NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Millennium Care Collaborative PPS

Appendix PPS Narratives

November 2016 **www.health.ny.gov** **Prepared by the DSRIP Independent Assessor**

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Organizational Narratives

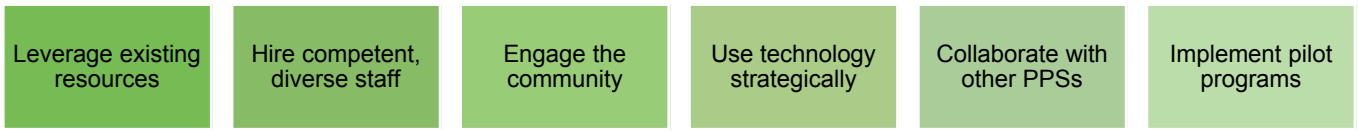
PPS must submit a narrative highlighting the overall organizational efforts to date.

PPS Name: Millennium Collaborative Care

Highlights and successes of the efforts:

Introduction

The following common themes and critical success factors cut across all of Millennium Collaborative Care's efforts:



Leverage existing resources:

Even though Millennium Collaborative Care ("Millennium") is a new organization, formed when six proposed PPSs in Western New York consolidated, it was able to become effective relatively quickly by leveraging existing resources available through its partners.

The lead entity, Erie County Medical Center (ECMC), provided facilities; oversight; staff; IT and communications infrastructure; and support from hospital departments including Legal, IT, and Compliance. Other partners provided office/meeting space, reporting support, interim leadership, and financial direction.

Relying on available structures whenever possible and appropriate allowed Millennium to meet aggressive DSRIP timelines and deadlines, especially in DY0 and DY1. As the PPS matures, it has replaced some of these "borrowed" resources with its own (e.g., by hiring dedicated legal counsel and a Compliance Officer).

Hire competent, diverse staff:

Complementing the resources available through its partners is Millennium's spirited startup culture—rich in energy, creativity, and resourcefulness. This is driven by the PPS's rapidly expanding roster of culturally diverse staff (now over 35 full-time equivalents), each with extensive experience and subject matter expertise. Millennium's employees hail from all corners of the local healthcare landscape, including community-based organizations (CBOs), healthcare networks, hospitals, payers, all manner of clinical environments, and technology firms. The staff includes several nurses and physicians who lend the organization credibility and focused knowledge.

Millennium makes the most of its staff's talents by fostering a collaborative, cooperative environment. There is a strong emphasis on openness and communication; this is further supported through technical tools that facilitate teamwork (e.g., Skype for Business, SharePoint).

Engage the community:

Community engagement is in Millennium's "DNA." The organization was created when diverse local interests came together to form a new entity. It's not always easy or natural for these organizations to work together—some are direct competitors, while others are so different from each other that they have barely any common ground. Millennium strives to be the neutral space and common ground in which the community can work together to visualize and initiate sweeping changes.

CBOs have been involved with the PPS from the start. Their role is critical to DSRIP success, as many of the services they provide will fill gaps left as healthcare utilization shifts. CBOs also serve as an essential "bridge" to the community and direct connection to the Medicaid beneficiaries the PPS serves. CBO representatives and consumers are represented on several governance committees, so the community always has a voice in determining the PPS's direction.

Use technology strategically:

Millennium developed a comprehensive IT roadmap which identifies the tools needed to support successful implementation of the projects and workstreams. These tools are at varying stages of design, development, testing, and production.

Collaborate with other PPSs:

An early mantra of DSRIP was "Collaborate, collaborate, collaborate." Millennium takes this instruction to heart in its approach to working with other PPSs, particularly the two bordering PPSs: Community Partners of Western New York (CPWNY, led by Catholic Medical Partners/Sisters Hospital) and Finger Lakes PPS (FLPPS). Every opportunity to coordinate with other PPSs is beneficial.

Implement pilot programs:

A common trait across Millennium staff is a willingness and ability to initiate projects "from scratch." One effort after another was launched on a 'pilot' basis, typically on a smaller scale and with a rapidly evolving approach. These pilots quickly generate lessons learned and suggest course corrections that can be implemented immediately in current efforts and documented to inform larger, future rollouts.

Project Management

The internal project management function is organized into five core teams representing Millennium's partner base: Ambulatory Services, Behavioral Health, Community Engagement, Post-Acute Care, and Acute Care.

This structure has helped create more holistic solutions, rather than a siloed project-by-project approach, implemented through the relevant settings of care. The following is a partial list of each team's accomplishments to date:

Ambulatory Services:

- Current state interoperability assessment of primary care and alternate care settings has been conducted
- Eight of Millennium's 23 safety net primary care practices are 2014 Patient Centered Medical Home (PCMH) recognized; remaining practices are working toward this recognition
- Millennium safety net providers are actively engaged and supportive in implementing cardiovascular disease (CVD) management, maternal/child health, and behavioral health integration programs

Behavioral Health:

- Three behavioral health organizations are currently engaged with Model 2 primary care integration, with another three in process
- Work with primary care practices includes behavioral health and substance abuse integration as integral to their practice transformation activities
- Millennium is sponsoring an ongoing series of "Community Conversations" to openly discuss and plan strategies for addressing the sharp increase in opiate usage in the region
- In partnership with CPWNY, Millennium co-sponsored a mental health awareness program/event (May 2016)
- CPWNY, Millennium, and partner organizations are working together on the Mental, Emotional, and Behavioral (MEB) Well-Being project (4ai); topics include nutrition, stigmas around mental health, and overall wellness

Community Engagement:

- In partnership with the Greater Buffalo United Ministries (GRUM, a network of 58 churches) and University at Buffalo School of Nursing, Millennium sponsored four community-based blood pressure screening events with another two scheduled in the near future
- Millennium is providing 78 community health workers/navigators to the community
- Maternal/child health services are being delivered via value-based payment (VBP) arrangements which include risk for achievement of both process and outcome measures
- Millennium and its CBO partners completed 14,800 Patient Activation Measures (PAM) surveys; 23% over the DY1 goal of 12,000

Post-Acute Care:

- INTERACT staff trainings have been completed at 46 of 55 SNFs and four of seven home health agencies

Acute Care:

- ED Care Triage has been implemented at four hospitals and work is underway at three others
- 12 health navigators have been trained

The project management team follows standard project management principles and best practices. Charters were initially developed for every project, and community members were identified as

project champions supporting the healthcare changes in the community. Weekly stand-up meetings are held with the entire team to promote collaboration across projects and workstreams. Bi-weekly operations meetings are held by the Project Management Office (PMO) to bring the project management team, workstream owners, and information technology (IT) staff together to communicate upcoming DSRIP changes, reporting enhancements, or introduce new tools to support the project (e.g., SharePoint, learning management system, etc.).

Project managers review lessons learned periodically throughout the project management lifecycle to incorporate what's working well and refine what's not working. The PAM project uses a lessons learned/best practice approach when they have their quarterly PAM "Huddle" with the community-based organizations (CBOs) responsible for the PAM surveys.

Millennium PMO staff and leadership meet with their CPWNY counterparts on a regular basis to explore opportunities for collaboration, discuss network/provider communications, and share best practices.

Community Engagement

Community engagement is not a separate effort—it underlies everything the PPS does. The overarching goal is "empowerment"—enabling communities to increase control over their lives. Millennium will continue to offer tools and resources while building relationships to allow the community the knowledge to act within its own interest. Millennium's role and that of partnering stakeholders will require "all hands on deck" and "boots on the ground" as long-term commitments are sustained beyond the five years identified for DSRIP. These partners and relationships will be essential to sustainability.

Millennium's Community Engagement Team is tasked with identifying and assessing PPS projects that require community engagement. The team works with the CBO Task Force to prioritize and schedule proposed events to address project milestones and community needs across WNY. This team works with FLPPS and CPWNY whenever possible to coordinate events and messaging.

A sample of some of Millennium's outreach activities follows:

- Every week, the Millennium *Health Matters* radio show is broadcast on WUFO radio. This inspiring and educational program, hosted by Rita Hubbard-Robinson, provides information about DSRIP efforts, PPS activities, and wellness. Millennium staff, community leaders, and clinical experts are frequent guests. This show has been running since June 2015 and reaches more than 125,000 listeners in Western New York, Monroe County, and Southern Ontario via radio, social media, and online streaming.

- Buffalo's National Public Radio affiliate station (WBFO 88.7 FM) interviewed Priti Bangia, Millennium's population health manager, to learn more about Millennium's efforts to prevent and treat the major health problems confronting our region.

- Al Hammonds, Millennium Executive Director, and the Rev. George F. Nicholas, Pastor of Lincoln Memorial United Methodist Church, appeared on *AM Buffalo,* a daily television program, for a recent segment on the current Million Hearts collaboration with the UB School of Nursing and Greater Buffalo United Ministries.

- Millennium coordinated with FLPPS and Lake Plains Community Care Network to co-host a "Voice of the Consumer" meeting at Lake Plains' office located in Batavia. Prior to the meeting, representatives from FLPPS and Millennium spoke to WBTA radio morning show host Jerry Warner about ongoing collaboration between FLPPS and Millennium and DSRIP improvement efforts.

- Dr. Anthony Billittier, UBMD/ECMC emergency physician and Millennium Chief Medical Officer, appeared on WUTV FOX Channel 29 to discuss the importance of having access to HEALTHeLINK in a hospital emergency department.

- Millennium began a community engagement partnership in 2015 with Greater Buffalo United Ministries (GRUM, a network of 58 churches), and the University at Buffalo School of Nursing to carry out the Million Hearts initiative (project 3bi). The objective of this national program is to prevent 1 million heart attacks and strokes by 2017. Million Hearts events offer blood pressure screenings; nutrition education; and either a connection to health insurance for the uninsured, a connection to a primary care doctor where one does not exist, and/or assistance scheduling an appointment when a primary care doctor has not been seen in two years.

- A media campaign and outreach efforts are underway in collaboration with CPWNY as part of the MEB Well-Being project (4ai). This project, which is shared by both PPSs, is an excellent demonstration of productive and mutually-beneficial collaboration. Millennium contracted with CPWNY to provide project management and oversight for all program activities.

- Collaborative work with FLPPS, CPWNY, P^2 Collaborative of Western New York, and HEALTHeLINK is ongoing.

The following is a partial list of community stakeholders with whom Millennium is establishing (or has established) partnerships:

- Law enforcement (partnership with community police officers)
- Housing providers (e.g., Buffalo and Niagara Falls Municipal Housing Authority)
- The WNY Homeless Alliance
- From the eight counties in Western New York:
    - Mental health departments
    - Departments of health
    - Departments of social services

Millennium COLLABORATIVE CARE
Igniting Healthcare Change in WNY

Millennium's recently redesigned logo and new marketing materials emphasize the PPS's emphasis on community engagement. A new tagline, "Igniting healthcare change in the community," reflects Millennium's role—as a catalyst for the changes that will improve healthcare delivery.

Governance

In mid-2014, six proposed PPSs in Western New York were consolidated into one. The governance of the resulting PPS was made up of representatives from each of those groups. This evolved into the PPS's 18-member community-based Board of Managers, which first met in March 2015. Two-thirds of the Board seats are ex officio seats that resulted from the six PPSs becoming one. The remaining third of the seats are appointed by other governance committees. The Project Advisory Committee (PAC) was formed during the application process, as required. In Fall 2015, the PPS undertook a concerted effort to put a formal governance structure into place.

A Governance Committee was formed to oversee development of the infrastructure required to meet Governance milestones. Millennium's governance practices address transparency, independence, accountability, fiduciary responsibilities, and management oversight. The Governance Committee is responsible for informing the Board of Managers of current best practices in PPS governance. The Governance Committee is also responsible for ongoing review of the PPS governance structure, including recommending modifications to the governance structure to best meet DSRIP goals.

Other committees that had been planned in the application began taking shape (e.g., "Voice of the Consumer," Finance, Physician Steering, Clinical Quality, IT Data, Workforce, and CBO Task Force). Legal counsel and the Governance Committee drafted the PPS Governance Agreement (bylaws).

The work products of these efforts included a defined governance structure, broad committee policies, committee charters and rosters, and the final Governance Agreement. These products were approved by the Board of Managers, and before the end of the year, the PPS had effectively brought to life the governance structure envisioned in its application. The Millennium Board of Managers meets monthly, and the subcommittees meet either monthly or quarterly. These committees are populated with community members representing diverse interests, settings of care, and geographic areas. The community is engaged and involved in the governance of the PPS.

SharePoint was implemented as a secure and effective way to communicate and share committee documents and dashboards. Committee members log in to the Governance portal within Millennium's SharePoint site to review meeting materials, calendars, and announcements.

The committees continued to meet throughout 2015 and into 2016, and as they grew into their respective roles it eventually became clear that the governance structure was top-heavy in comparison to the structure of the PPS itself. There were too many committees all at the same 'level' and all reporting to the Board of Managers monthly (or as frequently as they met). The Board requested more succinct, actionable updates. In addition, policies and charters were not consistent across committees.

The Governance Committee was charged with proposing a new governance structure that would do two things: reduce or combine committee functions where possible, and for the committees that remained, enforce consistent policies and procedures. As of summer 2016, this effort is underway. A new proposed structure has been drafted, committee policies have been proposed, and standard

charter language is being developed. The PPS expects to have the new governance structure in place, including revised charters and Governance Agreement, by the end of 2016.

Compliance

In keeping with its strategy of leveraging existing resources, Millennium initially relied on the expertise and structure of the lead entity's (ECMC's) Compliance Office to meet compliance-related milestones. This enabled Millennium to establish a compliance hotline, draft a Compliance Plan and policies, and create a Conflict of Interest form very quickly. ECMC Compliance Officer Nadine Mund initiated the efforts until Millennium hired its own Compliance Officer, Laura Fleming.

From the beginning, Nadine and Laura worked closely with compliance officers from other PPSs across the state to compare notes, ask questions, and identify issues and best practices. This collaboration is particularly crucial since PPS governance and compliance exists in relatively uncharted territory. The rules that apply to hospitals and other healthcare organizations—which compliance officers are extremely knowledgeable about—don't all apply to PPSs in the same way. The compliance group also investigates topics like data security and legal structures.

Millennium's Compliance Plan has been provided to all partners who signed a Master Participation Agreement (MPA) in DY1. Training is offered for organizations that do not already have a compliance program in place or who need additional support. For organizations that are required to have OMIG-certified plans in place, we collected certification documentation with the MPA.

Going forward, the compliance function will continue to be overseen by Laura Fleming, and a Compliance Committee will be established (the existing Governance Committee will be converted to a Compliance Committee and new members will be added).

IT Systems and Tools

Like community engagement, IT is part of Millennium's foundation. As a new organization launched under the ECMC organizational umbrella, Millennium adopted a successful hybrid strategy to leverage existing ECMC technologies when available and select enterprise applications as needed to support its enterprise technology and information needs. Millennium's IT roadmap identifies the tools the PPS would need, and key among these tools is a population health management system. Following a thorough due diligence process (in coordination with Kaleida and ECMC), Millennium selected Cerner's "HealtheIntent" solution. Recently Millennium's IT staff worked with Cerner to complete a subset of security control workbooks in order to issue an affidavit regarding their compliance. The solution is currently in the design/build phase and is expected to be operational by the end of 2016.

Millennium implemented another tool, Salesforce, to support the ED Care Triage project (2biii). This tool has been expanded and refined from its original state and is currently in use at several partner hospitals. In addition, Salesforce is being developed and deployed as a partner management database and (in conjunction with SharePoint) to support reporting and MPA tracking.

SharePoint is currently being used for a variety of functions. It is used on a daily basis to manage shared calendars (integrated with Outlook), and on a weekly basis by all employees to report their status to their managers. Millennium successfully designed and deployed an enterprise report

repository in SharePoint. It is also being used to support data collection and preparation for quarterly submissions via MAPP.

