

# Achieving Shared-Savings During COVID

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



# Speakers

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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)

# Complex Case Management

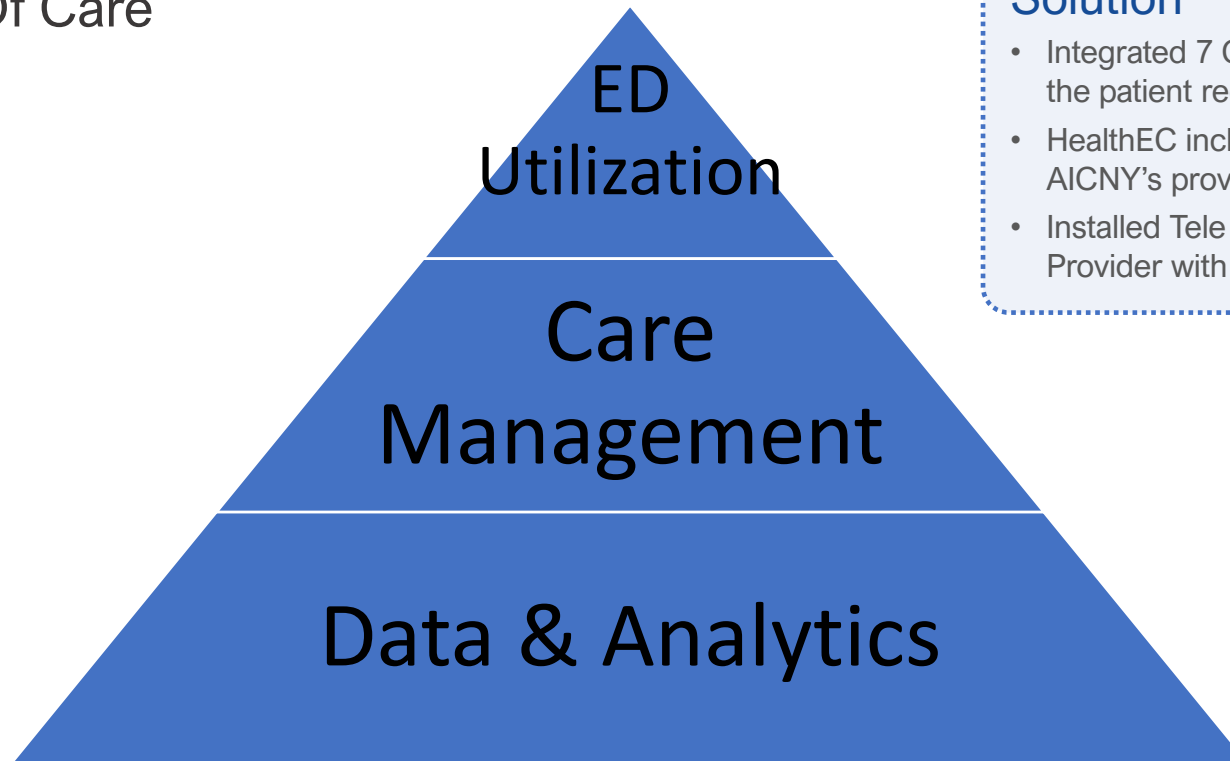
- Metro has a robust quality measures program (high risk groups)
- While COVID-19 exacerbated care coordination and telehealth needs for everyone, organizations that work with at-risk populations were hit especially hard. A new analysis of comorbidities as risk factors for COVID-19 found that coronavirus 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



