MSSNY Contract Number: CO24582

Deliverable # 7

Three Sub-Regional Solutions Implementation Plan

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Contents

1. HISTORY AND BACKGROUND

The DOH OHITT/MSSNY PPSO contract is a result of 2005 legislation directing the Department to "issue grant funding to one or more organizations broadly representative of physicians licensed in this state." Project funding was directed "to include, but not to be limited to":

a) efforts to incentivize electronic health record adoption;
b) interconnection of physicians through regional collaborations;
c) efforts to promote personalized health care and consumer choice;
d) efforts to enhance health care outcomes and health status generally through interoperable public health surveillance systems and streamlined quality monitoring."

The legislation also called for a final report from the Department that includes among other requirements "the appropriateness of a broader application of the health information technology program to increase the quality and efficiency of health care across the state."

The Medical Society of the State of New York (MSSNY) was awarded a contract in April 2009. The contract Statement of Work calls for MSSNY, along with representatives from NYS DOH and NYeC, to work with rural and solo and small group physician practices to plan, design, build, and initiate operations for PPSO's that will focus on the following goals to improve the efficiency and effectiveness of health care consistent with the HIT vision and strategy being employed by NYS DOH and NYeC:

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

2. DELIVERABLE #7 OVERVIEW

Previous deliverables have provided detailed recommendation for establishing governance structures, baseline information of physician practice readiness, the technology structures needed to exchange information, and the type of quality information that is expected to be collected, monitored, and shared between practices and payors.

This deliverable describes the further development and implementation of the three PODs, specifically focusing on critical success factors and the identification of common risks and mitigation strategies.

3. DEVELOPMENT PLANS

During the initial baseline assessment, it was determined that no organization was currently serving as the envisioned physician support organization (Pod). The goal was to develop Pods that facilitated full participation of solo, rural, and small group practices in the value-based healthcare envisioned by health reform; EPH focused on developing Pods that were capable of supporting the vision as previously listed on page 3.

Based on the location of participating practices, three geographic regions naturally formed, and practices were grouped into the following 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 of the State, there is significant variation among the three in terms of size, homogenization, community resources, and participating practices. These basic differences drove natural variations in the formation of the governing structures and service offering which were discussed in Deliverable 5.

As noted, an additional component of Pod development was to ensure standardized quality improvement efforts were integrated. Most quality improvement activity 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 recognition at the Level II or III. 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 augment their capacity to deliver improved care. As such, 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

4. CRITICAL SUCCESS FACTORS

As the Pod concept was being framed and operating processes developed, several critical success factors were identified to ensure improvements in overall health care systems:

Open Communication

As with any change, open communication is a key to success. By actively engaging all stakeholders, it becomes easier to transform processes in a standardized methodology. Transparency is essential. Each Pod developed a governance committee with representatives from the participating providers involved. This ensured buy-in and a clear understanding among the practitioners of NCQA Medical Home criteria, future services to be offered by the Pod, evidence-based guidelines to be used and measured across the Pods, and reporting requirements. Monthly meetings were held with participating practices within each of the Pods, and regular communication with State-level stakeholders including legal, Department of Health, and payors was elemental to successful implementation. These meetings encouraged all participants to move towards the same goal and not get derailed by “assumptions” or competing motives.

Technology

Technology implementation/utilization was another critical success factor to promote the transformation of primary care and the success of the Pods. During the baseline assessment, it was discovered that 28% of the participating practices did not yet have an electronic medical record. Selection and implementation of EHRs was critical to guarantee future goals could be met and that clinical information would be available to all providers in real time. This was also a requirement to give patients the information to empower them to exercise a degree of control over their individual health care decisions. For the 72% of practices that had an EHR, a significant percentage was not utilizing the tool to identify at risk patients or manage their care.

Scalability

Another identified critical success factor for the Pods was the ability to scale services to meet the needs of their providers and the associated communities. Each community has varying depth and breadth of programs available to supplement services, and participating providers within each of the Pods have differing levels of need for access to support services (including appropriate staff). Pods must have the ability to obtain accurate performance data from each practice which, in turn, allows the Pods to identify the staffing levels required for adequate support services such as administrative oversight, care management nurses, pharmacists, and social workers. As discussed in Deliverable 5, each Pod was sized to support the needs of the practices.

Quality Improvement and Coordination of Care

Transformed primary care ensures the care decisions are evidence-based and consistently applied. It also coordinates care among multiple providers, ensures transitions across care settings are actively managed, and information is appropriately exchanged. These efforts are dually designed to not only to improve patient care, but to minimize waste or overlap. During the baseline assessment, it was determined that only 9% of participating practices met the NCQA "Must Pass" criteria for access standards, only one practice reported compliance with all the quality improvement criteria, and most scored poorly on the coordination of care standards. Based on these findings, an intense focus on development of quality improvement and coordination of care processes was critical.

5. IMPLEMENTATION RISKS

As with any large scale change, there were risks to success:

Potential Inability to Develop Infrastructure

The organizations with established leadership structures, management teams, and capital (hospitals and the large Federally Qualified Health Center [FQHC]), out of necessity were forced

to champion the process and to provide guidance and capital as none of the primary care practices had the ballast, capability, or time to organize and develop Pod structures. Additionally, these organizations were required (and able) to leverage all aspects of their leadership teams including clinical (Medical Directors, VPMA's and CMO's), IT, Finance, and their current care management assets (Diabetic education centers, Discharge planning departments, Social Worker and Case managers).

