Lutheran Medical Center (PPS ID:32)

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	Develop a fully integrated delivery system of health and social service providers by DY 5	The Brooklyn Bridges PPS (the PPS) is committed to transforming health care delivery through an integrated delivery system (IDS) comprised of an organized, collaborative network of primary, specialty, behavioral, post-acute, long-term care, and community-based health and social service providers. The IDS will share data, eliminate care gaps, facilitate care transitions, and address the range of health and social needs, improving the health of the entire population served which will include, at minimum, DSRIP attributed patients. Community-based primary care partners, supported by a robust network of specialty and other ambulatory care and community-based organizations, are the foundation of the PPS. This community-based primary and ambulatory care focus will advance the transition of health care delivery from the inpatient to the outpatient setting and will be instrumental in meeting the needs of complex patients to reduce unnecessary hospital use by 25% by Demonstration Year (DY) 5.
2	Achieve PCMH NCQA 2014 Level 3 certification for all primary care partners by DY 3	Supporting partners to achieve Patient Centered Medical Home (PCMH) Level 3 certification is an essential part of the PPS system integration strategy. The PCMH model supports the PPS's goal to create an IDS with advanced primary care practice at its core. Pursuit of this goal will enable partners who are not already PCMH certified to undergo rapid practice transformation with the support and assistance of the PPS. Through the PCMH model, the PPS and its partners will improve patient engagement, outcomes of care, and population health management (PHM) that targets high-need populations and ensures access to and appropriate use of health care services.
3	Achieve Level 2 Meaningful Use and RHIO/SHIN-NY connectivity for eligible partners by DY 3	Effective access to a complete medical record, using electronic medical records (EMR), health information exchange (HIE) and other health information technology (HIT), improves a patient's episodic care and makes care coordination and PHM feasible, scalable and sustainable. The Meaningful Use (MU) standards and incentives, along with prior investments in RHIOs and the SHIN-NY for HIE, provide the infrastructure for data collection to populate repositories and registries and for analysis and reporting. Features such as direct exchange, secure messaging, encounter notifications, alerts, patient record lookup, referral tracking and direct messaging with patients enable providers to delivery higher quality episodic care, manage patient panels and best coordinate care among

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		providers. These tools allow care team members to spend less time performing routine tasks and more time interacting with patients who need their assistance.
4	Achieve clinical interoperability of PPS partners and the PPS by DY 2	Clinical interoperability is critical to improve episodic care, ensure caregiver access to complete patient information, make care delivery more patient-centered, facilitate PHM and support provider networks' transition to sustainable value-based reimbursement agreements. Interoperability allows data to be aggregated and efficiently analyzed to better assess patient need, stratify populations to target appropriate supports and interventions, coordinate care, and engage patients. It also supports the use of common clinical evidence-based protocols and care pathways, improving health care outcomes. Finally, interoperability will support the shift to value-based payment arrangements.
5	Implement evidence-based practices to address tobacco use, diabetes, asthma, and HIV in DY 1	Chronic illnesses, including diabetes and respiratory conditions, represent the greatest proportion of preventable hospitalizations in Brooklyn. Asthma is in the top four diagnoses of Medicaid beneficiaries who visit the Lutheran Medical Center emergency department (ED) more than 3 times annually. HIV was Brooklyn's fifth leading cause of premature death, and presents significant geographic and racial/ethnic disparities in prevalence. These conditions present opportunities to reduce preventable hospitalizations and ED use among the PPS's attributed patients and our community generally. Implementing evidence-based practices in ambulatory care settings will improve care, PHM, patient engagement, and patient self-efficacy and confidence in self-management. The PPS is collaborating with other PPSs to align the development and implementation of evidence-based clinical guidelines for these conditions, which will ensure consistency for all partners across the borough's PPSs.
6	Implement central services to support PPS clinical and fiscal integration beginning in DY 1	The PPS will develop central services to support clinical care transformation and partner integration. These central services will include a Patient Navigation Center (PNC), Information Technology (IT) infrastructure, data and analytics, PPS-wide clinical guidelines, performance monitoring, workforce training, and the financial infrastructure to distribute incentive payments. These services will equip partners with systems that: support PHM; allow optimal communication across organizations; position partners to play an active role in engaging patients in their care; and, enhance the ability to identify risk in the population and support high need patients.
7	Reduce excess acute and long-term care beds by DY 5	As part of its IDS vision, the PPS intends to shift financial, clinical and workforce resources from inpatient, acute care to community-based, ambulatory care, including patient-centered behavioral health, substance abuse, and social support services. System transformation and reallocation of resources consistent with this vision requires collaboration among all Brooklyn PPSs to develop a comprehensive strategy and action plan to reduce excess acute care and long-term care bed capacity in Brooklyn.
8	Integrate behavioral health screening and treatment services in primary care settings by DY 3	Access to high-quality mental health and substance abuse services in Brooklyn is a significant, unmet community need and a health care delivery system gap that contributes to high costs and poor health outcomes. The PPS will integrate behavioral health and primary care services by increasing primary care capacity within the PPS and integrating behavioral health services with partnering primary care sites through the PCMH and IMPACT models. This will increase the availability of behavioral health services and will concomitantly reduce care fragmentation for patients. Ultimately, the expansion of behavioral health capacity and access will support the PPS's goal to avoid unnecessary ED visits and inpatient utilization, thereby reducing health care costs and improving health outcomes in its service area.
9	Implement a PNC, beginning in DY 1; complete implementation by DY 4	The PNC will be the core of the PPS central service infrastructure. The PNC will provide culturally competent navigation and care coordination

