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State of the PPS

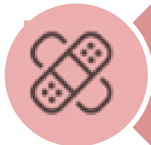
NewYork-Presbyterian/Queens PPS

February 2, 2017

NewYork-Presbyterian Queens

State of the PPS

Primary Care Plan


Clinical Projects

Quality Performance Initiatives

Finance & Funds Flow

NewYork-Presbyterian/Queens PPS

State of the PPS

NYP/Q PPS
State of the PPS

- 96.2% of AVs Achieved to Date
  - 2 Patient Engagement AVs missed in DY2, Q2 – 3.b.i Cardio & 3.d.ii Asthma
- Mid-Point Assessment
  - NYP/Q PPS was 1 of 4 PPS' that received no formal recommendations in the Midpoint Assessment from the IA
- MY1 Quality Measure Results
  - NYP/Q PPS was 1 of 2 PPSs that achieved more than 50% of MY1 Quality Measure Results*

Top range	Bottom range

% of performance measure targets met*	# of PPSs
Greater than 50%	2
41% - 50%	2
31% - 40%	3
21% - 30%	10
20% or less	8

*MY1 Measure Details can be found in the Appendix

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Primary Care Plan

FUNDAMENTAL #1: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs.	
Expand Primary Care Access at Behavioral Health (BH) sites at 9 clinics affecting 15 PCPs and 50 BH providers	In Progress
Implement Open access scheduling	
2014 PCMH Level 3 Certification of 36 Primary Care providers	
Identify Telehealth programs	
FUNDAMENTAL #2: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?	
Contract with Healthcare Association of New York State (HANYS) to provide implementation services to partners	**Completed**
Funds flow model to incentivize PCMH certification	
PPS website, network emails, committee meeting agenda items, PAC updates, and Town Hall	
FUNDAMENTAL #3: What is the PPS's strategy for how primary care will play a central role in an integrated delivery system?	
Ensure linkage of providers - RHIO Connectivity	In Progress
Ensure linkage of providers - Co-location of behavioral health providers into primary care clinics	In Progress
Ensure linkage of providers - Implementation of IT tool Cureatr for event notifications to PCPs	In Progress
Ensure linkage of providers - Care coordination trainings	**Completed**
Implement Best Practices and Evidence Based Medicine Protocols	**Completed**
Governing system offering committee appointments to all provider types based on their project commitments	**Completed**

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Primary Care Plan

FUNDAMENTAL #4: What is the PPS's strategy to enable primary care to participate effectively in value-based payments?	
Partner with the NYP PPS on Value Based Payment to outline strategy and roadmap	In Progress
VBP PPS survey to outline needs for education, partner quality analysis, and access to statewide VBP resources	**Completed**
FUNDAMENTAL #5: How does your PPS's funds flow support your Primary Care strategies?	
Funds flow incentivizes PCPs to engage in DSRIP activities and allows for reimbursement of all categories	**Completed**
PPS training program, which allocates $517,000 dedicated to workforce spend	
Implementation of the Healthstream education tool	
FUNDAMENTAL #6: How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?	
Co-locate primary care and behavioral health services at a pediatric site	In Progress
Contract with CBO partner, Elmcor, to develop a curriculum for substance use screening	**Completed**
Engage internal legal counsel to assist with determining proper regulatory and billing procedures for the integrated sites of care	In Progress
Facilitate collaboration between partners to staff primary care and behavioral health physicians at reciprocal sites	In Progress

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Clinical Project Highlights

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Clinical Project Highlights

PCMH
2.a.ii

- **On track to meet requirement**
  - 25 PCPs are Certified Level 3 2014 PCMH
  - 20 PCPs in process of transformation

INTERACT
2.b.vii

- **Training Completed during DY2 Q3**
  - 23 SNFs trained
  - 6 Home Care trained

Co-Location
3.a.i

- **PC / BH Integration in process**
  - Pediatric Co-Location – NYP/Q & The Child Center of NY
  - Tele-psychiatry in ED

"Having the opportunity to work closely with HANY's Solution for PCMH guidance is a valuable resource to the centers. Both of us share best practices as we transform from PCMH 2011 standards to the 2014 standards"

-***NYP/Q***

"Our goal to identify behavioral health, and medical diagnoses early in order to expedite treatment… within one familiar clinic where clients will feel safe and free of stigma."

-***MHPWQ***

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Clinical Project Highlights

Asthma
3.d.ii

- **Education & Care Coordination underway**
  - School Based Behavioral Health Clinics
  - PCPs
  - ED Staff

Palliative Care
3.g.ii

- **EPEC Training in progress**
  - Providers receive CMEs / CEUs
  - Certification in EPEC at the end of the program

"Participation in the EPEC program is valuable in so many ways and touches upon just about every sensitive topic and issue related to end of life care... Dr. Pan's sharing of her professional experiences was a very important aspect of the program and served to illustrate the challenges and demonstrate practical solutions and approaches."

