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Achieving Shared-Savings During COVID

Implementing Complex Case Management in an Intellectual and Developmental Disabilities (IDD) World

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Educational Webinar Series

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AIC

Speakers

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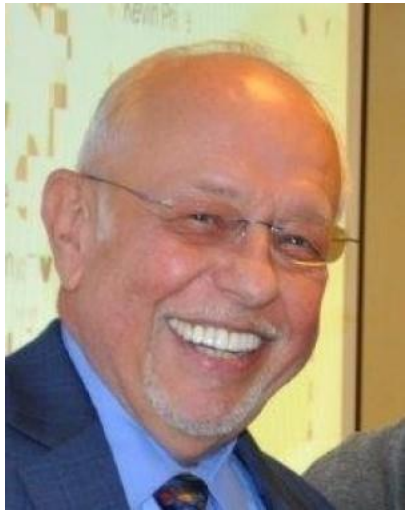
Chief Medical Officer –

Alliance for Integrated Care of New York, LLC, MSSP, ACO.

Metro Community Health Centers, Inc.

Duane Schielke

Executive Director, ACO – Alliance for Integrated Care of New York, LLC. MSSP ACO



Dr. Sanjay Seth

Executive Vice President - HealthEC

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Agenda

- Who is AICNY
- Our IDD Population
- Complex Case Management Landscape
- Our Strategy

Who is AICNY

The Alliance for Integrated Care of New York, LLC (AICNY) oversees the healthcare needs of individuals with intellectual and developmental disabilities (IDD).

- Originally named the Accountable Care Coalition of Greater New York, ACCGNY began operations in 2014 and is one of the nation's first approved Medicare Accountable Care Organizations (ACOs) to focus on the needs of IDD adults.
- AICNY was a partnership between eight developmental disabilities health services providers across New York State and 28 practices associated with the Queens County IPA from 2016 to 2019.
- The organization is currently comprised of 8 diagnostic and treatment centers, located across New York State, 5 of which are five federally qualified health centers (FQHCs)

Population Overview

- AICNY cares for approximately 6,200 dual eligible Medicare and Medicaid beneficiaries with developmental disabilities, and is the only MSSP-approved ACO of its kind in the country
- Beneficiaries present multiple complex chronic health conditions with a high coexistence of mental health conditions making the coordination of care more complex and inefficient.
- At-risk patient populations have challenging data capture, aggregation and analytics requirements. With diagnoses such as cerebral palsy, Down syndrome and multiple chronic conditions, IDD adults require long-term medical care and often reside in group home settings.

Challenges – Goals -Solution

Challenges

- Integrating care solutions
- Group Home records are difficult to access
- Coordination of Outside Specialists not onsite at Primary Care Facilities (FQHCs and Article 28s)
- Delivering proactive, personalized care
- Incorporating social determinants
- Polypharmacy and Medication Management
- Difficulty in ensuring preventive care
- High ED for population during COVID pandemic

Goals

- Identify and implement technology to create a centralized view of the patient's data, regardless of the originating system or setting of care
- Engage the physician community and illustrate opportunities for improved quality of care
- Manage care coordination and personalize patient communication for social determinants
- Reduce overall cost to serve a growing beneficiary population and geographic region
- Coordinate medical and behavioral health care

Solution

- Utilize HealthEC's longitudinal record and care management solution to enable chronic care management within ACO
- Care Coordinators in Chronic Care Management
- Telehealth Kiosk within group homes to triage patients for avoidable ED admissions
- Coordination with Regional health Information Organizations (RHIO)

