Adirondack Region Medical Home Pilot

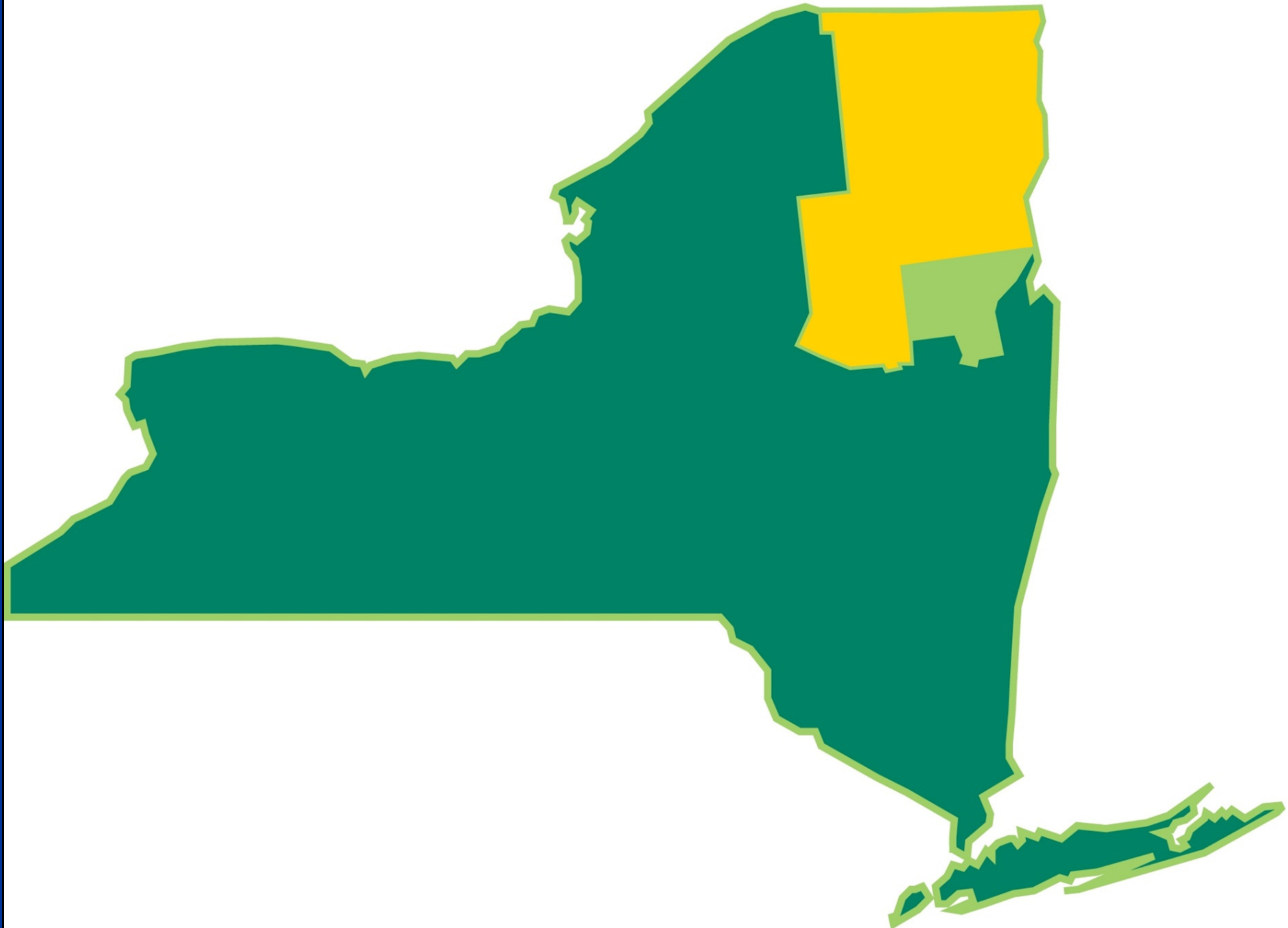
John Rugge, M.D

Adirondack Health Institute

Patient-Centered Primary Care Collaborative

February 10, 2011

Adirondack Medical Home Pilot



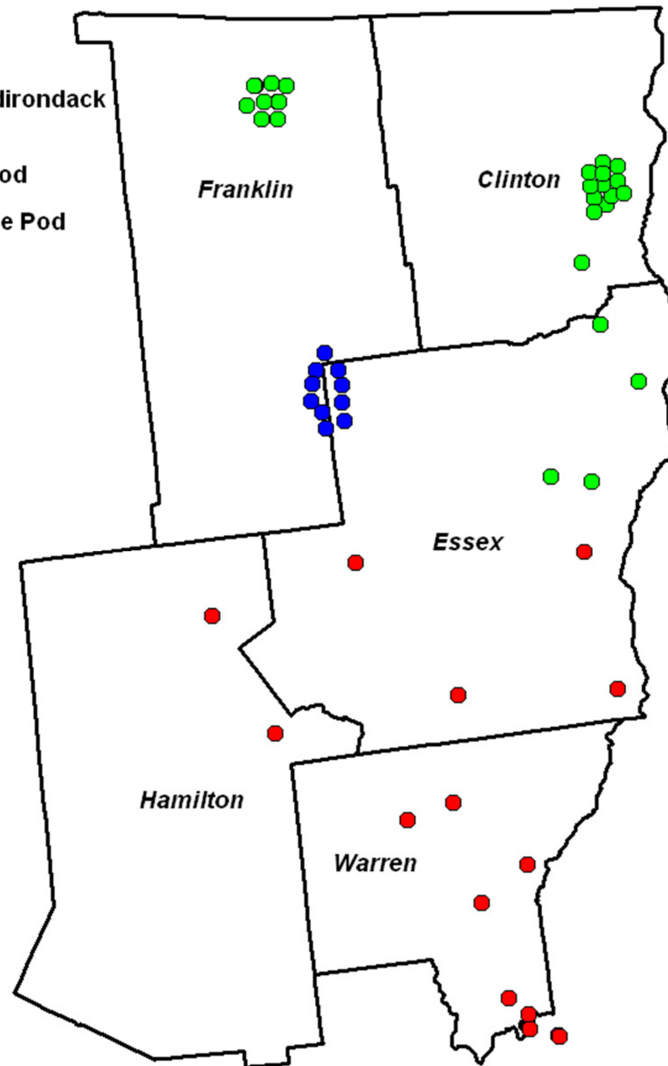
NORTH CREEK
RAILWAY DEPOT
DRY GOODS
BROOKS Pharmacy
North Creek Market Place
STAPLES LAW FIRM

Demographics

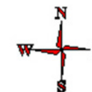
- Population ~ 200,000
- Micropolitan (2)/Rural/Frontier
- Second to SW Florida in Age
- Unusual and Stressed Economy

