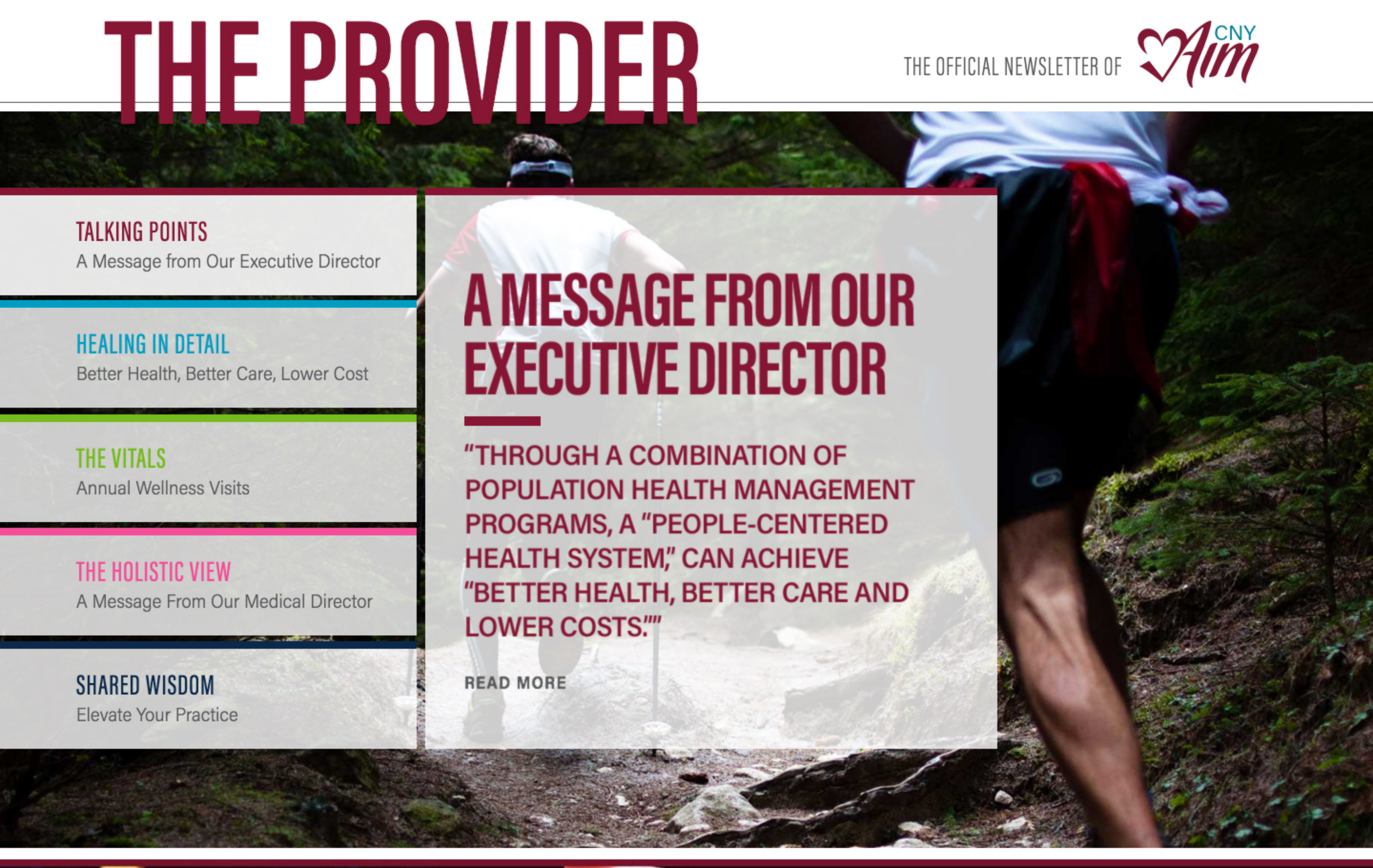
THE PROVIDER

THE OFFICIAL NEWSLETTER OF CNY Aim



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A MESSAGE FROM OUR EXECUTIVE DIRECTOR

"THROUGH A COMBINATION OF POPULATION HEALTH MANAGEMENT PROGRAMS, A "PEOPLE-CENTERED HEALTH SYSTEM," CAN ACHIEVE "BETTER HEALTH, BETTER CARE AND LOWER COSTS.""