The following is a partial list of additional IT-related accomplishments to date:

- Developed and expanded the IT Data Committee as our governance organization on technology, reporting, and analytics matters
- Developed and implementing a hybrid data strategy and interoperability plan that partners with HEALTHeLINK to capture continuity-of-care documents (CCDs) from patient visits to physician practices while capturing all clinical data available from three of our leading hospitals

Workforce Development

Rural-Area Health Education Centers (R-AHEC) was selected as Millennium's workforce vendor. Millennium staff worked closely with R-AHEC initially to develop the Workforce implementation plan and then to complete Workforce Development milestones. In addition, Millennium collaborates extensively with CPWNY to prevent duplication of efforts across the PPSs and to present a consistent message to partners. CPWNY also contracted with R-AHEC, and both PPSs aligned their milestone timelines and plans.

Initially, workforce development efforts were led by Juan Santiago, who is now the PPS Administrative Director. When Human Resources Director Jan Brown was hired, these duties were transferred to her. With R-AHEC's support, Millennium established a Workforce Development Work Group with 18–25 members which meets monthly. Millennium is unique in that it has five different bargaining units, which all hold seats on the Workforce Development Work Group:

- SEIU
- CSEA
- NYSNA
- CWA
- AFSCME

Many workforce efforts to date have centered around assessing the current state, identifying a future state, and developing a training strategy. Initial development of the PPS's overall training strategy began in Fall 2015.In April 2016, the Workforce Development Work Group established a Training Strategy Subcommittee (currently with eight members and expanding) to continue developing and finalizing the strategy.
A compensation and benefit survey was coordinated and disseminated to 124 facilities (return rate 68.5%). R-AHEC aggregated the data, aged it for three months, and then created the accompanying report. A current workforce survey was also developed and disseminated to 125 facilities (return rate 74.4%). Five informational webinars were offered to support organizations in completing both the current workforce survey and the compensation and benefit survey.

Millennium and R-AHEC researched and then, in March 2016, engaged a web-based workforce data collection platform and learning management system (LMS): HWapps. This tool will be used to collect and store data that will support the workforce transition roadmap, impact report, and budget report. It will also provide a career center/portal for partners to post positions, view and manage applications, and post and manage resumes. The LMS functionality will enable Millennium to offer

all types of training to participants across its network, to track participation in training, and to collect course evaluation information to drive improvements.

The following is a partial list of additional workforce-related accomplishments to date:

- Finalized a baseline staff impact report based on organizational assessments and project manager interviews
- Conducted 65 face-to-face organizational assessments with partnering facilities
- Led three informational teleconferences regarding the workforce spending data collection
- Produced a baseline target workforce state report in May 2016
- Researched emerging job titles, shortages, training sites, educational/training programs, certification requirements, and licensures; created database which is updated monthly

Value Based Payments (VBP)

New York State has committed to achieving the goal of having 90% of all Medicaid payments in a value-based arrangement by the end of the waiver period. Millennium management, along with its Finance Committee, VBP Subcommittee, and related workgroups, have undertaken this effort and begun the strategic planning process to achieve the goals set forth by the state. We have significant initiatives underway related to VBP including strategies addressing communications, education, payment models, partner readiness, and managed care organizations (MCOs).

VBP Subcommittee:

The VBP Subcommittee, in addition to the Finance Committee, has been charged with leading the formulation of a multi-year VBP transition plan. This charge includes the responsibility for developing a comprehensive description of the roles, responsibilities, and functions of the VBP Subcommittee, including education of partners, establishment and maintenance of working relationships with Medicaid MCOs, selection of external consultants to assist the subcommittee, development of a multi-year strategic plan to meet the VBP contracting goal, determination of bi-directional data sharing needs between Millennium and MCOs, and formulation of a process for tracking performance against guideposts in plan. This subcommittee includes representatives with a wide range of finance, legal, medical, and other experience. Additional assistance from consultants may also be leveraged.

The VBP Subcommittee was formed in late 2015. The subcommittee has a possible membership of 20, allowing Finance Committee members who do not hold official seats on the subcommittee to receive all meeting materials and attend all meetings. Subcommittee membership has also spread across regions and organization type. The subcommittee meets no less than monthly.
In order to manage the significant responsibilities to related to VBP and facilitate completion of tasks and deliverables, four workgroups within the subcommittee were formed. Every subcommittee member is required to sit on a workgroup, and additional members of the PPS community are allowed to join the workgroups without needing to maintain membership in the subcommittee.

VBP Communications:

The Communications Workgroup has been created to develop the communication plan to inform PPS partners of VBP program and milestone requirements. This would include identifying what communication tools suit various partners best, the frequency of the communications, and the

content. To date, the workgroup has identified its communications content and priorities, vehicles and strategies for such communications, and released its first communications to the PPS network.

VBP Education:

The Education Workgroup has been created to develop easy-to-understand educational tools for explaining NYS DOH's VBP goals, summarizing the VBP roadmap, explaining the various types and levels of VBP contract approaches, describing how VBP contracts can drive additional revenues, and facilitating the overall education related to VBP for all PPS partners. To date, the workgroup has developed an initial educational presentation, developed a course catalog for ongoing education, communicated widely to our partners regarding the VBP Bootcamp sessions, and requested that partners identify needs or gaps in their own education so the PPS can address those items specifically. Furthermore, the workgroup has defined what it means to be successful in terms of VBP education. Success includes establishing an appropriate level of understanding of VBP for all stakeholders, educating partners to help them prepare and plot their VBP path, and providing assistance to help partners and providers understand what they need for VBP.

Value-Based Payment Course Catalog

Title	Date
Suggested for All Stakeholders	
VBP 101	July 8, 2016
Educating the Consumer	September 2016
Reporting	September 2016
Public Health and the Social Determinants of Health	October 2016
Understanding Types of VBP	October 2016
Suggested for Organizations Intending to Participate in a VBP Program	
A Deep Dive into Risk: Are You Ready?	TBD
MCO Contracting and Penalties	TBD
Attribution/Target Budget	TBD
Understanding Total Cost of Care	TBD
For Targeted Audiences	
Implications of VBP for CBOs	TBD
VBP Impact on Organizations Serving _____	TBD
The MRDD Population	TBD

Millennium's Value-Based Payment course catalog, offered to partner organizations

Payment Models/Partner Readiness:

The Payment Models/Partner Readiness Workgroup has been created to design the plan to assess readiness of providers and partners in the PPS network to engage in various levels of VBP contracting, formulate and execute the assessment of readiness and assist partners in interpreting results, determine VBP options available to providers, assess the progressive complexity of risk in the VBP models, and develop a transition plan for each provider. To date, the workgroup has

examined various aspects to determine if an organization is "ready" to participate in a VBP, and through such examinations, developed a readiness assessment which was released to a large group of partners. Once the assessments are completed, the PPS will deliver individualized and aggregate results to partners, and meet individually to review the interpretation of such results. Aggregate results will be utilized to assess and provide detailed baselines of revenue linked to VBP, identify preferred compensation modalities, and inform the MCO strategy.

MCO Strategy:

The MCO Strategy Workgroup has been created to develop a formal structure to work with MCOs on the VBP program, a written MCO strategy, principles to achieve 90% of payments in a VBP arrangement by the end of year 5, and an overall transition plan for VBP. To date, the workgroup has analyzed state's most up-to-date VBP roadmap and other related materials to determine all elements that need to be included in MCO strategy for transforming to a VBP system; worked in concert with Millennium management and the MCOs to discuss the VBP transition; shared goals, obstacles, and a plan to move forward; and developed a set of guiding principles related to MCO strategy for the PPS network.

Challenges:

The PPS has identified significant obstacles that may impede the transition to VBP, including, but not limited to:

- Healthcare IT capabilities of both providers and MCOs
- Availability of systems to monitor providers' VBP performance
- Shortage of experience in VBP contracting by both providers and MCOs
- Lack of the ability to administer certain programs by the MCOs
- Absence of authority for the PPS to enforce compliance with DOH timelines for VBP transition
- Lack of clarification in the PPS' role to facilitate VBP
- Reluctance of Fidelis (MCO) to participate in DSRIP/VBP discussions

The PPS will be working, through various initiatives and acquisition of resources, on reducing such obstacles to ensure compliance with DOH requirements and successful completion of required deliverables.

Clinical Integration

Clinical integration refers to the coordination of care across a continuum of services including preventive; outpatient; inpatient acute hospital care; post-acute including skilled nursing, rehabilitation, home health services, and palliative care; and community-based services to improve the value of the care provided.

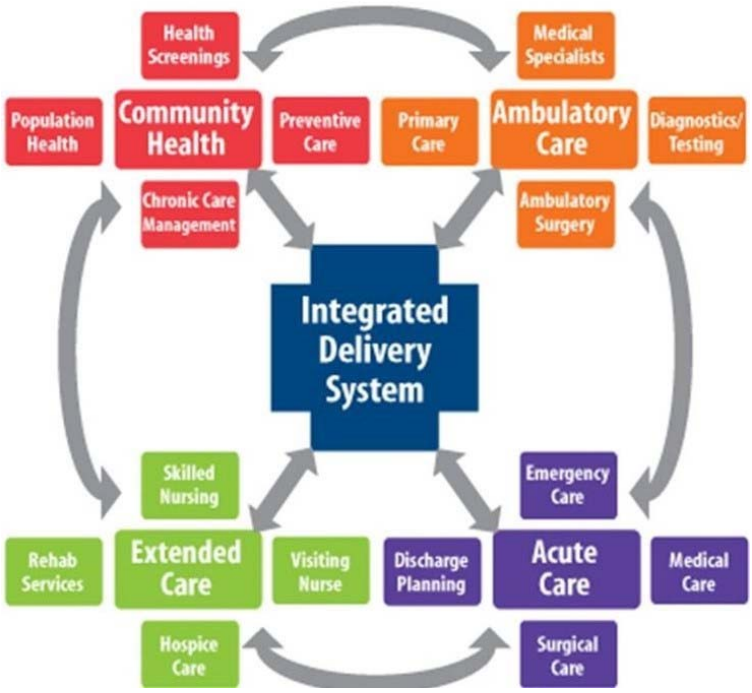
In a clinically integrated network, the participating providers share clinical and financial information to encourage improved coordination of care and adherence to evidence-based care protocols.

Clinically integrated networks are able to negotiate with payers to reward incentives for shifting from payment for the volume of services to rewarding better quality outcomes, improved patient access to needed services, and improved efficient use of healthcare resources.
Clinical integration also maintains a focus on quality, value, and population health management.

Millennium and its partners are making great strides in developing a clinically integrated network. Over the past year focus has been on the following foundational steps toward clinical integration:

- Providing support for achievement of PCMH and Meaningful Use
- Developing a "warm hand-off" process among partners
- Establishing an IT/data sharing interoperability infrastructure (and the legal/contractual structures required to do so)
- Building a care transitions and care coordination strategy across settings
- Implementing clinical integration training across settings regarding tools and communications that support care coordination
- Facilitating an organization that will support VBP arrangements

As Millennium's clinically integrated network continues to develop and grow, more robust data sharing and analytics will be built with Millennium's partners. The ultimate success of clinical integration is an infrastructure that supports continuous evaluation of metrics and performance which are necessary to modify clinical protocols or guidelines and foster collaboration among providers.



Clinical integration requires coordination across the healthcare landscape

Practitioner Engagement

Practitioner engagement and communication is another area where cross-PPS coordination is important. To that end, Millennium and CPWNY leadership meet frequently to discuss communication and activities that will be geared towards practices. The PPSs hope to provide a consistent message and experience across the region, while also sharing information and avoiding duplication of efforts.

For DY1, Millennium established MPAs with 47 partner organizations, focused primarily on engagement and implementation. The MPAs for DY2 rely more on measurable outcomes and metrics. To support this, Millennium staff developed comprehensive "Reference Guides" outlining the specific requirements that will accompany MPAs. These detailed guides, customized for different provider types, serve to outline best practices for our partners. The guides (and MPAs) were the result of enterprise-wide collaboration which included project managers, workstream owners, and representation from clinical integration, legal, finance, and IT. Excerpts from two of Millennium's draft Reference Guides are included in Appendix A.

Performance Reporting

To support the extensive quarterly reporting requirements to the state, Millennium established and has gradually refined internal reporting procedures. These procedures include frequent communication with and instructions/training for project managers and workstream owners. As the organization gains more experience with the process, more of these procedures are being automated. For example, a SharePoint site was set up based on the Medicaid Analytics Performance Portal (MAPP), so updates could be collected internally in the same format that they are provided to the state. This site is continually being expanded and improved. Automated workflows and alerts are currently being developed and tested.

To collect quarterly patient engagement data from its partners, Millennium leveraged a tool used by ECMC, WatchDox. This web-based application allows participating organizations (with appropriate BAAs in place) to securely transfer files to the PPS. These files are stored on Millennium's secure PHI server. Millennium then established a patient engagement database to perform data reconciliation, de-duplication, and validation of patient engagement data. This data is also harnessed to improve data quality, assist efforts at patient-level analysis across projects, and reconcile overlaps with other PPSs per NYS guidance.

Millennium successfully completed the required security workbooks and implemented controls to secure access to PHI data sets securely from the DOH and receive patient-level claims and attributed patient roster.

Based on information from MAPP, Millennium is delivering regular volume metric reports and geographic visualizations to the Clinical Quality Committee that provide insights on patient activity in each of our care settings.

Challenges:
Successful performance reporting initiatives depend on both partner engagement and available data. Our primary data sources have been MAPP and aggregated data available via Salient Interactive Miner (SIM), which have a latency of one to two years for performance measure results. We recently received identified Medicaid claims data that is also one to two years old. More recent SIM data does not offer a patient-level dimension that would allow us to aggregate measure data in-house at a pace appropriate to rapid cycle evaluation.

Cultural Competency and Health Literacy

Erie Niagara Area Health Education Centers (EN-AHEC) was selected as Millennium's cultural competency and health literacy vendor. Millennium staff worked closely with EN-AHEC initially to

develop the Cultural Competency and Health Literacy implementation plan and then to complete the related milestones.

Millennium established a Cultural Competency and Health Literacy Workgroup and identified a workstream champion: Al Dirschberger, PhD, Commissioner of Erie County Department of Social Services. With their support, and the support of EN-AHEC, Millennium prepared a strategic plan to assist in the integration of knowledge, attitudes, and skills reflective of a culturally competent organization in order to help ensure that everyone receives equitable and effective healthcare services. The proposed Cultural Competency and Health Literacy Strategy was reviewed by the Clinical Quality Committee, CBO Task Force, "Voice of the Consumer" Sub-Committee, and Board of Managers, and the final version was submitted to the state.

Meanwhile, the CBO Task Force and "Voice of the Consumer" Sub-Committee each established review workgroups. These groups are working to develop consumer-facing educational and informational materials which will be tested at a few community practices to gauge effectiveness, then revised and distributed more widely. The first of these, a brochure designed to help Medicaid beneficiaries understand when to use emergency and primary care services, is currently in production. A draft of this brochure is included in Appendix B.

Millennium's work with other PPSs includes attendance at and participation in the statewide cultural competency and health literacy symposia in Syracuse and Rochester. In addition, Millennium is working closely with CPWNY and FLPPS to develop solutions to reduce disparities and ensure a consistent approach to addressing regional gaps in cultural competency and health literacy. Together, CPWNY and Millennium issued a Culturally Linguistically Appropriate Services (CLAS) survey to 214 regional organizations (return rate 30%). Millennium and CPWNY has also included CBOs and P^2 Collaborative of WNY in these efforts.

Millennium is tasked with assessing and improving the level of cultural competency and health literacy across its network. To that end, project leads and staff identified cultural competency and health literacy training needs across the 11 projects and workstreams. A Cultural Competency and Health Literacy Training Plan was developed, including several modules and an evaluation. The training plan focuses on addressing drivers of health disparities and providing culturally respectful services—within a culturally safe work environment and with a culturally competent staff. The proposed Cultural Competency and Health Literacy Training Strategy was presented to the CBO Task Force, "Voice of the Consumer" Sub-Committee, and Board of Managers, and the final version was submitted to the state.

Training was already ongoing while the plan was being developed. Millennium has provided cultural competency and health literacy training to its staff and Board of Directors. In addition, training sessions have been provided for SNAPCAP members (at its quarterly meeting) and the UB School of Nursing (as part of the Million Hearts initiative). Five sites representing the three sub-regions of Western New York have been identified to take part in cultural competency and health literacy "pilot" training. Millennium's web-based LMS, HWapps, is being used initially for cultural competency and health literacy training, as the curricula and materials have already been developed and loaded.

