Care For The Future
Igniting Change; Driving Results
We’ve Come a Long Way…

• In 273 days !!!
  – 8 months and 29 days
  – 39 weeks
  – 6,552 hours
  – 393,120 minutes
  – 23,587,200 seconds

• SEPT. 30 = mid-point of DY2

Igniting Healthcare Change in WNY
Vision
Millennium Collaborative Care will be a champion for the underserved population, an innovator, and healthcare transformer.

Mission
Millennium Collaborative Care is a diverse, innovative, community-based collaboration to enable healthier people, better care, and smarter spending for all in Western New York.
Streamlining Governance

Igniting Healthcare Change in WNY
Streamlining Governance

Board of Managers

Governing Bodies
• Compliance/Governance Committee
• Physician Steering Committee
• Finance Committee
• Clinical Quality Committee

Geographic Councils
• Niagara Orleans Healthcare Organization
• Southern Tier Council

Advisory Entities
• Community-Based Organizations Task Force
• IT Data Committee
• Project Advisory Committee
• “Voice of the Consumer” Sub-Committee
• Workforce Development Work Group
Representatives of Community-Based Organizations Task Force to attend
Building Organizational Sustainability: People Strategy
New Integrated Approach

Igniting Healthcare Change in WNY
Igniting Change through…
Community-Based Organizations

- Maternal & Child Health
- Since November of 2015, we have enrolled more than 500 mothers or expectant mothers into the Community Health Worker Home Visiting Program.

Igniting Healthcare Change in WNY
Igniting Change through…
Faith-Based Organizations

- Million Hearts®
- National Best Practice Program
- Cardiovascular Disease Prevention
  - Greater Buffalo United Church Ministries
  - University at Buffalo School of Nursing
  - Kenneth Lee Gayles, M.D., Cardiologist, Gayles Medical; Project Champion

To date, over 222 participants have participated in screenings held at seven churches and one community event.
Igniting Change through... Law Enforcement

 Buffal o P o l i c e D e l t a D i s t r i c t
 COMMUNITY DAY!

FREE HOT DOGS & BEVERAGES!

2 NEW BIKES TO BE RAFFLED!

INFORMATIONAL TABLINGS & SO MUCH MORE!

THURSDAY
AUGUST 18
3-7PM AT RIVERSIDE PARK
(TONAWANDA & Vulcan ST)

For more information contact Community Police 851-5022 or Delilah Lombardo 877-3910

Igniting Healthcare Change in WNY
Since August 2015, over 15,000 recipients have participated in the Millennium Patient Activation Measure® (PAM®) process to identify the motivations of recipients (uninsured, non and under-utilizing populations) to seek healthcare.
Igniting Change through…
County Governments

Igniting Healthcare Change in WNY
Igniting Change through... County Mental Health

ACASA Allegany Council on Alcoholism & Substance Abuse, Inc.

Igniting Healthcare Change in WNY
Igniting Change through…
Funds Flow

• $3M in direct contracts to providers and CBOs
  – Funded 78 Community Health Workers

Igniting Healthcare Change in WNY
Igniting Change through…
Funds Flow

• Master Participation Agreements (MPA)/Contracts to Safety Net Providers
  – Distributed $10 M in DY1
  – Distributing $12 M for DY2
DY1–2 Partners

- Primary Care/Clinics: 15 (DY1) vs. 38 (DY2)
- Behavioral Health: 7 (DY1) vs. 14 (DY2)
- Hospitals: 4 (DY1) vs. 8 (DY2)
- Skilled Nursing Facilities: 49 (DY1) vs. 32 (DY2)
- Home Health Agencies: 3 (DY1) vs. 7 (DY2)

Igniting Healthcare Change in WNY
Sustainability: DSRIP Funding vs. Millennium Budget

Total project budget: $149

Not included in budget

- $42.5
- $51.5

Total Award: $243

- Unexpected Payments (Less likely to earn)
- Moderate Risk Payments
- Expected Payments (Guaranteed or likely to earn)

Igniting Healthcare Change in WNY
DSRIP Year 1 Scorecard Summary

• Achieved 98% of required deliverables
  – 579 out of 591 Achievement Values (AVs)
  – 1 deliverable, for Cultural Competency/Health Literacy, was not accepted by the independent assessor in the third quarter

• Achieved 98% of possible funds
  – $29.8M out of $30.3M
Sustaining/Increasing Change

Anthony J. Billittier IV, MD, FACEP
Chief Medical Officer
Four Areas of Change Necessary for Success

- Value-based payment
- Fee-for-service to population health management
- Education
- Motivation
- Incentives
- Care management
- Community-based organizations
- Public health
- Health homes
- Delivery System
- 11 projects and workstreams
- Transformation projects
- Master participation agreements

