Advocate Community Providers

Care Team Meeting

June 17, 2015

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Agenda

- Breakfast 9:00
- Care Teams/Partners 9:30
  - Who is the PAC
  - Expectations, Purpose and Structure
- Q&As 10:30
- Regional Breakouts 10:45

ACP Launch – RSVP Due Today!

YOU ARE INVITED

Advocate Community Providers invite you to gather in the spirit of celebration and preparation as we embark on the momentous journey of the transformation of the healthcare system for Medicaid recipients.

June 24, 2015 • 6-9 PM

Terrace on the Park
52-11 111th Street
Flushing, NY 11368

Business Attire
RSVP by June 16th
This invitation is extended to your colleagues, assistants and spouse.

Mi salud, mi comunidad 我的社區，我的健康 My community, my health

PAC Representatives

Group/Provider Name	Contact	Contact Email	Group Type
Amerigroup/Wellpoint	David Ackman	David.Ackman@amerigroup.com	Health Plan
Arms Acres/Conifer Park	Roy Wallach	rwallach@libertymgt.com	Nursing Home
Balance ACO	Oscar Fukhilman	webbliz@cm-ipa.com	ACO
Bioreference	Vincent Porcelli	vporcelli@BioReference.com	Laboratory
CBC	Marcia Holman	mholman@pgcmh.org	
Centers for Specialty Care	isaac Rubin	irubin@centersforcare.org	Skilled services, all counties
Chinese Community ACO	Dana Zhu	admin@ccaco.org	ACO
Fresenius	Gregg Miller	gmiller@fvc-na.com	Dialysis
Friends and Family	Yelena Schmidt	yelena@friendsfamilyhomecare.com	
Good Shepherd Services	Joan Siegel	joan_siegel@goodsheperds.org	Social Supports/Housing
Harlem East	Joanne King	jnk@helpmedical.org	OMH/OASAS (Art 31 and 32), BH/SA, Social Supports, Health Home
HealthFirst	susan Beane	sbeane@healthfirst.org	Health Plan
Isabella Nursing Home	Mark Kator	mkator@isabella.org	Nursing Home
Jamaica Hospital Nursing Home	Tom younghans	TYOUNGH@jhmc.org	Jamaica hospital Nursing Home
Medisys	Angelo Canedo	acanedo@jhmc.org	Hospital
Metropolitan Jewish Home Care Inc. d/b/a MJHS Home Care	Jay Gormley	jgormley@mjhs.org	Certified Home Health Agency
New York Congregational Nursing Center	Modupe Fajodi	madedeji-fajobi@nycnc.org	
NSLIJ	Jerry Hirsch	jhirsch@nshs.edu	Hospital
Preventive Diagnostics	Mark Tauber	mark@pdihealth.com	Mobile Diagnostics
Qazi Halim	Qazi Halim	qhalim@jhmc.org	JHMC
Queens community Care Partners	Valentine Cruz	VHernandez@chnnyc.org	
RAIN (Regional Aid for Interim Needs)	Dr Anderson Torres	DrTorres@RAINinc.org	
Rapid Care Solutions	Michelle Gonzalez	mgonzalez@rapidcaresolution.com	Physician Home Visits
Summit Home Health	Susan Katz	mariap@trustsummit.com	Certified Home Health Agency
the PAC Program	Lawrence Lang	lawrence@thepacprogram.com	OASAS
Upper Manhattan/Heritage	Alvaro Simmons	asimmons@heritagenyc.org	Health Home
VIP Community Services	Deborah Whitman	dwitham@vipservices.org	OMH/OASAS (Art 31 and 32), BH/SA, Social Supports, Health Home
Wellcare	Jeanette Gonzalez	jeanette.gonzalez@wellcare.com	

Care Teams – Expectations, Purpose and Structure

- Care Teams are the partners who will provide care to ACP's attributed members.
- Care teams will be regional – ensure that needs of patients are met timely
- Care Teams will be:
  - Be prepared to accept referrals from ACP partners and providers
  - Coordinate with other ACP partners and providers
  - Follow ACP clinical protocols
  - Allow for access to data (both send and receive)
- Formal Provider Participation Agreement being drafted

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How this will work

- ACP will take on the centralized Care Management role
  - Need to understand roles of partner Care Management functions to avoid duplication of efforts
- Directory will be released by early next week (final network recently released by DOH)
- **<u>Need to ensure contact information is updated</u>**
- Staff training has started with Primary Care locations – Partners are next!
  - Training: ACP policies, clinical protocols, contact info, how-to's

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Additional Information Needed From Partners

- IT Systems and Capabilities Surveys
- Referral Questionnaires
- Workforce Survey and Analysis
- Financial Sustainability Survey – To be released

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Patient Engagement – What PCPs are doing?