# Overall Strategy (2019/2020)

## Building Blocks

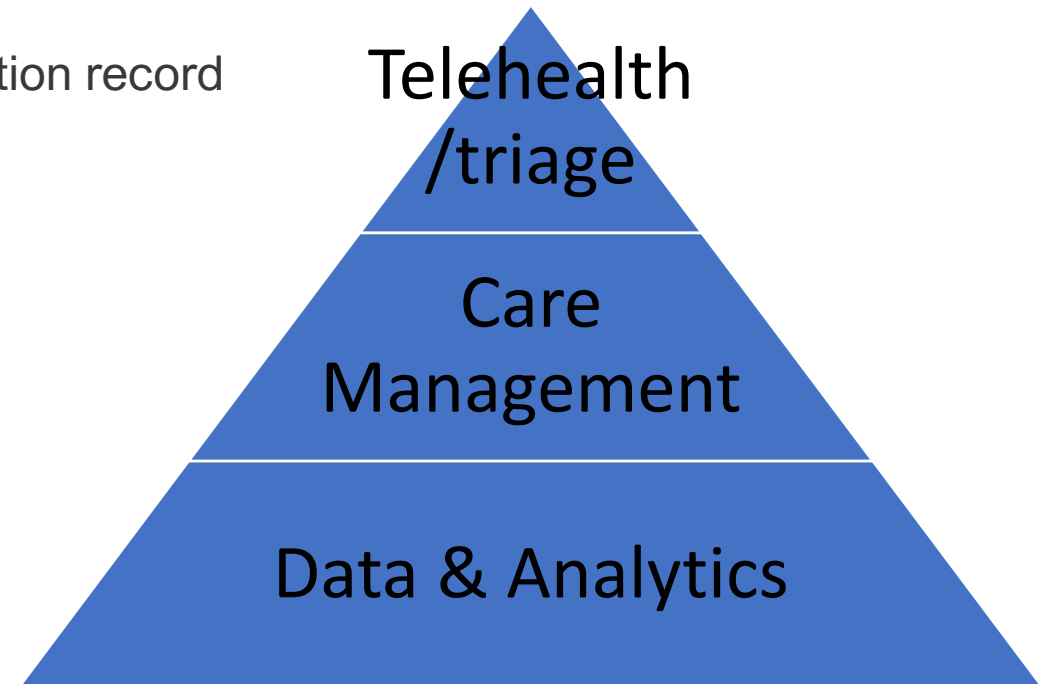
### PHM – Data & Analytics

- 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

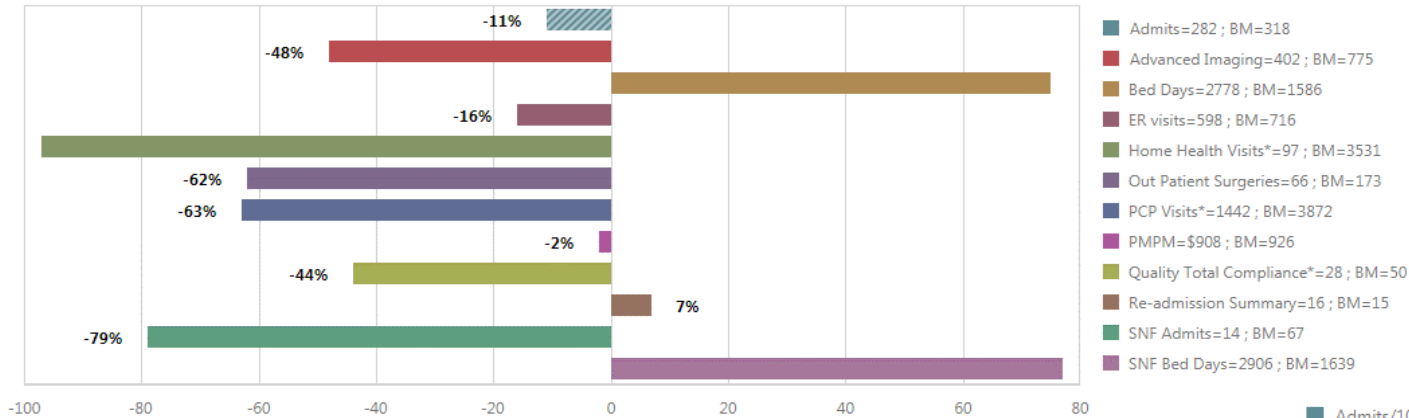
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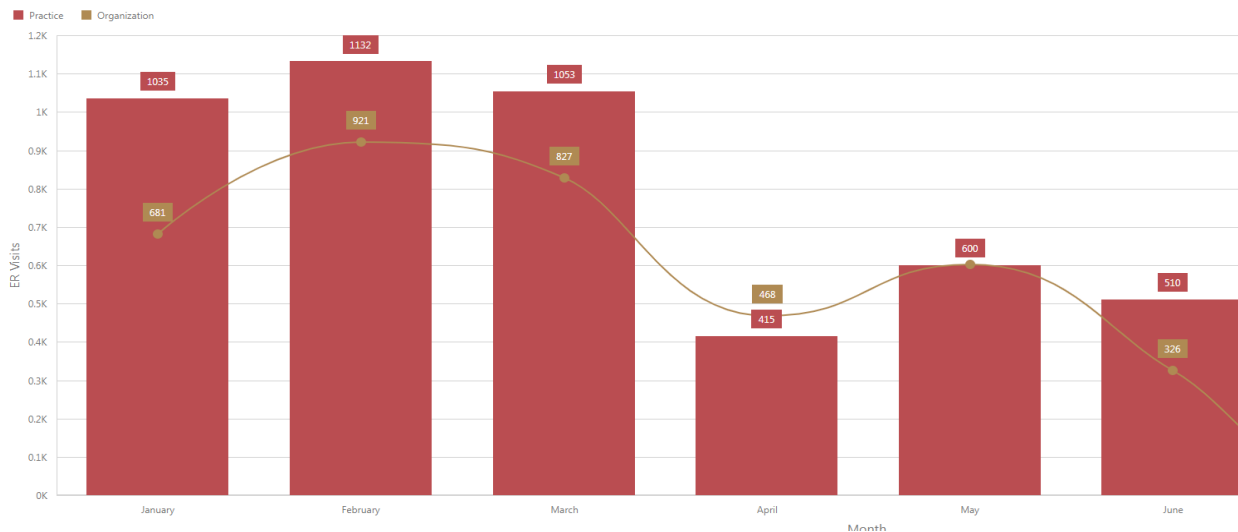
# AICNY Dashboards

