Westchester Medical Center PPS
Project Advisory Committee

June 1st, 2015

Via Webinar: 11:00 am – 12:00 pm

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Agenda

Discussion Topic	Time
Welcome & Status Update • **Valuation Update** • **Master Services Agreement** • **DSRIP Timeline**	11:00 – 11:15 am
Finalizing the Implementation Plan	11:15 – 11:30 am
July 31st Implementation Plan Submission	11:30 – 11:45 am
Partner Participation	11:45 – 11:50 am
Organization Contacts	11:50 – 11:55 am
Questions	11:55 – 12:00 pm

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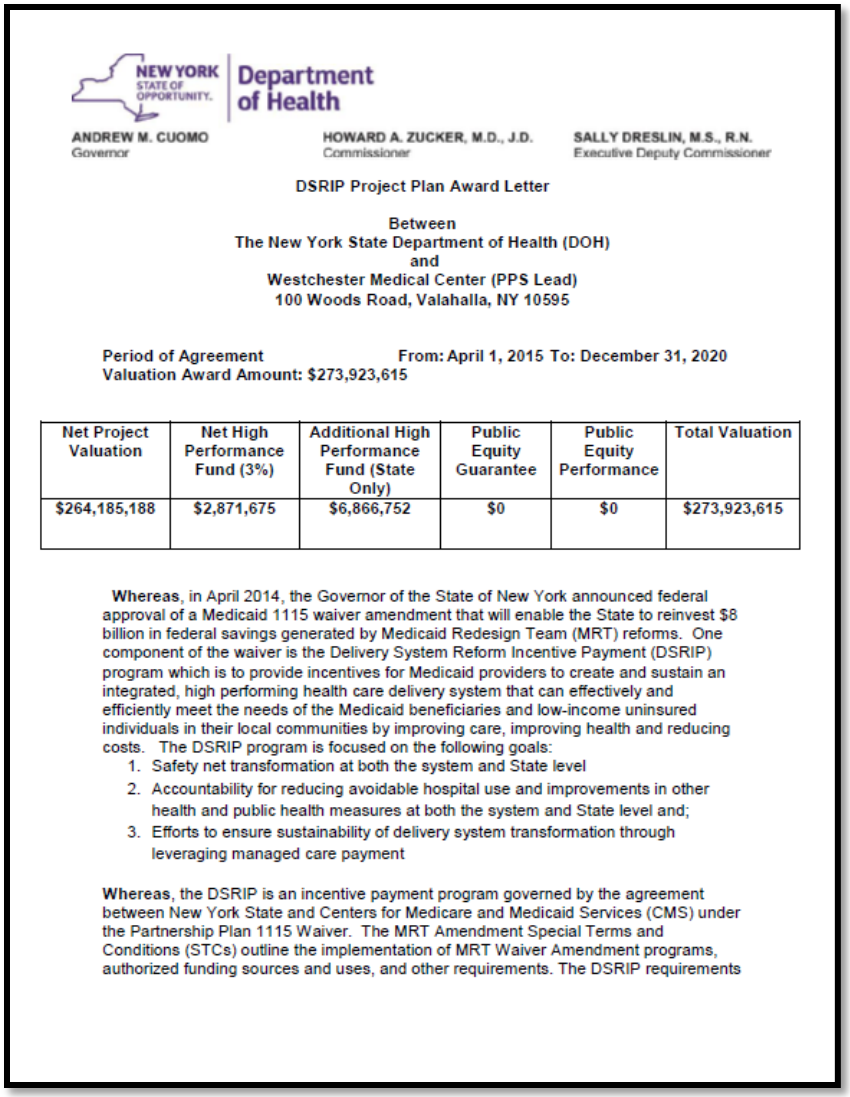
Status Update

DSRIP Award Letter

Valuation Amounts and Performance Funds



NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO, Governor | HOWARD A. ZUCKER, M.D., J.D., Commissioner | SALLY DRESLIN, M.S., R.N., Executive Deputy Commissioner

