Domain 2*: System Transformation Projects*

Project ID*: 2.a.i*

Project Title*: Creating an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management*

Objective:

Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management.

Description:

This project will require an organizational structure with committed leadership, clear governance and communication channels, a clinically integrated provider network, and financial levers to incentivize and sustain interventions to holistically address the health of the attributed population and reduce avoidable hospital activity. For this project, avoidable hospital activity is defined as potentially preventable admissions and readmissions (PPAs and PPRs) that can be addressed with the right community-based services and interventions. This project will incorporate medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system – from one that is institutionally-based to one that is community-based. 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.

Actively Engaged Patients for DSRIP Reporting Purposes:

N/A (DSRIP Project Implementation and Patient Engagement Speed and Scale requirements do not apply to Project 2.a.i.)

Providers Expected to Participate:

All members of BPHC are required to participate in the integrated provider network, as a prerequisite to involvement in other DSRIP projects. This includes primary care physicians, non PCP practitioners, hospitals, clinics, health homes / care management organizations, behavioral health / substance abuse treatment providers, skilled nursing facilities / nursing homes, pharmacies, hospice, community based organizations, and others.

Project Milestones
All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use

standards by the end of DY 3.
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.