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Deliverable # 9
Progress Report of Sub-Regional Solutions



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1. DELIVERABLE #9 OVERVIEW

Previous deliverables have provided detailed recommendations for establishing governance structures, baseline information of physician practice readiness, the technology structures needed to exchange information, the type of quality information that is expected to be collected, monitored, and shared between practices and payors, and the overall development of the three physician support organizations (Pods).

This deliverable provides a final progress update, specifically focusing on outstanding issues, the plan to resolve the issues, major and future activities.

At the beginning of the project, it was determined that Pods must be able to support:

1. Performance reporting capabilities and interoperable HIT capacity connecting patients, clinicians, and payors and leveraging health information exchange among all stakeholders
2. Readily available evidence-based care guidelines
3. Improved access to care
4. Enhanced practice-level quality of care evaluation and reporting of health care outcomes
5. Coordination of care for patients with chronic disease
6. Physician practice change management to leverage technology and delivery models
7. A new business model with payors actively supporting physician participation through an enhanced payment system
8. Performance reporting capabilities and interoperable HIT capacity connecting patients, clinicians, and payors and leveraging health information exchange among all stakeholders

Based on the location of participating practices, three geographic regions naturally developed. Practices were grouped into the following Physician Practice Support Organizations (“Pods”):

- Northern Adirondack, centered in Plattsburgh
- Tri-Lakes, centered in Saranac Lake
- Lake George, centered in Glens Falls

In each of these communities the Article 28 organizations have assumed the role of the Pod; they are 1) **Adirondack Medical Center (AMC)** in Saranac Lake; 2) **Hudson Headwaters Health Network (HHHN)** in Queensbury (Glens Falls); and 3) **Champlain Valley Physicians Hospital (CVPH)** in Plattsburgh. While each Pod resides within the same defined region, there is

significant variation among the three Pods in terms of size, homogenization, community resources, and participating practices.

As noted, an additional component of Pod development focused on ensuring that standardized quality improvement efforts were integrated. Most quality improvement is typically measured along four domains: access, experience, process, and outcomes. Providers participating in this pilot must exhibit progress in each of these domains as measured by NCQA certification at the Level II or III recognition level. Success is detailed for each area and includes:

1. Assignment of patients to a personal clinician who is available 24/7
2. Establishment of dedicated care coordination teams to actively manage those with chronic conditions across the continuum of care
3. Implementation and adherence to evidence-based guidelines
4. Reporting outcomes to measure success and to identify continued opportunities for improvement in care delivery

Ultimately, the role of each Pod is to assist the rural, solo, and small physician practices in meeting the NCQA medical home requirements. The Pods are also responsible for planning, designing, and building new quality and performance reporting requirements. Specifically, the Pods will help participating practices by providing:

1. Assistance in implementing needed technology platforms
2. Assistance to ensure participating practices submit NCQA certification applications
3. Standardized evidence-based guidelines
4. Quality care evaluation, reporting, and surveillance processes
5. Requirements for access to care
6. Performance reporting at the aggregate, group, and individual levels
7. Education and technical resources to support the implementation of quality improvements
8. Performance and compliance reporting to appropriate oversight organizations

2. OUTSTANDING OPERATIONAL ISSUES

Overall, the pilot program and Pod development has progressed as expected. Setbacks were overcome with constant communication, and obstacles surmounted through diligent, creative cooperation. There were two operational issues, however, worth discussing in depth. Both of these issues, while currently “on track”, could reemerge without continued monitoring.

Patient Attribution

One of the fundamental issues that arose during the initial phases of development was how to determine functional patient attribution lists. These lists were essential to determining which

patients were included in the pilot and to which practitioner they should be assigned. In addition, the development of the \$7 per patient per month was calculated on specific patient populations. Spirited discussions arose among payors, participating practices, and Pods questioning the following:

- The number of visits a patients must have had with a practitioner to be assigned
- The timeframe to be used to determine the assignable patient population
- The inclusion/exclusion of part time residents

Developing a common understanding of which patients were included and the rationale for patient exclusion was the basis for participating practices knowing the patient populations for which they were responsible and allowed for financial planning since patient attribution lists were important for determining the per member per month payments.

After significant discussion the stakeholders reached agreement on reasons for excluding a patient from an attribution list. This list was agreed upon and communicated to all stakeholders in mid-March, 2010. The reasons for patient exclusion include:

- The patient's insurance plan type is not in the demonstration
- The patient is no longer a plan member
- The patient has had no qualifying visits in the date range
- The patient has had only non-qualifying visits, such as urgent care
- The agreed upon attribution methodology assigns patient to different provider/practice
- The member resides out of area
- Non-contracted or non-credentialed provider

In addition to the collaborative dialogue, most practices had to learn how to utilize the capabilities of their electronic health records to manage specific patient populations. Developing the processes to enter the necessary data and then being able to identify patients by insurance plan and participation status took significant training and effort. These system capabilities allowed the practices to negotiate and validate patient attribution lists as developed by the payor participants. While the groups have defined common exclusion criteria, on-going communication and validation is required.

