Domain 2 Projects

2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management

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

Project Description: This project will require an organizational structure with committed leadership, clear governance and communication channels, a clinically integrated provider network, and financial levers to incentivize and sustain interventions to holistically address the health of the attributed population and reduce avoidable hospital activity. For this project, avoidable hospital activity is defined as potentially-preventable admissions and readmissions (PPAs and PPRs) that can be addressed with the right community-based services and interventions. This project will incorporate medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system – from one that is institutionally-based to one that is community-based. This project will create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services. If successful, this project will eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes.

Each organized integrated delivery system (IDS) will be accountable for delivering accessible evidence-based, high quality care in the right setting at the right time, at the appropriate cost. By conducting this project, the PPS will commit to devising and implementing a comprehensive population health management strategy – utilizing the existing systems of participating Health Home (HH) or Accountable Care Organization (ACO) partners, as well as preparing for active engagement in New York State's payment reform efforts.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.
2. Utilize partnering HH and ACO population health management systems and capabilities to implement the strategy towards evolving into an IDS.
3. Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
4. Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners,

including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.

5. Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
6. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
7. Achieve 2014 Level 3 PCMH primary care certification for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of Demonstration Year (DY) 3.
8. Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.
9. Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
10. Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
11. Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.

Project Response & Evaluation (Total Possible Points – 100):

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The community needs assessment (CNA) and actuarial data from Catholic Medical Partners' Medicaid managed care contracts indicate that the rate of potentially preventable inpatient admissions (PPIA) admissions is 16.5 per 1000 and the rate of potentially avoidable readmissions is 5.92 per 1000. Our commercial contract rates for PPIA are 6.66 per 1000 and our potentially avoidable readmissions are 1.78. This actuarial data highlights the opportunity that CPWNY has to improve the quality and reduce unnecessary admissions. The majority of the PPIA and readmissions for the Medicaid population are for chronic health conditions. Additionally, the rate of ER visits is approximately 681 per 1000, 50 % of which are considered avoidable based on NYS data and best practice research. There is observed variation across our geography but all regions have significant opportunity to improve. The CNA also found that Medicaid beneficiaries report problems in gaining access to primary care and less than optimal coordination of care. Providers noted high rates of "no shows" in the clinical office and ER staffs report many ER visits could be more efficiently and effectively treated in the ambulatory setting. It is noteworthy that a greater numbers of patients were attributed to our regional PPS's based on level III attribution including urologists, ophthalmologists and surgeons; more than on Level II primary care attribution. These observations from our cost and utilization data plus the CNA present a significant challenge for our PPS. Not only is more PCP access necessary but break through interventions are needed to improve coordination of care, and more proactive interventions are needed to improve overall

patient engagement and reduce no show rates. Published HEDIS data for the WNY Medicaid population shows that this group lags behind the commercial population in the following areas which will be addressed by our DSRIP projects: 1. behavioral health acute and continuation phase, 2.management of cardiovascular disease –cholesterol control, 3.flu vaccination, and 4.prenatal care in the first trimester. To close the gaps identified in our CNA, CPWNY will expand our IDS capabilities using Crimson Population Health Manager and increase our analytic staff to support our clinical transformation. Management of change and performance based contracting require strong data and analytics capabilities to support direct care staff and overall management. We will redeploy and retrain staff displaced due to declining hospital utilization and also recruit new personnel into newly created positions to achieve success. More specifically, Sisters of Charity Hospital (SOCH)/CMP will rapidly engage our PPS partners in identifying our patient population. We will stratify patients by need and by clinical practice. Our stratification will include but not be limited to: 1. Patients without a PCP. 2. Patients with a PCP but not meeting clinical goals for preventive or chronic illness. 3. Patients with chronic health conditions including Behavioral Health. 4. Patients with significant social & economic barriers to health – economic risk (i.e. homeless). 5. Patients in need of Palliative Care. Currently SOCH/CMP Project Management Team uses a stratification system based on Hierarchical Clinical Condition (HCC) coding and builds patient registries to monitor utilization and quality for the high risk population. This system is used to identify patients with the greatest burden of illness, and to focus practice efforts on providing the extra support to patients at risk for hospitalization. SOCH/CMP Project Management Team will use this method in our CPWNY IDS and our population health tools to identify the Medicaid patients. Once patient data is analyzed, SOCH/CMP Project Management Team will use our regional leadership team to work with the clinical office, health system and our community organizations to meet our process and outcome goals.

b. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

The Community Partners of WNY (CPWNY) PPS has a comprehensive and accountable provider network of over 1000 physicians, a major health system with urban and rural partners, a certified Health Home, community based Behavioral Health providers and major community organizations including Catholic Charities and the Urban League. CPWNY will expand the existing workforce to support Medicaid beneficiaries and design outreach and follow-up initiatives to improve patient engagement. The Project Management Team will use the data warehouse (MedInsight) and Crimson Population Health software to identify patient needs and the reporting and analytics system will produce practice specific reports on quality of care and hospital utilization. SOCH and CMP have been using these reports and know they will be effective in engaging clinical office leadership in making improvements in our CPWNY IDS. The majority of our practices have received rapid cycle improvement training following the Institute for Healthcare Improvement (IHI) model of improvement, and the SOCH/CMP Project Management Team will continue to provide this training with a specific focus on care management for prevention and for improving care to the high risk population. The Project Management Team will add additional components of training on best practices by using community health workers to reduce social and economic barriers to care. Currently, we have over 65% of our PCP practices at PCMH Level III. Approximately ninety (90%) of our practices have electronic health records and are actively engaged in implementing interoperability using the direct method via secure e-

mail. In addition we have a hospital to homecare transition team that visits high risk patients within 48 hours of discharge to ensure ambulatory follow up and reduce the potential for readmission. We will expand these resources and integrate with our community collaborators to achieve our DSRIP goals.

c. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project, and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

The top four challenges in our IDS are as follows: 1.engage providers to expand access and use community organizations to support clinical care and services 2.Integrate community health workers and clinical teams 3.improve EHR functionality, interoperability and reporting by integrating claims and EMR data 4.Staff training in proactive, patient-centered care. CPWNY will mitigate these challenges using registry and reporting systems to identify patients in need of interventions and use our mobile care management and regional lead teams to engage the provider community. Improving and reducing "no shows" will require creating linkages between clinical practices and community health workers so that CPWNY has active follow up. Improving interoperability, data and reporting will be a task delegated to the regional training teams and we will assess each practice's competencies and design intervention plans to achieve 100% lean interoperability over the next 2-3 years. The Project Management Team will expand the existing training teams and create training modules in the areas of patient centered care, best practices in preventing unnecessary admissions, CCD data interoperability, rapid cycle improvement and team based care. Achieving early success and rewarding results will require CPWNY to set reasonable expectations and ensure that the practice teams have the support needed to show early success. Sisters of Charity Hospital has a culture of accountability (responsibility with results) and we will leverage this to drive results in the CPWNY PPS.

d. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

CPWNY PPS and Millennium PPS have worked together since early August to coordinate our planning and projects. We have conducted a joint CNA with UB Regional Institute and P2 Collaborative. For this broad project we have jointly been working with HealtheLink, our Regional Health Information Organization, on interoperability, reporting, consent and data governance. We anticipate this type and level of collaboration will continue.

2. <u>System Transformation Vision and Governance</u> (Total Possible Points – 20)

a. Please describe the comprehensive strategy and action plan for reducing the number of unnecessary acute care or long-term care beds in parallel with developing community-based healthcare services, such as ambulatory, primary care, behavioral health and long term care (e.g.

reduction to hospital beds, recruitment of specialty providers, recruitment of additional primary care physicians, hiring of case managers, etc.). The response must include specific IDS strategy milestones indicating the commitment to achieving an integrated, collaborative, and accountable service delivery structure.

Catholic Medical Partners, who will be contracted to serve as Project Management, has extensive experience in risk based contracts that reward improvements in quality and utilization. CMP's CMS Shared Savings results were positive. CMP ACO reduced hospitalizations per 1000 by 26%, emergency room visits by 13%, CT scans by 10% and ambulatory care sensitive conditions by 15%. Improving quality in the following areas: patient experience, patient safety, and prevention, at risk population for CAD, CHF, IVD diabetes and hypertension. Our PPS strategy and action plan will build on CMP's CMS Shared Savings and Commercial managed care risk contracting experience and success in our contracting and improvement initiatives. The DSRIP outcome and process goals will create new challenges and opportunities for improvement. Mitigating social and economic barriers and the corresponding health care disparities will require new solutions and IDS support. Existing partner IDS infrastructure will need to be expanded and tailored to improve clinical care and service. The quality of care will improve through improving access and patient engagement, improved coordination of care, better exchange of reliable and valid data, improved provider performance reporting, adherence to best clinical and operational practices, and a culture of accountability built on the values of the common good. Culture is the key component to creating a high performing health care system and creating the administrative and operational support that can be used by practitioners to better serve the population. The CPWNY strategy is as follows: 1. Utilize Physician leadership and accountability in the clinical office, at the regional level and at the board governance level. 2. Strengthen the capacity of the PCP's clinical office to meet the needs of the population including: the integration of Behavioral Health and Palliative Care, proactive and chronic care management, and coordination of care with institutional, ambulatory and community partners. 3. Accelerate interoperability and the integration of EMR data and claims data to improve clinical reporting and practice performance including linkage and participation with the RHIO. 4. Expand patient consent for the RHIO. 5. Create a business model based on achieving margin or incentive payments for improved clinical care and service effectiveness and efficiency. Leadership at the board level will guide CPWNY strategy and decision making, oversight and implementation of our DSRIP improvement initiative. We expect the building of a more accessible and reliable care system will require the division of our PPS service areas into sub-regions. Each sub-region will have a leadership team with a PCP lead, a care management lead, a community service coordinator and a practice transformation specialist. This leadership team will be operationally accountable for our initiatives in distinct geographic areas. This model was selected to improve access to clinical and community services in close proximity to the target population. This team will provide the necessary support to the clinical practice and address gaps in continuity, access, and performance in the region. Health care delivery is an interactive process between care givers and patients. The Project Management Team will build clinical office capacity at the primary care level to meet the individual needs of the population. We will build capacity by integrating behavioral health and palliative care in the clinical office, by building reliable and timely referral relationships among providers and by addressing the preventive and chronic needs of the population. Our staffing component will be expanded to include care coordinators for each patient and a team of social workers, pharmacists and nutritionists available to make the individual interventions necessary to close gaps in care.

