CNY Care Collaborative

Project Planning Webinar
January 6th, 2015

Shawna Craigmile, DSRIP Program Manager
Kari Burke, DSRIP Program Coordinator
Agenda

- DSRIP goals and timeline
- Review selected projects
- Partner roles and responsibilities
- Process for plan development
- Questions & Answers
Project-Driven Transformation

Current State: Fee for Service

Project Implementation

Future State: Value & Performance Based Payment
DSRIP Timeline

Assessment, Planning & Project Development

Project Implementation
Performance Evaluation & Measurement
Metric & Milestones Achievement

2014
DY0
2015
DY1
2016
DY2
2017
DY3
2018
DY4
2019
DY5
**Funding**

**Form follows Function**

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Selected Projects

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11 Projects

**System Transformation (Domain 2)**
- 2.a.i Create Integrated Delivery Systems
- 2.a.iii Health Home At-Risk Intervention Program
- 2.b.iii ED Care Triage for At-Risk Populations
- 2.b.iv Care Transitions Intervention Model to Reduce 30 Day Readmissions for Chronic Health Conditions
- 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the Uninsured and Low/Non-utilizing Medicaid populations into Community Based Care

**Clinical Improvement (Domain 3)**
- 3.a.i Integration of Primary Care and Behavioral Health Services
- 3.a.ii Behavioral Health Community Crisis Stabilization Services
- 3.b.i Evidence-Based Strategies for Cardiovascular Disease Management in High Risk/Affected Populations
- 3.g.i Integration of Palliative Care into the Patient Center Medical Home Model

**Population Health (Domain 4)**
- 4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems
- 4.d.i Reduce Premature Births
2.a.i Create Integrated Delivery Systems

- **Project Objective:** Create an Integrated Delivery System focused on Evidence Based Medicine and Population Health Management

- **Deliverables (20)**
2.a.iii Health Home At-Risk Intervention Program

- **Project Objective:** Expand access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers from Health Homes) to meet the individual needs of higher risk patients. These patients do not qualify for care management services from Health Homes under current NYS HH standards (i.e., patients with a single chronic condition but are at risk for developing another), but on a trajectory of decreasing health and increasing need that will likely make them HH eligible in the near future.

- **Deliverables (15)**
2.b.iii  ED Care Triage for At-Risk Populations

- **Project Objective:** To develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health condition(s); and to improve provider-to-provider communication and provide supportive assistance to transitioning members to the least restrictive environment.

- **Deliverables (7)**
2.b.iv Care Transitions Intervention Model to Reduce 30 Day Readmissions for Chronic Health Conditions

- **Project Objective:** To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

- **Deliverables (10)**
Implementation of Patient Activation Activities to Engage, Educate and Integrate the Uninsured and Low/Non-utilizing Medicaid populations into Community Based Care

**Project Objective:** Address Patient Activation Measures® (PAM®) so that uninsured (UI), non-utilizing (NU), and low utilizing (LU) populations are impacted by DSRIP PPS’ projects. This project is focused on persons not utilizing the health care system and works to engage and activate those individuals to utilize primary and preventive care services.

**Deliverables (18)**
3.a.i Integration of Primary Care & Behavioral Health Services

• **Project Objective:** Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.

• **Deliverables (10)**
3.a.ii Behavioral Health Community Crisis Stabilization Services

• **Project Objective:** To provide readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis.

• **Deliverables (14)**
3.b.i Evidence-Based Strategies for CVD Management in High Risk/Affected Populations

• **Project Objective:** To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions. (Adults Only).

• **Deliverables (34)**
3.g.i Integration of Palliative Care into the Patient Center Medical Home Model

- **Project Objective:** To increase access to palliative care programs in PCMHs. Increasing access to palliative care programs for persons with serious illnesses and those at end of life can help ensure care and end of life planning needs are understood, addressed and met prior to decisions to seek further aggressive care or enter hospice. This can assist with ensuring pain and other comfort issues are managed and further health changes can be planned for.

- **Deliverables (6)**
4.a.iii  Strengthen Mental Health and Substance Abuse Infrastructure across Systems

- **Project Objective:** To strengthen mental health and substance abuse infrastructure across systems.

- **Deliverables (TBD)**
4.d.i  Reduce Premature Births

- **Project Objective:** To reduce premature births, defined as any birth before 37 weeks gestation.

- **Deliverables (TBD)**
Partner Roles and Responsibilities

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What is my Role in Project Planning?