Organizational Culture

The need to transition from "volume" to "value" was counterintuitive. The primary care practices were so engrained in the concept that they must generate visits to maximize revenue that it was difficult for them to create unfilled appointments for open access, or to take time in their schedules for team huddles, care management meetings, and quality improvement sessions.

Lack of funding

As discussed above, the hospitals and the FQHC were required to fund the initial establishment of the Pods. Development of the Pods required significant financial investment to deploy support services and technology platforms. While funding was anticipated through the Adirondack Health Institute, significant resource expenditure was required for implementation prior to the development of perpetuating funding streams. Without the willingness of **Adirondack Medical Center** (AMC) in Saranac Lake; **Hudson Headwaters Health Network** (HHHN) in Queensbury (Glens Falls); and **Champlain Valley Physicians Hospital** to advance the financial and human resources necessary for continued development, Pod development would have been slowed, if not stopped completely. Those costs will be eventually paid by medical home reimbursements, but cash flow was a problem initially.

Inability to measure quality or performance

Significant effort to develop support infrastructure and the needed technology infrastructure has been expended. Without adequate organizational structures and electronic health records, it would be impossible to collect, measure, and report the patient data needed to transform health. In addition, the ability to share quality, patient care, and payment data across multiple organizations while ensuring privacy and data security is vitally important. Inability to adequately address privacy and security issues would negatively impact the ability to successfully meet the program goals.

History

The historical method of healthcare delivery was identified as a significant risk to successful development of the Pod structure. Healthcare delivery for years has been considered an autonomous effort rather than a team-based, integrated effort. This autonomous viewpoint contributed to competition for patients and associated reimbursements. Additionally, legal

requirements made it difficult to transform and collaborate. Failure to recognize and address these historical and legal restrictions could be fatal to successful implementation.

6. RISK MITIGATION STRATEGIES

Communication among all participating stakeholders was identified as the single, biggest mechanism to mitigate risks and ensure success.

Strategic communication was imperative to ensure a common definition of success for this multi-year, multi-phased project was defined and communicated. This was accomplished through structured, regular meetings at the State level. These meetings included representatives from legal, political, participating payors, Adirondack Health Institute (AHI), Pods, participating practices, and contracted vendors; they frequently addressed obstacles and created solution sets with buy-in from all stakeholders. Ultimately, the goals and measures of success for the pilot project were established and distributed.

On the operational level, tactical communication translating the strategic goals to action were accomplished at the Pod level. Additionally, at the Pod level, communication through regular meetings to address governance, service offering, and technology needs ensured consistent application and practice compliance.

One of the first common requirements established by all three Pods was mandatory, monthly meetings between each participating practice and EastPoint Health. One, non-negotiable strategic goal was the requirement of each practice to complete the activities necessary to obtain NCQA certification. By requiring mandatory meetings, communication of these requirements and assistance in interpreting these requirements was assured.

Additionally, each Pod established communication strategies designed to meet the unique needs of their specific practices:

The officers and managers of Pod 1 (Tri-Lakes) began meeting on a monthly basis in November 2009 to determine the governance and operational functions of the POD based on the input/needs of the participating practices. The Advisory Committee identified the need for a Pod supervisor and selected Ms. Mary Welch in February 2010. Ms. Welch is responsible for the day-to-day operations of the POD, including NCQA Patient Centered Medical Home (PCMH) certification for all participants, as well as ensuring the governance committee is kept informed.

In Pod 2, Lake George (HHHN) chose to pair a physician and an administrator to provide leadership and guidance. Most day-to-day management decisions were made by Cyndi Nassivera-Cordes and Dr. John Sawyer, with Dr. Paul Bachman weighing in on quality assessment matters. It should also be noted that Dr. Rider and Kevin Bolan are considered

Adjunct Medical Staff, and as such, are included in clinical policy (usually arrived at by consensus during Medical Staff meetings). As Chief Executive Officer, Dr. John Rugge is also active in decision-making. On matters affecting the entire Network, the Board of Directors is consulted. This pod communicated effectively by providing a detailed "blueprint" for all participating locations and practices to follow. Described within this document are the services that each practice within this Pod will utilize to improve care outcomes and maximize efficient resource utilization. The "blueprint" transforming clinical operations and creating a care team provides a common framework to ensure all are "speaking the same language."

Pod 3, Northern Adirondack, is the largest and most diverse of the Pods. To effectively communicate, they established an Executive Committee, a Finance Committee, and a Services/Quality Committee. These committees met concurrently over the past twelve months to determine the governance, operational, and service provision functions of the Pod and to ensure coordination of efforts between governance, finance, and service/quality. They developed detailed guidance to allow the Pod to maximize the effective support of all participating practices. They immediately selected a POD administrator, Ms. Karen Ashline, who took the lead in coordinating communication efforts within the Pod, with AHI, and with payors.

Additionally, leveraging technology to effectively facilitate the exchange of practice performance data and to promote the subsequent linkage to outcomes improvement is imperative. As processes are refined and correlated to best practices and workflows, robust communication strategies across the three Pods will encourage providers in all areas to learn from each other.

On a parallel track, meetings defined technology requirements to standardize data submission elements, data security, and data flow across and between organizations.

Flexibility, along with a willingness to create a "medical neighborhood" honoring the variations among the three Pods was also important. Each Pod has uniquely-tailored community resources to supplement clinical services, and the ability to finesse these and yet-to-be determined additional initiatives will be vital to the evolution of each "medical neighborhood" to meet the goals of the Pilot program, with the ultimate success of long term sustainability.