NewYork-Presbyterian
Queens

Document Title:	Population Health Management Tool Utilization Guidelines
Recommending Committee:	Cardiovascular/PCMH
Approving Committee:	Clinical Integration
Approval Date:	TBD
Document Objective/Summary:	This document will serve as an outline for the utilization of a population health management tool for care coordination and tracking of engaged Medicaid patients related to DSRIP projects.

The utilization of a population health management (PHM) tool is imperative to the success of the DSRIP clinical programs. A PHM tool allows our network partners the ability to identify, track, and monitor engaged patients based on defined clinical criteria. The compilation of engaged patient information provides a clinical picture for the network to partner focused to care management and risk stratification in order to improve quality outcomes.

The NYP/Q PPS Clinical Integration Committee completed a Clinical Integration Gap Analysis that identified the following population health management gaps:

- 35% of partners are currently not utilizing a population health management tool
- 100% of partners do not utilize a patient registry to track pediatric asthma patients
- 60% of partners do not have care coordinators at primary care sites

Utilizing this information, the Clinical Integration Committee partnered with IT leadership to outline an action plan to support the implementation of a PPS PHM tool in order to improve coordination and quality. The plan included:

- Maximize capacity of existing EHR systems and other IT platforms
- Implement / Expand PHM tools based on cost effectiveness and budget availability

Understanding the complexity of our partners, patients, and projects, the PPS leadership will work with each provider to establish a unique plan for population health management based on their individual needs and project commitments. Partners will be encouraged to utilize an electronic PHM tool but it is expected that we will not be able to fund all partner access to such a tool and that some partners will not have the operational capability to implement such a tool; therefore, we will work with such partners to identify a roster / paper based tracking system with minimal expectations to report monthly engaged patients and basic care coordination efforts.

As part of the 2.a.ii project DSRIP partners are required to perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.

In support of these requirements to include patient engagement, analytics, care coordination and connectivity the NYP/Q PPS will implement Allscripts Care Director (“ACD”). This PHM tool

is a web-based solution which will support the PPS and its partners to coordinate patient care across healthcare settings. Specifically, the NYP/Q PPS will grant PPS partners' access to the ACD platform, where they can enroll patients, complete assessments, set risk scores, create care plans, and manage patient care post hospital discharge.

The ACD tool brings value to a multi-faceted PPS with complex projects and patients by ensuring offering the following:

- **Risk scoring functionality** - facilitate the management of high risk, high utilization and chronically ill patients.

- **Care coordination functionality** - facilitate care coordination through the use of the assessments and the care plans to track measureable goals and interventions.

- **Transitions of Care** - coordinate transitions of care between all care settings including home care, physician practices, post-acute care facilities, community services and hospitals.

The NYP/Q PPS partners will be expected to use the PHM tool to support the following goals;

- Identify and manage at-risk patients
- Improve transitions of care
- Reduce potential re-admissions
- Decrease redundancies
- Connect care settings.

The NYP/Q team will also use the ACD tool as the source for sending and receiving appropriate patient information from the RHIO, such as client event notifications (Alerts) related to admission, discharge or transfer information. The tool will support the NYP/Q goals for analytics through the aggregation of patient data across multiple health information resources. The analysis of captured data will facilitate an actionable patient record which will allow providers (Care Coordinators) to improve clinical outcomes.

The NYP/Q DSRIP team will launch phase 1 of Allscripts Care Director to its internal DSRIP staff in June 2016. The 2nd phase of the implementation will progress into August of 2016. During the 2nd phase of the implementation, the appropriate partners will be identified, trained and provided with the policies and expectations for use of the system, to support DSRIP requirements.
Confidentiality is the utmost priority of the PPS and its partners and the ACD tool will be managed according to the PPS data security policies and data use agreements. The tool will also

be included in the Performance Reporting strategy to maximize the use and produce actionable data sets to improve communication and quality.

The PPS IT Committee will govern the use and compliance of the ACD tool in partnership with the Clinical Integration Committee with final reporting of progress, risks, changes, or issues reported to the Executive Committee.