Advocate Community Providers Physician Engagement Meeting November 19, 2015

Astoria World Manor

Astoria, NY

Agenda

- DSRIP Update: Integrated Delivery System
- ACP DSRIP Incentives
- Workforce
- PPS Requirements
- DSRIP Patient Engagement

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DSRIP Update & Progress

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DSRIP Update & Progress

- ACP successfully submitted the second quarterly reporting (DY1 Q2)
- New Providers have been added and network adds have been extended 11/30 (internal deadline).

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DSRIP Incentive

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DSRIP Implementation Incentive

- ACP disbursement of DSRIP incentives for implementation to providers
- Incentives are based on DOH-approved DSRIP application:
  - 22% - Primary Care Physicians
  - 5% - Specialist Physicians
- DOH will audit ACP's distribution model
  - Required Compliance screening
  - Complying with terms and completion of participation package

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DSRIP Incentive

To receive incentive your DSRIP incentive, please complete and submit the following:

- Participating Provider Agreement (p. 12)
- Implementation Certification Checklist
- W-9

Participating Provider Agreement

SIGNATURE PAGE FOR THE COALITION PARTNER

IN WITNESS WHEREOF, the undersigned's signature on this Coalition Partner Signature Page evidences the undersigned's agreement to be bound (i) by the foregoing Advocate Community Providers, Inc. Terms and Conditions as a Coalition Partner (referred to in the Agreement as "you") and (ii) by each other document referenced therein.

Name of Practice

Legal Name of Coalition Partner

dba Name of Coalition Partner

Tax ID used for MEDICAID BILLING

Coalition Partner FEIN

Street Address

City, State, and Zip Code

Telephone Number

Email Address

Fax Number

Physician Signature

Signature (on behalf of Coalition Partner)

Name of Physician

Name of Signatory

Title of Signatory

Date Signed

Implementation Certification Checklist

- Completion of Provider Participation Agreement and Participation in ACP DSRIP Project Requirements, including Participation/Consent in the Health Information Exchange (HIE)
- Comply with DOH DSRIP Reporting Requirements for ACP and Periodic Audits using Practice Management Software/EMR/HIE
- Completion of DOH mandated surveys, including workforce, IT, financial sustainability
- Completion of all requested Compliance Training and Certifications
- Practice must use certified Electronic Medical Record (EMR) or commitment to EMR conversion by September 30, 2016
- Achievement of 2014 PCMH Level 3 certification by Primary Care Physicians by December 31, 2017

DSRIP Incentive Parameters - Physicians

2 phases of DSRIP Incentives

Implementation Parameters (Attribution/Participation based):

- *Attribution (PMPQ) – Based on DOH panels*
- *Participation/Reporting*
- *Connectivity/EHR Readiness*

Future Performance Parameters (Performance/Metric based):

- *Engagement/Reporting*
- *Connectivity/EHR Readiness*
- Performance: *based on number of patients engaged*
- *First term reporting April 1st - September 30th*
- Future reporting will be on a quarterly basis

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DSRIP Implementation Incentive – PCP Model

	1 Practice (4,500 attributed patients)	2 Practice (600 attributed patients)	3 Practice (200 attributed patients)
DOH Attribution *(PMPQ: $12.74)*	$57,328.29	$7,643.77	$2,547.92
Participation/ Reporting	$1,276.10	$1,276.10	$1,276.10
Connectivity/ EHR Readiness	$1,276.10	$1,276.10	$1,276.10
TOTAL	$59,880.49	$10,195.97	$5,100.12

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DSRIP Implementation Incentive – Specialist Model

	1 Practice (800 attributed patients)	2 Practice (200 attributed patients)	3 Practice (50 attributed patients)
DOH Attribution *(PMPQ: $14.26)*	$11,405.26	$2,851.32	$712.83
Participation/ Reporting	$408.92	$408.92	$408.92
Connectivity/ EHR Readiness	$408.92	$408.92	$408.92
TOTAL	$12,223.10	$3,669.16	$1,530.67