Patient engagement is foundational to our improvement agenda. Value based contracting is dependent upon giving provider data on quality, utilization and cost. Currently, SOCH and Catholic Medical Partners provides its network physicians with the following: 1. Semi-annual avoidable admissions and readmission data. 2. Quarterly quality of care reports on the CMS 33 quality metrics: 2.1. CAD/IVD (LDL screening and control, appropriate medication use). 2.2. CHF (Use of appropriate medication). 2.3. Diabetes (Control of HbA1c, LDL, BP; Tobacco use; Aspirin use). 2.4. Preventive Care (Influenza; Pneumococcal; Tobacco use; BMI measurement; Breast, Cervical and Colorectal Cancer Screening; Screening and treatment for Depression and Hypertension). 3. Patient Experience of Care Report – SOCH/CMP data and analytics system uses both claims and EMR data. MedInsight / Crimson Population Health tools will support our regional teams such that they will be able to bring actionable data to our practices. These reports will guide our management and oversight of the PPS and our incentive programs.

b. Please describe how this project's governance strategy will evolve participants into an integrated healthcare delivery system. The response must include specific governance strategy milestones indicating the commitment to achieving true system integration (e.g., metrics to exhibit changes in aligning provider compensation and performance systems, increasing clinical interoperability, etc.).

The CPWNY PPS governance strategy is designed to engage partners, promote competency and reward performance. The governance charter delineates a broad representation on the Executive Governance Body (EGB) which is empowered with board oversight and management of CPWNY DSRIP project plans. The EGB is supported by 3 committees comprised of individuals with expertise in finance, data/IT and clinical performance. The majority of the EGB and its committees have demonstrated success working in integrated delivery systems. The EGB will set forth roles and responsibilities, a comprehensive performance expectations, distribution of funds (project support/ bonus), clinical and data sharing responsibilities, and dispute resolution. Governance strategy milestones include partner completion of education and training (knowledge and competency), process evaluation, change and development (transformation), performance evaluation including competency/integration/clinical evaluation (aligned with project metrics). CPWNY will integrate the organizational, clinical and utilization goals for the PPS partners into SOCH/CMP's current integration program and by doing so share expertise and establish common expectations for performance on each metric for PPS partners' contractual arrangements. SOCH/CMP have been developing a high performing health care system with a distributed network for the past 8 years and have achieved success in improving triple aim metrics. Our strategy is designed to enhance and expand this IDS success, to contract with health plans based on a percentage of premiums, and demonstrate that CPWNY PPS can create a 2-3% margin as an IDS, while improving quality. It's expected that SOCH/CMP's current success with a Population Health Business Model will reinforce the importance of the CPWNY PPS initiatives to partners & vendors. Success will enable CPWNY PPS to continue transformation to a high performing health care system with the skills, knowledge and ability to assume full clinical and financial risk for population health.

3. <u>Scale of Implementation</u> (Total Possible Points - 20):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient

population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

Please use the accompanying Speed & Scale Excel document to complete this section.

5. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

This project will require capital funding for the development of the practices throughout the network, as well as for the additional required IT investments. Technology and a skilled workforce is paramount to our strategy for improving the coordination and integration of different services. Many of the practices do not currently have the physical capacity, nor some of the technology infrastructure to support their new roles. Even those with certified EHR's are not able to meet the interoperability demands that are needed to coordinate the care throughout the continuum. There is the possibility to shift some of those practices on EHR's not meeting the needs to other technology that does.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards the implementation of the IDS strategy and action plan, governance, completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics.** Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.