Payment System
- Value-based payment
- Fee-for-service to population health management

Provider Behavior
- Education
- Motivation
- Incentives

Patient Behavior
- Care management
- Community-based organizations
- Public health
- Health homes

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Population Health Challenge

+ 250,000 Medicaid lives

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Data Strategy: Cerner HealtheIntent

- Other providers’ EMRs
  - ADT, CCDs, and care plans
- ECMC
  - MEDITECH clinical data
  - Allscripts clinical data
- Kaleida Health
  - Cerner Millennium clinical data
- Project Catalyst
  - Cerner HealtheIntent
  - Enterprise data warehouse
- Millennium outputs:
  - Insights into action
    - Risk stratification
    - 22 patient registries
    - Action lists
    - DSRIP and other standard reporting
    - Ad hoc reporting
    - Analytics
- HEALTHeLINK
- Service providers
  - Lab results
  - Radiology results
- New York State
  - Medicaid member file
  - Medicaid claims files

Igniting Healthcare Change in WNY
Integrating the Delivery System
The Future: Health Homes

Health Homes are not a place. They are \textbf{FREE} community care management services. Health Homes serve eligible high need/high cost Medicaid beneficiaries with multiple and chronic conditions.
What is a Health Home?

- A Medicaid care management service model in which:
  - All individuals’ caregivers communicate with each other
  - All individuals’ needs are addressed
- Care is coordinated by a care manager who oversees and helps provide access to needed services to:
  - Ensure improved health
  - Avoid ER visits and hospital stays
- Various organizations provide services that will help that individual achieve their goal to stay healthy
- **Collectively these services are called a Health Home**

Reference: health.ny.gov
What is a Health Home? (continued)

- Participation is not mandatory but is encouraged.
- The Health Home benefits the individual as a whole, not just his or her chronic conditions.
- The care manager helps develop a care plan that is consistent with the goals of the individual.
- It is free of charge.
Eligible Population

- Medicaid eligible AND:
  
  Either

  - 2 chronic conditions (asthma, diabetes, COPD, obesity, substance abuse impacting patient’s ability to function, etc.)

  OR

  - 1 single qualifying condition:
    - HIV/AIDS
    - Serious mental illness (bipolar disorder, schizophrenia, etc.)
Determinants of Medical, Behavioral, and/or Social Risk Can Include:

- Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission)
- Lack of or inadequate social/family/housing support
- Lack of or inadequate connectivity with healthcare system
- Non-adherence to treatments or medication(s) or difficulty managing medications
- Recent release from incarceration or psychiatric hospitalization
- Deficits in activities of daily living such as dressing or eating
- Learning or cognition issues
How Do Health Homes Work?

- **Patients can be referred by:**
  - Primary care providers
  - Managed care organizations
  - **Any provider organization**
  - NYS Department of Health
  - Emergency departments
  - Inpatient/outpatient providers
  - Self referrals

- Patients are assigned a care manager who provides person-centered navigation of both:
  - Healthcare services
  - Social determinants of health needs (assisting with linkage to housing, transportation, behavioral health, nutrition, social services, etc.)

- **PCP relationship is retained**
Why a Health Home?

- Helps patients with complex medical, behavioral, and long-term needs navigate the healthcare system more effectively.
- Goal: to improve their health, stay linked with their PCP, and decrease healthcare costs.
- Core services free to patients include:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care
  - Referrals to community and social supports
  - Use of health information technology (HIT) to link services
Health Home Providers in WNY

- **Greater Buffalo United Accountable Healthcare Network:** GBUAHN (www.gbuahn.org)
- **Health Home Partners of WNY:** HHPWNY (healthhomewny.com)
  - Catholic Health
  - Spectrum Human Services
  - Evergreen Health Services of WNY
- **Health Homes of Upstate New York:** HHUNY (carecoordination.org)
  - Western: Lake Shore Behavioral Health
  - Southern: Chautauqua County Dept. of Mental Hygiene
- **Niagara Falls Memorial Medical Center:** NFMMC (nfmmcm.org)
Coming Soon!  
A Health Home for Children

- Targeted Start Date: 12/1/2016
- Eligibility: 2 or more chronic conditions OR one medical condition and risk of a second OR serious mental illness
- Age: Newborn to 18 years
- Children’s Health Homes in WNY will include:
  - Kaleida Health’s Oishei Healthy Kids
  - Encompass
  - Children’s Health Home of Western New York (CHHWNY)
  - Niagara Falls Memorial Medical Center (NFMMC)
How to Make a Referral

- Use Universal Referral Form which is available on MCO websites and Health Home websites
- Contact Health Home directly via website or phone