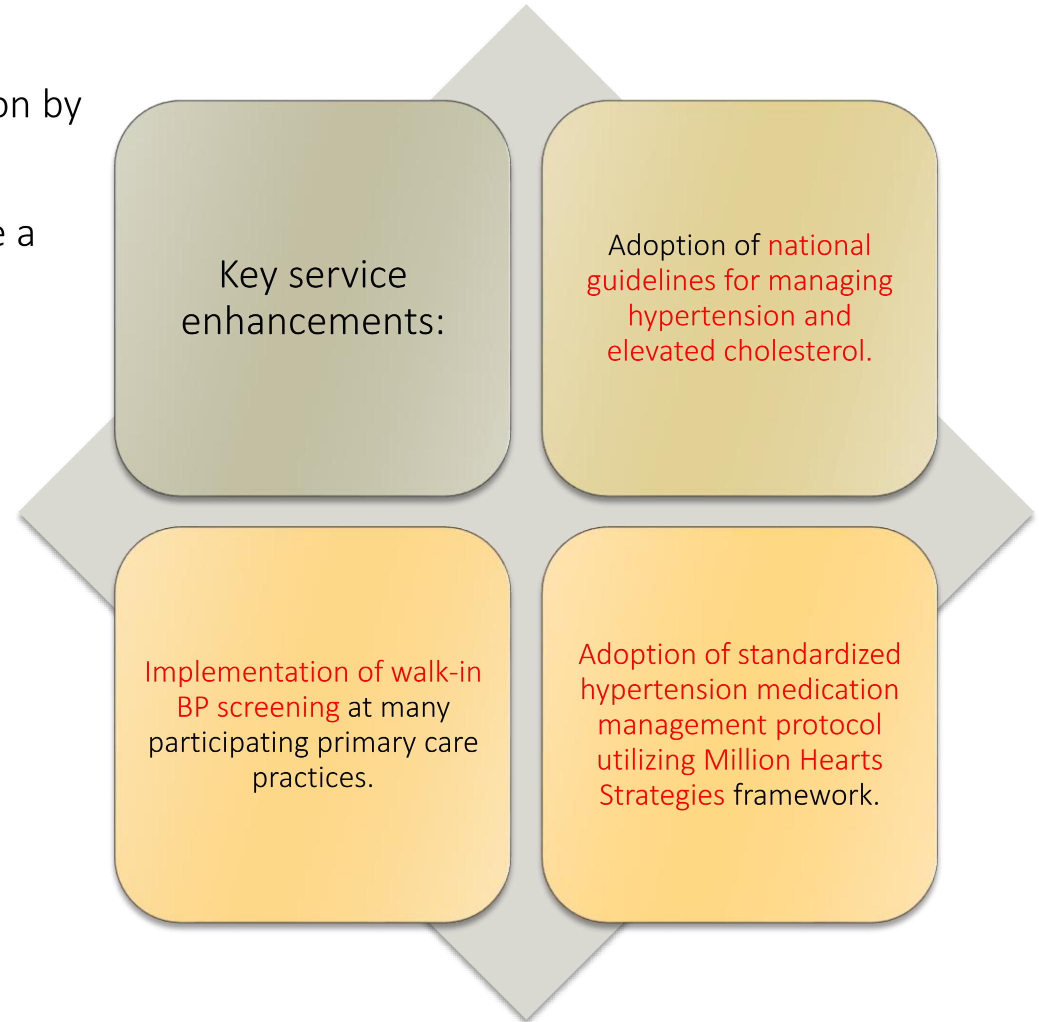
2biii ED care triage for at-risk populations

- 1 out of 4 milestones not completed.



