Advocate Community Partners (AW Medical) (PPS ID:25)

SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

Description:
The DSRIP PPS Organizational Application must include an executive summary clearly articulating how the PPS will evolve into a highly effective integrated delivery system. This section will also include questions about any application(s) for regulatory relief the PPS is pursuing.

Scoring Process:

This section is not factored into the scoring of the PPS application. This response will be reviewed for completeness and a pass/fail determination will be made.

Section 1.1 - Executive Summary:

***Goals:**
Succinctly explain the identified goals and objectives of the PPS. Goals and objectives should match the overall goals of the NY DSRIP waiver and should be measurable.

#	Goal	Reason For Goal
1	Create an Integrated Delivery System, begin DY1, ongoing through Q4DY5	The creation of a streamlined, clinically integrated delivery system (IDS) is essential to keeping patients healthy and better serving our community. The IDS will produce the following benefits: • Engage ACP's diverse, community-based primary care physicians, specialists, and service providers with infrastructure and DSRIP programs • Advance the "Triple Aim" of better care for individuals, better health for the population, and lower costs • Reduce avoidable inpatient hospitalizations, readmissions, and emergency department visits by 25% • Provide the information technology needed to link providers and support coordinated care delivery across the IDS • Support the adoption of evidence-based clinical protocols as well as the measurement and management of continuous quality improvement and clinical outcomes • Develop the organizational infrastructure, through a strong program management office, to support population health management capabilities
2	All Primary Care Practitioners Achieve PCMH 2014 Level 3 by Q4DY3	The Patient-Centered Medical Home (PCMH) model of care will transform primary care to better serve the community of Medicaid recipients. The PCMH model is critical to the improvement of cost-effective, efficient, patient-centered care for adults and children, including access to behavioral and oral health across the PPS. The benefits of PCMH practice transformation include, but are not limited to: • Higher quality and improved outcomes at lower costs • Better care experience focusing on the whole patient, including the involvement of family and friends • Better care through the use of evidence-based medicine and clinical decision-support tools • Use of EHR to support patient care, performance measurement, patient education, and communication • Enhanced access to care such as open scheduling, expanded hours and new communication options • A shift to value-based payments to support physicians who provide better care • Transform to team-based care to deliver patient care more effectively
3	Focus on care management and disease prevention	Building on the PCMH approach, ACP can have its greatest impact in

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#	Goal	Reason For Goal
	by Q4DY1	decreasing fragmented care, improving access to care and reducing chronic disease by ensuring care is coordinated across the continuum, especially for patients with complex conditions or at risk of becoming complex. Through this focus, ACP will: • Build on PCMH use of care plans, particularly for complex patients • Provide early intervention care management to patients on a declining trajectory • Develop centralized care management and care coordination functions that get patients to appropriate level of care when they need it • Ensure better discharge planning and transitions of care following hospitalization • Focus on increasing screenings, improving access to care, identifying mental and behavioral health issues earlier, and moving from episodic to whole person care
4	Adopt evidence-based protocols by Q4DY1	Across the health care industry there is room for improvement in provider's adoption of and adherence to evidence-based guidelines. Our PPS committed to implementing and hardwiring protocols and guidelines for enhanced clinical outcomes. Through our efforts, we will: • Adopt evidence-based, EMR integrated protocols for CVD, asthma, and diabetes to identify risk factors and focus on prevention and management of chronic diseases • Ensure that high-risk patients are appropriately monitored and treated through an integrated, multidisciplinary care team approach • Educate patients on lifestyle modification and self-management as key elements of their treatment • Ensure that care that is delivered in accordance with protocol • Improve use of clinical decision-support tools
5	Expand innovative health IT platform by Q4DY3	Sharing clinical data is critical to improving quality and safety of patient care and decreasing avoidable or duplicative services. Our PPS will share data both within and beyond our network. Our efforts will: • Increase use of information technology (IT) to support patient care, performance measurement, patient education, and enhanced provider to provider communication • Enhance technologies for data analytics, disease management and population health • Ensure two-way connectivity of clinical information, number of sites/providers connected to HIE, and Meaningful Use • Apply rapid cycle evaluation of partner performance on a monthly basis in order to identify best practices and assist low-performers in improvement • Ensure data security
6	Lower costs of care while preserving Medicaid safety net system by Q4DY5	Historically, providers have not been accountable for managing costs of care, and have been paid fee-for-service. We aim to shift providers to value-based payments that reward the efficient and effective use of healthcare resources. During this shift to value-based payments, we will: • Monitor the health of financially fragile providers to ensure access to care • Reduce avoidable hospitalizations, readmissions, and emergency department visits by 25%, consistent with DSRIP program goals • Dynamically assess the supply of providers to be sure it meets patient demand for services within the PPS • Coordinate care within the network to ensure complete understanding of patient healthcare needs and efficient use of services to meet those needs
7	Enhance patient satisfaction and outcomes by Q4DY4	When managing care, it is imperative that patient outcomes, including quality as well as patient satisfaction, are maintained or enhanced. Our PPS will: • Evaluate CAHPS performance

