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Performing Provider System

Western New York Bridging Gaps in Care for the Medicaid Population

Welcome!

- Father Richard E. Zajac -opening reflection.

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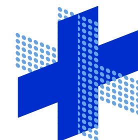
Department of
Health

Delivery
System
Reform
Incentive
Payment



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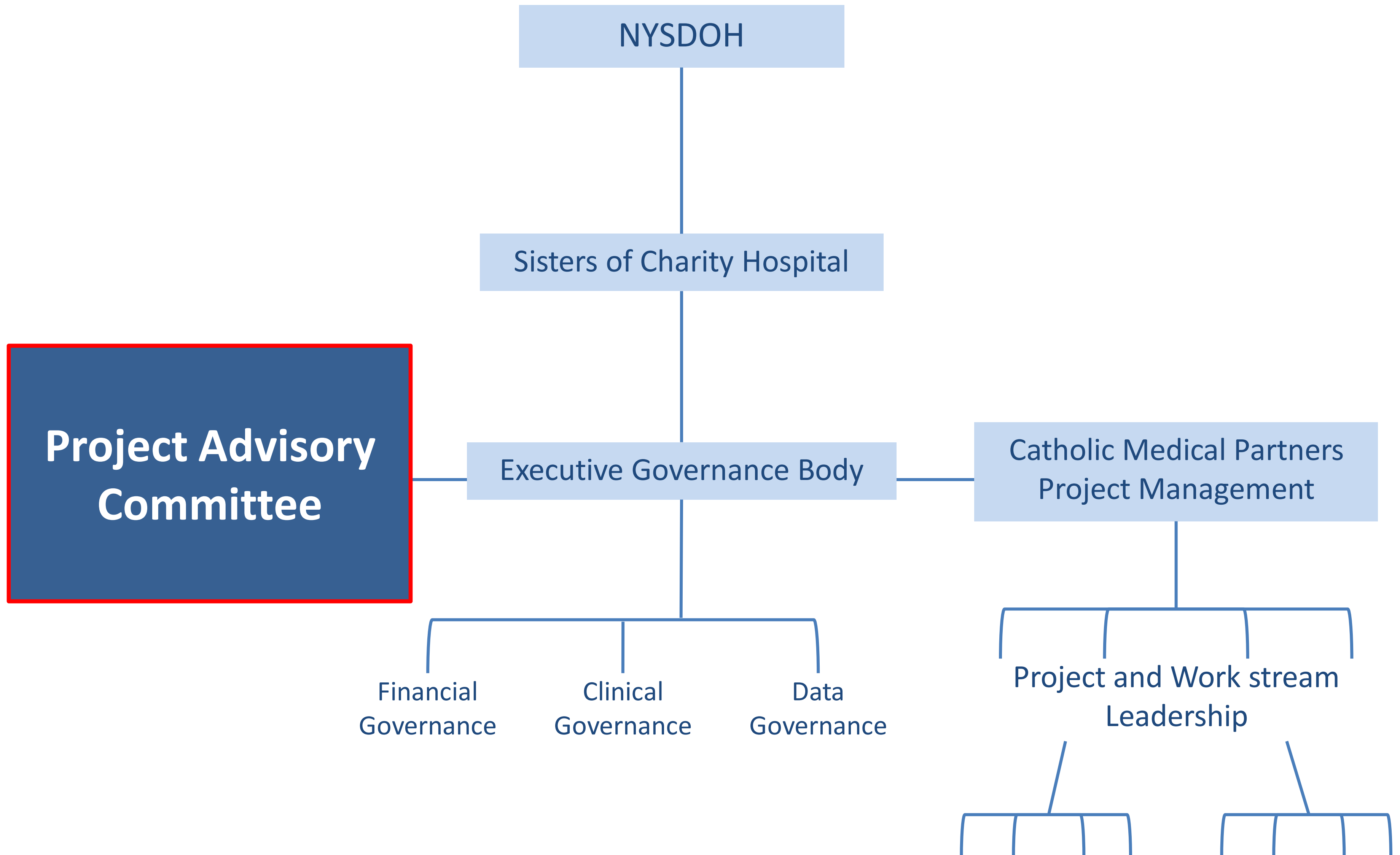
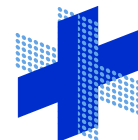
Community Partners of WNY PPS Organizational Structure:



Project Advisory Committee

- Open forum advisory committee to the EGB
- Offers regular feedback on project implementation and progress
- Representation from providers, Medicaid beneficiaries, health care workers, community organizations, union members, representatives of Medicaid managed care plans, representatives from our 3 counties, and a representative of the local RHIO
- Interested in continuing to contribute to the PAC please fill out the form



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PAC Feedback Exercise

Form from the sign up table:

1. Information about your organization
2. Interest in joining the PAC
3. Suggestions for success of projects and work streams
4. New partner recommendations

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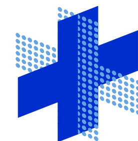
Community Partners of WNY Region



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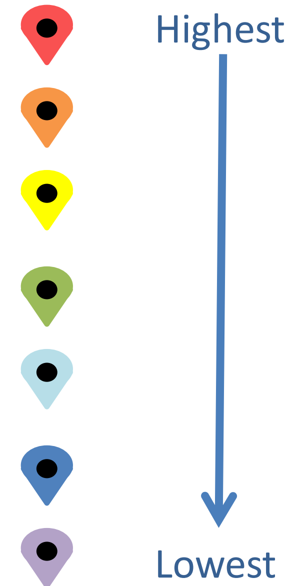
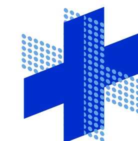
Serving the Medicaid Population