Variance to Benchmark (%)

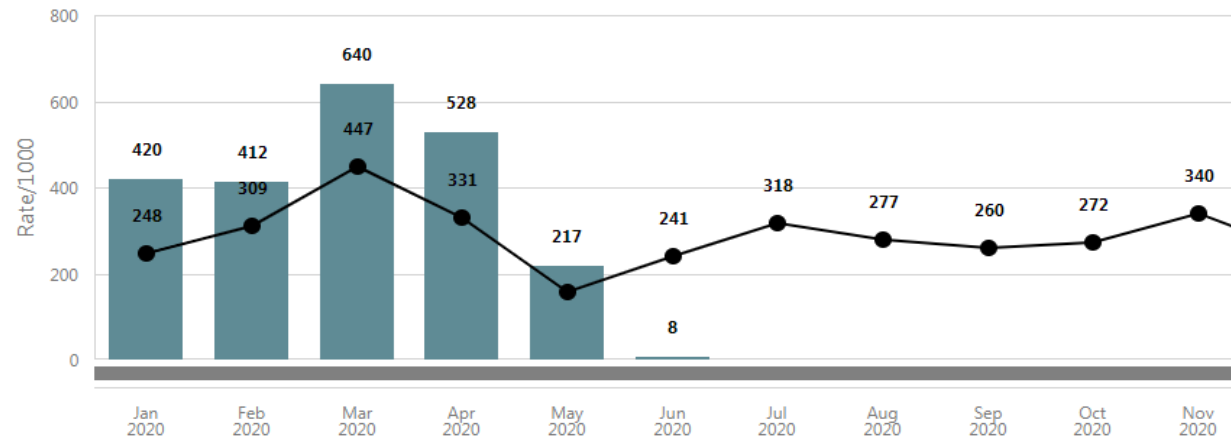


\* For this measure, if the KPI is above benchmark, that is a positive/good trend

ER visits/ 1000-- Practice Vs Organization Trend Graph



Admits/1000 - Rate (teal bars), Admits/1000 - Rate Previous Year (black line)



# 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.

Organizational
Practice
Provider
Care Manager
Other Reports

Line of Business: 
Coverage Type: 
Health Plan: 
Practice: 
Time Period: 
[View Report](#)

Non-Emergent Rate
ER Rate
Monthly Trends
High Utilizers

### Practice- ER Frequent Utilizers

Month	ER Visits
Dec	0
Jan	8
Feb	8
Mar	5
Apr	2
May	5
Jun	14
Jul	6
Aug	6
Sep	0

Export To:

### Practice- ER Frequent Utilizers by Member

Drag a column header here to group by that column

Member ID	Member Name	ER Visits	Age	Risk Score	Provider	Practice
M393S00S85P5AP5A	Lastname1147, Firstname1147	4	86	HealthCare Practice 6	HealthCare Practice 6	
M523S07S77P8AP8A	Lastname3188, Firstname3188	4	80	HealthCare11, Provider11	HealthCare Practice 6	
M773S27S02P9AP9A	Lastname5080, Firstname5080	4	92	HealthCare11, Provider11	HealthCare Practice 6	

