2018 ALLIANCE FOR BETTER HEALTH INNOVATION FUND: PROGRESSIVE PRIMARY CARE PROGRAM ANALYSIS

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TABLE OF CONTENTS

CONTENTS

COLLABORATIVE PARTNER OVERVIEW

LEAD PARTNER: NEW DIMENSIONS IN HEALTHCARE

New Dimensions in Health Care (New Dimensions) is a diagnostic and treatment Center operated by Liberty, the Montgomery County Chapter NYSARC. Liberty established New Dimensions in Health Care (a.k.a. the Health Center) in order to provide a high-quality dental and medical care to patients—with an emphasis on serving people who require special accommodation. It opened in July 1996. The staff at New Dimensions in Health Care emphasize the importance of building a personal connection with every patient. The ultimate goal is to provide positive reinforcement and make patients feel comfortable, making it more likely that they will continue to prioritize their all-important medical and dental care. New Dimensions in Health Care has had a positive impact on so many lives over the years.

PARTNER: PROGRESSIVE PRIMARY CARE SOLUTIONS, INC.

Progressive Primary Care Solutions, INC. connects medical groups, clinicians, hospital systems, communities and employers to highly trained and qualified nursing services in order to improve the health of patients and communities across the nation. Progressive Primary Care Solutions will always strive to add value to the health care experience by improving overall access to critical primary care resources, creating more cost-effective primary care nursing solutions for clients, and increasing the overall quality of care delivered in the primary care setting.

INNOVATION PROGRAM OVERVIEW

OBJECTIVES

The objective of the Progressive Primary Care Innovation program is to provide New Dimensions practice workflow efficiency solutions and a primary care clinician support program though consulting services provided by Progressive Primary Care Solutions.

- Need #1: Create cost savings by increasing productivity of nursing staff.
- Need #2: Streamline primary care visit workflows to keep valuable nurses in practice to increase efficiency, reduce burnout, add flexibility and retain workforce.
- Need #3: Increase efficiency of patient and providers time, including increasing time spent with patients to address increasing and emerging issues.

OPPORTUNITY

Progressive Primary Care Solutions will assist in finding creative workforce solutions and improving primary care access and the quality of care delivered, while simultaneously improving patient, clinician and staff satisfaction. Progressive Primary Care Solutions is also able to provide consulting services for workflow efficiency to assist New Dimensions in continuing to work towards growth and financial sustainability.

- Goal #1: Reduces clinician and nurse time by completing Pre-visit work, screenings, questionnaire, intake, etc.
- Goal #2: Prepare for Value Based Payment Reimbursement and compliance with quality metrics.

- Goal #3: Increase patient satisfaction scores.
- Goal #4: Increasing clinician average visits per hour and increase patient panel 10-20%
- Goal #5: Increased billable nurse visits through practice efficiency consulting and redesigning work flow during

EXPECTED OUTCOME

The implementation of the Progressive Primary Care program will accomplish an engagement of 1000 to 1200 unique Medicaid or Uninsured patients over the course of the one-year pilot, which would be a growth of 200 unique patients within the year. This program will increase access to Primary Care visits in adults and will reduce potentially preventable ED visits, admissions and readmission in adults.

DATA ANALYSIS

METHODOLOGY

PATIENT IDENTIFICATION AND MATCHING

As part of innovation program deliverables, Medicaid Patient Lists (MPLs) were submitted to Alliance for Better Health, MPLS are the roster of patients who receive/d services through innovation programs. The Medicaid patients who received services from the innovation program during the program timeframe (08/01/2018 – current) were identified. Of this cohort, the subsequent Medicaid Client Identification Number (CIN) was retrieved from the MPL or acquired using New York State (NYS) Department of Health (DOH) Alliance for Better Health DSRIP Attribution using a matching algorithm. Acquired CIN numbers were matched to claims using Salient Interactive Miner, emergency department encounters in Hixny, and the Healthy Together referral platform. Through this process, 457 unique members were matched to a corresponding CIN number.

FINANCIAL ANALYSIS

A financial analysis was conducted to measure the impact of the funded program. Tables 1 and 2 in the Charts and Figures section provides details on the budgets, allocation by category, ongoing costs, and rate of return based on Emergency Department utilization reduction.

ACCESS TO AMBULATORY CARE

Claims from Salient Interactive Miner are applied to the member cohort served by this innovation during the reporting period. A count of members who have had a visit for a Current Procedural Terminology (CPT) code rolling up to an ambulatory care visit in the six months before program funding was distributed (August 2018) and six months after (February 2019) are reported. The counts are reported on rolling 12-month intervals (i.e. March 2018 is representative of claims from April 2017 – March 2018), a proxy for compliance with the access to ambulatory care HEDIS quality measures.

Known Risks:
Because some members may be Medicaid/Medicare dual enrolled, denominators and rates cannot be established for this proxy measure.