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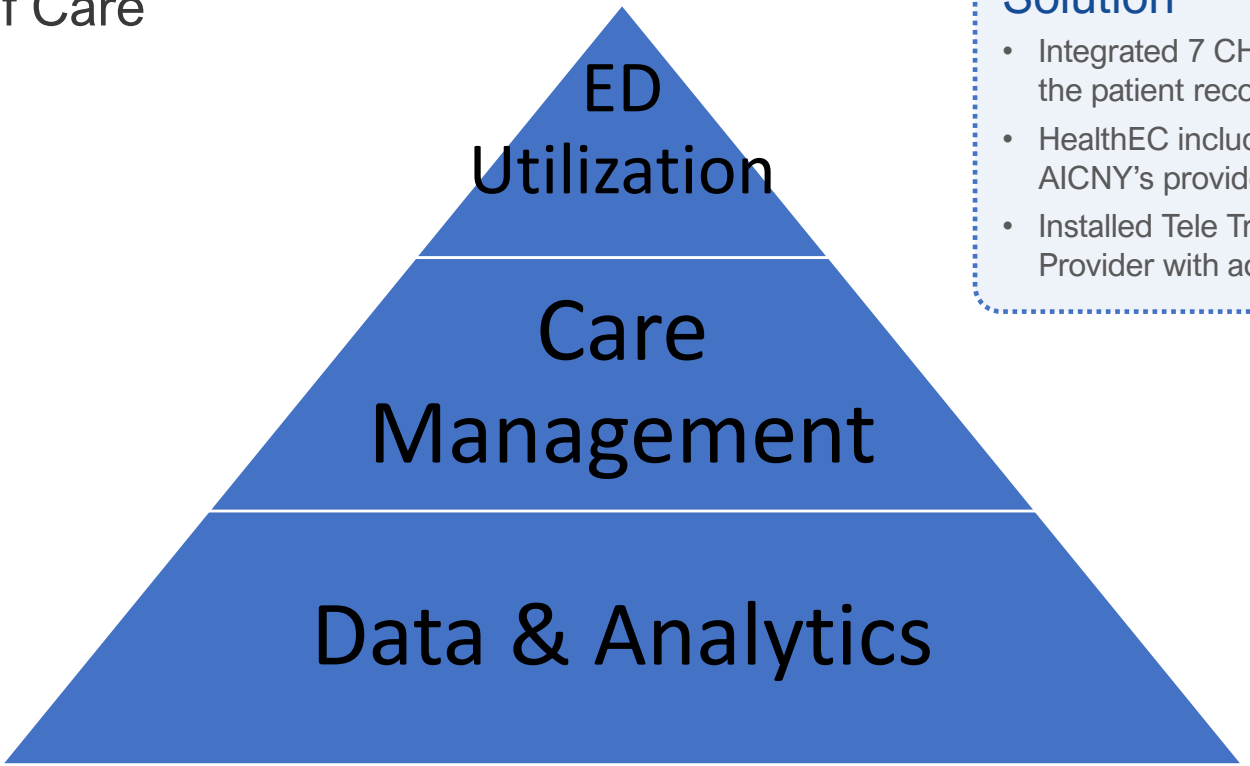
Complex Case Management

- Metro has a robust quality measures program (high risk groups)
- While COVID-19 exacerbated care coordination and telehealth needs for everyone, organizations that work with at-risk populations were hit especially hard. A new analysis of comorbidities as risk factors for COVID-19 found that coronavirus patients with developmental disorders are the most at risk of dying, followed by those with lung cancer and intellectual disabilities .
  - Poor medication adherence in select groups
  - Hindered Care Coordination efforts
  - Collaborative measures required

Overall Strategy (2019/2020)

- Building Blocks
  - Quality Measure Closure
    - NCQA Recognized Patient Centered Medical Home
  - Chronic Care Management
  - Transition Of Care



Solution

- Integrated 7 CHCs and 25 licensed private practices, completing the patient record.
- HealthEC included two care manager trainers to augment AICNY's providers for coordinate care
- Installed Tele Triage kiosks connected to local ER or Urgent care Provider with access to beneficiaries' longitudinal record

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Overall Strategy (2019/2020)

- Building Blocks
  - PHM – Data & Analytics
    - Visibility into centralized data across AICNY's network from HealthEC, revealed extraordinarily high emergency department utilization rates among the organization's IDD patients living in certified residences. A substantial portion of that ED use was unnecessary or avoidable, but also had a high correlation to inpatient admissions.
    - Allowed for a longitudinal record and care coordination record
  - Telemedicine Grant/ Kiosk Triage