-Chapin Home for the Aging

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Quality Performance Initiatives

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- Rapid Cycle Unit Development
  - Phase I strategy focuses on high impact / high value quality measures
  - Reinvigorating the Clinical Integration Committee to focus to Quality Measures
  - Includes DSRIP & Equity Performance Measures

Ambulatory Measures	Hospital Measures
Children's Access to Primary Care (2 - 6 yrs.)	PPV (Potentially Preventable ED Utilization)
Children's Access to Primary Care (7 -11 yrs.)	PPR (Potentially Preventable Readmissions)
Follow-up Care for ADHD Children – Initiation Phase	PQI – 90 (Adult Composite)
Med Assist with Smoking & Tobacco Use Cessation – Medication	PQI – 15 (Adult Asthma Admission Rate)
Med Assist with Smoking & Tobacco Use Cessation – Strategy	PQI – 14 (Uncontrolled Diabetes Admission Rate)
Controlling High Blood Pressure	PDI – 90 (Pediatric Composite)

- Root Cause Analysis (RCA) held quarterly with long term care partners
  - Goal is to utilize blinded cases to identify successes in TOC and areas for improvement associated with admissions & readmissions
  - Sessions include:
    - Review the case with blinded patient information
    - Brainstorm on gaps in care
    - Identify root-cause of admission / re-admission
    - Identify & review all partner organizations involved
    - Define action plan to address gaps in care
    - Implement improvement activities at identified facilities
  - 4 sessions have occurred to date – including review patient cases, discussion of best practices and alignment with DSRIP deliverables

RCA Patient Scenario:

- 87 year old male with shortness of breath & pneumonia
- Significant alcohol use in the past but denies present use
- Lives with wife & daughter
- Discharged with 13 meds & plan for PT/OT
- Home Health denied by patient

RCA Gap Assessment:

- Denial of Home Health should have triggered concerns
- Alcohol use was not addressed by medical staff
- No social worker present at the time of visit
- Medication reconciliation was inadequate

RCA Action Plan:

- Implement active responses to intake regarding alcohol use (social worker engagement, family interaction & discussions, etc.)
- Improve medication reconciliation / management policies at identified sites
- Identify CBO to partner with network partners for alcohol use prevention & education

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Quality Performance Initiatives – MAX Series

Homeless Population

- Target homeless population to increase engagement
- Registration at shelter instead of clinic

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High Utilizers / Readmissions

- Began DY2, Q4
- Multidisciplinary Action team
- Identify high utilizers – 4 ED/IP Visits annually
- Create action plans to address high utilizers

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Train the Trainer

- Assist partner organizations to run rapid cycle / QI projects
- 2 PMO Staff currently in training

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Financial Update

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NYP/Q PPS

Finance

Total Revenue Received	$	2,414,549
DSRIP		$ 1,839,060
EIP / EPP		$ 575,489

Total Revenue Received	$	2,414,549	Actual	Goal
Contingency	$	120,649	5.00%	5.00%
Workforce	$	188,702	7.82%	2.13%
Admin OH	$	518,866	21.50%	30.00%
Cost of Imp	$	156,652	6.49%	17.87%
Non Cov'd	$	120,649	5.00%	5.00%
Revenue Loss	$	241,297	10.00%	10.00%
Incentives	$	1,067,735	44.25%	30.00%

- Exceeding expectations for goals outlined in the application process
  - Administrative Overhead under by 8.5%
  - Incentive payments to partners exceeding by 14.25%

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Finance: PMO Expense Detail

MAPP Category	Spending Category	Spending Category Description	% of Expense Total
Admin Overhead	Legal Consulting	Governance Structure / PC : BH Co-Location	3.16%
	Marketing	Network Outreach	0.63%
	Meeting Expenses	Meeting Expenses	0.59%
	Other	Supplies	0.01%
	Rent	Rent / Facilities	3.84%
	Staffing	PMO (Non Clinical) Staffing	56.58%
	Supplies	Supplies	0.06%
COI	HANYS	PCMH Implementation Consultant	8.66%
	IT	IT Implementation Tools	5.10%
Workforce	Comp & Bene	Compensation & Benefit Analysis	10.54%
	Training	Training	10.83%

*NYP/Q PPS Reports all expenses in appropriate category in MAPP
**Percentages of Expenses included - not % of revenue
***Percentages represent DY1 - DY2 Q2 to mirror midpoint assessment analysis

Finance: Partner Payments

Partner Category	% of Total
CBO	7.40%
Clinic	11.70%
Federally Qualified Health Center (F.Q.H.C.)	11.50%
Home Health	8.32%
Hospital	30.69%
Mental Health	6.10%
Practitioner - Primary Care Provider (PCP)	9.23%
Skilled Nursing Facility	15.06%
Grand Total	**100.00%**