DSRIP Project Plan Award Letter

Between
The New York State Department of Health (DOH)
and
Westchester Medical Center (PPS Lead)
100 Woods Road, Valahalla, NY 10595

Period of Agreement From: April 1, 2015 To: December 31, 2020
Valuation Award Amount: $273,923,615

Net Project Valuation	Net High Performance Fund (3%)	Additional High Performance Fund (State Only)	Public Equity Guarantee	Public Equity Performance	Total Valuation
$264,185,188	$2,871,675	$6,866,752	$0	$0	$273,923,615

Whereas, in April 2014, the Governor of the State of New York announced federal approval of a Medicaid 1115 waiver amendment that will enable the State to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. One component of the waiver is the Delivery System Reform Incentive Payment (DSRIP) program which is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of the Medicaid beneficiaries and low-income uninsured individuals in their local communities by improving care, improving health and reducing costs. The DSRIP program is focused on the following goals:

1. Safety net transformation at both the system and State level
2. Accountability for reducing avoidable hospital use and improvements in other health and public health measures at both the system and State level and;
3. Efforts to ensure sustainability of delivery system transformation through leveraging managed care payment

Whereas, the DSRIP is an incentive payment program governed by the agreement between New York State and Centers for Medicare and Medicaid Services (CMS) under the Partnership Plan 1115 Waiver. The MRT Amendment Special Terms and Conditions (STCs) outline the implementation of MRT Waiver Amendment programs, authorized funding sources and uses, and other requirements. The DSRIP requirements

Key Points

The total amount WMC PPS can possibly earn is the "Total Valuation": $273,923,615.

Total Valuation is divided into three categories that the State has yet to define and describe:

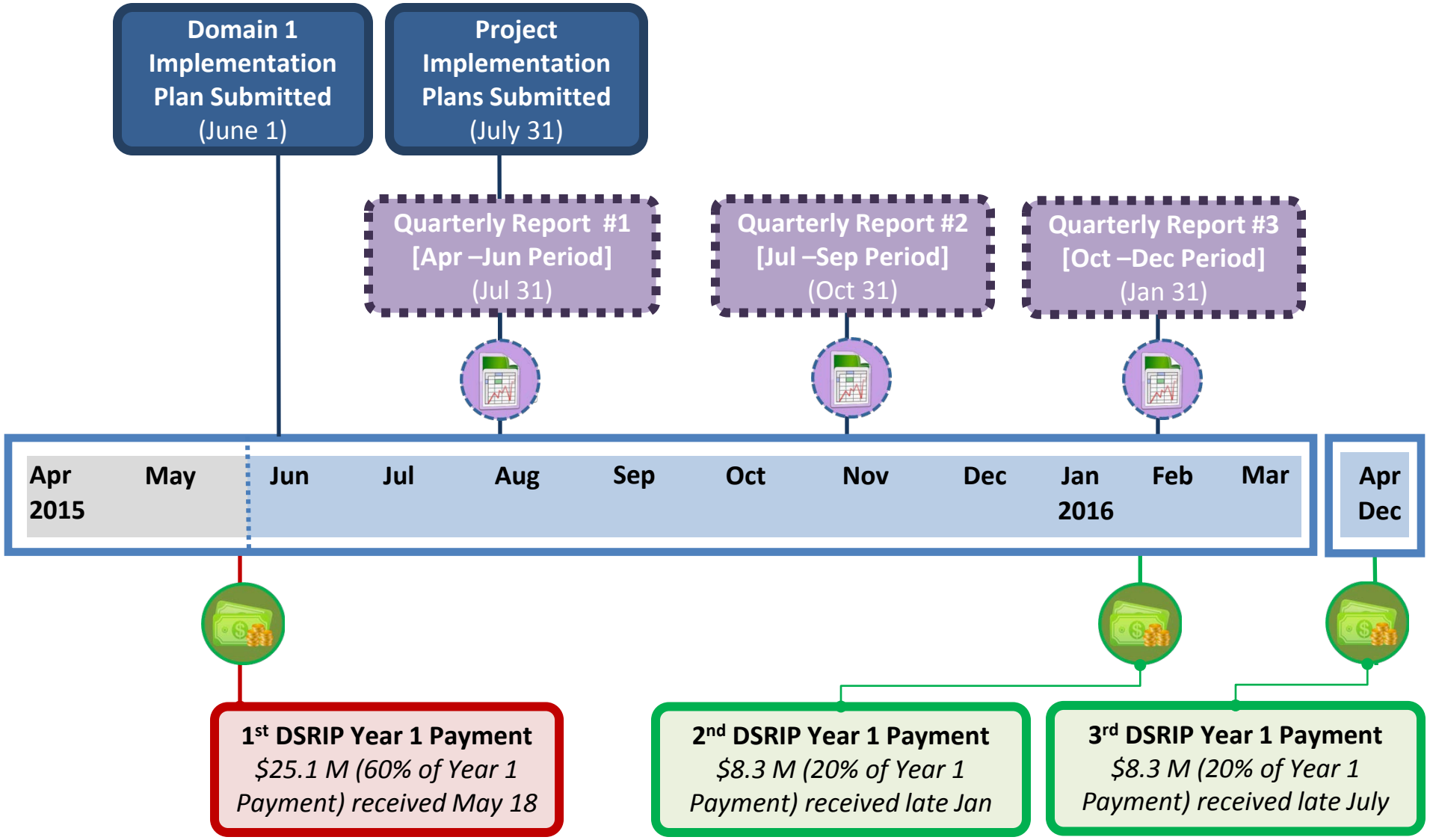
- "Net High Performance Fund": $2,871,675
- "Additional High Performance Fund": $6,866,752
- "Net Project Valuation": $264,185,188