READ MORE

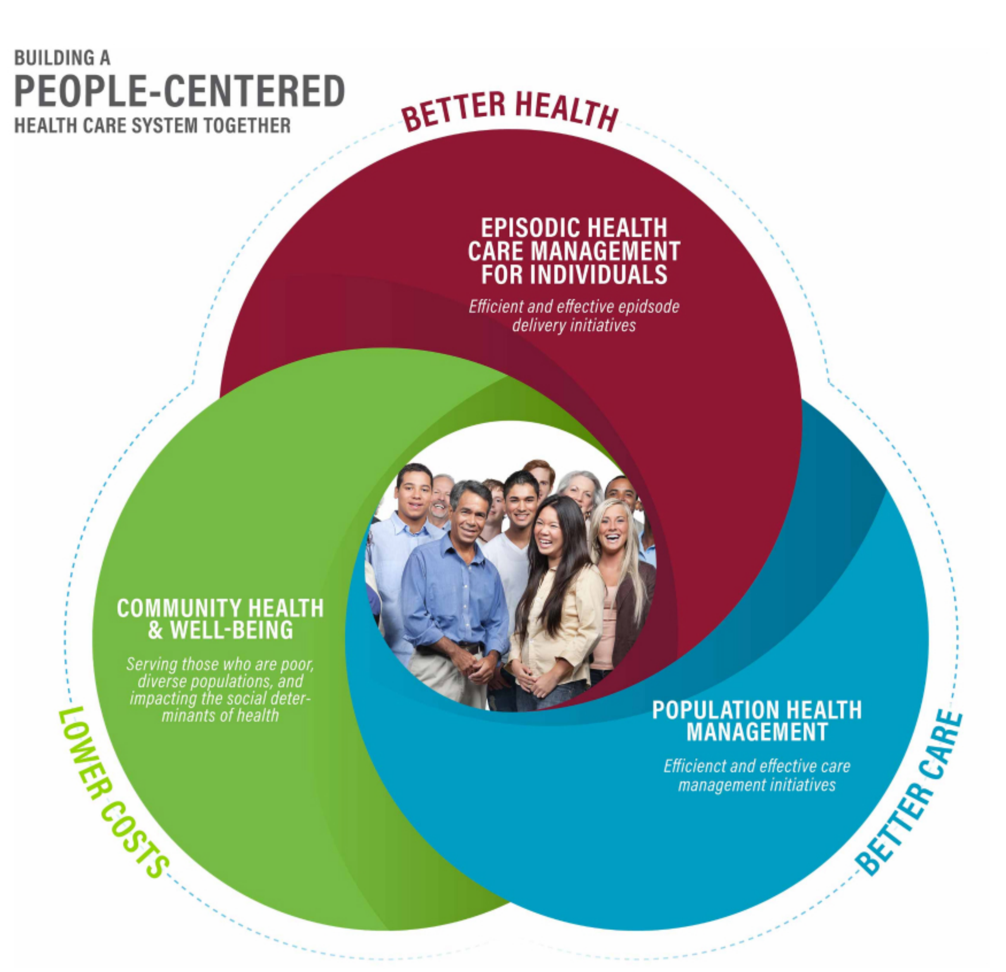
TALKING POINTS

A MESSAGE FROM OUR MEDICAL DIRECTOR

In our last installment of **The Provider**, we introduced CNY AIM (our Clinically Integrated Network) and explained both why it exists and what it can do for you. In short, CNY AIM is a clinically integrated network of more than 600 participating physicians, each of them united in achieving the "Triple Aim" objective of providing "Better Health, Better Care, Lower Costs." In this issue, I would like to discuss the strategy of creating a "People-Centered Health System" and how CNY AIM fits into that strategy.