NEW YORK STATE | Department of Health

Appendix A.

Excerpts from the Skilled Nursing Facility Provider Manual:

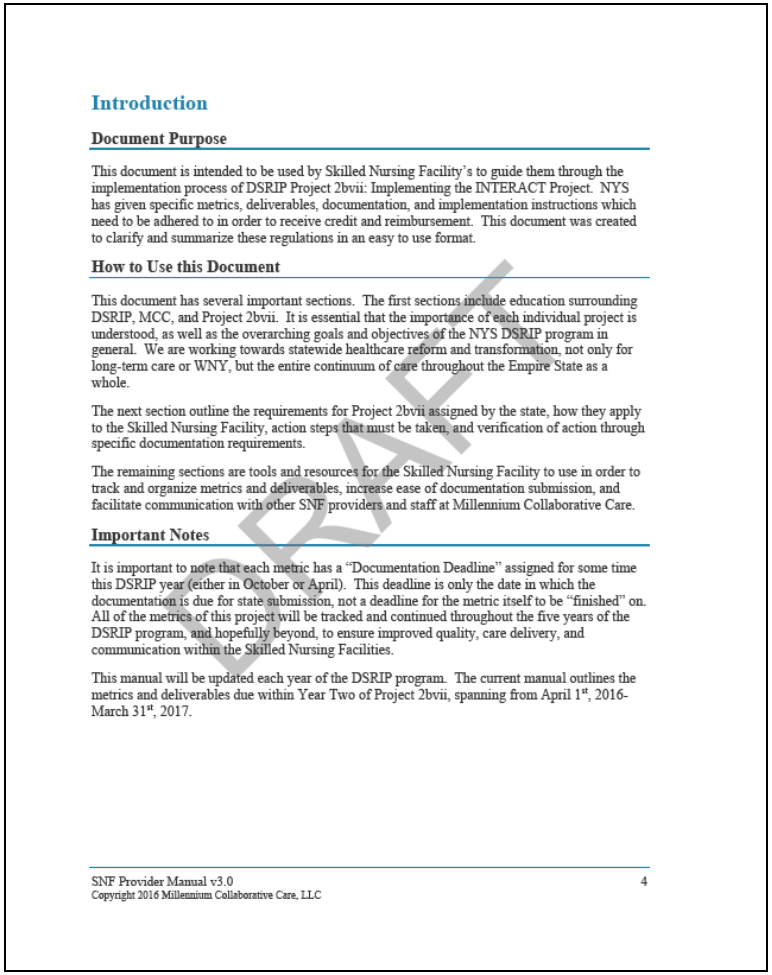
MILLENNIUM COLLABORATIVE CARE

Skilled Nursing Facility Provider Manual

Delivery System Reform Incentive Payment Program

Year Two: 4/1/16-3/31/17

Millennium Collaborative Care, PPS
462 Grider Street
Buffalo, New York 14215
www.millenniumcc.org



Introduction

Document Purpose

This document is intended to be used by Skilled Nursing Facility's to guide them through the implementation process of DSRIP Project 2bvii: Implementing the INTERACT Project. NYS has given specific metrics, deliverables, documentation, and implementation instructions which need to be adhered to in order to receive credit and reimbursement. This document was created to clarify and summarize these regulations in an easy to use format.

How to Use this Document

This document has several important sections. The first sections include education surrounding DSRIP, MCC, and Project 2bvii. It is essential that the importance of each individual project is understood, as well as the overarching goals and objectives of the NYS DSRIP program in general. We are working towards statewide healthcare reform and transformation, not only for long-term care or WNY, but the entire continuum of care throughout the Empire State as a whole.

The next section outline the requirements for Project 2bvii assigned by the state, how they apply to the Skilled Nursing Facility, action steps that must be taken, and verification of action through specific documentation requirements.

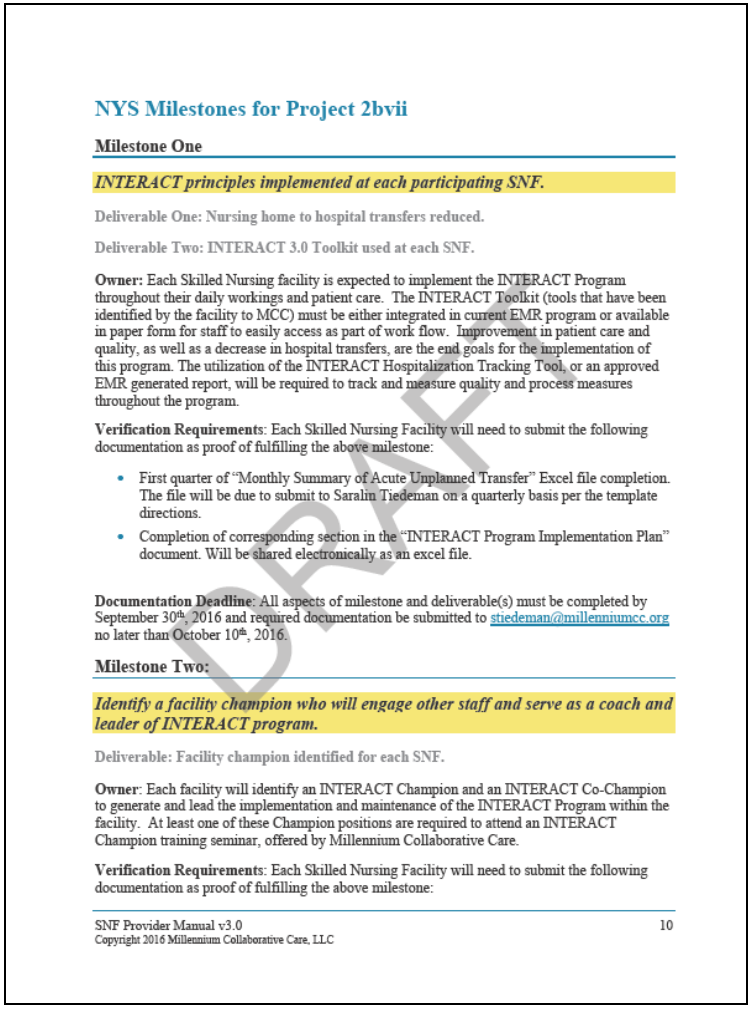
The remaining sections are tools and resources for the Skilled Nursing Facility to use in order to track and organize metrics and deliverables, increase ease of documentation submission, and facilitate communication with other SNF providers and staff at Millennium Collaborative Care.

Important Notes

It is important to note that each metric has a "Documentation Deadline" assigned for some time this DSRIP year (either in October or April). This deadline is only the date in which the documentation is due for state submission, not a deadline for the metric itself to be "finished" on. All of the metrics of this project will be tracked and continued throughout the five years of the DSRIP program, and hopefully beyond, to ensure improved quality, care delivery, and communication within the Skilled Nursing Facilities.

This manual will be updated each year of the DSRIP program. The current manual outlines the metrics and deliverables due within Year Two of Project 2bvii, spanning from April 1st, 2016-March 31st, 2017.

Excerpts from the Skilled Nursing Facility Provider Manual, continued:



NYS Milestones for Project 2bvii

Milestone One

INTERACT principles implemented at each participating SNF.

Deliverable One: Nursing home to hospital transfers reduced.

Deliverable Two: INTERACT 3.0 Toolkit used at each SNF.

Owner: Each Skilled Nursing facility is expected to implement the INTERACT Program throughout their daily workings and patient care. The INTERACT Toolkit (tools that have been identified by the facility to MCC) must be either integrated in current EMR program or available in paper form for staff to easily access as part of work flow. Improvement in patient care and quality, as well as a decrease in hospital transfers, are the end goals for the implementation of this program. The utilization of the INTERACT Hospitalization Tracking Tool, or an approved EMR generated report, will be required to track and measure quality and process measures throughout the program.

Verification Requirements: Each Skilled Nursing Facility will need to submit the following documentation as proof of fulfilling the above milestone:

- First quarter of "Monthly Summary of Acute Unplanned Transfer" Excel file completion. The file will be due to submit to Saralin Tiedeman on a quarterly basis per the template directions.
- Completion of corresponding section in the "INTERACT Program Implementation Plan" document. Will be shared electronically as an excel file.

Documentation Deadline: All aspects of milestone and deliverable(s) must be completed by September 30th, 2016 and required documentation be submitted to stiedeman@millenniumcc.org no later than October 10th, 2016.

Milestone Two:

Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.

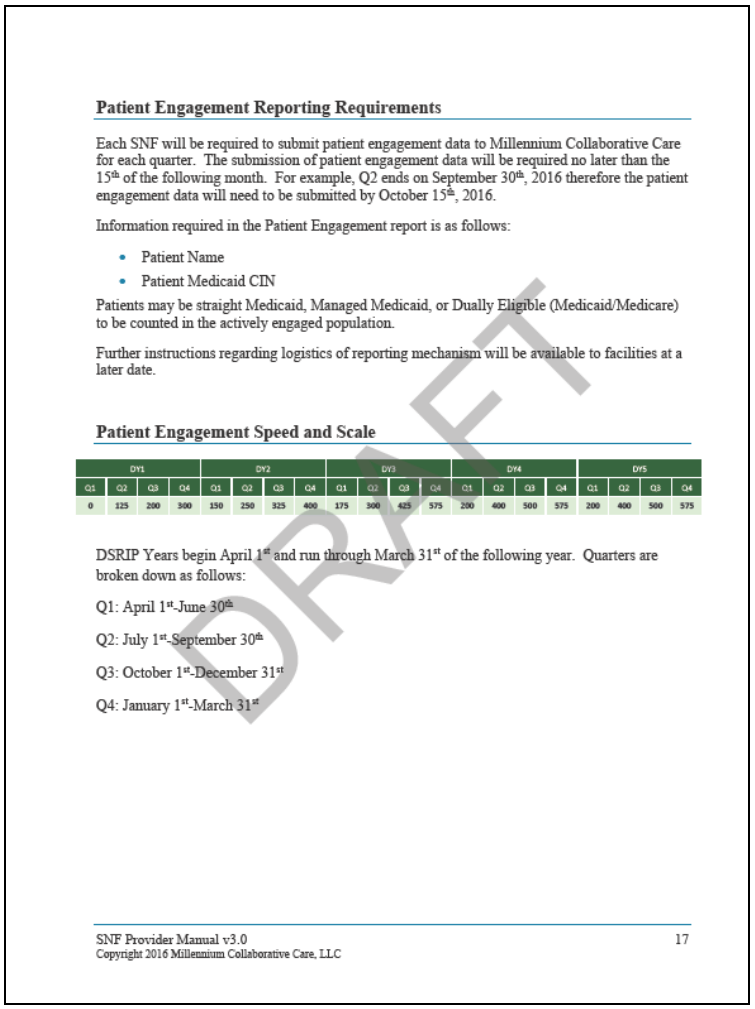
Deliverable: Facility champion identified for each SNF.

Owner: Each facility will identify an INTERACT Champion and an INTERACT Co-Champion to generate and lead the implementation and maintenance of the INTERACT Program within the facility. At least one of these Champion positions are required to attend an INTERACT Champion training seminar, offered by Millennium Collaborative Care.

Verification Requirements: Each Skilled Nursing Facility will need to submit the following documentation as proof of fulfilling the above milestone:

SNF Provider Manual v3.0 10
Copyright 2016 Millennium Collaborative Care, LLC

DRAFT



Patient Engagement Reporting Requirements

Each SNF will be required to submit patient engagement data to Millennium Collaborative Care for each quarter. The submission of patient engagement data will be required no later than the 15th of the following month. For example, Q2 ends on September 30th, 2016 therefore the patient engagement data will need to be submitted by October 15th, 2016.

Information required in the Patient Engagement report is as follows:

- Patient Name
- Patient Medicaid CIN

Patients may be straight Medicaid, Managed Medicaid, or Dually Eligible (Medicaid/Medicare) to be counted in the actively engaged population.

Further instructions regarding logistics of reporting mechanism will be available to facilities at a later date.

Patient Engagement Speed and Scale

DY1				DY2				DY3				DY4				DY5			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
0	125	200	300	150	250	325	400	175	300	425	575	200	400	500	575	200	400	500	575

DSRIP Years begin April 1st and run through March 31st of the following year. Quarters are broken down as follows:

Q1: April 1st-June 30th

Q2: July 1st-September 30th

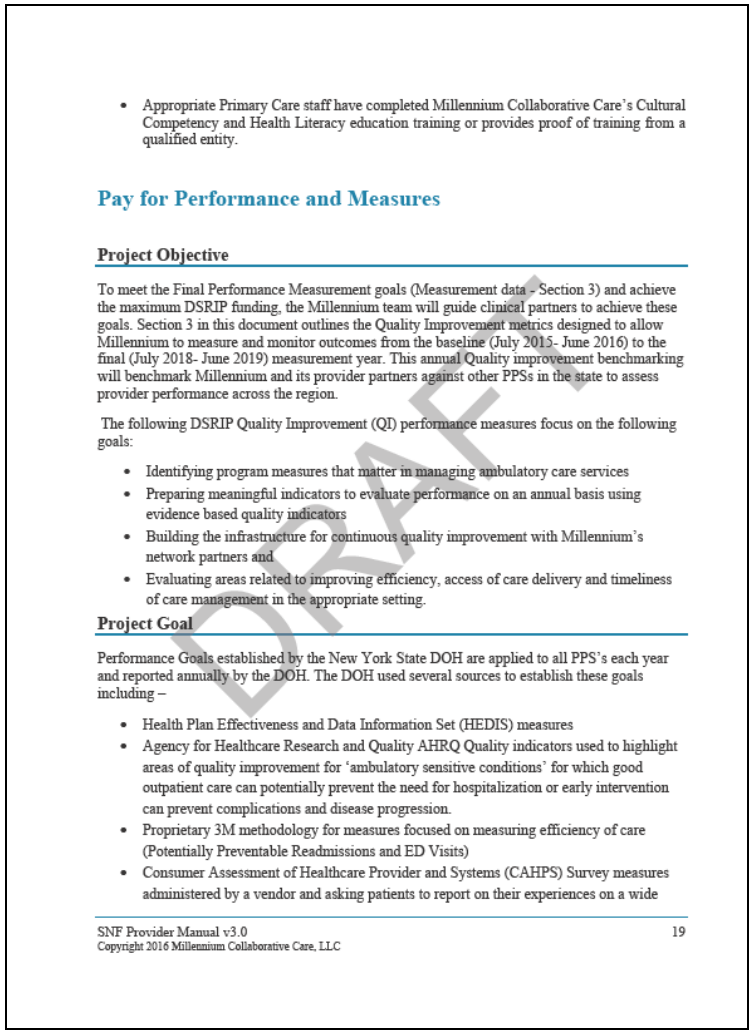
Q3: October 1st-December 31st

Q4: January 1st-March 31st

SNF Provider Manual v3.0 17
Copyright 2016 Millennium Collaborative Care, LLC

DRAFT

Excerpts from the Skilled Nursing Facility Provider Manual, continued:



- Appropriate Primary Care staff have completed Millennium Collaborative Care's Cultural Competency and Health Literacy education training or provides proof of training from a qualified entity.

Pay for Performance and Measures

Project Objective

To meet the Final Performance Measurement goals (Measurement data - Section 3) and achieve the maximum DSRIP funding, the Millennium team will guide clinical partners to achieve these goals. Section 3 in this document outlines the Quality Improvement metrics designed to allow Millennium to measure and monitor outcomes from the baseline (July 2015- June 2016) to the final (July 2018- June 2019) measurement year. This annual Quality improvement benchmarking will benchmark Millennium and its provider partners against other PPSs in the state to assess provider performance across the region.