Now
- Review commitment(s) for participation
- Submit request for access to member-only portion of website
- Interorganization communication

Through March 1\textsuperscript{st}
- Review project-related content and materials
- Engage subject matter experts and key stakeholders within your organization
- Participate in conference calls, webinars and online forums

Ongoing
- Prepare organization for project implementation
Project Planning Process

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1. **Now - Dec 22**
   - **Objective**: A successful application including high-level project plans for the 11 selected projects
   - **Rationale**: To develop high-level project plans with a limited time frame and not all details are necessary to complete the application

2. **Dec 22 - April 1**
   - **Objective**: Detailed project implementation plans aligned to high-level application plans
   - **Rationale**: To develop effective implementation plans, need to involve the appropriate key stakeholders

3. **April 1+**
   - **Objective**: Successful execution of plans, meeting milestones and metrics to receive incentive payments
   - **Rationale**: To execute change and transform care, all key stakeholders need to be actively engaged
### Inputs
- Partner organizations representing continuum of care
- Dedicated staff
- Consultants & subject matter experts
- Representative governance structure
- Current healthcare workforce
- Statewide initiatives (SHIP, SHIN-NY, HARP)
- Capital investment in physical and IT infrastructure

### Outputs

#### Activities
- Project planning & implementation
- Stakeholder engagement
- Education/ Training
- Performance monitoring
- Facilitate and enhance information flow
- Reporting
- Reform payment structure

#### Participation
- Medicaid beneficiaries
- Uninsured
- Managed Care Organizations
- Medical, behavioral and community service providers
- Labor
- Media
- NYS DOH
- Other PPSs

### Assumptions
- State and Federal funding allocations will be preserved
- Process and performance goals will be met as scheduled
- Regulatory relief (waivers) will be approved

### Outcomes – Impact

#### Short
- Generate understanding of integrated delivery system principles
- Increase consumer awareness of available resources and points of access
- Increase provider awareness of patient needs & preferences
- Greater support for HIT/HIE adoption & utilization

#### Medium
- Expand system capacity for primary care and disease management
- Care coordination and communication across providers
- Patient engagement with primary care provider
- Use of evidence-based care protocols
- Regional planning
- Data-driven decision making
- Pay for performance/value-based purchasing

#### Long
- Integrated and sustainable delivery system
- Accessible, high-quality ambulatory care
- Improved provider experience
- Improved patient experience
- Reduced morbidity/mortality

### External Factors
- Partner organizational structure/capacity
- Availability of funding
- Educational attainment
- Regional economy

### External Factors
- Community resources
## 2.a.ii: Health Home At-Risk Intervention Program

**Objective:** Expand access to community primary care services and develop integrated care teams to meet the individual needs of higher risk patients who do not qualify for care management services from Health Homes under current NYS standards, but are at-risk of becoming Health Home eligible in the near future.

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<td>• Current Health Homes&lt;br&gt;• Current PCMH Level 3 providers&lt;br&gt;• HealtheConnections RHIO&lt;br&gt;• Consultants &amp; subject matter experts&lt;br&gt;• Current healthcare workforce&lt;br&gt;• Capital investment in IT infrastructure&lt;br&gt;• Statewide initiatives (SHIP, SHIN-NY, HARP)&lt;br&gt;• Health Foundation of Western &amp; Central NY</td>
<td>• Establish partnerships: › between PCPs &amp; Health Homes&lt;br&gt;› with network resources for services (e.g. SPOA)&lt;br&gt;• Assess &amp; expand EMR/EHR capacity&lt;br&gt;• Develop culturally appropriate educational materials&lt;br&gt;• Develop transportation services&lt;br&gt;• Reporting</td>
<td>• Able to identify eligible beneficiaries&lt;br&gt;• Process and performance goals will be met as scheduled</td>
<td>• Participating PCPs meet Level 3 standards&lt;br&gt;• EHR systems meet Meaningful Use and PCMH Level 3 standards&lt;br&gt;• Reduced health risk &amp; avoidable service utilization</td>
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<td>• Medicaid beneficiaries with:&lt; › 1 chronic medical condition&lt;br&gt;› Dx of serious and persistent mental illness&lt;br&gt;› Seriously emotionally disturbed&lt;br&gt;• Health Homes (3)&lt;br&gt;• FQHCs and other PCPs&lt;br&gt;• Local gov’t</td>
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<td>• Participating providers are: › sharing EHR systems with RHIO and health information among clinical partners&lt;br&gt;› implementing evidence-based practices to reduce risk factors &amp; ensure appropriate disease management&lt;br&gt;› developing a comprehensive care management plan for each patient&lt;br&gt;› tracking target population via EMR registries/reports&lt;br&gt;Eligible beneficiaries are:</td>
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Questions & Answers
CNY Care Collaborative
Performing Provider System
Auburn Community Hospital
Tom Filiak
tfiliak@auburnhospital.org
(315) 255-7384

St. Joseph's Hospital Health Center
Kristen Heath
Kristen.Heath@sjhsyr.org
(315) 744-1383

Joe Reilly
Joseph.Reilly@sjhsyr.org
(315) 726-9850

Faxton-St. Luke's Hospital
Cheryl Perry
cperry@mvnhealth.com
(315) 624-6153

Upstate University Hospital
Shawna Craigmile
craigmis@upstate.edu
(315) 464-9671

Niki Sullivan
SullivaA@upstate.edu
(315) 464-9672

Lauren Wetterhahn
wetterhl@upstate.edu
(315) 464-9760

Kari Burke
burkeka@upstate.edu
(315) 464-9673

https://cnycares.org/contact