

NORTH
COUNTRY
HEALTH
SYSTEMS

REDESIGN
COMMISSION

WELCOME

January 22, 2014

Watertown | New York

NORTH COUNTRY HEALTH SYSTEMS

REDESIGN COMMISSION

MEDI CAID REIMBURSEMENT CURRENT AND FUTURE

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Agenda

- Current Medicaid FFS reimbursement
- Vital Access Provider program
- MRT Waiver Update
- Care Management for All
 - MMC and MLTC
- Behavioral Health
- Primary Care Enhancements
- Health Homes

CURRENT MEDICAID FFS REIMBURSEMENT

Hospital Inpatient

- Acute Services paid on per discharge using APR-DRG's which recognizes severity of patient and includes:
 - Graduate Medical Education
 - Non-comparables, such as Ambulance, and Schools of Nursing
 - Capital – Budget to actual
- Managed care plans use as the payment in many cases, also default for out of network services

Hospital Inpatient

- Exempt services paid on a per diem
 - Acute Detox based upon regional per diem plus capital
 - Medical Rehabilitation, Chemical Dependency Rehabilitation regional operating ceilings @ 110% plus capital
 - Psychiatric services paid on statewide price with adjustments for:
 - Case mix, rural, comorbidities, wages, length of stay and capital
 - Critical Access Hospitals use state wide average @ 110% as operating cost ceiling plus capital

Hospital Outpatient

- Emergency Room, Clinics and Ambulatory Surgery paid using Ambulatory Patient Group (APG) methodology
 - Base prices (upstate/downstate)
 - Adjusted for case mix, discounting and bundling of services plus capital

Clinics and Surgery Centers

- APG Methodology used for all clinics and surgery centers, similar to hospital, but use different base prices
- Federally Qualified Health Center (FQHC)
 - Reimbursed based upon federal PPS methodology which is a threshold visit method with annual inflation
 - Different rates for offsite and group psychotherapy service based upon price

Nursing Home FFS rate update

- The Nursing Home Base period has been updated to a 2007 base effective 1/1/2012
 - A new pricing methodology was implemented Utilizing a pure price for the direct and indirect components
 - MDS data is used to update the prices for facility specific Case mix updates.
- The state in collaboration with the NH industry is working on analyzing case mix growth over the last few years.
- Capital based upon 2 year old historical

Nursing Home Quality Pool

- Established in the 2010-11 NYS Executive Budget
 - The Department of Health (DOH) convened a sub-workgroup of industry experts to assist us in developing the Nursing Home Quality Pool (NH QP)
 - We anticipate refinements, modifications and improvements over time
 - \$50 million
- 2012 NH QP Pay for Reporting Year
 - Timely Submission and Certification of the 2011 Cost report (including staffing information)
 - 13 nursing homes did not submit 2011 cost reports on time
 - Timely Submission of 2011 Employee Flu Immunization data
 - 8 nursing homes did not submit 2011 employee flu data on time
- 2013 NH QP
 - Department will release result in October 2013
 - The benchmark results were released in early May, 2013
 - These results were not made public and facility A was only allowed to see facility A's result
 - Aligns with federal initiatives, such as Quality Assurance & Performance Improvement (QAPI) program

VITAL ACCESS PROGRAM (VAP)

Available Funding

- The 2013-14 Enacted Budget allocated \$152 million for VAP/Safety Net Programs and \$30 million for Financially Disadvantaged Nursing Homes

	Financially Disadvantaged Nursing Homes	VAP/Safety Net	Total
Total Available Funding	\$30 M	\$152 M	\$182 M
Phase 1 Funding (Years 1 and 2)	\$15.9 M	\$39.7	\$55.6 M
Phase 2 Award Funding	\$4.1 M	\$41.4 M	\$45.5 M
Remaining Funds	\$10.0 M	\$70.9 M	\$80.9M

- The 2014-2015 appropriation is \$154M

VAP Applications

- 156 applications, with a total estimated request of \$1.1 billion (excluding capital), received to date

Phase 2 Plans by Provider Type

Provider Type	Number of Providers	Number of Plans	Total Project Cost (Excluding Capital)
Hospital (CAHs)	13	20	\$ 21,222,884
Hospital (Non-CAHs)	62	67	\$ 618,081,092
Nursing Homes	24	24	\$ 114,308,950
D&TCs	36	39	\$ 285,284,796
CHHAs	6	6	\$ 24,119,573
Total	141	156	\$ 1,063,017,295

VAP Applications

- Scores are based on qualifying criteria outlined in the MRT Reinvestment Program as follows:
 - *Facility Financial Viability*
 - *Community Service Needs*
 - *Quality Care Improvements*
 - *Health Equity*
 - *Executive summary/program description*

CAHs and Providers with Negative Operating Margins			
Provider Type	Number of Providers	Number of Plans	Total Project Cost (Excluding Capital)
Hospital (CAHs)	13	20	\$21,222,884
Hospital (Non-CAHs)	23	25	\$264,447,537
Nursing Homes	17	17	\$102,224,073
D&TCs	27	30	\$239,333,857
CHHAs	4	4	\$8,059,791
Total	84	96	\$635,288,142

Process after Awards

- Submit a state plan amendment to CMS for approval
- Facilities submit a full program application laying out the objectives, activities, metrics and expenses over the life of their program
- Financial, Operational, Quality Metrics critical to this program
- Quarterly reporting on the program
- Strategic Planner can be assigned to assist the providers in developing, implementing and monitoring the program
- All information to be posted on the MRT website to provide transparency and progress of these programs

MRT WAIVER AMENDMENT

MRT Waiver Amendment

- In August 2012, New York submitted the MRT Waiver Amendment Proposal to CMS for approval that would allow us to reinvest \$10 billion in MRT generated federal savings back into New York's health care delivery system over 5 years.
- The amendment is essential to both fully implement the MRT action plan as well as prepare for ACA implementation.
- The amendment, which requires federal approval, is a unique opportunity to address the underlying challenges facing NYS health care delivery:
 - *Lack of primary care;*
 - *Weak health care safety net;*
 - *Health disparities; and*
 - *Transition challenges to managed care.*

MRT Waiver August 2012

Reinvestment Strategies

- Primary Care Expansion
- Health Home Development
- New Care Models
- Expand Vital Access/Safety Net Program
- Public Hospital Innovation
- Medicaid Supportive Housing
- Long Term Transformation - Integration to Managed Care

MRT Waiver August 2012

Reinvestment Strategies

- Capital Stabilization for Safety Net Hospitals
- Hospital Transition
- Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform
- Public Health Innovation
- Regional Health Planning
- MRT and Waiver Evaluation Program

CMS Feedback

- MRT Waiver Reinvestment Strategies determined “unfundable”
 1. **Capital**
 2. **Rental subsidies**
 3. **Regional Planning**
 4. **Evaluation**
 5. **Health Information Technology**

CMS Preferred Path Forward

- New York is moving forward with a three-part approach
 - **Delivery System Reform Incentive Payment (DSRIP) Plan**
 - **State Plan Amendment**
 - **Managed Care Contract Payments**
- Our aim is to stay true to the original goals of the MRT Waiver Amendment, while making our proposal consistent with CMS feedback on what can be approved

DSRIP – Key Components

- Focus on reducing inappropriate hospitalizations.
- Statewide initiative open to a wide array of safety-net providers.
- Payments are performance-based.
- Providers will choose from a menu of CMS-approved projects.
- Providers strongly encouraged to work together, across traditional health care silos, to develop single proposals -- transformation is most impactful when stakeholders are all working together in common cause.
- Proposals that reflect this collaborative approach will receive greater consideration and DSRIP funding.
- Total 5-year value = \$7.375 billion.