ADIRONDACK REGION MEDICAL HOME PRIMARY CARE PRACTICES

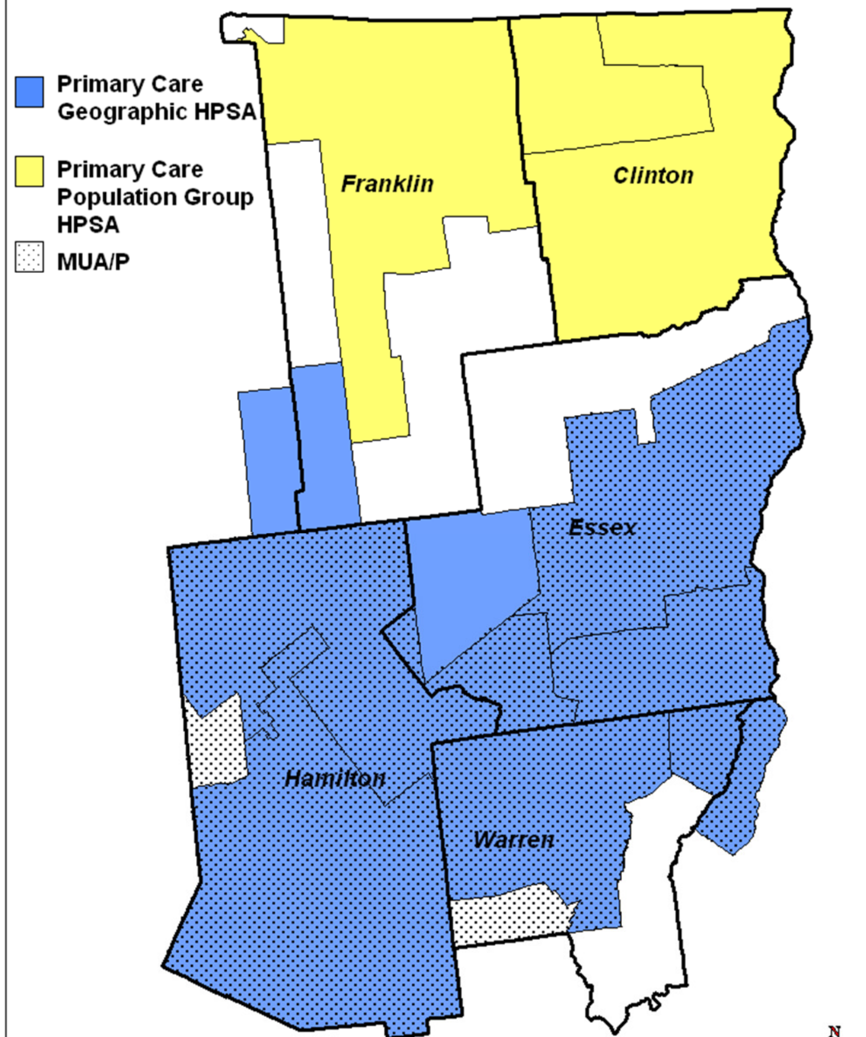
- Northern Adirondack Pod
- Tri-Lakes Pod
- Lake George Pod



0 10 20
miles



Data Source: Providers: Hudson Headwaters Health Network; HPSAs, MUA/Ps, HRSA
Map prepared by Community Data Services LLC, Voorheesville, NY
www.thecommunitydataservcies.com
January 2011


HEALTH CARE DEMOGRAPHY
Primary Care Geographic HPSA
Primary Care Population Group HPSA
MUA/P
Franklin
Clinton
Essex
Hamilton
Warren
Data Source: Providers: Hudson Headwaters Health Network; HPSAs, MUA/Ps, HRSA
Map prepared by Community Data Services LLC, Voorheesville, NY
www.thecommunitydataservcies.com
November 2009
0
10
20
miles
N
W
E
S