Solution

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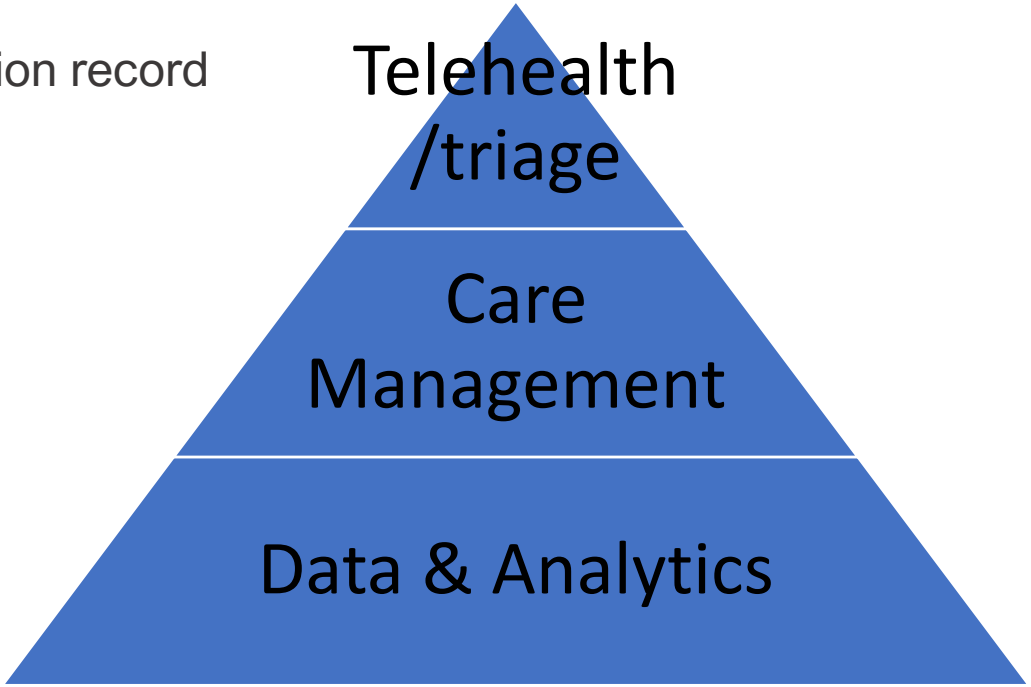