Provider Types:

- Primary Care (399)
- Specialists (1173)
- Hospitals (15)
- Clinics (25)
- Health Home/ Care Management (13)
- Behavioral Health (73)
- Substance Abuse (16)
- Skilled Nursing/ Nursing Homes (31)
- Pharmacy (5)
- Hospice (2)
- Community Based Organizations (26)

Number Patients Served:





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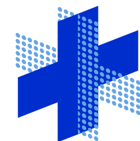
In June 2015 alone, our hospitals saw **72** Medicaid patients with **3 or more** ED visits accounting for **258** total visits, averaging **3.6** visits per person.



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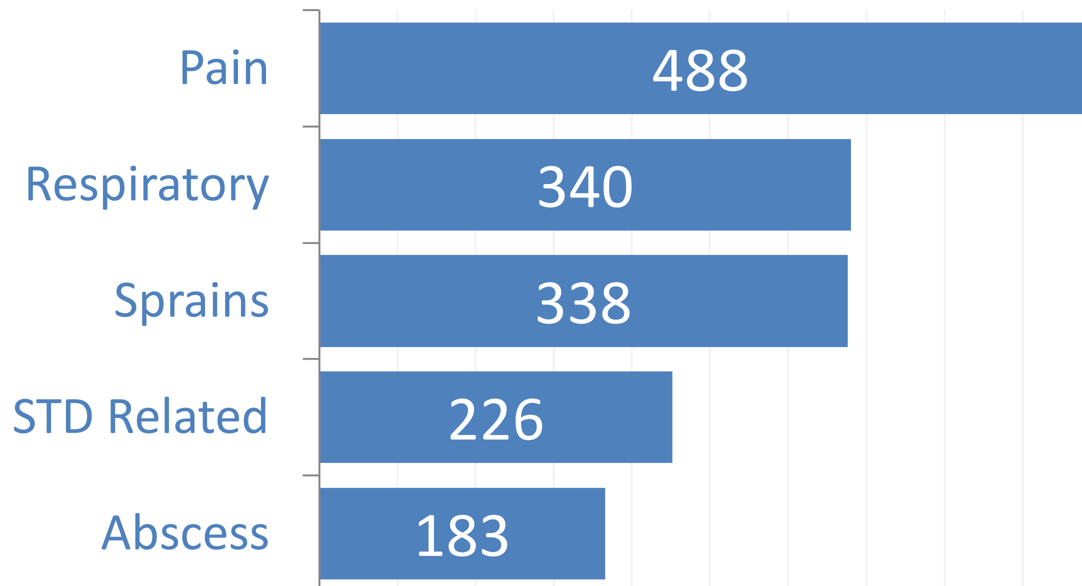
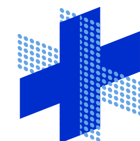
System Wide Non-Acute Medicaid Visits (Acuity 4 and 5), January - June 2015

13,655

Medicaid ED Visit Count by Top Diagnoses (Sisters of Charity Hospital), January-June 2015





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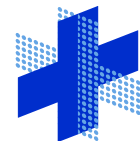
Bridging the Gaps in Care

Goal: Reduce health disparities in the Medicaid population in Western New York

Objectives:

1. Reduce unnecessary hospital utilization by 25% over the next five years
2. Improve health status by demonstrating improved preventive care and management of chronic health conditions



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THE WESTERN NEW YORK POPULATION AT A GLANCE

1,544,000 PEOPLE

MORE THAN 15.8%
OF THE POPULATION IS AGE 65 AND OLDER
(compared to 13.6% in New York State)

11%
OF THE WNY POPULATION HAS A DISABILITY
(almost double the NYS percentage)