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

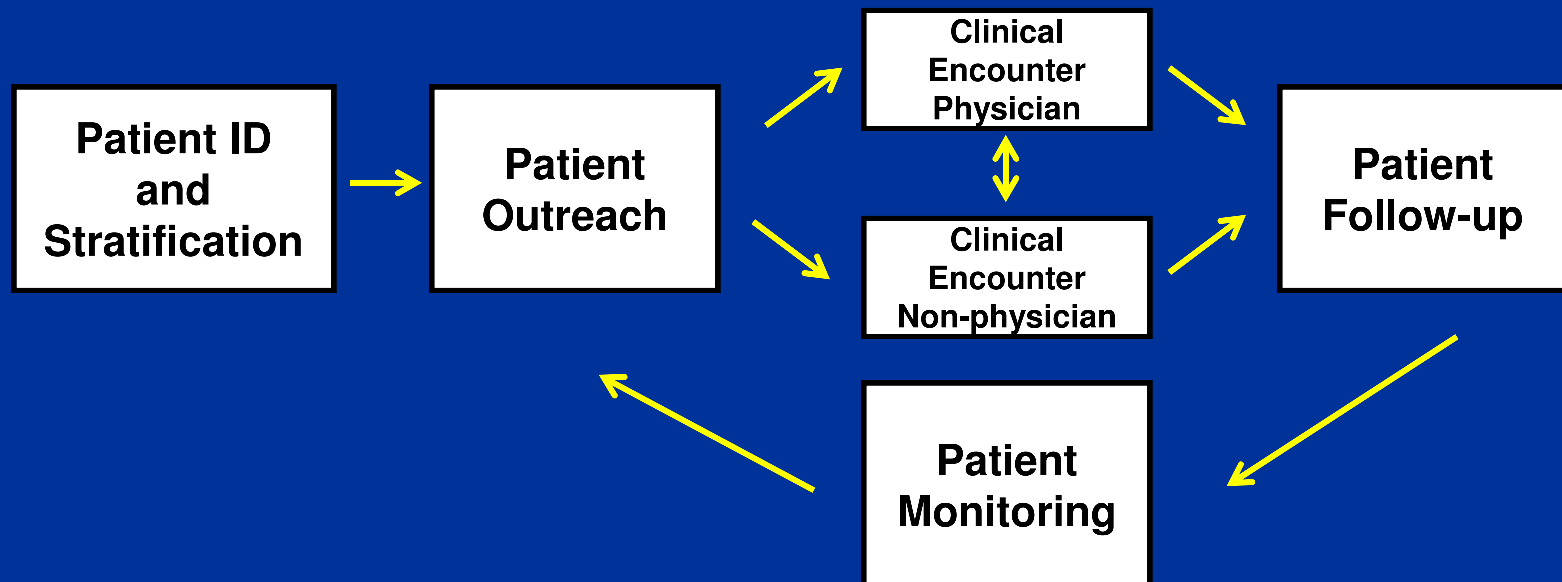
Chronic disease management

- 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



Pilot Participation Requires Measurement

Access to care

Clinical Quality - Evidence based guidelines

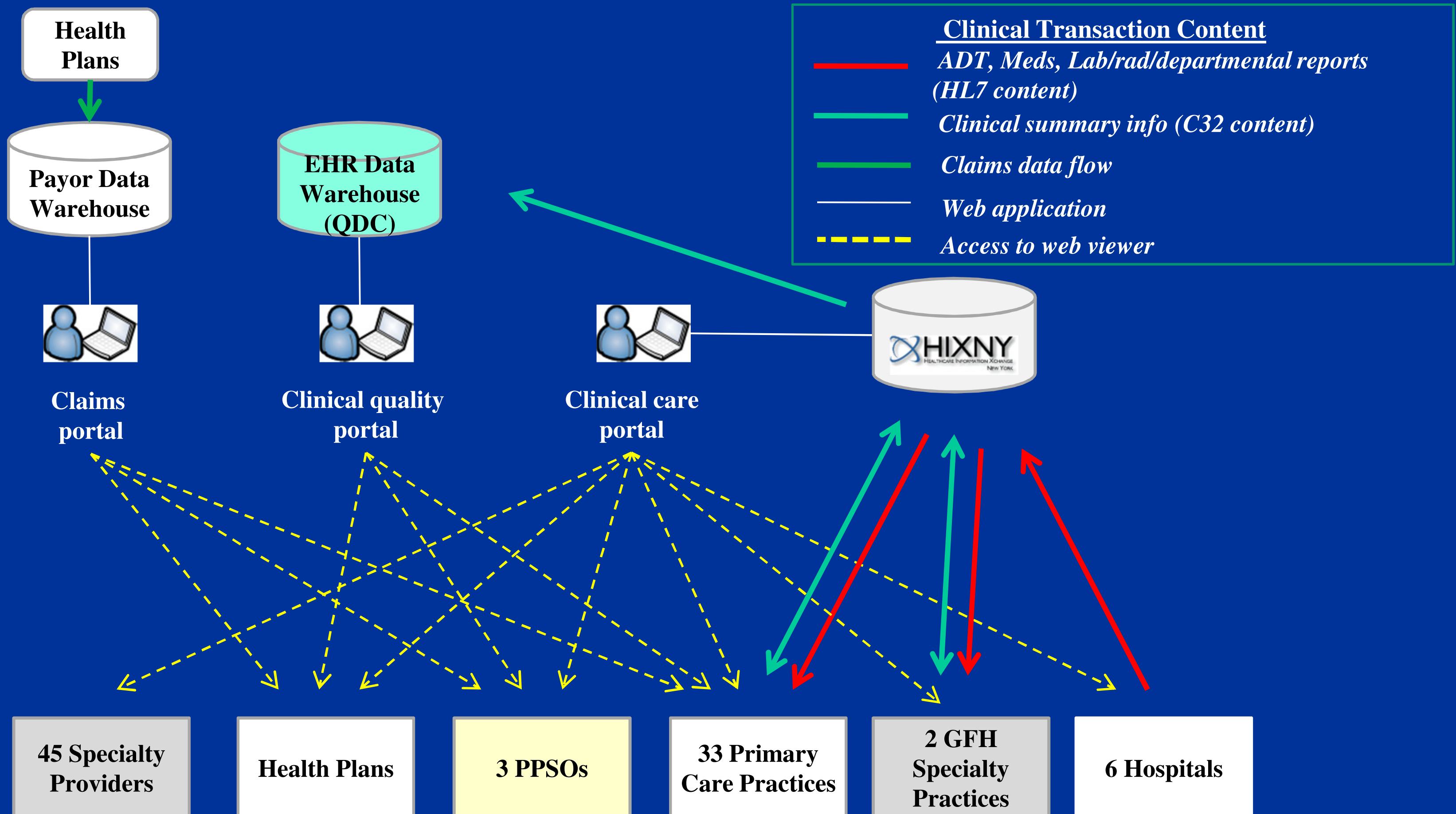
- **Adult – Diabetes / Hypertension / Coronary Disease**
- **Pediatric – Childhood Obesity /Asthma / Prevention**

Efficiency

- **Inpatient bed days / ER visits / Formulary compliance**
- **Risk adjusted total cost**

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

Abstract View



Clinical Transaction Content Detail

	Hospital-to-HIXNY	*Practice-to-HIXNY*	*HIXNY-to-practice*	*HIXNY-to-QDC*
ADT, Meds, Lab/rad/ departmental reports (HL7 content)	• ADT • Lab/path/micro results • Imaging reports • Current and prescribed medications • Departmental reports (availability may vary by hospital) • Discharge summaries	• NA	• C32 content will be available to Practice EHR's for consumption • EHR vendor consumption capabilities are vendor-specific • Lab/path/micro results • Imaging reports	• NA
Clinical summary info (C32 content) **Note: C32 content for Practice-to-HIXNY exchange is per HITSP harmonized standard. HIXNY version may differ slightly.**	• NA	• Patient demographics • Language spoken • Health care provider info • Health insurance info • Allergy/drug sensitivity • Problem/condition • Medications • Pregnancy • Information source • Advance directive • Immunizations • Vital signs • Results • Encounter type • Procedures • Social history • Comment • Plan of care • Family support	• C32 content / HIXNY Patient Record • Available through HIXNY portal	• Patient demographics • Language spoken • Health care provider info • Health insurance info • Allergy/drug sensitivity • Problem/condition • Medications • Pregnancy • Information source • Advance directive • Immunizations • Vital signs • Results • Encounter type • Procedures • Social history

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