State Plan Amendment

- Vehicle to implement Health Home Development Grants.
- Hope is the funds will be available for same uses as originally envisioned.
- Total 5-year value = \$525 million.

Managed Care Contract Amendments

- Vehicle to implementing:
 - 1. Primary Care Technical & Operational Assistance**
 - 2. Health Workforce Needs: Retraining, Recruitment and Retention**
 - 3. 1915i Services - New**
- Funds will flow to plans who will be contractually required to contract for those services.
- Plans for how funds will be used will be pre-approved by the state.
- Total 5-year value = \$2.1 billion.

Waiver Financing and Source of State Match

- Intergovernmental transfers (IGTs) will fund DSRIP projects and other MRT waiver amendment projects.
- NYS will also use Designated State Health Programs (DSHPs). Sources of DSHP funding include previously approved FSHRP and Partnership Plan DSHPs.

Next Steps

- Discussions are ongoing with CMS, working toward agreement
- Documents are posted on MRT website:
http://www.health.ny.gov/health_care/medicaid/redesign/
- Lots of work to do!
- We are making progress!
- Stay up-to-date by signing up for our listserv:
http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm

MEDICAID MANAGED CARE 2014 EXPANSION POPULATIONS AND BENEFITS

Overview of Transition

- All eligible recipients over age 21 in need of custodial care will be required to enroll in a Medicaid managed care plan (MMCP) or a Managed Long Term Care Plan (MLTC).
- Current custodial care consumer in a skilled nursing facility prior to March 1, 2014 will remain FFS and will not be required to enroll in an plan.
- Six months following transition period:
 - Any nursing home resident may enroll in MMCP on a voluntary basis.
 - Begins September 1, 2014 for individuals in first phase who are permanently placed in a nursing home.
 - These individuals will be exempt rather than excluded from enrollment in Medicaid managed care.

Overview of Transition

- Plans will be required to pay the NH the current FFS rate, or a negotiated rate acceptable to both plans and nursing homes, for 2 years after the transition (February 2016).
- DOH will assess the transition after 1 year to determine whether reimbursement policy should be extended beyond 2 years.
- After the transition period, NHs and plans will negotiate a rate of payment for services.

2014 Population Expansion

- March 1, 2014
 - Nursing Home:
 - New Duals and Non Duals
 - FIDA Region Adults - NYC, Nassau, Suffolk, Westchester
- September 1, 2014
 - Nursing Home:
 - New Duals and Non Duals
 - FIDA Region Adults - ROS

2014 Benefit Expansion

▪ April 1, 2014

- HIV genotypic and phenotypic drug resistance testing;
- Trofile assay.

▪ October 1, 2014

- School-Based Health Center Services.

2015 Population Expansions

- Assisted Living Program Residents: Dual and Non Dual
- Residents of State Operated Psychiatric Centers
- OMH District 97: Adults, Non Duals
- LT Chemical Dependence Program: Non Duals
- HCBS Waiver: NH Transition and Diversion; TBI; Care at Home; OMH
- Children in Agency Based Foster Care
- Bridges to Health
- Residential Rehabilitation Services for Youth

2015 Benefit Expansions

- Hemophilia Blood Factors;
- Risperidol Consta, Invega Sustena, Zyprexa Relprevw;
- Assisted Living Program for those currently enrolled;
- OASAS Services: BHO, Adults and Children;
- OMH Services: BHO, Adults and Children.

Managed Long Term Care (MLTC) – Mandatory Target Population

Transition from Fee-For-Service to Managed Long Term Care began in July 2012 and continues statewide

- Age 21 and older and in need of community-based long term care Services for more than 120 days must enroll in a Managed Long Term Care Plan or other Care Coordination Model.
- Duals ages 18 through 20 remain voluntary.

MLTC Mandatory Enrollment Plan

As plan capacity is established, dually eligible community based long term care service recipients will be enrolled as follows:

- **Phase I and II:** New York City and the suburbs
 - July 2012 - Personal Care for NYC
 - January 2013 – Personal Care for Nassau, Suffolk and Westchester Counties
 - January 2013 – Adult Day Health Care for NYC, Nassau, Suffolk and Westchester Counties
 - March 2013 – Home Health 120+ days and Private Duty Nursing for NYC, Nassau, Suffolk and Westchester Counties
 - April 2013 – Long Term Home Health Care Program for NYC, Nassau, Suffolk and Westchester Counties

Mandatory Enrollment Plan

- **Phase III:** Rockland and Orange Counties
 - Began September 2013 for all LTC services
- **Phase IV:** Albany, Erie, Onondaga and Monroe Counties
 - Began December 2013 for all LTC services
- **Phase V:** Other counties with capacity
 - Anticipated start June 2014 for all LTC services
- **Phase VI (Final Phase):** Previously excluded dual eligible groups contingent upon development of appropriate benefits:
 - Nursing Home Transition and Diversion waiver participants
 - Traumatic Brain Injury waiver participants
 - Assisted Living Program participants

FIDA- Fully Integrated Duals Advantage

- FIDA is designed to integrate the two payment structures (Medicaid – Medicare) into one single stream of funding.
 - Through FIDA Managed Care Organizations (MCO) will have to opportunity to managed all of the care for dual eligible patients.
 - The Demonstration is intended to remove the silos that have been created through the use of the separate funding streams.
 - Through the use of care management plan will be expected to achieve modest savings targets during the demonstration.

FIDA Demonstration Rate Update

- Draft Medicare and Medicaid FIDA Premiums have been established and released to current FIDA plans
 - Base period claim level detail was developed utilizing 2010 and 2011 Medicaid and Medicare claim
 - Trends and program changes were applied to the base level detail to ensure that the premiums were actuarially sound.

FIDA Demonstration Next Steps

- Premiums will continue to be reviewed by NYSDOH and CMS
 - Additional rate developments as they occur will be shared with Plans and stakeholders
 - At this time we are looking to finalize rates in early May (for a 10/1/2014 implementation date)
 - Both CMS and DOB will need to approve the premiums before they can be promulgated.