EMERGENCY DEPARTMENT UTILIZATION

Hixny, the local Regional Health Information Organization (RHIO), is the primary data source for assessing emergency department utilization. Emergency department encounters were calculated for the cohort of

patients submitted on the roster of Medicaid members served through the program. Unique members, time period parameters, and total number of encounters are included in this analysis. The charts illustrate the difference (+/-) in emergency department visits before and after program intervention, using the initial date of service from the MPL for each member.

Known Risks:
Alliance does not have access to encounters from non-partner hospitals.
Alliance only has access to patient-level information for our attributed population. Members who may appear on MPL and are attributed to another PPS, or who are not attributed to a PPS, are not captured in this report.

SOCIAL DETERMINANTS OF HEALTH

An aggregate of all Healthy Together referrals for members served by the innovation since implementation are included in this report. Referring organization, organization referred to, and the referral types are displayed. Social needs are captured exclusive of DSRIP and PPS attribution.

CHARTS AND FIGURES

TABLE 1: BUDGET

Budget	Indirect/admin	Indirect/non-personnel	Direct services	Ratio direct: indirect
$156,751	$12,450	$23,130	$121,170	4.3 : 1

TABLE 2: FINANCIAL ANALYSIS

Cost (+) startup Per patient/ to date	Costs (+) startup Per Patient/at projected volume	Cost (-) startup PMPM to date	Costs (-) startup PMPM at projected volume	Reduction in # ED visits *(- value means an overall increase in ED visits)	Cost savings Return compared to program funding *Based on National ED Visit cost of $1,600/visit
$108	$101	$15.00	$8.00	106	31%

CHART 1: POPULATION IMPACTED (ESTIMATED VERSUS ACTUAL)

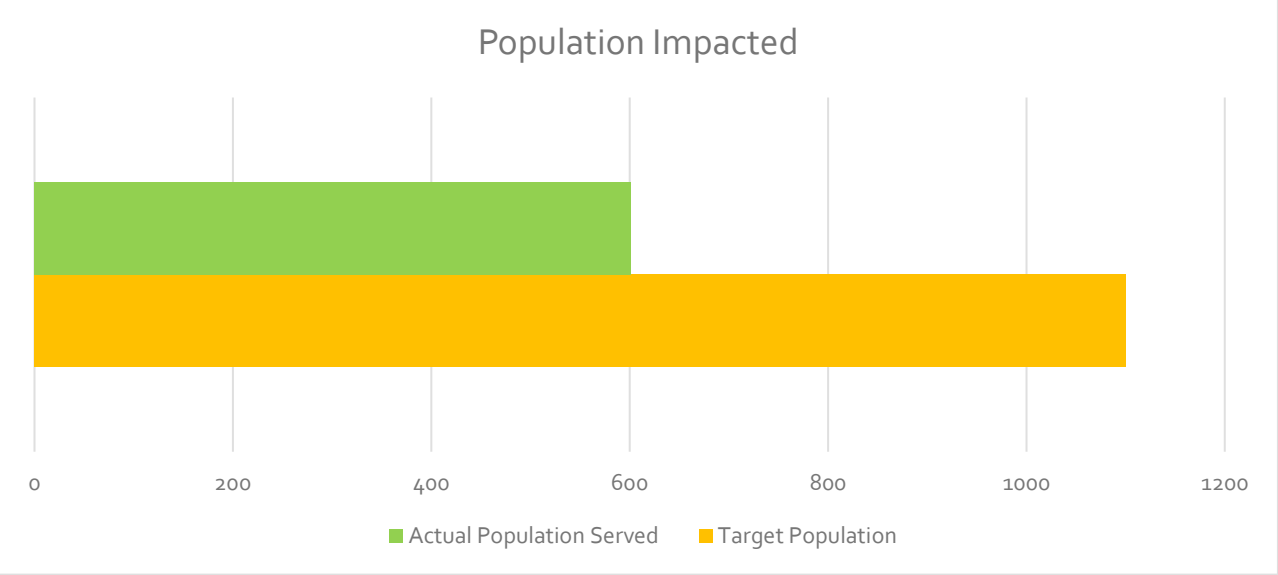
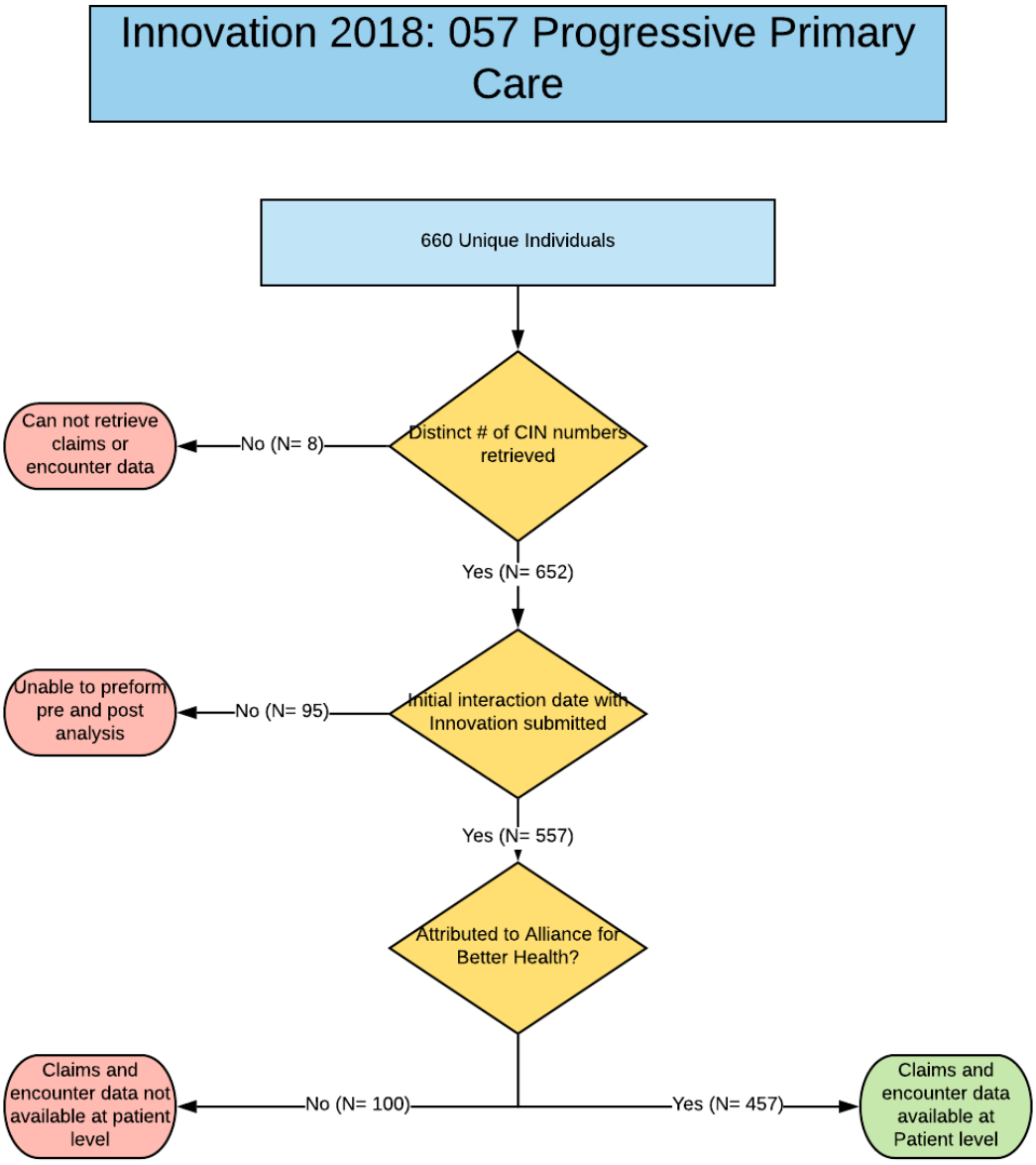