For the Operational Plan submission to the State on June 1, 2015, we will use the Total Valuation (i.e., $273,923,615) to calculate the budget and the funds flow.

Given the uncertainty around the parameters of the High Performance Funds and their relationship to incentive measures, we are seeking additional clarification from the State on how best to communicate the funding distribution.

DSRIP Timeline

The First Year…. Planning, Quarterly Reports, and Payments



Master Services Agreement Status

- ❑ March 13th-Draft MSAs sent to providers
- ❑ March 24th – Webinar on MSA
- ❑ April 24th- Webinar on MSA
- ❑ May 14th- 250 MSAs were sent to providers for signature
- ❑ May 27th- Signed MSAs due to CRHI
- ❑ May 29th- We have received 47

REMINDER- Please return MSAs ASAP

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Project Schedule Development: Summer-Fall 2015

- ❑ Continue development of programmatic cost categories and components
- ❑ Develop project schedules for contracting with providers
- ❑ Convene all project advisory quality committees
- ❑ Convene implementation workgroup; primary care, behavioral health and other projects
- ❑ Conduct in-depth assessment of IT, PCMH, workforce, and behavioral health crisis stabilization services
- ❑ Conduct community Focus Group
- ❑ Convene cross-PPS Clinical Council with Population Health Improvement Program (PHIP)
- ❑ Save the dates for WMC PPS Clinical Quality Conference- October 14th, 15th, or 16th TBD

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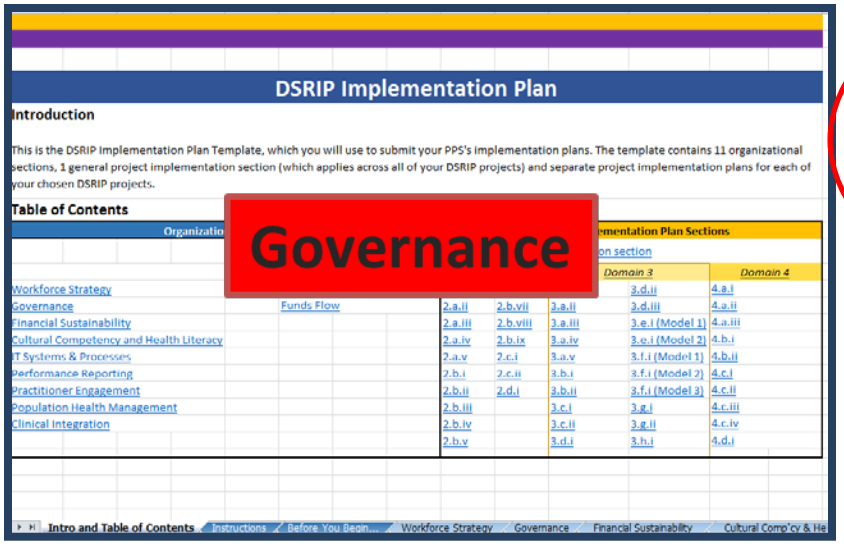
Finalizing the Implementation Plan