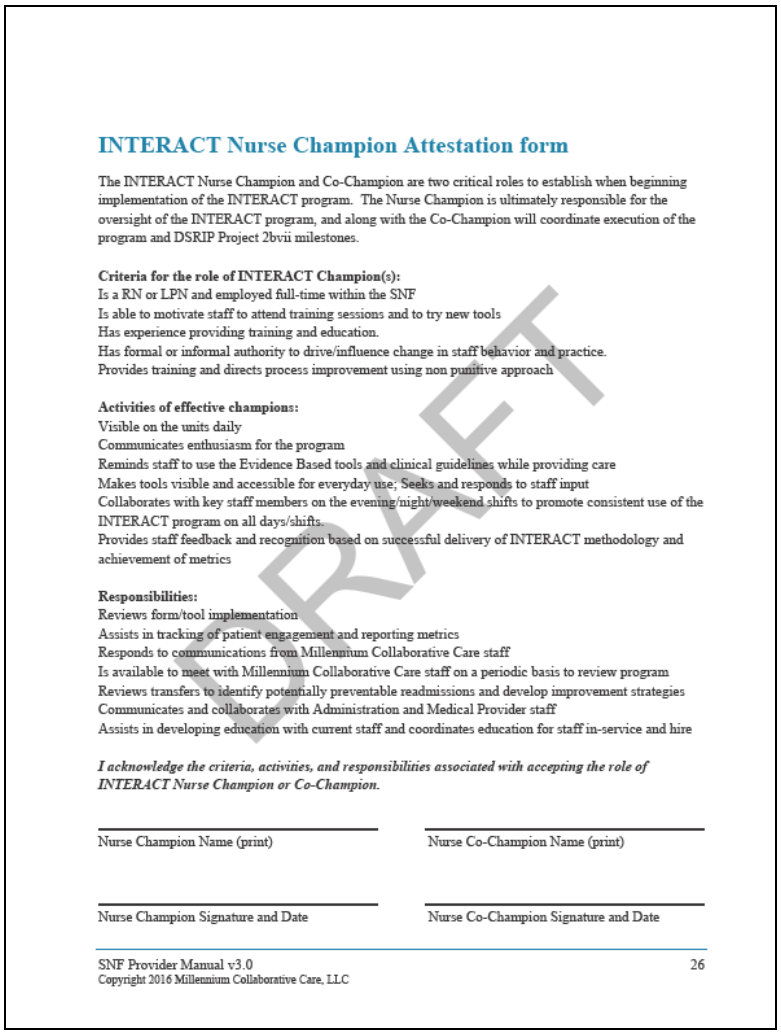
The following DSRIP Quality Improvement (QI) performance measures focus on the following goals:

- Identifying program measures that matter in managing ambulatory care services
- Preparing meaningful indicators to evaluate performance on an annual basis using evidence based quality indicators
- Building the infrastructure for continuous quality improvement with Millennium's network partners and
- Evaluating areas related to improving efficiency, access of care delivery and timeliness of care management in the appropriate setting.

Project Goal

Performance Goals established by the New York State DOH are applied to all PPS's each year and reported annually by the DOH. The DOH used several sources to establish these goals including –

- Health Plan Effectiveness and Data Information Set (HEDIS) measures
- Agency for Healthcare Research and Quality AHRQ Quality indicators used to highlight areas of quality improvement for 'ambulatory sensitive conditions' for which good outpatient care can potentially prevent the need for hospitalization or early intervention can prevent complications and disease progression.
- Proprietary 3M methodology for measures focused on measuring efficiency of care (Potentially Preventable Readmissions and ED Visits)
- Consumer Assessment of Healthcare Provider and Systems (CAHPS) Survey measures administered by a vendor and asking patients to report on their experiences on a wide



INTERACT Nurse Champion Attestation form

The INTERACT Nurse Champion and Co-Champion are two critical roles to establish when beginning implementation of the INTERACT program. The Nurse Champion is ultimately responsible for the oversight of the INTERACT program, and along with the Co-Champion will coordinate execution of the program and DSRIP Project 2bvii milestones.

Criteria for the role of INTERACT Champion(s):
Is a RN or LPN and employed full-time within the SNF
Is able to motivate staff to attend training sessions and to try new tools
Has experience providing training and education.
Has formal or informal authority to drive/influence change in staff behavior and practice.
Provides training and directs process improvement using non punitive approach

Activities of effective champions:
Visible on the units daily
Communicates enthusiasm for the program
Reminds staff to use the Evidence Based tools and clinical guidelines while providing care
Makes tools visible and accessible for everyday use; Seeks and responds to staff input
Collaborates with key staff members on the evening/night/weekend shifts to promote consistent use of the INTERACT program on all days/shifts.
Provides staff feedback and recognition based on successful delivery of INTERACT methodology and achievement of metrics

Responsibilities:
Reviews form/tool implementation
Assists in tracking of patient engagement and reporting metrics
Responds to communications from Millennium Collaborative Care staff
Is available to meet with Millennium Collaborative Care staff on a periodic basis to review program
Reviews transfers to identify potentially preventable readmissions and develop improvement strategies
Communicates and collaborates with Administration and Medical Provider staff
Assists in developing education with current staff and coordinates education for staff in-service and hire

I acknowledge the criteria, activities, and responsibilities associated with accepting the role of INTERACT Nurse Champion or Co-Champion.

Nurse Champion Name (print) | Nurse Co-Champion Name (print)

Nurse Champion Signature and Date | Nurse Co-Champion Signature and Date

Excerpts from the Primary Care Reference Guide:

Millennium
COLLABORATIVE CARE
Igniting Healthcare Change in WNY

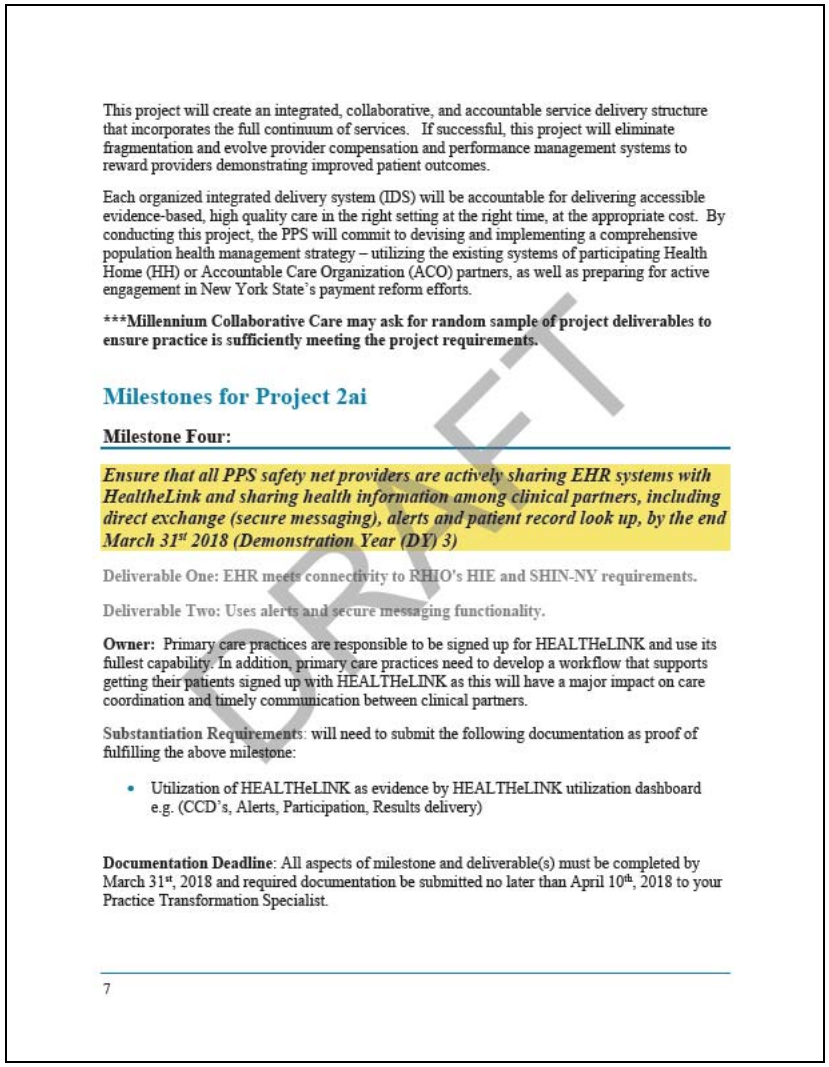
DRAFT

Primary Care Reference Guides

Delivery System Reform Incentive Payment Program

Year Two: 4/1/16-3/31/17

Millennium Collaborative Care, PPS
1461 Kensington Avenue
Buffalo, New York 14215
www.millenniumcc.org



This project will create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services. If successful, this project will eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes.

Each organized integrated delivery system (IDS) will be accountable for delivering accessible evidence-based, high quality care in the right setting at the right time, at the appropriate cost. By conducting this project, the PPS will commit to devising and implementing a comprehensive population health management strategy – utilizing the existing systems of participating Health Home (HH) or Accountable Care Organization (ACO) partners, as well as preparing for active engagement in New York State's payment reform efforts.

*****Millennium Collaborative Care may ask for random sample of project deliverables to ensure practice is sufficiently meeting the project requirements.**

Milestones for Project 2ai

Milestone Four:

Ensure that all PPS safety net providers are actively sharing EHR systems with HealtheLink and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end March 31st 2018 (Demonstration Year (DY) 3)

Deliverable One: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.

Deliverable Two: Uses alerts and secure messaging functionality.

Owner: Primary care practices are responsible to be signed up for HEALTHeLINK and use its fullest capability. In addition, primary care practices need to develop a workflow that supports getting their patients signed up with HEALTHeLINK as this will have a major impact on care coordination and timely communication between clinical partners.

Substantiation Requirements: will need to submit the following documentation as proof of fulfilling the above milestone:

- Utilization of HEALTHeLINK as evidence by HEALTHeLINK utilization dashboard e.g. (CCD's, Alerts, Participation, Results delivery)

Documentation Deadline: All aspects of milestone and deliverable(s) must be completed by March 31st, 2018 and required documentation be submitted no later than April 10th, 2018 to your Practice Transformation Specialist.

7

Excerpts from the Primary Care Reference Guide, continued:

Project 3bi: Implementing the Cardiovascular Disease Management/Million Hearts® Project

Project Objective:

Primary Care Practice partners will implement the evidence-based Million Hearts® program. Million Hearts® is a national initiative with an ambitious goal to prevent 1 million heart attacks and strokes by 2017. The Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services co-lead the initiative on behalf of the U.S. Department of Health and Human Services[1].

Project Description:

To reduce the number of heart attacks and strokes by 1 million nationally, the high level deliverables of the project are as follows:

- Improving Access to Effective Care
- Improving the Quality of Care by focusing on the A_B_C_S of heart health
  - Aspirin therapy, if appropriate
  - Blood Pressure Control
  - Cholesterol Management
  - Smoking Cessation
- Focusing Clinical Attention to the Prevention of Heart Attacks and Strokes
- Activating the public to lead a heart healthy lifestyle
- Improving prescription and adherence to medications to manage ABCS
- Use an Electronic Health Record to connect and share patient information with HEALTHeLINK to reduce gaps in transitions of care and reduce communication barriers

[1] About Million Hearts® at http://millionhearts.hhs.gov/

13

Summary of milestones and correlated documentation requirements.

Milestone	Validation Requirements	Due Date
Milestone 1 and 18: Implement Program to improve management of cardiovascular disease using evidence based strategies in the ambulatory and community settings Adopt strategies from the Million Hearts® Campaign	Complete training by logging on and using Millennium's Learning Management System Course – Million Hearts® Program.	March 31st, 2017.
Milestone 2: See 2ai Milestone 4 on Page 7.	Utilization of HEALTHeLINK as evidence by HEALTHeLINK utilization dashboard e.g. (CCD's, Alerts, Participation, Results delivery)	March 31st, 2018.
Milestone 3: See 2ai Milestone 5 and 7 on Page 8 .	-Copies of EHR Meaningful Use certification -Copy of NCQA Level 3 PCMH accreditation	March 31st, 2018.
Milestone 4 and 15: Use of EHR or other technical platforms to track all patients engaged in this project. Generate lists of patients who have not had a recent visit and schedule a follow up visit.	Electronic Health Record Screenshots demonstrating the creation of the two registries: -Hypertension Registry 1 -Undiagnosed Hypertension Registry 2 including blinded data for patient name, appointments and services received.	March 31st, 2017.
Milestone 5 and 16: Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask,	-Electronic Health Record screenshot demonstrating the implementation of clinical	March 31st, 2017.

22

Appendix B.

Consumer-facing materials in development by Millennium:

"Be Prepared"
What to bring to your visit

- Picture ID
- Medical Insurance Card(s)
- A trusted friend or family member
- Facts to share with your doctor
- Your medications, vitamins and other items you use to take care of your health.
- Any concerns or questions

This is information on available medical care, it is your decision to make the best choice for you.

Millennium Collaborative Care is igniting healthcare change in Western New York, by partnering with physicians, healthcare providers and community-based organizations to improve the delivery of health care for medicaid patients.

Millennium Collaborative Care is a Performing Provider System (PPS) headed by ECMC.

Learn more @ millenniumcc.org

Health Service Information

For 24 Hour Health Care Information look on the back of your Medical Insurance card.

HEALTHeLINK is a website for Western New York patients and their medical teams to share important health information. If you have not given consent at your doctor's office, please register online. This will give your medical team access to your health information securely and quickly. Go to: wnyhealthelink.com

Information to help you and your loved ones stay healthy. healthfinder.gov

Health care insurance information for you and your family. Local support to help you select or change a health care plan. nystateofhealth.ny.gov

You can also call:

Free and confidential service that helps people find the help they need at 211.org or dial: 211

Buffalo & Erie County Crisis Services addresses issues related to emergency mental health. 716-834-3131

To talk to a trained counselor at a crisis center in your area, (other than Erie County), call: 1-800-273-Talk (8255)

A Guide for Your
Medical Visits

Millennium
COLLABORATIVE CARE
Igniting Healthcare Change in WNY

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 2.a.i Create an Integrated Delivery System (IDS)

Challenges the PPS has encountered in project implementation:

The Millennium Integrated Delivery System (IDS) Team has encountered the following challenges with the implementation of an IDS:

1. **Primary Care:**
   Multiple challenges exist at the primary care level for Millennium, including the vast scope of provider partners, regional spread, and although improving, the ongoing lack of communication about project implementation from management to frontline staff within the primary care practices (PCP's).

   For practices whose current Patient Centered Medical Home (PCMH) status is 2011 Level 2 or 3, we have identified practices that did not fully adopt their policies or workflows to support true practice transformation. These practices are requiring a heavier lift than expected in preparation for 2014 Level 3 Accreditation. Having the correct skilled team in place in PCP's to support PCMH deliverables is a concern. Many practices do not recognize the urgency to process policy changes for PCMH to meet the timeline deliverables.

   As identified in the Community Needs Assessment, there is a primary care shortage. In order to address this issue, we need to increase the efficiency of existing PCP's with PCMH principles that include team-based care and population health. Our success is also dependent on having access to the primary care sites to engage Millennium's Transformation Specialists in ongoing productive meetings with our partners. Unfortunately, we have encountered competing demands within physician offices from governing and regulatory agencies, including CMS and Managed Care Organizations (MCO's).

2. **Care Coordination/Transitions of Care:**
   We lack the ability to organize patient care activities by sharing information among all the participants concerned with a patient's care to achieve more comprehensive and coordinated care. The related cost to Electronic Medical Records (EMRs) has been expressed from our key partners. In addition, standardized workflows and protocols have not been fully developed or implemented that outline the necessary steps to support care coordination and transitions of care.

3. **Health Homes:**
   Health Homes are not connected or engaged effectively with primary care partners in our region. Many downstream care management agencies currently reach out to PCP's in regards to their patients' care. PCP complaints include:
   - Too many care management agencies are reaching out to practices;
   - EMR connectivity between PCP and Health Home for data sharing does not exist;
   - PCP's do not know which patients are in outreach vs. enrolled into a Health Home;
   - PCP's cannot identify the patients' Health Home or Case Manager;
   - PCP's lack knowledge of the referral process to a Health Home;
   - PCP's prefer that only one Health Home number be used and one Care Manager responsible for the coordination of care for all their Medicaid patients; and
   - Regional Health Information Organization (RHIO), HEALTHeLINK has limited information on Health Home patients.