We plan to achieve the "Triple Aim" by:

- Aligning CNY AIM's provider base and our respective Health Systems' resources to provide efficient and effective health care for individuals with specific medical conditions in a set time period.
- Efficient and effective care management initiatives for chosen medical cohorts who share common diseases.
- Addressing the social determinants of health.



To date, I am pleased to report that our efforts have yielded exceptional results and our value proposition has been confirmed. Our first All Physicians and Noah's Ark Meetings proved to be very successful and well attended!

We have launched our new website: **www.cnyaim.com**. The goal of this site is to keep you updated and informed about activity in the ACO/CIN. This site will provide educational resources to patients and allow them to find physicians within our network.

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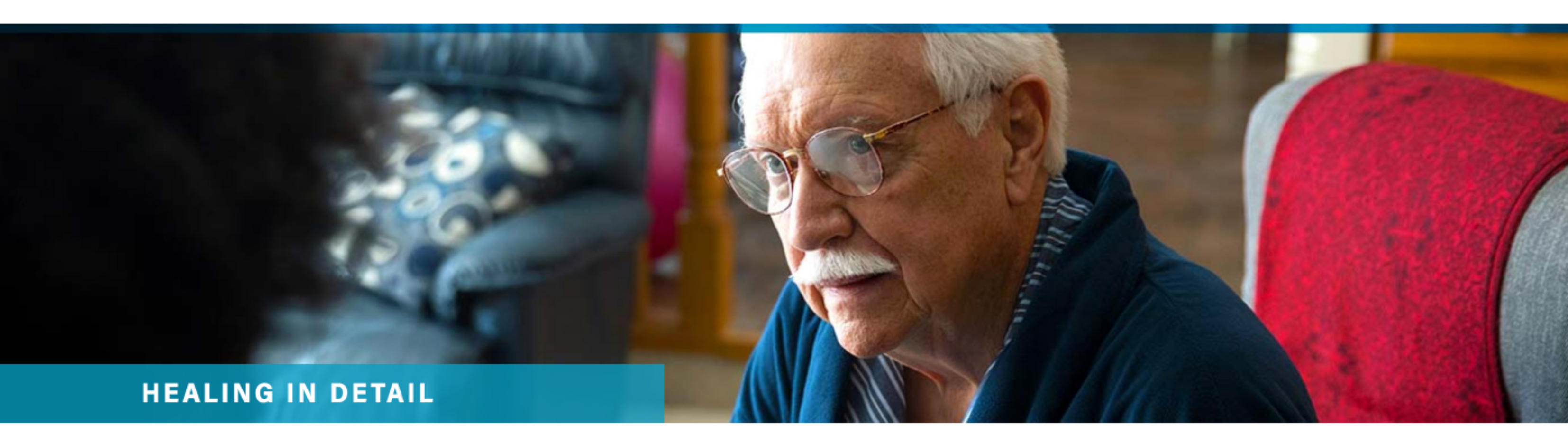