WNY HAS A HIGH PREVALENCE OF CARDIOVASCULAR DISEASE-RELATED CONDITIONS

7.6% CORONARY HEART

9.1% CARDIOVASCULAR

32.7% HIGH BLOOD PRESSURE

30.2%

OF ADULTS IN WNY ARE OBESE

18.9%

OF ADULTS IN WNY BINGE DRINK

20.8%

OF ADULTS IN WNY SMOKE CIGARETTES

12.1%
OF BABIES ARE BORN PRE-TERM

MATERNAL MORTALITY RATE
26.8/100,000 BIRTHS
IN WNY

10.9% OF HIGH-RISK PREGNANCIES OCCUR IN MEDICAID MOTHERS

Only 69.5%
OF CHILDREN IN GOVERNMENT-SPONSORED INSURANCE PROGRAMS HAVE HAD THE RECOMMENDED NUMBER OF WELL CHILD VISITS

FEDERAL POVERTY LEVEL

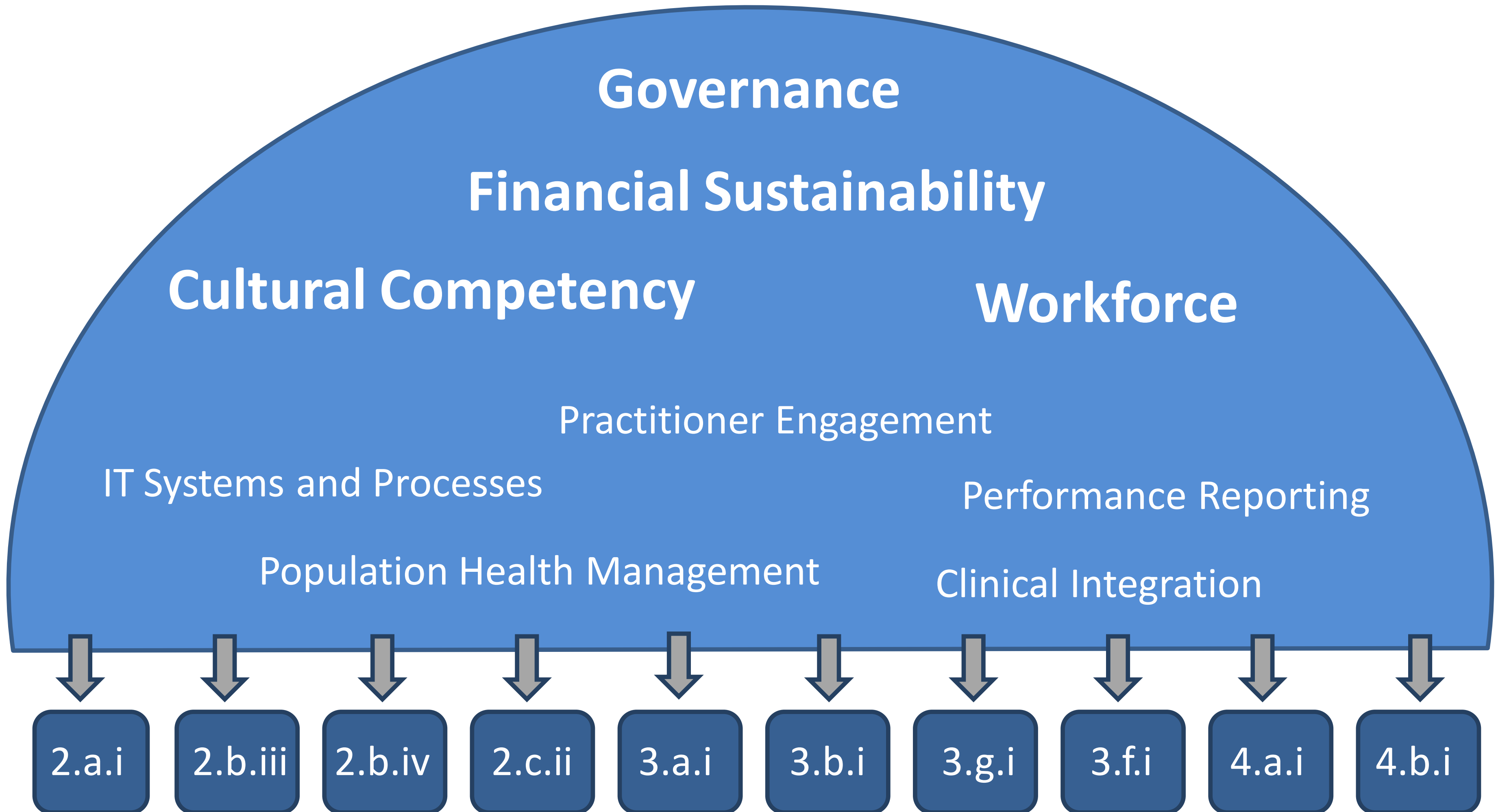
15% WNY

10% NYS

MEDIAN HOUSEHOLD INCOME IS
$49,304
(15% Below the NYS median of $58,003)

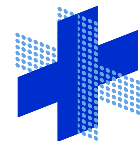
Based on Western New York Community Health Needs Assessment, Delivery System Reform Incentive Payment (DSRIP) Program

DSRIP Grant Structure



Major Themes of DSRIP

- Enhance primary care using Patient Centered Medical Home (PCMH) Model
- Improve care coordination and access to resources
- Improve cultural competency and health literacy
- Build health information technology infrastructure
- Develop a sustainable funding model
- Reduce unnecessary hospital use
- Integration of services



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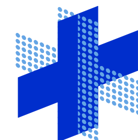
CPWNY DSRIP Initiatives

- **2.a.i Create Integrated Delivery Systems that are focused on Evidence-based Medicine and Population Health Management**
- **2.b.iii Emergency Department triage for at-risk patients**
- 2.b.iv Care transitions model to reduce 30-day readmission for chronic health conditions
- 2.c.ii Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services
- **3.a.i Integration of primary care and behavioral health services**
- **3.b.i Cardiovascular Health- Evidence-based strategies for disease management in high-risk affected populations (adult only)**
- **3.f.i Increase support programs for maternal and child health through the Nurse Family Partnership Model**
- 3.g.i Integration of palliative care into the PCMH model
- **4.a.i Promote mental, emotional and behavioral (MEB) well-being in communities**
- 4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health



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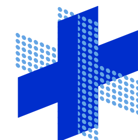
Project Leads

- 2.b.iii ED Triage – Cheryl Friedman, cfriedma@chsbuffalo.org
- 2.b.iv Care Transitions/ 3.b.i Cardiovascular Health – Peggy Smering, psmering@chsbuffalo.org
- 2.c.ii Telemedicine – Carlos Santos, MD, csantos@chsbuffalo.org
- 3.a.i Integration of Behavioral Health and Primary Care – Bruce Nisbet, nisbetb@shswny.org
- 3.f.i Nurse Family Partnership – Julie Lulek, jlulek@chsbuffalo.org
- 3.g.i Integration of Palliative and Primary Care – Chris Kerr, MD, ckerr@palliativecare.org
- 4.a.i Promote Mental and Behavioral Health, Karl Shallowhorn, karlmhacompeer@gmail.com, Ken Houseknecht, kenhouseknechtis@gmail.com, Erica Boyce, ejboyce@eccpasa.org
- 4.b.i Promote Tobacco Cessation, Andy Hyland, PhD, Andrew.Hyland@RoswellPark.org