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#	Goal	Reason For Goal
		services. These services, delivered telephonically, in-person and web-based by clinical care managers and community health workers (CHWs), will bolster PPS objectives related to: * Promoting effective and efficient use of healthcare services, including PCMH enrollment, by attributed Medicaid members; * Advancing patient activation to ensure treatment adherence/continuation; * Connecting patients to community-based resources that respond to unmet social needs that affect health and well-being; * Providing patient education and health coaching to improve patient self-management; and, * Providing support during care transitions including post-discharge. These objectives are central to supporting clinical integration of our partners and reducing avoidable ED and inpatient hospital use.
10	Reduce avoidable ED use and inpatient admissions by 25% by DY 5	The reduction of avoidable ED use and inpatient admissions by 25% during the DSRIP project period is a requirement of the State's waiver, and a pre-requisite to receipt of DSRIP dollars. The PPS will achieve this through system transformation. Implementing evidence-based programs will better facilitate management of chronic conditions, reducing unneeded admissions and ED use. Care management and navigation services will link high need patients to community-based services and provide supports (e.g., medication reconciliation) to avert ED visits. Additionally, the PPS's ED care triage and observation unit projects will be instrumental in reducing avoidable ED and inpatient utilization. The IDS and RHIO will provide data to a patient's care provider, allowing that provider to better address patient needs. Together these services and the reduction of avoidable ED visits and admissions also support success of value-based payment arrangements.
11	Enter value-based Medicaid managed care plan contracts, transitioning to risk contracts by DY 5	Value-based payment arrangements with Medicaid managed care (MMC) plans will help the PPS achieve two fundamental aims: financial integration of the IDS and long-term financial sustainability. Medicaid payment reform will change reimbursement systems from existing fee-for service (FFS) to value-based arrangements that promote quality outcomes, and clinical and financial integration. FFS Medicaid does not sufficiently reimburse providers to offer a full scope of population health and social services. Value-based payments will promote provider-driven care transformation by giving partners the resources and incentives to provide patients the right care, at the right time, in the right place. The PPS will successfully execute new, value-based payment arrangements to support the individual partners, the IDS as a whole, and, ultimately, sustainable high value care after the DSRIP program ends.

***Formulation:**

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

The Brooklyn Bridges PPS, led by Lutheran Medical Center (Lutheran) and NYU Langone Medical Center (NYULMC), is a tight-knit network of partners designed to produce meaningful results through the marriage of community-centered care and academic medicine. Primary care practices, including nine Federally Qualified Health Centers (FQHCs), seven Diagnostic Treatment Centers (DTCs) and over 29 primary care practice sites, anchor our network and account for over 60% of total attributed lives. Our nimble network is strengthened by a broad base of community partners working with us to transform health care delivery.

Through the Community Needs Assessment (CNA), the PPS identified the unmet needs of our community: inequitable distribution of health resources; inadequate access to primary, specialty and behavioral health care; poor connections to critical social services; and insufficient cultural and linguistic competency, among other needs. The PPS is committed to helping its partners through: 1) central IT and PNC services; 2) funding; and, 3) sharing Lutheran Family Health Centers (LFHC) and NYULMC expertise with PHM.

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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.

Within five years, Brooklyn Bridges will be a clinically and financially integrated delivery system entering into Medicaid value-based contracts. PPS-wide achievements will include: 1) PCMH NCQA 2014 Level 3 certification; 2) clinically interoperable systems; 3) patient navigation services that connect individuals with health and social services; and, 4) standard and widespread PHM systems and protocols. While DSRIP resources will be devoted to transforming care for Medicaid patients, the IDS care design will extend to all patients, regardless of payer. The PPS therefore intends to pursue a multi-payer, value based contracting strategy to include Medicare and commercial payers as well as Medicaid plans; this strategy is key to the PPS's long-term financial sustainability. The PPS has already initiated value-based contracting discussions with its largest Medicaid plans, HealthFirst and Amerigroup. Additionally, NYULMC experience with Medicare Advantage, commercial ACO contracts and Medicare's Bundled Payment for Care Improvement (BPCI) demonstration will be invaluable to the PPS as it develops central services and a strategy related to risk contracting.

***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	OMH: 14 §§ NYCRR 599.3(b), 599.4(r), (ab); OASAS: 14 NYCRR §§ 800.2(a)(6),(14), 810.3, 810.3(f), (l)	The PPS seeks this RR for project 3.a.i. Reason for request: Office of Mental Health (OMH) regulations require Article 28 providers to obtain an OMH license if they provide more than 10,000 mental health visits annually, or if mental health visits comprise more than 30% of the provider's annual visits and the total number of visits is at least 2,000 visits annually (OMH threshold). Office of Alcoholism and Substance Abuse Services (OASAS) regulations require an Article 28 provider to obtain a certification from OASAS if it provides any substance abuse services. Under 3.a.i, Article 28 partners will increase their provision of both mental health and substance abuse services so that patients can receive physical and behavioral health services in one setting. It is likely that some of the partners participating in 3.a.i will cross the OMH threshold, and all Article 28 providers that provide any substance abuse services would be required to obtain OASAS certification. Requiring OMH and/or OASAS licensure would impede 3.a.i goals and slow project implementation. Undergoing through the certification process would be an unnecessary administrative burden, and multiple certification requirements are financially and programmatically infeasible for many Article 28 providers. Further, complying with certification rules would have little benefit to patients. For example, Article 28 providers are already required to