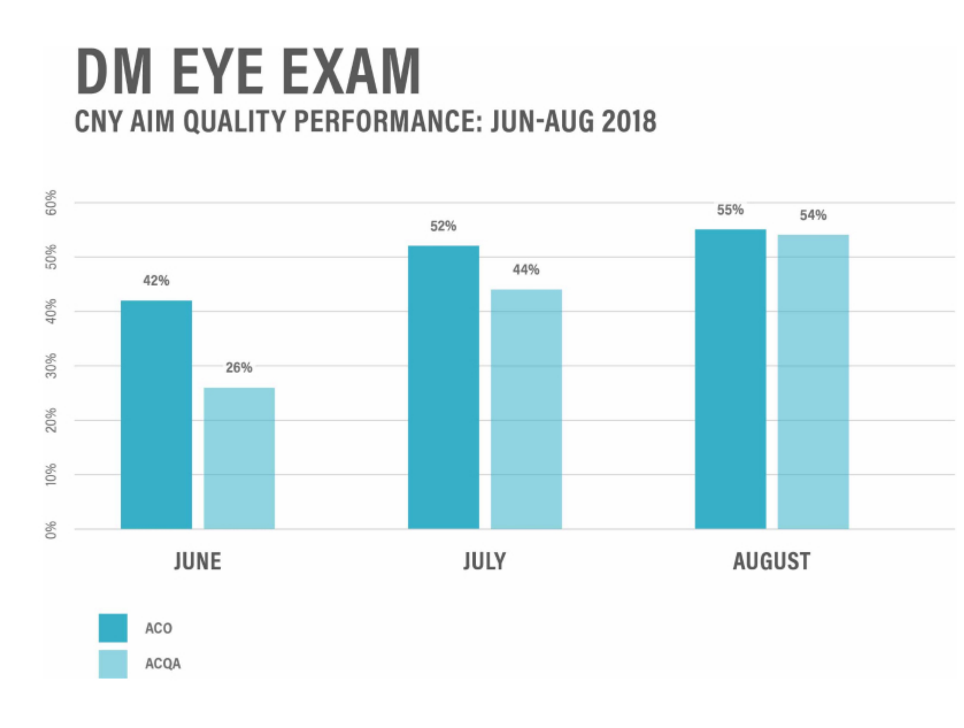
HEALING IN DETAIL

BETTER HEALTH, BETTER CARE, LOWER COST

In the last issue of **The Provider**, we talked about the importance of the diabetic eye exam. Unfortunately, documented compliance with vision-saving annual exams is often lower than 50%. One Solution: RetinaVue® Care Delivery Model.

A patient with multiple comorbidities was due for a diabetic eye exam, and during a recent visit, the patient's PCP encouraged him to stay a few extra minutes to have one performed. A Patient Navigator then used the Welch Allyn RetinaVue 100 Imager to capture images of the patient's retinas. The images were sent through the Welch Allyn RetinaVue Network software to a board-certified ophthalmologist for evaluation. Within 24 hours, the PCP received a diagnostic report indicating that the patient had Proliferative Diabetic Retinopathy and an Active Vitreous Hemorrhage. Knowing the multiple health challenges the patient faced, the PCP and Patient Navigator worked together to promptly schedule follow-up care with an eye specialist. The patient then received laser treatment to help prevent further deterioration and vision loss. Now the patient is closely monitored by his eye specialist and primary care physician.

Our Target Percentage: ACO=60.37%, ACQA=67.99%



Our CIN/ACO Health Coaches focus on high cost and high risk attributed patients.

Sharon's Story: I have a patient on whom I initially thought I would have very little impact. Some of the hindrances he deals with daily include a traumatic brain injury, hemodialysis treatment, diabetes, and mobility restrictions that cause him to be wheelchair bound. The patient has 24/7 basic home health aide assistance and weekly long-term home care. A family member does some basic grocery shopping and picks up medications but does not assist with insulin injections or ensure that an appropriate diabetic diet is followed. The patient has no other family or friends to help with insulin injections, and the health aides are not able to assist. The patient was warned that he was in serious danger of developing ketoacidosis, among other complications. The patient would not consent to moving into a nursing home, which was recommended to him as the best course of action. With much collaboration, his doctor, P.A., staff nurses, homecare nurses, case managers, aides and I convinced the family member to help us assist the patient. As a team, we worked together to coordinate the best care plan to keep the patient at home. The family member and aides have learned, through the clinical team, the importance of meal and snack portions; meal spacing; and purchasing appropriate food. With the proper diet and oral medications, the patient's blood sugar has decreased from frequent peaks of 300-400 to 62-130. This undeniable success was due to the combined efforts of the clinical team, the family and the patient.