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Workforce

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Workforce

- Key element: Identifying staffing gaps and training needs
- ACP is contracting with the Center for Health Workforce Studies, an Albany based research center to develop and distribute a survey tool for workforce assessment and analysis
- The survey tool will be distributed through an electronic link to all of our medical practices and community partners in mid January
- A quick response is required in order to conduct a thorough analysis of the workforce and to determine staffing requirements and training needs for the PPS as a whole.
- ACP staff will be available to assist in completing the survey

ACP PPS Requirements

ACP PPS Goals

- Implementing collaborative models of patient care
- Enhanced care coordination and care management models
- Monitoring specific performance measures
- Adherence to evidence-based protocols
- Adherence to standardized processes across the PPS
- EDI and PCMH level 3 certification

ACP Projects

2.a.i	Integrated Delivery System
2.a.iii	Health Home At-Risk Intervention Program
2.b.iii	ED care triage for at-risk populations
2.b.iv	Care Transition
3.a.1	Integration of Primary Care & Behavioral Health
3.b.1	Cardiovascular Disease Management
3.c.1	Diabetes Disease Management
3.d.iii	Asthma Management
4.b.i	Tobacco Use Cessation
4.b.ii	Increase Access to High Quality Chronic Disease Preventive Care and Management in both Clinical and Community Settings

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Paper vs EMR

- DSRIP requirement that all physicians must be EMR and 2014 PCMH Level 3 Certified
  - CMS Penalties for not having EMR

Paper	EMR
• Add the codes to your superbills and submit to your biller for posting Need to begin conversations on how to receive this information electronically • Portal option - in development • Some codes do not need to be billed - others have close quality care gaps and should be billed.	• Include the codes in CPT Codes (via Order Set) • Planning to include functionality for flags for some EMRs - future state Some codes do not need to be billed - others have close quality care gaps and should be billed.

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Project Implementation and Patient Engagement

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2.a.i Integrated Delivery Systems

Target: All patients and providers

Engagement: Every patient has a signed ACP HIE consent form

Action: Enter “HIE01” into CPT field

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DSRIP Update & Progress

ACP is developing the following:

- Provider portal to enter DSRIP activities - Website functionality to submit suggestions to ACP (www.acppps.org)
- Internal HIE and interfaces so we are able to effectively and efficiently report on DSRIP progress
- Please provide portal links so we can include in our website (PCMH requirement)

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2.a.iii 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: Enter “CP001” into CPT field

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2.b.iii ED Care Triage for At-risk Populations

Target: Every patient seen in the ED

Engagement: Every patient is given an appointment with their PCP or Health Home

Action:

- Availability of PCP for appointment setting
- Leaving ED with appointment in hand

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2.b.iv 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: Enter “PD001” into CPT field

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3.a.i Integration of Primary Care and Behavioral Health

Target: Every patient seen by the PCP

Engagement: Every patient receives a PHQ2 and if positive a PHQ9

Action:

- Implement IMPACT Model

  Depression care manager
- Use when screening patient:
  - **G8510 when negative**
  - G8431 when positive

3.b.i 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 “LSM01” into CPT field

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3.c.i Evidence Based Strategies for Diabetes

Target: Patients with Diabetes

Engagement: Every patient must have a documented HgbA1C

Action:

- Monitor HgbA1C **and Kidney Function**
- Life Style Modification/Nutrition
- Need physician Lab account numbers

3.d.iii 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 “AST01” into CPT field

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4.b.i 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

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4.b.ii 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

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DSRIP Update & Progress

- Lessons learned:
  - Need to configure Medicaid insurance groups (similar to MU requirements)
  - Identify/tag patients in a Health Home
  - Depression Care Manager Training
  - Lab Accounts
  - Asthma Action Plan
  - Million Hearts Next Steps (BP Stations, Logs)

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