MILLENNIUM
COLLABORATIVE CARE

Care for the Future

June 12, 2015

ED Overcrowding: A Symptom of the Underlying Disease

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Who are we?

- Millennium Collaborative Care (MCC) is a Performing Provider System (PPS) with over 231,00 attributed lives
- Over 400 hospital and health provider partners throughout the 8 counties of Western New York
- Diverse network of community based organizations
- Collaborating with:
  - Catholic Medical Partners on several projects
  - Finger Lakes PPS on overlapping counties
  - Community based organizations and unions

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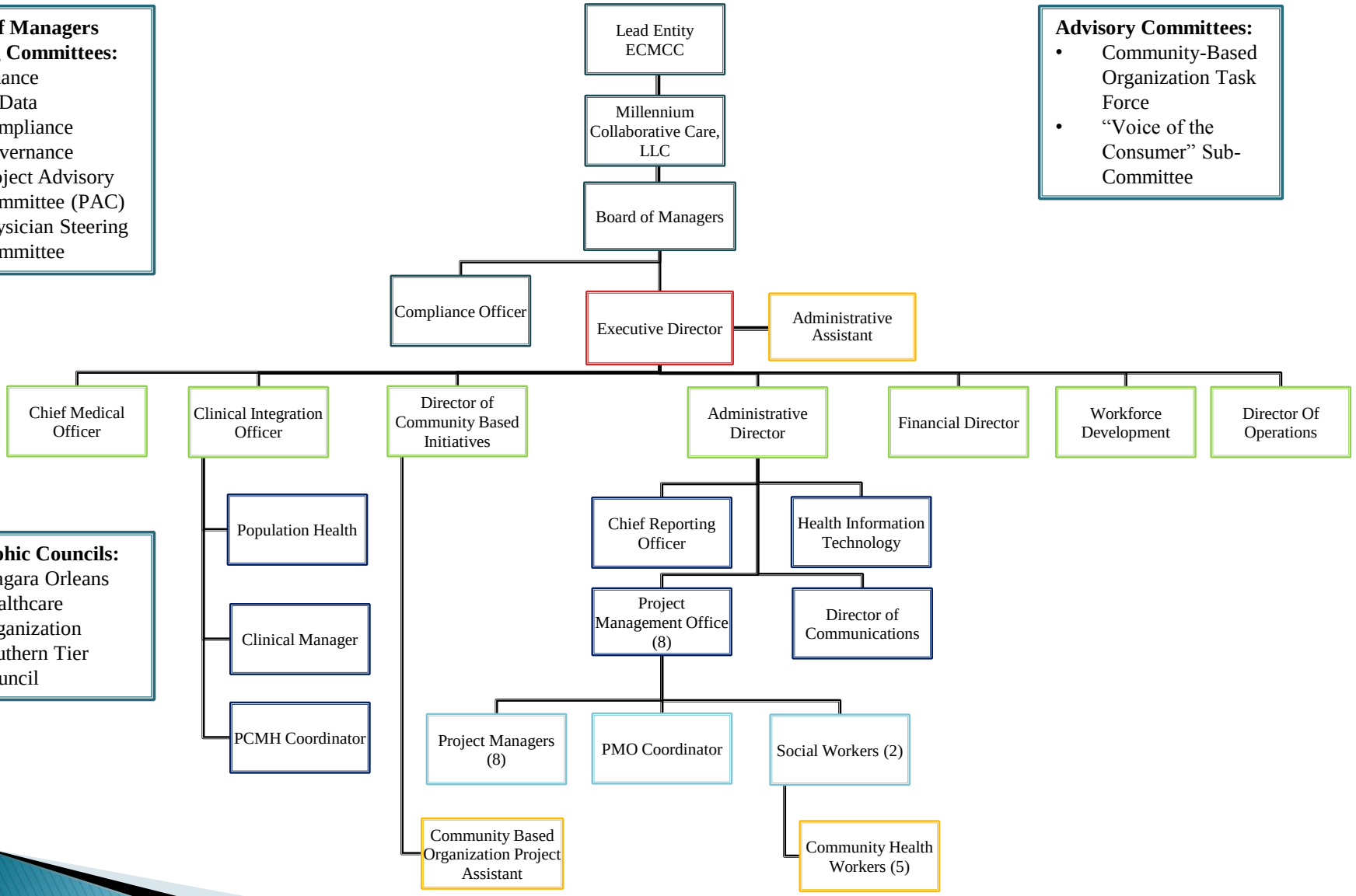
Millennium Collaborative Care, PPS Organization Chart

Board of Managers Steering Committees:
- Finance
- IT Data
- Compliance
- Governance
- Project Advisory Committee (PAC)
- Physician Steering Committee

Advisory Committees:
- Community-Based Organization Task Force
- "Voice of the Consumer" Sub-Committee



Geographic Councils:
- Niagara Orleans Healthcare Organization
- Southern Tier Council

Revised 6/8/15

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11 Projects – Many Moving Parts!