4. **The RHIO/HEALTHeLINK (HeL):**
   Challenges exist with RHIO/HeL being utilized to its fullest capabilities. The task of helping practices understand the value of HeL and the value of signing patients up for HeL will have a major impact on care coordination and timely communication between clinical partners. One main barrier expressed from the key partners includes the related costs to the EMR vendor imposes on practices.

5. **Managed Care Organizations (MCO's) - Value Based Payment (VBP):**
   Preparing MCO's and our community on VBP strategy and implementation requires input and coordination through meetings with our partners. Despite multiple efforts, we've had challenges with engaging with Fidelis Care and have been unable to meet with them.

6. **Information Technology:**
   IT survey assessments have been sent to PCP's, Health Homes, Hospitals, Skilled Nursing Facilities, and Home Care Agencies that are affiliated with Millennium's Network of Providers. Numerous EMRs are noted in our network, which complicate the work effort to resolve integration of data sharing.

7. **Workforce:**
   Qualified Behavioral Health professionals such as LCSW-R, LMHC's, Practice Care Coordinators, and/or Certified Case Managers are in limited supply in our PPS region. Also, training for expanded roles and responsibilities in PCP's is needed. Training on skills that are lacking could include pre-visit planning, billing, coding registry management, and portal communication.

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

Overall Strategy: During the first year, Millennium focused work efforts on the identified 11 projects with project managers responsible for one or two projects. It became evident that the projects overlap as well as the DSRIP partner organizations. Other "lessons learned" included a shift from a "project" mindset to a "relationship management" mindset where Millennium staff provides the expert resources for our partners to help translate how DSRIP deliverables impact their work. An overall restructuring of the Clinical Integration Team has been an internal transformation, which enabled

Millennium to focus more on partner organizations and their needs, as opposed to project outcomes. In addition we are actively involved with both Finger Lakes Performing Provider System and Catholic Partners of Western New York on projects that we have in common.

1. **Primary Care:**
   Practice Transformation Specialists continue to engage and monitor the status of Millennium's safety net practices and high volume Medicaid practices in relation to meeting DSRIP primary care deliverables. The team has completed IT and Clinical Assessments and identified clinical integration gaps. The number one priority for all of the primary care embedded projects (Clinical Integration, PCMH, MU2, RHIO Connectivity, Behavioral Health Integration, CVD/Million Hearts program, Patient Activation Measures, ED Triage, Cultural Competency/Health Literacy, and Maternal & Child Health) is to address the remediation efforts for each primary care site and track the progress to ensure success in meeting milestone deadlines. The Practice Transformation Specialist Team has developed a strong relationship with practices, and has created individual action plans for each practice to facilitate successful outcomes.

   Behavioral Health (BH) Integration into Primary Care: Active engagement with BH outpatient clinics has begun in order to establish referral agreements and establish warm handoffs with PCP's. In addition, there are PCP's integrating BH specialists within the walls of their practice. We are establishing:
   - PPS wide standards of care for triaging behavioral health patients and medication management;
   - Education for primary care providers to elevate their capacity to treat more of their BH patients in house;
   - Linkage of participating PCP's to collaborative care training grants when eligible; and
   - Leveraging other community wide resources, such as Screening Brief Intervention and Referral for Treatment (SBIRT) training.

   Primary care shortage numbers are being confirmed with various data sources. Calls have been scheduled with the NYS Department of Health to investigate statewide data and to increase efficiency of existing PCP's with PCMH principles of team-based care and population health. Resident training at Erie County Medical Center (ECMC) & Kaleida Health primary care clinics are taking place in order to educate residents on how PCMH processes can improve PCP's operations, staff satisfaction, financial viability, and primary care providers' lifestyles.

2. **Care Coordination/Transitions of Care:**
   The Clinically Interoperable System approach has included an IT assessment for each level of care/service that a patient may experience. The assessment also identifies data sharing capabilities per level of care setting. A complete gap analysis is being conducted and will be completed along with a plan to address those gap(s).

3. **Health Homes Community Alignment:**
   Monthly meetings have been established to bring together health plans, leading health homes, along with participation from both Community Partners of Western New York (CPWNY) and Millennium Collaborative Care PPS. All stakeholders agree to discuss the need to improve quality of care for our Health Home community and evolve Health Homes into an integrated service delivery system that includes bi-directional communication with key clinical partners. Our focus includes addressing the need for one central Health Home referral document, increased communication, coordination of care, and education to our provider community. In addition, projects that relate strongly with Health Homes have been discussed and IT assessments have been completed for the PPS Health Homes. We are working together on a plan to correct the identified gaps.

4. **Regional Health Information Organization (RHIO), HEALTHeLINK (HeL):**
   Millennium has a Practice Transformation Specialist who also works for HeL. By assuming both functions, this has added a value for the PCP's who are not fully engaged with HeL. Millennium along with CPWNY have monthly meetings with HeL and continues to work on CCD requirements and increasing PCP access and utilization. Master Participation Agreements will assist practices in offsetting any related cost for the EMR requirements.

5. **Managed Care Organizations (MCO's)** :
   Monthly meetings with MCO's have proven to be beneficial. These meetings have focused on project deliverables with a strong emphasis on Clinical Integration, trend reports, EIP, EPP and VBP. Each MCO has expressed a willingness to support DSRIP deliverables except for Fidelis Care.

   UNYHEALTH is an alliance of community–owned healthcare organizations and physicians delivering care in the major markets of New York State north of the metropolitan New York City area. Through this partnership, the upstate PPS's have expressed their concerns to UNYHEALTH that Fidelis has not engaged with the respective PPS's. As a result, UNYHEALTH is coordinating a meeting with Fidelis Care and the upstate PPS's to address our concerns.

6. **Work Force:**
   Coordinated efforts with Millennium's workforce strategy team has helped to define training needs for staff in PCP's along with the identification of key roles and job descriptions. Together with the work force team, a strategy is being created to address these identified areas.

NEW YORK STATE | Department of Health

Implementation approaches that the PPS considers a best practice:

The following indicates the implementation approaches Millennium feels are best practice:

1. **Millennium Transformation Team Strategy:**
   The strategy identified for primary care providers includes first targeting Millennium's high volume safety net providers, which includes many Federally Qualified Health Centers (FQHCs). Phase 2 includes other safety net providers, and Phase 3 includes high volume Medicaid primary care sites that are non safety net providers.

   Practice Transformation Strategy:
   a. Millennium staff assigned to work with safety net practices requiring PCMH
   b. Linking partners together with the same EMR for technical support
   c. Sharing best practices at regional PPS events and through our website
   d. Centralized care management training for practices in need of assistance
   e. Monetary awards available through master participation agreements for achievement of PCMH and other transformation deliverables
      i. Implementation of care coordination & transitions of care
      ii. Effective clinical data strategy via the RHIO

The following approach is utilized for implementation meetings with community and institution-based primary care practices:

Purpose of our Practice Transformation:
- Engage & educate practices on Millennium DSRIP deliverables
- Collaboratively implement projects in PCP's
- Ensure that sustainable workflows are in place when projects are complete
- Encourage and support true transformation through culture change
- Provide guidance and support on VBP transition
- Establish strong relationships in the practices

Practice Engagement & Transformation Strategy:
- Assign Practice Transformation Specialists to be the liaison & support for our practices
- Develop and maintain a practice project plan that ties back to project milestones and due dates
- Implement a PCMH mini audit to ensure transformation is sustained
- Ensure practices are prepared for outcome-based reimbursement

Each practice has or will receive the following:
- Leadership meeting - may or may not be required
- Practice engagement strategy - site level vs. centralized
- Kick-off meeting
- Provide DSRIP/Millennium/Projects overview
- Build consensus on collaborative work
- Engage practices with a top down approach
- Introduce Transformation Specialists
- Determine each practice site transformation team
- Summarize project deliverables
- Follow-up meeting
- Establish patient engagement reporting process

- Begin collaboratively developing the project plan
- PCMH-MU-RHIO
- Report/registry development
- Patient Activation Measures (PAM) score capture
- Mutually agree upon meeting frequency & touchpoints

This approach has been well received within the practices as it is building on relationship management.

2. Integrated Delivery System (Care Coordination and Transitions of Care)

The following PPS-wide strategy to establish collaboration among primary care, hospitals, other healthcare providers, and community-based organizations (Millennium partners) is being established via:

- Standardized care coordination policies
- Technology (HeL) & Population Health Platform (HealtheIntent)
- Engagement of primary care in Millennium DSRIP deliverables
- Collaboratively implement projects and ensure that sustainable workflows are in place
- Establish training regarding clinical integration, tools, & communication for coordination
- Build and maintain strong relationships with practices
- Ensure practices are prepared for Value Based Reimbursement through communication & training
- Reinforce medical home principles by championing culture change
    - More patient-centered encounters
    - Ensuring referrals are truly warm handoffs, consistent with PPS care coordination strategy

Workflows and protocols are being developed to outline the necessary steps that support care coordination and transitions of care based on evidence-based medicine. A training plan has been outlined that includes necessary training materials, identification of teams that need to be trained and deployment of training and tracking of attendees and a framework has been developed for measuring transitions of care success. This framework includes structure, measures, process, outcome, patient experience, efficiency, and effectiveness.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Integrated Delivery System Team is igniting healthcare transformation by engaging with multiple clinical and community partners across the eight counties of WNY. Millennium's IDS Team is actively meeting with PCP's, Behavioral Health specialists, MCO's, Health Homes, Skilled Nursing Facilities, and Home Care Agencies to collaborate on the DSRIP deliverables across each project.

The team also meets in partnership with local MCO's, Health Homes, and CPWNY. These meetings focus on how to make Health Homes an enhanced partner for clinical integration. We have developed a community-wide Health Home Referral document along with "Health Home 101" training for providers and a Health Home information sheet for patients. We are working on building a stronger model of integrated care.

Monthly meetings with our governance committees provide oversight and make recommendations to address our effectiveness and progress of DSRIP project deliverables. In addition, the team has been working on the **MAX Series for Super Utilizers of the Emergency Department** involving numerous teams and departments to address, train, and deploy a new process. This has been both challenging and successful. Some key tasks are listed below:

- The team has developed workflows for the ED and PCP Clinic, if and when, a Super Utilizer enters the healthcare delivery system
- All Super Utilizers are flagged in the ED and PCP Clinic EMR
- If a patient has not been enrolled into a Health Home, a Health Home partner is activated to meet the patient in the ED or PCP Clinic
- A patient tracker has been created that collects information on the Super Utilizer that includes historical ED visits. An index flag is stamped to the encounter - that will record that our new process for approaching the Super Utilizer patient has been implemented.
- The ED Care Management Team will approach the patient with the following questions:
    - What is going on with you that brings you to the ED frequently?
    - What are we doing here in the ED that you do not feel your primary care provider is not doing for you?
    - How can I be helpful?
- The patient tracker will then be updated with the outcome of that encounter in either the PCP clinic or ED
- Multidisciplinary Super Utilizer Case Conferences have been established and meetings are held bi-monthly. Care plans for the ED have been created and shared between the ED and PCP Clinics
- A process improvement tool, Plan Do Study Act (PDSA), is being conducted to appropriately tweak workflows/processes as needed

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to populations have been made at this time.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 2.b.iii Emergency Department Care Triage (EDCT) Project

Challenges the PPS has encountered in project implementation:

The Millennium Acute Care Team has encountered the following challenges with the implementation of the EDCT project:

1. Cuba Memorial Hospital has decommissioned their ED therefore we are unable to implement the EDCT project. Brooks Memorial Hospital initially were partners with both CPWNY and Millennium and were more closely aligned with CPWNY, but have since affiliated with Kaleida Health System, therefore, we will engage initially with their leadership team to discuss collaboration efforts.

2. Emergency Department (ED) staff members do not fully understand the role of patient navigators within the EDCT project team.

3. Documentation and tracking patient engagement proves challenging due to dissimilar and (or) inadequate Electronic Medical Record (EMR) systems used by each partner hospital. The barriers to care assessment given by the patient navigators are housed in a separate system (not in the EMRs), which makes the ability to integrate all relevant patient information and track patient outcomes difficult.

4. Patient navigators do not have the capability to access the schedules of the primary care practices (PCPs) electronically. They are currently calling the PCP's and working with the office staff to schedule an appointment, which proves very inefficient and time consuming.

5. Regional shortage of Primary Care Physicians/Pediatricians – they are unwilling or reluctant to accept Medicaid patients.

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

1. Millennium to establish meeting with Brooks Memorial Hospital leadership to determine their engagement and collaboration efforts for project implementation.

2. Through hospital site "Lessons Learned" sessions, we incorporate guidance from individual project champions to input initiatives in the ED for inclusion of patient navigators. Where indicated, site supervisors will regularly outline the role of patient navigators to ED staffers.

3. We have devised a plan for closely monitoring (monthly/per site) the strategies for embedding additional project data into the hospital EMRs. This includes, integration of patient information, barriers of care assessment and patient outcomes.

4. Erie County Medical Center (ECMC) and Buffalo General Medical Center (BGMC), are developing "open access" scheduling for the patient navigators to ensure that the patient navigators have electronic access to the PCP's schedules. This process is more efficient then calling each primary care office to schedule the patient's follow-up appointment. The goal is to expand this process to other primary care sites.

5. Millennium's Clinical Integration team provides comprehensive planning and trouble shooting for challenges that cross over multi sites of services. (PCP, Acute Care, Post Acute, Behavioral Health and other key partners). Therefore, our team is collaborating on strategies for Clinical Integration across healthcare locations, working with PCP practices to understand the EDCT objectives and the impact to their practice.

Implementation approaches that the PPS considers a best practice:

The following best practices are being implemented:

1. **Conducting "Lessons Learned" Sessions:** We have conducted three 'Lessons Learned' in order to share best practice learnings across our PPS partners. Sessions have taken place with patient navigators at ECMC, Niagara Falls Memorial Medical Center (NFMMC), and Olean General Hospital.
    a. "Lessons Learned" sessions will be conducted 90d-160d post full implementation
    b. "Lessons Learned" sessions are upcoming in Q3 or Q4 for hospital project champions

2. **Continuous Monitoring & Planning Efforts:** We have implemented Quality Improvement systems in order to monitor patient discharges to prevent re-admissions. In addition, the development of integrating the EDCT patient information into the hospital EMR is underway.

3. **Workgroup:** An Acute Care Team workgroup at BGMC has been established. Workgroup members discuss best practices. Topics include: Roles and responsibilities of patient navigators, high utilizers of the ED and care coordination/transitions of care.

4. **Conducting Combined Patient Navigator Trainings**
    a. By bringing together navigators from each hospital allows an opportunity to share lessons learned, challenges that they may be facing and strategies to mitigate these challenges.
    b. Combined Patient Navigator trainings with all four sites have been conducted in April and July of 2016. Bringing all the patient navigators together helped standardize the implementation approach.

NEW YORK STATE | Department of Health

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Acute Care Team is igniting healthcare transformation by collaborating and participating with the Million Hearts® initiative throughout the City of Buffalo to raise heart health awareness in at-risk communities. The team has volunteered and participated in community health events at area churches. The Acute Care Team members are regular guests on *Millennium Health Matters* radio show discussing the EDCT project and proper usage of the ED, including how to build meaningful connections with primary care providers. Acute Care Team members participated in the 2016 Juneteenth celebration this Quarter to increase awareness within African American communities about linking Medicaid recipients to PPS partners.

The Acute Care Team continues to engage the community by collaborating on training opportunities. For example, Health Home Providers, will train EDCT patient navigators on the value Health Homes can offer Medicaid patients. In addition, the team has linked with People Inc. in efforts to improve communication and make more appropriate after-care connections for patients with Developmental Disabilities.

The EDCT project has been implemented at the following hospital sites: ECMC, NFMMC, Olean General Hospital, and BGMC. Implementation talks are underway at Eastern Niagara Hospital, Women and Children's Hospital, and Millard Fillmore Suburban Hospital. Additionally, the Acute Care Team continues to refine EDCT training materials for project patient navigators. To date, 12 patient navigators have been trained.