THE VITALS

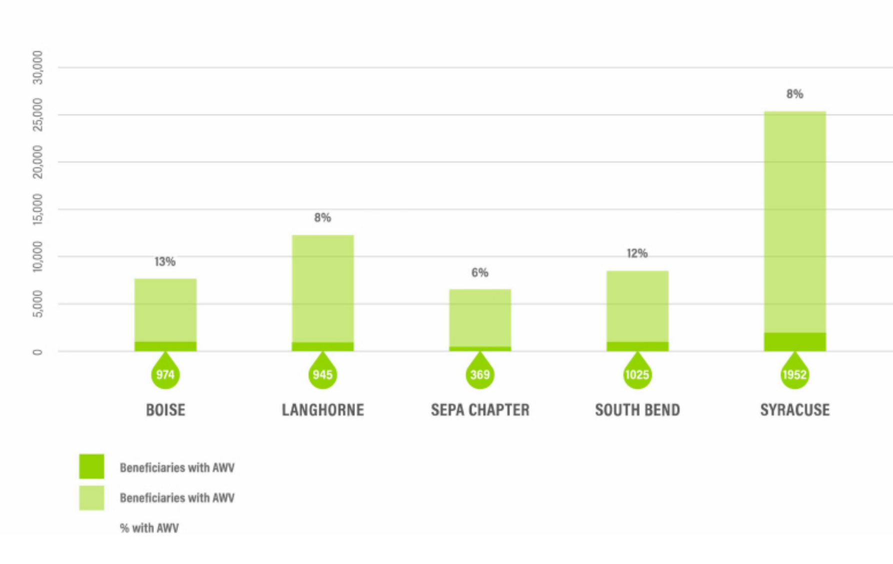
ANNUAL WELLNESS VISITS

The diagram below represents Annual Wellness Visits (AWV) conducted in the first quarter of 2018 based on claims for Track 3 beneficiaries. Even though our chapter is at 8%, the number of attributed beneficiaries is the largest. *August 2018 Trinity Health Quality Initiatives Meeting.

Realizing the value of the Annual Wellness Visit is the first step to achieving system goals and elite performance.

N(%) OF 2018 THIC ATTRIBUTED BENEFICIARIES WITH G0438/G0439 ANNUAL WELLNESS VISIT IN 2018

PROGRAM	CHAPTER	TOTAL BENEFICIARIES	BENEFICIARIES W/ AWV	BENEFICIARIES W/O AWV	% W/ AWV
MSSP-T3	BOISE	7,718	974	6,744	13%
MSSP-T3	LANGHORNE	12,274	945	11,329	8%
MSSP-T3	SEPA	6,645	369	6,276	6%
MSSP-T3	SOUTH BEND	8,495	1,025	7,470	12%
MSSP-T3	SYRACUSE	25,409	1,925	23,457	8%



THE HOLISTIC VIEW

A MESSAGE FROM OUR MEDICAL DIRECTOR

In the last Issue, I suggested that our ability to achieve the "Triple Aim" (Better Health, Better Care, Lower Cost) will depend on our success in disseminating strategic interventions. In this issue, I would like to explain one key intervention: the Annual Wellness Visit. As benign as these visits appear to be, they are key to achieving quality scores for our at-risk contracts. In addition, they provide income to primary care practices. In the recent past, healthcare has moved away from "prevention visits" and focused on acute visits. Since 2011, Medicare's goal has been to shift back primary care physicians developing and updating patients' personalized prevention plans while removing barriers to beneficiaries, thus supporting healthier lifestyles through disease prevention and early detection. A common misconception is that the provider does not need to perform these visits. At CNY Family Care, we are generating these wellness plans by performing the data collection in our waiting rooms. We incorporated an app designed by WellTrackOne (www.welltrackone.co/theo/) into the iPads in our waiting rooms. Medicare patients use them to perform 10 to 15-minute long self-assessments. This information is then routed to a nurse to update our Diabetes Management and Hypertension Management for the physician for review, eventually informing the development of patients' wellness plans. We are currently working with WellTrackONE to help us complete 13 of the 14 EMR measures that we report through GPRO (Group Practice Reporting Option).

