Care for the Future

June 12, 2015
ED Overcrowding: A Symptom of the Underlying Disease
Millennium Collaborative Care (MCC) is a Performing Provider System (PPS) with over 231,000 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
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

Chief Medical Officer
Clinical Integration Officer
Director of Community Based Initiatives
Director of Community Based Organization Project Assistant
Population Health
Clinical Manager
PCMH Coordinator

Clinical Officer
Chief Reporting Officer
Project Management Office (8)

Administrative Director
Chief Health Information Technology Officer
Director of Communications
Project Managers (8)
PMO Coordinator
Social Workers (2)

Administrative Assistant
Financial Director
Workforce Development
Director Of Operations

Revised 6/8/15
11 Projects – Many Moving Parts!
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
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)
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
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)
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)
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
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
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