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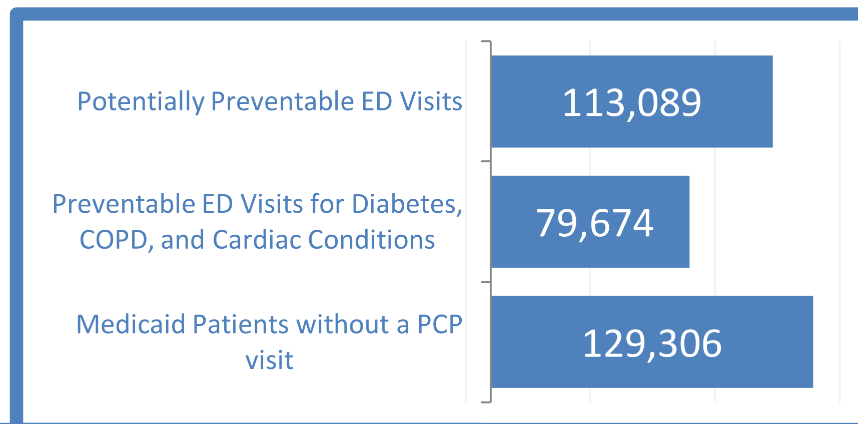
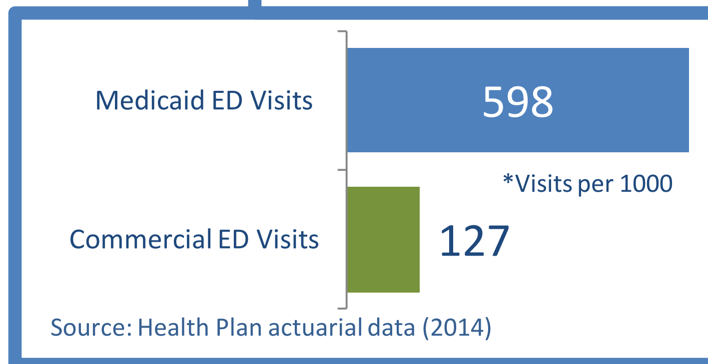
Emergency Department triage for at-risk patients

Measured on: The number of participating patients presenting to the ED, who after medical screening examination were successfully redirected to a PCP as demonstrated by a scheduled appointment.

Progress:

- Identified EDs with highest volumes of preventable admissions
- Identified peak hours of preventable utilization by site
- Collaborate with Health Homes to refer high-risk patients
- Begin planning to address gaps





Source: NYS Department of Health ED PPV by County (2012), total from Erie, Niagara, and Chautauqua.

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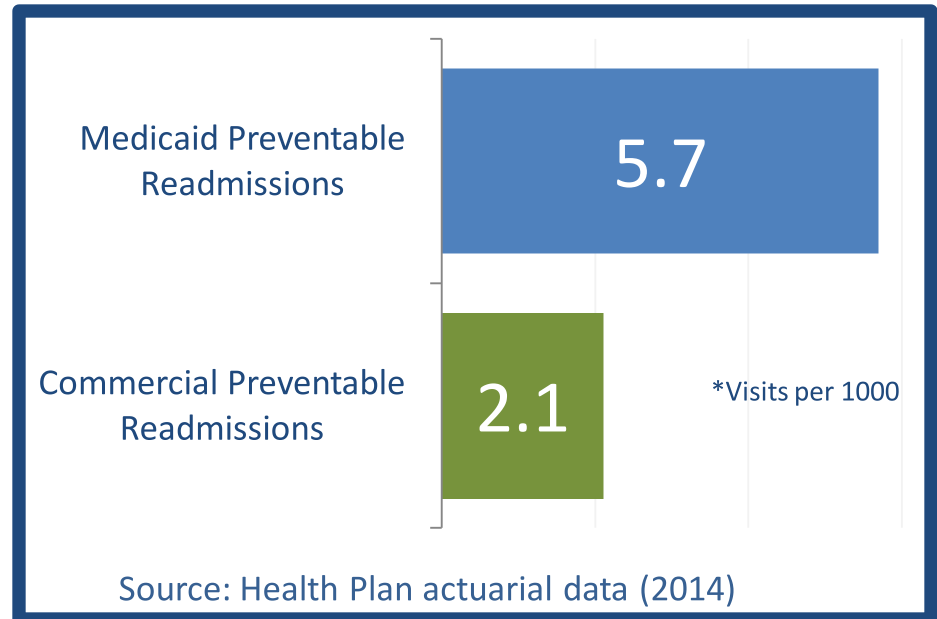
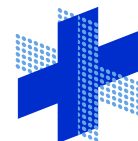
Care transitions model to reduce 30-day readmission

Measured on: The number of participating patients with a care transition plan developed prior to discharge.

Progress:

- Meeting with Primary care practices to determine existing care management capabilities
- Identify areas where additional resources are needed
- Identify best practices for care transitions





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Expand usage of telemedicine in underserved areas

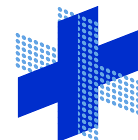
Measured on: The number of participating patients who receive telemedicine consultations.