Governance: Milestones and Steps



- Governance
- Budget
- Funds Flow
- Financial Sustainability
- Cultural Competency & Health Literacy
- Practitioner Engagement
- Workforce Strategy
- Clinical Integration
- IT Systems & Processes
- Population Health Management
- Performance Reporting

- ✓ Finalize governance structure and sub-committee structure
- ✓ Establish a clinical governance structure, including clinical quality committees for each DSRIP project
- ✓ Finalize bylaws and policies or Committee Guidelines where applicable
- ✓ Establish governance structure reporting and monitoring processes
- ✓ Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)
- ✓ Finalize partnership agreements or contracts with CBOs
- ✓ Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)
- ✓ Finalize workforce communication & engagement plan

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Governance Structure Updates: Milestone #1, DY1

i. Governance structure updates	Target Completion Date	Supporting Documentation
Milestone: Finalize governance structure and sub-committee structure	DY1, Q3	Governance and committee structure, signed off by PPS Board. Subsequent quarterly reports will require updates on committee structure and memberships (if relevant).
Step 1. Identify standing committees.	DY1, Q1	
Step 2. Transition Executive Committee (EC) from Planning EC to Operational EC; confirm member appointments.	DY1, Q1	
Step 3. In partnership with other PPSs in the region establish Hudson Region DSRIP Clinical Committee (HRDCC).	DY1, Q2	
Step 4. Solicit and appoint members of the: Nominating Committee, Finance Committee, IT Committee, Workforce Committee and Quality Steering Committee.	DY1, Q3	AHEAD OF SCHEDULE

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Governance Structure Updates: Milestone #2, DY1

Milestone: Establish a clinical governance structure, including clinical quality committees for each DSRIP project	DY1, Q4	Clinical Quality Committee charter and committee structure chart Subsequent quarterly reports will require minutes of clinical quality committee meetings to be submitted.
Step 1. Establish project-oriented workgroups of the WMC PPS Quality Committee.	DY1, Q2	NEED TO GIVE PRELIMINARY STATUS FIRST QUARTERLY REPORT
Step 2. Convene the WMC PPS Quality Committee.	DY1, Q3	
Step 3. Develop meeting schedules, identify staff support, and draft charter for each Committee and Workgroup.	DY1, Q4	

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Governance Structure Updates: Milestone #3, DY2

Milestone: Finalize bylaws and policies or Committee Guidelines where applicable	DY2, Q1	Upload of bylaws and policies document or committee guidelines. Subsequent quarterly reports will require PPSs to articulate any updates that have been made to their bylaws, policies or committee guidelines.
Step 1. Draft WMC PPS policies and procedures, including Committee guidelines, conflicts of interest policy, compliance plan and dispute resolution procedures.	DY1, Q4	
Step 2. WMC PPS Executive Committee approval of Committee Charters.	DY2, Q1	
Step 3. Publish policies and procedures and communicate to PAC members.	DY2, Q1	

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Implementation Plan Submission

