Advocate Community Providers Physician Engagement Meeting June 18, 2015

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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DSRIP Progress

ACP is in the process of developing the following:

- Participation Agreement & BAA
- Provider portal to enter DSRIP activities - Website functionality to submit suggestions to ACP
- Internal HIE and interfaces so we are able to effectively report on DSRIP progress

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DSRIP Process

- DSRIP is a new program, and as with all new programs, ACP will be continuously improving to make sure all goals and metrics are achieved.
- The proposed methodologies are intended to make tracking easier when reporting is due to the state – providers must be willing to allow access to this information
  - Procedure Codes are home-grown and should be posted but not necessarily billed.

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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: Use billing code HIE01

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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: Use billing code CP001

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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
- Phone: 844-ACP PPS2 (844-227-7772)

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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: Use billing code PD001

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

Target: Every patient seen by the PCP

Engagement: Every patient with a positive PHQ2 receives a PHQ9 screening

Action:

- Implement IMPACT Model

  Depression care manager

- Use G8431 when screening patient

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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 billing code LSM01

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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
- Life Style Modification/Nutrition

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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 billing code AST01

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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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Q & A

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