Progress:

- Select Vendor-Specialists on Call
- Plan to begin roll out at WCA Hospital
- Expand TM to other hospital partners

WNY Community Needs Assessment Identified:

- 14,100 Rural Households without a vehicle
- 70% of all Specialists are located in Erie County
- 2/3 of Mental Health providers are in Buffalo and its Suburbs
- 3/4 of OBGYN Providers are in Erie County



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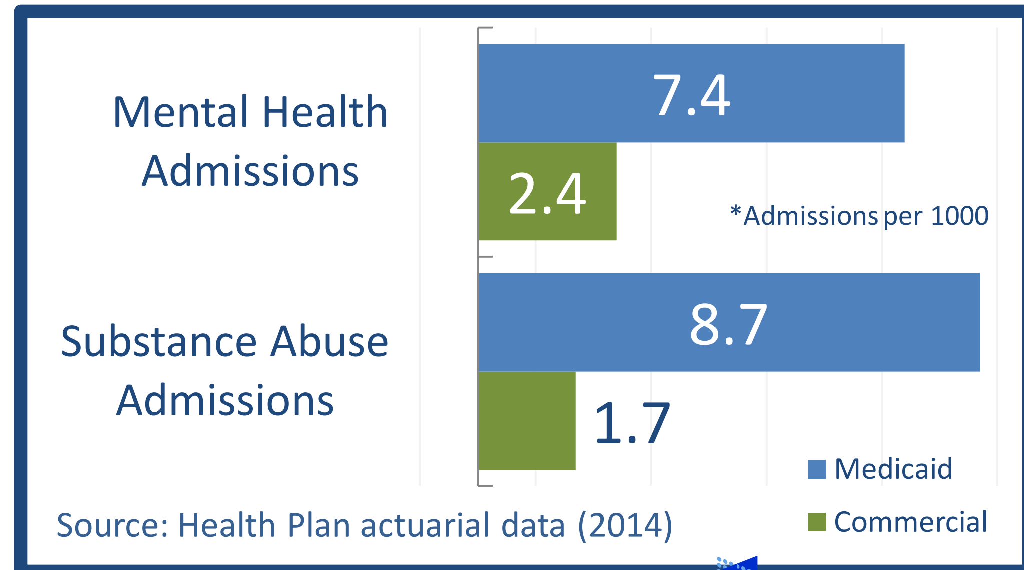
Integration of primary care and behavioral health services

Measured on:

1. The total number of patients receiving appropriate preventive care screenings that include mental health/SA.
2. The total number of patients receiving primary care services at a participating mental health or substance abuse site.

Progress:

- Identify primary care practices and behavioral health providers interested in coordinating services
- Meetings with Millennium Collaborative Care to coordinate on overlapping practices
- Discussion of different models of integration that comply with state and federal regulation



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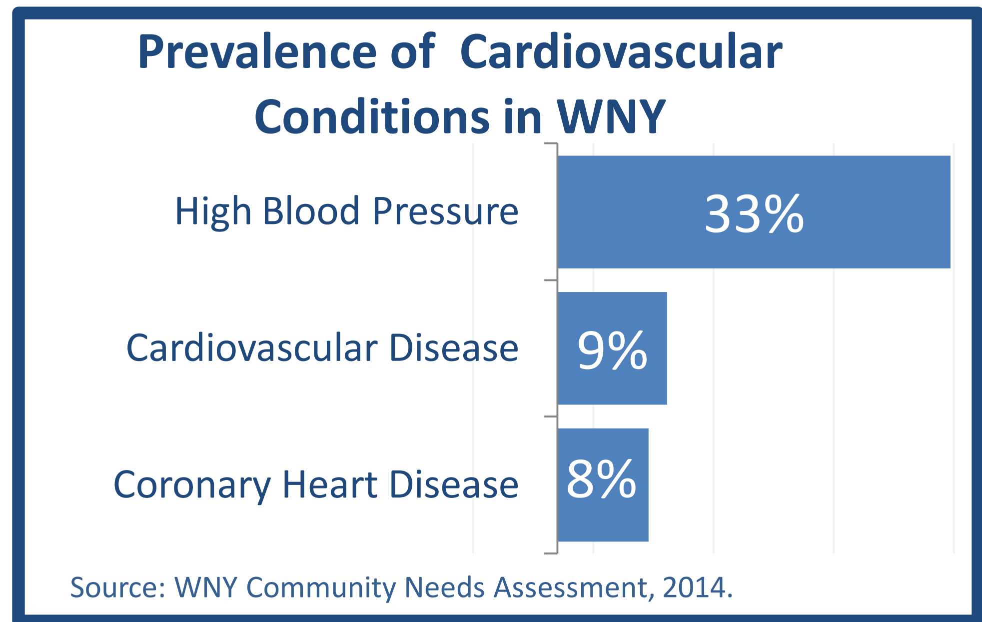
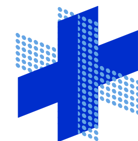
Cardiovascular Health- Evidence-based strategies for disease management

Measured on: The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).