BEHAVIORAL HEALTH

Principles of BH Benefit Design

- Person-Centered Care management
- Integration of physical and behavioral health services
- Recovery oriented services
- Patient/Consumer Choice
- Ensure adequate and comprehensive networks
- Tie payment to outcomes
- Track physical and behavioral health spending separately
- Reinvest savings to improve services for BH populations
- Address the unique needs of children, families & older adults

BH Benefit Design Models

- Behavioral Health will be Managed by:
 - Qualified Health Plans meeting rigorous standards (perhaps in partnership with BHO)
 - Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs

Qualified Plan vs. HARP

Qualified Managed Care Plan

- Medicaid Eligible
- Benefit includes Medicaid State Plan covered services
- Organized as Benefit within MCO
- Management coordinated with physical health benefit management
- Performance metrics specific to BH
- BH medical loss ratio

Health and Recovery Plan

- Specialized integrated product line for people with significant behavioral health needs
- Eligible based on utilization or functional impairment
- Enhanced benefit package - All current PLUS access to 1915i-like services
- Specialized medical and social necessity/ utilization review for expanded recovery-oriented benefits
- Benefit management built around higher need HARP patients
- Enhanced care coordination - All in Health Homes
- Performance metrics specific to higher need population and 1915i
- Integrated medical loss ratio

NYS MEDICAID BEHAVIORAL HEALTH TRANSFORMATION IMPLEMENTATION TIMELINE



*Rest of State (ROS) - Implementation for ROS will take place six months later starting with plan submission of RFQs.

AUGUST 2013

PRIMARY CARE ENHANCEMENT

ADK Multi-Payer Demonstration: History

- Initiated by providers in North Country and supported by public and private payers
 - 5 year ‘pilot’ ending 2014
- Eventually included in CMS/CMMI program – Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)
 - 3 year ‘pilot’ ending 2014
- Legislative, budget, Medicaid support
- Goals: stabilize/improve workforce and strengthen primary care

Enhanced Payment

- Hard fought consensus around \$7pmpm payment to qualifying providers
- Slow movement to incorporate P4P component to portion of payment
 - \$.50 pmpm ‘at risk’ based on quality, utilization, and patient experience metrics
- Some payers individually continued or began other P4P or shared savings arrangements
- HEAL 10 and other state/federal grants also supportive

Future Payment Opportunities/Challenges

- CMS role
 - Proposed care management payments within FFS
- Medicaid
 - PCP ‘bump’ from ACA to Medicare levels
 - PCMH recognition incentive
 - But unclear if providers will continue to pursue when expires – new standards more demanding/costly
 - MU
 - Health Home
- ADK Demo in context of SHIP
 - Multi-payer movement to performance/value based contracting?
- Leveraging/Expanding ADK PCMH relationships in furthering North Country Partnerships and Reforms?

New York State Vision for Health Homes



- Create integrated care management for high need/high risk individuals to improve the quality of care and reduce costs for complex populations.
- Minimize silos and designate the right number of provider-led Health Homes systems to ensure accountability and financial viability.
- Create choices between institutional led and community based Health Homes.

New York State Health Home Model



In New York State, a Health Home led by a single provider (e.g., hospital, FQHC, community based organization or other eligible entity) which is required to create a federated network to help members connect with all of the following:

- One or more hospital systems;
- Multiple ambulatory care sites (physical and behavioral health);
- Existing care management and converting targeted case management (TCM) programs;
- Social supports, e.g., housing and vocational services; and
- Managed care plans.

The continued development of the network capacity of Health Homes sets the stage for more advanced Health Homes to evolve into Accountable Care Organizations

New York State Health Home Model

Managed Care Organizations (MCOs)

New York State Designated Lead Health Homes

Administrative Services, Network Management, HIT Support/Data Exchange

Health Home Care Management Network Partners
(includes former TCM Providers)

Comprehensive Care Management
Care Coordination and Health Promotion
Comprehensive Transitional Care
Individual and Family Support
Referral to Community and Social Support Services
Use of Health Information Technology to Link Services (Electronic Care Management Records)

Access to Required Primary and Specialty Services
(Coordinated with MCO)

Physical Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS, Housing, Social Services and Supports

Health
Home
Portal

RHIO

Health Home Eligibility Criteria

- Medicaid recipients can be identified by the State using analytic tools; members are assigned to Health Homes (with choice to opt-out). Eligibility criteria includes determination of risk and:
 - Two or more chronic conditions (e.g., SUD, Asthma, Diabetes, Heart Disease);
 - One chronic condition – HIV/AIDS; and
 - One serious mental illness.
- Recipients can also be referred to Health Homes from providers and the community.

Eligible Health Home Population

- Over five million Medicaid recipients in New York State.
- 805,000 individuals meet the eligibility criteria for Health Homes.
- 20% are dual eligibles (Medicare/Medicaid).
- Target enrollment is 446,000 (prioritizing for highest risk).

North Country Health Homes

- 48 Health Homes (32 unique entities) operating in 58 counties have been designated
 - Implemented over three phases effective January 1, 2012, April 1, 2012 and July 1, 2012

Health Homes Serving the North Country	
Health Home	Service Area by County
Adirondack Health Institute (Phase 1)	Clinton, Essex, Franklin, Hamilton, Warren, Washington
Glens Falls Hospital (Phases 1 and 3)	Clinton, Essex, Franklin, Hamilton, Saratoga, Warren and Washington
Central New York Health Home (Phase 3)	Cayuga, Herkimer, Lewis, Madison, Oneida, St. Lawrence, Jefferson

NORTH COUNTRY HEALTH SYSTEMS

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ASSESSING THE REGIONAL POPULATION'S HEALTH CARE NEEDS AND THE SYSTEM'S ABILITY TO MEET THEM

Colleen McLaughlin, *Public Health Manager*
Office of Primary Care and Health Systems Management

Unmet Need

- Barriers to health care
 - Affordability
 - Availability
 - Accessibility
 - Acceptability
- Outcomes of unmet need in community
 - Preventable use of acute care and long term care
 - Preventable disease, complications
 - Premature disability & death

Concepts

- Concepts of affordability, availability, accessibility, and acceptability overlap.
- Measurement of outcomes and factors **directly** related to barriers to health care
 - Difficult to measure, increased bias
 - Often, no direct measures are available
- Measurement of factors **indirectly** associated with barriers
 - Often rely on existing health care utilization data to infer where there might be barriers
- Data related to many of the factors outlined in this presentation are not readily available

Affordability

- Direct measures
 - Uninsured & underinsured
 - Low prevalence of coverage by employer sponsored health insurance
 - Unpaid medical bills; charity care
 - Deferred health care due to cost
 - Seeing providers
 - Purchasing prescriptions
 - Use of free or low cost health care providers (such as FQHC)