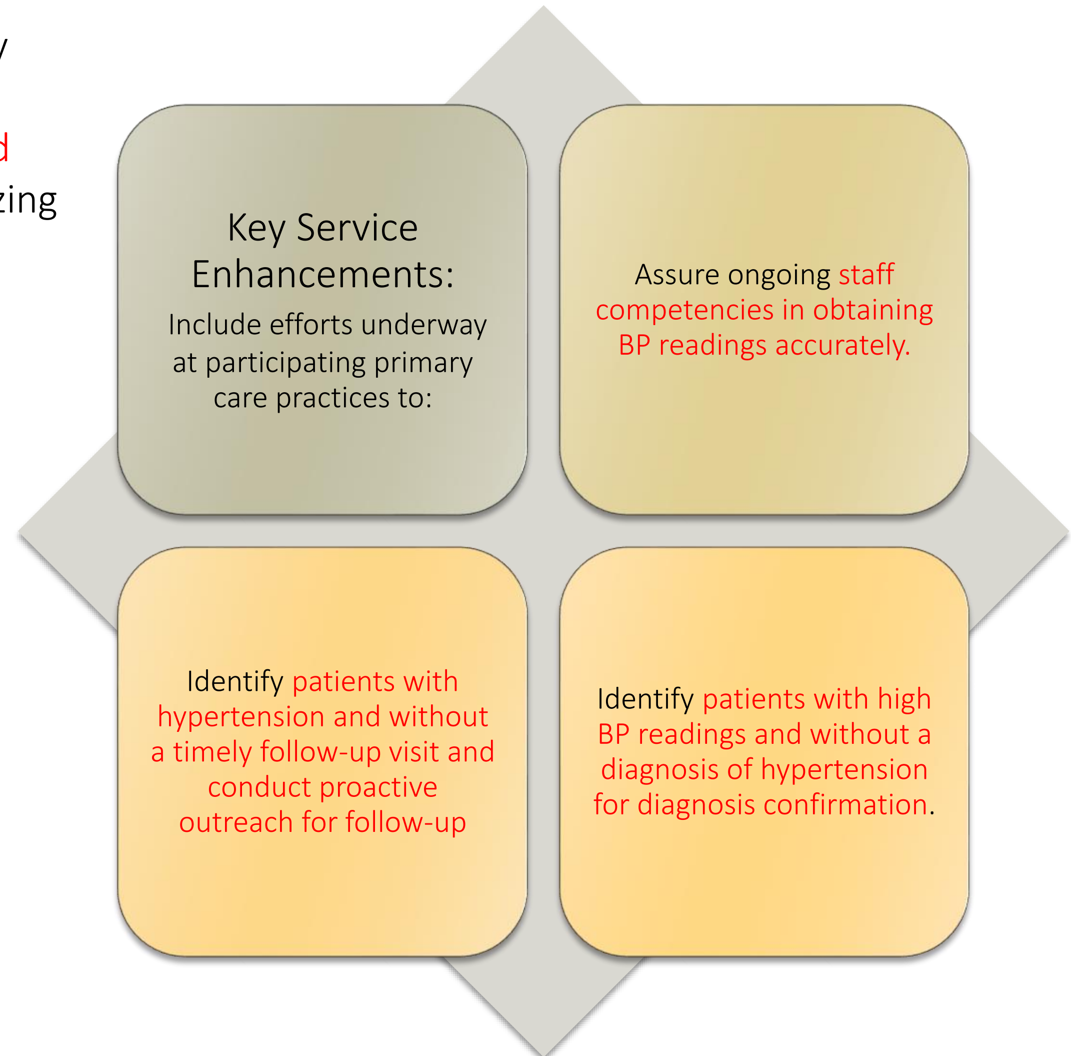
3bi Evidence-based strategies for disease management in high risk/affected populations (adult only)

- 13 out of 20 milestones not completed.
- 10-11 milestones are on track for completion by September 2017.
- Practitioner speed & scale milestone will be a challenge.



3bi Evidence-based strategies for disease management in high risk/affected populations (adult only)

- Discussions underway with three primary care groups and Albany County Health Department to implement Self-Measured Blood Pressure Monitoring program utilizing CDC/AMA protocols



3diii Implementation of evidence-based medicine guidelines for asthma management

- 3 out of 5 milestones not completed.
- Practitioner speed & scale milestone will be a challenge.
- Remaining milestones on track for completion by September, 2017

Key service enhancements:

Adoption and implementation of evidence-based asthma guidelines (EPR-3) based on most current national standards.