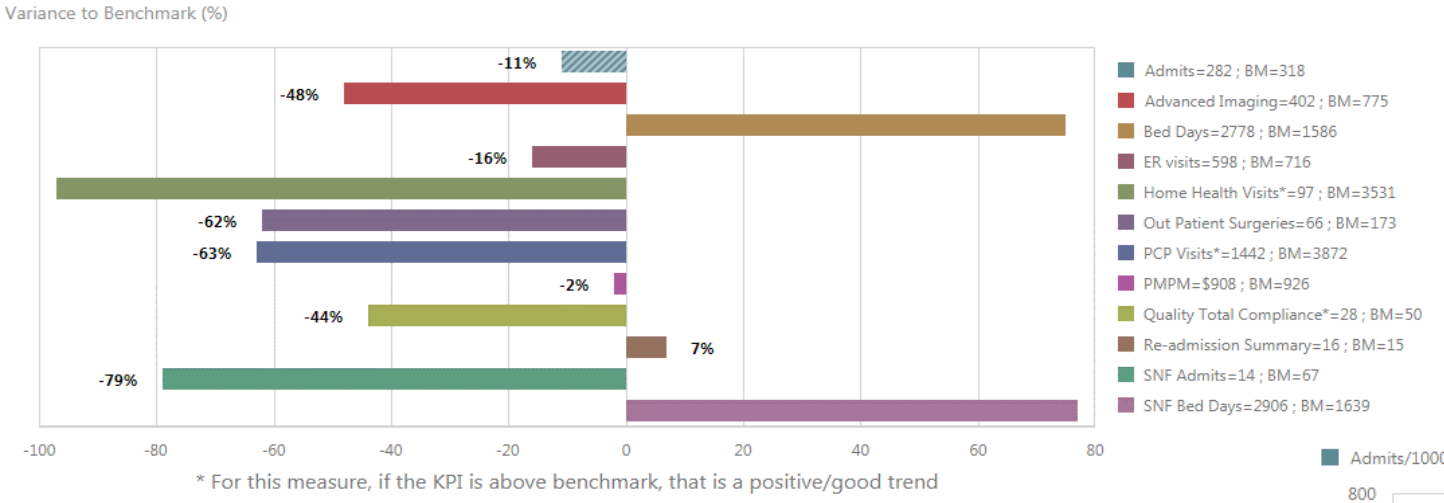
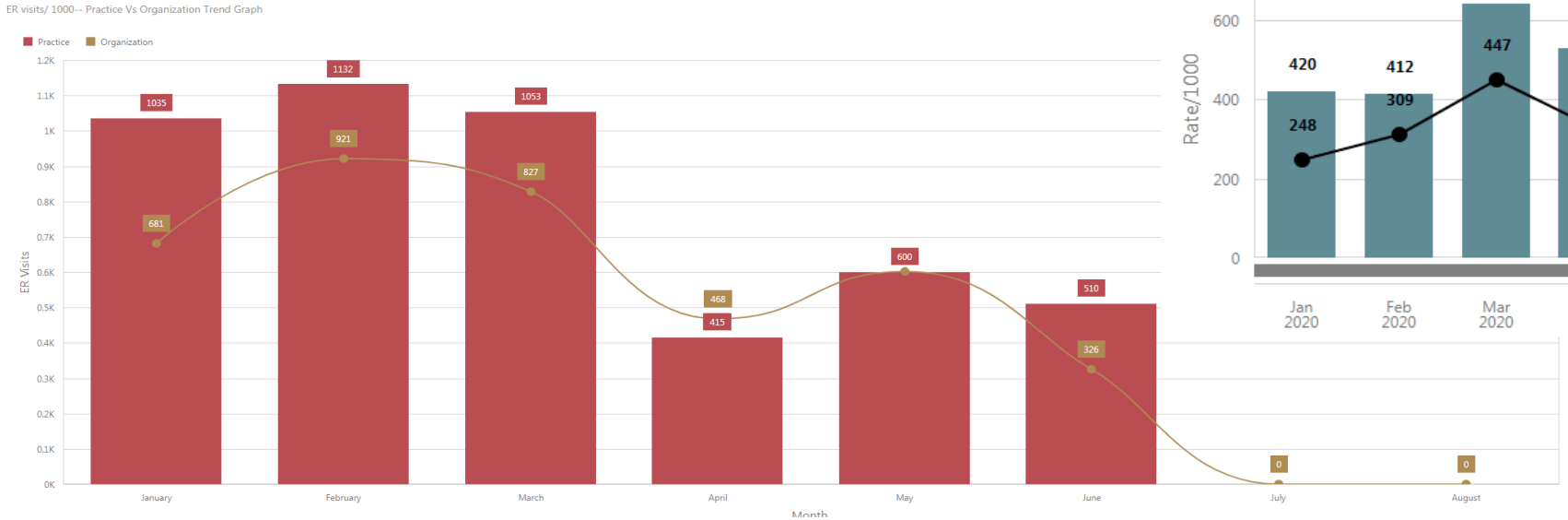
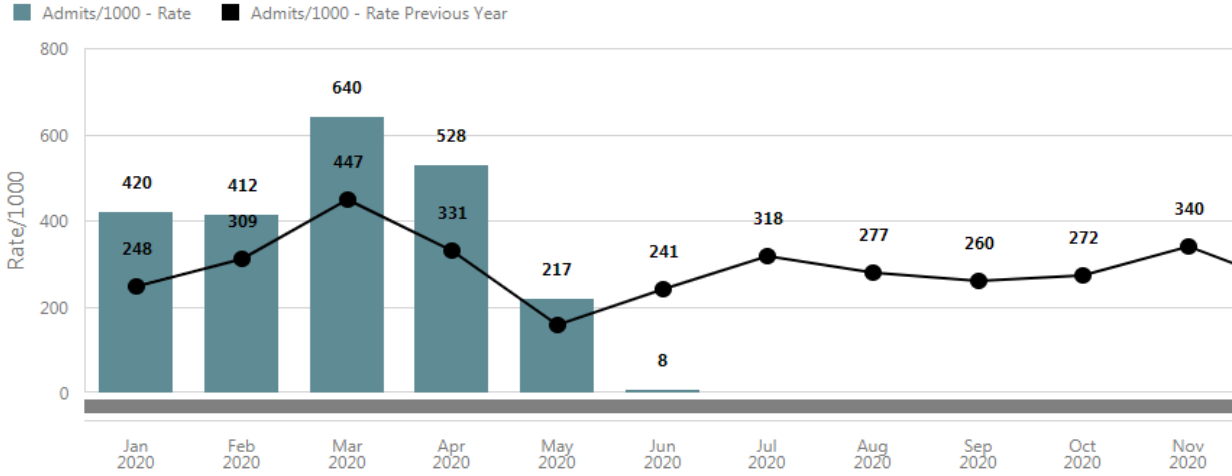