DSRIP Projects

Project	Description
Domain 2: Systems Transformation Projects	
2.a.i	Create an Integrated Delivery System Focused on Evidence-Based Medicine and Population Health Management
2.a.iii	Health Home At-Risk Intervention Program
2.a.iv	Create a Medical Village Using Existing Hospital Infrastructure
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 (Project 11)
Domain 3: Clinical Improvement Projects	
3.a.i	Integration of Primary Care and Behavioral Health Services
3.a.ii	Behavioral Health Community Crisis Stabilization Services
3.c.i	Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease – Diabetes
3.d.iii	Implementation of Evidence-Based Guidelines for Asthma Management
Domain 4: Population-Wide Prevention Projects	
4.b.i	Promote Tobacco Use Cessation, Especially Among Low SES Populations and Those with Poor Mental Health
4.b.ii	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings - Cancer

Activated Patients

	Project	Actively Engaged Patients	Sep-15	Mar-16	Sep-16	Mar-17	Sep-17	Mar-18	Sep-18	Mar-19
	2.a.iii Health Home At Risk	The number of participating patients who completed a comprehensive care management plan.	500	5,000	4,000	10,000	7,500	20,000	8,000	20,000
	2.a.iv Medical Village (Orange+Ulster)	The number of participating patients who had two or more distinct non-emergency services from at least two distinct participating providers at a Medical Village in a year.	600	2,000	2,200	6,000	3,500	9,450	4,400	12,000
	2.b.iv 30 d Readmits (all hospitals)	The number of participating patients with a care transition plan developed prior to discharge who are not readmitted within that 30-day period.	250	1,000	1,200	2,800	1,750	5,600	2,200	5,600
	3.a.i BH/PC Integration	Number of patients screened (PHQ-9 / SBIRT)	2,000	5,000	5,000	12,000	9,000	23,000	19,000	31,000
	3.a.ii BH Crisis Stabilization	Participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements	150	500	250	750	1,000	2,000	1,200	3,150
	3.c.i Diabetes	The number of participating patients with at least one hemoglobin A1c test within previous Demonstration Year (DY).	500	1,250	2,700	8,039	2,700	8,039	2,700	8,039
	3.d.iii Asthma (primary DX only)	The number of participating patients with asthma action plan	500	1,200	2,500	6,800	2,500	6,800	2,500	6,800
	2.d.i Patient Activation	Number of individuals who completed PAM® or other patient engagement techniques.	5,000	12,000	10,000	25,000	20,000	45,000	30,000	81,500

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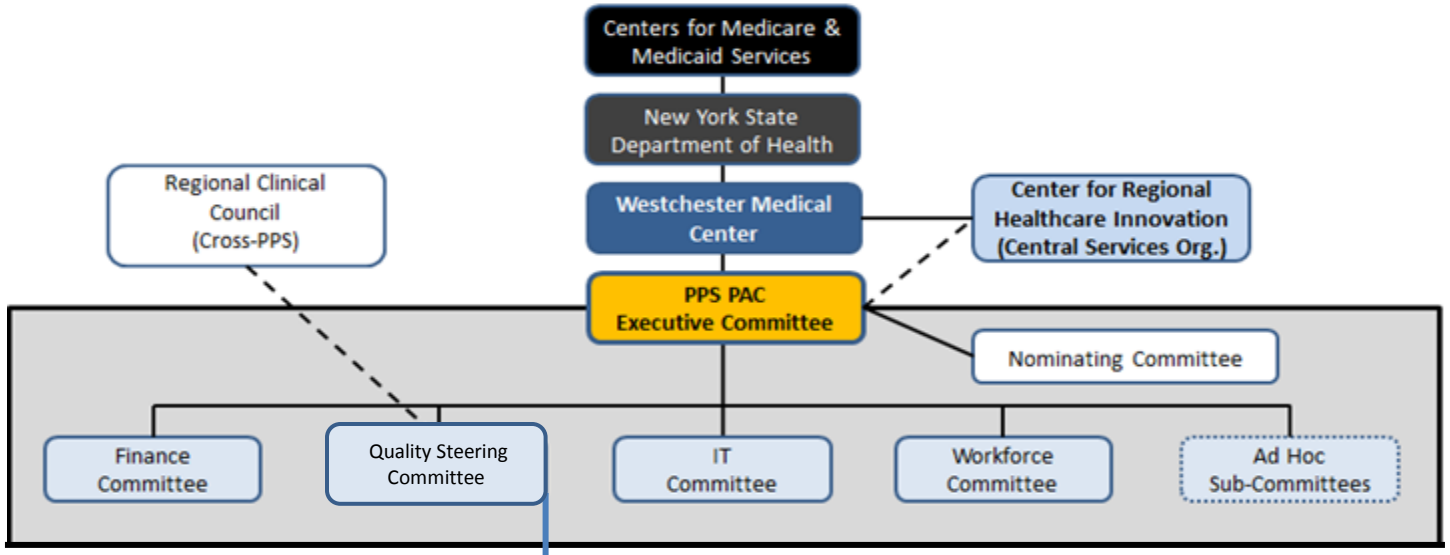
Project Advisory Quality Committees:

- **Asthma**
- **Behavioral Health**
  - Crisis
  - Primary Care Integration
- **Cancer Screening**
- **Diabetes**
- **Health Home at Risk**
- **Hospital Transition**
- **Patient Activation**
- **Tobacco Cessation**

- Asthma:
  - Guidelines; Standard treatment protocols; Training
  - Asthma Action Plan; Telemedicine
  - Clinical Interoperability System; Patient Registries
  - Agreements with MCOs
  - Connection to QE
- Cancer Screening
  - Clinical Guidelines for Cancer Screening
  - Technology plan to embed cancer screening guidelines and alert and reminders in EHR; Cancer screening registry
  - Analytics platform to support patient identification
  - Team based Care models
- Diabetes
  - Evidenced based best practices
  - Clinical interoperability system ; patient registries; alerts and reminders in EHR; tracking system
  - Agreements with MCOs;
  - PCP linkages to Health Homes
  - PCMH
- Health Home at Risk
  - Evidence based practice guidelines
  - PCMH; Connection to QE
  - Patient Registries; Engage patients with care plan
  - PCP partnerships with HH; links to Social Services
- Hospital Transition
  - Standard Protocols for Care Transition interventions; agreements with MCOs
  - Early notification of planned discharges
  - Social Services included in work-flow
  - Patient Registries; Engage patients with care plan

DSRIP Governance Overview



Local Hub Governance

Local Deployment Medical Villages: *Peg Moran*

- Bon Secours Charity Health System
- Health Alliance

Local Deployment BH: *Peg Moran*

- BH Crisis
- Integrated Delivery System at BH sites
  - EHR, MU, HIE
  - Medication Reconciliation
- Medical services at BH sites (Asthma, Cancer Screening, Cardiovascular, Diabetes, Tobacco)
- Patient Activation (PAM & Healthify)
- Links to Health Home Primary Care and Hospitals
- Cultural Competency