Affordability

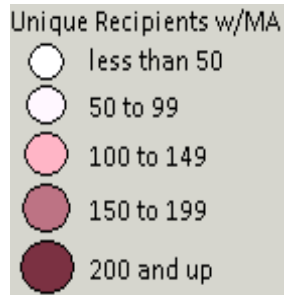
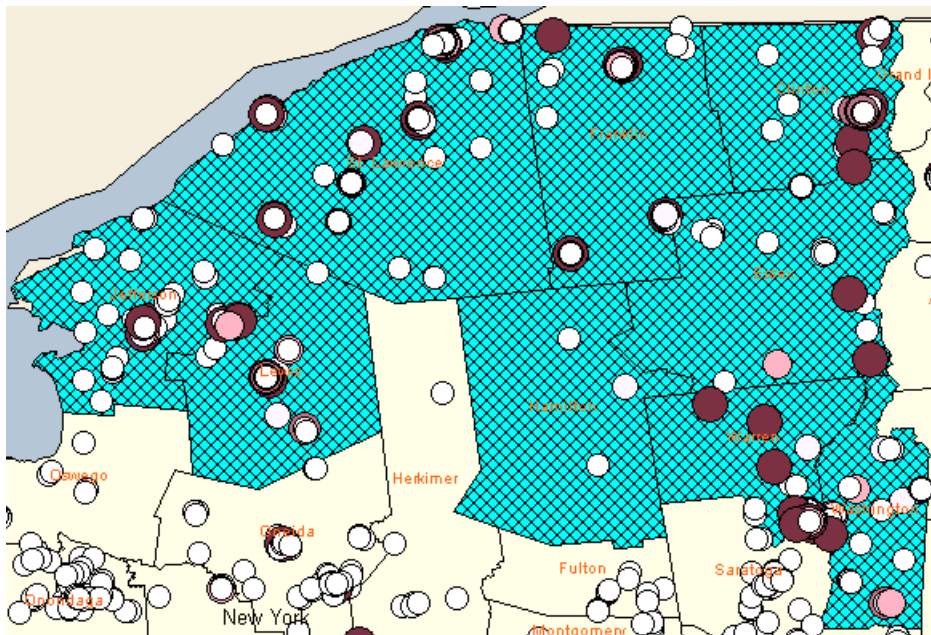
- Indirect measures
 - Medicaid enrollment; New York State of Health enrollment
 - Poverty, use of social service assistance programs
 - Use of emergency department for routine care
 - Insurance plan quality metrics

Affordability in North Country

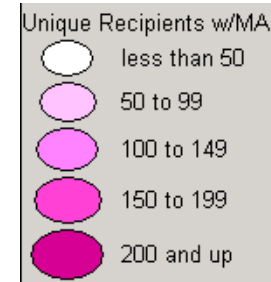
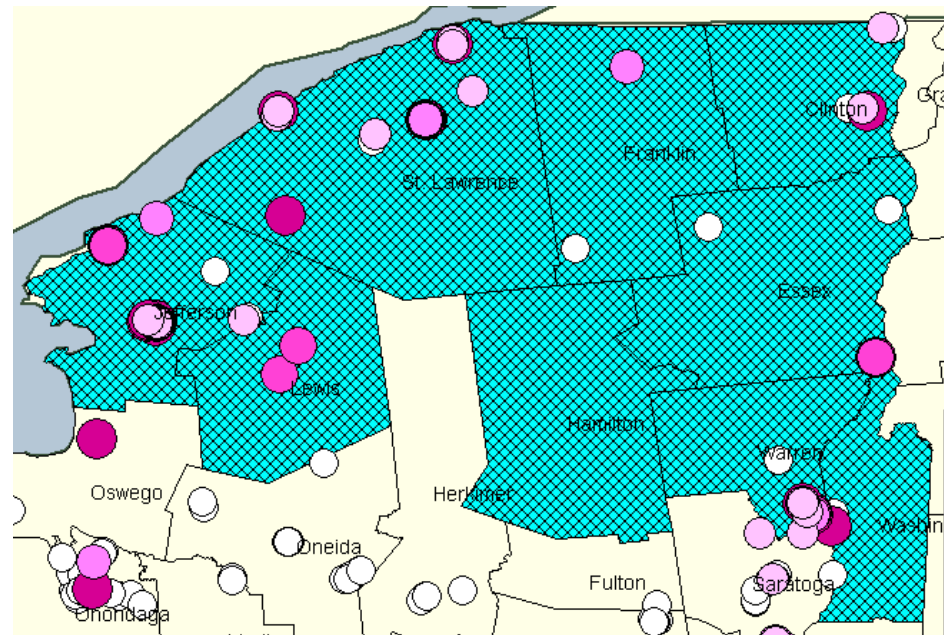
- Many indicators of lower socioeconomic status in area
 - Overall lower median income; higher percent of families in poverty; high percent of single parent households, high unemployment , etc.
- Pockets of poverty
 - St Lawrence, Franklin, and Jefferson counties ranked among lowest in state for social and economic indicators

Medicaid Dentist and Primary Care Providers and Recipient Volume

Primary Care



Dentist



Compared to Primary Care, there are fewer dental providers and the providers have lower volume of Medicaid recipients

Availability

- Direct measures
 - Unable to get care in timely manner
 - wait longer than 24 hours for urgent care appointment
 - long wait times in emergency department or psychiatric crisis unit due to lack of inpatient beds
 - Unable to get care in own community
 - lack of specialty services and providers
 - lack of allied health professionals to staff existing facilities

Availability

- Indirect measures
 - Workforce issues
 - Physicians per capita, especially primary care physicians
 - Allied health professionals, nurses, and pharmacists per capita (i.e. ability to staff)
 - Identification with “regular” health care provider
 - Distance travelled to health care
 - Distance to placement in long term care
 - Facility occupancy
 - Use of Emergency Room for primary care

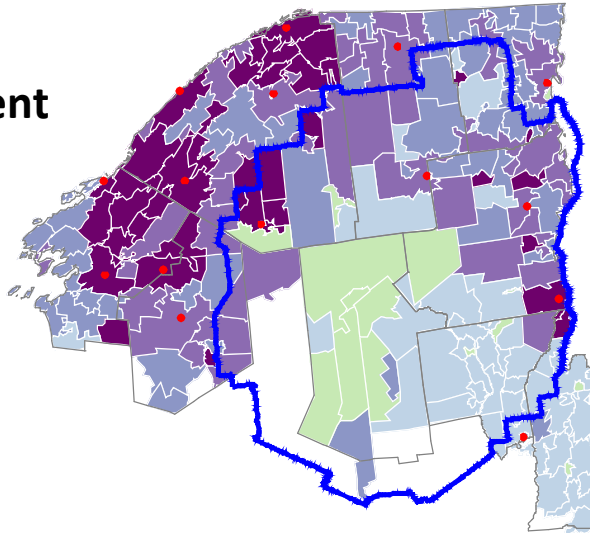
Availability in North Country

- Facilities
 - Threat presented by poor financial standing
 - Region is projected to need approximately 300 more Long Term Care beds by 2016
 - Low occupancy levels for hospitals
 - Average occupancy levels of long term care
- Low # of providers per capita
 - Physicians: primary care & specialists, dentists
 - Social workers, allied health, & nursing workforce in Hospitals, Nursing Homes, Home Health, etc
- Aging population and workforce