Finance: Next Steps

- Payment #3 – Completed January 2017
- Payment # 4 – Anticipated April 2017
  - Large partner pay-out due to EIP/EPP/DSRIP Revenue
  - Estimated partner incentive payout $500k - $700k
  - 1st Project Milestone Initiatives (non Patient Engagement)
    - INTERACT Certification
    - PCMH Certification
    - 5-A Tobacco Education / Implementation
- Update Funds Flow Model to add Quality Improvement Activities & Metrics

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Appendix

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MY1 Measure Results

Measure	Values
PDI 90 - Composite of all measures +/-	580 655
Pediatric Quality Indicator # 14 Pediatric Asthma +/-	507566
Potentially Avoidable Emergency Room Visits +/-	350
Potentially Avoidable Readmissions +/-	1,30953
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) +/-	9122
PQI 90 - Composite of all measures +/-	1,781 2,455
Prevention Quality Indicator # 7 (HTN) +/-	68122
Prevention Quality Indicator # 13 (Angina without procedure) +/-	354
Prevention Quality Indicator # 15 Younger Adult Asthma +/-	576

0 200 400 600 800 1000 1200 1400 1600 1800 2000 2200 2400 2600

*Measures highlighted in yellow indicate that the PPS did not meet MY1 target

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Measure Names
- MY1 Annual Improvement Target
- MY1 Results / Baseline for MY2

Measure	MY1 Annual Improvement Target	MY1 Results / Baseline for MY2
Adherence to Antipsychotic Medications for People with Schizophrenia	70.33	61.80
Adult Access to Preventive or Ambulatory Care - 20 to 44 years	[illegible]	[illegible]
Adult Access to Preventive or Ambulatory Care - 45 to 64 years	91.07	[illegible]
Adult Access to Preventive or Ambulatory Care - 65 and older	91.96	[illegible]
Antidepressant Medication Management - Effective Acute Phase Treatment	43.59	57.47
Antidepressant Medication Management - Effective Continuation Phase Treatment	28.70	39.37
Asthma Medication Ratio (5 - 64 Years)	65.71	52.98
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	49.72	72.73
Children's Access to Primary Care - 7 to 11 years	92.16	97.83
Children's Access to Primary Care - 12 to 19 years	84.44	95.38
Children's Access to Primary Care - 12 to 24 Months	96.58	[illegible]
Children's Access to Primary Care - 25 months to 6 years	[illegible]	[illegible]
Diabetes Monitoring for People with Diabetes and Schizophrenia	72.51	58.33
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	[illegible]	[illegible]
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	19.47	25.56
Follow-up after hospitalization for Mental Illness - within 7 days	40.15	50.00
Follow-up after hospitalization for Mental Illness - within 30 days	53.82	60.00
Follow-up care for Children Prescribed ADHD Medications - Initiation Phase	54.87	70.21
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	51.02	56.14
Medication Management for People with Asthma (5 - 64 Years) - 50% of Treatment Days Covered	51.06	[illegible]
Medication Management for People with Asthma (5 - 64 Years) - 75% of Treatment Days Covered	26.33	31.13

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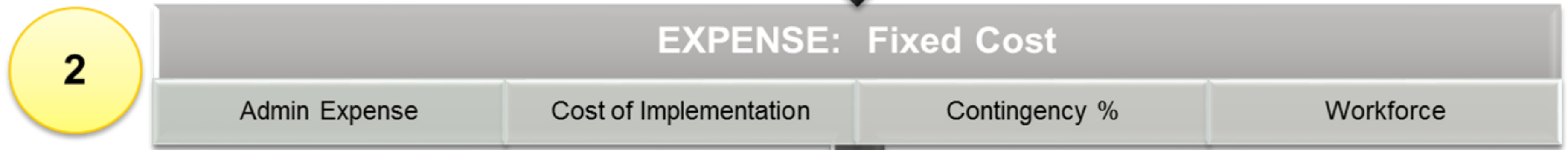
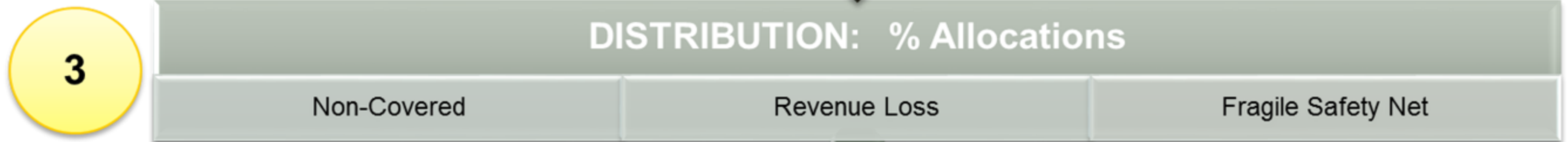
Funds Flow Model

PPS Level

PPS Level





NYP/Q PPS
Funds Flow Model

4

DISTRIBUTION: Incentive

EIP

CBO

Project Requirements

Engaged Patients