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#	Goal	Reason For Goal
		• Monitor patient feedback, complaints, and appeals • Through cultural competency efforts, improve patient knowledge and e perience of the healthcare system • Overcome barriers to care, through efforts to link with community resources
8	Improve community health status, ongoing through Q4DY5	Social determinants of health, including but not limited to social, environmental, cultural and educational factors, have a measurable impact on population health. Therefore, improving community health status requires coordination, collaboration, and an ongoing effort to address these issues. ACP and our partners will: • Monitor health education and compliance • Improve prevention and health literacy and reduce health disparities • Address social and workforce issues which affect community health status • Effectively draw on the expertise of partner CBOs to further strengthen cultural competence and engage patients • Build population health capabilities, with a focus on tobacco use cessation and chronic condition prevention and screenings
9	Ensure workforce stability during system transformation, DY2 through Q4DY 5	Population health initiatives are successful by decreasing utilization of high cost services, such as hospital use, while increasing use of lower costs services and settings. It is inevitable that efforts such as these have the potential to destabilize the workforce if not managed with care. Our PPS is unwavering in our commitment to: • Mitigate job loss through skill enhancement, retraining and redeployment efforts • Offer opportunities created through expansion of certain services (e.g., care management) to displaced workers • Invest in training to assist workforce in supporting new models of care delivery
10	Secure financial sustainability during and after DSRIP program period, ongoing through Q4DY5	Building on the IDS infrastructure and population health programs, ACP will be able to pursue financial arrangements with value-based payments, so ACP providers can continue to: • Further pursue relationships with managed care organizations that reward value-based care to secure long term sustainable funding for ACP's initiatives • Monitor the financial impact of DSRIP on ACP's financially fragile safety net providers • Assist safety net providers in the transition to value-based payments through DSRIP revenue loss funds

***Formulation:**

Explain how the PPS has been formulated to meet the needs of the community and address identified healthcare disparities.

Advocate Community Partners (ACP) is a collaboration of diverse providers working with one of the state's largest and most respected hospital systems, North Shore-Long Island Jewish Health System, Inc. (NSLIJ). ACP physicians are in the neighborhoods we serve, and able to engage patients effectively in improving their health through culturally sensitive care supported. ACP exists as a not-for-profit Delegated Governance Model incorporating physician and hospital constituents. We maintain a physician-led Board supplemented by representation from NSLIJ and participation from other community-based safety-net hospitals to produce delivery system reform. A Steering Committee and PMO are the central control points for the work of committees. ACP's Board, professional staff, committee structure and PAC seek to achieve measurable improvements in culturally competent care and address healthcare disparities. ACP governance will oversee implementation of projects through collaboration with providers across the broad continuum of care—encompassing behavioral health and community social services organizations.

***Steps:**

Provide the vision of what the delivery system will look like after 5 years and how the full PPS system will be sustainable into future.

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The vision for ACP in five years, is the transformation from a large collection of healthcare providers, practicing largely in siloes, to a clinically integrated, efficient and effective care system. Advanced health IT will support our community-based physicians to connect even more closely with their patients to achieve DSRIP's "triple aim" of better care for individuals, better health for the population and lower costs.

ACP will foster disease prevention; improve clinical system integration and care transitions using evidence-based clinical protocols; demonstrate increased availability, access and use of primary care services to reduce cost, improve quality and enhance outcomes, using initiatives such as expanding PCMH capacity; integrate physical and behavioral health by building enhanced communication and collaboration between physical and behavioral health providers to reach better outcomes. ACP providers will expand value-based payment and direct payment approaches, which will increase effectiveness, efficiency and sustainability.

***Regulatory Relief:**

Is the PPS applying for regulatory relief as part of this application? Yes

For each regulation for which a waiver is sought, identify in the response below the following information regarding regulatory relief:

- Identify the regulation that the PPS would like waived (please include specific citation);
- Identify the project or projects in the Project Plan for which a regulatory waiver is being requested and outline the components of the various project(s) that are impacted;
- Set forth the reasons for the waiver request, including a description of how the waiver would facilitate implementation of the identified project and why the regulation might otherwise impede the ability of the PPS to implement such project;
- Identify what, if any, alternatives the PPS considered prior to requesting regulatory relief; and
- Provide information to support why the cited regulatory provision does not pertain to patient safety and why a waiver of the regulation(s) would not risk patient safety. Include any conditions that could be imposed to ensure that no such risk exists, which may include submission of policies and procedures designed to mitigate the risk to persons or providers affected by the waiver, training of appropriate staff on the policies and procedures, monitoring of implementation to ensure adherence to the policies and procedures, and evaluation of the effectiveness of the policies and procedures in mitigating risk.

PPS' should be aware that the relevant NYS agencies may, at their discretion, determine to impose conditions upon the granting of waivers. If these conditions are not satisfied, the State may decline to approve the waiver or, if it has already approved the waiver, may withdraw its approval and require the applicant to maintain compliance with the regulations.

#	Regulatory Relief(RR)	RR Response
1	Prohibited Business Practices: 10 NYCRR 34-1.3, 10 NYCRR 34-2.3, 10 NYCRR 34-2.4	Projects: • 2ai-creation of an integrated delivery system (IDS) that is focused on evidence-based medicine and population health management • 2aiii-health home at-risk intervention program for patients with one progressive chronic disease who are likely to evolve a second chronic condition • 2biii- emergency department (ED) care triage for the at-risk population • 2biv-care transitions intervention model to reduce 30 day readmissions for chronic health conditions Project Components: • 2ai-ACP has an expansive integrated network of providers who will work as team to care for patients, improving overall health outcomes by monitoring and follow up. To ensure that each patient's care is managed in a comprehensive and efficient manner, it is imperative for providers to refer patients to partners within the PPS, all of whom share the common goal of meeting project metrics. • 2aiii-Primary care physicians (PCPs) will take a lead role in patient care by creating a plan to address issues related to chronic disease. This will entail referrals to appropriate providers within the PPS for clinical/testing services, to ensure that the patient's condition is monitored in a timely manner.