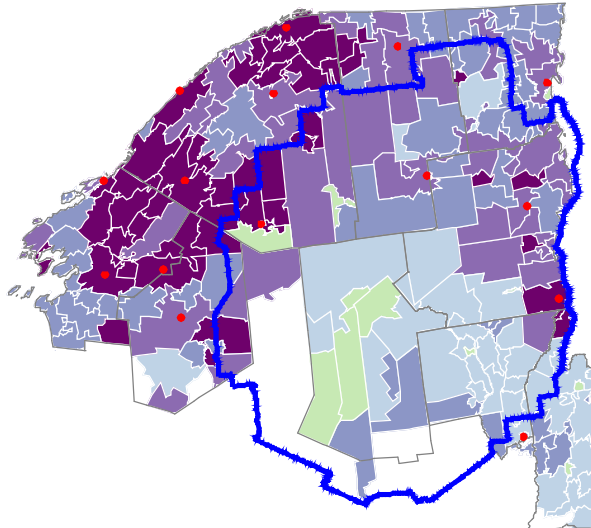
Avoidable ED Visits

Visits to the Emergency department that did not result in an admission and possibly could have been treated in another setting or prevented with good quality primary care. Rates of these visits are higher in the North County region than in NYS as a whole.

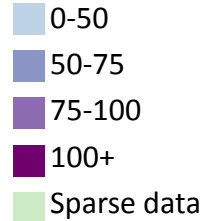
Non Emergent
12% higher
than NYS



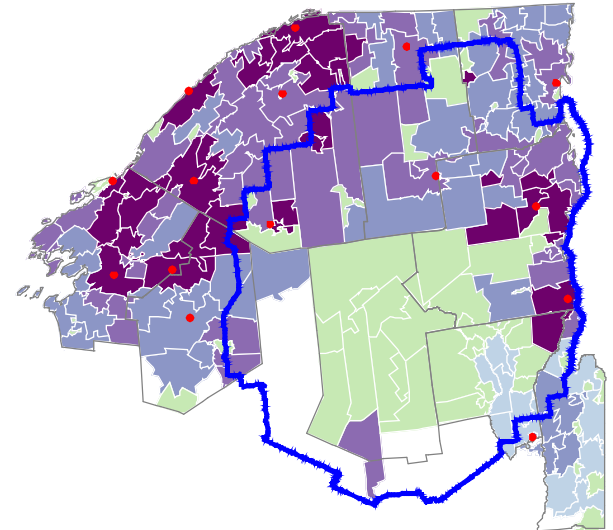
Emergent, Treatable in Primary Care
25% higher
than NYS



Admissions per
1000 residents



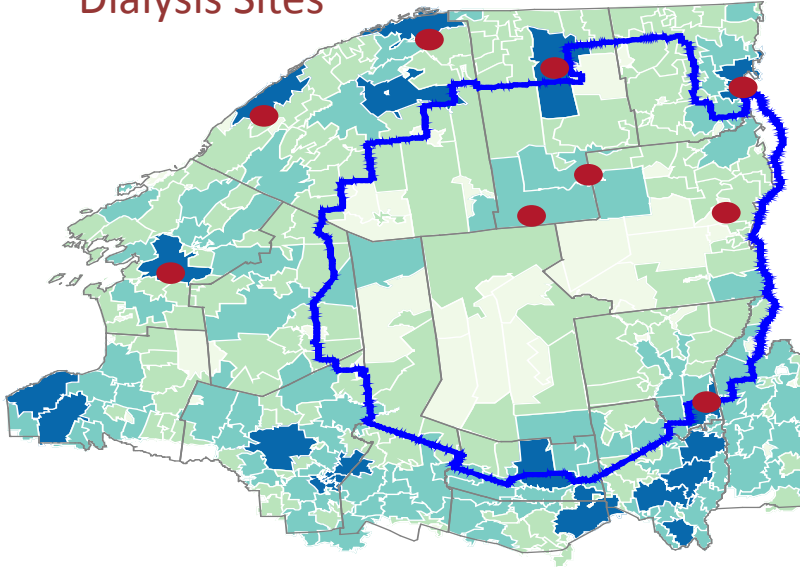
Emergent, Preventable With Primary Care
14% higher
than NYS



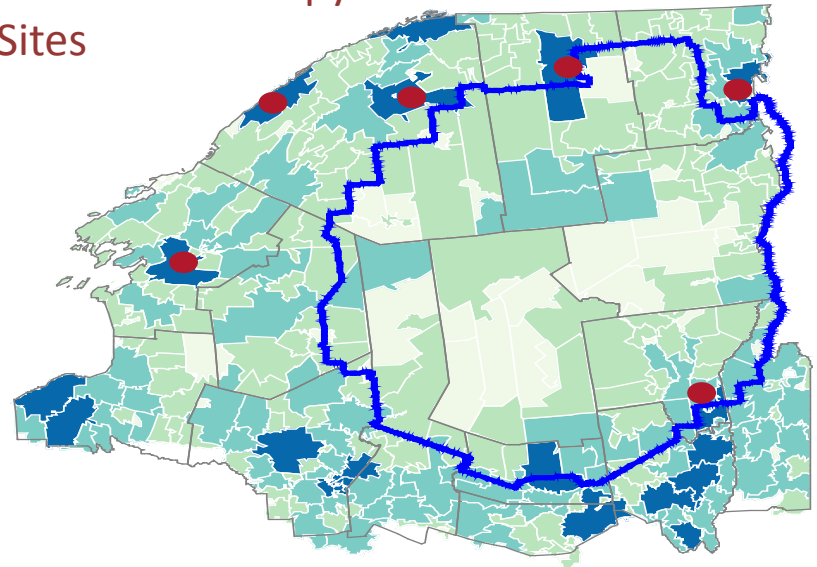
Locations of Dialysis and Radiation Therapy

Dialysis and radiation treatment are examples of two services that require substantial travel for patients. Although the dialysis and radiation treatment sites are located in the population centers of the North County, the residents of the less densely populated areas will have a significant travel burden for treatment.