Lack of Trust

Another significant issue encountered was the fundamental lack of trust between and among stakeholders, which significantly slowed the change management efforts designed to smooth the transformation of care. Traditionally, each participant has a different goal and a different relationship with the patient. Payors organizations are typically entities whose priority is to make a profit by managing the distribution of risks. Their relationship with patients is removed and they generally view patients as risk stratified groups rather than individuals. Their relationship with a patient is usually dictated by the patient's employer rather than a selection by the patient. Hospitals' relationships with patients are primarily through the patient's physician, who sends the patient to the facilities for procedures, imaging services, and inpatient services; these relationships are typically short-term and episodic. In contrast, physicians' relationships with patients are the most personalized, and the priority is to treat patients using their medical judgment. Their relationships with patients are long term and deeply personal on both sides. These differing relationships and priorities created fundamental trust issues among the major stakeholders of this pilot.

Inaccurate attribution lists created tension that was exacerbated by the lack of trust. While agreeing the lists were not accurate, the participating payors continued to push for the providers to begin changing the way they practiced medicine (with significant start up costs) before the agreement was reached on how to develop an accurate list. Providers were less willing to change the way in which they provided care because of the delayed payments. They were concerned that the payors were trying to shift significant financial risk to them and potentially reap the reward of enhanced medical care without providing the full per member per month payment to which they were entitled.

The lack of trust also slowed the change management process by allowing the discussions to become "sidetracked." Many meetings were spent discussing operational issues not related to the pilot program such as insurance credentialing requirements, historical payment disagreements, and billing problems, to name a few.

Change Fatigue

The final issue to be recognized is the mental and physical fatigue that occurs when transformations of this magnitude occur. The factors contributing to this fatigue include:

- Rapid rate of change
- Technology
- Process changes
- Fundamental mindset changes

This project was condensed into roughly a twelve month timeframe. Significant changes in workflow, patient management, organizational relationships, and technology utilization were required to accomplish the transformation. The timeframe in which practices were forced to adapt and accept the changes can be likened to the path of an avalanche and not the traditionally glacial pace of healthcare change. Many practices were forced to identify electronic health record vendors, select a system, and implement the system during this timeframe. Daily processes were required to be modified to allow the transition from treating episodically to comprehensively. Accurate, timely information about patients now must cross organizational boundaries and each entity is being persuaded out of their silo.

Participants were forced to change their basic mindset about the delivery of healthcare from autonomous to collaborative. The requirement for collaboration was multiplied across all organizations – each entity needing to work together versus against each other. In short, participants had to change their world view from one in which they were the “top dog” to one in which they are an important part of a team.

3. ISSUE RESOLUTION

Two facts contributed to the resolution of the issues discussed above, as well as the many other opportunities for conflict that arose. The first was the significant leadership of the New York Department of Health, and the second was using program management to recognize the need for delayed deadlines without sacrificing the overall project timeline.

Leadership of the New York State Department of Health

The New York State Department of Health (NYSDOH) should be recognized for the leadership and guidance throughout this project. The NYSDOH set the tone for the project by including all participating stakeholders from the beginning. They developed impartial, collaborative relationships with all and provided mandatory, regularly scheduled meetings at which all stakeholders could voice concerns, discuss solutions, and reach consensus. They also leverage their governance oversight position to ensure resolution and forward progression on contentious issues rather than allowing the project to languish due to competing interests. When patient attribution lists became an obstacle to continued progress, the NYSDOH forced JOINT meetings between the participating providers and payors. The issues were brought to the joint governance meeting and they facilitated a resolution. Without their leadership this issue would still be in the discussion phase and the project would be harmed.

The NYSDOH also facilitated constant communication among all stakeholders. They enforced a key requirement of regular meetings and transparent, timely communication on all issues. This prevented the formation of erroneous assumptions and ensured everyone remained focused on the ultimate goal: health care delivery improvement for the region.

The NYSDOH ensured program management skills were applied to this project. Program management differs from project management by strategy and scope. Program management ensures the correct projects are selected, coordinated, and completed to deliver long term improved performance. The NYSDOH ensured the efforts of this project, the HEAL 10 grants, and HIXNY project all supported the transformation and improvement of healthcare delivery through the development of technology, performance improvement, and required reporting.

Delayed Deadlines

While the NYSDOH ensured program management skills were applied, EastPoint Health used project management tools to keep the day-to-day activities of the participating practices moving forward despite the fatigue resulting from near constant change. Transformation on this scale requires training and performance coaching to minimize the dissonance that occurs when expected patterns and processes are disrupted. The original program plan established aggressive performance timelines. The NYDOH worked closely to ensure the original project milestones were adjusted when necessary to ensure stakeholder success. This insight and flexibility was critical to mitigating the change fatigue and helped break down some of the inherent lack of trust.

