NYC-based ACO Tackles Complex Care Delivery Challenges for its Patients with Intellectual and Developmental Disabilities

Integrated population health data, analytics tools and customized care plans improve quality and decrease costs.

Goals:

- Achieve optimal health for its patients and drive holistic, patient-centric care by giving physicians access to comprehensive data.
- Care for the needs of IDD patients using an integrated population healthcare platform.
- Seamlessly capture and share relevant IDD patient data across all providers of record, such as routine and follow-up visits, prescription orders and refills, and longitudinal medical records.
- Share electronic, pre-service summaries with providers prior to IDD patient visits.
- Create workflows to optimize the appropriate sharing of clinical information.
- Meet quality data collection and reporting requirements.

Alliance for Integrated Care of New York, LLC (AICNY) was formed in 2014 to oversee the healthcare needs of individuals with intellectual and developmental disabilities (IDDs). Comprised of approximately 200 healthcare providers, AICNY cares for about 5,000 dually eligible Medicare and Medicaid beneficiaries and is the only Medicare Shared Savings Program (MSSP)-approved ACO of its kind in the U.S.

Challenges:

Patient compliance and pre-visit planning. Primary care physicians, specialists and residential care managers had to overcome IDD patients' inability to articulate their chief complaints and symptoms.

Multiple providers. AICNY's 600 IDD patients had 7,000 to 8,000 specialty medical appointments outside the network each year, leading to a series of logistic and patient satisfaction concerns such as:

- Encounters documented in different EMRs
- Primary care providers lacking visibility into the specialist's assessment and plan
- Doctors unaware of recurring follow-up appointments scheduled with specialists
- Unnecessary visits contributing to higher costs
- Transportation issues due to numerous medical appointments
- Physical and mental distress in patients following multiple encounters

Emergency services. Certain patients with multiple chronic conditions were seeking, or being transported for, emergency care multiple times per month from their group homes. AICNY leaders identified two contributing challenges: a group home protocol for after-hours triage that did not incorporate the patient's primary care provider, and a cautious approach to ensure compliance with their certification by state regulatory agencies.

Paper records. Finally, a significant number of IDD patients live in long-term care facilities or independent residences aided by in-home support staff. Nurse case managers document the patients' care in paper records, which are prone to damage, mishandling and interpretation, and are grossly ineffective in coordinating cross-continuum care.

The Solution:

AICNY tackled its fundamental care delivery challenges by implementing HealthEC's Population Health Management platform. The organization now aggregates and analyzes IDD beneficiaries' EMR and claims data across all providers and service delivery settings. From there, risk stratification tools were used to identify high-need and high-cost patients who would most benefit from targeted care interventions. The collected data also satisfies physicians' GPRO MIPS quality data collection and reporting requirements.

HealthEC's solutions also armed AICNY physicians and care managers with analytical tools and training on how to interpret clinical and utilization data, and determine the best care management strategy for each patient. The technology enabled the care managers and providers to focus on patients with the highest resource utilization, and compare performance against pre-established quality and utilization benchmarks to track care improvements.

The organization now uses data to customize workflows, sending patient-specific information to AICNY, and referring providers prior to encounters. Pre-service summaries are automatically populated with the most relevant documentation accessible for every provider's IDD patient visit.

Producing Remarkable Results

Average cost of care for IDD patients prior to the project

Average cost of care reduced after AICNY launched the project

Prior to the project, the average cost of care for IDD patients was increasing at a rate between 9% to 13% per member per quarter, for four quarters.

AICNY first introduced care managers to meet with physicians to identify and review complex, high-cost cases. Through this simple awareness, providers were able to reduce unnecessary hospital encounters. The growth of PMPM costs slowed to an increase of 7% to 10% for the IDD population over the next two quarters, while the combined population of the MSSP group experienced a decrease in PMPM costs by -2%.

Over the final quarter of 2017 and the first quarter of 2018, case managers initiated direct contact with patients, caregivers and group home teams to close care gaps, provide education and facilitate follow-up communication. As a result, PMPM costs for IDD patients are now showing no increase for the IDD population while showing a 1% decline for the combined population in the fourth quarter of 2017.

Contact us to learn how HealthEC enables value-based, whole person care with integrated data, analytics and care coordination strategies.

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