Integrated Delivery Systems

Target: All patients and providers
Engagement: Every patient has a signed ACP HIE consent form
Action: Use billing code HIE01

Health Home At-Risk Intervention Program

Target: Patients with one progressive chronic disease, serious mental Illness or traumatic brain Injury
Engagement: Every patient has a documented comprehensive care plan
Action: Use billing code CP001

Care transitions to reduce 30 day readmissions

Target: Every patient with a hospital admission
Engagement: Every patient has a pre-discharge planning and transitional care visit 7 - 10 days in office or at home
Action: Use billing code PD001

Integration of Primary Care and Behavioral Health

Target: Every patient seen by the PCP
Engagement: Every patient must have a PHQ2 screening. If positive, then must have a PHQ9.
Action:
- Implement IMPACT Model
  Depression care manager
- Use G8431 when screening patient

Evidence Based Strategies for Cardiovascular Disease

Target: Patients with Cardiovascular disease or Hyperlipidemia
Engagement: Every patient must have life style modification documented
Action:
- Implement Million Hearts Campaign
- Enter billing code LSM01

Evidence Based Strategies for Diabetes

Target: Patients with Diabetes
Engagement: Every patient must have a documented HgbA1C
Action:
- Monitor HgbA1C
- Life Style Modification/Nutrition

Evidence based medicine strategies for Asthma

Target: Every patient with Asthma
Engagement: Every patient must have a Asthma action plan in place
Action:
- School/Work and Home Asthma action plan in place
- Enter billing code AST01

Tobacco Use Cessation

Target: All smokers
Engagement: Every patient must be screened for tobacco use
Action:
- Cessation counseling
- Referral to NY QUITS documented
- Provide educational material

Chronic Disease Prevention

Target: All patients
Engagement: Document and Prescribe Colorectal cancer screening, Mammogram, Pap Smear, Prostate exam, HPV Vaccination, Safe Sex Education
Action:
- Provide educational material

How this impacts the partners

- Multiple layers within DSRIP goals
  - Patient Engagement – A1Cs, Pre-discharge Plans, Asthma Action Plans)
  - Provider Engagement – IDS inclusion, Meaningful Use State 2, Social Services Participation, IMPACT model
  - Closing of care gaps (Domain 2,3) – Access to Preventive Care, Tobacco Use Cessation
  - Overall goal of reducing avoidable hospital use (Potentially Preventable Admissions, Readmissions, ER Visits)
- Full spectrum of care required to achieve all goals
  - Partners: Post-acute, Home Health, Behavioral/Mental Health, Social Services, etc

Coordination of Services

- End Goal: Fully integrated system with connectivity requirements to facilitate coordination via alerts and other direct and seamless methods of communication
  - In the meantime:
    - 'Manual' communication with ACP care managers regarding care plan
    - Notification to ACP if members are under your care
    - Call Center w ACP phone number

Key Next Steps

- The DOH has mentioned release of membership rosters by end of June and claims by end of July
  - Consent is still an issue and will not be resolved in the near term
  - DOH has explicitly stated that data cannot be shared until consent issues have been resolved
- However, engagement starts **NOW**

What's in it for me? Funds Flow

- ACP PPS's total award is $700m
- Appx 26% is awarded only if the PPS if considered 'High Performance'
- Funds flow
  - 38% categorized as PPS payments to providers
  - 62% Remainder categorized as project implementation, revenue loss, costs for services not covered and contingency funds
- Reminder that 95% of total payments to providers are to go to safety net providers and 5% to non-safety net providers

Q&As/Regional Breakouts

- Q&As
- Regional Breakouts - intent is to familiarize yourself with our network within the four counties
- **RSVP by today to ACP's Launch on June 24.**