Dialysis Sites



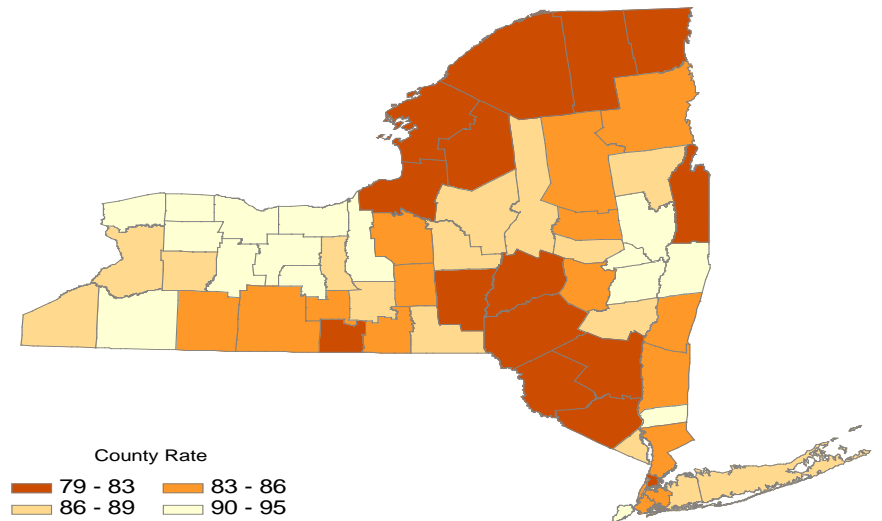
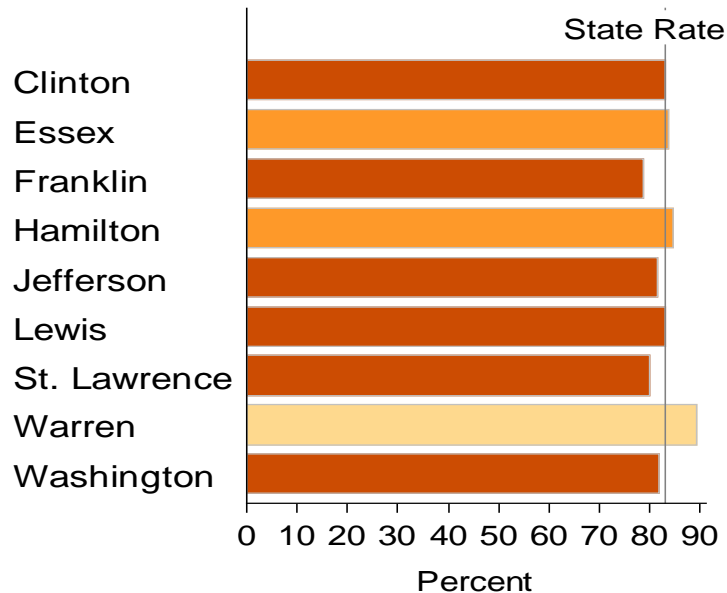
Radiation Therapy Sites



Map shows total population size, Census 2010

Percent of population with a regular health care provider

Most counties in the North Country rank in the bottom half of the state for the percent of the population that had a regular health care provider. Similar patterns were found for percent of respondents who had seen a dentist in the past year.



Accessibility

- Direct measures
 - Distance travelled to nearest appropriate health care
 - Response time and transport time for prehospital care system (EMS)

Accessibility

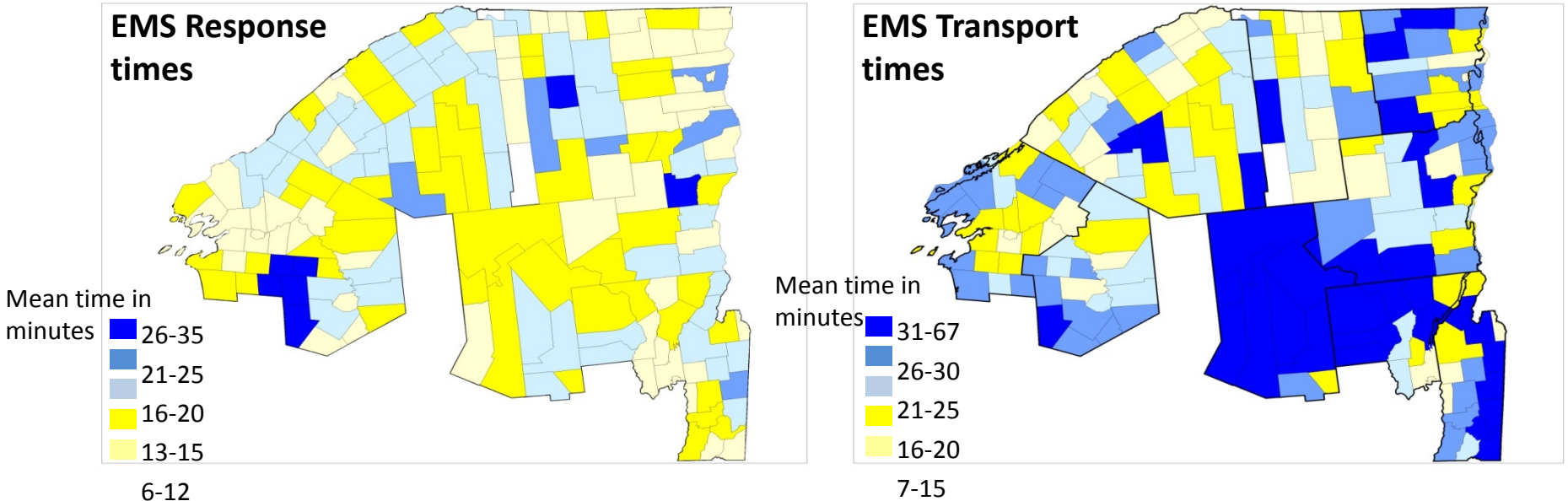
- Indirect measures
 - Distance travelled to health care (reflects patient and referring physician choice in addition to than nearest available)
 - Road access / road network modeling
 - Public transportation, car ownership
 - Population density

Accessibility in North Country

- Long distances to care
- Long EMS response times

Prehospital Care (EMS) timeliness

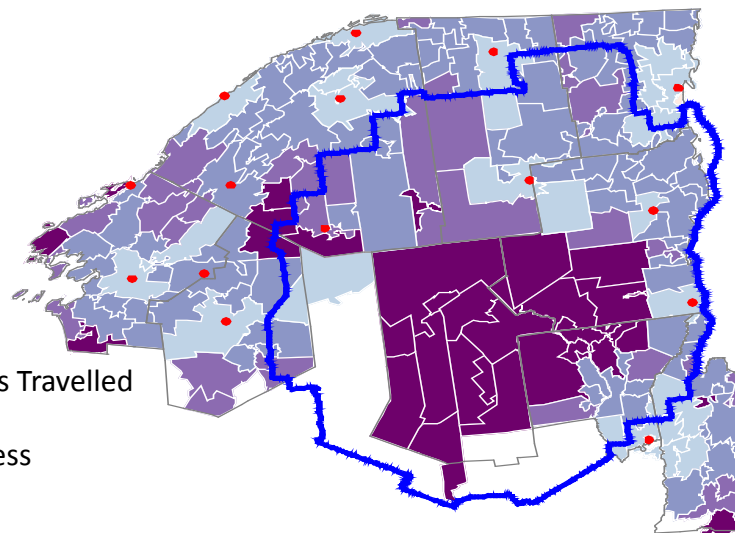
State average response time is 12 minutes. State average transport time is 15 minutes. Many towns in the North County have substantially longer response and transport times.