At CNY Family Care we have been effective with operationalizing this into our waiting room to prevent tying up exam rooms and providers.

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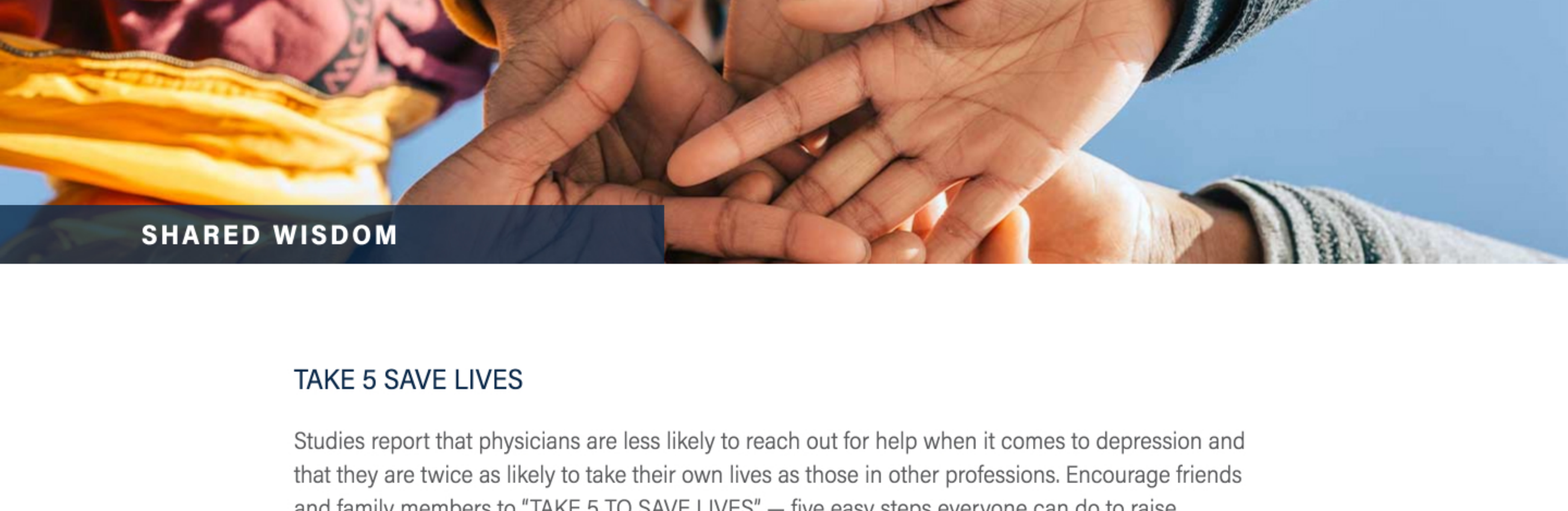

SHARED WISDOM

TAKE 5 SAVE LIVES

Studies report that physicians are less likely to reach out for help when it comes to depression and that they are twice as likely to take their own lives as those in other professions. Encourage friends and family members to "TAKE 5 TO SAVE LIVES" — five easy steps everyone can do to raise awareness for suicide prevention. You can help prevent Physician Suicide by visiting https://www.take5tosavelives.org.

REDUCING DRUG COST

Erectile Dysfunction Medications:
Consider prescribing tadalafil, generic Cialis, for your patients. The savings over the next year is projected to increase as there is an increase in manufacturers. The anticipated savings per patient could be over $1000 each year.

ADHD Medications:
When using amphetamines to treat ADHD, consider prescribing dextroamphetamine/amphetamine ER or methylphenidate hcl CD instead of Vyvanse. The savings per patient could be over $2400 each year.

Antidepressants:
Consider prescribing paroxetine ER instead of Trintellix. The savings per patient could be over $2600 each year. If the patient is newly diagnosed with MDD, starting with sertraline or citalopram could save over $4000 each year per patient.

CNY Aim
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