The Acute Care Team has been working to expand its efforts across the eight county region. Such efforts include collaborating with The Practice Transformation team to establish connections and build partnerships with primary care providers. The Olean community has been targeted with these efforts due to their high volume Medicaid patients.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

There is an identified need to engage the Developmental Disabilities population because of their frequent usage of the ED. As a result EDCT patient navigators/community health workers are undergoing training by People, Inc. with the goal of increasing awareness and engagement of this specialized population of patients who present to the ED. Patients with behavioral health issues also tend to frequent the ED and will therefore be provided patient navigator interventions within ECMC's Comprehensive Psychiatric Emergency Program (CPEP). This model will be piloted at ECMC and is anticipated to be replicated at other acute care settings throughout the PPS's footprint.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 2.b.vii Implementation of the INTERACT Project for Skilled Nursing Facilities

Challenges the PPS has encountered in project implementation:

The Millennium INTERACT Team has encountered the following challenges with the implementation of the INTERACT project for Skilled Nursing Facilities:

1. Implementing the INTERACT Program throughout Millennium's entire network of Skilled Nursing Facilities (SNF's) has been challenging mainly due to the size of the provider group. There are more than 50 SNF's who have attested to Millennium and this group requires an extensive amount of guidance, supervision, and oversight. The turnover rate, of not only direct care staff within the facilities, but also the administrative and management staff, has been a significant challenge.

2. Many of the facilities have made the transition from paper-based medical records to Electronic Medical Records (EMRs) this year in order to comply with the original E-MAR deadline this spring. Although this transition is a beneficial one for the SNF's, the training demands on direct care staff and management have been burdensome. Attempting to implement the INTERACT program at the same time has been stressful and taken longer than it potentially would have if an EMR transition had been completed previously, rather than occurring simultaneously with project implementation.

3. Engaging the practitioners (Physicians, Nurse Practitioners, and Physician Assistants) who work within the SNF setting has also been a challenging task. Many of the practitioners who are responsible for treating the patients within the SNF settings are not employed by the SNF's. As a result, many times the facility has little say over what protocols or evidence is followed by the practitioners. The practitioners ultimately make the final determination on whether or not a patient is sent to the hospital; therefore, orienting them to the goals of reduced avoidable hospital and Emergency Department use and enlisting their support of INTERACT methodology is key.

4. Balancing the financial repercussions of avoiding hospitalization for SNF patients has been a continual challenge. Many of the revenue-generating opportunities in SNF's are available only after a patient has had a qualifying hospital stay and is therefore eligible to activate their Medicare Part A services. When SNF's treat these patients in-house instead, they are assuming an increased risk without the benefit of increased reimbursement.

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

1. Millennium has developed a comprehensive training program, which includes the offering of a quarterly Nurse Champion training for any of its partners to attend. To accommodate Millennium's partners, the course is offered in two different locations, one in Central WNY and one in the Southern Tier region of WNY. These training opportunities have been critical due to the high staff turnover as noted above.

2. In order to decrease the burden on the management and In-service staff of each facility, Millennium hired a full-time INTERACT Coach to be available at each facility for direct care staff training. Templates, training materials, INTERACT Toolkits, and presentations are offered to each SNF to assist in decreasing the effort required to implement the training components of the INTERACT program.

3. Millennium has worked diligently to identify the EMR capabilities of each individual SNF, and to work the different components of the INTERACT program into the individualized training program for each building. Project staff has also become familiar with several of the most popular EMR systems in an effort to increase staff buy-in and ensure training relevance from a patient care workflow perspective.

4. Millennium is working collaboratively with its Physician Engagement team, as well as the Physician Steering committee, to engage, educate, and transform the care that is delivered in the SNF setting.

5. The development of Value Based Payment (VBP) arrangements and bundled payments are underway.

Implementation approaches that the PPS considers a best practice:

The following indicates the implementation approaches Millennium feels are best practice:

1. **Meeting with administrative staff prior to implementation:** Meeting with administration at each building prior to INTERACT Implementation is an essential component to the success of this model. INTERACT Implementation planning meetings have been held at each site prior to implementing the INTERACT program. Attendance by the following is recommended: Site Administrator, Director of Nursing, Assistant Director of Nursing, In-Service Education Coordinator, as well as any other applicable nursing management staff. These meetings are crucial to ensure all Administration staff has a good working knowledge of the INTERACT Program and the specific components of the program that are to be implemented within the building. These meetings also help to ensure a plan is outlined for training, workflow, and quality improvement, and that all staff members are in agreement with this plan. A best practice is having the opportunity to discuss "lessons learned" and best practices/approaches for implementing various tools and/or concepts of INTERACT.

2. **Conducting Nurse Champion Training:** Millennium has found that having the availability of multiple Nurse Champion training sessions has also been a successful technique for this project. Ensuring that the nurse management responsible for the INTERACT program within the SNF has been properly oriented and educated about the INTERACT program by the project team assists down the line when project staff are trying to implement different tools or workflows in the buildings. At the Nurse Champion trainings, a thorough orientation is given that provides an overview of DSRIP, PPS's, VBP, and all of the changes in legislation and reimbursement that are occurring. This orientation section is critical in insuring that participants understand the importance of the need to reduce hospitalizations and improve quality outcomes.

3. **Regular meetings with individual provider groups:** Meeting with individual provider groups at regular intervals to review program implementation, discuss barriers and "lessons learned", and coordinate next steps is an essential component of this project.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Post-Acute Care Team is igniting healthcare transformation by uniting our network of over 50 SNF's and seven Certified Home Healthcare Agencies across the eight counties of WNY. Working collaboratively to implement standardized care protocols and best practice models across the network in order to improve patient care, patient outcomes, and hospitalization rates is the primary goal. Working as a network to coordinate connection to the local Regional Health Information Organization (RHIO), submit waiver requests to address legal and regulatory audit concerns, as well as developing standardized protocols for care transitions are other priorities of the network.

Efforts have begun to shift the focus to the concepts of clinical integration and care coordination across the care continuum. The goals at this time are identifying the current barriers at each setting, strategizing steps able to be enforced at each setting to ensure a smooth transition, and developing an implementation plan across the care continuum.

Workgroups are focusing on areas such as EMR to RHIO connectivity, quality improvement, community engagement and education, as well as Palliative Care and Advance Care Planning. The Palliative Care and Advance Care Planning Workgroup has been established to address the needs of enhanced Advance Care Planning efforts in the Post-Acute Care sector. This committee is responsible for assessing the current capacity and current models that exist in the community, identifying barriers and needs, and developing curriculum and training education opportunities to increase effectiveness of staff and providers in having Advance Care Planning conversations.

A subcommittee has been developed to focus on individuals with Developmental Disabilities and the unique legal and regulatory barriers that currently exist surrounding End-of-Life care and Advance Care Planning for this population. The goals for this group of individuals include increasing awareness and promoting enhanced Advance Care Planning services.

Millennium's Post-Acute Care Team has partnered with the P2 Collaborative's "Quality Living Until the End" Committee in order to develop, implement, and promote end-of-life planning, education, and awareness opportunities for providers and the community-at-large. Whereas Millennium's

Palliative Care and Advance Care Planning Committee is targeting the Post-Acute Care sector, efforts with the P2 Collaborative are intended to reach a more global community audience, as well as the primary care and specialist providers who have the opportunity to have these conversations with patients and families before patients arrive at an acute or post-acute care setting.

Millennium is also working with other community-based organizations, such as the WNY Alzheimer's Association, Health Homes, and the various county Offices of the Aging to promote local resources that are available for patients and caregivers.

Address any changes to population that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to populations have been made at this time.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 2.b.viii Hospital-Home Care Collaboration Solutions – INTERACT-like Program

Challenges the PPS has encountered in project implementation:

The Millennium INTERACT Team has encountered the following challenges with the implementation of the INTERACT-like project in the home care setting:

1. Developing a collaborative Rapid Response Team between Emergency Departments (ED's), Home Care Agencies, and Skilled Nursing Facilities (SNF's) has been challenging. This model requires enhanced communication between the multiple players of each institution (Physicians, Case Management, and Insurance Plans). The Emergency Physicians and Primary Care Physicians or SNF Physicians must be able to communicate in order to feel comfortable authorizing a diversion from the ED to an alternate level of care.

2. Diverting patients from the ED into Post-Acute Care has its challenges due to time and authorization requirements. Depending on the time of day or night a patient may present to the ED, staff on the Post-Acute side may not be available to coordinate a diversion. This is commonly the case when attempting to obtain insurance authorization. Health plans traditionally work a Monday through Friday work week with limited availability of nighttime hours. It is difficult to coordinate a diversion when patients present to the ED outside of standard working hours.

3. Addressing hospital readmissions for patients who are receiving home care services also presents difficulties. A home care agency on many occasions will attempt to contact the Primary Care Practice (PCP) when a patient is noticeably declining or when he/she may require an adjustment in medication or testing orders. Unfortunately, many PCP's would prefer to send their patients to the ED for a work-up instead of authorizing orders for homecare assessment and intervention.

4. Connecting all provider groups to interoperable Electronic Health Records (EHRs) to avoid medication errors and duplicative tests and services is often complicated. Many times providers are not willing to spend the extra time to access an external database to research patient information. Increasing buy-in and integrating the use of the Regional Health Information Organization (RHIO) into current workflows is one of Millennium's top priorities.

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

1. Coordinating direct lines of communication between PCP's and ED's has been one strategy Millennium has deployed in an effort to improve communication and timeliness in coordinating patient care. Meeting with and educating physicians and mid-level providers (Nurse Practitioners and Physician Assistants) on the Rapid Response Team model, the services offered, and the expected time for delivery has become one of the major goals for this project. Increasing physicians and provider buy-in to the program is critical to its success. Pilot programs between specific PCP's and ED's are beginning to be developed for smooth transitions of care and effectively diverting patients from the ED into Post-Acute Care settings.

2. Encouraging Home Care partners to work with health plans to develop preauthorization agreements has been a strategy used in order to work around the barrier of obtaining authorization on nights and weekends when offices are closed.

3. Working with the home care agencies to track readmissions - specifically intervention attempts and refusal of PCP's to keep patients in the home setting for treatment - has been a large focal point in Millennium's program. Without data available, Millennium is unable to track which providers are uncomfortable with maintaining a patient in the home setting during a change in condition; therefore, this precludes Millennium's ability to intervene and educate the practice and provider. Plans are to utilize the Practice Transformation Team through Project 2ai to push out the message of avoiding unnecessary hospital and ED use and increase awareness and understanding of the Post-Acute capabilities.

4. Working collaboratively with the staff from its local RHIO has helped Millennium to overcome some of the barriers seen with HEALTHeLINK usage. Having the HEALTHeLINK team provide trainings to staff and integrating into current Electronic Medical Record systems have been a few approaches used to address this challenge.

Implementation approaches that the PPS considers a best practice:

The following indicates the implementation approaches Millennium feels are best practice:

1. **Meeting with administrative staff prior to implementation:** Meeting with each agency's administrative staff prior to INTERACT-like program Implementation is an essential component to the success of this model. INTERACT Implementation planning meetings have been held at each site prior to implementing the INTERACT program tools and methodology. These meetings are crucial to ensure all Administration/management staff have a good working knowledge of the INTERACT Program and the specific components of the program that are to be implemented within the agency. The meetings also help to ensure a plan is laid out for training, workflow, and quality improvement and that all staff members have agreed. These meetings provide the opportunity to speak to the "lessons learned" and best practices for implementing various tools and concepts of INTERACT.

2. **Conducting Nurse Champion Training:** Millennium has found that having the availability of multiple Nurse Champion training sessions has also been a successful technique for this project. Ensuring that the nurse management responsible for the INTERACT-like program within the home care agency has been properly oriented and educated on the INTERACT program is crucial. At the Nurse Champion trainings, a thorough orientation is given that provides an overview of DSRIP, PPS's, VBP, and all of the changes in legislation and reimbursement that are occurring. This orientation section is critical in insuring that participants understand the importance of the need to reduce hospitalizations and improve quality outcomes.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Post-Acute Care Team is igniting healthcare transformation by uniting our network of over 50 SNF's and seven Certified Home Healthcare Agencies across the eight counties of WNY. Working collaboratively to implement standardized care protocols and best practice models across the network in order to improve patient care, patient outcomes, and hospitalization rates is the primary goal. Working as a network to coordinate connection to the local RHIO, submit waiver requests to address legal and regulatory audit concerns, as well as developing standardized protocols for care transitions are other priorities of the network.

Efforts have begun to shift the focus to the concepts of clinical integration and care coordination across the care continuum. The goals at this time are identifying the current barriers at each setting, strategizing steps able to be enforced at each setting to ensure a smooth transition, and developing an implementation plan across the care continuum.

Workgroups are focusing on areas such as EMR to RHIO connectivity, quality improvement, community engagement and education, as well as Palliative Care and Advance Care Planning. The Palliative Care and Advance Care Planning Workgroup has been established to address the needs of enhanced Advance Care Planning efforts in the Post-Acute Care sector. This committee is responsible for assessing the current capacity and current models that exist in the community, identifying barriers and needs, and developing curriculum and training education opportunities to increase effectiveness of staff and providers in having Advance Care Planning conversations.

A subcommittee has been developed to focus on individuals with Developmental Disabilities and the unique legal and regulatory barriers that currently exist surrounding End-of-Life care and Advance Care Planning for this population. The goals for this group of individuals include increasing awareness and promoting enhanced Advance Care Planning services.

Millennium's Post-Acute Care Team has partnered with the P2 Collaborative's "Quality Living Until the End" Committee in order to develop, implement, and promote end-of-life planning, education, and awareness opportunities for providers and the community-at-large. Whereas Millennium's Palliative Care and Advance Care Planning Committee is targeting the Post-Acute Care sector, efforts with the P2 Collaborative are intended to reach a more global community audience, as well as the primary care and specialist providers who have the opportunity to have these conversations with patients and families before patients arrive at an acute or post-acute care setting.

Millennium is also working with other community-based organizations, such as the WNY Alzheimer's Association, Health Homes, and the Offices of the Aging in various counties to promote local resources that are available for patients and caregivers.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to populations have been made at this time.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 2.d.i Implementation of Patient Activation Measures and Engagement (PAM)

Challenges the PPS has encountered in project implementation:

PAM is an important step in connecting Medicaid members to their Personal Care Physicians. Medicaid members and uninsured individuals are sought out by Community Health Workers (CHWs) from six community-based organizations (CBOs) throughout the eight county WNY region who subcontract with Millennium to administer PAM. There is a primary focus on hotspots in the community where higher concentrations of Medicaid members reside. Through the efforts of these six CBOs, PAM surveys were administered to 14,862 members in Demonstration Year 1 (DY1).

The Millennium PAM Team has encountered the following challenges with the implementation of the PAM project:

1. The 2.d.i project began in August 2015 with a great focus on meeting the aggressive Speed and Scale milestones established for the project (6,000 Medicaid members/uninsured individuals surveyed). In a concentrated effort to achieve this task, little attention was given to navigating the PAM'd Medicaid members to primary care. During DY1 Quarter 3 and when CBOs had a better handle on the actual process of administering the PAM instrument to individuals, efforts were shifted to ramp up the navigation component of the project. It was at this time that Millennium was able to observe the challenges and difficulties in locating/following-up and contacting individuals for scheduling primary care appointments.

2. Another challenge was the location of providers who would agree to accept Medicaid members as new patients.

3. Millennium has also encountered a trend across the state in other NYS DSRIP PPS's: the skewing of PAM activation levels toward Levels 3 and 4, meaning that the patients are answering all questions with "agree" or "mostly agree", placing them at Level 3 or 4 for the overall survey, which is providing inaccurate results.

4. CG CAHPS Survey for the uninsured population has been a challenge. Because we did not know that the base number for uninsured individuals who needed to be surveyed increased from 250 to 4,000 until Quarter 4 of DY1, it left Millennium with little time to focus our outreach and attention on this population. This may have impeded the number of responses to the CG CAHPS survey.

NEW YORK STATE | Department of Health

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

1. Multiple approaches have been used in efforts to address the Primary Care Practice (PCP) scheduling/navigation issue:
    - when PAM'ing new Medicaid members, multiple addresses and telephone numbers have been collected;
    - connecting Medicaid members who qualify, to free government cell phones and contacting members using the cell phone texting feature (which is unlimited); and
    - sending follow-up letters/having CHWs follow-up by in-person visitations to the homes of the Medicaid members – however, this is costly and labor intensive.