AICNY Dashboards







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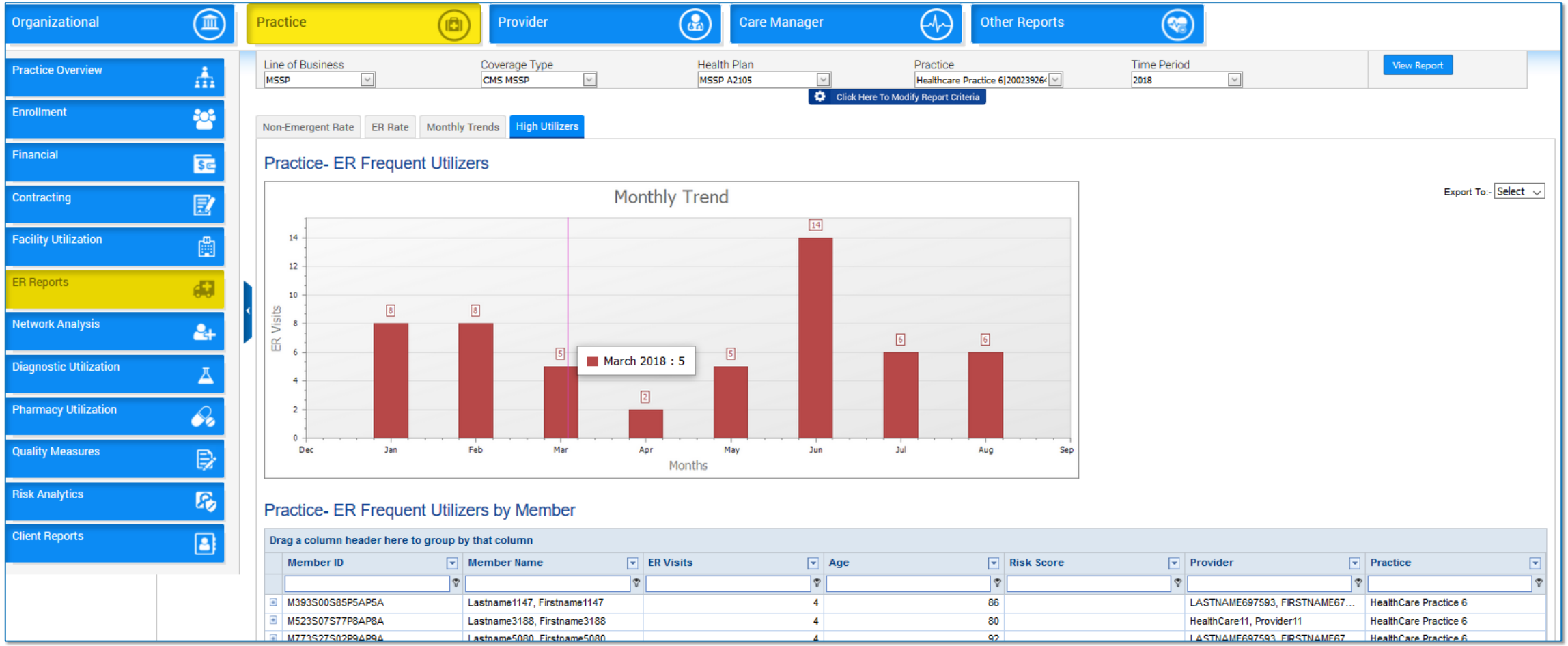
High Utilizers at the Practice Level