Progress:

- Meeting with Primary care practices to determine existing care models and use of patient self-management goals
- Select national evidence-based guidelines for cardiovascular conditions
- Begin planning strategy for PPS-wide adoption of selected guidelines





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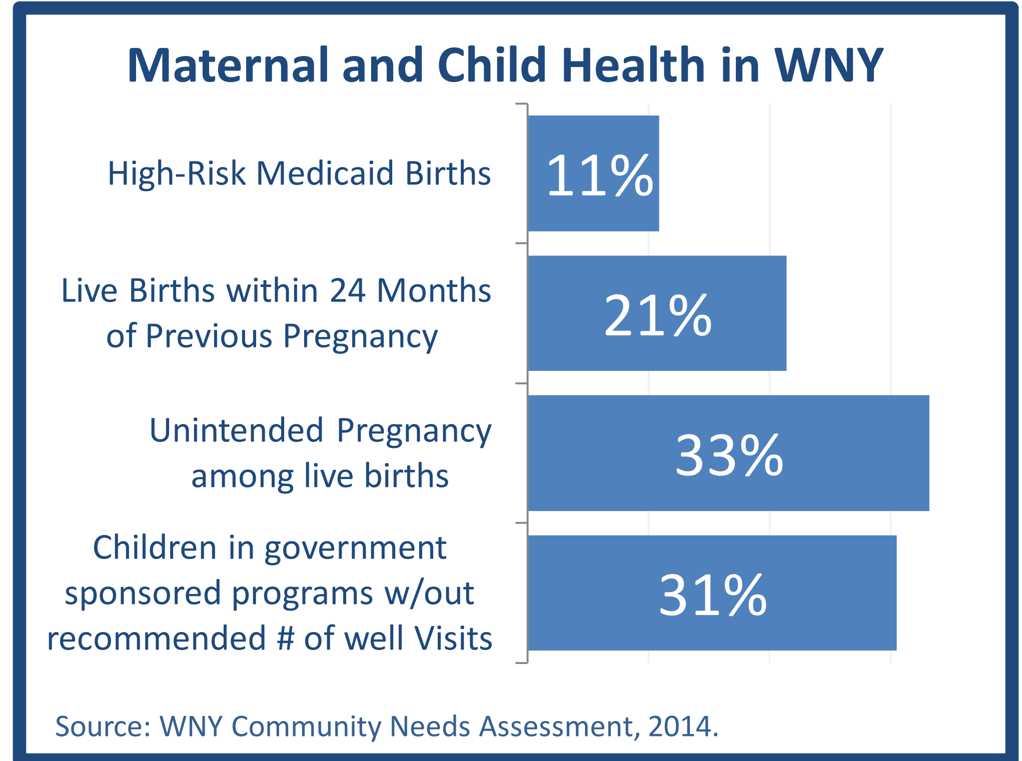
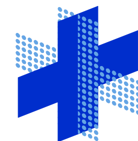
Adopt Nurse Family Partnership Model

Measured on: The number of expecting mothers and mothers participating in this program.

Progress:

- Meetings with local organizations to develop a referral network
- Working on participation agreement with NFP
- Hiring and training new nurses and project leadership
- Begin enrolling high-risk moms in Chautauqua County in September





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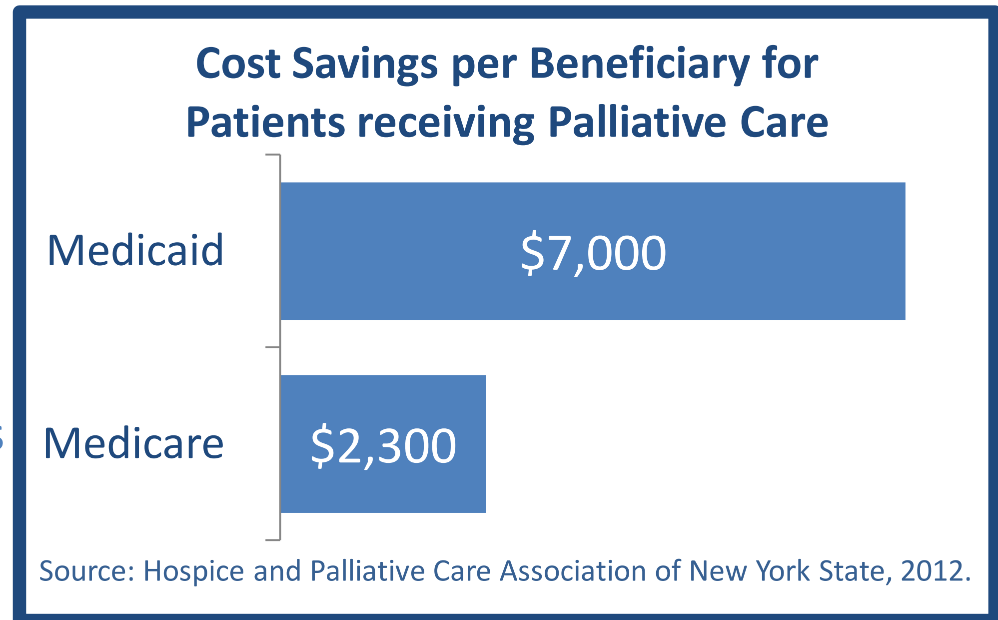
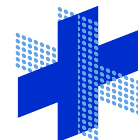
Integration of palliative care into the PCMH model

Measured on: The number of participating patients receiving palliative care procedures at participating PCMH sites, in accordance with the adopted clinical guidelines.