2. To address navigation to PCP's accepting Medicaid members as new patients, efforts have been enacted to work with Millennium Collaborative Care Clinical Integration and the Physician Engagement Teams to identify PCP's that will take new Medicaid patients and communicating this information to the CBO CHWs that administer the PAM survey and schedule doctor visits for the Medicaid members.

3. In order to address the skewing of PAM Levels to 3 and 4, key staff of three PPS's - Millennium Collaborative Care, Finger Lakes Performing Provider System and Central New York Care Collaborative - are joining together to receive "Super User" training by Insignia Health. This training will provide more technical expertise at the PPS level for the purposes of providing assistance to CBOs CHWs in the administering of PAM surveys, as well as providing Counseling For Activation support at the PCP level.

    a. The Millennium PAM CBOs have also been asked to pay close attention to try to reduce the number of PAM surveys that are not answered with fidelity. Strategies for accomplishing this include:
        - creating a private environment and giving individuals the time they need to concentrate and answer the questions;
        - letting the individual know that they are not expected to answer all of the questions with "agree";
        - offering to read the survey to the individual; and
        - moving on to the next person to survey if the CHW notices that a person is impaired or refuses the survey.

        We are hopeful that these activities will improve the fidelity of the results with the PAM activation levels.

4. In order to address the potential of the CG CAHPS being administered in DY3, specific efforts are being made to locate opportunities PAM uninsured individuals. Efforts to increase the volume of surveying uninsured individuals include: working more collaboratively with NYS Facilitated Enrollers, working at homeless shelters and with businesses that tend to have part-time employees, like the school bus companies.

NEW YORK STATE | Department of Health

Implementation approaches that the PPS considers a best practice:

The following indicates the implementation approach Millennium feels is best practice:

1. **Working directly with CBOs:** Millennium CBOs are working directly in the community at hotspot locations, including supermarkets each month when SNAP benefits are typically used to purchase groceries. Other practices include working with the free government cell phone distributers to provide referrals to Medicaid members so that they may follow-up and reach the Medicaid member to schedule appointments and make sure that the appointments are kept, including addressing any barriers from attending the appointment. Lastly, the CBOs have partnered with government agencies, such as the Erie County Department of Social Services where CHWs provide PAM surveys to homeless individuals and connect them to PCP's and other preventative services.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Patient Activation Measures and Engagement Team is igniting healthcare transformation through the collaborative efforts undertaken by Millennium's partner CBOs. Millennium hosts PAM "How To Huddles" every other month with the PAM CBO team to provide updates, offer technical assistance, network and brainstorm ideas and strategies to improve quality, meet project metrics and plan for future Demonstration Year goals.

These events are extremely useful as the team is regional and located throughout eight WNY counties. This adds to cohesion, improves lessons learned, and provides for standardized communications, opportunities for idea sharing and the development of cross-project processes.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

The NYS exchange has been extremely aggressive in reducing the number of NYS residents without medical insurance. This has resulted in an almost daily reduction in the number of uninsured individuals.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 3.a.i Behavioral Health Integration Project (Model 1 and 2)

Challenges the PPS has encountered in project implementation:

The Millennium Behavioral Health Team has encountered the following challenges with the implementation of the Behavioral Health Integration project:

1. Financial challenges exist in achieving the goals for implementation of Model: embedding Behavioral Health (BH) specialists into safety net Primary Care Practices (PCP's), also known as The Collaborative Care Model, and Model 2: embedding Primacy Care services into BH sites. At primary care sites, the practitioners cannot bill for all of the services rendered and they may feel overwhelmed with practice-wide transformation.

2. Staff turnover and lack of qualified providers (Psychiatrists and Licensed Therapists/Social Workers) in the workforce: the high demand for Licensed Mental Health Counselors/Social Workers accompanied by the low volume of these qualified practitioners creates instability in staffing and impedes the progress of project implementation.

3. Regulatory barriers are restricting the provision of primary care services within BH settings and vice versa, especially the current requirement of having separate waiting rooms for BH clients and primary care patients.

4. BH clients having severe mental illness that are not connected to PCP's may be reluctant to receive services for many reasons, including feeling uncomfortable with a different provider, uneasiness with a change in their routine and the PCP environment, transportation issues, and poor past treatment by PCP's.

5. Exchange of information across physical and mental health disciplines is lacking due to Federal Confidentiality Laws that prohibit sharing protected mental health information with PCP's.

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

1. Millennium's Behavioral Health Team is helping to ease the financial burden by providing training and technical support within the PCP's on Patient Centered Medical Home (PCMH) Level 3 2014 status. This PCMH support specifically focuses on BH integration. Millennium is providing technical assistance and training and has been exploring the use of telemedicine to stretch available resources. If telemedicine is not feasible, agreements for phone consultations, rapid access referrals, and exchange of information through EMR and the Regional Health Information Organization (RHIO) will be established.

2. Through our workforce development plans, Millennium is working to enhance and build strong relationships with area colleges to incorporate a plan and long-term strategies to fill the workforce gaps identified.

3. Millennium has been participating in statewide workgroups and conferences on the topic of regulatory barrier issues in order to focus on specific regulations that need to be changed to allow services to be offered in a shared setting and eligible for reimbursement. These workgroup(s) have not seen many results at this time. Therefore, Model 2 implementation has been very slow moving/nonexistent in our region.

4. Millennium has researched best practice trainings on topics such as Motivational Interviewing, Screening Brief Intervention and Referral for Treatment (SBIRT) and person-centered approaches. Suggested webinars on how best to connect patients facing BH issues to PCP's have been forwarded to partners and will continue to be passed on as they become available. In addition, The Collaborative Care Model (Model 1) has shown to be promising and a few of our partners have been trained in this model.

5. Millennium is collaboratively working with our PPS partners to incorporate standardized referral protocols and uniform tracking/reporting systems. The team is working on the development of a multidisciplinary approach to case conference sessions, warm hand-offs, and other strategies. The team has also engaged our local RHIO – HEALTHeLINK (HeL) to increase the communication across physical and mental health disciplines through the development of a BH-specific secured portal within HeL to capture and share data amongst the partners.

Implementation approaches that the PPS considers a best practice:

The following indicates the implementation approach Millennium feels is best practice:

1. **The Collaborative Care Model by the AIMS Center:** The most commonly reported best practice model for integrating BH into primary care sites is the Collaborative Care Model (Model 1) by the AIMS Center. A couple of our primary care sites have engaged in training and consultation by the AIMS Center after hearing of their expertise from Millennium.
    a. In Niagara Falls, NY, the Niagara Falls Memorial Medical Center recently opened the Golisano Center, which provides comprehensive integrated health care services to adults with special needs and their families and houses a range of services and programs for the community. The Golisano Center staff was trained by the AIMS

Center. Among those services are primary care, mental health, Health Home care management, housing assistance, community outreach, satellite services, social services, health insurance enrollment, financial assistance counseling, wellness education, and the training of healthcare professionals. This is a great achievement for the region and for the Behavioral Health Integration project in particular since such comprehensive services are available for individuals who may traditionally seek Emergency Care in the off hours.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Behavioral Health Team is igniting healthcare transformation by engaging a variety of community-based organizations and PCP's throughout the eight WNY counties. Through the establishment of key collaborative workgroups, Millennium has begun to identify BH service gaps and barriers in our region and has prioritized with our key partners the next steps that need to occur in order to achieve our long-term goals and outcomes. Subcommittees consist of local experts across the spectrum of healthcare delivery including physicians, behavioral healthcare executives, psychiatrists, nurse practitioners, mental health professionals and substance abuse prevention experts.

Workgroups are focusing on areas such as Health Homes/Care Coordination, the exchange of healthcare information, best practices for healthcare screenings, SBIRT, warm-handoffs across systems, and other essential areas relevant to successful integration. The Millennium Behavioral Health Team is also participating in various community-based efforts so that we do not duplicate services. These groups include the WNY Chemical Dependency Consortium, the P2 Collaborative Population Health Incentive Program (PHIP), two opiate task forces and participation in/and sponsorship of a few community-based forums.

The Behavioral Health Integration Team has partnered with our bordering PPS Community Partners of Western New York (CPWNY) for the majority of activities related to integration of primary care services into BH sites. The team is collaborating with both CPWNY and the Finger Lakes Preferred Provider System (FLPPS) on patient engagement for the shared BH partner sites across the three PPS's. Collaboration with the main BH organizations that are engaged is essential in order to ensure consistency across both PPS's. One of our first endeavors for Model 2 integration of primary care services into BH sites was to embark on a pilot project with some of our larger BH organizations along with our local Managed Care Organizations (MCO's) and focus on data sharing. The intent was to gather data in "real time" about our high-need clients who are frequent utilizers of services. Through this partnership, Millennium will be better prepared to serve high-risk clientele as additional information on healthcare diagnoses and healthcare needs are identified. The efforts by this subcommittee will continue through 2016.

Millennium has also made great progress with Model 1 BH Integration. Practice Transformation Specialists have been focusing on engaging partners and assisting with achieving PCMH Level 3 2014 status, which includes BH Integration through training and support. Over the past 15 months, Millennium's Transformation Specialists have been meeting with our primary care partners to assess their PCMH Level 3 2014 status and help them work on achieving BH Integration. Staff focused on the safety-net providers with the highest volume first, and are now reaching out to additional sites throughout the region. These assessments will help integrate BH into PCP's.

Training plans are being developed for PCP's on such topics as SBIRT, Motivational Interviewing and other essential areas relevant to successful integration. Millennium Transformation Specialists will also provide instruction on how to properly bill for services, while ensuring adequate funding is in place to support outcomes.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to populations have been made at this time.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 3.a.ii Behavioral Health Crisis Stabilization Services Project

Challenges the PPS has encountered in project implementation:

The Millennium Behavioral Health Team has encountered the following challenges with the implementation of the Behavioral Health Crisis Stabilization Services project:

1. Many of our partners for this project are community-based organizations that are/were not currently billing for Medicaid services. They had a difficult time in the beginning of the project because they were not accustomed to collecting Medicaid information for reporting and/or billing purposes.

2. Overlapping counties and providers with other PPS's make it difficult to coordinate project activities.

3. Crisis Stabilization Services are not consistently reimbursed by Medicaid and require an intense level of training, time, and services provided.

4. Many partner community-based agencies either have outdated or no Electronic Health Records (EHRs).

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

1. Millennium has been trying to pair community-based agencies with larger entities that can assist them with Medicaid billing. In addition, some agencies have been engaged in training for Home and Community Based Services (HCBS) waivers and are learning about billing through that process.

2. Collaborative meetings and shared strategies have made this challenge a bit easier. Millennium has attended Finger Lakes Preferred Provider System (FLPPS) meetings and vice versa. In the near future, we need to work with FLPPS to devise a strategy for sharing any costs for shared counties/partner agencies for project requirements.

3. The reimbursement issue continues to be addressed at Managed Care Organization (MCO's) meetings. Now a HBCS waiver has been issued that allows select services to be billed.

4. An initial assessment to determine agency IT capabilities is underway.

Implementation approaches that the PPS considers a best practice:

The following indicates the implementation approach Millennium feels is best practice:

1. **Collaborating with our expert Behavioral Health partners**: Our BH partners have recommended utilizing the following best practices:

    - The Australian Model for Community Behavioral Health – Triage Scale in Emergency Departments
    - The National Institute of Health Care Excellence (NICE) guidelines on self-harm
    - The Columbia Suicide Severity Rating Scale (C-SSRS screener) with triage points

    At this time, we have included the above best practices into our draft triage tool that partner agencies have helped us to put together based on the above guidelines and best practice tools.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Millennium's Behavioral Health Team is igniting healthcare transformation by successfully engaging all eight of the County Department of Mental Health Commissioners on our community crisis stabilization project. These key stakeholders have been essential in building a comprehensive gaps and barriers analysis for hotline, mobile outreach, respite/peer services, and substance abuse services across the eight county region. In addition, representatives from hospitals, hotline, mobile outreach, substance abuse/mental health and respite service providers have been participating in bi-monthly workgroups to pinpoint needs and gaps and to address the gaps identified.

Workgroups are focusing on areas such as the development of a centralized triage tool that the partners can agree upon to utilize in the field. Initial meetings have proven to be successful; a second draft of the tool is currently in circulation and training plans are being discussed. In addition, upcoming meetings will focus on best practice treatment protocols for hotlines and mobile outreach programs.

Millennium's Behavioral Health Integration Team has partnered with bordering PPS FLPPS since four of our eight counties overlap with their PPS counties on this project. We are working collaboratively and sharing ideas, attending each other's meetings and sharing meeting formats. One of our first collaborative endeavors was to ensure adequate capturing of the gaps and barriers to Crisis Care Services across our region(s). Millennium's Behavioral Health Team will continue to work with the Finger Lakes Region to coordinate a plan to address gaps in services.

NEW YORK STATE | Department of Health

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
No changes to populations have been made at this time.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 3.b.i Implementing Evidence-Based Strategies for Cardiovascular Disease (CVD)

Challenges the PPS has encountered in project implementation:

The Millennium CVD project team has encountered the following challenges with the implementation of the CVD project:

1. A major project goal is focusing on implementing the A_B_C_S of the Million Hearts® initiative in clinical practice sites. The implementation of the ABCS of the Million Hearts® initiative for clinical care management includes, prescribing Aspirin (when appropriate), managing Blood Pressure, treatment of LDL Cholesterol using Statin therapy and addressing Smoking Cessation. The current challenge comes from the newly released clinical quality measures related to the management of cholesterol. The interventions and assessments performed within the Primary Care settings will now have to reflect these guidelines.

2. The project requires that Millennium work with practices in referring patients to lifestyle-based Chronic Disease Self-Management Workshops. However, these workshops are highly structured, cannot presently be billed for treatment of Medicaid recipients, and may not meet the needs of the patients for many reasons, such as patients with developmental disabilities, patients with co-morbid behavioral health conditions or the time commitment these workshops require for patients.

3. Referrals for Smoking Cessation will be made easier by electronic referrals to the NYS Quitline. Currently however, referrals to the NYS Quitline are not automated in the physician's Electronic Health Record (EHR). The ability to refer patients to the NYS Quitline electronically will need to be developed – and require additional resources on the part of the EHR vendor and the Primary Care Practice (PCP).

4. The clinical quality metrics and care guidelines for blood pressure management, aspirin use for primary prevention and the cholesterol management guideline have undergone changes; confusion exists among PCP's as to what entails guideline recommended care.

5. Unlike the EHR referrals for clinical treatment, there is no EHR tracking mechanism for referrals made to outside agencies to address barriers related to social determinants of health. Some practices may not have the care coordination team necessary to address such social barriers (transportation, housing, food insecurity, etc.) that play an integral role in improving health and health behaviors. Therefore, a new tracking tool will have to be used to

make and manage referrals to community-based agencies assisting with social and health barriers.

6. Data sharing between organizations is a challenge. In order to improve transitions of care, multiple providers involved in patient care must be able to share data between facilities. Now there is a push for providers to use the Regional Health Information Organization (RHIO), HEALTHeLINK (HeL), to share continuity of care documentation, laboratory test results, pharmaceutical claims and other data to have a common repository of information for providers. The data available through the RHIO, HeL will be linked to the new Millennium Population Health IT platform. However, not all practices are using the RHIO for data sharing or data collection and the patient level data available through the RHIO may not be complete.

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

1. Millennium hired Practice Transformation Specialists who focus on working with Safety Net Primary Care Practices, including Federally Qualified Health Centers (FQHCs) to implement cardiovascular program requirements. They also serve as a single point of contact for the Primary Care Practice.

2. In addition to the CDSMP workshops offered through the Quality and Technical Assistance Center (QTAC), efforts are underway to identify alternative wellness educational programs. Millennium and two other partners - the Greater Buffalo United Ministries (GRUM) and the University at Buffalo School of Nursing – have partnered to implement Million Hearts® interventions in the WNY region[1]. Millennium is also working on a training plan on topics such as Motivational Interviewing to address lifestyle goals in clinical settings.

3. The Project Lead is working closely with the NYS Quitline Team at Roswell Park and Health Systems Change Center along with the Community Partners of WNY (CPWNY) PPS to identify effective ways to refer to the NYS Quitline.

