Millennium Collaborative Care PPS (ECMC) (PPS ID:48)

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	Resolve excess bed capacity in inpatient and SNF facilities	There are currently 22 hospitals providing acute care services across Western New York (WNY), 10 of which are in MCC. In the region there are on average 1,240 beds not in use, of which 511 unused beds are in MCC. There are 74 nursing home facilities, of which 41 are in MCC. Projected estimates of WNY public need for SNF beds indicate an excess of 499 beds. Deactivation of unused beds would not have large workforce implications since these unused beds are largely unstaffed. Reuse of these facilities will be explored using redeployed staff. We will work collaboratively to decertify unused, unstaffed beds in hospitals and skilled nursing facilities (SNFs), while seeking beneficial ways of repurposing the unused space for non-inpatient services by the facility.
2	Activate a continuum or providers in the IDS including medical, behavioral, and community	MCC presently has a wide array of providers and community partners participating. They have joined MCC, coming from environments and settings that have traditionally functioned in isolation. The goal is to activate them as one.
3	Achieve care management integration across the IDS including medical, behavioral, and community	Enhanced communication and care management data sharing among primary care, specialists, mental health, Health Homes, and community support agencies does not exist, and interoperability with hospitals and pharmacies needs to be enhanced. This requires universal protocols across settings and interoperable health information exchange (HIE) to makes information accessible in real time.
4	Achieve clinically interoperable care management and community support across the system	We will enhance regional health information organization (RHIO) interoperability by: (a) care coordination for high risk patients in transitions; (b) emergency care changes to prevent improper use; (c) hospital care changes to prevent readmissions; (d) integrated referral to subspecialists; (e) medication safety enhancements; and (f) interoperability with behavioral health and community supports. We will train key personnel across the system to participate in the new model.
5	Achieve PCMH/APCM standards and meaningful use requirements in all safety net primary care locations	In MCC, only 36% (85) out of 235 MCC primary care locations are currently NCQA recognized. Various types of PCMH Coordinators will be deployed to reach Level 3 PCMH rapidly. Evidence-based approaches such as the TRANSLATE model will be used to drive the PCMH recognition process. We will use PCMH workflow changes in pre-visit planning to address access, transportation, and community linkage problems in underserved areas
6	Achieve EHR connectivity to RHIO's HIE for all safety	Gaps in interoperability include lack of enhanced communication and care

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#	Goal	Reason For Goal
	net primary care locations	management data sharing among safety net primary care, specialists, mental health, Health Homes, and community support agencies. The interoperability among hospitals and pharmacies needs to be enhanced.
7	Achieve HIT integrated population health management in all safety net primary care locations	In addition to the RHIO interoperability needed for patient care, it is also needed for population health management that would involve: (a) managing panels of high-risk, rising risk, and low-risk patients; and (b) quality improvement reports for DSRIP metrics that must have practice-level reporting (used by practices for performance feedback to drive continuous improvement) and PPS/community-level reporting (used by the PPS for rapid cycle evaluation).
8	Establish contracts with Medicaid MCOs that includes value-based payment	It is essential for the integrated system to establish value-based payment arrangements with Medicaid managed care organizations (MMCOs) and other payers to support system transformation that is not encounter-based, but is performance-based using an array of means to effect change (community-based and other supports) that are presently not covered by fee-for-service.
9	Achieve transition to a provider compensation model that includes incentive-based payments	Transitioning to value-based payment arrangements with MMCOs will require downstream value-based provider contracts to support and incentivize practice change to reduced avoidable complications an
10	Achieve real service integration with all Health Home agencies	The six emerging Health Home agencies have just started and have limited presence in some areas. There is limited meaningful integration of behavioral health with primary care due in large part to the structural barriers (regulatory, confidentiality, lack of interoperability, lack of cross-training). Health Homes need to be ingrained in the infrastructure for this behavioral health and primary care integration. In support of leveraging Health Homes for integration, there is a need to create new functionality in primary care safety net settings dedicated to this integration; and in behavioral health settings serving seriously mentally ill, there is a need to embed primary care providers in high-need targeted locations.
11	Engage patients in the integrated delivery system at all levels	Patient engagement is essential for the system transformation to be informed by the patient's perspective in terms of (a) what the problems are and (b) what is feasible and practical. Patient engagement is also essential to understanding how to make real changes occur in the way patients access care and self-manage their health risks and chronic conditions.
12	Address shortages and access gaps for primary care and specialty services in high-need areas	There are primary care shortages throughout the region, including: (a) inadequate primary care physicians and mid-levels (physician assistants, or PAs, and nurse practitioners, or NPs) working in primary care settings; (b) inadequate primary care locations; and (c) inadequate number of safety net primary care locations. We will work with Area Health Education Center (AHEC) partners to influence primary career choice, while working with health professional schools to place mid-levels and physicians in safety net PCP settings. We will also work to increase the number of dentists that accept Medicaid or increase dental services in more safety net primary care settings. We will work with AHEC partners to recruit specialists, such as psychiatrists, clinical psychologists, and other subspecialists into shortage areas.

***Formulation:**

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

MCC will establish a delegated governance structure which will allow for collective accountability for quality of care and foster shared incentive structures that will reduce fragmentation and reward collaboration. Communication across this network of connected providers will be transparent.

The delegated governance structure has been chosen to allow for influence from an extensive network of providers including meaningful consumer advocate and patient representation to improve population health as the collaborative envelops community-based care as opposed to care provided in the traditional hospital setting. MCC will utilize an interoperable data exchange system to share data which will identify high-risk patients in real time and promote quality care that is provided effectively, efficiently, and in a timely manner.

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***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.

Over time, deep relationships across the care network will be fully developed, leading to the expansion of primary care access, strong participation in payment reform, and the rebalancing and restructuring of health delivery to all patients in the WNY region. A comprehensive population health strategy and reformed payment model will reward for quality of care delivered and not input from volume. Hospitalizations will be reduced to trauma emergencies, surgical emergencies, and tertiary prevention emergencies. The health of the population we serve will improve significantly, and the cost to deliver emergent care will be reduced. Further, focusing resources is likely to improve HCAHPS scores. As the need for inpatient services decreases, acute inpatient facilities will transform into community emergency hospitals providing an array of outpatient services.

***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	Determinations of Public Need (10 NYCRR 760.5)	Project: 2.b.vii: CON waiver expedition in order to establish women's behavioral health unit at Terrace View/ECMC to decrease hospitalizations for this underserved segment of the population 2.b.viii: CON waiver expedition for home care agency (CHHA); application to add new services to operating certificate (ECMC) to serve the entire PPS geography Reason for request: 2.b.vii: We have identified a need for a higher level of SNF based behavioral health for women, mirroring a very successful men's behavioral health unit at Terrace View ECMC. This would cross multiple projects, allowing for most appropriate care for a population that is frequently admitted to the hospital. 2.b.viii: There are very few safety net home care providers, and no CHHA in our PPS. There is great need in the Medicaid and uninsured population for continued skilled services post discharge. Expanding ECMC's operating certificate to include a CHHA would allow us to continue to treat patients through the entire continuum, at a level of accountability and quality that will allow us to meet all of our metrics. Alternatives considered: 2.b.vii: We considered consolidating units on the ECMC campus, as this would be where the admission would likely come from or be transferred to. Terrace View has a typical occupancy greater than 98%, which would not allow us to transfer these beds without offset or displacing another population in need. 2.b.viii: We considered engaging partnering organizations, however their