Progress:

- Identify practices with high volumes of eligible Medicaid patients
- Meetings with Safety net clinics and designated PCMH practices to discuss integration possibilities
- Discussions and trainings on different models of integration
- Begin enrolling patients by the end of August





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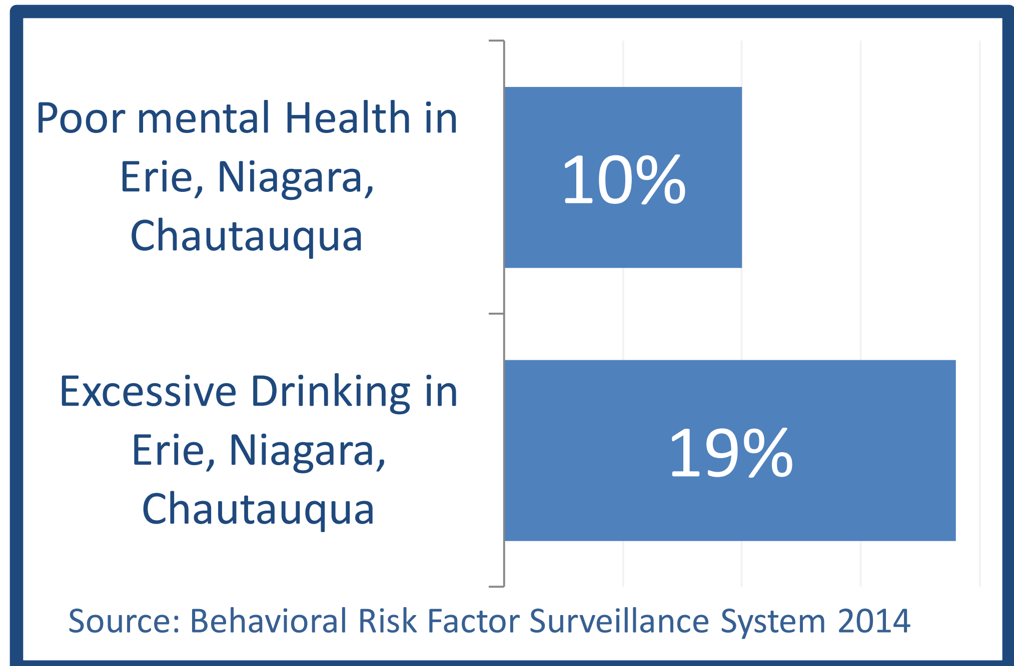
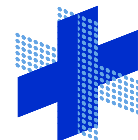
Promote mental, emotional and behavioral (MEB) well-being

Measured on: Metrics established by our project team

Progress:

- Use the Community Needs Assessment to identify greatest need for MEB services
- Select programs to expand based on identified community need
  - Teen Intervene
  - Wellness in the workplace
  - Mental Health First Aid
  - Compeer, etc.
- Work with Millennium Collaborative Care to coordinate projects





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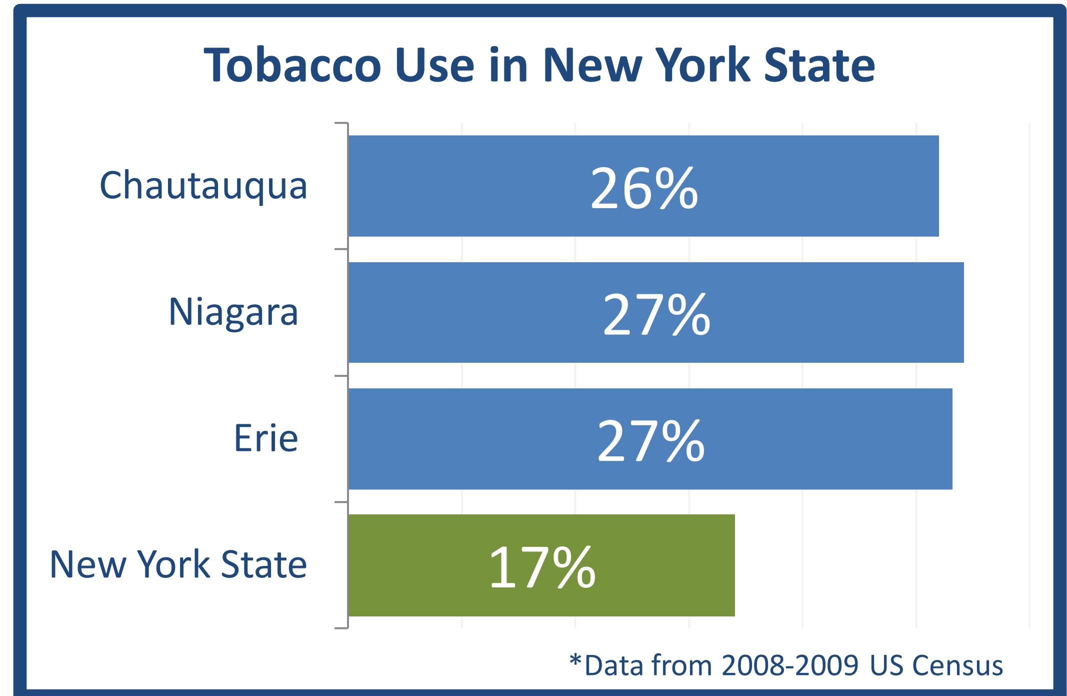
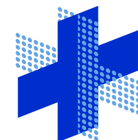
Promote tobacco use cessation

Measured on: Metrics established by tobacco project team

Progress:

- Expanding relationships with current PPS partners and the NYS Smoker's Quitline
- Work with the team of the Cardiovascular project to coordinate efforts





