New York City Health and Hospitals-led PPS (PPS ID:52)

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	Create a patient- and family-centered integrated delivery system in New York City	The lack of integrated approaches to address the healthcare needs of our communities and the many social determinants of health adversely impacts the health status of New Yorkers. The CNA demonstrates a lack of access to primary and behavioral healthcare, and a lack of coordination among healthcare organizations, providers, and community-based organizations. Additionally, the CNA underscores the challenges faced by providers in ensuring appropriate care to over 1.5 million residents who are disengaged from the delivery system or are uninsured. To address these gaps, we propose to develop an integrated delivery system capable of providing patient- and family-centered care across the continuum, including essential social services. We will enter into formal contractual arrangements with a range of community-based providers and organizations, and we expect these arrangements to evolve over time into a more consolidated and integrated delivery system driven by value-based payment models.
2	Decrease potentially avoidable emergency room visits	Potentially preventable visits to the emergency department (PPV-ED) per 100 Medicaid beneficiaries are 38 in the Bronx, 29 in Brooklyn, 42 in Manhattan, and 27 in Queens. Twenty-one UHF neighborhoods that encompass 61% of our PPS's Medicaid population will be targeted for patient engagement as their observed/risk-adjusted expected ("O/E") ratios of PPV are above 1.0 (indicating a gap in care). Through our PPS's analyses, an estimated 41% of patients who visited the ED were found to not have their own primary care provider (PCP). Several of the top 10 diagnoses of patients presenting to EDs could often be treated instead by a PCP. To address these gaps, the PPS has developed an approach to ED care management which will strengthen patient relationships with PCPs, triage their conditions, and provide navigation support for patients with non-emergent illnesses, and facilitate care coordination for patients treated and released from the ED.
3	Decrease potentially preventable readmissions	Potentially preventable readmissions (PPRs) are frequently caused by poor care coordination or ineffective transitions of care. PPS analyses show an opportunity to reduce PPR rates since risk-adjusted O/E PPR ratios reach 1.04 in Brooklyn, 1.13 in the Bronx, 1.17 in Manhattan, and 0.79 in Queens.

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		Twenty-one UHF neighborhoods have risk-adjusted O/E ratios greater than one (indicating a gap in care) for four Prevention Quality Indicator (PQI) measures: COPD or asthma; respiratory composite; chronic composite; and heart failure. Patient engagement activities will be enhanced in these neighborhoods since they constitute a significant proportion of our PPS's total population (69%). To address these gaps, our PPS will pursue a two-pronged approach to improve care transitions: (1) standardize Project Re-Engineered Discharge (RED), a proven method to improve care transitions, across all hospitals and (2) strengthen coordination across the continuum.
4	Provide greater access to primary care and enroll patients in appropriate care models	Expanding access to primary care services and enrolling patients in appropriate care models will be essential to meeting the DSRIP goals and achieve long-term sustainability. As part of our planned activities, we will link primary and behavioral healthcare services and expand our capacity to more efficiently treat larger patient populations. We intend to develop new resources and programs to meet the needs of our communities, including an enhanced care management platform to identify, stratify, and manage the care of patients and populations, and to retrain and hire a large cadre of patient navigators, care managers, and care coordinators. In addition to these programs, we will work to expand the capacity of and enrollment in our affiliated Health Homes, and to assist our community-based PCPs in attaining 2014 NCQA Level 3 patient centered medical home (PCMH) recognition and meet Stage 2 Meaningful Use standards.
5	Promote integrated primary and behavioral health services in an outpatient setting	New York's Medicaid beneficiaries with mental health (MH) and substance abuse (SA) diagnoses are high users of ED and inpatient services: 42.3% and 58.4% of MH and SA patients, respectively, had at least one ED visit and 32.3% and 65.0% had at least one admission. Readmission rates for individuals with MH diagnoses are high as well; 23.3% in NYC, and 20.9% for NYS. The CNA indicates low utilization of behavioral health (BH) resources, which CNA participants note are difficult to access. The CNA posits that low utilization may also be due to stigma associated with BH, inconvenient BH clinic operating hours and lack of awareness of available resources. To address the needs of individuals with co-morbid physical and BH needs before they reach an ED or inpatient setting, we will pursue physical co-location of BH providers at primary care sites, physical co-location of PCPs at BH sites, and expansion of IMPACT, the evidence based depression care model, across the PPS service area.
6	Form a Central Services Organization to serve as the nexus for all population health activities	To successfully implement and continuously improve DSRIP programs throughout our large and diverse PPS, significant dedicated resources and an intensive focus on improving population health will be required. Our PPS is developing a Central Services Organization (CSO), which will be supported by robust analytics and health IT infrastructure to manage a range of population health functions required for DSRIP and long-term success. As currently envisioned, it will provide an integrated platform for all DSRIP projects and initiatives. Its functions are designed to include: protocol management, care transformation, patient engagement, risk stratification, patient navigation, care coordination, IT, and other central support services (e.g., human resources, finance, communications, etc.). Subject to implementation planning, the workforce will include project managers, data analysts, PPS partner coordinators, and engagement workers, among others.
7	Actively engage the uninsured and low- and non-utilizing patients in care before they become sick	There are approximately 1.1 million uninsured and 700,000 low-and non-utilizers in our PPS. The CNA estimates that nearly 21% of all individuals live below 100% of the Federal Poverty Level, 18.6% of which are non-US citizens, 22% have less than a high school diploma, and 24.6% speak