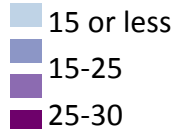
Distance from Home to Hospital Care

As we know, residents in some areas of the North Country travel substantial distances to get to a hospital compared to other areas of New York State. In general, however, these areas are less densely populated. The total distance travelled (person-miles) is a rough measure of the cumulative cost of travel for hospital care among all residents of the community.

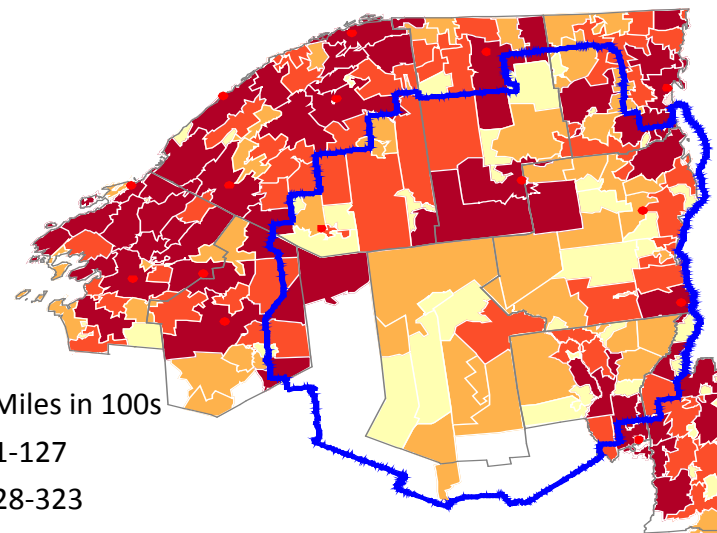
Distance travelled is measure in straight line. This provides a very conservative estimate.



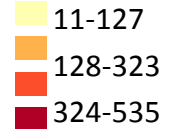
Average Miles Travelled per Visit



More than 30



Person Miles in 100s



536-4278

SPARCS 2012

Acceptability

- Direct measures
 - Customer feedback
 - Physician choices

Acceptability

- Indirect measures
 - Patient satisfaction survey
 - Complaints
 - Health care quality metrics
 - Referral patterns, patient flow out of facility market area, travelling to health care sites that are not the nearest available
 - Hours of operation of urgent care, clinics, physicians offices, etc.

Acceptability in North Country

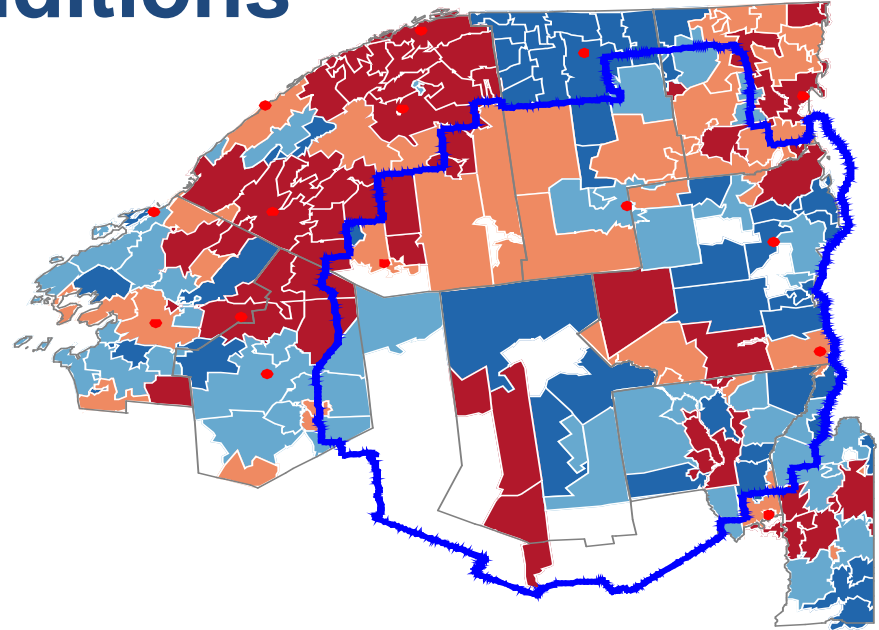
- Overall good customer satisfaction for hospitals in NC
- Loss of patients to facilities outside of region

Outcomes from unmet need

- Preventable diseases and complications;
Preventable use of acute care and long term care; Premature disability and death
 - Admissions for preventable complications
 - Use of emergency department for non emergent care or preventable emergent care
 - Use of prehospital care (EMS) for primary care
 - Preventable readmissions

Hospital Inpatient Visits for Ambulatory Care Sensitive Conditions

Prevention Quality Indicators (PQI) are a measure of the hospital inpatient admissions that potentially could have been avoided with better quality primary care. This map displays the rate of PQIs in the community relative to the rate in New York State as a whole, adjusted for differences in the distribution of age and race compared to NYS.