# 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

# 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

Care Management +  
Patient Management -

[Return to Patient Search](#)  
[Update Program](#)  
[Contacts/Outreach](#)  
[Interventions](#)  
[Care Notes Summary](#)  
[Assign Patient](#)  
[Time Spent on CM Services](#)

Clinical Profile

Assessments -

- Disease Mgmt
- Complex Case Mgmt
- Psychiatric
- Fall Risk
- Chronic Kidney Disease
- Social Determinants of Health
- Food Insecurity
- Depression Assessment
- Cognitive Evaluation
- Alcohol Misuse Screening
- Tobacco Use
- Patient CCM Survey
- Intake Form
- PrEP-PEP
- TOC
- Nursing Review Assessment
- Pre-Visit Summary
- Nursing Annual / Semi-Annual Review
- Telemedicine Triage

1. What is your housing situation today?
2. Are you worried about losing your housing?
3. What is the highest level of school that you have finished?
4. What is your current work situation?
5. What is your main insurance?
6. What is the total income that YOU currently receive on a monthly basis? *This information will help us determine your eligibility for certain services.*
7. During the past year, what was the total combined income for you and the family members you live with? *This information will help us determine if you are eligible for certain services.*
8. In the past 12 months, how often have you been hospitalized or in the ER?
9. How often do you have trouble sleeping?
10. Depression: How often do you consider you have depression?
11. Has lack of transportation ever prevented you from getting to a doctor's appointment?

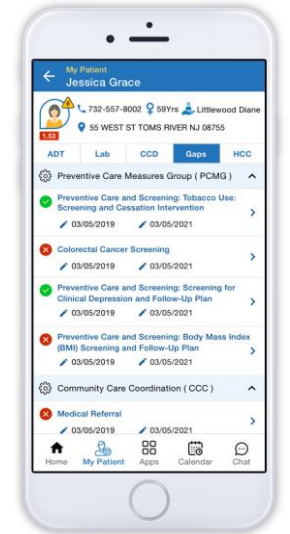
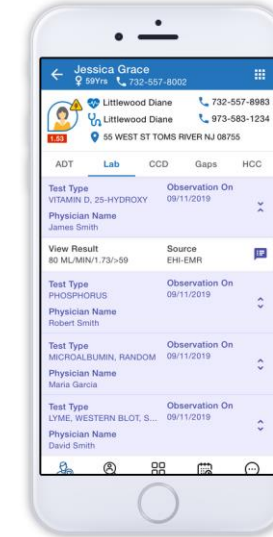
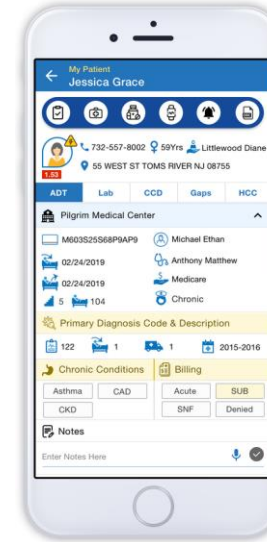
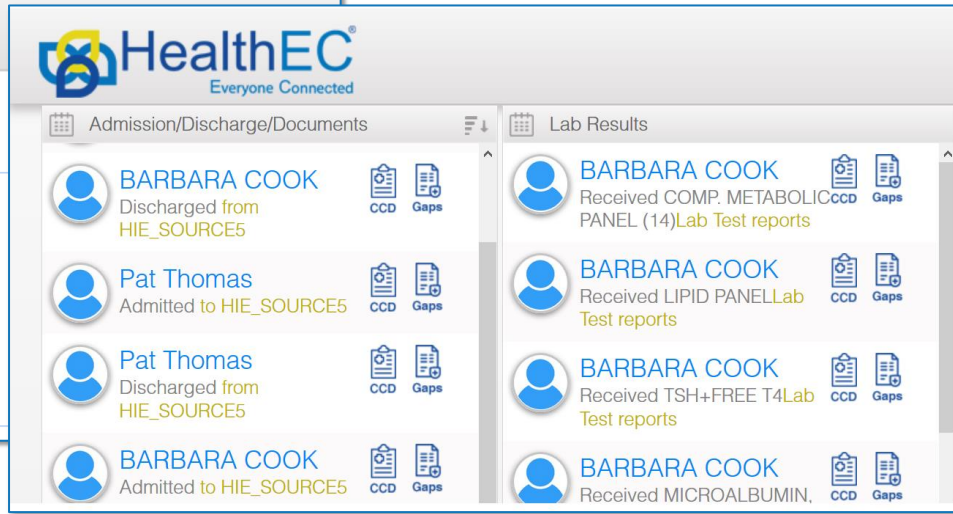
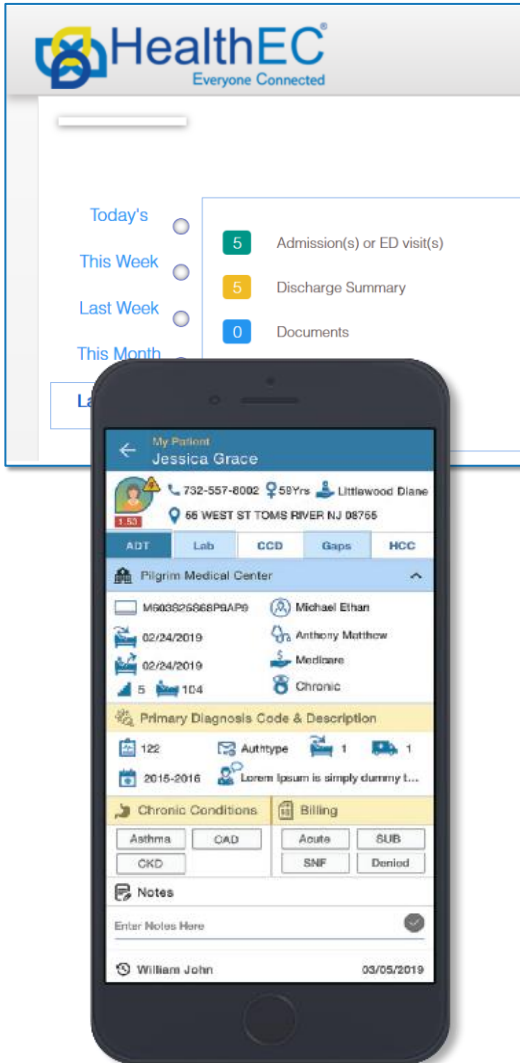
Automate  
Actionable  
Task List