The Org-ER Frequent Utilizers report display members who had frequent visits to the emergency room. The report represents individual members who have incurred ER charges on multiple occasions.



Data & Analytics

- HealthEC's PHM platform, which sits in the middle of the medical records and precision care data and acts like a hub to aggregate, send and see virtually any information on the patient.
- HealthEC corrals a large amount of unstructured data received from outside medical providers and adds it to the structured claims data received from CMS.
- Platform creates a pre-visit referral packet so, in advance of a visit, health centers get an electronic packet with charts and the purpose of visit

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Telemedicine Kiosks

- Added telemedicine kiosks to IDD patients' residential homes and engaged providers with triage expertise
  - Triage provider assesses the situation and makes a recommendation for transfer to ER and contacts the ER; prescribes medication; recommends other home treatment
- Telemedicine Statewide
  - 7,000 patients with access to Kiosks at over 1,000 locations (through grants)
- New kiosk versions have a heart monitor component, so one can get EKG information, as well as chest and abdomen sounds

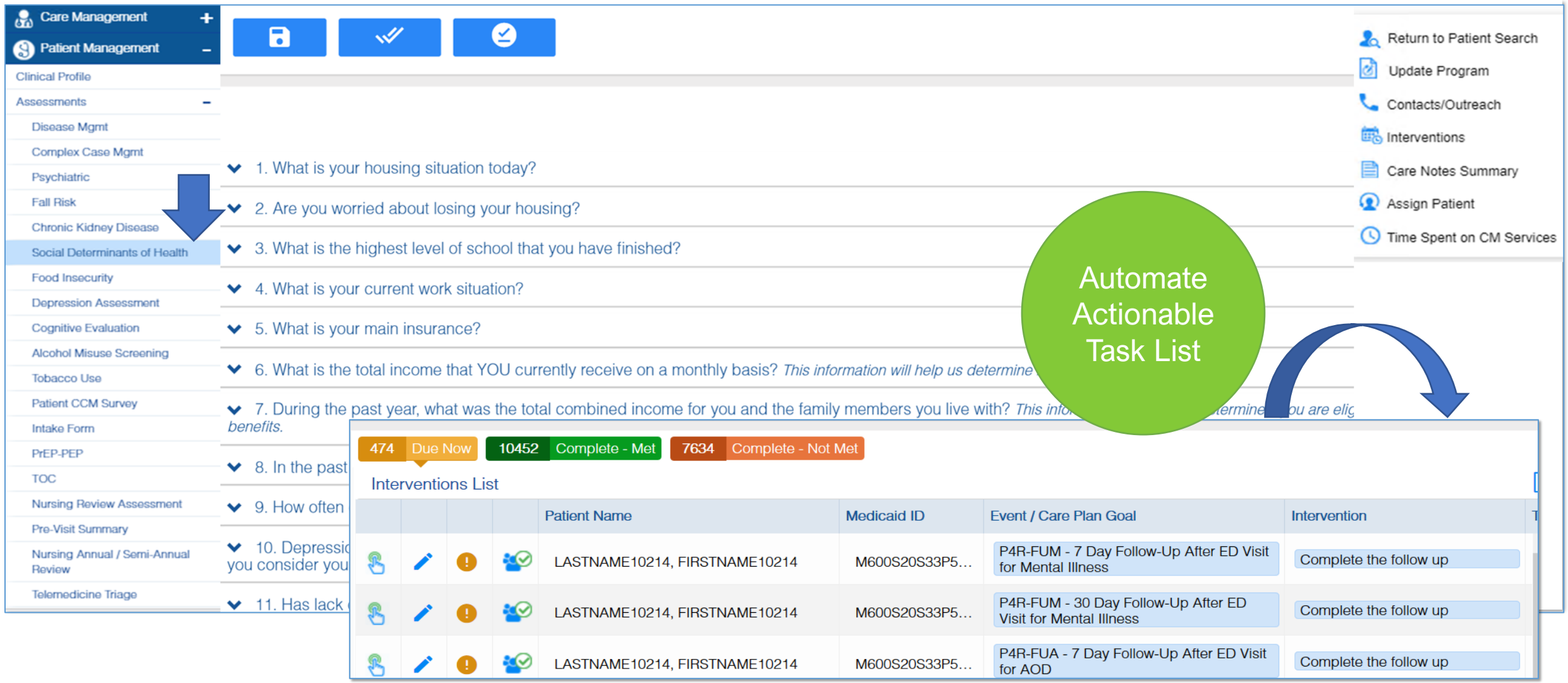
Responsive CCM Program

- Hybrid Model- 2 dedicated care managers
- CCM is with the Care Givers
- 100% Reach Rate
- Active Engagement
- Adoption of decreasing barriers to care
- Unenrollment rate is minimal
- Billing the CPT (2020)
  - Majority of our CCM is non complex- billed at 99490
  - Small percentage of CCM is complex billed at 99487 and 99489

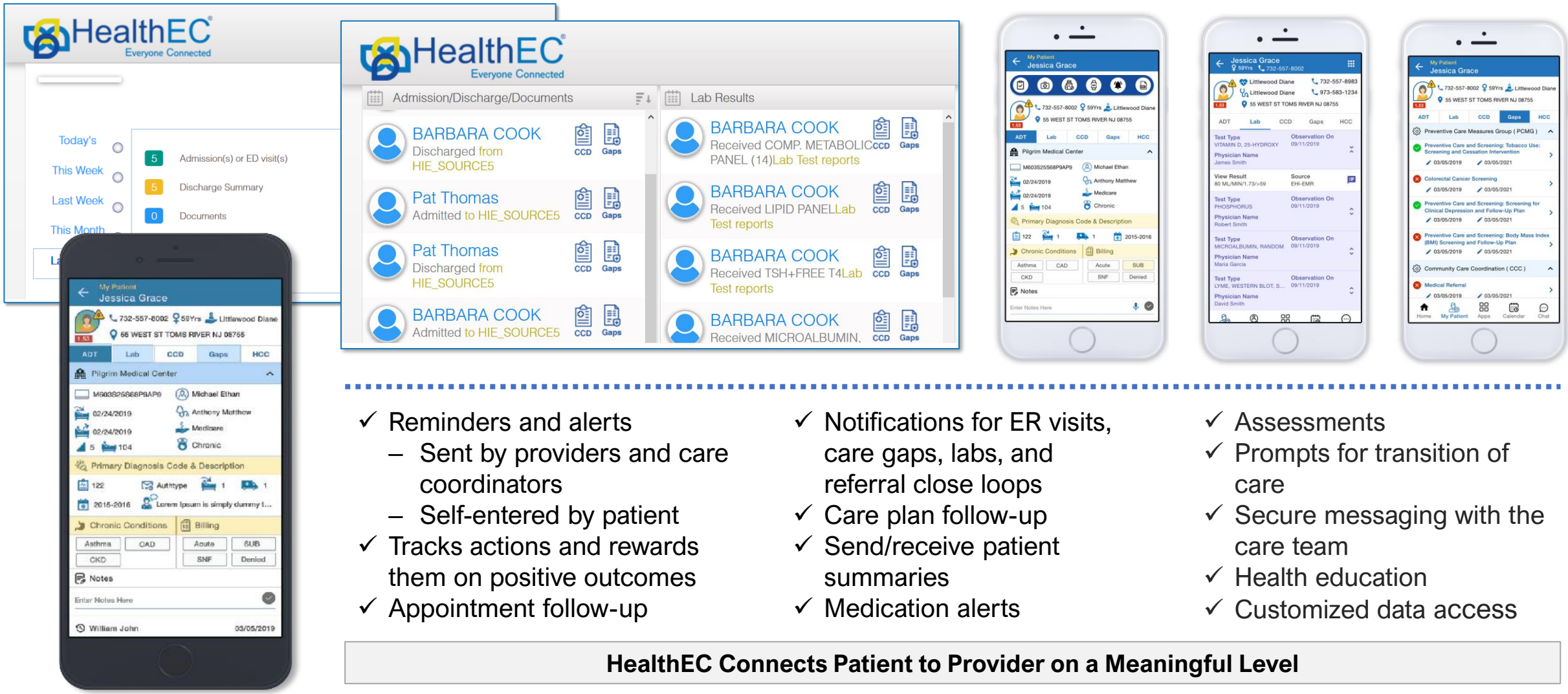
Strategic Initiatives

- Comprehensive data analysis
- Implement CMS Chronic Care Management and utilize Annual Wellness Visits across all practices
- NCQA Patient Centered Medical Home Recognition
- Respond to COVID-19 related issues
- Improve coordination with long term care providers and interoperability with electronic record systems
- Improve interdisciplinary clinical care