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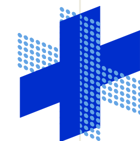
CPWNY Patient Engagement Commitments

Project	Patient Engagement Commitments
3.a.i Primary Care and Behavioral Health	64,468
2.b.iii ED Triage	22,695
3.b.i Cardiovascular Health	20,019
2.c.ii Telemedicine	13,862
2.b.iv Care transitions	11,740
3.g.i Primary Care and Palliative Care	1,070
3.f.i Nurse Family Partnership	300



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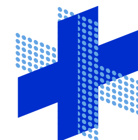
Cultural Competency and Health Literacy

- Finalize cultural competency and health literacy strategy by December 31, 2015.
- The strategy should:
  - Identify groups experiencing health disparities
  - Identify factors to improve access to quality primary , behavioral health , and preventive care
- Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material) by March 31, 2016.
- Deliverable: Describe training programs delivered, participant-level data and training outcomes.



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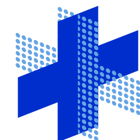
Cultural Competency and Health Literacy

Progress:

- Collaborating with P2 Collaborative and Millennium Collaborative in developing a strategy
- Formalizing a survey of our partners on what they currently have in place for cultural competency and health literacy
- Formed an ad hoc meeting to advise
- Continue to collaborate and attend joint meetings to address this work stream as a “community”.



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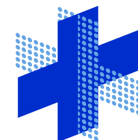
Workforce Strategy

- Due with the October 31st Submission (DY1 Q2)
- Working on hiring a contractor to complete this work stream



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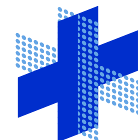
Financial Sustainability

- The Finance Governance Committee (FGC) has been established, consisting of six members from CPWNY partners.
  - Monthly meetings since May, 2015.
- Specific tasks of the Finance group include:
  - Reporting on the receipt and distribution of project funds
  - Development of an annual budget for CPWNY PPS
  - Review Financial Stability of CPWNY and partners
  - Ensure the development and maintenance of an effective compliance plan
  - Assess baseline of network for Value Based Payments, and develop a plan to achieve 90% value-based payments across network by year 5 of the waiver



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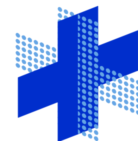
Upcoming Deliverables for Partners

- Feedback from Today's Meeting
- Cultural Competency and Health Literacy Survey sent out September 30, 2015
- Information Technology Capabilities Survey
- Tax ID Forms
- HEALTHeLINK sign ups
- Service Agreements
- Training



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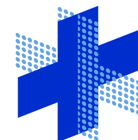
Upcoming Opportunities for Partners

- Regulatory Waiver Requests – Due Sept 15, 2015
  - DOH, OMH, OASAS and OPWDD to waive certain regulatory requirements for DSRIP projects and capital projects associated with DSRIP
  - Waivers apply to all patients regardless of payer
- Opportunity to Add Partners – Mid September
  - Addition of new providers that can contribute to performance
  - Any provider will need to have been added through the appropriate attestation process.
  - Please contact the PMO with recommendations for additional partners



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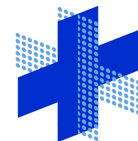
Community Partners of WNY Executive Governing Board

- Peter Bergmann, President and CEO, Sisters of Charity Hospital
- Michael Edbauer, DO, Chief Medical Officer, Catholic Medical Partners
- Dennis Horrigan, President and CEO, Catholic Medical Partners
- Christopher Kerr, MD, Chief Medical Officer, Hospice Buffalo
- Joyce Markiewicz, President and CEO, Catholic Health Home and Community-Based Care
- Mark Sullivan, Executive VP and COO, Catholic Health
- Bruce Nisbet, President and CEO, Spectrum Human Services
- Michael Osborne, VP of Finance, Catholic Health
- Bart Rodrigues, Senior VP and Chief Mission Officer, Catholic Health
- Edward Stehlik, MD, Chairman of the Department of Medicine, Kenmore Mercy Hospital
- Grace Tate, VP of Community Initiatives and Human Resources, Buffalo Urban League
- Dennis Walczyk, CEO, Catholic Charities of Buffalo
- Betsy Wright, President and CEO, WCA Hospital



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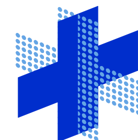
Community Partners of WNY Leadership Team:

- Dennis Horrigan, President and CEO, Catholic Medical Partners
- Michael Edbauer, DO, CMO Catholic Health
- Carlos Santos, MD, CMO Community Partners of WNY
- Rachael Nees, Director of Grants, Catholic Health
- Thomas Schifferli, DSRIP Interim Director
- Patti Podkulski, Director of Medical Policy and Accreditation
- Dapeng Cao, PhD, Manager of Healthcare Analytics
- Sarah Cotter, Director of Clinical Transformation
- Peggy Smering, Director of Care Management
- Cara Petrucci, Project Coordinator



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PAC Feedback Exercise

Form from the sign up table:

1. Information about your organization
2. Interest in joining the PAC
3. Suggestions for success of projects and work streams
4. New partner recommendations

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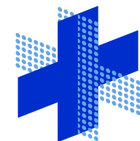
Thank You!



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Questions?

- Patti Podkulski

  Phone: 716-862-2160

  Email: ppodkuls@chsbuffalo.org

- Cara Petrucci

  Phone: 716-862-2462

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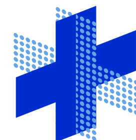
- Website: wnycommunitypartners.org



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