474
Due Now
10452
Complete - Met
7634
Complete - Not Met

				Patient Name	Medicaid ID	Event / Care Plan Goal	Intervention
				LASTNAME10214, FIRSTNAME10214	M600S20S33P5...	P4R-FUM - 7 Day Follow-Up After ED Visit for Mental Illness	Complete the follow up
				LASTNAME10214, FIRSTNAME10214	M600S20S33P5...	P4R-FUM - 30 Day Follow-Up After ED Visit for Mental Illness	Complete the follow up
				LASTNAME10214, FIRSTNAME10214	M600S20S33P5...	P4R-FUA - 7 Day Follow-Up After ED Visit for AOD	Complete the follow up



# 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

Problems, Goals, Barriers and Interventions - View/Edit All

	Nursing Diagnosis/Problems	Goals	Barriers	Interventions	Scheduled Intervention	Goal Due
		Patient discharged from hospital			02/06/2020	
		Patient needs follow up appointment			02/08/2020	
		Patient admitted to hospital			10/02/2019	
	Abdominal pain	Decrease barriers	Access to health care	Administer Ask-20 Survey or Notify PCP if Adherence rate is <80%	02/06/2020	02/07/2020
		Patient admitted to hospital			02/05/2020	
	Access to Care	Decrease barriers	Transportation	Arrange appointment	02/04/2020	02/05/2020

1 - 10 of 369 items

Role	Name	Phone
Provider	Healthcare11 Provider11	732-271-0600
Care Manager	BHAT ANI	732-271-0600
Care Manager	SETH SANJAY	972-592-0520

# 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.

# Going forward (COVID)

## ▣ Lessons Learned for 3<sup>rd</sup>/4<sup>th</sup> 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?



# Stop by our ACO Exhibit Hall Virtual Booth



<https://www.acoexhibithall.com/vendor-booth/healthec/population-health-ii-software-tools-data-analytics/114/>

# Thank You

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