FIGURE 1: LOGIC TREE-MEMBERS SERVED



The Logic Tree is an illustration of the unique number of individuals that were reported to have had an interaction with the innovation that analysis could be run on at the patient level.

TABLE 3: ACCESS TO AMBULATORY CARE

Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
427	431	437	439	442	447	454	457	456	450	450	444

Table 3 illustrates a count of members who have had a visit for a Current Procedural Terminology (CPT) code rolling up to an ambulatory care visit in the six months before program funding was distributed (August 2018) and six months after (February 2019) are reported.

TABLE 4: ED VISITS BEFORE AND AFTER THE INITIAL INTERATION

Measure	Before Initial Interaction	After Initial Interaction	% Difference
# ED Visits	257	177	-31.13%
Distinct Members w. ED Visit	128	87	-32.03%
Denominator	325	325	

Table 4 illustrates the total number of ED visits 6 months pre and post initial interaction with the innovation. Analysis was limited to 457 members affiliated with Alliance, and 325 of those who had 6 months of measurable data.

TABLE 5: DIRECTIONALITY OF ED VISITS POST INITIAL INTERACTION WITH INNOVATION

ED Visits	# of Members
Increased	50
Decreased	89

Table 5 illustrates the number of unique members who had an increase and the number of unique members who had a decrease in the number of ED visits 6 months post initial interaction with the innovation.

TABLE 6: HEALTHY TOGETHER REFERRALS BY SERVICE TYPE

Service Type	Service Subtype	Resolution	
Housing & Shelter	Emergency Housing	Resolved	1
	Permanent Housing	Unresolved	1
Physical Health	Primary Care	Resolved	1
Transportation	Ride Coordination	Resolved	1
Distinct Members			1

Table 6 details total referrals made for members engaged in the program.