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Integrated Delivery System

- Must integrate all medical, behavioral, post-acute, long term care & community-based services (social determinants of health)
- Actively share health information with RHIO/SHIN-NY (and clinical partners, includes secure notification/ messaging
- All EHRs must meet Meaningful Use & PCMH Level 3 standards
- Achieve 2014 Level 3 PCMH primary care certification

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Emergency Department Triage

- Develop processes & procedures to establish connectivity between ED & community PCPs
- Ensure real time notification to Health Homes
- Patient Navigators assist patients presenting with minor illness:
  - Schedule a timely follow-up appointment with a PCP
  - Assist patient with needed community support resources (social determinants of health)
- Allow ED & first responders to transport patients to alternate care sites/"treat & street" (optional)

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INTERACT (Inpatient Transfer Avoidance Program for SNF)

- Champion at each facility
- Develop care pathways & other clinical tools for monitoring chronically ill patients with goal of early identification & intervention to avoid hospital transfer
- Develop advanced care planning tools to document patient near/end of life wishes (e/MOLST)
- Educate all staff, patients & family/caretakers
- Establish enhanced communication with acute care hospitals
- Use EHRs & other technical platforms to track all patients, measure outcomes, QI

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Hospital-Home Care Collaboration

- Implement INTERACT-like program in the home care setting to reduce risk of re-hospitalization for high risk patients
- Assemble rapid response teams to facilitate patient discharge and community services
- Develop advanced care planning tools to document patient near/end of life wishes (e/MOLST)
- Integrate primary care, behavioral health, pharmacy and other services into the model
- Utilize telehealth/telemedicine
- Measure outcomes (QA/root cause analyses)

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Patient Activation Measure (PAM)

- Challenging populations of uninsured, low and non utilizers
- Partner with Community Based Organizations
- Increase volume of non-emergent care (primary, behavioral, dental) to Primary Care Providers
- Train providers in PAM & patient activation techniques such as shared decision-making, measurements of health literacy & cultural competency

Integration of Primary Care & Behavioral Health/Substance Abuse Services

- Co-locate behavioral health services at primary care practice sites and vice versa
- Develop collaborative evidence-based standards of care including medication management
- Conduct preventive care screenings
- Use IMPACT model (Improving Mood – Providing Access to Collaborative Treatment)

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Behavioral Health Community Crisis Stabilization Services

- Implement crisis intervention outreach, mobile crisis, intensive crisis services & deploy mobile crisis team(s) that use evidence-based protocols
- Establish clear linkages with Health Homes, emergency departments & hospitals to divert patients
- Expand access to observation unit within hospital outpatient or off campus crisis residence for stabilization monitoring (up to 48 hours)
- Ensure electronic medical records connectivity
- Use HIE & technology to track patients, quality, performance metrics

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Cardiovascular Health – Million Hearts Project

- Implement evidence-based strategies in ambulatory and community care setting
- Adopt & follow standardized treatment protocols for hypertension and elevated cholesterol
- Develop care coordination teams including nurses, pharmacists, dieticians & community health workers to address lifestyle changes, medication adherence, health literacy issues & patient self-efficacy & confidence in self-management

Increase Support Programs for Maternal & Child Health

- Reduce avoidable poor pregnancy outcomes & subsequent hospitalization, as well as improve maternal & child health through 1st 2 years of child's life
- Implement CHW Maternal & Infant Community Health Collaborative (MICHC)
- Coordinate with MA MCOs
- Use EHR & other technology to track all patients

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Promote Mental, Emotional, and Behavioral (MEB) Well-Being

- Pre-K to 8th grade evidence-based classroom programing
- High school intervention assistance (immediate counseling & information & referral) for signs of drug abuse
- Media campaign, Mental Health First Aid project, other community-based services for adults

Reduce Premature Births

- Work with paraprofessionals including peer counselors, lay health advisors & CHWs to reinforce health education, healthcare service utilization & enhance social support to high-risk pregnant women
- Implement practices to expedite enrollment of low-income women in Medicaid
- Utilize HIE to facilitate more robust intake/enrollment, screening/risk assessment, referral, follow-up & care coordination across health & human service providers including Health Homes
- Refer high-risk pregnant women to home visiting services in the community

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