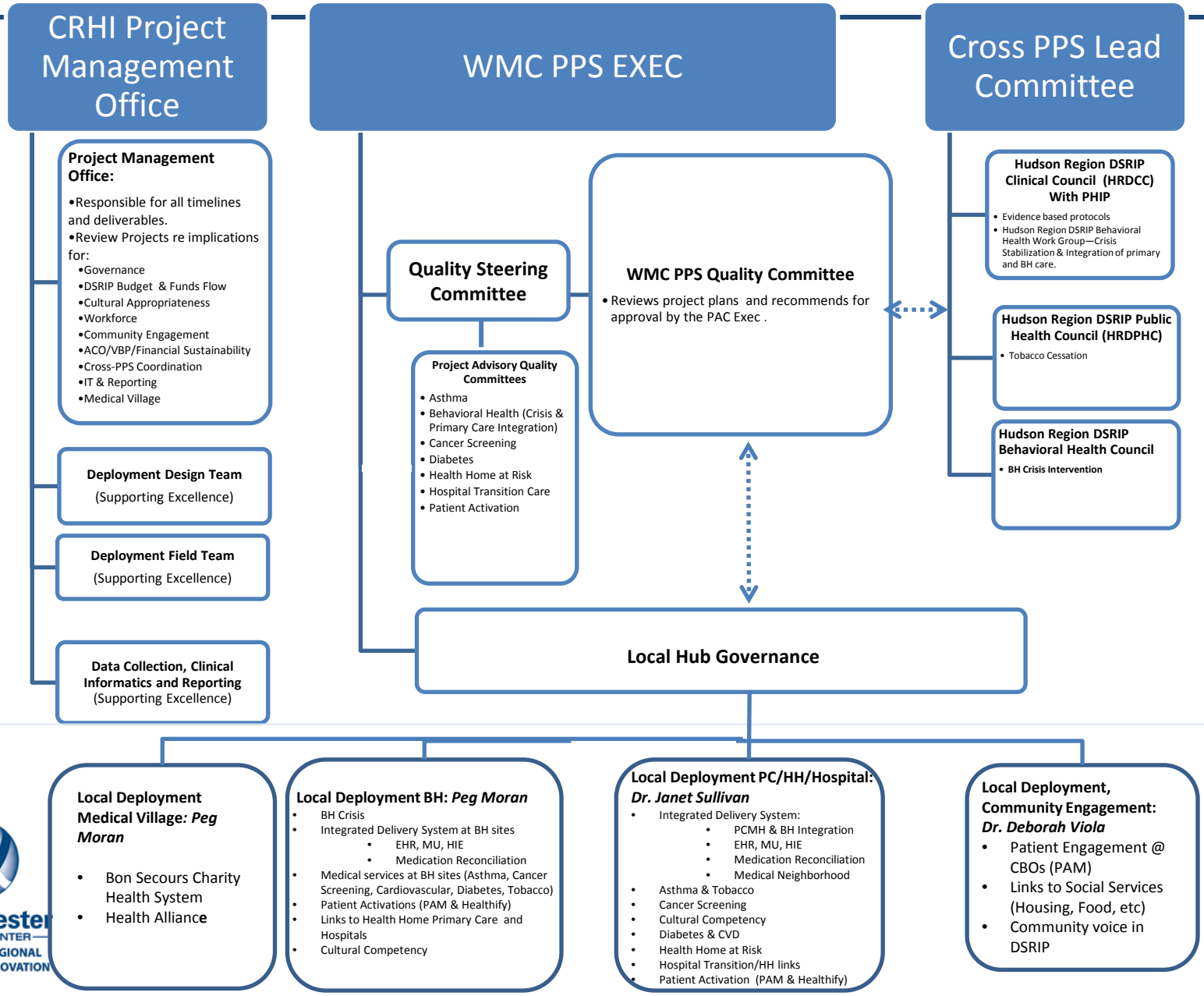
Local Deployment PC/HH/Hospital: *Dr. Janet Sullivan*

- Integrated Delivery System:
  - PCMH & BH Integration
  - EHR, MU, HIE
  - Medication Reconciliation
  - Medical Neighborhood
- Asthma & Tobacco
- Cancer Screening
- Cultural Competency
- Diabetes & CVD
- Health Home at Risk
- Hospital Transition/HH links
- Patient Activation (PAM & Healthify)

Local Deployment Community Engagement: *Dr. Deborah Viola*

- Patient Engagement @ CBOs (PAM & Healthify)
- Links to Social Services (Housing, Food, etc)
- Cultural Competency & Health Literacy
- Training
- Public Health Initiatives @ LGUs
- Community voice in DSRIP

Clinical Governance Detail



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Opportunities to Participate

Participation Opportunities

WHAT'S YOUR PASSION?

- ❑ We are committed to being *a learning organization*!

- ❑ We will be forming groups within our PPS and with the other PPSs in our region to discuss and share information about our projects. Look for announcements in our newsletter and on our website: www.crhi-ny.org

- ❑ We will be mixing it up on the MIX to share information within our groups.

JOIN THE MRT Innovation eXchange - MIX
https://www.ny-mix.org/login

- ❑ Save the dates for WMC PPS Clinical Quality Conference- October 14th, 15th, or 16th TBD

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Contacts

WMC PPS Contacts

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Questions