Demographics

- Population ~ 200,000
- Micropolitan (2)/Rural/Frontier
- Second to SW Florida in Age
- Unusual and Stressed Economy
The Emerging Adirondack Crisis

**Departure of Primary Care Providers**
- Low Pay
- Long Hours
- Grinding Work

**Destabilized Health Care System**
- Hospitals
- Specialists
Crisis Response: The Providers

Adirondack Health Institute (AHI)

Private Practices
FQHC
FQHC Look-Alike
Hospital Clinics
MSO
PHO

Project Manager: Dennis Weaver, M.D.
EastPoint Health
Crisis Response: NY State

Rural Health Network Designation
  Antitrust Protection for AHI

Adirondack Medical Home Pilot
  2009 NYS Budget
  Antitrust Protection for AHI/Payers
  Enhanced Medicaid Payments

Civil Service Commission
  Empire Plan
Crisis Response: The Payers

- Blue Shield of NENY
- CDPHP
- Empire Blue Cross
- Excellus
- Fidelis
- MVP
- United Health Care
- Medicaid
- Medicare
Crisis Response: The Community

- New York State Association of Counties (NYSAC)
- Adirondack Health Summits (07 & 09)
- Local, State, Federal Officials
Pilot Goals

- Improve Clinical Outcomes
- Control Health Care Costs
- Improve Provider and Patient Experience
- Enable Retention and Recruitment
Pilot Design

Care Coordination Pods

Plattsburgh – Integrated Hospital System
Saranac - PHO
Lake George - FQHC
Pilot Terms

- Five-Year Demo: 2010-2014
- Readiness Assessment & Work Plan: 1/10
- E-Prescribing: 7/10
- Level II NCQA Recognition: 2/11
- “Crossover” Point: Year 3
Pilot Financing

Enrolled Patients
One E&M Visit in Previous 24 Months
Household Members

Continue Existing Reimbursement

Add $7 pmpm
Care Coordinating Teams
Physician Compensation
Data Sets

Consider Additional Incentives in Out-Years
Pilot Data

Focus on 3 Clinical Conditions

Shared Performance Standards

Pooling of Data
   Providers and Payers
   RHIO
   HEAL - 10
Pilot Oversight

Governance Council

NYSDOH as Voting Chair
8 Providers (Including MSSNY)
8 Payers
Non-Voting Participants

NYSAC, Legal Staff, Consumers, Public Health, Employers, Service Organizations, Invited Experts
Pilot Budget

Developmental Investment

- $ 85,000 HRSA Project Planning
- $ 540,000 HRSA Project Development
- $3,000,000 MSSNY Reg. Pod Capacities
- $7,000,000 HEAL 10 Electronic Connectivity
- $8,000,000 Providers Matching Commitments

Operating Revenue/Expenses

$55,000,000 (Estimated) Five Years
Dennis Weaver, M.D.
EastPoint Health
Physician Practice Support Organizations: “Pods”

Patient identification and payment coordination
Data aggregation and analysis reporting
Quality improvement activities

Chronic disease management
  • PharmD, Social Worker, Disease Management Nurse
  • Care coordination / Case management
  • Disease registry management

Transitions of Care
  • Hospital to home to primary care
Clinical Process Flow

- Patient ID and Stratification
- Patient Outreach
- Clinical Encounter Physician
- Clinical Encounter Non-physician
- Patient Monitoring
- Patient Follow-up
Pilot Participation Requires Measurement

Access to care

Clinical Quality - Evidence based guidelines
  • Adult – Diabetes / Hypertension / Coronary Disease
  • Pediatric – Childhood Obesity / Asthma / Prevention

Efficiency
  • Inpatient bed days / ER visits / Formulary compliance
  • Risk adjusted total cost

Health Plans & Providers will utilize the same measures!!!
Abstract View

Health Plans

Payor Data Warehouse

Claims portal

EHR Data Warehouse (QDC)

Clinical quality portal

Clinical care portal

Clinical Transaction Content
ADT, Meds, Lab/rad/departmental reports (HL7 content)
Clinical summary info (C32 content)
Claims data flow
Web application
Access to web viewer

45 Specialty Providers

Health Plans

3 PPSOs

33 Primary Care Practices

2 GFH Specialty Practices

6 Hospitals
## Clinical Transaction Content Detail

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<th>ADT, Meds, Lab/rad/departmental reports (HL7 content)</th>
<th>Hospital-to-HIXNY</th>
<th>Practice-to-HIXNY</th>
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<td>• Current and prescribed medications</td>
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<td>• Departmental reports (availability may vary by hospital)</td>
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<td>• Discharge summaries</td>
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Note: C32 content for Practice-to-HIXNY exchange is per HITSP harmonized standard. HIXNY version may differ slightly.
Cyndi Nassivera-Cordes, RN, CRM
Hudson Headwaters Health Network
Using Technology to Assist Transformation

- E-prescribing
- Population Management
- Transition Care/Care Management
- Increased Efficiencies
  - Automated Reminder/Results Calls
  - Centralized Referrals
  - Centralized Document Management
  - Others in Discussion (Centralized Prescription Refills, Prior Auth, Telephone Triage, and Appt Scheduling)

- EMR Templates
- Quality Measurement and Improvement
E-Prescribing

- Pilot Practices E-prescribing at rates >90% by July 2010
- Most E-prescribing Systems Include Safety and Efficiency Alerts
Using Systems for Population Management

- Practice Management System Identifies Patients With Upcoming Visits/Important Conditions/Conduct Outreach prior to visit
- Determine Who Would Benefit from Care Management
- Next Step - Incorporate Clinical Details from the EMR to Increase Efficiency
Using Systems for Population Management

**Chronic Condition Flow Sheet**

- Automatically Pulls in Pertinent Medication and Co-morbidity Information
- Manages Historical Clinical Information
- Outlines Patient’s Goals and Progress
- Patient Self-Management Support Tool
Using Systems for Population Management

Automated Patient Communication

- Reminder Call/Appointment Tickler
- For Preventive Care Visits/Tests and Follow-up Care for a Chronic Condition
Preventive Service Clinician Reminder

- Age-Appropriate Screening Tests and Immunizations built into EMR Templates
- Risk Assessment/Social History Based on Age
- Specific Assessments built into Social History Templates (BHS, Cage and Smoker’s Questionnaires)
Continuity of Care

Transition Care Program

- Hospital Provider Can Access Outpatient EMR
- Follow-up Outpatient Visit Scheduled Prior to Discharge
- Patients Who Can Benefit From Transition Care Coordination (Coleman Model) Identified Prior to Discharge
- Program Reinforced by Hospital Provider
Continuity of Care

Transition Care Program

- Medication Reconciliation Completed on the Medication List in the Patient’s EMR
- Transition Care Coordinator Documents Patient Interaction in the EMR
Test Tracking

- Efficiencies in Notifying Patients of Normal and Abnormal Test Results
- Results Call/Patient Portal
Measures of Performance

- **Measure Adherence to the Pilot’s Evidence-Based Treatment Guidelines**
  - Diabetes
  - Hypertension
  - CAD
  - Preventive Services (pap smear, mammogram, colonoscopy)

- **Can be Reported at Multiple Levels**
  - Patient
  - Provider
  - Health Center
  - Network
  - Pod
  - Pilot