Westchester Medical Center (PPS ID:21)

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 centered integrated delivery system (IDS) in our region	There is a lack of coordination across the healthcare continuum in our region, with providers largely operating in silos, without the benefit of comprehensive patient information or ways to easily access critical community-based resources, perpetuated through reimbursement policies that reward providers on a fee-for-service (FFS) basis, rather than on their impact on health outcomes or quality of care. Under the current system, resources are wasted and patients often experience inefficient care or are unable to navigate resources to obtain appropriate care in a timely manner. Our Performing Provider System (PPS) will address these issues by creating a patient-centered IDS characterized by effective and targeted care management, integration of behavioral health and primary care services, expanded use of PCMHs and Health Homes, enhanced provider communication, and access to meaningful data to impact and inform patient care and treatment decisions.
2	Decrease potentially avoidable hospitalizations and unnecessary emergency department (ED) visits	Avoidable inpatient and ED utilization accounts for significant costs that may be otherwise avoided by linking patients to appropriate primary care services, promoting preventive care, and addressing social factors impacting patients' health. Our PPS identified significant "hot spots" of preventable hospitalizations and ED visits linked to prevalent conditions such as coronary artery disease and congestive heart failure. Our PPS will, through its 30 day readmission management, behavioral health crisis stabilization and other projects, implement care coordination and management services to direct patients to appropriate care, increase access to primary care and other services, enroll patients in Health Homes, and address social determinants that may prevent patients from managing existing conditions or improving their overall health.
3	Transform siloed delivery of behavioral and physical care in safety net to integrated model	Addressing the siloed system of behavioral health and physical care is a sub-component of goals 1 and 2, but is a critical goal of the PPS in its own right. Behavioral health conditions, including mental illness and substance use disorders, are widespread among the region's Medicaid high-need beneficiaries, many of whom also have chronic physical conditions. Additionally, a high percentage of patients with repeat ED visits in our region have unmet behavioral health needs. Our PPS will develop behavioral health crisis teams; advance comprehensive physical and behavioral health screenings across the PPS; develop tools and resources to support patient and engagement; expand care coordination and navigation support and develop shared care plans (when appropriate); and

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#	Goal	Reason For Goal
		both physically and virtually integrate medical and behavioral health in primary care sites.
4	Develop region-wide technology infrastructure for data sharing and communication between providers	A survey of our PPS providers' health information technology (IT) and electronic health record (EHR) capabilities found significant disparities in provider adoption and electronic access to health information. Without these capabilities, providers and community-based organizations are unable to effectively access and share information about the patients and populations they are treating, undermining care coordination and population health management efforts. Further, providers need actionable data to monitor quality and improve outcomes. Our PPS has identified a health IT and population health management strategy and infrastructure as a critical priority to enable participating providers to deliver the best care possible to assigned patients and achieve the goals of all DSRIP projects. This infrastructure will also be critical to tracking PPS and individual Participant and provider progress toward DSRIP goals and objectives.
5	Improve the overall health of the Medicaid and uninsured populations in our region	There are significant health disparities among our PPS' target patient population. Our region is characterized by densely populated urban areas, sparsely populated rural communities with suburban communities in-between, and pockets of great wealth and pervasive poverty. We have selected projects that focus on identified health challenges, for example: high rates of tobacco use; lack of primary care and behavioral health integration; and hot spots of diabetes and asthma. Through the CNA we identified critical community-based resources as well as gaps in needed resources to help bridge and coordinate patient care between the outpatient and inpatient settings and ultimately improve the overall health of the population. We established a cross-PPS Regional Clinical Council that will advance common clinical protocols and quality metrics and foster cross-PPS collaboration to ensure that "all boats rise together" in our region to best serve our residents and patients.
6	Advance the readiness and capacity of PPS Participants to enter into value-based contracts	The existing Medicaid FFS payment model rewards volume and frequency of services, rather than coordinated services that produce improved population health outcomes. As DSRIP drives PPS Participants toward improving outcomes and reducing avoidable utilization, payment models must also shift to reward providers based on value. Our proposed PPS funds flow model will begin this transition through provider bonus payments tied to individual DSRIP projects and program goals and objectives via mutually agreed upon metrics. The PPS intends for these bonus payments to shift Participants' focus from siloed services to comprehensive care management and encourage coordination and communication among Participants and providers. The PPS has actively engaged Medicaid Managed Care Organizations (MCOs) and plans to develop its IDS to enter into value-based contracts in years 3–5 of DSRIP and provide infrastructure to support accountable care organizations (ACOs) as they move to risk-based contracting.

***Formulation:**

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

Our PPS was formulated with input from the CNA, PPS Participants, and community-based stakeholders to ensure the PPS can meet the needs of the community and address identified health care disparities.

Our governance model is centered around an inclusive, transparent committee structure and process with representation of all partners. Within the PPS, four regional Hubs of providers and community-based organizations within defined geographic regions will work collaboratively toward implementing DSRIP and achieving targeted goals. Under the Hub model, our PPS will be able to quickly and effectively mobilize Participants and resources deeply familiar with the needs of the local population to address unique health care challenges and disparities. This model will also allow each Hub to benefit from centralized services operated by the Center for Regional Healthcare Innovation (CRHI), while determining and customizing their approach to rolling out such services and supporting project implementation.

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Our CNA guided the selection of DSRIP projects and we have built an analytics capability to continuously assess the health status and needs of our population across DSRIP implementation.

***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.

Successful integration is an ongoing adaptive process rather than a one-off initiative. Skilled and trusted leadership at multiple levels and a culture of collaboration is required. Our PPS will advance provider-led, regional clinical, financial and IT governance that will improve care coordination to create one seamless system of care by leveraging the investment New York State (NYS) has made in IT, PCMHs and Health Homes. The first three years of DSRIP will allow us to develop the clinical and financial integration capabilities necessary to manage the health of populations. Within five years, we will achieve quality-based improvements and savings through measuring, understanding, and managing variation among clinicians. Our network will be capable of entering into value-based contracts both directly as the IDS and by providing the supporting infrastructure for regional ACOs to expand into Medicaid risk-based contracting. We are already working closely with Medicaid MCOs (the largest Medicaid plan in the Hudson Valley serves on our PPS Executive Committee) to advance innovative ways to align both benefits and financial incentives to reward outcomes and care improvement.

***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	14 NYCRR §§ 599.3(b), 599.4(r), (ab); 14 NYCRR §§ 800.2(a)(6), (14), 810.3, 810.3(f), (l)	Project(s): 3.a.i Reason for request: 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 percent of the provider's annual visits and the total number of visits is at least 2,000 visits annual (the OMH threshold). 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 providers 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 highly likely that some of the providers 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 conflict with the goals of 3.a.i. Going through the certification process would be an unnecessary administrative burden. Further, having to comply with multiple licenses would force Article