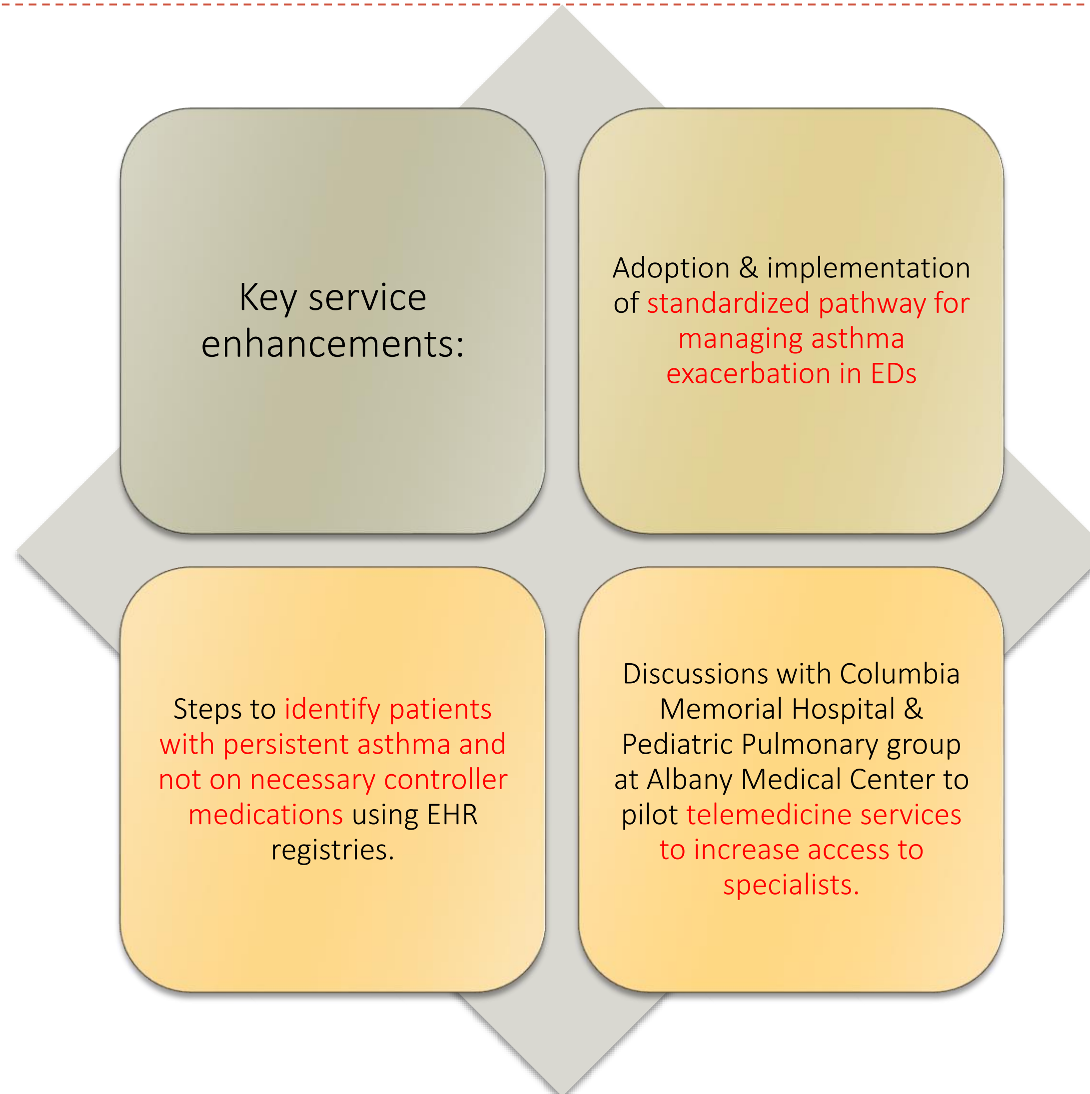
Standardized assessment and monitoring

Increase controller medication prescription & adherence

Patient education & self-management support

Control of environmental factors and other triggers

3diii Implementation of evidence-based medicine guidelines for asthma management



Project-Specific Service Delivery Enhancements