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#	Goal	Reason For Goal
		English "less than very well". These rates exceed NYC and NYS averages and are shown to be associated with disconnectedness from the healthcare system. In order to engage these patients in care, we will implement a comprehensive patient engagement program with two-fold goals: enroll patients in coverage, where possible, and engage patients in high-quality, patient-centered care, regardless of their insurance status. Our PPS will initially focus on those with chronic illness, those with limited English proficiency (LEP), immigrants, and the undocumented, as these groups are shown to have lower insurance coverage rates and less regular contact with the healthcare system.

***Formulation:**

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

In formulating our PPS, we were guided by several core principles. First, our PPS should be organized around the needs of the patient, the family, and the community, with an emphasis on high-quality, patient-centered care that also addresses the social determinants of health. Thus, we engaged a large number of community-based organizations (CBOs) to join our PPS. Second, our PPS's ability to deliver patient-centered care depends on a well-trained workforce focused on providing seamless care across the continuum. To address this, we engaged our labor partners throughout the process, and are committed to a robust program of training and education across clinical and community-based settings. Third, our PPS will operate transparently with a strong bias toward inclusivity. Thus, our governance structure ensures that our community-based partners hold a majority of the seats on our Executive Committee, and also provides ample opportunity for local involvement and guidance. Fourth, we must become self-sustaining. Thus, we have included two managed care organizations as partners in our PPS, and expect to leverage their expertise to increase PPS adoption of value-based payment models.

***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.

Our vision is to become a fully-functioning, integrated delivery system (IDS) of health and social service providers that spans the entire care continuum, with a focus on addressing the social determinants of health, such as housing. Linked by a Central Services Organization (CSO), we will manage the health of defined populations. Our PPS would be paid using value-based payment models for delivering high-quality care and avoiding unnecessary ED and inpatient admissions. As the only NYC PPS sponsored by a public hospital, we will develop population health programs to care for all, regardless of insurance status. DSRIP will allow us to fully engage the uninsured population, which has received much of its care on an episodic basis, by using care management programs to improve continuity and coordination. Long-term sustainability of our PPS depends critically on the adequacy of value-based payment models used to compensate the PPS for services and programs. We look forward to working with our partners and the State as we leverage our experience with risk-based payment models and work closely with our managed care organization partners to achieve sustainability post-DSRIP.

***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