The original program plan identified the goal for all participating practices to submit their NCQA certification applications by December 2010. However, as the initial assessment and gap analysis of capabilities was completed, it became apparent that significant time and effort was needed to ensure the technology foundation was solidly in place to guarantee successful performance improvement and reporting. This recognition resulted in the NYSDOH allowing a two month delay for NCQA medical home certification submission, with a new deadline of February 2011 being communicated to all stakeholders. Each practice successfully met the new deadline. Additionally, they established a new milestone for EMR measurement reporting of 3rd quarter 2011 to ensure success.

As discussed previously, the NYSDOH also worked with participants to establish a new deadline for patient attribution lists to be finalized. This will promote reduced discrepancies and will allow for accurate payments to participating providers.

As deadlines were adjusted, all stakeholders were notified and included in the decision. This constant communication is a theme of success and a key risk mitigation factor at all levels and stages of this pilot.

4. HISTORICAL OVERVIEW OF MAJOR IMPLEMENTATION ACTIVITIES

Major implementation activities completed include the establishment of governance structure, legal contract, operational Pods, and successful NCQA certification submissions.

Governance Structure

The NYSDOH has established the Governance Committee to provide ongoing oversight for this pilot. They have identified representatives from each stakeholder group, identified routine meeting frequency, and communicated reporting requirements to all participants. The establishment of the overarching governing body is essential to continued progress and reporting.

Legal Contracts

After many months of discussion, legal contracts are almost in place outlining the exchange of patient-level clinical and financial data. The contracts were instrumental in defining how patient information would be reported and who could access the data. Participating payors should be commended for the unprecedented transparency, breadth, and depth of patient level data they have agreed to submit to the Payor Data Warehouse. The finalization and implementation of these legal contracts was a key activity to ensuring successful performance reporting, measurement, and improvement.

Operational Pods

Thanks to the commitment of the Article 28 organization within each CCZ, three functioning Pods have been established and are fully operational. Each Pod has hired a dedicated manager to coordinate the functions of the Pod. In addition, all three have hired the additional staff needed to assist participating providers with continuous quality improvement, care coordination, pharmaceutical management, technology support, and other identified services. Having operational Pods takes significant pressure off participating practices and increases provider commitment to the ongoing performance measurement and reporting requirements.

Successful NCQA Certification

One of the major goals required of all participating providers is the successful submission of a complete NCQA patient centered medical home certification application. Although the submission deadline was delayed, each practice has at this point successfully completed and submitted their application.

5. FUTURE ACTIVITIES

Future activities focus on continuing and delivering additional improvements in financial and quality changes that have occurred.

Financial

Despite the significant amount of agreement/standardization, there are still some areas driving continued dialogue. As would be expected, the major issues of disagreement revolve around the distribution of the enhanced payment. It is understood that the participating practices will

be required to share a portion of the enhanced per member per month or “plus up” payment to operate each Pod. This “assessment” will enable the Pods to provide the agreed-upon services including data aggregation and access to advanced practice support practitioners. While acknowledging the need for the Pod structure and subsequent support, there is significant variation among the participating practices as to what a reasonable assessment will be. In the Lake George and Northern Adirondack Pods, the practices have explored multiple options and are currently utilizing a 50-50 split of the potential \$7 per member per month enhanced payment. In the other Tri-Lakes Pod, discussions have resulted in methodology that leverages the services utilized on an as needed hourly basis with payment then made retrospectively for the services utilized.

In addition, while the majority of participating practices have agreed to the services being offered by the Pods, there are a few practices still expressing disagreement with the need for some of the services offered. Some practices believe they already meet the standards of a fully operational PCMH and do not need any support services. Other practices believe their needs encompass the entire menu of options. Determining the standard expectations for all practices will be an on-going process.

Participants have begun utilizing evidence-based guidelines and developing the capability to coordinate care across the continuum regardless of location. These changes are designed to deliver financial and care improvements. However, the comprehensive transition of healthcare from one where funding is based on volume (fee for service) to one based on value (outcomes) must be ongoing. Future activities must include working within each Pod to enhance the collaborative relationship between the hospitals and the practices. This collaboration will be elemental to meeting the goals of preventing hospital admissions/readmissions and emergency department utilization. Responsible reduction in the inappropriate usage of these resource intensive activities will be essential to meeting the financial goals of the participating payors.

Quality

Quality enhancements have been integrated at all levels of the participating organizations. Each practice has been trained and will follow the same evidence-based care guidelines. Participating practices have also been trained to utilize the Plan Do Act Study (PDSA) process. Future activities must ensure participants use the information collected to improve care and ultimately healthcare outcomes. They must also utilize the PDSA cycle to continuously improve their operations and collaborative management of populations of patients.

Operational

Perhaps the most challenging future activities will be sustaining the changes in the operational culture. Ensuring all participants institutionalize the view of healthcare delivery as an

interconnected system rather than autonomous, revolving “parts” is imperative. Without constant care it can be expected that each organization will slowly revert to their previous autonomous sphere of influence. Failing to replicate a “systemness” world view will compromise the ability to improve care and ultimately reduce costs which can result from interconnected relationships.