Assessments Actionable Interventions



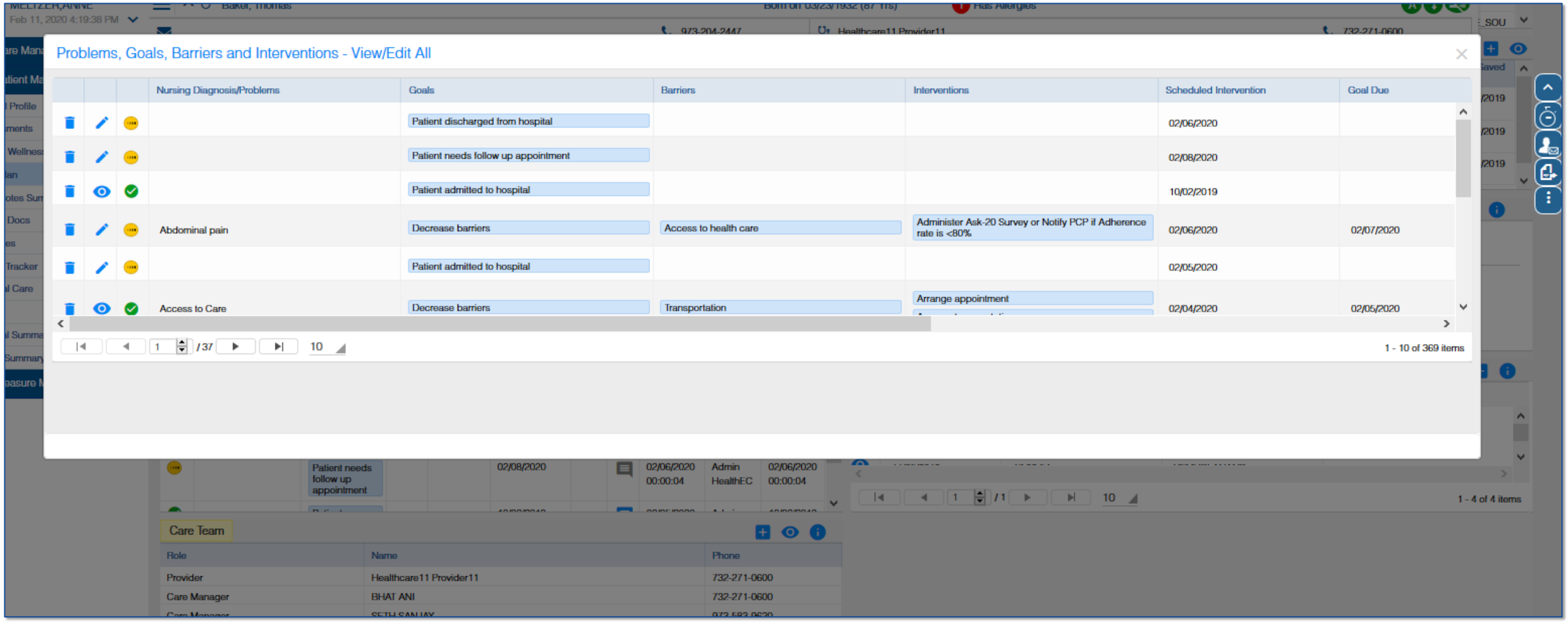
Event Alerting and Mobile Apps



- ✓ Reminders and alerts
  - – Sent by providers and care coordinators
  - – Self-entered by patient
- ✓ Tracks actions and rewards them on positive outcomes
- ✓ Appointment follow-up
- ✓ Notifications for ER visits, care gaps, labs, and referral close loops
- ✓ Care plan follow-up
- ✓ Send/receive patient summaries
- ✓ Medication alerts
- ✓ Assessments
- ✓ Prompts for transition of care
- ✓ Secure messaging with the care team
- ✓ Health education
- ✓ Customized data access

HealthEC Connects Patient to Provider on a Meaningful Level

Problems, Goals, Barriers and Interventions



The Results

$8.2 million In savings

Risk-stratifying patients & targeted interventions using care coordinators interacting with providers lead to increased savings.

AICNY achieved a savings of $2,996,768 in 2018 followed by a savings of $2,963,431 in 2019 with total shared savings of $3,530,793.

6.3% reduction in expenditures for 4,464 beneficiaries

AICNY saw a 6.3% reduction between 2017 and 2018, or $617 per beneficiary

ER visits dropped by 11% & admits dropped by 7%

Tele-triage kiosks in IDD group homes led to 11% reduction in ER use

- 80% of the time, patients do not go to the ER if they engage telemedicine kiosks.