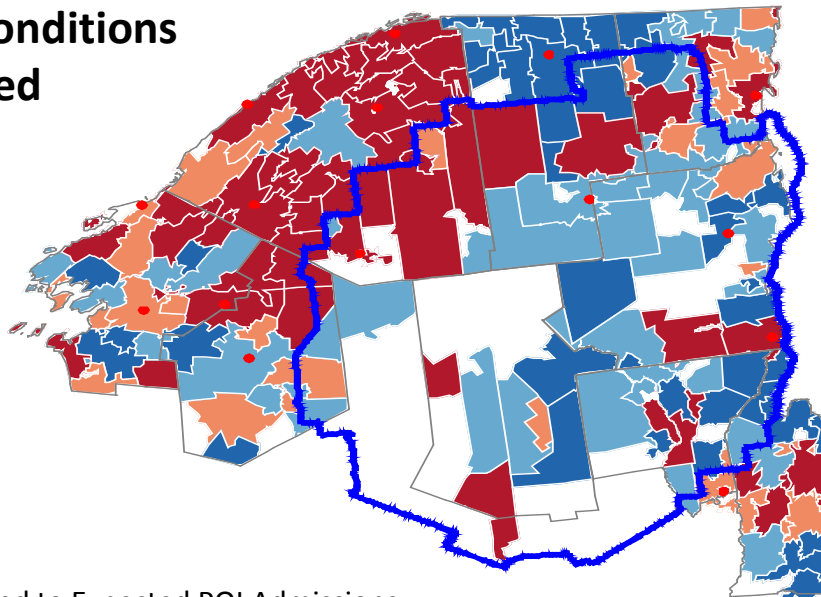


Ratio of Observed to Expected PQI Admissions

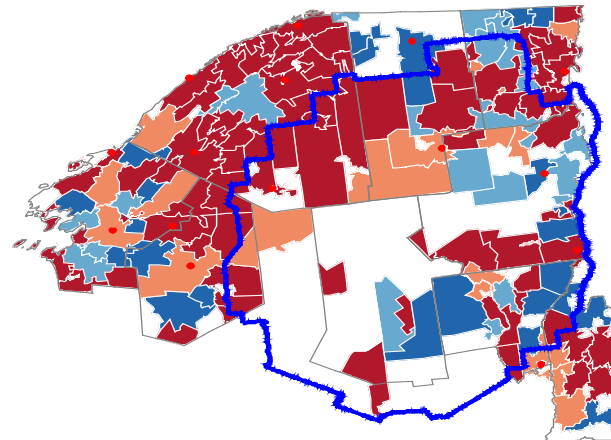
- 20% or more lower than expected
- within 20% of expected
- 20% to 50% higher than expected
- More than 50% higher than expected

Preventable Hospital Inpatient Visits for Acute Conditions

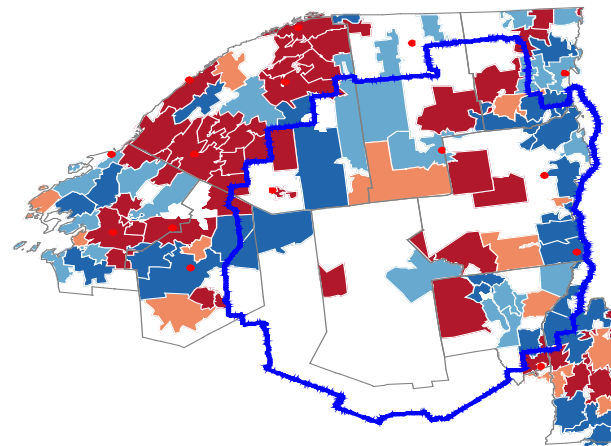
Acute Conditions Combined



Bacterial Pneumonia



Dehydration

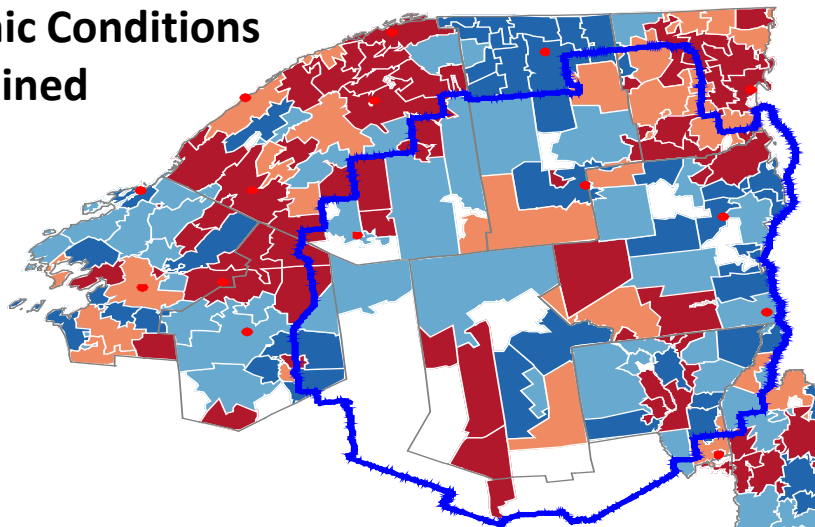


Ratio of Observed to Expected PQI Admissions

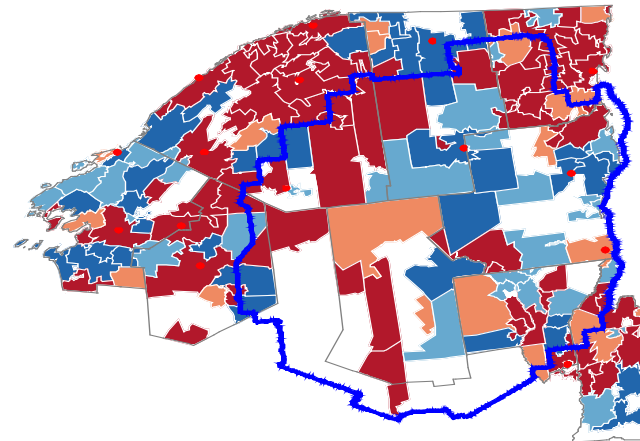
- 20% or more lower than expected
- within 20% of expected
- 20% to 50% higher than expected
- More than 50% higher than expected

Preventable Hospital Inpatient Visits for Chronic conditions

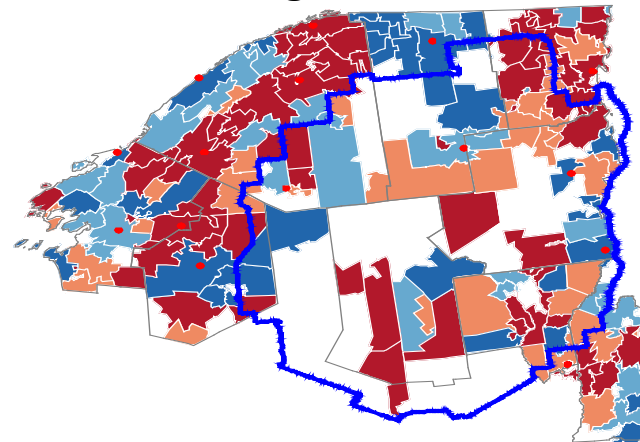
Chronic Conditions Combined



Chronic Obstructive Pulmonary Disease



Congestive Heart Failure



Ratio of Observed to Expected PQI Admissions

- 20% or more lower than expected
- within 20% of expected
- 20% to 50% higher than expected
- More than 50% higher than expected

NORTH COUNTRY HEALTH SYSTEMS

REDESIGN
COMMISSION

DATA IMPLICATIONS

Dan Sisto, *Chair, NCHSRC*

**NORTH
COUNTRY
HEALTH
SYSTEMS**

**REDESIGN
COMMISSION**

BREAK

**NORTH
COUNTRY
HEALTH
SYSTEMS**

**REDESIGN
COMMISSION**

**STATE HEALTH
INNOVATION PLAN
(SHIP)**

Hope Plavin, *Director of Programs*
Office of Quality and Patient Safety

NORTH COUNTRY HEALTH SYSTEMS

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ESTABLISHING WORKING PRINCIPLES

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NEXT STEPS

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