4. A CVD Best Practices Subcommittee consisting of subject matter experts from primary care and specialty cardiology is building a standardized set of best-practice recommendations that will be shared with all clinical providers.

5. The Reporting and Analytics Team is exploring options to determine a solution for referral tracking and management for non-clinical referrals/services. This referral-tracking tool will have to be flexible enough to integrate with the new population health management platform.

6. Providers are being incentivized to use the RHIO, HeL to share continuity of care documentation, laboratory test results, pharmaceutical, and other data to support sharing of data between providers and make it easier to access information for better care transitions.

[1] Greater Buffalo United Ministries, University at Buffalo School of Nursing and Millennium Collaborative care are partnering on Million Hearts® screening opportunities. Accessed on July 27th at http://www.millenniumcc.org/million-hearts-health-screenings-scheduled-for-july-16-friendship-baptist-church-july-20-ub-on-green-unity-in-the-community-care-fair-night/

A provider database is being implemented to track providers who are using EHRs and sharing data with HeL for improved coordination of care.

Implementation approaches that the PPS considers a best practice:

The following indicates the implementation approaches Millennium feels are best practice:

1. **Aligning the national Million Hearts® campaign within community and ambulatory care settings:** The goal of the CVD project is to deliver high quality chronic disease prevention and management through successful alignment of the Million Hearts® campaign. The Million Hearts® national webpage contains evidence-based resources for clinical practices including tools (videos, fact sheets and patient education), clinical protocols, and action guides that are being used to identify patients with undiagnosed hypertension and improve patient access to managing their chronic high blood pressure.

2. **Continual collaboration with partners:** The Primary Care Transformation Team is working closely with Safety Net Primary Care Practices to implement clinical treatment for Aspirin Therapy, Blood Pressure Control, Cholesterol Management and Tobacco Cessation.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The CVD/Million Hearts® Team is igniting healthcare transformation through a regional strategic community-based partnership called the Western New York Health Coalition (the Coalition). The Coalition includes the UB School of Nursing, Millennium Collaborative Care, the Western New York AHA Chapter, and the Greater Buffalo United Ministries (GRUM - a group of 58 Baptist Churches serving the WNY region). The Coalition has developed and implemented a Million Hearts® community intervention (including blood pressure screenings and health education) in high-risk zip codes in Buffalo to help lower cardiovascular risk factors in African American faith-based communities. To date, seven GRUM churches have hosted screening events and over 200 members of the community have received blood pressure screenings and education. The Coalition will use the experience to help improve future design of Million Hearts® events in WNY. This Million Hearts® community intervention is scalable and adaptable to other regions through interdisciplinary collaboration between Health Ministries, the WNY Heart Association, and a school of Higher Education. There are plans to roll out similar Million Hearts® community screenings in the Southern Tier and the Niagara Region where rates of death and morbidity due to CVD are high.

Workgroups are focusing on areas such as coordinating care for Health Home eligible recipients, and working in partnership with the IT Data Committee on health information exchange between the providers and the local RHIO, HeL. Millennium's Clinical Quality Committee is focused on improving quality of care and clinical metrics related to the Million Hearts® project. The CVD Best Practices Subcommittee is focused on treatment guidelines and workflows to implement the ABCS of the Million Hearts® initiative.

Millennium's CVD/Million Hearts® project lead has partnered with other PPS's implementing the project statewide to form a '3.b.i All-PPS collaborative'. The collaborative holds a monthly conference call to review project barriers and challenges as well as share best practices for project implementation. We are also sharing implementation strategies with our bordering PPS, CPWNY, and the regional Managed Care Organizations on activities related to the improvement of addressing tobacco cessation strategies and managing high blood pressure in PCP's. Through this partnership, the team hopes to identify barriers to care and improve the clinical care related to the CVD project.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

In addition to focusing on the population receiving care within ambulatory settings, the CVD project will focus efforts on improving transitions of care between primary care, emergency departments (ED's), hospitals and home health, and skilled nursing providers to support patients as they move from one care setting to the next. The overarching goal is to improve the management of chronic diseases and ambulatory care sensitive conditions (CVD and other associated chronic conditions including upper respiratory, diabetes, and acute conditions) within the primary care setting and avoid transfer of patients to the ED or to an inpatient setting for such preventable conditions.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 3.f.i Increase Support Programs for Maternal & Child Health

Challenges the PPS has encountered in project implementation:

The Millennium Maternal & Child Health project team has encountered the following challenges with the implementation of these support programs:

1. Training: Millennium is facing challenges in utilizing the core training requirements as outlined by the NYS Department of Health and the Maternal and Infant Community Health Collaborative (MICHC). Issues with capacity are being experienced because interested participants are unable to enroll due to such limited available space in the training sessions.

2. Early Elective Delivery Reporting: Proactive monitoring of timely data upload is difficult to monitor without access to the database in “real-time” or the ability to see the platform to enable the project manager to assist in responding to questions that users may have.

3. Data availability: Data is becoming available slowly; we only have previous year’s data to analyze. We are anxious to begin looking at more recent data to monitor outcomes and adjust project priorities.

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

1. Training: Millennium has worked directly with Cicatelli Associates, Inc. (an online learning services group for training, technical assistance and other staff development efforts) to prioritize space for new hires without previous Community Health Worker (CHW) training. The program is now shifting to the University of Rochester (the new sole source contract for the NYS Maternal and Infant Health Center of Excellence). We have met with the program director and are awaiting the program schedule.

2. Early Elective Delivery Reporting: Millennium continues to follow up with user contacts when notified of delays in data entry and has offered assistance to the sites.

3. Data availability: Millennium is working to analyze the new data as it becomes available and reports are built.

NEW YORK STATE | Department of Health

Implementation approaches that the PPS considers a best practice:

The following indicates the implementation approaches Millennium feels are best practice:

1. **Closely partnering with the lead community-based organizations on instituting a Value Based Payment (VBP) model:** These specific community-based organizations with CHWs programs typically function with philanthropic and grant funding supporting their operations. A value-based-at-risk model is a new concept for these organizations, which presents new and different challenges to their operations and the way they deliver services to the community. The arrangement includes both process and outcome metrics which include the following:
    - Enrollment
    - Smoking cessation
    - 1st prenatal visit completed
    - 1st well-child visit completed
    - Post-partum visit completed
    - Birth weight greater than 2500Gm
    - Average number of home visits (with documented goal(s) aimed at prevention and reducing adverse outcomes)

2. **Defining roles, services, and protocols:** The project team has worked diligently to assure standardization across organizations by defining the roles and services and creating protocols outlining the risks assessed at community visits. The project team also takes on the supportive role and makes referrals to assure that needs are met.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Maternal & Child Health project is igniting healthcare transformation by initiating a value- based payment arrangement with the lead community-based organizations. Millennium Collaborative Care is partnering with four lead organizations to meet the deliverables. Each of the partners has backgrounds and expertise within maternal and child health in the communities they serve. These organizations have a depth of knowledge but also reach to the areas identified in the Community Needs Assessment (CNA) with outcomes and risk for this population. These organizations include:

- Buffalo Prenatal-Perinatal Network
- Jericho Road Community Health Center
- P3 Center for Teens, Moms & Kids (Niagara Falls Memorial Medical Center)
- Southern Tier Community Health Center Network, Inc.

Each organization is fully functioning with a minimum of one CHW team (one CHW supervisor with 4-6 CHWs).

With the initial basics of the MICHC Model, the process has been outlined directing the deployment and use of the CHWs from outreach to enrollment, through home visiting to the completion of the program. This includes outlining the multiple screenings and educational opportunities that address prevention aimed to reduce avoidable poor pregnancy outcomes and hospitalizations to improve maternal and child health through the first two years of life. The development and standardization phase is nearing completion, and the focus will be shifting to outcome monitoring and improvement phase as the data becomes available.

The project team is partnering with our bordering PPS partners (Community Partners of Western New York and Finger Lakes Performing Provider System) to reduce the potential for duplication and overlap of services. The project managers meet periodically to review program advancements and the potential for partnering to assure coverage without duplication.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

The target population serves expectant mothers and mothers with a child up to two years of age. The data is utilized to identify high-risk areas for prioritizing coverage. With this information, multiple forms of outreach occur such as door-to-door education visits, referrals, workshops, outreach at street and community events, soup kitchens, food pantries, refugee reassignment agency resources, etc. Millennium will continue to monitor as more data becomes available and will adjust the program to meet the identified needs.

The program is continually assessing the needs of the population and adding to the services. An example is the issue of human trafficking. The team has created protocols involving observational evaluation techniques to identify potential signs of human trafficking situations. When a situation is detected, the CHW contacts his/her supervisor and they work together as a team with the appropriate referral agency to address the concern with trained personnel who are knowledgeable about safety considerations and who have the expertise needed for appropriate intervention.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 4.a.i Promote Mental, Emotional, and Behavioral Well-Being in Communities (MEB project)

Challenges the PPS has encountered in project implementation:

The Millennium Behavioral Health Team has encountered the following challenges with the implementation of the MEB project:

1. Millennium collaborates with Community Partners of WNY (CPWNY) on the MEB project. The main challenge the team experienced was related to the delay of signing of contracts between the two PPS entities (Millennium and CPWNY). Due to this delay, the following challenges have arisen:
    a. Most of our community partners could not implement school-based programs as scheduled. School programs typically begin in the fall/spring; therefore, school administrators were not open to starting new programming in the final quarter of the school year.
    b. Community-based partners were lacking the initial resources and financial support typically needed to sufficiently build capacity for personnel and technical assistance to ensure fidelity, monitoring, supervision, and sustainability of programs.

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

1. The partners are working with school administrators to begin evidence-based programming in the fall. Individualized service plans are being developed for each school outlining their desired program and dates for implementation.

2. The contracts have been issued and signed with the community partner organizations. The hiring of personnel is underway and plans to deliver programs and resources are in development.

NEW YORK STATE | Department of Health

Implementation approaches that the PPS considers a best practice:

The following indicates the implementation approach Millennium feels is best practice:

1. **Identifying evidence-based practices and environmental strategies:** Millennium has identified evidence-based practices and environmental strategies that promote mental, emotional, and behavioral well-being. These programs are recognized on the National Substance Abuse and Mental Health Services Administration (SAMHSA) registry of effective programs and practices and include:
    - Too Good For Violence
    - Too Good For Drugs
    - Wellness in the Workplace
    - Strengthening Families
    - Compeer
    - Project Northland
    - Ripple Effects
    - Alcohol Literacy Challenge
    - Challenging College Alcohol Abuse
    - Atlas and Athena
    - Teen Intervene
    - An Apple A Day
    - Building Skills
    - Botvin's Life Skills Program

    In addition, information and referral services are included in the plan along with a community-based public awareness campaign that aims to focus on the areas identified in the WNY Community Needs Assessment.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Behavioral Health Team is igniting healthcare transformation by engaging a variety of community-based organizations and primary care practices (PCPs) throughout the eight WNY counties. Millennium's MEB team formed new partnerships and held its first of many MEB Community Conversations in late spring. Faith-based groups, community-based organizations, law enforcement, and County Health Officials took part in this community event. In addition, Millennium has been working alongside CPWNY to ensure the expanded delivery of SAMHSA's evidence-based programs and practices throughout the eight counties of WNY.

Millennium's Mental, Emotional and Behavioral Well-Being workgroup is divided into three subcommittees, which includes a substance abuse prevention workgroup, mental health promotion workgroup and a media subcommittee. The substance abuse prevention workgroup consists of a partnership between Millennium and the WNY Chemical Dependency Consortium. The team convenes monthly to address best practices, policy issues, and community norms to enhance the effective delivery of services to our community. The workgroup has representation from all eight counties served.

The Mental Health Promotion subcommittee meets approximately every six weeks to discuss and plan mental health promotion programming across the region. Thus far, a number of Mental Health First Aid Trainings have been scheduled and delivered across the region due to the efforts of this subcommittee. The group is expanding to include additional trainings for law enforcement and school officials.

Millennium's Mental and Emotional Behavioral Well-Being Team has partnered with The Erie County Council for the Prevention of Alcohol and Substance Abuse (ECCPASA) and the Mental Health Association (MHA) of Erie County as the lead agencies that will help plan and implement a comprehensive array of school and community evidence-based programs. The MHA of Erie County serves as the lead entity for the mental health promotion component of the project and manages the public awareness campaign, which will reach all eight WNY counties. MHA has hired a Director of Community Awareness to coordinate the media aspect, along with a creative team of independent contractors who will assist with concept development and the strategic launch of the public awareness campaign. The team is concurrently working with ECCPASA, Millennium, CPWNY, and other partner agencies to establish the community-wide public awareness campaign, which aims to change the pervasive negativity toward those facing mental health and/or substance abuse challenges.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

No changes to populations have been made at this time.

NEW YORK STATE | Department of Health

DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Millennium Collaborative Care

Project: 4.d.i Reduce Premature Births

Challenges the PPS has encountered in project implementation:

The Millennium Maternal & Child Health project team has encountered the following challenges with the implementation of programs to reduce premature births:

1. Data availability: Data is becoming available slowly; we only have previous year's data to analyze. We are anxious to begin looking at more recent data to monitor outcomes and adjust project priorities.

2. Change Theory: Although difficult, change and transformation are needed in order for the project to deliver on its expected outcomes. The entire healthcare team must be engaged in the process for change to occur and the project to succeed. This includes a shared commitment and involvement by the entire team: patient, family, care providers, therapists, social workers, paraprofessionals, and community health care workers.

3. Standards of care: Physicians and practices have different approaches to meeting the standards of care. As a result, there is no consistency in documentation across organizations.

Efforts to mitigate challenges identified above:

The following reflect our efforts to mitigate these challenges:

1. Data availability: Millennium is working to analyze the new data as it becomes available and reports are built.

2. Change Theory: Millennium has partnered with multiple levels of providers, provider types and community partners to take a lead role in facilitating the process of evaluating, innovating and designing the change process. It is recognized that change will be difficult, yet Millennium is working to strategically align all the partners and supporting organizations within all phases of the work to be done.

3. Standards of care: Millennium has formed a best practice team to compile and compare the information existing across the various organizations creating standards of care. The team is working to combine and recommend standards that will be shared in draft form with all providers. In an effort to build consensus, a timeframe will be integrated into the process allowing for questions and feedback from providers before the final standards are established as the process progresses and is finalized.

NEW YORK STATE | Department of Health

Implementation approaches that the PPS considers a best practice:

The following indicates the implementation approach Millennium feels is best practice:

1. **Creating Advisory Workgroups:** The Maternal & Child Health Team has created one advisory workgroup for both Maternal & Child Health projects. This team is comprised of different types and levels of healthcare providers with clinical expertise and paraprofessionals, along with community-based organizations, with common goals and/or expertise in this type of work. Together, the partnership will serve to provide the expertise needed to advise the projects and the work teams in order for them to complete the requirements in meeting project deliverables.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Maternal & Child Health Team is igniting healthcare transformation through a shared vision and common goals across projects. Millennium Collaborative Care is partnering to transform care with the formation of an active team of practitioners (including Regional Perinatal Center, representatives for the Central, Northern and Southern regions of WNY and different practice types) to develop best practice standards and the steps toward regional adoption and monitoring. The first step was the completion of a charter to outline the roles and expectations. This will be followed by the work needed to compare the various standards to develop a common document.

Transformation of the practice level of care is also in progress. A diverse team was formed to evaluate evidenced-based and promising models of care. This team evaluated 14 innovative models aimed at improving poor pregnancy-related outcomes and has developed a pilot project proposal for practice transformation. The pilot will combine the evidence-based model of group care with the promising model of the Priscilla Project, a volunteer mentoring program for expectant mothers at risk of experiencing birth complications. Millennium is in the process of making a decision and identifying the pilot sites.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

Millennium is utilizing the Community Needs Assessment and prevention agenda data to determine the best alignment for pilot partners. The data reflects that the highest volume of adverse pregnancy-related outcomes (low birth weight and premature births) occur in Erie County; this is followed by Niagara County; and the highest % occurs in Cattaraugus County. Therefore, pilot projects will be targeted to align with these identified areas of need: two in Erie County, one in Niagara County, and one in Cattaraugus County.