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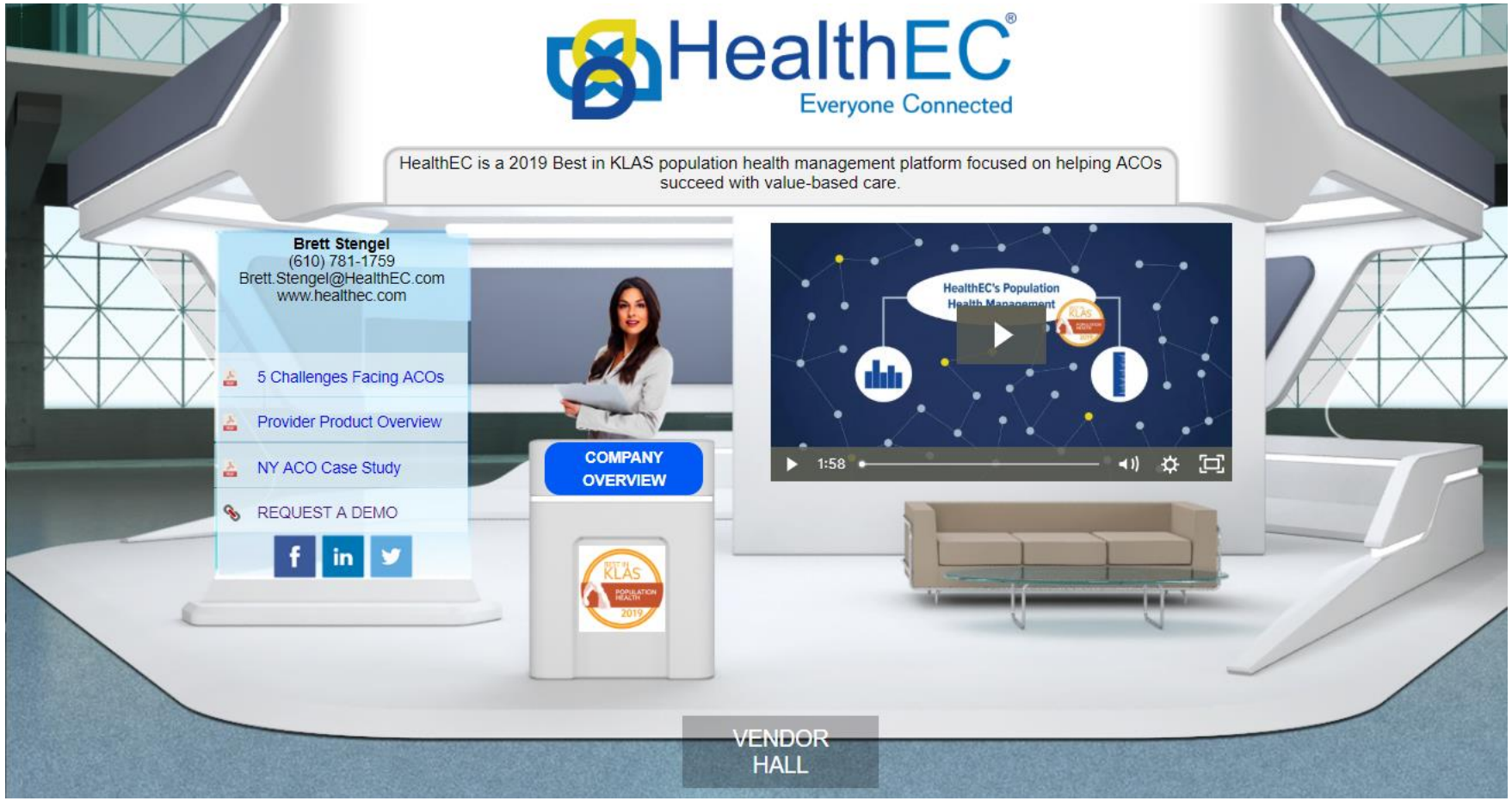
Going forward (COVID)

- Lessons Learned for 3rd/4th wave
  - Individuals with IDD are experiencing very high infection rates. As of December 30, 2020, there have been 6,356 confirmed COVID-19 positive cases statewide. Of those that tested positive, 4,829 of individuals resided in certified residential programs. A total of 519 individuals statewide who tested positive have passed. A total of 8,556 staff were reported as confirmed COVID-19 positive.
- Vaccinations
- Continue to expand access to the telemedicine kiosks to the health center patients to eliminate travel and community exposure.
  - Further, providing access to some specialists for consults who are not available for typical office visits.

Questions?


CORONAVIRUS | COVID-19 |
PULSE 82
54
38
FUNC ATAT : STABLE
TEMP : 104.2

Stop by our ACO Exhibit Hall Virtual Booth



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Thank You

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